FY2017

SINAI HOSPITAL

[A LIFEBRIDGE HEALTH HOSPITAL]
FY 2017 COMMUNITY BENEFIT NARRATIVE REPORT

Sinai Hospital of Baltimore, Inc.

FY 2017 Community Benefit Narrative Report

Founded in 1866 as the Hebrew Hospital and Asylum, Sinai has evolved into a Jewish -sponsored health care organization providing care for all people. Today, Sinai is a 480-bed community teaching hospital that provides patient care in a variety of settings including inpatient, surgical, outpatient, as well as a trauma unit (Level II designation), a high risk Neonatal Unit, a state-of-the-art Emergency Department and responsive community outreach and community health improvement programs. Sinai has 16 Centers of Excellence, including the Lapidus Cancer Institute, Berman Brain & Spine Institute, and Samuelson Children's Hospital.

Sinai 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 others each year from the Johns Hopkins University, University of Maryland, and teaching institutions in the Baltimore/ Washington/ Southern Pennsylvania region.

Sinai is a member of LifeBridge Health – a Baltimore-based health system composed of Sinai Hospital, Northwest Hospital, Carroll Hospital, and Levindale – and is a constituent agency of The ASSOCIATED: Jewish Community Federation of Baltimore.

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:[1]	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:	Percentage of the Hospital's patients who are Medicare beneficiaries
480	Total: 18,750	21215 21207 21208 21209 21117 21216 21133 21244 21136	-University of Maryland Medical Center -Mercy Medical Center -Johns Hopkins Medical Center -St. Agnes Hospital -Bon Secours -MedStar Union Memorial -University of Maryland Midtown -Northwest Hospital -Greater Baltimore Medical Center -University of Maryland Rehab and Orthopedic -University of Maryland St. Joseph's -Levindale Hebrew Geriatric Center and Hospital	Total: 79 admissions or 0.4% of total admissions PSA: 42 admissions or 0.4% of PSA admissions	Total: 5,518 admissions or 29.4% of total admissions PSA: 3,600 admissions or 31.2% of PSA admissions	Total: 7,957 admissions or 42.4% of total admissions PSA: 5,316 admissions or 46.1% of PSA admissions

1. Community Benefit Service Area Description: Sinai Hospital of Baltimore (SHOB) 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 (BNIA) as Southern Park Heights (SPH) and Pimlico/Arlington/Hilltop (PAH). 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 and 21216. Portions of those zip codes include the following communities: Pimlico/Arlington/Hilltop; Southern Park Heights; Howard Park/West Arlington; Dorchester/Ashburton; Greater Mondawmin; and Penn North/Reservoir Hill. Together, these zip codes and community designations define the hospital's Community Benefit Service Area (CBSA). 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.

[1] Health Services Cost Review Commission (HSCRC), FY2015

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 which 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.

Table II

Community Benefit Service Area (CBSA) Basic Demographics (2017 Estimates)*		
Community Benefit Service Area (CBSA) Zip Code	21215, 21207, 21208, 21209, 21117, 21216	
Median Household Income within the CBSA	21215: 34885	Avg within CBSA: 56047
Percentage of households with incomes below the federal poverty guidelines within the CBSA	21215: 25.3	Avg within CBSA: 14.85
For the counties within the CBSA, what is the percentage of uninsured for each county?	Baltimore City: 10.3	Baltimore County: 8.1
Percentage of Medicaid recipients by County within the CBSA	3,100 admissions or 31.6% of PSA admissions	
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).	Baltimore City: Females: 76.0; Males: 68.2	Baltimore County: Females: 81.7; Males: 77.1
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Baltimore City: Females: 929.4; Males: 1443.3	Baltimore County: Females: 632.4; Males: 893.6
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources)	See chart below for chart describing Sinai Hospital's Catchment Area as described by Baltimore City Health Department in 2017.	
Available detail on race, ethnicity, and language within CBSA.		

CHNA Metric Estimates for Baltimore City and Catchment Area			
Metric [1]	***Year(s)***	***Baltimore City***	***Catchment Area****
Demographics and social determinants of health			
Percentage of adults 18 years and older without health insurance	2011-2015	11.7%	12.7%
Percentage of children under 18 years without health insurance	2011-2015	4.4%	4.6%
Unemployment rate	2011-2015	13.1%	15.3%
Family poverty rate	2011-2015	28.8%	27.5%
Percentage of 8th graders meeting or exceeding at reading [3]	2013-2014	54.9%	54-85% (range)
Percentage of land area covered by food desert	2015	12.5%	12.3%
Liquor store density per 10,000 residents	2015	3.8	2.1
Homicide rate per 10,000 residents (based on location of event)	2011-2015	3.9	3.7
Health outcomes			
Life expectancy at birth, in years	2011-2015	73.6	75.6
Age-adjusted mortality rate per 10,000 - All causes of death	2011-2015	99.5	87.2
Age-adjusted mortality rate per 10,000 - Cardiovascular disease	2011-2015	24.4	20.9
Age-adjusted mortality rate per 10,000 - Cancer, all forms	2011-2015	21.2	17.5
Age-adjusted mortality rate per 10,000 - Drug- and/or alcohol-induced	2011-2015	4.4	3.5
Age-adjusted mortality rate per 10,000 - Homicide (based on victim's residence)	2011-2015	3.3	3.9
Age-adjusted mortality rate per 10,000 - Diabetes	2011-2015	3.0	2.5
Age-adjusted mortality rate per 10,000 - HIV/AIDS	2011-2015	1.8	1.5
Teen birth rate per 1,000 females 15 to 19 years	2010-2014	42.3	37.6
Infant mortality rate per 1,000 live births (IMR)	2011-2015	10.4	10.0
Additional metrics			
Percentage of children living in single-parent households	2011-2015	64.8%	55.0%
Hardship Index [4]	2011-2015	51	23-73 (range)
Percentage of adults 25 years and older with a high school diploma/equivalent or less	2011-2015	47.2%	49.9%
Percentage of adults 25 years and older with a college degree	2011-2015	28.7%	25.2%
Carryout restaurant density per 10,000 residents	2016	11.4	9.4
Corner store density per 10,000 residents	2016	14.1	10.4
Non-fatal shooting rate per year per 10,000 residents (based on location of event)	2011-2015	6.9	5.7
Youth homicide rate per year per 100,000 youth under 25 years (based on residence of victim)	2010-2014	31.3	32.5
Birth rate per 1,000 residents	2011-2015	14.3	12.6
Percentage of women receiving prenatal care in the first	2010-2014	54.7%	54.7%

trimester			
Percentage of women who reported smoking while pregnant	2010-2014	10.7%	7.8%
Percentage of live births occurring preterm	2010-2014	12.4%	10.8%
Percentage of births classified as low birth weight	2010-2014	11.5%	10.3%

*Catchment area consists of the neighborhoods of Cross-Country/Cheswolde, Dorchester/Ashburton, Glen-Fallstaff, Howard Park/West Arlington, Mt. Washington/Coldspring, Pimlico/Arlington/Hilltop, and Southern Park Heights.

[1] All data are calculated from the Baltimore City Health Department's (BCHD's) 2017 Neighborhood Health Profiles (NHPs) unless otherwise noted. Please see the 2017 NHPs for a list of data sources, including year(s), and methodology. https://goo.gl/GCEYKF

[2] BCHD analysis of data provided by the Baltimore City Department of Planning.

[3] Due to its agreement with the Baltimore City Public Schools, the Baltimore Neighborhood Indicators Alliance was unable to calculate education metrics for CHNA areas. BCHD does not have access to these education data.

[4] The Hardship Index is a measure of comparison, weighing relative hardship of one CSA against another or against the City as a whole. The calculation methodology reflects this relativity by standardizing six socioeconomic components of Baltimore's 55 CSAs to a scale of 1 to 100, then averaging the component scores to provide a final index score. Aggregating CSAs into a single CHNA area and calculating a score using that discrete area can impact the scores of the remaining individual CSAs, thus changing the apparent relative hardship of the CHNA area. Therefore, a range of scores within a CHNA area is provided. In this way, we hope to show the range of socioeconomic conditions within the CHNA area.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

   __X_Yes Provide date here. 06/30 /2016 submitted to IRS
   ____No

   If you answered yes to this question, provide a link to the document here.
http://www.lifebridgehealth.org/uploads/public/documents/community%20health/2015/2015CHNAFINAL.pdf

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

   _x_Yes Enter date approved by governing body here: 11/10/16
   ___No

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

http://www.lifebridgehealth.org/uploads/public/documents/community%20health/2015/2015CHNAFINAL.pdf

III. COMMUNITY BENEFIT ADMINISTRATION

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

   _X__Yes
   ____No

Sinai Hospital's Community Benefit activities fit into the hospital strategic plan as well as the hospital Strategic Transformation Plan. In 2016, LifeBridge Health added a new pillar in its updated strategic plan, focusing on managing the total cost of care. Strategies within this pillar include "prioritizing population health and the continuum of care." Sinai Hospital's community benefit activities are administered by departments and staff within the Department of Population Health, and are considered crucial to this pillar of the hospital strategic plan. In the 2016 Strategic Transformation Plan, Sinai Hospital commits to a series of strategies to support alignment with the Maryland Global Budget. One strategy is "Ensuring continued and expanded community outreach, education, and programming." This strategy includes the hospital's Community Benefit initiatives, as well as those additional initiatives reported in this Community Benefit Report.

Please see below for relevant excerpts from these plans:

LifeBridge Health Strategic Plan – Pillar on Total Cost of Care

"Prioritize population health and the continuum of care
- Provide care to patients in convenient and cost efficient locations
- Strengthen integration across continuum
- Expand standardized clinical pathways
- Expanded post-acute offerings
- Continue to find new ways to address the needs of underserved patients"

LifeBridge Health Strategic Transformation Plan – strategy for community programming

"Ensuring continued and expanded community outreach, education, and programming:
As part of our overall population health strategy we will be expanding and integrating our existing community outreach programs and partnering with other entities to provide new services for our community.
Our outreach programs in the **M. Peter Moser Community Initiatives** Department are designed to attend to not only the health but also the social well-being of the people in our surrounding neighborhoods. The Diabetes Medical Home Extender program focuses on helping people with poorly controlled diabetes who live in the communities surrounding the hospital. Clients, who are identified during their inpatient stay, are then provided nursing and community health worker services in their homes post-hospitalization to connect with support services and receive education. **Perinatal Mood Disorders** identifies women at-risk for perinatal depression or anxiety at delivery and provides follow-up counseling and referrals to educate and support women during the perinatal period in order to improve maternal mental health, thereby enhancing maternal infant bonding. Services include: perinatal depression risk assessment, psychosocial assessments, supportive counseling, services coordination, and mental health and community referrals. **The Kujichagulia Center** is a youth development and violence prevention intervention with the goal to reduce street violence, create a venue for youth to escape the cycle of violence, and increase youth employment. Services include: youth development and violence prevention services to residents of 21215, mentoring services for middle schools students; facilitation of a **YouthWorks Summer jobs** program for students 14 to 21 years old; violence intervention services for local youth 16 to 25 years old who have been admitted to the Trauma Unit after suffering injuries due to street violence. **HIV Support Services** provides counseling, information & referrals to HIV+ men, women, children and youth receiving care at Sinai Hospital. Referrals of newly identified HIV+ individuals or patients who have been lost to care come from providers in the hospital's infectious disease specialty clinic or the OB/GYN service. Staff provide psychosocial assessment, supportive counseling, services coordination and home visiting. **Perinatal Home Visiting** is a partner with the Baltimore City Health Department's **B'more for Healthy Babies** infant mortality prevention initiative. Its primary objective is to prevent the abuse and neglect of children through intensive home visiting through in-home education, using an evidence-based program model and curriculum from **Healthy Families America**, on pregnancy, infant development and parenting. The **Family Violence Program** is a hospital-wide domestic violence identification and follow-up and counseling program with the goal

of increasing the knowledge, safety and healing experiences for victims of intimate partner violence. All patients ages 14 and over are screened for intimate partner violence upon entry into the hospital. Those acknowledging violence are referred to the program. Staff provide crisis intervention, lethality assessment, safety counseling, psychotherapy and referral to shelter, and legal assistance.
Our **Community Improvement Department** will provide expanded health education and screenings in addition to administering the **Changing Hearts Program**. This program is designed to help individuals understand their identified risk(s) for heart disease, demonstrate how to minimize/modify those risk factors, and provide education on how to maintain a healthy lifestyle to prevent heart disease. The **Changing Hearts Program** includes: heart health risk assessment, screenings, body composition analysis, health education counseling with a registered nurse, educational materials, follow-up calls and/or home visits with a CHW focusing on an individualized plan developed with participant, lifestyle classes to help maintain a long-term change, and web-based links to resources to improve cardiac health. Sinai Hospital and **Comprehensive Housing Assistance Inc.** (CHAI) have been awarded a grant from Civic Works to be a service site for the **Housing Upgrades to Benefit Seniors (HUBS)** initiative to serve older residents in the communities of northwest Baltimore City. In addition CHAI is working collaboratively with Sinai Hospital to house a **Sinai NP in CHAI's Independent Living facility** across the street from Sinai, to help reduce PAU's.
Finally, we are embarking on a new partnership and piloting the **Maryland Faith Community Health Network (MFCHN)** with **Maryland Health Care For All** and numerous faith communities. MFCHN is designed to promote health, maximize enrollment in health care coverage and support Maryland's health care system transformation under the waiver. Through our efforts, we aim to serve hundreds of residents in the LifeBridge Health communities through their congregations and health care providers. Timely evaluation of our efforts will contribute to the professional knowledge base regarding potential impact of faith/health partnerships on promoting access to timely, primary care. This model is characterized by deep faith leader engagement and agreements between individual congregations and hospitals that commit to working with appointed congregation-based liaisons to support congregant network members and their caregiver(s) before, during and after a hospital stay. This project has garnered the attention of the **American Hospital Association's Health Research and Educational Trust and the Robert Wood Johnson Foundation through their Culture of Health Learning Collaborative**. LifeBridge Health has been identified as an industry leader that is taking an innovative approach to collaboration. LifeBridge Health will be participate in site visits and collaborative webinars to foster learning, networking and sharing of expertise and resources among other industry leaders participating in the collaborative. These learnings will inform case studies we will embed in a Roadmap Guide that provides resources for community partnerships. The Roadmap Guide will be a publicly available tool to help hospitals and community partners learn how to develop and implement effective partnerships."

2. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and provide additional information if necessary):

ii. Senior Leadership
1. _X_ CEO – Dr. Jonathan Ringo, President
2. _X_ CFO - David Krajewski
3. _X_ Other Martha Nathanson, Vice President of Government Affairs

Describe the role of Senior Leadership.
These members of the senior leadership team provide general oversight and direction to the Population Health Department in identifying the interventions that are specifically helpful for the Sinai CBSA, including community benefit output and other Population Health-related initiatives.

iii. Clinical Leadership

1. _X_ Physician – Dr. Michelle Gourdine, Medical Director, Sinai Community Care
2. _X_ Nurse – Diane Johnson, RN, VP of Nursing
3. ___ Social Worker
4. ___ Other (Community Health Nurse Educators, Community Health Workers)

These members of the clinical leadership team provide more directed oversight and direction to the Population Health Department in identifying the interventions that are specifically helpful for the Sinai CBSA, including community benefit output and other Population Health-related initiatives.

iv. Population Health Leadership and Staff

1. __X__ Darleen Won, Assistant Vice President of Population Health

Describe the role of population health leaders and staff in the community benefit process.
Darleen leads the Population Health department in creating, managing, tracking and reporting on all initiatives in the outpatient and community setting that are meant to address access to care, chronic and primary care, and social determinants of health.

3. Community Benefit Operations

1. ___Individual (please specify FTE)
2. ___Committee (please list members)
3. _X__Department (Lane Levine, Population Health Project Manager, Livia Kessler, Director of Business Intelligence, Population Health; Sue Westgate, Director of Community Care Coordination; Jacquetta Robinson, Health Ambassador; Reverend Domanic Smith, Pastoral Outreach Coordinator)
4. **Community Mission Committee:** LifeBridge Health, Inc., the parent corporation that includes Sinai Hospital, has a board committee for the oversight and guidance for all community services and programming. Community Mission Committee members include Sinai, Northwest, and Levindale Board Members and Executives, CEO of LifeBridge Health, Inc., and Vice Presidents. The Community Mission Committee is responsible for reviewing, reporting, and advising community benefit activities. This committee reviews specific programs on a regular basis, making recommendations to the program managers for improvements or new programming approaches. This is the committee that reviews the Community Benefit Report each year and makes recommendations for approval of the report at the full board level.
5. **Direct Service Staff:** In the department of Population Health, The M. Peter Moser Community Initiatives Department employs a staff of 36 full time equivalent community health workers, social workers, and counselors to implement and deliver community benefit programming. The core function of Community Initiatives is to provide services to benefit the community at no charge.
6. **Community Health Improvement**: LifeBridge Health Inc. created the Office of Community Health Improvement to implement community health improvement projects, as well as provide community health education. Although the department provides services to individuals living in or around Northwest, Sinai and Levindale Hospitals' surrounding communities, the department is physically located at Northwest Hospital.
7. Other clinical departments also provide community benefit programming in addition to regular clinical functioning.

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

Spreadsheet ____ Yes _X___ No
Narrative ____ Yes _X__ No

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

Spreadsheet __X__ Yes ____ No

Narrative __X__ Yes ____ No

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

__x__Other hospital organizations
__x__ Local Health Department
__x__ Local health improvement coalitions (LHICs)
__x__ Schools
__x__ Behavioral health organizations
__x__ Faith based community organizations
__x__ Social service organizations

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities with each partner (please add as many rows to the table as necessary to be complete)

Organization	**Name of Key Collaborator**	**Title**	**Collaboration Description**
Baltimore City Health Department	Darcy Phelan-Emrick, DrPH, MHS; , Shannon Mace Heller, JD, MPH; Sonia Sarkar	Chief of Epidemiology Services; Director of the Office of Policy and Planning; Chief Policy and Engagement Officer	Discussed recent health assessment updates to the 2011 citywide health assessment that resulted in the City's Healthy Baltimore 2015 report and Neighborhood Health Profiles. Participated in Health Department's LHIC.
Baltimore County Health Department	Laura Culbertson, RN, MSN; Della J. Leister, RN	Public Health Nurse Administrator; Baltimore County Deputy Health Officer	Discussion focused on the County's recently completed needs evaluation, its availability to the public and potential programming that might be developed as a result of its findings. Participate in County LHIC and Accreditation Steering Committee.
Park Heights Renaissance Center	Cheo Hurley	Executive Director	Facilitate community involvement and input during the community health needs assessment process
Park Heights Community Health Alliance	Willie Flowers	Executive Director	Facilitate community involvement and input during the community health needs assessment process

Liberty Road Business Association	Kelly Carter	Executive Director	Facilitate community involvement and input during the community health needs assessment process
CHAI	Mitchell Posner	Executive Director	facilitate community involvement and input during the community health needs assessment process
Manna Bible Baptist Church	Reverend David Gaines	Pastor	facilitate community involvement and input during the community health needs assessment process

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

_____yes __X__no

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

__x__yes _____no

LifeBridge Health's AVP of Population Health, Darleen Won, participates on the LHIC in Baltimore City as well as in Baltimore County.

V. HOSPITAL COMMUNITY BENEFIT PROGRAMS AND INITIATIVES

1. Hospital Initiatives Identified by the CHNA

Identified Need	*According to the Baltimore City Health Department, Heart Disease is the No. 1 cause of death in Baltimore City with a 20 year life expectancy gap between high and low income neighborhoods. Heart Disease was identified as a top priority concern of the community during the 2012 and 2015 Community Health Needs Assessments and the Office of Community Health Improvement (OCHI) developed the Changing Hearts Program in response to the identified need. The program is focused on improving the cardiovascular health of pre-hypertensive individuals in the community. The collaborative nurse and community health worker model enables the program participants to identify wellness strategies related not only to their clinical status, but also psychosocial needs. The participants receive assistance with reducing risk factors that are important components of a cardiovascular health improvement plan.*
Name of hospital initiative	***Changing Hearts Program, Office of Community Health Improvement***
Total number of people within the target population	*4,800 patients were flagged as pre-hypertensive based on primary blood pressure reports of patients that have utilized LifeBridge services during the fiscal year* **Source: Cerner HealtheIntent, Comp Wellness Registry, BP Re-Screen*
Total number of people reached by the initiative	*74 participants were enrolled in the program during FY17*
Primary Objective of the Initiative	*The program is focused on improving cardiac health among pre-hypertensive patients. Staff provides Live Heart Risk Assessments in the community to identify pre-hypertensive patients (assessment includes cholesterol, glucose, blood pressure and body composition analysis). Based on the assessment, health*

	education counseling is provided by a registered nurse. Patients receive on-going support from staff to facilitate lifestyle changes. This includes follow-up calls and/or home visits by a CHW with a focus on individualized care plans developed with patients, lifestyle classes to maintain a long term change, and educational material and resources to improve health.
Single or Multi-Year Plan	*Multi-year initiative started in 2013*
Key Collaborators in Delivery	• *American Heart Association, Kimberly Mays, Senior Director – Community and Multicultural Health* • *BCHD Cardiovascular Disparities Task Force, Emilie Glide, Director of Tobacco use and Cardiovascular Disease Prevention* • *Forest Park Senior Center, Reverend J. Worth, Director* • *American Stroke Association, Faye Elliot, RN (Stroke Ambassador)* • *Sandra and Malcolm Berman Brain and Spine Institute Stroke Programs at LBH, Lorraine Newborn-Palmer, RN Program Coordinator* • *Shop Rite Howard Park, Josh Thompson, Manager and Susan Tran, Pharmacist* • *Park Heights Community Health Alliance, Willie Flowers, Executive Director* • *Assorted community churches and businesses*
Impact of Hospital Initiative	*Cumulative changes in* ***maintaining and improving behavioral and biometric outcomes are below:*** (see table below)
Evaluation of outcome	*Changing Hearts has been able to pilot successfully with a subgroup of participants in need. Future short-term and mid-term targets will be set during FY18 with the support of the Population Health Business Intelligence team to identify attainable goals.*
Continuation of Initiative	*The initiative will continue to be funded by the hospital with a goal to provide program services to more individuals in the community. The program has identified methods to improve data collection and reporting, as well as use data analytics for program development and capacity building.*
Expense	*1.Hospital's costs = $61,002.64* *2.Amount provided through restricted grant or donation= $0*

Metric	***% Improvement***		***Metric***	***% Improvement***
Blood pressure	*74%*		*Quality of life*	*73%*
Blood sugar	*95%*		*Smoking cessation*	*99%*
BMI	*93%*		*Physical Activity*	*81%*
HDL	*92%*		*Healthy Eating*	*82%*
LDL	*76%*			

Identified Need	*Health education was identified as a top priority concern during the 2012 Community Health Needs Assessment (CHNA). Based on the question "What health screenings or education services are needed in your community" during the 2015 CHNA, the top five responses were Blood pressure, HIV/Sexually transmitted diseases, Diabetes, Mental Health and Heart Disease. In addition, diabetes and hypertension are two of the leading indicators of heart disease, which is the leading cause of death in Baltimore City. The initiative provides a forum for the community to understand how to manage chronic conditions and overcome barriers to self-care.*
Name of hospital initiative	***Community Health Education, Office of Community Health Improvement***
Total number of people within the target population	*153,424 patients over 18 years, residing in Sinai primary service areas and utilizing LifeBridge Health Services are qualified for comprehensive adult wellness.* **Source: Cerner HealtheIntent, Comp Wellness Registry*
Total number of people reached by the initiative	*3,804 individuals were educated through multiple forums and health fairs during FY17*

Primary Objective of the Initiative	*The initiative is focused on improving health literacy. Primary goals include:* • *Provide health education offerings to the community* • *Provide tools for dealing with hypertension and other components of metabolic syndrome* • *Provide community-based offerings focused on health-related services and information*
Single or Multi-Year Plan	*Multi-year plan*
Key Collaborators in Delivery	• *American Heart Association, Kimberly Mays, Senior Director – Community and Multicultural Health* • *BCHD Cardiovascular Disparities Task Force, Emilie Gildie, Director of Tobacco use and Cardiovascular Disease Prevention* • *Forest Park Senior Center, Reverend J. Worth, Director* • *American Stroke Association, Faye Elliot, RN (Stroke Ambassador)* • *Sandra and Malcolm Berman Brain and Spine Institute Stroke Programs at LBH, Lorraine Newborn-Palmer, RN Program Coordinator* • *Shop Rite Howard Park, Josh Thompson, Manager and Susan Tran, Pharmacist* • *Park Heights Community Health Alliance, Willie Flowers, Executive Director* • *Assorted community churches and businesses*
Impact of Hospital Initiative	*Process metrics to support the program include:* • *Attended 342 community-based forums by Community Health Education Staff* • *Provided 651 hours of community health fairs and risk assessments* • *Completed 25 community blood pressure screenings*
Evaluation of outcome	*Outcomes are based on the participants' understanding of how to manage health and the ability to exhibit an improved change in lifestyle. Future short term and mid-term targets will be set during FY18 with the support of the Population Health Business Intelligence team to identify attainable goals.*
Continuation of Initiative	*The initiative will continue to be funded by the hospital with a goal to provide program services to more individuals in the community. The program has identified methods to improve data collection and reporting as well as use data analytics for program development and capacity building. In addition, OCHI staff also plan to increase the educational offerings as part of efforts to prevent chronic disease and provide tools for dealing with hypertension and other components of metabolic syndrome.*
Expense	*1.Hospital's costs= $142,177.95 across Sinai Hospital and Northwest Hospital* *2.Amount provided through restricted grant or donation= $0*

Identified Need	*Youth/Street Violence was identified as a top priority concern of the Park Heights community during the 2012 and 2015 Community Health Needs Assessments. As a result of the identified need, services to prevent violent retaliation and reduce street violence were developed. This includes expanding the Middle School Mentoring Program and enhancing the Workforce Readiness/Life skills program and the Sinai Violence Intervention Program within the Kujichaguila Center.*
Name of hospital initiative	***Kujichagulia Center, M. Peter Moser Community Initiatives***
Total number of people within the target population	*During FY17, 218 male youth, between 18 and 25 years of age, were admitted to Sinai Hospital for violence-related injuries. Upon recognizing the need to broaden services, the program has expanded to serve men older than 25 years as well as include women, thus an additional 1,147 patients were within the potential clientele population.*
Total number of people reached by the initiative	*138 participants were engaged across all programs under the Kujichagulia Center during FY17*
Primary Objective of the Initiative	*1) Prevent violent retaliation and reduce street violence by creating a venue to escape the cycle of violence. This includes:* • *Provide service coordination, advocacy, education and support* • *Address trauma through ongoing social work support* *2) Provide services for male opportunity youth residing in 21215 to secure a viable future. This includes:* • *Internship and job placement services* • *Providing on-going wraparound social services* *3) Mentoring middle school students from Grade 5 – Grade 8 in Park Heights community regarding bullying and violence in the African American/Black community.*
Single or Multi-Year Plan	*Multi-year plan started in 2013*
Key Collaborators in Delivery	• *Sinai Vocational Services, Sinai Emergency Medicine Department, Trauma Unit, and Palliative Medicine* • *Park Heights Renaissance--Tony Bridges, Director, Human Services and Operations* • *Baltimore City Health Department – Safe Streets—Rashard Singletary, Director Safe Streets Park Heights* • *South Baltimore Learning Center—Natashia Heggins, Program Manager* • *University of Maryland School of Social Work--Tanya Sharpe & Jodi Frey, Professors* • *HomeFree USA—Milan Griffin, Vice President, Marketing & Outreach* • *NPower—Marquise O'Neal, Program Coordinator*
Impact of Hospital Initiative	*SVIP Program:* • *Among 33 clients enrolled since program inception (27 new clients enrolled beginning January 2017), there has been a* ***75% reduction*** *in Inpatient admissions within 30 days of the intervention* *Workforce Readiness/Lifeskills program:* • *27 active and 7 new clients participated* • *70% (5 of the 7 new clients) completed Workforce Readiness and Life skills training* • *80% (4 of the 5 clients with completed training) completed internships* • *88% (30 of the 34 active clients) received assistance with job placement and 53% (16 of the 30 clients) are currently employed* *Middle School Mentoring Program* • *96 students engaged in the "Dare To Be King" curriculum over 29 weeks during FY17* • *88% was the average attendance rate*
Evaluation of outcome	*The program outcomes are based on the reduction in violent retaliation, increase in workforce readiness and life skills training, and improved engagement in positive male development. Future short and mid-term targets will be set during FY 18 with support of the Business Intelligence team to identify attainable goals.*
Continuation of Initiative	*Upon recognition of the need to provide services to more victims of street violence in the community, the program has been expanded to serve both men and women of all age groups.*
Expense	*1.Hospital's costs = $44,253.31* *2.Amount provided through restricted grant or donation= $74,741.00*

2. **Were there any primary community health needs that were identified through a community needs assessment that were not addressed by the hospital? If so, why not?**

Alcohol/Substance Abuse and Behavioral Health
The CHNA's finding that drug and alcohol abuse is a top community health need in Sinai's surrounding community is not a new concern. Indeed, Sinai has endeavored to respond to this need through the services of Sinai Hospital's Addictions Recovery Program (SHARP), an outpatient substance abuse treatment program that has provided treatment services to opiate-addicted patients for over 20 years. SHARP's mission is to serve the uninsured and under-insured individuals who are opioid-dependent in Baltimore City.

SHARP currently has 350 treatment slots to serve many individuals at any one time. Through this program, medication assisted treatment utilizing methadone is provided to patients 18 years of age and older. SHARP uses a comprehensive model of treatment that combines methadone maintenance with the following services including: individual, group and family counseling; substance abuse education for patients and families; primary medical care (assessment and referral) for uninsured patients until connected with a provider; fully integrated dual diagnosis services for patients with co-existing psychiatric disorders; on-site testing and counseling for HIV and sexually transmitted diseases; and linkages with adjunctive services as needed.

Sinai's Department of Psychiatry is currently working closely with the Population Health department to implement LBH's population health strategy for those with behavioral health needs. This includes several strategies to improve care coordination for patients with behavioral health care needs and ensure that all patients with such needs are appropriately screened, diagnosed, referred to treatment, and monitored for compliance with treatment recommendations and recovery.

Cancer
Cancer is the second leading cause of death in Baltimore City. Survey respondents selected 'cancer' as the third top cause of death in their community, and the third biggest health concern. In community feedback sessions, participants rated cancer as the fifth prioritized health concern.

The LifeBridge Health Alvin & Lois Lapidus Cancer Institute located at Sinai Hospital offers advanced specialized care in all areas of cancer diagnosis and treatment. Cancer treatment centers and programs address the following conditions: breast, gynecologic, hematologic, lung/thoracic, gastroenterological and urologic cancers, as well as bone, soft tissue and endocrine tumors. In addition to diagnosis and treatment, the Institute provides supportive services and personal development and enrichment opportunities for patients undergoing cancer treatment. Integrated therapies designed to relieve anxiety and promote socialization include stress reduction techniques for patients and families, art workshops, music therapy classes, guided imagery, meditation and chair yoga. Programs such as the American Cancer Society's Look and Feel Better Program, which provides makeup demonstrations, skin care therapies and special products, are also available to patients.

In addition, the Institute also provides outreach and screening services to its communities, in an effort to raise awareness to certain cancer risks and provide secondary prevention for those whose cancer may be found through screening. The Freedom to Screen program at Sinai's sister hospital, Northwest Hospital in nearby Baltimore County, provides community outreach, breast cancer education, screenings and exams, mammograms, and follow-up diagnostic procedures for lower-income, uninsured and under-insured women in both hospitals' catchment areas (e.g. Baltimore County and City). The goal of the program is to provide women with the resources they need to increase breast cancer awareness and prevention. Additional assistance is offered to women who need help with patient navigation services. Patient navigators help women who have received a breast cancer diagnosis deal with their medical fears and develop a road to recovery.

In November 2015 LifeBridge Health implemented a Lung Cancer Screening Program, targeted to certain high risk smokers, those ages 55-74 years of age who smoked either a pack a day for 30 years or more, or two packs a day for 15 years or more. Those eligible for the program receive a lung cancer screening using CT scanning. If there is a positive or abnormal finding, a nurse navigator helps guide the patient through the

process of selecting physicians, understanding treatment plans, and communication with the primary care physician.

HIV/AIDS
HIV/AIDS is among the community's top health concerns identified through the CHNA. This need is being addressed by current hospital programming both for primary and specialty medical care through the hospital's Infectious Disease Ambulatory Clinic (IDAC) and for psychosocial needs through Community Initiatives HIV Support Services.

The IDAC serves HIV+ adults in a comprehensive medical setting with attention to patients' primary medical care as well as specialty services for HIV infection needs. The HIV Support Services program began in 1989 and addresses the social and economic barriers that impact the health and well-being of individuals and families affected by HIV. Sinai's HIV Support Services is more robust than typical HIV support or "case management" services in that it serves several groups simultaneously: women with children, women of childbearing age, pregnant women, infants, children, and youth, a growing number of women of menopausal/post-menopausal age, and men. Services are provided by clinical social workers and community health workers who use interventions which enhance access to care and facilitate integration of medical and psychosocial services.

Other Hospital Initiatives
Although there are several health needs that were not prioritized by the Community Health Needs Assessment and subject for new Community Health Improvement Projects, they remain an important concern for community residents, stakeholders and Sinai Hospital.
Sinai Hospital has a long history of providing community outreach services to residents of its neighboring communities for the purpose of improvement of their health and well-being. Such services have been developed in response to expressions of need by patients and their families when they have sought Sinai's care or because of health improvement initiatives by public health experts from local, state or national governments. In addition, in 2005 Sinai participated in a consultant-led community health needs assessment with other LifeBridge hospitals. The department that has been responsible for the development and management of most such community health improvement programs is the M. Peter Community Initiatives (CI). The model that CI uses to provide services free-of-charge to community residents whose health is impaired or at risk of impairment because of social determinants uses a team of community health workers paired with social workers and counselors. The current CI services include:

- Family Violence Program – hospital-wide domestic violence identification and follow up counseling
- Perinatal Mood Disorders – identification of women at-risk for perinatal depression or anxiety at delivery with follow-up counseling and referrals
- Diabetes Medical Home Extender – follow up home visiting and education following an inpatient admission
- Healthy Families America – as part of the BCHD B'more for Healthy Babies infant mortality prevention home visiting for in-home education on pregnancy, infant development and parenting
- HIV Support Services – provide counseling, information & referrals to HIV+ men, women, children and youth receiving care at Sinai Hospital.

Other departments have developed services specific to the department's area of expertise such as VSP (Vocational Services Program), HUBS (Housing Upgrades to Benefit Seniors), or Case Management's Patient Financial Assistance and Psychiatry's Community Support Specialist. All of these services predated the recent CHNA and its mandate to develop services in response to the CHNA's findings. Further description of them can be found in the attached Table IV.

Table IV: ADDITIONAL SINAI HOSPITAL COMMUNITY BENEFIT PROGRAMS AND INITIATIVES

Identified Need	*A significant proportion of Sinai patients reside in 21215, a zip code that includes Southern Park Heights (SPH) and Pimilico/Arlington/Hilltop (PAH) communities. Within these communities, nearly one in three families (29%) lives below the poverty level, and diabetes is among the top 10 causes of death. (U.S. Census Bureau) Specifically, the age-adjusted mortality rate of SPH and PAH is 4.0 deaths 7.5 deaths per 10,000 respectively, compared to 3.0 deaths for Baltimore City as a whole. (U.S. Census Bureau). Both communities are designated as a Medically Underserved Area (MUA) and a Primary Care/Dental Health Professional Shortage Area (HPSA) with insufficient ratios of primary care physicians to community members. (U.S. Dept. of HHS) The Diabetes Medical Home Extender program is designed to achieve measurable improvement for the high-risk diabetic population by enhancing health and healthy behaviors among persons who experience chronic disease and whose poor health status is influenced by the poverty in which they live.*
Name of hospital initiative	***Diabetes Medical Home Extender, M. Peter Moser Community Initiatives***
Total number of people within the target population	*During FY17, approximately 5,700 patients were admitted to Sinai Hospital with a Diabetes diagnosis. Of these patients, 249 were identified as high risk and referred to the program.*
Total number of people reached by the initiative	*During FY17, 84 people were active in the program.*
Primary Objective of the Initiative	*The program has two primary objectives:* • *Provide comprehensive care coordination for patients with chronically unmanaged diabetes and help resolve psychosocial barriers preventing patients from utilizing primary care.* • *To ensure patients have appropriate medications, transportation, and home support services in order for them to make a healthy recovery*
Single or Multi-Year Plan	*Multi-year plan started in 2013*
Key Collaborators in Delivery	• *Sinai Hospital Endocrinology practice* • *JHU/Sinai Residency Program* • *Sinai Community Care practice* • *Sinai Diabetes Resource Center*
Impact of Hospital Initiative	*The program includes process measures focused on ongoing monitoring of patient behaviors (e.g., medication compliance) and outcome measures focused on changes in patient health status and the likelihood of hospital readmittances and emergency room visits. Process measures focus on more short-term changes while outcome measures focus on longer-term health changes. Key outcomes are below:* • *At least 53% of participants showed improvement on a clinical measure (e.g., decrease in A1C value over time during FY17)* • *At least 32% of participants showed improvement on a behavioral measure (e.g., Response change for "Taking Medications" from "Rarely" to "Most Times") after beginning the DMHE program during FY17.* • *Participants showed a 24.1% reduction in inpatient admissions and a 47.2% reduction in ER visits 90 days pre- and post- intervention during FY17.*
Evaluation of outcome	*Hospital utilization, measured by inpatient admissions and ER visits, declined for participants during FY17.*
Continuation of Initiative	*The program recognized the need to expand services to a larger geographic area (many of Sinai's patients also seek care at Northwest Hospital) and now include nine different zip codes that surround both hospitals. Also, the number of eligible referrals accepting services was low therefore; the position of Community Health Worker Intake Specialist was piloted to increase recruitment of eligible clients. Given the success of expanding service areas and incorporating a specialized position to garner participant enrollment, the program will continue to be supported by the hospital with the hopes to continue to scale up for a greater impact in the community. Steps include:* • *Reviewing acceptance rates of patients who accept services* • *Reviewing retention rates of patients who accept services but do not participate as*

	anticipated • *Increase the program's participation in educational outreach events for diabetes.*
Expense	*1.Hospital's costs = $129,176.69 across Sinai and Northwest Hospitals* *2.Amount provided through restricted grant or donation = $230,331.00*

Identified Need	*The 2015 Maryland Uniform Crime Report stated a 51% increase in Domestic Violence between 2014 to 2015 in Baltimore City, and this stat continues to rise. Domestic violence affects the lives of millions and creates devastating lifelong health consequences, both physical and emotional, for abuse victims. The Northwest sector of Baltimore is drastically underserved in regard to services for abuse victims. At the present time, there are only two shelters available to Intimate Partner Violence (IPV) victims in Baltimore City and are located on the far southeast corner of the city. Sinai Hospital has the only formal support program in the western half of the city equipped to handle family violence crises, thus, there is a critical need to continue providing services at Sinai in order to respond to the severe gap available programs and support. The Sinai Hospital Family Violence Program provides services to the underserved group of domestic violence survivors in the Park Heights community and surrounding neighborhoods.*
Name of hospital initiative	***Family Violence Program, M. Peter Moser Community Initiatives***
Total number of people within the target population	*Approximately 236 patients were identified by hospital staff as potential clients for the Family Violence Program during FY17.*
Total number of people reached by the initiative	*During FY17, 163 patients agreed to Family Violence Program services.*
Primary Objective of the Initiative	*The overall goal of the program is to increase the knowledge, safety, and healing experiences for victims of IPV.*
Single or Multi-Year Plan	*Multi-year grant started in 1996*
Key Collaborators in Delivery	• *Governor's Office of Crime Control and Prevention – VOCA: Kimberly Herndon, Manager* • *Governor's Office of Crime Control and Prevention – VAWA: Sun Jang, Manager* • *Baltimore City Police Department – Charles Mitchell, Detective* • *Maryland Network Against Domestic Violence – Michaele Cohen, Executive Director*
Impact of Hospital Initiative	*The program includes the following identified process metrics for FY17:* • *72% of the clients completed Safety Planning during crisis encounter* • *75% of clients were educated about Domestic Violence dynamics* • *69% of the clients were educated about the services offered by the Family Violence Program* • *70% of clients received successful follow-ups* • *100% of the clients requesting shelter were assisted with access to shelters* • *Clients displayed a 66% reduction in ER visits 30 days pre and post enrollment in the Family Violence program*
Evaluation of outcome	*The outcomes are based on demonstration of increased knowledge of actions to improve their safety through safety planning, obtaining protective order and/or describing safe behaviors, as well as depicting a decrease in ED utilization. Future short term and mid-term targets will be set during FY18 with the support of the Population Health Business Intelligence team to identify attainable goals.*
Continuation of Initiative	*The initiative will continue providing services as designed to support survivors of IPV. The program is currently evaluating the referral process to identify clients who were not appropriately screened for FVP services. Through reports and data, the program staff has focused on identifying departments that need training to better identify and refer the survivors. In addition, the program leadership has*

	identified a need to track "readiness for change" to better serve the survivors and are collaborating with the BI team to create a method for tracking the metric.
Expense	*1.Hospital's costs = $84,330.28* *2.Amount provided through restricted grant or donation= $145,261.00*

Identified Need	*Sinai Hospital serves a high-risk population of young, vulnerable families who face multiple obstacles that may interfere with establishing nurturing relationships with their newborn children. Through a program of intensive home visiting services, the Healthy Families America program at Sinai promotes child well-being and works to reduce child maltreatment.*
Name of hospital initiative	***Healthy Families America, M. Peter Moser Community Initiatives***
Total number of people within the target population	*The program is designed to reach a maximum of 100 families (based on available staffing).*
Total number of people reached by the initiative	*97 families were supported by the program during FY17*
Primary Objective of the Initiative	*The primary objective of the program is to provide support to at-risk families in nurturing new born children and preventing the abuse and neglect of those children.*
Single or Multi-Year Plan	*Multi-year plan started in 2012*
Key Collaborators in Delivery	• *Baltimore City Health Department* • *Sinai Hospital of Baltimore* • *Family League of Baltimore City* • *Maternal, Infant and Early Childhood Home Visiting (MIECHV/MDH)*
Impact of Hospital Initiative	*The program includes the following identified process metrics for FY17:* • *Provided services to 97 families* • *Performed 1,572 home visits* • *Achieved and maintained a home visit completion rate of 84% for the year* • *Conducted 654 Safe Sleep checks for infants with 84% of families showing compliance with acknowledging and practicing safe sleep habits.*
Evaluation of outcome	*Outcomes are based on increase in knowledge about safe sleeping and child growth/ development and improved care at home through home visits. During FY17, the HFA program:* • *Promoted healthy outcomes for newborns by achieving a high Safe Sleep compliance rate among participating families* • *Provided support for new families in the Sinai community with a high home visit completion rate based on the level of support families required*
Continuation of Initiative	*Gaps/barriers identified by the program and acted upon by staff include:* • *Stable housing- Given the transient nature of the clientele served, the program struggled with following families across catchment areas. Now staff is allowed to follow participating families moving in and out of the Sinai original catchment areas as long as they reside within Baltimore city limits.* • *Mental Health- A key concern for clients in the program is focused around Mental Health services. To begin to address this issue, the program performs screenings for depression and makes referrals to mental health providers at Sinai and within the surrounding communities.* • *Intimate Partner Violence- Another concern of clients in the program related to domestic violence. To provide awareness and begin to address the issue, the program performs screenings for domestic violence and makes referral to the Family Violence Program at Sinai and to other community programs, as well as, devises safety plans for families and the home visiting staff.*

	• *Financial Support- The targeted population is one of an under-served demographic, so often financial stability is an area to address. The program assists families with referrals/connections to Department of Social Services (DSS) benefits and employment opportunities. Family Support Workers assist with clients' DSS work program schedules as well as provide connections with various community resources for financial assistance.* *The initiative will continue providing services as designed to support families in need. The program plans to continue to work with B'More for Healthy Babies in collaborative service delivery.*
Expense	*1.Hospital's costs = $56,698.25* *2.Amount provided through restricted grant or donation = $468,090*

Identified Need	*In a survey conducted in 2003 at Sinai Hospital of Baltimore, 40% of new mothers referred to the OB/GYN social worker reported symptoms of Perinatal Mood and Anxiety Disorders. Launched in 2005, the Perinatal Depression Outreach Program identifies women at-risk for perinatal depression or anxiety symptoms at delivery and provides follow-up counseling and referrals to educate and support women during the perinatal period in order to improve maternal mental health, thereby enhancing maternal infant bonding. Services include: perinatal depression risk assessment, psychosocial assessments, supportive counseling, group support, services coordination, and mental health and community referrals.*
Name of hospital initiative	***Perinatal Depression Outreach Program, M. Peter Moser Community Initiatives***
Total number of people within the target population	*2,057 babies were born at Sinai Hospital during FY17. Over 1,394 screening surveys were administered to mothers delivering their babies at Sinai, and more than 25% of the women indicated a need for outreach/follow up.*
Total number of people reached by the initiative	*Besides screenings at the time of birth, other referrals have been made from sources including hospital medical staff, OBs & Pediatricians in the community, and family or friends. 706 women have been received services or support from the program.*
Primary Objective of the Initiative	*The primary objective is to increase awareness of depression and anxiety among new mothers and among health care staff, as well as improve the infant and maternal well-being through identification and treatment of maternal mental health struggles.*
Single or Multi-Year Plan	*Multi-year plan*
Key Collaborators in Delivery	• *Sinai Hospital Mother/Baby and Labor & Delivery Units* • *Sinai Ob/Gyn Department* • *Sinai Community Care OB/GYN Clinic*
Impact of Hospital Initiative	*During FY17, PDOP had direct contact with over 450 women as well as provided 256 women with informational letters and pamphlets for those unable to reach in person. Other process metrics include:* • *242 mothers were seen for inpatient assessments* • *588 follow-up, outreach, and advocacy contacts were made* • *60 participants attended 40 group sessions*
Evaluation of outcome	*Evaluation of the program is based on numbers of women screened and assessed, numbers of women offered support via direct telephone or e-mail contact, and the number of women attending Postpartum Support Group sessions. Short-term and mid-term goals include hiring additional staff to support mothers post-discharge with home visits. A longer-term goal is to facilitate an increase in provider and community awareness of Perinatal Mood and Anxiety Disorders.*
Continuation of Initiative	*The primary barrier for the program is the lack of available and accessible behavioral health service providers in the community with an understanding of perinatal mood and anxiety disorders. Recognizing this ongoing shortage of appropriate providers, PDOP staff actively sought out ways to connect with area providers, provide specialized training opportunities regarding perinatal mental health, and facilitate/ participate in community conversations to raise awareness and improve*

	provider skill level. Also, staff attended 6 meetings of the Maryland Task Force to Study Maternal Mental Health; the Task Force submitted recommendations to the Governor in December 2016 regarding needs, policies, and practices related to maternal mental health in Maryland. Staff also facilitated regular meetings of the Baltimore Perinatal Mental Health Professional Study Group, created to connect interested providers and provide a forum for ongoing discussion. Lastly, in an attempt to expand PDOP's referral network, PDOP hosted a free training in June 2016 for local therapists seeking additional expertise on providing appropriate care to women struggling with perinatal mood and anxiety disorder. *The initiative will continue providing services as designed to support this population. In August 2018 PDOP will host a 2-day Training on Perinatal Mood & Anxiety Disorders, offered on site by Postpartum Support International (PSI). The program will also continue education of Obstetrical Providers.*
Expense	*1.Hospital's costs = $31,742* *2.Amount provided through restricted grant or donation = $30,000*

Identified Need	*According to the Maryland DHMH, Sinai's service area has some of the highest rates of HIV living cases in Baltimore City (age adjusted HIV/AIDS mortality rate of 2.2 per 10,000 residents). The area is predominantly African American (94.5%) with 1 in 3 families live below the poverty line. To support this community, the HIV Support Services program provides wraparound services to HIV infected men, women, children, youth and infants as well as affected caregivers. Clients are provided with medical and non-medical case management including, coordination of medical care, treatment adherence counseling and/or referrals and service coordination to address psychosocial needs. The program plays a unique role in the Maryland Part D Network by serving HIV positive and HIV indeterminate children and youth through an integrated pediatric patient population, providing a community-based, non-specialty option of care.*
Name of hospital initiative	***HIV Support Services, M. Peter Moser Community Initiatives***
Total number of people within the target population	*335 patients diagnosed with HIV visited the Sinai Infectious Disease Associates clinic during FY17.*
Total number of people reached by the initiative	*436 patients were supported by the program and of these, 70 new clients were enrolled during FY17.*
Primary Objective of the Initiative	*HIV Support Services strives to provide services that mirror the National HIV/AIDS Strategy (NHAS). The three primary goals of the HIV Support services include:* • *To improve access to care for HIV positive and HIV indeterminate clients by reducing the barriers to care* • *To improve the emotional and social wellbeing of HIV positive women, children, youth and families to optimize health through overall wellness.* • *To provide HIV education to enhance the effectiveness of care through early identification and treatment as well as reduce the incidence of new HIV infections*
Single or Multi-Year Plan	*Multi-year plan started in 1989*
Key Collaborators in Delivery	• *Maryland Department of Health, Edna Reynolds, Division Chief Health Services* • *Sinai Infectious Disease Ambulatory Center, Dr. Johns Cmar, Division Head* • *Johns Hopkins WICY Partnership, Dr. Nancy Hutton, Medical Director* • *Sinai ED HIV rapid testing , Twila Marks, Program Coordinator*
Impact of Hospital Initiative	*195 clients received Medical Case Management and 224 clients received Non-Medical Case Management services* • *90% of the patients receiving medical case management have suppressed viral loads* • *72% of the new patients have completed at least one visit with the infectious disease clinic* • *90% completion of 557 referrals to connect clients to the necessary services* • *69 clients received housing support and 111 clients received medical transportation support*

	Wellness Program: The HIV Wellness Program had a successful first year with 41 clients participating in the workshops, receiving 197 clinical interactions during 42 sessions. Upon completion of the workshop, patients indicated: • *95% reported that the HIV Wellness Program positively impacted adherence to medical appointments* • *96% felt more connected with the hospital and their medical setting* • *33% reported feeling less stressed or anxious*
Evaluation of outcome	*Outcomes are based on increased treatment adherence, ability to reduce and maintain a low viral load and increased patient knowledge and utilization of resources.*
Continuation of Initiative	*The program identified the need to assist clients with successful completion of referrals and this assistance will continue. In addition, the program is focused on increasing appointment adherence at IDAC to 75% for new patients. Based on positive client feedback, the HIV Wellness Group will continue into its second year to support clients as they become active participants in their medical care.*
Expense	*1.Hospital's costs = $270,648.30* *2.Amount provided through restricted grant or donation= $514,540.00*

Identified Need	Financial assistance for indigent patients to ensure a safe discharge from the acute care hospital
Hospital Initiative	**Financial Assistance, Case Management Department**
# of people within target population (how many people in the target area are affected by the particular disease being addressed by the initiative)	--
# of people reached by the initiative (how many people in the target population were served by the initiative)	4,680 patients received direct financial assistance in FY2016
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	To ensure indigent patients have the appropriate medications, transportation, home support services in order for them to make a healthy recovery
Single or Multi-Year Initiative Time Period	Multi-year
Key Partners and/or Hospitals in initiative development and/or implementation	Sinai Hospital senior leadership and Department of Case Management
Outcome (Include process and impact measures)	In FY 2017, a total of $266,784.00 was spent on direct financial assistance to patients at Sinai Hospital: Home Health Care services - $9, 478.00 Assisted Living Facilities - $8, 400.00 Skilled Living Facilities - $102, 799.00 Cabs and County Ride - $59, 303.00 Life Vest - $12, 300.00 Durable Medical Equipment and Respiratory Supplies - $34, 904.00 Pharmacy - $39, 600.00

How were the outcomes evaluated?	As this does not qualify as a distinct program, no specific outcomes are evaluated for this form of community benefit.
Continuation of Initiative	This resource will continue.
Expense	Direct Hospital Expense: $266,784.00

Identified Need	Job readiness skills and employment
Hospital Initiative	**Vocational Services Program**
# of people within target population (how many people in the target area are affected by the particular disease being addressed by the initiative)	311 Total Referrals to the program
# of people reached by the initiative (how many people in the target population were served by the initiative)	244 individuals were enrolled in the program in FY2017
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	To maximize the employability of persons with significant barriers to employment through an array of workforce development services. Annually, VSP provides career assessment, work readiness, office technology training, youth services, job training and placement services to Baltimore area residents.
Single or Multi-Year Initiative Time Period	Multi-year
Key Partners and/or Hospitals in initiative development and/or implementation	• Maryland Department of Education - Division of Rehabilitation Services • Department of Veterans Affairs – Vocational Rehabilitation and Employment unit • Baltimore City Mayor's Office of Employment Development • LifeBridge Health's Population Health department • Many local community agencies.
Impact of Hospital Initiative	• 81% of trainees successfully completed services and acquiring soft and/or hard skills. • VSP assisted in placing nearly 40% of job seeking program graduates at local employers • Graduates earned an average wage of $11.36 per hour • Trainees were very satisfied with VSP training services, with an average 4.72 satisfaction score (on a 5-point scale, with a "1" rating equal to "very dissatisfied" and a "5" rating equal to "extremely satisfied") for the fiscal year
Evaluation of outcome	This past fiscal year, VSP was able to meet or exceed most program goals as noted above. While VSP's training completion rate was higher than average, VSP saw a decrease in employment of program graduates. Some graduates were not recommended for job placement services and others required more intensive support services during job search. Some graduates were recommended for further training, while job seekers lacked overall motivation to obtain employment and/or did not want to work for fear of losing entitlements.
Continuation of Initiative	This program will continue.

Expense	Hospital expenses: $163,234 Amount provided through restricted grant or donation: $156,216

Identified Need	Senior citizens need assistance with housing upgrades to improve their health and safety How need was identified: the City Health Department took the lead in identifying priorities for seniors, and fall prevention was identified by the city as a needed focus area. Sinai determined it had the capabilities and target population that would make our participation worthwhile.
Hospital Initiative	**Housing Upgrades for Benefit Seniors (HUBS), Community Development**
# of people within target population (how many people in the target area are affected by the particular disease being addressed by the initiative)	Received 297 referrals in FY2017
# of people reached by the initiative	155 new clients
Primary Objective of the Initiative	To help provide application assistance to older adults for home-related service and modifications that will improve their health and safety, preserve the integrity of their properties, and extend the time that they can remain in their homes.
Single or Multi-Year Initiative Time Period	Multi-year. Began in 2015.
Key Partners and/or Hospitals in initiative development and/or implementation	• CHAI (Comprehensive Housing Assistance, Inc.) – Mitchell Posner, CEO • CivicWorks – Dana Stein, Executive Director
Impact of Hospital Initiative	480 repairs/modifications completed in 113 homes.
Evaluation of outcome	Sinai HUBS has met its 3 year goal of completing 150 homes—225 homes with CHAI's numbers included. We've met this goal by the completion of year 2.
Continuation of Initiative	a. The largest barrier we have encountered is long wait times for rehab services such as roof replacement, furnace replacement, plumbing, electrical and structural work. We still have clients that we applied for this work in 2015 who are still waiting two years later. We are getting close, but two years is a long time to wait when your roof is leaking or you do not have a furnace. b. We hope the initiative will be continued. In March we will apply to continue the HUBS program for years 4, 5, and 6. c. There was discussion of expanding it, but that is yet to be determined. We unfortunately will not know if this is possible until we apply in March. Our ideal expansion would be to add another social worker to the Sinai team, as Sinai Hospital receives the highest number of referrals for HUBS in the city.
Expense	Hospital's costs: $36,173.13 Amount provided through restricted grant: $82,675.00

Identified Need	Sinai's population of high utilizers of health care services requires us to address avoidable inpatient readmissions and frequent utilization of emergency room care.
Hospital Initiative	**Care Navigation Program**
# of people within target population (how many people in the target area are affected by the particular disease being addressed by the initiative)	1,653 patients of Sinai Hospital were identified as "high utilizers" – having had 3 or more instances of bedded care within one year.
# of people reached by the initiative	25 new clients in year 1

Primary Objective of the Initiative	To provide community-based care coordination in support of individual patients, improving their health, chronic disease management and utilization of acute hospital-based services.
Single or Multi-Year Initiative Time Period	2 years – began in 2016
Key Partners and/or Hospitals in initiative development and/or implementation	• Sinai Hospital • General Internal Medicine – Harold Berlin, Director
Impact of Hospital Initiative	For the 11 patients in the program long enough to measure pre- and post- outcomes, ED visits decreased 58%.
Evaluation of outcome	The sample size is too small to make concrete conclusions about the success of the program. However, the reduction in Emergency Department visits for 11 people shows that the program is moving patients' use of health care in the right direction. Since the program had to start from the very beginning, the low rate of enrollment is understandable and we expect enrollment to increase dramatically in the next year.
Continuation of Initiative	Initially we faced client shortages because we were restricted to 21215, but we have broadened that parameter. Additionally, we are still educating physicians and other clinicians about the program. The program was also slow in enrolling new clients because the team and all of its processes had to be built. This grant will continue into the next year, and it has been incorporated into a larger Community Care Coordination Team, which allows for economy of scale and the ability to reach more people.
Expense	Hospital's costs: $142,633.00 Amount provided through restricted grant: $221,268.00

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

The ultimate goals of the Sinai Hospital's Community Benefit activities – as well as the other activities listed that do not fall squarely under the "community benefit" category – are fully contained within the Maryland State Health Improvement Process. The expected outcomes of Population Health, Community Initiatives, and the Office of Community Health Improvement address multiple categories within the Access to Health Care and Quality Preventive Care focus areas. As SHIP aims to improve outcomes for Maryland's most at-risk populations, so too do the programs enumerated in this report. In addition, through our variety of preventative interventions, these programs will allow Sinai Hospital to reduce readmission rates and high utilization of the emergency department for non-emergency services.

VI. PHYSICIANS

1.Gaps in availability of specialty providers: As a teaching hospital with its own accredited, non-university-affiliated residency training programs, Sinai Hospital employs a faculty of 140 physicians in several specialties including Internal Medicine, Obstetrics and Gynecology, and Pediatrics. Faculty physicians provide services to patients through a faculty practice plan. When patients request appointments in the faculty practice offices, they are not screened on their ability to pay for services. Physician fees for uninsured patients are determined on a sliding scale based on income. Fees may be waived if a patient has no financial resources or health insurance.

Additionally, in those specialties in which the hospital does not have a faculty, such as Dentistry, Otolaryngology, Vascular and Neuro-surgery, we employ specialists in order to provide continuous care for patients admitted to the hospital through the Emergency Department. In these cases, the hospital covers these specialists' consultation fees and fees for procedures for indigent patients. Because of these two arrangements for providing specialty care for uninsured patients, we are not able to document gaps in specialist care for uninsured patients.

Although we provide subsidized care for certain indigent patients, we do have other sources of information on specialty care gaps. These are those persons who are uninsured or who have Medicaid who use the Emergency Department for all of their medical needs. We find that uninsured persons and often also those who have Medicaid will seek care, both for primary and specialty care needs, in the Emergency Department because they do not have a medical home and they cannot afford specialty care, or physicians they seek help from are not Medicaid providers. Often those who use the Emergency Department for their sole source of care are too ill for primary care and are in need of specialty care because they have delayed care for so long.

Finally, we do health promotion activities as a community benefit. When we do screening programs we must have a physician to whom we can refer those who demonstrate risk factors upon screening. However, specialists are often reluctant to participate in those screenings because they fear that they will discover conditions that require extensive and expensive interventions, which will not be paid for because of lack of or under-insurance. For example, urologists are reluctant to participate in prostate screenings because they do not want to be responsible for potential surgery that will be uncompensated.

2.Physician subsidies:

Category of Subsidy	**Explanation of Need for Service**	**Amount**
Hospital-Based physicians	Anesthesia, Radiology and NICU coverage	9,873,453
Non-Resident House Staff and Hospitalists	Hospitalists and Perinatology	3,176,197
Coverage of Emergency Department Call	ER call in various specialties	484,496
Physician Provision of Financial Assistance	Charity care to match Hospital policy	452,795
Physician Recruitment to Meet Community Need	n/a	N/A
Other – (provide detail of any subsidy not listed above – add more rows if needed)	Sinai Community Care	3,927,796

Sinai Hospital of Baltimore
Financial Assistance Procedures 06/30/2017

The following describes means used at Sinai Hospital to inform and assist patients regarding eligibility for financial assistance under governmental programs and the hospital's charity care program.

- Financial Assistance notices, including contact information, are posted in Admitting, as well as at points of entry and registration throughout the Hospital.

- Patient Financial Services Brochure '*Freedom to Care'* is available to all inpatients; brochures are available in all outpatient registration and service areas.

- Sinai Hospital employs one FTE Financial Assistance Liaison who is available to answer questions and to assist patients and family members with the process of applying for Financial Assistance.

- A Patient Information Sheet is given to all inpatients prior to discharge.

- The Patient Information Sheet content is printed on every Maryland Summary Statement, which is mailed to all inpatients.

- The Patient Information Sheet content is provided on the Sinai Hospital and the LifeBridge Health web-sites.

- Sinai Hospital's uninsured (self-pay) and under-insured (Medicare beneficiary with no secondary) Medical Assistance Eligibility Program screens, assists with the application process and ultimately converts patients to various Medical Assistance coverages and includes eligibility screening and assistance with completing the Financial Assistance application as part of that process.

- Sinai Hospital participates with local Associated Jewish Charities to provide Financial Assistance eligibility for qualifying patients.

- All Hospital statements and active A/R outsource vendors include a message referencing the availability of Financial Assistance for those who are experiencing financial difficulty and provides contact information to discuss Sinai's Financial Assistance Program.

- Collection agencies initial statement references the availability of Financial Assistance for those who are experiencing financial difficulty and provides contact information to discuss Sinai's Financial Assistance Program.

- All Hospital Patient Financial Services staff, active A/R outsource vendors, collection agencies and Medicaid Eligibility vendors are trained to identify potential Financial Assistance eligibility and assist patients with the Financial Assistance application process.

- Financial Assistance application and instruction cover sheet is available in Russian

- Patient Information Sheet is available in Spanish.

- Sinai Hospital complies with all requirements of 403b regulations including direct mailings describing the hospital's Financial Assistance Policy to area schools and places of worship.

Appendix II

LifeBridge Health facility Financial Assistance Policies did not change as a result of the ACA Health Care Coverage Expansion Option in January 2014.

Insurance Exchange:

- LifeBridge Health facility Financial Assistance practices and adjustments saw little impact from the ACA Health Care Coverage Expansion of January 2014. We believe most uninsured patients serviced by LifeBridge Health facilities did not take advantage of the Health Insurance Exchange coverage and remained uninsured or qualified for Medical Assistance. We believe most Health Insurance Exchange activity involved previously insured patients selecting a new carrier through the exchange. Payer mix shifts from self-pay to Health Insurance Exchange carriers were minimal through fiscal year 2015.

Medicaid Expansion:

- Medicaid expansion, specifically the conversion of Primary Access to Care (PAC) recipients to full Community Medicaid coverage, significantly impacted LifeBridge Health facility Financial Assistance practices and adjustments. Prior to 2014, PAC recipients receiving hospital based services were presumptively eligible for Financial Assistance adjustment. In January 2014, after receiving full Community Medicaid coverage, hospitals were reimbursed for services provided to former PAC patients. The expansion of Medicaid eligibility significantly reduced hospital Financial Assistance adjustments through fiscal year 2015.

SINAI HOSPITAL OF BALTIMORE
HOSPITAL ADMINISTRATIVE POLICY

DOCUMENTATION/APPENDICES:

- Attachment #1 Maryland State Uniform Financial Assistance Application
- Attachment #2 Financial Assistance Cover Letter
- Attachment #3 Sinai Hospital Financial Assistance Calculation Sheet
- Attachment #4 Financial Assistance Eligibility Determination Letter
- Attachment #5 Financial Assistance Presumptive Eligibility Determination Letter
- Attachment #6 Sinai Hospital Installment Agreement
- Attachment #7 Sinai Hospital and Northwest Hospital Qualifications for Financial Assistance
- Attachment #8 LifeBridge Health Patient Financial Services Contact Telephone Numbers

STATEMENT OF COLLABORATION:

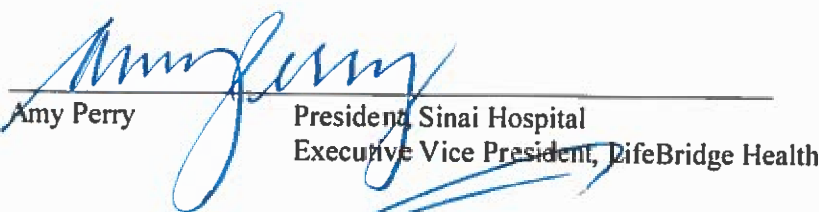
Director, Patient Access
Director, Professional Practice Operations

SOURCES:

Health Services Cost Review Commission
Federal Register (Current Federal Poverty Guidelines)

Original Date: 7/92
Review Date: 6/96
Revised Date: 9/96, 5/98, 9/01, 12/02, 8/04, 2/05, 3/05, 6/08, 10/08, 01/09, 04/11, 03/13, 04/16

Sinai Hospital Board of Directors Approval — 04/28/16 Date



Amy Perry — President, Sinai Hospital; Executive Vice President, LifeBridge Health — 04/28/16 Date

Anthony K. Morris — Vice President, Revenue Cycle — 4/28/16 Date

SINAI HOSPITAL OF BALTIMORE
HOSPITAL ADMINISTRATIVE POLICY

SUBJECT: Financial Assistance

SCOPE: Sinai Hospital of Baltimore

RESPONSIBILITY: Patient Financial Services; Patient Access

PURPOSE: For medically necessary care, to assist uninsured and underinsured patients or any immediate family member of the patient living in the same household who do not qualify for Financial Assistance from State, County or Federal Agencies, but may qualify for uncompensated care under Federal Poverty Guidelines. Medically necessary care is defined as medical treatment that is absolutely necessary to protect the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice and not mainly for the convenience of the patient. Medically necessary care for purposes of this policy does not include elective or cosmetic procedures.

POLICY: To provide Uniform Financial Assistance applications compliant with IRS Section 501 (r) and in the manner prescribed by the Health Services Cost Review Commission (HSCRC) to patients experiencing financial difficulty paying for their hospital bill(s). Eligibility is based on gross household income and family size according to current Federal Poverty Guidelines or Financial Hardship Guidelines, as defined by the HSCRC.

IRS Section 501 (r) requires Financial Assistance Policy and related information be made available to the public through hospital websites, on billing statements, through advertisements, via letters sent to churches and schools, in writing summarized in plain language, as well as verbally at points of registration. Third parties collecting debt on the behalf of the hospital are required to provide related information on billing statements.

Financial Assistance information is also made available to the public through multiple sources including: 1) HSCRC mandated Patient Information Sheet included in the admission packet, 2) signage and pamphlets located in Patient Access, the Emergency Department, Patient Financial Services (PFS), as well as other patient access points throughout the hospital, 3) patient statements and 4) Patient Financial Services, Patient Access and other registration area staff.

Financial Assistance eligibility determinations cover hospital/facility patient charges only. Physicians and ancillary service providers outside the Hospital are not covered by this policy.

The Sinai Hospital Board of Directors shall review and approve the Financial Assistance Policy every two years. The Hospital may not alter its Financial Assistance Policy in a material way without approval by the Board of Directors.

IMPLEMENTATION/PROCEDURE: Implementation procedures are different for non-emergent and emergent services.

A. Unplanned, Emergent Services and Continuing Care Admissions

1. Unplanned and Emergent services are defined as admissions through the Emergency Department. Continuing care admissions are defined as admissions related to the same diagnosis/treatment as a prior admission for the patient.

2. Patients who believe they will not be able to meet their financial responsibility for services received at the Hospital will be referred to a Patient Financial Advisor or Customer Service Technician in Patient Financial Services.

3. For inpatient visits the Patient Financial Advisor or Customer Service Technician will work with the Medical Assistance Liaison to determine if the patient is eligible for Maryland Medical Assistance (Medicaid). The patient will provide information to make this determination.

4. If the patient does not qualify for Medicaid, the Patient Financial Advisor or Customer Service Technician will determine if the patient has financial resources to pay for services rendered based on Federal Poverty Guidelines.

5. If the patient does have the financial resources according to the Guidelines, the Patient Financial Advisor or Customer Service Technician will arrange for payment from the patient following the Hospital's payment arrangement guidelines.

6. If the patient does not have the financial resources according to the Guidelines, the Patient Financial Advisor or Customer Service Technician will assist the patient with the Financial Assistance application process.

7. Patients may request Financial Assistance prior to treatment or after billing.

8. Patients must complete the Maryland State Uniform Financial Assistance Application (Attachment #1) and provide the Patient Financial Advisor or the Customer Service Technician documented proof of medical debt and household income for consideration as requested in the Financial Assistance Cover Letter (Attachment #2). Medical debt is defined as debt incurred over a period of time at least twelve (12) months preceding the date of the application at Sinai Hospital or other LifeBridge Health facility. Household income is defined as the patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, rental income, retirement/pension income, Social Security benefits and other income as defined by the Internal Revenue Service, for all members of the immediate family residing in the household for the twelve (12) calendar months preceding the date of the application. At least one of the following items is required:

   a. Patient's recent paycheck stub
   b. Copy of the prior year's tax statement and/or W-2 form

c. Verification of other household income, i.e. Social Security Award Letter, retirement/pension payment, etc

d. 'Letter of support' for patients claiming no income

9. Financial Assistance Eligibility:

a. Eligibility includes any patient for which the Financial Assistance application was completed, as well as any immediate family member of the patient living at the same address and listed on the application as household members.
Immediate family is defined as –
- if patient is a minor: mother, father, unmarried minor siblings, natural or adopted, residing in the same household.
- if patient is an adult: spouse, natural or adopted unmarried minor children residing in the same household.
- any disabled minor or disabled adult living in the same household for which the patient is responsible.

b. Eligibility covers services provided by all LifeBridge Health facilities (Health System Eligibility): Sinai Hospital, Northwest Hospital, Carroll Hospital, Levindale Hebrew Geriatric Center and Hospital. Patients approved for Financial Assistance through another facility within the LifeBridge Health System must notify the Hospital of their eligibility, which is validated prior to Financial Assistance adjustment. Validation can be made by contacting the approving Hospital's Patient Financial Services Department (Attachment #8).

c. The Financial Assistance Liaison will consider all hospital accounts within the consideration period for the patient. The approval or denial determination will apply to the patient as well as immediate family members listed on the application.

d. For dates of service October 1, 2010 and after, approved Medicare inpatients and outpatients are certified for one year from date of service or one year from approval date, whichever is greater. For yearly re-certification, Medicare patients are required to provide a copy of their Social Security Award Letter.

e. For dates of service October 1, 2010 and after, approved Non-Medicare inpatients and outpatients are certified for one year from date of service or one year from approval date, whichever is greater. However, if it is determined during the course of that period that the patient meets Medicaid eligibility requirements, we will assist the patient with this process while still considering requests for Financial Assistance.

f. Eligibility ends on the last calendar day of the last month of eligibility. For instance, a patient eligible May 15, 2016 will be eligible through May 31, 2017.

g. Outpatient surgical procedures, including multiple procedures as part of a treatment plan, may be certified for one time only. Additional surgical procedures would require a new application.

h. At time of application, all open accounts within the consideration period are eligible. Consideration period is defined as beginning with the oldest date of service for which the application is intended and ending twelve months from that date. Accounts previously written-off to bad debt will be considered on a case-by-case basis.

i. Dates of service outside the Financial Assistance consideration period, prior to the approval date, will be considered on a case-by-case basis.

j. The Hospital must give the most favorable applicable reduction to the patient that is available: Free Care or Reduced Cost Care as a result of Financial Hardship qualification. Note that Reduced Cost Care for income greater than 200% through

300% does not apply due to the Hospital's application of Free Care up to 300% (regulation requires Free Care only up to 200%).

10. Financial Assistance is based upon the Federal Poverty Guidelines (FPG) published in the Federal Register. The poverty level guidelines are revised annually. It is the responsibility of Patient Financial Services to maintain current FPG as updates are made to the Federal Register. Free Care: Patients with an annual income up to 300% of the Federal Poverty Level may have 100% of their hospital bill(s) covered by Financial Assistance. Financial Hardship: Patients with an annual income greater than 300% but less than 500% of the Federal Poverty Level may be covered by Financial Assistance based on the HSCRC's Financial Hardship criteria, which is defined as medical debt incurred by a family (as defined in 9a. above) over a twelve-month period that exceeds 25% (twenty-five percent) of family income. Medical debt is defined as out-of-pocket expenses, including co-payment, coinsurance, and deductible amounts due the Hospital, as well as related LifeBridge Health physician out-of-pocket expenses. Note: the Hospital has chosen to include co-payment, coinsurance and deductible amounts for Financial Assistance consideration, although the regulation allows for their exclusion. The Hospital is not required to consider medical debt incurred from other healthcare providers.

11. Applications above 300% annual income will be considered on a case-by-case basis, which may include an asset test in addition to income test. The following interest-free payment options may be considered:

    a) Standard installment options of three – six months in accordance with Installment Agreement Letter (Attachment #6).
    b) Extended installment options greater than six months will be considered on a case-by-case basis.
    c) Spend-down option to income level of 300% of the Federal Poverty Guidelines will also be considered on a case-by-case basis.
    d) In accordance with HSCRC regulation, the following will be excluded from asset test consideration: 1) at a minimum, the first $10,000 of monetary assets; 2) a 'safe harbor' equity of $150,000 in a primary residence; and 3) retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including, but not limited to, deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred compensation plans.

12. The Sinai Hospital Financial Assistance Calculation Sheet (Attachment #3) will be used to calculate eligibility as follows:

    a) Financial Assistance Eligibility up to 300% of FPL -
        - Identify the annual household income based on the income tax form, W-2 or calculated annual income (A)
        - Identify 300% of the Federal Poverty Level for the patient based on household size (B).
        - Annual Household Income (A) minus Federal Poverty Level (B) = Result (C)
        - If the result is $0.00 or less than $0.00, the patient qualifies for 100% adjustment.

- If the result is greater than $0.00, apply the Financial Hardship test (next).

b) Financial Hardship Eligibility between 300% - 500% of FPL -

- If annual household income is greater than 300% but less than 500% of FPL and the Financial Hardship percentage of income (E) is 25% or greater, the patient qualifies for reduced cost care as a result of Financial Hardship.
- The patient is responsible to pay the calculated amount of 25% of the annual household income. The difference between the total charge and the calculated amount of 25% of the annual household income will be adjusted to Financial Assistance.
- For example, the annual household income for a family of 5 is $100,000. Medical bills total $60,000. The Financial Hardship percentage of income (E) is 60%, which is greater than the required 25%, so the patient is eligible.
- Patient responsibility under Financial Hardship eligibility equals 25% of the annual household income. In this example, the patient responsibility equals $25,000 or 25% of the annual household income. The difference between the total medical bills ($60,000) minus the patient liability ($25,000) equals the Financial Assistance adjustment ($35,000).

- Case-by-case considerations are subject to Management approval and may qualify the patient for full or partial Financial Assistance eligibility. To determine patient responsibility for partial Financial Assistance eligibility, one or more of the following may be utilized:
  - spend-down calculation
  - sliding scale
  - total assets
  - total indebtedness
  - other useful information helpful in determining eligibility

- Financial Assistance allowances greater than 12% will be considered on a case-by-case basis.

- If Financial Hardship percentage is less than 25%, the application may be considered on a case-by-case basis.

- Failure to pay patient responsibility as agreed could result in reversal of the Financial Assistance adjustment. The patient may be liable for the balance in full.

13. The Director of Patient Financial Services or his/her designee approves or denies the application. The designee will sign as Reviewer and obtain appropriate Approver/Denial signature(s) as directed. Authorizing signatures are required for amounts $10,000.00 and greater –

$10,000.00 – 24,999.99	Director, PFS
$25,000.00 +	VP Revenue Cycle

The Financial Assistance Eligibility Determination Letter (Attachment #4) will be sent timely and include appeal process instructions. Appeals must be in written form describing the basis for reconsideration, including any supporting documentation. The Director of Patient Financial Services will review all appeals and make a final determination. The patient is notified in writing.

14. The Hospital will make every effort to identify patients previously approved and currently eligible for Financial Assistance both systematically and through available reports. However, it is ultimately the patient's responsibility to present the Financial Assistance Eligibility Determination Letter at each visit or notify the hospital by other means of Financial Assistance eligibility. Additionally, it is the responsibility of the patient to notify the hospital of material changes in financial status, which could impact the patient's eligibility for Financial Assistance. Such notification is acceptable in the form of written correspondence by letter or e-mail to Patient Access or Patient Financial Services, in-person or by telephone.

B. Planned, Non-Emergent Services

1. Prior to an admission, the physician's office or hospital scheduler will determine if the patient has medical insurance and if so, provide complete insurance information at time of scheduling. If the patient does not have medical insurance, the physician's office or hospital scheduler will schedule the services as a self-pay. The Financial Clearance Representative (FCR) will contact the patient to confirm the patient is uninsured, provide a verbal estimate (written upon request), screen for potential Medicaid eligibility and/or determine ability to pay and establish payment arrangements with the patient.

   The FCR will determine if the patient is currently pending Medicaid (defined as a complete application under consideration at the Department of Health and Mental Hygiene (DHMH), or if patient has potential for Medicaid eligibility permitting the patient to receive services as scheduled.

   If patient is not potentially eligible for Medicaid, FCR will determine patient's ability to pay. Refer to #2 and #3 in this section.

   If patient is unable to pay, FCR will contact physician's office and attempt to postpone the service. If unable to postpone, the case will be considered for Financial Assistance (F.A.) FCR will refer the case to Manager, Financial Clearance and/or Director, Patient Financial Services for case-by-case consideration.

   Manager/Director may contact physician's office for additional information to determine if approval will be granted. In certain instances, the Director may refer a case to the Vice President of Revenue Cycle or Chief Financial Officer for approval.

   The FCR will either complete the F.A. application on behalf of patient, or if time allows, send an application to the patient to complete. Patient must mail completed F.A. application and required documentation to Financial Assistance Liaison or bring completed F.A. application and required documentation on date of service. Completed

F.A. application and required documentation must be delivered to Hospital F.A. Liaison for approval, formal notification to patient and necessary adjustment(s). If the patient is not cooperative and does not complete the application or provide the required documentation, Financial Assistance is denied.

Note: Procedures, including multiple procedures as part of a treatment plan, will be certified for one time only. Additional procedures would require a new application and consideration.

2. Written estimates are provided on request from an active or scheduled patient made before or during treatment. The Hospital is not required to provide written estimates to individuals shopping for services. The Hospital shall provide to the patient a written estimate of the total charges for the hospital services, procedures, and supplies that are reasonably expected to be provided and billed to the patient by the hospital. The written estimate shall state clearly that it is only an estimate and actual charges could vary. The hospital may restrict the availability of a written estimate to normal business office hours. The Director of Patient Financial Services and/or designee shall be responsible for providing all estimates (verbal and written).

3. For planned, non-emergent services, Self Pay patients who are United States citizens must pay at least 50% of estimated charges prior to service, with an agreement to pay the remaining 50% not to exceed two (2) years. For patients who are not United States citizens, 100% of the estimated charges must be paid prior to date of service. Financial Assistance eligibility may be considered on a case-by-case basis for non-emergent, yet medically necessary services, based on the policies documented herein. Vice President of Revenue Cycle and/or Chief Financial Officer approval are required.

4. If an agreement is made, the patient must provide payment at least three (3) business days prior to service, and sign the Sinai Hospital Installment Agreement (Attachment #6). If the patient has the financial resources according to the Federal Poverty Guidelines, but fails to pay prior to service or sign the Sinai Hospital Installment Agreement, the Financial Clearance Representative will contact the physician's office to request the planned service is cancelled due to non- payment.

5. If there are extenuating circumstances regarding the patient, the patient's clinical condition, or the patient's financial condition, the patient or the physician may seek an exception from the Vice President of Revenue Cycle and/or the Chief Financial Officer. If an exception is requested, the Patient Financial Advisor will provide documented proof of income as stated in the emergent section of this procedure to Director, Patient Financial Services. The Vice President of Revenue Cycle and/or the Chief Financial Officer will review the case, including clinical and financial information, business impact, and location of the patient's residence in determining whether Financial Assistance should be provided. Final determination will be made on a case-by-case basis.

C. Presumptive Eligibility and Other Financial Assistance Considerations

1. The Hospital may apply Presumptive Eligibility when making Financial Assistance determinations on a case-by-case basis. Additionally, other scenarios may be considered. Note that a completed Financial Assistance application and/or supporting documentation may/may not be required. The Financial Assistance Presumptive Eligibility Determination Letter (Attachment #5) will be sent timely and include appeal process instructions. Appeals must be in written form describing the basis for reconsideration, including any supporting documentation. The Director of Patient Financial Services will review all appeals and make a final determination. The patient will subsequently be notified.

Presumptive Eligibility:

a. Eligibility covers services provided by all LifeBridge Health facilities (Health System Eligibility): Sinai Hospital, Northwest Hospital, Carroll Hospital, Levindale Hebrew Geriatric Center and Hospital. Patients approved for Financial Assistance through another facility within the LifeBridge Health System must notify the Hospital of their eligibility, which is validated prior to Financial Assistance adjustment. Validation can be made by contacting the approving Hospital's Patient Financial Services Department (Attachment #8).
b. Maryland Medicaid 216 (resource amount) will be adjusted for patients eligible for Medicaid during their eligibility period.
c. Patients eligible for non-reimbursable Medicaid eligibility programs such as PAC (Primary Adult Care), family planning only, pharmacy only, QMB (Qualified Medicare Beneficiary) and SLMB (Specified Low Income Medicare Beneficiary), X02 Emergency Services Only.
d. Patients eligible for an out-of-state Medicaid program to which the hospital is not a participating provider.
e. Patients enrolled in State of Maryland grant funded programs (Department of Vocational Rehabilitation – DVR; Sinai Hospital Addictions Recovery Program – SHARP) where reimbursement received from the State is less than the charge.
f. Patients denied Medicaid for not meeting disability requirements with confirmed income that meets Federal Medicaid guidelines.
g. Patients eligible under the Jewish Family Children Services (JFCS) (Y Card) program
h. Households with children in the free or reduced lunch program (proof of enrollment within 30 days is required).
i. Eligibility for Supplemental Nutritional Assistance Program (SNAP) (proof of enrollment within 30 days is required).
j. Eligibility for low-income-household energy assistance program (proof of enrollment within 30 days is required).
k. Eligibility for Women, Infants and Children (WIC) (proof of enrollment within 30 days is required).

Note: An additional 30 days to provide proof of enrollment will be granted at the request of the patient or patient's representative.

Other Financial Assistance Considerations:

a. Expired patients with no estate.
b. Confirmed bankrupt patients.
c. Unknown patients (John Doe, Jane Doe) after sufficient attempts to identify.

2. Financial Assistance adjustments based on other considerations must be documented completely on the affected accounts. When appropriate, form: Sinai Hospital and Northwest Hospital Qualifications for Financial Assistance (Attachment #7) must be completed. The Director of Patient Financial Services or designee will sign as Reviewer and obtain appropriate Approver/Denial signature(s) as directed. Authorizing signatures are required for amounts $10,000.00 and greater –

$10,000.00 – 24,999.99	Director, PFS
$25,000.00 +	V.P. Revenue Cycle

D. Collection Agency Procedures

1. The hospital will ensure third parties collecting on its behalf provide statements that contain Financial Assistance information including how and where to apply, where to find information including: on-line, in person at the hospital and by telephone.

2. The hospital will ensure third parties collecting on its behalf do not initiate Extraordinary Collection Actions (ECAs) until at least 120 days from the date the first post-discharge billing statement is provided.

3. Upon patient request and/or agency determination of inability to pay, agency will mail cover letter and Financial Assistance application with instructions to complete and return to the Hospital Patient Financial Services Department. Agency will suspend collection activities (ECAs) until a determination of Financial Assistance eligibility has been made by the hospital and the agency has been notified accordingly. Agency will request status from hospital 45 days after sending the Financial Assistance application. Agency will resume its collection activity only after receiving notification from the hospital.

E. Patient Refunds

1. Effective with dates of service October 1, 2010, the Hospital shall provide for a full refund of amounts exceeding $25 in total, collected from a patient or the guarantor of a patient who, within a two-year period after the date of service, was found to be eligible for free care on the date of service.

2. The Hospital may reduce the two-year period to no less than 30 days after the date the hospital requests information from a patient, or the guarantor of a patient, to determine the patient's eligibility for free care at the time of service, if the hospital documents the lack of cooperation of the patient or the guarantor of a patient in providing the required information.

3. If the patient or the guarantor of the patient has entered into a payment contract, it is the responsibility of the patient or guarantor of the patient to notify the hospital of material changes in financial status, which could impact the ability to honor the payment contract and qualify the patient for Financial Assistance.

4. The Hospital must refund amounts paid back-dated to the date of the financial status change, or the date the financial status change was made known to the Hospital, whichever is most favorable for the patient. Previous amounts paid in accordance with a payment contract will not be considered refundable.

F. IRS Section 501 (r) requirements effective July 1, 2016

1. Hospital shall post on websites in PDF format the following documents:
   a. Written summary of Financial Assistance information in plain language.
   b. Financial Assistance Application and Cover Letter
   c. Hospital Financial Assistance Policy
   d. Hospital Debt Collection Policy

2. Hospital's website will display on home page and main billing page the following message: "Need help paying your bill? You may be eligible for Financial Assistance. Click here for more information →". Clicking the link will display a web page that includes the information described in #1 above.

3. The Hospital will provide on admission a plain language summary of the Financial Assistance Policy which provides eligibility criteria, how to apply and where to find information, including on-line, in person at points of Registration and in Customer Service and by telephone.

4. The Hospital's Registration Staff will verbally offer a copy of the Financial Assistance Policy to patients as they present for service. This will comply with oral notification requirements, as the patient will be notified at least 30 days before Extraordinary Collection Actions (ECAs) are engaged.

5. The Hospital's billing statements will explain where to find Financial Assistance information including how and where to apply and where to find information including: on-line, in person at points of Registration and in Customer Service and by telephone.

6. The Hospital will advertise the Financial Assistance Plain Language Summary in local newspapers and will mail a cover letter and the summary to area churches and schools.

7. The Hospital will ensure third parties collecting on its behalf provide statements that contain Financial Assistance information including how and where to apply, where to find information including: on-line, in person at the hospital and by telephone.

8. The Hospital will ensure third parties collecting on its behalf do not initiate Extraordinary Collection Actions (ECAs) until at least 120 days from the date the first post-discharge billing statement is provided.

9. The Hospital ensures the period allowed for submission of the Financial Assistance application is at least 240 days from the date the first post-discharge billing statement is provided.

Maryland State Uniform Financial Assistance Application
Information About You

Name ____
First Middle Last

Social Security Number ______ - ______ - ______ Marital Status: Single Married Separated
US Citizen: Yes O No O Permanent Resident: Yes O No O

Home Address ______________________________________ Phone ______________

______________________________________ ______________
City State Zip Code County

Employer Name ______________________________________ Phone ______________

Work Address ______________________________________

____
City State Zip Code

Household members:

Name	Date of Birth	Age	Relationship	Have you ever been a patient at Sinai?	Yes	No
					O	O
					O	O
					O	O
					O	O
					O	O
					O	O

Have you applied for Medical Assistance? Yes O No O
If yes, what was the Date you applied? ______________
If yes, What was the determination? ______________________________

Do you receive any type of state or county assistance ? Yes O No O

Return application to: Sinai Hospital of Baltimore
2401 W. Belvedere Avenue
Attention: Customer Service
Baltimore, MD 21215

Patient Financial Services
For Hospital / Department / Agency use only

Originator Name: ______________________

Department: ______________ **Ext** ________

Agency Name ______________________

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses.
If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	
Retirement/pension benefits	
Social Security benefits	
Public Assistance benefits	
Disability benefits	
Unemployment benefits	
Veterans benefits	
Alimony	
Rental property income	
Strike Benefits	
Military allotment	
Farm or self employment	
Other income source	
Total:	

II. Liquid Assets

	Current Balance
Checking account	
Savings account	
Stocks, bonds, CD, or money market	
Other accounts	
Total:	

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance		Approximate value
Automobile	Make	Year	Approximate value
Additional vehicle	Make	Year	Approximate value
Additional vehicle	Make	Year	Approximate value
			Total:

IV. Monthly Expenses

	Amount
Rent or Mortgage	
Utilities	
Car Payment(s)	
Health Insurance	
Other medical expenses	
Other expenses	
Total:	________

Do you have any other unpaid medical bills? Yes ○ No ○
For what service?
If you have arranged a payment plan, what is your monthly payment?

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

X ______________________________
Applicants signature

X ______________________________
Date

X ______________________________
Relationship to Patient

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SINAI HOSPITAL
a LifeBridge Health center

Date: ______________________ Account #: ______________________

Patient Name ______________________ Account #: ______________________

Dear: ______________________ Account #: ______________________

In order to determine your eligibility for Financial Assistance please complete the enclosed application and forward the following items:

1. The following is required as proof of income. Please provide proof of income for any household members considered in this application process. **(Please check all sources of income)**

   A. Two most recent pay stubs ______
   B. Bank statement showing interest ______
   C. Award letter, Social Security Administration **(If Citizen of US)** ______
   D. Award letter, pension fund ______
   E. Award letter, Maryland Dept.of Social Services **(If resident of Maryland)** ______
   F. Proof of Unemployment Compensation ______

2. Please provide copies of the following tax information:

   A. W-2 Forms ______
   B. Previous year's Tax Forms ______

3. **If resident of Maryland** please provide denial letter from the Maryland Medical Assistance Program.

4. Notarized letter stating you presently have no income

5. **Presumptive Eligibility:** If you are a beneficiary/recipient of the following means-tested social services program, submit proof of enrollment with your application; households with children in the free or reduced lunch program; Supplemental Nutritional Assistance Program (SNAP); Low-income-household energy assistance program; Primary Adult Care Program (PAC); Women, Infants and Children (WIC). If you are eligible for any of the following means-tested Medicaid programs, submit eligibility identification with your application: Family Planning or Pharmacy Only Program(s); Qualified Medicare Beneficiary (QMB); Specified Low Income Medicare Beneficiary (SLMB); X02 Emergency Services Only. If you are eligible for any of the following other programs, please submit proof of eligibility with your application: State Grant Funded programs including Department of Vocational Rehabilitation (DVR), Intensive Outpatient Psychiatric Block Grant (IOP), Sinai Hospital Addiction Recovery Program (SHARP); Jewish Family Children Services (JFCS).

   You must return your completed application and all applicable documents within 14 days of receipt. Your application will not be reviewed without providing the above information. Please return this letter with your application. Your personal information will be kept confidential. The Hospital's Financial Assistance Program covers hospital/facility charges only. Professional physician fees are not covered under this program.

   If you have further questions regarding this application, wish to appeal or make a complaint, please Contact Customer Service at 410 601-1094 or (800) 788-6995 Monday – Friday 7:30 a.m. – 5:00 p.m.

Please return to **Sinai Hospital of Baltimore, 2401 West Belvedere Avenue, Patient Financial Services Attention: Customer Service, Baltimore, Maryland 21215**

Yours truly,

Patient Financial Services
Customer Service

For Hospital / Department / Agency use only

Originator Name: ______________________

Department: ______________________ **Ext.** ____________

Agency Name: ______________________

Sinai Hospital
Financial Assistance Calculation Sheet

Pt Name: ______________________________

Acct #: ______________________________

Calculation

Patient Responsibility on Bill
Patient Annual Income
Family Size

x-ref to Policy

A	Annual Income	$ -
B	300% Poverty Guidelines	
C	Sliding Scale - Patient Responsibility	$ -
	Patient Responsibility on Bill	$ -
	Sliding Scale - Patient Responsibility	$ -
D	Financial Assistance	$ -
	Financial Assistance %	#DIV/0!

2017 300%

Size of Family Unit			Annual Income
1	$ 12,060	Less than	$ 36,180
2	$ 16,240	Less than	$ 48,720
3	$ 20,420	Less than	$ 61,260
4	$ 24,600	Less than	$ 73,800
5	$ 28,780	Less than	$ 86,340
6	$ 32,960	Less than	$ 98,880
7	$ 37,140	Less than	$ 111,420
8	$ 41,320	Less than	$ 123,960
		Less than	
		Less than	
For each additional person add	$ 4,180		$ 12,540

Financial Assistance Eligibility Determination Letter

Date: ____

Re: ____

Account #: ____

Date of Service: ___________________________________

Financial Assistance Eligibility Expiration Date: ______________

Dear: ______________________________

Thank you for choosing Sinai Hospital of Baltimore. We have processed your Financial Assistance application and after careful review, are providing a ________ % reduction to the hospital bill(s) listed above. As a result, you are receiving $ ________ in Financial Assistance, reducing your financial responsibility to $ ________ You must re-apply when your eligibility expires.

The Financial Assistance approval covers only hospital fees. Physicians and non-hospital-based providers may require that you complete their Financial Assistance eligibility process. **Financial Assistance eligibility covers services provided by all LifeBridge Health facilities: Sinai Hospital, Northwest Hospital, Carroll Hospital, Levindale Hebrew Geriatric Center and Hospital.**

Sinai Hospital of Baltimore is continually working to meet the needs of our patients and our community. Sinai's Financial Assistance Program is an example of our commitment.

If you wish to appeal this decision, please submit in writing the basis for reconsideration, Including any supporting documentation. Include a copy of this document with your appeal.

If you believe you are being billed for an amount due which falls within your Financial Assistance eligibility period, or if you have a complaint, or require additional assistance, please contact Customer Service at 410 601-1094 or 800 788-6995 Monday – Friday 7:30 a.m. - 5:00 p.m.

Sincerely,

Customer Service

If you receive hospital bills for service dates within your eligibility period contact Customer Service: 410 601-1094 or 800 788-6995.

SINAI HOSPITAL

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Financial Assistance Presumptive Eligibility Determination Letter

Date:____

Re: ____

Account # : ____________________________________

Date of Service:___________________________________

Financial Assistance Eligibility Expiration Date: _______________

Dear: ______________________________

Thank you for choosing Sinai Hospital of Baltimore. We have processed your Financial Assistance application and after careful review, are providing a _______% reduction to the hospital bill(s) listed above. As a result, you are receiving $ _________ in Financial Assistance, reducing your financial responsibility to $ _________ You must re-apply when your eligibility expires.

This decision is based on your enrollment/eligibility in one or more of the following means-tested Social programs: households with children in the free or reduced lunch program; Supplemental Nutritional Assistance Program (SNAP); Low-income-household energy assistance program; Primary Adult Care Program (PAC); Women, Infants and Children (WIC) or means-tested Medicaid programs; Family Planning or Pharmacy Only Program(s); Qualified Medicare Beneficiary (QMB); Specified Low Income Medicare Beneficiary (SLMB); X02 Emergency Services only or other programs: State Grant Funded Programs including Department of Vocational Rehabilitation (DVR), Intensive Outpatient Psychiatric Block Grant (IOP), Sinai Hospital Additions Recovery Program (SHARP); Jewish Family Children Services (JFCS).

The Financial Assistance approval covers only hospital fees. Physicians and non-hospital-based providers may require that you complete a separate Financial Assistance eligibility process.

If you wish to appeal this decision, please submit in writing the basis for reconsideration, Including any supporting documentation. Include a copy of this document with your appeal.

If you believe you are being billed for an amount due which falls within your Financial Assistance eligibility period, or if you have a complaint, or require additional assistance, please Contact Customer Service at 410 601-1094 or 800 788-6995 Monday – Friday 9:00 a.m. – 3:30 p.m.

Sincerely

Customer Service

If you receive hospital bills for service dates within your eligibility period, contact Customer Service: 410 601-1094 or 800 788-6995.

Attachment #6

PATIENT NAME: ______________________________

ACCOUNT NUMBER: ______________ ______________

CONTRACT AMOUNT: $ ______________________________

DATES OF SERVICE: ______________________________

CONTRACT DATE: ______________________________

INSTALLMENT AGREEMENT

I, ______________________________ agree to pay Sinai Hospital of Baltimore, Inc. ______________ installments, beginning ______________

Shaded area for hospital use only

New contract amount: $ ______________

2 month	50% first month	$______	and final payment of	$______
3 Months	50% first month	$______	and then 2 payments of	$______
3 Months	3 payments of	$______		
4 Months	50% first month	$______	and then 3 payments of	$______
4 Months	4 payments of	$______		
5 Months	20% first month	$______	and then 4 payments of	$______
5 Month	5 payments of	$______		
6 month	20% first month	$______	and then 5 payments of	$______
	6 payments of	$______		

Monthly Payment due date ______________ Final payment of $ ______________

- I understand that the above balance is an estimated amount, and the payment arrangement may change accordingly.
- I understand that if I do not make payments as agreed, the Installment Agreement will be canceled and the full balance becomes due immediately.

Date: X______________ Signed: X______________________

Name: X______________________

Address: X______________________

____

(Please Print)

This signed agreement must be accompanied with payment and in our office by ______________ Installment agreement not valid without appropriate signature and agreed payment amount. If you have any questions please contact Customer Service at 800-788-6995.

Sinai Hospital
2401 W. Belvedere Avenue
Hoffberger Bldg. Suite G-10
Patient Financial Services/Customer Service
Baltimore, Maryland 21215

____
Employee Signature and Date

Sinai Hospital

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Date: ______________

SINAI HOSPITAL AND NORTHWEST HOSPITAL
QUALIFICATIONS FOR FINANCIAL ASSISTANCE

(PLEASE CIRCLE LINE #)

1. **Health System Eligible:** Patient eligible as determined by Northwest, Levindale or Courtland Gardens.

2. **Bankrupt:** The patient/debtor has filed a petition of bankruptcy, either before or after placement. If applicable, vendor files a proof of claim in a Chapter 13 for a pro rata distribution to unsecured creditors.

3. **Expired:** The patient/debtor has died and an investigation for assets has revealed no estate exists.

4. **Eligible for non-reimbursable Medicaid Program:** (Copy of EVS website eligibility attached) including PAC (Primary Adult Care), family planning only pharmacy only, QMB (Qualified Medicare Beneficiary, SLMB (Special Low Income Medicare Beneficiary), (Breast Cancer Screening)

5. **Enrolled in means-tested social programs:** (proof of enrollment may be required) including WIC (Women, Infants and Children), SNAP (Supplemental Nutrition Assistance Program, Low-income-household energy assistance program, households with children in the free or reduced lunch program.

6. **Enrolled in State of Maryland grant funded program where reimbursement is less than the** charge: including DVR (Department of Vocational Rehabilitation), Intensive Outpatient Psychiatry Block Grant, SHARP (Sinai Hospital Addiction Recovery Program).

7. **Eligible under Jewish Family Children Services (JFCS) (Y Card) Program:** Sinai Hospital only.

8. **Out-of-State Medicaid Program:** to which the hospital is not a participating provider.

9. **Maryland Medicaid Eligible after Admission**: charges incurred prior to Maryland Medicaid eligibility

10. **Maryland Medicaid 216 (resource amount):** patient/debtor eligible for Maryland Medicaid with resource.

11. **Denied Medicaid for not meeting disability requirements:** with confirmed income that meets Federal Medicaid guidelines.

12. **Unknown/Unidentifiable Patient (John Doe, Jane Doe)**: After sufficient attempts to identify

13. **Pending SRT** (State review team)

14. **Original Financial Assistance approved:** based on US Poverty Guideline income level

Additional accounts see attached

Patient Name: ____
Last First Middle Initial

Account #: ______________________ Date of Service: ______________________

Account # : ______________________ Date of Service: ______________________

Account #: ______________________ Date of Service: ______________________

Financial Assistance Write off reason: Reason #: ________

Financial Assistance Write off date: ______________

Financial Assistance Write off amount: $ ______________

Reviewer signature: X ______________________ Date: ______________________

1st Approval signature: X ______________________ Date: ______________________

2nd Approval signature: X ______________________ Date: ______________________

(Director) > $10,000. 00 Approval Signature: X ______________________ Date: ______________________

(VP) > $25,000 Approval Signature: X ______________________ Date: ______________________

Comments :

Attachment #8

LifeBridge Health
Patient Financial Services
Contact Telephone Numbers

Sinai Hospital Customer Service
(410) 601-1094
(800) 788-6995

Northwest Hospital
(410) 521-5959
(800) 617-1803

Levindale Hebrew Geriatric Center and Hospital
(410) 601-2213

Appendix IV

SINAI HOSPITAL OF BALTIMORE
PATIENT INFORMATION SHEET

Sinai Hospital offers several programs to assist patients who are experiencing difficulty in paying their hospital bills. Our Patient Financial Services Department is available to assist patients who do not carry medical insurance (uninsured) or face significant co-payment, coinsurance and/or deductible charges, which may be challenging to manage due to personal hardship or financial distress. Depending on the specific financial situation, a patient may be eligible to receive Maryland Medical Assistance (Medicaid), Financial Assistance or take advantage of extended payment plans.

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

Sinai Hospital patient representatives can also assist you with the Maryland Medical Assistance application process.

Financial Assistance – Based on your circumstances and program criteria, you may qualify for full or partial assistance from Sinai Hospital. To qualify for full assistance, you must show proof of income 300% or less of the federal poverty guidelines; income between 300% - 500% of the federal poverty guidelines may qualify you for Financial Hardship Reduced Cost Care, which limits 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. The program covers uninsured patients and liability after all insurance(s) pay. Approvals are granted for twelve months. Patients are encouraged to re-apply for continued eligibility.

Extended Payment Plans – In the event that you do not qualify for Maryland Medicaid or Financial Assistance, you may be eligible for an extended payment plan for your outstanding hospital bill(s).

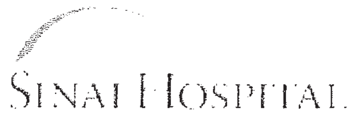
Patient's Rights and Obligations – As a patient, you will receive a uniform summary statement within thirty days of discharge. It is your responsibility to provide correct insurance information to the hospital. You have the right to receive an itemized statement and explanation of charges and to receive full information and necessary counseling on the availability of known financial resources for the care as requested. If you believe you have wrongly been referred to a collection agency, you have the right to contact the hospital to request assistance. You are obligated to pay the hospital in a timely manner. You must also take an active part in cooperating during the Medical Assistance and/or Financial Assistance application process. Additionally, you are responsible to contact the hospital if you are unable to pay your outstanding balance(s). Sinai Hospital offers flexible interest-free payment arrangements. Failure to pay or make satisfactory payment arrangements may result in your account being referred to a collection agency.

Physician and Other Charges – Physician and certain non-hospital charges are not included in the hospital bill and are billed separately.

Contact Sinai Hospital Customer Service – Our representatives are available to assist you Monday through Friday between the hours of 9:00 a.m. – 3:30 p.m. at (410) 601-1094 or (800) 788-6995.

Original Date: 06/25/09
Revision Date: 10/01/10

Appendix V



Core Purpose

- Our reason for being
- It reflects employee's idealistic motivations for dong the organization's work
- It captures the "soul" of the organization

Core Purpose Defined

Creating a healthier community one person at a time

Core Values

- Support our core purpose
- Provide the filter through which we make decisions and determine goals and strategies
- Provide continuity through change
- Sacred, deep rooted and don't change very often

Core Values Defined

Value every person

Show compassion and respect

Deliver excellence

Work together

November 2013

Mission Statements Sinai Hospital

- Maintaining and improving health
- Favored by the greatest number of patients and physicians
- Compassionate, high quality, cost-effective health services
- Provides undergraduate and graduate medical education
- Regardless of age, race, ethnicity, emphasizing Jewish values of community concern for all