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. Hospitals are expected to respond to any follow-up/clarifying questions from staff to ensure completeness and accuracy of the report.

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: MedStar Union Memorial Hospital	●	○	
Your hospital's ID is: 210024	●	○	
Your hospital is part of the hospital system called MedStar Health	●	○	
The primary hospital community benefit (HCB) Narrative contact at your hospital is Meghan Monpremier	●	○	
The primary HCB Narrative contact email address at your hospital is Meghan.A.Monpremier@medstar.net	●	○	
The primary HCB Financial report contact at your hospital is Beth Kelly	●	○	
The primary HCB Financial report contact email at your hospital is Beth.e.Kelly@medstar.net	●	○	

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

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

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

The hospital utilizes a wide variety of metrics including hospital patient utilization data, disease incidence and prevalence, density of underserved or low-income residents and evidenced health disparities, and presence of existing programs and partnerships.

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
- [x] Baltimore City
- [ ] 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.

- [ ] 21201
- [ ] 21202
- [ ] 21203
- [ ] 21205
- [ ] 21206
- [ ] 21207
- [ ] 21208
- [ ] 21209
- [ ] 21210
- [ ] 21211
- [ ] 21212
- [x] 21213
- [ ] 21214
- [ ] 21215
- [ ] 21216
- [ ] 21217
- [x] 21218
- [ ] 21222
- [ ] 21223
- [ ] 21224
- [ ] 21225
- [ ] 21226
- [ ] 21227
- [ ] 21228
- [ ] 21229
- [ ] 21230
- [ ] 21231
- [ ] 21233
- [ ] 21234
- [ ] 21236
- [ ] 21237
- [ ] 21239
- [ ] 21251
- [ ] 21263
- [ ] 21270
- [ ] 21278
- [ ] 21281
- [ ] 21287
- [ ] 21290

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

☐ Based on ZIP codes in your Financial Assistance Policy. Please describe.

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

☐ Based on patterns of utilization. Please describe.

☑ Other. Please describe.

The CBSA was selected based on hospital patient utilization data; elevated disease incidence and prevalence; a high density of underserved or low-income residents and evidenced health disparities; proximity to the hospital; and/or an existing presence of programs and partnerships.

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

https://www.medstarunionmemorial.org/our-hospital/mission-vision-and-values/

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)

6/30/2024

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

https://bluetoad.com/publication/?i=821502&p=&pn=

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

2024 MedStar_CHNA.pdf
10.2MB
application/pdf

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

Q44. Please use the table below to tell us about the internal partners involved in 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)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
CB/ Community Health/ Population Health Director (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☐	☑	☑	☑	☑	☐	☐	☐	
Board of Directors or Board Committee (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Board of Directors or Board Committee (system level)	☐	☐	☐	☑	☑	☐	☐	☐	☐	☐	
Clinical Leadership (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Clinical Leadership (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	

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

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)	☐	☐	☑	☑	☑	☐	☑	☑	☑	☐	
CB/ Community Health/ Population Health Director (system level)	☐	☐	☑	☑	☑	☐	☐	☐	☑	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☐	☑	☑	☐	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (facility level)	☐	☐	☐	☑	☐	☐	☐	☐	☑	☐	
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)	☐	☐	☐	☐	☑	☐	☑	☐	☑	☐	

	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:
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 2024 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is mandatory for FY 2024.

	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: JHH, UMD, MHH, MGSH, Lifebridge, Ascension St. Agnes	☐	☑	☐	☐	☐	☐	☑	☑	☐	☑	☐	☑	☐	☑

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Departments -- Please list the Local Health Departments here: Baltimore City Health Dept	☐	☐	☐	☑	☐	☐	☑	☑	☑	☑	☐	☑	☑	☑
Local Health Improvement Coalition -- Please list the LHICs here: Baltimore City LHIC	☐	☐	☐	☑	☐	☐	☑	☑	☐	☑	☐	☑	☐	☑
Maryland Department of Health	☐	☐	☐	☑	☐	☐	☑	☑	☑	☑	☐	☑	☐	☑
Other State Agencies -- Please list the agencies here: Maryland Dept of Social Services	☐	☐	☐	☑	☐	☐	☑	☑	☐	☑	☐	☑	☐	☑
Local Govt. Organizations -- Please list the organizations here: Mayor's office of Neighborhood Safety and Engagement Mayor's office of Employment Development Mayor's office of Homeless Services	☐	☐	☐	☑	☐	☐	☑	☑	☐	☑	☐	☑	☑	☑
Faith-Based Organizations	☐	☐	☐	☑	☐	☐	☑	☑	☐	☑	☐	☑	☑	☑

Organization	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - K-12 -- Please list the schools here: Northwood ES, Yorkwood ES	☐	☐	☐	☑	☐	☐	☑	☑	☐	☑	☐	☑	☑	☑
School - Colleges, Universities, Professional Schools -- Please list the schools here: Towson U, UMD, Morgan State U	☐	☐	☐	☑	☐	☐	☑	☑	☐	☑	☐	☑	☑	☑
Behavioral Health Organizations -- Please list the organizations here: Mosaic, NAMI, Baltimore Behavioral Health Services, Oasis, Glowing Souls, Behavioral Health Systems Baltimore	☐	☐	☐	☑	☐	☐	☑	☑	☐	☑	☐	☑	☐	☑
Social Service Organizations -- Please list the organizations here: GEDCO, Keswick-MD, Turnaround Tuesday, Y of Central MD, Franciscan Center	☐	☐	☐	☑	☐	☐	☑	☑	☐	☑	☐	☑	☑	☑
Post-Acute Care Facilities -- please list the facilities here: FutureCare-Charles Village,Coldspring,Good Samaritan, Homewood Autumn Lake-Cromwell, Homewood Center,Loch Raven, Long Green Keswick MultiCare Promedica / Manor Care-Powerback	☐	☐	☐	☑	☐	☐	☑	☑	☐	☑	☐	☑	☐	☑

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

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.

6/30/2024

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

https://bluetoad.com/publication/?i=821502&p=&pn=

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

2024 MedStar_CHNA.pdf
10.2MB
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.

MedStar Health identified priorities for healthcare disparity reduction in hospital care, transitional care, perinatal care, and ambulatory care. As part of our system strategy to advance health equity, we routinely examine and monitor healthcare disparities that exist among historically marginalized communities, including but not limited to the following: racial and ethnic minorities, individuals with limited English proficiency, and low-income individuals who are uninsured or Medicaid insured. Each MedStar Health acute care hospital is committed to advancing health equity in sepsis care, a life-threatening medical emergency. Additionally, in partnership with MedStar Health Clinical Care Transformation and Home Care, each acute care hospital and rehabilitation facility is committed to reducing readmission disparities and supporting smooth care transitions after hospitalization for every community it serves. Further, recognizing the ongoing national maternal health crisis, each MedStar Health hospital that provides obstetrics services is committed to reducing severe maternal morbidity, which disproportionally affects people of color.

Q62. Other than Charity Care, Graduate Medical Education, and the Nurse Support Programs, please select the rate supported programs in which your hospital participates:

- [ ] 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?

- (x) Yes
- ( ) No

Q68. Please describe the community benefit narrative audit process.

The internal review of the Community Benefit Report is performed by the Administrative Director, Population Health, the Financial Services Manager, and the CFO. The CFO provides oversight of the CBISA reporting function, auditing process and approval of Community Benefit funding. The CEO's and CFO's signature is obtained through an attestation letter supporting their approval of the Community Benefit Report. The MedStar Health Corporate Office also conducts a review/audit of the hospital's Community Benefit Report annually.

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

- (x) 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?

- (x) 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?

- (x) Yes
- ( ) No

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

MedStar Health's vision is to be the trusted leader in caring for people and advancing health. As part of MedStar Health's fiscal year 2021-2025 system strategic plan (which acts as the umbrella plan for all MedStar Health entities, including its hospitals), community health and community benefit initiatives and tactics ladder up to the Develop Care Management Capabilities strategy focus area. This strategy provides guidance and context for the community health needs assessments, priorities and initiatives for each MedStar Health hospital.

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

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

The hospital provides programs that focus on different aspects of reducing the mean BMI for Maryland residents including improving fitness, improving access to healthy foods, improving knowledge related to nutrition and diabetes.

- [x] Opioid Use Disorder - Improve overdose mortality

The hospital provides programs that focus on early identification of substance abuse and supports substance abuse recovery in the community including promoting access to behavioral health programs. High risk residents are linked to treatment services and naloxone trainings, and provided a point of contact should health care services be needed.

- [ ] 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.)

Q80. Section V - Financial Assistance Policy (FAP)

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

MedStar Health Corporate Financial Assistance Policy_12.2021 web version.pdf
298.1KB
application/pdf

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

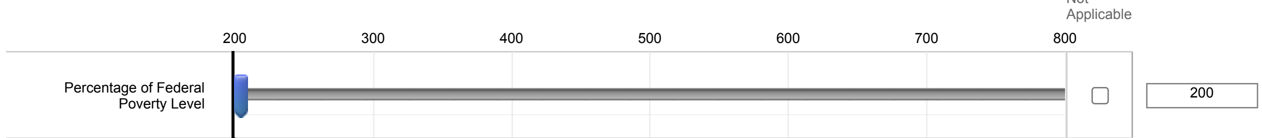
https://www.medstarhealth.org/mhs/patients-and-visitors/medstar-health-financial-assistance/

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:

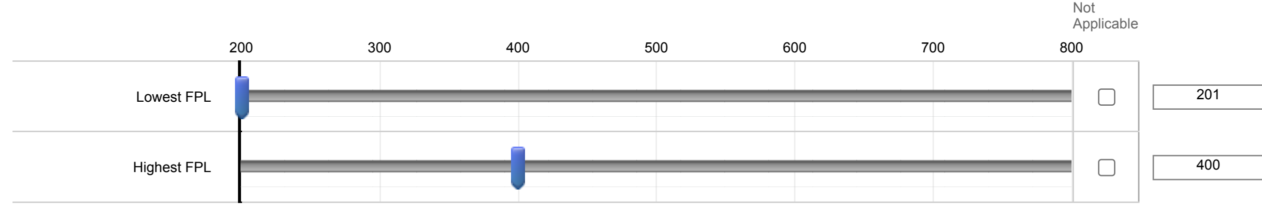
Q84. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



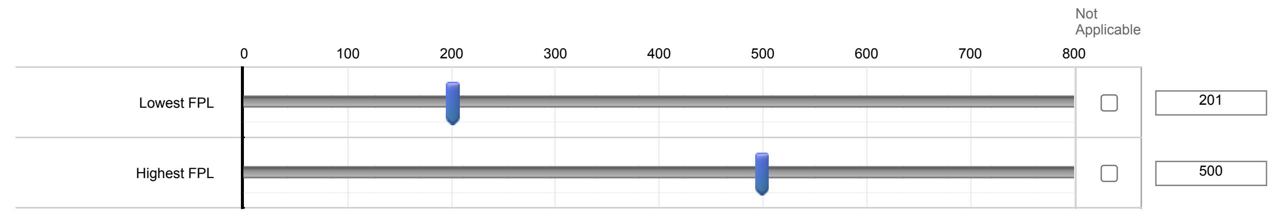
Q85. Maryland acute care and chronic care hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

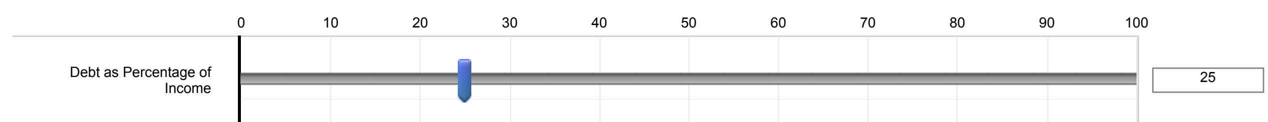


Q86. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3)(a) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial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

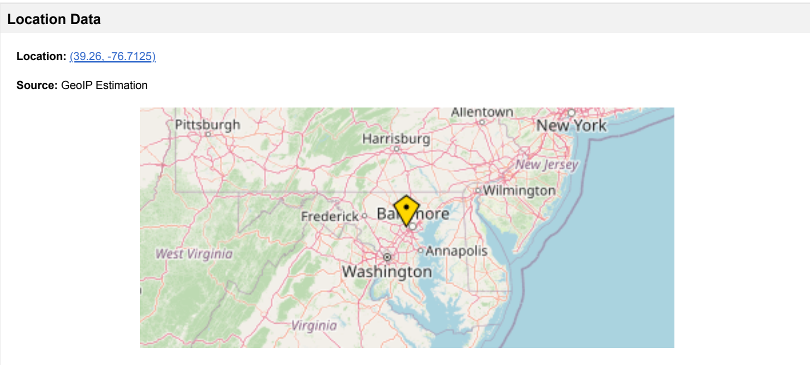
Attention Hospital Staff! IMPORTANT!

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.



2024 Community Health Needs Assessment

It's how we **treat people.**

Table of contents

2 **Executive summary**
Geographic footprint

4 **CHNA approach**
About MedStar Health
CHNA process at MedStar Health
Methodology and data collection
Community Benefit Service Areas (CBSAs)
Priorities and implementation strategies
Hospital role in identified priority areas
CHNA process limitations and key considerations
Evaluation

8 **Assessing the needs of the community**
Planning and execution
Our health equity approach
Guiding principles and framework
Key contributors and participant groups
Disease areas of focus

12 **Community engagement**
Survey methodology
Key findings
Survey limitations and key considerations
Systemwide respondent demographics

14 **Community input data summary**
Community input methodology
Summary of systemwide priorities

18 **Longitudinal analyses**
Methodology
Key takeaways

20 **Individual hospital CHNAs and strategies**
20 MedStar Franklin Square Medical Center
30 MedStar Georgetown University Hospital
40 MedStar Good Samaritan Hospital
50 MedStar Harbor Hospital
61 MedStar Montgomery Medical Center
70 MedStar National Rehabilitation Hospital
79 MedStar St. Mary's Hospital
89 MedStar Southern Maryland Hospital Center
98 MedStar Union Memorial Hospital
108 MedStar Washington Hospital Center

118 **References**

Executive summary

As a not-for-profit healthcare system, MedStar Health is deeply rooted in our mission to serve communities across Maryland and the Washington, D.C., region. Our dedication to advancing medicine extends beyond the traditional boundaries of healthcare delivery. Through continuous investment in education, innovation, and research, we strive to push the boundaries of what is possible in health care.

Operating a vast network of over 300 care locations, including hospitals situated strategically throughout the Baltimore–Washington, D.C. metropolitan area, MedStar Health is at the forefront of providing high-quality care to diverse populations. From our hospitals to ambulatory care centers, urgent care facilities, and even telehealth and home care services, we are committed to ensuring that patients receive the right care, at the right time, in the right setting.

Our commitment to improving health does not stop at the doors of our facilities. We recognize that the health of individuals is intricately linked to the health of the communities they belong to. This understanding drives us to actively engage with our communities, seeking to address not just immediate healthcare needs but also underlying social drivers of health.

One of the key tools in our arsenal is the Community Health Needs Assessment (CHNA), a comprehensive examination of local health needs, conducted every three years. This assessment serves as a roadmap, providing valuable insights into the unique health challenges facing different communities. By understanding these challenges, we can develop targeted strategies and partnerships to address them effectively.

Employing a coordinated, formal, and systematic approach, we develop and implement a comprehensive plan aimed at improving health outcomes for the communities we serve. The CHNA shapes the framework for future community health initiatives and the allocation of resources for fiscal years 2025–2027 across MedStar Health's 10 hospitals. Complying with Affordable Care Act guidelines and Internal Revenue Service (IRS) requirements, MedStar Health's CHNAs are central to our dedication to community wellbeing.

However, the CHNA is more than just a document—it is a call to action. It guides us in our mission to improve health outcomes for all members of our community, particularly those who are disproportionately affected by health disparities. From developing innovative programs to increasing access to care and advocating for policy changes, the CHNA informs every aspect of our work.

Looking ahead, we are committed to using the findings of the CHNA to shape our priorities and initiatives for the coming years. By staying true to our mission and leveraging the power of collaboration, innovation, and compassion, we will continue to make a meaningful difference in the lives of those we serve.

CHNA quick facts:

- Guides MedStar Health in understanding and addressing local health needs
- Directs the development of plans to enhance the health of populations disproportionately affected by disease
- Informs strategies for new community health programming
- Published comprehensively every three years

Committed to our communities

At MedStar Health, we use the best of our minds and the best of our hearts to serve our patients, those who care for them, and our communities. As a not-for-profit healthcare system, MedStar Health is deeply invested in the wellbeing of the communities we serve. Many of our associates live and work in the same neighborhoods as our patients, allowing us to forge strong connections and a deep understanding of local needs. Through community outreach programs, health education initiatives, and partnerships with local organizations, we strive to promote health and wellness at every level, making a positive impact on the lives of individuals and families throughout our region.

MedStar Health mission and vision

Our vision: To be the trusted leader in caring for people and advancing health.
Our mission: To serve our patients, those who care for them, and our communities.

Our MedStar Health hospitals are dedicated to enhancing our community's health and wellbeing by offering high-quality, compassionate, and personalized care. We are dedicated to continuous learning and innovation, constantly seeking new knowledge, and applying it to improve the quality and effectiveness of our care in the diverse communities we serve.

MedStar Health hospital geographic footprint

Greater Baltimore region

Baltimore City: MedStar Good Samaritan Hospital, MedStar Union Memorial Hospital, and MedStar Harbor Hospital
The three MedStar Health Baltimore City hospitals serve North, Central, and South Baltimore.
Baltimore County: MedStar Franklin Square Medical Center
This hospital is located in the Rosedale area of eastern Baltimore County.

Central Maryland

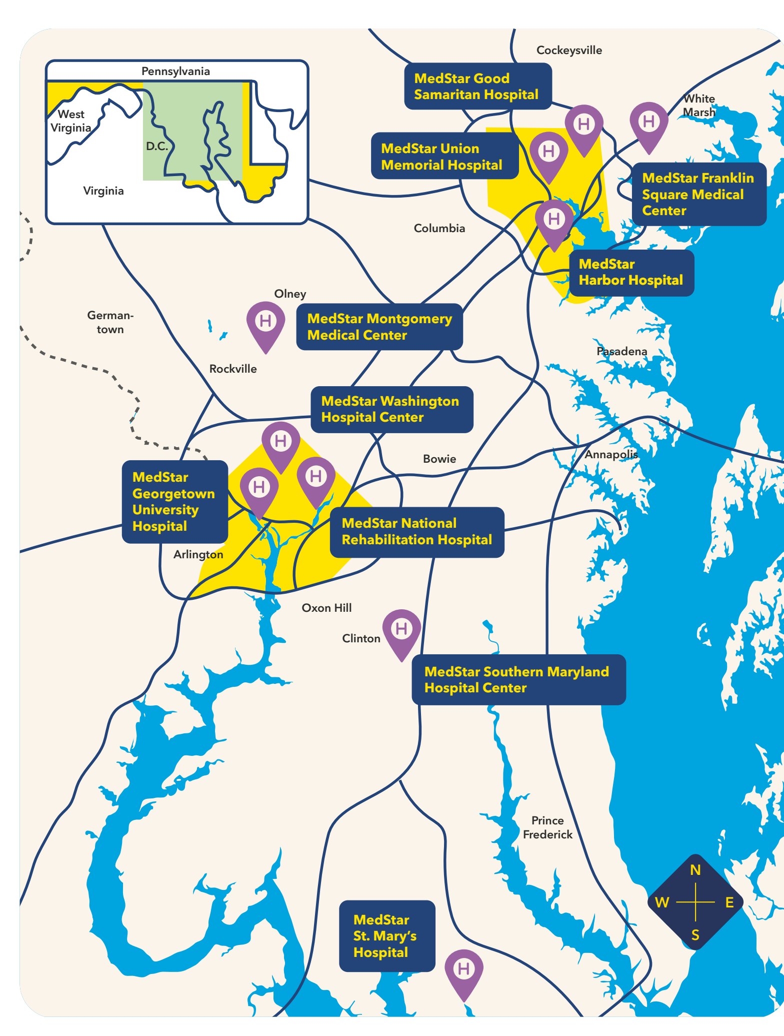
Montgomery County: MedStar Montgomery Medical Center
This hospital is located in Olney, a suburb of the D.C. metro area, in north-central Montgomery County.

Southern Maryland

Prince George's County: MedStar Southern Maryland Hospital Center
St. Mary's County: MedStar St. Mary's Hospital
These MedStar Health hospitals are located in the southern portion of Prince George's and St. Mary's counties.

District of Columbia region

Washington, D.C.: MedStar Georgetown University Hospital, MedStar Washington Hospital Center, and MedStar National Rehabilitation Hospital
MedStar Health has two large acute hospitals and one specialty hospital in Washington, D.C.



CHNA approach

About MedStar Health

MedStar Health is the largest healthcare provider in Maryland and the Washington, D.C., region, renowned for the integration of academic medicine, research, and innovation to advance patient care. With over 300 care locations, including 10 hospitals, 33 urgent care clinics, ambulatory care centers, and an extensive array of primary and specialty care providers, MedStar Health offers a comprehensive spectrum of clinical services. We are also home to the MedStar Health Research Institute and a comprehensive scope of health-related organizations all recognized regionally and nationally for excellence. MedStar Health boasts one of the nation's largest graduate medical education programs, training 1,150 medical residents annually and serving as the medical education and clinical partner of Georgetown University. MedStar Health is committed to its patient-first philosophy, emphasizing care, compassion, and clinical excellence, supported by a dedicated team of over 32,000 physicians, nurses, and many other clinical and non-clinical associates.

CHNA process at MedStar Health

The CHNA serves as a structured framework guiding targeted health promotion strategies within the hospitals' Community Benefit Service Areas (CBSAs). Over the course of a three-year cycle, the efficacy and impact of hospitals' initiatives within their respective CBSAs will be monitored and evaluated. Integral to the CHNA process is the active participation of residents, community partners, and stakeholders, ensuring that the assessment accurately reflects the unique health needs and priorities of each community.

Each hospital's CHNA is spearheaded by an Advisory Task Force (ATF) comprised of a diverse group of stakeholders, including community activists, residents, faith-based leaders, hospital representatives, and public health experts. ATF members utilize a comprehensive array of data sources, including population-level data, community health surveys, and community input sessions, to formulate recommendations for the hospital's health priorities and corresponding implementation strategies.

In partnership with the Georgetown University School of Health, rigorous data analysis is performed to derive a comprehensive understanding of the health landscape within each CBSA. Extensive community engagement initiatives, including the completion of over 10,320 surveys and the facilitation of 16 community input sessions with more than 300 participants, ensure that community perspectives are integrated into the decision-making process.

The completion of this process results in the development of CHNA implementation strategies, which undergo thorough review and endorsement by each hospital's Board of Directors before final approval by MedStar Health's Board of Directors. This collaborative approach ensures that the strategies are evidence-based and community-driven, effectively addressing the health needs of the populations served by MedStar Health hospitals.

Methodology and data collection

The CHNA process was a comprehensive and collaborative endeavor aimed at understanding and addressing the health needs of the communities served by MedStar Health's hospitals. This process involved a multifaceted approach to data collection and analysis, ensuring that a wide range of perspectives and insights were considered.

10,323 **surveys were completed**

10,323 questionnaires were completed and **16** community input sessions were facilitated to identify community needs and develop targeted implementation strategies across each of the 10 hospitals' CBSAs.

The CHNA process incorporated various data sources, including quantitative secondary population-level data, hospital healthcare utilization data, a community survey, and qualitative community input sessions. These sources provided a comprehensive understanding of the health needs and priorities within each community and engaged a diverse group of internal and external stakeholders in the CHNA process.

- **Secondary data:** National, state, and local health and health disparity data, public health priorities, community health improvement plans, as well as county-level zip code and neighborhood-level data (where available) were analyzed.
- **Hospital utilization data:** Patient healthcare utilization and charity care data (a proxy for economic status) were used to identify each hospital's CBSAs and geographic areas of focus for strategy implementation.
- **Community survey:** A survey consisting of open-ended and multiple-choice questions about healthcare access, health equity, health concerns, social drivers, and community strengths and assets was distributed by the hospitals in the community.
- **Community input sessions:** Hospitals facilitated 16 community input sessions with diverse community stakeholders to identify the most critical community health issues. Guided discussion areas included topics related to community health and wellness, access to care and services, and the social drivers of health.

The combined information gathered from these sources was used to inform the recommendations of the ATFs responsible for each hospital's CHNA. The ATFs recommendations focused on:

1. Identifying a community benefit service area
2. Prioritizing identified health needs
3. Determining the hospitals' role in addressing the prioritized health issues
4. Establishing system, regional, and hospital-specific strategies, and outcome measures

The CHNA process culminated in the endorsement of final implementation strategies by each hospital's Board of Directors and MedStar Health's Board of Directors. These strategies outlined the actions to be taken by the hospitals over the next three years to address identified health needs and improve community health outcomes. Through this collaborative and data-driven approach, MedStar Health aims to make meaningful and sustainable contributions to the health and wellbeing of the communities we serve.

Community Benefit Service Areas (CBSAs)

Each hospital designated a specific community or target population for focus, referred to as a Community Benefit Service Area (CBSA). A CBSA is a defined geographical area that is disproportionately burdened by disparities in health outcomes and socio-economic conditions that influence health, such as education, income, housing, and insurance status. The CHNA will function as a structured guide for implementing targeted health promotion strategies within the CBSA. While programs and services are open to residents in any zip code in the Maryland and Washington, D.C. regions, programs and services are tailored to the specific needs and vulnerable populations identified in the CBSA. The effectiveness of the hospitals' initiatives within their respective CBSAs will be monitored and evaluated over the course of a three-year cycle.

MedStar Health Hospital	CBSA zip codes
MedStar Franklin Square Medical Center	21220, 21221, 21222, 21237
MedStar Georgetown University Hospital	20002, 20011, 20019
MedStar Good Samaritan Hospital	21206, 21218, 21239
MedStar Harbor Hospital	21225, 21226
MedStar Montgomery Medical Center	20906
MedStar National Rehabilitation Hospital	Residents with disabilities in the greater D.C. area
MedStar St. Mary's Hospital	20653
MedStar Southern Maryland Hospital Center	20735, 20748, 20772
MedStar Union Memorial Hospital	21218
MedStar Washington Hospital Center	20002, 20010, 20011, 20019

Priorities and implementation strategies

The CHNA process involved identifying and categorizing three overarching domains crucial to community health: health and wellness, access to care and services, and social drivers of health. Within the health and wellness domain, priority areas such as chronic disease prevention and management (including diabetes, heart disease, obesity, and cancer) as well as behavioral health and substance use disorders were highlighted across MedStar Health's hospitals.

In the realm of access to care and services, the CHNA emphasized the critical need for increased access to health insurance, assistance with the cost of healthcare services, access to healthcare providers, and transportation. Additionally, various social drivers of health, such as food insecurity, housing and homelessness, and neighborhood safety, were identified as key factors impacting community health and wellbeing.

Health and wellness

- Chronic disease prevention and management
- Behavioral health: mental health and substance use disorders

Access to care

- Access to affordable health care and insurance
- Access to healthcare providers
- Appointment wait times
- Transportation

Social drivers of health

- Housing and homelessness
- Food insecurity
- Neighborhood safety and community violence

As part of the CHNA process, hospital ATFs were responsible for determining the appropriate level of engagement for each hospital in addressing priority needs. This involved assessing factors such as hospital strengths and assets, community expertise, and existing programming. Based on these considerations, three levels of engagement—leader, partner, and supporter—were established.

Each hospital then developed tailored implementation strategies to address the identified priorities, ensuring alignment with community needs and resources. These strategies aimed to address the root causes of health disparities and improve health outcomes by leveraging the hospital's resources, expertise, and partnerships within the community.

Prioritization process and criteria

The identification of priorities involved a comprehensive assessment of public health priorities, local community needs, existing partnerships, and programming, considering each hospital's strengths within the broader context of the system's priorities. The ATFs engaged in prioritization exercises, aimed at systematically grouping and ranking the identified needs based on their significance and potential impact. These exercises provided a structured approach to discerning the most pressing issues requiring attention. Additionally, the ATFs facilitated discussions regarding both existing and potential new initiatives and partnership opportunities. By fostering open dialogue and collaboration, the ATFs ensured that the priorities identified were aligned with the overarching goals of the system and reflected the diverse perspectives and expertise of all involved stakeholders.

Hospital role in identified priority areas

MedStar Health hospitals acknowledge the limitations in addressing all identified health needs outlined in the CHNA. Therefore, each of the 10 hospitals undertook the task of defining their respective roles in tackling the identified priorities.

After prioritizing the community health needs, the ATF of each hospital, in conjunction with hospital leadership, defined the appropriate roles for addressing the identified priorities. This determination predominantly relied on the evaluation of hospital and community strengths, findings from the assessment process, and the selected priorities.

See below the types of hospital roles that were established.

Focus (leader) role

Areas in which MedStar Health is well-positioned, has internal strengths, expertise, and capacity to take a leadership role in the execution of the implementation strategy for a designated priority area along with established or newly identified partners.

Collaboration (partner) role

Areas in which MedStar Health is best positioned to serve as a collaborator or partner with community organizations and external stakeholders who have a stronger leadership position in identified priority areas.

Participation (supporter) role

Areas that MedStar Health recognizes are significant contributors to health but are beyond the scope of organizational strengths.

CHNA process limitations and key considerations

The reliability and comprehensiveness of survey responses are subject to certain limitations. The opinions expressed within surveys reflect the individuals who chose to participate, potentially resulting in a sample that does not fully represent the diversity of the CBSA. Factors such as response bias, where certain demographic groups are overrepresented or underrepresented, can skew the findings and lead to a misrepresentation of the community's perspectives.

Furthermore, the data collected through surveys are inherently constrained by the information available at the time of the survey administration. This means that responses may not accurately capture the most up-to-date trends or developments occurring in 2024.

Changes in societal attitudes, economic conditions, healthcare policies, and other contextual factors may have transpired since the data collection period, rendering the survey findings less reflective of the current landscape.

Evaluation

Over the next three years, the hospitals will actively engage in executing the implementation strategies developed in response to the identified priority areas. This involves a concerted effort to translate plans into action, with a focus on delivering targeted programs and interventions aimed at addressing the specific health needs identified through the CHNA.

Central to this process is the systematic measurement and tracking of program effectiveness. Hospitals will implement robust monitoring and evaluation mechanisms to assess the impact of their initiatives, ensuring that progress is measured against predefined objectives and benchmarks. This iterative evaluation process allows hospitals to adapt and refine their strategies based on real-time feedback, optimizing outcomes, and maximizing the impact of their interventions.

MedStar Health hospitals are committed to transparently reporting progress and outcomes relative to both internal performance measures and broader public health goals at the local and national levels. This includes regular communication of key findings and achievements to ATF members, who play a vital role in providing oversight and guidance throughout the CHNA process. Additionally, progress updates will be shared with each hospital's Board of Directors, ensuring that organizational leadership remains informed and engaged in efforts to improve community health.

To facilitate ongoing evaluation and refinement of strategies, the progress and impact of hospitals' initiatives will be assessed annually. This assessment will involve a comprehensive review of key metrics, program outcomes, and community feedback. The findings will then be shared with ATF members, who play a crucial role in guiding community health initiatives, as well as each hospital's Board of Directors. By sharing these updates with relevant stakeholders, hospitals can solicit feedback, foster collaboration, and ensure alignment with organizational objectives, ultimately enhancing the effectiveness of community health initiatives.

Assessing the needs of the community

CHNA planning and execution

The Community Health department operates as the central hub responsible for orchestrating and managing initiatives aimed at enhancing health outcomes throughout the service areas across the system. With a meticulous approach grounded in evidence-based methodologies, the department strategically evaluates and supports hospitals in implementing interventions to address the diverse array of health-related challenges faced by the community.

Drawing upon the expertise and strengths of our hospitals and partners, MedStar Health has thoughtfully crafted a systemwide process to execute the CHNA. By leveraging existing resources and knowledge, we ensure a comprehensive and efficient assessment of community health needs.

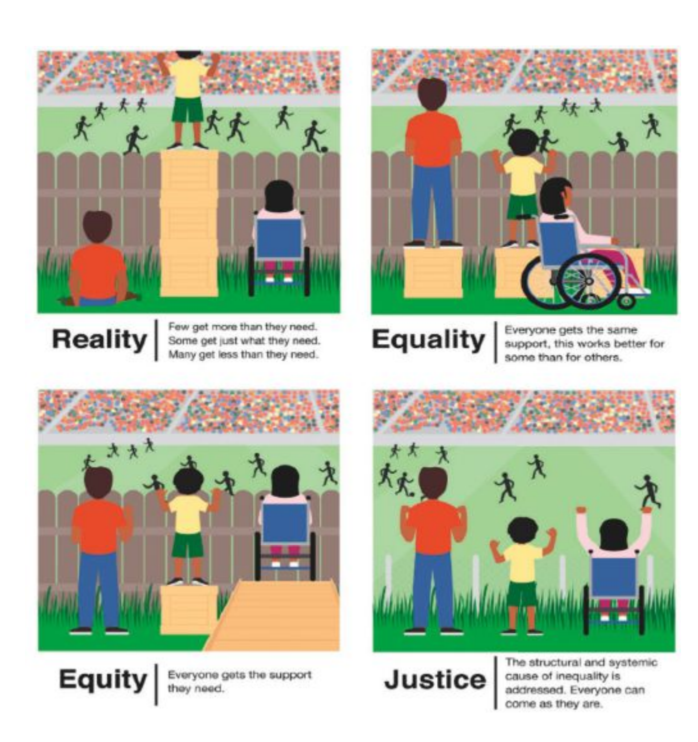
In conducting the CHNA, our focus revolves around three primary domains: health and wellness, access to care, and social drivers of health. These domains serve as the focal points guiding MedStar Health's endeavors and shaping our community health initiatives. By addressing these key areas, we aim to make meaningful contributions to improving health outcomes within the communities we serve, aligning our efforts with broader community health goals.

Our health equity approach

Central to the community health team's mission is a dedicated focus on underserved populations, recognizing the disproportionate burden of health disparities borne by these communities. Through targeted interventions tailored to the specific needs of underserved groups, we aim to narrow the gap in health outcomes and promote health equity for all members of the community.

By prioritizing health equity, we are committed to reducing systemic barriers and addressing the root causes of health disparities within our community. This commitment permeates every facet of our work, from the identification of health needs to the implementation of targeted interventions.

Our CHNA process is inherently guided by these priorities, ensuring that our initiatives, partnerships, and methods of evaluation are all aligned with the goal of promoting equity and justice in healthcare access and outcomes. Through a deliberate and intentional approach, we track and address disparities in health outcomes, striving to ensure that every member of our community has equitable access to the resources and opportunities necessary to achieve optimal health and wellbeing.

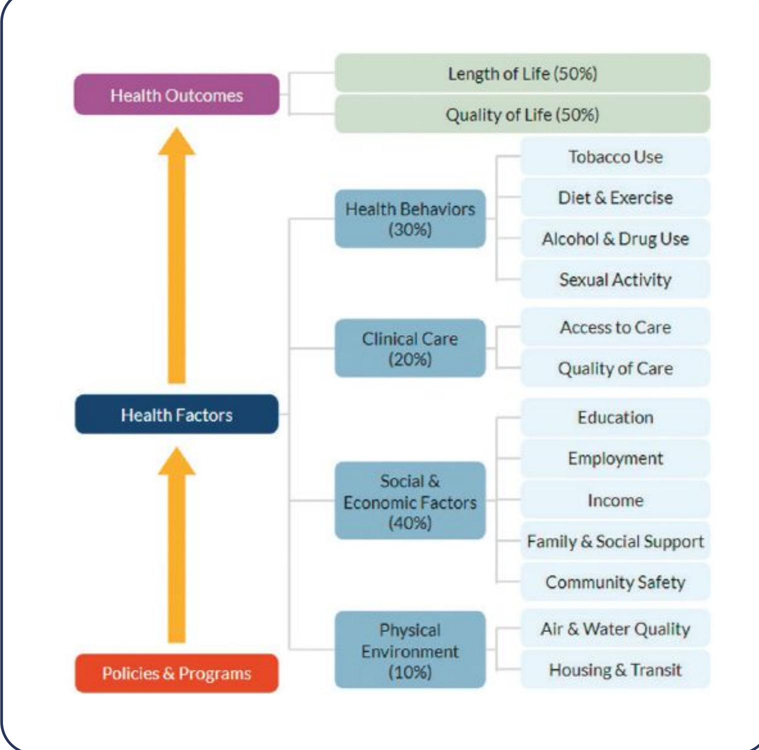


Gearheart Consulting, Marisa Rahman and Craig Froehle, 2024

Guiding principles and framework

The foundation of the CHNA at MedStar Health is anchored in the robust framework established by the Robert Wood Johnson Foundation's County Health Rankings Model. This framework, built upon nationally recognized best practice standards within the healthcare sector, serves as the cornerstone for our assessment methodology.

At MedStar Health, we rely on the Robert Wood Johnson Foundation's County Health Rankings framework to gain insights into the multifaceted drivers of community health. This framework acknowledges the interplay between factors that affect health outcomes measuring how long and how well we live.



Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, 2024

Key contributors and participant groups

The CHNA process involved active participation from a variety of community residents, partners, and stakeholders. Each hospital's CHNA was guided by an ATF, comprised of a diverse array of members including hospital leaders, grassroots activists, community activists, residents, faith-based leaders, hospital representatives, public health leaders, and other external stakeholders such as local health departments. ATF members utilized several sources of data, including population-level data, CHNA survey findings, and feedback from community input sessions to formulate recommendations for each hospital's health priorities and implementation strategies.

Key contributors to the CHNA process included:

- **Community Health team at MedStar Health**
  Established the CHNA methodology for all hospitals; assisted in identifying strategic partners; provided expertise and technical support throughout the process; designed and disseminated the CHNA survey tool; reviewed and assessed survey findings; ensured that processes, deliverables, and deadlines complied with the IRS regulations.
- **Hospital ATFs**
  Reviewed secondary public health data; distributed CHNA survey and reviewed findings; recommended the hospital's CBSA, health priorities, and associated strategies.
- **Hospital executive sponsors**
  Served as liaisons between ATFs and hospital executive leadership to ensure alignment of selected priorities and implementation strategies with hospital strengths, population health management strategies, and clinical priorities.
- **CHNA survey respondents and community input session participants**
  More than 10,320 people completed the CHNA survey, and over 300 participated in input sessions as part of the CHNA process. These participants represented diverse groups of community stakeholders, including CBSA residents and organizations, civic and faith-based leaders, public health officials, government agencies, and hospital leadership. Their engagement provided valuable insights into the most pressing health issues across CBSAs.

MedStar Health partnership with Georgetown University

Research and data analysis for this report was conducted by Georgetown University's School of Health, a part of our academic health system partnership. This partnership played a vital role in driving the CHNA efforts forward, prioritizing health equity and overall population health improvement for vulnerable communities. Dr. Christopher King, renowned for his proficiency in navigating the complex interplay between racial equity, health care, and public health, was at the forefront leading this work along with Amelia Bedri, MSHA. Secondary data collection for the 2024 CHNA drew from the priority focus areas and the specific indicators from the 2021 MedStar Health CHNA Report. The approach focuses on disease prevalence, mortality and morbidity rates, health disparities, and associated social drivers across the geographic footprint of MedStar Health.

In order to provide consistency and allow comparison with the previous CHNA reporting period, the 2024 CHNA builds upon the prior report.

Aggregated findings from the key data sources (i.e., secondary data and the 2021 CHNA report) were used to derive themes and identify health priorities in three domains: 1) health and wellness; 2) access to care, and 3) social drivers of health.

To maintaining the most up to date measures, measurement periods vary and are specified accordingly. Data drawn from multiple sources should be interpreted with caution, as methodologies may differ. Secondary data sources (i.e., Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), U.S. Census Bureau American Community Survey (ACS), Maryland Department of Health, and CDC National Center for Health Statistics) have varying data collection time periods. The most recently published figures are captured in this report. As much as possible, we relied on the original data source for each indicator, rather than the sources in which they were summarized or cited (i.e., referring to the CDC BRFSS instead of the County Health Rankings or D.C. Health Matters website, if that was where the data originated). To maintain consistency with the previous CHNA report, all measures were rounded to the nearest whole number.

Disease areas of focus

The following charts show the age-adjusted death rate due to heart disease, stroke, cancer, and diabetes. The data in these charts show the changes since data were gathered for the 2021 CHNA report.

For comparison purposes, green boxes in the graph represent an improvement since the last reporting period; red represents worsening of a condition since the last reporting period.

Figure 1. Age-adjusted death rate due to heart disease[1,2,3,4]

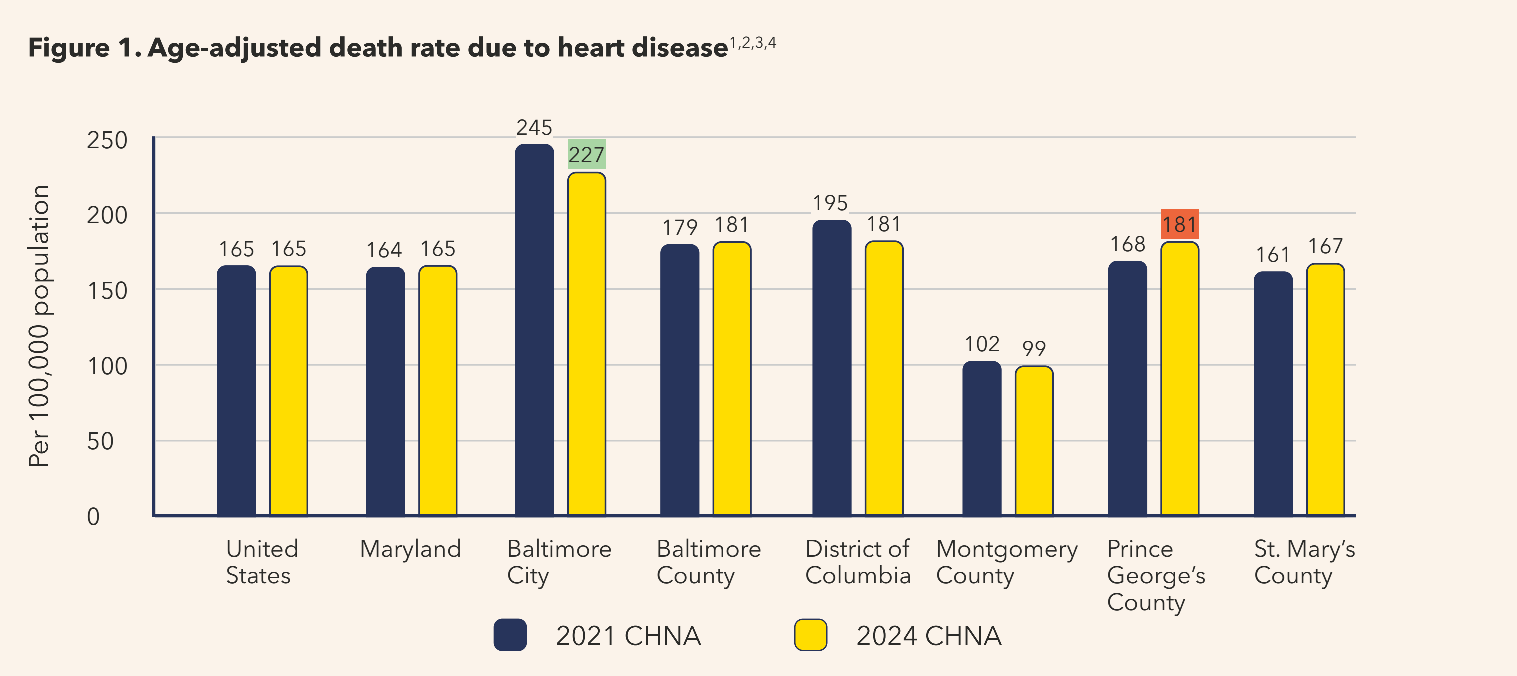


Figure 2. Age-adjusted death rate due to stroke[3]

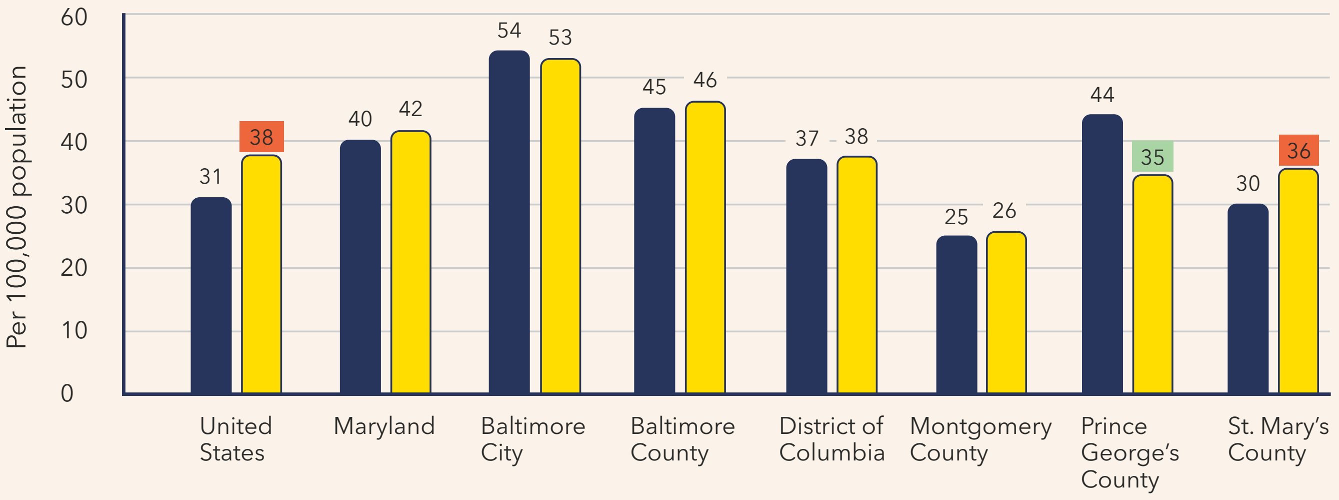


Figure 3. Age-adjusted death rate due to cancer[5,6]

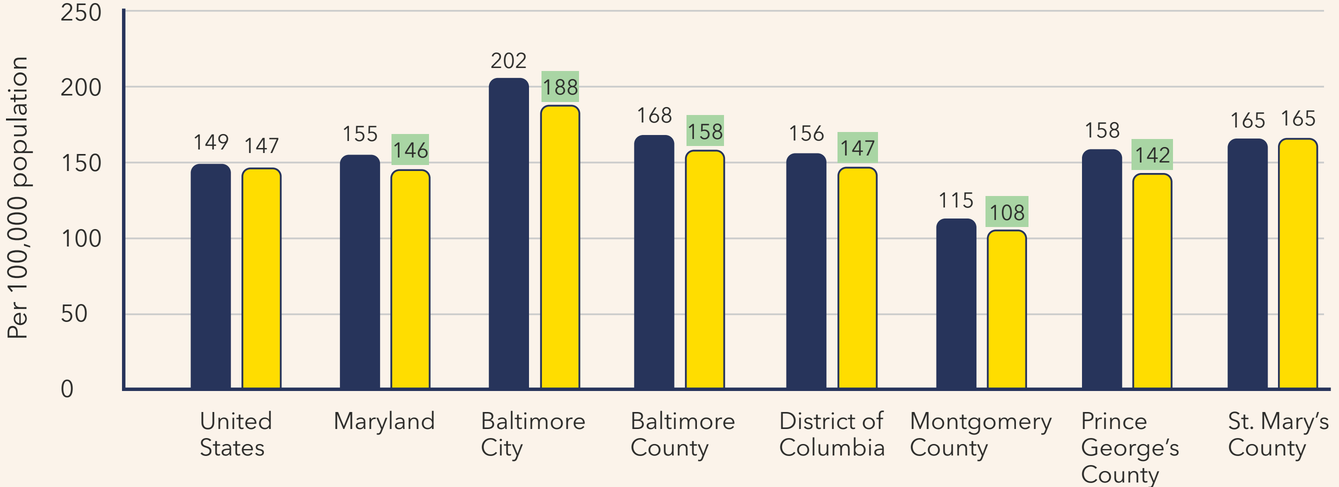
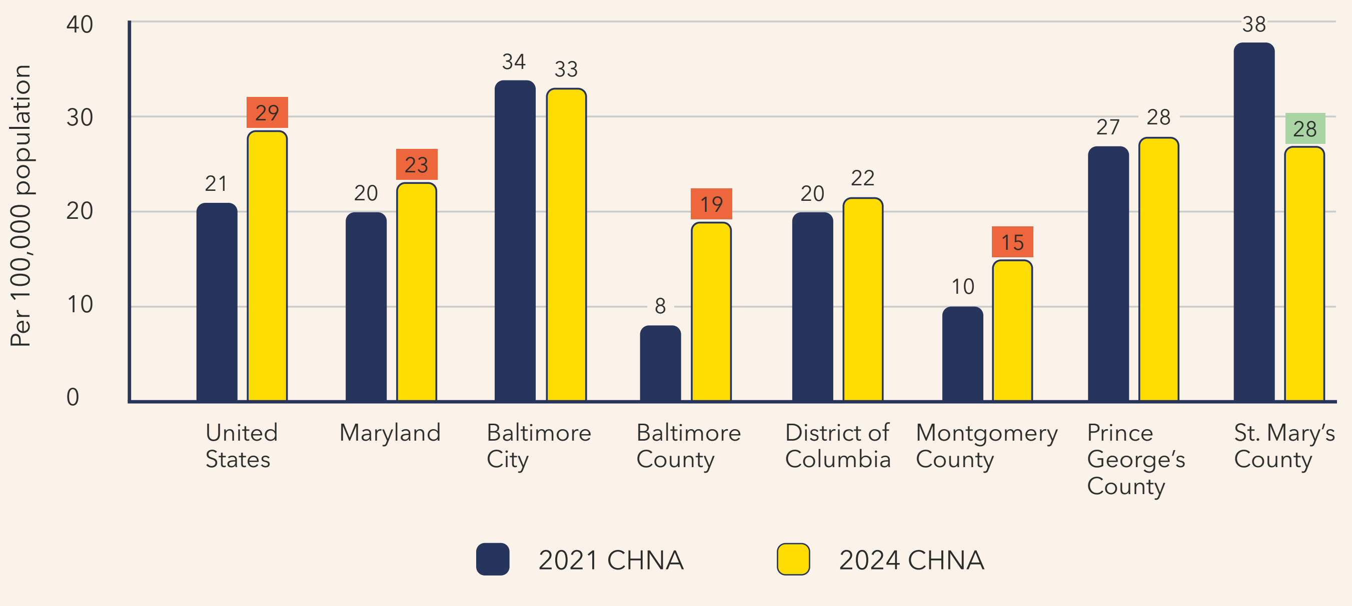


Figure 4. Age-adjusted death rate due to diabetes[4,7,8,9,10,11]



Community engagement

This section includes a description of the methodology, as well as a high-level overview of key findings from the CHNA survey instrument. Issues that are unique to a specific hospital, community, or region are not presented. It should be noted that questions are based on what respondents observed in their community, not their personal experiences.

Survey methodology

In 2023, MedStar Health coordinated efforts with several public health departments in Washington D.C., Baltimore City, and Baltimore, Montgomery, Prince George's, and St. Mary's counties in Maryland to develop and distribute a community survey. The CHNA included an array of engagement opportunities including, QR codes, promotional fliers, postcards, paper surveys, text message campaigns with survey links, and outreach events.

For cultural and linguistic appropriateness, the community survey was available in print and accessible online in ten different languages: English, Chinese, Spanish, Russian, Vietnamese, French, Portuguese, Korean, Arabic, and Amharic.

In addition to external community health engagement, we partnered with many internal MedStar Health departments to promote participation in the CHNA process. The Marketing department assisted with social media campaigns and website promotion. Our Informatics and Data, Strategic Planning, and Finance departments assisted with identifying underserved populations and communities.

Local community-based organizations, safety-net clinics, and primary care providers assisted with survey distribution. Additionally, fliers with QR codes were provided throughout hospital settings, including waiting areas, cafeteria tables and room trays, elevators, registration, and front desks to encourage patients and their family members to provide their perspective on the community's health needs. Working closely with each hospital's ATF, community organizations were identified to promote the assessment. Local recreation departments, YMCAs, food banks, libraries, school partners, and many more assisted with outreach.

Input sessions were conducted in each community, both in person and virtually. More than 500,000 text messages were sent to people living in communities in Baltimore City, Montgomery, Prince George's, St. Mary's, and Baltimore counties as well as the District of Columbia. Consistent with prior cycles, questions were formatted according to three overarching areas: health and wellness, access to care, and social drivers of health.

Key findings

Health issues

The top five health problems that affect people in the community are high blood pressure (50%), diabetes (48%), chronic pain and arthritis (37%), addiction and substance use disorders (35%), and mental health issues, i.e., depression, post-traumatic stress disorder (PTSD), and trauma (34%).

When stratifying this question for persons with household incomes of $20,000 to $50,000, the majority of respondents cited addiction and substance use disorders as the most significant issues affecting their community.

Access to care

The top five reasons people in the community do not get health care when they need it include cost or inability to pay (69%), no insurance or limited coverage (48%), had to wait too long for an appointment (47%), finding a doctor who accepts my insurance (33%), and getting a referral or appointment with a specialist (23%). This was closely followed by lack of or limited transportation (22%). Despite high insurance coverage rates, the cost of health care continues to be a barrier. This is likely due to co-payments, medication costs, and other services that may not be covered, such as dental procedures and mental health services.

While the majority of respondents (82%) obtain health information from a doctor or health professional, some respondents cite a lack of provider diversity as a key driver of distrust or hesitancy.

Social issues

The top five social issues that "affect people in the community" include lack or limited access to a doctor's office (34%), housing problems and homelessness (32%), neighborhood safety and community violence (28%), gun violence (27%), and hunger and food insecurity (27%). High costs of housing and limited access to grocery stores in some communities were documented as significant barriers to health.

Survey limitations and key considerations

As findings are interpreted, there are noteworthy limitations and considerations. Males were underrepresented and only accounted for 28% of the sample. Asian American, Native Hawaiian/Pacific Islanders and American Indian/Alaskan natives were also underrepresented. Heterogeneity exists within racial groups. For example, Black classifications may include African-American, Jamaican, Haitian, Ethiopian, Somalian, and others. Due to limitations in data collection methodologies, diversity within racial groups is not captured.

Nine percent (9%) of the total number of respondents identified as Hispanic or Latino. Persons with annual household incomes greater than $100,000 represented the highest income category of the sample (31%). Findings should be carefully contextualized as the intent of the CHNA is to uncover opportunities to improve the health and wellbeing of the most socially and economically vulnerable.

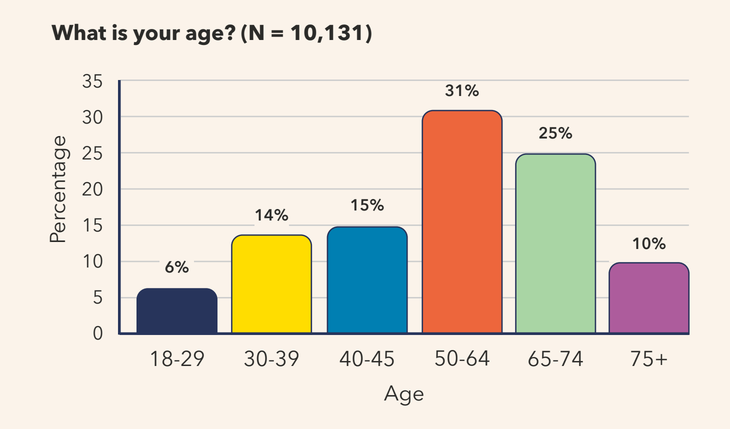
Additionally, MedStar Health hopes to feature more gender-inclusive identity statistics by zip code in future reports. Due to these limitations, data regarding the population of transgender and nonbinary individuals is not reflected in zip code demographics.

Systemwide respondent demographics

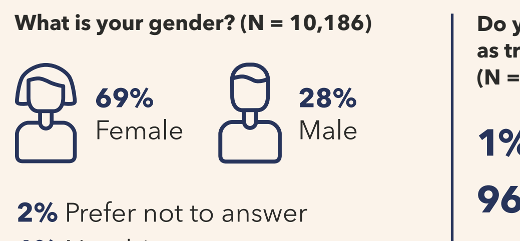
As part of the 2024 MedStar Health Community Health Needs Assessment primary data collection process, 10,323 unique individuals aged 18 and older completed a survey. This figure represents a twofold increase since the 2021 CHNA.

- 71% of respondents were between ages 40 and 74.
- 69% of the total population self-identified as female, 28% identified as male.
- Black residents represented 41% of the sample, white residents represented 44%.
- 9% of participants identified as Hispanic or Latino.
- 31% of respondents had annual household incomes over $100,000; 17% had annual household incomes less than $20,000.
- Nearly 48% of respondents did not have a college degree.
- 43% of respondents worked full-time; 29% of respondents were retired.
- 81% of respondents had health insurance, of whom 13% were exclusively covered by Medicaid; 28% of respondents were Medicaid and Medicare dual eligible.

What is your age? (N = 10,131)



What is your gender? (N = 10,186)



2% Prefer not to answer
1% Non-binary
0% Prefer not to self-identify
0% Genderqueer/nonconforming

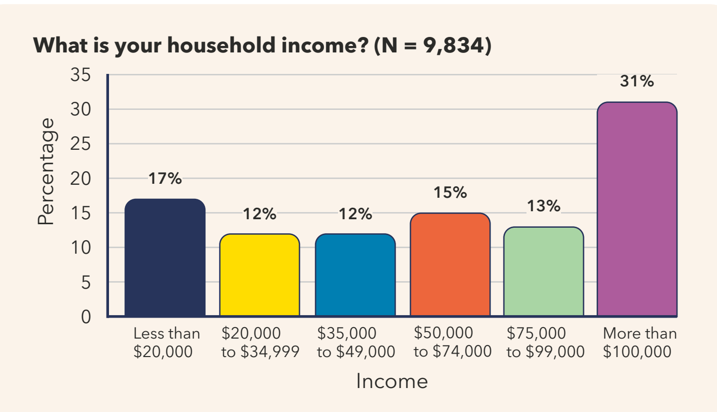
Do you identify as transgender? (N = 10,010)

1% Yes
96% No
3% Prefer not to answer

What is your race? (N = 10,093)

- White (44%)
- Black (41%)
- Am. Indian or Alaskan Native (2%)
- Asian (3%)
- Native Hawaiian/Pac. Islander (0%)
- Other races (5%)
- Two or more races (4%)
- Arab American, Middle Eastern, or North African (1%)

What is your household income? (N = 9,834)



Community input data summary

This section includes a high-level overview of key findings from 16 community input sessions. Systemwide, approximately 300 persons aged 18 and older participated. Issues that are unique to a specific hospital, community, or region are not presented and can be found in individual hospital summaries.

Community input methodology

The purpose of an input session is to create a welcoming, trusted environment to facilitate dialogue to uncover barriers to health and establish priorities for intervention. Sixteen community input sessions were conducted in person, hybrid, and virtually between September and October 2023.

- Hosted 16 focus groups and community input sessions in partnership with local health departments and hospital collaboratives for community-based organization partners to share their perspectives on health needs. Subpopulations were targeted:
  - Seniors and older adults
  - Rental and Housing Assistance recipients
  - Spanish-speaking communities
  - Participants in disease management and prevention programs
  - Disabled populations in collaboration with Adaptive Fitness programs
  - Families participating in social or collaborative community family service programs including food resource distribution locations.
- Launched a text messaging campaign to established patients of MedStar Medical Group offices who opted-in to receive text messaging.
  - More than 500,000 text messages were sent to individuals across the Washington, D.C. and Maryland region.

Health and wellness

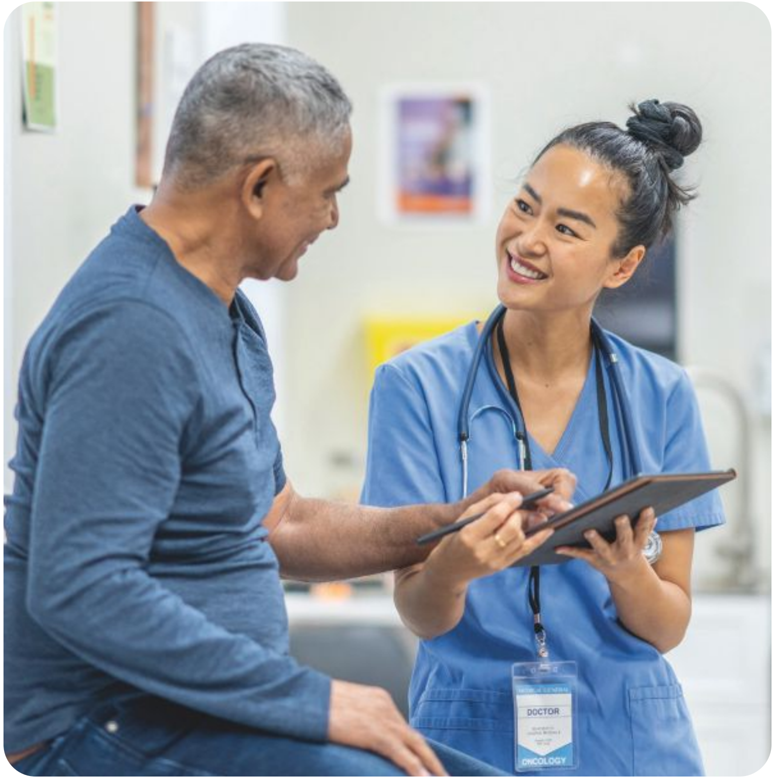
According to the community surveys, the most common health conditions faced by residents were high blood pressure, diabetes, chronic pain and arthritis, addiction and substance use disorders, and mental health issues, to include depression, PTSD, and trauma. Many of these conditions align with both public health and hospital utilization data. Health and wellness barriers and potential solutions (below) were key themes in community input sessions.

Barriers	Potential solutions
Alcohol and substance use disorders	Increase access to mental health services and expand health insurance coverage for accessibility.
Food deserts, poor diet, cost of food	Make healthy foods affordable and more accessible; establish nutrition programs using a peer support method.
Mental health: a key driver for poor health behaviors (e.g., depression, stress, trauma, abuse)	Explore ways to eradicate the mental health stigma; increase access to mental health and wellness support services; develop strategic partnerships with faith-based organizations. Train hospital personnel to be more understanding and compassionate.

Access to care

According to the community surveys, inability to pay, lack of insurance and/or insurance limitations, long wait times for an appointment, and lack of transportation are the leading reasons cited for not receiving health care when needed. Access to care barriers and potential solutions (below) were key themes in community input sessions.

Barriers	Potential solutions
Delaying or forgoing care	Providers should work in partnership with public health officials to achieve consistency in messaging. Continue to offer community-based virtual education sessions. Offer unconventional hours of operation (evenings and weekends).
Some insurance plans are not accepted by providers	Explore partnerships with Federally Qualified Health Centers (FQHCs) and other safety-net providers and advocate for reimbursement parity (e.g., Medicaid vs. commercial).
Long wait times for primary and specialty care appointments	Expand hours of operation to include evenings and/or weekends. Continue to offer virtual visits as an option.
Lack of access to mental health care, and medication due to cost	Advocate for coverage expansion.
Cultural or linguistic insensitivity; fear; distrust	Employ racially and ethnically diverse lay extenders (e.g., community health workers, patient navigators) as key agents of healthcare delivery models; ensure materials are in plain language and linguistically appropriate. Implement tactics to cultivate a diverse pipeline of providers who reflect the communities served.
Lack of transportation	Expand coverage for unconventional transportation modalities (e.g., Uber Health, LYFT). Offer bus tokens and/or vouchers for medical and social service visits.
Busy schedules; limited provider hours; long wait time for appointments	Expand provider hours of operation; deliver care at the neighborhood level; expand mobile units where available; and expand virtual visits. As virtual visits become more common, special accommodations are necessary for seniors and those without dependable internet connectivity.
Complexity in navigating the healthcare system	Simplify instructions; ensure information is linguistically appropriate; employ patient navigators.



Social drivers of health

According to the community surveys, lack of affordable housing, violence, food insecurity, limited programs for youth, lack of job opportunities, and lack of resources for exercise are the leading social issues that affect residents. Social barriers and potential solutions (below and right) were key themes in community input sessions.

Barriers	Potential solutions
Limited employment options	More jobs with "livable wages" are needed close to low-income communities; expand access to alternative training/education programs that target persons with a high school diploma. Work with private/public employers to increase access to internships and jobs for teens.
Housing problems and homelessness	Refer and link patients with housing resources and organizations.
Community violence	Access to jobs and employment opportunities for youth.
Wages not keeping up with inflation	Advocate for livable wage compensation.

Barriers	Potential solutions
Healthy foods either unaffordable or unattainable	Incentives are needed for grocery stores housed in low-income communities; expand frequency and geography of pop-up food markets.
Racial inequities	Invest in marginalized communities of color; increase access to quality resources (e.g., schools, medical providers, fitness centers, jobs with livable wages, job training and pipeline development programs, etc.).
Residents feel disempowered	Work with community partners to promote civic engagement to ensure residents' needs are heard and appropriate policies and practices are normalized.
Lack of awareness of community resources	Explore creative ways to make residents aware of community resources and entitlements. Streamline and make eligibility requirements simple.

Summary of systemwide priorities

Diseases and/or health conditions

The top five leading health problems affecting our communities are:

1. High blood pressure
2. Diabetes and/or high blood sugar
3. Chronic pain and arthritis
4. Addiction and substance use disorders
5. Mental health conditions

Access to care

The top five reasons people do not receive the health care they need are:

1. Cost
2. Limited or no insurance coverage
3. Waiting too long for an appointment
4. Finding a doctor that accepts their insurance
5. Getting a referral or appointment with a specialist

Social drivers of health

The top five issues affecting quality of life include:
1. Lack of or limited access to healthcare providers
2. Housing problems and homelessness
3. Neighborhood safety and community violence
4. Gun violence
5. Hunger and food insecurity

Longitudinal analyses

This section compares trends in select indicators since MedStar Health's first official CHNA in 2012.

Methodology

The health indicators highlighted in this section were selected because of a high confidence of consistency in data collection methodologies across a longitudinal period. Where appropriate, figures are adjusted for consistent comparisons across data collection time periods.

Prince George's County

(MedStar Southern Maryland Hospital Center)

What has improved?
- Age-adjusted death rate due to heart disease, stroke, and cancer
- Lower percentage of unemployed adults
- Reduced the infant mortality rate

Areas to address
- Percentage of adults who are obese
- Number of persons living in poverty

St. Mary's County

(MedStar St. Mary's Hospital)

What has improved?
- Age-adjusted death rate due to heart disease, stroke, and cancer
- Lower percentage of unemployed adults

Areas to address
- Percentage of adults with obesity
- Percentage of persons living in poverty

Baltimore City

(MedStar Good Samaritan Hospital,
MedStar Harbor Hospital,
MedStar Union Memorial Hospital)

What has improved?
- Age-adjusted death rate due to heart diseases and cancer

Areas to address
- Age-adjusted death rate due to diabetes

Montgomery County

(MedStar Montgomery Medical Center)

What has improved?
- Age-adjusted death rate due to heart disease, stroke, and cancer
- Lower percentage of unemployed adults

Areas to address
- Percentage of adults who are obese

Baltimore County

(MedStar Franklin Square Medical Center)

What has improved?
- Age-adjusted death rate due to heart diseases and cancer
- Lower percentage of unemployed adults

Areas to address
- Percentage of adults who are obese

Washington, D.C.

(MedStar Georgetown University Hospital, MedStar National Rehabilitation Hospital, MedStar Washington Hospital Center)

What has improved?
- Age-adjusted death rate due to heart disease and cancer
- Lower percentage of unemployed adults

Areas to address
- Percentage of adults who are obese

Key takeaways

The communities served by MedStar Health have experienced significant and consistent downward trends in age-adjusted death rates due to both heart disease and cancer. However, when rates are stratified by race and ethnicity, Black and low-income residents continue to be disproportionately impacted.

Morbidity, mortality, and socioeconomic data collected for this report were based on time periods prior to the onset of COVID-19. Therefore, the true effect of the impact of COVID-19 on health and socioeconomic conditions remains unclear. As data are refreshed, the 2027 CHNA should better contextualize the impact.

While unemployment rates have trended downward, more research is needed to explore trends in livable wages.

Obesity continues to rise across the region. Systemic, cross-sectoral interventions are needed to increase access to affordable healthy foods as well as opportunities for physical activity.

While HIV rates have trended upward, advancements in pharmacological therapies are allowing persons to live long, healthy lives. In addition to HIV infection rates, HIV death rates should be considered as a key metric in future analyses.

MedStar Franklin Square Medical Center

Community Health Needs Assessment

Primary Service Area   Community Benefit Service Area

History
Our team at MedStar Franklin Square Medical Center has served the eastern Baltimore County community since it opened in 1969. Today MedStar Franklin Square is one of the fastest growing and most highly regarded hospitals in the region, with 338 beds and more than 3,500 employees. We offer comprehensive, innovative treatment for a wide range of medical conditions.

The community
We value the input and feedback from the communities we serve and make it a priority to collaboratively identify local healthcare needs and develop programs, partnerships, and initiatives to meet those needs. Our Advisory Task Force Committee is comprised of community residents as well as representatives from the local health department, local schools, higher education institutions, federally qualified health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): Southeast Baltimore County, Maryland
The CBSA representing MedStar Franklin Square includes residents living in zip codes 21220, 21221, 21222, and 21237. This geographic area was selected as our CBSA based on hospital utilization data and secondary public health data, as well as its proximity to the hospital and partnerships with local organizations.

Prioritized health needs:

Health and wellness
Turn to page 23 for goals and initiatives

- Chronic disease prevention and management
- Behavioral health: mental health and substance use disorders
- Maternal health

Access to care
Turn to page 26 for goals and initiatives

- Access to affordable health care and insurance
- Access to healthcare providers
- Cost of health care
- Transportation

Social drivers of health
Turn to page 28 for goals and initiatives

- Housing and homelessness
- Food insecurity

Red indicates a negative trend in this statistic.

Green indicates a positive trend in this statistic.

Demographics

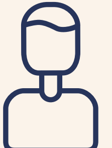
Zip code 21220

Average household income in 2020:
$61,042[12]

Gender and age*[12]

52% Female
Median age: **38**

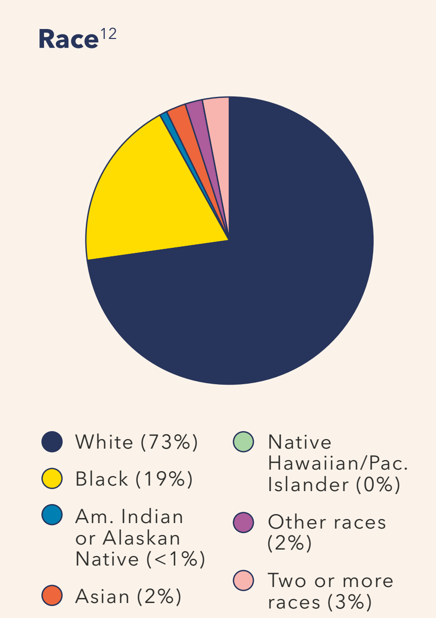
48% Male
Median age: **36**



Median age:
37

Total population[12] **39,199**

Race[12]



Educational attainment
(those 25+ years)[12]

<High school diploma	**16%**
High school graduate	**62%**
Associate's degree	**7%**
Bachelor's degree	**9%**
Master's degree	**4%**
Professional degree	**<1%**
Doctorate degree	**<1%**

Zip code 21221

Average household income in 2020:
$52,560[13]

Gender and age*[13]

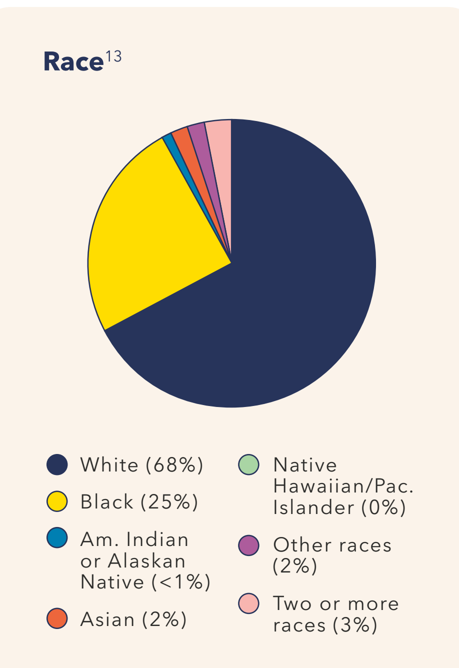
52% Female
Median age: **39**

48% Male
Median age: **37**

Median age:
38

Total population[13] **42,154**

Race[13]



Educational attainment
(those 25+ years)[13]

<High school diploma	**16%**
High school graduate	**65%**
Associate's degree	**6%**
Bachelor's degree	**9%**
Master's degree	**3%**
Professional degree	**<1%**
Doctorate degree	**<1%**

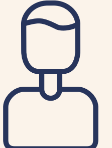
Zip code 21222

Average household income in 2020:
$44,824[14]

Gender and age*[14]

52% Female
Median age: **40**

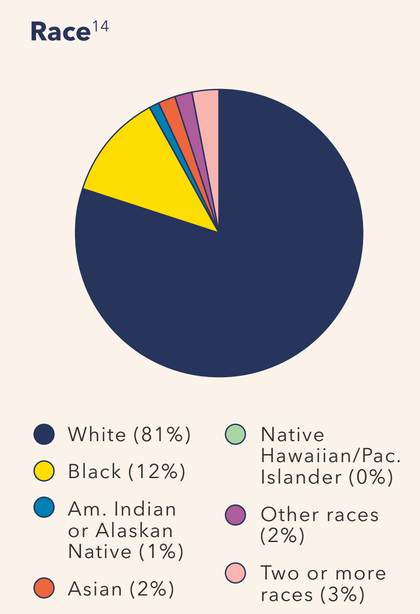
48% Male
Median age: **38**



Median age:
39

Total population[14] **55,786**

Race[14]



Educational attainment
(those 25+ years)[14]

<High school diploma	**20%**
High school graduate	**65%**
Associate's degree	**5%**
Bachelor's degree	**6%**
Master's degree	**3%**
Professional degree	**<1%**
Doctorate degree	**<1%**

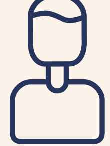
Zip code 21237

Average household income in 2020:
$56,142[15]

Gender and age*[15]

52% Female
Median age: **38**

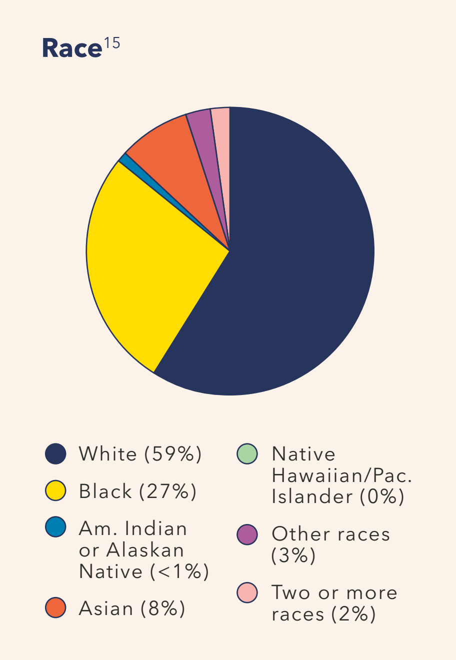
48% Male
Median age: **36**



Median age:
37

Total population[15] **30,059**

Race[15]



Educational attainment
(those 25+ years)[15]

<High school diploma	**13%**
High school graduate	**55%**
Associate's degree	**8%**
Bachelor's degree	**17%**
Master's degree	**5%**
Professional degree	**1%**
Doctorate degree	**1%**

Health and wellness

Chronic disease prevention and management

Heart disease, stroke, and diabetes are among the main health concerns of residents in Baltimore County. For this reason, our team at MedStar Franklin Square prioritizes keeping people healthy and empowering communities to choose healthy behaviors. These priorities are consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, which include reducing the average BMI for adults in Maryland and reducing avoidable admissions and readmissions.

Goals

- Improve health and quality of life through prevention, detection, and treatment of risk factors for chronic diseases.
- Improve health and quality of life for those living with chronic diseases while working to prevent chronic conditions.
- Improve and expand community access to comprehensive, quality healthcare providers and programs, as well as medical and non-medical services.
- Expand access to essential health services through safety net partnerships.

Initiatives

- Host and provide diabetes community education and support groups and actively support local diabetes prevention community activities.
- Host and provide access to wellness services, education, and fitness activities.
- Participate in and/or lead local heart disease community activities and provide community education.
- Facilitate Food Rx programs designed to provide nutrition education, lifestyle change classes, and access to fresh, healthy foods.
- Improve awareness of prediabetes and gestational diabetes.
- Partner with local farmer's markets, food distribution organizations, and food preparation demonstrations to support access to and use of fresh, healthy foods.
- Provide primary care services through MedStar Mobile Health Center to address risk factors of chronic disease and refer community members to specialty care, if needed.

Heart disease and stroke

- Baltimore County's death rates due to heart disease and stroke are higher than the national average.[1,2,3]
- Baltimore County has a heart disease death rate of 181 deaths per 100,000 people, which is higher than the statewide and nationwide rate of 165 per 100,000 people.[1,2,3]
  - This is a slight increase from 2021, in which Baltimore County had a heart disease death rate of 179 per 100,000 people.

These heart disease death rates are a significant decrease from 205 per 100,000 people in 2010.

- Baltimore County has a stroke death rate of 46 deaths per 100,000 people, compared to the statewide rate of 42 per 100,000 people and the nationwide rate of 38 per 100,000 people.[3]
  - This is nearly equal to the death rate of 47 per 100,000 people in 2010.
- 34% of adults in Baltimore County have high blood pressure.[16,17]
  - 49% of MedStar Franklin Square CHNA survey respondents indicated that high blood pressure was among the main health problems affecting people in their community.

Obesity

- 32% of adults in Baltimore County are obese, compared to 28% in 2010.[18,19]

Diabetes and high blood sugar

- 10% of adults in Baltimore County have diabetes.[4,18,19] This is equal to the statewide percentage.
  - 45% of survey respondents indicated that diabetes and high blood sugar are among the main health problems affecting people in their community.
- Baltimore County has a diabetes death rate of 10 per 100,000 people.[7,8,9] This is a slight decrease from 13 per 100,000 in 2010.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of participants enrolled
- Number of activities and events attended; number of sessions and groups held
- Number of screenings
- Number of referrals
- Number of linkages to care

Key partners

- Baltimore County Department of Health
- Baltimore County Public Library
- Baltimore County Schools
- Community Assistance Network
- Eastern Interfaith Outreach
- Faith-based organizations
- Family Crisis Center
- Healthy Babies Collaborative
- Hunger for Change
- Hungry Harvest
- Maryland Department of Aging
- Maryland Food Bank
- Maryland Department of Health
- Maryland Medicaid
- Meals on Wheels
- Parent University
- Sodexo
- Southeast Network
- The Y of Central Maryland
- United Way

Behavioral health: mental health and substance use disorders

People in communities throughout Baltimore County are affected by substance use disorders and mental health issues. In response to these issues, we prioritize initiatives that improve access to treatment and support services at MedStar Franklin Square. This priority is consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, including reducing overdose mortality.

Goals

- Support substance use disorder recovery and promote access to behavioral health programs.
- Ensure access to appropriate quality behavioral health and substance use disorder services.

Initiatives

- Conduct Screening, Brief Intervention, Referral to Treatment (SBIRT) in emergency department, Women's Services, and ambulatory sites supported by Peer Recovery Coaches.
- Host and provide smoking cessation programming.
- Engage as member of the Central Maryland Regional Crisis System to expand mental health and crisis services in the Baltimore metro region.
- Advocate for and expand access to telehealth mental health counseling.
- Support mental health training for community service providers.
- Host and provide behavioral health community education, screenings, and support groups; sponsor events or walks for behavioral health.
- Serve as a community health hub for behavioral health resources, overdose prevention, and peer-to-peer support.

Mental health

- People in Baltimore County average five poor mental health days per 30 days, compared to the nationwide average of four days.[20]
- 10% of survey respondents indicated that social isolation and loneliness are some of the main health problems affecting people in their community.

Addiction and substance use disorders

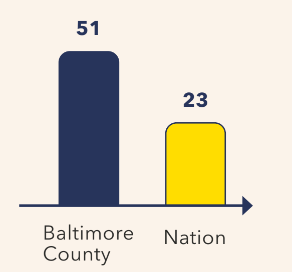
- 16% of adolescents in Baltimore County reported using tobacco products.[21,22] This is higher than the nationwide average of 11% but equal to the statewide average.
- Opioid-related deaths remained the same as reported in our 2021 CHNA report.[23,24]

The number of fentanyl-related intoxication deaths increased from 308 in 2021 to 328 in 2023.[23,24]

- 46% of survey respondents indicated that addiction is one of the main health problems affecting people in their community.
- 37% of survey respondents indicated that mental health is one of the main health problems affecting people in their community.

Opioids
- In Baltimore County, 42 opioid prescriptions are dispensed per 100 people, compared to 43 prescriptions per 100 people nationwide and the statewide rate of 40 prescriptions per 100 people.[25]

Baltimore County has 51 drug overdose deaths per 100,000 people.[24,26] This is significantly higher than the nationwide rate of 23 per 100,000 people.



Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of referrals and linkages to support services and treatment
- Number of SBIRT screenings, referrals, and linkages to treatment
- Number of participants enrolled

Key partners

- Baltimore County Health Department
- Baltimore County Public Schools
- Baltimore Public Libraries
- Behavioral Health Systems of Baltimore
- Children's Community Health Services
- Faith-based organizations
- Family Crisis Center
- Healthy Babies Collaborative
- Inquiring Minds
- Local Behavioral Health Authority
- Local Health Improvement Coalition (LHIC) Workgroups
- Maryland Department of Health
- NAMI Metropolitan Baltimore - National Alliance of Mental Illness
- Parent University
- Project ACT

Maternal health

The wellbeing of mothers and children is fundamental to the overall health of our communities. Our team's commitment lies in championing initiatives that foster the wellbeing of mothers and babies, address disparities, enhance outcomes, and advocate for the health of both mothers and infants. These priorities are consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, including reducing the severe maternal morbidity rate.

Goals

- Improve health outcomes related to maternal and child health.
- Connect people to local and state agency resources and services to improve maternal morbidity and mortality rates.
- Improve health of expecting mothers and babies by providing education sessions, resources, and mental health screenings.

Initiatives

- Provide maternal and child health services, including birth and family education, breastfeeding education and assistance, OB outpatient services, and support groups.
- Provide support and project management for Healthy Babies Collaborative working toward reducing morbidity and mortality for women and infants.
- Provide community-based medication assisted therapy and support groups for expectant mothers.

- Baltimore County has an infant mortality rate of seven infant deaths per 1,000 live births, compared to the state and nationwide rates of six infant deaths per 1,000 live births.[8,27]
- Baltimore County has 12 teen births per 1,000 females ages 15-19.[27] This is slightly higher than the statewide average of 11 teen births per 1,000 females ages 15-19, but lower than the nationwide rate of 14 teen births per 1,000 females ages 15-19.

29% of survey respondents indicated that **a lack of affordable child care is one of the most important social issues** affecting the quality of life in the community.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of participants served in maternal health programs
- Number of maternal health events, classes, and support groups held
- Number of Children's Community Health Services programs and events supported

Key partners

- Abilities Network
- Baltimore County Department Health
- Baltimore County Public Library
- Baltimore County WIC
- B'more for Healthy Babies
- Greater Baltimore Medical Center
- Harford County Department of Health
- Healthcare Access Maryland
- Healthy Babies Collaborative
- Maryland Department of Health
- Maryland WIC
- Northwest Hospital Center
- Sheppard Pratt Health System
- Southeast Network
- St. Joseph Medical Center

Access to health care and services

Our team at MedStar Franklin Square prioritizes initiatives to expand healthcare access in Baltimore County to promote and maintain health, prevent and manage disease, and achieve health equity for all. These priorities are consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, including care transformation and care coordination.

Goals

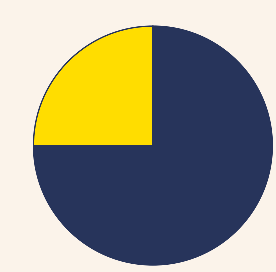
- Improve and expand community access to comprehensive, quality healthcare providers and programs, as well as medical and non-medical services.
- Increase access to healthcare providers, including virtual care.
- Increase insurance enrollment.
- Eliminate barriers to healthcare access, including transportation and financial resources.
- Improve access to transportation for vulnerable populations related to cost and systemic barriers to public transportation access.

Initiatives

- Ensure community experience and integration of providers and recruit providers in areas of need.
- Support uninsured patients by assisting with enrollment to publicly funded programs, community health financial education, and hospital charity care programs.
- Provide primary care without the need for transportation or insurance through MedStar Health Mobile Health Center to serve populations including immigrant communities.
- Expand services through virtual care and urgent care centers.
- Identify social needs and non-medical barriers that impact health outcomes.

Access to health care and services

- Baltimore County has a 260:1 ratio of population to mental health providers.[28,29] This is better than the nationwide ratio of 328:1.
- 7% of adults in Baltimore County cannot afford to see a doctor, compared to the nationwide percentage of 13%.[30]
- 46% of survey respondents indicated that lack of or limited access to a doctor is one of the most important social issues affecting quality of life in their community.
  - Of those who selected lack of or limited access to a doctor's office, 54% are white, 26% are Black, and 5% are multi-racial.
- 17% of survey respondents indicated that they or a family member in their household have difficulties with mobility and require medical equipment.



75% of survey respondents say that **cost is the main reason people in their community do not get health care when they need it.**

Availability of affordable healthcare providers and health insurance

- 31% of survey respondents indicated that finding a doctor who accepts their insurance is one of the most common reasons people in their community do not get health care when they need it.
- 53% of survey respondents indicated that not having health insurance is one of the most common reasons people in their community do not get health care when they need it.
- 19% of survey respondents indicated that getting a referral or appointment with a specialist is one of the most common reasons people in their community do not get health care when they need it.
- The budgeted monthly cost of health care for a family with two adults and two school-age children in Baltimore County is $853.[31]

Cost of health care

- 75% of survey respondents indicated that cost is one of the most common reasons people in their community do not get health care when they need it.
- 22% of survey respondents indicated a fear of losing their job for taking time off from work as one of the most common reasons people in their community do not get health care when they need it.
- 21% of the population in Baltimore County is enrolled in Medicaid/CHIP program.[32,33,34]

Transportation

- 23% of survey respondents indicated that a lack of or limited transportation is one of the most common reasons people in their community do not get health care when they need it.

Transportation continued

- 26% of survey respondents indicated that limited access to transportation is one of the most important social issues affecting quality of life in their community.
- The budgeted monthly cost of transportation for a family with two adults and two school-age children in Baltimore County is $527.[31]

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Cost of health care

- Number of patients referred
- Number of education sessions offered
- Number of participants

Availability of affordable healthcare providers and health insurance

- Number of patients
- Number of patients connected to specialty services
- Number of uninsured individuals connected to primary care services
- Number of experiences
- Number of participants
- Number of providers recruited
- Number of screenings
- Percentage screening positive

Transportation

- Number of patients served
- Number of Uber Health rides provided
- Number of vouchers and/or bus tokens provided
- Number of patients served through MedStar Health Mobile Health Center
- Number of patients connected to specialty services
- Number of uninsured individuals connected to care
- Number of advocacy events attended

Key partners

- Baltimore County Health Department
- Baltimore County Public Library
- Baltimore County Public Schools
- Children's Community Health Services
- Community Assistance Network
- Creating Assets, Savings and Hope Campaign
- Faith-based organizations
- Health Care Access Maryland
- Southeast Network

Social drivers of health

Housing and food insecurity are among the main social concerns of residents in Baltimore County. To address these problems, our team prioritizes initiatives such as expanding access to healthy foods and advocacy for housing services. These priorities are consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, including care transformation.

Goals

- Promote safe, affordable, and equitable housing.
- Reduce inequities caused by lack of affordable housing or substandard housing conditions by promoting the intersection of housing and health care.
- Promote expanded food access.
- Provide resources to address food insecurity.
- Improve medical food and nutrition intervention services.
- Reduce inequities caused by lack of access to healthy foods through partnerships and collaboration with community organizations focused on reducing household food insecurity.
- Implement a strategic approach to identifying and addressing social needs at MedStar Franklin Square Medical Center.

Initiatives

- Screen patients for food security and provide fresh produce prescriptions through community health workers while focusing in on long-term sustainability for food access to community-based partners.
- Facilitate Food Rx programming to provide nutrition education, lifestyle change classes, and access to fresh, healthy foods.
- Participate in coalitions; support referrals to medically tailored meals, evidence-based programs, and nutrition counseling; advocate for policy change.
- Support basic home maintenance education for renters and homeowners.
- Join and participate in Baltimore County Communities for Homeless to advocate for and act on specific opportunities to address homelessness, including referring patients to federal and state agencies for housing.

Initiatives continued

- Advocate for affordable, safe housing.
- Expand social needs screenings to adult hospitalized patients in collaboration with nursing and acute case management teams.
- Engage with local community-based organizations to address social needs risk factors to advance health equity strategies.
- Leverage the MedStar Health Social Needs Tool powered by Findhelp to provide referrals and connections to social support services in the community.

Employment

- 3% of adults in Baltimore County are unemployed.[35,36]
  - This is consistent with the state and nationwide adult unemployment rates.

Since our first CHNA: this is an improvement from an 8% unemployment rate in 2010.

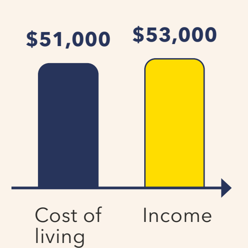
Housing

- 67% of Baltimore County housing is occupied by the owner.[37]
- In 52% of renter-occupied housing units in Baltimore County, tenants pay 30% or more of their household income on rental costs.[36] This is slightly higher than the nationwide percentage of 51% and equal to statewide percentage of 52%.
- 33% of survey respondents indicated that housing problems and homelessness are some of the most important social issues affecting the quality of life in the community.

Costs of living

- The median household income reported in Baltimore County in 2021 was $80,200.[37,38] This is higher than the national median of $70,784, and lower than the statewide median of $90,100. **When viewing cost-of-living data, however, these wages often are not sufficient to cover household expenses. Ultimately, this can significantly impact access to care.**
- 10% of people in Baltimore County live in poverty, compared to 12% nationwide.[38]
- The average annual cost for a family with two adults and two children is $76,584.[31]
  - The average annual cost for a household with two adults and two children **in childcare** is $88,176.

The approximate cost of living for a one-child and one-adult household is **$51,000**. The average annual income for these households is less than **$53,000** (before taxes), based on an estimated hourly wage of $25.33.[31]



- 73% of single-female-headed households with children in Baltimore County are below the ALICE* threshold, compared to 17% of married households with children being below the threshold.[31] **ALICE: Asset Limited, Income Constrained, Employed - Those earning more than the Federal Poverty Level, but not enough to afford the basics where they live.*

Food insecurity

- 10% of households in Baltimore County experience food insecurity, equal to the nationwide percentage.[39]
- 13% of Baltimore County households with children experience food insecurity.[39] This is nearly equal to the state and nationwide proportions of 12% and 13%, respectively.
- 27% of survey respondents indicated that hunger and food insecurity are some of the most important social issues affecting the quality of life in the community.
  - Of those who selected hunger and food insecurity as an important issue, 62% are white, 24% are Black, and 5% are multi-racial.
- In fiscal year 2023, 27% of social needs searches through the MedStar Health Social Needs Tool in Baltimore were related to requests for food; 24% were related to housing or housing support services.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Housing and homelessness

- Number of patients served
- Number of events attended

Program-specific metrics continued

Food insecurity

- Number of participants
- Number of social screenings completed
- Number of patients linked to food resources
- Number of participants enrolled in medical nutrition services

Key partners

- Baltimore County Communities for the Homeless
- Baltimore County Department of Health
- Baltimore Department of Housing and Community Development
- Community Assistance Network
- Creating Assets, Savings and Hope Campaign
- Findhelp
- Health Care Access Maryland
- Hungry Harvest
- Maryland Food Bank
- Meals on Wheels
- Southeast Network

Baltimore County

(MedStar Franklin Square Medical Center)

What has improved?

- Age-adjusted death rate due to heart diseases and cancer
- Lower percentage of unemployed adults

Areas to address

- Percentage of adults who are obese

1,479 surveys completed for MedStar Franklin Square

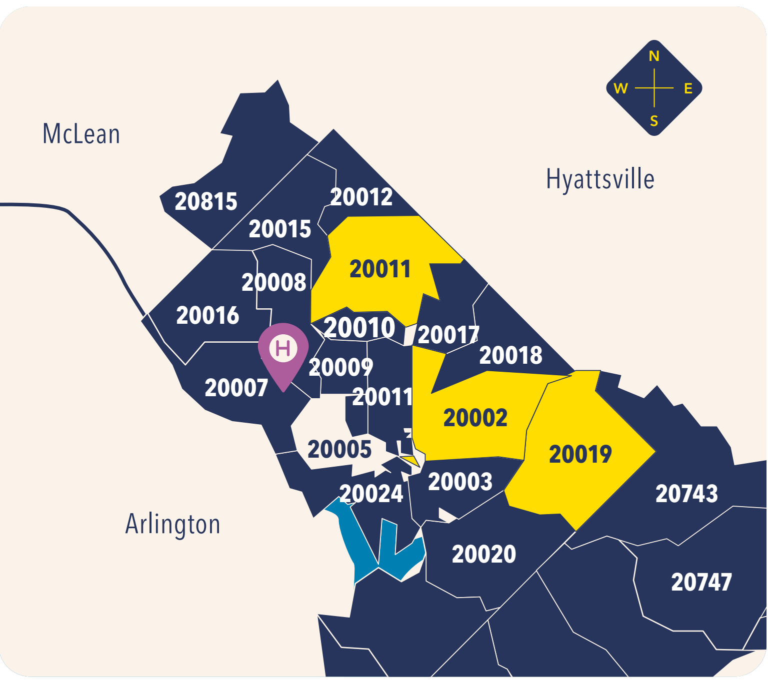
The 25-question survey was conducted from early September to the end of October 2023.

Survey was distributed in person and online.

To learn more about health needs in the MedStar Franklin Square Medical Center community, **scan the QR Code or visit MedStarHealth.org/CommunityHealth.**

MedStar Georgetown University Hospital

Community Health Needs Assessment



Primary Service Area   Community Benefit Service Area

History
Our team at MedStar Georgetown University Hospital is committed to creating an environment of personalized care. Our physicians—many of them fellowship-trained—are nationally and internationally renowned for their expertise, as well as for their innovative approaches from diagnosis to treatments.

Founded in the Jesuit principle of cura personalis, caring for the whole person, MedStar Georgetown is dedicated to focusing on the full needs of our patients and their families that go beyond their immediate health care needs and providing the comfort they need to help them heal. This philosophy empowers our associates to work together to provide holistic care, as well as a trusting and compassionate environment.

The community
We value the input and feedback from the communities we serve and make it a priority to collaboratively identify local health care needs and develop programs, partnerships, and initiatives to meet those needs. Our Advisory Task Force Committee is comprised of community residents as well as representatives from the local health department, local schools, higher education institutions, federally qualified health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): Washington, D.C.
The CBSA representing MedStar Georgetown includes residents living in zip codes 20019, 20011, and 20002. This geographic area was selected as the CBSA representing MedStar Georgetown based on hospital utilization data and secondary public health data, as well as its proximity to the hospital.

Prioritized health needs:

Health and wellness
Turn to page 33 for goals and initiatives

- Chronic disease prevention and management
- Chronic pain and arthritis
- Aging and older adults
- Behavioral health: mental health and substance use disorders

Access to care
Turn to page 36 for goals and initiatives

- Access to health insurance and healthcare providers, appointments, and transportation
- Cost of health care

Social drivers of health
Turn to page 38 for goals and initiatives

- Food insecurity
- Housing and homelessness
- Violence: neighborhood safety and gun violence

Red indicates a negative trend in this statistic.

Green indicates a positive trend in this statistic.

Demographics

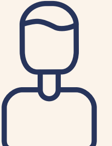
Zip code 20019

Average household income in 2020:
$43,661[40]

Gender and age*[40]

56% Female
Median age: **38**

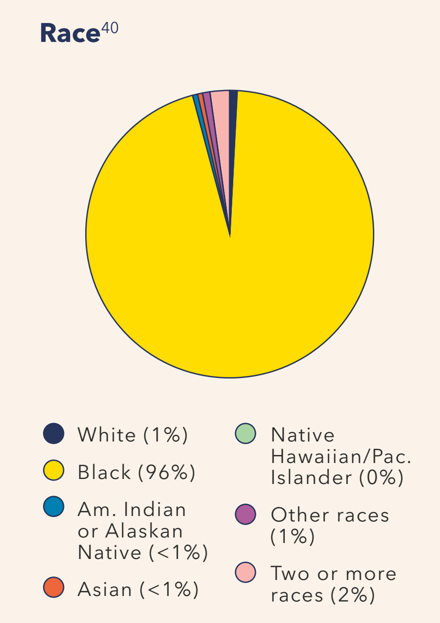
44% Male
Median age: **32**



Median age:
35

Total population[40] **54,358**

Race[40]



Educational attainment
(those 25+ years)[40]

<High school diploma	**19%**
High school graduate	**63%**
Associate's degree	**4%**
Bachelor's degree	**8%**
Master's degree	**5%**
Professional degree	**1%**
Doctorate degree	**<1%**

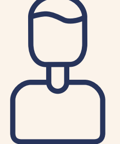
Zip code 20011

Average household income in 2020:
$52,560[41]

Gender and age*[41]

53% Female
Median age: **40**

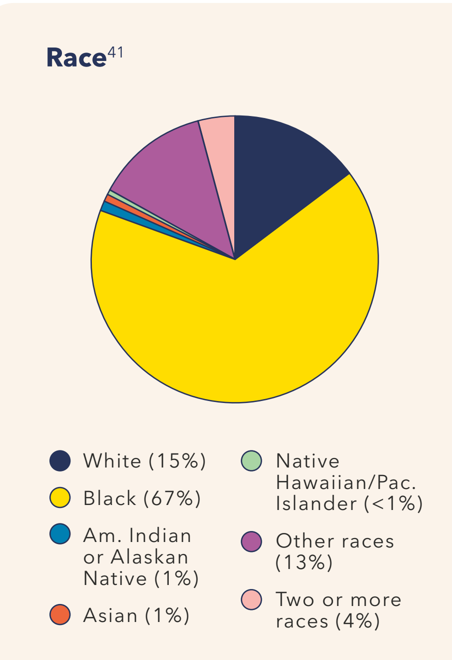
47% Male
Median age: **37**



Median age:
39

Total population[41] **58,536**

Race[41]



Educational attainment
(those 25+ years)[41]

<High school diploma	**16%**
High school graduate	**46%**
Associate's degree	**4%**
Bachelor's degree	**18%**
Master's degree	**11%**
Professional degree	**4%**
Doctorate degree	**2%**

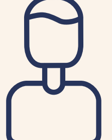
Zip code 20002

Average household income in 2020:
$96,674[42]

Gender and age*[42]

52% Female
Median age: **35**

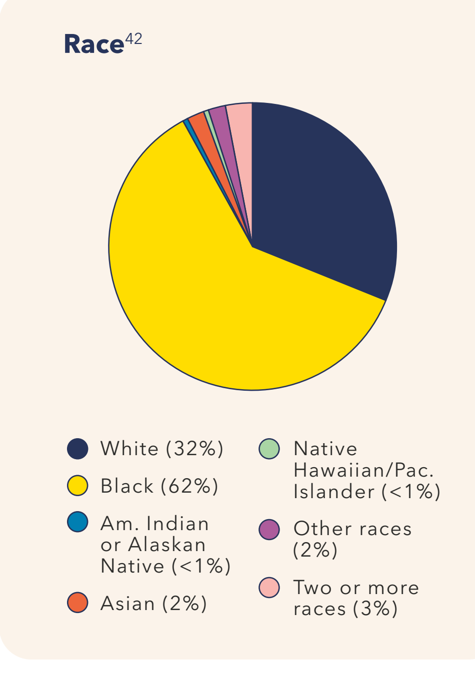
48% Male
Median age: **35**



Median age:
35

Total population[42] **52,370**

Race[42]



Educational attainment
(those 25+ years)[42]

<High school diploma	**14%**
High school graduate	**35%**
Associate's degree	**3%**
Bachelor's degree	**24%**
Master's degree	**16%**
Professional degree	**5%**
Doctorate degree	**3%**

Health and wellness

Chronic disease prevention and management

Chronic disease prevention and management and chronic pain are some of the main health problems affecting residents in Washington, D.C. To address these issues, our team at Medstar Georgetown prioritizes keeping people healthy and empowering communities to choose healthy behaviors through education and prevention. These initiatives are consistent with the D.C. Community Health Improvement Plan (CHIP) and D.C. Healthy People 2030 objectives.

Goals

- Improve the health and quality of life through prevention, detection, and treatment of risk factors for chronic diseases.
- Improve community health and wellbeing through health education programs.
- Expand chronic disease prevention and management programming.
- Improve quality of life for those living with chronic pain and arthritis.
- Promote self-management techniques for chronic pain.

Initiatives

- Provide health, fitness, nutrition education classes, and screenings to prevent or manage high blood pressure and/or diabetes.
- Provide programs and education services for mothers and infants on diabetes management, mental health, pre- and post-partum care, breastfeeding, health screenings, and nutrition.
- Provide chronic pain self-management sessions at Washington, D.C. facilities.

Heart disease and stroke

- Washington, D.C. has a heart disease death rate of 181 per 100,000 people, which is higher than the nationwide rate of 165 per 100,000 people.[2,3,4]

Heart disease and stroke continued

- Washington, D.C. has a stroke death rate of 38 deaths per 100,000 people, equal to the nationwide rate.[3]
- 30% of adults in Washington, D.C. have high blood pressure.[16,17,43]
  - 48% of MedStar Georgetown CHNA survey respondents indicated that high blood pressure is among the main health problems affecting people in their community.

Obesity

- 25% of adults in Washington, D.C. are obese.[4,18,19]

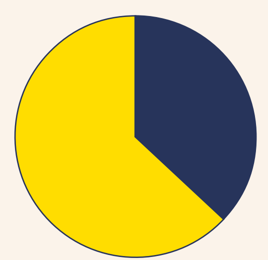
Since our last CHNA: this is is an increase from the 2010 rate of 22%.

Diabetes and high blood sugar

- 8% of adults in Washington, D.C. have diabetes.[4,18,19] This is lower than the national average of 11%.
  - 40% of survey respondents indicated that diabetes and/or high blood sugar are among the top health problems affecting people in their community.

Chronic pain and arthritis

- 16% of survey respondents indicated that they or a family member they live with has age-related mobility issues; 15% of survey respondents require medical equipment (cane, wheelchair, walker, etc.).



37% of survey respondents indicated that **chronic pain and arthritis are top health problems affecting their community.**

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of educational classes
- Number of participants
- Number of screenings
- Number of chronic pain self-management training cohorts offered
- Number of enrollees to chronic pain self-management training

Key partners

- American Diabetes Association
- Capital Area Food Bank
- Community of Hope
- D.C. Safe Babies Safe Moms Initiative
- D.C. WIC
- Fort Lincoln Family Medicine Center
- Mamatoto Village
- Maryland Living Well Center of Excellence

Behavioral health: mental health and substance use disorders

Substance use disorders and mental health issues affect people in communities throughout Washington, D.C. To respond to these concerns, our team prioritizes initiatives to improve access to services that treat substance use disorders and mental health issues.

Goals

- Ensure access to appropriate quality behavioral health services.
- Support substance use disorder recovery and promote access to behavioral health programs.
- Improve access to quality behavioral health and substance use disorder services and providers.

Initiatives

- Conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT) program.
- Host and provide behavioral health community education and support groups to include amputee, transplant, liver, kidney, and multiple myeloma.
- Support mental health programs at schools through MedStar Georgetown Center for Wellbeing in School Environments (WISE).
- Support adolescents through the Early Childhood Innovation Network.
- Provide mental health services for parents during post-partum screening.

Mental health

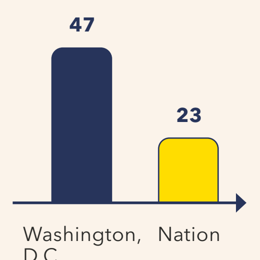
- People in Washington, D.C. average five poor mental health days per 30 days, slightly higher than the nationwide average of four poor mental health days.[20]
- 38% of survey respondents indicated that mental health is one of the main issues affecting people in their community.
- 14% of survey respondents indicated that social isolation and loneliness are among the main health problems affecting people in their community.

Addiction and substance use disorders

- 19% of adolescents in Washington, D.C. reported using tobacco products.[21,22,44] This is higher than the nationwide average of 11%.
- 26% of survey respondents indicated that addiction is among the main health problems affecting people in their community.

Opioids

Washington, D.C. has 47 drug overdose deaths per 100,000 people.[24,26] **This is much higher than the nationwide rate of 23 per 100,000 people.**



- In Washington, D.C., 33 opioid prescriptions are dispensed per 100 people, compared to 43 prescriptions per 100 people nationwide.[25]

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of SBIRT screenings, referrals, and linkages to treatment
- Number of participants reached
- Number of events held
- Number of schools
- Number of providers trained
- Number of children and families served
- Number of participants in parental mental health services
- Number of screenings

Key partners

- AppleTree Institute
- Capital Caring Health
- D.C. Department of Health
- D.C. Public Schools
- D.C. Safe Babies Safe Moms
- Girls Global Academy
- Ingenuity Prep Public Charter School
- Inquiring Minds
- Local Health Improvement Coalition (LHIC) Workgroups
- Mosaic Group
- Mundo Verde
- NAMI D.C. - National Alliance of Mental Illness
- Rocketship D.C.
- Senior Wellness Centers
- Statesmen College Preparatory Academy for Boys
- Thurgood Marshall Academy

Aging and older adult issues

At MedStar Georgetown, our team is committed to honoring the dignity and wellbeing of older adults in Washington, D.C. For this reason, we are prioritizing initiatives that promote healthy, successful aging.

Goals

- Promote healthy aging by improving health, function, and quality of life of older adults.

Initiatives

- Provide resources focused on health, fitness, and nutrition education in partnership with senior centers.
- Collaborate with senior organizations to provide resources specific to aging such as grief support, finance, resource navigation, etc.

40% of survey respondents indicated that **aging and older adult issues (Alzheimer's, dementia, falls, etc.) affect people in their community.**

- Of the households ages 65 and up in Washington, D.C., 56.5% are at or below the ALICE threshold.*[45]
  **ALICE: Asset Limited, Income Constrained, Employed - Those earning more than the Federal Poverty Level, but not enough to afford the basics where they live.*

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of health screenings
- Number of events held
- Number of participants reached

Key partners

- Alzheimer's Association
- Capital Caring Health
- D.C. Department of Aging
- Washington Senior Wellness Center

Access to health care and services

Access to quality care and services is an important issue for people living in Washington, D.C. It is essential for promoting and maintaining health, preventing, managing disease, and achieving health equity for all. For this reason, our team prioritizes initiatives to expand health care access and reduce financial barriers to care in Washington, D.C. These initiatives are consistent with the D.C. Community Health Improvement Plan (CHIP) and D.C. Healthy People 2030 objectives.

Goals

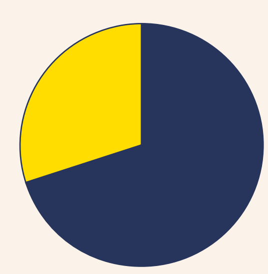
- Increase timely access to providers and health care.
- Improve and expand community access to comprehensive, quality healthcare providers and programs as well as medical and non-medical services.
- Eliminate barriers to accessing health care.
- Improve and expand community access to health insurance.
- Reduce financial barriers to care.

Initiatives

- Promote MedStar Health Urgent Care centers and telehealth appointments.
- Provide healthcare services through mobile clinics and health centers embedded in community, including school-based health centers and in-home care services.
- Provide transportation and financial support to increase access to providers and programs.
- Assist with enrollment in publicly funded programs and refer to state or Federal Insurance Exchange navigator resources.
- Provide case management and care navigation for patients at community-based clinics and link to financial services.
- Connect patients to hospital-based Financial Advocates and support services.
- Provide patient care at Unity Health Care, East of the River Health Center (Family Medicine Patient Care), community, and school-based settings through Graduate Medical Education.
- Provide training for future healthcare professionals.
- Provide expanded support to medical, behavioral, and developmental services for children through the Healthy Steps Zero to Three program.

Access to health care and services

- Washington, D.C. has a 160:1 ratio of population to mental health providers.[28,29] This is better than the nationwide ratio of 328:1.



66% of survey respondents say that cost is the main reason people in their community do not get health care when they need it.

- 28% of survey respondents indicated that lack of or limited access to a doctor's office is one of the most important social issues affecting quality of life in their community.
- 10% of adults in Washington, D.C. cannot afford to see a doctor, compared to the nationwide percentage of 13%.[30,46]

Availability of affordable healthcare providers and health insurance

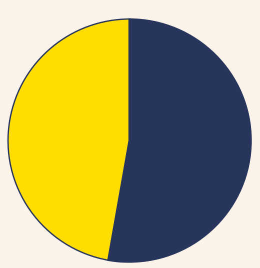
40% of survey respondents indicated that not having health insurance is **one of the most common reasons people in their community do not get health care when they need it.**

- 39% of survey respondents indicated that finding a doctor who accepts their insurance is one of the most common reasons people in their community do not get health care when they need it.
- 27% of survey respondents indicated that getting a referral or appointment with a specialist is one of the most common reasons people in their community do not get health care when they need it.
- 18% of survey respondents indicated that limited access to health insurance is one of the most important social issues affecting quality of life in their community.

Availability of affordable healthcare providers and health insurance continued

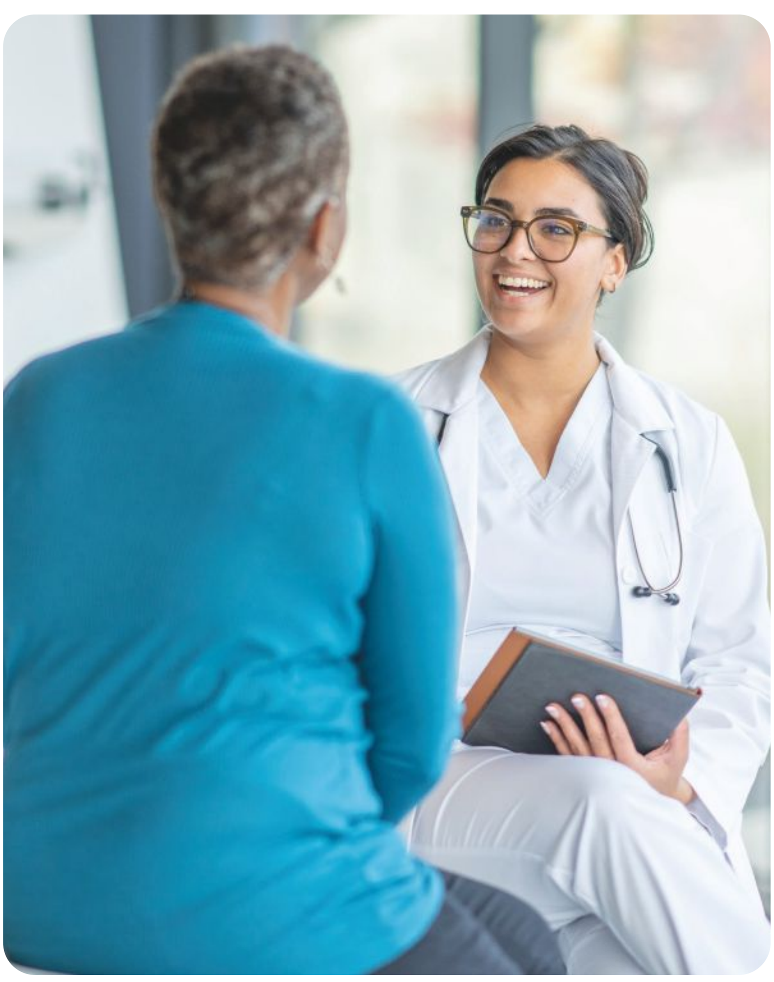
- 69% of adults in Washington, D.C. have had a routine check-up, compared to 71% nationwide.[30,46]
- 96% of adults in Washington, D.C. have health insurance.[30,46,47]

Cost of health care



53% of survey respondents indicated that waiting too long for an appointment is one of the most common reasons people in their community do not get health care when they need it.

- 66% of survey respondents indicated that cost is one of the most common reasons people in their community do not get health care when they need it.
- 40% of survey respondents indicated that not having health insurance is one of the most common reasons people in their community do not get health care when they need it.



Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Availability of affordable healthcare providers and health insurance

- Number of encounters sharing resources
- Number of patients served

Cost of health care

- Number of patients enrolled in programs
- Number of referrals
- Number of linkages to services
- Total funds provided
- Number of patients referred to financial services
- Number of residents, families, and participants served
- Number of linkages to primary care

Transportation

- Number of rides
- Total funds dedicated

Key partners

- Association of Clinicians for the Underserved
- Bread for the City
- Breathe D.C.
- Catholic Charities
- Community of Hope
- D.C. Public Schools
- East of the River Health Center
- Findhelp
- Georgetown HOYA Clinic
- Harriet Tubman Foot Shelter
- Healthy Steps
- Hill Daniels Group
- Migrant Farmworker Health
- National Collaborative for Health Equity
- Network Victim Recovery of D.C.
- Piedmont Health Services
- Roger Heights Elementary School
- The National Capital Consortium
- The Triumph
- Uber Health
- Unity Clinic
- Unity Health Care, Inc.
- Veteran's Affairs
- Zero to Three

Social drivers of health

To make Washington, D.C. more accessible for all, our team at MedStar Georgetown has developed a series of initiatives to address community needs such as housing, food insecurity, and violence. These initiatives are consistent with the D.C. Community Health Improvement Plan (CHIP) and D.C. Healthy People 2030 objectives.

Goals

- Support community housing and homelessness initiatives.
- Promote equitable access to housing resources in the community.
- Reduce inequities caused by lack of affordable housing by promoting the intersection of housing and health care.
- Identify individuals experiencing food insecurity and link to resources.
- Reduce inequities caused by lack of access to healthy foods through partnership and collaboration with community organizations focused on reducing household food insecurity.
- Promote the expansion of food access and provide resources to address food insecurity.
- Support initiatives addressing community violence, including prevention, recovery, and contributing factors.
- Reduce community violence and create a support system that can lead to long-term change through community partnerships and advocacy.
- Implement a strategic approach to identifying and addressing social needs at MedStar Georgetown University Hospital.

Initiatives

- Conduct social needs screenings and provide resources to address social needs.
- Partner with community organizations to support initiatives focused on homelessness, prison reform, and reintegration.
- Provide health services, assessments, primary care, and care packages (footwear) for shelter residents.
- Develop and launch program to increase access to healthy food.
- Partner with community organizations addressing access to food insecurity and hunger in the community.
- Partner with the Healthy Children and Families program to provide healthy food to families.

Initiatives continued

- Partner with community organizations to support initiatives ongoing focused on addressing community violence and prevention.
- Expand social needs screenings to adult hospitalized patients in collaboration with nursing and acute case management teams.
- Engage with local community-based organizations to address social needs risk factors to advance health equity strategies.
- Leverage the MedStar Health Social Needs Tool powered by Findhelp to provide referrals and connections to social support services in the community.

Employment

- 5% of adults in Washington, D.C. are unemployed.[35,36] This is higher than the nationwide rate of 4%.

Since our first CHNA: this is an improvement from 11% unemployment in 2010.

- 18% of the population age 16 and over is not in the labor force.[48]

Housing

- 42% of Washington, D.C. housing is occupied by the owner.[37]
- In 48% of renter-occupied housing units in Washington, D.C., tenants pay 30% or more of their household income on rental costs.[36] This is less than the nationwide average of 51% of renter-occupied housing units costing tenants 30% or more of their income.
- 33% of survey respondents indicated that housing problems and homelessness are among the most important social issues affecting quality of life in their community.

Costs of living

- The median household income in Washington, D.C. is $91,100.[37,38] This is higher than the national median of $70,784. **When viewing cost-of-living data, however, these wages often are not sufficient to cover household expenses. Ultimately, this can significantly impact access to care.**

Costs of living continued

- 17% of people in Washington, D.C. live in poverty, higher than the nationwide average of 12%.[37]
- The average annual cost for a family with two adults and two children is $88,140.[49]
  - The average annual cost for a household with two adults and two children **in childcare** is $92,736.
- The approximate cost of living for a one-child and one-adult household is $60,900.[49] The average annual income for these households is less than $64,000 (before taxes), based on an estimated hourly wage of $30.45.
- 78% of single-female-headed households with children in Washington, D.C. are below the Asset Limited, Income Constrained, Employed (ALICE) threshold, compared to 14% of married households with children being below the threshold.[49]
- 19% of survey respondents indicated that income gaps and/or wage inequality are top social issues affecting people in their community.

Food insecurity

33% of survey respondents indicated that hunger and food insecurity are some of the most important social issues affecting the quality of life in the community.

- 10% of households in Washington, D.C. experience food insecurity, which is equal to the nationwide percentage.[39]
- 14% of Washington, D.C. households with children experience food insecurity, which is slightly higher than nationwide percentage of 13%.[39]

Violence: neighborhood safety and gun violence

- 28% of survey respondents believe gun violence is a top issue in their community.
- 28% of survey respondents say that neighborhood safety and community violence are the main social issues affecting the quality of life in their community.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Housing and homelessness

- Number of social needs screenings
- Number of patients served
- Number of linkages to services
- Number of meetings
- Number of events and advocacy initiatives
- Number of shelter residents served

Food insecurity

- Number of participants served
- Number of families receiving healthy food

Program-specific metrics continued

Violence: neighborhood safety and gun violence

- Number of events held
- Number of meetings attended

Key partners

- ArchAngels
- Bread for the City
- Capital Caring Health
- Catholic Charities
- D.C. Prevention Center
- Evergreen Baptist Church
- Findhelp
- Georgetown HOYA Clinic
- Harriet Tubman Homeless Shelter
- Health Justice Alliance
- My Senior's Keeper Foundation, Inc.
- Office of Neighborhood Engagement and Safety
- Pennsylvania Avenue Baptist Church
- Pilgrim Rest Baptist Church
- Power of 10
- Progressive National Baptist Church
- R.W. Turner Lab – The Black Male Caregiver Program
- Shining Light
- The Center for Racial Equity and Justice
- The Holy Trinity United Baptist Church
- The Talking Drum Inc

Washington, D.C.

(MedStar Georgetown University Hospital, MedStar Washington Health Center, MedStar National Rehabilitation Hospital)

What has improved?

- Age-adjusted death rate due to heart disease and cancer
- Lower percentage of unemployed adults

Areas to address

- Percentage of adults who are obese

1,315 surveys completed for MedStar Georgetown

The 25-question survey was conducted from early September to the end of October 2023.

Survey was distributed in person and online.

To learn more about health needs in the MedStar Georgetown University Hospital community, **scan the QR Code or visit MedStarHealth.org/CommunityHealth.**

MedStar Good Samaritan Hospital

Primary Service Area   Community Benefit Service Area

History
Our team at MedStar Good Samaritan Hospital has provided high-quality care to the community since its founding in 1968. We offer the latest treatments for inpatient rehabilitation with MedStar National Rehabilitation Network; geriatrics with the Center for Successful Aging; wound care, hyperbaric medicine, and limb saving as part of the MedStar Health Wound Healing Institute; and cancer care, with MedStar Franklin Square Medicine Center and MedStar Georgetown Cancer Institute. We also work with MedStar Union Memorial Hospital to offer the latest medical and surgical advances in heart care, orthopedics, and spine care, and hand care with the Curtis National Hand Center.

The community
We value the input and feedback from the communities we serve and make it a priority to collaboratively identify local health care needs and develop programs, partnerships, and initiatives to meet those needs. Our Advisory Task Force Committee is comprised of community residents as well as representatives from the local health department, local schools, higher education institutions, federally qualified health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): Baltimore City, Maryland
The CBSA representing MedStar Good Samaritan includes residents living in zip code 21239, 21218, and 21206. This geographic area was selected as the CBSA representing MedStar Good Samaritan based on hospital utilization data and secondary public health data, as well as its proximity to the hospital.

Prioritized health needs:

Health and wellness
Turn to page 42 for goals and initiatives

- Chronic disease prevention and management
- Behavioral health: mental health and substance use disorders

Access to care
Turn to page 45 for goals and initiatives

- Access to health insurance and providers
- Cost of health care
- Transportation

Social drivers of health
Turn to page 47 for goals and initiatives

- Housing and homelessness
- Food insecurity
- Poverty: economic inequality and wage inequality
- Violence: neighborhood safety and gun violence

Red indicates a negative trend in this statistic.

Green indicates a positive trend in this statistic.

Demographics

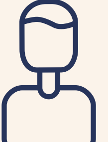
Zip code 21239

Average household income in 2020:
$46,609[50]

Gender and age*[50]

56% Female
Median age: **39**

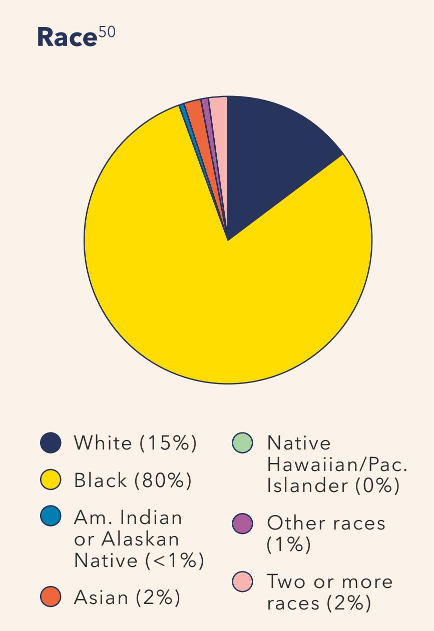
44% Male
Median age: **32**



Median age:
36

Total population[50] **28,793**

Race[50]



Educational attainment
(those 25+ years)[50]

<High school diploma	**14%**
High school graduate	**56%**
Associate's degree	**3%**
Bachelor's degree	**14%**
Master's degree	**9%**
Professional degree	**2%**
Doctorate degree	**1%**

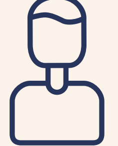
Zip code 21218

Average household income in 2020:
$67,925[51]

Gender and age*[51]

52% Female
Median age: **34**

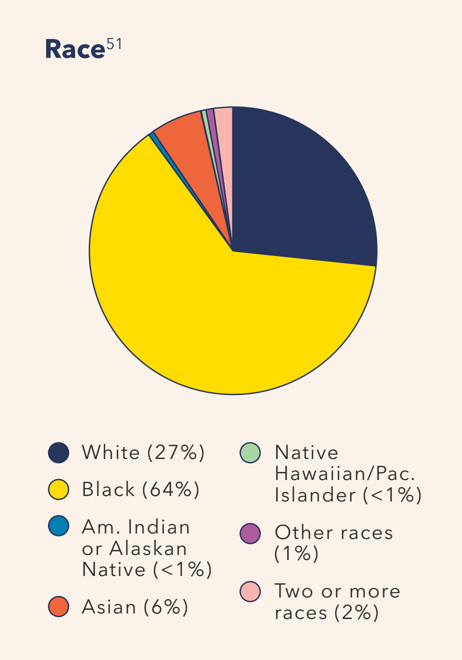
48% Male
Median age: **32**



Median age:
33

Total population[51] **49,796**

Race[51]



Educational attainment
(those 25+ years)[51]

<High school diploma	**16%**
High school graduate	**48%**
Associate's degree	**5%**
Bachelor's degree	**15%**
Master's degree	**10%**
Professional degree	**4%**
Doctorate degree	**3%**

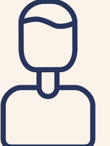
Zip code 21206

Average household income in 2020:
$43,537[52]

Gender and age*[52]

54% Female
Median age: **37**

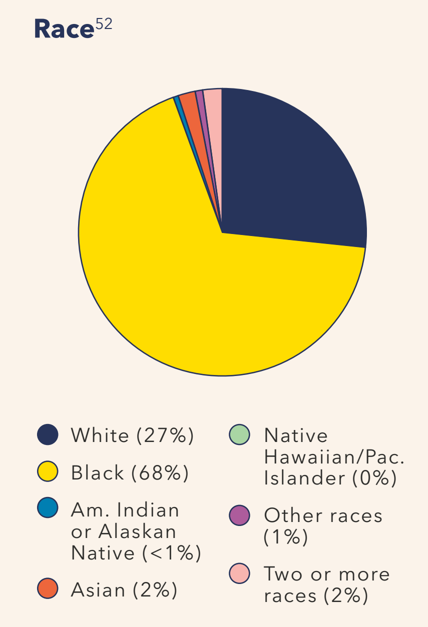
46% Male
Median age: **34**



Median age:
35

Total population[52] **50,846**

Race[52]



Educational attainment
(those 25+ years)[52]

<High school diploma	**15%**
High school graduate	**63%**
Associate's degree	**5%**
Bachelor's degree	**11%**
Master's degree	**6%**
Professional degree	**1%**
Doctorate degree	**<1%**

Health and wellness

Chronic disease prevention and management

Residents in Baltimore City experience a higher rate of heart disease deaths, stroke deaths, and cancer deaths on average than the state and nationwide rates. In response to these concerns, the team at MedStar Good Samaritan prioritizes initiatives that keep people healthy and empower communities to choose healthy behaviors, while aligning with Maryland's Total Cost of Care (TCOC) and Statewide Integrated Health Improvement Strategies (SIHIS), which include reducing the average BMI for adults in Maryland and reducing avoidable admissions and readmissions.

Goals

- Improve health and quality of life through prevention, detection, and treatment of risk factors for chronic diseases.
- Improve community health and wellbeing through health education programs.
- Expand chronic disease prevention and management programs.

Initiatives

- Host and provide diabetes community education and heart disease community awareness programming.
- Improve awareness of prediabetes and gestational diabetes and implement practice mechanisms to assure referral of patients to interventions.
- Facilitate Food Rx programs designed to provide nutrition education, lifestyle change classes, and access to fresh, healthy foods.
- Provide services for chronic, medically complex patients through the Collaborative Care Center.
- Provide primary care services through the MedStar Mobile Health Center to address risk factors of chronic disease and refer community members to specialty care.
- Serve as a hub for the MedStar Health House Call program, expanding access to primary care within communities.

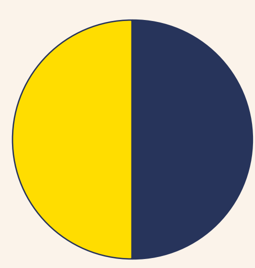
Heart disease and stroke

Baltimore City's heart disease death rate and stroke death rate are **higher than the statewide and nationwide rate.**[1,2,3]

- Baltimore City has a heart disease death rate of 227 per 100,000 people, which is higher than the statewide and nationwide rate of 165 per 100,000 people.[1,2,3]

Since our first CHNA: this is an improvement from the 2010 rate of 278 deaths per 100,000 people.

- Baltimore City has a stroke death rate of 53 deaths per 100,000 people, which is higher than the statewide rate of 42 per 100,000 people and the nationwide rate of 38 per 100,000 people.[3]
- 35% of adults in Baltimore City have high blood pressure.[16,17]



50% of MedStar Good Samaritan CHNA survey respondents indicated that **high blood pressure is among the main health problems affecting people in their community.**

Cancer

- Baltimore City has a cancer death rate of 188 deaths per 100,000 people, which is higher than the nationwide rate of 147 per 100,000 people.[5,6]

Since our first CHNA: this is an improvement from the 2010 rate of 225 cancer deaths per 100,000 people.

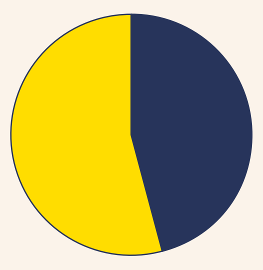
Obesity

- 37% of adults in Baltimore City are obese.[18,19] This is lower than the nationwide average of 42%.

Since our first CHNA: this is an increase from 22% in 2010.

Diabetes and high blood sugar

- 11% of adults in Baltimore City have diabetes, which is equal to the nationwide percentage.[4,18,19]



46% of survey respondents indicated that **diabetes and high blood sugar** are among the main health problems affecting people in their community.

- There are 33 diabetes deaths per 100,000 people in Baltimore City.[7,8,9]

Chronic pain and arthritis

- 37% of survey respondents indicated that chronic pain and arthritis are among the main health problems affecting people in their community.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of participants enrolled
- Number of activities and/or events attended
- Number of sessions and/or groups held
- Number of referrals to services and/or interventions
- Number of patients served through the Collaborative Care Center
- Number of patients served

Key partners

- Baltimore County Department of Aging
- Baltimore County Health Department
- Center for Successful Aging
- Central Baltimore Partnership
- Enoch Pratt Libraries
- Faith-based organizations
- Govans Ecumenical Development Corporation
- Hungry Harvest
- Joy Wellness Center
- Keswick
- Maryland Department of Health
- Maryland Food Bank
- Maryland Medicaid
- Meals on Wheels
- Northeast Community Organization
- The Franciscan Center
- The Y in Waverly (Weinberg)

Behavioral health: mental health and substance use disorders

Substance use disorders and mental health issues affect people in communities throughout Baltimore City. To address these concerns, we prioritize initiatives to support substance use disorder recovery and improve access to services for substance use disorders and mental health.

Goals

- Support substance use disorder recovery and promote access to behavioral health programs.
- Ensure access to appropriate quality behavioral health and substance use disorder services.

Initiatives

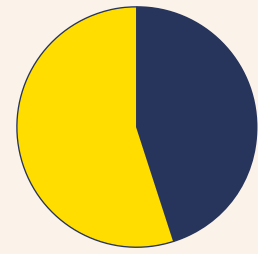
- Conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program in emergency department, Women's Services, and ambulatory sites supported by Peer Recovery Coaches.
- Serve as a community health hub for behavioral health resources, community education (virtual or in-person), overdose preventions, and peer-to-peer support.
- Engage as a member of the Central Maryland Regional Crisis System to expand mental health and crisis services in the Baltimore metro region.
- Provide behavioral health services offering Intensive Outpatient and Inpatient Program Services; Psychiatry and Therapy clinic, Crisis teams, Partial Hospitalization program, and therapeutic and education groups for specific audiences.
- Advocate for tele-mental health counseling expansion.
- Host and provide smoking cessation program.

Mental health

- People in Baltimore City average five poor mental health days per 30 days, compared to the nationwide average of four days.[20]

Addiction and substance use disorders

- 19% of adults in Baltimore City currently smoke.[53] This is higher than 11% statewide and 16% nationwide.
- 15% of adolescents in Baltimore City reported using tobacco products.[21,22] This is higher than the nationwide average of 11% but equal to the statewide average.



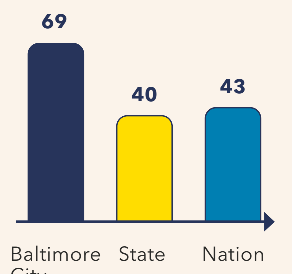
45% of survey respondents indicated that addiction is one of the top health issues affecting people in their community.

Opioids

6x

Baltimore City has 124 drug overdose deaths per 100,000 people.[24,26] This is **six times higher** than the nationwide rate of 23 deaths per 100,000 people.

In Baltimore City, 69 opioid prescriptions are dispensed per 100 people.[25] **This is significantly higher** than 43 prescriptions dispensed per 100 people nationwide and 40 prescriptions per 100 people statewide.



Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of referrals and linkages to support services and treatment
- Number of SBIRT screenings, referrals, and linkages to treatment
- Number of participants enrolled in smoking cessation program

Key partners

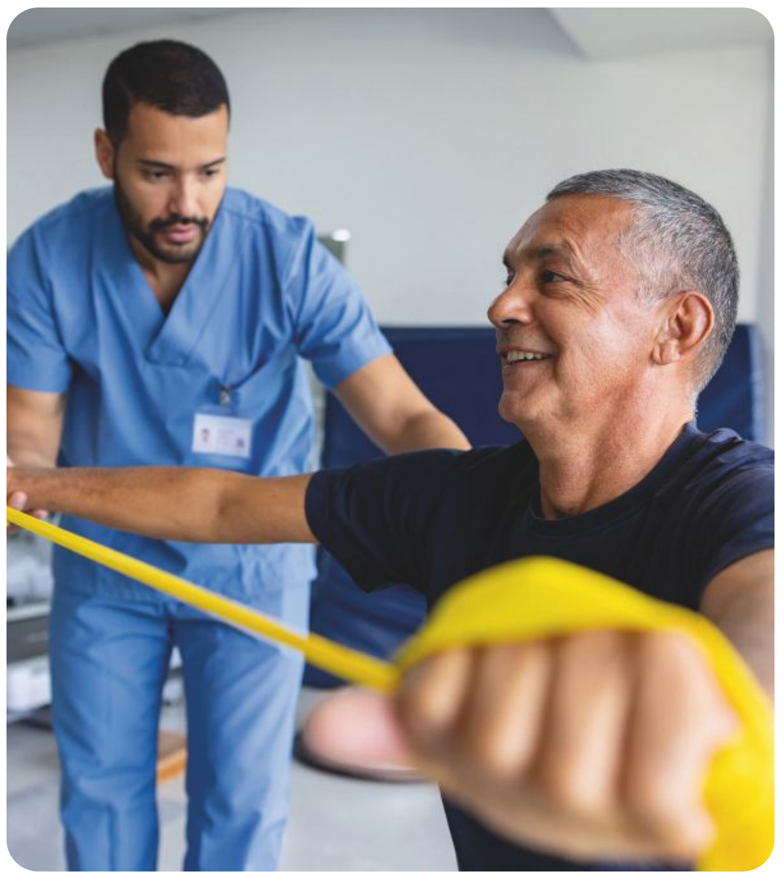
- Baltimore City Health Department
- Behavioral Health Equity Across Maryland
- Behavioral Health Systems of Baltimore
- Enoch Pratt Libraries
- Faith-based organizations
- Govans Ecumenical Development Corporation
- Joy Wellness Center
- Keswick
- Local Behavioral Health Authority
- NAMI Metropolitan Baltimore - National Alliance of Mental Illness
- The Y in Waverly (Weinberg)

Access to health care and services

Access to quality care and services is an important issue for people living in Baltimore City. It is essential for promoting and maintaining health, preventing and managing disease, and achieving health equity for all. For this reason, our team at MedStar Good Samaritan prioritizes initiatives to expand healthcare access, reduce healthcare costs, and advocate for improved transportation access in Baltimore City. These priorities are consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, which include promotion of strategically designed services for underserved populations.

Goals

- Improve and expand community access to health insurance.
- Eliminate barriers to health care and expand community access to medical and non-medical services.
- Expand access to essential health services through virtual care.
- Increase access to healthcare providers.
- Manage hospital health care costs and assist patients and community members to access financial education and assistance.
- Improve access to transportation for vulnerable populations.



Initiatives

- Provide primary care through MedStar Mobile Health Center without need for insurance or transportation, including for immigrant communities.
- Assist patients in need of insurance through screenings, referrals, and linkage to community resources.
- Provide financial assistance to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs, including individuals without US-documentation status.
- Recruit providers in areas of need.
- Ensure providers receive community experience and integration.
- Improve health of the community through social needs and SBIRT screenings, prevention, referrals, and linkage to community resources through hospital-based community health workers and Peer Recovery Coaches.
- Expand access to essential health services through virtual care and urgent care centers.
- Refer patients to financial advocates and support services.
- Offer and support community health financial education.
- Educate and advocate for cost containment.
- Support health care navigation education, programs, and services, and publicize resources.
- Screen patients for transportation needs and arrange ride-shares; provide cab vouchers and bus tokens to patients without adequate financial resources.
- Advocate for safe, accessible public transportation.

Access to health care and services
- Baltimore City has a 170:1 ratio of population to mental health providers.[28,29] This is better than the nationwide ratio of 328:1.
- 10% of adults in Baltimore City cannot afford to see a doctor, compared to the nationwide percentage of 13%.[30]
- 21% of survey respondents indicated that they or a family member in their household have difficulties with mobility and require medical equipment.

Availability of affordable healthcare providers and health insurance
- 66% of survey respondents say that cost is the main reason people in their community do not get health care when they need it.
- 50% of survey respondents say that no insurance is a main reason why people in their community do not get health care when they need it.

Availability of affordable healthcare providers and health insurance continued
- 33% of survey respondents indicated that limited access to doctors' offices is a top social issue affecting people in their community.

Transportation
- 26% of survey respondents indicated that a lack of or limited transportation is one of the most common reasons why people in their community do not get health care when they need it.
- 14% of survey respondents indicated that limited access to transportation is one of the most important social issues affecting quality of life in their community.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Availability of affordable healthcare providers and health insurance
- Number of patients provided primary care
- Number connected to specialty services
- Number of uninsured individuals
- Number of screenings
- Number of referrals
- Number of experiences
- Number of participants
- Number of providers recruited
- Number of screenings completed
- Number of positive screenings
- Number of patients served through MedStar Mobile Health Center
- Number connected to specialty services
- Number of ininsured individuals served
- Number of patients served through virtual care

Key partners

- Baltimore City Health Department
- Baltimore City Public Libraries
- Baltimore City Public Schools
- Central Baltimore Partnership
- Children's Community Health Services
- Community Access Network
- Community Housing Partners
- Faith-based organizations
- Healthcare Access Maryland
- Hungry Harvest
- Johns Hopkins Medicine
- Joy Wellness Center
- Keswick
- Maryland Food Bank
- Meals on Wheels
- Northeast Community Organization
- Shepherd's Clinic
- Sheppard Pratt Health System
- The Franciscan Center
- Uber Health
- University of Maryland School of Nursing
- University of Maryland School of Social Work

Social drivers of health

To make Baltimore City more accessible for all, our team has developed a series of initiatives to address needs such as housing, food insecurity, economic inequality and wage inequality, and neighborhood safety and gun violence. These priorities are consistent with the Maryland State Integrated Health Improvement Strategies (SIHIS).

Goals

- Promote equitable access to housing resources in the community.
- Support community housing and homelessness initiatives.
- Reduce inequities caused by lack of affordable housing, or substandard housing conditions, by promoting the intersection of housing and health care.
- Promote expanded food access.
- Improve medical food and nutrition interventions.
- Identify individuals experiencing food insecurity and link to resources.
- Improve access to basic needs and resources.
- Promote equitable access to employment opportunities to include a livable wage.
- Reduce community violence through community partnerships and employing a trauma-informed approach to care delivery.
- Implement a strategic approach to identifying and addressing social needs at MedStar Good Samaritan Hospital.

Initiatives

- Join and participate in Baltimore City Continuum of Care to advocate and act on specific opportunities to address homelessness, including referring patients to federal and state agencies for housing.
- Advocate for affordable, safe housing.
- Screen patients for food security and provide fresh produce prescriptions.
- Investigate long-term sustainability for food access.
- Facilitate Food Rx programming to provide nutrition education, lifestyle change classes, and access to fresh, healthy foods, including access to local farmer's markets.
- Refer to medically tailored meals and/or nutrition counseling.
- Participate in food inequality coalitions, seek evidence-based programs, and advocate for policy change.

Initiatives continued

- Advocate for pay equity and living wages.
- Support and coordinate drives for food, clothing, and basic needs.
- Partner to provide wrap around service through a trauma-informed care approach for individuals experiencing violence.
- Participate in violence prevention advocacy and community events to reduce the level of neighborhood violence.
- Advocate for funding and resources to address violence in the community, including domestic, intimate partner, human trafficking, and elder abuse.
- Expand social needs screenings to adult hospitalized patients in collaboration with nursing and acute case management teams.
- Engage with local community-based organizations to address social needs risk factors to advance health equity strategies.
- Leverage the MedStar Health Social Needs Tool powered by Findhelp to provide referrals and connections to social support services in the community.

Education

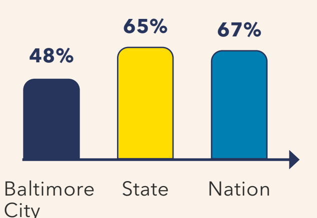
- 69% of public high school students in Baltimore City graduate within four years.[54,55] This is a significantly lower rate than the state and nationwide rates of 86% and 87%, respectively.

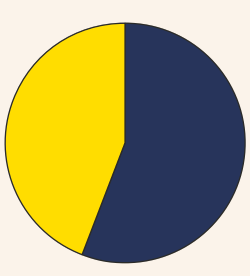
Employment

- 4% of adults in Baltimore City are unemployed.[35,36] This is slightly higher than the statewide rate of 3% and equal to the nationwide rate.

Housing

48% of Baltimore City housing is occupied by the owner.[37] **This is significantly lower than 65% nationwide and 67% statewide.**





In 56% of renter-occupied housing units in Baltimore City, tenants pay 30% or more of their household income on rental costs.[31] This is higher than the nationwide percentage of 51% and the statewide percentage of 52%.

- 38% of households in Baltimore City face at least one of the following housing problems: incomplete kitchen facilities, incomplete plumbing facilities, overcrowding, and a cost burden greater than 30%.[56]
- 28% of survey respondents indicated that housing problems and homelessness are among the main issues affecting people in their community.

Violence

- 20% of survey respondents indicated that gun violence is a top social issue affecting people in their community.
- 29% of survey respondents indicated that neighborhood safety and community violence are among the main social issues affecting people in their community.

Economic inequality

The median household income in Baltimore City is $54,100, which is significantly lower than the nationwide median household income of $70,784.[37,39] In Baltimore City, the average annual cost of living is close to the median household income.

- 20% of people in Baltimore City live in poverty, compared to 12% nationwide and 10% statewide.[37]

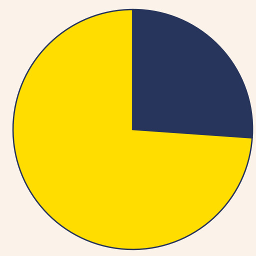
Economic inequality continued

32% of households with children in Baltimore City receive public assistance or SNAP benefits.

- The average annual cost for a family with two adults and two children is $75,726.[31]
  - The average annual cost for a household with two adults and two children **in childcare** is $83,496.
- The approximate cost of living for a one-child and one-adult household is $49,068.[31] The average annual income for these households is less than $52,000 (before taxes), based on an estimated hourly wage of $24.53.
- 80% of single-female-headed households with children in Baltimore City are below the ALICE* threshold, compared to 26% of married households with children being below the threshold.[31] **ALICE: Asset Limited, Income Constrained, Employed - Those earning more than the Federal Poverty Level, but not enough to afford the basics where they live*

Food insecurity

- 14% of households in Baltimore City experience food insecurity, higher than the state and nationwide average of 10%.[39]



26% of Baltimore City households with children experience food insecurity.[39] **This is significantly higher than the state and nationwide proportions** of 12% and 13%, respectively.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Housing and homelessness
- Number of patients served
- Number of enrollees in supportive housing services
- Number of people housed
- Number of housing advocacy events

Food insecurity
- Number of screenings
- Percentage of positive screenings
- Number of participants in Food Rx programming
- Number of farmer's market participants
- Number of patients served

Economic inequality
- Number of individuals served through events for food, clothing, and basic needs

Violence
- Number of participants
- Percentage reduction in re-injury, violent and nonviolent crimes, and incidents of retaliation
- Number of violence prevention advocacy events held
- Number of encounters for resource connections
- Number of programs developed
- Number of partnerships formed
- Number of staff trained

Key partners

- Baltimore City Communities for the Homeless
- Baltimore City Department of Planning
- Baltimore City Health Department
- Baltimore City Office of Food Planning
- Baltimore City Police
- Findhelp
- Greater Baltimore Cultural Alliance
- Healthcare Access Maryland
- Hungry Harvest
- Maryland Food Bank
- Mayor's Office of Neighborhood Safety and Engagement
- Meals on Wheels
- The Franciscan Center
- Uber Health

Baltimore City

(MedStar Good Samaritan Hospital, MedStar Harbor Hospital, MedStar Union Memorial Hospital)

What has improved?
- Age-adjusted death rate due to heart diseases and cancer

Areas to address
- Age-adjusted death rate due to diabetes

900 surveys completed for MedStar Good Samaritan

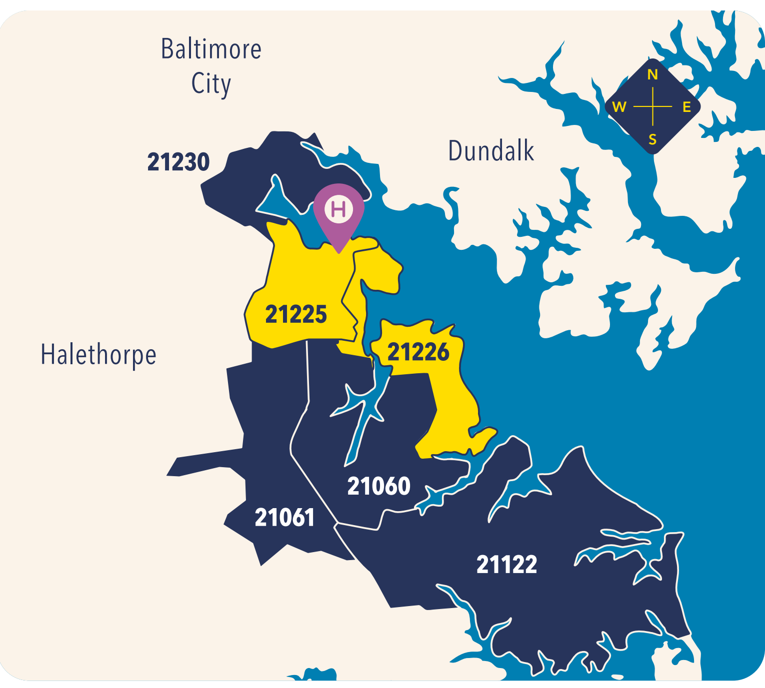
The 25-question survey was conducted from early September to the end of October 2023.

Survey was distributed in person and online.

To learn more about health needs in the MedStar Good Samaritan Hospital community, **scan the QR Code or visit MedStarHealth.org/CommunityHealth.**

MedStar Harbor Hospital

Community Health Needs Assessment



Primary Service Area   Community Benefit Service Area

History
With more than a century of healing, our team at MedStar Harbor Hospital serves patients from Baltimore City, and Anne Arundel, Baltimore, and Howard counties. Our convenient waterside location offers services of a large, regional medical center in a smaller, more personal environment. From internal medicine and surgery, obstetrics, diabetes, behavioral health, orthopaedics, and emergency medicine, our team of caring physicians and associates serves the unique needs of every patient. We also offer one of the nation's leading internal medicine residency programs and several innovative partners.

The community
We value the input and feedback from the communities we serve and make it a priority to collaboratively identify local healthcare needs and develop programs, partnerships, and initiatives to meet those needs. Our Advisory Task Force Committee is comprised of community residents as well as representatives from the local health department, local schools, higher education institutions, federally qualified health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): Baltimore City, Maryland
The CBSA representing MedStar Harbor Hospital includes residents living in zip code 21225 and 21226. This geographic area was selected as the CBSA representing MedStar Harbor based on hospital utilization data and secondary public health data, as well as its proximity to the hospital.

Prioritized health needs:

Health and wellness
Turn to page 52 for goals and initiatives

- Chronic disease prevention and management
- Behavioral health: mental health and substance use disorders
- Maternal health

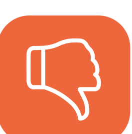
Access to care
Turn to page 55 for goals and initiatives

- Cost of health care
- Access to health insurance and providers
- Transportation

Social drivers of health
Turn to page 58 for goals and initiatives

- Housing and homelssness
- Food insecurity
- Poverty: economic and wage inequality
- Violence: neighborhood safety and gun violence

Red indicates a negative trend in this statistic.



Green indicates a positive trend in this statistic.

Demographics

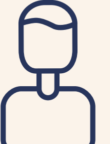
Zip code 21225

Average household income in 2020:
$39,665[57]

Gender and age*[57]

53% Female
Median age: **33**

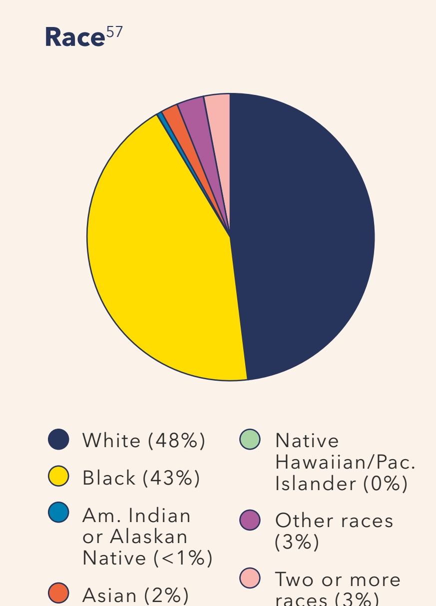
47% Male
Median age: **31**



Median age: **32**

Total population[57] **33,545**

Race[57]



Educational attainment
(those 25+ years)[57]

<High school diploma	**25%**
High school graduate	**60%**
Associate's degree	**6%**
Bachelor's degree	**7%**
Master's degree	**1%**
Professional degree	**<1%**
Doctorate degree	**<1%**

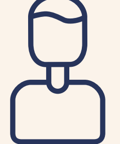
Zip code 21226

Average household income in 2020:
$57,284[58]

Gender and age*[58]

50% Female
Median age: **35**

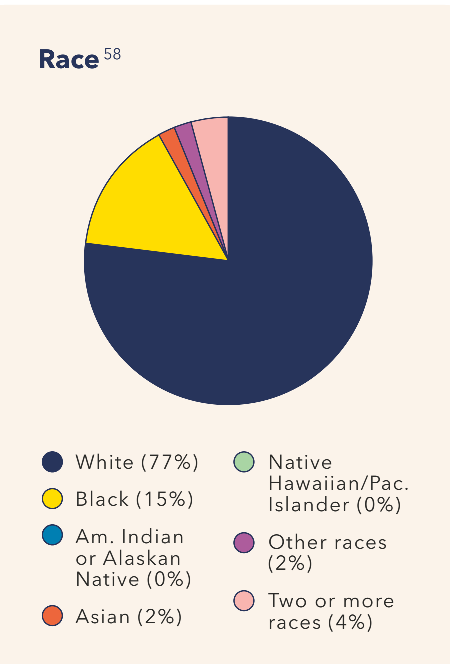
50% Male
Median age: **34**



Median age: **33**

Total population[58] **7,561**

Race[58]



Educational attainment
(those 25+ years)[58]

<High school diploma	**22%**
High school graduate	**57%**
Associate's degree	**6%**
Bachelor's degree	**12%**
Master's degree	**2%**
Professional degree	**<1%**
Doctorate degree	**<1%**

Health and wellness

Chronic disease prevention and management

Our team at MedStar Harbor Hospital prioritizes keeping people healthy and empowering communities to choose healthy behaviors. Additionally, Baltimore City's heart disease, stroke, and cancer rates are higher than state and nationwide averages. These priorities are consistent with the Maryland State Integrated Health Improvement Strategies (SIHIS), which include reducing the average BMI for adults in Maryland and reducing avoidable admissions and readmissions.

Goals

- Improve the health and quality of life through prevention, detection, and treatment of risk factors for chronic diseases.
- Improve community health and wellbeing through health education programs.
- Expand chronic disease prevention and management programming.

Initiatives

- Host and provide diabetes and heart disease community awareness and education, support groups, access to wellness services and education and fitness activities.
- Support local prevention activities.
- Improve awareness of pre- and gestational diabetes; implement practices to assure referral of patients to interventions through the MedStar Diabetes Institute.
- Facilitate Food Rx Programs designed to provide nutrition education, lifestyle change classes, and access to fresh, healthy foods.

Heart disease

- Baltimore City has a heart disease death rate of 227 per 100,000 people, which is higher than the statewide and nationwide rate of 165 per 100,000 people.[1,2,3]

Since our first CHNA: this is an improvement from the 2010 rate of 278 deaths per 100,000 people.

Obesity

- 37% of adults in Baltimore City are obese.[18,19]
- 35% of adults in Baltimore City have high blood pressure.[16,17]
  - 45% of MedStar Harbor CHNA survey respondents indicated that high blood pressure was among the main health problems affecting people in their community.
- Baltimore City has a stroke death rate of 53 deaths per 100,000 people, compared to the statewide rate of 42 per 100,000 people and the nationwide rate of 38 per 100,000 people.[3]

Diabetes and high blood sugar

- 11% of adults in Baltimore City have diabetes.[18,19] This is higher than the statewide average and equal to the national percentage.
  - 50% of survey respondents indicated that diabetes and/or high blood sugar are among the main health problems affecting people in their community.

Cancer

- Baltimore City's cancer death rate is 188 deaths per 100,000 people.[5,6]

Since our first CHNA: this is an improvement from the 2010 rate of 225 deaths per 100,000 people.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of participants
- Number of activities and/or events attended
- Number of sessions and/or groups held
- Number of screenings
- Number of referrals and/or linkages to care

Key partners

- American Heart Association
- Baltimore City
- Baltimore City Department of Recreation and Parks
- Baybrooke Connector Pedestrian Bridge and Trails
- Black Yield Institute
- Cherry Hill Purpose Built Community program
- Faith-based organizations
- Food Rx
- Hungry Harvest
- Johns Hopkins Diabetes Prevention Program
- Local Health Improvement Coalition Workgroup
- Maryland Department of Health
- Maryland Food Bank
- Maryland Medicaid
- Middlebranch Recreation and Wellness Center
- Meals on Wheels
- Reimagine Middlebranch
- University of Maryland Diabetes Prevention Program

Behavioral health: mental health and substance use disorders

Our team prioritizes initiatives to respond to substance use disorders and mental health issues affecting communities throughout Baltimore City, including conducting free HIV testing screening services in the emergency department. This initiative is particularly vital given the correlation between substance use and HIV prevalence in South Baltimore City and northern Anne Arundel County, aiming to improve access to services for those in need.

Goals

- Support substance use disorder recovery and promote access to behavioral health programs.
- Ensure access to appropriate quality behavioral health and substance use disorder services.

Initiatives

- Conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program in emergency department and Women's Services supported by Peer Recovery Coaches.
- Conduct Opioid Survivor Outreach program providing referral for treatment.
- Serve as a community health hub for behavioral health resources, community education (virtual or in-person), overdose preventions, and peer-to-peer support.
- Engage as member of the Central Maryland Regional Crisis System to expand mental health and crisis services in the Baltimore metro region.
- Provide behavioral health services, offering Intensive Outpatient and Inpatient programs and services, Psychiatry and Therapy clinic, Crisis Teams, Partial Hospitalization program, and therapeutic and education groups for specific audiences.
- Advocate for tele-mental health counseling expansion.
- Host and provide smoking cessation program (virtual or in-person).
- Conduct free HIV testing screening services.

Mental health

People in Baltimore City average five poor mental health days per 30 days, **higher than the state and nationwide average.**[20]

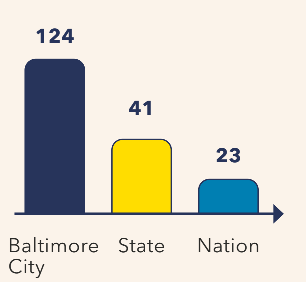
- 8% of survey respondents indicated that mental health is one of the main issues affecting people in their community.

Addiction and substance use disorders

- The rate of drug overdose deaths in Baltimore City is six times higher than the national rate.[24,26]
- 15% of adolescents in Baltimore City reported using tobacco products.[22] This is lower than the statewide average of 16% but higher than the nationwide average of 11%.
- 43% of survey respondents indicated that addiction is among the main health problems affecting people in their community.

Opioids

Baltimore City has 124 drug overdose deaths per 100,000 people.[24,26] This is significantly higher than the nationwide rate of 23 and statewide rate of 41 per 100,000 people.



- In Baltimore City, 69 opioid prescriptions are dispensed per 100 people, compared to 43 prescriptions per 100 people nationwide and the statewide rate of 40 prescriptions per 100 people.[25]

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of referrals and linkages to support services and treatment
- Number of SBIRT screenings, referrals, and linkages to treatment
- Number of patients served in mobile crisis teams
- Number of participants enrolled in smoking cessation program

Key partners

- Baltimore City Health Department
- Behavioral Health Equity Across Maryland
- Behavioral Health Systems of Baltimore
- Local Behavioral Health Authorities
- Maryland Department of Health
- NAMI Metropolitan Baltimore - National Alliance of Mental Illness

Maternal health

The wellbeing of mothers and children is fundamental to the overall health of our communities. At MedStar Harbor, our commitment lies in championing initiatives that foster the wellbeing of mothers and babies, address disparities, enhance outcomes, and advocate for the health of both mothers and infants.

Goals

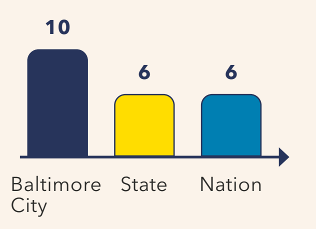
- Improve health outcomes related to maternal and child health.
- Serve as a connector to resources and services to improve maternal morbidity and mortality with local and state agencies.
- Improve the health of expecting mothers and babies through engagement in education sessions, providing resources and providing mental health screenings.

Initiatives

- Provide support and project management for Healthy Babies Collaborative, working toward reducing morbidity and mortality outcomes for women and infants.
- Provide community-based medication-assisted therapy and support groups for expectant mothers.
- Provide maternal and child health services, including birth and family education, breastfeeding education and assistance, OB outpatient services, and support groups.

Infant mortality

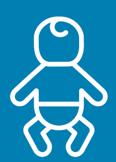
There are 10 infant deaths per 1,000 live births in Baltimore City.[8,27] This is higher than the state and nationwide average of six infant deaths per 1,000 live births.



- 8% of survey respondents indicated that infant health issues are among the main health problems affecting people in their community.
- 12% of live births in Baltimore City between the years of 2014-2020 had a low birth weight.[59,60]

Teen births

Baltimore City has 27 teen births per 1,000 females ages 15-19.[27] **This is significantly higher than the state and nationwide averages** of 11 teen births and 14 teen births per 1,000 females ages 15-19.



Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of participants served in maternal health programs
- Number of maternal health events, classes, and support groups
- Breastfeeding initiation rates
- Duration of breastfeeding

Key partners

- Baltimore City Health Department
- Baltimore City WIC
- B'more for Healthy Babies
- Healthcare Access Maryland
- Maryland Department of Health

Access to health care and services

Access to quality care and services is a key issue for people living in Baltimore City. It is important for promoting and maintaining health, preventing, managing disease, and achieving health equity for all. For this reason, we prioritize initiatives to expand healthcare access in Baltimore City. These priorities are consistent with the Maryland State Integrated Health Improvement Strategies (SIHIS).

Goals

- Assist patients and community members with access to financial education and assistance.
- Improve and expand community access to health insurance.
- Expand access to essential health services through virtual care.
- Increase access to healthcare providers.
- Improve access to transportation for vulnerable populations.

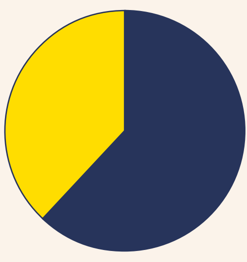
Initiatives

- Refer patients to financial advocate and support services.
- Offer and support community health financial education.
- Educate and advocate for cost containment.
- Provide primary care services through MedStar Mobile Health Center without need for insurance, including immigrant communities.
- Connect patients to telehealth care and urgent care centers for appropriate utilization of services.
- Recruit providers in areas of need.
- Increase provider community experience and integration.
- Improve health of the community through SDOH and SBIRT screenings, prevention, referrals, and linkage to community resources through hospital-based community health worker and Peer Recovery Coaches.
- Provide financial assistance to uninsured patients by assisting with enrollment to publicly-funded programs, hospital charity care programs, including individuals without U.S. documentation status.
- Promote and support insurance enrollment.
- Screen patients for transportation needs and arrange ride-shares and provide cab vouchers and/or bus tokens to patients without adequate financial resources.
- Advocate for safe, accessible public transportation.
- Lead bike and pedestrian pathway project connecting Gwynn's Falls trail and BWI Trail.

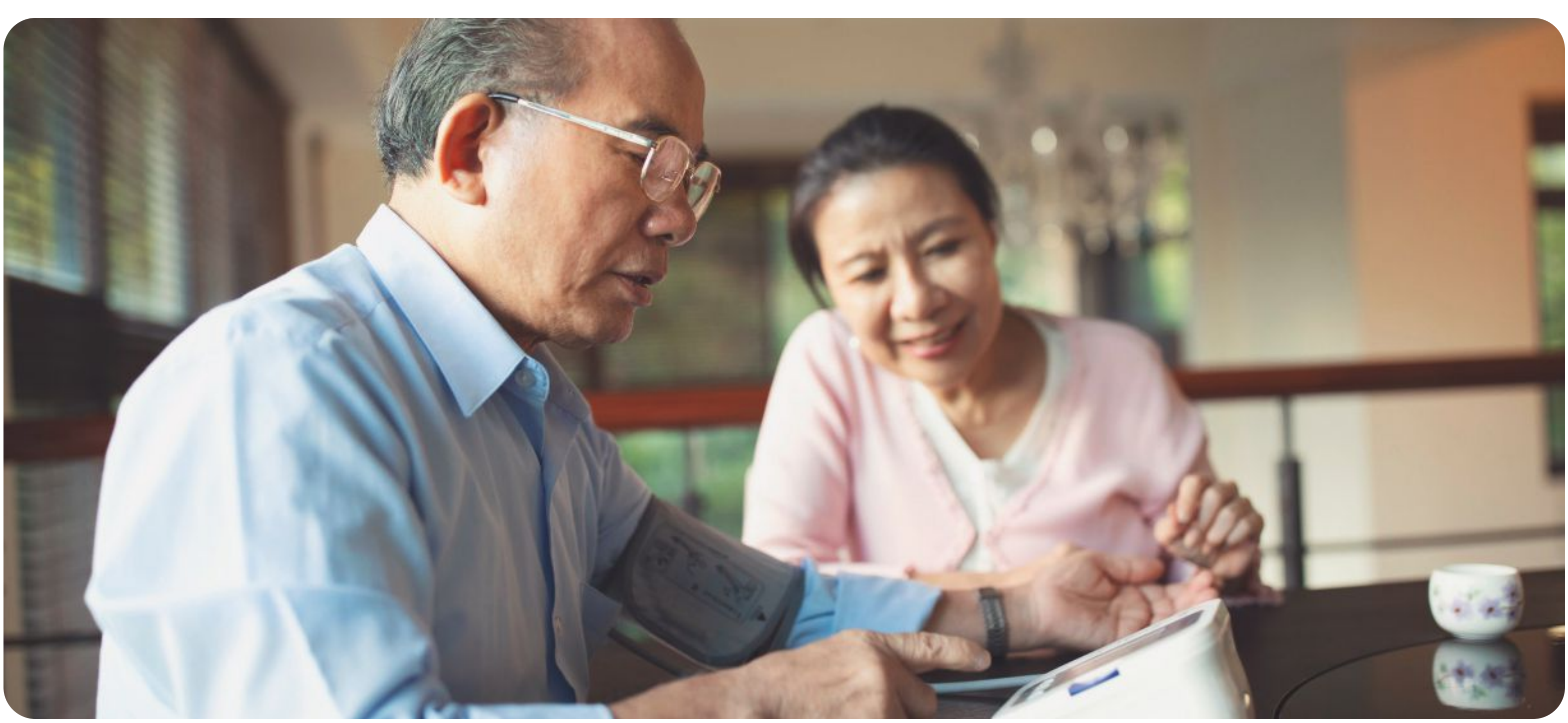
Access to health care and services

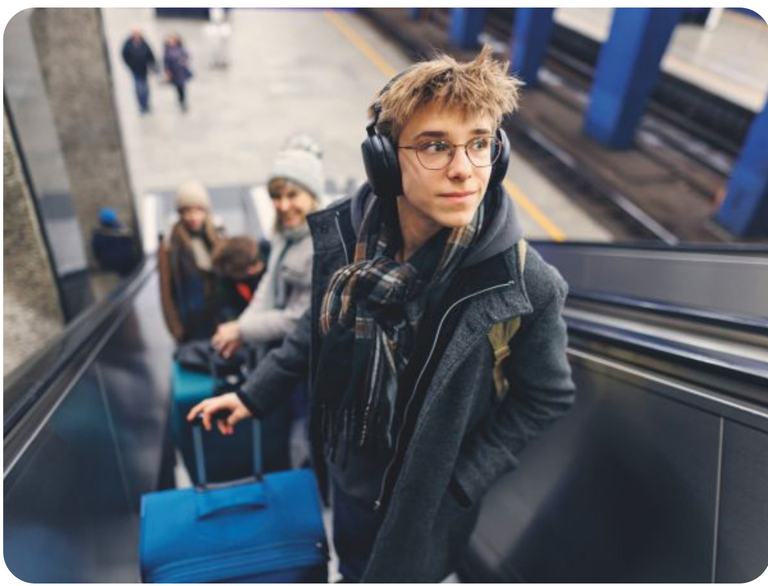
Baltimore City has a 170:1 ratio of population to mental health providers.[28,29] **This is lower than the nationwide ratio of 328:1.**

- 10% of adults in Baltimore City cannot afford to see a doctor, compared to the nationwide percentage of 13%.[30]
- 30% of survey respondents indicated that lack of and/or limited access to a doctor is one of the most important social issues affecting quality of life in their community.
  - Of those who selected lack of and/or limited access to a doctor's office, 24% are white, 44% are Black, 13% are multi-racial, and 5% are American Indian/Alaskan native.
- 17% of survey respondents indicated that they or a family member in their household have difficulties with mobility and require medical equipment.

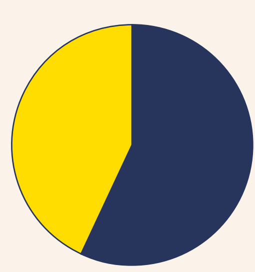


62% of survey respondents say that **cost is the main reason people in their community do not get health care when they need it.**





Availability of affordable healthcare providers and health insurance



57% of survey respondents indicated that not having health insurance is one of the most common reasons people in their community do not get health care when they need it.

- 29% of survey respondents indicated that finding a doctor who accepts their insurance is one of the most common reasons people in their community do not get health care when they need it.
- 12% of survey respondents indicated that getting a referral or appointment with a specialist is one of the most common reasons people in their community do not get health care when they need it.

Transportation
- 21% of survey respondents indicated that a lack of or limited transportation is one of the most common reasons people in their community do not get health care when they need it.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Cost of health care
- Number of patients referred to financial services
- Number of financial education sessions offered
- Number of cost containment education opportunities provided

Program-specific metrics continued

Availability of affordable healthcare providers and health insurance
- Number of patients served through MedStar Mobile Health Center
- Number of patients connected to specialty services
- Number of uninsured individuals connected to primary care services
- Number of patients served through telehealth
- Number of providers participating in community experiences
- Number of experiences
- Number of providers recruited
- Number of SDOH and SBIRT screenings completed
- Number of referrals to community resources

Transportation
- Number of patients served
- Number of Uber Health rides provided
- Number of vouchers and/or bus tokens provided
- Number of patients attending MedStar Mobile Health Center
- Number of advocacy events attended for safe, accessible public transportation

Key partners

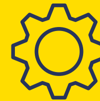
- Anne Arundel County Department of Recreation and Parks
- Anne Arundel County Department of Transportation
- Anne Arundel County Health Department
- Anne Arundel Elementary
- Baltimore City Department of Transportation and Planning
- Baltimore City transit system
- Baltimore County Department of Transportation
- Baltimore County Health Department
- Brooklyn Library
- Brooklyn Park Library
- Cherry Hill Tenant Homes
- Community financial institutions
- Creating Assets, Savings, and Hope campaign
- Greater Baybrook Alliance
- Healthcare Access Maryland
- Housing Upgrades to Benefit Seniors
- Hungry Harvest
- Lakeland Elementary School
- Maryland Department of Transportation
- Maryland Food Bank
- Maryland Hospital Association
- Maryland Transit Authority - Mobility
- Meals on Wheels
- South Baltimore 7 Coalition
- The City of Refuge
- The Transformation Center
- The Well
- Uber Health
- Westport Academy

Social drivers of health

To make Baltimore City more accessible for all, our team at MedStar Harbor has developed a series of initiatives to address community concerns such as housing, food insecurity, and violence. In response to these needs, our team prioritizes initiatives such as expanding access to healthy foods and advocacy for housing services and violence prevention. These priorities are consistent with the Maryland State Integrated Health Improvement Strategies (SIHIS).

Goals

- Identify individuals experiencing food insecurity and link to resources.
- Reduce inequities caused by lack of access to healthy foods through partnership and collaboration with community organizations focused on reducing household food insecurity.
- Promote the expansion of food access and provide resources to address food insecurity.
- Promote equitable access to housing resources in the community.
- Support community housing and homelessness initiatives.
- Reduce inequities caused by lack of affordable housing, or substandard housing conditions by promoting the intersection of housing and health care.
- Improve access to basic needs and resources.
- Promote equitable access to employment opportunities to include a livable wage.
- Reduce community violence through community partnerships and employing a trauma-informed approach to care delivery.
- Implement a strategic approach to identifying and addressing social needs at MedStar Harbor Hospital.



Initiatives

- Conduct social needs screenings through Community Health Advocate program and Findhelp tool to focus on food insecurity and long-term sustainability for food access.
- Facilitate Food Rx programming to provide nutrition education, lifestyle change classes, and access to fresh, healthy foods.
- Support pop-up food markets to offer fresh produce.
- Participate in coalitions, support referrals to medically tailored meals, evidence-based programs, and nutrition counseling; advocate for policy change.
- Join and participate in Baltimore City Communities for Homeless to advocate and act on opportunities to address homelessness, including referring patients to federal and state agencies for housing.
- Advocate for affordable, safe housing.
- Advocate and evaluate pay for equity and living wage increases.
- Support and coordinate drives for food, clothing, and basic living needs.
- Partner to provide wrap-around service through a trauma-informed care approach for individuals experiencing violence.
- Participate in violence prevention advocacy and community events to reduce neighborhood violence.
- Advocate for funding and resources to address violence in the community, including domestic, intimate partner, human trafficking, and elder abuse.
- Expand social needs screenings to adult hospitalized patients in collaboration with nursing and acute case management teams.
- Engage with local community-based organizations to address social needs risk factors to advance health equity strategies.
- Leverage the MedStar Health Social Needs Tool powered by Findhelp to provide referrals and connections to social support services in the community.

Employment

- 4% of adults in Baltimore City are unemployed.[35,36]
  - This is 1% higher than the state unemployment rates and equal to the nationwide rate.

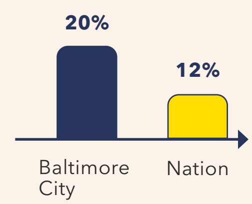
Housing

- 48% of Baltimore City housing is occupied by the owner.[37]
- In 56% of renter-occupied housing units in Baltimore City, tenants pay 30% or more of their household income on rental costs.[36] This is consistent with the nationwide percentage and lower than the statewide percentage of 52%.
- 31% of survey respondents indicated that housing problems and homelessness are among the most important social issues affecting the quality of life in their community.
- 38% of households in Baltimore City face at least one of the following housing problems: incomplete kitchen facilities, incomplete plumbing facilities, overcrowding, and a cost burden greater than 30%.[56]

Economic inequality

- The median household income reported in Baltimore City in 2021 was $54,100.[37,38] This is lower than the national median of $70,784 and the statewide median of $90,100. **When viewing cost-of-living data, these wages often are not sufficient to cover household expenses. Ultimately, this can significantly impact access to care.**

20% of people in Baltimore City live in poverty, compared to 12% nationwide.[37]



- The average annual cost for a family with two adults and two children is $75,276.[31]
  - The average annual cost for a household with two adults and two children **in childcare** is $83,496.
- The approximate cost of living for a one-child and one-adult household is $49,068.[31] The average annual income for these households is less than $51,000 (before taxes), based on an estimated hourly wage of $24.37.
- 80% of single-female-headed households with children in Baltimore City are below the ALICE* threshold, compared to 26% of married households with children being below the threshold.[31] **ALICE: Asset Limited, Income Constrained, Employed - Those earning more than the Federal Poverty Level, but not enough to afford the basics where they live.*

Food insecurity

- 14% of households in Baltimore City experience food insecurity, higher than the nationwide percentage of 10%.[39]
- 26% of Baltimore City households with children experience food insecurity.[39] This is higher than the state and nationwide proportions of 12% and 13%, respectively.
  - 26% of survey respondents indicated that hunger and food insecurity are some of the most important social issues affecting quality of life in their community.
  - Of those who selected hunger and food insecurity as an important issue, 32% are white, 42% are Black, and 11% are multi-racial.

Violence and neighborhood safety
- 35% of survey respondents indicated that neighborhood safety is one of the most important social issues affecting quality of life in their community.
- 17% of survey respondents indicated that gun violence is one of the most important social issues affecting quality of life in their community.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Food insecurity
- Number of social needs screenings completed
- Number of participants in Food Rx programming
- Number of farmer's market pop-ups
- Number of participants
- Number of patients served

Housing and homelessness
- Number of patients served
- Number of housing advocacy events

Economic inequality
- Number of individuals served through events for food, clothing, and basic living needs

Violence and neighborhood safety
- Number of participants in wrap-around service
- Number of referrals to community-based organizations
- Percentage reduction in re-injury
- Percentage reduction in violent and non-violent incidents of retaliation
- Number of violence prevention events held
- Number of resource connections
- Number of programs developed to address community violence
- Number of community partnerships formed
- Number of staff trained

Key partners

- Anne Arundel County Health Department
- Baltimore City Communities for the Homeless
- Baltimore City Department of Planning
- Baltimore City Health Department
- Baltimore City Police Department
- Black Yield Institute
- Cherry Hill Development Corporation
- Cherry Hill Tenant Association
- Findhelp
- Food Rx
- Greater Baybrooke Alliance
- Health Care Access Maryland
- Hungry Harvest
- Maryland Food Bank
- Maryland Hospital Association
- Mayor's Office of Neighborhood Safety and Engagement
- Meals on Wheels
- The City of Refuge
- The Well
- Towson University
- Uber Health

Baltimore City

(MedStar Harbor Hospital, MedStar Good Samaritan Hospital, MedStar Union Memorial Hospital)

What has improved?
- Age-adjusted death rate due to heart diseases and cancer

Areas to address
- Age-adjusted death rate due to diabetes

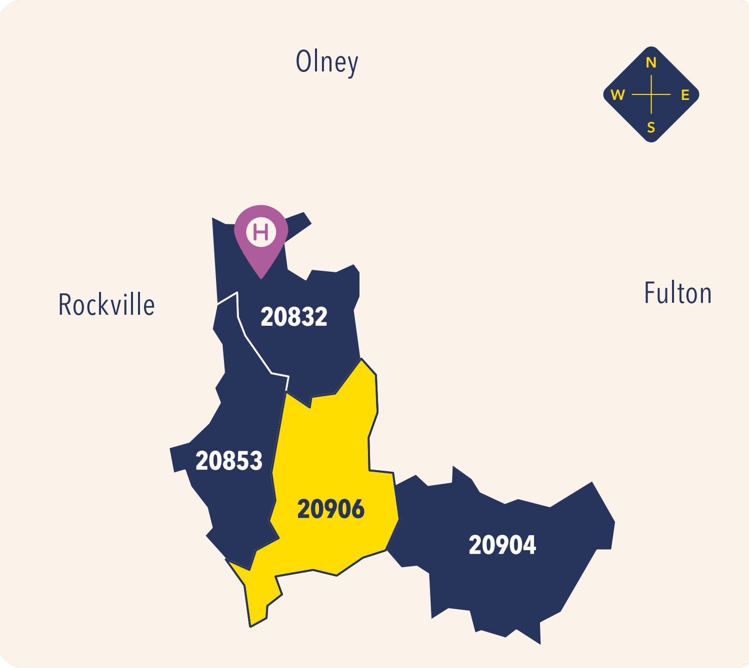
533 surveys completed for MedStar Harbor Hospital

The 25-question survey was conducted from early September to the end of October 2023.

Survey was distributed in person and online.

To learn more about health needs in the MedStar Harbor Hospital community, **scan the QR Code or visit MedStarHealth.org/CommunityHealth.**

MedStar Montgomery Medical Center



Primary Service Area ● Community Benefit Service Area

History
Located in Olney, Maryland, our team at MedStar Montgomery Medical Center offers sophisticated, compassionate, and high-quality medical care in a personal and individualized atmosphere. The medical center was founded in 1919 by Jacob Wheeler Bird, MD, and became part of MedStar Health in 2008. MedStar Montgomery is a Joint Commission-certified Primary Stroke Center, a member of the American Academy of Sleep Medicine, and has received the Gold Plus Performance Achievement Award from the American Heart and American Stroke Association, as well as the American Nurses Credentialing Center's (ANCC) Commission on Magnet Recognition. It is also a member of the American College of Surgeons (ACS), the American Society for Metabolic and Bariatric Surgery (ASMBS), and the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSQIP).

The community
We value the input and feedback from the communities we serve and make it a priority to collaboratively identify local healthcare needs and develop programs, partnerships, and initiatives to meet those needs. We seek input from community residents in addition to representatives from the local health department, local schools, higher education institutions, federally qualified health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): Montgomery County, Maryland
The CBSA representing MedStar Montgomery includes residents living in zip code 20906. This geographic area was selected as the CBSA representing MedStar Montgomery based on hospital utilization data and secondary public health data, as well as its proximity to the hospital and its collaborative partnership with local organizations.

Prioritized health needs:

Health and wellness
Turn to page 63 for goals and initiatives

- Chronic disease prevention and management
- Aging and older adults
- Behavioral health: mental health and substance use disorders

Access to care
Turn to page 66 for goals and initiatives

- Access to health insurance and healthcare providers

Social drivers of health
Turn to page 67 for goals and initiatives

- Food insecurity
- Housing and homelessness

Red indicates a negative trend in this statistic.

Green indicates a positive trend in this statistic.

Demographics

Zip code 20906

Average household income in 2020:
$62,531[61]

Gender and age*[61]

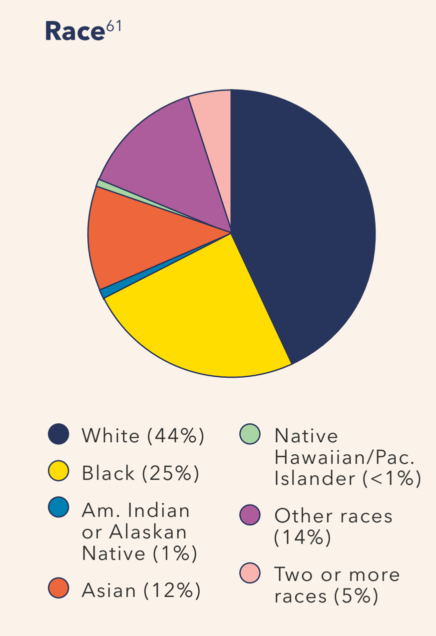
54% Female
Median age: **43**

46% Male
Median age: **37**

Median age:
40

Total population[61] **64,696**

Race[61]



Educational attainment
(those 25+ years)[61]

Level	Percent
<High school diploma	**18%**
High school graduate	**40%**
Associate's degree	**5%**
Bachelor's degree	**20%**
Master's degree	**11%**
Professional degree	**3%**
Doctorate degree	**3%**

Health and wellness

Chronic disease prevention and management

Residents in Montgomery County have a lower heart disease death rate, stroke death rate, and diabetes rate when compared to state and nationwide averages. To maintain these positive statistics, we prioritize keeping people healthy and empowering communities to choose healthy behaviors. This priority is consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, which include reducing avoidable admissions and readmissions and reducing BMI for adult Maryland residents.

Goals

- Improve health and quality of life through prevention, detection, and treatment of risk factors for chronic diseases.
- Improve community health and wellbeing through health education programs.
- Expand chronic disease prevention and management programming.
- Promote obesity reduction and improve community health and wellbeing through nutrition and fitness programs.

Initiatives

- Host and participate in healthy lifestyle education programs, wellness activities, workshops, support groups, health fairs, community screening events, and connected care transition clinic.
- Expand or implement programs and educational classes and materials for diabetes prevention and chronic disease self-management.
- Host and provide obesity prevention fitness programs.

Obesity

- 22% of adults in Montgomery County are obese.[4,18,19]

Since our first CHNA: this is an increase from the 2010 rate of 17%.

Heart disease and stroke

- Montgomery County has a heart disease death rate of 99 per 100,000 people, which is lower than the statewide and nationwide rate of 165 per 100,000 people.[2,3,4]

Since our first CHNA: this is an improvement from the 2010 rate of 144 heart disease deaths per 100,000 people.

- Montgomery County has a stroke death rate of 26 deaths per 100,000 people, compared to the statewide rate of 42 per 100,000 people and the nationwide rate of 38 per 100,000 people.[3]
- 27% of adults in Montgomery County have high blood pressure.[16,17,43]
- 47% of MedStar Montgomery CHNA survey respondents indicated that high blood pressure is among the main health problems affecting people in their community.

Diabetes and high blood sugar

- 7% of adults in Montgomery County have diabetes.[4,18,19] This is lower than the statewide and national percentage.
  - 49% of survey respondents indicated that diabetes and high blood sugar are among main health problems affecting people in their community.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of attendees at events
- Number of screenings
- Number of classes and events held
- Number of participants enrolled in chronic disease prevention and mangement programs
- Number of obesity prevention class participants

Key partners

- African American Health Program
- American Diabetes Association
- Asian American Health Initiative
- Latino Health Initiative
- Leisure World of Maryland
- Linkages to Learning program
- Lions Club of Olney
- Longwood Community Center
- Mid-County Recreation Center
- Millian United Methodist Church
- Montgomery County Department of Health and Human Services
- Montgomery County Recreation
- University of Maryland Extension

Behavioral health: mental health and substance use disorders

Substance use disorders and mental health issues affect people in communities throughout Montgomery County. To address these concerns, our team prioritizes initiatives to improve access to services. This priority is consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, including improving overdose mortality.

Goals

- Support substance use disorder recovery and promote access to behavioral health programs.
- Improve access to quality behavioral health and substance use disorder services and providers.

Initiatives

- Conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT) program.
- Offer Mindoula Behavioral Health program.
- Engage as a member of Nexus Montgomery Regional Behavioral Health Partnership by centralizing crisis services ecosystem, expanding mobile crisis delivery, and offering same-day access services.

Mental health

- People in Montgomery County average four poor mental health days per 30 days, which is equal to the nationwide average.[20]
- 36% of survey respondents indicated that mental health is one of main health problems affecting people in their community.
- 12% of survey respondents indicated that social isolation and loneliness are among the main health problems affecting people in their community.

Addiction and substance use disorders

- 12% of adolescents in Montgomery County reported using tobacco products.[21,22,44] This is lower than the statewide average of 16% but slightly above the nationwide average.
- 21% of survey respondents indicated that addiction is one of the main health problems affecting people in their community.

Opioids

- Montgomery County has 12 drug overdose deaths per 100,000 people.[24,26] This is lower than the nationwide rate of 23 per 100,000 people.
- In Montgomery County, 25 opioid prescriptions are dispensed per 100 people, compared to 43 prescriptions per 100 people nationwide and 40 prescriptions per 100 people statewide.[25]

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of referrals and linkages to support services and treatment
- Number of SBIRT screenings, referrals, and linkages to treatment
- Number of participants served
- Number of emergency department encounters for high utilizer patients
- Number of emergency department readmissions for behavioral health high utilizer patients

Key partners

- Cornerstone Montgomery
- Department of Health and Human Services
- Local Behavioral Health Authority
- Mindoula Behavioral Health
- Montgomery County Fire and Rescue Service
- Mosaic Group
- Nexus Behavioral Health Crisis Workgroup
- Sheppard Pratt Health System

Aging and older adult issues

At MedStar Montgomery, our team is committed to honoring the dignity and wellbeing of older adults in Montgomery County. We prioritize initiatives that promote healthy, successful aging. This priority is consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, including care transformaton.

Goals

- Promote healthy aging by improving health, function, and quality of life of older adults.

Initiatives

- Partner with local skilled nursing facilities to improve transitions of care and quality between hospital and nursing home community.
- Host and offer age-friendly senior wellness virtual and in-person health education programs, dementia-friendly seminars, and fall prevention workshops.
- Offer an age-friendly Senior Wellness Fitness program.
- Partner with community organizations by linking 55+ community members and patients to transportation services for improved access to health care.

- 43% of survey respondents indicated that aging and older adult issues (Alzheimer's, dementia, falls) are among the main health issues in their community.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of participants, events, and classes
- Number of rides provided
- Number of people served

Key partners

- Greater Olney Rides
- Leisure World of Maryland
- Longwood Community Center
- Mid-County Recreation Center
- Montgomery County Recreation
- Nexus Montgomery Skilled Nursing Facilities Alliance
- The Alzheimer's Association
- Uber Health

Access to health care and services

Access to quality care and services is a key issue for people living in Montgomery County. It is important for promoting and maintaining health, preventing, managing disease, and achieving health equity for all. For this reason, our team at MedStar Montgomery prioritizes initiatives to expand healthcare access in Montgomery County. These priorities are consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, including care transformation and care coordination.

Goals

- Improve and expand community access to comprehensive, quality healthcare providers, and programs as well as medical and non-medical services.
- Eliminate barriers to accessing health care and expand community access to health insurance.

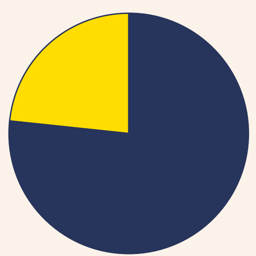
Initiatives

- Assist patients in need of health insurance through screenings, referrals, and linkage to community resources through hospital-based programs, including Community Health Advocate program.
- Provide financial and in-kind support to primary care safety-net community clinics.
- Provide support to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs.
- Partner with Uber Health and local transportation service providers (i.e., taxi and rideshare companies) to provide rides for individuals with financial needs.

Access to health care and services

Montgomery County has a 260:1 ratio of population to mental health providers.[28,29] **This is better than the nationwide ratio of 328:1.**

- 10% of adults in Montgomery County cannot afford to see a doctor, compared to the nationwide rate of 13%.[30,46]
- 29% of survey respondents indicated that lack of or limited access to a doctor is one of the most important social issues affecting quality of life in their community.
  - Of those who selected lack of or limited access to a doctor's office, 67% are white, 18% are Black, and 4% are multi-racial.
- 14% of survey respondents indicated that they or a family member in their household have difficulties with mobility and require medical equipment.



69% of survey respondents say that **cost is the main reason people in their community do not get health care when they need it.**

- 12% of survey respondents indicated that language barriers are a common reason people in their community do not get health care when they need it.
- 15% of people ages five and older in Montgomery County are classified as having a limited English language proficiency.[56]

Availability of affordable healthcare providers and health insurance

- 27% of survey respondents indicated that finding a doctor who accepts their insurance is one of the most common reasons people in their community do not get health care when they need it.
- 44% of survey respondents indicated that not having health insurance is one of the most common reasons people in their community do not get health care when they need it.
- 24% of survey respondents indicated that getting a referral or appointment with a specialist is one of the most common reasons people in their community do not get health care when they need it.

Appointment wait times

- 49% of survey respondents indicated that waiting too long for an appointment is one of the most common reasons people in their community do not get health care when they need it.
- 14% of survey respondents indicated a fear of losing their job for taking time off from work as one of the most common reasons people in their community do not get health care when they need it.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Availability of affordable healthcare providers and health insurance

- Number of screenings
- Dollar amount provided
- Number of persons served
- Number of enrolled clients
- Dollar amount provided
- Number of rides providved
- Number of people served

Key partners

- Findhelp
- Greater Olney Rides
- Holy Cross Health Center Aspen Hill
- Montgomery Cares Program
- Montgomery Cares Safety Net Clinics
- Primary Care Coalition
- Proyecto Salud Clinic
- Uber Health

Social drivers of health

To make Montgomery County more accessible for all, our team has developed a series of initiatives to address needs such as housing and food insecurity. We prioritize initiatives such as expanding access to healthy foods and advocacy for housing services. These priorities are consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, including care transformation.

Goals

- Promote equitable access to housing resources in the community.
- Support community housing and homelessness initiatives.
- Identify individuals experiencing food insecurity and provide resources.
- Reduce inequities caused by lack of access to healthy foods through partnership and collaboration with community organizations focused on reducing household food insecurity.
- Promote the expansion of food access.
- Implement a strategic approach to identifying and addressing social needs at MedStar Montgomery Medical Center.

Initiatives

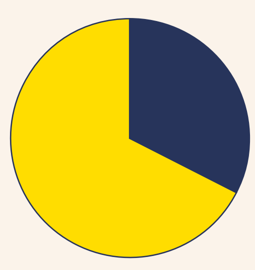
- Provide social needs screenings through hospital-based Community Health Advocate program and Findhelp tool to address housing problems and homelessness.
- Provide grant funding and sponsorships to community organizations addressing housing cost burden.
- Partner with community organizations to support access to housing resources.
- Conduct social needs screenings through Community Health Advocate program and Findhelp tool to focus on food insecurity.
- Partner and provide grant funding and sponsorships to community organizations addressing access to food insecurity and hunger in the community.
- Host and partner with community farmer's market.
- Expand social needs screenings to adult hospitalized patients in collaboration with nursing and acute case management teams.
- Engage with local community-based organizations to address social needs risk factors to advance health equity strategies.
- Leverage the MedStar Health Social Needs Tool powered by Findhelp to provide referrals and connections to social support services in the community.

Employment

- 3% of adults in Montgomery County are unemployed.[35,36]
  - This is consistent with the state unemployment rates and 1% lower than the nationwide rate.
- 31% of workers in Montgomery County commute alone, with a travel time of 30 minutes or more.[56]

Housing

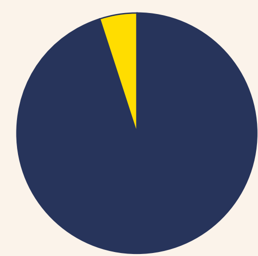
- 65% of Montgomery County housing is occupied by the owner.[37]
- In 51% of renter-occupied housing units in Montgomery County, tenants pay 30% or more of their household income on rental costs.[36] This is consistent with the nationwide average and lower than the statewide average of 52%.
- 19% of survey respondents indicated that housing problems and homelessness are among the most important social issues affecting the quality of life in their community.



33% of households in Montgomery face at least one of the following housing problems: **incomplete kitchen facilities, incomplete plumbing facilities, overcrowding, and a cost burden greater than 30%.**[56]

Costs of living

- The median household income reported in Montgomery County in 2021 was $112,400.[37,38] This is higher than the national median of $70,784 and the statewide median of $90,100.
- 9% of people in Montgomery County live in poverty, compared to 12% nationwide.[37]
- The average annual cost for a family with two adults and two children is $95,964.[31]
  - The average annual cost for a household with two adults and two children **in childcare** is $110,292.



The approximate cost of living for a one-child and one-adult household is **$67,680**.[31] The average annual income for these households is less than **$71,000** (before taxes), based on an estimated hourly wage of $33.84.

- 63% of single-female-headed households with children in Montgomery County are below the ALICE* threshold, compared to 17% of married households with children being below the threshold.[31] **ALICE: Asset Limited, Income Constrained, Employed - Those earning more than the Federal Poverty Level, but not enough to afford the basics where they live.*

Food insecurity

- 9% of households in Montgomery County experience food insecurity, lower than the nationwide percentage of 10%.[39]
- 8% of Montgomery County households with children experience food insecurity.[39] This is lower than the state and nationwide proportions of 12% and 13%, respectively.
  - 27% of survey respondents indicated that hunger and food insecurity are among the most important social issues affecting the quality of life in the community.
  - Of those who selected hunger and food insecurity as an important issue, 67% are white, 18% are Black, and 4% are multi-racial.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Food insecurity

- Number of social needs screenings completed
- Total dollar amount provided
- Number of people served
- Number of awards
- Number of participants reached
- Number of events

Housing and homelessness

- Number of social needs screenings completed
- Number referred to housing resources
- Number of people served
- Number of awards
- Total dollar amount provided
- Number of participants reached
- Number of programs held in partnership with community organizations.

Key partners

- Findhelp
- Harmony Hills Elementary School
- Housing Opportunities Commission
- Interfaith Works
- Linkages to Learning
- Manna Food Center
- Milian United Methodist Church
- Montgomery County Coalition for the Homeless
- Olney Farmers Market
- Seabury Resources for Aging

Montgomery County

(MedStar Montgomery Medical Center)

What has improved?

- Age-adjusted death rate due to heart disease, stroke, and cancer
- Lower percentage of unemployed adults

Areas to address

- Percentage of adults who are obese

1,092 surveys completed for MedStar Montgomery

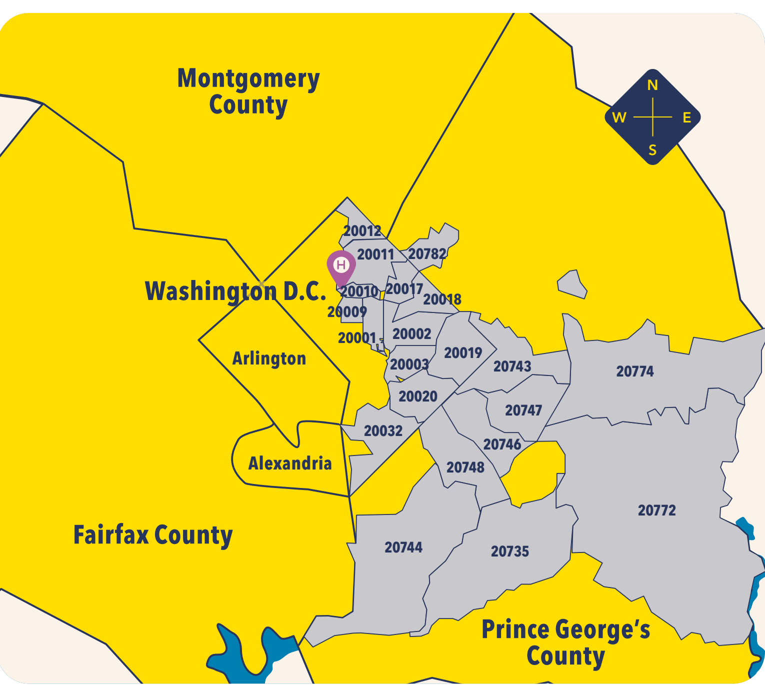
The 25-question survey was conducted from early September to the end of October 2023.

Survey was distributed in person and online.

To learn more about health needs in the MedStar Montgomery Medical Center community, **scan the QR Code or visit MedStarHealth.org/CommunityHealth.**

MedStar National Rehabilitation Hospital

Community Health Needs Assessment



Primary Service Area Community Benefit Service Area

History
Our team at MedStar National Rehabilitation Hospital (NRH) treats some of the nation's most complex cases. In partnership with Georgetown University School of Medicine, our highly specialized physicians are prepared to treat any injury. In recent years, we have dramatically increased our outpatient network with more than 50 locations in the greater Washington, D.C., Baltimore, and Northern Virginia region.

The community
We value the input and feedback from the communities we serve and make it a priority to collaboratively identify local health care needs and develop programs, partnerships, and initiatives to meet those needs. Our Advisory Task Force Committee is comprised of community residents as well as representatives from the local health department, local schools, higher education institutions, federally qualified health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): Greater Washington Area
The CBSA representing MedStar NRH includes residents with disabilities living in the Greater Washington area, which includes all of Washington D.C., Montgomery and Prince George's counties in Maryland, and Arlington and Fairfax counties in Virginia. This geographic area was selected as the CBSA representing MedStar NRH based on hospital utilization data and secondary public health data, as well as its proximity to the hospital.

Prioritized health needs:

Health and wellness
Turn to page 73 for goals and initiatives

- Chronic disease prevention and management
- Chronic pain
- Behavioral health: mental health and substance use disorders

Access to care
Turn to page 75 for goals and initiatives

- Access to health insurance
- Access to health care and providers
- Transportation

Social drivers of health
Turn to page 77 for goals and initiatives

- Violence education and prevention

Red indicates a negative trend in this statistic.

Green indicates a positive trend in this statistic.

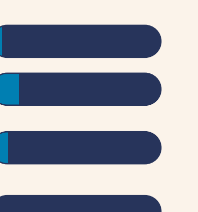
Demographics*

Washington, D.C.

Total Population[62]
661,425

Race[62]

White (6%)
Black (16%)
Hispanic or Latino (10%)
Asian (5%)
Other races (12%)
Two or more races (8%)



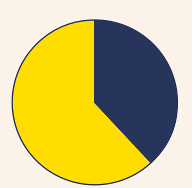
Percent of disabled population (by age)[62]

Age	Percent
Under 5	**1%**
5 to 17	**6%**
18 to 34	**6%**
35 to 64	**11%**
65 to 74	**24%**
75+	**42%**

Employment[63]

49% employment rate for working-age individuals with a disability.

Poverty[64]



28% poverty rate among individuals with a disability, which is higher than the poverty rate for those without disabilities, 11%.

11% Population with a disability[62]

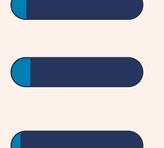
13% Of women have a disability
9% Of men have a disability

Maryland

Total Population[62]
6,073,039

Race[62]

White (13%)
Black (13%)
American Indian and Alaskan Native (19%)
Hispanic or Latino (7%)
Asian (7%)
Other races (6%)
Two or more races (11%)



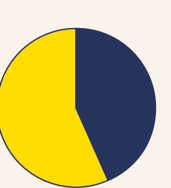
Percent of disabled population (by age)[62]

Age	Percent
Under 5	**<1%**
5 to 17	**6%**
18 to 34	**7%**
35 to 64	**11%**
65 to 74	**22%**
75+	**42%**

Employment[63]

49% employment rate for working-age individuals with a disability.

Poverty[64]



22% poverty rate among individuals with a disability, which is higher than the poverty rate for those without disabilities, 7%.

12% Population with a disability[62]

12% Of women have a disability
12% Of men have a disability

Virginia

Total Population[62]
8,446,378

Race[62]

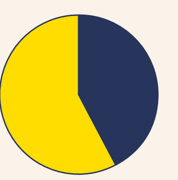
- White (14%)
- Black (15%)
- American Indian and Alaskan Native (16%)
- Hispanic or Latino (8%)
- Asian (7%)
- Other races (7%)
- Two or more races (10%)

Percent of disabled population
(by age)[62]

Age	Percent
Under 5	**1%**
5 to 17	**6%**
18 to 34	**8%**
35 to 64	**12%**
65 to 74	**22%**
75+	**44%**

Employment[63]

46% employment rate for working-age individuals with a disability.



Poverty[64]

24% poverty rate among individuals with a disability, which is higher than the poverty rate for those without disabilities, 8%.

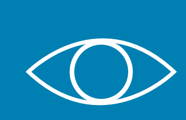
13% Population with a disability[62]

13% Of women have a disability
12% Of men have a disability

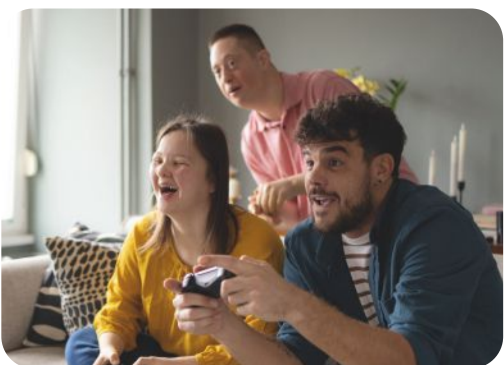
**Demographic data is specific to the civilian non-institutionalized disabled population.*

Six types of disabilities

Hearing



Visual



Cognitive

Independent living

Ambulatory

Self-care

Health and wellness

Chronic disease prevention and management

Our team at Medstar NRH prioritizes keeping people healthy and empowering communities to choose healthy behaviors. These initiatives are consistent with the D.C. Community Health Improvement Plan (CHIP) and D.C. Healthy People 2030 objectives.

Goals

- Improve health and wellbeing of people with physical disabilities.
- Increase education and social and emotional support for individuals and families.
- Expand illness and injury prevention education.
- Promote obesity reduction and improve community health and wellbeing through awareness and nutrition programs.
- Improve the health, function, and quality of life of people with chronic pain.
- Identify methods for people managing chronic pain.

Initiatives

- Provide health screenings, guided wellness programs, and offer educational nutrition programs.
- Host and provide adaptive sport fitness programs.
- Provide support groups and community activities, including community safety education, injury prevention trainings, and community events.
- Introduce Living Well with Chronic Pain program.
- Offer education and exercise programs and mind-body wellness (yoga, meditation).
- Provide increased access to mental health resources.
- Refer and connect patients to on-site pain management providers.

High blood pressure

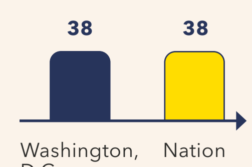
- 52% of MedStar NRH CHNA survey respondents with an income $100K or under indicated that high blood pressure is among the main health problems affecting people in their community.

Heart disease and stroke

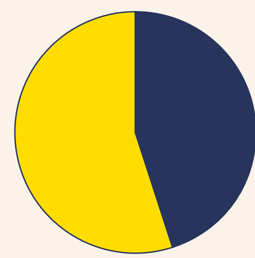
- Washington, D.C. has a heart disease death rate of 181 per 100,000 people, which is higher than the nationwide rate of 165 per 100,000 people.[2,3,4]

Since our first CHNA: the heart disease death rate in Washington, D.C. has improved from 260 per 100,000 in 2010.

Washington, D.C. has a stroke death rate of 38 deaths per 100,000 people, equal to the nationwide rate.[3]



Chronic pain



44% of survey respondents with an income $100K or under indicated that chronic pain and arthritis are among the main health problems affecting people in their community.

- 36% of survey respondents indicated that they or a family member they live with requires medical equipment (cane, wheelchair, walker, etc.).
- 17% of survey respondents and/or their family members indicated having age-related mobility issues.

Obesity

- 25% of adults in Washington, D.C. are obese.[4,18,19]

Since our first CHNA: this is an increase from the 2010 obesity rate of 22%.

- 35% of survey respondents with an income $100K or under indicated that obesity is one of the main health problems affecting people in their community.

Diabetes and high blood sugar

- 8% of adults in Washington, D.C. have diabetes.[4,18,19] This is lower than the national percentage.
- 44% of survey respondents with an income $100K or under indicated that diabetes and/or high blood sugar are among the main health problems affecting people in their community.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Chronic disease prevention and management

- Number of blood pressure screenings
- Number of individuals participating in obesity reduction education and programming
- Number of Sport Fitness program participants
- Number of individuals served through support groups and community activities

Chronic pain

- Number of individuals served through Living Well with Chronic Pain program
- Number of participants in education and exercise programs
- Number of on-site pain management referrals made

Key partners

- Amputee Coalition
- Brain Injury Association of D.C.
- D.C. Department of Recreation and Parks
- United Spinal Metro D.C. Chapter

Behavioral health: mental health and substance use disorders

Communities throughout Washington, D.C. are affected by substance use disorders and mental health issues. In response to these issues, our team prioritizes initiatives that improve access to treatment and support services.

Goals

- Improve access to mental health treatment and services.
- Promote engagement in care for those with mental health issues.
- Improve awareness of mental health treatment and services through outreach and social media promotion.

Initiatives

- Promote 988 Suicide and Crisis Lifeline through education and resource sharing.
- Offer support groups with MedStar NRH psychiatry department promoting anti-stigma efforts.

Mental health

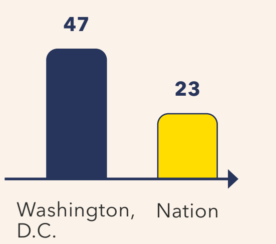
- People in Washington, D.C. average five poor mental health days per 30 days, slightly more than the nationwide average of four.[20]
- 45% of survey respondents with an income $100K or under indicated that mental health is among the main health issues affecting people in their community.
- 13% of survey respondents with an income $100K or under indicated that social isolation and loneliness is a main issue affecting people in their community.

Addiction and substance use disorders

- 19% of adolescents in Washington, D.C. reported using tobacco products.[21,22,44] This is higher than the nationwide average of 11%.
- 38% of survey respondents with an income $100K or under indicated that addiction is one of the main health problems affecting people in their community.

Opioids

Washington, D.C. has 47 drug overdose deaths per 100,000 people.[24,26] **This is much higher than the nationwide rate of 23 per 100,000 people.**



- In Washington, D.C., 33 opioid prescriptions are dispensed per 100 people, compared to 43 prescriptions per 100 people nationwide.[25]

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of patients provided resources at time of discharge
- Number of support groups
- Number of support group attendees
- Number of individuals referred to services

Key partners

- D.C. Health Department
- D.C. Department of Behavioral Health
- NAMI D.C. – National Alliance on Mental Illness

Access to health care and services

We prioritize initiatives to expand health care access in Washington, D.C. to promote and maintain health, prevent and manage disease, and achieve health equity for all. These initiatives are consistent with the D.C. Community Health Improvement Plan (CHIP) and D.C. Healthy People 2030 objectives.

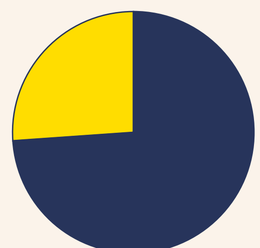
Goals

- Improve and expand community access to comprehensive, quality healthcare providers and programs as well as medical and non-medical services.
- Eliminate barriers to accessing health care and expand community access to health insurance.
- Improve access to transportation.

Initiatives

- Expand and host Ask a Doc series and outreach opportunities and promote community engagement.
- Provide support to uninsured patients by assisting with enrollment in hospital charity care programs.
- Host and offer Spinal Cord Injury and Pathway to Primary Care programs.
- Create awareness for Americans with Disabilities Act regulation compliance through educational resources for community-based medical facilities.
- Promote wheelchair-accessible equipment at provider locations.
- Advocate to decrease physical barriers for individuals with disabilities using Americans with Disabilities Act regulations.
- Increase accessibility to doctor's offices.
- Promote Metro Access-Para transit and insurance-based transportation services.
- Host and provide accessible driving education and support through the MedStar NRH driving program.
- Advocate for transportation services.

Access to health care and services
- Washington, D.C. has a 160:1 ratio of population to mental health providers.[28,29] This is better than the nationwide ratio of 328:1.
- 10% of adults in Washington, D.C. cannot afford to see a doctor, compared to the nationwide percentage of 13%.[30,46]



73% of survey respondents with a disability say that cost is the main reason people in their community do not get health care when needed.

60% of survey respondents with a disability indicated that waiting too long for an appointment is one of the most common reasons people do not get health care when they need it.

Availability of affordable healthcare providers and health insurance
- 41% of survey respondents with a disability indicated that not having health insurance is one of the most common reasons people in their community do not get health care when they need it.
- 41% of survey respondents with a disability indicated that finding a doctor who accepts their insurance is one of the most common reasons people in their community do not get health care when they need it.
- 32% of survey respondents with a disability indicated that getting a referral or appointment with a specialist is one of the most common reasons why people in their community do not get health care when they need it.

Appointment wait times
- 11% of survey respondents with a disability indicated that lack of childcare is one of the most common reasons why people in their community do not get health care when they need it.

Transportation
- 28% of survey respondents who indicated that they have a disability reported a lack of or limited transportation as one of the most common reasons people in their community do not get care when they need it.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Access to health insurance and providers
- Number of Ask a Doc series
- Number of attendees or participants in programs and events
- Number of events hosted
- Number of resources provided to uninsured patients
- Number of education sessions
- Number of educational resources provided
- Number of offices consulted to implement wheelchair-friendly equipment

Transportation
- Number of education sessions
- Number of individuals served
- Number of attendees enrolled in driving program
- Number of advocacy events attended

Key partners

- D.C. Center for Independent Living
- D.C. Department of Health
- Disability Partnership
- Medicare
- Mobility Works
- United Spinal Association
- United Spinal Metro - D.C. Chapter

Social drivers of health

To make Washington, D.C. more accessible for all, our team has developed a series of initiatives to address community concerns such as housing, food insecurity, and violence. These initiatives are consistent with the D.C. Community Health Improvement Plan (CHIP) and D.C. Healthy People 2030 objectives.

Goals

- Reduce community violence and create support systems through community partnerships and advocacy groups.
- Create long-term change for violence prevention.
- Implement a strategic approach to identifying and addressing social needs at MedStar National Rehabilitation Hospital.

Initiatives

- Educate youth on gun safety and injuries due to violence.
- Partner with "Beat the Streets" program to educate and promote gun safety.
- Expand social needs screenings to adult hospitalized patients in collaboration with nursing and acute case management teams.
- Engage with local community-based organizations to address social needs risk factors to advance health equity strategies.
- Leverage the MedStar Health Social Needs Tool powered by Findhelp to provide referrals and connections to social support services in the community.

Costs of living

- The median household income in Washington, D.C. is $91,100.[37,38] This is higher than the national median of $70,784. **When viewing cost-of-living data, however, these wages often are not sufficient to cover household expenses. Ultimately, this can significantly impact access to care.**
- 17% of people in Washington, D.C. live in poverty, higher than the 12% nationwide percentage.[37]
  - 29% of survey respondents with a disability indicated that poverty and economic inequality are among the main social issues affecting people in their community.

Costs of living continued

- The average annual cost for a family with two adults and two children is $88,140.[49]
  - The average annual cost for a household with two adults and two children **in childcare** is $92,736.
- The approximate cost of living for a one-child and one-adult household is $60,900.[49] The average annual income for these households is less than $64,000 (before taxes), based on an estimated hourly wage of $30.45.
- 78% of single-female-headed households with children in Washington, D.C. are below the Asset Limited, Income, Constrained, Employed (ALICE) threshold, compared to 14% of married households with children being below the threshold.[65]
- 29% of survey respondents with a disability indicated that income gaps and/or wage inequality are among the main social issues affecting people in their community.

Violence

- 28% of survey respondents with a disability believe gun violence is among the main social issues affecting people in their community.

24% of survey respondents with a disability say that **neighborhood safety and community violence are among the main social issues affecting people in their community.**

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Violence
- Number of youth education events
- Number of individuals served
- Number of Beat the Streets events
- Number of encounters

Key partners

- Findhelp
- Metropolitan Police Department
- YMCA of Metropolitan Washington

Washington, D.C.

(MedStar Georgetown University Hospital, MedStar National Rehabilitation Hospital, MedStar Washington Hospital Center)

What has improved?
- Age-adjusted death rate due to heart disease and cancer
- Lower percentage of unemployed adults

Areas to address
- Percentage of adults who are obese

174
surveys completed for MedStar NRH

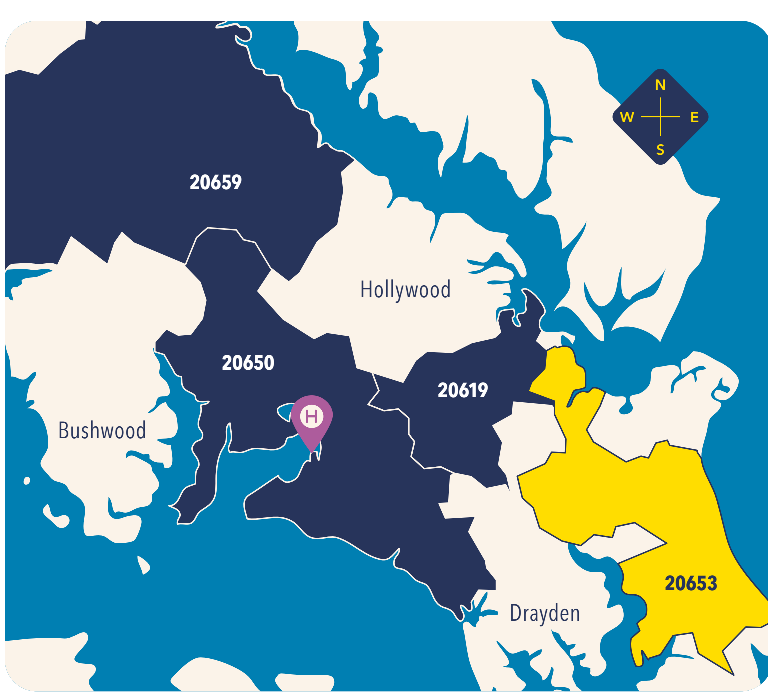
97
respondents identified as having a disability

The 25-question survey was conducted from early September to the end of October 2023.

To learn more about health needs in the MedStar National Rehabilitation Hospital community, **scan the QR Code or visit MedStarHealth.org/CommunityHealth.**

MedStar St. Mary's Hospital

Community Health Needs Assessment



Primary Service Area Community Benefit Service Area

History
Nestled in the waterside community of Leonardtown, Maryland, MedStar St. Mary's Hospital is a full-service, not-for-profit community hospital delivering emergency, acute inpatient, and outpatient care. Since 1912, our committed healthcare providers and team members put the patient first in every way.

The community
We value the input and feedback from the communities we serve and make it a priority to collaboratively identify local health care needs and develop programs, partnerships, and initiatives to meet those needs. Our Advisory Task Force Committee is comprised of community residents as well as representatives from the local health department, schools, higher education institutions, federally qualified health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): St. Mary's County, Maryland
The CBSA representing MedStar Southern Maryland includes residents living in zip code 20653. This geographic area was selected as MedStar St. Mary's CBSA based on hospital utilization data and secondary public health data, as well as its proximity to the hospital and collaboration with local organization partners.

Prioritized health needs:

Health and wellness
Turn to page 81 for goals and initiatives

- Chronic disease prevention and management
- Aging and older adults
- Behavioral health: mental health and substance use disorders
- Maternal health

Access to care
Turn to page 85 for goals and initiatives

- Mistrust of healthcare providers
- Transportation
- Access to health insurance
- Access to primary and specialty care

Social drivers of health
Turn to page 87 for goals and initiatives

- Housing and homelessness
- Food insecurity

Red indicates a negative trend in this statistic.

Green indicates a positive trend in this statistic.

Demographics

Zip code 20653

Average household income in 2020:
$66,669[66]

Gender and age*[66]

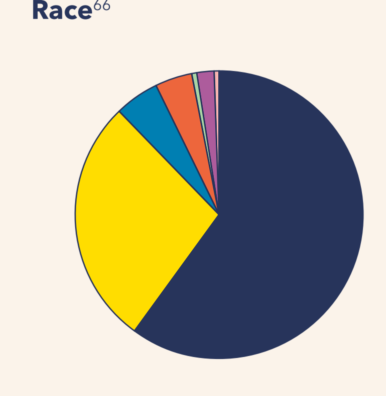
51% Female
Median age: **31**

49% Male
Median age: **30**

Median age:
31

Total population[66] **24,481**

Race[66]



- White (60%)
- Black (28%)
- Am. Indian or Alaskan Native (5%)
- Asian (4%)
- Native Hawaiian/Pac. Islander (<1%)
- Other races (2%)
- Two or more races (<1%)

Educational attainment
(those 25+ years)[66]

<High school diploma	**11%**
High school graduate	**50%**
Associate's degree	**7%**
Bachelor's degree	**20%**
Master's degree	**10%**
Professional degree	**1%**
Doctorate degree	**1%**

Health and wellness

Chronic disease prevention and management

Keeping our communities healthy and empowering people to choose healthy behaviors are important priorities at MedStar St. Mary's. This priority is consistent with the Total Cost of Care priorities (diabetes) and the Maryland Statewide Integrated Health Improvement Strategy, including diabetes, maternal and child health, and timely follow-up care.

Goals

- Reduce disease burden of diabetes, high blood pressure, and stroke.
- Improve quality of life for all persons who have or are at risk for related disease or conditions.
- Provide community health education resources about the importance of maintaining a healthy lifestyle and prevention of chronic disease.
- Improve community health and wellbeing through health education programs.
- Expand chronic disease prevention and management programs.

Initiatives

- Offer virtual or in-person healthy living educational programs.
- Participate in health fairs and provide health screenings.
- Offer a variety of support group topics in partnership with local organizations, agencies, and partners.

Obesity

- 37% of adults in St. Mary's County are obese.[4,18,19]

Since our first CHNA: this is an increase from the 2008 rate of 33%.

Heart disease and stroke

- St. Mary's County has a heart disease death rate of 167 per 100,000 people, which is higher than the state and nationwide rate of 165 per 100,000 people.[2,3,4]

Since our first CHNA: this is an improvement from 2007, in which St. Mary's County had a heart disease death rate of 251 per 100,000 people.

- St. Mary's County has a stroke death rate of 36 deaths per 100,000 people, compared to the statewide rate of 42 per 100,000 people and the nationwide rate of 38 per 100,000 people.[3]

Since our first CHNA: this is an improvement from 2007, in which St. Mary's County had a stroke death rate of 51 per 100,000 people.

High blood pressure

- 34% of adults in St. Mary's County have high blood pressure.[16,17,43]
  - 47% of MedStar St. Mary's CHNA survey respondents indicated that high blood pressure is among the main health problems affecting people in their community.

Diabetes and high blood sugar

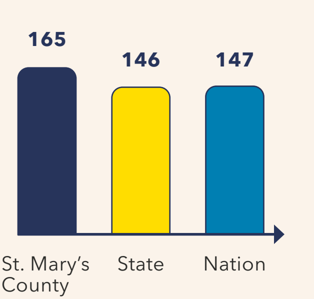
- 10% of adults in St. Mary's County have diabetes.[4,18,19] This is lower than the nationwide percentage of 11%, but equal to the statewide percentage.

Since our first CHNA: this is an increase from 6% in 2007.

  - 52% of survey respondents indicated that diabetes and/or high blood sugar are among the main health problems affecting people in their community.

Cancer

St. Mary's County has a cancer death rate of 165 deaths per 100,000 people, which is higher than the statewide rate of 146 per 100,000 people and the nationwide rate of 147 per 100,000 people.[5,6]



Since our first CHNA: this is an improvement from 2007, in which St. Mary's County had a cancer death rate of 206 per 100,000 people.

- 39% of survey respondents indicated that cancer is among the main health problems affecting people in their community.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of participants
- Number of cohorts offered
- Number of screenings
- Number of events attended
- Number of support groups offered
- Number of attendees
- Number of screenings completed

Key partners

- Faith-based organizations
- St. Mary's County Health Department
- St. Mary's County Office on Aging
- Totally Linking Care

Behavioral health: mental health and substance use disorders

Substance use disorders and mental health issues affect communities throughout St. Mary's County. MedStar St. Mary's prioritizes initiatives to respond to these issues to improve access to services. This priority is consistent with Statewide Integrated Health Improvement Strategy (SIHIS) goals, including reducing overdose mortality.

Goals

- Ensure access to appropriate, quality, behavioral health and substance use disorder services.
- Support Harm Reduction efforts for at-risk patients to prevent overdose.
- Improve access to mental health services.

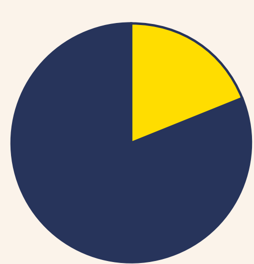
Initiatives

- Conduct Screening, Brief Intervention, Referral to Treatment (SBIRT) in emergency department, supported by Peer Recovery Coaches and Opioid Survivor Outreach program field outreach.
- Participate in Local Behavioral Health Action team to support mental health first aid, naloxone training, and promotion of outpatient programs.
- Provide, participate, and support in-person and virtual evidence-based programs addressing mental health.
- Support and promote utilization of the nationwide 988 suicide and crisis lifeline service.

Mental health disorders

- People in St. Mary's County average four poor mental health days per 30 days, equal to the nationwide and statewide averages.[20]
- 38% of survey respondents indicated that mental health is one of the issues affecting people in their community the most.
- 7% of survey respondents indicated that social isolation and loneliness is a top health problem affecting people in their community.

Addiction and substance use disorders

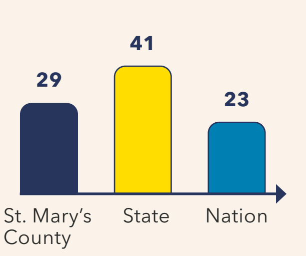


19% of adolescents in St. Mary's County reported using tobacco products.[21,22,24] This is higher than the statewide average of 16% and the nationwide average of 11%.

- 41% of survey respondents indicated that addiction and substance use are among the main health problems affecting people in their community.

Opioids

St. Mary's County has 29 drug overdose deaths per 100,000 people.[24,26] This is higher than the nationwide rate of 23 per 100,000 people and lower than the statewide rate of 41 per 100,000 people.



- In St. Mary's County, 22 opioid prescriptions are dispensed per 100 people, compared to 43 prescriptions per 100 people nationwide and the statewide rate of 40 prescriptions per 100 people.[25]

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of referrals and linkages to support services and treatment
- Number of SBIRT screenings, referrals, and linkages to treatment
- Number of trainings offered
- Number of attendees
- Number of LBHA meetings attended
- Number of associates trained
- Number of programs offered
- Number of events promoting 988 crisis line services
- Number of encounters sharing 988 materials

Key partners

- 988 Suicide Prevention crisis line
- Local Health Improvement Coalition
- Mindoula
- NAMI Southern Maryland - National Alliance on Mental Illness
- Southern Maryland Community Network
- St. Mary's County Health Department

Maternal health

The wellbeing of mothers and children is fundamental to the overall health of our communities. Our commitment lies in championing initiatives that foster the wellbeing of mothers and babies, address disparities, enhance outcomes, and advocate for the health of both mothers and infants. These priorities are consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, including reducing the severe maternal morbidity rate.

Goals

- Reduce disparities for minority women.
- Improve maternal outcomes for minority women.

Initiatives

- Provide education and support services pre- and post-delivery.

Maternal health continued

- St. Mary's County has an infant mortality rate of five infant deaths per 1,000 live births, compared to the state and nationwide rates of six infant deaths per 100,000 live births.[67,68]
- St. Mary's County has 10 teen births per 1,000 females ages 15-19.[27] This is lower than the statewide average of 11 teen births per 1,000 females ages 15-19 and the nationwide rate of 14 teen births per 1,000 females ages 15-19.
- 8% of survey respondents indicated that maternal health and/or reproductive health are among the main health concerns affecting people in their community.
- 3% of survey respondents indicated that lack of or limited reproductive rights are among the most important social issues affecting quality of life in their community.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of education events attended
- Number of attendees at support services
- Number of reduced cost birthing classes and lactation consultations

Key partners

- Delicados, Inc.
- St. Mary's County Health Department

Aging and older adult issues

We are committed to honoring the dignity and wellbeing of older adults in St. Mary's County. For this reason, we are prioritizing initiatives that promote healthy, successful aging. This priority is consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, including care coordination.

Goals

- Promote healthy aging by improving health, function, and quality of life of older adults.
- Improve community health and wellbeing through health education programs.

Initiatives

- Offer community engagement opportunities to educate the community on topics such as advance directives, healthy lifestyle, and social programs focused on senior populations.

- 34% of survey respondents indicated that aging and older adult issues (Alzheimer's, dementia, falls) affect people in their community.
- Of the households ages 65 and up in St. Mary's County, 41% are below the ALICE* threshold or at poverty level.[69] **ALICE: Asset Limited, Income Constrained, Employed - Those earning more than the Federal Poverty Level, but not enough to afford the basics where they live.*

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of events held
- Number of attendees

Key partners

- Faith-based organizations
- St. Mary's County Department of Aging
- St. Mary's County Parks & Recreation

Access to health care and services

Access to quality care and services is an important issue for people living in St. Mary's County. To promote health and achieve health equity for all, our team prioritizes initiatives to expand healthcare access in St. Mary's County. These priorities are consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, including care transformation and care coordination.

Goals

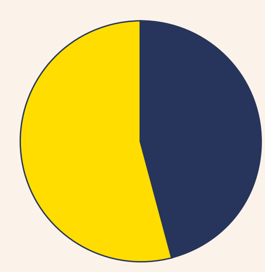
- Improve health outcomes and narrow disparity gaps.
- Improve patient-provider relationships.
- Improve and expand community access to health insurance.
- Improve and expand community access to comprehensive, quality healthcare providers and programs, as well as medical and non-medical services.
- Reduce potentially avoidable utilization and hospital readmissions.
- Improve access to transportation resources for vulnerable populations.

Initiatives

- Improve the quality of life for community members by restoring trust and building patient loyalty.
- Provide care coordination services, including connection to insurance resources.
- Increase access to Maternal Health services in underserved areas.
- Partner with transportation services to provide rides for individuals with financial needs.
- Assist with utilizing St. Mary's Transit System (STS), door-to-door, and paratransit service program.

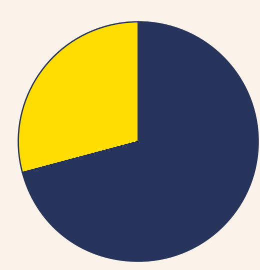
Access to health care and services

- St. Mary's County has a 720:1 ratio of population to mental health providers.[28,29] This is significantly worse than the nationwide ratio of 328:1 and statewide ratio of 310:1.



46% of survey respondents indicated that lack of or limited **access to a doctor is one of the most important social issues affecting quality of life.**

- 16% of survey respondents indicated that they or a family member in their household have difficulties with mobility and require medical equipment.



71% of survey respondents say that **cost is the main reason people in their community do not get health care when they need it.**

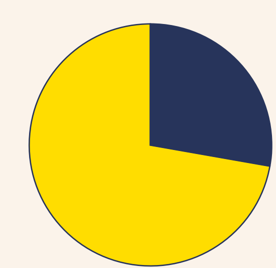
Mistrust of healthcare providers

- 16% of survey respondents indicated that a fear or mistrust of doctors is one of the most common reasons people in their community do not get health care when they need it.

Availability of affordable healthcare providers and health insurance

- 43% of survey respondents indicated that not having health insurance is one of the most common reasons people in their community do not get health care when they need it.
- 32% of survey respondents indicated that finding a doctor who accepts their insurance is one of the most common reasons people in their community do not get health care when they need it.
- 27% of survey respondents indicated that getting a referral or appointment with a specialist is one of the most common reasons people in their community do not get health care when they need it.
- 7% of adults in St. Mary's County cannot afford to see a doctor, compared to the nationwide average of 13% and the statewide average of 9%.[30,46]

Transportation



28% of survey respondents indicated that a **lack of or limited transportation is one of the most common reasons** people in their community do not get health care when they need it.

- 26% of survey respondents indicated that limited access to transportation is one of the most important social issues affecting quality of life in their community.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Mistrust of healthcare providers

- Number of meetings held
- Number of attendees
- Number of community members served

Availability of affordable healthcare providers and health insurance

- Number of providers recruited
- Number of patients served by TCN team
- Number of patients referred to CHA team
- Number of patients referred to insurance providers
- Number of Maternal Health visits

Transportation

- Number of rides completed
- Number of bus vouchers and/or tokens provided
- Number of patients assisted with applying for paratransit and door-to-door services

Key partners

- Maryland Primary Care Program
- Patient Experience Program
- Patient and Family Advisory Council
- St. Mary's County Department of Social Services
- St. Mary's County Government
- St. Mary's County Health Department
- St. Mary's County Health Hub
- Wheels to Wellness

Social drivers of health

To make St. Mary's County more accessible for all, our team at MedStar St. Mary's has developed a series of initiatives to address needs such as housing and food insecurity. For this reason, we prioritize initiatives such as expanding access to healthy foods and advocacy for housing services. These priorities are consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, including care transformation.

Goals

- Support community housing and homelessness initiatives.
- Provide resources to address food insecurity.
- Identify individuals experiencing food insecurity and link to resources.
- Reduce inequities caused by lack of access to healthy foods through partnership and collaboration with community organizations focused on reducing household food insecurity.
- Promote expansion of food access.
- Implement a strategic approach to identifying and addressing social needs at MedStar St. Mary's Hospital.

Initiatives

- Increase enrollment at Medical Respite facility.
- Screen individuals for food insecurity.
- Establish food pantry resource list for associates and community members who screen positive for food insecurity.
- Provide referrals to organizations that support access to food, such as local food banks, food pantries, and local departments of health and human services.
- Research avenues to provide health education about nutrition and strategies to improve food security.
- Expand social needs screenings to adult hospitalized patients in collaboration with nursing and acute case management teams.
- Engage with local community-based organizations to address social needs risk factors to advance health equity strategies.
- Leverage the MedStar Health Social Needs Tool powered by Findhelp to provide referrals and connections to social support services in the community.

Employment

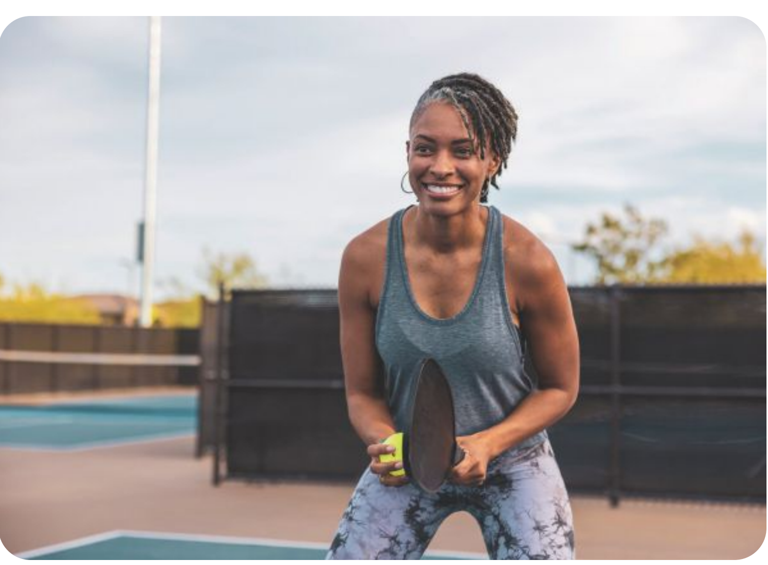
- 3% of adults in St. Mary's County are unemployed.[35,36]
  - This is consistent with the state unemployment rate and 1% lower than the nationwide rate.

Since our first CHNA: this is an improvement from 6% in 2007.

- 19% of the population ages 16 and over are not in the labor force.[31]

Housing

- 72% of St. Mary's County housing is occupied by the owner.[37]
- In 45% of renter-occupied housing units in St. Mary's County, tenants pay 30% or more of their household income on rental costs.[36] This is lower than the nationwide average of 51% and the statewide average of 52%.
- 33% of survey respondents indicated that housing problems and homelessness are among the most important social issues affecting the quality of life in the community.
- 28% of households in St. Mary's County face at least one of the following housing problems: incomplete kitchen facilities, incomplete plumbing facilities, overcrowding, and a cost burden greater than 30%.[56]



Costs of living
- 8% of people in St. Mary's County live in poverty, equal to the nationwide rate and slightly lower than 10% statewide.[37]

Since our first CHNA: this is an increase from 7% in 2008.

- The median household income reported in St. Mary's County in 2020 was $106,500.[36,37] This is higher than the national median of $70,784 and the statewide median of $90,100.
- The average annual cost for a family with two adults and two children is $71,592.[31]
  - The average annual cost for a household with two adults and two children **in childcare** is $80,868.[31]
- The approximate cost of living for a one-child and one-adult household is $47,148.[31] The average annual income for these households is less than $50,000 (before taxes), based on an estimated hourly wage of $23.57.
- 73% of single-female-headed households with children in St. Mary's County are below the ALICE* threshold, compared to 14% of married households with children being below the threshold.[31] **ALICE: Asset Limited, Income Constrained, Employed - Those earning more than the Federal Poverty Level, but not enough to afford the basics where they live.*

Food insecurity
- 9% of households in St. Mary's County experience food insecurity, lower than the nationwide percentage of 10%.[39]
- 8% of St. Mary's County households with children experience food insecurity.[39] This is lower than the state and nationwide proportions of 12% and 13%, respectively.
- 27% of survey respondents indicated that hunger and food insecurity are among the most important social issues affecting the quality of life in the community.
  - Of those who selected hunger and food insecurity as an important issue, 74% are white, 17% are Black, and 2% are multi-racial.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Housing problems and homelessness
- Number of participants enrolled in medical respite program

Food insecurity
- Number of community members served
- Number of individuals screening positive for food insecurity
- Number of associates served
- Number of referrals provided

Key partners

- Faith-based organizations
- Feed St. Mary's
- Findhelp
- St. Mary's County Health Department
- Three Oaks Homeless Shelter

St. Mary's County
(MedStar St. Mary's Hospital)

What has improved?
- Age-adjusted death rate due to heart disease, stroke, and cancer
- Lower percentage of unemployed adults

Areas to address
- Percentage of adults with obesity
- Percentage of persons living in poverty

1,190 surveys completed for MedStar St. Mary's

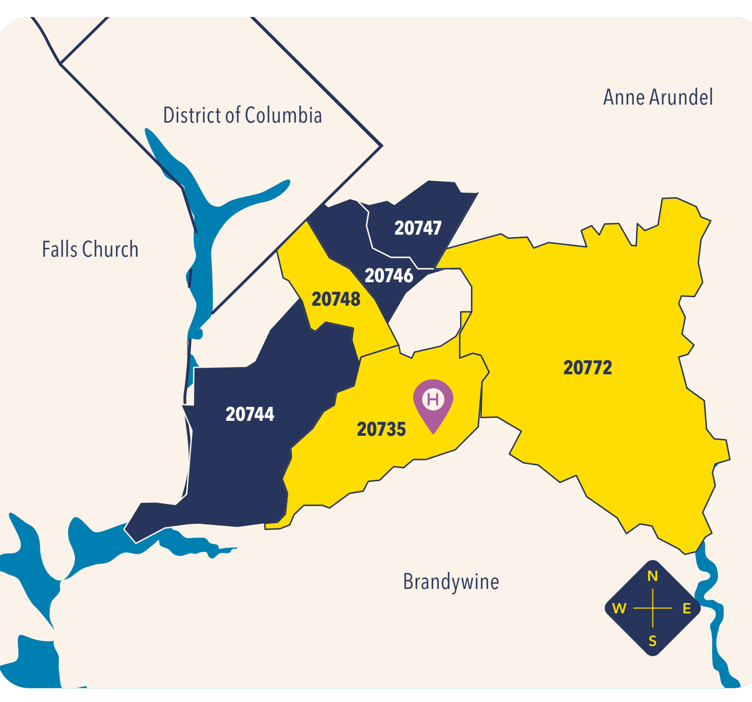
The 25-question survey was conducted from early September to the end of October 2023.

Survey was distributed in person and online.

To learn more about health needs in the MedStar St. Mary's Hospital community, **scan the QR Code or visit MedStarHealth.org/CommunityHealth.**

MedStar Southern Maryland Hospital Center

Community Health Needs Assessment



Primary Service Area   Community Benefit Service Area

History
MedStar Southern Maryland Hospital Center is a full-service acute care facility with more than 44,000 emergency room visits and nearly 11,000 admissions each year. Distinguished by a commitment to advanced technology, our goal is to help residents of Southern Maryland achieve the highest possible level of physical and mental health, allowing for a better quality of life in our community.

The community
We value the input and feedback from the communities we serve and make it a priority to collaboratively identify local healthcare needs and develop programs, partnerships, and initiatives to meet those needs. Our Advisory Task Force Committee is comprised of community residents as well as representatives from the local health department, local schools, higher education institutions, federally qualified health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): Prince George's County, Maryland
The CBSA representing MedStar Southern Maryland includes residents living in zip code 20748, 20772, and 20735. This geographic area was selected as the CBSA representing MedStar Southern Maryland based on hospital utilization data and secondary public health data, as well as its proximity to the hospital.

Prioritized health needs:

Health and wellness
Turn to page 91 for goals and initiatives

- Chronic disease prevention and management
- Behavioral health: mental health and substance use disorders
- Maternal health

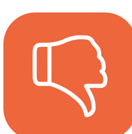
Access to care
Turn to page 95 for goals and initiatives

- Access to health insurance and providers
- Transportation

Social drivers of health
Turn to page 96 for goals and initiatives

- Food insecurity

Red indicates a negative trend in this statistic.



Green indicates a positive trend in this statistic.

Demographics

Zip code 20748

Average household income in 2020:
$52,229[70]

Gender and age*[70]

54% Female Median age: **40**

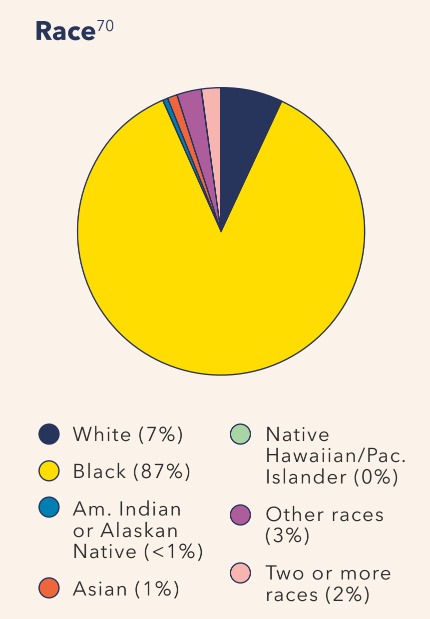
46% Male Median age: **36**

Median age:

38

Total population[70] **38,792**

Race[70]



Educational attainment
(those 25+ years)[70]

<High school diploma	**10%**
High school graduate	**63%**
Associate's degree	**6%**
Bachelor's degree	**14%**
Master's degree	**5%**
Professional degree	**1%**
Doctorate degree	**1%**

Zip code 20772

Average household income in 2020:
$84,229[71]

Gender and age*[71]

52% Female Median age: **40**

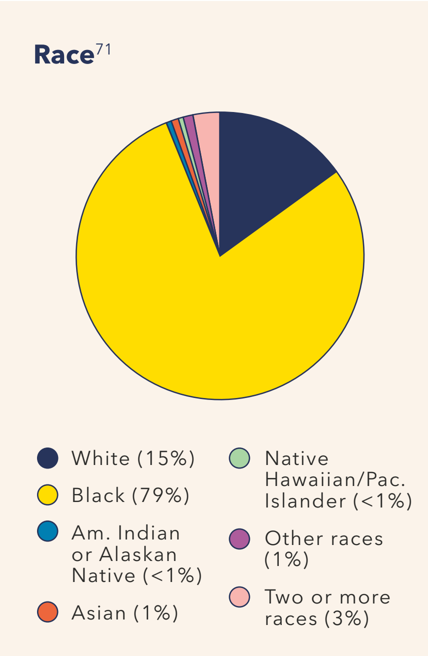
48% Male Median age: **37**

Median age:

39

Total population[71] **42,625**

Race[71]



Educational attainment
(those 25+ years)[71]

<High school diploma	**7%**
High school graduate	**49%**
Associate's degree	**8%**
Bachelor's degree	**20%**
Master's degree	**14%**
Professional degree	**2%**
Doctorate degree	**1%**

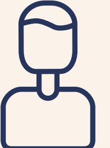
Zip code 20735

Average household income in 2020:
$71,035[72]

Gender and age*[72]

53% Female Median age: **43**

47% Male Median age: **40**

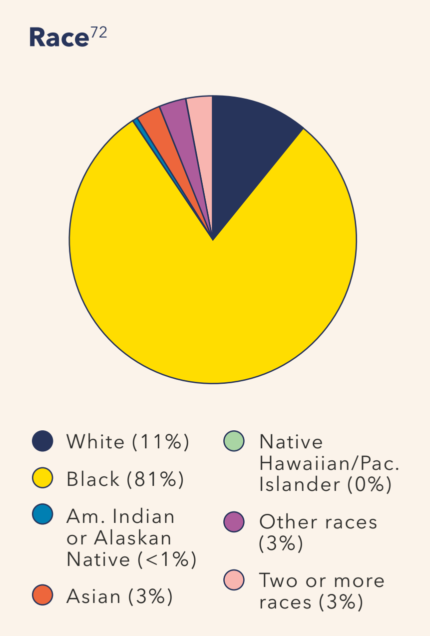


Median age:

41

Total population[72] **35,421**

Race[72]



Educational attainment
(those 25+ years)[72]

<High school diploma	**8%**
High school graduate	**60%**
Associate's degree	**6%**
Bachelor's degree	**17%**
Master's degree	**8%**
Professional degree	**1%**
Doctorate degree	**<1%**

Health and wellness

Chronic disease prevention and management

Prevention and management of chronic diseases is a main health concern of people living in Prince George's County. To address these issues, our team at MedStar Southern Maryland prioritizes initiatives that keep people healthy and empower communities to choose healthy behaviors. These priorities are consistent with the Maryland State Integrated Health Improvement Strategies (SIHIS).

Goals

- Reduce disease burden of diabetes, hypertension, high blood pressure, and chronic kidney disease.
- Improve quality of life for all persons who have or are at risk for chronic disease or conditions.
- Provide community health education resources about the importance of maintaining a healthy lifestyle and preventing chronic disease.
- Improve community health and wellbeing through health education programs.
- Expand chronic disease prevention and management programming.

Initiatives

- Offer education related to chronic kidney disease, hypertension, and diabetes at community events and health fairs.
- Promote prevention programs such as diabetes prevention program.
- Host regular ongoing blood drives open for the community and collaborate to reduce chronic shortage of life-saving blood supplies.
- Host and provide community education and support groups for chronic diseases such as heart disease and stroke.

Heart disease and stroke

- Prince George's County has a heart disease death rate of 181 per 100,000 people, which is higher than the state and nationwide rate of 165 per 100,000 people.[2,3,4]

Since our first CHNA: this is an improvement from 234 heart disease deaths per 100,000 people in 2007.

- Prince George's County has a stroke death rate of 35 deaths per 100,000 people, compared to the statewide rate of 42 per 100,000 people and the nationwide rate of 38 per 100,000 people.[3]

Since our first CHNA: this is an improvement from 42 stroke deaths per 100,000 people in 2007.

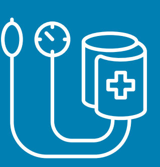
Obesity

- 37% of adults in Prince George's County are obese.[4,18,19]

Since our first CHNA: this is an increase in obesity rates from the 2008 rate of 30%.

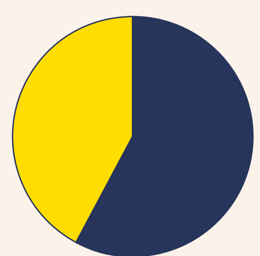
- 36% of adults in Prince George's County have high blood pressure.[16,17,43]

63% of MedStar Southern Maryland CHNA survey respondents indicated that **high blood pressure is one of the main health problems affecting the community.**



Diabetes and high blood sugar

- 11% of adults in Prince George's County have diabetes.[4,18,19] This is equal to the statewide percentage.



58% of survey respondents indicated that diabetes and high blood sugar are the leading health problems affecting people in their community.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of chronic disease screenings
- Number of flyers or brochures distributed
- Number of community education events attended
- Number of participants who lose 5-7% bodyweight by end of Diabetes Prevention Program
- Number of blood drives hosted
- Number of donors present
- Number of blood pints collected

Key partners

- American Heart Association
- American Red Cross
- Branchwood Towers
- Camp Springs Senior Center
- Clinton Baptist Church
- Evelyn Cole Senior Center
- GeneTech
- Hillcrest Heights Baptist Church
- John E. Howard Senior Center
- Maryland Institute for Emergency Medical Services Systems
- Prince George's County Department of Parks and Recreation
- Southern Area Aquatic Recreational Center

Behavioral health: mental health and substance use disorders

Substance use disorders and mental health issues affect people in communities throughout Prince George's County. To address these concerns, we prioritize initiatives that improve access to services.

Goals

- Improve access to addiction and mental health treatment.
- Identify, engage, and serve those with behavioral health and medical challenges across the continuum of care.
- Promote engagement in care for those with mental health and substance use disorders.

Initiatives

- Conduct Screening, Brief Intervention, Referral to Treatment (SBIRT) in emergency department, outpatient Behavioral Health, Mother Baby, and ambulatory sites supported by Peer Recovery Coaches.
- Provide behavioral health community education, support groups, and sponsor events or walks for mental health awareness.
- Implement the Crisis Now model in Prince George's County.
- Provide referrals to the Mindoula program.

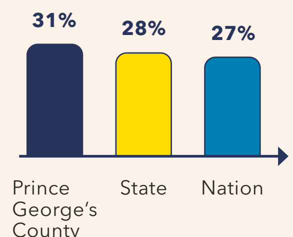
Mental health

- People in Prince George's County average four poor mental health days per 30 days, equal to the nationwide average.[20]

30% of survey respondents indicated that **mental health is one of the main issues affecting people in their community.**

Addiction and substance use disorders

Alcohol was involved in 31% of driving deaths in Prince George's County.[73] This is higher than the state and nationwide percentages of 28% and 27%, respectively.



- 12% of adults in Prince George's County currently smoke, compared to 10% statewide.[53] Nationally, 14% of adults smoke.
- Prince George's County has 19 drug overdose deaths per 100,000 people.[24,26] This is lower than the state average of 41 per 100,000 and the nationwide average of 23 per 100,000.
- 25% of survey respondents indicated that addiction is among the main health issues affecting people in their community.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of Mindoula referrals and linkages to support services and treatment
- Number of SBIRT screenings, referrals, and linkages to treatment
- Number of attendees in behavioral health community education and support groups

Key partners

- Adventist Fort Washington
- Arch of Knowledge
- Behavioral Health Authority
- Clinton Baptist Church
- Hope Connections
- Maryland Department of Health
- Mindoula
- University of Maryland: Capital Region

Maternal health

The wellbeing of mothers and children is fundamental to the overall health of our communities. Our commitment lies in championing initiatives that foster the wellbeing of mothers and babies, address disparities, enhance outcomes, and advocate for the health of both mothers and infants.

Goals

- Improve health of expecting mothers and babies through engagement in education sessions and providing resources and mental health screenings.

Initiatives

- Engage participants in lactation education, nutrition education, regular blood pressure screenings, birthing education, and birth plan assistance.
- Offer referrals to local services such as Women, Infants, and Children (WIC).

- Prince George's County has an infant mortality rate of five infant deaths per 1,000 live births, compared to the state and nationwide rates of six infant deaths per 100,000 live births.[67,68]

Since our first CHNA: the infant mortality rate has improved from 12 per 1,000 births in 2007 to five per 1,000 births in 2020.

Prince George's County has 17 teen births per 1,000 females ages 15-19.[27] This is higher than the statewide rate of 11 teen births per 1,000 females ages 15-19 and the nationwide rate of 14 teen births per 1,000 females ages 15-19.

Maternal health continued

- 28% of survey respondents indicated that a lack of affordable child care is among the most important social issues affecting the quality of life in the community.
- 9% of survey respondents indicated that a lack of or limited childcare is one of the most common reasons people in their community do not get health care when they need it.
- 8% of survey respondents indicated that maternal health and/or reproductive health are one of the health problems affecting people in their community.
- Prince George's County has 96 infant and childcare facilities per 100,000 children.[56]
- 9% of live births in Prince George's County have a low birth weight.[59,60]

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of participants served in maternal health programs
- Number of maternal health events, classes, and support groups
- Breastfeeding initiation rates
- Duration of breastfeeding

Key partners

- Coaching Salud Holistica
- Faith-based organizations
- Greater Baden Medical Services
- Greater D.C. Diaper Bank
- Health Resources and Services Administration
- Maryland Department of Health
- Maryland WIC
- Prince George's County Health Department
- Prince George's County WIC

Access to health care and services

Access to quality care and services is a key issue for people living in Prince George's County. It is important for promoting and maintaining health, preventing, managing disease, and achieving health equity for all. For this reason, our team at MedStar Southern Maryland prioritizes initiatives to expand healthcare access in Prince George's County. These priorities are consistent with the Maryland State Integrated Health Improvement Strategies (SIHIS).

Goals

- Improve and expand community access to comprehensive, quality healthcare providers and programs, as well as medical and non-medical services.
- Improve health in the community through prevention, referrals, and linkage to community resources.
- Improve access to transportation resources for vulnerable populations.

Initiatives

- Expand Ask the Doc sessions to increase physician visibility and increase engagement with the community.
- Collaborate with community partners to expand the availability of screenings in the community.
- Hire and retain CHAs to provide screenings, education, referrals, and linkages to social service programs.
- Partner with transportation services to provide rides for individuals with financial needs.
- Provide bus tokens, taxi vouchers, ride share programs, and shuttle bus.

Access to health care and services

Prince George's County has a mental health patient-to-provider ratio of 520:1.[28,29] This is significantly worse than the statewide ratio of 310:1 and the nationwide ratio of 328:1.

- 74% of survey respondents indicated that cost is the most common reason why people in their community do not get health care when they need it.
- 50% of survey respondents indicated that waiting too long for an appointment is a main issue affecting quality of life in their community.
- 88% of adults in Prince George's County have health insurance.[30,46,47] This is lower than the state and nationwide averages of 93% and 92%, respectively.

Access to health insurance and health providers

- 49% of survey respondents indicated that not having health insurance is a top reason why people in their community do not get health care when they need it.
- 33% of survey respondents indicated that finding a doctor who accepts their insurance is a top reason why people in their community do not get health care when they need it.
- 93% of children in Prince George's County have health insurance, lower than the state and nationwide averages of 96% and 95%, respectively.[46]
- 13% of adults in Prince George's County are unable to see a doctor.[30,46] This is higher than the statewide average of 9%, but equal to the nationwide percentage.

Transportation

- 25% of survey respondents indicated that limited transportation is one of the most common reasons why people in their community do not get health care when they need it.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Availability of affordable healthcare providers and health insurance
- Number of Ask a Doc attendants
- Number of flyers distributed
- Number of sessions hosted
- Number of screenings and participants
- Number of positive screens
- Number of CHAs providing screenings
- Number of patients supported by CHA

Transportation
- Number of transportation vouchers and/or bus tokens provided
- Number of rides completed

Key partners

- Arch of Knowledge
- Center Point Baptist
- Clinton Baptist Church
- Hillcrest Baptist Church
- Prince George's County Department of Parks and Recreation
- Prince George's County Public Schools
- The Arc of Prince George's County
- Uber Health

Social drivers of health

To make Prince George's County more accessible for all, our team has developed a series of initiatives to address needs such as food insecurity, such as expanding access to healthy foods and education nutrition. These priorities are consistent with the Maryland State Integrated Health Improvement Strategies (SIHIS).

Goals

- Reduce inequities caused by lack of access to healthy foods through partnership and collaboration with community organizations focused on reducing household food insecurity.
- Identify individuals experiencing food insecurity and link them to resources.
- Educate community on available food resources.
- Implement a strategic approach to identifying and addressing social needs at MedStar Southern Maryland Hospital Center.

Initiatives

- Screen individuals for food insecurity.
- Establish food pantry that provides resources to associates and community members who screen positive for food insecurity.
- Provide referrals to organizations that support access to healthy food, local food banks and food pantries, and local departments of health and human services.
- Provide health education about good nutrition and strategies to improve food security.
- Expand social needs screenings to adult hospitalized patients in collaboration with nursing and acute case management teams.
- Engage with local community-based organizations to address social needs risk factors to advance health equity strategies.
- Leverage the MedStar Health Social Needs Tool powered by Findhelp to provide referrals and connections to social support services in the community.

Costs of living

- The median household income reported in Prince George's County in 2021 was $89,700. [37,38] This is higher than the national median of $70,784, and lower than the statewide median of $90,100. **When viewing cost-of-living data, however, these wages often are not sufficient to cover household expenses. Ultimately, this can significantly impact access to care.**
- 12% of people in Prince George's County live in poverty, equal to the nationwide rate.[37]

Since our first CHNA: this is an increase from 7% in 2008.

- The average annual cost for a family with two adults and two children is $85,572.[31]
  - The average annual cost for a household with two adults and two children **in childcare** is $93,228.

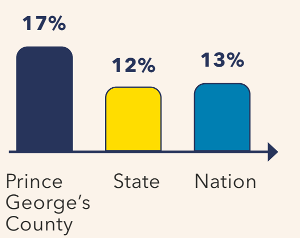
The approximate cost of living for a one-child and one-adult household is $60,444.[35] The average annual income for these households is less than $63,000 (before taxes), based on an estimated hourly wage of $30.22.

- 66% of single-female-headed households with children in Prince George's County are below the ALICE* threshold, compared to 26% of married households with children being below the threshold.[31] **ALICE: Asset Limited, Income Constrained, Employed - Those earning more than the Federal Poverty Level, but not enough to afford the basics where they live.*

Food insecurity

- 7% of households in Prince George's County experience food insecurity.[39] This is lower than the state and nationwide rate of 10%.

17% of Prince George's County households with children experience food insecurity.[39] This is higher than the state and nationwide proportions of 12% and 13%, respectively.



- 31% of survey respondents indicated that hunger and food insecurity are some of the most important social issues affecting the quality of life in the community.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Food insecurity

- Number of community members served
- Number of positive screenings for food insecurity
- Number of associates served
- Number of referrals provided for healthy food access

Key partners

- Capital Area Food Bank
- Findhelp
- Food Justice DMV
- Greater D.C. Diaper Bank
- Hungry Harvest

Prince George's County

(MedStar Southern Maryland Hospital Center)

What has improved?

- Age-adjusted death rate due to heart disease, stroke, and cancer
- Lower percentage of unemployed adults
- Reduced the infant mortality rate

Areas to address

- Percentage of adults who are obese
- Number of persons living in poverty

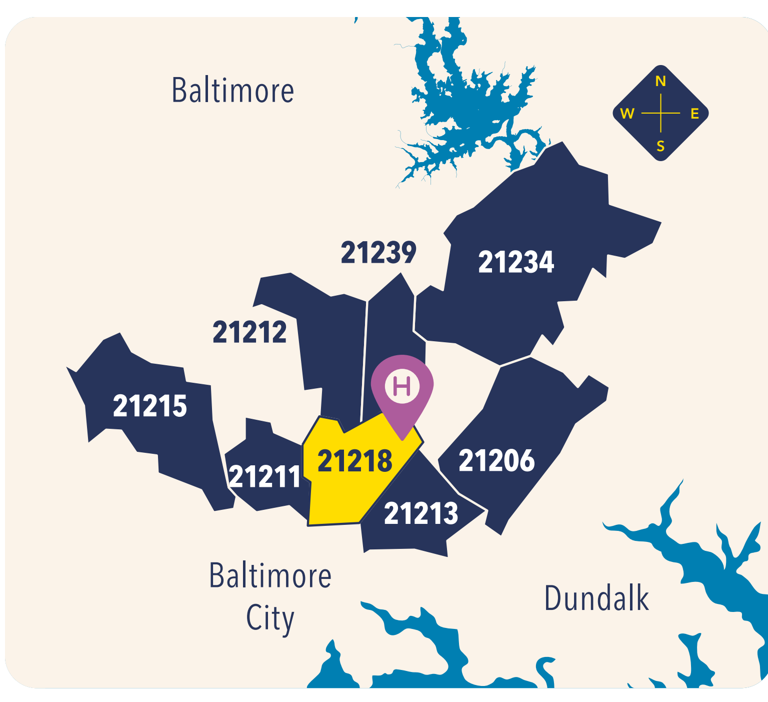
953 surveys completed for MedStar Southern Maryland Hospital Center

The 25-question survey was conducted from early September to the end of October 2023.

Survey was distributed in person and online.

To learn more about health needs in the MedStar Southern Maryland community, **scan the QR Code or visit MedStarHealth.org/CommunityHealth.**

MedStar Union Memorial Hospital



Primary Service Area   Community Benefit Service Area

History
Our team at MedStar Union Memorial Hospital has provided high-quality care to northeast Baltimore City for more than 160 years. It is a not-for-profit, 223-bed acute care teaching hospital with a strong emphasis on cardiac care, orthopedics, and sports medicine. As one of the region's top specialty hospitals, we are known for The Curtis National Hand Center, MedStar Heart & Vascular Institute, MedStar Orthopaedic Institute, and the development of the first hospital-based sports medicine program in the country.

The community
We value the input and feedback from the communities we serve and make it a priority to collaboratively identify local healthcare needs and develop programs, partnerships, and initiatives to meet those needs. Our Advisory Task Force Committee at MedStar Union Memorial includes local residents as well as representatives from the local health department, schools, higher education institutions, federally qualified health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): Baltimore City, Maryland
The CBSA representing MedStar Union Memorial includes residents living in zip code 21218. This geographic area was selected as the CBSA representing MedStar Union Memorial based on hospital utilization data and secondary public health data, as well as its proximity to the hospital and collaboration with community partners.

Prioritized health needs:

Health and wellness
Turn to page 100 for goals and initiatives

- Chronic disease prevention and management
- Behavioral health: mental health and substance use disorders

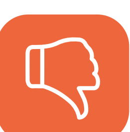
Access to care
Turn to page 103 for goals and initiatives

- Access to health insurance and providers
- Access to healthcare appointments
- Cost of health care
- Transportation

Social drivers of health
Turn to page 105 for goals and initiatives

- Housing and homelessness
- Food insecurity
- Poverty: economic inequality and wage inequality
- Violence: neighborhood safety and gun violence

Red indicates a negative trend in this statistic.



Green indicates a positive trend in this statistic.

Demographics

Zip code 21218

Average household income in 2020:
$67,925[51]

Gender and age*[51]

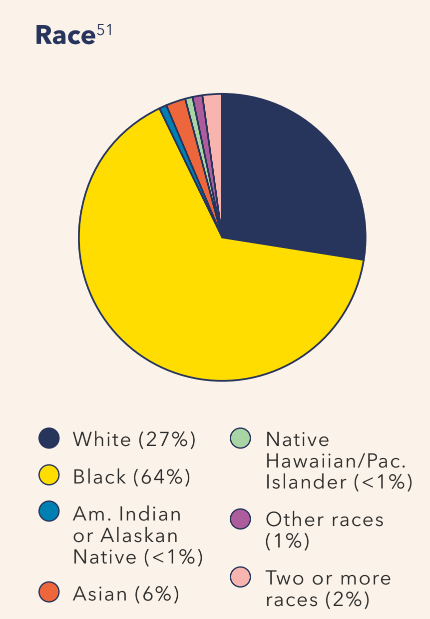
52% Female
Median age: **34**

48% Male
Median age: **32**

Median age: **33**

Total population[51] **49,796**

Race[51]



Educational attainment
(those 25+ years)[51]

<High school diploma	**16%**
High school graduate	**48%**
Associate's degree	**5%**
Bachelor's degree	**15%**
Master's degree	**10%**
Professional degree	**4%**
Doctorate degree	**3%**

Health and wellness

Chronic disease prevention and management

Residents in Baltimore City have higher rates of death due to heart disease, stroke, diabetes, and cancer than the state and nationwide averages. To address these concerns and keep communities healthy, our team at MedStar Union Memorial prioritizes initiatives to improve health and expand chronic disease prevention and management programming. These priorities are consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, which include diabetes, reducing the average adult BMI, and reducing avoidable admissions and readmissions.

Goals

- Improve health and quality of life through prevention, detection, and treatment of risk factors for chronic diseases.
- Improve community health and wellbeing through health education programs.
- Expand chronic disease prevention and management programming.

Initiatives

- Host and provide diabetes community education and heart disease community awareness.
- Improve awareness of prediabetes and gestational diabetes and implement practices to refer patients to interventions.
- Facilitate Food Rx programs designed to provide nutrition education, lifestyle change classes, and access to fresh, healthy foods.
- Provide services for chronic, medically complex patients via Collaborative Care Center.
- Provide primary care services through MedStar Mobile Health Center to address risk factors of chronic disease and refer community members to specialty care, if needed.
- Serve as hub for MedStar Health House Call program, expanding access to primary care within communities.

Heart disease and stroke

- Baltimore City has a heart disease death rate of 227 per 100,000 people, which is higher than the statewide and nationwide rate of 165 per 100,000 people.[1,2,3]

Since our first CHNA: this is an improvement from the 2010 rate of 278 heart disease deaths per 100,000 people.

- Baltimore City has a stroke death rate of 53 deaths per 100,000 people, compared to the statewide rate of 42 per 100,000 people and the nationwide rate of 38 per 100,000 people.[3]
- 35% of adults in Baltimore City have high blood pressure.[16,17]
  - 56% of MedStar Union Memorial CHNA survey respondents indicated that high blood pressure is among the main health problems affecting people in their community.

Cancer

- Baltimore City has a cancer death rate of 188 deaths per 100,000 people, which is higher than the nationwide rate of 147 deaths per 100,000 people.

Since our first CHNA: this is an improvement from the 2010 rate of 225 cancer deaths per 100,000 people.

Obesity

- 37% of adults in Baltimore City are obese.[18,19] This is less than the nationwide average of 42%.

Since our first CHNA: this is an increase from 35% in 2010.

Diabetes and high blood sugar

- 11% of adults in Baltimore City have diabetes, which is equal to the nationwide percentage.[18,19]
  - 50% of survey respondents indicated that diabetes and high blood sugar are some of the main health problems affecting people in their community.
- There are 33 diabetes deaths per 100,000 people in Baltimore City.[7,8,9]

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of participants enrolled
- Number of activities and/or events attended
- Number of sessions and/or groups held
- Number of referrals
- Number of patients served
- Number of patients connected to specialty services
- Number of uninsured individuals connected to primary care

Key partners

- Baltimore City Department of Aging
- Baltimore City Health Department
- Center for Successful Aging
- Central Baltimore Partnership
- Enoch Pratt Libraries
- Faith-based organizations
- Govans Ecumenical Development Corporation
- Hungry Harvest
- Joy Wellness Center
- Keswick
- Maryland Department of Health
- Maryland Food Bank
- Maryland Medicaid
- Meals on Wheels
- The Franciscan Center
- The Y in Waverly (Weinberg)

Behavioral health: mental health and substance use disorders

Substance use disorders and mental health issues affect people in communities throughout Baltimore City. To address these concerns, MedStar Union Memorial prioritizes initiatives to improve access to substance use recovery and behavioral health services. This is consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, including reducing overdose mortality.

Goals

- Support substance use disorder recovery and promote access to behavioral health programs.
- Ensure access to appropriate quality behavioral health and substance use disorder services.

Initiatives

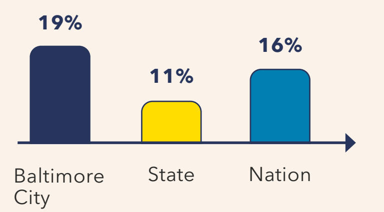
- Conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program in emergency department, Women's Services, and ambulatory sites supported by Peer Recovery Coaches.
- Serve as a community health hub for behavioral health resources, community education (virtual or in-person), overdose preventions, and peer-to-peer support.
- Engage as member of the Central Maryland Regional Crisis System to expand mental health and crisis services in the Baltimore metro region.
- Provide behavioral health services offering Intensive Outpatient and Inpatient Program Services, Psychiatry and Therapy clinic, Crisis Teams, Partial Hospitalization Program, and Therapeutic and education groups for specific audiences.
- Advocate for tele-mental health counseling expansion.
- Host and provide smoking cessation program.

Mental health

- People in Baltimore City average five poor mental health days per 30 days, compared to the nationwide average of four days.[20]
  - 33% of survey respondents indicated that mental health concerns like depression, suicide, PTSD, and trauma are one of the top five issues affecting people in their community the most.

Addiction and substance use disorders

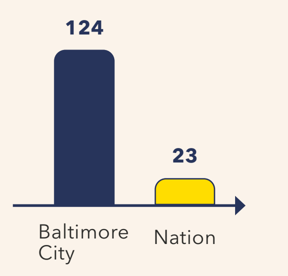
19% of adults in Baltimore City currently smoke.[40] This is higher than 11% statewide and 16% nationwide.



- 9% of survey respondents indicated that smoking, vaping, and/or tobacco use are some of the main health issues affecting people in their community.
- 15% of adolescents in Baltimore City reported using tobacco products.[21,22] This is higher than the nationwide average of 11% but nearly equal to the statewide average of 15%.
- 41% of survey respondents indicated that addiction is one of the main health issues affecting people in their community.

Opioids

Baltimore City has 124 drug overdose deaths per 100,000 people. [24,26] This is **six times higher** than the nationwide rate of 23 deaths per 100,000 people.



In Baltimore City, 67 opioid prescriptions are dispensed per 100 people.[25] **This is significantly higher than 43 prescriptions dispensed per 100 people nationwide and 40 prescriptions per 100 people statewide.**

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of referrals and linkages to support services and treatment
- Number of SBIRT screenings, referrals, and linkages to treatment
- Number of participants enrolled in smoking cessation program

Key partners

- Baltimore City Health Department
- Behavioral Health Equity Across Maryland
- Behavioral Health Systems of Baltimore
- Enoch Pratt Libraries
- Faith-based organizations
- Govans Ecumenical Development Corporation
- Joy Wellness Center
- Keswick
- Local Behavioral Health Authority
- NAMI Metropolitan Baltimore
- The Y in Waverly (Weinberg)

Access to health care and services

People living in Baltimore City report community health concerns such as access to health insurance and healthcare providers, cost of healthcare, and transportation. To address these issues, our team prioritizes initiatives that improve access to care. These priorities are consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, including care transformation and care coordination.

Goals

- Improve and expand community access to health insurance.
- Eliminate barriers to healthcare access and expand community access to medical and non-medical services.
- Expand access to essential health services through virtual care.
- Increase access to healthcare providers.
- Manage hospital healthcare costs and assist patients and community members to access finance education and assistance.
- Improve access to transportation for vulnerable populations.

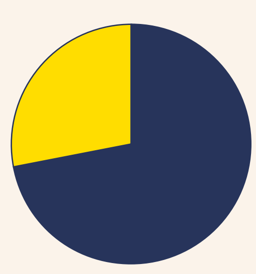
Access to health care and services

- Baltimore City has a 170:1 ratio of population to mental health providers.[28,29] This is better than the nationwide ratio of 328:1.
- 10% of adults in Baltimore City cannot afford to see a doctor, compared to the nationwide percentage of 13%.[30]
- 24% of survey respondents indicated that they or a family member in their household have difficulties with mobility and require medical equipment.

Initiatives

- Provide primary care through MedStar Mobile Health Center without need for insurance, including immigrant communities.
- Assist patients in need of insurance through screenings, referrals, and linkage to community resources.
- Provide financial assistance to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs, including individuals without US-documentation status.
- Recruit providers in areas of need.
- Provider community experience and integration.
- Improve health of the community through SDOH and SBIRT screenings, prevention, referrals, and linkage to community resources through hospital-based community health worker and peer recovery specialists.
- Expand access to essential health services through virtual care and urgent care centers.
- Provide medical and non-medical services, testing the intersection of health and housing through partnership at J Van Story Branch Health and Wellness Hub.
- Expand access to primary care and behavioral health services for uninsured and underinsured community members.
- Refer patients to financial advocate and support services.
- Offer and support community health financial education.
- Educate and advocate for cost containment.
- Support Health Care Navigation education, programs, and services, and publicize resources.
- Screen patients for transportation needs and arrange ride-share; provide cab vouchers and bus tokens to patients without adequate financial resources.
- Provide primary care services through MedStar Mobile Health Center in community to remove transportation barriers from seeing a provider.
- Advocate for safe, accessible public transportation.

Availability of affordable health care providers and health insurance



72% of survey respondents say that **cost is the main reason people in their community do not get health care when needed.**

- 52% of survey respondents say that no insurance is a top reason why people in their community do not get health care when needed.
- 40% of survey respondents indicated that finding a doctor who accepts their insurance is one of the most common reasons people in their community do not get health care when they need it.

Transportation
- 32% of survey respondents indicated that a lack of or limited transportation is one of the most common reasons people in their community do not get health care when they need it.
- 17% of survey respondents indicated that limited access to transportation is one of the most important social issues affecting quality of life in their community.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Availability of affordable healthcare providers and health insurance
- Number of participants in healthcare navigation programs
- Number of social needs screenings
- Number of linkages to insurance and social resources
- Number of new providers recruited
- Number of patients referred to specialty services
- Number of positive screenings

Transportation
- Number of transportation vouchers and/or bus tokens provided

Access to services
- Number of patients connected to virtual care
- Number of Mobile Health Center events

Key partners

- Baltimore City Health Department
- Baltimore City Public Library
- Baltimore City Public Schools
- Central Baltimore Partnership
- Children's Community Health Services
- Community Housing Partners
- Faith-based organizations
- Healthcare Access Maryland
- Hungry Harvest
- Johns Hopkins Medicine
- Joy Wellness Center
- Keswick
- Maryland Food Bank
- Meals on Wheels
- Shepherd's Clinic
- Sheppard Pratt Health System
- The Franciscan Center
- Uber Health
- University of Maryland School of Nursing
- University of Maryland School of Social Work

Social drivers of health

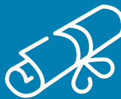
To make Baltimore City more accessible for all, we have developed a series of initiatives to address social health concerns such as housing, food insecurity, poverty, and violence. For this reason, our team prioritizes initiatives such as reducing inequities, improving access to basic needs, and reducing violence through community partnerships. These priorities are consistent with the Statewide Integrated Health Improvement Strategy (SIHIS) goals, including care transformation.

Goals

- Promote equitable access to housing resources in the community.
- Support community housing and homelessness initiatives.
- Reduce inequities caused by lack of affordable housing or substandard housing conditions by promoting the intersection of housing and health care.
- Promote expansion of food access.
- Implement a strategic approach to identifying and addressing social needs at MedStar Union Memorial Hospital.
- Improve medical food and nutrition interventions.
- Identify individuals experiencing food insecurity and link to resources.
- Improve access to basic needs and resources.
- Promote equitable access to employment opportunities and a livable wage.
- Reduce community violence through community partnerships and a trauma-informed approach to care delivery.
- Implement a strategic approach to identifying and addressing social needs at MedStar Union Memorial Hospital.

Education

69% of public high school students in Baltimore City graduate within four years.[54,55] **This is a significantly lower rate than the state and nationwide rates of 86% and 87%, respectively.**



Employment

- 4% of adults in Baltimore City are unemployed.[35,36] This is slightly higher than the statewide rate of 3% and equal to the nationwide rate.

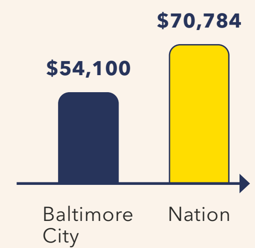
Initiatives

- Join and participate in Baltimore City Continuum of Care to advocate and act on opportunities to address homelessness, including referring patients to federal and state agencies for housing.
- Advocate for affordable, safe housing.
- Screen patients for food security and provide fresh produce prescriptions.
- Investigate long-term sustainability for food access.
- Facilitate Food Rx programming to provide nutrition education, lifestyle change classes, and access to fresh, healthy foods including farmer's markets.
- Participate in coalitions, support, and refer to medically tailored meals, seek evidence-based programs, nutrition counseling, and advocate for policy change.
- Advocate for pay equity and living wages.
- Support and coordinate drives for food, clothing, and basic needs.
- Partner to provide wraparound service through a trauma-informed care approach for individuals experiencing violence.
- Participate in violence prevention advocacy and community events to reduce neighborhood violence.
- Advocate for funding and resources to address violence in the community, including domestic, intimate partner, human trafficking, and elder abuse.
- Expand social needs screenings to adult hospitalized patients in collaboration with nursing and acute case management teams.
- Engage with local community-based organizations to address social needs risk factors to advance health equity strategies.
- Leverage the MedStar Health Social Needs Tool powered by Findhelp to provide referrals and connections to social support services in the community.

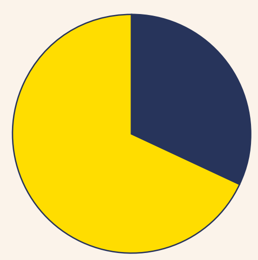
Costs of living

- The median household income in Baltimore City is significantly lower than the median household income nationwide.[37,38] In Baltimore City, the average annual cost of living is close to the median household income.
- 20% of people in Baltimore City live in poverty, compared to 12% nationwide and 10% statewide.[37]

The median household income in Baltimore City is $54,100, **lower than the nationwide median of $70,784.**[33,34]

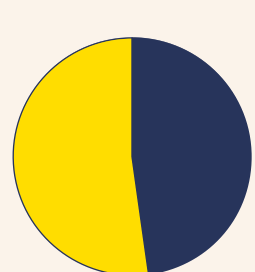


- The average annual cost for a family with two adults and two children is $75,276.[31]
  - The average annual cost for a household with two adults and two children **in childcare** is $81,948.
- The approximate cost of living for a one-child and one-adult household is $49,068.[31] The average annual income for these households is less than $52,000 (before taxes), based on an estimated hourly wage of $24.53.
- 80% of single-female-headed households with children in Baltimore City are below the ALICE* threshold, compared to 26% of married households with children being below the threshold.[31] *ALICE: Asset Limited, Income Constrained, Employed - Those earning more than the Federal Poverty Level, but not enough to afford the basics where they live.*



32% of households with children in Baltimore City receive public assistance or Supplemental Nutrition Assistance Program (SNAP) benefits.[74]

Housing



48% of Baltimore City housing is occupied by the owner.[37] **This is significantly lower than 65% nationwide and 67% statewide.**

- In 56% of renter-occupied housing units in Baltimore City, tenants pay 30% or more of their household income on rental costs.[36] This is higher than the nationwide percentage of 51% and equal to statewide percentage of 52%.
- 41% of survey respondents indicated that housing problems and homelessness are among the most important social issues affecting quality of life in their community.
- 38% of households in Baltimore City face at least one of the following housing problems: incomplete kitchen facilities, incomplete plumbing facilities, overcrowding, and a cost burden greater than 30%.[56]

Food insecurity
- 14% of households in Baltimore City experience food insecurity, higher than the state and nationwide percentage of 10%.[39]

26% of Baltimore City households with children experience food insecurity.[39] This is significantly higher than the state and nationwide proportions of 12% and 13%, respectively.

- 36% of survey respondents indicated that hunger and food insecurity are among most important social issues affecting the quality of life in their community.

Violence
- 41% of survey respondents indicated that neighborhood safety and community violence is a main social issue affecting their community.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Housing and homelessness
- Number of patients served
- Number of enrollees
- Number of people housed
- Number of affordable housing advocacy events

Food insecurity
- Number of screenings completed
- Percentage screening positive
- Number of participants
- Number of patients served

Economic inequality
- Number of individuals served

Violence
- Number of participants
- Number of referrals to Community Based Organizations (CBOs)
- Percentage reduction in re-injury, violent and nonviolent crimes, and incidents of retaliation
- Number of events held
- Number of encounters for resource connections
- Number of programs developed
- Number of partnerships formed
- Number of staff trained

Key partners

- Baltimore City Communities for the Homeless
- Baltimore City Department of Planning
- Baltimore City Health Department
- Baltimore City Office of Food Planning
- Baltimore City Police
- Findhelp
- Greater Baltimore Cultural Alliance
- Health Care Access Maryland
- Hungry Harvest
- Maryland Food Bank
- Mayor's Office of Neighborhood Safety and Engagement
- Meals on Wheels
- Uber Health
- The Franciscan Center
- The Y in Waverly (Weinberg)

Baltimore City

(MedStar Good Samaritan Hospital, MedStar Harbor Hospital, MedStar Union Memorial Hospital)

What has improved?
- Age-adjusted death rate due to heart diseases and cancer

Areas to address
- Age-adjusted death rate due to diabetes

717 surveys completed for MedStar Union Memorial

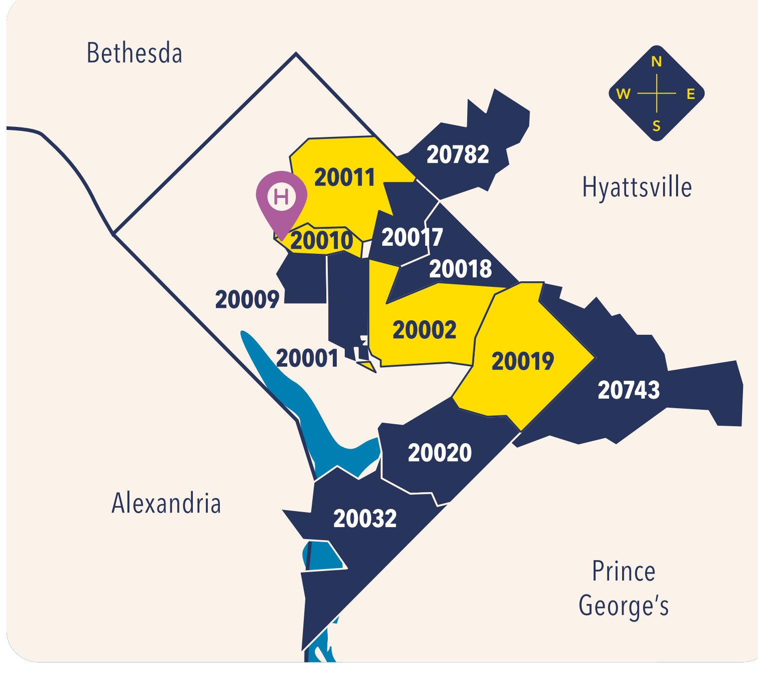
The 25-question survey was conducted from early September to the end of October 2023.

Survey was distributed in person and online.

To learn more about health needs in the MedStar Union Memorial community, **scan the QR Code or visit MedStarHealth.org/ CommunityHealth.**

MedStar Washington Hospital Center

Community Health Needs Assessment



Primary Service Area
Community Benefit Service Area

History
MedStar Washington Hospital Center is a not-for-profit, 912-bed academic medical center, serving the center of the nation's capital. With 400,000 annual patient visits, MedStar Washington is the busiest and largest hospital in Washington, D.C., and the surrounding area. Serving as as a referral center and the central hub for the region's most advanced acute medical care, MedStar Washington is especially renowned for its expertise in trauma, burn, cardiovascular disease, stroke, cancer, and neurosurgery.

The community
We value the input and feedback from the communities we serve and make it a priority to collaboratively identify local healthcare needs and develop programs, partnerships, and initiatives to meet those needs. Our Advisory Task Force Committee at MedStar Washington includes residents of surrounding communities as well as local health department representatives, schools, higher education institutions, federally qualifed health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): Washington, D.C.
The CBSA representing MedStar Washington includes residents living in zip codes 20019, 20011, 20002, and 20010. This geographic area was selected as the CBSA representing MedStar Washington based on hospital utilization data and secondary public health data, along with its proximity to the hospital and collaborative partnerships with local organizations.

Prioritized health needs:

Health and wellness
Turn to page 111 for goals and initiatives

- Chronic disease prevention and management
- Behavioral health: mental health and substance use disorders
- Chronic pain and arthritis

Access to care
Turn to page 114 for goals and initiatives

- Mistrust of healthcare providers
- Cost of health care
- Access to healthcare providers

Social drivers of health
Turn to page 116 for goals and initiatives

- Food insecurity
- Housing and homelessness
- Violence: neighborhood safety and gun violence

Red indicates a negative trend in this statistic.

Green indicates a positive trend in this statistic.

Demographics

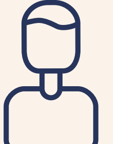
Zip code 20019

Average household income in 2020:
$43,661[40]

Gender and age*[40]

56% Female
Median age: **38**

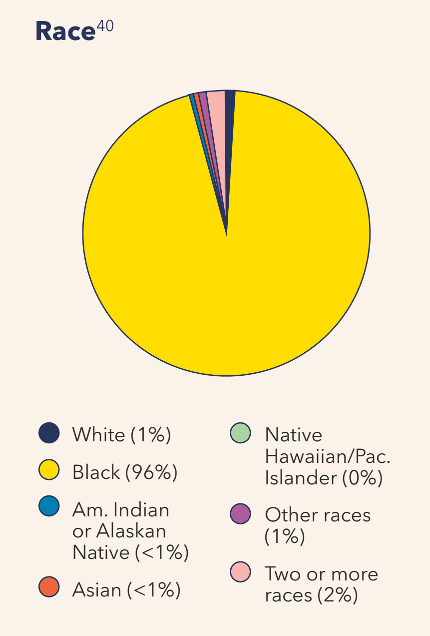
44% Male
Median age: **32**



Median age: **35**

Total population[40] **54,358**

Race[40]



Educational attainment
(those 25+ years)[40]

<High school diploma	**19%**
High school graduate	**63%**
Associate's degree	**4%**
Bachelor's degree	**8%**
Master's degree	**5%**
Professional degree	**1%**
Doctorate degree	**<1%**

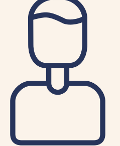
Zip code 20011

Average household income in 2020:
$73,649[41]

Gender and age*[41]

53% Female
Median age: **40**

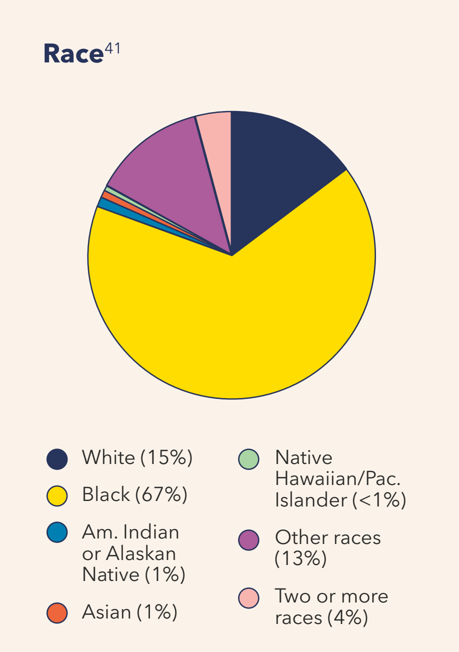
47% Male
Median age: **37**



Median age: **39**

Total population[41] **58,536**

Race[41]



Educational attainment
(those 25+ years)[41]

<High school diploma	**16%**
High school graduate	**46%**
Associate's degree	**4%**
Bachelor's degree	**18%**
Master's degree	**11%**
Professional degree	**4%**
Doctorate degree	**2%**

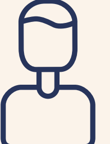
Zip code 20002

Average household income in 2020:
$96,674[42]

Gender and age*[42]

52% Female
Median age: **35**

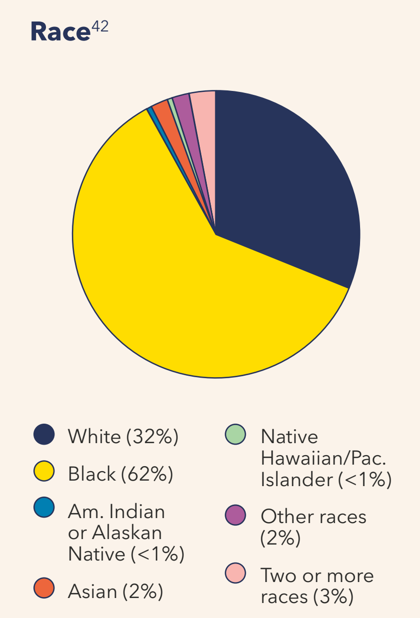
48% Male
Median age: **35**



Median age:
35

Total population[42] **52,370**

Race[42]



Educational attainment
(those 25+ years)[42]

<High school diploma	**14%**
High school graduate	**35%**
Associate's degree	**3%**
Bachelor's degree	**24%**
Master's degree	**16%**
Professional degree	**5%**
Doctorate degree	**3%**

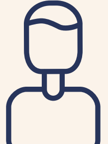
Zip code 20010

Average household income in 2020:
$105,233[75]

Gender and age*[75]

53% Female
Median age: **34**

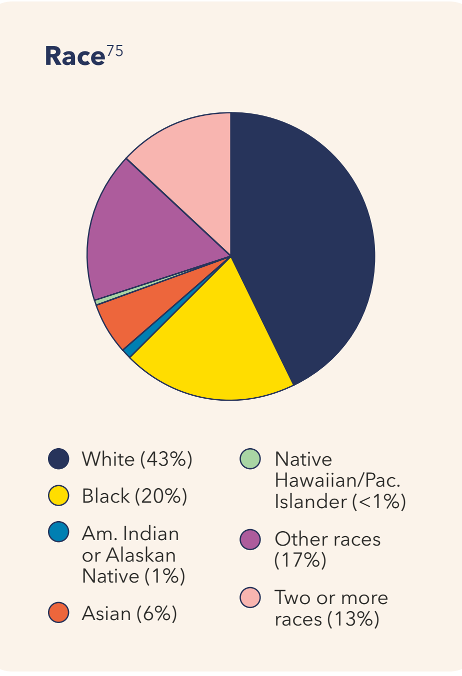
51% Male
Median age: **34**



Median age:
34

Total population[75] **31,646**

Race[75]



Educational attainment
(those 25+ years)[75]

<High school diploma	**15%**
High school graduate	**22%**
Associate's degree	**2%**
Bachelor's degree	**25%**
Master's degree	**25%**
Professional degree	**7%**
Doctorate degree	**4%**

Health and wellness

Chronic disease prevention and management

Chronic diseases are among the main health concerns of residents living in Washington, D.C. Based on this concern, our team at MedStar Washington prioritizes initiatives that improve lives through prevention, detection, and resources for health management. These initiatives are consistent with the D.C. Community Health Improvement Plan (CHIP) and D.C. Healthy People 2030 objectives.

Goals

- Improve health and quality of life through prevention, detection, and treatment of risk factors for chronic diseases.
- Improve community health and wellbeing through health education programs.
- Expand chronic disease prevention and management programming.
- Improve quality of life for those living with chronic pain and arthritis.
- Promote self-management techniques for chronic pain.

Initiatives

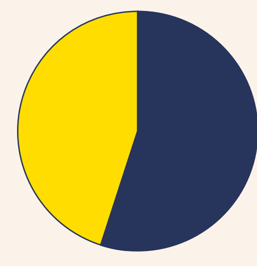
- Offer virtual and in-person Ask a Doc sessions covering a wide array of topics relating to chronic disease, pain, and healthy living.
- Participate in health fairs and provide screenings, online healthcare seminars, blogs, and videos.
- Provide warm handoff to managed care partners and follow up to those living with chronic illness.
- Partner with D.C. Health to lead chronic disease management and diabetes management training workshops to community members.
- Provide chronic pain self-management sessions and training to local facilities.
- Provide patient advocate support groups for those living with chronic pain.

Heart disease and stroke

- Washington, D.C. has a heart disease death rate of 181 per 100,000 people, which is higher than the nationwide rate of 165 per 100,000 people.[2,3,4]

Since our first CHNA: this is an improvement from the 2010 rate of 260 deaths per 100,000 people.

- Washington, D.C. has a stroke death rate of 38 deaths per 100,000 people, which is lower than the nationwide rate of 38 per 100,000 people.[3]
- 31% of adults in Washington, D.C. have high blood pressure.[16,17,43]



53% of Medstar Washington CHNA survey respondents indicated that **high blood pressure is among the main health problems affecting people in their community.**

- 31% of adults in Washington, D.C. have high cholesterol.[4,17,37]

Cancer

- Washington, D.C. has a cancer death rate of 147 deaths per 100,000 people, which is equal to the nationwide rate.[5,6] This is an improvement from Washington, D.C.'s 2021 CHNA data, with 156 cancer deaths per 100,000 people.

Since our first CHNA: this is an improvement from the 2010 rate of 199 cancer deaths per 100,000 people.

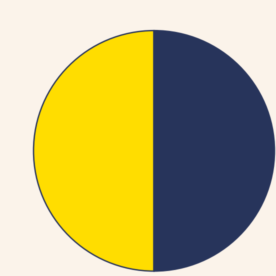
Obesity

- 25% of adults in Washington, D.C. are obese.[4,18,19] This is significantly less than the nationwide average of 42%.

Since our first CHNA: this is an increase from 22% in 2010.

Diabetes and high blood sugar

- 8% of adults in Washington, D.C. have diabetes.[4,18,19]



50% of survey respondents indicated that **diabetes and high blood sugar** are among the main health problems affecting people in their community.

- There are 22 diabetes deaths per 100,000 people in Washington, D.C.[4,7,8,9,10,11]

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of Ask a Doc sessions
- Number of attendees
- Number of screenings
- Number of referrals to managed care partners
- Number of chronic disease and diabetes management sessions
- Number of participants
- Number of Chronic Pain Self-Management training cohorts offered
- Number of enrollees
- Number of support group sessions; number of participants

Key partners

- Arthritis Foundation
- D.C. Department of Health
- Maryland Living Well Center of Excellence

Behavioral health: mental health and substance use disorders

Substance use disorders and mental health issues affect people in communities throughout Washington, D.C. To address these concerns, our team prioritizes initiatives to improve access to substance use disorder recovery and behavioral health programs. This priority is consistent with the D.C. Community Health Improvement Plan (CHIP) and D.C. Healthy People 2030 objectives.

Goals

- Support substance use disorder recovery and promote access to behavioral health programs.
- Improve access to quality behavioral health and substance use disorder services and providers.

Initiatives

- Identify and train new behavioral health professionals through residency and fellowship prospector programs.
- Offer SBIRT screenings to emergency department, outpatient Behavioral Health, Mother Baby, and other sites.
- Deploy Peer Recovery Coaches to support linkages to resources.
- Host and provide behavioral health community education and support groups; sponsor events supporting behavioral health initiatives.
- Support and promote utilization of the nationwide 988 suicide and crisis lifeline service.

Mental health

- Adults in Washington. D.C. reported an average of five poor mental health days in a span of 30 days.[20]
- The suicide death rate of Washington, D.C. is five deaths per 100,000 people, compared to 14 per 100,000 people nationwide.[76,77,78,79]

Addiction and substance use disorders

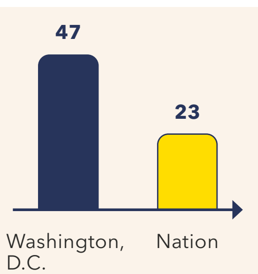
- 22% of adults in Washington, D.C. reported binge drinking.[80] This is higher than the nationwide average of 19%.
- 10% of adults in Washington. D.C. reported being a current smoker.[53] This is lower than the nationwide average of 14%.

Addiction and substance use disorders continued

- 19% of adolescents in Washington. D.C. reported using tobacco products.[21,22,44] This is higher than the nationwide average of 11%.
- 38% of survey respondents indicated that addiction is one of the main health problems affecting people in their community.
- 34% of survey respondents indicated that mental health is one of the main health problems affecting people in their community.

Opioids

Washington, D.C. has 47 drug overdose deaths per 100,000 people.[24,26] **This is significantly higher than the nationwide rate of 23 per 100,000 people.**



Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of trained providers
- Number of identified providers
- Number of SBIRT screenings, referrals, and linkages to treatment
- Number of behavioral health support groups offered
- Number of events supported
- Number of participants
- Number of referrals and linkages to support services and treatment
- Number of events promoting 988 information
- Number of encounters

Key partners

- D.C. Department of Behavioral Health
- Faith-based organizations
- Metropolitan Police Department
- NAMI D.C. - National Alliance of Mental Illness

Access to health care and services

Mistrust of healthcare providers, cost of healthcare, and access to care are key issues for residents living in Washington, D.C. Access to quality care and services important for promoting and maintaining health, preventing and managing disease, and achieving health equity for all. For this reason, we prioritize initiatives to improve access to quality health care providers and insurance. These priorities are consistent with the D.C. Community Health Improvement Plan (CHIP) and D.C. Healthy People 2030 objectives.

Goals

- Improve the rapport and access to healthcare providers within the community.
- Provide cultural competency training and education to healthcare professionals.
- Improve community health and wellbeing through health education programs.
- Eliminate barriers to accessing health care and expand community access to health insurance.
- Improve and expand community access to comprehensive, quality healthcare providers, and programs as well as medical and non-medical services.

Initiatives

- Offer virtual or in-person Ask a Doc sessions covering wide array of chronic disease, pain, and healthy living topics.
- Participate in health fairs and provide screenings, online healthcare seminars, blogs, and videos.
- Engage and support a Patient and Family Advisory Council.
- Offer Ask a Healthcare Professional Health Disparities Town Hall series with MedStar National Rehabilitation Hospital and MedStar Georgetown University Hospital, allowing a safe place for community members and other healthcare professionals to learn and combat healthcare bias.
- Offer virtual or in-person Managed Care Organization (MCO) healthcare sessions or MCO baby showers that explain how to apply Medicaid.
- Provide continued education on what is covered through Medicaid benefits.
- Provide access to community programs that better health.
- Provide education to patients about selecting the best MCO during open enrollment.
- Partner with Department of Health Care Finance (DHCF) to host educational seminars on selecting the best MCO for the individual.
- Support homebound patients through home care services with the House Calls program.
- Provide medical and non-medical services to people living with HIV through the Ryan White program.
- Promote social drivers of health screenings and link to social service programs.
- Identify social needs and non-medical barriers that impact health outcomes for vulnerable populations.

Access to health insurance and providers
- Washington, D.C. has a 160:1 ratio of population to mental health providers.[28,29] This is better than the nationwide ratio of 328:1.
- 96% of adults and children in Washington, D.C. have health insurance.[30,46,47]
- 44% of Washington, D.C. residents are enrolled in Medicaid.[32,33,34,81]
- 69% of adults in Washington, D.C. reported having a routine checkup, compared to 71% on average nationwide.[30,46]
- 51% of survey respondents indicated that not having health insurance is one of the most common reasons people in their community do not get health care when they need it.
- 24% of survey respondents indicated that getting a referral or appointment with a specialist is one of the most common reasons people in their community do not get health care when they need it.

Mistrust of providers
- 22% of survey respondents indicated a fear or mistrust of doctors as one of the most common reasons people in their community do not get health care when they need it.
- 17% of survey respondents indicated a worry or discomfort with telling their healthcare provider about their health as one of the most common reasons people in their community do not get health care when they need it.

Cost of health care
- 66% of survey respondents indicated that the cost of health care is one of the most common reasons people in their community do not get health care when they need it.

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

- Number of Ask a Doc sessions
- Number of participants
- Number of HIV patients receiving services
- Number of council events and/or meetings attended
- Number of Ask a Healthcare Professional health disparities town hall sessions
- Number of participants
- Number of MCO healthcare sessions
- Number of participants
- Number of patient encounters
- Number of events
- Number of patients served through homecare services
- Number of patients referred
- Number of referrals to providers
- Number of screenings

Key partners

- Bread for the City
- Capital Area Food Bank
- D.C. Department of Health
- D.C. Department of Health and Human Services
- D.C. Healthy Families
- D.C. Managed Care Organizations
- Hungry Harvest
- Mary's Center
- Ryan White HIV/AIDS program
- Unity Community Clinic

Social drivers of health

To improve accessibility and safety for residents in Washington, D.C., our team at MedStar Washington prioritizes initiatives to address food insecurity, housing issues, and community violence. These priorities align with the D.C. Community Health Improvement Plan (CHIP) and D.C. Healthy People 2030 objectives.

Goals

- Identify individuals experiencing food insecurity and link to resources.
- Reduce inequities caused by lack of access to healthy foods through partnership and collaboration with community organizations focused on reducing household food insecurity.
- Promote expansion of food access and provide resources to address food insecurity.
- Support community housing and homelessness initiatives.
- Promote equitable access to housing resources in the community.
- Reduce inequities caused by lack of affordable housing or substandard housing conditions by promoting the intersection of housing and health care.
- Reduce community violence and create a support system that can lead to long-term change through community partnerships and advocacy.
- Implement a strategic approach to identifying and addressing social needs at MedStar Washington Hospital Center.

Initiatives

- Facilitate Food Rx programming to provide nutrition education, lifestyle change classes, and access to fresh, healthy foods.
- Partner with faith-based leaders to address food insecurity initiatives for caregivers and families.
- Provide healthy produce to patients in need through continued partnership with food access community benefit-based organizations.
- Participate in housing and homelessness community advocacy workgroups and committees.
- Strengthen partnership with Metropolitan Police Department (MPD) via MPD Beat the Streets violence prevention initiative.
- Provide violence prevention resources and education through the community violence intervention program.
- Expand social needs screenings to adult hospitalized patients in collaboration with nursing and acute case management teams.
- Engage with local community-based organizations to address social needs risk factors to advance health equity strategies.
- Leverage the MedStar Health Social Needs Tool powered by Findhelp to provide referrals and connections to social support services in the community.

Violence

- 38% of survey respondents indicated that neighborhood safety and community violence are among the most important social issues affecting quality of life in their community.
- 25% of survey respondents indicated that gun violence is one of the most important social issues affecting quality of life in their community.

Housing

- 48% of renters in Washington, D.C. reported spending 30% or more on rent.[36]
- 42% of homes in Washington, D.C. are occupied by the owner.[37]
- 46% of survey respondents indicated that live in a house or apartment that they own.

Housing continued
- 40% of survey respondents indicated that housing problems and homelessness are among the main social issues affecting quality of life in their community.

Costs of living
- The median household income reported in Washington, D.C. in 2021 was $91,100.[37,38] This is higher than the national median of $70,784, however, when viewing cost-of-living data, **these wages often are not sufficient to cover household expenses. Ultimately, this can significantly impact access to care.**
- 17% of people in Washington, D.C. live in poverty, compared to 12% nationwide.[37]
- In 2021, household costs in Washington, D.C. were well above the Federal Poverty Level of $12,880 for a single adult and $26,500 for a family of four.[49] Overall, household costs increased in Washington, D.C. between 2019 and 2021.
- The average annual cost for a family with two adults and two children is $88,140.[49]
  - The average annual cost for a household with two adults and two children **in childcare** is $92,736.
- The approximate cost of living for a one-child and one-adult household is $60,900.[49] The average annual income for these households is less than $64,000 (before taxes), based on an estimated hourly wage of $30.45.
- 42% of Washington, D.C. households with children receive public assistance or SNAP benefits.[74]
- 78% of single female-headed households with children in Washington, D.C. are below the ALICE* threshold, compared to 14% of married households with children being below the threshold.[49] **ALICE: Asset Limited, Income Constrained, Employed - Those earning more than the Federal Poverty Level, but not enough to afford the basics where they live.*

Food insecurity
- 76% of children enrolled in public schools in Washington, D.C. are eligible for free or reduced-price lunches.[82,83]
- 10% of households in Washington, D.C. experience food insecurity, equal to the nationwide percentage.[39]
- 35% of survey respondents indicated that hunger and food insecurity are among the main social issues affecting quality of life in their community.
- 13% of Washington, D.C. households with children experience food insecurity, equal to the nationwide percentage.[39]

Program-specific metrics

Key factors will be monitored to assess the effectiveness of implemented programs and services, as well as their alignment with current external public health objectives.

Food insecurity
- Number of patients enrolled
- Number of patients connected to CHA and/or care team

Program-specific metrics continued

Housing and homelessness
- Number of workgroups and/or committees attended

Violence
- Number of violence prevention events attended
- Number of referrals
- Number of patients connected to resources

Key partners

- Capital Area Food Bank
- Capital Caring Health
- D.C. Housing Collaborative
- Faith-based organizations
- Findhelp
- Hungry Harvest
- Metropolitan Police Department
- Ward 7 Health Council

Washington, D.C.

(MedStar Georgetown University Hospital, MedStar National Rehabilitation Hospital, MedStar Washington Hospital Center)

What has improved?
- Age-adjusted death rate due to heart disease and cancer
- Lower percentage of unemployed adults

Areas to address
- Percentage of adults who are obese

1,970 surveys completed for MedStar Washington

The 25-question survey was conducted from early September to the end of October 2023.

Survey was distributed in person and online.

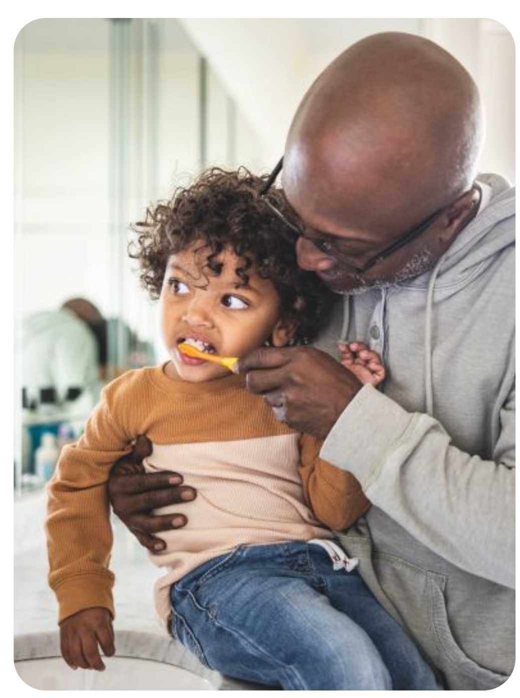
To learn more about health needs in the MedStar Washington community, **scan the QR Code or visit MedStarHealth.org/CommunityHealth.**

References

1. SHIP Age-Adjusted Mortality Rate from Heart Disease. 2009-2020: Open data. https://opendata.maryland.gov/Health-and-Human-Services/SHIP-Age-Adjusted-Mortality-Rate-From-Heart-Diseas/e3du-cv4i. Published July 13, 2023.
2. Stats Of the States - Heart Disease Mortality. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/pressroom/sosmap/heart_disease_mortality/heart_disease.htm. Published February 25, 2022.
3. Interactive Atlas of Heart Disease and Stroke. Centers for Disease Control and Prevention. https://nccd.cdc.gov/DHDSPAtlas/reports.
4. All Data. DC Health Matters: Indicators: All Data. http://www.dchealthmatters.org/indicators/index/dashboard?alias=alldata.
5. Maryland Department of Health Office of Population Health Improvement. Maryland.gov Enterprise Agency Template. https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx.
6. Total Cancer Deaths. KFF. https://www.kff.org/other/state-indicator/cancer-deathrateper100000/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D. Published May 15, 2023.
7. Behavioral Risk Factor Surveillance System. Centers for Disease Control and Prevention. https://www.cdc.gov/brfss/.
8. CDC Wonder. Centers for Disease Control and Prevention. https://wonder.cdc.gov/.
9. Chronic Disease Burden Tables 2020 - Maryland Department of Health. https://health.maryland.gov/phpa/ccdpc/Reports/Documents/Chronic%20Disease%20Burden%20Tables%202020.pdf.
10. Indicator Gauge Icon Legend. Prince George's County Health Department: Indicators: Age-Adjusted Death Rate due to Diabetes: County: Prince George's. https://www.pgchealthzone.org/indicators/index/view?indicatorId=100&localeId=1260.
11. What is Healthy Montgomery? Healthy Montgomery Homepage. https://www.montgomerycountymd.gov/healthymontgomery/.
12. ZIP Code 21220. ZIP Code 21220 Map, Demographics, More for Middle River, MD. https://www.unitedstateszipcodes.org/21220/.
13. ZIP Code 21221. ZIP Code 21221 Map, Demographics, More for Essex, MD. https://www.unitedstateszipcodes.org/21221/.
14. ZIP Code 21222. ZIP Code 21222 Map, Demographics, More for Dundalk, MD. https://www.unitedstateszipcodes.org/21222/.
15. ZIP Code 21237. ZIP Code 21237 Map, Demographics, More for Rosedale, MD. https://www.unitedstateszipcodes.org/21237/.
16. Facts About Hypertension. Centers for Disease Control and Prevention. https://www.cdc.gov/bloodpressure/facts.htm. Published July 6, 2023.
17. Dataset Query System. IBIS. https://ibis.health.maryland.gov/ibisph-view/query/result/brfss21/BpHigh4/AgeAdj.html.
18. FastStats – Overweight Orevalence. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/fastats/obesity-overweight.htm. Published January 5, 2023.
19. County Health Rankings & Roadmaps - Maryland. https://www.countyhealthrankings.org/app/maryland/2020/measure/outcomes/60/data.
20. Poor Mental Health Days. County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-outcomes/quality-of-life/poor-mental-health-days?year=2023&state=24&tab=1.
21. 2021-2022 Maryland Youth Risk Behavior Survey and Youth Tobacco Survey. https://health.maryland.gov/phpa/ccdpc/Reports/Documents/2021%20YRBS%20YTS%20Reports/2021-22%20Middle%20School/YRBS-YTS%20MS%20Figures%202021-2022%20%28July%202023%29.pd.
22. Tobacco Product Use Among Middle and High School Students - United States. Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/volumes/71/wr/mm7145a1.htm?s_cid=mm7145a1_w. Published November 10, 2022.
23. U.S. Department of Health and Human Services. Drug Overdose Death Rates. National Institutes of Health. https://nida.nih.gov/research-topics/trends-statistics/overdose-deathrates#:~:text=%2C%201999%2D2021.,The%20figure%20above%20is%20a%20bar%20and%20line%20graph%20showing,and%209%2C173%20deaths%20in%202021. Published July 10, 2023.
24. Unintentional Drug and Alcohol Related Intoxication Deaths in Maryland. https://health.maryland.gov/vsa/Documents/Overdose/Annual_2020_Drug_Intox_Report.pdf.
25. U.S. Opioid Dispensing Rate Maps. Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/rxrate-maps/index.html#:~:text=The%20overall%20national%20opioid%20dispensing%20rate%20declined%20from%202012%20to,than%20142%20million%20opioid%20prescriptions). Published November 10, 2021.
26. Opioid Overdose Deaths by Race/Ethnicity. KFF. https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D. Published May 15, 2023.
27. National Center for Health Statistics. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/index.htm.

28. Explore Mental Health Providers in the United States. America's Health Rankings. https://www.americashealthrankings.org/explore/measures/MHP.
29. Mental Health Providers. County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/clinical-care/access-to-care/mental-health-providers?year=2023&tab=1.
30. Maryland Behavioral Risk Factor Surveillance System (BRFSS). 2021. https://health.maryland.gov/phpa/ccdpc/Reports/Pages/brfss.aspx.
31. United for ALICE. County Reports. https://www.unitedforalice.org/county-reports/maryland.
32. Maryland Alliance for the Poor. 2019. https://mapadvocacy.org/wp-content/uploads/2020/02/Maryland-Poverty-Profiles_2020-FINAL.pdf.
33. U.S. Census Bureau. Quick facts: 2021. https://www.census.gov/quickfacts/fact/table/US.
34. Medicaid. March 2023 Medicaid and CHIP Enrollment Data Highlights. 2023. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.
35. Annual Local Area Unemployment Statistics (LAUS), Not Seasonally Adjusted - Workforce Information & Performance (OWIP). https://www.dllr.state.md.us/lmi/laus/lausann.shtm.
36. U.S. Census Bureau. Explore census data. https://data.census.gov/table.
37. U.S. Census Bureau quick facts: United States. https://www.census.gov/quickfacts/fact/table/US/PST045222.
38. Explore Health Rankings. County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/explore-health-rankings/.
39. Overall Hunger & Poverty in District of Columbia: Map the Meal Gap. Overall Hunger & Poverty in the United States. https://map.feedingamerica.org/county/2021/overall/district-of-columbia.
40. ZIP Code 20019. ZIP Code 20019 Map, Demographics, More for Washington, DC. https://www.unitedstateszipcodes.org/20019/.
41. ZIP Code 20011. ZIP Code 20011 Map, Demographics, More for Washington, DC. https://www.unitedstateszipcodes.org/20011/.
42. ZIP Code 20002. ZIP Code 20002 Map, Demographics, More for Washington, DC. https://www.unitedstateszipcodes.org/20002/.
43. Behavioral Risk Factor Surveillance System. (BRFSS) Prevalence & Trends Data. Centers for Disease Control and Prevention. https://nccd.cdc.gov/BRFSSPrevalence/rdPage.aspx?rdReport=DPH_BRFSS.ExploreByTopic&irbLocationType=StatesAndMMSA&islClass=CLASS10&islTopic=TOPIC31&islYear=2021&rdRnd=67749.
44. State Fact Sheets. Centers for Disease Control and Prevention. https://www.cdc.gov/tobacco/stateandcommunity/state-fact-sheets/index.htm#DC.
45. United for ALICE. Washington, D.C. Demographics. https://www.unitedforalice.org/demographics/washington-dc.
46. U.S. Census Bureau. American Community Survey (ACS). https://data.census.gov/.
47. Chronic Disease and Health Promotion Data and Indicators. CDC 500 Cities Project. Centers for Disease Control and Prevention. https://www.cdc.gov/500cities/.
48. United for ALICE. Washington, D.C. Labor Force. https://www.unitedforalice.org/labor-force/washington-dc.
49. United for ALICE. Washington, D.C. Household Budgets. https://www.unitedforalice.org/household-budgets/washington-dc.
50. ZIP Code 21239. ZIP Code 21239 Map, Demographics, More for Baltimore, MD. https://www.unitedstateszipcodes.org/21239/.
51. ZIP Code 21218. ZIP Code 21218 Map, Demographics, More for Baltimore, MD. https://www.unitedstateszipcodes.org/21218/.
52. ZIP Code 21206. ZIP Code 21206 Map, Demographics, More for Baltimore, MD. https://www.unitedstateszipcodes.org/21206/.
53. Adult Smoking. County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/health-behaviors/tobacco-use/adult-smoking?keywords=mary&f%5B0%5D=type%3Astates&f%5B1%5D=type%3Acounties&year=2023&county=24510.
54. Coe - Public High School Graduation Rates. https://nces.ed.gov/programs/coe/indicator/coi/high-school-graduation-rates.
55. Graduation Rate, AP, SAT, Postsecondary Enrollment. https://marylandpublicschools.org/stateboard/Documents/2023/0228/CohortRatesSBOE_022023.pdf.
56. United for ALICE. Maryland Data + Indicators of Well-Being. https://www.unitedforalice.org/well-being/maryland.
57. ZIP Code 21225. ZIP Code 21225 Map, Demographics, More for Brooklyn, MD. https://www.unitedstateszipcodes.org/21225/.
58. ZIP Code 21226. ZIP Code 21226 Map, Demographics, More for Curtis Bay, MD. https://www.unitedstateszipcodes.org/21226/.
59. National Center for Health Statistics. 2014-2020. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/index.htm.
60. National Center for Health Statistics. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/index.htm.
61. ZIP Code 20906. ZIP Code 20906 Map, Demographics, More for Silver Spring, MD. https://www.unitedstateszipcodes.org/20906/.
62. Census Data. https://data.census.gov.
63. Annual Disability Statistics Compendium – Section 3: Employment. https://www.researchondisability.org/ADSC/compendium-table-contents/section-3-employment.

64. Annual Disability Statistics Compendium – Section 6: Poverty. https://www.researchondisability.org/ADSC/compendium-table-contents/section-6-poverty.
65. United for ALICE. Washington, D.C. County Reports. https://www.unitedforalice.org/county-reports/washington-dc.
66. ZIP Code 20653. ZIP Code 20653 Map, Demographics, More for Lexington Park, MD. https://www.unitedstateszipcodes.org/20653/.
67. Wide-Ranging Online Data for Epidemiologic Research. Centers for Disease Control and Prevention. Published 2016-2018.
68. National Center for Health Statistics. 2019. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/index.htm.
69. United for ALICE. Maryland. Demographics. https://www.unitedforalice.org/demographics/maryland.
70. ZIP Code 20748. ZIP Code 20748 Map, Demographics, More for Temple Hills, MD. https://www.unitedstateszipcodes.org/20748/.
71. ZIP Code 20772. ZIP Code 20772 Map, Demographics, More for Upper Marlboro, MD. https://www.unitedstateszipcodes.org/20772/.
72. ZIP Code 20735. ZIP Code 20735 Map, Demographics, More for Clinton, MD. https://www.unitedstateszipcodes.org/20735/.
73. (Alcohol-impaired driving deaths). County Health Rankings & Roadmaps. (n.d.-b). https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/health-behaviors/alcohol-and-drug-use/alcohol-impaired-driving-deaths?year=2023&state=24.
74. 2021 Community Health Needs Assessment. MedStar Health. https://www.medstarhealth.org/-/media/project/mho/medstar/pdf/community-health-needs-assessment/medstar_health_2021_chna_report.pdf.
75. ZIP Code 20010. ZIP Code 20010 Map, Demographics, More for Washington, DC. https://www.unitedstateszipcodes.org/20010/.
76. Stats of the State - Suicide Mortality. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm.
77. Products - Data Briefs - Number 464. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/products/databriefs/db464.htm#:~:text=The%20total%20age%2Dadjusted%20suicide,the%20period%20(Figure%201). Published April 2023.
78. Explore Suicide in District of Columbia. America's Health Rankings. https://www.americashealthrankings.org/explore/measures/Suicide/DC.
79. County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/social-economic-factors/community-safety/suicides?year=2023&county=24510.
80. County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/health-behaviors/alcohol-and-drug-use/excessive-drinking?year=2023&county=24005.
81. D.C. Department of Health Behavioral Risk Factor Surveillance System. 2017. https://dchealth.dc.gov.
82. National Center for Education Statistics. 2019-2020. https://nces.ed.gov.
83. Free and Reduced-Price Meal Statistics. Maryland State Department of Education. Office of School & Community Nutrition Programs. 2021-2022. https://marylandpublicschools.org/programs/SchoolandCommunityNutrition/Pages/FreeReducedPriceMealStatistic.aspx.aspx?geographyType=county&state=MD&themeId=3&filterIds=2%2C3%2C4%2C7%2C9&filterOptions=1%2C1%2C1%2C1%2C1.



MedStarHealth.org

MedStar Health

Corporate Policies

Title:	**Corporate Financial Assistance Policy**	Section:	
Purpose:	To ensure uniform management of the MedStar Health Corporate Financial Assistance Program across all MedStar Health Hospitals and Hospital-based Physician Practices.	Number:	
Forms:		Effective Date:	01/01/2022

Policy

1. As one of the region's leading not-for-profit healthcare systems, MedStar Health is committed to ensuring that uninsured and underinsured patients meeting eligibility criteria, and patients determined eligible for presumptive eligibility within the communities we serve who lack financial resources have access to medically necessary hospital services. MedStar Health hospitals and hospital based-physician practices will:

   1.1 Treat all patients equitably, with dignity, respect, and compassion.
   1.2 Serve the emergency health care needs of everyone who presents to our MedStar Health hospitals and hospital-based physician practices regardless of a patient's ability to pay for care.
   1.3 Assist those patients who are admitted through our admission process for non-urgent, medically necessary care who cannot pay for the care they receive.
   1.4 Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep its hospitals' doors open for all who may need care in the community.

2. MedStar Health will not 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. In addition, MedStar Health will not use a patient's citizenship or immigration status as an eligibility requirement for financial assistance.

Scope

1. In meeting its commitments, MedStar Health hospitals and hospital-based physician practices will work with their patients seeking emergency and medically necessary care to gain an understanding of each patient's financial resources. Based on this information, MedStar Health hospitals and hospital-based physician practices will make eligibility determinations for financial assistance for patients who reside within the communities that we serve. In determining eligibility for financial assistance, MedStar Health hospitals and hospital-based physician practices will:

   1.1 Determine whether the patient has health insurance.
   1.2 Determine whether the patient is presumptively eligible for Free or Reduced-Cost Care.
   1.3 Determine whether uninsured patients are eligible for public or private health insurance.
   1.4 To the extent possible, offer assistance to uninsured patients if the patient chooses to apply for public or private health insurance.
   1.5 To the extent practicable, determine whether the patient is eligible for other public programs that may assist with health care costs.

   1.6 Use information in the possession of the hospital, if available, to determine whether the patient is qualified for Free or Reduced-Cost Care under the hospital's financial assistance policy.

Definitions

1. **Free Care**

   100% financial assistance for medically necessary care provided to uninsured and underinsured patients with household income at or below 200% of the federal poverty level (FPL). Free Care is calculated at the time of service or updated, as appropriate, to account for any changes in financial circumstances of the patient that occurs within 240 days after the initial hospital bill is provided.

2. **Reduced-Cost Care**

   Partial financial assistance for medically necessary care provided to uninsured and underinsured patients with household income between 201% and 400% of the FPL. Reduced-cost care is calculated at the time of service or updated, as appropriate, to account for any changes in financial circumstances of the patient that occurs within 240 days after the initial hospital bill is provided.

3. **Underinsured Patient**

   An "Underinsured Patient" is defined as an individual who elects third party insurance coverage with high out of pocket insurance benefits or a patient with Medicare coverage resulting in large patient account balances.

4. **Financial Hardship**

   Medical Debt, incurred by a household over a 12-month period, at the MedStar Health hospitals and hospital-based physician practices that exceeds 25% of the family household income. This means test is applied to uninsured and underinsured patients with income below 500% of the Federal Poverty Guidelines.

5. **MedStar Health Uniform Financial Assistance Application**

   A uniform financial assistance data collection document. The Maryland State Uniform Financial Assistance Application will be used by all MedStar Health hospitals and hospital-based physician practices regardless of the hospital or practice geographical locations. The Uniform Financial Assistance Application is written in simplified language; and does not require documentation that presents an undue barrier to a patient's receipt of financial assistance.

6. **MedStar Health Patient Information Sheet**

   A plain language summary that provides information about MedStar Health's Financial Assistance Policy, and a patient's rights and obligations related to seeking and qualifying for Free or Reduced Cost medically necessary care. The Maryland State Patient Information Sheet format, developed through the joint efforts of Maryland Hospitals and the Maryland Hospital Association, will be used by all MedStar Health hospitals and hospital-based physician practices regardless of the hospital or practice geographical locations. The MedStar Health Patient Information Sheet will include a section that allows for a patient to initial that the patient has been made aware of the financial assistance policy.

7. **AGB – Amount Generally Billed**

   Amounts billed to patients who qualify for Reduced-Cost Sliding Scale Financial Assistance.

8. **Medical Debt**

   "Medical Debt" means out-of-pocket expenses, excluding co-payments, coinsurance, and deductibles, for medical costs billed by a hospital.

9. **Payment Plans**

"Payment Plans" are payment plans offered on a Medical Debt owed for services rendered to patients who are not eligible for Free Care in accordance with guidelines as may be established and amended by appropriate regulatory agencies and further described in the MedStar Billing and Collection Policy.

Responsibilities

1. MedStar Health will widely publicize the MedStar Health Financial Assistance Policy by:

1.1 Providing access to the MedStar Health Financial Assistance Policy, Financial Assistance Applications, and MedStar Health Patient Information Sheet on all hospital websites and patient portals.

1.2 Providing hard copies of the MedStar Health Financial Assistance Policy, MedStar Health Uniform Financial Assistance Application, and MedStar Health Patient Information Sheet to patients upon request.

1.3 Providing hard copies of the MedStar Health Financial Assistance Policy, MedStar Health Uniform Financial Assistance Application, and MedStar Health Patient Information Sheet to patients upon request by mail and without charge.

1.4 Providing notification and information about the MedStar Health Financial Assistance Policy by:

1.4.1 Offering copies as part of all registration or discharges processes and answering questions on how to apply for assistance.
1.4.2 Providing written notices on billing statements.
1.4.3 Displaying MedStar Health Financial Assistance Policy information at all hospital registration points, including the business office, informing patients of their rights to apply for financial assistance and who to contact at the hospital for additional information.
1.4.4 Translating the MedStar Health Financial Assistance Policy, MedStar Health Uniform Financial Assistance Application, and the MedStar Health Patient Information Sheet into primary languages that constitute the lesser of 1000 individuals or 5% of the overall population within the city or county in which the hospital is located as measured by the most recent census.

1.5 MedStar Health will provide public notices yearly in local newspapers serving all hospital target populations.

1.6 Providing samples documents and other related material as attachments to this Policy:

1.6.1 Appendix #1 – MedStar Health Uniform Financial Assistance Application
1.6.2 Appendix #2 – MedStar Health Patient Information Sheet
1.6.3 Appendix #3 – Translated language listing for all significant populations with Limited English Proficiency (documents will be available upon request and on hospital websites and patient portals).
1.6.4 Appendix #4 – Hospital Community Served Zip Code listing
1.6.5 Appendix # 5 – MedStar Health Financial Assistance Data Requirement Checklist
1.6.6 Appendix #6 – MedStar Health Financial Assistance Contact List and Instructions for Obtaining Free Copies and Applying for Assistance
1.6.7 Appendix #7 – MedStar Health FAP Eligible Providers

1.7 The MedStar Health Patient Information Sheet shall be provided to the patient, the patient's family, or the patient's authorized representative:

1.7.1 Before discharge;
1.7.2 With the hospital bill;
1.7.3 On request; and
1.7.4 In each written communication to the patient regarding collection of the hospital bill.

2. MedStar Health will provide a financial assistance probable and likely eligibility determination to the patient within two business days from receipt of the initial MedStar Health Uniform Financial Assistance Application.

2.1 Probable and likely eligibility determinations will be based on:

2.1.1 Receipt of an initial submission of the MedStar Health Uniform Financial Assistance Application.

2.2 The final eligibility determination will be made and communicated to the patient based on receipt and review of a completed application.

2.2.1 Completed application is defined as follows:

2.2.1.a All supporting documents are provided by the patient to complete the application review and decision process.
- See Appendix #5 – MedStar Health Financial Assistance Data Requirement Checklist.

2.2.1.b Application has been approved by MedStar Health Leadership consistent with the MedStar Health Adjustment Policy as related to signature and dollar limits protocols.

2.2.1.c Pending a final decision for the Medicaid application process.

2.3 On receipt of a completed application, MedStar Health will make a final eligibility determination within 14 days. During this period, any billing and collection actions will be suspended.

3. MedStar Health believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Financial assistance and Payment Plans available under this policy will not be available to those patients who fail to fulfill their responsibilities. For purposes of this policy, patient responsibilities include:

3.1 Comply with providing the necessary financial disclosure forms to evaluate their eligibility for publicly-funded healthcare programs, charity care programs, and other forms of financial assistance. These disclosure forms must be completed accurately, truthfully, and timely to allow MedStar Health's facilities to properly counsel patients concerning the availability of financial assistance.

3.1.1 All patients must provide proof of residency within the defined hospital service area. Proof of residency documentation would include gas and electric bills, pay stubs, bank statements, rent statements, etc. Patient must first apply for Medical Assistance, Medical Assistance Emergency Services, and other coverage program(s) eligibility.

3.2 Working with MedStar Health hospital Patient Advocates and Patient Financial Services staff to ensure there is a complete understanding of the patient's financial situation and constraints. Staff are trained to work with the patient, the patient's family, and the patient's authorized representative in order to understand:

3.2.1 The patient's bill;

3.2.2 The patient's rights and obligations with regards to the hospital bill, including the patient's rights and obligations with regards to reduced-cost medically necessary care due to a financial hardship;

3.2.3 How to apply for State Medical Assistance Programs and any other programs that may help pay the hospital bill; and

3.2.4 How to contact the hospital for assistance.

3.3 Making applicable payments for services in a timely fashion, including any payments made pursuant to deferred and periodic payment schedules.

3.4 Providing updated financial information to MedStar Health hospital Patient Advocates or Customer Service Representatives on a timely basis as the patient's financial circumstances may change.

3.5 It is a patient's responsibility, during their 12-month eligibility period, to notify MedStar Health of their existing household eligibility for Free Care, Reduced Cost-Care, and/or eligibility under Financial Hardship provisions for medical necessary care received during the 12-month eligibility period.

3.6 In the event a patient fails to meet these responsibilities, MedStar Health reserves the right to pursue additional billing and collection efforts. In the event of non-payment billing, and collection efforts are defined in the MedStar Health Billing and Collection Policy. A free copy is available on all hospital websites and patient portals via the following URL: **www.medstarhealth.org/FinancialAssistance**, or by call customer service at 1-800-280-9006.

4. Patients of MedStar Health's hospitals and hospital-based physician practices may be eligible for full financial assistance or partial sliding-scale financial assistance as set forth under this policy. The Patient Advocate and Patient Financial Services staff will determine eligibility for full financial assistance and partial sliding-scale financial assistance based on review of income for the patient and their family (household), other financial resources available to the patient's family, family size, and the extent of the medical costs to be incurred by the patient.

5. **ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE**

5.1 Federal Poverty Guidelines. Based on household income and family size, the percentage of the then-current Federal Poverty Level (FPL) for the patient will be calculated.

5.1.1 Free Care: Free Care (100% Financial Assistance) will be available to uninsured and underinsured patients with household incomes between 0% and 200% of the FPL. FPL's will be updated annually.

5.1.2 Reduced Cost-Care: Reduced Cost-Care will be available to uninsured and underinsured patients with household incomes between 201% and 400% of the FPL. Reduced Cost-Care will be available based on a sliding-scale as outlined below. Discounts will be applied to amounts generally billed (ABG). FPL's will be updated annually.

5.1.3 In determining the family income of a patient, a hospital shall apply a definition of household size that consists of the patient and, at a minimum, the following individuals:

5.1.3.a A spouse, regardless of whether the patient and spouse expect to file a joint federal or State tax return;
5.1.3.b Biological children, adopted children, or stepchildren; and
5.1.3.c 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 the following individuals:

5.1.3.d Biological parents, adopted parents, or stepparents or guardians;
5.1.3.e Biological siblings, adopted siblings, or stepsiblings; and
5.1.3.f Anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.

5.2 Basis for Calculating Amounts Charged to Patients: Free Care or Reduced-Cost Care Sliding Scale Levels:

	Financial Assistance Level Free / Reduced-Cost Care	
Adjusted Percentage of Poverty Level	**HSCRC-Regulated Services**	**Washington Hospitals, Hospital-Based Physician Practices, and non-HSCRC Regulated Services**
0% to 200%	100%	100%
201% to 250%	40%	80%
251% to 300%	30%	60%
301% to 350%	20%	40%
351% to 400%	10%	20%
more than 400%	no financial assistance	no financial assistance

5.3 **MedStar Health Hospitals and Hospital-Based Physician Practices** will comply with IRS 501(r) requirements on limiting the amounts charged to uninsured patients seeking emergency and medically necessary care.

5.3.1 The MedStar Health calculation for AGB will be the amount Medicare would allow for care, including amounts paid or reimbursed and amounts paid by individuals as co-payments, co-insurance, or deductibles.

5.3.2 Amounts billed to patients who qualify for Reduced-Cost Sliding Scale Financial Assistance will not exceed the AGB.

Example:

GROSS CHARGES	MEDICARE ALLOWABLE AGB AMOUNT	**PATIENT ELIGIBLE FOR SLIDING SCALE ASSISTANCE	FINANCIAL ASSISTANCE AMOUNT APPROVED AS A % OF THE MEDICARE ALLOWABLE AGB AMOUNT	PATIENT RESPONSIBILITY
$1,000.00	**$800.00**	**40%**	**$320.00**	**$480.00**
****Sliding Scale % will vary per Section 5.2 - Basis for Calculating Amounts Charge Patients in this Policy**				

5.4 MedStar Health will not collect additional fees, including interest, in an amount that exceeds the established charges for the hospital service for which the Medical Debt is owed on a bill for a patient who is eligible for Free or Reduced-Cost care under the MedStar Health Financial Assistance Policy.

6. FINANCIAL ASSISTANCE: ADDITIONAL FACTORS USED TO DETERMINE ELIGIBILITY FOR FINANCIAL ASSISTANCE: FINANCIAL HARDSHIP.

6.1 MedStar Health will provide Reduced-Cost Care to patients, both uninsured and underinsured, with household incomes between 201% and 500% of the FPL that, over a 12-month period, have incurred Medical Debt at the same hospital or hospital-based physician practice in excess of 25% of the patient's household income. Reduced Cost-Care will be available based on a sliding-scale as outlined below.

6.2 A patient receiving Reduced-Cost Care for Financial Hardship and the patient's immediate family members shall receive/remain eligible for Reduced Cost medically necessary care when seeking subsequent care for 12 months beginning on the date that the reduced-care was received. It is the responsibility of the patient to inform the MedStar Health hospital and hospital-based physician practice of their existing eligibility under a Financial Hardship during the 12-month period.

6.3 If a patient is eligible for Free Care / Reduced-Cost Care, and Financial Hardship, the hospital and hospital-based physician practice will employ the more generous policy to the patient.

6.4 Financial Hardship Reduced-Care Sliding Scale Levels:

	Financial Assistance Level – Financial Hardship	
Adjusted Percentage of Poverty Level	**HSCRC-Regulated Services**	**Washington Hospitals, Hospital-Based Physician Practices, and non-HSCRC Regulated Services**
201% to 500%	**Not to Exceed 25% of Household Income**	**Not to Exceed 25% of Household Income**

EXAMPLE: Financial Hardship Calculation		
12 - Month Medical Debt (A)	**Annual Household Income**	**% Medical Debt to Annual Household Income**
$25,000	**$50,000**	**50%**
25% Annual Household Income / Patient Responsibility (B)		
$12,500		
Financial Hardship Allowance = (A) less (B)		
$12,500		

7. **METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE: INCOME AND ASSET DETERMINATION**.

7.1 Patients may obtain a Financial Assistance Application and other informational documents:

7.1.1 On Hospital Websites and Patient Portals via the following URL: **www.medstarhealth.org/FinancialAssistance**;
7.1.2 From MedStar Health hospital Patient Advocates and/or Admission / Registration Associates; or
7.1.3 By contacting Patient Financial Services Customer Service.
- See Appendix #6 – Financial Assistance Contact List and Instruction for Obtaining Free Copies and How to Apply for Assistance.

7.2 MedStar Health will evaluate the patient's financial resources **EXCLUDING**:

7.2.1 The first $250,000 in equity in the patient's principal residence.
7.2.2 Retirement assets for which the IRS has granted preferential treatment as a retirement account, including deferred-compensation plans qualified under the Internal Revenue Code or non-qualified deferred-compensation plans

7.2.3 The first $10,000 in monetary assets e.g., bank account, stocks, CD, etc.

7.2.4 One motor vehicle used for the transportation needs of the patient or any family member of the patient.

7.2.5 Any resources excluded in the determining financial eligibility under Medical Assistance Programs under the Social Security Act.

7.2.6 Prepaid higher education funds in a State specific 529 Program account.

Monetary assets excluded from the determination of eligibility for Free and Reduced-Cost Care shall be adjusted annually for inflation in accordance with the Consumer Price Index.

7.3 MedStar Health will use the MedStar Health Uniform Financial Assistance Application as the standard application. MedStar Health will require the patient to supply all documents necessary to validate information to make eligibility determinations.

7.4 Financial assistance applications and support documentation will be applicable for determining program eligibility one (1) year from the application date. Additionally, MedStar Health will consider for eligibility all accounts (including bad debts) 240 days after the initial bill is provided.

7.5 Patients to whom discounts, payment plans, or financial assistance are extended have continuing responsibility to provide accurate and complete financial information.

8. PRESUMPTIVE ELIGIBILTY

8.1 Patients already enrolled in certain means-tested programs are deemed eligible for Free Care on a presumptive basis. Examples of programs eligible under the MedStar Health Financial Assistance Program include but are not limited to:

8.1.1 Federal Supplemental Nutrition Assistance Program (SNAP);
8.1.2 Maryland Temporary Cash Assistance (TCA);
8.1.3 All Dual eligible Medicare / Medicaid Program – SLMB QMB;
8.1.4 All documented Medicaid Spend Down amounts as documented by Department of Social Services;
8.1.5 Patients living in a household with children enrolled in the free or reduced-cost meal program;
8.1.6 State’s Energy Assistance Program;
8.1.7 Federal Special Supplemental Food Program for Women, Infants, and Children (WIC);
8.1.8 Patients receiving benefits from any other social service program as determined by the Department and the Commission; and
8.1.9 Out of State Medicaid Programs.

MedStar Health will continually evaluate any publicly-funded programs for eligibility under the Presumptive Eligibility provision of this policy.

8.2 Additional presumptively eligible categories will include with minimal documentation:

8.2.1 Homeless patients as documented during the registration/clinical intake interview processes.
8.2.2 Deceased patients with no known estate based on medical record documentation, death certificate, and confirmation with Registrar of Wills.
8.2.3 MedStar Health will utilize automated means test scoring campaigns and databases to determine presumptive financial assistance eligibility. Patients determined to have income scoring up to 200% of the FPL will be deemed presumptively eligible for Free Care.

8.3 Patients found to be eligible for Presumptive Eligibility, as defined in Sections 8.1 and 8.2 of this policy, are automatically waived from Program Exclusions as defined in the Exclusion section of this policy.

9. MEDSTAR HEALTH FINANCIAL ASSISTANCE APPEALS

9.1 In the event a patient is denied financial assistance, the patient will be provided the opportunity to appeal the MedStar Health denial determination.

9.2 Patients are required to submit a written appeal letter to the Director of Patient Financial Services with additional supportive documentation. Contact information for submission an appeal will be found on the MedStar Health denial determination letter sent to the patient.

9.3 Appeal letters must be received within 30 days of the financial assistance denial determination.

9.4 Financial assistance appeals will be reviewed by a MedStar Health Appeals Team. Team members will include the Director of Patient Financial Services, Assistance Vice President of Patient Financial Services, and the hospital's Chief Financial Officer.

9.5 Denial reconsideration decisions will be communicated, in writing, within 30 business days from receipt of the appeal letter.

9.6 The patient or the patient's authorized representative may request the assistance of the Health Education and Advocacy Unit's (HEAU) in filing and mediation of reconsideration requests. Requests for assistance should be directed to:

Health Education and Advocacy Unit
200 St Paul Place
Baltimore, Maryland 21202
Email - heau@oag.state.md.us

Telephone Number: (410) 528-1840, or 1 (877) 261-8807
Fax Number: (410) 576-6571

HEAU Website: https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx

9.**7** If the MedStar Health Appeals Panel upholds the original denial determination, the patient will be offered a Payment Plan in order to facilitate payment.

10. PAYMENT PLANS

10.1 Patients to whom discounts, Payment Plans, or financial assistance are extended have continuing responsibilities to provide accurate and complete financial information. In the event a patient fails to meet these continuing responsibilities, MedStar Health will pursue collections of open patient balances per the MedStar Health Corporate Billing and Collection Policy. MedStar Health reserves the right to reverse financial assistance account adjustments and pursue payment for original balances owed.

11. BAD DEBT RECONSIDERATIONS AND REFUNDS

11.1 In the event a patient who, within a two (2) year period after the date of service was found to be eligible for Financial Assistance on that date of service, MedStar Health will initiate a review of the account(s) to determine the appropriateness for a patient refund for amounts collected exceeding $5. MedStar Health may reduce the 2-year period to no less than 30 days after the date the hospital requests information from a patient, or the guarantor of a patient, to determine the patient's eligibility for Free Care at the time of service, if the hospital documents the lack of cooperation of the patient or the guarantor of a patient in providing the requested information.

11.2 It is the patient's responsibility to request an account review and provide the necessary supportive documentation to determine Free Care financial assistance eligibility.

11.3 If the patient fails to comply with requests for documentation, MedStar Health will document the patient's non-compliance. The patient will forfeit any claims to a patient refund or Financial Assistance.

11.4 If MedStar Health obtains a judgment or reports adverse information to a credit reporting agency for a patient who was later to be found eligible for financial assistance, MedStar Health will seek to vacate the judgment or strike the adverse information.

11.5 If a patient is enrolled in a means-tested government health care plan that requires the patient to pay out-of-pocket for hospital services, a hospital shall provide for a refund that complies with the terms of the patient's plan

Exclusions

1 **PROGRAM EXCLUSIONS**

The MedStar Health Financial Assistance Program excludes the following from financial assistance eligibility:

1.1 Patients seeking non-medically necessary services, including cosmetic procedures.

1.2 Patients residing outside a hospital's defined zip code service area, except that certain waivers may be made for:

1.2.1 Patient referrals within the MedStar Health System.
1.2.2 Patients arriving for emergency treatment via land or air ambulance transport.

1.3 Patients who are non-compliant with enrollment processes for publicly funded healthcare programs, charity care programs, and other forms of financial assistance.

****

This Page Intentionally Left Blank

****