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: UM Upper Chesapeake Health	◉	○	
Your hospital's ID is: 210049	◉	○	
Your hospital is part of the hospital system called University of Maryland Medical System	◉	○	
The primary hospital community benefit (HCB) Narrative contact at your hospital is Kimberly Theis (primary); Dr. Roderick King	◉	○	
The primary HCB Narrative contact email address at your hospital is ktheis@umm.edu (primary); Roderick.King@umm.edu	◉	○	
The primary HCB Financial report contact at your hospital is Steve Bowman	◉	○	
The primary HCB Financial report contact email at your hospital is sbowman@umm.edu	◉	○	

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

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

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

Quantitative Data: Existing Secondary Data: Statistical data was compiled from various sources, including demographic analysis, social and economic factors, education, morbidity and mortality, incident rates, and other health statistics. Sources are publicly available and can be easily accessed. It should be noted that due to the COVID-19 pandemic, there were limitations in obtaining up-to-date data. Harford County Community Health Survey: An online community survey of Harford County residents was conducted between October 2023 and February 2024. The community survey aimed to gather data on demographics, access to care, health behaviors, and health status. A total of 2,242 resident surveys were completed. Respondents had a diverse, geographical, gender, race, and ethnic background, however, the survey could not be weighted to offer a statistically representative sample of the community. Qualitative Data: Stakeholder and General Public Focus Groups: To gain a better understanding of community efforts that are in place, a key informant focus group was conducted. The focus group consisted of a series of 7 questions on Kahoot! (a game-based learning platform), so that respondents could answer directly on their phone. Questions aimed to identify the problems/concerns of the community, as well as the strengths and resources available to the residents. The focus group was concluded with a discussion of possible solutions to the barriers identified. Following the key informant focus group, a similar concept was repeated for the general population, with 8 total questions asking for their view of the health and community strengths and barriers. Groups from various backgrounds were contacted to participate in a focus group. This resulted in 4 focus groups, which included the Susquehanna Ministerium (Harford County Faith Based Group), Spanish Speaking Residents, Minority Health Community Advisory Board Members, and Seniors/Caregivers.

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

CHNA 2024 Primary Data.docx
9.5MB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

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

Q8. The next group of questions asks about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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.

- [x] 21001
- [x] 21005
- [x] 21009
- [x] 21010
- [x] 21013
- [x] 21014
- [x] 21015
- [x] 21017
- [x] 21018
- [x] 21028
- [x] 21034
- [x] 21040
- [x] 21047
- [x] 21050
- [x] 21078
- [x] 21082
- [x] 21084
- [x] 21085
- [x] 21087
- [x] 21111
- [x] 21130
- [x] 21132
- [x] 21154
- [x] 21160
- [x] 21161

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

- [ ] Based on ZIP codes in your Financial Assistance Policy. Please describe.

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

- [ ] Based on patterns of utilization. Please describe.

- [x] Other. Please describe.

The Harford County CHNA includes all 21 Harford County zip codes. This includes zip codes where our most vulnerable populations reside (21009, 21040, 21001 and 21078). In keeping with University of Maryland Upper Chesapeake Health's mission of maintaining and improving the health of the people in its communities and providing high quality care to all, the CBSA was identified as all of Harford County. While the above four zip codes are identified as containing concentrated areas of poverty, there are pockets of poverty throughout many of the Harford County zip codes particularly in the northern zip codes where it is very rural. Identifying all of Harford County as the CBSA gives the organization a better opportunity to meet the needs of the vulnerable residents of Harford County.

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

https://www.umms.org/uch/about/mission-vision-values

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

The demographic profile of the respondents who completed the online survey: Approximately 66% of all respondents reside in zip codes 21014, 21078, 21015, 21009, 21001 and 21050. Of the total 2,242 respondents, 73% were female and 26% were male. Whites comprise 79.29% of study participants and Blacks/African-Americans represented 14.25%. Approximately 2% of all respondents identify as Latino/Hispanic. Approximately 42% of all respondents were age 65 and above. An additional 38% of all respondents were between the ages of 45 and 64 years. The marital status, education level, employment status, and income level were also assessed for each respondent. The majority of respondents (65.43%) are married. Approximately 9.78% of respondents were single (never married) and 11.84% were divorced. The marital status, education level, employment status, and income level were also assessed for each respondent. The majority of respondents (65.43%) were married. Approximately 9.78% of respondents were single (never married) and 11.84% were divorced. 13.19% of respondents attained a high school diploma or GED and below. Approximately one-third (31.37%) of respondents attained some college or technical school, and 55.45% of respondents had an undergraduate degree or higher. The majority of respondents were retired or currently employed and working full-time (38.01% and 45.42% respectively). In addition, more than half of the respondents (59.8%) had an annual household income of $75,000 or more. 7.8% of respondents indicated that they had a household income of less than $25,000. A high portion of respondents had heath care coverage (96%) and 73% said they have at least one provider or family doctor that they can go to once a year for routine checkups, vaccines, or minor illnesses.

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)

6/11/2024

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

https://www.umms.org/uch/community/assessment-and-implementation-plan

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

CHNA 2024.pdf.pdf
16.5MB
application/pdf

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

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

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

	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:
Clinical Leadership (facility level)	☐	☐	☑	☐	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Clinical Leadership (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Population Health Staff (facility level)	☐	☐	☑	☐	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Population Health Staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Community Benefit staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Physician(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Senior Vice President/CMO Medical Staff Affairs reviews to assu community benefit activities are addressing the three identified n the CHNA
	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:
Nurse(s)	☐	☐	☑	☑	☑	☐	☑	☑	☐	☐	
	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:
Social Workers	☐	☐	☑	☐	☐	☐	☑	☑	☐	☐	

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

Q45. Section II - CHNAs and Stakeholder Involvement Part 3 - Internal Hospital Community Benefit Partners

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

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

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Clinical Leadership (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Population Health Staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Community Benefit staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Physician(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Several of our employed physicians participated in community education for the community and community partners (ie., faith based community, EMS), such as webex presentations, tv, radio, and podcasts on various health topics.
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:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Local Health Departments -- Please list the Local Health Departments here: Harford County Health Department	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Local Health Improvement Coalition -- Please list the LHICs here: Behavioral Health, Chronic Disease Prevention & Wellness, and Family Health & Resilience	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Maryland Department of Health	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Other State Agencies -- Please list the agencies here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Govt. Organizations -- Please list the organizations here: Bel Air Police Department, Harford County Council, Harford County Emergency Service, Harford County Government, Harford County Government Planning & Zoning, Harford County Sheriff's Office, Harford County Office on Aging, Harford County Parks & Rec, Harford County Public Libraries, and Town of Bel Air	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Faith-Based Organizations	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
School - K-12 -- Please list the schools here: Harford County Public Schools	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
School - Colleges, Universities, Professional Schools -- Please list the schools here: Harford Community College and Towson University	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Behavioral Health Organizations -- Please list the organizations here: Addictions Connection Resource, Addiction Recovery Systems, Ashley Addiction Treatment, BHA Maryland Commitment to Veterans, Brantwood Family Services, Char Hope Foundation, Core Services Agency, Department of Juvenile Services, District Court of Maryland for Harford County, Empowering Minds Resource Center, Hannah's Hope, Harbor of Grace Recovery, Harford County Detention Center, Harford County Volunteer Fire and EMS Foundation, Maryland Circuit Court, Maryland Coalition of Families, Medmark Treatment Centers, New Day Wellness and Recovery Center, Norkris Services, Northern Chesapeake Counseling, LLC, Office of Drug Control Policy, OIC Counseling Services, Inc., Opioid Operational Command Center, Pyramid Healthcare, Riverside Treatment, Springboard Community Services, The Bergand Group, The Homecoming Project, Upper Bay Counseling, and Voices of Hope	☑	☑	☑	☑	☐	☑	☐	☐	☑	☑	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Social Service Organizations -- Please list the organizations here: Harford County Department of Social Services and Department of Community Services	☑	☑	☑	☑	☐	☑	☐	☐	☑	☑	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Post-Acute Care Facilities -- please list the facilities here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	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: Breathe 379, Epicenter, Girls on the Run, Horowitz Center for Health Literacy, Klein's Shoprite, LASOS (Linking All So Others Succeed), Mason-Dixon Community Services, National Coalition of 100 Black Women, Leukemia & Lymphoma Society, United Way of Central Maryland, and Y of Central Maryland	☑	☑	☑	☑	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other -- If any other people or organizations were involved, please list them here: CareFirst, Habitat for Humanity, Inner County Outreach, Joyce Steinberg – Pharmacist, Meghan Crosby Budinger, LCPC, LLC, Mosaic Group, Seedco, The Judy Center, and United Healthcare	☑	☑	☑	☑	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐

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

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

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

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

- (●) Yes
- ( ) No

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

6/11/24

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

https://www.umms.org/uch/community/assessment-and-implementation-plan

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

UM UCH Implementation Strategy 2024.pdf
336.5KB
application/pdf

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

This question was not displayed to the respondent.

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

While our CHNA identifies our priorities as Chronic Disease Prevention and Wellness, Behavioral Health and Family Stability, we provide a variety of other community benefit programs and activities that are outside of these three priority areas.

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.

- [ ] Health Conditions - Addiction
- [ ] Health Conditions - Arthritis
- [ ] Health Conditions - Blood Disorders
- [ ] Health Conditions - Cancer
- [ ] Health Conditions - Chronic Kidney Disease
- [ ] Health Conditions - Chronic Pain
- [ ] Health Conditions - Dementias
- [ ] Health Conditions - Diabetes
- [ ] Health Conditions - Foodborne Illness
- [ ] Health Conditions - Health Care-Associated Infections
- [ ] Health Conditions - Heart Disease and Stroke
- [ ] Health Conditions - Infectious Disease
- [ ] Health Conditions - Mental Health and Mental Disorders
- [x] Health Conditions - Oral Conditions
- [ ] Health Conditions - Osteoporosis
- [ ] Health Conditions - Overweight and Obesity
- [ ] Health Conditions - Pregnancy and Childbirth
- [ ] Health Conditions - Respiratory Disease
- [ ] Health Conditions - Sensory or Communication Disorders
- [ ] Health Conditions - Sexually Transmitted Infections
- [ ] Health Behaviors - Child and Adolescent Development
- [ ] Health Behaviors - Drug and Alcohol Use
- [ ] Health Behaviors - Emergency Preparedness
- [ ] Health Behaviors - Family Planning
- [ ] Health Behaviors - Health Communication
- [ ] Health Behaviors - Injury Prevention
- [ ] Health Behaviors - Nutrition and Healthy Eating
- [ ] Health Behaviors - Physical Activity
- [ ] Health Behaviors - Preventive Care
- [ ] Health Behaviors - Safe Food Handling
- [ ] Health Behaviors - Sleep
- [ ] Health Behaviors - Tobacco Use
- [ ] Health Behaviors - Vaccination
- [ ] Health Behaviors - Violence Prevention
- [ ] Populations - Adolescents
- [ ] Populations - Children
- [ ] Populations - Infants
- [ ] Populations – LGBT
- [ ] Populations - Men
- [ ] Populations - Older Adults
- [ ] Populations - Parents or Caregivers
- [ ] Populations - People with Disabilities
- [ ] Populations - Women
- [ ] Populations - Workforce
- [ ] Settings and Systems - Community
- [ ] Settings and Systems - Environmental Health
- [ ] Settings and Systems - Global Health
- [ ] Settings and Systems - Health Care
- [ ] Settings and Systems - Health Insurance
- [ ] Settings and Systems - Health IT
- [ ] Settings and Systems - Health Policy
- [ ] Settings and Systems - Hospital and Emergency Services
- [ ] Settings and Systems - Housing and Homes
- [ ] Settings and Systems - Public Health Infrastructure
- [ ] Settings and Systems - Schools
- [ ] Settings and Systems - Transportation
- [ ] Settings and Systems - Workplace
- [ ] Social Determinants of Health - Economic Stability
- [ ] Social Determinants of Health - Education Access and Quality
- [ ] Social Determinants of Health - Health Care Access and Quality
- [ ] Social Determinants of Health - Neighborhood and Built Environment
- [ ] Social Determinants of Health - Social and Community Context
- [ ] Other Social Determinants of Health
- [ ] Other (specify)

Q60. Why were these needs unaddressed?

Oral health in Harford County is addressed by the Harford County Health Department through a Dental Care Clinic. The dental clinic provides services to include oral health of children ages 1 -20 enrolled in the Maryland Children's Health Program (MCHP), and pregnant women on the Medical Assistance Program who may not have previously had access to dental care. The clinic is also committed to treating same-day dental emergencies involving infection and trauma. In addition, an FQHC, Beacon Health Center, provides dental services to include pediatric and adult preventative and restorative care, replacement care with dentures, partials, and bridges, emergency care such as extractions and root canals, and cosmetic care.

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

Our Comprehensive Care Center (CCC) and Care Transformation Organization (CTO) programs provide participants with interdisciplinary teams that manage medical and social challenges as a way of reducing health disparities in our community. Comprised of RNs, SWs, CHWs and supported by behavioral health specialists and a pharmacist, these teams engage with patients- even directly in the patient's home. Early identification of medical issues and social barriers to care is critical to reducing health disparities. UMUCH assists practices with implementing standardized screening tools, including the Patient Health Questionnaire (PHQ-9) and other evidence-based instruments that help to match patients with resources. The CCC and CTO have also developed analytical tools that drive continuous improvement. For example, our Data Warehouse highlights the heightened readmission risk for patients with COPD within four days of discharge. As a result, these patients are prioritized such that care now results in a virtual visit with a nurse prior to the PCP appointment. UMUCH has initiated practice transformation activities through the NCQA PCMH program. The patients in both the CCC and CTO are screened for social determinant of health. We are working with EPIC to develop tracking reports. In addition, UMMS has developed a multi-year plan, backed by a $40 million investment, that outlines our commitment to equity in care delivery, diversity in our workforce, meaningful investments in local communities and expanded opportunities for minority-owned businesses.

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

- [x] None
- [ ] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program

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

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

Q64. Section III - CB Administration

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

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

Q66. Please describe the third party audit process used.

After the completion of audits performed by hospital staff and the hospital system's staff, a final audit is conducted by Earnest and Young, LLP.

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

- (●) Yes
- ( ) No

Q68. Please describe the community benefit narrative audit process.

The Director of Community Outreach and Health Improvement and the Community Benefit and Community Health Improvement Business Manager are responsible for the oversight and management of data collection and reporting of all activities. Data is collected throughout the year, validated, and entered into CBISA, a Community Benefit Inventory for Social Accountability Program by Lyon's Software. The director and manager refer to the Catholic Health Association's "A Guide for Planning & Reporting Community Benefit" guide to determine which category is most appropriate for reporting activities. Once the data collection process is been completed, a draft of the State of Maryland Community Inventory Report is generated and submitted to the Director of Reimbursement, who is the UM UCH financial lead for community benefit reporting. The Director of Reimbursement completes the State of Maryland Inventory Report to include hospital related financial data. Once the narrative and inventory report are complete, it is reviewed by the internal hospital Community Benefit Reporting Advisory Committee and the UMMS Senior Director of Community Health. It is then presented through Quality Care Council for Board of Director's approval.

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

- (●) Yes
- ( ) No

Q70. Please explain:

This question was not displayed to the respondent.

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

- (●) Yes
- ( ) No

Q72. Please explain:

This question was not displayed to the respondent.

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

- (●) Yes
- ( ) No

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

University of Maryland Upper Chesapeake Health incorporates community benefit planning into the annual strategic and operational planning process each Spring. This includes creating annual tactics that are tracked on a quarterly basis in the following fiscal year. In addition, UM UCH updates a long term strategic plan every couple of years in association with the community health needs assessment. The planning process allows the organization to invest in and develop programs that increase patient access to existing services, introduce new services, optimize prevention programs and explore how technology can be used to support the health needs of our patients. The planning process runs concurrently with the annual capital and operating budget process to ensure that these ideas are incorporated into the fiscal plan.

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

UM UCH delivers the year-long diabetes prevention lifestyle change program with fidelity to all CDC Diabetes Prevention Recognition Program (DPRP) Standards. We have received full recognition for in person and combination class recognition. During FY24, we provided 12 cohorts, of which 8 cohorts started and 4 cohorts concluded.

There are other activities that are being done to address these issues, but they do not meeting the definition of a community benefit.

- [x] Opioid Use Disorder - Improve overdose mortality

Participation in stakeholder meetings and committees to address opioid use and overdose mortality:
• Overdose Fatality Review Board
• Law Enforcement Assisted Diversion (LEAD) Operational Workgroup
• Mental Health Advisory Council
• Recovery Planning Committee
• LHIC MHAAC-LHIC-OIT Behavioral Health Workgroup – Local Health Improvement Coalition (LHIC), Mental Health and Addictions Advisory Council (MHAAC), Overdose Intervention Team (OIT)

There are other activities that are being done to address these issues, but they do not meeting the definition of a community benefit.

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

Participation in statewide collaborations:
• Maryland Perinatal-Neonatal Quality Collaborative
• Maryland Perinatal Education Consortium
• NICU/SCN Antibiotic Stewardship Collaborative
• Child Fatality Review

There are other activities that are being done to address these issues, but they do not meeting the definition of a community benefit.

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

Created and implemented a Pediatric Asthma Program to provide 1:1 follow-up asthma education to children/caregivers who are seen in UCH EDs for treatment of asthma ages 2-18.

☐ 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.

UMMS%20Financial%20Assistance%20Policy%20070124%20English.pdf
310KB
application/pdf

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

https://www.umms.org/patients-visitors/umms-financial-assistance/policy-and-form

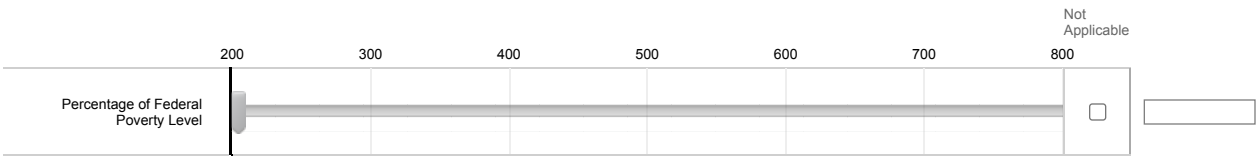
Q83. Has your FAP changed within the last year? If so, please describe the change.

○ No, the FAP has not changed.

◉ Yes, the FAP has changed. Please describe: Federal Poverty Level and Maryland Department of Health Annual Income Eligibility Limit Updated

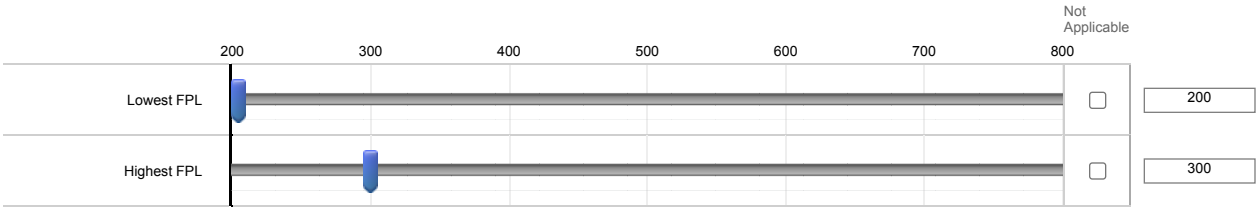
Q84. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



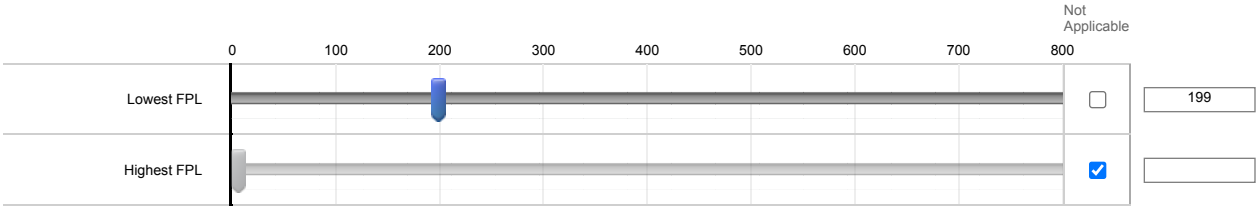
Q85. Maryland acute care and chronic care hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

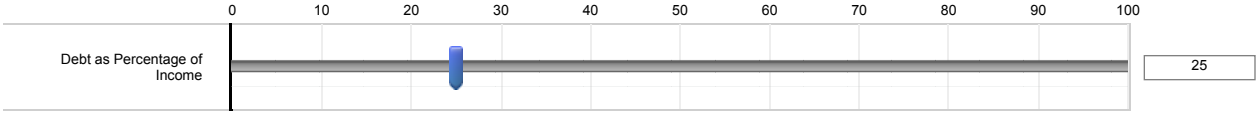


Q86. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3)(a) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

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



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



Q88. Section VI - Tax Exemptions

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

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

Q90. Summary & Report Submission

Q91.

Attention Hospital Staff! IMPORTANT!

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

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

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

Location Data

Location: (39.26, -76.7125)

Source: GeoIP Estimation

PRIMARY DATA COMMUNITY HEALTH SURVEY

Background

The customized survey consisted of 50 questions to assess access to care, health status and behaviors, and health-related community strengths and opportunities. The online survey took respondents approximately 15-20 minutes to complete. 2,242 total respondents completed the survey, which is a 65% increase from the previous Community Health Needs Assessment (CHNA) Survey in 2021.

The following section provides an overview of the findings from the CHNA Survey including highlights of important health indicators and health disparities. The sample was not representative of the population of Harford County based on age, race, and sex. When looking at the data, please take this into consideration.

Demographic Info

Tables 1 and 2 depict the demographic profile of the respondents who completed the online survey.

Table 1. ZIP Code Representation

ZIP Code (City)		ZIP Code (city)	
21014 (Bel Air)	15.55%	21040 (Edgewood)	6.28%
21078 (Havre de Grace)	13.27%	21047 (Fallston)	5.35%
21015 (Bel Air south)	10.91%	21085 (Joppa)	4.63%
21009 (Abingdon)	9.84%	21084 (Jarrettsville)	2.23%
21001 (Aberdeen)	8.86%	21154 (Street)	2.05%
21050 (Forest Hill)	7.66%	Other	8.55%

Table 2. Demographic Information

Demographics	Percentage
Gender	
Male	26%

Female	73%
Preferred not to answer	
Age	
18-44	20%
45-65	38%
65+	42%
Race/Ethnicity	
White	79.29%
African American/Black	14.25%
Hispanic/Latino*	1.92%
Asian	2.23%
Middle Eastern	.31%
Other	.49%

*Hispanic/Latino respondents can be of any race, for example, White Hispanic or Black/African American Hispanic

The marital status, education level, employment status, and income level were also assessed for each respondent. The majority of respondents (65.43%) were married. Approximately 9.78% of respondents were single (never married) and 11.84% were divorced. 13.19% of respondents attained a high school diploma or GED and below. Approximately one-third (31.37%) of respondents attained some college or technical school, and 55.45% of respondents had an undergraduate degree or higher. The majority of respondents were retired or currently employed and working full-time (38.01% and 45.42% respectively). In addition, more than half of the respondents (59.8%) had an annual household income of $75,000 or more.

7.8% of respondents indicated that they had a household income of less than $25,000.

Table 3. Demographic Information

Demographics	Percentage

Demographics	
Marital Status	
Married	65.43%
Divorced	11.84%
Widowed	8.49%
Separated	1.25%
Never Married	9.78%
Member of an unmarried couple	3.22%
Education Level	
Never attended school or only kindergarten	.04%
Grades 1-8	
Grades 9-11	.98%
Grade 12	11.92%
College 1-3 Years	29.91%
College 4 or more Years	26.79%
Graduate Level Degree	28.21%
Other	2.01%
Employment Status	
Employed, full time	45.42%
Employed, part time	8.29%
Not employed, looking	1.84%
Not employed, not looking	.83%
Retired	38.01%
Disabled, not able to work	3.24%
Student	.79%
Homemaker	1.58%

Annual Household Income	Percentage
Less than $10,000	2.27%
$10,000 - $24,999	5.55%
$25,000 - $49,999	11.99%
$50,000 - $74,999	17.41%
$75,000 - $99,000	15.42%
$100,000 - $149,000	23.59%
$150,000 +	20.57%

Access to Healthcare

The survey reported that 96% of respondents had health care coverage and 73% said they have at least one provider or family doctor that they can go to once a year for routine checkups, vaccines, or minor illnesses. The sources of health insurance are detailed in Table 4.

Table 4. Source of Health Insurance Coverage

Health Insurance Source	
Medicare/Advantage	51%
Commercial Insurance/private Insurance	46%
TriCare (Military)	7%
Medicaid/Medical Assistance (MCHP)	
Don't know/Not sure	

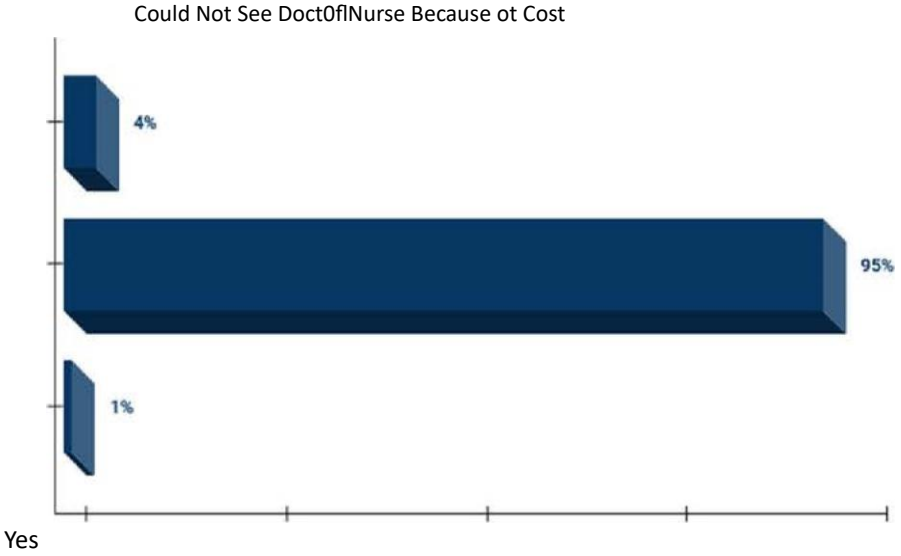
Uninsured/self-pay	

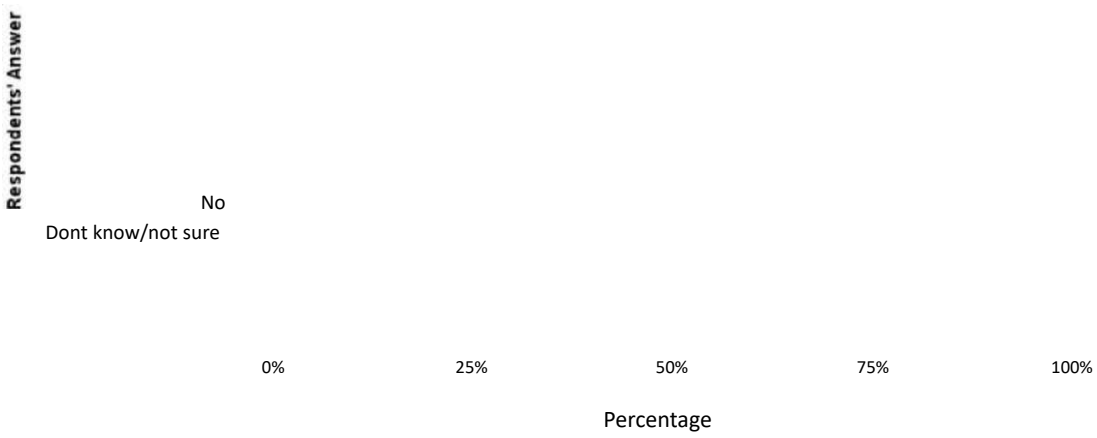
In addition, 92% of respondents had a routine checkup within the past year and 6% had one within the last 2-5 years. The responses are detailed in Table 5.

Table 5. Routine Checkup

How long since last visited a doctor for a routine checkup?	
Within the past year (anytime less than 12 months ago)	92%
Within 2 to 5 years	
5 or more years ago	1%
Don't know/Not sure	
Never had a routine physical or doctor's visit	0%

About 4% of respondents said that they needed to see a doctor but could not because of cost in the past 12 months, which was 2% lower than the previous survey, 3 years ago.





Respondents were asked if they were delayed in getting needed medical care in the past 12 months for any of the following reasons, see Table 6. 72% said they did not delay getting medical care or did not need medical care. Of those that were delayed, 18% said they could not get an appointment soon enough/ 8% said they could not get through on the telephone, 5% said the wait was too long once in the office, and another 5% said they did not trust the doctor/healthcare.

Table 6. Delayed Medical Care

Have you delayed getting needed medical care for any of the following reasons in the past 12 months?	
No, I did not delay getting medical care/did not need medical care.	72%
You couldn't get an appointment soon enough.	18%
You couldn't get through on the telephone.	8%
Lack of trust in doctor(s)/healthcare.	5%
Once you got there, you had to wait too long to see the doctor.	5%
Other (please specify)	4%
You didn't have transportation.	2%
The clinic/doctor's office wasn't open when you got there.	

Respondents were asked if they travel outside of Harford County to seek medical care and 49% said yes. Table 7 details the type of care received outside of the county.

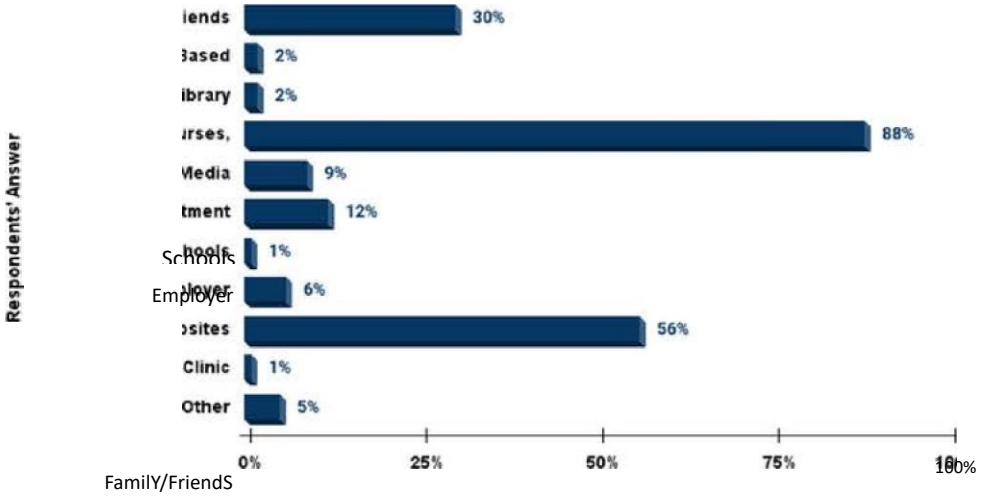
Table 7. Medical Care Received from Outside of Harford County

Medical Care Received	# of Respondents
Primary Care	70
Surgery	50
OBIGYN	26
Dermatology	24
Neurology	20
Orthopedic	18
Dental Care	18
Cancer Care	17
Rheumatologist	14
Cardiac	2

Health Information

Respondents were asked where they get their health information and 88% said doctors, nurses, pharmacists, or from a hospital, followed by 56% who said they also get their information from the internet or websites. The graph below shows all the sources that respondents say they use.

Where Do You Get Your Health Intormation?



FamilY/FriendS

Faith Based

Public Library Doctors. Nurses.

Social Media

Health Department

InternetWebsites

Community Clinie

Percentage

Health Status & Chronic Health Issues

Overall Physical & Mental Health

Respondents were asked to rate their general health status. Approximately 74.7% of respondents stated their general health is good or very good. Approximately 16% of respondents stated their general health is fair or poor. Respondents were also asked to rate their overall physical and mental health. In general, selfreported measures of poor physical and mental health days were favorable among Harford County respondents. 38.74% and 45.54% of respondents reported having no poor physical health (including physical illness and injury) or mental health (including stress, depression, and problems with emotions) days during the past 30 days, respectively. 26.92% of respondents reported having poor physical health and 23.77% reported having poor mental health for a maximum of only one to two days during the past 30 days.

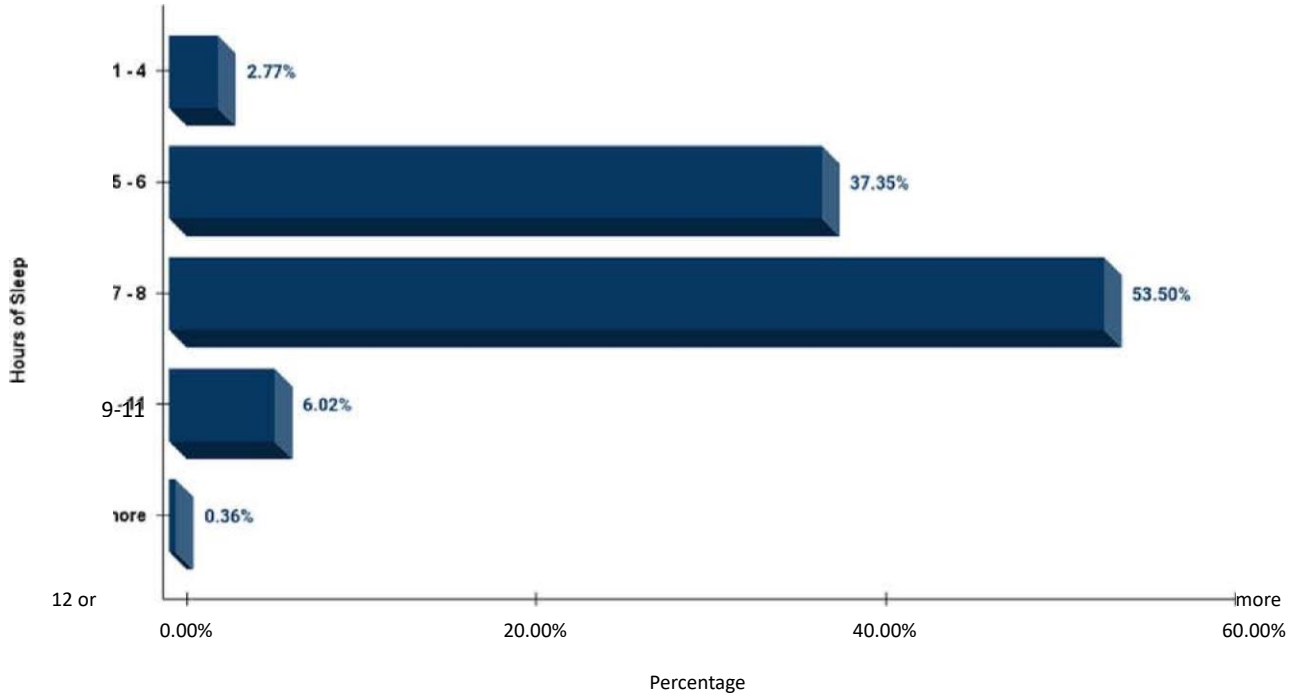
Table 8: Number of Days per Month Physical/Mental Health Has Not Been Good

	Physical Health	Mental Health
	Percentage	Percentage
No Days	38.74%	45.54%
1-2 Days	26.92%	23.77%
3-7 Days	18.48%	15.33%
8-14 Days	7.60%	7.95%
15-30 Days	7.55%	6.49%

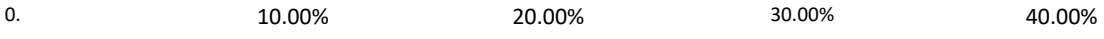
Sleep

Respondents were also asked how many hours of sleep they get in a 24-hour period, on average. The vast majority of respondents (90.85%) reported getting 5 to 8 hours of sleep and 6.38% reported getting 9 or more hours of sleep. An average of 7 to 8 hours of sleep is recommended for adults by the National Sleep Foundation.

Average Amount of Sleep


Hours of Sleep
1 - 4
5 - 6
7 - 8
9 - 11
12 or more
2.77%
37.35%
53.50%
6.02%
0.36%
0.00%
20.00%
40.00%
60.00%
Percentage

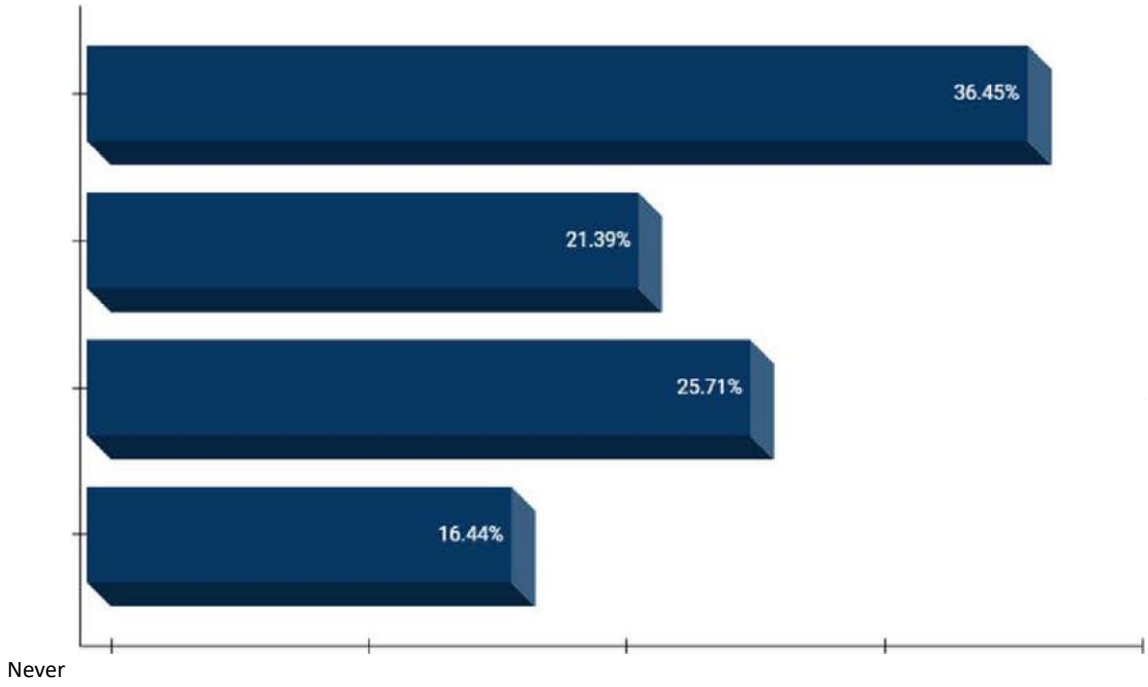
Physical Activity


0.
10.00%
20.00%
30.00%
40.00%

percentage

It is widely supported that physical activity can reduce health concerns such as obesity and overweight, heart disease, and joint and muscle pain. It is recommended that individuals regularly engage in at least 30 minutes of moderate physical activity, preferably daily, and at least 20 minutes of vigorous physical activity several days a week. Approximately 63.54% of respondents reported that they have participated in physical activities or exercises such as running, calisthenics, golf, gardening, or walking during the past month.

How Often Did You Take Part in Physical Activity for 30 Minutes or More per Week?



Dietary Behaviors

Respondents were asked about their consumption of fruits and vegetables. 45%-50% of respondents reported that they consumed fruits and vegetables at least 1-3 times per week.

Table 9: Frequency of fruit and vegetable consumption

	Fruits	Vegetables
1-3 Times per week	45.67%	50.67%
4-6 Times per week	29.62%	31.58%
7 or more times	18.15%	12.53%
Never	6.56%	5.22%

Participants were also asked about the frequency in which they consume sugar sweetened beverages. This includes sodas, flavored juice drinks, sports drinks, sweetened tea, coffee drinks, energy drinks, and electrolyte replacement drinks. "Never" and "1-3 times per week" reported an equal number of respondents at 37.81% each.

Table 10: Sugar Sweetened Drink Consumption

Times per Week	
Never	37.81%
1-3 Times per week	37.81%
4-6 Times per week	11.47%
7 or more times	12.9%

Chronic Conditions

Some chronic conditions are of concern in Harford County, including high cholesterol, high blood pressure, anxiety disorder and depressive disorder. Approximately 49.73% of respondents have been told they have high cholesterol and 50.09% have high blood pressure. In addition, 18.72% of respondents have been told they have cancer. 27.72% of respondents have been told they have an anxiety disorder and 23.26% have been told they have depressive disorder. Respondents also mentioned other chronic conditions that they have been diagnosed with but were not included in the survey list. Hyper/hypothyroidism and obesity were the most frequently mentioned conditions. A summary of chronic condition diagnoses among respondents is reported in the Table below.

Table 11: Chronic Condition Diagnosis

Chronic Condition	%
High Blood Pressure	50.09%
High Cholesterol	49.73%
Arthritis	42.83%
Anxiety Disorder	27.72%
Depressive Disorder	23.26%
Cancer	18.72%
Asthma	17.34%
Diabetes	16.93%
Heart Disease	13.99%
Autoimmune Disease	13.73%
Chronic Obstructive Pulmonary Disease (COPD)	5.48%
Heart Attack	4.46%
Stroke	4.14%

Health Risk Factors

Health Behaviors

Respondents were asked how often they practice certain health and safety practices. As detailed in Table 12, respondents were highly likely to use health and safety measures including wearing a seatbelt, driving responsibly, practicing safe sex, and using sunscreen regularly.

In addition, respondents were less likely to misuse illegal drugs, use electronic cigarettes or tobacco, use marijuana, or eat fast food more than once a week. However, 40% of respondents reported exercising 30 minutes a day, 3 times a week, 18% wear a helmet while riding a bicycle, riding a scooter, rollerblading, etc., and 10% feel stressed out or overwhelmed "always" or "most of the time."

Table 12. Health and Safety Practices

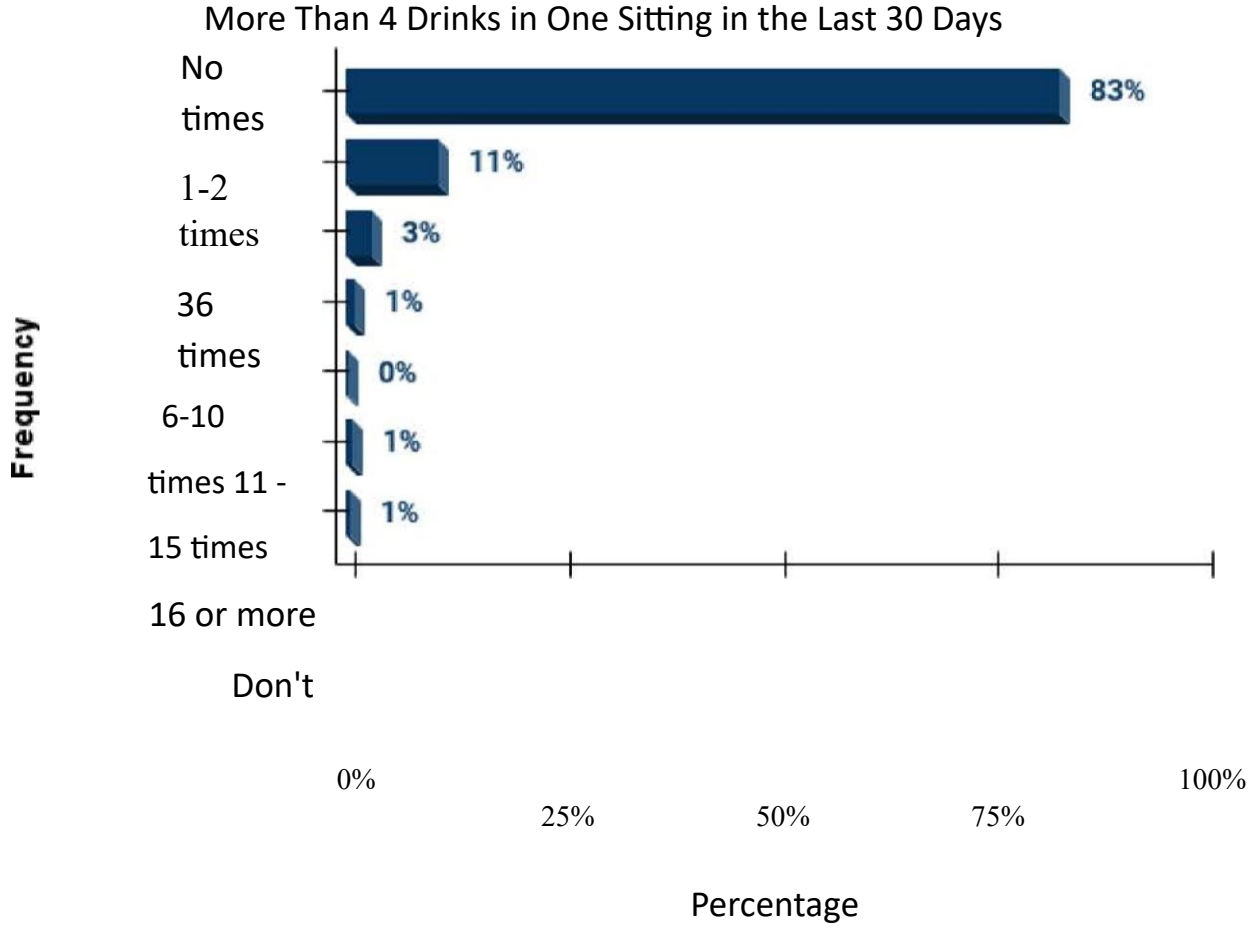
How often do you do the following?	% of respondents who said "always" or "most of the time".	% of respondents who said "sometimes"	0 of respondents who sai "rarely" or "never"	Not available responses
Wear a seatbelt	98%	0%	1%	0%
Wear a helmet while riding a bicycle, scooter, rollerblading, etc.	18%	2%	8%	71%
Eat fast food more than once a week	6%	23%	70%	1%
Use electronic cigarettes/vape	2%	2%	86%	
Use tobacco/nicotine products	4%	3%	85%	9%
Get exposed to secondhand smoke or vaping mist at home or work	3%	6%	84%	8%
Use cannabis (marijuana) products	3%	5%	84%	8%
Misuse prescription drugs, opioids, heroin, or other illegal drugs	0%	0%	93%	
Exercise 30 mins a day, 3 times a week	40%	24%	34%	1%

Use sunscreen regularly	48%	24%	24%	5%
Practice safe sex i.e., use a condom, monogamous, get tested	47%	1%	9%	43%
Feel stressed out or overwhelmed	10%		46%	1%
Drive responsibly, follow safe rules of the road, drive within the speed limit	92%	3%	1%	4%

Alcohol Use

Risky behaviors related to alcohol use were measured as part of the survey. Approximately 11% of respondents reported drinking more than four drinks in one

sitting, at least 1-2 times in the last 30 days.



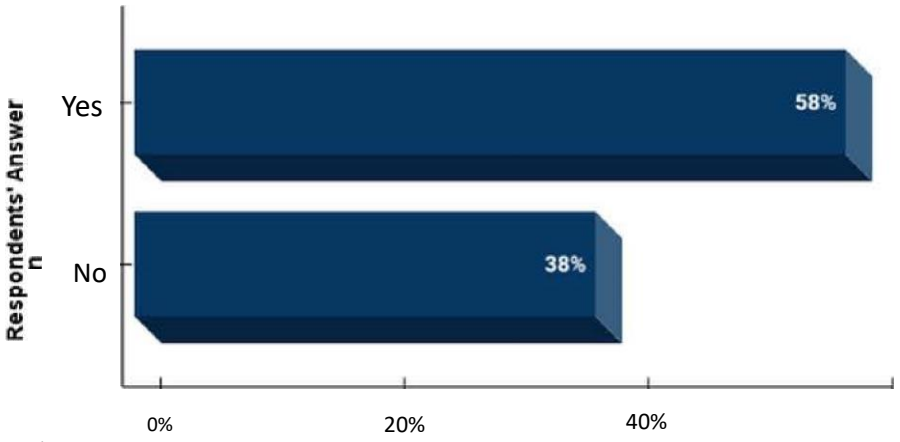
Nutrition

Respondents were asked several questions about their eating habits. When asked how often they drank a sugar-sweetened beverage, 34% said 1-3 times per week. About 47% of respondents said they eat fruit 1-3 times per week and 52% said they eat dark green vegetables 1-2 times per week. Lastly, sodium is closely associated with heart disease. Respondents were asked if they were currently watching or reducing their sodium intake, and 58% said yes.

Table 13. Eating Habits

	Never	1-3 times per week	4-6 times per week	7 or more times per week
How often do you drink a sugarsweetened beverage (non-diet soft drinks/sodas, flavored juice drinks, sports drinks, sweetened tea, coffee drinks, energy drinks, and electrolyte replacement drinks)?	43%	34%		
How often do you eat fruit, not counting juice? Count fresh, frozen, or canned fruit. Do not include jam, jelly, or fruit preserves.		47%	28%	17%
How often do you eat dark green vegetables, for example, broccoli or dark leafy greens such as romaine, chard, collard greens, spinach, or kale?		52%	30%	

Are you currently watching or reducing your sodium or salt intake?



Health Preventive Practices

Immunizations

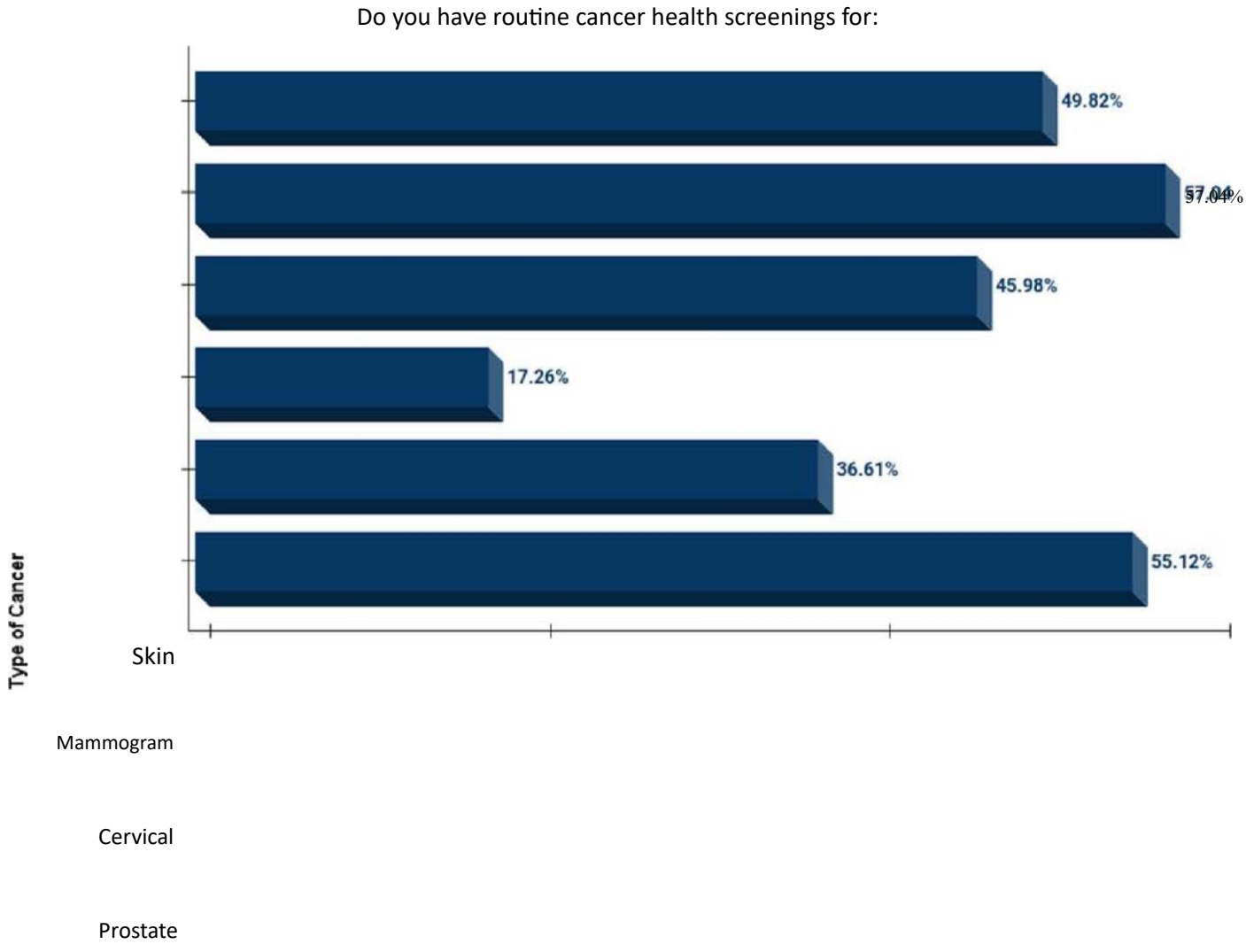
Immunizations are a crucial preventive health practice that is designed to prevent disease, create herd immunity, and reduce morbidity and mortality.

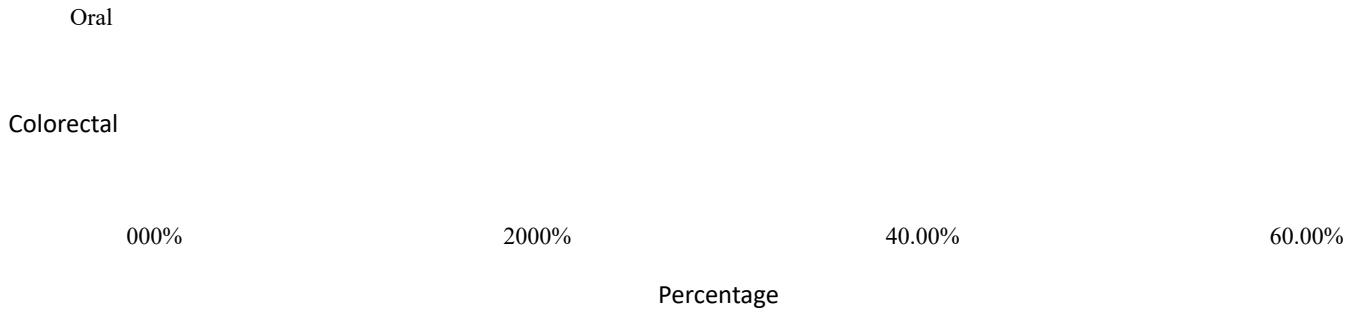
A finding among Harford County survey respondents was the prevalence of immunizations. In the past 12 months, 74.64% of respondents received a flu

vaccine. Additionally, 58.06% said they are up to date on their COVID-19 vaccination.

Screenings

The prevalence of routine health screenings among Harford County respondents varies based on the type of screening. In general, Harford County respondents are less likely to receive oral cancer screenings. Only 49.82% of respondents have routine health screenings for skin-related conditions. Oral/throat health screenings and prostate screenings are also less prevalent among Harford County respondents (36.61% and 17.26% respectively). Larger proportions of respondents participate in routine mammogram screening at 57.04%, and colorectal screenings at 55.12%. The following chart shows participants who responded 'Yes' to receiving specific routine health screenings.





Key Health Issues

Top Health Issues

Respondents were asked what they think are the top 3 most important health issues facing Harford County. They were given 17 choices and from those, the top 3 were overweight/obesity, drug and alcohol misuse, and mental health/suicide. Table 14 shows the percentage of respondents who selected each health issue, in rank order.

Table 14. Top Health Issues

Rank	Health Issue	%
	Overweight/Obesity	50%
2	Drug misuse/Alcohol misuse	50%
3	Mental Health/suicide	38%
4	Cancer	28%
5	Diabetes	21%
6	Heart Disease	21%
7	Access to Care/Uninsured	20%
8	Alzheimer's Disease/Aging Issues	20%
9	Gun violence/mass shooting	13%
10	Tobacco Use/smoking	12%
11	Other (please specify)	7%
12	Dental Health	
13	Child Abuse/Violence	

14	Stroke	
15	Intimate Partner Violence/Abuse	3%
16	Maternal/lnfant Health (Pregnancy) Care	2%
17	Sexually Transmitted Diseases (STDs)	1%

Health Care Barriers

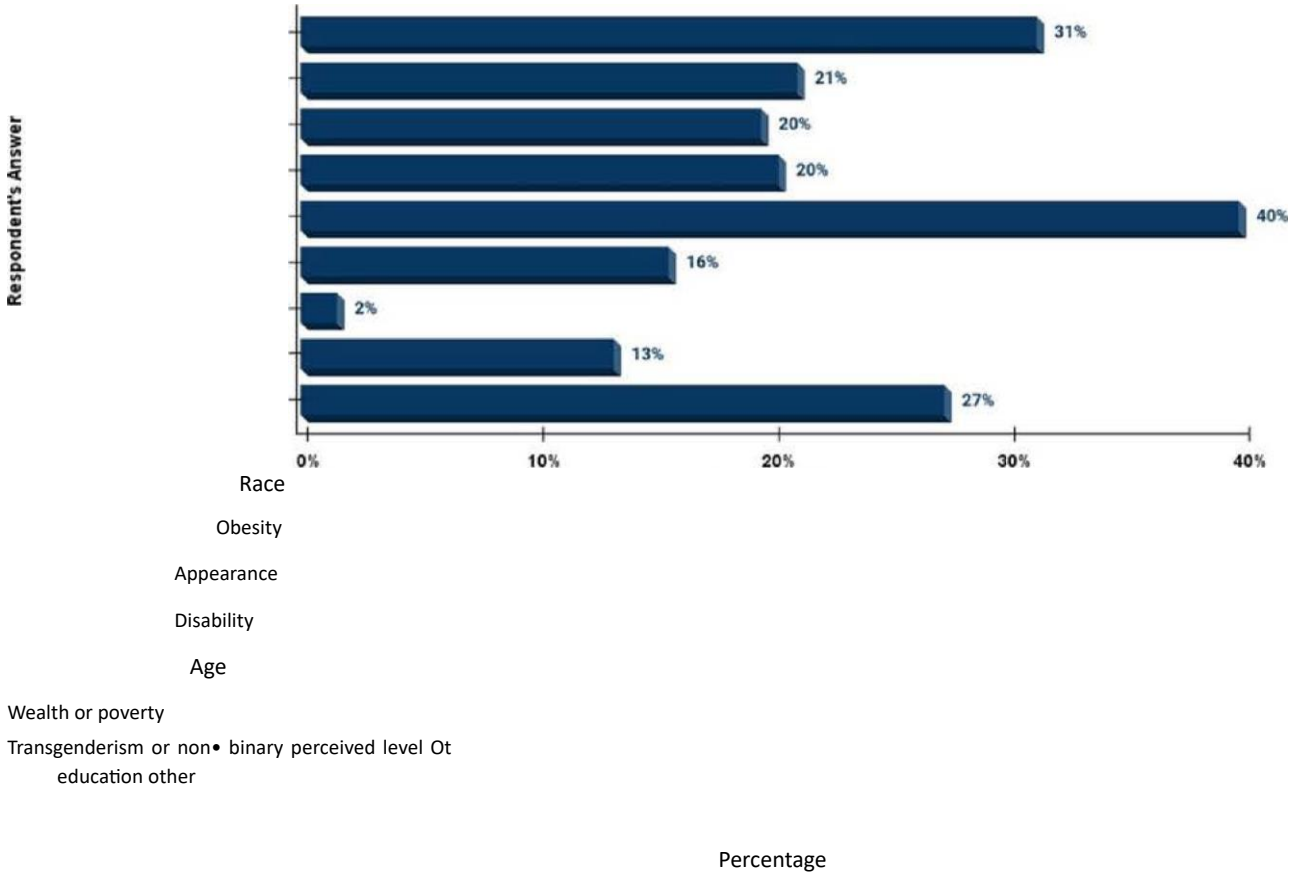
In addition, respondents were asked what they think are the most significant barriers that keep people in the community from accessing health care when needed. The top responses were cost/paying out of pocket, lack of health insurance coverage, and inability to get an appointment.

Table 15. Health Care Barriers

Barrier	%
Cost/Paying Out of Pocket Expenses (Co-pays, Prescriptions, etc.)	71%
Lack of Health Insurance Coverage	61%
Can't Get Appointment	40%
Difficult to Understand/Navigate Health Care System	33%
Can't Find Doctor	24%
Basic Needs Not Met (Food/Shelter)	23%
Lack of Transportation	23%
Lack of Trust	21%
Not enough time	
Lack of Child Care	9%
Other (please specify)	
Lack of language/translation services available	4%
None/No barriers	4%

When respondents were asked if they felt that they were treated unfairly or differently from other patients in a medical setting, 14% said yes and the top reasons were age, race, and obesity; 27% of respondents selected "other" for their reason.

Why do you think you were treated untairly or differently trom other patients?



Resources Needed to Improve Access

Respondents were asked what resources or services they think are needed more of in the community, regarding health. The top suggestions were affordable medication (58%), elder care/senior services (47%), mental health services (45%), free/low-cost dental care (45%), and primary care providers (44%). Table 16 shows the breakdown of all resources needed in the county.

Table 16. Health Resources Needed in the County

Resource	
Affordable Medication	58%
Elder Care/senior Services	47%
Mental Health Services	45%
Free/Low-Cost Dental Care	45%
Primary Care Providers (Family Doctors)	44%

Free/Low-Cost Medical Care	38%
Free/Low-Cost Vision/Eye Care	34%
Substance Use Services	28%
Health Screenings	27%
Medical Specialists (Ex. Cardiologist)	26%
Transportation	21%
Access to Affordable Fresh Fruits and Vegetables	21%
Health Education/Information/Outreach	19%
Immunization/Vaccination Programs	14%
Parks & Recreation Areas	12%
Prenatal Care Services	7%
Other (please specify)	
Don't know/Not sure	6%
Language Services	4%
None	

Risky Behaviors

Respondents were asked what they thought were the three most "risky behaviors" in the community. They were given 13 options and could pick up to three. The top risky behaviors were drug abuse (69%), being overweight (41%), and alcohol abuse (38%). Table 17 includes a listing of risky behaviors in rank order.

Table 17. Top Risky Behaviors

Rank	Risky Behavior	%
1	Drug abuse	69%
2	Being overweight	41%
3	Alcohol abuse	38%
4	Poor eating habits	29%

5	Not getting "shots" or vaccines to prevent disease	27%
6	Gun Violence	24%
7	Lack of exercise	24%
8	Tobacco use	22%
9	Dropping out of school	8%
10	Unsafe sex	7%
11	Not using birth control	
12	Not using seat belts/child safety seats	
13	Other (please specify)	3%

Needs for a Healthy Community/Quality of Life

Respondents were asked what they think are the three most important things needed for a "Healthy Community?." Respondents had 19 options and could pick their top three choices. Access to health care ranked number one (38%), followed by low crime/safe neighborhoods ranking number two (37%), and number three being strong family life (32%). Table 18 shows what community factors respondents thought were most important.

Table 18. Top Needs for a Healthy Community

Rank	Healthy Community Factors	%
1	Access to health care (e.g., family doctor)	38%
2	Low crime/safe neighborhoods	37%
3	Strong family life	32%
4	Good jobs and healthy economy	29%
5	Healthy behaviors and lifestyles	29%
6	Good schools	25%
7	Respect for all persons and groups	23%
8	Affordable housing	21%
9	Religious or spiritual values	19%

10	Good place to raise children	11%
11	Clean environment	9%
12	Responsible gun usage	8%
13	Parks and recreation	5%
14	Excellent race relations	4%
15	Other (please specify)	3%
16	Low adult death and disease rates	2%
17	Low level of child abuse	
18	Arts and cultural events	2%
19	Low infant deaths	

Pediatrics

Survey participants were asked several questions regarding youth. 23.40% of respondents said they have someone living in their home under 18 years of age. This aligns with the county data as a whole where the population ages 0-17 is at 22.10% in 2022. About 7% of those children had to go to the emergency room within the last year of completing this survey.

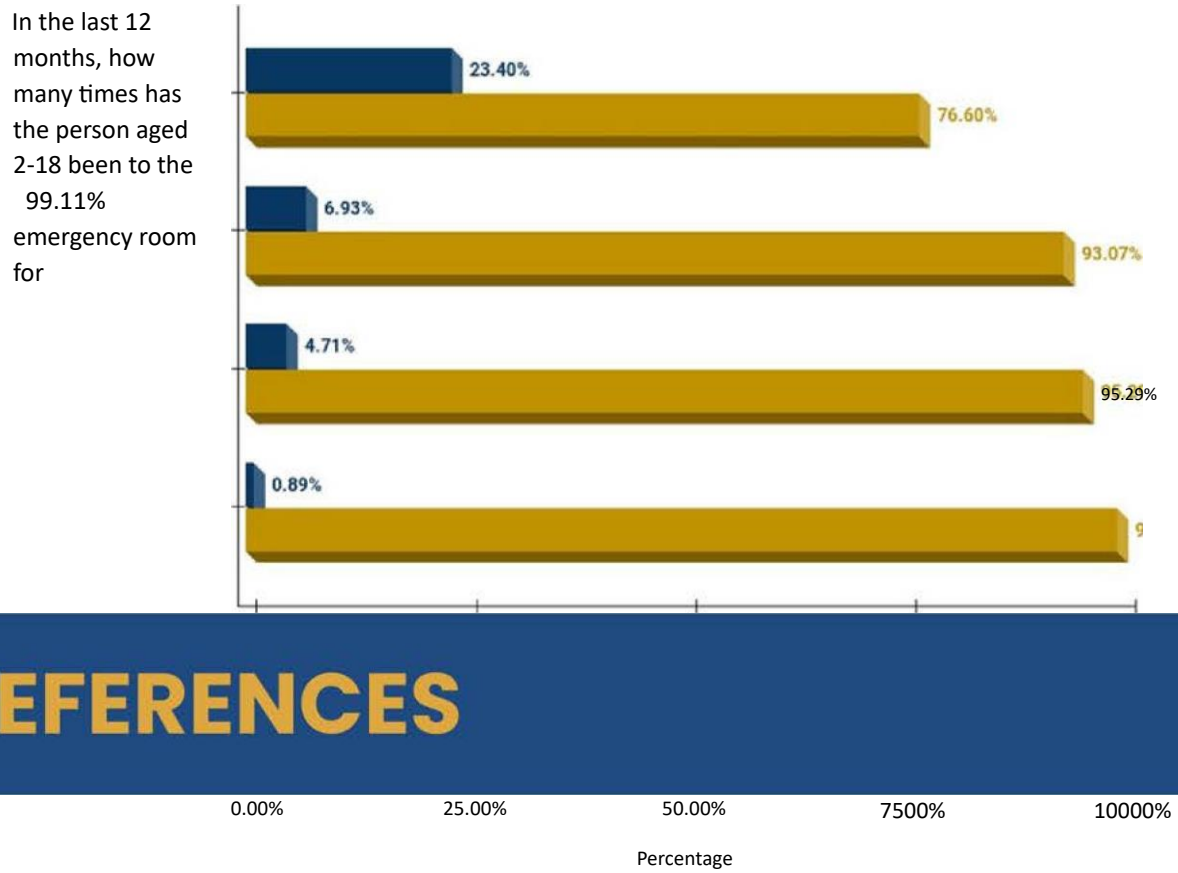
Another area of focus was regarding diagnosed asthma in children. Only 4.7% of participants said someone in their home ages 2-18 was diagnosed with asthma, and of those children, less than 1% used the ED because of their asthma.

Pediatric Questions

Do you have someone jn your household under the age of 18?

In the last year, has someone living in your household under the age of 18 needed to visit the emergency c

- Has someone jn your O household, ages 2•18, been told they have asthma?



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APPENDICES

- Focus Group and Key Informant Survey Summaries
- Harford County Health Equity Report

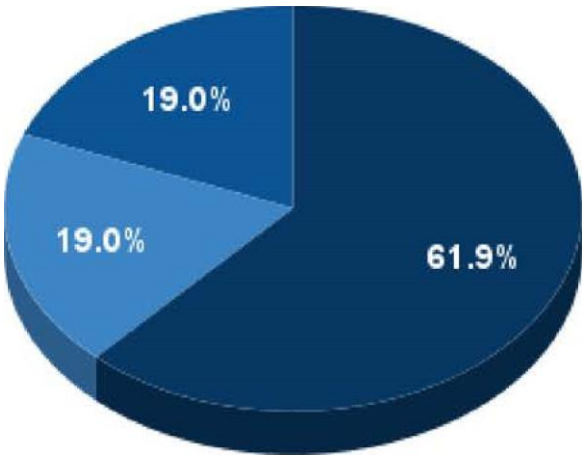
FOCUS GROUP & KEY INFORMANT SURVEY SUMMARIES

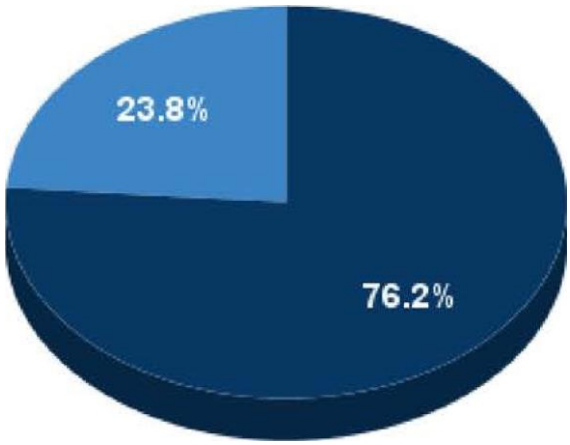
Background

1. The purpose of the focus group and key informant survey was to discuss/report for their community in a few particular areas. In addition, the groups discussed resources currently available in the community to address the problems identified and any barriers to accessing the services.
2. The focus groups were done to prioritize needs, create solutions, and plan for services in Harford County.
3. Each focus group lasted approximately one hour and participants were given the option of being in-person or virtual. Below is just a summary of discussion points from each focus group.
4. The key informant survey was an 8-question survey sent to the Local Health Improvement Coalition stakeholders with a mix of open-ended and rankingstyle questions to give feedback on the health of Harford County.

Demographic Breakdown of Focus Groups

O White Black O Hispanic O Female O Male





Strengths

Barriers

Health Department
Faith-based orgs.
Boys and Girls Clubs
Link Bus (better than nothing)

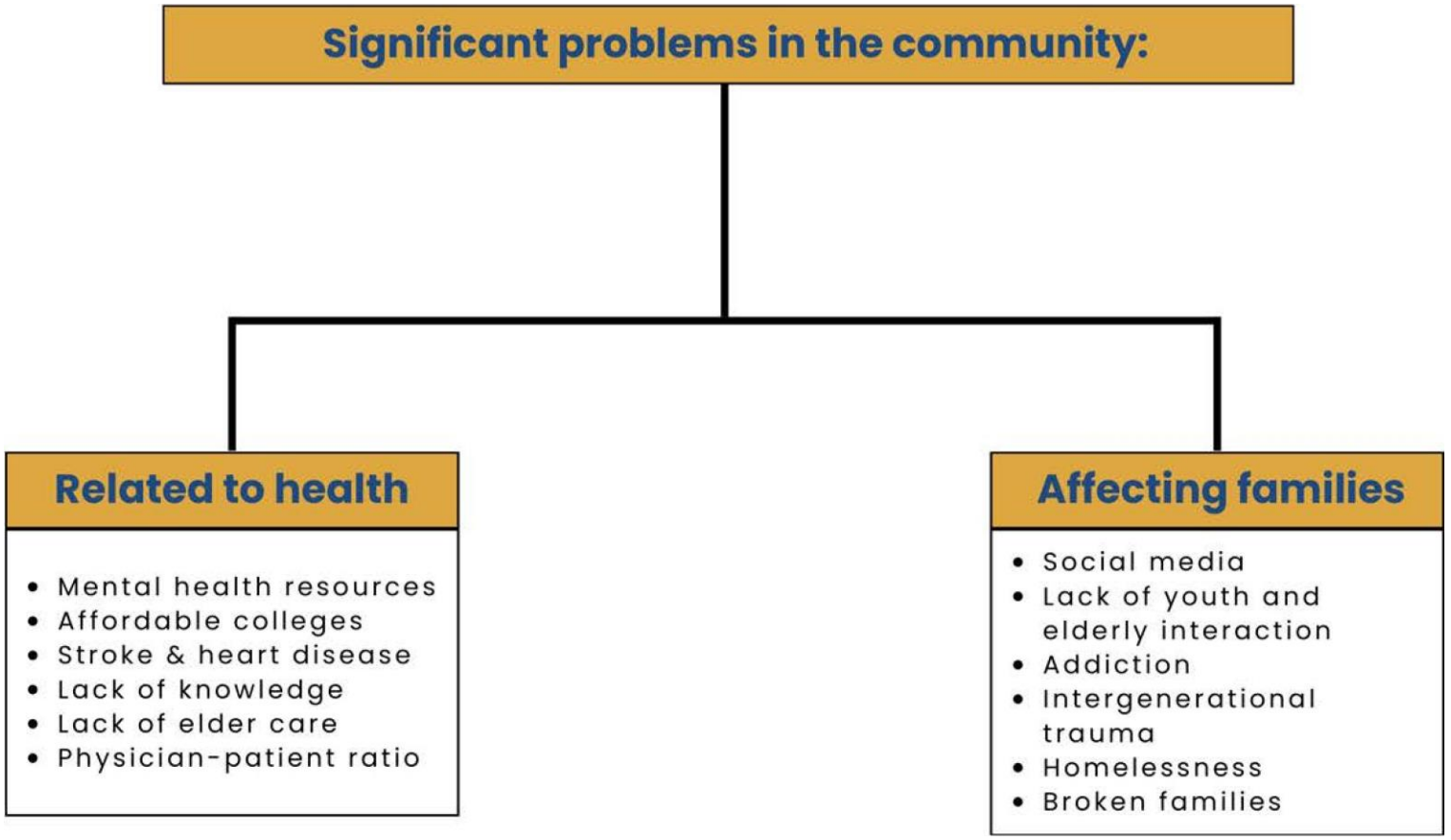
Transportation
Money
Navigating Insurance
Technology
Stigma of mental health

SUSQUEHANNA MINISTERIUM

Date: February 12, 2024

What a healthy & welcoming community looks like:

- Trust
  Equality
  Fearlessness
- Public space



Strengths	Barriers

Women, Infants, and Children (WIC)
Dentists
Head Start Program

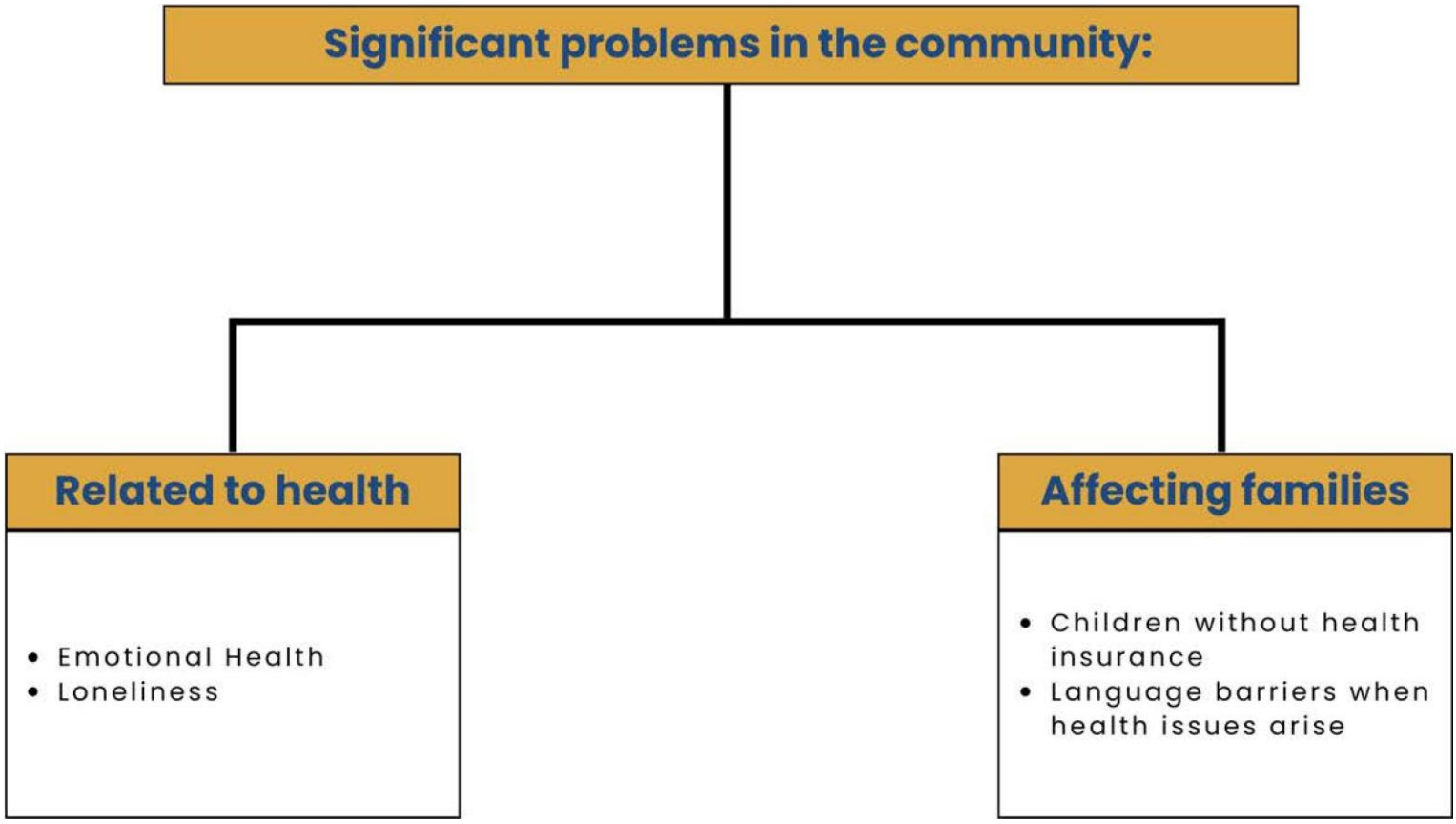
Transportation
- Hours services are available usually conflict with work

SPANISH SPEAKING PARENTS

Date: February 21, 2024

What a healthy & welcoming community looks like:

- No violence
- No drugs/ alcohol
- Everyone is kind and attentive
- Promoting nutrition (blood pressure control)


Significant problems in the community:
Related to health
Emotional Health
Loneliness
Affecting families
Children without health insurance
Language barriers when health issues arise

MINORITY HEALTH

Date: March 7, 2024

What a healthy & welcoming community looks like:
Welcoming & Respectful Equality of services Staffing diversity Safe, clean, secure

SENIORS / CAREGIVERS

Date: February 28, 2024

Significant problems in the community:

Related to health

- Mental Health
- Substance Use
- The System is designed to keep you poor
- Multigenerational caregivers

Affecting families

- Social Media
- Lack of insurance
- Medication dependence
- Single parenting
- Isolation
- Systematic racism

Strengths

Faith-based orgs.

- Collaboration

Minority Health Program

Resources (YMCA, LASOS, CHOSEN)

Barriers

Communication

- Financial

Not having a "It takes a village" mentality

Transportation

What a healthy & welcoming community looks like:

Health promotion activities for all ages

Easily accessible (limited mobility)

- Access to care

Access to information (health literacy)

- Proactive Communication

Significant problems in the community:

Related to health

- Lack of mobility/physical health
- Isolation/Loneliness
- Transportation
- Lack of skills
- Resiliency

Affecting families

- Medical Issues
- Single Income
- Multigenerational homes
- Technology
- Alcohol and drugs

Strengths

Harford community college

Senior Centers

Faith-based organizations

Healthy Harford

Barriers

Money/ Funding

Transportation

The system being too difficult to navigate

- Ability to have knowledge of services and resources
- Political will - speaking up to county reps.

KEY INFORMANTS

Date: December 5, 2023

WHAT A HEALTHY COMMUNITY LOO

Access to healthcare
Affordable Care
Clean Environment
- Equality and Equity

Community Support and Programs

MOST SIGNIFICANT PROBLEMS FACING THE COMMUNITY

- Access and Affordability
- Mental Health
- Transportation
- Disparities
- Substance Use
- Lack of Providers

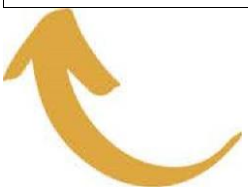
RESOURCES TO ADDRESS THESE ISSUES IN HARFORD COUNTY

- Network and Collaboration of Organizations
- Upper Chesapeake Hospital
  Healthcare Providers
  Funding is available (though slim)
- Data to drive programs

"A community where the people are aware of the health issues within that community, and work effectively to address those issues and achieve positive outcomes."

WHAT WOULD IT TAKE TO MAKE OUR COMMUNITY HEALTHIER	IN THE NEXT...

12 MONTHS	5 YEARS
More funding and programs Outreach and awareness Hiring and resources, more providers Collaborative efforts	More funding and programs Strategic planning Targeted programs • Collaborative efforts



BARRIERS [redacted] TO REACHING SOLUTIONS/GOALS

- Lack of funding
- Stigmatization of seeking help
- Political and Systemic Issues
- Some collaboration is not enough, needs to be community wide

HOW IS HEALTH EQUITY ADDRESSED?

Minority Health Program
Outreach and access
Use of data to identify disparities and inequities

[redacted] IMPACT ON HEALTH FROM COMMUNITY PARTNERSHIPS [redacted]

Expansive reach to all parts of the county
Increase efficiency and eliminate duplicate efforts
Increased awareness of programs and available resources

PublicHealth

Prevent. Promote. Protect.

Health Department

Equity Report 2023

Prepared by

HARFORD COUNTY

HEALTH DEPARTMENT

TABLE OF CONTENTS

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A Healthy Harford County For All

What does a healthy Harford County look like? The answer: Equal access to health opportunities for all residents in Harford County regardless of race/ethnicity, religion, socioeconomic status, gender, age, mental health, cognitive, sensory, or physical disability, sexual orientation or gender identity, or geographic location.

Harford County, located in the northeast region of Maryland, is a mix of rural and suburban development leading outside of Baltimore City. Home to approximately 263,000 residents; Harford County is the sixth largest county in the State and has a population density of 560/sq mi. Harford County's geographical location and abundant opportunities allow many people to thrive in the area. According to the 2021 Census, only 7.8% of residents live in poverty, however taking a closer look at other zip codes in the county shows a greater need to examine different communities throughout the area.

The Harford County Health Department (HCHD) strives to promote public health and prevention in the community for all while helping to minimize barriers to receiving care. This report will describe and explain where and why inequities exist within Harford County, along with how we can improve these issues in our community so that everyone can achieve optimal health.

Health Equity Report



What is Health Equity?

According to the Centers for Disease Control and Prevention, "Health equity is achieved when every person has the opportunity to attain their full health potential and no one is at a disadvantage to achieve that potential because of social position or other socially determined circumstances. Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment."

Health Equity vs. Health Equality

Health equity and health equality might sound the same, but they are actually different concepts. Health equity strives for the highest possible standard of health for all, while health equality means everyone receives the same services. Health equity is achieved when one's health is not affected by their social position or other socially determined circumstances, such as income or race, rather than by providing the same services to all.

Health Disparities & Health Inequities

A health disparity is a difference in health outcomes and their causes among groups of people. For example, a health disparity that exists in Harford County is infant mortality rates which are higher for Non-Hispanic African Americans/Blacks compared to Non-Hispanic White babies. Health inequity is a difference in the

distribution or allocation of a resource between groups. An example of health inequity in Harford County is that adult poverty rates are significantly higher in Edgewood, Aberdeen, and Havre de Grace, and poverty is linked to shorter life expectancy. It is important to work on reducing health disparities in Harford County to achieve health equity for all and improve our lives. By working together and creating meaningful partnerships, we can address health equity to allow members of our community to live the healthiest and longest lives possible.

Social Determinants of Health

Social Determinants of Health (SDOH), conditions in the environment where we are born, live, learn, work, play, worship, and age, affect a wide range of health, functioning, and quality-of-life outcomes and risks. These are non-medical factors that influence health outcomes. There are five determinant areas that make up the underlying factors of the SDOH and contribute to health equity: Education Access and Quality, Health Care and Quality, Neighborhood and Built Environment, Social and Community Context, and Economic Stability.

Economic stability coupled with having low unemployment and poverty rates, allows people to provide for themselves and their families. In the United States, 1 in 10 people live in poverty, and many people cannot afford healthcare, healthy foods, and housing. Many people have trouble finding and keeping a job. Employment programs, career counseling, and high-quality childcare opportunities can help more people find and keep jobs. In addition, policies to help people pay for food, housing, health care, and education can reduce poverty and improve health and well-being. A consistent source of income positively correlates to health improvement.

Education, another area of SDOH, is highly relevant starting with school-age children all the way up to adults.

Early childhood education and development provides a solid foundation for children to learn and thrive at a young age, the effects of which continue to high school and potential enrollment into higher education. Good education also allows for better employment opportunities, which ultimately means better pay and housing stability that contributes to overall health. Persons with higher education levels are more likely to be healthier and live longer.

Having access to health care and primary care options are key areas of SDOH. Healthcare access means that individuals can obtain needed medical services with ease. Primary care is a crucial component of health care because it provides early detection and treatment, management of chronic diseases, and preventive care.

Places of employment may offer health insurance options with lower rates that provide better opportunities for preventive health, such as free/low-cost primary care visits, flu shots, prescriptions, etc., and time to take off work to attend medical appointments.

Language skills, including low health literacy, can also present barriers to access to health care. Health literacy, as defined by the U.S. Department of Health and Human Services (HHS), is the degree to which individuals have the ability to understand and process basic health information, whether from a doctor or from written materials so that they can make appropriate health decisions. Low health literacy, related to poor health outcomes, can be seen in people with both lower education and higher education levels and across certain population groups. Ultimately, if a patient receives any information they cannot comprehend, then that person may make poor decisions regarding their health.

Another area of SDOH, neighborhoods and built environment (the human-made area where we live, work, and play), contributes to health in many ways. Access to foods that allow us to make healthy eating decisions, areas that allow people to walk, bike, or take public transportation safely, and environmental conditions, such as clean air and water are just a few examples of how neighborhoods can affect health outcomes.

Lastly, social and community context reflects another key issue. There is a strong association between social ties and health. For example, strong relationships are important for one's physical and psychosocial well-being and can influence health outcomes through social support such as helping people maintain a healthy diet, reducing emotional stress, and assisting with transportation to see a doctor. Participating in formal and informal activities that are available can also help reduce poor health outcomes. Being able to vote, participating in community watch groups, being a member of an advisory board, and volunteering to help with a community garden are just some activities to help build social capital and a sense of purpose in the community.

By promoting good health and addressing all factors of the SDOH, we can create opportunities for people to live their best, healthiest lives and achieve health equity.

Harford County Health Department has numerous programs that address SDOH to create health equity in our county. By asking our patients and participants what their SDOH needs are, we can help aid these individuals with the resources and services they need.

"A healthy family means having communication and support"

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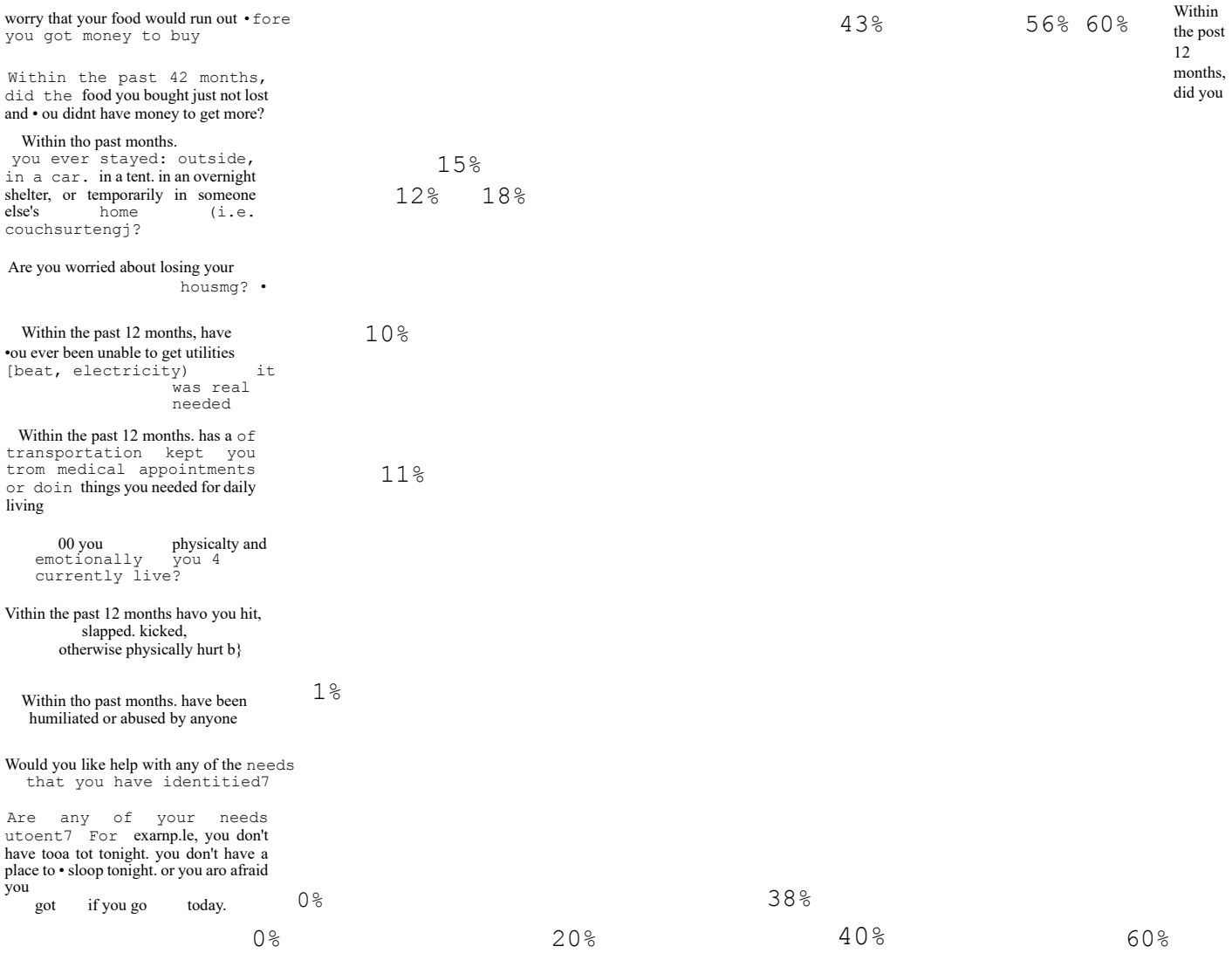
worry that your food would run out • fore you got money to buy
43%
56%
60%
Within the post 12 months, did you
Within the past 42 months, did the food you bought just not lost and • ou didnt have money to get more?
Within tho past months. you ever stayed: outside, in a car. in a tent. in an overnight shelter, or temporarily in someone else's home (i.e. couchsurtengj?
15%
12%
18%
Are you worried about losing your housmg? •
Within the past 12 months, have •ou ever been unable to get utilities [beat, electricity) it was real needed
10%
Within the past 12 months. has a of transportation kept you trom medical appointments or doin things you needed for daily living
11%
00 you physicalty and emotionally you 4 currently live?
Vithin the past 12 months havo you hit, slapped. kicked, otherwise physically hurt b}
Within tho past months. have been humiliated or abused by anyone
1%
Would you like help with any of the needs that you have identitied7
Are any of your needs utoent7 For examp.le, you don't have tooa tot tonight. you don't have a place to • sloop tonight. or you aro afraid you got if you go today.
0%
38%
0%
20%
40%
60%
Percentag e

The above questions are asked to our program participants in order to be able to refer them to the appropriate service that either the HCHD or the community offers, with the goal that their needs will be addressed. Transportation and food access seem to be the largest disparity areas among our participants.

"Transportation is definitely an issue. If someone lives in Edgewood and has to go to Forest Hill for an appointment with no car, how would they get there?"

Our Commitment

The Harford County Health Department is committed to improving health equity in the community and has begun looking into ways to incorporate this concept into our work. The 2019-2024 HCHD Strategic Plan addresses strong awareness regarding the importance of health equity in the community we serve, as well as increasing the understanding of these issues by our employees. HCHD will prioritize increasing the standardization of public health messaging through community outreach workers and increasing the cultural competency of our staff. These objectives will be completed by:

- Working on a unified health promotion, education, and communications strategy.
- Identifying effective cultural competency training.

Additionally, HCHD will look to the Public Health Accreditation Board (PHAB) standards for guidance because they are consistent with essential public health services and align well with the Strategic Plan and Community Health

Improvement Plan (CHIP). Three CHIP priorities, which are being addressed with our Local Health Improvement Coalition (LHIC) workgroups include Behavioral Health, Family Health & Resilience, and Chronic Disease Prevention & Wellness.

Goals of this Report

The objective of this report is to outline the existing health inequities and pinpoint specific areas in Harford County that are most affected by these disparities. Throughout this report, readers will gain a deeper comprehension of the underlying causes that drive these inequities. Additionally, it will showcase the efforts that have been undertaken by the HCHD, alongside other organizations and groups, to address these issues, and will shed light on areas where there is potential for improvement. The report will also empower our community to understand the locations and nature of these inequities while providing the Health Department with invaluable insights to enhance our public service efforts.

METHODS OF [ANALYSIS*

Indicator Selection

Indicators selected for analysis in this report were drawn from a number of sources, including existing community priorities that were determined by HCHDs Community Health Needs Assessment (CHNA), Community Health Improvement Plan (CHIP), and Strategic Plan, and some disease categories based on State Health Improvement Plan (SHIP) priorities. Data were drawn from multiple sources including HCHD Data, Maryland Vital Statistics, United States Census Bureau, Behavioral Risk Factor Survey, and the Maryland Department of Health. Indicators that were selected, but did not have zip code/geographical data were omitted from this report. These indicators may be revisited in the future based on newly available data or increased capacity for data assessment.

Community Geographical Information System (GIS) Mapping

Geographic Information System (GIS) mapping of zip code level data was used to understand where inequities exist in the county based on selected indicators. Harford County comprises 23 zip codes. Maps were created by the Harford County Health Department Population Health Unit and were based on data from the health department and the Chesapeake Regional Information System for our Patients (CRISP), the regional health information exchange (HIE) serving Maryland and the District of Columbia. Other maps were created by the Maryland Department of Health and are identified as such in the report.

Community Input Process

The Harford County Health Department Minority Health Program collects community needs information from the community on a monthly basis to help prioritize their voices. The data that was collected was used to obtain input for the Health Equity Report and to inform stakeholders.

SUMMARY OF NDING

Priority Areas

The three geographic locations highlighted in this assessment include Aberdeen, Edgewood, and Havre de Grace, which are located on the Route 40 and 1-95 corridor; all three have a higher concentration of health issues than the county as a whole. Gaps in behavioral health and substance use treatment were identified, specifically in the Edgewood area. Aberdeen, home to Aberdeen Proving Grounds and the biggest employer in the county, requires greater access to mental health services and chronic disease prevention interventions. Havre de Grace, an area with a higher concentration of risk factors such as mental health and substance-exposed newborns, requires focused prevention efforts and medical care for those experiencing health concerns. The southern region of the county is shown to have more issues, but it should not be overlooked that there are separate health issues in the northern/rural areas such as transportation, poverty, health insurance coverage, sexual health, adverse pregnancy outcomes, and high colorectal cancer rates.

Since 2011, the Centers for Disease Control and Prevention (CDC), has reported on effective public health programs that have helped reduce disparities. By implementing evidence-based programs that advance health equity, the opportunity will arise for people to live longer and healthier lives. As public health professionals and passionate members of our community, it is up to us to make the change we need.

These next few pages will lay a foundation for the future of health equity in Harford County.

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Social Inequities

Social inequities are disparities that are found when comparing population groups by race/ethnicity, class, gender, disability, etc. Inequities often reflect the unequal distribution of resources in a geographic area or within a population. An example of this is fewer educational opportunities.

Whites account for the majority of Harford County's population. Hispanics, Asians, and Native Hawaiians and Pacific Islanders have experienced the most population growth in recent years. The male and female population is evenly split throughout the area.

Each population group may have different needs, which is why it is important to examine groups individually to determine how that group can be served more effectively.

Population By Race and Hispanic Origin, Harford County, Maryland, 2019 and 2021

Harford County	2019 Census	2021 Census	% Change
Total	255,441	262,997	3%
White alone	191,517	191,595	0%
African American / Black	35,826	35,344	
Asian	7,229	8,291	15%
American Indian / Alaskan Native	165	63	-62%

Native Hawaiian and Pacific Islander	92	251	173%
Hispanic	12215	13,344	9%

Population By Race and Hispanic Origin, Aberdeen, Maryland		
Aberdeen	27,379	Percentage
White	15305	55.9%
African American I Black	7803	28.5%
Indian I Alaskan Native	82	.3%
Asian	903	3.3%
Pacific Islander	54	.2%
Hispanic	1917	7%
Multiple Races	1232	4.5%
Other	54	.2%

Population By Race and Hispanic Origin, Edgewood, Maryland		
Edgewood	24,792	Percentage
White	9966	40.2%
African American Black	10958	44.2%
Indian Alaskan Native	74	.3%
Asian	520	2.1%
Pacific Islander	25	

Hispanic	2206	8.9%
Multiple Races	1016	4.1%
Other	25	
[redacted]Population By Race and Hispanic Origin, Havre de Grace, Maryland [redacted]		
Havre de Grace	19,746	Percentage
White	13,822	
African American I Black	3298	16.7%
Indian / Alaskan Native	59	
Asian	612	3.1%
Pacific Islander	20	
Hispanic	1165	5.9%
Multiple Races	750	3.8%
Other	20	

Income & Poverty

How much money you make can also influence health. Income and poverty may not initially seem like a problem in Harford County, but taking a closer look at local municipalities uncovers unequal income distributions. Looking at Harford County household income by zip codes, we see lower income in those high priority areas compared to zip codes in northern Harford County. The average household income in the high priority areas of Aberdeen, Edgewood, Havre de Grace, and Joppatowne is $76,415, whereas the average household income of the northern zip codes including Bel Air, Darlington, Fallston, and Forest Hill is $115,171 (United States Census, 2020).

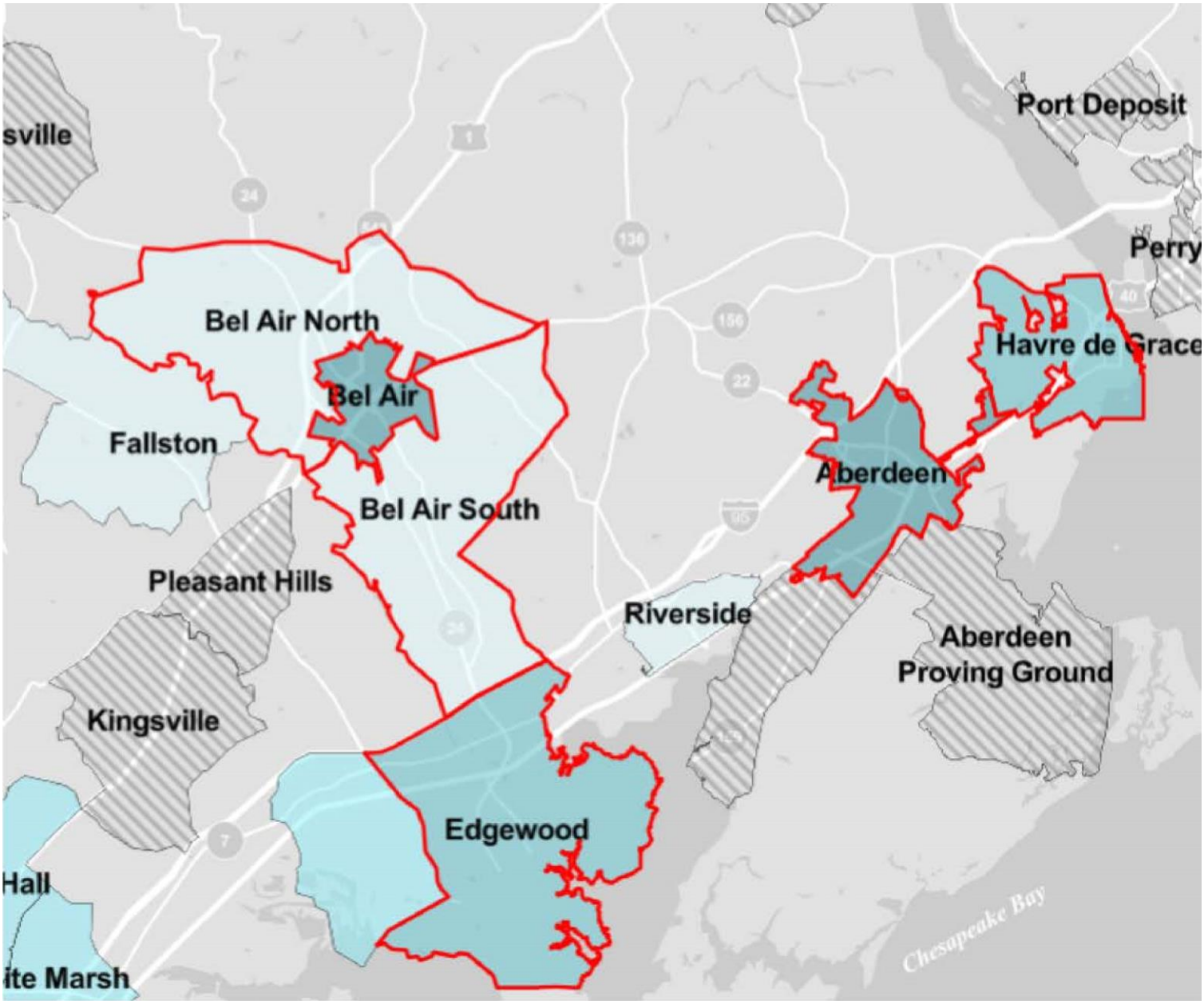
In the county, 6.2% of residents make less than the 2021 U.S. Federal Poverty Guidelines, which state that the Federal Poverty Level for a household of 1 person is $12,880; for 2 people is $17,420; for 3 people is $21,960. That percentage is higher in areas such as Aberdeen. High rates of poverty and low income have been linked to shorter life expectancy. Poverty and low income can affect health in

other ways, such as creating barriers to affordable housing, school funding, access to health care, healthy foods, and many more.

Income and Povery in Harford County, 2016-2020	
Median Household Income	$94,003
Persons in Poverty, Percent	7.8%
Income and Poverty in Aberdeen, 2016-2020	
Median Household Income	$66,481
Persons in Poverty, Percent	14g%
Income and Poverty in Havre de Grace, 2016-2020	
Median Household Income	$80,583
Persons in Poverty, Percent	88%
Income and Poverty in Edgewood,2016-2020	
Median Household Income	$68,420
Persons in Poverty, Percent	136%

Persons in poverty, percent

Darlin;ton



Education

Education is a social determinant of health, with people who have attained a higher level of education more likely to have positive health outcomes. Educational skills learned in school provide a foundation of knowledge needed to help make better decisions. To reach health equity, education programs need to close the gap between low-income and/or racial and ethnic populations and higher-income and/or majority populations.

Promoting social and institutional equity will require looking at all the inequities above and reducing their impact through strategic partnerships, advocacy,

policy/access, community engagement, social capital building, and coalition building.

Education in Harford County, 2016-2020	
High school graduate or higher, percent of persons age 25 years+	93.1%
Bachelor's Degree or higher, percent of persons age 25 years+	36.9%
Education in Aberdeen, 2016-2020	
High school graduate or higher, percent of persons age 25 years+	86.7%
Bachelors Degree or higher, percent of persons age 25 years+	22.3%
Education in Edgewood, 2016-2020	
High school graduate or higher, percent of persons age 25 years+	90.7%
Bachelors Degree or higher, percent of persons age 25 years+	20.1%
Education in Havre de Grace, 2016-2020	
High school graduate or higher, percent of persons age 25 years+	91
Bachelor's Degree or higher, percent of persons age 25 years+	39.4%

Living Conditions

According to County Health Rankings, residential segregation is the index of dissimilarity where higher values indicate greater residential segregation between African American/Black and White county residents. This index ranges from 0 (complete integration) to 100 (complete segregation). Harford County ranks 4th worst in African American[White segregation and 5th worst in NonWhite[White segregation. Baltimore City ranked highest for segregation in both measures.

Even though policies around segregated schools, transportation, and other public places no longer exist, segregation caused by structural, institutional, and individual racism can be found in many parts of the county. Though it may not seem like a health issue at first, residential segregation has been linked to poor

health outcomes including mortality, a wide variety of reproductive, infectious, and chronic diseases, and other adverse conditions. Having areas that are diverse can help foster stronger cross-sector collaborations and social support among neighborhoods.

Housing in Harford County, 2016-2020	
Housing Units*	104 488
Owner Occupied IJnit Rate"	79.0%
Medium Value of Owner-Occupied Housing Units**	S3027900
Median Gross Rate**	Sl 7294

*2021 U.S. Census Bureau, County Business Patterns

**US Census 2016-2021 American Community Survey 5-Year Estimates, 20162021

County Health Rankings: Residential Segregation Index	
Non-WhitelWhite:	African American/White.
Maryland: 55	Maryland: 63
Harford County = 42	Harford County = 50
United States = 46	United States = 63

This index can range from O to 100, with lower values representing less residential segregation and a value of 100 representing complete segregation.

Crime

Violence is a public health issue, adversely affecting not only the victims of the violence but also their families, and also increasing the mortality and morbidity in the community. As crime rates continue to change and occur in different areas throughout Harford County, it is important to identify effective programs and policies that have to do with behavioral challenges underlying violence.

Violent Crimes in Harford County, 2020

Area	Crimes Reported
Aberdeen	110 Reported
Edgewood	105 Reported
Havre de Grace	38 Reported
Bel Air	21 Reported

Property Crimes in Harford County, 2020

Area	Crimes Reported
Aberdeen	280 Reported
Edgewood	393 Reported
Havre de Grace	149 Reported
Bel Air	155 Reported

While crimes in Harford County have shown a significant downward trend, there has only been a slight change in the number of both violent and property crimes in Aberdeen, Edgewood, and Havre de Grace when compared to previous years. These zip codes continue to show the most inequities in Harford County.

Health Care

According to County Health Rankings, 5% of Harford County residents under the age of 65 are uninsured, a 50% decrease since 2008 when 10% of residents under the age of 65 were uninsured. This trend is also significant in the state of Maryland, which has decreased from 12% in 2008 to 7% in 2019. Geographically, the percentage of uninsured under the age of 65 in different zip codes differs throughout Harford County. Without insurance, people are less likely to receive preventive care such as vaccines, screenings, and medical check-ups and more likely to contribute to frequent visits to the emergency department for care. The percentage of persons uninsured in Aberdeen has improved since 2016, nearly

cutting the number in half, which is a positive shift in one of the most underserved zip codes in the county.

The northeast part of the county, another area with a high percentage of no health insurance coverage, also deals with transportation issues due to its rural geography. Lack of transportation can cause access to care issues, which decreases the quality of life for individuals in that area.

Persons Without Health Insurance, Under Age 65 Years, 2016-2020

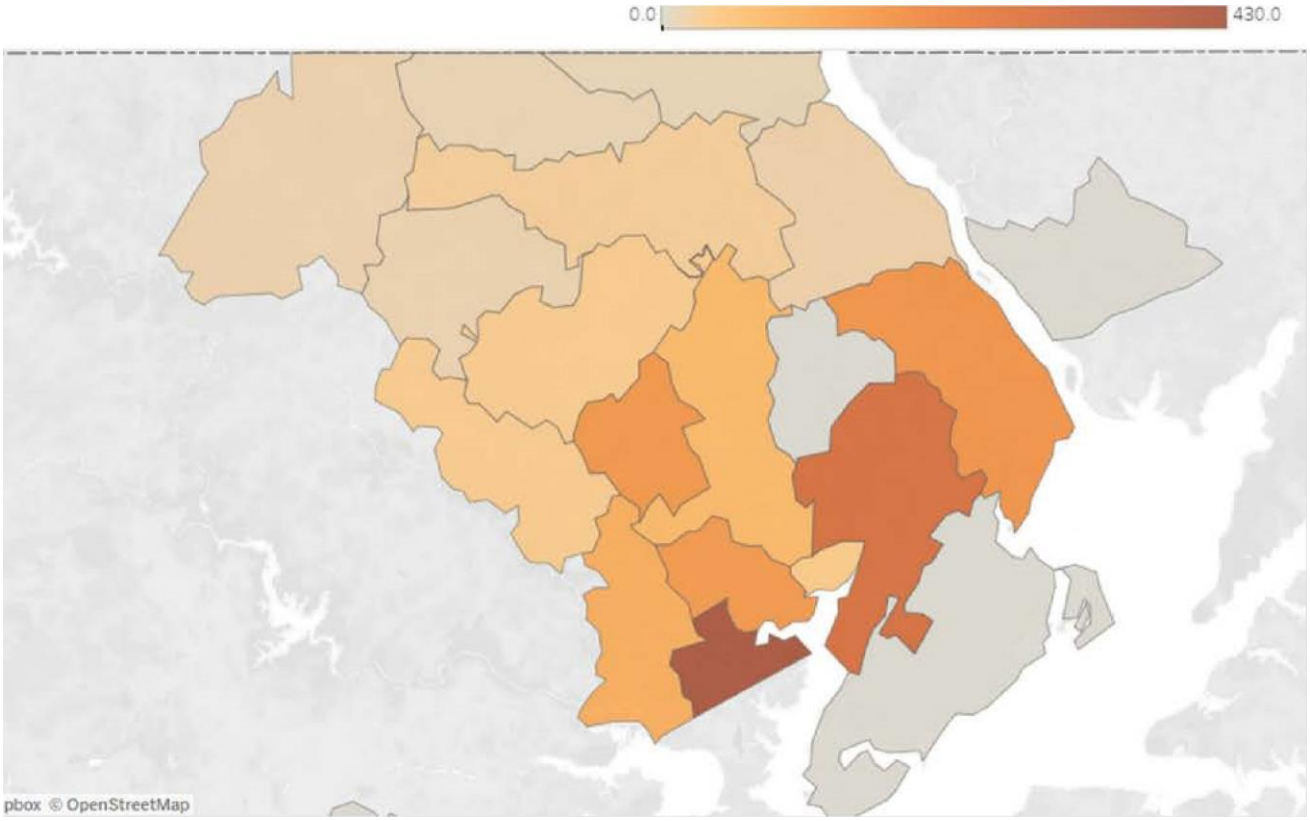
Area	Percent
Harford County	4.2%
Aberdeen	
Edgewood	5.8%
Havre de Grace	

Throughout the report, the state-designated health information exchange known as CRISP Reporting Services was used to create hospitalization utilization maps of Harford County to show geographical disparities in a variety of different topics surrounding health.

"The biggest thing that prevents me from going to the doctor is health insurance and having high copays"

Care Coordination Plus is an HCHD service that assists clients in accessing the care they need. The program, which is for all Harford County residents regardless of medical insurance type, works with the University of Maryland Upper Chesapeake Medical Center and the Comprehensive CARE Center, Harford Memorial Hospital, and other agencies to assist clients in receiving needed services. The areas that have the largest number of patients using this service and which also have higher numbers of emergency department visits and hospitalizations, are Aberdeen, Havre de Grace, and Edgewood.

Hospitalizations that used "self-pay" as a method of payment, 2022



Risk Behaviors

Smoking

Even though smoking rates have decreased in recent years, tobacco use is still a concern for Maryland residents. In Harford County, 12.7% of residents are current smokers. In 2017, a higher rate of residents from Aberdeen, Edgewood, and Havre de Grace who visited the emergency room in Harford County reported using some kind of tobacco product. Data from the 2021-2022 Youth Risk Behavior Survellience/ Youth Tobacco Survey (YRBS/YTS) show that 18.6% of high school students in Harford County currently use Electronic Smoking Devices.

Obesity

Obesity continues to be an issue, not just in Maryland, but also in Harford County. Harford County rates continue to be higher than the state average. In 2020, a higher rate of residents from Aberdeen, Edgewood, and Havre de Grace who visited the emergency room in Harford County were obese as compared to the county as a whole. According to the 2018-2020 Behavioral Risk Factor Surveillance Survey (BRFSS), 70.6% of the population in Harford County was not at a healthy weight.

In 2021, the non-Hispanic African American/Black population had the highest rates of obesity at 44.1% compared to non-Hispanic whites at 31.3% in Maryland.

Sexually Transmitted Infections

Maryland law requires that all cases of gonorrhea, chlamydia, and primary and secondary syphilis be reported to the Maryland Department of Health. A higher number of cases of gonorrhea and chlamydia were reported in Edgewood, followed by Aberdeen, Havre de Grace, Belcamp, and Perryman. A higher number of cases of primary and secondary syphilis were reported in Abingdon, Edgewood, Aberdeen, Perryman, and Belcamp.

Positive trend from previous Report

14.7% of students YRBS

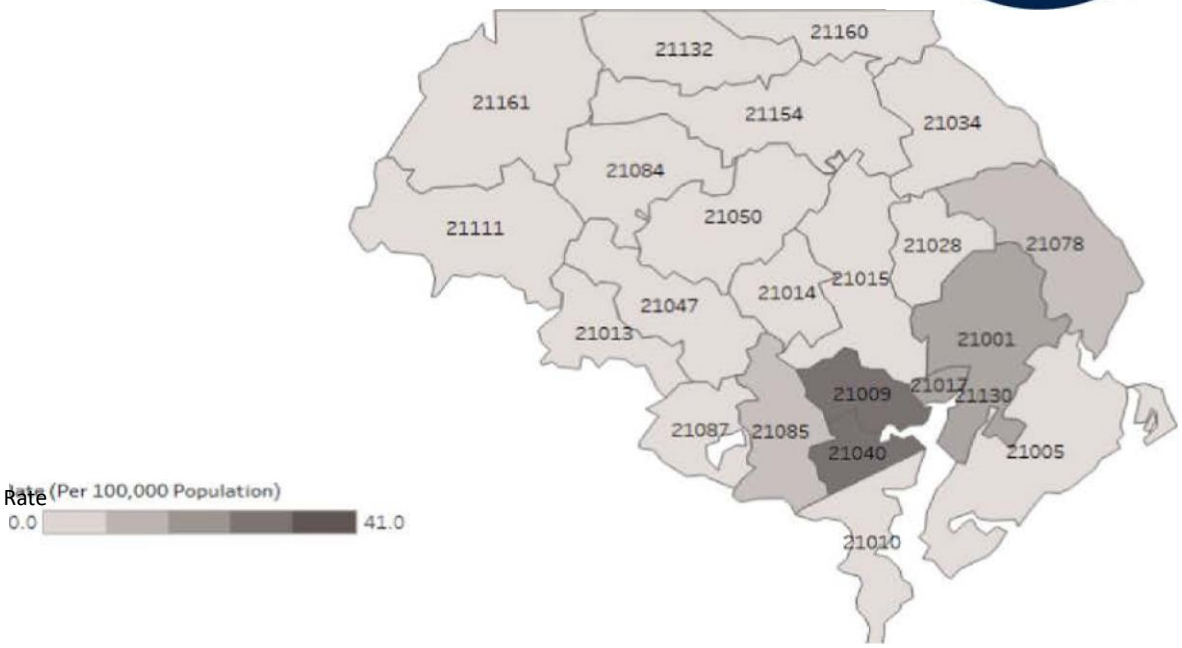
High in youth reported having obesity

School

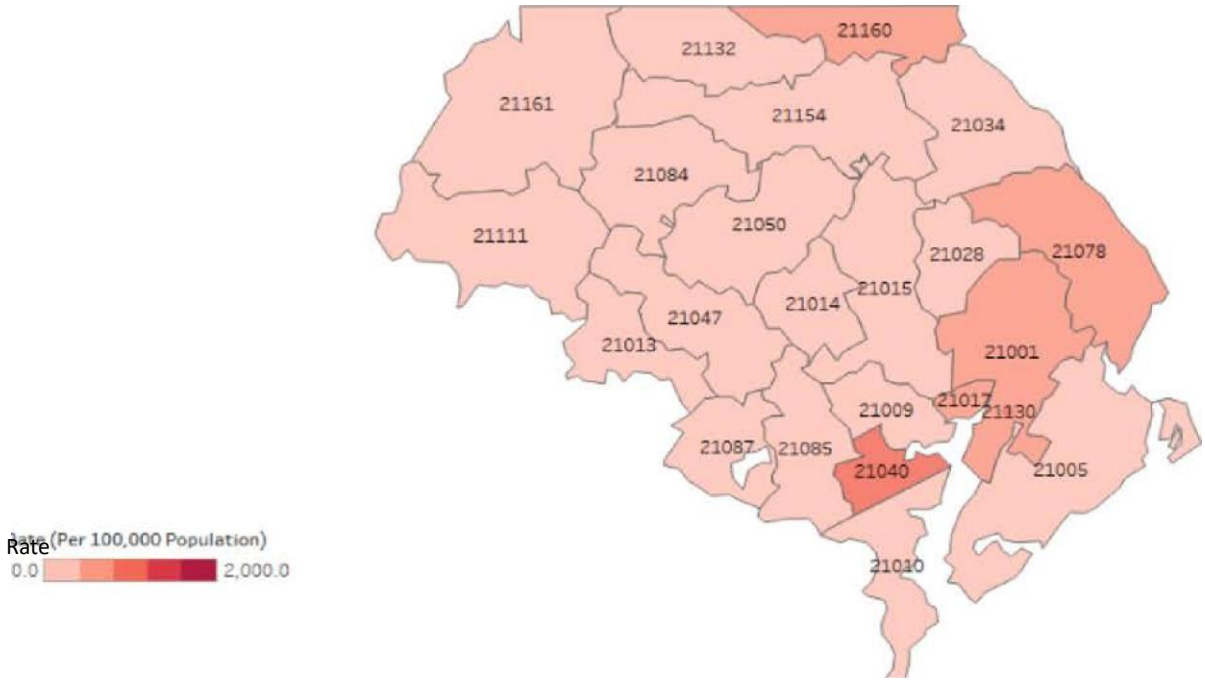
smoking

51% of High School students use protection during sex

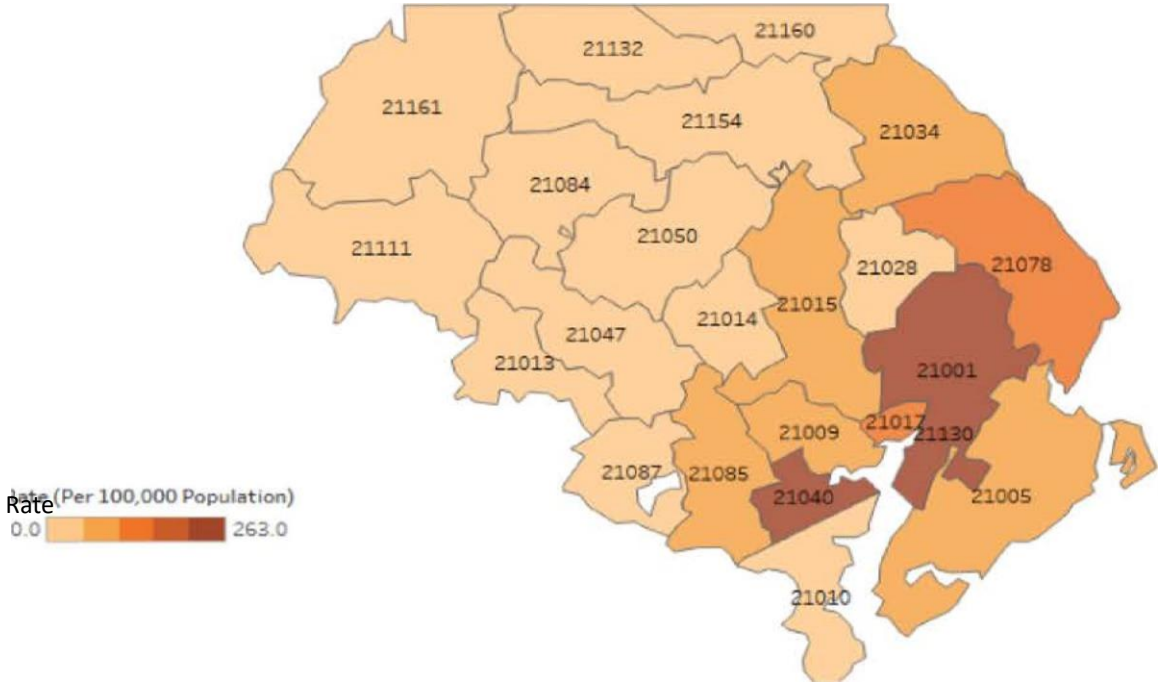
Syhpilis in Harford County 2020, Incidence Rates by Zipcodes



Chlamydia in Harford County 2020, Incidence Rates by Zipcodes



Gonorrhea in Harford County 2020, Incidence Rates by Zipcodes

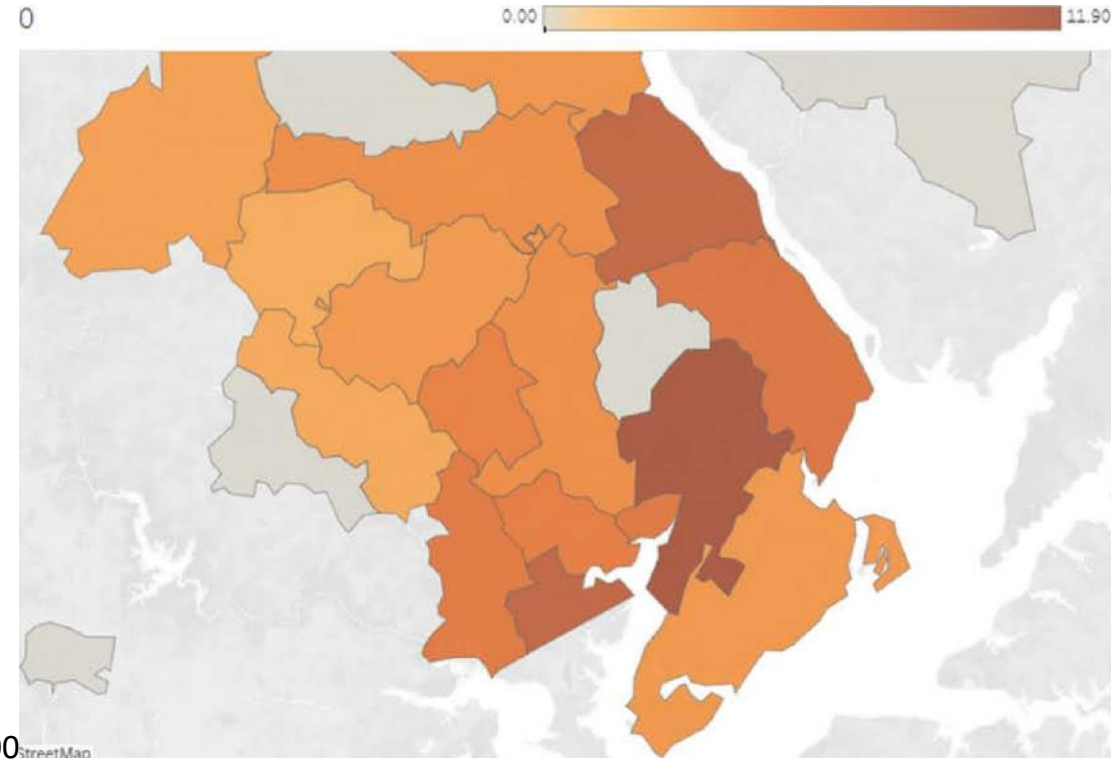




Behavioral Health

In 2022, there were 7 emergency department visits for depression per 1,000 residents and 27 depression-related hospital visits per 1,000 residents in Harford County. In the past few years, depression has slowly increased in not only adults but middle and high-school-aged children and teens as well. In 2022, 40.1% of high school students indicated they felt sad or hopeless almost every day for 2 weeks or longer. 23.2% of high school students in Harford County have seriously considered attempting suicide and the percentage of high school students who have actually attempted suicide is 16.5%. When looking at rates between zip codes, Aberdeen, Havre de Grace, and Edgewood were three areas that experienced a higher rate of residents with clinical depression who went to the emergency department in 2021. These rates are alarming and Harford County continues to raise its efforts to improve behavioral health care.

Emergency Department Visits Rate for Depression per 1,000 Residents in Harford County, 2022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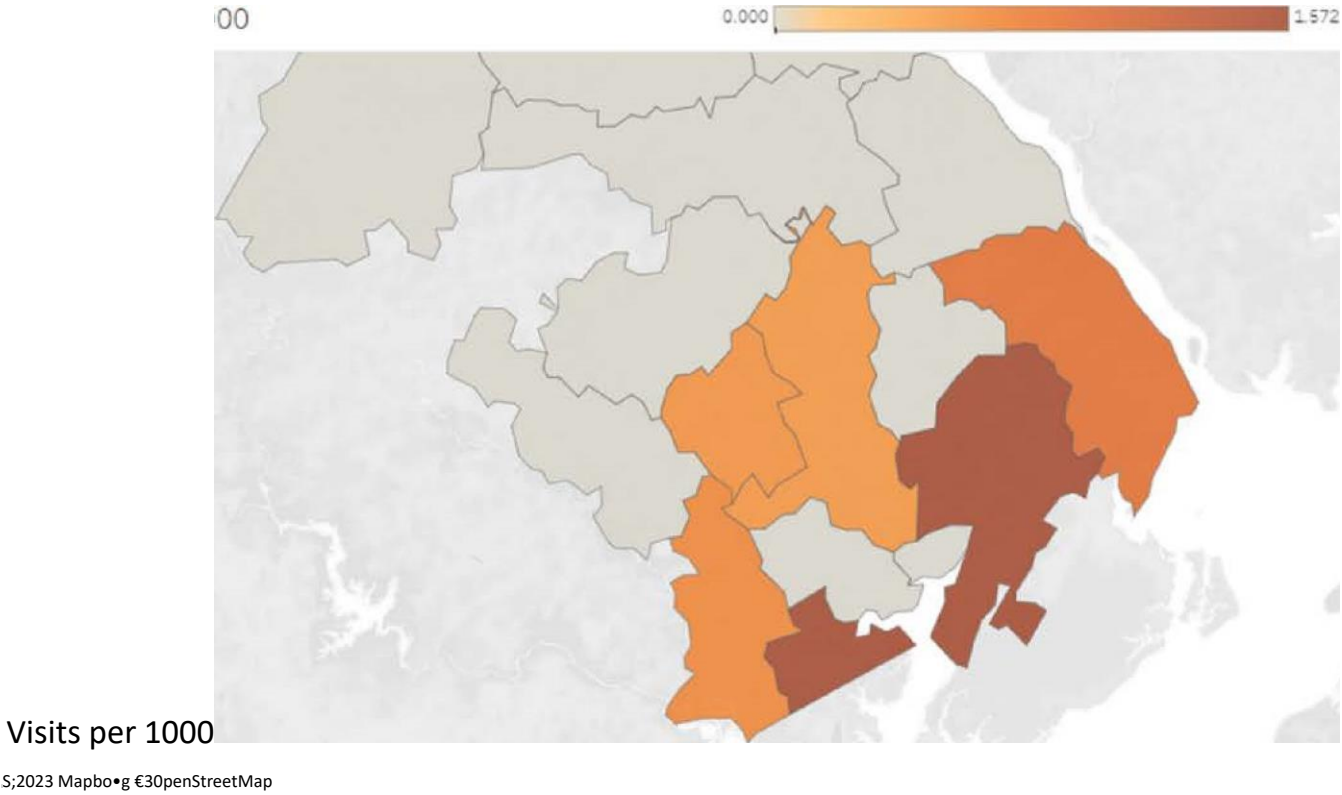
0.00
11.90
Visits per 1000
StreetMap
©2023 Mapbox OpenStreetMap

Substance Use

In 2021, Harford County experienced 344 opioid-related overdoses. In the past 5 years, the number of opioid overdoses has been declining, with almost a 14% decrease since 2019. The decrease in opioid overdoses is a positive result but efforts are still being made in order to bring this number down even more. Harford County's daily high number of overdoses may be a result of its location along the Interstate 95 corridor, which is known to be a major route for the movement of illegal drugs. Though the number of overdoses in 2021 appears to be scattered across Harford County, there is a higher concentration in Edgewood, Joppa, and Bel Air, all areas in which there is also a high rate of residents who have a depressive disorder.

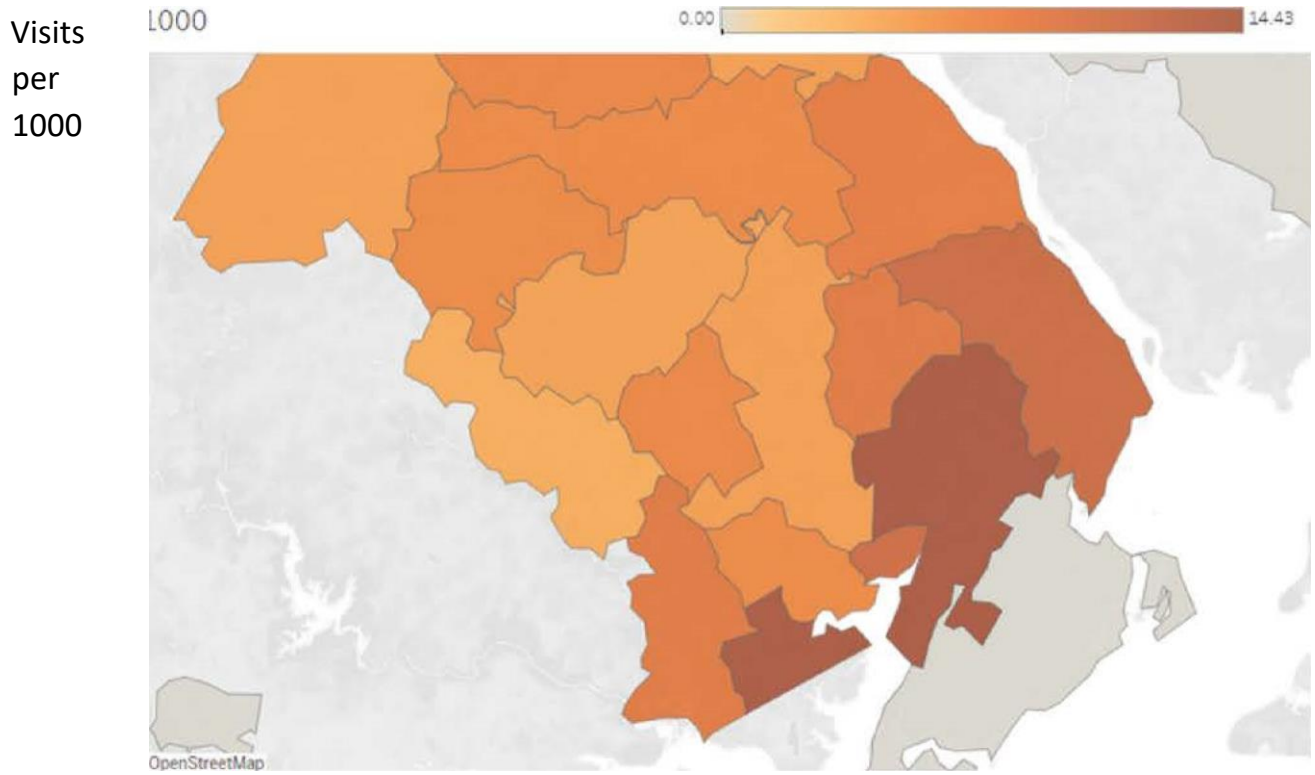
Emergency Department Visits per 1,000 due to Opioid Overdoses in Harford County, 2022



'Having healthy relationships and being supportive to your family is very important.

The mental aspect of health can drive everything else"

Emergency Department Visits per 1,000 due to Any Substance Use Disorder in Harford County, 2022



@2023 Maobox @OoenStreetMaD

Neonatal Abstinence Syndrome & Substance Exposed Newborns

Neonatal abstinence syndrome (NAS) refers to the group of conditions an infant experiences from being exposed to addictive opiate drugs in the womb. As a state, Maryland's rate of NAS is increasing, as is the national rate. The data indicates that Havre de Grace and Darlington have the highest rates of NAS in Harford County. Rates in Aberdeen, Street, and Edgewood follow closely behind. A substance-exposed newborn (SEN) is an infant, under 30 days old, who was exposed to a drug or a substance while in the womb. SEN patterns are consistent with NAS and can be found in the same areas and beyond, making it a growing geographic issue. Locally, Havre de Grace and Darlington are experiencing the highest rates of SEN, while other areas such as Aberdeen, Joppa, Edgewood, Street, and Jarrettsville are right behind them.

Chronic Diseases

A chronic disease, as defined by the U.S. National Center for Health Statistics, is a disease lasting three months or longer. According to the Centers for Disease Control and Prevention (CDC), chronic diseases are among the most common, costly, and preventable of all health problems. Early detection and screening are important parts of primary prevention. Six out of the ten leading causes of death in Harford County in 2020 are chronic diseases: heart disease, cancer, chronic obstructive pulmonary disease (COPD), diabetes, Parkinson's, and Alzheimer's disease.

Maryland Condition	Age-Adjusted Mortality Rate African American/Black	Age-Adjusted Mortality Rate White
Heart Disease	202.9	167.1
Cancer	162.7	
Diabetes	37	20.1

*rates per 100,000

"Health is taking care of yourself and having a balance with everything you do. "

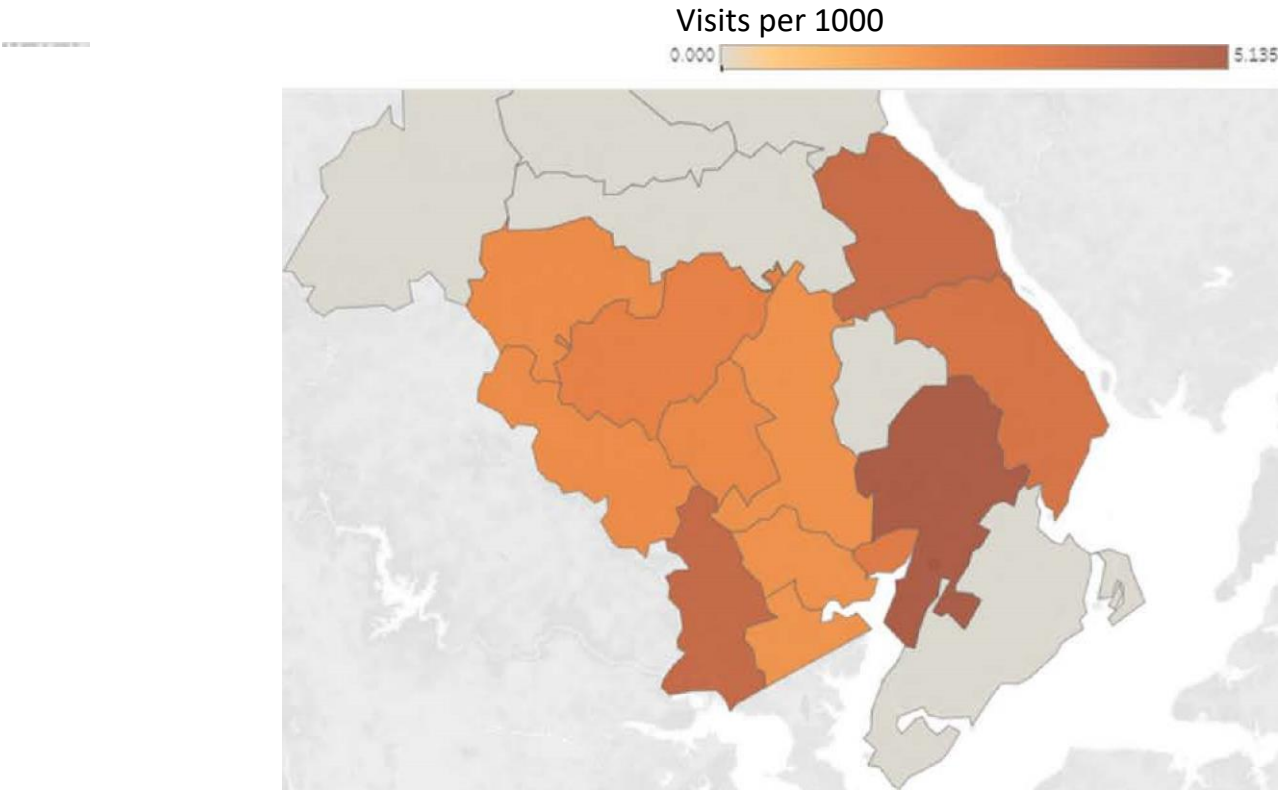
Cancer

Cancer of all types was the second leading cause of death in 2020 in Maryland behind heart disease, and residents with lung cancer had the highest mortality rates. Data shows that African Americans/Blacks have the highest age-adjusted mortality rates for cancer in Harford County and Maryland. Cancer was the second leading cause of mortality in Harford County, resulting in 497 deaths. African Americans/Blacks have seen the most deaths per 1,000 population from 2015-2019 at 175.7, out of all other races.

Lung Cancer

In 2021, the rate of emergency room visits for lung cancer patients was highest in the Aberdeen zip code. This is consistent with the number of hospitalizations related to tobacco use, which is known to cause lung cancer. Lung cancer was the specific cancer type causing the most deaths, at 24% of all cancers in Harford County (Maryland Vital Statistics Report 2020). Aberdeen and Joppatowne have the highest emergency department visit rates for lung cancer (CRISP).

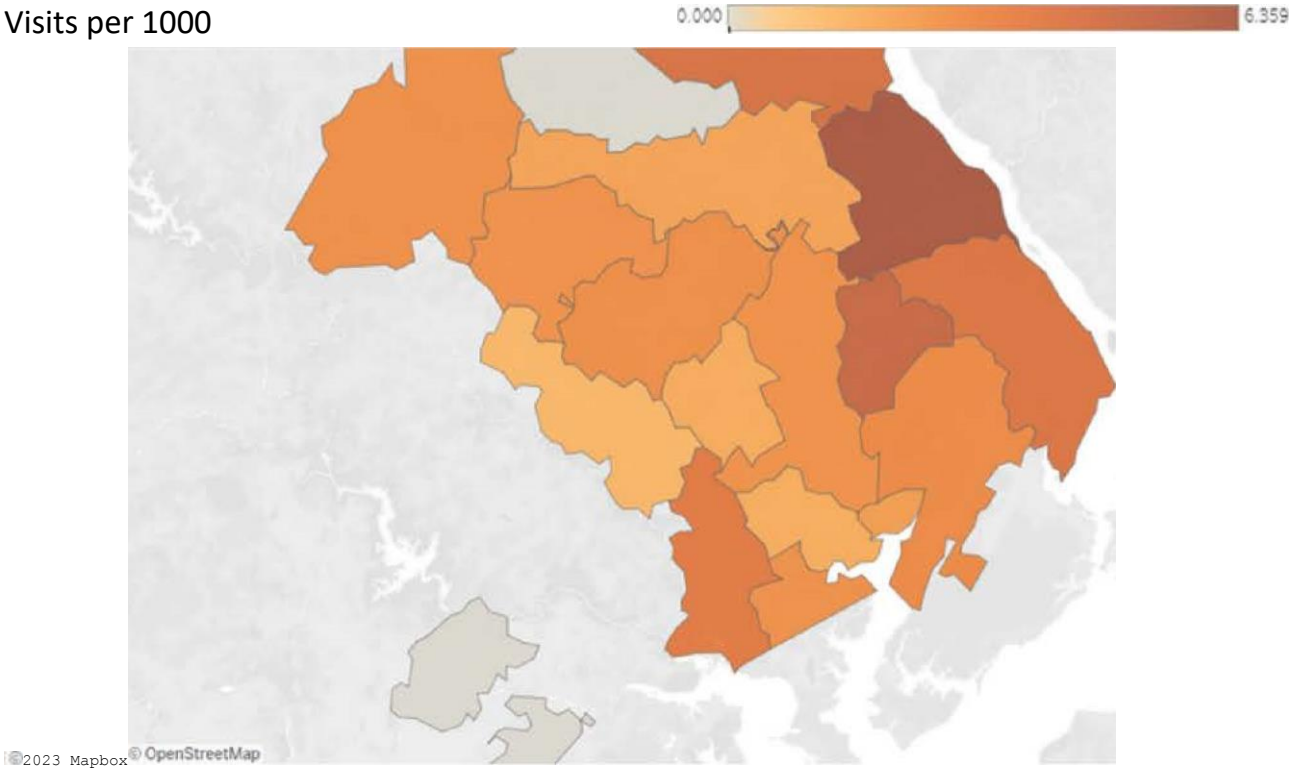
Emergency Department Visits for Lung Cancer per 1,000 Residents in Harford County, 2022



Colorectal Cancer

The next leading cause of cancer deaths, colorectal cancer, can be found through early detection and screening efforts. A higher rate of hospitalizations from this cancer can be found in the Aberdeen area, followed by Edgewood and Havre de Grace. Increasing physical activity, having a healthy diet, limiting alcohol consumption, and avoiding tobacco are some suggestions for preventing colorectal cancer. African American/Black residents have a higher incidence rate for both colorectal and lung cancer than White residents and the rate is even higher for males compared to females.

Emergency Department Visits for Colorectal Cancer per 1,000 Residents in Harford County, 2022

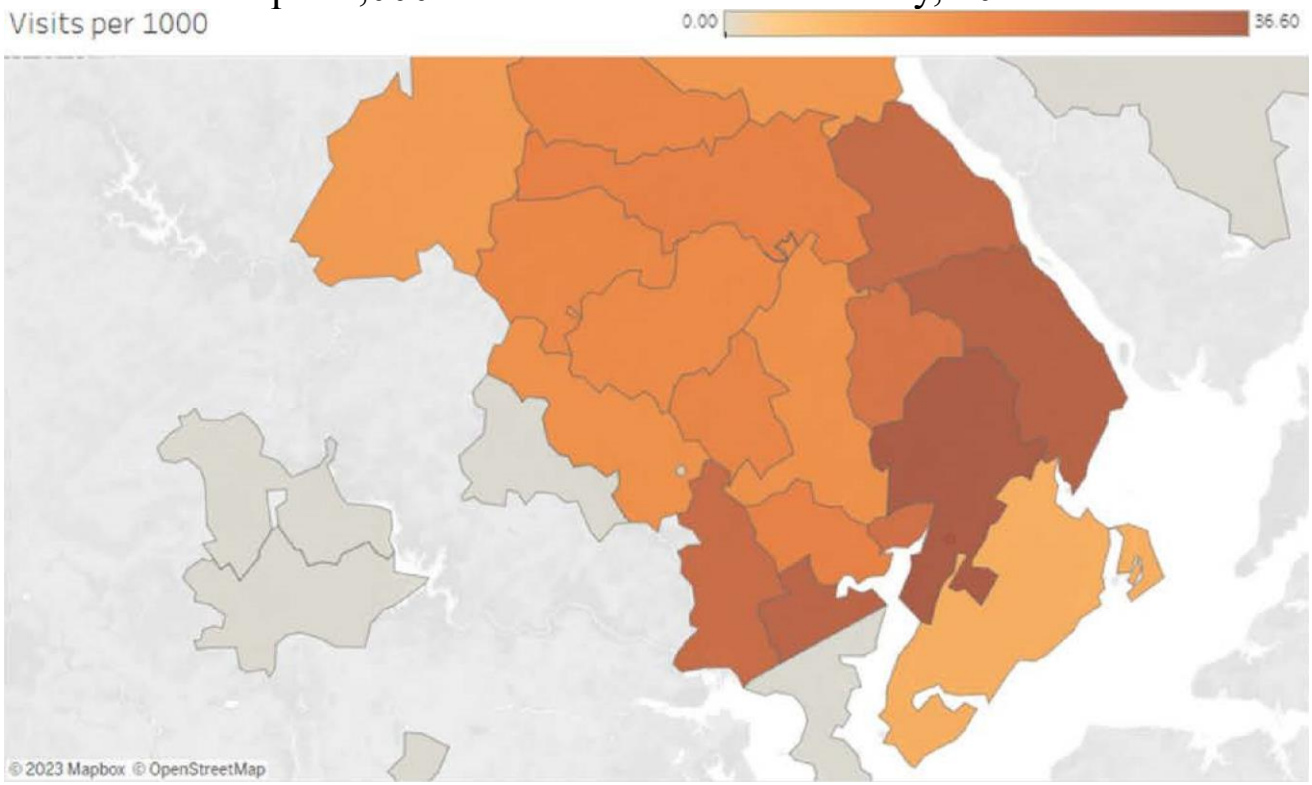


Hypertension

Hypertension, also known as high blood pressure, is a component of heart disease, which is the number one cause of death in the United States and the number one cause of death in Harford County. In 2020, heart disease accounted for 571 total deaths in Harford County (Maryland Vital Statistics, 2020). Hypertension is a major risk factor for heart disease, and accounted for over 19,700 emergency department (ED) visits in 2022, more than any other condition in Harford County (CRISP). Of those, African Americans/Blacks show significantly higher rates of ED visits at 113.97 per 1,000, compared to Whites (84.48 per 1,000). Locally,

Aberdeen, Bel Air, and Edgewood have a higher concentration of adults with hypertension who are going to the emergency department. Seventy-six percent of all ED visits in 2022 were from the White population, whereas 20% were from the African American/Black population.

Emergency Department Visits Rate for Hypertension
per 1,000 Residents in Harford County, 2022



Diabetes

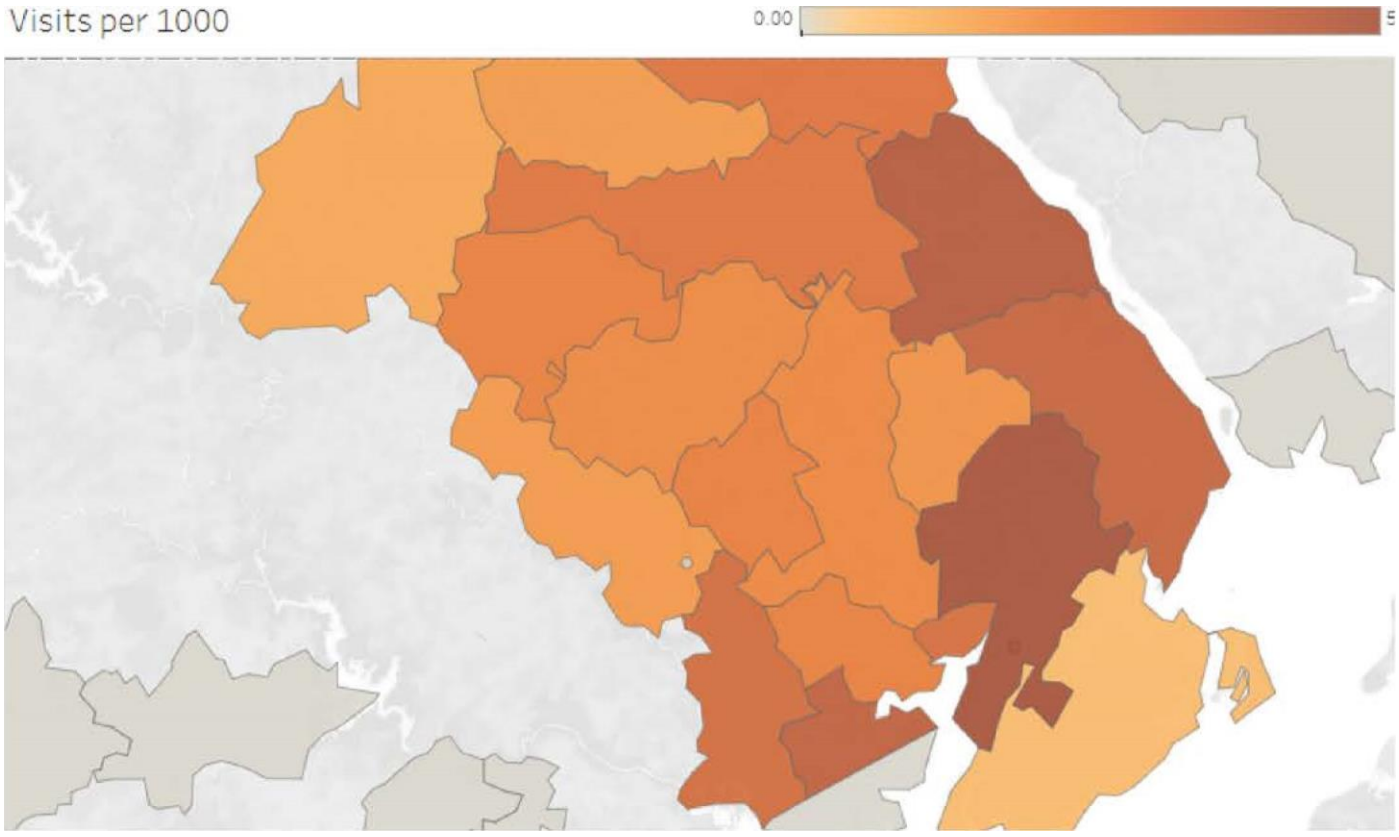
Diabetes is a group of diseases that affect blood sugar levels. There are several types of diabetes, but the two most common are type 1 and type 2. Type 1 is a chronic condition in which the pancreas produces little or no insulin. Type 2 is a chronic condition that affects the way the body processes blood sugar and is the most common form of diabetes. Some risk factors for type 2 diabetes are obesity, a sedentary lifestyle, and physical inactivity. In Maryland, an estimated 10.5% of the adult population (488,942 adults) have diabetes, while an estimated 34% (1.6 million adults) have prediabetes.

Diabetes is the 6th leading chronic disease resulting in emergency department visits in Harford County at 9,042 visits in 2022. Diabetes was the 7th leading cause of death in Harford County in 2020 (6th excluding COVID-19), as well as the 7th leading cause of death in Maryland, with an age-adjusted mortality rate of 23.9 per

100,000 population. This is a 17% increase from 2019 (Maryland Vital Statistics Report, 2020). The age-adjusted prevalence rate of diagnosed diabetes is highest in Non-Hispanic Blacks at 13.3%, followed by Non-Hispanic Asians at 9.7%, and Hispanics at 9.4% (Maryland Diabetes Action Plan, 2020). The ageadjusted death rate in Maryland has been highest in Non-Hispanic Blacks since prior to 2009. The age-adjusted death rate among Non-Hispanic Blacks (37 per 100,000) is nearly twice that of non-Hispanic Whites (20.1 per 100,000). People with low socioeconomic status are more likely to be diagnosed with diabetes. The risk of developing type 2 diabetes is 30 to 40% higher for people who smoke cigarettes than for people who don't (CDC, 2022).

Diabetes was the seventh leading cause of death in the county in 2020. Residents in Aberdeen, Havre de Grace, and Edgewood have a higher rate of emergency department visits associated with diabetes. These three areas also have high rates of obesity. Diabetes prevalence is also higher in White residents than African American/Black residents in Harford County.

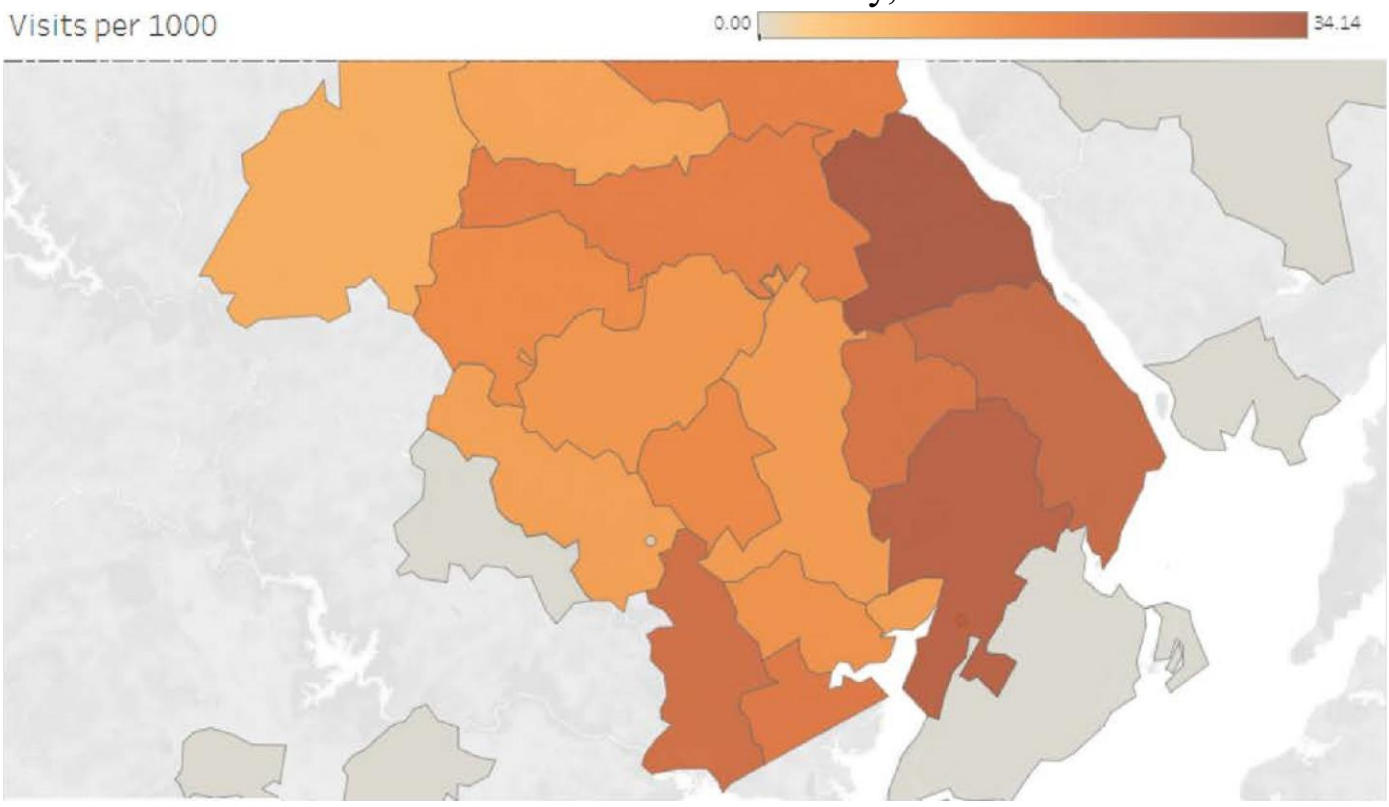
Emergency Department Visits Rate for Diabetes per 1,000 Residents in Harford County, 2022



Chronic Obstructive Pulmonary Disease (COPD)

COPD, a group of diseases that cause airflow blockage and breathing-related problems, was the fifth leading cause of death among Harford County residents in 2020. COPD can include diagnoses of emphysema, chronic bronchitis, and in some cases, asthma. Former and current smokers are at risk of developing these diseases. Aberdeen, an area with a high percentage of tobacco users, also has a higher rate of emergency visits by residents diagnosed with COPD, with Havre de Grace and Edgewood having the second and third-highest rates in the county.

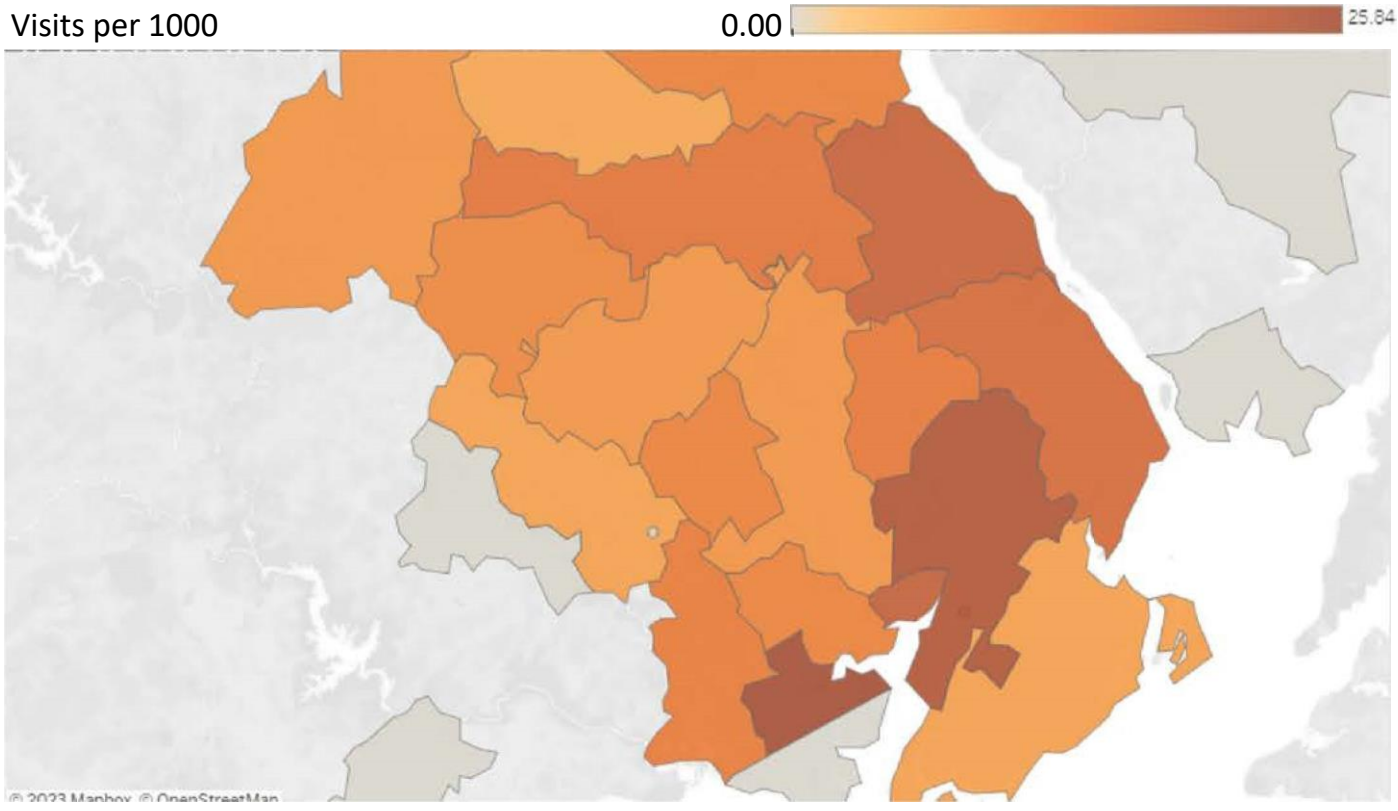
Emergency Department Visits Rate for COPD per 1,000 Residents in Harford County, 2022



Asthma

Asthma is a chronic disease that affects the lungs, causing narrowing and constriction of the airway, making it more difficult to breathe. This can cause major problems for a child's healthy development, and an adult's quality of life. Poor air quality, environmental factors, and poor asthma management can lead to hospital visits. Asthma is currently a health priority in Maryland. Racial disparities can be seen in Maryland when analyzing the data on emergency department visits since the beginning of 2018. For example, in December of 2021, asthma ED visits were on the rise. African Americans/Blacks had 4 times more ED visits than the White population.

Emergency Department Visits Rate for Asthma Per 1,000 Residents in Harford County, 2022



CONCLUSION

Our Efforts

The first step in achieving health equity is recognizing that health status is very different depending on your location in Harford County. Use this information to shape your work and partner with organizations that can help leverage your goals. Sustainable programs and partnerships are essential, and building health equity depends on community-wide collaboration! HCHD is making efforts daily to develop new programs and provide services that achieve health equity throughout the entire county.

One of the biggest SDOH factors that affects our community is transportation. HCHD provides Medical Assistance (MA) Transportation to ensure that transportation is not an obstacle for our community in order to make their medical appointments on time. MA Transportation provides services to active, non-restrictive Medicaid recipients or for those who have no other means of transportation.

HCHD offers a wide variety of services at its seven locations such as immunizations, STI testing, harm reduction, behavioral health services, family planning services, and more! One of our programs includes MEGAN's (meaningful environment to gather and nurture) Place, a trusted, safe environment for at-risk pregnant and postpartum women and their families in Harford County. It aims to provide guidance and information, referrals and services, care coordination, and support to its families. Services include home visiting with its Healthy Families America component, peer recovery support, and referrals to excellent community resources through Care Coordination Plus in order to extend its services to its families by addressing numerous SDOH factors. Our newest addition to care coordination services includes Nuestra Comunidad, a program that allows undocumented individuals to get connected to a variety of services, including, immunizations, health screenings, and referrals to outside care.

The Minority Health Program is a rapidly growing component of our health department. Our community health workers are determined to improve minority health in our community by creating relationships throughout our county to develop educational and resourceful events that help to educate the public on the most prevalent health disparities as well as provide a guide on where to go and how to address these health issues. These educational components include; screening and testing for various diseases and infections, mental health and self-care, lack of food or transportation, mental health youth symposiums for middle and high school students, and much more.

The Health Department is constantly looking for ways to help our community to end health disparities and inequities. Partnering and building relationships with other community members is the best way to achieve this in the most effective way possible.

CONCLUSION

Where do we go from here?

Where you live matters! This report is the first step in understanding health equity in Harford County. Based on the findings of this report, there are health inequities due to geographic factors in Harford County, as evidenced by poorer living conditions, lower health insurance rates, and higher negative risk behaviors and diseases compared to other zip codes in the county. The three priority areas are Aberdeen, Edgewood, and Havre de Grace. This places residents in those areas at higher risk for increased morbidity and mortality. Now that priority areas have been identified, the health department can continue to strengthen cross-sector partnerships with community leaders, increase access to services, and improve health for residents who need the most care. The assessment can also identify which programs need to be expanded to increase capacity and educate employees on the importance of health equity. This type of program and policy advocacy will help make Harford County the healthiest community in Maryland.

"I am very thankful and I hope that this place always exists because they help so much. Thank you. "



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2024

COMMUNITY HEALTH NEEDS ASSESSMENT

HARFORD COUNTY, MD

JULY 2024

Public Health
Prevent. Promote. Protect.
Harford County Health Department

University of Maryland Upper Chesapeake Health

Healthy Harford
LIVE WELL. BE WELL.

TABLE OF CONTENTS

GLOSSARY

ACEs - Adverse Childhood Experiences; ACEs are tough events in childhood, like mental illness in the family, abuse, or having a family member in prison, that can cause lasting harm.

BMI - Body Mass Index is a person's (adults 20 and older) weight in kilograms divided by the square height in meters. A healthy weight is 18.5-24.9, overweight is 25-29.9, and obese is 30 and above.

Age-adjusted rates - Age-adjusted rates help compare rates among different populations by accounting for differences in age distribution per 1,000 or 100,000 people.

Incidence - Number of new cases of disease during a specified time interval.

Infant Mortality Rates - Number of infant deaths per 1,000 live births

Live Births - Live Births are when a baby is born and shows signs of life, like breathing, heartbeat, or moving muscles, regardless of how long the pregnancy was.

Low Birth Weight - A live birth weighing less than 2,500 grams (5.5 pounds). Low birth weight babies are at risk for poor health outcomes.

Mortality Rate - Mortality Rate is how often deaths occur in a specific group over a certain time.

NAS - Neonatal Abstinence Syndrome; a group of conditions caused when a baby withdraws from certain drugs that they are exposed to in the womb before birth.

Per 1,000 or 100,000 Cases - number of cases/births/deaths use 1,000 or 100,000 as the denominator for mortality or case rates.

SNAP - Supplemental Nutrition Assistance Program provides nutrition benefits to supplement the food budget of families in need.

SENs - Substance Exposed Newborns are babies who show signs of being exposed to drugs or alcohol before birth, as confirmed by medical staff.

YPLL - Years of Potential Life Lost; measures how many years of life are lost when someone dies before they turn 75, focusing on deaths that might have been preventable.

EXECUTIVE SUMMARY

The Harford County Community Health Needs Assessment (CHNA) provides a thorough evaluation of the health status of Harford County. The report includes both primary and secondary data in qualitative and quantitative forms. Primary data is collected through an online survey that is distributed to residents throughout the county and asks questions regarding their health status, risk factors, and health outcomes. Primary data is also collected through focus groups with key informants in the community and residents in the county. Focus groups provide a diverse perspective on the health of the county and help determine health priorities. Secondary data is collected through a compilation of data from several sources; Maryland Vital Statistics, Behavioral Risk Factor Surveillance System (BRFSS), County Health Rankings, Maryland Department of Health, U.S. Census Bureau, University of Maryland Upper Chesapeake Health, Health Services Cost Review Commission (HSCRC), Chesapeake Regional Information System (CRISP), and the Youth Behavioral Risk Survey/ Youth Tobacco Survey (YRBS/YTS).

The CHNA has five sections. The first two sections are an overview of the county's demographics and its social and physical environment. The remaining sections focus on health behaviors, health outcomes, and access to healthcare for variant groups and geographic areas. Results are compared with the broader state and national data, where relevant, to identify discrepancies across zip codes, age groups, ethnicities, and races, shedding light on health equity within our community. The findings of this report have led Harford County's key stakeholders to prioritize the following top health concerns, in order of importance: Behavioral Health (mental health and substance use disorder-addiction), Chronic Disease Prevention and Wellness, and Family Health and Resiliency.

Harford County Profile: Harford County sits at the top of the Chesapeake Bay, just 25 miles northeast of Baltimore, and falls right on I-95. Home to 264,644 residents, this suburban/rural community is relatively wealthy, educated, well-insured, and has a median household income of $100,915, and 94.2% of residents earning a high school degree or higher, both of which are higher than the state average. Despite these statistics, Harford County has many areas along the Route 40 corridor that are pockets of poverty, with uninsured populations, high rates of chronic diseases, and untreated mental health disorders. The majority of the population is White (77.2%), followed by African American/Black (16%), Hispanic (5.3%), Asian (3.2%), and multi-racial (3.1%). In Harford County, 7.3% of persons live in poverty in 2022.

Key Findings Regarding the Prioritization of Mental Health and Wellness, Prevention and Health Management, and Community and Family Well-being.

Community Feedback: The community survey consisted of 50 questions about demographics, access to care, health behaviors, and health status. This year's survey had 2,242 respondents, a 65% increase from the previous CHNA survey. Of the respondents, 73% were female, 42% were over 65, and 27% resided in Bel Air. The respondents identified that the top three health issues facing Harford County were overweight/obesity, drug misuse/alcohol misuse, and mental health/suicide. The most commonly reported chronic disease in Harford County was high blood pressure, affecting 62% of residents, and high cholesterol, affecting 60% of residents. The most commonly reported barriers keeping residents from accessing health care were high cost/paying out-of-pocket, lack of insurance, and inability to get an appointment. Residents believe the county needs more of the following resources: affordable medication, free/low-cost dental care, and more primary care providers.

When conducting focus groups, each group brought its unique perspectives on the questions but there were common themes that followed throughout. Most participants expressed that the largest barriers in the county were lack of transportation, lack of social connectedness, lack of awareness of resources, and lack of mental health care. A key takeaway from the focus groups was that residents were not aware of the resources available in the county and an increase of health promotion is needed in various forms of communication.

Secondary Data:

- **Prevention and Health Management:** Unhealthy behaviors can lead to chronic diseases that can be life-threatening. The leading causes of mortality in Harford County are heart disease, cancer, and stroke. These conditions can be prevented with lifestyle changes, such as healthy eating habits, physical activity, and avoiding smoking and drinking. There were 168.9 deaths per 100,000 persons in Harford County in 2021 due to heart disease. Hypertension, a large factor of heart disease, was shown to be higher in African Americans, with 106.24 hospital visits per 1,000 compared to 77.27 hospital visits per 1,000 for the white population. Smoking in adults has been high for several years in Harford County but has declined in 2022, with a rate of 7.9% of adults who currently smoke. Smoking is known to cause many chronic conditions, such as lung cancer and chronic obstructive pulmonary disease (COPD). Lung cancer was the specific cancer type causing the most deaths, at 24% of all cancers in Harford County in 2020. COPD also remains higher than the state rate, with the death rate being 36.9 per 100,000 residents.

7.9% of adults in Harford County reported they smoked in 2022.

Top 3 health issues in Harford County were overweight/obesity, drug misuse/alcohol misuse, and mental health/suicide.

168.9 deaths per 100,000 persons in Harford County in 2021 due to heart disease.

- **Community and Family Well-being:** Maternal and child health is an area of concern in Harford County, especially for those in the African American/Black community. In 2021, 11.5% of African American/Black babies were born with a low birth weight (<2,500 grams), double the percentage of white babies born with a low birth weight. Teen births remain lower than the state rate, with 8.5 births per 1,000 born to mothers under 18. When comparing between race, African American/Black women had 15 teen births per 1,000 and 18 teen births per 1,000 for Hispanic women. Between 2018-2022, the infant mortality rate was 4.9 per 1,000 live births. In addition, the substance-exposed newborn (SEN) rate has been increasing each year since 2010, with 45.6 SEN per 1,000 live births in 2022. In contrast, the neonatal abstinence syndrome (NAS) rate has been decreasing since 2013, with the rate being 11.9 per 1,000 live births in 2022.

- **Mental Health and Wellness:** The Chesapeake Regional Information System for Our Patients (CRISP) reported that 7,380 visits to the hospital were due to depression in 2023, increasing about 12% from the previous year. When looking at anxiety, it has decreased by 46.6%, with 1,635 visits in 2023. In addition, the suicide rate was 12 deaths by suicide per 100,000 residents, in 2023. The Maryland Vital Statistics report indicates that the total intoxication death rate for 2021 was 36.5 per 100,000. The most used drug that caused intoxication deaths was fentanyl, followed by cocaine and prescription opioids. County Health Rankings indicated that 16% of adults reported binge or heavy drinking in 2021. While the rate for intoxication-related deaths has decreased, there is still a large concern for the county with rates much higher than they were a decade ago. The issue now lies with an increase in fentanyl, especially when laced with other products, such as cocaine.

COVID-19 Pandemic: The COVID-19 Pandemic officially ended in the United States on May 11, 2023. Social distancing, masking, and widespread vaccination contributed to its resolution, especially for Harford County. At the end of 2022, 68% of Harford County residents were fully vaccinated with both initial doses of the COVID-19 vaccine. Since then, there has been a significant decrease in deaths related to COVID-19. In 2023, there were a total of 66 deaths due to COVID-19, compared to 256 deaths in 2021. COVID-19 is still closely monitored in the county but guidelines are much less restrictive as confirmed.

ACKNOWLEDGEMENTS AND OVERVIEW

University of Maryland Upper Chesapeake Health

Mission: The University of Maryland Upper Chesapeake Health (UM UCH) is dedicated to maintaining and improving the health of the people in its communities through an integrated health delivery system that provides high-quality care to all. UM UCH is committed to service excellence as it offers a broad range of healthcare services, technology, and facilities. It will work collaboratively with its communities and other health organizations to serve as a resource for health promotion and education.

Vision: The Vision of the University of Maryland Upper Chesapeake Health is to become the preferred, integrated healthcare system creating the healthiest community in Maryland. UM UCH is a community-based, integrated, non-profit health system. Presently, UM UCH is the leading healthcare system and second largest private employer in Harford County, employing 3,500 team members and over 650 medical staff physicians. UM UCH is dedicated to maintaining and improving the health of the people in northeastern Maryland through an integrated health delivery system that provides high-quality care to all. Their commitment to service excellence is evident through a broad range of healthcare services, technologies, and facilities. They work collaboratively with the community and other health organizations to serve as a resource for health promotion and education.

Major centers and services include two acute care hospitals – University of Maryland Upper Chesapeake Medical Center Bel Air (UM UCMC Bel Air) and University of Maryland Upper Chesapeake Medical Center Aberdeen (UM UCMC Aberdeen). Each of the two facilities offers certain services solely at that institution. Harford County residents, no matter their ZIP code, requiring a specific service must receive that service at the facility that offers that service (e.g. cancer services at the Kaufman Cancer Center at UM UCMC Bel Air). As a result of how services are provided between the two facilities, the CHNA was completed as a joint document for the two facilities.

As part of the Bel Air campus, UM UCH also operates the Klein Ambulatory Care Center, two medical offices, and the Patricia D. and M. Scot Kaufman Cancer Center. UM UCH also owns and operates the Senator Bob Hooper House Hospice Center, and provides community outreach, health screenings, and educational programs through Community Outreach and Health Improvement. A combined facility to treat mental health and opioid addiction issues was opened in the Summer of 2018 in Bel Air. The Klein Family Center offers walk-in crisis services, and a 24/7 call/triage center, and residential crisis beds.

Recent significant expansions include a new three-story bed tower which introduced 72 new patient beds in 2023. Additionally, in early 2024, UM UCH closed Harford Memorial Hospital in Havre de Grace and opened UM UCMC Aberdeen, a new and modern 130,000-square-foot freestanding medical facility with an expanded behavioral health/psychiatric pavilion catering to inpatient and outpatient services, and a state-of-the-art emergency department

Harford County Health Department

The Harford County Health Department (HCHD) serves as the local operating arm of the Maryland Department of Health (MDH). While adhering to state regulations, HCHD reports to the Harford County Council, comprising the Harford County Board of Health, to ensure the well-being of our residents.

The mission of the health department is clear: to protect and promote the health, safety, and environment of the citizens of Harford County through comprehensive community assessment, education, collaboration, and assurance of service. With a dedicated team of over 180 professionals, their services have extended throughout the entire county.

Central to their efforts is the gathering of data on health trends, environmental factors, and emerging health challenges. Through close collaboration with various community stakeholders, they craft effective policies and solutions, ensuring their implementation and ongoing refinement. Their commitment to improvement is evident through partnerships forged via the Local Health Improvement Coalition and its subcommittees, focusing on behavioral health, chronic disease prevention and wellness, and family health to coordinate collective solutions.

The Health Department’s mission is driven by a vision of making Harford County the healthiest community in Maryland. To achieve this, the Harford County Health Department operates seven distinct bureaus, each dedicated to serving the community's diverse needs with many different programs within each. Bureaus include Administrative Services, Behavioral Health, Care Coordination, Clinical Health, Environmental Health, Family Health, and Population Health.

Healthy Harford

Healthy Harford is the healthy communities initiative of Harford County, dedicated to the health and wellness of the northern Chesapeake community - in mind, body, and spirit. Founded in 1993 as a non-profit 501c3 by leaders from the University of Maryland Upper Chesapeake Health, Harford County Health Department, and Harford County Government - Healthy Harford is a coalition of local government agencies, businesses, non-profits, and citizens dedicated to improving the health of Harford County residents through education, policy changes, programs, and improvements to the built environment, with a focus on social determinants of health and health equity.

METHODOLOGY

The CHNA was informed by both quantitative and qualitative research components. A brief synopsis of the research methods is included below with further details provided throughout the document.

Quantitative Data: Existing Secondary Data

Statistical data was compiled from various sources, including demographic analysis, social and economic factors, education, morbidity and mortality, incident rates, and other health statistics. Sources are publicly available and can be easily accessed. It should be noted that due to the COVID-19 pandemic, there were limitations in obtaining up-to-date data.

Harford County Community Health Survey

An online community survey of Harford County residents was conducted between October 2023 and February 2024. The community survey aimed to gather data on demographics, access to care, health behaviors, and health status. A total of 2,242 resident surveys were completed. Respondents had a diverse, geographical, gender, race, and ethnic background, however, the survey could not be weighted to offer a statistically representative sample of the community.

Qualitative Data: Stakeholder and General Public Focus Groups

To gain a better understanding of community efforts that are in place, a key informant focus group was conducted with 56 major community partners who are experts in the community. The focus group consisted of a series of seven questions on Kahoot! (a game-based learning platform), so that respondents could answer directly on their phone. Questions aimed to identify the problems/concerns of the community, as well as the strengths and resources available to the residents. The focus group was concluded with a discussion of possible solutions to the barriers identified.

Following the key informant focus group, a similar concept was repeated for the general population, with ten total questions asking for their view of the health and community strengths and barriers. Groups from various backgrounds were contacted to participate in a focus group. This resulted in four focus groups, which included the Susquehanna Ministerium (Harford County Faith Based Group), Spanish Speaking Residents, Minority Health Community Advisory Board Members, and Seniors/Caregivers.

LOCAL PLANNING INITIATIVES

Local Health Improvement Coalition

To improve the health of all Marylanders, the Maryland Department of Health (MDH) launched the State Health Improvement Process (SHIP) through the Office of Population Health Improvement. SHIP focuses on statewide and local health priorities, providing a framework for accountability, local action, and public engagement. SHIP measures align with the national Healthy People 2030 objectives and MDH state goals, emphasizing social determinants of health (SDOH)—factors like where people are born, live, work, and age. Each of Maryland's 24 jurisdictions must convene a Local Health Improvement Coalition (LHIC) to set local health priorities. In Harford County, the Harford County Health Department leads the LHIC.

LHIC Priority Groups

Priority setting is the process of determining how best to address the health needs of the county and determine how available resources can be allocated to improve the health of the county. Priority setting is complex and requires input from county stakeholders and decision makers and relies on the use of diverse data sources as well as stakeholder input. In April of 2024, the key community stakeholders met to review the community health needs assessment survey and focus group results. Stakeholders included:

- University of Maryland Upper Chesapeake Health
- Harford County Health Department
- Healthy Harford
- Harford County Council
- Harford County Public Schools
- Harford County Public Library
- Harford County Office on Aging
- Harford County Emergency Services
- Department of Social Services
- Department of Community Services

Once the group reviewed the data and information, they determined and prioritized the county's health needs and priorities for the next three years. The priorities are listed below which were ranked from first to third:

1 MENTAL HEALTH AND WELLNESS

2 PREVENTION AND HEALTH MANAGEMENT

3 COMMUNITY AND FAMILY WELLBEING

HARFORD COUNTY FAST FACTS

Measures (2018-2022 5-Year Estimates Unless Otherwise Specified)	Harford	Maryland
Total Population	264,644	6,180,253
Median Age	41	39.7
Married	55%	49%
Median Household Income	$100,915	$94,991
Unemployment Rate	2.0%	2.1%
Language Other Than English Spoken at Home	7.5%	19.8%
Persons Below the Poverty Line	7.5%	9.6%
Mean Travel to Work	32.3 Minutes	32.0 Minutes
High School Degree or Higher	94.2%	91.0%
Bachelor's Degree or Higher	42.2%	38.8%
Foreign-born Population	5.0%	15.7%
Veteran Status	9.2%	6.8%
Persons Without Health Insurance	5.1%	7.1%
Top 3 Causes of Death	Heart Disease Cancer *COVID Stroke	Heart Disease Cancer *COVID Stroke
Birth Rate (per 1,000)	10.0	11.1
Low Birth Weight for Non-Hispanic White Mothers	6.8%	6.7%
Low Birth Weight for Non-Hispanic Black Mothers	11.5%	12.8%
Suicide Rate (per 100,000)	14.4	10.1
Age-adjusted Death Rate for All Causes (per 100,000)	821.9	786.3
Age-adjusted Death Rate for Heart Disease (per 100,000)	168.9	160.1
Age-adjusted Death Rate for Diabetes (per 100,000)	18.2	22.7

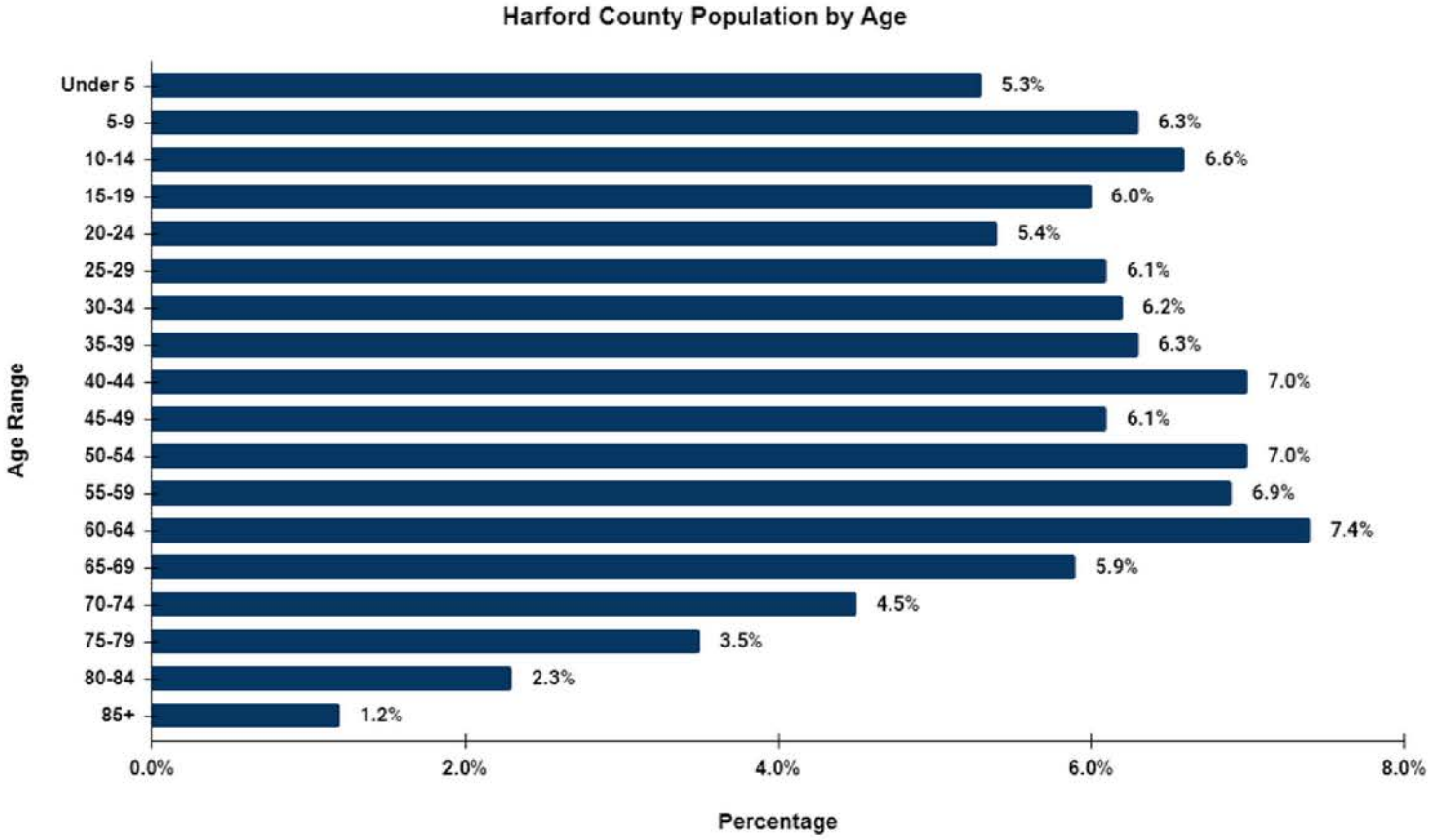
DEMOGRAPHIC PROFILE

Demographic characteristics such as age, gender, race, and ethnicity have an impact on people's health. Understanding these characteristics across Harford County helps determine the resources needed for optimum health and well-being of the population. The Town of Bel Air is the Harford County seat, which has a population of 10,630, or about 4% of the county's population. The cities of Aberdeen and Havre de Grace each make up approximately 6.2% and 5.5%, respectively. The remaining population in the county is mostly distributed along the Route 40 corridor and in rural and suburban parts of the county. The table below illustrates the change in population size for Maryland, Harford County, and selected zip codes (U.S. Census Bureau, 2019-2022).

In 2022, the total population of Harford County was estimated to be 264,644, which was a 3.6% increase from 2019 (255,441). The county is located in the northeastern part of Maryland, with towns and cities of various sizes, wealth, and diversity.

Location	2019	2022	Percent Change
Maryland	**6,045,680**	**6,164,660**	**1.96% Increase**
Harford County	**255,441**	**264,644**	**3.60% Increase**
Edgewood	**25,574**	**25,116**	**1.79% Decrease**
Aberdeen	**15,848**	**16,422**	**3.62% Increase**
Havre de Grace	**13,652**	**14,743**	**7.99% Increase**
Town of Bel Air	**10,071**	**10,630**	**5.55% Increase**

The population chart below provides a breakdown of Harford County residents by age. The age category with the largest percentage of the population was adults ages 60-64. The median age for the county was 41 years old. Harford County is comprised of 49.7% males and 50.3% females. 22.1% of the Harford County population is under the age of 17. (U.S. Census Bureau, American Community Survey 2022).



Data on the racial and ethnic diversity of a population allows leaders to understand health disparities and racial gaps. It also allows for organizations to target culturally competent healthcare services. For example, in Harford County, 7.8% of residents (age 5 and up) speak a language other than English at home. Therefore, it is important to address health literacy in the community (U.S. Census Bureau, American Community Survey 2022). The table below shows the variation in race throughout the county. While 73.2% of Harford County is White, Aberdeen, Edgewood, and Havre de Grace have larger minority populations.

Race/Ethnicity	Maryland	Harford	Aberdeen	Edgewood	Havre de Grace
White	**48.4%**	**73.2%**	**54.1%**	**36%**	**68.2%**
African American/Black	**29.6%**	**16%**	**24.6%**	**46.9%**	**18.2%**
American Indian/Alaskan Native	**.40%**	**.40%**	**.30%**	**.30%**	**.40%**
Hispanic/Latino	**11.4%**	**5.3%**	**11.1%**	**7.2%**	**7.6%**
Asian/Pacific Islander	**6.7%**	**3.3%**	**3.7%**	**1.5%**	**2.0%**
Two or more races	**8.2%**	**3.1%**	**8.7%**	**11.3%**	**5.7%**

SOCIAL AND PHYSICAL ENVIRONMENT

Income

The environment where people are born, work, live, learn, worship, and play can have an impact on health and well-being. Examples include education level, transportation, and access to nutritious foods and physical activity. Many of these social factors can lead to poor health outcomes, health disparities, and inequities.

Compared to the United States, Maryland is a wealthy state. The median household income in Harford County is $100,915 compared to the US median household income of $74,800, and Maryland's at $95,000. There are significant differences in median income across municipalities in Harford County with Bel Air at $104,767, Havre de Grace at $95,025, Edgewood at $85,742, and Aberdeen at $74,555 (U.S. Census Bureau, 2022).

United States	Maryland	Harford County	Bel Air	Aberdeen	Edgewood	Havre de Grace
$74,800	**$95,000**	**$100,915**	**$104,767**	**$74,555**	**$85,742**	**$95,025**

67.1% of the Harford County population aged 16 and over were employed, while 32.9% were not in the labor force. The unemployment rate in Harford County is 2%. Furthermore, 73.4% of Harford County employees were private wage and salary workers, 22.4% were government workers, and 4% were self-employed (U.S. Census Bureau, 2022).

The percentage of Harford County families that are below the poverty level is 5.8%. There are racial disparities in poverty within the county. There are 5.5% of White families below the poverty level, while 8.1% of African American/Black families are below the poverty level.

The unemployment rate in Harford County stands at 2%

Education

The Harford County Public School District has 55 schools. The school district's mission is that each student will attain academic and personal success in a safe and caring environment that honors the diversity of our students and staff. Within the 55 schools, there are nine Title I schools that aim to ensure academic achievement for at-risk students attending schools in high-poverty areas. Three schools are located in Aberdeen, two in Edgewood and Joppa, and one in Havre de Grace and Abingdon (Harford County Public Schools, 2023). Harford County Public Schools had a total of 38,105 students enrolled as of September 30, 2023, with a 93% attendance rate. The high school graduation rate for Harford County was 90.8%, which was higher than the state of Maryland's rate of 85.8% (Maryland State Department of Education, 2023).

The Maryland State Department of Education administers assessments each year for each school district in Maryland. Based on the test scores, each school district is ranked by SchoolDigger. Due to the pandemic, school assessments were not taken for the 2019-2020 year. For the 2022-2023 school year, Harford County was ranked 9th out of 24 public school systems in Maryland (SchoolDigger, 2023). This was a significant improvement from the previous school year when Harford County was ranked 12th. When it comes to attained education in the county as a whole, it was estimated that 94.2% of people 25 years and over in Harford County had a high school diploma or higher, and 38.8% had a bachelor's degree or higher in 2022.

Housing and Transportation

The median value of homes in 2023 for Harford County ($351,100) is less than Maryland's ($380,500), and the difference when considering housing prices by zip code is dramatic. The median home value has increased by 18.5% since 2020. Prices range below the state value in the Edgewood area, where the median value of a home is $217,800, to well above the state in areas like Fallston where the median home value is $485,800.

Rental costs must also be taken into account when assessing the housing landscape of a community. It is estimated that 22% of households rent rather than own their house. Limited access to public transportation is especially troublesome for rural and low-income areas of Harford County. Lack of transportation impacts accessing healthcare services. Among workers 16 and over, 3% do not have a vehicle available. Rates are higher along the Route 40 corridor with Edgewood at 9%, Aberdeen at 8.8%, and Havre de Grace at 7.5% (U.S. Census Bureau, 2022). The HCHD offers a program called Medical Assistance Transportation which provides transportation to medical appointments. The service is available to Harford County residents who have active, non-restrictive Medical Assistance (Medicaid) coverage, or have no other means of transportation. Since Fiscal Year 2021, this program has completed an average of 33,465 rides per year.

Transportation to and from work has proven to be a challenge for many. 61.8% of Harford County residents work within the county, with 35.5% of residents working outside of the county, and 2.7% working outside of Maryland. The average commute time to work is about 31.1 minutes. Only .8% of residents use public transportation. The Harford Transit Link is the bus system for Harford County that offers seven bus routes (Harford County Government, n.d.). While this aids in access to care, there are still gaps in transportation throughout many areas of the county.

Access to Healthy Food

The 2024 County Health Rankings estimate that 5% of Harford County residents had limited access to healthy foods. This percentage is based on 2019 data of those who do not live close to a grocery store and are low-income. In addition, 9% of Harford County residents are considered food insecure. This is measured by the percentage of the population who did not have access to a reliable source of food during the past year (based on 2021 data). The County Health Rankings created a food environment index to score a given area on a scale from 0-10 (zero being the worst and ten being the best). The score is based on limited access to food and food insecurity. Harford County was given a score of 8.6 out of 10 which was slightly less than Maryland as a whole (County Health Rankings, 2021).

It should also be noted that the US Census estimates that 7.6% of households in Harford County use the Supplemental Nutrition Assistance Program (SNAP benefits) (U.S. Census Bureau, 2022). In summary, while most Harford County residents have access to healthy foods and a reliable source of food, there are still gaps in the county. Lacking reliable access to food is related to poor outcomes such as obesity and premature mortality.

Access to Recreational Opportunities

It is estimated that access to exercise opportunities in Harford County is 94% while the state of Maryland is at 92%. This is measured by the percentage of individuals in a county who live reasonably close to a park or recreational facility (County Health Rankings, 2023). The Harford County public recreation system is a combination of sites owned by municipal, County, State, and Federal government, and the Harford County Board of Education. There are numerous opportunities for Harford County residents to stay active through parks, trails, and recreation centers. Note that this is limited to public facilities and there are additional recreation opportunities through apartment complexes' playgrounds or private gyms.

Crime

In 2022, Harford County had an annual overall crime rate of 2,002 per 100,000 people. The most recent available crime data for the state is from 2016, which reported an annual overall crime rate of 2,801.3 per 100,000. The crime rate in Maryland has been consistently higher than in Harford County for years, being 3,810 per 100,000 (Governor's Office of Crime Prevention, Youth, And Victim Services, 2022).

Graduation rate is higher than Maryland's rate

90.8%

94% of residents live close to a park or rec facility

Food Environmental Index is **8.6 of 10**

Crime rate is better than Maryland's rate

2,002 per 100,000

HEALTH BEHAVIORS

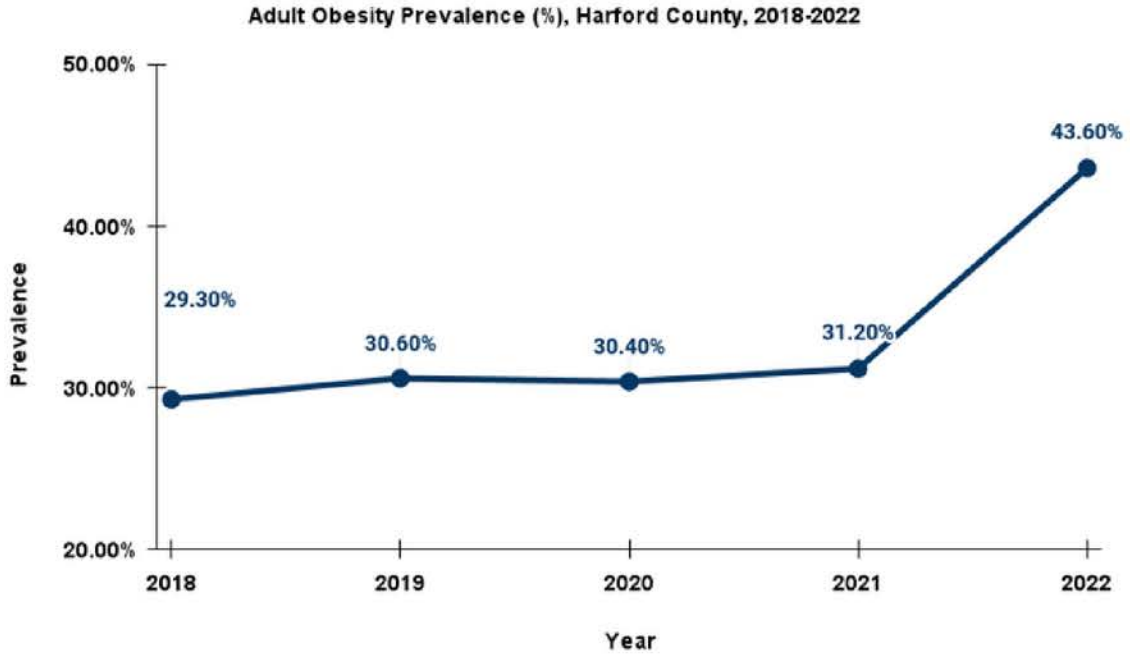
Chronic diseases such as heart disease, diabetes, and cancer are often caused by unhealthy behaviors such as poor nutrition, physical inactivity, and alcohol and drug use. Engaging in healthy behaviors not only reduces risks for chronic illness but can improve quality of life and overall health and wellness.

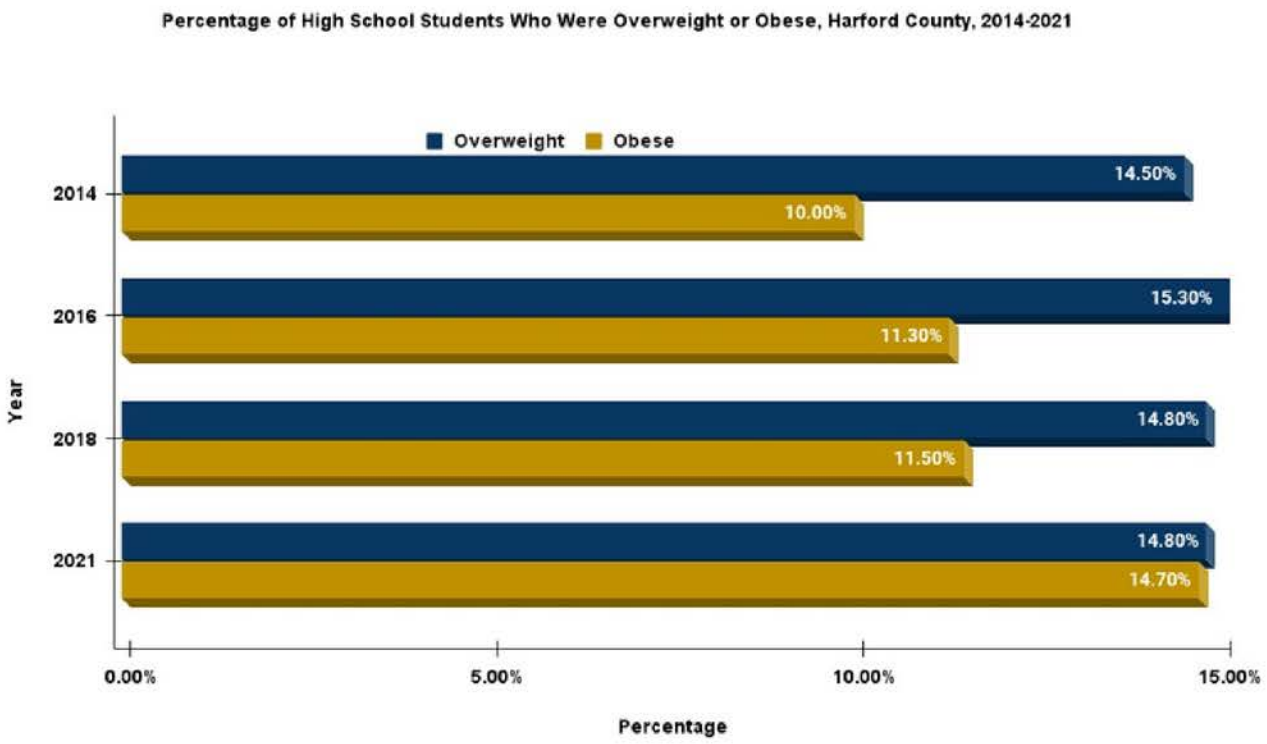
Poor Nutrition and Physical Inactivity

Eating well-balanced meals and exercising regularly have a major impact on one's health and well-being, both physically and mentally. Data from the 2021 BRFSS reports that 17% of the population reported eating a vegetable less than 1 time per day and 35% reported eating fruit less than 1 time per day. The consumption of fruit and vegetables closely mirrors the state average.

It is recommended that adults engage in 150 minutes of moderate-intensity physical activity per week (or equivalent of vigorous physical activity). In Harford County, the monthly exercise percentage is high, with 77% reporting they exercised within the past 30 days but the adult obesity prevalence is at 31%, which closely aligns with the state and national average, according to the BRFSS.

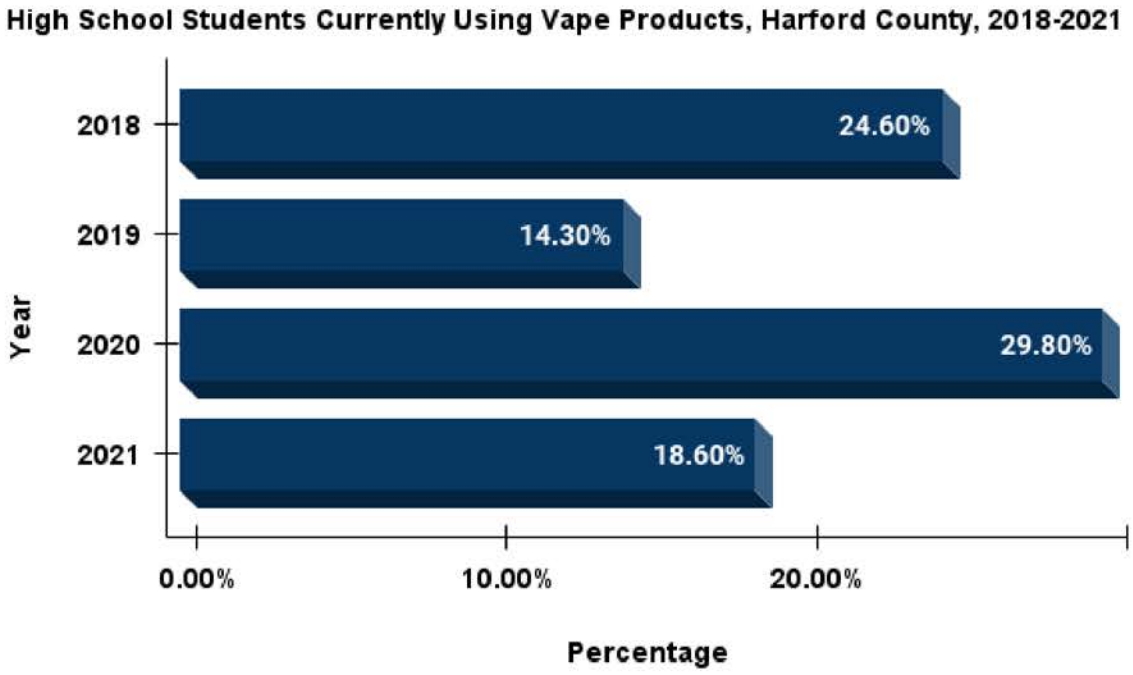
The BRFSS reports that the obesity prevalence for adults in 2022 was 43.6%, a 39.74% increase from 2021. Youth being overweight and obese is also a major health concern in Harford County. In 2021, 14.8% of high school students were reported being overweight (>= 85th percentile for body mass index but <95th percentile body mass index) and 14.7% were reported being obese (>= 85th percentile for body mass index). The obesity percentage in high school students has increased by 47% from 2018 to 2021.

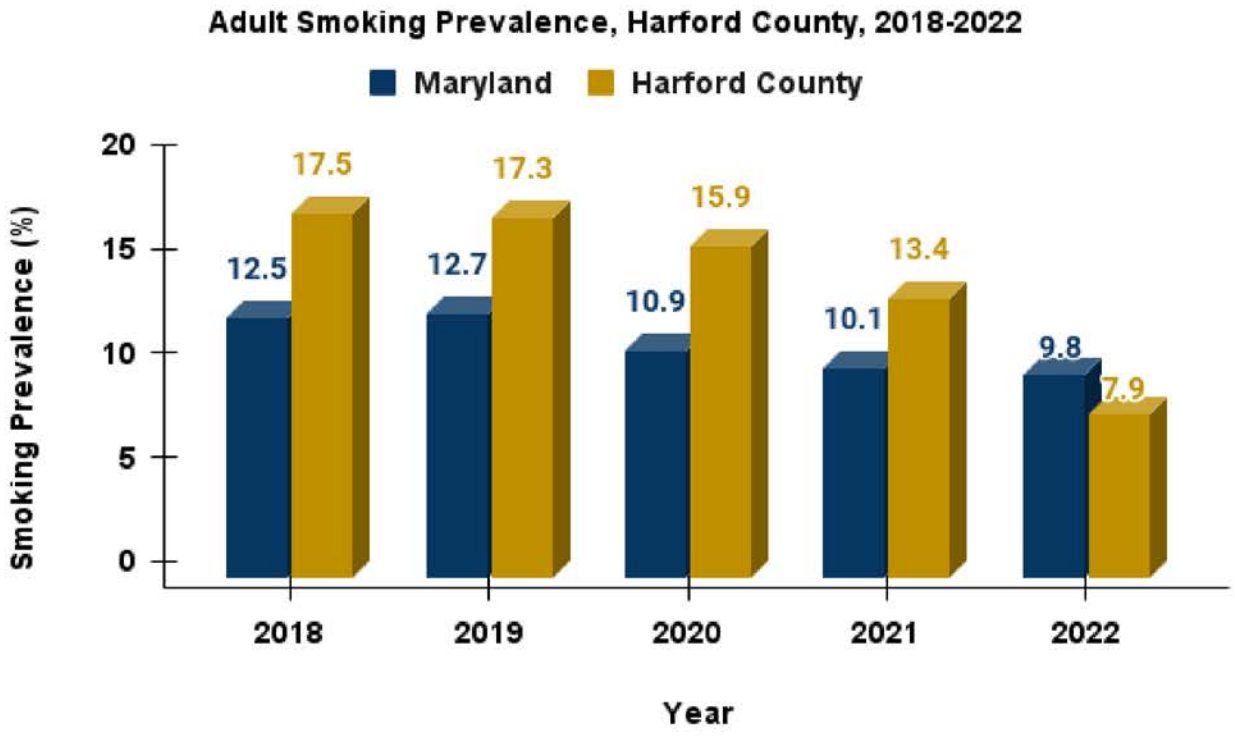




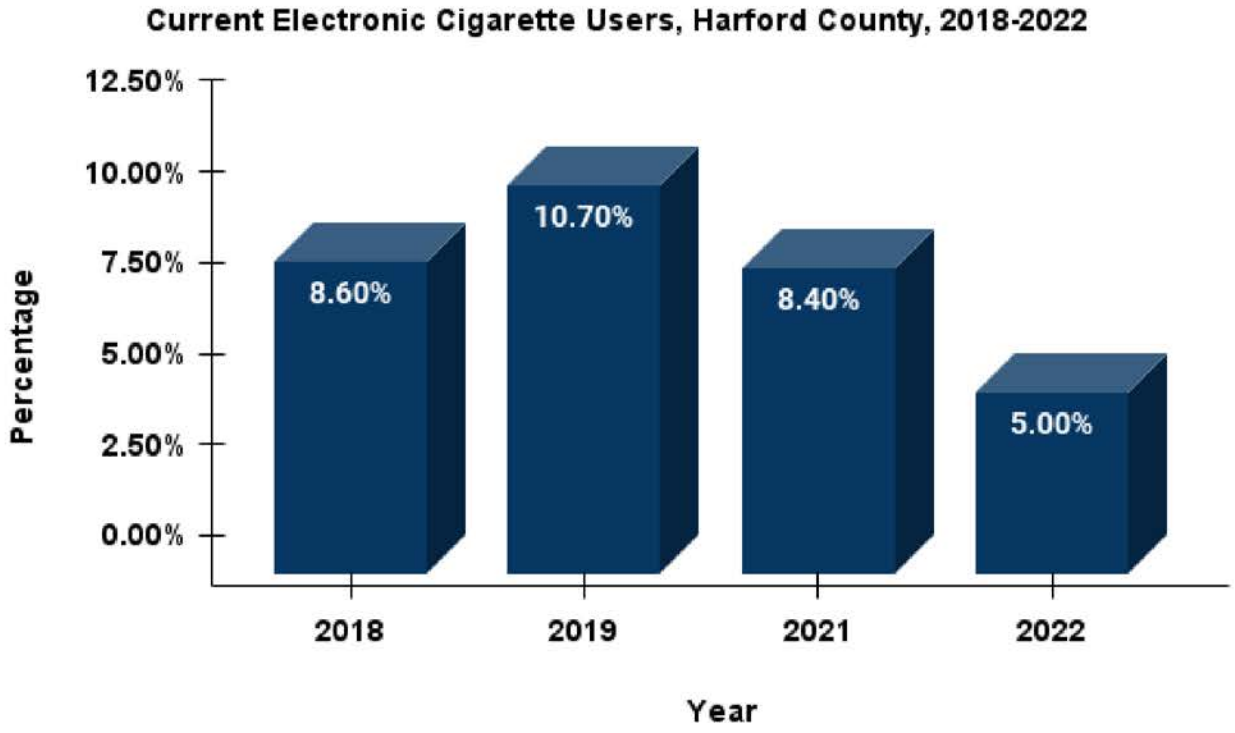
Tobacco/Vape Use

The 2021 YRBS/YTS reports that 18.6% of high school students currently use an electronic vape product, a 60% decrease from 2019. For adults over the age of 18, the smoking prevalence has been decreasing since 2018 in Harford County, with the prevalence in 2021 being 7.9%. See the chart below for comparing rates in Harford County versus Maryland.



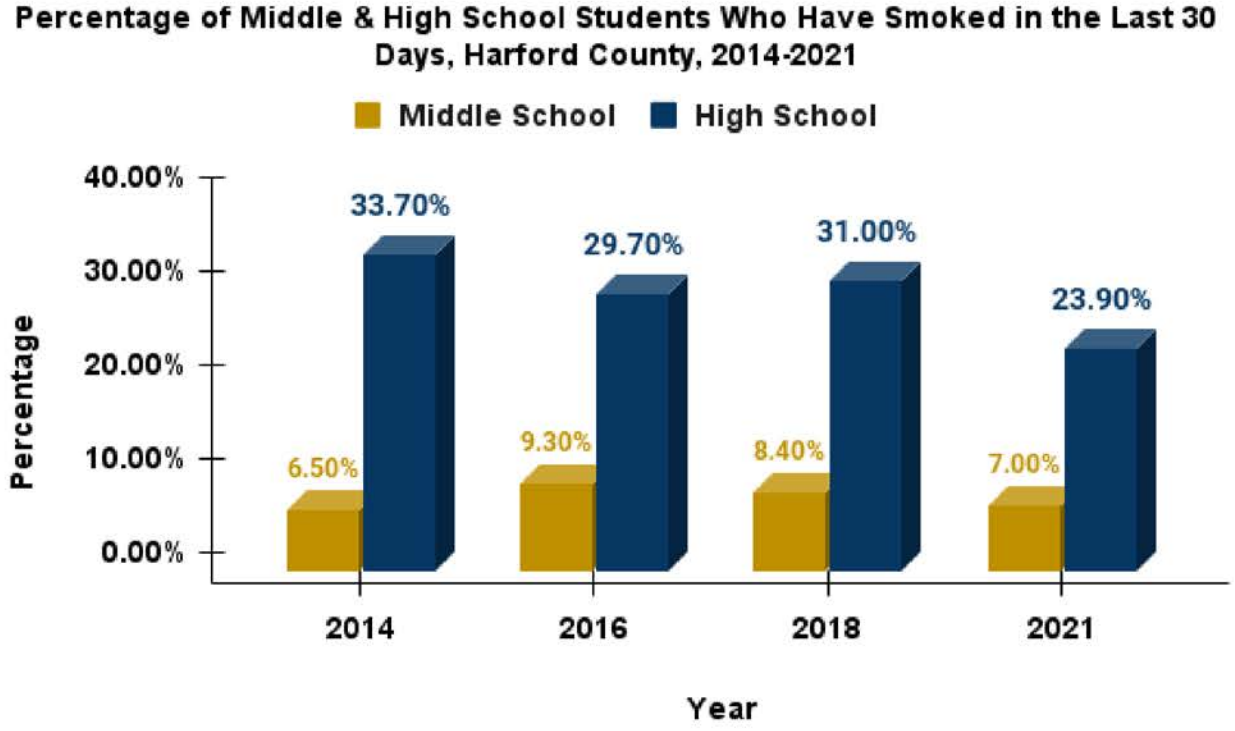


Adult electronic cigarette (e-cig) use has also decreased in the past few years, with 5% of adults indicating they currently smoke an e-cig in 2022, a 53% decrease since 2019.

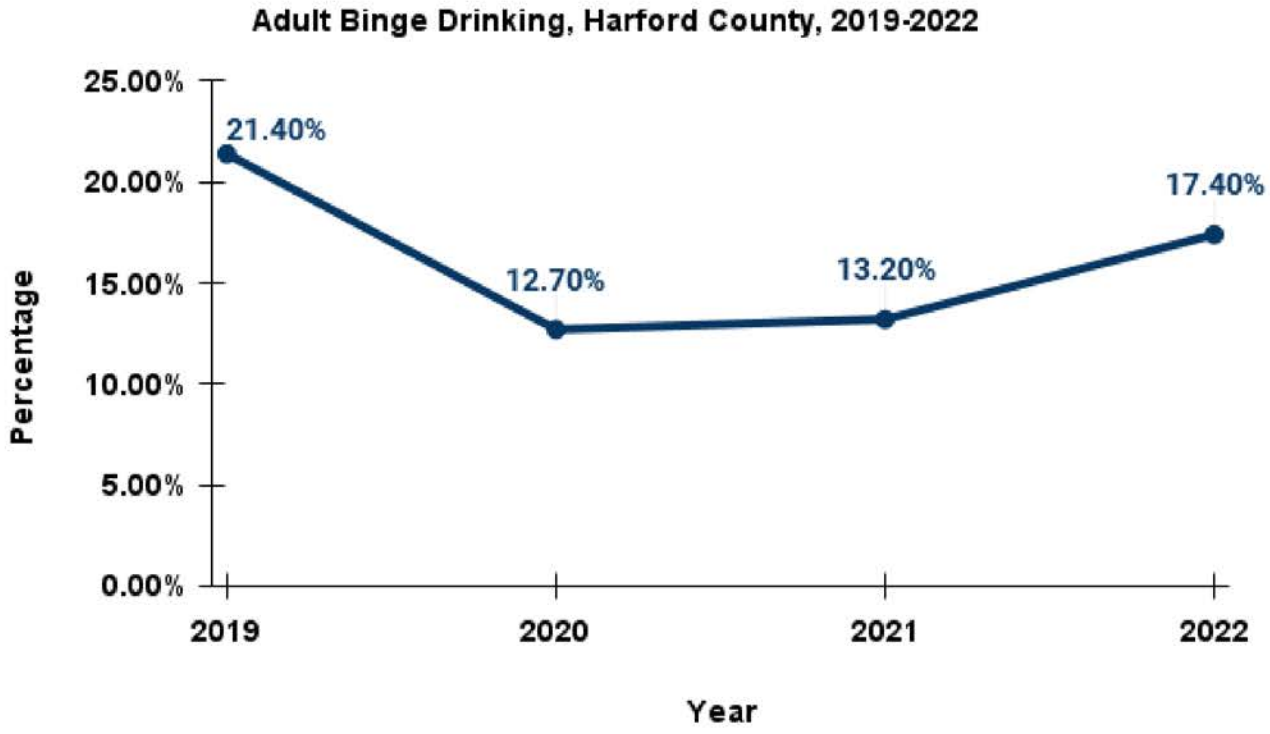


Alcohol and Drug Use

In 2021, 7% of middle school students reported having at least one drink of alcohol in the last 30 days. High school students reported higher, with 23.9% of students reporting they had at least one drink of alcohol in the last 30 days.

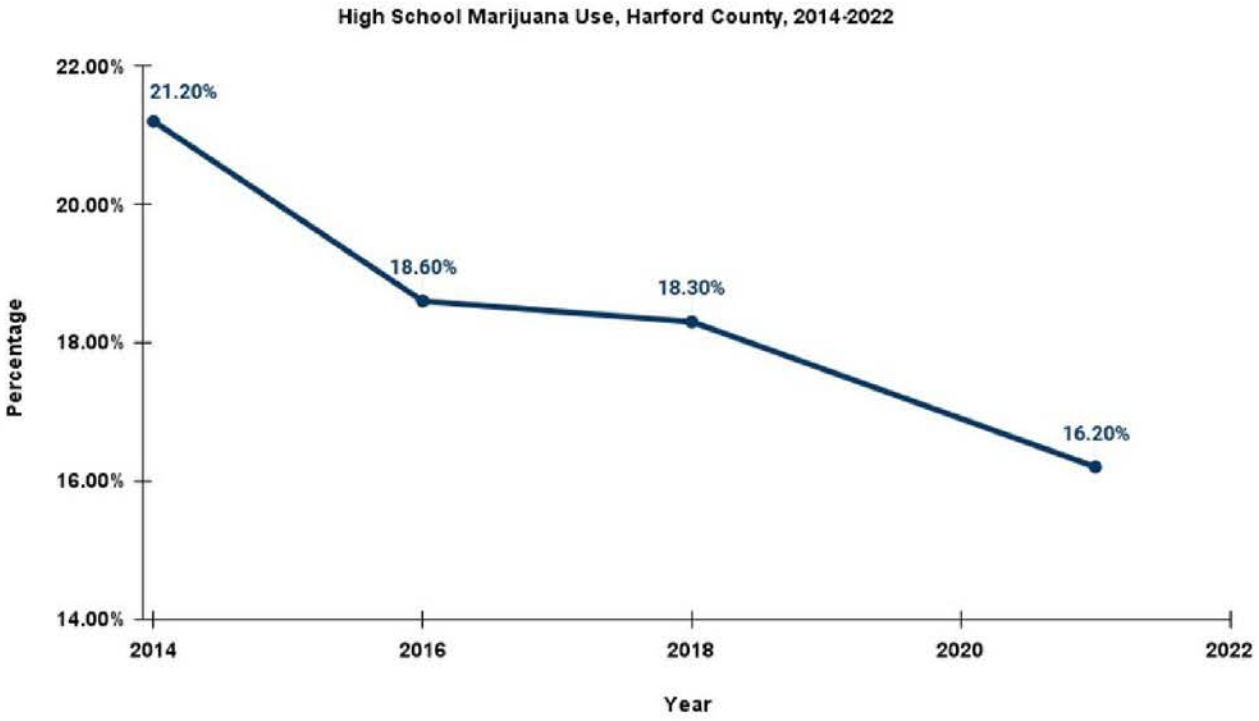


Adults were asked if they binge drank (having 5 or more drinks for men and 4 or more drinks for women on one occasion) and 17.4% of adults reported they did in the past 30 days in 2022.



Marijuana

In 2023, recreational marijuana became legal in Maryland for adults over the age of 21. While adult use is legal, anyone under the age of 21 cannot smoke marijuana or use marijuana products. In 2022, 16.2% of high school students reported using marijuana.



HEALTH OUTCOMES

The section on health outcomes reports the perceived health status, rates of occurrence, and prevalence of various health conditions in Harford County. It encompasses hospitalizations and mortality related to specific health issues, covering chronic and communicable diseases, injuries, mental health, and maternal and child health. The above section on health factors, which explored positive and negative behaviors, is linked to these health outcomes.

Perceived Health Status

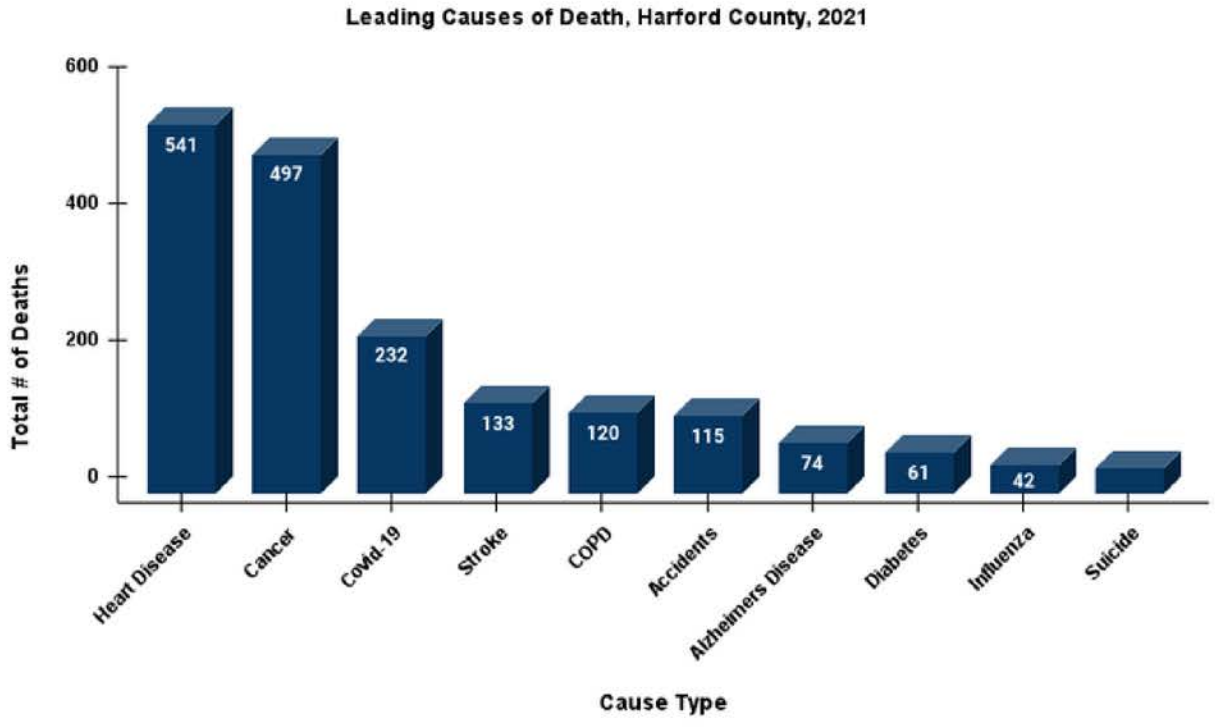
In 2021, County Health Rankings reports that 13% of adults consider themselves in fair or poor health. In the past 5 years, the findings have been fairly consistent, with the range being 11-16%. When looking at mental health status, individuals were asked how many days in the past 30 days was their mental health not good. The amount of poor mental health days has increased from 2017 to 2021 for adults. The table below shows the breakdown by each year.

Year	Percentage of adults reporting they consider themselves in fair or poor health	Poor Mental Health Days
2017	12%	3.7
2018	14%	4.3
2019	16%	4.0
2020	11%	4.4
2021	13%	5.0

Leading Causes of Death and Hospitalization

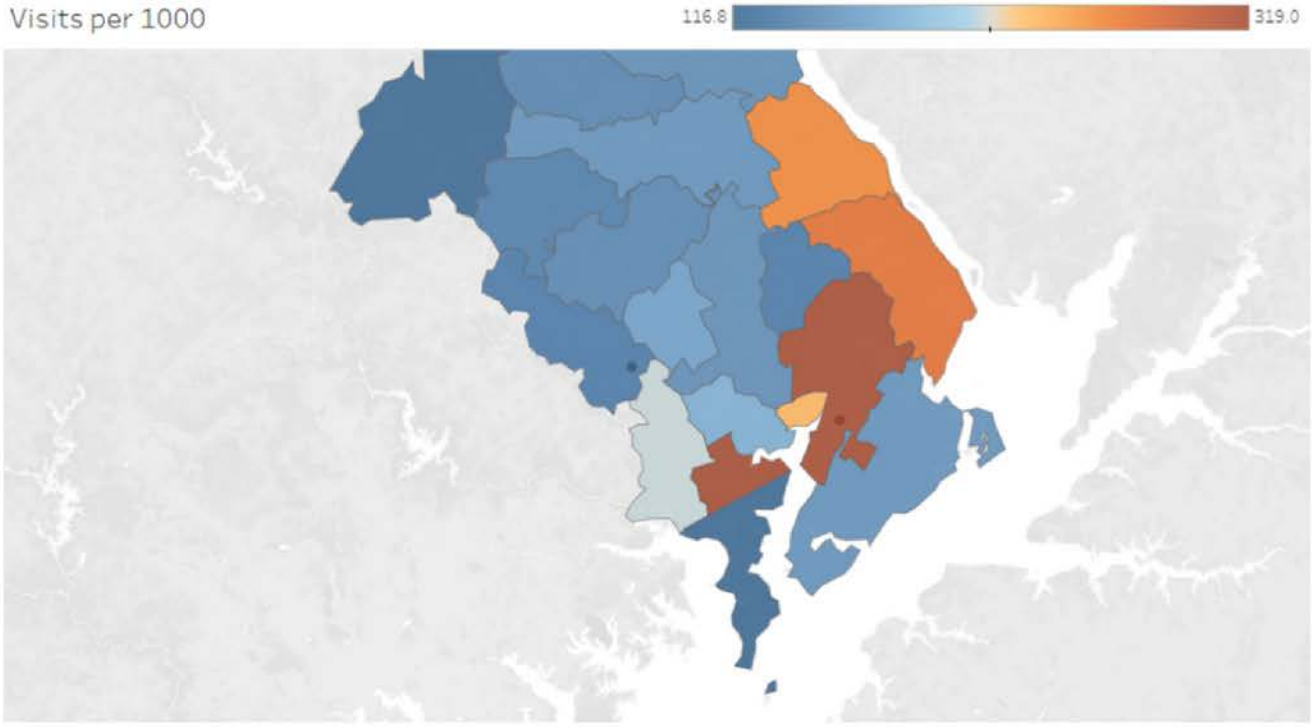
In the 2024 County Health Rankings, Harford County was ranked 8th among 24 jurisdictions for health outcomes. Years of potential life (YPLL) is used to measure premature mortality (before the age of 75) rather than overall mortality to focus on deaths that could have been prevented. Based on County Health Rankings, 7,300 years of life were lost to deaths of people under age 75, per 100,000. This rate was significantly higher for African Americans/Blacks with the YPLL being 10,400 per 100,000 deaths.

Maryland Vital Statistics reports 2,606 total deaths in 2021 and the top three causes of death were heart disease, cancer, and COVID-19. *Due to the rise of COVID-19 in 2020, COVID-19 became the 3rd leading cause of death in Harford County. If COVID were not a factor in 2020, the 3rd leading cause would be cerebrovascular disease (stroke). Stroke closely follows as the 4th leading cause of death. The age-adjusted mortality rate in 2021 for all causes was 821.9 per 100,000 deaths in Harford County and 786.3 per 100,000 in Maryland. The chart below shows all the leading causes of death in Harford County, in 2021.

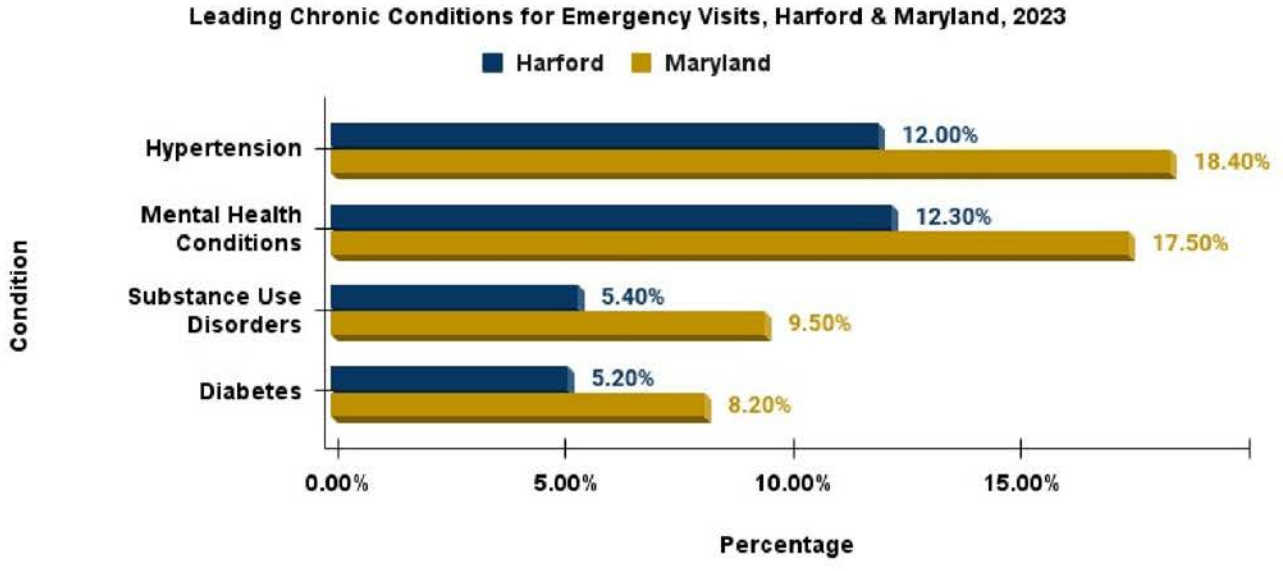


Emergency Department Visits

For 2023, CRISP's utilization map indicates that there were 204 emergency department visits per 1,000 compared to the state rate of 244 visits per 1,000. In the map below, the orange colors indicate a higher rate and the blue colors indicate a lower rate. The highest rates of ED visits in the county were for residents in Aberdeen (317 per 1,000), Edgewood (319 per 1,000), Havre de Grace (276 per 1,000), and Darlington (261 per 1,000).

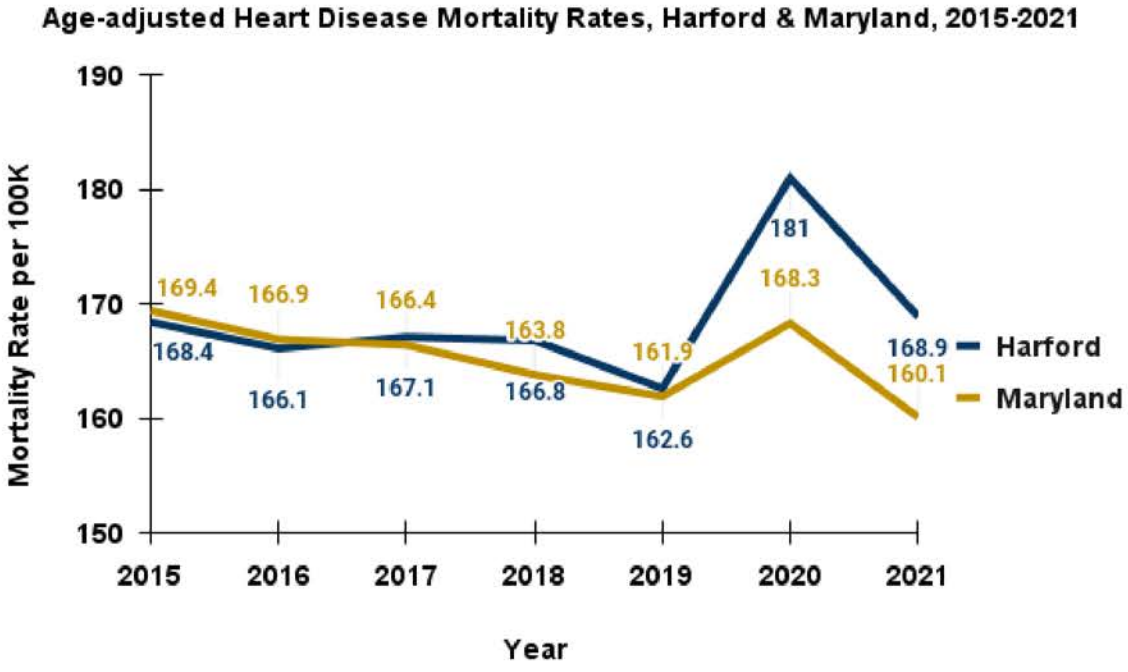


CRISP reports that the top conditions that patients came to the emergency department were hypertension, mental health conditions, substance use disorders, and diabetes, all of which aligned with the state's top conditions as well.

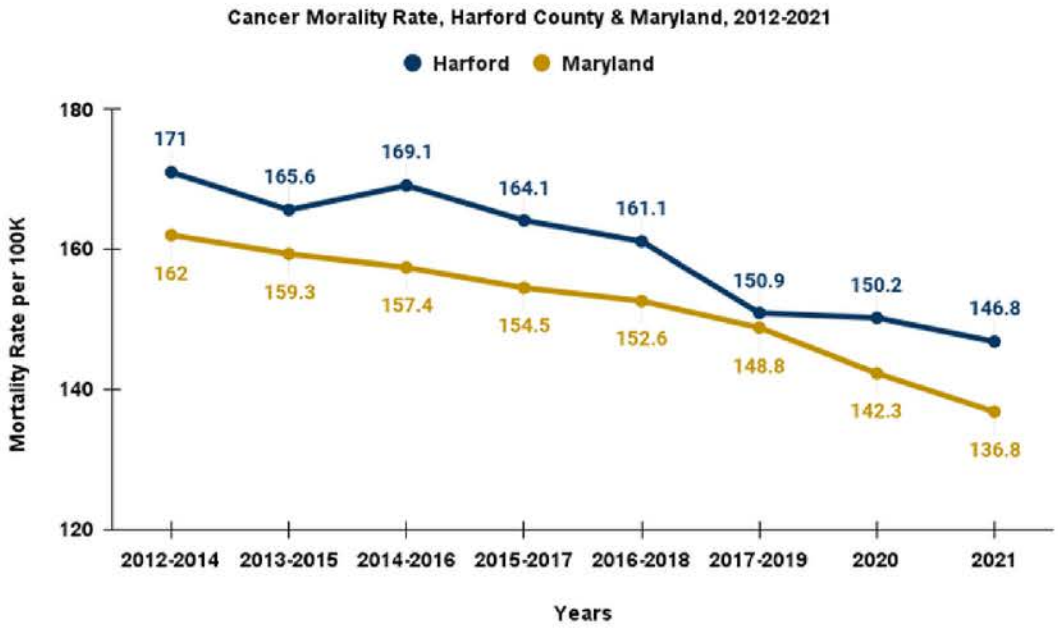


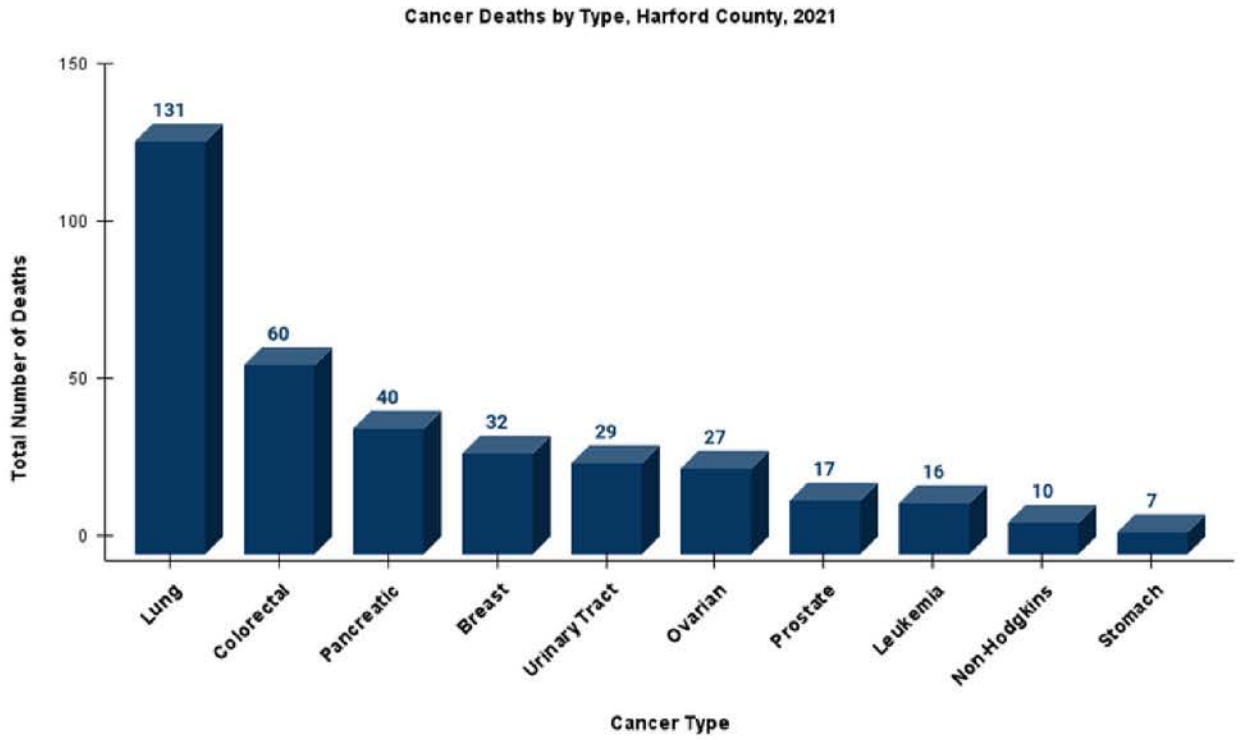
Chronic and Communicable Diseases

Heart disease is the number one cause of death in Harford County and Maryland. In 2021, 168.9 per 100,000 died from heart disease, compared to the state with a rate of 160.1 per 100,000. The rate increased in 2019 and has remained higher than the state for several years.



The cancer mortality rate has been on a decline in Harford County for several years but when compared to the state of Maryland, rates are much higher. The mortality rate for all cancers in 2021 was 146.8 per 100,000, compared to Maryland, with a rate of 136.8 per 100,000. Lung Cancer was the single cancer type resultng in the most deaths in Harford County in 2021, followed by colorectal and pancreatic.

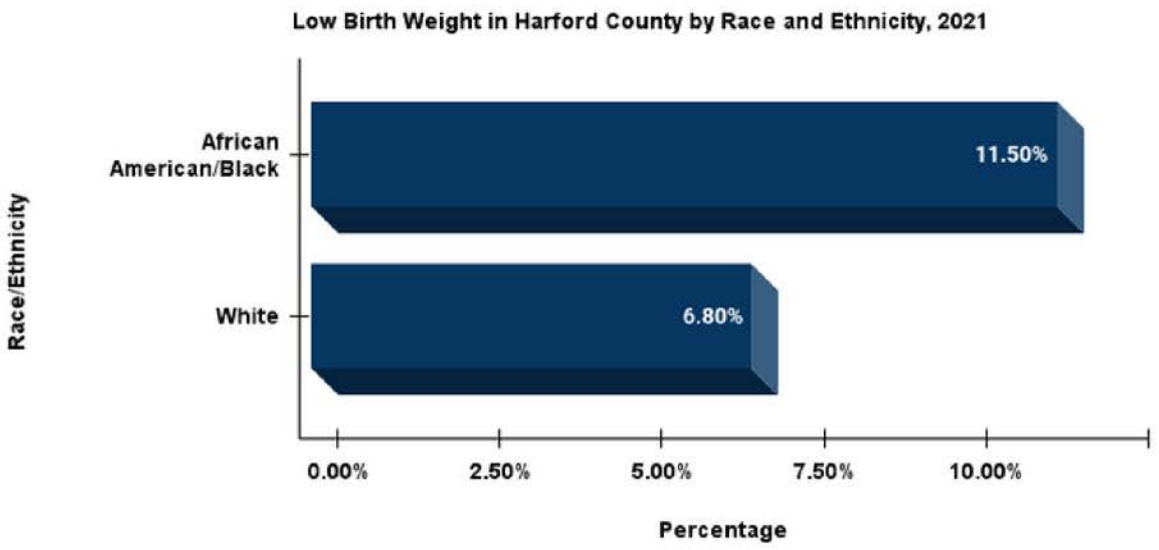




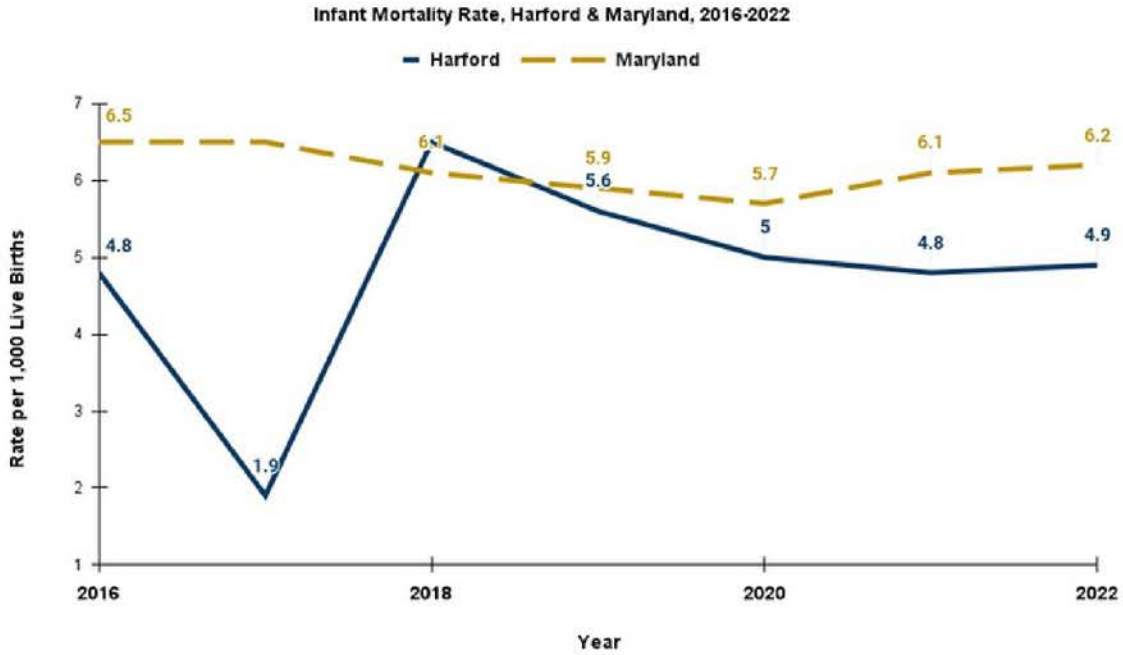
Maternal and Child Health

Maternal and child health refers to a woman's health during pregnancy, childbirth, and postpartum as well as the health of children. A mother's health immensely impacts a child's health; therefore, they must attend regular checkups and maintain their well-being. In 2021, Harford County had 2,632 live births in Harford County but only 79% of mothers received care in their first trimester and 3.8% received late (at third trimester) or no care at all during pregnancy.

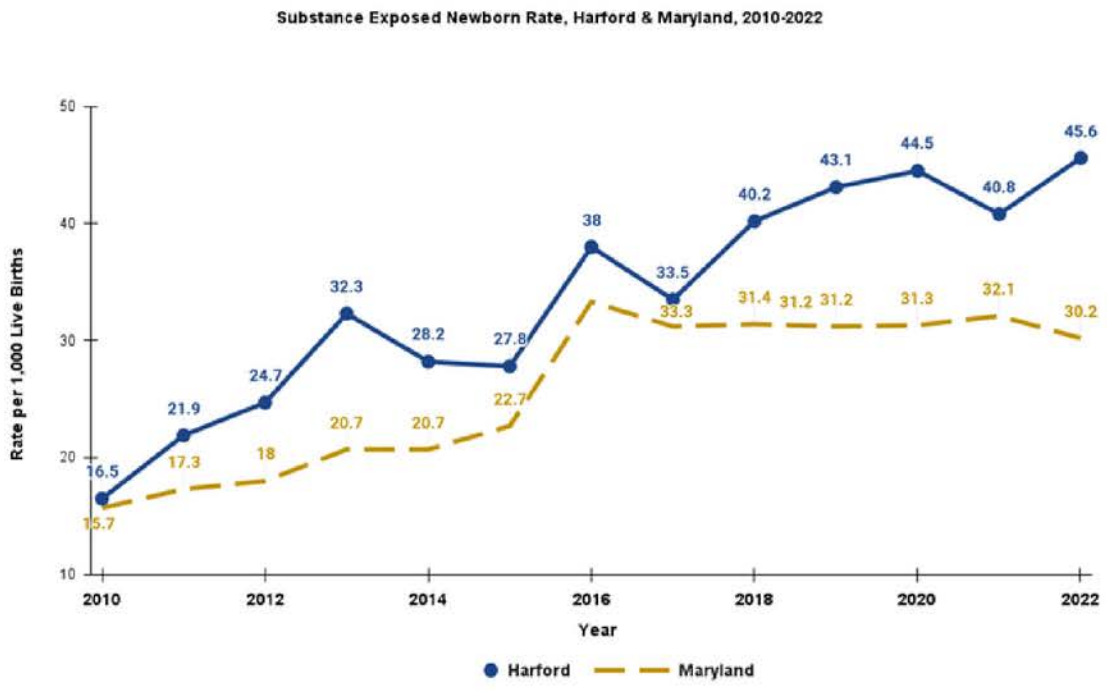
In Harford County, there are large racial disparities when it comes to maternal and child health. The rates for low birth weight (>2500 grams) were much higher for non-Hispanic African American/Black mothers (11.5%) compared to non-Hispanic White mothers (6.8%) in 2021. Low birth weight can cause health complications that start from infancy and carry on to adulthood and lead to poor outcomes.



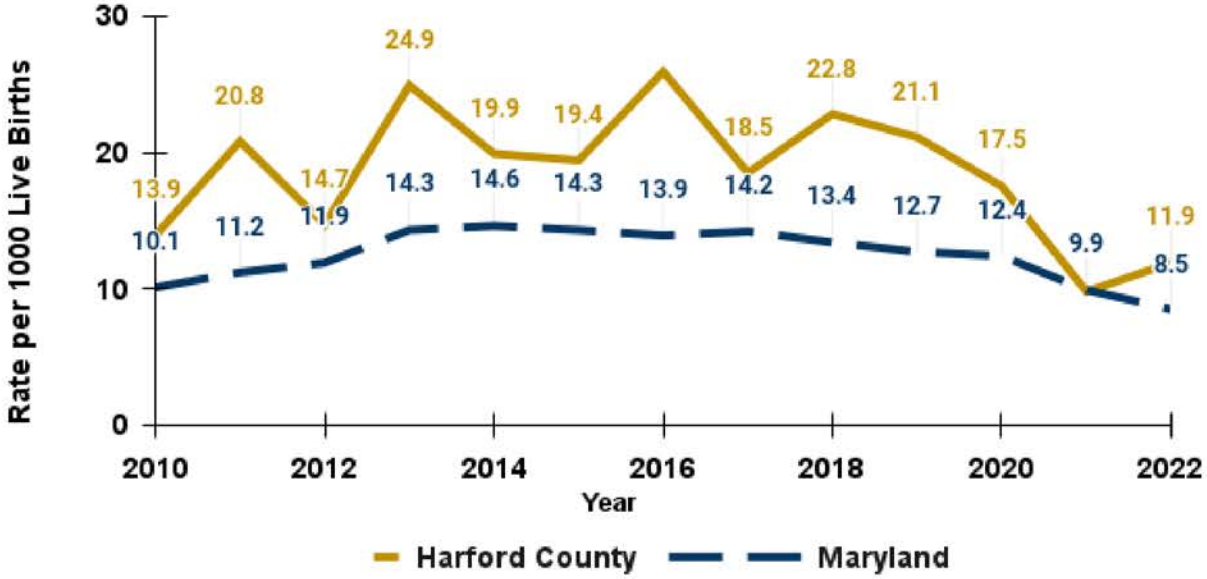
In 2022, the infant mortality rate in Harford County was 4.9 per 1,000 live births, which is lower than the state at 6.0 per 1,000 live births. The rate has declined for several years, but it is still much higher than in 2017. Racial disparities exist in infant mortality too, with the infant mortality rate being 9.8 per 1,000 births in the state of Maryland for non-Hispanic African American/Black women compared to 6.1 per 1,000 live births in the White population.



The substance exposed newborn (SEN) rate has been inclining in Harford County and remained higher than the state for several years. In 2022, the rate per 1,000 live births in Harford County was 45.6, compared to the state, at 30.2. In contrast, the neonatal abstinence syndrome (NAS) rate has been declining in Harford but remains higher than the state rate. In 2022, the NAS rate in Harford County was 11.9 per 1,000 live births, compared to the state at 8.5 per 1,000 live births.



Neonatal Abstinence Syndrome Rate in Maryland and Harford County, 2010-2020



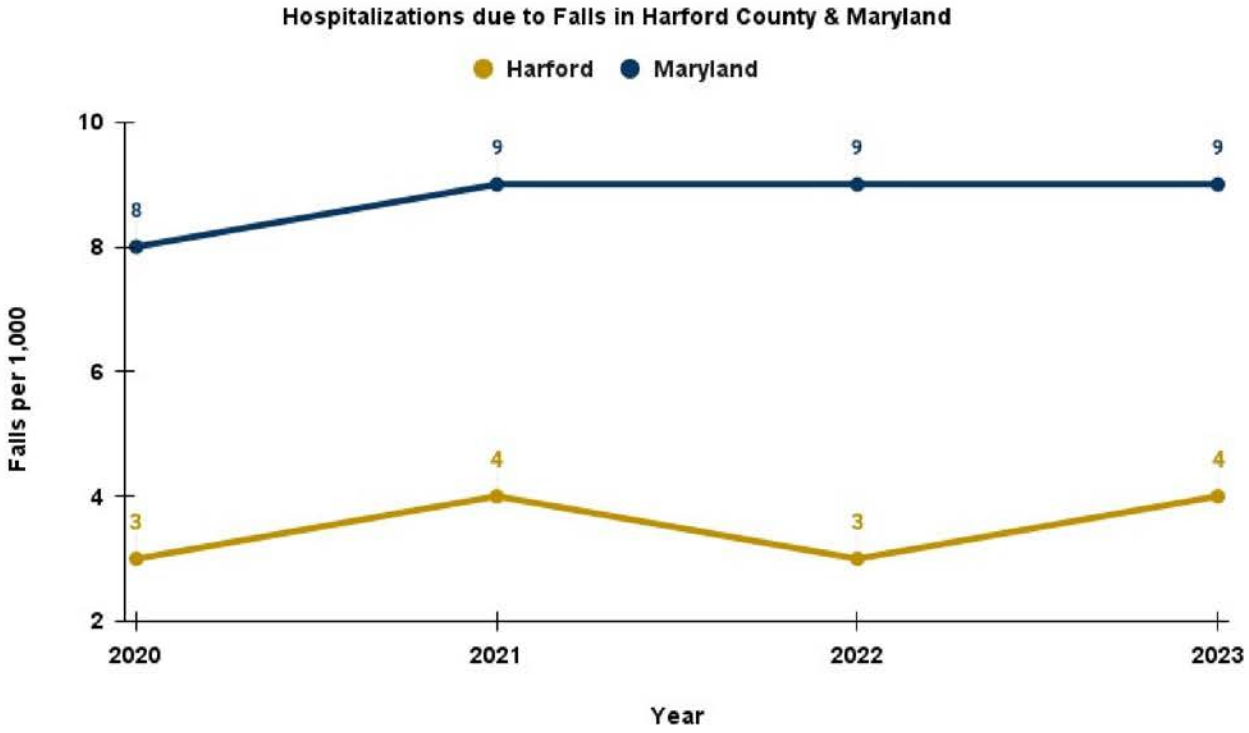
Injury

In Harford County, the total amount of deaths due to injury was 87 per 100,000, in 2021. These deaths include homicides, suicides, motor vehicle crashes, and poisonings. The age-adjusted rate for deaths by an accident was 39 per 100,000, lower than the state, at 45.1 per 100,000. The rate of homicide deaths in Harford was 4 per 100,000 compared to the state, at a higher rate, at 10 per 100,000.

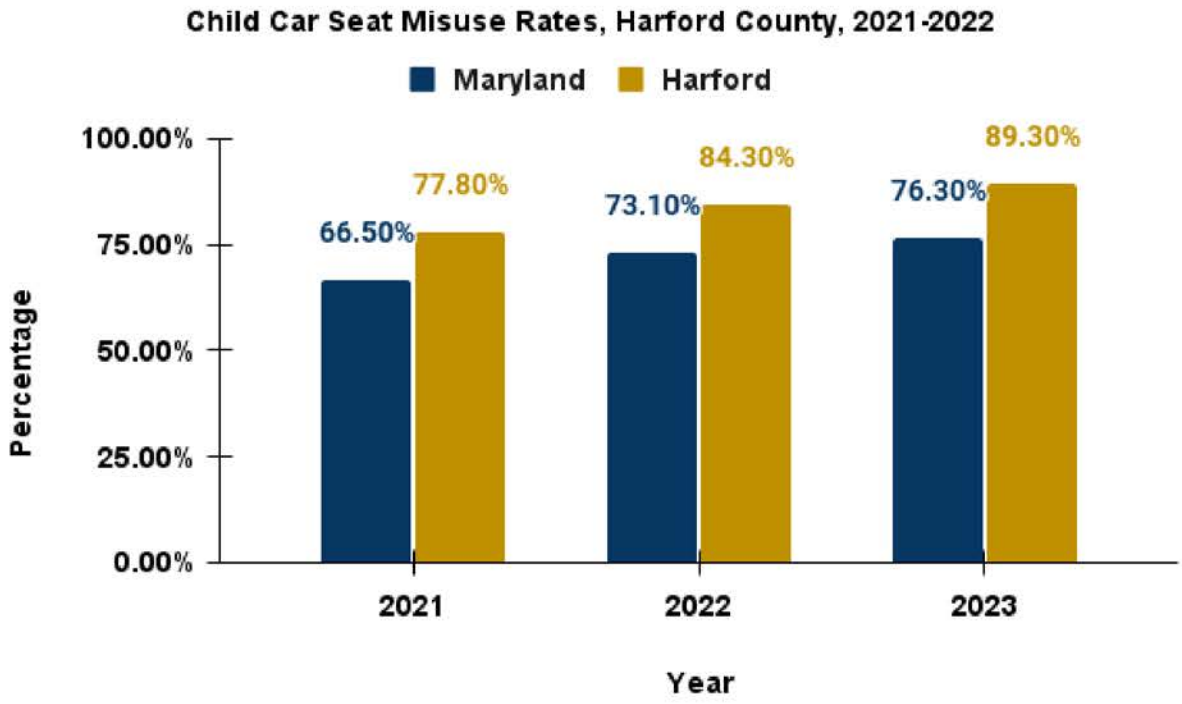
Suicide deaths have been increasing in the past few years and remain higher than the state. In Harford County, the suicide rate was 13.6 per 100,000, compared to the state at 9.7 per 100,000. Motor vehicle crashes resulted in 8 deaths per 100,000 in Harford County, compared to the state at 9 per 100,000.

	Harford	Maryland
Homicide	**4.0 per 100,000**	**10.0 per 100,000**
Intentional self-harm (suicide)	**13.6 per 100,000**	**9.7 per 100,000**
Motor vehicle crash	**8.0 per 100,000**	**9.0 per 100,000**

Falls in older adults can lead to serious injury and complications that can prevent them from completing day-to-day tasks. CRISP reports a steady number of fall hospitalizations per year in Harford County and Maryland. In 2023, Harford County had 4 per 1,000 hospitalizations due to falls and all of Maryland had 9 per 1,000.

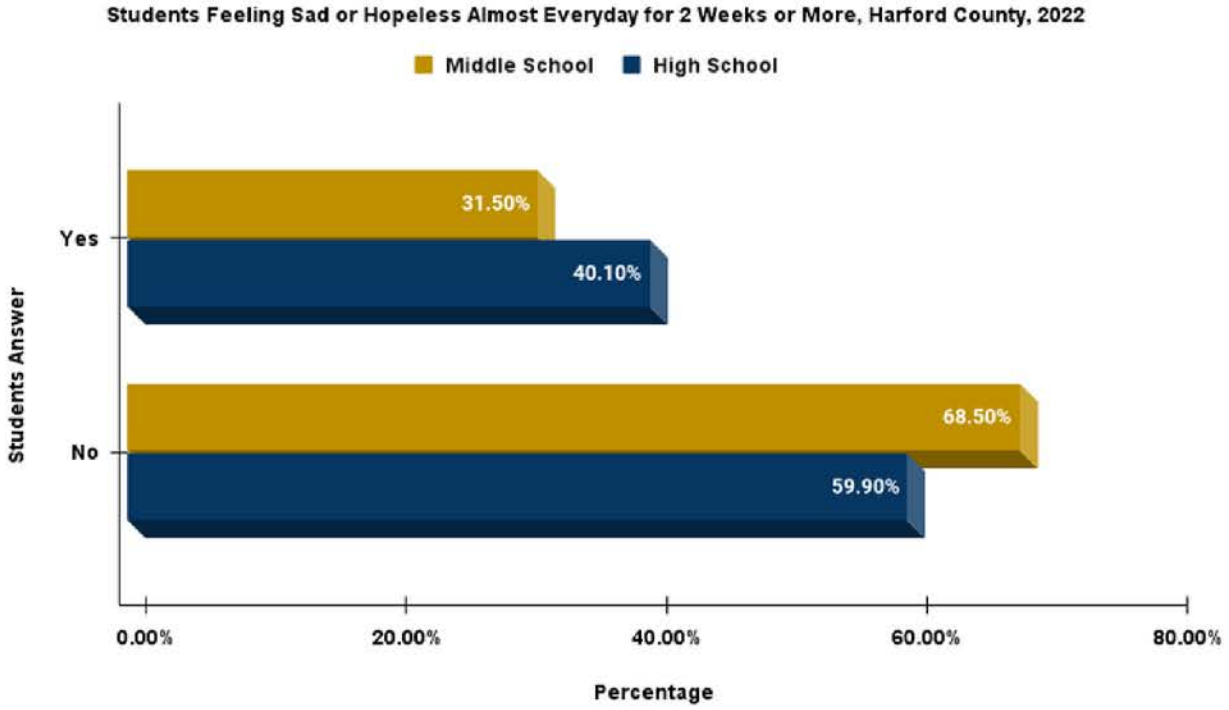


The American Automobile Association and National Safety Council observed that the car seat misuse rate in children was at 89.3% in Harford County, higher than the state average at 76.3%.

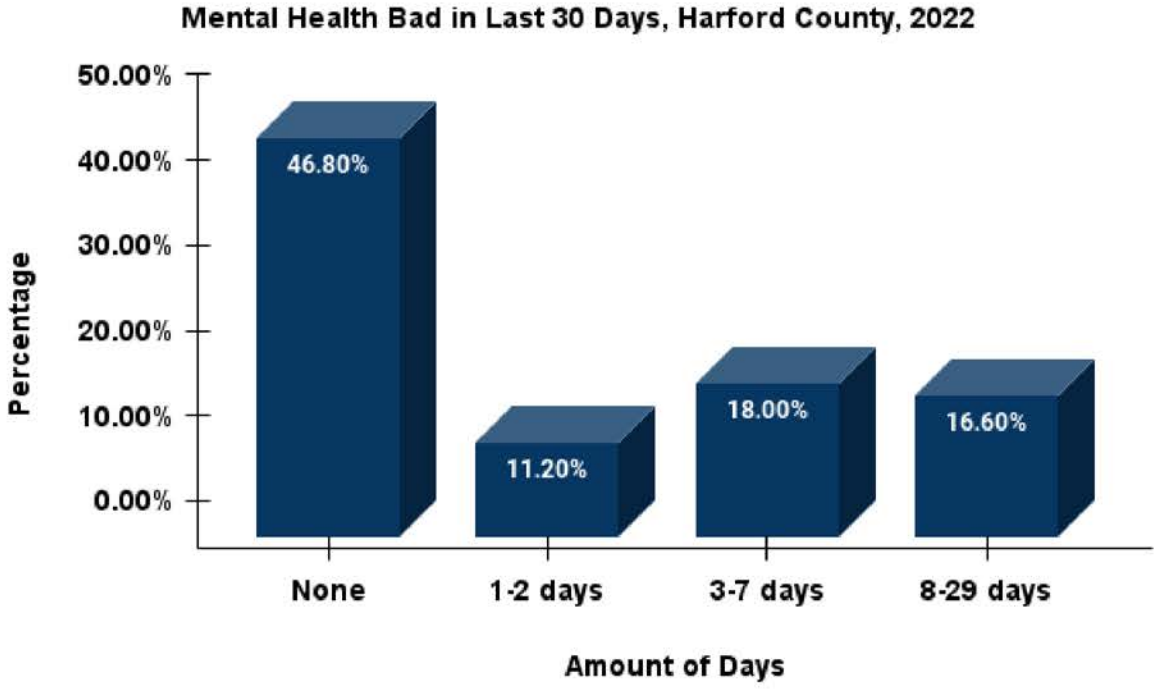


Behavioral Health

The YRBS reports 40.1% of high school students feeling sad or hopeless almost every day for two weeks or more in a row, in the past 12 months, in 2022. When middle school students were asked the same question, 31.5% answered yes.



Adults were asked how many days their mental health was not good in the past 30 days, 46.8% said none, 11.2% said 1-2 days were not good, 18% said 3-7 days were not good, and 16.6% said 8-29 days were not good.



ACCESS TO HEALTHCARE

Age	Percent Uninsured
Under 6	7.0%
6-18	2.5%
19-25	4.8%
26-34	4.3%
35-44	4.2%
45-54	3.8%
55-64	3.4%
Sex	
Male	3.7%
Female	2.9%
Education Level Attained	
Less than High School	11.4%
High School Graduate	4.7%
Some College	2.4%
Bachelors or Higher	1.1%

Access to health care has a significant influence on a person's overall health and well-being. Health Insurance is a major contributor to access to care as well as physician shortages, lack of transportation, and language barriers.

Health Insurance Coverage

Health insurance allows more people to receive quality health care and improves overall health and wellness. People without health insurance may be more likely to delay or skip receiving health care or skip preventive screenings due to costs. The table to the left shows the percentage of those uninsured broken down by different demographic variables.

While the uninsured rate for Harford County is relatively low, disparities in coverage are very prevalent. For example, 10.8% of the Hispanic population is uninsured, while 2.2% of the White population is uninsured. Percentages have been improving slightly over the last couple of years.

Language Barriers

Language barriers are also an access to care issue in the county. Effective communication is a key principle within public health and healthcare settings. Patient and client understanding is important so they can make informed decisions about their health and build trust with providers and healthcare professionals.

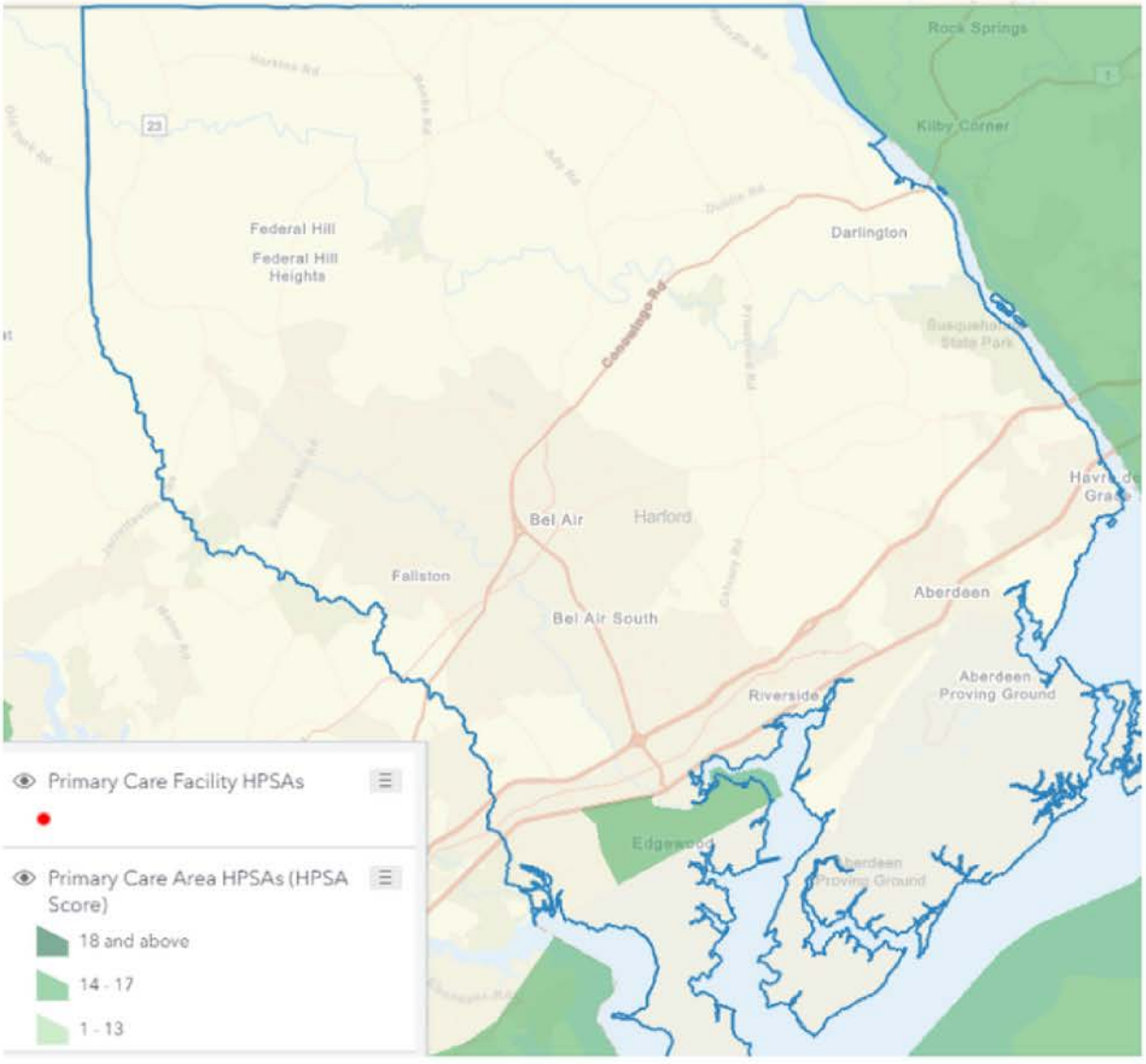
Many organizations recognize the importance of language services and offer a variety of options including professional interpreters, language line services, bilingual staff members, cultural competency training, and Limited English-Proficient (LEP) groups. As previously mentioned, the racial and ethnic diversity of Harford County is steadily growing every year, with about 7% of the population speaking a language other than English at home, see the table below. An example of how these services are utilized is the Health Department offering no-cost translation services to the LEP population who utilize their services and programs. In fiscal year 2023, HCHD used LEP services 2,781 times in 27 different languages. Bi-lingual staff can assist at all locations of HCHD.

Language	Percentage of Primary Language Used at Home
English	**92.2%**
Other Indo-European languages	**3.0%**
Asian and Pacific Islander languages	**2.2%**
Other languages	**1.0%**

Access to Primary Care and Preventive Service

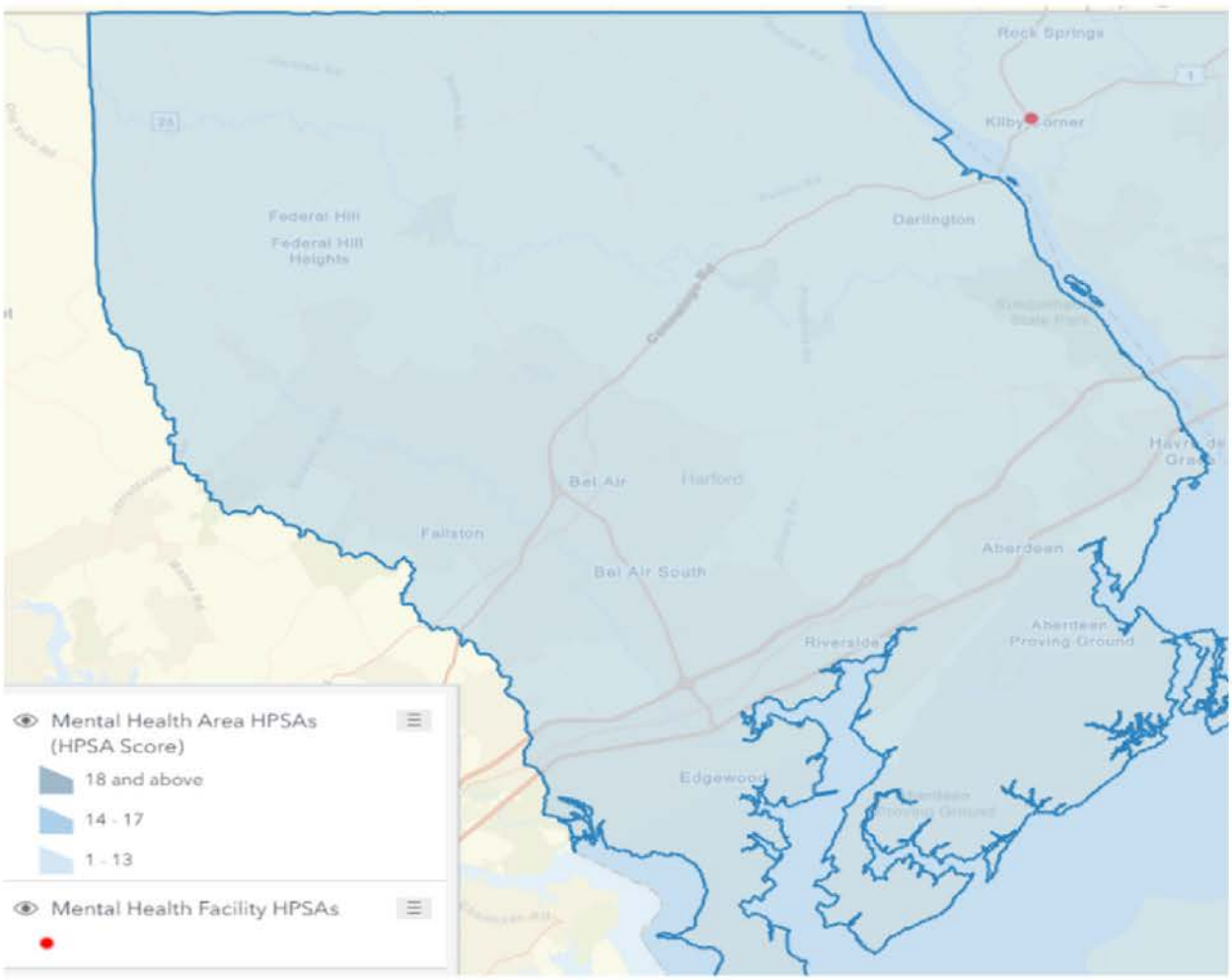
Regular exams and screening tests play a key role in detecting disease early which can lead to proper intervention. Vaccinations for influenza or coronavirus, for example, are also used to stop the spread of disease. Typically, screening exams and vaccines are at no cost to those with insurance. In Harford County, there are opportunities for these screenings to be provided at little or no cost to those without insurance.

There are approximately 143 primary care providers in Harford County, with the ratio of the population to primary care providers in Harford County being 1,850:1. This rate has continued to grow worse over the years and is higher than Maryland as a whole at 1,180:1 (County Health Rankings, 2024). The map below is from the Health Resources and Services Administration (HRSA) and they have designated Edgewood as a Health Professional Shortage Area with a score of 11 out of 25 (HRSA, n.d.) Scores range from 1 to 25 for primary care and mental health, and 1 to 26 for dental health. The higher the score, the greater the priority.



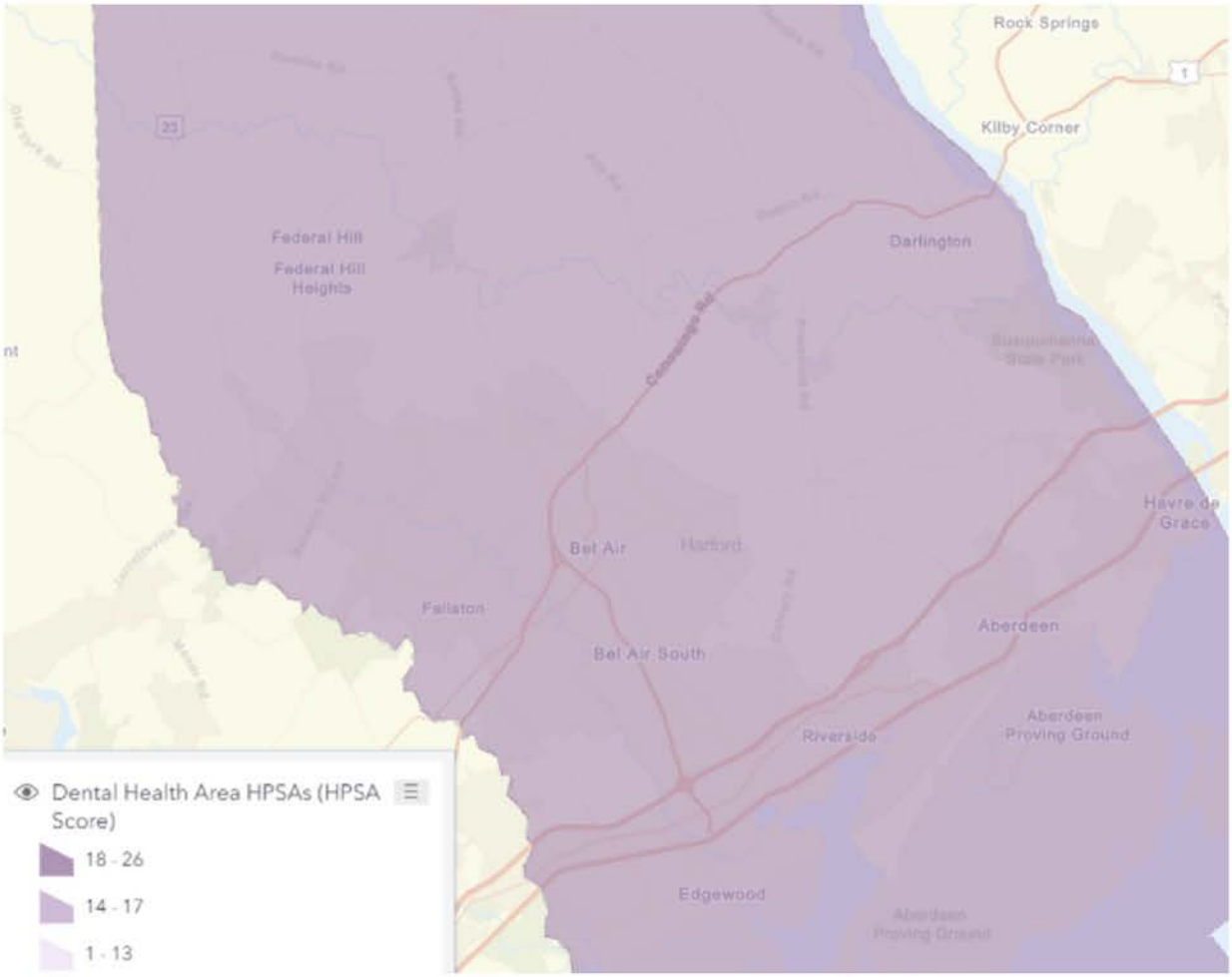
Access to Mental Health and Substance Use

Mental health is just as important as physical health for overall health and well-being. Mental illness can also lead to physical illness such as heart disease and type 2 diabetes. The COVID-19 pandemic allowed residents to access primary and mental health services via telehealth. In Harford County, there are an estimated 677 mental health providers, while the ratio of the population to mental health providers was 390:1. This rate improved from 500:1 in 2021. (County Health Rankings, 2024). Similarly to primary care providers, Harford County's ratio is worse than the state rate of 290:1. Harford County as a whole has been designated as a mental health shortage area with a score of 7 out of 25.



Access to Oral Care

Oral health is an important aspect of overall health and wellness and should not be overlooked. Poor oral health not only affects the mouth, gums, and teeth with problems such as cavities and gingivitis, but has also been linked to cancer, diabetes, heart disease, and pregnancy complications. There are an estimated 172 dentists in Harford County and the ratio of population to dentists is 390:1 (County Health Rankings, 2024). Harford County has been named a dental health shortage area, with a rating of 13 out of 26.



COVID-19 PANDEMIC

The COVID-19 outbreak officially became a global pandemic in January 2020. COVID-19 is an infectious disease caused by the SARS-CoV-2 virus. The virus spreads through liquid particles when a person coughs, sneezes or breathes. Infected individuals will experience mild to moderate respiratory illness and recover without needing special treatment. Symptoms may include coughing, congestion, fever, headaches, and loss of taste. Older individuals and those who may have an underlying medical condition could get seriously ill and require medical attention.

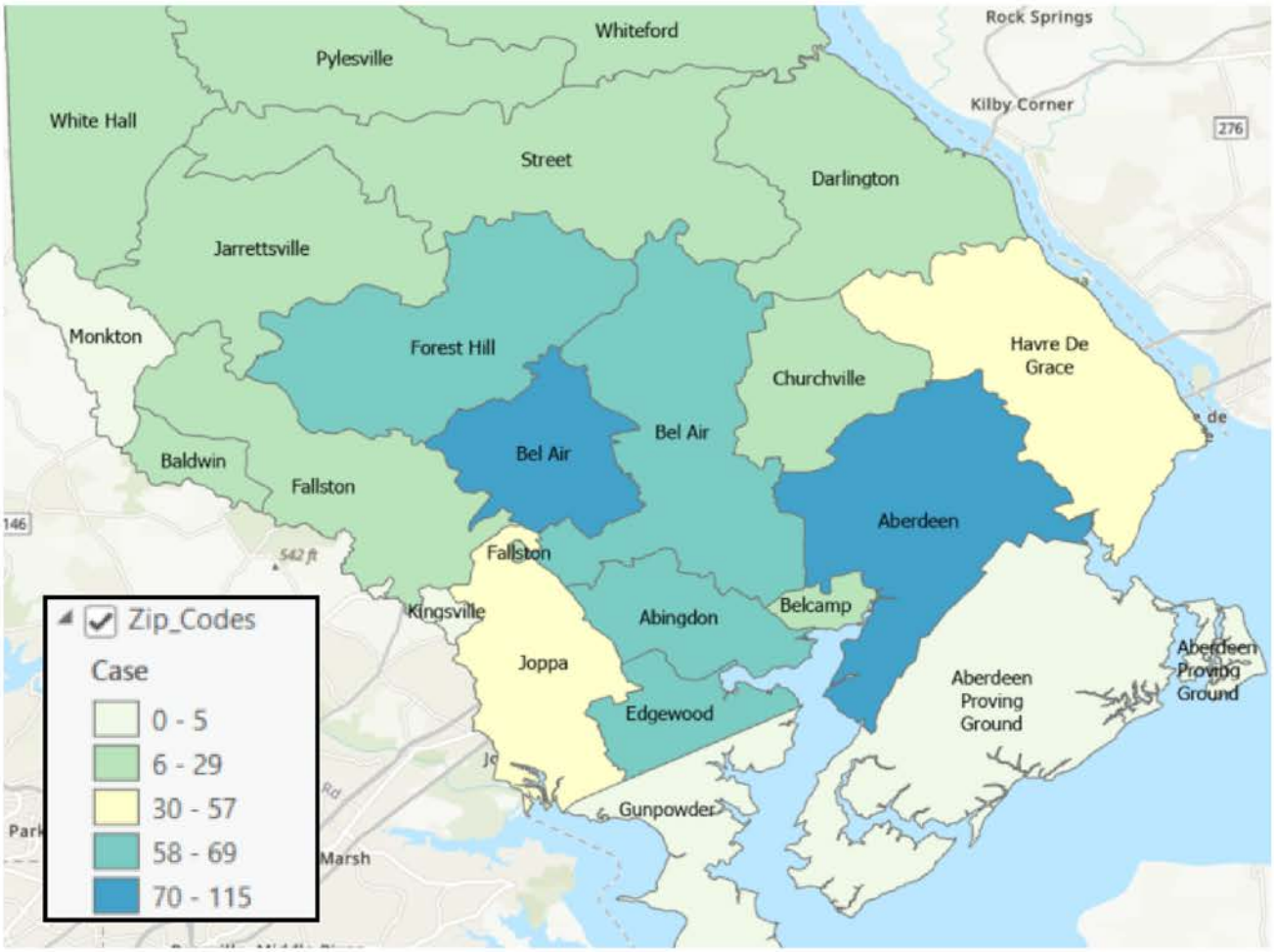
On March 5, 2020, Governor Larry Hogan declared a state of emergency for Maryland. In 2020, there were a total of 8,910 confirmed cases in Harford County, with a major spike in October 2020. The total deaths in 2020 were 177, with 85% of deaths being individuals over the age of 65. In 2021, there was an even larger spike in the summer, resulting in 20,474 confirmed cases for the entire year, and 259 deaths. As more individuals were getting vaccinated, the rate of confirmed cases went down in 2022, with 17,819 cases and 220 deaths. In 2023, the national public health emergency ended as the percentage of the population vaccinated increased. There were only 2,580 confirmed cases. An important item to note is in 2022-2023, at-home testing kits were also readily available and many people utilized this method to test if they were COVID-19 positive, and if they were, their case was most likely not reported. Regardless of the unreported cases, there was significant progress at the end of the COVID-19 pandemic in the county with 65 deaths total, a 70% decrease from 2022. From the total number of deaths between 2020 to 2024, the age group most affected was between 80-89 years old, followed by 70-79. Males were affected slightly higher, with 52.7% of deaths being males. When looking at race, 80% of COVID-19 deaths in Harford County were White, 16% African American/Black, and less than 2% for all other races. Only 2% of COVID-19 deaths were Hispanic or Latino.

Sex	Deaths by sex	Total deaths	Percentage
Male	**380**	**721**	**52.70%**
Female	**341**	**721**	**47.30%**

Age group	Deaths in age group	Total Deaths	Percentage
0-19	0	721	0.00%
20-29	5	721	0.69%
30-39	7	721	0.97%
40-49	18	721	2.50%
50-59	65	721	9.02%
60-69	133	721	18.45%
70-79	178	721	24.69%
80-89	208	721	28.85%
90-99	105	721	14.56%
100+	2	721	0.28%

Race	Deaths by race	Total deaths	Percentage
American Indian or Alaskan Native	0	721	0.00%
Asian	10	721	1.39%
Black/African American	117	721	16.23%
Native Hawaiian or Other Pacific Islander	0	721	0.00%
Other	6	721	0.83%
White	577	721	80.03%
Ethnicity	**Deaths by ethnicity**	**Total deaths**	**Percentage**
Not Hispanic or Latino	710	721	98.47%
Hispanic or Latino	11	721	1.53%

The zip codes with the highest number of deaths in Harford County were Bel Air (21014) with 115 deaths, Aberdeen (21001) with 89 deaths, Abingdon (21009) with 69 deaths, Bel Air South (21015) with 65 deaths, Forest Hill (21050) with 65 deaths, and Edgewood (21040) with 61 deaths. See the map below.



PRIMARY DATA COMMUNITY HEALTH SURVEY

Background

The customized survey consisted of 50 questions to assess access to care, health status and behaviors, and health-related community strengths and opportunities. The online survey took respondents approximately 15-20 minutes to complete. 2,242 total respondents completed the survey, which is a 65% increase from the previous Community Health Needs Assessment (CHNA) Survey in 2021.

The following section provides an overview of the findings from the CHNA Survey including highlights of important health indicators and health disparities. The sample was not representative of the population of Harford County based on age, race, and sex. When looking at the data, please take this into consideration.

Demographic Info

Tables 1 and 2 depict the demographic profile of the respondents who completed the online survey.

Table 1. ZIP Code Representation

ZIP Code (City)	%	ZIP Code (City)	%
21014 (Bel Air)	15.55%	21040 (Edgewood)	6.28%
21078 (Havre de Grace)	13.27%	21047 (Fallston)	5.35%
21015 (Bel Air South)	10.91%	21085 (Joppa)	4.63%
21009 (Abingdon)	9.84%	21084 (Jarrettsville)	2.23%
21001 (Aberdeen)	8.86%	21154 (Street)	2.05%
21050 (Forest Hill)	7.66%	Other	8.55%

Table 2. Demographic Information

Demographics	Percentage
Gender	
Male	**26%**
Female	**73%**
Preferred not to answer	**1%**
Age	
18-44	**20%**
45-65	**38%**
65+	**42%**
Race/Ethnicity	
White	**79.29%**
African American/Black	**14.25%**
Hispanic/Latino*	**1.92%**
Asian	**2.23%**
Middle Eastern	**.31%**
Other	**.49%**

*Hispanic/Latino respondents can be of any race, for example, White Hispanic or Black/African American Hispanic

The marital status, education level, employment status, and income level were also assessed for each respondent. The majority of respondents (65.43%) were married. Approximately 9.78% of respondents were single (never married) and 11.84% were divorced. 13.19% of respondents attained a high school diploma or GED and below. Approximately one-third (31.37%) of respondents attained some college or technical school, and 55.45% of respondents had an undergraduate degree or higher. The majority of respondents were retired or currently employed and working full-time (38.01% and 45.42% respectively). In addition, more than half of the respondents (59.8%) had an annual household income of $75,000 or more. 7.8% of respondents indicated that they had a household income of less than $25,000.

Table 3. Demographic Information

Demographics	Percentage
Marital Status	
Married	65.43%
Divorced	11.84%
Widowed	8.49%
Separated	1.25%
Never Married	9.78%
Member of an unmarried couple	3.22%
Education Level	
Never attended school or only kindergarten	.04%
Grades 1-8	.13%
Grades 9-11	.98%
Grade 12	11.92%
College 1-3 Years	29.91%
College 4 or more Years	26.79%
Graduate Level Degree	28.21%
Other	2.01%
Employment Status	
Employed, full time	45.42%
Employed, part time	8.29%
Not employed, looking	1.84%
Not employed, not looking	.83%
Retired	38.01%
Disabled, not able to work	3.24%
Student	.79%
Homemaker	1.58%

Annual Household Income	Percentage
Less than $10,000	2.27%
$10,000 - $24,999	5.55%
$25,000 - $49,999	11.99%
$50,000 - $74,999	17.41%
$75,000 - $99,000	15.42%
$100,000 - $149,000	23.59%
$150,000 +	20.57%

Access to Healthcare

The survey reported that 96% of respondents had health care coverage and 73% said they have at least one provider or family doctor that they can go to once a year for routine checkups, vaccines, or minor illnesses. The sources of health insurance are detailed in Table 4.

Table 4. Source of Health Insurance Coverage

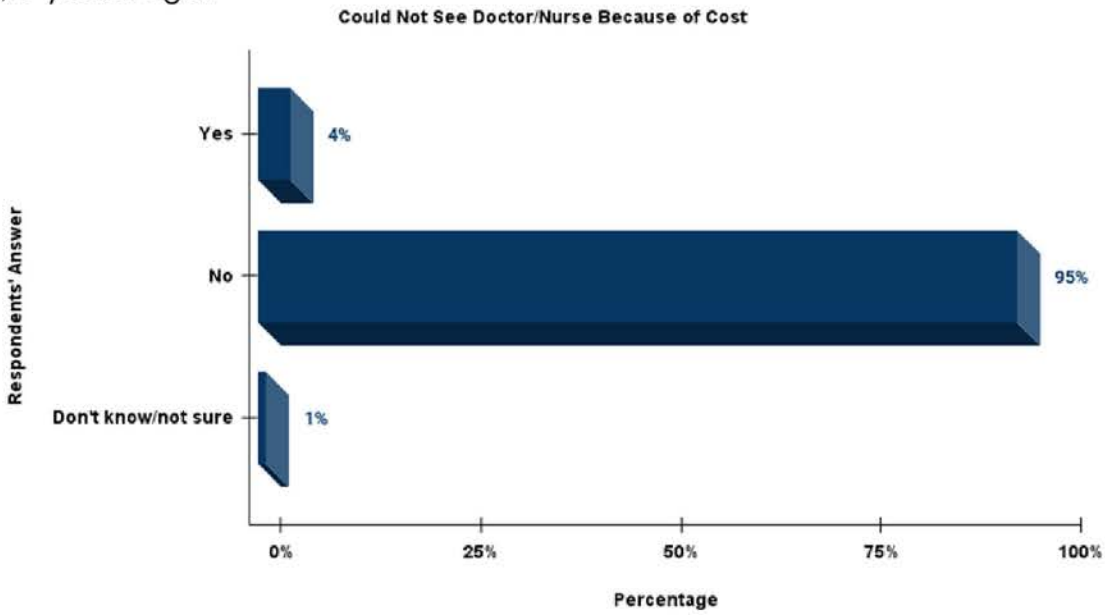
Health Insurance Source	%
Medicare/Advantage	51%
Commercial Insurance/Private Insurance	46%
TriCare (Military)	7%
Medicaid/Medical Assistance (MCHP)	6%
Don't know/Not sure	4%
Uninsured/Self-pay	0%

In addition, 92% of respondents had a routine checkup within the past year and 6% had one within the last 2-5 years. The responses are detailed in Table 5.

Table 5. Routine Checkup

How long since last visited a doctor for a routine checkup?	%
Within the past year (anytime less than 12 months ago)	92%
Within 2 to 5 years	6%
5 or more years ago	1%
Don't know/Not sure	1%
Never had a routine physical or doctor's visit	0%

About 4% of respondents said that they needed to see a doctor but could not because of cost in the past 12 months, which was 2% lower than the previous survey, 3 years ago.



Respondents were asked if they were delayed in getting needed medical care in the past 12 months for any of the following reasons, see Table 6. 72% said they did not delay getting medical care or did not need medical care. Of those that were delayed, 18% said they could not get an appointment soon enough, 8% said they could not get through on the telephone, 5% said the wait was too long once in the office, and another 5% said they did not trust the doctor/healthcare.

Table 6. Delayed Medical Care

Have you delayed getting needed medical care for any of the following reasons in the past 12 months?	%
No, I did not delay getting medical care/did not need medical care.	**72%**
You couldn't get an appointment soon enough.	**18%**
You couldn't get through on the telephone.	**8%**
Lack of trust in doctor(s)/healthcare.	**5%**
Once you got there, you had to wait too long to see the doctor.	**5%**
Other (please specify)	**4%**
You didn't have transportation.	**2%**
The clinic/doctor's office wasn't open when you got there.	**1%**

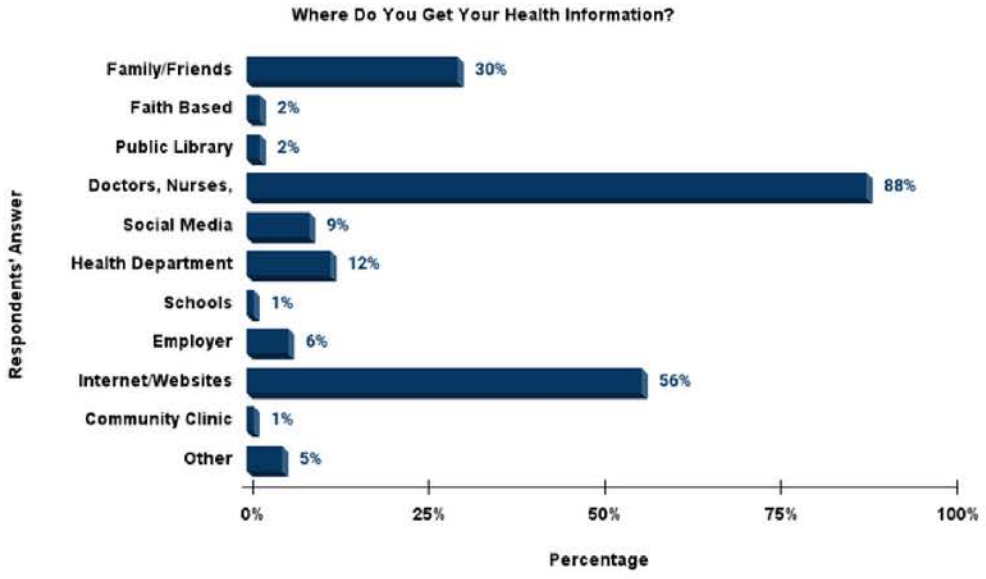
Respondents were asked if they travel outside of Harford County to seek medical care and 49% said yes. Table 7 details the type of care received outside of the county.

Table 7. Medical Care Received from Outside of Harford County

Medical Care Received	# of Respondents
Primary Care	70
Surgery	50
OB/GYN	26
Dermatology	24
Neurology	20
Orthopedic	18
Dental Care	18
Cancer Care	17
Rheumatologist	14
Cardiac	2

Health Information

Respondents were asked where they get their health information and 88% said doctors, nurses, pharmacists, or from a hospital, followed by 56% who said they also get their information from the internet or websites. The graph below shows all the sources that respondents say they use.



Health Status & Chronic Health Issues

Overall Physical & Mental Health

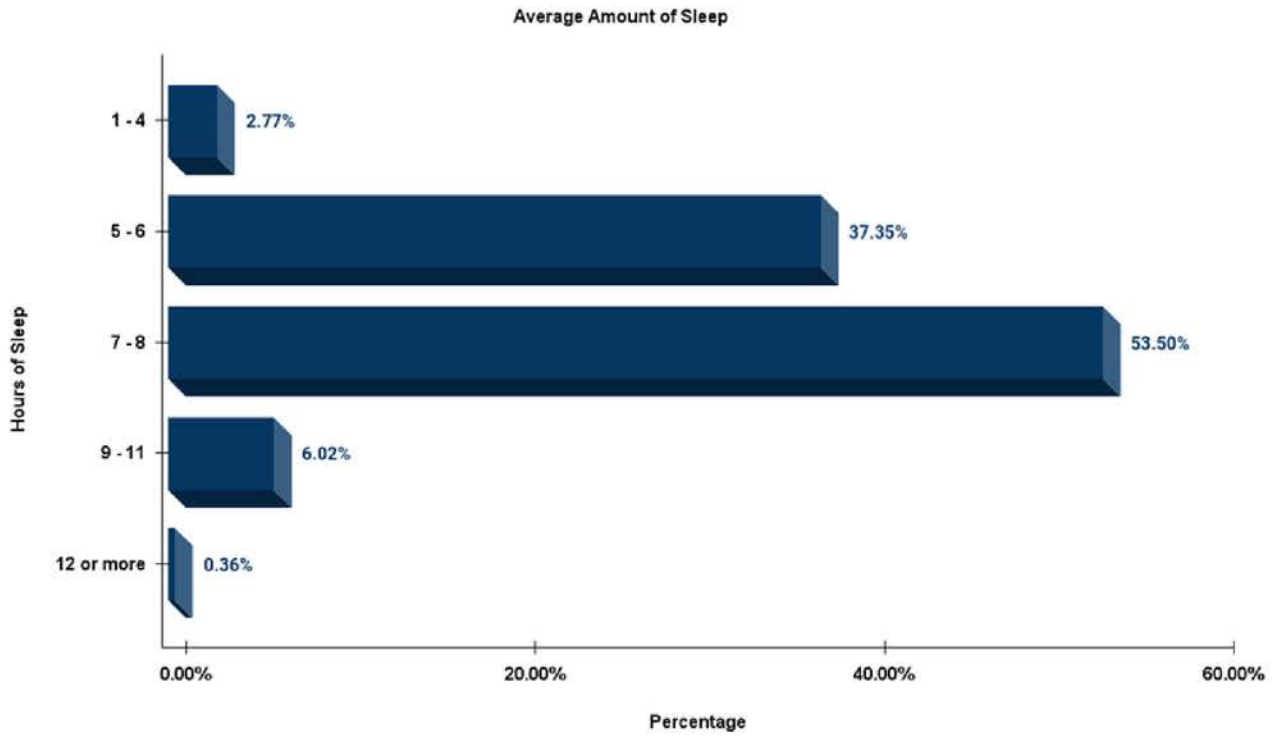
Respondents were asked to rate their general health status. Approximately 74.7% of respondents stated their general health is good or very good. Approximately 16% of respondents stated their general health is fair or poor. Respondents were also asked to rate their overall physical and mental health. In general, self-reported measures of poor physical and mental health days were favorable among Harford County respondents. 38.74% and 45.54% of respondents reported having no poor physical health (including physical illness and injury) or mental health (including stress, depression, and problems with emotions) days during the past 30 days, respectively. 26.92% of respondents reported having poor physical health and 23.77% reported having poor mental health for a maximum of only one to two days during the past 30 days.

Table 8: Number of Days per Month Physical/Mental Health Has Not Been Good

	Physical Health	Mental Health
	Percentage	Percentage
No Days	38.74%	45.54%
1-2 Days	26.92%	23.77%
3-7 Days	18.48%	15.33%
8-14 Days	7.60%	7.95%
15-30 Days	7.55%	6.49%

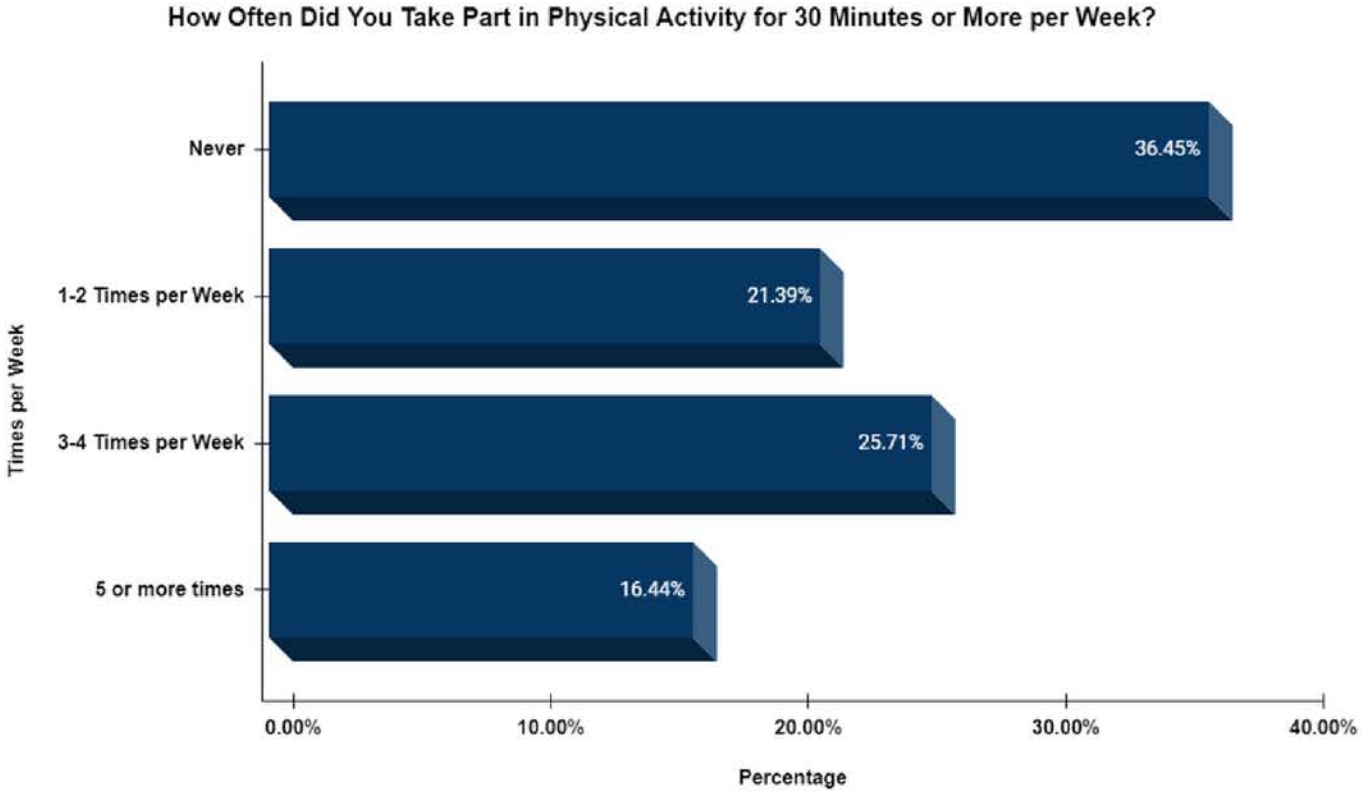
Sleep

Respondents were also asked how many hours of sleep they get in a 24-hour period, on average. The vast majority of respondents (90.85%) reported getting 5 to 8 hours of sleep and 6.38% reported getting 9 or more hours of sleep. An average of 7 to 8 hours of sleep is recommended for adults by the National Sleep Foundation.



Physical Activity

It is widely supported that physical activity can reduce health concerns such as obesity and overweight, heart disease, and joint and muscle pain. It is recommended that individuals regularly engage in at least 30 minutes of moderate physical activity, preferably daily, and at least 20 minutes of vigorous physical activity several days a week. Approximately 63.54% of respondents reported that they have participated in physical activities or exercises such as running, calisthenics, golf, gardening, or walking during the past month.



Dietary Behaviors

Respondents were asked about their consumption of fruits and vegetables. 45%-50% of respondents reported that they consumed fruits and vegetables at least 1-3 times per week.

Table 9: Frequency of fruit and vegetable consumption

	Fruits	Vegetables
	%	%
1-3 Times per week	45.67%	50.67%
4-6 Times per week	29.62%	31.58%
7 or more times	18.15%	12.53%
Never	6.56%	5.22%

Participants were also asked about the frequency in which they consume sugar sweetened beverages. This includes sodas, flavored juice drinks, sports drinks, sweetened tea, coffee drinks, energy drinks, and electrolyte replacement drinks. "Never" and "1-3 times per week" reported an equal number of respondents at 37.81% each.

Table 10: Sugar Sweetened Drink Consumption

Times per Week	%
Never	37.81%
1-3 Times per week	37.81%
4-6 Times per week	11.47%
7 or more times	12.9%

Chronic Conditions

Some chronic conditions are of concern in Harford County, including high cholesterol, high blood pressure, anxiety disorder and depressive disorder. Approximately 49.73% of respondents have been told they have high cholesterol and 50.09% have high blood pressure. In addition, 18.72% of respondents have been told they have cancer. 27.72% of respondents have been told they have an anxiety disorder and 23.26% have been told they have depressive disorder. Respondents also mentioned other chronic conditions that they have been diagnosed with but were not included in the survey list. Hyper/hypothyroidism and obesity were the most frequently mentioned conditions. A summary of chronic condition diagnoses among respondents is reported in the Table below.

Table 11: Chronic Condition Diagnosis

Chronic Condition	%
High Blood Pressure	**50.09%**
High Cholesterol	**49.73%**
Arthritis	**42.83%**
Anxiety Disorder	**27.72%**
Depressive Disorder	**23.26%**
Cancer	**18.72%**
Asthma	**17.34%**
Diabetes	**16.93%**
Heart Disease	**13.99%**
Autoimmune Disease	**13.73%**
Chronic Obstructive Pulmonary Disease (COPD)	**5.48%**
Heart Attack	**4.46%**
Stroke	**4.14%**

Health Risk Factors

Health Behaviors

Respondents were asked how often they practice certain health and safety practices. As detailed in Table 12, respondents were highly likely to use health and safety measures including wearing a seatbelt, driving responsibly, practicing safe sex, and using sunscreen regularly.

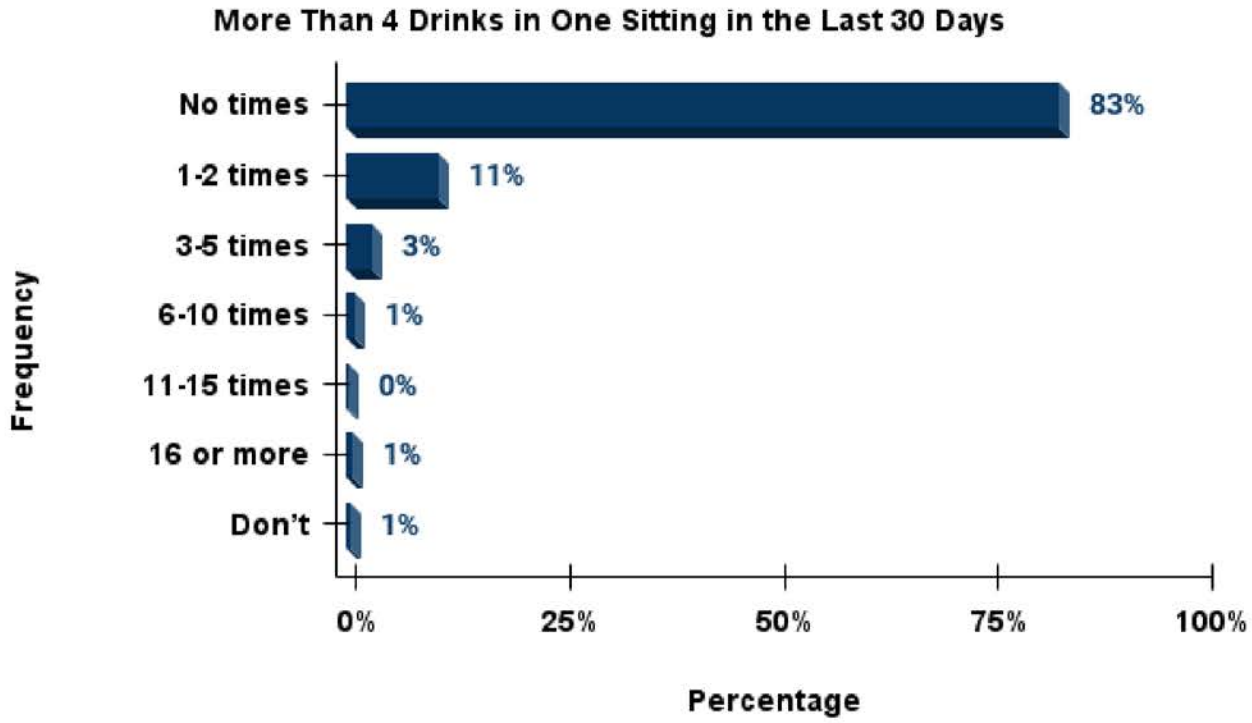
In addition, respondents were less likely to misuse illegal drugs, use electronic cigarettes or tobacco, use marijuana, or eat fast food more than once a week. However, 40% of respondents reported exercising 30 minutes a day, 3 times a week, 18% wear a helmet while riding a bicycle, riding a scooter, rollerblading, etc., and 10% feel stressed out or overwhelmed "always" or "most of the time."

Table 12. Health and Safety Practices

How often do you do the following?	% of respondents who said "always" or "most of the time"	% of respondents who said "sometimes"	% of respondents who said "rarely" or "never"	Not available responses
Wear a seatbelt	98%	0%	1%	0%
Wear a helmet while riding a bicycle, scooter, rollerblading, etc.	18%	2%	8%	71%
Eat fast food more than once a week	6%	23%	70%	1%
Use electronic cigarettes/vape	2%	2%	86%	11%
Use tobacco/nicotine products	4%	3%	85%	9%
Get exposed to secondhand smoke or vaping mist at home or work	3%	6%	84%	8%
Use cannabis (marijuana) products	3%	5%	84%	8%
Misuse prescription drugs, opioids, heroin, or other illegal drugs	0%	0%	93%	7%
Exercise 30 mins a day, 3 times a week	40%	24%	34%	1%
Use sunscreen regularly	48%	24%	24%	5%
Practice safe sex i.e., use a condom, monogamous, get tested	47%	1%	9%	43%
Feel stressed out or overwhelmed	10%	41%	46%	1%
Drive responsibly, follow safe rules of the road, drive within the speed limit	92%	3%	1%	4%

Alcohol Use

Risky behaviors related to alcohol use were measured as part of the survey. Approximately 11% of respondents reported drinking more than four drinks in one sitting, at least 1-2 times in the last 30 days.

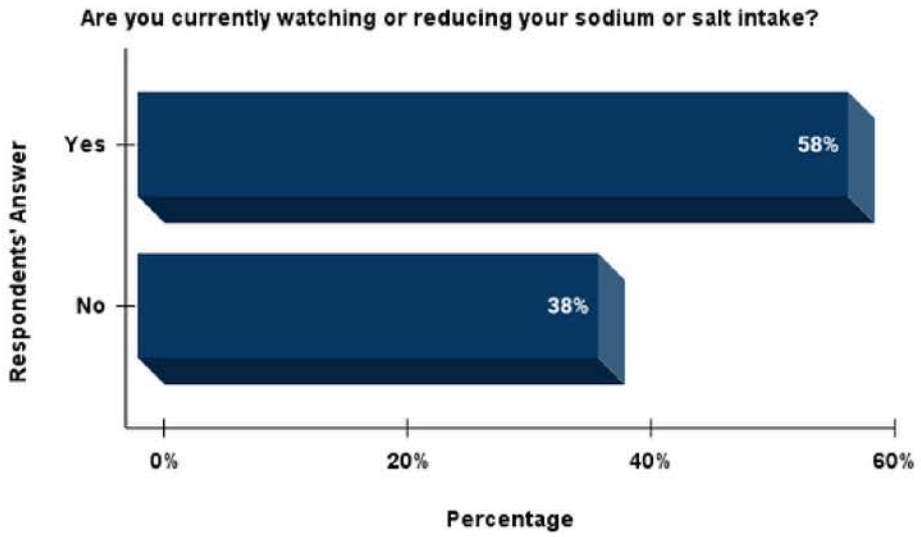


Nutrition

Respondents were asked several questions about their eating habits. When asked how often they drank a sugar-sweetened beverage, 34% said 1-3 times per week. About 47% of respondents said they eat fruit 1-3 times per week and 52% said they eat dark green vegetables 1-2 times per week. Lastly, sodium is closely associated with heart disease. Respondents were asked if they were currently watching or reducing their sodium intake, and 58% said yes.

Table 13. Eating Habits

	Never	1-3 times per week	4-6 times per week	7 or more times per week
How often do you drink a sugar-sweetened beverage (non-diet soft drinks/sodas, flavored juice drinks, sports drinks, sweetened tea, coffee drinks, energy drinks, and electrolyte replacement drinks)?	**43%**	**34%**	**10%**	**12%**
How often do you eat fruit, not counting juice? Count fresh, frozen, or canned fruit. Do not include jam, jelly, or fruit preserves.	**7%**	**47%**	**28%**	**17%**
How often do you eat dark green vegetables, for example, broccoli or dark leafy greens such as romaine, chard, collard greens, spinach, or kale?	**5%**	**52%**	**30%**	**12%**



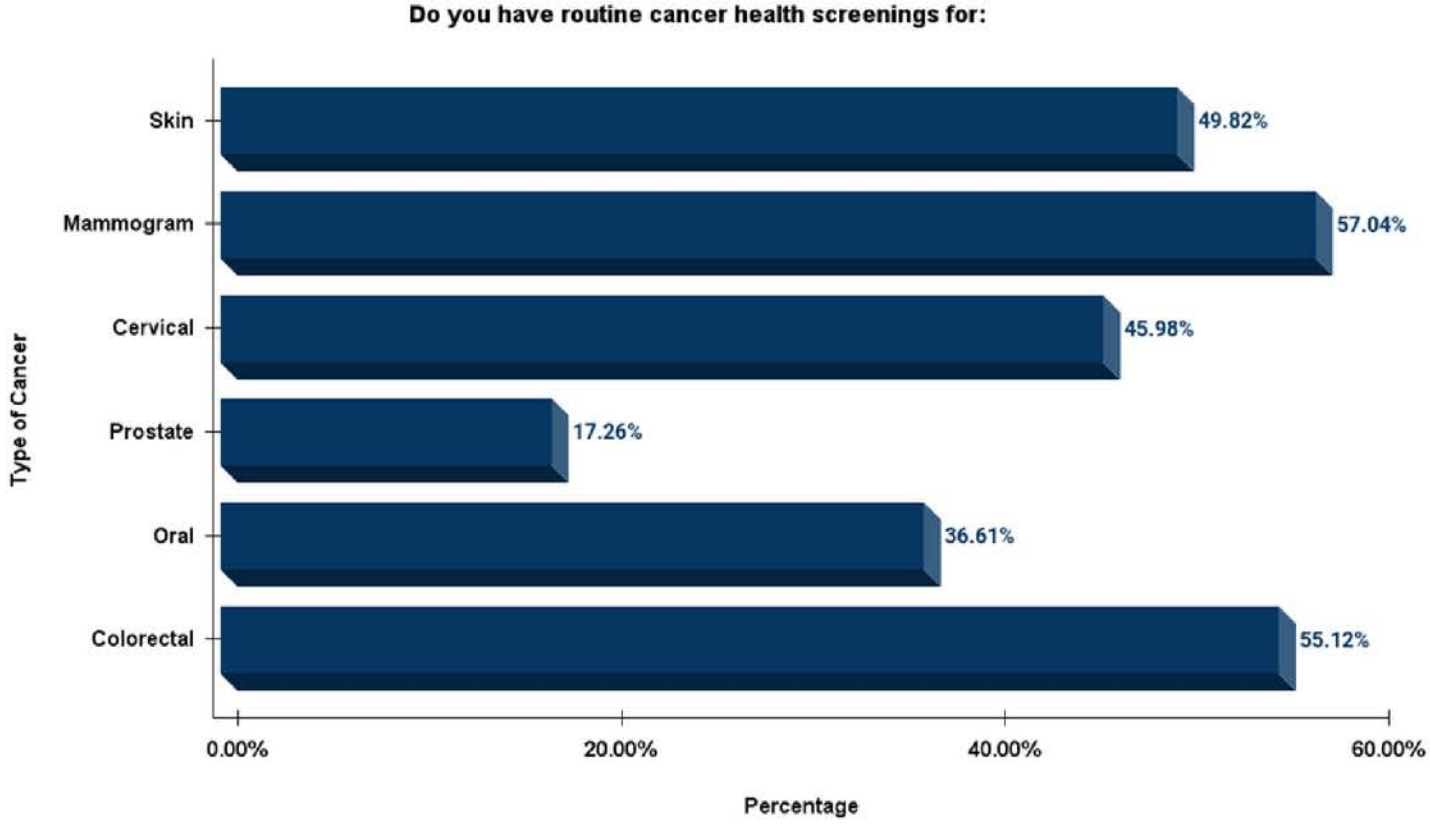
Preventive Health Practices

Immunizations

Immunizations are a crucial preventive health practice that is designed to prevent disease, create herd immunity, and reduce morbidity and mortality.
A finding among Harford County survey respondents was the prevalence of immunizations. In the past 12 months, 74.64% of respondents received a flu vaccine. Additionally, 58.06% said they are up to date on their COVID-19 vaccination.

Screenings

The prevalence of routine health screenings among Harford County respondents varies based on the type of screening. In general, Harford County respondents are less likely to receive oral cancer screenings. Only 49.82% of respondents have routine health screenings for skin-related conditions. Oral/throat health screenings and prostate screenings are also less prevalent among Harford County respondents (36.61% and 17.26% respectively). Larger proportions of respondents participate in routine mammogram screening at 57.04%, and colorectal screenings at 55.12%. The following chart shows participants who responded 'Yes' to receiving specific routine health screenings.



Key Health Issues

Top Health Issues

Respondents were asked what they think are the top 3 most important health issues facing Harford County. They were given 17 choices and from those, the top 3 were overweight/obesity, drug and alcohol misuse, and mental health/suicide. Table 14 shows the percentage of respondents who selected each health issue, in rank order.

Table 14. Top Health Issues

Rank	Health Issue	%
1	Overweight/Obesity	50%
2	Drug misuse/Alcohol misuse	50%
3	Mental Health/Suicide	38%
4	Cancer	28%
5	Diabetes	21%
6	Heart Disease	21%
7	Access to Care/Uninsured	20%
8	Alzheimer's Disease/Aging Issues	20%
9	Gun violence/mass shooting	13%
10	Tobacco Use/Smoking	12%
11	Other (please specify)	7%
12	Dental Health	6%
13	Child Abuse/Violence	5%
14	Stroke	4%
15	Intimate Partner Violence/Abuse	3%
16	Maternal/Infant Health (Pregnancy) Care	2%
17	Sexually Transmitted Diseases (STDs)	1%

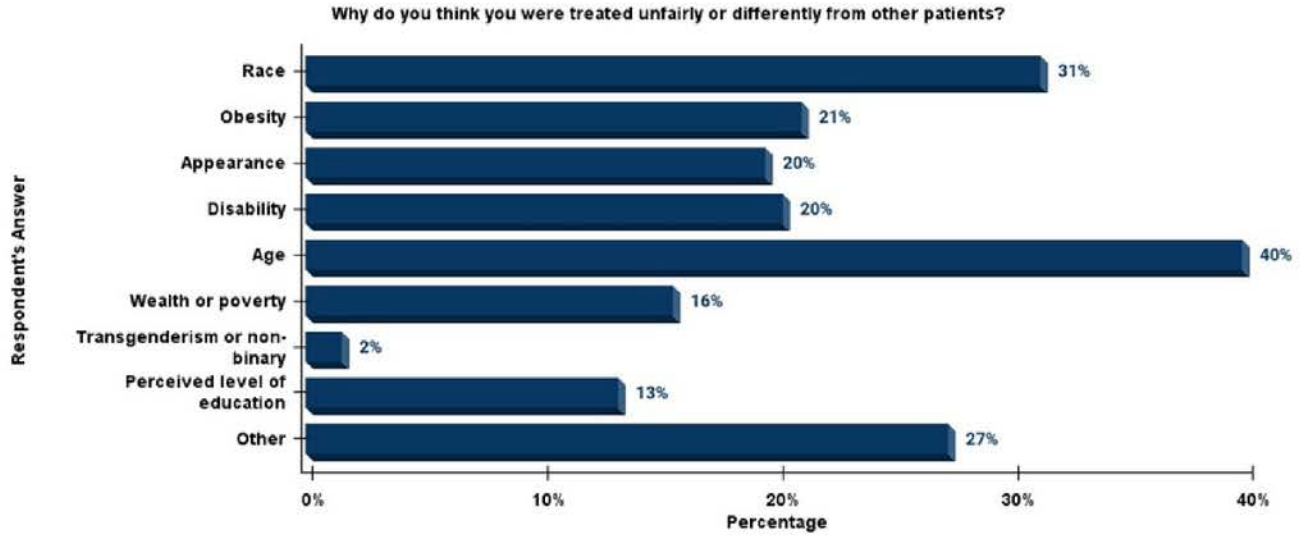
Health Care Barriers

In addition, respondents were asked what they think are the most significant barriers that keep people in the community from accessing health care when needed. The top responses were cost/paying out of pocket, lack of health insurance coverage, and inability to get an appointment.

Table 15. Health Care Barriers

Barrier	%
Cost/Paying Out of Pocket Expenses (Co-pays, Prescriptions, etc.)	71%
Lack of Health Insurance Coverage	61%
Can't Get Appointment	40%
Difficult to Understand/Navigate Health Care System	33%
Can't Find Doctor	24%
Basic Needs Not Met (Food/Shelter)	23%
Lack of Transportation	23%
Lack of Trust	21%
Not enough time	10%
Lack of Child Care	9%
Other (please specify)	8%
Lack of language/translation services available	4%
None/No barriers	4%

When respondents were asked if they felt that they were treated unfairly or differently from other patients in a medical setting, 14% said yes and the top reasons were age, race, and obesity; 27% of respondents selected "other" for their reason.



Resources Needed to Improve Access

Respondents were asked what resources or services they think are needed more of in the community, regarding health. The top suggestions were affordable medication (58%), elder care/senior services (47%), mental health services (45%), free/low-cost dental care (45%), and primary care providers (44%). Table 16 shows the breakdown of all resources needed in the county.

Table 16. Health Resources Needed in the County

Resource	%
Affordable Medication	**58%**
Elder Care/Senior Services	**47%**
Mental Health Services	**45%**
Free/Low-Cost Dental Care	**45%**
Primary Care Providers (Family Doctors)	**44%**
Free/Low-Cost Medical Care	**38%**
Free/Low-Cost Vision/Eye Care	**34%**
Substance Use Services	**28%**
Health Screenings	**27%**
Medical Specialists (Ex. Cardiologist)	**26%**
Transportation	**21%**

Access to Affordable Fresh Fruits and Vegetables	**21%**
Health Education/Information/Outreach	**19%**
Immunization/Vaccination Programs	**14%**
Parks & Recreation Areas	**12%**
Prenatal Care Services	**7%**
Other (please specify)	**7%**
Don't know/Not sure	**6%**
Language Services	**4%**
None	**1%**

Risky Behaviors

Respondents were asked what they thought were the three most "risky behaviors" in the community. They were given 13 options and could pick up to three. The top risky behaviors were drug abuse (69%), being overweight (41%), and alcohol abuse (38%). Table 17 includes a listing of risky behaviors in rank order.

Table 17. Top Risky Behaviors

Rank	Risky Behavior	%
1	Drug abuse	69%
2	Being overweight	41%
3	Alcohol abuse	38%
4	Poor eating habits	29%
5	Not getting "shots" or vaccines to prevent disease	27%
6	Gun Violence	24%
7	Lack of exercise	24%
8	Tobacco use	22%
9	Dropping out of school	8%
10	Unsafe sex	7%
11	Not using birth control	5%
12	Not using seat belts/child safety seats	5%
13	Other (please specify)	3%

Needs for a Healthy Community/Quality of Life

Respondents were asked what they think are the three most important things needed for a "Healthy Community?." Respondents had 19 options and could pick their top three choices. Access to health care ranked number one (38%), followed by low crime/safe neighborhoods ranking number two (37%), and number three being strong family life (32%). Table 18 shows what community factors respondents thought were most important.

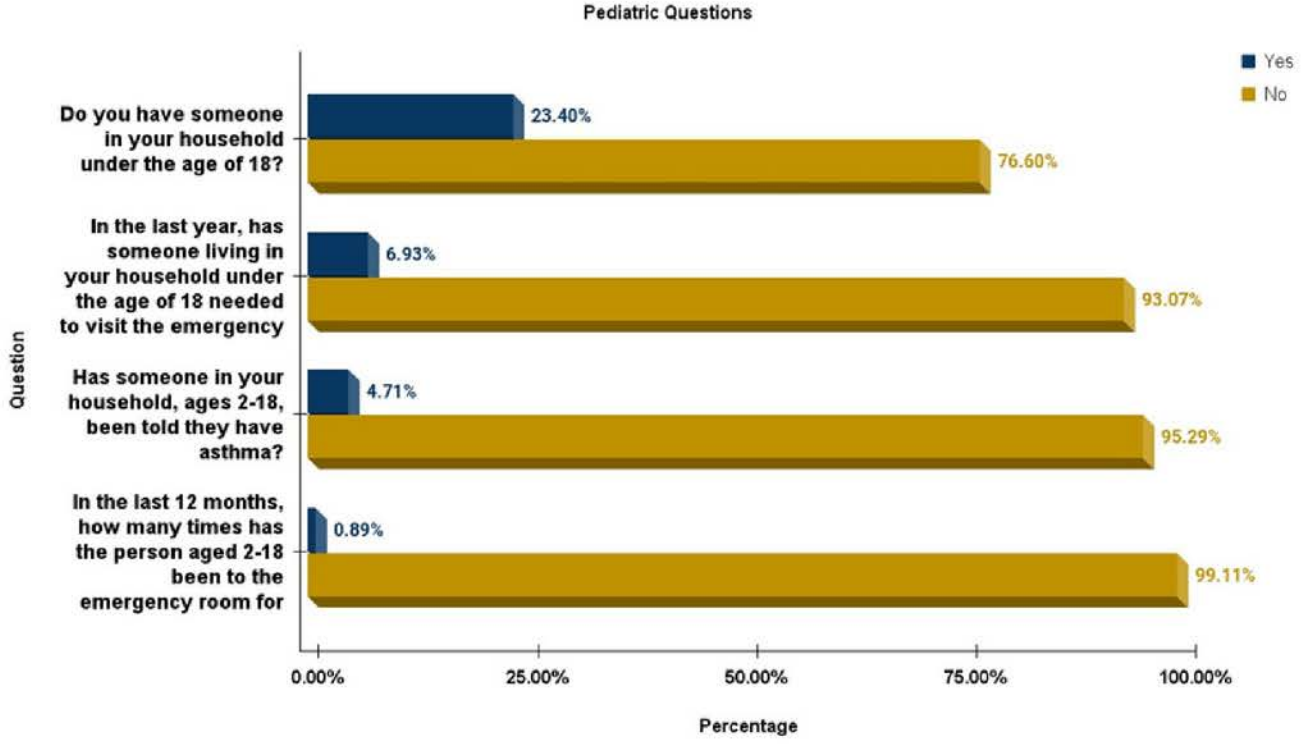
Table 18. Top Needs for a Healthy Community

Rank	Healthy Community Factors	%
1	Access to health care (e.g., family doctor)	38%
2	Low crime/safe neighborhoods	37%
3	Strong family life	32%
4	Good jobs and healthy economy	29%
5	Healthy behaviors and lifestyles	29%
6	Good schools	25%
7	Respect for all persons and groups	23%
8	Affordable housing	21%
9	Religious or spiritual values	19%
10	Good place to raise children	11%
11	Clean environment	9%
12	Responsible gun usage	8%
13	Parks and recreation	5%
14	Excellent race relations	4%
15	Other (please specify)	3%
16	Low adult death and disease rates	2%
17	Low level of child abuse	2%
18	Arts and cultural events	2%
19	Low infant deaths	1%

Pediatrics

Survey participants were asked several questions regarding youth. 23.40% of respondents said they have someone living in their home under 18 years of age. This aligns with the county data as a whole where the population ages 0-17 is at 22.10% in 2022. About 7% of those children had to go to the emergency room within the last year of completing this survey.

Another area of focus was regarding diagnosed asthma in children. Only 4.7% of participants said someone in their home ages 2-18 was diagnosed with asthma, and of those children, less than 1% used the ED because of their asthma.



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- SchoolDigger. (2023). Maryland School District Rankings.
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APPENDICES

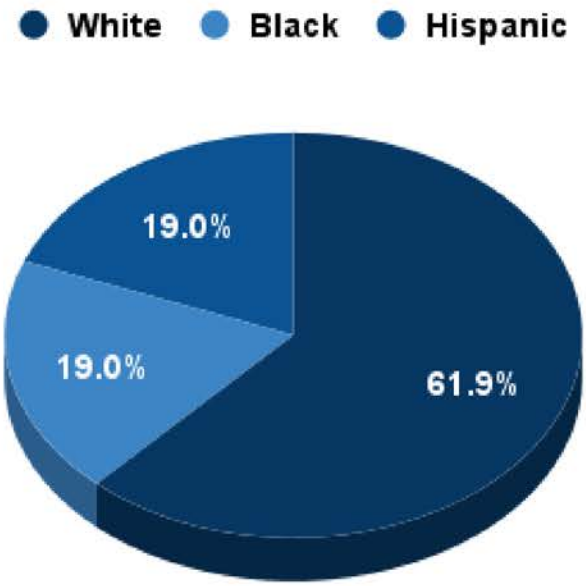
- Focus Group and Key Informant Survey Summaries
- Harford County Health Equity Report

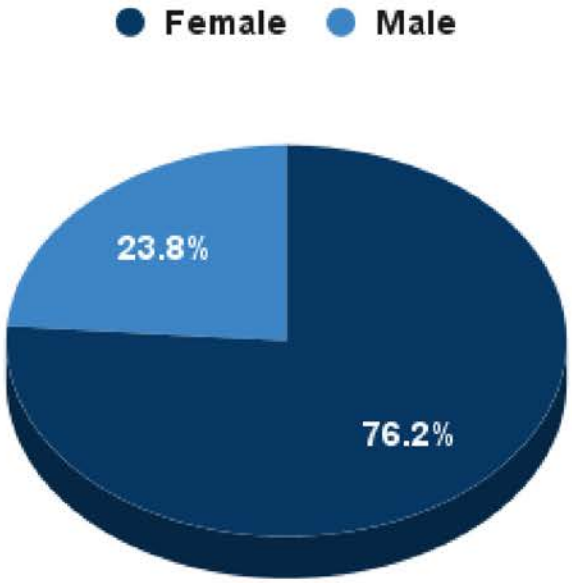
FOCUS GROUP & KEY INFORMANT SURVEY SUMMARIES

Background

1. The purpose of the focus group and key informant survey was to discuss/report for their community in a few particular areas. In addition, the groups discussed resources currently available in the community to address the problems identified and any barriers to accessing the services.
2. The focus groups were done to prioritize needs, create solutions, and plan for services in Harford County.
3. Each focus group lasted approximately one hour and participants were given the option of being in-person or virtual. Below is just a summary of discussion points from each focus group.
4. The key informant survey was an 8-question survey sent to the Local Health Improvement Coalition stakeholders with a mix of open-ended and ranking-style questions to give feedback on the health of Harford County.

Demographic Breakdown of Focus Groups





SUSQUEHANNA MINISTERIUM

Date: February 12, 2024

What a healthy & welcoming community looks like:

- Trust
- Equality
- Fearlessness
- Public space

Significant problems in the community:

Related to health

- Mental health resources
- Affordable colleges
- Stroke & heart disease
- Lack of knowledge
- Lack of elder care
- Physician-patient ratio

Affecting families

- Social media
- Lack of youth and elderly interaction
- Addiction
- Intergenerational trauma
- Homelessness
- Broken families

Strengths

- Health Department
- Faith-based orgs.
- Boys and Girls Clubs
- Link Bus (better than nothing)

Barriers

- Transportation
- Money
- Navigating Insurance
- Technology
- Stigma of mental health

SPANISH SPEAKING PARENTS

Date: February 21, 2024

What a healthy & welcoming community looks like:

- No violence
- No drugs/alcohol
- Everyone is kind and attentive
- Promoting nutrition (blood pressure control)

Significant problems in the community:

Related to health

- Emotional Health
- Loneliness

Affecting families

- Children without health insurance
- Language barriers when health issues arise

Strengths

- Women, Infants, and Children (WIC)
- Dentists
- Head Start Program

Barriers

- Transportation
- Hours services are available usually conflict with work

MINORITY HEALTH

Date: March 7, 2024

What a healthy & welcoming community looks like:

- Welcoming & Respectful
- Equality of services
- Staffing diversity
- Safe, clean, secure

Significant problems in the community:

Related to health

- Mental Health
- Substance Use
- The System is designed to keep you poor
- Multigenerational caregivers

Affecting families

- Social Media
- Lack of insurance
- Medication dependence
- Single parenting
- Isolation
- Systematic racism

Strengths

- Faith-based orgs.
- Collaboration
- Minority Health Program
- Resources (YMCA, LASOS, CHOSEN)

Barriers

- Communication
- Financial
- Not having a "It takes a village" mentality
- Transportation

SENIORS / CAREGIVERS

Date: February 28, 2024

What a healthy & welcoming community looks like:

- Health promotion activities for all ages
- Easily accessible (limited mobility)
- Access to care
- Access to information (health literacy)
- Proactive Communication

Significant problems in the community:

Related to health

- Lack of mobility/physical health
- Isolation/Loneliness
- Transportation
- Lack of skills
- Resiliency

Affecting families

- Medical Issues
- Single Income
- Multigenerational homes
- Technology
- Alcohol and drugs

Strengths

- Harford community college
- Senior Centers
- Faith-based organizations
- Healthy Harford

Barriers

- Money/Funding
- Transportation
- The system being too difficult to navigate
- Ability to have knowledge of services and resources
- Political will - speaking up to county reps.

KEY INFORMANTS

Date: December 5, 2023

WHAT A HEALTHY COMMUNITY LOOKS LIKE

- Access to healthcare
- Affordable Care
- Clean Environment
- Equality and Equity
- Community Support and Programs

MOST SIGNIFICANT PROBLEMS FACING THE COMMUNITY

- Access and Affordability
- Mental Health
- Transportation
- Disparities
- Substance Use
- Lack of Providers

→

RESOURCES TO ADDRESS THESE ISSUES IN HARFORD COUNTY

- Network and Collaboration of Organizations
- Upper Chesapeake Hospital
- Healthcare Providers
- Funding is available (though slim)
- Data to drive programs

"A community where the people are aware of the health issues within that community, and work effectively to address those issues and achieve positive outcomes."

WHAT WOULD IT TAKE TO MAKE OUR COMMUNITY HEALTHIER IN THE NEXT...

12 MONTHS

- More funding and programs
- Outreach and awareness
- Hiring and resources, more providers
- Collaborative efforts

5 YEARS

- More funding and programs
- Strategic planning
- Targeted programs
- Collaborative efforts

BARRIERS TO REACHING SOLUTIONS/GOALS

- Lack of funding
- Stigmatization of seeking help
- Political and Systemic Issues
- Some collaboration is not enough, needs to be community wide

HOW IS HEALTH EQUITY ADDRESSED?

- Minority Health Program
- Outreach and access
- Use of data to identify disparities and inequities

IMPACT ON HEALTH FROM COMMUNITY PARTNERSHIPS

- Expansive reach to all parts of the county
- Increase efficiency and eliminate duplicate efforts
- Increased awareness of programs and available resources

Public Health
Prevent. Promote. Protect.
Harford County
Health Department

Health Equity Report

2023

Prepared by
HARFORD COUNTY
HEALTH DEPARTMENT

TABLE OF CONTENTS

OVERVIEW

A Healthy Harford County For All

What does a healthy Harford County look like? The answer: Equal access to health opportunities for all residents in Harford County regardless of race/ethnicity, religion, socioeconomic status, gender, age, mental health, cognitive, sensory, or physical disability, sexual orientation or gender identity, or geographic location.

Harford County, located in the northeast region of Maryland, is a mix of rural and suburban development leading outside of Baltimore City. Home to approximately 263,000 residents; Harford County is the sixth largest county in the State and has a population density of 560/sq mi. Harford County's geographical location and abundant opportunities allow many people to thrive in the area. According to the 2021 Census, only 7.8% of residents live in poverty, however taking a closer look at other zip codes in the county shows a greater need to examine different communities throughout the area.

The Harford County Health Department (HCHD) strives to promote public health and prevention in the community for all while helping to minimize barriers to receiving care. This report will describe and explain where and why inequities exist within Harford County, along with how we can improve these issues in our community so that everyone can achieve optimal health.

What is Health Equity?

According to the Centers for Disease Control and Prevention, "Health equity is achieved when every person has the opportunity to attain their full health potential and no one is at a disadvantage to achieve that potential because of social position or other socially determined circumstances. Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment."

Health Equity vs. Health Equality

Health equity and health equality might sound the same, but they are actually different concepts. Health equity strives for the highest possible standard of health for all, while health equality means everyone receives the same services. Health equity is achieved when one's health is not affected by their social position or other socially determined circumstances, such as income or race, rather than by providing the same services to all.

Health Disparities & Health Inequities

A health disparity is a difference in health outcomes and their causes among groups of people. For example, a health disparity that exists in Harford County is infant mortality rates which are higher for Non-Hispanic African Americans/Blacks compared to Non-Hispanic White babies. Health inequity is a difference in the distribution or allocation of a resource between groups. An example of health inequity in Harford County is that adult poverty rates are significantly higher in Edgewood, Aberdeen, and Havre de Grace, and poverty is linked to shorter life expectancy. It is important to work on reducing health disparities in Harford County to achieve health equity for all and improve our lives. By working together and creating meaningful partnerships, we can address health equity to allow members of our community to live the healthiest and longest lives possible.

Social Determinants of Health

Social Determinants of Health (SDOH), conditions in the environment where we are born, live, learn, work, play, worship, and age, affect a wide range of health, functioning, and quality-of-life outcomes and risks. These are non-medical factors that influence health outcomes. There are five determinant areas that make up the underlying factors of the SDOH and contribute to health equity: Education Access and Quality, Health Care and Quality, Neighborhood and Built Environment, Social and Community Context, and Economic Stability.

Economic stability coupled with having low unemployment and poverty rates, allows people to provide for themselves and their families. In the United States, 1 in 10 people live in poverty, and many people cannot afford healthcare, healthy foods, and housing. Many people have trouble finding and keeping a job. Employment programs, career counseling, and high-quality childcare opportunities can help more people find and keep jobs. In addition, policies to help people pay for food, housing, health care, and education can reduce poverty and improve health and well-being. A consistent source of income positively correlates to health improvement.

Education, another area of SDOH, is highly relevant starting with school-age children all the way up to adults.

Early childhood education and development provides a solid foundation for children to learn and thrive at a young age, the effects of which continue to high school and potential enrollment into higher education. Good education also allows for better employment opportunities, which ultimately means better pay and housing stability that contributes to overall health. Persons with higher education levels are more likely to be healthier and live longer.

Having access to health care and primary care options are key areas of SDOH. Healthcare access means that individuals can obtain needed medical services with ease. Primary care is a crucial component of health care because it provides early detection and treatment, management of chronic diseases, and preventive care.

Places of employment may offer health insurance options with lower rates that provide better opportunities for preventive health, such as free/low-cost primary care visits, flu shots, prescriptions, etc., and time to take off work to attend medical appointments.

Language skills, including low health literacy, can also present barriers to access to health care. Health literacy, as defined by the U.S. Department of Health and Human Services (HHS), is the degree to which individuals have the ability to understand and process basic health information, whether from a doctor or from written materials so that they can make appropriate health decisions. Low health literacy, related to poor health outcomes, can be seen in people with both lower education and higher education levels and across certain population groups. Ultimately, if a patient receives any information they cannot comprehend, then that person may make poor decisions regarding their health.

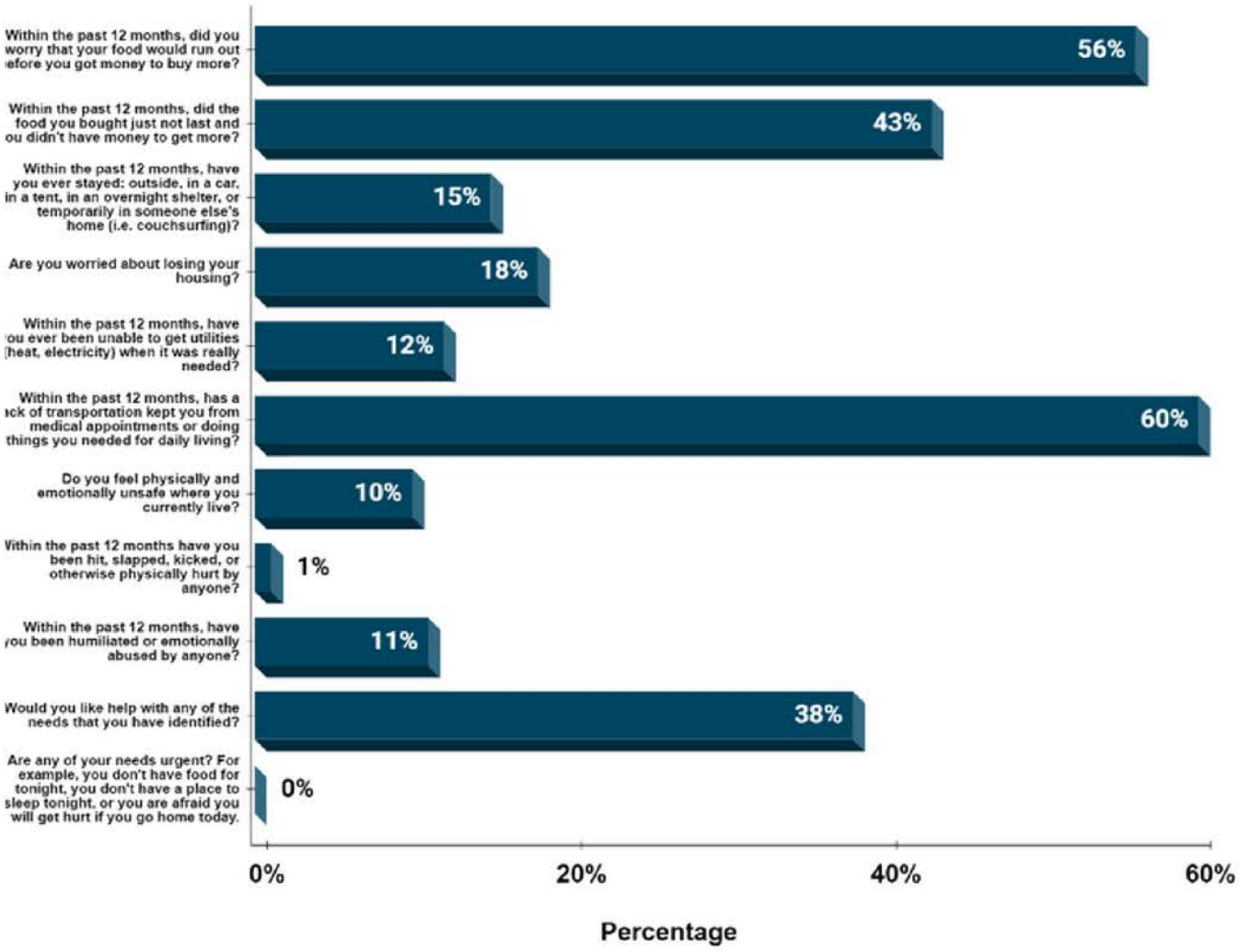
Another area of SDOH, neighborhoods and built environment (the human-made area where we live, work, and play), contributes to health in many ways. Access to foods that allow us to make healthy eating decisions, areas that allow people to walk, bike, or take public transportation safely, and environmental conditions, such as clean air and water are just a few examples of how neighborhoods can affect health outcomes.

Lastly, social and community context reflects another key issue. There is a strong association between social ties and health. For example, strong relationships are important for one's physical and psychosocial well-being and can influence health outcomes through social support such as helping people maintain a healthy diet, reducing emotional stress, and assisting with transportation to see a doctor. Participating in formal and informal activities that are available can also help reduce poor health outcomes. Being able to vote, participating in community watch groups, being a member of an advisory board, and volunteering to help with a community garden are just some activities to help build social capital and a sense of purpose in the community.

By promoting good health and addressing all factors of the SDOH, we can create opportunities for people to live their best, healthiest lives and achieve health equity.

Harford County Health Department has numerous programs that address SDOH to create health equity in our county. By asking our patients and participants what their SDOH needs are, we can help aid these individuals with the resources and services they need.

"A healthy family means having communication and support"



The above questions are asked to our program participants in order to be able to refer them to the appropriate service that either the HCHD or the community offers, with the goal that their needs will be addressed. Transportation and food access seem to be the largest disparity areas among our participants.

"Transportation is definitely an issue. If someone lives in Edgewood and has to go to Forest Hill for an appointment with no car, how would they get there?"

Our Commitment

The Harford County Health Department is committed to improving health equity in the community and has begun looking into ways to incorporate this concept into our work. The 2019-2024 HCHD Strategic Plan addresses strong awareness regarding the importance of health equity in the community we serve, as well as increasing the understanding of these issues by our employees. HCHD will prioritize increasing the standardization of public health messaging through community outreach workers and increasing the cultural competency of our staff. These objectives will be completed by:

- Working on a unified health promotion, education, and communications strategy.
- Identifying effective cultural competency training.

Additionally, HCHD will look to the Public Health Accreditation Board (PHAB) standards for guidance because they are consistent with essential public health services and align well with the Strategic Plan and Community Health Improvement Plan (CHIP). Three CHIP priorities, which are being addressed with our Local Health Improvement Coalition (LHIC) workgroups include Behavioral Health, Family Health & Resilience, and Chronic Disease Prevention & Wellness.

Goals of this Report

The objective of this report is to outline the existing health inequities and pinpoint specific areas in Harford County that are most affected by these disparities. Throughout this report, readers will gain a deeper comprehension of the underlying causes that drive these inequities. Additionally, it will showcase the efforts that have been undertaken by the HCHD, alongside other organizations and groups, to address these issues, and will shed light on areas where there is potential for improvement. The report will also empower our community to understand the locations and nature of these inequities while providing the Health Department with invaluable insights to enhance our public service efforts.

METHODS OF ANALYSIS

Indicator Selection

Indicators selected for analysis in this report were drawn from a number of sources, including existing community priorities that were determined by HCHD's Community Health Needs Assessment (CHNA), Community Health Improvement Plan (CHIP), and Strategic Plan, and some disease categories based on State Health Improvement Plan (SHIP) priorities. Data were drawn from multiple sources including HCHD Data, Maryland Vital Statistics, United States Census Bureau, Behavioral Risk Factor Survey, and the Maryland Department of Health. Indicators that were selected, but did not have zip code/geographical data were omitted from this report. These indicators may be revisited in the future based on newly available data or increased capacity for data assessment.

Community Geographical Information System (GIS) Mapping

Geographic Information System (GIS) mapping of zip code level data was used to understand where inequities exist in the county based on selected indicators. Harford County comprises 23 zip codes. Maps were created by the Harford County Health Department Population Health Unit and were based on data from the health department and the Chesapeake Regional Information System for our Patients (CRISP), the regional health information exchange (HIE) serving Maryland and the District of Columbia. Other maps were created by the Maryland Department of Health and are identified as such in the report.

Community Input Process

The Harford County Health Department Minority Health Program collects community needs information from the community on a monthly basis to help prioritize their voices. The data that was collected was used to obtain input for the Health Equity Report and to inform stakeholders.

SUMMARY OF FINDINGS

Priority Areas

The three geographic locations highlighted in this assessment include Aberdeen, Edgewood, and Havre de Grace, which are located on the Route 40 and I-95 corridor; all three have a higher concentration of health issues than the county as a whole. Gaps in behavioral health and substance use treatment were identified, specifically in the Edgewood area. Aberdeen, home to Aberdeen Proving Grounds and the biggest employer in the county, requires greater access to mental health services and chronic disease prevention interventions. Havre de Grace, an area with a higher concentration of risk factors such as mental health and substance-exposed newborns, requires focused prevention efforts and medical care for those experiencing health concerns. The southern region of the county is shown to have more issues, but it should not be overlooked that there are separate health issues in the northern/rural areas such as transportation, poverty, health insurance coverage, sexual health, adverse pregnancy outcomes, and high colorectal cancer rates.

Since 2011, the Centers for Disease Control and Prevention (CDC), has reported on effective public health programs that have helped reduce disparities. By implementing evidence-based programs that advance health equity, the opportunity will arise for people to live longer and healthier lives. As public health professionals and passionate members of our community, it is up to us to make the change we need.

These next few pages will lay a foundation for the future of health equity in Harford County.

THE FINDINGS

Social Inequities

Social inequities are disparities that are found when comparing population groups by race/ethnicity, class, gender, disability, etc. Inequities often reflect the unequal distribution of resources in a geographic area or within a population. An example of this is fewer educational opportunities.

Whites account for the majority of Harford County's population. Hispanics, Asians, and Native Hawaiians and Pacific Islanders have experienced the most population growth in recent years. The male and female population is evenly split throughout the area.

Each population group may have different needs, which is why it is important to examine groups individually to determine how that group can be served more effectively.

Population By Race and Hispanic Origin, Harford County, Maryland, 2019 and 2021			
Harford County	**2019 Census**	**2021 Census**	**% Change**
Total	255,441	262,997	3%
White alone	191,517	191,595	0%
African American / Black	35,826	35,344	-1%
Asian	7,229	8,291	15%
American Indian / Alaskan Native	165	63	-62%
Native Hawaiian and Pacific Islander	92	251	173%
Hispanic	12,215	13,344	9%

50.8%
Female

10.8%
with a disability

5.9%
foreign-born persons

Population By Race and Hispanic Origin, Aberdeen, Maryland		
Aberdeen	**27,379**	**Percentage**
White	15305	55.9%
African American / Black	7803	28.5%
Indian / Alaskan Native	82	.3%
Asian	903	3.3%
Pacific Islander	54	.2%
Hispanic	1917	7%
Multiple Races	1232	4.5%
Other	54	.2%

Population By Race and Hispanic Origin, Edgewood, Maryland		
Edgewood	**24,792**	**Percentage**
White	9966	40.2%
African American / Black	10958	44.2%
Indian / Alaskan Native	74	.3%
Asian	520	2.1%
Pacific Islander	25	.1%
Hispanic	2206	8.9%
Multiple Races	1016	4.1%
Other	25	.1%

Population By Race and Hispanic Origin, Havre de Grace, Maryland		
Havre de Grace	**19,746**	**Percentage**
White	13,822	70%
African American / Black	3298	16.7%
Indian / Alaskan Native	59	.3%
Asian	612	3.1%
Pacific Islander	20	.1%
Hispanic	1165	5.9%
Multiple Races	750	3.8%
Other	20	.1%

Income & Poverty

How much money you make can also influence health. Income and poverty may not initially seem like a problem in Harford County, but taking a closer look at local municipalities uncovers unequal income distributions. Looking at Harford County household income by zip codes, we see lower income in those high priority areas compared to zip codes in northern Harford County. The average household income in the high priority areas of Aberdeen, Edgewood, Havre de Grace, and Joppatowne is $76,415, whereas the average household income of the northern zip codes including Bel Air, Darlington, Fallston, and Forest Hill is $115,171 (United States Census, 2020).

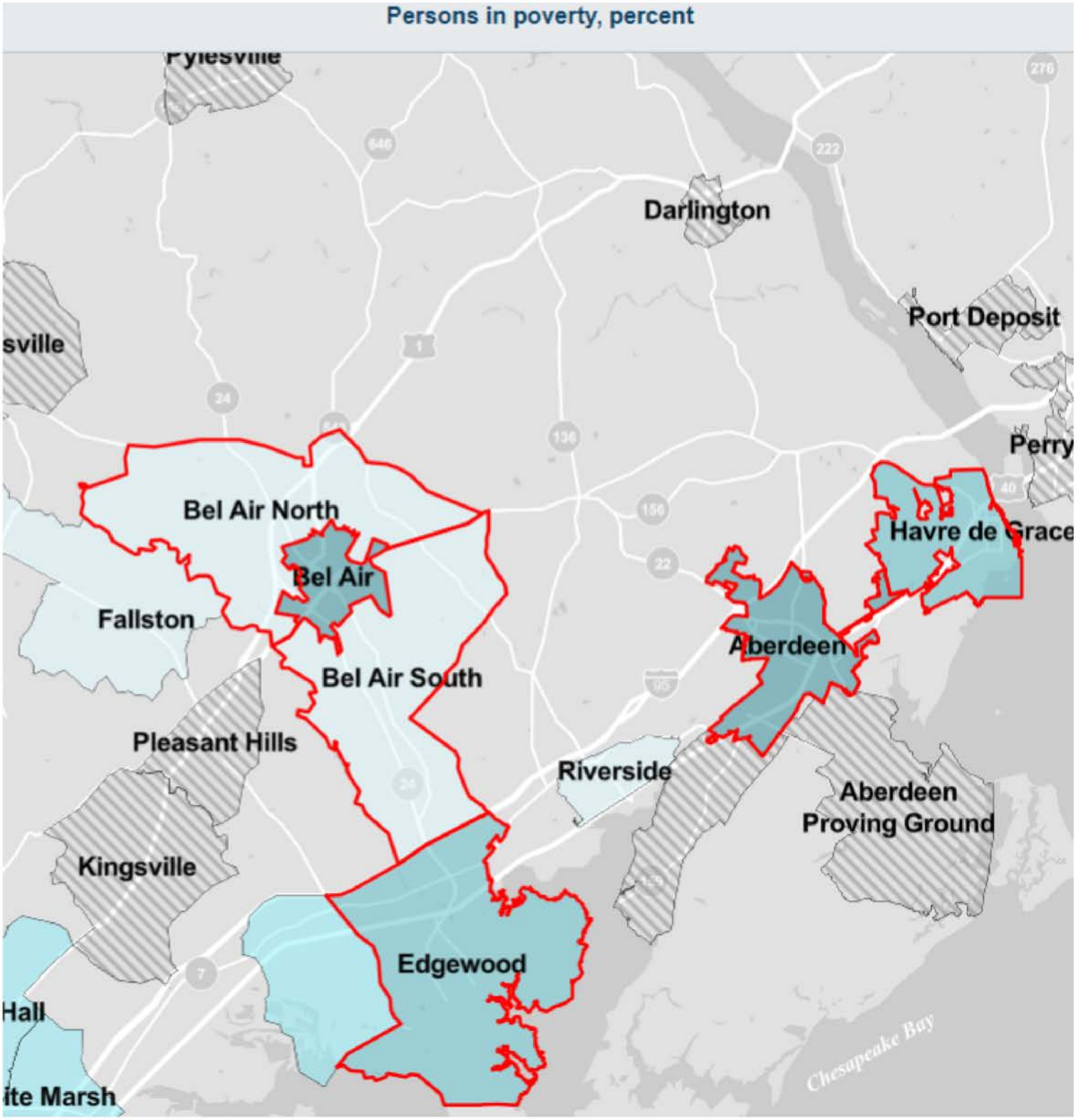
In the county, 6.2% of residents make less than the 2021 U.S. Federal Poverty Guidelines, which state that the Federal Poverty Level for a household of 1 person is $12,880; for 2 people is $17,420; for 3 people is $21,960. That percentage is higher in areas such as Aberdeen. High rates of poverty and low income have been linked to shorter life expectancy. Poverty and low income can affect health in other ways, such as creating barriers to affordable housing, school funding, access to health care, healthy foods, and many more.

Income and Poverty in Harford County, 2016-2020	
Median Household Income	$94,003
Persons in Poverty, Percent	7.8%

Income and Poverty in Aberdeen, 2016-2020	
Median Household Income	$66,481
Persons in Poverty, Percent	14.9%

Income and Poverty in Havre de Grace, 2016-2020	
Median Household Income	$80,583
Persons in Poverty, Percent	8.8%

Income and Poverty in Edgewood, 2016-2020	
Median Household Income	$68,420
Persons in Poverty, Percent	13.6%


Persons in poverty, percent
Darlington
Port Deposit
Perry
Havre de Grace
Bel Air North
Bel Air
Fallston
Bel Air South
Aberdeen
Pleasant Hills
Riverside
Aberdeen
Proving Ground
Kingsville
Edgewood
Chesapeake Bay

Education

Education is a social determinant of health, with people who have attained a higher level of education more likely to have positive health outcomes. Educational skills learned in school provide a foundation of knowledge needed to help make better decisions. To reach health equity, education programs need to close the gap between low-income and/or racial and ethnic populations and higher-income and/or majority populations.

Promoting social and institutional equity will require looking at all the inequities above and reducing their impact through strategic partnerships, advocacy, policy/access, community engagement, social capital building, and coalition building.

Education in Harford County, 2016-2020	
High school graduate or higher, percent of persons age 25 years+	93.1%
Bachelor's Degree or higher, percent of persons age 25 years+	36.9%

Education in Aberdeen, 2016-2020	
High school graduate or higher, percent of persons age 25 years+	86.7%
Bachelors Degree or higher, percent of persons age 25 years+	22.3%

Education in Edgewood, 2016-2020	
High school graduate or higher, percent of persons age 25 years+	90.7%
Bachelors Degree or higher, percent of persons age 25 years+	20.1%

Education in Havre de Grace, 2016-2020	
High school graduate or higher, percent of persons age 25 years+	91.3%
Bachelor's Degree or higher, percent of persons age 25 years+	39.4%

Living Conditions

According to County Health Rankings, residential segregation is the index of dissimilarity where higher values indicate greater residential segregation between African American/Black and White county residents. This index ranges from 0 (complete integration) to 100 (complete segregation). Harford County ranks 4th worst in African American/White segregation and 5th worst in Non-White/White segregation. Baltimore City ranked highest for segregation in both measures.

Even though policies around segregated schools, transportation, and other public places no longer exist, segregation caused by structural, institutional, and individual racism can be found in many parts of the county. Though it may not seem like a health issue at first, residential segregation has been linked to poor health outcomes including mortality, a wide variety of reproductive, infectious, and chronic diseases, and other adverse conditions. Having areas that are diverse can help foster stronger cross-sector collaborations and social support among neighborhoods.

Housing in Harford County, 2016-2020	
Housing Units*	104,488
Owner Occupied Unit Rate**	79.0%
Medium Value of Owner-Occupied Housing Units**	$302,900
Median Gross Rate**	$1,294

***2021 U.S. Census Bureau, County Business Patterns**
****US Census 2016-2021 American Community Survey 5-Year Estimates, 2016-2021**

County Health Rankings: Residential Segregation Index	
Non-White/White:	**African American/White:**
Maryland= 55	Maryland= 63
Harford County = 42	Harford County = 50
United States = 46	United States = 63

This index can range from 0 to 100, with lower values representing less residential segregation and a value of 100 representing complete segregation.

Crime

Violence is a public health issue, adversely affecting not only the victims of the violence but also their families, and also increasing the mortality and morbidity in the community. As crime rates continue to change and occur in different areas throughout Harford County, it is important to identify effective programs and policies that have to do with behavioral challenges underlying violence.

Violent Crimes in Harford County, 2020	
Area	**Crimes Reported**
Aberdeen	110 Reported
Edgewood	105 Reported
Havre de Grace	38 Reported
Bel Air	21 Reported

Property Crimes in Harford County, 2020	
Area	**Crimes Reported**
Aberdeen	280 Reported
Edgewood	393 Reported
Havre de Grace	149 Reported
Bel Air	155 Reported

While crimes in Harford County have shown a significant downward trend, there has only been a slight change in the number of both violent and property crimes in Aberdeen, Edgewood, and Havre de Grace when compared to previous years. These zip codes continue to show the most inequities in Harford County.

Health Care

According to County Health Rankings, 5% of Harford County residents under the age of 65 are uninsured, a 50% decrease since 2008 when 10% of residents under the age of 65 were uninsured. This trend is also significant in the state of Maryland, which has decreased from 12% in 2008 to 7% in 2019. Geographically, the percentage of uninsured under the age of 65 in different zip codes differs throughout Harford County. Without insurance, people are less likely to receive preventive care such as vaccines, screenings, and medical check-ups and more likely to contribute to frequent visits to the emergency department for care. The percentage of persons uninsured in Aberdeen has improved since 2016, nearly cutting the number in half, which is a positive shift in one of the most underserved zip codes in the county.

The northeast part of the county, another area with a high percentage of no health insurance coverage, also deals with transportation issues due to its rural geography. Lack of transportation can cause access to care issues, which decreases the quality of life for individuals in that area.

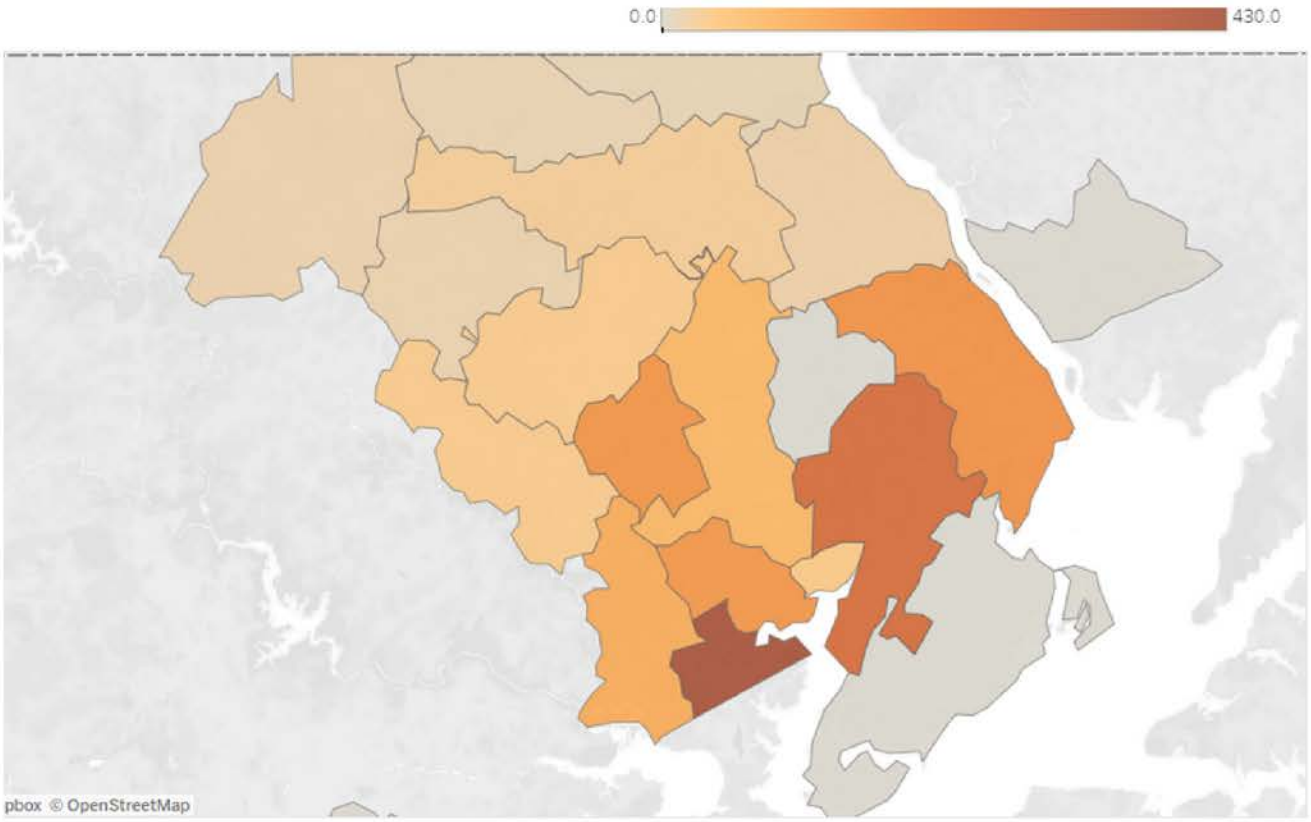
Persons Without Health Insurance, Under Age 65 Years, 2016-2020	
Area	**Percent**
Harford County	4.2%
Aberdeen	5.9%
Edgewood	5.8%
Havre de Grace	4.5%

Throughout the report, the state-designated health information exchange known as CRISP Reporting Services was used to create hospitalization utilization maps of Harford County to show geographical disparities in a variety of different topics surrounding health.

"The biggest thing that prevents me from going to the doctor is health insurance and having high copays"

Care Coordination Plus is an HCHD service that assists clients in accessing the care they need. The program, which is for all Harford County residents regardless of medical insurance type, works with the University of Maryland Upper Chesapeake Medical Center and the Comprehensive CARE Center, Harford Memorial Hospital, and other agencies to assist clients in receiving needed services. The areas that have the largest number of patients using this service and which also have higher numbers of emergency department visits and hospitalizations, are Aberdeen, Havre de Grace, and Edgewood.

Hospitalizations that used "self-pay" as a method of payment, 2022



Risk Behaviors

Smoking

Even though smoking rates have decreased in recent years, tobacco use is still a concern for Maryland residents. In Harford County, 12.7% of residents are current smokers. In 2017, a higher rate of residents from Aberdeen, Edgewood, and Havre de Grace who visited the emergency room in Harford County reported using some kind of tobacco product. Data from the 2021-2022 Youth Risk Behavior Survellience/ Youth Tobacco Survey (YRBS/YTS) show that 18.6% of high school students in Harford County currently use Electronic Smoking Devices.

Obesity

Obesity continues to be an issue, not just in Maryland, but also in Harford County. Harford County rates continue to be higher than the state average. In 2020, a higher rate of residents from Aberdeen, Edgewood, and Havre de Grace who visited the emergency room in Harford County were obese as compared to the county as a whole. According to the 2018-2020 Behavioral Risk Factor Surveillance Survey (BRFSS), 70.6% of the population in Harford County was not at a healthy weight. In 2021, the non-Hispanic African American/Black population had the highest rates of obesity at 44.1% compared to non-Hispanic whites at 31.3% in Maryland.

Sexually Transmitted Infections

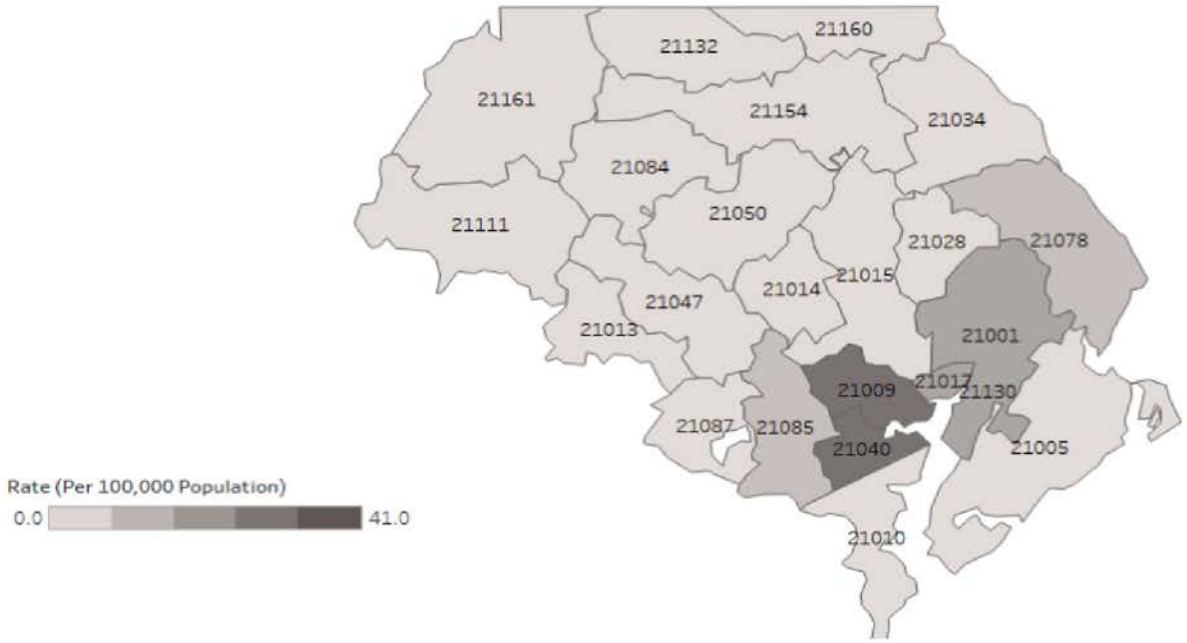
Maryland law requires that all cases of gonorrhea, chlamydia, and primary and secondary syphilis be reported to the Maryland Department of Health. A higher number of cases of gonorrhea and chlamydia were reported in Edgewood, followed by Aberdeen, Havre de Grace, Belcamp, and Perryman. A higher number of cases of primary and secondary syphilis were reported in Abingdon, Edgewood, Aberdeen, Perryman, and Belcamp.

Positive trend in youth smoking from previous YRBS Report

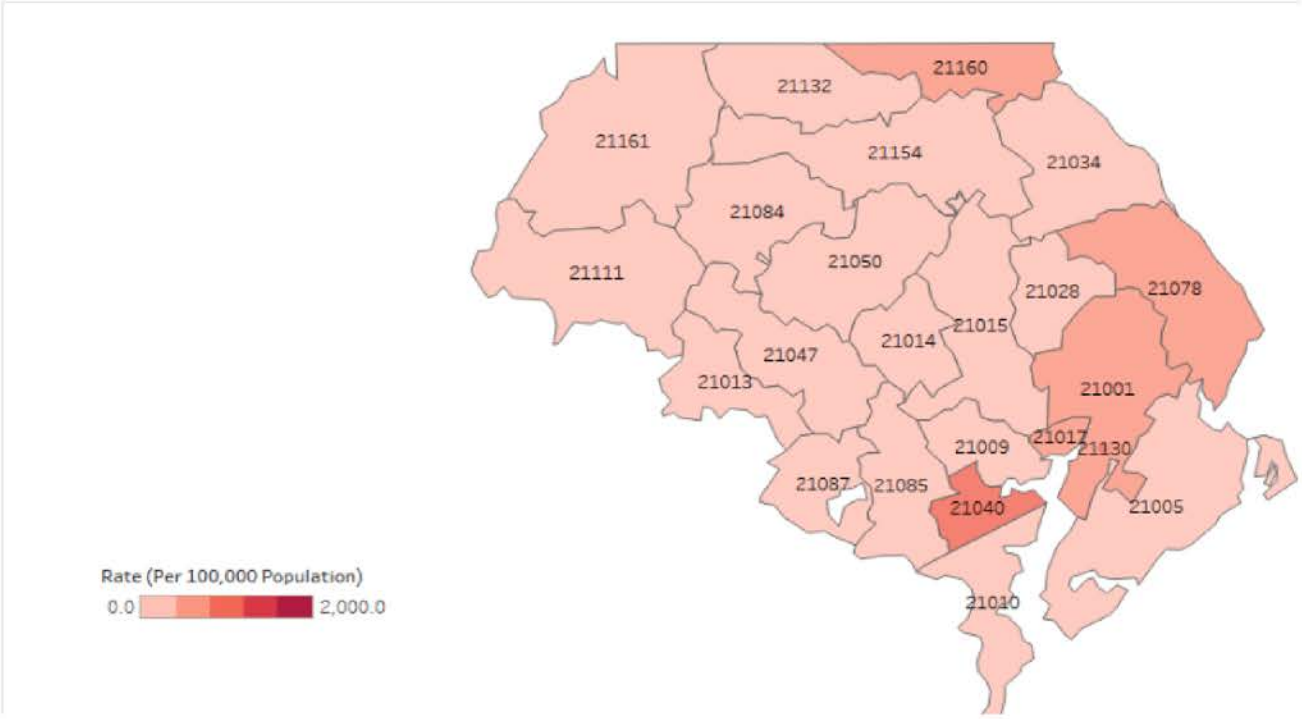
14.7% of High School students reported having obesity

51% of High School students use protection during sex

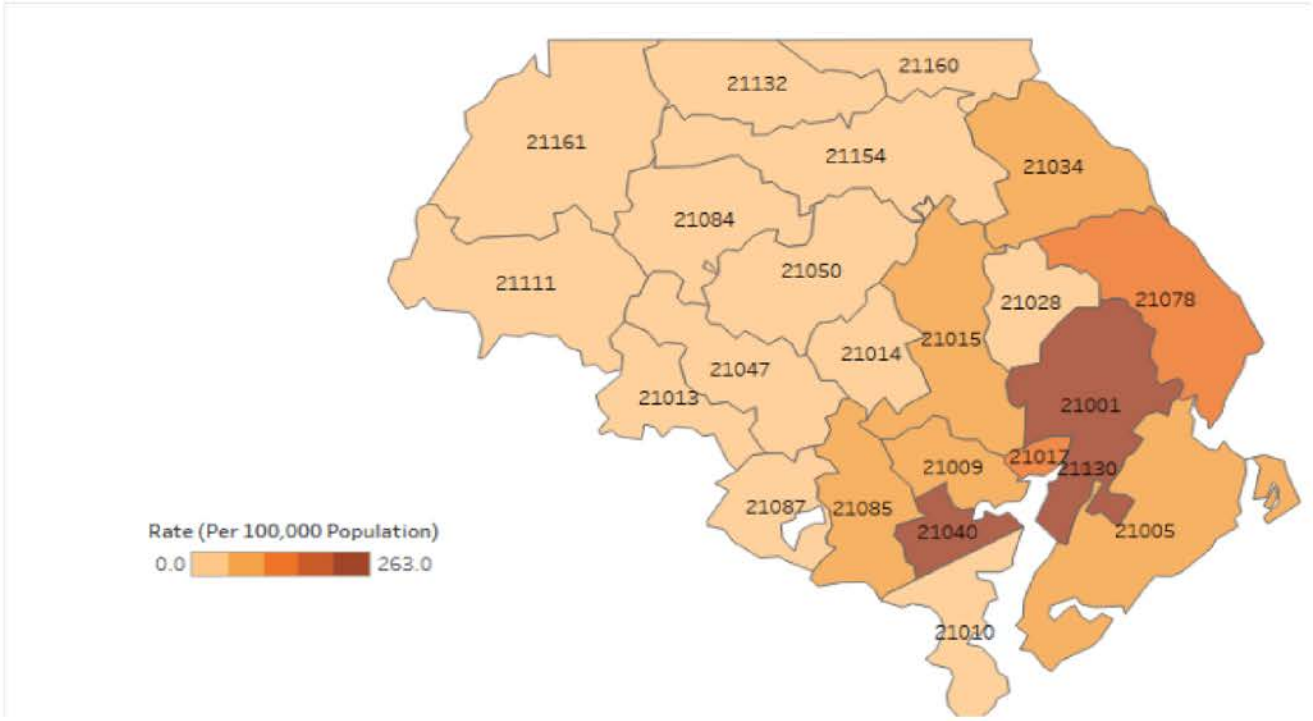
Syhpilis in Harford County 2020, Incidence Rates by Zipcodes



Chlamydia in Harford County 2020, Incidence Rates by Zipcodes



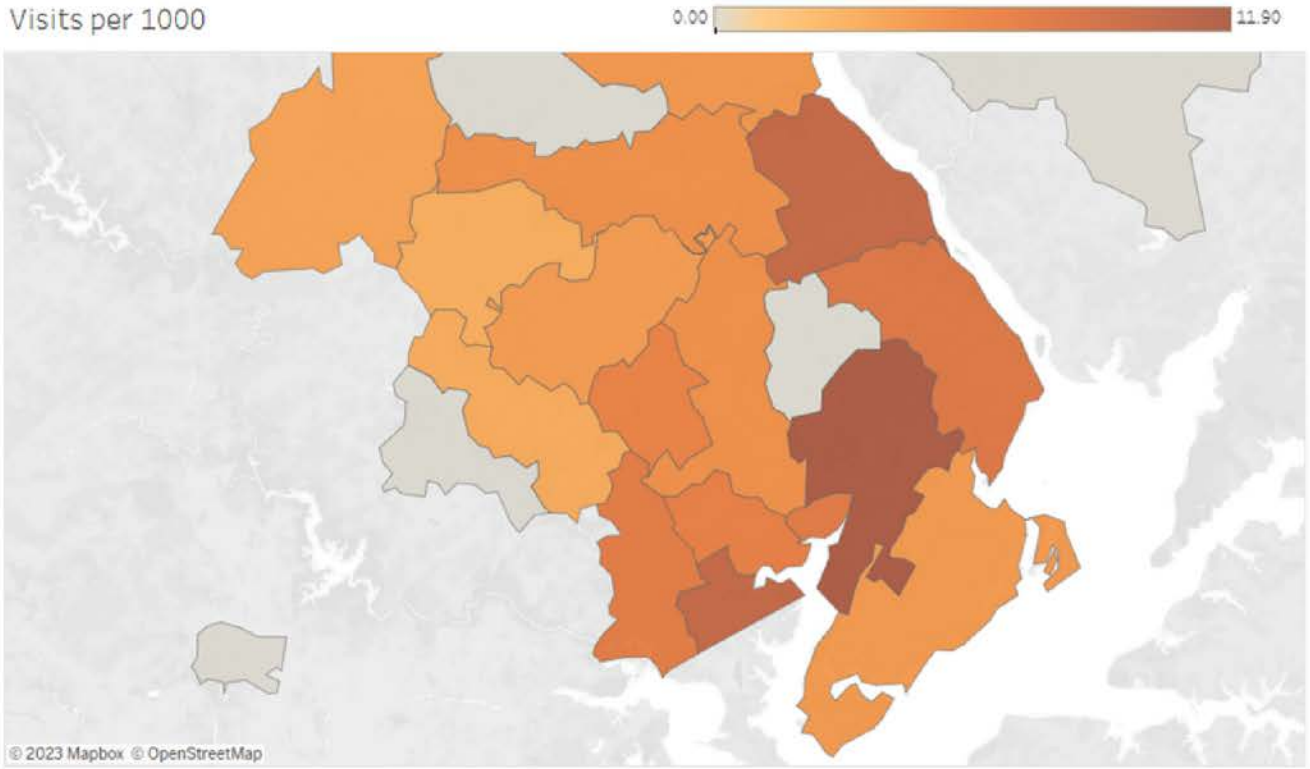
Gonorrhea in Harford County 2020, Incidence Rates by Zipcodes



Behavioral Health

In 2022, there were 7 emergency department visits for depression per 1,000 residents and 27 depression-related hospital visits per 1,000 residents in Harford County. In the past few years, depression has slowly increased in not only adults but middle and high-school-aged children and teens as well. In 2022, 40.1% of high school students indicated they felt sad or hopeless almost every day for 2 weeks or longer. 23.2% of high school students in Harford County have seriously considered attempting suicide and the percentage of high school students who have actually attempted suicide is 16.5%. When looking at rates between zip codes, Aberdeen, Havre de Grace, and Edgewood were three areas that experienced a higher rate of residents with clinical depression who went to the emergency department in 2021. These rates are alarming and Harford County continues to raise its efforts to improve behavioral health care.

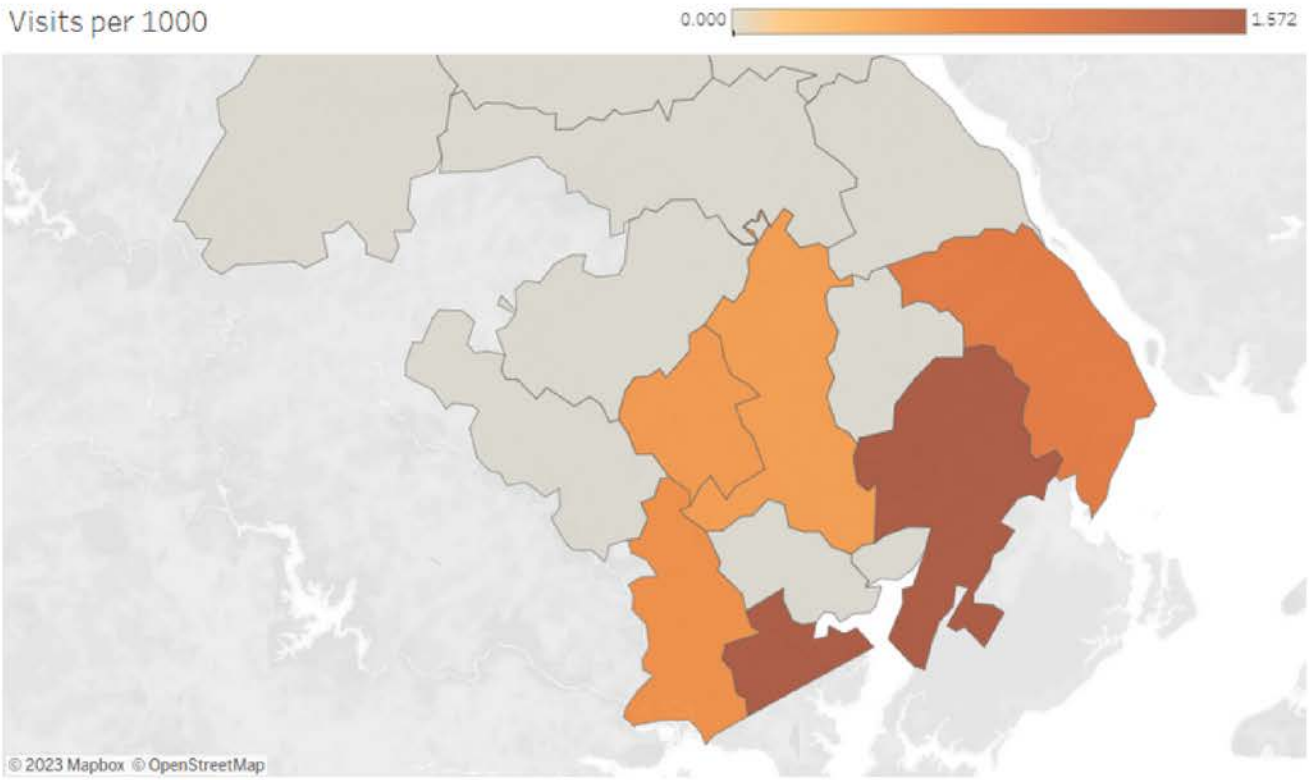
Emergency Department Visits Rate for Depression per 1,000 Residents in Harford County, 2022



Substance Use

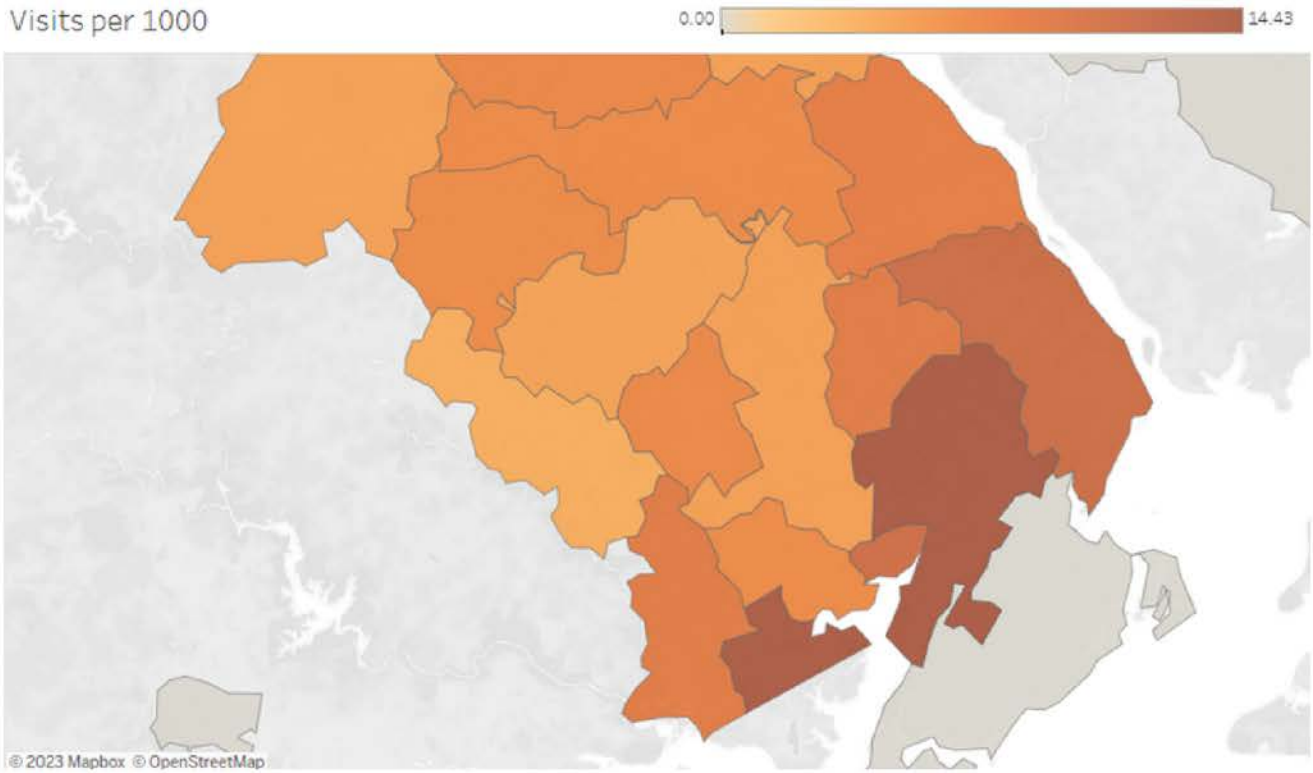
In 2021, Harford County experienced 344 opioid-related overdoses. In the past 5 years, the number of opioid overdoses has been declining, with almost a 14% decrease since 2019. The decrease in opioid overdoses is a positive result but efforts are still being made in order to bring this number down even more. Harford County's daily high number of overdoses may be a result of its location along the Interstate 95 corridor, which is known to be a major route for the movement of illegal drugs. Though the number of overdoses in 2021 appears to be scattered across Harford County, there is a higher concentration in Edgewood, Joppa, and Bel Air, all areas in which there is also a high rate of residents who have a depressive disorder.

Emergency Department Visits per 1,000 due to Opioid Overdoses in Harford County, 2022



"Having healthy relationships and being supportive to your family is very important. The mental aspect of health can drive everything else"

Emergency Department Visits per 1,000 due to Any Substance Use Disorder in Harford County, 2022



Neonatal Abstinence Syndrome & Substance Exposed Newborns

Neonatal abstinence syndrome (NAS) refers to the group of conditions an infant experiences from being exposed to addictive opiate drugs in the womb. As a state, Maryland's rate of NAS is increasing, as is the national rate. The data indicates that Havre de Grace and Darlington have the highest rates of NAS in Harford County. Rates in Aberdeen, Street, and Edgewood follow closely behind. A substance-exposed newborn (SEN) is an infant, under 30 days old, who was exposed to a drug or a substance while in the womb. SEN patterns are consistent with NAS and can be found in the same areas and beyond, making it a growing geographic issue. Locally, Havre de Grace and Darlington are experiencing the highest rates of SEN, while other areas such as Aberdeen, Joppa, Edgewood, Street, and Jarrettsville are right behind them.

Chronic Diseases

A chronic disease, as defined by the U.S. National Center for Health Statistics, is a disease lasting three months or longer. According to the Centers for Disease Control and Prevention (CDC), chronic diseases are among the most common, costly, and preventable of all health problems. Early detection and screening are important parts of primary prevention. Six out of the ten leading causes of death in Harford County in 2020 are chronic diseases: heart disease, cancer, chronic obstructive pulmonary disease (COPD), diabetes, Parkinson's, and Alzheimer's disease.

Maryland - Condition	Age-Adjusted Mortality Rate African American/Black	Age-Adjusted Mortality Rate White
Heart Disease	202.9	167.1
Cancer	162.7	143.4
Diabetes	37	20.1

***rates per 100,000**

"Health is taking care of yourself and having a balance with everything you do."

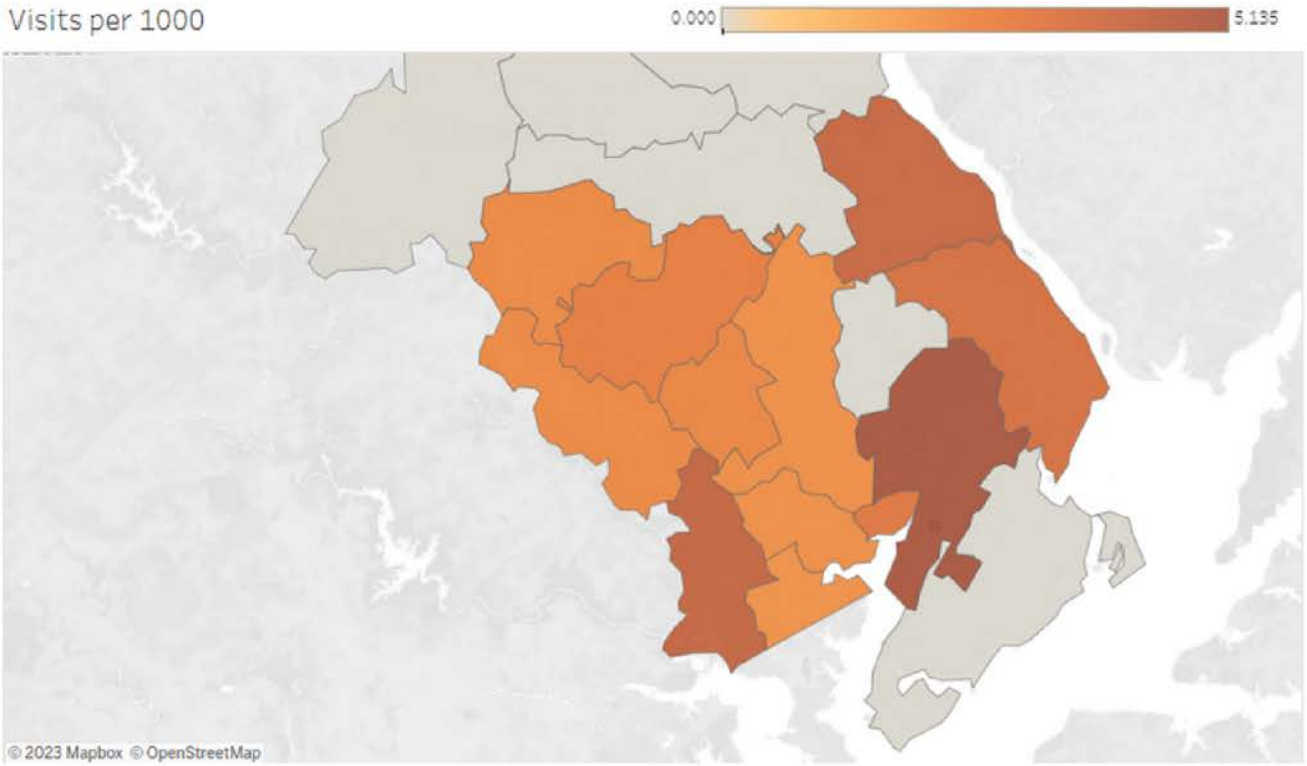
Cancer

Cancer of all types was the second leading cause of death in 2020 in Maryland behind heart disease, and residents with lung cancer had the highest mortality rates. Data shows that African Americans/Blacks have the highest age-adjusted mortality rates for cancer in Harford County and Maryland. Cancer was the second leading cause of mortality in Harford County, resulting in 497 deaths. African Americans/Blacks have seen the most deaths per 1,000 population from 2015-2019 at 175.7, out of all other races.

Lung Cancer

In 2021, the rate of emergency room visits for lung cancer patients was highest in the Aberdeen zip code. This is consistent with the number of hospitalizations related to tobacco use, which is known to cause lung cancer. Lung cancer was the specific cancer type causing the most deaths, at 24% of all cancers in Harford County (Maryland Vital Statistics Report 2020). Aberdeen and Joppatowne have the highest emergency department visit rates for lung cancer (CRISP).

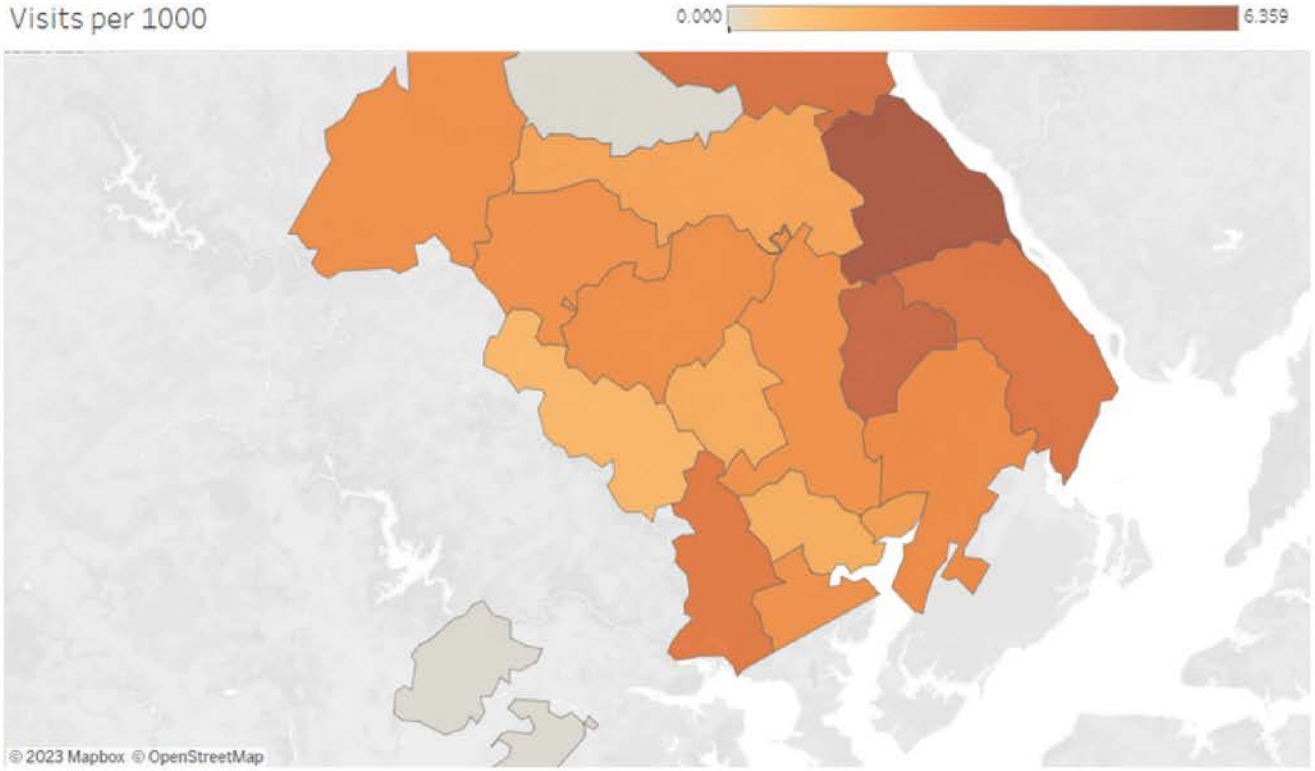
Emergency Department Visits for Lung Cancer per 1,000 Residents in Harford County, 2022



Colorectal Cancer

The next leading cause of cancer deaths, colorectal cancer, can be found through early detection and screening efforts. A higher rate of hospitalizations from this cancer can be found in the Aberdeen area, followed by Edgewood and Havre de Grace. Increasing physical activity, having a healthy diet, limiting alcohol consumption, and avoiding tobacco are some suggestions for preventing colorectal cancer. African American/Black residents have a higher incidence rate for both colorectal and lung cancer than White residents and the rate is even higher for males compared to females.

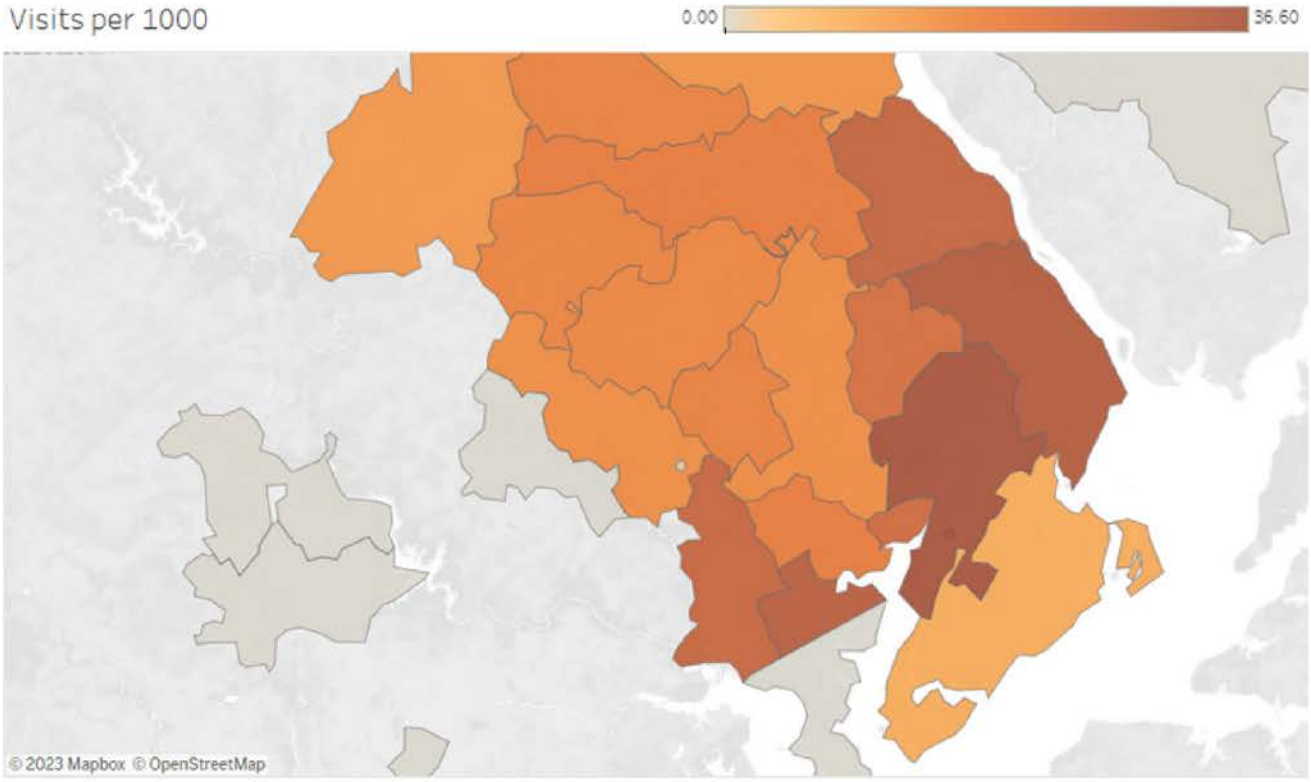
Emergency Department Visits for Colorectal Cancer per 1,000 Residents in Harford County, 2022



Hypertension

Hypertension, also known as high blood pressure, is a component of heart disease, which is the number one cause of death in the United States and the number one cause of death in Harford County. In 2020, heart disease accounted for 571 total deaths in Harford County (Maryland Vital Statistics, 2020). Hypertension is a major risk factor for heart disease, and accounted for over 19,700 emergency department (ED) visits in 2022, more than any other condition in Harford County (CRISP). Of those, African Americans/Blacks show significantly higher rates of ED visits at 113.97 per 1,000, compared to Whites (84.48 per 1,000). Locally, Aberdeen, Bel Air, and Edgewood have a higher concentration of adults with hypertension who are going to the emergency department. Seventy-six percent of all ED visits in 2022 were from the White population, whereas 20% were from the African American/Black population.

Emergency Department Visits Rate for Hypertension per 1,000 Residents in Harford County, 2022



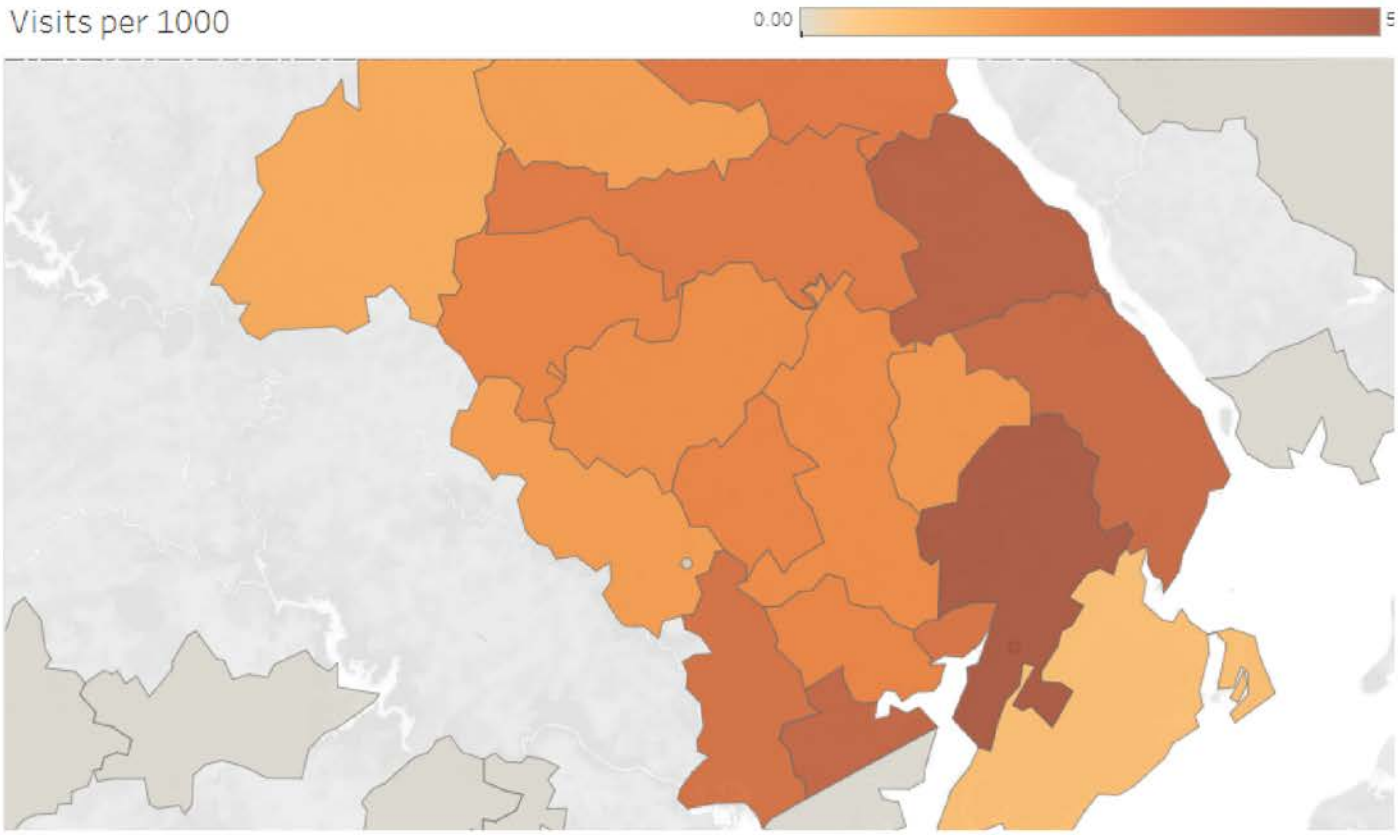
Diabetes

Diabetes is a group of diseases that affect blood sugar levels. There are several types of diabetes, but the two most common are type 1 and type 2. Type 1 is a chronic condition in which the pancreas produces little or no insulin. Type 2 is a chronic condition that affects the way the body processes blood sugar and is the most common form of diabetes. Some risk factors for type 2 diabetes are obesity, a sedentary lifestyle, and physical inactivity. In Maryland, an estimated 10.5% of the adult population (488,942 adults) have diabetes, while an estimated 34% (1.6 million adults) have prediabetes.

Diabetes is the 6th leading chronic disease resulting in emergency department visits in Harford County at 9,042 visits in 2022. Diabetes was the 7th leading cause of death in Harford County in 2020 (6th excluding COVID-19), as well as the 7th leading cause of death in Maryland, with an age-adjusted mortality rate of 23.9 per 100,000 population. This is a 17% increase from 2019 (Maryland Vital Statistics Report, 2020). The age-adjusted prevalence rate of diagnosed diabetes is highest in Non-Hispanic Blacks at 13.3%, followed by Non-Hispanic Asians at 9.7%, and Hispanics at 9.4% (Maryland Diabetes Action Plan, 2020). The age-adjusted death rate in Maryland has been highest in Non-Hispanic Blacks since prior to 2009. The age-adjusted death rate among Non-Hispanic Blacks (37 per 100,000) is nearly twice that of non-Hispanic Whites (20.1 per 100,000). People with low socioeconomic status are more likely to be diagnosed with diabetes. The risk of developing type 2 diabetes is 30 to 40% higher for people who smoke cigarettes than for people who don't (CDC, 2022).

Diabetes was the seventh leading cause of death in the county in 2020. Residents in Aberdeen, Havre de Grace, and Edgewood have a higher rate of emergency department visits associated with diabetes. These three areas also have high rates of obesity. Diabetes prevalence is also higher in White residents than African American/Black residents in Harford County.

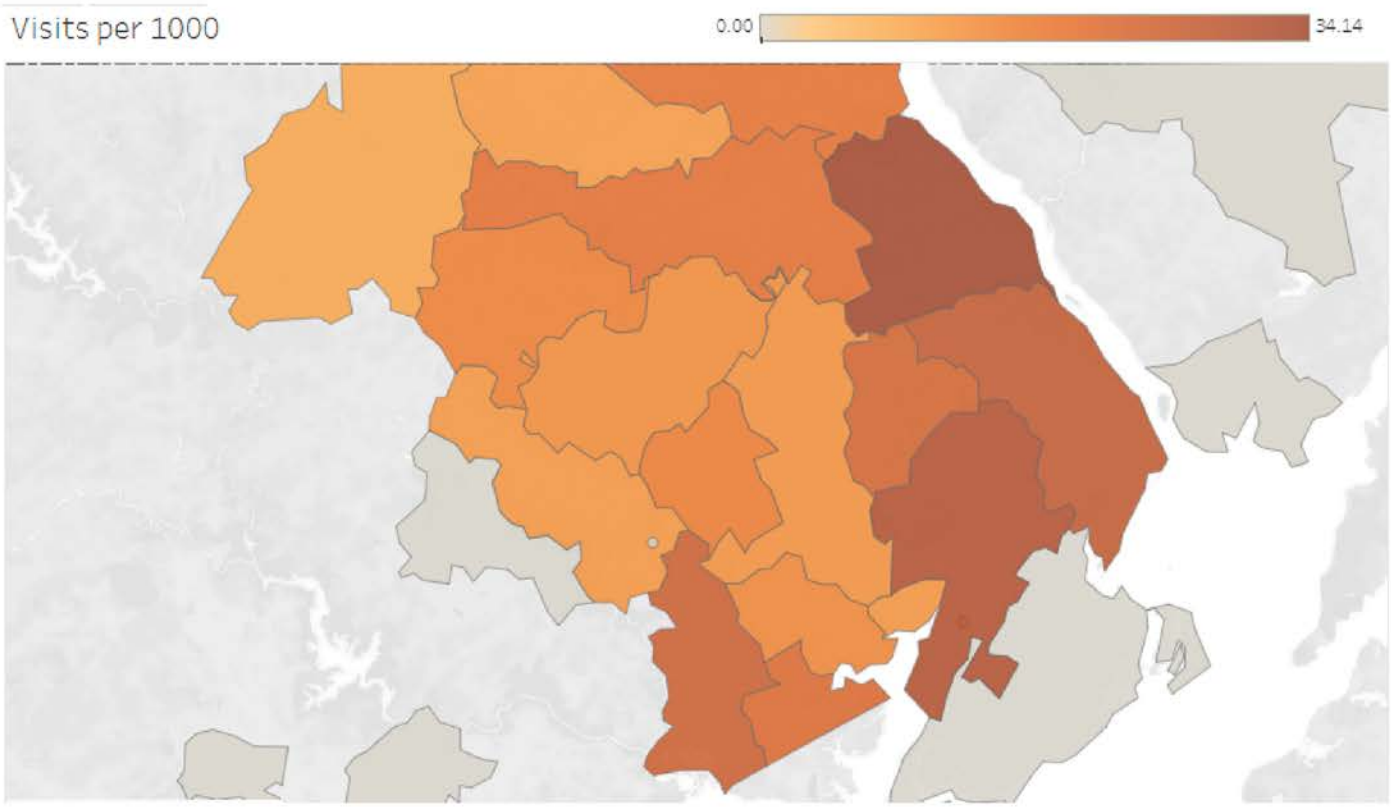
Emergency Department Visits Rate for Diabetes per 1,000 Residents in Harford County, 2022



Chronic Obstructive Pulmonary Disease (COPD)

COPD, a group of diseases that cause airflow blockage and breathing-related problems, was the fifth leading cause of death among Harford County residents in 2020. COPD can include diagnoses of emphysema, chronic bronchitis, and in some cases, asthma. Former and current smokers are at risk of developing these diseases. Aberdeen, an area with a high percentage of tobacco users, also has a higher rate of emergency visits by residents diagnosed with COPD, with Havre de Grace and Edgewood having the second and third-highest rates in the county.

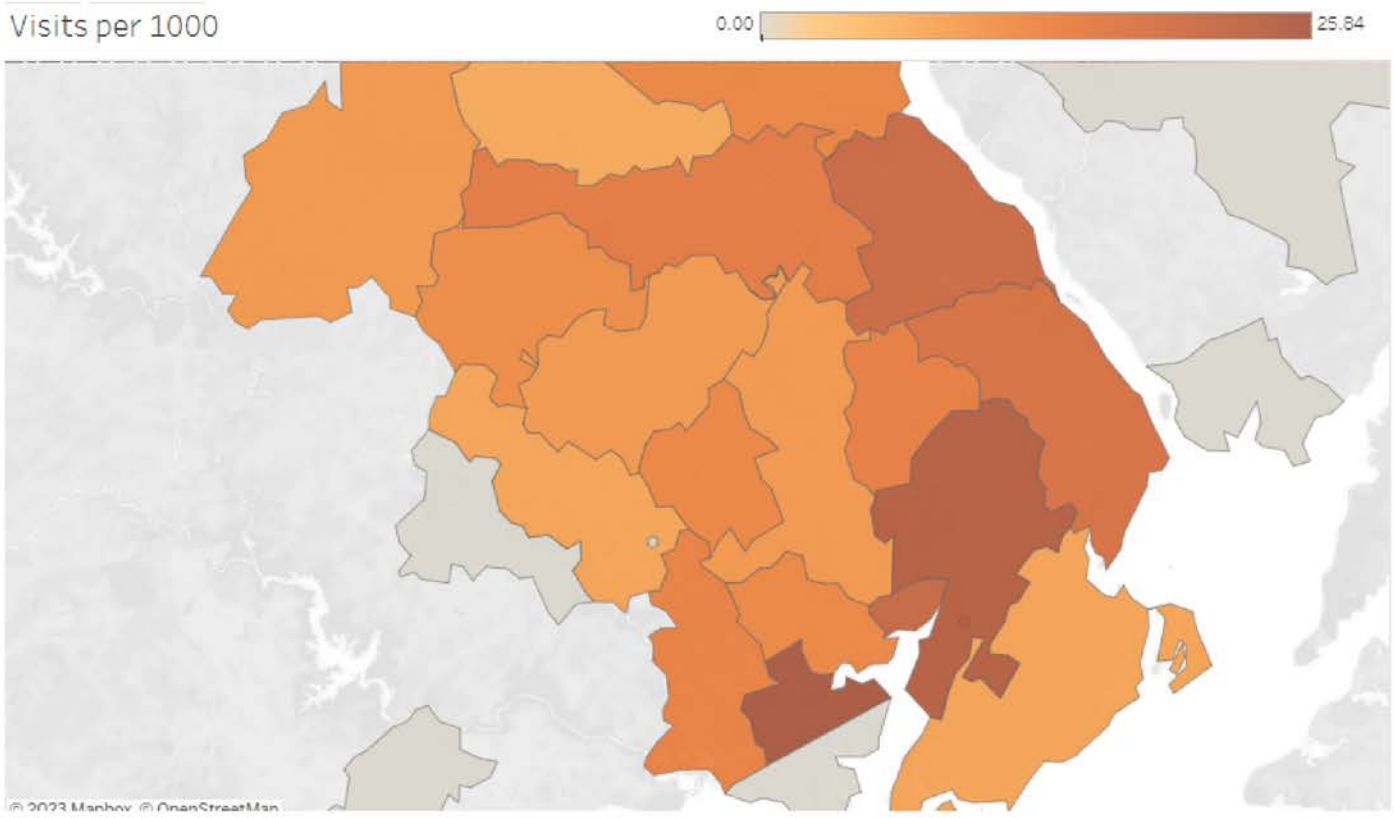
Emergency Department Visits Rate for COPD per 1,000 Residents in Harford County, 2022



Asthma

Asthma is a chronic disease that affects the lungs, causing narrowing and constriction of the airway, making it more difficult to breathe. This can cause major problems for a child's healthy development, and an adult's quality of life. Poor air quality, environmental factors, and poor asthma management can lead to hospital visits. Asthma is currently a health priority in Maryland. Racial disparities can be seen in Maryland when analyzing the data on emergency department visits since the beginning of 2018. For example, in December of 2021, asthma ED visits were on the rise. African Americans/Blacks had 4 times more ED visits than the White population.

Emergency Department Visits Rate for Asthma Per 1,000 Residents in Harford County, 2022



CONCLUSION

Our Efforts

The first step in achieving health equity is recognizing that health status is very different depending on your location in Harford County. Use this information to shape your work and partner with organizations that can help leverage your goals. Sustainable programs and partnerships are essential, and building health equity depends on community-wide collaboration! HCHD is making efforts daily to develop new programs and provide services that achieve health equity throughout the entire county.

One of the biggest SDOH factors that affects our community is transportation. HCHD provides Medical Assistance (MA) Transportation to ensure that transportation is not an obstacle for our community in order to make their medical appointments on time. MA Transportation provides services to active, non-restrictive Medicaid recipients or for those who have no other means of transportation.

HCHD offers a wide variety of services at its seven locations such as immunizations, STI testing, harm reduction, behavioral health services, family planning services, and more! One of our programs includes MEGAN's (meaningful environment to gather and nurture) Place, a trusted, safe environment for at-risk pregnant and postpartum women and their families in Harford County. It aims to provide guidance and information, referrals and services, care coordination, and support to its families. Services include home visiting with its Healthy Families America component, peer-recovery support, and referrals to excellent community resources through Care Coordination Plus in order to extend its services to its families by addressing numerous SDOH factors. Our newest addition to care coordination services includes Nuestra Comunidad, a program that allows undocumented individuals to get connected to a variety of services, including, immunizations, health screenings, and referrals to outside care.

The Minority Health Program is a rapidly growing component of our health department. Our community health workers are determined to improve minority health in our community by creating relationships throughout our county to develop educational and resourceful events that help to educate the public on the most prevalent health disparities as well as provide a guide on where to go and how to address these health issues. These educational components include; screening and testing for various diseases and infections, mental health and self-care, lack of food or transportation, mental health youth symposiums for middle and high school students, and much more.

The Health Department is constantly looking for ways to help our community to end health disparities and inequities. Partnering and building relationships with other community members is the best way to achieve this in the most effective way possible.

CONCLUSION

Where do we go from here?

Where you live matters! This report is the first step in understanding health equity in Harford County. Based on the findings of this report, there are health inequities due to geographic factors in Harford County, as evidenced by poorer living conditions, lower health insurance rates, and higher negative risk behaviors and diseases compared to other zip codes in the county. The three priority areas are Aberdeen, Edgewood, and Havre de Grace. This places residents in those areas at higher risk for increased morbidity and mortality. Now that priority areas have been identified, the health department can continue to strengthen cross-sector partnerships with community leaders, increase access to services, and improve health for residents who need the most care. The assessment can also identify which programs need to be expanded to increase capacity and educate employees on the importance of health equity. This type of program and policy advocacy will help make Harford County the healthiest community in Maryland.

"I am very thankful and I hope that this place always exists because they help so much. Thank you."

REFERENCES

Behavioral Risk Factor Surveillance Survey, 2021

Census, 2021

Center for Sexually Transmitted Infection Prevention, 2021

Centers for Disease Control and Prevention, 2023

Chesapeake Regional Information System for our Patients, 2023

Harford County Health Department, 2023

Maryland Department of Health, 2023

Maryland Vital Statistics, 2021

Robert Wood Johnson County Health Rankings, 2023

World Health Organization, 2023

Youth Risk Behavior Survey/Youth Tobacco Survey, 2023

UM UPPER CHESAPEAKE HEALTH

UNIVERSITY of MARYLAND MEDICAL SYSTEM

2024

COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLAN

This is the hospital specific implementation strategy for University of Maryland Upper Chesapeake Health (UM UCH) and addresses the community health needs identified through a collaborative community health needs assessment (CHNA) process conducted with local and regional partners. This document outlines plans for UMUCH to support specific community benefit efforts as part of a larger community-wide and system plan.

OUR COMMUNITY AND KEY PARTNERS

Serving Harford County for more than 100 years, University of Maryland Upper Chesapeake Health (UM UCH) is a member of the University of Maryland Medical System, the State's largest health system. UM UCH includes two acute care, not-for-profit medical centers — UM Upper Chesapeake Medical Center in Bel Air and Aberdeen totaling 366 licensed beds. Driven by the growing healthcare needs of the community UM UCH provides cancer care, orthopedics, cardiology, behavioral health, and pulmonary medicine among more. In 2024, The Kaufman Cancer Center in Bel Air celebrated its 10th anniversary of providing comprehensive cancer services to the community. Additionally, both the Klein Family Center and the Aberdeen Behavioral Health Pavilion offer a continuum of behavioral health programs to our community.

In recent years UM UCH invested over $260 million to expand medical services including recruiting over 32 primary care and specialty care providers. Investments include a new 72 bed inpatient tower in Bel Air, an expanded emergency room waiting area, expanded surgical robotics programs, core infrastructure and a new cafeteria. In the Summer of 2024, Pavilion III on the Bel Air campus will introduce a new ambulatory surgery center with 2 operating rooms and 2 procedure rooms, along with sports medicine and a surgical institute featuring orthopedics, spine and hand and plastics.

In Aberdeen, a major campus was introduced including a new emergency room, short-stay observation unit, the Anna and James Lambdin Health and Wellness Center in Aberdeen.

A major expansion of primary care services is underway across UM UCH's 7 practice Harford County locations, with over 46,000 community members served annually.

In support of these expanded clinical services in Harford County, the University of Maryland School of Medicine now provides specialty care services in over 21 specialties, including 9 pediatric sub-specialties, major cancer programs, spine surgery and others.

Driven by the health needs of Harford and Cecil County, UM UCH is proud to offer expanded access to primary care and specialty services along with a comprehensive network of health and wellness focused education and preventative care services support by our Community Health and Outreach Team. As part of the University of Maryland Medical System, we continue to provide A BETTER STATE OF CARE.

The Harford County CHNA includes all 21 Harford County zip codes. This includes zip codes where our most vulnerable populations reside (21009, 21040, 21001 and 21078). In keeping with University of Maryland Upper Chesapeake Health's mission of maintaining and improving the health of the people in its communities and providing high quality care to all. While the above four zip codes are identified as containing concentrated areas of poverty, there are pockets of poverty throughout many of the Harford County zip codes particularly in the northern zip codes where it is very rural. Surveying all of Harford County gives the organization a better opportunity to meet the needs of the vulnerable residents of Harford County.

HOW THIS IMPLEMENTATION STRATEGY WAS DEVELOPED

Community Health Needs Assessment

Process and Product

The UM UCH community health needs assessment (CHNA) was conducted in partnership with the Harford County Health Department and Healthy Harford. This written report describes:

- The community served
- Community demographics
- Existing health resources in the community available to respond to needs
- How data was collected in the assessment process
- The priority health needs of the community
- Health needs and issues of uninsured, low-income, and minority groups
- The process for identifying and prioritizing community needs and services to meet the needs
- The process for consulting with persons representing the community's interests

Sharing Results

Detailed findings for our assessment is posted on the UM UCH website Community | UM Upper Chesapeake Health (umms.org) and the Harford County Health Department

harfordcountyhealth.com/wp-content/uploads/2021/06/Harford-County-Community-Health-Needs-Assessment-2021.pdf website(s) in June 2024. The CHNA was presented to the Quality Care Council on June 11, 2024, for discussion and approval. The Quality Care Council is a subcommittee of the Hospital Board whose focus is to direct and approve quality and comprehensive initiatives. The Board gives the Quality Care Council the purview to approve the CHNA and Implementation Plan.

PRIORITY HEALTH NEEDS & HOW THEY WERE ESTABLISHED

Prioritization Process

Process & Criteria

Priority setting is complex and requires input from county stakeholders and decision makers and relies on the use of diverse data sources as well as stakeholder input.

In April of 2024, the key community stakeholders met to review the community health needs assessment survey and focus group results. The stakeholders included:

- UM UCH
- Klein Family Center
- Health Harford County Health Department
- Healthy Harford
- Harford County Council
- Harford County Public Schools
- Harford County Public Library
- Harford County Office on Aging
- Harford County Emergency Services
- Department of Social Services
- Department of Community Services

Once the group reviewed the data and information, they determined and prioritized the county's health needs and priorities for the next three years.

Identified Priorities

The following priority health issues are the final community-wide priorities that were selected through the process described above:

Harford County*:*

1. Mental Health and Wellness
2. Prevention and Health Management

3. Community and Family Wellbeing

Engagement in a Community-Wide Plan

Internally, upon adoption of this plan, UM UCH will convene regularly with the Community Benefit Advisory Board. This Board is comprised of department leaders who oversee initiatives that may potentially impact the identified needs.

Externally, UM UCH will collaborate with our community partners on a regular basis through the standing meets of the three operating LHICs in the County:

- The Chronic Diseases Prevention and Wellness Workgroup
- The Family Health & Resiliency Workgroup
- The Harford County Mental Health and Addictions Advisory Council (MHAAC). Meets jointly with the Harford County Local Health Improvement Coalition (LHIC) Behavioral Health Workgroup and the Overdose Intervention Team (OIT). The three groups merged to form the MHAAC | LHIC | OIT in 2019 in order to streamline action for addressing mental and behavioral health priorities within the county.

The Community Health Improvement Plan CHIP) for Harford County can be found at Harford County Health Department. harfordcountyhealth.com. The UMMC CHIP is available at harfordcountyhealth.com/wp-content/uploads/2022/06/Revised-2019-CHIP.pdf

IMPLEMENTATION STRATEGY DETAILS

Priority Health Issue #1: Mental Health and Wellness

Description of Community Need

The Chesapeake Regional Information System for Our Patients (CRISP) reported that 7,380 visits to the hospital were due to depression, increasing about 12% from the previous year. When looking at anxiety, it has decreased by 46.6%, with 1,635 visits in 2022. In addition, the suicide rate was 12 deaths by suicide per 100,000 residents. The Maryland Vital Statistics report indicates that the total intoxication death rate for 2021 was 36.5 per 100,00. The most used drug that caused intoxication deaths was fentanyl, followed by cocaine and prescription opioids. County Health Rankings indicated that 16% of adults reported binge or heavy drinking in 2021. While the rate for intoxication-related deaths has decreased, there is still a large concern for the county with rates much higher than they were a decade ago. The issue now lies with an increase in fentanyl, especially when laced with other products, such as cocaine, which was legalized in Maryland in July 2023.

Desired Community Result

- Reduce emergency room visits and inpatient admissions for behavioral health patients while providing comprehensive behavioral health services that will serve the entire County; and provide the Community an easy-to-access alternative to the hospital emergency room for behavioral health (mental illness and substance use) crises.
- Improve access to mental health services and treatments for all Harford County residents.
- Increase knowledge and awareness for the Harford County community on behavioral health and substance use and the resources available in the community.

Partner Agencies and Roles

In addition to the community partners listed above, UM UCH will collaborate with the following partnering agencies.

Harford Community Action Agency
Harford County Department of Community Services
Harford County Department of Social Services
Harford County Emergency Services
Harford County Office on Aging
Harford County Office on Drug Control Policy
Harford County Office on Mental Health/Core Services Agency
Harford County Public Schools
Harford County Sheriff's Office
NAACP

Related Hospital Strategies

- Through the use of telehealth, collaborative care clinical staff could increase the ability to service more individuals in need of behavioral health and psychiatric care within the primary care physician's office.
- Provide educational classes specific to behavioral health:
    - Mental Health First Aid
    - QPR
    - Mental health/substance use disorder topics
    - How nutrition affects depression and anxiety
    - Linkages between diabetes and depression.
- Work with the Harford County Sheriff's Office to provide crisis management consultation as part of their Crisis Intervention and Crisis Negotiation Teams.
- Participate in community stakeholder meetings:
    - Mental Health Addiction Advisory Council/Local Health Coalition
    - Behavioral Health Workgroup/Harford County Opioid Intervention Team Meeting

    - All (Behavioral Health) Providers Meeting
    - Crisis Response Provider Meeting
    - Office on Mental Health Board Meetings
    - Police Commission Meeting
    - QPR (Question, Persuade, Refer) /Suicide Prevention Workgroup
    - Involuntary Commitment Stakeholders Meeting
    - Law Enforcement Assisted Diversion Operational Workgroup
- Increase education to Harford County Public Schools, pediatricians and OB/GYN practices on local mental health resources for Women and Children.

Evaluation and Metrics

We will use the following metrics to identify trends and corrective action for the above strategies.

1. # Mental Health First Aid and QPR Trainings, # individuals trained
2. # patients utilizing the Klein Family Center
3. # patients referred to the Klein Family Center
4. # patients referred to substance use treatment

Priority Health Issue #2: Prevention and Health Management

Description of Community Need

Unhealthy behaviors can lead to chronic diseases that can be life-threatening. The leading causes of mortality in Harford County are heart disease, cancer, and stroke. These conditions can be prevented with lifestyle changes, such as healthy eating habits, physical activity, and avoiding smoking and drinking. There were 168.9 deaths per 100,000 persons in Harford County in 2021 due to heart disease deaths. Hypertension, a large factor of heart disease, was shown to be higher in African Americans, with 106.24 hospital visits per 1000 compared to 77.27 hospital visits per 1000 for the white population. Smoking in adults has been high for several years in Harford County, with 14% of adults reporting they smoked in 2021. Smoking is known to cause many chronic conditions, such as lung cancer and chronic obstructive pulmonary disease (COPD). Lung cancer was the specific cancer type causing the most deaths, at 24% of all cancers in Harford County in 2020. COPD also remains higher than the state rate, with the death rate being 36.9 per 100,000 residents. The diabetes mortality rate was at 18.2 per 100,00 in 2021. The African American population had almost double the rates that the white population did. From 2018 to 2021 there was a slight increase in youth obesity, with 14.7% of high school students falling into the obese category for Body Mass Index (BMI) and 14.8% of students in the overweight category for BMI. County Health Rankings reported that 32% of

adult residents are in the obese category. This rate coincides with the percentage of inactive adults, with 21% of adults reporting they had no physical activity outside of work.

Desired Community Result

- Improve care coordination and continuity of care for identified high risk, rising risk and high ED utilizers through navigation services ensuring these patients receive the right care in the right setting.
- Decrease avoidable ED utilization for identified high risk.
- Improve general wellness in Harford County with a reduction on chronic disease burden.
- Improve education and awareness of prevention and wellness through community programming, health screenings, and vaccinations.

Partner Agencies

UM UCH will partner with local community agencies as listed below, but not limited to:

Breathe 379
Harford Community Action Agency
Harford County Department of Community Services
Harford County Department of Social Services
Harford County Office on Aging
Harford County Public Libraries
Harford County Public Schools
LASOS, Inc.
Mason Dixon
NAACP
Susquehanna Ministerium
United Way of Central Maryland
Y of Central Maryland

Related Member Organization Strategies

- Provide health education and access to community programs, targeted disease specific community events, resources, and health and wellness screenings throughout Harford County to include, but not limited to, addressing diabetes, heart disease, stroke, cancer, and respiratory diseases.

- Offer nurse navigation, dietician and social work services to assist all Harford County residents, with a diagnosis of cancer, free of charge with obtaining access to care for

clinical services, diagnostic procedures, treatment and distress management due to their cancer, regardless of where they plan to receive their treatment.

- Provide monitored cardiac rehabilitation program for any Harford County resident requiring rehabilitation after a cardiac event

Evaluation and Metrics

We will use the following metrics to identify trends and corrective action for the above strategies.

1. # of participants in educational programs
2. # of participants meeting program identified goals
3. # of participants in health screenings
4. # of participants attending support groups
5. % reduction in avoidable diabetes related hospital admissions

Priority Health Issue #3: Community and Family Wellbeing

Description of Community Need

Social Determinants of Health (SDOH), conditions in the environment where we are born, live, learn, work, play, worship, and age, affect a wide range of health, functioning, and quality-of-life outcomes and risks. These are non-medical factors that influence health outcomes. There are five determinant areas that make up the underlying factors of the SDOH and contribute to health equity: Education Access and Quality, Health Care and Quality, Neighborhood and Built Environment, Social and Community Context, and Economic Stability. There is a strong association between social ties and health. Strong relationships are important for one's physical and psychosocial well-being and can influence health outcomes through support such as helping people maintain a healthy diet, reducing emotional stress, increasing physical activity, and helping to connecting people to health and wellness services. By promoting good health and addressing all factors of the SDOH, we can create opportunities for people to live their best, healthiest lives and achieve health equity.

Desired Community Result

- Work collaboratively with community partners to address the SDOH issues.
- Improve food access to populations in need (seniors, children, and families)
- Provide opportunities for safe and inclusive physical activities.
- Improve access to, education and awareness of community health and wellness resources.

Partner Agencies and Roles

In addition to the community partners listed above, UM UCH will collaborate with the following partnering agencies.

Harford County Health Department/Minority Health Program
Breathe 379
Harford Community Action Agency
Harford County Department of Social Services
Harford County Office on Aging
Harford County Public Libraries
Harford County Public Schools
LASOS, Inc.
Mason Dixon
NAACP
Susquehanna Ministerium
United Way of Central Maryland
Y of Central Maryland

Related Member Organization Strategies

- Provide health education and access to community programs.
- Offer nurse navigation, dietician, and social work services to assist all Harford County residents with address SDOH.
- Partner with community stakeholders in health and wellness programing.

Evaluation and Metrics

We will use the following metrics to identify trends and corrective action for the above strategies.

1. # of people served in the various programs.
2. # of events held to educate and increase awareness of opportunities for assistance.
3. # individuals connected to additional resources needed.
4. % of minorities participating in events
5. % of minorities connected to services

NEXT STEPS

As part of the community health improvement process, UM UCH will continue to work with community partners in the development, implementation, and monitoring of our collaborative community health improvement plan (CHIP) that includes some of the hospital strategies outlined in this document. The next community health needs assessment (CHNA) will be conducted in 2027. As a note, this implementation is dynamic in nature and reflective of the communities that we serve and partners that we work with. Strategies may change in scope or fluctuate accordingly based on the aforementioned.

UNIVERSITY of MARYLAND MEDICAL SYSTEM **Revenue Cycle Services**	**PAGE:** **1 OF 14**	**POLICY NO:** **RCS - 01**
	EFFECTIVE DATE: 09/18/19	**REVISION DATE(S):** 07/01/24
SUBJECT: UMMS Financial Assistance Policy		

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

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

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

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

DEFINITIONS:

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

POLICY:

The University of Maryland Medical System ("UMMS") is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation.

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

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

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

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

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

PROCEDURE:

I. How To Apply for Financial Assistance

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

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

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

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

Supporting Documentation for Financial Assistance Applications

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

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

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

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

II. Reviewing and Determining Eligibility of Financial Assistance Applications

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

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

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

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

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

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

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

If a Financial Assistance Application is Approved

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

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

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

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

If a Financial Assistance Application is Not Approved

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

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

III. Eligibility Criteria

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

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

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

Financial Assistance Eligibility

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

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

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

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

Patients may be deemed ineligible for financial assistance:

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

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

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

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

Presumptive Financial Assistance Eligibility

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

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

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

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

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

Financial Hardship Assistance Eligibility

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

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

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

IV. Appealing a Determination of Eligibility for Financial Assistance

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

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

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

Provider Driven Financial Clearance and Reconsideration

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

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

V. Notice of Availability of Financial Assistance

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

- UMMS will post notices of financial assistance availability in each UMMS hospital's emergency room (if any), admissions areas, key patient access areas, and the hospital billing office. Notice of availability will also be sent to the patient with patient statements.

- The Patient Billing and Financial Assistance Information Sheet will be provided at preadmission and before discharge for each hospital encounter, with each hospital statement, and it will be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas.
- The Financial Assistance Policy and the Financial Assistance Application will also be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas.
- The Financial Assistance Policy, the Patient Billing and Financial Assistance Information Sheet, and the Financial Assistance Application will also be conspicuously posted on the UMMS website (www.umms.org).

Patient Billing and Financial Assistance Information Sheet Content

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

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

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

VI. Extraordinary Collection Actions

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

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

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

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

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

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

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

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

UMMS will not engage in the following ECAs:

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

ATTACHMENTS:

ATTACHMENT A: Sliding Scale – Reduced Cost of Care

2024 Federal Poverty Limits (FPL) Annual Income Eligibility Limit Guidelines							
House-hold (HH) Size	1	2	3	4	5	6	See UMMS Charity Thresholds below
Income Limit (up to Max)	$15,060	$20,440	$25,820	$31,200	$36,580	$41,960	

2024 Maryland Dept of Health (MDH) Annual Income Eligibility Limit Guidelines							
House-hold (HH) Size	1	2	3	4	5	6	See UMMS Charity Thresholds below
Income Limit (up to Max)	$20,784	$28,224	$35,640	$43,056	$50,496	$57,912	

UMMS Financial Assistance Charity Income Thresholds							
If your total annual household (HH) income level is at or below:							You are eligible for the following level of charity at UMMS:
House-hold (HH) Size	1	2	3	4	5	6	
Income Limit (up to Max)	$41,568	$56,448	$71,280	$86,112	$100,992	$115,824	**100% Charity** (Equals Up to 200% of MDH Annual Income limits)
Income Limit (up to Max)	$43,646	$59,270	$74,844	$90,418	$106,042	$121,615	**90% Charity** (Equals Up to 210% of MDH Annual Income limits)
Income Limit (up to Max)	$45,725	$62,093	$78,408	$94,723	$111,091	$127,406	80% Charity (Equals Up to 220% of MDH Annual Income limits)
Income Limit (up to Max)	$47,803	$64,915	$81,972	$99,029	$116,141	$133,198	**70% Charity** (Equals Up to 230% of MDH Annual Income limits)
Income Limit (up to Max)	$49,882	$67,738	$85,536	$103,334	$121,190	$138,989	60% Charity (Equals Up to 240% of MDH Annual Income limits)
Income Limit (up to Max)	$51,960	$70,560	$89,100	$107,640	$126,240	$144,780	**50% Charity** (Equals Up to 250% of MDH Annual Income limits)
Income Limit (up to Max)	$54,038	$73,382	$92,664	$111,946	$131,290	$150,571	**40% Charity** (Equals Up to 260% of MDH Annual Income limits)
Income Limit (up to Max)	$56,117	$76,205	$96,228	$116,251	$136,339	$156,362	**30% Charity** (Equals Up to 270% of MDH Annual Income limits)
Income Limit (up to Max)	$58,195	$79,027	$99,792	$120,557	$141,389	$162,154	**20% Charity** (Equals Up to 280% of MDH Annual Income limits)
Income Limit (up to Max)	$60,274	$81,850	$103,356	$124,862	$146,438	$167,945	**10% Charity** (Equals Up to 290% of MDH Annual Income limits)

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

Effective 7/1/24

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

POLICY OWNER:
UMMS Revenue Cycle Services

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

Federal Poverty Level and Maryland Department of Health Annual Income Eligibility Limit Updated: 07/01/20, 07/01/21, 07/01/22, 07/01/23, 07/01/24

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

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