FY2016

LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL OF BALTIMORE, INC.

Levindale Hebrew Geriatric Center and Hospital was founded in Baltimore City in 1890 as the Hebrew Friendly Inn and Aged Home, giving temporary shelter to the waves of incoming Jewish immigrants fleeing the pogroms of Europe. In 1927, the residents of the Hebrew Friendly Inn and Aged Home moved to a 22-acre lot at Greenspring and Belvedere Avenues in Baltimore, the former home of The Jewish Children's Society orphanage. The facility was renamed Levindale, in honor of Louis Levin, secretary of the Children's Society and first executive director of the Associated Jewish Charities.

Today, Levindale has evolved into a 330-bed multi-denominational geriatric hospital and long term care facility that offers a complete range of quality health care programs for the elderly and disabled. Programs include a nursing home, a chronic specialty hospital that provides complex/chronic care, high intensity care, medical/behavioral health services and acute rehabilitation services, , a sub-acute care unit, a partial hospitalization program (PHP), an outpatient mental health clinic and adult day services at two locations.

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

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Table I describes general characteristics of Levindale Hospital. During FY 2016, Levindale served 3,306 patients in the following settings: Chronic Specialty Hospital 1,555, Nursing Home 842, Partial Hospitalization Program (PHP) 213, Adult Day Services at Levindale 97, Adult Day Services at Pikesville 101, outpatient mental health clinic 338, Medical Clinic 77, Outpatient Rehab 59, Lamplight Assisted Living 24.

Primary Service Area

a) *Race and Ethnicity*
During the reporting period, 1,847 of the patients were White (56%), 1,365 were African American (41)% and 45 were Asian (1%) and 48 (1%) could otherwise be defined.

The racial breakdown of *all* Levindale patients does not mirror that of the surrounding community because many patients who do not live in the local 21215 zip code come to Levindale to receive long-term or specialty care services not available in the patient's home zip code. However, the racial breakdown of older adults and elders served by the Adult Day Care Center on the Levindale campus *more closely* matches the racial breakdown of the local community. In FY 2016, the Adult Day Services at Levindale served 97 individuals, 86 patients (89%) of whom were African American and 9 patients (9%) were White. This reflects the racial composition of the combined communities constituting zip code 21215 in which Levindale is located. This is in contrast to the Adult Day Services at Pikesville located in the nearby Baltimore County zip code 21208 that served 101 individuals, 47 patients (47%) of whom were African American and 45 White (45%)

b) *Age*
Approximately 3,137 (95%) of Levindale's patient population were 55 or older with very few

(nine) patients under age 25. Of the 167 patients aged 55 and younger who were treated at Levindale in FY16, 82 patients or 49% received care in the Chronic Hospital.

c) *Gender*
Women comprised 1,964 (59%) of the patient population, while men accounted for 1,339 patients (41%).

For more information about the socioeconomic characteristics of the community benefit service area (CBSA), see Table II.

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:	Percentage of the Hospital's patients who are Medicare beneficiaries
330 beds, including 120 Specialty Care, 126 comprehensive care (long-term), 35 subacute, 28 dementia care, 21 respiratory care	2397	21207 21208 21215 21133 21234 21117 21136 21209 21216 21228 21244 21206 21211 21229 21220 21236 21218 21239 21227 21212 21204	UMD St. Joseph's Mercy Johns Hopkins St. Agnes Sinai Bon Secours Franklin Square Union Memorial Hopkins Bayview Harbor Maryland General Northwest GBMC Good Samaritan	5% of all patients in FY16 living in the PSA were uninsured.	Medicaid patients accounted for 11% in FY16 living in the PSA (Including Specialty Care and Nursing Home)	Medicare Beneficiaries accounted for 74% in FY16 living in the PSA

		21221	James Kernan Mt. Washington Pediatrics Sheppard Pratt			

Table I (Top 60% of FY2016 Discharges as defined by HSCRC)

2. *Description of the Community Service Area*

Levindale is located in the northwest quadrant of Baltimore City, serving both its immediate neighbors and others from throughout the Baltimore City and County region. However, solely for the purpose of local community benefit reporting, the neighborhoods surrounding Levindale 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. Since Levindale does not have an address requirement for community benefit activity, we use the zip code 21215 as the primary CBSA designation. This 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.

For further description of the area, we rely on the data from the 2012 American Community Survey, which indicates the median household income for SPH was $27,635 and PAH's median household income was $25,397. This is compared to Baltimore City's median household income of $53,889. The percentage of families with incomes below the federal poverty guidelines in SPH was 25.9% and in PAH, 22.6%; compared to 13.5% in Baltimore City. The average unemployment rates for SPH and PAH were 26.5% and 19.6% respectively while the Baltimore City's unemployment rate recorded in 2015 was 7.4%.

The Baltimore City Health Department uses Community Statistical Areas (CSA) when analyzing health outcomes and risk factors. The CSAs represent clusters of neighborhoods based on census track data rather than zip code and were developed by the City's Planning Department based on recognizable city neighborhood perimeters.

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, PAH and SPH have a predominantly African American population at 94.4% and 95.7% respectively. This is in contrast to the neighboring Mount Washington/Coldspring community in which the median household income is $72,348 and the unemployment rate was 4.9%. The racial/ethnic composition of the MW/C community is much more complex but the population is predominantly white.

Table II

Community Benefit Service Area (CBSA) Basic Demographics (2016 Estimates)*

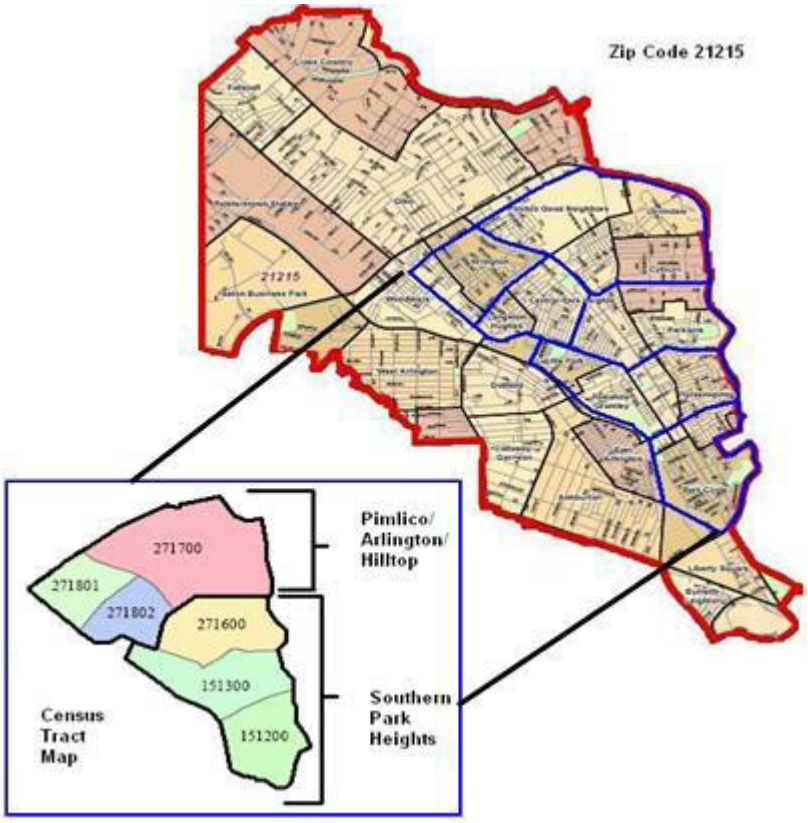
Community Benefit Service Area (CBSA) Zip Code	21215, 21207, 21208, 21209, 21117, 21216 inclusive of Community Statistical Areas of Pimlico/Arlington/Hilltop and Southern Park Heights		
Total Population within the CBSA:	**253,917**		
Sex:	Male:	116,038	45.70%
	Female:	137,879	54.30%
Age:	0-14:	49,234	19.06%
	15-17:	9,244	3.58%
	18-24:	12,853	4.97%
	25-34:	36,089	13.96%
	35-54:	31,330	12.12%
	55-64:	34,414	13.31%
	65+ :	42,628	16.49%
Ethnicity:	Hispanic or Latino:	10,571	4.09%
	Not Hispanic or Latino:	247,913	95.91%
Race:	White Alone:	76,222	29.49%
	Black Alone:	161,748	62.58%
	American Indian and Alaska Native Alone:	660	0.26%
	Asian Alone:	9,495	3.67%
	Native Hawaiian and Other Pacific Islander Alone:	166	0.06%
	Some Other Race Alone:	4,504	1.74%
	Two or More Races:	5,689	2.2%
Language Spoken At Home (Age 5+)	Speak only English	211,155	87.46%
	Speak Asian or Pacific Island Language	4,552	1.89%
	Speak Indo-European Language	12,392	5.13%
	Speak Spanish	8,000	3.31%
	Speak Other Language	5,334	2.21%

Additional Community Demographics			
Education (CBSA)	Residents with no diploma	117,982	19%
	Residents with a high school diploma	502,357	80.9%
	Residents with a bachelor's degree	172,006	27.7%
Economic (Sinai CBSA)	Median Household Income	$55,276	
	Unemployment rate	46,036	7.4%

Housing	Vacant units	44,381	43.01%
	Renter-occupied units	58,803	57%
	Owner-occupied units	129,819	20.9%
Social Environment	Homicide incidence rate	252,184	40.6%
	Domestic Violence rate	1.1	4.6%
	Alcohol store density rate	117,982	19%
Transportation	Households with no vehicles	18,047	17.49%
	Households with one vehicle	42,884	41.56%
	Households with two vehicles	31,491	30.52%
Health Insurance (Baltimore City)	Uninsured residents	24,883	9.8%
	Medicaid recipients		
Life Expectancy & Mortality	Life expectancy at birth	71.8	
	Age adjusted mortality	110.4	

*Expected updated demographic information to be available in early 2016 for the next reporting cycle.

In an effort to create better healthcare alignment and to focus attention where it is most needed, Levindale has further narrowed its 'community served' definition from the entire 21215 zip code where socially determining factors have more of an impact. Those neighborhoods are located below Northern Parkway and nearby Levindale Hospital, excluding more affluent neighborhoods above Northern Parkway. Prior to the designation of Baltimore City Health Department's Community Service Areas, local residents referred to the geographic area above Northern Parkway as Upper Park Heights, while south of the major thoroughfare was considered "Lower Park Heights" However, for the sake of reporting, we have defined, Pimlico, Arlington, Hilltop and Southern Park Heights will be considered the Park Heights community.



Park Heights, (SPH and PAH) represent six census tracts that make up a Northwest Baltimore City area categorized as a "medically underserved area/population designation" (MUA/P) according to the U.S. Department of Health and Human Services.

In addition to using demographic data that describes the general characteristics of the community, Levindale also included in its queries, social determining variables as recommended by the World Health Organization, including income, education and access to healthy foods. When including these factors, these communities exhibit other environment factors such as, high dropout rates, household income levels below the federal poverty guidelines, high unemployment rates that far exceed the national level and much less access to healthy and whole foods.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

__X__ Yes
____ No

Provide date here. 6/30 /2016 submitted to IRS.

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

(please cut and paste into a browser; if you click on the link directly, you may not get proper text)

The process used to identify health needs of LifeBridge Health's community included analyzing primary and secondary data at the community level and included public health experts, community members and key community groups in further prioritization of concerns and needs. The CHNA Team is listed below and included a host of employees across the LifeBridge Health system.

Employee Name	Department	Title
Karen Adams	Government Relations & Community Development	Administrative Assistant
Terrie Dashiell, RN	Office of Community Health Improvement (OCHI)	Program Manager
Ademola Ekulona	Community Initiatives	Program Supervisor
Joy Hall	Women's Health Education	Community Health Educator
Sharon Demarest	Government Relations & Community Development	Coordinator
Sharon Hendricks	Patient Experience at Northwest Hospital	Director
Livia Kessler	Population Health	Operations Manager
Martha Nathanson	Government Relations & Community Development	Vice President
Israel (Izzy) Patoka	Government Relations & Community Development	Director, Community Development
Jacquetta Robinson	Population Health	Health Ambassador
Carmera Thomas	Strategic Marketing & Communications	Community Outreach Coordinator
Garrick Williams	Community Initiatives	Community Outreach Worker
Darleen Won	Population Health	Director
Pamela Young, PhD*	Independent Contractor	Consultant

Review of Public Health Data

The CHNA team used publicly available data sources from national, state and local government and private organizations. This included the U.S. Census information from 2014, State of Maryland Vital Statistics from 2013, the Baltimore City Health Department neighborhood profiles from 2013, and the Baltimore County Department of Health CHNA completed in 2015. In order to supplement the public health data obtained from publicly available sources and to complete the CHNA, the team engaged with local public health partners and community residents to gather input from persons representing community interests.

Engagement with Public Health Partners and Community Human Services Partners

LifeBridge Health, Inc. initiated early talks with both Baltimore City and Baltimore County Health Departments around local health improvement plans to support the Maryland State Health Improvement Plan (SHIP). In summer 2015, a representative of the CHNA team met with Baltimore City Health Department's Chief of Epidemiology Services, Darcy Phelan-Emrick, DrPH, MHS and the Director of the Office of Policy and Planning, Shannon Mace Heller, JD, MPH to discuss recent health assessment updates to the 2011 citywide health assessment that resulted in the City's Healthy Baltimore 2015 report and Neighborhood Health Profiles. The Neighborhood Health Profiles represented the city's public health sector's own assessment of community needs throughout Baltimore City. LifeBridge Health is now actively involved in the Baltimore City Health Department's revitalized Local Health Improvement Council (LHIC).

Additionally, because LifeBridge Health hospitals are located in both Baltimore City and Baltimore County, members of the CHNA team also met with the Public Health Nurse Administrator of the Baltimore County Health Department, Laura Culbertson, RN, MSN, as well as the Baltimore County Deputy Health, Officer Della J. Leister, RN. The discussion with Baltimore County 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. LifeBridge Health also currently serves on the Baltimore County LHIC and the Baltimore County Accreditation Steering Committee.

Following LifeBridge Health's 2012 CHNA and the partnerships developed with both the Baltimore City and County Health Departments during that process, representatives of LifeBridge Health were invited to serve on the Local Health Improvement Councils of both public health departments. Involvement in those councils by hospital staff kept communication between the public health sector and LifeBridge Health active and fostered increased collaboration during the interval between the two CHNAs.

LifeBridge Health also continued and enhanced its routine practice of collaborating with community and human service partners in order to facilitate community involvement and input during the community health needs assessment process. Key partners representing the community stakeholders include: representatives from Baltimore County Recreation & Parks, Park Heights Renaissance Center, Park Heights Community Health Alliance, Liberty Road Business Association, CHAI, Manna Bible Baptist Church and a County Executive Official. Other community partners that assisted during the CHNA process or provide program support are identified in Section 6: LBH Resources and Partners. LifeBridge Health representatives attended meetings of each partner organization and sought support from each to facilitate the CHNA process. Assistance from partner organizations included spreading the word about the assessment, distributing and collecting community surveys, providing space and allocating meeting time for gathering community input on health needs and offering consistent support for other tasks as needed. In addition, partners contributed feedback and participated in the prioritization of community health needs.

Prior to the completion of the community health needs assessment, LifeBridge Health also identified clinical

and community needs based on feedback from individual hospital departments. This practice continues and offers additional clinical input identifying and prioritizing needs. Clinical input is derived from the treatment of patients and interactions with both patients and their families or caregivers. For example, hospital departments providing community benefit services continue to conduct routine assessments of patient and community needs resulting from day-to-day experiences with population groups served by the hospital.

Data Collection: Surveys and In-person Feedback

In order to gather community input on health needs as well as stakeholder representatives, the CHNA team used a two-pronged approach yielding both a written survey and in-person feedback session data.

Surveys

During the 2012 CHNA process, the CHNA team identified an existing survey tool created and used by Tanner Health System (Carrollton, Georgia). With approval, the CHNA team adapted that survey to use in the Sinai CHNA in 2012 and repeated its use again in 2015. The survey has a total of 19 questions, including 18 multiple choice questions and one additional free response question to allow for feedback on the questionnaire and additional concerns. The first section of the survey asks questions about health concerns, barriers to seeking quality health care, community needs and health information sources. The second section asks eight demographic questions, including gender, age, race, ethnicity, highest level of education and insurance status in order to capture a snapshot of the survey respondents.

The CHNA team distributed paper surveys at community events, meetings and fairs, as well as in waiting rooms, lobbies and communal spaces around various community sites within the LifeBridge Health primary service areas (PSA). Sites included community centers, restaurants, pharmacies, places of worship, etc. The team also relied upon partners to spread awareness about the survey as well as to distribute surveys for completion. All completed surveys were returned to the CHNA team located at Sinai Hospital.

In total, 1,530 surveys were collected for the entire LifeBridge Health system. A single CHNA team conducted Sinai, Levindale and Northwest Hospitals surveys, as all hospitals are in relatively close proximity and share certain PSA zip codes. Sinai and Levindale are directly across the street from each other and thus share the same geographic community in northwest Baltimore City and the bordering communities of Baltimore County; however due to the unique nature of the patients utilizing Levindale, separate PSA's were established and included from the state regulatory body known as the Health Services Cost Review Commission (HSCRC). Northwest Hospital is situated further north and west in Baltimore County. Due to this overlapping of Primary Service Area zip codes, the data analysis relied upon a second level of decision-making to categorize survey responses as 'Sinai, Levindale, or Northwest.'

When the survey respondent's residence was indicated to be in one of the overlapping zip codes, the respondent's answer to the question 'When seeking care, which [acute care] hospital would you visit first?' became the tiebreaker for categorizing responses from individuals living in a service area zip code shared by

Sinai and Northwest Hospitals. If that question was not answered, then the location where the survey was collected was the final means of attribution to the appropriate hospital.

In-Person Feedback: Community Feedback Sessions

The CHNA team worked with local partners to participate in six face-to-face community feedback sessions. Feedback sessions were open to the general public including residents and representatives from local community-based organizations, places of worship, schools, etc. Community members and stakeholders learned about the feedback sessions through a variety of mechanisms including paper flyer distribution, e-mail notices, event postings on community calendars, announcements at community meetings and gatherings, and through word of mouth. Due to the fact that the feedback sessions were scheduled to occur during regularly scheduled community meetings at partner organizations, most participants heard about the meeting through attendance at previous meetings.

The feedback sessions were at least one hour in length. During each session, CHNA team members explained the CHNA process thus far and the reason for the meeting. The facilitator on the CHNA team also reviewed the 2012 CHNA outcomes and introduced the program managers of the two community health improvement projects that were developed in response to the findings of the 2012 CHNA. Each program manager then gave a report on the program's purpose, development and outcomes to date. Following those presentations, the facilitator reported on 2015 survey findings, asked participants for their opinions on what the surveys indicated and for input on how to prioritize and address identified needs. Participants offered ideas for resources, partners and community health improvement project strategies.

In order to prioritize community health needs, the CHNA team facilitated a multi-voting exercise at the community feedback sessions. Each participant used three Post-It notes as their ballots for the health needs that they perceived to be greatest. Participants were instructed to vote by placing the Post-It notes onto flip charts posted around the meeting room. Each flip chart was labeled with a different health concern, which had been selected based on preliminary survey results of the top 6 causes of death (survey question 1) and top 6 community health concerns (survey question 2) identified by survey respondents. The CHNA team decided to present the six health conditions representing either top cause of death or top health concern to meeting participants for the voting exercise. Participants were asked to place their three votes in any distribution, weighting any health concern with more than one vote, if they wished; they could also submit write-in votes for health concerns not posted. Through this process of multi-voting, the prioritization of health needs was clearly identified and endorsed by community stakeholders, partners, and residents.

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

(please cut and paste into a browser; if you click on the link directly, you may not get proper text)

III. COMMUNITY BENEFIT ADMINISTRATION

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

_X__Yes
___No

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

i. Senior Leadership

1. ___ CEO
2. X COO Idriz Limaj,
3. _X_ CFO David Krajewski, Vice President at LifeBridge
4. _X_ Other (Michelle Mills, Director of Adult Day Services and Care Management)

Describe the role of Senior Leadership.
These members of the senior leadership team provide oversight and direction to the Population Health Department in identifying the interventions that are specifically helpful for Levindale's portion of the CBSA. Levindale's leadership directs Levindale staff in carrying out the SAFE program at Levindale, and to that end provides feedback on the need for, and the operation of, the program.

ii. Clinical Leadership

1. _X__ Physician – Ron Ginsberg, Vice President, Medical Affairs/CMO, Post-Acute Services
2. _X_ Nurse – Marian Chima, Vice President, Nursing Home Operations, Post-Acute Services, Levindale
3. _X_____Social Worker - Michelle Mills, Director Adult Day Services and Case Management
4. ___ Other (please specify)

Describe the role of Clinical Leadership
Clinical Leadership provides additional oversight and direction to the Population Health Department in identifying the interventions that are specifically helpful for

Levindale's portion of the CBSA. Levindale's clinical leadership directs Levindale staff in carrying out the SAFE program at Levindale, and to that end provides feedback on the need for, and the operation of, the program.

iii. Population Health Leadership and Staff

1. __X__ Population health VP or equivalent - Dr. Jonathan Ringo, VP of Clinical Transformation
2. __X__ Darleen Won, Director of Population Health
3. __X__ Dr. Joseph Wiley, Medical Director of Population Health

Describe the role of population health leaders and staff in the community benefit process.
Dr. Ringo leads the effort of the whole LifeBridge system to reorient its care model to focus on preventive health and to conform to increasingly value-based health care reimbursement environment. 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. Dr. Wiley provides clinical expertise to the teams that are developing or running programs aimed at improving population health.

iv. Community Benefit Operations

1. ___Individual (please specify FTE)
2. ___Committee (please list members)
3 _X__Department (Lane Levine, Population Health Project Manager, Livia Kessler, Population Health Operations Manager; Jacquetta Robinson, Health Ambassador; Reverend Domanic Smith, Pastoral Outreach Coordinator; Donielle White, Data Integration Analyst)

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, President 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 40 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. This department replaced the Community Health Education Department that was responsible for health promotion and prevention efforts at Northwest Hospital. 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.

2. 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

The activities within the report are audited through the process of creating the Population Health Infrastructure reports for the Health Services Cost Review Commission (HSCRC).

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

Spreadsheet	__X___yes	_____no
Narrative	___X__yes	_____no

If no, please explain why.

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

X__Yes
___No

2. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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. Participation in Baltimore City LHIC.
	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. Participation in Baltimore 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

3. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

<table>
<tr><td colspan="2">FY 16. Initiative 1 -Changing Hearts/ Healthy Hearts Initiative</td></tr>
<tr><td>Identified Need</td><td>Heart disease is the leading cause of death among the community. The program improves the cardiovascular health of individuals in the community that addresses prevention and wellness for clients that are pre-hypertensive. The nurse and community health worker-model enables CHP to help participants identify wellness strategies related not only to their clinical status, but also their social needs during in-home assessments. Participants are monitored based on an individualized and mutually agreed upon plan of care. They receive assistance in obtaining access to care, maintaining healthy lifestyles, and the clinical aspects of health maintenance.</td></tr>
<tr><td>Hospital Initiative</td><td>Office of Community Health Improvement – Changing Hearts</td></tr>
<tr><td># of people within target population (how many people in the target area are affected by the particular disease being addressed by the initiative)</td><td>1500 patients were flagged as pre-hypertensive based on primary blood pressure reports

*Source: Cerner HealtheIntent Comp Wellness Registry, BP Rescreen</td></tr>
<tr><td># of people reached by the initiative (how many people in the target population were served by the initiative)</td><td>70 patients were enrolled in the program</td></tr>
<tr><td>Primary Objective of the Initiative/Metrics that will be used to evaluate the results</td><td>The Changing Hearts Program includes:
Live Heart health risk assessment (Cholesterol, glucose, etc. screenings work, blood pressure reading, body composition analysis)
Health education counseling with a registered nurse
Educational materials to help facilitate lifestyle change
Follow-up calls and/or home visits with a CHW focusing on an individualized plan developed with participants
Lifestyle classes to help maintain a long-term e change
Web-based links to resources to improve cardiac health</td></tr>
<tr><td>Single or Multi-Year Initiative
Time Period</td><td>Multi-year initiative that started in conjunction with the 2012 Community Health Needs Assessment- Community Health Improvement Project, but will continue to be funded by the hospital as well as enhanced to serve more clients.</td></tr>
<tr><td>Key Partners and/or Hospitals in initiative development and/or implementation</td><td>American Heart Association
BCHD Cardiovascular Disparities Task Force
Baltimore City’s Department of Aging
Forest Park Senior Center American Stroke Association
Sandra and Malcolm Berman Brain and Spine Institute Stroke Programs at LBH
Shop Rite Howard Park,
Park Heights Community Health Alliance, and
Assorted community churches & businesses within the CSA</td></tr>
<tr><td>Outcome (Include process and impact measures)</td><td>
<table>
<tr><td colspan="3">Biometrics Outcomes</td></tr>
<tr><td>N= 70 participants</td><td>% change</td><td>Direction of change</td></tr>
<tr><td>Blood pressure</td><td>79%</td><td>⬇</td></tr>
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	<table><tr><td>BMI</td><td>83%</td><td>⬇</td></tr><tr><td>Glucose measurement</td><td>29%</td><td>⬇</td></tr><tr><td>LDL measurement*</td><td>89%</td><td>⬇</td></tr><tr><td>HDL measurement*</td><td>100%</td><td>⬇</td></tr><tr><td colspan="3">Note: cumulative changes in maintaining and improving biometric outcomes applied *N=17</td></tr></table> <table><tr><td colspan="3">Behavioral Outcomes</td></tr><tr><td>N= 70 participants</td><td>% change</td><td>Direction of change</td></tr><tr><td>Smoking habits</td><td>94%</td><td>⬇</td></tr><tr><td>Physical activity</td><td>93%</td><td>⬆</td></tr><tr><td>Nutritional concerns</td><td>66%</td><td>⬇</td></tr><tr><td>Quality of Life response</td><td>91%</td><td>⬆</td></tr><tr><td>Health Education</td><td>96%</td><td>⬆</td></tr><tr><td colspan="3">Note: cumulative changes in maintaining and improving behavioral outcomes applied</td></tr></table>
How were the outcomes evaluated?	Outcomes are based on the ability to increase personal awareness and to exhibit an improved change in lifestyle over time.
Continuation of Initiative	This program will continue.
Expense	$4,718

Initiative 2 –Community Health Education at Levindale Hospital	
Identified Need	One of the biggest concerns of the community during the CHNA performed in 2012 was health education. The program will provide a forum for the community to understand how to manage their chronic conditions and overcome barriers to self-care.
Hospital Initiative	Office of Community Health Improvement – Community Health Education
# of people within target population (how many people in the target area are affected by the particular disease being addressed by the initiative)	121,159 patients between the ages of 18 and 74 years
# of people reached by the initiative (how many people in the target population were served	1307 patients were educated through forums and health fairs

by the initiative)	
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	- Provide health educational offerings to the community to understand lab results, managing medication, stress management, healthy eating and physical activity - Provide tools for dealing with hypertension and other components of metabolic syndrome - Create avenues for community members to request health education - Provide community based offerings that will render health-related services and information
Single or Multi-Year Initiative **Time Period**	Multi-year initiative.
Key Partners and/or Hospitals in initiative development and/or implementation	• American Heart Association • BCHD Cardiovascular Disparities Task Force • Baltimore City's Department of Aging • Forest Park Senior Center American Stroke Association • Sandra and Malcolm Berman Brain and Spine Institute Stroke Programs at LBH • Shop Rite Howard Park, • Park Heights Community Health Alliance, and • Assorted community churches & businesses within the CSA
Outcome (Include process and impact measures)	6 community-based forums were attended 260 hours of community health fair hours were attended and risk assessments were provided 200% CHNA community-based forums were provided
How were the outcomes evaluated?	Outcomes are based on improvement in participant's understanding of how to manage their health and their ability to exhibit an improved change in lifestyle
Continuation of Initiative	This program will continue.
Expense	$9,559

Initiative 3 – Stop Abuse of Elders	
Identified Need	Prevention and Treatment of Elder Abuse
Hospital Initiative	Stop Abuse of Elders (SAFE)
# 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)	2
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	To establish an interagency response to elder abuse in the Jewish community by creating a SAFE Program for the treatment and prevention of elder abuse. This collaboration assures the community of an effective and coordinated response for victims, perpetrators, and their families and provides prevention education for the entire community.

	To provide a comprehensive approach will include: crisis intervention, shelter, psychotherapy, advocacy, service coordination and community education. This report only addresses Levindale's contribution, which is the provision of shelter for abuse victims
Single or Multi-Year Initiative Time Period	Multi-year initiative.
Key Partners and/or Hospitals in initiative development and/or implementation	• CHANA • Jewish Community Services • Maryland Department of Aging
Outcome (Include process and impact measures)	2 people received shelter in FY 2016
How were the outcomes evaluated?	The number of clients who receive shelter from elder abuse
Continuation of Initiative	This program will continue.
Expense	$4,954

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

Because Levindale is designated as a geriatric center, does not provide acute care services and serves a much older population compared to its sister hospitals, Sinai and Northwest Hospitals, that provide acute care services and serve a more age-diverse population, many responses to community health needs will be addressed at the system level, involving all three LifeBridge Health hospitals. The following health needs that were identified as priorities by the CHNA can already be addressed within the LifeBridge Health System:

- Cancer - The Alvin & Lois Lapides Cancer Institute at Sinai and Northwest is a comprehensive cancer center providing treatment and support to patients and families as well as community education. The Freedom to Screen program at 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).
- Drug & Alcohol Abuse - Sinai Hospital Addiction Recovery Program provides outpatient treatment and education to those uninsured and under-insured individuals with addictions to drugs and alcohol.
- HIV/AIDS - Sinai's Infectious Disease Ambulatory Center provides treatment to HIV+ persons, including those who are uninsured, and the HIV support services provide outreach & access to care, counseling and other support services to HIV+ adults, children and youth.
- Mental Health – Levindale provides outpatient behavioral health services including a Partial Hospitalization Program (PHP) and Outpatient Services (OPS) dedicated to providing effective, outpatient gero-psychiatric treatment to older adults (usually 60 or older) who are experiencing behavioral or emotional difficulties.

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

The ultimate goals of Levindale'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 Levindale to reduce readmission rates and high utilization of the emergency department for non-emergency services.

VI.PHYSICIANS

1. Gaps in the Availability of Specialist Providers:

   Levindale, a chronic hospital and part of the LifeBridge Health System benefits from its affiliation with Sinai and Northwest Hospitals. As a teaching hospital, Sinai has accredited, non-university-affiliated residency training programs and employs a faculty of 140 physicians in several specialties. Northwest hospital has an attending staff of approximately 700 physicians. As a result, specialist services at Levindale are readily available in cardiology, pulmonary, neurology and infectious disease. Additionally, in those specialties in which those hospitals do not have staff, such as Dentistry, Levindale contracts with a community provider to offer on-site clinic services based on patient needs.
   Although Levindale does not have an Emergency Department through which to accept admissions, patients from the LBH affiliated hospitals are routinely transferred to Levindale for additional care and services. These transfers and patient care decisions are made without consideration of ability to pay for services.

2. Physician Subsidies

Category of Subsidy	**Explanation of Need for Service**	**Amount**
Hospital-Based physicians	n/a	-
Non-Resident House Staff and Hospitalists	SNFist coervage	1,477,851
Coverage of Emergency Department Call	n/a	-
Physician Provision of Financial Assistance	n/a	-
Physician Recruitment to Meet Community Need	n/a	-
Other – (provide detail of any subsidy not listed above – add more rows if needed)	n/a	-

Appendix I

LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL

FINANCIAL ASSISTANCE PROCEDURE

Financial Assistant information sheet is given on all new admissions. Financial Assistance information signs are posted in the Patient Access areas. Brochures are available in PFS.

WHEN CAN THE PATIENT APPLY:
The patient can apply at any time before or after they receive care or upon receipt of Insurance denials that meet medical necessity.
Levindale's referrals that are unisured or under-insured are screened by PFS FC for Financial Assistance.
Patient Billing that not paid are screened by PFS CC for Financial Assistance.

US Department of Health and Human Services Revised Poverty Guidelines- effective January 24, 2014

Size of Family	Income
1	$11,670
2	$15,730
3	$19,790
4	$23,850
5	$27,910
6	$31,970
7	$36,030
8	$40,090

For family units with more than 8 members, add $4,060 for each additional member.

ELIGIBILITY:

- If resident's income is less than the current Poverty guidelines, facility services may be free.
- A copy of the Poverty Guidelines issued by the Dept. of Health and human Services will tell the patient what income levels qualify for free care.
- Levindale request information to verify eligibility, such as proof of income.
- Levindale facilities will make a determination of patient eligibility within a set time frame. The time frames will depend on when a request is made and on whether the services are provided in the hospital, nursing home, Adult Day Care or Partialization Program.
- Levindale provides applicants verification which says either when the patient may obtain reduced or free care or why they have been denied.

REASONS FOR DENYING CHARITY CARE:

- Levindale may deny a patient's request upon receipt of income verification and the income exceeds the Poverty Guidelines
- If the patient does not provide Levindale with proof of income, such as a pay stub or Social Security Award Letter.
- If the services requested or received is to be paid by Medicare/Medicaid, Insurance or other financial assistance programs

IMPLEMENTATION PROCEDURES:

Pre-admission Interviews

- Prior to admission the Admission Department will contact the Financial Counselor on residents being admitted without an insurance.
- Within 10 days of the admission the Financial Counselor meets the Responsible Party/Patient to review the Financial Packet. The Financial Packet is a questionaire to determine assets/income.
- When its determined that Medical Assistance is needed the Responsible Party/Patient will meet with the Medicaid Coordinator and an appointment for DSS will be completed.
- If the patient does not qualify for Medical Assistance, the Medicaid Coordinator will determine the charge for services based on day x rate and bill as self-pay until spend down is accomplished. Process for Medical Assistance will start again
- When it is determined that no Insurance is available for the inpatient services the Financial packet will be completed and will then follow the Poverty Guidelines.

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.

Appendix III

LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL POLICIES AND PROCEDURE MANUAL

POLICY/PROCEDURE NUMBER:	**6.2.1**
POLICY/PROCEDURE NAME:	**Financial Assistance**
APPROVED BY:	**Maggie Morgan-Lamb/Anthony K. Morris**
EFFECTIVE DATE:	**October 2010**

RESPONSIBLE PARTY:

The Patient Accounting and Patient Access Departments at Levindale

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 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.

Financial Assistance information is 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, Patient Accounting, as well as other patient access points throughout the facilities within Levindale, and 3) patient statements.

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

The Board of Directors shall review and approve the Financial Assistance Policy every two years. The Hospital may not alter its Financial Assistance Policy in any 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/Nursing Home will be referred to a the Financial Coordinator (FC), or Billing Coordinator (BC) or the Patient Account Manager (PAM) in the Patient Accounting Department.

3. For inpatient visits the FC, BC and PAM will work with the Medicaid Coordinators 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 Medicaid Coordinator 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 case will be referred to the PAM to arrange for payment from the patient following the Hospital's/Nursing Home's payment arrangement guidelines.

6. If the patient does not have the financial resources according to the Guidelines, the PAM 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 PAM 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 the twelve (12) months preceding the date of the application at Levindale 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, Levindale, Courtland Gardens Nursing and Rehabilitation Center. 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.
   c. The PAM 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 on or after October 1, 2010, 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 on or after October 1, 2010, 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, 2012, will be eligible through May 31, 2013.
g. Outpatient procedures, including multiple procedures as part of a treatment plan, may be certified for one time only.
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/Nursing Home 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/Nursing Home, 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/Nursing Home 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 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, Patient Accounting
$25,000.00 +	Vice President, 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/Nursing Home 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, patient access registers at all areas of Levindale 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 patient access registers at all areas of Levindale will schedule the services as a self-pay. The Financial Counselor for inpatient and the designee for outpatient 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 registrars within all areas of Levindale will determine if the patient is currently pending Medicaid as defined with 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, the PAM will determine patient's ability to pay. Refer to #2 and #3 in this section.

   Admissions are referred to the Vice President/CNO for approval
   Outpatient services are referred to the Director of the Outpatient Program for approval

   The Financial application must be completed upon admission or prior to receiving outpatient services and sent to the Director of Patient Accounting. If the patient is unable to complete the application it is mailed to the patient at their home. If the patient is not cooperative and does not complete the application or provide the required documentation, Financial Assistance is denied.

2. Written estimates are provided on request from an active or scheduled patient made before or during treatment. The Hospital/Nursing Home is not required to provide written estimates to individuals shopping for services. The Hospital/Nursing Home shall provide to the patient a written estimate of the total charges for the inpatient and outpatient 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/Nursing Home may restrict the availability of a written estimate to normal business office hours. The Patient Account Manager or the designee for the outpatient areas 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 CFO/Senior Vice President 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 Installment Agreement Letter (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 Installment Agreement Letter, the Director of Patient Accounting is to be notified to determine next steps.

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 CFO/Senior Vice President. 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 Access. The Vice President of Revenue Cycle and/or the CFO/Senior Vice President 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/Nursing Home 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, Levindale and Courtland Gardens Nursing and Rehabilitation Center. 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; Intensive Outpatient Psychiatric Block Grant; 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: Qualifications for Financial Assistance (Attachment #7) must be completed. The Director of Patient Accounting 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, Patient Accounting
$25,000.00 +	Vice President, Revenue Cycle

D. Collection Agency Procedures

1. Written communication to Early Out Self-Pay (EOS) patients contains language regarding the Hospital's/Nursing Home's Financial Assistance Program and contact information.

2. The initial communication to Bad Debt referrals contains language regarding the Hospital's/Nursing Home's Financial Assistance Program and contact information.

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 resume its collection activity if patient is non-compliant with timely completion and return of the application. Agency will be notified upon the Hospital's determination of approval or denial.

E. Patient Refunds

1. Effective with dates of service October 1, 2010, the Hospital/Nursing Home 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/Nursing Home 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/nursing home 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/nursing home 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/Nursing Home 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/nursing home, whichever is most favorable for the patient. Previous amounts paid in accordance with a payment contract will not be considered refundable.

DOCUMENTATION/APPENDICES:

Attachment #1	Maryland State Uniform Financial Assistance Application
Attachment #2	Financial Assistance Cover Letter
Attachment #3	Financial Assistance Calculation Sheet
Attachment #4	Financial Assistance Eligibility Determination Letter
Attachment #5	Financial Assistance Presumptive Eligibility Determination Letter
Attachment #6	Installment Agreement Letter
Attachment #7	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: 7/99
Revised Date: 1/04, 1/05, 10/05, 1/06, 1/07, 11/07, 1/08, 1/09, 1/10, 10/10, 4/13, 6/14

Approvals:

Name:	Title:
Barry Eisenberg	Executive Director/COO
David Krajewski	CFO/Senior Vice President
Anthony K. Morris	Vice President/Revenue Cycle

Barry Eisenberg _____ _____
Executive Director/COO Date

David Krajewski _____ _____
CFO/Senior Vice President Date

_____ _____
Anthony K. Morris Vice President, Revenue Cycle Date

Board of Directors Approval _____ _____
Date

Appendix IV

LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL
PATIENT INFORMATION SHEET

Levindale 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

Levindale Hospital Patient Accounting department can also assist you with the Maryland Medical Assistance application process. Please contact April Todd Medicaid Manager at 410-601-2396 for further information

Financial Assistance – Based on your circumstances and program criteria, you may qualify for full or partial assistance from Levindale 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). Levindale 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 Levindale Hospital Patient Accounting Department – Our representatives available to assist you Monday through Friday between the hours of 9:00 a.m. – 3:30 p.m. at (410) 601- 2399 or (410) 601 – 2182 or (410) 601-2213.

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

Mission Values Vision

Our Mission

Levindale is a geriatric center and hospital dedicated to providing superior service for the aged, frail and ill in institutional, community and home settings. As an advocate for the elderly, Levindale accepts a leadership role in defining and developing, in collaboration with other agencies, a comprehensive continuum of nursing, medical and social services within the Jewish community of the Baltimore metropolitan area. Programs are operated within the values inherent in Judaism pursuant to Levindale's charter. As part of our Eden Alternative and Neighborhood Model programs, we are committed to creating an environment that promotes the celebration of life. L'Chaim (to Life).

Our Vision

Levindale will expand upon our capacities to be the leader of the community's post-acute and elder care service continuum. We will continue to be committed to developing and providing innovative services for residents and their families in organizational and community settings.

As part of our vision, we embraced the ten principles of the Eden Alternative philosophy and continue to turn the Neighborhood Model into a reality. We will continue to find fresh, inventive ways to bring variety, spontaneity, empowerment and companionship into the daily life of our community.

Our Values

- Our existence is built on Judaic values and beliefs.
- We are committed to the highest standards of quality care and excellence in service.
- We hold respect for people.
- We deliver care in a cost-effective manner.
- We will serve the needs of the community.
- We are dedicated to advancement through education and research.