Saint Agnes Hospital (21-0011)

COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

FY2017 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/);
(2) the Maryland Chartbook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(3) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(4) Local Health Departments;
(5) County Health Rankings & Roadmaps (http://www.countyhealthrankings.org);
(6) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(7) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(8) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(9) CDC Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(10) CDC Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth);
(11) Youth Risk Behavior Survey (http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx);
(12) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(13) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(14) Survey of community residents;
(15) Use of data or statistics compiled by county, state, or federal governments such as Community Health Improvement Navigator (http://www.cdc.gov/chinav/); and
(16) CRISP Reporting Services.

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

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

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

HSCRC COMMUNITY BENEFIT REPORTING REQUIREMENTS

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

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

   a. Bed Designation – The total number of licensed beds

   b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;

c. Primary Service Area (PSA) zip codes;

d. Listing of all other Maryland hospitals sharing your PSA;

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

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

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

Table I

a. Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area zip codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	e. Percentage of the Hospital's Patients who are Uninsured:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries
287	17,616	21229, 21228, 21227, 21207, 21216, 21223, 21230, 21244	Sinai, BWMC, UMMC, Harbor, Mercy, UMMC Midtown, Bon Secours, JHH, Northwest, Howard County	Balt. City – 47.7% Balt. Cnty – 31.4% Howard Cnty – 4.3% Anne Arundel – 3.9% Other – 12.6% Source: Hospital discharge date	Balt. City – 61.3% Balt. Cnty – 29.2% Howard Cnty – 3.5% Anne Arundel – 3.2% Other – 2.8% Source: Hospital discharge date	Balt. City – 46.1% Balt. Cnty – 38.0% Howard Cnty – 6.8% Anne Arundel – 5.2% Other – 3.9% Source: Hospital discharge date

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

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

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

      (ii) An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.

      (iii) A description of how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, e.g., individuals with > 3 hospitalizations in the past year). This information may be copied directly from the community definition section of the organization's federally-required CHNA Report (26 CFR § 1.501(r)–3).

Statistics may be accessed from:

The Maryland State Health Improvement Process (http://dhmh.maryland.gov/ship/);

The Maryland Vital Statistics Administration (http://dhmh.maryland.gov/vsa/Pages/home.aspx);

The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf);

The Maryland Chart Book of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%20Data%20Chartbook%202012%20corrected%202013%2002%2022%2011%20AM.pdf);

The Maryland State Department of Education (The Maryland Report Card) (http://www.mdreportcard.org) Direct link to data– (http://www.mdreportcard.org/downloadindex.aspx?K=99AAAA)

Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth)

Table II

Demographic Characteristic	Description	Source
Zip codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.	West Baltimore – 21215, 21216, 21217 South Baltimore City – 21223, 21230 Brooklyn/Linthicum – 21090, 21225 Southwest Baltimore City – 21229 Woodlawn – 21207, 21244 Glen Burnie – 21060, 21061 Arbutus – 21227 Catonsville – 21228 Pasadena – 21122 South Carroll – 21104, 21163, 2184 Ellicott City – 21042, 21043, 21075 Saint Agnes uses a community health index score to identify areas where the most vulnerable populations reside. The more urban based communities of West Baltimore City 2.01, South Baltimore City 1.78, Brooklyn/Linthicum 1.58, Southwest Baltimore City 1.58 represent the greatest healthcare needs, each with overall indices exceeding 1.50.	The Saint Agnes CBSA represents zip codes that comprise 80% of Saint Agnes Hospital patient population. FY 16 community health index scores were provided by *Healthy Communities Institute*.
Median Household Income within the CBSA	Baltimore City - $41,988 Baltimore County - $64,624 Howard County - $108,503 Anne Arundel County - $85,685 Carroll County - $82,073	National Environmental Public Health Tracking Network – CDC (2013 data)
Percentage of households in the CBSA with household income below the federal poverty guidelines	Baltimore City – 22.7% Baltimore County – 9.5% Howard County - 5.3% Anne Arundel County – 7.3% Carroll County – 6.8%	National Environmental Public Health Tracking Network – CDC (2013 data)
For the counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	Baltimore City – 9.8% Baltimore County – 8.4% Howard County – 5.2% Anne Arundel County – 6.6% Carroll County – 5.5%	Small Area Health Insurance Estimates (SAHIE) – (U.S. Census 2014 data)
Percentage of Medicaid recipients by County within the CBSA.	Baltimore City – 33.4% Baltimore County – 18.4% Howard County – 11.1% Anne Arundel County – 13.0% Carroll County – 10.8%	Maryland Medicaid Enrollment Statistics (2016) & National Environmental Public Health Tracking Network – CDC

Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/Pages/Home.aspx	Male Life Expectancy Baltimore City – 67.8 Baltimore County – 75.5 Howard County – 79.8 Anne Arundel County – 759 Carroll County – 76.7 Female Life Expectancy Baltimore City –76.5 Baltimore County – 80.6 Howard County – 83 Anne Arundel County – 80.7 Carroll County – 81.4	http://www.worldlifeexpectancy.com/usa/maryland-life-expectancy-by-county
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). http://dhmh.maryland.gov/ship/Pages/home.aspx	Infant Mortality - White Baltimore City – 3.4 Baltimore County – 3.3 Howard County – 5.1 Anne Arundel County – 5.5 Carroll County – 4.0 Infant Mortality - Black Baltimore City –12.6 Baltimore County – 9.5 Howard County – N/A Anne Arundel County – 9.0 Carroll County – N/A	Maryland Department of Health and Mental Hygiene - Vital Statistics Administration (2012)
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://ship.md.networkofcare.org/ph/county-indicators.aspx	Please refer to Appendix 5 of our CHNA (*Service Area Health Risk Summary*). This assessment compares 35 community specific health indicators, against Central Maryland averages. The extent to which a community is at higher than average risk, for a specific indicator, the index score will exceed 1.00. The inverse is true for an index scores below 1.00, which indicates a comparatively lower level of health risk. The overall health index, which is an average of all community need indices, highlights those communities with the greatest healthcare needs in the Saint Agnes Hospital service area. This assessment has identified that the more urban based communities of West Baltimore City, South Baltimore City, Brooklyn/Linthicum and	Healthy Communities Institute.

	Southwest Baltimore City represent the greatest healthcare needs, each with overall indices exceeding 1.50. The suburban communities of Pasadena, Ellicott City and South Carroll have comparatively fewer healthcare needs, as determined by this assessment.	
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://ship.md.networkofcare.org/ph/county-indicators.aspx	Baltimore City: White 31.8% Black 63.4% Hispanic 2.7% Other 2.1% Baltimore County: White 68.3% Black 24.5% Hispanic 3.0% Other 4.2% Anne Arundel: White 78.0% Black 14.8% Hispanic 4.3% Other 2.9% Howard County: White 67.6% Black 16.7% Hispanic 4.9% Other 10.8% Carroll County: White 92.8% Black 3.7% Hispanic 1.8% Other 1.7%	The Environmental Public Health Tracking Site (2009)
Other		

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

_X_Yes Provide date approved by the hospital's governing body or an authorized body thereof here: 06/24/16 (mm/dd/yy)

____No

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

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

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

_X__Yes Enter date approved by governing body/authorized body thereof here: __/ 06/24/16 (mm/dd/yy)

___No

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

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

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

_X_Yes
___No

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

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

b. What stakeholders within the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved

in the structure of the CB process and describe the role each plays in the planning process (additional positions may be added as necessary)

i. Senior Leadership

1. _X__CEO
2. ___CFO
3. _X__Other (please specify) CMO, Chief Strategy Officer

Describe the role of Senior Leadership.

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

ii. Clinical Leadership

1. _X__Physician
2. _X__Nurse
3. _X__Social Worker
4. _X__Other (please specify)

Describe the role of Clinical Leadership

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

iii. Population Health Leadership and Staff

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

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

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

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

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

iv. Community Benefit Operations

1. ___the Title of Individual(s) (please specify FTE)
2. ___Committee (please list members)
3. ___Department (please list staff)
4. ___Task Force (please list members)
5. _X__Other (please describe) Community Benefit evaluation is managed by a multi-disciplinary group that includes the following staff:

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

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

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

Spreadsheet _X____yes _____no

Narrative _X____yes _____no

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

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

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

Spreadsheet __X___yes _____no

Narrative __X___yes _____no

If no, please explain why.

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

___X___Yes _____No

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

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

__X___Other hospital organizations

_ X___Local Health Department

_____Local health improvement coalitions (LHICs)

__X___ Schools

_____Behavioral health organizations

__X___Faith based community organizations

__X___Social service organizations

_____Post-acute care facilities

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

Organization	Name of Key Collaborator	Title	Collaboration Description
American Diabetes Association – Maryland Area	David McShea Tracy Newsome	Executive Director Director, Community Health Strategies	Reviewed CHNA data analytics, provided input to CHNA priorities and discussed options to address needs related to education, prevention, and care related to diabetes.
Baltimore City Health Department	Sonia Sarkar Darcy Phelan-Emrick	Chief Policy and Engagement Officer Chief Epidemiologist	Reviewed CHNA data analytics, provided input to CHNA priorities and relationship to BCHD health improvement plan priorities. Discussed opportunities for further collaboration including CMMI Accountable Health Communities Grant and BCHD LHIC.
Baltimore Medical Systems, Inc.	Shirley Sutton	President/CEO	Reviewed CHNA data analytics, provided input to CHNA priorities and discussed opportunities for Saint Agnes and BMS to advance clinical collaboration through BMS site located on Saint Agnes campus.
Catholic Charities	William McCarthy, Jr.	Executive Director	Reviewed CHNA data analytics, provided input to CHNA priorities and discussed options to

			enhance collaboration through Catholic social services agencies to address social determinants of health.
Equity Matters	Michael P. Scott	Chief Equity Officer/President	Reviewed CHNA data analytics, provided input to CHNA priorities and discussed options to improve collaboration between health care institutions and community-based organization to address disparities and social determinants of health.
Green & Healthy Homes	Ruth Ann Norton	President/CEO	Reviewed CHNA data analytics, provided input to CHNA priorities and discussed impact of safe, affordable housing and the impact on health status and mechanisms to address housing needs, particularly for high need patients.
HealthCare Access Maryland	Traci Kodeck, MPH	Interim CEO	Reviewed CHNA data analytics, provided input to CHNA priorities and discussed options to address needs related to community-based care management to address social determinants of health.

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

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

_____yes __X___no

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

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

_X___yes _____no

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

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

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

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

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

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

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

e. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need,

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

g. Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative. For collaborating organizations, please provide the name and title of at least one individual representing the organization for purposes of the collaboration.

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

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

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

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

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

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

i. Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? To what extent do the measurable results indicate that the objectives of the initiative were met? (Please refer to the short-term, mid-term, and long-term population health targets listed by the hospital in response to item h, above, and provide baseline data when available.)

j. Continuation of Initiative:
What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? If not, why? What is the mechanism to scale up successful initiatives for a greater impact in the community?

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

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

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

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP) http://dhmh.maryland.gov/ship/SitePages/Home.aspx
COMMUNITY HEALTH RESOURCES COMMISSION http://dhmh.maryland.gov/mchrc/sitepages/home.aspx

PHYSICIANS

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

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

Table IV – Physician Subsidies

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

VI. APPENDICES

To Be Attached as Appendices:

1. Describe your Financial Assistance Policy (FAP):

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

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

      - Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
        - in a culturally sensitive manner,
        - at a reading comprehension level appropriate to the CBSA's population, and
        - in non-English languages that are prevalent in the CBSA.
      - Posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
      - Provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
      - Provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
      - Includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills;
      - Besides English, in what language(s) is the Patient Information sheet available;
      - Discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

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

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

   d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with Health-General §19-214.1(e). Link to instructions: http://www.hscrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).

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

Attachment A

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

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

a. 1. Identified Need
 	
2. Was this identified through the CHNA process?
	Cardiovascular Disease Burden
	In the Saint Agnes Healthcare Community Benefit Service Area cardiovascular disease and its comorbidities impacts adults. Screening for hypertension and heart disease followed by education on lifestyle changes and self-management skills enables prevention. Saint Agnes Healthcare partnered with several community organizations provide screening, education and care for hypertension and cardiovascular disease aimed to reduce the burden of CVD.
	
	Saint Agnes Healthcare Community Benefit Service Area Data:
	Cardiovascular Disease
	• ED visit rate due to hypertension (data from 2014 – from MD State Health Improvement Process)
	  • MD 2017 goal – 234 per 100,000 population
	  • Howard (112.1), Carroll (150.4), & Anne Arundel (183.6) < MD goal
	  • Baltimore County (234.5) = MD goal
	  • Baltimore City (658.9) > MD goal
	• Age-adjusted mortality rate from heart disease (data from 2013-2016 – from MD State Health Improvement Process)
	  • Health People Baltimore 2020 goal – 152.7 per 100,000 population
	  • Howard (122.8) < HP goal
	  • Anne Arundel (159.3), Baltimore County (176.6), Carroll (184.2), & Baltimore City (241.1) > HP goal
	  • MD 2017 goal – 166.3 per 100,000 population
	  • Howard (122.8) & Anne Arundel (159.3) < MD goal
	  • Baltimore County (176.6), Carroll (184.2), & Baltimore City (241.1) > MD goal
	• Adults who currently smoke by percentage (data from 2015 from MD State Health Improvement Process)
	  • MD 2017 goal - 15.5
	  • Anne Arundel (14.9), Baltimore County (12.8), Carroll (11.6), Howard (5.6) < MD goal
	  • Baltimore City (25.1) > MD goal
	
	Yes, this was identified through the CHNA process.

b. Hospital Initiative	Reduce the incidence and burden of cardiovascular disease in the community by providing screening, education and care for CVD and its comorbidities.
c. Total Number of People Within the Target Population	25.1%% of adults who currently smoke in Baltimore City (2015) = 156,084 30% of all deaths in MD were attributed to heart disease and stroke = 13,706 (2014. MD State Health Improvement Process, https://health.maryland.gov/vsa/Documents/14annual_revised.pdf)

d. Total Number of People Reached by the Initiative Within the Target Population	3,292 adults participated in a hypertension screening program in FY17 12 adults participated in women's heart screening program in FY17 443 adults participated in lung screening program in FY17 218 adults with diagnosed heart failure participated in educational initiative to understand advance directives and goals of care in FY17 27 adults received education and care for Heart Failure through collaboration with CEP America and the Saint Agnes HFC
e. Primary Objective of the Initiative	Objective 1 Increase by a percentage the implementation of effective community based education programs, screening, and case management for cardiovascular disease for the target population. Objective 2 Decrease the rate of inpatient and ED use by cardiovascular patients as measured by a decrease in Prevention Quality Indicator discharges.
f. Single or Multi-Year Initiative –Time Period	Multi-Year
g. Key Collaborators in Delivery of the Initiative	Saint Agnes Hospital Community Benefits Program The Heart Failure Center at Saint Agnes Maryland Cardiovascular Specialists CEP America, Inc. (ED physicians group) ACP Decisions/Nous Foundation, Inc.
h. Impact/Outcome of Hospital Initiative?	Objective 1 – Metrics: *Track number of participants in community based programs providing education, screening and case management to reduce the incidence and burden of cardiovascular disease.* • Outcomes: a) 3,292 adults participated in a hypertension screening program. b) 29.7% of screened for hypertension at risk and referred to a primary care physician. c) 12 adults participated in women's heart screening program. d) 443 adults participated in lung screening program. e) 218 adults with diagnosed heart failure participated in educational initiative to understand advance directives and goals of care f) 27 adults received education and care for Heart Failure through a collaboration with CEP America ED physicians and the Saint Agnes Heart Failure Center. Objective 2 – Metrics: *Decrease the rate of inpatient and ED use by cardiovascular patients as measured by a decrease in Prevention Quality Indicator charges.* • Outcomes: a) PQI 07 Hypertension Admission Rate decreased from baseline of 0.66% to 0.23%

i. Evaluation of Outcomes:	Saint Agnes has worked to increase access to screening, education and care for cardiovascular disease and its comorbidities through the implementation of targeted programming. Screening programs conducted in the community screened 3,304 individuals for hypertension and CVD and referred those identified at high risk to treatment. Lung screening program for current and former smokers screened 443 community members. 245 individuals with diagnosed heart failure received education on advanced directives and goals of care.	
j. Continuation of Initiative	Saint Agnes has an ongoing commitment to screening, education and care for community members with chronic conditions including cardiovascular disease and its comorbidities. In October 2017 Saint Agnes implemented the Health Institute which is focused on engaging with our community on specific health issues, chronic diseases and health disparities. The Health Institute houses the Comprehensive Care Center, Diabetes Center and National Diabetes Prevention Program, the Heart Failure Center, Million Hearts Program, COPD Clinic and community engagement and outreach initiatives.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative <u>FY17 Costs</u> • Costs of community-based cardiovascular screenings Total: $318,731	B. Direct Offsetting Revenue from Restricted Grants $720

Appendix I

Communication of Saint Agnes Charity Care Policy – FY 2017

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

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

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

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

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

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

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

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

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

Saint Agnes Healthcare System Policy and Procedure Manual	**Page 1 of 5**	**SYS FI 05**
Subject: Charity Care/Financial Assistance	**Effective Date:** 7/16	
	Reviewed: **Revised:** 11/90, 1/91, 6/91, 4/98, 3/01, 3/03, 6/08, 9/09, 6/16	
Approval(s): Board of Directors: See Board Resolution dated June 24, 2016		

POLICY/PRINCIPLES

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

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

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

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

SCOPE

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

DEFINITIONS

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

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

covering such care.

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

Financial Assistance Provided

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

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

3. At a minimum, Patients with incomes above 250% of the FPL but not exceeding 400[1]% of the FPL, will receive a sliding scale discount on that portion of the charges for

services provided for which the Patient is responsible following payment by an insurer, if any. A Patient eligible for the sliding scale discount will not be charged more than the lesser of (1) charges minus hospital markup, (2) the calculated AGB charges. The sliding scale discount(s) can be found at Exhibit A.

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

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

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

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

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

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

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

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

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

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

Limitations on Charges for Patients Eligible for Financial Assistance

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

Applying for Financial Assistance and Other Assistance

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

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

Billing and Collections

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

Interpretation

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

Exhibit A

Saint Agnes Healthcare

FINANCIAL ASSISTANCE SCALE

As of July 1, 2016

For Hospital Facility Services Only (Regulated)

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

For Professional Services (Deregulated)*

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

** Includes the following services:*

Seton Imaging

Lab Outreach

Seton Medical Group

Ascension Medical Group

Integrated Specialist Group

Radiologists Professional Services

Anesthesia Professional Services

Exhibit B

Saint Agnes Healthcare

AMOUNT GENERALLY BILLED CALCULATION

AVAILABLE UPON REQUEST

Exhibit C

Saint Agnes Healthcare

LIST OF PROVIDERS COVERED BY THE FINANCIAL ASSISTANCE POLICY

As of July 1, 2016

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	ZUNIGA,LUIS M MD

SAINT AGNES HOSPITAL

Summary of Financial Assistance Policy

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

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

Who Is Eligible?

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

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

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

What Services Are Covered?

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

How Can I Apply?

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

How Can I Get Help with an Application?

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

How Can I Get More Information?

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

What If I Am Not Eligible?

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

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

Arabic
Chinese
French
Gujarati
Italian
Korean
Persian
Russian
Spanish
Tagalog
Urdu
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Appendix V

Saint Agnes Hospital Mission, Vision and Core Values

Built on a Mission of Service

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

Our Mission

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

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

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

Our Vision

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

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

Our Core Values

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

Saint Agnes Hospital

Community Health Needs Assessment & Implementation Strategies
June 2016

Approved by Board of Directors June 24, 2016

Table of Contents

Executive Summary

Introduction & Background:

Beginning in 1862, and continuing over the last 154 years, Saint Agnes Hospital has been dedicated to the art of healing by providing exceptional care to the Greater Baltimore area. Built on a strong foundation of excellent medical care and compassion, Saint Agnes and the associates and physicians who practice here are committed to providing the best care for our patients for many years to come.

Today, Saint Agnes Hospital is a 251-bed, full-service teaching hospital with residency programs in a number of medical and surgical specialties. Saint Agnes completed a $200+ million expansion that emphasizes patient safety in a high quality healthcare environment. The expansion includes a new patient tower, the new 80,000-square-foot Angelos Medical Pavilion which is home to a variety of specialties, including an expanded Cancer Institute, a new parking garage, and the Hackerman-Patz House for families of patients being treated for long-term ailments. We believe that healthcare is about more than healing the sick; it is also about encouraging the growth and vitality of our community. To this end, Saint Agnes is committed to sharing the talents of our skilled physicians and associates as widely as possible, with a dedication to moving beyond the campus and into the communities we serve. We have demonstrated this commitment with our investment in our campus, Route 40, and Gibbons Commons, as well as our founding involvement in community partnerships which increase access not only to clinical services, but to jobs and opportunities as well.

Saint Agnes was founded on a mission of service to the community, particularly those who struggle, and our community outreach programs continue to expand that mission today. Based on the Saint Agnes' FY 13 Community Health Needs Assessment, the hospital has launched a broad range of community initiatives to address our highest health need priorities in cardiovascular disease, obesity and related chronic conditions, and to improve access to primary care, especially for the poor and vulnerable. As a result, in Fiscal Year 2015, Saint Agnes provided $28.2M in charitable giving to the community. In addition to measuring the financial contributions of our community health and charity care services, the leadership team via the Community Health Advisory Council has implemented a Community Health Outcomes Dashboard to track progress of community health initiatives and impact on improving health status.

Source: http://www.stagnes.org/wp-content/uploads/2014/09/Saint-Agnes-Fact-Sheet-15.pdf

Our Mission

At Saint Agnes Hospital, we commit ourselves to spiritually-centered healthcare which is rooted in the healing ministry of Jesus.

In the spirit of St. Elizabeth Ann Seton, and in collaboration with others, we continually reach out to all people in our community, with a special concern for those who struggle.

As a Catholic health care ministry and member of Ascension Health, we are dedicated to the art of healing to sustain and improve the lives of the individuals and communities we serve. We are also called to advocate for a just society.

Through our words and deeds, our ministry is provided in an atmosphere of deep respect, love and compassion.

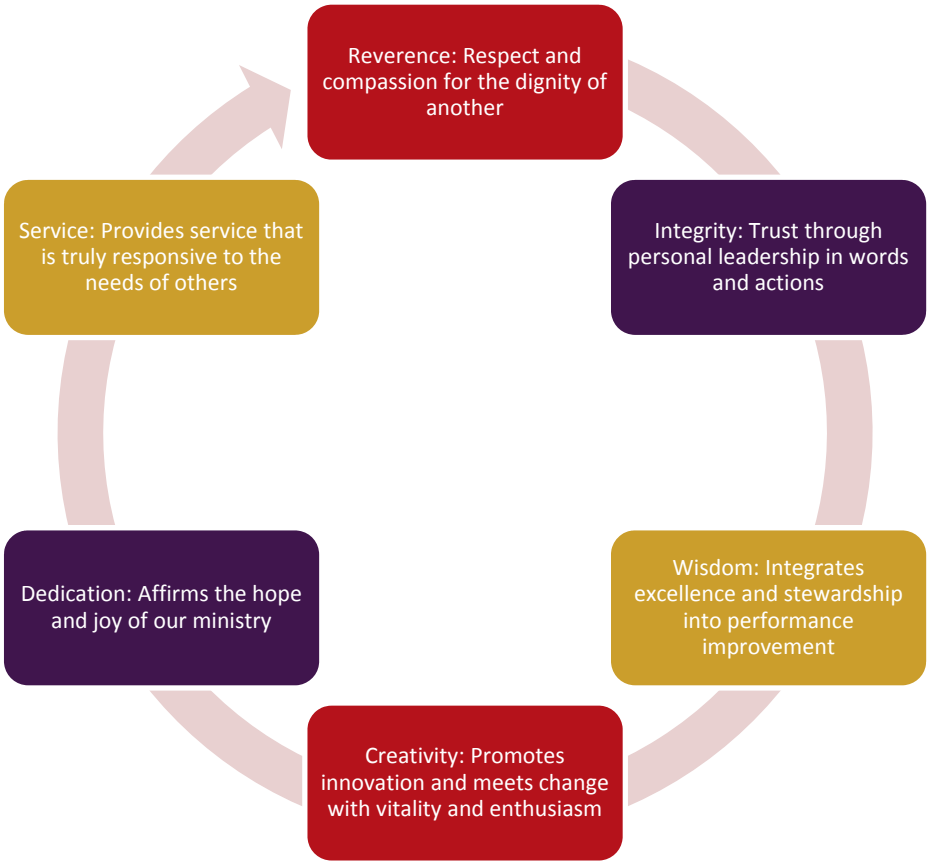
Our Vision

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

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

Source: http://www.stagnes.org/about-us/mission-and-values/

Our Core Values



Our Community Health Improvement Mission

Saint Agnes Hospital is dedicated to the art of healing to sustain and improve the lives of the individuals and communities we serve. We are committed to the health and well-being of our entire community. Through expanding outreach and community integration services our dedicated team strives to enhance the social and physical environments that promote good health for all.

I. CHNA: Purpose and Scope

The 2016 Community Health Needs Assessment process is about improving health - the health of individuals, families, and communities. The objective of the assessment is to evaluate the health status of the people residing in the communities served by Saint Agnes Hospital and to highlight the geographic regions and populations within the community benefit service area that have greater health needs and determine how Saint Agnes might best respond to identified health need priorities.

In accordance with IRS requirements and the enactment of the Affordable Care Act in March of 2010, hospital facilities with a tax-exempt status must complete an assessment of the health needs of the community every three years. Additionally, the assessment must include the input from persons who represent the broad interests of the community, including those with special knowledge of or expertise in public health. Hospital services and health improvement programs are to be linked to the prioritized needs identified in the assessment process. Improvements in community health are to be tracked and demonstrated through measurable outcomes metrics.

The needs present in the Saint Agnes Hospital Community Benefit Service Area (CBSA) are highly variable from community to community. This assessment highlights each community individually, identifying the risk factors and health needs that are unique to that specific population. For the FY 16 CHNA, Saint Agnes expanded the level of community input from the FY 13 assessment methodology conducting six focus groups across the four most vulnerable communities identified in the FY 13 assessment.

The FY 16 community health needs assessment update follows two seminal events in the health care environment. The first is the dramatic changes in Maryland's health care system reimbursement as part of the waiver modernization and implementation of value-based global revenue reimbursement model with focus on population health. Second, and more importantly, the civil unrest that occurred in Baltimore City, particularly West Baltimore illustrated the outcry of the community in part due to the decades of neglect to address social determinants of health that are vital to a healthy community. The refocusing of the health care system to population health further heightens the need for health care systems to be engaged and collaborating with community-based organization and the private sector to respond to and address the significant social needs in West Baltimore.

The assessment process involved both quantitative and qualitative components. See Figure 1. Saint Agnes engaged the participation of the general public as well as key internal and external stakeholders who represent the broad interest of the communities served by Saint Agnes to review the

quantitative analysis. The public provided input through a structured online survey and via focus groups across the assessment process during Fiscal Year 2016. The internal and external stakeholders were individuals with expertise in provision of health care services and public health and included community leaders, physicians, nursing, social work, pastoral care, care management, emergency

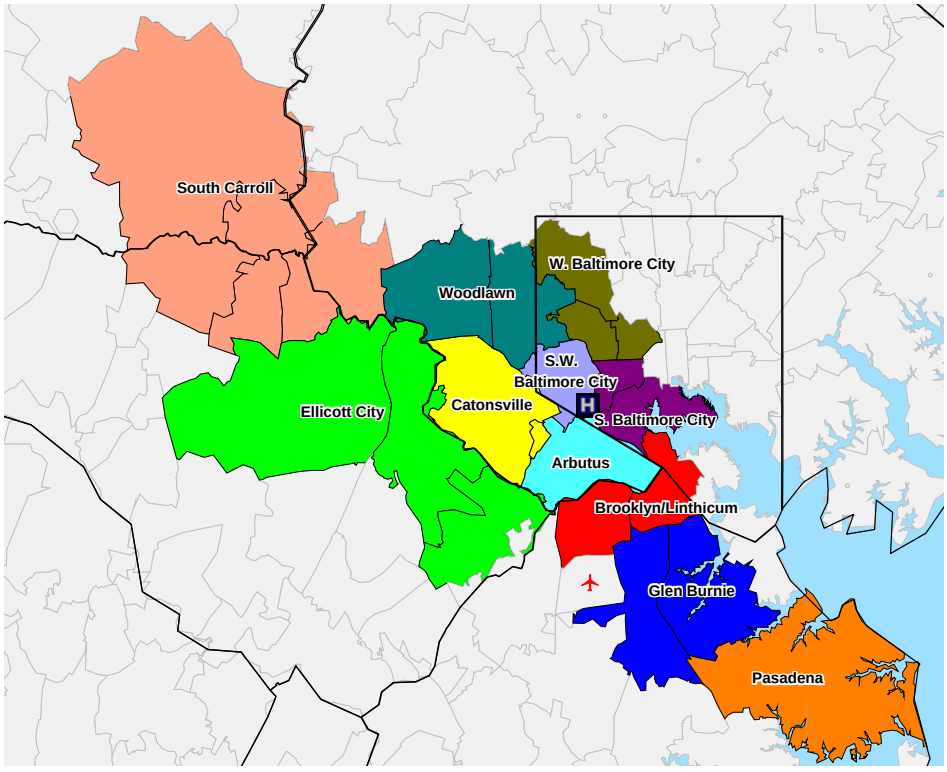
outpatient and management representatives and a broad range of community organizations.

Figure 1 - FY 16 CHN Assessment Methodology

Community Benefit Service Area

Due to its location in the southwest segment of the Baltimore Metropolitan Area, Saint Agnes serves a diverse patient population. Saint Agnes' community benefit service area (Southwest Baltimore City and Baltimore County, Northern Anne Arundel County, Eastern Howard County, and Southern Carroll County) has a population of approximately 766,900 and represents the zip codes that comprise 80% of Saint Agnes Hospital patient population. A map of the communities Saint Agnes serves can be seen in Figure 2. Within the community benefit service area (CBSA), Saint Agnes has defined eleven communities based on grouping zip codes that have similar demographic characteristics and considering various geographic boundaries. A brief overview description of each of the individual community's is provided in Appendix 1.

Figure 2 - Saint Agnes Community Benefit Service Area Communities(CBSA)



II. FY 16 Community Health Needs Assessment

Community Service Area – Electronic Survey

A quantitative assessment was conducted using a survey administered electronically and on paper to gain broad public input. A copy of the survey is included as Appendix 2. The survey had three components. First, participants were asked to rate their perception of their own personal health as well as the perception of the health of the community. Second, participants were asked to identify their three top health concerns out of a list of 26 health needs and social determinants of health. Finally, participants were asked about perceived barriers to health care access.

Survey Methods

Multiple approaches were utilized to reach the largest number of residents within the 21 zip codes in the defined community benefit service area.

- The Family Research Center was engaged to acquire email addresses for households within the CBSA. The Family Research Center conducted three email waves over a 9 week period.
- Email addresses were obtained from patients of Saint Agnes Hospital who were discharged within the last year and reside within the CBSA.
- The survey was posted on the Saint Agnes website and promoted via the hospital's social media channels as well as at community outreach events by paper copy.
- Baltimore Medical Systems, a campus-based FQHC, surveyed patients for a two week period in January 2016.
- Total number of respondents was 823 with 801 residing in the CBSA. The distribution of respondents by community is shown in Figure 3.

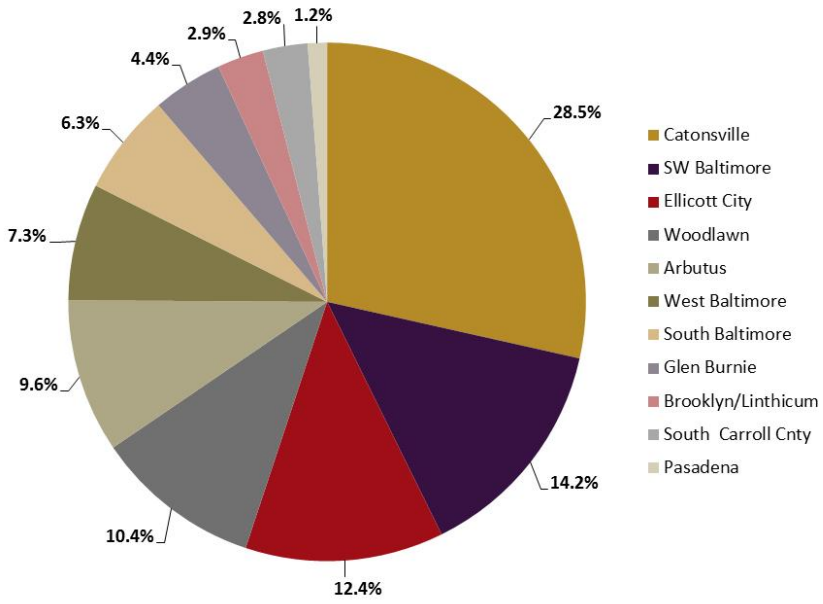


Figure 3 - Percent Survey Respondents by CBSA Community

Not unexpected, the highest number of responses came from those areas closest to Saint Agnes Hospital. However, there was good representation from urban communities that were identified as vulnerable in the Saint Agnes FY 13 Community Health Needs Assessment. The overall composition of the survey participants was 75% female, 75% age 50 or above, 30% African American, 58% Caucasian and 5% Hispanic.

The perceptions of community and personal health were segmented to compare the urban and suburban communities and results are shown in Figures 4 and 5. Urban respondents generally rated their own personal health higher than the health of their community. 76% of urban residents reported their personal health as excellent, very good or good while 74% reported their community health as excellent, very good or good. 82% of suburban respondents reported their personal health as excellent, very good or good and 90% reported their community health as excellent, very good or good. Urban residents perceived their own health as better than that of their community and suburban residents perceived their community health to be better than their own health. Despite the vulnerability of the urban communities, 76% rated their personal health to be excellent, very good and good; this was not much lower than the 82% rate of those from more stable suburban communities.

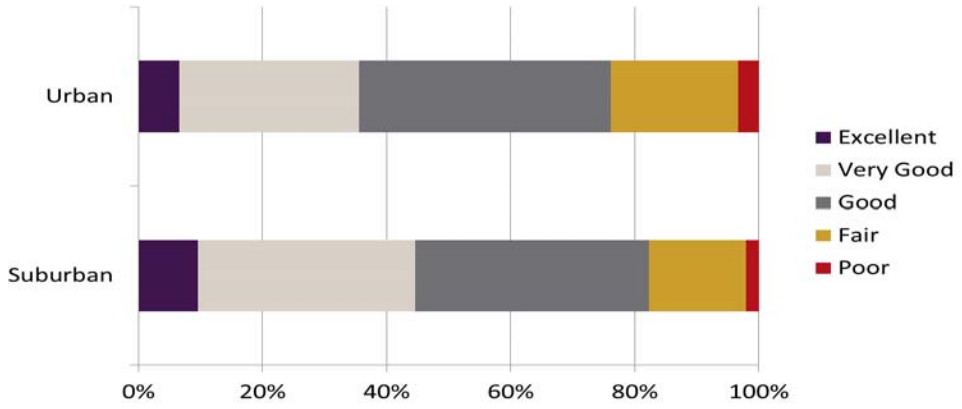


Figure 4 - Perception of Personal Health Status

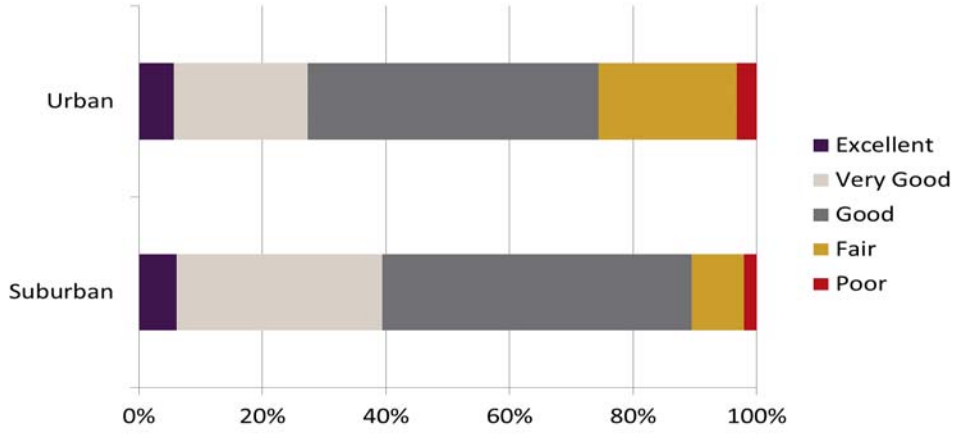


Figure 5 - Perception of Community Health Status

Figure 6 highlights respondents top three health concerns from a list that was comprised of social determinants of health, social issues, and a variety of chronic and acute diseases. Consistent with the Saint Agnes FY 13 community health need priorities, Obesity and Diabetes along with Cardiovascular Disease ranked as the top two health concerns. However, new in the FY 16 assessment Behavioral Health and Socio-Economic Conditions ranked among the top four concerns. Behavioral Health includes Alcohol and Drug Abuse and Mental Health Issues. Socio-Economic *

Conditions represent some of the social determinants of health. These are defined as *conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks (Source: https://www.healthy people.gov/2020/topics-objectives/topic/social-determinants-of-health)*. This includes but is not limited to poverty, employment opportunities and affordable housing.

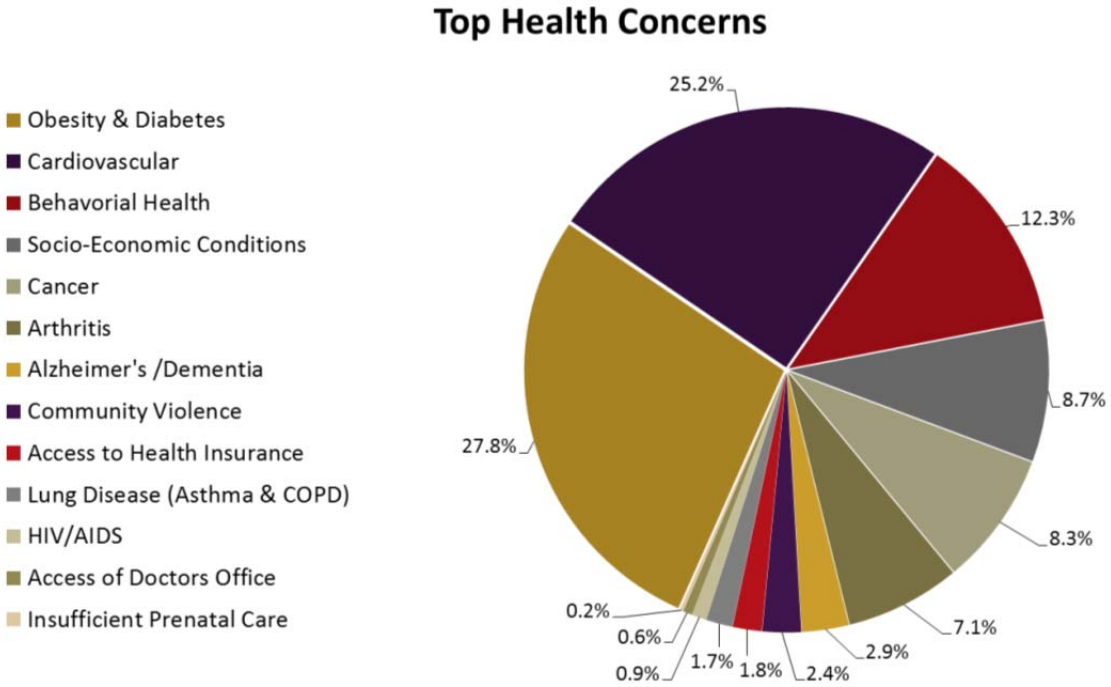


Figure 6 - CBSA Electronic Survey Top Health Concerns

The survey respondents chose from a list what they experience as barriers to primary health care for residents of their community. The types of access were related to financial issues, geographic issues, insurance issues, etc. Figure 7 illustrates these reasons.

The top reason chosen for not having Primary Health Care was affordability, this included co-pays and deductibles. The high cost of health care was seen as the greatest deterrent for people having regular, stable health care. A little over one quarter of the respondents cited a lack of health insurance as an important reason as well. Other barriers chosen were transportation issues and wait time for appointments.

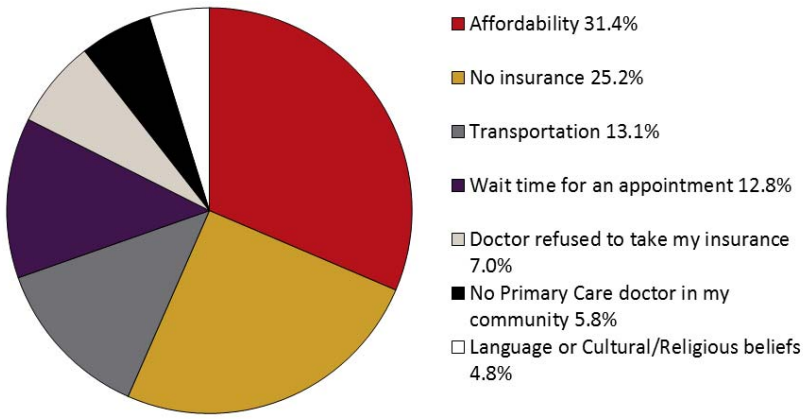


Figure 7 - Top Health Care Access Barriers

Key Findings – Electronic Survey

Obesity & Diabetes, Cardiovascular Disease and Behavioral Health & Socio-Economic Factors were cited as the top concerns facing the community according to the data from the electronic surveys. Although residents in these communities did not see their neighborhoods in a poor light, they still struggle to afford health care to stem the effects of these chronic health conditions.

Community Service Area – Focus Groups

A qualitative assessment was conducted using focus groups facilitated by Observation Baltimore; a division of The Research Group/Family Research Center. Six focus groups were conducted for Saint Agnes Hospital to better understand the healthcare needs of the medically underserved, low-income, and minority populations in the most vulnerable communities identified in the FY 13 assessment. The composition of the focus groups was recruited to match the demographic composition of the community's survey. Participants were also included by either a personal history or family history of chronic disease with a consideration of environmental risks [specifically smoking tobacco, drinking alcohol daily or occasionally, and use of non-prescription drugs]. The Hispanic population was also targeted to ensure input from all ethnicities. Participants were paid a stipend and transportation was provided, if needed.

Figures 8-10 illustrate the demographic composition of the focus group participants on race/ ethnicity , household income and CBSA community for the total 55 participants.

The focus groups were conducted in three segments. The first segment was completion of a questionnaire on Top Health Concerns consistent with the electronic survey. Second, there was a facilitated discussion to solicit opinions of their health care experiences, health care providers and concerns with preventive health needs. The third segment was a structured exercise to identify and prioritize needs related to experiences with the health care system.

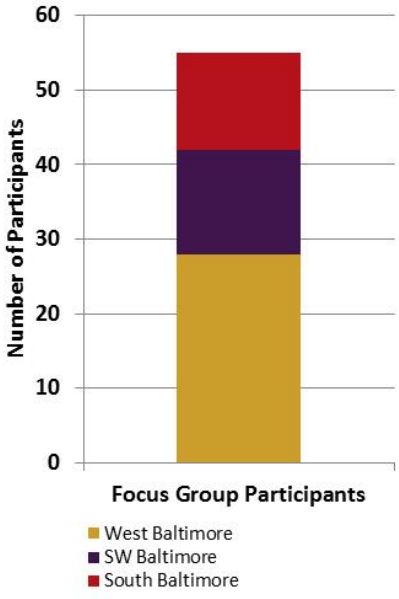


Figure 8 - Focus Group Participants by Community

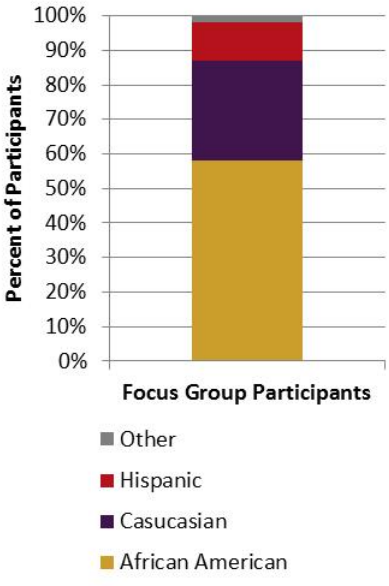


Figure 9- Focus Group Participants by Race/Ethnicity

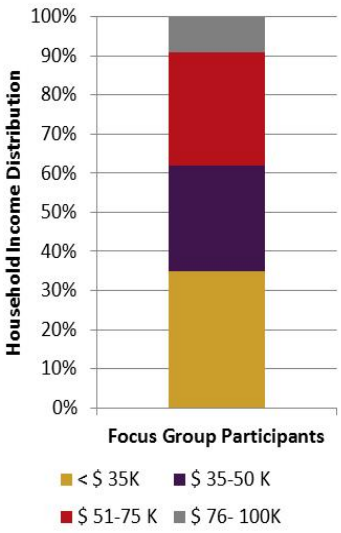


Figure 10 - Focus Group Participants by HH Income

Figure 11 shows the results of the questionnaire of focus group participants top health concerns. The top four concerns of the focus group participants were consistent with the CBSA survey. Similar to the broader CBSA survey Obesity and Diabetes ranked the highest health concern. However, as might be expected given the urban communities that comprised the groups, Behavioral Health was the second highest concern. Cardiovascular and Socio-Economic Conditions rounded out the top four concerns.

The focus groups began with a facilitated top-of-mind discussion about health care in their communities. A copy of the 90 minute discussion guide is included in Appendix 3. The topics discussed included self-care and preventive health needs, where they went for health care services, where they learned about health care issues and their general experiences within health care. Participants also discussed barriers they experience with maintaining healthy lifestyle habits, and accessing health care services. Figure 12 is a word cloud diagram that illustrates the key themes that emerged during the facilitated discussion.

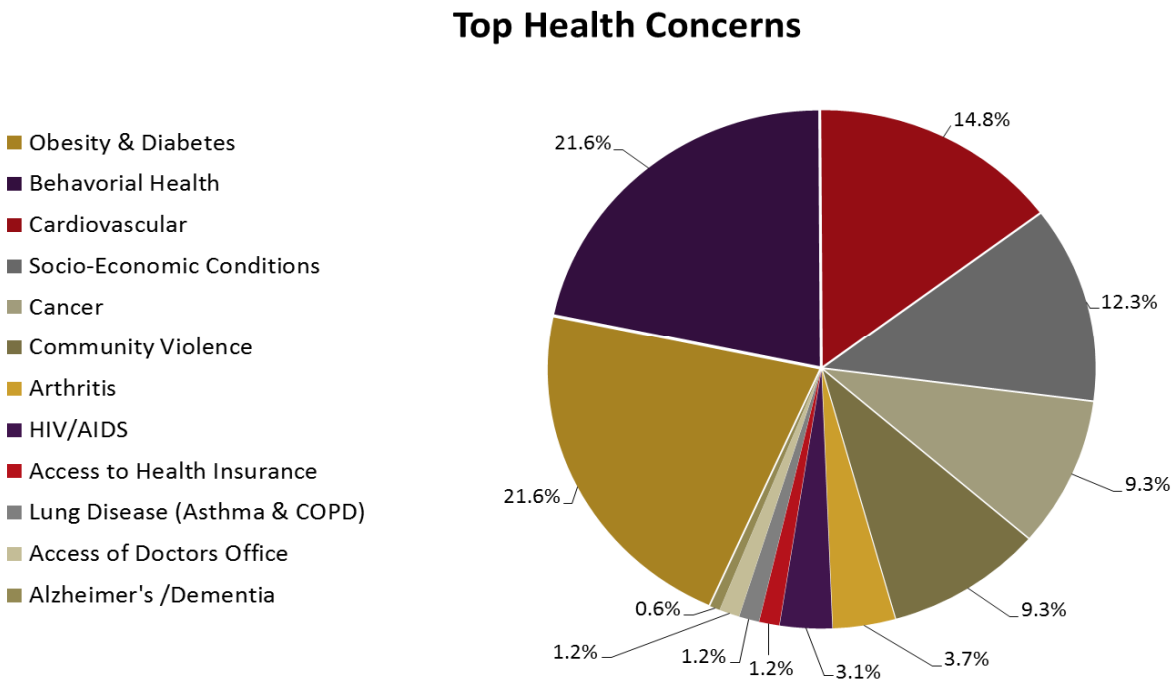


Figure 11- Focus Group Participants Top Health Concerns

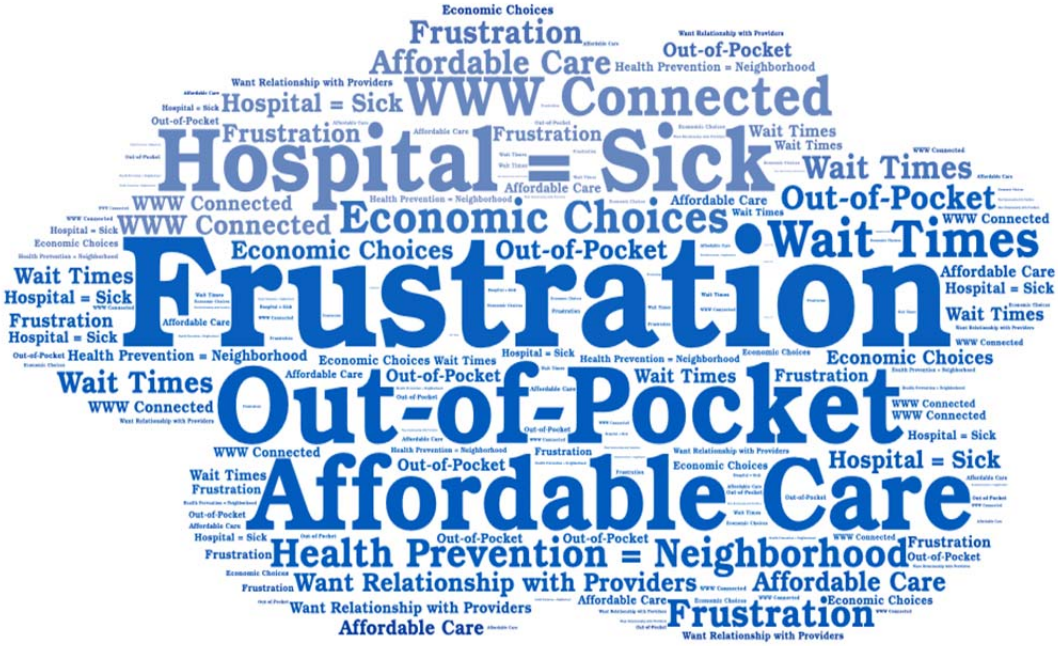


Figure 12 - Focus Group Key Themes from Facilitated Discussion

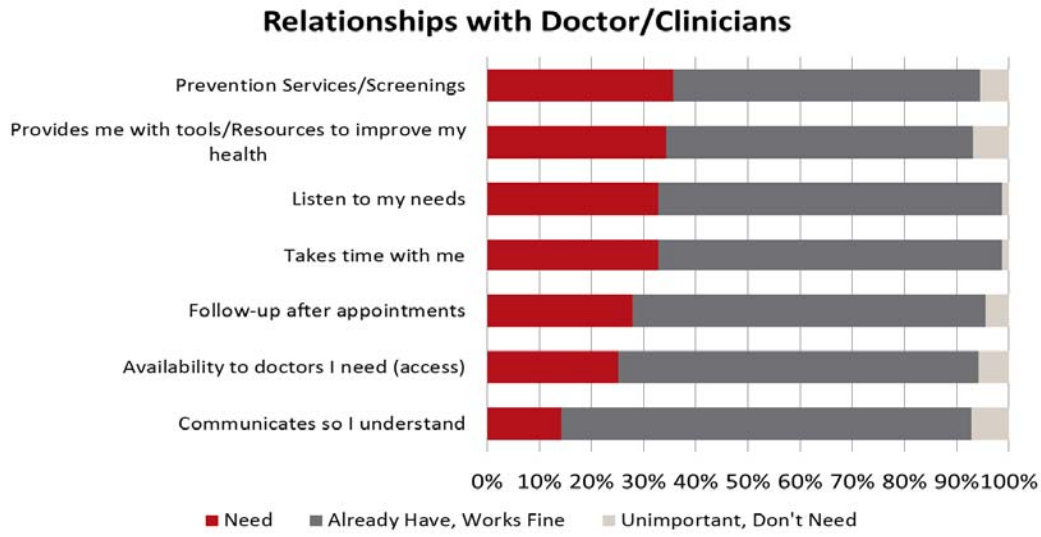
- Frustration – Strong expressions of frustration with many aspects of the health care system including complexities with insurance, access to care, appointment availability, wait times, provider turnover, inadequate time spent with providers, and understanding diagnosis and treatment.
- Out-Of-Pocket Expenses – While having insurance coverage participants struggle with co-pays and deductibles and economic impacts, particularly related to prescriptions.
- Affordable Care – Participants describe struggles by themselves or family members on fixed or limited incomes to balance choices between health care expenses and those necessary for daily living.
- Want Relationship with Providers – Inadequate time with providers and or high provider turnover were cited as limitations to establish meaningful, trusting relationship that support preventive health care.
- WWW Connected – Participants were very well connected to the digital world, especially social media. Most have access to smart phones and note that those devices would be good mechanism to better connect with the health care system.
- Hospital = Sick – Given the new waiver and incentives for hospitals to maintain health of population, participant related hospitals as places to go when sick and need care. Health prevention initiatives are preferred in the neighborhood.

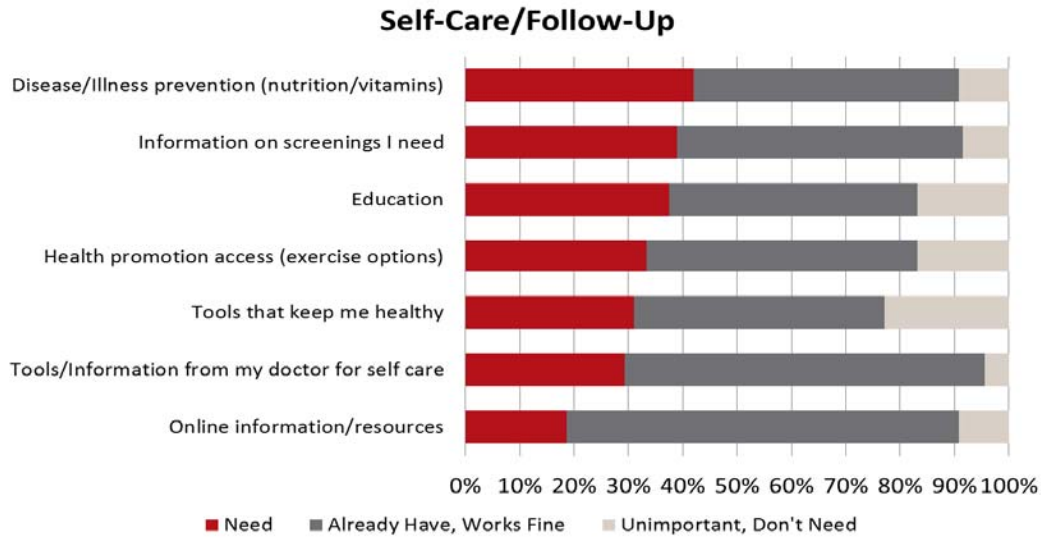
Following the top-of-mind discussion, the groups participated in a structured evaluation and prioritization of specific aspects of the health care system and their experiences. The aspects probed were Relationships with Doctors and/or Clinicians, Self-Care/Follow-up Care, and

Accessibility to a Community Health Care Facility. They were asked to rank attributes within each area into three categories, 1- this is something they have already and it is working well, 2- aspect is a need and/or there is need of improvement or 3- this is unimportant and/or not needed for their care experiences. The results are shown in Figure 13. There was an overall frustration with trying to balance work & family life with the available health care. This was described by problems getting time off work to go to appointments or take others to appointments as well as arranging and paying for the transportation to get there. This would be further complicated if they had to go multiple places to get prescriptions, lab work, x-rays, etc. The focus group participants ranked the attributes lacking in their health care in line with the key ideas from the facilitated top-of-mind discussion. One third would like a more focused relationship with their doctor. They were lacking adequate time to discuss their individual needs with their doctors about preventions and screenings. Over one third expressed a need for more personalized information and education on prevention and screenings needed to stay healthy. The greatest needs were in the facility aspect. Over half of the participants cited a need for reasonable wait times, same day appointments and the ability to take care of all of their needs in one visit and one location.

Key Findings – Focus Groups

The top four health concerns identified by participants were consistent with the CBSA community survey and included Obesity and Diabetes, Behavioral Health, Cardiovascular Disease, and Socio-economic conditions. Top-of-mind discussion surfaced concerns impacted by the social determinants of health. In terms of experiences with the health care system, participants cited needs for health care sites within the community that provide easy access defined as same day appointment with limited wait times and multiple services (pharmacy, imaging, etc.) in a singular location. Participants also expressed need for stronger relationship with providers that afford more time in appointments and listening to their needs.





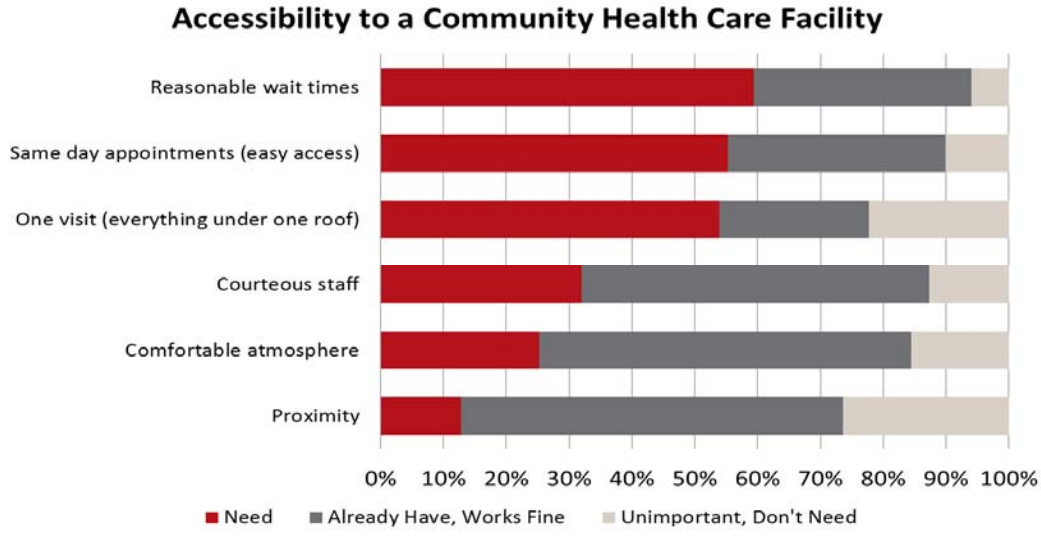


Figure 13- Focus Group Needs to Improve Health Care Experience

Service Area Community Health Rankings

A quantitative assessment was conducted by updating Community Health Rankings that were used for the FY 13 assessment. Saint Agnes has used this methodology for its community health needs assessment prior to the ACA requirements and consistently over the last 12 years. The analysis was modeled after Maryland's Department of Health and Mental Hygiene legacy Primary Care Access Plan. The approach also mirrors later methodologies such as the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute in their ***County Health Ranking*** project. The analysis utilizes secondary data sources and includes 26 health metrics which were grouped into 4 major categories and determined areas of health need vulnerability:

- Demographic and socio-economic characteristics (Socio-Economic/Vulnerable Population)
- Lifestyle & behavioral factors
- Co-morbid precursor diagnoses
- Major disease diagnoses

For the analysis each metrics within each community in the Saint Agnes CBSA was compared to results for Central Maryland and expressed as an index score. The Index scores were calculated to show the health need gaps. An index score of 1, or close to 1, meant the need was the same or similar to the overall need in Central Maryland. If the index score was above 1 it was an indication of health need vulnerability. The overall health index scores by community are shown in Table 1. Detailed information on the individual health indicators and each service area can be found in Appendix 4.

As part of the assessment a comparison of the CBSA index scores data to the National SocioNeeds Index from The Healthy Communities Institute was conducted to verify findings. As shown in Table 1 the CBSA index scores were positively correlated to the Healthy Communities Institute index results. The sources of the secondary data utilized in the CBSA community health rankings included:

- Sg2 – The Nielsen Company, LLC 2016 Maryland Market Demographics
- MSAWeb+ 2015; Market Share Analyst, St. Paul Computer Center
- Healthy Communities Institute SocioNeeds Index

As in the FY 13 assessment, the urban areas of Baltimore remain adversely affected by the social determinants of health. These areas contain a more vulnerable population as defined by age (under 5 or over 65), a lower education level, and more families living below the poverty level. There was also a greater proportion with negative lifestyle/behavior index score for substance abuse, obesity and HIV. These indicators lead to higher co-morbid conditions and higher ambulatory sensitive admissions as well as a higher number of mental health issues. All of these factors lead to higher major disease index scores for cancer, infant mortality and Cardiovascular Disease as examples.

FY 16 Service Area Community Health Rankings				
Community	Overall Score		Benchmark to FY 13	AVG Socio Need Index*
West Baltimore City	2.01	🔴	Worse	92.6
South Baltimore City	1.78	🔴	Worse	70.3
Brooklyn/Linthicum	1.58	🔴	Worse	59.3
Southwest Baltimore City	1.58	🔴	Worse	75.7
Woodlawn	1.16	🟡	Same	50.2
Arbutus	1.02	🟢	Same	61.2
Glen Burnie	1.03	🟢	Same	38.4
Catonsville	0.79	🟢	Better	12.4
Pasadena	0.73	🟢	Worse	11.0
Southern Carroll County	0.48	🟢	Better	2.4
Ellicott City	0.47	🟢	Better	2.1

Table 1 - Saint Agnes CBSA Community Health Ranking

* *Healthy Communities Institute SocioNeeds Index is a measure of socioeconomic need that combines multiple socioeconomic indicators into a single composite value that is correlated with poor health outcomes.*

Key Findings – Service Area Community Health Rankings

In comparison to the FY 13 assessment there is little or no change to the CBSA Community Health Index Scores in FY 16. The urban communities of West Baltimore, SW Baltimore, South Baltimore, and Brooklyn/Linthicum remain the most vulnerable. The comparison of CBSA Community Health Rankings to the National Healthy Communities Institute SocioNeeds Index benchmark shows a high degree of similarity between local results of this assessment and a nationally recognized methodology.

West Baltimore High Need Patient Analysis

In collaboration with the University of Maryland Medical Center, UM – Midtown Hospital and Bon Secours Hospital, the Berkley Research Group conducted a comprehensive review of inpatient, observation and emergency department utilization to identify and profile high need patients* (admitted to acute care bed >=3 times in 12 months). This collaboration was developed to strengthen the health care system, improve access to care and reduce persistent and profound health disparities in a large section of West Baltimore. As shown in Table 2, there were nearly 136K unique patients identified for calendar year 2014 with $1,700.9M in total health care charges and

approximately 253K episodes of care. Of these patients, 3,606 were identified as high need patients.

The high need patient population had a total of 26.3K encounters at a cost of $326M which averages to 7.3 encounters per person at $90.4K for each person. 64% of these patients used two hospitals and 27% used three hospitals.

	All Patients	High Need Patients*
Unique Patients	135,830	3,606
Total Charges	$1,700.9M	$321.6M
Total Encounters	252,986	26,382
IN Visits	60,028	12,632
INO (Observation) Visits	17,077	3,475
ED Visits	175,881	10,275

Table 2 - High Need Patient Utilization

The cost for treatment attributed to the high need patients falls largely on government programs such as Medicare and Medicaid. They account for $265.9M of the total high need expenses for 3,122 unique patients.

As noted in Figure 14 and Table 3 the documented coded EMR diagnosis data of the high need patients demonstrates that 8% of patients had diagnoses of 7-10 chronic conditions with an average of $140K in annual acute care charges per person, 75% with 2-6 chronic conditions with average acute care charges of $87.3K per person annually. The majority of these conditions are ambulatory sensitive admissions which could potentially be avoidable with better access and coordination of care in community based settings.

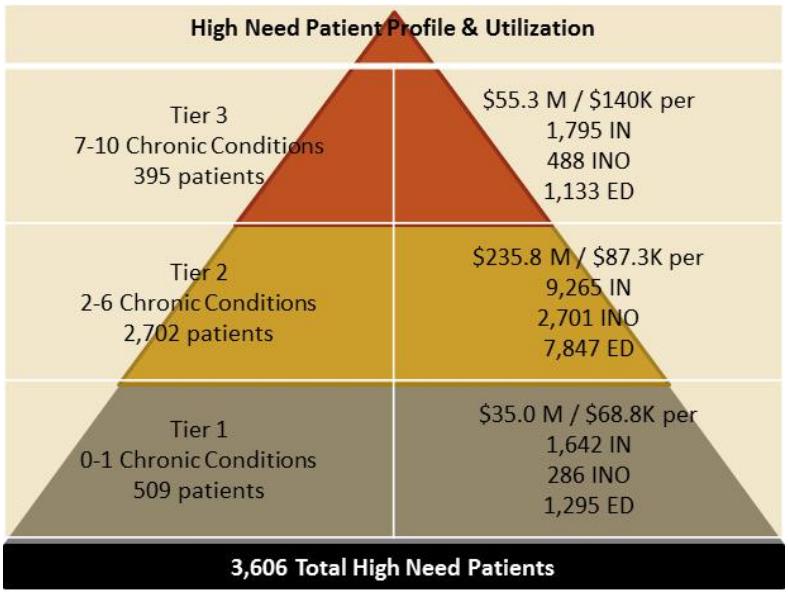


Figure 14 - High Need Patient Profile

The study finds that Hypertension, Diabetes, Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) rank among the most prevalent chronic diseases in this patient population.

Chronic Disease Prevalence	Percent Patients Primary Diagnosis	Percent Patients Any Diagnosis
Hypertension	9%	82%
Diabetes	8%	48%
Chronic Obstructive Pulmonary Disease (COPD)	13%	43%
Congestive Heart Failure (CHF)	13%	40%
Chronic Kidney Disease	1%	36%
Coronary Artery Disease (CAD)	3%	33%
Obesity	0%	29%
Pneumonia	9%	28%
Septicemia	15%	25%
Hepatitis	1%	21%
Note: Conditions identified are based on AHRQ CCS level 3 classification.		

Table 3 - High Need Patient Chronic Disease Profile

Of the total number of High Need patients, 78% (2,805 or 3,606) have been diagnosed with mental health and/or substance abuse issues. Of those patients, 71% had substance abuse disorder documented. This finding correlates with the well documented and discussed significant opioid and other substance addictions that permeate our communities and impact the health care system, particularly the emergency departments. There were only 801 patients, 22%, without one of these diagnoses. Figure 15 shows the prevalence and overlap of mental health and substance abuse issues.

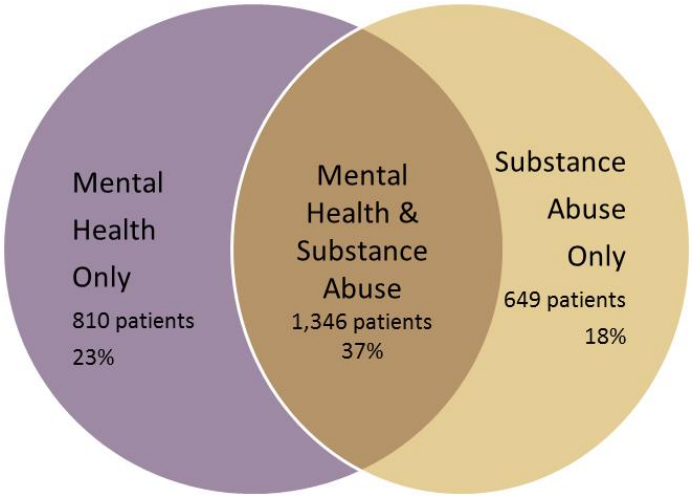


Figure 15 - High Need Patient Profile Behavioral Health Profile

Key Findings – West Baltimore High Need Patient Analysis

Chronic disease prevalence and behavioral health diagnosis are key drives for health care utilization in identified high need patients. The significant degree of chronic disease and behavioral health is likely attributable to impact of social determinants of health.

III. CHNA: Community Engagement

Once the data collection and analysis was complete, we engaged the input from persons who represent the broad interests of the community, including those with special knowledge of or expertise in public health. Internal and External participants are listed in Appendix 6. Internal Stakeholders were identified as those within Saint Agnes Hospital with the community knowledge and resources to help implement strategic plans to address the identified health needs. Internal Stakeholders were asked to complete a short survey and prioritization ranking (Appendix 7) prior to focus group sessions.

The survey was designed to prioritize the health needs and was divided into two sections, the first asked for Top-of-Mind health needs facing the Saint Agnes Hospital service area communities. The second asked for a ranking each of health need against the other. This forced ranking gave more detailed results. The Top-of-Mind section resulted in the following top needs:

- Obesity & Diabetes
- Mental Health/Behavioral Health Issues
- Access to Care
- Cardiovascular, Heart Disease, Hypertension

The forced ranking results showed several Social Determinants of Health coming to the top of the list but also similarities.

- Poverty
- Depression/Anxiety/Mental Health Issues
- Alcohol/Drug Abuse
- **High Blood Pressure**
- Access to Nutritious Food
- **Heart Disease**
- **Diabetes**
- **Obesity**
- Homicide/Violent Crime
- Employment Opportunities

It was noted that Social Determinants of Health such as poverty and access to nutritious food rose higher on the list when the respondent was forced to rank one need against each of the others.

Obesity & Diabetes, mental health/behavioral issues and cardiovascular issues remained a high priority for both methods of selection.

Saint Agnes engaged the support and participation of community-based academic, advocacy, government health, and social service organizations (external stakeholders) in one-on-one interviews. Participants were provided with a summary overview discussion guide that highlighted key findings of the assessment as well as priority health needs. The interviews were structured to solicit feedback on findings of the CHNA analysis as well as broaden the context of the analytics within the knowledge base of each organizations experience with the community. A summary of key themes includes:

- General consensus on the health needs identified through the CHNA analysis.
- Behavioral health is significant issue within the community.
- Life trauma and community violence exposure are key drivers of individuals health status and onset of comorbid conditions and risk for substance abuse disorder.
- Social determinants of health, particularly those related to nutrition, exercise, job training, and housing have significant impact on individual health status.
- Health providers should utilize broader range of screening and assessment tools to identify trauma and social determinants risk factors that impact health status and drive utilization to guide care management initiatives.
- Broad recognition of the generation-to-generation culture that drives individual and community health status, particularly in vulnerable communities impacted by poverty, racial disparities, social injustice, and decades long neglect of key social determinants of a healthy community. As health systems and others prepare to address population health, they must understand the full magnitude of community health improvement required.
- Social institutions of government, health, business, and academia must forge meaningful partnerships in the common interest in addressing and improving the health status of the community.
- Broad and collaborative partnerships across social institutions will result in the most efficient use of resources, ability to impact policy, system or environmental change, and ultimately the greatest ability to have meaningful improvement in community health status.

IV. CHNA Priorities

After using both primary and secondary research methods to assess the health needs of the community and taking into account the input received from persons who represent the broad interests of the community, including those with special knowledge of or expertise in public health, the Community Health Advisory Council prioritized the top three health needs as a result of the assessment.

1) Address Obesity and Diabetes Prevalence
2) Reduce Cardiovascular Disease Burden

3) Create Person-Centered Healthy Neighborhoods

The FY 16 assessment priorities retain two of the priorities of the FY 13 assessment and Saint Agnes will continue to expand and enhance its work to address obesity and diabetes and cardiovascular disease. The third priority for FY 16 is a broader objective than that in FY 13 to increase access to primary care to Create Person-Centered Healthy Neighborhoods. This current objective looks to address a wider variety of the Social Determinants of Health including affordable housing, creating green space and more nutritious food options to job training and small business encouragement.

National, State and Local health policies and objectives were used to validate and align our priorities and objectives. The identified priorities are highly aligned with local, state and national priorities as found in Healthy Baltimore 2015, State of Maryland State Health Improvement Plan (SHIP) Vision Areas and Healthy People 2020 (See Table 4).

Table 4- CHNA Priority Alignment with Local, State and National Health Initiatives

Saint Agnes CHN Priorities	Healthy People 2020 (National)	Maryland S.H.I.P. (State)	Healthy Baltimore 2015 (City)
Obesity and Diabetes	Reduce the proportion of adults who are obese. NWS-9	Reduce the proportion of adults who are obese.	Decrease the percent of adults who are obese.
	Reduce the diabetes death rate. D-3	Reduce the proportion of adults diagnosed with diabetes.	Decrease the hospitalization and ER rates for diabetes.
Cardiovascular Disease Burden	Reduce the proportion of adults with hypertension. HDS-5.1	Reduce ED visits due to Hypertension.	Increase % of adults with high blood pressure on medication.
	Increase cardiac rehab referrals for heart attack survivors. HDS-22	Reduce Age-Adjusted Mortality from Heart Disease	Decrease rate of premature deaths from cardiovascular disease.
	Increase the number of community based organizations providing prevention services for chronic diseases. ECBP-10.7		Decrease percent of adults who currently smoke.
Person-Centered Healthy Neighborhoods - Become a Community Partner	Increase the proportion of persons who have access to rapidly responding prehospital emergency medical care. AHS-8	Decrease uninsured ED visits.	Decrease hospitalization rate for ambulatory sensitive indicators.
	Increase the proportion of adults with ongoing health care. AHS-5	Increase the percentage of persons with a Usual Primary Care Provider	Decrease rate of ED visits for ambulatory sensitive indicators.
			Decrease the percent of adults with unmet mental health care needs.
Person-Centered Healthy Neighborhoods - Gibbons Commons	Decrease the proportion of households that experience housing cost burden. SDOH-4.2	Increase the percentage of affordable housing.	Decrease the density of vacant buildings.
	Reduce the percentage of household food insecurity. NWS-13	Increase the percentage of people reporting physical activity.	
	Increase policies for built environment that enhance access to and availibility of physical activity opportunities. PA-15.1		
	Decrease the proportion of households living in poverty. SDOH-3.1		

Needs that Will Not Be Addressed

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

V. Documenting and Communicating Results

The completion of this community health needs assessment marks a milestone in community involvement and participation with input from community leaders, the general public, Saint Agnes Hospital administration, and health experts. This report will be posted on the Saint Agnes website. Reports and data will also be shared with our community partners and community leaders as we work together to make a positive difference in our community by empowering and building healthy communities.

VI. Planning for Action and Monitoring Progress

After using both primary and secondary research methods to assess the health needs of the community and taking into account the input received from persons who represent the broad interests of the community, including those with special knowledge of or expertise in public health, the next step in the process identified and prioritized the top three health needs to be concentrated on in the next fiscal year(s). As noted in earlier sections, certain chronic diseases and lifestyle/ behavioral issues were ranked as a high need by the community being served and experts in the public health field within our community. Table 5 lists health needs that have been identified and prioritized with corresponding target population and objectives.

Table 5 – CHNA Priorities & Implementation Plan

<table>
<tr><td colspan="2">PRIORITIZED NEED #1: Obesity and Diabetes</td></tr>
<tr><td colspan="2">GOAL: Increase awareness of and access to medical and surgical options for reducing obesity and diabetes, particularly for the vulnerable population.</td></tr>
<tr><td>STRATEGY 1: Provide increased outreach, education and medical intervention when appropriate to patients suffering from the physical & mental effects of morbid obesity and seeking a change in their health status.</td><td>Target population: Patients experiencing health problems due to obesity and/or diabetes, particularly the vulnerable population with limited access to primary care, care management and education.</td></tr>
<tr><td colspan="2">Objective I. Decrease the proportion of adults with comorbidities associated with obesity through effective education, outreach, and medical intervention.</td></tr>
<tr><td colspan="2">Objective II. Within one year of intervention decrease BMI by 20% for patients engaging in medical weight loss techniques and/or bariatric surgery.</td></tr>
<tr><td colspan="2">PRIORITIZED NEED #2: Cardiovascular Disease Burden</td></tr>
<tr><td colspan="2">GOAL: Reduce the incidence and burden of cardiovascular disease in the community.</td></tr>
<tr><td>STRATEGY 1: Continue to offer and promote a series of community based programs providing education, screening and case management to reduce the incidence and burden of cardiovascular disease.</td><td>Target population: People at risk for experiencing health problems due to cardiovascular disease, particularly the most vulnerable with limited access to medical services and education and support in reducing the causes of cardiovascular disease.</td></tr>
<tr><td colspan="2">Objective I. Increase by a percentage the implementation of effective community based education programs, screening, and case management for cardiovascular disease for the target population.</td></tr>
<tr><td colspan="2">Objective II. Decrease the rate of inpatient and ED use by cardiovascular patients as measured by a decrease in Prevention Quality Indicator discharges.</td></tr>
<tr><td colspan="2">PRIORITIZED NEED #3: Person-Centered Healthy Neighborhoods</td></tr>
<tr><td colspan="2">GOAL:
Collaborate with community agencies to provide health education and care management for populations that have the greatest needs and least resources.
Become a community partner to create healthy, thriving neighborhoods with a visible presence where the community needs us the most.</td></tr>
<tr><td>STRATEGY 1: Collaborate with community agencies to provide health education and care management for populations that have the greatest needs and least resources.</td><td>Target population: Focus on high need patients (high utilizers) in our service area that lack connection to community programs that would address medical and social determinants of health to improve quality of life, particularly in West Baltimore.</td></tr>
<tr><td colspan="2">Objective I. By 2020, increase the proportion of adults who have a primary health care provider.</td></tr>
<tr><td colspan="2">Objective II. Decrease acute care utilization (IN, INO, ED), particularly potentially avoidable utilization by high needs patients through community-based care management initiatives.</td></tr>
<tr><td>STRATEGY 2: Transform the 32 acre former Cardinal Gibbons High School and create Gibbons Commons, a healthy neighborhood with housing, retail, recreation, and support services in Southwest Baltimore.</td><td>Target population: Southwest Baltimore residents lacking a safe and health place to live, work, play and learn.</td></tr>
<tr><td colspan="2">Objective I. Have at least 100% of the apartments under rental contracts by 2017.</td></tr>
<tr><td colspan="2">Objective II. Provide indoor and outdoor space for physical activity that is safe and affordable by 2018.</td></tr>
<tr><td colspan="2">Objective II. In conjunction with the Caroline Center, provide education and job training to community residents by 2016.</td></tr>
</table>

Appendix 1 – Community Profiles

Arbutus (Zip Code 21227):

Arbutus is an older suburban community, located south of Caton and Wilkens Avenues, and has a population of 34,245. The traditionally blue collar community is part of the Baltimore County Health Jurisdiction. Saint Agnes Hospital is the primary hospital provider best positioned to address the specific health needs of this community.

Brooklyn-Linthicum (Zip Codes 21090, 21225):

Brooklyn-Linthicum is an older urban/suburban community, located southeast of Caton and Wilkens Avenues, and has a population of 43,816. The industrial and blue collar community has seen an increase in the uninsured population and is part of both the Baltimore City and Baltimore County Health Jurisdictions. Harbor Hospital is the primary hospital provider best positioned to address the specific health needs of this community.

Catonsville (Zip Code 21228):

Catonsville is an older suburban community, located west of Caton and Wilkens Avenues, and has a population of 49,586, with a growing proportion of seniors. The traditionally white collar community is part of the Baltimore County Health Jurisdiction. Saint Agnes Hospital is the primary hospital provider best positioned to address the specific health needs of this community.

Ellicott City (Zip Codes 21042, 21043, 21075):

Ellicott City is a growing suburban community, located west/southwest of Caton and Wilkens Avenues, and has a population of 119,615. The predominantly white collar community is part of the Howard County Health Jurisdiction. Howard County General Hospital is the primary hospital provider best positioned to address the specific health needs of this community.

Glen Burnie (Zip Codes 21060, 21061):

Glen Burnie is an older suburban community, located west/southwest of Caton and Wilkens Avenues, and has a population of 87,752, with a growing proportion of seniors. The traditionally blue collar community is part of the Anne Arundel County Health Jurisdiction. Baltimore Washington Medical Center is the primary hospital provider best positioned to address the specific health needs of this community.

Pasadena (Zip Code 21122):

Pasadena is a suburban community, located southeast of Caton and Wilkens Avenues, and has a population of 62,625, with a growing proportion of seniors. The growing community is primarily served by Baltimore Washington Medical Center and is part of the Anne Arundel County Health Jurisdiction. Baltimore Washington Medical Center and Anne Arundel Medical Center are the primary hospital providers best positioned to address the specific health needs of this community.

Appendix 1 – Community Profiles

South Baltimore City (Zip Code 21223, 21230):

South Baltimore City is an older urban community, located east/southeast of Caton and Wilkens Avenues, and has a population of 60,356. The urban community is projected to experience population declines. South Baltimore City is part of the Baltimore City Health Jurisdiction. Baltimore Washington Medical Center is the primary hospital provider best positioned to address the specific health needs of this community.

South Carroll (Zip Codes 21104, 21163, 21784):

South Carroll is a suburban community, located northwest of Caton and Wilkens Avenues, and has a population of 52,609, with a growing proportion of seniors. The traditionally rural community has transitioned to a growing suburb of the Metro Baltimore Region. South Carroll is part of Carroll County Health Jurisdiction. Carroll County General Hospital and Northwest Hospital are the primary hospital providers best positioned to address the specific health needs of this community.

Southwest Baltimore City (Zip Code 21229):

Southwest Baltimore City is an older urban community, located at Caton and Wilkens Avenues, and has a population of 44,997. Similar to other urban areas, Southwest Baltimore is projected to experience population declines. Southwest Baltimore City is part of the Baltimore City Health Jurisdiction. Saint Agnes Hospital is the primary hospital provider best positioned to address the specific health needs of this community.

West Baltimore City (Zip Code 21215, 21216, 21217):

West Baltimore City is an older urban community, located north of Caton and Wilkens Avenues, and has a population of 126,744. Similar to other urban areas, West Baltimore is projected to experience population declines. West Baltimore City is part of the Baltimore City Health Jurisdiction. Sinai Hospital, University of Maryland and Bon Secours Hospital are the primary hospital providers best positioned to address the specific health needs of this community.

Woodlawn (Zip Code 21207, 21244):

Woodlawn is a suburban community, located northwest of Caton and Wilkens Avenues, and has a population of 84,545, with a growing proportion of seniors. Woodlawn is part of the Baltimore County Health Jurisdiction. Northwest Hospital is the primary hospital provider best positioned to address the specific health needs of this community.

Appendix 2 – Community Health Needs Assessment Survey – Tool

About you

1. What is your zip code? _____
2. Are you male or female? ☐ Male ☐ Female
3. What is your race/ethnicity?
   - ☐ African American/Black
   - ☐ Asian/Pacific Islander
   - ☐ Hispanic/Latino
   - ☐ Native American
   - ☐ White/Caucasian
   - ☐ Other/more than one race/ethnicity
4. What is your age group?
   - ☐ 18-29
   - ☐ 30-39
   - ☐ 40-49
   - ☐ 50-64
   - ☐ 65-74
   - ☐ 75+
5. Are there children under 18 living with you? ☐ Yes ☐ No

About the Health of your Community

1. How is the overall health of your community?
   ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

2. Check the 3 most important problems or behaviors that affect the health of your community.
   - ☐ Alzheimer's/Dementia
   - ☐ Arthritis
   - ☐ Cancer
   - ☐ Diabetes/sugar
   - ☐ Heart disease
   - ☐ High blood pressure
   - ☐ HIV/AIDS
   - ☐ Mental health issues
   - ☐ Overweight/Obesity
   - ☐ Lung disease/Asthma/ COPD
   - ☐ Stroke
   - ☐ Availability/Access to Dr. office
   - ☐ Poverty
   - ☐ Affordable Housing
   - ☐ Employment Opportunities
   - ☐ Child abuse/neglect
   - ☐ Domestic violence
   - ☐ Dropping out of school
   - ☐ Alcohol/Drug abuse
   - ☐ Homicide/violent crime
   - ☐ Lack of exercise
   - ☐ Insufficient prenatal care
   - ☐ Access to nutritious food
   - ☐ Access to health insurance
   - ☐ Smoking/tobacco use
   - ☐ Depression/Anxiety

3. Check the 3 most important reasons people in your community do not get primary health care.
   - ☐ Cost – couldn't afford co-pay/deductible
   - ☐ Had to wait too long for an appointment
   - ☐ No insurance
   - ☐ No Primary Care doctor in my community
   - ☐ Doctor refused to take my insurance
   - ☐ Transportation
   - ☐ Cultural/Religious beliefs
   - ☐ Language barrier
   - ☐ Other

TURN OVER

Appendix 2 – Community Health Needs Assessment Survey – Tool

About your Personal Health

1. How is your health? (Circle one)
   ☐Excellent ☐Very good ☐Good ☐Fair ☐Poor
2. Do you have one doctor you see for check-ups (a personal doctor)? Yes No
3. Have you seen this doctor in the last 12 months? Yes No
4. Do you get a check-up (wellness visit) at least once a year? Yes No
5. Has a doctor ever told you that you have any of the following conditions? (Check all that apply.)
   - ☐ Alzheimer's/Dementia
   - ☐ Arthritis, joint/back pain
   - ☐ Cancer
   - ☐ Diabetes
   - ☐ Heart disease
   - ☐ High blood pressure
   - ☐ HIV/AIDS
   - ☐ Kidney disease
   - ☐ Mental health issues
   - ☐ Depression/Anxiety
   - ☐ Lung disease/Asthma/COPD
6. Has a doctor ever spoken to you about or do you have concerns about any of the following for your health? (Check all that apply.)
   - ☐ Alcohol or drug intake
   - ☐ Obesity or being overweight
   - ☐ Diabetes or pre-diabetes
   - ☐ Smoking
7. Check your health insurance status.
   - ☐ No insurance
   - ☐ Commercial insurance through a job
   - ☐ Health exchange
   - ☐ Medicare
   - ☐ Medicaid
   - ☐ Other government program
8. Do you have any ideas or suggestions for Saint Agnes or other hospitals in your area to help improve the health of your neighborhood or your own personal health?

Appendix 3 – Discussion Guide – CHNA Focus Groups

Study Objectives:

- ✓ Explore general health care habits
- ✓ Understand health priorities by health risk and define related quality of care
- ✓ Evaluate access to care and characterize services
- ✓ Identify how health care needs are currently met and gather suggestions to improve health overall

Composition:

Medically Underserved/Low Income/Minority Communities, including Southwest and West Baltimore City zips: 21215, 21216, 21217, 21223, 21229, and 21230

I. **INTRODUCTION** [10 minutes]
Purpose: ***Understand the health care needs of your community.***
Logistics: Outside consultant, permission to disagree, equal airtime.
Disclosures: Microphone/recording/observers.

Introductions

- First name only (for confidentially purposes);
- Who or what lives with you;
- How do you learn about new things?

II. **Advertising Recall and Health Information Resources** [15 minutes]

Objective: *Understand consumers' information resources, influencers of health care decisions, and provide an opportunity for participants to become comfortable in the setting.*

1. How helpful is advertising to learn about new services or products?
[TV, Print, Billboard, Mail, Radio... these are all forms of advertising.]

[Distribute response forms]

1. List one of your favorite advertisements.
2. List two advertisements you remember about health or health care.
    2a. what specifically stands out about those two advertisements?

2. {Discussion}
    a. Please tell me about the ads you remember about health or health care?
    b. What about those ads make them memorable?
        i. When a sponsor is telling you about health or health care, what is most important about the approach?

Moving on... tell me about you.

3. Who do you **trust** most when it comes to your health? Doctors? **Hospitals?**
4. What do you currently do to stay healthy?

[LIST]

    a. What are the THREE most important habits to staying healthy?

5. What health services do you have available that keep you healthy?
    a. Hospitals? How do they contribute to you staying healthy?
        i. Newsletters from hospitals? Seminars? Events?
        ii. What is most motivating to get you to act on a screening, seminar, health fair, event, etc.?

III. **Needs by Aspects of Health Care** [45-60 minutes]

Objective: *Understand health care needs in the community, and identify areas where SAH can have the most impact.*

[Priority Exercise]

1. In front of you, you have three post-its, one of each: GREEN, BLUE, and PINK. In the middle are [COLOR].
   a. I want to learn about the **health care services** you and your family Need, Already Have, or Do Not Need.
   b. Please think about what is currently available to you and your family, and consider about the doctors, clinics, hospitals, and health-oriented services that will be most beneficial to you staying healthy:

      What you **Need** (this includes services, people, or things you do not have now, or may need additional services, or improvement)
      What you **Already Have** [Satisfied with this]
      What you **Do Not Need** [Not important]

[LIMIT TO 5 'SERVICES'/CARE AREA].

Green = Doctors/Clinicians

Availability (access) to doctors I need
Communicates so I understand
Takes time with me
Listens to my needs
Provides me with Tools/Resources to improve my health
Prevention Services / Screenings
Follow-up after appointments...

Blue = Self-Care / Follow-Up

Education
Information on screenings I need
Tools/information from my doctor to take care of myself after doctor's appointment
Online information/resources
Information on disease/illness prevention (nutrition/vitamins)
Access to tools that keep me healthy (blood pressure monitors/diabetes blood meter/ oxygen)
Health promotion access (exercise options)...

Pink = Facilities

Proximity
Easy access—same day appointments
Everything under one roof—one visit
Reasonable wait times
Comfortable atmosphere
Courteous staff...

[COLOR] – These are here in case I forgot to include something you think is important and you feel I need to include here. Please write ONE aspect of care per post-it. Use as many post-its as you need.

REVEAL CHARTS:

Need ***Do Not Need*** ***Already Have***

6. Please place your post it on the chart you feel best represents where that care area belongs considering what is currently available to you.
    a. For example, if you feel 'Comfortable Atmosphere' is something you need, place it here [Need] – or if you feel like the place you go for health care already has it, place it here [Already Have], or if you feel you can do without a 'Comfortable Atmosphere' put it here [Do Not Need].
    Any questions?

[Participants place post-its on charts] {Discussion}

b. Let's begin with ***Need...***

[Probes:

1. Please tell me about... [care area].
2. Please describe your experiences.
3. What specific types of care/services/amenities do you need around [care area] that you currently do not have?
4. What else is important for me to learn about [care area], specifically what is and is not currently available to you?

C. Repeat for: ***Already Have & Do Not Need***

III. **Image Perceptions** [30 minutes]

Objective: *Understand Saint Agnes' image among competitive options in supporting wellness, primary care behaviors, and understand the value of Ascension Health.*

1. **What happens when you or a family member are sick and need a doctor**? Reasons?
    a. Do you have a regular (primary care) doctor?
    b. How do you decide where to go when? ED vs. PCP?
        i. What (criteria) enters into the decision of where to go for care?
2. How does a **hospital help you stay healthy**?
    a. What can they do to help you stay healthy?
3. Let's list all the hospitals you have available to you.
    a. For these three of hospitals: SAH [vary competitive options: MS Harbor, UM Medical Center, Mercy, Sinai].

Apples to Apples Cards: Words appear on each of these cards. Green=Adjectives/Adverbs – Red=Nouns. For each of the three hospitals, select one word that for whatever reason belongs to that hospital. You will end with three cards, one for each hospital.

a. For what reasons does [word] belong [hospital]?
b. What else about hospital causes you to select [word]?
c. Could [word] also describe [other hospitals]? Reasons?

4. In summary, [SAH, competitive options] is best known for? Specialty?
    a. What is [hospital's] reputation? Quality? Patient centered?
    b. When you choose a hospital, what is the most important thing to you? Quality? Convenience? Familiar?
5. How important is it to you that a hospital is affiliated with a larger entity?
    a. What examples come to mind?
    b. [Index card:] What is *Ascension Health*?
    c. What hospital is affiliated with Ascension Health?

Saint Agnes Hospital is a hospital within the Ascension health system:

The largest nonprofit health system in the United States and the world's largest Catholic health system, Ascension Health is dedicated to spiritually-centered, holistic care that sustains and improves the health of the individuals and communities we are privileged to serve.

More than 150,000 associates and 40,000 employed and affiliated providers serve in 1,900 sites of care – including 131 hospitals and more than 30 senior care facilities – in 24 states and the District of Columbia. Our facilities and services are building or participating in regional clinically integrated systems of care to better meet health needs across the entire continuum of care.

Thoughts? New information?

a. What makes this affiliation important?

b. When a hospital has an affiliation, like MedStar or Hopkins, how does it impact how you feel about that hospital?

i. If one hospital has an affiliation – and one does not, what's the difference?

IV. Closure [10 minutes]

Objective: *Gather client questions.*

I'm going to excuse myself for a few minutes. While I'm gone:
As a group, please use the flip chart to create:

Option #1: A wish list for health care services in your community.

Option #2: A list of advice for Saint Agnes Hospital so they can become a partner in staying healthy for you and people in your community.

[REQUEST VOLUNTEER] [GATHER CLIENT QUESTIONS]

[REVIEW EXERCISE – POSE CLIENT QUESTIONS].

Thank you, you've been extremely helpful!

Appendix 4 – Community Health Indicators, Definitions & Sources

I. Socio-Economic/Vulnerable Population

What degree of vulnerability exists with regards to greater health care needs, or greater disparities in access to health care? These indicators identify vulnerable populations, such as age groups which have a higher propensity to utilize healthcare, as well as those which are more likely to experience financial barriers and disparities in access to health care.

a. Age Under 5
b. Age 65+
c. Diversity
d. Uninsured
e. High School Diploma or less
f. Families living below the poverty level

II. Lifestyle/Behavior

How prevalent are certain lifestyle choices and behavior patterns, which are highly correlated to increased risk of developing health-related complications and co-morbid conditions? These indicators identify lifestyle choices and behavioral patterns which increase the risk of developing co-morbid conditions. Metrics such as behavioral health, substance abuse and HIV can be predictive of overall health status.

a. Obesity
b. HIV Positive
c. Insufficient Prenatal Care
d. Substance Abuse
e. Tobacco Use

III. Co-Morbid Conditions

How prevalent are co-morbid conditions, which indicate greater risk of developing major disease, and how well those conditions are managed? These indicators identify the prevalence of co-morbid conditions which are often precursors to major disease. High ambulatory sensitive admission rates may indicate poor access or inadequate health care management.

a. Arthritis
b. Joint & Back Pain
c. Asthma
d. Heart Disease
e. Diabetes
f. Hypertension
g. Ambulatory Sensitive Admissions
h. Mental Health Issues

IV. Major Disease

How prevalent are major diseases, which require high levels of care and intensive health services? These indicators identify the prevalence of major disease which requires high levels of care and intensive health services. A high prevalence of major disease represents a significant degree of health need in a community.

a. Cancer
b. Cardiovascular
c. Stroke
d. Joint & Spine Procedures
e. Infant Mortality (in hospital)
f. Cancer - GYN

Appendix 4 – Community Health Indicators, Definitions & Sources

Socio-Economic/Vulnerable Pop.	Definition
Age Under 5	Sg2 - The Nielsen Company, LLC 2016 Maryland Market Demographics*
Age 65+	Sg2 - The Nielsen Company, LLC 2016 Maryland Market Demographics*
High School Diploma/Less	Highest achieved education for population age 25+*
Diversity	Non-Caucasian population*
Uninsured Households	Uninsured households*
Low Income Families	Families below the poverty level
Lifestyle/Behavior Index	
Obesity	Maryland IN & OP Data, ICD-9 Dx Codes 278-278.03 excluding 278.02**
HIV Positive	Maryland IN & OP Data, ICD-9 Dx Codes 42 & 79.53; APR-DRG Codes 890-894**
Insufficient Prenatal Care	Maryland IN & OP Data, ICD-9 DX Code V23.7**
Substance Abuse	Maryland IN & OP Data, MDC 20, APR-DRG Codes 770-776**
Tobacco Use	Maryland IN & OP Data, ICD-9 Dx Code 305.1**
Co-Morbid Conditions Index	
Arthritis	Maryland IN & OP Data, ICD-9 Dx Codes 714-716.9**
Back and Joint Pain	Maryland IN & OP Data, ICD-9 Dx Codes 719.4-719.49, 724.1-724.3**
Asthma	Maryland IN & OP Data, ICD-9 Dx Codes 493-493.92**
Chronic Bronchitis	Maryland IN & OP Data, ICD-9 Dx Codes 491-491.2**
Diabetes	Maryland IN & OP Data, ICD-9 Dx Codes 249-250.93**
Hypertension	Maryland IN & OP Data, ICD-9 Dx Codes 401-45.99**
Ambulatory Sensitive Admissions	Maryland IN & OP Data, Asthma, Diabetes and Hypertension**
Mental Health Issues	Maryland IN & OP Data, MDC20, APR-DRG Codes 740-760**
Major Disease Index	
Cancer	Maryland IN & OP Data, ICD-9 Dx Codes 140-239**
Cardiovascular	Maryland IN & OP Data, Product Lines Cardiac Surgery, Cardiology & Vascular Surgery**
Stroke	Maryland IN & OP Data, ICD-9 Dx Codes 433-436**
Joint & Spine Procedures	Maryland IN & OP Data, ICD-9 Proc Codes .7-.87, 3.09, 80.51, 81-81.08, 81.3-81.39, 81.5-81.55, 81.6-81.64**
Infant Mortality	Maryland IN & OP Data, ICD-9 Dx Codes 656.4**
Cancer - Gyn	Maryland IN & OP Data, ICD-9 Dx Codes 179-184**

Sources
*Sg2 Market Demographics - The Nielsen Company, LLC 2016
**MSAWeb+ 2015; Market Share Analyst, St. Paul Computer Center

*Sg2's market demographics module is powered by Nielsen Pop-Facts® which relies on rich data input from public and private agencies as well as national compilers and service bureaus. Nielsen's methodology incorporates knowledge gained through the decennial Census, the American Community Survey (ACS) and the Bureau's Current Population Survey (CPS).

Appendix 5 – Service Area Health Risk by Community

Service Area Health Risk Summary by Community

Community Health Indicators	Central Maryland Average	Arbutus	Brooklyn/ Linthicum	Catonsville	Ellicott City	Glen Burnie	Pasadena	South Baltimore City	South Carroll	Southwest Baltimore City	West Baltimore City	Woodlawn
Socio-Economic / Vulnerable Pop.	**Percent of Population**											
Age Under 5	6.06%	🔴	🔴	🟢	🟢	🟡	🟢	🔴	🟢	🟡	🔴	🔴
Age 65+	14.66%	🟢	🟢	🔴	🟢	🟢	🟢	🟢	🟡	🟡	🟡	🟢
High School Diploma/Less	25.33%	🔴	🔴	🟢	🟢	🔴	🔴	🔴	🟢	🔴	🔴	🟡
Diversity	42.26%	🟢	🟡	🟢	🟢	🟢	🟢	🔴	🟢	🔴	🔴	🔴
Uninsured	2.24%	🔴	🔴	🟢	🟢	🟡	🟢	🔴	🟢	🔴	🔴	🔴
Families under the Poverty Level	2.02%	🔴	🔴	🟢	🟢	🟢	🟢	🔴	🟢	🔴	🔴	🔴
Overall Index Score		🔴	🔴	🟢	🟢	🟡	🟢	🔴	🟢	🔴	🔴	🔴
Lifestyle/Behavior Index	**Rate per 1,000 Population**											
Obesity	45.22	🔴	🔴	🟢	🟢	🔴	🟡	🔴	🟢	🔴	🔴	🔴
HIV Positive	7.89	🟢	🔴	🟢	🟢	🟢	🟢	🔴	🟢	🔴	🔴	🔴
Insufficient Prenatal Care	0.94	🔴	🔴	🟢	🟢	🔴	🟢	🔴	🟢	🔴	🔴	🔴
Substance Abuse	25.26	🟢	🔴	🟢	🟢	🔴	🔴	🔴	🟢	🔴	🔴	🔴
Tobacco Use	74.44	🔴	🔴	🟢	🟢	🔴	🔴	🔴	🟢	🔴	🔴	🟢
Overall Index Score		🔴	🔴	🟢	🟢	🔴	🟢	🔴	🟢	🔴	🔴	🟡
Co-Morbid Conditions Index	**Rate per 100 Population**											
Arthritis	4.52	🟢	🔴	🟡	🟢	🔴	🟢	🔴	🟢	🔴	🔴	🟡
Back and Joint Pain	7.83	🟢	🔴	🟢	🟢	🟢	🟢	🔴	🟢	🔴	🔴	🔴
Asthma	6.27	🔴	🔴	🟢	🟢	🔴	🟢	🔴	🟢	🔴	🔴	🟡
Diabetes	11.12	🔴	🔴	🟢	🟢	🔴	🟢	🔴	🟢	🔴	🔴	🔴
Hypertension	20.19	🟡	🔴	🟢	🟢	🔴	🟢	🔴	🟢	🔴	🔴	🔴
Ambulatory Sensitive Admissions	37.58	🟡	🔴	🟢	🟢	🔴	🟢	🔴	🟢	🔴	🔴	🔴
Mental Health Issues	8.84	🟢	🔴	🟢	🟢	🟢	🟢	🔴	🟢	🔴	🔴	🟢
Overall Index Score		🟢	🔴	🟢	🟢	🟡	🟢	🔴	🟢	🔴	🔴	🔴
Major Disease Index	**Rate per 100 Population**											
Cancer	10.09	🟢	🟢	🔴	🟢	🟢	🟢	🟢	🟢	🔴	🔴	🔴
Cardiovascular	10.52	🟢	🔴	🟢	🟢	🟢	🟢	🔴	🟢	🔴	🔴	🔴
Stroke	0.91	🟡	🔴	🔴	🟢	🔴	🔴	🔴	🟢	🔴	🔴	🟡
Joint & Spine Procedures	11.54	🟢	🟢	🟢	🟢	🟢	🟢	🔴	🟢	🔴	🔴	🟢
Infant Mortality	0.60	🟢	🟢	🟢	🟢	🟢	🟢	🔴	🟢	🔴	🔴	🔴
Cancer - Gyn	0.59	🟢	🟢	🔴	🟢	🟢	🟢	🟢	🟢	🟢	🔴	🔴
Overall Index Score		🟢	🟢	🟢	🟢	🟢	🟢	🔴	🟢	🔴	🔴	🔴
Summary Need Index		🟡	🔴	🟢	🟢	🟡	🟢	🔴	🟢	🔴	🔴	🔴
Comparison to FY13 CHNA		worse	same	same	same	worse	same	same	same	same	same	worse

Index Definition

A community health indicator which measures exactly at the Central Maryland average is represented by an index score of 1.00. The extent to which a community health indicator is favorable, or unfavorable, to the Central Maryland average is represented by an index score below 1.00, or above 1.00, respectively. The "stoplight" signals correspond to index scores as noted to the right.

Appendix 5 – Service Area Health Risk by Community

Health Index Summary

Community	Zip Codes	Population	SAH Market Share	SAH Dependence	Vulnerable Population Index	Lifestyle Behavior Index	Co-Morbid Conditions Index	Major Disease Index	Overall Health Index
West Baltimore City	21215, 21216, 21217	126,744	5.8%	7.3%	1.70	2.74	2.07	1.52	2.01
South Baltimore City	21223, 21230	60,386	15.1%	7.7%	1.42	2.53	1.92	1.25	1.78
Brooklyn/Linthicum	21090, 21225	43,816	6.6%	2.8%	1.46	2.23	1.61	1.04	1.58
Southwest Baltimore City	21229	44,997	40.9%	15.8%	1.45	1.81	1.74	1.34	1.58
Woodlawn	21207, 21244	84,545	12.5%	7.8%	1.27	1.05	1.11	1.20	1.16
Glen Burnie	21060, 21061	87,752	4.2%	2.7%	1.04	1.17	1.02	0.89	1.03
Arbutus	21227	34,225	45.4%	11.1%	1.13	1.11	0.98	0.85	1.02
Catonsville	21228	49,586	49.0%	15.8%	0.89	0.46	0.80	1.00	0.79
Pasadena	21122	62,625	3.4%	1.2%	0.70	0.73	0.72	0.77	0.73
South Carroll	21104, 21163, 21784	52,609	4.2%	1.1%	0.62	0.27	0.45	0.57	0.48
Ellicott City	21042, 21043, 21075	119,615	10.3%	5.6%	0.70	0.23	0.39	0.55	0.47

The communities included in this health needs assessment represent the Saint Agnes Hospital primary and secondary service areas. The assessment compares 35 community specific health indicators, against Central Maryland averages. The extent to which a community is at higher than average risk, for a specific indicator, the index score will exceed 1.00. The inverse is true for an index scores below 1.00, which indicates a comparatively lower level of health risk.

The overall health index, which is an average of all community need indices, highlights those communities with the greatest healthcare needs in the Saint Agnes Hospital service area. This assessment has identified that the more urban based communities of West Baltimore City, South Baltimore City, Brooklyn/Linthicum and Southwest Baltimore City represent the greatest healthcare needs, each with overall indices exceeding 1.50. The suburban communities of Pasadena, Ellicott City and South Carroll have comparatively fewer healthcare needs, as determined by this assessment. Community needs, market share and community dependence rates, suggest that Saint Agnes Hospital can make the greatest impact in West Baltimore City.

Appendix 6 – Internal & External Stakeholders

Internal Stakeholders - Saint Agnes Hospital:

Shadi Barakat, MD, Medical Director Diabetes Center
Pinar Miski, MD, Chief of Psychiatry
Richard Pomerantz, MD, Chairman Department of Medicine
Michael Burke, MD, Chairman Department of Pediatrics
James Richardson, MD, Section Chief Geriatric Medicine
Nancy Hammond, MD, Interim Chairman Department of OB/GYN
Kirstan Cecil, Director of Marketing & Communications
Allison Mackenzie, Director Maryland Metabolic Institute
Sharon Berry, MNPM, Nursing Director Maternal Child Health
Lori Franklin, Director Managed Care and Government Relations
Anne Buening, Vice President Mission Integration
Patrick Mutch, Executive Vice President, Physician and Population Health Services
Mary Austin, Assistant Vice President Cancer Institute
Carolyn Moore, Director Rehabilitation Services
Jane Hofherr, RN, Director Care Management
Jennifer Broaddus, LCSW-C, OSW-C, Social Worker Cancer Institute
Susan Mathers, RN, Nursing Director Emergency Department
Kabir Yousuf, MD, Cardiologist
Shannon Winakur, MD, Director Women's Heart Center
Jenene Washington, MD, Chief Medical Officer, Baltimore Medical System

External Stakeholders:

American Diabetes Association – Maryland Area
- David McShea, Executive Director
- Tracy Newsome, Director, Community Health Strategies

Baltimore City Health Department
- Sonia Sarkar, Chief Policy and Engagement Officer
- Darcy Phelan-Emrick, Chief Epidemiologist

Baltimore Medical Systems, Inc.
- Shirley Sutton, President/CEO

Catholic Charities
- William J. McCarthy, Jr., Executive Director

Equity Matters
- Michael P. Scott, Chief Equity Officer/President/Co-Founder

Green & Healthy Homes
- Ruth Ann Norton, President/CEO

HealthCare Access Maryland
Traci, Kodeck, MPH, Interim CEO

The Caroline Center
Patricia McLaughlin, SSND, Executive Director

University of Maryland School of Nursing
Katherine Fornili, MPH, RN, CARN, Assistant Professor, Department of Family & Community Health
Michelle R. Spencer, MS, RN, Clinical Instructor, Department of Family & Community Health

University of Maryland School of Social Work
Wendy E. Shaia, Ed.D., MSW, Clinical Assistant Professor and Executive Director Social Work Community Outreach Service
Tanya L. Sharpe, PhD., MSW, Associate Professor
Stacey Stephens, Director, B'More for Healthy Babies, Upton/Druid Heights
Frederick Strieder, Ed.D., MSW, Clinical Associate Professor and Director, Family Connections
Lane Victorson, MSW, Clinical Field Instructor, Neighborhood Fellows / Peace Corps Fellows

West Baltimore Maha Sampath, MHSA | Director Care (Health Enterprise Zone)
Maha Sampath, MHSA | Director

Appendix 7 – Internal Stakeholder Survey

1. Based on your experience with patients in the community, what do you see as the **greatest** health need facing the population in the Saint Agnes service area?

   _____

   _____

2. Based on your experience in the community, please list the **next three** greatest health concerns facing the population?

   1) _____

   2) _____

   3) _____

Appendix 7 – Internal Stakeholder Survey

Community Health Needs Assessment - Concerns for the Community

		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X
		Access to Health Insurance	Access to Nutritious food	Affordable Housing	Alcohol/ Drug abuse	Alzheimer's/ Dementia	Arthritis	Availability /Access to Doctors Office	Cancer	Depression/ Anxiety Mental Health Issues	Diabetes	Domestic Violence Women & Children	Adequate Education	Employment Opportunities	Heart Disease	High Blood Pressure	HIV /AIDS	Homicide/ Violent Crime	Insufficient Prenatal Care	Lack of Exercise	Lung Disease/ Asthma /COPD	Obesity	Poverty	Smoking/ Tobacco Use	Stroke
X	Stroke																								
W	Smoking/ Tobacco Use																								
V	Poverty																								
Y	Obesity																								
T	Lung Disease/ Asthma /COPD																								
S	Lack of Exercise																								
R	Insufficient Prenatal Care																								
Q	Homicide/ Violent Crime																								
P	HIV /AIDS																								
O	High Blood Pressure																								
N	Heart Disease																								
M	Employment Opportunities																								
L	Adequate Education																								
K	Domestic Violence Women & Children																								
J	Diabetes																								
I	Depression/ Anxiety Mental Health Issues																								
H	Cancer																								
G	Availability /Access to Doctors Office																								
F	Arthritis																								
E	Alzheimer's/ Dementia																								
D	Alcohol/ Drug abuse																								
C	Affordable Housing																								
B	Access to Nutritious food																								
A	Access to Health Insurance																								