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?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: UM St. Joseph Medical Center	◉	○	
Your hospital's ID is: 210063	◉	○	
Your hospital is part of the hospital system called University of Maryland Medical Center	○	◉	University of Maryland Medical System
The primary hospital community benefit (HCB) Narrative contact at your hospital is Erin Selby	○	◉	Jill Brown Hong
The primary HCB Narrative contact email address at your hospital is erinselby@umm.edu	○	◉	Jill.Brown@umm.edu
The primary HCB Financial report contact at your hospital is Paul Nicholson, CFO	◉	○	
The primary HCB Financial report contact email at your hospital is paulnicholson@umm.edu	◉	○	

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

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

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

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.

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

- [x] 21013
- [x] 21020
- [x] 21022
- [x] 21023
- [x] 21027
- [x] 21030
- [x] 21031
- [x] 21043
- [x] 21051
- [x] 21052
- [x] 21053
- [x] 21057
- [x] 21065
- [x] 21071
- [x] 21074
- [x] 21082
- [x] 21085
- [x] 21087
- [x] 21092
- [x] 21093
- [x] 21094
- [x] 21102
- [x] 21104
- [x] 21105
- [x] 21111
- [x] 21117
- [x] 21120
- [x] 21128
- [x] 21131
- [x] 21133
- [x] 21136
- [x] 21139
- [x] 21152
- [x] 21153
- [x] 21155
- [x] 21156
- [x] 21161
- [x] 21162
- [x] 21163
- [x] 21204
- [x] 21206
- [x] 21207
- [x] 21208
- [x] 21209
- [x] 21210
- [x] 21212
- [x] 21215
- [x] 21219
- [x] 21220
- [x] 21221
- [x] 21222
- [x] 21224
- [x] 21225
- [x] 21227
- [x] 21228
- [x] 21229
- [x] 21234
- [x] 21235
- [x] 21236
- [x] 21237
- [x] 21239
- [x] 21241
- [x] 21244
- [x] 21250
- [x] 21252
- [x] 21282
- [x] 21284
- [x] 21285
- [x] 21286

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

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

The Community Benefit Service Area for the University of Maryland St. Joseph Medical Center encompasses all of Baltimore County. This is in keeping with our commitment to serve all county residents and our partnership with the Baltimore County Department of Health, Baltimore County Department of Aging, and University of Maryland Medical System. Current priorities such as physical health, behavioral health, and health disparities extend across all communities in the area. The most recent Community Health Needs Assessment conducted by UM SJMC was done so in conjunction with other health organizations and included all of Baltimore County. Within Baltimore County, there are more vulnerable populations where more targeted efforts occur. Zip codes with the highest utilization rates include: 21234, 21093, 21030, 21212, and 21286. Zip codes with the greatest socioeconomic needs include: 21207, 21221, 21222, 21227, 21030, 21237, 21252 (CNI, 2021).

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

https://www.umms.org/sjmc/about

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)

06/09/2021

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.umms.org/sjmc/community/assessment

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

2020_21_Baltimore_County_CHNA___Final___Accessible_.pdf
1.6MB
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										
	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 expla below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☐	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
CB/ Community Health/ Population Health Director (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☐	☐	☐	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Board of Directors or Board Committee (facility level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Approved CHNA report and Implementation Plan
	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 expla 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 expla below:
Board of Directors or Board Committee (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Clinical Leadership (facility level)	☐	☐	☑	☑	☐	☑	☑	☑	☐	☐	
Clinical Leadership (system level)	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	
Population Health Staff (facility level)	☐	☐	☑	☑	☐	☑	☑	☑	☐	☐	
Population Health Staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Community Benefit staff (system level)	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	
Physician(s)	☐	☐	☐	☐	☐	☑	☑	☑	☐	☐	
Nurse(s)	☐	☐	☑	☑	☐	☑	☑	☑	☐	☐	
Social Workers	☐	☐	☐	☐	☐	☑	☑	☑	☐	☐	

	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 expla below:
Hospital Advisory Board	☐	☐	☐	☐	☐	☑	☑	☑	☐	☐	
	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 expla below:
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	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 expla below:

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

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

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

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

Refer to the FY 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: MedStar Franklin Square Medical Center, GBMC, Sheppard Pratt, LifeBridge Northwest Hospital	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Local Health Departments -- Please list the Local Health Departments here: Baltimore County Department of Health	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Local Health Improvement Coalition -- Please list the LHICs here: Baltimore County Local Health Coalition	☐	☐	☐	☐	☐	☐	☑	☐	☑	☑	☐	☐	☐	☐
Maryland Department of Health	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other State Agencies -- Please list the agencies here: Baltimore County Department of Aging	☐	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

	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
Post-Acute Care Facilities -- please list the facilities here: St. Elizabeth Hall; Holly Hill Nursing and Rehab Center	☐	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Community/Neighborhood Organizations -- Please list the organizations here: Y of Central Maryland; Knollwood Donnybrook Association; Trinity House; Tabco Towers	☐	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Consumer/Public Advocacy Organizations -- Please list the organizations here: BCDA Ombudsman; Nueva Vida; Student Support Network; Baltimore Hunger Project	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other -- If any other people or organizations were involved, please list them here: St. Clare Medical Outreach; Baltimore County Senior Centers	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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.

06/09/2021

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

https://www.umms.org/sjmc/community/assessment

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

FY22_24_Implementation_Plan_UMSJMC.pdf
207.9KB
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.

UMMS has developed a multi-year plan, backed by a $40million investment, that outlines our commitment to equity in care delivery, diversity in our workforce, meaningful investments in local communities and expanded opportunities for minority-owned businesses.

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
- [x] 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.

- [x] Yes, by the hospital's staff
- [x] 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 narrative is reviewed by the UMSJMC VP of Population Health, Values Based Care and Amy Gyau-Moyer UMMS Sr. Director of Community Health. It is then approved by the UMSJMC Finance Committee of the board and shared with all members of the Board of Directors.

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.

The UMSJMC FY21-25 Strategic plan includes a goal devoted entirely to providing access to integrated, value drive care, to improve community health and wellbeing , and advance the culture of philanthropy.

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

https://www.umms.org/sjmc/about/facts-about-um-sjmc

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.

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

  We offer the Prevent T2 diabetes prevention program to prevent/delay onset of type 2 diabetes and the main goal of the program is to have all participants reduce their body weight by at least 4-7%, which also reduces their BMI.

- [ ] Opioid Use Disorder - Improve overdose mortality

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

- [ ] 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.)

UMMS_Financial_Assistance_Policy_07.01.22.pdf
7.2MB
application/pdf

Q80. Section V - Financial Assistance Policy (FAP)

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

UMMS_Financial_Assistance_Policy_07.01.22.pdf
7.2MB
application/pdf

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

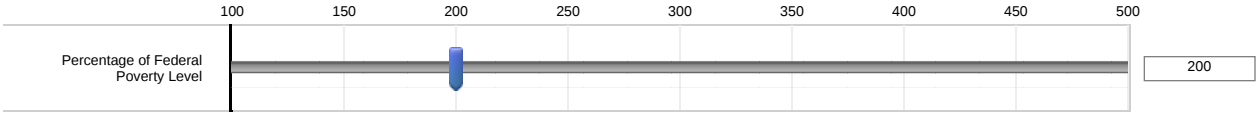
https://www.umms.org/-/media/files/umms/patients-and-visitors/financial-assistance-policy/july-2023/umms-financial-assistance-policy-7-1-23-english.pdf?upd=20230808192913

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:

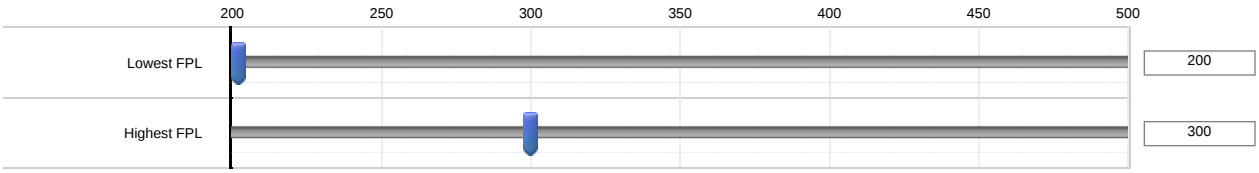
Q84. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



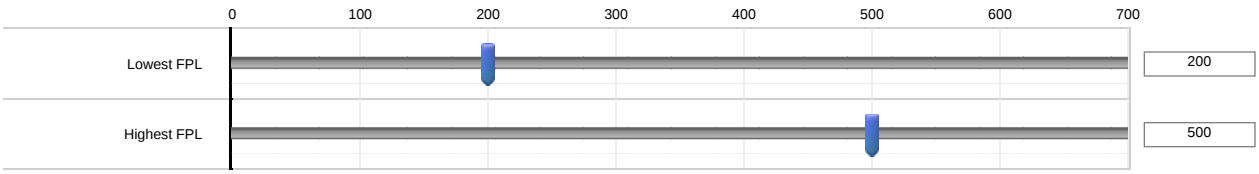
Q85. Maryland acute care and chronic care hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

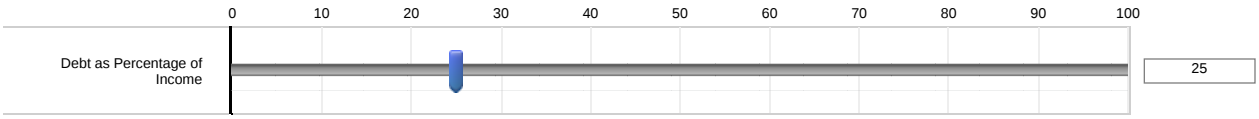


Q86. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3)(a) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial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

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

Location Data

Location: (37.5538, -77.4603)

Source: GeoIP Estimation

Baltimore County

2020-2021

Community Health Needs Assessment

Healthy people living, working, and playing in Baltimore County

Approved by the University of Maryland St. Joseph Medical Center Board of Directors on June 9, 2021.

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 Isennock	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

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

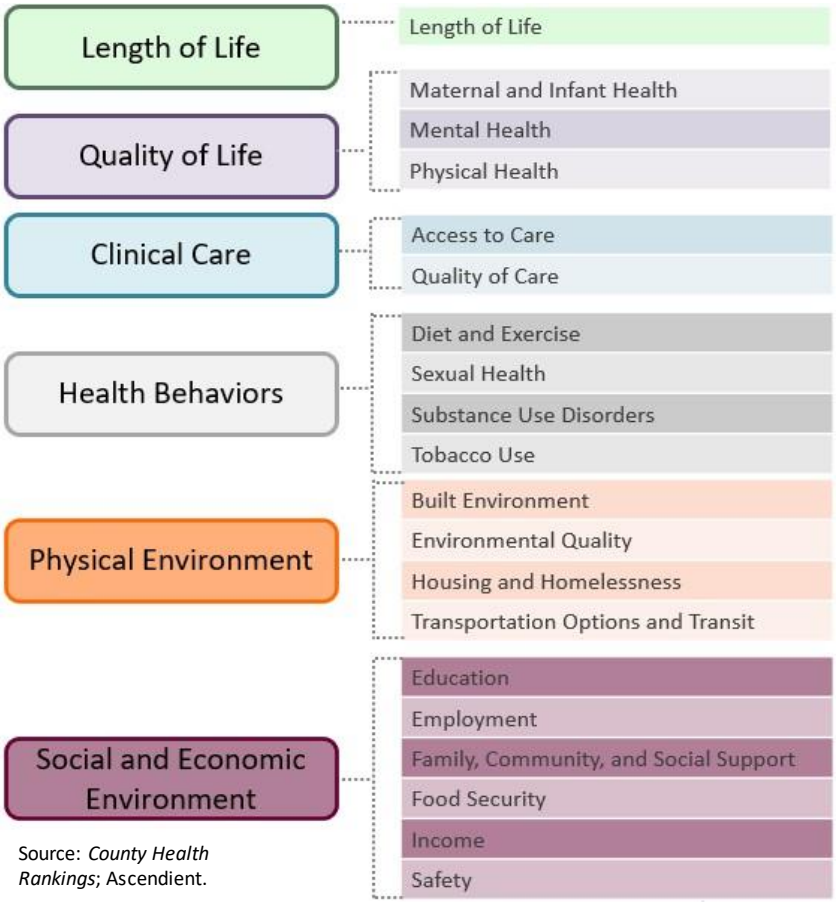
The existing data collected throughout the process are only relevant if compared to a benchmark, goal, or comparative geography. In other words, without the ability to compare Baltimore County with an outside measure, it would be impossible to determine how the county is performing. For the 2020-2021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

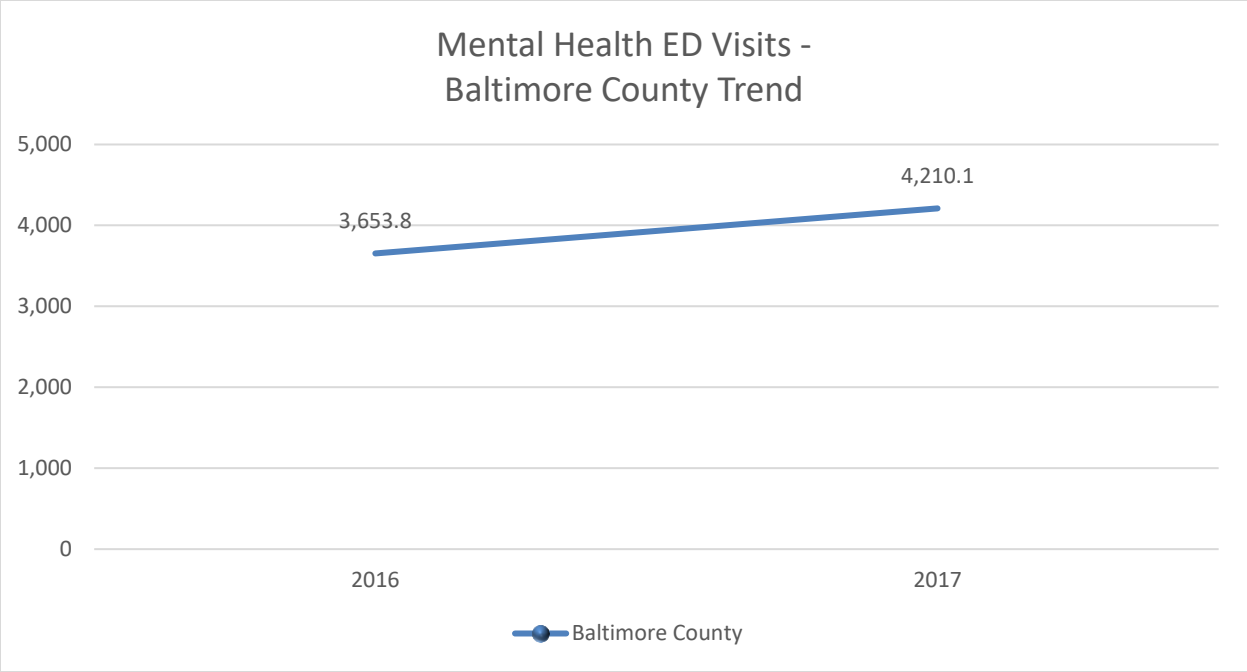
Mental Health

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

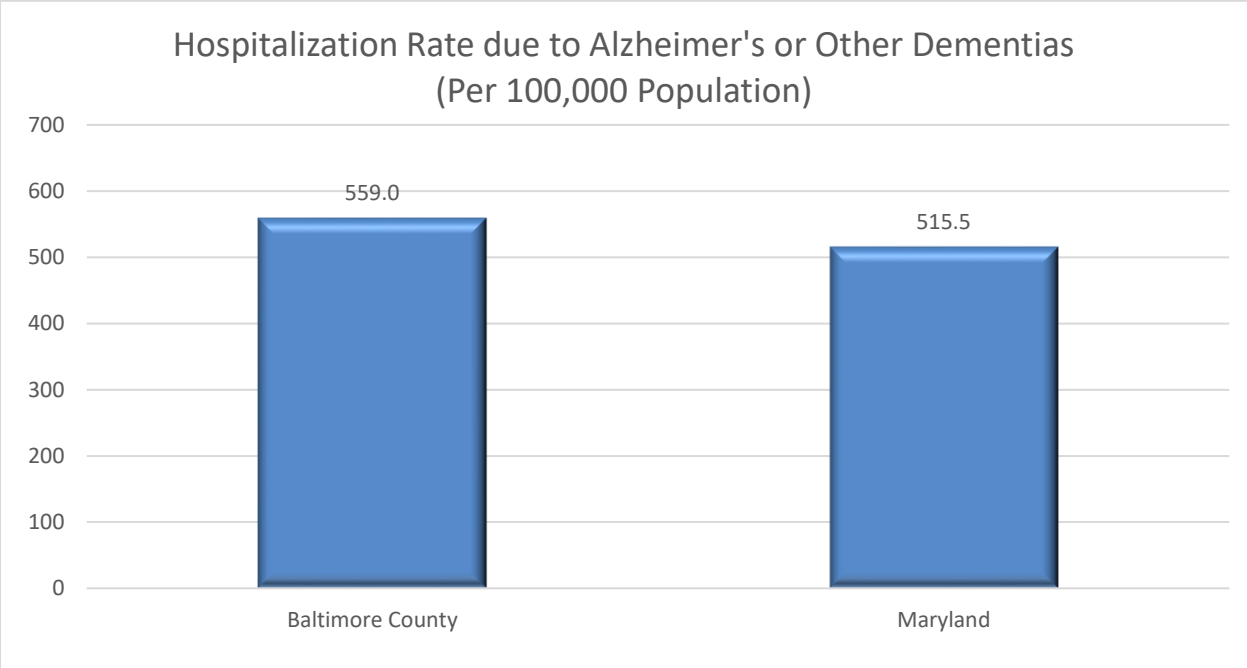
As shown in Appendix 2, existing data reveal that Baltimore County's performance varies when compared to Maryland and national top performers. Although Baltimore County has improved over recent years on some measures, performance on most measures has worsened.

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.



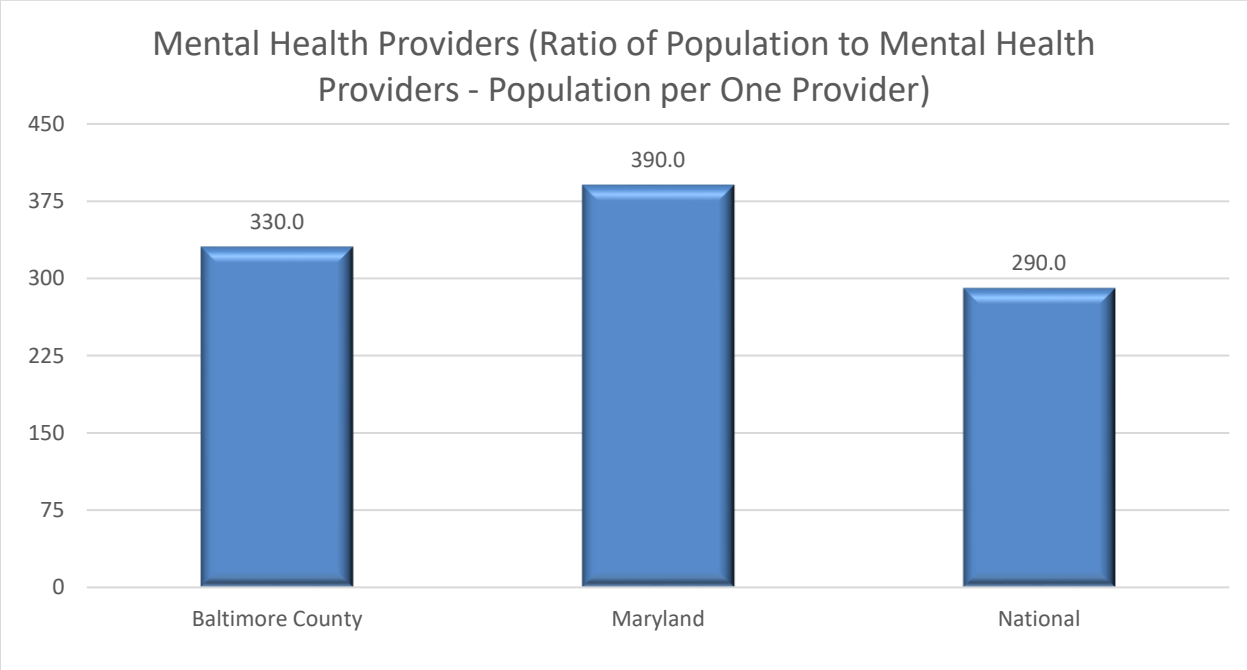
Source: Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.

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.

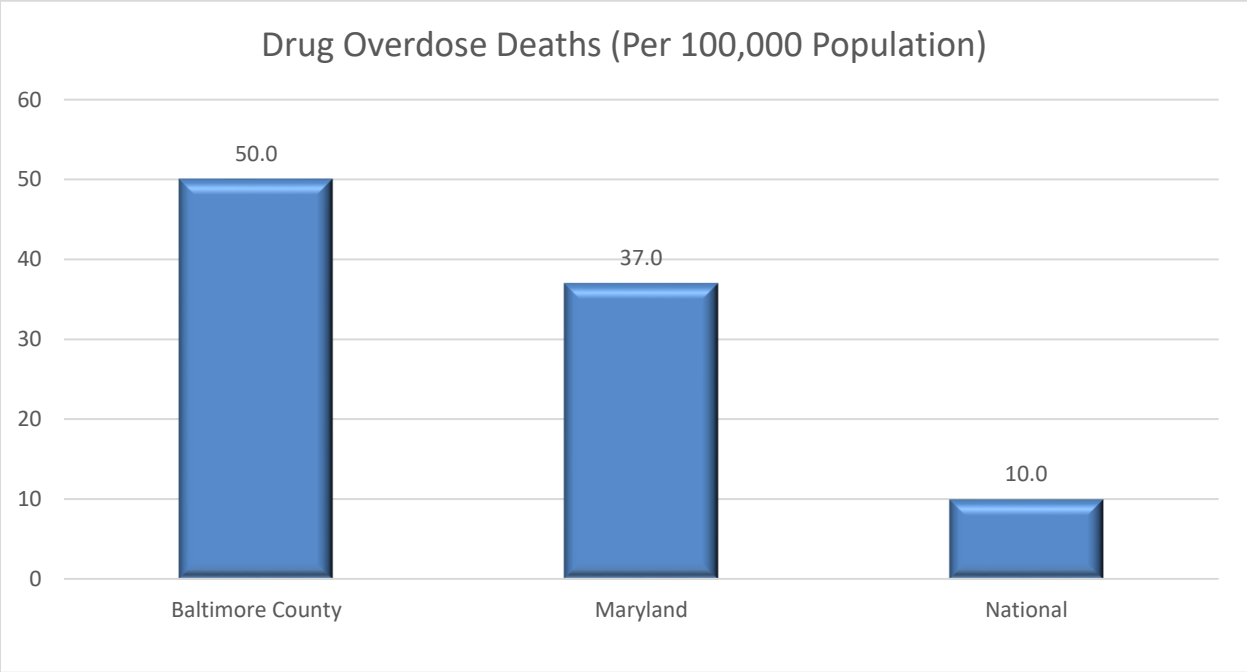
Substance Use Disorders

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.

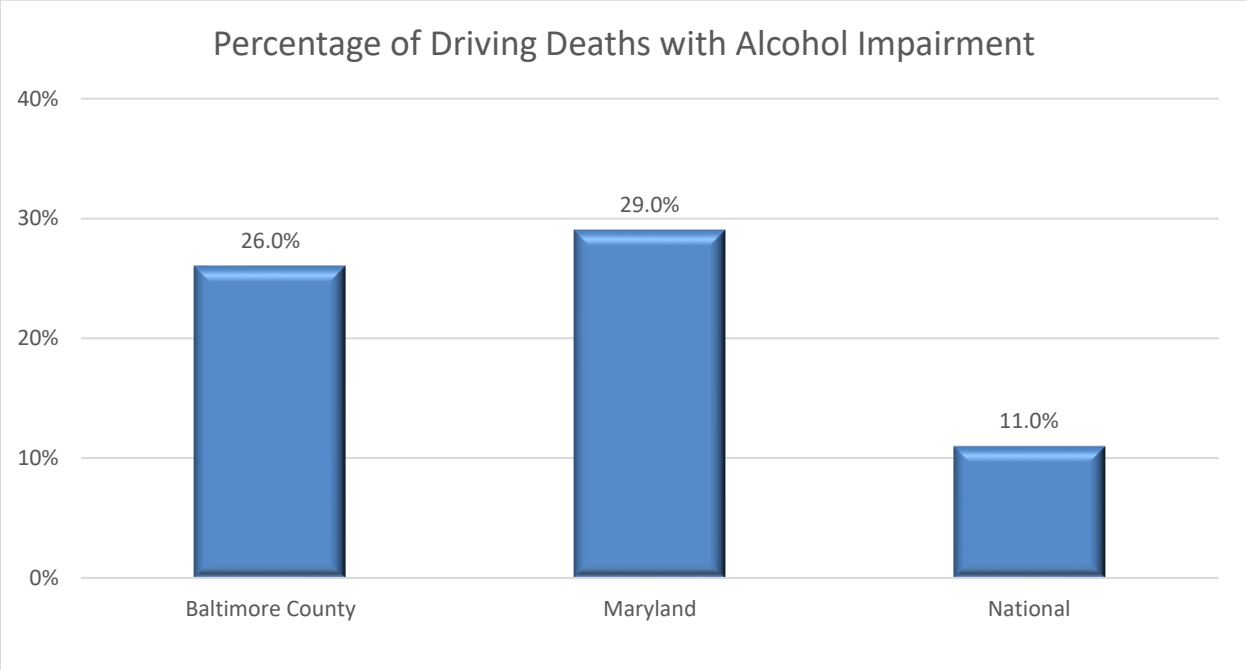
According to data from MedStar Franklin Square, Baltimore County is doing worse than Maryland and/or the nation for the following substance-related health measures:

- 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.

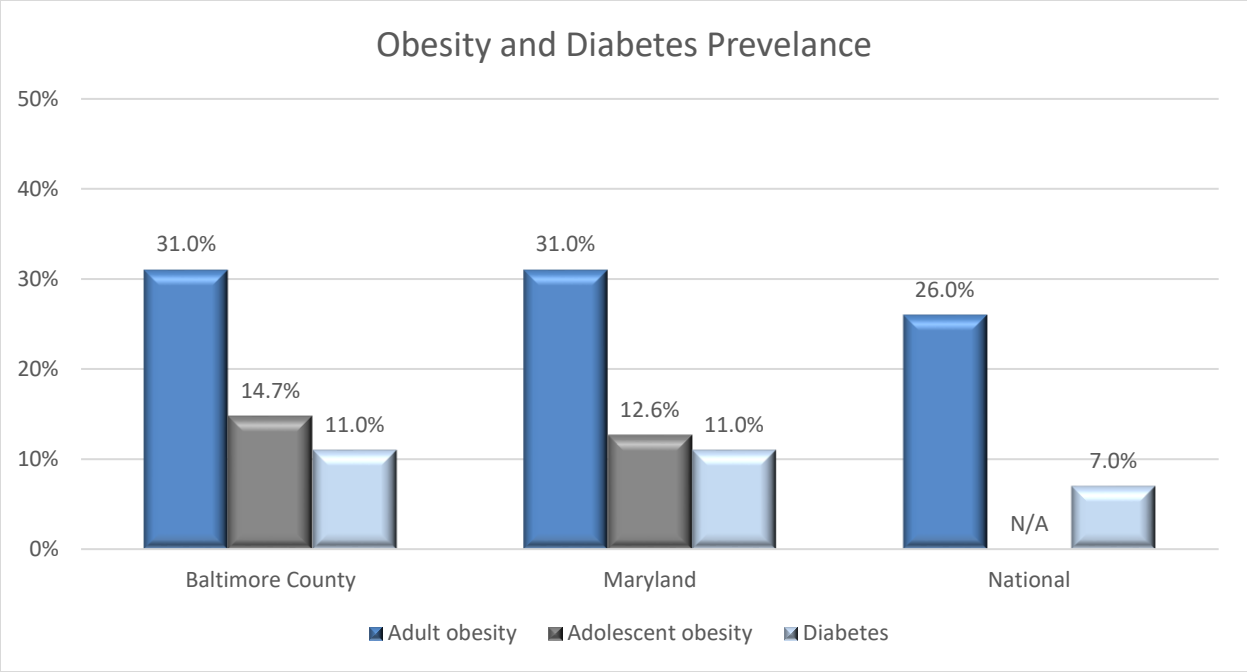
Priority Need: Physical Health

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

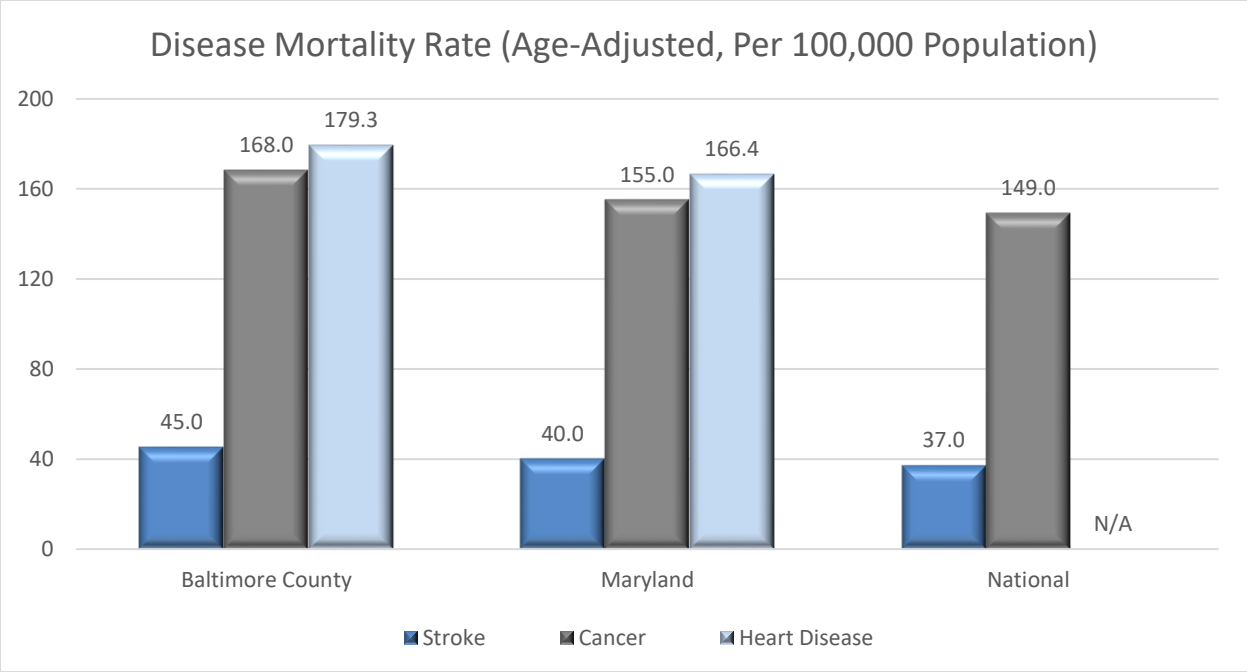
As shown in Appendix 2, existing data reveal that Baltimore County is performing worse than Maryland and the nation overall in many areas related to Physical Health. In addition, Baltimore County is improving in some of these high need areas but getting worse in others.

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.

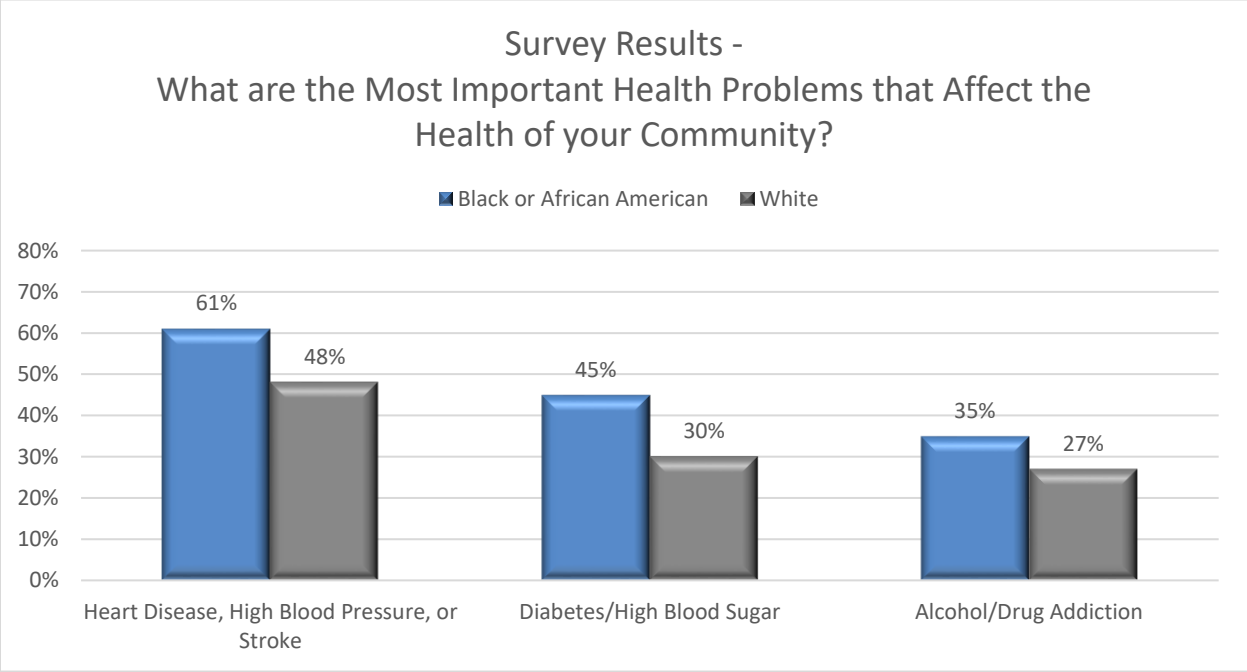
Additionally, the high cost of prescription medications was discussed. Without health insurance coverage, many residents are unable to afford their prescription medications. Even for those with health insurance coverage that extends to cover the cost of medications, there is still difficulty associated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

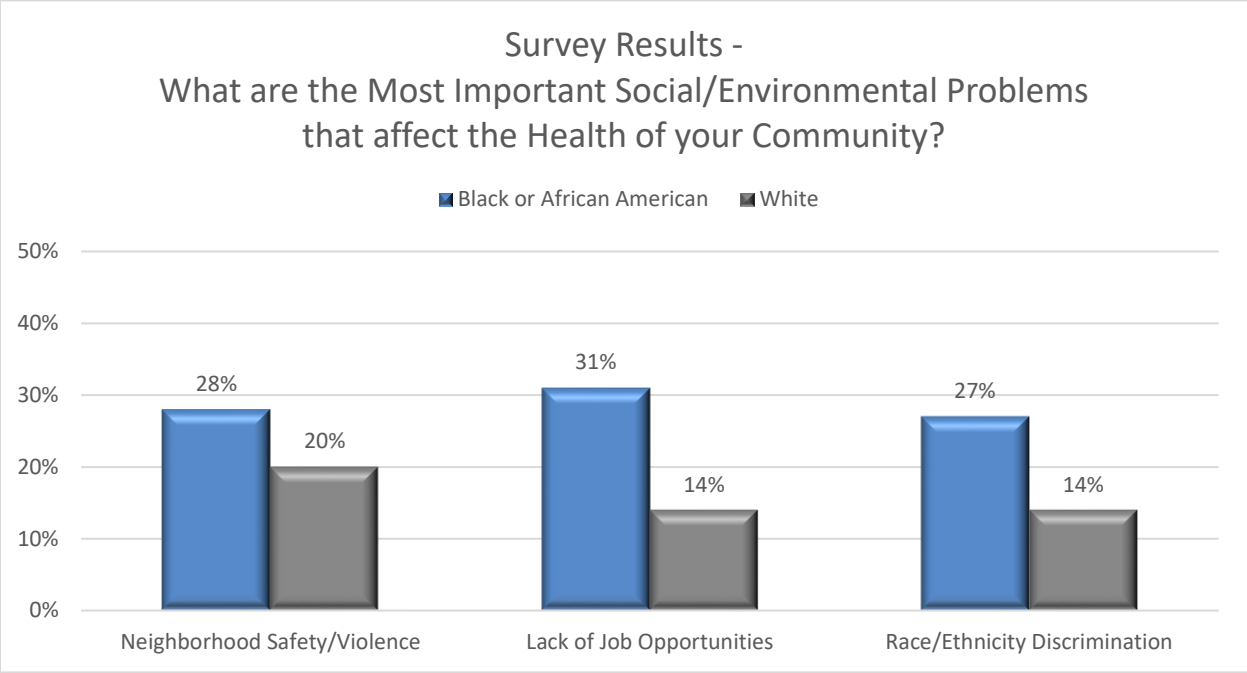
Health-related racial disparities exist in many communities. The new data gathered throughout the CHNA process demonstrates these disparities in Baltimore County, particularly regarding the perceived priority needs of the community and access to healthcare. Due to the racial composition of the respondents 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.

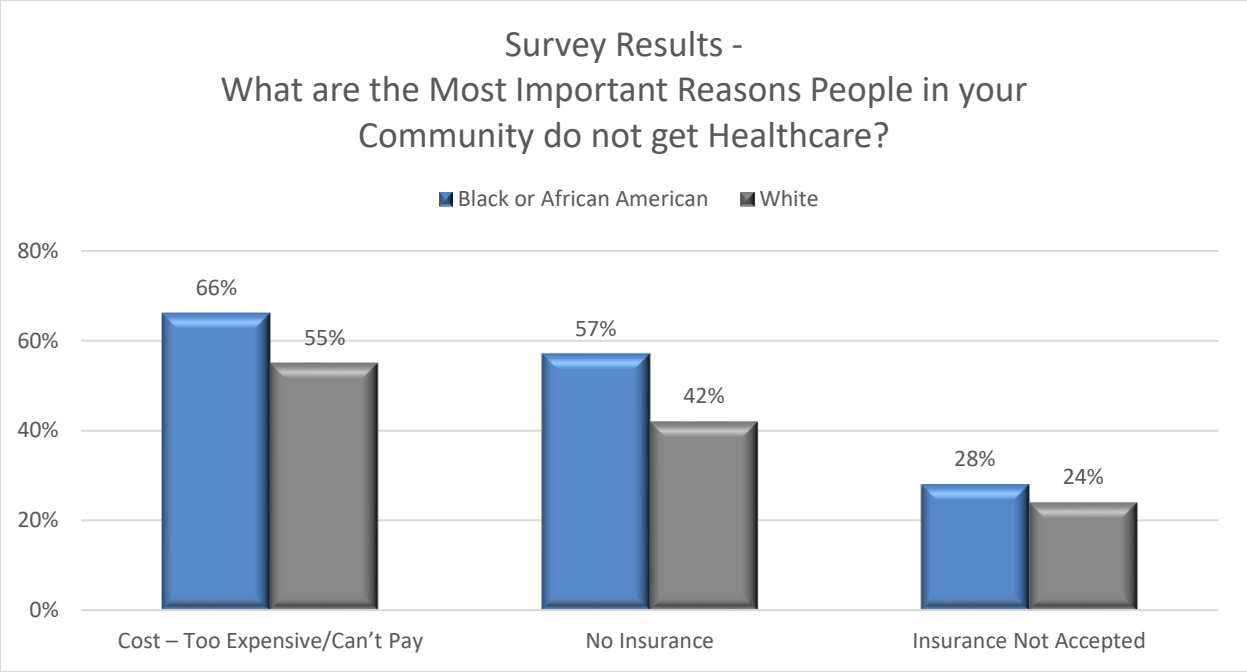
As demonstrated in the chart below, differences were also present in the perceived social/environmental problems facing the community.



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.

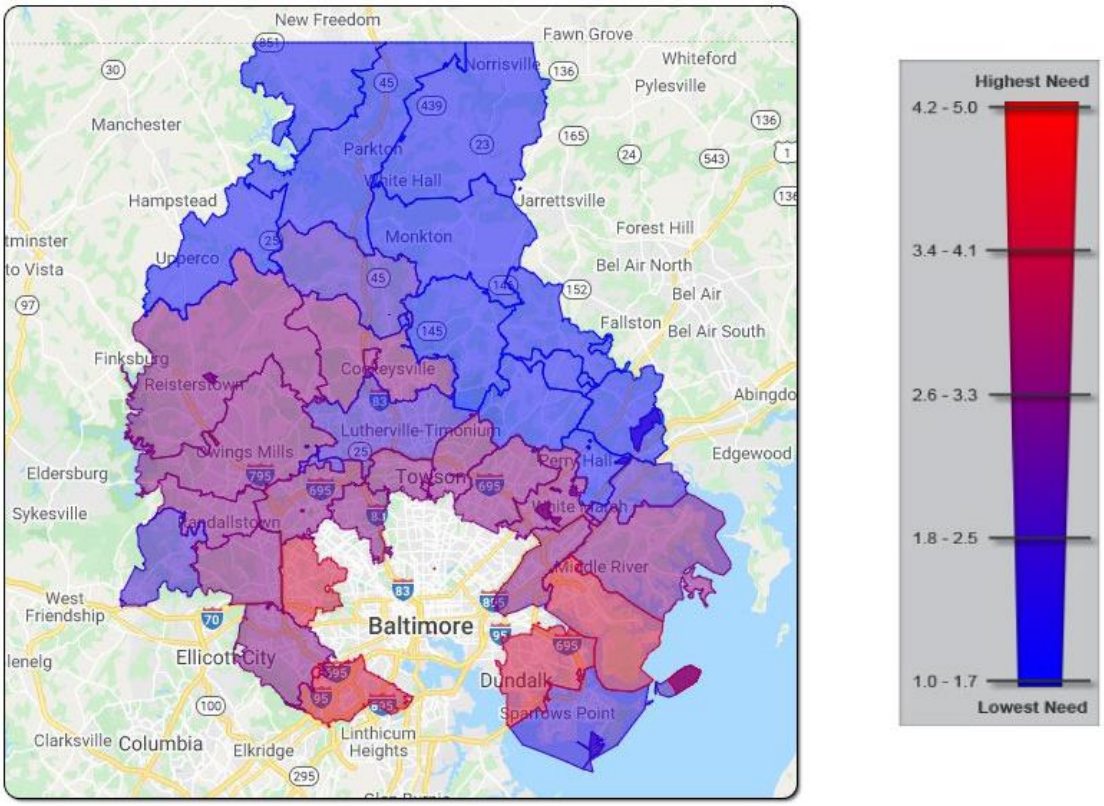
Geographic Disparities

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



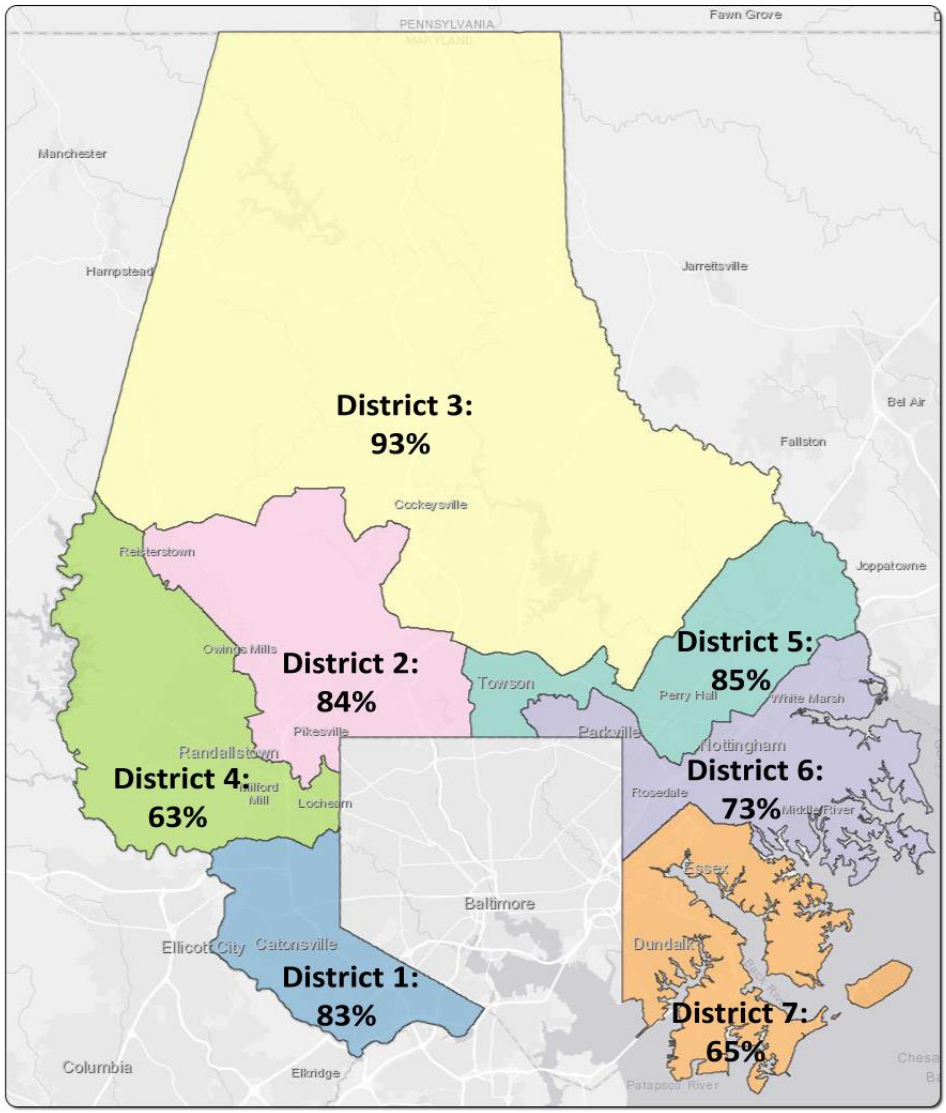
Source: Dignity Health and Truven Health Analytics, Community Need Index. Data accessed December 2020.

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"

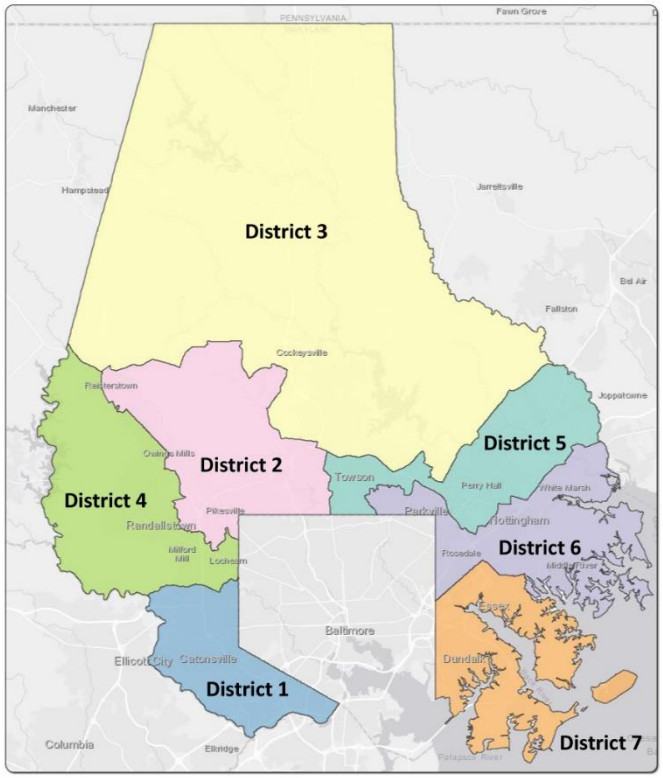


Source: Data compiled from community surveys.

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.

<u>Healthcare Facilities</u>

- 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.

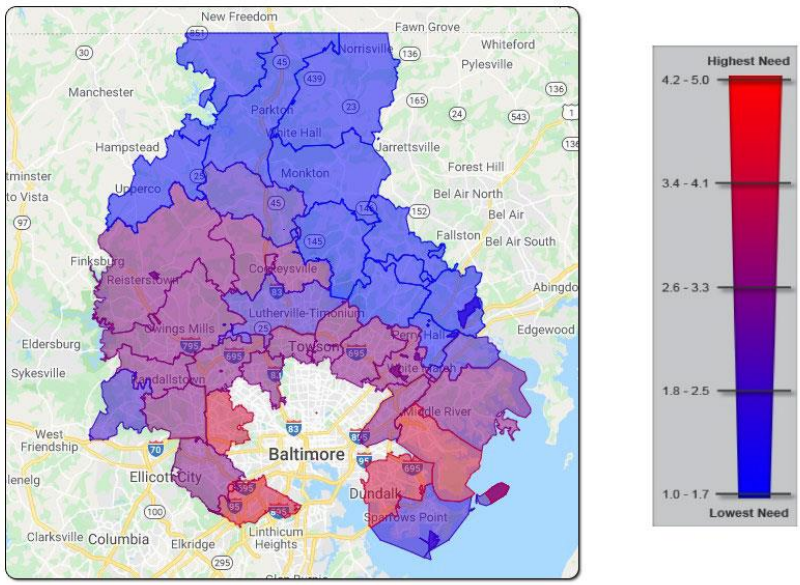
2018 Median Household Income			
	Baltimore County	Maryland	National
Income	$75,800	$83,100	$69,000

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

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))	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. 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.	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)
	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.		

Diet and Exercise

Measure	Description	Data Source	Most Recent Data Year(s)
Physical inactivity (percent of adults that report no leisure time physical activity)	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	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)
	diameter less than 2.5 micrometers (PM2.5). 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. 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.	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 t hat someone at a given age would be expected to live if current mortality conditions remaine d 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)
	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?" 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. 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.	Health Rankings. Data accessed December 2020.	
Adult obesity (percent of adults that report a BMI >= 30)	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	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

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

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
	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.
	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.
	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%

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 >= 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:

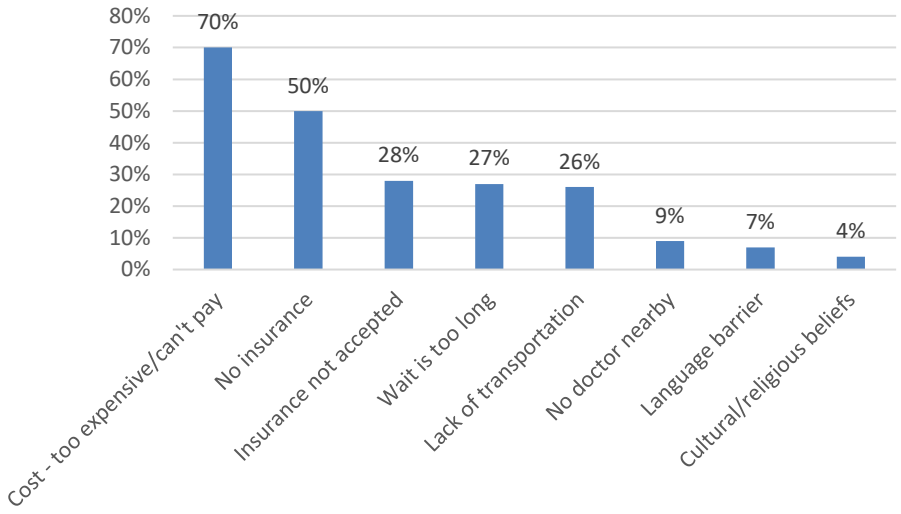
- 15 percent of community survey respondents listed lack of affordable childcare as one of the three most important social/environmental problems affecting the community

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.
  a. Access to Care **(Access to Care)**
  b. Cancer **(Physical Health)**
  c. Dental Health **(Physical Health)**
  d. Diabetes **(Physical Health)**
  e. Heart Disease and Stroke **(Physical Health)**
  f. Maternal/Infant Health **(Maternal and Infant Health)**
  g. Mental Health/Suicide **(Mental Health)**
  h. Primary and Preventive Healthcare **(Physical Health)**
  i. Obesity **(Physical Health)**
  j. Sexually Transmitted Disease **(Sexual Health)**
  k. Substance Use/Alcohol Use **(Substance Use Disorders)**
  l. Tobacco and Electronic Smoking Devices **(Tobacco Use)**
  m. Housing **(Housing and Homelessness)**
  n. Uninsured **(Access to Care)**
  o. Other

- What are the most significant barriers that keep people in the community from accessing healthcare when they need it? Choose all that apply
  a. Availability of providers/ appointments
  b. Basic needs not met (food/shelter) **(Food Security)**
  c. Inability to navigate healthcare system
  d. Inability to pay out of pocket expenses (co pays, prescriptions)
  e. Lack of child care
  f. Lack of health insurance coverage
  g. Lack of transportation **(Transportation Options and Transit)**
  h. Lack of trust
  i. 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

University of Maryland St. Joseph Medical Center Community Health Improvement Implementation Plan FY22-24

Priority Area: Physical Health		
Objective	**Action Items**	**Metrics**
Increase the number of adults with a usual primary provider (HP 2030).	▪ St. Clare Medical Outreach- provides preventative and primary medical care to underserved populations ▪ Recruit primary care providers	▪ # of patients served by St. Clare Medical Outreach ▪ PCP new patient panel size
Reduce the number of diabetes cases diagnosed yearly (HP 2030).	▪ Continue National Diabetes Prevention Program- an evidence-based lifestyle change program ▪ Increase participation and referrals for the National Diabetes Prevention Program ▪ Offer support groups and education	▪ # of NDPP participants ▪ # of NDPP completers ▪ Percent of program participants that lose 5-7% of body weight ▪ # of referrals to NDPP ▪ # of support group participants
Reduce the mortality rate from heart disease and stroke.	▪ Heart Failure Clinic- provides multidisciplinary care to those lacking access to specialty care ▪ Partner with local EMS to support education ▪ Offer screenings and education	▪ # served in Heart Failure Clinic ▪ # of screenings ▪ # of educational programs and events ▪ # of participants
Reduce the overall cancer death rate (HP 2030).	▪ Offer screenings for early detection and education for prevention ▪ Cancer Institute Wellness and Support Center- provides survivorship programs and services	▪ # of screenings ▪ # of cancer cases detected ▪ # of survivorship services offered ▪ # of participants in survivorship services
Reduce the rate of emergency department visits due to falls among	▪ Continue Stepping On- free seven week evidence-based fall prevention program	▪ # of programs offered ▪ # of participants

older adults (HP 2030).	▪ Continue Tai Ji Quan: Moving for Better Balance- free 12 week evidence based fall prevention program ▪ Offer bone density screenings and education ▪ Partner with the Department of Aging to support state and county fall prevention events and initiatives	▪ Confidence and activity levels of participants measured pre and post series
Increase the proportion of adults who do enough aerobic and muscle-strengthening activity (HP 2030).	▪ Continue free yoga classes ▪ Partner locally to promote access to physical activity programs and reduce barriers	▪ # of physical activity programs offered ▪ # of participants
Increase the proportion of persons who are vaccinated annually against seasonal influenza (HP 2030).	▪ Offer free community flu vaccination clinics ▪ Partner with community organizations to educate and promote seasonal flu vaccination	▪ # of flu immunizations administered ▪ # of community sites and partners

Priority Area: Behavioral Health		
Objective	**Action Items**	**Metrics**
Increase the proportion of people with substance use and mental health disorders who get treatment for both (HP 2030).	▪ Behavioral Health Center- supports counseling, medication adherence, and transition back to community ▪ Mental health counseling delivered at St. Clare Medical Outreach ▪ Use of Peer Recovery Specialists ▪ Offer Chronic Pain Self-Management Classes ▪ Promote and support UMMS Mental Health education series ▪ Continue to partner with Baltimore County Department	▪ # of individuals served ▪ Readmission rate ▪ # of Chronic Pain classes and participants

	of Health and other area hospitals/ organizations to promote access to mental health and addiction services ▪ Support the Greater Baltimore Regional Integrated Crisis System (GBRICS)- a cross-county partnership to expand the capacity of mobile crisis teams and community-based providers to reduce police interaction and overreliance on emergency departments	
Reduce current tobacco use in adolescents and adults (HP 2030).	▪ Partner with Baltimore County Department of Health on smoking cessation and youth education efforts	▪ # of educational events supported

Priority Area: Health Disparities		
Objective	**Action Items**	**Metrics**
Identify and address barriers to care.	▪ Transitional Care Clinic- delivers multidisciplinary care to high risk patients with barriers to care ▪ Screen for social determinants of health ▪ Partner locally to help those with barriers obtain health insurance and care	▪ # of individuals served ▪ Readmission rate ▪ # screened and connected to resources
Reduce language barriers.	▪ Partner with Nueva Vida as a trusted source of information and support for screenings ▪ Per policy, utilize language services for all UM SJMC patients identified with language barriers ▪ Increase the use of bilingual staff and literature for	▪ Use of translation and interpretation services ▪ # of events and resources offered in other languages

	community screenings and programs	
Reduce transportation barriers.	▪ Provide transportation assistance as needed ▪ Offer programs, screenings and immunization clinics at trusted community sites ▪ Continue offering virtual programs ▪ Continue telehealth services	▪ Investment in transportation support ▪ # of offsite programs ▪ # of virtual programs
Support health literacy and health resource awareness.	▪ Promote and support UMMS Let's Talk About Health Series ▪ Maintain Patient Family Resource Center ▪ Support regular and robust partner communications on local events and resources ▪ Maintain active involvement in the following coalitions and workgroups: o Baltimore County Local Health Improvement Coalition o State Cancer Control Plan Workgroup o Age Friendly Baltimore County o Smoke Free Baltimore County o Maryland Falls Free Coalition o Northern Networking Committee	▪ # of programs ▪ # of participants
Increase employment among the working-age population (HP 2030).	▪ Continue to support Humanim Start on Success program- providing high school and college students with disabilities the opportunity to participate in paid internships to gain skills and confidence in the workplace ▪ Continue to support Cristo Rey Corporate Integrity Program- providing a monetary donation and placements for student interns ▪ Partner with local schools to serve as internship sites for	▪ # of students hosted

	accredited programs ▪ Support student shadow experiences	
Reduce household food insecurity and in doing so reduce hunger (HP 2030).	▪ Partner locally for healthy food access efforts ▪ Expand Caring Cupboard to serve employees, patients, and community members	▪ Investments in local food security efforts ▪ # of families served

UNIVERSITY of MARYLAND MEDICAL SYSTEM Revenue Cycle Services	PAGE: 1 OF 14	POLICY NO: RCS - 01
	EFFECTIVE DATE: 09/18/19	REVISION DATE(S): 07/01/22
SUBJECT: UMMS Financial Assistance Policy		

KEY WORDS:
Financial Assistance, Financial Hardship, Financial Clearance, Medical Assistance

OBJECTIVE/BACKGROUND:
The purpose of the following policy statement is to describe the financial assistance application process, how applications are reviewed and determinations of eligibility are made, eligibility criteria for financial assistance programs (including presumptive eligibility and financial hardship assistance), financial clearance of patients with medically unique or humanitarian needs, how UMMS notifies patients of the availability financial assistance availability, the appeal process, and extraordinary collection actions.

APPLICABILITY:
This policy applies to all team members, vendors, and agents [volunteers, medical team members] of any of the following University of Maryland Medical System member organizations:

University of Maryland Medical Center (UMMC)
UM Midtown Campus (MTC)
UM Rehabilitation & Orthopaedic Institute (UMROI)
UM St. Joseph Medical Center (UMSJMC)
UM Baltimore Washington Medical Center (UMBWMC)
UM Shore Regional Health (UMSRH)
UM Shore Medical Center at Dorchester (UMSMCD)
UM Shore Medical Center at Easton (UMSME)
UM Charles Regional Medical Center (UMCRMC)
UM Upper Chesapeake Health (UCHS)
UM Capital Region Health (UMCRH)
UM Physician Networks (UMPN)
UMMS Outpatient Rx Weinberg
UMMC Pharmacy at Redwood
UMMS Pharmacy Services
UMMC Mid-Town Campus Pharmacy
UMMC Pharmacy at Capital Region
UMMC Pharmacy at Baltimore Washington

DEFINITIONS:

Federal Poverty Level	A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits.
Financial Hardship	Instances in which member organization charges incurred at UMMS member organizations for medically necessary treatment by a family household over a twelve (12) month period that exceeds 25% of that family's annual income.
MDH Limits	Refers to the income eligibility limits for reduced cost care, set by Maryland Department of Health (MDH) office of Medical Assistance Planning. The State of Maryland accepted the Federal Medicaid expansion on January 1, 2014 vs the Federal Poverty Levels, under the Affordable Care Act, which expanded the eligible income limits for Maryland Medicaid. UMMS adopted these new limits for the reduced cost care sliding scale, as set forth in Attachment A.
Medical Debt	Out-of-pocket expenses, including co-payments, coinsurance, and deductibles, incurred at UMMS member organizations for medically necessary treatment.
Presumptive Eligibility	Instances in which information provided by the patient or through other sources provides sufficient evidence that the patient is eligible for financial assistance, but there is no financial assistance form on file.

POLICY:

The University of Maryland Medical System ("UMMS") 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.

It is the policy of the University of Maryland Medical System ("UMMS") member organizations to provide financial assistance which meets or exceeds the requirements set forth by the State of Maryland for patients who meet specified financial criteria and request such assistance.

I. **Free Care -** Those with income up to 200% of the income eligibility limits established by the Maryland Department of Health are eligible for free care.

II. **Reduced Cost Care -** Those between 200% and 300% of the income eligibility limits established by the Maryland Department of Health are eligible for discounts on a sliding scale, as set forth in Attachment A.

III. **Financial Hardship -** Those who otherwise do not qualify for financial assistance under the primary guidelines of this policy, but for whom their medical debt incurred at all UMMS member organizations exceeds 25% of the Family Annual Household Income, are eligible for financial hardship assistance.

Payment plans are also available to all patients. Plan terms may be modified at the request of the patient. Additional information on payment plans is available in the UMMS Payment Plan Policy. UMMS retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent/urgent services, financial assistance applications will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

PROCEDURE:

I. How To Apply for Financial Assistance

For any episode of care, the financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill for the care is sent. Patients may voluntarily apply for financial assistance before or after receiving healthcare services, or they may be identified as potential candidates for financial assistance during the financial clearance process or a presumptive financial assistance eligibility screening.

Financial clearance is a process that determines a patient's ability and likelihood to pay. When possible effort will be made to provide financial clearance prior to date of service. During the financial clearance process, patients who indicate they are unemployed and have no insurance coverage will be required to submit a financial assistance application before receiving non-emergency medical care (unless they meet presumptive financial assistance eligibility criteria).

There will be one application process for all UMMS member organizations. UMMS will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications (and application requirements) in determining eligibility for the UMMS Financial Assistance program. Patients are required to provide a completed financial assistance application (with all required information and documentation), unless they meet the criteria for presumptive eligibility. To facilitate this process, each applicant must provide information about

family size and income. Oral submission of needed information will be accepted, where appropriate. UMMS will provide the financial assistance application to all patients regardless of health insurance status to all patients, including uninsured patients, and the application will be readily available on the UMMS website and by request.

Supporting Documentation for Financial Assistance Applications

To help applicants complete the process, required and suggested documentation will be clearly listed on the financial assistance application, including:

- A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return); proof of disability income (if applicable), proof of social security income (if applicable).
- If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
- A copy of their most recent pay stubs (if employed) or other evidence of income.
- A Medical Assistance Notice of Determination (if applicable).
- Copy of their Mortgage or Rent bill (if applicable), or written documentation of their current living/housing situation.
- If a patient submits both a copy of their most recent Federal Income Tax Return and a copy of their most recent pay stubs (or other evidence of income), and only one of the two documents indicates eligibility for financial assistance, the most recent document will dictate eligibility.

Financial assistance may not be denied based on the omission of information or documentation that is not specifically required in this policy or on the financial assistance application, and UMMS reserves the right to offer financial assistance to patients that have not provided all supporting documentation.

- If a patient submits a financial assistance application without the information or documentation required for a final determination of eligibility, a written request for the missing information or documentation will be sent to the patient.
- This written request will also contain the contact information (including telephone number and physical location) of the office or department that can provide information about financial assistance and assistance with the application process.
- The patient will have thirty (30) days from the date this written request is provided to submit the required information or documentation to be considered for eligibility. If no the information is not received within the 30 days, a letter will be sent notifying the patient that the case is now closed for lack of the required documentation.
- The patient may re-apply for financial assistance and initiate a new case by submitting the missing information or documentation

II. Reviewing and Determining Eligibility of Financial Assistance Applications

There are designated team members who will be responsible for taking financial assistance applications. These team members can be financial counselors, patient financial receivable coordinators, customer service representatives, or third party agencies working as an extension of the central business office. To help applicants complete the process, UMMS will provide the financial assistance application that will let them know what paperwork is required for a final determination of eligibility. Where possible, designated team

members will consult via phone or meet with patients who request financial assistance to determine if they meet preliminary criteria for assistance.

Preliminary data will be entered into a third party data exchange system which will allow the designated team member to track the application and determine eligibility for financial assistance. Designated team members will:

- Determine whether the patient has health insurance. Patients who have access to other medical coverage (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for financial assistance.
- If the patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the designated team member and recommendations shall be made to Senior Leadership.
- Complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage. To facilitate this process each applicant must provide information about family size and income.
- Determine whether the patient is presumptively eligible for free or reduced-cost care.
- Determine whether uninsured patients are eligible for public or private health insurance. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

To the extent practicable, the designated team members will offer assistance to uninsured patients if the patient chooses to apply for public or private health insurance, determine whether the patient is eligible for other public programs that may assist with health care costs, and use information available to UMMS to determine whether the patient is qualified for free or reduced-cost care under the UMMS Financial Assistance policy.

Within two business days of receipt of a patient's request for financial assistance or an application for medical assistance, UMMS must make a determination of probable eligibility. The determination of probable eligibility is subject to change, based on the receipt of supporting documentation.

If the patient's financial assistance application is determined to be complete and appropriate, the designated team member will recommend the patient's level of eligibility and forward for a second and final approval. UMMS will provide final determination the patient's eligibility within 14 days after the patient submits a completed application for financial assistance and suspend any billing or collections actions while eligibility is being determined.

If a Financial Assistance Application is Approved

Once a patient is approved for financial assistance, financial assistance coverage is effective for the month of determination and a year prior to the determination.

- A letter of final determination will be submitted to each patient who has formally requested financial assistance, which includes (if applicable): the assistance for which the individual is eligible and the basis for the determination.
- UMMS may decide to extend the financial assistance eligibility period further into the past or the future on a case-by-case basis.

- Financial assistance is generally applicable to all emergency and other medically necessary care provided by each UMMS member organization (See Exclusions for more information).
- If additional healthcare services are provided beyond the eligibility period, patients must reapply for financial assistance.
- If the patient is determined to be eligible for reduced-cost care, and has already received a statement for eligible healthcare services rendered during the financial assistance coverage period, the patient will also be provided with a billing statement that indicates the amount the patient owes for the care after financial assistance is applied.
- If a patient made payments for healthcare services prior to receiving approval for financial assistance, they may be eligible for a refund. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. If the amount that the patient is determined able to pay is less than the amount of the patient payment, the resulting credit balance will be issued to the patient as a refund if the amount exceeds the patient's determined responsibility by $5.00 or more. This includes determinations of eligibility for financial assistance within 240 days after the initial bill was provided.

If there are changes to the patient's income, assets, expenses or family status, the patient is expected to notify the Financial Assistance Department at 410-821-4140. To facilitate this process, and ensure that patients have the opportunity to be re-evaluated for eligibility for financial assistance within 240 days of the initial statement, UMMS will notify patients that if their income has changed, they should contact the Financial Assistance Program Department on each statement.

If a Financial Assistance Application is Not Approved

If a patient is determined to be ineligible for financial assistance prior to receiving a service (for that service), all efforts to collect co-pays, deductibles, or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

- If the patient is determined to be ineligible for financial assistance, and they applied in order to obtain financial clearance for non-emergent or non-urgent hospital based services, the designated team member will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.
- A clinician may appeal this decision and request reconsideration by the Financial Clearance Executive Committee on a case-by case basis.
- For emergent or urgent services, financial assistance applications will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.
- Patients who are ineligible for financial assistance will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.
- The patient may appeal the decision, please see the Appeals section for more information.
- For any episode of care, the financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill for the care is sent.

III. Eligibility Criteria

UMMS will offer financial assistance when a review of a patient's individual financial circumstances has been conducted and documented. UMMS will not use a patient's citizenship or immigration status as an eligibility

requirement for financial assistance; or withhold financial assistance or deny a patient's application for financial assistance on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or on the basis of disability.

The following criteria will be applied in assessing a patient's eligibility for financial assistance, presumptive eligibility for financial assistance, and eligibility for financial hardship assistance.

Financial Assistance Eligibility

UMMS will refer to the MDH household income thresholds to determine eligibility for financial assistance and the level of free or reduced cost care to award to eligible patients. UMMS will calculate a patient's family (household) income at time of service. To account for any changes in financial circumstance, UMMS will recalculate family (household) income within 240 days after the initial hospital bill is provided.

UMMS may consider household monetary assets in determining eligibility for free and reduced-cost care under the financial assistance policy in addition to income-based criteria. Monetary assets shall be adjusted annually for inflation in accordance with the Consumer Price Index. The following monetary assets that are convertible to cash shall be excluded:

- At a minimum, the first $10,000 of monetary assets.
- A safe harbor equity of $150,000 in a primary residence.
- Retirement assets that the Internal Revenue Service has granted preferential tax treatment as a retirement account, including deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred-compensation plans.
- One motor vehicle used for the transportation needs of the patient or any family member of the patient;
- Any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act.
- Prepaid higher education funds in a Maryland 529 Program account.

In determining the family income of a patient, UMMS shall apply a definition of household size that consists of the patient and, at a minimum, a spouse (regardless of whether the patient and spouse expect to file a joint federal or State tax return), biological children, adopted children, or stepchildren, and anyone for whom the patient claims a personal exemption in a federal or State tax return. For a patient who is a child, the household size shall consist of the child and biological parents, adopted parents, or stepparents or guardians, biological siblings, adopted siblings, or stepsiblings, and anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.

Patients may be deemed ineligible for financial assistance:

- If they have insurance coverage (e.g., HMO, PPO, or Workers Compensation, Medicaid, or other insurance programs), that denies access to UMMS due to insurance plan restrictions/limits.
- If they refuse to be screened for other assistance programs prior to submitting an application for financial assistance.
- If they refuse to divulge information pertaining to a pending legal liability claim.

Financial assistance generally applies to all emergency and other medically necessary care provided by each UMMS member organization; however, the following exclusions may apply:

- Services provided by healthcare providers not affiliated with UMMS member organizations (e.g., durable medical equipment, home health services).
- Services denied by a patient's insurance program or policy (e.g., HMO, PPO, or Workers Compensation). Exceptions may be made on a case by case basis considering medical and programmatic implications.
- Cosmetic or other non-medically necessary services.
- Patient convenience items, meals, and lodging.
- Supervised Living accommodations and meals while a patient is in the Day Program.
- Third Party Liability claims (Auto Accident, Workers Compensation, Bodily Injury, or other legal claim) until all means of payment are exhausted.

Financial assistance for professional charges awarded under this policy applies to the UM Physician Network (UMPN). Patients who wish to pursue financial assistance for non-UM Physician Network charges must contact the physician or provider group directly. A list of providers delivering medically necessary care in each UMMS hospital can be obtained on the website of each UMMS entity. This list specifies which such as providers do not participate in the UMMS Financial Assistance Policy.

Presumptive Financial Assistance Eligibility

In the event there is no evidence to support a patient's eligibility for financial assistance, UMMS reserves the right to determine presumptive financial assistance eligibility for all hospital accounts. To determine presumptive eligibility for financial assistance, UMMS may use outside agencies or information to estimate income which can be used to assess the patient's eligibility for financial assistance eligibility. Due to the inherent nature of presumptive circumstances, UMMS will award free care to patients deemed presumptively eligible for financial assistance. Presumptive eligibility for financial assistance shall only cover the patient's specific date of service. UM Physician Network provider groups will offer financial assistance on a physician balance based on a determination of eligibility on a hospital balance.

Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

a. Active Medical Assistance pharmacy coverage
b. Specified Low Income Medicare (SLMB) coverage
c. Primary Adult Care (PAC) coverage
d. Homelessness
e. Patient currently has Medical Assistance coverage
f. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
g. Medical Assistance spend down amounts
h. Eligibility for other state or local assistance programs, such as:
    i) Supplemental Nutrition Assistance Program
    ii) State Energy Assistance Program
    iii) Special Supplemental Food Program for Women, Infants, and Children
    iv) Any other social service program as determined by MD DHMH and Health Services Cost Review Commission (HSCRC).

i. Patient is deceased with no known estate
j. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
k. Non-US Citizens deemed non-compliant
l. Non-Eligible Medical Assistance services for Medical Assistance eligible patients
m. Unidentified patients (Doe accounts that we have exhausted all efforts to locate and/or ID)
n. Bankruptcy, by law, as mandated by the federal courts
o. Eligibility in certain UMMS clinical programs (including: St. Clare Outreach Program, UMMS Maternity Program, UMSJMC Hernia Program).

Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered for presumptive financial assistance until the Maryland Medicaid Psych program has been billed.

Financial Hardship Assistance Eligibility

Financial hardship assistance is available for patients who otherwise do not qualify for financial assistance under the primary guidelines of this policy, but for whom medical debt for medically necessary treatment over a twelve (12) month period exceeds 25% of that family's annual income.

- The amount of uninsured medical costs incurred at all UMMS member organizations will be considered in determining a patient's eligibility (including any accounts having gone to bad debt, except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses.
- For the patients who are eligible for reduced-cost care under the financial assistance criteria and also meet the criteria for financial hardship assistance criteria, UMMS will grant the total eligible reduction in charges.
- To calculate household income, UMMS will use the same criteria outlined in the Financial Assistance Eligibility section of this policy to calculate assets, household income, and family size.
- Once a patient is approved for financial hardship assistance, coverage will be effective for the month of the first qualifying date of service and a year prior to the determination. UMMS may decide to extend the financial hardship eligibility period further into the past or the future on a case-by-case basis.
- Financial hardship assistance will cover the patient and the eligible family members living in the household for the approved reduced cost and eligibility period for medically necessary care and will remain eligible for reduced-cost medically necessary care when seeking subsequent care at the same member organization during the 12–month period beginning on the date on which the reduced-cost medically necessary care was initially received. To avoid an unnecessary duplication of UMMS' determination of eligibility for free and reduced-cost care, the patient or eligible family members shall inform UMMS of the patient's or family member's eligibility for the reduced-cost medically necessary care.

All other eligibility, ineligibility, and procedures for primary financial assistance criteria apply to financial hardship assistance criteria, unless otherwise stated above.

IV. Appealing a Determination of Eligibility for Financial Assistance

Patients whose financial assistance applications are denied have the option to appeal the decision. Appeals can be initiated verbally or written. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.

If a patient wishes to make an appeal, UMMS will:

- Notify the patient that the Health Education and Advocacy Unit is available to assist them or their authorized representative in filing and mediating a reconsideration request.
- Provide the address, phone number, facsimile number, e-mail address, mailing address, and website of the Health Education and Advocacy Unit: Office of the Attorney General, Health Education and Advocacy Unit | 200 St. Paul Place, 16th Floor, Baltimore, MD 21202 | Phone: (410) 528-1840 | Toll-free in Maryland 1-877-261-8807 | Fax: (410) 576-6571 | Email: heau@oag.state.md.us
- Document appeals within the third party data and workflow tool for review by the next level of management above the representative who denied the original application.
- Submit a letter of final determination to each patient who has formally submitted an appeal.

Provider Driven Financial Clearance and Reconsideration

Where there is a compelling educational, medical, and/or humanitarian benefit, UMMS clinical team members may request financial clearance of patients that are not otherwise able or likely to pay for their healthcare services. Clinical team members must submit appropriate justification in advance of the patient receiving services. UMMS Revenue Cycle central billing office will evaluate the patient's eligibility for Medical Assistance and financial assistance. A Financial Clearance Executive Committee at the member organization level, comprised of clinical and financial leadership, will request the information submitted by the requesting clinical and the central billing office and make the final determination on whether to grant financial clearance on a case-by-case basis.

If financially cleared, patients are still responsible to complete the financial assistance application process, and may be subject to presumptive eligibility screening, as outlined in this policy.

V. Notice of Availability of Financial Assistance

UMMS will advise patients, patient's families, and authorized representatives of the availability of financial assistance using posted notices and the Patient Billing and Financial Assistance Information Sheet. The Patient Billing and Financial Assistance Information Sheet notifies the patient of the availability of financial assistance and payment plans, includes a description of UMMS Financial Assistance Policy, explains how to apply for financial assistance, and includes a description of the patient's rights and obligations with regard to hospital billing and collection under the law.

- UMMS will post notices of financial assistance availability in each UMMS hospital's emergency room (if any), admissions areas, key patient access areas, and the hospital billing office. Notice of availability will also be sent to the patient with patient statements.
- The Patient Billing and Financial Assistance Information Sheet will be provided at preadmission and before discharge for each hospital encounter, with each hospital statement, and it will be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas.

- The Financial Assistance Policy and the Financial Assistance Application will also be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas.
- The Financial Assistance Policy, the Patient Billing and Financial Assistance Information Sheet, and the Financial Assistance Application will also be conspicuously posted on the UMMS website (www.umms.org).

Patient Billing and Financial Assistance Information Sheet Content

In addition to the content referenced above, the Patient Billing and Financial Assistance Information Sheet will include:

- The website and physical location(s) where patients can obtain copies of the financial assistance policy and financial assistance application form
- Instructions on how to obtain a free copy of the financial assistance policy and financial assistance application form by mail.
- A statement of the availability of translations of the financial assistance documents.
- Contact information for UMMS Hospital Billing Customer Service Department, which is available to assist the patient, the patient's family, or the patient's authorized representative understand their statement, understand the patient's rights and obligations regarding the statement, learn how to apply for free or reduced cost care, or learn how to apply for Maryland Medical Assistance, or any other programs that may help pay their medical bills.
- Contact information for the Maryland Medical Assistance Program.
- A notification that physician charges are not included in the hospital statement and are billed separately.
- A notification informing patients of the right to request and receive a written estimate of the total charges for hospital nonemergency services, procedures, and supplies that reasonably are expected to be provided for professional services by the hospital.
- A notification that a patients who are eligible for free or reduced care may not be charged more than AGB for emergency or other medically necessary care.
- A section that informs the patient of their ability to make a formal complaint with the HSCRC and the Office of the Attorney General of Maryland.
- A section for the patient to initial to indicate that they have been made aware of UMMS Financial Assistance Policy

The Patient Billing and Financial Assistance Information Sheet will be written in plain language, as specified by the Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r), and will be made available in the patient's preferred language. It will also include a section that allows for patients to initial that they have been made aware of the financial assistance policy.

VI. Extraordinary Collection Actions

Account balances that have not been paid may be transferred to Bad Debt (deemed uncompensated care) and referred to an outside collection agency or to UMMS's attorney for legal and/or collection activity. Third party agencies and/or attorneys are jointly and severally responsible for meeting the debt collection requirements listed in this policy, and in the UMMS Credits and Collections Policy. Collection activities taken on behalf of

UMMS by a collection agency or UMMS' attorney may include the following Extraordinary Collection Actions (ECAs):

- Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus. UMMS will not report adverse information to a consumer reporting agency regarding a patient who was uninsured or eligible for free or reduced-cost care at the time of service. UMMS will not report to a consumer reporting agency until at least 180 days after the initial statement was provided. Prior to reporting to a consumer reporting agency, UMMS will determines whether the patient is eligible for free or reduced-cost care. UMMS will not report adverse information about a patient to a consumer reporting agency if UMMS was notified in accordance with federal law by the patient or an insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days, or if UMMS has completed a requested reconsideration of the denial of free or reduced-cost care that was appropriately completed by the patient within the immediately preceding 60 days.
- Commencing a civil action against the individual. UMMS will not hold a spouse or another individual liable for the debt owed on a hospital bill of an individual who is at least 18 years old. UMMS will not file a civil action to collect debt until at least 180 days of after the initial bill was provided. Prior to filing the civil action, UMMS will determines whether the patient is eligible for free or reduced-cost care. UMMS will not file a civil action to collect debt if UMMS was notified in accordance with federal law by the patient or an insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days. UMMS will not file a civil action to collect debt if UMMS has completed a requested reconsideration of the denial of free or reduced-cost care that was appropriately completed by the patient within the immediately preceding 60 days.
- Attaching or seizing an individual's bank account or any other personal property.
- Garnishing an individual's wage. UMMS will not request a garnishment of wages or file an action that would result in an attachment of wages against a patient if the patient is eligible for free or reduced-cost care.

ECAs may be taken on accounts that have not been disputed or are not on a payment arrangement. ECAs will occur no earlier than 180 days from submission of first post-discharge bill to the patient and will be preceded by a written notice 45 days prior to commencement of the ECA. This written notice will be accompanied by an application for financial assistance (and instructions for completing the application) and a notice of availability of a payment plan to satisfy the medical debt, and the Patient Billing and Financial Assistance Information Sheet. The written notice will include the following information:

- Specified contact and procedural information.
    - The name and telephone number for UMMS,
    - The name and telephone number for the debt collector (if applicable)
    - The contact information for the UMMS Financial Assistance Department (or third party agency acting on behalf of UMMS), authorized to modify the terms of a payment plan (if applicable)
    - Telephone number and internet address of the Health Education Advocacy Unit in the Office of the Attorney General, available to assist patients experiencing medical debt.
- The amount required to satisfy the debt (including any past due payments, penalties, or fees, if applicable)

- Identification of ECAs that UMMS (or its collection agency, attorney, or other authorized party) intends to utilize in order to obtain payment for the care, and state a deadline after which such ECAs may be initiated.
- A deadline after which such ECA(s) may be initiated that is no earlier than 45 days after the date that the written notice is provided.
- A statement recommending that the patient seek debt counseling services,
- An explanation of the UMMS Financial Assistance Policy, and a notification of availability of financial assistance for eligible individuals
- And any other information as prescribed by the HSCRC

Written notice and accompanying documentation will be sent to the patient by certified mail and first class mail, in the patient's preferred language, or another language, as specified. The written notice will be in simplified language of at least 10 point type.

In addition to the written notification, UMMS (and/or its collection agency or attorney) will make reasonable efforts to orally communicate the availability of financial assistance to the patient and tell the patient how he or she may obtain assistance with the application process. A presumptive eligibility review will occur prior to any ECA being taken. Finally, no ECA will be initiated until approval has been obtained from the UMMS Revenue Cycle Services leadership.

If a patient is determined to be eligible for financial assistance, UMMS (and/or its collection agency or attorney) will take all reasonably available measures to reverse any ECAs taken against the patient to obtain payment for care rendered during the financial assistance eligibility window. Such reasonably available measures will include measures to vacate any judgment against the patient, lift levies or liens on the patient's property, and remove from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau. All ECAs will cease once the patient is approved for financial assistance and all the patient responsible balances are paid.

UMMS will not engage in the following ECAs:

- Selling debt to another party.
- Charge interest on bills incurred by patients before a court judgement is obtained
- Requesting a lien against a patient's primary residence. In some cases, Local, State, or Federal judicial protocols may mandate that a lien is placed, but UMMS will not force the sale or foreclosure of a patient's primary residence.
- Request the issuance of or take action causing a court to issue a body attachment or an arrest warrant against a patient.
- Make a claim against the estate of a deceased patient if the deceased patient was known by UMMS to be eligible for free care or if the value of the estate after tax obligations are fulfilled is less than half of the debt owned. However, UMMS may offer the family of the deceased patient the ability to apply for financial assistance.
- Require payment of medical debt prior to providing medically necessary care.

ATTACHMENTS:

ATTACHMENT A: Sliding Scale – Reduced Cost of Care

2022 Federal Poverty Limits (FPL) Annual Income Eligibility Limit Guidelines							
House-hold (HH) Size	1	2	3	4	5	6	See UMMS Charity Thresholds below
Income Limit (up to Max)	$13,590	$18,310	$23,030	$27,750	$32,470	$37,190	

2022 Maryland Dept of Health (MDH) Annual Income Eligibility Limit Guidelines							
House-hold (HH) Size	1	2	3	4	5	6	See UMMS Charity Thresholds below
Income Limit (up to Max)	$18,768	$25,272	$31,800	$38,304	$44,808	$51,336	

UMMS Financial Assistance Charity Income Thresholds							
If your total annual household (HH) income level is at or below:							You are eligible for the following level of charity at UMMS:
House-hold (HH) Size	1	2	3	4	5	6	
Income Limit (up to Max)	$37,536	$50,544	$63,600	$76,608	$89,616	$102,672	**100% Charity** (Equals Up to 200% of MDH Annual Income limits)
Income Limit (up to Max)	$39,413	$53,071	$66,780	$80,438	$94,097	$107,806	**90% Charity** (Equals Up to 210% of MDH Annual Income limits)
Income Limit (up to Max)	$41,290	$55,598	$69,960	$84,269	$98,578	$112,939	80% Charity (Equals Up to 220% of MDH Annual Income limits)
Income Limit (up to Max)	$43,166	$58,126	$73,140	$88,099	$103,058	$118,073	**70% Charity** (Equals Up to 230% of MDH Annual Income limits)
Income Limit (up to Max)	$45,043	$60,653	$76,320	$91,930	$107,539	$123,206	60% Charity (Equals Up to 240% of MDH Annual Income limits)
Income Limit (up to Max)	$46,920	$63,180	$79,500	$95,760	$112,020	$128,340	**50% Charity** (Equals Up to 250% of MDH Annual Income limits)
Income Limit (up to Max)	$48,797	$65,707	$82,680	$99,590	$116,501	$133,474	40% Charity (Equals Up to 260% of MDH Annual Income limits)
Income Limit (up to Max)	$50,674	$68,234	$85,860	$103,421	$120,982	$138,607	**30% Charity** (Equals Up to 270% of MDH Annual Income limits)
Income Limit (up to Max)	$52,550	$70,762	$89,040	$107,251	$125,462	$143,741	**20% Charity** (Equals Up to 280% of MDH Annual Income limits)
Income Limit (up to Max)	$56,303	$75,815	$95,399	$114,911	$134,423	$154,007	**10% Charity** (Equals Up to 290% of MDH Annual Income limits)

*All discounts stated above shall be applied to the amount the patient is personally responsible for paying after insurance reimbursements.
*Amounts billed to patients who qualify for Reduced-Cost of Care on a sliding scale (or for Financial Hardship Assistance) will be less than the amounts generally billed to those with insurance (AGB), which in Maryland is the charge established by the Health Services Cost Review Commission (HSCRC). UMMS determines AGB by using the amount Medicare would allow for the care (including the amount the beneficiary would be personally responsible for paying, which is the HSCRC amount; this is known as the "prospective Medicare method".

Effective 7/1/22

RELATED POLICIES:
UMMS Credit & Collections Policy
UMMS Payment Plan Policy

POLICY OWNER:
UMMS Revenue Cycle Services

APPROVED:
Executive Compliance Committee Approved Initial Policy: 09/18/19
Executive Compliance Committee Approved Revisions: 10/19/2020, 11/07/22

This policy was approved by the UMMS Executive Compliance Committee (ECC) Board on October 19, 2020.
This policy was adopted for:

- UM St. Joseph Medical Center (UMSJMC) effective June 1, 2013.
- UM Midtown Campus (MTC) effective September 22, 2014.
- UM Baltimore Washington Medical Center (UMBWMC) effective July 1, 2016.
- UM Shore Regional Health (UMSRH) effective September 1, 2017.
- UM Charles Regional Medical Center (UMCRMC) effective December 2, 2018.
- UM Upper Chesapeake Health (UCHS) effective July 1, 2019
- UM Capital Region Health (UMCRH) effective September 18, 2019