

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?		If no, please provide the correct information here:
	Yes	No	
The proper name of your hospital is: UMMC Midtown Campus	☒	☐	
Your hospital's ID is: 210038	☒	☐	
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 Christine Crabbs, Dr. Roderick King	☒	☐	
The primary HCB Narrative contact email address at your hospital is Christine.Crabbs@umm.edu; Roderick.King@umm.edu	☒	☐	
The primary HCB Financial report contact at your hospital is Catherine Njoka	☐	☒	Patrick Morris
The primary HCB Financial report contact email at your hospital is cnjoka@umm.edu	☐	☒	PatrickMorris@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.

UMMC uses data obtained in the FY24-26 Baltimore City Community Health Needs Assessment. In addition, UMMC uses statistics to measure Maternal/ Prenatal outcomes, Infant Mortality rate, Substance Use rate, Healthy Food Priority Areas, Social Needs index statistics, Vaccination Rates, UMMS Health Equity data, and other data provided the BCHD.

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

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

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

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

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

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

☒ Based on patterns of utilization. Please describe.

CBSA is based on the top 60% of discharges from West Baltimore City in the past fiscal year.

☐ Other. Please describe.

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

<https://www.umms.org/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?

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)

March 15, 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/ummc/-/media/files/umms/community/needs-assessment/202324-baltimore-city-chna.pdf?upd=20240821134641>

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

[2023-24 Baltimore City CHNA FINAL 3.15.24.pdf](#)
7.6MB
application/pdf

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

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

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

[illegible]

[illegible]

Local Health Departments -- Please list the Local Health Departments here:
Baltimore City Health Department

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

Local Health Improvement Coalition -- Please list the LHICs here:
Baltimore City LHIC

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Maryland Department of Health

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☒	☒	☐	☐	☐	☐	☐	☐	☒	☒	☒	☐	☐	☐

Other State Agencies -- Please list the agencies here:
N/A

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☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Local Govt. Organizations -- Please list the organizations here:
Mayor's Office of Employment Development

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Faith-Based Organizations

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School - K-12 -- Please list the schools here: Cristo Rey Jesuit High School, James McHenry Elem/Middle School, Matthew Henson Elem. School, Dorothy Height Elem. School, Robert Coleman Elem. School, The Historic Samuel Coleridge Taylor Elem. School, Vivien Thomas Medical Arts Academy, Edmonson Westside High School	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
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School - Colleges, Universities, Professional Schools -- Please list the schools here: University of Maryland Baltimore, Coppin University, Morgan University, Baltimore City Community College, Howard Community College	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
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Behavioral Health Organizations -- Please list the organizations here: Penn North Wellness & Recovery Center, Marian House	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
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Social Service Organizations -- Please list the organizations here: Baltimore Social Service Department, Safe House, Humanim, Paul's Place, PIVOT Baltimore, St. Vincent de Paul Society	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
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Post-Acute Care Facilities -- please list the facilities here: University of Maryland Rehabilitation & Ortho Institute	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
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	☒	☒	☒	☒	☐	☐	☒	☒	☐	☒	☐	☐	☐	☐

Community/Neighborhood Organizations -- Please list the organizations here:
Housing Authority of Baltimore City, Seton Hill Community Assoc., Fayette Street Community Outreach, Upton Planning Committee, Yale Heights Community Association, Druid Heights Community Development Corp., Southwest Partnership, Laburt Improvement Community Association, The Community Builders

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Community-Driven/Led - To support the actions of community initiated, driven and/or led processes

Identify & Engage Stakeholders

Define the community to be assessed

Collect and analyze the data

Select priority community health issues

Document and communicate results

Plan Implementation Strategies

Implement Improvement Plans

Evaluate Progress

Consumer/Public Advocacy Organizations -- Please list the organizations here:
N/A

☐ ☐ ☐ ☐ ☐ ☐

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

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Community-Driven/Led - To support the actions of community initiated, driven and/or led processes

Identify & Engage Stakeholders

Define the community to be assessed

Collect and analyze the data

Select priority community health issues

Document and communicate results

Plan Implementation Strategies

Implement Improvement Plans

Evaluate Progress

Other -- If any other people or organizations were involved, please list them here:
BACH, Building Steps, Caroline Center, Celebrate Us, Center for Urban Families, Turn Around Tuesday, YMaryland

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☒ ☒ ☐ ☐ ☐ ☒ ☒ ☐

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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.

6/4/2024

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

<https://www.umms.org/ummc/-/media/files/umms/community/needs-assessment/fy24fy26-chna-implementation-plan-ummc.pdf?upd=20240821134652>

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

[UMMC- FY24-FY26 Implementation-Strategy-Final.doc.pdf](#)
809.6KB
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.

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

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

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

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

- ☐ Yes
- ☒ No

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

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

☐ Health Behaviors - Tobacco Use

☐ Other (specify)

Q60. Why were these needs unaddressed?

Our community benefit activities, resources and efforts are aligned to addressing the CHNA identified priorities. These areas, while still important to the health of the community, will be met through either existing clinical operations and/or, population health programs, and through collaboration with other health care organizations as needed. The unmet needs not addressed by this CHNA will also continue to be addressed by key Baltimore City governmental agencies and existing community-based organizations. In addition, there are population health initiatives that address these health needs, but they do not meet the definition of community benefit and as a result they were not reported here.

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

UMMS has developed a multi-year plan, backed by a \$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. Currently, we track data by race, ethnicity, gender, age and zip code to identify disparities (see CHNA). Our implementation plans will continue to track outcomes and we will adapt plans to meet the needs of the community and reduce health disparities. Furthermore, some of our programs such as diabetes prevention and workforce development target zip codes and populations (e.g. recently incarcerated) who have significant health disparity. In addition, UMMS has provided an EDI dashboard for all member hospitals across six health outcomes. Each hospital has identified which health equity program to address. UMMC MTC is focusing on re-admissions and pediatric asthma to improve health outcomes for Black patients.

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

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

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

Q64. Section III - CB Administration

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

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

Q66. Please describe the third party audit process used.

The University of Maryland Medical System (UMMS Corporate Internal Audit Group (CIAG) conducted an audit of the processes and controls in place over Community Benefit reporting to the Maryland Health Services Cost Review Commission (HSCRC) at the University of Maryland Medical Center (UMMC) downtown and midtown campuses (DTC and MTC, respectively). The audit was performed by PwC. The scope of this assessment included gaining an understanding and evaluating the processes and controls in place over the compilation and submission of the Community Benefit Narrative and Financial Reports, including, but not limited to, the following areas: • Policies and procedures, roles and responsibilities, and the oversight and approval structure around Community Benefit reporting • Process to track and compile qualifying costs in accordance with HSCRC regulations • Completeness and accuracy of selected responses from the FY23 Community Benefit Narrative and Financial reports CIAG's procedures included interviewing the Community Benefit and Finance teams from UMMC DTC and MTC, reviewing relevant procedural documentation, and performing testing of selected areas of the FY23 Narrative and Financial reports from UMMC DTC and MTC. Testing procedures included obtaining supporting evidence for the selected report responses and evaluating UMMS protocols as compared to HSCRC guidance. The period under review was July 1, 2022 – June 30, 2023.

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

- ☒ Yes
- ☐ No

Q68. Please describe the community benefit narrative audit process.

Using the prior year CB Report as a guide, the narrative report is completed. A PDF copy is requested from HSCRC/ Hilltop and distributed via email to the Sr. Director of Community Health at UMMS, who completes the final review with a year to year comparison. Changes are made and a Final Draft is requested for from Hilltop. It is submitted to UMMC executives for review and approval. The reports are reviewed, questions or concerns are communicated verbally or via email. Once approval is obtained and documented, the reports are sent to the Board for approval, then submission of the completed narrative report to Hilltop.

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.

As part of the strategic plan, which is conducted every five years, an annual operating plan is developed with several sources of data, and input from multiple stakeholders. We focus on the programs we offer, needs that are not being met, and barriers to service. Community investments and community benefits are one of the organization's seven strategic plan goals. The Medical Center develops annual strategic objectives and initiatives for the strategic plan goals and shares the same with the UMMS Board of Directors.

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.](#)

☒ Diabetes - Reduce the mean BMI for Maryland residents

The Johns Hopkins Health System (JHHS) and the University of Maryland Medical Center (UMMC) have created the Baltimore Metropolitan Diabetes Regional Partnership (BMDRP) to address diabetes prevention and management in Baltimore. BMDRP has built infrastructure and aims to increase access to DPP for the prevention of type 2 diabetes in 20% more of the population with prediabetes and will aim to expand access to DSMT for management of diabetes in 25% more of the population with diabetes. Both programs are designed to reduce BMI through healthy eating and increase in physical activity.

☒ Opioid Use Disorder - Improve overdose mortality

UMMC partners with the Baltimore City Health Department to distribute free nalcron to patients at high risk for overdose. In addition, we provide community outreach and education regarding opioid risk reduction, screenings for substance use and referrals for care.

☐ Maternal and Child Health - Reduce severe maternal morbidity rate

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

A health equity committee was convened including physicians, nurses, community health staff, and patients to work with a consultant to develop a plan to improve health outcomes surrounding pediatric asthma. The plan includes timely follow up, improved education in the ED. These initiatives are supported through our population health and University of Maryland partners and expenses are not reported here.

☐ 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 Financial Assistance Policy 070124 English /1.pdf](#)

310KB
application/pdf

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

<https://www.umms.org/-/media/files/umms/patients-and-visitors/financial-assistance-policy/july-2024/umms-financial-assistance-policy-070124-english.pdf?upd=20240711132921>

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.

Percentage of Federal Poverty Level

200

300

400

500

600

700

800

Not Applicable

☐

200

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.

Lowest FPL

200

300

400

500

600

700

800

Not Applicable

☐

Highest FPL

200

300

400

500

600

700

800

Not Applicable

☐

300

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.

Lowest FPL

0

100

200

300

400

500

600

700

800

Not Applicable

☐

201

Highest FPL

0

100

200

300

400

500

600

700

800

Not Applicable

☒

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

Debt as Percentage of Income

0

10

20

30

40

50

60

70

80

90

100

☐

25

Q88. Section VI - Tax Exemptions

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

- ☒

Federal corporate income tax
- ☒

State corporate income tax
- ☒

State sales tax
- ☒

Local property tax (real and personal)
- ☐

Other (Describe)

Q90. Summary & Report Submission

Q91. **Attention Hospital Staff! IMPORTANT!**

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

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

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

Location Data

Location: [\(39.26, -76.7125\)](#)

Source: GeoIP Estimation



CITY OF BALTIMORE



COMMUNITY HEALTH NEEDS ASSESSMENT

2023-2024



ACKNOWLEDGEMENTS

This Community Health Needs Assessment (CHNA) represents the culmination of work completed by multiple individuals and groups. The Baltimore City Health Department (BCHD) and local health systems including Ascension St. Agnes (ASA), Johns Hopkins Health System (JHHS), Mercy Medical Center, MedStar Health, Mt. Washington Pediatric Hospital (MWPH), Grace Medical Center and Sinai and Levindale Hospitals of LifeBridge Health, and University of Maryland Medical Center (UMMC) have served an integral role in making this comprehensive assessment possible. This group, the Collaborative, would like to extend its gratitude to focus groups participants, key community health leaders, and community members who provided information used to develop this assessment.

The CHNA Collaborative

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Tamara England-Wilson	Director – Community Benefit	MWPH
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Kim Floyd	RN Program Manager	MedStar Health
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Brenda Wolcott	Community Health System Manager	MedStar Health

Ascendient Healthcare Advisors served as consultants, directing the CHNA process and developing the content of this report.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	3
TABLE OF CONTENTS.....	4
EXECUTIVE SUMMARY	7
INTRODUCTION	9
Background	9
Process Overview	11
Summary Findings: Baltimore City Priority Health Need Areas.....	13
CHAPTER 1 METHODOLOGY.....	15
Study Design	15
New (Primary) Data.....	15
Existing (Secondary) Data	15
Comparisons	16
Prioritization Process Overview and Results.....	16
Study Limitations	19
CHAPTER 2 CITY PROFILE.....	21
Geography.....	21
Population.....	21
Age and Sex Distribution.....	22
Race and Ethnicity.....	22
Social Determinants of Health	26
Disparities	27
Social Vulnerability Index.....	29
Health Outcome and Health Factor Rankings.....	31
CHAPTER 3 PRIORITY NEED AREAS.....	34
Priority Need: Mental Health.....	34
Context and National Perspective	34
Secondary Data Findings.....	35
Primary Data Findings – Community Member Survey.....	37
Primary Data Findings – Key Leader Survey.....	38

Primary Data Findings – Focus Groups	39
Priority Need: Chronic Health Conditions.....	39
Context and National Perspective	39
Secondary Data Findings.....	41
Primary Data Findings – Community Member Survey.....	42
Primary Data Findings – Key Leader Survey.....	43
Primary Data Findings – Focus Groups	43
Priority Need: Access to Care.....	44
Secondary Data Findings.....	46
Primary Data Findings – Community Member Survey.....	49
Primary Data Findings – Key Leader Survey.....	50
Primary Data Findings – Focus Groups	53
CHAPTER 4 HEALTH RESOURCE INVENTORY.....	55
CHAPTER 5 NEXT STEPS.....	56
APPENDICES	57
APPENDIX 1 EVALUATION OF PRIOR CHNA IMPLEMENTATION PLANS.....	58
APPENDIX 2 CITY DEMOGRAPHIC AND SOCIOECONOMIC DETAIL	64
City Demographics	64
Age and Total Population.....	64
Sex.....	64
Race.....	65
Ethnicity	65
Socioeconomic Detail.....	66
APPENDIX 3 SECONDARY DATA METHODOLOGY AND SOURCES	69
Methodology.....	69
Data Sources	70
APPENDIX 4 SECONDARY DATA COMPARISONS	95
Description of Focus Area Comparisons	95
Detailed Focus Area Benchmarks	96
APPENDIX 5 SECONDARY DATA SUMMARY	103
APPENDIX 6 DETAILED PRIMARY DATA FINDINGS	104

Methodologies	104
Focus Groups.....	104
Key Leader Web Survey	107
Community Survey.....	118
APPENDIX 7 PRIMARY DATA SUMMARY	144

EXECUTIVE SUMMARY

A Community Health Needs Assessment (CHNA) helps health leaders evaluate the health and wellness of the community they serve and identify gaps and challenges that should be addressed through new programs, services and policy changes. This report was created in compliance with the Public Health Accreditation Board's Standards & Measures for Initial Accreditation, Version 2022, as well as Internal Revenue Service requirements for not-for-profit hospitals.

Several local health organizations came together as the CHNA Collaborative to help develop this CHNA, including:

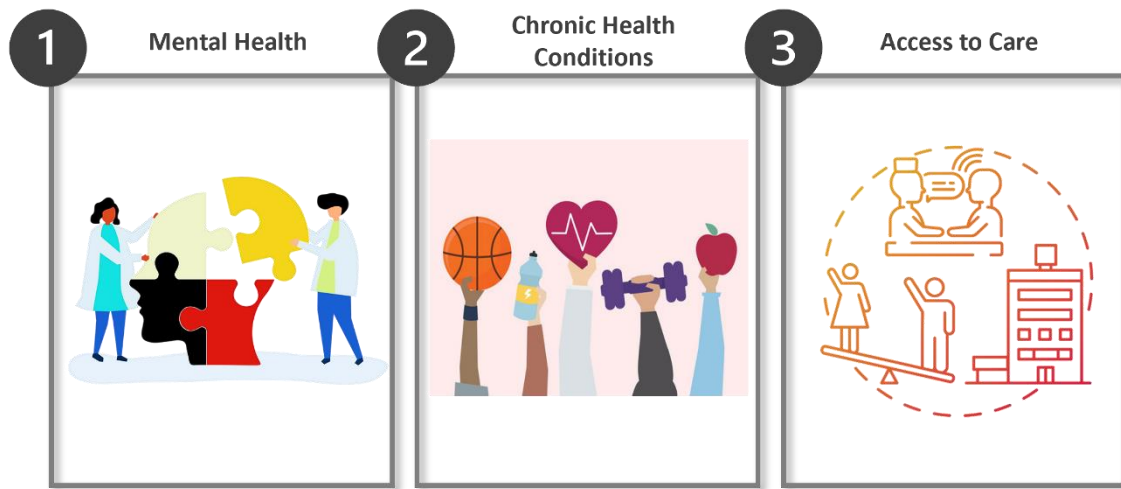
- Ascension St. Agnes Hospital
- Baltimore City Health Department
- Johns Hopkins Health System
- Lifebridge Health
- Medstar Health
- Mercy Medical Center
- Mt. Washington Pediatric Hospital
- University of Maryland Medical Center

Secondary (existing) data is an important piece of the CHNA process. More than 100 data indicators were chosen for analysis from data sources like the Robert Wood Johnson Foundation County Health Rankings, the University of North Carolina Health Literacy Data Map, and the Centers for Disease Control and Prevention. Secondary data measures were gathered into six categories and 20 detailed sub-categories based on common themes. Each data measure was also compared to state or national benchmarks to identify areas of specific concern for Baltimore City. Top community needs identified through secondary data analysis included social determinants of health, access to healthcare, mental or behavioral health, and health equity.

Primary (new) data were collected through community-based focus groups and web-based surveys for community members and key community leaders and included feedback from more than 2,600 people who live, work or receive healthcare in Baltimore City. Key leaders most frequently represented nonprofit organizations, but participants also included government, health, and faith leaders among others. A total of 33 focus groups were conducted, either virtually or in person, with a variety of community members from different backgrounds, age groups and life experiences. Primary data identified behavioral health conditions, access to healthcare, food insecurity, housing, and transportation among the top needs that impact the health and well-being of people living in Baltimore City.

The CHNA Collaborative worked together to identify the priorities city health leaders should focus on over the following three-year period. Leaders evaluated the primary and secondary data collected throughout the process to identify needs based on the size and scope, severity, ability for hospitals or health departments to make an impact, associated health disparities, and importance to the community. Although it was not possible for every single area of potential need to be identified as a priority, the CHNA

Collaborative selected three top priority health needs (mental health, chronic health conditions and access to care), which are shown here in no particular order:



The Collaborative also compiled a Health Resources Inventory, which provides links to resources available to help Baltimore City residents meet their health and social needs.

Following completion of this report, health leaders throughout Baltimore City will use its findings to collaborate with community organizations and local residents to develop effective health strategies, new implementation plans and interventions, and action plans to improve the communities they serve.

INTRODUCTION

Background

To illustrate its commitment to the health and well-being of the community, the Baltimore City CHNA Collaborative has completed this assessment to understand and document the greatest health needs currently faced by its residents. The Collaborative includes representation from Ascension St. Agnes (ASA), Baltimore City Health Department (BCHD), Johns Hopkins Health System (JHHS) including Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC), LifeBridge Health's Sinai Hospital/Grace Medical Center and Levindale Hospital, Mercy Medical Center (Mercy), MedStar Health (MedStar),¹ Mt. Washington Pediatric Hospital (MWPH), and University of Maryland Medical Center (UMMC). These organizations helped gather the focus group and survey data that are detailed in this report. The CHNA process helps local leaders continuously evaluate how best to improve and promote the health of the community. The CHNA builds upon formal collaborations between the Collaborative and other community partners to proactively identify and respond to the needs of Baltimore City residents.

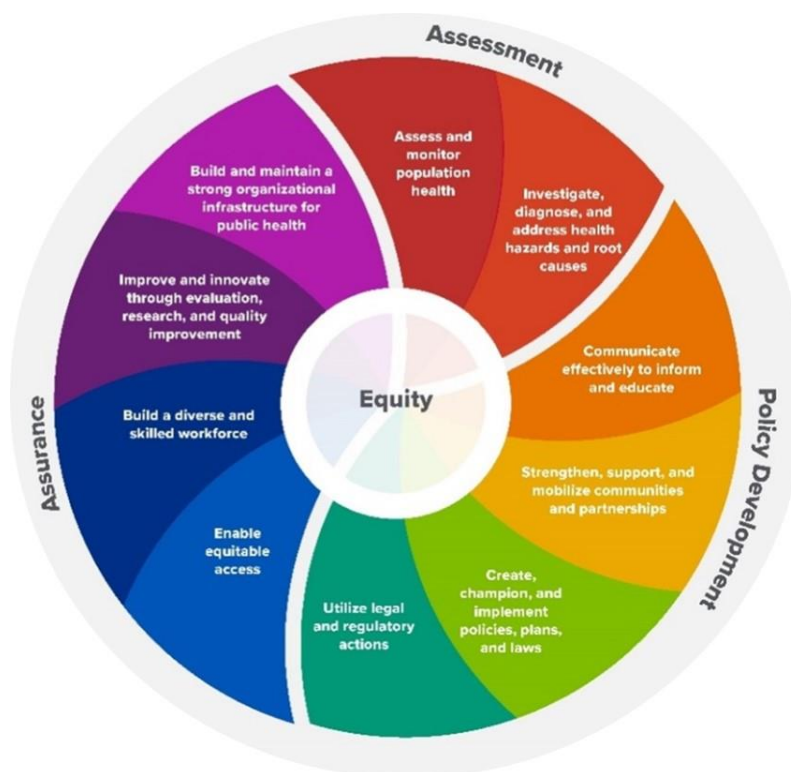
This report was created in compliance with the Public Health Accreditation Board's (PHAB) Standards & Measures for Initial Accreditation, Version 2022. The Standards "provide requirements and guidance for public health departments"² and help ensure public health departments align their standards with the CDC's "10 Essential Public Health Services," which are outlined in Figure 1.1 below. In its demonstration of data and prioritization of the City of Baltimore's community needs, this report aligns with all PHAB Standards and Measures for Initial Accreditation, including the need to:

- Conduct and disseminate assessments focused on population health status and public health issues facing the community;
- Participate in or conduct a collaborative process resulting in a comprehensive community health assessment;
- Collect and maintain reliable, comparable, and valid data that provide information on conditions of public health importance and on the health status of the population;
- Analyze public health data to identify trends in health problems, environmental public health hazards, and social and economic factors that affect the public's health;
- Describe disparities in health status and health behaviors, as well as inequities in the factors that contribute to health challenges; and
- Provide and use the results of health data analysis to develop recommendations regarding public health policy, processes, programs, or interventions.

¹ MedStar operates three hospitals within Baltimore City limits: MedStar Good Samaritan Hospital, MedStar Union Memorial Hospital, and MedStar Harbor Hospital.

² Source: *Standards & Measures for Initial Accreditation*. (2022). Public Health Accreditation Board, Centers for Disease Control and Prevention. Retrieved September 27, 2022, from <https://phaboard.org/wp-content/uploads/Standards-Measures-Initial-Accreditation-Version-2022.pdf>.

Figure 1.1: The 10 Essential Public Health Services



Further, this process complies with Internal Revenue Service (IRS) requirements for not-for-profit hospitals to complete a CHNA every three years and to adopt an implementation strategy to meet CHNA-identified community health needs.³ Specifically, the IRS requires that hospital facilities do the following:

- Define the community it serves;
- Assess the health needs of that community;
- Through the assessment process, take into account input received from people who represent the community's broad interests, including those with special knowledge of or expertise in public health;
- Document the CHNA in a written report that is reviewed and adopted by the hospital facility's authorizing body; and
- Make the CHNA widely available to the public.

³ Source: *Community Health Needs Assessment for Charitable Hospital Organizations – Section 501^c(3)* (2023). Internal Revenue Service. Retrieved February 13th, 2024 from <https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3>.

Process Overview

A significant amount of information has been reviewed during this planning process, and the Collaborative has been careful to ensure that a variety of sources were used to deliver a truly comprehensive report. Both existing (secondary) data and new (primary) data were collected directly from the community throughout this process. It is also important to note that, although unique to the City of Baltimore, the sources and methodologies used to develop this report comply with the current PHAB and IRS requirements for health departments and not-for-profit hospital organizations.

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

- Identify the health needs of Baltimore City residents.
- Identify disparities in health status and health behaviors, as well as inequities in the factors that contribute to health challenges.
- Understand the challenges residents face when trying to maintain and/or improve their health.
- Understand where underserved populations turn for services needed to maintain and/or improve their health.
- Understand what is needed to help residents maintain and/or improve their health.
- Prioritize the needs of the community and clarify/focus on the highest priorities.

There are ten phases in the CHNA process, as described in figure 1.2 below. Results of the first seven phases are discussed throughout this assessment and the development of community health action plans and subsequent phases will take place after the completion of the CHNA report.

Figure 1.2: The CHNA Process



Report Structure

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

- 1) [Methodology](#) – The methodology chapter provides an overall summary of how the priority health need areas were selected as well as how information was collected and incorporated into the development of this CHNA, including study limitations.
- 2) [City Profile](#) – This chapter details the demographic (such as age, gender, and race) and socioeconomic data of Baltimore City residents.
- 3) [Priority Need Areas](#) – This chapter describes each identified priority health need area for the City of Baltimore and summarizes the new and existing data that support these prioritizations. This chapter also describes the impact of health disparities among various sub-groups in Baltimore City.
- 4) [Health Resource Inventory](#) – This chapter documents existing health resources currently available to the Baltimore City community.

- 5) [Next Steps](#) – This chapter briefly summarizes the next steps that will occur to address the priority health need areas discussed throughout this document.

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

- 1) [Summary of Prior CHNA Implementation Plans](#) – Information about Collaborative partners and actions taken to address the priority health needs identified in previous CHNAs are presented in Appendix 1.
- 2) [City Demographic and Socioeconomic Data](#) – Information regarding the population characteristics (such as age, gender, and race) of Baltimore City are presented in Appendix 2.
- 3) [Detailed Summary of Secondary Data Measures and Findings](#) – Existing data measures and findings used in the prioritization process are presented in Appendices 3-5.
- 4) [Detailed Summary of Primary Findings](#) – Summaries of new data findings from community member and key community health leader surveys as well as focus groups are presented in Appendices 6-7.

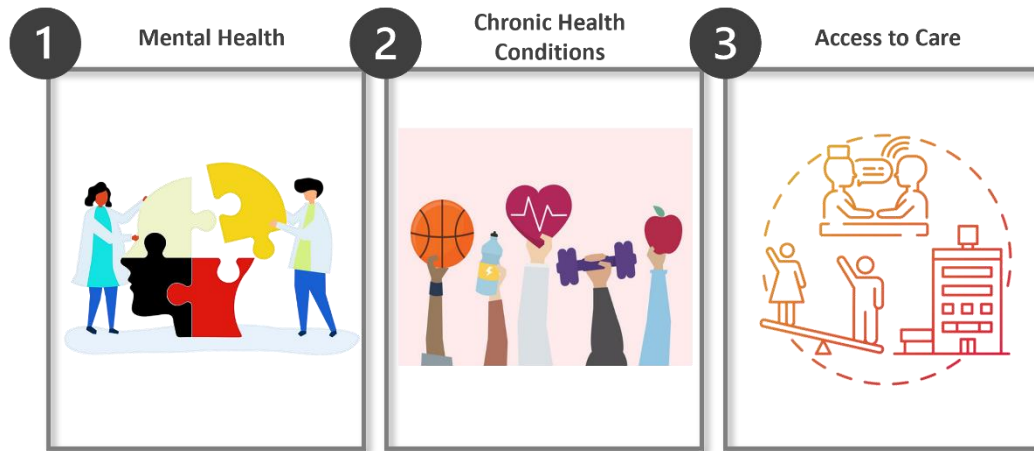
Summary Findings: Baltimore City Priority Health Need Areas

To achieve the study objectives, both new and existing data were collected and reviewed. New data included information from web-based surveys of adults (18 years+) and focus groups; various local organizations, community members, and health service providers within Baltimore City participated. Existing data included information regarding city demographics, health and healthcare resources, behavioral health, disease trends, and more. The data collection and analysis process began in July 2023 and continued through to the development of this document.

Given the size and diversity of Baltimore City, both in geography and population, significant variations in demographics and health needs exist within its borders. At the same time, consistent needs are present across the whole city and serve as the basis for determining priority health needs at the city level. This document will discuss the priority health need areas for the City of Baltimore, as well as how the severity of those needs might vary across subpopulations based on the information obtained and analyzed during this process.

Through the prioritization process, the CHNA Collaborative identified Baltimore City's priority health need areas from a list of over 100 health indicators. Please note that the final priority needs were not ranked in any order of importance and the Collaborative and the LHIC will engage in each of the three priority need areas. After looking at all relevant data and feedback from the CHNA Collaborative, the three focus areas identified as citywide priorities for the 2023-2024 CHNA are mental health, chronic health conditions and access to care, as seen in Figure 1.3 below.

Figure 1.3: Priority Health Needs, 2023-2024



Health, healthcare and associated community needs are very much interrelated, and often impact each other. Although this CHNA process considered these areas separately, their impact on each other should be considered when planning for programs or services to address community needs.

Many health needs are related to underlying societal and socioeconomic factors. Research has consistently shown that income, education, physical environment, and other demographic and socioeconomic factors affect the health status of individuals and communities. This CHNA acknowledges that link and focuses on identifying and documenting the greatest health needs as they present themselves today. As plans are developed to address these needs, the Collaborative's goal is to work with other community organizations to address underlying factors that could drive long-term improvements to the city population's health.

For additional discussion of current priority needs and the data that supports those priorities, please see Chapter 3.

CHAPTER 1 | METHODOLOGY

Study Design

The process used to assess Baltimore City’s community needs, challenges, and opportunities included multiple steps. Both new and existing data were used throughout the study to paint a more complete picture of the community’s health needs. While the CHNA Collaborative largely viewed the new and existing data equally, there were situations where one provided clearer evidence of community health need than the other. In these instances, the health needs identified were discussed based on the most appropriate data gathered. Data analysis, community feedback review, and stakeholder engagement were all used to identify key areas of need.

Specifically, the following data types were collected and analyzed:

New (Primary) Data

Public engagement and feedback were received through online community member and key health leader surveys, along with community focus groups and significant input and direction from the CHNA Collaborative and the LHIC. Additional prioritization meetings with three LHIC workgroups – Diabetes, Care Coordination and Social Determinants of Health – were also conducted to better understand community needs. The Collaborative worked together to develop the survey questions for the two web-based surveys. Community members were asked to identify the most significant health and social needs in their community, as well as asked questions about their experiences seeking or receiving medical care. Key leaders were asked to answer similar questions about the community they serve. Focus group participants were also asked a standard set of questions about health and social needs, in order to identify trends across various groups and to highlight areas of concern for specific populations. In total, the CHNA Collaborative was able to gather input from over 2,600 Baltimore City residents and other stakeholders. This included web survey responses from 2,282 community members and 33 key leaders, as well as 33 focus groups featuring more than 300 community members and other people who live, work or receive healthcare in Baltimore City.

For more information regarding specific questions asked as part of the focus groups and surveys, please refer to Appendix 6.

Existing (Secondary) Data

Key sources for existing data on Baltimore City included information provided by the Collaborative and a variety of public data sources related to demographics, social and economic determinants of health, environmental health, health status and disease trends, mental/behavioral health trends, and individual health behaviors. Key information sources used during this process included:

- *County Health Rankings*, developed in partnership by Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute
- Maryland Department of Health’s State Health Improvement Process (MD SHIP) and Division of Vital Records
- The Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS)

- *The Opportunity Atlas*, developed in partnership by the U.S. Census Bureau, Harvard University, and Brown University
- *The National Equity Atlas*, developed by PolicyLink and the University of Southern California (USC) Equity Research Institute
- *Food Access Research Atlas*, published by the U.S. Food and Drug Administration
- *Minority Health Social Vulnerability Index*, published by U.S. Department of Health and Human Services Office of Minority Health
- *American Community Survey*, as collected and published by the U.S. Census Bureau
- Data provided by CHNA Collaborative members and other affiliated organizations, including CHNA reports from BCHD, St. Agnes, JHHS and JHBMC, Mercy, MedStar, MWPH, Sinai Hospital, and UMMC.

For more information regarding data sources and data time periods, please refer to Appendix 3.

Comparisons

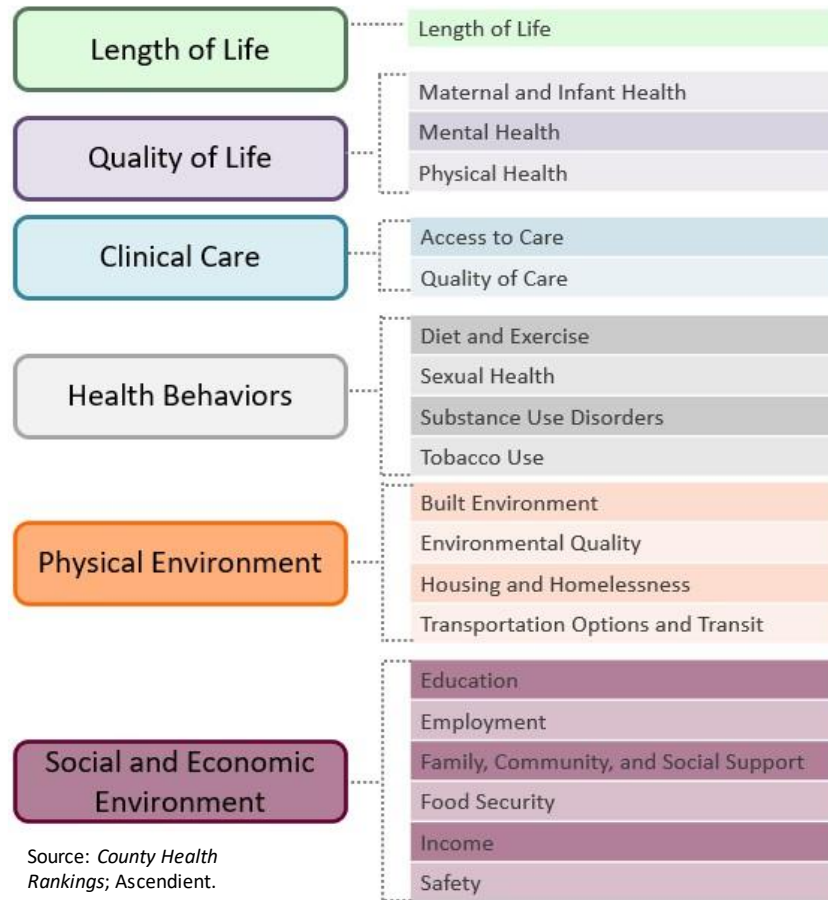
To understand the relevance of existing data collected throughout the process, each measure must be compared to a benchmark, goal, or similar geographic area. In other words, without being able to compare Baltimore City to an outside measure, it would be impossible to determine how the city is performing. For this process, each data measure was compared to outside data as available, including the following:

- *County Health Rankings* Top Performers: This is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute that ranks counties across the nation by various health factors.
- Baltimore County and State of Maryland: The Collaborative determined that comparisons with Baltimore County and the state of Maryland as a whole were appropriate. While certain differences exist between the city and the county, the close proximity and overlap between resources creates a meaningful opportunity for comparison.

Prioritization Process Overview and Results

The process of identifying the priority health needs for the 2023-2024 CHNA began with the collection and analysis of hundreds of new and existing data measures. In order to create more easily discussable categories, all individual data measures were then grouped into six categories and 20 corresponding focus areas based on “common themes,” as seen in Figure 2.1 below. These focus areas are detailed further in Appendix 4.

Figure 2.1: Areas of Focus



Since a large number of individual data measures were collected and analyzed to develop these 20 focus areas, it was not reasonable to make each of them a priority. The CHNA Collaborative considered which focus areas had data measures of high need or worsening performance, priorities from the primary data, and how possible it is for health departments or hospitals to impact the given need to help determine which health needs should be prioritized. Once the primary and secondary data had been grouped into the focus areas detailed in Appendix 3, the CHNA Collaborative used a polling software to evaluate and prioritize the city's health needs while considering the following factors:

- Size and scope of the health need;
- Severity and intensity of the health need;
- Whether possible interventions would be possible and effective;
- Health disparities associated with the need; and
- Importance the community places on addressing the need

The final priority need areas were not ranked in any particular order of importance, and each will be addressed by the Collaborative. The following three focus areas (mental health, chronic health conditions and access to care) were identified as the City of Baltimore’s top priority health needs to be addressed over the next three years, as seen in Figure 2.2 below:

Figure 2.2: Priority Health Needs, 2023-2024

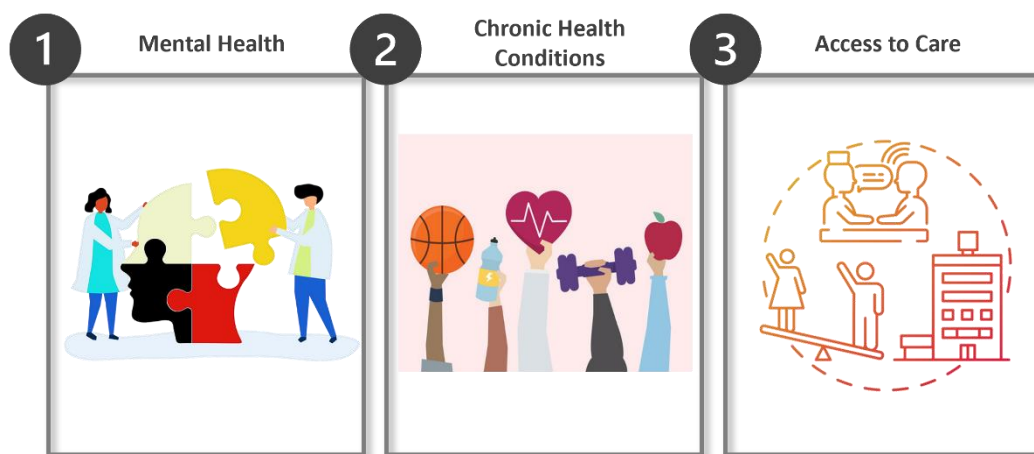


Figure 2.3: Social Determinants of Health

Throughout the process, the Collaborative also considered *Healthy People 2030’s* “Social Determinants of Health and Health Equity.” The CDC defines social determinants of health (SDoH) as the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality of life outcomes and risks. These factors can include healthcare access and quality, neighborhood and built environment, social and community context, economic stability, and education access and quality, as outlined in Figure 2.3.⁴

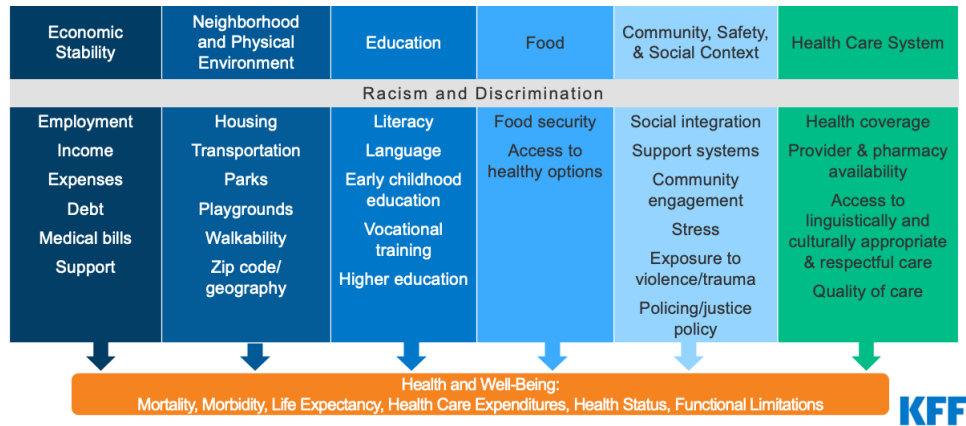
Recognizing that SDoH have an impact on health disparities and inequities in the community was a key point the Collaborative considered throughout the CHNA process. Figure 2.4 below describes the way various social and economic conditions may affect health and well-being.



⁴ Source: CDC (2022). *Social Determinants of Health at CDC*. Accessed March 7th, 2024 via <https://www.cdc.gov/about/sdoh/index.html>

Figure 2.4: SDoH and Health Disparities

Health Disparities are Driven by Social and Economic Inequities



Study Limitations

Developing a CHNA is a long and time-consuming process. Because of this, more recent data may have been made available after the collection and analysis timeframe. Existing data typically become available between one and three years after the data is collected. This is a limitation, because the “staleness” of certain data may not depict current trends. For example, the U.S. Census Bureau’s American Community Survey is a valuable source of demographic information, however data for a particular year is not published until late the following year. This means 2022 data on community characteristics, such as languages spoken at home, did not become available until late fall 2023. The Collaborative tried to account for these limitations by collecting new data, including focus groups and web-based community member and key community leader surveys. Another limitation of existing data is that, depending on the source, it may have limited demographic information, such as gender, age, race, and ethnicity.

Given the size of Baltimore City in both population and geography, this study was limited in its capacity to fully capture health disparities and health needs across racial and ethnic groups. While efforts were made to include diverse community members in survey efforts, roughly 48% of all respondents were Black or African American, and another 41% were white. Although survey respondents could choose from multiple race or ethnicity categories,⁵ limited responses were received from these groups; however, nearly 18% of respondents described their ethnicity as Hispanic or Latino. This made it difficult for the Collaborative to assess health needs and disparities for other racial/ethnic minority groups in the community.

In addition, there are existing gaps in information for some population groups. Many available datasets are not able to isolate historically underserved populations, including the uninsured, low-income persons, and/or certain minority groups. Despite the lack of available data, attempts were made to include underserved sub-segments of the greater population through the new data gathered throughout the CHNA process. For example, the CHNA Collaborative chose to focus on Spanish-speaking members of the community by providing a Spanish language version of the web-based community survey and facilitating Spanish-language focus groups. Paper surveys were also distributed in an effort to reach as much of the community as possible, although usage of paper surveys was low. To increase future survey responses,

⁵ Categories included Asian, American Indian/Alaskan Native (AIAN), Black or African American, Hispanic/Latino, Native Hawaiian/Other Pacific Islander (NHPI) and White.

members of the Collaborative should consider working directly with partner organizations in the community who can connect directly with populations who are hard to access through traditional outreach methods, including people with disabilities, the uninsured and people who are disengaged.

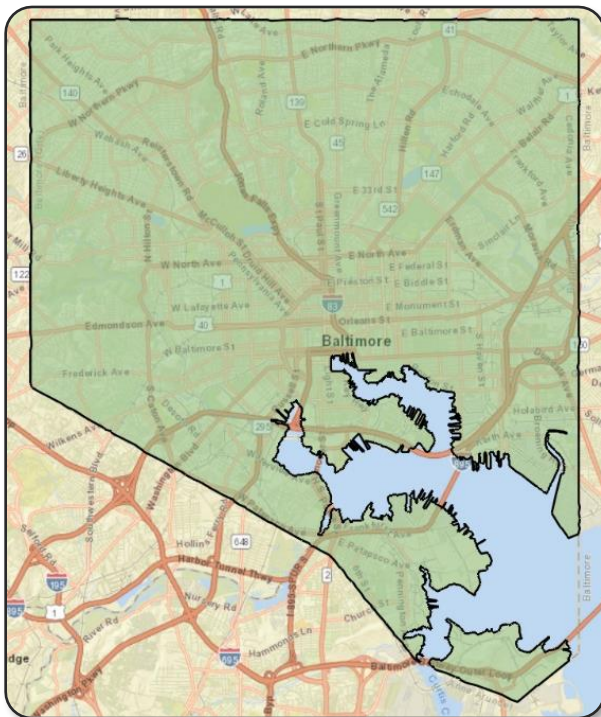
In the future, assessments should make efforts to include other underserved communities whose needs are not specifically discussed here because of data and input limitations during this CHNA cycle. Of note, residents in the disabled, blind, deaf, and hard-of-hearing communities can be a focus of future new data collection methods. Using a primarily web-based survey collection method might have also impacted response rates of community members with no internet access or low technological literacy. Additionally, more input from both patients and providers of SUD services would also be helpful in future assessments.

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

Geography

Baltimore City occupies 81 square miles of land in the geographic center of Baltimore County, and consequently, the state of Maryland. Baltimore County surrounds most of Baltimore City, however, the city was separated from the county in 1851. Today, Baltimore City is an independent city on par with county jurisdictions.

Figure 3.1: Baltimore City Map



Population

Population figures discussed throughout this chapter were obtained from Esri, a leading GIS provider that utilizes U.S. Census data projected forward using proprietary methodologies.

With a population of roughly 575,000 people, Baltimore City is the largest city in Maryland.

Table 3.1: Total Population, 2023

	Baltimore City	Baltimore County	Maryland	United States
Population	573,794	859,710	6,259,408	337,470,185

Source: Esri 2023

Age and Sex Distribution

Data on age and sex helps health providers understand who lives in the community and informs planning for needed health services. The age distribution of Baltimore City skews slightly younger than that of Baltimore County, Maryland, and the U.S. Younger populations are likely to need more preventive services and health education, while older populations may have a need for higher acuity healthcare and specialized services such as cancer care or chronic disease management.

Table 3.2: Age Distribution, 2023				
	Baltimore City	Baltimore County	Maryland	United States
Percentage below 15	16.8%	16.4%	17.6%	18.0%
Percentage between 15 and 44	43.7%	38.9%	39.2%	39.6%
Percentage between 45 and 64	23.0%	24.9%	25.7%	24.6%
Percentage 65 and older	16.5%	19.7%	17.5%	17.8%

Source: Esri 2023

Baltimore City's population skews more heavily female compared to the state of Maryland, and the U.S.

Table 3.3: Sex Distribution, 2023				
	Baltimore City	Baltimore County	Maryland	United States
Female	52.8%	52.2%	51.3%	50.6%
Male	47.2%	47.8%	48.7%	49.4%

Source: Esri 2023

Race and Ethnicity

Data on race and ethnicity help us understand the need for healthcare services as well as cultural factors that can impact how care is delivered. Almost 60% of Baltimore City residents identify as Black or African American, roughly double the proportion found in Baltimore County and the state of Maryland, and nearly five times that of the U.S. as a whole.

Table 3.4: Racial Distribution, 2023								
	Baltimore City		Baltimore County		Maryland		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Black Non-Hispanic	332,377	57.9%	260,766	30.3%	1,834,049	29.3%	40,898,542	12.1%
White Non-Hispanic	146,924	25.6%	431,552	50.2%	2,867,623	45.8%	191,314,266	56.7%
Asian	21,210	3.7%	57,506	6.7%	439,514	7.0%	20,811,620	6.2%
AIAN	1,270	0.2%	1,921	0.2%	11,977	0.2%	2,284,715	0.7%
NHPI	152	0.0%	255	0.0%	2,635	0.0%	643,202	0.2%

Source: Esri 2023

By ethnicity, less than 10% of Baltimore City’s population is Hispanic.⁶ The proportion of Hispanic individuals residing in Baltimore City is slightly higher than in Baltimore County but lower than in the state of Maryland and the U.S. overall.

Table 3.5: Ethnic Distribution, 2023								
	Baltimore City		Baltimore County		Maryland		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Non-Hispanic	525,925	91.7%	793,133	92.3%	5,470,733	87.4%	271,934,049	80.6%
Hispanic	47,869	8.3%	66,577	7.7%	788,675	12.6%	65,536,136	19.4%

Source: Esri 2023

The proportion of foreign-born individuals residing in Baltimore City is lower than that of Baltimore County, Maryland, and the U.S. overall.

Table 3.6: Foreign Born Population, 2022				
	Baltimore City	Baltimore County	Maryland	United States
Foreign Born	9.7%	13.0%	16.7%	13.9%

Source: U.S. Census Bureau (2022), American Community Survey (2018-2022)

The diversity of Baltimore City and Baltimore County is reflected in the languages that their residents speak at home. According to the most recent American Community Survey, approximately 10% of Baltimore City and 15% of Baltimore County residents indicated that they speak a language other than English at home, compared to around 20% of Maryland and U.S. residents. Less than 5% of city or county residents speak Spanish at home. Spanish is more commonly spoken at home in the state of Maryland and the U.S. overall.

Table 3.7: Language Spoken at Home, 2022				
	Baltimore City	Baltimore County	Maryland	United States
English Only	89.0%	85.8%	79.3%	78.0%
Spanish	4.7%	4.0%	8.9%	13.3%
Indo-European Languages	2.5%	4.5%	4.7%	3.8%
Asian and Pacific Islander Languages	1.9%	2.7%	3.9%	3.6%
Other Languages	1.8%	3.0%	3.2%	1.2%

Source: American Community Survey 2022 1-Year Estimates

⁶ Race and ethnicity (Hispanic origin) are two separate concepts, according to federal guidelines. People who are Hispanic may be of any race, and people in each race group may be either Hispanic or Not Hispanic. Source: [U.S. Census Bureau Guidance on the Presentation and Comparison of Race and Hispanic Origin Data](#).

Economic Indicators

In addition to demographic data, socioeconomic factors in the community such as income, poverty, and food scarcity play a significant role in identifying healthcare needs. The median household income in Baltimore City is approximately 60-70% that of Baltimore County, Maryland, and the U.S. overall, contributing to, among other things, higher rates of uninsured and underinsured residents who face barriers to accessing quality healthcare services. These disparities contribute to poorer health outcomes and lower life expectancy for Baltimore City residents, especially for those who are Black, Hispanic, or living in poverty. Some of the causes of these inequities include historical and structural racism, lack of affordable housing, low educational attainment, and limited economic opportunities.

Table 3.8: Median Household Income, 2023

	Baltimore City	Baltimore County	Maryland	United States
Income	\$55,224	\$82,607	\$93,432	\$72,603

Source: Esri 2023

In 2021, approximately 20% of Baltimore City households were below the federal poverty level (FPL) – more than double the share of households below the FPL in Baltimore County, Maryland, and the U.S. overall. Poverty has a significant impact on health. Across the lifespan, people who live in impoverished communities have a higher risk of poor health outcomes, including mental illness, chronic diseases, higher mortality and lower life expectancy. Poverty is a concern across the lifespan; children who live in poverty are at risk for developmental delays, toxic stress and poor nutrition, and are likely to live in poverty as adults as well. Unmet social needs, including having low or no income, can also limit people’s ability to access healthcare when they need it, or to provide for basic necessities needed to live healthy lives, such as safe housing or healthy food.⁷

Table 3.9 Percent of Households Below the Federal Poverty Level, 2021

	Baltimore City	Baltimore County	Maryland	United States
Percent Below FPL	19.6%	9.1%	9.1%	12.4%

Source: Esri 2023

Similar to the percentage of households below the FPL, 23% of Baltimore City households received Food Stamps/SNAP⁸ in 2021. This is more than double the percentage reported in Baltimore County, Maryland, and the U.S. overall.

⁷ Source: Healthy People 2030 (2023). *Poverty*. Accessed March 7th, 2024 via:

<https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty>

⁸ The Supplemental Nutrition Assistance Program (SNAP) provides nutrition assistance to eligible, low-income individuals and households. It is the largest Federal nutrition assistance program. Source: [USDA Supplemental Assistance Program fact sheet](#).

Table 3.10: Households Receiving Food Stamps/SNAP, 2021

	Baltimore City	Baltimore County	Maryland	United States
Number of Households Receiving Food Stamps/SNAP	56,208	34,031	238,288	14,105,231
Total Number of Households	244,893	326,932	2,294,270	124,010,992
Percentage of Households receiving Food Stamps/SNAP	23.0%	10.4%	10.4%	11.4%

Source: Esri 2023

In 2023, 12.3% of Baltimore City residents had earned less than a high school diploma and 29.1% had a high school diploma or GED – proportions that are higher than Baltimore County, Maryland or the U.S. overall. Conversely, a smaller proportion of Baltimore City residents had completed some college (22.6%) or earned a bachelor’s degree (18.3%) compared to the county, the state or the nation. However, both Baltimore City and Baltimore County had a higher percentage of residents with graduate or professional degrees than the U.S. overall, indicating a high level of educational achievement among some segments of the population.

Table 3.11: Educational Attainment, 2023

	Baltimore City	Baltimore County	Maryland	United States
Less than 9 th Grade	3.5%	2.6%	3.2%	4.1%
Some High School/No Diploma	8.8%	4.8%	4.9%	5.5%
High School Diploma	23.9%	22.1%	21.4%	22.9%
GED/Alternative Credential	5.2%	3.3%	3.1%	4.1%
Some College/No Diploma	16.9%	17.1%	16.4%	17.7%
Associate’s Degree	5.7%	7.8%	7.5%	9.5%
Bachelor’s Degree	18.3%	23.8%	23.3%	22.3%
Graduate/ Professional Degree	17.7%	18.4%	20.2%	13.9%

Source: Esri 2023

The overall unemployment rate in Baltimore City was higher than Baltimore County, Maryland, and the U.S. overall in 2023. This was a consistent finding across all age groups, with the highest unemployment among city residents ages 25 to 54 (2.8%). Unemployment among older adults (ages 65+) was 2.5 times higher than the rate in the state of Maryland.

Table 3.12: Unemployment, 2023				
	Baltimore City	Baltimore County	Maryland	United States
Percentage unemployed ages 16 to 24	1.7%	1.3%	1.2%	1.3%
Percentage unemployed ages 25 to 54	2.8%	1.9%	1.9%	2.2%
Percentage unemployed ages 55 to 64	0.7%	0.6%	0.5%	0.6%
Percentage unemployed ages 65 or more	0.5%	0.3%	0.2%	0.2%
Total unemployment	5.7%	4.1%	3.8%	3.7%

Source: Esri 2023

In 2023, the group in both Baltimore City and Baltimore County least likely to have health insurance was adults ages 35 to 64. Baltimore City has proportions of uninsured individuals across almost every age group that are lower than the U.S. as a whole, but similar to both Baltimore County and Maryland.

Table 3.13: Health Insurance Status, 2023				
	Baltimore City	Baltimore County	Maryland	United States
Percentage uninsured ages 18 or below	0.8%	0.9%	0.9%	1.3%
Percentage uninsured ages 19 to 34	2.2%	1.9%	2.1%	3.2%
Percentage uninsured ages 35 to 64	2.9%	2.3%	2.8%	4.2%
Percentage uninsured ages 65 or more	0.1%	0.1%	0.1%	0.1%

Source: Esri 2023

Social Determinants of Health

In addition to the considerations noted above, there are many other factors that can positively or negatively influence a person's health. The Collaborative recognizes this and believes that, to portray a complete picture of the city's health status, it first must address the factors that impact community health. The Centers for Disease Control and Prevention (CDC) defines social determinants of health (SDoH) as the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality of life outcomes and risks. According to the CDC's "Social Determinants of Health" "Social Determinants of Health" from its *Healthy People 2030* public health priorities initiative, factors contributing to an individual's health status can include the following: healthcare access and quality, neighborhood and built environment, social and

Figure 3.2: Social Determinants of Health



community context, economic stability, and education access and quality.

As seen in Figure 3.2, many of the factors that contribute to health are hard to control or societal in nature. As such, health and healthcare organizations need to consider many underlying factors that may impact an individual's health and not simply their current health conditions.

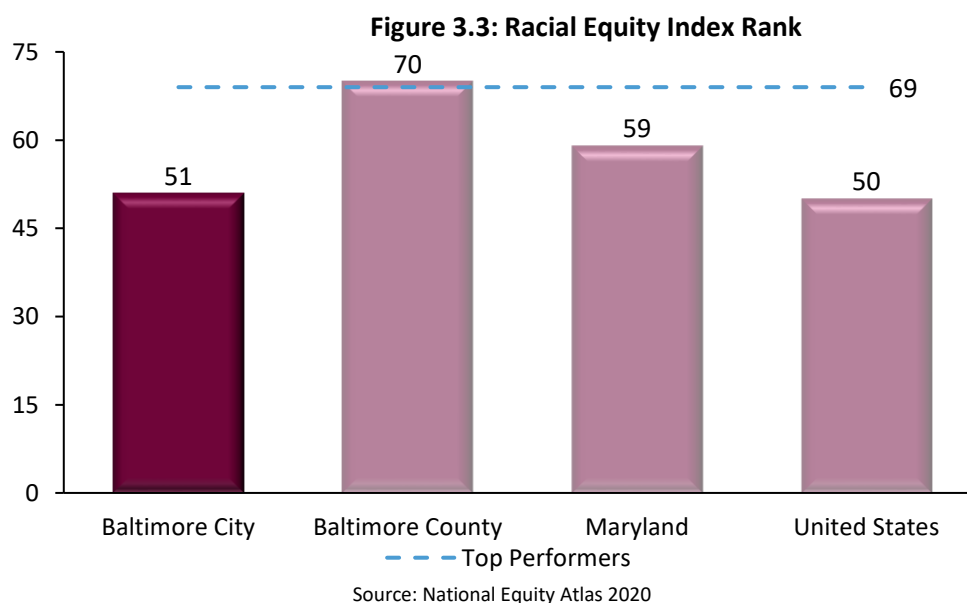
It is widely acknowledged that people with lower income, social status and levels of education find it harder to access healthcare services compared to people in the community with more resources. Being unable to access healthcare services is a factor that contributes to poor health status. Further, people in communities with fewer resources may also experience high levels of stress, which also contributes to worse health outcomes, particularly related to mental and behavioral health.

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

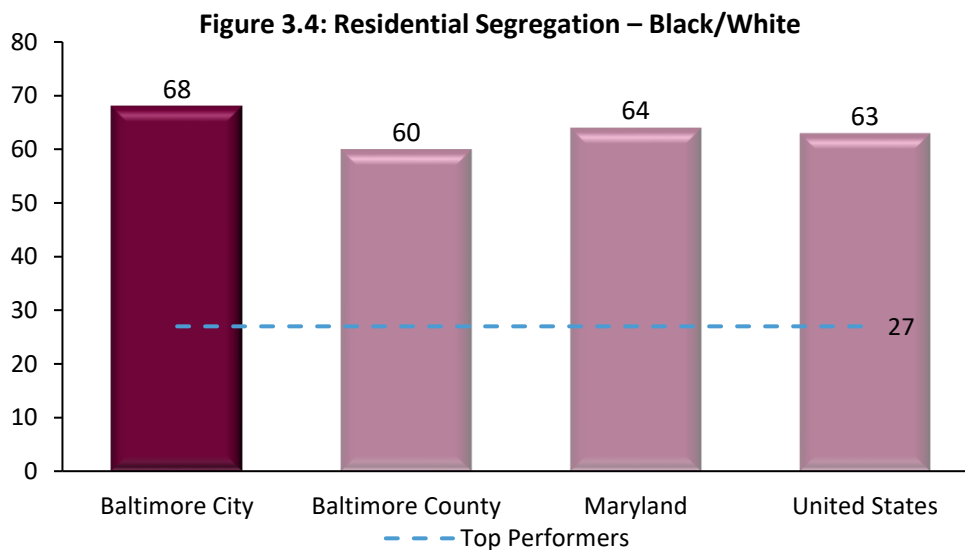
Disparities

Recognizing the diversity of Baltimore City, as discussed above, the Collaborative evaluated factors that may contribute to health disparities in its community. These included racial equity; racial segregation; financial barriers; nutrition; social, behavioral, and economic factors that influence health; and English language proficiency. As detailed below, Baltimore City has greater disparity and housing segregation between racial groups and a higher level of income inequality when compared to the county or state.

The Racial Equity Index measures disparities between racial groups based on inclusion and prosperity. As seen in Figure 3.3, Baltimore City performs lower than the county and the state of Maryland, and slightly higher than the U.S. overall. Higher scores are better and indicate smaller racial gaps. In this graphic and the following, the blue line indicates scores for geographies that perform best in that indicator.

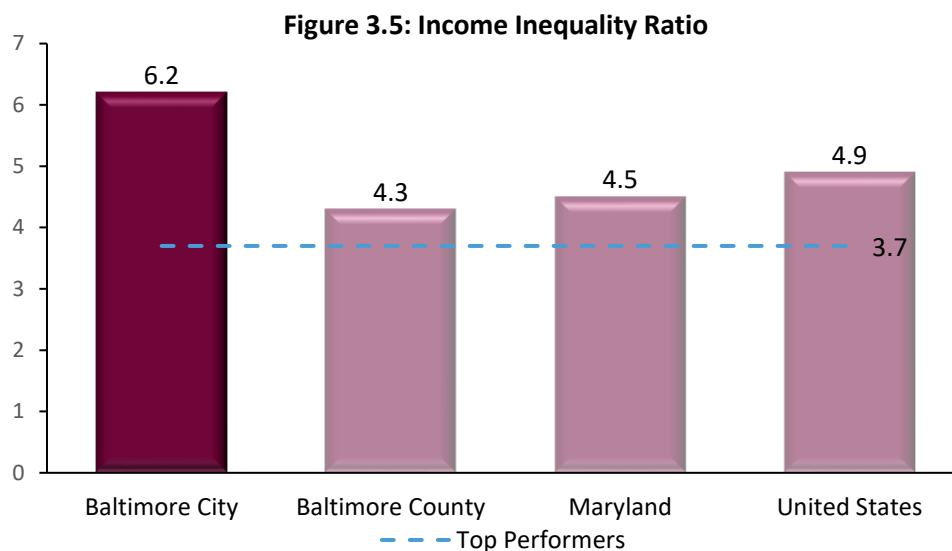


Residential segregation is measured by the index of dissimilarity, a demographic measure ranging from 0 to 100 that represents how evenly two demographic groups are distributed across a county's census tracts. Lower scores represent a higher level of integration. Baltimore City has a higher level of segregation between Black and white residents than Baltimore County, Maryland and the U.S. overall, as seen in Figure 3.4.



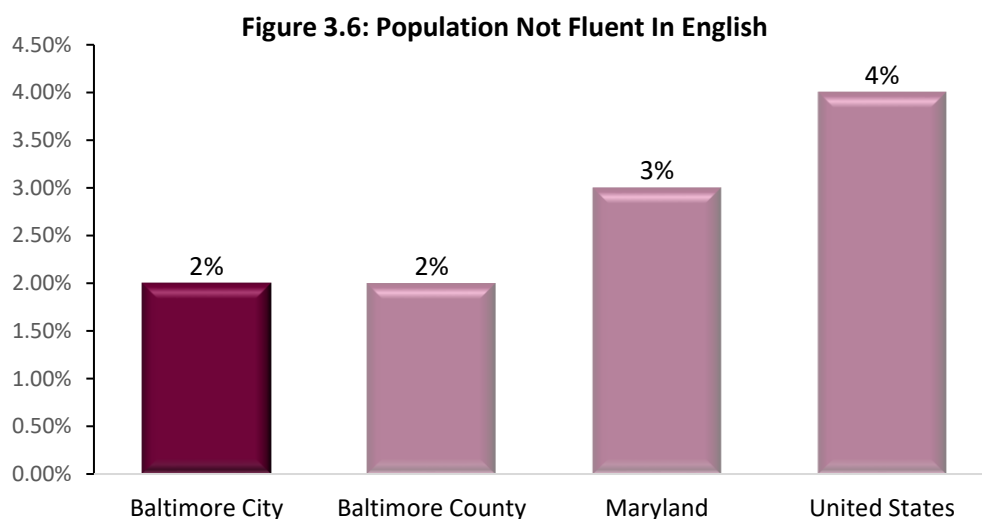
Source: Robert Wood Johnson County Health Rankings 2023

Income inequality is measured as a ratio of household income at the 80th percentile to household income at the 20th percentile. Communities with greater income inequality may have worse outcomes on metrics such as mortality, poor health, sense of community, and social support. As seen in Figure 3.5, Baltimore City's has a much higher income inequality ratio than the county, the state and the U.S. overall.



Source: Robert Wood Johnson County Health Rankings 2023

People with limited English proficiency (LEP) may face greater challenges accessing care and resources compared to fluent English speakers. Language barriers may make it hard to access transportation, medical, and social services as well as limit opportunities for education and employment. Importantly, LEP community members may not understand critical public health and safety notifications, such as safety-focused communications during the COVID-19 pandemic. In 2022, just 2% of Baltimore City residents reported speaking English less than “very well.” This is comparable to the rate of Baltimore County, but lower than the rates in Maryland and the U.S., as seen in Figure 3.6.



Source: American Community Survey 5-year estimates (2017-2022)

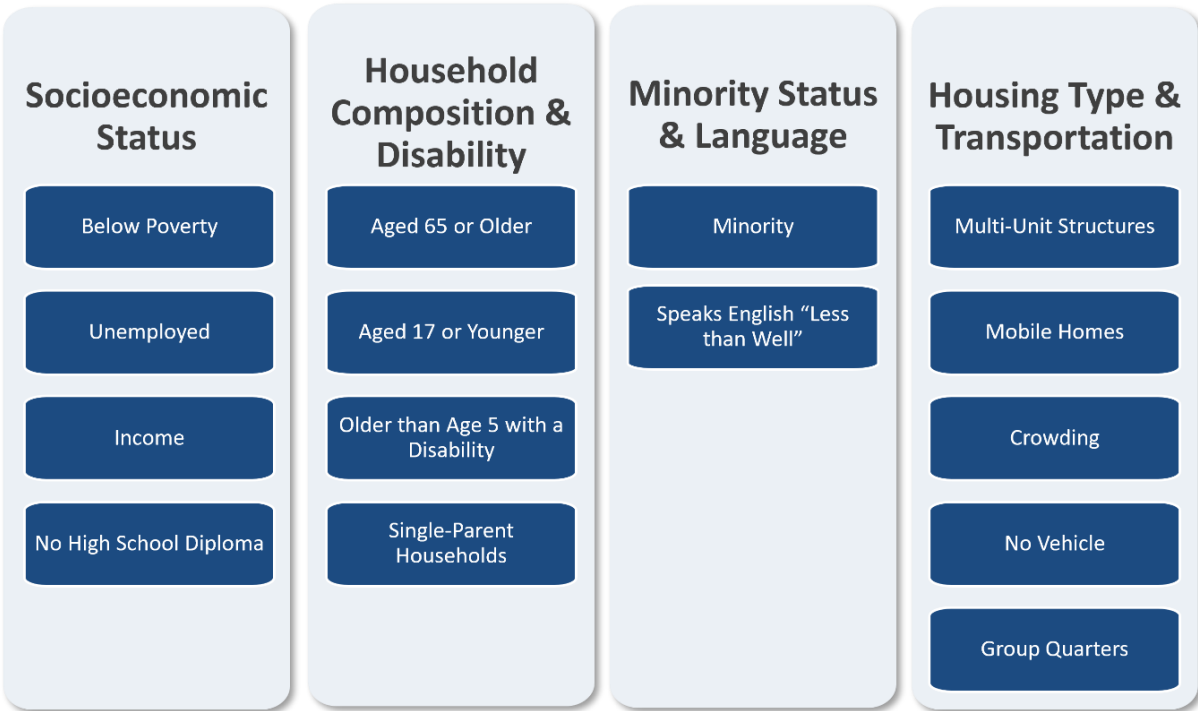
Social Vulnerability Index

One resource that can help show variation and disparities between geographic areas is the Social Vulnerability Index (SVI), which was developed by the CDC and the Agency for Toxic Substances and Disease Registry (ATSDR). Social vulnerability refers to negative effects communities may experience due to external stresses that impact human health, like natural or human-caused disasters, or disease outbreaks. Socially vulnerable populations are at especially high risk during public health emergencies.

The SVI uses 16 U.S. Census variables to help local officials identify communities that may need support before, during, or after a public health emergency.⁹ Communities with a higher SVI score are generally at a higher risk for poor health outcomes. Instead of relying on public health data alone, the SVI accounts for underlying economic and structural conditions that affect overall health, including SDoH. SVI scores are calculated at the census tract level and based on U.S. Census variables across four related themes: socioeconomic status, household characteristics, racial and ethnic minority status, and housing type/transportation. Figure 3.7 outlines the variables used to calculate SVI scores.

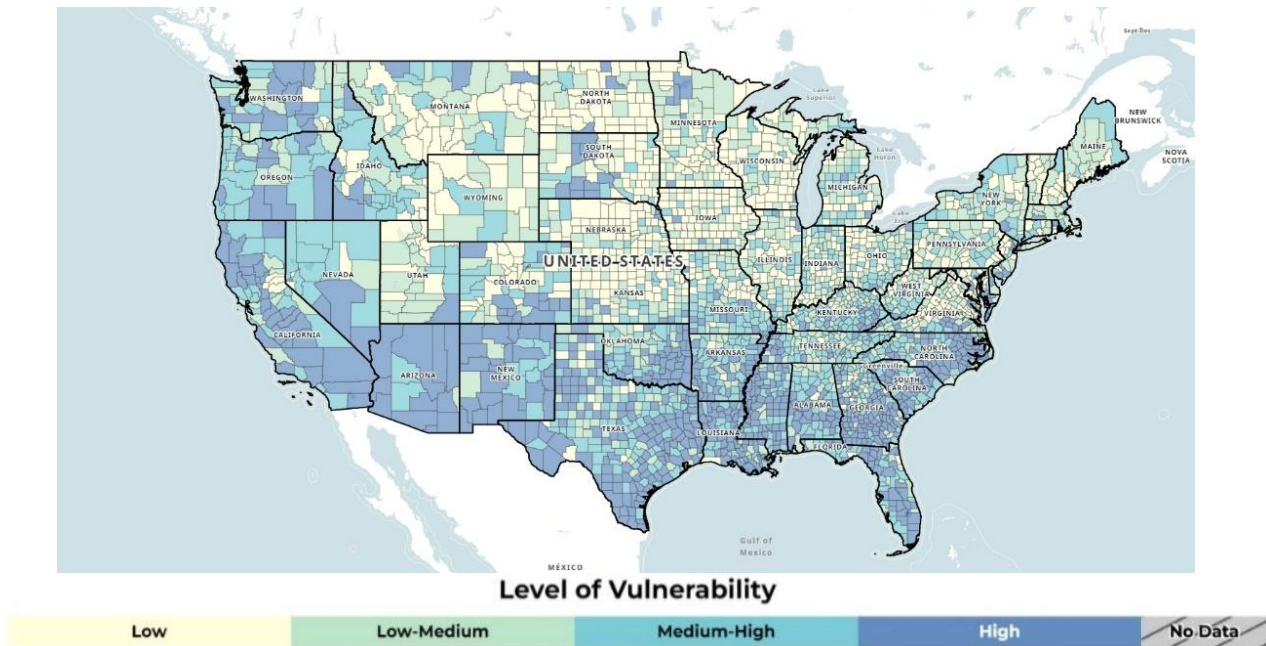
⁹ Tsai, et al (2022). CDC/ATSDR Social Vulnerability Index (SVI). Retrieved from <https://www.atsdr.cdc.gov/placeandhealth/svi/index.html>.

Figure 3.7: Social Vulnerability Index Indicators



The United States SVI by county is shown in Figure 3.8 below. As shown, a lot of variation exists across the country, and even within individual states.

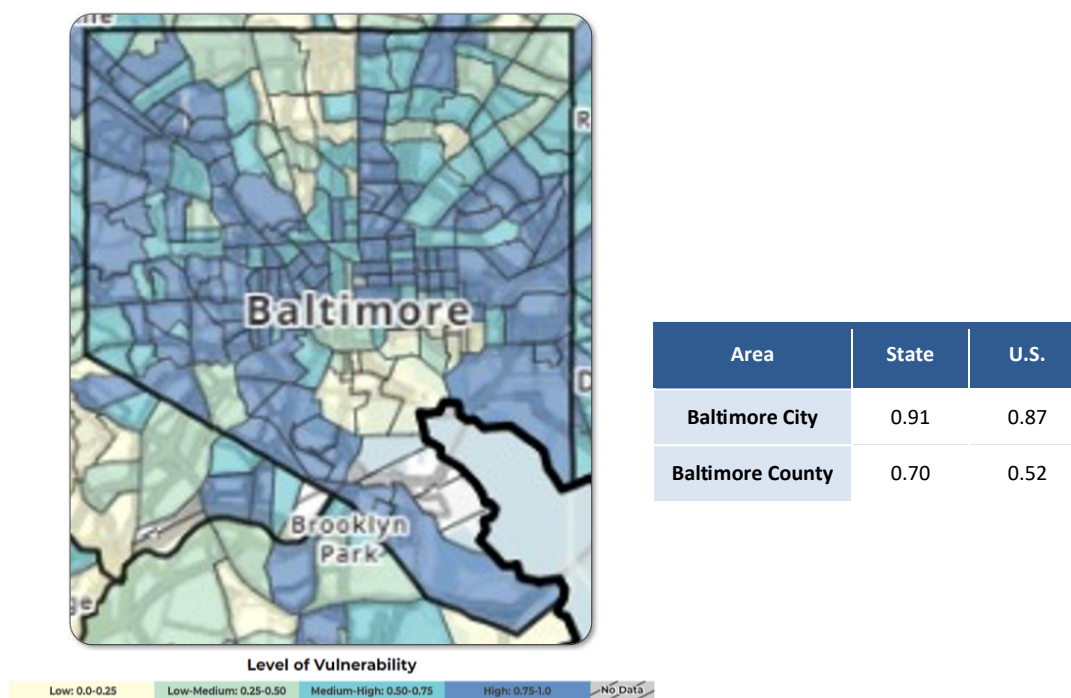
Figure 3.8: Social Vulnerability Index by U.S. County, 2020



Source: CDC/ATSDR Social Vulnerability Index (SVI) 2020 SVI by County; accessed at https://www.atsdr.cdc.gov/placeandhealth/svi/interactive_map.html.

The 2020 SVI scores for Baltimore City and Baltimore County are shown in Figure 3.9 below. Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability), and these scores show a relative comparison with other counties and census tracts in Maryland. Given this, the vulnerability of Baltimore City overall is very high compared to the state, with an SVI score of 0.91. Baltimore City's SVI score is also high when compared to the U.S. as a whole (0.87). Many neighborhoods throughout the city demonstrate the highest level of vulnerability, shown as the darkest blue in the city map. However, vulnerability is not evenly distributed throughout the city, with some neighborhoods surrounding the Inner Harbor and located in the north-central parts of the city showing lower vulnerability.

Figure 3.9: Baltimore City Social Vulnerability Index, 2020



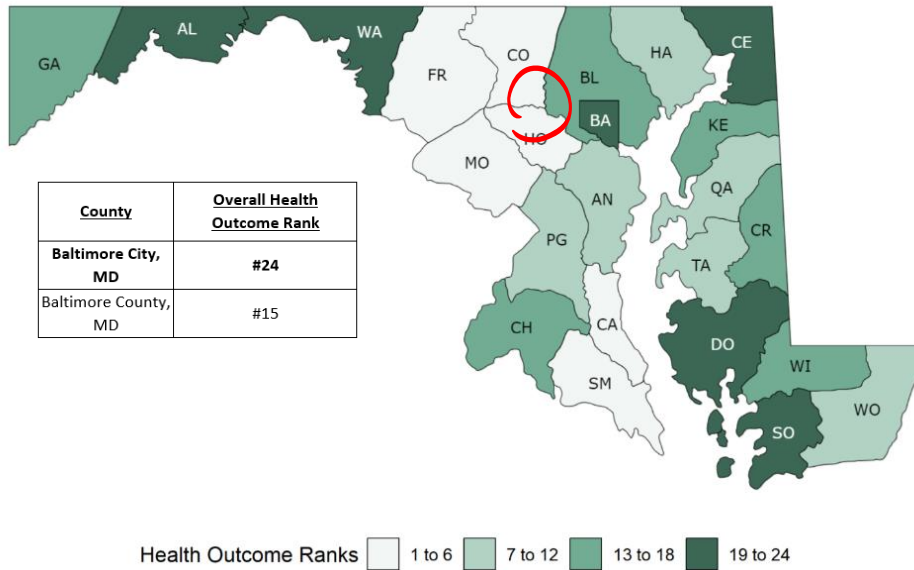
Source: CDC/ATSDR Social Vulnerability Index (SVI) 2020 SVI by County; accessed at https://www.atsdr.cdc.gov/placeandhealth/svi/interactive_map.html.

Health Outcome and Health Factor Rankings

The Collaborative also reviewed and analyzed data from the Robert Wood Johnson Foundation and the University of Wisconsin County Health Rankings for the year 2023. Out of 24 reported counties in Maryland for health outcomes, Baltimore City ranks 24th overall, as seen in Figure 3.10. This includes ranking 24th among 24 reported counties on both Length of Life and Quality of Life. These categories are discussed further in Appendices 2 through 4.

Figure 3.10

2023 Health Outcomes - Maryland

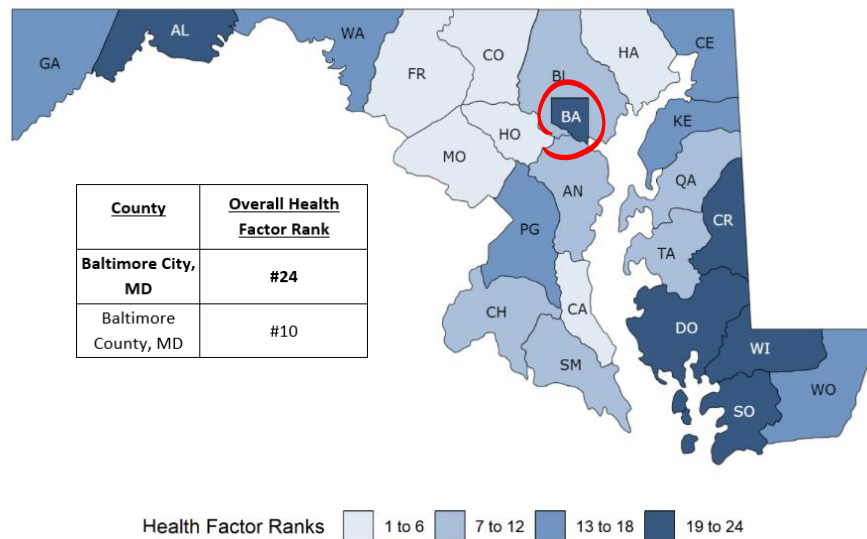


Source: Robert Wood Johnson Foundation, 2023 County Health Rankings.

Lastly, out of 24 reported counties in Maryland for health factors, Baltimore City also ranks 24th overall, as seen in Figure 3.11 below. This includes ranking 23rd among 24 reported counties for Health Behaviors and 24th for Social & Economic factors.

Figure 3.11

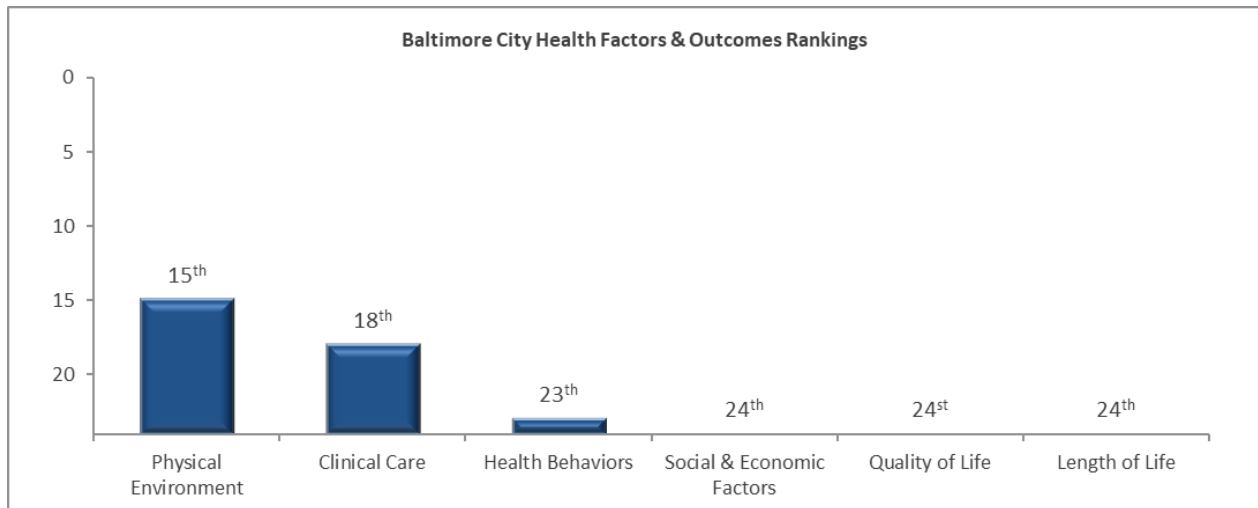
2023 Health Factors - Maryland



Source: Robert Wood Johnson Foundation, 2023 County Health Rankings

Figure 3.12 shows that Baltimore City also ranks 15th among 24 reported Maryland counties for Physical Environment and 18th for Clinical Care. These categories are also discussed further in Appendices 2 through 4.

Figure 3.12 Baltimore City Health Factors and Outcomes



Source: Robert Wood Johnson Foundation, 2023 County Health Rankings.

CHAPTER 3 | PRIORITY NEED AREAS

This chapter describes each of the three priority areas in more detail and discusses the data that supports each priority. The information in this section includes context and national perspective, secondary data findings, and primary data findings (including key leader survey, community member survey, and focus groups).

As mentioned previously, these priority needs areas are not listed in any hierarchical order of importance and all will be addressed by the Collaborative in health improvement plans guided by this CHNA. As noted in Chapter 1, the CHNA Collaborative considered the following factors when determining the priority needs reported in this assessment:

- Size and scope of the health need
- Severity and intensity of the health need
- Estimated feasibility and effectiveness of possible interventions
- Health disparities associated with the need
- Importance the community places on addressing the need

Priority Need: Mental Health

Context and National Perspective

Mental health is the state of one's emotional, psychological, and social well-being, according to the Centers for Disease Control and Prevention (CDC).¹⁰ While mental health is often used to describe conditions related to both behavioral health and substance use, it is specifically being used to describe conditions related to mental illness or wellness in this report. After evaluating data from a variety of sources including surveys and focus groups conducted throughout the assessment process, the Collaborative identified mental health to be an area of urgent need within Baltimore City.

Mental illnesses are common in the United States: in 2021, an estimated 57.8 million U.S. adults – nearly one in five – were living with a mental illness.¹¹ Four years following the onset of the COVID-19 pandemic, concerns about mental health remain high nationwide. The pandemic impacted public mental health and well-being in many ways. Community members continue to grapple with the pandemic-related effects of isolation and loneliness, financial instability, long-term health impacts and grief. In addition, both drug

¹⁰ Source: Centers for Disease Control and Prevention (CDC) (2023). *About Mental Health*. Retrieved February 2nd, 2024 from <https://www.cdc.gov/mentalhealth/learn/index.htm>.

¹¹ Source: National Institute of Mental Health (2023). *Mental Illness*. Retrieved September 13th, 2023, from <https://www.nimh.nih.gov/health/statistics/mental-illness>.

overdose and suicide deaths have sharply increased over the past several years – often disproportionately impacting younger people and communities of color.¹²

Access to services that address mental health is an ongoing challenge across the U.S. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2021, less than half (47.2%) of U.S. adults who reported having a mental illness utilized any type of mental health services, including inpatient, outpatient or telehealth services or prescription drug therapies.¹³ Demand for mental health services, particularly anxiety and depression treatment, remains high across the nation, while the prevalence of stress- and trauma-related disorders, along with substance use disorders, continues to grow. The American Psychological Association reports that the percentage of psychologists in the U.S. seeing more patients than they did before the pandemic increased from 15% in 2020 to 38% in 2021 to 43% in 2022. Further, 60% of psychologists reported having no openings for new patients and 38% maintained a waitlist for their services.¹⁴

Secondary Data Findings

Secondary data collected through the CHNA process identified mental health as an area of particular concern for residents of Baltimore City. In 2021, 20.7% of Baltimore City residents self-reported that a health professional has told them that they have a depressive disorder, higher than both the state of Maryland (16.6%) and the US (20.5%). Multiple mental health indicators in Baltimore City were higher than the state and national averages, with 16% of the population experiencing frequent mental distress (compared to 13% for state and 14% for national, respectively), and residents reporting an average of 5.4 poor mental health days per month (4.1 for state and 4.4 for national, respectively).

Table 4.1: Mental Health Indicators				
Indicator	Baltimore City	Baltimore County	Maryland	United States
Percent of Population Experiencing Frequent Mental Distress	16%	15%	13%	14%
Number of Poor Mental Health Days in the Past Month	5.4	4.5	4.1	4.4

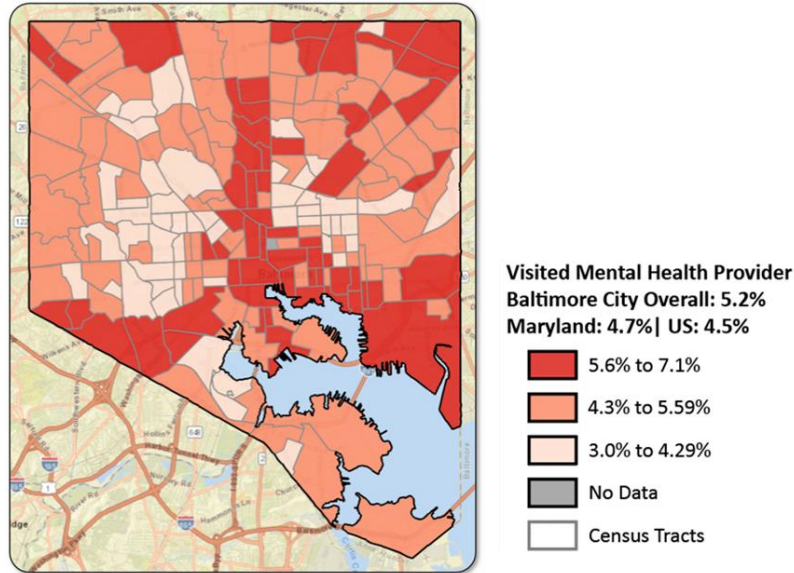
Figure 4.1 shows that, in 2021, there were more visits to mental health providers concentrated around Baltimore’s Downtown core, and fewer visits occurring in the western regions of the city. Similar trends are reflected in both antidepressants and antianxiety medication usage in Baltimore City, as seen in figure 4.2.

¹² Source: Panchal, N., Saunders H., Rudowitz, R. and Cox, C. (2023). The Implications of COVID-19 for Mental Health and Substance Use. *Kaiser Family Foundation*. Retrieved from <https://www.kff.org/mental-health/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use>.

¹³ Source: SAMHSA (2023). *Highlights from the 2022 National Survey on Drug Use and Health*. Retrieved January 16th, 2023, from <https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-main-highlights.pdf>.

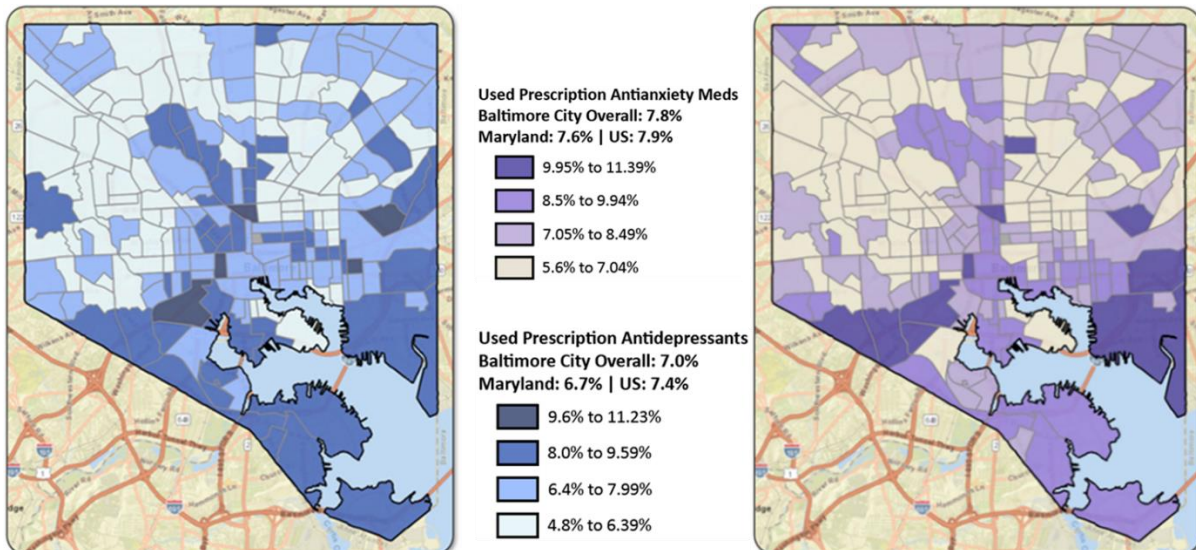
¹⁴ Source: American Psychological Association (2022). *2022 COVID-19 Practitioner Impact Survey*. Retrieved September 13th, 2023, from <https://www.apa.org/pubs/reports/practitioner/2022-covid-psychologist-workload.pdf>.

Figure 4.1: Percentage of Population who Visited a Mental Health Provider, 2021



In 2021, 7.0% of Baltimore City residents used prescription antidepressants, which was slightly higher than the state average of 6.7%. As described above, there is a nearly identical geographic distribution in the usage of antidepressants and antianxiety medication as mental health provider visits. As Figure 4.2 shows, the highest concentration of usage occurred in the neighborhoods adjacent to the southern city border, especially the southeastern region surrounding the harbor.

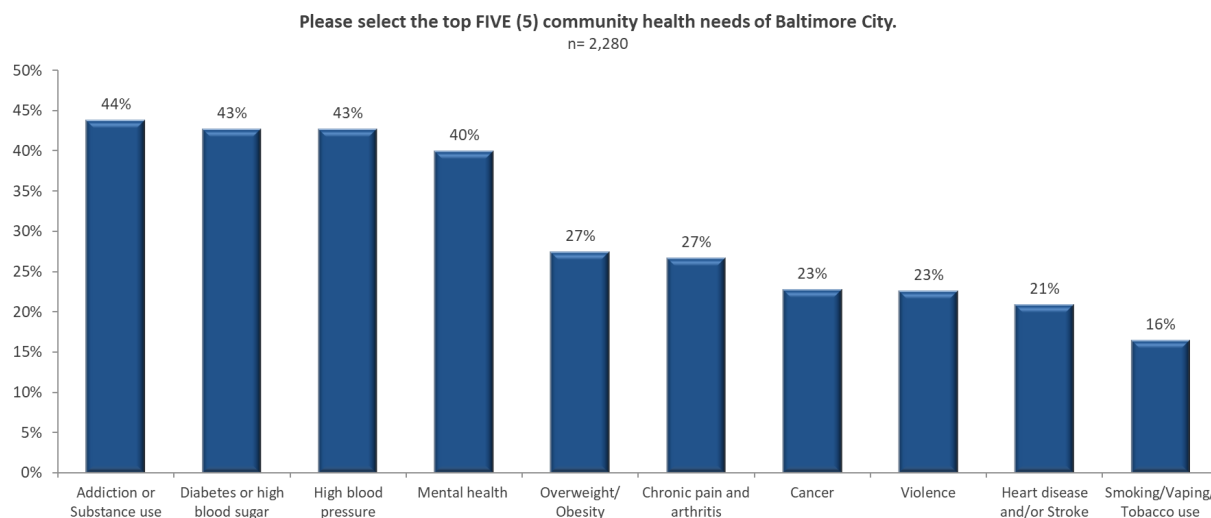
Figure 4.2: Percentage of Population who Used Prescription Antidepressants and Anti-Anxiety Medications, 2021



Primary Data Findings – Community Member Survey

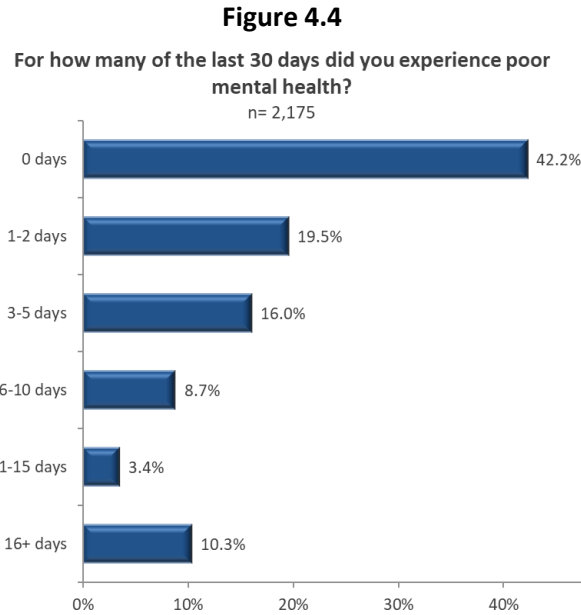
The Baltimore City community member survey received nearly 2,300 responses. When asked to identify the top five community health needs in Baltimore City, mental health was identified as a top concern by 40% of respondents.

Figure 4.3



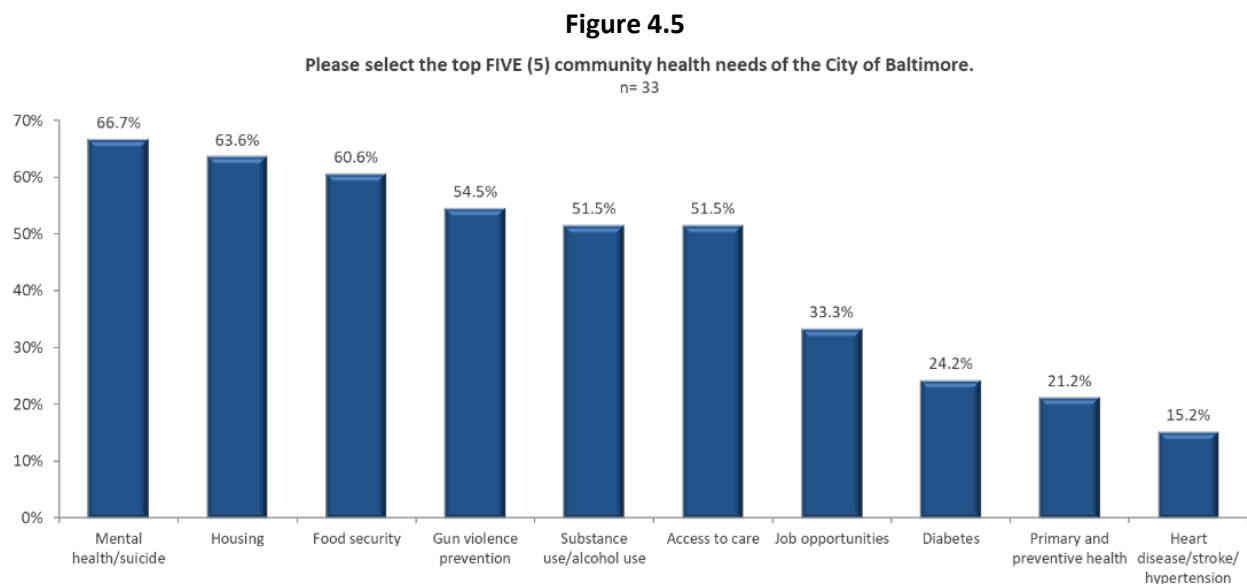
During the CHNA process, some community health data was broken down by age, gender, race and ethnicity, in order to further determine specific need in populations. When reviewing responses identifying the top 5 community health needs, white respondents were more likely to rank mental health as a top concern (45%) when compared to Black (38%) or Hispanic (39%) respondents. Female respondents also ranked mental health higher than male respondents (40% vs. 36%). When breaking down the responses by age group, younger respondents ranked mental health higher than their older counterparts, with those between the ages of 30-39 ranking mental health the highest (53%).

Initial responses related to individual mental health concerns were largely positive, with nearly half of respondents (42.2%) reporting that they had not experienced any poor mental health days the prior 30-day period. Conversely, just under half of respondents reported that they had experienced between 1 and 10 poor mental health days in the previous month (44%), and an additional 14% reported having poor mental health on 11 or more days in the previous month. While the majority of Baltimore City residents reported fewer poor mental health days than the state average (4.1 days per month), a significant proportion of residents (14%) spent more than one-third of the month experiencing mental health concerns, as seen in Figure 4.4.



Primary Data Findings – Key Leader Survey

Key leaders surveyed during the CHNA process identified mental health as the top health issue impacting residents of Baltimore City. Among 33 key leaders from various organizations who responded to the survey, 66.7% identified mental health and suicide as a top community health need in Baltimore City. Multiple community resources to address behavioral and mental health were identified in this survey as being both helpful to address these concerns and insufficient to meet existing levels of community need. Key leaders described a need for more comprehensive resources or easier access to existing resources.



Respondents were also asked to identify the five most significant social needs in the community they serve. The need for expanded substance and alcohol use treatment was selected by 39.4% of respondents.

A lack of resources to address mental health was also noted when respondents were asked to indicate how strongly they agreed or disagreed with statements about different types of providers in the community. Nearly half (45%) of key leaders disagreed or strongly disagreed when asked to evaluate the statement “there are enough mental health providers” available in the community they serve.

Primary Data Findings – Focus Groups

Thirty-three focus groups were conducted during the CHNA process, with more than 300 community members and other local stakeholders providing input on a variety of health and social concerns. Many of the focus groups identified mental health as being a major health concern in Baltimore City.

Focus group participants were given the opportunity to share their personal experiences surrounding mental health. For example, one focus group featured clients at a center that serves women and children needing temporary shelter assistance. Participants within this focus group shared that the biggest health need for them was access to mental health services. These community members described being unable to seek mental health care due to a lack of insurance, or a lack of trust that providers would listen to their concerns due to previous history of addiction. Participants within this group recommended that mental health in the community could be improved by reducing and removing stigma related to mental health, promoting equity, and increasing access to mental health services.

A lack of mental health services available to those experiencing homelessness or living in temporary housing was a common theme across the focus groups. In addition, many groups cited a need for reduced stigma around mental health conditions and seeking treatment when needed, noting that this was a particular challenge for some communities, such as African American community members. Some focus groups recommended that providers treat mental and physical health conditions as complementary to each other, rather than treating them separately.

Priority Need: Chronic Health Conditions

Context and National Perspective

Chronic health conditions are illnesses that affect a person for one year or longer, and may require ongoing medical care or limit one’s ability to live their daily life.¹⁵ As society has changed and people live longer, chronic health conditions have become more common than communicable diseases like typhoid and cholera. According to the WHO, chronic diseases are influenced by a combination of genetic, environmental, psychological, or behavioral factors.¹⁶ Chronic health conditions are extremely common in the United States, with 6 in 10 Americans living with at least one chronic disease, such as diabetes, obesity, cancer, hypertension, heart disease, autoimmune conditions like lupus, arthritis and some forms of dementia.¹⁷

¹⁵ Source: CDC (2022). *About Chronic Diseases*. Retrieved March 7th, 2024, from: <https://www.cdc.gov/chronicdisease/about/index.htm>.

¹⁶ Source: World Health Organization (WHO) (2023). *Noncommunicable diseases*. Retrieved January 23rd, 2024, from: <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>.

¹⁷ Source: CDC (2024). *National Center for Chronic Disease Prevention and Health Promotion*. Retrieved January 23, 2024, from: <https://www.cdc.gov/chronicdisease/index.htm>.

Chronic diseases are the leading cause of death and disability in the United States. According to the WHO, chronic health conditions kill 41 million people globally each year and are responsible for 7 in 10 deaths in the U.S. annually.¹⁶ The number of individuals living with a chronic health condition is expected to increase, particularly as the U.S. population continues to age. The population over the age of 50 is expected to increase by 61% to 221.1 million people by 2050.¹⁸ Among those 221 million, nearly two-thirds (142.7 million people) are expected to have at least one chronic health condition, with approximately 15 million people living with multiple chronic health conditions.¹⁸

Cancer is a group of diseases characterized by the uncontrolled growth and spread of abnormal cells that can result in death if not treated. While the risk of dying from cancer has declined significantly over the past 30 years, it remains the second most common cause of death in the U.S. Incidence of new cancer cases has continued to rise, with 2 million new cases expected to be identified in 2024.¹⁹ This trend is largely affected by the aging and growth of the population and by a rise in diagnoses of 6 of the 10 most common cancers—breast, prostate, endometrial, pancreatic, kidney, and melanoma. Some research has attributed this rise to the impact of the obesity epidemic.¹⁹ Cigarette smoking is another significant risk factor for cancer, and is responsible for about 20% of all cancers and 30% of cancer deaths in the U.S. each year.²⁰

The WHO defines overweight and obesity as abnormal or excessive fat that accumulates on the body and presents risks to a person's health.¹⁶ Obesity is one of the fastest rising chronic conditions in the United States. According to the CDC, the U.S. obesity prevalence rate for obesity between 2017-2020 was 41.9%. This represents a significant increase from 30.5% reported in 2000.²¹ Obesity is often a factor in other chronic health conditions, such as diabetes, heart disease, strokes and in some types of cancer.

The CDC recommends four ways to prevent chronic conditions and maintain good physical health, including not smoking, eating low-fat whole food diets, exercising moderately for at least 150 minutes a week, and limiting alcohol consumption.²² Annual physicals with a primary care provider are also necessary to help prevent or treat chronic health conditions. Yearly screenings can allow providers to identify any warning signs for developing conditions and enable patients to correct or develop healthy behaviors to avoid developing a physical health condition. A CDC study noted that one-third of visits to health centers in 2020 were for preventive care.²³ For those living with chronic conditions, the CDC recommends some general steps people can take to manage their diseases. These include taking medications as prescribed by a provider, self-monitoring symptoms as needed (such as conducting home blood sugar checks), and regularly seeing a provider for check-ups.

¹⁸ Source: Ansah, J.P. & Chiu, T.C., (2022). Projecting the chronic disease burden among the adult population in the United States using a multi-state population model. *Frontiers in Public Health*. Retrieved January 23, 2024, from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9881650/>.

¹⁹ Source: American Cancer Society (ACS) (2024). *ACS Fast & Figures 2024*. Retrieved January 24th, 2024, from <https://www.cancer.org/research/acs-research-news/facts-and-figures-2024.html>.

²⁰ ACS (2020). *Health Risks of Smoking Tobacco*. Retrieved March 7th, 2024 from <https://www.cancer.org/cancer/risk-prevention/tobacco/health-risks-of-tobacco/health-risks-of-smoking-tobacco.html>

²¹ Source: CDC (2022). *Adult Obesity Facts*. Retrieved January 23rd, 2024, from <https://www.cdc.gov/obesity/data/adult.html>.

²² Source: CDC (2023). *Top 4 tips to Prevent Chronic Diseases*. Retrieved January 31, 2024, from: <https://www.cdc.gov/chronicdisease/about/top-four-tips/index.htm>.

²³ CDC (2022). *Characteristics of visits to health centers: United States, 2020*. Retrieved January 31, 2024, from <https://www.cdc.gov/nchs/products/databriefs/db438.htm>.

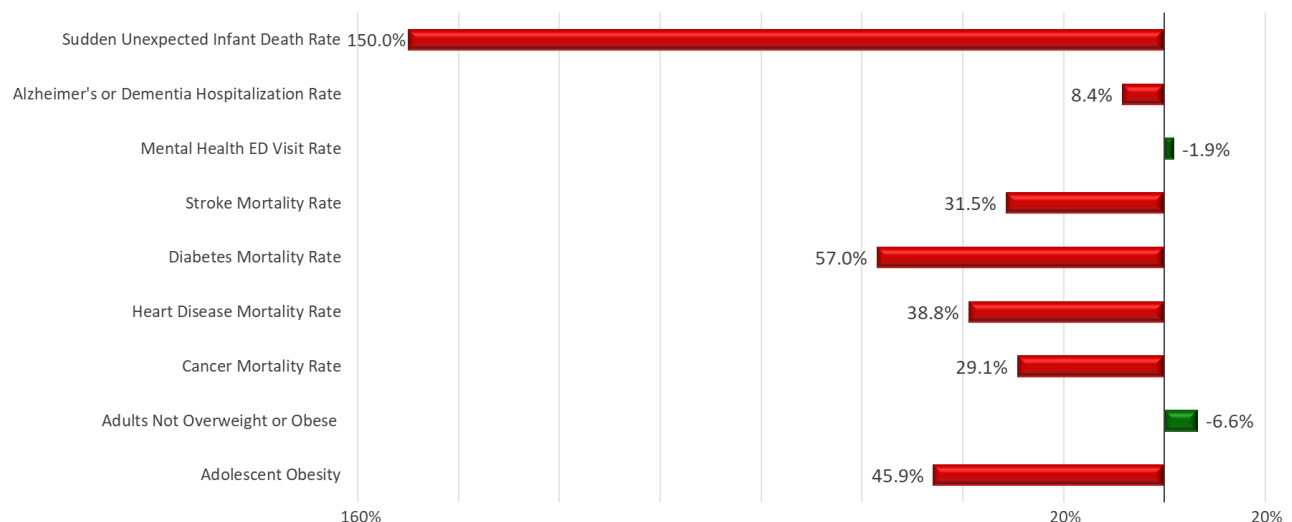
Secondary Data Findings

Baltimore City performed worse than the state of Maryland in nearly all physical health indicators, as shown in Table 4.2. This includes a higher percentage of residents experiencing frequent physical distress, or self-reporting poor or fair health status. Baltimore City also had a higher prevalence of both diabetes and obesity among adults when compared to the state.

Indicator	Baltimore City	Baltimore County	Maryland	United States
Percentage of Population Experiencing Frequent Physical Distress	10%	8%	7%	9%
Number of Poor Physical Health Days in the Last 30 Days	3.3	2.5	2.5	3
Percentage of Population Reporting Poor or Fair Health	17%	12%	11%	12%
Percent of Population Reporting Insufficient Sleep	40%	34%	34%	33%
Adult Diabetes Prevalence	13%	9%	9%	9%
Adult Obesity Prevalence	37%	32%	31%	32%

When compared to the state overall, Baltimore City had measurably worse rates of hospitalization for Alzheimer’s disease or other dementias, as well as higher rates of mortality due to stroke, heart disease and cancer. Most notably, the rate of sudden unexpected infant deaths in Baltimore City was more than 1.5 times higher than the rate in the state overall.

Figure 4.6: Physical Health Indicators: Variance from State



Baltimore City also underperformed relative to the state in a number of health behaviors that have an impact on physical health. Baltimore City residents had higher rates of physical inactivity and smoking –

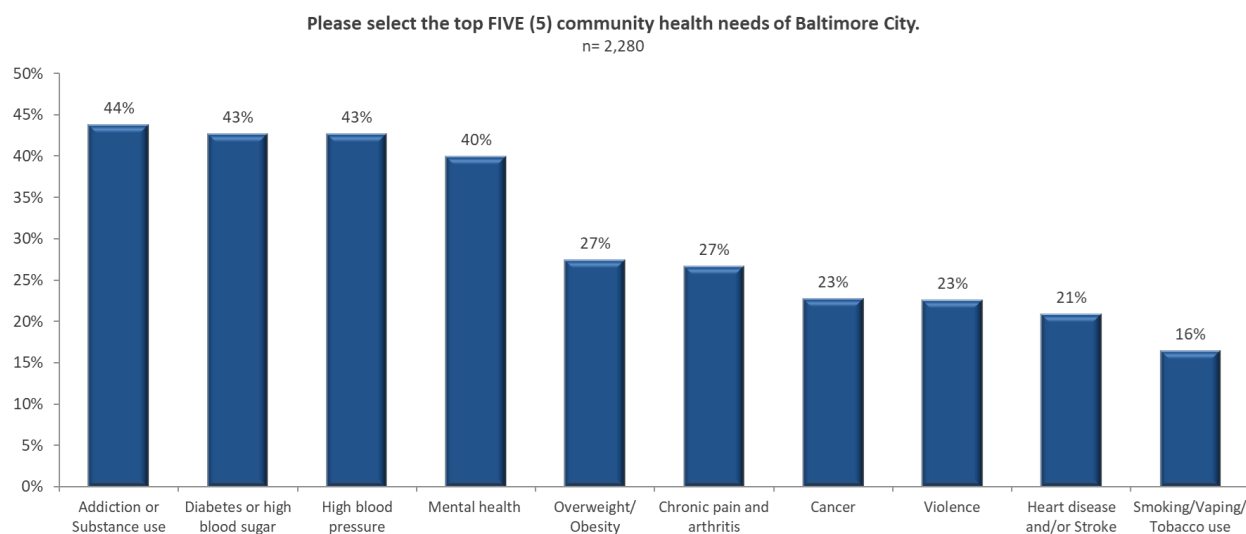
both of which have been shown to increase the risk of various chronic health conditions. Food insecurity was also a concern for Baltimore City residents, which is notable due to the impact diet has on overall physical health.

Table 4.3: Health Behavior and Food Security Indicators				
Indicator	Baltimore City	Baltimore County	Maryland	United States
Percent of Physically Inactive Adults	25%	22%	21%	22%
Percent of Adult Smokers	19%	14%	11%	16%
Percent of Population Experiencing Food Insecurity	16%	10%	9%	12%
Percent with Limited Access to Healthy Foods	2%	4%	4%	6%
Percent of Children Eligible for Free or Reduced Lunch	66%	52%	45%	53%

Primary Data Findings – Community Member Survey

Community members who responded to the survey identified several chronic conditions among the top community health needs in Baltimore City. Diabetes and high blood sugar were identified as the second highest need alongside high blood pressure, having each been selected by 43% of respondents. Other chronic health conditions ranked among the top health needs included obesity (27%), chronic pain and arthritis (27%), cancer (23%), and heart disease and/or stroke (21%). In addition, 16% of respondents identified smoking or tobacco use as a primary concern, which is of note due to the significant health impacts that can result from tobacco exposure. In addition, nearly one in five respondents reported experiencing poor physical health on six or more days in the prior 30-day period.

Figure 4.7

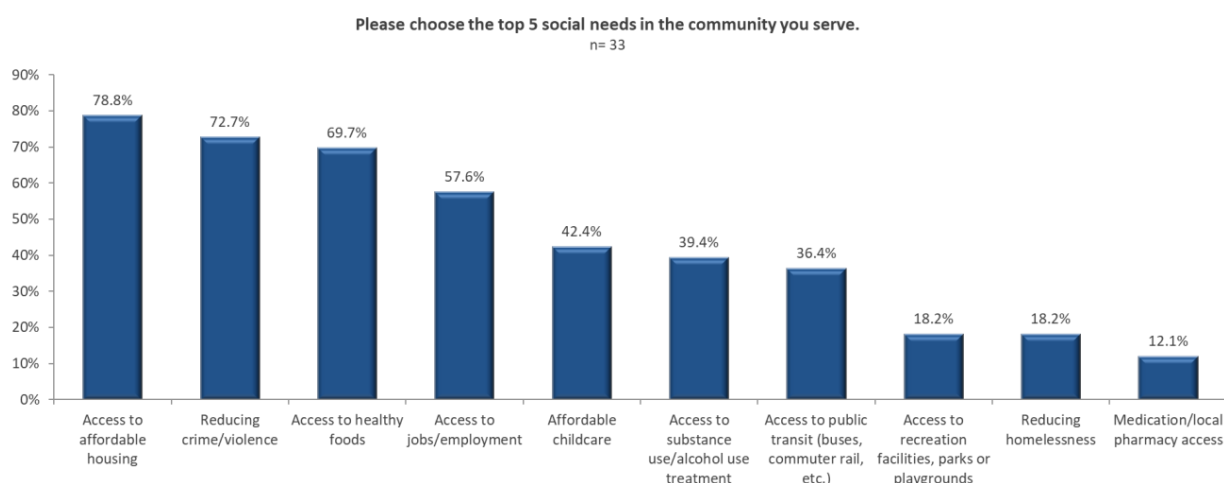


Primary Data Findings – Key Leader Survey

Among respondents to the key leader survey, approximately 24% identified diabetes and 15% identified heart disease, stroke or hypertension among the five most pressing health needs in Baltimore City. The need for primary and preventive healthcare, which helps to prevent or manage chronic disease, was identified as a top need by 21.2% of respondents. For additional information on these health needs, please refer to Figure 4.6 in the Mental Health primary data findings.

Key leaders also identified key SDoH factors that can impact chronic diseases and overall well-being among the most pressing social needs, including access to healthy foods (69.7%), access to recreation facilities, parks or playgrounds (18.2%) and access to medications or local pharmacies (12.1%).

Figure 4.8



In addition, more than half of Baltimore City key leaders (57%) indicated that there were not enough outdoor places for residents to get physical activity, and two-thirds of key leaders (66%) felt that children did not have enough opportunities to play and socialize outside of school.

Primary Data Findings – Focus Groups

When asked to identify the most significant health issues impacting their community, focus group participants noted several chronic conditions as being particularly impactful. These included diabetes, stroke, high blood pressure, chronic kidney disease, asthma, and autoimmune disorders like lupus.

One significant theme identified during the focus groups was the need for more community-facing education about chronic health conditions and SDoH behaviors. Focus group participants expressed that health information was often confusing when presented to them in a medical setting. This was a particular concern for older adults when they did not have a loved one available to speak with their physician or help them understand their treatments or medications. Suggestions to address this concern included using community health workers to follow up with patients in their homes, or finding opportunities for hospitals or the health department to provide more health information at community events, so local residents can learn more about how to prevent or manage chronic health conditions.

Priority Need: Access to Care

Context and National Perspective

Access to care means patients are able to get high quality, affordable healthcare in a timely fashion to achieve the best possible health outcomes. It includes several components, including health coverage (i.e. insurance), a physical location where care is provided, the ability to receive timely care when needed, and enough providers in the workforce. The CHNA Collaborative identified access to care as a high priority need for residents of Baltimore City.

From a national perspective, according to Healthy People 2030, approximately one in ten people in the U.S. do not have health insurance, which means they are less likely to have a primary care provider or to be able to afford the services or medications they need.²⁴ Access challenges are a concern even for those who do have health insurance.²⁵

The availability and distribution of health providers across the U.S. contributes to healthcare access challenges. According to the Association of American Medical Colleges (AAMC), there is estimated to be a shortage of 37,800 to 124,000 physicians in the U.S. by 2034, impacting both primary and specialty care.²⁶ Access issues are anticipated to increase in coming years. Growing shortages of both nurses and doctors are being driven by several factors, including population growth, the aging U.S. population requiring higher levels of care, provider burnout (physical, mental and emotional exhaustion) made worse by the COVID-19 pandemic, and a lack of clinical training programs and teachers – particularly for nurses.²⁷ The aging of the current physician workforce is also driving expected shortages. In Maryland, in 2020, 35.8% of actively practicing physicians were over the age of 60.²⁸ Access is also impacted by the overall number of practicing physicians. In 2020, there were just 7,075 primary care physicians in Maryland, with 23,791 physicians actively practicing across all specialties.²⁸

The ability to access healthcare is not evenly distributed across groups in the population. Groups who may have trouble accessing care include the chronically ill and disabled (particularly those with mental health or substance use disorders), low-income or homeless individuals, people located in certain geographical areas (rural areas; tribal communities), members of the LGBTQIA+ community, and certain age groups – particularly the very young or the very old.²⁹ In addition, individuals with limited English proficiency (LEP)

²⁴Source: U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion (2023). *Healthy People 2030: Health Care Access and Quality*. Retrieved September 14th, 2023 from <https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality>.

²⁵ Source: Phillips, K.A., Marshall, D.A., Adler, L., Figueroa, J., Haeder, S.F., Hamad, R., Hernandez, I., Moucheraud, C., Nikpay, S. (2023). Ten health policy challenges for the next ten years. *Health Affairs Scholar*. Retrieved from: <https://academic.oup.com/healthaffairsscholar/article/1/1/qxad010/7203673>.

²⁶ Source: Association of American Medical Colleges (AAMC) (2021). *The complexities of physician supply and demand: Projections from 2019 to 2034*. Retrieved from: <https://www.aamc.org/media/54681/download?attachment>.

²⁷ Source: University of Southern California Keck School of Medicine (2023). *A Public Health Crisis: Staffing Shortages in Health Care*. Retrieved September 14th, 2023, from <https://mphdegree.usc.edu/blog/staffing-shortages-in-health-care>.

²⁸ Source: AAMC (2021). *Maryland physician workforce profile*. Retrieved January 24, 2024, from <https://www.aamc.org/media/58211/download>

²⁹ Source: Joszt, L. (2018). 5 Vulnerable Populations in Healthcare. *American Journal of Managed Care*. Retrieved September 14th, 2023 from <https://www.ajmc.com/view/5-vulnerable-populations-in-healthcare>.

face barriers to accessing care, experience lower quality care and have worse outcomes for health concerns. LEP is known to worsen health disparities and can make challenges related to other SDoH (access to housing, employment, etc.) worse.³⁰ Both primary and secondary data resources analyzed for this report highlight the need for greater access to health services within Baltimore City.

Access to care and overall community health are affected by SDoH, which have a critical impact on health needs and outcomes. The World Health Organization defines SDoH as the non-medical factors that influence health outcomes. These are the conditions in which people are born, grow, work, live and age, and the wider set of external forces and systems shaping the conditions of daily life. Examples of SDoH that can influence health in positive or negative ways include income, education, unemployment/job security, food insecurity, housing, early childhood development, social inclusion or non-discrimination, structural conflict and access to affordable, high-quality healthcare.³¹

As seen in Figure 4.9, the American Hospital Association categorizes SDoH factors into the following domains: food, housing, transportation, health behaviors, violence, education, social support and employment.

Figure 4.9: Social Determinants of Health



Source: American Hospital Association

SDoH are not experienced equally by all people and are often linked to one another. The impacts of SDoH on populations are profound, can persist across generations, and often drive health inequities based on race, ethnicity or socioeconomic status. When health systems use their resources to address SDoH among patient populations, it can strengthen the quality of the care they provide while reducing health inequities.³² Evidence-based SDoH programs that can be adopted by hospitals or health systems that may reduce healthcare costs and improve outcomes include supportive housing for individuals with chronic health conditions, food and nutrition access, patient transportation services, cash payment or income

³⁰ Source: Espinoza, J. and Derrington, S. (2021). How Should Clinicians Respond to Language Barriers That Exacerbate Health Inequity? *AMA Journal of Ethics*. Retrieved from: <https://journalofethics.ama-assn.org/article/how-should-clinicians-respond-language-barriers-exacerbate-health-inequity/2021-02>.

³¹ Source: WHO (2023). *Social Determinants of Health*. Retrieved September 14th, 2023, from https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

³² Source: American Medical Association (2022). *What are social determinants of health?* Retrieved September 14th, 2023, from <https://www.ama-assn.org/delivering-care/health-equity/what-are-social-determinants-health>.

support for individuals with disabilities, and multidisciplinary patient care coordination teams.³³ Research published in JAMA suggests that collecting patient data on social adversity and health-related social needs can not only be used to develop better trust and support for their patients but can also help identify broader social needs in the community.³⁴

Throughout the primary and secondary data findings below, various SDoH emerged as areas of priority need for Baltimore City. Specifically, based on these findings, key concerns include dynamics related to food insecurity, violence and neighborhood safety, affordable housing, and transportation. City health leaders will continue to evaluate their potential to play a role in impacting these domains in the years to come.

Secondary Data Findings

Various factors contribute to healthcare access, not all of which were determined to be of high need for Baltimore City, as detailed in Appendix 4. Relative to the state of Maryland and the U.S., Baltimore City performs well on a number of access to care metrics, including the ratios of population to primary care physicians, non-physician primary care providers, dentists and mental health providers. This is likely due to the multiple large health systems and academic medical centers that operate in and around Baltimore City, which means there are a significant number of physicians and other health providers operating in the community. However, due to various healthcare-related challenges such as transportation access and clinic hours, those who are under resourced may still experience barriers to receiving appropriate care.

Table 4.4: Social Determinants of Health: Access to Care Indicators				
Indicator	Baltimore City	Baltimore County	Maryland	United States
Percentage of Population Uninsured	6%	6%	7%	10%
Total Population per Primary Care Physician	800	1,100	1,130	1,310
Total Population per Non-Physician Primary Care Provider	320	770	770	810
Total Population per Dentist	1,210	1,300	1,260	1,380
Total Population per Mental Health Provider	170	260	310	340

As previously described in the Context and National Perspective section above, SDoH have an impact on individual health status, and many SDoH factors can influence a person’s ability to access healthcare. While access to care metrics in Baltimore City are largely positive, the city performed worse across many SDoH metrics, suggesting a need to address these factors that influence health and well-being in the

³³ Source: Whitman, A., De Lew, N., Chappel, A., Aysola, V., Zuckerman, R. & Sommers, B. (2022). *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts*. Retrieved from <https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf>.

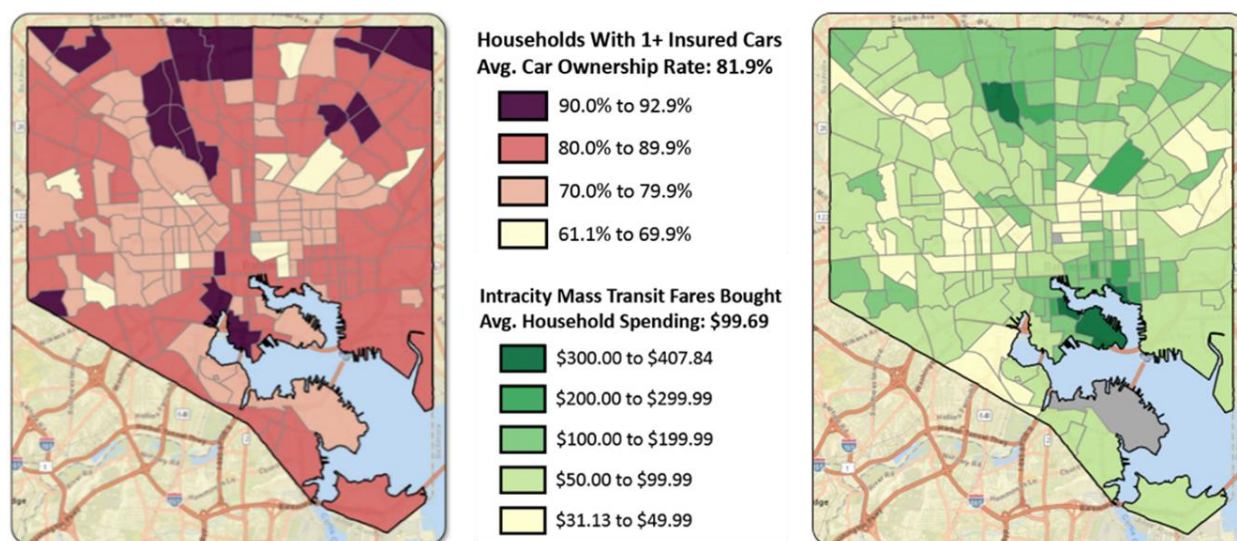
³⁴ Chen, A., Gwynn, K. & Schmidt, S. (2023). Addressing health-related social needs in the clinical, community, and policy domains. *JAMA Network*. Retrieved January 31, 2024 from: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2804105>.

community. Built environment and food security indicators fell below county, state, and national benchmarks, with the exception of healthy food access and access to exercise opportunities. The most significant difference was the percentage of children who are eligible for free or reduced lunch, which was more than 20% higher in Baltimore City (66%), than the state of Maryland (45%).

Table 4.5: Social Determinants of Health: Built Environment and Food Insecurity Indicators				
Indicator	Baltimore City	Baltimore County	Maryland	United States
Food Environment Index Score	7.5	8.3	8.7	7
Percentage of Population with Access to Exercise Opportunities	99%	97%	92%	84%
Percentage of Population with Broadband Internet Access	80%	89%	90%	87%
Percentage of Population Experiencing Food Insecurity	16%	10%	9%	12%
Percentage of Population with Limited Access to Healthy Foods	2%	4%	4%	6%
Percentage of Children Eligible for Free or Reduced-Price Lunch	66%	52%	45%	53%

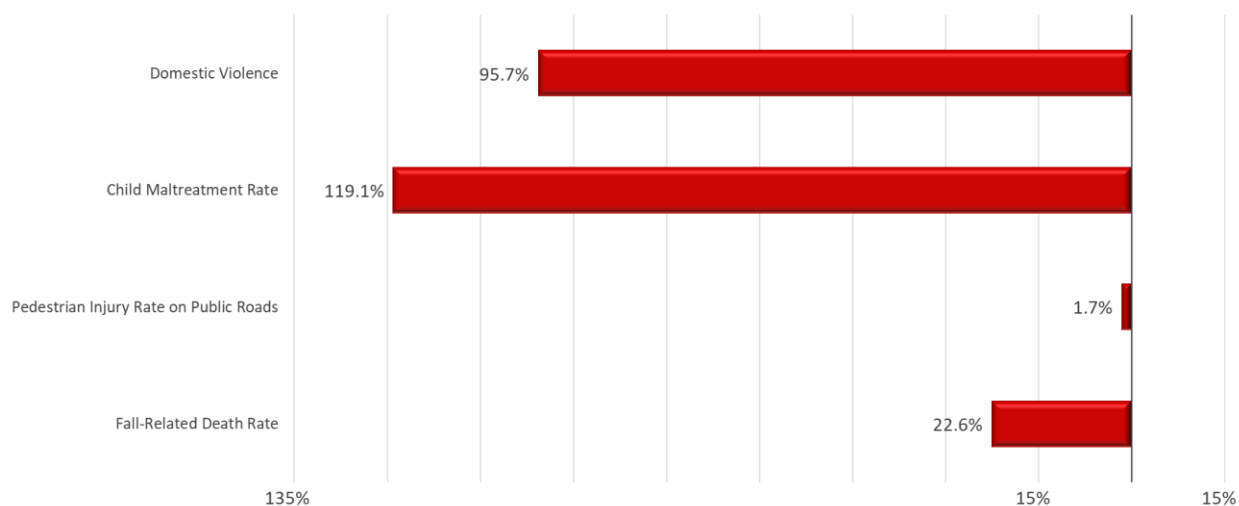
Transportation was another category of focus for Baltimore City, due to the impact it has on patients' ability to access medical care. While more than three-quarters of Baltimore City households own at least one car (81%), car ownership rates were lower in the central areas of the city. This coincides with areas that have higher usage of public transit, as shown in Figure 4.10. Baltimore City residents who rely on mass transportation to get around may be limited as to where they can seek care based on where bus or other transit lines are available.

Figure 4.10: Percentage of Car Ownership and Amount of Mass Transit Spending



Neighborhood violence and safety was another SDoH indicator of concern to the Collaborative. Baltimore City's rates of domestic violence are nearly double (95%) the rate in the state and child maltreatment approximately 120% worse than the state of Maryland overall.

Figure 4.11: Public Safety Indicators – Variance from State



Nearly all local safety indicators were significantly worse in Baltimore City compared to the state, with exceptions for deaths from vehicle accidents, and juvenile arrests. The rate of deaths attributed to injuries was more than double the state rate, and nearly double that of Baltimore County. Most notably, firearm-related fatalities in Baltimore City were nearly four times the rate in the county, the state or the U.S. overall. Violence and concerns about safety in the community have an impact on community members' ability to safely move about in their community, whether for personal reasons like exercise or to seek medical care when needed. High levels of community violence are also linked to poor mental health among community members.

Table 4.6: Social Determinants of Health: Neighborhood Safety and Violence Indicators				
Indicator	Baltimore City	Baltimore County	Maryland	United States
Injury Mortality (per 100,000 population)	200	109	88	76
Homicides (per 100,000 population)	43	9	9	6
Firearm Fatalities (per 100,000 population)	44	13	12	12
Motor Vehicle Crash Deaths (per 100,000 population)	9	8	9	12
Juvenile Arrests per 1,000 Juveniles	25	39	27	24

Housing (including homelessness) was also identified as a primary SDoH concern that may impact access to healthcare. More than 20% of Baltimore City residents experience severe housing problems, defined as the percentage of homes that have at least one of four significant housing problems: overcrowding,

high housing costs, lack of kitchen facilities, or a lack of plumbing facilities.³⁵ In addition, one in five Baltimore City residents spends more than half their monthly income on housing, which may significantly impact their ability to pay for prescriptions, medical bills or other associated healthcare costs. Less than half of housing units in the city were occupied by homeowners (48%), a lower rate than Baltimore County, the state or the U.S.

Table 4.7: Social Determinants of Health: Housing and Homelessness Indicators				
Indicator	Baltimore City	Baltimore County	Maryland	United States
Percentage of Households with Severe Housing Problems	21%	15%	16%	17%
Percentage of Owner-Occupied Housing	48%	66%	67%	65%
Percent of Renters with Severe Housing Cost Burden	20%	14%	14%	14%
Percentage of Sold Housing Units Considered Affordable	91.9%	64.1%	56.7%	NA

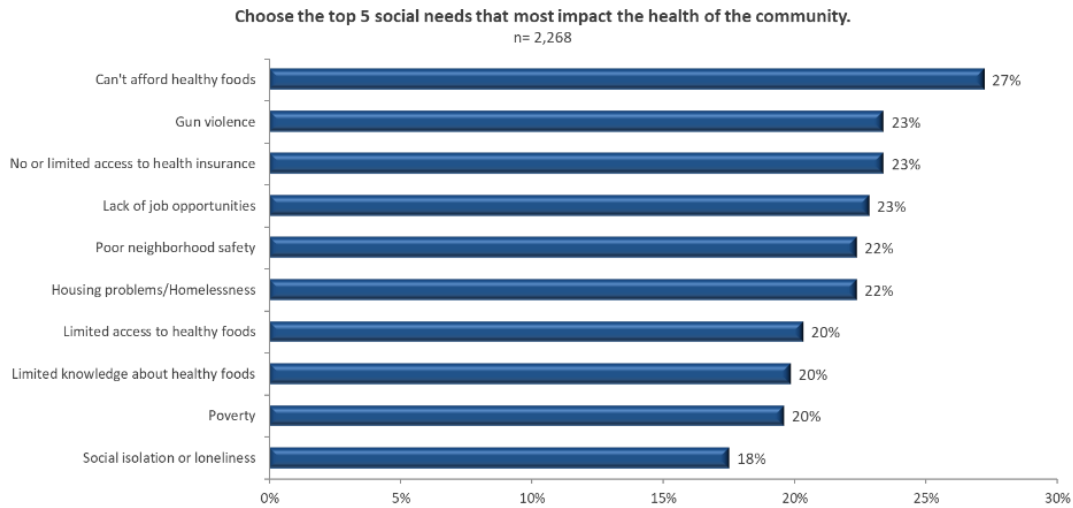
Primary Data Findings – Community Member Survey

Nearly all community survey respondents (86.9%) identified that they currently have health insurance. However, among those who did not, two-thirds of respondents described a lack in confidence in knowing how to obtain coverage.

Similar concerns were reflected when community members were asked to identify the top five social needs in the community. Nearly a quarter (23%) of respondents cited no or limited access to health insurance as having a major impact on community health. Several SDoH needs identified by survey respondents aligned with secondary data findings, and may impact community members' ability to access healthcare or live healthy lives. The inability to afford healthy food was identified as the top social need by 27% of respondents. Gun violence (23%) and neighborhood safety (22%) were identified by nearly a quarter of the respondents as well.

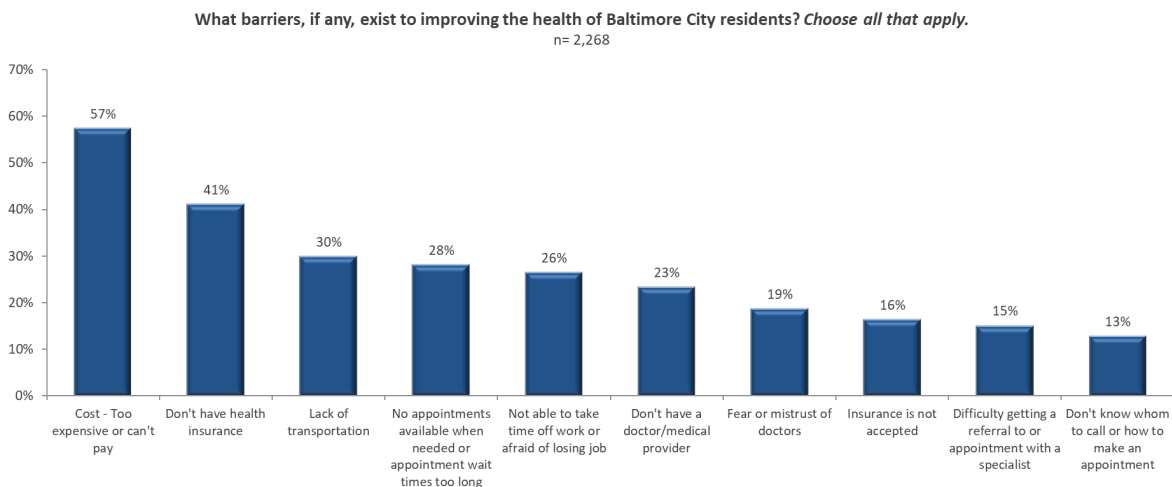
³⁵ Source: County Health Rankings (2023). *Severe housing problems*. Retrieved February 9, 2024 from: <https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/physical-environment/housing-and-transit/severe-housing-problems?year=2023>.

Figure 4.12



Community members were also asked to identify top barriers to improving and accessing care, as seen in Figure 4.13 below. The high cost of care (57%) and lack of health insurance (41%) were the top two identified barriers. Cost overall was highly identified in both the key leader and the community member survey as one of the top three barriers to receiving and accessing care. When breaking down responses to barriers to care further by demographic, the high cost of healthcare and concerns around obtaining insurance were consistent across race, age, and gender.

Figure 4.13



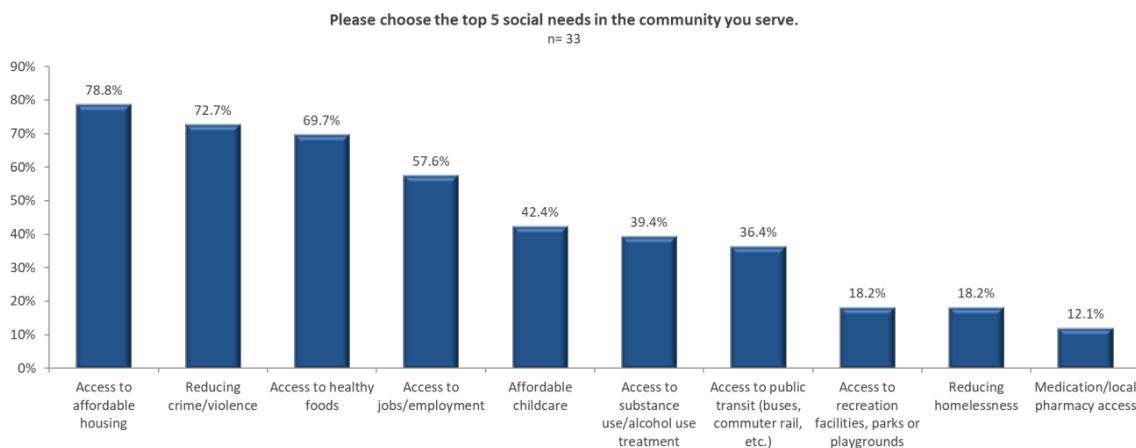
Primary Data Findings – Key Leader Survey

Over half (51.5%) of respondents to the key leader survey ranked access to care among the highest priority health needs in Baltimore City, while 21.2% identified the need for primary and preventive healthcare as a top concern. Key leaders identified various SDoH needs among the top health needs of the community. Housing and homelessness was ranked as the second highest community health need, selected by 63.6% of respondents. Food security (60.6%) and gun violence prevention (54.5%) were also highlighted as top

health needs by key leaders, highlighting a growing understanding of the impact these factors have on individual and community health.

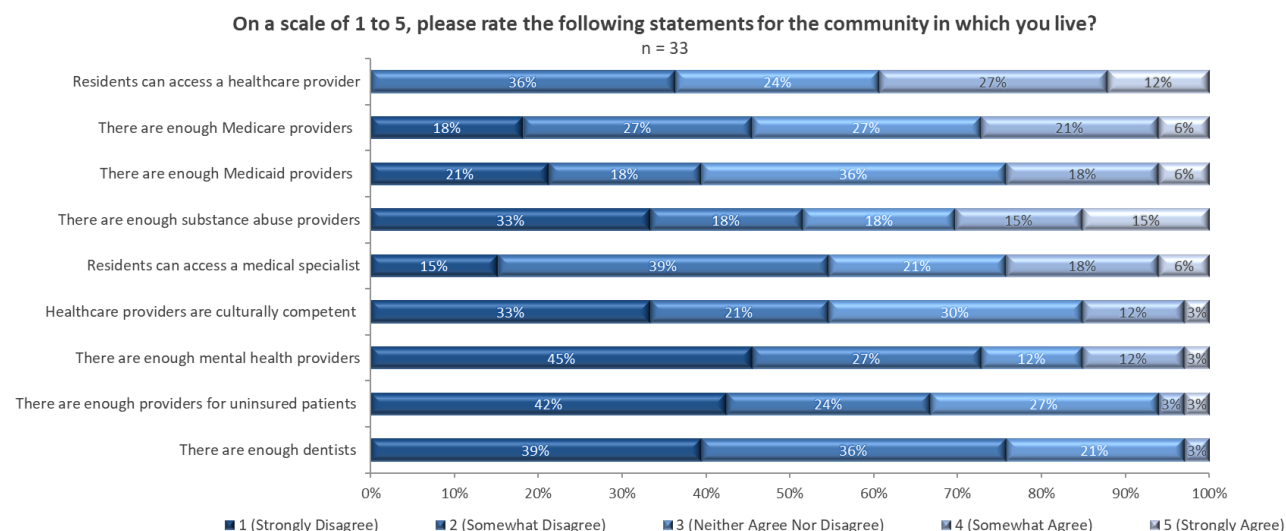
These metrics were explored further when respondents were asked to identify top social needs in the communities they serve. Access to affordable housing was identified as the top social need in the community by over two thirds of key leaders (78.8%). Reducing crime and violence followed as a close second, with 72.7% of key leaders identifying the concern. Just over a third of respondents indicated a need for access to public transit as well.

Figure 4.14



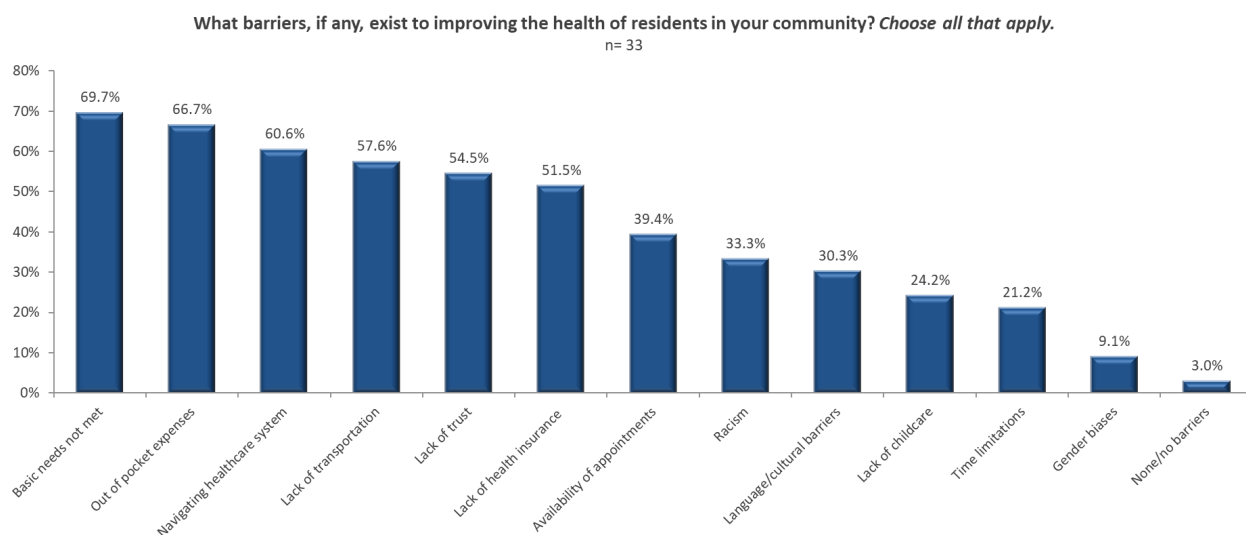
The majority of respondents (60%) disagreed that residents could access any type of healthcare provider when needed. In addition, more than half (54%) of respondents disagreed that residents could access specialty care when needed. Key leaders also disagreed that there were enough providers available to meet the needs of uninsured patients (66%), Medicare patients (45%) or Medicaid patients (39%) in their communities. Over half (54%) of key leaders also felt that there were not enough culturally competent healthcare providers to meet the needs of the community.

Figure 4.15



Respondents to the key leader survey were also asked to identify any barriers to improving the health of residents in their communities. Almost two thirds (69.7%) of respondents felt that their residents could not access healthcare because they did not have their basic needs met, and 66.7% felt that residents' out of pocket expenses were a significant barrier to care. Key leaders also felt that community members struggle to navigate the healthcare system, which was echoed through participant feedback in the focus groups. Lack of trust in healthcare providers was cited as a primary barrier by 54.5% of survey respondents, while many key leaders also identified racism (33.3%) and language or cultural barriers (30.3%) as impacting community members' ability to access care. Other SDoH factors were highly ranked as barriers to care, with lack of transportation (57.6%) and a lack of health insurance (51.5%) identified as top concerns as well.

Figure 4.16

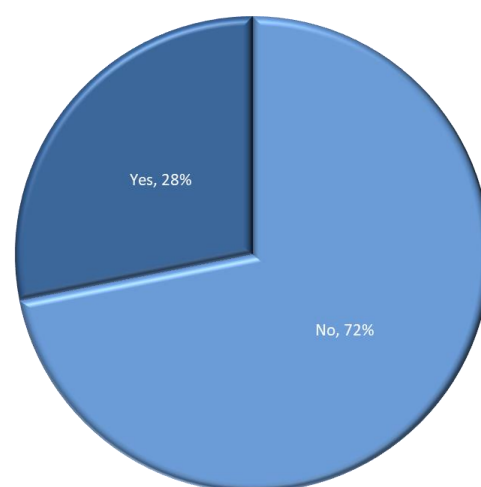


Key leaders were also asked whether they felt that the residents of the community they serve were health literate, or able to understand health-related information when it is presented to them. Almost three-quarters (72%) indicated that community members were not health literate. Key strategies for improving health literacy suggested by key leaders include using simplified language, providing LEP community members with translation services, and providing information to people where they are, such as at community events or offering home-based services.

Finally, key leaders were asked to identify the most common settings where community members seek medical care. Nearly all respondents (91%) identified the most common location for accessing care as the emergency department. The second most common was walk in/urgent care, at 58%. This aligns with community survey results that noted a lack of appointment availability and the high cost of care as

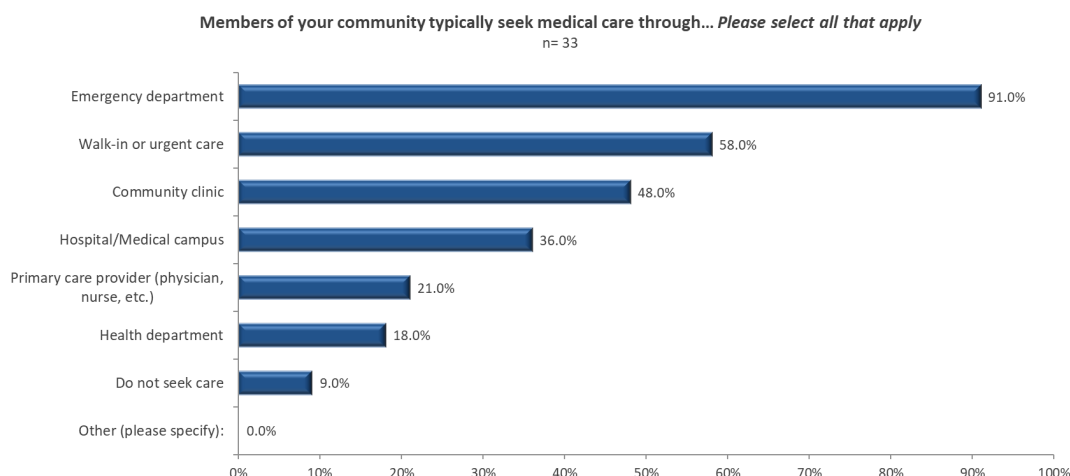
Figure 4.17

Do you feel that the residents of the community you serve are health literate? n = 33



major barriers. Individuals cannot be turned away at emergency departments for care, and many low-income individuals may also not be able to see a primary care provider in a timely fashion, or may lack health insurance to access primary care in the first place.

Figure 4.18



Primary Data Findings – Focus Groups

Access to care and various SDoH factors were primary concerns among participants across all focus groups. Multiple groups cited transportation, food access and quality, and community crime or violence as barriers to receiving care and incorporating healthy behaviors into their lives.

To best understand the factors impacting community health in Baltimore City, all focus group participants were asked about their perceptions of the medical services in the community, and their experiences accessing healthcare. Challenges relating to accessing care, care quality, and patient experiences were voiced frequently throughout these groups, particularly among minority community members and new immigrants to Baltimore City. The cost of care and access to health insurance were also noted as barriers in the community member and key leader surveys described earlier in this report. Focus group participants voiced concerns about their ability to pay expensive medical bills, copays or prescription costs, and overall fear of using the medical system – a particular challenge for those who are undocumented.³⁶ Other participants voiced a desire for access to free or low-cost preventative care directly in their communities, at events such as local health fairs.

Many participants described challenges related to the quality of care they received when they did need medical care. Community members described long wait times to be able to see their primary care provider or specialists when needed. Wait times were also a concern when accessing care through urgent care clinics or the emergency department. Many participants described the healthcare system overall as confusing, and this was a particularly strong sentiment when it came to understanding or accessing health insurance. Many participants described feeling mistrustful toward their providers and nurses, due to prior negative experiences with medical care. Some participants expressed frustration when seeking care, describing situations where an immediate or partial concern was addressed, but where the provider did not treat them as a whole person or set up an effective plan of care tailored to their individual needs. One

³⁶ [Undocumented persons are individuals living in the U.S. without legal immigration status.](#)

participant in a focus group featuring older adults described an experience with a local hospital emergency department, and how a lack of timely care led to them spending two days in the waiting room, only to be sent home with over-the-counter medication.

Participants also described some of their experiences with providers, which often left them feeling discriminated against based on their race, age or medical diagnosis. Many focus group participants described feeling a sense of stigma that made them feel hesitant to seek care, even when needed. Other individuals expressed concern with their providers treating them as textbook cases or numbers, rather than human beings. Health literacy among community members was also described as a concern that impacts health. Participants noted that providers should be able to describe health-related information to their patients in terms that could be easily understood. Participants with limited English proficiency also described negative experiences with translators lacking the training to properly relay health-related information.

Overall themes related to the need for greater equity and empathy by medical providers were described across many focus groups. One focus group featuring participants from a hospital-based HIV clinic described a need for increased provider sensitivity training, community forums and additional opportunities for communication between clinical staff and the community as a way to build trust. Perception of medical services within this group in particular was not positive; many participants described a lack accountability from their providers, feeling stigmatized due to their HIV-positive status and frustration around difficulty accessing resources or services due to restrictive income thresholds. Other focus groups, especially those focused on new parents, cited specific concerns related to racial profiling, financial stress during the postpartum period, and an overall need for support in family planning and during medical crisis situations.

Focus group participants also noted several SDoH challenges that directly impact their ability to access healthcare and live healthy lives. Transportation was a key factor that impacts access. Many residents described being reliant on city buses or mobility transportation services; however, these were inconvenient and, often, dangerous. The high cost of healthy food was also described as a driver of poor health in the community, as well as an important basic need that may force people to make difficult choices between paying for food or paying for prescriptions or medical care. Similarly, the high cost of housing was noted as a basic need that often forces people to cut health-related costs in order to keep a roof over their heads. Older adults, in particular, noted that many seniors live in unsafe housing conditions because they cannot afford to move or to install safety equipment in their homes. Finally, many community members who participated in the focus groups described community violence as a significant challenge that impacts community members' ability to walk or exercise outdoors, and as a contributor to high levels of stress that impact overall health and well-being.

Baltimore City is home to a wide array of programs and services that may be used to address community health and many of the needs identified throughout this report. Please note that while the city overall may be adequately served by existing capacity in some areas, not every area of the city is equally served, and the need for additional resources may be greater in one geography as compared to another.

As multiple resources are available and are constantly changing, electronic databases are utilized to locate resources which best meet the needs of Baltimore City community members. The databases are maintained with current information, contact sources, descriptions, directions and, in some cases, applications and referral follow-up capability. To ensure that these resources are readily available to meet community needs, some facilities have embedded these databases directly into their websites and/or electronic medical record platforms.

Select citywide resource databases are described here:

- [211 Maryland](#) is the state's most comprehensive health and human services resource database. With more than 7,500 resources, individuals with essential needs can get connected to local help 24/7/365. In Baltimore, specifically, 211 Maryland provides direct assistance for community members in need of water bill assistance, utility assistance, access to free or reduced cost food, housing navigation, financial support, tax preparation and more.
- [CHARMCare](#) is a service of BCHD and its partners, which was developed through the Accountable Communities project – a citywide program that aims to connect patients to resources for social needs. CHARMCare is a free online resource guide where community members can find free or reduced-cost programs and services in Baltimore City to help meet their needs. The directory has information for resources that can help with food, housing, transportation, utilities, employment, education, mental healthcare, and substance use care.
- [FindHelp](#) is a web-based platform that helps health plan case managers connect their members with local services. It can also help participating organizations track social care outcomes. Through FindHelp, community members can be connected with free or reduced-cost resources in Baltimore City, including food, housing, financial assistance, healthcare, and more.

CHAPTER 5 | NEXT STEPS

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

APPENDIX 1 | EVALUATION OF PRIOR CHNA IMPLEMENTATION PLANS

A CHNA is an ongoing process that begins with an evaluation of the previous CHNA. In 2017, the BCHD, in partnership with the Local Health Improvement Coalition (LHIC), completed its previous assessment. In compliance with IRS regulations for not-for-profit hospitals, individual members of the CHNA Collaborative have completed their own CHNAs more recently (primarily in 2021). While members of the Collaborative have coordinated on various data gathering efforts in the past, the present CHNA is the first time Baltimore City health leaders have developed a unified assessment of the City's health and social needs.

Below are brief summaries of the findings of and implementation plans for each organization's CHNA between 2017 and the writing of this report. Each organization developed their goals and implementation plans separately and may also have identified additional priorities that are specific to the populations served by their facilities.

Ascension St. Agnes Hospital

ASA is a member of Ascension Health – one of the nation's leading not-for-profit and Catholic health systems. St. Agnes published its FY 2021 CHNA after conducting a large-scale community survey; facilitating seventeen focus groups with leaders and members of community organizations, neighborhood associations, and faith-based organizations; conducting eight additional online focus groups with community leaders, local public health experts, and community members; engaging Conduent Healthy Communities Institute to provide local community health indicator data; examining its internal hospital utilization data; and analyzing demographic and other maps provided by BCHD.

ASA's CHNA ultimately identified the following three stated community health need priorities to be addressed in the FY 2021–2024 cycle: address mental health and substance use disorders (SUD), prevent diabetes and improve health, and build person-centered healthy neighborhoods to address social determinants of health (SDoH). Among the most significant health and SDoH needs were found to be SUDs; mental health; chronic disease, including diabetes and heart disease; economic opportunity; affordable housing and safe neighborhoods; affordable healthcare; and transportation.

Programs implemented to address mental health and SUDs included assessment and referrals for ASA patients as needed, increasing patient access to medication assisted treatment, increasing mental health visits in the Ascension Medical Group and Health Institute programs, conducting naloxone trainings on campus and throughout the community, and providing trauma-informed care trainings for ASA staff. Diabetes-specific programs included expanding the Food Rx program to meet the nutritional needs of patients with diabetes or prediabetes, expanding the ASA Diabetes Prevention Program (DPP), developing an ASA care pathway for diabetes care management, increasing care management services for primary care patients with diabetes, and continuing to offer the Diabetes in Pregnancy program to provide nutrition therapy, health education, and monitoring for pregnant women with or at risk for diabetes. To address SDoH in the community, ASA established violence prevention programming for patients with violent injuries, provided health services in the community to help meet local neighborhood needs, grew the volunteer chaperoned ride program to reduce transportation barriers to accessing healthcare, expanded access to technology infrastructure for individuals to access telehealth, and connected patients to community resources that address SDoH.

Baltimore City Health Department

The Baltimore City Health Department was founded in 1793 and is the oldest continuously operating health department in the United States. BCHD has a wide-ranging area of responsibility, including acute communicable diseases, animal control, chronic disease prevention, emergency preparedness, HIV/STD, maternal-child health, restaurant inspections, school health, senior services, and youth and trauma services.

BCHD published its last CHNA in 2017 in partnership with the LHIC, a body comprised of community members and key stakeholders from various local healthcare systems, community-based organizations, faith-based institutions, businesses, and foundations that aims to improve health outcomes throughout Baltimore City. The 2017 Baltimore City CHNA focused on demographics, education, socioeconomic, housing, safety, food, and various health outcomes and health behaviors, such as maternal and child health, mortality and illnesses, and health behaviors. Some key findings and points of consideration focused on racial and economic health disparities, systemic discrimination, a crude mortality rate 30% higher than the rest of Maryland, and a staggering 20-year difference in life expectancy between city regions ranking highest in life expectancy to those ranking lowest.

To address needs identified in its 2017 CHNA, BCHD continued to support a variety of programs and services. Examples of those programs included continuation of Naloxone education and training for city residents and support of hospital-based substance use disorder related services. Chronic disease-focused programs such as tobacco cessation, lead poisoning prevention, food access programs such as Virtual Supermarket sites, continued to grow and reach city residents. To foster and maintain community outreach, BCHD continued to nurture its partnership with Healthcare Access Maryland to expand the use of community health workers throughout its programs. Currently, through the work of the LHIC, diabetes, care coordination and social determinants of health are being addressed through monthly convenings and community member engagement.

Johns Hopkins Health System (Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center)

The Johns Hopkins Hospital (JHH) is the teaching hospital and biomedical research facility of Johns Hopkins School of Medicine in Baltimore City, and Johns Hopkins Bayview Medical Center (JHBMC) is home to the teaching hospital's trauma center, neonatal intensive care unit, geriatrics center and the Johns Hopkins Burn Center – the only adult burn trauma unit in the state of Maryland. The CHNA process for JHH and JHBMC included the collection and analysis of primary and secondary data. Both public and private organizations, such as faith-based organizations, government agencies, educational systems, and health and human services entities were engaged to assess the needs of the community. In total, the extensive primary data collection phase resulted in more than 1,700 responses from community stakeholders/leaders and community residents.

The JHH/JHBMC FY2021 CHNA Implementation Strategy addresses community identified direct health needs and SDoH areas including mental health, substance use, diabetes, cardiovascular disease, chronic disease management and health education, access to care and support, housing, neighborhood safety, job opportunities, and healthy food environment. Although the COVID-19 pandemic provided new challenges to in-person community programming, JHH and JHBMC continued to address the identified needs through over 250 community benefit activities including quickly transitioning a paid summer student intern program to a virtual platform for the summer 2020 session to avoid cancelling during the COVID lock down which would result in a loss of income for over 300 Baltimore students. Other JHH and

JHBMC Programs that addressed community needs identified in the 2021 CHNA included, but was not limited to, comprehensive SDoH screenings, a food access program providing over a million meals to East Baltimore residents over the past three years, the launch of a new violence intervention program, a housing project with other Baltimore hospitals and public and private city partners to provide housing and wrap around services to homeless persons or those at risk of becoming homeless, and supporting a longtime supportive housing organization partner by providing over 18,000 bed nights to 280 individuals in treatment for substance use. JHH and JHBMC continue to support and collaborate with over 100 community organizations to deliver direct health services to community members based on the CHNA identified needs.

LifeBridge Health: Levindale Hospital

Levindale is a 330 licensed-bed facility located in Baltimore that offers a full continuum of post-acute services to help patients regain function and vitality after a life-altering illness or injury. Levindale Hospital's 2021-2024 implementation plan addressed the following priority areas: chronic heart disease, diabetes, mental health and substance use disorder, community health and wellness education, housing, food insecurity, community safety, and health disparities.

To address these issues, Levindale patients and family members had access to virtual and in-person chronic disease management education classes, the hospital's service area benefited from implementation of Mobile Health Clinics in surrounding neighborhoods, had access to Sinai Hospital of Baltimore's vocational services and workforce readiness program (VSP) for training and workforce development services, and created new partnerships and strengthened existing ones with community based organizations to improve access and trust for patients needing medical and behavioral health services.

Some examples of programs and services implemented by Levindale Hospital include:

- *Provided Adult Housing for displaced adults:* Levindale Hospital housed adults from Sinai and other hospitals who no longer require an acute hospital stay but have nowhere else to be discharged to.
- *Dedicated Social Work Support:* Provided dedicated social work support to assist housed community patients with placement.

LifeBridge Health: Sinai Hospital and Grace Medical Center

For more than 150 years, Sinai Hospital has been committed to the principles of inclusion, innovation and caring for the whole person. With 483 beds, Sinai is the largest community hospital in Maryland. Grace Medical Center, formerly Bon Secours Hospital, has provided healthcare services to the West Baltimore community for more than 100 years.

Sinai Hospital's 2021-2024 implementation plan addressed the following priority areas: chronic heart disease, diabetes, mental health and substance use disorder, community health and wellness education, housing, food insecurity, community safety, and health disparities. To address these respective issues, LifeBridge and Sinai Hospital and Grace Medical Center staff implemented virtual and in-person chronic disease management education classes, increased staff to expand reach into surrounding communities, operated Mobile Health Clinics in surrounding neighborhoods, utilized Sinai Hospital of Baltimore's VSP for training and workforce development services, and created new partnerships and strengthened existing

ones with community based organizations—including with local faith-based organizations—to improve access and trust for patients needing medical and behavioral health services.

Some examples of programs and services implemented in the Sinai Hospital and Grace Medical Center service area include:

- *Diabetes Medical Home Extender Program:* Provides comprehensive care coordination for patients with chronically unmanaged diabetes and help resolve psychosocial barriers preventing patients from utilizing primary care. Ensure patients have appropriate medications, transportation, and home support services. In FY23, the program had 2,524 encounters.
- *Diabetes Education and Healthy Food Support:* Provided in five high-priority West Baltimore zip codes. Free home delivery of fruits and vegetables for food insecure people with diabetes in West Baltimore. This program has provided access to healthy food for more than 360 participants to date.
- *SBIRT (Screening, Brief Intervention, and Referral to Treatment) Program:* Peer recovery coaches stationed in the hospitals' Emergency Departments connect substance use disorder patients with treatment and community resources. In FY23, Sinai Hospital and Grace Medical Centers provided over 8,500 screenings.
- *Community Mobile Health Clinic:* Mobile health initiative reaches traditionally underserved communities that face a variety of access and other social barriers to achieving and maintaining good health. People served are typically at higher risk for chronic disease and potentially avoidable hospital utilization. Community-based clinical touches included COVID testing, vaccinations, chronic disease prevention and identification, pediatric wellness visits, and provision of various other community-based health supporting services. In FY23, the Mobile Clinic provided 209 encounters.
- *Cardiovascular Telemonitoring Program:* Remote patient monitoring program to improve the quality of care, patient outcomes, and reduce hospital utilization for patients with chronic diseases by improving patient-provider communication, improving coordination of care, and improving time of follow up with a Primary Care Provider. In FY23, Sinai and Grace enrolled 395 patients in the GetWell Loop Chronic Disease Management program.
- *Community Care Coordination:* Care management services provided to high-risk community members. This program includes collaboration with internal and external mental health practices and referrals to community support resources. The initiative also coordinates transportation to medical appointments and social services. In FY23, this service provided 30,752 encounters.

MedStar Health

MedStar Health operates three hospitals in Baltimore City: MedStar Good Samaritan Hospital, MedStar Harbor Hospital and MedStar Union Memorial Hospital. MedStar's 2021 CHNA process identified three overarching health needs that impact the communities it serves: health and wellness, access to care and services, and SDoH. The health and wellness category was also sub-divided into chronic disease prevention and management; maternal and child health; and behavioral health and SUDs.

The hospitals conduct many community programs related to chronic disease, including diabetes prevention and management classes, blood pressure screenings, tobacco cessation programming, and

stroke support groups. To address behavioral health issues, MedStar Health has expanded the SBIRT strategy in emergency department and primary care settings and embedded Peer Recovery Coaches on hospital care teams. Relative to maternal and child health, the hospital has supported and coordinated an expanded Healthy Babies Collaborative and increased its Birth and Family education scope. To better provide access to care and services, MedStar Health has included mental health services as part of its primary care model and conducted social needs screenings and support linkages as part of care delivery. It has partnered with outside organizations to address SDoH, including the MedStar Health Uber transportation program and workforce development initiatives. MedStar Health assumed the full cost for continuing the Public Health Workforce Support for Disadvantaged Areas post-collaboration grant. To address food access challenges, the Food Rx program is now available through three hospitals with added community partnerships.

Mercy Medical Center

Mercy Medical Center (MMC) is a 183-licensed-bed, general acute care teaching hospital affiliated with the University of Maryland School of Medicine. The MMC campus is located in the heart of Downtown Baltimore, Maryland. MMC is both a prominent community hospital, providing a broad range of primary and secondary acute care services, as well as a preferred tertiary referral center in certain select specialties. MMC gathered both quantitative and qualitative data during its 2021 CHNA process. As part of the quantitative data gathering process for its 2018 and 2021 CHNAs, MMC's Community Benefit Committee worked collaboratively with BCHD and a consortium of Baltimore City Hospitals to obtain uniform quantitative and qualitative data including demographic and health data for Community Statistical Areas (CSAs) and qualitative findings from hundreds of community health surveys and stakeholder interviews.

MMC's Implementation Strategy addresses these priority areas identified in its CHNA: improve healthcare access for people experiencing homelessness; support victims of violence and addiction; enhance birth outcomes and prenatal care; expand access to preventive services; and provide targeted health education and training for future physicians, providers, and nurses. To address these, MMC has implemented evidence-based programs and strong partnerships. For example, MMC's collaboration with Health Care for the Homeless and the Assistance in Community Integration Services Program reduces barriers to care and housing among people experiencing homelessness. Additionally, MMC's Forensic Nurse Examiner program provides timely, trauma-informed care to victims of violence and abuse, including examinations, evidence collection, and support services. MMC screens all patients for substance use through the SBIRT program and offers one of two inpatient detoxification units in Baltimore City. MMC offers various childbirth wrap-around services through its Family Childbirth & Children's Center to improve maternal health outcomes. Further, MMC's Population Health Program develops care plans and provides interventions for high-risk patients to prevent hospitalizations by connecting them to community resources and primary care. MMC also facilitates preventive services and affordable medications for underserved residents through initiatives like the Prescription for Health Program.

Mt. Washington Pediatric Hospital

MWPH, a jointly owned corporate affiliate of the University of Maryland Medical System (UMMS) and Johns Hopkins Medicine, is a specialty rehabilitative and transitional pediatric hospital with 100 years of service in Baltimore. Its 2021 CHNA research was conducted between July 2020 and May 2021 and examined several health indicators, including chronic health conditions, access to healthcare, and SDoH. MWPH collaborated with other local health partners on several key data collection strategies for inclusion

in the CHNA. Nearly 2,500 online and in-person surveys were collected, representing all Baltimore City ZIP codes, and more than 2,700 community members participated in telephonic town halls. Various health experts and community leaders were interviewed and asked to discuss barriers related to accessing healthcare services in Baltimore City. MWPH also analyzed BCHD- and state-provided demographic and statistical information to better understand local health needs and outcomes.

MWPH's implementation strategy addressed the following priority areas, as identified by its CHNA: healthcare access and literacy, food insecurity, mental health and violence prevention. To address these priorities, MWPH implemented a number of programs and activities. MWPH offered immunization clinics in partnership with Baltimore City Public Schools (BCPS), BCHD and Vaccines for Children (State of Maryland) for students missing their childhood immunizations, as well as physicals, hearing, and vision screenings for undocumented, displaced, and guardian-appointed children in Baltimore City. It also revitalized four community gardens in Park Heights. MWPH provided sponsorship to parents and educators at the Maryland Head Start National Conference and worked with various community partners through its Community Health Advisory Board. Other programs included 4-week youth fitness and leadership programs for 75 underserved youth, CPR and First Aid training for 3 Girls Scouts of America troops, and a pilot swim program for underserved local children. MWPH also partnered with MileOne to provide car safety seats for children, and with the Weekend Backpack Program to provide hygiene kits for new moms, families experiencing homelessness, and BCPS.

University of Maryland Medical Center

UMMC, a private, non-profit acute care hospital with two campuses totaling over 800 acute care beds, focused its 2021 CHNA on the seven West Baltimore ZIP codes that represent the majority of its city admissions. UMMC used primary and secondary sources of quantitative and qualitative data, consulting with numerous individuals and organizations, including the general public, community leaders and partners, local health experts, the University of Maryland Rehabilitation and Orthopedic Institute, the University of Maryland Baltimore (UMB) academic community, and BCHD. Using their input and the data collected alongside other Baltimore City CHNA Collaborative members, UMMC collected and analyzed the following data collection components together: public surveys of Baltimore City residents, community member town halls, key stakeholder interviews, key community health focus groups, and key community partner focus groups.

UMMC's FY2021-2024 implementation plan addressed the following priority areas: chronic health conditions (diabetes, hypertension, HIV), maternal and child health, mental health, substance abuse, pediatric asthma, pediatric obesity, pediatric mental health, violence reduction, and career readiness. Although the COVID-19 pandemic created challenges, UMMC formed new partnerships with local schools and community organizations to distribute needed resources including COVID-19 wellness kits, vaccine education and registration support, and flyers for programs and resources.

To address chronic health conditions, UMMC provided community screenings including blood pressure, glucose and A1C, and HIV to raise awareness and provide referrals to manage chronic disease. Maryland Moms program continued to provide virtual learning to educate pregnant women about prenatal care. The workforce development program partnered with many Baltimore city schools, non-profit organizations and local government agencies to support expungement programs and implement career readiness programs for the residents of Baltimore.

APPENDIX 2 | CITY DEMOGRAPHIC AND SOCIOECONOMIC DETAIL

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

City Demographics

Age and Total Population

The table below shows the total population in Baltimore City, Baltimore County, Maryland and the United States.

Table A2.1: Total Population, 2023				
	Baltimore City	Baltimore County	Maryland	United States
Population	573,794	859,710	6,259,408	337,470,185

Source: ESRI 2023

The table below shows the percentage of Baltimore City, Baltimore County, Maryland and United States residents by age cohort.

Table A2.2: Age Distribution, 2023				
	Baltimore City	Baltimore County	Maryland	United States
Percentage below 15	16.8%	16.4%	17.6%	18.0%
Percentage between 15 and 44	43.7%	38.9%	39.2%	39.6%
Percentage between 45 and 64	23.0%	24.9%	25.7%	24.6%
Percentage 65 and older	16.5%	19.7%	17.5%	17.8%

Source: ESRI 2023

Sex

The table below shows the total population in Baltimore City, Baltimore County, Maryland and the United States by sex.

Table A2.3: Sex Distribution, 2023				
	Baltimore City	Baltimore County	Maryland	United States
Female	52.8%	52.2%	51.3%	50.6%
Male	47.2%	47.8%	48.7%	49.4%

Source: ESRI 2023

The table below shows the percentage and total population of Baltimore City, Baltimore County, Maryland and the United States by sex and age cohort.

A2.4: Sex and Age Distribution, 2023								
	Baltimore City		Baltimore County		Maryland		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Total	573,794	100.0%	859,710	100.0%	6,259,408	100.0%	337,470,185	100.0%
0-14 years	96,327	16.8%	141,397	16.4%	1,104,084	17.6%	60,750,786	18.0%
15-44 years	250,740	43.7%	334,433	38.9%	2,451,298	39.2%	133,591,630	39.6%
45-65 years	131,800	23.0%	214,154	24.9%	1,606,433	25.7%	83,061,508	24.6%
65+ years	94,927	16.5%	169,726	19.7%	1,097,593	17.5%	60,066,261	17.8%
Males	270,691	47.2%	411,367	47.8%	3,046,001	48.7%	166,821,938	49.4%
0-14 years	48,640	18.0%	71,977	17.5%	563,396	18.5%	31,023,901	51.1%
15-44 years	120,887	44.7%	164,997	40.1%	1,223,965	40.2%	67,793,310	50.7%
45-65 years	62,390	23.0%	101,173	24.6%	773,251	25.4%	40,903,399	49.2%
65+ years	38,774	14.3%	73,220	17.8%	485,389	15.9%	27,101,328	45.1%
Females	303,103	52.8%	448,343	52.2%	3,213,407	51.3%	170,648,247	50.6%
0-14 years	47,687	15.7%	69,420	15.5%	540,688	16.8%	29,726,885	48.9%
15-44 years	129,853	42.8%	169,436	37.8%	1,227,333	38.2%	65,798,320	49.3%
45-65 years	69,410	22.9%	112,981	25.2%	833,182	25.9%	42,158,109	50.8%
65+ years	56,153	18.5%	96,506	21.5%	612,204	19.1%	32,964,933	54.9%

Source: ESRI 2023

Race

The table below shows the total population in Baltimore City, Baltimore County, Maryland and the United States by race.

Table A2.5: Racial Distribution, 2023								
	Baltimore City		Baltimore County		Maryland		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
White Non-Hispanic	146,924	25.6%	431,552	50.2%	2,867,623	45.8%	191,314,266	56.7%
Black Non-Hispanic	332,377	57.9%	260,766	30.3%	1,834,049	29.3%	40,898,542	12.1%
Asian	21,210	3.7%	57,506	6.7%	439,514	7.0%	20,811,620	6.2%
American Indian & Alaska Native	1,270	0.2%	1,921	0.2%	11,977	0.2%	2,284,715	0.7%
Native Hawaiian/ Other Pacific Islander	152	0.0%	255	0.0%	2,635	0.0%	643,202	0.2%

Source: ESRI 2023

Ethnicity

The table below shows the total population in Baltimore City, Baltimore County, Maryland and the United States by ethnicity.

Table A2.6: Ethnic Distribution, 2023								
	Baltimore City		Baltimore County		Maryland		United States	
	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total	Count	Pct. of Total
Hispanic	47,869	8.3%	66,577	7.7%	788,675	12.6%	65,536,136	19.4%
Non-Hispanic	525,925	91.7%	793,133	92.3%	5,470,733	87.4%	271,934,049	80.6%

Language

The table below shows the total population in Baltimore City, Baltimore County, Maryland and the United States by language spoken at home.

Table A2.7: Language Spoken at Home, 2022				
	Baltimore City	Baltimore County	Maryland	United States
English Only	89.0%	85.8%	79.3%	78.0%
Spanish	4.7%	4.0%	8.9%	13.3%
Indo-European Languages	2.5%	4.5%	4.7%	3.8%
Asian and Pacific Islander Languages	1.9%	2.7%	3.9%	3.6%
Other Languages	1.8%	3.0%	3.2%	1.2%

Source: ESRI 2023

Socioeconomic Detail

Household Income

The table below shows the median household income of Baltimore City, Baltimore County, Maryland and the United States.

Table A2.8: Median Household Income, 2023				
	Baltimore City	Baltimore County	Maryland	United States
Income	\$55,224	\$82,607	\$93,432	\$72,603

Source: ESRI 2023

Poverty

The table below shows the percentage of households living below the federal poverty level in Baltimore City, Baltimore County, Maryland and the United States.

Table A2.9: Percent of Households Below the Federal Poverty Level, 2021				
	Baltimore City	Baltimore County	Maryland	United States
Percent Below FPL	19.7%	9.1%	9.1%	12.4%

Source: ESRI 2023

Food Stamps/SNAP

The table below shows the percentage of households receiving food stamps or SNAP in Baltimore City, Baltimore County, Maryland and the United States.

Table A2.10: Percent of Households Receiving Food Stamps/SNAP, 2021				
	Baltimore City	Baltimore County	Maryland	United States
Households Receiving Food Stamps/SNAP	56,208	34,031	238,288	14,105,231
Total Households	248,855	333,180	2,363,944	124,010,992
Percentage of Households receiving Food Stamps/SNAP	22.6%	10.2%	10.1%	11.4%

Source: ESRI 2023

Educational Attainment

The table below shows the percentage of the population in Baltimore City, Baltimore County, Maryland and the United States and the United States broken out by educational attainment.

Table A2.11: Educational Attainment, 2023				
	Baltimore City	Baltimore County	Maryland	United States
Less than 9 th Grade	3.5%	2.6%	3.2%	4.1%
Some High School/No Diploma	8.8%	4.8%	4.9%	5.5%
High School Diploma	23.9%	22.1%	21.4%	22.9%
GED/Alternative Credential	5.2%	3.3%	3.2%	4.1%
Some College/No Diploma	16.9%	17.1%	16.4%	17.7%
Associate's Degree	6.5.7%	7.8%	7.5%	9.5%
Bachelor's Degree	18.4%	23.8%	23.3%	22.3%
Graduate/Professional Degree	17.7%	18.4%	20.2%	13.9%

Source: ESRI 2023

Unemployment

The table below shows the percentage of the population that is unemployed in Baltimore City, Baltimore County, Maryland and the United States and the United States broken out by age cohort.

Table A2.12: Unemployment, 2023				
	Baltimore City	Baltimore County	Maryland	United States
Percentage unemployed ages 16 to 24	1.7%	1.3%	1.2%	1.3%
Percentage unemployed ages 25 to 54	2.8%	1.9%	1.9%	2.2%
Percentage unemployed ages 55 to 64	0.7%	0.6%	0.5%	0.6%
Percentage unemployed ages 65 or more	0.5%	0.3%	0.2%	0.2%

Source: ESRI 2023

Uninsured Population

The table below shows the percentage of the population that is uninsured in Baltimore City, Baltimore County, Maryland and the United States and the United States broken out by age cohort.

Table A2.13: Uninsured Population, 2021				
	Baltimore City	Baltimore County	Maryland	United States
Percentage uninsured ages 18 or below	0.8%	0.9%	0.9%	1.3%
Percentage uninsured ages 19 to 34	2.2%	1.9%	2.1%	3.2%
Percentage uninsured ages 35 to 64	2.9%	2.3%	2.8%	4.2%
Percentage uninsured ages 65 or more	0.1%	0.1%	0.1%	0.1%

Source: ACS 2021

APPENDIX 3 | SECONDARY DATA METHODOLOGY AND SOURCES

Many individual secondary data measures were analyzed as part of the CHNA process. This data provides detailed insight into the health status and health-related behavior of residents in the city. These secondary data are based on statistics of actual occurrences, such as the incidence of certain diseases, as well as statistics related to SDoH.

Methodology

All individual secondary data measures were grouped into six categories and 20 corresponding focus areas based on “common themes.” In order to draw conclusions about the secondary data for Baltimore City, its performance on each data measure was compared to targets/benchmarks. If Baltimore City’s performance was more than five percent worse than the comparative benchmark, it was concluded that improvements could likely be needed to better the health of the community. Conversely, if an area performed more than five percent better than the benchmark, it was concluded that while a need is still present, the significance of that need relative to others is likely less acute. The most recently available data were compared to these targets/benchmarks in the following order (as applicable):

- For all available data sources, state and national averages were compared.
- Peer Community for Comparison: For the purposes of this analysis, Baltimore County has been identified as a peer community for comparison, due to the two communities’ relatively similar population density and demographic makeup.

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

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

These measures are noted with an asterisk.

Additionally, data measures were also viewed with regard to performance over time and whether the measure has improved or worsened compared to the prior CHNA timeframe.

Data Sources

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

Table A3.1: Access to Care

Measure	Description	Data Source	Most Recent Data Year(s)
Uninsured (percent of population < 65 without health insurance)	Percentage of the population under age 65 without health insurance coverage.	ESRI Business Analyst. Data accessed September 2023.	2021
Primary Care (ratio of population to primary care physicians - population per one provider)	Ratio of the population to primary care physicians. Primary care physicians include practicing non-federal physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. The ratio represents the number of individuals served by one physician in a county, if the population was equally distributed across physicians. Prior to the 2013 County Health Rankings, primary care physicians were defined only as M.D.s. In 2013, D.O.s were incorporated into the definition of primary care physicians and obstetrics/gynecology was removed as a primary care physician type.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020
Dentists (ratio of population to dentists - population per one dentist)	Ratio of the population to dentists. The ratio represents the population served by one dentist if the entire population of a county was distributed equally across all practicing dentists.	ESRI Business Analyst. Data accessed September 2023.	2021
Other primary care providers (ratio of population to other primary care providers - population per one provider)	Ratio of the county population to the number of other primary care providers. Other primary care providers include nurse practitioners (NP), physician assistants (PA), and clinical nurse specialists. Please note that the methods for calculating this measure changed in the 2017 Rankings.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2022
Children receiving dental care (ages 0 to 20)	This indicator reflects the percentage of children (aged 0-20 years) enrolled in Medicaid (320+ days) who received at least one dental visit during the past year.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2021

Measure	Description	Data Source	Most Recent Data Year(s)
ED visit rate due to addiction-related conditions	This indicator shows the rate of emergency department visits related to substance use disorders (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2017
ED visit rate due to asthma	This indicator shows the rate of emergency department visits due to asthma (per 10,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2017
ED visit rate due to diabetes	This indicator shows the emergency department visit rate due to diabetes (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2017
ED visit rate due to hypertension	This indicator shows the rate of emergency department visits due to hypertension (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2017
ED visit rate due to dental problems	This indicator shows the emergency department visit rate related to dental problems (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2017
Persons with a usual primary care provider	This indicator shows the percentage of people who reported that they had one person they think of as their personal doctor or healthcare provider.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2021
Uninsured ED visits	This indicator shows the percentage of persons without health (medical) insurance.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2017
Mental health providers (ratio of population to mental health providers - population per one provider)	Ratio of the population to mental health providers. Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and mental health providers that treat alcohol and other drug abuse, as well as advanced practice nurses specializing in mental healthcare. The ratio represents the number of individuals served by one mental health provider in a county, if the population were equally distributed	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2022

Measure	Description	Data Source	Most Recent Data Year(s)
	across providers. In 2015, marriage and family therapists and mental health providers that treat alcohol and other drug abuse were added to this measure.		

Table A3.2: Built Environment

Measure	Description	Data Source	Most Recent Data Year(s)
Food environment index (index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best))	The Food Environment Index measures the quality of the food environment in a county on a scale from 0 to 10. The Food Environment Index is comprised of two variables: Limited access to healthy foods from the USDA's Food Environment Atlas estimates the percentage of the population who are low income and do not live close to a grocery store. Living close to a grocery store is defined differently in rural and nonrural areas: in rural areas, it means living less than 10 miles from a grocery store whereas in nonrural areas, it means less than 1 mile. Low income is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size. Food insecurity from Feeding America estimates the percentage of the population who did not have access to a reliable source of food during the past year. The two variables are scaled from 0 to 10 (zero being the worst value in the nation, and 10 being the best) and averaged to produce the Food Environment Index. In 2016, the average value for counties was 7.0 and most counties fell between about 5.4 and 8.3.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2019 & 2020
Access to exercise opportunities (percent of the population with adequate access to locations for physical activity)	Percentage of individuals in a county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities. Individuals are considered to have access to exercise	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2022 & 2020

Measure	Description	Data Source	Most Recent Data Year(s)
	opportunities if they: reside in a census block that is within a half mile of a park or reside in an urban census block that is within one mile of a recreational facility or reside in a rural census block that is within three miles of a recreational facility. The numerator is the number of individuals who live in census blocks meeting at least one of the above criteria. The denominator is the total county population. Locations for physical activity are defined as parks or recreational facilities. Parks include local, state, and national parks. Recreational facilities include YMCAs as well as businesses identified by the following Standard Industry Classification (SIC) codes and include a wide variety of facilities including gyms, community centers, dance studios and pools: 799101, 799102, 799103, 799106, 799107, 799108, 799109, 799110, 799111, 799112, 799201, 799701, 799702, 799703, 799704, 799707, 799711, 799717, 799723, 799901, 799908, 799958, 799969, 799971, 799984, or 799998. The way this measure is calculated has changed over time. In 2018, County Health Rankings switched from using North American Information Classification System (NAICS) codes to using Standard Industry Classification (SIC) codes due to lack of availability of a nationally reliable and updated data source.		
% Broadband Access	Percentage of households with broadband internet connection.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2017-2021

Table A3.3: Diet and Exercise

Measure	Description	Data Source	Most Recent Data Year(s)
Physical inactivity (percent of adults that report no leisure time physical activity)	Percentage of adults ages 20 and over reporting no leisure-time physical activity in the past month. Examples of physical activities include running, calisthenics, golf, gardening, or walking for exercise. The method for calculating Physical Inactivity changed. Data for Physical Inactivity are provided by the CDC Interactive Diabetes Atlas which combines 3 years of survey data to provide county-level estimates. In 2011, BRFSS changed their methodology to include cell phone and landline participants. Previously only landlines were used to collect data. Physical Inactivity is created using statistical modeling.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020
Physical Activity (percentage)	This indicator shows the percentage of persons who reported at least 150 minutes of moderate physical activity or at least 75 minutes of vigorous physical activity per week.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2019

Table A3.4: Education

Measure	Description	Data Source	Most Recent Data Year(s)
Students entering kindergarten ready to learn	This indicator shows the percentage of students who enter Kindergarten ready to learn.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2017
School Segregation	The extent to which students within different race and ethnicity groups are unevenly distributed across schools when compared with the racial and ethnic composition of the local population. The index ranges from 0 to 1 with lower values representing a school composition that approximates race and ethnicity distributions in the student populations within the county, and higher values representing more segregation.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2021-2022
School Funding Adequacy	The average gap in dollars between actual and required spending per pupil among public school districts. Required spending is an estimate of	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County	2020

Measure	Description	Data Source	Most Recent Data Year(s)
	dollars needed to achieve U.S. average test scores in each district.	Health Rankings. Data accessed September 2023.	
% Less than 9 th Grade	Percentage of adults over age 25 who have less than a 9 th grade education.	ESRI Business Analyst. Data accessed September 2023.	2023
% Some High School	Percentage of adults over age 25 who attended some high school but did not earn their diploma or alternative credential.	ESRI Business Analyst. Data accessed September 2023.	2023
% High School Diploma	Percentage of adults over age 25 who earned a high school diploma.	ESRI Business Analyst. Data accessed September 2023.	2023
% GED/Alternative Credential	Percentage of adults over age 25 who earned a GED or an alternative credential.	ESRI Business Analyst. Data accessed September 2023.	2023
% Some College	Percentage of adults over age 25 who attended some college but did not earn their diploma.	ESRI Business Analyst. Data accessed September 2023.	2023
% Associate's Degree	Percentage of adults over age 25 who earned an Associate's degree.	ESRI Business Analyst. Data accessed September 2023.	2023
% Bachelor's Degree	Percentage of adults over age 25 who earned a four-year college Bachelor's degree.	ESRI Business Analyst. Data accessed September 2023.	2023
% Graduate/ Professional Degree	Percentage of adults over age 25 who earned a graduate or professional degree.	ESRI Business Analyst. Data accessed September 2023.	2023

Table A3.5: Employment

Measure	Description	Data Source	Most Recent Data Year(s)
Unemployment rate (percent of population age 16+ unemployed)	Percentage of a county's workforce that is not employed. The numerator is the number of individuals over age 16 in a county who are seeking work but do not have a job. The denominator is the total labor force, which includes all individuals over age 16 who are actively searching for work and unemployed plus those who are employed. Unemployment estimates are modeled.	ESRI Business Analyst. Data accessed September 2023.	2023

Table A3.6: Environmental Quality

Measure	Description	Data Source	Most Recent Data Year(s)
Air pollution (avg daily measure of fine particulate matter in micrograms per cubic meter)	Average daily density of fine particulate matter in micrograms per cubic meter. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers (PM2.5). Air Pollution is modeled. For 2017, County Health Rankings is using data provided by the EPHT Network. From 2013-2016 the County Health Rankings used data provided by the NASA Applied Sciences Program, which used a similar methodology but also incorporates satellite data. For 2012 and prior years of the County Health Rankings, data were obtained from the EPHT Network, but the measures of air quality differed from the current measure: County Health Rankings reported the average number of days annually that both PM2.5 and ozone pollution were reported to be over the accepted limit.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2019
Presence of Water Violation	Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2021
Days with Unhealthy Air Quality	Number of days where the daily 8-hour maximum concentration of ozone exceeded 71 parts per billion, the minimum value deemed by the Environmental Protection Agency as unhealthy for sensitive groups.	American Lung Association. Data accessed September 2023.	2019-2021
Days with Unhealthy Particle Pollution	Number of days where the daily 24-hour maximum concentration for particles with diameter less than 2.5 micrometers exceeded 33.5 micrograms per cubic meter, the minimum value deemed by the Environmental Protection Agency as unhealthy for sensitive groups.	American Lung Association. Data accessed September 2023.	2019-2021

Table A3.7: Family, Community, and Social Support

Measure	Description	Data Source	Most Recent Data Year(s)
Percentage of children that live in single-parent household	Percentage of children (less than 18 years of age) in family households that live in a household headed by a single parent. The single parent could be a male or female and is without the presence of a spouse. Foster children and children living in non-family households or group quarters are not included in either the numerator or denominator.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2017-2021
Social associations (number of membership associations per 10,000 population)	Number of organizations per 10,000 population in a county. The numerator is the number of organizations or associations in a county. Associations include membership organizations such as civic organizations, bowling centers, golf clubs, fitness centers, sports organizations, political organizations, labor organizations, business organizations, and professional organizations. The denominator is the population of a county. Social Associations does not measure all of the social support available within a county. Data and business codes are self-reported by businesses in a county. We use the primary business code of organizations, which in some cases may not match up with our notion of what should be labeled as a civic organization. This measure does not take into account other important social connections offered via family support structures, informal networks, or community service organizations, all of which are important to consider when understanding the amount of social support available within a county.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020
Disconnected youth	Percentage of teens and young adults ages 16-24 who are neither working nor in school.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2017-2021
Residential segregation - black/white	Degree to which two or more groups live separately from one another in a geographic area. The index of	Robert Wood Johnson Foundation & University of Wisconsin Population	2017-2021

Measure	Description	Data Source	Most Recent Data Year(s)
	dissimilarity is a demographic measure of the evenness with which two groups (black and white residents, in this case) are distributed across the component geographic areas (census tracts, in this case) that make up a larger area (counties, in this case). The index score can be interpreted as the percentage of either black or white residents that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area.	Health Institute, County Health Rankings. Data accessed September 2023.	
Percentage not proficient in English	Percentage of population that is not proficient in English.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2017-2021
Childcare Cost Burden	Childcare costs for a household with two children as a percent of median household income.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2022 & 2021
Childcare Centers	Number of childcare centers per 1,000 population under 5 years old.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2010-2022
Diversity Index	Likelihood of two people chosen at random being from a different race/ethnicity.	ESRI Business Analyst. Data accessed September 2023.	2023

Table A3.8: Food Security

Measure	Description	Data Source	Most Recent Data Year(s)
Percentage of households experiencing food insecurity	Percentage of the population who did not have access to a reliable source of food during the past year. This measure was modeled using information from the Community Population Survey, Bureau of Labor Statistics, and American Community	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020

Measure	Description	Data Source	Most Recent Data Year(s)
	Survey. More detailed information can be found here. This is one of two measures that are used to construct the Food Environment Index.		
Limited access to healthy foods	Percentage of population who are low-income and do not live close to a grocery store.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2019
Children eligible for free or reduced-price lunch	Percentage of children enrolled in public schools, grades PK - 12, eligible for free (family income less than 130 percent of federal poverty level) or reduced price (family income less than 185 percent of federal poverty level) lunch.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020-2021
Food Insecurity Among Middle School Students: All races/ethnicities	Percentage of students who, when asked, said they were worried that their food money would run out before they could buy more, and/or if the food their family bought did not last and they did not have money to get more.	The Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS). Data accessed September 2023.	2021-2022
Food Insecurity Among High School Students: All races/ethnicities	Percentage of students who, when asked, said they were worried that their food money would run out before they could buy more, and/or if the food their family bought did not last and they did not have money to get more.	The Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS). Data accessed September 2023.	2021-2022

Table A3.9: Housing and Homelessness

Measure	Description	Data Source	Most Recent Data Year(s)
Severe housing problems (percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities)	Percentage of households with one or more of the following housing problems: Housing unit lacks complete kitchen facilities; Housing unit lacks complete plumbing facilities; Household is severely overcrowded; or Household is severely cost burdened. Incomplete kitchen facilities is defined as a unit which lacks a sink with running water, a range or a refrigerator. Incomplete plumbing facilities is defined as lacking hot and	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2015-2019

Measure	Description	Data Source	Most Recent Data Year(s)
	cold piped water, a flush toilet, or a bathtub/shower. Severe overcrowding is defined as more than 1.5 persons per room. Severe cost burden is defined as monthly housing costs (including utilities) that exceed 50 percent of monthly income. The numerator is the number of households in a county with at least one of the above housing problems and the denominator is the number of total households in a county.		
Percentage of owner-occupied housing	Percentage of occupied housing units that are owned.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2017-2021
Percentage of people spending more than 50 percent of their income on rental housing	Number of renter-occupied housing units spending 50 or more percent of household income on rent as a percentage of total renter-occupied housing units.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2017-2021
Affordable Housing (percentage)	This indicator shows the percentage of housing units sold that are affordable on the median teacher's salary.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2016

Table A3.9: Income

Measure	Description	Data Source	Most Recent Data Year(s)
Children in poverty (percent of children under age 18 in poverty)	Percentage of children under age 18 living in poverty. Poverty status is defined by family size and income and is measured at the household level. If a household's income is lower than the poverty threshold for a household of their size, they are considered to be in poverty. Poverty thresholds differ by household size and geography. For more information on how poverty thresholds are calculated please see	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	the Census poverty page. Children in Poverty estimates are modeled.		
Median household income	Income where half of households in a county earn more and half of households earn less. Income, defined as “Total income”, is the sum of the amounts reported separately for: wage or salary income; net self-employment income; interest, dividends, or net rental or royalty income or income from estates and trusts; Social Security or Railroad Retirement income; Supplemental Security Income (SSI); public assistance or welfare payments; retirement, survivor, or disability pensions; and all other income. Receipts from the following sources are not included as income: capital gains; money received from the sale of property (unless the recipient was engaged in the business of selling such property); the value of income “in kind” from food stamps, public housing subsidies, medical care, employer contributions for individuals, etc.; withdrawal of bank deposits; money borrowed; tax refunds; exchange of money between relatives living in the same household; gifts and lump-sum inheritances, insurance payments, and other types of lump-sum receipts.	ESRI Business Analyst. Data accessed September 2023.	2023
Income inequality (ratio of household income at the 80th percentile to income at the 20th percentile)	Ratio of household income at the 80th percentile to that at the 20th percentile, i.e., when the incomes of all households in a county are listed from highest to lowest, the 80th percentile is the level of income at which only 20 percent of households have higher incomes, and the 20th percentile is the level of income at which only 20 percent of households have lower incomes. A higher inequality ratio indicates greater division between the top and bottom ends of the income spectrum.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2017-2021

Measure	Description	Data Source	Most Recent Data Year(s)
Percentage of individuals living in poverty	Number of people living below poverty level as percent of total population.	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed September 2023.	2017-2021
Household Income (\$, 000s) - All	Average annual household income in 2014-2015 for children (now in their mid-30s) who grew up in this area.	The Opportunity Atlas, developed in partnership by the U.S. Census Bureau, Harvard University, and Brown University. Data accessed September 2023.	2014-2015
% Asset Limited, Income Constrained, Employed Households	Percentage of households who are earning more than the Federal Poverty Level, but not enough to afford the basics where they live.	United for ALICE. Data accessed September 2023.	2021
Gender Pay Gap	Ratio of women's median earnings to men's median earnings for all full-time, year-round workers, presented as "cents on the dollar."	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2017-2021

Table A3.10: Length of Life

Measure	Description	Data Source	Most Recent Data Year(s)
Premature Death (years of potential life lost before age 75 per 100,000 population age-adjusted)	Number of events (i.e., deaths, births, etc.) in a given time period (three-year period) divided by the average number of people at risk during that period. Years of potential life lost measures mortality by giving more weight to deaths at earlier ages than deaths at later ages. Premature deaths are deaths before age 75. All of the years of potential life lost in a county during a three-year period are summed and divided by the total population of the county during that same time period-this value is then multiplied by 100,000 to calculate the years of potential life lost under age 75 per 100,000 people. These are age-adjusted.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2018-2020

Measure	Description	Data Source	Most Recent Data Year(s)
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2018-2020
Life expectancy	Average number of additional years that someone at a given age would be expected to live if current mortality conditions remained constant throughout their lifetime. Based on life expectancy at birth. State data are a single year while county data are a three-year aggregate. Data were not reported in the County Health Book prior to 2013.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2018-2020
Child mortality	Number of deaths among children under age 18 per 100,000 population	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2017-2020

Table A3.11: Maternal and Infant Health

Measure	Description	Data Source	Most Recent Data Year(s)
Low birthweight (percent of live births with birthweight < 2500 grams)	Percentage of live births where the infant weighed less than 2,500 grams (approximately 5 lbs., 8 oz.). The numerator is the number of low birthweight infants born over a 7-year time span, while the denominator is the total number of births in a county during the same time.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2014-2020
Infant mortality	Number of all infant deaths (within 1 year), per 1,000 live births.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2014-2020

Table A3.12: Mental Health

Measure	Description	Data Source	Most Recent Data Year(s)
Poor mental health days (avg number in past 30 days age-adjusted)	Average number of mentally unhealthy days reported in past 30 days. This measure is based on responses to the Behavioral Risk Factor Surveillance System (BRFSS) question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" The value reported in the County Health Rankings is the average number of days a county's adult respondents report that their mental health was not good. Poor Mental Health Days is age-adjusted. Prior to the 2016 County Health Rankings, the CDC's BRFSS provided the County Health Rankings with county-level estimates that were constructed from seven years of responses from participants who used a landline phone. However, even with multiple years of data, these did not provide reliable estimates for all counties, particularly those with smaller respondent samples. In 2016, the CDC began producing single-year estimates at the county level using a combination of BRFSS data and a multilevel modeling approach based on respondent answers and individual characteristics such as age, sex, and race/ethnicity, along with county-level poverty and county and state-level contextual effects. Poor Mental Health Days estimates are created using statistical modeling.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020
Frequent mental distress	Percentage of adults who reported ≥ 14 days in response to the question, "Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020
ED visit rate due to mental health conditions	This indicator shows the rate of emergency department visits related	Maryland Department of Health, State Health Improvement Process	2017

Measure	Description	Data Source	Most Recent Data Year(s)
	to mental health disorders (per 100,000 population).	(SHIP). Data accessed September 2023.	
Suicide Rate	This indicator shows the suicide rate per 100,000 population.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2016-2020
Hospitalization rate due to Alzheimer's or other dementias	This indicator shows the rate of hospitalizations related to Alzheimer's or other dementias (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2017
% Visited Mental Health Provider	Percent of adults who saw a psychologist or psychiatrist in the past 12 months.	ESRI Business Analyst. Data accessed September 2023.	2023
% Used Prescription Antidepressant Medications	Percent of adults who were prescribed and used antidepressant medications in the last 12 months.	ESRI Business Analyst. Data accessed September 2023.	2023
% Used Prescription Antianxiety Medications	Percent of adults who were prescribed and used antianxiety medications in the last 12 months.	ESRI Business Analyst. Data accessed September 2023.	2023
% Depressive Disorder Diagnosis	Percent of adults reporting that a health professional has told them that they have a depressive disorder.	American Health Rankings. Data accessed September 2023.	2022

Table A3.13: Physical Health

Measure	Description	Data Source	Most Recent Data Year(s)
Poor or fair health (percent of adults reporting fair or poor health age-adjusted)	Percentage of adults in a county who consider themselves to be in poor or fair health. This measure is based on responses to the Behavioral Risk Factor Surveillance Survey (BRFSS) question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" The value reported in the County Health Rankings is the percentage of respondents who rated their health "fair" or "poor." Poor or Fair Health is age-adjusted. Prior to the 2016 County Health Rankings, the CDC's BRFSS provided the County Health Rankings with county-level estimates that were constructed from seven years of responses from participants who used a landline phone.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020

Measure	Description	Data Source	Most Recent Data Year(s)
	However, even with multiple years of data, these did not provide reliable estimates for all counties, particularly those with smaller respondent samples. In 2016, the CDC began producing single-year estimates at the county level using a combination of BRFSS data and a multilevel modeling approach based on respondent answers and individual characteristics such as age, sex, and race/ethnicity, along with county-level poverty and county and state-level contextual effects. Poor or Fair Health estimates are created using statistical modeling.		
Poor physical health days (avg number of unhealthy days in past 30 days, age-adjusted)	Average number of physically unhealthy days reported in past 30 days. This measure is based on responses to the Behavioral Risk Factor Surveillance System (BRFSS) question: “Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?” The value reported in the County Health Rankings is the average number of days a county’s adult respondents report that their physical health was not good. Poor Physical Health Days is age-adjusted. Prior to the 2016 County Health Rankings, the CDC’s BRFSS provided the County Health Rankings with county-level estimates that were constructed from seven years of responses from participants who used a landline phone. However, even with multiple years of data, these did not provide reliable estimates for all counties, particularly those with smaller respondent samples. In 2016, the CDC began producing single-year estimates at the county level using a combination of BRFSS data and a multilevel modeling approach based on respondent answers and individual characteristics such as age,	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020

Measure	Description	Data Source	Most Recent Data Year(s)
	sex, and race/ethnicity, along with county-level poverty and county and state-level contextual effects. Poor Physical Health Days estimates are created using statistical modeling.		
Adult obesity (percent of adults that report a BMI ≥ 30)	Based on responses to the Behavioral Risk Factor Surveillance Survey (BRFSS) and is the percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m ² . Participants are asked to self-report their height and weight. From these reported values, BMIs for the participants are calculated. The method for calculating Adult Obesity changed. Data for Adult Obesity are provided by the CDC Interactive Diabetes Atlas which combines 3 years of survey data to provide county-level estimates. In 2011, BRFSS changed their methodology to include cell phone and landline participants. Previously only landlines were used to collect data. Adult Obesity is created using statistical modeling.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020
Frequent physical distress	Percentage of adults who reported ≥ 14 days in response to the question, "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?"	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020
Diabetes prevalence	Prevalence of diagnosed diabetes in a given county. Respondents were considered to have diagnosed diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020
Insufficient Sleep	Percentage of adults who report fewer than 7 hours of sleep on average.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020

Measure	Description	Data Source	Most Recent Data Year(s)
Adolescents who are obese	This indicator shows the percentage of adolescent public high school students who are obese.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2016
Sudden unexpected infant death rate	This indicator shows the rate of sudden unexpected infant deaths (SUIDs) per 1,000 live births. Sudden unexpected infant deaths (SUIDs) include deaths from Sudden Infant Death Syndrome (SIDS), unknown cause, accidental suffocation and strangulation in bed.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2016-2020
Adults who are not overweight or obese (percentage)	This indicator shows the percentage of adults who are not overweight or obese.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2021
Cancer mortality rate	This indicator shows the age-adjusted mortality rate from cancer (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2018-2020
Age-Adjusted Mortality Rate from Heart Disease	This indicator shows the age-adjusted mortality rate from heart disease (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2018-2020
Age-adjusted Death Rate due to Diabetes (per 100,000 population)	Age-adjusted Death Rate due to Diabetes (per 100,000 population).	MD Vital Statistics Report. Data accessed September 2023.	2020
Age-adjusted Death Rate due to Stroke (per 100,000 population)	Age-adjusted Death Rate due to Stroke (per 100,000 population).	MD Vital Statistics Report. Data accessed September 2023.	2020

Table A3.14: Quality of Care

Measure	Description	Data Source	Most Recent Data Year(s)
Preventable hospital stays (rate for ambulatory sensitive conditions per 1,000 Medicare enrollees)	Hospital discharge rate for ambulatory care-sensitive conditions per 1,000 fee-for-service Medicare enrollees. That means it looks at people who were discharged from the hospital for conditions that, with appropriate care, can normally be treated without the need for a hospital stay. Examples of these conditions include convulsions, chronic obstructive pulmonary	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020

Measure	Description	Data Source	Most Recent Data Year(s)
	disease, bacterial pneumonia, asthma, congestive heart failure, hypertension, angina, cellulitis, diabetes, gastroenteritis, kidney/urinary infection, and dehydration. Preventable hospital stays are measured among fee-for-service Medicare enrollees and is age-adjusted.		
Mammography screening (percent of female Medicare enrollees)	Percentage of female Medicare enrollees ages 67-69 that received at least one mammogram during the last two years. The numerator is women ages 67-69 on Medicare who have received at least one mammogram during the past year. The denominator is all women ages 67-69 on Medicare in a specific geography.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020
Children and adults who are vaccinated annually against seasonal influenza	Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020
Children receiving blood lead screening	This indicator reflects the percentage of children (aged 12-35 months) enrolled in Medicaid (90+ days) screened for lead in their blood.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2021
Children with elevated blood lead levels	Number of children (0-72 months old) with blood lead levels > 10 µg/dL divided by the Total Number of Children (0-72 months old) tested.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2020
Early prenatal care	This indicator shows the percentage of pregnant women who receive prenatal care beginning in the first trimester.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2020

Table A3.15: Safety

Measure	Description	Data Source	Most Recent Data Year(s)
Injury mortality per 100,000 population	Number of deaths from planned (e.g., homicide or suicide) and unplanned (e.g., motor vehicle deaths) injuries per 100,000	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County	2016-2020

Measure	Description	Data Source	Most Recent Data Year(s)
	population. This measure includes injuries from all causes and intents over a 5-year period. Deaths are counted in the county of residence for the person who died, rather than the county where the death occurred.	Health Rankings. Data accessed September 2023.	
Motor vehicle crash deaths	Number of deaths due to traffic accidents involving a motor vehicle per 100,000 population. Motor vehicle crash deaths include traffic accidents involving motorcycles; 3-wheel motor vehicles; cars; vans; trucks; buses; street cars; ATVs; industrial, agricultural, and construction vehicles; and bicyclists or pedestrians when colliding with any of the previously listed motor vehicles. Deaths due to boating accidents and airline crashes are not included in this measure. In prior years, non-traffic motor vehicle accidents were included in this definition. ICD10 codes included are V02-V04 (.1, .9), V09.2, V12-V14 (.3-.9), V19 (.4-.6), V20-V28 (.3-.9), V29-V79 (.4-.9), V80 (.3-.5), V81.1, V82.1, V83-V86 (.0-.3), V87 (.0-.8), and V89.2.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2014-2020
Homicides	Number of deaths from assaults, defined as ICD-10 codes X85-Y09, per 100,000 population	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2016-2020
Firearm fatalities	Number of deaths due to firearms, defined as ICD-10 codes W32-W34, X72-X74, X93-X95, Y22-Y24, and Y35.0, per 100,000 population.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2019
Juvenile arrests	Rate of delinquency cases per 1,000 juveniles.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2022

Measure	Description	Data Source	Most Recent Data Year(s)
Child maltreatment rate	This indicator shows the rate of children who are maltreated per 1,000 population under the age of 18.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2018-2020
Fall-related death rate	This indicator shows the rate of fall-related deaths per 100,000 population.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2017
Pedestrian injury rate on public roads	This indicator shows the rate of pedestrian injuries on public roads per 100,000 population.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2020
Domestic Violence	Number of domestic violence crimes divided by total population.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2020

Table A3.16: Sexual Health

Measure	Description	Data Source	Most Recent Data Year(s)
Sexually transmitted infections (chlamydia rate per 100,000)	Number of newly diagnosed chlamydia cases per 100,000 population	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020
Teen birth rate (per 1,000 females ages 15-19)	Number of births to females ages 15-19 per 1,000 females	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2014-2020
HIV prevalence	Number of diagnosed cases of HIV for persons aged 13 years and older in a county per 100,000 population.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020
HIV incidence rate	This indicator shows the rate of adult/adolescent cases (age 13+) diagnosed with HIV (per 100,000 population).	Maryland Department of Health, State Health Improvement Process	2021

Measure	Description	Data Source	Most Recent Data Year(s)
		(SHIP). Data accessed September 2023.	

Table A3.17: Substance Use Disorders

Measure	Description	Data Source	Most Recent Data Year(s)
Excessive drinking	Percentage of adults that report either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than one (women) or 2 (men) drinks per day on average. Please note that the methods for calculating this measure changed in the 2011 Rankings and again in the 2016 Rankings. Excessive Drinking estimates are created using statistical modeling.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020
Alcohol-impaired driving deaths	Percentage of motor vehicle crash deaths which had alcohol involvement. The National Highway Traffic Safety Administration defines a fatal crash as alcohol-related or alcohol-involved if either a driver or a non-motorist (usually a pedestrian or bicyclist) had a measurable or estimated blood alcohol concentration of 0.01 grams per deciliter or above. Alcohol-Impaired Driving Deaths are measured in the county of occurrence.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2016-2020
Drug overdose deaths	Number of deaths due to drug poisoning per 100,000 population. ICD-10 codes used include X40-X44, X60-X64, X85, and Y10-Y14. These codes cover accidental, intentional, and undetermined poisoning by and exposure to: 1) nonopioid analgesics, antipyretics and antirheumatics, 2) antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, 3) narcotics and psychodysleptics [hallucinogens], not elsewhere classified, 4) other drugs acting on the autonomic nervous system, and 5) other and unspecified drugs,	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2018-2020

Measure	Description	Data Source	Most Recent Data Year(s)
	medicaments and biological substances.		
Opioid prescriptions dispensed (per 100 persons)	Opioid prescriptions dispensed (per 100 persons).	Center for Disease Control and Prevention. Data accessed September 2023.	2020

Table A3.18: Tobacco Use

Measure	Description	Data Source	Most Recent Data Year(s)
Adult smoking	Percentage of the adult population that currently smokes every day or most days and has smoked at least 100 cigarettes in their lifetime. Please note that the methods for calculating this measure changed in the 2016 Rankings. Adult Smoking estimates are created using statistical modeling.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2020
Adolescents who use tobacco products	This indicator shows the percentage of adolescents (public high school students) who used any tobacco product in the last 30 days.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed September 2023.	2016

Table A3.19: Transportation Options and Transit

Measure	Description	Data Source	Most Recent Data Year(s)
Driving alone to work (percent of the workforce that drives alone to work)	Percentage of the workforce that usually drives alone to work. The numerator is the number of workers who commute alone to work via a car, truck, or van. The denominator is the total workforce.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2017-2021
Long commute/driving alone (among workers who commute in their car alone, the percentage that commute more than 30 minutes)	Percentage of workers who drive alone (via car, truck, or van) with a commute longer than 30 minutes. The numerator is the number of workers who drive alone for more than 30 minutes during their commute. The denominator is the number of workers who drive alone during their commute.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed September 2023.	2017-2021
Traffic volume	Average traffic volume per meter of major roadways in the county.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data	2019

Measure	Description	Data Source	Most Recent Data Year(s)
		accessed September 2023.	
% Car Ownership	Percent of households that own at least one insured car.	ESRI Business Analyst. Data accessed September 2023.	2023
Household Intracity Mass Transit Spending	Average household spending on fares for mass transit trips within the city.	ESRI Business Analyst. Data accessed September 2023.	2023

APPENDIX 4 | SECONDARY DATA COMPARISONS

Description of Focus Area Comparisons

When viewing the secondary data summary tables, please note that the following color shadings have been included to identify how Baltimore City compares to Maryland and the national benchmark. If both statewide Maryland and national data was available, Maryland data was preferentially used as the target/benchmark value.

Secondary Data Summary Table Color Comparisons

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

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

Please note that to categorize each metric in this manner and identify the priority level, the Baltimore City value was compared to the benchmark by calculating the percentage difference between the values, relative to the benchmark value:

$$(Baltimore\ Value - Benchmark\ Value) / (Benchmark) \times 100 = \% \text{ Difference Used to Identify Priority Level}$$

For example, for the % Children Receiving Dental Care metric, the following calculation was completed:

$$(50.8 - 56.3) / (56.3) \times 100\% = -9.77\% = \text{Displayed as High Priority Level, Shaded in Red}$$

This metric indicates that the percentage of children with access to dental care in Baltimore City is 9.8 percent worse than the percentage of children with access to dental care in the state of Maryland.

Detailed Focus Area Benchmarks

Table A4.1: Access to Care

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Uninsured	10.0%	6.7%	5.9%	2021	Medium
Primary Care Physicians Ratio	1,310:1	1,133:1	804:1	2020	Low
Dentist Ratio	1,380:1	1,258:1	1,206:1	2021	Medium
Other Primary Care Provider Ratio	810:1	775:1	316:1	2022	Low
Children receiving dental care	N/A	56.3%	50.8%	2021	High
ED visits due to addiction-related conditions	N/A	2,017	1,689	2017	Low
ED visits due to asthma	N/A	68.4	68.0	2017	Medium
ED visits due to diabetes	N/A	243.7	224.6	2017	Low
ED visits due to hypertension	N/A	351.2	340.7	2017	Medium
ED visits due to dental care	N/A	362.7	281.1	2017	Low
Persons with usual primary care provider	N/A	87.3%	85.3%	2021	Medium
Uninsured ED visits	N/A	8.6	7.9	2017	Low

Table A4.2: Built Environment

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Food Environment Index	7.0	8.7	7.5	2019/2020	High
% with Access to Exercise Opportunities	84.0%	92.0%	98.8%	2020/2022	Low
Broadband Access	87.0%	90.0%	80.0%	2017-2021	High

Table A4.3: Diet and Exercise

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Physically Inactive	22.0%	20.6%	25.3%	2020	High

Table A4.4: Education

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Students entering kindergarten ready to learn	N/A	45.0%	47.0%	2017	Medium
School segregation	0.25	0.26	0.29	2021-2022	High
School funding adequacy	1,062	724	-7,285	2020	High

Table A4.5: Employment

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Unemployed	5.4%	3.8%	5.7%	2023	High

Table A4.6: Environmental Quality

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Average Daily PM2.5	7.4	7.4	8.6	2019	High

Table A4.7: Family, Community and Social Support

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Children in Single-Parent Households	25.0%	26.2%	49.2%	2017-2021	High
Social Association Rate	9.1	8.9	10.0	2020	Low
% Disconnected Youth	7.0%	6.0%	10.1%	2017-2021	High
Segregation Index – Black/White	63.0	63.5	67.6	2017-2021	High
% Not Proficient in English	14.0%	3.0%	1.6%	2017-2021	Low
Childcare Cost Burden	27.0%	22.0%	39.0%	2021/2022	High

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Childcare Centers	7.0	6.0	6.0	2010-2022	Medium

Table A4.8: Food Security

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Food Insecure	12.0%	9.0%	15.5%	2020	High
% Limited Access to Health Foods	6.0%	3.6%	1.8%	2019	Low
% Eligible for Free or Reduced Lunch	53.0%	45.0%	66.1%	2020-2021	High
% Households with Children Receiving Public Assistance	24.4%	21.2%	47.7%	2020	High
Food Insecurity: Middle Schoolers	N/A	27.5%	41.8%	2021-2022	High
Food Insecurity: Middle Schoolers	N/A	27.5%	43.9%	2021-2022	High

Table A4.9: Housing and Homelessness

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Severe Housing Problems	17.0%	15.7%	21.4%	2015-2019	High
% Homeowners	65.0%	67.3%	47.9%	2017-2021	High
% Severe Housing Cost Burden	14.0%	14.0%	20.0%	2017-2021	High
% Affordable Housing	N/A	48.1%	91.9%	2016	Low

Table A4.10: Income

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Children in Poverty	17.0%	14.0%	33.8%	2021	High
Median Household Income	\$69,700	\$93,432	\$55,224	2023	High

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Income Inequality	4.9	4.5	6.2	2017-2021	High
% Living in Poverty	12.8%	10.3%	23.0%	2017-2021	High
ALICE Households	28%	29%	53%	2021	High
Gender Pay Gap	0.81	0.87	0.93	2017-2021	Low

Table A4.11: Length of Life

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Years of Potential Life Lost Rate	7,300	7,547	14,844.8	2018-2020	High
Premature Age-Adjusted Mortality	360	360	683.6	2018-2020	High
Life Expectancy	78.5	78.6	71.8	2018-2020	High
Child Mortality Rate	50.0	48.5	90.0	2017-2020	High

Table A4.12: Maternal and Infant Health

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Low Birthweight	8.0%	8.7%	11.9%	2014-2020	High
Infant Mortality Rate	6.0	6.3	9.1	2014-2020	High

Table A4.13: Mental Health

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Mental Health Provider Ratio	340:1	315:1	170:1	2022	Low
Average No. of Mentally Unhealthy Days	4.4	4.1	5.4	2020	High
% Frequent Mental Distress	14.0%	12.7%	16.2%	2020	High
ED visits due to mental health conditions	N/A	4,291.5	4,210.1	2017	Medium
Hospitalization rate due to Alzheimer's or other dementias	N/A	515.5	559.0	2017	High

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Visited Mental Health Provider	N/A	4.7%	5.2%	2023	High
% Used Prescription Antidepressant Medications	N/A	6.7%	7.0%	2023	High
% Used Prescription Antianxiety Medications	N/A	7.6%	7.8%	2023	Medium
Depression rate	20.5%	16.6%	20.7%	2022	High
Suicide death rate	14.0	10.0	8.8	2016-2020	Low

Table A4.14: Physical Health

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Adults with Obesity	32.0%	30.9%	37.4%	2020	High
% Adults with Diabetes	9.0%	9.1%	13.4%	2020	High
% Frequent Physical Distress	9.0%	6.8%	10.1%	2020	High
% Insufficient Sleep	33.0%	34.1%	39.8%	2020	High
% Fair or Poor Health	12.0%	10.6%	39.8%	2020	High
Avg. No. of Physically Unhealthy Days	3.0	2.5	3.3	2020	High
Adolescents who are obese	N/A	15.9%	23.2%	2016	High
Adults who are not overweight or obese (%)	N/A	33.4%	33.9%	2021	Low
Age-Adjusted Death Rate from Heart Disease	N/A	163.3	226.7	2018-2020	High
Cancer Mortality Rate	N/A	145.5	187.9	2018-2020	High
Sudden unexpected infant death rate	N/A	0.8	2.0	2016-2020	High

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Age-adjusted Death Rate due to Stroke	38.8	42.5	55.9	2020	High

Table A4.15: Quality of Care

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Children/adults vaccinated annually against seasonal influenza	51.0%	55.0%	51.0%	2020	High
Mammography screening	37.0%	37.0%	36.0%	2020	Medium
Preventable hospital stays	28.1	26.5	40.9	2020	High
Children receiving blood lead screening	N/A	67.1	65.9%	2021	Medium
Children with elevated blood lead levels	N/A	0.2	0.2%	2020	Medium
Early prenatal care	N/A	70.2%	67.1%	2020	Medium

Table A4.16: Safety

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Firearm fatalities	12.0	12.3	43.7	2019	High
Homicides	6.0	9.1	43.2	2016-2020	High
Injury mortality	76.0	88.3	200.2	2016-2020	High
Juvenile arrests	24.0	27.1	25.3	2022	Low
Motor vehicle crash deaths	12.0	8.9	9.5	2014-2020	High
Child maltreatment rate	N/A	4.6	10.3	2018-2020	High
Domestic Violence	N/A	568.6	1,112.9	2020	High
Fall-related death rate	N/A	10.6	13.0	2017	High
Pedestrian injury rate on public roads	N/A	53.5	54.4	2020	Medium

Table A4.17: Sexual Health

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Teen Birth Rate	19.0	15.2	32.2	2014-2020	High
HIV Prevalence Rate	380.0	655.4	1,984.7	2020	High
HIV Incidence Rate	N/A	15.0	32.8	2021	High
Chlamydia Rate	481.3	535.9	1,181.8	2020	High

Table A4.18: Substance Use Disorders

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Drug Overdose Mortality Rate	23.0	41.1	123.7	2018-2020	High
% Excessive Drinking	19.0%	14.6%	17.9%	2020	High
% Driving Deaths with Alcohol	27.0%	28.3%	20.3%	2016-2020	Low
Opioid prescriptions dispensed	43.3	39.5	68.6	2020	High

Table A4.19: Tobacco Use

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Smokers	16.0%	11.1%	19.2%	2020	High
Adolescents who use tobacco products	N/A	14.4%	16.5%	2016	High

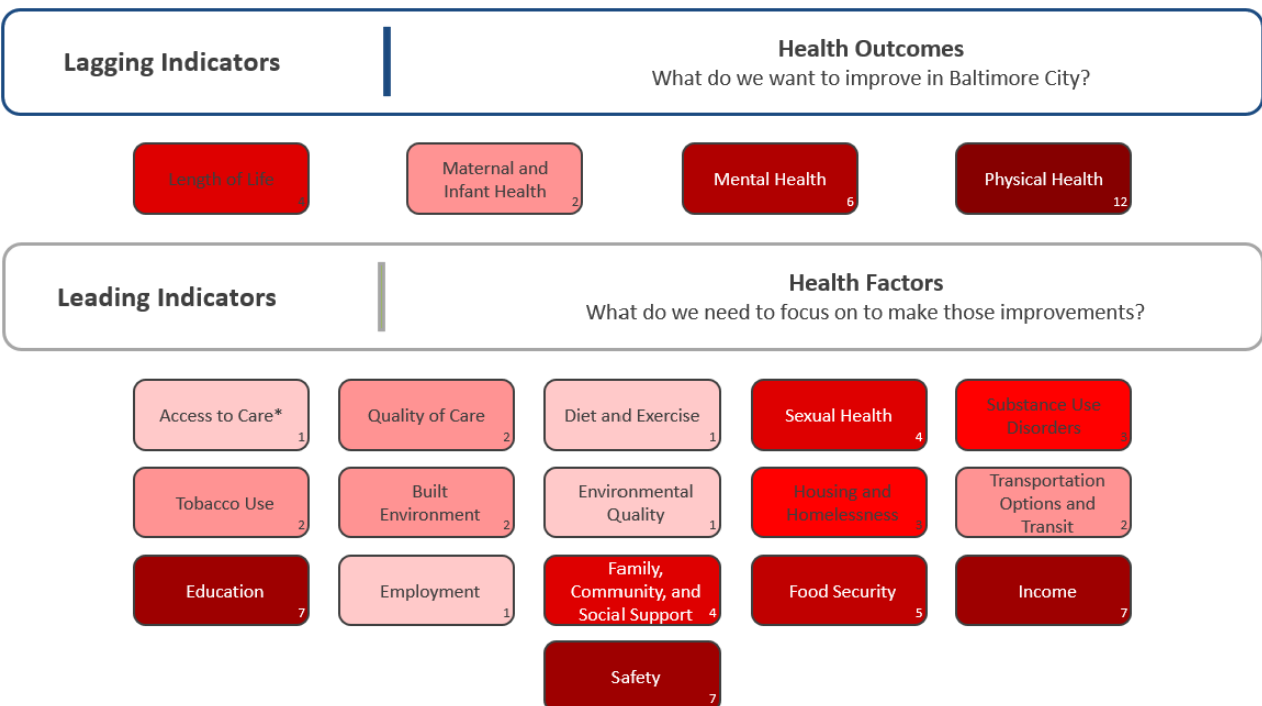
Table A4.20: Transportation Options and Transit

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Traffic Volume	505.0	695.2	1,443.3	2019	High
% Drive Alone to Work	73.0%	69.8%	42.9%	2017-2021	Low
% Long Commute – Drives Alone	37.0%	49.6%	58.2%	2017-2021	Low
% Car Ownership	N/A	89.8%	81.9%	2023	High
Mass Transit Spending	N/A	102.6	99.7	2023	Medium

APPENDIX 5 | SECONDARY DATA SUMMARY

The table and graphic below include summaries of potential priority need areas, as identified by the secondary data analysis process, as well as priority areas of need identified by other state, local, and national sources.

Priority Area	Secondary Data Findings	Mercy Medical 2021	MedStar Health 2021	Kennedy Krieger 2022	Sheppard Pratt 2022	Alivet Maryland 2022	Baltimore Medical 2020	Healthy People 2030
Social Determinants of Health	✓	✓	✓	✓	✓	✓	✓	✓
Access to Health Care	✓	✓	✓	✓	✓	✓	✓	✓
Mental Health and Behavioral Health/ Wellness	✓	✓	✓	✓	✓	✓	✓	
Health Equity		✓	✓	✓		✓	✓	✓
Substance Use	✓	✓	✓		✓		✓	
Health Literacy and Communication		✓	✓	✓	✓	✓	✓	✓
Specialty Care		✓	✓	✓		✓		
Childhood Support	✓	✓		✓			✓	
Chronic Disease	✓	✓	✓				✓	
Sexual Health	✓	✓				✓	✓	
Primary Care		✓	✓			✓	✓	
Obesity/Diabetes/Fitness/Nutrition	✓		✓				✓	
Staffing Support				✓	✓	✓		
Infant and Maternal Health	✓	✓					✓	



Values in bottom right represent number of measures with high need.

*Access to care metrics are based on the ratio of city population to providers, which does not account for the significant in-migration that occurs into Baltimore City facilities for healthcare.

APPENDIX 6 | DETAILED PRIMARY DATA FINDINGS

Primary data were collected through web-based Key Leader and Community surveys, and focus groups, which were conducted in-person or in a virtual format.

Methodologies

The methodologies varied based on the type of primary data being analyzed. The following section describes the various methodologies used to analyze the primary data, along with key findings.

Focus Groups

The following 33 focus groups were conducted virtually, hybrid or in person between October 3, 2023 and November 8, 2023. These groups included representation from key leaders, non-profit partners, patients, and community members, and totaled more than 300 participants.

- Anchor Group
- Baltimore Medical System Case Managers
- BCHD HIV Services and Ryan White (two focus groups)
- BCHD Youth Advisory Council and Youth Ambassadors
- B'More for Healthy Babies
- CASA de Maryland (two focus groups)
- Catholic Charities' Esperanza Center
- Charm City Care Connection
- Druid Hill YMCA
- East Baltimore Faith Leaders
- Eastside Yo! (Historic East Baltimore Community Action Coalition)
- Health Care Access Maryland
- Health Care for the Homeless
- Healthy Start Father's Group
- Helping Up Mission
- J Van Story Branch Apartments
- MedStar Fetal Assessment Center
- Morgan State University's Nutrition in the Community Class
- Northeastern Community Organization
- Senior Network of North Baltimore
- Sinai Hospital Diabetes patients
- Sinai Hospital HIV Clinic patients
- Sinai Hospital Families with Children
- St. Agnes Community Council
- St. Agnes Patient Family Advisory Council
- The Mayor's Commission on Aging and Retirement Education
- UMMC Chronic Disease patients
- UMMC Cancer patients
- UMMC Community Engagement Committee
- Victory Village Senior Center
- Zeta Senior Center

Input was gathered on the following topics:

- Community health concerns
- Access to care
- Social and environmental concerns that may impact community health

Key findings from the focus groups are summarized by topic in the graphic below.



Healthcare: Access

- The high cost of healthcare, health insurance and prescriptions was mentioned consistently
- Difficulty obtaining or understanding health insurance was also a significant concern



Healthcare: Quality

- Quality issues included stigma/discrimination and not feeling listened to by providers
- Participants also expressed frustration with long wait times and difficulty navigating a complicated system



Education

- Educational needs primarily focused on community health education and building awareness of existing resources



Food Insecurity

- Food deserts and inequitable access to healthy and nutritious food were frequent concerns
- Participants also noted the cost of food as a challenge to maintaining a healthy lifestyle



Mental Health

- Community members of all age groups and walks of life are experiencing poor mental health, particularly since COVID-19.
- Participants described a lack of mental health resources in the community



Housing & Homelessness

- The affordability of housing was a primary concern that forces people to de-prioritize their health
- Inadequate support for individuals experiencing homelessness is also a serious concern



Transportation & Transit

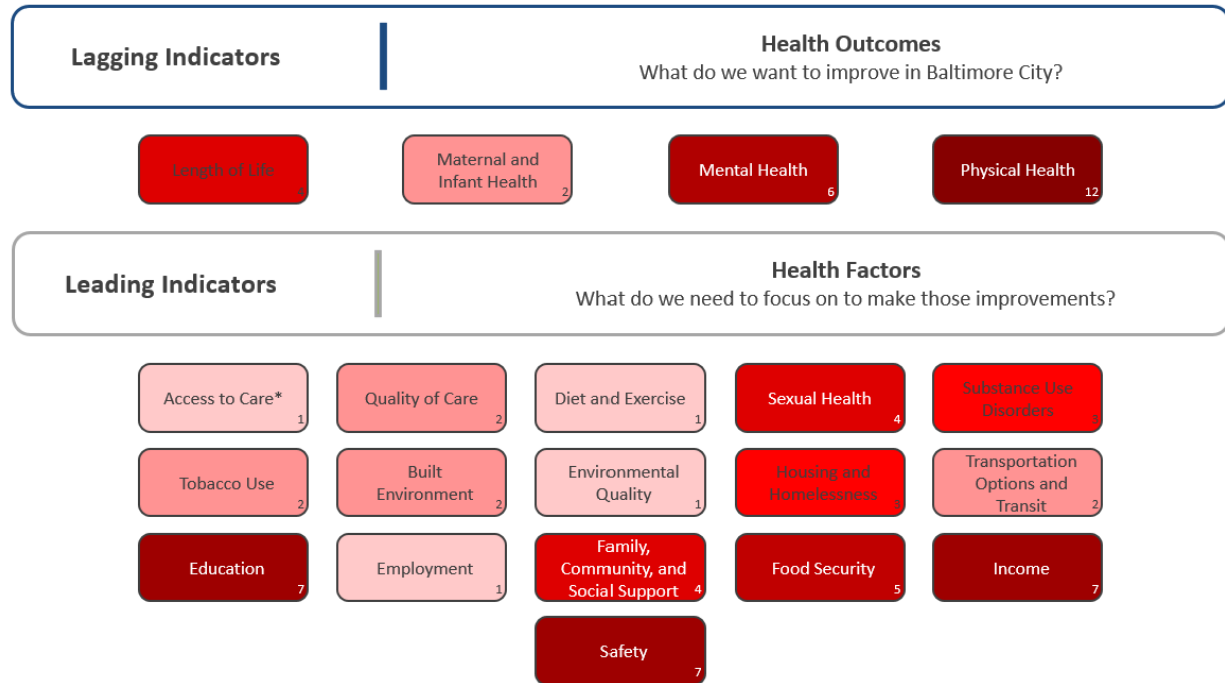
- Lack of safe and affordable transportation was described as a significant barrier to healthcare
- Transportation challenges also impact community members' ability to find high-paying jobs



Safety

- Gun violence and overall crime were noted as barriers to healthy living throughout the city
- Many participants expressed little faith in the ability of local police to address safety concerns

Focus Group Findings by Category



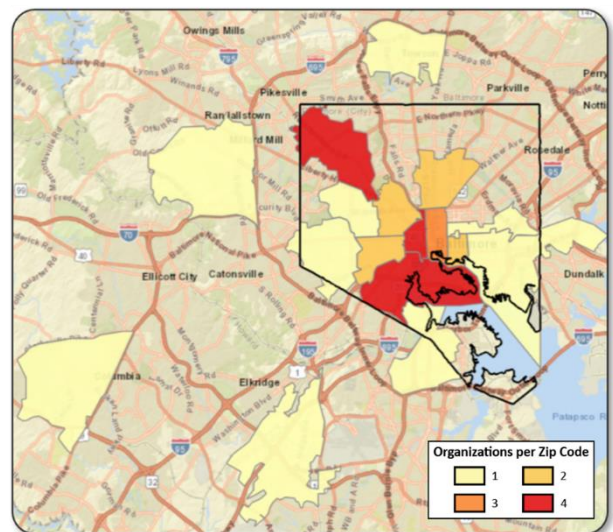
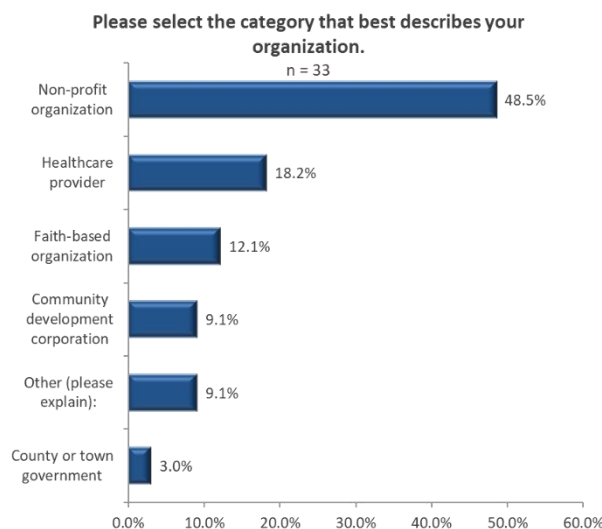
Key Leader Web Survey

A total of 33 key leaders completed the web-based Key Leader Survey, which was live from September 5, 2023 to November 17, 2023.

Key leaders represented a variety of organizations with geographies throughout Baltimore City. Broad categories included:

- Not-for-profit partners
- Government officials
- Healthcare providers
- Academic partners
- First responders
- Business leaders

The chart below shows the distribution of Key Leader survey respondents by type of organization. The map below shows the geographic distribution of Key Leader survey respondents based on the ZIP code in which the organization they represent is located.



In general, survey questions focused on the following topics:

- Top community health needs of Baltimore City
- Top social drivers that impact health
- Availability of community resources
- Access to care (barriers to care and locations of care)
- Health literacy

The key findings from the Key Leader Survey are detailed below:

- Key leaders identified the top 3 health needs of Baltimore City as: mental health/suicide, housing and food security.

- Key leaders identified the following areas as having the most impact on health in the community: access to affordable housing, crime and violence, and access to healthy foods.
- Key leaders identified SDoH, cost of care and health literacy as the most significant barriers to care.
- Black or African American residents were identified as the community group in Baltimore City most in need of assistance.
- The most common suggestions for improving community health focused on improving affordability, awareness, and mental health resources, as well as increasing the presence of neighborhood clinics.

Charts detailing key findings from the Key Leader Survey are displayed below:

Figure A6.1
How do you believe the health of the community you serve has changed over the past three years?
n= 33

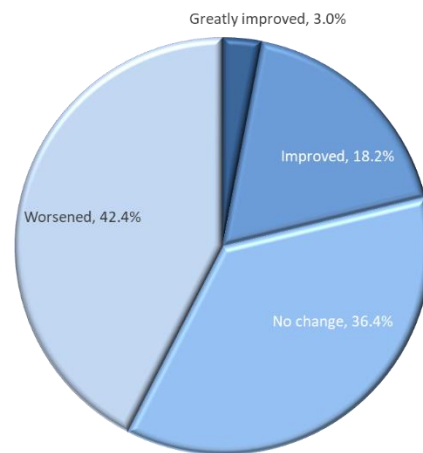


Figure A6.2
Please select the top FIVE (5) community health needs of the City of Baltimore.
n= 33

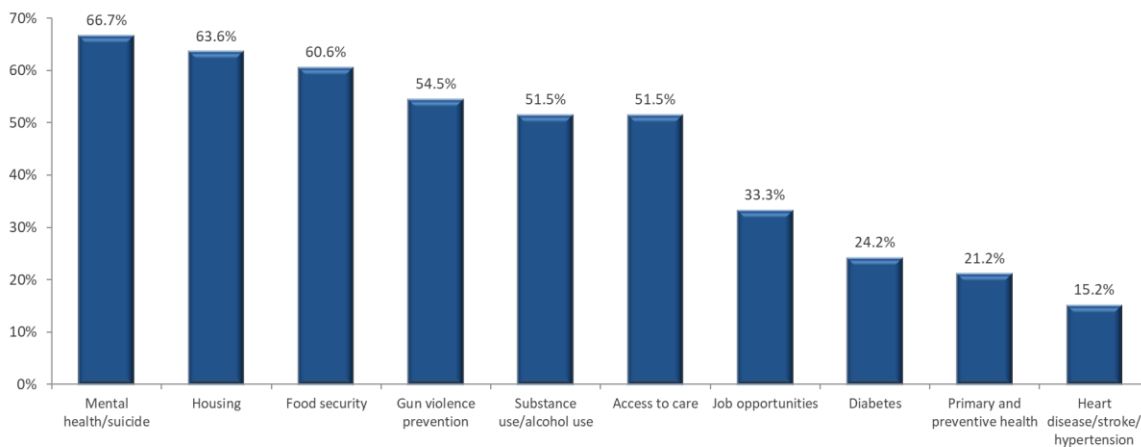


Figure A6.3

Please choose the top 5 social needs in the community you serve.
n= 33

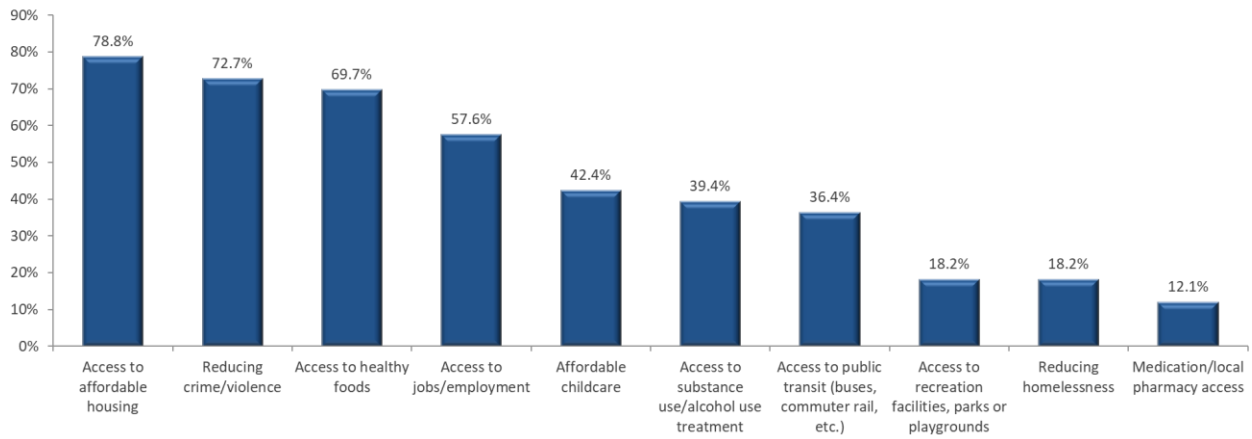


Figure A6.4

Choose the group(s) that needs more help in the community you serve. Choose *all that apply*.
n= 33

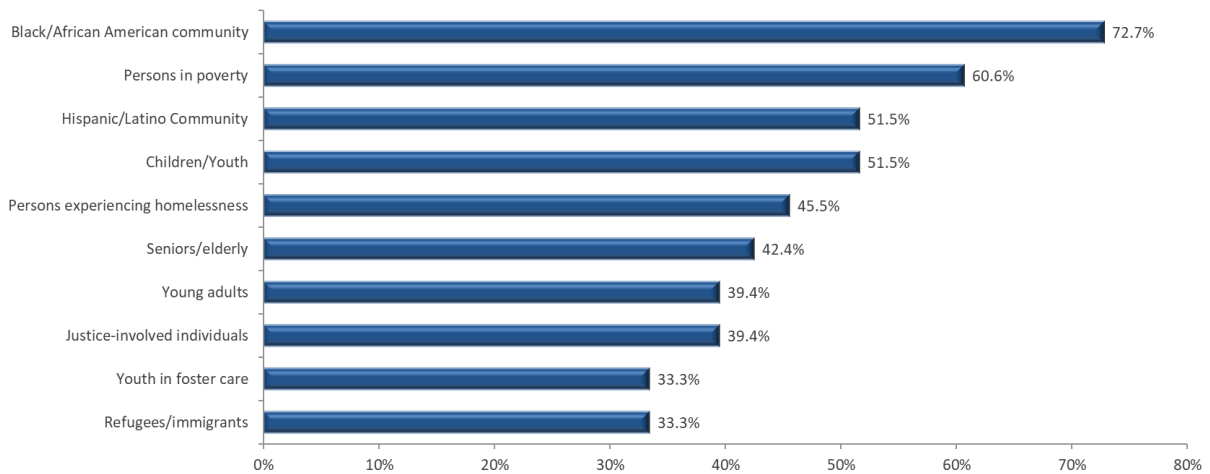


Figure A6.5

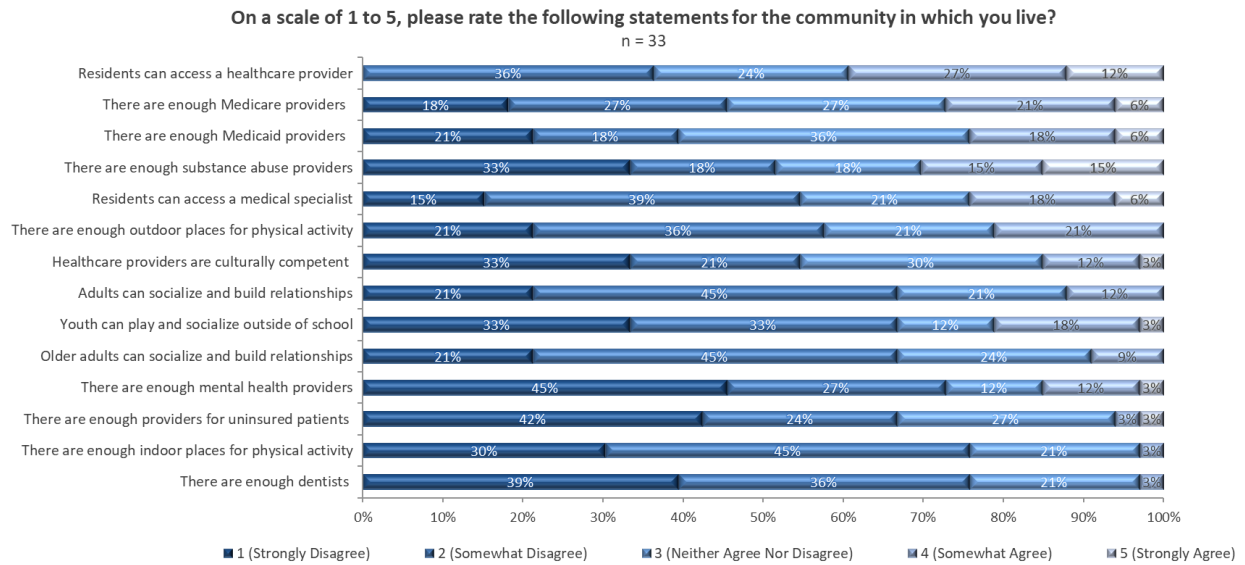


Figure A6.6

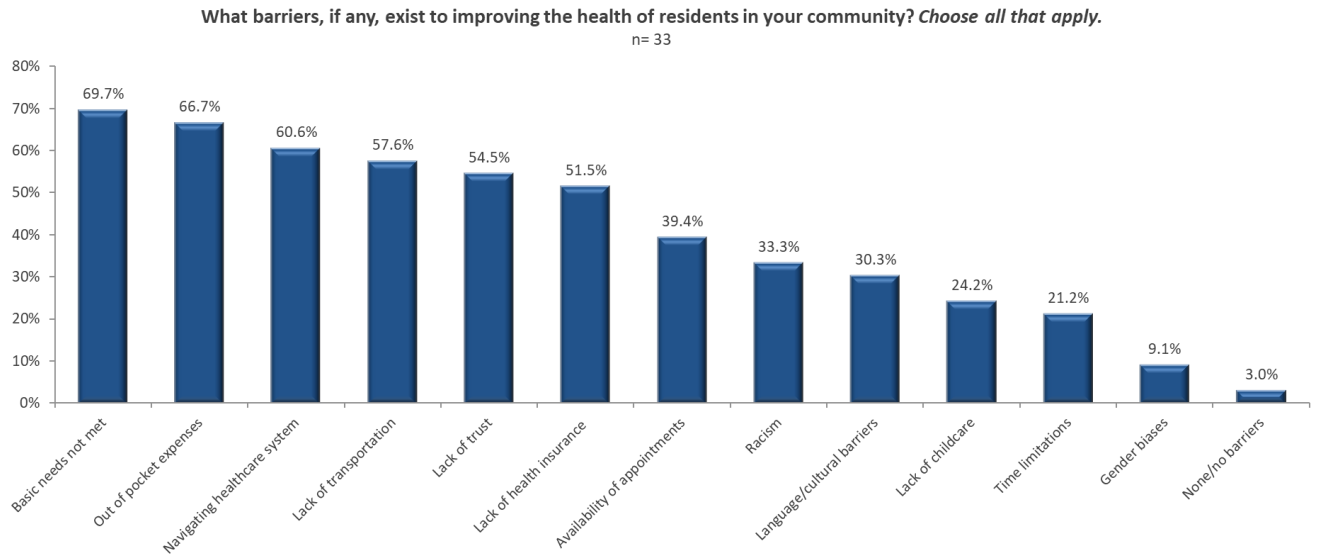


Figure A6.7

Do you feel that the residents of the community you serve are health literate? n = 33

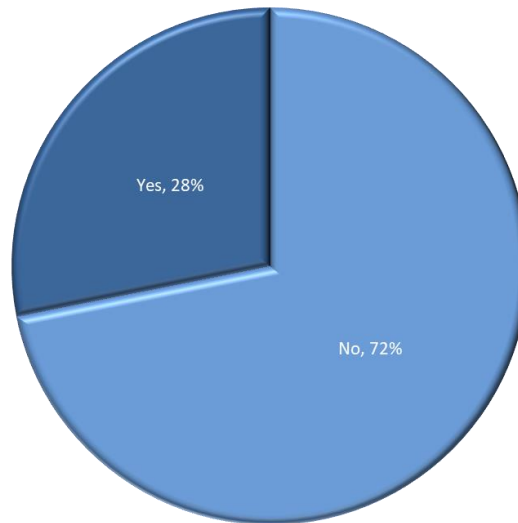
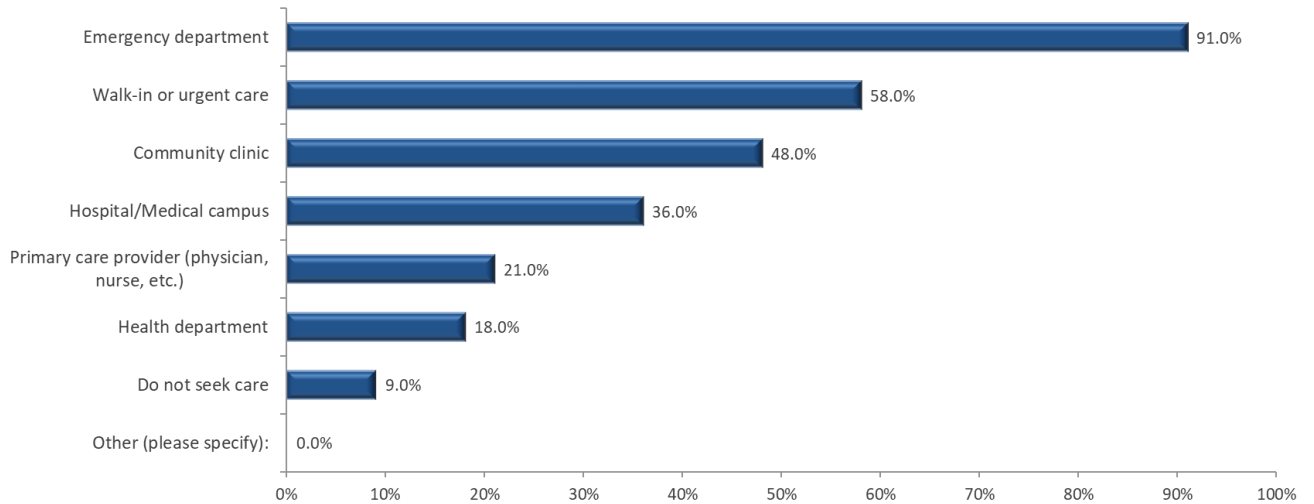


Figure A6.8

Members of your community typically seek medical care through... *Please select all that apply*
n= 33



The questions administered via the Key Leader Survey instrument are below:

City of Baltimore | 2024 Key Community Health Leader Survey

1. Please select the category that best describes your organization.

- a. Faith-based organization
- b. Non-profit organization
- c. Media
- d. County or town government
- e. Institute of higher education
- f. Healthcare provider
- g. Public – private partnership
- h. Community Development Corporation
- i. Other (please explain) _____

2. What is the ZIP code of your organization/facility? Please write 5-digit ZIP code.

3. How do you believe the health of the community you serve has changed over the past three years?

- a. Greatly improved
 - b. Improved
 - c. No change
 - d. Worsened
 - e. Greatly worsened
- [if “Greatly improved” or “Improved”] In what way(s) has the health of the community you serve improved?
 - [if “Greatly worsened” or “Worsened”] In what way(s) has the health of the community you serve worsened?

4. From the list provided, please rank the top FIVE (5) community health needs of Baltimore City.

- a. Access to Care
- b. Accidents (falls)
- c. Cancer
- d. Dental Health
- e. Diabetes
- f. Food security
- g. Gun violence prevention
- h. Heart Disease/Stroke/Hypertension
- i. Maternal/Infant Health
- j. Mental Health/Suicide
- k. Primary and Preventive Health Care
- l. Obesity
- m. Sexually Transmitted Disease

- n. Substance Use/Alcohol Use
 - o. Tobacco and Electronic Smoking Devices
 - p. Housing
 - q. Uninsured
 - r. Other (please explain)
 - s. None
 - t. Unsure/Do not know
 - u. Prefer not to respond
- 5. What resources are available in the community you serve to address the top health issues you identified?**
-
- 6. Please share any additional information regarding these health issues and your reasons for ranking them this way.**
-
- 7. In your opinion, which FIVE (5) of the following need the most improvement within the community you serve? If a need that requires the most improvement is not listed, please select "Other" and write it in.**
- a. Access to affordable housing
 - b. Access to healthy foods
 - c. Access to public transit (buses, commuter rail, etc.)
 - d. Access to recreation facilities, parks or playgrounds
 - e. Access to substance use/alcohol use treatment
 - f. Affordable childcare
 - g. Availability of alternative transportation options (biking, walking, carpooling, etc.)
 - h. Improved air quality
 - i. Improved water quality
 - j. Medication/local pharmacy access
 - k. Reducing homelessness
 - l. Reducing crime/violence
 - m. Language/Immigrant services
 - n. Other (please explain)
 - o. None
 - p. Unsure/Do not know
 - q. Prefer not to respond
- 8. Please share any additional information regarding these needs and your reasons for prioritizing them.**
-
- 9. In your opinion, which population sub-group(s) has the greatest need for additional resources within the community you serve? Please select all that apply. If a population sub-group that needs additional resources is not listed, please select "Other" and write it in.**

- a. Black/African American community
- b. Children/Youth
- c. Hispanic/Latino community
- d. LGBTQIA+ community
- e. Justice-involved individuals
- f. Persons experiencing homelessness
- g. Persons in poverty
- h. Persons with disabilities
- i. Refugees/Immigrants
- j. Seniors/Elderly
- k. Uninsured population
- l. Women in pregnancy
- m. Young adults
- n. Youth in foster care
- o. Other (please explain) _____
- p. None
- q. Unsure/Do not know
- r. Prefer not to respond

10. Please share any additional information regarding these population sub-group(s) and your reasons for choosing them.

11. On a scale of 1 to 5 (with 1 being strongly disagree and 5 being strongly agree), please rate each of the following statements for the community you serve:

- a. Residents can access a doctor, including nurse practitioners and physician assistants (Family/General Practitioner, Ob/Gyn, Pediatrician) when needed.
- b. Residents can access a medical specialist (Cardiologist, Dermatologist, etc.) when needed.
- c. There are enough providers accepting Medicaid in the community.
- d. There are enough providers accepting Medicare in the community.
- e. There are enough providers accepting patients without insurance in the community.
- f. There are enough dentists in the community.
- g. There are enough culturally competent healthcare providers in the community.
- h. There are enough mental health providers in the community.
- i. There are enough substance abuse treatment providers in the community.

12. From the list provided, where do you feel most members of the community you serve most often seek medical care? Choose all that apply.

- a. Community Clinic
- b. Hospital/Medical Campus
- c. Emergency Department
- d. Walk-in or Urgent Care
- e. Primary care provider (physician, nurse, etc.)
- f. Health department
- g. Other (please specify): _____

h. Do not seek care

13. Why do you think members of the community you serve primarily seek care in the location(s) you selected above? _____

14. What are the most significant barriers that keep people in the community you serve from accessing healthcare when they need it? Choose all that apply.

- a. Availability of providers/ appointments
- b. Basic needs not met (food/shelter)
- c. Gender biases
- d. Inability to navigate healthcare system
- e. Inability to pay out of pocket expenses (co pays, prescriptions)
- f. Lack of/limited childcare
- g. Lack of health insurance coverage
- h. Lack of/limited transportation
- i. Lack of trust
- j. Language/cultural barriers
- k. Racism
- l. Time limitations
- m. None/no barriers
- n. Other: _____

15. Please share any additional information regarding these barriers and your reasons for choosing them. _____

16. Do you believe health and social needs are similar across Baltimore City?

- a. Yes
- b. No
- c. Prefer not to answer

• [If “No”]:

- In your opinion, which geographic areas experience the greatest level of need?

- Please describe any unique health and social needs you have observed within these areas:

17. What challenges do older adults face in the community you serve?

18. Do you feel that the people in the community you serve are health literate, or able to understand health-related information?

- a. Yes
- b. No
- c. Prefer not to answer

19. What strategies do you find most effective in communicating information related to health or social needs to members of the community you serve?

20. On a scale of 1 to 5 (with 1 being strongly disagree and 5 being strongly agree), please rate each of the following statements for the community you serve:

- a. There are enough indoor places to get regular exercise or physical activity in the community you serve.
- [If disagree or strongly disagree]: Please share any additional information related to the answer you selected.
- b. There are enough outdoor places to get regular exercise or physical activity in the community you serve.
- [If disagree or strongly disagree]: Please share any additional information related to the answer you selected.

21. On a scale of 1 to 5 (with 1 being strongly disagree and 5 being strongly agree), please rate each of the following statements for the community you serve:

- a. Children and youth living in the community you serve have access to places to play and socialize outside of school.
- [If disagree or strongly disagree]: What strategies could help address loneliness or social isolation in children/youth in the community you serve?
- b. Adults in the community you serve have access to places to socialize and build relationships outside of work or home.
- [If disagree or strongly disagree]: What strategies could help address loneliness or social isolation in adults in the community you serve?
- c. Older adults in the community you serve have access to places to socialize and build relationships outside of the home.
- [If disagree or strongly disagree]: What strategies could help address loneliness or social isolation in older adults in the community you serve?

22. Have you already gotten, or do you plan to get, your annual flu shot?

- a. Yes
- b. No
- c. Prefer not to answer

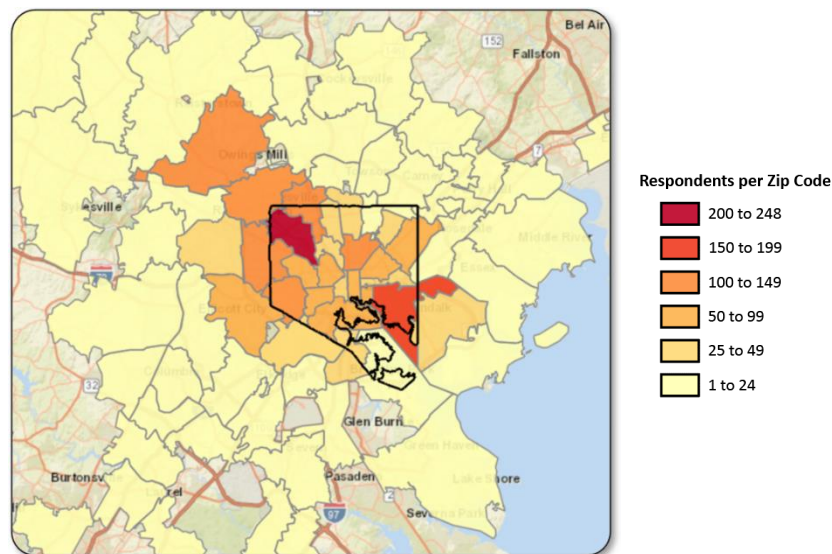
23. What ideas or suggestions do you have to improve health in the community you serve?

Thank you for completing the survey!

Community Survey

A total of 2,282 web-based surveys were completed by individuals living, working or receiving healthcare in the Baltimore City community. For the sake of accessibility, the survey was available in both English and Spanish. Approximately 13% of the surveys were completed in Spanish. Consistent with one of the survey process goals, survey community member respondents were representative of a broad geographic area encompassing areas throughout the city. The map below provides additional information on survey respondents' ZIP code of residence.

Figure A6.9: Survey Respondents by Zip Code of Residence



In general, survey questions focused on:

- Community health problems and concerns
- Community social/environmental problems and concerns
- Access to healthcare
 - Barriers to care
 - Health insurance status
 - Locations of care
 - Telehealth
 - Pediatric care

The key findings from the Community Survey are detailed below:

- Community members identified the top 3 health needs of Baltimore City as substance use, high blood pressure and diabetes.
- Relative to areas that have the most impact on health, community members mentioned: access to healthy foods, and violence and safety.
- Community members identified cost of care as the largest barrier to health in the community.

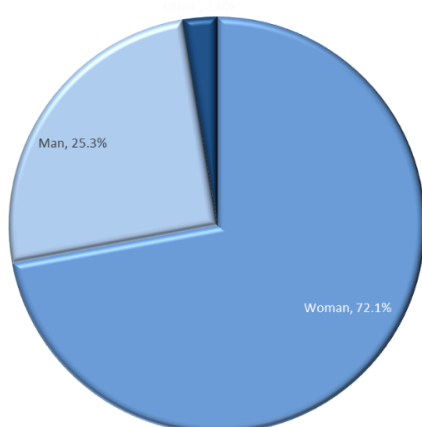
- The most common suggestions for improving community health were increasing affordability, awareness, childcare, transportation, mental health resources, community programming, education, and language support, as well as increasing the number of neighborhood clinics and decreasing violence.

Charts detailing key findings from the Community Member Survey are displayed below:

Figure A6.10

What term best expresses how you describe your gender identity?

n= 2,282



What is your age?

n= 2,280

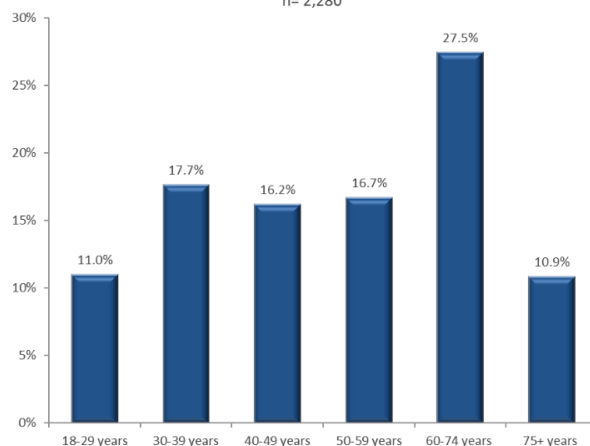
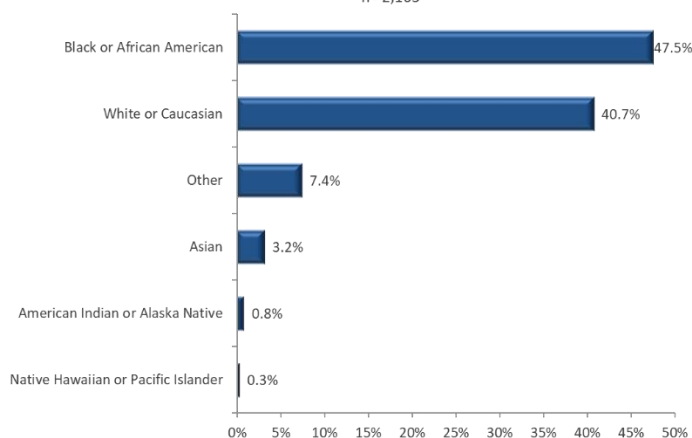


Figure A6.11

What is your race?

n= 2,165



What is your ethnicity?

n= 2,213

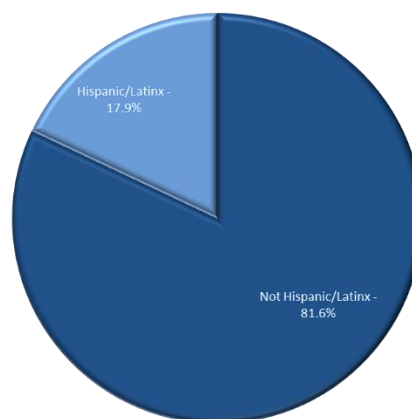


Figure A6.12

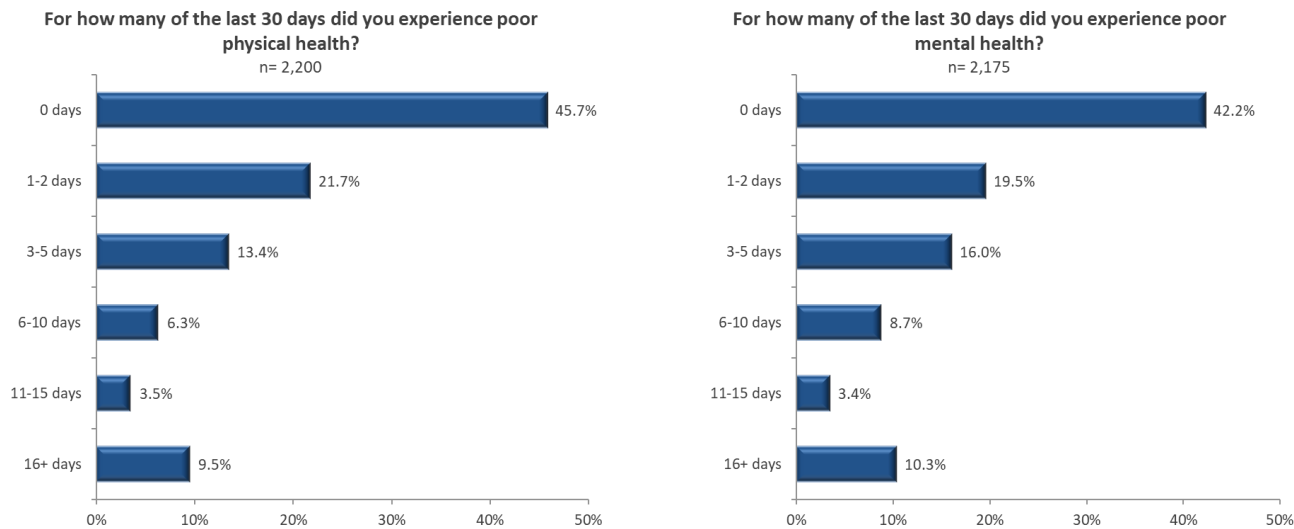


Figure A6.13

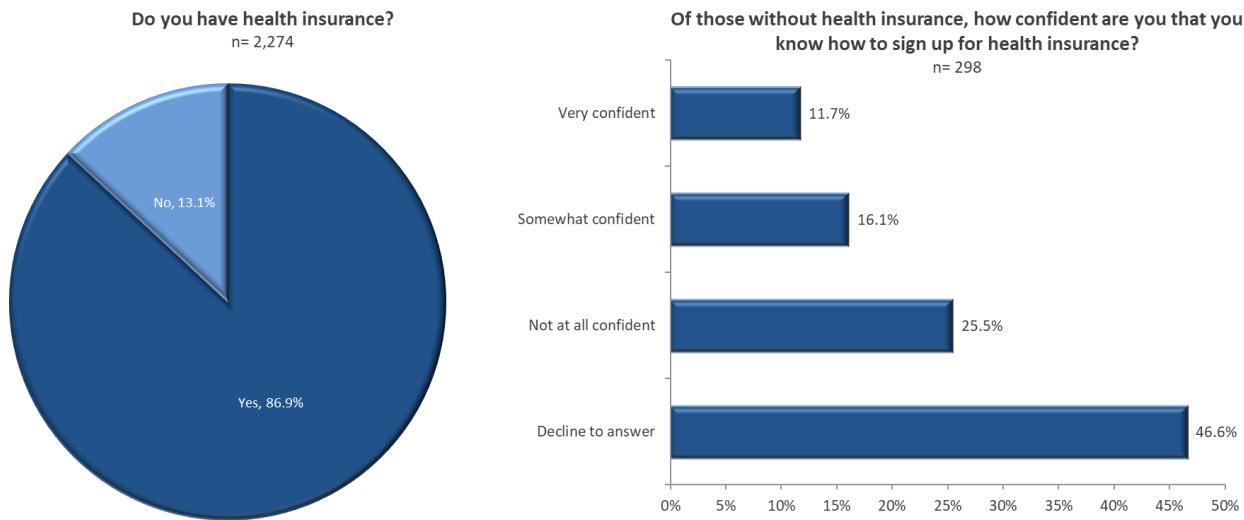


Figure A6.14

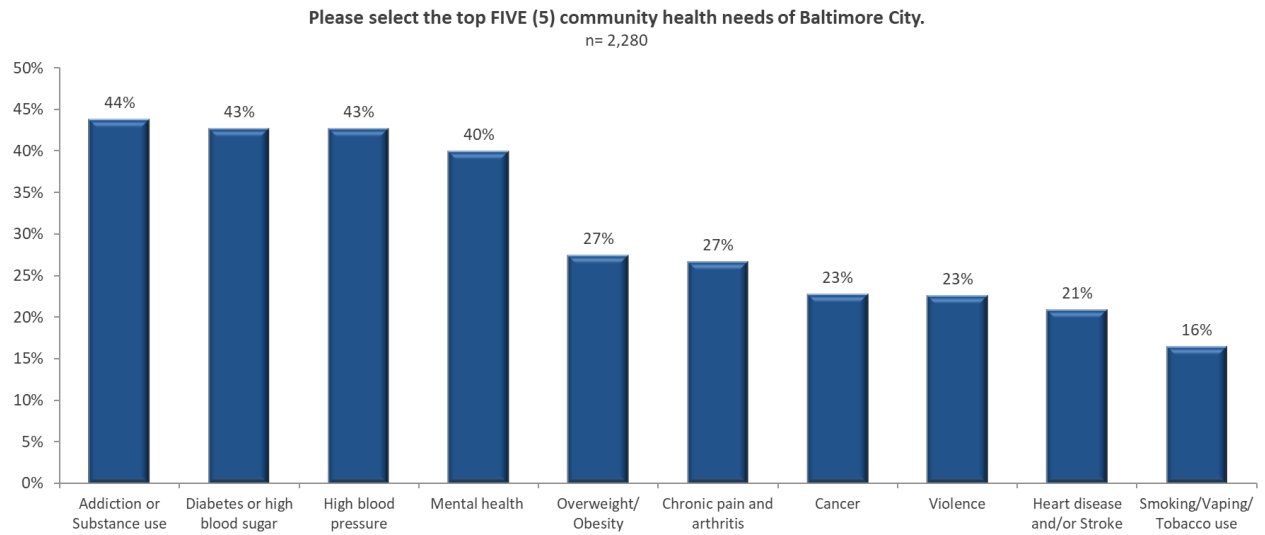


Figure A6.15

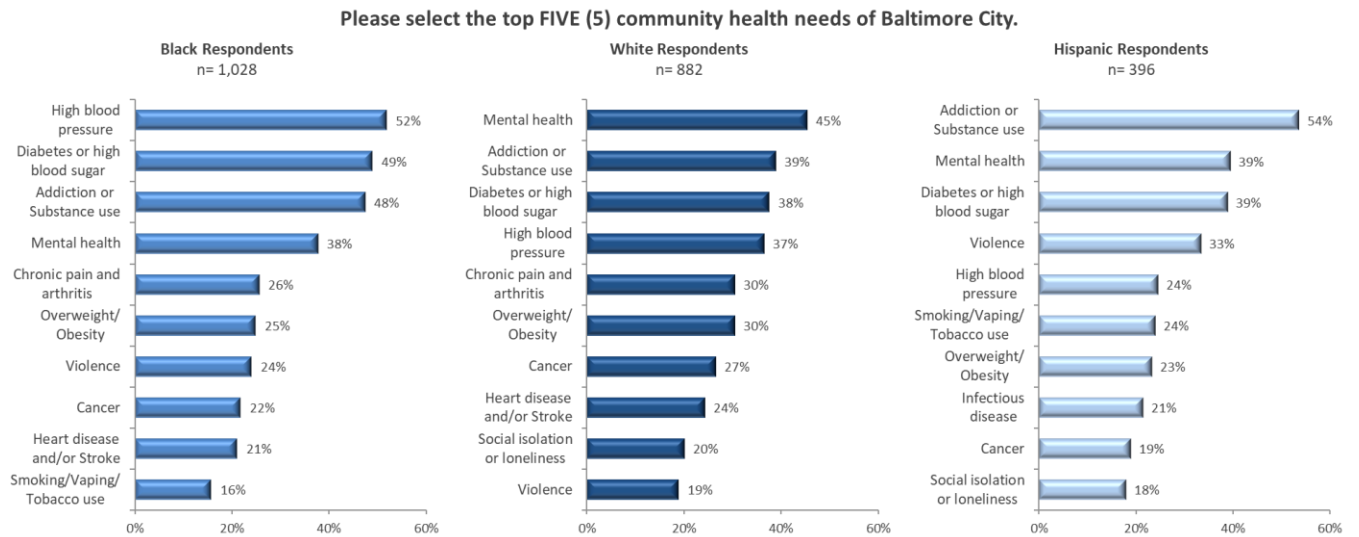


Figure A6.16

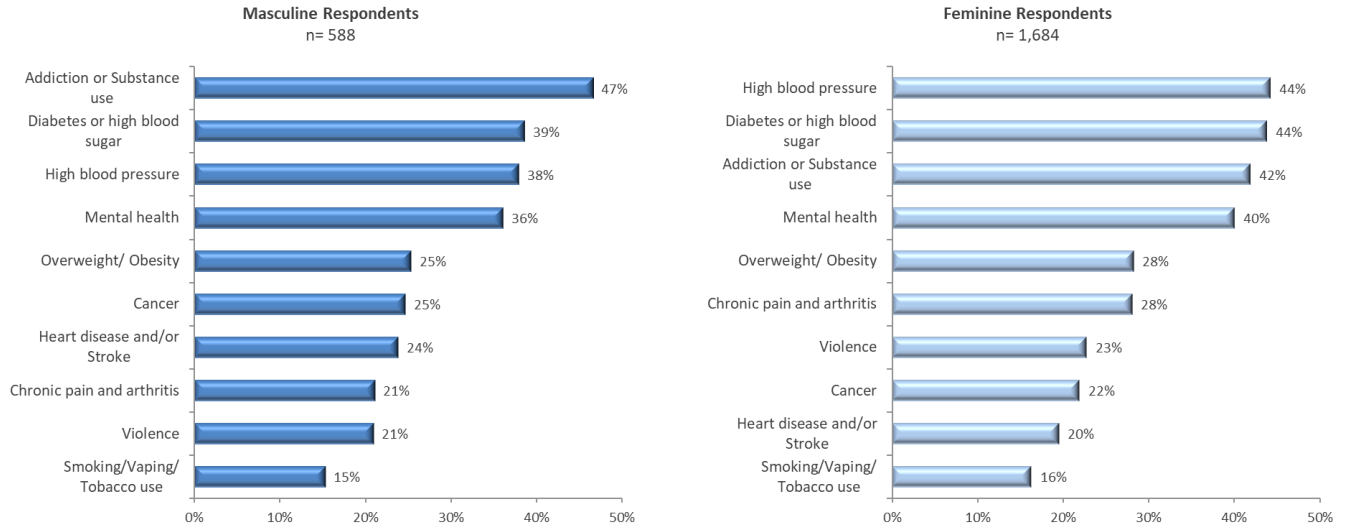


Figure A6.17

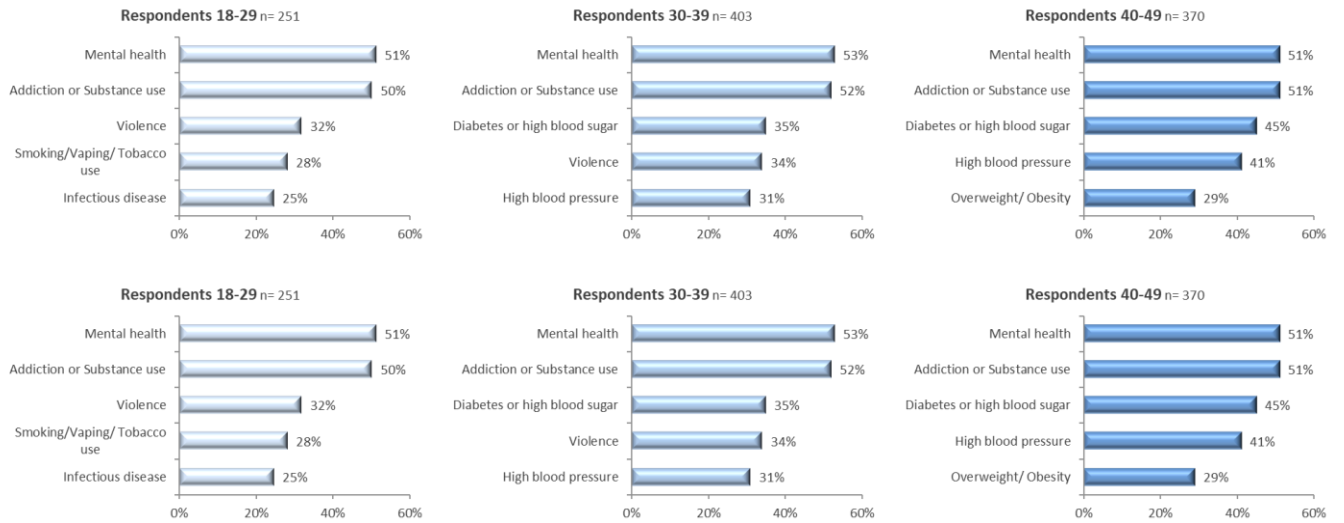


Figure A6.18

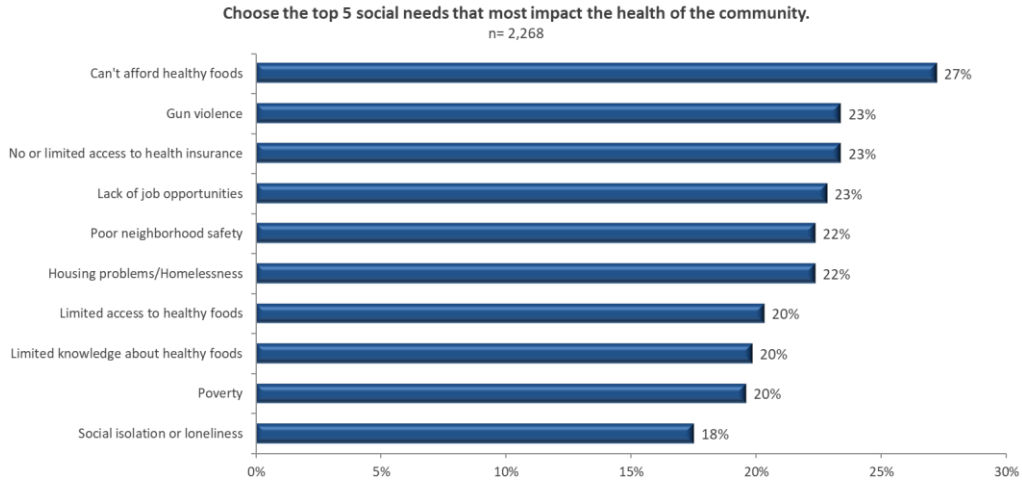


Figure A6.19

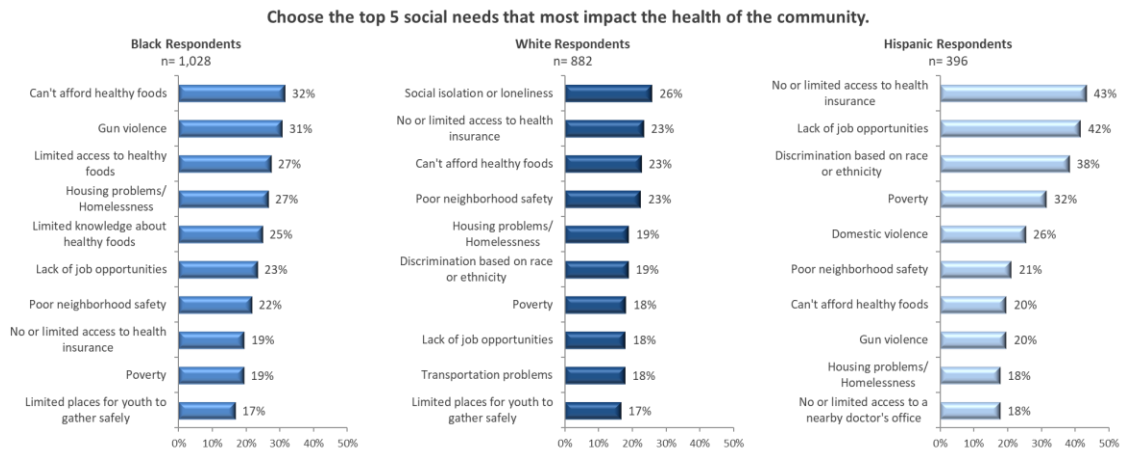


Figure A6.20

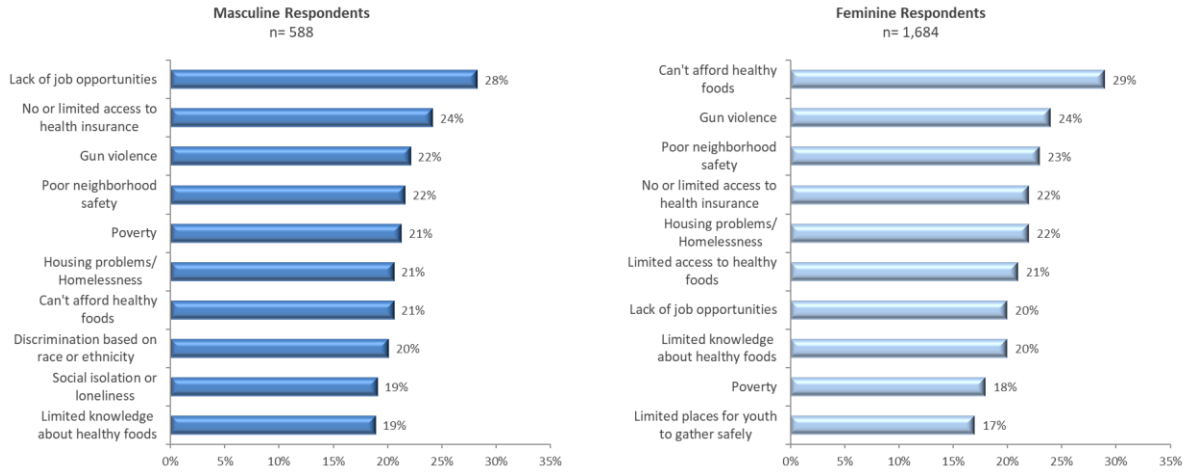


Figure A6.21

Choose the top 5 social needs that most impact the health of the community.

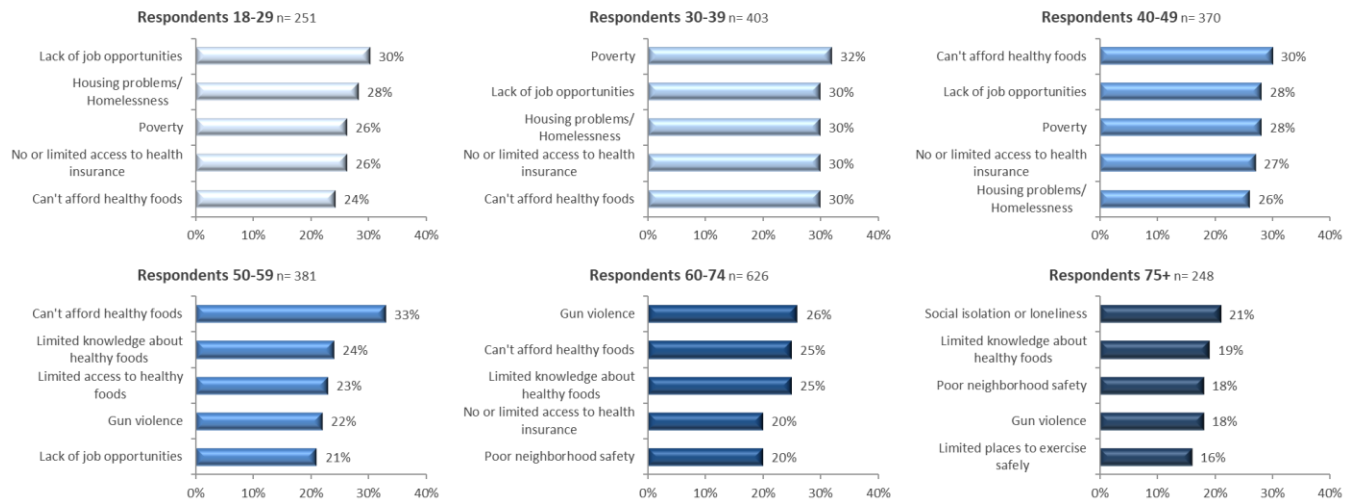


Figure A6.22

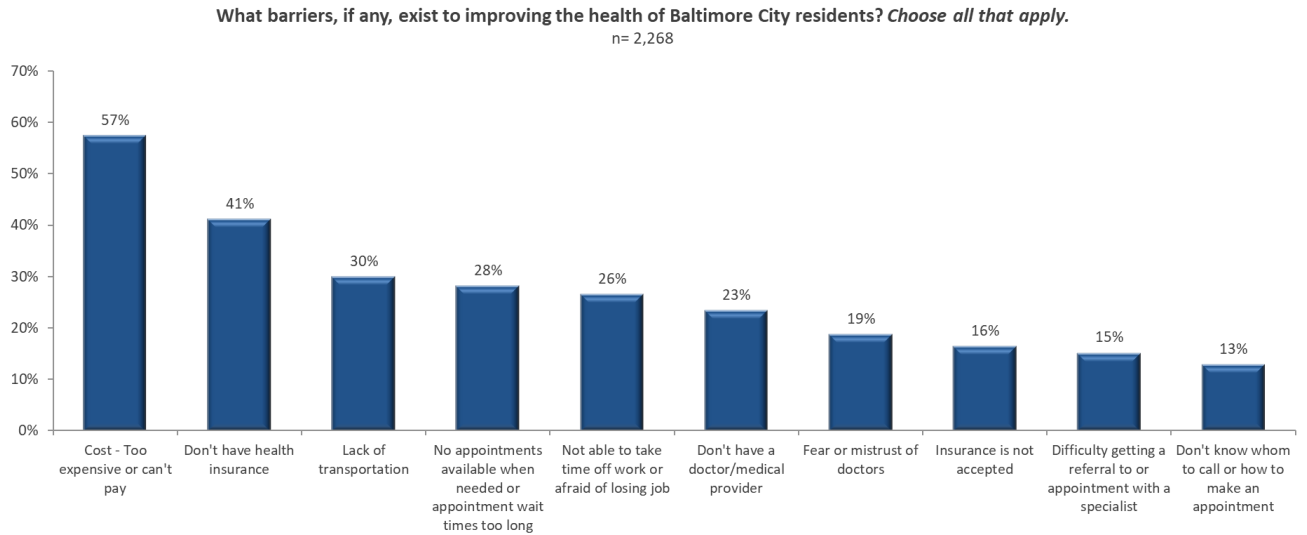


Figure A6.23

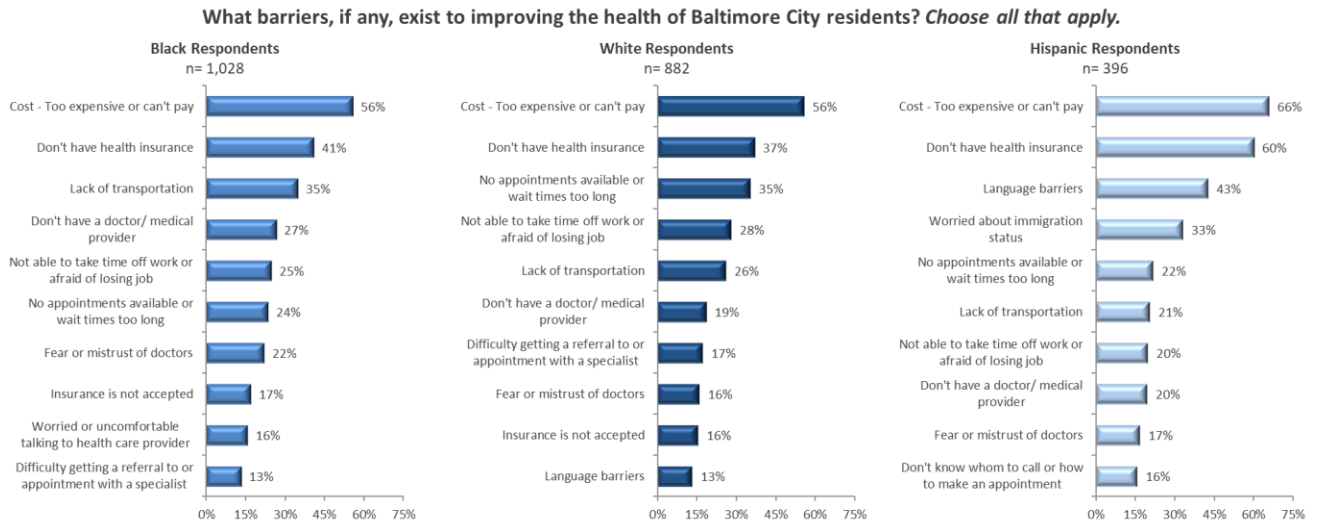


Figure A6.24

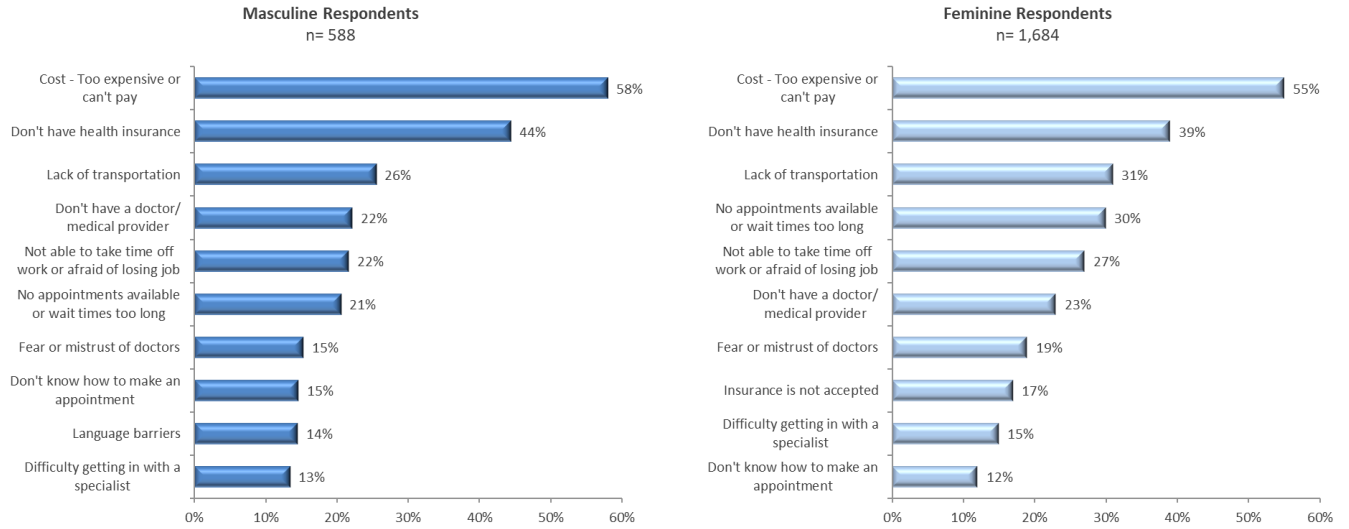


Figure A6.25

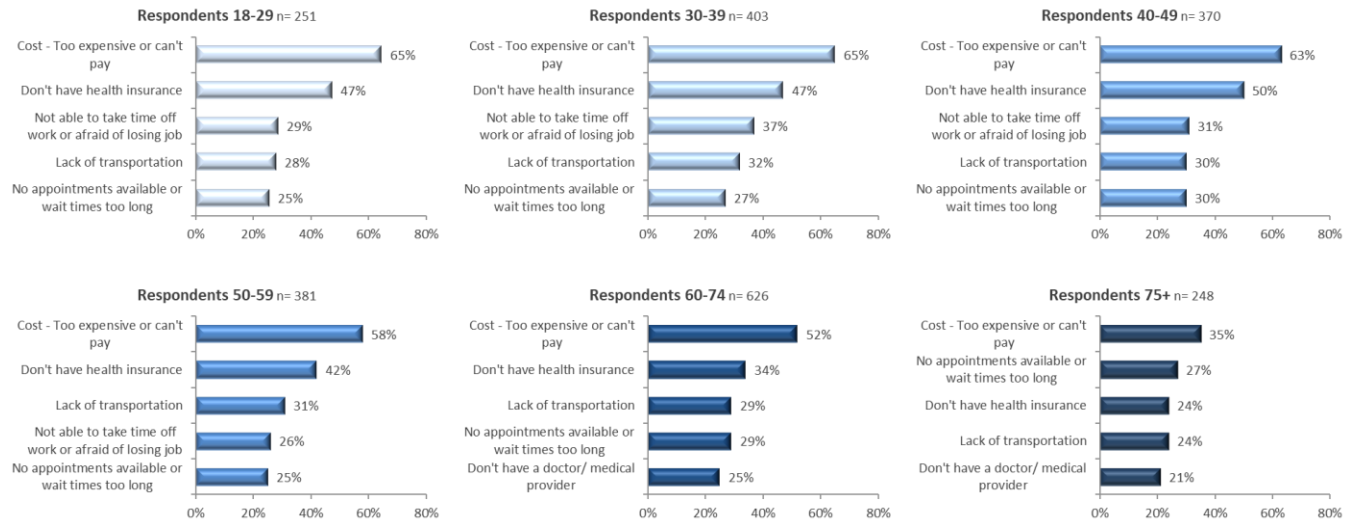


Figure A6.26

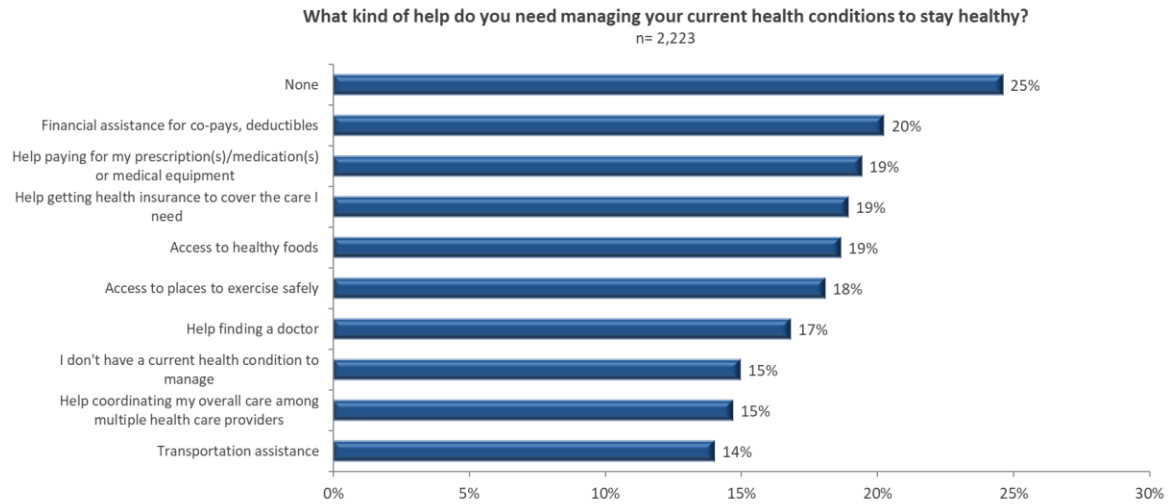


Figure A6.27

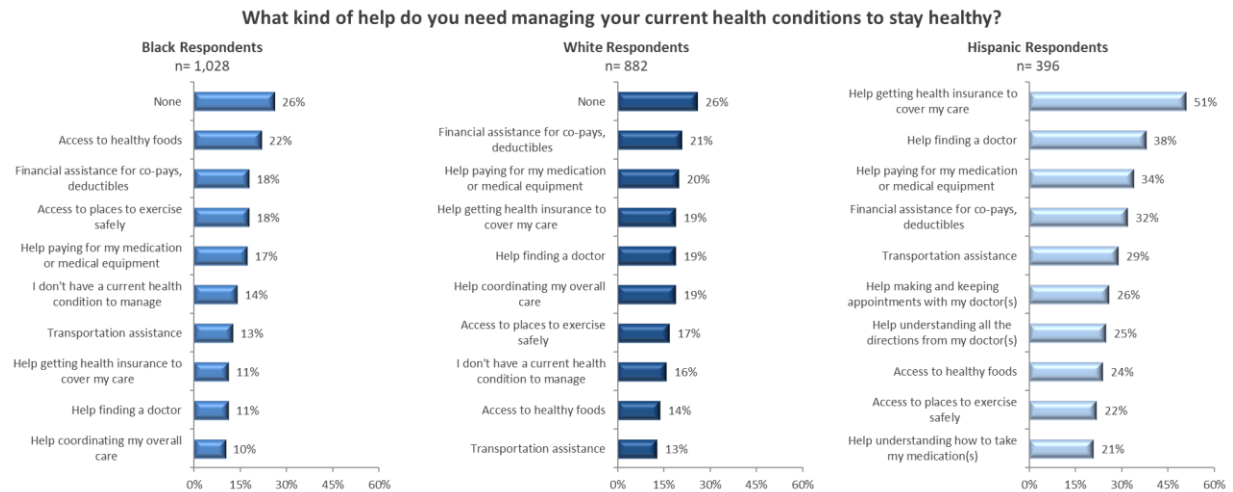


Figure A6.28

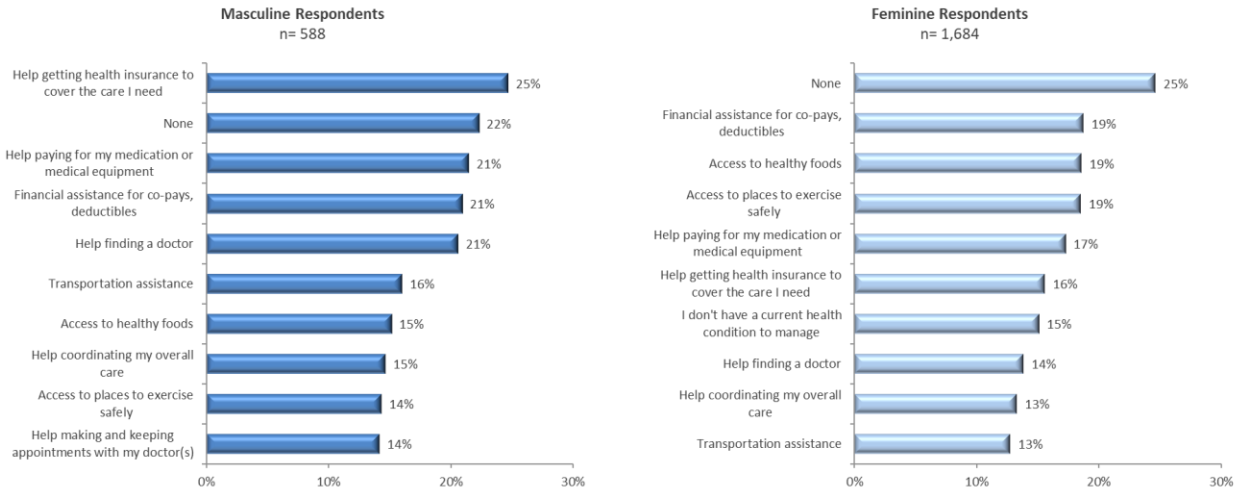


Figure A6.29

What kind of help do you need managing your current health conditions to stay healthy?

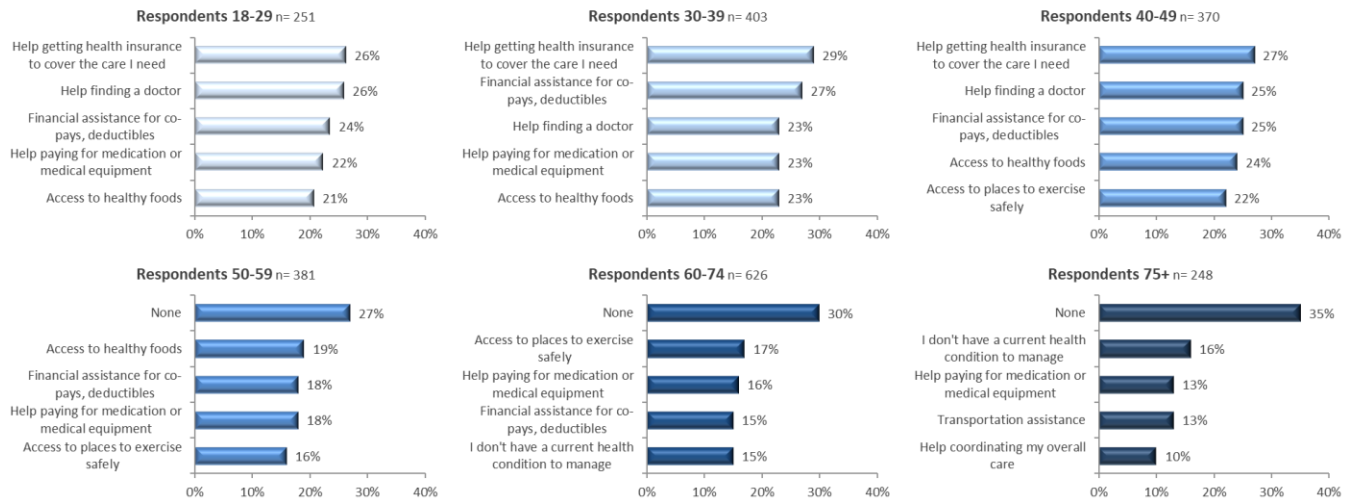


Figure A6.30

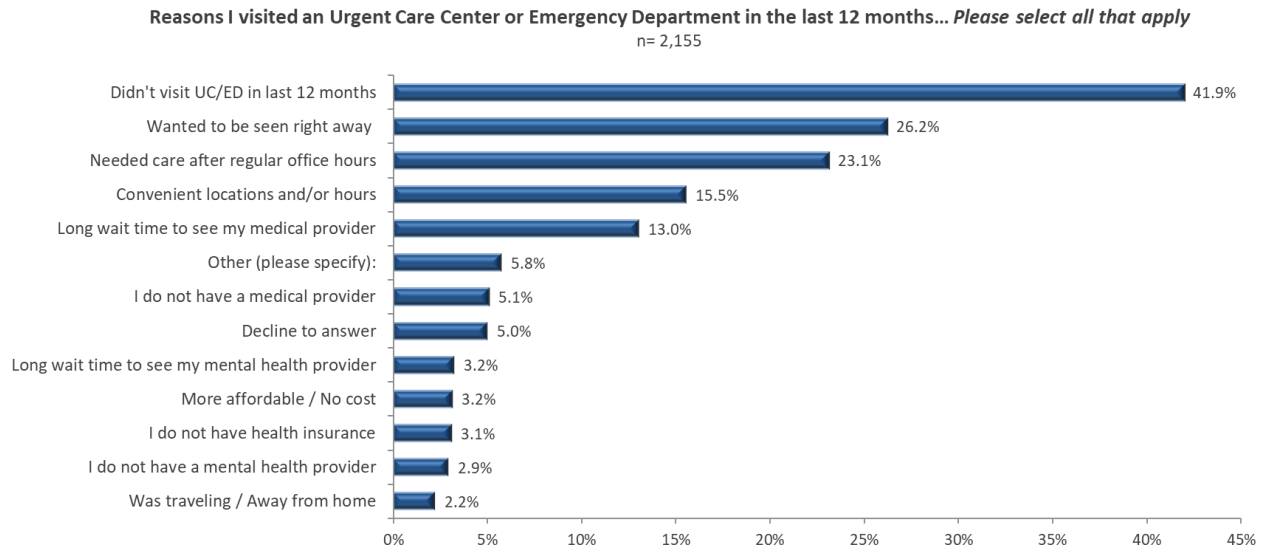


Figure A6.31

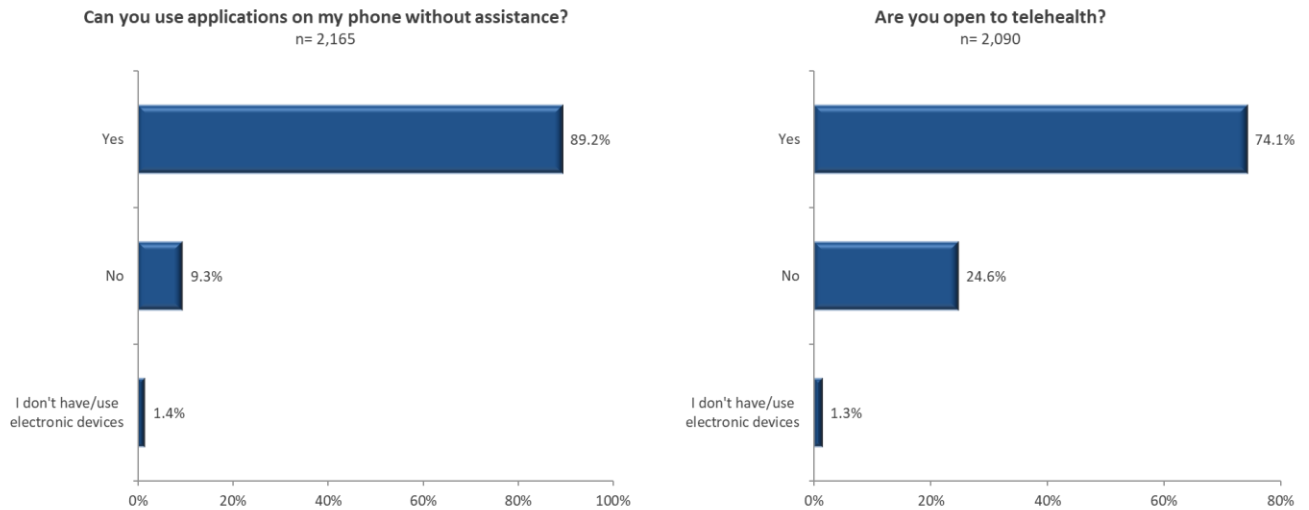
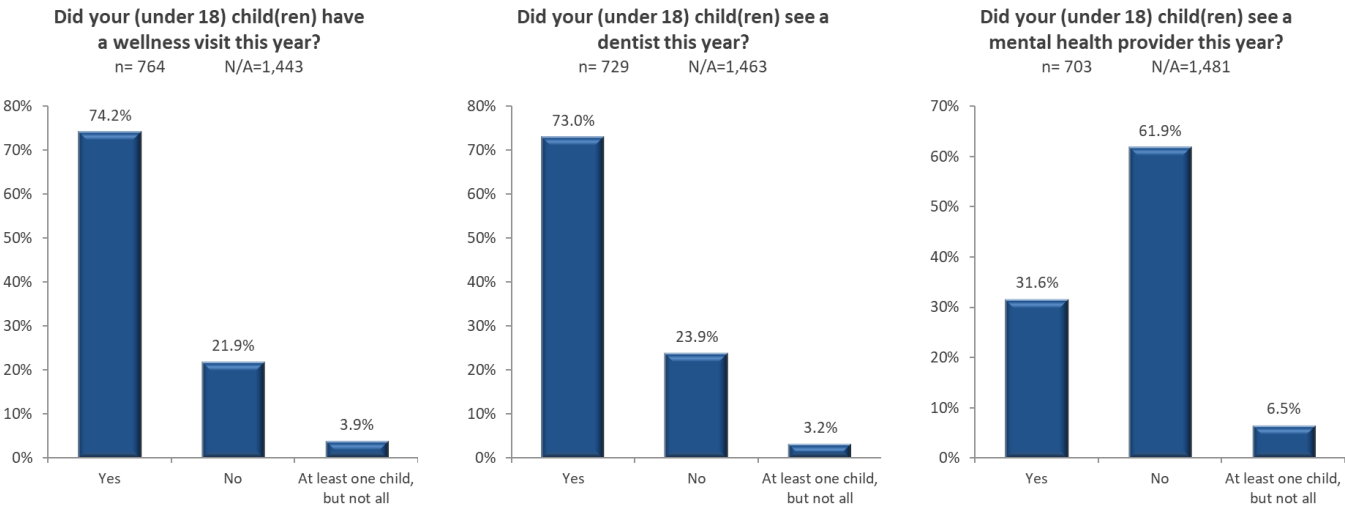


Figure A6.32



The questions administered via the Community Member Survey instrument are below:

1. What is your ZIP code?

Please write 5-digit ZIP code. _____

2. Which neighborhood do you live in?

Please select one of the options listed.

- | | | |
|--|--|---|
| ☐ Allendale/Irvington/S. Hilton | ☐ Greater Roland Park/Poplar Hill | ☐ Patterson Park North & East |
| ☐ Beechfield/Ten Hills/West Hills | ☐ Greater Rosemont | ☐ Penn North/Reservoir Hill |
| ☐ Belair-Edison | ☐ Greentown/Bayview | ☐ Pigtown/Carroll Park |
| ☐ Brooklyn/Curtis Bay/Hawkins Point | ☐ Hamilton | ☐ Pimlico/Arlington/Hilltop |
| ☐ Canton | ☐ Hamilton Hills | ☐ Poppleton/The Terraces/ Hollins Market |
| ☐ Cedonia/Frankford | ☐ Hampden/Remington | ☐ Sandtown-Winchester/ Harlem Park |
| ☐ Cherry Hill | ☐ Harbor East/Little Italy | ☐ South Baltimore |
| ☐ Chinquapin Park/Belvedere | ☐ Highlandtown | ☐ Southeastern |
| ☐ Clifton-Berea | ☐ Howard Park/West Arlington | ☐ Southern Park Heights |
| ☐ Cross-Country/Cheswolde | ☐ Inner Harbor/Federal Hill | ☐ Southwest Baltimore |
| ☐ Dickeyville/Franklinton | ☐ Loch Raven | ☐ The Waverlies |
| ☐ Dorchester/Ashburton | ☐ Madison/East End | ☐ Upton/Druid Heights |
| ☐ Downtown/Seton Hill | ☐ Midtown | ☐ Westport/Mount Winans/ Lakeland |
| ☐ Edmondson Village | ☐ Midway/Coldstream | ☐ Other (<i>please specify</i>): _____ |
| ☐ Fells Point | ☐ Morrell Park/Violetville | ☐ Don't know |
| ☐ Forest Park/Walbrook | ☐ Mount Washington/Coldspring | ☐ Decline to answer |
| ☐ Glen-Fallstaff | ☐ North Baltimore/Guilford/Homeland | |
| ☐ Greater Charles Village/Barclay | ☐ Northwood | |
| ☐ Greater Govans | ☐ Oldtown/Middle East | |
| ☐ Greater Lauraville | ☐ Oliver/Johnson Square | |
| ☐ Greater Mondawmin | ☐ Orchard Ridge/Armistead | |

3. What is your age group (years)?

Please select one.

- ☐ 18-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60-74
- ☐ 75+
- ☐ Don't know
- ☐ Decline to answer

4. What is your race?

Please select all that apply.

- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ White or Caucasian
- ☐ Asian
- ☐ Other, *specify* _____
- ☐ Don't know
- ☐ Decline to answer

5. Are you Hispanic or Latino/a?

Please select one.

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Decline to answer

6. Do you think of yourself as:

Please select one.

- ☐ Male
- ☐ Female
- ☐ Transgender man
- ☐ Transgender woman
- ☐ Gender queer/gender nonconforming, i.e., neither exclusively male nor female
- ☐ Additional gender category (or other) (*please specify*): _____
- ☐ Don't know
- ☐ Decline to answer

8. Do you think of yourself as:

Please select one.

- ☐ Straight or heterosexual
- ☐ Lesbian or Gay
- ☐ Bisexual
- ☐ Queer
- ☐ Pansexual
- ☐ Questioning
- ☐ Something else (*please specify*): _____
- ☐ Don't know
- ☐ Decline to answer

9. Do you have health insurance?

Please select one.

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Decline to answer

10. If you don't have health insurance, how confident do you feel about knowing how to sign up for health insurance coverage?

Please select one.

- ☐ I have health insurance
- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not at all confident
- ☐ Don't know
- ☐ Decline to answer

11. Thinking about your physical health, which includes physical illness and injury, about how many days during the past 30 days was your physical health not good?

Please select one.

- ☐ None
- ☐ 1-2 days
- ☐ 3-5 days
- ☐ 6-10 days
- ☐ 11-15 days
- ☐ 16 or more days
- ☐ Don't know
- ☐ Decline to answer

12. Thinking about your mental health, which includes stress, depression, and problems with emotions, about how many days during the past 30 days was your mental health not good?

Please select one.

- ☐ None
- ☐ 1-2 days
- ☐ 3-5 days
- ☐ 6-10 days
- ☐ 11-15 days
- ☐ 16 or more days
- ☐ Don't know
- ☐ Decline to answer

13. What do you think are the top 5 health issues that affect people the most in the neighborhood where you live? Please select up to five.

- ☐ Addiction/Substance use
- ☐ Alzheimer's Disease/dementia
- ☐ Cancer
- ☐ Children with illnesses
- ☐ Chronic pain & arthritis
- ☐ Diabetes/High blood sugar
- ☐ Falls
- ☐ Heart disease/Stroke
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Infant death
- ☐ Infectious disease (e.g., COVID, flu, hepatitis)
- ☐ Lung disease/Asthma/COPD
- ☐ Maternal health/Reproductive health
- ☐ Mental health (e.g., depression, anxiety, suicide, PTSD, trauma)
- ☐ Overweight / Obesity
- ☐ Preventable injuries
- ☐ Sexually transmitted infections
- ☐ Smoking/ Vaping/Tobacco use
- ☐ Social isolation / Loneliness
- ☐ Violence
- ☐ Other (please specify):

-
- ☐ None
 - ☐ Don't know
 - ☐ Decline to answer

14. What do you think are the top 5 social/environmental problems that affect the health of people the most in the neighborhood where you live? Please select up to five.

- ☐ No or limited access to a nearby doctor's office
- ☐ No or limited access to health insurance
- ☐ Domestic violence
- ☐ Limited knowledge about healthy foods
- ☐ Limited access to healthy foods
- ☐ Can't afford healthy foods
- ☐ Limited access to/can't afford any food
- ☐ School dropout/Poor schools
- ☐ Lack of job opportunities
- ☐ Racial/Ethnicity discrimination
- ☐ Social isolation/Loneliness
- ☐ Child abuse/Neglect
- ☐ Elder abuse/Neglect
- ☐ Lack of affordable childcare
- ☐ Housing problems/Homelessness
- ☐ Poor neighborhood safety
- ☐ Gun violence
- ☐ Poverty
- ☐ Limited places to exercise safely
- ☐ Limited places for youth to gather safely
- ☐ Transportation problems
- ☐ Other (please specify): _____
- ☐ None
- ☐ Don't know
- ☐ Decline to answer

15. What are the top 5 reasons people in your neighborhood *do not get* health care when they need it?

Please select up to five.

- ☐ Cost – Too expensive / Can't pay
- ☐ Don't have health insurance
- ☐ Insurance is not accepted
- ☐ Don't have a doctor/medical provider
- ☐ No doctor/medical provider nearby
- ☐ Don't know whom to call or how to make an appointment
- ☐ No appointments available when needed/Wait for an appointment is too long
- ☐ Lack of transportation
- ☐ Lack of / Limited childcare
- ☐ Language barrier
- ☐ Worried about immigration status
- ☐ Fear or mistrust of doctors
- ☐ Difficulty getting a referral to or appointment with a specialist
- ☐ Not able to take time off work/Afraid of losing job
- ☐ Worried or uncomfortable telling a health care provider about my health problem
- ☐ Cultural / Religious beliefs
- ☐ Other (*please specify*): _____
- ☐ People do not have any issues accessing health care
- ☐ None
- ☐ Don't know
- ☐ Decline to answer

16. What kind of help do you need managing your current health conditions (for example, heart conditions, high blood pressure, stroke, diabetes, asthma, cancer, COPD, congestive heart failure, arthritis, HIV, depression, anxiety, other mental health condition, etc.) to stay healthy?

Please choose all that apply.

- | | |
|--|--|
| ☐ I don't have a current health condition to manage | ☐ Help coordinating my overall care among multiple health care providers |
| ☐ Help getting health insurance to cover the care I need | ☐ Access to healthy foods |
| ☐ Help finding a doctor | ☐ Access to places to exercise safely |
| ☐ Help making and keeping appointments with my doctor(s) | ☐ Transportation assistance |
| ☐ Help understanding all the directions from my doctor(s) | ☐ Financial assistance for co-pays, deductibles |
| ☐ Help understanding how to take my medication(s) | ☐ Home modification assistance (for example, installing a wheelchair ramp or a handicapped-accessible shower) |
| ☐ Help paying for my prescription(s)/medication(s) or medical equipment | ☐ Other (<i>please specify</i>): _____ |
| ☐ Health care in my home | ☐ None |
| | ☐ Don't know |
| | ☐ Decline to answer |

17. If you visited an Urgent Care Center or Emergency Department in the past 12 months instead of going to your medical provider, what was your reason?

Please choose all that apply.

- ☐ Didn't visit Urgent Care or Emergency Dept in last 12 months
- ☐ Needed care after regular office hours
- ☐ Convenient locations and/or hours
- ☐ Wanted to be seen right away/No wait time for appointments
- ☐ I do not have a medical provider
- ☐ Couldn't get a timely appointment with my medical provider
- ☐ I do not have a mental health provider
- ☐ Couldn't get a timely appointment with my mental health provider
- ☐ I do not have health insurance
- ☐ More affordable/No cost
- ☐ Was traveling/Away from home
- ☐ Other (*please specify*): _____
- ☐ Don't know
- ☐ Decline to answer

18. I can use applications on my computer, cell phone, or another electronic device on my own without asking for help from someone else.

Please select one.

- ☐ Agree
- ☐ Disagree
- ☐ Don't have/use electronic devices
- ☐ Don't know
- ☐ Decline to answer

19. I am open to participating in "telehealth," i.e., having my health assessed and managed virtually through a phone and/or electronic device.

Please select one.

- ☐ Agree
- ☐ Disagree
- ☐ Don't have/use electronic devices
- ☐ Don't know
- ☐ Decline to answer

20. Did your child/ren (under 18 years old) have a yearly wellness visit with a medical provider in the past 12 months?

Please select one.

- ☐ Yes
- ☐ No
- ☐ At least one child, but not all
- ☐ I don't have any children under 18 years old
- ☐ Don't know
- ☐ Decline to answer

21. Did your child/ren (under 18 years old) receive a regular dental checkup at least once in the past 12 months?

Please select one.

- ☐ Yes
- ☐ No
- ☐ At least one child, but not all
- ☐ I don't have any children under 18 years old
- ☐ Don't know
- ☐ Decline to answer

22. In the past 12 months, did your child/ren (under 18 years old) need help from a doctor, therapist, counselor, or social worker for emotional or mental health problems or challenges such as feeling sad, depressed, angry or anxious?

Please select one.

- ☐ Yes
- ☐ No
- ☐ At least one child, but not all
- ☐ I don't have any children under 18 years old
- ☐ Don't know
- ☐ Decline to answer

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

Please write your answer.

Thank you for completing the survey!

APPENDIX 7 | PRIMARY DATA SUMMARY

Primary data findings are summarized in full by the table below.

	Priority Area	Community	Key Leaders	Focus Groups*
★	Access to Care	✓	✓	✓
★	Behavioral Health/Mental Health	✓	✓	✓
★	Food Insecurity	✓	✓	✓
	Housing and Homelessness	✓	✓	✓
★	Transportation and Transit	✓	✓	✓
★	Substance Use	✓	✓	
★	Chronic Diseases	✓	✓	
	Education			✓
★	Income and Employment	✓	✓	
	Health Equity		✓	
★	Overweight/Obesity	✓	✓	
	Mistrust in Healthcare System	✓	✓	
★	Violence and Safety		✓	✓

★ Top priority area from secondary data

*Focus group results are limited to the highest priority needs.



UNIVERSITY of MARYLAND
MEDICAL CENTER

**FY2024-
FY2026
Community
Health Needs
Assessment
Implementation
Plan**

Executive Summary

The FY2024 Community Health Needs Assessment (CHNA) represents the culmination of work completed by multiple individuals, groups, and the Collaborative, which includes the Baltimore City Health Department (BCHD) and local health systems such as Ascension St. Agnes (ASA), Johns Hopkins Health System (JHHS), Mercy Medical Center, MedStar Health, Mt. Washington Pediatric Hospital (MWPH), Grace Medical Center and Sinai and Levindale Hospitals of LifeBridge Health, and University of Maryland Medical Center (UMMC). The Collaborative partnered with Ascendent Health to complete the assessment and prioritization process.

The purpose of the needs assessment was to better understand, quantify, and articulate the health needs of Baltimore City residents. Key objectives of the CHNA include:

- Identify the health needs of Baltimore City residents.
- Identify disparities in health status and health behaviors, as well as inequities in the factors that contribute to health challenges.
- Understand the challenges residents face when trying to maintain and/or improve their health.
- Understand where underserved populations turn for services needed to maintain and/or improve their health.
- Understand what is needed to help residents maintain and/or improve their health.
- Prioritize the needs of the community and clarify/focus on the highest priorities.

This report includes the implementation strategy for (UMMC) that addresses the prioritized needs obtained from the CHNA. In addition, this document outlines plans for UMMC to support specific community benefit efforts as part of a larger community-wide and system plan. This plan also aligns with the joint strategic plan between UMMC and UMB and is unique in that the partnership has provided the opportunity to provide innovative and evidence-based programs that address social needs and strives to improve health disparity. Specifically, our mobile health screening and education programs, access to early detection lung cancer screening program, and proven strategies to address violence and workforce development are highlights of the plan.

HOW THIS IMPLEMENTATION STRATEGY WAS DEVELOPED

Community Health Needs Assessment

Process and Product

The CHNA was conducted in partnership with the Collaborative which includes the Baltimore City Health Department, and local health systems including Ascension St. Agnes (ASA), Johns Hopkins Health System (JHHS), Mercy Medical Center, MedStar Health, Mt. Washington Pediatric Hospital (MWPH), Grace Medical Center and Sinai and Levindale Hospitals of LifeBridge Health, and Ascendient Health. This written report describes:

- The community served
- Community demographics
- 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
- Information gaps that limit the hospital facility's ability to assess the community's health needs.

Sharing Results

Detailed findings for our assessment is posted on the UMMC website [\[insert hyperlink\]](#) and the Baltimore City Health Department website [\[insert hyperlinks\]](#) in [\[insert month/year\]](#). The CHNA was presented to the UMMC, Community Engagement Committee/ Board Subcommittee on June 4, 2024 for discussion and approval.

PRIORITY HEALTH NEEDS & HOW THEY WERE ESTABLISHED

Prioritization Process

Process & Criteria

Approximately fifty leaders from UMMC and the University of Maryland, Baltimore (UMB), including clinicians and the Community Anchor team, were included in a half day retreat held on April 12, 2024 to assess the data presented by Ascendient Health from the FY2024 CHNA. Leaders were then provided an opportunity to vote for their top 5 priorities based on criteria, such as documented unmet community health needs and UMMC's key strengths and resources. Goals, objectives, owners and partners were identified through breakout sessions. Fully developed plans were further developed and included in this report. All plans will include strategies to target both pediatric and adult populations as described below.

Identified Priorities

While there were numerous health and social needs that were documented in the FY2024 CHNA, UMMC has prioritized the following needs to address within this plan.

1. Access to Care
2. Chronic Disease Management
3. Mental Health & Substance Use
4. Maternal Health
5. Workforce Development & Income Generation
6. Violence Prevention

IMPLEMENTATION STRATEGY DETAILS

Priority Health Issue #1: Access to Care

Description of Community Need

Baltimore City ranks 24 out of 24 counties in Maryland for reported health outcomes and disease mortality rates. The top 5 barriers to access care include: cost, lack of insurance, lack of transportation, no access to available appointments, and don't have a medical provider. Nearly 25 percent of adults and children have not seen a physician in the last 12 months.

Desired Community Result

UMMC is committed to partnering with community agencies to improve residents' access to healthcare for children and adults. All Baltimore City residents, children and adults, should establish care in a medical home with a pediatrician/ family practice or primary care provider. Accessing care should be easy for the patient, and be provided through alternative sites such as mobile or telehealth to promote ease.

Partner Agencies and Roles

UMMC partner organizations will provide space and leadership to support community-based programs at their location. In addition, they will partner with UMMC (1) to identify patients (adults and children) who may not have access to a primary care provider and refer for services, and (2) identify resources or information to reduce barriers to care. The following organizations are key to success, but it is not comprehensive.

- YMaryland, Druid Hill
- Faith based organizations
- UMMC designated partner schools
- Baltimore City Senior Housing
- Baltimore City Community Centers
- Baltimore City Health Department
- The Community Builders, CityView @McCulloh Homes
- Public Markets (Lexington & Hollins)
- Other non-profits

Key Hospital Strategies (NOTE: This plan will address children and adults)

1. In alignment with the FY24-FY27 shared strategic plan (UMMC and UMB), develop a multi-service centralized health care delivery model to improve primary care, chronic disease management, and care coordination between caregivers, services and patients.
2. Address barriers to care:
 - a. Cost - provide guidance and instructions to finding health insurance in the community setting and in the provider office. In addition, partner with the patient to complete UMMC charity care application.
 - b. Ensure access materials (health insurance, UMMC phone numbers and instructions) are available in English and Spanish, and are published at a second grade reading level. Use simplified language when speaking to residents and patients.
 - c. Streamline the process for making appointments.
3. Provide ease in establishing a medical home for patients, demonstrate the benefit for patients.
 - a. Screen for social needs at provider appointment; address social needs during the visit.
 - i. Food Access
 1. Pediatric patients will be linked to the UMMC Pediatric Food Pantry on site for urgent food needs.
 2. Adult patients will be referred to Maryland Food Bank locations for immediate assistance.
 - b. Refer patients with chronic disease, mental health or substance use to care coordination for on- going management.
 - c. Expand telehealth access for visits.
 - d. Employ the CH mobile van to community locations to provide screenings and education and engage residents to care by reducing barriers.
4. Improve health literacy - increase opportunities for community based health education (strategies in cross over to Chronic Disease)
5. Ensure community programs connect to UMMC value based care programs for continuity.

Evaluation & Metrics We will use the following metrics to identify trends and corrective action for the above strategies. NOTE: The following metrics will be reported separately for adults and children.

1. Response time for appointments
2. # follow up phone calls
3. Wait time to appointments
4. # applications to charity care, Medicaid
5. # referrals to health insurance exchange

6. # mobile health/ telehealth visits
7. # referrals to food pantry, social service organizations
8. See process metrics for chronic disease management below

As Baltimore residents have improved access to healthcare, then it follows that disease rates, avoidable utilization rates, and re-admission- rates will slowly reduce. Conversely, appointment wait times and length of time to appointments may increase as patient volumes increase. UMMC will address additional barriers as they arise.

Priority Health Issue #2: Chronic Disease Management

Description of Community Need

Diabetes, hypertension, heart disease, lung disease (including lung cancer), stroke, and mental health are the leading causes of morbidity and mortality for Baltimore City adults. Pediatric asthma is a leading health disparity in the city. More than 70 percent of city residents report that they do not understand health information when it is presented to them.

Desired Community Result

UMMC is committed to providing support and education to improving health literacy in Baltimore City. Improved health literacy is connected to improved health outcomes and a reduction in the morbidity associated with chronic disease. UMMC will target efforts to improve rates of diabetes, hypertension, stroke, adult pulmonary disease (including lung cancer) and pediatric asthma.

Partner Agencies and Roles

UMMC has numerous partners engaged in community health (see partners listed in previous section). The partners are committed to providing space to offer community health literacy events.

Key Hospital Strategies

1. General – strategies
 - a. Increase educational programs in community settings to improve health knowledge in Baltimore residents (measured by pre-post tests)
 - i. Increase number of and variety of health education programs to include addressing diabetes, hypertension, pulmonary disease, stroke and pediatric asthma.
 - ii. Increase social media messaging
 - iii. Implement increased use of Community Health Workers to reach patients and provide messaging.

- b. Increase access to and number of screenings to create awareness of Know Your Numbers campaigns, including the Community Health Education Center at UMMC MTC, Community Health mobile van, community partner sites.
 - i. Leverage EPIC EMR to communicate results and programs to primary and specialty providers at UMMC MTC.
 - c. Support Access to Care Initiative (#1) that health education materials are developed in easy to read language in English and Spanish.
 - 2. Disease specific strategies:
 - a. Continue collaboration and education with Baltimore city governments and partners in the Stroke Smart campaign
 - b. Provide Pediatric Asthma Education literature at time of ED discharge to promote improve health literacy.
 - c. Implement early detection lung screening program in collaboration with UMB. C
 - d. Integrate mental health screening into primary care and specialty care practices.
 - 3. Ensure community programs connect to UMMC value based care programs for continuity

Evaluation and Metrics

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

- 1. Change in knowledge as measured by pre-post tests from community interventions
- 2. # screenings, # referrals to care
- 3. Trend screening outcomes over time BMI, A1C, Blood pressure screenings. Process metrics: # individuals reached (include age). #programs, # partnerships, #Screening hubs
- 4. # Community touches
- 5. # Pediatric asthma education bags provided

As Baltimore residents increase their health literacy, referrals to health care and appointments with providers will initially increase. Over time, disease rates will decrease as will, avoidable utilization rates, and re-admission- rates.

Priority Health Issue #3: Mental Health and Substance Use

Description of Community Need

In 2021, 20.7% of Baltimore City residents self-reported that a health professional has told them that they have a depressive disorder, yet, only 5.2% of residents visited a mental health provider. Baltimore City residents ranked substance use (43%) and mental health (39%) within the top 5 health needs in the city. Baltimore City leaders ranked mental health/ suicide (66.7%) and substance use (51.5%) within the top 5 health needs in the city.

Desired Community Result

UMMC is dedicated to working with community agencies to reduce the stigma around mental health and substance abuse. UMMC would like to increase access to mental health and substance use treatment in Baltimore City by increasing provider and staff awareness of mental health needs and trauma informed care modalities.

Partner Agencies and Roles

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

- SAMHSA (Substance Abuse and Mental Health Services Administration)
- NAMI (National Alliance on Mental Illness)
- GBRICS (Greater Baltimore Regional Integrated Crisis System) and its members

Key Hospital Strategies

1. Increase knowledge and awareness of UMMC mental health and substance use treatment programs.
 - a. Target UMMC providers for education on referral process.
 - b. Provide general awareness campaigns regarding programs for the community.
2. Continue to support GBRICS (Greater Baltimore Regional Integrated Crisis System) to promote access to urgent mental health care for city residents.
 - a. Attend meetings and support initiatives.
 - b. Increase community outreach and education about 988 services and mobile crisis care
3. Expand peer recovery support into the community to screen residents and refer to services.
 - a. Link SBIRT program to increase referrals to treatment
4. Expand mental health first aid training to ambulatory staff and community leaders.
5. Leverage partnerships to understand how trauma impacts patient care. Extend and expand education and information to primary and specialty UMMC clinics about trauma-informed care.
6. Develop mental health screening tool (similar to SBIRT for substance use) that can be implemented by staff to refer patients to mental health care.
7. Ensure community programs connect to UMMC value based care programs for continuity.

Evaluation and Metrics

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

1. # Mental Health First Aid Trainings, # individuals trained
2. # Trauma informed care trainings, # healthcare professionals trained

3. # patients referred to mental health care treatment
4. # patients utilizing 988 and mobile crisis services
5. # GBRICS meetings attended and action taken
6. #patients referred to substance use treatment

Priority Health Issue #4: Maternal Health

Description of Community Need

Severe maternal morbidity and mortality is a significant need in Baltimore. There is also disparity between white and black mothers. In addition, infant mortality rates are worse than local, state and national averages. Mothers face access to care barriers as described in #1 above.

Desired Community Result

Mothers and infants should have easy access to state of the art prenatal and postnatal care. UMMC strives to improve maternal and infant health outcomes, reduce disparities in maternal health indicators such as preterm birth and severe maternal morbidity and mortality and enhance access to healthcare and education for pregnant women and new mothers.

Partner Agencies and Roles

In addition to the partners identified above, UMMC will partner with local community providers to expand training and access for reproductive services.

Key Hospital Strategies

1. Improve healthcare access for women of childbearing age:
 - Increase the number of maternal health providers at UMMC.
 - Expand telehealth services across UMMS hospitals.
 - Expand reproductive health training to community providers via state's well-mobile efforts.
2. Address social needs for women of childbearing age.
 - Transportation – improve transportation strategies so women can access healthcare appointments.
 - Food security - refer pregnant women and their children to the pediatric food pantry at UMMC MTC.
3. Strengthen Health Education/ literacy:
 - Implement community-based health education programs.
 - Distribute multilingual educational materials (see chronic disease management #2 above).
4. Expand Mental Health Services (see #3 above Mental health and substance use):
 - Train healthcare providers to screen for postpartum depression.
 - Connect patients with community counseling and support groups.

Evaluation and Metrics

1. # UMMC and community providers who accept patients

2. # Referrals to food pantry and transportation services
3. # Community education programs
4. # patients referred to mental health services.

Priority Health Issue #5: Workforce Development/ Income Stability

Description of Community Need

Multiple social needs impact Baltimore City residents. However, low household income drives poverty, crime, and a lack of housing/food/ transportation. In the UMMC service area, nearly 10 percent of households receive SNAP and median household income ranges from \$21,530 to \$49,999. A third of residents state lack of job opportunities as a need. UMMC needs local talent to staff units and departments.

Desired Community Result

UMMC will strategically bolster career trajectories within the healthcare sector through targeted recruitment and comprehensive training of new personnel. Additionally, UMMC aims to retain skilled staff and cultivate robust partnerships that seamlessly connect educational advancements to career readiness. This program is specifically tailored to enhance the professional development of UMMC employees and to contribute positively to the West Baltimore community, fostering a sustainable healthcare workforce, who earn a fair living wage.

Partner Agencies and Roles

UMMC Career Academy partners with numerous organizations including our partner schools, non-profits, city based colleges and universities, local government, and other workforce development programs.

Key Hospital Strategies

1. **Recruitment:** Aim to recruit 250 new employees by leveraging traditional and digital marketing strategies and hosting job fairs in collaboration with community partners.
2. **Retention:** Retain at least 80% of newly recruited employees by implementing structured onboarding processes and continuous professional development programs.
3. **Upskilling:** Offer upskilling opportunities to community program participants and current UMMC staff to earn stackable credentials. For example, enabling career progression from Patient Care Technician (PCT) Level 1, to Registered Nurse (RN), or from Surgical Support Technician to Central Sterile Processing (CSP) to Surgical Technician.
4. **School to Career Partnerships:** Increase school-to-career partnerships by developing satellite sites in collaboration with various Community-Based Organizations (CBOs) and stakeholders. Implement programs like career readiness and digital literacy courses at locations such as the Druid Heights Community Center.

5. **Internships and Apprenticeships:** Develop paid internship and apprenticeship opportunities within the Career Academy. Seek funding opportunities that provide incentives for participation in these programs, enhancing the attractiveness and accessibility of health careers.
6. **Student Incentives:** Incentivize students by organizing interactive sessions with healthcare professionals, such as nurses, community health workers (CHW), and doctors, where students can engage directly and gain insights into various health careers.
7. **Mental Health Focus:** Address the mental health components of career development by integrating mental health support and awareness into all training and employment programs. This includes providing mental health first aid training and ensuring access to mental health services for all participants.

Evaluation and Metrics

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

1. # recruited
2. Retention Rate
3. # Upskilling employees
4. # new partnerships with training schools as feeder programs

Priority Health Issue #6: Violence Prevention

Description of Community Need

Firearm fatalities and injuries rank higher in Baltimore City as compared to local, state and national statistics. Gun violence ranks in the top five of health concerns for Baltimore City residents. Over 70 percent of community leaders believe that reducing crime and violence should be addressed as a priority.

Desired Community Result

Community based violence prevention and intervention programs can lower the rates of future offending with fewer retaliations. There will be less violence and overall cost and life saving.

Partner Agencies and Roles

In addition to the community partners listed above, UMMC will collaborate with the following partnering agencies:

- Mayor's Office of Neighborhood Safety and Engagement (MONSE)
- UMB Rebuild Overcome and Rise (ROAR) Center
- The Hospital Alliance for Violence Intervention (HAVI)
- States Attorney's Office
- Department of Juvenile Services (Baltimore City and Baltimore County)
- UMB Center for Violence Prevention

- Roca
- Public School Systems (Baltimore City, Baltimore County, Howard County)
- Baltimore City HVIP programs

Key Hospital Strategies

1. Establish Baltimore City's first wrap-around clinic for victims of violence to provide follow-up medical, psychosocial, and community needs support (To be located in Shock Trauma Outpatient Pavilion)
2. Increase engagement rate within hospital violence intervention program (HVIP) program > 60% of eligible patients
3. Increase primary violence prevention programming for the community, specifically high-risk teen populations utilizing the Saving Maryland At Risk Teens (SMART) Program and the Schools in Courts Programming.
4. Continue partnership with city-wide HVIP programs and community partners to increase resources, educational opportunities, and collaboration to our community and patients.

Evaluation and Metrics

- % violent injury admission to Shock Trauma by age and gender
- HVIP participation rate/engagement rate
- # HVIP client intake assessments completed
- Readmission rates for victims of violence and no-show rates for clinic follow up appointments

UMMC Leadership and Community Anchor Program Participation

The following UMMC and UMB team members and leaders participated in the CHNA prioritization process, plan development and implementation process.

UMMC

Dana Farrakhan, DrPH, MHS, FACHE, SVP Strategy, Community and Business Development
Jeanette Gibbs, MSHA, SVP Ambulatory Services and Value Based Care
Rebecca Altman, RN, MBA Senior Vice President and CAO UMMC MTC
Melissa Lambdin, Vice President and Chief of Staff
Christine Crabbs, Sr. Director of Community Health
Karen Dates-Dunmore, Sr. Director Community Engagement and Workforce Development
Julie Kubiak, RN, Nursing Director, Ambulatory Services
Aislynn Moyer, RN, Nursing Director, Ambulatory Services
Alexandra Moran, Director of Diabetes Program
Carly Pick, RN Manager Center for Injury Prevention
Caitlyn Palmisano, RN, Stroke Coordinator
Michael Franklin, Manager of Career Academy and Workforce Development
Rhonda Boozer Yeary, Community Engagement Manager
Mariellen Synan, Community Health Improvement Manager
Shakurah Duffie, Community Health Improvement Manager
Tyla Johnson, Community Resource Liaison
Aniyah Community Health Specialist
Lauren Synan, Community Health Specialist
Quianna Howell, Community Health Specialist
Anthony Redd, Community Health Worker
Griselda Funn, Community Health Worker,
Natasha Stanley, Baltimore City resident

UMB

Rebecca Carter, MD, Chief of General Pediatrics
Jill Rachbeisel, MD, Chief of Psychiatry
Irina Burd, MD, Chief of OB/GYN & Reproductive Sciences
William Joyner, Assistant Vice President
Lisa Rawlings, Manager of Workforce Development

Engagement in Community-Wide Plans

Internally, upon adoption of this plan, UMMC will convene oversight committees to address each priority area. Each committee will be chaired by a UMMC/ UMB leader and meet regularly to detail the existing plan, establish goals and timelines, responsibilities and resources required to achieve goals. The Community Health team leadership will develop a plan-wide dashboard that incorporates all metrics to be reported out on a quarterly basis (when data is available) and distributed to UMMC executive leadership and the Community Engagement Committee of the Board to monitor progress. Modifications to plans will be required as resources fluctuate or goals are not achieved.

Externally, UMMC will collaborate with Baltimore public health experts and other key community stakeholders to develop a written description of the activities that hospital facilities, public health agencies, and other local organizations plan to undertake collectively to address specific health needs in our community. This collaborative action planning process will result in the development of a community health improvement plan (CHIP) for Baltimore City. The prioritized needs for Baltimore City, as identified by the Baltimore City Health Department include Access to Care and Mental Health (for the adult population) and Youth Violence Prevention to address social needs for children.

The Community Health Improvement Plan (CHIP) for Baltimore City can be found at Baltimore City Health Department. [\[Insert Link\]](#). The UMMC CHIP is available at [\[insert link\]](#).

Needs Not Addressed in this Plan

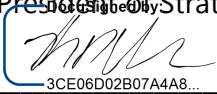
Though we recognize that each community health need identified by the community is important, our hospital has prioritized the above mentioned needs. UMMC will dedicate new or additional resources to address these needs. There are other needs within the CHNA that we will still address, but resources may not be prioritized. Those needs include cancer, tobacco use prevention, neurological diseases and hospitalizations, chronic pain and arthritis, discrimination based on race/ ethnicity, and social isolation. Needs such as adolescent obesity, school funding adequacy, childcare costs, disconnected youth, English proficiency, childhood support, and housing will not be addressed by UMMC due to a lack of resources and are not an area of expertise.

NEXT STEPS

As part of the community health improvement process, UMMC 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 FY2027. 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.

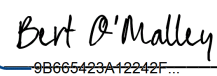
APPROVAL

This report was prepared for the June 4, 2024 UMMC Community Engagement Board meeting, and is approved as signed below by the Board Chairperson, President and CEO, and Senior Vice President of Strategy, Community and Business Development.


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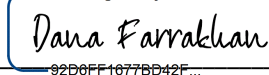
Robert Wallace

6/21/2024

Date
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Bert W. O'Malley, MD

8/15/2024

Date
DocuSigned by:

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Dana D. Farrakhan, DrPH, MHS, FACHE

6/19/2024

Date

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

 UNIVERSITY of MARYLAND MEDICAL SYSTEM Revenue Cycle Services	PAGE: 2 OF 14	POLICY NO: RCS - 01
	EFFECTIVE DATE: 09/18/19	REVISION DATE(S): 07/01/24
SUBJECT: UMMS Financial Assistance Policy		

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

 UNIVERSITY of MARYLAND MEDICAL SYSTEM Revenue Cycle Services	PAGE: 3 OF 14	POLICY NO: RCS - 01
	EFFECTIVE DATE: 09/18/19	REVISION DATE(S): 07/01/24
SUBJECT: UMMS Financial Assistance Policy		

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

 UNIVERSITY of MARYLAND MEDICAL SYSTEM Revenue Cycle Services	PAGE: 4 OF 14	POLICY NO: RCS - 01
	EFFECTIVE DATE: 09/18/19	REVISION DATE(S): 07/01/24
SUBJECT: UMMS Financial Assistance Policy		

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.

 UNIVERSITY of MARYLAND MEDICAL SYSTEM Revenue Cycle Services	PAGE: 5 OF 14	POLICY NO: RCS - 01
	EFFECTIVE DATE: 09/18/19	REVISION DATE(S): 07/01/24
SUBJECT: UMMS Financial Assistance Policy		

- 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

 UNIVERSITY of MARYLAND MEDICAL SYSTEM Revenue Cycle Services	PAGE: 6 OF 14	POLICY NO: RCS - 01
	EFFECTIVE DATE: 09/18/19	REVISION DATE(S): 07/01/24
SUBJECT: UMMS Financial Assistance Policy		

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.

 UNIVERSITY of MARYLAND MEDICAL SYSTEM Revenue Cycle Services	PAGE: 7 OF 14	POLICY NO: RCS - 01
	EFFECTIVE DATE: 09/18/19	REVISION DATE(S): 07/01/24
SUBJECT: UMMS Financial Assistance Policy		

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).

 UNIVERSITY of MARYLAND MEDICAL SYSTEM Revenue Cycle Services	PAGE: 8 OF 14	POLICY NO: RCS - 01
	EFFECTIVE DATE: 09/18/19	REVISION DATE(S): 07/01/24
SUBJECT: UMMS Financial Assistance Policy		

- 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.

 UNIVERSITY of MARYLAND MEDICAL SYSTEM Revenue Cycle Services	PAGE: 9 OF 14	POLICY NO: RCS - 01
	EFFECTIVE DATE: 09/18/19	REVISION DATE(S): 07/01/24
SUBJECT: UMMS Financial Assistance Policy		

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.

 UNIVERSITY of MARYLAND MEDICAL SYSTEM Revenue Cycle Services	PAGE: 10 OF 14	POLICY NO: RCS - 01
	EFFECTIVE DATE: 09/18/19	REVISION DATE(S): 07/01/24
SUBJECT: UMMS Financial Assistance Policy		

- 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

 UNIVERSITY of MARYLAND MEDICAL SYSTEM Revenue Cycle Services	PAGE: 11 OF 14	POLICY NO: RCS - 01
	EFFECTIVE DATE: 09/18/19	REVISION DATE(S): 07/01/24
SUBJECT: UMMS Financial Assistance Policy		

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 determine 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 after the initial bill was provided. Prior to filing the civil action, UMMS will determine 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.

 UNIVERSITY of MARYLAND MEDICAL SYSTEM Revenue Cycle Services	PAGE: 12 OF 14	POLICY NO: RCS - 01
	EFFECTIVE DATE: 09/18/19	REVISION DATE(S): 07/01/24
SUBJECT: UMMS Financial Assistance Policy		

- 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.

 UNIVERSITY of MARYLAND MEDICAL SYSTEM Revenue Cycle Services	PAGE: 13 OF 14	POLICY NO: RCS - 01
	EFFECTIVE DATE: 09/18/19	REVISION DATE(S): 07/01/24
SUBJECT: UMMS Financial Assistance Policy		

ATTACHMENTS:

ATTACHMENT A: Sliding Scale – Reduced Cost of Care

2024 Federal Poverty Limits (FPL) Annual Income Eligibility Limit Guidelines							See UMMS Charity Thresholds below
House-hold (HH) Size	1	2	3	4	5	6	
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							See UMMS Charity Thresholds below
House-hold (HH) Size	1	2	3	4	5	6	
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

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

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