

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 it 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. Detailed reporting instructions have been distributed to your hospital's community benefit contacts, and additional copies can be requested at the email below.

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?		If no, please provide the correct information here:
	Yes	No	
The proper name of your hospital is: Greater Baltimore Medical Center.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="text"/>
Your hospital's ID is: 210044	<input checked="" type="radio"/>	<input type="radio"/>	<input type="text"/>
Your hospital is part of the hospital system called None - Independent Hospital.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="text"/>
The primary hospital community benefit (HCB) Narrative contact at your hospital is D'Ambr Anderson.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="text"/>
The primary HCB Narrative contact email address at your hospital is DANDERSON@gbmc.org	<input checked="" type="radio"/>	<input type="radio"/>	<input type="text"/>
The primary HCB Financial report contact at your hospital is Carl Prazenica.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="text"/>
The primary HCB Financial report contact email at your hospital is cprazenica@gbmc.org	<input checked="" type="radio"/>	<input type="radio"/>	<input type="text"/>

Q4. Please select the community health statistics that your hospital uses in its community benefit efforts.

- | | |
|--|---|
| <input checked="" type="checkbox"/> Median household income | <input checked="" type="checkbox"/> Race: percent White |
| <input checked="" type="checkbox"/> Percentage below federal poverty level (FPL) | <input checked="" type="checkbox"/> Race: percent Black |
| <input checked="" type="checkbox"/> Percent uninsured | <input checked="" type="checkbox"/> Ethnicity: percent Hispanic or Latino |
| <input checked="" type="checkbox"/> Percent with public health insurance | <input checked="" type="checkbox"/> Life expectancy |
| <input checked="" type="checkbox"/> Percent with Medicaid | <input checked="" type="checkbox"/> Crude death rate |
| <input type="checkbox"/> Mean travel time to work | <input type="checkbox"/> Other |
| <input checked="" type="checkbox"/> Percent speaking language other than English at home | |

Q5. Please describe any other community health statistics that your hospital uses in its community benefit efforts.

The data used for our Community Benefit efforts are taken from our Community Health Needs Assessment which I've attached below.

Q6. Attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Q7. Section I - General Info Part 2 - Community Benefit Service Area

Q8. 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.

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Allegany County | <input type="checkbox"/> Charles County | <input type="checkbox"/> Prince George's County |
| <input type="checkbox"/> Anne Arundel County | <input type="checkbox"/> Dorchester County | <input type="checkbox"/> Queen Anne's County |
| <input checked="" type="checkbox"/> Baltimore City | <input type="checkbox"/> Frederick County | <input type="checkbox"/> Somerset County |
| <input checked="" type="checkbox"/> Baltimore County | <input type="checkbox"/> Garrett County | <input type="checkbox"/> St. Mary's County |
| <input type="checkbox"/> Calvert County | <input type="checkbox"/> Harford County | <input type="checkbox"/> Talbot County |
| <input type="checkbox"/> Caroline County | <input type="checkbox"/> Howard County | <input type="checkbox"/> Washington County |
| <input type="checkbox"/> Carroll County | <input type="checkbox"/> Kent County | <input type="checkbox"/> Wicomico County |
| <input type="checkbox"/> Cecil County | <input type="checkbox"/> Montgomery County | <input type="checkbox"/> 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.

- | | | | |
|---|---|---|---|
| <input checked="" type="checkbox"/> 21201 | <input checked="" type="checkbox"/> 21212 | <input checked="" type="checkbox"/> 21225 | <input checked="" type="checkbox"/> 21237 |
| <input checked="" type="checkbox"/> 21202 | <input checked="" type="checkbox"/> 21213 | <input checked="" type="checkbox"/> 21226 | <input checked="" type="checkbox"/> 21239 |
| <input type="checkbox"/> 21203 | <input checked="" type="checkbox"/> 21214 | <input checked="" type="checkbox"/> 21227 | <input type="checkbox"/> 21251 |
| <input checked="" type="checkbox"/> 21205 | <input checked="" type="checkbox"/> 21215 | <input checked="" type="checkbox"/> 21228 | <input type="checkbox"/> 21263 |
| <input checked="" type="checkbox"/> 21206 | <input checked="" type="checkbox"/> 21216 | <input checked="" type="checkbox"/> 21229 | <input type="checkbox"/> 21270 |
| <input checked="" type="checkbox"/> 21207 | <input checked="" type="checkbox"/> 21217 | <input checked="" type="checkbox"/> 21230 | <input type="checkbox"/> 21278 |
| <input checked="" type="checkbox"/> 21208 | <input checked="" type="checkbox"/> 21218 | <input checked="" type="checkbox"/> 21231 | <input type="checkbox"/> 21281 |
| <input checked="" type="checkbox"/> 21209 | <input checked="" type="checkbox"/> 21222 | <input type="checkbox"/> 21233 | <input type="checkbox"/> 21287 |
| <input checked="" type="checkbox"/> 21210 | <input checked="" type="checkbox"/> 21223 | <input checked="" type="checkbox"/> 21234 | <input type="checkbox"/> 21290 |
| <input checked="" type="checkbox"/> 21211 | <input checked="" type="checkbox"/> 21224 | <input checked="" type="checkbox"/> 21236 | |

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

- | | | | |
|---|---|---|---|
| <input checked="" type="checkbox"/> 21013 | <input type="checkbox"/> 21092 | <input checked="" type="checkbox"/> 21156 | <input type="checkbox"/> 21225 |
| <input type="checkbox"/> 21020 | <input checked="" type="checkbox"/> 21093 | <input checked="" type="checkbox"/> 21161 | <input checked="" type="checkbox"/> 21227 |
| <input type="checkbox"/> 21022 | <input type="checkbox"/> 21094 | <input checked="" type="checkbox"/> 21162 | <input type="checkbox"/> 21228 |
| <input type="checkbox"/> 21023 | <input type="checkbox"/> 21102 | <input checked="" type="checkbox"/> 21163 | <input type="checkbox"/> 21229 |
| <input type="checkbox"/> 21027 | <input type="checkbox"/> 21104 | <input checked="" type="checkbox"/> 21204 | <input checked="" type="checkbox"/> 21234 |
| <input checked="" type="checkbox"/> 21030 | <input type="checkbox"/> 21105 | <input type="checkbox"/> 21206 | <input type="checkbox"/> 21235 |
| <input checked="" type="checkbox"/> 21031 | <input checked="" type="checkbox"/> 21111 | <input checked="" type="checkbox"/> 21207 | <input checked="" type="checkbox"/> 21236 |
| <input type="checkbox"/> 21043 | <input checked="" type="checkbox"/> 21117 | <input checked="" type="checkbox"/> 21208 | <input checked="" type="checkbox"/> 21237 |
| <input checked="" type="checkbox"/> 21051 | <input checked="" type="checkbox"/> 21120 | <input checked="" type="checkbox"/> 21209 | <input type="checkbox"/> 21239 |
| <input checked="" type="checkbox"/> 21052 | <input checked="" type="checkbox"/> 21128 | <input type="checkbox"/> 21210 | <input type="checkbox"/> 21241 |
| <input checked="" type="checkbox"/> 21053 | <input checked="" type="checkbox"/> 21131 | <input type="checkbox"/> 21212 | <input checked="" type="checkbox"/> 21244 |
| <input checked="" type="checkbox"/> 21057 | <input checked="" type="checkbox"/> 21133 | <input type="checkbox"/> 21215 | <input checked="" type="checkbox"/> 21250 |
| <input type="checkbox"/> 21065 | <input checked="" type="checkbox"/> 21136 | <input checked="" type="checkbox"/> 21219 | <input checked="" type="checkbox"/> 21252 |

- | | | | |
|---|---|---|---|
| <input checked="" type="checkbox"/> 21071 | <input type="checkbox"/> 21139 | <input checked="" type="checkbox"/> 21220 | <input type="checkbox"/> 21282 |
| <input type="checkbox"/> 21074 | <input checked="" type="checkbox"/> 21152 | <input checked="" type="checkbox"/> 21221 | <input type="checkbox"/> 21284 |
| <input checked="" type="checkbox"/> 21082 | <input checked="" type="checkbox"/> 21153 | <input checked="" type="checkbox"/> 21222 | <input type="checkbox"/> 21285 |
| <input type="checkbox"/> 21085 | <input checked="" type="checkbox"/> 21155 | <input type="checkbox"/> 21224 | <input checked="" type="checkbox"/> 21286 |
| <input checked="" type="checkbox"/> 21087 | | | |

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.

Based on ZIP codes in your global budget revenue agreement. Please describe.

Based on patterns of utilization. Please describe.

Other. Please describe.

Greater Baltimore Medical Center (GBMC) defined its current service area based on an analysis of the geographic area where individuals utilizing its services reside. GBMC's primary service area is considered Baltimore County, Maryland but in recent years our service area has expanded into Baltimore City where we have a practice and provide services. An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.

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

<https://www.gbmc.org/about-gbmc/accreditations-mission-and-vision>

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

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

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

- Yes
- No

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

This question was not displayed to the respondent.

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

06/01/2021

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

<https://www.gbmc.org/our-community/community-health-needs-assessment>

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

[2021_chna_summary.pdf](#)
1.7MB
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 the development of your most recent CHNA.

	CHNA Activities										Other - If you selected "Other (explain)," please type your explanation below:
	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)	
CB/ Community Health/Population Health Director (facility level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other - If you selected "Other (explain)," please type your explanation below:

	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 explanation below:
Board of Directors or Board Committee (facility level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Board of Directors or Board Committee (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Clinical Leadership (facility level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Clinical Leadership (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Population Health Staff (facility level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Population Health Staff (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Community Benefit staff (facility level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Community Benefit staff (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Staff primarily in financial group assisting with Community Benefit financial reports.
Physician(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

	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 explanation below:
Nurse(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Social Workers	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Hospital Advisory Board	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Q45. Section II - CHNAs and Stakeholder Involvement Part 3 - Internal Hospital Community Benefit 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										Other - If you selected "Other (explain)," please type your explanation below:
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	
CB/ Community Health/Population Health Director (facility level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
CB/ Community Health/ Population Health Director (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Senior Executives (CEO, CFO, VP, etc.) (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)
Hospital Advisory Board	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other - If you selected "Other (explain)," please type your explanation below:

Other - If you selected "Other (explain)," please type your explanation below:

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 2023 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is mandatory for FY 2023.

	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: Lifebridge, UMMS St. Joseph Medical Center, MedStar, Sheppard Pratt	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Local Health Departments -- Please list the Local Health Departments here: Baltimore City and County Health Departments	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Local Health Improvement Coalition -- Please list the LHICs here: Baltimore County LHIC	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Behavioral Health Organizations -- Please list the organizations here:
Sheppard Pratt, Mental Health Association of Maryland, Behavioral Health Advisory Counsel

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

Social Service Organizations -- Please list the organizations here:
Department of Social Services

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

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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

Post-Acute Care Facilities -- please list the facilities here:
Holly Hill Nursing and Rehabilitation, Ombudsman, Stella Maris

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

Community/Neighborhood Organizations -- Please list the organizations here:
Community Law Center, Bykota Senior Center, Trinity House, Tabco Towers, Baltimore Hunger Project, Student Support Network, Meals on Wheels, Y of Central MD, Nueva Vida, Urgent Care CHOICEONE, Knollwood Donnybrook Ass., Humanim, GEDCO, Live Chair Health, Lyft, MVLS, Living Classrooms, & Mack Lewis Foundation

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

Consumer/Public Advocacy 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

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Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered

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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 -- If any other people or organizations were involved, please list them here:
Ascendient

<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.

06/01/2021

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

https://www.gbmc.org/assets/documents/our-community/chna/fy22_chna_implementation_plan.pdf

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

[GBMC FY22 CHNA Implementation Plan.pdf](#)
174.5KB
application/pdf

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

This question was not displayed to the respondent.

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

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

Q57. Section II - CHNAs and Stakeholder Involvement Part 6 - Initiatives

Q58. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- Yes
- No

Q59. Using the checkboxes below, select the Community Health Needs identified in your most recent CHNA that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q60. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q61. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

In February 2022, GBMC was awarded a \$1.5 Million grant from the Maryland Community Health Resource Commission to address health disparities in Baltimore City. The 2-year grant is focused on East Baltimore in zip codes 21202 and 21218 where there are high rates of chronic disease; persistent socioeconomic and racial disparities; designated health provider shortages and medically underserved areas; and poor primary and geriatric service delivery when compared to nearby areas of Baltimore City and Maryland overall. The project is focused on expanding primary care service delivery and access; eliminate health disparities for hypertension, diabetes, and obesity; and reducing healthcare costs. GBMC is also collaborating with community based organizations to address social determinants of health including transportation, food insecurity, social connectivity, exercise, mental health and other barriers to health care access.

Q62. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

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

Q63. (Optional) If you wish, you may upload a document describing your community benefit initiatives in more detail.

Q64. Section III - CB Administration

Q65. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

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

Q66. Please describe the third party audit process used.

This question was not displayed to the respondent.

Q67. Does your hospital conduct an internal audit of the community benefit narrative?

- Yes
- No

Q68. Please describe the community benefit narrative audit process.

The Community Benefit report is reviewed for accuracy by the Internal Audit Department. The report is then shared with the Audit Committee, a sub-committee of the Board, and certain data is then used within the annual form 990 IRS filings.

Q69. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

Yes

No

Q70. Please explain:

This question was not displayed to the respondent.

Q71. Does the hospital's board review and approve the annual community benefit narrative report?

Yes

No

Q72. Please explain:

This question was not displayed to the respondent.

Q73. Does your hospital include community benefit planning and investments in its internal strategic plan?

Yes

No

Q74. Please describe how community benefit planning and investments were included in your hospital's internal strategic plan during the fiscal year.

GBMC is committed to process improvement and organizes its efforts around a 3 year strategic plan and leadership system. The Community Benefit investments made by GBMC are directly resultant from decisions made within the GBMC Community Support System. This system considers the initiatives identified in our Community Health Needs Assessment for investment; the strategic planning process and annual goals; the provision of funding for community benefit efforts; and the performance oversight of community initiatives supported by GBMC.

Q75. If available, please provide a link to your hospital's strategic plan.

Strategic Plan not available online

Q76. 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.](#)

Diabetes - Reduce the mean BMI for Maryland residents

GBMC was awarded a 2-year, 1.5 Million grant by the Maryland Community Health Resources Commission (CHRC) to address disparities in diabetes, overweight/obesity and hypertension in Baltimore City. The grant is focused on African American, Hispanic and senior populations. Key interventions include an expansion of the number of patients treated at GBMC Jonestown Clinic, where patients will receive comprehensive primary and preventive care services including vaccinations and screenings; disease management and care coordination services; at home care for elderly participants; and support to address Social Determinants of Health (SDOH) needs. The project will also conduct public screenings and education at community events, and healthy lifestyle interventions such as community walks/runs, education workshops, patient support groups, peer challenges to support water and protein intake goals, and healthy cooking demonstrations.

Opioid Use Disorder - Improve overdose mortality

In collaboration with our CHNA partners, GBMC participated in Prescription Drug Takeback Day with the DEA and the Baltimore County Police Department. The goal of this initiative was to facilitate safe disposal of drugs by communicating and educating the community through campaigns. The DEA host the event April & October annually and GBMC provided leadership with the April 2022 event. It was a collaborative effort between University of Maryland St. Joseph Medical Center, MedStar, LifeBridge, and the Baltimore County Health Department. In 2023, all partners promoted this initiative through various outlets including social media, flyers, meetings, resource fairs, and word of mouth.

Maternal and Child Health - Reduce severe maternal morbidity rate

The Maternal Newborn Health (MNH) team has taken proactive steps to address these disparities and attaching an equity component to every quality improvement initiative they undertake. In fiscal year 2023, they participated in a statewide collaborative focused on timely treatment of severe hypertension across races and also investigated data on maternal morbidity. MNH is grateful to have engaged with a grant-funded collaborative called MDMOM (Maryland Maternal Health Innovation Program) to receive education, review cases of morbidity, and work on equity. Our MNH nurses and providers have completed an implicit bias module and received education on reducing bias in the care of patients with substance use disorder. MNH is also providing free BP cuffs through MDMOM to patients in need as part of the hypertension collaborative. MNH has reviewed 12 cases through the MDMOM severe maternal morbidity review (SMM) process and have reduced SMM related to hemorrhage from 6.4% to 3.5%. Additionally, GBMC is participating in the Maryland Hospital Association Birth Outcomes Accountability Workgroup, which is providing implicit bias education to staff and providers who may care for pregnant and postpartum patients in the Emergency Department.

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

None of the Above

Q77. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q78. Section IV - Physician Gaps & Subsidies

Q79. (Optional) Please attach any files containing further information and data justifying physician subsidies at your hospital.

(This year, all information on physician gap subsidies is collected on the financials. However, if you have additional information on these subsidies to report, you may do so through attachments here.)

Q80. Section V - Financial Assistance Policy (FAP)

Q81. Upload a copy of your hospital's financial assistance policy.

[gbmc-financial-assistance-policy.pdf](#)
75.1KB
application/pdf

Q82. Provide the link to your hospital's financial assistance policy.

<https://www.gbmc.org/assets/documents/billing/gbmc-financial-assistance-policy.pdf>

Q83. Has your FAP changed within the last year? If so, please describe the change.

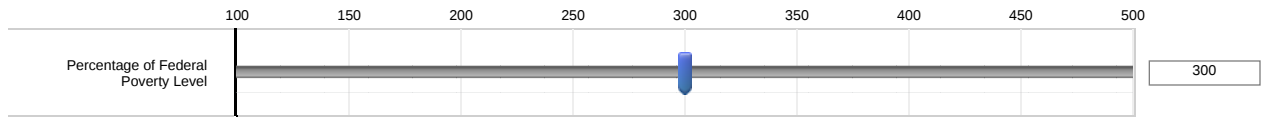
No, the FAP has not changed.

Yes, the FAP has changed. Please describe:

We do not require Maryland residency any longer. We do not apply a strict asset test

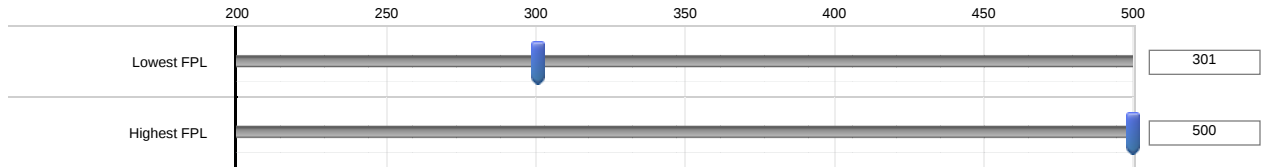
Q84. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



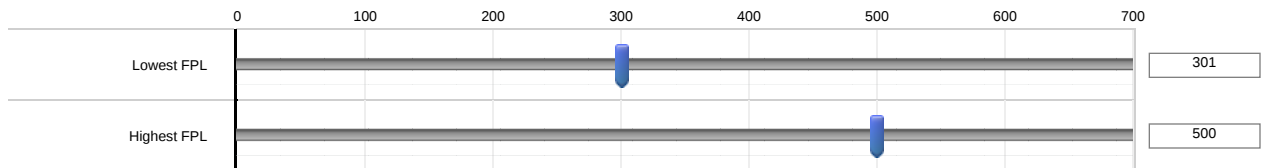
Q85. Maryland acute care and chronic care hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

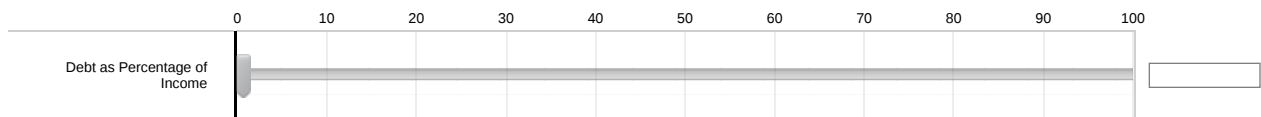


Q86. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3)(a) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial 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.



Q87. Please select the threshold for medical debt as a percentage of family income above which qualifies as a financial hardship.



Q88. Section VI - Tax Exemptions

Q89. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding taxable year (select all that apply)

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

Q90. Summary & Report Submission

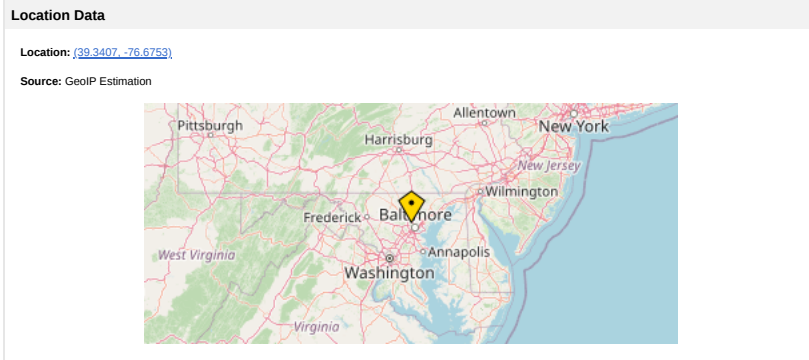
Q91.

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.



Baltimore County

2020-2021

Community Health Needs Assessment



Healthy people living, working, and playing in Baltimore County

ACKNOWLEDGEMENTS

This Community Health Needs Assessment (CHNA) represents the culmination of work completed by multiple individuals and groups. The Baltimore County Department of Health (BCDH) and local health systems including Northwest Hospital of LifeBridge Health, Sheppard Pratt, Greater Baltimore Medical Center Healthcare (GBMC), the University of Maryland St. Joseph Medical Center (UM SJMC), and MedStar Franklin Square Medical Center (MedStar Franklin Square) have served an integral role in making this comprehensive assessment possible and will be referred to as the Collaborative throughout this CHNA. The Collaborative would like to extend its gratitude to all the focus groups participants, key community health leaders, and community members who provided information used in the development of this assessment. In addition, the Collaborative would specifically like to thank the following members of the CHNA Steering Committee who provided their time and knowledge throughout the entirety of this process:

Name	Title	Organization
D'Ambra Anderson	Population Health Data Analyst	GBMC
Kristen Artes	Community Outreach Manager	The University of Maryland St. Joseph Medical Center
Laura Culbertson	Chief, Office of Quality Improvement	Baltimore County Department of Health
Sarah Fogler	Senior Director of Population Health	GBMC
Dorothy L. Fox	Executive Director and CEO	LifeBridge Health
Thomas B. Glenn	Director of Strategy and Business Development	Sheppard Pratt
Leah Gutermuth	Population Health Program Manager	GBMC
Patricia Isenock	Administrative Director of Population and Community Health	MedStar Franklin Square
Della Leister	Deputy Health Officer	Baltimore County Department of Health
Sharon McClernan	Vice President of Clinical Integration	LifeBridge Health

Additionally, the Collaborative would like to recognize Ascendient Healthcare Advisors for its efforts in directing this process and drafting the content of this Community Health Needs Assessment.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS..... 1

TABLE OF CONTENTS..... 2

INTRODUCTION..... 4

 Background 4

 Process Overview..... 4

 Report Structure 6

 Summary Findings: Baltimore County Priority Health Need Areas 7

CHAPTER 1 | EVALUATION OF PRIOR CHNA IMPLEMENTATION STRATEGIES/ACTION PLANS..... 8

CHAPTER 2 | METHODOLOGY..... 10

 Study Design 10

 New (Primary) Data..... 10

 Existing (Secondary) Data 10

 Comparisons 11

 Prioritization Process Overview and Results..... 11

 Study Limitations 13

CHAPTER 3 | COUNTY PROFILE..... 15

CHAPTER 4 | PRIORITY NEED AREAS..... 17

 Priority Need: Behavioral Health 17

 Mental Health 17

 Existing Data..... 17

 Focus Group Findings..... 19

 Community and Key Community Health Leader Survey Results 19

 Substance Use Disorders..... 20

 Existing Data..... 20

 Community and Key Community Health Leader Survey Results 21

 Priority Need: Physical Health 22

 Existing Data..... 22

 Focus Group Findings..... 24

Community and Key Community Health Leader Survey Results 24

Priority Need: Health Disparities 24

 Racial Disparities 26

 Geographic Disparities 28

CHAPTER 5 | HEALTH RESOURCE INVENTORY 32

 Health Resources 32

 Healthcare Facilities 32

 Home-based Health Services 33

 Other Healthcare Services 33

 Community Services 33

CHAPTER 6 | NEXT STEPS 35

APPENDICES 36

APPENDIX 1 | COUNTY DEMOGRAPHIC AND SOCIOECONOMIC DETAIL 37

 County Demographics 37

 Age and Total Population 37

 Gender 37

 Race 38

 Ethnicity 39

 Socioeconomic Detail 40

 Income 40

 Community Need Index 40

APPENDIX 2 | DETAILED EXISTING (SECONDARY) DATA FINDINGS 43

 Methodology 43

 Data Sources 43

 Complete Data by Focus Area 69

APPENDIX 3 | DETAILED NEW (PRIMARY) DATA FINDINGS 82

 Methodologies 82

 Focus Groups 82

 Community Surveys 84

 Key Community Health Leader Surveys 88

INTRODUCTION

Background

To further illustrate its commitment to the health and well-being of the community, the Collaborative completed this assessment to understand and document the greatest health needs currently faced by its residents. BCDH, Northwest Hospital of LifeBridge Health, Sheppard Pratt, GBMC, UM SJMC, and MedStar Franklin Square make up the Collaborative, and representatives from each of these organizations worked together as the CHNA Steering Committee to guide the development of this CHNA. These organizations provided the focus group and survey data that are further analyzed in this report. In addition, MedStar Franklin Square provided some existing data from their FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting that are utilized in this report. The CHNA process examines the overall health needs of the residents of Baltimore County and allows the county to continuously evaluate how best to improve and promote the health of the community. While each of these organizations has historically assessed the health needs of the community and responded accordingly, this CHNA is a more formal and collaborative approach by community partners to proactively work together to identify and respond to the needs of Baltimore County residents.

Process Overview

A significant amount of information has been reviewed during this planning process, and the CHNA Steering Committee has been careful to ensure that a variety of sources were used to deliver a truly comprehensive report. Assessment methods included both existing (secondary) data as well as new (primary) data that were collected directly from the community throughout this process. It is also important to note that, although unique to Baltimore County, the sources and methodologies used to develop this report comply with the current standards and measures of the Public Health Accreditation Board (PHAB) and IRS requirements for nonprofit hospital organizations.

The purpose of this study is to better understand, quantify, and articulate the health needs of Baltimore County residents. Key objectives of this CHNA include:

- Identify the health needs of Baltimore County residents.
- Understand racial and geographic health disparities that exist in Baltimore County.
- Understand the challenges residents face when trying to maintain and/or improve their health.
- Understand where underserved populations turn for services needed to maintain and/or improve their health.
- Understand what is needed to help residents maintain and/or improve their health.
- Prioritize the needs of the community and clarify/focus on the highest priorities.

There are ten phases in the CHNA process. Results of the first seven phases are discussed throughout this assessment and the development of community health action plans and subsequent phases will take place in the near future.



Report Structure

The outline below provides detailed information about each section of the report.

- 1) *Evaluation of Prior CHNA Implementation Strategies* – This chapter provides a reflective summary on the progress made towards addressing the priority health needs identified in the previous CHNAs developed by the organizations that make up the Collaborative.
- 2) *Methodology* – The methodology chapter provides an overall summary of how the priority health need areas were selected as well as how information was collected and incorporated into the development of this CHNA, including study limitations.
- 3) *County Health Profile* – This chapter details the demographic data (such as age, gender, and race) and socioeconomic data of Baltimore County residents.
- 4) *County Priority Health Need Areas* – This chapter describes each identified priority health need area for Baltimore County and summarizes the new and existing data that support these prioritizations. This chapter also describes the impact of health disparities among racial and geographic sub-groups in Baltimore County.
- 5) *Health Resource Inventory* – This chapter documents existing health resources currently available to the Baltimore County community.
- 6) *Next Steps* – This chapter briefly summarizes the next steps that will occur to address the priority health need areas discussed throughout this document.

In addition, the appendices discuss all of the data used during the development of this report in detail, including:

- 1) *County Demographic and Socioeconomic Data* – Information regarding the population characteristics (such as age, gender, and race) as well as the Community Need Index rankings of Baltimore County are presented in Appendix 1.
- 2) *Detailed Summary of Existing (Secondary) Data Measures and Findings* – Existing data measures and findings used in the prioritization process are presented in Appendix 2.
- 3) *Detailed Summary of New (Primary) Findings* – Summaries of new data findings from community and key community health leader surveys as well as focus groups are presented in Appendix 3.

Summary Findings: Baltimore County Priority Health Need Areas

To achieve the study objectives, both new and existing data were collected and reviewed. New data included information from internet-based surveys and focus groups; various local organizations, community members, and health service providers within Baltimore County participated. Existing data included information regarding the demographics, health and healthcare resources, behavioral health, disease trends, and county rankings of Baltimore County. The data collection and analysis process began in June 2020 and continued through to the development of this document.

Given the size of Baltimore County, both in geography and population, significant variations in demographics and health needs exist within the county. At the same time, consistent needs are present across the whole county and thus serve as the foundation for determining priority health needs at the county level. This document will discuss the priority health need areas for Baltimore County, as well as how the severity of those needs might vary across racial and geographic sub-groups based on the information obtained and analyzed during this process.

Through the prioritization process discussed in this document, the CHNA Steering Committee identified Baltimore County's priority health need areas from a list of over 100 potential health needs. Please note that the final priority need areas were not ranked in any hierarchical order of importance and all will be addressed by the Collaborative and the Local Health Improvement Coalition (LHIC). After analysis of all relevant data and discussions with the CHNA Steering Committee, the following three focus areas have been identified as county-wide priorities for the 2020-2021 CHNA:

Priority Health Need Areas

- Behavioral Health, including Mental Health and Substance Use Disorders
- Physical Health
- Health Disparities

The process used to prioritize findings in this assessment are discussed later in the report. It is important to note that health, healthcare, and associated community needs rarely exist in a vacuum. Instead, they are very much interrelated with each other, with improvements in one driving advancements within another. As such, although it was necessary for this process to separate the various areas for purposes of measuring need, the interrelationship should be acknowledged as improvement initiatives are considered going forward.

Further, many health needs are the result of underlying societal and socioeconomic factors. Many studies show that factors such as income, education, and the physical environment affect the health status of individuals and communities. This CHNA acknowledges that linkage and focuses on identifying and documenting the greatest health needs as they present themselves today. As strategic and health improvement plans are developed to address these needs, it is clear that the Collaborative's goal is to work with other community organizations to address more systemic factors that have the potential for long-term improvements to the population's health.

CHAPTER 1 | EVALUATION OF PRIOR CHNA IMPLEMENTATION STRATEGIES/ACTION PLANS

A Community Health Needs Assessment (CHNA) is an ongoing process that begins with the evaluation of the previous CHNA. Previously, each organization making up the Collaborative completed its own assessment process and report. Below is a summary evaluation of each Collaborative organization's implementation plan from its prior assessment. To avoid the development of multiple CHNAs and the duplication of efforts among various agencies, the organizations making up the Collaborative decided that the development of a joint 2020-2021 CHNA and expansion of existing efforts to work together to impact priority need areas would be most efficient moving forward.

Baltimore County Department of Health

BCDH's FY2021 Community Health Improvement Plan (CHIP) addresses the following priority areas: access to care, behavioral health, and chronic disease. Due to challenges related to the COVID-19 pandemic, some planned action items have not yet been conducted. However, BCDH has successfully increased access to care through expanded use of bilingual staff and enhanced cultural competencies in surveys and focus groups. To address behavioral health concerns, BCDH has held Narcan trainings (including virtual trainings) and provided access to Narcan kits, developed new peer case manager positions, and tracked the number of clients placed in behavioral health treatment programs. As part of its strategy related to chronic disease, BCDH and the Fetal and Infant Mortality Community Action Team (FIMR CAT) have conducted case reviews to promote healthy pregnancies and birth outcomes.

Northwest Hospital of LifeBridge Health

Northwest Hospital's 2018-2020 implementation plan addressed the following priority areas: chronic disease, health education/knowledge of available resources, medical insurance, workforce development, and its relationship with Chase Brexton Primary Care. To address these respective issues, the Office of Community Health Improvement has implemented the Diabetes Wellness Series, continued the Changing Hearts Program, increased staff to expand reach into surrounding communities, trained staff to assist patients with navigating and applying for Medicaid health insurance, utilized Sinai Hospital of Baltimore's vocational services and workforce readiness program (VSP) for training and workforce development services, and strengthened existing partnerships with Chase Brexton to increase access for patients needing behavioral health services.

Sheppard Pratt

Sheppard Pratt's 2019 Implementation Plan addresses priority areas related to behavioral health including mental health and substance use disorders. Sheppard Pratt Leadership met to determine which identified needs fall within its purview to impact as a behavioral health provider and to discuss which of the organization's programs could be expanded upon to meet community needs more effectively. The system has taken steps to serve the community by expanding access to its urgent psychiatric care clinic, improving care coordination with local health system partnerships, implementing mental health training programs for providers, developing a hub-and-spoke opioid treatment program, and advocating for policy change to better support community behavioral health.

Greater Baltimore Medical Center Healthcare

GBMC's 2020-2022 implementation plan addresses the following priority areas: behavioral health/substance use disorders, access to care, and obesity. To address issues related to behavioral health/substance use disorders, GBMC expanded Mental Health First Aid Training and continues to support the GBMC Sexual Assault Forensic Examination (SAFE) Program. Relative to access to care, GBMC has facilitated connections to meet the needs of underserved populations through the Elder Medical Care program, the Complex Care Clinic, and the Moveable Feast program. To reduce risk factors contributing to obesity, GBMC has encouraged community weight loss as a means of diabetes prevention and partnered with Hungry Harvest for Produce in a SNAP initiative.

University of Maryland St. Joseph Medical Center

UM SJMC's FY2020-2022 implementation plan addresses the following priority areas: access to care, chronic health conditions, cancer, fall prevention, and mental health and substance abuse. Although the COVID-19 pandemic created challenges related to care access, UM SJMC formed new partnerships with local schools and community organizations to distribute needed resources including COVID-19 wellness kits, vaccine education and registration support, and flyers for programs and resources. UM SJMC also successfully transitioned many programs to virtual offerings and the St. Clare Medical Outreach team continued serving underserved communities through telehealth visits.

To address chronic health conditions, UM SJMC adopted the National Diabetes Prevention Program and partnered with the Baltimore County Department of Health to plan and deliver education about the dangers of vaping to local schools and youth organizations. UM SJMC also opened the Wellness and Support Center to provide a variety of support services for cancer survivors. Programs focused on fall prevention have also been expanded through the adoption of the "Tai Ji Quan: Moving for Better Balance" program which has also been offered virtually throughout the pandemic. The University of Maryland Health System has led several webinar series on mental health and health literacy topics that have been shared widely across system hospitals.

MedStar Franklin Square Medical Center

MedStar Franklin Square's 2018 implementation plan addresses the following priority areas: health and wellness, access to care and services, and social determinants of health. The hospital conducts many programs and support groups related to chronic disease including its Living Well Chronic Disease Self-Management Program, a Diabetes Prevention Program, a Smoking Cessation Program, and a Stroke Support group. To address behavioral health issues, MedStar Franklin Square has implemented the Screening, Brief Intervention, and Referral to Treatment (SBIRT) strategy in emergency department and primary care settings and embedded Peer Recovery Coaches on hospital care teams. Relative to maternal and child health, the hospital has supported and coordinated the Healthy Babies Collaborative. To better provide access to care and services, MedStar Franklin Square has included mental health services as part of its primary care model and conducted social needs screenings and support linkages as part of care delivery. It has partnered with outside organizations to address social determinants of health related to transportation and employment, including implementing the MedStar Health UBER program, conducting the PHWSDA program, and conducting the Rx for Success Pipeline Summer Internship Program for underserved high school students.

CHAPTER 2 | METHODOLOGY

Study Design

A multi-step process was used to assess the community needs, challenges, and opportunities for Baltimore County. Multiple sources, including new and existing sources, were incorporated throughout the study to paint a more complete picture of Baltimore County's health needs. While the CHNA Steering Committee viewed the new and existing data equally, there were instances where one provided more compelling evidence of community health needs than the other. In these instances, the health needs identified were discussed based on the applicable data gathered. Multiple methodologies, including analysis of data, content analysis of community feedback, and stakeholder engagement, were utilized to identify key areas of need.

Specifically, the following data types were collected and analyzed:

New (Primary) Data

Community engagement and feedback was obtained through community internet-based surveys, key community health leader internet-based surveys, and seventeen unique community focus groups, as well as significant input and direction from the CHNA Steering Committee. Leveraging these sources, the CHNA Steering Committee was able to incorporate input from over 4,000 Baltimore County residents.

Existing (Secondary) Data

Key sources for existing data on Baltimore County included data made available by participating organizations and numerous public data sources related to demographics, social and economic determinants of health, environmental health, health status and disease trends, mental/behavioral health trends, and modifiable health risks. Key information sources leveraged during this process included:

- *County Health Rankings*, developed in partnership by Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute
- Maryland Department of Health's State Health Improvement Process (MD SHIP)
- Data provided by CHNA Steering Committee Members and affiliated organizations, including data from MedStar Franklin Square's FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting
- The Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS)
- *The Opportunity Atlas*, developed in partnership by the U.S. Census Bureau, Harvard University, and Brown University

For more information regarding data sources and data time periods, please refer to Appendix 2.

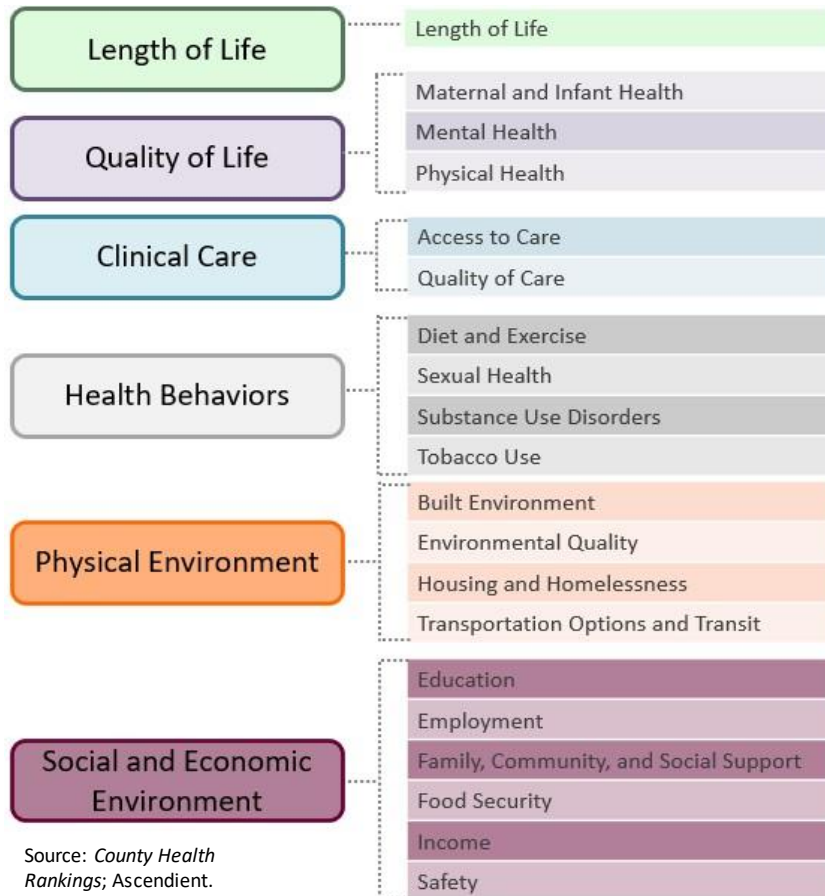
Comparisons

The existing data collected throughout the process are only relevant if compared to a benchmark, goal, or comparative geography. In other words, without the ability to compare Baltimore County with an outside measure, it would be impossible to determine how the county is performing. For the 2020-2021 CHNA, each data measure was compared to outside data as available, including the following:

- *County Health Rankings* Top Performers: This is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute that ranks counties across the nation by various health factors.
- State of Maryland: As part of the process, the Steering Committee determined that comparisons with the state of Maryland in total would be appropriate. While certain differences exist, the geographic overlap creates similarities that increase the meaningfulness of comparisons.

Prioritization Process Overview and Results

The process of determining the priority health needs for the 2020-2021 CHNA began with the collection and analysis of hundreds of data points. All individual data measures from both new and existing sources were gathered, analyzed, and interpreted. In order to combine data points into more easily discussable categories, all individual data measures were grouped into six categories and twenty corresponding focus areas based on “common themes.”



Source: *County Health Rankings*; Ascendient.

Given the large number of individual data measures that were collected, analyzed, and interpreted throughout this process to develop the twenty categories, it was not feasible to make each of them a priority. To help determine which health needs should be priorities, the CHNA Steering Committee developed a prioritization matrix to estimate the need areas that are of greatest concern.

The prioritization matrix included findings from the analysis of the new and existing data. Each type of data offers unique insights into the health needs of Baltimore County residents. To ensure that the prioritization process accounts for these various perspectives, existing data were weighted 50 percent in the prioritization matrix. To account for the numerous methods of new data collection, community survey findings were weighted 10 percent while focus group data and key community health leader survey findings were weighted 20 percent, respectively.

In order to draw conclusions about the existing data, Baltimore County's performance on each data measure were compared to targets/benchmarks. If Baltimore County's performance was more than five percent worse than the comparative benchmark, it was concluded that improvements are needed to better the health of Baltimore County residents. Conversely, if Baltimore County performed more than five percent better than the benchmark, it was concluded that the need for improvement is less acute. For each data measure that was deemed high need, the corresponding focus area received a value of one. Focus areas were then ranked based on the number of data measures within the focus area that were flagged as high need and corresponding percentages of total high need counts were calculated. This percentage was then multiplied by the assigned weight for existing data (50 percent) to become part of each focus area's weighted percentage score. For example, the Transportation Options and Transit focus area contained two data measures determined to be high need. Thirty-two data measures were flagged as high need across all focus areas, so the Transportation Options and Transit focus area's percentage of high need was 6.25 percent ($2 \div 32$).

Conclusions from the new data were drawn based on the frequency in which each focus area was discussed in focus groups or selected in survey responses. If a topic was discussed or selected with high frequency, then it was determined to be more of a need than those that were mentioned fewer times. Each focus area was ranked based on the number of mentions within each data collection method (focus groups, community surveys, key community health leader surveys) and corresponding percentages of total mentions were then calculated. This percentage was then multiplied by the assigned weight (20 percent for focus group data, 10 percent for community survey data, and 20 percent for key community health leader survey data) to become part of each focus area's weighted percentage score.

Please refer to the appendices for detailed descriptions of the methodologies used to analyze and determine the need level for each data component.

The preliminary priority scores for each of the various focus areas are provided in the following table.

Focus Area	Preliminary Score
Physical Health	3.0
Safety	1.9
Substance Use Disorders	1.7
Food Security	1.6
Access to Care	1.5
Income	1.5
Mental Health	1.4
Built Environment	1.4
Transportation Options and Transit	1.1

*Focus areas excluded from the table due to preliminary scores below 1.0 were Family, Community and Social Support, Diet and Exercise, Housing and Homelessness, Tobacco Use, Quality of Care, Environmental Quality, Length of Life, Employment, Maternal and Infant Health, Sexual Health, and Education.

Though the prioritization matrix serves as a useful tool in identifying high need areas, additional input from the CHNA Steering Committee on February 12, 2021 was considered to identify which high need areas would be defined as priority health need areas in the 2020-2021 CHNA. Please note that although Mental Health and Substance Use Disorders were viewed separately through the data collection process, the CHNA Steering Committee decided to combine these two focus areas as a single priority (Behavioral Health) for Baltimore County overall and will view these together for purposes of action planning and implementation. In addition, given the size of Baltimore County, it can be expected that health needs will not be uniform for all residents. As research was conducted for this CHNA, several health disparities were identified and discussed with the Steering Committee. So important is the need to understand these inequalities that the Steering Committee decided to make Health Disparities a priority area in this CHNA. Chapter 4 discusses the findings related to each of the priority areas in detail, including the key racial and geographic health disparities that emerged in the information obtained and analyzed during this process. The final priority need areas were not ranked in any hierarchical order of importance and all will be addressed by the Collaborative. The following three focus areas were identified as the top priority health need areas in Baltimore County to be addressed over the next three years:

Priority Health Need Areas

- Behavioral Health, including Mental Health and Substance Use Disorders
- Physical Health
- Health Disparities

Study Limitations

The development of a CHNA is a lengthy and time-consuming process. As such, more recent data may have been made available after the collection and analysis period of this process. Existing data are typically available at a lag time of one to three years from the data occurrence. One limitation in the data analyses process is the staleness of the data which may not depict the most recent occurrences

experienced within the community. Given the staleness of existing data, the CHNA Steering Committee attempted to compensate for these limitations through the collection of new data, including focus groups, internet-based community surveys, and internet-based key community health leader surveys. Existing data are also limited regarding availability by demographic cohorts such as gender, age, race, and ethnicity.

Given the size of Baltimore County in both population and geography, this study was limited in its capacity to fully capture health disparities and health needs across racial and ethnic lines. While efforts were made to include a diverse group of community members to participate in surveys, roughly two-thirds of all survey respondents were white individuals. Although survey respondents were given the option of selecting from numerous race categories – including but not limited to Asian, American Indian/Alaskan Native, and Native Hawaiian/Other Pacific Islander – limited responses were received from these racial groups. Because of these data limitations, race was categorized as one of three groups for the survey analysis: White, Black, or Other/Prefer Not to Answer. The Other/Prefer Not to Answer group includes responses from those who selected Asian, American Indian/Alaskan Native, Native Hawaiian/Other Pacific Islander, or other. This limited the ability to assess health needs and disparities for other racial/ethnic minority groups in the community.

Additionally, gaps in information for particular sub-segments of the population exist. Many of the available data sets do not necessarily isolate historically underserved populations including the uninsured, low-income persons, and/or certain minority groups. However, in an effort to capture a more holistic and culturally competent view of the need in Baltimore County despite the lack of available data, attempts were made to include underserved sub-segments of the greater population through the new data gathered throughout the CHNA process. By way of example, the CHNA Steering Committee chose to focus on the non-English-speaking members of the community by developing an internet-based community survey that was available in Spanish. Paper surveys were also distributed in an effort to reach as much of the community as possible.

Future assessments can expand upon such efforts to include additional underserved communities whose needs are not specifically discussed throughout this assessment due to limitations in the ability to gather data and input during this CHNA cycle. Of note and of example, residents within the disabled and deaf and hard-of-hearing communities can be a focus of future new data collection methods. Additionally, more input from both patients and providers of substance use disorder services would also be beneficial in future assessments.

Finally, components of this assessment have relied on input from community members and key community health leaders through the internet-based surveys and focus groups. Since it would be unrealistic to gather input from every single member of the community, the community members that participated have offered their best expertise and understanding on behalf of the entire community. As such, the CHNA Steering Committee has assumed that participating community members accurately and completely represented their fellow residents.

CHAPTER 3 | COUNTY PROFILE

Baltimore County occupies 612 square miles — plus an additional 28 square miles of water — in the geographic center of Maryland. With a population in excess of 825,000 persons, the county is the largest jurisdiction in the Central Maryland Metropolitan Area.

Population figures discussed throughout this chapter were obtained from the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute's *County Health Rankings*. Baltimore County's total population has remained relatively constant over recent years, however, the 65 and older age cohort has grown at an annual rate of 2.1 percent.

Total Population – Baltimore County			
	2014	2018	CAGR*
Below 18	178,621	178,931	0.0%
Between 18 and 65	517,521	507,190	-0.5%
65 and older	130,783	142,310	2.1%
Total	826,925	828,431	0.0%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

*Compound Annual Growth Rate

As compared to Maryland, Baltimore County has a slightly older population with a higher percentage of the population over the age of 65.

2018 Population – Age Distribution		
	Baltimore County	Maryland
Percentage below 18	21.6%	22.2%
Percentage between 18 and 65	61.2%	62.4%
Percentage 65 and older	17.2%	15.4%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

The population distribution by gender is similar between Baltimore County and the state of Maryland.

2018 Population – Gender Distribution		
	Baltimore County	Maryland
Female	52.6%	51.5%
Male	47.4%	48.5%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Baltimore County and the state of Maryland have similar racial distributions, but Baltimore County has a smaller Hispanic population when compared to Maryland. Overall, Baltimore County is slightly less diverse than Maryland as a whole.

2018 Population – Racial Distribution		
	Baltimore County	Maryland
White	64.2%	62.8%
Black	29.0%	29.8%
Asian	6.3%	6.7%
American Indian/Alaskan Native	0.4%	0.6%
Native Hawaiian/Other Pacific Islander	0.1%	0.1%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

2018 Population – Ethnic Distribution		
	Baltimore County	Maryland
Hispanic	5.7%	10.4%
Non-Hispanic	94.3%	89.6%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

In addition to demographic data, socioeconomic factors in the county such as income, poverty, and unemployment play a significant role in identifying healthcare needs. The median household income in Baltimore County is higher than the national benchmark but roughly 10 percent lower than the median household income in Maryland.

2018 Median Household Income			
	Baltimore County	Maryland	National
Income	\$75,800	\$83,100	\$69,000

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

To understand how Baltimore County compares regarding other key socioeconomic factors, see the Community Need Index discussion in Chapter 4 and Appendix 1.

CHAPTER 4 | PRIORITY NEED AREAS

This chapter looks at each of the three priority areas in more detail and discusses the data that supports each priority. As mentioned previously, these priority needs areas are not listed in any hierarchical order of importance and all will be addressed by the Collaborative.

Priority Need: Behavioral Health

The Behavioral Health priority includes mental health conditions (like depression and Alzheimer's) and access to psychiatric and/or behavioral health services, as well as alcohol, opioid, and illegal drug use and data related to overdoses. Although Mental Health and Substance Use Disorders were viewed separately through the data collection process, the CHNA Steering Committee decided to combine these two focus areas as a single priority (Behavioral Health) for Baltimore County overall. Both the Mental Health and Substance Use Disorders focus areas were identified as areas of high need for Baltimore County after considering new and existing data. Due to the overlap in contributing factors and prevalence of dual diagnoses, the Steering Committee ultimately decided to combine them for purposes of action planning and implementation and defined the single priority area as Behavioral Health. Each focus area is discussed in more detail below.

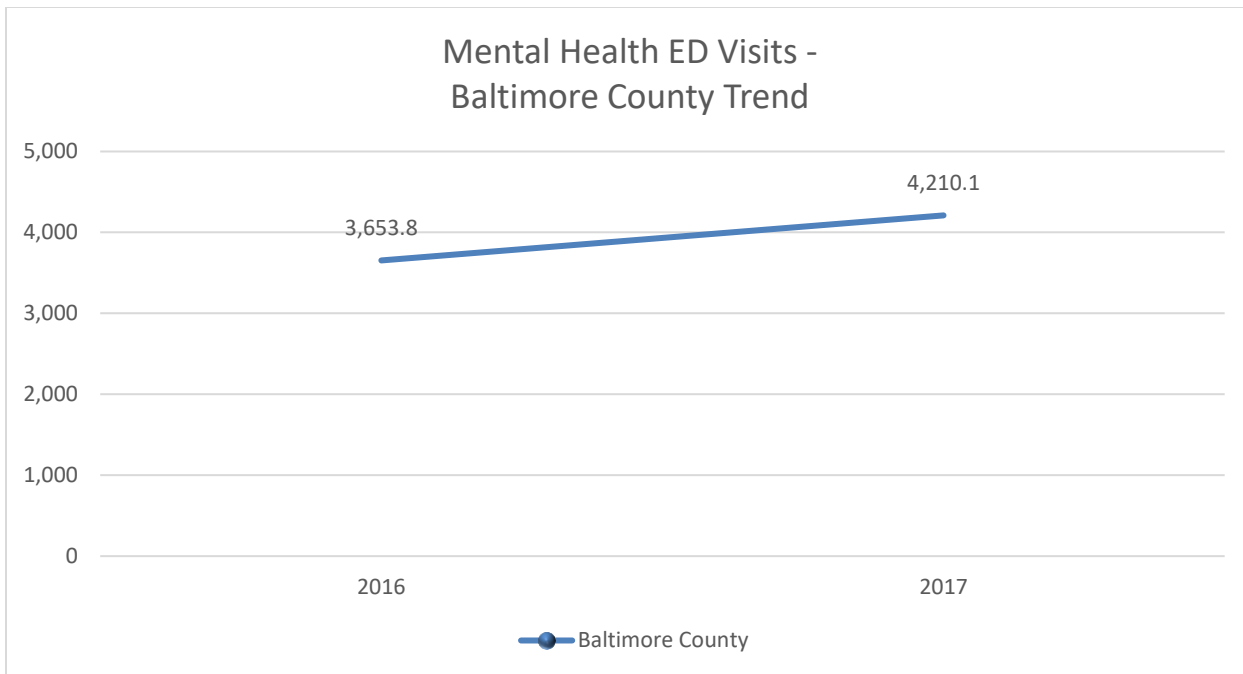
Mental Health

Mental Health, including dementia and depression, as well as access to psychiatric and/or behavioral health services, was identified as a high need area based on new and existing data. Additional input from the CHNA Steering Committee on February 13, 2021 was considered to include Mental Health as part of the Behavioral Health priority need area in this assessment. This priority aligns with the state's initiative to improve behavioral health crisis services over the next five years through the Greater Baltimore Regional Integrated Crisis System (GBRICS) partnership. Findings that support the identification of Mental Health as a priority area in Baltimore County include:

Existing Data

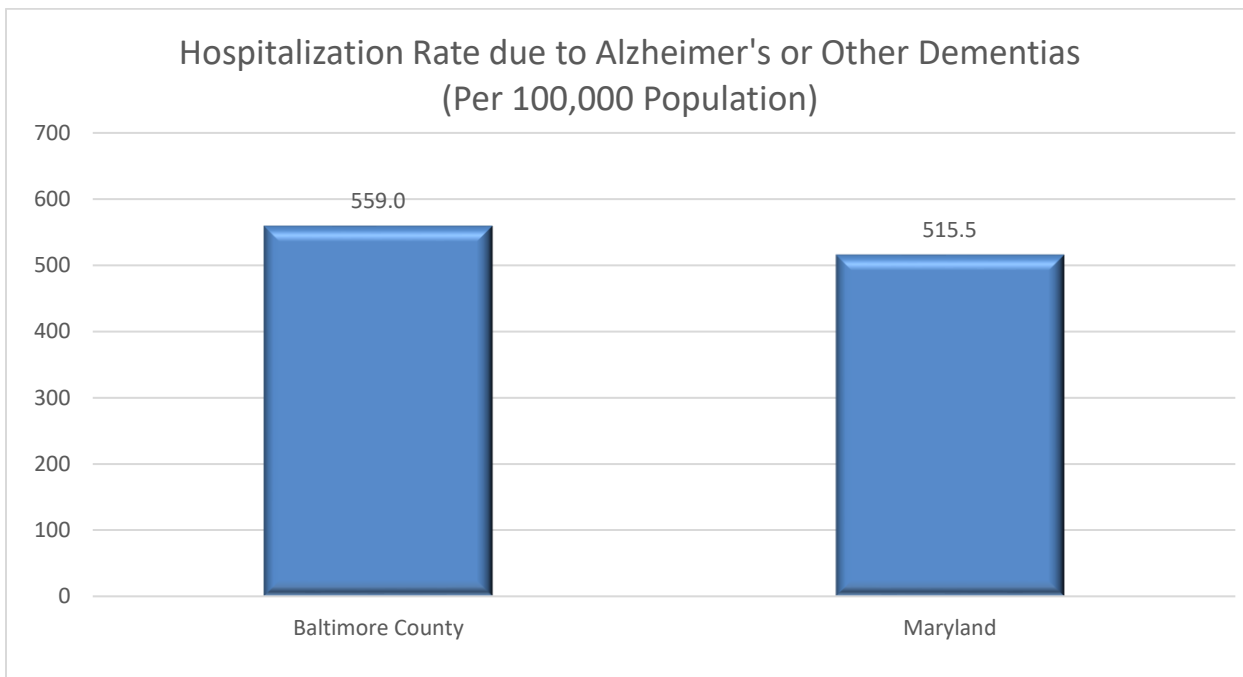
As shown in Appendix 2, existing data reveal that Baltimore County's performance varies when compared to Maryland and national top performers. Although Baltimore County has improved over recent years on some measures, performance on most measures has worsened.

According to MD SHIP, mental health problems place a heavy burden on the healthcare system, especially when people in crisis use emergency departments instead of other sources of care when available. Existing data, illustrated in the chart below, shows that while Baltimore County's rate of mental health ED visits is slightly lower than the Maryland target (4,291.5 per 100,000 population), the county is trending in the wrong direction.



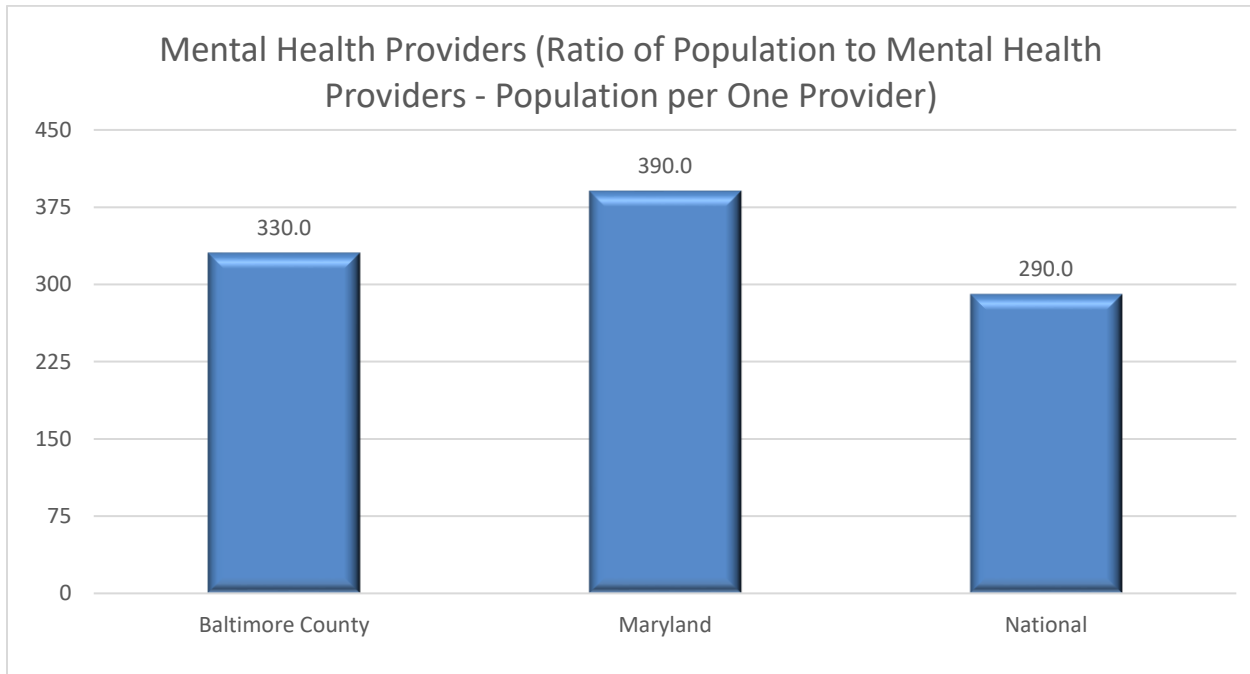
Source: Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.

Further, as Baltimore County’s population ages, certain neurological disorders such as Alzheimer’s and dementia become more common. According to MD SHIP data, the hospitalization rate due to Alzheimer’s or other dementias in Baltimore County is 8 percent greater than Maryland’s benchmark (515.5 hospitalizations per 100,000 population).



Source: Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.

Existing data show that while Baltimore County has a lower ratio of population to mental health providers than the state of Maryland, it has a higher ratio when compared to the national benchmark. According to *County Health Rankings*, lower ratios are desired to ensure adequate access to mental health services. Although there has been some improvement over recent years, feedback from surveys and focus groups supports that there is still more work to be done.



Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, *County Health Rankings*. Data accessed December 2020.

Focus Group Findings

Mental Health was identified by seven of 17 focus groups as a community need, with depression, anxiety, and stress discussed as a concern in most focus groups. Focus group participants also mentioned the increased prevalence of mental and behavioral health conditions within the past five years. Of note, focus group participants reported that isolation during the COVID-19 pandemic had worsened mental health conditions and challenged access to mental health services. Mental health needs were seen as a dominant problem faced by the community as a whole.

Community and Key Community Health Leader Survey Results

40 percent of community survey respondents indicated mental health conditions, such as anxiety and depression, as one of the most important health problems affecting Baltimore County residents. Further, approximately one in three community respondents (32 percent) reported experiencing six or more poor mental health days in the last month, and 18 percent of community respondents reported 11 or more poor mental health days in the last month. Additionally, 78 percent of key community health leaders surveyed chose Mental Health as one of the top three areas of need.

As discussed throughout this document, health disparities are present across Baltimore County. For information regarding disparities across racial and geographic sub-groups, please refer to the Health Disparities Priority Need section of this report.

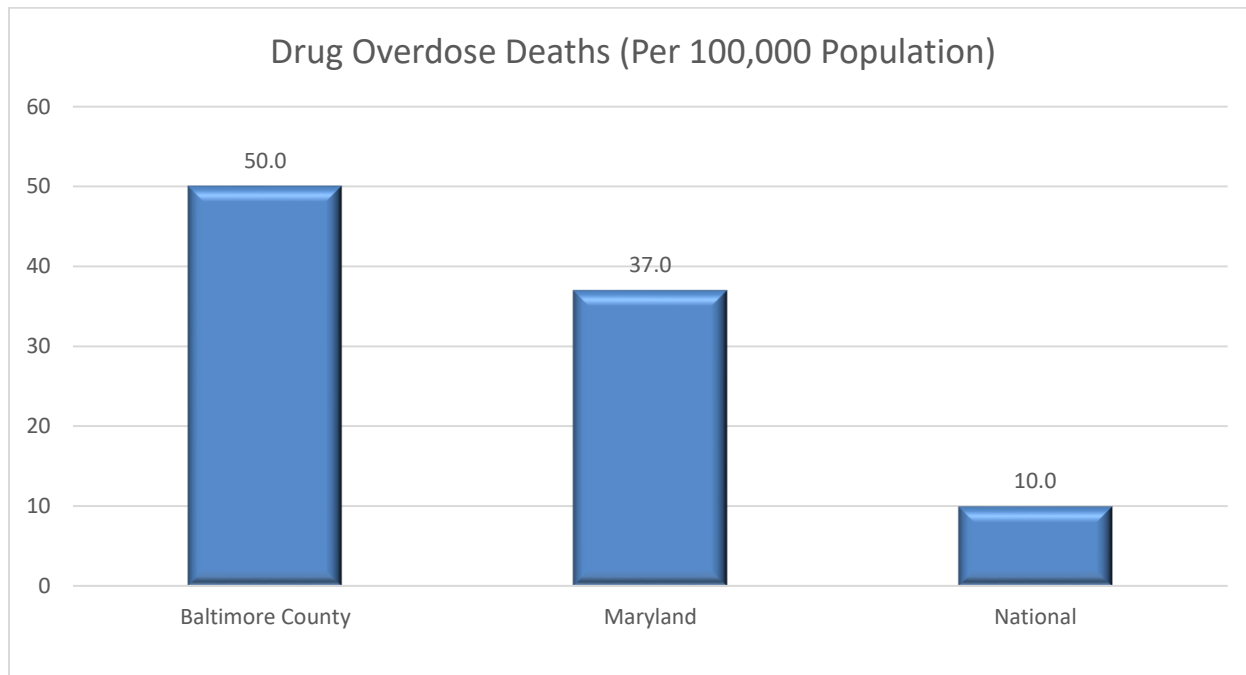
Substance Use Disorders

Substance Use Disorders were identified as an area of high need for Baltimore County after considering new and existing data. Additional input from the CHNA Steering Committee on February 13, 2021 was considered to include Substance Use Disorders as part of the Behavioral Health priority need area in this assessment. Findings that support the identification of Substance Use Disorders as a priority area in Baltimore County include:

Existing Data

As shown in Appendix 2, existing data reveal that Baltimore County is performing worse than Maryland and the nation overall in many areas related to Substance Use Disorders. Recent trends in high need areas vary in Baltimore County with fewer adolescents using tobacco products but increased drug-induced deaths.

According to data analyzed by *County Health Rankings*, Baltimore County experiences more drug-induced deaths (50 per 100,000 population) than both the Maryland and national targets (37 per 100,000 population and 10 per 100,000, respectively). Further, the number of drug-induced deaths in Baltimore County has risen significantly in recent years.

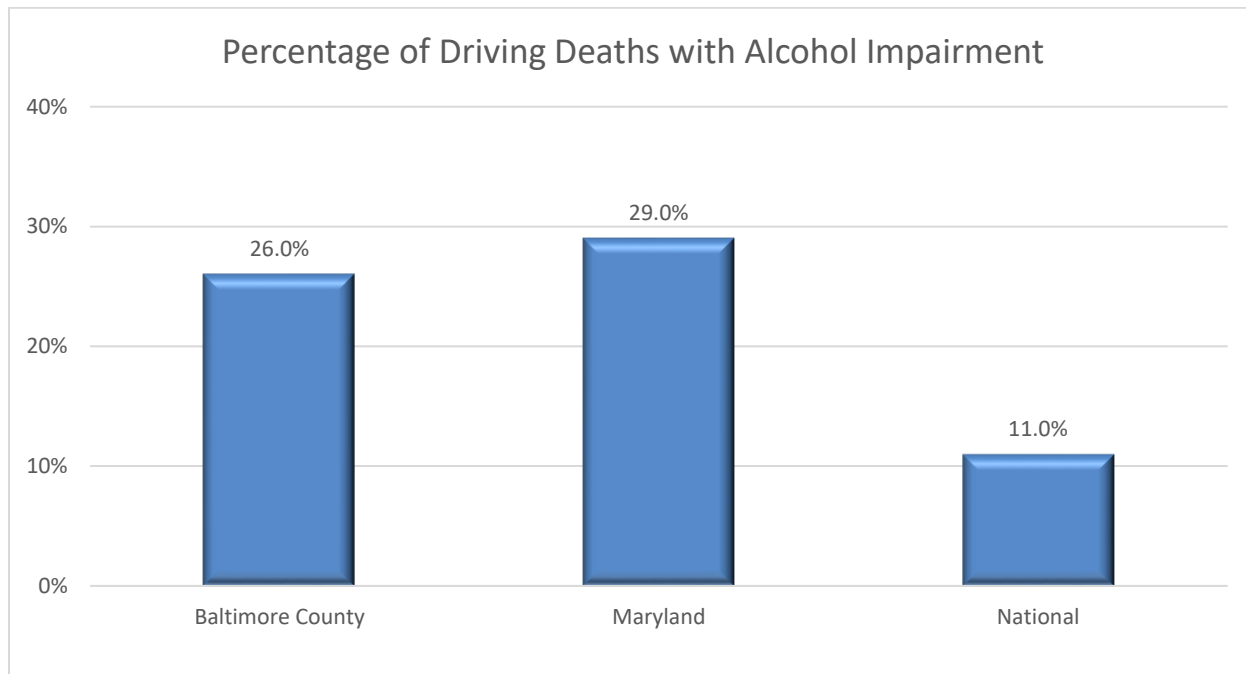


Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

According to data from MedStar Franklin Square, Baltimore County is doing worse than Maryland and/or the nation for the following substance-related health measures:

- Percentage of population impacted by fentanyl-related deaths (0.04 percent in Baltimore County, 0.01 percent nationally)
- Percentage of population impacted by opioid-related deaths (0.04 percent in Baltimore County, 0.01 percent nationally)
- Opioid prescriptions dispensed per 100 persons (53.0 in Baltimore County, 45.0 in Maryland)

Additionally, as shown in the chart below, *County Health Rankings* indicate that 26 percent of all driving deaths in Baltimore County involve alcohol impairment, exceeding the national benchmark of 11 percent. Moreover, according to the most recent data available from the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute’s *County Health Rankings*, nearly one in five adults in Baltimore County report excessive drinking.



Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Community and Key Community Health Leader Survey Results

Substance use disorders, including drug and alcohol abuse, were indicated as one of the most important health problems affecting Baltimore County by 28 percent of community survey respondents. Further, 61 percent of key community health leaders selected substance use disorders as one of the top three need areas, with 30 percent of key community health leaders indicating that there are not enough substance use treatment providers available to meet the community’s needs.

As discussed throughout this document, health disparities are present across Baltimore County. For information regarding disparities across racial and geographic sub-groups, please refer to the Health Disparities Priority Need section of this report.

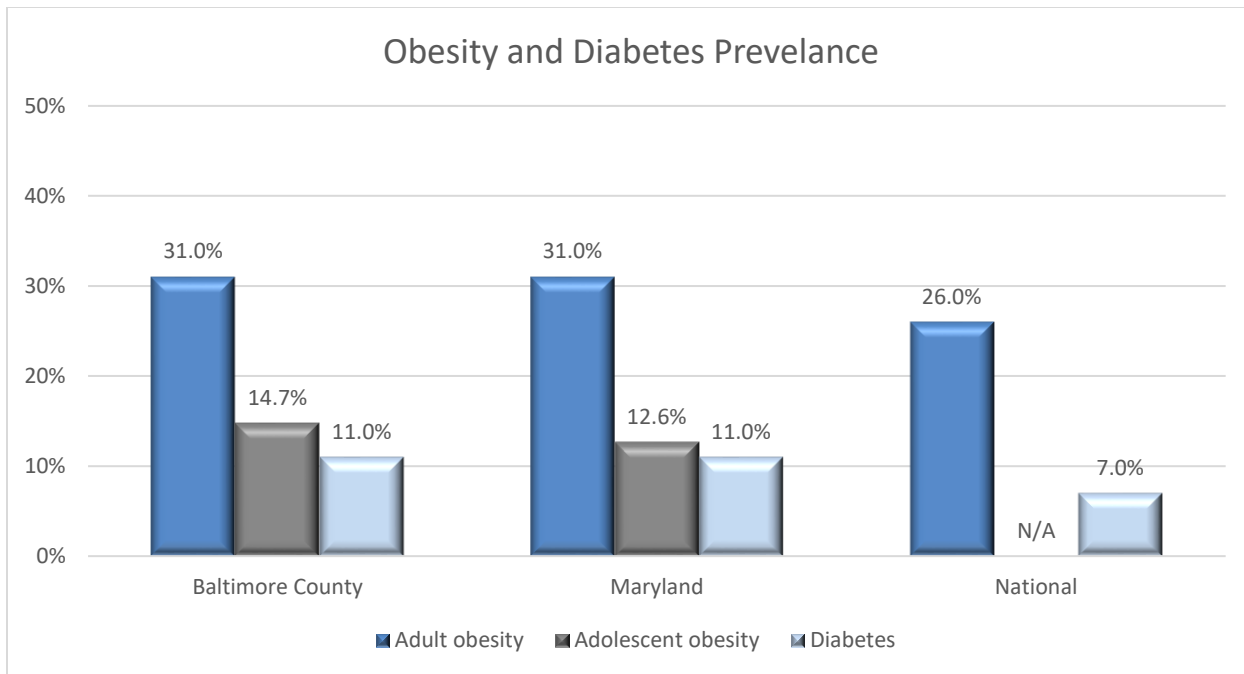
Priority Need: Physical Health

Physical Health, including diabetes, hypertension, heart disease, obesity, and cancer, as well as access to health services, particularly during the COVID-19 pandemic, has been identified as a top priority need area in this CHNA. As shown in Chapter 2 of this report, Physical Health was identified as an area of high need for Baltimore County after considering new and existing data, and the additional input gathered from the CHNA Steering Committee on February 13, 2021 identified Physical Health as a priority need. The Steering Committee also discussed more narrowly defining Physical Health as a specific condition or illness but decided to make the broader category of Physical Health the priority, which will then allow each partner organization to define how that relates to their local community as they develop implementation and action plans. Findings that support the identification of Physical Health as a priority area in Baltimore County include:

Existing Data

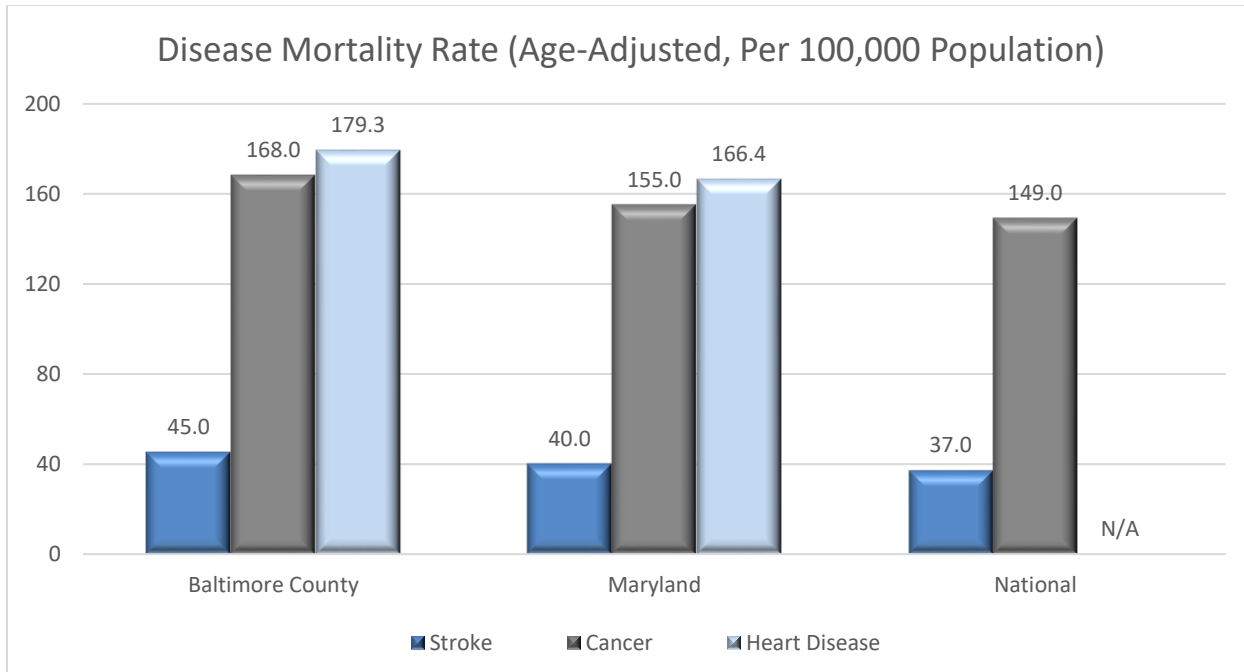
As shown in Appendix 2, existing data reveal that Baltimore County is performing worse than Maryland and the nation overall in many areas related to Physical Health. In addition, Baltimore County is improving in some of these high need areas but getting worse in others.

According to data available from *County Health Rankings*, the percentage of obese adults is five percentage points greater in Baltimore County than the national benchmark for adult obesity (26 percent). National benchmark data were not available for those under 20 years of age, but MD SHIP data indicates that 14.7 percent of adolescents are obese in Baltimore County, as compared to the 12.6 percent in Maryland. Baltimore County also has a greater prevalence of adults diagnosed with diabetes (11 percent) than the national benchmark (7 percent).



Sources: Maryland Department of Health, State Health Improvement Process (SHIP). Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Baltimore County performs worse than national and Maryland benchmarks on mortality rates related to stroke, cancer, and heart disease. According to data provided by MedStar Franklin Square, deaths due to stroke are higher in Baltimore County (45 stroke-related deaths per 100,000 population) than both the national and Maryland benchmarks (37 and 40 stroke-related deaths per 100,000, respectively). In addition, Baltimore County has the highest cancer-related deaths among comparative geographies per 100,000 (168 in Baltimore County, 155 in Maryland, and 149 nationally). Deaths related to heart disease are also more common in Baltimore County (179.3 per 100,000 population) than Maryland (166.4 per 100,000 population).



Sources: MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.

Focus Group Findings

Although Physical Health was only ranked as a top health need in three of the 17 focus groups, existing data and community surveys support that more progress can be made in this area. Focus group participants believed that diabetes, cancer, obesity, hypertension, and heart disease were significant community concerns. Educational sessions, particularly for those who are at increased risk of these conditions, were identified as a much-needed resource by focus group members.

Community and Key Community Health Leader Survey Results

When aggregated, Physical Health was considered the greatest community health problem by both community members and key community health leaders. When asked to choose the three most important health problems that affect the health of their community, physical health problems such as heart disease, hypertension, and stroke were identified by 48 percent of respondents. In addition, 37 percent of respondents chose obesity, and 42 percent of respondents chose diabetes.

As discussed throughout this document, health disparities are present across Baltimore County. For information regarding disparities across racial and geographic sub-groups, please refer to the Health Disparities Priority Need section of this report.

Priority Need: Health Disparities

There are many contributing factors that can either positively or negatively influence an individual's health. The Collaborative recognizes this fact and believes that in order to portray a complete picture of the health-related status of the county it first must address the factors contributing to the health of the community. According to the Centers for Disease Control and Prevention, factors contributing to an individual's health status can include the following:

Five Determinants of Health

1. Biological – sex, age, and genetics
2. Behavioral – alcohol use, drug abuse, smoking, and nutrition
3. Social – discrimination, income, and gender
4. Physical environment – where a person lives and crowding conditions
5. Availability of health services – access to quality healthcare and whether or not a person has health insurance

As seen in the examples above, many of the factors that contribute to health are either not controllable or are societal in nature. As such, healthcare providers need to consider many underlying factors that may impact an individual's health and not simply their current health conditions.

It is widely acknowledged that those with lower income, lower social status and lower levels of education have more difficulty obtaining healthcare services than their counterparts in the community. The inability to access healthcare services contributes to poor health status. Further, members of impoverished communities can also function under high levels of day-to-day stress which contributes to worse health outcomes, particularly as it relates to mental and behavioral health.

One area of particular importance that was repeatedly mentioned and discussed throughout the process of gathering new data was the limited financial resources available to residents of Baltimore County. Community members, key community health leaders, and focus group participants all voiced that the lack of health insurance or other financial resources is a primary reason residents do not seek medical attention. Lack of health insurance significantly influences one's ability to access healthcare services particularly if there are not many providers who offer services on a sliding fee scale. In fact, some participants mentioned that in order to receive care they have to travel into Baltimore City or even out of state since they believe these areas have more resources available than the county. However, due to fiscal hardship or transportation issues, this may not be a feasible alternative. Further, many stated that medical attention was delayed due to the difficult decision of choosing between the necessities of day-to-day life, including electricity and food, and medical care and medications. For many, the consensus was that when faced with these choices, members of the community would choose not to seek medical attention or fill their prescriptions in favor of spending their limited financial resources on other necessities deemed more immediate and critical.

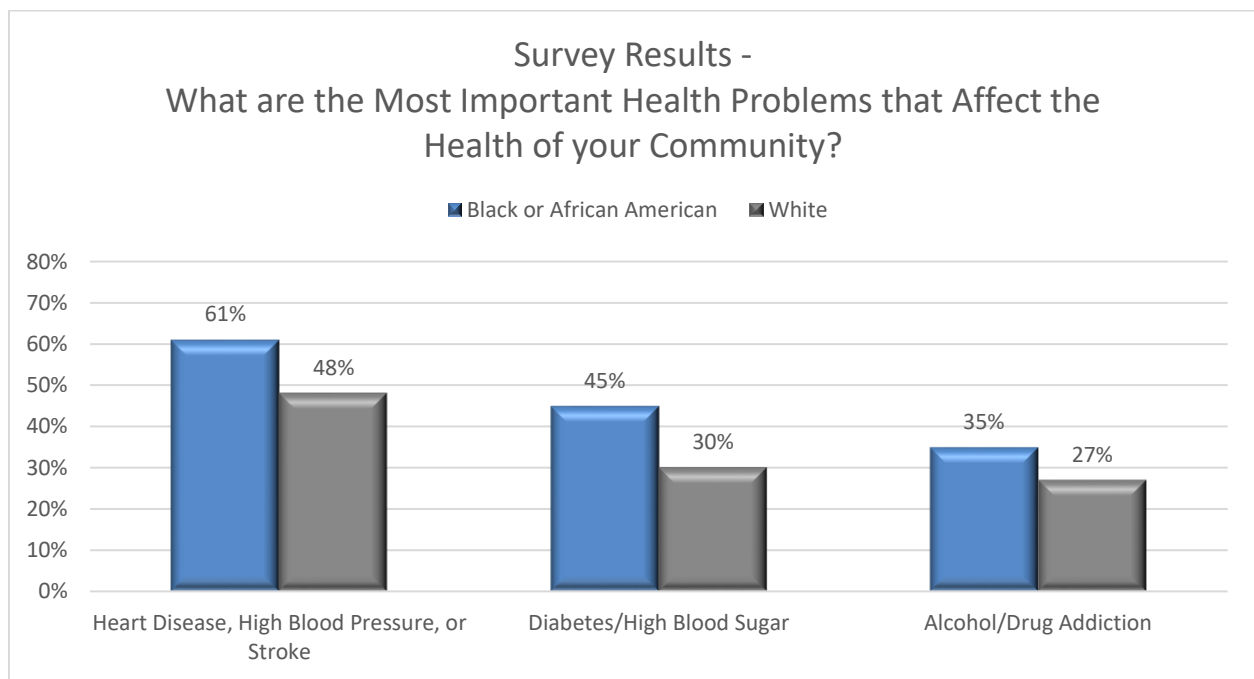
Additionally, the high cost of prescription medications was discussed. Without health insurance coverage, many residents are unable to afford their prescription medications. Even for those with health insurance coverage that extends to cover the cost of medications, there is still difficulty associated with finding a

conveniently located pharmacy that will accept certain forms of insurance. As a result, many simply go without their medication which often worsens their health condition.

The CHNA Steering Committee collected new data via focus groups and various surveys to ensure that residents and key community health leaders could provide input regarding the needs of their specific communities. An analysis of the racial and geographic disparities that emerged in the information obtained and analyzed during this process is detailed below.

Racial Disparities

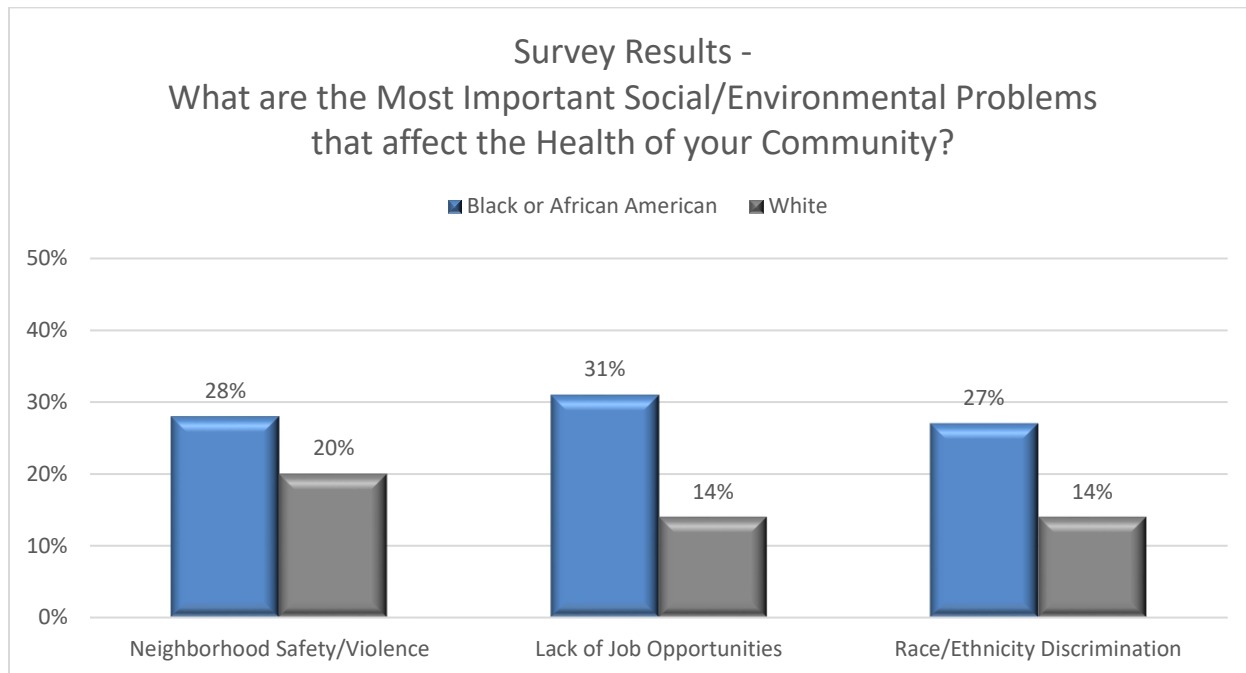
Health-related racial disparities exist in many communities. The new data gathered throughout the CHNA process demonstrates these disparities in Baltimore County, particularly regarding the perceived priority needs of the community and access to healthcare. Due to the racial composition of the respondents of the community internet-based surveys, the following discussion centers on the comparison of results between White and Black or African American respondents. There were slight differences in perceived needs and the prioritization of those needs among the two groups.



Source: Data compiled from community surveys.

As shown in the chart above, opinions varied when respondents were asked to identify the most important health problems affecting their community. 61 percent of all Black or African American respondents indicated heart disease, hypertension, or stroke as opposed to 48 percent of all White respondents. Additionally, 45 percent of all Black or African American respondents indicated diabetes and high blood sugar as opposed to 30 percent of all White respondents. Substance use disorders, such as alcohol and drug addiction, were noted by 35 percent of all Black or African American survey respondents and 27 percent of all White respondents.

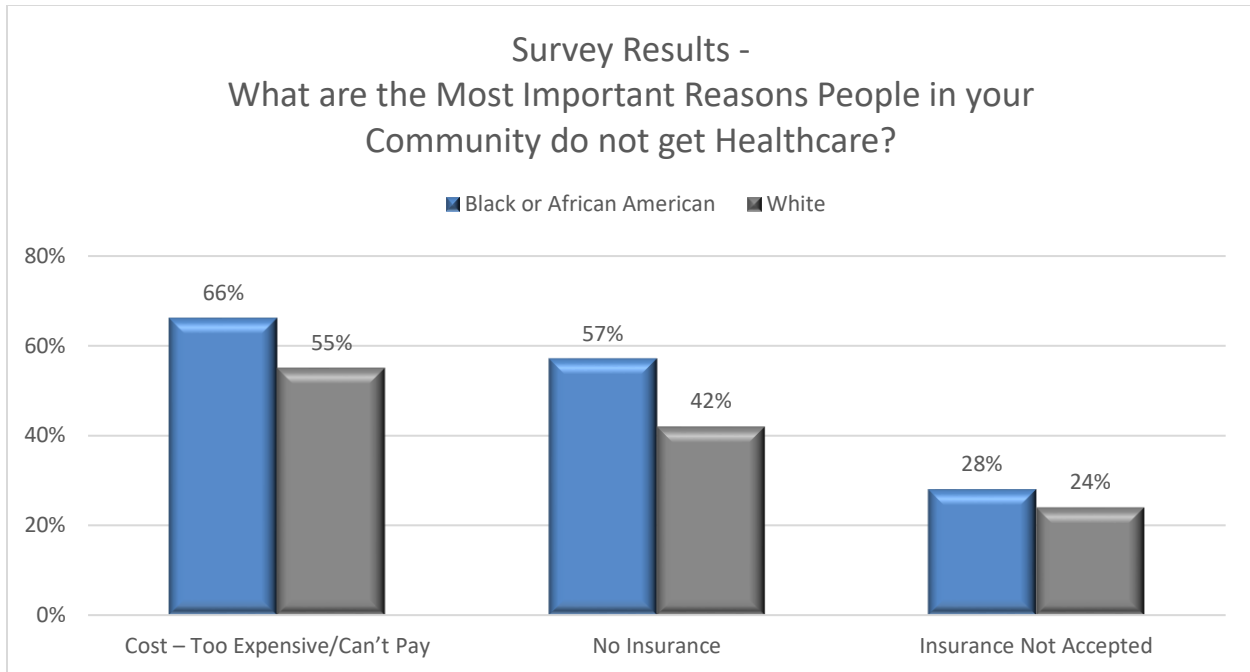
As demonstrated in the chart below, differences were also present in the perceived social/environmental problems facing the community.



Source: Data compiled from community surveys.

28 percent of all Black or African American respondents and 20 percent of all White respondents specified neighborhood safety/violence as a major issue. 31 percent of all Black or African American respondents believe that a lack of job opportunities is one of the most important social/environmental problems affecting the health of the community, while only 14 percent of White respondents indicated the same concern. Further, 27 percent of Black or African American survey respondents selected racial/ethnic discrimination as one of the most important social/environmental problems affecting the health of the community, as compared to approximately 14 percent of all White respondents.

Community survey respondents were also asked to choose the most important reasons why they believe people in the community do not get healthcare. As shown in the chart below, the responses collected demonstrate a notable consensus across racial groups, with the majority of respondents in both groups selecting high costs, lack of insurance, and denial of insurance as the top reasons people in the community do not get healthcare. However, there were slight differences that are illustrated in the chart below.



Source: Data compiled from community surveys.

Cost (too expensive/can't pay) was selected by 66 percent of all Black or African American survey respondents and only 55 percent of all White respondents. Lack of insurance was chosen by 57 percent of all Black or African American survey respondents as opposed to 42 percent of all White respondents. Insurance (not accepted) was the most similar across racial groups, indicated by 28 percent of all Black or African American respondents and 24 percent of all White respondents.

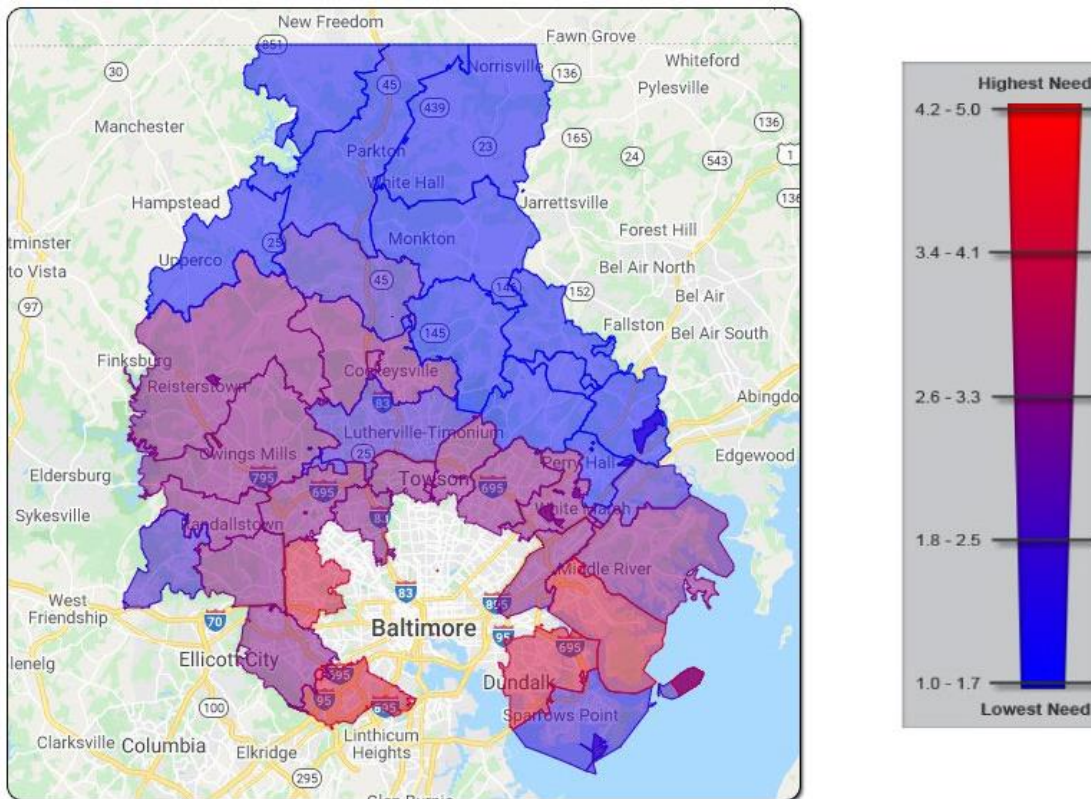
Geographic Disparities

As discussed throughout this document, health needs can vary based on many factors. One resource that is helpful in demonstrating need variation among geographies is the Community Need Index (CNI) developed by Dignity Health and Truven Health Analytics. The CNI identifies the severity of health disparity at the ZIP code level and demonstrates the link among community need, access to care, and healthcare utilization. Rather than relying solely on public health data, the CNI accounts for the underlying economic and structural barriers that affect overall health including social determinants of health. The CNI identifies five prominent barriers that make it possible to quantify healthcare access in communities across the nation. These barriers include those related to income, culture/language, education, insurance, and housing.

Using data related to these barriers, a score is assigned to each barrier condition (with one (1) representing less community need and five (5) representing more community need). The scores are then aggregated and averaged for a final CNI score (each barrier receives equal weight in the average). A score of 1.0 indicates a ZIP code with the lowest socioeconomic barriers, while a score of 5.0 represents a ZIP code with the most socioeconomic barriers. Although Baltimore County received an overall CNI score of 2.3, there is significant variability within the county as half of the county's ZIP codes fall into the mid to mid-high CNI score range indicating the presence of socioeconomic barriers to health and healthcare for the population in those areas. As shown on the map below, areas of greatest need are located in the

southern portion of the county. Please note that since the CNI is based on ZIP code, some of the highlighted areas extend beyond the county borders.

Community Need Index



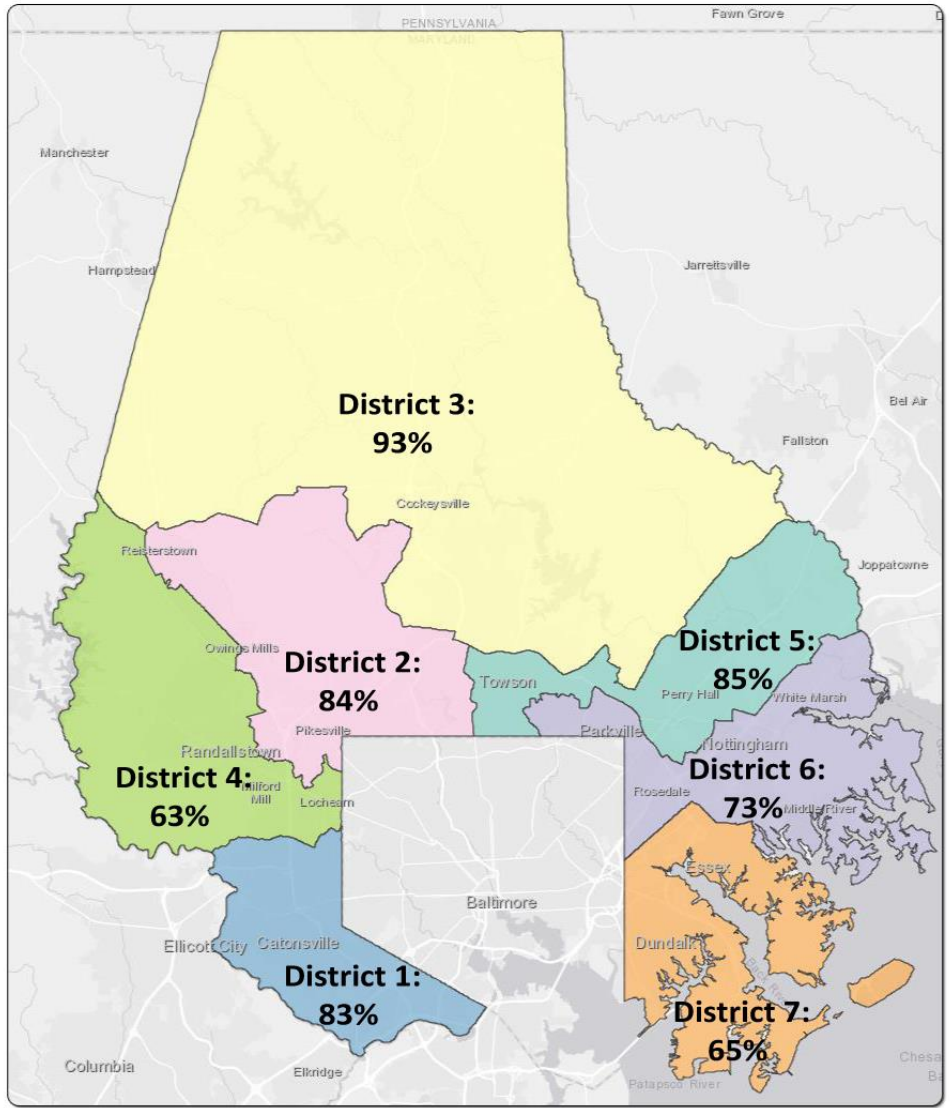
Source: Dignity Health and Truven Health Analytics, Community Need Index. Data accessed December 2020.

The CHNA Steering Committee also analyzed ZIP code level data corresponding to each of the seven Councilmanic districts when aggregating the community survey data to further understand how the severity of need might vary by location. Two of the survey questions highlighted significant need disparity across Baltimore County and are illustrated in the maps on the following pages.

Community Survey Findings

Do you have the ability to find healthy foods around where you live? (By Councilmanic District)

Percentage of total respondents per district that answered “Yes”

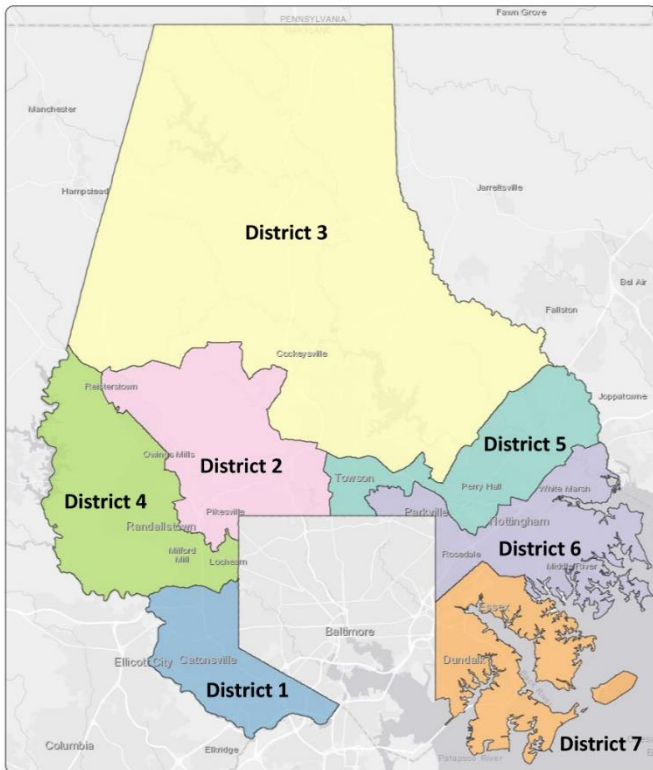


Source: Data compiled from community surveys.

The information shown in the map above highlights the significance of the gap and differences within Baltimore County with 93 percent of community survey respondents in District 3 stating they had the ability to find healthy foods where they lived, whereas only approximately 65 percent of respondents in Districts 4 and 7 reported having that ability.

Community Survey Findings

What are the three most important health problems that affect the health of your community?



Percentage of total responses per selection by district:

District 1	1. Alcohol/drug addiction (51%) 2. Heart disease (48%) 3. Diabetes (40%)
District 2	1. Mental health (40%) 2. Alcohol/drug addiction (39%) 3. Diabetes (37%)
District 3	1. Mental health (45%) 2. Obesity (42%) 3. Heart disease (41%)
District 4	1. Diabetes (50%) 2. Mental health (38%) 3. Obesity (35%)
District 5	1. Heart disease (64%) 2. Alcohol/drug addiction (47%) 3. Diabetes (45%)
District 6	1. Heart disease (76%) 2. Alcohol/drug addiction (52%) 3. Diabetes (46%)
District 7	1. Alcohol/drug addiction (62%) 2. Heart disease (57%) 3. Diabetes (42%)

Source: Data compiled from community surveys.

The perceived priority needs of the community differed significantly across districts. Districts 1 and 7 reported alcohol/drug addiction as the most important health need affecting the community. In addition, Districts 2, 5 and 6 ranked addiction as the second highest health need, while Districts 3 and 4 did not consider it to be one of the most important issues at all. Similarly, mental health was highly ranked in Districts 2, 3 and 4, but it was not considered to be one of the most important issues in the remaining districts.

Given the size of Baltimore County, both in population and geography, it can be expected that health needs will not be uniform for all residents. The Community Need Index and survey data demonstrate that there are significant geographic disparities in Baltimore County, particularly regarding socioeconomic factors and the perceived needs of the community.

CHAPTER 5 | HEALTH RESOURCE INVENTORY

The following section details existing resources, facilities, and programs throughout Baltimore County.

Health Resources

The list of resources below is representative of the services available in Baltimore County; however, this list is not exhaustive. Additionally, while the resources, facilities, and programs listed in this section have been categorized into common groups, these organizations and programs may offer additional services as well. Please note that while the county overall may be adequately served by existing capacity in some areas, not every area of the county is equally served, and the need for additional resources may be greater in one geography as compared to another.

As shown, this health resource inventory was compiled based on input and information from all Collaborative partners and have been categorized into the following areas, including Healthcare Facilities, Home-based Health Services, Other Healthcare Services, and Community Services.

Healthcare Facilities

- Baltimore County Department of Health – Offers a variety of health services for the general public and specialty groups, including general health services, children’s health services, senior health services, uninsured health services, and women’s health services.
- Northwest Hospital of LifeBridge Health – 231-bed hospital offering a variety of services at its hospital location as well as nearby outpatient facilities offering service such as outpatient surgery, adult day care, and physical rehabilitation.
- Sheppard Pratt – Provider of mental health, substance use, special education, developmental disability, and social services offering services in inpatient, outpatient, and virtual settings.
- Greater Baltimore Medical Center Healthcare – 342-bed medical center offering a variety of services at its hospital and main campus medical office buildings as well as primary care offices throughout the community. GBMC also provides and operates integrated behavioral health services, The Geckle Diabetes and Nutrition Center, and the Bariatric Surgery and Comprehensive Obesity Management Program.
- University of Maryland St. Joseph Medical Center – 218-bed hospital offering a variety of services at its hospital and associated practices. UM SJMC also offers many community programs to support families, chronic disease and pain management, physical activity and fall prevention. Additionally, the Barbara Posner Wellness and Support Center offers many support services for cancer patients. St. Clare Medical Outreach is a devoted team that provides primary care and health education to those who have no access to healthcare.
- MedStar Franklin Square Medical Center – 338-bed hospital offering a variety of services at its hospital location as well as primary care, family health, diabetes prevention, nutrition, and smoking cessation services in outpatient settings. Additionally, MedStar Health operates numerous Diabetes Institute locations, the MedStar Health Research Institute, and various behavioral health and outpatient psychiatry services. MedStar Health also offers numerous support groups including those focused on living well with chronic pain, diabetes, and stroke.

Home-based Health Services

Organization	Example Service Offerings
Affiliated Santé Group's Baltimore County Mobile Crisis Team	Dispatches to assist in crisis events related to mental health
Baltimore County Department of Aging	Many evidence-based programs such as Stepping On Fall Prevention, BeCAUSE, senior meals
Baltimore County Department of Health	In-home aide services, Community Health Workers, Nurse home visiting
Baltimore County Department of Social Services	In-home Aides and Case management for specific populations, Guardianship unit
Meals on Wheels of Central Maryland	Home-delivered meals, Grocery Assistance Program
Sheppard Pratt	In-home medication management

Other Healthcare Services

Other healthcare services are offered by the following organizations.

Organization
Baltimore County Department of Health
Baltimore County Department of Social Services
Baltimore County Public Schools
Baltimore Medical Systems
Center for Family Success
Chase Brexton
County shelters
Gilchrist
House of Ruth
Maryland Department of Health
Nueva Vida
Planned Parenthood
St. Clare Medical Outreach
Total Health Care
Towson University Institute for Well Being

Community Services

Additional community services are offered by the following organizations.

Organization
Alzheimer's support group
American Cancer Society
American Diabetes Association
American Heart Association
Assistance Center of Towson Churches

Organization
Baltimore County Communities for the Homeless
Baltimore County Public Library
Baltimore County Recreation and Parks
Baltimore County Senior Centers
Baltimore Hunger Project
Baltimore Jobs Program
BCPS Allied Health Magnets
CCBC
Community Assistance Network
Epiphany Community Services
Food distribution sites (various)
Gilchrist Grief Counseling and Support Resources
Harbel Prevention and Recovery Center
Healthy Babies Collaborative
Healthcare Access Maryland
Healthcare for the Homeless
Humanim
Hungry Harvest
League for People with Disabilities
MD Food Bank
Mental Health Association of Maryland
Mosaic Community Services
Moveable Feast
NAMI
Pro Bono Counseling
Shining Star Baptist
Southeast Network
St. Stevens AME
Streets of Hope
Student Support Network
United Way
Y of Central Maryland

CHAPTER 6 | NEXT STEPS

The CHNA findings are used to develop effective community health improvement strategies to address the priority needs identified throughout the process. The next and final step in the CHNA process is to develop community-based health improvement strategies and action plans to address the priorities identified in this assessment. The organizations making up the Collaborative will leverage information from this CHNA to develop implementation and action plans for their local community, while also working together with other members of the Collaborative to ensure the priority need areas are being addressed in the most efficient and effective way. The Collaborative believes that the most effective strategies will be those that have the collaborative support of community organizations and residents. The strategies developed will include measurable objectives through which progress can be measured.

APPENDICES

APPENDIX 1 | COUNTY DEMOGRAPHIC AND SOCIOECONOMIC DETAIL

Detailed information regarding the demographics and socioeconomics of Baltimore County can be found in the tables below.

County Demographics

Age and Total Population

The tables below show the change in population in Baltimore County and Maryland by age cohort.

Total Population by Age – Baltimore County			
	2014	2018	CAGR
Below 18	178,621	178,931	0.0%
Between 18 and 65	517,521	507,190	-0.5%
65 and older	130,783	142,310	2.1%
Total	826,925	828,431	0.0%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Total Population by Age – Maryland			
	2014	2018	CAGR
Below 18	1,350,668	1,341,483	-0.2%
Between 18 and 65	3,800,995	3,770,656	-0.2%
65 and older	824,744	930,579	3.1%
Total	5,976,407	6,042,718	0.3%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Gender

The tables below show the change in population in Baltimore County and Maryland by gender.

Total Population by Gender – Baltimore County			
	2014	2018	CAGR
Female	435,789	435,755	0.00%
Male	391,136	392,676	0.10%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Total Population by Gender – Maryland			
	2014	2018	CAGR
Female	3,077,850	3,112,000	0.28%
Male	2,898,557	2,930,718	0.28%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Race

The tables below show the change in population in Baltimore County and Maryland by race.

Total Population by Race – Baltimore County			
	2014	2018	CAGR
White	549,503	531,501	-0.8%
Black	224,627	240,203	1.7%
Asian	48,675	52,462	1.9%
American Indian/Alaskan Native	3,500	3,637	1.0%
Native Hawaiian/Other Pacific Islander	620	628	0.3%
Total	826,925	828,431	0.0%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Total Population by Race – Maryland			
	2014	2018	CAGR
White	3,807,063	3,792,775	-0.1%
Black	1,749,444	1,801,327	0.7%
Asian	380,168	405,682	1.6%
American Indian/Alaskan Native	33,413	36,188	2.0%
Native Hawaiian/Other Pacific Islander	6,319	6,746	1.6%
Total	5,976,407	6,042,718	0.3%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Ethnicity

The tables below show the change in population in Baltimore County and Maryland by ethnicity.

Total Population by Ethnicity – Baltimore County			
	2014	2018	CAGR
Hispanic	41,346	47,221	3.38%
Non-Hispanic	785,579	781,210	-0.14%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Total Population by Ethnicity – Maryland			
	2014	2018	CAGR
Hispanic	555,806	628,443	3.12%
Non-Hispanic	5,420,601	5,414,275	-0.03%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Socioeconomic Detail

Income

The table below shows the median household income in 2018 for Baltimore County, Maryland, and the nation overall.

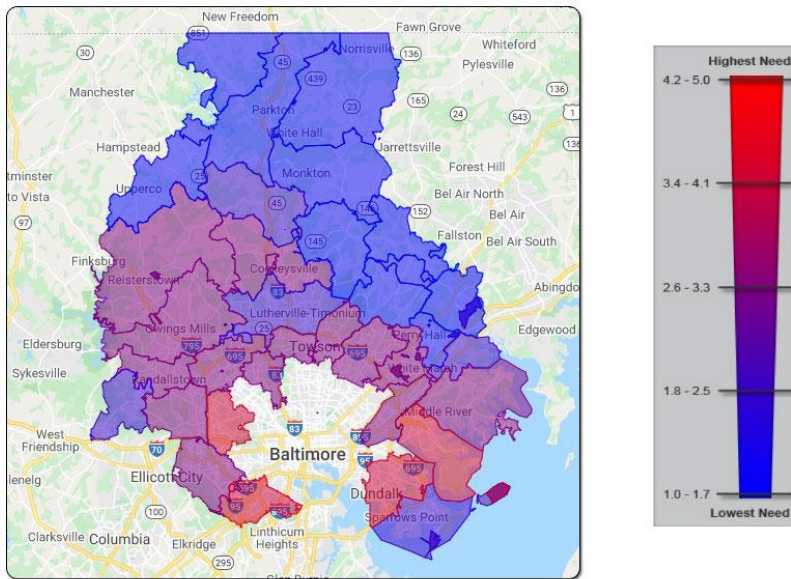
2018 Median Household Income			
	Baltimore County	Maryland	National
Income	\$75,800	\$83,100	\$69,000

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Community Need Index

One resource that is helpful in demonstrating need variation among geographies is the Community Need Index (CNI) developed by Dignity Health and Truven Health Analytics. The CNI identifies the severity of health disparity at the ZIP code level and demonstrates the link among community need, access to care, and healthcare utilization. Rather than relying solely on public health data, the CNI accounts for the underlying economic and structural barriers that affect overall health including social determinants of health. The CNI identifies five prominent barriers that make it possible to quantify healthcare access in communities across the nation. These barriers include those related to income, culture/language, education, insurance, and housing.

Using data related to these barriers, a score is assigned to each barrier condition (with one (1) representing less community need and five (5) representing more community need). The scores are then aggregated and averaged for a final CNI score (each barrier receives equal weight in the average). A score of 1.0 indicates a ZIP code with the lowest socioeconomic barriers, while a score of 5.0 represents a ZIP code with the most socioeconomic barriers. As shown on the map below, areas of greatest need are



located in the southern portion of the county. Please note that since the CNI is based on ZIP code, some of the highlighted areas extend beyond the county borders.

Although Baltimore County received an overall CNI score of 2.3, there is significant variability within the county as half of the county's ZIP codes fall into the mid to mid-high CNI score range indicating the presence of socioeconomic barriers to health and healthcare for the population in those areas.

Baltimore County		
ZIP Code	CNI Score	City
21227	3.8	Halethorpe
21207	3.6	Gwynn Oak
21221	3.6	Essex
21222	3.6	Dundalk
21250	3.4	Baltimore
21030	3.2	Cockeysville
21234	3.2	Parkville
21237	3.2	Rosedale
21031	3.0	Hunt Valley
21136	3.0	Reisterstown
21204	3.0	Towson
21220	3.0	Middle River
21244	3.0	Windsor Mill
21252	3.0	Towson
21117	2.8	Owings Mills
21236	2.8	Nottingham
21286	2.8	Towson
21133	2.6	Randallstown
21208	2.6	Pikesville
21209	2.6	Baltimore
21228	2.6	Catonsville
21219	2.4	Sparrows Point
21153	2.0	Stevenson
21162	2.0	White Marsh
21052	1.8	Fort Howard
21071	1.8	Glyndon
21093	1.8	Lutherville Timonium
21152	1.8	Sparks Glencoe
21156	1.8	Upper Falls
21163	1.8	Woodstock
21128	1.6	Perry Hall
21053	1.4	Freeland
21057	1.4	Glen Arm
21120	1.4	Parkton
21131	1.4	Phoenix
21155	1.4	Upperco

Baltimore County		
ZIP Code	CNI Score	City
21013	1.2	Baldwin
21082	1.2	Hydes
21087	1.2	Kingsville
21111	1.2	Monkton
21161	1.2	White Hall
21051	1.0	Fork

APPENDIX 2 | DETAILED EXISTING (SECONDARY) DATA FINDINGS

Many individual existing data measures were analyzed as part of the CHNA process. These data provide detailed insight into the health status and health-related behavior of residents in the county. These existing data are based on statistics of actual occurrences, such as the incidence of certain diseases, as well as statistics related to social determinants of health.

Methodology

All individual existing data measures were grouped into six categories and 20 corresponding focus areas based on “common themes.” In order to draw conclusions about the existing data, Baltimore County’s performance on each data measure were compared to targets/benchmarks. If Baltimore County’s performance was more than five percent worse than the comparative benchmark, it was concluded that improvements are needed to better the health of Baltimore County residents. Conversely, if Baltimore County performed more than five percent better than the benchmark, it was concluded that the need for improvement is less acute. The most recently available Baltimore County data were compared to these targets/benchmarks in the following order (as applicable):

- Maryland
- National Benchmark/University of Wisconsin Population Health Institute’s County Health Rankings Top Performers Benchmark

The following methodology was used to assign a priority level to each individual existing data measure:

- If the data were more than 5 percent worse = High need
- If the data were within or equal to 5 percent (better or worse) = Medium need
- If the data were more than 5 percent better = Low need

Data Sources

The following tables are organized by each of the twenty focus areas and contain information related to the existing data measures analyzed including a description of each measure, the data source, and most recent data time periods.

Access to Care

Measure	Description	Data Source	Most Recent Data Year(s)
Uninsured (percent of population < 65 without health insurance)	Percentage of the population under age 65 without health insurance coverage.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Primary Care (ratio of population to primary care physicians - population per one provider)	Ratio of the population to primary care physicians. Primary care physicians include practicing non-federal physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. The ratio represents the number of individuals served by one physician in a county, if the population was equally distributed across physicians. Prior to the 2013 County Health Rankings, primary care physicians were defined only as M.D.s. In 2013, D.O.s were incorporated into the definition of primary care physicians and obstetrics/gynecology was removed as a primary care physician type.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Dentists (ratio of population to dentists - population per one dentist)	Ratio of the population to dentists. The ratio represents the population served by one dentist if the entire population of a county was distributed equally across all practicing dentists.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2018
Uninsured adults (ages 18 to 64)	Percentage of the population ages 18 to 64 that has no health insurance coverage in a given geography.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Uninsured children (ages under 19)	Percentage of the population under age 19 that has no health insurance coverage.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Other primary care providers (ratio of population to other primary care providers -	Ratio of the county population to the number of other primary care providers. Other primary care providers include nurse practitioners	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County	2019

BALTIMORE COUNTY 2020-2021 COMMUNITY HEALTH NEEDS ASSESSMENT

Measure	Description	Data Source	Most Recent Data Year(s)
population per one provider)	(NP), physician assistants (PA), and clinical nurse specialists. Please note that the methods for calculating this measure changed in the 2017 Rankings.	Health Rankings. Data accessed December 2020.	
Children receiving dental care (ages 0 to 20)	This indicator reflects the percentage of children (aged 0-20 years) enrolled in Medicaid (320+ days) who received at least one dental visit during the past year.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
ED visit rate due to addiction-related conditions	This indicator shows the rate of emergency department visits related to substance use disorders (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
ED visit rate due to asthma	This indicator shows the rate of emergency department visits due to asthma (per 10,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
ED visit rate due to diabetes	This indicator shows the emergency department visit rate due to diabetes (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
ED visit rate due to hypertension	This indicator shows the rate of emergency department visits due to hypertension (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
ED visit rate due to dental problems	This indicator shows the emergency department visit rate related to dental problems (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Persons with a usual primary care provider	This indicator shows the percentage of people who reported that they had one person they think of as their personal doctor or healthcare provider.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Uninsured ED visits	This indicator shows the percentage of persons without health (medical) insurance.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Persons unable to afford physician visits	Percentage of adults unable to afford to see a doctor.	MedStar Franklin Square, FY21 Community Health	2015

Measure	Description	Data Source	Most Recent Data Year(s)
		Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	

Built Environment

Measure	Description	Data Source	Most Recent Data Year(s)
Food environment index (index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best))	<p>The Food Environment Index measures the quality of the food environment in a county on a scale from 0 to 10. The Food Environment Index is comprised of two variables: Limited access to healthy foods from the USDA's Food Environment Atlas estimates the percentage of the population who are low income and do not live close to a grocery store. Living close to a grocery store is defined differently in rural and nonrural areas: in rural areas, it means living less than 10 miles from a grocery store whereas in nonrural areas, it means less than 1 mile. Low income is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size.</p> <p>Food insecurity from Feeding America estimates the percentage of the population who did not have access to a reliable source of food during the past year. The two variables are scaled from 0 to 10 (zero being the worst value in the nation, and 10 being the best) and averaged to produce the Food Environment Index. In 2016, the average value for counties was 7.0 and most counties fell between about 5.4 and 8.3.</p>	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2015, 2017
Access to exercise opportunities (percent of the population with adequate access to locations for physical activity)	Percentage of individuals in a county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities. Individuals are considered to have access to exercise	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2010, 2019

Measure	Description	Data Source	Most Recent Data Year(s)
	<p>opportunities if they: reside in a census block that is within a half mile of a park or reside in an urban census block that is within one mile of a recreational facility or reside in a rural census block that is within three miles of a recreational facility. The numerator is the number of individuals who live in census blocks meeting at least one of the above criteria. The denominator is the total county population. Locations for physical activity are defined as parks or recreational facilities. Parks include local, state, and national parks. Recreational facilities include YMCAs as well as businesses identified by the following Standard Industry Classification (SIC) codes and include a wide variety of facilities including gyms, community centers, dance studios and pools: 799101, 799102, 799103, 799106, 799107, 799108, 799109, 799110, 799111, 799112, 799201, 799701, 799702, 799703, 799704, 799707, 799711, 799717, 799723, 799901, 799908, 799958, 799969, 799971, 799984, or 799998. The way this measure is calculated has changed over time. In 2018, County Health Rankings switched from using North American Information Classification System (NAICS) codes to using Standard Industry Classification (SIC) codes due to lack of availability of a nationally reliable and updated data source.</p>		

Diet and Exercise

Measure	Description	Data Source	Most Recent Data Year(s)
Physical inactivity (percent of adults that report no leisure time physical activity)	<p>Percentage of adults ages 20 and over reporting no leisure-time physical activity in the past month. Examples of physical activities include running, calisthenics, golf, gardening, or walking for exercise. The method for calculating Physical</p>	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016

Measure	Description	Data Source	Most Recent Data Year(s)
	Inactivity changed. Data for Physical Inactivity are provided by the CDC Interactive Diabetes Atlas which combines 3 years of survey data to provide county-level estimates. In 2011, BRFSS changed their methodology to include cell phone and landline participants. Previously only landlines were used to collect data. Physical Inactivity is created using statistical modeling.		
Physical Activity (percentage)	This indicator shows the percentage of persons who reported at least 150 minutes of moderate physical activity or at least 75 minutes of vigorous physical activity per week.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017

Education

Measure	Description	Data Source	Most Recent Data Year(s)
High school graduation (percent of ninth grade cohort that graduates in four years)	Percentage of the ninth-grade cohort in public schools that graduates from high school in four years. Please note this measure was modified in the 2011, 2012, and 2014 Rankings.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016-2017
Some college (percent of adults aged 25-44 years with some post-secondary education)	Percentage of the population ages 25-44 with some post-secondary education, such as enrollment in vocational/technical schools, junior colleges, or four-year colleges. It includes individuals who pursued education following high school but did not receive a degree as well as those who attain degrees. The numerator is the number of adults ages 25-44 who have obtained some level of post-secondary education. The denominator is the population ages 25-44 in a county.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Reading Scores	Average grade level performance for 3rd graders on English Language Arts standardized tests.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016

Measure	Description	Data Source	Most Recent Data Year(s)
Math Scores	Average grade level performance for 3rd graders on math standardized tests.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016
Students entering kindergarten ready to learn	This indicator shows the percentage of students who enter Kindergarten ready to learn.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Percentage of adults with a high school diploma or higher	Percentage of adults with a high school diploma or higher.	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2014-2018
Percentage of adults with a bachelor's or more advanced degree	Percentage of adults with a bachelor's or more advanced degree.	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2014-2018

Employment

Measure	Description	Data Source	Most Recent Data Year(s)
Unemployment rate (percent of population age 16+ unemployed)	Percentage of a county's workforce that is not employed. The numerator is the number of individuals over age 16 in a county who are seeking work but do not have a job. The denominator is the total labor force, which includes all individuals over age 16 who are actively searching for work and unemployed plus those who are employed. Unemployment estimates are modeled.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2018

Environmental Quality

Measure	Description	Data Source	Most Recent Data Year(s)
Air pollution (avg daily measure of fine particulate matter in micrograms per cubic meter)	Average daily density of fine particulate matter in micrograms per cubic meter. Fine particulate matter is defined as particles of air pollutants with an aerodynamic	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County	2014

Measure	Description	Data Source	Most Recent Data Year(s)
	<p>diameter less than 2.5 micrometers (PM2.5).</p> <p>Air Pollution is modeled. For 2017, County Health Rankings is using data provided by the EPHT Network. From 2013-2016 the County Health Rankings used data provided by the NASA Applied Sciences Program, which used a similar methodology but also incorporates satellite data.</p> <p>For 2012 and prior years of the County Health Rankings, data were obtained from the EPHT Network, but the measures of air quality differed from the current measure: County Health Rankings reported the average number of days annually that both PM2.5 and ozone pollution were reported to be over the accepted limit.</p>	Health Rankings. Data accessed December 2020.	

Family, Community, and Social Support

Measure	Description	Data Source	Most Recent Data Year(s)
Percentage of children that live in single-parent household	Percentage of children (less than 18 years of age) in family households that live in a household headed by a single parent. The single parent could be a male or female and is without the presence of a spouse. Foster children and children living in non-family households or group quarters are not included in either the numerator or denominator.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Social associations (number of membership associations per 10,000 population)	Number of organizations per 10,000 population in a county. The numerator is the number of organizations or associations in a county. Associations include membership organizations such as civic organizations, bowling centers, golf clubs, fitness centers, sports organizations, political organizations, labor organizations, business organizations, and professional organizations. The denominator is the population of a county. Social Associations does not measure all of	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017

Measure	Description	Data Source	Most Recent Data Year(s)
	the social support available within a county. Data and business codes are self-reported by businesses in a county. We use the primary business code of organizations, which in some cases may not match up with our notion of what should be labeled as a civic organization. This measure does not take into account other important social connections offered via family support structures, informal networks, or community service organizations, all of which are important to consider when understanding the amount of social support available within a county.		
Disconnected youth	Percentage of teens and young adults ages 16-24 who are neither working nor in school.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Residential segregation - black/white	Degree to which two or more groups live separately from one another in a geographic area. The index of dissimilarity is a demographic measure of the evenness with which two groups (black and white residents, in this case) are distributed across the component geographic areas (census tracts, in this case) that make up a larger area (counties, in this case). The index score can be interpreted as the percentage of either black or white residents that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Residential segregation - non-white/white	Degree to which two or more groups live separately from one another in a geographic area. The index of dissimilarity is a demographic measure of the evenness with which two groups (non-white and white residents) are distributed across the component geographic areas (census tracts, in this case) that make up a larger area (counties, in this case).	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018

Measure	Description	Data Source	Most Recent Data Year(s)
	The index score can be interpreted as the percentage of white or non-white that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area.		
Percentage not proficient in English	Percentage of population that is not proficient in English.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018

Food Security

Measure	Description	Data Source	Most Recent Data Year(s)
Percentage of households experiencing food insecurity	Percentage of the population who did not have access to a reliable source of food during the past year. This measure was modeled using information from the Community Population Survey, Bureau of Labor Statistics, and American Community Survey. More detailed information can be found here. This is one of two measures that are used to construct the Food Environment Index.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Limited access to healthy foods	Percentage of population who are low-income and do not live close to a grocery store.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2015
Children eligible for free or reduced-price lunch	Percentage of children enrolled in public schools, grades PK - 12, eligible for free (family income less than 130 percent of federal poverty level) or reduced price (family income less than 185 percent of federal poverty level) lunch.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017-2018
Percentage of households with children receiving public assistance or SNAP benefits	Percentage of households with children receiving public assistance or SNAP benefits	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2018
Percentage of households with children	Percentage of households with children experiencing food insecurity	MedStar Franklin Square, FY21 Community Health	2018

Measure	Description	Data Source	Most Recent Data Year(s)
experiencing food insecurity		Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	
Food Insecurity Among Middle School Students: All races/ethnicities	Percentage of students who, when asked, said they were worried that their food money would run out before they could buy more, and/or if the food their family bought did not last and they did not have money to get more.	The Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS). Data accessed December 2020.	2018
Food Insecurity Among High School Students: All races/ethnicities	Percentage of students who, when asked, said they were worried that their food money would run out before they could buy more, and/or if the food their family bought did not last and they did not have money to get more.	The Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS). Data accessed December 2020.	2018

Housing and Homelessness

Measure	Description	Data Source	Most Recent Data Year(s)
Severe housing problems (percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities)	Percentage of households with one or more of the following housing problems: Housing unit lacks complete kitchen facilities; Housing unit lacks complete plumbing facilities; Household is severely overcrowded; or Household is severely cost burdened. Incomplete kitchen facilities is defined as a unit which lacks a sink with running water, a range or a refrigerator. Incomplete plumbing facilities is defined as lacking hot and cold piped water, a flush toilet, or a bathtub/shower. Severe overcrowding is defined as more than 1.5 persons per room. Severe cost burden is defined as monthly housing costs (including utilities) that exceed 50 percent of monthly income. The numerator is the number of households in a county with at least one of the above housing problems and the denominator is the number of total households in a county.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2012-2016

Measure	Description	Data Source	Most Recent Data Year(s)
Percentage of owner-occupied housing	Percentage of occupied housing units that are owned.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Percentage of people spending more than 50 percent of their income on rental housing	Number of renter-occupied housing units spending 50 or more percent of household income on rent as a percentage of total renter-occupied housing units.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Affordable Housing (percentage)	This indicator shows the percentage of housing units sold that are affordable on the median teacher's salary.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2016

Income

Measure	Description	Data Source	Most Recent Data Year(s)
Children in poverty (percent of children under age 18 in poverty)	Percentage of children under age 18 living in poverty. Poverty status is defined by family size and income and is measured at the household level. If a household's income is lower than the poverty threshold for a household of their size, they are considered to be in poverty. Poverty thresholds differ by household size and geography. For more information on how poverty thresholds are calculated please see the Census poverty page. Children in Poverty estimates are modeled.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2018
Median household income	Income where half of households in a county earn more and half of households earn less. Income, defined as "Total income", is the sum of the amounts reported separately for: wage or salary income; net self-employment income; interest, dividends, or net rental or royalty income or income from estates and trusts; Social Security or Railroad Retirement income; Supplemental Security Income (SSI); public assistance or welfare payments;	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2018

Measure	Description	Data Source	Most Recent Data Year(s)
	retirement, survivor, or disability pensions; and all other income. Receipts from the following sources are not included as income: capital gains; money received from the sale of property (unless the recipient was engaged in the business of selling such property); the value of income “in kind” from food stamps, public housing subsidies, medical care, employer contributions for individuals, etc.; withdrawal of bank deposits; money borrowed; tax refunds; exchange of money between relatives living in the same household; gifts and lump-sum inheritances, insurance payments, and other types of lump-sum receipts.		
Income inequality (ratio of household income at the 80th percentile to income at the 20th percentile)	Ratio of household income at the 80th percentile to that at the 20th percentile, i.e., when the incomes of all households in a county are listed from highest to lowest, the 80th percentile is the level of income at which only 20 percent of households have higher incomes, and the 20th percentile is the level of income at which only 20 percent of households have lower incomes. A higher inequality ratio indicates greater division between the top and bottom ends of the income spectrum.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Percentage of individuals living in poverty	Number of people living below poverty level as percent of total population.	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2018
Household Income (\$, 000s) - All	Average annual household income in 2014-2015 for children (now in their mid-30s) who grew up in this area.	The Opportunity Atlas, developed in partnership by the U.S. Census Bureau, Harvard University, and Brown University. Data accessed December 2020.	2014-2015

Length of Life

Measure	Description	Data Source	Most Recent Data Year(s)
Premature Death (years of potential life lost before age 75 per 100,000 population age-adjusted)	Number of events (i.e., deaths, births, etc.) in a given time period (three-year period) divided by the average number of people at risk during that period. Years of potential life lost measures mortality by giving more weight to deaths at earlier ages than deaths at later ages. Premature deaths are deaths before age 75. All of the years of potential life lost in a county during a three-year period are summed and divided by the total population of the county during that same time period-this value is then multiplied by 100,000 to calculate the years of potential life lost under age 75 per 100,000 people. These are age-adjusted.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016-2018
Life expectancy	Average number of additional years that someone at a given age would be expected to live if current mortality conditions remained constant throughout their lifetime. Based on life expectancy at birth. State data are a single year while county data are a three-year aggregate. Data were not reported in the County Health Book prior to 2013.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016-2018
Child mortality	Number of deaths among children under age 18 per 100,000 population	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2015-2018

Maternal and Infant Health

Measure	Description	Data Source	Most Recent Data Year(s)
Low birthweight (percent of live births with birthweight < 2500 grams)	Percentage of live births where the infant weighed less than 2,500 grams (approximately 5 lbs., 8 oz.). The numerator is the number of low birthweight infants born over a 7-year time span, while the denominator is the total number of births in a county during the same time.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2012-2018
Infant mortality	Number of all infant deaths (within 1 year), per 1,000 live births.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2012-2018

Mental Health

Measure	Description	Data Source	Most Recent Data Year(s)
Poor mental health days (avg number in past 30 days age-adjusted)	Average number of mentally unhealthy days reported in past 30 days. This measure is based on responses to the Behavioral Risk Factor Surveillance System (BRFSS) question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" The value reported in the County Health Rankings is the average number of days a county's adult respondents report that their mental health was not good. Poor Mental Health Days is age-adjusted. Prior to the 2016 County Health Rankings, the CDC's BRFSS provided the County Health Rankings with county-level estimates that were constructed from seven years of responses from participants who used a landline phone. However, even with multiple years of data, these did not provide reliable estimates for all counties, particularly those with smaller	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017

Measure	Description	Data Source	Most Recent Data Year(s)
	respondent samples. In 2016, the CDC began producing single-year estimates at the county level using a combination of BRFSS data and a multilevel modeling approach based on respondent answers and individual characteristics such as age, sex, and race/ethnicity, along with county-level poverty and county and state-level contextual effects. Poor Mental Health Days estimates are created using statistical modeling.		
Mental health providers (ratio of population to mental health providers - population per one provider)	Ratio of the population to mental health providers. Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and mental health providers that treat alcohol and other drug abuse, as well as advanced practice nurses specializing in mental healthcare. The ratio represents the number of individuals served by one mental health provider in a county, if the population were equally distributed across providers. In 2015, marriage and family therapists and mental health providers that treat alcohol and other drug abuse were added to this measure.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2019
Frequent mental distress	Percentage of adults who reported ≥ 14 days in response to the question, "Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
ED visit rate due to mental health conditions	This indicator shows the rate of emergency department visits related to mental health disorders (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Suicide Rate	This indicator shows the suicide rate per 100,000 population.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2014-2017

Measure	Description	Data Source	Most Recent Data Year(s)
Hospitalization rate due to Alzheimer's or other dementias	This indicator shows the rate of hospitalizations related to Alzheimer's or other dementias (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017

Physical Health

Measure	Description	Data Source	Most Recent Data Year(s)
Poor or fair health (percent of adults reporting fair or poor health age-adjusted)	Percentage of adults in a county who consider themselves to be in poor or fair health. This measure is based on responses to the Behavioral Risk Factor Surveillance Survey (BRFSS) question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" The value reported in the County Health Rankings is the percentage of respondents who rated their health "fair" or "poor." Poor or Fair Health is age-adjusted. Prior to the 2016 County Health Rankings, the CDC's BRFSS provided the County Health Rankings with county-level estimates that were constructed from seven years of responses from participants who used a landline phone. However, even with multiple years of data, these did not provide reliable estimates for all counties, particularly those with smaller respondent samples. In 2016, the CDC began producing single-year estimates at the county level using a combination of BRFSS data and a multilevel modeling approach based on respondent answers and individual characteristics such as age, sex, and race/ethnicity, along with county-level poverty and county and state-level contextual effects. Poor or Fair Health estimates are created using statistical modeling.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Poor physical health days (avg number of unhealthy days in past 30 days, age-adjusted)	Average number of physically unhealthy days reported in past 30 days. This measure is based on responses to the Behavioral Risk	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County	2017

Measure	Description	Data Source	Most Recent Data Year(s)
	<p>Factor Surveillance System (BRFSS) question: “Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?”</p> <p>The value reported in the County Health Rankings is the average number of days a county’s adult respondents report that their physical health was not good. Poor Physical Health Days is age-adjusted.</p> <p>Prior to the 2016 County Health Rankings, the CDC’s BRFSS provided the County Health Rankings with county-level estimates that were constructed from seven years of responses from participants who used a landline phone. However, even with multiple years of data, these did not provide reliable estimates for all counties, particularly those with smaller respondent samples. In 2016, the CDC began producing single-year estimates at the county level using a combination of BRFSS data and a multilevel modeling approach based on respondent answers and individual characteristics such as age, sex, and race/ethnicity, along with county-level poverty and county and state-level contextual effects. Poor Physical Health Days estimates are created using statistical modeling.</p>	Health Rankings. Data accessed December 2020.	
Adult obesity (percent of adults that report a BMI \geq 30)	<p>Based on responses to the Behavioral Risk Factor Surveillance Survey (BRFSS) and is the percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m². Participants are asked to self-report their height and weight. From these reported values, BMIs for the participants are calculated. The method for calculating Adult Obesity changed. Data for Adult Obesity are provided by the CDC Interactive Diabetes Atlas which combines 3</p>	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016

Measure	Description	Data Source	Most Recent Data Year(s)
	years of survey data to provide county-level estimates. In 2011, BRFSS changed their methodology to include cell phone and landline participants. Previously only landlines were used to collect data. Adult Obesity is created using statistical modeling.		
Frequent physical distress	Percentage of adults who reported ≥ 14 days in response to the question, "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?"	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Diabetes prevalence	Prevalence of diagnosed diabetes in a given county. Respondents were considered to have diagnosed diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016
Insufficient Sleep	Percentage of adults who report fewer than 7 hours of sleep on average.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016
Adolescents who are obese	This indicator shows the percentage of adolescent public high school students who are obese.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2016
Sudden unexpected infant death rate	This indicator shows the rate of sudden unexpected infant deaths (SUIDs) per 1,000 live births. Sudden unexpected infant deaths (SUIDs) include deaths from Sudden Infant Death Syndrome (SIDS), unknown cause, accidental suffocation and strangulation in bed.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2013-2017
Adults who are not overweight or obese (percentage)	This indicator shows the percentage of adults who are not overweight or obese.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017

Measure	Description	Data Source	Most Recent Data Year(s)
Cancer mortality rate	This indicator shows the age-adjusted mortality rate from cancer (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2012-2016
Age-Adjusted Mortality Rate from Heart Disease	This indicator shows the age-adjusted mortality rate from heart disease (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2014-2017
Age-adjusted Death Rate due to Diabetes (per 100,000 population)	Age-adjusted Death Rate due to Diabetes (per 100,000 population).	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2019
Age-adjusted Death Rate due to Stroke (per 100,000 population)	Age-adjusted Death Rate due to Stroke (per 100,000 population).	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2019
Age-adjusted Death Rate due to Cancer (per 100,000 population)	Age-adjusted Death Rate due to Cancer (per 100,000 population).	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2019

Quality of Care

Measure	Description	Data Source	Most Recent Data Year(s)
Preventable hospital stays (rate for ambulatory sensitive conditions per 1,000 Medicare enrollees)	Hospital discharge rate for ambulatory care-sensitive conditions per 1,000 fee-for-service Medicare enrollees. That means it looks at people who were discharged from the hospital for conditions that, with appropriate care, can normally be treated without the need for a hospital stay. Examples of these conditions include convulsions, chronic obstructive pulmonary disease, bacterial pneumonia, asthma, congestive heart failure, hypertension, angina, cellulitis, diabetes, gastroenteritis, kidney/urinary infection, and	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017

Measure	Description	Data Source	Most Recent Data Year(s)
	dehydration. Preventable hospital stays are measured among fee-for-service Medicare enrollees and is age-adjusted.		
Mammography screening (percent of female Medicare enrollees)	Percentage of female Medicare enrollees ages 67-69 that received at least one mammogram during the last two years. The numerator is women ages 67-69 on Medicare who have received at least one mammogram during the past year. The denominator is all women ages 67-69 on Medicare in a specific geography.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Children and adults who are vaccinated annually against seasonal influenza	Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Children receiving blood lead screening	This indicator reflects the percentage of children (aged 12-35 months) enrolled in Medicaid (90+ days) screened for lead in their blood.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Children with elevated blood lead levels	Number of children (0-72 months old) with blood lead levels > 10 µg/dL divided by the Total Number of Children (0-72 months old) tested.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Early prenatal care	This indicator shows the percentage of pregnant women who receive prenatal care beginning in the first trimester.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017

Safety

Measure	Description	Data Source	Most Recent Data Year(s)
Violent crime rate per 100,000 population	Number of violent crimes reported per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between a victim and a perpetrator, including homicide, rape, robbery, and aggravated assault. Information for this measure comes from the FBI's Uniform Crime Reporting (UCR) Program. Crimes are counted where they are committed rather than based on the residence of people involved.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014, 2017
Injury mortality per 100,000 population	Number of deaths from planned (e.g., homicide or suicide) and unplanned (e.g., motor vehicle deaths) injuries per 100,000 population. This measure includes injuries from all causes and intents over a 5-year period. Deaths are counted in the county of residence for the person who died, rather than the county where the death occurred.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Motor vehicle crash deaths	Number of deaths due to traffic accidents involving a motor vehicle per 100,000 population. Motor vehicle crash deaths include traffic accidents involving motorcycles; 3-wheel motor vehicles; cars; vans; trucks; buses; street cars; ATVs; industrial, agricultural, and construction vehicles; and bicyclists or pedestrians when colliding with any of the previously listed motor vehicles. Deaths due to boating accidents and airline crashes are not included in this measure. In prior years, non-traffic motor vehicle accidents were included in this definition. ICD10 codes included are V02-V04 (.1, .9), V09.2, V12-V14 (.3-.9), V19 (.4-.6), V20-V28 (.3-.9), V29-V79 (.4-.9), V80 (.3-.5), V81.1, V82.1, V83-V86 (.0-.3), V87 (.0-.8), and V89.2.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2012-2018

BALTIMORE COUNTY 2020-2021 COMMUNITY HEALTH NEEDS ASSESSMENT

Measure	Description	Data Source	Most Recent Data Year(s)
Homicides	Number of deaths from assaults, defined as ICD-10 codes X85-Y09, per 100,000 population	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2012-2018
Firearm fatalities	Number of deaths due to firearms, defined as ICD-10 codes W32-W34, X72-X74, X93-X95, Y22-Y24, and Y35.0, per 100,000 population.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Juvenile arrests	Rate of delinquency cases per 1,000 juveniles.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Child maltreatment rate	This indicator shows the rate of children who are maltreated per 1,000 population under the age of 18.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Fall-related death rate	This indicator shows the rate of fall-related deaths per 100,000 population.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2014-2017
Pedestrian injury rate on public roads	This indicator shows the rate of pedestrian injuries on public roads per 100,000 population.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Domestic Violence	Number of domestic violence crimes divided by total population.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017

Sexual Health

Measure	Description	Data Source	Most Recent Data Year(s)
Sexually transmitted infections (chlamydia rate per 100,000)	Number of newly diagnosed chlamydia cases per 100,000 population	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Teen birth rate (per 1,000 females ages 15-19)	Number of births to females ages 15-19 per 1,000 females	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2012-2018
HIV prevalence	Number of diagnosed cases of HIV for persons aged 13 years and older in a county per 100,000 population.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016
HIV incidence rate	This indicator shows the rate of adult/adolescent cases (age 13+) diagnosed with HIV (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017

Substance Use Disorders

Measure	Description	Data Source	Most Recent Data Year(s)
Excessive drinking	Percentage of adults that report either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than one (women) or 2 (men) drinks per day on average. Please note that the methods for calculating this measure changed in the 2011 Rankings and again in the 2016 Rankings. Excessive Drinking estimates are created using statistical modeling.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Alcohol-impaired driving deaths	Percentage of motor vehicle crash deaths which had alcohol involvement. The National Highway Traffic Safety Administration defines a fatal crash as alcohol-related or	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County	2014-2018

BALTIMORE COUNTY 2020-2021 COMMUNITY HEALTH NEEDS ASSESSMENT

Measure	Description	Data Source	Most Recent Data Year(s)
	alcohol-involved if either a driver or a non-motorist (usually a pedestrian or bicyclist) had a measurable or estimated blood alcohol concentration of 0.01 grams per deciliter or above. Alcohol-Impaired Driving Deaths are measured in the county of occurrence.	Health Rankings. Data accessed December 2020.	
Drug overdose deaths	Number of deaths due to drug poisoning per 100,000 population. ICD-10 codes used include X40-X44, X60-X64, X85, and Y10-Y14. These codes cover accidental, intentional, and undetermined poisoning by and exposure to: 1) nonopioid analgesics, antipyretics and antirheumatics, 2) antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, 3) narcotics and psychodysleptics [hallucinogens], not elsewhere classified, 4) other drugs acting on the autonomic nervous system, and 5) other and unspecified drugs, medicaments and biological substances.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016-2018
Opioid prescriptions dispensed (per 100 persons)	Opioid prescriptions dispensed (per 100 persons).	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2018
Percentage of population impacted by fentanyl-related deaths	Percentage of population impacted by fentanyl-related deaths (Number of related deaths taken as a percentage of the total population).	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2018
Percentage of population impacted by heroin-related deaths	Percentage of population impacted by heroin-related deaths (Number of related deaths taken as a percentage of the total population).	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2018
Percentage of population impacted by opioid-related deaths	Percentage of population impacted by opioid-related deaths (Number of related deaths taken as a percentage of the total population).	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce	2018

Measure	Description	Data Source	Most Recent Data Year(s)
		Kickoff Meeting. Data accessed December 2020.	

Tobacco Use

Measure	Description	Data Source	Most Recent Data Year(s)
Adult smoking	Percentage of the adult population that currently smokes every day or most days and has smoked at least 100 cigarettes in their lifetime. Please note that the methods for calculating this measure changed in the 2016 Rankings. Adult Smoking estimates are created using statistical modeling.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Adolescents who use tobacco products	This indicator shows the percentage of adolescents (public high school students) who used any tobacco product in the last 30 days.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2016

Transportation Options and Transit

Measure	Description	Data Source	Most Recent Data Year(s)
Driving alone to work (percent of the workforce that drives alone to work)	Percentage of the workforce that usually drives alone to work. The numerator is the number of workers who commute alone to work via a car, truck, or van. The denominator is the total workforce.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Long commute/driving alone (among workers who commute in their car alone, the percentage that commute more than 30 minutes)	Percentage of workers who drive alone (via car, truck, or van) with a commute longer than 30 minutes. The numerator is the number of workers who drive alone for more than 30 minutes during their commute. The denominator is the number of workers who drive alone during their commute.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Traffic volume	Average traffic volume per meter of major roadways in the county.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2018

Complete Data by Focus Area

When viewing the existing data summary tables, please note that the following color shadings have been included to identify how Baltimore County compares to Maryland/the national benchmark.

Existing Data Summary Table Color Comparisons

Color Shading	Baltimore County Description
Green	Represents measures in which Baltimore County scores are more than five percent better than the most applicable target/benchmark and for which a low priority level was assigned.
Yellow	Represents measures in which Baltimore County scores are comparable to the most applicable target/benchmark scoring within or equal to five percent, and for which a medium priority level was assigned.
Red	Represents measures in which Baltimore County scores are more than five percent worse than the most applicable target/benchmark and for which a high priority level was assigned.

Note: Please see methodology section of this Appendix for more information on assigning need levels to the existing data.

Access to Care

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Uninsured (percent of population <65 without health insurance)	6.0%	7.0%	6.0%	2017	Trending in Correct Direction	-14.1%
Primary Care (ratio of population to primary care physicians - population per one provider)	1,030.0	1,140.0	990.0	2017	Trending in Wrong Direction	0.5%
Dentists (ratio of population to dentists - population per one dentist)	1,240.0	1,290.0	1,340.0	2018	Trending in Correct Direction	-0.6%
Uninsured adults (ages 18 to 64)	7.0%	8.0%	7.0%	2017	Trending in Correct Direction	-15.9%
Uninsured children (ages under 19)	3.0%	4.0%	3.0%	2017	Trending in Correct Direction	-12.0%
Other primary care providers (ratio of population to other primary care providers - population per one provider)	665.0	937.0	916.0	2019	Trending in Correct Direction	-9.3%
Children receiving dental care (ages 0 to 20)	NA	63.7	62.9	2017	Trending in Correct Direction	0.1%
ED visit rate due to addiction-related conditions	NA	2,017.0	1,689.0	2017	Trending in Correct Direction	-2.7%
ED visit rate due to asthma	NA	68.4	68.0	2017	Trending in Correct Direction	-4.8%
ED visit rate due to diabetes	NA	243.7	224.6	2017	Trending in Wrong Direction	12.8%
ED visit rate due to hypertension	NA	351.2	340.7	2017	Trending in Wrong Direction	11.1%
ED visit rate due to dental problems	NA	362.7	281.1	2017	Trending in Correct Direction	-45.6%

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Persons with a usual primary care provider	NA	83.2%	88.2%	2017	Trending in Correct Direction	2.2%
Uninsured ED visits	NA	8.6	7.9	2017	Trending in Correct Direction	-15.4%
Persons unable to afford physician visits	13.0%	11.0%	11.0%	2015	NA	NA

Built Environment

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Access to exercise opportunities (percent of the population with adequate access to locations for physical activity)	91.0%	93.0%	96.0%	2010, 2019	Trending in Correct Direction	0.0%
Food environment index (index of factors that contribute to a healthy food environment)	8.6	9.0	8.4	2015, 2017	Trending in Correct Direction	1.2%

Diet and Exercise

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Physical inactivity (percent of adults that report no leisure time physical activity)	20.0%	22.0%	24.0%	2016	Trending in Correct Direction	-1.0%
Physical Activity (percentage)	NA	50.6%	49.7%	2017	Trending in Correct Direction	0.7%

Education

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
High school graduation (percent of ninth grade cohort that graduates in four years)	96.0%	88.0%	89.0%	2016-2017	Trending in Correct Direction	2.1%
Some college (percent of adults aged 25-44 years with some post-secondary education)	73.0%	70.0%	70.0%	2014-2018	Trending in Correct Direction	0.0%
Students entering kindergarten ready to learn	NA	45.0%	47.0%	2017	Trending in Wrong Direction	-2.0%
Percentage of adults with a high school diploma or higher	90.0%	91.0%	91.0%	2014-2018	NA	NA
Percentage of adults with a bachelor's or more advanced degree	35.0%	40.0%	39.0%	2014-2018	NA	NA
Reading scores	3.4	3.1	3.1	2016	NA	NA
Math scores	3.4	3.0	3.1	2016	NA	NA

Employment

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Unemployment rate (percent of population age 16+ unemployed)	2.6%	3.9%	4.0%	2018	Trending in Correct Direction	-10.4%

Environmental Quality

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Air pollution (avg daily measure of fine particulate matter in micrograms per cubic meter)	6.1	9.6	10.9	2014	Trending in Correct Direction	-2.5%

Family, Community and Social Support

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Percent of children that live in single-parent household	20.0%	33.0%	34.0%	2014-2018	Trending in Correct Direction	-1.4%
Social associations	18.4	9.0	8.4	2017	Trending in Correct Direction	0.6%
Disconnected youth	4.0%	6.0%	5.0%	2014-2018	Trending in Correct Direction	-19.7%
Residential segregation - Black/White	23.0	62.0	58.0	2014-2018	Trending in Correct Direction	-0.8%
Residential segregation - non-White/White	14.0	55.0	50.0	2014-2018	Trending in Correct Direction	-1.0%
Percentage not proficient in English	NA	3.0P	2.0%	2014-2018	Trending in Wrong Direction	0.0%

Food Security

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Percentage of households experiencing food insecurity	9.0%	11.0%	11.0%	2017	Trending in Correct Direction	-4.1%
Percentage of households with children receiving public assistance or SNAP benefits	31.0%	12.0%	12.0%	2018	NA	NA
Percentage of households with children experiencing food insecurity	7.0%	16.0%	26.0%	2018	NA	NA
Limited access to healthy foods	2.0%	3.0%	3.0%	2015	Trending in Correct Direction	-3.1%
Children eligible for free or reduced-price lunch	32.0%	46.0%	49.0%	2017-2018	Trending in Wrong Direction	4.7%

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Food Insecurity Among Middle School Students: All races/ethnicities	NA	25.2%	28.5%	2018	NA	NA
Food Insecurity Among High School Students: All races/ethnicities	NA	28.0%	30.1%	2018	NA	NA

Housing and Homelessness

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Percentage of owner-occupied housing	81.0%	67.0%	66.0%	2014-2018	Trending in Wrong Direction	0.0%
Percentage of renters spending 50 percent or more on rent	7.0%	14.0%	14.0%	2014-2018	Trending in Correct Direction	-6.7%
Severe housing problems (percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities)	9.0%	16.0%	16.0%	2012-2016	Trending in Wrong Direction	0.0%
Affordable Housing (percent)	NA	48.1%	64.1%	2016	Trending in Wrong Direction	-0.4%

Income

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Children in poverty (percent of children under age 18 in poverty)	11.0%	12.0%	13.0%	2018	Trending in Wrong Direction	0.0%
Income Inequality	3.7	4.5	4.2	2014-2018	Trending in Wrong Direction	0.6%
Socioeconomics - Median HH Income	\$69,000.0	\$83,100.0	\$75,800.0	2018	Trending in Correct Direction	2.8%
Percentage of persons living in poverty	12.0%	9.0%	10.0%	2018	NA	NA
Household Income (\$, 000s) - All	\$60.0	\$81.9	\$49.0	2014-2015	NA	NA

Length of Life

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Life expectancy	81.1	79.1	78.1	2016-2018	Trending in Wrong Direction	-0.3%
Premature Death (years of potential life lost before age 75 per 100,000 population age-adjusted)	5400.0	7100.0	8100.0	2016-2018	Trending in Wrong Direction	4.5%
Child mortality	40.0	50.0	50.0	2015-2018	Trending in Wrong Direction	0.0%

Maternal and Infant Health

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Infant mortality	4.0	6.0	6.0	2012-2018	Trending in Correct Direction	-2.5%
Low birthweight (percent of live births with birthweight < 2500 grams)	6.0%	9.0%	9.0%	2012-2018	Trending in Wrong Direction	0.0%

Mental Health

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Mental health providers (ratio of population to mental health providers)	290.0	390.0	330.0	2019	Trending in Correct Direction	-7.5%
Poor mental health days (avg number in past 30 days age-adjusted)	3.4	3.8	3.8	2017	Trending in Wrong Direction	1.7%
ED visit rate due to mental health conditions	NA	4291.5	4210.1	2017	Trending in Wrong Direction	15.2%
Hospitalization rate due to Alzheimer's or other dementias	NA	515.5	559.0	2017	Trending in Correct Direction	-6.6%
Suicide Rate	NA	9.3	9.7	2014-2017	Trending in Correct Direction	-2.0%
Frequent mental distress	11.0%	12.0%	12.0%	2017	Trending in Wrong Direction	6.3%

Physical Health

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Adult obesity (percent of adults that report a BMI >= 30)	26.0%	31.0%	31.0%	2016	Trending in Wrong Direction	2.6%
Poor or fair health (percent of adults reporting fair or poor health age-adjusted)	12.0%	15.0%	14.0%	2017	Trending in Wrong Direction	0.0%
Poor physical health days (avg number of unhealthy days in past 30 days, age-adjusted)	3.1	3.4	3.2	2017	Trending in Correct Direction	-0.6%
Adults who are not overweight or obese (percentage)	NA	32.6%	31.9%	2017	Trending in Wrong Direction	-1.1%
Adolescents who are obese	NA	12.6	14.7	2016	Trending in Wrong Direction	2.7%

BALTIMORE COUNTY 2020-2021 COMMUNITY HEALTH NEEDS ASSESSMENT

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Sudden unexpected infant death rate	NA	0.5	0.5	2013-2017	Trending in Correct Direction	-4.5%
Age-adjusted Death Rate due to Diabetes (per 100,000 population)	21.0	20.0	8.0	2019	Trending in Correct Direction	-23.7%
Age-adjusted Death Rate due to Stroke (per 100,000 population)	37.0	40.0	45.0	2019	Trending in Correct Direction	-4.7%
Age-adjusted Death Rate due to Cancer (per 100,000 population)	149.0	155.0	168.0	2019	Trending in Wrong Direction	0.8%
Frequent physical distress	9.0%	10.0%	10.0%	2017	Trending in Wrong Direction	3.6%
Diabetes prevalence	7.0%	11.0%	11.0%	2016	Trending in Wrong Direction	2.4%
Insufficient sleep	27.0%	36.0%	34.0%	2016	Trending in Correct Direction	-5.4%
Cancer Mortality Rate	NA	154.5	167.8	2014-2017	Trending in Correct Direction	-0.1%
Age-Adjusted Mortality Rate from Heart Disease	NA	166.4	179.3	2014-2017	Trending in Wrong Direction	1.1%

Quality of Care

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Children and adults who are vaccinated annually against seasonal influenza	53.0%	50.0%	53.0%	2017	Trending in Correct Direction	3.9%
Mammography screening (percent of female Medicare enrollees)	50.0%	41.0%	45.0%	2017	Trending in Wrong Direction	-7.2%
Preventable hospital stays (rate for ambulatory sensitive conditions per 1,000 Medicare enrollees)	27.6	45.5	51.7	2017	Trending in Correct Direction	-0.6%
Children receiving blood lead screening	NA	65.7	69.4	2017	Trending in Correct Direction	0.5%
Children with elevated blood lead levels	NA	0.3	0.2	2017	Trending in Wrong Direction	0.0%
Early prenatal care	NA	69.6%	69.0%	2017	Trending in Correct Direction	1.0%

Safety

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Injury mortality per 100,000 population	58.0	76.0	95.0	2014-2018	Trending in Wrong Direction	8.9%
Violent crime rate per 100,000 population	63.0	459.0	511.0	2014, 2017	Trending in Correct Direction	-1.8%
Child maltreatment rate	NA	7.1	6.4	2017	Trending in Correct Direction	-6.8%
Domestic Violence	NA	537.1	1146.7	2017	Trending in Wrong Direction	9.9%
Fall-related death rate	NA	10.1	14.1	2014-2017	Trending in Wrong Direction	6.6%

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Pedestrian injury rate on public roads	NA	53.5	54.4	2017	Trending in Wrong Direction	4.5%
Motor vehicle crash deaths	9.0	9.0	8.0	2012-2018	Trending in Correct Direction	-2.3%
Homicides	2.0	8.0	7.0	2012-2018	Trending in Wrong Direction	3.1%
Firearm fatalities	8.0	11.0	11.0	2014-2018	Trending in Wrong Direction	6.9%
Juvenile arrests	NA	29.0	41.0	2017	NA	NA

Sexual Health

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Sexually transmitted infections (chlamydia rate per 100,000)	161.4	552.1	538.0	2017	Trending in Wrong Direction	10.3%
Teen birth rate (per 1,000 females ages 15-19)	13.0	17.0	14.0	2012-2018	Trending in Correct Direction	-9.5%
HIV incidence rate	NA	20.4	15.9	2017	Trending in Correct Direction	-3.1%
HIV prevalence	41.0	643.0	461.0	2016	Trending in Wrong Direction	0.4%

Substance Use Disorders

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Alcohol-impaired driving deaths (proportion of driving deaths with alcohol impairment)	11.0%	29.0%	26.0%	2014-2018	Trending in Correct Direction	-3.5%
Excessive drinking (percent of adults who report heavy or binge drinking)	13.0%	17.0%	17.0%	2017	Trending in Wrong Direction	1.2%
Opioid prescriptions dispensed (per 100 persons)	51.0	45.0	53.0	2018	NA	NA
Percentage of population impacted by fentanyl-related deaths	0.01%	0.03%	0.04%	2018	NA	NA
Percentage of population impacted by heroin-related deaths	0.01%	0.01%	0.01%	2018	NA	NA
Percentage of population impacted by opioid-related deaths	0.01%	0.04%	0.04%	2018	NA	NA
Drug overdose deaths	10.0	37.0	50.0	2016-2018	Trending in Wrong Direction	25.7%

Tobacco Use

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Adult smoking (percent of adults that report smoking \geq 100 cigarettes and currently smoking)	14.0%	14.0%	13.0%	2017	Trending in Correct Direction	-5.2%
Adolescents who use tobacco products	NA	14.4%	16.5%	2016	Trending in Correct Direction	-8.3%

Transportation Options and Transit

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Driving alone to work (percent of the workforce that drives alone to work)	72.0%	74.0%	79.0%	2014-2018	Trending in Wrong Direction	0.0%
Long commute/driving alone (among workers who commute in their car alone, the percentage that commute more than 30 minutes)	16.0%	50.0%	47.0%	2014-2018	Trending in Wrong Direction	1.1%
Traffic volume	NA	578.0	718.0	2018	NA	NA

APPENDIX 3 | DETAILED NEW (PRIMARY) DATA FINDINGS

New data were collected through focus groups, internet-based community surveys, and internet-based key community health leader surveys.

Methodologies

The methodologies varied based on the type of new data being analyzed. The following section describes the various methodologies used to analyze the new data.

Focus Groups

17 focus groups were conducted throughout the county with the following groups:

- Local Health Improvement Coalition
- Diabetes Prevention Program SJMC
- Behavioral Health Advisory Council
- Baltimore Hebrew Congregation Brotherhood
- Homeless Roundtable
- Chase Brexton LGBT Resource Center, FreeState Justice, PFLAG
- Court Appointed Special Advocates – Towson (CASA)
- Interfaith
- Mount Olive Baptist Church
- Veterans
- North East Towson Improvement Association
- Towson University – BCDA Age Friendly Survey
- Patient Family Advisory Council
- Homebound Clients
- Hispanic Cycle/Walking Group
- Community Input FSMC
- FSMC Telephone Town Hall

Responses to the following question were analyzed to identify the issues most important to participants at each focus group:

- What are the biggest problems facing this community?

Responses were then assigned to the 20 focus areas based on similarities and common themes. The following methodology was used to assign a need level to each response topic:

- If mentioned in 7 or more groups = High Need
- If mentioned in 4-6 groups = Medium Need
- If mentioned in 0-3 groups = Low Need

Focus Group Findings	
Focus Area	Health Need
Length of Life	Low Need
Maternal and Infant Health	Low Need
Mental Health	High Need
Physical Health	Low Need
Access to Care	High Need
Quality of Care	Low Need
Diet and Exercise	Low Need
Sexual Health	Low Need
Substance Use Disorders	Low Need
Tobacco Use	Low Need
Built Environment	High Need
Environmental Quality	Low Need
Housing and Homelessness	Low Need
Transportation Options and Transit	Low Need
Education	Low Need
Employment	Low Need
Family, Community, and Social Support	Low Need
Food Security	Low Need
Income	Low Need
Safety	Low Need

The feedback from the focus groups was diverse, but several key themes emerged, including:

Access to Care:

- Access to Care was mentioned in 11 of 17 focus groups, with high cost or lack of/insufficient insurance being the most frequent barriers to accessing care

Built Environment:

- Built Environment was identified by 9 of 17 focus groups as a community need, with accessible home modifications, AED availability, food delivery for seniors, offices where Spanish speaking translators are available, and more mentioned

Mental Health:

- Mental Health was identified by 7 of 17 focus groups as a community need, with depression, anxiety, and stress mentioned

Additional comments related to priority needs identified in this CHNA include:

Physical Health:

- Diabetes Prevention Program SJMC: Issues of lack of exercise, obesity, smoking/tobacco use
- Interfaith Council: More dental care needed for older adults
- FSMC Telephone Town Hall: Issue of chronic disease

Community Surveys

A total of 4,276 internet-based surveys were completed by individuals whose self-reported ZIP code is located within Baltimore County. Surveys were available in both English and Spanish. Paper versions of surveys were made available upon request.

Survey responses were assigned to the 20 focus areas based on similarities and common themes. The focus areas to which each statement/response option was assigned is denoted in bold parenthesis next to the statement/response. Focus areas that were mentioned most frequently were categorized as High Need, while focus areas that were mentioned least frequently were categorized as Low Need. For all questions, non-responses and responses of unsure/do not know were not factored into the assigned need level.

Responses to the following questions were analyzed to identify the issues most important to the respondents of the community survey:

- 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.* **(Mental Health)**
- What are the three most important health problems that affect the health of your community? *Please check only three.*
 - a. Alcohol/drug addiction **(Substance Use Disorders)**
 - a. Alzheimer’s/dementia **(Mental Health)**
 - b. Mental health (depression, anxiety) **(Mental Health)**
 - c. Cancer **(Physical Health)**
 - d. Diabetes/high blood sugar **(Physical Health)**
 - e. Heart disease/blood pressure **(Physical Health)**
 - f. HIV/AIDS **(Sexual Health)**
 - g. Infant death **(Maternal and Infant Health)**
 - h. Lung disease/asthma/COPD **(Physical Health)**
 - i. Stroke **(Physical Health)**
 - j. Smoking/tobacco use **(Tobacco Use)**
 - k. Overweight/obesity **(Physical Health)**
 - l. Don’t know
 - m. Prefer not to answer

- What are the three most important social/environmental problems that affect the health of your community? *Please check only three.*
 - a. Availability/access to doctor's office (**Access to Care**)
 - b. Child abuse/neglect (**Safety**)
 - c. Availability/access to insurance (**Access to Care**)
 - d. Lack of affordable child care (**Family, community, and social support**)
 - e. Domestic violence (**Safety**)
 - f. Housing/homelessness (**Housing and Homelessness**)
 - g. Limited access to healthy foods (**Food security**)
 - h. Neighborhood safety/violence (**Safety**)
 - i. School dropout/poor schools (**Education**)
 - j. Poverty (**Income**)
 - k. Lack of job opportunities (**Employment**)
 - l. Limited places to exercise (**Diet and Exercise**)
 - m. Race/ethnicity discrimination (**Family, community, and social support**)
 - n. Transportation problems (**Transportation Options and Transit**)
 - o. Don't know
 - p. Prefer not to answer

- What are the three most important reasons people in your community do not get healthcare? *Please check only three.* (**Access to Care**)
 - a. Cost – too expensive/can't pay
 - b. No Insurance
 - c. Insurance not accepted
 - d. Lack of transportation
 - e. Cultural/religious beliefs
 - f. Language barrier
 - g. No doctor nearby
 - h. Wait is too long
 - i. Don't know
 - j. Prefer not to answer

- Do you have the ability to find healthy foods around where you live? (**Food Security**)

- Do you have access to a dentist or dental services? (**Access to Care**)

Community Survey Findings	
Focus Area	Health Need
Length of Life	Low Need
Maternal and Infant Health	Low Need
Mental Health	Medium Need
Physical Health	High Need
Access to Care	High Need
Quality of Care	Low Need
Diet and Exercise	Medium Need
Sexual Health	Low Need
Substance Use Disorders	High Need
Tobacco Use	Low Need
Built Environment	Medium Need
Environmental Quality	Low Need
Housing and Homelessness	Medium Need
Transportation Options and Transit	Low Need
Education	Low Need
Employment	Low Need
Family, Community, and Social Support	High Need
Food Security	Low Need
Income	Low Need
Safety	High Need

Several key themes emerged, including:

Physical Health:

- 48 percent of respondents identify heart disease/blood pressure as an important health problem that impacts the community
- 34 percent of respondents identify diabetes/high blood sugar as an important health problem that impacts the community

Substance Use Disorders:

- 46 percent of respondents identify alcohol/drug addiction as an important health problem that affects the community

Family, Community, and Social Support:

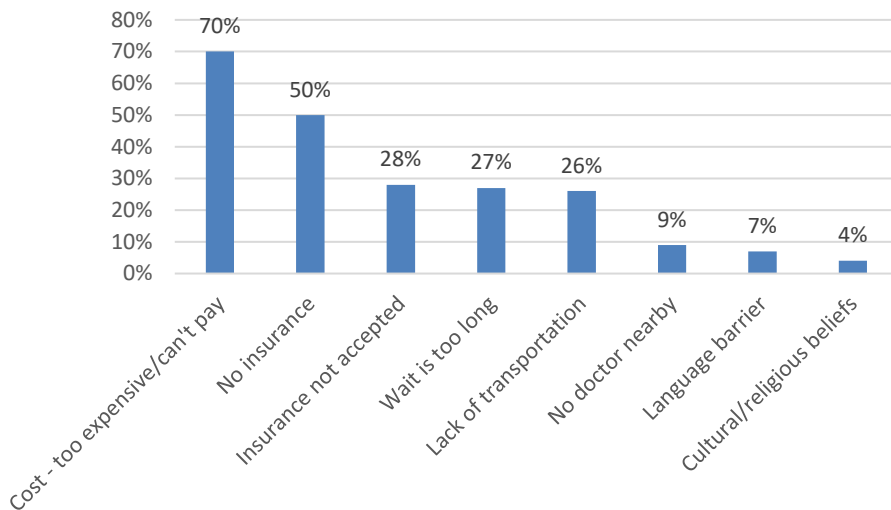
- 15 percent of community survey respondents listed lack of affordable childcare as one of the three most important social/environmental problems affecting the community

Safety:

- 22 percent of respondents identify neighborhood safety/violence as an important social/environmental problem that impacts the community
- 7 percent of respondents identify domestic violence as an important social/environmental problem that impacts the community
- 5 percent of respondents identify child abuse/neglect as an important social/environmental problem that impacts the community

Access to Care

- Most important reasons people don't get healthcare, by percent of respondents:



Additional comments related to priority needs identified in this CHNA include:

Mental Health:

- 40 percent of respondents believe mental health is an important health problem in their community
- 18 percent of respondents experienced 11 or more poor mental health days in the past month
- 32 percent of respondents experienced 6 or more poor mental health days in the past month

Built Environment:

- 11 percent of respondents identify limited places to exercise as an important social/environmental problem that impacts the community
- 14 percent of respondents identify limited access to healthy foods as an important social/environmental problem that impacts the community

Food Security:

- 14 percent of respondents identify limited access to healthy foods as an important social/environmental problem that impacts the community

Income:

- 70 percent of respondents identify cost as one of the most important reasons people don't receive healthcare
- 18 percent of respondents identify poverty as an important social/environmental problem that affects the health of the community

Transportation Options and Transit:

- 26 percent of respondents listed lack of transportation as an important reason people don't receive healthcare
- 15 percent of respondents listed transportation problems as an important social/environmental problem that impacts the community

Key Community Health Leader Surveys

45 key community health leaders representing the following organizations were surveyed:

- Arbutus United Methodist Church (1)
- Baltimore County Department of Aging (4)
- Baltimore County Department of Health (4)
- Baltimore County Department of Social Services (1)
- Baltimore County Government (1)
- Baltimore County Head Start (1)
- Baltimore County Health and Human Services (2)
- Baltimore County Local Management Board (1)
- Baltimore County Police Department (1)
- Baltimore County Public Library (1)
- Baltimore County Public Schools (3)
- Chase Brexton (2)
- Chase United Methodist Church (1)
- Christus Victor Lutheran Church (1)
- DABS Consulting, LLC (1)
- GBMC HealthCare (2)
- Jewish Community Services (1)
- Johns Hopkins Bayview Medical Center (1)
- Knollwood Association (1)
- Lansdowne Alliance Church (1)
- Loch Raven High School (1)
- Maryland Department of Health (1)
- Meals on Wheels of Central Maryland (1)
- MedStar Franklin Square Medical Center (1)
- New Psalmist Baptist Church (1)
- Sheppard Pratt (1)
- St. Michael Lutheran Church (1)
- The League for People with Disabilities (1)
- The Tabernacle at GBT (1)

- Towson University (2)
- University of Maryland – St. Joseph Medical Center (3)

Survey responses were assigned to the 20 focus areas based on similarities and common themes. The focus areas to which each question/response option was assigned is denoted in bold parenthesis next to the question/response. In instances of open-ended questions, frequently used key words and phrases were used to identify commonly mentioned focus areas. In order to assign a need level to each response topic, the following methodology was used to score the issues mentioned as areas of need:

- If mentioned in 32 or more responses = High Need
- If mentioned in 16-31 responses = Medium Need
- If mentioned in 0-15 responses = Low Need

Responses to the following questions were analyzed to identify the issues most important to the respondents of the key community health leader survey:

- How do you believe the health of your community has changed over the past 3 years?
- From the list provided, please select the top five community health needs of Baltimore County.
 - Access to Care (**Access to Care**)
 - Cancer (**Physical Health**)
 - Dental Health (**Physical Health**)
 - Diabetes (**Physical Health**)
 - Heart Disease and Stroke (**Physical Health**)
 - Maternal/Infant Health (**Maternal and Infant Health**)
 - Mental Health/Suicide (**Mental Health**)
 - Primary and Preventive Healthcare (**Physical Health**)
 - Obesity (**Physical Health**)
 - Sexually Transmitted Disease (**Sexual Health**)
 - Substance Use/Alcohol Use (**Substance Use Disorders**)
 - Tobacco and Electronic Smoking Devices (**Tobacco Use**)
 - Housing (**Housing and Homelessness**)
 - Uninsured (**Access to Care**)
 - Other
- What are the most significant barriers that keep people in the community from accessing healthcare when they need it? Choose all that apply
 - Availability of providers/ appointments
 - Basic needs not met (food/shelter) (**Food Security**)
 - Inability to navigate healthcare system
 - Inability to pay out of pocket expenses (co pays, prescriptions)
 - Lack of child care
 - Lack of health insurance coverage
 - Lack of transportation (**Transportation Options and Transit**)
 - Lack of trust
 - Language/cultural barriers

- j. Time limitations
- k. None/no barriers

- What is missing or represents a gap in your community for its residents?
- What challenges do older adults face in your community?
- In terms of places to get regular exercise, are there enough in your community? (**Built Environment**)

Key Community Health Leader Survey Findings	
Focus Area	Health Need
Length of Life	Low Need
Maternal and Infant Health	Low Need
Mental Health	High Need
Physical Health	High Need
Access to Care	High Need
Quality of Care	Low Need
Diet and Exercise	Medium Need
Sexual Health	Low Need
Substance Use Disorders	Medium Need
Tobacco Use	Low Need
Built Environment	Medium Need
Environmental Quality	Low Need
Housing and Homelessness	High Need
Transportation Options and Transit	High Need
Education	Low Need
Employment	Low Need
Family, Community, and Social Support	Low Need
Food Security	Medium Need
Income	Low Need
Safety	Low Need

Several key themes emerged, including:

Mental Health:

- 78 percent of respondents listed mental health as a community health need

Physical Health:

- 63 percent of respondents identify Diabetes, Obesity, or Heart Disease as a community health need

Access to Care:

- 59 percent of respondents listed access to care as a community health need

Housing and Homelessness:

- 43 percent of respondents listed housing as one of the top five health needs in the community

Transportation Options and Transit:

- 70 percent of respondents listed lack of transportation as a significant barrier keeping people in the community from accessing healthcare when they need it

Additional comments related to priority needs identified in this CHNA include:

Substance Use Disorders:

- 61 percent of respondents identify Substance/Alcohol Abuse as a community health need
- 54 percent of respondents strongly disagree with the following statement: “There are enough substance use treatment providers”
- 30 percent of respondents somewhat disagree to the above statement

Food Security:

- 52 percent of respondents believe their communities basic needs (food/shelter) not being met are a barrier to accessing healthcare services

Built Environment:

- 44 percent of respondents said there weren’t enough places to get regular exercise in the community

Income:

- 13 percent of respondents noted that low-income populations were not being adequately served by local health services

IMPLEMENTATION PLAN – PRIORITY AREAS**Priority Area #1 – Health Disparities**

Overarching Goal: Reduce barriers related to accessing care by increasing resources, targeting racial and geographic disparities by focusing on social determinants of health. (Address root causes of other priority areas)

Focus Area #1 – Address social determinants of health (SDOH), with a focus on food insecurity.

Actions	Responsible Parties/ Partners	Timeline	Metrics for Success	Status
Expand social determinants of health resources <ul style="list-style-type: none"> Integrate Aunt Bertha community referrals with GBMC's electronic health record 	Adam Conway D'Ambra Anderson EPIC Team Marketing	3-year CHNA Cycle	<ul style="list-style-type: none"> Creation of GBMC community site Integration of Aunt Bertha into EHR Number of organizations for referral Number of referrals closed Number of Care Team members trained on referral system 	Initial program plan has been drafted and key roles have been identified
Partner with food service providers (e.g. Moveable Feast, BMore Community Food) to address food insecurity for high risk patients and communities.	Rhandi Morgan D'Ambra Anderson Diane Sancilio	3-year CHNA Cycle	<ul style="list-style-type: none"> Number of patients referred Number of meals delivered Pounds of food provided to communities Pre-/post- utilization changes Change in a1C, BMI, and blood pressure Client satisfaction survey Health outcomes tool (in process of being implemented by Moveable Feast) Medical nutrition survey 	MOU with Moveable Feast complete. Piloting phase 2 of the program for diabetic patients at practices with highest rates of food insecurity, Elder Medical Care, and Complex Care.
Partner with organizations that improve the quality of life of Baltimore County/	Karen Thompkins	3-year CHNA Cycle	MVLS Housing Stabilization/Aging in Place Initiative	MVLS MOU executed December 2021.

<p>City residents through initiatives that address the social determinants of health.</p> <ul style="list-style-type: none"> Maryland Volunteer Lawyers Services (MVLS) MOU 			<ul style="list-style-type: none"> Number of residents reached via door knocking Number of community events Number of participants in community events Resources distributed Number of residents participating in city/state homeowner assistance and repair programs 	
<p>Expand SDOH screenings throughout the GBMC system (e.g. pediatric practices)</p>	<p>GBMC Practice Managers (e.g. Harold Kuwazi) and EPIC Team (Jessica Swank)</p>	<p>3-year CHNA Cycle</p>	<ul style="list-style-type: none"> Patients receiving screening Number of connections to resources Adolescent obesity Tobacco screening 	<p>Workflows and screenings are in place for primary care practices.</p>
<p>Identify opportunities to partner with the Baltimore County CHNA Collaborative to address health disparities.</p>	<p>Adam Conway, Baltimore County CHNA health system leads</p>	<p>3-year CHNA Cycle</p>	<p>Identify at least 1 health system for partnership and resource sharing.</p>	

Focus Area #2 – Expand access to care for underserved and low-income populations for Baltimore County and surrounding areas.

Actions	Responsible Parties/ Partners	Timeline	Metrics for Success	Status
<p>Conduct meetings of providers in the Baltimore County CHNA Collaborative to discuss barriers to care and initiatives and resources reaching underserved populations.</p>	<p>Adam Conway CHNA health system leads</p>	<p>3-year CHNA Cycle</p>	<ul style="list-style-type: none"> Number of meetings held Number of new partnerships to address barriers identified 	<p>CHNA health system leads have been identified.</p>

Expand reach of GBMC’s Helping Up Mission practice and Stadium Place	Ericka Easley	3-year CHNA Cycle	<ul style="list-style-type: none"> • Number of new patients per month • Ratio of HUM residents to community patients • Increase services for Stadium Place patients served for EOL and Serious Illness by 10% 	Epic report has been built for monitoring HUM resident patients.
Provide free community health screening events to residents in underserved areas.	Dr. Collins Ericka Easley D’Ambra Anderson	3-year CHNA Cycle	<ul style="list-style-type: none"> • Number of patients served • Number of patients connected to medical services • Participants in community events • Number of resources shared 	Piloting hearing and vision screenings at HUM practice.

Priority Area #2 – Behavioral Health (Mental Health and Substance Use Disorder)

Overarching Goal: Increase access to behavioral health resources in the community by removing barriers and supporting regional initiatives.

Focus Area #1 – Expand access to mental health services (and reduce barriers) for patients experiencing routine and crisis mental health needs.

Actions	Responsible Parties/ Partners	Timeline	Measures/Outcomes	Status
Support Greater Baltimore Regional Integrated Crisis System (GBRICS) Implementation <ul style="list-style-type: none"> • Educate GBMC system on GBRICS objectives and program components • Provide status reports on key deliverables • Conduct community-wide educational campaign 	Karen Thompkins D’Ambra Anderson Dr. Robin Motter-Mast	CHNA 3-Year Cycle	<ul style="list-style-type: none"> • # of committees joined • Marketing outreach metrics • Status reports to GBMC leadership 	Currently member of the Community Engagement Committee and attending GBRICS Council.

<p>Expand opportunities for integrated behavioral health care</p> <ul style="list-style-type: none"> • Conduct test pilots to identify strategies to improve access to mental health services (2 Medicaid pilots, Jarrettsville specialty practice) 	<p>Rachel Smolowitz</p>	<p>CHNA 3-year Cycle</p>	<ul style="list-style-type: none"> • Patients/practices served by CoCM program • Change in PHQ-9 and GAD-7 scores (are they getting better) • Number of patients enrolled in pilot program • Summary of lessons learned 	<p>Priority Partners (in development) has approved CoCM pilot for select practices.</p>
<p>Advocate for expansion of CoCM services and coverage in Maryland.</p>	<p>Rachel Smolowitz Adam Conway Tommy Glenn</p>	<p>CHNA 3-year Cycle</p>	<ul style="list-style-type: none"> • Number of meetings with stakeholders • Number of payers covering CoCM codes. • Number of CoCM providers in MD 	<p>Met with advocates for Medicaid coverage</p>
<p>Train Care Coordinators on how to deliver CoCM to expand access and reduce stigma (those with Bachelor’s degrees are able to provide collaborative care).</p>	<p>Rhandi Morgan Rachel Smolowitz</p>	<p>CHNA 3-year Cycle</p>	<ul style="list-style-type: none"> • Number of staff trained 	
<p>Identify opportunities to partner with the Baltimore County CHNA Collaborative to increase access to behavioral and mental health services.</p>	<p>Adam Conway Karen Thompkins</p>	<p>CHNA 3-Year Cycle</p>	<ul style="list-style-type: none"> • Identify at least 1 health system for partnership and resource sharing. • # of partnership meetings or initiatives completed 	

Focus Area #2 – Promote early detection of substance use disorder and reduce overdoses due to opioids and other drugs

Actions	Responsible Parties/ Partners	Timeline	Measures/Outcomes	Status
Develop or enhance prescription drug monitoring programs (PDMP) throughout the GBMC system.	Dr. Joseph Fuscaldo	CHNA 3-Year Cycle	<ul style="list-style-type: none"> • Reduce the amount of Rx drugs prescribed (7-day max e-prescribe vs. 30-day) • PDMP policies and practices created or updated • # of providers or educational sessions held on PDMP policies/practices 	
Create education and communication campaign for Prescription Drug Takeback Day to facilitate safe disposal of drugs and educate the community on signs and resources for medication abuse.	Karen Thompkins Kimberly Davenport	CHNA 3-Year Cycle	<ul style="list-style-type: none"> • # of community members reached • # of medications safely disposed • # planning meetings 	GBMC convening Baltimore County partners to plan for April 2022 Drug Takeback
Improve and expand SBIRT within GBMC system and county-wide <ul style="list-style-type: none"> • Reassess SBIRT workflows and reeducate staff across care continuum. • Expand SBIRT referral to treatment options by partnering with the Baltimore County CHNA Collaborative. 	Dr. Karin Mirkin Mosaic Rachel Smolowitz Karen Thompkins	CHNA 3-Year Cycle	<ul style="list-style-type: none"> • # of positive screens • # of brief interventions • # of referrals to treatment • # of referral partners 	Reassessment and re-education has occurred by Mosaic

Priority Area #3 – Physical Health

Overarching Goal: Create an environment that expands access to healthier resources to reduce heart disease, obesity, and diabetes risk factors.

Focus Area #1 – Develop health engineering strategies that guide patients, staff, and community members to make healthier choices.

Actions	Responsible Parties/ Partners	Timeline	Measures/Outcomes	Status
<p>Provide patients, staff, and community members with more access to healthy foods.</p> <ul style="list-style-type: none"> Partner with organizations (Hungry Harvest, BMore Community Food, Moveable Feast) that provide healthy and affordable foods. Sponsor events that create opportunities to distribute healthy foods. 	<p>Karen Thompkins D’Ambra Anderson Diane Sancilio</p>	<p>CHNA 3-Year Cycle</p>	<ul style="list-style-type: none"> Number/pounds of produce items distributed Number of customers Customer satisfaction surveys 	<p>Successful pilot in fall 2020with Hungry Harvest. Expand beyond GBMC’s campus to primary care practices.</p> <p>BMore Community Food and Moveable Feast are being tracked under health disparities implementation.</p>
<p>Improve the built environment at GBMC (and surrounding communities) to promote physical activity and social interaction.</p> <ul style="list-style-type: none"> Create signage to identify safe walking routes, trails, and distance. Create a regional map (GBMC, Towson University, St. Joseph, Sheppard Pratt) to identify walking routes and trails Promote and educate opportunities for physical activity 	<p>Grounds Managers of GBMC, Towson University, St. Joseph, and Sheppard Pratt</p> <p>Director of Community Partnerships</p> <p>Marketing Departments of GBMC, Towson, St. Joseph, Sheppard Pratt</p>	<p>CHNA 3-Year Cycle</p>	<ul style="list-style-type: none"> Regional map of walking routes and trails. Marketing analytics Number of events held on campuses to promote physical activity Number of individuals using routes/trails Community surveys 	<p>GBMC campus has safe sidewalks, but no signage for mileage, encouragement of physical activity on campus, etc.</p> <p>Preliminary meetings with adjacent organizations were held to confirm their interest in a joint effort to improve the built environment in the Towson community.</p>

utilizing various marketing strategies.				
Expand healthy vending machines on GBMC campus to reach more patients, staff, and physicians.	Adam Conway D'Ambra Anderson	CHNA 3-Year Cycle	<ul style="list-style-type: none"> # of vending machines # of healthy items added 	Health vending machine has been implemented, but not across campus.
Identify opportunities to partner with the Baltimore County CHNA Collaborative to address physical health.	Adam Conway, Baltimore County CHNA health system leads	CHNA 3-Year Cycle	<ul style="list-style-type: none"> Identify at least 1 health system for partnership and resource sharing. 	

Focus Area #2 – Provide patients and community members with tools to prevent and manage diabetes, heart disease, and obesity risk factors.

Actions	Responsible Parties/ Partners	Timeline	Measures/Outcomes	Status
Develop program to address patients at high risk for obesity, diabetes, and heart disease. <ul style="list-style-type: none"> Implementation of the Community Health Resources Commission (CHRC) Pathways to Health Equity Grant in Baltimore City Conduct community wide initiative for early detection of diabetes with deployment of diabetes risk test. Provide access to the online CDC Pre-Diabetes Risk Assessment 	Karen Thompkins Erlene Washington Marketing	CHNA 3-Year Cycle	<ul style="list-style-type: none"> Number of patients enrolled in program Changes in a1C, blood pressure, and BMI. Completed risk assessments 	GBMC has been awarded CHRC grant in February 2022.

GBMC Financial Assistance Policy

POLICY STATEMENT

This policy applies to Greater Baltimore Medical Center, Inc., its division, GBMC Health Partners, and certain affiliates (collectively “GBMC”). GBMC is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation.

All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent/urgent services, applications for financial assistance will be completed and evaluated retrospectively and will not delay a patient from receiving care.

GBMC patients, depending on their financial condition and subject to the criteria in this policy, may be eligible to receive medical assistance (Medicaid), full or partial financial assistance, or extended payment plans. To be consistent in the provision of financial assistance with all members of the community, GBMC applies definitive criteria, outlined herein, when making determinations of full or partial financial assistance.

This policy covers all hospital facility services and services provided by GBMC physician practices/practice groups delivering emergent or medically necessary care. This policy does not cover emergent or medically necessary care provided by non-employed providers with privileges at GBMC. **Exhibit A** lists all providers who may provide care to a patient at GBMC and indicates whether such provider is employed by GBMC. Non-employed providers bill separately for their services and should be directly contacted regarding any financial assistance options.

An individual who is eligible for full or partial assistance under this policy for emergency or other medically necessary care will never be charged more than the amounts generally billed (AGB) to an individual who is not eligible for assistance.

GBMC will give notice of its Financial Assistance Policy by providing access on its website and patient portal; providing notice of the policy in a newspaper with circulation in GBMC's service area on an annual basis; providing hard copies upon request and by mail free of charge; by providing notice and information about the policy as part of the pre-admission, registration, and discharge processes; providing notice and information on billing statements; and, by displaying information about the policy at the Billing Office and all hospital registration points, which includes the Emergency Department. English and Spanish versions of the Financial Assistance Policy and related documents will be made available in all locations and on the hospital website. Also, upon request, GBMC will translate the policy into all other primary languages of all significant patient populations in the community with limited English proficiency.

DEFINITIONS

- A. Eligible Services: Medically necessary services, as defined below, may be eligible for financial assistance. Services that are not medically necessary are not eligible for financial assistance. Services for patients who incur additional out-of-pocket expenses, in compliance

GBMC Financial Assistance Policy

with the federal No Surprises Act, by intentionally going out of their health insurance network, as specified by their insurance carrier, are not eligible for consideration.

- B. Family Income: means the gross income of an individual and all of their Household Members, including, without limitation, compensation for services (wages, salaries, commissions, etc.), interest, dividends, royalties, capital gains, annuities, pension, retirement income, Social Security, public or government assistance, rents, alimony, child support, business income, income from estates or trusts, survivor benefits, income from life insurance or endowment contracts, and any other gross income or remuneration, from whatever source derived, all on a pre-tax basis.
- C. Household Member: means an individual residing in the same household as the patient who:
 - A. For a patient who is an adult, is a spouse, regardless of whether the patient and spouse expect to file a joint federal or State tax return; biological child, adopted child, or stepchild; and anyone for whom the patient claims a personal exemption in a federal or State tax return.
 - B. For a patient who is a child, is a biological parent, adoptive parent, stepparent, or guardian; biological sibling, adopted sibling, or stepsibling; and anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.
- D. Liquid Assets: Cash, securities, promissory notes, stocks, bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property easily convertible to cash. A safe harbor of \$150,000 in equity in a patient's primary residence shall not be considered an asset convertible to cash. Equity in other real property shall be subject to liquidation. Liquid Assets do not include retirement assets to which the IRS has granted preferential tax treatment. Liquid Assets do not include the first \$15,000 of monetary assets.
- E. Medically Necessary Services: Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of condition(s) that endanger life, cause suffering or pain, resulting in illness or infirmity, threatening to cause or aggravate a handicap, or cause physical deformity or malfunction.

PROCEDURES FOR STANDARD WORK

TWO-STEP ELIGIBILITY PROCESS

Eligibility for full or partial financial assistance involves a two-step process. A patient or a patient's representative may seek and obtain a determination of probable eligibility before receiving a final determination of eligibility. The determination of probable eligibility is a prediction of eligibility for full or partial final assistance. To obtain full or partial financial assistance, a patient or patient representative must seek and obtain a final determination of eligibility.

A. STEP ONE: DETERMINATION OF PROBABLE ELIGIBILITY

GBMC Financial Assistance Policy

1. Following a patient's or a patient representative's request for financial assistance, application for medical assistance, or both, GBMC will render and communicate to the patient or patient representative a determination of probable eligibility within two (2) business days.
2. To obtain a determination of probable eligibility of financial assistance, a patient or patient representative may:
 - a. complete and submit a Request for Determination of Probable Eligibility (**Exhibit B**); or
 - b. call and speak with a GBMC Financial Assistance representative at 443-849-2450.
3. Final determinations of eligibility will be based on all criteria and requirements set forth in this policy.

B. STEP TWO: FINAL DETERMINATION OF ELIGIBILITY

1. Application Requirements for Final Determination of Eligibility.
 - a. Self-pay patients who are scheduled for non-emergency surgery must complete a financial assistance application prior to the scheduled procedure or be required to pay a deposit prior to the surgery.
 - b. Patients meeting eligibility criteria for medical assistance (Medicaid) must apply and be determined ineligible prior to GBMC's final financial assistance determination.
 - c. Patients or patient representatives seeking full or partial financial assistance must submit a Maryland Uniform Financial Assistance Application (**Exhibit C**) and all of the applicable documentation listed on the financial assistance application letter (**Exhibit D**) or otherwise requested by GBMC that applies to the patient and other adult members of the household.
2. Procedures for Final Determination of Eligibility
 - a. To qualify for full or partial financial assistance, a patient must supply all requested documentation and proof. Failure to supply requested information or documentation within 240 days (approximately 8 months) after receipt of the initial bill may be found ineligible for financial assistance.
 - b. Each patient must agree to a credit bureau report as a condition of consideration for financial assistance.
 - c. GBMC will communicate final determinations of eligibility for full or partial financial assistance in writing, directed to the address identified in the patient's Maryland Uniform Financial Assistance Application. If a patient is approved for financial assistance or a payment plan, he/she will receive a financial assistance award letter. If a patient is denied financial assistance, he/she will receive a denial letter.

GBMC Financial Assistance Policy

- d. Patients have the right to request an appeal of any denial by responding to the denial letter within fifteen (15) days of the date of the denial letter. Appeals will be reviewed by the Executive Director of Revenue Cycle Management, who will review the documentation submitted and make a determination based on this policy's criteria. The Executive Director of Revenue Cycle Management's decision is final, and patients who appeal an initial determination will receive a final appeal determination letter at least thirty days prior to any additional collection efforts.
- e. Upon denial, patients have the right to request assistance from the Maryland Health Education and Advocacy Unit (HEAU) in filing and mediation of a reconsideration request. Requests for assistance should be directed to:

Health Education and Advocacy Unit
200 St. Paul Place
Baltimore, MD 21202
Email: heau@aog.state.md.us
Phone: (410) 528-1840 or 1 (877) 261-8807
FAX: (410) 576-6571
<https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx>
- f. Financial assistance awards apply to all open accounts at the time of the financial assistance award and are valid for six months from the date of the financial assistance award for non-Medicare patients and for one year for Medicare patients.

C. FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA

1. For each patient, the percentage of the current Federal Poverty Level ("FPL") will be calculated, based on modified adjust gross income, as defined in the Federal Poverty Guidelines, and family size.
2. For patients with family income at or below 300% of the FPL, GBMC will provide 100% financial assistance for Eligible Services.
3. For patients with family income between 301%-500% of the FPL, GBMC will provide 50% financial assistance for Eligible Services.
4. For patient's 501% FPL, financial assistance will not be provided by GBMC, but a patient may request an income-based payment plan.
5. A patient may be found ineligible for financial assistance under this Section if the Patient is deemed to have sufficient assets to pay pursuant to an "Asset Test." GBMC will look at a patient's Liquid Assets, as defined above, and if such assets, combined with family income, exceeds 500% of the FPL, a patient will not be eligible for financial assistance.

D. EXCLUSION CRITERIA

The following patients are not eligible for financial assistance:

1. Uninsured and under-insured patients who do not meet the financial assistance criteria.

GBMC Financial Assistance Policy

2. Patients who have insurance and chose self-pay for Eligible Services.
3. Patients seeking assistance for charges incurred for services that are not medically necessary.
4. Patients who are non-compliant with enrollment for publicly funded healthcare programs, charity care programs and other forms of financial assistance.
5. Patients who fail to provide accurate and complete financial information within 240 days (approximately 8 months) after receipt of the initial bill.

E. PRESUMPTIVE FINANCIAL ASSISTANCE:

1. In addition to the procedures described above, Presumptive Financial Assistance is an alternative method for obtaining financial assistance. It is a program run in partnership with an established credit reporting agency. Self-pay accounts for Maryland residents are referred to the agency, which utilizes a proprietary credit scoring system to determine the likelihood and ability to pay based on estimated income and family size. The results from the credit score are compared to GBMC's Financial Assistance eligibility criteria and a decision is made to write off or to pursue collection on certain accounts.
2. Presumptive Eligibility Based on Enrollment in Means-Tested Program: Patients enrolled in the following means-tested programs are deemed eligible for free care on a specific date of service. Patients are required to submit proof of enrollment within thirty (30) days of eligibility determination.
 - a. Household Members - enrolled in the free and reduced-cost meal program;
 - b. Enrolled in the federal Supplemental Nutrition Assistance Program (SNAP);
 - c. Enrolled in State's Energy Assistance Program;
 - d. Enrolled in Women, Infants, and Children (WIC);
 - e. Enrolled in other social service program as determined by the Maryland Department of Health and the Health Services Cost Review Commission (HSCRC).

- F. **COLLECTION EFFORTS:** The billing cycle will initiate fifteen 15 days after date of the denial letter. Three (3) billings statements are sent in 28-day intervals in attempt to collect the outstanding amounts. If there is no collection or payment arrangements made, the outstanding amounts are sent to a collection agency. If a patient files for bankruptcy during the financial assistance application process, award period, or during any collection efforts, the patient should provide written notification from the U.S. Bankruptcy Court to the GBMC Collection Manager. GBMC does not report delinquent accounts to any credit bureaus.