Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

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

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

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

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

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

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Johns Hopkins Bayview Medical Center	◉	○	
Your hospital's ID is: 210029	◉	○	
Your hospital is part of the hospital system called Johns Hopkins Heath System	◉	○	
The primary Narrative contact at your hospital is Sharon Tiebert-Maddox	◉	○	
The primary Narrative contact email address at your hospital is tiebert@jhu.edu	◉	○	
The primary Financial contact at your hospital is Sharon Tiebert-Maddox	◉	○	
The primary Financial email at your hospital is tiebert@jhu.edu	◉	○	

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

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

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

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

In 2015, the Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC) merged their respective Community Benefit Service Areas (CBSA) in order to better integrate community health and community outreach across the East and Southeast Baltimore City and County region. The geographic area contained within the nine ZIP codes includes 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, and 21231. This area reflects the population with the largest usage of the emergency departments and the majority of recipients of community contributions and programming. Within the CBSA, JHH and JHBMC have focused on certain target populations such as the elderly, at-risk children and adolescents, uninsured individuals and households, and underinsured and low-income individuals and households. The CBSA covers approximately 27.9 square miles within the City of Baltimore or approximately thirty-four percent of the total 80.94 square miles of land area for the city and 25.6 square miles in Baltimore County. In terms of population, an estimated 305,895 people live within CBSA, of which the population in City ZIP codes accounts for thirty eight percent of the City's population and the population in County ZIP codes accounts for eight percent of the County's population (2020 Census estimate of Baltimore City population, 585,708, and Baltimore County population, 854,535). Within the CBSA, there are three Baltimore County neighborhoods - Dundalk, Sparrows Point, and Edgemere. Baltimore City is truly a city of neighborhoods with over 270 officially recognized neighborhoods. The Baltimore City Department of Health has subdivided the city area into 23 neighborhoods or neighborhood groupings that are completely or partially included within the CBSA. These neighborhoods are Belair-Edison, Canton, Cedonia/Frankford, Claremont/Armistead, Clifton-Berea, Downtown/Seton Hill, Fells Point, Greater Charles Village/Barclay, Greater Govans, Greenmount East (which includes neighborhoods such as Oliver, Broadway East, Johnston Square, and Gay Street), Hamilton, Highlandtown, Jonestown/Oldtown, Lauraville, Madison/East End, Midtown, Midway-Coldstream, Northwood, Orangeville/East Highlandtown, Patterson Park North & East, Perkins/Middle East, Southeastern, and The Waverlies. The Johns Hopkins Hospital is in the neighborhood called Perkins/Middle East, and the neighborhoods that are contiguous to Perkins/Middle East include Greenmount East (including Oliver, Broadway East, Johnston Square, and Gay Street), Clifton-Berea, Madison/East End, Patterson Park North & East, Fells Point, Canton, and Jonestown/Oldtown. Residents of most of these neighborhoods are primarily African American, with the exceptions of Fells Point, which is primarily white, and Patterson Park North & East, which represents a diversity of resident ethnicities. With the exceptions of Fells Point, Canton, and Patterson Park N&E, the median household income of most of these neighborhoods is significantly lower than the Baltimore City median household income. Median income in Fells Point, Canton, and Patterson Park N&E skews higher, and there are higher percentages of white households having higher median incomes residing in these neighborhoods. In southeast Baltimore, the population demographics have historically trended as white middle-income, working-class communities, Highlandtown, Southeastern, Orangeville/E. Highlandtown; however, in the past few decades, Southeast Baltimore has become much more diverse with a growing Latino population clustered around Patterson Park, Highlandtown, Orangeville/E. Highlandtown. Median incomes in these neighborhoods range from significantly below the City median in Southeastern to well above the median in Highlandtown. In Baltimore County, largely served by JHBMC, Dundalk, Sparrows Point, and Edgemere have been predominantly white with increasing populations of Hispanic and African American residents. Neighborhoods farther north of the Johns Hopkins Hospital include Belair-Edison, Cedonia/Frankford, Claremont/Armistead, CliftonBerea, Greater Charles Village/Barclay, Greater Govans, Hamilton, Lauraville, Midtown, Midway-Coldstream, Northwood, and The Waverlies. Residents of these neighborhoods are racially more diverse than in the neighborhoods closest to JHH and median household incomes range from significantly above the median to close to the median household income for Baltimore City. Since the end of the Second World War, the population of Baltimore City has been leaving the city to the surrounding suburban counties. This demographic trend accelerated in the 1960s and 1970s, greatly affecting the neighborhoods around the Johns Hopkins Hospital and JHBMC. As the population of Baltimore City dropped, there has been a considerable disinvestment in housing stock in these neighborhoods. Economic conditions that resulted in the closing or relocation of manufacturing and industrial jobs in Baltimore City and Baltimore County led to higher unemployment in the neighborhoods around the Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, and social trends during the 1970s and 1980s led to increases in substance abuse and violent crime as well. Greater health disparities are found in these neighborhoods closest to the Hospitals compared to Maryland state averages and surrounding county averages. The June 2012 Charts of Selected Black vs. White Chronic Disease SHIP Metrics for Baltimore City prepared by the Maryland Office of Minority Health and Health Disparities highlights some of these health disparities including higher emergency department visit rates for asthma, diabetes, and hypertension in blacks compared to whites, higher heart disease and cancer mortality in blacks than whites, higher rates of adult smoking, and lower percentages of adults at a healthy weight.

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

JHBMC CBSA 2021 Final.pdf
1.5MB
application/pdf

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

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

☐ 21201	☐ 21212	☐ 21225	☐ 21237
☑ 21202	☑ 21213	☐ 21226	☐ 21239
☐ 21203	☐ 21214	☐ 21227	☐ 21251
☑ 21205	☐ 21215	☐ 21228	☐ 21263
☑ 21206	☐ 21216	☐ 21229	☐ 21270
☐ 21207	☐ 21217	☐ 21230	☐ 21278
☐ 21208	☑ 21218	☑ 21231	☐ 21281
☐ 21209	☑ 21222	☐ 21233	☐ 21287
☐ 21210	☐ 21223	☐ 21234	☐ 21290

- [ ] 21211
- [x] 21224
- [ ] 21236

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

- [ ] 21013
- [ ] 21020
- [ ] 21022
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- [ ] 21252
- [ ] 21282
- [ ] 21284
- [ ] 21285
- [ ] 21286

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

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

  21202, 21205, 21213, 21219, 21222, 21224, 21231 are the ZIP codes in our GBR agreement
- [ ] Based on patterns of utilization. Please describe.
- [x] Other. Please describe.

  21218 and 21206 have also been included in the hospital CBSA in the past based on utilization and community health needs.

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

https://www.hopkinsmedicine.org/johns_hopkins_bayview/about_hospital/mission_vision_values.html

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

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

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

- (●) Yes
- ( ) No

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

This question was not displayed to the respondent.

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

05/24/2021

Q41. Please provide a link to your hospital's most recently completed CHNA.

https://www.hopkinsmedicine.org/about/community_health/johns-hopkins-bayview/health_needs_initiatives/community_health_needs_assessment.html

Q42. Please upload your hospital's most recently completed CHNA.

2021-community-needs.pdf
8.2MB
application/pdf

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

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

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

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

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

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

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

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

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

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

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

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

Refer to the FY 2021 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is optional for FY 2021, but will be mandatory for FY 2022.

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

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

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

Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes

Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress

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

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

- (●) Yes
- ( ) No

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

05/24/2021

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

https://www.hopkinsmedicine.org/about/community_health/johns-hopkins-bayview/health_needs_initiatives/community_health_needs_assessment.html

Q222. Please upload your hospital's CHNA implementation strategy.

2021-community-needs.pdf
8.2MB
application/pdf

Q53. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q54. Please select the CHNA Priority Area Categories most relevant to your most recent CHNA. The list of categories is based on the Healthy People 2030 objectives available here. This list is not exhaustive. Please select "other" and describe any CHNA Priority Area Categories that are not captured by this list. Select all that apply even if a need was not addressed by a reported initiative.

- [x] Health Conditions - Addiction
- [x] Health Conditions - Arthritis
- [x] Health Conditions - Blood Disorders
- [x] Health Conditions - Cancer
- [x] Health Conditions - Chronic Kidney Disease
- [x] Health Conditions - Chronic Pain
- [x] Health Conditions - Dementias
- [x] Health Conditions - Diabetes
- [ ] Health Conditions - Foodborne Illness
- [x] Health Conditions - Health Care-Associated Infections
- [x] Health Conditions - Heart Disease and Stroke
- [x] Health Conditions - Infectious Disease
- [x] Health Conditions - Mental Health and Mental Disorders
- [x] Health Conditions - Oral Conditions
- [x] Health Conditions - Osteoporosis
- [x] Health Conditions - Overweight and Obesity
- [ ] Health Conditions - Pregnancy and Childbirth
- [x] Health Behaviors - Drug and Alcohol Use
- [ ] Health Behaviors - Emergency Preparedness
- [ ] Health Behaviors - Family Planning
- [x] Health Behaviors - Health Communication
- [ ] Health Behaviors - Injury Prevention
- [x] Health Behaviors - Nutrition and Healthy Eating
- [x] Health Behaviors - Physical Activity
- [x] Health Behaviors - Preventive Care
- [ ] Health Behaviors - Safe Food Handling
- [ ] Health Behaviors - Sleep
- [x] Health Behaviors - Tobacco Use
- [ ] Health Behaviors - Vaccination
- [x] Health Behaviors - Violence Prevention
- [x] Populations - Adolescents
- [x] Populations - Children
- [x] Populations - Infants
- [ ] Populations – LGBT
- [x] Populations - Women
- [x] Populations - Workforce
- [x] Settings and Systems - Community
- [ ] Settings and Systems - Environmental Health
- [ ] Settings and Systems - Global Health
- [x] Settings and Systems - Health Care
- [x] Settings and Systems - Health Insurance
- [x] Settings and Systems - Health IT
- [x] Settings and Systems - Health Policy
- [x] Settings and Systems - Hospital and Emergency Services
- [x] Settings and Systems - Housing and Homes
- [ ] Settings and Systems - Public Health Infrastructure
- [x] Settings and Systems - Schools
- [x] Settings and Systems - Transportation
- [x] Settings and Systems - Workplace
- [x] Social Determinants of Health - Economic Stability
- [x] Social Determinants of Health - Education Access and Quality

- [x] Health Conditions - Respiratory Disease
- [ ] Health Conditions - Sensory or Communication Disorders
- [ ] Health Conditions - Sexually Transmitted Infections
- [ ] Health Behaviors - Child and Adolescent Development
- [x] Populations - Men
- [x] Populations - Older Adults
- [x] Populations - Parents or Caregivers
- [x] Populations - People with Disabilities
- [x] Social Determinants of Health - Health Care Access and Quality
- [x] Social Determinants of Health - Neighborhood and Built Environment
- [x] Social Determinants of Health - Social and Community Context
- [ ] Other (specify)

Q56. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q57. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q58. Section II - CHNAs and Stakeholder Involvement Part 6 - Initiatives

Q59. Please use the questions below to provide details regarding the initiatives to address the CHNA Priority Area Categories selected in the previous question.

For those hospitals completing the ***optional*** CHNA financial reporting in FY 2021, please ensure that these tie directly to line item initiatives in the financial reporting template.

For those hospitals **not** completing the ***optional*** CHNA financial template, please provide this information for as many initiatives as you deem feasible.

Please note that hospitals will be required to report on each CHNA-related initiative in FY 2022.

Q163. Please describe the initiative(s) addressing Health Conditions - Addiction.

	Health Conditions - Addiction Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Screening, Brief Intervention and Referral to Treatment in the Emergency Room (SBIRT)	Screening, Brief Intervention and Referral to Treatment (SBIRT) in the Emergency Department is provided for all patients upon triage using the Audit-C tool. Patients who screen for brief intervention are seen by the Peer Recovery Specialist and if ready are referred to treatment. The goal of this program is to use an evidence-based intervention to link patients with substance use d/o to treatment.	FY21 SBIRT # - 24,987 encounters Brief Intervention # - 840 Referral for treatment # - 813	Outcomes tracked are: 1. Number of SBIRT in the ED 2. Reduction of readmissions for opioid use disorder and alcohol use disorder 3. Number of patients referred for treatment
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q182. Please describe the initiative(s) addressing Health Conditions - Arthritis.

	Health Conditions - Arthritis Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				

Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q183. Please describe the initiative(s) addressing Health Conditions - Blood Disorders.

	Health Conditions - Blood Disorders Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q184. Please describe the initiative(s) addressing Health Conditions - Cancer.

	Health Conditions - Cancer Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q185. Please describe the initiative(s) addressing Health Conditions - Chronic Kidney Disease.

	Health Conditions - Chronic Kidney Disease Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				

Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q186. Please describe the initiative(s) addressing Health Conditions - Chronic Pain.

	Health Conditions - Chronic Pain Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q187. Please describe the initiative(s) addressing Health Conditions - Dementias.

	Health Conditions - Dementias Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q188. Please describe the initiative(s) addressing Health Conditions - Diabetes.

	Health Conditions - Diabetes Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q189. Please describe the initiative(s) addressing Health Conditions - Foodborne Illness.

This question was not displayed to the respondent.

Q190. Please describe the initiative(s) addressing Health Conditions - Health Care-Associated Infections.

	Health Conditions - Health Care-Associated Infections Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q191. Please describe the initiative(s) addressing Health Conditions - Heart Disease and Stroke.

	Health Conditions - Heart Disease and Stroke Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q192. Please describe the initiative(s) addressing Health Conditions - Infectious Disease.

	Health Conditions - Infectious Disease Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q193. Please describe the initiative(s) addressing Health Conditions - Mental Health and Mental Disorders.

Health Conditions - Mental Health and Mental Disorders Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q194. Please describe the initiative(s) addressing Health Conditions - Oral Conditions.

Health Conditions - Oral Conditions Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q195. Please describe the initiative(s) addressing Health Conditions - Osteoporosis.

Health Conditions - Osteoporosis Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q196. Please describe the initiative(s) addressing Health Conditions - Overweight and Obesity.

Health Conditions - Overweight and Obesity Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				

Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q197. Please describe the initiative(s) addressing Health Conditions - Pregnancy and Childbirth.

This question was not displayed to the respondent.

Q198. Please describe the initiative(s) addressing Health Conditions - Respiratory Disease.

	Health Conditions - Respiratory Disease Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Lung Health Ambassadors	The LHAP is intended to teach students (from 7th grade to 12th grade) about the lungs, lung health, and risk factors that impact the lungs. These conversations are emphasized around health disparities, discussing how these lung risk factors and outcomes impact certain populations more than others. Each class is taught with one of the science teachers of the schools and a physician (specifically, Chest member, Dr. Panagis Galiatsatos). The LHAP for the school year 2021-2022 will focus on cystic fibrosis, with special attention to recognizing that it can impact any race and ethnicity, while also teaching the students how to take a comprehensive family history (whereby concerns for things like cystic fibrosis may become apparent.)	5 classes underway, 92 students currently involved	Attendance in class, advocacy project through social media post class
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q199. Please describe the initiative(s) addressing Health Conditions - Sensory or Communication Disorders.

This question was not displayed to the respondent.

Q200. Please describe the initiative(s) addressing Health Conditions - Sexually Transmitted Infections.

This question was not displayed to the respondent.

Q201. Please describe the initiative(s) addressing Health Behaviors - Child and Adolescent Development.

This question was not displayed to the respondent.

Q202. Please describe the initiative(s) addressing Health Behaviors - Drug and Alcohol Use.

	Health Behaviors - Drug and Alcohol Use Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Screening, Brief Intervention and Referral to Treatment in the Emergency Room (SBIRT)	Screening, Brief Intervention and Referral to Treatment (SBIRT) in the Emergency Department is provided for all patients upon triage using the Audit-C tool. Patients who screen for brief intervention are seen by the Peer Recovery Specialist and if ready are referred to treatment. The goal of this program is to use an evidence-based intervention to link patients with substance use d/o to treatment.	FY21 SBIRT # - 24,987 encounters Brief Intervention # - 840 Referral for treatment # - 813	Outcomes tracked are: 1. Number of SBIRT in the ED 2. Reduction of readmissions for opioid use disorder and alcohol use disorder 3. Number of patients referred for treatment
Initiative B				

Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q203. Please describe the initiative(s) addressing Health Behaviors - Emergency Preparedness.

This question was not displayed to the respondent.

Q204. Please describe the initiative(s) addressing Health Behaviors - Family Planning.

This question was not displayed to the respondent.

Q205. Please describe the initiative(s) addressing Health Behaviors - Health Communication.

	Health Behaviors - Health Communication Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q206. Please describe the initiative(s) addressing Health Behaviors - Injury Prevention.

This question was not displayed to the respondent.

Q207. Please describe the initiative(s) addressing Health Behaviors - Nutrition and Healthy Eating.

	Health Behaviors - Nutrition and Healthy Eating Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q208. Please describe the initiative(s) addressing Health Behaviors - Physical Activity.

Health Behaviors - Physical Activity Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q209. Please describe the initiative(s) addressing Health Behaviors - Preventive Care.

Health Behaviors - Preventive Care Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Lung Health Ambassadors Program	The LHAP is intended to teach students (from 7th grade to 12th grade) about the lungs, lung health, and risk factors that impact the lungs. These conversations are emphasized around health disparities, discussing how these lung risk factors and outcomes impact certain populations more than others. Each class is taught with one of the science teachers of the schools and a physician (specifically, Chest member, Dr. Panagis Galiatsatos). The LHAP for the school year 2021-2022 will focus on cystic fibrosis, with special attention to recognizing that it can impact any race and ethnicity, while also teaching the students how to take a comprehensive family history (whereby concerns for things like cystic fibrosis may become apparent.)	5 classes underway, 92 students currently involved	Attendance in class, advocacy project through social media post class
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q210. Please describe the initiative(s) addressing Health Behaviors - Safe Food Handling.

This question was not displayed to the respondent.

Q211. Please describe the initiative(s) addressing Health Behaviors - Sleep.

This question was not displayed to the respondent.

Q212. Please describe the initiative(s) addressing Health Behaviors - Tobacco Use.

Health Behaviors - Tobacco Use Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				

Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q213. Please describe the initiative(s) addressing Health Behaviors - Vaccination.

This question was not displayed to the respondent.

Q214. Please describe the initiative(s) addressing Health Behaviors - Violence Prevention.

	Health Behaviors - Violence Prevention Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q215. Please describe the initiative(s) addressing Populations - Adolescents.

	Populations - Adolescents Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Lung Health Ambassadors	The LHAP is intended to teach students (from 7th grade to 12th grade) about the lungs, lung health, and risk factors that impact the lungs. These conversations are emphasized around health disparities, discussing how these lung risk factors and outcomes impact certain populations more than others. Each class is taught with one of the science teachers of the schools and a physician (specifically, Chest member, Dr. Panagis Galiatsatos). The LHAP for the school year 2021-2022 will focus on cystic fibrosis, with special attention to recognizing that it can impact any race and ethnicity, while also teaching the students how to take a comprehensive family history (whereby concerns for things like cystic fibrosis may become apparent.)	5 classes underway, 92 students currently involved	Attendance in class, advocacy project through social media post class
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q216. Please describe the initiative(s) addressing Populations - Children.

	Populations - Children Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				

Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q217. Please describe the initiative(s) addressing Populations - Infants.

	Populations - Infants Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q218. Please describe the initiative(s) addressing Populations - LGBT.

This question was not displayed to the respondent.

Q219. Please describe the initiative(s) addressing Populations - Men.

	Populations - Men Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Screening, Brief Intervention and Referral to Treatment in the Emergency Room (SBIRT)	Screening, Brief Intervention and Referral to Treatment (SBIRT) in the Emergency Department is provided for all patients upon triage using the Audit-C tool. Patients who screen for brief intervention are seen by the Peer Recovery Specialist and if ready are referred to treatment. The goal of this program is to use an evidence-based intervention to link patients with substance use d/o to treatment.	FY21 SBIRT # - 24,987 encounters Brief Intervention # - 840 Referral for treatment # - 813	Outcomes tracked are: 1. Number of SBIRT in the ED 2. Reduction of readmissions for opioid use disorder and alcohol use disorder 3. Number of patients referred for treatment
Initiative B	Population Health Workforce Support for Disadvantaged Areas	BPHWC is designed to provide the training needed to fill new health care jobs, while also improving the health of high poverty communities BPHWC will target high poverty communities throughout Baltimore City to recruit, train, and hire residents for 198 newly established entry level core jobs over three years. Individual hospitals will establish 35 other new positions related to BPHWC, to include social workers, care coordinators, for a total of 233 new jobs.	10 essential skills training, 6 technical training, no new hires, 15 retained employees (11 CHWs, 4 PRS)	#s trained, successfully credentialed, and hired/retained. BACH tracks workforce training effectiveness.
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				

All Other Initiatives				

Q220. Please describe the initiative(s) addressing Populations - Older Adults.

	Populations - Older Adults Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q221. Please describe the initiative(s) addressing Populations - Parents or Caregivers.

	Populations - Parents or Caregivers Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q222. Please describe the initiative(s) addressing Populations - People with Disabilities.

	Populations - People with Disabilities Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q223. Please describe the initiative(s) addressing Populations - Women.

	Populations - Women Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Screening, Brief Intervention and Referral to Treatment in the Emergency Room (SBIRT)	Screening, Brief Intervention and Referral to Treatment (SBIRT) in the Emergency Department is provided for all patients upon triage using the Audit-C tool. Patients who screen for brief intervention are seen by the Peer Recovery Specialist and if ready are referred to treatment. The goal of this program is to use an evidence-based intervention to link patients with substance use d/o to treatment.	FY21 SBIRT # - 24,987 encounters Brief Intervention # - 840 Referral for treatment # - 813	Outcomes tracked are: 1. Number of SBIRT in the ED 2. Reduction of readmissions for opioid use disorder and alcohol use disorder 3. Number of patients referred for treatment
Initiative B	Population Health Workforce Support for Disadvantaged Areas	BPHWC is designed to provide the training needed to fill new health care jobs, while also improving the health of high poverty communities BPHWC will target high poverty communities throughout Baltimore City to recruit, train, and hire residents for 198 newly established entry level core jobs over three years. Individual hospitals will establish 35 other new positions related to BPHWC, to include social workers, care coordinators, for a total of 233 new jobs.	10 essential skills training, 6 technical training, no new hires, 15 retained employees (11 CHWs, 4 PRS)	#s trained, successfully credentialed, and hired/retained. BACH tracks workforce training effectiveness.
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q224. Please describe the initiative(s) addressing Populations - Workforce.

Populations - Workforce Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Population Health Workforce Support for Disadvantaged Areas	BPHWC is designed to provide the training needed to fill new health care jobs, while also improving the health of high poverty communities BPHWC will target high poverty communities throughout Baltimore City to recruit, train, and hire residents for 198 newly established entry level core jobs over three years. Individual hospitals will establish 35 other new positions related to BPHWC, to include social workers, care coordinators, for a total of 233 new jobs.	10 essential skills training, 6 technical training, no new hires, 15 retained employees (11 CHWs, 4 PRS)	#s trained, successfully credentialed, and hired/retained. BACH tracks workforce training effectiveness.
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q225. Please describe the initiative(s) addressing Settings and Systems - Community.

Settings and Systems - Community Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				

Initiative I				
Initiative J				
All Other Initiatives				

Q226. Please describe the initiative(s) addressing Settings and Systems - Environmental Health.

This question was not displayed to the respondent.

Q227. Please describe the initiative(s) addressing Settings and Systems - Global Health.

This question was not displayed to the respondent.

Q228. Please describe the initiative(s) addressing Settings and Systems - Health Care.

	Settings and Systems - Health Care Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q229. Please describe the initiative(s) addressing Settings and Systems - Health Insurance.

	Settings and Systems - Health Insurance Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q230. Please describe the initiative(s) addressing Settings and Systems - Health IT.

	Settings and Systems - Health IT Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				

Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q231. Please describe the initiative(s) addressing Settings and Systems - Health Policy.

	Settings and Systems - Health Policy Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q232. Please describe the initiative(s) addressing Settings and Systems - Hospital and Emergency Services.

	Settings and Systems - Hospital and Emergency Services Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q233. Please describe the initiative(s) addressing Settings and Systems - Housing and Homes.

	Settings and Systems - Housing and Homes Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q234. Please describe the initiative(s) addressing Settings and Systems - Public Health Infrastructure.

This question was not displayed to the respondent.

Q235. Please describe the initiative(s) addressing Settings and Systems - Schools.

	Settings and Systems - Schools Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q236. Please describe the initiative(s) addressing Settings and Systems - Transportation.

	Settings and Systems - Transportation Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q237. Please describe the initiative(s) addressing Settings and Systems - Workplace.

	Settings and Systems - Workplace Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q238. Please describe the initiative(s) addressing Social Determinants of Health - Economic Stability.

Social Determinants of Health - Economic Stability Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Population Health Workforce Support for Disadvantaged Areas	BPHWC is designed to provide the training needed to fill new health care jobs, while also improving the health of high poverty communities BPHWC will target high poverty communities throughout Baltimore City to recruit, train, and hire residents for 198 newly established entry level core jobs over three years. Individual hospitals will establish 35 other new positions related to BPHWC, to include social workers, care coordinators, for a total of 233 new jobs.	10 essential skills training, 6 technical training, no new hires, 15 retained employees (11 CHWs, 4 PRS)	#s trained, successfully credentialed, and hired/retained. BACH tracks workforce training effectiveness.
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q239. Please describe the initiative(s) addressing Social Determinants of Health - Education Access and Quality.

Social Determinants of Health - Education Access and Quality Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q240. Please describe the initiative(s) addressing Social Determinants of Health - Health Care Access and Quality.

Social Determinants of Health - Health Care Access and Quality Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q241. Please describe the initiative(s) addressing Social Determinants of Health - Neighborhood and Built Environment.

Social Determinants of Health - Neighborhood and Built Environment Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q242. Please describe the initiative(s) addressing Social Determinants of Health - Social and Community Context.

	Social Determinants of Health - Social and Community Context Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q243. Please describe the initiative(s) addressing other priorities.

This question was not displayed to the respondent.

Q130. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- (●) Yes
- ( ) No

Q131.

In your most recently completed CHNA, the following community health needs were identified:
Health Conditions - Addiction, Health Conditions - Arthritis, Health Conditions - Blood Disorders, Health Conditions - Cancer, Health Conditions - Chronic Kidney Disease, Health Conditions - Chronic Pain, Health Conditions - Dementias, Health Conditions - Diabetes, Health Conditions - Health Care-Associated Infections, Health Conditions - Heart Disease and Stroke, Health Conditions - Infectious Disease, Health Conditions - Mental Health and Mental Disorders, Health Conditions - Oral Conditions, Health Conditions - Osteoporosis, Health Conditions - Overweight and Obesity, Health Conditions - Respiratory Disease, Health Behaviors - Drug and Alcohol Use, Health Behaviors - Health Communication, Health Behaviors - Nutrition and Healthy Eating, Health Behaviors - Physical Activity, Health Behaviors - Preventive Care, Health Behaviors - Tobacco Use, Health Behaviors - Violence Prevention, Populations - Adolescents, Populations - Children, Populations - Infants, Populations - Men, Populations - Older Adults, Populations - Parents or Caregivers, Populations - People with Disabilities, Populations - Women, Populations - Workforce, Settings and Systems - Community, Settings and Systems - Health Care, Settings and Systems - Health Insurance, Settings and Systems - Health IT, Settings and Systems - Health Policy, Settings and Systems - Hospital and Emergency Services, Settings and Systems - Housing and Homes, Settings and Systems - Schools, Settings and Systems - Transportation, Settings and Systems - Workplace, Social Determinants of Health - Economic Stability, Social Determinants of Health - Education Access and Quality, Social Determinants of Health - Health Care Access and Quality, Social Determinants of Health - Neighborhood and Built Environment, Social Determinants of Health - Social and Community Context Other:

Using the checkboxes below, select the needs that appear in the list above that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q132. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q244. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

This question was not displayed to the respondent.

Q245. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

This question was not displayed to the respondent.

Q129. If you wish, you may upload a document describing your community benefit initiatives in more detail.

This question was not displayed to the respondent.

Q60. Section III - CB Administration

Q61. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

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

Q246. Please describe the third party audit process used.

This question was not displayed to the respondent.

Q62. Does your hospital conduct an internal audit of the community benefit narrative?

- (●) Yes
- ( ) No

Q63. Please describe the community benefit narrative audit process.

Senior leadership directs, oversees and approves all community benefit work including the allocation of funds that support community outreach directed at underserved and high-need populations in the CBSA. This high level review and evaluation sets the priorities of the hospital's outreach work and ensures the effective, efficient usage of funds to achieve the largest impact in improving the lives of those who live in the communities we serve. This group conducts the final review and approval of the final report's financial accuracy to the hospitals' financial statements, alignment with the strategic plan, and compliance with regulatory requirements. Individual clinical leaders along with administrators make decisions on community benefit programs that each department supports/funds through their budget. Clinical leaders will also identify and create strategies to tackle community health needs that arise in the CBSA and oversee department programs for content accuracy, adherence to department protocols and best practices. Population health leadership is involved in the process of planning the 2018 JHBMC Community Health Needs Assessment and Implementation Strategy by providing input, feedback and advice on the identified health needs and health priorities. The JHBMC Community Benefit Team interacts with all groups in the hospital performing community benefit activities. They educate, advocate and collaborate with internal audiences to increase understanding, appreciation and participation of the Community Benefit report process and community outreach activities. Team members collect and verify all CB data, compile report, provide initial audit and verification of CBR financials and write CBR narrative. Throughout the year, the CB team attends local and regional community health conferences and meetings, represents the Hospital to external audiences, and works with community and JHBMC clinical leaders to identify promising projects or programs that address CBSA community health needs. The JHHS Community Health Improvement Strategy Council (JCHISC) convenes monthly to bring Community Health/Community Benefit groups together with Tax, Financial Assistance, and Health Policy staff from across the Health System to coordinate process, practice, and policy. JCHISC members discuss issues and problems they face in community benefit reporting, regulatory compliance to state and federal community benefit requirements, and technical aspects of administering and reporting community benefit systems. When needed, a designated representative from the group contacts the governing agency for clarification or decision regarding the issues in question to ensure that all hospitals reports are consistent in the interpretation of regulations.

Q64. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- (●) Yes
- ( ) No

Q65. Please explain:

This question was not displayed to the respondent.

Q66. Does the hospital's board review and approve the annual community benefit narrative report?

- (●) Yes
- ( ) No

Q67. Please explain:

This question was not displayed to the respondent.

Q68. Does your hospital include community benefit planning and investments in its internal strategic plan?

- (●) Yes
- ( ) No

Q69. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

Community Benefit planning is an integral part of the Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center's strategic plan through an annual Strategic Objectives planning process that involves evaluating the Hospital's progress at meeting two community health goals and defines metrics for determining progress. The commitment of Johns Hopkins' leadership to improving the lives of its nearest neighbors is illustrated by the incorporation of community engagement initiatives at the highest level in the Johns Hopkins Medicine Strategic Plan. JHM consists of the JHU School of Medicine and the Johns Hopkins Health System, which includes education and research in its tri-partite mission (Education, Research and Healthcare). Even at this cross entity level (JHU and JHHS) Community Benefit activities and planning go beyond hospital requirements and expectations and are a core objective for all departments, schools and affiliates. The Johns Hopkins Medicine Innovation 2023 Strategic Plan has made a strategic goal of "Support the Well-Being of Our People and Our Communities" The subgoal will be to "Grow our local community engagement efforts to address identified needs to improve health." Our five year strategy will be to "Prioritize community engagement efforts and focus resources on local health needs." Our outcome will be from improved community health statistics.

Q70. If available, please provide a link to your hospital's strategic plan.

https://www.hopkinsmedicine.org/strategic-plan/

Q133. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- [x] Diabetes - Reduce the mean BMI for Maryland residents
- [x] Opioid Use Disorder - Improve overdose mortality
- [ ] Maternal and Child Health - Reduce severe maternal morbidity rate
- [x] Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17

Q134. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q135. Section IV - Physician Gaps & Subsidies

Q223. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- ( ) No
- (●) Yes

Q218. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

This question was not displayed to the respondent.

Q219. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

This question was not displayed to the respondent.

Q139. Please attach any files containing further information and data justifying physician subsidies your hospital.

This question was not displayed to the respondent.

Q140. Section VI - Financial Assistance Policy (FAP)

Q141. Upload a copy of your hospital's financial assistance policy.

PFS035.pdf
169.3KB
application/pdf

Q220. Provide the link to your hospital's financial assistance policy.

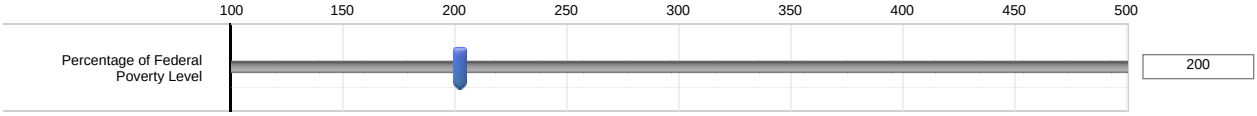
https://www.hopkinsmedicine.org/patient_care/patients-visitors/billing-insurance/_docs/pfs035-2020/PFS035.pdf

Q147. Has your FAP changed within the last year? If so, please describe the change.

- (●) No, the FAP has not changed.
- ( ) Yes, the FAP has changed. Please describe: [ ]

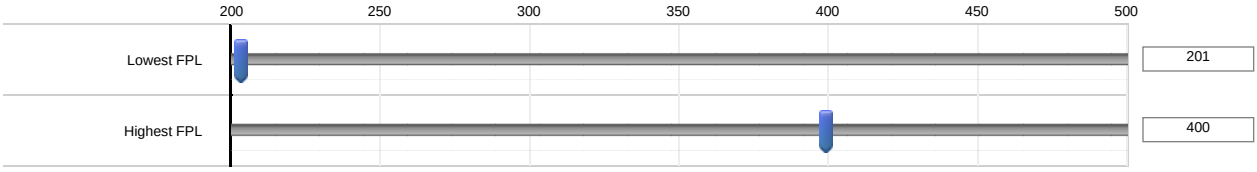
Q143. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



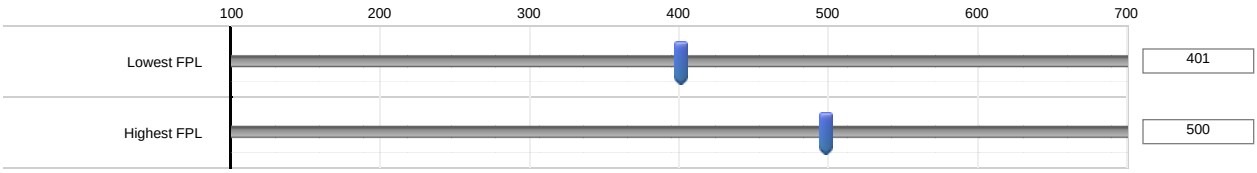
Q144. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

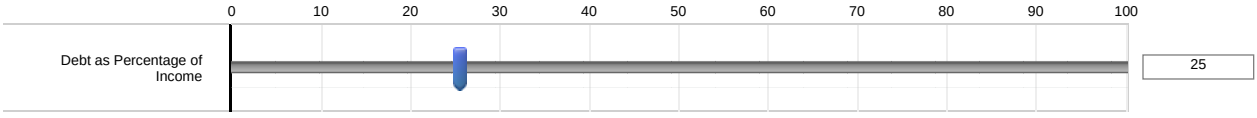


Q145. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

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



Q146. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q221. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding tax able year (select all that apply)

- [x] Federal corporate income tax
- [x] State corporate income tax

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

Q150. Summary & Report Submission

Q151.

Attention Hospital Staff! IMPORTANT!

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

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

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

Location Data

Location: (39.351593017578, -76.628997802734)

Source: GeoIP Estimation

Community Benefit Report
Johns Hopkins Bayview Medical Center
Community Benefit Service Area

Prepared by:

JHM Planning and Market Analysis
October 25, 2021

This information was developed exclusively for planning and quality improvement purposes and shall not be used, directly or indirectly, to determine physician compensation, or any other monetary or non-monetary benefit to a physician or physician owned entity. Additionally, any information related to past or anticipated referrals may not be used to determine a physician's/physician group's participation in a shared savings, gain sharing, or other program, including, but not limited to the provision of Electronic Health Records items or services. If you have any questions please contact the JHHS Legal Department.

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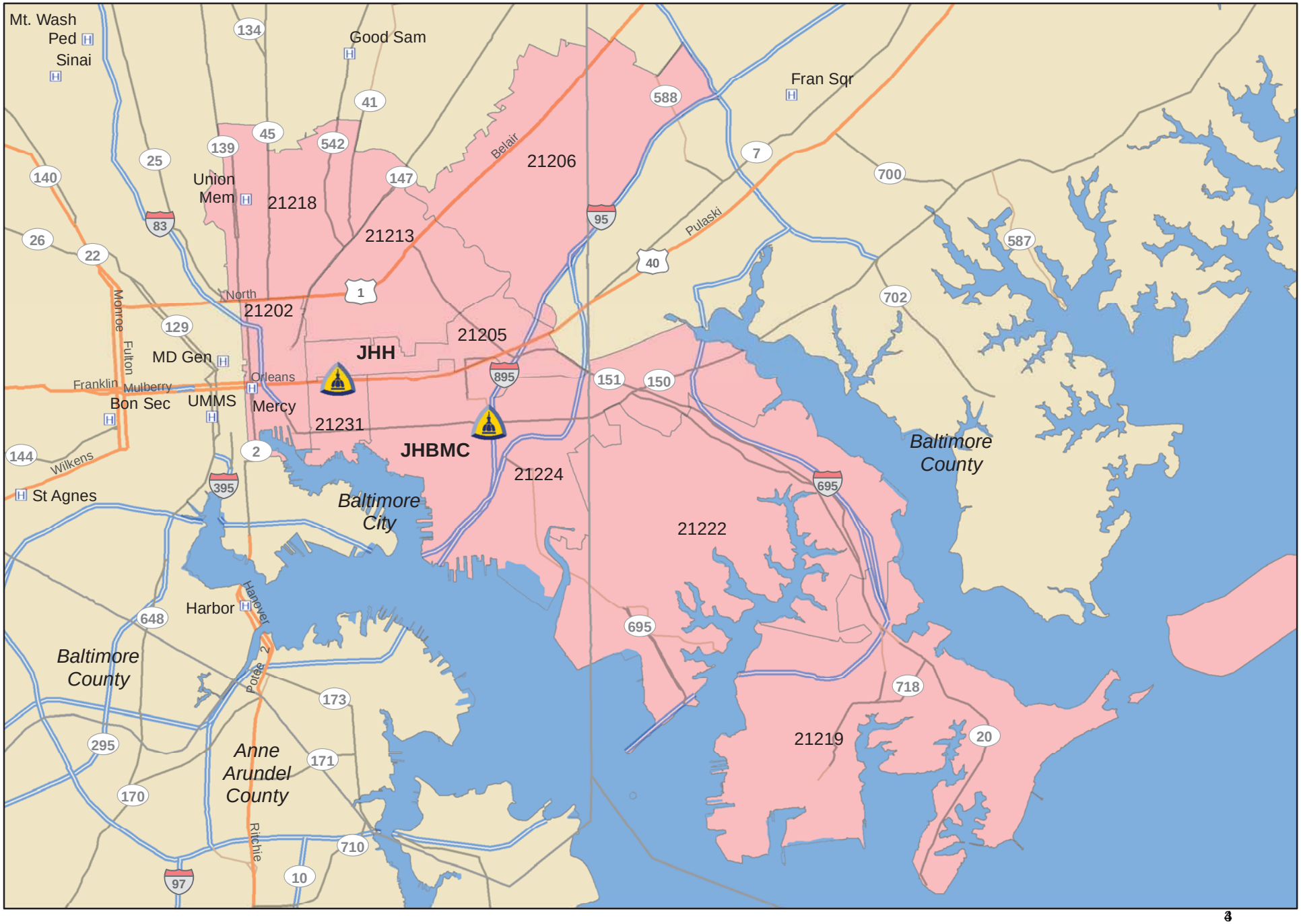
Johns Bayview Medical Center
Community Benefit Service Area
FY 2020 Q2-Q4, FY 2021 Q1
Source: HSCRC, IBM Watson Health
Includes Newborns

Zip Code	Zip City	JHBMC Discharges	JHBMC Market Share	All Hospital Discharges	JHBMC Discharges from Zip Code as a % of all JHBMC Discharges***
21202	Baltimore	157	6.0%	2,600	0.8%
21205	Baltimore	540	19.8%	2,726	2.9%
21206	Baltimore	976	15.2%	6,429	5.3%
21213	Baltimore	633	12.1%	5,227	3.4%
21218	Baltimore	230	3.9%	5,892	1.2%
21219	Sparrows Point	493	41.1%	1,200	2.7%
21222	Dundalk	4,007	47.5%	8,437	21.6%
21224	Baltimore	2,712	41.8%	6,482	14.6%
21231	Baltimore	227	13.0%	1,742	1.2%
Total		**9,975**	**24.5%**	**40,735**	**53.9%**

*Includes Maryland, DC, Pennsylvania, and Northern VA Hospitals (Source: HSCRC and IBM Watson Health)
**PA data for FY2020Q4 is estimated based on FY2019Q4. FY2021Q1 is estimated based on FY2020Q1
***JHBMC had 18,520 discharges between FY 2020 Q2 and FY 21 Q1

The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center

Community Benefit Service Area



2021 Insurance Coverage Estimates by Zipe Code and Payor Type
Area: JHH-JHBMC CBSA

Insurance Coverage Estimates								
Zip Code	**Zip City**	**Commercial**	**Medicaid**	**Medicare**	**Other Insured**	**Uninsured**	**Veterans**	**Total Households**
21202	Baltimore	6,146	1,245	1,393	110	485	247	**9,626**
21205	Baltimore	3,173	970	868	79	409	146	**5,645**
21206	Baltimore	11,316	2,839	3,633	316	1,276	607	**19,987**
21213	Baltimore	6,384	2,048	2,033	141	802	301	**11,709**
21218	Baltimore	11,583	2,675	3,668	293	1,095	545	**19,859**
21219	Sparrows Point	2,196	225	1,214	118	171	166	**4,090**
21222	Dundalk	13,323	2,391	5,221	475	1,461	1,001	**23,872**
21224	Baltimore	13,710	2,221	4,014	352	1,057	717	**22,071**
21231	Baltimore	5,616	826	1,412	120	312	238	**8,524**
Total Households		**73,447**	**15,440**	**23,456**	**2,004**	**7,068**	**3,968**	**125,383**

Source: Sg2 Insurance Coverage Estimates

2021 Demographic Snapshots
Area: JHH-JHBMC CBSA

DEMOGRAPHIC CHARACTERISTICS

	Selected Area
2021 Total Population	291,345
2026 Total Population	287,754
Population Change	-3,591
% Change 2020 - 2025	-1.20%

	2021	2026	Population Change	% Change
Total Male Population	142,049	140,659	-1390	-1.00%
Total Female Population	149,296	147,095	-2,201	-1.50%

Age Distribution

	Distribution	
Age Group	Population 2021	% of Total
0-4	17,345	6.0%
5-9	16,960	5.8%
10-14	16,170	5.6%
15-17	9,340	3.2%
18-19	8,132	2.8%
20	3,754	1.3%
21	3,615	1.2%
22-24	10,279	3.5%
25-29	26,314	9.0%
30-34	27,118	9.3%
35-39	22,113	7.6%
40-44	19,098	6.6%
45-49	16,680	5.7%
50-54	17,281	5.9%
55-59	18,121	6.2%
60-61	7,482	2.6%
62-64	10,180	3.5%
65-66	6,408	2.2%
67-69	8,713	3.0%
70-74	10,552	3.6%
75-79	7,003	2.4%
80-84	4,234	1.5%
85-Up	4,453	1.5%
Total	291,345	100.0%

Education Level

	Education Level Distribution	
2021 Adult Education Level	Pop Age 25+ 2021	% of Total
No Schooling Completed	3,760	1.8%
Nursery - 4th Grade	1,250	0.6%
5th - 6th Grade	2,004	1.0%
7th - 8th Grade	4,161	2.0%
9th Grade	3,702	1.8%
10th Grade	6,276	3.1%
11th Grade	6,689	3.3%
12th Grade - No Diploma	4,924	2.4%
High School Graduate	65,262	31.7%
Some College <1 Year	12,762	6.2%
Some College >1 Year No Degre	25,573	12.4%
Associates Degree	10,119	4.9%
Professional Degree	5,265	2.6%
Bachelors Degree	31,290	15.2%
Masters Degree	18,778	9.1%
Doctorate Degree	3,941	1.9%
Total	205,756	100.0%

Household Income Distribution

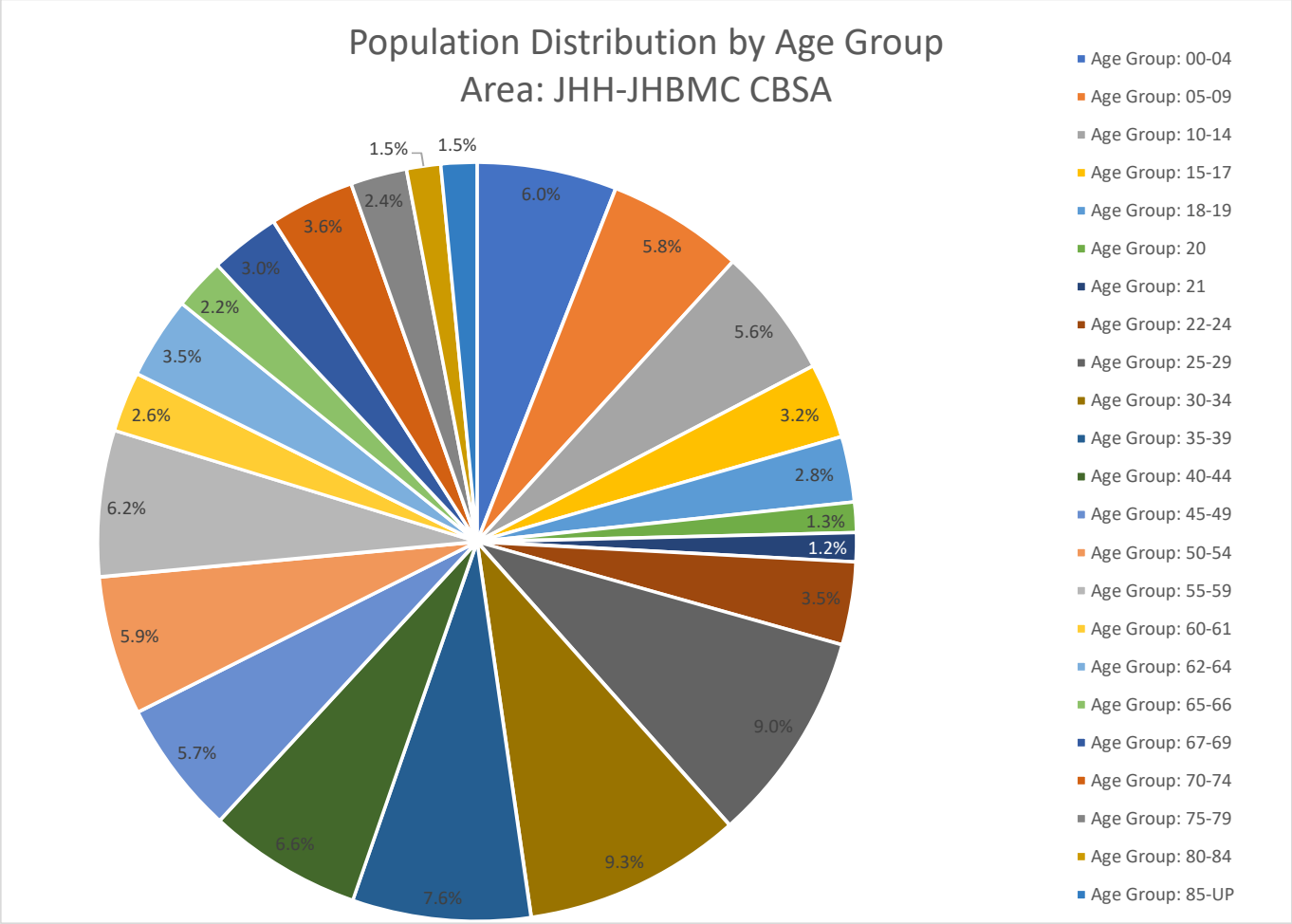
	Income Distribution	
2021 Household Income	Households	% of Total
< $10,000	10,312	9.0%
$10,000 - $14,999	5,794	5.1%
$15,000 - $19,999	5,720	5.0%
$20,000 - $24,999	4,536	4.0%
$25,000 - $29,999	4,019	3.5%
$30,000 - $34,999	4,635	4.1%
$35,000 - $39,999	5,172	4.5%
$40,000 - $44,999	4,643	4.1%
$45,000 - $49,999	5,157	4.5%
$50,000 - $59,999	8,289	7.3%
$60,000 - $74,999	10,896	9.5%
$75,000 - $99,999	12,876	11.3%
$100,000 - $124,999	9,961	8.7%
$125,000 - $149,999	7,046	6.2%
$150,000 - $199,999	7,041	6.2%
$200,000+	8,075	7.1%
Total	114,172	100.0%

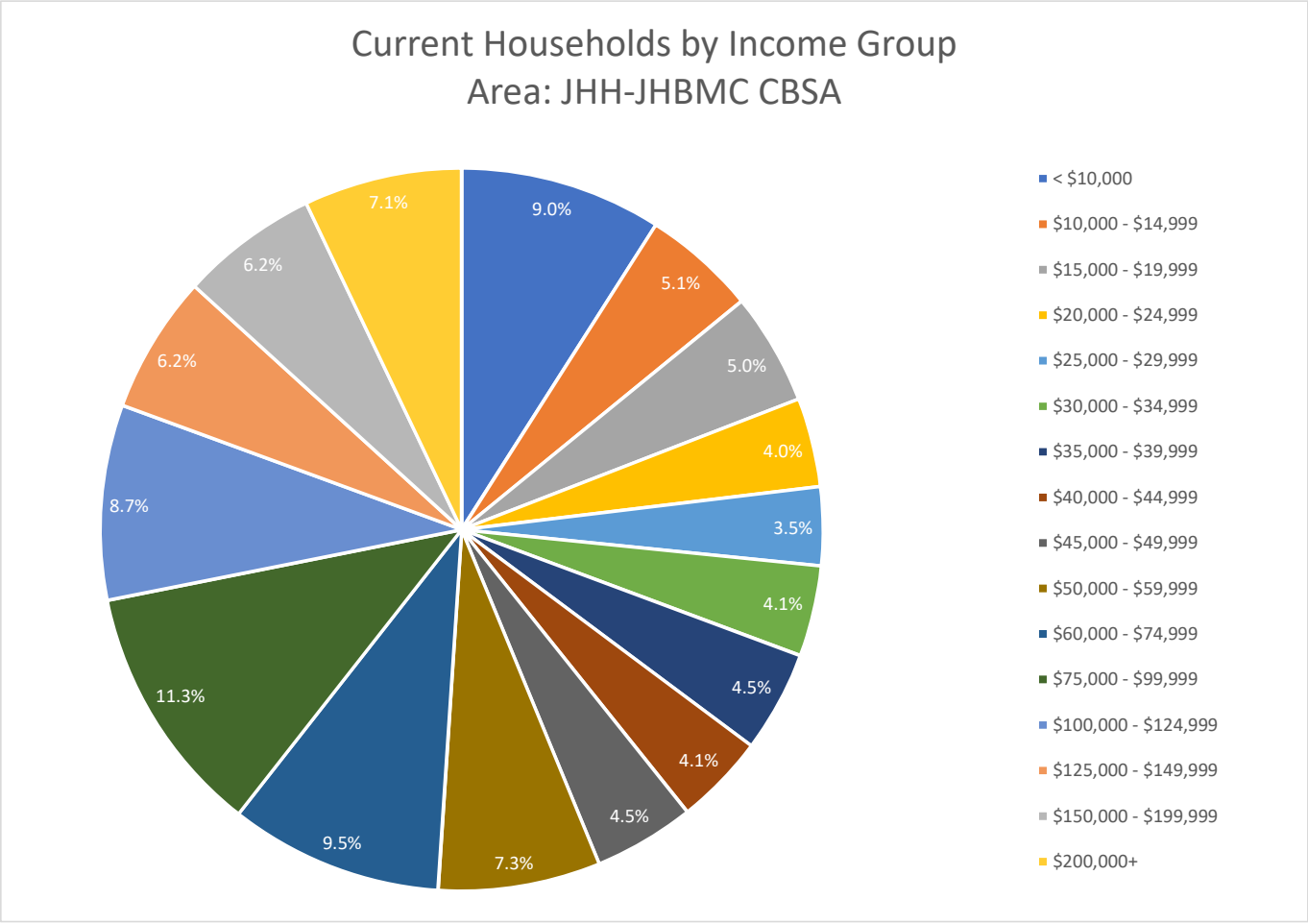
Race/Ethnicity

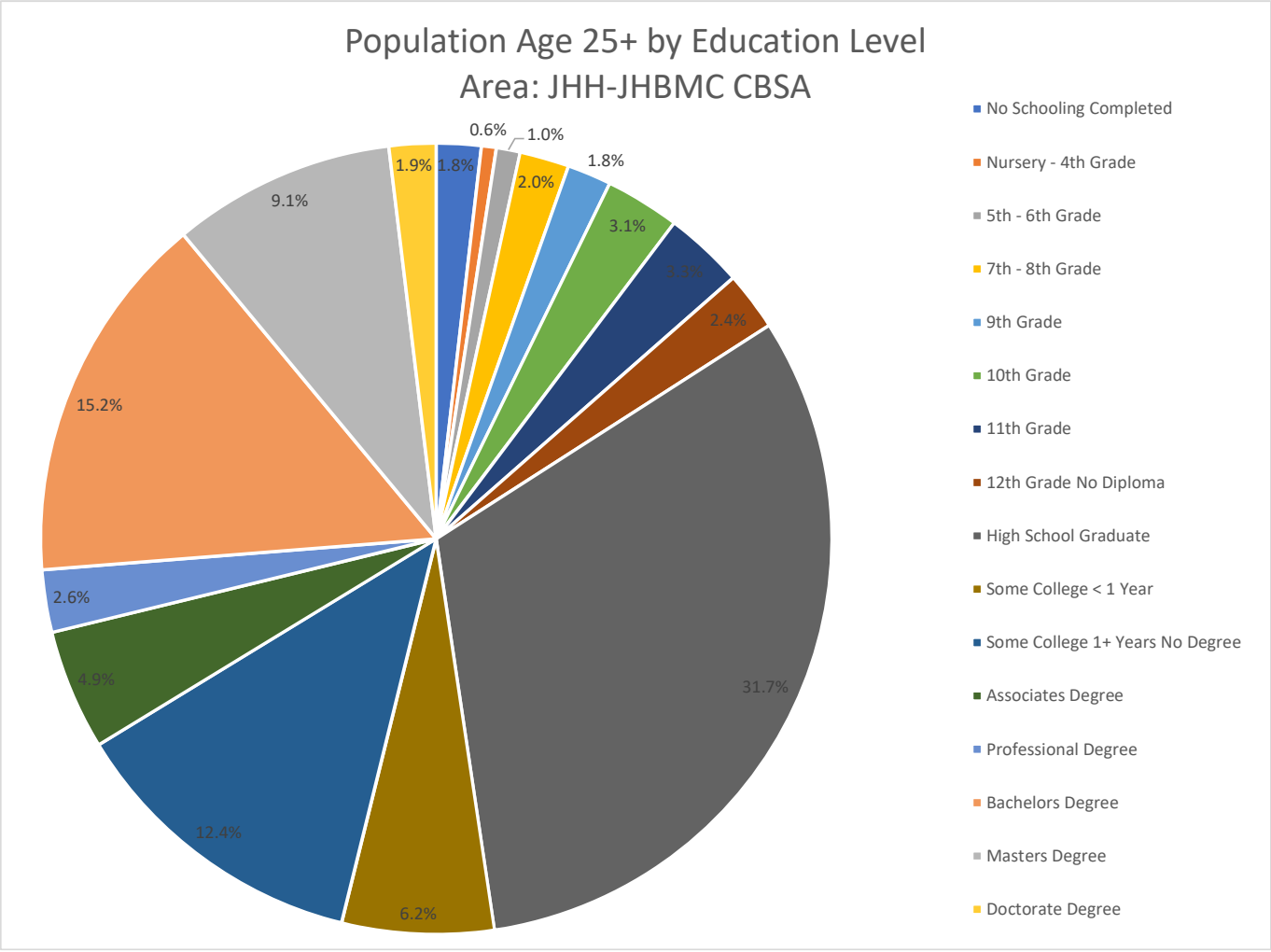
Race	Race Distribution	
	2021 Population	% of Total
American Indian / Alaska N	1,726	0.6%
Asian	9,192	3.2%
Black / African American	133,729	45.9%
Multiple Races	9,244	3.2%
Native Hawaiian Islander /	159	0.1%
Other	11,877	4.1%
White	125,418	43.0%
Total	291,345	100.0%

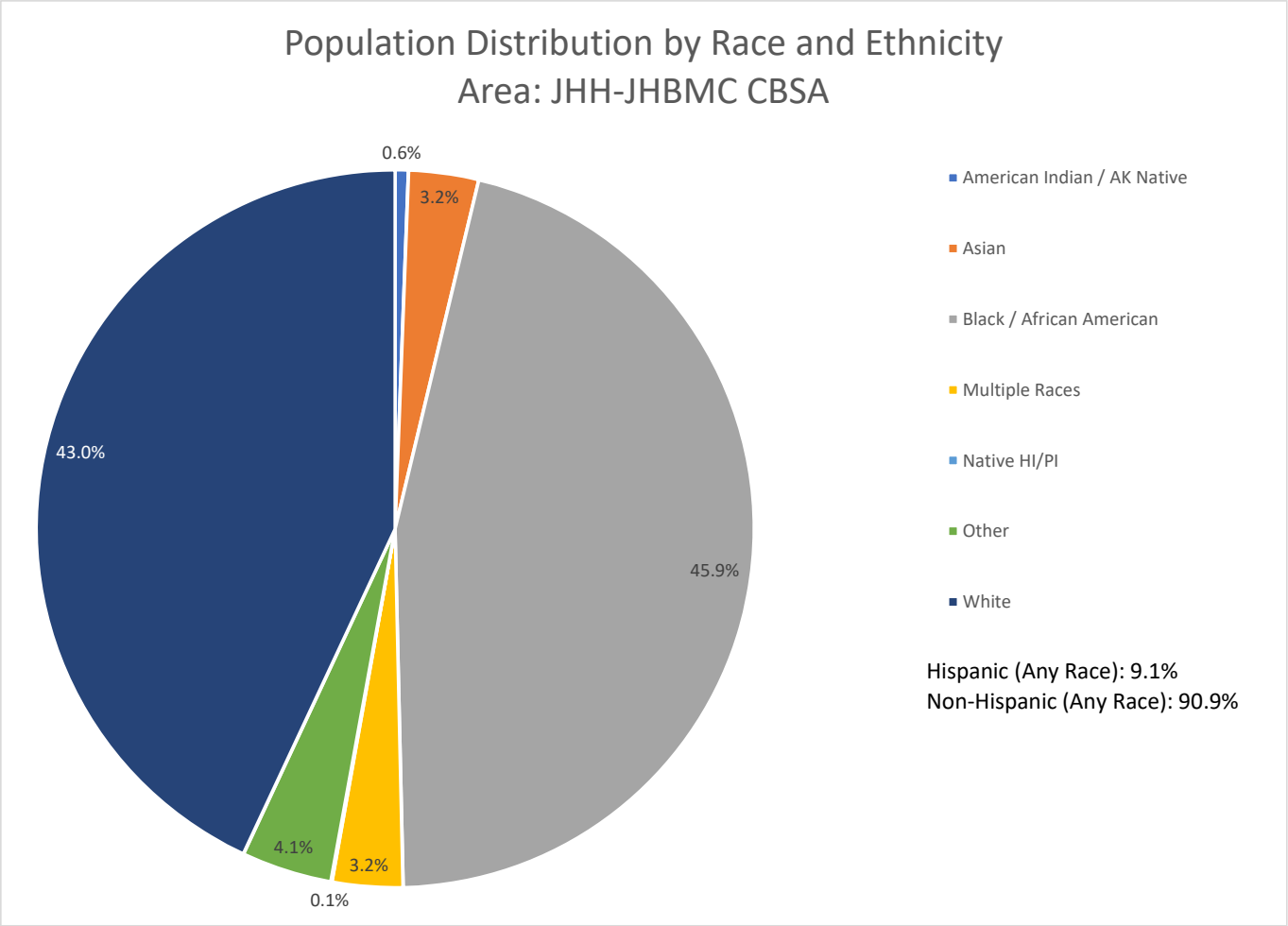
	Ethnicity Distribution	
Ethnicity	2021 Population	% of Total
Hispanic (Any Race)	26,426	9.1%
Non-Hispanic (Any Race)	264,919	90.9%
Total	291,345	100.0%

Source: Sg2 Market Demographics Tool


Population Distribution by Age Group
Area: JHH-JHBMC CBSA
6.0%
5.8%
5.6%
3.2%
2.8%
1.3%
1.2%
3.5%
9.0%
9.3%
7.6%
6.6%
5.7%
5.9%
6.2%
2.6%
3.5%
2.2%
3.0%
3.6%
2.4%
1.5%
1.5%
Age Group: 00-04
Age Group: 05-09
Age Group: 10-14
Age Group: 15-17
Age Group: 18-19
Age Group: 20
Age Group: 21
Age Group: 22-24
Age Group: 25-29
Age Group: 30-34
Age Group: 35-39
Age Group: 40-44
Age Group: 45-49
Age Group: 50-54
Age Group: 55-59
Age Group: 60-61
Age Group: 62-64
Age Group: 65-66
Age Group: 67-69
Age Group: 70-74
Age Group: 75-79
Age Group: 80-84
Age Group: 85-UP


Current Households by Income Group
Area: JHH-JHBMC CBSA
9.0%
5.1%
5.0%
4.0%
3.5%
4.1%
4.5%
4.1%
4.5%
7.3%
9.5%
11.3%
8.7%
6.2%
6.2%
7.1%
< $10,000
$10,000 - $14,999
$15,000 - $19,999
$20,000 - $24,999
$25,000 - $29,999
$30,000 - $34,999
$35,000 - $39,999
$40,000 - $44,999
$45,000 - $49,999
$50,000 - $59,999
$60,000 - $74,999
$75,000 - $99,999
$100,000 - $124,999
$125,000 - $149,999
$150,000 - $199,999
$200,000+


Population Age 25+ by Education Level
Area: JHH-JHBMC CBSA
0.6%
1.0%
1.8%
1.8%
2.0%
1.9%
3.1%
9.1%
2.4%
15.2%
2.6%
4.9%
31.7%
12.4%
6.2%
No Schooling Completed
Nursery - 4th Grade
5th - 6th Grade
7th - 8th Grade
9th Grade
10th Grade
11th Grade
12th Grade No Diploma
High School Graduate
Some College < 1 Year
Some College 1+ Years No Degree
Associates Degree
Professional Degree
Bachelors Degree
Masters Degree
Doctorate Degree


Population Distribution by Race and Ethnicity
Area: JHH-JHBMC CBSA
0.6%
3.2%
45.9%
43.0%
4.1%
3.2%
0.1%
American Indian / AK Native
Asian
Black / African American
Multiple Races
Native HI/PI
Other
White
Hispanic (Any Race): 9.1%
Non-Hispanic (Any Race): 90.9%

The Johns Hopkins Hospital & Johns Hopkins Bayview Medical Center 2021 Community Health Needs Assessment & Implementation Strategy

JOHNS HOPKINS MEDICINE

JOHNS HOPKINS HEALTH SYSTEM

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Introduction and Methodology

With the enactment of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, tax-exempt hospitals are required to conduct community health needs assessments (CHNA) and develop implementation strategies, which are approaches and plans to actively improve the health of communities served by health systems. These strategies provide hospitals and health systems with the information they need to deliver community benefits that can be targeted to address the specific needs of their communities. Coordination and management strategies based upon the outcomes of a CHNA, along with implementing strategies, can improve the impact of hospital community benefits.

To adhere to the requirements imposed by the Internal Revenue Service (IRS), tax-exempt hospitals and health systems must:

- Conduct a CHNA every three years.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how they are addressing the needs identified in the CHNA and provide a description of needs that are not being addressed, with the reasons why.

The Department of the Treasury and the IRS require a CHNA to include:

1. A description of the community served by the hospital facility and how the description was determined.
2. A description of the process and methods used to conduct the assessment.
    - A description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs.
    - A description of information gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility.
    - Identification of organizations that collaborated with the hospital/health system and an explanation of their qualifications.
3. A description of how the hospital organization took into account input from persons who represent the broad interests of the community served by the hospital. In addition, the report must identify any individual providing input who has special knowledge of or expertise in public health. The report must also identify any individual providing input who is a "leader" or "representative" of populations.
4. A prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs.
5. A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

6. A description of the needs identified that the hospital intends to address, the reasons those needs were selected, and the means by which the hospital will undertake to address the selected needs.[1]

The CHNA process for The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC) included the collection and analysis of primary and secondary data. Both public and private organizations, such as faith-based organizations, government agencies, educational systems, and health and human services entities were engaged to assess the needs of the community. In total, the extensive primary data collection phase resulted in more than 1,700 responses from community stakeholders/leaders and community residents. The 2018, 2016 and 2013 CHNAs served as a baseline to provide a deeper understanding of the health as well as the socioeconomic needs of the community and emerging trends.

In order to collaborate with the Baltimore City Health Department and a coalition of Baltimore City hospitals, JHH and JHBMC accelerated their CHNA process in 2018, one year ahead of the three-year cycle required by the IRS. The 2021 report will be the second report for the continuing collaboration. The initial goal for the coalition members was to determine and adopt a common priority identified by all Baltimore communities through the CHNA process. That goal was achieved with the determination of mental health as the shared need to be addressed in each hospital's CHNA Implementation Strategy.

Primary data collected included a survey to solicit feedback on the previous CHNA and Implementation Strategy. A health needs survey, available online and in paper formats in both English and Spanish, was distributed by coalition hospitals and partners city-wide. In total, 3,252 responses were collected, including 1,122 responses from residents of the JHH/JHBMC community benefit service area (CBSA).

Stakeholder interviews were conducted with individuals who represented a) broad interests of the community, b) populations of need, or c) persons with specialized knowledge in public health. JHH/JHBC conducted 50 in-depth stakeholder interviews. Six focus groups with vulnerable populations were conducted by JHH/JHBMC with 37 participants. Due to limitations experienced as a result of the COVID-19 pandemic, in-person interviews and focus groups were limited by design in size and scope to ensure open conversation in a safe environment. Another 12 focus groups were conducted by the other coalition hospitals. Although the number of participants in the coalition groups was not disclosed, the results were shared with all hospitals for use in their CHNAs.

The Baltimore City Collaborative piloted an interactive telephone town hall using a 3rd party company where nearly 4,100 community members joined the call, over 2,800 stayed on the call, and nearly 100 asked questions. We estimate that approximately 500 of the residents were from East Baltimore.

[1] The outcomes from the CHNA will be addressed through an implementation planning phase.

An interactive resource inventory was created to highlight available programs and services within JHH and JHBMC's CBSA[2]. The inventory identifies organizations and agencies in the community that are serving the various target populations within each of the priority needs.

A secondary data profile was compiled with local, state, and federal figures to provide essential information, insight, and knowledge on a broad range of health and social issues. Collecting and examining information about different community aspects and behaviors can help identify and explain factors that influence the community's health.

Data collected encompassed socioeconomic information, health statistics, demographics, children's health, mental health issues, etc. This report is a summary of primary and secondary data collected throughout the CHNA.

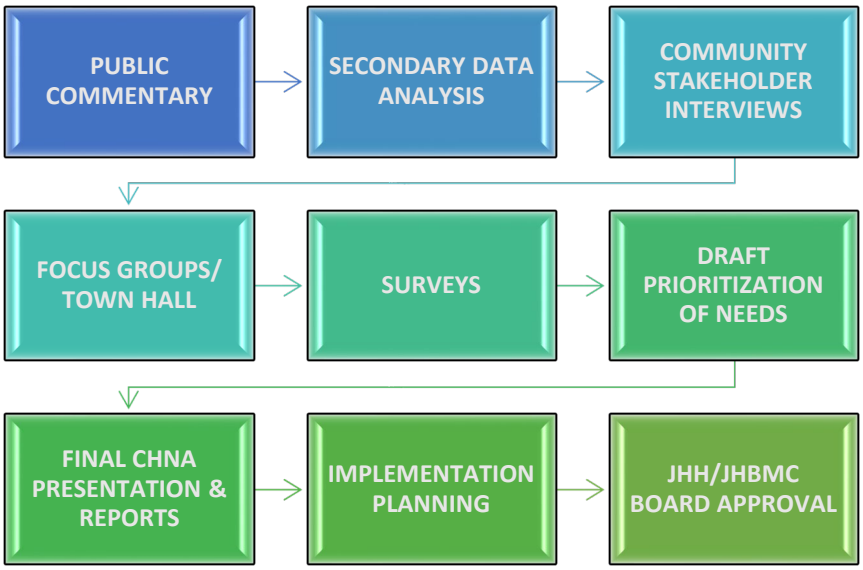
The development of the CHNA and the Implementation Strategy was led by the Office of Government and Community Affairs (Tom Lewis, Vice President), Dr. Redonda Miller (JHH President), and Dr. Richard Bennett (JHBMC President), and involved the contributions of over 1,700 individuals through direct interviews, surveys, and focus groups. Contributors included, but were not limited to, community residents, members of faith-based organizations, state and local public health department representatives, neighborhood association leaders, other nonprofit and community based organization leaders, academic experts, local government officials, local school district representatives, health care consumers and providers, health professionals, members of medically underserved, low-income and minority populations in the community served by the hospitals, Johns Hopkins Medicine leadership, and other experts, both internal and external to Johns Hopkins.

The 2021 CHNA reflects the top five socioeconomic priorities and five health priorities determined and prioritized by community representatives and residents through a five-month process of community engagement and primary data collection. The information collected through surveys, interviews, focus groups, and a town hall meeting were consolidated and reviewed in conjunction with collected secondary data. A group of community partners affiliated with Baltimore CONNECT, a coalition of more than 30 East Baltimore community organizations, were asked to review the process and findings and participate in the prioritization of needs. During the review and discussion session, the community participants were asked to identify any oversights or weaknesses in the CHNA process and to ensure an appropriately diverse and representative group of CBSA residents contributed to the findings. Their final review and discussion resulted in the list of needs as presented in this report.

The overall CHNA involved multiple steps that are depicted in the flow chart below. Additional information regarding each component of the project and the results can be found in Appendix A. More details on the specific needs and priorities also appear in the Key Community Needs section of this report (pages 15-17).

[2] The Community Benefit Service Area (CBSA) or the overall study area referenced in the report refers to the nine ZIP codes that defined the communities for JHH and JHBMC in the CHNA. The ZIP codes included are 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224 and 21231.

Flow Chart 1: CHNA Process



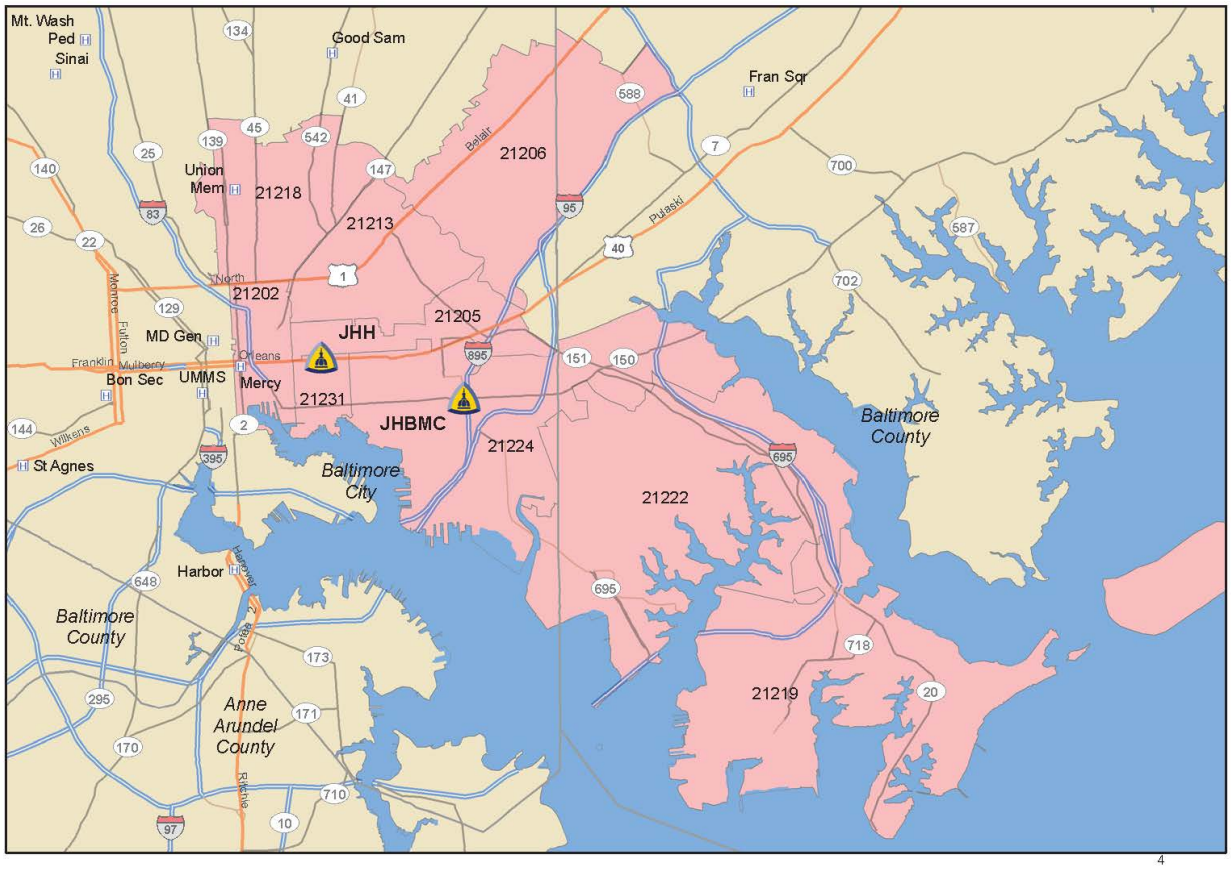
Community Benefit Service Area (CBSA)

In 2020-21, a total of nine ZIP codes were analyzed by the Johns Hopkins Institutions. These ZIP codes represent the CBSA for The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center. The Johns Hopkins Institutions provide services to communities throughout Maryland, adjoining states, and internationally. The community health needs assessment focused on nine specific ZIP codes: 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, and 21231. This area reflects the population with the largest usage of the emergency departments and the majority of recipients of community benefit contributions and programming. Within the CBSA, JHH and JHBMC have focused on certain target populations such as the elderly, at-risk children and adolescents, uninsured individuals and households, and underinsured and low-income individuals and households.

The following map geographically depicts the community benefit service area by showing the communities that are shaded. (See Map 1).

Map 1: Overall Community Benefit Service Area – 2020 Study Area Map

The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center
Community Benefit Service Area



Between 2017 and 2020 there has been a 3.7 percent decline in the CBSA population. The CBSA is expected to have an additional 0.5 percent population decline from 2020 to 2025. With regard to income distribution, the CBSA continues to see the percentage of households earning less than $15,000

to be higher than the state average and the percentage of households earning over $100,000 lower than the state average, although there has been some improvement since the last CHNA. In terms of education level, the CBSA has a higher percentage of working age population with a high school degree, but lower percentages of residents with some college/associates degree and bachelor's degree or greater. (See Table 1).

Table 1: 2020 CBSA Demographic Snapshot

2020 Demographic Snapshots
Area: JHH-JHBMC CBSA

DEMOGRAPHIC CHARACTERISTICS

2020 Total Population	295,169
2025 Total Population	293,765
Population Change	-1,404
% Change 2020 - 2025	-0.50%

	2020	2025	Population Change
Male Population	144,030	143,802	-228
Female Population	151,139	149,963	-1,176

Age Distribution

	Distribution	
Age Group	2020 Population	% of Total
0-4	17,812	6.0%
5-9	17,427	5.9%
10-14	16,397	5.6%
15-17	9,409	3.2%
18-19	8,051	2.7%
20	3,882	1.3%
21	3,745	1.3%
22-24	10,585	3.6%
25-29	27,509	9.3%
30-34	27,293	9.2%
35-39	22,078	7.5%
40-44	18,931	6.4%
45-49	17,006	5.8%
50-54	17,982	6.1%
55-59	18,689	6.3%
60-61	7,527	2.6%
62-64	10,249	3.5%
65-66	6,306	2.1%
67-69	8,583	2.9%
70-74	10,254	3.5%
75-79	6,806	2.3%
80-84	4,170	1.4%
85-Up	4,478	1.5%
Total	295,169	100.0%

Education Level Distribution

	Distribution	
Education Level	2020 Pop Age 25+	% of Total
No Schooling Completed	3,667	1.8%
Nursery - 4th Grade	1119	0.5%
5th - 6th Grade	2231	1.1%
7th - 8th Grade	4,544	2.2%
9th Grade	4194	2.0%
10th Grade	6,984	3.4%
11th Grade	6,946	3.3%
12th Grade - No Diploma	5,317	2.6%
High School Graduate	66,787	32.1%
Some College <1 Year	12,251	5.9%
Some College >1 Year No Degree	27,821	13.4%
Associates Degree	9,987	4.8%
Professional Degree	5,032	2.4%
Bachelors Degree	30,052	14.5%
Masters Degree	17,073	8.2%
Doctorate Degree	3,847	1.9%
Total	207,852	100.0%

Household Income Distribution

	Distribution	
Income	2020 Households	% of Total
< $10,000	10,979	9.5%
$10,000 - $14,999	5,828	5.0%
$15,000 - $19,999	5,458	4.7%
$20,000 - $24,999	4,948	4.3%
$25,000 - $29,999	5,000	4.3%
$30,000 - $34,999	5,482	4.7%
$35,000 - $39,999	5,519	4.8%
$40,000 - $44,999	4,832	4.2%
$45,000 - $49,999	4,673	4.0%
$50,000 - $59,999	8,874	7.7%
$60,000 - $74,999	10,576	9.1%
$75,000 - $99,999	12,738	11.0%
$100,000 - $124,999	9,724	8.4%
$125,000 - $149,999	6,827	5.9%
$150,000 - $199,999	7,081	6.1%
$200,000+	7,232	6.2%
Total	115,771	100.0%

Race/Ethnicity Distribution

	Distribution	
Race	2020 Population	% of Total
American Indian / Alaska Native	1745	0.6%
Asian	9,437	3.2%
Black / African American	135,911	46.0%
Multiple Races	9,177	3.1%
Native Hawaiian Isl / Pacific Isl	166	0.1%
Other	11,719	4.0%
White	127,014	43.0%
Total	295,169	100.0%

	Distribution	
Ethnicity	2020 Population	% of Total
Hispanic (Any Race)	26,007	8.8%
Non-Hispanic (Any Race)	269,162	91.2%
Total	295,169	100.0%

Source: Sg2 Market Demographics Tool

Area	2020 Population	% Families Below Poverty Line	% Familes without Married Couple and with Children Below Poverty Line	% English Not Well or Not At All	% Age 25+ No H/S Diploma	% Age 16+ Unemployed	% Age 16+ Not in Labor Force	% Households Uninsured	% Households Rented
21202	23,893	22.9%	**45.60%**	0.64%	**19.07%**	3.60%	**51.70%**	5.00%	**78.80%**
21205	15,131	**28.50%**	**42.20%**	**3.78%**	**28.22%**	**8.30%**	**41.60%**	**7.30%**	**60.60%**
21206	48,203	11.10%	27.30%	1.54%	11.02%	4.30%	29.80%	**6.30%**	39.80%
21213	30,318	**23.20%**	36.40%	1.00%	**19.47%**	**8.00%**	**43.00%**	**6.80%**	43.30%
21218	46,813	**15.60%**	37.90%	1.18%	15.11%	5.30%	**45.50%**	5.50%	55.20%
21219	9,353	4.40%	17.70%	0.52%	14.73%	4.10%	**42.10%**	4.00%	19.00%
21222	55,968	9.00%	23.60%	1.91%	**18.58%**	4.50%	39.60%	**6.00%**	33.30%
21224	49,506	14.00%	**45.00%**	**5.50%**	**18.91%**	3.20%	27.60%	4.80%	42.50%
21231	15,984	13.70%	37.60%	2.40%	10.35%	3.10%	26.10%	3.80%	**63.80%**
CBSA	**295,169**	**14.40%**	**34.80%**	**2.22%**	**16.84%**	**4.70%**	**37.80%**	**5.60%**	**46.80%**
Maryland	**6,075,320**	**6.30%**	**22.00%**	**3.14%**	**10.09%**	**3.60%**	**32.20%**	**4.20%**	**32.40%**

Total Population
Sources:
Sg2 Market Demographics
Sg2 Insurance Coverage Estimates

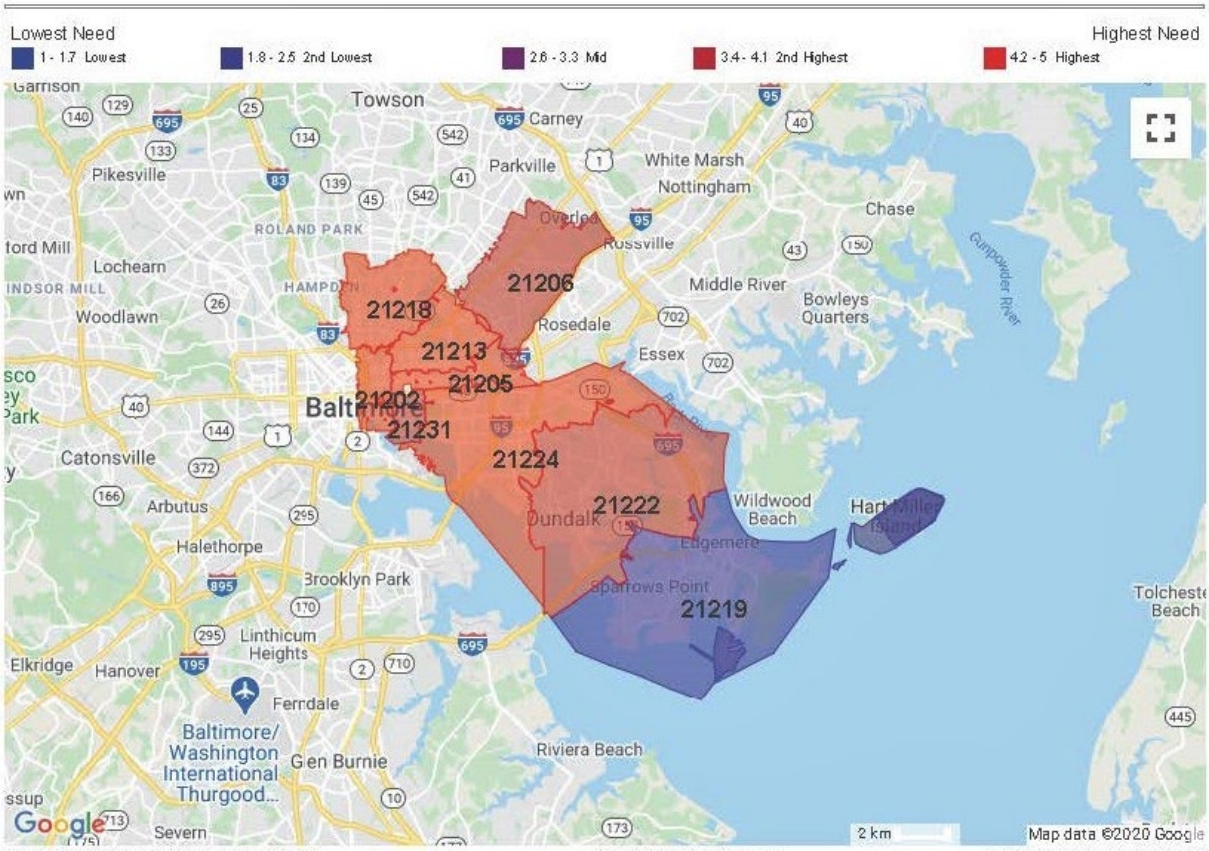
Area	2020 Population	% American Indian / AK Native	Asian	Black / African American	Multiple Races	Native HI/PI	Other Race	White	% Hispanic/ Latinx (Any Race)
21202	23,893	0.20%	4.90%	58.90%	2.30%	0.00%	1.10%	32.50%	4.10%
21205	15,131	0.70%	1.30%	68.70%	3.20%	0.10%	6.70%	19.30%	**14.10%**
21206	48,203	0.40%	2.10%	71.40%	2.90%	0.00%	1.10%	22.20%	3.00%
21213	30,318	0.30%	0.40%	90.50%	1.70%	0.00%	0.60%	6.40%	1.70%
21218	46,813	0.20%	6.40%	60.60%	2.70%	0.10%	1.20%	28.80%	4.00%
21219	9,353	0.60%	1.20%	4.00%	1.90%	0.00%	0.50%	91.80%	2.00%
21222	55,968	1.00%	2.50%	14.60%	4.60%	0.00%	2.60%	74.60%	7.30%
21224	49,506	1.00%	3.10%	16.40%	3.60%	0.10%	13.70%	62.20%	**25.90%**
21231	15,984	0.50%	5.80%	28.50%	2.90%	0.10%	5.40%	56.90%	**12.50%**
CBSA	**295,169**	**0.60%**	**3.20%**	**46.00%**	**3.10%**	**0.10%**	**4.00%**	**43.00%**	**8.80%**
Maryland	**6,075,320**	**0.40%**	**6.90%**	**30.20%**	**3.60%**	**0.10%**	**4.80%**	**54.10%**	**11.10%**

Total Population
Sources:
Sg2 Market Demographics
Sg2 Insurance Coverage Estimates

The Dignity Health Community Need Index (CNI) considers multiple factors that are known to impact health care access. The tool is useful in identifying and addressing the disproportionate and unmet health-related needs of neighborhoods. The five prominent socioeconomic barriers to community health quantified in the CNI are income barriers, cultural/language barriers, educational barriers, insurance barriers, and housing barriers. CNI scores are ranked from 1.0 to 5.0, with 1.0 representing the least need and 5.0 representing the highest barriers to accessing care.

In assessing the CNI scores for the overall study area or CBSA, the CNI score in 2020 of 4.1 has shown no improvement to barriers since 2017 when there was a small decrease from a score of 4.3 in 2015 to 4.1 in 2017. It is important to note that a low score (e.g., 1.0) does not imply that no attention should be given to that neighborhood; rather, hospital leadership should determine specifically what is working well to account for a low neighborhood score. CNI data from 2020 in the map below provides a geographic representation of the CNI scores for the CBSA. ZIP codes that have higher socioeconomic barriers (5.0) are represented in darker orange. As the socioeconomic scores decrease (i.e., improve), the coding color lightens, with blue representing the lowest barriers. As indicated in Map 2, there are concentrated areas within Baltimore City that clearly signify high socioeconomic barriers to care.

Map 2: Community Need Index (CNI) Study Area Map



Mean(zipcode): 4.1 / Mean(person): 4.2 CNI Score Median: 4.4 CNI Score Mode: 4, 4.4, 4.8

Zip Code	CNI Score	Population	City	County	State
21202	4.8	23893	Baltimore	Baltimore City, Md	Maryland
21205	4.8	15131	Baltimore	Baltimore City, Md	Maryland
21206	4	48203	Baltimore	Baltimore City, Md	Maryland
21213	4.8	30318	Baltimore	Baltimore City, Md	Maryland
21218	4.4	46813	Baltimore	Baltimore City, Md	Maryland
21219	2.4	9353	Sparrows Point	Baltimore	Maryland
21222	3.6	55968	Dundalk	Baltimore	Maryland
21224	4.4	49506	Baltimore	Baltimore City, Md	Maryland
21231	4	15984	Baltimore	Baltimore City, Md	Maryland

Source: Dignity Health, 2020

Key Community Health Needs

The health status of a community depends on many factors, including quality of health care, social and economic determinants, individual behaviors, heredity, education, and the physical environment. Healthy People, coordinated by the Office of Disease Prevention and Health Promotion within the U.S. Department of Health and Human Services, identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being.

Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first 4 decades and creates targets for improving health status, promoting community health, and challenging individuals, communities, and professionals to take specific steps to ensure that good health, as well as long life, are enjoyed by all. Health is more than just the absence of disease. Social determinants of health (SDOH) contribute to health disparities and inequities. As reflected in Chart 1, SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

SDOH have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Air and water quality
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Simply promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

Chart 1: Social Determinants of Health

Socioeconomic status is a reflection of an individual's economic and social position in relation to others based on income, education, and occupation. The environment—in particular, where we work and live—as well as education, income, and age, play a significant role in an individual's socioeconomic status. It is well documented that residents who have limited education and limited financial resources often experience challenges such as poor housing, inadequate opportunities for employment advancement, and a low quality of life. All of these challenges ultimately affect their health outcomes.

Children attending schools in poor neighborhoods are likely to lack a rich educational infrastructure. Parents who struggle with employment opportunities are less likely to be able to offer their children educational resources such as computers, tutors, and books—materials typically needed for students to become successful.

Similarly, community residents living in neighborhoods that are underserved may face higher levels of stress if their community is plagued with crime, drugs, and poverty. Furthermore, the social injustices and inequalities in a community can produce high levels of stress and contribute to civil unrest, mental and behavioral health problems, and the potential for increased use and abuse of drugs and alcohol products.

Residents in east Baltimore City and southeast Baltimore County are well aware of the health and social inequalities and disparities that exist. Addressing these disparities and working to reduce the socioeconomic gaps can bridge and provide sustainable support for those who have limited options.

The Johns Hopkins Institutions have significant strategies that are geared toward addressing the health and well-being of the community's marginalized youth and adult residents. As a major economic driver in the region, JHH's and JHBMC's leaders have encouraged the health and well-being of the marginalized populations through their programs, community initiatives, economic development projects, and strategic partnerships.

The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center will continue to address the SDOH of their community residents with innovative and effective programs, community outreach efforts, and collaboration and partnerships with nonprofits and local organizations to reach vulnerable residents and those most affected by the health and social disparities across the city.

One of the objectives of the Patient Protection and Affordable Care Act (PPACA) is to identify ways to better coordinate health services to allow greater accessibility, while reducing health care costs for patients and caregivers. As a result, health care organizations are streamlining services and collaborating with community agencies and organizations to capitalize on the ability to share resources. By providing affordable health care insurance, a large portion of the previously uninsured population now has a pathway to affordable and accessible preventive services.

The key need areas identified during the CHNA process through the gathering and analysis of primary and secondary data as described in the Introduction and Appendix A are depicted in Chart 2 below, in order of priority. Socioeconomic needs are depicted in orange and direct health needs in blue.

The key community needs are grouped into two overarching categories, socioeconomic needs and health needs to maintain the labeling methodology used in previous CHNAs. In 2018, the identified needs in prioritized order were: employment, crime/neighborhood safety, housing/homelessness, education, and food environment for socioeconomic priorities, and substance abuse/addiction, mental health, chronic diseases, access to care, and dental services for direct health conditions. The key needs from the 2021 CHNA were similarly defined and the updated priority order appears in the chart below (See Chart 2).

Please note that some of the CHNA community-identified needs encompass more than one commonly defined health or social need. For example, "chronic disease" not only includes health conditions such as cancer, arthritis, asthma, and oral health, but also health education and literacy to manage and/or prevent chronic health issues. Also, job opportunities include job training and education, which are essential to gainful employment with living wages and advancement opportunities. Likewise, food environment includes access to healthy foods and nutrition education which could overlap with similar initiatives focused specifically on diabetes prevention and management. In the 2021 CHNA, diabetes and cardiovascular disease were identified at a much higher priority than in previous assessments.

Therefore, they have been presented in independent and distinct categories. All identified key community needs are addressed either directly through designation as a prioritized key community need or incorporated as a component of a prioritized key community need.

Chart 2: JHH/JHBMC Prioritized Community Health Needs

Improving Socioeconomic Factors

While biological makeup or genetics determine some health issues an individual will experience, socioeconomic factors, such as income, education, and employment opportunities, can shape how people make decisions related to their health as well as the access they have to health care services. There is both a direct and indirect relationship between community residents' overall health and low levels of educational attainment and the inability to secure employment. It is not uncommon for residents living in poverty to face multiple challenges related to high crime rates, poor home conditions, and low educational attainment. Often, individuals in these situations are focused on obtaining basic

living needs (e.g., food, utilities, and housing) for themselves and their families. Without access to higher education and associated employment opportunities, community residents will continue to struggle with these challenges.

The table below provides a snapshot from County Health Rankings and Roadmaps of where Baltimore City compares to Baltimore County in years 2012, 2015, 2017 and to the most current year 2020. The ranking scale enables communities, organizations, and agencies to see where their communities lie in comparison to the remaining 23 counties in Maryland. Table 2 shows that Baltimore City ranks 24 out of 24 on Socioeconomic Factors in all years compared, while Baltimore County ranks 12 in those years. The rankings show no improvement in total score for either Baltimore City or County.

Variables used to derive the overall socioeconomic rankings are high school graduation, some college, unemployment, children in poverty, income inequality, children in single-parent households, social associations, violent crime, and injury deaths.

Table 2: County Health Rankings and Roadmaps Social and Economic Factors

County Health Rankings and Roadmaps[3]	Social and Economic Factors Rankings
Baltimore City	
2012	24
2015	24
2017	24
2020	24
Baltimore County	
2012	12
2015	12
2017	12
2020	12

Source: County Health Rankings & Roadmaps 2020, 2017, 2015 and 2012

Another socioeconomic factor, a healthy or livable environment, refers to the surroundings in which one resides, lives, and interacts. A livable environment refers to the availability of safe, affordable, clean housing, a community with healthy food options, and low crime rates. A poor or unlivable environment can lead to poorer health outcomes, a shorter lifespan, and health disparities.

In the CBSA, safe and affordable housing is a critical environmental need. Outdated and unsafe infrastructures in many Baltimore City homes often present hazardous elements that can trigger and exacerbate chronic conditions. The lack of affordable, clean housing, the inaccessibility to healthy foods,

[3] Maryland has 24 counties; the rating scale for Maryland is 1 to 24 (1 being the healthiest county and 24 being the least healthy). Counties are ranked relative to the health of other counties in the same state on specific measures.

and the area's high crime rates are common issues for families and individuals who struggle to secure employment in order to improve their environmental conditions.

Families are often deterred from engaging in outdoor activities in neighborhoods where high crime rates and safety issues are prevalent. The inability to be outside hinders residents from walking and playing, thus contributing to higher rates of physical inactivity and obesity. This is detrimental, in particular, for community residents whose primary form of exercise is walking.

Housing/Homelessness

As shown in Table 3 from the County Health Rankings & Roadmaps report for 2020, Baltimore City had a much higher severe housing cost burden at 21 percent than did Baltimore County and the state at 14 percent. This means that 21 percent of households spend 50 percent or more of their household income on housing. In addition, the percent of occupied housing units that are owned is much lower at 47 percent for the city versu s 66 percent for the county and 67 percent for the state.

Table 3: County Health Rankings & Roadmaps Physical Environment

Physical Environment	Baltimore City	Baltimore County	Maryland
Severe Housing Cost Burden	**21%**	**14%**	**14%**
Homeownership	**47%**	**66%**	**67%**

Source: County Health Rankings and Roadmaps 2020

Children under the age of six are vulnerable to lead poisoning, which affects mental and physical development. Lead poisoning at very high levels can be fatal. Older homes and buildings in the city are common sources of lead poisoning. Other sources include contaminated air, water, and soil. Adults who complete home renovations, who are employed in auto repair shops, and who work with batteries may also be exposed to unhealthy levels of lead.

When examining lead paint violations, the highest number of lead paint violations were found in the neighborhoods of Madison/East End (81.6), Greenmount East (57.2), Clifton-Berea (48.7), Midway-Coldstream (36.1), and Patterson Park North & East (21.7). However, when compared to 2011 lead paint violation rates, all five of these neighborhoods have shown decreases (See Table 4).

Table 4: Lead Paint Violations

	ZIP Code	2011 Average Annual Lead Paint Violations*	2017 Average Annual Lead Paint Violations*
Madison/East End	21205	90.3	81.6
Greenmount East	21202	64.6	57.2
Clifton-Berea	21213	63.6	48.7
Midway-Coldstream	21218	47.1	36.1
Patterson Park North & East	21224	34	21.7
Perkins/Middle East	21205	24.9	n/a
Oldtown/Middle East	21205/21231	n/a	13.5
Greater Govans	21218	12.6	10.1
Baltimore City	N/A	11.8	9.8
Belair Edison	21213	9.3	9.9
Orangeville/East Highlandtown	21224	9.3	11.6
The Waverlies	21218	9.1	6.1
Greater Charles Village/Barclay	21218	7.7	6.3
Lauraville	21206	5.2	3.4
Highlandtown	21224	4.5	4.4
Fells Point	21231	3.3	1.1
Cedonia/Frankford	21206	2.5	2.8
Hamilton	21206	2.2	3.1
Northwood	21218	1.8	1.4
Midtown	21202	1.5	1
Claremont/Armistead	21205	1.3	0.6
Canton	21231	1.3	0.7
Jonestown/Oldtown	21202	1.1	
Oldtown/Middle East	21205/21231		13.5
Downtown/Seton Hill	21202	0.9	0.8
Southeastern	21224	0.5	1.2
Harbor East/Little Italy (now includes Perkins)	21201/21231		2.2

Source: Neighborhood Health Profiles, 2011 and 2017

*Per 10,000 households in each specific neighborhood

Primary data collected from the survey identified affordable housing/homelessness (36.5 percent) as the highest social/environmental concern among a list of 15 available options. Findings from primary data collected during the CHNA align with secondary data findings regarding housing problems in the City.

Affordable, clean, and safe housing was a common theme discussed by community stakeholders. Public housing and rental properties are often in poor condition and can contain harmful elements that lead to respiratory conditions. Landlords often do not maintain their rental properties or adhere to building codes, and families are often unsure where to seek housing assistance. There are limited services and programs for residents who struggle with homelessness.

From the 2016 CHNA, community stakeholders also reported that residents in transitional housing situations are there, in part, due to the lack of affordable homes. Additional factors such as unemployment and lack of education prohibit residents from finding better housing options. Older row homes, common to the Baltimore region, present challenges because many are not conducive to individuals with disabilities and mobility issues, in particular seniors who require the use of assistive mobility devices (e.g., walkers, canes, or wheelchairs).

In the current and previous CHNAs, focus group participants indicated that access to safe, clean, and affordable housing is difficult to obtain and is especially challenging for minorities and those on limited or fixed incomes. Contractors and large construction companies are purchasing and renovating properties, then increasing the rents and mortgages, thus further limiting access to residents who need affordable homes. The lack of affordable housing is leading to homelessness in the community. Group participants agreed that low-cost housing in their communities is in poor condition and that there are limited resources and housing services for people seeking clean and safe housing.

It is important to evaluate and strategize on ways to assist community residents in addressing the growing housing crisis that plagues the region. There are multiple factors that prohibit community residents from affordable, clean, and safe housing, and understanding the societal elements can help resolve some disparities that Baltimore residents face.

Job Opportunities

The lack of job opportunities was ranked as the second highest concern among CBSA residents at 31.1 percent of respondents in the current CHNA survey. In past CHNAs, this concern was ranked as the top concern.

Adequate employment and income can provide a lifestyle that offers choices and options that influence health status and environmental factors such as housing, food, skill building for better employment opportunities, transportation, health care, and more. Data reveal that there are significant income disparities in the CBSA as compared to the state, although there is some improvement since the data collected in 2017. Households below $25,000 decreased from 28.4 percent to 23.5 percent, although they are still far higher than the Maryland rate of 12.7 percent.

Table 5 provides a detailed breakdown of household income for the CBSA and how the CBSA compares to Maryland statistics. In the CBSA, although there is a high percentage of households who earned an

income in excess of $100,000 a year (26.7 percent), there are significantly more low-income households (<$15K) compared to state averages.

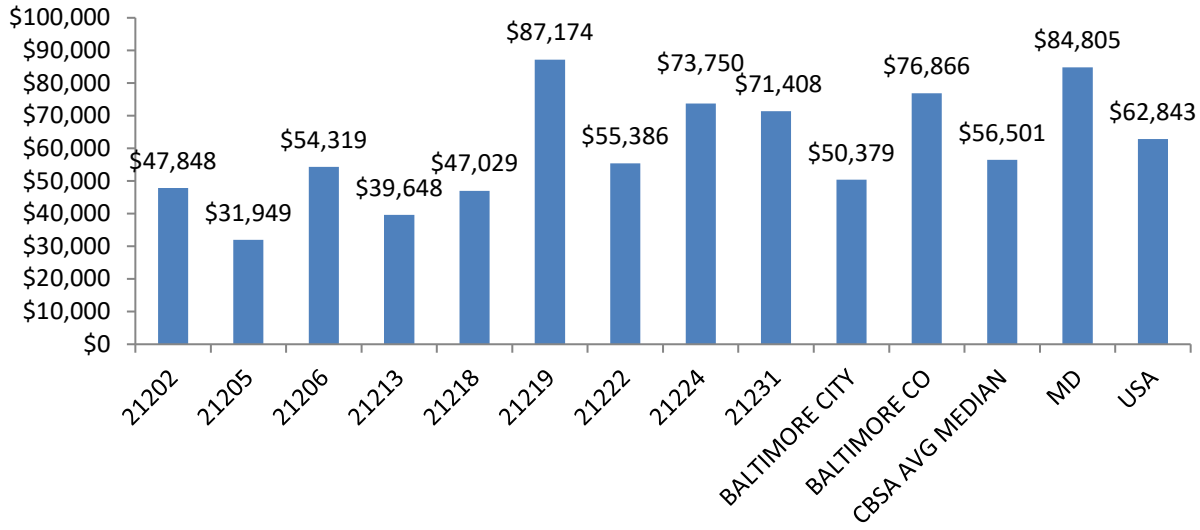
Table 5: Household Income Detail

	CBSA	Maryland
<$15K	14.5%	7.1%
$15-25K	9.0%	5.6%
$25-50K	22.0%	15.7%
$50-75K	16.8%	15.1%
$75-100K	11.0%	12.8%
Over $100K	26.7%	43.8%

Source: Sg2 Market Demographics, 2020

Providing a median household income snapshot across all ZIP codes, we can note that ZIP codes 21205 ($31,949) and 21213 ($39,648) have the lowest yearly household income compared to their counterparts in the CBSA. Additionally, it is evident that the median household income in Baltimore City ($50,379) is significantly lower than that for Baltimore County ($76,866), the state ($84,805), and the nation ($62,843) (See Chart 2). In ZIP code 21219, 7.7 percent of households are indicated as "High Income" making in excess of $200,000 per year. In contrast, only 2 percent of households are designated as such in 21213 and 21222 and only 1 percent in 21205.

Chart 3: Median Household Income



Source: U.S. Census Bureau, American Community Survey, 2019 5-year Estimates

Community residents with a low household income can struggle to afford basic necessities such as food, shelter, and clothing. These community residents fare worse than those within a higher income bracket on many levels. Residents who are economically disadvantaged will continue to face significant life challenges affecting the ability to obtain resources and improve their living environment. Without good employment prospects and access to a sustainable living wage, these residents are more likely to engage in unhealthy behaviors, ignore mental health issues, not engage in preventive health practices, and fall victim to the generational cycle of living in poverty.

Reviewing CHNA discussions, community leaders are aware that employment opportunities for low-income residents can improve their quality of life on multiple levels. It is often necessary to provide training, education, workforce development, and resources to those in need.

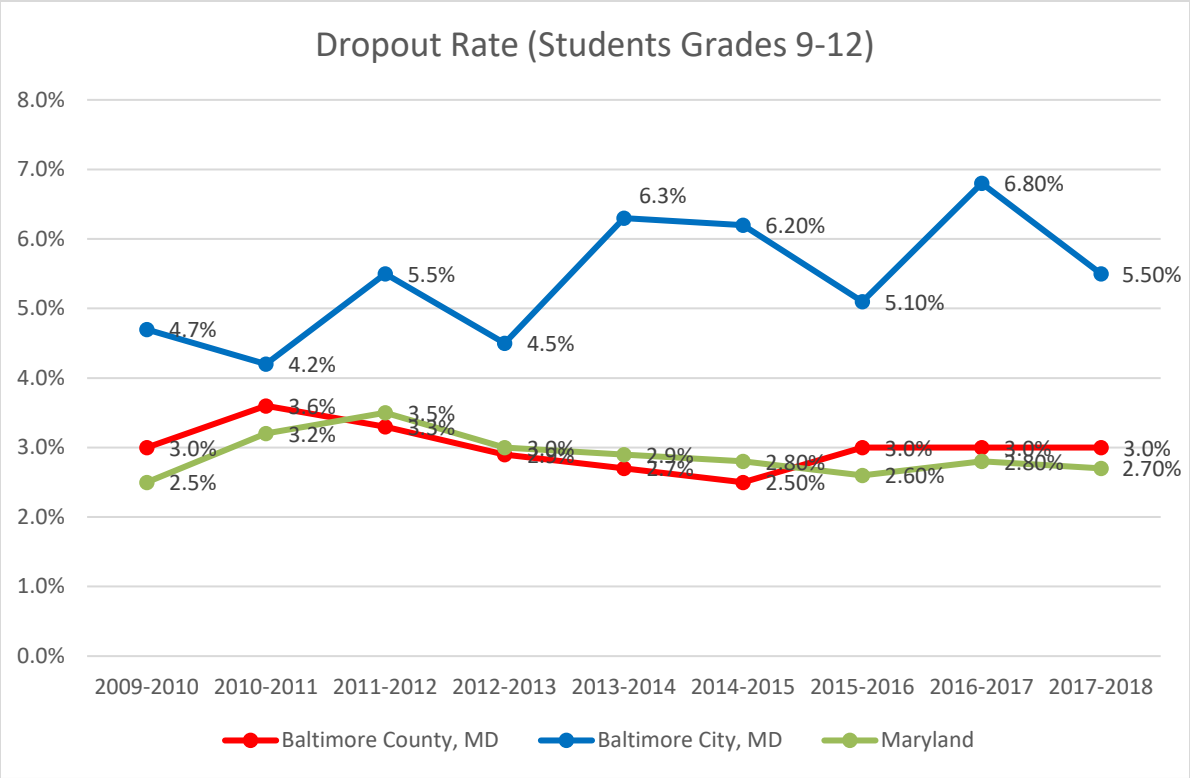
The lack of employment opportunities for many community residents has not changed over the years, and the employment prospects for those with limited skills and those who have been incarcerated are bleak; thus, re-entry opportunities from businesses continue to provide hope. Community residents in the 2016 focus group cited extreme employment challenges due to multiple factors. Prior criminal history, lack of skills, and not being properly educated are some barriers that prohibit many from securing employment. While obtaining steady employment can be difficult, it is a goal many want to achieve.

From the 2016 CHNA study and continuing to the current study, focus group participants stated that they believed employment training or workforce development programs can assist those struggling to gain the skills and resources they need. It comes as no surprise that community residents who actively seek employment also cite the lack of transportation options as hindering their job prospects.

An individual's level of education affects their health status as it can dictate employment opportunities and comprehension capabilities. Educated individuals are more likely to have job security, are often better equipped to access and navigate through the services they need, and can understand the importance of taking preventive health measures and making healthy choices for themselves and their families. Educated residents typically are more aware of their own health status and the health status of their family. Being educated can mitigate some of the environmental factors that negatively affect the health status of disadvantaged populations by providing tools needed to better understand the environment and to take advantage of opportunities for life improvement.

In 2020, Sg2 Market Demographics indicated a larger portion of residents age 25+ in the CBSA do not have a high school diploma, 16.8 percent, as compared to 10.0 percent for residents in the state of Maryland. Data from The Annie E. Casey Foundation highlight the dropout rate (see Chart 4). Baltimore City had a higher dropout rate (5.5 percent in 2017-2018) consistently over the years, nearly double that of the county and state for students in grades 9-12. Particularly concerning is the increasing trend of the dropout rate over the last nine years in Baltimore City.

Chart 4: Dropout Rate (Students in Grades 9-12)



Source: Annie E. Casey Foundation, Kids Count, 2016, 2017, 2018. Profile for Maryland

In the 2016 CHNA community stakeholders reported that health education should begin at the elementary stage, addressing and reinforcing information beyond basic subjects (e.g., nutrition, health topics/disease, mental health, etc.). It was cited that most often community residents do not foresee or comprehend how education is linked to a pathway toward a healthier, more productive life.

A greater emphasis needs to be placed on the relationship between education and income, noting there are greater employment opportunities, options, and availability for those who have a higher level of educational attainment. Higher education enables community residents to understand concepts and theories, expanding their overall knowledge base, which in turn leads to residents having a better understanding of their community, environment, and health.

Community leaders' concerns about employment opportunities were often communicated in conjunction with residents expressed need for affordable transportation. Improved transportation can increase employment opportunities for low-income residents. It was voiced that strong employment opportunities exist outside of the city; however, many residents struggle to secure reliable transportation due to limited and insufficient bus routes. Light rail trains and buses do not extend far enough to access employment opportunities in outlying areas.

Having a strong, economically healthy community contributes to a healthier environment for residents and for neighborhoods overall. Community organizations and area agencies work diligently trying to connect residents to services and programs. Community leaders and participants reported that area

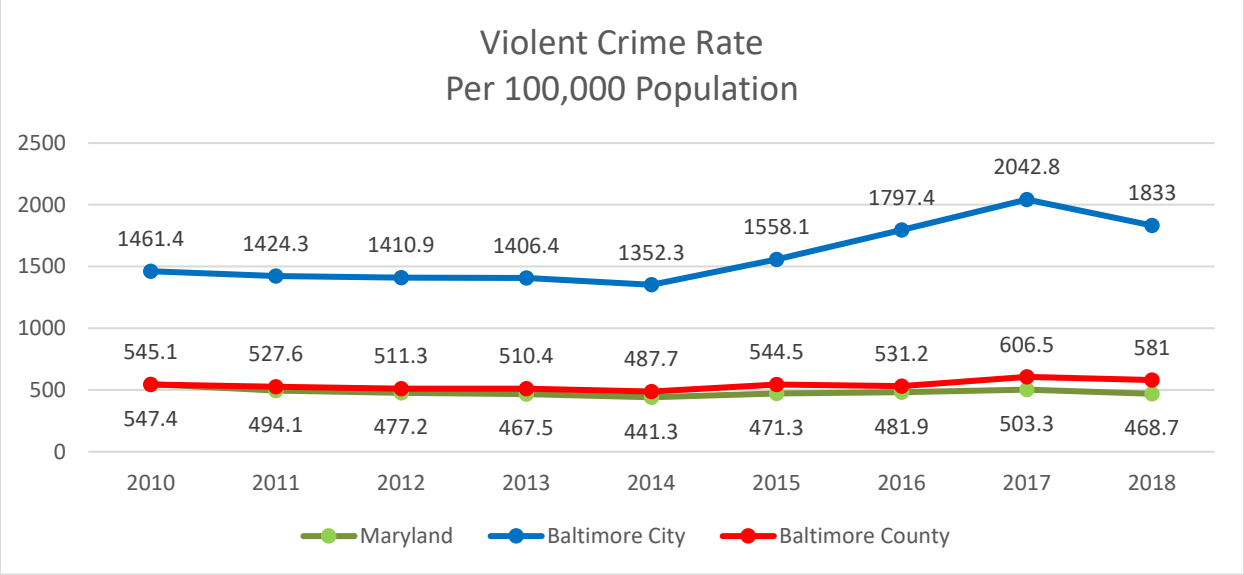
residents are loyal and faithful. Many have immense pride in their neighborhoods and hope to obtain the education and employment opportunities in order to be better, more productive citizens.

Neighborhood Safety

While many families and individuals live in a comfortable and safe environment, there are a large number of Baltimoreans who do not. Crime and safety factors significantly impact the ability of an individual to enjoy a full and productive life. The lack of a livable environment affects the ability of individuals to access adequate preventive health care services, engage in outdoor activities, and obtain other basic needs. Unfortunately, many city residents face the threat of crime each day.

In 2014, the overall rates of crime reached a low point in the State. Since then, following the 2015 Baltimore City unrest, overall crime rates in the City and the State have increased. Particularly problematic, the violent crime rate in Baltimore City has accelerated significantly. Data obtained from the FBI Uniform Crime Reports indicate that Baltimore City's violent crime rate of 1833 per 100,000 greatly exceeded that of Baltimore County (581) and the state (468.7) in 2018 (See Chart 5).

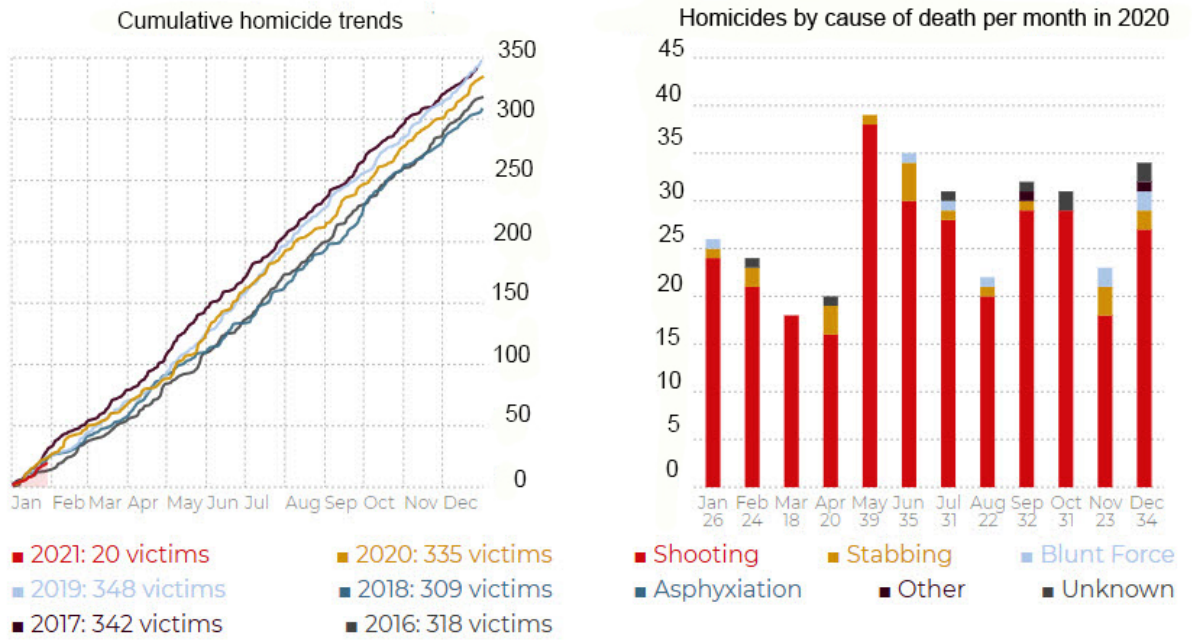
Chart 5: Violent Crime (per 100,000 Population)



Source: FBI Uniform Crime Reports 2008-2018

Further evidence that progress made in 2013 and 2014 has been negated since then can be found in the homicide rates. Baltimore reached its highest ever homicide rate in 2019 at 348 victims, topping the previous high in 2015. As reported by The Baltimore Sun, Chart 6 shows homicides by month and type of death in 2020. In total, homicides in Baltimore City for the year 2020 decreased slightly from the high in 2019 to 335 victims, a decrease of only 3.7 percent over the previous year.

Chart 6: Baltimore City Homicides



Source: The Baltimore Sun 2021

Data from the 2016 CHNA survey revealed that more than one-half of survey respondents (62 percent) feel 'somewhat safe' from crime in their neighborhood/community, while 11.3 percent do not feel safe at all. Crime, violence, and drugs were the top reasons why respondents did not feel safe in their neighborhood/community. In the current survey, 28.1 percent of all respondents listed neighborhood safety/violence as a high social/environmental concern. Although not as high a concern as in the previous survey, it is clear it is still a top priority as seen by the community. In addition, many survey respondents indicated the corruption within the police department was a major concern.

Within the community, many stakeholders reported that serious crime is prevalent in Baltimore City. Trauma experienced at an early age, drug addiction, and incarcerated family members can create an emotional toll. Many families are one-parent households struggling to support and provide a safe and positive environment for their families.

Community leaders expressed awareness that safety is a significant concern for many parents, and children are often forced to stay inside as a result of their unsafe environment. Regions within the city are also plagued with urban decay, further creating an atmosphere that can attract unwanted illegal activities. Having an unsafe community creates an environment conducive to drug use and limits the ability to attract employment opportunities to the region.

Focus group participants stated that residents are exposed to drugs, alcohol abuse, and violence in their neighborhoods on a regular basis. Domestic violence and other types of assaults were also mentioned as issues that the community deals with regularly. For residents of Baltimore City, crime is a significant part of their communities.

Reducing the crime rate and providing a safe environment requires participation from all city entities. Some would argue that improvements in law enforcement and more severe consequences could deter offenders, while others point out that this approach could lead to further disintegration of families. However, if the ultimate outcome is to have community residents contribute fruitfully as part of society, income disparities must be addressed. Closing the income gap and providing economic opportunities for residents could prove to be a long-term solution and a pathway to assist those who currently have limited future opportunities.

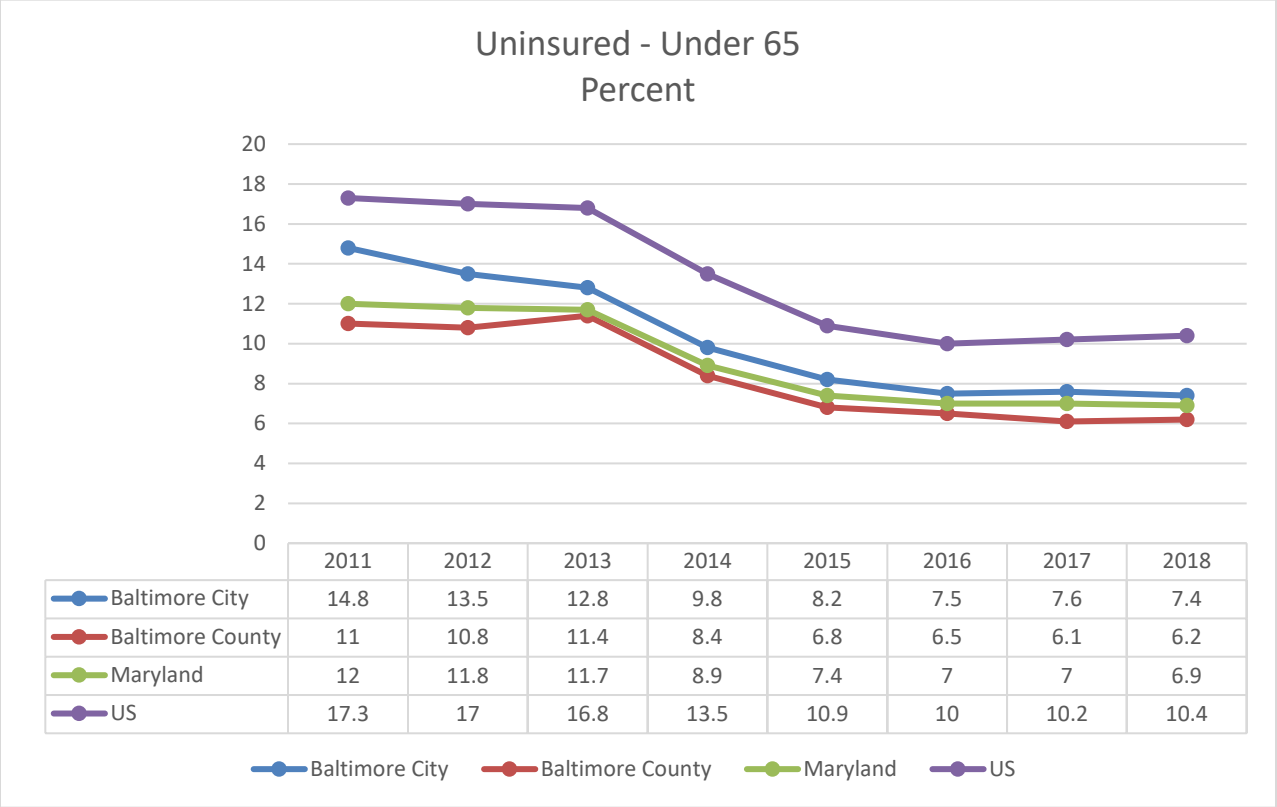
Access to Care / Support

The availability of health care insurance is one of the most important elements in obtaining primary health care access. For many Americans, there remains a need to make it more available. The limitations in health care coverage affect the vulnerable, underserved, and low-income populations. Many factors influence the availability of health insurance, including economic factors, language, knowledge, citizenship, and ease of accessibility.

The Patient Protection and Affordable Care Act (PPACA) provides Americans with better health security by putting in place comprehensive health insurance reforms that expand coverage, hold insurance companies accountable, lower health care costs, guarantee more choice, and enhance the quality of care for all Americans. Although this legislation introduced historic reform, millions of Americans still find themselves unable to afford health insurance. Often forced to choose between meeting basic needs or paying health insurance premiums, too many Americans go without health insurance coverage, increasing the impact of injury and illness.

The availability and ease of use for insurance have increased with the passage of the PPACA. In 2018, the U.S. Census Bureau estimated that 6.9 percent of Marylanders, compared to 10.4 percent of the U.S. population, lives without any type of health care insurance. These numbers are a good indication of progress made, as 2011 levels were significantly higher with 12 percent of Marylanders and 17.3 percent of the U.S. population living without insurance coverage. The U.S. Census Bureau estimates on the county level from 2011 to 2018 show that Baltimore City and Baltimore County both lowered the percentage of uninsured population aged 18 to 64 years to 7.4 percent and 6.2 percent, respectively (See Chart 7). While the coverage of community residents in Baltimore City is above the national rate, the uninsured population still remains vulnerable to the difficulty of obtaining health care services.

Chart 7: Uninsured Population Aged 18-64 years (2011 to 2018)



	2011	2012	2013	2014	2015	2016	2017	2018
Baltimore City	14.8	13.5	12.8	9.8	8.2	7.5	7.6	7.4
Baltimore County	11	10.8	11.4	8.4	6.8	6.5	6.1	6.2
Maryland	12	11.8	11.7	8.9	7.4	7	7	6.9
US	17.3	17	16.8	13.5	10.9	10	10.2	10.4

Source: U.S. Census Bureau, Small Area Health Insurance Estimates 2018

The CDC estimates that for 2018, 20.1 percent of the Hispanic population in the United States did not have health insurance coverage. In the current CHNA survey, 68 percent of the respondents who identified as Hispanic/Latino indicated they did not have insurance. Many of these people were seeking free COVID-19 testing or health services from East Baltimore Medical Center, a hub for undocumented immigrants, so the results may not be representative of the overall Hispanic/Latino population in the JHH/JHBMC CBSA.

Table 6 shows a trend of the Community Needs Index (CNI) by ZIP code within the CBSA from 2014 through 2020 (refer to Appendix C for information on how CNI is calculated). The CNI score is an average of five different barrier scores that measure socioeconomic indicators: income, cultural/language, educational, insurance and housing barriers. Higher scores indicate more barriers. As shown in the table, ZIP codes 21202, 21205 and 21213 had the highest scores at 4.8, indicating that community residents in these specific neighborhoods experience the most barriers. Although the trend has been improving for most of the ZIP codes, the improvement has been marginal with some ZIP codes like 21206 and 21218 getting worse. The average score for the CBSA at 4.1 is worse than the city as a whole at 3.7 and much higher than Baltimore County at 2.9.

Table 6: CBSA CNI ZIP Codes and Scores: Specific Data and Measures

ZIP	County	City	2020 Population	% Population Increase/ (Decrease)	2014 CNI Score	2015 CNI Score	2017 CNI Score	2020 CNI Score	Increase/ (Decrease) 2017 to 2020
21202	Baltimore City	Baltimore	23,893	-2.8%	5.0	5.0	4.8	**4.8**	**0.0**
21205	Baltimore City	Baltimore	15,131	-5.3%	5.0	5.0	4.8	**4.8**	**0.0**
21206	Baltimore City / County	Baltimore	48,203	-4.2%	3.8	4.0	3.6	**4.0**	**0.4**
21213	Baltimore City	Baltimore	30,318	-4.7%	4.6	4.8	4.8	**4.8**	**0.0**
21218	Baltimore City	Baltimore	46,813	-4.4%	4.4	4.4	4.2	**4.4**	**0.2**
21219	Baltimore County	Sparrows Point	9,353	-3.9%	2.6	2.6	2.8	**2.4**	**-0.4**
21222	Baltimore City / County	Dundalk	55,968	-2.0%	3.6	3.4	3.6	**3.6**	**0.0**
21224	Baltimore City / County	Baltimore	49,506	-2.8%	4.6	4.6	4.4	**4.4**	**0.0**
21231	Baltimore City	Baltimore	15,984	-2.7%	4.8	4.6	4.2	**4.0**	**-0.2**
Overall Study Area			295,169	-3.5%	**4.2**	**4.3**	**4.1**	**4.1**	-
Baltimore City							**4.1**	**3.7**	
Baltimore County							**2.3**	**2.9**	

Source: Dignity Health, 2020

Community leaders believe there are a number of factors that affect insurance status within the community. Fear and a lack of trust were two consistent points that surfaced during community leader discussions.

Input from focus group sessions and surveys found that many residents do not have health insurance because they do not know how to obtain it or are undocumented. There was the belief that the process is difficult and that 'Obamacare' does not provide adequate, affordable coverage.

Some stated that they avoid seeking health services because they are not eligible, nor can they afford health insurance premiums or the costs associated with uninsured medical care. For many who were aware of health resources, there was a concern about the fear of doctors and the trustworthiness of information and services provided by these organizations. There is a need for this information to come from trusted community-based organizations and leaders.

Overall, the cost of care, insurance, and lack of community awareness are barriers to receiving health care. Many feel that payment for health care services is expensive, which includes out-of-pocket costs,

prescription medications, and high deductibles. Several respondents commented that preventive health care services should be free, with fees for preventive services blocking participation for those who cannot afford basic needs.

Language barriers and fear of deportation are the main reasons the Hispanic/Latino population does not seek care. Language barriers create problems while scheduling appointments and communicating with providers during visits. While providing information is important, information to community residents must be basic and clearly understandable in order for residents to make appropriate and informed health decisions, even when a foreign language is not an issue.

Many people don't understand how to navigate the insurance and health care systems. Assistance programs are complicated and people don't know what is needed to apply. In the case of Hispanic/Latino participants, they feel information may not be held in confidence and could be used to deport them. Additionally, many reported they fear assistance programs are going away because of the previous federal administration.

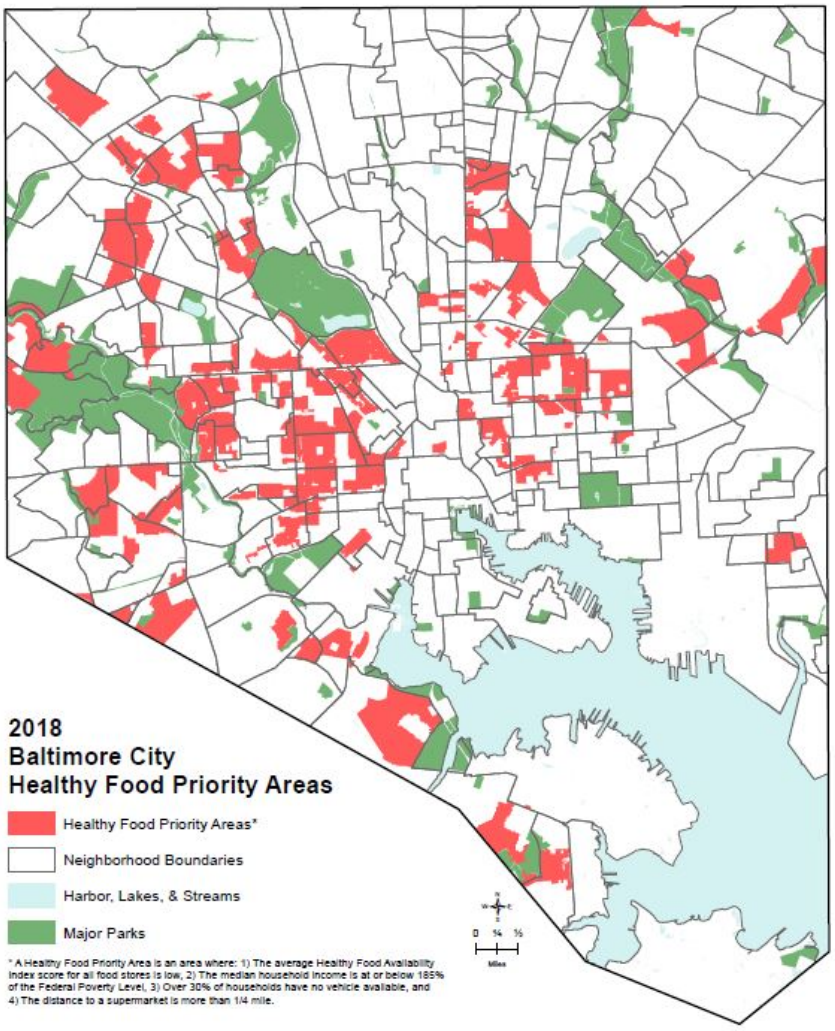
Other concerns included transportation for groups that are not mobile, such as the disabled and older adults, and getting the prescriptions needed for care after leaving the health care facility. Increasing the number of community health workers was mentioned as a way to get services directly into the community, especially preventive measures and follow-up care.

Food Environment

A healthy food environment ensures that residents have the ability to purchase nutritious foods and that those foods are affordable and conveniently located. The term "food desert" or "healthy food priority area" describes geographic regions where affordable, nutritious foods are typically difficult to obtain, especially for residents with limited transportation options. Healthy food choices, such as fresh fruits and vegetables, are often unavailable or too expensive in the small convenience-type stores characteristic of underserved and low-income areas. Food options found in such convenience stores are usually processed and high in calories and unhealthy fats. The unavailability of large grocery stores, supermarkets, and farmers' markets, along with the convenience of junk foods, has contributed to the obesity epidemic. It is important to address the food environment if we are to reduce health disparities and improve patient management of chronic disease conditions such as obesity, high blood pressure, cardiovascular disease, and diabetes.

The 2018 edition of Baltimore City's Food Environment Report provides new insights into the issue of healthy food availability. Of a total city population of 621,000, about 146,000 people, or 23.5 percent, live in areas identified as Healthy Food Priority Areas, which qualify as meeting all four factors that are considered: supply of healthy food, household income, vehicle availability, and distance to a supermarket. These Priority Areas are located primarily in neighborhoods that are not close to either supermarkets or public markets and where residents rely primarily on convenience stores or small groceries and corner stores.

Map 3: Map of Healthy Food Priority Areas in Baltimore City

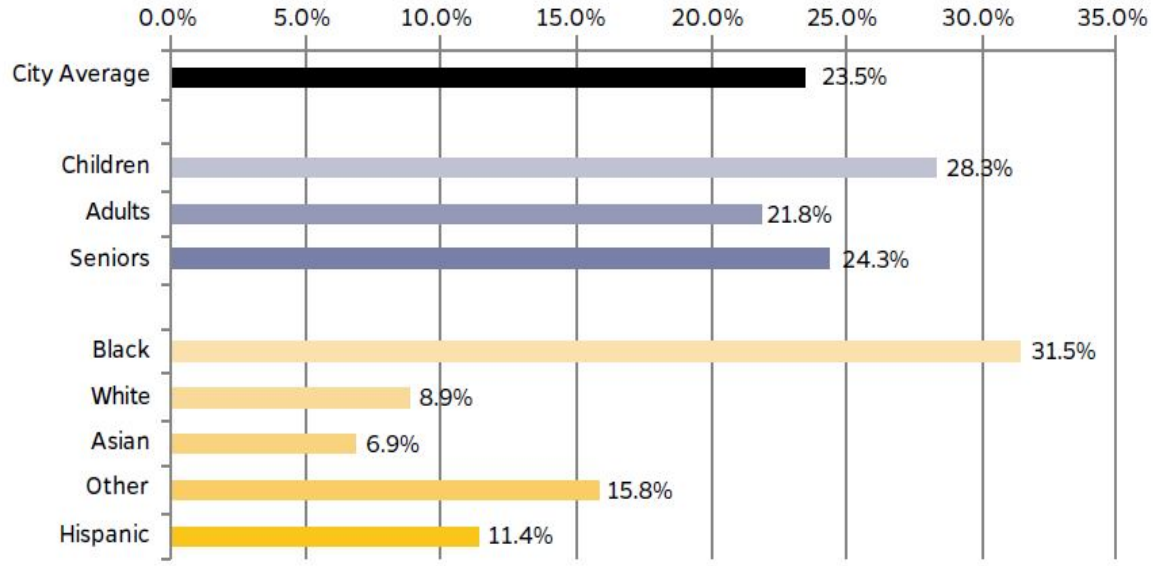


Source: 2018 Baltimore City Food Environment Report

As indicated in Table 7, children are the more likely age group to live in a Priority Area. Black/African American residents of Baltimore are the most likely of any racial/ethnic group to live in a Priority Area – 31.5 percent in comparison to only 8.9 percent of White residents who live in a Priority Area. Since 2005, about 5,000 fewer residents in the CBSA live in a Healthy Food Priority Area due to the opening of a grocery store in the McElderry Park neighborhood. Also, following publication of the 2018 Food Environment Report, the Salvation Army opened its first nonprofit grocery store called DMG Foods in the Waverly neighborhood.[4] DMG Foods partners with a variety of local farms, retailers, and community organizations to provide quality produce, meal solutions, supplemental benefits, and skilled workforce training. Ultimately, DMG Foods is designed not just to fill a gap in an urban community in critical need, but to address the needs of each member of the community with dignity and empowerment.

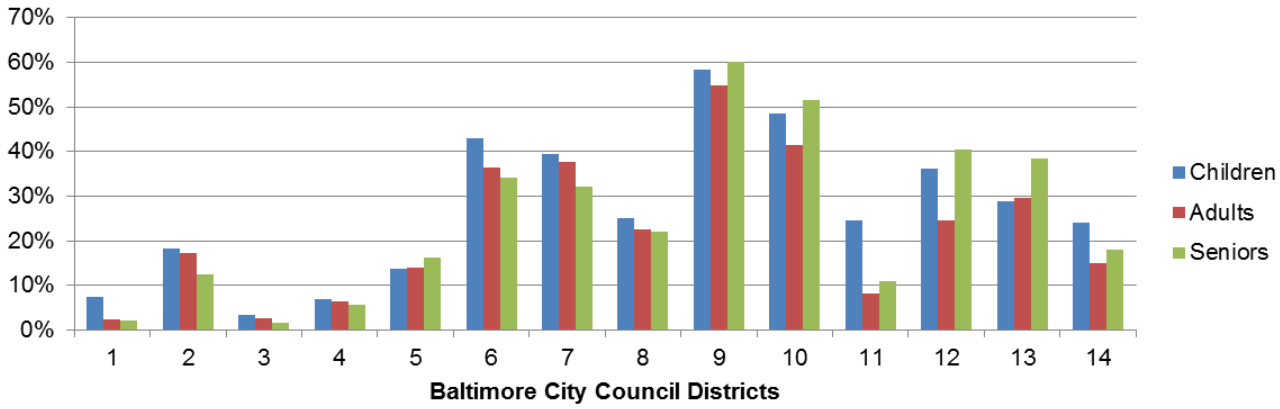
[4] http://www.baltimoresun.com/business/bs-md-ci-salvation-army-grocery-20180228-story.html

Table 7: Percent of Population Groups Living in a Healthy Food Priority Area



Source: 2018 Baltimore City Food Environment Report

Chart 8: Percentage of Each Age Group Living in a Healthy Food Priority Area by District



Source: 2018 Baltimore City Food Environment Report

As shown in Chart 8 above, the districts of most concern in the JHH/JHBMC CBSA are districts 12 and 13 where close to 40 percent of seniors live in a food priority area, many with limited mobility. The percentage of children living in a food priority area is also high in these districts.

It was reported by the U.S. Census Bureau American Community Survey that more than one-third of Baltimore City residents (40.3 percent) live below 200 percent of the Federal Poverty Level (FPL); this is nearly twice the level of the state (21.6 percent) and higher than the U.S. (30.9 percent).[5] This indicator

[5] U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

is relevant because poverty creates barriers to access, including health services, healthy food, and other necessities that contribute to poor health status. The 2020 Annual Guidelines state that a family of four below 200 percent FPL has an average household income below $52,400.

Fortunately, the Supplemental Nutrition Assistance Program (SNAP) offers nutrition assistance to millions of eligible, low-income individuals and families and provides economic benefits to communities. This program is essential to many as it assists community residents with food options that allow them to be healthy and maintain their well-being. The U.S. Census Bureau reported for 2015-2019 that Baltimore City had 24.0 percent of its residents receiving SNAP benefits in the past twelve months. This is more than twice the rate of residents in Baltimore County (9.5 percent), Maryland (10.2 percent), and the U.S. (11.7 percent).

Based on discussions from the current and previous CHNAs, community leaders are aware from the residents they serve that access to fresh, healthy foods is limited. Typically, residents have little access to grocery stores, yet fast foods and highly processed meals are easily accessible.

The inaccessibility of healthy food options paired with the absence of health education and the inability to participate in outdoor activities or in a structured physical exercise regimen creates an environment that perpetuates chronic health problems. Access to proper nutrition is vital to maintaining good health, according to focus group participants. There is general awareness regarding the connection between nutrition and making healthy food choices and the role both play in overall health.

Focus group participants reported cultural eating habits, the lack of quality grocery stores (living in a food desert), and the unaffordability of healthy foods are underlying factors causing high rates of diabetes, particularly among African Americans. There was a perception that food establishments and restaurants were more inclined to serve unhealthy foods (e.g., fried foods, salty foods, etc.) and limit healthy food options to their customers due to the popularity of fried or salty foods in neighborhoods they serve. Fast food restaurants and convenience stores are widely available in their communities; unfortunately, large, full-scale grocery stores are not readily available.

Another barrier for many low-income residents is education. Community residents may not have the proper health education and understanding of how to prepare a healthy meal. Proper educational information and dietary guidelines can assist those who want to eat healthy meals; however, the availability of healthy food choices must be present.

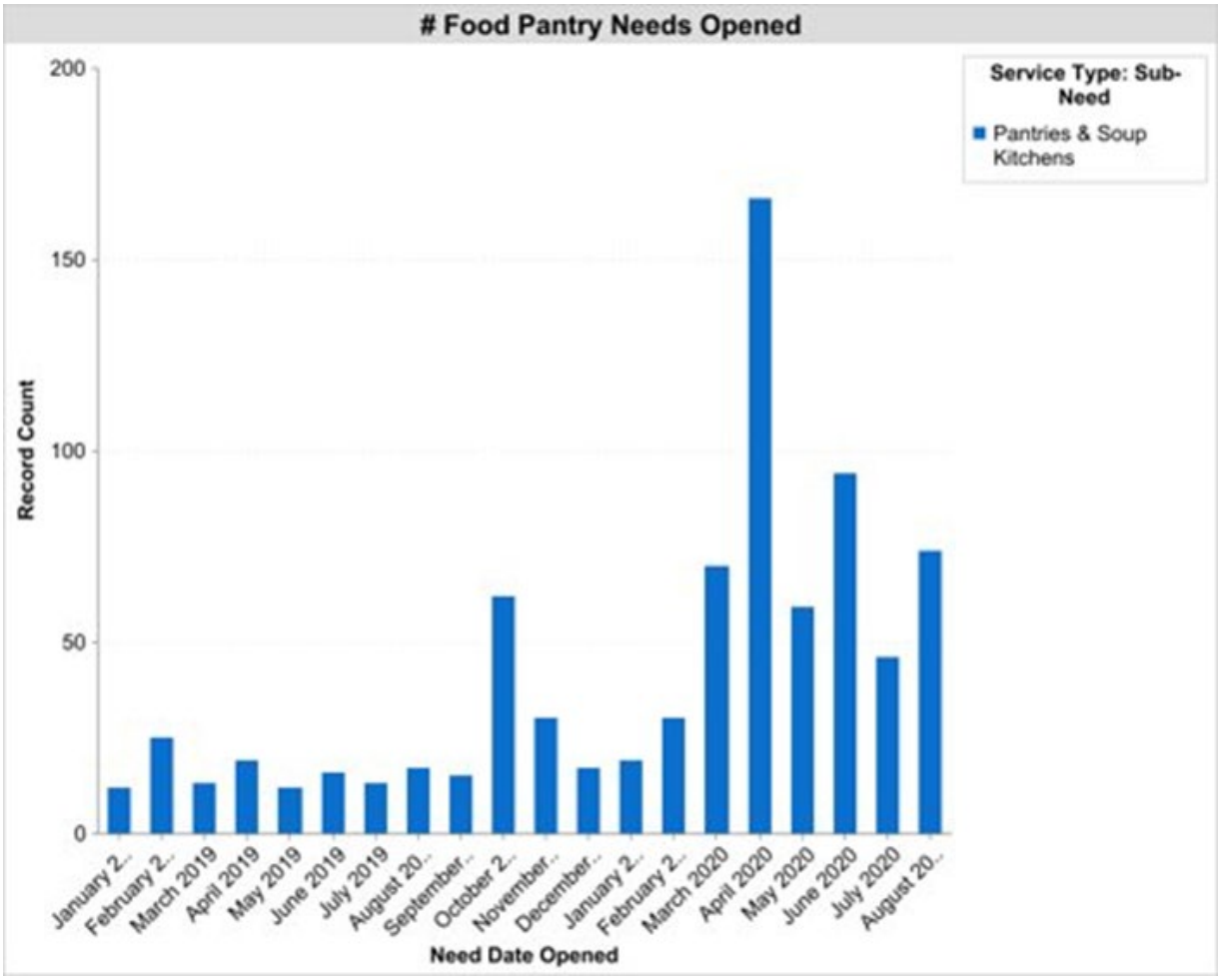
Fortunately, there are noteworthy initiatives underway in Baltimore City to combat the food environment problem. The Baltimore City Department of Food Policy and Planning has adapted its previous Food Desert Retail Strategy to be a more comprehensive and inclusive strategy, now called the Healthy Food Environment Strategy. Their strategy addresses aspects of food access beyond food retail including food assistance and food production, as well as the processes necessary to engage stakeholders across the food system.

Another initiative is Baltimore's Healthy Food Systems, led by the Johns Hopkins Bloomberg School of Public Health. The Healthy Food Systems project aims to improve health and prevent obesity and disease in low-income communities through culturally appropriate educational, environmental, and policy interventions that increase access to healthy foods and promote their purchase, preparation, and

consumption. Projects currently underway include the B'MORE Healthy Community for Kids and Fresh Shelves, Healthy Pantries.

In response to the urgent needs presented in 2020 as a result of the COVID-19 pandemic, Johns Hopkins has opened food pantries at three different clinics at JHH and JHBMC through the Hopkins Community Connection (HCC) program. In addition, HCC became an official partner with the Maryland Department of Human Services (myDHR) to allow direct application on behalf of patients for public benefits (SNAP, TCA, disability, and energy assistance). This allows for an expedited application process and direct avenues to follow up with the state if there are any processing delays. As shown in Chart 9 below, the need for food had more than tripled with the high point in March 2020. For FY20, more than 350 unique families received groceries through the program.

Chart 9: Food Pantry Needs



Source: Healthy Community Connection, 2020

Access to Health Services

Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all Americans. Access to health care services is a recurring problem in the community. As a point of reference, this typically refers to the ability and ease with which people can obtain health care or use health care coverage.

Across the nation and during the CHNA process, access to behavioral health services, which include substance abuse and mental health services, arose as a key priority in the study area. Secondary data, results from the survey, discussions with community leaders, and focus groups with vulnerable populations all highlighted the growing national and local need to increase access to behavioral health services. Behavioral health concerns, both substance abuse and mental health, were listed by focus group participants and survey respondents as their number one health concern.

The shortage of mental and behavioral health providers is recognized as a serious challenge for those struggling with mental and behavioral health issues. The loss of independence, the loss of a loved one, and the overall decline of health are also some contributing factors that make mental health a critical concern. Mental health is shaped in part by the socioeconomic factors and physical environment where people live. Primary and secondary data collected from the CHNA reinforced these statements. In the community, health services should be effective and relevant for community residents to be able to obtain them. Health insurance coverage can only go so far for those living in the community. There are a multitude of factors and barriers that prevent residents from obtaining care and services. These include affordability, health literacy, navigation through the health care system, the availability of providers, lack of culturally competent care, transportation, etc.

The CHNA identified specific areas of focus regarding access to health services. They include obtaining behavioral health services for substance abuse and mental health, diabetes/obesity, cardiovascular disease, and access to services and education related to chronic diseases.

Behavioral Health - Substance Abuse

A major growing concern along with mental illnesses is substance abuse, which refers to the abuse of alcohol, the inappropriate use of prescription medicine, and the use of illegal drugs. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) 2019 National Survey of Drug Use and Health, 7.4 percent, or 20.4 million individuals aged 12 years or older, had a substance use disorder (SUD) in the past year. As seen in Chart 10 below, SUD was higher among males (9.4 percent) vs their female counterparts (5.5 percent) and highest among adults aged 18-25 (14.1 percent). This included 14.5 million people who had an alcohol use disorder and 8.3 million who had an illicit drug use disorder. More specifically, 4.8 million people had a marijuana use disorder, 1.6 million people had an opioid use disorder, and 0.7 million had a heroin use disorder. Misuse of prescription pain relievers was estimated at 9.7 million people, or 3.5 percent of the population.

Chart 10: Past-Year Substance Use Disorder among People 12 or Older in the U.S.

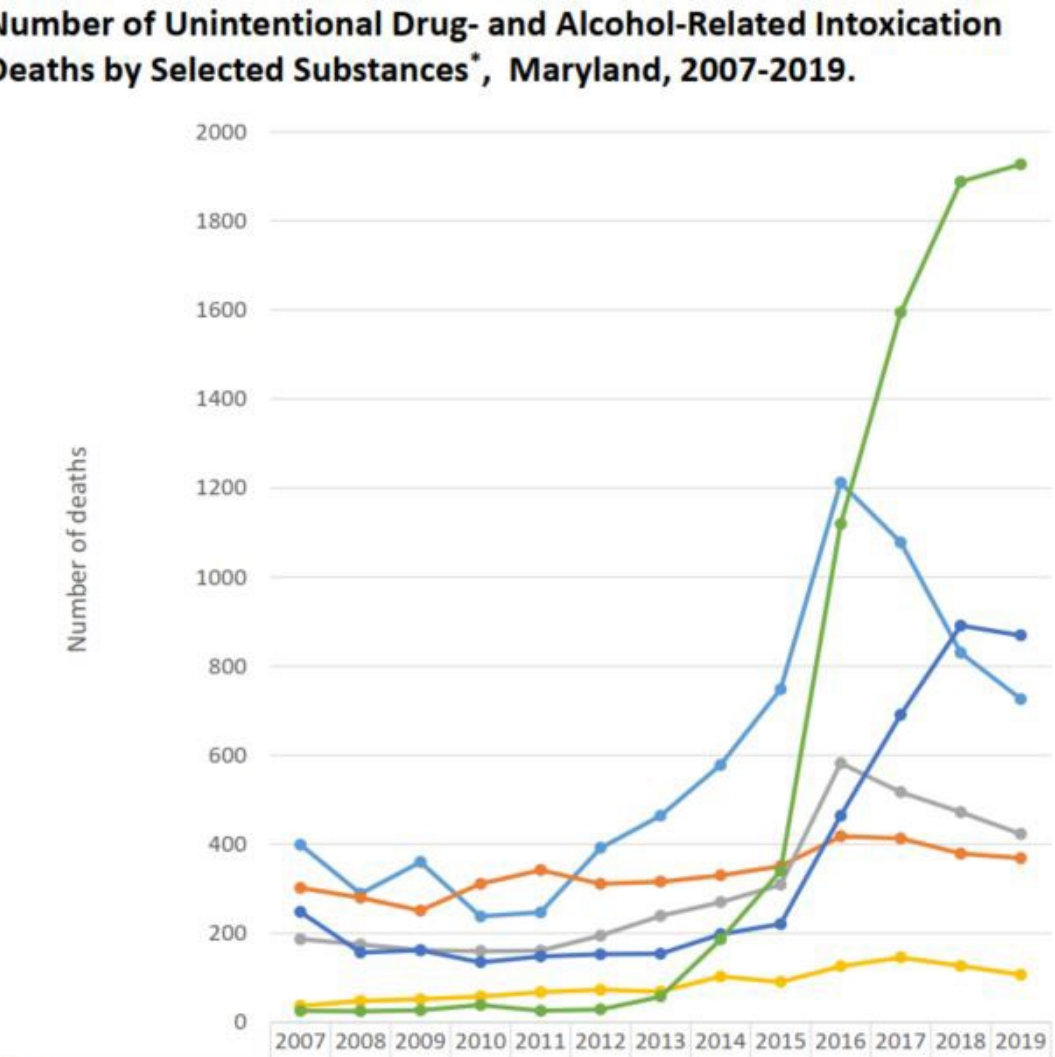
Error bars indicate 95% confidence interval of the estimate.
U.S. = United States; NH = non-Hispanic; NH AI/AN = NH American Indian or Alaska Native; NH NH/OPI = NH Native Hawaiian or Other Pacific Islander.
# Estimate is significantly different from the estimate for males ($p < .05$).
† Estimate is significantly different from the national average ($p < .05$).
* Omitted due to low precision of data.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2019.

In a single-day count in March 2019, 1.5 million people in the United States were enrolled in substance use treatment—an increase from 1.3 million people in 2015. Among people aged 12 or older with a past-year alcohol use disorder in the United States in 2019, about 9 in 10 people (92.3 percent) did not perceive a need for treatment for their alcohol use and did not receive treatment at a specialty facility. Among people in the United States enrolled in substance use treatment in a single-day count in March 2019, 52.2 percent received treatment for a drug problem only, 33.4 percent received treatment for both drug and alcohol problems, and 14.4 percent received treatment for an alcohol problem only.

Maryland Department of Health's 2018 Report on Drug- and Alcohol-related Intoxication Deaths show that, like the nation, Maryland has seen a sharp increase in opioid-related deaths, primarily due to fentanyl deaths and less as a result of prescription opioids and heroin (see Charts 11-16). The number of opioid-related deaths in Maryland increased by 70 percent between 2015 and 2016, and has more than quadrupled since 2010. (Note: Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum to the total number of deaths in the report.)

Chart 11: Drug- and alcohol-related intoxication deaths by selected substances, Maryland



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Heroin	399	289	360	238	247	392	464	578	748	1212	1078	830	726
Prescription opioids	302	280	251	311	342	311	316	330	351	418	413	379	369
Alcohol	187	175	162	160	161	195	239	270	309	582	517	472	423
Benzodiazepines**	37	48	52	58	68	73	69	103	91	126	146	127	107
Cocaine	248	157	162	135	148	153	154	198	221	464	691	891	869
Fentanyl	26	25	27	39	26	29	58	186	340	1119	1594	1888	1927

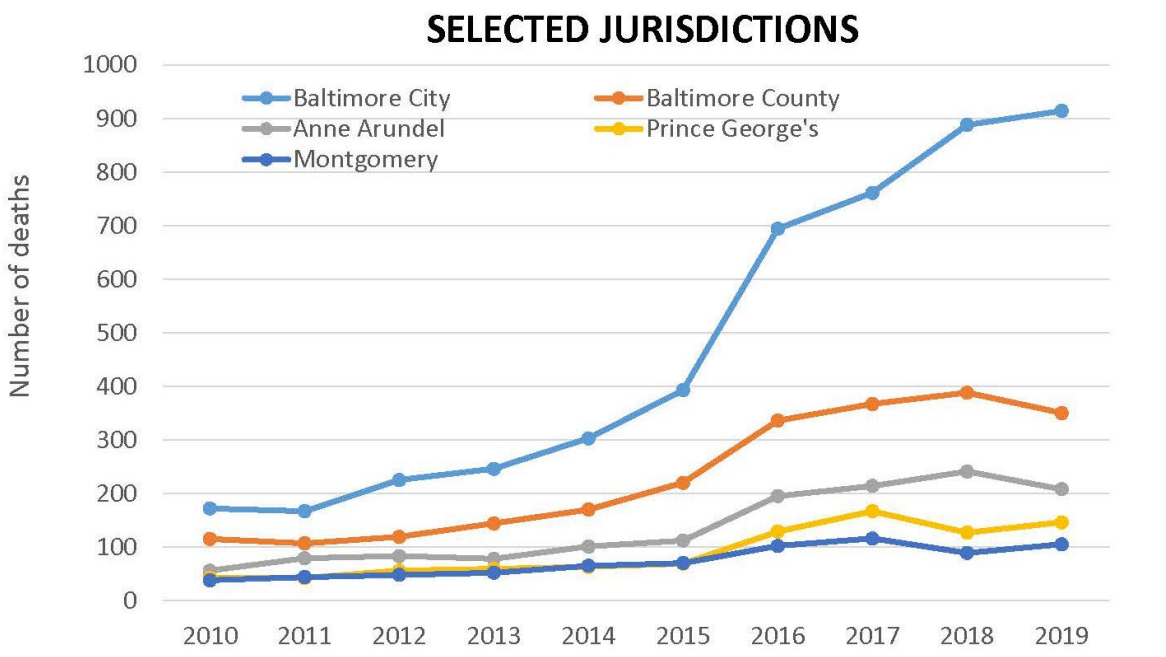
*Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum to the total number of deaths.
**Includes deaths caused by benzodiazepines and related drugs with similar sedative effects.

Source: Maryland Department of Health Report on Drug- and Alcohol-related Intoxication Deaths (2020)

Baltimore City, in particular, has experienced large increases in fentanyl, cocaine, and alcohol-related deaths, followed by Baltimore County, Anne Arundel County, and Prince George's County. The number

of heroin-related deaths in Maryland increased five-fold between 2010 and 2016 but has since declined dramatically.

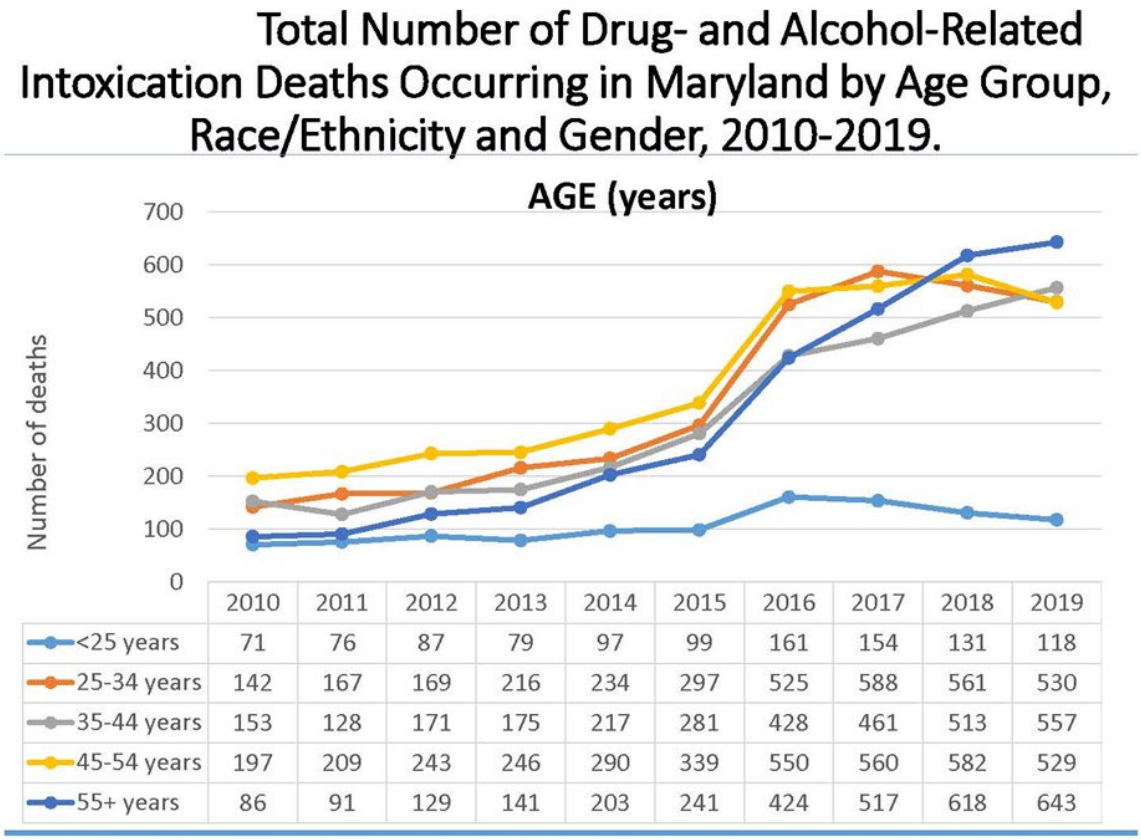
Chart 12. Drug- and alcohol-related intoxication deaths by jurisdiction



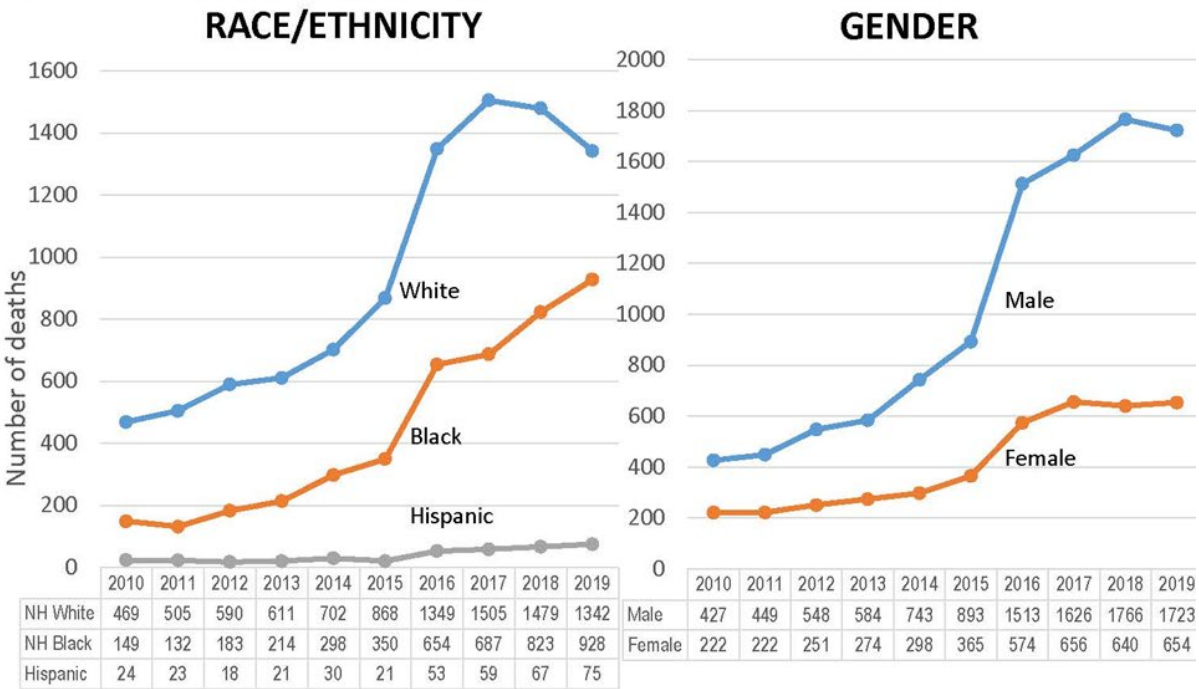
Source: Maryland Department of Health Report on Drug- and Alcohol-related Intoxication Deaths (2020)

In terms of demographics for drug- and alcohol-related intoxication deaths, although intoxication deaths have been increasing among all age groups, the increase has been greatest among individuals 55 years of age and above. The number of deaths among this age group increased more than seven-fold between 2010 and 2019, from 86 to 643. The number of deaths among Whites is about 50 percent higher than among Blacks in 2019. The number of deaths among Hispanics is at a relatively low level as compared to other groups; however, the number of deaths among this group have been steadily increasing since 2015. Men are dying at a much higher rate than women 2.6:1.

Chart 13. Drug- and alcohol-related intoxication deaths age group, race/ethnicity and gender in Maryland



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
<25 years	71	76	87	79	97	99	161	154	131	118
25-34 years	142	167	169	216	234	297	525	588	561	530
35-44 years	153	128	171	175	217	281	428	461	513	557
45-54 years	197	209	243	246	290	339	550	560	582	529
55+ years	86	91	129	141	203	241	424	517	618	643

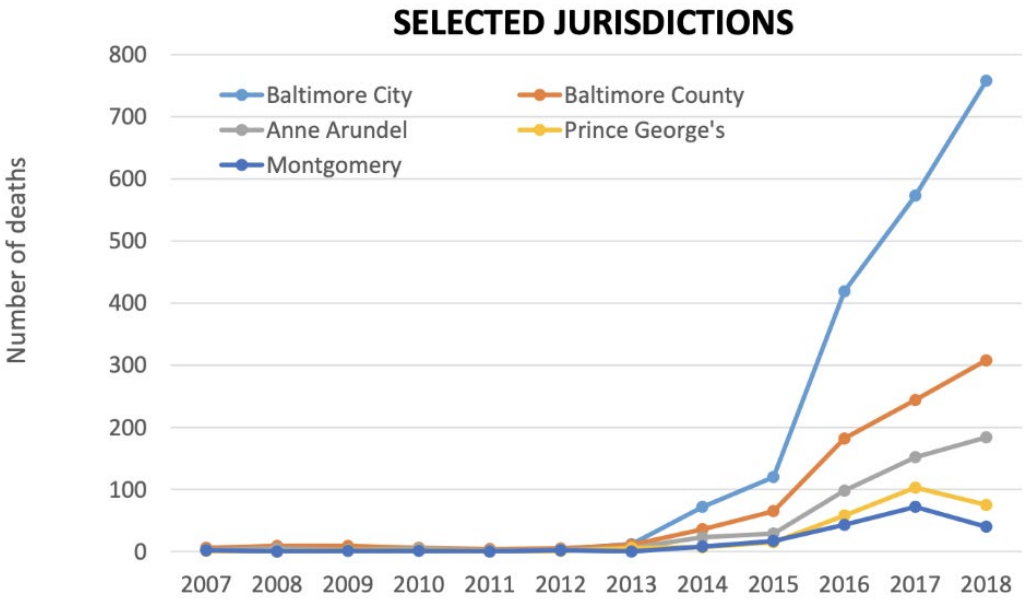


	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
NH White	469	505	590	611	702	868	1349	1505	1479	1342
NH Black	149	132	183	214	298	350	654	687	823	928
Hispanic	24	23	18	21	30	21	53	59	67	75

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Male	427	449	548	584	743	893	1513	1626	1766	1723
Female	222	222	251	274	298	365	574	656	640	654

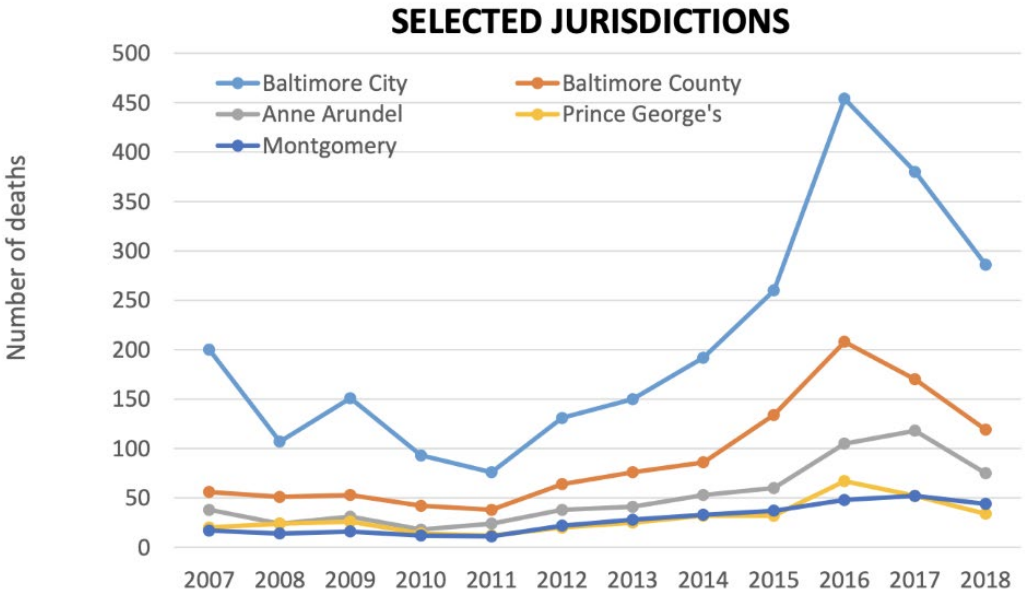
Source: Maryland Department of Health Report on Drug- and Alcohol-related Intoxication Deaths (2020)

Chart 14. Fentanyl deaths by jurisdiction (Note: Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum to the total number of deaths in the report.)



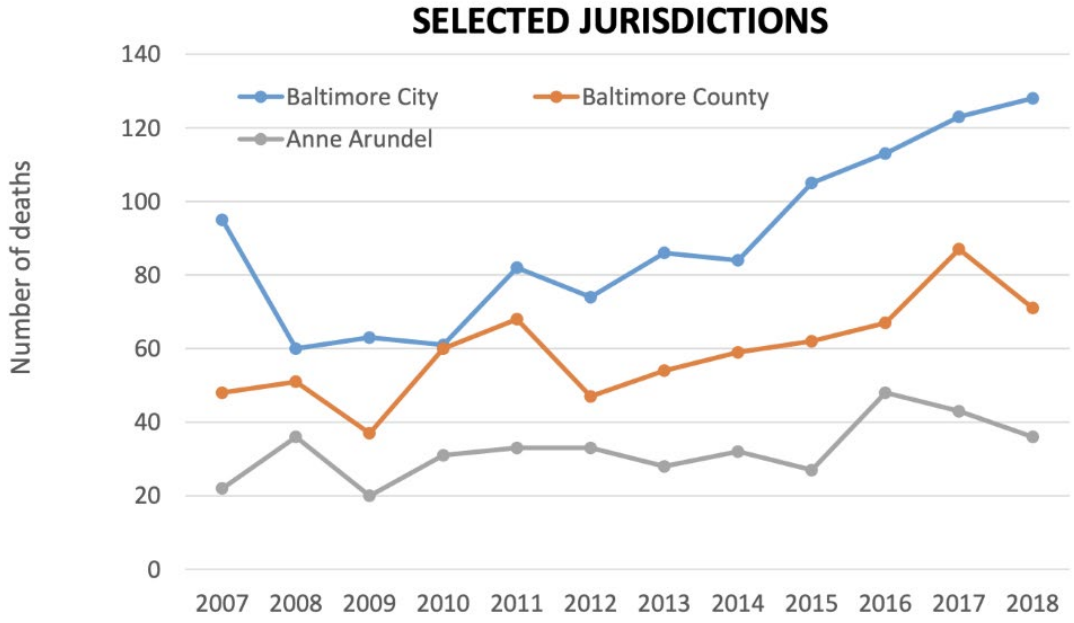
Source: Maryland Department of Health Report on Drug- and Alcohol-related Intoxication Deaths (2018)

Chart 15. Heroin deaths by jurisdiction. (Note: Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum to the total number of deaths in the report.)



Source: Maryland Department of Health Report on Drug- and Alcohol-related Intoxication Deaths (2018)

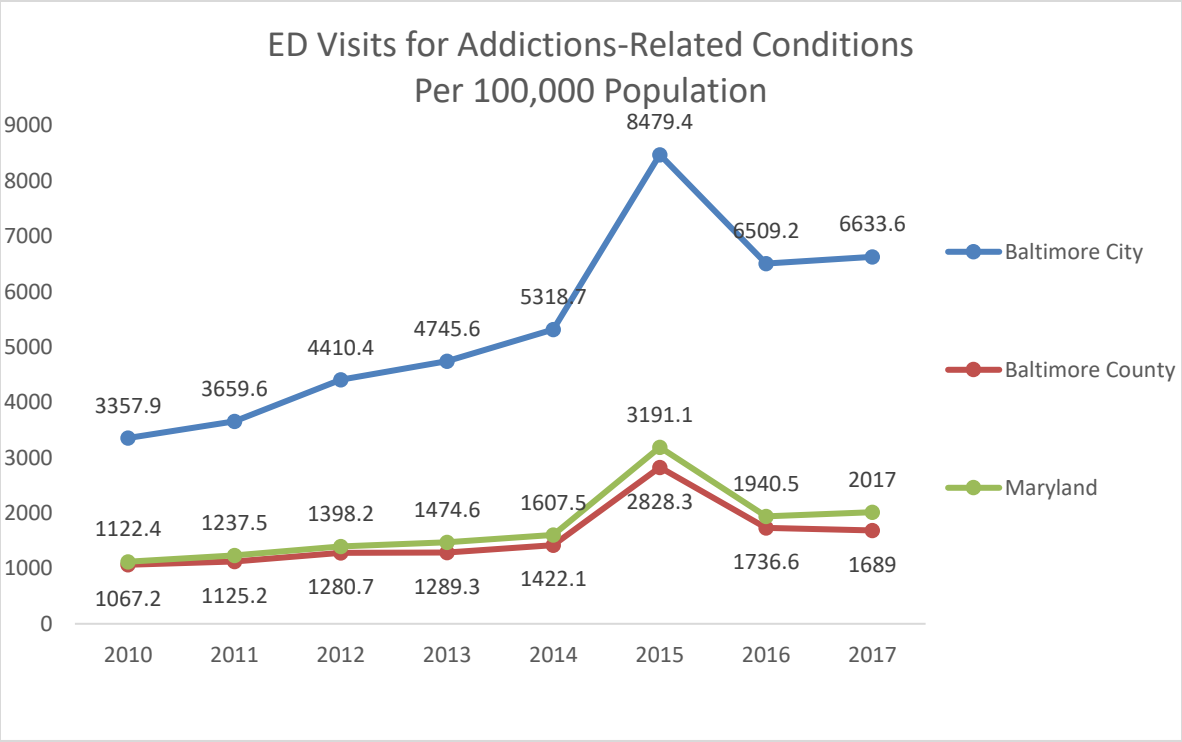
Chart 16. Prescription opioid deaths by jurisdiction. (Note: Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum to the total number of deaths in the report.)



Source: Maryland Department of Health Report on Drug- and Alcohol-related Intoxication Deaths (2018)

Additional data revealed that Baltimore City residents saw a steady increase in emergency room visits for addiction-related conditions from 2010 to 2014 and a sharp increase in 2015, rates significantly higher rates than Baltimore County and the state. Rates in 2016 and 2017 are lower than 2015 but still trending higher than previous years. In 2017, Baltimore City had 6633.6 (per 100,000 population) emergency room visits for addiction-related conditions compared to 1689.0 in Baltimore County and 2017.0 in the state. (See Chart 17).

Chart 17: ED Visits for Addiction-Related Conditions (Per 100,000 population)



Source: Maryland State Health Improvement Process 2010-2017

Community residents recognize the dangers associated with drug and alcohol abuse. Results from the current survey revealed that 71.7 percent of respondents indicated it one of their greatest health concerns. This is up significantly from the 2016 survey when only 11.5 percent of survey respondents were most concerned about drug and alcohol use/addiction in their community. Discussions with community leaders echoed the concerns of survey respondents. Community leaders understood the severity of substance abuse in the community and the negative impact it has on the community at large.

Community stakeholders reported that substance abuse is widespread in the city. Many community residents, especially young Black/African American males, struggle with the disease, and this contributes to a higher incidence of crime and violence. Without counseling and treatment options, community residents are less likely to obtain employment due to their erratic behavior, typical of individuals with substance abuse issues. Programs and services are lacking in the community and counseling and treatment options are scarce. Focus group participants expressed a strong need for more community resources and funding to combat the substance abuse problem, as well as a need for more mental and behavioral health programs.

Per the SAMHSA survey, an estimated 8.2 million adults aged 18 and older had co-occurring mental illness and substance use disorders in 2016, about half of whom did not receive either mental health care or specialty substance use treatment. Behavioral health disorders, which include mental illness and substance abuse, left undiagnosed and untreated, can lead to physical, emotional, and spiritual issues manifesting into larger health problems. Community residents dealing with behavioral health issues

need access to adequate services and resources, as well as the knowledge of where to obtain care. Communities will suffer and face damaging effects if behavioral services and treatment options are not addressed.

Behavioral Health - Mental Health

There are many factors linked to mental health including genetics, age, income, education, employment, and environmental conditions. As identified by primary and secondary data, mental health provider shortages, overall access issues, high rates of co-occurring mental disorders, and substance abuse issues all create significant concerns about the state of behavioral health issues and the need to bring additional focus on providing behavioral health services.

Community residents also struggle with environmental stress such as loss of or limited employment opportunities, poor living environments, and an overall sense of hopelessness creating feelings of depression and anxiety, all of which can impact the mental and spiritual well-being of the individual. The use and abuse of drugs and alcohol are attractive avenues for community residents who struggle to face their mental health problems. In many cases, residents who have a mental health issue also are substance abusers.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), behavioral health is essential to overall health, with prevention and effective treatment measures allowing individuals to recover from mental health crises. Direct access to health professionals and health services for behavioral health problems enables community residents to obtain proper care and treatment leading to healthier lives.

SAMHSA reported, based on the results of their 2019 national survey, that 15.7 percent of adolescents aged 12 to 17 (3.8 million), an increase from 9.0 percent (2.2 million) in 2004, and 15.2 percent of young adults aged 18 to 25 (5.0 million), an increase from 8.8 percent (2.8 million) in 2005, had a major depressive episode (MDE) during the past year. Among those adolescents and young adults who had a past year MDE, only 43.9 percent of adolescents and 50.9 percent of young adults received treatment for depression.

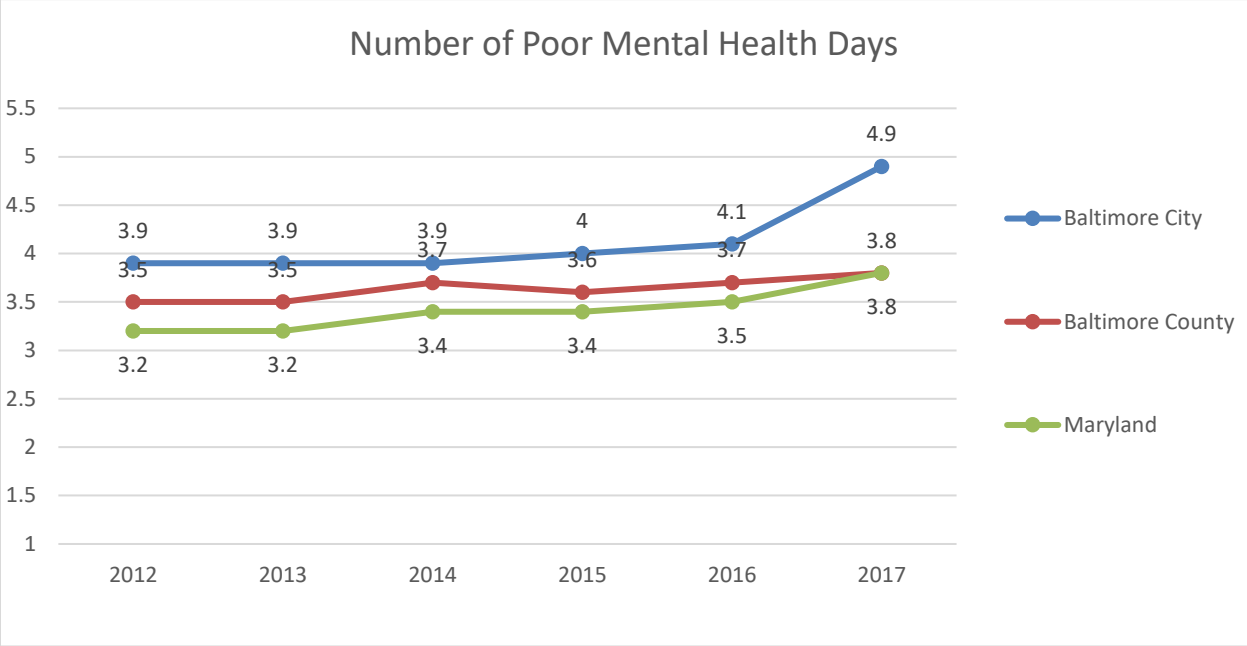
Across the nation, mental illness continues to be a major issue for individuals and families. The Centers for Disease Control and Prevention (CDC) defines mental illness as “collectively all diagnosable mental disorders” or “health conditions that are characterized by alterations in thinking, mood, or behavior associated with distress and/or impaired functioning.” According to the CDC, serious mental illness costs in the United States amount to $193.2 billion in lost earnings per year. In 2019, 19.2 percent of adults received mental health treatment in the past 12 months, including 15.8 percent who had taken prescription medication for their mental health and 9.5 percent who received counseling or therapy from a mental health professional. Women were more likely than men to receive treatment; non-Hispanic White adults (23 percent) were more likely than non-Hispanic Black/African American (13.6 percent) and Hispanic/Latino (12.9 percent) to receive treatment.

Data show roughly 60 percent of adults with mental illness received no mental health treatment within the last year, indicating a nationwide issue with individuals being able to receive proper mental health services and treatment. This is due, in part, to the lack of mental health providers across the U.S. According to the U.S. Department of Health and Human Services, nearly 122 million adults live in areas

where shortages of mental health professionals make obtaining treatment difficult. In Maryland, 64 percent of the population, or nearly 1.3 million people, live in a mental health professional shortage area.

From a local perspective, the CDC Behavioral Risk Factor Surveillance System reported that Baltimore City residents had an average of 4.9 mentally unhealthy days in the past 30 days, which was higher than both Baltimore County and Maryland at 3.8 days (See Chart 18).

Chart 18: Average number of mentally unhealthy days reported in past 30 days (age-adjusted)



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2012- 2017

Information collected from the surveys showed that community residents in the CBSA have an even greater need for mental health services. When asked to indicate if they had poor mental health days in the last month, 22.4 percent of people indicated they had one or more poor mental health days. The average number of poor mental health days overall was 11.8 days. A higher percentage of White respondents indicated poor days overall (37 percent) versus Black/African American respondents (17 percent) and those who identified as Hispanic/Latino (25 percent). However, the average number of poor mental health days reported by White respondents was lower at 10.7 days versus 12.1 days for Black/African Americans. The average for Hispanics/Latinos was 10.4 days.

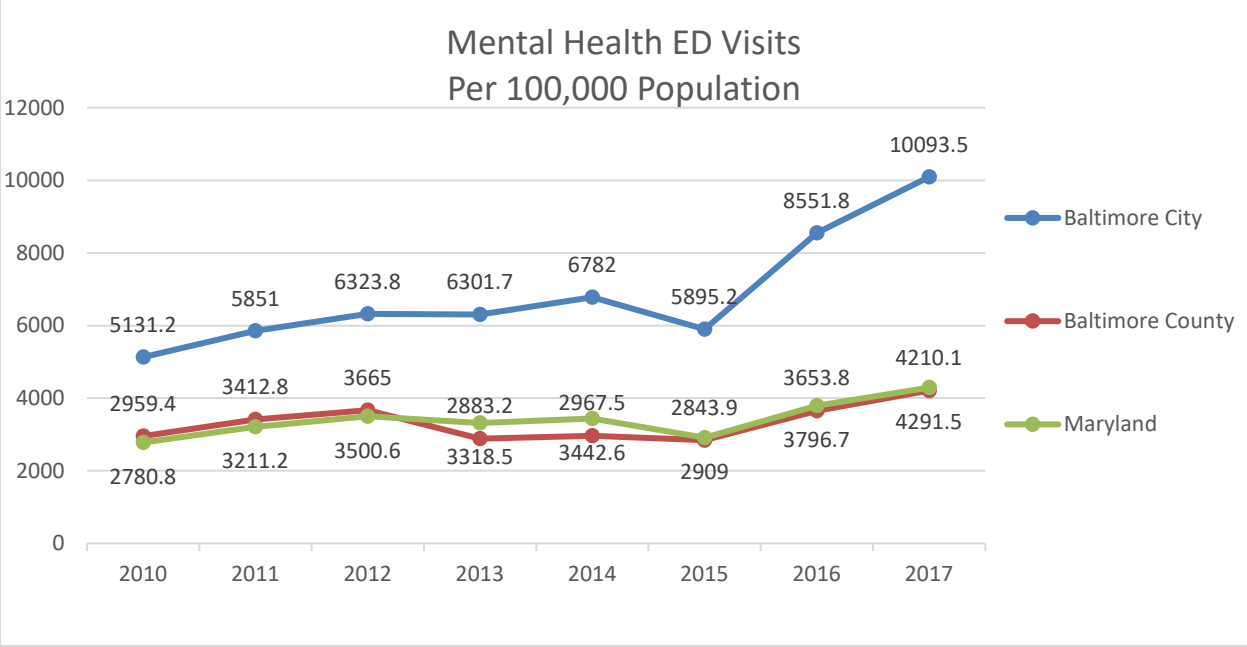
In the 2016 CHNA, more specific questions were asked of survey respondents. More than one-fourth of respondents reported having depression (29.7 percent), while 25.1 percent reported having problems remembering things or concentrating, and 23.2 percent reported having anxiety, nervousness, and/or panic attacks. Among survey respondents, more than one-third received mental health services in the past 12 months (36 percent). Of those survey respondents who received mental health services, 41.5 percent obtained services from a mental health counselor or provider while 18.6 percent obtained

services from their community or neighborhood organization, 18.6 percent went to the hospital/emergency department, 17.8 percent saw their primary care provider/health clinic, while the remaining 3.4 percent indicated “other”.

Additionally, 16 percent of respondents reported they needed but did not receive mental health services in the past 12 months. Of those survey respondents who needed mental health services but did not receive care, 18.4 percent reported that their insurance did not cover the care. Other responses to the question included that they did not know where to go (13.2 percent) and/or preferred alternative forms of treatment (13.2 percent). It was reported that 20.3 percent had a mental/emotional problem that affected their daily activities. Information collected from the surveys highlights the growing local problem and the need to increase the availability of mental health providers for this population.

The Maryland State Health Improvement Process data revealed that Baltimore City residents saw a steady increase from 2010 to 2014 in emergency department visits related to mental health conditions (with the only decreases occurring in 2013 and 2015). However, sharp increases have occurred in 2016 and 2017. In 2017 there were 10,093.5 per 100,000 population of Baltimore City residents who visited the emergency department related to a mental health condition, compared to 4291.5 in the State and 4210.1 in Baltimore County (See Chart 19).

Chart 19: Emergency Department Visits Related to Mental Health Conditions (Per 100,000 population)



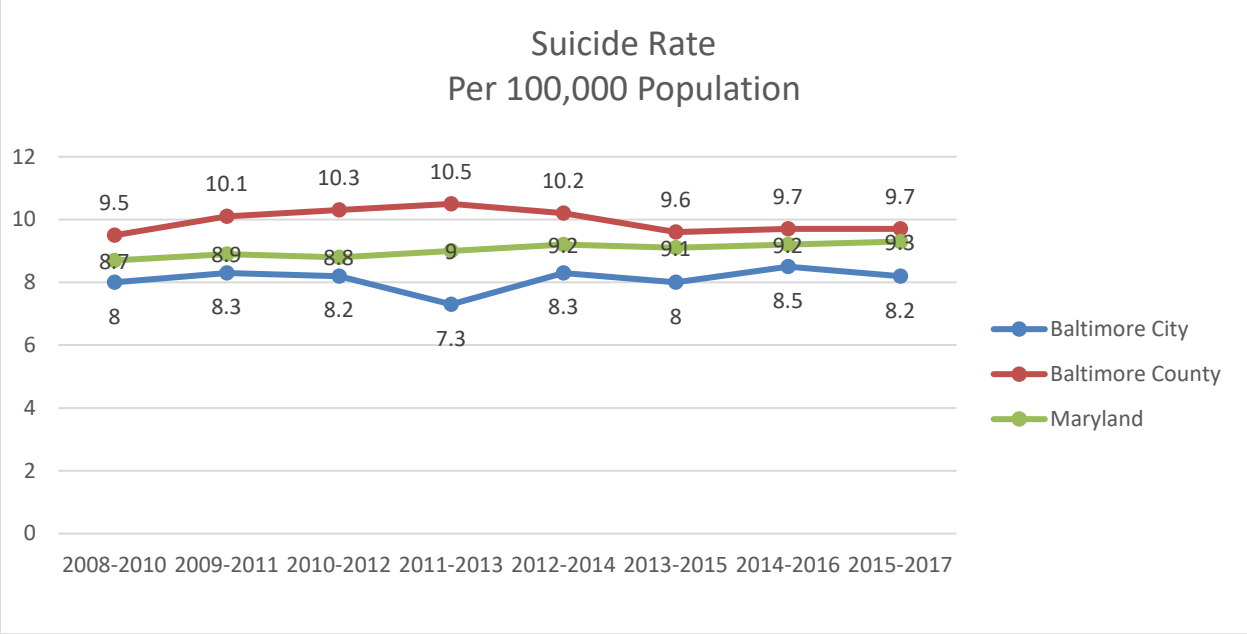
Source: Maryland State Health Improvement Process 2020

Suicide is a serious public health problem and is a preventable cause of death. Residents who attempt suicide are typically depressed and/or face other significant mental health challenges for which they believe there are limited or no solutions. Suicide is the second leading cause of death among people aged 10-34 according to the National Institute of Mental Health and the CDC.

According to SAMHSA, among adults aged 18 or older in the United States in 2019, 4.8 percent (or 12.0 million) had serious thoughts of suicide in the past year. Past-year serious thoughts of suicide were higher among adult females (5.1 percent) than among their male counterparts (4.5 percent). Compared to the national average, past-year serious thoughts of suicide were lower among non-Hispanic Black/African American, Native Hawaiian or Other Pacific Islander, and Asian adults (4.0, 2.3, and 3.6, percent respectively). Compared to the national average, past-year serious thoughts of suicide were higher among young adults aged 18–25 (11.8 percent) and adults aged 26–44 (5.6 percent) and lower among adults aged 45–64 (3.1percent) and 65 or older (1.8 percent).

The Maryland State Health Improvement Partnership from 2015-2017 reported 9.3 suicides per 100,000 population among Maryland residents, meaning that more than 550 lives are lost each year in Maryland due to suicide (See Chart 20). This rate was higher in Baltimore County at 9.7 suicides and lower in Baltimore City at 8.2 suicides.

Chart 20: Suicide Rate, Maryland



Source: Maryland State Health Improvement Process 2020

Community stakeholders reported the need to continue to invest in improving access to health care, especially mental health and addiction recovery services. Shortages of mental health providers and facilities, lack of access, and challenges associated with obtaining employment can interfere with individuals seeking the mental health services they need.

According to community stakeholders, many residents with a mental and/or a behavioral health issue also have a substance use disorder. Poor socioeconomic factors can contribute to substance use disorders. Additionally, some underlying chronic diseases such as diabetes, high blood pressure, heart disease, high cholesterol, and asthma often are exacerbated by the inability to control and receive treatment for a mental health issue. Daily trauma (e.g., not having enough food for the family, being

homeless, etc.), adapting to new cultural surroundings, and domestic violence are also perceived concerns that affect whole communities within the region. Community leaders reported that many community residents who have mental health issues also have dual behavioral diagnoses, making access to care and treatment essential.

Additional primary data collected from focus group participants reported mental health is a significant issue that affects all members of the community regardless of age or race. Barriers such as the lack of insurance coverage, social stigma, and lack of health education prevent individuals from seeking needed care. Educating community members on the signs and symptoms of depression and other mental health issues can enable them to be more aware of the disease in order to seek and obtain services.

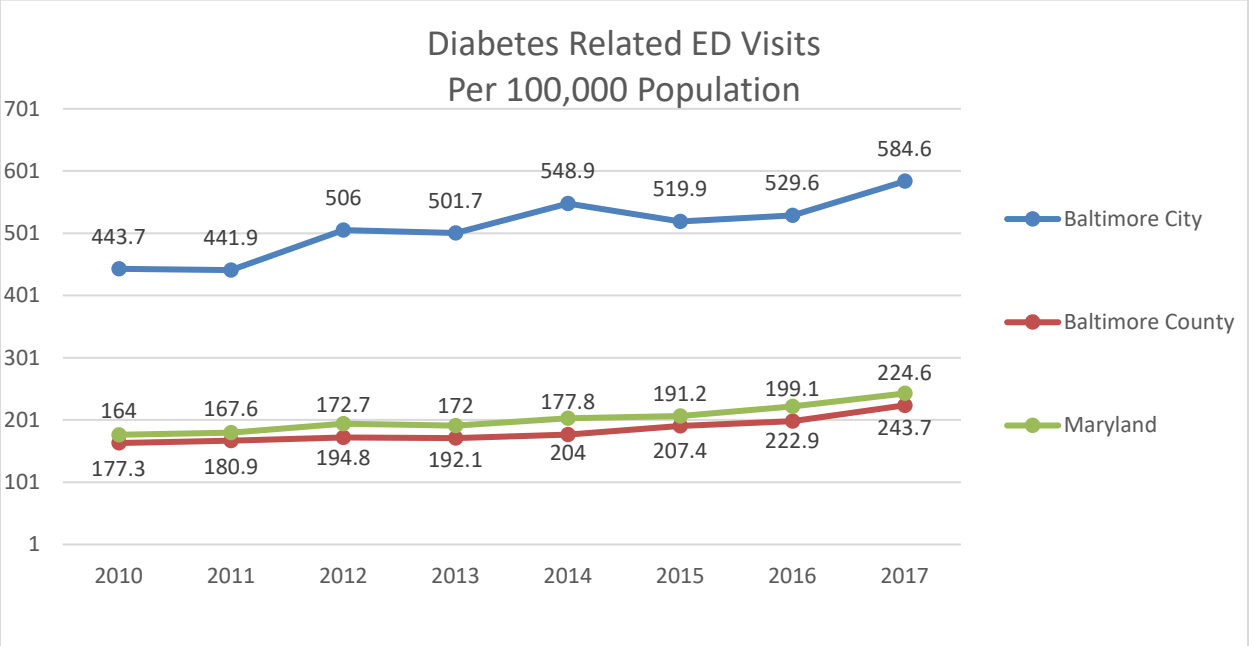
Focus group participants also cited the stress and anxiety many families face because they are unable to meet the basic needs of their children. The prevalence of violence and crime in neighborhoods is a contributing factor to increased mental health issues. Focus group participants reported that youth in middle school are overwhelmed trying to address issues related to violence, peer pressure, depression, abuse, sexually transmitted infections, and early pregnancy. One solution suggested was that if funding were available, students could take advantage of school-sponsored therapy sessions, providing long-term benefits to those students who struggle with a mental illness. Overall, both community leaders and focus group participants were aware of their communities' mental health issues, yet access and the availability of treatment options hinder residents from obtaining appropriate care.

Diabetes / Obesity

Diabetes is a widespread, chronic disease caused by the inability of the body to produce or properly use insulin. It is characterized by high blood sugar levels. Diabetes predisposes people to costly complications, including heart disease, kidney failure, hypertension, and stroke. Diabetes is the leading cause of new cases of blindness, end-stage renal failure, and non-traumatic lower extremity amputation. In 2017, the American Diabetes Association estimated the cost of diagnosed diabetes at $327 billion in medical costs and lost productivity.

The rate of residents in Baltimore City from 2010-2017 who visited the emergency department due to their diabetes was more than two times higher than in Baltimore County and the State (See Chart 21).

Chart 21: Emergency Department Visit Rate Due to Diabetes (per 100,000 population)



Source: Maryland State Health Improvement Process 2020

Leaders also cited that the region has a large population of people with diabetes (including a growing number of youth), high blood pressure, and obesity. Community leaders are aware that Blacks/African Americans are more likely to have diabetes, and state data reinforce that notion. The Maryland Vital Statistics Annual Report (2018) continued to show a disparity in the age-adjusted rate of death for diabetes between Black/African American and White males (39.1 vs 20.1 per 100,000 population) and between Black/African American and White females (26.8 vs 12.3 per 100,000 population). The age-adjusted rate of death for diabetes for all residents in Maryland increased from 19.0 per 100,000 population in 2013 to 19.6 per 100,000 population in 2018.

Obesity, a growing national concern, has affected many communities and neighborhoods and shows no signs of waning. Communities are seeing children as young as two years old diagnosed as being overweight and/or obese. In the U.S., childhood obesity alone is estimated to cost $14 billion annually in direct health expenses. In 2017-18, 19.3 percent of kids ages 2 to 19 were obese according to the National Health and Nutrition Examination Survey. The adult obesity rate for ages 20+ was 42.4 percent for the same period. Since 1980, obesity rates among teens ages 12 to 19 quadrupled, from 5 percent to 20.6 percent.

In 2019, Maryland is reported as having the 25th highest adult obesity rate in the nation. Maryland's adult obesity rate is currently 32.3 percent, up from 29.9 percent in 2017, 19.6 percent in 2000 and 10.8 percent in 1990. Maryland is ranked tenth in the U.S. for obesity in the 10 to 17 age group at 17.6 percent.

Specifically examining the body mass index (BMI) of adults, the CDC reported that there were more Baltimore City (35.3 percent) residents aged 18 and older with a BMI of 30 or greater (which indicates

that they are obese) when compared to residents in the state (31.3 percent) and the U.S. (29.5 percent) in 2017.

Physical inactivity is associated with a higher prevalence of risk for Type 2 diabetes and many other maladies, including cardiovascular diseases, hypertension, certain cancers, dementia, anxiety, and depression. According to the United Health Foundation, costs associated with physical inactivity account for more than 11 percent of total health care expenditures and are estimated at $117 billion annually. In their annual health rankings for 2020, 23.4 percent of Maryland adults reported no physical activity or exercise other than their regular job in the past 30 days. This compares to 26.4 percent for the United States. Individuals making less than $25K (40.7 percent), ages 65+ (29.6 percent), Native Americans (31.2 percent), and those with less than a high school education (44 percent) were the most inactive.

Results from 2016 CHNA survey identified more than one-third of respondents (40.2 percent) had been told by a health professional that they are overweight or obese. More than one-half of survey respondents (51.5 percent) reported that they had high blood pressure, 22.5 percent said they had diabetes, and 20.6 percent acknowledged heart problems. Top health concerns reported by current survey respondents include drug and alcohol abuse, mental health problems, diabetes/high blood sugar, heart disease/high blood pressure, smoking/tobacco use, obesity/overweight, and cancer, in that order.

Obesity, according to community stakeholders, has become a community epidemic. While obesity can be considered an intergenerational issue, there are additional contributing factors - for example, the limited availability of fresh, healthy foods in the community. Low-income areas are stricken with poverty, and certain regions in the city have access to only fast food. It is understood from community stakeholders that accessibility is an issue, and socioeconomic factors play a significant role in the obesity epidemic.

Information cited from focus group participants, especially Hispanic/Latino respondents, and from the stakeholder interviews also revealed their growing concerns over obesity in the community. The groups discussed the role obesity plays in an individual's overall physical health as well as mental health issues. The lack of accessibility to affordable healthy foods along with limited opportunities for physical fitness contribute to the rise in obesity. The inability to engage in outdoor activities due to factors such as crime and safety pose limited options for residents to engage in exercise. Community leaders and residents are aware that obesity can lead to diabetes and other chronic diseases and that exercising and eating healthy can often alter and help manage the condition. However, not having access to primary care services makes chronic diseases difficult to diagnose, treat, and manage.

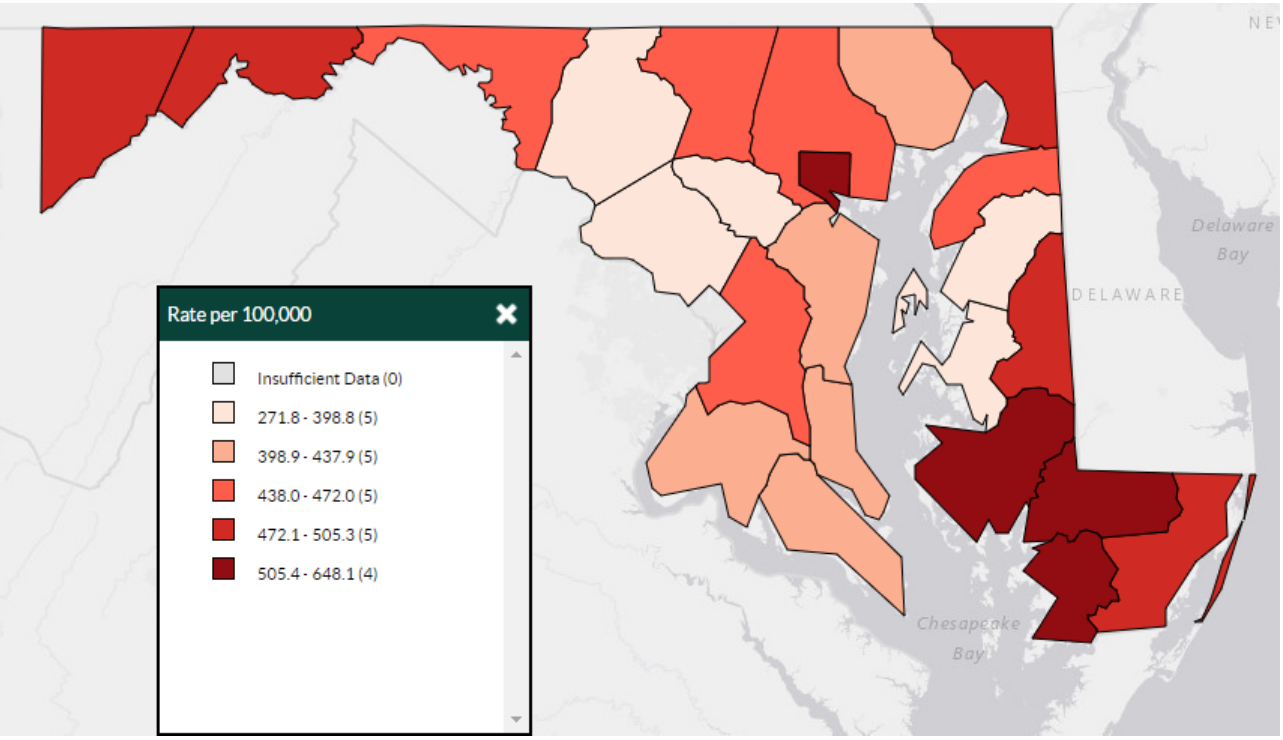
There is an awareness of the high rates of Blacks/African Americans who have diabetes, and many cite cultural eating habits, the lack of quality grocery stores (living in a food desert), and the unaffordability of healthy foods as being underlying factors that contribute to the high rates of diabetes in their community.

Cardiovascular Disease (CVD)

Heart disease is the number one cause of death in Americans, killing more than 868,000 people each year, costing the health care system $214 billion annually, and causing $138 billion in lost productivity on the job. As indicated in Chart 22, the CDC reported that Baltimore City is a major hot spot within

Maryland for deaths due to cardiovascular disease. The City has a death rate of 584.5 per 100,000 compared to Baltimore County at 461.3 per 100,000 and 422.3 per 100,000 for the U.S.

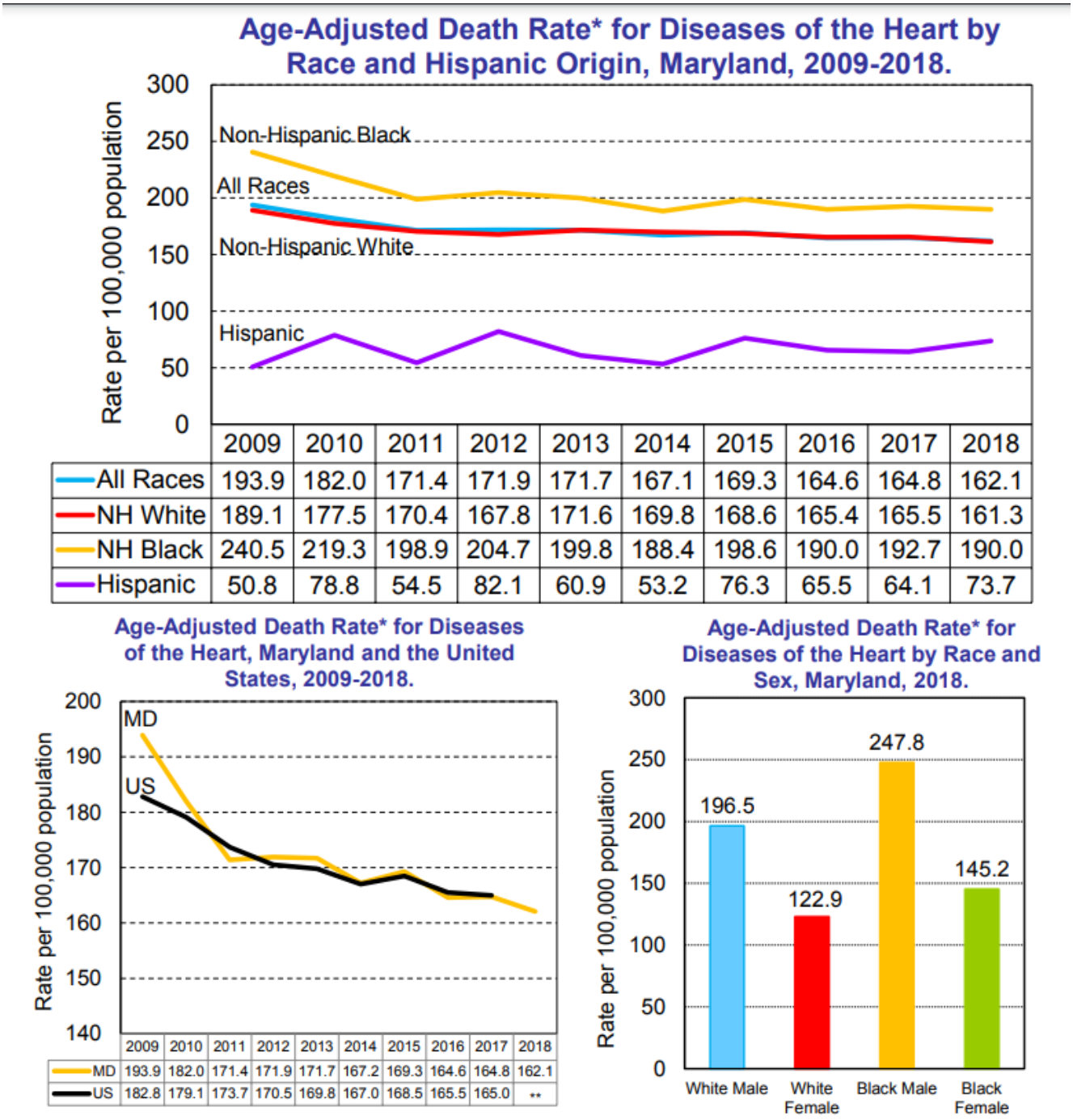
Chart 22: Total Cardiovascular Disease Death Rate per 100,000, 35+, in Maryland 2016-2018



Source: National Center for Chronic Disease Prevention and Health Promotion, 2021

Hypertension is one of the most common risk factors for diseases of the heart. The presence of hypertension doubles the risk of heart disease in men and triples the risk in women. It is documented that Blacks/African Americans have a greater risk than Whites for cardiovascular disease, due in part to more severe high blood pressure problems. Educating the broad community to understand the risks and signs of heart disease and stroke serves as the major impetus in the prevention and treatment of heart disease. As shown in Chart 23, the rate of death due to diseases of the heart have been steadily declining since 2009. Black/African American males are 27 percent more likely than their White counterparts to die from heart disease.

Chart 23: Age-Adjusted Death Rate for Diseases of the Heart by Race and Hispanic Origin, Trend, and Race and Sex. Rate per 100,000 Population.



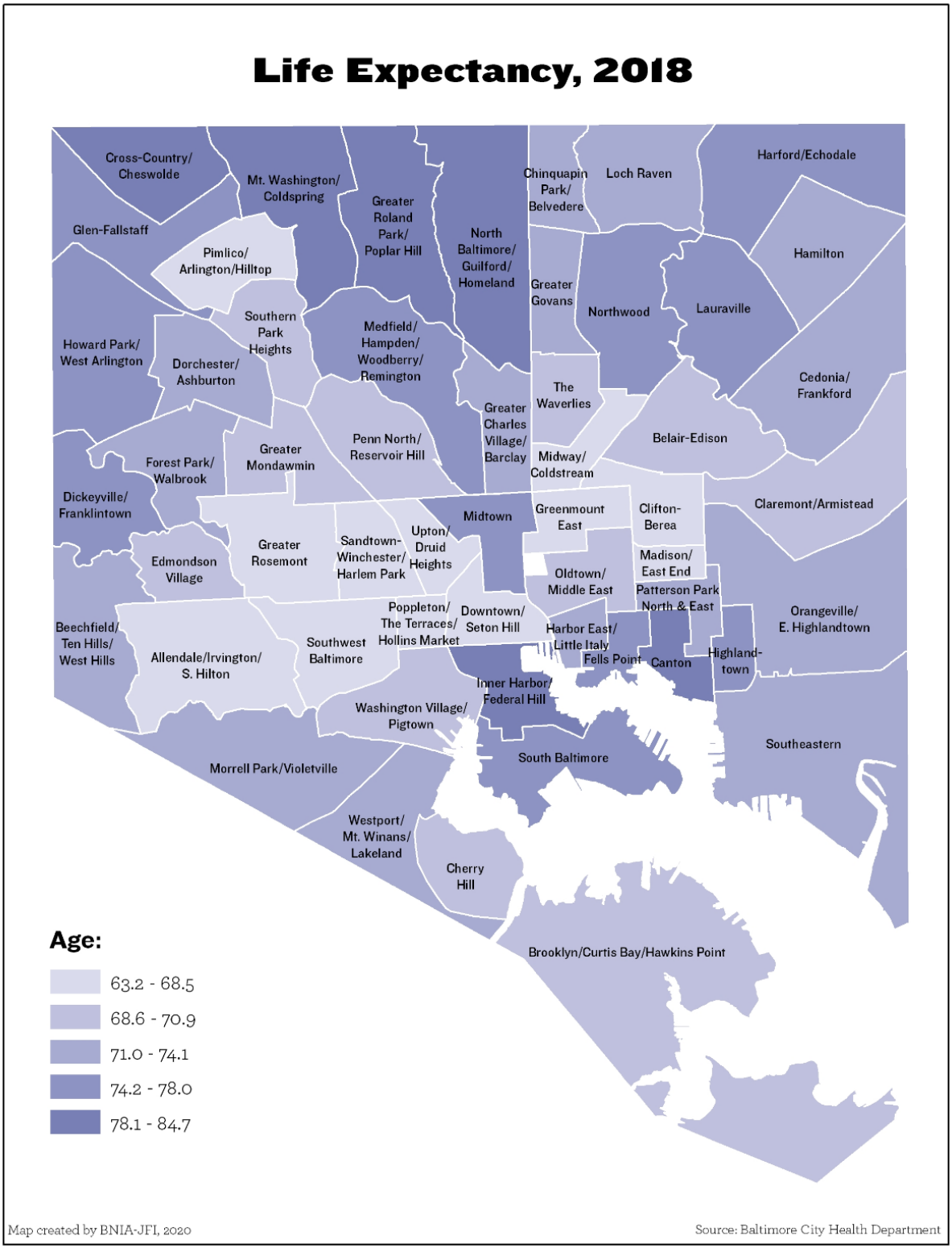
Source: Maryland Department of Health and Mental Hygiene Vital Statistics, 2020

Chronic Disease Management & Education

Maryland State Health Improvement Process (SHIP) reported that Marylanders have a life expectancy of 79.2 years (2015-2017) and Baltimore County residents have a slightly lower life expectancy at 78.3 years, while Baltimore City residents have a dramatically lower life expectancy of 72.8 years. Heart disease, cancer, diabetes, and stroke are a few leading causes of death and disability among Maryland and Baltimore City and County citizens. These and other chronic diseases are responsible for seven of the top ten causes of death each year. According to the CDC, 90 percent of the nation's $3.8 trillion in annual health care expenditures are for treating people with chronic and mental health conditions. Although common, many of the chronic diseases diagnosed in community members are preventable. Living a healthy lifestyle by incorporating exercise, eating healthy foods, and avoiding tobacco and alcohol can reduce the risk of developing certain diseases.

The average life expectancy in Baltimore City in 2018 was 72.7 years. Life expectancy in our CBSA varies greatly from the high end at 80.8 years in Canton to the low end of 70.1 years in Belair-Edison, 68.4 in Madison/East End, and 67.4 in Clifton-Berea.

Chart 24: Life Expectancy, Baltimore City, 2018



Source: Baltimore Neighborhood Indicators Alliance, 2020

Data obtained from the Maryland Department of Health and Mental Hygiene identify the leading causes of death in Baltimore City and Baltimore County as heart disease, cancer, accidents and stroke. These are also the top four leading causes of death for Maryland (See Tables 8-9, Chart 25).

Table 8: Top 10 Causes of Death in Baltimore City, 2018

	Percent of Total Deaths
1. Heart Disease	21.3
2. Cancer	19.8
3. Accidents	6.1
4. Stroke	5.1
5. Assault/Homicide	3.8
6. Diabetes	3.3
7. Chronic lower respiratory disease	3.2
8. Septicemia	2.4
9. Nephritis	1.9
10. Influenza and pneumonia	1.7

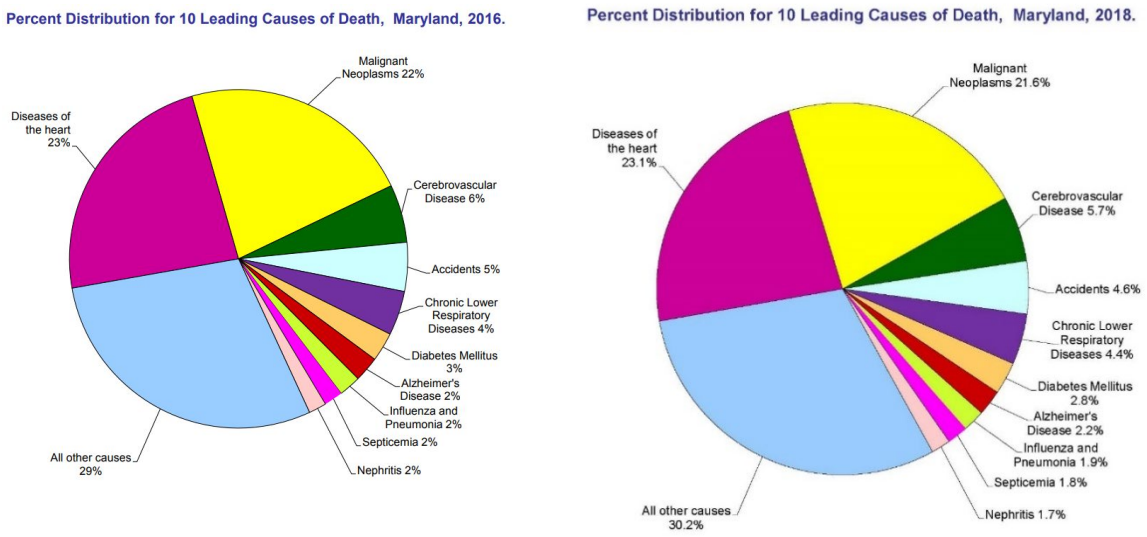
Source: Maryland Vital Statistics 2018 Annual Report

Table 9: Top 10 Causes of Death in Baltimore County, 2018

	Percent of Total Deaths
1. Heart Disease	24.0
2. Cancer	20.7
3. Stroke	6.1
4. Accidents	5.0
5. Chronic lower respiratory diseases	4.5
6. Diabetes	2.3
7. Alzheimer disease	2.1
8. Influenza and pneumonia	2.1
9. Nephritis	1.7
10. Septicemia	1.7

Source: Maryland Vital Statistics 2018 Annual Report

Chart 25: Top 10 Causes of Death in Maryland, 2016 compared to 2018



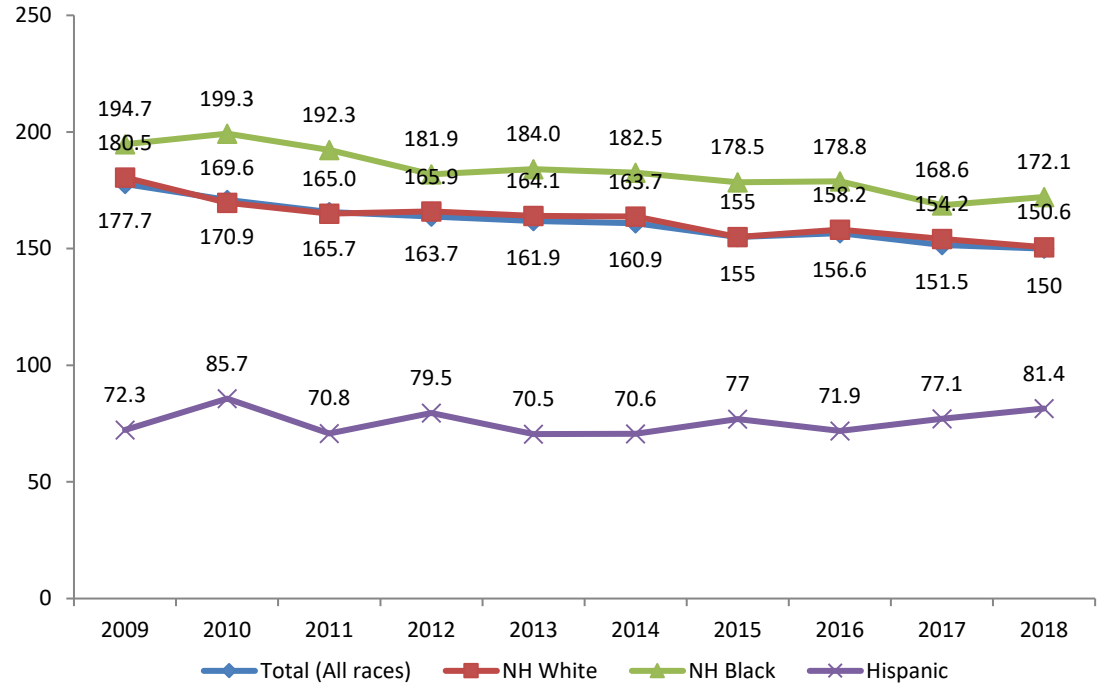
Source: Maryland Vital Statistics Annual Report 2016 and 2018

Cancer in some form affects more than 1.7 million people annually as reported by the American Cancer Society (ACS). The death rate from cancer in the U.S. has continued to decline. From 1991 to 2018, the cancer death rate has fallen 31 percent, including a 2.4 percent decline from 2017 to 2018. This is the largest one-year drop in the cancer death rate. Unfortunately, cancer is still the second leading cause of all deaths. Declines since 1991 are mainly due to fewer people smoking, but also advances in early detection and treatment for some cancers.

The decline in cancer rates is mostly due to long-term drops in the four most common cancers: lung, colorectal, breast, and prostate. These four cancers account for more than four out of every ten cancer deaths in the U.S., with lung cancer accounting for more than the other three combined.

Malignant neoplasms is the second leading cause of death in Baltimore City, Baltimore County and the state of Maryland. The rate of malignant neoplasms was higher among Blacks/African Americans (172.13 per 100,000) as compared to Whites at (150.6 per 100,000) as shown in Chart 26. Both are significantly higher than the rate for Hispanics/Latinos at 81.4 per 100,000.

Chart 26: Age-Adjusted Death Rate for Malignant Neoplasms by Race and Hispanic Origin. Rate per 100,000 Population.



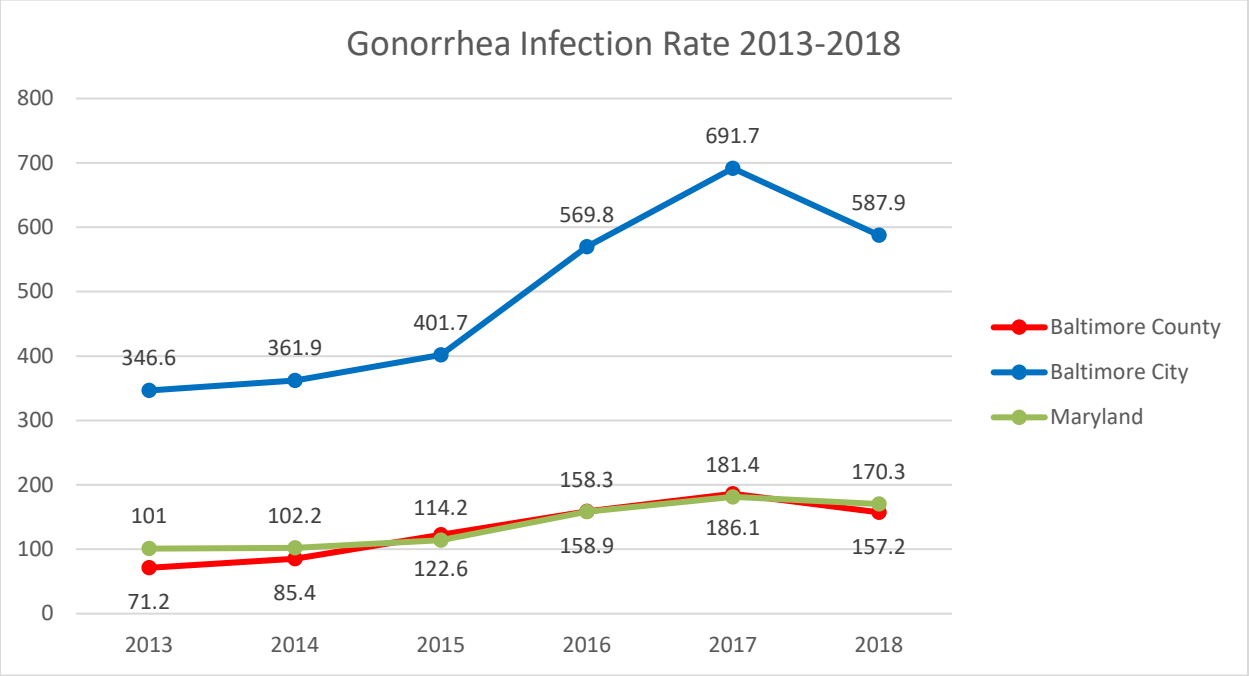
Source: Maryland Department of Health and Mental Hygiene Vital Statistics, 2018 Annual Report

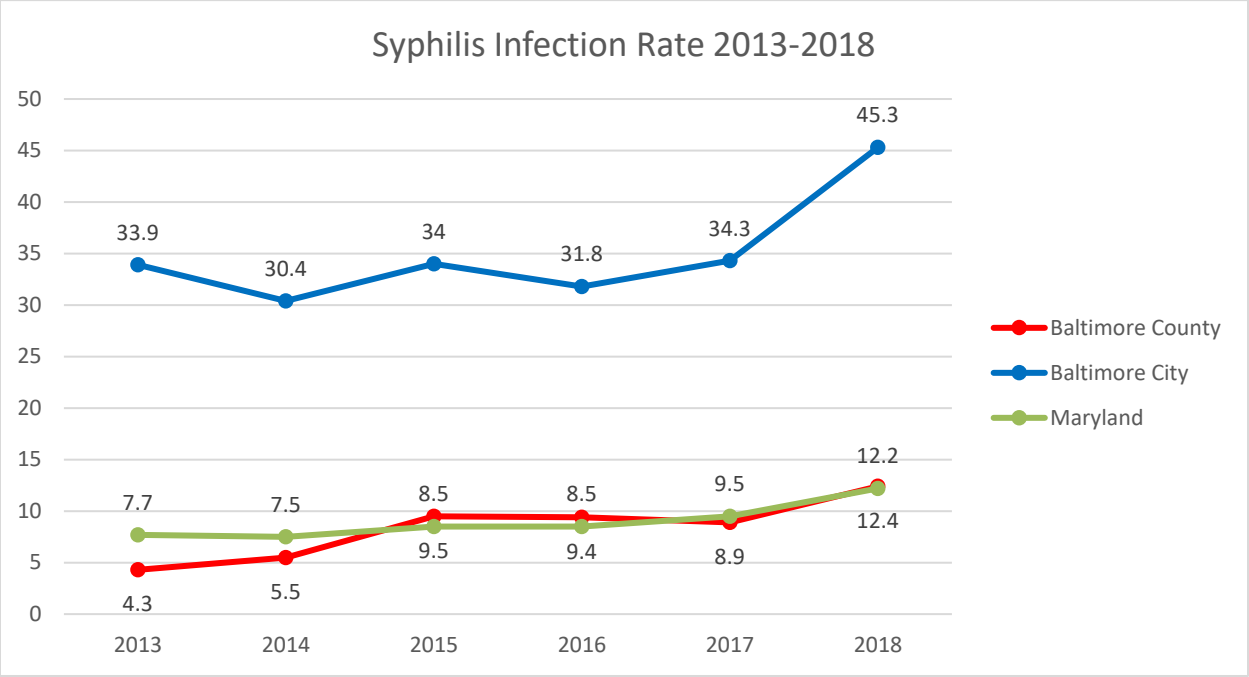
The ACS noted that much of the suffering and death caused by cancer could be prevented by more systematic efforts to reduce underlying causes and to expand the use of established screening tests. Therefore, a greater emphasis must be placed on cancer screenings to provide early detection and public education and awareness to reduce the risk and prevent the various types of cancer.

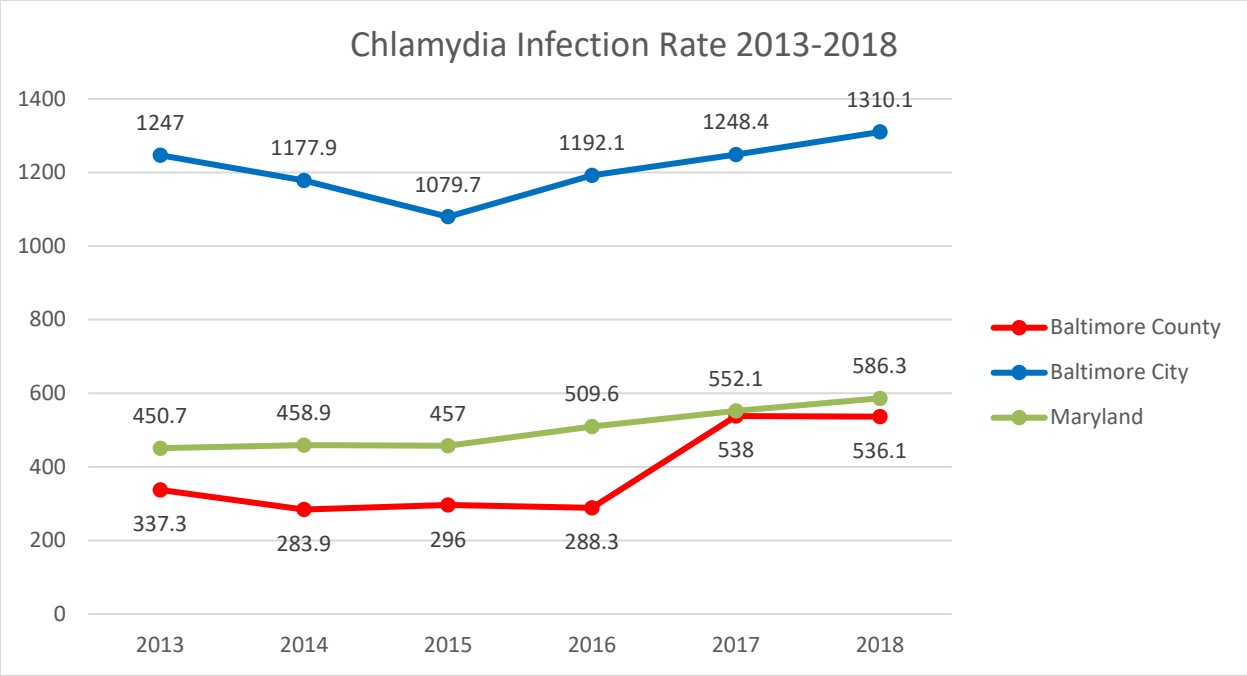
Sexually transmitted infections (STIs) are significant health issues that are largely preventable. Socioeconomic factors have a strong relationship with how STIs are spread. Racial and ethnic disparities, poverty, drug abuse, and access to care are some factors that contribute to the spread of the disease. The Maryland Department of Health reported estimates that at the end of 2019, 10,600 people were living with HIV in Baltimore City, 33 percent were between the ages of 50-59, 65.5 percent male, 83.5 percent Non-Hispanic Black/African American. This rate is almost three times the rate of Baltimore County residents. Baltimore City and Prince George's County had the highest rates (per 100,000) of new HIV diagnoses.

Baltimore City residents had higher rates of chlamydia, gonorrhea, and syphilis compared to Baltimore County residents. Baltimore City residents, compared to those in Baltimore County, had more than double the cases of chlamydia and more than three times the gonorrhea and syphilis cases in 2018. Alarmingly, between 2013 and 2017, Baltimore City saw a marked increase in the rate of gonorrhea cases (See Charts 27-29), although a decline was seen in 2018.

Charts 27-29: Sexually Transmitted Infection Rates, 2013-2018







Source: Maryland Dept. of Health and Mental Hygiene Vital Statistics, 2018

Chronic diseases can be managed, and many are preventable; however, generational attitudes along with the ability to obtain necessary health care services need to be addressed in order to allow community residents the opportunity to live healthier lives. Information gathered related to causes of death, high blood pressure, diabetes, etc. all point toward the need for community action. Education, information, improved access, and care management for those in the area can have a significant impact in reducing the chronic conditions of residents.

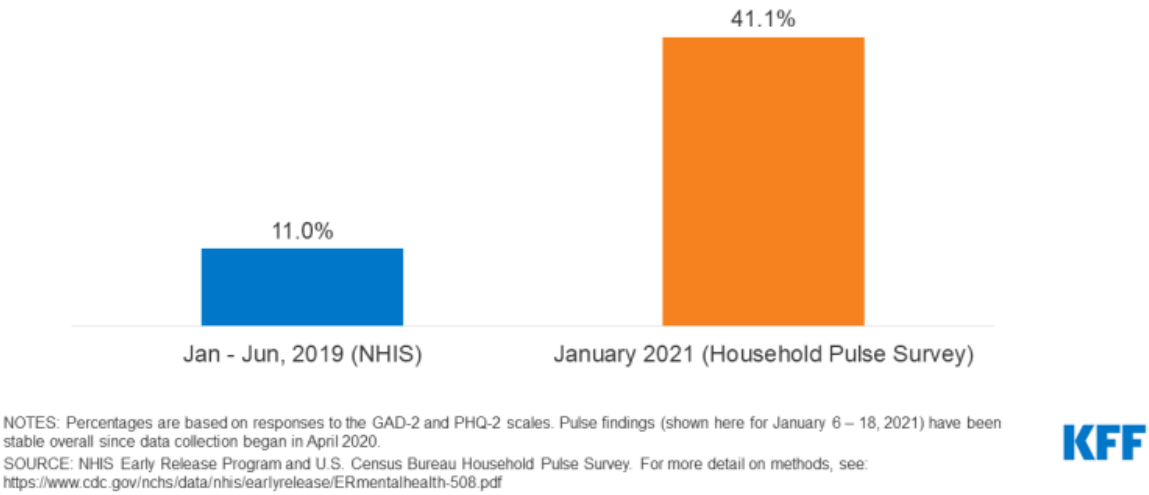
Community stakeholders reported lifestyle choices to be a major factor that contribute to the development of chronic diseases. Many cited smoking, obesity, substance abuse, high blood pressure, and poor food choices to be significant contributing factors for chronic diseases in residents. It was noted that more education and information is needed for community residents and patients who have these conditions to reduce complications and improve their overall health. Some stakeholders reported the lack of available community resources to assist diabetic patients in complying with treatment plans (e.g., diet, weight loss, exercise, and medications). Lack of access to affordable healthy food, safe venues for physical exercise, and adequate education and support are major road blocks to many who want to improve their health. Many feel a need for a more concerted effort to make a significant change in the community.

COVID-19 Pandemic Notations

The COVID-19 pandemic and the subsequent economic recession has affected the mental health of many Americans and has created new barriers for people already suffering from mental illness and substance use disorders. During the pandemic, about 4 in 10 adults in the U.S. reported symptoms of

anxiety or depressive disorder, up from one in 10 adults who reported these symptoms from January to June 2019. A Kaiser Family Foundation (KFF) Health Tracking Poll from July 2020 also found that many adults are reporting specific negative impacts on their mental health and well-being, such as difficulty sleeping (36 percent) or eating (32 percent), increases in alcohol consumption or substance use (12 percent), and worsening chronic conditions (12 percent), due to worry and stress over the coronavirus. As the pandemic wears on, ongoing and necessary public health measures expose many people to experiencing situations linked to poor mental health outcomes, such as isolation and job loss.[6]

Chart 30: Average Share of Adults Reporting Symptoms of Anxiety Disorder and/or Depressive Disorder



The National Center for Health Statistics (NCHS) partnered with the Census Bureau to monitor recent changes in mental health through the Household Pulse Survey. This survey is designed to rapidly respond and provide relevant information about the impact of the coronavirus pandemic in the U.S. The NCHS included questions to obtain information on the frequency of anxiety and depression symptoms, collecting information on symptoms over the last 7 days. The data reflects the percentage of adults who reported symptoms of anxiety or depression that have been shown to be associated with the diagnosis of generalized anxiety disorder or major depressive disorder. These symptoms occur more than half the days or nearly every day. The majority of participants were females between 18-29 years of age identifying as non-Hispanics/other races. As shown in Table 10 below, there has been a significant increase in anxiety and depressive symptoms since the start of the pandemic.

[6] Panchal, N., Kamal, R., Cox, C., and Garfield, R. (2021). The implications of COVID-19 for mental health and substance use. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

Table 10: Trend of Adults Reporting Symptoms of Anxiety and/or Depressive Order

Period	% Anxiety Disorder	% Depressive Disorder	% Anxiety or Depressive Disorder
Jan 2019 – Jun 2019	8.2	6.6	11.0
Apr 2020 – Jul 2020	31.8	25.9	36.7
Aug 2020 – Feb, 2021	34.8	27.0	39.6

Source: KFF Health Tracking Polls, 2021

Key takeaways identified from the KFF analysis of data include:

- Young adults have experienced a number of pandemic-related consequences, such as closures of universities and loss of income, that may contribute to poor mental health. During the pandemic, a larger than average share of young adults (ages 18-24) report symptoms of anxiety and/or depressive disorder (56 percent). Compared to all adults, young adults are more likely to report substance use (25 percent vs. 13 percent) and suicidal thoughts (26 percent vs. 11 percent). Prior to the pandemic, young adults were already at high risk of poor mental health and substance use disorder, though many did not receive treatment.
- The pandemic has disproportionately affected the health of communities of color. Non-Hispanic Black/African American adults (48 percent) and Hispanic/Latino adults (46 percent) are more likely to report symptoms of anxiety and/or depressive disorder than Non-Hispanic White adults (41 percent). Historically, these communities of color have faced challenges accessing mental health care.
- Research from prior economic downturns shows that job loss is associated with increased depression, anxiety, distress, and low self-esteem and may lead to higher rates of substance use disorder and suicide. During the pandemic, adults in households with job loss or lower incomes report higher rates of symptoms of mental illness than those without job or income loss (53 percent vs. 32 percent).
- Research during the pandemic points to concerns around poor mental health and well-being for children and their parents, particularly mothers, as many are experiencing challenges with school closures and lack of childcare. Women with children are more likely to report symptoms of anxiety and/or depressive disorder than men with children (49 percent vs. 40 percent). In general, both prior to, and during, the pandemic, women have reported higher rates of anxiety and depression compared to men.
- Many essential workers continue to face a number of challenges, including greater risk of contracting the coronavirus than other workers. Compared to nonessential workers, essential workers are more likely to report symptoms of anxiety or depressive disorder (42 percent vs. 30 percent), starting or increasing substance use (25 percent vs. 11 percent), and suicidal thoughts (22 percent vs. 8 percent) during the pandemic.

There are a variety of ways the pandemic has likely affected mental health, particularly with widespread social isolation resulting from necessary safety measures. A broad body of research links social isolation and loneliness to both poor mental and physical health. The widespread experience of loneliness became a public health concern even before the pandemic, given its association with reduced lifespan and greater risk of both mental and physical illnesses. Both those newly experiencing mental health or

substance abuse disorders and those already diagnosed before the pandemic may require mental health and substance use services but could face additional barriers because of the pandemic.

According to a recent article published by the Proceedings of the National Academy of Sciences, life expectancy in the U.S. is projected to be reduced in 2020 by 1.13 years due to COVID-19.[7] Estimated reductions for the Black/African American and Hispanic/Latino populations are three to four times that for Whites. Consequently, COVID-19 is expected to reverse over 10 years of progress made in closing the Black/African American-White gap in life expectancy and reducing the Hispanic/Latino mortality advantage by over 70 percent. Some reduction in life expectancy may persist beyond 2020 because of continued COVID-19 mortality and long-term health, social, and economic impacts of the pandemic.

[7] Theresa Andrasfay and Noreen Goldman, "Reductions in 2020 life expectancy due to COVID-19 and the disproportionate impact on the Black/African American and Latino populations", PNAS February 2, 2021, https://www.pnas.org/content/118/5/e2014746118.

Conclusions and Recommendations

With the completion of the 2021 CHNA, The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC) will develop updated goals and strategies for the CHNA implementation phase. In this phase, the hospitals will leverage their strengths, resources, and outreach and work with community partners to identify ways to address their communities' health needs, thus improving overall health and addressing the critical health issues and well-being of residents in their communities. The community health needs assessment and implementation planning builds on the previous CHNA assessment and planning reports (2018, 2016 and 2013). The comprehensive CHNA addressed who was involved, what, where, and why, while the implementation planning phase will address how and when JHH and JHBMC will address the identified community health needs.

The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, partnering with community organizations and regional partners, understand that the CHNA document is not the last step in the assessment phase, but rather the first step in an ongoing evaluation process. Communication and continuous planning efforts are vital throughout the next phase of the CHNA. Information regarding the CHNA findings will be important to residents, community groups, leaders, and other organizations that seek to better understand the health needs of the communities surrounding JHH and JHBMC and how to best serve those needs.

In the assessment process, common themes and issues rose to the top as each project component was completed. The data collected from the overall assessment included feedback and input from community leaders and hard-to-reach, underserved, and vulnerable populations. The information collected provides JHH and JHBMC with a framework to begin identifying, evaluating, and addressing gaps in services and care, which will ultimately alleviate challenges for individuals living in the community.

Solidifying and reinforcing existing relationships and creating new relationships must be paramount in order to address the needs of community residents. Expanding and creating new partnerships with multiple regional entities is vital to developing community-based strategies to tackle the region's key community health needs.

The key community health needs identified by JHH and JHBMC include improving socioeconomic factors (housing/homelessness, job opportunities including education and job training, neighborhood safety, access to care/support, and food environment) and improving access to direct health services (substance abuse, mental health, diabetes/obesity, cardiovascular disease, and chronic disease management and education).

The collection and analysis of primary and secondary data provided the working group with an abundance of information, which enabled the group to identify key health services gaps. Collaborating with local, regional, statewide, and national partners, JHH and JHBMC understand the CHNA is one component of creating strategies to improve the health and well-being of community residents.

Implementation strategies will take into consideration the higher need areas that exist in regions that have greater difficulties obtaining and accessing services.

Action Steps:

- Communicate the results of the CHNA process to staff, providers, leadership, boards, community stakeholders, and the community as a whole.
- Use the inventory of available resources in the community to explore further partnerships and collaborations.
- Implement a comprehensive grassroots community engagement strategy to build upon the resources that already exist in the community, including committed community leaders that have been engaged in the CHNA process.
- Develop working groups to focus on specific strategies to address the top identified needs of the communities the health system serves and develop a comprehensive implementation plan.
- Invite key community stakeholders to participate or be involved with working groups that will strategically address and provide expert knowledge on ways to address key community health needs.

Implementation Strategy

The CHNA is a report based on epidemiological, qualitative, and comparative methods that assess the health issues in a hospital organization's community and that community's access to services related to those issues. The Implementation Strategy is a list of specific actions and goals that demonstrate how The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC) plan to meet the CHNA-identified health needs of the residents in the communities surrounding the hospitals, i.e. the Community Benefit Service Area (CBSA). This Implementation Strategy was approved by the hospitals' Boards of Trustees on June 2, 2021 for The Johns Hopkins Hospital and May 24, 2021 for the Johns Hopkins Bayview Medical Center.

Internal Revenue Service Requirements – Implementation Strategy

The Implementation Strategy that is developed and adopted by each hospital must address each of the needs identified in the CHNA by either describing how the hospital plans to meet the need or identifying it as a need not to be addressed by the hospital and why. Each need addressed must be tailored to that hospital's programs, resources, priorities, plans, and/or collaboration with governmental, non-profit, or other health care organizations. If collaborating with other organizations to develop the implementation strategy, the organizations must be identified. The board of each hospital must approve the Implementation Strategy for the hospital.

Health Priorities

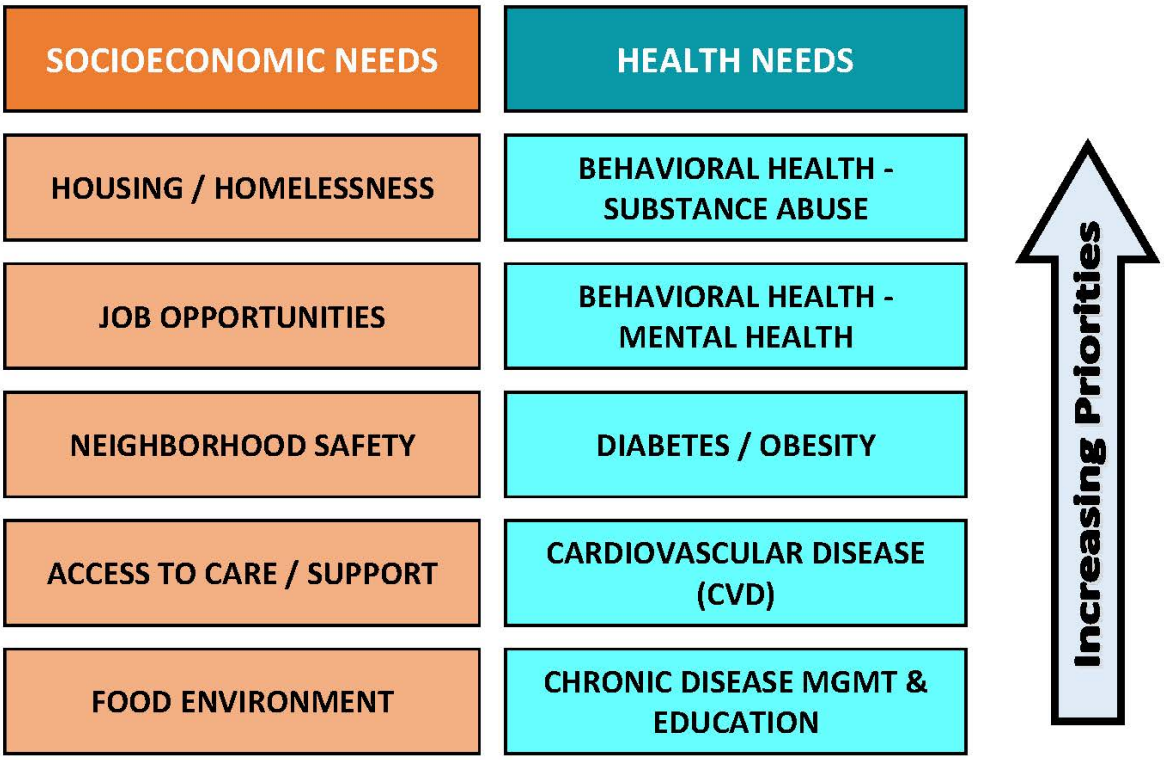
Based on the primary and secondary data collected and analyzed during the CHNA process, JHH and JHBMC's Implementation Strategy remains committed to the goals and strategies identified in the previous CHNA work sessions. Although some of the focus areas have changed in their order of priority per community feedback, the overall needs remain relatively the same as those reported in the 2018 CHNA. For the first time, housing/homelessness has escalated to the top concern among socioeconomic needs, with job opportunities and neighborhood safety remaining in the top three. Behavioral health/substance abuse and mental health are the top direct health needs. Dental services were not identified as a need in the 2021 CHNA, but it's importance to overall health will be addressed as appropriate under chronic disease management and education.

Johns Hopkins is engaged in hundreds of programs addressing the identified needs in their surrounding communities. The hospitals work to strategically allocate scarce resources to best serve the communities, partnering with Community Based Organizations (CBOs) whenever possible to expand the depth and breadth of resources. The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center share the same Community Benefit Service Area and as such are considered to be partners in delivering programs to local residents for the purposes of CHNA reporting regardless of the distinction of specific hospital funding sources.

The Implementation Strategy is the action plan component of the CHNA that guides strategic planning on community engagement. As noted in the CHNA, ten key need areas were identified through the gathering of primary and secondary data from local, state, and national resources, community stakeholder interviews, surveys, focus groups with vulnerable populations, and a health provider inventory (highlighting organizations and agencies that serve the community). The identified community needs are depicted in order of priority in the graph below, with socioeconomic needs in orange and direct health needs in blue (See Chart 1). The Implementation Strategy items which follow provide action plan strategies that address the identified needs. Programs listed are examples and may change

as resources avail themselves or unexpected needs arise, such as has been experienced during the COVID-19 pandemic.

Chart 1: JHH/JHBMC Key Community Health Needs



IMPROVING SOCIOECONOMIC FACTORS

SOCIOECONOMIC NEED 1: HOUSING/HOMELESSNESS			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partner Organizations:**
Increase access to housing and healthy homes in the CBSA	**Strategy 1**: Expand capacity to identify housing issues among low-income, uninsured, and homeless residents and connect to resources.	Number of encounters addressing housing issues Number of positive screenings and referrals to resources for housing issues	Community based organizations (CBOs) Hopkins Community Connection External resource providers Charitable organizations
	Strategy 2: Support "safe at home" initiatives for seniors and low-income residents in need.	Number of persons served Amount invested in home improvement partnerships	Banner Neighborhoods Civic Works Southeast CDC Habitat for Humanity Meals on Wheels
	Strategy 3: Support housing opportunities to decrease homelessness in East Baltimore.	Number of persons housed (short term and long term)	Helping Up Mission HEBCAC BCHD / City Hospital coalition Charm City Care Connection

SOCIOECONOMIC NEED 2: JOB OPPORTUNITIES/EDUCATION			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partner Organizations:**
Increase employment and procurement opportunities to local and minority communities	**Strategy 1**: Increase youth and adult workforce training and education programs.	Number of participants in career development and mentoring programs Number of programs offered in vulnerable neighborhood locations	Baltimore City Public Schools Baltimore City Community College Kaiser Permanente University of Baltimore
	Strategy 2: Create new employment opportunities for underserved community residents including hires and/or recruitment and/or training to at risk populations i.e. justice involved, victims of violence and trauma.	Number of program participants and/or number of programs for at-risk populations Number of trade school or certification program placements Number of hires from target populations	BUILD Community Organizations Faith Based partners MD Dept of Human Services (DHS)
	Strategy 3: Support/contract with local, minority- and women-owned businesses to improve the local economy.	Number of hires from underserved neighborhoods Amount spent with minority owned vendors Number of hires from minority contractor firms	Local minority owned business partners

SOCIOECONOMIC NEED 3: CRIME AND NEIGHBORHOOD SAFETY			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partner Organizations:**
Enhance neighbor-hood safety and reduce violent encounters	**Strategy 1**: Implement "Break the Cycle Intentional Violence Intervention Program "	Success rate of encounters to successful engagement of victims of blunt force intentional trauma (incl. gunshot wounds, stabbings) Number of participants linked to needed SDoH resources	ROCA UMB ROAR Safe Streets Baltimore City Health Department
	Strategy 1: Partner with community engagement outreach programs to increase safe after school activities and reduce youth violence.	Number of youth participants in programs	Baltimore Police Dept. Buddies Inc. Patterson High School John Ruhrah School Mack Lewis Foundation Faith-based partners and other CBOs
	Strategy 2: Reduce violent encounters and STI transmission among local sex workers through increased access to health services and support.	Number of referrals to mobile healthcare clinic and/or community clinics Number of STI tests administered Number of street outreach contacts reached with information packets.	Safe Haven Southeast Community Development Corp Charm City Care Connection Baltimore City District 1 Health Committee Creative Alliance

HEALTH NEED 4: ACCESS TO CARE/SUPPORT			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partner Organizations:**
Improve access to healthcare services for residents across JHH/ JHBMC CBSA	**Strategy 1:** **I**nsure/improve access to health care services and health education for the Hispanic/Latino and immigrant communities.	Spanish speaking CHWs and PRSs Number of new programs Number of Participants	Centro SOL Care-A-Van Esperanza Center Sacred Heart
	Strategy 2: Improve ease of access to services and provide support to increase connection to care (e.g. transportation, financial assistance, pharmacy assistance etc.)	Number of patients linked to insurance and/or financial assistance Number of persons served in programs designed to improve physical access to care. Numbers of transportation vouchers disbursed Number of patients receiving post discharge medication access Reduction of no shows	Transportation services (Lyft/Uber etc.) MDHD - MD Primary Care Program
	Strategy 3: Increase telehealth capacity to extend beyond the hospital walls to deliver care to more community members.	Number of sessions Number of programs Expansion of care / number served	Primary Care physicians Skilled Nursing Facilities (SNFs)

SOCIOECONOMIC NEED 5: FOOD ENVIRONMENT (INCLUDING ACCESS & NUTRITION)			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partner Organizations:**
GOAL: Improve access to healthy food and healthy behaviors among youth and adults	**Strategy 1:** Screen and provide resources to community residents with food insecurity.	Number of people served Amount of food distributed Number of programs etc.	MD Food Bank (Hopkins Community Connection) Civic Works (delivering food to seniors) Let's Eat Hungry Harvest
	Strategy 2: Expand program education on healthy eating and food preparation. (Nutrition / cooking etc.)	Number of people served Number of programs etc. nutrition, zoom cooking classes, podcasts etc. Measured increased skills/knowledge for healthy eating	Days of Taste Baltimore City Public Schools American Heart Association External programming partners

DIRECT HEALTH NEEDS

HEALTH NEED 1: BEHAVIORAL HEALTH/ SUBSTANCE ABUSE (SA)			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partner Organizations:**
Improve access to available substance abuse (SA) services	**Strategy 1:** Provide medical stabilization and linkage to treatment to persons with SA who present to the emergency department.	Number of persons linked to treatment through the Next Step program Number of patients seen by Peer Recovery coaches	Helping Up Mission Dayspring Program House of Ruth External service providers in the community
	Strategy 2: Provide crisis services/SUD treatment services to address opioid use disorder in local community.	Number served by community outreach crisis and/or treatment services Number of homeless served	G-BRICS Broadway Center for Addictions Amazing Grace Dee's Place Spot Van: Community clinic referral partners (Baltimore City Health Department, Esperanza Center, Health Care for the Homeless, Chase Brexton Health Care)
	Strategy 3: Provide community members with Naloxone access and education for emergency response in opioid overdose cases.	Number served Number of kits distributed	BCHD CBOs and Faith-based partners

HEALTH NEED 2: BEHAVIORAL HEALTH/ MENTAL HEALTH			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partner Organizations:**
Improve access and coordination to mental health and behavioral health services	**Strategy1**: Provide psychiatric consults for undocumented adults.	Number of consults	EBMC Behavioral Health System Baltimore Community clinic referral partners (Baltimore City Health Department, Esperanza Center, Health Care for the Homeless, Chase Brexton Health Care)
	Strategy 2: Provide psychiatric in-home outreach and support to seniors in their homes and provide caregiver training; improve referrals and coordination of community services for seniors.	Patient Health Questionnaire (PHQ-9) Psychiatric Symptoms Scale, e.g. patient rating of symptoms of depression, anxiety, sleep, etc.	Behavioral Health System Baltimore GEDCO Univ of MD Senior Outreach Services Senior centers BCHD JH community partners
	Strategy 3: Participate in new HSCRC regional partnership track for behavioral health by collaborating with area hospitals and health agencies to develop and implement a Crisis Now model program for greater Baltimore (G-BRICS).	Milestone progress on creation, setup, launch and numbers served	Baltimore City hospitals BCHD and MDHD
	Strategy 4: Provide individual, group, family therapy, medication treatment, and other mental health services, as well as prevention interventions and supportive outreach.	Number of schools participating in program Number of children who receive services Number of adults who receive services Number of engagements addressing barriers to care for behavioral health care	Baltimore City and County School Districts Head Start Programs Judy Center at Commodore John Rogers School After Care Clinic Faith based organizations (CDAP program partners) Helping Up Mission Office of Behavioral Health Integration (OBHI)

HEALTH NEED 3: DIABETES/OBESITY			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partner Organizations:**
Increase access to and utilization of resources that address obesity and diabetes	**Strategy 1:** The Access Partnership/JHBMC Endocrine partnership to increase access to care and patient support services in endocrine/diabetes clinic	Number of patients referred and seen Number of patients served by bariatric clinic for surgery	Community clinic referral partners (Esperanza Center, Health Care for the Homeless, Chase Brexton Health Care, Baltimore Medical System at East Baltimore Medical Center and Highlandtown Healthy Living Center)
	Strategy 2: Increase physical activity and healthy lifestyle choice education to prevent obesity among adults and youth	Number of education and exercise programs Number of participants Number of community and school-based partners Increase in % of healthy BMI measurements in patient visits	Youth organizations, schools, and churches Playworks (Baltimore City Youth Program) Partnering CBOs American Heart Association
	Strategy 3: Increase access to the Diabetes Prevention Program (DPP) to people with an elevated BMI and high-risk for developing diabetes and/or Diabetes Self-Management Training (DSMT) for those with diabetes	Number of people enrolled, referred, losing weight and/or completing the DPP from local communities Number of people screened at community-based outreach events Number of people initiating, engaged, and retained in DSMT	Brancati Center outreach events Maryland Health Department Faith-based organizations Centro SOL Community clinic referral partners (Esperanza Center, Health Care for the Homeless, Chase Brexton Health Care, Baltimore Medical System at East Baltimore Medical Center and Highlandtown Healthy Living Center)

HEALTH NEED 4: CARDIOVASCULAR DISEASE			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partner Organizations:**
Increase the awareness of CVD in the community, the factors contributing to heart disease and connection to care	**Strategy 1:** Increase access to specialty heart failure care and promote health equity in our community.	Number of appointments to specialty care at the Heart Failure Bridge Clinic or to followup connections with a cardiologist within seven days of discharge	Community clinic referral partners (Baltimore City Health Department, Esperanza Center, Health Care for the Homeless, Chase Brexton Health Care) and other external providers Baltimore City Health Department
	Strategy 2: Provide blood pressure screenings and education sessions with community partners, senior centers, faith-based orgs and outreach to high-risk patients residing in the community.	Number of "Train the trainer" sessions Number of blood pressure screenings and education sessions in community	Called to Care Faith Partnership Orgs CONNECT & other CBOs Center for Urban Environmental Health
	Strategy 3: Provide smoking cessation counseling and screening for COPD and asthma patients, congregations, and community members.	Number of tobacco-free clinics set up at our community partners Number of educational and screening sessions Number of air quality and air pollution educational sessions	American Lung Association JH BREATHE Center Medicine for the Greater Good (MGG) Faith partners ((Healthy Community Partnership, Spiritual Care & Chaplaincy)

HEALTH NEED 5: CHRONIC DISEASE MANAGEMENT & EDUCATION			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partner Organizations:**
Share clinical expertise with community organizations to prevent, detect, and manage chronic diseases	**Strategy 1:** Increase prevention, care coordination and management of chronic diseases though outreach in partnership with community organizations, congregational health networks and individuals to reach residents via in-person contact and electronic media.	Number of health education/outreach encounters provided to community- based organizations and churches Number of participants in health events and number of screenings performed Number of vision screenings (retinopathy, glaucoma, testing in schools, etc.) Number of support groups / podcasts / programs	Called to Care East Baltimore schools Faith Partnership Orgs CONNECT & other CBOs BCHD Comendo Juntos / Centro SOL Isaiah Wellness Center
	Strategy 2: Ensure high-risk patients with chronic disease receive access to coordinated health and support services, assistance with social determinants, medications, nutrition education and other resources to better manage their disease.	Number of visits Readmission rates Nutrition education sessions held with number of participants	Community clinic referral partners (Baltimore City Health Department, Esperanza Center, Health Care for the Homeless, Chase Brexton Health Care) and other social determinant support resources SPOHNC Baltimore Debbie's Dream Foundation Support for Gastric Cancer JSTEPP JHHS
	Strategy 3: Provide in-home care to individuals over 65 years old who are limited in physical or cognitive function due to chronic illness and unable to leave their homes for medical care in an office setting.	Number of patients Number of deaths at home	Gilcrest Hospice and other facilities and providers JHOME partners

Note: For more information on community benefit programs and support please see the annual Community Benefit Report for each hospital available at http://web.jhu.edu/administration/gca/CHNA or contact the Johns Hopkins Office of Government and Community Affairs at gca@jhu.edu.

Appendix A: Primary Data

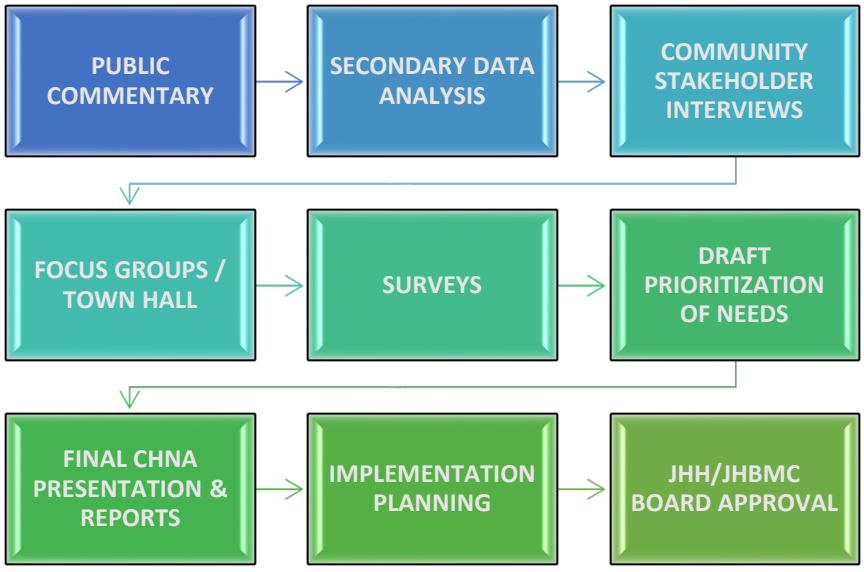
Process Overview

A comprehensive community-wide CHNA process was completed for The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC), connecting public and private organizations, such as health and human services entities, government officials, faith-based organizations, and educational institutions to evaluate the needs of the community. The 2021 assessment included primary and secondary data collection that incorporated public commentary, community stakeholder interviews, a resident survey, and focus groups.

Collected primary and secondary data led to the identification of key community health needs in the region. Johns Hopkins leadership will develop an Implementation Strategy that will highlight, discuss, and identify ways the health system will meet the needs of the communities they serve.

As shown in Flow Chart 2, the process of each project component in the CHNA is outlined.

Flow Chart 2: CHNA Process



Public Commentary

As part of the CHNA, The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center solicit public comments and feedback on the methods, findings, and subsequent actions taken as a result of the previous CHNA and planning process. For past reports, a notice was posted at several locations in the hospital, including information desks where patients and visitors would see the request and have access to the materials and comment sheets to respond. Due to the COVID-19 pandemic and the closure of hospitals to visitors and members of the public per a mandate by the Governor of Maryland, the 2021 CHNA public commentary request was limited to electronic delivery channels.

Respondents agreed that:

- The report included input from community members or organizations.
- The assessment did not exclude any community members or organizations that should have been involved in the assessment.
- The Implementation Plan was directly related to the needs identified in the CHNA.
- The Implementation Plan benefited them and their community by the following:
    - Provided access to familiar and in-place community resources, including educational programs and professional resources for the uninsured and homeless via referrals.
    - The implementation plan focused on the socioeconomic needs of Baltimore City and addressed the ways in which Johns Hopkins Health System can improve the health of Baltimore City residents while reducing the existing health disparities.
- In response to the question "Are there needs in the community related to health (e.g., physical health, mental health, medical services, dental services, etc.) that were not represented in the CHNA", one commenter indicated Black maternal health outcomes and infant mortality were not covered and another commenter said reduced or limited access to eye care due to barriers similar to those limiting dental care were not addressed.

There was no additional feedback shared on the CHNA/Implementation Plan via the final open-ended question.

Community Stakeholder Interviews

As part of the CHNA, telephone interviews were completed with community stakeholders in the community benefit service area to better understand the changing health environment. Community stakeholder interviews were conducted between September and December 2020.

Community stakeholders targeted for interviews encompassed a wide variety of professional backgrounds including: 1) public health expertise; 2) professionals with access to community health-related data; and 3) representatives of underserved populations. The 50 stakeholders interviewed represented a diverse group of community-based organizations and agencies. The interviews offered community stakeholders an opportunity to provide feedback on the needs of the community, secondary data resources, and other information relevant to the study.

Each interview was conducted by a Johns Hopkins manager and was approximately 30 to 60 minutes in duration. The interviews provided a platform for stakeholders to identify health issues and concerns affecting residents in their service area, as well as ways to address those concerns.

The qualitative data collected from community stakeholders are the opinions, perceptions, and insights of those who were interviewed as part of the CHNA process.

The common themes from the stakeholder interviews were (in no particular order):

1) Environment (crime/safety issues, the economy, housing, education and job training, employment availability, parks/recreation, and systematic racism)
2) Health services (access)
3) Health issues (mental health, substance abuse, trauma, chronic diseases)
4) Barriers to health (employment, environment, poverty, transportation, language, physical inactivity, and lack of grocery stores)
5) Populations/residents (children, seniors, Blacks/African Americans, Latinos/Hispanics, LGBTQ)

Key suggestions (in no particular order):

- Neighborhood Navigators and Community Health Workers (community based)
- School-based services (health clinics, social workers, mental health, full time nurse practitioners)
- Case management needed for substance abuse population
- Jobs with good pay/living wages
- Affordable, safe quality housing (free of lead paint, mold, rodents, pests)
- Transportation services and lower co-pays to assist with access issues
- Deal with the crime, violence, and drug epidemic
- Access to healthy foods
- Replace vacant houses with community gardens
- Community engagement training
- Free screenings at the hospital and in the community

Focus Groups

Between October and November 2020, Johns Hopkins facilitated six focus groups within the study area with at-risk populations. Targeted underserved focus group audiences were identified and selected with direction from hospital leadership based on their knowledge of their Community Benefit Service Area (CBSA). Johns Hopkins worked closely with community-based organizations and their representatives to schedule, recruit, and facilitate focus groups within each of the at-risk communities. Due to the COVID-19 pandemic, the average number of participants per focus group was limited to allow for social distancing, with each focus group lasting roughly 1.5 hours. Participants were provided with a cash incentive and, where possible, food and refreshments for their participation.

Additionally, the Baltimore City coalition of hospitals conducted 12 other city-wide focus groups with other at-risk populations between the months of August and December 2020. The input from all focus groups was shared amongst the coalition hospitals for consideration in their individual CHNAs.

The common themes from the focus group audiences were (in alphabetical order):

1) Access to care / insurance coverage
2) Chronic diseases
3) COVID-19
4) Crime and safety
5) Employment / job training
6) Food environment
7) Housing
8) Isolation / loneliness
9) Mental health / trauma
10) Patient engagement
11) Physical inactivity / obesity
12) Poverty
13) Racism
14) Sexually transmitted infections
15) Substance abuse
16) Transportation

Table 11 below lists the focus group audiences and the locations where each group was conducted.

Table 11: Focus Group Audiences

East Baltimore

FOCUS GROUP AUDIENCE:	LOCATION OF THE EVENT:
Latinos/Spanish-Speaking Mixed Adults Number of Attendees: 6	Zoom
Latinos/Spanish-Speaking Men Number of Attendees: 3	Patterson Park
Latinos/Spanish-Speaking Women Number of Attendees: 5	Zoom
Substance Users Number of Attendees: 10	Dee's Place/HEBCAC
Homeless Latinos Number of Attendees: 3	Beans and Bread
Justice Involved Number of Attendees: 10	Men and Family Center

Town Hall

The Baltimore City Hospital Collaborative piloted a new telephone town hall in the greater Baltimore region, facilitated by The Sexton Group. This new communication tool directly connects with thousands of people at once using a phone with a 21st century web interface to create an interactive town hall meeting. Participants interacted with a speaker from the comfort of their homes. There were more than 58,000 call attempts from the list of Baltimore City residents, with 11,959 calls answered by humans. Nearly 4,100 community members joined the call, over 2,800 stayed on the call, and nearly 100 asked questions.

The key findings are as follows:

- Health Issues –the top three leading health problems that affect people in their community:
    - Addiction/substance abuse (27 percent)
    - Chronic diseases (26 percent)
    - Senior health (17 percent)
- Access to Care – the top three reasons why people in their community do not get the health care they need at the right time:
    - Cost (67 percent)
    - Transportation (17 percent)
    - Language, fear, and no doctor in the area (tied at 6 percent each)
- Social Needs – the top three leading social problems:
    - Neighborhood safety (41 percent)
    - Social isolation (21 percent)
    - Access to doctor's office (18 percent)

Live questions resulted in many concerns of community safety, trauma, and education needed. Noted as a limitation and key consideration, the survey was administered during the COVID-19 pandemic. As a result, many respondents were likely to endure temporarily unique challenges associated with social isolation, unemployment, mixed messages from health care providers, media, and officials, and personal fear of contracting the virus.

Surveys

As part of a city-wide effort, Baltimore City hospitals collectively developed a short survey in order to identify health risk factors and health needs in the community. The survey was similar to the one administered in 2017 with questions added related to COVID-19. The survey was distributed by the hospitals through community-based organizations, community associations, faith-based organizations, local elected officials, FQHCs/clinics, blood drives, and COVID-19 testing sites. The survey was available in English and Spanish either online or in paper format.

Due to COVID-19 restrictions on in-person events, several email lists were utilized to request participation including the following:

- Johns Hopkins Bayview Community Update e-newsletter with approximately 15,000 Baltimore City and County residents
- Healthy Community Partnership weekly e-mail – 850 recipients
- JH CONNECTS e-newsletter – 2,900 recipients
- INSIDE HOPKINS e-newsletter to approximately 50,000 JHM employees, estimated it included 13,000 Baltimore residents
- Inclusion in Baltimore City Councilpersons Zeke Cohen, Shannon Sneed and Robert Stokes emails to their constituent bases

Various social media avenues were utilized to solicit participation, including a targeted Facebook campaign to East Baltimore City residents, dedicated informational pages on the web sites of Johns Hopkins Medicine, Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC),

along with an employee notice on the JHH plasma screens throughout the hospital, and a screensaver on clinical workstations.

Several community-based organizations assisted with paper surveys that were collected and entered into the online tool. Engagement of local community organizations was vital in the distribution process to vulnerable populations in the city. The information collected from the paper surveys is representative of residents who utilize and obtain services from local community-based organizations including Sisters Together and Reaching (STAR), CONNECT, Men & Families Center, Dee's Place, Helping Up Mission, and Beans and Bread via the Johns Hopkins School of Nursing.

In total, 3,268 surveys were collected. There were 1,122 surveys representing residents in the JHH/JHBMC CBSA that were used for analysis. Fifty-five percent of survey respondents were female; roughly half were under 50 and half were 50+; 61 percent identified as Black/African American, and 10.5 percent identified as Hispanic/Latino.

The information below represents key findings collected from the survey. Respondents were told to skip any question they did not want to answer. The percentages referenced below are based on the total number of respondents since respondents were able to choose more than one answer for several questions including their top health and social concerns and reasons why they do not get health care.

Key Findings:

- Drug and alcohol addiction (72 percent), mental health/depression/anxiety (39 percent), diabetes/high blood sugar (28 percent), heart disease/blood pressure (27 percent), smoking/tobacco use (21 percent), and overweight/obesity (19 percent) were the top health concerns reported by survey respondents.
- The top social concerns were housing/homelessness (37 percent), lack of job opportunities (31 percent), neighborhood safety/violence (28 percent), poverty (19 percent), availability/access to insurance (17 percent), and limited access to healthy foods (16 percent).
- Twenty-two percent of survey respondents indicated that within the past 30 days, they had a number of days when their mental health was not good. The average number of poor mental health days was 11.8, more than one-third of the past 30 days.
- Eighty-five percent of respondents indicated they had health insurance coverage. This number was impacted significantly by the Hispanic/Latino respondents who completed the survey in Spanish, 89 percent of which did not have insurance coverage.
- The main reasons people in the community do not get health care are that it's too expensive (67 percent), no insurance (58 percent), lack of transportation (24 percent), wait is too long (22 percent), and insurance not accepted (18 percent). These reasons remain relatively unchanged from the last survey.
- Forty-three percent of people who responded to the COVID-19 specific questions indicated they did not know anyone who had been diagnosed with COVID-19; 28 percent said a friend or someone outside their family was diagnosed; 13 percent said a family member outside their household had been diagnosed; 5 percent said they were personally diagnosed and 3.5 percent said a household member was diagnosed.

- Asked if they needed any assistance as a result of COVID, 43 percent indicated none, 31 percent said food assistance, 28 percent financial assistance, 13 percent energy assistance, 11 percent rental assistance, 9 percent Wi-fi/internet assistance, 8 percent housing/shelter, and 6 percent childcare.
- Asked to rank their concerns when it comes to COVID-19, 46 percent indicated their biggest concern was members of their household becoming infected, followed by financial hardship, the emotional health of their household, and then the health of the community as the pandemic continues.
- The final question on the survey asked for any ideas or suggestions to improve health in the respondent's community. Many responses were directed toward COVID-19 such as wearing masks, social distancing, hand washing, and free testing sites. Additional comments and suggestions:
    - Clear information and access to services
    - Free basic preventative health care, low copays, and prescriptions
    - Health education including healthy living, eating and exercise
    - Helping the homeless and veterans, convert abandoned buildings into affordable housing
    - Fewer liquor stores and more healthy food alternatives
    - More detox beds
    - Funding of mental health resources
    - More focus groups and avenues for residents to have input and voice concerns
    - Crime reduction and less corruption

Provider Resource Inventory

An inventory of programs and services available in the region was developed in 2016 and is updated regularly as appropriate. The provider inventory highlights available programs and services within the JHH/JHBMC CBSA. The inventory identifies the range of organizations and agencies in the community that are serving the various target populations within each of the priority needs. The inventory provides program descriptions and collects information about the potential for coordinating community activities and creating linkages among agencies.

An interactive link of the provider resource inventory is available on JHH's and JHBMC's website.

https://www.hopkinsmedicine.org/about/community_health/johns-hopkins-hospital/community_health_needs_assessment.html

https://www.hopkinsmedicine.org/about/community_health/johns-hopkins-bayview/health_needs_initiatives/community_health_needs_assessment.html

Prioritization of Needs

Based upon feedback and input from hospital leadership, community stakeholders, community residents, project leadership, and extensive primary and secondary data research, ten CBSA needs were identified. To finalize the prioritization within the list, community partners affiliated with Baltimore CONNECT, a coalition of over 30 East Baltimore community organizations, were asked to review the process, the findings, and participate in the prioritization. During the review and discussion session the community participants ensured an appropriately diverse group of residents from the CBSA contributed and were represented from the perspective of demographics and location of residence. The group was also asked to identify any oversights or weaknesses in the process. Their final review resulted in the list of needs as presented in this report.

The key community needs were grouped into broader areas (i.e., socioeconomic needs and health needs) while taking into account the previous CHNA results of the Johns Hopkins Institutions (e.g., employment, crime/neighborhood safety, housing/homelessness, education, food environment, substance abuse/addiction, mental health, chronic diseases, access to care, and dental services.) Please note that some of the CHNA community-identified needs encompass more than one commonly defined health or social need. For example, "chronic disease" not only includes health conditions such as cancer, arthritis, asthma, and oral health, but also health education and literacy to manage and/or prevent chronic health issues. Also, job opportunities include job training and education, which are essential to gainful employment with living wages and advancement opportunities. Likewise, food environment includes access to healthy foods and nutrition education which could overlap with similar initiatives focused specifically on diabetes prevention and management. In the 2021 CHNA, diabetes and cardiovascular disease were identified at a much higher priority than in previous assessments. Therefore, they have been presented in independent and distinct categories. All identified key community needs are addressed either directly through designation as a prioritized key community need or incorporated as a component of a prioritized key community need.

The key need areas from the 2021 CHNA are aligned and merged with the previous CHNA needs and are depicted in the chart below (See Chart 31).

Chart 31: JHH/JHBMC Prioritized Key Community Health Needs

Implementation Planning

Based on the primary and secondary data collected and analyzed during the CHNA process, JHH and JHBMC's Implementation Strategy remains committed to the goals and strategies identified in the previous CHNA work sessions. Although some of the focus areas have changed in their order of priority per community feedback, the overall needs remain relatively the same as those reported in the 2018 CHNA. For the first time, housing/homelessness has escalated to the top concern among socioeconomic needs, with job opportunities and neighborhood safety remaining in the top three. Behavioral health/substance abuse and mental are the top direct health needs. Dental services were not identified as a need in the 2021 CHNA.

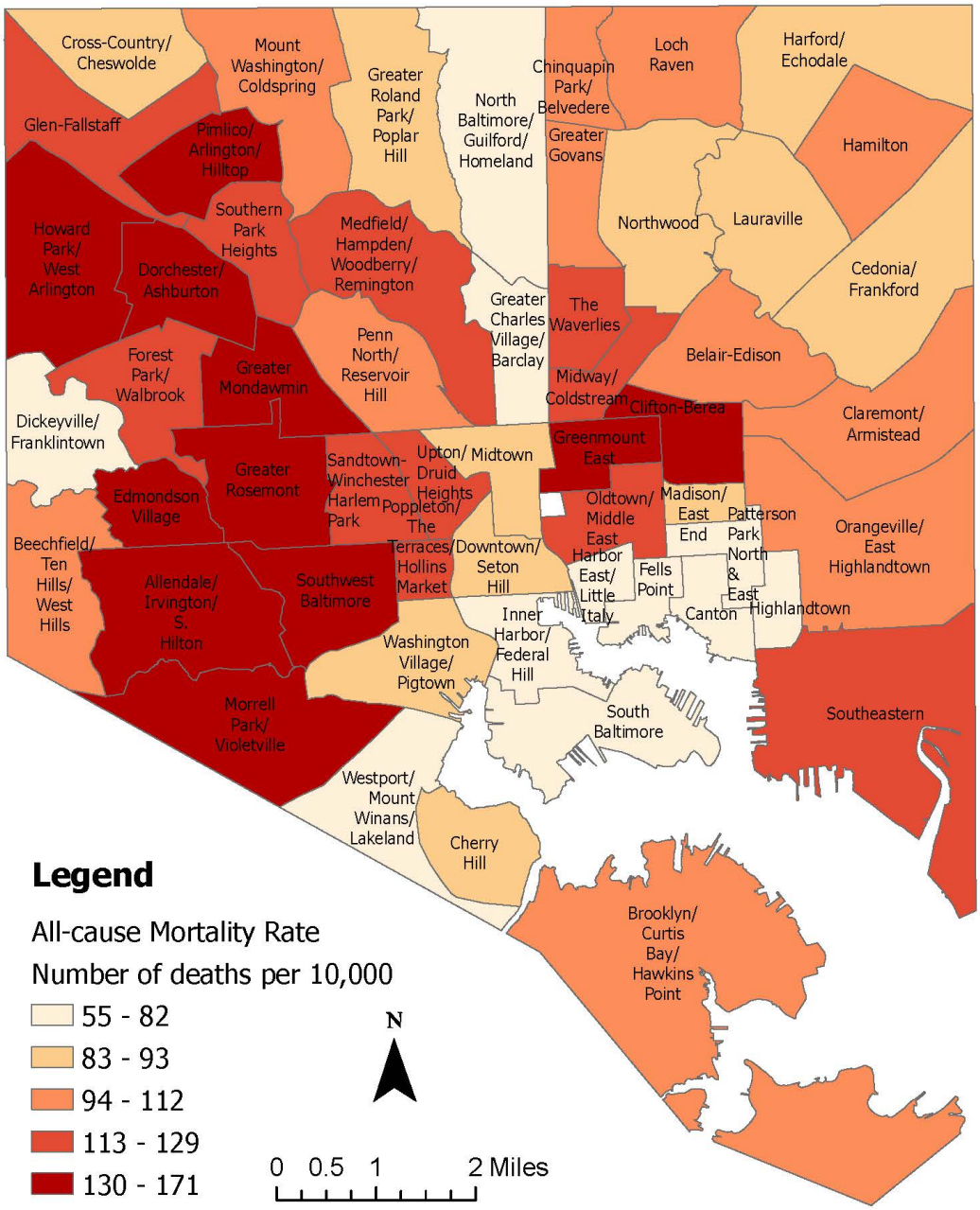
Johns Hopkins is engaged in hundreds of programs addressing the identified needs in their surrounding communities. The hospitals work to strategically allocate scarce resources to best serve the communities, increase trust, and build stronger community partnerships. The Implementation Strategy is the action plan component of the CHNA that guides strategic planning on community engagement.

Board of Trustees Approval

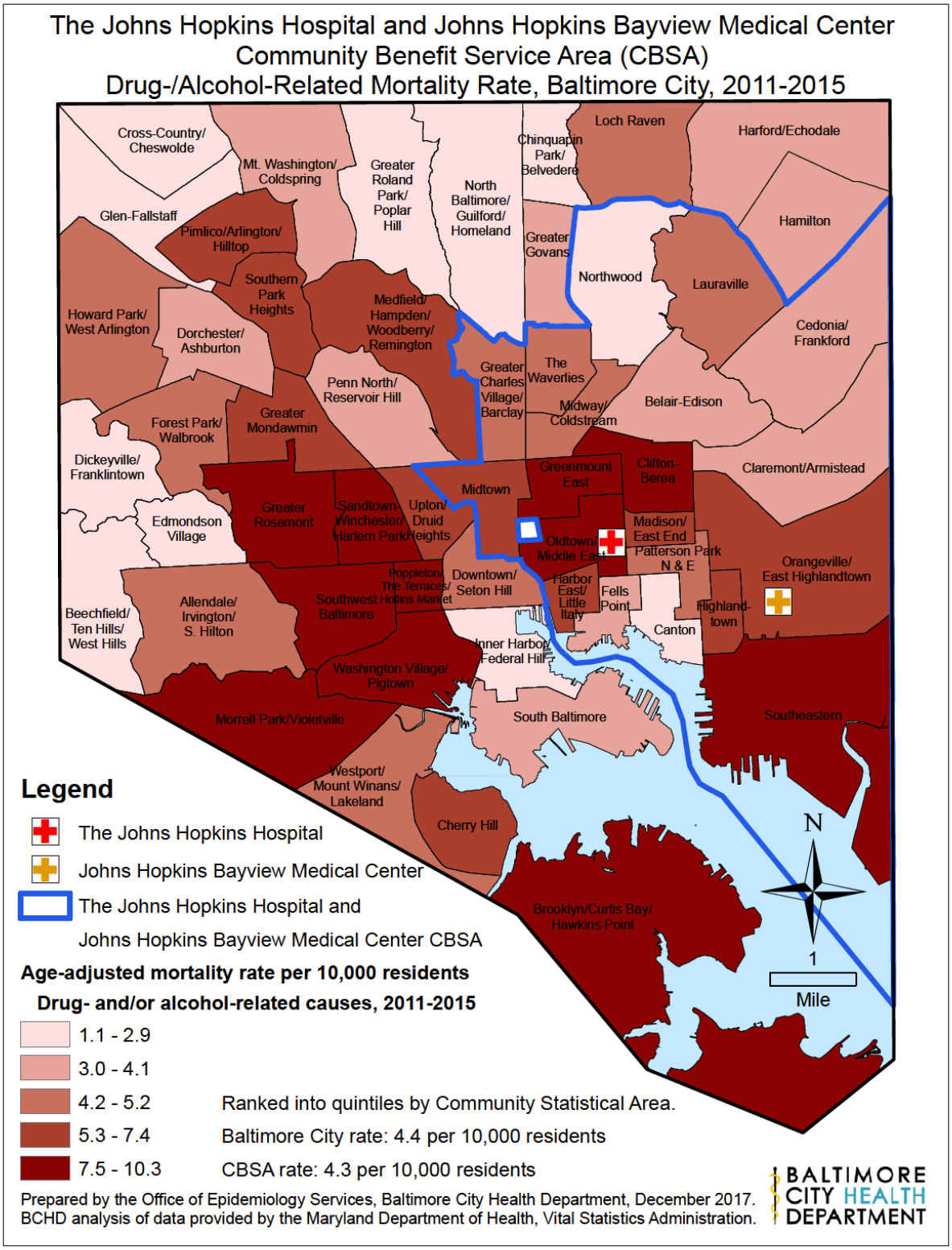
The CHNA and Implementation Strategy were presented to and approved by the Board of Trustees of The Johns Hopkins Hospital on June 2, 2021 and the Board of Trustees of Johns Hopkins Bayview Medical Center on May 24, 2021.

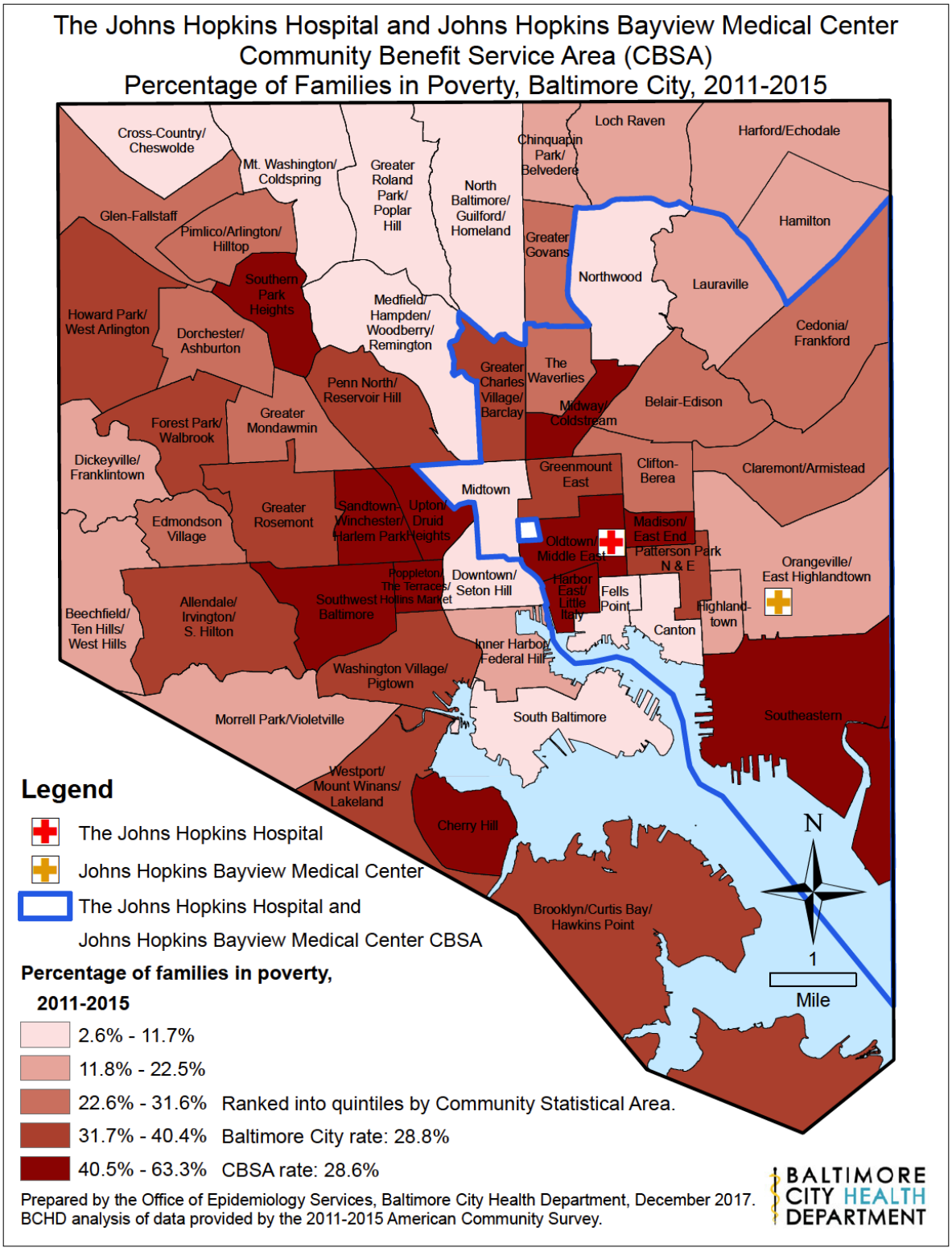
Appendix B: Baltimore City Health Department Community Maps

All-Cause Mortality Rate per 10,000 by Community Statistical Area (CSA), Baltimore City, 2014-2018



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


The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center
Community Benefit Service Area (CBSA)
Drug-/Alcohol-Related Mortality Rate, Baltimore City, 2011-2015
Cross-Country/ Cheswolde
Mt. Washington/ Coldspring
Greater Roland Park/ Poplar Hill
North Baltimore/ Guilford/ Homeland
Chinquapin Park/ Belvedere
Loch Raven
Harford/Echodale
Glen-Fallstaff
Pimlico/Arlington/ Hilltop
Greater Govans
Hamilton
Northwood
Lauraville
Southern Park Heights
Howard Park/ West Arlington
Dorchester/ Ashburton
Medfield/ Hampden/ Woodberry/ Remington
Cedonia/ Frankford
Greater Charles Village/ Barclay
The Waverlies
Penn North/ Reservoir Hill
Midway/ Coldstream
Belair-Edison
Forest Park/ Walbrook
Greater Mondawmin
Dickeyville/ Franklintown
Greenmount East
Clifton-Berea
Claremont/Armistead
Midtown
Greater Rosemont
Sandtown-Winchester/ Harlem Park
Upton/ Druid Heights
Edmondson Village
Madison/ East End
Oldtown/ Middle East
Patterson Park N & E
Orangeville/ East Highlandtown
Roppleton/ The Terraces/ Southwest Hollins Market
Downtown/ Seton Hill
Harbor East/ Little Italy
Fells Point
Highland-town
Allendale/ Irvington/ S. Hilton
Beechfield/ Ten Hills/ West Hills
Baltimore
Canton
Inner Harbor/ Federal Hill
Washington Village/ Pigtown
Morrell Park/Violetville
South Baltimore
Southeastern
Westport/ Mount Winans/ Lakeland
Cherry Hill
Brooklyn/Curtis Bay/ Hawkins Point
N
1
Mile
Legend
The Johns Hopkins Hospital
Johns Hopkins Bayview Medical Center
The Johns Hopkins Hospital and
Johns Hopkins Bayview Medical Center CBSA
Age-adjusted mortality rate per 10,000 residents
Drug- and/or alcohol-related causes, 2011-2015
1.1 - 2.9
3.0 - 4.1
4.2 - 5.2
5.3 - 7.4
7.5 - 10.3
Ranked into quintiles by Community Statistical Area.
Baltimore City rate: 4.4 per 10,000 residents
CBSA rate: 4.3 per 10,000 residents
Prepared by the Office of Epidemiology Services, Baltimore City Health Department, December 2017.
BCHD analysis of data provided by the Maryland Department of Health, Vital Statistics Administration.
BALTIMORE CITY HEALTH DEPARTMENT


The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center
Community Benefit Service Area (CBSA)
Percentage of Families in Poverty, Baltimore City, 2011-2015
Cross-Country/ Cheswolde
Mt. Washington/ Coldspring
Greater Roland Park/ Poplar Hill
North Baltimore/ Guilford/ Homeland
Chinquapin Park/ Belvedere
Loch Raven
Harford/Echodale
Hamilton
Glen-Fallstaff
Pimlico/Arlington/ Hilltop
Greater Govans
Northwood
Lauraville
Cedonia/ Frankford
Howard Park/ West Arlington
Dorchester/ Ashburton
Southern Park Heights
Medfield/ Hampden/ Woodberry/ Remington
Greater Charles Village/ Barclay
The Waverlies
Midway/ Coldstream
Belair-Edison
Penn North/ Reservoir Hill
Forest Park/ Walbrook
Greater Mondawmin
Dickeyville/ Franklintown
Greenmount East
Clifton-Berea
Claremont/Armistead
Midtown
Edmondson Village
Greater Rosemont
Sandtown-Winchester/ Harlem Park
Upton/ Druid Heights
Madison/ East End
Oldtown/ Middle East
Patterson Park N & E
Orangeville/ East Highlandtown
Roppleton/ The Terraces/ Southwest Baltimore
Downtown/ Seton Hill
Harbor East/ Little Italy
Fells Point
Highland-town
Canton
Allendale/ Irvington/ S. Hilton
Beechfield/ Ten Hills/ West Hills
Hollins Market
Inner Harbor/ Federal Hill
Washington Village/ Pigtown
South Baltimore
Southeastern
Morrell Park/Violetville
Westport/ Mount Winans/ Lakeland
Cherry Hill
Brooklyn/Curtis Bay/ Hawkins Point
N
1
Mile
Legend
The Johns Hopkins Hospital
Johns Hopkins Bayview Medical Center
The Johns Hopkins Hospital and
Johns Hopkins Bayview Medical Center CBSA
Percentage of families in poverty,
2011-2015
2.6% - 11.7%
11.8% - 22.5%
22.6% - 31.6%
31.7% - 40.4%
40.5% - 63.3%
Ranked into quintiles by Community Statistical Area.
Baltimore City rate: 28.8%
CBSA rate: 28.6%
Prepared by the Office of Epidemiology Services, Baltimore City Health Department, December 2017.
BCHD analysis of data provided by the 2011-2015 American Community Survey.
BALTIMORE CITY HEALTH DEPARTMENT

Appendix C: Secondary Data Profile

Secondary Data Profile

Johns Hopkins collected and analyzed secondary data from multiple sources, including Baltimore City Health Department, Community Commons, County Health Rankings, Maryland Department of Health and Human Services, Governor's Office on Crime Control and Prevention, Neighborhood Health Profiles, Substance Abuse and Mental Health Services Administration, The Annie E. Casey Foundation, The Centers for Disease Control and Prevention (CDC), and Dignity Health, as well as other sources.

The secondary data profile includes information from multiple health, social, and demographics sources which was utilized during the 2016 and 2018 CHNA and updated with current data from sources as available. The secondary data sources were used to compile information related to disease prevalence, socioeconomic factors, and behavioral habits. Where applicable, data were benchmarked against state and national trends. ZIP code analysis was also completed to illustrate community health needs at the local level.

A robust secondary data report was compiled for JHH and JHBMC; select information collected from the report has been presented throughout the CHNA. Data specifically related to the identified needs were used to support the key health needs.

The Community Need Index (CNI) was obtained for the CHNA through Dignity Health and used to quantify the severity of health disparities for ZIP codes in The Johns Hopkins Hospital's and Johns Hopkins Bayview Medical Center's community benefit service area (CBSA). CNI considers multiple factors that are known to limit health care access. The tool is useful in identifying and addressing the disproportionate and unmet health-related needs of neighborhoods. The five prominent socioeconomic barriers to community health quantified in the CNI are income barriers, cultural/language barriers, educational barriers, insurance barriers, and housing barriers.

Dignity Health: Community Needs Index (CNI) Overview

Dignity Health and IBM Watson Health™ jointly developed a Community Need Index (CNI) in 2004 to assist in the process of gathering vital socioeconomic factors in the community. The CNI is strongly linked to variations in community health care needs and is a strong indicator of a community's demand for various health care services.

Based on a wide array of demographic and economic statistics, the CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need compared to the US national average (score of 3.0). The CNI is strongly linked to variations in community health care needs and is a good indicator of a community's demand for a range of health care services. Not-for-profit and community-based hospitals, for whom community need is central to the mission of service, are often challenged to prioritize and effectively distribute hospital resources. The CNI can be used to help them identify specific initiatives best designed to address the health disparities of a given community.

Methodology

The CNI score is an average of five different barrier scores that measure various socioeconomic indicators of each community using the source data. The five barriers are listed below along with the individual statistics that are analyzed for each barrier. The following barriers, and the statistics that comprise them, were carefully chosen and tested individually by both Dignity Health and Truven Health:

1. Income Barrier

- Percentage of households below poverty line, with head of household aged 65 or older
- Percentage of families, with children under age 18, below poverty line
- Percentage of single female-headed families, with children under age 18, below poverty line

2. Cultural Barrier

- Percentage of population that is a minority (including Hispanic ethnicity)
- Percentage of population, over age 5, that speaks English poorly or not at all

3. Education Barrier

- Percentage of population, over age 25, without a high school diploma

4. Insurance Barrier

- Percentage of population in the labor force, age 16 or older, without employment
- Percentage of population without health insurance

5. Housing Barrier

- Percentage of households renting their home

Every populated ZIP code in the United States is assigned a barrier score of 1,2,3,4, or 5, depending upon the ZIP national rank (quintile). A score of 1 represents the lowest (i.e., best) rank nationally for the statistics listed, while a score of 5 indicates the highest rank nationally. For example, ZIP codes that score a 1 for the education barrier contain highly educated populations; ZIP codes with a score of 5 have a very small percentage of high school graduates.

For the two barriers with only one statistic each (education and housing), Truven Health used only the single statistic listed to calculate the barrier score. For the three barriers with more than one component statistic (income, cultural, and insurance), Truven Health analyzed the variation and contribution of each statistic for its barrier; Truven Health then weighted each component statistic appropriately when calculating the barrier score.

Once each ZIP code is assigned its barrier scores from 1 to 5, all five barrier scores for each ZIP code are averaged together to yield the CNI score. Each of the five barrier scores receives equal weight (20 percent each) in the CNI score. An overall score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need.

2020 Data Sources

- 2020 Demographic Data, © 2020 The Claritas Company
- 2020 Poverty Data, © 2020 The Claritas Company
- 2020 Insurance Coverage Estimates, IBM Watson Health™

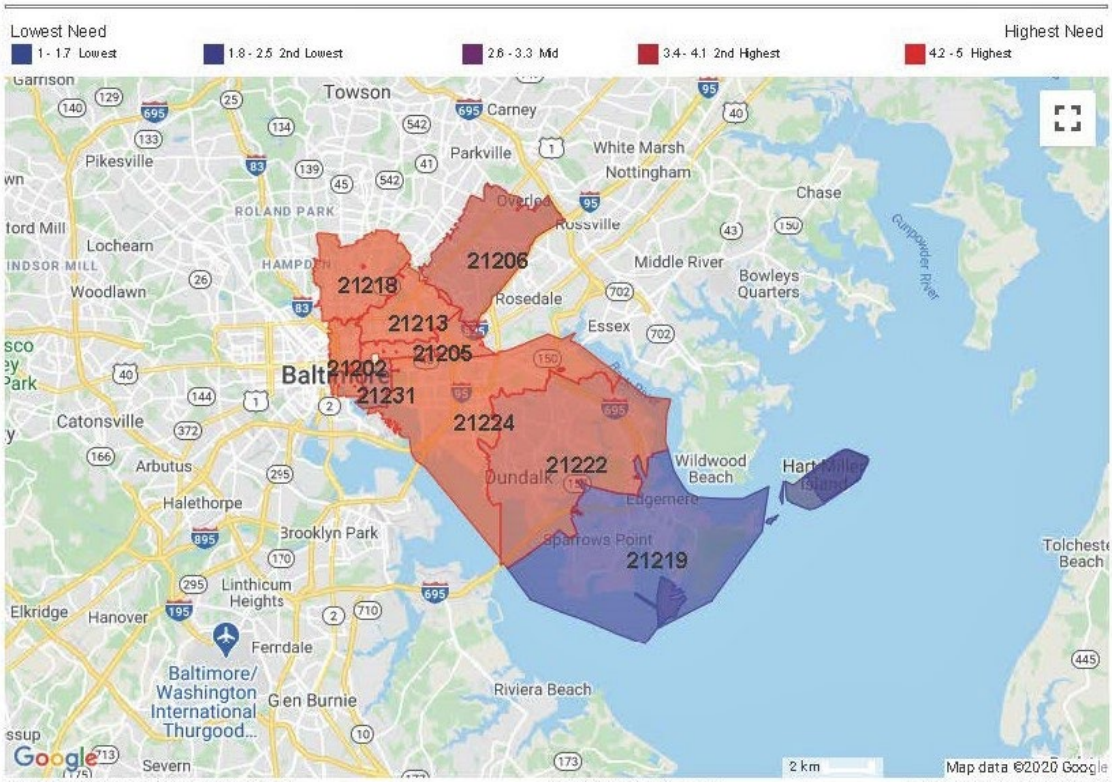
Applications and Caveats

- CNI scores are not calculated for non-populated ZIP codes. These include such areas as national parks, public spaces, post office boxes, and large unoccupied buildings.
- CNI scores for ZIP codes with small populations (especially less than 100 people) may be less accurate. This is due to the fact that the sample of respondents to the 2010 census is too small to provide accurate statistics for such ZIP codes.

A total of nine ZIP codes were analyzed for the Johns Hopkins Institutions. These ZIP codes represent the community served by JHH and JHBMC as portions of the health institutions' community benefit service areas. The community health assessment focused on these nine specific ZIP codes which fell into Baltimore City and parts of Baltimore County. They included 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224 and 21231.

The following map geographically depicts the community benefits service area by showing the communities that are shaded. As indicated in Map 4, the CBSA encompasses nine ZIP codes across east and southeast Baltimore City and County.

Map 4: Overall Community Benefits Service Area – 2020 Study Area Map



Mean(zipcode): 4.1 / Mean(person): 4.2 CNI Score Median: 4.4 CNI Score Mode: 4,4.4,4.8

Zip Code	CNI Score	Population	City	County	State
21202	4.8	23893	Baltimore	Baltimore City, Md	Maryland
21205	4.8	15131	Baltimore	Baltimore City, Md	Maryland
21206	4	48203	Baltimore	Baltimore City, Md	Maryland
21213	4.8	30318	Baltimore	Baltimore City, Md	Maryland
21218	4.4	46813	Baltimore	Baltimore City, Md	Maryland
21219	2.4	9353	Sparrows Point	Baltimore	Maryland
21222	3.6	55968	Dundalk	Baltimore	Maryland
21224	4.4	49506	Baltimore	Baltimore City, Md	Maryland
21231	4	15984	Baltimore	Baltimore City, Md	Maryland

TRUVEN HEALTH ANALYTICS

Table 12: Community Needs Index Summary Trend by ZIP code 2014-2020

ZIP	County	City	2020 Population	% Population Increase/ (Decrease)	2014 CNI Score	2015 CNI Score	2017 CNI Score	2020 CNI Score	Increase/ (Decrease) 2017 to 2020
21202	Baltimore City	Baltimore	23,893	-2.8%	5.0	5.0	4.8	**4.8**	**0.0**
21205	Baltimore City	Baltimore	15,131	-5.3%	5.0	5.0	4.8	**4.8**	**0.0**
21206	Baltimore City / County	Baltimore	48,203	-4.2%	3.8	4.0	3.6	**4.0**	**0.4**
21213	Baltimore City	Baltimore	30,318	-4.7%	4.6	4.8	4.8	**4.8**	**0.0**
21218	Baltimore City	Baltimore	46,813	-4.4%	4.4	4.4	4.2	**4.4**	**0.2**
21219	Baltimore County	Sparrows Point	9,353	-3.9%	2.6	2.6	2.8	**2.4**	**-0.4**
21222	Baltimore City / County	Dundalk	55,968	-2.0%	3.6	3.4	3.6	**3.6**	**0.0**
21224	Baltimore City / County	Baltimore	49,506	-2.8%	4.6	4.6	4.4	**4.4**	**0.0**
21231	Baltimore City	Baltimore	15,984	-2.7%	4.8	4.6	4.2	**4.0**	**-0.2**
Overall Study Area			295,169	-3.5%	**4.2**	**4.3**	**4.1**	**4.1**	-
Baltimore City							**4.1**	**3.7**	
Baltimore County							**2.3**	**2.9**	

As shown in Table 12, the CNI analysis for the CBSA encompassed nine ZIP codes in the 2020 CHNA study. They include 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224 and 21231. Of the nine ZIP codes in The JHH and JHBMC study area:

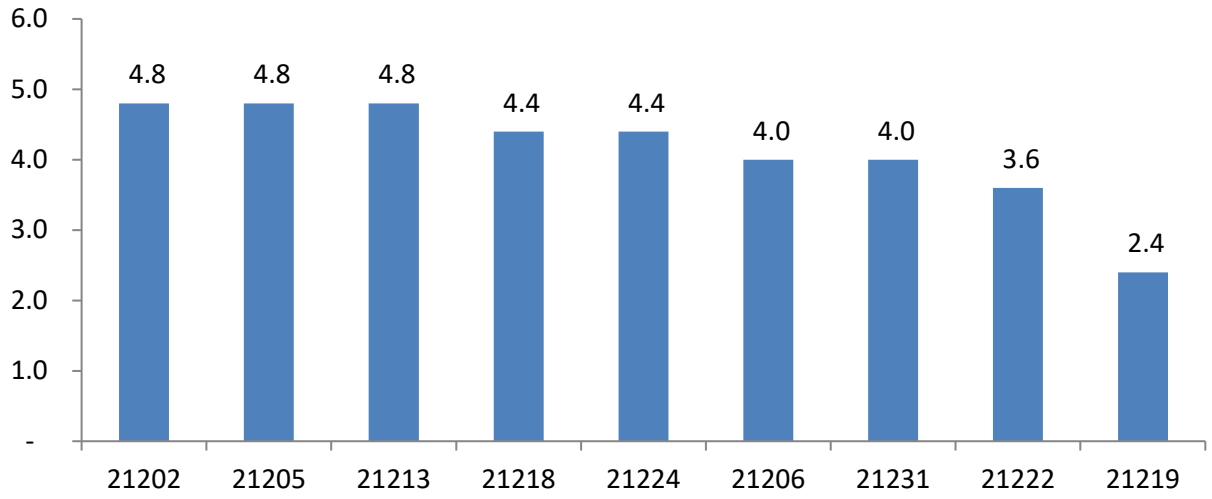
- CNI scores in green indicate a positive change in scores, showing a decrease in score from 2017 to 2020. Only 21219 and 21231 saw declines in CNI scores (reduced barriers to health care.)
- CNI scores in red indicate a negative change in scores, showing an increase in score from 2017 to 2020. ZIP codes 21206 and 21218 experienced rises in CNI scores (increased barriers to health care.)
- Five ZIP codes showed no improvement or degradation in score since 2017.

The CNI score for the CBSA in 2014 was 4.2, 2015 was 4.3, 2017 was 4.1 and 2020 was 4.1. While the CNI increased by +0.1 from 2014 to 2015, the CNI decreased in subsequent years to 4.1, indicating that the overall CBSA faces fewer barriers to accessing care. Even though the CBSA CNI has improved during this period, it is well behind the CNI of the overall city at 3.7 and Baltimore County at 2.9.

At the ZIP code level, the highest CNI score in the study area is 4.8 for the ZIP codes of 21202, 21205 and 21213. This indicates that these ZIP codes have the most barriers to accessing health care when compared to other ZIP codes in the study area.

The lowest CNI score in the study area was 2.4 in ZIP code 21219 (Sparrows Point). This ZIP code has the least barriers to health care access in the study area, but this does not imply that this area requires no attention. The median income for this ZIP code as shown previously in Chart 3 is $87,174, which is the highest in the CBSA. By comparison, the median income for 21205 was only $31,949.

Chart 33: Community Needs Index Overall Study Area Summary



Source: Dignity Health 2020

Appendix D: General Description of Johns Hopkins Medicine, The Johns Hopkins Hospital, and Johns Hopkins Bayview Medical Center

Johns Hopkins Medicine (JHM), headquartered in Baltimore, Maryland is an integrated global health enterprise and one of the leading health care systems in the United States. Johns Hopkins Medicine has six academic and community hospitals, four suburban health care and surgery centers, over 40 patient care locations, a home care group, and an international division, and it offers an array of health care services.

JHM's vision, "Together, we will deliver the promise of medicine," is supported by its mission to improve the health of the community and the world by setting the standard of excellence in medical education, research, and clinical care. Diverse and inclusive, JHM educates medical students, scientists, health care professionals and the public; conducts biomedical research, and provides patient-centered medicine to prevent, diagnose, and treat human illness.

Opened in 1889, The Johns Hopkins Hospital (JHH) has been consistently ranked by U.S. News & World Report as one of the top hospitals in the nation. JHH is a premier medical facility serving the health care needs of the greater Baltimore community, those in Maryland, nationally, and internationally. Training and educating researchers, scientists, health care professionals, and students are part of JHH's mission and tradition. The advancement of medicine, detection and treatment of diseases sets the standard in medical education and research. JHH has 1,162 licensed beds and over 2,400 full-time attending physicians. JHH is home to the Johns Hopkins Children's Center and the Johns Hopkins Kimmel Cancer Center, both of which are consistently ranked among the top in the nation by U.S. News & World Report.

Johns Hopkins Bayview Medical Center (JHBMC), committed to superior and innovative health care, education, and research, traces its history back to 1773. Since Johns Hopkins acquired Baltimore City Hospitals in 1984, more than $600 million has been invested to transform and modernize the campus. Uniting with The Johns Hopkins Hospital, the medical campus of JHBMC has been transformed to connect clinical care and medical education focusing on distinctive models of care in Johns Hopkins Centers of Excellence, including the Burn Center, Women's Center for Pelvic Health, Asthma & Allergy Center, and Memory and Alzheimer's Treatment Center. JHBMC's Geriatric Medicine and Rheumatology programs are consistently ranked highly by U.S. News & World Report. JHBMC has 455 licensed beds and over 680 attending physicians.

Appendix E: Communities Served by JHH and JHBMC

Community Benefit Service Area of JHH and JHBMC[8]

In 2015, The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC) merged their respective Community Benefit Service Areas (CBSA) in order to better integrate community health and community outreach across the east and southeast Baltimore City and County region. The CBSA geographic area is comprised of nine ZIP codes: 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, and 21231. This area reflects the population with the largest usage of the emergency departments and the majority of recipients of community contributions and programming. Within the CBSA, JHH and JHBMC have focused on certain target populations such as the elderly, at-risk children and adolescents, uninsured individuals and households, and underinsured and low-income individuals and households.

The CBSA covers approximately 27.9 square miles within the City of Baltimore, or approximately 34 percent of the total 80.94 square miles of land area for the city, and 25.6 square miles in Baltimore County. In terms of population, an estimated 295,169 people live within the CBSA, of which the population in City ZIP codes accounts for 37 percent of the City's population and the population in the County ZIP codes accounts for 9 percent of the County's population (2019 Census estimate of Baltimore City population, 593,490, and Baltimore County population, 827,370).

Within the CBSA, there are three Baltimore County neighborhoods - Dundalk, Sparrows Point, and Edgemere. The Baltimore City Department of Health has subdivided the city area into 23 neighborhoods or neighborhood groupings that are completely or partially included within the CBSA. These neighborhoods are Belair-Edison, Canton, Cedonia/Frankford, Claremont/Armistead, Clifton-Berea, Downtown/Seton Hill, Fells Point, Greater Charles Village/Barclay, Greater Govans, Greenmount East, Hamilton, Highlandtown, Jonestown/Oldtown, Lauraville, Madison/East End, Midtown, Midway- Coldstream, Northwood, Orangeville/East Highlandtown, Patterson Park North & East, Perkins/Middle East, Southeastern, and the Waverlies.

The Johns Hopkins Hospital is in the neighborhood known as Perkins/Middle East, and the neighborhoods that are adjacent to the campus include Greenmount East, Clifton-Berea, Madison/East End, Patterson Park North & East, Fells Point, and Jonestown/Oldtown. Residents of most of these neighborhoods are primarily Black/African American, with the exceptions of Fells Point, which is primarily White, and Patterson Park North & East, which represents a diversity of resident ethnicities. With the exceptions of Fells Point and Patterson Park N&E, the median household income of most of these neighborhoods is significantly lower than the Baltimore City median household income. Median income in Fells Point and Patterson Park N&E skews higher, and there are higher percentages of White households having higher median incomes residing in these neighborhoods.

Johns Hopkins Bayview Medical Center is located in east Baltimore City and southeast Baltimore County where the CBSA population demographics have historically trended as White middle-income, working-class communities; however, in the past few decades, southeast Baltimore City has become much more diverse with a growing Hispanic/Latino population clustered around Patterson Park and Highlandtown. In Baltimore County, Dundalk, Sparrows Point, and Edgemere have been predominantly White with increasing populations of Hispanic/Latino and Black/African American residents. Many of these new residents come to JHBMC for their

[8] Information in this section (Communities Served by JHH and JHBMC) was obtained from the Johns Hopkins Health System Community Benefits Report.

health care needs. Challenges for Hispanic/Latino families include poor access to primary care, need for prenatal care for women, unintentional injury-related deaths, and high rates of alcohol use among Hispanic/Latino men. To address these disparities, Johns Hopkins Bayview has increased clinical services and developed new initiatives, including more language interpretation for patient services, the Care-a-Van mobile health unit, the Children's Medical Practice, and Centro SOL, which provides outreach, education, mental health support, and improved access to services.

Neighborhoods farther north of The Johns Hopkins Hospital include Belair-Edison, Cedonia/Frankford, Claremont/Armistead, Clifton-Berea, Greater Charles Village/Barclay, Greater Govans, Hamilton, Lauraville, Midtown, Midway-Coldstream, Northwood, and The Waverlies. These neighborhoods are racially more diverse than the neighborhoods closest to JHH, and median household incomes range from significantly above the median to close to the median household income for Baltimore City.

Since the end of the Second World War, much of the population of Baltimore City has been leaving the city and moving to the surrounding suburban counties. This demographic trend accelerated in the 1960s and 1970s, greatly affecting the neighborhoods around JHH and JHBMC. As the population of Baltimore City dropped, there has been a considerable disinvestment in housing stock in these neighborhoods. Economic conditions that resulted in the closing or relocation of manufacturing and industrial jobs in Baltimore City and Baltimore County led to higher unemployment in the neighborhoods around The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, and social trends during the 1970s and 1980s led to increases in substance abuse and violent crime as well.

Greater health disparities are found in these neighborhoods closest to the hospitals compared to Maryland state averages and surrounding county averages. The June 2012 Charts of Selected Black/African American vs. White Chronic Disease SHIP Metrics for Baltimore City prepared by the Maryland Office of Minority Health and Health Disparities highlights some of these health disparities, including higher emergency department visit rates for asthma, diabetes, and hypertension in Black/African Americans compared to Whites, higher heart disease and cancer mortality in Black/African Americans than Whites, higher rates of adult smoking and lower percentages of adults at a healthy weight.

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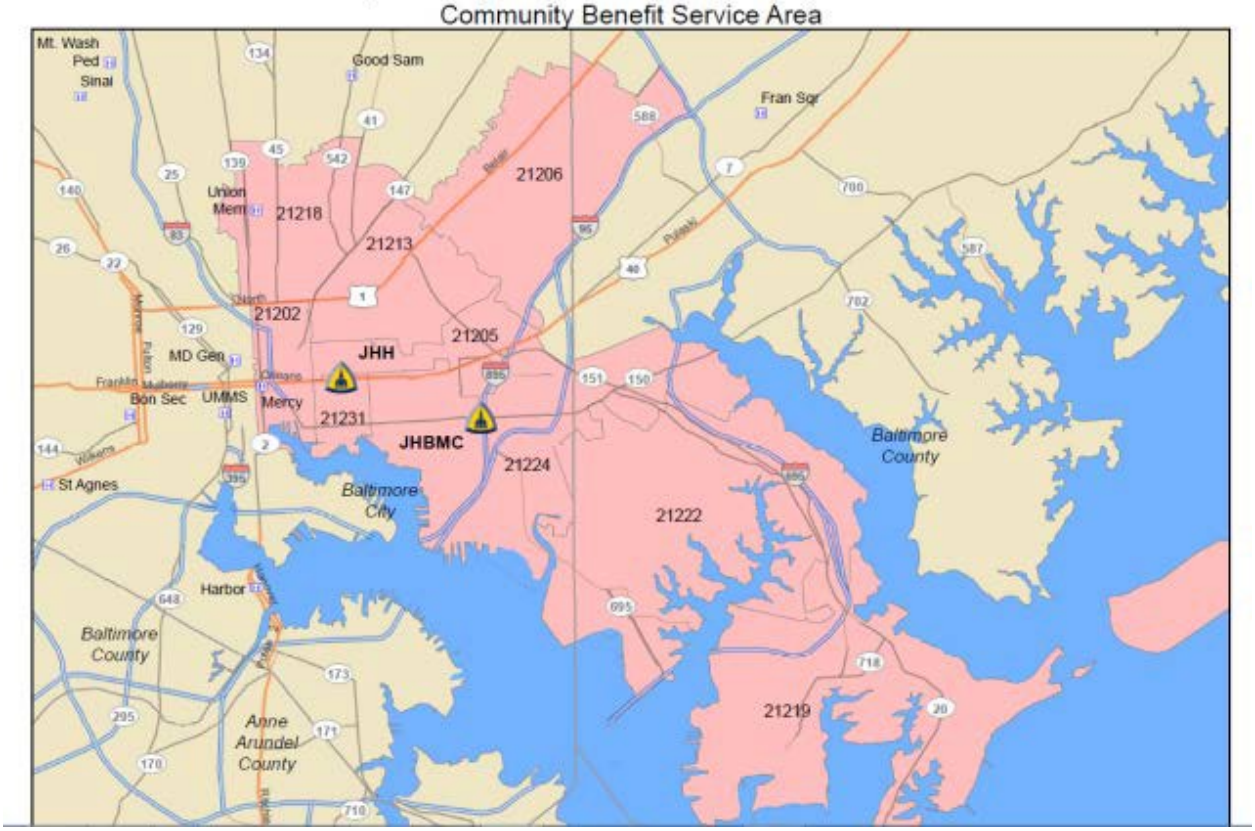
The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center
Community Benefit Service Area



Appendix F: JHH and JHBMC Community Benefit Service Area - Demographic Snapshot

		Data Source
Community Benefits Service Area (CBSA)	21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, 21231	JHM Market Analysis & Business Planning
CBSA demographics, by sex, race, ethnicity and average age	Total population: 295,169 Sex Male: 144,030/48.8% Female: 151,139/51.2% Race White: 127,014/43.0% Black/African American/African American: 135,911/46.0% Multiple Races: 9,177/3.1% Asian: 9,437/3.2% American Indian/Alaska Native: 1,745/.6% All others: 11,885/4.1% Ethnicity Hispanic (Any Race): 26,007/8.8% Non-Hispanic (Any Race): 269,162/91.28% Age 0-14: 51,636/17.5% 15-17: 9,409/3.2% 18-24: 26,263/8.9% 25-34: 54,802/18.5% 35-54: 75,997/25.8% 55-64: 36,465/12.4% 65+: 40,597/13.7% Household Income <$15K: 16,807/14.5% $15-25K: 10,406/9.0% $25-50K: 25,506/22.1% $50-75K: 19,450/16.8% $75-100K: 12,738/11.0% >$100K: 30,864/26.6%	Sg2 Market Demographics Tool
Median household income	Baltimore City: $50,500 Baltimore County: $75,800 Maryland: $83,100	2020 County Health Rankings
Percentage of uninsured adults within CBSA counties	Baltimore City: 9% Baltimore County: 7% Maryland: 8%	2020 County Health Rankings

Insurance coverage estimates by payor type within CBSA	Commercial: 58.9% Medicaid: 12.2% Medicare: 18.7% Veterans: 3.2% Other: 1.6% Uninsured: 5.6%	Sg2 Market Demographics Tool
Life expectancy by County within CBSA (2017-2019)	Baltimore City: 72.8 years at birth Baltimore County: 78.1 years at birth Maryland: 79.2 years at birth Baltimore City by Race White: 76.2 years at birth Black/African American: 70.8 years at birth Baltimore County by Race White: 78.3 years at birth Black/African American: 76.8 years at birth Maryland by Race White: 79.9 years at birth Black/African American: 76.9 years at birth	Maryland Vital Statistics Annual Report 2019 http://dhmh.maryland.gov/vsa
Infant mortality rates within CBSA	Baltimore City - 2019 All: 8.8 per 1,000 live births White: 4.4 per 1,000 live births Black/African American: 11.4 per 1,000 live births Hispanic: 6.3 per 1,000 live births Baltimore County - 2019 All: 7.1 per 1,000 live births White: 4.0 per 1,000 live births Black/African American: 12.0 per 1,000 live births Hispanic: 6.9 per 1,000 live births Maryland - 2019 All: 5.9 per 1,000 live births White: 4.1 per 1,000 live births Black/African American: 9.3 per 1,000 live births Hispanic: 5.1 per 1,000 live births	Maryland Vital Statistics Infant Mortality in Maryland, 2019 http://dhmh.maryland.gov/vsa
Education Level/Language other than English spoken at home within CBSA (Pop. Age 25+)	Less than H.S.: 11,561/5.6% Some H.S.: 23,441/11.3% H.S. Degree: 66,787/32.1% Some College: 55,091/ 26.5% Bachelor's Degree or Greater: 50,972/24.6%	Sg2 Market Demographics Tool
Access to healthy food	23.5% of Baltimore City residents live in a healthy food priority area	Baltimore City 2018 Food Environment Brief

	28.3% of all school age children in Baltimore City live in a healthy food priority area Percentages of Baltimore City population living in healthy food priority areas by race/ethnicity: 31% African Americans 8.9% White Baltimore City Food insecurity: 21% Limited access to healthy foods: 1% Baltimore County Food insecurity: 11% Limited access to healthy foods: 3% Maryland Food insecurity: 11% Limited access to healthy foods: 3%	2020 County Health Rankings
Access to transportation – percentage of households with no vehicle available	Baltimore City White:15% People of color: 37% Maryland White:6% People of color: 14%	National Equity Atlas, 2017
Healthy Behaviors	Baltimore City Adult smoking: 20% Adult obesity: 35% Physical inactivity: 27% Excessive drinking: 19% Baltimore County Adult smoking: 13% Adult obesity: 31% Physical inactivity: 24% Excessive drinking: 17% Maryland Adult smoking: 14% Adult obesity: 31% Physical inactivity: 22% Excessive drinking: 17%	2020 County Health Rankings

Appendix G: Community Stakeholder Interviewees

Johns Hopkins completed interviews with community stakeholders throughout the region to gain a better understanding of community health needs from the perspective of organizations, agencies, and government officials that have a deep understanding from their day-to-day interactions with populations in greatest needs.

Interviews and focus groups provided information about the community's health status, risk factors, service utilizations, and community resource needs, as well as gaps and service suggestions.

Listed below in alphabetic order by last name are the community stakeholders that participated in this CHNA.

Name	Organization
Stephanie Archer-Smith	Meals on Wheels of Central Maryland
Lauren Averella	Civic Works
Barbara Bates-Hopkins	Johns Hopkins Bloomberg School of Public Health
Brooke Baumberger	Greektown Neighborhood Association
Vance Benton	Patterson High School
David Bishai	Baltimore City District 1 Health Committee; Johns Hopkins University
Delegate D. Antonio Bridges	Maryland State Delegate – District 41
Councilman Kristerfer Burnett	Baltimore City Council – District 8
Councilman Zeke Cohen	Baltimore City Council – District 1
Lisa Cooper	Johns Hopkins Urban Health Institute
Patricia DeBerry	Chapel Springs Senior Housing
Gary Dittman	Amazing Grace Lutheran Church
Mary Donnelly	John Ruhrah Elementary School
Ryan Durr	Bluford Drew Jemison STEM Academy
Janice Evans	Johns Hopkins Bayview Community Advisory Board
Leonard Feldman	Johns Hopkins / East Baltimore Medical Center
Alejandra Flores-Miller	Johns Hopkins Centro SOL
Ronald SirRon Fountain	Dee's Place
David Harris	McElderry Park Community Association
Margie Hatch	John Ruhrah Elementary School / Southeast Community Development Corporation
Councilman Bill Henry	Baltimore City Council – District 4
Debbie Hickman	Sisters Together and Reaching (STAR)
Donte Hickman	Southern Baptist Church
Norma Kanarek	Johns Hopkins Bloomberg School of Public Health
Anne Langley	Maryland State Health Department
Bruce Lewandowski	Sacred Heart of Jesus

Name	Organization
Amy Menzer	Dundalk Renaissance Corporation
Doris Minor-Terrell	New Broadway East Community Association
Lois Mitchel	Dee's Place
Gloria Nelson	Turner Station Conservation Team
Kathleen Page	Johns Hopkins Centro SOL
Leon Purnell	Men and Families Center
Samuel Redd	Operation Pulse
Natanya Robinowitz	Charm City CARE Connection
Joshua Sharfstein	Johns Hopkins Bloomberg School of Public Health
Katherine Shaw	Johns Hopkins / East Baltimore Medical Center
Betsy Simon	Zeta Center for Healthy and Active Aging
Oscar Smith	First Baptist Church of Maryland
Kari Snyder	Southeast Community Development Corporation (SECDC)
Barry Solomon	Johns Hopkins Community Connection
Dana Stein	Civic Works
Councilman Robert Stokes	Baltimore City Council – District 12
Shirley Sutton	Baltimore Medical System, Inc.
Heang Tan	Baltimore City Health Department, Division of Aging and CARE Services
Kristen Topel	Johns Hopkins Community Connection
Jeff Thompson	Historic East Baltimore Community Action Coalition (HEBCAC)
Vincent Truant	Matrix Ventures, LLC.
Robin Truiett-Theodorson	Banner Neighborhoods Community Corporation
Alicia Wilson	Johns Hopkins University Office of Economic Development
Thema Wilson	The Door

Appendix H: Community Organizations and Partners

The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center came together to conduct a community health needs assessment (CHNA). As leading health care providers, JHH and JHBMC are dedicated to understanding community needs and offering and enhancing quality programs to address those needs and promote population wellness.

The primary data collected in the CHNA provided invaluable input and represents ongoing dedication to assisting JHH and JHBMC in identifying community health needs priorities and building a foundation upon which to develop strategies that will address the needs of residents in east Baltimore City and southeast Baltimore County.

Listed below are the community organizations that assisted JHH and JHBMC with the primary collection for the 2021 CHNA.

	Community Organizations and Partners
1.	Abell Improvement Association
2.	Action in Maturity
3.	Amazing Grace Lutheran Church
4.	Asylee Women's Enterprise
5.	Baltimore City Council
6.	Baltimore City District 1 Health Committee
7.	Baltimore City Health Department
8.	Baltimore CONNECT
9.	Baltimore Medical System, Inc.
10.	Banner Neighborhoods Community Corporation
11.	Bayview Community Association
12.	Bea Gaddy Family Center
13.	Berea East Side Community Association
14.	Better Waverly Community Organization
15.	Bluford Drew Jemison STEM Academy
16.	Bon Secours Community Works
17.	BUILD (Baltimoreans United in Leadership Development)
18.	C.A.R.E. Community Association
19.	CCBC - Dundalk
20.	Central Baptist Church
21.	Chapel Springs Senior Housing
22.	Charles Village Civic Association
23.	Charles Village Community Benefits District
24.	Charm City Care Connection
25.	Civic Works
26.	Coldspring Senior Housing
27.	Dayspring Programs
28.	Dee's Place
29.	Dundalk Renaissance Corporation
30.	East Baltimore Medical Center

	Community Organizations and Partners
31.	Echo Resource Development Inc.
32.	Esperanza Center
33.	First Apostolic Church
34.	First Baptist Church of Maryland
35.	Fort Worthington Neighborhood Association
36.	Franciscan Center
37.	Friends of Patterson Park
38.	Fulton Mortgage Company
39.	Greater Remington Improvement Association
40.	Greektown Neighborhood Association
41.	Green & Healthy Homes Initiative
42.	Harwood Community Association
43.	Helping Up Mission
44.	Historic East Baltimore Community Action Coalition, Inc.
45.	John Ruhrah Elementary Middle School/The Judy Center
46.	Johns Hopkins Bayview Community Advisory Board
47.	Johns Hopkins Centro SOL
48.	Johns Hopkins Community Connection
49.	Johns Hopkins Community Physicians
50.	Johns Hopkins Diaspora Employee Resource Group
51.	Johns Hopkins School of Medicine
52.	Johns Hopkins School of Nursing
53.	Johns Hopkins University Bloomberg School of Public Health American Health Initiative
54.	Johns Hopkins University Bloomberg School of Public Health Center for Health Equity
55.	League for People with Disabilities
56.	Life Bridge Health
57.	Life Bridge Health Hispanic Latino Employee Network
58.	Local Meals
59.	Manna Bible Baptist Church
60.	Manna House Inc.
61.	Maryland New Directions
62.	Maryland State Health Department
63.	Matrix Ventures
64.	Mayor's Office of Neighborhoods
65.	McElderry Park Community Association
66.	Meals on Wheels of Central Maryland
67.	MedStar Health
68.	MedStar Total Elder Care
69.	Men & Families Center
70.	Mercy Medical Center
71.	Midtown Community Benefits District
72.	Ministerial Alliance of Baltimore County
73.	Ministers Conference of Baltimore

	Community Organizations and Partners
74.	Mount Vernon Belvedere Association
75.	Moveable Feast
76.	NAMI Metro Baltimore
77.	New Broadway East Community Association
78.	New Solid Rock Fellowship Church
79.	Northwest Faith Based Partnership
80.	Old Goucher Community Association
81.	Oliver Community Association
82.	Operation P.U.L.S.E. (People United to Live in a Safe Environment)
83.	Our Daily Bread / Catholic Charities
84.	Patterson High School
85.	Roberta's House
86.	Rolling Oaks Community Association
87.	Sacred Heart of Jesus
88.	Sisters Together and Reaching (STAR)
89.	South East Community Development Corporation
90.	Southern Baptist Church
91.	St. Agnes / Ascension
92.	St. Ambrose Housing Aid Center
93.	St. Vincent de Paul of Baltimore/ Beans & Bread
94.	Stevenswood Community Association
95.	Susanna Wesley House
96.	The Door Inc. (Baltimore Urban Leadership Foundation)
97.	The Mix Church
98.	Turner Station Community Conservation Organization
99.	University of Maryland Medical System
100.	Urban Health Institute
101.	Washington Hill Community
102.	Waverly Improvement Association
103.	Waxter Center for Senior Citizens
104.	Zeta Healthy Aging Partnership
105.	Zion Baptist Church

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Appendix J: CHNA Task Force/Working Group & Consulting Group Members

Members of the task force/working group were charged with the project components of the CHNA, report preparation, and implementation planning. Members of the task force/working group are listed below.

Task Force/Working Group Members:

1. Dr. Redonda Miller, President, The Johns Hopkins Hospital
2. Dr. Richard Bennett, President, Johns Hopkins Bayview Medical Center
3. Sharon Tiebert-Maddox, Director, Strategic Initiatives and Community Health Improvement, Government and Community Affairs, Johns Hopkins Institutions
4. Dr. Dan Hale, Special Advisor, Office of the President, Johns Hopkins Bayview Medical Center
5. Sherry Fluke, Senior Financial/Project Manager, Government and Community Affairs, Johns Hopkins Institutions
6. Kimberly Monson, Community Program Coordinator, Healthy Community Partnership, Johns Hopkins Bayview Medical Center

Consulting group members were advisory to the task force and brought in for review and consultation as needed during various phases of the CHNA development and needs prioritization. The members of the consulting group are listed below.

Consulting Group Members:

1. Nicole McCann, Vice President Provider/Payor Transformation, Johns Hopkins Health System
2. Thomas Lewis, Vice President, Government and Community Affairs, Johns Hopkins Institutions
3. Selwyn Ray, Director, Community Relations, Health and Wellness, Johns Hopkins Bayview Medical Center
4. Adrianna Moore, Senior Project Manager, Healthcare Transformation and Strategic Planning, Johns Hopkins Health System
5. Lindsay Hebert, DrPH, Johns Hopkins Bloomberg School of Public Health and Baltimore CONNECT

Appendix K: 2020 Survey (English and Spanish Version)

2020 Baltimore Health Needs Survey

Your responses to this optional survey are anonymous and will inform how hospitals and agencies work to improve health in our Baltimore community. Thank you!

Instructions: You must be 18 years or older to complete this survey. Please answer all questions and return the survey as indicated. For questions about this survey, contact 1-800-492-5538.

1. What is your ZIP code? *Please write 5-digit ZIP code.* _____

2. What is your gender? *Please check one.*

☐ Male ☐ Female ☐ Transgender
☐ Other *specify*_____ ☐ Don't know ☐ Prefer not to answer

3. What is your age group (years)? *Please check one.*

☐ 18-29 ☐ 40-49 ☐ 65-74 ☐ 75+
☐ 30-39 ☐ 50-64 ☐ Don't know ☐ Prefer not to answer

4. Which one of the following is your race? *Please check all that apply.*

☐ Black or African American ☐ White or Caucasian
☐ Native Hawaiian or Other Pacific Islander ☐ Asian
☐ American Indian or Alaska Native ☐ Other / More than one race *specify*_____
☐ Don't know ☐ Prefer not to answer

5. Are you Hispanic or Latino/a? *Please check one.*

☐ Yes ☐ No ☐ Don't know ☐ Prefer not to answer

6. Do you have health insurance? ☐Yes ☐No

7. On how many days during the past 30 days was your mental health not good? Mental health includes stress, depression, and problems with emotions. *Please write number of days.*

_____ **days** ☐ Zero days ☐ Don't know ☐ Prefer not to answer

8. What are the <u>three</u> most important health problems that affect the health of your community? *Please check only three.*

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

9. What are the three most important social/environmental problems that affect the health of your community? *Please check only three.*

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

10. What are the three most important reasons people in your community do not get health care? *Please check only three.*

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

COVID-19 QUESTIONS

11. Which of the following apply to you? Check all that apply.

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

12. As a result of COVID19, have you needed any of the following? Check all that apply.

☐ Financial assistance
☐ Food assistance
☐ Rental assistance
☐ Translation/Interpretation Services
☐ None
☐ Energy assistance
☐ Wi-Fi / Internet assistance
☐ Housing/shelter
☐ Childcare
☐ Other: _____

13. When it comes to COVID-19 what are you most concerned about right now?

Rank the following options in order of importance (1 = most important to 4 = least important).

_____ Members of my household becoming infected
_____ The health of my community as the pandemic continues
_____ The emotional health of my household
_____ Financial hardship

14. What ideas or suggestions do you have to improve health in your community?

_____

_____ __☐ Don't know or prefer not to answer

Thank you for completing the survey!

Encuesta sobre las necesidades de salud en Baltimore en 2020

Sus respuestas a esta encuesta opcional son anónimas e informarán sobre cómo trabajan los hospitales y agencias para mejorar la salud en nuestra comunidad de Baltimore. ¡Gracias!

Instrucciones: Debe tener 18 años o más para completar esta encuesta. Por favor, responda a todas las preguntas y devuelva la encuesta como se indica. Si tiene preguntas sobre esta encuesta, llame al 1-800-492-5538.

1. **¿Cuál es su código postal?** *Por favor escriba el código postal de 5 dígitos.* _____

2. **¿Cuál es su género?** *Por favor, marque uno.*
☐ Masculino ☐ Femenino ☐ Transgénero
☐ Otro *especificar* _____ ☐ No lo sé ☐ Prefiero no contestar

3. **¿Cuál es su grupo de edad (años)?** *Por favor, marque uno.*
☐ 18-29 ☐ 40-49 ☐ 65-74 ☐ 75+
☐ 30-39 ☐ 50-64 ☐ No lo sé ☐ Prefiero no contestar

4. **¿Cuál de las siguientes es su raza?** *Por favor, marque todas las que correspondan.*
☐ Negro o afroamericano ☐ Blanco o caucásico
☐ Nativo de Hawái o de otra isla del Pacífico ☐ Asiático
☐ Indio americano o nativo de Alaska ☐ Otro / más de una raza *especificar* _____
☐ No lo sé ☐ Prefiero no contestar

5. **¿Es hispano o latino?** *Por favor, marque uno.*
☐ Sí ☐ No ☐ No lo sé ☐ Prefiero no contestar

6. **¿Tiene seguro médico?**
☐Sí ☐No

7. **¿Durante los últimos 30 días, cuántos días su salud mental no fue buena?**
La salud mental incluye estrés, depresión y problemas con las emociones. *Por favor, escriba el número de días.*
_____ **días** ☐ Cero días ☐ No lo sé ☐ Prefiero no contestar

8. **¿Cuáles son <u>los tres</u> problemas de salud más importantes que afectan a la salud de su comunidad?**
Por favor, solo marque tres.
☐ Alcohol / Adicción a las drogas
☐ Salud mental (depresión, ansiedad)
☐ Diabetes /alto nivel de azúcar en la sangre
☐ VIH/SIDA
☐ Enfermedad pulmonar / Asma / EPOC
☐ Fumar / Consumo de tabaco
☐ Infecciones de transmisión sexual
☐ Alzheimer / Demencia
☐ Sobrepeso / Obesidad
☐ Cáncer
☐ Enfermedad cardíaca / Hipertensión arterial
☐ Muerte infantil
☐ Embolia
☐ No lo sé o prefiero no contestar
☐ Otras _____

9. ¿Cuáles son <u>los tres</u> problemas sociales/ambientales más importantes que afectan a la salud de su comunidad?
Por favor, solo marque tres.

☐ Disponibilidad / Acceso al consultorio del doctor
☐ Disponibilidad / Acceso al seguro
☐ Violencia familiar
☐ Acceso limitado a alimentos saludables
☐ Abandono escolar / Escuelas pobres
☐ Falta de oportunidades de trabajo
☐ Discriminación racial y étnica
☐ Aislamiento social / Soledad
☐ No lo sé o prefiero no contestar
☐ Abuso infantil / Negligencia
☐ Falta de cuidado de niños económico
☐ Vivienda / Sin hogar
☐ Seguridad en el vecindario / Violencia
☐ Pobreza
☐ Lugares limitados para hacer ejercicio
☐ Problemas de transporte
☐ Otra: _____

10. ¿Cuáles son las <u>tres</u> razones más importantes por las que la gente de su comunidad no recibe atención médica?
Por favor, solo marque tres.

☐ Costo - demasiado caro / No puede pagar
☐ No cuenta con seguro
☐ Falta de transporte
☐ Barrera del lenguaje
☐ Preocupado por el estatus migratorio
☐ Miedo o desconfianza de los doctores
☐ No lo sé o prefiero no contestar
☐ No hay un doctor cerca
☐ No se acepta el seguro
☐ Creencias culturales y religiosas
☐ Cuidado de niños
☐ La espera es muy larga
☐ Otra: _____

<u>PREGUNTAS COVID-19</u>

11. ¿Cuáles de los siguientes aplican a usted? Marque todo lo que aplique.

☐ Yo he sido diagnosticado con Coronavirus
☐ Un miembro del hogar ha sido diagnosticado con Coronavirus
☐ Un miembro de la familia, fuera de mi casa, ha sido diagnosticado con Coronavirus
☐ Un amigo o alguien que conozco, fuera de mi familia, ha sido diagnosticado con Coronavirus
☐ No conozco personalmente a nadie que haya sido diagnosticado con Coronavirus
☐ Prefiero no decirlo

12. Como resultado de COVID19, ¿ha necesitado algo de lo siguiente? Marque todo lo que aplique.

☐ Apoyo financiero
☐ Apoyo con alimentos
☐ Apoyo para el pago de la renta
☐ Servicios de Traducción/Interpretación
☐ Ninguno
☐ Apoyo para el pago de los recibos de la electricidad
☐ Apoyo para el pago del Wi-Fi / Internet
☐ Vivienda/albergue
☐ Cuidado de niños
☐ Otra: _____

13. ¿En relación con el COVID-19, ¿qué es lo que más le preocupa en este momento?
Clasifique las siguientes opciones en orden de importancia (1 = más importante a 4 = menos importante).

_____ Que los miembros de mi casa se infecten
_____ La salud de mi comunidad mientras continúa la pandemia
_____ La salud emocional de mi hogar
_____ Dificultades financieras

14. ¿Qué ideas o sugerencias tiene para mejorar la salud en su comunidad?

_____

_____ ☐ No lo sé o prefiero no contestar

¡Gracias por completar la encuesta!

Encuesta sobre el panorama de salud en Baltimore 2017 V2

2017 Baltimore Health Needs Survey

Your responses to this optional survey are anonymous and will inform how hospitals and agencies work to improve health in Baltimore City. Thank you!

Instructions: You must be 18 years or older to complete this survey. Please answer all questions and return the survey as indicated. For questions about this survey, contact 667-234-2102 or 1-800-492-5538.

1. What is your ZIP code? *Please write 5-digit ZIP code.* _____

2. What is your sex? *Please check one.*

☐ Male ☐ Female ☐ Transgender
☐ Other *specify*_____ ☐ Don't know ☐ Prefer not to answer

3. What is your age group (years)? *Please check one.*

☐ 18-29 ☐ 40-49 ☐ 65-74 ☐ 75+
☐ 30-39 ☐ 50-64 ☐ Don't know ☐ Prefer not to answer

4. Which one of the following is your race? *Please check all that apply.*

☐ Black or African American ☐ White ☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ American Indian or Alaska Native
☐ Other/more than one race *specify*_____
☐ Don't know ☐ Prefer not to answer

5. Are you Hispanic or Latino/a? *Please check one.*

☐ Yes ☐ No ☐ Don't know ☐ Prefer not to answer

6. On how many days during the past 30 days was your mental health not good? Mental health includes stress, depression, and problems with emotions. *Please write number of days.*

_____ **days** ☐ Zero days ☐ Don't know ☐ Prefer not to answer

PLEASE TURN OVER FOR NEXT PAGE

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7. What are the <u>three</u> most important health problems that affect the health of your community? *Please check only three.*

☐ Alcohol/drug addiction
☐ Mental health (depression, anxiety)
☐ Diabetes/high blood sugar
☐ HIV/AIDS
☐ Lung disease/asthma/COPD
☐ Smoking/tobacco use
☐ Don't know
☐ Alzheimer's/dementia
☐ Cancer
☐ Heart disease/blood pressure
☐ Infant death
☐ Stroke
☐ Overweight/obesity
☐ Prefer not to answer

8. What are the <u>three</u> most important social/environmental problems that affect the health of your community? *Please check only three.*

☐ Availability/access to doctor's office
☐ Availability/access to insurance
☐ Domestic violence
☐ Limited access to healthy foods
☐ School dropout/poor schools
☐ Lack of job opportunities
☐ Race/ethnicity discrimination
☐ Don't know
☐ Child abuse/neglect
☐ Lack of affordable child care
☐ Housing/homelessness
☐ Neighborhood safety/violence
☐ Poverty
☐ Limited places to exercise
☐ Transportation problems
☐ Prefer not to answer

9. What are the <u>three</u> most important reasons people in your community do not get health care? *Please check only three.*

☐ Cost – too expensive/can't pay
☐ No insurance
☐ Lack of transportation
☐ Language barrier
☐ Don't know
☐ Wait is too long
☐ No doctor nearby
☐ Insurance not accepted
☐ Cultural/religious beliefs
☐ Prefer not to answer

10. What ideas or suggestions do you have to improve health in your community? _____

_____

_____

_____ ☐ Don't know ☐ Prefer not to answer

Thank you for completing the survey!

Encuesta de Necesidades de Salud de Baltimore de 2017

Sus respuestas a esta encuesta opcional son anónimas e informarán sobre la labor que realizan los hospitales y las agencias para mejorar la salud en la ciudad de Baltimore. ¡Muchas Gracias!

Instrucciones: Solo participantes mayores de 18 años pueden completar esta encuesta. Por favor conteste todas las preguntas y devuelva la encuesta como se indica. Si tiene alguna pregunta acerca de esta encuesta, llame al 667-234-2102 o al 1-800-492-5538.

1. ¿Cuál es su código postal? *Por favor escriba el código postal de 5 dígitos.* _____

2. ¿Cuál es su sexo? *Por favor marque uno.*

❑ Hombre ❑ Mujer ❑ Transgénero
❑ Otros *especifique* _____ ❑ No sé ❑ Prefiero no contestar

3. Elija la respuesta que corresponde a su edad *Por favor marque uno.*

❑ 18-29 ❑ 40-49 ❑ 65-74 ❑ 75+
❑ 30-39 ❑ 50-64 ❑ No sé ❑ Prefiero no responder

4. ¿Cuál de las siguientes es su raza? *Marque todas las que apliquen.*

❑ Negro o Afroamericano ❑ Blanco ❑ Asiático
❑ Nativo de Hawái o de otras islas del Pacífico
❑ Indio Americano o Nativo de Alaska
❑ Otra/más de una raza *especifique* _____
❑ No sé ❑ Prefiero no contestar

5. ¿Es usted hispano o latino? *Por favor marque uno.*

❑ Sí ❑ No ❑ No sé ❑ Prefiero no contestar

6. ¿Cuántos días durante los últimos 30 días tuvo problemas de salud mental? La salud mental incluye estrés, depresión, y problemas emocionales. *Por favor escriba el número de días.*

_____días ❑ Cero días ❑ No sé ❑ Prefiero no contestar

POR FAVOR PASE A LA SIGUIENTE PÁGINA

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7. ¿Cuáles son los <u>tres</u> problemas de salud más importantes que afectan la salud de su comunidad? *Por favor marque solo tres.*

- ❑ Alcohol/drogadicción
- ❑ Salud mental (depresión, ansiedad)
- ❑ Diabetes/altos niveles de azúcar en la sangre
- ❑ VIH/SIDA
- ❑ Enfermedad pulmonar/Asma/EPOC
- ❑ Fumar/tabaquismo
- ❑ No sé
- ❑ Alzheimer/demencia
- ❑ Cáncer
- ❑ Enfermedad cardíaca/hipertensión
- ❑ Mortalidad infantil
- ❑ Embolia
- ❑ Sobrepeso/obesidad
- ❑ Prefiero no contestar

8. ¿Cuáles son los <u>tres</u> problemas sociales/ambientales más importantes que afectan la salud de su comunidad? *Por favor marque solo tres.*

- ❑ Disponibilidad/acceso a un consultorio médico
- ❑ Disponibilidad/acceso a seguro de salud
- ❑ Violencia doméstica
- ❑ Acceso limitado a alimentos saludables
- ❑ Deserción escolar/escuelas deficientes
- ❑ Falta de oportunidades laborales
- ❑ Discriminación racial/étnica
- ❑ No sé
- ❑ Abuso/negligencia infantil
- ❑ No contar con servicios de guardería accesibles
- ❑ Vivienda/desamparo
- ❑ Seguridad/violencia vecindaria
- ❑ Pobreza
- ❑ Escasez de lugares para hacer ejercicio
- ❑ Problemas de transporte
- ❑ Prefiero no contestar

9. ¿Cuáles son las <u>tres</u> razones más importantes que impiden que la gente de su comunidad reciba atención médica? *Por favor marque solo tres.*

- ❑ Costo – muy caro/no puede pagar
- ❑ Falta de cobertura médica
- ❑ Falta de transporte
- ❑ No dominar el inglés
- ❑ No sé
- ❑ La espera es muy larga
- ❑ Falta de consultorios médicos cercanos
- ❑ No se acepta cobertura
- ❑ Creencias culturales/religiosas
- ❑ Prefiero no contestar

10. ¿Tiene alguna idea o sugerencia para mejorar la salud en su comunidad?

_____

_____

_____

_____ ❑No sé ❑ Prefiero no contestar

¡Gracias por completar esta encuesta!

JOHNS HOPKINS
MEDICINE
THE JOHNS HOPKINS HOSPITAL

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS BAYVIEW MEDICAL CENTER

For more information contact:
Johns Hopkins
Government and Community Affairs
1101 E 33rd Street, Suite B301
Baltimore, MD 21218
(443) 997-5999
www.jhu.edu/gca
gca@jhu.edu

From: William Wang
To: Hilltop HCB Help Account
Cc: Sharon Tiebert-Maddox
Subject: RE: Clarification Required - Johns Hopkins Bayview Medical Center FY 21 Community Benefit Narrative
Date: Thursday, May 19, 2022 12:53:19 PM

Report This Email

Hello – I've submitted the supplementary survey. Thank you again for your help.

Will

From: William Wang <>
Sent: Thursday, May 19, 2022 12:40 PM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Sharon Tiebert-Maddox <tiebert@jhu.edu>
Subject: RE: Clarification Required - Johns Hopkins Bayview Medical Center FY 21 Community Benefit Narrative

Thank you very much!

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Thursday, May 19, 2022 12:37 PM
To: William Wang <wwang3@jhu.edu>; Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Sharon Tiebert-Maddox <tiebert@jhu.edu>
Subject: RE: Clarification Required - Johns Hopkins Bayview Medical Center FY 21 Community Benefit Narrative

External Email - Use Caution

Apologies for the oversight. The answers you submitted are attached. Please use this link, where a new screen has been added just before submission. This will allow you to save your answers.

https://umbc.co1.qualtrics.com/jfe/form/SV_cSxgeDdw2IbuaWO?Q_CHL=gl&Q_DL=ibECPtRu5HwK4Qr_cSxgeDdw2IbuaWO_MLRP_3dtAvJIlbgV2gFE

From: William Wang <wwang3@jhu.edu>
Sent: Thursday, May 19, 2022 12:10 PM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Sharon Tiebert-Maddox <tiebert@jhu.edu>

Subject: RE: Clarification Required - Johns Hopkins Bayview Medical Center FY 21 Community Benefit Narrative

Hello – we were in the process of investigating the questions that needed responses but as soon as we moved to another section the supplementary survey saved and closed. Can the survey be re-opened? Is there a way to fill in answers and save but not submit? Thanks,

William Wang

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Thursday, May 19, 2022 8:54 AM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>; Sharon Tiebert-Maddox <tiebert@jhu.edu>
Subject: Clarification Required - Johns Hopkins Bayview Medical Center FY 21 Community Benefit Narrative

Thank you for submitting the FY 2021 Hospital Community Benefit Narrative report for Johns Hopkins Bayview Medical Center, a copy of which is attached to this message. Questions 244, 245, 218, 219, and 139 had no response. Please respond to these questions using the following supplementary survey:

https://umbc.co1.qualtrics.com/jfe/form/SV_cSxgeDdw2IbuaWO?Q_CHL=gl&Q_DL=9dSQWCe8SGgtDNd_cSxgeDdw2IbuaWO_MLRP_3dtAvJIlbgV2gFE

Q244. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

The Hospital has invested in updating its EHR system to include social determinants of health. Providers are trained to screen patients about their social determinants needs. The EHR is able to track the needs identified by providers and then refer patients to services that may address those needs.

Q245. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

- [ ] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program
- [ ] The COVID-19 Long-Term Care Partnership Grant
- [x] The COVID-19 Community Vaccination Program
- [x] The Population Health Workforce Support for Disadvantaged Areas Program
- [ ] Other (Describe)

Q218. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

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

Ololaryngology	○	◉	
Pathology	○	◉	
Pediatrics	◉	○	Coverage of emergency department call
Physical Medicine & Rehabilitation	○	◉	
Plastic Surgery	○	◉	
Preventive Medicine	○	◉	
Psychiatry	○	◉	
Radiology	○	◉	
Surgery	◉	○	Coverage of emergency department call
Urology	○	◉	
Other, (Describe) Neonatology, burn center	◉	○	Coverage of emergency department call

Q219. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

As a state-designated Level II trauma center for Maryland, JHBMC provides subsidies to physicians for trauma on-call services that they would otherwise not provide to the Hospital. Subsidy is required to maintain sufficient care standards and due to high Medicaid and uninsured population, which results in lack of physicians willing to provide service without increased payment. This includes coverage of emergency department call for the burn center, neurosurgery, orthopedics, surgery, emergency medicine, intensivist, oncology, surgery, neonatology, and pediatrics. The Hospital staffs a team of hospitalists and intensivists to provide primary care for patients, working collaboratively alongside specialists and patients' primary care physician. This includes non-resident house staff and hospitalists in internal medicine.

Q139. Please attach any files containing further information and data justifying physician subsidies your hospital.

Q224. Thank you. To edit your answers, please use the "back" button below. To submit your answers, please use the "forward" button below.

Location Data

Location: (39.3248, -76.6062)

Source: GeoIP Estimation