Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission (HSCRC or Commission) is required to collect community benefit information from individual hospitals in Maryland and compile into an annual statewide, publicly available report. The Maryland General Assembly updated §19-303 of the Health General Article in the 2020 Legislative Session (HB1169/SB0774), requiring the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments. The reporting is split into two components, a Financial Report and a Narrative Report. This reporting tool serves as the narrative report. In response to the legislation, some of the reporting questions have changed for FY 2021. Detailed reporting instructions are available here: https://hscrc.maryland.gov/Pages/init_cb.aspx

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

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

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

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

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Sinai Hospital of Baltimore, Inc.	◉	○	
Your hospital's ID is: 210012	◉	○	
Your hospital is part of the hospital system called LifeBridge Health	◉	○	
The primary Narrative contact at your hospital is Sharon McClernan	◉	○	
The primary Narrative contact email address at your hospital is smcclernan@lifebridgehealth.org	◉	○	
The primary Financial contact at your hospital is Julie Sessa	◉	○	
The primary Financial email at your hospital is jsessa@lifebridgehealth.org	◉	○	

Q4. The next group of questions asks about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

Q5. Please select the community health statistics that your hospital uses in its community benefit efforts.

- [x] Median household income
- [x] Percentage below federal poverty line (FPL)
- [x] Percent uninsured
- [ ] Percent with public health insurance
- [x] Percent with Medicaid
- [ ] Mean travel time to work
- [ ] Percent speaking language other than English at home
- [ ] Race: percent white
- [x] Race: percent black
- [x] Ethnicity: percent Hispanic or Latino
- [ ] Life expectancy
- [ ] Crude death rate
- [ ] Other

Q6. Please describe any other community health statistics that your hospital uses in its community benefit efforts.

Q7. Attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Q8. Section I - General Info Part 2 - Community Benefit Service Area

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

- [ ] 21201
- [ ] 21202
- [ ] 21203
- [ ] 21205
- [ ] 21206
- [x] 21207
- [x] 21208
- [x] 21209
- [ ] 21210
- [ ] 21211
- [ ] 21212
- [ ] 21213
- [ ] 21214
- [x] 21215
- [ ] 21216
- [ ] 21217
- [ ] 21218
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- [ ] 21233
- [ ] 21234
- [ ] 21236
- [ ] 21237
- [ ] 21239
- [ ] 21251
- [ ] 21263
- [ ] 21270
- [ ] 21278
- [ ] 21281
- [ ] 21287
- [ ] 21290

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

- [ ] 21013
- [ ] 21020
- [ ] 21022
- [ ] 21023
- [ ] 21027
- [ ] 21030
- [ ] 21031
- [ ] 21043
- [ ] 21051
- [ ] 21052
- [ ] 21053
- [ ] 21057
- [ ] 21065
- [x] 21071
- [ ] 21092
- [ ] 21093
- [ ] 21094
- [ ] 21102
- [ ] 21104
- [ ] 21105
- [ ] 21111
- [x] 21117
- [ ] 21120
- [ ] 21128
- [ ] 21131
- [x] 21133
- [x] 21136
- [ ] 21139
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- [ ] 21161
- [ ] 21162
- [ ] 21163
- [ ] 21204
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- [ ] 21234
- [ ] 21235
- [ ] 21236
- [ ] 21237
- [ ] 21239
- [ ] 21241
- [x] 21244
- [ ] 21250
- [ ] 21252
- [ ] 21282

- [ ] 21074
- [ ] 21082
- [ ] 21085
- [ ] 21087
- [ ] 21152
- [ ] 21153
- [ ] 21155
- [ ] 21221
- [ ] 21222
- [ ] 21224
- [ ] 21284
- [ ] 21285
- [ ] 21286

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

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

  Please view full narrative in the "Other" section that follows.

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

  Please view full narrative in the "Other" section that follows.

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

  Please view full narrative in the "Other" section that follows.

- [x]

Other. Please describe.

Sinai Hospital of Baltimore is located in the northwest quadrant of Baltimore City, serving both its immediate neighbors and others from throughout the Baltimore City and County region.The neighborhoods surrounding Sinai are identified by the Baltimore Neighborhood indicators Alliance as Sounthern Park Heights and Pimlico/Arlington/ Hilltop. These two neighborhoods make up the great majority of community health benefit activities, both by virtue of where the activities take place and because the majority of participants in those activities live in these neighborhoods. However, Sinai Hospital does not have an address requirement for participation in community benefit activity, so those activities serve people living in 21215, 21207,21208,21209, 21117,21216, 21071 those zip codes include the following communities: Pimlico/Arington/Hilltop; Southern Park Heights; Howard Park/ West Arlington; Dorchester/Ashburnton; Greater Mondawmin; and Penn North/Reservoir Hill. Together, these zip codes and community designations define the hospital's Community Benefit Service Area. This entire area is predominately African American with a below average median family income, above average rates for unemployment, and other social determining factors that contribute to poor health. The most vulnerable populations reside in 21215,21207, 21208, 21209 and 21216. A majority of Sinai's interventions focus on the neighborhoods within 21215. To further illustrate the social factors that influence the health of those in our CBSA, the following highlights many social determinants in the area closest to the hospital and in with the majority of community benefit participants live, Southern Park Heights (SPH) and Pimlico/Arlington/Hilltop (PAH). Relying on data from The 2017 Baltimore Neighborhood Health Profiles, the median household income for SPH was $26,015 and PAH’s median household income was $32,410. This is compared to Baltimore City’s median household income of $41,819. The percentage of families with incomes below the federal poverty guidelines in SPH was 46.4% and in PAH, 28.4%; compared to 28.8% in Baltimore City. The average unemployment rates for SPH and PAH were 23.6% and 17.1% respectively while Baltimore City’s unemployment rate recorded in 2017 was 13.1%. The racial composition and income distribution of the above indicated zip codes reflect the racial segregation and income disparity characteristic of the Baltimore metropolitan region. For example,SPH and PAH have a predominantly African American population at 94.5% and 96.3% respectively. This is in contrast to the neighboring Mount Washington/Coldspring community in which the median household income is $76,263 and the unemployment rate was 4.5%. The racial/ethnic composition of the MW/C community is much more complex but the population is predominantly (65.8%) white.

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

https://www.lifebridgehealth.org/main/about-sinai-hospital

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

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

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

- (●) Yes
- ( ) No

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

This question was not displayed to the respondent.

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

06/30/2021

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

https://www.lifebridgehealth.org/main/community-health

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

Sinai CHNA_Final.pdf
933.5KB
application/pdf

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

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

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

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

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

Q45. Section II - CHNAs and Stakeholder Involvement Part 3 - Internal HCB Partners

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

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

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

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

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

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

Refer to the FY 2022 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is mandatory for FY 2022.

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

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

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Behavioral Health Organizations -- Please list the organizations here: Behavioral Health Systems of Baltimore	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Social Service Organizations -- Please list the organizations here: N/A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Post-Acute Care Facilities -- please list the facilities here: N/A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Community/Neighborhood Organizations -- Please list the organizations here: Park Heights Renaissance, Jewish Community Center, Zeta Center, League for People with Disabilities, Center for Urban Families, Park Heights Community Health Alliance, Green and Healthy Homes Initiative	☑	☑	☑	☐	☐	☐	☑	☑	☐	☑	☑	☐	☐	☐
Consumer/Public Advocacy Organizations -- Please list the organizations here: N/A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other -- If any other people or organizations were involved, please list them here: American Heart Association, American Diabetes Association	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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

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

- (●) Yes
- ( ) No

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

4/29/2021

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

https://www.lifebridgehealth.org/main/community-health

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

Sinai CHNA Implementation Plan 2021.pdf
1.5MB
application/pdf

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

This question was not displayed to the respondent.

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

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

Q57. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- (●) Yes
- ( ) No

Q58.
Using the checkboxes below, select the Community Health Needs identified in your most recent CHNA that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q59. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q60. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

Q61. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

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

Q62. If you wish, you may upload a document describing your community benefit initiatives in more detail.

Q63. Section III - CB Administration

Q64. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

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

Q65. Please describe the third party audit process used.

This question was not displayed to the respondent.

Q66. Does your hospital conduct an internal audit of the community benefit narrative?

- (●) Yes
- ( ) No

Q67. Please describe the community benefit narrative audit process.

The community benefit narrative is reviewed regularly by the health system's Community Benefit Committee that makes recommendation for approval of the Community Benefit Report by the LifeBridge Health Board.

Q68. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- (●) Yes
- ( ) No

Q69. Please explain:

This question was not displayed to the respondent.

Q70. Does the hospital's board review and approve the annual community benefit narrative report?

- (●) Yes
- ( ) No

Q71. Please explain:

This question was not displayed to the respondent.

Q72. Does your hospital include community benefit planning and investments in its internal strategic plan?

- (●) Yes
- ( ) No

Q73. Please describe how community benefit planning and investments were included in your hospital's internal strategic plan during the fiscal year.

The Community Health Needs Assessment results are prioritized by community leaders and system leadership. A Community Benefit plan is created from this prioritization process. The community benefit plan is used to identify needs and priorities for the organizational strategy.

Q74. If available, please provide a link to your hospital's strategic plan.

Q75. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

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

  Regular diabetes management classes promoted and provided to community members each month (telephonically and in-person) including on topics to reduce BMI like healthy eating and exercise.

- [x] Opioid Use Disorder - Improve overdose mortality

  Sinai Hospital's Addiction Recovery Program (SHARP) offers a range of services to assist community members with Opioid Use Disorder. Hospital also promotes semi-annual Prescription Drug Takeback days with drop boxes available at Sinai's Outpatient Pharmacy.

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

  Healthy Families America initiative: one of the leading family support and evidence-based home visiting programs in the nation; fostering early, nurturing relationships to create and maintain the foundation for healthy child and family development. Includes a focus on improving full-term births. Link community members to health insurance and stable health care providers. Connects pregnant individuals to supportive health resources through LifeBridge and/or HCAM and Baltimore City Health Dept. programs.

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

  ED providers and navigators assist families to get them access to asthma management resources, inhalers and regular preventive care to prevent future asthma-related ED visits.

- [ ] None of the Above

Q76. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q77. Section IV - Physician Gaps & Subsidies

Q78. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- ○ No
- ◉ Yes

Q79. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

This question was not displayed to the respondent.

Q80. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

This question was not displayed to the respondent.

Q81. Please attach any files containing further information and data justifying physician subsidies at your hospital.

This question was not displayed to the respondent.

Q82. Section VI - Financial Assistance Policy (FAP)

Q83. Upload a copy of your hospital's financial assistance policy.

LBH Hospital Information Sheet 220302_ENGLISH.pdf
184.8KB
application/pdf

Q84. Provide the link to your hospital's financial assistance policy.

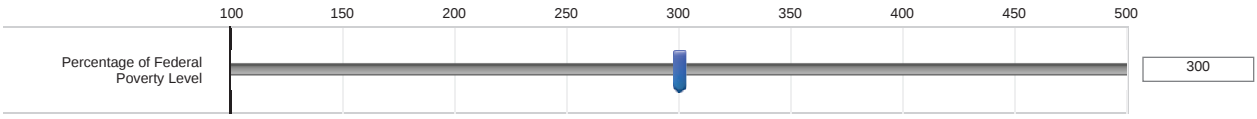
https://www.lifebridgehealth.org/main/financial-assistance

Q85. Has your FAP changed within the last year? If so, please describe the change.

- ◉ No, the FAP has not changed.
- ○ Yes, the FAP has changed. Please describe:

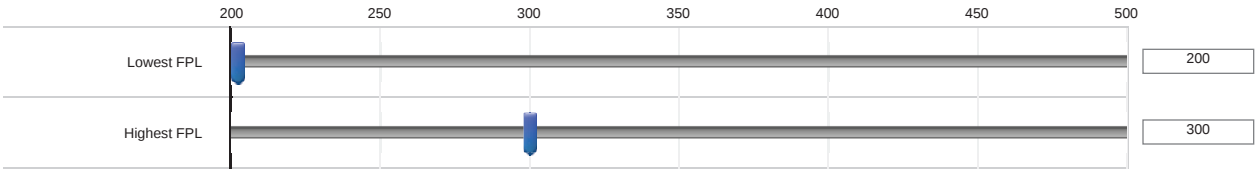
Q86. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



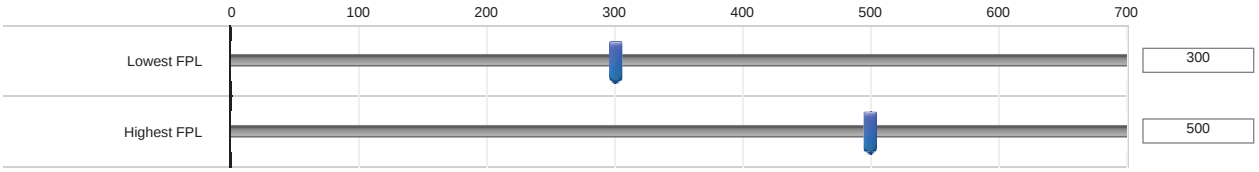
Q87. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

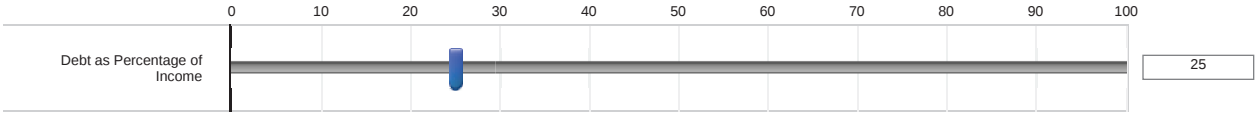


Q88. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

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



Q89. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q90. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding taxable year (select all that apply)

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

Q91. Summary & Report Submission

Q92.

Attention Hospital Staff! IMPORTANT!

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

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

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

Location Data

Location: (38.2539, -85.76)

Source: GeoIP Estimation

LifeBridge Health

Sinai Hospital

Community Health Needs Assessment

2021

Executive Summary

Sinai Hospital is a 483-bed acute care facility licensed in the state of Maryland providing acute, primary and specialty care services to residents in various communities in and near north and west side Baltimore. Sinai Hospital is the most comprehensive and largest community hospital in Maryland and is the state's third largest teaching hospital.

Sinai Hospital is part of LifeBridge Health, Inc. which also includes Grace Medical Center in southwest Baltimore, Levindale Hebrew Geriatric Center and Hospital, Northwest Hospital in Baltimore County and Carroll Hospital in Carroll County.

The Baltimore City Health Department and the resident health systems previously collaborated on a Community Health Needs Assessment ("CHNA") in 2017-2018 and have sought to do so again in 2020-21 though in a more limited manner due to the COVID-19 virus. As part of the LifeBridge Health system participation in this collaborative effort, Sinai Hospital has participated in the City-wide survey, focus groups and stakeholder interviews. This CHNA incorporates a variety of secondary data sourced through the Baltimore Neighborhood Indicators Alliance as well as the Baltimore City Health Department's Neighborhood Health Profile.

2021 Community Health Needs Assessment

Approach and Methodology: Similar to the CHNA conducted in 2018, in 2020-21 Sinai Hospital used an inclusive approach to complete the CHNA to ensure that the CHNA was conducted in a way that best identifies north and west Baltimore's health needs and meets the IRS CHNA requirements for not-for-profit hospitals. Sinai Hospital's leadership recognized the importance of continuity with previous CHNAs and the corresponding Implementation Plans (IP). A report on the impact of actions taken under the 2018 Implementation Plan can be found on page 8.

Sinai Hospital utilized its Community Health and Wellness team to conduct the CHNA. As part of the CHNA methodology, Sinai Hospital collected and analyzed both primary and secondary data for seven Community Statistical Areas (CSAs) that comprise the majority of the hospital's service area. The following CSAs make up Sinai Hospital's CHNA Service Area - Cross-Country/Cheswolde, Dorchester/Ashburton, Glen-Falstaff, Howard Park/West Arlington, Mount Washington/Coldspring, Pimlico/Arlington/Hilltop, and Southern Park Heights.

Key Findings from Secondary Data Analysis: The 2020 US Census population estimate for the Sinai Hospital service area is 251,771. This represents a decline of approximately 2,100 residents since 2010. The demographics of the service area commonly reflect Baltimore City as a whole in regard to age (18 percent over 65 and 22 percent under 18), ethnicity (4.7 percent Hispanic/Latinx), race (63 percent Black, 31 percent White, 4 percent Asian), and gender (54/46 percent female/male). With respect to education, residents of the service area have attained higher education levels than the City's overall population (37 percent with bachelor's degree or greater versus 32 percent for Baltimore City).

Within the CHNA service area, the communities of Southern Park Heights and Pimlico – Arlington – Hilltop had health outcomes and socio-economic factors significantly less favorable than other service area communities and Baltimore City as a whole. In particular:

- Life expectancy across the service area ranged from 84.7 years in Cross-Country/Cheswolde to 67.1 years in Pimlico/Arlington/Hilltop and 68.7 years in Southern Park Heights. The city of Baltimore has a life expectancy of 72.7 years.
- The all-cause mortality rate per 10,000 people in the CSAs served by Sinai Hospital range from 44.9 in Cross-Country/Cheswolde to 128.2 for Pimlico – Arlington – Hilltop, nearly 29 percent higher than the Baltimore rate. Southern Park Heights has an all-cause mortality rate of 119.1 per 10,000 people.
- More than 50 percent of households in Southern Park Heights and 41 percent of households in Pimlico-Arlington-Hilltop have incomes less than $25,000. The city-wide percentage is 28.4.

Community and Stakeholder Involvement: The CHNA team used a multi-pronged approach to solicit input from the Baltimore community regarding their health needs. Data collection methodologies included surveys, stakeholder interviews, and focus groups. Focus groups and interviews included community leaders, associations, as well as expressed demographic groups – those with disabilities, re-entry residents, and Spanish-speaking employees.

Participants highlighted the following themes as **top health concerns**:

- High Blood Pressure, Diabetes, and High Cholesterol
- Mental Health and Illness, Depression, Loneliness
- Drug and Alcohol Addiction, Substance Abuse

The leading **social and environmental barriers** referenced were:

- Unemployment, Poverty, as well as Crime and Trash
- Lack of Transportation

- Safety across the community
- Lack of open space, recreation, and a sense of community
- Language barriers

A web-based and hardcopy survey instrument was distributed in 2020 to collect information from Baltimore City residents regarding their health and social needs. A total of 3,170 surveys were completed in the fall of 2020 across Baltimore City. Six hundred sixty-three of the respondents (21%) were from the Sinai service area.

The most important problems that affect the health of the community are:

- Alcohol/Drug addiction – 60 percent of respondents
- Mental Health (Depression/Anxiety) – 44 percent
- Diabetes/High Blood Sugar – 33 percent
- Heart Disease/Blood Pressure – 31 percent

The most important social/environmental problems that affect the health of the community are:

- Lack of Job Opportunities – 32 percent of respondents
- Housing/Homelessness – 29 percent
- Neighborhood Safety/Violence – 27 percent
- Limited Access to Healthy Foods – 22 percent

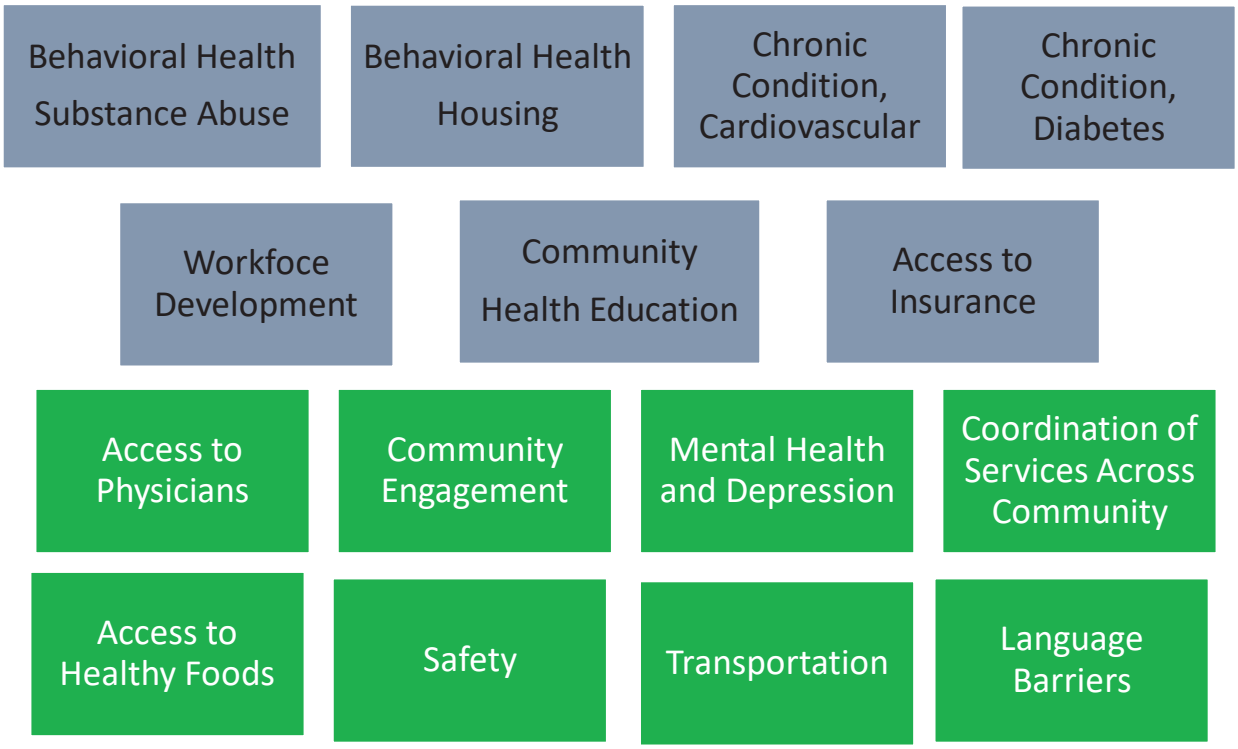
Sinai Hospital Identified Health Needs and Priorities

In 2018, Sinai Hospital identified and prioritized the following health needs in the community:

- Behavioral Health/Substance Abuse
- Behavioral Health and Housing
- Chronic Disease, Diabetes
- Chronic Disease, Cardiovascular
- Workforce Development
- Community Health Education
- Access to Insurance

In 2021, the seven needs (above) remained as **Identified Needs** of the community, and eight additional needs (in green boxes below) were added.

Identified Needs of Community Served



The Sinai Hospital CEO and CHNA leadership met with representatives of the Sinai Hospital Board, Leadership team, key community stakeholders, and the LifeBridge Health Community Mission Committee members on March 19, 2021 to review findings of the CHNA and to seek recommendations to prioritize the identified needs above. Following review of secondary and survey data, as well as findings of the interviews and conducted focus groups, the participants were asked to select those identified needs for which there was **"High Need"** (significance and prevalence) and **"High Feasibility"** (ability to impact).

The following Identified Needs were selected as **Priorities** for Sinai Hospital and will be included in the 2021 – 2024 Implementation Plan:

1. Heart Disease
2. Mental Health and Depression/Substance Abuse
3. Community Health and Wellness Education
4. Diabetes
5. Housing
6. Food Insecurity

7. Community Safety

In addition, the leadership of Sinai Hospital recognizes the significant need to address imbalances among racial and minority groups and those impacted by longstanding social determinants of health. An eighth priority, Health Disparities, is intended to expand community relationships and extend coordinated services more closely to socio-economically impacted neighborhoods.

Sinai Hospital leadership anticipates the 2021 – 2024 Implementation Plan will address these needs in conjunction with both LifeBridge Health resources and with well-established community partners and organizations.

Sinai Hospital will also support the work of City agencies and collaborative organizations to address and advocate for solutions to additional Identified Needs not prioritized in its Implementation Plan.

2021 Community Health Needs Assessment

A community health needs assessment (CHNA) provides the foundation for improving and promoting the health of a community. Through the assessment process, Sinai Hospital ("Sinai") identifies and describes the health status of the community that it serves; any factors in the community that contribute to health challenges; and existing community assets and resources that can be mobilized to improve the health status of the community. The community health needs assessment, therefore, ensures that Sinai and partner resources are directed toward activities and interventions that address critical and timely community health needs. This Report documents the results of Sinai's CHNA for fiscal year 2021. This Report will inform Sinai's CHNA Implementation Strategy that will describe how Sinai Hospital plans to address prioritized health needs.

Federal CHNA Requirement

The Patient Protection and Affordable Care Act [§ 9007, 26 U.S.C. 501(c) (2010], (commonly referred to as "Obamacare") requires non-profit hospitals to conduct a community health needs assessment (CHNA) and adopt an implementation strategy (i.e., community health improvement plan (CHIP)) every 3 years to be considered a non-profit by the Internal Revenue Service (IRS). A CHNA defines the community a hospital serves, surveys the health of their community, and listens to their community members' opinions in order to decide what the greatest needs of their community are and what resources are available. An implementation strategy then describes how the hospital plans to address the greatest needs in their community.

A CHNA will only meet the requirements of the law if it:

(i) Defines the community it serves.
(ii) Assesses the health needs of that community.
(iii) Reviews input from their community and local public health officials.
(iv) Documents the CHNA in a written report (CHNA Report) that is adopted for the hospital by an authorized body of the hospital facility.
(v) Makes the CHNA report widely available to the public.

1 Impact of Implementation Plan (2018 – 2020)

2018 SINAI IMPLEMENTATION STRATEGY

Category: Health Concerns; ***Prioritized Need:*** Behavioral Health

In response to the continued prioritized need of Behavioral Health, the Office of Community Health Improvement implemented the Screening and Brief Intervention and Referral to Treatment (SBIRT) protocol in Sinai Emergency Department. The protocol

is designed to work with patients who may have substance use disorder and provide some level of support and navigation for them before they leave the facility. Sinai Hospital partnered with Mosaic to train support workers who provide the interventions and Emergency Department staff who complete the screening and treat the patient before referral. Since November of 2019, of the 43,342 ED registrations, 35,304 screenings were completed and 4,560 of those patients screened were positive for substance use. SBIRT staff completed 1,262 brief interventions, 286 referrals to treatment were made and 137 of the referral appointments made were kept.

Category: Health Concerns ***Prioritized Need***: Chronic Disease

In response to the prioritized need of chronic disease, the Office of Community Health Improvement implemented the Diabetes Wellness Series. This education series offered education on the treatment strategies and self-management of Diabetes for patients and family members. Also included in the curriculum is information on pre-diabetes, medication management, food, physical activity and healthy lifestyle choices. We partnered with various community organizations, American Diabetes Association, Maryland Department of Health, Baltimore City Health Department, Sinai Hospital's Diabetes Resource Center, and many others. Between July 2017 and March 2020, there were 38 in-person classes offered serving 167 people. 93% of attendees surveyed indicated that they would institute lifestyle changes and behavioral change based on the information heard and received during events.

Category: Health Concerns ***Prioritized Need***: Chronic Disease

In response to the prioritized need of chronic disease, the Office of Community Health Improvement continued the Changing Hearts Program (through June 2019) to maintain and improve behavioral and biometric outcomes connected to heart disease. Various aspects of the program continued after June 2019 through March 2020. Components included but were not limited to providing on-going support to facilitate lifestyle change; improve quality of life, smoking status, healthy eating practices and physical activity. The program also held regular education sessions and shared materials to improve biometric elements such as blood pressure, fasting blood sugar, body mass index, and cholesterol levels. We partnered with many organizations throughout the communities including the American Heart Association, Baltimore City Health Department Cardiovascular Disparities Task Force, and the Park Heights Community Health Alliance. 69% of program participants presented with either pre-hypertension and either Stage One or Stage Two Hypertension as defined by the American Heart Association. Of those completing the program, 42% demonstrated an improvement in their blood pressure compared to the beginning measurement. 87% presented as overweight or obese and after completing the program 14% had an improvement in their BMI compared to the beginning measurement. 71% of participants presented as pre-diabetic

or diabetic according to their fasting blood glucose measurements. 21% demonstrated improvement in their fasting blood sugar upon completion of the program. 58% presented with cholesterol numbers that were above normal, with 18% of individuals demonstrating an improvement in cholesterol levels upon program completion. 93% of program participants reported making healthier lifestyle choices regarding diet, activity, communication with healthcare providers and smoking status (38% began smoking cessation programs). Upon conclusion of the Changing Hearts Program, in-person screening and risk assessment activities continued (June 2019-March 2020) serving 362 people during which time 96% committed to and/or reported making healthier lifestyle choices based on the results of their assessment and education provided.

Category: Access to Health Care ***Prioritized Need***: Health Education/Knowledge of Available Resources

In response to the prioritized needs of health education and the knowledge of available resources the Office of Community Health Improvement increased staff to expand reach into surrounding communities. The addition of the Community Pastoral Outreach Coordinator (Nov. 2017) and additional Health Educators (July 2017-June 2019 and Jan. 2020-present) allowed for the increase in health events and expansion of topics. In addition to illness and prevention related topics, information was added on the connection between faith and health; and the inclusion of more information on community resources facilitated more access. Staff hours for workshops FY18-FY20 (health fairs and other in-person events through March 2020), increased by 37% compared to the previous CHNA cycle (FY15-FY17). The overall number of people receiving health education increased by 47% during the same time frame (including a 13% increase in the faith-based partners) compared to the previous cycle. Coalition building saw an exceptional increase (more than 100%) as our Community Pastoral Outreach Coordinator facilitated better, more collaborative relationships with our surrounding faith communities.

Category: Access to Health Care ***Prioritized Need***: Medical Insurance

Access to health care impacts our overall physical, social, and mental health status and quality of life. Health insurance coverage helps patients enter the health care system. Uninsured or underinsured individuals are more likely to delay healthcare and to go without the necessary healthcare or medication they should have been prescribed. Training staff to assist patients with navigating and applying for Medicaid health insurance has been the focus of one Community Health Worker's work. In the past 2.5 years, approximately 700 patients have received assistance with new applications, renewal applications or referrals to other insurance services. During the second half of 2020, 60% of those in need of insurance have become insured. Those who have not

been eligible for Medicaid due to income requirements, citizen requirements or eligibility for other insurance have been referred to other resources.

2 Overview of Sinai Hospital and the LifeBridge Health System

Founded in 1866 as the Hebrew Hospital and Asylum, Sinai Hospital has evolved into a Jewish-sponsored health care organization providing care for all people. Today, Sinai Hospital is a 483-bed community teaching hospital that provides patient care in a variety of settings including inpatient, surgical, outpatient, trauma center (Level II designation), high risk Neonatal Unit, state-of-the-art Emergency Department, and responsive community outreach provided by M. Peter Moser Community Initiatives Department (Community Initiatives), an integral part of the Population Health Department. Sinai Hospital has 16 specialized clinical Centers of Excellence, including the Alvin & Lois Lapidus Cancer Institute, Sandra and Malcolm Berman Brain & Spine Institute, the Rubin Institute for Advanced Orthopedics, and the Krieger Eye Institute, and the Herman & Walter Samuelson Children's Hospital.

Sinai Hospital is the most comprehensive and largest community hospital in Maryland and is the state's third largest teaching hospital. Community teaching hospitals such as Sinai find one of their greatest strengths is their clinicians' commitment to direct patient care. The residents and medical students who train at Sinai have chosen a community-teaching setting over a classic academic medical center setting. Sinai provides medical education and training to 2,000 medical students, residents, fellows, nursing students, and other health professionals each year from the Johns Hopkins University, University of Maryland, and other teaching institutions in the Baltimore/ Washington/ Southern Pennsylvania region.

Sinai Hospital is a member of the LifeBridge Health system, which was formed in 1998 by the merger between Sinai Health System, Inc., that included Sinai and Levindale Hebrew Geriatric Center and Hospital, and Northwest Health System, Inc. A fourth hospital, Carroll County Health Services Corporation, joined the LifeBridge Health system in April 2015.

3 CHNA Approach and Methodology

Sinai used a work group ("team") to complete the CHNA to ensure that the CHNA was conducted in a way that best identifies the health needs of its service area and meets the IRS CHNA requirements for not-for-profit hospitals.

The CHNA team, which had representation from the Population Health department partnered with health systems across Baltimore City in dissemination of a community survey as well as stakeholder interviews and focus groups. (The list of team members can be found in Appendix A).

As part of the CHNA methodology to identify community health needs, the team collected and analyzed both qualitative and quantitative data via community input and review of secondary data sources. Quantitative data was provided by the Baltimore City Health Department as well as Baltimore Neighborhood Indicators Alliance – Jacob Francis Institute (BNIA), and the Center for Disease Control.

The CHNA team used a multi-pronged approach to solicit input from the community across the service area regarding their health needs. Qualitative data collection methodologies included stakeholder interviews, focus groups, and a survey. In addition to soliciting public input via social media the CHNA team contacted community partners and association leaders, faith organizations as well as senior housing facilities in the service area.

All data collection efforts were significantly impaired by the COVID-19 virus. Health Department officials were focused on pandemic virus responses and unable to update the 2017 Baltimore Neighborhood Health Profile Reports. Availability of staff for interviews was limited. Outreach to potential participants was substantially constrained and limited to electronic venues and materials.

Methods were based on the intended target audience and information needs. The chart below shows the data collection method used to meet CHNA requirements.

Figure X - CHNA Requirement and Data Collection Methodology

CHNA Requirement	Data Collection Methodology
Secondary Data sources reflecting health and social conditions of the community served.	• Baltimore City Health Dept; Baltimore Neighborhood Indicators Alliance; CDC
At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency), or a State Office of Rural Health with knowledge, information, or expertise relevant to the health needs of that community;	• Collaborative stakeholder Interviews
Members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations;	• Stakeholder Interviews • Survey • Focus Groups
Input received from a broad range of persons located in or serving its community including but not limited to health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers, and community health centers, health insurance and managed care organizations, private businesses and labor and workforce representatives.	• Survey • Focus Groups

4 Description of the Community Served

Sinai Hospital is located in the northwest quadrant of Baltimore City, serving both its immediate neighbors and others throughout the Baltimore City and Baltimore County. The community served by Sinai Hospital can be defined by its Primary Service Area (PSA) and geographically represents the zip codes immediately surrounding Sinai Hospital. Listed in order from largest to smallest number of discharges for fiscal year 2020, Sinai Hospital's CHNA service area includes the following zip codes: 21215, 21207, 21117, 21216, 21208, and 21209. (represented by the red and purple areas of the map, Appendix B).

More specifically, the CHNA service area is comprised of the following Community Statistical Areas ("CSAs") – Cross-Country/Cheswolde, Dorchester/Ashburton, Glen-Falstaff, Howard Park/West Arlington, Mount Washington/Coldspring,

Pimlico/Arlington/Hilltop, and Southern Park Heights. These CSAs overlap with the zip codes from which the top 53% of 2020 total patient discharges originate.

The table below provides comparative Demographic information across the Sinai Hospital service area, the City of Baltimore, and those from the Sinai service area who participated in the 2020 survey.

Demographic Highlights

Category	Sinai Hospital Service Area	Baltimore City, US Census Bureau 2019	2020 Survey Respondents from Service Area
Population	2010 Census: 253,870 2016 Census: 261,160 2020 Estimate: 251,771	2019: 593,490	663
Gender	Female: 54% Male: 46%	Female: 53% Male: 47%	Female: 66% Male: 31% Transgender: 1%
Race	Black/African American: 63% White: 31% Asian: 4.1% Multiple Races: 2.3%	Black/AA: 62.7% White: 31.8% Asian: 2.7% Multiple Races: 2.2%	Black/AA: 78% White: 14% Asian: 1% Multiple Races: 1%
Ethnicity	Hispanic/Latinx: 4.7%	Hispanic/Latinx: 5.7%	Hispanic/Latinx: 4.5%
Age	Under 18: 22.3% 18 to 64: 59.7% 65 and Older: 18.0%	Under 18: 20.2% 18 to 64: 65.3% 65 and Older: 14.5%	Under 18: N/A 18 to 64: 75% 65 and Older: 25%
Uninsured		7.4%	11%
Education	Non-HS grad: 10.4% High School grad: 52.6% Bachelors+: 37.0%	Non-HS grad: 14.8% High School grad: 53.3% Bachelors+: 31.9%	Were not asked

Baltimore City is comprised of 593,490 people (US Census Bureau, July 2019 estimate), of which 251,771 (42.4%) live in the Sinai service area. The demographics of service area commonly reflect Baltimore City as a whole for age, ethnicity, race, and

gender. With respect to education, residents of the service area have attained higher education levels than the City's population collectively.

5 Qualitative Findings

Survey

A web-based and hardcopy survey instrument was distributed in 2020 to collect information from Baltimore City residents regarding their health and social needs. The survey consisted of 14 questions (both open and closed ended) covering the following categories (number of questions):

- Demographics (5),
- Health problems (1),
- Social and Environmental problems (1),
- Mental Health (1),
- Access to Health Insurance and Barrier to Healthcare Access (2),
- Impact of COVID-19 (3), and
- Suggestions for Improving the Health of the Community (1).

A total of 3,170 surveys were completed in the fall of 2020 across Baltimore City. Six hundred sixty-three of the respondents (21%) were from the Sinai service area.

While females represented 63% of the respondents overall, in the Sinai service area they represented 66% of those who completed the survey. The proportion of respondents from within the Sinai service area under the age of 50 was 41% versus 47% for the whole survey participants. Seven percent of respondents were 75 years or older from the Sinai zip codes compared to 5.7% of all respondents.

A larger percentage of African-Americans (78% vs. 61% overall) in the Sinai service area took the survey and a slightly greater percentage (5% vs. 4%) considered themselves Hispanic. A slightly lower percentage (86% vs 90.6% overall) indicated they had health insurance.

While 43% of Sinai area respondents reported zero (0) days of the past 30 days in which their mental health was not good (compared to 28% of all who took the survey), as the subsequent question and response demonstrate, Mental Health is secondly only to Alcohol and Drug addiction as the most important health problem for the health of the community. Within the Sinai service area, Mental Health is a more significant concern for survey respondents than for survey respondents across the city.

What are the three most important health problems that affect the health of your community? Please check only three.	Number of Sinai area Respondents	Percent of total Sinai area Respondents	% of City-Wide Respondents
Alcohol/Drug Addiction	396	60%	63%
Mental Health (Depression/Anxiety)	295	44%	36%
Diabetes/High Blood Sugar	221	33%	34%
Heart Disease/Blood Pressure	208	31%	34%
Smoking/Tobacco Use	152	23%	18%
Cancer	111	17%	18%

Across the Sinai service area, and consistent with all respondents in the City survey, the three most important social / environmental problems affecting the health of the community are Lack of Job Opportunities, Housing and Homelessness, as well as Neighborhood Safety and Violence. Among respondents, Neighborhood Safety and Access to Healthy Foods are of more concern in the hospital's service area than the City as a whole.

What are the three most important social/environmental problems that affect the health of your community? Please check only three.	Number of Sinai area Respondents	Percent of total Sinai area Respondents	% of City-Wide Respondents
Lack of Job Opportunities	215	32%	32%
Housing/Homelessness	189	29%	30%
Neighborhood Safety/Violence	177	27%	25%
Limited Access to Healthy Foods	143	22%	19%
Availability/Access to Doctor's Office	122	18%	19%

The top three reasons residents in the community do not get health care are linked to the cost of health care, a lack of insurance, and/or a lack of transportation. The responses of those in the Sinai service area are similar, though to a lesser extent, to those across the whole City.

What are the three most important reasons people in your community do not get health care? Please check only three.	Number of Sinai area Respondents	Percent of total Sinai area Respondents	% of City-Wide Respondents
Cost - Too Expensive/Can't Pay	409	62%	69%
No Insurance	346	52%	56%
Lack of Transportation	188	28%	27%

The impact of COVID-19 on residents is reflected in a variety of significant needs. Food assistance, and financial assistance were identified as needs by more than one-third of respondents in the Sinai service area. Energy and rental assistance were listed by 18 percent of Sinai respondents. All four needs exceeded the percent of respondents city-wide who referenced these types of assistance.

As a result of COVID-19, have you needed any of the following? (Check all that apply)	Number of Sinai area Respondents	Percent of total Sinai area Respondents	% City-Wide Respondents
Food Assistance	280	44%	32%
Financial Assistance	233	37%	30%
None	231	36%	49%
Energy Assistance	117	18%	15%
Rental Assistance	114	18%	13%
WiFi/Internet Assistance	84	13%	10%
Housing/Shelter	70	11%	7%
Child Care	62	10%	7%
Translation/Interpretation Services	19	3%	2%

When asked “What ideas or suggestions do you have to improve the health in your community?”, respondents from the Sinai Hospital service area spoken to the following themes:

- **Health** - Universal healthcare, affordable insurance, equity and access, mental health resources, and better quality of care;
- **Community** - More community investment and resources, outreach and rehabilitation across the community, cleanliness, and safety;
- **Economy** - Opportunities for people, less socio-economic discrimination; and
- **Nutrition** - Access to healthier foods, more affordable fresh foods.

Focus Groups and Stakeholder Interviews

In addition, Sinai and its companion LifeBridge Health facilities conducted focus groups as well as conversations with key stakeholders within the primary service areas. Representatives included community leaders, associations, as well as expressed demographic groups – those with disabilities, re-entry residents, and Spanish-speaking employees. Four stakeholder interviews and four focus groups were conducted between August 2020 and November 2020. The stakeholders were selected because they had special knowledge of or expertise in public health or represented the broad interest of the community served by Sinai, including the interests of medically underserved, low-income and minority populations with chronic disease needs.

The conversations asked the following questions:

1. What are the top health concerns in your community?
    a) Pre-COVID?
2. What are the top social/environmental barriers in your community?
3. What are the top reasons people in your community don't access healthcare?
4. As a result of COVID-19, what barriers have emerged or gotten worse in your community?
5. What ideas or suggestions do you have to improve the health and or healthcare system in your community?

Participants highlighted the following themes as **top health concerns:**

- High Blood Pressure, Diabetes, and High Cholesterol
- Mental Health and Illness, Depression, Loneliness
- Drug and Alcohol Addiction, Substance Abuse
- Additional concerns included Nutrition, Wellness, Cancer, HIV/AIDS, and stroke.

The leading **social and environmental barriers** referenced were:

- Unemployment, Poverty, as well as Crime and Trash
- Lack of Transportation
- Safety across the community
- Lack of open space, recreation, and a sense of community
- Language barriers

The top reasons for not accessing healthcare services included:

- Lack of Insurance, and underlying lack of funds
- A distrust in the healthcare system and corresponding misinformation and perceived discrimination
- Delays in receiving care, more timely care needed
- Lack of education
- Lack of transportation and distance from doctors

Increased barriers as a result of COVID-19 include:

- Food insecurity and access to grocery stores
- General fearfulness, safety, depression, loneliness and mental health
- Housing security
- Domestic violence
- Transportation and resources for Spanish speaking populations

Suggestions made to improve health or healthcare systems were:

- More engagement with the community; expand beyond social media
- Establishment of care coaches/coordinators to help patients navigate health care and services needed
- Services for new families, parenting classes
- Language resources
- Attention to senior wellness, prostate screenings.

A complete summary of the individual interviews and focus groups conducted can be found in Appendix C.

6 Secondary Data Analysis

Health Outcomes

As in 2018, the following CSAs were selected by **Sinai Hospital** to be included in this CHNA quantitative profile: Cross-Country/Cheswolde, Dorchester/Ashburton, Glen-Falstaff, Howard Park/West Arlington, Mt. Washington/Coldspring, Pimlico/Arlington/Hilltop, Southern Park Heights.

Life Expectancy: For 2018, the most recently reported data indicates that the overall life expectancy at birth in Baltimore City was 72.7 years. In the Sinai service area, the Pimlico/Arlington/Hilltop and Southern Heights CSAs have life expectancies below the City-wide life expectancy. The remaining CSAs all exceed City-wide life expectancy.

Table – Life expectancy at birth by Sinai CSAs, and Baltimore City (2018)

Community Statistical Area (CSA)	Life expectancy at birth, in years
Cross-Country/Cheswolde	84.7
Dorchester/Ashburton	72.0
Glen-Falstaff	76.7
Howard Park/West Arlington	74.7
Mt. Washington/Coldspring	79.9
Pimlico/Arlington/Hilltop	67.1
Southern Park Heights	68.9
Baltimore City	**72.7**

Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

In the 2018 CHNA, several important data indicators were provided by the Baltimore City Health Department through their 2017 Neighborhood Health Profile Reports. The City Health Department has not issued new Reports since 2017. These important health and social indicators are included in this CHNA for their continued significance in reflecting the health status of the Sinai Hospital service area.

Mortality Rate: The all-cause age-adjusted mortality rate in Baltimore City is 99.5 per 10,000 residents. The CSAs served by Sinai Hospital range from 44.9 in Cross-Country Cheswolde to 128.2 for Pimlico/Arlington/Hilltop. The top causes of death in Baltimore City are due to heart disease, cancer, stroke, and drug-and/or alcohol-related. (Maps for All-Causes Mortality and Drug/Alcohol Mortality can be found in Appendix D and E.)

The number of homicides that occurred per 10,000 residents (all ages) per year in Baltimore City is 3.9. Homicide mortality rate is also a large health disparity in the Sinai service area with age-adjusted mortality rates as high as 9.3 (Pimlico/Arlington/Hilltop).

Table 3 – All-cause mortality, Homicide, and Drug/Alcohol Rate by CSAs in Sinai Service Area, and Baltimore City

Community Statistical Area (CSA)	All Causes Mortality Rate	Homicide Mortality Rate	Drug/Alcohol Mortality Rate
Cross-Country/Cheswolde	44.9	0.3	1.4
Dorchester/Ashburton	101.7	5.6	3.7
Glen-Falstaff	70.2	2.7	2.4
Howard Park/West Arlington	89.9	1.9	4.1
Mt. Washington/Coldspring	65.8	0.6	3.5
Pimlico/Arlington/Hilltop	128.2	9.3	5.6
Southern Park Heights	119.1	5.6	7.0
Baltimore City	**99.5**	**3.9**	**4.4**

***Data from BCHD Neighborhood Health Profile Reports 2017.**

Heart Disease, Cancer, HIV/AIDS: Deaths (per 10,000 lives) due to Heart Disease for three of the CSAs in Sinai's service area exceed the City-wide rate of 24.4. HIV/AIDS in Pimlico/Arlington/Hilltop (3.5) is almost twice the percentage in Baltimore City (1.8).

Table 4 – Percentage of Deaths due to Heart Disease, Cancer, and HIV/AIDS by CSAs, Bon Secours Service Area and Baltimore City

Community Statistical Area (CSA)	Deaths due to Heart Disease	Deaths due to Cancer	Deaths due to HIV/AIDS
Cross-Country/Cheswolde	11.5	11.5	0.4
Dorchester/Ashburton	22.8	19.9	2.6
Glen-Falstaff	19.6	13.7	0.6
Howard Park/West Arlington	29.0	23.4	1.3
Mt. Washington/Coldspring	24.0	17.1	0.0
Pimlico/Arlington/Hilltop	34.3	27.2	3.5
Southern Park Heights	29.4	29.1	2.2
Baltimore City	**24.4**	**21.2**	**1.8**

***Data from BCHD Neighborhood Health Profile Reports 2017.**

Other Health Issues: For Infant Mortality and Teen Birth (15-19 years old) rates, the 2017 BCHD Neighborhood Health Profile Reports relies on 2011-2014 data. At that time, the Baltimore City infant mortality rate per 10,000 residents was 10.4 and the teen birth rate per 1,000 teens was 42.3. The corresponding Maryland state-wide rates for 2018 (per CDC) were 6.8 infant mortality and 14.1 teen births.

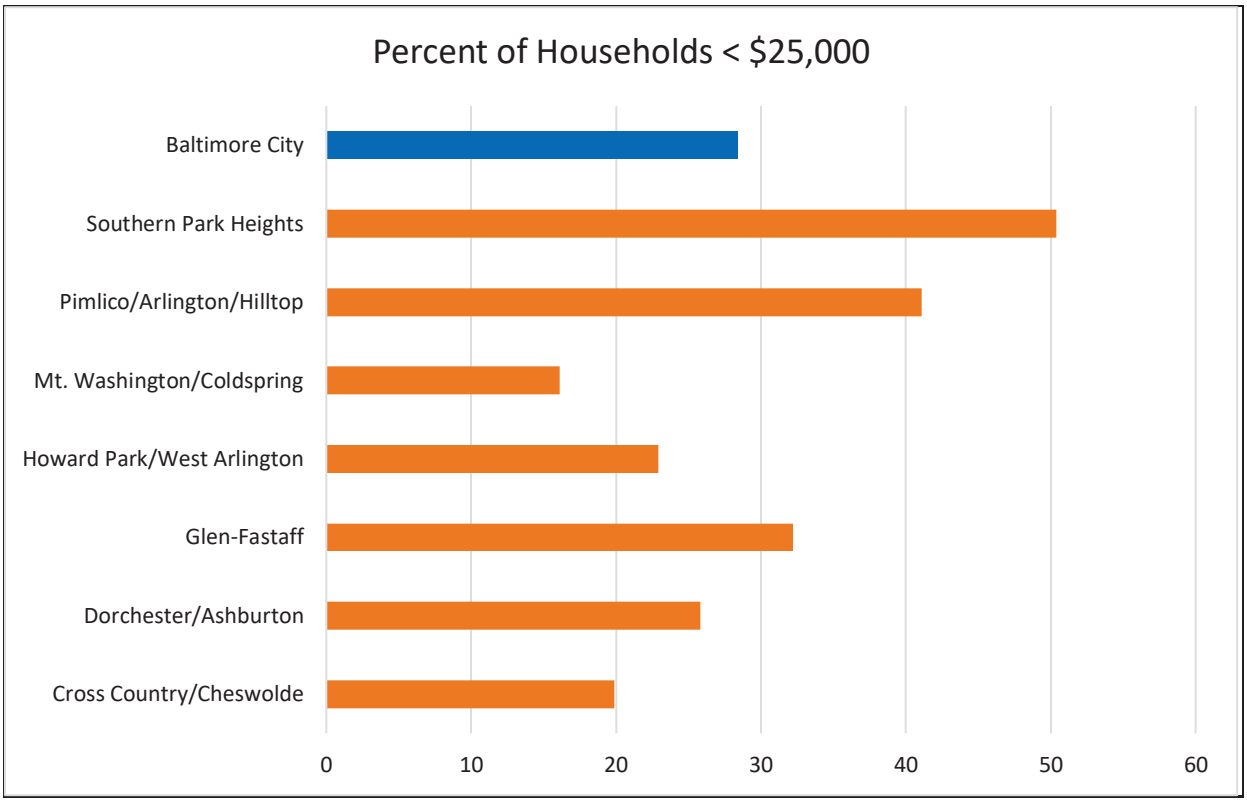
For the Sinai Hospital service area, four of the CSAs have infant mortality rates below both the City of Baltimore as well as Maryland state rates. Pimlico/Arlington/Hilltop and Southern Park Heights, however, had infant mortality rates of 20.0 and 15.5 respectively. Both these neighborhoods with teen birth rates of 55.4 for

Pimlico/Arlington/Hilltop and 57.0 for Southern Park Heights also significantly exceeded the Baltimore City and state of Maryland teen birth rates.

Social and Economic Factors

Percent of Households Earning Less Than $25,000: This indicator reflects potential for economic stress and capacity for achieving and maintaining good health. In Southern Park Heights more than 50% of households earning less than $25,000 suggesting limited economic security across the community. Three of the Sinai CSA have a greater proportion of their population earning less than $25,000 than the City as a whole.

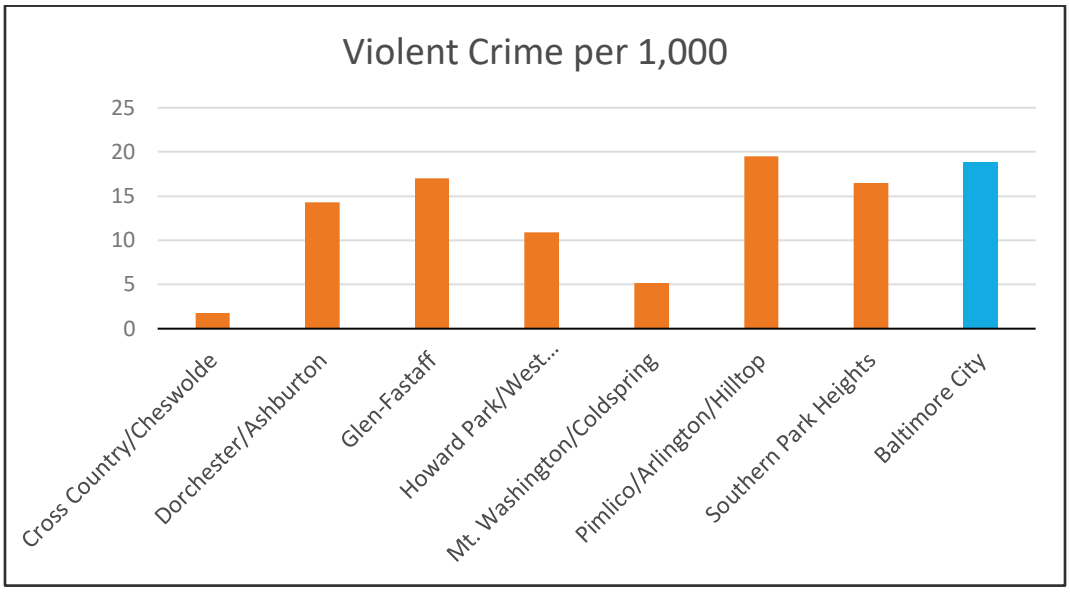
Figure 11 – Percentage of Households earning less than $25,000 in Sinai CSAs, and Baltimore City



Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

Violent Crimes: Violent crimes involve homicide, rape, aggravated assault, and robbery reported to the police department. The violent crime rate varies across the Sinai service area from 1.8 crimes per 1,000 residents in Cross-Country/Cheswolde CSA to 19.5 crimes per 1,000 residents in Pimlico/Arlington/Hilltop CSA. The Baltimore City rate is 18.8 crimes per 1,000 residents.

Figure 13 – Violent Crimes per 1,000 residents by CSAs in Sinai service area, and Baltimore City



Source - Baltimore Neighborhood Indicators Alliance – Jacob France Institute

Hardship Index

Hardship Index: The Hardship Index is a measure of combined socioeconomic factors that include income, education, unemployment, poverty, crowded housing, and dependency (persons aged less than 18 years and 65+ years). As a multi-factor measurement, the Hardship Index more substantially reflects the wider context and varied dimensions of a community's overall health.

The Index has a range from 0 to 100, where a higher score reflects greater hardship across the community. In Baltimore City, the Hardship Index is 51. The CSAs in the Sinai Service Area have a Hardship Index ranging from 23 to 73. Southern Park Heights has the highest (worst) score of 73. Five of the CSAs have Hardship Index scores that exceed the City-wide Index score.

Table 7 – Hardship Index by CSAs in the Sinai service area, and Baltimore City

Community Statistical Area (CSA)	Hardship Index
Cross-Country/Cheswolde	37
Dorchester/Ashburton	61
Glen-Falstaff	63
Howard Park/West Arlington	55
Mt. Washington/Coldspring	23
Pimlico/Arlington/Hilltop	61
Southern Park Heights	73
Baltimore City	**51**

***Data from BCHD Neighborhood Health Profile Reports 2017.**

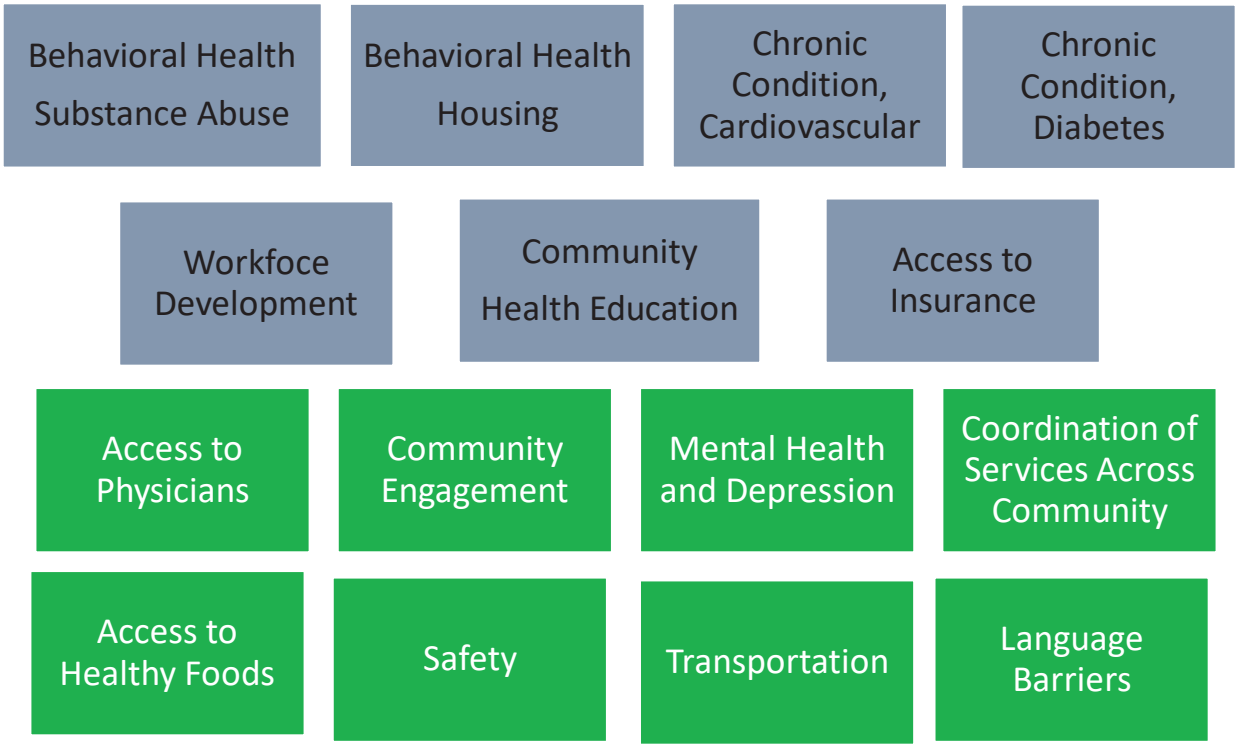
7 Sinai Hospital Identified Health Needs and Priorities

In 2018, Sinai Hospital identified and prioritized the following health needs in the community:

- Behavioral Health/Substance Abuse
- Behavioral Health and Housing
- Chronic Disease, Diabetes
- Chronic Disease, Cardiovascular
- Workforce Development
- Community Health Education
- Access to Insurance

In 2021, the seven needs (above) remained as **Identified Needs** of the community, and eight additional needs (in green boxes below) were added. See Figure below.

Identified Needs of Community Served



7.1 Prioritization Process and Criteria Used to Prioritize Needs

The Sinai Hospital CEO and CHNA leadership met with representatives of the Sinai Hospital Board, Leadership, key community stakeholders and members of the LifeBridge Health Community Mission Committee on March 19, 2021 to review findings of the CHNA and to seek recommendations to prioritize the identified needs above. Following review of secondary and survey data, as well as findings of the stakeholder interviews and conducted focus groups, the participants were asked to select those identified needs for which there was **"High Need"** (significance and prevalence) and **"High Feasibility"** (ability to impact).

For the above **Criteria** participants indicated on a scale of 1 to 6, where 1 indicated little Significance/Prevalence or Ability to Impact and 6 indicated a high Significance/Prevalence or Ability to Impact, those Needs which should be strongly considered for Prioritization. These two polling questions reflected the following underlying considerations:

- Supported by Community Service Area data;
- Consistent with Public Health and health expert input of Baltimore City;
- In support of benefitting a significant population of the community;
- In consideration of 2020 community survey results;
- In support of continuity and progress made by the 2018 Implementation Plan;
- Consistent with the capacities and resources of the hospital.

7.2 Priorities for 2021 - 2024

The following **Identified Needs were selected as Priorities** for Sinai Hospital and will be included in the 2021 – 2024 Implementation Plan:

1. Heart Disease
2. Mental Health and Depression/Substance Abuse
3. Community Health and Wellness Education
4. Diabetes
5. Health Disparities
6. Housing
7. Food Insecurity
8. Community Safety

8 Needs not addressed by Implementation Plan

The following needs were identified either as priorities by populations or conversations, but ultimately were not chosen priorities for implementation as the hospital does not have sufficient resources or other organizations are more capable of meeting the need.

Lack of transportation: Lack of transportation arose in the surveys as an important reason for why people do not get health care. Through the Care Management Department and other programs that work with people in the community, transportation funding is provided for many patients who need help in getting to their doctors' appointments. Since patients and clients are served well by these resources, this concern was not prioritized for further investment.

Access to Insurance: Sinai Hospital provides sign-up assistance to patients without insurance when they present at the hospital. A staffer person oversees this function.

Workforce Development: Sinai Hospital refers residents and patients without employment to partner organizations, particularly Bon Secours CommunityWorks in south and west Baltimore, to address this pressing social need. Sinai Hospital also supports various agencies in addressing underlying factors, e.g. financial literacy and education to mitigate conditions of poverty.

Access to Physicians: A system-wide effort has been developed since the 2018 CHNA to address needs of various patients. Specialists are readily identified and referrals are appropriately made. Departments and team members continue in efforts to reduce appointment wait times for health care services lacking community capacity such as mental health therapy.

Coordination across services: Since the last CHNA Sinai Hospital departments, including social services and care management, have worked more closely both internally as well as with community resources to enable patients to access necessary and valuable resources in as timely a manner as possible. Inclusion of social resources in coordination is intended to reduce reoccurrence of acute health episodes that require hospitalizations.

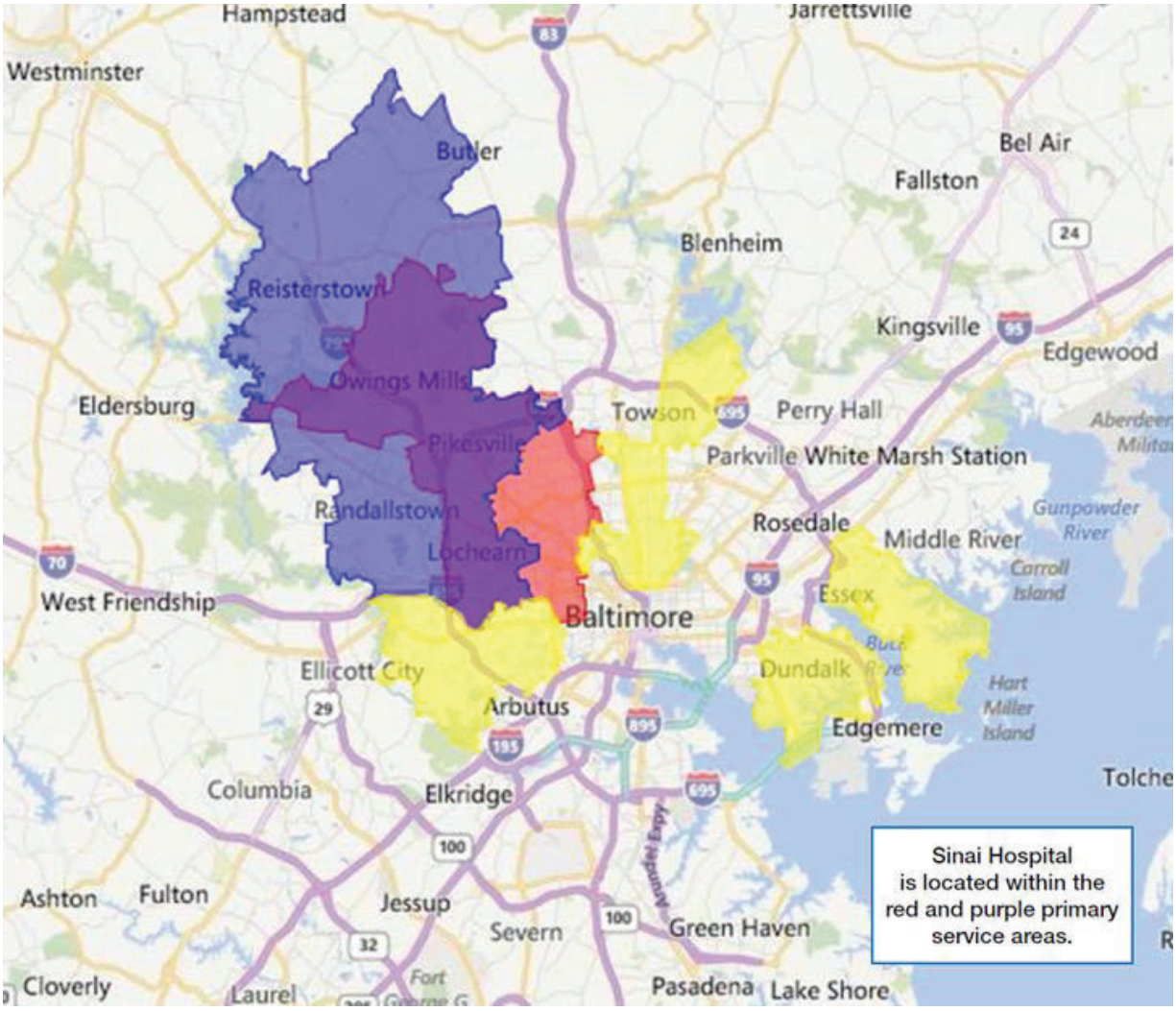
Language barriers: Sinai Hospital has interpretive services available and signs in multiple languages are posted in ER as well as in hard copy forms in the welcome packet patients receive. Forms are available in Spanish as well as other languages, e.g. Russian. Consent forms are translated into several languages as well.

Appendices

Appendix A – CHNA Team

- Dorothy Fox
- Regina Merritt
- Michelle Berkley-Brown
- Rhonda Williams
- Karen Jarrell
- Dan Meltzer
- Kurt Sommer
- Terrie Dashiell
- David Baker
- Sharon McClernan
- Dr. Susan Mani

Appendix B – Map of Sinai Hospital Service Area



Appendix C –

Report on Focus Groups and Stakeholder Interviews

Questions asked:

2. What are the top health concerns in your community?
    b) Pre-COVID?
4. What are the top social/environmental barriers in your community?
5. What are the top reasons people in your community don't access healthcare?
5. As a result of COVID-19, what barriers have emerged or gotten worse in your community?
6. What ideas or suggestions do you have to improve the health and or healthcare systemin your community?

8/11/2020 Focus Group: Baltimore City Parks and Recreation-Older Adults (8 participants – frequent Sinai, Levindale, Grace, and Northwest hospitals) Participants came from both Baltimore City and Baltimore County.

Top health concerns: High Blood pressure, diabetes, mental illness, high cholesterol, drug addiction, depression, loneliness

Top social/environmental: Depression, loneliness, unemployment, crime, poverty,

Why people don't access healthcare: Transportation, lack of education, doctors are too far, lack of money to pay for care.

COVID Barriers/Concerns: Food insecurity and lack of transportation were heavily discussed. They haven't been able to do as much or get the necessary supplies. Increased loneliness.

Suggestions: Hospitals should provide transportation to appointments and getting their medications.

8/26/2020 Stakeholder: Aaron Plymouth-Stevenswood Community Association (Northwest)

Top health concerns: Obesity, Wellness, Mental, Hypertension, Strokes, Renal failure.

Top social/environmental: Transportation, Food/Nutrition/access to grocery stores, risks of falling (lack of handrails, ramps, etc.)

Why people don’t access healthcare: Insurance, fear of bad news, COVID fears (masks, handwashing, etc.), crossing busy streets and handicap ramps for sidewalks to walk to the hospital.

COVID Barriers/Concerns: COVID fears (masks, handwashing, etc.)

Suggestions: Better emphasis on wellness for seniors, prostate screenings/education/etc.

8/27/2029 Stakeholder: Gail Edmonds-Member of Central Baptist Church and former Resident of the same neighborhood (Grace)

Top health concerns: Diabetes, high blood pressure, drug addiction, alcoholism.

Top social/environmental: Poverty, unemployment, access to healthcare, education, early childhood programming and childcare.

Why people don’t access healthcare: Lack of trust in the healthcare system.

COVID Barriers/Concerns: Increased unemployment; housing, education, and employment systemic barriers that have continued and were exacerbated; the increase of crime.

Suggestions: Providing stable service to families from birth to they leave (nutrition, advice, etc.) this includes wraparound services that includes assistance to single parents, parenting classes, etc.

9/21/2020 Focus Group-League of People with Disabilities (13 participants; Citywide) Participants also came from all over the city as well as a few county residents.

Top health concerns: COVID, high blood pressure, diabetes.

Top social/environmental: Accessibility, violence, device repairs that take a long time, transportation, MTA Mobility (late or treated badly).

Why people don’t access healthcare: Transportation, length of time to get equipment from insurance/doctors, referral issues, lack of financial means for things outside of insurance, complicated systems.

COVID Barriers/Concerns: Transportation (underlying issues and being removed from spaces due to fear), depression and anxiety have increased, loneliness and decrease in social access.

Suggestions: Hospitals streamlining insurance/equipment suppliers/referrals; having a program that would cover the cost that insurance does not cover.

9/3/2020 Stakeholder: Pastor Terrye Moore-Senior Pastor of New Solid Rock Fellowship Church and Executive Director North West Faith Based Partnership (Sinai Hospital)

Top health concerns: Mental health, high blood pressure, diabetes, HIV/AIDS, substance abuse.

Top social/environmental: Trash; lack of community; not enough clean, open space, safe; crime/violence.

Why people don't access healthcare: Lack of insurance, fear of being underserved without insurance, distrust of the medical community, negative outlook on life (won't live very long).

COVID Barriers/Concerns: Isolation, depression, domestic violence, mental health challenges.

Suggestions: Streamline healthcare so all treatment was equitable and accessible.

9/10/2020 Stakeholder: Tony Bayesmore-Rolling Oaks Community Association (Baltimore County/Northwest)

Top health concerns: COVID, obesity, high blood pressure, diabetes, cancer, and heart issues.

Top social/environmental: Lack of community centers, safe spaces, and green spaces.

Why people don't access healthcare: Culture and history (distrust of medical professionals); lack of personal relationships with health professionals, access to healthcare/insurance.

COVID Barriers/Concerns: Heightened vulnerability/sense of safety to go outside and go to the doctor now.

Suggestions: Make a concerted effort to be a part of the community where the hospital sits.

9/18/2020 Focus Group: Re-Entry Bon Secours Community Works (3 participants, Grace) located in West Baltimore and all participants come from West and Southwest Baltimore

Top health concerns: COVID, diabetes, alcoholism, substance abuse, obesity, lack of good nutrition.

Top social/environmental: Unemployment, domestic violence, child abuse, lack of resources, lack of insurance, gun violence, lack of recreation facilities.

Why people don't access healthcare: Health insurance, racism, access to doctors, money, substance abuse, misinformation.

COVID Barriers/Concerns: Unemployment, hunger, further distrust of healthcare/law enforcement, depression, anxiety.

Suggestions: Create a friendly open environment, treat people with dignity, be more relatable.

11/20/2020 Focus Group-Spanish-Speaking, LifeBridge Health Hispanic Latino Employee Network (3 participants)

Top health concerns: COVID, mental health, access to preventative medicine.

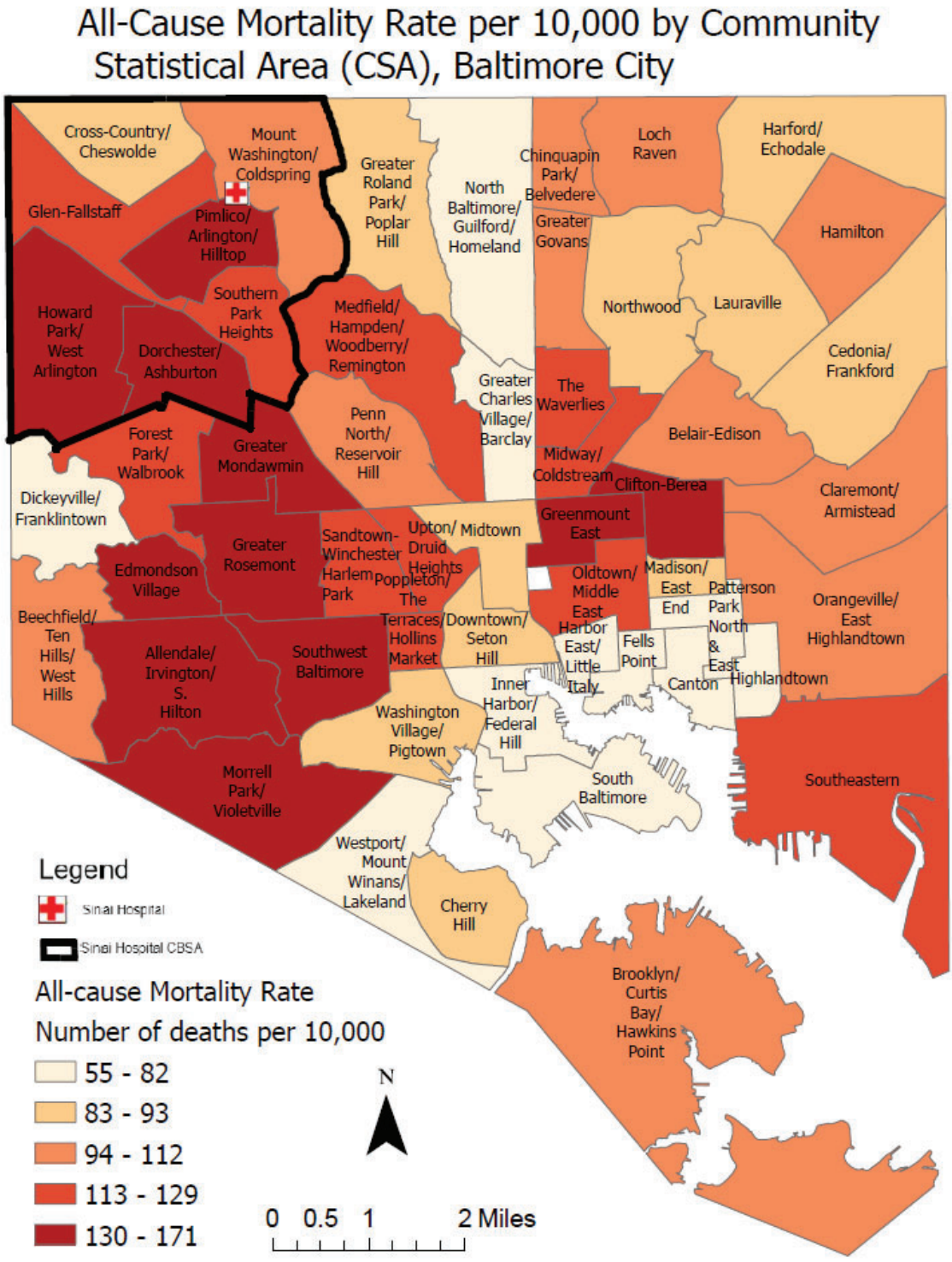
Top social/environmental: Language barriers, lack of trust to share information, adequate housing and family support, safety, food access, lack of resources for Spanish speaking people.

Why people don't access healthcare: Religious beliefs, lack of interpreters, insurance, lack of financial resources, lack of connection, lack of education of rights, transportation.

COVID Barriers/Concerns: Lack of urgent care access, lack of access to technology, lack of access to childcare, increase of disconnect and fear of separation.

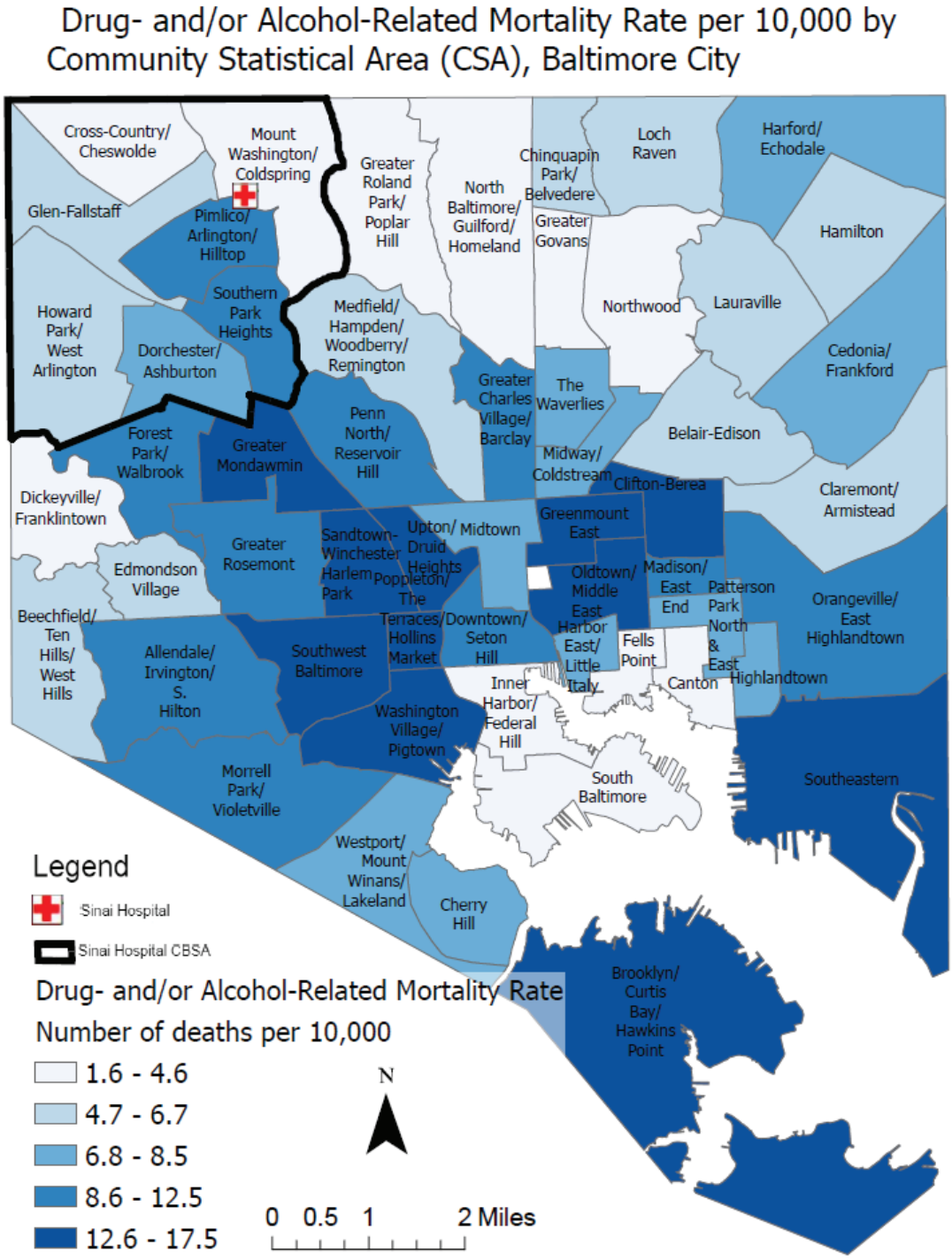
Suggestions: Increase of a diverse workforce; central location/directory for resources in patient language; utilize employee skills to their full potential.

Appendix D – All Cause Mortality Map



Data source: Baltimore City Health Dept. analysis of data provided by the Maryland Dept. Health. Data categorized by quintile. February 2, 2021.

Appendix E – Drug/Alcohol Mortality Map



Data source: Baltimore City Health Dept. analysis of data provided by the Maryland Dept. Health. Data categorized by quintile. February 2, 2021.

Implementation Plans for Sinai Hospital Prioritized Needs 2021-2024

The following Identified Needs were selected as **Priorities** for Sinai Hospital of Baltimore and will be included in the 2021 – 2024 Implementation Plan:

1. Chronic Heart Disease
2. Mental Health, Depression, and Substance Use Disorder
3. Community Health and Wellness Education
4. Diabetes
5. Housing
6. Food Insecurity
7. Community Safety
8. Health Disparities

Specific implementation plans for each of these areas are described in the following pages.

In addition, Sinai Hospital will also work to address the following needs identified by the community:

- Workforce Development
- Transportation
- Improved Access to Care and Health Insurance
- Community Engagement and Coordination of Services

CHRONIC HEART DISEASE - IMPLEMENTATION PLAN

July 2021

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Provider adherence to latest cardiac disease management guidelines.	• CIN Heart Failure Pathway implementation (e.g., consistent use of HF order set in hospital). • Cardiologists update LBH primary and specialty care providers on best practice management for Ischemic Heart Disease, Heart Failure (i.e., via series of CME webinars). • Define, measure, and improve use of Guideline-Directed Medical Therapy for pts with Ischemic Heart Disease, Heart Failure. • Define expectations, criteria, and process to assess for and refer eligible patients to Palliative/Supportive Care. • Implement comprehensive training (clinical, medication reconciliation, use of SDOH tools, etc.) at various intervals to keep all care providers up to date on optimal approaches for care of this population. • Develop reporting to track progress on performance measures.	- Usage of HF order set. - Cardiologist-led webinars for Primary Care Providers completed; number of participants. - % patients on ACE/ARB, Beta Blocker, Statin - # of palliative/ supportive care consultations.
Reliable transition planning and communication at discharge.	• Follow-up appt with PCP set, prior to hospital discharge, for within 7 days post-discharge. • Med Rec completed, Rx filled prior to discharge. Med Rec includes assessment of meds patient already has at home. • Communicate discharge summary with primary care provider within 2 days of discharge. • Follow-up call to patient within 2 days of discharge (preferably by RN).	- % of follow-up phone calls to patients completed within 2 days of discharge. - % of discharges with clinic visits within 7 days. - Number of medication issues identified post-discharge. - Track and document standard categories of social issues identified, i.e., financial, health literacy/ numeracy issues.
Regular access to primary care and cardiologists.	• Utilize mobile clinics and/or community partnerships to improve health care access for cardiovascular patients in communities. • Outreach to established patients who haven't been seen in primary care in last year. • Monitor/improve screening for heart disease in primary care. • Explore expansion of home/remote monitoring (e.g., BP cuff, scales) • Regularly screen to identify and address depression. • Increase annual visits with cardiac specialists.	- % of Ischemic Heart Disease, Heart Failure pts with 1+ primary care/ cardiologist visits per year. - % of CVD, HF pts screened for depression and action taken if depressed.
Identify, address social barriers to better health management.	• Regularly screen this population to identify Social Determinants of Health (SDOH). • Refer patients with social needs to support programs.	% of SDOH pts with completed referrals to social support programs.

CHRONIC HEART DISEASE - IMPLEMENTATION PLAN

July 2021

Improvement Drivers	Tactics	Metrics to Assess Progress
	• Assess for, then create and implement strategies for patient health literacy/numeracy issues. • Caretaker – Ask patient if they have someone who helps them manage; invite that person to encounters. • Review and teach clinicians/community health workers best practices on how to conduct SDOH assessments and enhance patient self-reporting.	- Create strategies to target/track specific patients for more individualized/focused support.
Community/ Patient education and engagement on prevention and self-management.	• Regular educational calls, webinars, screenings for community members, focused on high-risk populations. • Create and distribute comprehensive Heart Failure patient self-management guide. • Utilize mobile clinics and/or community partnerships to improve health care access for cardiovascular patients in communities. • Identify/establish healthy, affordable recipe resources, including recipes that are culturally relevant. • Identify/establish grocery store partnerships on nutrition, medication support. • Support physical activity resources and opportunities for this population (e.g., walking groups, 'Fitness Fridays,' LBH Health and Fitness).	# of PCP pts, caretakers referred to education sessions. # of pts, caretakers participating in education programs. # of pts with improved meds adherence, diet or exercise habits, reduced tobacco usage.
Partner with American Heart Association.	• Work with American Heart Assn. to identify and implement relevant AHA resources/tools to support this population.	- AHA programs/ tools implemented.

MENTAL HEALTH AND SUBSTANCE USE DISORDER – IMPLEMENTATION PLAN

July 2021

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Develop crisis response alternatives to ED for Mental Health/SUD.	• GBRICS Program (including a centralized call center)	- GBRICS call volumes and related data.
Access to Medically Assisted Treatment (MAT) for SUD	• Sinai Hospital Addition Recovery Program (SHARP)	- # of individuals treated in SHARP program
Peers counsel patients into SUD treatment	• SBIRT Program with Peer Counselors based in Emergency Departments	- # of SBIRT/OSOP referrals - # of SBIRT/OSOP Referrals kept.
Screen/refer patients with substance abuse disorder	• Implement universal screening questionnaire in Cerner for outpatient practices.	- # of LBH internal referrals received from PCPs.
Screen/refer patients with depression/anxiety	• Implement universal screening questionnaire in Cerner for outpatient practices.	- # of LBH internal referrals received from PCPs.
Expand availability/access to non-crisis behavioral health services: e.g., walk-in, virtual behavioral health services, resources	• Reassess need for more community-based clinics in Sinai service area. • Explore embedding behavioral health at Sinai Community Care. • Explore use of Mosaic Community Services to improve rapid accessibility to mental health services. • Explore Telehealth/TelePsych as a mode of improving access.	- Readmission data - ED visit data Market analysis
Improve access, reduce barriers to residential, long-term care	• Explore local area/Pimlico real estate purchase to support residential, long-term care for Sinai community residents.	-# of Sinai patients using residential, long-term care
Stigma reduction campaign	• Explore stigma reduction campaign opportunities with City government.	

COMMUNITY HEALTH & EDUCATION – IMPLEMENTATION PLAN

July 2021

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Education on prevention of chronic disease	• Develop and implement educational initiatives in communities about preventing chronic disease (e.g., preparation of healthy foods, transportation to supporting resources/activities). • Explore referral 'bonus' for referring family and friends to education programs.	-# of patients participating in programs - # of patients demonstrating decreased risk factors and/or hospital utilization based on pre and post measurements
Targeted education/support on diabetes management	• Implement Diabetes Regional Partnership grant (with St. Agnes): zips 21229, 21223, 21216, 21215, 21207. - Improve healthy behaviors through education and support with focus on pre-diabetes • Create and distribute comprehensive Diabetes and Heart Failure patient self-management guides. • Implement regular educational calls, webinars, screenings for community members focusing on high-risk populations. • Explore/implement use of Mobile Clinic to assist with education in community.	-# of pts participating in education programs. - # of pts with improved medication adherence, diet or exercise habits, reduced tobacco usage.
Reliable transition planning and communication at discharge	• Med Rec completed, Rx filled prior to discharge. Med Rec includes assessment of meds patient already has at home. Ensure patient/family member understands medication regimen (e.g., use "teach back") • Provide needed education, resources/equipment prior to discharge (e.g., testing strips). • Follow-up call to patient within 2 days of discharge (preferably by RN). Provide education to support self-management. • Communicate discharge summary with primary care provider within 2 days of discharge. • Explore implementation of a Community Pastoral Outreach process for spiritual needs of hospitalized patients and to reach individuals who have been discharged.	- Number of medication issues identified post-discharge. - Track and document categories of social issues identified that can impact health.
Target disease processes with specific disease management education	• Education offerings that focus on living in a community of limited resources and managing disease • Education offerings that focus on resources that are available both during crisis and when patient may just need something small • Explore marketing and public relations initiatives to educate/benefit community members	-Decrease in ED visits -Increase in the use of other resources (e.g., 24 hr nurse line)

DIABETES – IMPLEMENTATION PLAN

July 2021

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Provider adherence to latest diabetes disease management guidelines.	• CIN Diabetes Pathway implementation (e.g., update and implement inpatient Diabetes order set) • Endocrinologists update LBH primary and specialty care providers on best practice management for Diabetes (i.e., via series of CME webinars). • Monitor and improve guideline-directed medical therapy for pts with Diabetes. • Assess for and refer eligible patients to Palliative/Supportive Care. • Develop reporting to track progress on performance measures.	- Consistent use of Diabetes order set - Webinars completed, number of participants - # of palliative/ supportive care consultations
Reliable transition planning and communication at discharge.	• Follow-up appt with PCP set, prior to hospital discharge, for within 7 days post-discharge. • Med Rec completed, Rx filled prior to discharge. Med Rec includes assessment of meds patient already has at home. • Communicate discharge summary with primary care provider within 2 days of discharge. • Follow-up call to patient within 2 days of discharge (preferably by RN).	- % of follow-up phone calls completed within 2 days of discharge. - % of discharges with clinic visits in 7 days. - # of meds issues identified post-discharge. - Track and document standard categories of social issues identified that can impact health outcomes, i.e., financial, health literacy/ numeracy issues.
Improve healthy food availability in priority areas	• Implement Diabetes Regional Partnership grant (with St. Agnes): zips 21229, 21223, 21216, 21215, 21207. - Improve education around diabetes prevention/management and access to healthy food	
Improve access to care. Regular primary care visits; endocrinologist visits when needed.	• Primary Care reaches out to patients with Diabetes and A1c≥7 for regular testing (3x a year). • Outreach to established patients who haven't been seen in primary care in last year. • Monitor/improve screening for pre-diabetes in primary care. • Utilize mobile clinics and/or community partnerships to improve health care access for diabetes patients in communities. • Regularly screen for and address depression. • Refer to Endocrinologist pts with Type 1 diabetes or poorly controlled Type 2 diabetes.	- % of pts with new primary care access. - % of diabetic pts w/ A1c test 3x annually. - % of Diabetic pts screened for depression and action taken if depressed.

DIABETES – IMPLEMENTATION PLAN

July 2021

Improvement Drivers	Tactics	Metrics to Assess Progress
Identify, address social barriers to better health management.	• Regularly screen this population to identify Social Determinants of Health (SDOH). • Refer patients with social needs to support programs. • Assess for, then create and implement strategies for patient health literacy/numeracy issues. • Review and teach clinicians/community health workers best practices on how to conduct SDOH assessments and enhance patient self-reporting.	- % of SDOH pts with completed referrals to social support programs. - Create strategies to target/track specific patients for more individualized/focused support.
Community/Patient education and engagement focused on prevention and mgmt.	• Regular educational calls, webinars, screenings for community members focused on high-risk populations. • Create and distribute comprehensive Diabetes patient self-management guide. • Implement Diabetes Regional Partnership grant (with St. Agnes): zips 21229, 21223, 21216, 21215, 21207. - Improve healthy behaviors with focus on pre-diabetes • Utilize mobile clinics and/or community partnerships to improve health care access for diabetic patients in communities. • Identify/establish healthy, affordable recipe resources, including recipes that are culturally relevant. • Identify/establish grocery store partnerships on nutrition, medication support. • Support physical activity resources and opportunities for this population (e.g., walking groups, 'Fitness Fridays,' LBH Health and Fitness).	- Pts participating in education programs. - Pts with improved medication adherence, diet or exercise habits, reduced tobacco usage.
Partner with American Diabetes Association.	• Work with ADA to identify and implement relevant ADA resources/tools for this population.	- ADA programs/ tools implemented.

HOUSING INSECURITY – IMPLEMENTATION PLAN

July 2021

Aims and Drivers Diagram

Improvement Drivers	Programs/Tactics	Metrics to Assess Progress
Create **health care resources/access where people live** (meet individuals where they are)	• Explore partnerships with large residences to provide periodic health education programs. • Possible pilot: "Integrated Complex Care at Home (ICCH)" for seniors in affordable housing. Potential CHRC grant opportunity (Aug/Sep 2021). Collaboration with National Well Home Network, Enterprise Community Development. • Live Near Your Work program	-# of educational program participants. -CRISP Pre/Post report assessing hospital utilization before and after program enrollment. -# of LifeBridge employees participating in Live Near Your Work program.
Improve living conditions to reduce injuries and chronic disease exacerbations (e.g., grab bars, air conditioners, address mold, lead paint, radon)	• Housing Upgrades to Benefit Seniors (HUBS) program.	-Sinai/Levindale patients accepted into HUBS program.
Reduce homelessness	• Baltimore City and 10-hospital partnership to provide housing for homeless residents.	-# of Sinai/Levindale patients benefiting from program.
Identify/help **address social determinant of health barriers that may impact housing security.**	• Identify housing and/or social issues that threaten housing security at hospital or primary care visit. • Address housing and/or social issues that threaten housing security at hospital or primary care visit. • Referrals to community housing support partners. • Keep active directory of housing counseling services.	-# of Sinai/Levindale patients with identified social issues that may impact housing security. -# of Sinai/Levindale patients referred to services that support housing security.
Address loneliness and isolation	• Partner with or create neighborhood-based programs, clubs, walks that can bring residents together to reduce isolation.	
Help enhance quality of neighborhoods (green space, crime reduction, walkability)	• Explore connecting Cylburn and Pimlico (e.g., development of a shared-use biking path) • Explore programs to "green" Lanier and Cylburn areas • Explore implementation of a Pimlico safe walkability/ wayfinding project	
Temporary respite – safe place	• Explore creation/use of housing resources for a health recovery support program	

FOOD INSECURITY – IMPLEMENTATION PLAN

July 2021

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Healthy Food Availability (quality, quantity, variety, price, location)	• Partner with community organizations working to enhance healthy food availability and/or delivery. • Explore partnership with community organizations working to establish/expand urban vegetable gardens. • Explore creation of farmers market on or near Sinai/Levindale facilities. • Diabetes Regional Partnership grant (with St. Agnes): zips 21229, 21223, 21216, 21215, 21207 to improve access to healthy food for residents at risk for diabetes.	- # of individuals served through programs. - Sales at farmers' market. - Community testimony.
Access (transportation, income, social support, time, priorities)	• Explore Hungry Harvest program implementation (farmers market; tailored food delivery (e.g., diabetic friendly)) • Explore ongoing area Food Waste Reduction initiatives for potential to redirect/repurpose food. • Explore implementation of Healthy Food as Medicine programs (e.g., providers can provide vouchers for vegetables). • Explore opportunities with Maryland Food Bank on access points and delivery. • Explore partnerships with schools on access to and distribution of healthy food. • Explore partnerships with schools to provide teaching on nutrition for health.	- # of individuals served through programs. - # of new initiatives launched. - Community testimony.
Utilization (food literacy, cooking ability, cooking facilities, time)	• Diabetes Regional Partnership Program – Food Project – meal preparation classes planned. Identify/create/adapt healthy recipe book. Consider food preferences, especially re: cultural needs (e.g., Passover). • Identify and refer patients to cooking demonstrations for healthy/affordable/culturally relevant meals. • Explore collaboration with American Heart Association, American Diabetes Association to improve access to healthy meal options. • Explore opportunities through 4H Extension offices – curriculum geared around healthy meal preparation in city.	- # of individuals served through programs. - # of cooking demonstrations held. - Community testimony
Stability (Availability and Access at all times)	• Explore sustainability of farmers markets at or near Sinai/Levindale. • Identify/develop and make accessible to LifeBridge care managers and social workers a list of active food pantries in area and their schedules. • Explore funding to provide food vouchers to community residents at Sinai/Levindale (e.g., to get meals at facility's cafeteria, etc.)	- # of multi-year food access initiatives launched/underway.

COMMUNITY SAFETY – IMPLEMENTATION PLAN

July 2021

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Improve economic opportunity for youth and adults (e.g., job opportunity, job placement)	• Work with community elementary/middle schools to assist with training in workforce expectations and career skills. • Support local training programs to develop Community Health Workers. • LBH Talent Acquisition works to hire candidates from community organizations that provide job training. • Partner with "Turnaround Tuesday" community organization • Clean and Green Initiative (training, mentorship) - partner with Park Heights Renaissance Foundation.	- # of completed trainings/ initiatives at community elementary/middle schools. - # of students participating in training. - Funding/resources expended to support CHW training. -# of individuals hired by LBH through community organizations that provide job training.
Address mental health, stress, depression/anxiety	• Connect referred community residents to case managers and victim advocates • Incorporate trauma training into mental health treatment • Partnership with the National Alliance on Mental Illness (NAMI) to focus on support for adults in our community	-% improvements in Hope & Resiliency scores
Build a strong social network; support a robust socio-cultural environment to counter community trauma and promote healing and connection	• Promote community violence prevention education & awareness • Implement youth mentoring programs. • Build/Foster neighborhood support groups.	-# of people trained/benefiting from prevention/awareness programs. -# of neighborhood support groups created/supported.
Address Adverse Childhood (abuse, neglect, household dysfunction) **& Adverse Community Experiences** (witness to violence, poverty, foster care)	• Screening in practices, ED, and various points of entry • Improve internal LBH education & awareness	-% improvements in Hope & Resiliency scores
Provide a coordinated system of response and care to suspected abuse, intrapersonal violence, and trauma	• Operate accredited advocacy centers in coordination with partners in law enforcement, social services, prosecution	Satisfaction survey results of partner agencies
Improve Safety	• Track number of people supported through Safe Streets Program. • Track number of individuals benefiting from work of Kuji Center.	-# of individuals served by/benefiting from Safe Streets and Kuji programs.

HEALTH DISPARITIES REDUCTION – IMPLEMENTATION PLAN

July 2021

Goal: Reduce disparities, especially for communities of color in targeted areas compared to white population at baseline. In addition, reduce disparities for non-English speaking populations and LGBTQ communities.

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Build trust in health care services by linking to existing community relationships	• Work with Faith-Based Organizations in prioritized communities to better provide community residents with education, information about maintaining health. • Work with Barbershops/Salons in prioritized communities to better provide community residents with education, information about maintaining health and accessing care resources.	- # of pts participating in education programs, screenings. - # of new pts referred to LBH providers.
Reduce implicit bias in provision of health care services	• Explore implementation of training for health care providers on what implicit bias is and how to recognize and address it.	- # of health care workers trained
Bring health care access closer to where people are	• Deploy Mobile Clinic to communities of opportunity. • Work with Barbershops/Salons in prioritized communities to increase access/referrals to health care services. • Explore expansion of behavioral health care access in community. • Explore partnerships with school-based health centers (e.g., on topics such as healthy behaviors, telehealth, obesity, depression).	- COVID vaccination uptake among communities of color. - # of pts referred to LBH providers.
Expand non-traditional access to primary health care	• Use Mobile Clinic to reach underserved neighborhoods. • Explore options to expand telehealth access in communities. • Explore implementation of a 24-hour nurse line.	- # of telehealth visits in priority communities. - # of calls to 24-hour nurse line.
Improve patients' skills to manage their chronic conditions	• Implement regular educational calls, webinars, community screenings to support better patient understanding and self-management of their chronic conditions. • Update and distribute comprehensive chronic condition patient self-management guides (e.g., diabetes, heart failure).	- # of ED visits of pts with diabetes, chronic heart disease. - Change in # of primary care visits among priority populations. - # of participants in educational events, screenings.
Identify and address Health Literacy, Numeracy, Cultural, Language differences	• Implement screening for patient health literacy/numeracy across the care continuum. • Develop recommendations for care team on ways to assist patients with low health literacy/numeracy. • Create/update patient education materials, instructions that take into account potential health literacy and numeracy barriers.	-# of patients screened for health literacy/numeracy. -Sharing of health literacy/ numeracy status among health care team (e.g., in electronic medical record)

HEALTH DISPARITIES REDUCTION – IMPLEMENTATION PLAN

July 2021

Goal: Reduce disparities, especially for communities of color in targeted areas compared to white population at baseline. In addition, reduce disparities for non-English speaking populations and LGBTQ communities.

Improvement Drivers	Tactics	Metrics to Assess Progress
Reduce Food Insecurity, Expand access to healthier food	• Diabetes Regional Partnership grant (with St. Agnes): zips 21229, 21223, 21216, 21215, 21207. ○ Improve access to healthier food and knowledge about diabetes prevention and management • Partner with local organizations, businesses, and/or government to explore improvements to community access to healthy, affordable food choices. • Advocate policy changes with City, State governments.	- # of healthy food initiatives/ access points established in priority communities. - # of community members served by new food initiatives.

LIFEBRIDGE HEALTH
CARE BRAVELY

FINANCIAL ASSISTANCE:

You may qualify for full or partial Financial Assistance from LifeBridge Health. To qualify for full assistance, you must show proof of income up to 300% of the federal poverty guidelines; income between 301% - 500% may qualify you for Financial Hardship Reduced Cost Care, limiting your liability to 25% of your gross annual income. Eligibility is calculated based on the number of people in the household and extends to any immediate family member living in the household. You may also qualify for presumptive eligibility if you are a beneficiary/recipient of a means-tested Federal, State or Local social service program. Financial Assistance covers uninsured and under-insured patients. Approvals are granted for twelve months. Patients are encouraged to re-apply for continued eligibility. An individual eligible for Financial Assistance cannot be charged more than the amounts generally billed (AGB) for emergency or other medically necessary care.

Where to Find Information - To obtain a Financial Assistance application and cover letter: 1) ask any member of Registration 2) visit our Customer Service Representatives in the main lobby of the Hospital 3) call Customer Service at (800) 788-6995 (Monday - Friday 7:30 AM – 5:00 PM) 4) visit www.lifebridgehealth.org

How to Apply - Complete the Financial Assistance application available online or at any registration area and return the application and required documentation to Customer Service at the Hospital or by mail to: LifeBridge Health, Inc., Financial Assistance Representative, 2401 West Belvedere Avenue, Baltimore, Maryland 21215.

Payment Plans – Interest free monthly payment plans are available without application and no service charges to those who are uninsured. Monthly payment plan amounts must not exceed 5% of an individual monthly adjusted gross income and are available with no credit screening after a quick and easy paperless enrollment. Visit www.lifebridgehealth.org or call Customer Service for more information. Governing Law: This agreement/payment plan is made pursuant and subject to Subtitle 10 of Title 12 of the Commercial Law Article of the Annotated Code of Maryland.

Maryland Medical Assistance (Medicaid) – For information, call the Department of Health and Mental Hygiene (DHMH) Recipient Relations Hotline at (800) 492-5231 or your local Department of Social Services at (800) 332-6347 or on the web at www.dhr.state.md.us. LifeBridge Health Patient Representatives can also assist you with the Maryland Medical Assistance application process.

Patient's Rights and Responsibilities – You have the right to receive information about hospital and physician charges and ask for an estimate of hospital charges before care is provided, as long as your care is not impeded. Patients admitted to the hospital will receive a Uniform Summary Statement within thirty days of discharge. You have the right to receive an itemized statement and explanation of charges. You are responsible to provide correct insurance information, pay your hospital bill timely and contact the hospital if you are unable to pay. Failure to pay or make satisfactory payment arrangements may result in your account being referred to a collection agency.

ADDITIONAL IMPORTANT INFORMATION:

Physician charges to hospital inpatients and outpatients are generally not included in the hospital bill and are billed separately.

LifeBridge Health, Inc. is permitted to bill outpatients a fee, commonly referred to as a "facility fee," for their use of hospital facilities, clinics, supplies, and equipment and non-physician services, including but not limited to the services of non-physician clinicians, in addition to physician fees billed for professional services provided in the hospital.

Patients have the right to request and receive a written estimate of the total charges for hospital nonemergency services, procedures, and supplies that reasonably are expected to be provided and billed for by LifeBridge Health, Inc.

Patients and their authorized representatives have the right to file a complaint with the Health Services Cost Review Commission (HSCRC) or jointly with the Health Education and Advocacy Unit of the Maryland Attorney General's Office (HEAU) against a hospital for an alleged violation of Maryland law regarding financial assistance and debt collection (MD Code, Health-General Article, §§19-214.1 & 19-214.2). The HEAU is located at 200 Saint Paul Place, Baltimore, Maryland 21202-2021 and can be contacted as follows: phone (410-528-1840 or 1-877-261-8807); email (heau@oag.state.md.us); fax (410-

576-6571); or website (www.marylandattorneygeneral.gov/pages/cpd/heau/default.aspx). Complaints can be sent to the HSCRC by email at hscrc.patient-complaints@maryland.gov. The HSCRC can also be contacted at 410-764-2605 or 1-888-287-3229 and found online at hscrc.maryland.gov/Pages/default.aspx.

I have been made aware of the LifeBridge Health Inc., Hospital Financial Assistance Policy: _____ (Patient's or Representative's Initials)

_____ (Date) _____ (Relationship to patient if representative initialed above)

From:	Julie A. Sessa
To:	Hilltop HCB Help Account; David Baker
Cc:	Stephanie Resetar; Sharon McClernan
Subject:	RE: Clarification Required - FY 22 Lifebridge Hospitals Narratives
Date:	Thursday, May 25, 2023 3:03:24 PM
Attachments:	image001.png image002.png Updated 052523 - Northwest FY 2022 Community Benefit Financial Report Template.xlsx Updated 052523 Carroll FY 2022 Community Benefit Financial Report Template.xlsx Updated 052523 Sinai FY 2022 Community Benefit Financial Report Template.xlsx

Report This Email

Good afternoon-

The supplemental surveys for Northwest, Carroll and Sinai Hospitals have been updated. We have also further updated the Physician Subsidy tab on the data reports to make sure the two are aligned.

Please let us know if you have any questions.

Julie

Julie Sessa
CFO
LifeBridge Health Partners
410.601.7238 office
410.469.5518 fax
jsessa@lifebridgehealth.org

LIFEBRIDGE HEALTH PARTNERS

CARE BRAVELY

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Thursday, May 18, 2023 1:17 PM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>; David Baker <Dbaker@lifebridgehealth.org>
Cc: Julie A. Sessa <JSessa@lifebridgehealth.org>; Stephanie Resetar <Sresetar@lifebridgehealth.org>; Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: RE: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Thank you very much for the responses submitted yesterday; we had a couple more questions. The following table represents the remaining items from LifeBridge Health hospitals' supplemental survey responses for which we need clarification (the discrepancies are listed in red).

Specialty Selected on Suppl. Survey	Suppl. Survey Subsidy Type	Specialty Listed on Financials	Financials Subsidy Type
Carroll Hospital Center			
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Med Surg*	Non-Resident House Staff and Hospitalists
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Critical Care*	Non-Resident House Staff and Hospitalists
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Physician Recruitment*	Physician Recruitment to Meet Community Need
Internal Medicine	Non-resident house staff and hospitalists	[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]
Northwest Hospital Center, Inc.			
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Orthopedics*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Surgery*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Neurology*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Opthalmology*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Hospitalists*	Physician Provision of Financial Assistance
Internal Medicine	Non-resident house staff and hospitalists (different on suppl. survey vs. financials)	*Internal Medicine*	Physician Provision of Financial Assistance (different on suppl. survey vs. financials)
Sinai Hospital of Baltimore, Inc.			
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Hospitalists*	Non-Resident House Staff and Hospitalists
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Rehabilitation Medicine*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Neurology*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Cardiology*	Non-Resident House Staff and Hospitalists
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Orthopedics*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Oncology*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Surgery*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Opthamalogy*	Physician Provision of Financial Assistance
[corresponding specialty	[corresponding specialty	*OB/GYN*	Physician Provision of Financial Assistance

unclear / not present]	unclear / not present]		
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*Psychiatry*	Physician Provision of Financial Assistance
[corresponding specialty unclear / not present]	[corresponding specialty unclear / not present]	*NICU Coverage*	Non-Resident House Staff and Hospitalists
Internal Medicine	Non-resident house staff and hospitalists (different on suppl. survey vs. financials)	*Internal Medicine*	Physician Provision of Financial Assistance (different on suppl. survey vs. financials)

Additionally, please find the requested links to the LifeBridge Health hospitals' supplemental surveys below, with our apologies for the delay in getting them to you.

Carroll Hospital Center:
https://umbc.co1.qualtrics.com/jfe/form/SV_9XryoB7vuQA7NJk?Q_CHL=gl&Q_DL=EMD_eafzoAPzeWz6GAQ_9XryoB7vuQA7NJk_CGC_YdyYBV7aLB1sJeP&_g_=g

Northwest Hospital Center, Inc.:
https://umbc.co1.qualtrics.com/jfe/form/SV_aYn6n81gUDDAiay?Q_CHL=gl&Q_DL=EMD_bIeuBhK4J9V38NR_aYn6n81gUDDAiay_CGC_YdyYBV7aLB1sJeP&_g_=g

Sinai Hospital of Baltimore, Inc.:
https://umbc.co1.qualtrics.com/jfe/form/SV_1TXaRWWAfSXiUCi?Q_CHL=gl&Q_DL=EMD_zAgCnplH5llBPq5_1TXaRWWAfSXiUCi_CGC_YdyYBV7aLB1sJeP&_g_=g

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From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Wednesday, April 19, 2023 8:59 AM
To: David Baker <Dbaker@lifebridgehealth.org>; Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Julie A. Sessa <JSessa@lifebridgehealth.org>; Stephanie Resetar <Sresetar@lifebridgehealth.org>; Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: RE: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Thanks for your patience. We've just sent a clarification request regarding the financials for the LifeBridge hospitals, which should give you an opportunity to clarify some of the specialties involved.

For any specialties not captured in your response to the financials clarification request, please respond to this email explaining which subsidies reported on each respective hospital's narrative response correspond to the financials entries we asked about below. For subsidies without a category that corresponds directly, please feel free to answer by saying so, and we'll update our record of your narrative responses accordingly. In the future, please use the "Other" category on the narrative survey to capture any subsidies listed on the hospital's financials not described by the other specialty options on the narrative survey.

From: David Baker <Dbaker@lifebridgehealth.org>
Sent: Monday, April 17, 2023 1:22 PM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Julie A. Sessa <JSessa@lifebridgehealth.org>; Stephanie Resetar <Sresetar@lifebridgehealth.org>; Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: Re: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Hello,
Can you please clarify how best we can provide you with this information? We're a bit stumped trying to reconcile the categories in the financial reports with those in the supplemental surveys as the available options are different for each.

For example, for Carroll Hospital, there is no option in the supplemental survey to select the financial report categories of "Med Surg," "Critical Care," and "Physician Recruitment." Should we somehow be using the supplemental survey's "Other" section for this?

Also, can you please re-send us the supplemental survey links for the 3 hospitals listed below?

Thanks,
Dave

David R. Baker, DrPH, MBA
Executive Director, Population Health

LifeBridge Health
dbaker@lifebridgehealth.org
Assistant: Cheryl Ebaugh, chebaugh@lifebridgehealth.org

LIFEBRIDGE HEALTH
CARE BRAVELY

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Monday, April 10, 2023 9:55 AM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>; David Baker <Dbaker@lifebridgehealth.org>
Cc: Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: RE: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Good morning. When reviewing the supplemental survey responses for the Lifebridge Health hospitals, we encountered several discrepancies between the physician subsidies indicated on the supplemental surveys and their respective corresponding financial reports (the physician subsidies should align between the two reports). Please clarify the following:

Carroll Hospital Center

- The following entries were only present on the financial sheet, or it was unclear which subsidy indicated on the narrative survey corresponds to the program/specialty in question:
    - *Med Surg*
    - *Critical Care*

- *Physician Recruitment* – the subsidy type indicated for this specialty is "Physician Recruitment to Meet Community Need," which does not match the subsidy type indicated for any of the specialties on the supplemental survey response.

- The specialty *Internal Medicine* was only selected on the supplemental survey response, or it was unclear which subsidy indicated on the financial sheet corresponds to this specialty.

Northwest Hospital Center, Inc.

- The item *Physician Charity Care* was only indicated on the financial sheet, or it was unclear which subsidy selected on the supplemental survey corresponds to this specialty.

Sinai Hospital of Baltimore, Inc.

- The item *Physician Charity Care* was only indicated on the financial sheet, or it was unclear which subsidy selected on the supplemental survey corresponds to this specialty.

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Friday, March 24, 2023 11:08 AM
To: David Baker <Dbaker@lifebridgehealth.org>; Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: RE: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Thank you for providing additional clarification. We will review your message along with the supplemental surveys that were submitted yesterday and will reach back out if we have any further questions.

From: David Baker <Dbaker@lifebridgehealth.org>
Sent: Friday, March 24, 2023 9:37 AM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: Re: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Please see our additional clarifications below.
Best regards,
Dave

David R. Baker, DrPH, MBA
Executive Director, Population Health

LifeBridge Health
dbaker@lifebridgehealth.org
Assistant: Cheryl Ebaugh, chebaugh@lifebridgehealth.org

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>

Sent: Thursday, March 23, 2023 12:56 PM
To: David Baker <Dbaker@lifebridgehealth.org>; Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: RE: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Thank you for your response. Could you please provide further clarification on the following items?

- Regarding your clarification of the response given for Question 61, please confirm whether your intended meaning was that each of the following hospitals reported rate support for all of the rate support categories selected.
    - Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore
    - Northwest Hospital Center
    - Sinai Hospital of Baltimore

  Clarification for Question 61:
  If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs below or indicate if there were none.

    - Regional Partnership Catalyst Grant Program
        - Diabetes: Sinai Hospital only
        - Behavioral Health: Sinai, Carroll, and Northwest Hospitals
    - The Medicare Advantage Partnership Grant Program
    - The COVID-19 Long-Term Care Partnership Grant
        - Sinai Hospital only
    - The COVID-19 Community Vaccination Program
        - Sinai Hospital only
    - The Population Health Workforce Support for Disadvantaged Areas Program
    - Other (describe)

  Clarification for Question 44 for Levindale:

- To clarify the responses to Question 44 on the narrative for Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, for each of the following positions, please indicate whether the intended response was (a) “N/A – Person or Organization was not involved” or (b) “N/A – Position or Department does not exist.”

    - CB/ Community Health/Population Health Director (facility level)

        i. N/A – Person or Organization was not involved
        ii. N/A – Position or Department does not exist
    - Population Health Staff (facility level)
        i. N/A – Person or Organization was not involved
        ii. N/A – Position or Department does not exist
    - Community Benefit staff (facility level)
        i. N/A – Person or Organization was not involved
        ii. N/A – Position or Department does not exist
    - Community Benefit staff (system level)
        i. N/A – Person or Organization was not involved
        ii. N/A – Position or Department does not exist
    - Hospital Advisory Board
        i. N/A – Person or Organization was not involved
        ii. N/A – Position or Department does not exist

Additionally, we look forward to receiving your responses to the supplemental surveys.

From: David Baker <Dbaker@lifebridgehealth.org>
Sent: Thursday, March 23, 2023 11:46 AM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: Fw: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Hello,
Following up on your request, please see below our responses to follow-up questions in **blue** or **highlighted in yellow.** I will submit the supplemental reports for the facilities by the end of the day today.

Thank you,
Dave

David R. Baker, DrPH, MBA
Executive Director, Population Health

LifeBridge Health
dbaker@lifebridgehealth.org
Assistant: Cheryl Ebaugh, chebaugh@lifebridgehealth.org

LIFEBRIDGE HEALTH
CARE BRAVELY

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Tuesday, March 7, 2023 3:56 PM
To: Sharon McClernan <smcclernan@lifebridgehealth.org>; Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>

Subject: Clarification Required - FY 22 Lifebridge Hospitals Narratives

Thank you for submitting the FY 2022 Hospital Community Benefit Narrative reports for Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore, Northwest Hospital Center, Sinai Hospital of Baltimore, and Grace Medical Center. In reviewing the narrative, we encountered several items that require clarification:

All Lifebridge Hospitals Except for Grace Medical Center

- Question 60 was left blank. Please describe your hospital's efforts to track and reduce health disparities in the community it serves.

  Our hospitals screen inpatients for social determinant of health (SDOH) needs and to assess health disparities. Our system-wide Population Health Department uses community-level mapping tools (e.g., the Area Deprivation Index) as well as CRISP and hospital-level data to identify specific neigborhoods facing inequities to target its outreach and support. LifeBridge proactively brings health screening, chronic disease education, health insurance sign-up, and referrals to health care providers to underserved communities surrounding our hospitals through community-based health events and mobile clinic outreach to reduce disparities. LifeBridge organizes and supports partnerships with community organizations (e.g., senior centers, public libraries, faith-based organizations, healthy food delivery programs, barber shops/salons, senior buildings, local Ys) to deliver these services and improve our ability to enhance community members' access to preventive screening, health care, and health-supporting resources.

- Question 61 was left blank. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs below or indicate if there were none.
  - Regional Partnership Catalyst Grant Program
  - The Medicare Advantage Partnership Grant Program
  - The COVID-19 Long-Term Care Partnership Grant
  - The COVID-19 Community Vaccination Program
  - The Population Health Workforce Support for Disadvantaged Areas Program
  - Other (describe)

Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore

- For Question 44 on pages 6-8 and Question 46 on pages 8-10 both options "N/A – Person or Organization was not involved" and "N/A – Position or Department does not exist" were selected for the internal partner categories listed below. Please clarify which option you

meant to select.

- CB/ Community Health/Population Health Director (facility level)
- Population Health Staff (facility level)
- Community Benefit staff (facility level)
- Community Benefit staff (system level)
- Hospital Advisory Board

- For Question 48 on pages 10-12, the level of community engagement was selected for four stakeholder categories, but none of the recommended practices were selected. Please clarify which recommended practices should be selected for the following stakeholder groups:
  - Local Health Improvement Coalition

    Baltimore City Health Department helped collect and analyze data.

  - Maryland Department of Health

    Maryland Department of Health helped collect and analyze data.

  - School - K-12

    Pimlico Elementary and Middle Schools helped document and communicate results.

  - Other

    American Heart Association, American Diabetes Association helped implement improvement plans.

- Your community benefit narrative report appears to have experienced an error by not displaying the follow up questions regarding physician subsidies: questions 79 through 81 on page 16 of the attached. Please use this link to complete a supplemental report with only these questions: https://umbc.co1.qualtrics.com/jfe/form/SV_9XryoB7vuQA7NJk?Q_CHL=gl&Q_DL=EMD_Q5msih4UfQ4Z0IO_9XryoB7vuQA7NJk_MLRP_3dtAvJIlbgV2gFE&_g_=g

Northwest Hospital Center

- For Question 48 on page 11 of the attached, the level of community engagement was selected for Maryland Department of Health and Faith-Based Organizations but none of the recommended practices were selected. Please clarify which recommended practices listed below should be selected for these two stakeholder groups:
  - Identify & engage stakeholders -- Faith-Based Organizations
  - Define the community to be assessed
  - Collect and analyze the data -- Maryland Dept of Health

Select priority community health issues
    - Document and communicate results -- Faith-Based Organizations
    - Plan implementation strategies
    - Implement improvement plans
    - Evaluate progress
- The response to Question 73 on page 15 is unclear. Please provide more detail on how community benefit planning and investments were included in your hospital's internal strategic plan.

  The top community needs identified through our hospital's CHNA were used by our hospital senior leaders to prioritize them within the year's strategic planning.

- Your community benefit narrative report appears to have experienced an error by not displaying the follow up questions regarding physician subsidies: questions 79 through 81 on page 16 of the attached. Please use this link to complete a supplemental report with only these questions: https://umbc.co1.qualtrics.com/jfe/form/SV_aYn6n81gUDDAiay?Q_CHL=gl&Q_DL=EbfMGBSrXW166mt_aYn6n81gUDDAiay_MLRP_0SM4usoj365lEGy

Sinai Hospital of Baltimore

- Question 6 on page 1 was left blank. Please describe the community health statistics that your hospital uses in its community benefit efforts.

  Sinai Hospital uses:

  - Data powered by the Healthy Communities Institute and can be found at https://healthycarroll.org/lifebridge/

  - The Robert Wood Johnson Foundation's County Health Rankings and Roadmaps (https://www.countyhealthrankings.org/)

  - The Baltimore Neighborhood Indicators Alliance (https://bniajfi.org/)

  - Maryland Department of Health's Vital Statistics and Reports (https://health.maryland.gov/vsa/Pages/reports.aspx)

  - The Robert Wood Johnson Foundation's City Health Dashboard (https://www.cityhealthdashboard.com/md/baltimore/city-overview?metric=37&dataRange=city)

  - The University of Wisconsin School of Medicine and Public Health's Neighborhood Atlas/Area Deprivation Index Map (https://www.neighborhoodatlas.medicine.wisc.edu/)

- For Question 48 on pages 11-12 of the attached, the level of community engagement was selected for the following stakeholder categories: Local Health Improvement Coalition,

Maryland Department of Health, Schools-K-12 and Other. However, none of the recommended practices were selected. Please clarify which recommended practices listed below should be selected for these four stakeholder groups:

- Identify & engage stakeholders
- Define the community to be assessed
- Collect and analyze the data -- Maryland Dept of Health
- Select priority community health issues -- LHIC
- Document and communicate results -- Schools K-12
- Plan implementation strategies -- Other (American Heart Association, American Diabetes Association)
- Implement improvement plans
- Evaluate progress

- The response to Question 73 on page 15 is unclear. Please provide more detail on how community benefit planning and investments were included in your hospital's internal strategic plan.

  The top community needs identified through our hospital's CHNA were used by our hospital senior leaders to prioritize them within the year's strategic planning.

- Your community benefit narrative report appears to have experienced an error by not displaying the follow up questions regarding physician subsidies: questions 79 through 81 on page 16 of the attached. Please use this link to complete a supplemental report with only these questions: https://umbc.co1.qualtrics.com/jfe/form/SV_1TXaRWWAfSXiUCi?Q_CHL=gl&Q_DL=GKJnNyYJFz9UjKz_1TXaRWWAfSXiUCi_MLRP_0SM4usoj365lEGy

Grace Medical Center

- Your community benefit narrative report appears to have experienced an error by not displaying the follow up questions regarding physician subsidies: questions 79 through 81 on page 14 of the attached. Please use this link to complete a supplemental report with only these questions: https://umbc.co1.qualtrics.com/jfe/form/SV_cMZBRrFewsWFmNU?Q_CHL=gl&Q_DL=YAKyf0FyUpkqnKy_cMZBRrFewsWFmNU_MLRP_3dtAvJIlbgV2gFE

Please provide your clarifying answers as a response to this message.

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Q77. Section IV - Physician Gaps & Subsidies

Q78. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- ○ No
- ◉ Yes

Q79. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	○	◉	
Anesthesiology	○	◉	
Cardiology	◉	○	Non-resident house staff and hospitalists
Dermatology	○	◉	
Emergency Medicine	◉	○	Coverage of emergency department call
Endocrinology, Diabetes & Metabolism	◉	○	Non-resident house staff and hospitalists
Family Practice/General Practice	○	◉	
Geriatrics	○	◉	
Internal Medicine	◉	○	Non-resident house staff and hospitalists
Medical Genetics	○	◉	
Neurological Surgery	○	◉	
Neurology	○	◉	
Obstetrics & Gynecology	○	◉	
Oncology-Cancer	○	◉	
Ophthalmology	○	◉	
Orthopedics	○	◉	
Otolaryngology	○	◉	
Pathology	○	◉	
Pediatrics	◉	○	Non-resident house staff and hospitalists
Physical Medicine & Rehabilitation	○	◉	
Plastic Surgery	○	◉	
Preventive Medicine	○	◉	
Psychiatry	○	◉	
Radiology	◉	○	Non-resident house staff and hospitalists
Surgery	○	◉	

Urology	○	◉	
Other, (Describe)	○	◉	

Q80. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

Cardiology – Non-resident house staff and hospitalists: LifeBridge determined that this service provides treatment and/or promotes health and healing as a response to needs expressed by our community for better access to health care, as identified through the hospital's Community Health Needs Assessment. Without this subsidy, residents in the community would not be able to access needed care. Emergency Medicine – Coverage of emergency department call: LifeBridge determined that this service provides treatment and/or promotes health and healing as a response to needs expressed by our community for better access to health care, as identified through the hospital's Community Health Needs Assessment. Without this subsidy, residents in the community would not be able to access needed care. Endocrinology, Diabetes & Metabolism – Non-resident house staff and hospitalists: LifeBridge determined that this service provides treatment and/or promotes health and healing as a response to needs expressed by our community for better access to health care, as identified through the hospital's Community Health Needs Assessment. Without this subsidy, residents in the community would not be able to access needed care. Internal Medicine – Non-resident house staff and hospitalists: LifeBridge determined that this service provides treatment and/or promotes health and healing as a response to needs expressed by our community for better access to health care, as identified through the hospital's Community Health Needs Assessment. Without this subsidy, residents in the community would not be able to access needed care. Pediatrics – Non-resident house staff and hospitalists: LifeBridge determined that this service provides treatment and/or promotes health and healing as a response to needs expressed by our community for better access to health care, as identified through the hospital's Community Health Needs Assessment. Without this subsidy, residents in the community would not be able to access needed care. Radiology – Non-resident house staff and hospitalists: LifeBridge determined that this service provides treatment and/or promotes health and healing as a response to needs expressed by our community for better access to health care, as identified through the hospital's Community Health Needs Assessment. Without this subsidy, residents in the community would not be able to access needed care.

Q81. Please attach any files containing further information and data justifying physician subsidies at your hospital.

Q91. Summary & Report Submission

Q92.

Attention Hospital Staff! IMPORTANT!

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

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

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

Location Data

Location: (37.751, -97.822)

Source: GeoIP Estimation

Q77. Section IV - Physician Gaps & Subsidies

Q78. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- ○ No
- ◉ Yes

Q79. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	○	◉	
Anesthesiology	○	◉	
Cardiology	◉	○	Non-resident house staff and hospitalists
Dermatology	○	◉	
Emergency Medicine	◉	○	Coverage of emergency department call
Endocrinology, Diabetes & Metabolism	◉	○	Non-resident house staff and hospitalists
Family Practice/General Practice	○	◉	
Geriatrics	○	◉	
Internal Medicine	◉	○	Non-resident house staff and hospitalists
Medical Genetics	○	◉	
Neurological Surgery	○	◉	
Neurology	◉	○	Physician provision of financial assistance
Obstetrics & Gynecology	◉	○	Physician provision of financial assistance
Oncology-Cancer	◉	○	Physician provision of financial assistance
Ophthalmology	◉	○	Physician provision of financial assistance
Orthopedics	◉	○	Physician provision of financial assistance
Otolaryngology	○	◉	
Pathology	○	◉	
Pediatrics	◉	○	Non-resident house staff and hospitalists
Physical Medicine & Rehabilitation	◉	○	Physician provision of financial assistance
Plastic Surgery	○	◉	
Preventive Medicine	○	◉	
Psychiatry	◉	○	Physician provision of financial assistance
Radiology	◉	○	Non-resident house staff and hospitalists
Surgery	◉	○	Physician provision of financial assistance

Urology	○	◉	
Other, (Describe) NICU/PICU	◉	○	Physician provision of financial assistance

Q80. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

Cardiology – Non-resident house staff and hospitalists: LifeBridge determined that this service provides treatment and/or promotes health and healing as a response to needs expressed by our community for better access to health care, as identified through the hospital's Community Health Needs Assessment. Without this subsidy, residents in the community would not be able to access needed care. Emergency Medicine – Coverage of emergency department call: LifeBridge determined that this service provides treatment and/or promotes health and healing as a response to needs expressed by our community for better access to health care, as identified through the hospital's Community Health Needs Assessment. Without this subsidy, residents in the community would not be able to access needed care. Endocrinology, Diabetes & Metabolism – Non-resident house staff and hospitalists: LifeBridge determined that this service provides treatment and/or promotes health and healing as a response to needs expressed by our community for better access to health care, as identified through the hospital's Community Health Needs Assessment. Without this subsidy, residents in the community would not be able to access needed care. Internal Medicine – Non-resident house staff and hospitalists: LifeBridge determined that this service provides treatment and/or promotes health and healing as a response to needs expressed by our community for better access to health care, as identified through the hospital's Community Health Needs Assessment. Without this subsidy, residents in the community would not be able to access needed care. Pediatrics – Non-resident house staff and hospitalists: LifeBridge determined that this service provides treatment and/or promotes health and healing as a response to needs expressed by our community for better access to health care, as identified through the hospital's Community Health Needs Assessment. Without this subsidy, residents in the community would not be able to access needed care. Radiology – Non-resident house staff and hospitalists: LifeBridge determined that this service provides treatment and/or promotes health and healing as a response to needs expressed by our community for better access to health care, as identified through the hospital's Community Health Needs Assessment. Without this subsidy, residents in the community would not be able to access needed care.

Q81. Please attach any files containing further information and data justifying physician subsidies at your hospital.

Q91. Summary & Report Submission

Q92.

Attention Hospital Staff! IMPORTANT!

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

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

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

Location Data

Location: (37.751, -97.822)

Source: GeoIP Estimation