Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission (HSCRC or Commission) is required to collect community benefit information from individual hospitals in Maryland and compile it into an annual statewide, publicly available report. The Maryland General Assembly updated §19-303 of the Health General Article in the 2020 Legislative Session (HB1169/SB0774), requiring the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments. The reporting is split into two components, a Financial Report and a Narrative Report. This reporting tool serves as the narrative report. Detailed reporting instructions have been distributed to your hospital's community benefit contacts, and additional copies can be requested at the email below.

In this reporting tool, responses are mandatory unless specifically marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCBHelp@hilltop.umbc.edu.

Q2. Section I - General Info Part 1 - Hospital Identification

Q3. Please confirm the information we have on file about your hospital for the fiscal year.

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Mercy Medical Center	◉	○	
Your hospital's ID is: 210008	◉	○	
Your hospital is part of the hospital system called None	◉	○	
The primary hospital community benefit (HCB) Narrative contact at your hospital is Elinor Petrocelli	◉	○	
The primary HCB Narrative contact email address at your hospital is epetrocelli@mdmercy.com	◉	○	
The primary HCB Financial report contact at your hospital is Elinor Petrocelli	◉	○	
The primary HCB Financial report contact email at your hospital is epetrocelli@mdmercy.com	◉	○	

Q4. Please select the community health statistics that your hospital uses in its community benefit efforts.

- ☑ Median household income
- ☑ Percentage below federal poverty level (FPL)
- ☑ Percent uninsured
- ☐ Percent with public health insurance
- ☐ Percent with Medicaid
- ☐ Mean travel time to work
- ☐ Percent speaking language other than English at home
- ☑ Race: percent White
- ☑ Race: percent Black
- ☑ Ethnicity: percent Hispanic or Latino
- ☑ Life expectancy
- ☐ Crude death rate
- ☐ Other

Q5. Please describe any other community health statistics that your hospital uses in its community benefit efforts.

Statistics can be found in our Community Health Needs Assessment https://mdmercy.com/about-mercy/policies-and-documents/community-health-needs-assessment

Q6. Attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Q7. Section I - General Info Part 2 - Community Benefit Service Area

Q8. The next group of questions asks about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

Q9. Please select the county or counties located in your hospital's CBSA.

- [ ] Allegany County
- [ ] Anne Arundel County
- [x] Baltimore City
- [ ] Baltimore County
- [ ] Calvert County
- [ ] Caroline County
- [ ] Carroll County
- [ ] Cecil County
- [ ] Charles County
- [ ] Dorchester County
- [ ] Frederick County
- [ ] Garrett County
- [ ] Harford County
- [ ] Howard County
- [ ] Kent County
- [ ] Montgomery County
- [ ] Prince George's County
- [ ] Queen Anne's County
- [ ] Somerset County
- [ ] St. Mary's County
- [ ] Talbot County
- [ ] Washington County
- [ ] Wicomico County
- [ ] Worcester County

Q10. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q11. Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q12. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

- [ ] 21201
- [ ] 21202
- [ ] 21203
- [ ] 21205
- [ ] 21206
- [ ] 21207
- [ ] 21208
- [ ] 21209
- [ ] 21210
- [ ] 21211
- [ ] 21212
- [ ] 21213
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- [ ] 21236
- [ ] 21237
- [ ] 21239
- [ ] 21251
- [ ] 21263
- [ ] 21270
- [ ] 21278
- [ ] 21281
- [ ] 21287
- [ ] 21290

Q13. Please check all Baltimore County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q14. Please check all Calvert County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q15. Please check all Caroline County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q16. Please check all Carroll County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q17. Please check all Cecil County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q18. Please check all Charles County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q19. Please check all Dorchester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q20. Please check all Frederick County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q21. Please check all Garrett County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q22. Please check all Harford County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q23. Please check all Howard County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q24. Please check all Kent County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q25. Please check all Montgomery County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q26. Please check all Prince George's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q27. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q28. Please check all Somerset County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q29. Please check all St. Mary's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q30. Please check all Talbot County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q31. Please check all Washington County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q32. Please check all Wicomico County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q33. Please check all Worcester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

- [ ] Based on ZIP codes in your Financial Assistance Policy. Please describe.

- [ ] Based on ZIP codes in your global budget revenue agreement. Please describe.

- [x] Based on patterns of utilization. Please describe.

Mercy defined its CHNA 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), 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

- [ ] Other. Please describe.

Q35. Provide a link to your hospital's mission statement.

https://mdmercy.com/about-mercy/our-mission

Q36. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

Q37. Section II - CHNAs and Stakeholder Involvement Part 1 - Timing & Format

Q38.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- (●) Yes
- ( ) No

Q39. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q40. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

06/01/2021

Q41. Please provide a link to your hospital's most recently completed CHNA. Please provide the entire CHNA, not just an Executive Summary.

https://mdmercy.com/about-mercy/policies-and-documents/community-health-needs-assessment

Q42. Please upload your hospital's most recently completed CHNA. Please provide the entire CHNA, not just an Executive Summary.

2021_CHNA_FINAL cbrfile.pdf
5.6MB
application/pdf

Q43. Section II - CHNAs and Stakeholder Involvement Part 2 - Internal CHNA Partners

Q44. Please use the table below to tell us about the internal partners involved in the development of your most recent CHNA.

	CHNA Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
CB/ Community Health/Population Health Director (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
CB/ Community Health/ Population Health Director (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (facility level)	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Clinical Leadership (facility level)	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	

Clinical Leadership (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Population Health Staff (facility level)	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Population Health Staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Community Benefit staff (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Community Benefit staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Physician(s)	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Nurse(s)	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Social Workers	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:

Q45. Section II - CHNAs and Stakeholder Involvement Part 3 - Internal Hospital Community Benefit Partners

Q46. Please use the table below to tell us about the internal partners involved in your community benefit activities during the fiscal year.

	Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
CB/ Community Health/ Population Health Director (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (facility level)	☐	☐	☑	☑	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Clinical Leadership (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Clinical Leadership (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Population Health Staff (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Physician(s)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Nurse(s)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Workers	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q47. Section II - CHNAs and Stakeholder Involvement Part 4 - Meaningful Engagement

Q48. Community participation and meaningful engagement is an essential component to changing health system behavior, activating partnerships that improve health outcomes and sustaining community ownership and investment in programs. Please use the table below to tell us about the external partners involved in your most recent CHNA. In the first column, select and describe the external participants. In the second column, select the level of community engagement for each participant. In the third column, select the recommended practices that each stakeholder was engaged in. The Maryland Hospital Association worked with the HSCRC to develop this list of eight recommended practices for engaging patients and communities in the CHNA process.

Refer to the FY 2023 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is mandatory for FY 2023.

	Level of Community Engagement						Recommended Practices							
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals -- Please list the hospitals here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Departments -- Please list the Local Health Departments here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Improvement Coalition -- Please list the LHICs here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Maryland Department of Health	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other State Agencies -- Please list the agencies here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Govt. Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Faith-Based Organizations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - K-12 -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - Colleges, Universities, Professional Schools -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Behavioral Health Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Social Service Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Post-Acute Care Facilities -- please list the facilities here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Community/Neighborhood Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other -- If any other people or organizations were involved, please list them here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q49. Section II - CHNAs and Stakeholder Involvement Part 5 - Follow-up

Q50. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (●) Yes
- ( ) No

Q51. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

06/01/2021

Q52. Please provide a link to your hospital's CHNA implementation strategy.

https://mdmercy.com/about-mercy/policies-and-documents/community-health-needs-assessment

Q53. Please upload your hospital's CHNA implementation strategy.

2021_CHNA_FINAL cbrfile.pdf
5.6MB
application/pdf

Q54. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q55. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q56. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q57. Section II - CHNAs and Stakeholder Involvement Part 6 - Initiatives

Q58. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- (●) Yes
- ( ) No

Q59.
Using the checkboxes below, select the Community Health Needs identified in your most recent CHNA that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q60. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q61. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

The hospital tracks disparities in our key focus areas of maternal health and readmissions

Q62. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

- [x] None
- [ ] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program
- [ ] The COVID-19 Long-Term Care Partnership Grant
- [ ] The COVID-19 Community Vaccination Program
- [ ] The Population Health Workforce Support for Disadvantaged Areas Program
- [ ] Other (Describe)

Q63. (Optional) If you wish, you may upload a document describing your community benefit initiatives in more detail.

Q64. Section III - CB Administration

Q65. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- [x] Yes, by the hospital's staff
- [ ] Yes, by the hospital system's staff
- [ ] Yes, by a third-party auditor
- [ ] No

Q66. Please describe the third party audit process used.

This question was not displayed to the respondent.

Q67. Does your hospital conduct an internal audit of the community benefit narrative?

- ( ) Yes
- (•) No

Q68. Please describe the community benefit narrative audit process.

This question was not displayed to the respondent.

Q69. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- (•) Yes
- ( ) No

Q70. Please explain:

This question was not displayed to the respondent.

Q71. Does the hospital's board review and approve the annual community benefit narrative report?

- (•) Yes
- ( ) No

Q72. Please explain:

This question was not displayed to the respondent.

Q73. Does your hospital include community benefit planning and investments in its internal strategic plan?

- ( ) Yes
- (•) No

Q74. Please describe how community benefit planning and investments were included in your hospital's internal strategic plan during the fiscal year.

This question was not displayed to the respondent.

Q75. If available, please provide a link to your hospital's strategic plan.

This question was not displayed to the respondent.

Q76. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- [ ] Diabetes - Reduce the mean BMI for Maryland residents

- [x] Opioid Use Disorder - Improve overdose mortality

Mercy's detox program contributes to the reduction of opioid mortality through inpatient and outpatient referrals.

- [x] Maternal and Child Health - Reduce severe maternal morbidity rate

Mercy Medical Center outlines many programs as part of the community benefit report that align with maternal child health initiatives including helping to reduce maternal morbidity rate, infant low birth rate, and provide equitable access to prenatal care.

- [ ] Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17

- [ ] None of the Above

Q77. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q78. Section IV - Physician Gaps & Subsidies

Q79. (Optional) Please attach any files containing further information and data justifying physician subsidies at your hospital.

(This year, all information on physician gap subsidies is collected on the financials. However, if you have additional information on these subsidies to report, you may do so through attachments here.)

Q80. Section V - Financial Assistance Policy (FAP)

Q81. Upload a copy of your hospital's financial assistance policy.

MMC Patient Financial Assistance Policy 923 (1).pdf
3.2MB
application/pdf

Q82. Provide the link to your hospital's financial assistance policy.

https://mdmercy.com/patients-and-visitors/billing-and-insurance/financial-assistance

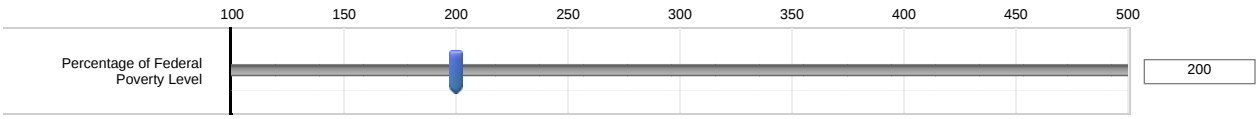
Q83. Has your FAP changed within the last year? If so, please describe the change.

- ◯ No, the FAP has not changed.

◉ Yes, the FAP has changed. Please describe: Services eligible under this policy section added which defines “medically necessary care” and exclusions. A section was updated to include the availability of payment plans to all patients that are MD residents and provides the link that goes directly to MMC’s Financial Assistance page. Changes to a Patient’s Eligibility, Reconsideration Requests, and Refunds sections were added.

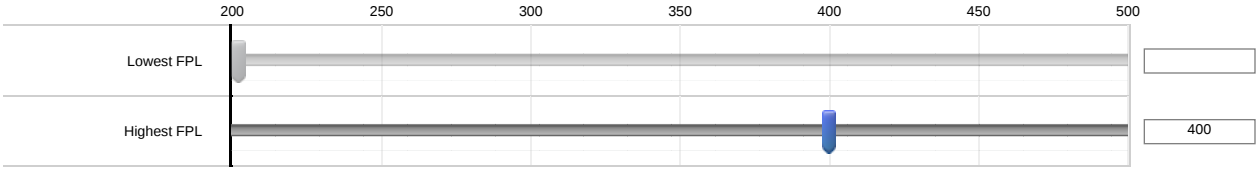
Q84. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

Please select the percentage of FPL below which your hospital’s FAP offers free care.



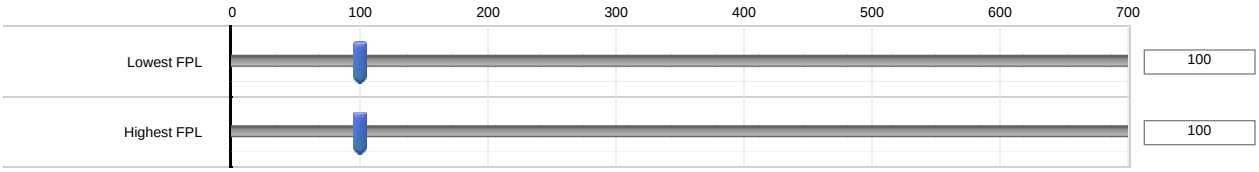
Q85. Maryland acute care and chronic care hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

Please select the range of the percentage of FPL for which your hospital’s FAP offers reduced-cost care.

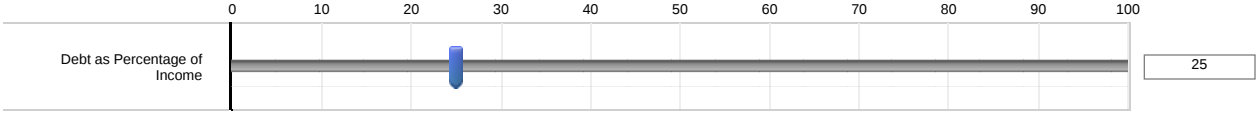


Q86. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3)(a) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship.



Q87. Please select the threshold for medical debt as a percentage of family income above which qualifies as a financial hardship.



Q88. Section VI - Tax Exemptions

Q89. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding taxable year (select all that apply)

- [x] Federal corporate income tax
- [x] State corporate income tax
- [x] State sales tax
- [x] Local property tax (real and personal)
- [ ] Other (Describe)

Q90. Summary & Report Submission

Q91.

Attention Hospital Staff! IMPORTANT!

You have reached the end of the questions, but you are not quite finished. Your narrative has not yet been fully submitted. Once you proceed to the next screen using the right arrow button below, you cannot go backward. You cannot change any of your answers if you proceed beyond this screen.

We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can use the Table of Contents feature to navigate to the appropriate section of the narrative.

Once you are fully confident that your answers are final, return to this screen then click the right arrow button below to officially submit your narrative.

Location Data

Location: (39.0397, -77.1918)

Source: GeoIP Estimation

Mercy Medical Center

2021 Community Health Needs Assessment

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

Mercy

345 Saint Paul Place | Baltimore, Maryland 21202
mdmercy.com

June 2021

ABSTRACT: Community Health Needs Assessments (CHNA) and implementation strategies are required of tax-exempt hospitals as a result of the Patient Protection and Affordable Care Act. The CHNA and implementation strategies create an important opportunity to improve the health of communities by ensuring that hospitals have the information they need to provide community benefits that meet the needs of their communities. They also provide an opportunity to improve coordination of hospital community benefits with other efforts to improve community health. On December 31, 2014, the Internal Revenue Service (IRS) published final rules implementing the "Additional Requirements for Charitable Hospitals" section of the Affordable Care Act (ACA). The hospital facility must conduct a community health needs assessment (CHNA) during the current taxable year or in either of the two taxable years immediately preceding such taxable year, and an "authorized body of the hospital facility" must adopt an "implementation strategy" to meet the community health needs identified through the CHNA. Included in this document is Mercy Medical Center's CHNA and Implementation Strategy as approved by the Mercy Health Services Mission & Corporate Ethics Committee on June 9, 2021.

The Sisters of Mercy were founded by Catherine McAuley, who used her inheritance to build a refuge for homeless and abused women in Dublin, Ireland in 1827. For 146 Years, Mercy Medical Center has carried out the mission of the Sisters of Mercy.

Table of Contents

Executive Summary

Mercy Health Services is an independent, not-for-profit, mission-driven health system serving Baltimore since 1874. At its center is a general acute care teaching hospital affiliated with the University of Maryland School of Medicine located in the heart of downtown Baltimore. The Sisters of Mercy have sponsored Mercy since its healthcare operations began and Mercy has maintained a special commitment to poor and underserved persons consistent with the mission of the Sisters of Mercy. Mercy Medical Center is one of 12 general acute care hospitals in Baltimore City and one of five hospitals within the defined CHNA Service Area. It serves a unique role as a high-quality community hospital, providing a broad range of primary and secondary acute care services, as well as a preferred tertiary referral center providing services to patients from a broad geographic area.

Mercy generates most of its total revenue from regionally oriented, surgically focused specialty programs from patients from nearly every zip code across Maryland. However, when it comes to Community Health Needs and Community Benefit activities, Mercy has focused its attention and resources on a smaller geographic area that represents downtown and inner-city neighborhoods including medically underserved, low income, and minority populations. Mercy provides an array of specialized citywide support programs for these targeted populations including: lower-income pregnant women, individuals experiencing homelessness, substance abusers, 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.

Baltimore City faces numerous social and economic challenges that negatively impact the overall health status of the population. More than 21% of persons in Baltimore live below the federal poverty line. Baltimore's economic challenges also translate to significant social challenges including high rates of violent crime and drug addiction. As a result, Baltimore City, especially Mercy's defined CHNA Service Area, suffers from higher rates of mortality and lower life expectancy. The top causes of death are cardiovascular disease, cancer, drug- and/or alcohol-related, and stroke. In addition, Baltimore City has higher rates of infant mortality and low birth weight births. Significantly more people die prematurely from all causes in the defined CHNA Service Area than in the City as a whole. Further, significant populations of individuals experiencing homelessness are found in Mercy's CHNA Service Area. The estimated life expectancy for individuals experiencing homelessness is only 48 years. Alcohol and drug addiction, mental health, and housing/homelessness were top health and social environmental problems identified by the local community.

Mercy's location in the middle of a disproportionately poor city presents challenges and health disparities that are not evident in other parts of Maryland. Mercy has identified areas of opportunity where the mission and strengths of the institution intersect with the unmet health needs that merit attention. Consistent with feedback received from community representatives, Mercy intends to focus its resources specifically on interventions, programs, and initiatives to: improve access to care and the frequency of care for our homeless neighbors; provide support to victims of violence and addiction; implement strategies to improve birth outcomes and pre-natal care for expectant mothers; expand access to preventative health services such as primary care to improve outcomes, manage chronic disease, and reduce total cost of care; and provide targeted health education opportunities to the public and support the education of future physicians, advance practice providers, nurses, and other healthcare workers who in turn serve the community. Finally, Mercy has been successful in improving quality, lowering costs and responding to community health needs by building up its population health program to serve patients with chronic illnesses within the CHNA service area and beyond.

General Background

Mercy Health Services, Inc. (MHS), a Maryland nonstock corporation that has been determined by the Internal Revenue Service to be a tax-exempt organization described in Section 501(c)(3) of the United States Internal Revenue Code, owns and operates a health care delivery system in Maryland (the Health System). The Health System is a patient-centered, integrated system delivering high-quality, high-value health care services in various locations throughout the Baltimore metropolitan area and State of Maryland. MHS is the parent of Mercy Medical Center, Inc. (Mercy or MMC), a non-profit corporation, which owns and operates a 183-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 is currently one of only three hospitals in the state to achieve the highest 5-Star Overall Hospital Rating from the Centers for Medicare and Medicaid Services (CMS). The Overall Hospital Rating is based on performance on several dozen inpatient and outpatient quality measures that are grouped into seven categories, including mortality, safety of care, readmission, patient experience, effectiveness of care, timeliness of care, and efficient use of medical imaging. Mercy was awarded an "A" in both the Fall 2020 and Spring 2021 Leapfrog Hospital Safety Grades—a national distinction recognizing the hospital's achievements protecting patients and providing safe health care. Mercy earned "high performing" ratings for both hip replacement and knee replacement from *U.S. News & World Report* in its annual "Best Hospitals" edition. "High performing" is the highest rating *U.S. News* awards in the adult procedure category, recognizing care that was significantly better than the national average as measured by patient outcomes.

History

The Sisters of Mercy have sponsored Mercy since its healthcare operations began in 1874 when six Sisters of Mercy arrived in Baltimore to take charge of a health dispensary named Baltimore City Hospital. Established four years prior by the Washington University School of Medicine, the dispensary was located in a former schoolhouse at the corner of Calvert and Saratoga Streets. Mercy has had a continuing presence in downtown Baltimore since its founding. In 1999, the Sisters of Mercy and MHS entered into a formal Sponsorship Agreement. MHS is an independent health system governed by a 29 member self-perpetuating Board of Trustees comprised primarily of Baltimore area residents with deep roots in the local business, healthcare, and philanthropic communities.

Mission & Values

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.

Dignity: We celebrate the inherent value of each person as created in the image of God. We respond to the needs of the whole person in health, sickness and dying.

Hospitality: From many religious traditions and walks of life, we welcome one another as children of the same God, whose mercy we know through the warmth, fidelity and generosity of others.

Justice: We base our relationships with all people on fairness, equality and integrity. We stand especially committed to persons who are poor or vulnerable.

Excellence: We hold ourselves to the highest standards of care and to serving all with courtesy, respect and compassion. Maintaining our involvement in the education of physicians and other healthcare professionals is a priority.

Stewardship: We believe that our world and our lives are sacred gifts which God entrusts to us. We respond to that trust by constantly striving to balance the good of all with the good of each, and through creative and responsible use of all our resources.

Prayer: We believe that every moment in a person's journey is holy. Prayer is our response to God's faithful presence in suffering and in joy, in sickness and in health, in life and in death

2025 Vision

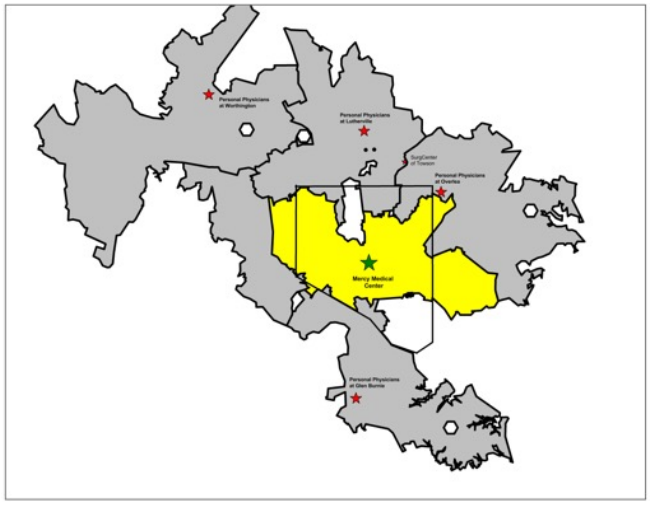
As an independent, innovative Catholic health system, we pledge to enhance the health of our region, with a special commitment to the poor and underserved, by offering:

- The hospital and health system of choice in our market;
- Integrated, cost-effective care across the continuum;
- A comprehensive ambulatory network readily accessible to everyone;
- Nationally and regionally recognized, patient-focused Centers of Excellence; and
- Leadership in clinical quality, customer experience, and value.

MMC Service Area

Mercy provides healthcare services to patients from a broad geographic area within the State of Maryland and beyond. 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 (see map below). These service areas accounted for approximately 76% of Mercy's total discharges in the 12 months ended June 30, 2020. The remaining 24% 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-six percent (66%) of its total revenue from regionally oriented, surgically focused specialty programs (Centers of Excellence) drawing patients from nearly every zip code across Maryland.



Mercy Primary & Secondary Service Areas

While patients throughout Maryland seek-out Mercy's high-quality health services, it has traditionally focused its numerous community benefit programs and services on economically disadvantaged neighborhoods within Baltimore City, consistent with its long-standing special commitment to poor and underserved persons. This includes an array of specialized citywide support programs for lower-income pregnant women, individuals and families experiencing homelessness, substance abusers, and coordination with Federally Qualified Health Centers to meet the community health needs.

Baltimore's Challenges

Baltimore City faces numerous social and economic challenges that negatively impact the overall health status of the population. The City has suffered a dramatic decline in population, employment and wealth since the 1950s. Following the post-war industrial era, Baltimore City's population declined from 949,708 (1950) to 593,490 (2019 estimate), a 38% decrease. Likewise, its population rank among U.S. cities declined from 6th largest to 31st largest. Meanwhile, Maryland's total population grew from 2,343,001 to 6,045,680 during the same period, a 258% increase.

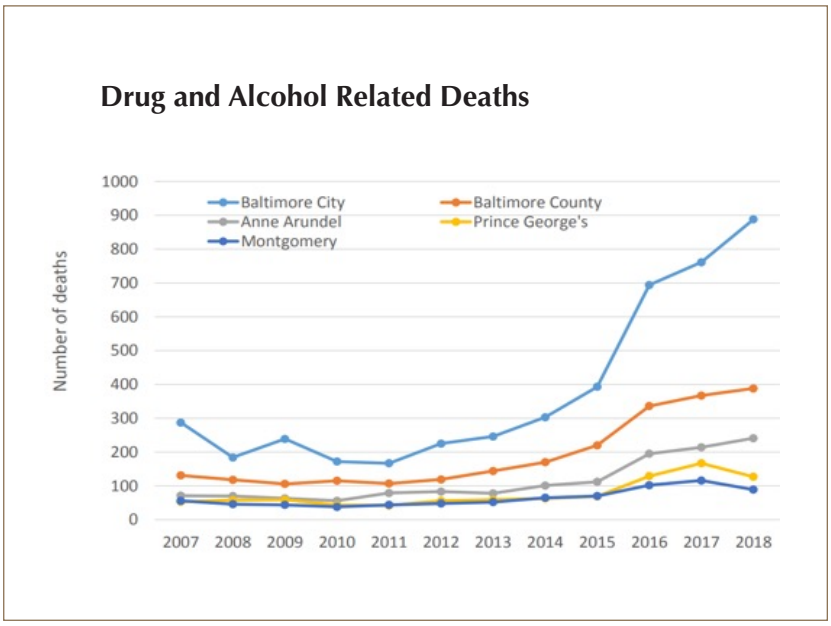
As population, jobs, and wealth migrated out to the suburbs and exurbs of the broader metropolitan area; Baltimore's poor remained, making the City a concentrated "poorhouse for the region's minority poor," according to one urban scholar (Rusk 1995). Indeed, Baltimore's current unemployment rate stands at 7.6% (April 2021), well above Maryland's rate of 6.2%. The City's Median Household Income is $ $50,379 (2019 dollars) compared to $84,804 for Maryland. Perhaps most poignantly, more than 1-in-5 (21.2%) or roughly

126,000 persons in Baltimore live below the federal poverty line, more than double Maryland's poverty rate of 9.0% (including Baltimore City), and significantly higher than the national poverty rate of 10.5%. A staggering nearly one-half of Baltimore City residents live below 200% of the federal poverty line and nearly one-third of children in Baltimore City live in poor households.

Not surprisingly, these economic factors—high unemployment, low income, and extraordinary levels of poverty—often result in reduced access to health care, especially preventative treatment that could improve population health and limit potentially avoidable hospital utilization. While the Affordable Care Act has greatly expanded health insurance to the poor, an estimated 9.5% of individuals in Baltimore under age 65 lack health insurance coverage, according to the most recent available data from the U.S. Census Bureau's Small Area Health Insurance Estimates.

Linked to Baltimore's economic challenges are significant social challenges impacting community health, including high rates of violent crime and drug addiction. Baltimore has one of the highest violent crime rates among major U.S. Cities with a rate of 18.76 per 1000 residents. The Baltimore City Health Department estimates that roughly 60,000 Baltimore residents are suffering from drug addiction. The U.S. Drug Enforcement Agency reports Baltimore has the highest per capita heroin addiction rate in the country. In 2017, Baltimore City recorded nearly 900 drug and alcohol-related intoxication deaths, most of which were opioid-related, representing more than a third of all intoxication deaths in the state.

Against this backdrop, Mercy has remained in Baltimore as a prominent community hospital for more than 146 years, serving the health care needs of Baltimore City's residents regardless of creed, color, economic or social condition. In 2010, Mercy rededicated its commitment to serving Baltimore City with the completion of a new, state-of-the-art replacement hospital, the Mary Catherine Bunting Center, representing a $400+ million investment in its downtown medical campus in the heart of Baltimore City.



In FY2020, Mercy provided $71.6 million in community benefits representing 14.6% of total hospital operating expenses—including $17.8 million in charity care. Mercy consistently performs above state average and other Maryland Catholic Hospitals as a percentage of operating expense.

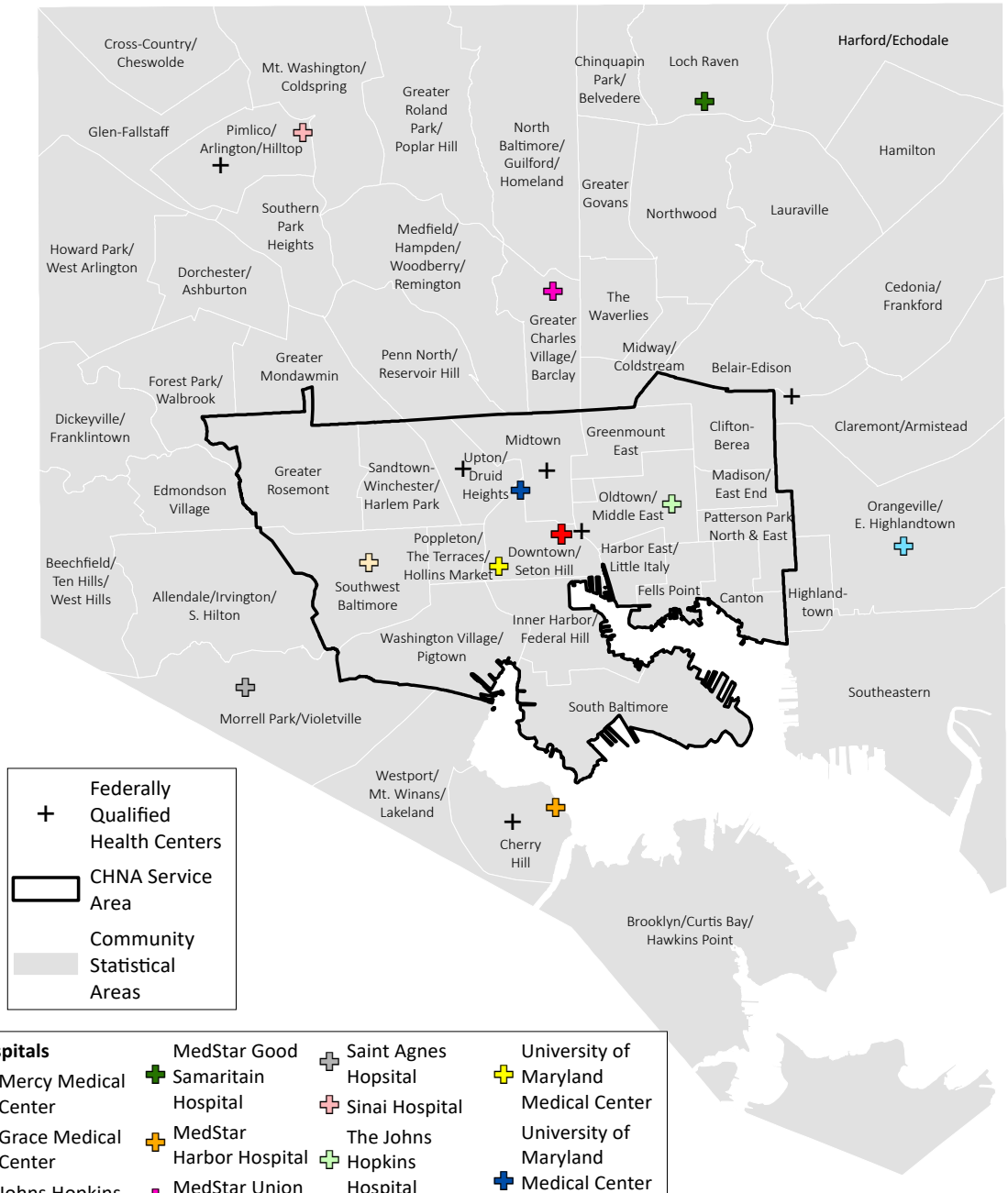
Mercy CHNA Service Area

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. Mercy defined its CHNA 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 socio-economic and health parameters that define Mercy's "community". Following a data driven process (See: Mercy Medical Center 2013 CHNA), 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 CHNA Service Area 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, 2016, and 2018, and 2021 Mercy representatives sought input regarding its proposed CHNA Service Area from community leaders, public health experts, and representatives of minority, low income, and medically underserved populations. The consensus feedback from these discussions validates Mercy's CHNA Service Area Definition. In accordance with IRS regulations governing CHNAs, Mercy's defined CHNA community includes "medically underserved, low income or minority populations".

The following Community Statistical Areas (CSAs) make up Mercy's CHNA Service Area: Canton, Clifton Berea, Downtown/Seton Hill, Fells Point, Greater Rosemont, Greenmount East, Harbor East/Little Italy, Inner Harbor/Federal Hill, Madison/East End, Midtown, Oldtown/Middle East, Patterson Park North & East, Poppleton/The Terraces/Hollins Market, Sandtown-Winchester/Harlem Park, South Baltimore, Southwest Baltimore, Upton/Druid Heights, and Washington Village/Pigtown.

Mercy Medical Center CHNA Service Area



Map created by BNIA-JFI, 2021

CHNA Process and Methods

Quantitative and qualitative data was gathered by Mercy in order to undertake the 2021 CHNA. As part of the quantitative data gathering process for the 2018 and 2021 CHNA, Mercy's Community Benefit Committee members worked collaboratively with the Baltimore City Health Department and a consortium of Baltimore City Hospitals to obtain uniform quantitative and qualitative data including demographic and health data for Community Statistical Areas (CSAs) and qualitative findings of hundreds of community health surveys and stakeholder interviews.

Quantitative Data

As part of the quantitative data gathering process for the 2021 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's Community Benefit Committee a broad array of neighborhood data indicators that provide all of the facts and circumstances present in Mercy's CHNA 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 socio-economic datasets are individual Neighborhood Health Profiles completed by the Baltimore City Health Department. The Neighborhood Health Profiles examine 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 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 (2017) 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. The 2017 BCHD Neighborhood Health Profile Data was incorporated into Mercy's 2018 CHNA and is not replicated again here as BCHD has not published more recent data at the neighborhood level since that time.

Additional 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, 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.

The Baltimore City Health Department (BCHD) is the oldest, continuously-operating health department in the United States, formed in 1793, when the governor appointed the city's first health officers in response to a yellow fever outbreak in the Fells Point neighborhood. In collaboration with other city agencies, health care providers, community organizations and funders, the department seeks to empower all Baltimoreans with the knowledge, access, and environment that will enable healthy living. The Health Department has a wide-ranging area of responsibility, including acute communicable diseases, animal control, chronic disease prevention, emergency preparedness, HIV/STD, maternal-child health, restaurant inspections, school health, senior services and youth violence issues. The agency includes a workforce of approximately 800 employees and has a budget of approximately $126 million.

KEY FINDINGS

Demographics

Baltimore City, Maryland, has a population of 620,961 (2010 Census) and the geographic area of the CSAs included in this profile (referred to hereafter as the CHNA area) has a total population of 186,653 (29% of Baltimore City's population). In 2040, Baltimore City's population is projected to be 693,029 (11.6% change from 2010 decennial census) while the CHNA area's population is expected to be 224,871 (20.5% change from 2010 decennial census) (Baltimore City Health Department (BCHD) analysis of data provided by the Baltimore City Department of Planning). Fifty-two percent of the CHNA area is female and 58% of the area is African American, compared to 53% and 61% for Baltimore City, respectively. 20.7% percent of Baltimore City's population is aged less than 18 years and 13.6% is aged 65+ years compared to 19.5% and 11.5% in the CHNA area, respectively.

Demographics - Population	**Total Population (2010 for all)**	**Total Male Population**	**Total Female Population**
Canton	8,100	4,011	4,089
Clifton-Berea	9,874	4,473	5,401
Downtown/Seton Hill	6,446	3,164	3,282
Fells Point	9,039	4,613	4,426
Greater Rosemont	19,259	8,783	10,476
Greenmount East	8,184	3,737	4,447
Harbor East/Little Italy	5,407	2,628	2,779
Inner Harbor/Federal Hill	12,855	6,528	6,327
Madison/East End	7,781	3,587	4,194
Midtown	15,020	7,305	7,715
Oldtown/Middle East	10,021	4,543	5,478
Patterson Park North & East	14,549	7,289	7,260
Poppletown/Terraces/Hollins Market	5,086	2,403	2,683
Sandtown-Winchester/Harlem Park	14,896	6,810	8,086
South Baltimore	6,406	3,263	3,143
Southwest Baltimore	17,885	8,685	9,200
Washington Village/Pigtown	5,503	2,743	2,760
Upton/Druid Heights	10,342	4,621	5,721
CHNA Service Area Estimate	**186,653**	**89,186**	**97,467**
Baltimore City	**620,961**	**292,249**	**328,712**

Demographics - Race Ethnicity Percent of Residents	Black/African-American (Non-Hispanic) (2015-2019)	White/ Caucasian (Non-Hispanic) (2015-2019)	Asian (Non-Hispanic) (2015-2019)	Two or More Races (Non-Hispanic) (2015-2019)	All Other Races (Non-Hispanic) (2015-2019)	Hispanic (2015-2019)
Canton	5.0	83.0	5.7	1.6	0.3	4.4
Clifton-Berea	90.8	4.1	0.4	0.2	1.1	3.4
Downtown/Seton Hill	37.7	35.8	13.4	2.7	2.5	7.8
Fells Point	6.3	73.2	6.0	3.4	0.0	11.1
Greater Rosemont	97.3	1.1	0.1	0.7	0.2	0.6
Greenmount East	94.1	3.9	0.5	0.1	0.4	1.0
Harbor East/Little Italy	56.0	31.1	3.4	0.5	0.8	8.2
Inner Harbor/Federal Hill	12.3	74.2	4.9	2.3	2.2	4.1
Madison/East End	86.1	3.0	0.1	0.2	1.9	8.7
Midtown	34.0	48.7	6.0	4.3	1.0	6.0
Oldtown/Middle East	85.6	8.5	2.8	1.2	0.1	1.8
Patterson Park North & East	35.3	44.0	3.6	3.1	0.2	13.9
Poppletown/Terraces/Hollins Market	77.1	17.9	0.5	2.2	0.1	2.3
Sandtown-Winchester/Harlem Park	94.9	2.5	0.4	0.7	1.1	0.4
South Baltimore	2.4	88.7	2.6	1.0	0.9	4.4
Southwest Baltimore	73.9	15.8	2.7	3.1	0.5	4.0
Washington Village/Pigtown	55.7	31.2	2.7	4.5	0.0	5.8
Upton/Druid Heights	91.9	4.6	0.5	1.9	0.2	0.9
CHNA Service Area Estimate	**58.0**	**31.3**	**3.1**	**2.0**	**0.7**	**4.8**
Baltimore City	**61.8**	**27.5**	**2.6**	**2.2**	**0.7**	**5.3**

Demographics - Age	Percent of Population Under 5 Years old (2015-2019)	Percent of Population 5-17 Years old (2015-2019)	Percent of Population 18-24 Years old (2015-2019)	Percent of Population 25-64 Years old (2015-2019)	Percent of Population 65 Years and over (2015-2019)
Canton	5.6	3.1	4.1	76.7	10.4
Clifton-Berea	6.7	17.8	6.6	51.0	17.8
Downtown/Seton Hill	4.5	4.7	17.6	68.9	4.4
Fells Point	5.7	4.4	6.4	74.6	8.9
Greater Rosemont	5.7	16.4	8.5	58.1	11.2
Greenmount East	7.3	19.1	5.7	53.5	14.4
Harbor East/Little Italy	4.7	14.2	7.0	61.8	12.2
Inner Harbor/Federal Hill	4.2	6.2	10.0	67.1	12.5
Madison/East End	10.4	21.9	13.0	45.5	9.2
Midtown	1.4	3.4	13.7	65.8	15.7
Oldtown/Middle East	4.7	21.4	9.0	52.1	12.7
Patterson Park North & East	8.7	13.9	6.6	63.0	7.9
Poppletown/Terraces/Hollins Market	7.0	17.3	6.5	60.5	8.8
Sandtown-Winchester/Harlem Park	6.5	21.1	7.5	49.6	15.3
South Baltimore	7.2	5.0	4.6	76.8	6.3
Southwest Baltimore	9.9	16.4	7.7	53.7	12.3
Washington Village/Pigtown	7.1	11.7	7.6	65.3	8.3
Upton/Druid Heights	7.8	22.1	8.8	49.2	12.0
CHNA Service Area Estimate	**6.3**	**13.2**	**8.6**	**60.4**	**11.5**
Baltimore City	**6.4**	**14.2**	**9.8**	**56.0**	**13.6**

Demographics - Family Poverty	Percent of Female-Headed Households with Children Under 18 (2015-2019)	Percent of Family Households Living Below the Poverty Line (2015-2019)	Percent of Children Living Below the Poverty Line (2015-2019)
Canton	15.0	2.2	4.8
Clifton-Berea	54.5	19.2	39.7
Downtown/Seton Hill	57.1	3.7	6.2
Fells Point	10.8	5.7	8.4
Greater Rosemont	68.0	26.4	46.8
Greenmount East	73.8	25.5	45.7
Harbor East/Little Italy	69.1	25.5	32.8
Inner Harbor/Federal Hill	15.9	3.3	7.0
Madison/East End	83.0	34.4	55.9
Midtown	28.6	6.5	13.2
Oldtown/Middle East	80.9	35.5	49.5
Patterson Park North & East	33.4	24.2	55.0
Poppletown/Terraces/Hollins Market	77.5	40.6	51.4
Sandtown-Winchester/Harlem Park	68.8	36.4	61.1
South Baltimore	13.3	0.0	0.0
Southwest Baltimore	57.0	33.7	50.9
Washington Village/Pigtown	75.5	25.3	38.1
Upton/Druid Heights	84.4	41.7	66.5
CHNA Service Area Estimate	**58.3**	**22.5**	**43.9**
Baltimore City	**51.0**	**16.0**	**31.0**

Social Determinants of Health

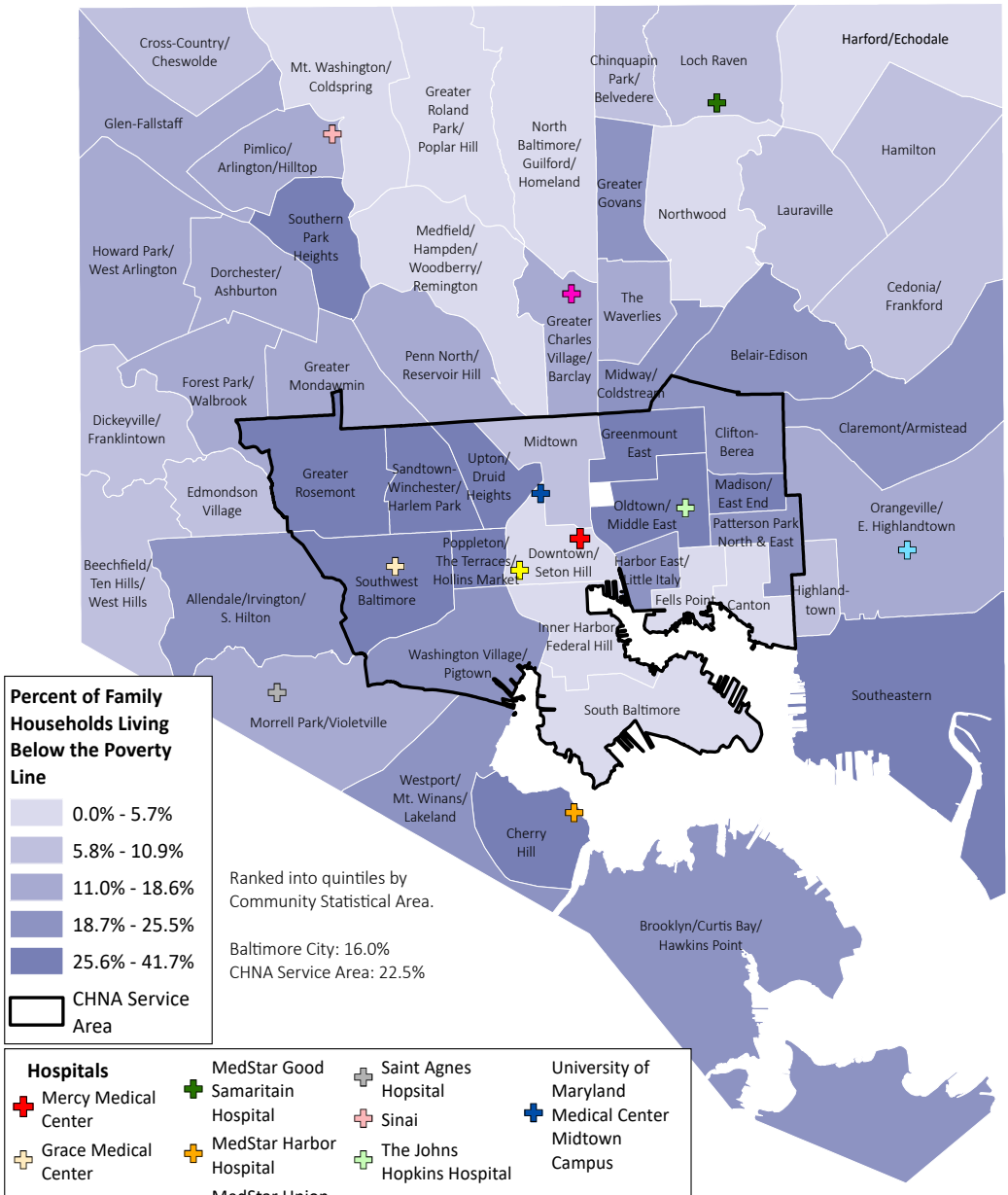
The social determinants of health include a wide variety of exposures that impact health across all ages, from the individual to the population level. They include factors such as employment, income, education, the built environment, access to healthy foods, exposure to violence, and stress.

Like most places, employment and income are key social determinants of health in Baltimore. The family poverty rate (families with children under 18 years) is 16.0% in Baltimore City compared to 22.5% in the CHNA area.

Regarding the built environment, the percentage of residential properties that are vacant and abandoned (2019) in Baltimore City is 8.0% vs. 14.7% in the CHNA area. Food access is a major challenge in Baltimore City with nearly 13% of land classified as a food desert. Exposure to violence is another concern; the violent crime rate is 18.5 per 1,000 residents in Baltimore City and 27.9 per 1,000 residents in the CHNA area.

Mercy Medical Center CHNA Service Area

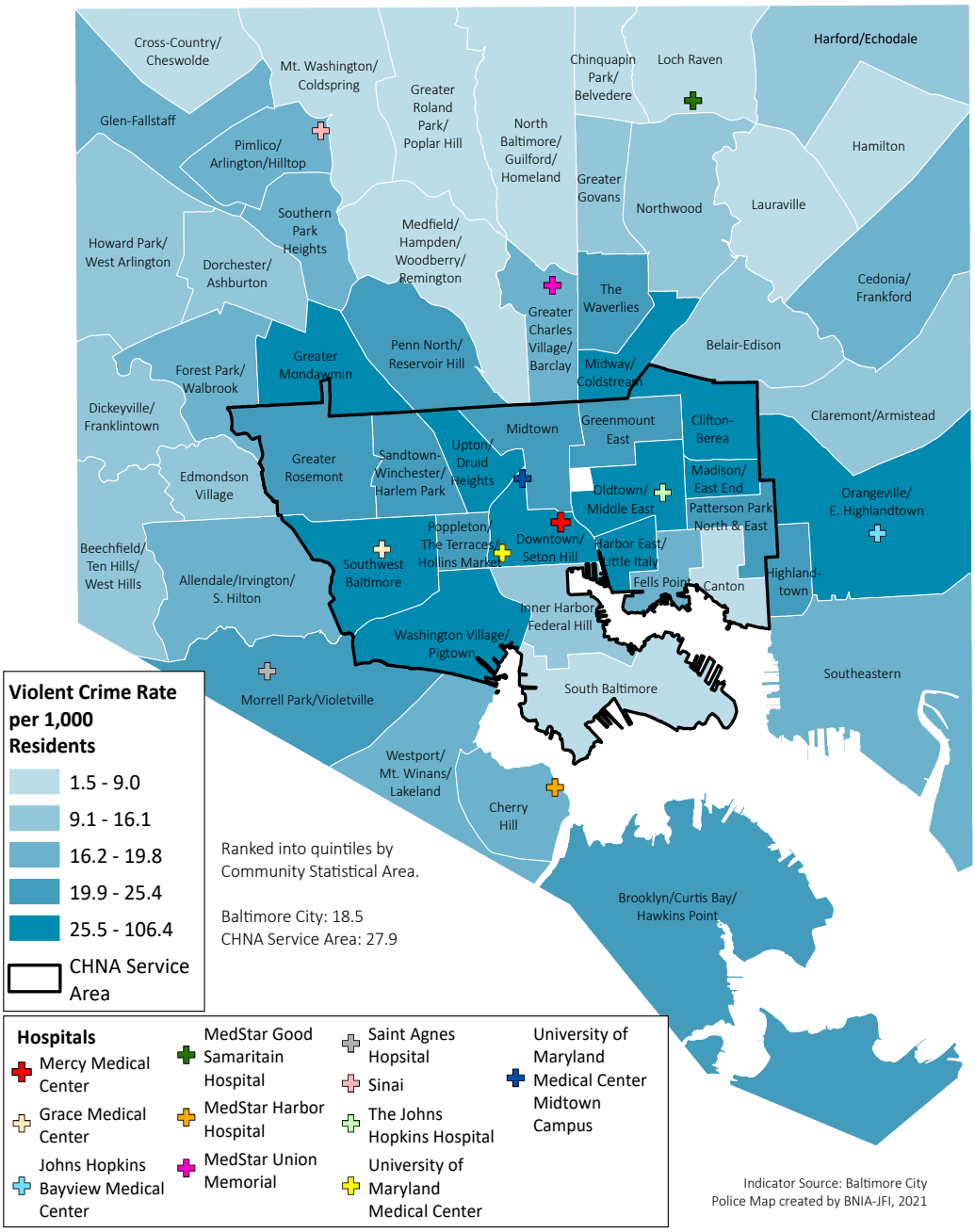
Percentage of Family Households in Poverty, Baltimore City, 2015-2019



Indicator Source: American Community Survey Map created by BNIA-JFI, 2021

Mercy Medical Center CHNA Service Area

Violent Crime Rate, Baltimore City, 2015-2019



Indicator Source: Baltimore City Police Map created by BNIA-JFI, 2021

Social Determinants of Health	Number of Children (Aged 0-6) Tested for Elevated Blood Lead Levels (2018)	Percent of Children (Aged 0-6) with Elevated Blood Lead Levels (2018)	Percentage of Residential Properties that are Vacant and Abandoned (2019)	Average Healthy Food Availability Index (2015)	Violent Crime Rate per 1,000 Residents (2019)	Number of Shootings per 1,000 Residents (2019)
Canton	94	0.0	0.5	15.2	6.9	0.2
Clifton-Berea	160	0.0	24.5	8.2	27.9	11.1
Downtown/Seton Hill	94	0.0	10.8	8.9	106.4	14.7
Fells Point	132	0.0	0.9	11.3	19.7	0.7
Greater Rosemont	NA	NA	19.6	7.5	21.9	5.7
Greenmount East	63	0.0	30.5	10.2	25.4	6.7
Harbor East/Little Italy	105	0.0	1.5	10.4	32.9	5.4
Inner Harbor/Federal Hill	161	0.0	0.4	8.5	16.1	0.8
Madison/East End	214	7.5	19.8	9.7	31.5	9.3
Midtown	58	0.0	1.3	11.2	23.8	0.9
Oldtown/Middle East	248	0.0	11.8	8.9	44.1	11.5
Patterson Park North & East	43	0.0	3.8	10.8	23.6	4.4
Poppletown/Terraces/Hollins Market	82	0.0	11.0	10.7	24.2	7.1
Sandtown-Winchester/Harlem Park	176	2.8	32.5	9.1	22.2	9.4
South Baltimore	175	0.0	0.3	14.0	5.6	0.6
Southwest Baltimore	205	2.4	30.7	8.9	35.3	9.6
Washington Village/Pigtown	129	0.0	6.0	9.0	38.2	2.0
Upton/Druid Heights	239	0.0	28.5	8.5	26.5	9.9
CHNA Service Area Estimate	**2,378**	**1.1**	**14.7**	**10.0**	**27.9**	**5.5**
Baltimore City	**15,900**	**1.0**	**8.0**	**9.4**	**18.5**	**3.7**

Social Determinants of Health - Education	Percent of 1st-5th Grade Students that are Chronically Absent (Missing at least 20 days) (2018-2019)	Percent of 6th-8th Grade Students that are Chronically Absent (Missing at least 20 days) (2018-2019)	Percent of 9th-12th Grade Students that are Chronically Absent (Missing at least 20 days) (2018-2019)	Percent Population (25 Years and over) With Less Than a High School Diploma or GED (2015-2019)	Percent Population (25 Years and over) With High School Diploma and Some College or Associates Degree (2015-2019)	Percent Population (25 Years and over) with a Bachelor's Degree or Above (2015-2019)
Canton	2.1	5.3	27.8	4.6	20.3	75.2
Clifton-Berea	30.3	26.9	63.0	24.4	62.6	13.0
Downtown/Seton Hill	34.7	41.8	59.3	4.8	26.3	68.8
Fells Point	13.2	18.2	50.7	5.5	17.5	77.0
Greater Rosemont	30.8	34.9	55.7	18.7	75.0	6.3
Greenmount East	26.5	35.4	56.2	19.7	68.0	12.3
Harbor East/Little Italy	25.2	34.6	60.1	18.7	40.8	40.5
Inner Harbor/Federal Hill	11.1	15.9	37.0	5.0	20.7	74.4
Madison/East End	18.1	26.5	62.5	24.2	68.1	7.7
Midtown	15.4	28.2	36.5	8.4	30.7	60.9
Oldtown/Middle East	31.3	28.2	59.7	26.1	53.1	20.8
Patterson Park North & East	18.0	27.5	61.6	15.7	36.0	48.2
Poppletown/Terraces/Hollins Market	26.3	26.8	65.5	22.8	57.6	19.7
Sandtown-Winchester/Harlem Park	37.9	34.3	56.6	25.0	68.2	6.8
South Baltimore	5.1	14.9	25.6	7.7	16.2	76.0
Southwest Baltimore	31.0	41.2	61.8	32.1	59.2	8.7
Washington Village/Pigtown	33.3	22.5	52.2	18.5	44.1	37.4
Upton/Druid Heights	34.8	37.1	61.8	21.7	64.3	14.0
CHNA Service Area Estimate	**27.7**	**31.4**	**57.8**	**16.1**	**44.9**	**39.0**
Baltimore City	**23.9**	**24.3**	**50.6**	**14.8**	**53.3**	**31.9**

Health Outcomes

Life Expectancy

The overall life expectancy at birth in Baltimore City is 72.7 years compared to 71.3 years in the CHNA area. Life expectancy is highly impacted by deaths among young people, which are often due to intentional and unintentional injuries. Mortality for ages 1-14 is 2.90 in Baltimore City vs. 3.80 in the CHNA area.

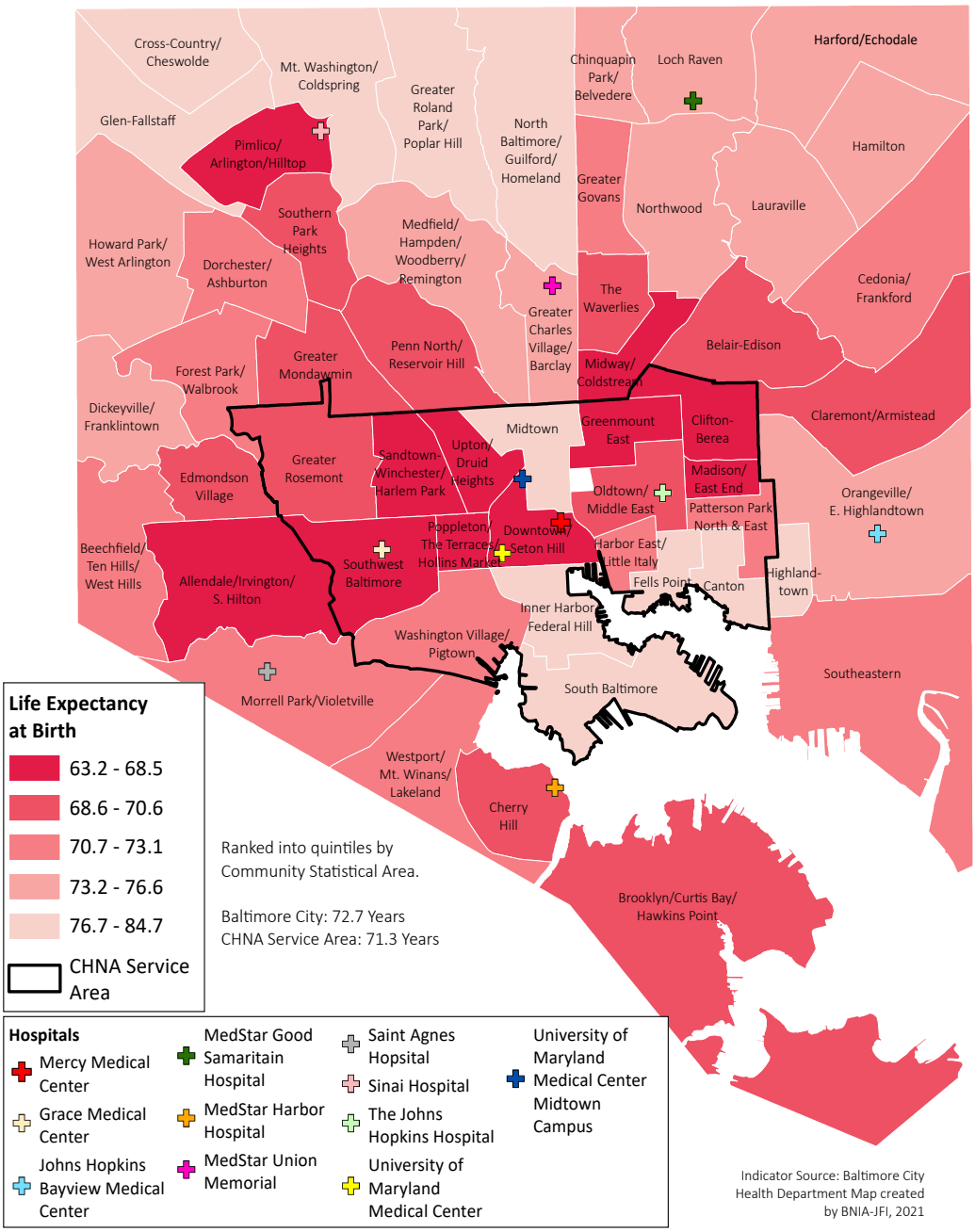
The top causes of death in Baltimore City are cardiovascular disease, cancer, stroke, and drug- and/or alcohol-related. In the CHNA area, the top causes are cardiovascular disease, cancer, drug- and/or alcohol-related, and stroke. Among cancer deaths, lung cancer is the most common in Baltimore City, and lung cancer is the most common in the CHNA area.

While the overall death rates in Mercy's CHNA Service Area are higher than the city average, the data for the Downtown/Seton Hill community, Madison/East End, Poppleton, and Southwest Baltmore merits further examination. The data indicates that residents in these areas are dying far earlier than residents in higher income neighborhoods. One likely factor in the Downtown/Seton Hill data point 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.

Health Outcomes	Life Expectancy (2018)	Infant Mortality Rate (2018)	Mortality by Age (1-14 Years old) (2018)	Mortality by Age (15-24 Years old) (2018)	Mortality by Age (25-44 Years old) (2018)	Mortality by Age (45-64 Years old) (2018)	Mortality by Age (65-84 Years old) (2018)	Mortality by Age (85 and over) (2018)
Canton	80.80	7.90	-	-	6.10	57.40	324.30	1,000.0
Clifton-Berea	67.40	23.00	4.20	18.60	47.80	186.40	394.30	1,497.6
Downtown/Seton Hill	63.20	15.00	25.90	1.40	19.00	188.80	968.00	1,769.2
Fells Point	78.00	7.50	-	5.30	8.60	61.30	336.10	1,444.4
Greater Rosemont	68.50	12.90	1.60	19.50	59.10	158.20	425.40	1,236.7
Greenmount East	67.70	11.70	2.60	12.20	57.40	171.90	488.10	1,092.4
Harbor East/Little Italy	71.90	11.50	1.90	14.50	23.90	125.00	433.40	1,764.7
Inner Harbor/Federal Hill	80.80	1.30	-	3.30	6.60	60.30	291.90	1,218.5
Madison/East End	68.40	7.50	4.20	15.00	40.30	172.80	500.00	1,315.8
Midtown	76.70	9.90	-	2.90	15.90	107.00	367.30	840.3
Oldtown/Middle East	68.90	13.10	5.10	9.70	42.20	184.90	419.40	1,172.4
Patterson Park North & East	72.90	4.80	4.90	10.30	16.70	130.20	449.80	1,114.8
Poppletown/Terraces/Hollins Market	67.20	11.20	2.00	18.60	49.30	215.60	400.90	1,500.0
Sandtown-Winchester/Harlem Park	68.10	8.80	4.10	20.60	59.50	174.40	454.60	996.0
South Baltimore	77.30	2.90	4.00	5.40	6.70	68.60	386.80	1,403.0
Southwest Baltimore	66.40	10.30	5.40	25.50	60.90	196.50	448.20	1,289.5
Washington Village/Pigtown	70.90	10.10	-	9.80	27.10	162.10	472.60	1,066.7
Upton/Druid Heights	68.50	3.80	2.50	24.90	47.70	193.20	420.90	1,089.3
CHNA Service Area Estimate	**71.31**	**9.62**	**3.80**	**12.08**	**33.04**	**145.26**	**443.44**	**1,267.3**
Baltimore City	**72.70**	**9.10**	**2.90**	**11.70**	**29.10**	**127.20**	**395.20**	**1,273.8**

Mercy Medical Center CHNA Service Area

Life Expectancy at Birth, Baltimore City, 2018



Indicator Source: Baltimore City Health Department Map created by BNIA-JFI, 2021

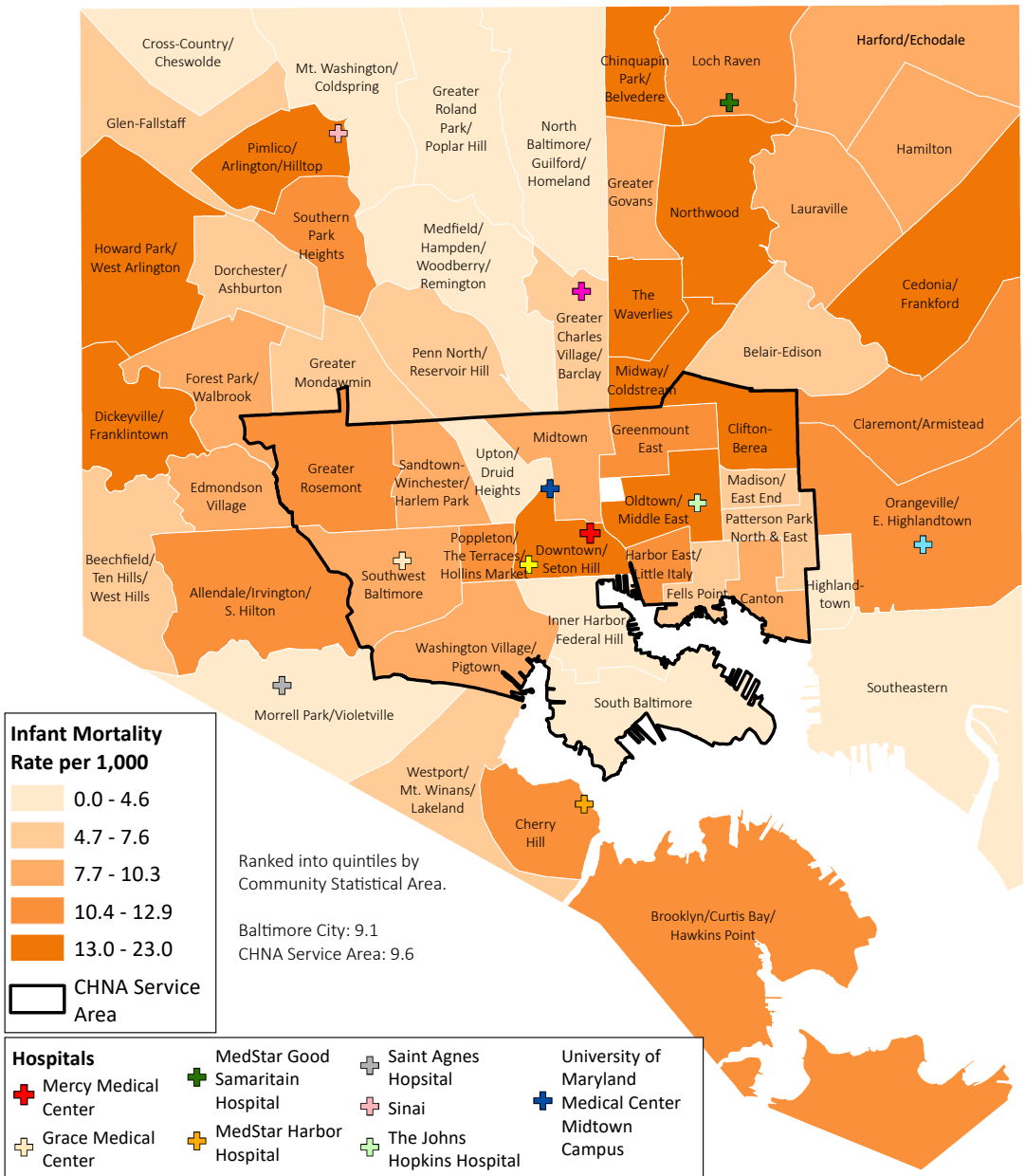
Maternal Health, Birth Outcomes and Infant Mortality

Measures of maternal health are important to understanding the public's health. 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 (more than 70% of mothers delivering at Mercy are Medicaid-insured). Additionally, Mercy has a long-standing practice partnering with Federally Qualified Health Centers (FQHCs) 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 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 CHNA Service Area remain unacceptably high. The infant mortaility rate in Baltimore city is 9.10 vs. 9.62 in the CHNA Service Area.

The teen birth rate in Baltimore City is 21.5 births per 1,000 residents while the same rate in the CHNA area is 26.8 births per 1,000 residents. 63.1% of pregnant women receive prenatal care in the first trimester in Baltimore City vs. 65.5% in the CHNA area. The percentage of mothers receiving care has increased in recent years which may be attributed to the the City's B'more for Healthy Babies campaign and Mercy's efforts.

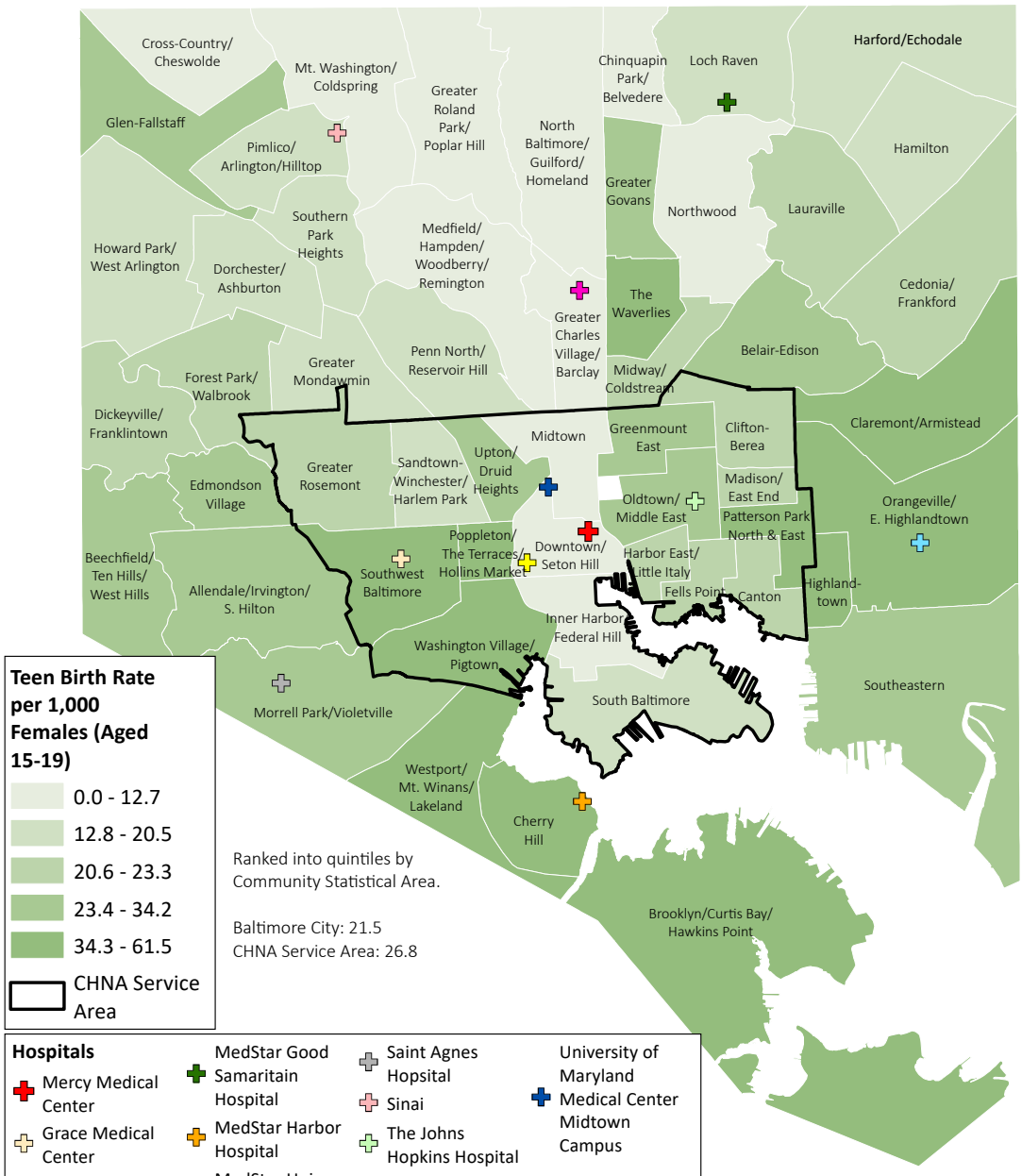
Maternal Health	Teen Birth Rate per 1,000 Females (Aged 15-19) (2019)	Percent of Births Where the Mother Received Early Prenatal Care (First Trimester) (2019)
Canton	23.3	85.3
Clifton-Berea	20.6	57.5
Downtown/Seton Hill	10.9	74.1
Fells Point	22.2	79.8
Greater Rosemont	22.4	56.5
Greenmount East	24.8	61.4
Harbor East/Little Italy	21.1	72.3
Inner Harbor/Federal Hill	0.0	84.9
Madison/East End	22.8	44.7
Midtown	1.6	78.0
Oldtown/Middle East	29.7	65.8
Patterson Park North & East	39.8	58.2
Poppletown/Terraces/Hollins Market	35.7	49.3
Sandtown-Winchester/Harlem Park	17.5	61.1
South Baltimore	15.4	85.2
Southwest Baltimore	39.2	55.5
Washington Village/Pigtown	34.9	69.4
Upton/Druid Heights	34.2	59.8
CHNA Service Area Estimate	**26.8**	**65.5**
Baltimore City	**21.5**	**63.1**

Mercy Medical Center CHNA Service Area
Infant Mortality



Indicator Source: Baltimore City Health Department
Map created by BNIA-JFI, 2021

Mercy Medical Center CHNA Service Area Teen Birth Rate



Indicator Source: Maryland Department of Vital Statistics Map created by BNIA-JFI, 2021

Qualitative Data

CHNA Public Survey

Mercy collaborated with a consortium of Baltimore City hospitals and the Baltimore City Health Department to develop and distribute a Community Health Needs Assessment Survey to obtain community feedback and input from thousands of the Baltimore City and Baltimore County residents regarding community health and social concerns. Mercy then aggregated survey response data from four zip codes (21201, 21202, 21217, 21231) that align/overlap with its CHNA Community Benefit Service Area shown in detail below (which includes four other hospitals), representing 617 individual completed surveys. The responses to the geographic, gender, race, and age demographic questions reflect a healthy and broad sample of Mercy's CHNA Service Area, including medically underserved, low income or minority populations.

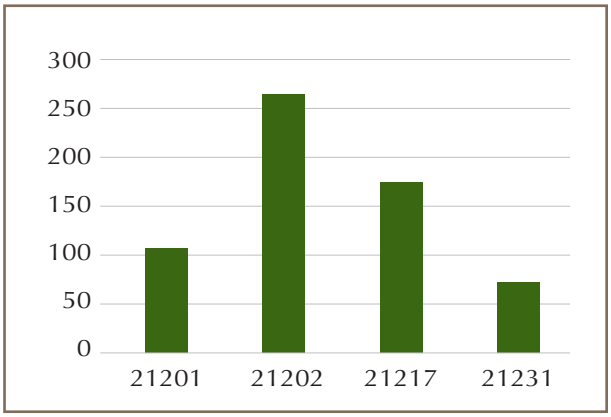
Survey respondents identified alcohol/drug addiction, mental health, and smoking as the three most important health problems that affect the health of their community. Survey respondents identified homelessness, lack of job opportunities, and neighborhood violence as three most important social/environmental problems that affect the health of their community. Survey respondents identified health care costs, no insurance, and lack of transportation as the three most important reasons people in their community do not access health care treatment. These top concerns are the same as the prior 2018 CHNA survey.

Survey respondents also answered several COVID-19 related questions. The survey also provided space for free response/written feedback regarding ideas or suggestions individuals had to improve the health in their community. Here, survey respondents identified COVID-19 testing and vaccination, better access to health care, affordable insurance, and community safety as the primary suggestions to improve health in their community.

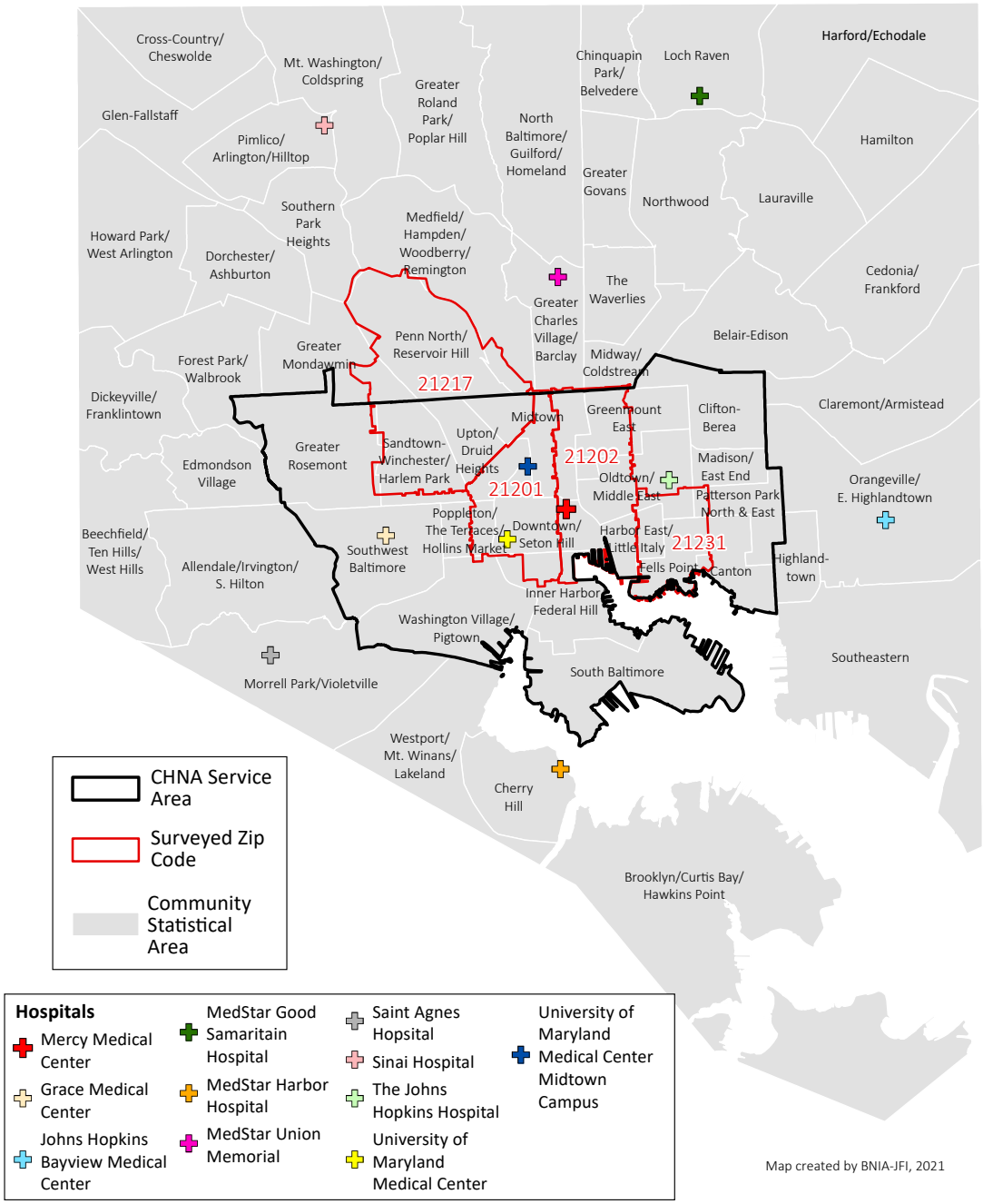
The complete questions and results of the Community Health Needs Assessment Public Survey are summarized and shown below.

Q1: What is your Zip Code?

	Frequency
21201	107
21202	264
21217	174
21231	72



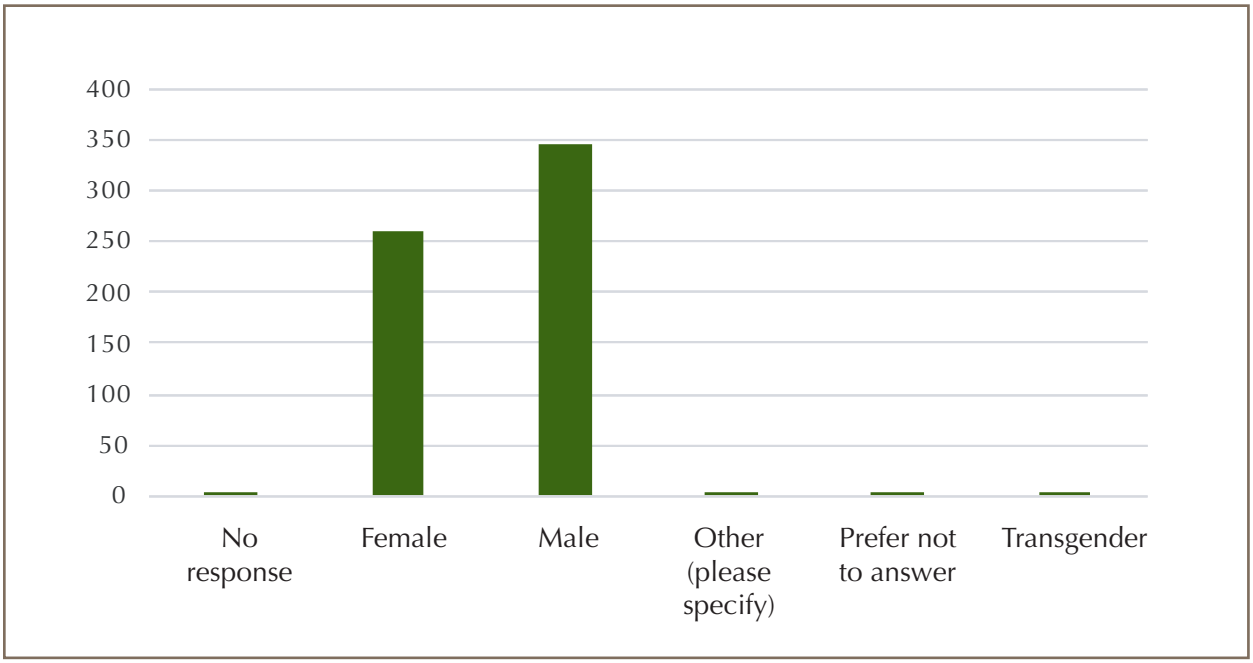
Mercy Medical Center CHNA Service Area by Zip Code



Map created by BNIA-JFI, 2021

Q2: What is your gender?

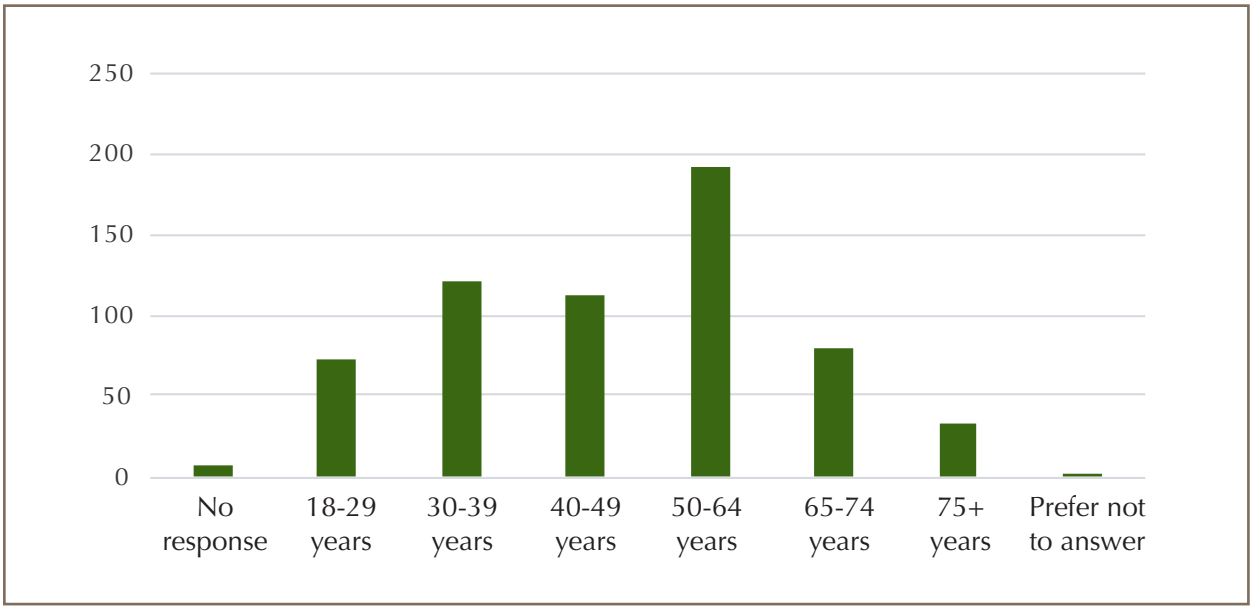
Respondent could select only one. Male; Female; Transgender; Other specify; Don't know; Prefer not to answer.



	Frequency	Percent
No Response	2	0.3
Female	259	42
Male	347	56.2
Other (please specify)	4	0.6
Prefer Not to Answer	3	0.5
Transgender	2	0.3

Q3: What is your age group (years)?

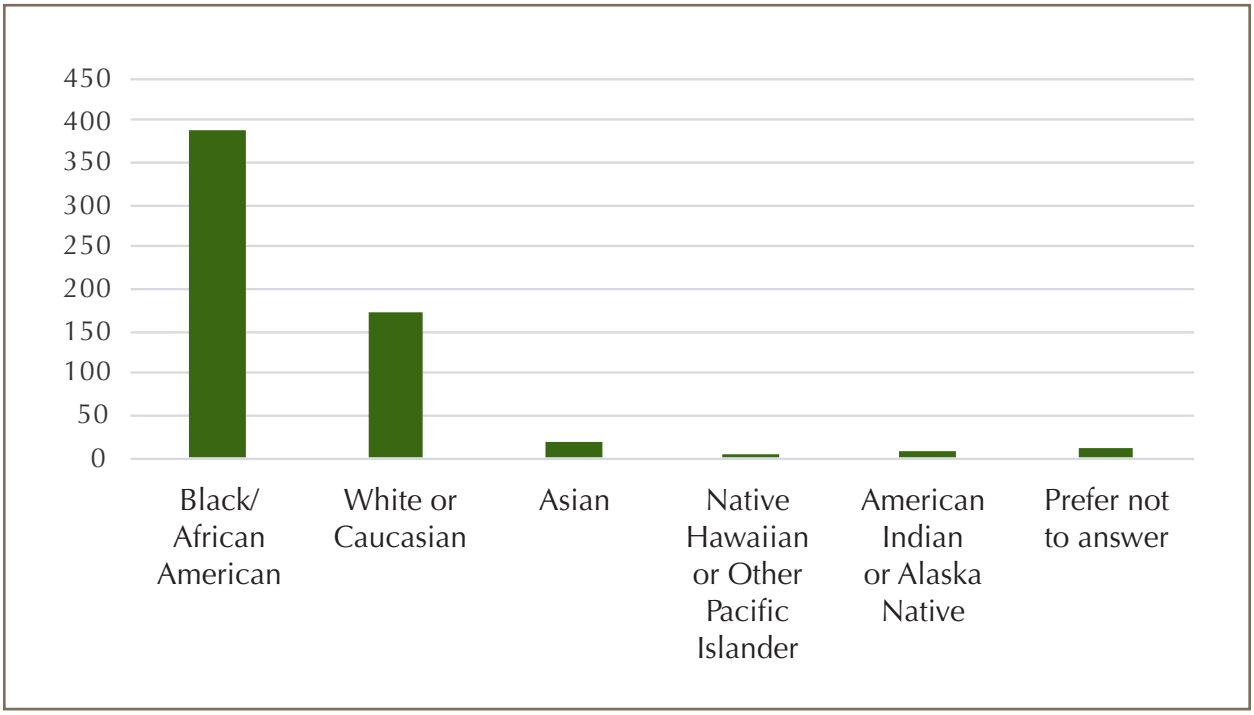
Respondent could select only one. 18-29; 30-39; 40-49; 50-64; 65-74; 75+; Don't know; Prefer not to answer.



	Frequency	Percent
No Response	7	1.1
18-29 years	72	11.7
30-39 years	121	19.6
40-49 years	112	18.2
50-64 years	192	31.1
65-74 years	80	13
75+	32	5.2
Prefer Not to Answer	1	0.2

Q4: Which one of the following is your race?

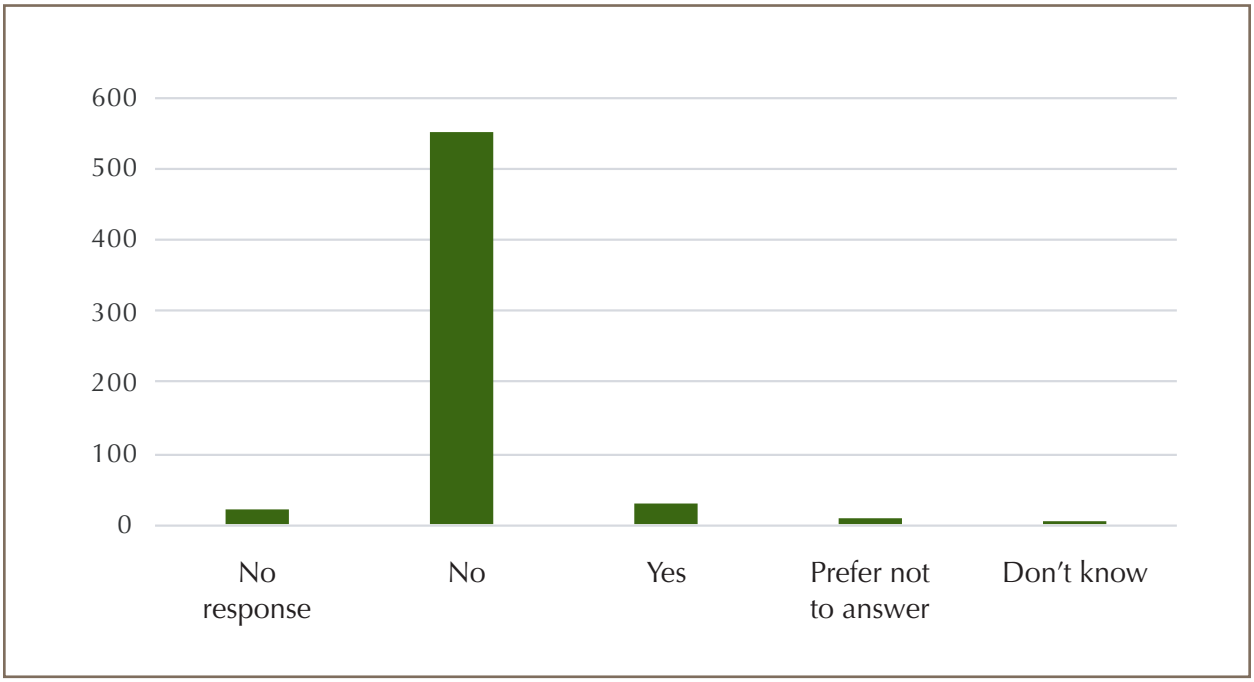
Respondent could select all that apply. Black or African American; White or Caucasian; Native Hawaiian or Other Pacific Islander; Asian; American Indian or Alaska Native; Other; More than one race specify; Don't know; Prefer not to answer.



	Frequency	Percent
Black/African American	389	63
White or Caucasian	174	28.2
Asian	18	2.9
Native Hawaiian or Other Pacific Islander	1	0.2
American Indian or Alaska Native	6	1
Prefer Not to Answer	11	1.8

Q5: Are you Hispanic or Latino/a?

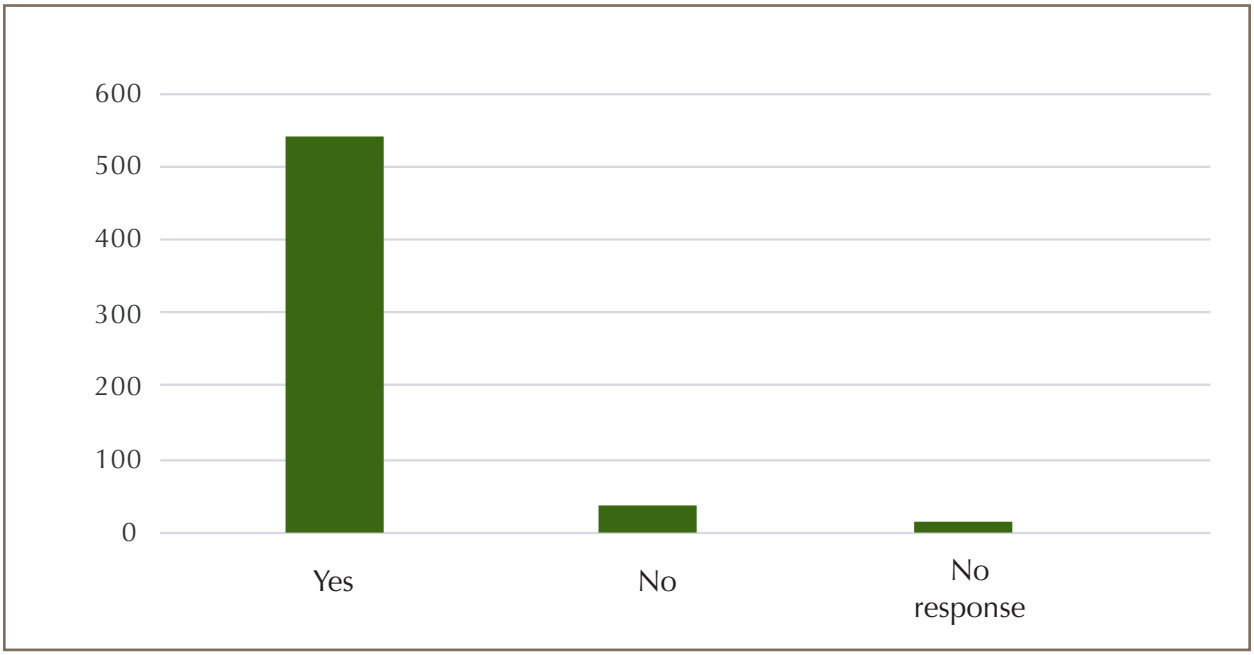
Respondent could select only one. Yes; No; Don't know; Prefer not to answer.



	Frequency	Percent
No Response	22	3.6
No	552	89.5
Yes	30	4.9
Prefer Not to Answer	10	1.6
Don't Know	3	0.5

Q6: Do you have health insurance?

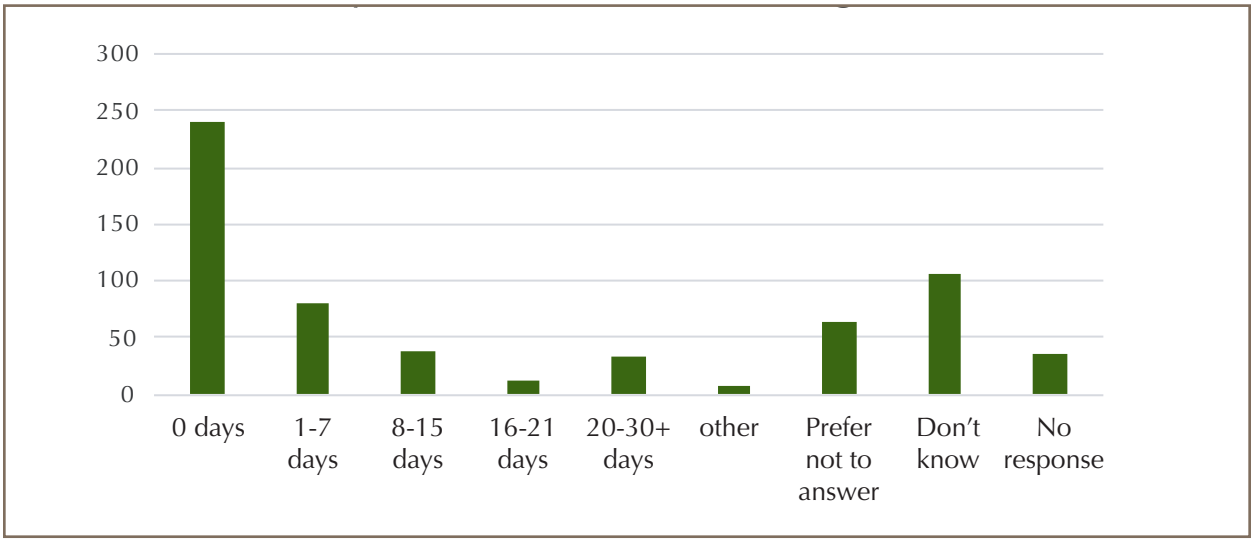
Respondent could select only one. Yes; No.



	Frequency	Percent
Yes	562	91.1
No	38	6.2
No Response	17	2.8

Q7: On how many days during the past 30 days was your mental health not good?

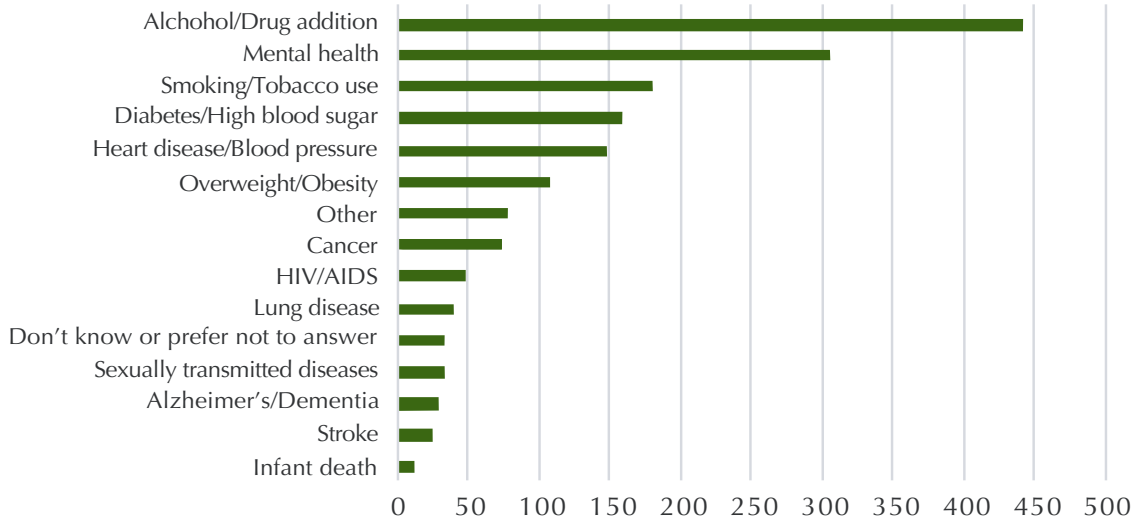
Mental health includes stress, depression, and problems with emotions. Please write number of days. _____ days; Zero days; Don't know; Prefer not to answer



	Frequency	Percent
0 Days	240	38.9
1-7 Days	81	13.1
8-15 Days	37	6
16-21 Days	12	1.9
22-30+ Days	33	5.3
Other	8	1.5
Prefer Not to Answer	63	10.2
Don't Know	107	17.3
No Response	36	5.8

Q8: What are the three most important health problems that affect the health of your community?

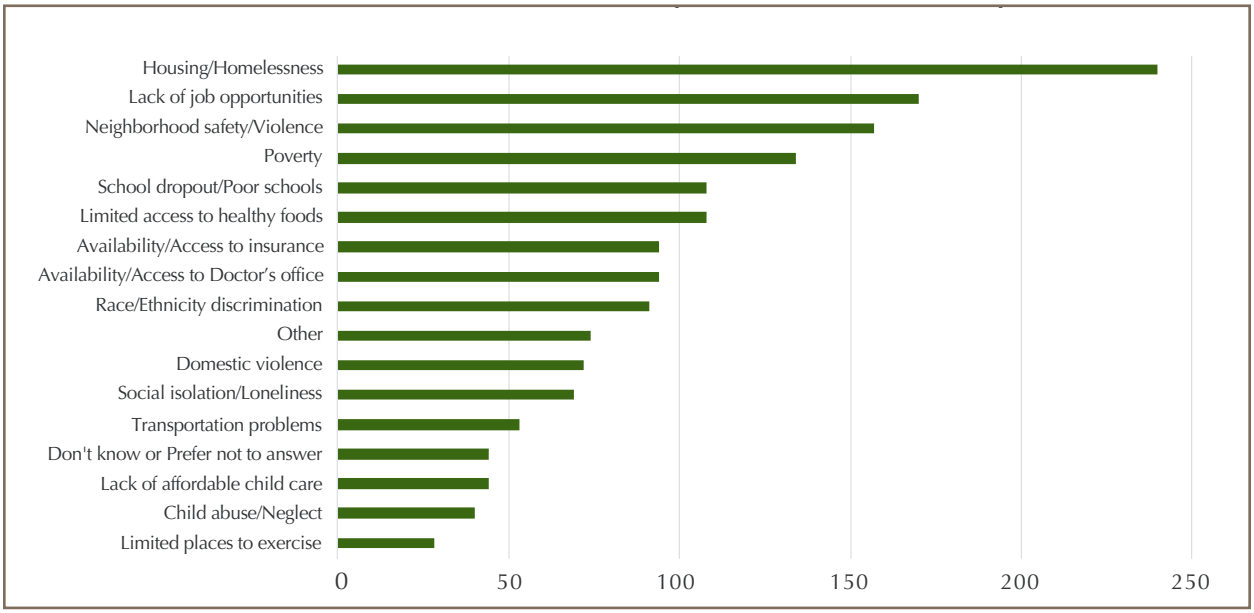
Respondent could select three. Alcohol/Drug addiction; Overweight/Obesity; Mental health (depression, anxiety); Cancer; Diabetes/High blood sugar; Heart disease/High blood pressure; HIV/AIDS; Infant death; Lung disease/Asthma/COPD; Stroke; Smoking/Tobacco use; Sexually Transmitted Infections; Alzheimer's/Dementia; Don't know or prefer not to answer; Other.



	Frequency	Percent
Infant Death	9	1.5
Stroke	23	3.7
Alzheimer's/Dementia	26	4.2
Sexually Transmitted Diseases	31	5
Don't Know or Prefer Not to Answer	31	5
Lung Disease/Asthma/COPD	37	6
HIV/AIDS	47	7.6
Cancer	72	11.7
Other	75	12.2
Overweight/Obesity	106	17.2
Heart Disease/Blood Pressure	146	23.7
Diabetes/High Blood Sugar	156	25.3
Smoking/Tobacco Use	178	28.8
Mental Health (Depression/Anxiety)	304	49.3
Alcohol/Drug Addiction	439	71.2

Q9: What are the three most important social; environmental problems that affect the health of your community?

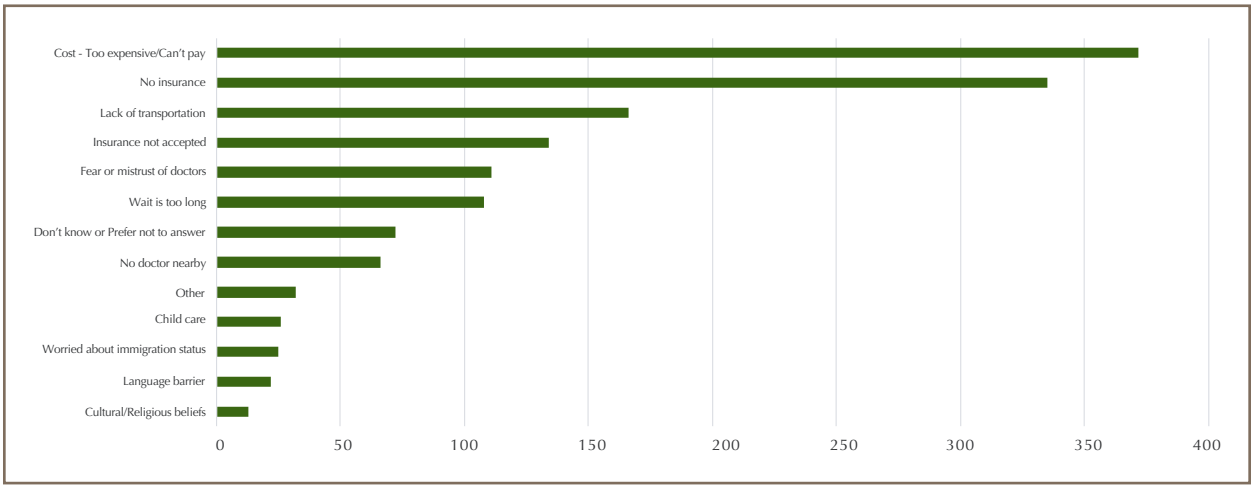
Respondent could select three. Availability/Access to doctor's office; Availability/Access to insurance; Child abuse/Neglect; Domestic violence; Lack of affordable child care; Limited access to healthy foods; Limited places to exercise; School dropout; Poor schools; Lack of job opportunities; Poverty; Housing/ Homelessness; Neighborhood safety/Violence; Racial/Ethnicity discrimination; Social isolation/ Loneliness; Transportation problems; Don't know or prefer not to answer; Other: _____



	Frequency	Percent
Limited Places to Exercise	28	4.5
Child Abuse/Neglect	40	6.5
Lack of Affordable Child Care	44	7.1
Don't Know or Prefer Not to Answer	44	7.1
Transportation Problems	53	8.6
Social Isolation/Loneliness	69	11.2
Domestic Violence	72	11.7
Other	74	12
Race/Ethnicity Discrimination	91	14.7
Availability/Access to Doctor's Office	94	15.2
Availability/Access to Insurance	94	15.2
Limited Access to Healthy Foods	108	17.5
School Dropout/Poor Schools	108	17.5
Poverty	134	21.7
Neighborhood Safety/Violence	157	25.4
Lack of Job Opportunities	170	27.6
Housing/Homelessness	240	38.9

Q10: What are the three most important reasons people in your community do not get health care?

Respondent could select three. Cost – Too expensive/Can't pay; No insurance; No doctor nearby; Insurance not accepted; Lack of transportation; Language barrier; Cultural/Religious beliefs; Worried about immigration status; Childcare; Fear or mistrust of doctors; Wait is too long; Don't know or prefer not to answer; Other: _____



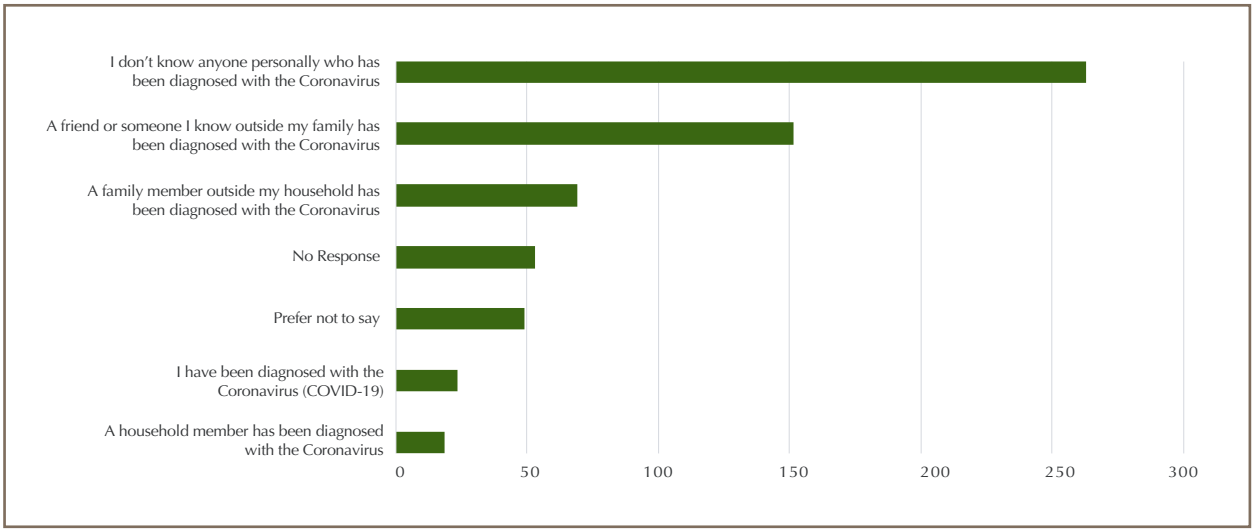
	Frequency	Percent
Cultural/Religious Beliefs	13	2.1
Language Barrier	22	3.6
Worried about Immigration Status	25	4.1
Child Care	26	4.2
Other	32	5.2
No Doctor Nearby	66	10.7
Don't Know or Prefer Not to Answer	72	11.7
Wait is Too Long	108	17.5
Fear or Mistrust of Doctors	111	18
Insurance Not Accepted	134	21.7
Lack of Transportation	166	26.9
No Insurance	335	54.3
Cost - Too Expensive/Can't Pay	372	60.3

COVID-19 QUESTIONS

Q11: Which of the following apply to you?

Respondent could select all that apply.

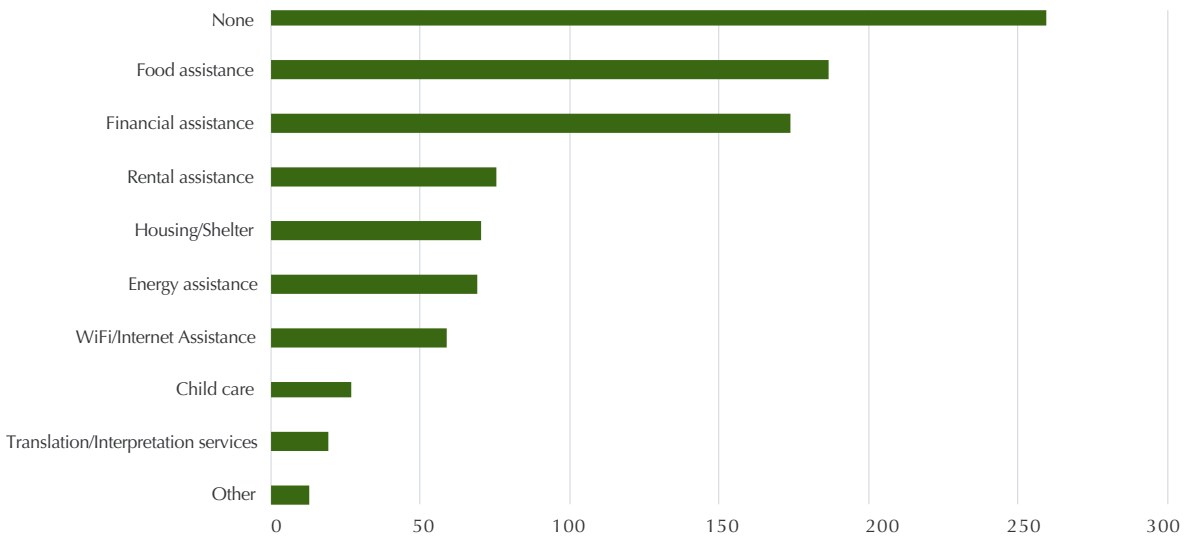
I have been diagnosed with the Coronavirus.
A household member has been diagnosed with the Coronavirus.
A family member outside my household has been diagnosed with the Coronavirus.
A friend or someone I know outside of my family has been diagnosed with the Coronavirus
I don't know anyone personally who has been diagnosed with the Coronavirus.
Prefer not to say.



	Frequency	Percent
A household member has been diagnosed with the Coronavirus	18	2.9
I have been diagnosed with the Coronavirus (COVID-19)	23	3.7
Prefer not to say	48	7.8
No Response	52	8.4
A family member outside my household has been diagnosed with the Coronavirus	68	11
A friend or someone I know outside my family has been diagnosed with the Coronavirus	149	24.1
I don't know anyone personally who has been diagnosed with the Coronavirus	259	42

Q12: As a result of COVID19, have you needed any of the following?

Respondent could select all that apply. Financial assistance; Energy assistance; Food assistance; Wi-Fi /Internet assistance; Rental assistance; Housing/shelter; Translation/Interpretation Services; Childcare; None; Other: _____



	Frequency	Percent
Other	13	2.1
Translation/Interpretation Services	19	3.1
Child Care	27	4.4
WiFi/Internet Assistance	58	9.4
Energy Assistance	69	11.2
Housing/Shelter	70	11.3
Rental Assistance	75	12.2
Financial Assistance	174	28.2
Food Assistance	187	30.3
None	259	42

Q13: When it comes to COVID-19, what are you most concerned about right now?

Rank the following options in order of importance (**1 = most important to 4 = least important**). Members of my household becoming infected; The health of my community as the pandemic continues; The emotional health of my household; Financial hardship.

Members of my household becoming infected		Frequency	Percent
	1	149	24.1
	2	88	14.3
	3	61	9.9
	4	50	8.1
	Total Responses	**348**	**56.4**
	No Response	**269**	**43.6**

The health of my community as the pandemic continues		Frequency	Percent
	1	89	14.4
	2	85	13.8
	3	84	13.6
	4	95	15.4
	Total Responses	**353**	**57.2**
	No Response	**264**	**42.8**

The emotional health of my household		Frequency	Percent
	1	43	7
	2	100	16.2
	3	127	20.6
	4	58	9.4
	Total Responses	**328**	**53.2**
	No Response	**289**	**46.8**

Financial hardship		Frequency	Percent
	1	124	20.1
	2	61	9.9
	3	47	7.6
	4	118	19.1
	Total Responses	**350**	**56.7**
	No Response	**267**	**43.3**

Q14: What ideas or suggestions do you have to improve the health in your community?

Respondent could offer suggestions or select - Don't know or prefer not to answer.

	Number of Responses
COVID 19 Testing/Social Distancing/Vaccines	36
Better Access to Health Care	17
Affordable Insurance	13
Community Safety	7
End Homelessness	7
Social Connections	7
Literacy/Education	6
Access to Information	6
Better Community Relations and Outreach	6
City Leadership	6
Access to Healthy Food	5
Affordable Housing	5
Access to Jobs	5
End Poverty	4
Better Transportation Access	4
Access to Mental Health Services	4
Dismantle Structural Racism	4
Assistance with community needs	4
Support for Substance Abuse	3
Healthy Lifestyles and Wellbeing	2
Support for Small Businesses	2
Community Cleanliness	2
Affordable Childcare	2
Suicide Prevention	1

Stakeholder Interviews

Mercy worked with BNIA-JF to reach out to key stakeholders from within the CHNA Service Area to solicit input including neighborhood association leaders and representatives of organizations that provide important services to residents in the CHNA area. These included:

- Traci Kodek, President, Healthcare Access Maryland
- Kevin Lindamood, President, Healthcare for the Homeless
- Danny Bellamy, President, Total Health Care
- Diane Bell-McKoy President, Associated Black Charities
- Mary Beth Haller, Deputy Commissioner, Baltimore City Health Department/B'more for Healthy Babies
- Towanda Carter, President, New South Clifton Park Community Association
- Earl Johnson, President, Oliver Economic Development Corporation
- Dave Harris, President, McElderry Park Community Association, Inc.
- Lauren Kelly-Washington, President, New Greenmount West Community Association.
- Terry Summerhill, President, Latrobe Resident Council, Inc.

A series of individual interviews were conducted. A summary of the feedback is below.

Themes from Mercy Health Services Stakeholder Interviews

BNIA-JFI conducted one-on-one interviews[1] with resident leaders from Mercy's CHNA service area as well as other key partners over a two-week period (May 26-June 11). Interviews were conducted virtually via Zoom or by phone. Community members were offered an incentive to participate. Interviews follow a structured set of questions regarding general community issues around the COVID-19 pandemic and then specifically for Mercy's CHNA Implementation Plan focus areas.

Concerns about COVID 19 moving forward:

Respondents were concerned about immediate issues regarding the COVID 19 pandemic such as increasing vaccination rates and managing the physical health delivery system with COVID 19 restrictions. More so, however, respondents worried about the ramifications of preparing for a surge in long term health disparities that were not addressed during the pandemic because of delayed or missed medical appointments. Will there be backsliding in progress to reduce infant mortality or impacts of unmanaged diabetes and hypertension? Will there be an increase in cancer diagnoses without access to routine services such as mammograms?

[1] IRB protocol 283 Mercy Health Community Needs Assessment (PI: Iyer, Seema) was Exempt approved on Wednesday, May 19th, 2021 by The University of Baltimore IRB Committee.

Key partners were particularly concerned about ensuring access to mental health services for clients and staff. *"The past 14 months have been devastating for the staff. Staff had to navigate change after change serving a population with a lot of trauma and crisis."*

Community members were concerned about getting people back to their jobs and restarting the economy.

- *"Who lost jobs, which businesses closed and how will people recover and get back to work?"*
- *"How will the influx of recovery funding be spent? Who is deciding?"*

Community Health Concerns

Overall community health concerns for the community included controlling chronic issues like diabetes, hypertension, asthma and cancer diagnoses. Respondents also referred to high risk pregnancies, drug addiction and mental health/trauma issues. Food insecurity and lack of proper nutrition were mentioned for many issues throughout the interviews

- *"Preventative care and access to healthy food go hand in hand"*

Community Social/Environmental Concerns

Respondents mentioned concerns about unsafe behaviors and incidents such as high rates of prostitution, domestic violence and other acts of violence. They also pointed to the fact that many communities have very transient populations which make monitoring and follow-ups difficult. There was also a sense of social isolation or lack of integration of people of different socio-economic status who may be living in the same neighborhood. Some interviewees mentioned a general lack of empowerment among residents, particularly when low-income households are concentrated in public housing.

- *"I think it's wonderful that we have food giveaways I also see that as stifling people and not giving them the means to empower themselves"*
- *"Health is economics; the two are converse relationship of each other"*

Partners provided statistics about the dramatic increase of Hispanic residents in Baltimore, which "exploded" during the pandemic. Homelessness (couch-surfing) has risen within Hispanic population, and because the American Care Act (ACA) does not cover undocumented clients, providing healthcare is a challenge to this growing population in Baltimore.

Finally, respondents stated a broad range of other social and environmental concerns impacting their communities:

- Addressing systemic racism and its impact on health disparities
- Housing equity/insecurity
- Food insecurity
- Poor access to transportation
- Poor access to the internet
- Staff burnout

Concerns about utilizing healthcare services

The most stated reason for why residents hesitate to utilize healthcare services was lack of trust.

- *"The whole Henrietta lacks story that still plagues Baltimore"*
- *"Trust is hard to establish and easily broken. There are huge trust issues"*

Trust is also difficult for undocumented immigrants and growing Spanish-speaking/Hispanic clientele. To overcome these issues, respondents universally recommended more extended care into the community. More mobile units and more services in the community would ease access for individuals and create more connection with neighbors who are more likely to recommend services through word of mouth which is the most effective means of encouraging others to use services as well.

More community-based services would also address the issue of isolation where people are not likely to cross the boundaries of their neighborhood. It would help mitigate the complexity of programs or resources that may be otherwise hard to navigate. Community members wanted to be involved in the creation of these kinds of services:

- *"I think the intentions are good. There needs to be input from the communities. Does it actually work?"*
- *"Take a walk around the neighborhood and see what the person is faced with. Walk a mile in someone else's shoes before starting a program."*
- *"It's important to listen to the community. These services are long overdue."*

Lack of transportation was also a major barrier cited among respondents. Other barriers include real or perceived tradeoffs for the cost of health services for low-income households; people have to make difficult choices between spending money on healthcare or food. People also may not want to take off work to go to the doctor's office if there is no paid time off.

- *"People don't know where they are going to live or what they are going to eat, so healthcare is last on their list of priorities."*
- *"A lot of people are caregivers but take care of themselves last."*

Comments regarding Mercy's CHNA Implementation Plan Focus areas

Improving access to care and the frequency of care for our homeless neighbors.

Mercy's reputation and long history of working with the homeless community were mentioned among all respondents. Some partners noted a rise in youth homelessness and a rise in homelessness among Spanish-speaking residents. Although housing is the most salient problem, there is the need to address the root causes of homelessness with wrap around services for mental health, addiction, and other issues. Some respondents questioned if Mercy's supportive housing model will or should come back. Regardless, Mercy will need to leverage its approach with community partners who take care of other aspects such as food or housing.

Providing support to victims of violence and addiction.

While there was support for this focus area, many were not sure violence and addiction should be part of the same focus area. There may be interplay between the two but they are different issues as not all violence comes from addiction and visa versa. In terms of violence, respondents pointed to prior trauma and the daily stressors that impact the way people interact with each other. There is shame related to violence particularly for the victims of domestic violence who need clear and safe access to resources.

There was concern that there will be a resurgence of the opioid epidemic as fatal and non-fatal overdoses climb. Most saw the connection between substance abuse and mental health. But community members wanted to see holistic approached to addressing substance abuse.

- *"What I do not want to see is mental health be looped into another method methadone clinic"*

Identifying tactics and strategies to improve birth outcomes and pre-natal care for expectant mothers. Respondents viewed Mercy's experience in this area at the forefront among peers institutions. Partners noted that many more women are experiencing homelessness and therefore many more pregnancies and children. Currently, 44% of Healthcare for the Homeless clients are women. The system of care does not have enough shelters for women or for families or unaccompanied youth. They also mentioned the need for more resources among younger mothers and within Spanish speaking communities. However, nutrition and food security were noted by multiple respondents for better birth outcomes.

- *"Nutrition is very important for expectant mothers. We haven't been taught it. What your body needs, what the developing baby needs. Teach people how to cook."*
- *"Lack of good nutrition is a huge problem. Too much access to corner stores with unhealthy food options. Bad food is convenient"*

Expanding access to preventative community health services such as primary care to improve outcomes, manage chronic disease, and reduce total cost of care.

Respondents recognized that primary and preventative care will need to be connected to overall patient outcomes. As hospitals are being charged with that total cost of care, and there is greater understanding of the relationship between housing and health, partnerships with community organizations to encourage access to primary care will be key. However, transportation is a major barrier for people to arrive at routine appointments. Some opportunities might exist with better use of technology to help people with tele-health or monitoring issues like hypertension. Mercy's marketing efforts of their preventive care in the community seem to be effective.

Provide targeted health education opportunities to the public and support the education of future physicians, advance practice providers, nurses, and other healthcare workers who in-turn serve the community.

Community education provides a huge opportunity to help people with health and wellness, and community members suggested to make these efforts fun and accessible. This could mean leveraging health education in all aspects of the community such as in churches or grocery stores. Community outreach through education is also a way to build trust.

In terms of staffing, more training is needed about the realities of healthcare disparities and structural racism within a healthcare context. Staff need unique kinds of training for the kind of work that they are doing which is different than potentially other kinds of medical training. Respondents strongly suggested recruiting and retaining people that are from the communities that those were serving or accessing more resources to relieve staff such as the National Health Service corps.

General Comments About Mercy

- If there are ever any pilot programs they want to institute, Mount Clare would welcome them with open arms.
- Mercy has a high reputation in the community
- Always treat people with respect
- Mercy has built relationships with many Federal Qualified Health Center around the city
- We really look to mercy as a partner and seek their input and advice in many areas
- Mercy has a high level of customer service from people who answer the phones to the person that greets you to screen you for COVID at the front door or the receptionist who's taking your information. Their level of customer service has always been extremely good
- Mercy is my hospital of choice. I have been very impressed with how welcoming and beautiful the spaces are.
- Can the entities doing separate Community Needs Assessments review each other's before they go public?

Prioritization of Needs

Mercy's location in the middle of a disproportionately poor, urban City presents challenges and health disparities that are not evident in other parts of Maryland. The health needs and societal needs identified in our Community Health Profile and interviews are staggering; simply put, a hospital like Mercy cannot singlehandedly move the needle on many of these key community metrics. Therefore, Mercy intends to focus its limited resources on a defined number of health needs within the community, while continuing to execute our mission "to witness God's healing love for all people by providing excellent clinical and residential services within a community of compassionate care".

In order to prioritize the multitude of health needs and disparities identified by the CHNA, the Mercy's Mission and Corporate Ethics Committee (the authorized body of the hospital) reviewed all the quantitative and qualitative data described above and identified areas of opportunity where the mission and strengths of our institution intersect with the unmet public health needs that merit attention and feedback from community health leaders. In determining health needs that Mercy will not attempt to meet pursuant to this CHNA, focus will be placed on whether other organizations or governmental entities are better placed to respond to such health needs than Mercy.

Mercy generally intends to continue its focus on the specific needs identified in its 2013 CHNA with some modifications. The desire to continue with these focus areas is validated by the feedback from community stakeholders in 2021 to build upon existing successful efforts, as well the recognition that these needs require focused intervention over the long-term. They are:

- **Improving access to care and the frequency of care for our homeless neighbors.**
- **Providing support to victims of violence and addiction.**
- **Implement strategies to improve birth outcomes and pre-natal care for expectant mothers.**
- **Expanding access to preventative health services such as primary care to improve outcomes, manage chronic disease, and reduce total cost of care.**
- **Provide targeted health education opportunities to the public and support the education of future physicians, advance practice providers, nurses, and other healthcare workers who in-turn serve the community.**

In contrast, at this time Mercy does not intend to create a new community-based program focused solely on heart disease and lung cancer. 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 and provide significant cardiology and cancer programs to the community. While Mercy does not plan to create new stand-alone programs in these two high priority fields, we do plan to continue our efforts to reduce these top causes of premature death through our existing clinical programs and by improving care coordination and health education in the community setting.

CHNA Implementation Strategy

The Mercy Mission and Corporate Ethics committee reviewed all the Quantitative & Qualitative summary data noted in the Community Health Needs Assessment. The Mission and Corporate Ethics committee is the authorized body of the hospital. On Wednesday, June 9, 2021, the committee discussed, developed and approved the following strategy focus areas for Mercy's 2021 CHNA and Implementation Strategy:

- Improving access to care and the frequency of care for our homeless neighbors.
- Providing support to victims of violence and addiction.
- Implement strategies to improve birth outcomes and pre-natal care for expectant mothers.
- Expanding access to preventative health services such as primary care to improve outcomes, manage chronic disease, and reduce total cost of care.
- Provide targeted health education opportunities to the public and support the education of future physicians, advance practice providers, nurses, and other healthcare workers who in-turn serve the community.

These focus areas also align with the Population health goals of the Health Services Cost Review Commission's Statewide Integrated Health Improvement Strategy including improving overdose mortality and reducing the state's severe maternal morbidity rate.

Adoption of Implementation Strategy

In accordance with IRS guidelines for the Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3), Mercy's Mission & Corporate Ethics Committee (the authorized body of the hospital facility) will adopt a formal implementation strategy on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility finishes conducting the CHNA 2021.

Aligned Population Health Initiatives

In addition, since the implementation of the Maryland Total Cost of Care (TCOC) Model, Mercy is increasingly focused on high-utilizer patients, including those within our defined CHNA Service Area. Under the TCOC Model Mercy Health Services 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. Mercy has reduced its population of high utilizers through highly effective readmission reduction and

extended care activities. Mercy knows its high risk population including individuals experiencing homeless (proximity driven), end stage liver disease (program driven) and high risk mothers. Mercy has tailored specific interventions for these target populations. Mercy will continue to build on its successful population health strategies. A hospital stay provides a critical opportunity to identify and interact with high-risk/high need patients to prevent future hospitalizations.

Central to Mercy's success in managing complex patients and reducing potentially avoidable utilization is a centralized care management infrastructure. Mercy will continue to build its core care management capabilities in and pursue additional strategies alone and/or in collaboration with other hospitals, FQHCs or payer partners. Mercy's complex care coordination and improvement activities include:

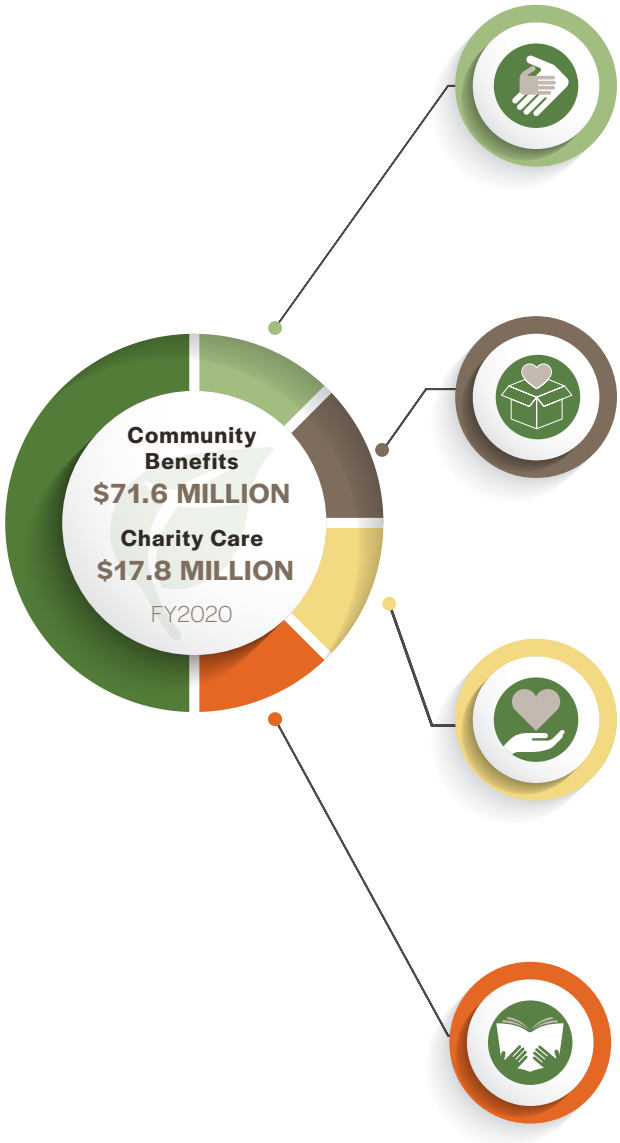
- Participation in the Maryland Primary Care Program to improve care coordination and population health.
- Risk stratification of the population with a focus on patients with a high risk diagnosis
- A bedside medication delivery at discharge program
- Intensive education for patients and families through MyChart Bedside
- Timely communication with primary care providers (PCP) and connecting patients without primary care physicians to PCP's in the community (including Obstetricians)
- Extended care activities by a physician-led population health team including a clinic for post-discharge needs, scheduling or checking on follow-up appointments
- Expedited charity care policy to speed transitions home or to lower cost settings
- Care coordination across settings.

Community Partnerships

Mercy has long-standing, and strong, community partnerships with Federally Qualified Health Centers (FQHC's). FQHC's fill a vital role in the community and our partnerships emphasize cooperation in caring for patients rather than competition. Mercy specifically maintains active partnerships with Health Care for the Homeless, Family Health Centers of Baltimore, Total Health Care and Park West Medical Center to help manage high risk populations including pregnant women. MHS executives or physician leaders currently serve on the Boards of Total Health Care, Family Health Centers of Baltimore, Health Care for the Homeless and Park West Medical Systems.

Community Impact

As an anchor institution of Baltimore, Mercy continually seeks to strengthen the communities we serve by providing affordable health care, patient-centered programs and connections to social support services through our Charity Care and Community Benefits initiatives.



CARE & SERVICES

In Fiscal Year 2020, Mercy conducted thousands of surgeries, procedures, health visits and COVID-19 tests. We offered at-risk patients peer recovery coaching about substance use and provided crisis interventions for victims of domestic violence, sexual assault and other abuse.

FOOD & SUPPLIES

In addition to hosting on-site discount produce stands and enrolling chronically ill patients in a free food delivery program, Mercy donated wearable infant blankets, breast pumps, car seats, clothing, wigs and head coverings, medicines, medical devices and boxes of groceries to hundreds of patients in need.

ASSISTANCE & SUPPORT

Patients experiencing economic hardship were provided free transportation vouchers to and from appointments, after-hours and follow-up counseling, wraparound care management, connections to community service programs and supportive housing placements.

TRAINING & EDUCATION

Mercy hosted free healthy cooking demonstrations for people managing chronic illness, trained hundreds of health providers about identifying and treating domestic violence and abuse, and increased the number of Certified Lactation Consultants and trained service line workers we have on staff.

In Fiscal Year 2020, Mercy provided $71.6 million in Community Benefits representing 14.5 percent of total hospital operating expenses—including $17.8 million in Charity Care. Over the years, Mercy's total Community Benefits as a percentage of our operating expenses has consistently remained above the state average. Mercy's Community Benefits expenses support a variety of programs and initiatives that address disparities in health, promote access to quality care and services, and improve the overall health of our shared communities.

Filling Charity Prescriptions

Mercy's Prescription for Health Program provides assistance to patients who are unable to afford prescription medications. People who visit the Emergency Department, undergo surgery or receive inpatient care often must continue with medicine at home. Our Emergency Department provides "to-go packs" of prescription medicine to meet a patient's acute needs. We also provide bedside delivery of prescription medicines to outpatients prior to their discharge from the hospital. Our partner Walgreens helps us dispense more than 41,000 prescriptions at no cost to patients each year. The goal of the program is to improve health and reduce potentially avoidable hospital readmissions.

Providing Pre-Natal Care and Childbirth Services

Mercy is the largest birthing hospital in Baltimore City and the second-largest hospital provider of obstetrical services in Maryland for Medicaid-insured patients. Approximately one in five babies in the City is born here. At Mercy, women have access to pre-natal care, programs and education to help prepare for pregnancy, birth and the transition to parenthood. The Family Childbirth & Children's Center at Mercy uses a family-centered model of care in a state-of-the-art facility for expectant mothers, newborn babies, pediatric patients and families. High-risk pregnancy patients with underlying health issues receive specialized care in our Center for Advanced Fetal Care.

Supporting Population Health

Many Mercy patients with chronic health issues such as diabetes, heart disease or morbid obesity often also struggle with financial hardship. The Population Health Program offers qualified patients connections to public benefits, free or reduced-cost medications, free at-home medical equipment, vouchers for transportation to and from follow-up appointments, free cooking demonstrations, delivered boxes of groceries and more. The goal of the program is to help high-risk patients manage their health before an expensive hospital visit or medical procedure becomes necessary.

Addressing Abuse

The Sisters of Mercy were originally founded in Dublin, Ireland to care for homeless, abused and neglected women and children. Established in March 2000, Mercy's Family Violence Response Program continues that tradition by providing compassionate care and confidential services to more than 600 patients each year who are victims of domestic violence, sexual assault and other abuse.

The program staff offers crisis intervention, counseling, safety planning, advocacy services and community resource referrals to shelter and legal aid. This program coordinates with our skilled team of forensic nurse examiners who document the details of assault, collect crucial time-sensitive evidence, and provide medical exams, tests and treatments. We are the only hospital in Baltimore City to offer a forensic exam for adult victims.

Assisting with Transportation

Many patients who come to Mercy for chemotherapy, radiation treatments, dialysis or physical therapy have no means of transportation when they are ill. The Transportation Assistance Program ensures that hundreds of patients a year receive complimentary transportation to and from Mercy for appointments and treatment.

Offering Addiction Services

SBIRT stands for Screening, Brief Intervention and Referrals to Treatment. Mercy was the second hospital in Baltimore to implement the SBIRT framework, which has now become a standard best practice. We employ four SBIRT Peer Recovery Coaches who help reframe patients' understanding of the health risks associated with substance use. Over the course of a year, the Peer Recovery Coaches educate hundreds of individual patients about the potential health effects of drug and alcohol use. Mercy also offers one of two inpatient detoxification units in Baltimore City and provides physician subsidies for the professional component of these inpatient services.

Supporting Homeless Services

On any given night, more than 2,500 people experience homelessness in Baltimore. The lack of stable housing makes them more likely to have health issues and need urgent care. Due to the unavoidable intersection between housing and health, Mercy has been a longstanding supporter of the mission of Healthcare for the Homeless.

Additionally, Mercy has been participating in a partnership between Baltimore City's hospitals and Health Care for the Homeless to provide 200 homes and supportive services for individuals and families experiencing homelessness. The pilot program, entitled Assistance in Community Integration Services, was implemented in 2019. For these efforts, the partnership won the prestigious American Hospital Association Dick Davison NOVA Award.

Mercy nurses assisted with the delivery of meals at Our Daily Bread, Maryland's largest hot meal program serving those experiencing hunger in Baltimore City.

Existing Health Care Facilities & Other Community Resources

Five of twelve 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. However, Mercy maintains an array of specialized citywide support programs for pregnant women, homeless individuals and substance abusers are supported, in part, by our community benefits program.

General Acute Care Hospitals in Baltimore City:

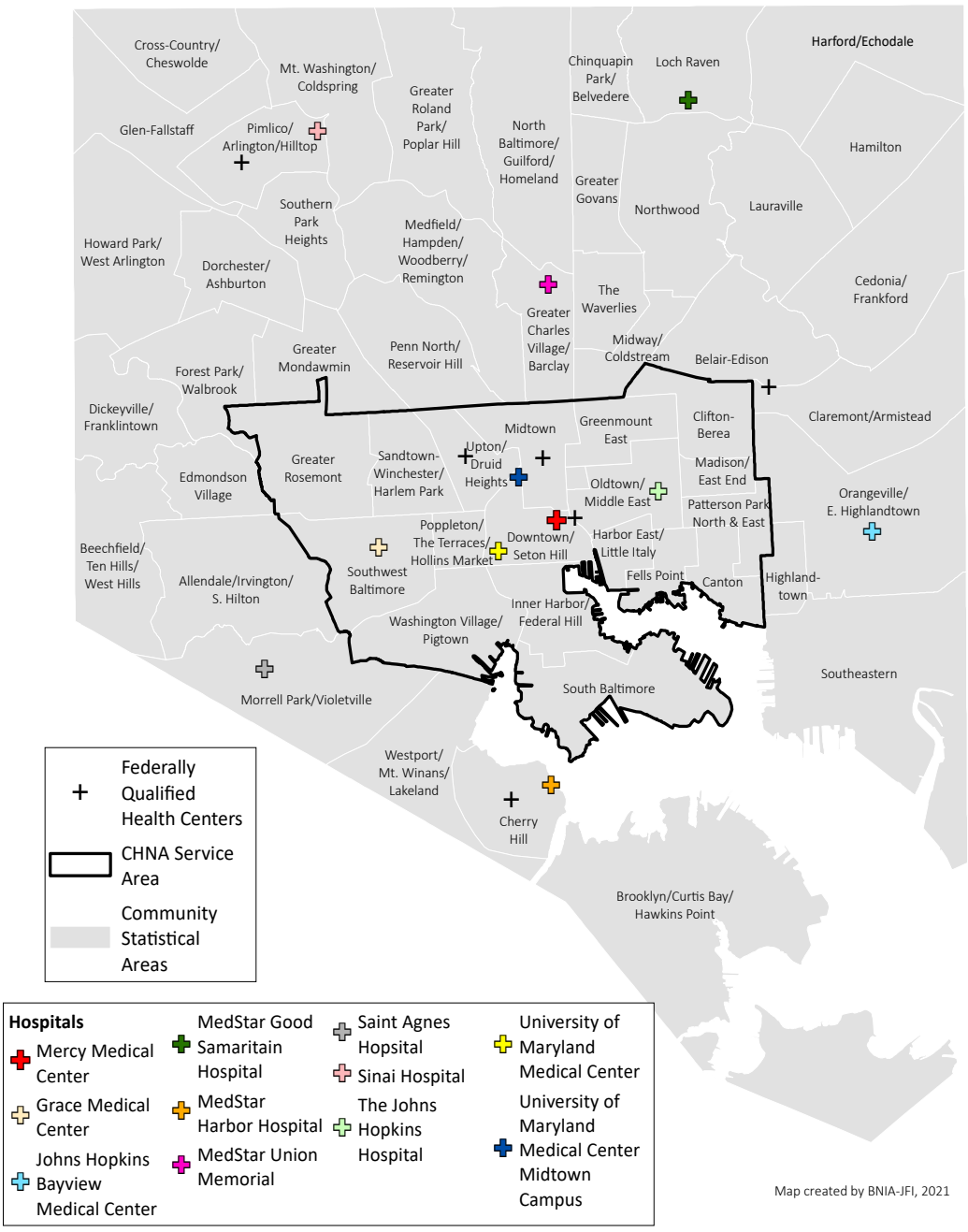
1. Grace Medical Center
2. Johns Hopkins Hospital
3. Johns Hopkins Bayview Medical Center
4. MedStar Good Samaritan Hospital
5. MedStar Harbor Hospital
6. MedStar Union Memorial Hospital
7. Mercy Medical Center
8. Mt. Washington Pediatric Hospital
9. St. Agnes Hospital
10. Sinai Hospital of Baltimore
11. University of Maryland Medical Center
12. University of Maryland Medical Center Midtown Campus

Federally Qualified Health Centers:

In addition to hospitals, seven different Federally Qualified Health Centers operate more than 15 different community health clinics inside or within walking distance of our community.

Mercy Medical Center CHNA Service Area

Hospitals and FQHCs



Mission & Corporate Ethics Committee

Mercy thanks members of the Mercy Health Services Mission & Corporate Ethics Committee for their direction and support of Mercy's 2021 Community Health Needs Assessment & Implementation Strategy.

As the authorized body of the hospital, the Mission & Corporate Ethics Committee approved the 2021 CHNA & Implementation Strategy as part of its regular meeting held on June 9, 2021.

Committee Roster:

Ms. Mary Louise Preis, Chair, Mercy Health Services Mission & Corporate Ethics Committee and member of the Mercy Health Services Board of Trustees

Sister Helen Amos, RSM, Executive Chair, Mercy Health Services Board of Trustees

David N. Maine, M.D., President and CEO, Mercy Health Services

Ms. Beverly Cooper, Board Member, Mercy Health Services Board of Trustees

Albert Polito, M.D., Medical Director, The Lung Center at Mercy Medical Center

Sister Fran Demarco, RSM, Director, Mission Services, Mercy Medical Center

Ms. Susan Finlayson, Sr. V.P., Operations, Mercy Medical Center

Rev. Larry Johnson, Director of Pastoral Care, Stella Maris

Rev. Thomas Malia, Assistant to the President for Mission, Mercy Medical Center

Mr. Joe Marana, Mgr., Nursing Unit, Mercy Medical Center

Ms. Cheryl Mohn, Director, Dining Services, Stella Maris

Mr. Ryan O'Doherty, Sr. V.P., External Affairs, Mercy Health Services

Ms. Elinor Petrocelli, V.P. Finance & Revenue Cycle

Sister Augusta Reilly, RSM, Board Member, Mercy Health Services Board of Trustees

Wilma Rowe, M.D., Sr. V.P., Medical Affairs, Mercy Health Services

Ms. Erin Tribble, Director, Pastoral Care, Mercy Medical Center

Disclaimer

Mercy's Implementation Strategy addresses the community health needs described in Mercy Medical Center's Community Health Needs Assessment that Mercy plans to address in whole or in part and that are consistent with its mission. Mercy reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternatively, other organizations in the community may decide to address certain needs, indicating that Mercy then should refocus its limited resources to best serve the community. Beyond the initiatives and programs described herein, Mercy is addressing some of these needs simply by providing health care to the community, regardless of ability to pay.

MERCY MEDICAL CENTER
POLICY AND PROCEDURE
PATIENT FINANCIAL SERVICES

FINANCIAL ASSISTANCE POLICY

POLICY#: 602-176-93 REVISED: 9/2023

Mercy Medical Center ("MMC") provides and promotes health services for the people of Maryland 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, Monetary 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 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. The charges to which a discount may apply under this policy are the Facility/Hospital Charges (defined below), which are set by Maryland's rate regulation agency, the Health Services Cost Review Commission. 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. Actions that MMC may take in the event of non-payment are described in a separate billing and collections policy. To obtain a free copy of this policy, please contact Customer Service at 410-951-1700.

Financial Assistance under this Policy is available for all emergency and Medically Necessary Care (defined below) provided by MMC. All MMC Facility/Hospital Charges are subject to this Policy.

Services Eligible Under this Policy

For purposes of this Policy, "Medically Necessary Care" means 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 generally accepted standards of medical practice and not mainly for the convenience of the patient. This includes treatment of Emergency Medical Conditions and non-urgent or elective care that is Medically Necessary.

The following services are excluded from coverage under this Policy:

1. Cosmetic procedures and other non-Medically Necessary Care.
2. Non-covered benefits or services under the patient's insurance program or policy. Exceptions may be made on a case-by-case basis considering medical and other implications.
3. Services or supplies that are primarily for the patient or family's convenience, lodging, and meals.
4. Services or supplies related to third party liability claims (e.g., auto accident, workers compensation, bodily injury, or other legal claims) until all other means of coverage and payment are exhausted.

Notification and Application Process

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 provide contact information for additional resources. MMC will also provide patients with a Financial Assistance Patient Information Sheet upon admission, when presenting the bill for services (each bill also references the Patient Information Sheet), and upon request. Patients will be asked to sign an acknowledgment that they have received the Patient Information Sheet. Patients may also request a copy of this Financial Assistance Policy at any time during a collection process. Upon request, translations of the policy are available in several languages and interpreter services are also available by calling Customer Service at 410-951-1700.

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"). Free copies of the UFAA are available to download at https://mdmercy.com/about-mercy/policies-and-corporate- documents or by calling Customer Service at 410-951-1700 or Financial Counseling at 410-332-9273 to request a copy by mail; or visiting the MMC billing office, admissions office, business office, or emergency department. For questions or assistance with completing the UFAA, please contact Financial Counseling at 410-332-9273.

Within two (2) business days following a patient's request for Financial Assistance, application for Medical Assistance, or both, MMC will make a determination of probable eligibility for Financial Assistance and communicate the determination to the patient or the patient's representative. In some instances, probable eligibility for Financial Assistance may be determined on the basis of a patient's circumstances, such as when a patient is a beneficiary of a means-tested social services program, as described under category 2 below. In other instances, MMC may request information from a patient or use information available from outside agencies as a basis for determining probable eligibility for Financial Assistance. MMC uses the completed UFAA applications to make a final determination of eligibility under the requirements described below. Once a patient submits a completed UFAA and all required documentation, MMC will provide a final determination of eligibility within 14 calendar days. 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's need for Financial Assistance shall be re-evaluated at each subsequent time of service if the last financial evaluation was performed more than 12-months prior. To avoid an unnecessary duplication of MMC's determinations of eligibility for Financial Assistance, a patient who has received a Financial Assistance determination in the prior year shall inform MMC of the prior determination. A patient must also notify MMC if about any change in financial circumstances that occurs within 240 days after the initial hospital bill is provided or if additional information regarding the patient's eligibility becomes known.

A patient who disagrees with a determination by MMC that the patient is not entitled to Financial Assistance, or who has a change in financial circumstances within 240 days after the initial hospital bill is provided, may contact MMC using the contact information provided in the determination letter 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.

The Health Education and Advocacy Unit ("HEAU") is available to assist a patient or patient's representative with filing a reconsideration request by contacting: Address - Office of the Attorney General, HEAU, 200 Saint Paul Place, 16th Floor, Baltimore, Maryland 21202; Phone - (410)-528-8662; Fax - (410)-576-6571; Email - heau@oag.state.md.us; website - https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx.

Eligibility & Benefits

Financial Assistance under this policy is available for Medically Necessary Care (defined below) provided by MMC. In order to qualify for Financial Assistance, a patient must be a Maryland 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. A patient's Family Income will be calculated at the time of service or updated, as appropriate, to account for any change in financial circumstances of the patient that occurs within 240 days after the initial hospital bill is provided.
2. A patient who is not eligible for the Maryland Medical Assistance Program or Maryland Children's Health Program and 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 (30 additional days permitted upon request):

    a. Households with children enrolled in the free or reduced-cost meal program;

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

    c. Maryland's Energy Assistance Program;

    d. Special Supplemental Food Program for Women, Infants, and Children; or

    e. Other means-tested social service programs as determined by the Maryland Department of Health and the Health Services Cost Review Commission.

3. A patient with Family Income at or below 500% 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 based on the FPL Guidelines which are updated annually. The table below provides an example of the sliding scale discounts based on the FPL Guidelines from calendar year 2021. A patient's Family Income will be calculated at the time of service or updated, as appropriate, to account for any change in financial circumstances of the patient that occurs within 240 days after the initial hospital bill is provided.

		Example of Discounts Applied to Hospital Gross Charges Based on CY 2021 FPL Guidelines							
	% Discount	**100%**	**75%**	**67%**	**50%**	**40%**	**30%**	**20%**	**10%**
Family Size	CY2021 FPL(1)	*Gross Yearly Income*							
1	$12,880	$25,760	$32,200	$34,261	$38,640	$41,216	$43,792	$46,368	$64,400
2	$17,420	$34,840	$43,550	$46,337	$52,260	$55,744	$59,228	$62,712	$87,100
3	$21,960	$43,920	$54,900	$58,414	$65,880	$70,272	$74,664	$79,056	$109,800
4	$26,500	$53,000	$66,250	$70,490	$79,500	$84,800	$90,100	$95,400	$132,500
5	$31,040	$62,080	$77,600	$82,566	$93,120	$99,328	$105,536	$111,744	$155,200
6	$35,580	$71,160	$88,950	$94,643	$106,740	$113,856	$120,972	$128,088	$177,900
7	$40,120	$80,240	$100,300	$106,719	$120,360	$128,384	$136,408	$144,432	$200,600
8	$44,660	$89,320	$111,650	$118,796	$133,980	$142,912	$151,844	$160,776	$223,300

For families/households with more than 8 persons, add $4,180 for each additional person.
Note (1): Federal HHS Poverty Guidelines for CY 2021, which are updated annually in the Federal Register.

4. A patient with: (i) Family Income at or below 500% of FPL; (ii) with Medical Debt (defined below) 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. MMC makes payment plans available to all patients who are Maryland residents upon request. Additional information regarding payment plans is available in MMC's Payment Plan Policy and its Credit and Collections Policy, which is available on MMC's website (see: https://mdmercy.com/patients-and-visitors/billing-and-insurance/financial-assistance)..

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

6. A homeless patient qualifies for Financial Assistance in the form of free Medically Necessary Care.

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 in the form of free Medically Necessary Care.

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 self-pay collection process. Factors include propensity to pay or FPL 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.

Changes to a Patient's Eligibility

If a patient's Family Income, Monetary Assets, expenses, family status, or other financial circumstances change, the patient must notify MMC. MMC will reconsider a patient's eligibility for financial assistance based on any changes in financial circumstances that occurs within 240 days after the initial hospital bill is provided.

Reconsideration Requests

A patient who disagrees with a determination by MMC that the patient is not entitled to Financial Assistance, or who has a change in financial circumstances within 240 days after the initial hospital bill is provided, may contact MMC using the contact information provided in the determination letter and request that MMC reconsider such denial. Reconsideration requests may be made verbally or in writing.

The Health Education and Advocacy Unit ("HEAU") is available to assist a patient or patient's representative with filing a reconsideration request by contacting: Address – Office of the Attorney General, HEAU, 200 Saint Paul Place, 16th Floor, Baltimore, Maryland 21202; Phone - (410)-528-8662; Fax - (410)-576-6571; Email – heau@oag.state.md.us; website - https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx.

Refunds

If, within two years after a date of service, MMC is informed that a patient was eligible for Financial Assistance on that specific date of service (using the eligibility standards applicable on that date of service), the patient may be entitled to a refund of amounts collected from the patient exceeding $25. In such instances, MMC may request information and documentation

from the patient to determine the patient's eligibility for financial assistance at the time of the service. If MMC's documentation demonstrates a lack of cooperation by the patient in providing the requested information to determine eligibility at the date of service, MMC may reduce the refund period from two years to 30 days after the date of MMC's request for information.

If the patient is enrolled in a means-tested government health care plan that requires the patient to pay out-of-pocket costs for hospital services, then the patient shall not be refunded any funds that would result in the patient losing financial eligibility for such health coverage.

Patients who believe they may be eligible for a refund are responsible for contacting MMC to request a refund.

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 affect 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.

Facility/Hospital Charges: Hospital rate regulation in Maryland was established by an act of the Maryland legislature in 1971. The law created the Health Services Cost Review Commission ("HSCRC"), an independent State agency. The HSCRC establishes hospital rates for each Maryland hospital and the rates are set on an all-payer basis, meaning all payers pay the same rates as outlined by the HSCRC. This includes the uninsured or self- pay population. The HSCRC's rate regulatory authority applies to inpatient services (as defined by Medicare) and outpatient and emergency services at a hospital (on the campus), and cover costs such as support staff, supplies, and medications. The HSCRC does not regulate Physician Charges. **For further information, go to: https://hscrc.maryland.gov/.**

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. Mercy considers a patient's immediate family members to include a spouse, regardless of whether the patient and spouse expect to file a joint federal or state tax

return; biological, adopted, and/or step children; and any person for whom the patient claims a personal exemption in a federal or state tax return. If the patient is a child, the patient's immediate family includes any biological, adopted, and/or step parents or guardians; biological, adopted, or stepsiblings; and anyone for whom the patient's parent(s) or guardian(s) claim a personal exemption in a federal or state tax return. Mercy will consider additional individuals residing in the patient's household as part of the patient's household size for purposes of calculating Family Income on a case-by-case basis.

Federal Poverty Level (" FPL"): Guidelines for federal poverty issued each year by the U.S. 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.

Mercy Medical Center ("MMC"): This policy applies to Medically Necessary Care provided at Mercy Medical Center. All Facility/Hospital Charges are subject to this policy. Fees for physicians' Professional Charges provided at MMC are not included in the Facility/Hospital bill and are billed separately. Physicians at MMC make their own determination of Financial Assistance for non-emergent care provided at MMC.

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; (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; (4) one motor vehicle used for the transportation needs of the patient or any family member of the patient; (5) any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social security Act; and (6) prepaid higher education funds in a Maryland 529 Program account.

Physician Charges: Physician Charges are charges separate from the Facility/Hospital Bill related to services from providers such as anesthesiologists, pathologists, oncologists, or other specialists who contribute to your care at MMC.

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