

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 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. In response to the legislation, some of the reporting questions have changed for FY 2021. Detailed reporting instructions are available here: https://hscrc.maryland.gov/Pages/init_cb.aspx

In this reporting tool, responses are mandatory unless specifically marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCbHelp@hilltop.umbc.edu.

Q2. Section I - General Info Part 1 - Hospital Identification

Q3. Please confirm the information we have on file about your hospital for the fiscal year.

	Is this information correct?		If no, please provide the correct information here:
	Yes	No	
The proper name of your hospital is: Anne Arundel Medical Center	<input checked="" type="radio"/>	<input type="radio"/>	
Your hospital's ID is: 210023	<input checked="" type="radio"/>	<input type="radio"/>	
Your hospital is part of the hospital system called Luminis Health.	<input checked="" type="radio"/>	<input type="radio"/>	
The primary Narrative contact at your hospital is Christine Crabbs	<input checked="" type="radio"/>	<input type="radio"/>	
The primary Narrative contact email address at your hospital is ccrabbs@aahs.org	<input checked="" type="radio"/>	<input type="radio"/>	
The primary Financial contact at your hospital is UNKNOWN	<input type="radio"/>	<input checked="" type="radio"/>	Christine Crabbs
The primary Financial email at your hospital is breilly@aahs.org	<input type="radio"/>	<input checked="" type="radio"/>	ccrabbs@aahs.org

Q4. 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.

Q5. Please select the community health statistics that your hospital uses in its community benefit efforts.

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

Q6. Please describe any other community health statistics that your hospital uses in its community benefit efforts.

AAMC uses the Community Health Needs Assessments for Anne Arundel County to identify under-served areas. The links are below:
https://aaahs.org/uploadedFiles/Contents/Eyebrow/About_Us/CHNA Master.pdf AAMC also uses the Poverty Amidst Plenty report to guide us with regard to underserved communities. The report is attached below.

Q7. Attach any files containing community health statistics that your hospital uses in its community benefit efforts.

[2018-needs-assessment-poverty.pdf](#)
9.4MB
application/pdf

Q8. Section I - General Info Part 2 - Community Benefit Service Area

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

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

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

This question was not displayed to the respondent.

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

- | | | | |
|--------------------------------|---|---|---|
| <input type="checkbox"/> 20701 | <input type="checkbox"/> 20776 | <input type="checkbox"/> 21062 | <input checked="" type="checkbox"/> 21146 |
| <input type="checkbox"/> 20711 | <input type="checkbox"/> 20778 | <input type="checkbox"/> 21076 | <input type="checkbox"/> 21225 |
| <input type="checkbox"/> 20714 | <input type="checkbox"/> 20779 | <input type="checkbox"/> 21077 | <input type="checkbox"/> 21226 |
| <input type="checkbox"/> 20724 | <input type="checkbox"/> 20794 | <input type="checkbox"/> 21090 | <input type="checkbox"/> 21240 |
| <input type="checkbox"/> 20733 | <input checked="" type="checkbox"/> 21012 | <input type="checkbox"/> 21106 | <input checked="" type="checkbox"/> 21401 |
| <input type="checkbox"/> 20736 | <input checked="" type="checkbox"/> 21032 | <input type="checkbox"/> 21108 | <input type="checkbox"/> 21402 |
| <input type="checkbox"/> 20751 | <input type="checkbox"/> 21035 | <input checked="" type="checkbox"/> 21113 | <input checked="" type="checkbox"/> 21403 |
| <input type="checkbox"/> 20754 | <input checked="" type="checkbox"/> 21037 | <input type="checkbox"/> 21114 | <input type="checkbox"/> 21404 |
| <input type="checkbox"/> 20755 | <input checked="" type="checkbox"/> 21054 | <input checked="" type="checkbox"/> 21122 | <input type="checkbox"/> 21405 |
| <input type="checkbox"/> 20758 | <input type="checkbox"/> 21056 | <input type="checkbox"/> 21123 | <input checked="" type="checkbox"/> 21409 |
| <input type="checkbox"/> 20764 | <input checked="" type="checkbox"/> 21060 | <input type="checkbox"/> 21140 | <input type="checkbox"/> 21411 |
| <input type="checkbox"/> 20765 | <input checked="" type="checkbox"/> 21061 | <input checked="" type="checkbox"/> 21144 | <input type="checkbox"/> 21412 |

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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.

- | | | |
|--------------------------------|--------------------------------|---|
| <input type="checkbox"/> 21607 | <input type="checkbox"/> 21638 | <input type="checkbox"/> 21657 |
| <input type="checkbox"/> 21617 | <input type="checkbox"/> 21640 | <input type="checkbox"/> 21658 |
| <input type="checkbox"/> 21619 | <input type="checkbox"/> 21644 | <input checked="" type="checkbox"/> 21666 |
| <input type="checkbox"/> 21620 | <input type="checkbox"/> 21649 | <input type="checkbox"/> 21668 |
| <input type="checkbox"/> 21623 | <input type="checkbox"/> 21651 | <input type="checkbox"/> 21670 |
| <input type="checkbox"/> 21628 | <input type="checkbox"/> 21656 | <input type="checkbox"/> 21679 |

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.

- | | | |
|---|--------------------------------|--------------------------------|
| <input checked="" type="checkbox"/> 21601 | <input type="checkbox"/> 21653 | <input type="checkbox"/> 21665 |
| <input type="checkbox"/> 21612 | <input type="checkbox"/> 21654 | <input type="checkbox"/> 21671 |
| <input type="checkbox"/> 21624 | <input type="checkbox"/> 21657 | <input type="checkbox"/> 21673 |
| <input type="checkbox"/> 21625 | <input type="checkbox"/> 21662 | <input type="checkbox"/> 21676 |
| <input type="checkbox"/> 21647 | <input type="checkbox"/> 21663 | <input type="checkbox"/> 21679 |
| <input type="checkbox"/> 21652 | | |

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.

AAMC defines the CBSA as the primary service area for AAMC in which the HSCRC identified the zip codes that compose the highest number of inpatient discharges. In addition, AAMC provides community benefit programs in locations of our ambulatory offices.

Other. Please describe.

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

<https://www.aahs.org/About-Us/AAMC-Experience/Mission,-Vision-and-Values/>

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

See Community Health Needs Assessment reports and data include in previous section

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)

Q41. Please provide a link to your hospital's most recently completed CHNA.

https://www.aahs.org/uploadedFiles/Contents/Eyebrow/About_Us/FINAL%20CHNA%20IP%20FY19-21.pdf

Q42. Please upload your hospital's most recently completed CHNA.

[FY19CHNA.pdf](#)
3.8MB
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 your most recent CHNA development.

	CHNA Activities										Other (explain) Other - If you selected "Other (explain)," please type your exp below:
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	
CB/ Community Health/Population Health Director (facility level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other - If you selected "Other (explain)," please type your exp below:
CB/ Community Health/ Population Health Director (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other - If you selected "Other (explain)," please type your exp below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other - If you selected "Other (explain)," please type your exp below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other - If you selected "Other (explain)," please type your exp below:
Board of Directors or Board Committee (facility level)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Reviewed and approve CHNA, priorities, and implementa
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other - If you selected "Other (explain)," please type your exp below:
Board of Directors or Board Committee (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Reviewed and approved CHNA IP and yearly updates

	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 exp below:
Clinical Leadership (facility level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clinical Leadership (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Population Health Staff (facility level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Population Health Staff (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Community Benefit staff (facility level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Community Benefit staff (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Physician(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nurse(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social Workers	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Hospital Advisory Board	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Input was received from Patient Family Advisory Council
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other - If you selected "Other (explain)," please type your explanation below:
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other - If you selected "Other (explain)," please type your explanation below:

Q45. Section II - CHNAs and Stakeholder Involvement Part 3 - Internal HCB Partners

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

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

Post-Acute Care Facilities -- please list the facilities here:

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

Community/Neighborhood Organizations -- Please list the organizations here:

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

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

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

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

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

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

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.

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

https://www.aahs.org/uploadedFiles/Contents/Eyebrow/About_Us/FINAL%20CHNA%20IP%20FY19-21.pdf

Q222. Please upload your hospital's CHNA implementation strategy.

[FINAL CHNA IP FY19-21.pdf](#)
989.8KB
application/pdf

Q53. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q54. Please select the CHNA Priority Area Categories most relevant to your most recent CHNA. The list of categories is based on the Healthy People 2030 objectives [available here](#). This list is not exhaustive. Please select "other" and describe any CHNA Priority Area Categories that are not captured by this list. Select all that apply even if a need was not addressed by a reported initiative.

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

Q56. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q57. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q59. Please use the questions below to provide details regarding the initiatives to address the CHNA Priority Area Categories selected in the previous question.

For those hospitals completing the **optional** CHNA financial reporting in FY 2021, please ensure that these tie directly to line item initiatives in the financial reporting template.

For those hospitals **not** completing the **optional** CHNA financial template, please provide this information for as many initiatives as you deem feasible.

Please note that hospitals will be required to report on each CHNA-related initiative in FY 2022.

Q163. Please describe the initiative(s) addressing Health Conditions - Addiction.

This question was not displayed to the respondent.

Q182. Please describe the initiative(s) addressing Health Conditions - Arthritis.

This question was not displayed to the respondent.

Q183. Please describe the initiative(s) addressing Health Conditions - Blood Disorders.

This question was not displayed to the respondent.

Q184. Please describe the initiative(s) addressing Health Conditions - Cancer.

Health Conditions - Cancer Initiative Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q185. Please describe the initiative(s) addressing Health Conditions - Chronic Kidney Disease.

This question was not displayed to the respondent.

Q186. Please describe the initiative(s) addressing Health Conditions - Chronic Pain.

This question was not displayed to the respondent.

Q187. Please describe the initiative(s) addressing Health Conditions - Dementias.

Health Conditions - Dementias Initiative Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q188. Please describe the initiative(s) addressing Health Conditions - Diabetes.

Health Conditions - Diabetes Initiative Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q189. Please describe the initiative(s) addressing Health Conditions - Foodborne Illness.

This question was not displayed to the respondent.

Q190. Please describe the initiative(s) addressing Health Conditions - Health Care-Associated Infections.

This question was not displayed to the respondent.

Q191. Please describe the initiative(s) addressing Health Conditions - Heart Disease and Stroke.

Health Conditions - Heart Disease and Stroke Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q192. Please describe the initiative(s) addressing Health Conditions - Infectious Disease.

Health Conditions - Infectious Disease Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				

All Other Initiatives

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Q193. Please describe the initiative(s) addressing Health Conditions - Mental Health and Mental Disorders.

Health Conditions - Mental Health and Mental Disorders Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q194. Please describe the initiative(s) addressing Health Conditions - Oral Conditions.

Health Conditions - Oral Conditions Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q195. Please describe the initiative(s) addressing Health Conditions - Osteoporosis.

This question was not displayed to the respondent.

Q196. Please describe the initiative(s) addressing Health Conditions - Overweight and Obesity.

Health Conditions - Overweight and Obesity Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q197. Please describe the initiative(s) addressing Health Conditions - Pregnancy and Childbirth.

Health Conditions - Pregnancy and Childbirth Initiative Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q198. Please describe the initiative(s) addressing Health Conditions - Respiratory Disease.

Health Conditions - Respiratory Disease Initiative Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q199. Please describe the initiative(s) addressing Health Conditions - Sensory or Communication Disorders.

This question was not displayed to the respondent.

Q200. Please describe the initiative(s) addressing Health Conditions - Sexually Transmitted Infections.

Health Conditions - Sexually Transmitted Infections Initiative Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q201. Please describe the initiative(s) addressing Health Behaviors - Child and Adolescent Development.

Health Behaviors - Child and Adolescent Development Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q202. Please describe the initiative(s) addressing Health Behaviors - Drug and Alcohol Use.

Health Behaviors - Drug and Alcohol Use Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q203. Please describe the initiative(s) addressing Health Behaviors - Emergency Preparedness.

Health Behaviors - Emergency Preparedness Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q204. Please describe the initiative(s) addressing Health Behaviors - Family Planning.

Health Behaviors - Family Planning Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				

Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q205. Please describe the initiative(s) addressing Health Behaviors - Health Communication.

	Health Behaviors - Health Communication Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q206. Please describe the initiative(s) addressing Health Behaviors - Injury Prevention.

This question was not displayed to the respondent.

Q207. Please describe the initiative(s) addressing Health Behaviors - Nutrition and Healthy Eating.

	Health Behaviors - Nutrition and Healthy Eating Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q208. Please describe the initiative(s) addressing Health Behaviors - Physical Activity.

	Health Behaviors - Physical Activity Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				

Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q209. Please describe the initiative(s) addressing Health Behaviors - Preventive Care.

	Health Behaviors - Preventive Care Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q210. Please describe the initiative(s) addressing Health Behaviors - Safe Food Handling.

This question was not displayed to the respondent.

Q211. Please describe the initiative(s) addressing Health Behaviors - Sleep.

This question was not displayed to the respondent.

Q212. Please describe the initiative(s) addressing Health Behaviors - Tobacco Use.

	Health Behaviors - Tobacco Use Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q213. Please describe the initiative(s) addressing Health Behaviors - Vaccination.

	Health Behaviors - Vaccination Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				

Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q214. Please describe the initiative(s) addressing Health Behaviors - Violence Prevention.

	Health Behaviors - Violence Prevention Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q215. Please describe the initiative(s) addressing Populations - Adolescents.

	Populations - Adolescents Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q216. Please describe the initiative(s) addressing Populations - Children.

	Populations - Children Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				

Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q217. Please describe the initiative(s) addressing Populations - Infants.

Populations - Infants Initiative Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q218. Please describe the initiative(s) addressing Populations - LGBT.

This question was not displayed to the respondent.

Q219. Please describe the initiative(s) addressing Populations - Men.

Populations - Men Initiative Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q220. Please describe the initiative(s) addressing Populations - Older Adults.

Populations - Older Adults Initiative Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				

Initiative I				
Initiative J				
All Other Initiatives				

Q221. Please describe the initiative(s) addressing Populations - Parents or Caregivers.

This question was not displayed to the respondent.

Q222. Please describe the initiative(s) addressing Populations - People with Disabilities.

	Populations - People with Disabilities Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q223. Please describe the initiative(s) addressing Populations - Women.

	Populations - Women Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q224. Please describe the initiative(s) addressing Populations - Workforce.

This question was not displayed to the respondent.

Q225. Please describe the initiative(s) addressing Settings and Systems - Community.

	Settings and Systems - Community Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				

Initiative H			
Initiative I			
Initiative J			
All Other Initiatives			

Q226. Please describe the initiative(s) addressing Settings and Systems - Environmental Health.

Settings and Systems - Environmental Health Initiative Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q227. Please describe the initiative(s) addressing Settings and Systems - Global Health.

This question was not displayed to the respondent.

Q228. Please describe the initiative(s) addressing Settings and Systems - Health Care.

Settings and Systems - Health Care Initiative Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q229. Please describe the initiative(s) addressing Settings and Systems - Health Insurance.

Settings and Systems - Health Insurance Initiative Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				

Initiative I				
Initiative J				
All Other Initiatives				

Q230. Please describe the initiative(s) addressing Settings and Systems - Health IT.

This question was not displayed to the respondent.

Q231. Please describe the initiative(s) addressing Settings and Systems - Health Policy.

This question was not displayed to the respondent.

Q232. Please describe the initiative(s) addressing Settings and Systems - Hospital and Emergency Services.

Settings and Systems - Hospital and Emergency Services Initiative Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q233. Please describe the initiative(s) addressing Settings and Systems - Housing and Homes.

This question was not displayed to the respondent.

Q234. Please describe the initiative(s) addressing Settings and Systems - Public Health Infrastructure.

Settings and Systems - Public Health Infrastructure Initiative Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q235. Please describe the initiative(s) addressing Settings and Systems - Schools.

Settings and Systems - Schools Initiative Details				
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				

Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q236. Please describe the initiative(s) addressing Settings and Systems - Transportation.

This question was not displayed to the respondent.

Q237. Please describe the initiative(s) addressing Settings and Systems - Workplace.

This question was not displayed to the respondent.

Q238. Please describe the initiative(s) addressing Social Determinants of Health - Economic Stability.

This question was not displayed to the respondent.

Q239. Please describe the initiative(s) addressing Social Determinants of Health - Education Access and Quality.

This question was not displayed to the respondent.

Q240. Please describe the initiative(s) addressing Social Determinants of Health - Health Care Access and Quality.

This question was not displayed to the respondent.

Q241. Please describe the initiative(s) addressing Social Determinants of Health - Neighborhood and Built Environment.

This question was not displayed to the respondent.

Q242. Please describe the initiative(s) addressing Social Determinants of Health - Social and Community Context.

	Social Determinants of Health - Social and Community Context Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q243. Please describe the initiative(s) addressing other priorities.

This question was not displayed to the respondent.

Q130. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

Yes

No

Q131. In your most recently completed CHNA, the following community health needs were identified:

Health Conditions - Cancer, Health Conditions - Dementias, Health Conditions - Diabetes, Health Conditions - Heart Disease and Stroke, Health Conditions - Infectious Disease, Health Conditions -

Mental Health and Mental Disorders, Health Conditions - Oral Conditions, Health Conditions - Overweight and Obesity, Health Conditions - Pregnancy and Childbirth, Health Conditions - Respiratory Disease, Health Conditions - Sexually Transmitted Infections, Health Behaviors - Child and Adolescent Development, Health Behaviors - Drug and Alcohol Use, Health Behaviors - Emergency Preparedness, Health Behaviors - Family Planning, Health Behaviors - Health Communication, Health Behaviors - Nutrition and Healthy Eating, Health Behaviors - Physical Activity, Health Behaviors - Preventive Care, Health Behaviors - Tobacco Use, Health Behaviors - Vaccination, Health Behaviors - Violence Prevention, Populations - Adolescents, Populations - Children, Populations - Infants, Populations - Men, Populations - Older Adults, Populations - People with Disabilities, Populations - Women, Settings and Systems - Community, Settings and Systems - Environmental Health, Settings and Systems - Health Care, Settings and Systems - Health Insurance, Settings and Systems - Hospital and Emergency Services, Settings and Systems - Public Health Infrastructure, Settings and Systems - Schools, Social Determinants of Health - Social and Community Context

Other:

Using the checkboxes below, select the needs that appear in the list above that were NOT addressed by your community benefit initiatives.

- | | |
|--|--|
| <input checked="" type="checkbox"/> Access to Health Services: Health Insurance | <input type="checkbox"/> Heart Disease and Stroke |
| <input checked="" type="checkbox"/> Access to Health Services: Practicing PCPs | <input checked="" type="checkbox"/> HIV |
| <input type="checkbox"/> Access to Health Services: Regular PCP Visits | <input type="checkbox"/> Immunization and Infectious Diseases |
| <input checked="" type="checkbox"/> Access to Health Services: ED Wait Times | <input checked="" type="checkbox"/> Injury Prevention |
| <input checked="" type="checkbox"/> Access to Health Services: Outpatient Services | <input checked="" type="checkbox"/> Lesbian, Gay, Bisexual, and Transgender Health |
| <input checked="" type="checkbox"/> Adolescent Health | <input type="checkbox"/> Maternal and Infant Health |
| <input checked="" type="checkbox"/> Arthritis, Osteoporosis, and Chronic Back Conditions | <input type="checkbox"/> Nutrition and Weight Status |
| <input type="checkbox"/> Behavioral Health, including Mental Health and/or Substance Abuse | <input type="checkbox"/> Older Adults |
| <input type="checkbox"/> Cancer | <input checked="" type="checkbox"/> Oral Health |
| <input checked="" type="checkbox"/> Children's Health | <input type="checkbox"/> Physical Activity |
| <input checked="" type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Respiratory Diseases |
| <input checked="" type="checkbox"/> Community Unity | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Dementias, including Alzheimer's Disease | <input checked="" type="checkbox"/> Sleep Health |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Telehealth |
| <input type="checkbox"/> Disability and Health | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Educational and Community-Based Programs | <input type="checkbox"/> Violence Prevention |
| <input type="checkbox"/> Environmental Health | <input checked="" type="checkbox"/> Vision |
| <input checked="" type="checkbox"/> Family Planning | <input checked="" type="checkbox"/> Wound Care |
| <input checked="" type="checkbox"/> Food Safety | <input type="checkbox"/> Housing & Homelessness |
| <input checked="" type="checkbox"/> Global Health | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Health Communication and Health Information Technology | <input type="checkbox"/> Unemployment & Poverty |
| <input type="checkbox"/> Health Literacy | <input type="checkbox"/> Other Social Determinants of Health |
| <input type="checkbox"/> Health-Related Quality of Life & Well-Being | <input type="checkbox"/> Other (specify) <input type="text"/> |

Q132. Why were these needs unaddressed?

AAMC had to prioritize resources to make an impact. In addition, we aligned our resources to our strengths as a health system. We also assessed the strengths of our community resources. Therefore, we funded programs that we felt we could make an impact (our strengths) along with our community partner strengths.

Q244. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

October 4, 2021 – Luminis Health has released a bold plan to become a national model for justice, equity, diversity and inclusion (JEDI). The groundwork for the plan began in 2020 with the formation of the health system's Health Equity and Anti-Racism Task (HEART) Force, a multidisciplinary group consisting of members of the boards of trustees, senior leaders, medical staff, community partners and stakeholders. The events of the year 2020 prompted Luminis Health to assess data and information to identify greater opportunity to affect change in confronting racism, addressing the effects of systemic inequity, and dismantling structural injustice. The recommendations are structured by three major categories: *Lead as an anti-racist organization, and confront racism and eradicate inequities in health care. *Enhance culturally informed communications and community collaboration. * Measure and integrate accountability. While Luminis Health/ AAMC tracks utilization patterns by race and ethnicity, there are additional plans to measure efforts to reduce disparity. The next year will structure the process to track and reduce disparities in the communities we serve.

Q245. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

- 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)

Q129. If you wish, you may upload a document describing your community benefit initiatives in more detail.

Q60. Section III - CB Administration

Q61. 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

Q246. Please describe the third party audit process used.

This question was not displayed to the respondent.

Q62. Does your hospital conduct an internal audit of the community benefit narrative?

Yes

No

Q63. Please describe the community benefit narrative audit process.

We collect narrative and financial data and information from all departments and maintain records. When the reports are completed, the drafts are reviewed with the CFO, CEO, and the AAMC Executive team. Edits and changes are made from their recommendations. Final reports are reviewed by the CEO of the health system. The report is submitted and final adoption is provided by the Board of AAMC.

Q64. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

Yes

No

Q65. Please explain:

This question was not displayed to the respondent.

Q66. Does the hospital's board review and approve the annual community benefit narrative report?

Yes

No

Q67. Please explain:

This question was not displayed to the respondent.

Q68. Does your hospital include community benefit planning and investments in its internal strategic plan?

Yes

No

Q69. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

AAMC's mission is to enhance the health of the people it serves. It is also guided by its core principles of compassion, trust, dedication, quality, innovation, diversity and collaboration. In February 2020, the Governing Board adopted a 10-year strategic plan and outlined a vision of Living Healthier Together. That means that the care that AAMC provides is centered on the patient. AAMC operates beyond the walls of the hospital and serves a broad geography and diverse population of patients. Our work builds on partnerships, relationships and connectivity. We hold shared accountability among patients, physicians, hospital, employees and community. We are driven by standards based on evidence and outcomes while remaining viable, cost-effective, and responsible. AAMC uses a strategic planning framework that categorized 35 initiatives into 5 strategic goal areas (Quality, Community Health, Workforce, Growth, and Finance). This is reviewed annually by senior leadership, clinical leadership, and administrative leadership to identify opportunities for growth and health improvement through planning retreats, meetings, and data analysis. These initiatives were chosen based on their ability to have significant impact on the care of patients and the community; improve health, increase quality, reduce costs, and strengthen workforce. Leaders identify Community Benefit through the strategic initiatives and report the data and information to Department of Community Health Improvement for collection and analysis. Community Health tracks the data and reports monthly to leadership through the True North Metrics process and the Annual Operating Plan.

Q70. If available, please provide a link to your hospital's strategic plan.

Q133. 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
- Opioid Use Disorder - Improve overdose mortality
- Maternal and Child Health - Reduce severe maternal morbidity rate
- Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17

Q134. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q135. Section IV - Physician Gaps & Subsidies

Q223. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- No
- Yes

Q218. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Anesthesiology	<input checked="" type="radio"/>	<input type="radio"/>	Non-resident house staff and hospitalists
Cardiology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Dermatology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Emergency Medicine	<input checked="" type="radio"/>	<input type="radio"/>	Coverage of emergency department call
Endocrinology, Diabetes & Metabolism	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Family Practice/General Practice	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Geriatrics	<input checked="" type="radio"/>	<input type="radio"/>	Non-resident house staff and hospitalists
Internal Medicine	<input checked="" type="radio"/>	<input type="radio"/>	Non-resident house staff and hospitalists
Medical Genetics	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Neurological Surgery	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Neurology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Obstetrics & Gynecology	<input checked="" type="radio"/>	<input type="radio"/>	Non-resident house staff and hospitalists
Oncology-Cancer	<input checked="" type="radio"/>	<input type="radio"/>	Non-resident house staff and hospitalists
Ophthalmology	<input checked="" type="radio"/>	<input type="radio"/>	Non-resident house staff and hospitalists
Orthopedics	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Otolaryngology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Pathology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Pediatrics	<input checked="" type="radio"/>	<input type="radio"/>	Coverage of emergency department call

Physical Medicine & Rehabilitation	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Plastic Surgery	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Preventive Medicine	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Psychiatry	<input checked="" type="radio"/>	<input type="radio"/>	Coverage of emergency department call
Radiology	<input checked="" type="radio"/>	<input type="radio"/>	Non-resident house staff and hospitalists
Surgery	<input checked="" type="radio"/>	<input type="radio"/>	Non-resident house staff and hospitalists
Urology	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>
Other (Describe)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="text"/>

Q219. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

AAMC must contract with external physician groups to provide inpatient services (see specialties listed above). If the physician subsidies were not available for contracting, patients would not have have access to specialty care.

Q139. Please attach any files containing further information and data justifying physician subsidies your hospital.

Q140. Section VI - Financial Assistance Policy (FAP)

Q141. Upload a copy of your hospital's financial assistance policy.

[FAP-FY21.pdf](#)
191.6KB
application/pdf

Q220. Provide the link to your hospital's financial assistance policy.

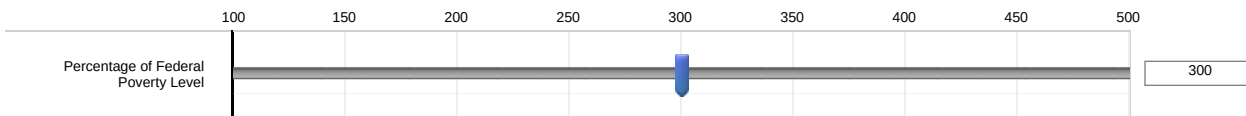
<https://aahs.org/Plan-Your-Visit/Patient-Resources/Billing-and-Insurance/Financial-Assistance/>

Q147. 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:

Q143. Maryland 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).

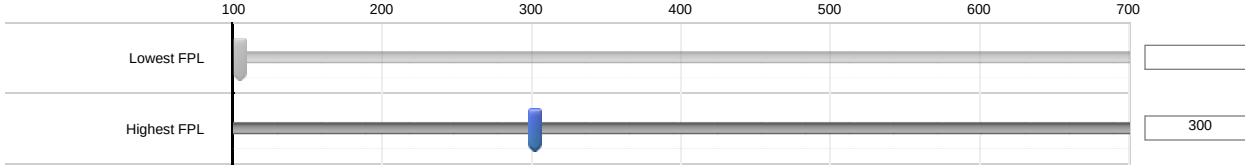
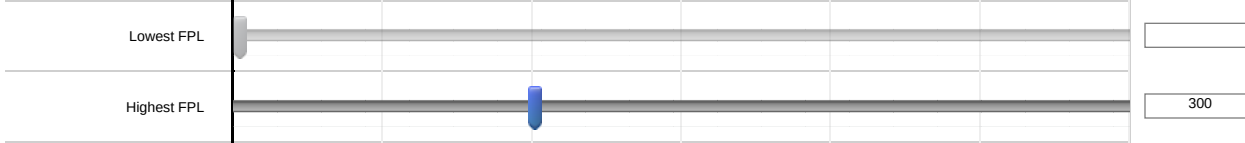
Please select the percentage of FPL below which your hospital's FAP offers free care.



Q144. Maryland 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.





Q221. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding tax able year (select all that apply)

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

Q150. Summary & Report Submission

Q151. **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: [\(38.989395141602, -76.54940032959\)](#)

Source: GeolIP Estimation



POVERTY AMIDST PLENTY VI:

On the Road to Progress For All

Sixth Edition, 2018

Poverty Amidst Plenty VI. Sixth Edition. Annapolis, MD:
Community Foundation of Anne Arundel County 2019.

Prepared and written for the Community Foundation of Anne Arundel County
by Dr. Pamela M. Brown with assistance from Lisa Kovacs, Martha Blaxall and Cindy O'Neill.

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Forward

The 2018 Anne Arundel County Community Needs Assessment, *Poverty Amidst Plenty VI*, is the result of an extended collaboration between the following partners: The Community Foundation of Anne Arundel County, Anne Arundel Medical Center, University of Maryland Baltimore Washington Medical Center, Anne Arundel County Department of Health, Anne Arundel County Mental Health Agency, Anne Arundel County Partnership for Children, Youth and Families and the YWCA of Annapolis and Anne Arundel County.

The report contains summative (quantitative) data from a variety of local, state and national sources. Population and socio-economic statistics were compiled using data from the United States (U.S.) Census Bureau's Population Estimates Program and the American Community Survey 1-Year and 5-Year Estimates. This data should be considered less reliable due to the gap of eight years since the last full census. All data here is based on census estimates. Birth and death data files were obtained from the Maryland Department of Health and Mental Hygiene, Vital Statistics Administration. The emergency department and inpatient hospital discharge data files were obtained from the Maryland Health Services Cost Review Commission for topics like birth, mortality and hospital utilization. Other data sources used for this report were: Maryland Vital Statistics Annual Reports, Maryland Department of Health and Mental Hygiene's Annual Cancer Reports, Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention's CDC WONDER Online Database, Centers for Medicare and Medicaid Services, National Vital Statistics Reports and County Health Rankings, and a variety of local databases. The specific data sources are listed throughout the report.

The report draws on qualitative data gathered from 26 key informants and 11 focus groups. Focus group areas included emergency department personnel, low income youth, behavioral health providers, Hispanic residents, advocates, domestic violence victims and a host of others representing a total of 185 participants. The author thanks Lisa Kovacs, Administrative Coordinator at the Anne Arundel County Partnership for Children, Youth and Families, for the hours of transcription time spent ensuring this Needs Assessment accurately represents the voices of our community. The data was read and reread until dominant themes emerged which became the subtext of the report. All participants gave permission for their words to be used in the final report, although their identities are protected. The author would also like to thank Cindy O'Neill and Martha Blaxall for the hundreds of hours they spent editing and refining this report.

ABOUT THE AUTHOR

Dr. Pamela Brown is currently the Executive Director of the Anne Arundel County Partnership for Children, Youth and Families. She completed her Ph.D. in Educational Leadership at Florida Atlantic University. Her dissertation focused on the importance of community partnerships in diverse neighborhoods. She is a Dissertation Chair for the University of Phoenix specializing in qualitative case study methods. She is certified to conduct ethical research through the Collaborative Institutional Training Initiative at the University of Miami. She has been conducting community needs assessments for over 20 years. The author takes full responsibility for the interpretations and analyses represented here. They do not necessarily represent the interpretations or the views of the Community Foundation of Anne Arundel County, the Anne Arundel County Partnership for Children, Youth and Families, or the staff, boards, officers, or donors of these organizations.

The Community Foundation of Anne Arundel County (CFAAC) is pleased to present the 2018 needs assessment *Poverty Amidst Plenty VI* to the residents of Anne Arundel County. The purpose of this report is to provide an overview of the issues in Anne Arundel County that impact the economy and quality of life. CFAAC is deeply grateful to Dr. Pamela Brown and the Anne Arundel County Partnership for Children, Youth, and Families for their extensive work in compiling data and drafting this report.

CFAAC's mission is to connect people who care with causes that matter in our community. The report intends to increase knowledge and awareness, as well as to frame informed discussions about persistent local trends and needs. This report is also meant to inform fund holders, donors, nonprofit grantees, professional adviser partners, and all stakeholders in the county about the challenges facing our community and the importance of their participation in critical conversations focused on transforming and strengthening our community.

CFAAC is dedicated to convening both private and public sectors – individual, family and corporate philanthropists, civic and faith-based organizations, nonprofits, community advocates, volunteers, business leaders, elected officials, policymakers, government agencies, foundations, professional advisors, and others – to prioritize and develop strategies and implementation plans with measurable goals to address the most pressing needs of our community.

We believe that by tracking key measures of community well-being, and developing a common vision for Anne Arundel County supported by shared commitment and strong leadership, dynamic partnerships across all sectors can be forged to determine real community solutions. To support these efforts, CFAAC plays an important role by continuing to build a permanent source of philanthropic assets to sustain nonprofit agencies and the important work they do.

Founded in 1998, CFAAC is the largest institutional funder of nonprofits in Anne Arundel County. With over \$14 million dollars in assets, and \$2.3 million dollars in grants made in 2018 alone, CFAAC remains committed to providing an increasingly powerful pool of resources to sustain the kind of impact that strong philanthropic support can achieve in a community.

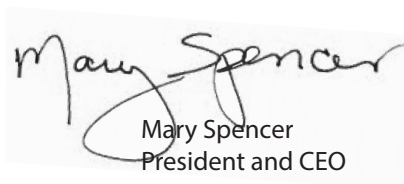
Since the last community needs assessment report done in 2016, the most pressing community needs have remained constant. Affordable housing and child care, quality health care, jobs that pay a living wage, and the availability of transportation continue to be identified as key determinants to a strong and thriving community in Anne Arundel County. Newer concerns have swept across our county as well, including the increasingly devastating effects on the lives of those impacted by the opioid crisis. Additionally, the too-close-to-home threat of gun violence has increasingly jumped to the forefront, affecting our entire community, especially in light of the tragic shooting at the Capital Gazette Newspaper office on June 28, 2018. The federal and state laws associated with the national issue of gun violence, and the political landscape affecting those laws, is beyond the scope of this community needs assessment report. Knowing that Anne Arundel County is engaged with federal, state, and other local authorities in looking at this as a public health issue is an indication of the next steps in the local community, and broader, conversation. Correlations between mental health issues, drug and alcohol abuse, poverty, and increases in gang activity, among other things, all would seem to play a part in the growing concern over gun violence in our community and in our country.

With knowledge comes power, and it is our hope that the information contained in this report sparks powerful conversations and meaningful progress toward achieving a healthy and strong community for all of the residents of Anne Arundel County.

Together we remain steadfast and committed to Achieving Progress for All.



James P. Nolan
Chair, Board of Trustees



Mary Spencer
President and CEO

Summary of Principal Findings



Population: The Anne Arundel County population has grown 15.3 percent since 2000 to 564,600 residents. The county's population is aging. Those over the age of 65 have increased since 2014 while the percentages of those 19 and under have decreased slightly.

Hispanic Population: The Hispanic population is growing more significantly than all other races/ethnicities and is now at 7.3 percent (41,275 residents) of the county's population. The county has the fourth largest Hispanic population, by percentage, among Maryland counties. The location of the Hispanic population in the county is uneven, with a high of just over 20 percent of the population of the City of Annapolis.



Poverty: As of 2018, a family of four (two adults, two children) with an annual income below \$25,100 is defined as living in poverty by the federal government. There are roughly 33,000 Anne Arundel County residents (6.1 percent) living below the poverty level. There are 31,377 households led by single parents, of which 22,565 have a female as the head of household. Estimates suggest nearly 15 percent of the single parent households in the county make an income that is below the federal poverty level.



The Income Gap: The gap between rich and poor continues to widen. The number of resident households with an income above \$200,000 has grown by over 38 percent while the number of households with an income below \$25,000 has shrunk, but only by 1.8 percent. The 2018 median household income for the county stood at \$99,652; 19 percent more than the state and 65 percent more than the nation.



Economic Opportunity: Anne Arundel County is the fifth largest jurisdiction in the state in terms of population yet it has the third largest economy at \$36 billion. There are approximately 15,000 businesses within county boundaries. The median home price has increased 6.6 percent since 2017 with an average value of \$325,333. The unemployment rate has dropped from almost 7 percent in 2010 to 2.8 percent at the end of 2018.



Transportation: The lack of public transportation continues to be a major issue for the county. The majority of county residents (80 percent) drive to work alone in their cars every day; 7.7 percent car pool, two percent walk, and two percent take a bus. There are now five regional transit routes, eight Annapolis routes, four local bus routes, and four commuter bus routes. Additionally, there are two pilot bus routes in South County. Nonetheless, public transportation continued to be a major concern for all participants in this needs assessment. There are large areas of the county that are underserved (or not served at all), including North and West County.



Housing: As of September 2018, the median home sale price was \$345,000, an increase of 10 percent or \$30,000 compared to last year. Renters account for 26.4 percent or 52,948 of the 203,336 households in the county. Of those renters, 24,172 or 45 percent are overburdened. Renters are considered overburdened when they pay more than 30 percent of their gross income in rent. There is a decreasing amount of public and subsidized housing in the county. There are 10,278 county families on the waiting list for Housing Choice Vouchers and 17,683 families on the waiting list for public housing. There are 1,514 families on the Annapolis public housing wait list.



Homelessness: Homelessness is a continuing concern for individuals and families in the county. The county served 1,684 homeless individuals in 2017. There are still only three homeless shelters in the county and three rapid rehousing programs. In 2018, 1,260 homeless youth were identified in the county public school system.



Child Care: Child care continues to be a huge issue for those seeking employment, especially single parents. The average cost of family day care for two children is over \$20,000 per year, more for a child care center. The distribution of child care centers is uneven across the county. There are none in Brooklyn Park, Harmans or Shadyside. The numbers of family day care providers are dropping and that trend is predicted to continue until 2022.



Youth Development: There are 127,512 children under the age of 18 living in Anne Arundel County. Of those, 35,002 (27.4 percent) are under five years of age, and over 12,000 (10 percent) live below the federal poverty level; an increase of two percent since 2015.

- In 2015, a new kindergarten readiness tool was introduced to Anne Arundel County Public Schools: Ready4Kindergarten or R4K. While scores have slightly improved from a low of 43 percent in 2015, the 2018 score of 48 percent shows less than half of county children are ready for kindergarten.
- In the 2018 Maryland school district rankings, Anne Arundel County ranked 13th of 24 school districts based on the most recent standardized test scores. Over 80 percent of Anne Arundel County 8th graders are not meeting standards in math and less than half are meeting standards in reading.
- There are still gaps in achievement related to race, ethnicity, income, disability, and Limited English Proficient students. However, between 2010 and 2016, African American students have shown an 8.56 percent improvement, and Free and Reduced Meal Students (FARMS) have shown a 7.96 percent improvement in graduation rates.
- The county's chronic truancy or habitual absenteeism rate has risen across all grade levels and student populations. Children from low income families who receive free lunch (FARMS) have the highest levels of chronic truancy, an increase of three percent since 2014.
- The overall county unemployment rate for youth ages 17 to 24 stands at 13.6 percent. The rate of youth unemployment for African Americans stands at 25 percent, almost double that of the overall rate.



Health: County life expectancy has risen to 79.6 years. In 2017, cardiovascular disease was the leading cause of death followed by cancer. Accidental (unintentional injury) deaths are the fifth leading cause of death, driven most likely by increases in opioid overdose deaths. Cardiovascular disease accounted for about 31 percent of all county deaths in 2017, an increase of almost 10 percent since 2013.



Mental Health: There has been a 70 percent increase in residents seeking mental health services since 2012; 16,348 residents were served by the county mental health agency in 2018. The two highest increases in numbers served are the early childhood population and those over 65. Increased mental health and behavioral issues in the birth to five early childhood population are causing widespread concern in every system. The county's hospital emergency departments are often the receiving facilities for behavioral health issues. In 2017, there were 12,446 behavioral health encounters; mood disorders accounted for 26.3 percent of those.



Substance Abuse: In 2018, Anne Arundel County police reported almost 1,100 opioid-related overdoses occurring within the county, a 171 percent increase since 2014. Fentanyl-related deaths in the county have increased significantly since 2013 and surpassed heroin related deaths in 2018. The current opioid crisis has many victims. The number of newborns assessed positive for substances in their systems, including methadone, has risen 144 percent since 2014 from 74 to 181. Grandparents and great grandparents are raising children with little governmental help.



The Environment: The annual *State of the Bay* Report from the Chesapeake Bay Foundation tracks several indicators detailing the overall health of the Bay. The record precipitation that fell in Maryland in 2018 led to an overall increase in pollution in the Bay and other waterways. Despite many efforts by federal, state, and local governments and other interested parties, pollution in the Bay does not meet existing water quality standards. All of the county's waterways are considered "impaired" because of excessive levels of major contaminants, which are largely a result of untreated storm water runoff.



Social Media: The use of social media, including the active use of smart phones and tablets, is a major concern for residents and professionals in every area of the county. The constant access to electronic information is impacting every age group and demographic. Babies as young as 12 months have been observed in the county holding iPhones and tablets. One early childhood provider described this as "soothing by cell phone".

Chapter 1 | Introduction & Demographics

Anne Arundel County is the fifth largest county in Maryland, covering 415 square miles with 534 miles of natural shoreline. For the majority of residents it is a wonderful place to live. Most recent household median income estimates stand at \$99,652.¹ The unemployment rate as of December 2018 is 2.8 percent, lower than the state average of 3.4 percent.² However, there are 33,246 Anne Arundel County residents (6.1 percent) living below the poverty level. The rate of poverty for children is much higher at 9.3 percent. Single female head of household numbers are even higher, and there are racial disparities. Nearly 15 percent of White and 20 percent of African American single female head of households are at or below the poverty level.³ Economic distress is spread unequally throughout the county, with pockets of low income and poverty level families clustered in North and South County areas and in Annapolis.

In 2018, residents are most concerned about the heroin/opioid crisis, youth gun and gang violence, behavioral issues among the very young, and the impact of social media on every facet of our lives and the lives of our children. Participants in this needs assessment agreed that lack of transportation was the most often cited barrier to success in Anne Arundel County. Transportation impacts all facets of life, from accessing appropriate medical care to acquiring and retaining employment. The lack of quality, affordable child care and affordable housing are continuing barriers for poverty-level and low income families as they try to move towards self-sufficiency.

Population Demographics

The most recent census estimates on the diversity of the county illustrate a diminishing White, Caucasian population. The Hispanic population has grown 219 percent since the year 2000 (Table 1). The most common foreign languages in Anne Arundel County are Spanish (26,124 speakers), Tagalog (2,810 speakers), and Korean (2,751 speakers). Compared to other places, Anne Arundel County has a relatively high number of individuals who speak Greek (737 speakers), Korean (2,751 speakers), and African languages (2,387 speakers).⁴

Table 1

Ethnic/Racial Composition Anne Arundel County, 2000-2017							
	2000		2010		2017		% Change 2000-2017
	Number	%	Number	%	Number	%	%
Total Population	489,656	100	537,656	100	564,600	100	15.3
Non-Hispanic Whites	390,519	79.8	405,456	75.4	393,139	69.6	0.6
Other Races	99,137	20.2	132,200	24.6	171,191	30.3	72.6
Hispanic or Latino	12,902	2.6	32,902	6.1	41,275	7.3	219.9
Black or African-American	65,755	13.4	83,484	15.5	89,365	15.9	77
Other*	20,480	4.2	15,814	3	40,551	7.1	98

U.S. Census Bureau, American Community Survey, 2016. "Other" here includes "American Indian and Alaskan Native and "Asian," "Native Hawaiian or other Pacific Islander," "Some other race," or "Two or more races." Therefore, the "White" and "Black" figures are those who were counted as "White alone" or "Black alone."

¹ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, 2018.

² Maryland Department of Labor, Licensing and Regulation, Local Area Unemployment Statistics, 2019.

³ U.S. Census Bureau, American Community Survey 2013-2017 5-year Estimates.

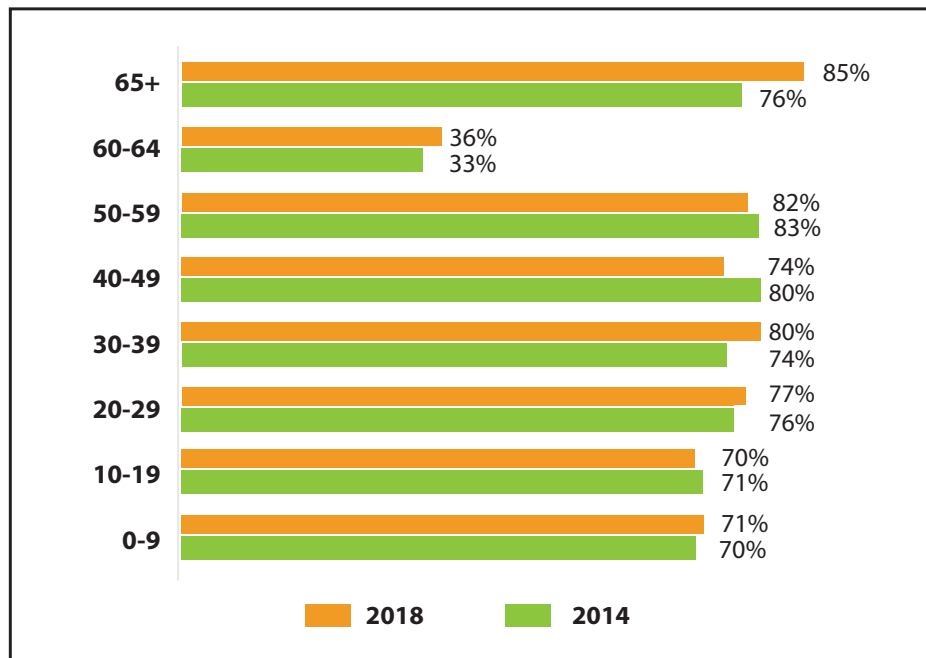
⁴ Ibid.



Anne Arundel County has an aging population. Since 2014, the percentage of residents over the age of 65 has increased while the percentage of residents 19 and under have decreased slightly (Figure 1).

Figure 1

**ANNE ARUNDEL COUNTY AGE DISTRIBUTION
(2014-2018)**



Anne Arundel County Economic Development Corporation, 2018

The Hispanic Community

While the White Caucasian population of the county continues to diminish, the Hispanic population is growing more significantly than all other races/ethnicities and is now at 7.3 percent, still lower than the state average of 9.8 percent.⁵ The county has the fourth largest Hispanic population by percentage among Maryland counties. The distribution of the population is uneven in the county, with a high of 20.3 percent in the City of Annapolis. The largest sector of the Hispanic population is from Central American countries, including a growing population from El Salvador. This is significantly different from the overall U.S. Hispanic population, which is overwhelmingly Mexican (63 percent).⁶

Traditional governmental systems, from the city and county police departments to the public schools and health systems, are struggling to adequately respond to this growing Spanish-speaking population. Only seven Annapolis City and nine county police officers speak Spanish, and only nine percent of full-time civilian personnel speak Spanish.⁷ The public school system has a shortage of teachers for English Language Learners.⁸ The county mental health agency reports a woeful lack of Spanish-speaking counselors. There is only one Spanish-speaking psychiatrist in the county.⁹

⁵ Pew Research Center, *Hispanic Trends: Anne Arundel County, Maryland*, 2016.

⁶ Flores, Antonio, *How the U.S. Hispanic Population is Changing*, Pew Research Center, 2017.

⁷ City of Annapolis Police Department, 2017.

⁸ Anne Arundel County Public Schools, 2018.

⁹ Anne Arundel County Mental Health Agency, 2018.

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Community focus group participants in this Needs Assessment noted the following general trends in the Hispanic community:

- The Hispanic community lives in clusters within the county, in close proximity to public and subsidized housing and low rent private accommodations. Many family members live together in overcrowded conditions; some townhouses hold up to four families. Approximately 90 percent of families are sharing homes.
- Many Hispanic residents are actively seeking English lessons, but the lack of transportation to the community college or Centro de Ayuda, and the lack of time due to long working hours, are barriers.
- Children of Hispanic families spend many hours alone as the parent/caregiver often works two or three jobs. School personnel and others report that hunger is a problem for some of the children. Several respondents noted the man of the family is rarely present in the home. They work seasonal and low paying jobs with long hours.
- Focus group participants stated that many Hispanic parents are scared to allow their children to stay for after-school activities due to immigration and gang-recruitment concerns.
- Many Hispanic residents are living in a state of constant fear of ‘the knock on the door’ that could signal a return to their country of origin. The large El Salvadoran population has created a well-documented MS-13 gang presence that has led to the development of an active city/county gang taskforce. However, the number of Hispanic residents involved in gang activity is extremely small. Some of the Hispanic residents now living in Annapolis left El Salvador specifically to get away from gangs, only to find themselves re-recruited here. Law enforcement officials in both the City of Annapolis and Anne Arundel County are working diligently to combat gang activity.

Income

The gap between rich and poor continues to widen. The number of resident households with an income above \$200,000 has grown by over 38 percent. Those households with an income below \$25,000 have shrunk, but only slightly (Table 2). According to the most recent estimates by the Anne Arundel County Economic Development Corporation (2018), the median household income for the county now stands at \$99,652; 19 percent more than the state and 65 percent more than the nation.

Table 2

Estimated Annual Household Income Numbers 2010-2016					
Totals	2010 195,999		2016 204,829		
Per Households	Number	%	Number	%	Percent Change
Less than \$25,000	20,819	10.7%	20,439	10%	-1.8%
\$25,000 - 34,999	12,201	6.2%	10,875	5.3%	-10.9%
\$35,000 - 49,000	19,077	9.7%	18,775	9.2%	-1.6%
\$50,000-74,999	34,853	17.7%	32,573	15.9%	-6.5%
\$75,000 - 99,999	29,982	15.3%	29,148	14.2%	-2.8%
\$100,000 - 199,999	20,480	31%	68,734	33.6%	11.6%
\$200,000 and Above	17,498	9%	24,285	11.9%	38.8%

U.S. Census Bureau, American Community Survey, 2016 Estimates



Poverty

The Federal Government determines the official United States poverty rate. As of 2018, a family of four (two adults, two children) with an annual income below \$25,100 is living in poverty. There are 32,368 Anne Arundel County residents (6.1 percent) living below the poverty level; the trend line is up slightly since 2014 (Table 3). There are 31,377 households led by single parents, of which 22,565 have a female as the head of household. Economic well-being for households headed by a single parent can be fragile. Estimates suggest 14.7 percent of the single parent households in the county make an income that is below the federal poverty level.

Table 3

Poverty Status Anne Arundel County (2014-2017)								
	2014		2015		2016		2017	
	# below poverty level	% below poverty level	# below poverty level	% below poverty level	# below poverty level	% below poverty level	# below poverty level	% below poverty level
Overall Population	31,573	5.9%	31,573	5.9%	33,168	6.1%	32,246	6.1%
Age								
Under 18 years	8,846	7.1%	8,359	6.7%	8,923	7.1%	9,234	7.4%
18-64 years	8,377	6.8%	19,571	5.7%	20,126	5.8%	19,823	5.7%
65 years and over	3,563	5.2%	3,643	5.1%	4,119	5.6%	4,189	5.5%
Race & Ethnicity								
White, not Hispanic or Latino	18,365	4.6%	18,875	4.7%	18,237	4.7%	18,361	4.8%
Black or African American alone	8,608	10.5%	8,622	10.3%	8,153	9.7%	7,967	9.2%
Asian alone	1,744	9.1%	1,524	7.8%	1,423	7.2%	1,280	6.3%
Hispanic or Latino origin (of any race)	3,165	8.9%	3,018	8.2%	3,643	9.5%	4,176	10.4%

U.S. Census Bureau, American Community Survey Estimates 2017

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Poverty continues to be concentrated in the north and south of the county (Table 4). The highest percentage of poverty is in the ZIP Code that contains Brooklyn Park at a staggering 27.3 percent, followed by Curtis Bay at 16.6 percent; both areas border Baltimore City. In South County, Deale has almost twice the level of poverty as the county average.

Table 4

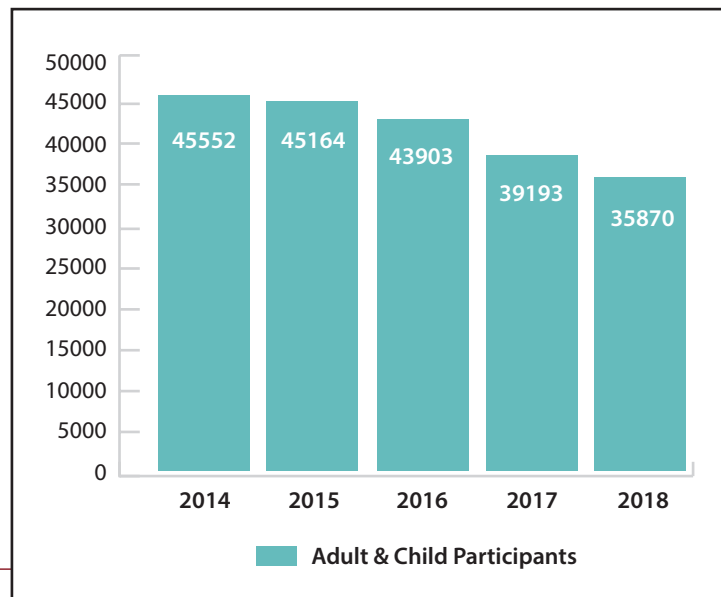
Selected Poverty Percentages by Zip Code in Anne Arundel County (2016)		
Zip Code	Area	Poverty Percentage
21225	Brooklyn Park	27.3%
21226	Curtis Bay	16.6%
21060	Glen Burnie (East)	7.9%
21061	Glen Burnie (West)	9.2%
20751	Deale	10.8%
	Anne Arundel County	6.1% (2018)

U.S. Census Bureau, American Community Survey, Estimates 2016 and 2017

Data about low income residents can also be measured by the numbers receiving (what used to be called food stamps and is now the Supplemental Nutrition Assistance Program (SNAP)). SNAP participation is down 21 percent since peaking in 2014 at 45,552 (Figure 2). This is partly due to reinstated work requirements and a decrease in adult eligibility, as well as the improving economy.

Figure 2

ANNE ARUNDEL COUNTY SNAP RECIPIENTS (2014-2018)



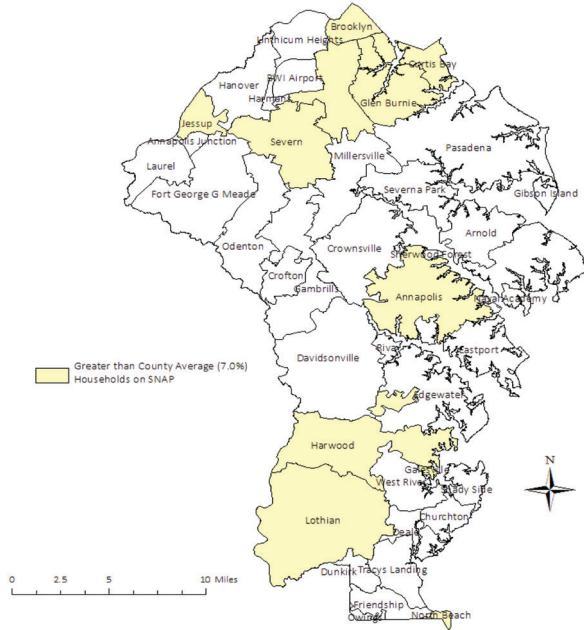
Anne Arundel County Department of Social Services, 2018



According to the 2016 U.S. Census Bureau American Community Survey estimates, SNAP recipients are spread unevenly across the county (Figure 3) with the largest number in North and South County areas and Annapolis.

Figure 3

ANNE ARUNDEL COUNTY SNAP RECIPIENTS (2016)



U.S. Census Bureau, American Community Survey, Estimates 2016

According to the Centers for Disease Control, high poverty and concentrated neighborhood disadvantage increases the likelihood that a child will suffer abuse and neglect.¹⁰ In Anne Arundel County, an average of 481 children per month were abused or neglected from July 2017 through June 2018, an increase of about 25 percent since 2014.

Table 5

Counties in Maryland with the Highest Number of Child Maltreatment Reports (2018)	
	Monthly Average from July 2017-June 2018
Prince George's	734
Baltimore City	559
Montgomery	481
Anne Arundel	471
Baltimore County	370

Maryland Department of Human Resources, 2018

The number of Anne Arundel County families receiving in-home services from county social services has risen every year since 2014. Most alarming, the number of newborns exposed to illegal substances has increased 158 percent since 2014 (Table 6).

Table 6

Anne Arundel County Child Welfare Key Indicators (2014 to present)					
	2014	2015	2016	2017	2018 (Jan. - Sept.)
Families Receiving in Home Services	483	607	662	753	625
New Children Receiving in Home Services	1005	1016	1139	1429	1196
New Child Protective Services Accepted Investigations	2400	2154	2161	2185	2243
New Substance Exposed Newborn Assessments	74	169	197	174	191

Anne Arundel County Department of Social Services, 2018

¹⁰ Centers for Disease Control and Prevention, *Violence Prevention, Child Abuse and Neglect: Risk Protective Factors*, 2018.

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The Environment

Anne Arundel County is a place of natural beauty that can be enjoyed through two state parks and 70 county parks linked by an extensive network of recreation and transportation trails. With 534 miles of linear coastline, the county ranks second for waterfront in the state.

The Chesapeake Bay is perhaps Anne Arundel County’s most treasured natural resource, constituting the largest estuary in the United States. The annual *State of the Bay Report* from the Chesapeake Bay Foundation tracks several indicators detailing the overall health of the Bay (Table 7). The record precipitation that fell over the region in 2018 led to increased pollution, nitrogen and phosphorus levels in the Bay. The Bay did show some positive signs of health and resiliency despite the weather challenges, although it remains a fragile estuary.¹¹

Despite many efforts by federal, state, and local governments and other interested parties, the amount of pollution in the Bay does not meet existing water quality standards. According to the Anne Arundel County Department of Public Works, all of Anne Arundel County’s waterways are considered “impaired” because of excessive levels of major contaminants, which are largely a result of untreated stormwater runoff. All stormwater runoff ends up in nearby streams, rivers and eventually the Chesapeake Bay without prior treatment. Since stormwater comes into contact with litter, gasoline, oils, brake pad dust from our cars, pesticides, waste from our pets, and many other toxins along its journey, stormwater is a significant source of pollution to our waterways.

Many Anne Arundel communities are within one mile of the Bay shoreline. The county has 500 miles of Chesapeake Bay shoreline and a wealth of waterways, including the Magothy River, the Upper Patuxent River, the Rhode River, the Severn River, the South and West Rivers, and the Patapsco River.

Table 7

CHESAPEAKE BAY HEALTH INDICATORS 2018 COMPARED TO 2016

	Indicator	2016 Score	Change from 2016	Grade
Tan area = Pollution	Nitrogen	12	-5	F
	Phosphorus	19	-9	F
	Dissolved Oxygen	42	+2	C
	Water Clarity	16	-4	F
	Toxins	28	0	D
Green area = Habitat	Forested Buffers	57	0	B
	Wetlands	42	0	C
	Underwater Grasses	25	+1	D
	Restored Lands	33	+1	D+
Blue area = Fisheries	Rockfish	66	0	A-
	Blue Crabs	55	0	B
	Oysters	10	0	F
	Shad	10	-1	F

Chesapeake Bay Foundation, 2018

¹¹ Chesapeake Bay Foundation, *State of the Bay*, 2018.



The Anne Arundel County Department of Health identified five potential groundwater problem areas for water quality within the county due to saltwater intrusion, volatile organic compounds (VOCs), and elevated levels of nitrate, radium, arsenic, and cadmium. The areas are Annapolis Neck, Gambrills Area, Northern Anne Arundel County (generally all areas north of U.S. Route 50), the Fort Meade/Odenton Area and the Annapolis/Edgewater Peninsula.

As of August 2018, 19 public schools had unacceptable levels of lead in their drinking water. Although the Centers for Disease Control do not set an unsafe level of lead, the U.S. Environmental Protection Agency recommends water should be shut off at any faucet where lead levels exceed 20 parts per billion. Children are especially susceptible to lead poisoning. It can result in an array of negative health affects including reduced IQ, impaired growth, hearing loss, and severe neurological problems. At Glen Burnie High School, 71 water outlets tested above that level. Nineteen elementary schools had at least one faucet at an unacceptable lead level; all are located in North County (Table 8). The testing is on going throughout the county.

Table 8

SCHOOL LEAD RATES - ANNE ARUNDEL COUNTY 2018

Schools with faucets above 20 parts per billion for lead	Number of Faucets
Brooklyn Park Elementary School	23
Sunset Elementary	14
Hilltop Elementary	13
High Point Elementary	13
Overlook Elementary	10
Park Elementary	10
Belle Grove Elementary	8
Linthicum Elementary	5
Solley Elementary	5
Oakwood Elementary	3
Marley Glen Special Elementary	4
George Cromwell Elementary	2
Glendale Elementary	2
Richard Henry Lee Elementary	2
Woodside Elementary	2
Ferndale Elementary	1
North Glen Elementary	1
Point Pleasant Elementary	1

Maryland Department of the Environment, 2018

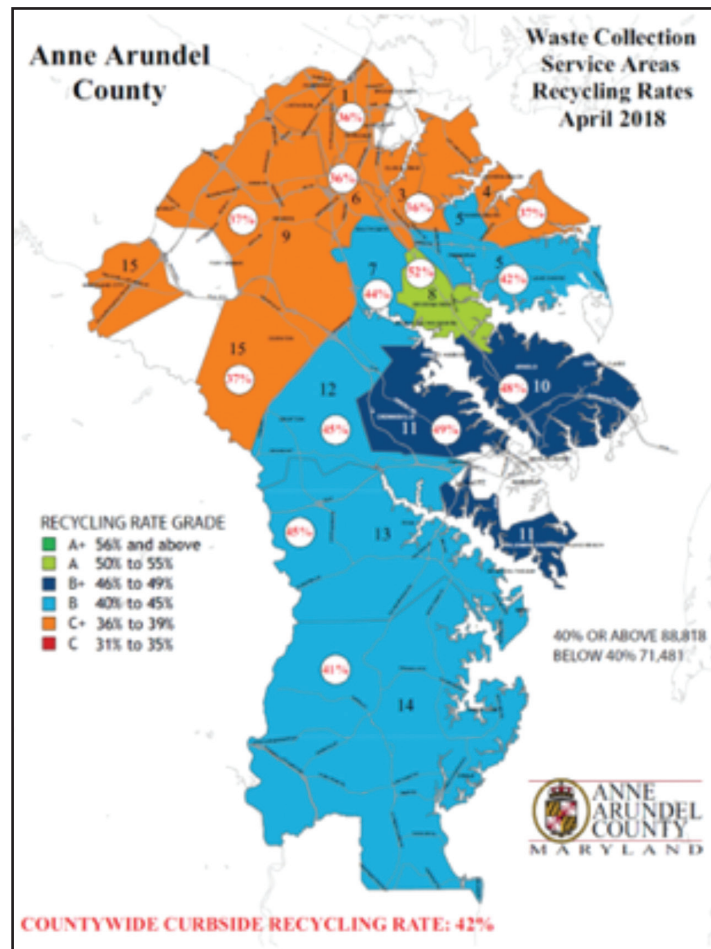
Chapter 1 | Introduction & Demographics

Air quality is another concern for the county. Anne Arundel scored an “F” on the American Lung Association’s “State of the Air” report in 2018 for an average of 13 high ozone days per year between 2014 and 2016, a reduction from 23 days in 2013.¹² High ozone causes respiratory harm (e.g. worsened asthma, worsened COPD, inflammation), can cause cardiovascular harm (e.g. heart attacks, strokes, heart disease, congestive heart failure) and may cause harm to the central nervous system.

Recycling is a way to protect the environment and reduce pollution. According to the Anne Arundel County recycling program, the county average recycling rate is 42 percent. As of April 2018, the Severna Park area has the highest rate at 52 percent and is the only area to receive an “A”. Brooklyn Park and parts of North County have the lowest rate at 36 percent.

Figure 4

WASTE COLLECTION SERVICE AREAS RECYCLING RATES AS OF APRIL 2018



Anne Arundel County Department of Public Works, 2018

¹² American Lung Association, *State of the Air Report*, 2018.



While our Bay and watersheds are improving, air quality is still an issue for vulnerable residents. Newly required testing for lead pollution in the drinking water at public schools points to the need for public action, especially at the elementary level when children are most susceptible.

Summary

In 2018, Anne Arundel County is still a land of plenty. Low unemployment, high median household income, growing cultural diversity and acres of natural beauty make the county a desirable place to live. However, deep and stubborn pockets of poverty to the south and north of the county and in the City of Annapolis, require focused attention. As one administrator noted:

“There is a lot of suffering, there are a lot of people with challenges in this community and as good a job as we’re doing, these problems are not going to be solved overnight.”

Although this report focuses on all of Anne Arundel County, it should be noted that there are four distinct quadrants in the county that differ considerably in economic and social characteristics.

North County is the most densely populated area in the county, with a healthy mix of residential, commercial and industrial development. North County (specifically Glen Burnie, Brooklyn and Pasadena) touches the edges of Baltimore City and shares its issues related to urban poverty. North County has the highest population of residents living in poverty, the highest rate of substance abuse in the county, and has the highest rate of parental incarceration. Much of the area is a food desert, with few locations where healthy food can be purchased.

South County, a region generally defined as that part of Anne Arundel County south of the South River. Much of South County is wealthy, including Davidsonville and communities along the waters of the Bay, and much of it below Edgewater is largely rural. There are several small pockets of poverty in South County that lack access to jobs, health care, transportation, and affordable housing. Many families in these poor communities suffer from poor health, lack of access to healthy food, and chronic truancy. The large number of South County opioid overdoses and deaths, relative to population size, also characterize areas surrounding Deale and Lothian.

Annapolis, as the state capital, thrives economically on government activity, but is also known for its maritime and tourism businesses. The city is located on the Chesapeake Bay at the mouth of the Severn River. The growth of the Hispanic community in Annapolis has strained many social service, healthcare, school, and law enforcement resources. The city has a high proportion of public housing and other subsidized housing, most of which is in need of repair and/or replacement. With no transportation and little affordable child care, most families in public housing have become mired in intergenerational poverty.

West County, dominated by the military installation of Fort George G. Meade (Fort Meade), has experienced much greater economic growth than any other part of the county, fueled by job and operational additions at Fort Meade, the National Security Agency, Baltimore Washington International Thurgood Marshall Airport (BWI Airport) and the Arundel Mills complex featuring Maryland Live! Casino and Hotel. The rapid economic growth in West County has put pressure on many county schools and other services.

Chapter 2 | Expanding Economic Opportunity

Anne Arundel County is a significant economic force in the Baltimore-Washington Metropolitan Area. Annual economic activity now exceeds \$36 billion, the third largest economic entity in Maryland.¹ Its population base is estimated at about 565,000, the fifth highest in the State.² Approximately 15,000 businesses — government agencies, technology firms, healthcare facilities, construction companies, hotels, entertainment centers, restaurants, retail outlets, and agricultural entities are located within county boundaries.³ These industries have grown substantially since the Great Recession of 2008-2010.

Employment

The overall effect of recent economic growth has been beneficial for Anne Arundel County. State of Maryland data show continuing improvement from the end of December 2014 to the end of December 2018. As shown in Table 9, the total number of individuals employed in the county grew 17 percent during this period, and the average weekly wage from December 2014 to December 2017 increased 7.6 percent. The service industry remains the largest single employer in the county, with an average of 194,879 jobs followed by trade, transportation, and utilities with 57,013 jobs. The top wage earning jobs in the county are in manufacturing, where there are currently 11,843 jobs. The county's largest single private employer, Northrop Grumman, is a manufacturing employer. Fort George G. Meade is the county's largest employment center.⁴

Table 9

Anne Arundel County Employment Growth, 2014-2018						
Date	December 2014	December 2015	December 2016	December 2017	December 2018	percent change 2014-2018
Number Employed	258,125	264,231	271,011	297,640	301,207	17 %
Average Weekly Wage	\$1,094	\$1,144	\$1,159	\$1,177	n/a	7.6 % (2014-2017)

State of Maryland, Department of Labor, Licensing and Regulation, Office of Workforce Information and Performance, County Industry Series, Maryland's Quarterly Census of Employment and Wages (QCEW) for 2014-2017, and DLLR's Monthly Labor Review, December 2018, for Number Employed, December 2017 and 2018.

¹ Anne Arundel County Economic Development Corporation, *Anne Arundel County Snapshot*.

² U.S. Census Bureau, *2013-2017 American Community Survey 5-Year Estimates*, 2018.

³ U.S. Census Bureau, *American Fact Finder Quick Facts*, 2016.

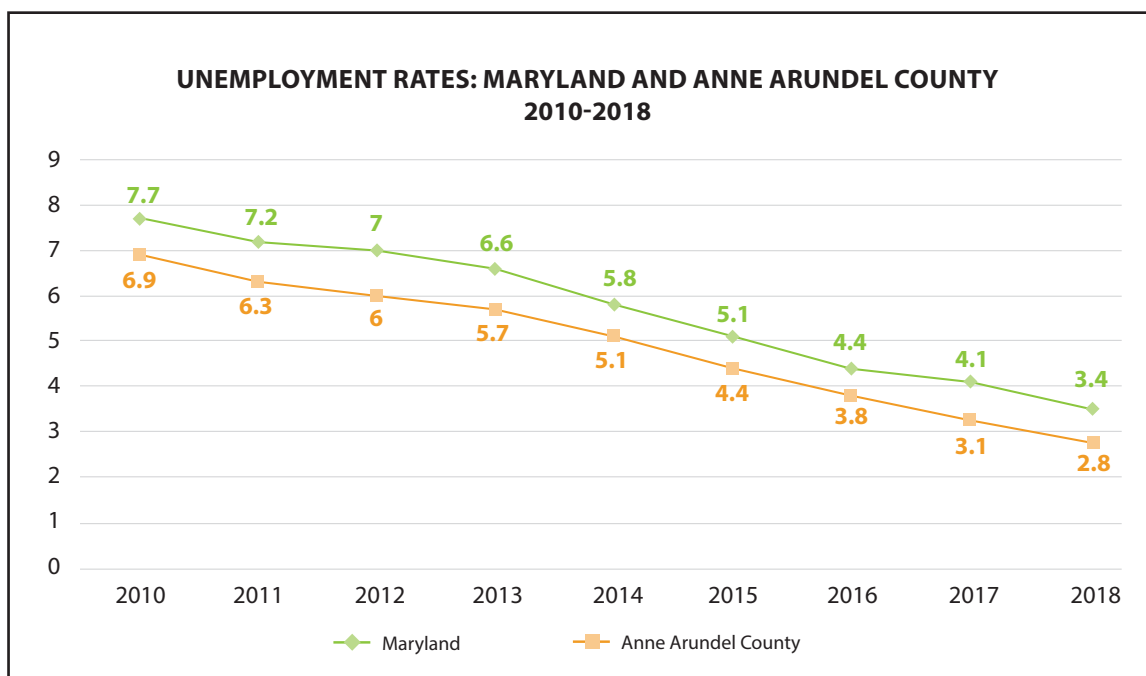
⁴ Maryland Department of Labor, Licensing and Regulation, Office of Workforce Information and Performance, *County Industry Series, Maryland's Quarterly Census of Employment and Wages (QCEW) for 2014-2017*, and DLLR's Monthly Labor Review, December 2018.



Unemployment

Anne Arundel County's employment growth during the last five years has reversed the high unemployment rates experienced during the Great Recession, as shown in Figure 5.

Figure 5



Bureau of Labor Statistics, MD Office of Workforce Information & Performance
(Seasonally unadjusted data)

By December 2018, the county's unemployment rate (not-seasonally adjusted) has declined to 2.8 percent, almost half of the levels seen in 2012. Unemployment rates vary by zip code. The northeast part of the county represented by Glen Burnie, Brooklyn Park, and Pasadena has the highest rate of unemployment (Figure 6). These areas represent parts of the county that contain a significant number of low income residents and those living in poverty. Inadequate transportation to and from potential employers and lack of affordable child care contribute to the chronic unemployment and low wage opportunities that characterize the economic conditions in much of these geographic areas. It is often easier for residents of Baltimore City to commute to these communities for jobs than it is for current residents to find local transportation to them. As one resident indicated in a focus group:

“The problem we still have countywide is transportation....public transportation is almost non-existent in West County. Certainly not enough to get people to jobs and places they need to go....the lack of transportation hasn't changed since 2015.”

Chapter 2 | Expanding Economic Opportunity

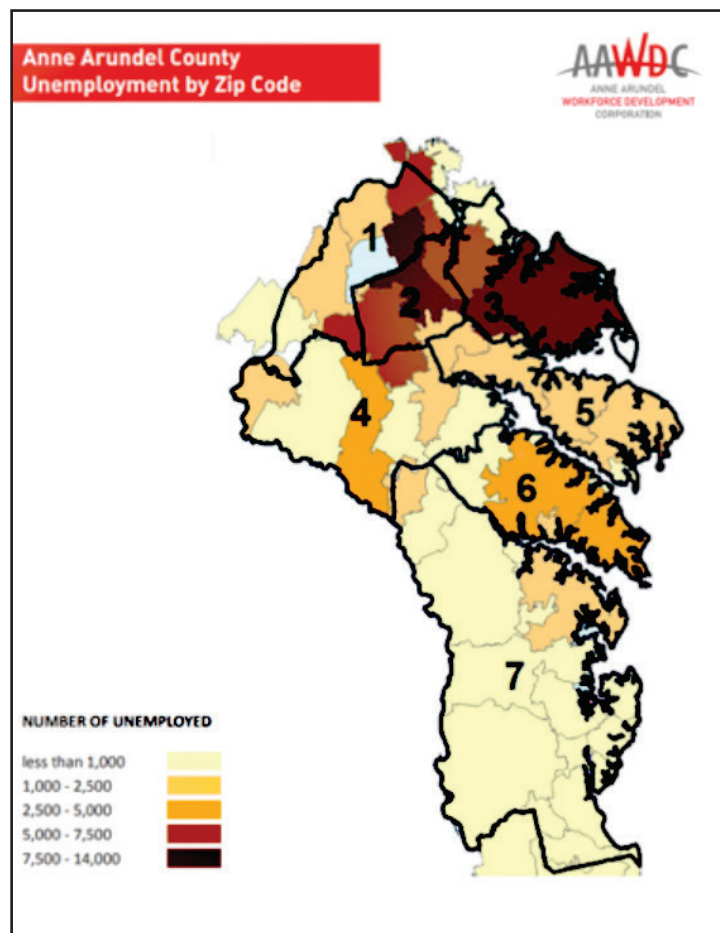
Income Distribution and Poverty

Anne Arundel County as a whole is a wealthy county. The median household income in 2018 reached \$99,652,⁵ higher than that of Maryland (\$80,776) and of the United States (\$60,336).⁶ About 92 percent of the population over age 25 has at least a high school diploma, and almost 40 percent of the population has a Bachelor's or post-graduate degree.⁷

While the majority of county residents are economically secure, there were still about 34,314 county residents estimated to be living in poverty at the end of 2017.⁸ A little over a quarter of these individuals were age 17 or younger.⁹

The current federal poverty guideline is \$25,100 for a family of four. Anne Arundel County residents deemed to be living in poverty have incomes far below the level of the median household income for the county. Families living in poverty also earn well below the "Living Wage Incomes" as defined by Massachusetts Institute of Technology (MIT) to be the minimum incomes that can provide a semblance of comfort for a working family.

Figure 6



Anne Arundel Workforce Development Corporation, 2018

⁵ Anne Arundel County Economic Development Corporation, *Anne Arundel County Snapshot*, 2019.

⁶ Departmentofnumbers.com, *Maryland Household Income*, September, 2018.

⁷ U.S. Department of Labor, Federal Bureau of Statistics, 2018.

⁸ U.S. Census Bureau, *Estimate of People of All Ages in Poverty in Anne Arundel County, MD*, 2019.

⁹ Ibid.



The Living Wage Model

Anne Arundel County has a high cost of living, including high rents and high real estate costs. The Living Wage Model, developed at the MIT, is a tested measure of required income given a geographic location. It is a market-based approach that examines specific expenditure data related to a family's likely minimum costs for food, child care, health insurance, housing, transportation, and other basic necessities. It offers a comparison between what a family in Anne Arundel County has to live on at the federal poverty level, Maryland's minimum wage of \$9.25 per hour (2017 rate); the higher 2018 rate of \$10.10 per hour and what a minimum living wage would realistically be (Table 10). The living wage shown is the hourly rate that an individual must earn to support their family if they are working full-time (2,080 hours per year). The state minimum wage is the same for all individuals, regardless of how many dependents they may have. The poverty guideline, shown in Table 10, is typically quoted as gross annual income. It has been converted to an hourly wage for comparison purposes.

Table 10

Living Wage Calculation for Anne Arundel County, 2017				
Family Size	Poverty Hourly Wage	Maryland Minimum Hourly Wage	Living Hourly Wage	Required Living Wage Annual Salary
1 Adult	\$5.00	\$9.25	\$13.28	\$28,479
1 Adult 1 Child	\$7.00	\$9.25	\$28.46	\$60,010
1 Adult 2 Children	\$9.00	\$9.25	\$32.27	\$69,083
1 Adult 3 Children	\$11.00	\$9.25	\$40.24	\$84,972
2 Adults (1 Working) 1 Child	\$9.00	\$9.25	\$25.38	\$44,953
2 Adults (1 Working) 2 Children	\$11.00	\$9.25	\$28.35	\$54,678
2 Adults (1 Working) 3 Children	\$13.00	\$9.25	\$31.69	\$67,399
2 Adults (both working) 1 Child	\$4.00	\$9.25	\$15.09	\$64,710
2 Adults (both working) 2 Children	\$5.00	\$9.25	\$17.67	\$74,603
2 Adults (both working) 3 Children	\$6.00	\$9.25	\$20.44	\$86,623

Living Wage Calculator, MIT 2017

The Living Wage rates have increased considerably since 2014. A single adult in 2017 needed to earn \$13.28 per hour to be self-sufficient, an increase of almost 11 percent since 2014. A single adult with one child had to earn \$28.46 per hour, an increase of almost 14 percent since 2014. The average teacher in Anne Arundel County made only \$23.74 per hour in 2017, with a small raise in 2018. There are many job opportunities in the county that do not offer even \$12 per hour.¹⁰

¹⁰ Indeed.com, *Anne Arundel County Salaries*, 2018.

Chapter 2 | Expanding Economic Opportunity

Table 11 presents typical annual salaries for various professions in Anne Arundel County. More than a third of salaries listed provide far less than the required living wage estimated for Anne Arundel County, yet many of the lowest income individuals in the county are employed in these fields.

Table 11

Typical Annual Salaries in Anne Arundel County, 2017			
Occupational Area	Average Salary	Occupational Area	Average Salary
Management	\$120,175	Food Prep & Serving	\$22,231
Business/Financial Operations	\$77,493	Building & Grounds Cleaning & Maintenance	\$27,364
Computer & Mathematical	\$98,592	Personal Care & Service	\$24,658
Architecture & Engineering	\$93,973	Sales and Related	\$27,960
Community & Social Service	\$48,730	Office and Administrative Support	\$38,525
Legal	\$69,263	Farming, Fishing & Forestry	\$34,441
Education, Training, Library	\$58,678	Construction & Extraction	\$46,508
Healthcare Practitioners & Technical	\$75,395	Installation, Maintenance & Repair	\$50,891
Healthcare Support	\$31,736	Production	\$36,231
Protective Service	\$46,621	Transportation & Material Moving	\$35,357

Source: MIT Living Wage Calculator for Anne Arundel County, 2018

The Geography of Poverty

Low income families live predominantly in pockets of poverty to the south and north of the county and in Annapolis. Table 12 shows several zip codes with poverty areas greater than the county average.

North County has the highest population of residents living in poverty, (a staggering 27.3 percent in Brooklyn Park), as shown in Table 12. The most recent estimates show child poverty at 23 percent. This part of the county also has the highest rate of parental incarceration; 4,203 individuals with children were incarcerated in Anne Arundel County jails in 2017, over 40 percent of whom have a home address in one of four communities in North County.¹¹ As one North County participant noted:

“Some kids come to school because it’s a safe place and a place to eat and has someone who cares about them.”

Much of North County is a food desert, with few locations where healthy food can be purchased. North County also has the highest rate of substance abuse in the county.

¹¹ Anne Arundel County Jail, 2018.



Table 12

Selected Poverty Percentages and Median Household Income by ZIP Code Anne Arundel County, 2017			
Zip Code	Area	Poverty Percentage	Median Household Income
21225	Brooklyn Park	27.3%	\$41,904
21226	Curtis Bay	16.6%	\$73,438
21060	Glen Burnie (East)	7.9%	\$69,388
21061	Glen Burnie (West)	9.2%	\$65,321
	Anne Arundel County	6.10% (2017 estimates)	\$94,502

Source: Poverty Percentages were supplied by the Maryland Department of Health; Median Household Income is from the U.S. Census Bureau, American Community Survey, 2013-2017. The population base for these two numbers may not be the same.

South County, a region generally defined as that part of Anne Arundel County south of the South River, has a population of just less than 50,000. Much of South County is wealthy, including Davidsonville and communities along the waters of the Bay, and much of it below Edgewater is largely rural. There are several small pockets of poverty in South County that lack access to jobs, health care, transportation, and affordable housing. About 14 percent of its families make less than \$35,000 annually.

Many families in these poor communities suffer from poor health, lack of access to healthy food, and chronic truancy. In Deale and Lothian, the youth unemployment figures are 16 percent and 21 percent, respectively, compared to a 10 percent youth unemployment rate for the county as a whole. Disconnected youth in these areas of South County is a growing concern, as is truancy at Southern High School. The large number of South County heroin overdoses and deaths, relative to population size, also characterize areas surrounding Deale and Lothian.¹²

Annapolis has a population of 39,321, of which almost 11 percent live at or below the Federal Poverty level of approximately \$25,000 for a family of four. African Americans and Hispanics constitute almost 25 percent and 20 percent, respectively, of the total population, and represent a higher proportion of those living in poverty.¹³ Annual median household income for Annapolis is \$74,187, about \$25,000 lower than that of the county overall.

The City has 790 public housing units for low and moderate-income residents, which is inadequate to meet the demand. The age of public housing ranges from 40 to 70 years old and all of it is in need of repair and/or replacement. The Housing Authority of the City of Annapolis also administers 331 rental vouchers and 53 project-based vouchers. There are six Section 8 complexes within the city limits. The crack cocaine epidemic, mass incarceration, and an ever increasing gap between rich and poor, have helped change the demographics and the culture of public and subsidized housing. The majority (almost 85 percent) of residents are African American females living with their children on an average of \$25,000 per year, equal to or below the poverty threshold.¹⁴ With no transportation and little affordable child care, most families in public housing have become mired in intergenerational poverty.

¹² Anne Arundel County Police Department.

¹³ U.S. Census Bureau, *American Community Survey, American Fact Finder*, 2017.

¹⁴ Housing Authority of the City of Annapolis, 2018.

Chapter 2 | Expanding Economic Opportunity

Transportation

The lack of public transportation continues to be a major issue for the county. Eighty percent of county residents drive to work in their own automobile, alone, every day. Almost eight percent participate in a car pool, two percent walk, and two percent take a bus.¹⁵

In 2014, the county created an Office of Transportation, which has led to some improvements. There are now five regional transit routes, eight Annapolis routes, four local bus routes and four commuter bus routes. Additionally, there are two pilot bus routes in South County. Nonetheless, public transportation continues to be a major concern for all participants in this needs assessment. There are large areas of the county that are underserved or not served at all, including North and West County. As one provider noted:

“A family I am working with relocated to Severn. She works at a senior living community in Annapolis. It’s a 3-hour commute via MTA, that’s what you have to do for connections. What about transportation in West County? You’re in Sarah’s House but you are from Annapolis and you want to come back to work here. Forget it. You can’t.”

Low income residents who have no car or share a car have major difficulties getting to work, to college, to the hospital, even to the nearest grocery store. Many low income residents do not know how to drive a car and lessons are prohibitively expensive. Even when that hurdle is overcome, the required number of hours needed for driving is a huge barrier, especially for young drivers. Uber and Lyft are fine for populated areas, but very expensive in outlying or rural areas such as South County. Taxis are in the same category. Cheaper transportation, such as instant rentals of electric scooters and bikes, are increasingly regulated which requires a high initial outlay. Insurance, tags, and title are other costs that have to be factored in to owning an automobile.

Affordable Child Care

As of 2017 there were 494 family child care providers, 120 child care centers, 12 Head Start sites and 41 public pre-kindergarten sites in Anne Arundel County.¹⁶ The distribution of child care centers is uneven across the county. There are none located in Brooklyn Park, Harmans or Shadyside, for example.¹⁷

Table 13

Average Weekly Cost of Full-Time Child Care in Anne Arundel County		
	Family Child Care Programs	Child Care Centers
0-23 months	\$218.55	\$305.53
2-4 years	\$108.64	\$196.09
5 years	\$169.19	\$189.64
School Age Full	\$155.97	\$174.14
School Age B/A	\$102.35	\$107.40

Maryland Family Network, 2018

¹⁵ U.S. Census Bureau, *American Community Survey*, 2016.

¹⁶ Maryland State Department of Education, 2017.

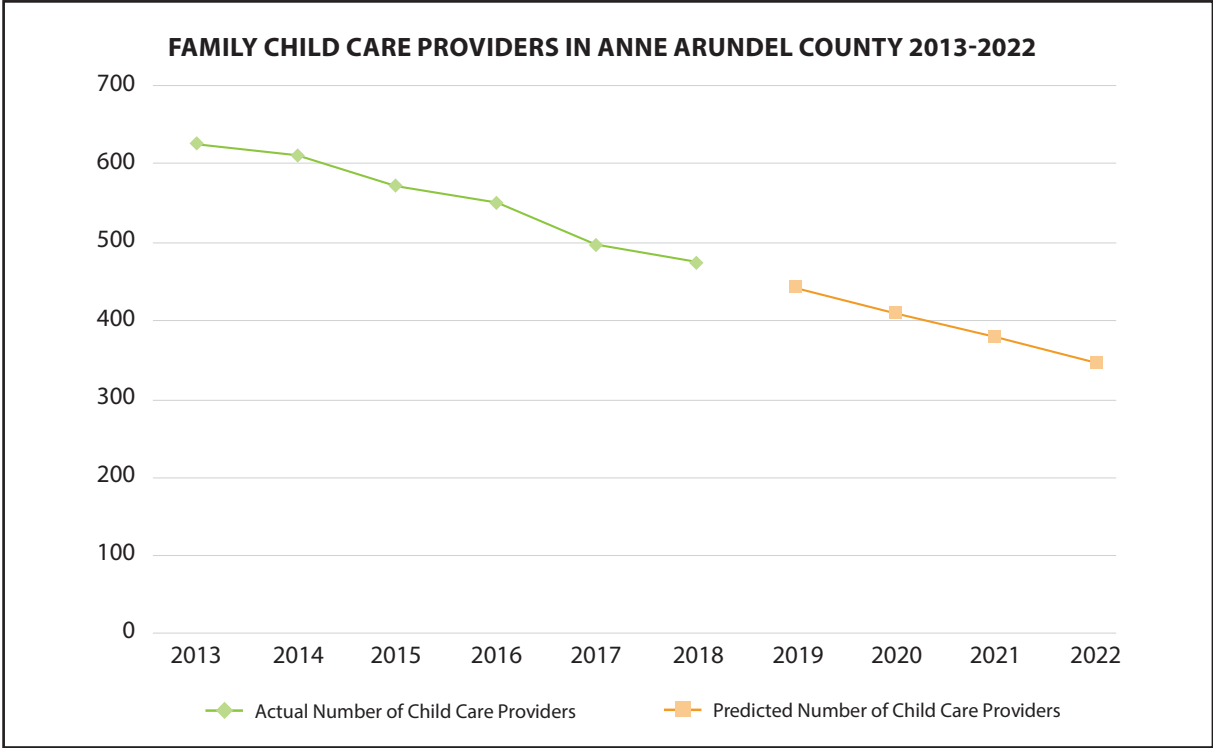
¹⁷ Maryland Family Network, 2018.



The cost of child care continues to rise. The average cost of family day care for two children is over \$20,000 per year, and even more in a licensed child care center.¹⁸ The majority of middle and low income families, therefore, still choose family day care, although the numbers of family day care providers are dropping and are predicted to continue to decline until 2022, as seen in Figure 7.

According to early childhood advocates, the issues driving child care costs upward include the high costs associated with licensed day care as licensing standards increase, and the difficulty in finding qualified employees who will work for the relatively low wages paid by day care providers. The wages for teachers and aides are well below the living wage levels for a single adult with no children, seen in Table 14.

Figure 7



Maryland Family Network, 2018

Table 14

Average Salary of Child Care Professionals in Maryland	
Family Child Care Provider	\$38,790
Child Care Center Director	\$40,766
Center Senior Staff/Teacher	\$25,203
Center Aide	\$17,265

Maryland Family Network, 2018

¹⁸ Ibid.

Housing

As of September 2018, the median home sale price in Anne Arundel County was roughly \$345,000, an increase of 10 percent, or \$30,000, compared to the previous year. The number of houses sold declined 9 percent during the same period to 8,619, with realtors ascribing the decline to low inventory and an increase in mortgage rates.

Renters account for 26.4 percent or 52,948 of the 203,336 households in the county. The median gross

rent paid by Anne Arundel County renters in 2017 was \$1,579 monthly, or almost \$19,000 annually. Forty-five percent of all renters – 24,172 – are “overburdened,” in that they pay more than 30 percent of their gross income in rent. In Anne Arundel County, a household making less than \$4,990 a month – about \$60,000 annually – would be considered overburdened when renting an apartment at or above the median rent.¹⁹

According to the 2016-2020 Consolidated Plan for Anne Arundel County, 66 percent of extremely low income renters and 72 percent (4,645 homeowners) of extremely low income homeowners are paying more than 50 percent of their income for housing. If an emergency, such as sudden unemployment, seasonal lay-off, unexpected medical event, or other difficulties occur, these households risk losing their homes and becoming homeless. Single parent families, the elderly, and those with disabilities who are dependent on one paycheck or on a fixed income are also at risk of homelessness.

There is a decreasing amount of public and subsidized housing in the county. There were 10,278 county families on the waiting list for Housing Choice vouchers as of 2017. There were 17,683 families on the waiting list for public housing in the county in 2018²⁰ and 1,514 families on the Annapolis public housing list.²¹ Eighty-eight percent of the families on the county waiting list included children, five percent represented families with disabilities, three percent were elderly families and the remaining four percent were undesignated. White families constituted 14 percent of the total waiting list, African American families 29 percent, Asian families 0.7 percent and unassigned, 55.9 percent (Table 15).

Homelessness

Homelessness remains a serious socio-economic problem in Anne Arundel County as seen in Table 16. The county served 1,684 homeless individuals in 2017, an increase of 13 percent since 2015. The family homelessness count is only of those families who were served in a shelter program. Many families are doubled up or living in their cars. Anecdotal estimates suggest family homelessness is far higher in the county than shown in the table due to the lack of affordable housing. There are still only three homeless shelters in the county, and three rehousing programs.

Of the 308 homeless people in need of housing services who attended the 2018 Anne Arundel County Homeless Resource Day, only 34 percent were in a shelter or receiving some kind of resident services (Table 17).

Table 15

Anne Arundel County Housing Choice Voucher Waiting List, by Income Level, 2018			
	# of Families	% of total families	Average Days Waiting
Waiting list total	10,278		966
Extremely low income (<=30% but <=50% AMI)	7,414	72.1%	
Very low income (>50% but 80% AMI)	1,836	17.9%	
Low income (>50% but 80% AMI)	746	7.3%	
Over limit for low income (>80% AMI)	282	2.7%	

Housing Commission of Anne Arundel County, Agency Plan FY2018

¹⁹ Towncharts.com, *United States Demographics Data*, 2016.

²⁰ Anne Arundel County Housing Commission, 2018.

²¹ Housing Authority of the City of Annapolis, 2018.



Table 16

Anne Arundel County Homeless Served 2015-2017			
	2015	2016	2017
Single Adult	1138	1215	1290
Veteran	44	41	37
Youth Under 21	15	19	4
Family	256	274	269
Senior 62+	17	40	43
Chronic	46	82	41
Total Served	1516	1671	1684

Anne Arundel County Department of Social Services, 2018

Table 17

Anne Arundel County Homeless Resource Day Attendees 2018, by Living Arrangement		
Type of Living Arrangement	Number of Attendees	Percent of total
Total	308	100%
Living in Shelters	64	21%
Living in Residential Programs/ Halfway Houses, etc.	40	13%
Staying with Family	40	13%
Staying with Friends	40	13%
Renting their own Apartment	40	13%
Living in a place not meant for habitation	31	10%
Other	52	17%

Source: Anne Arundel County, Department of Social Services, 2018

Summary:

Anne Arundel County offers great economic opportunity for the majority of its residents. However, the high cost of living and especially the housing market, creates difficulties for middle class and low-income residents. Wages for public employees – teachers, police officers, and other local government employees – have increased slowly or remained stagnant since the Great Recession, which has made it even more difficult to afford living and working in the county. Too many low income residents are now paying well over 30 percent of their income for rent. Those who work in the lower paid service industries often choose to live in other counties or Baltimore City.

Needs and Gaps

- For those county residents who don't have their own car, or share a car, transportation is a major barrier to self-sufficiency. The major institutions: the community college, county government, the school system, the workforce development agency, and the private sector need to cooperate to develop transportation hubs to their services.
- Quality, affordable child care continues to be a huge barrier to the pursuit of economic opportunity for many residents, particularly those in neighborhoods without any affordable child care services and for single parents.
- Job training and apprenticeships are not accessible to low income residents in the locations they are currently offered.
- The lack of affordable housing continues to be problematic, not just for low income residents but also for middle income professionals.

Chapter 3 | Youth Development

There are approximately 127,512 children under the age of 18 living in Anne Arundel County; a 0.6 percent increase since 2015. Of those, 27.4 percent (35,002) are under five years of age, and 10 percent (over 12,000) live below the federal poverty level; an increase of two percent since 2015.¹

School Readiness

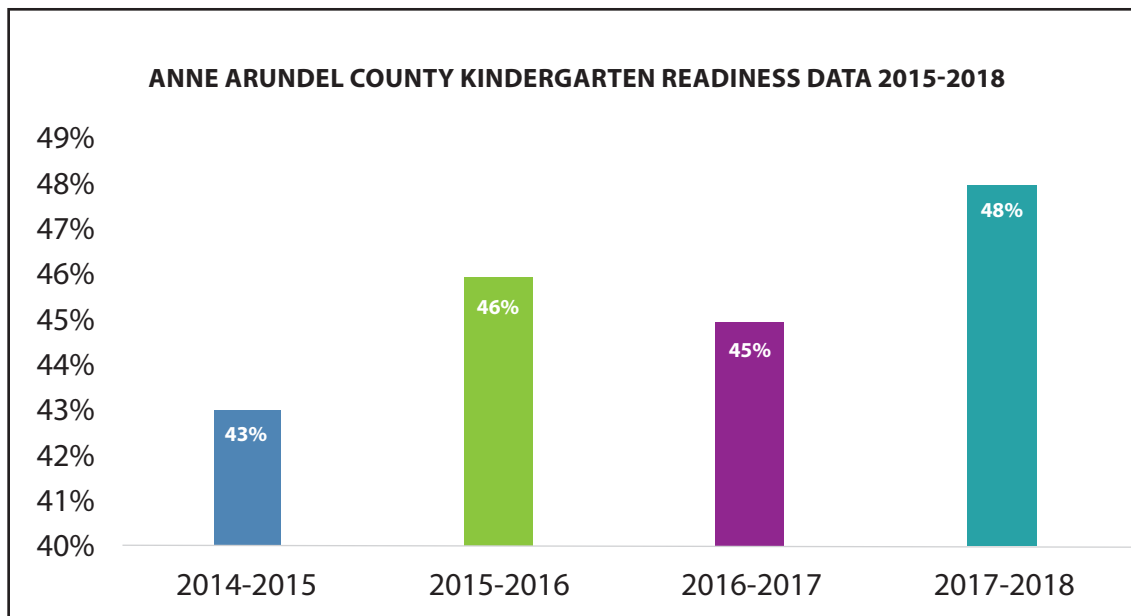
The first five years of a child's life can be the most prophetic in terms of future success and achievement. The brain develops more quickly during the early years than at any other time in life. Babies and young children grow, learn and develop when they receive love and affection, encouragement and stimulation, as well as nutritious meals and good health care.²

The level of income within a community is a statistically significant predictor of differences in kindergarten readiness.³ Numerous studies have documented that low income children as young as age two perform worse across cognitive measures. Further, the number of Adverse Childhood Experiences (ACES) a child has experienced can also decrease readiness. ACES have been associated with risky health behaviors, chronic health conditions, low life potential, and early death.⁴ ACES may also cause inability to process verbal and nonverbal or written information, inability to effectively use language to relate to others, lack of sequential organization, and inability to distinguish emotions, all essential skills in the kindergarten classroom.⁵ As one participant noted:

“...you don't know colors, and you don't know letters, and you have a 100 word vocabulary and your peers are coming in with a 3,000 -10,000 word vocabulary. That's a huge gap that puts you at a disadvantage.”

In 2015, a new kindergarten readiness tool was introduced to Anne Arundel County Public Schools: Ready4Kindergarten or R4K. While scores have improved from a low of 43 percent in 2015 (Figure 8), the 2018 score still shows less than half of county children are ready for kindergarten.

Figure 8



Anne Arundel County Public Schools, 2018

¹ U.S. Census Bureau, *American Community Survey*, 2017 Estimates

² The Annie E. Casey Foundation, Baltimore: *The First Eight Years: Giving Kids a Foundation for Lifetime Success*, 2013

³ Loughan, A. and Perna, R., *Neuropsychological Profiles and Subsequent Diagnoses of Children With Early Life Insults: Do Caregiver Reports Suggest Deficits?*, 2014.

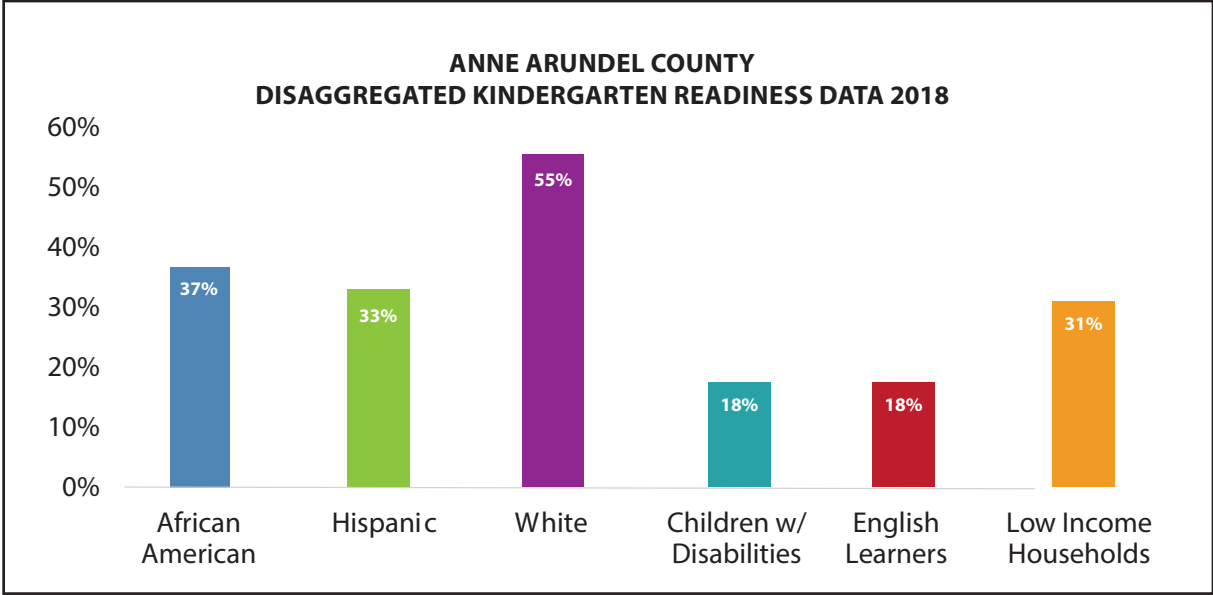
⁴ Centers for Disease Control and Prevention, *Violence Prevention - Adverse Childhood Experiences*, 2018.

⁵ Hertel, R. and Fretzo, L. *Compassionate Schools*, 2011.



When the data is disaggregated by disability status, race/ethnicity, English proficiency, and low income, the scores are much lower and the achievement gap is clearly visible.

Figure 9



Anne Arundel County Public Schools, 2018

Mental Health and Behavioral Issues in Early Childhood

Increased mental health and behavioral issues in the early childhood population are causing widespread concern in every system. Behavioral problems in children as young as two years old are disrupting child care facilities including Early Head Start and Head Start. They are causing consternation for parents, and increasing stress for preschool and kindergarten teachers. Hospital personnel described young children in the emergency department as “totally out-of-control” and physically assaulting staff who try to calm them. Parents are described as “exhausted and desperate - looking for a place they can keep their child safe.” As one provider commented:

“The shift is more and more towards younger children. It used to be that when five, six, and seven year olds came in we thought they just needed better parenting. We don’t say that anymore because a lot of these kids are really sick. About 50 percent of them need to be hospitalized.”

Professionals are divided as to the cause of this increase, but they all agree that this is a new phenomenon unrelated to income. Many suggested the use of social media by parents and young children is leading to huge deficits in social and emotional skills. It is no longer surprising to see young children “biting, scratching,” and even “throwing chairs” in kindergarten classrooms. Children as young as two are being diagnosed with Attention Deficit Disorder and medicated accordingly.

Chapter 3 | Youth Development

Some serious mental health issues are surfacing earlier, often co-occurring with developmental issues such as autism. As one professional commented “we’ve seen some kids with psychotic issues at a very young age.” According to the Anne Arundel County Mental Health Agency (2018) the birth to age five population is showing another large increase in use of mental health services, a rise of 11.4 percent in one year. Yet there is a huge lack of resources inside the public school system and within the community for this age group. According to participants from hospitals and schools, suicidal ideation and “cutting” behaviors are becoming more and more common at the elementary school level. Pediatricians are attempting to manage the crisis, usually with medications. Many professionals commented that for the age 0-5 population, parents are the most important piece of the picture. As one noted:

“If you took the child out of the environment would we still see the behavior? It is not just the traditional intergenerational poverty environments, it is truly parents. Even if you have an environment that feels or looks okay, you may have a parent who is not skilled. We obviously have more vulnerable families who have issues with opioids. Kids may be acting out, but when you see the parenting up close ...”

The K-12 years

The Anne Arundel County Public School System consists of 111 schools: 80 elementary, 19 middle, and 12 high schools. These numbers have not changed since 2014 despite continuing growth in the number of students. The total enrollment rose from 79,720 in 2015, to 83,307 in 2018 (Table 18). In 2018, ground was broken on the \$124.5 million Crofton High School that will serve 1,700 students.

Table 18

Enrollment Data for Anne Arundel County Public Schools (2015 – 2018) Anne Arundel County Public Schools Overview					
Type of School	# of Schools in County	Total Number of Students Enrolled			
		September 2015	September 2016	September 2017	September 2018
Elementary School (Grades PreK-5)	80	39,947	40,649	41,323	45,284
Middle School (Grades 6-8)	19	17,620	17,747	18,089	16,977
High School (Grades 9-12)	12	22,153	22,370	22,715	21,046
Totals	111	79,720	80,766	82,127	83,307

Anne Arundel County Public Schools, 2018



The Hispanic Population

There are 11,147 Hispanic students in the Anne Arundel County Public School System, over 14 percent of the student body. The students hail from several Spanish speaking countries, although currently the majority are from El Salvador. Some elementary schools now have a majority (or over 50 percent) Hispanic students. Many are English Language Learners, some were forced to flee their own countries due to violence, and a very small percentage are illiterate in their own language. School system officials expect this demographic to grow and are responding as quickly as possible to the growing need for English for Speakers of Other Languages (ESOL) teachers, but there is a shortage within the county. Those available are itinerant (move from school to school) in order to serve as many students as possible, which often means they serve each student only once per week. Parents are increasingly difficult to engage because they are afraid. As one focus group participant noted:

“They are becoming more and more afraid to call for anything or ask for anything. It’s been a lot more difficult to persuade them, and say ‘no really this isn’t going to hurt your immigration status.’”

Academic Achievement

Maryland now uses the Maryland Comprehensive Assessment Program (MCAP) as the umbrella for all standardized state testing. Anne Arundel County uses the Partnership for Assessment of Readiness for College and Careers (PARCC) as the test to assess Language Arts and Math. In the 2018 Maryland school district rankings, Anne Arundel County ranked 13 of 24 school districts based on the most recent test scores. As illustrated in Tables 19 and 20, over 85 percent of Anne Arundel County 8th graders are not meeting standards in math, and less than half are meeting standards in reading. The constantly changing scoring mechanisms at the state level makes interpreting the scores more difficult.

Table 19

8th Grade Math Performance Levels - PARCC (2018 Name Change to MCAP)						
Location	Achievement Level	Data Type	2015	2016	2017	2018
Maryland	Not meeting or exceeding	Number	31,627	33,865	31,504	31,524
		Percent	76.8%	78.1%	83.2%	84.1%
Anne Arundel County	Not Meeting or exceeding	Number	2,902	2,845	2,843	2,916
		Percent	85.5%	90.4%	86.7%	88.7%

The Annie E. Casey Foundation, Kids Count Data Center, 2018

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Table 20

8th Grade Reading Performance Levels - PARCC (2018 Name Change to MCAP)						
Location	Achievement Level	Data Type	2015	2016	2017	2018
Maryland	Not meeting or exceeding	Number	35,320	38,098	38,489	37,614
		Percent	59.5%	61.4%	61.1%	58.7%
Anne Arundel County	Not Meeting or exceeding	Number	2,746	3,342	3,315	3,351
		Percent	50.2%	58.5%	56.8%	56.4%

The Annie E. Casey Foundation, Kids Count Data Center, 2018

Free and Reduced Meals (FARMS) Students

Eight of ten children from low income households receive FARMS, which is a measure of household poverty. The Anne Arundel County Public School System has a reasonably low rate of FARMS students overall: 37 percent at the elementary school level; 31.8 percent in middle schools and 37 percent at the high school level. However, when we compare two school feeders, one in a relatively high income area and one in a low income area, the differences in rates are dramatic. The range is from 76.86 percent at Park Elementary in Brooklyn Park, to 1.53 percent at Shipley's Choice Elementary in Severna Park (Tables 21 and 22).

Table 21

North County High School Feeder System, Free and Reduced Meals (2018)		
School	Total Free and Reduced	Percentage Free and Reduced
North County High	989	44.5%
Brooklyn Park Middle	388	53.81%
Lindale Middle	485	44.41%
Belle Grove Elementary	206	71.53%
Brooklyn Park Elementary	236	53.76%
Ferndale Early Education Center	73	50.69%
George Cromwell Elementary	133	42.77%
Hilltop Elementary	539	76.13%
Linthicum Elementary	93	8.73%
North Glen Elementary	179	65.09%
Overlook Elementary	197	52.39%
Park Elementary	372	76.86%

Anne Arundel County Public Schools, 2018



Table 22

Severna Park High School Feeder System, Free and Reduced Meals (2018)		
School	Total Free and Reduced	Percentage Free and Reduced
Severna Park High	62	3.28%
Severna Park Middle	68	4.67%
Benfield Elementary	15	3.43%
Folger McKinsey Elementary	24	3.83%
Jones Elementary	29	8.73%
Oak Hill Elementary	54	7.79%
Severna Park Elementary	24	5.76%
Shipley's Choice Elementary	6	1.53%

Anne Arundel County Public Schools, 2018

Achievement Gap

Nationally standardized (NAEP) Reading and Math testing data from 2007 to 2017 illustrates a downward trend in 8th grade Math and Reading achievement for the 2017 school year (Tables 23 and 24). The achievement gap related to race, ethnicity and low income children (as measured by FARMS) is clearly visible.

Table 23

Anne Arundel County Public School Students Scoring at "Basic" or Above on 8th Grade NAEP Math Assessments (2007-2017)						
	2007	2009	2011	2013	2015	2017
All Students	73%	75%	74%	74%	71%	66%
African American/Black	53%	55%	55%	59%	52%	49%
Hispanic/Latino	64%	64%	61%	69%	64%	55%
FARMS	57%	55%	55%	60%	53%	48%

National Center for Education Statistics, 2018

Chapter 3 | Youth Development

Table 24

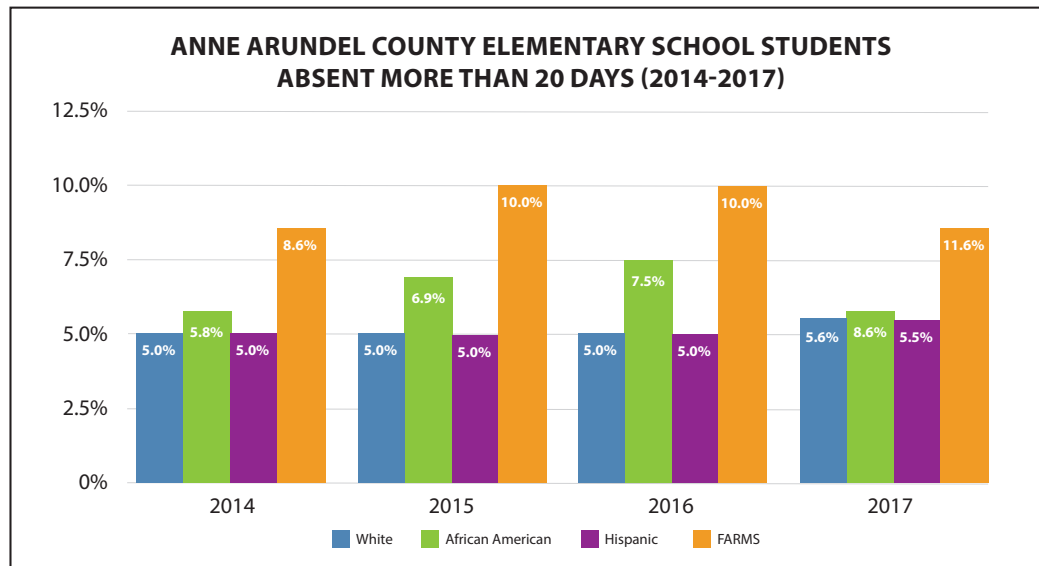
Anne Arundel County Public School Students Scoring at "Basic" or Above on 8th Grade NAEP Reading Assessments (2007-2017)						
	2007	2009	2011	2013	2015	2017
All Students	76%	77%	80%	82%	76%	74%
African American/Black	60%	61%	66%	70%	60%	60%
Hispanic/Latino	69%	71%	71%	78%	69%	64%
FARMS	61%	61%	63%	72%	62%	59%

National Center for Education Statistics, 2018

Truancy

Students are considered habitually or chronically truant if they are absent for 20 or more days during the school year. Research shows that students who miss more than 20 days of school in preschool, kindergarten, and first grade are much less likely to read at grade level by the third grade. Students who cannot read at grade level by the end of third grade are four times more likely than proficient readers to drop out of high school. The likelihood of chronic absenteeism increases as students progress into high school and often leads to poor outcomes later in life, from poverty and diminished health, to involvement in the criminal justice system.⁶ According to the 2018 Maryland Report Card, the county's chronic truancy or habitual absenteeism rate has risen across all grade levels and student populations. This should be of great concern at the elementary level (Figure 11). Children from low income families who receive free lunch (FARMS) have the highest levels of chronic truancy, an increase of three percent since 2014. Hispanic children have the least chronic absences of all students.

Figure 10



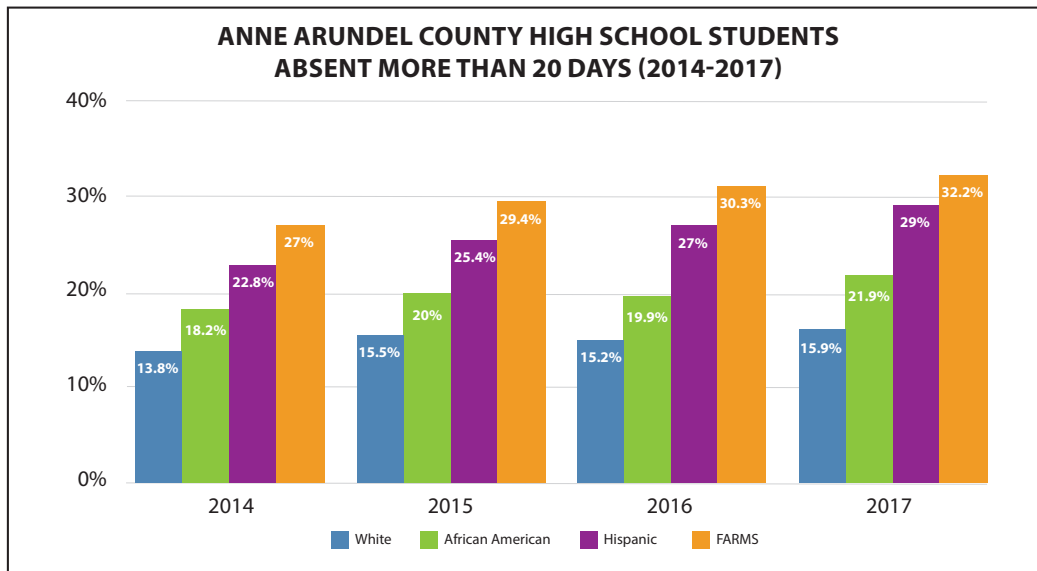
Maryland Report Card, 2018

⁶ U.S. Department of Education, *Chronic Absenteeism in the Nation's Schools*, 2016.



According to participants in this needs assessment, by ninth grade many vulnerable and struggling students have effectively already dropped out of school, although they may turn up every so often and “roam the halls.” Figure 11 shows a steady increase in chronic absenteeism over three years for all student populations; the highest being an over three percent increase for FARMS students.

Figure 11



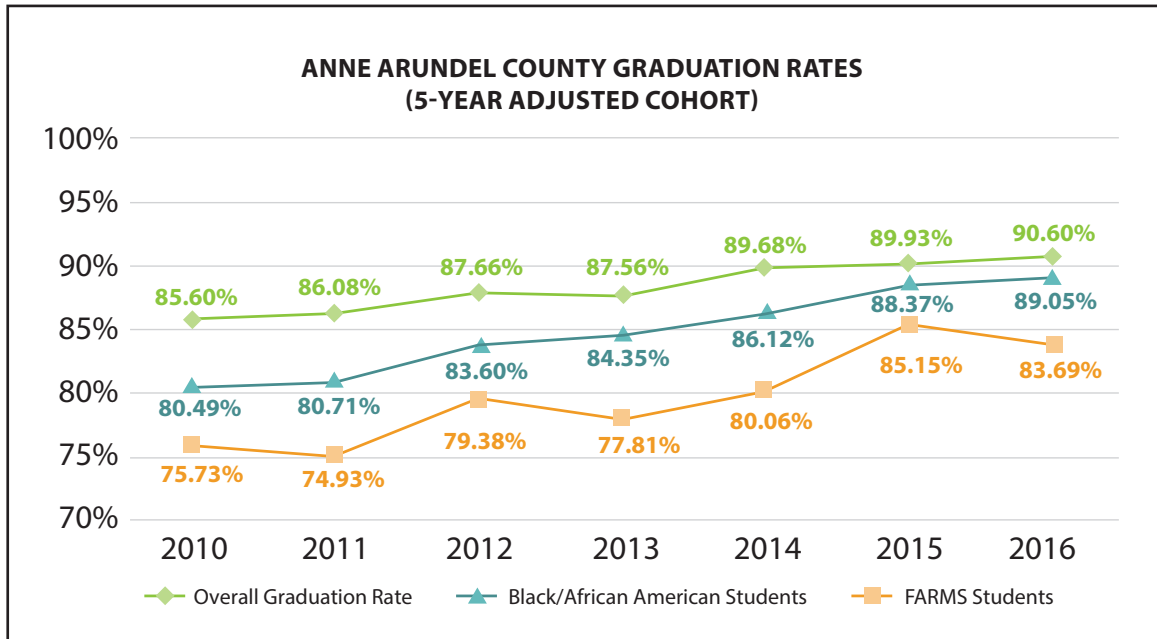
Maryland Report Card, 2018

Graduation Rates

The on-time graduation rate is the number of students graduating divided by the number of students entering ninth grade four years earlier. High school graduation rates are one of the measures of the overall effectiveness of our school system. Among the school districts in the state of Maryland, high school graduation rates range from 74.84 percent in the Baltimore City district, to 95 percent in Queen Anne’s, Calvert, and Carroll counties. Anne Arundel County’s overall graduation rate has risen just shy of five points from 85.6 percent in 2010 to 90.5 percent in 2016, a rate approximately 3 percent higher than the state of Maryland at 87.67 percent. Nine of the county’s 12 high schools have graduation rates of 90 percent and higher, led by Severna Park High School (over 95 percent). There are still gaps in achievement related to race and income, (Figure 12) but these gaps do slowly appear to be shrinking. Between 2010 and 2016, African American students have shown an 8.56 percent improvement, and FARMS students have shown 7.96 percent improvement in graduation rates.

Chapter 3 | Youth Development

Figure 12

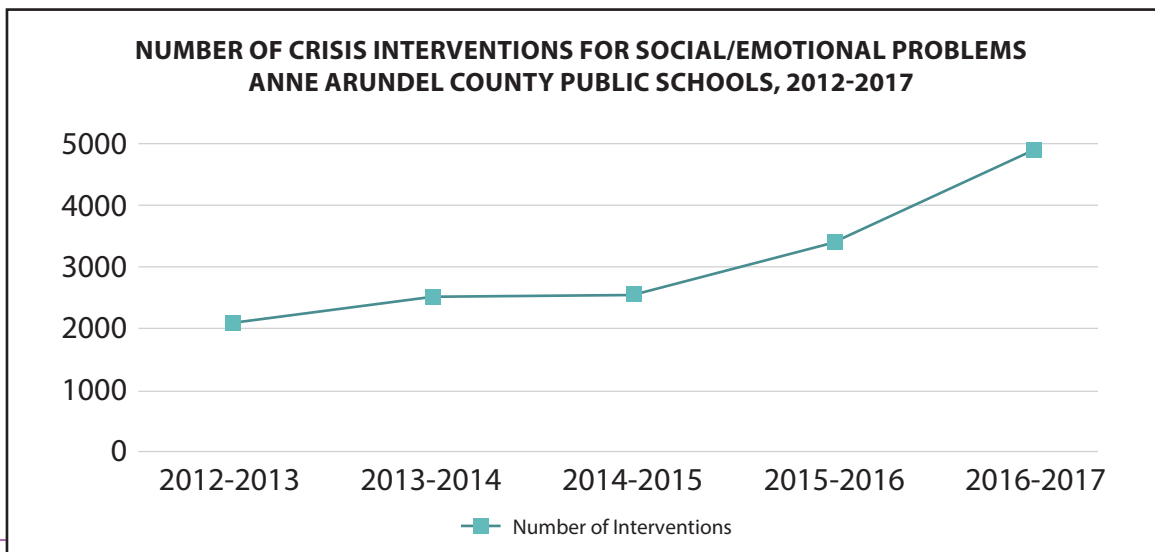


Maryland Report Card, 2018

Mental Health and Older Youth

The Anne Arundel County Department of Health provides school health services to all public school students through school nurses. The nurses work with school system guidance counselors to address students' physical and mental health issues as they are identified and to coordinate interventions as needed. The number of crisis interventions in the public school system for social and emotional issues has doubled since the 2012 - 2013 school year (Figure 13).

Figure 13



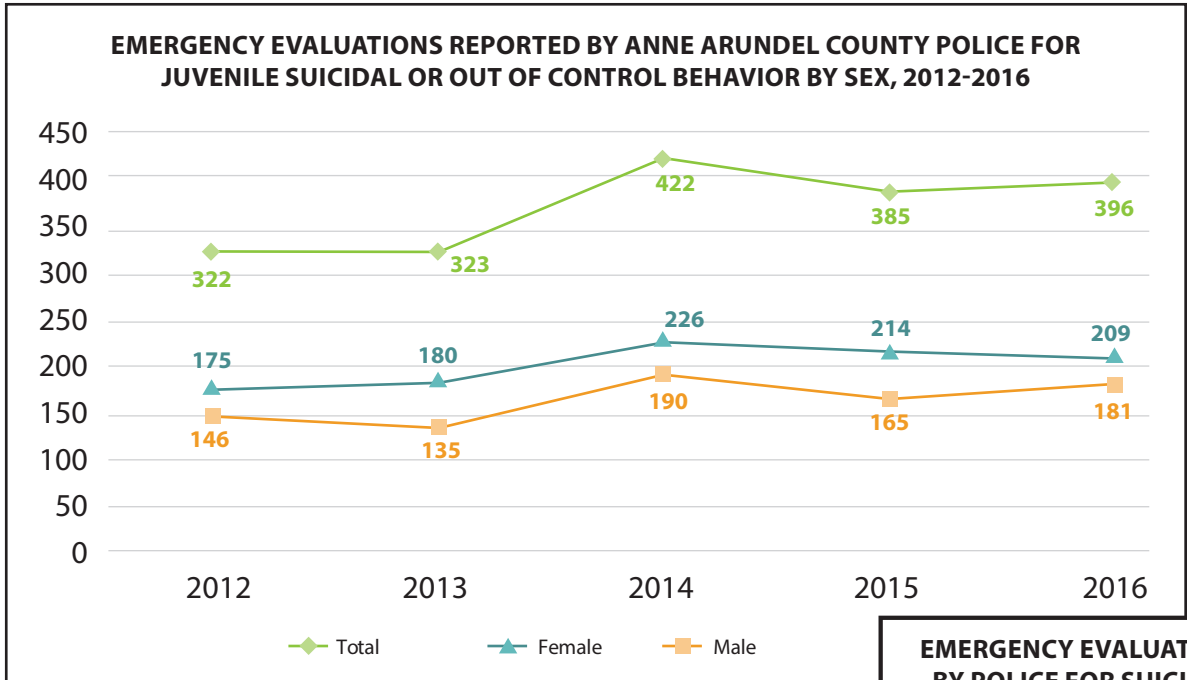
Anne Arundel County Department of Health, 2018



As of 2016, the Anne Arundel County youth suicide rate was 7.8 per 100,000, an increase from the rate of 5.3 per 100,000 in 2012. The American Foundation for Suicide Prevention estimates that for each youth suicide, there are 25 suicide attempts.⁷ Between 2012 and 2016, there were 1,306 Emergency Department encounters in Maryland hospitals for suicide attempts by Anne Arundel County youth aged 10 to 24 years, an average of 261 per year. Similar to the completed suicides among this age group, there were more Emergency Department encounters for suicide attempts between 2012-2016 (compared to the previous report for 2008-2012) costing Emergency Departments an estimated \$1.1 million. According to the 2016 High School Youth Risk Behavior Survey, the percentage of Anne Arundel County high school students who felt sad or hopeless almost every day for 2 weeks in a row so that they stopped doing some usual activities increased significantly between 2014 and 2016.

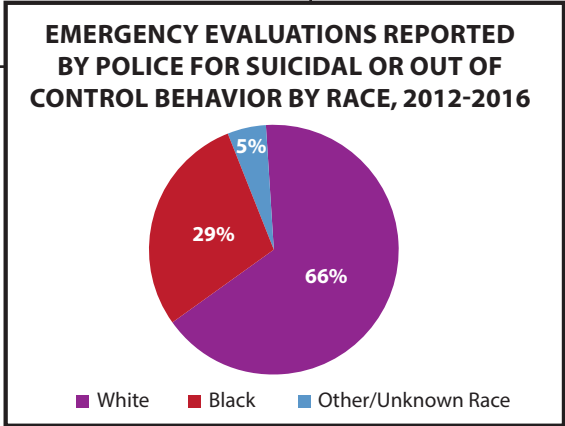
The number of emergency evaluations by county police for juvenile suicidal or out of control behavior has been steadily rising since 2012 (Table 14). County police performed over 1,800 emergency evaluations for juveniles (ages 17 years and under) for suicidal or out of control behavior from 2012 through 2016. Two thirds of the juveniles were White, 29 percent were Black (Table 15).

Figure 14



Anne Arundel County Police Department, 2016

Figure 15



Anne Arundel County Police Department, 2016

⁷ American Foundation for Suicide Prevention, *Suicide Statistics*, 2017

Chapter 3 | Youth Development

Participants in this needs assessment emphasized the growing mental health issues for youth throughout the school system. Cutting behaviors, depression and anxiety are increasing. Since 2016, there has been an over ten percent rise in mental health services for youth ages 6-12 years, and an 8.1 percent rise for youth ages 12-17. Educators stressed that trauma, poverty and substance abuse at home impact many children. As one noted:

“We have kids that are totally out of control. It’s coming from a multitude of factors, and lack of parenting is a huge piece of it. The worst cases we have managed include parents who were on pills, experiencing homelessness or about to be evicted.”

Hungry Children

In several research studies, childhood hunger has been associated with significantly poorer cognitive functioning, decreased school attendance, and diminished academic achievement. Many participants in this needs assessment from school personnel to the faith community, noted that they are seeing more hungry children who are unprepared for the school day than ever before. As one school administrator noted:

“They haven’t eaten at home, they barely have a sofa to sleep on, and there are things happening at home so they are not getting a good night’s sleep. Therefore, when they come to school and their homework isn’t done, as a teacher, that’s really the least of your worries. We worry about what’s happening at home and how can we help?”

While there are volunteer backpack programs that send children home from school with a weekend supply of food, and/or church food pantries and SNAP (food stamps) programs for those eligible, there are many gaps, particularly for those children living with grandparents, relatives, and friends. The free breakfast and lunch program within the public school system has seen a persistent increase in the number of children registering for and receiving free breakfast and lunch. The number of children receiving free breakfast has risen almost 21 percent in four years. An added concern is that school breakfasts are served only 181 days of the year, just over half of the potential days for a child to eat breakfast. The number of free lunches served daily to students has increased from 14,351 in 2014 to 15,216 in 2018, a seven percent increase.⁸

⁸ Anne Arundel County Public Schools, 2018.



Youth Gang Violence

For some youth in Anne Arundel County, informal gangs (neighborhood crews) or legitimate, international gangs such as Mara Salvatrucha (MS-13) provide the consistency, safety, and security usually provided by the family. The sense of belonging and purpose has been described, eloquently, by gang members. The Annapolis Collaborative for Change, a cross sector partnership on gun and gang violence, has inventoried at least ten identifiable neighborhood crews in Annapolis alone, and four sects of MS-13 across the county. Neighborhood crews appear to have developed from the rivalries or neighborhood 'beefs' in low income and public housing communities. Thirty years ago these natural turf wars, waged fiercely on a sunny Saturday afternoon, were most often settled with a cross-community get together or cook-out on the same evening. As one ex-resident of a public housing complex noted:

“The neighborhood was like a family – everyone looked after everyone’s kids. I grew up with a single parent who warned against ever having a cop knocking on the door. We were all raised as brothers and sisters. Even the drunk on the corner would threaten to tell your Mom if you were up to no good.”

Young people get involved in gangs to belong. They sell drugs to be perceived as successful and entrepreneurial, to buy tennis shoes, and sometimes to buy food or pay rent for the family. It is a local cottage industry described by a community member as “a pyramid scheme and no-one wants to stop the flow.” Arguments over drug territory and sales have become entangled with the old neighborhood rivalries. As another resident noted, “There are territories. They are controlling territories so they can do drug transactions.”

MS-13 (an international criminal gang that originated in Los Angeles, California, in the 1980s) has an organized presence in the county. Members are searching for young recruits. According to one Hispanic resident:

“They are active in schools in Annapolis, Arnold, and Glen Burnie. Some elementary school children are very familiar with MS-13. They are second generation – their parents are gang members. Children as young as 13 in Annapolis have been invited in. No one wants to ‘snitch.’”

Since the Needs Assessment, *Poverty Amidst Plenty V: Striving to Achieve Progress For All* (2015), youth violence has increased in the public school system, both in amount and intensity. While the incidents of fatal youth gun violence have declined in the county, anxiety related to gun violence was expressed by several participants. The concern about the possibility of a gun related incident in one of the local schools was expressed by some. As one professional noted:

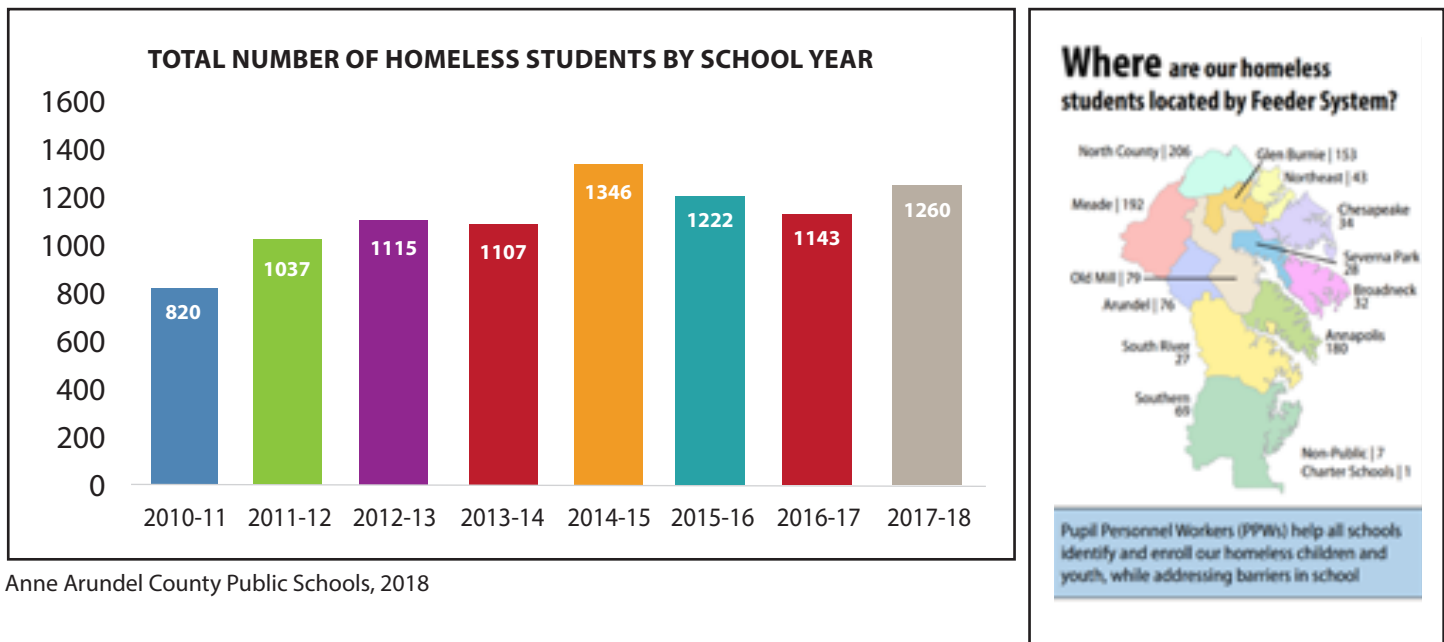
“What they are being disciplined for is qualitatively different ... fights were fights, and now fights involve weapons. Aggression was aggression, but now the aggression is more dangerous, more volatile, having more serious repercussions in terms of injuries and the like.”

Chapter 3 | Youth Development

As of June 2018, there were 1,260 homeless youth identified in the county public school system (Figure 16). North County schools accounted for 337 of the homeless children, triple the amount for 2016. The county Youth Reach Survey for 2018 documented 137 unaccompanied, homeless youth. A disproportionate number of unaccompanied homeless youth live in North County; 18 percent are living outside or in an abandoned building, over 33 percent have spent time in adult jail or juvenile detention facilities, and only 10 percent of older youth (age 16 to 24) have a full-time job (down from 17 percent in 2017).

Figures 16 and 17

ANNE ARUNDEL COUNTY HOMELESS STUDENTS BY SCHOOL YEAR & GEOGRAPHY



Anne Arundel County Public Schools, 2018

There are an estimated 6,702 disconnected youth in the county, a small drop from the 2017 figure of 7,000.⁹ Disconnected youth are young people aged 16 to 24 who have dropped out of school, are not in college, and are without employment or any sort of career path. These youth are disproportionately found in North County, but a South County needs assessment (completed in 2017) showed unemployment and disconnection among South County youth is a growing concern. In fact, many youth are leaving South County to find employment, which is contributing to the majority aging population in the area.

When youth employment figures for county youth aged 17-24 are disaggregated, the African American rate of unemployment is 25 percent as opposed to an overall rate of 13.2 percent (Table 25).

⁹ Opportunity Nation, *Opportunity Index*, 2018.



Table 25 EMPLOYMENT STATUS BY RACE AND ETHNICITY, AGES 17-24, (2012 – 2016)

Employment Status Race and Ethnicity	July 2012	July 2013	July 2014	July 2015	July 2016
Total					
Population	38,799	38,861	38,735	38,589	44,175
Employed	19,461	19,684	20,085	20,333	32,696
Unemployed	4,011	3,821	3,353	2,829	5,144
Unemployment Rate	17.1%	16.3%	14.3%	12.2%	13.6%
White					
Population	28,956	28,866	28,718	28,488	31,552
Employed	15,498	15,679	15,917	15,903	25,277
Unemployed	2,715	2,525	2,220	1,832	3,267
Unemployment Rate	14.9%	13.9%	12.2%	10.3%	11.4%
Black or African-American					
Population	5,971	5,997	5,973	5,916	7,461
Employed	2,323	2,315	2,376	2,645	5,496
Unemployed	933	910	784	691	1,835
Unemployment Rate	28.6%	28.2%	24.8%	20.7%	25%
Hispanic of Latino Ethnicity					
Population	8,164	8,229	8,313	8,406	8,488
Employed	3,799	3,897	3,903	4,127	4,244
Unemployed	860	859	772	601	536
Unemployment Rate	18.5%	18.1%	16.5%	12.7%	11.2%

U.S. Department of Labor, 2017

According to the Opportunity Nation website, the lost revenue and social service investments for disconnected youth are estimated to cost taxpayers \$93 billion a year and \$1.6 trillion over their lifetimes.¹⁰

¹⁰ Opportunity Nation, *Disconnected Youth*, 2018.

Chapter 3 | Youth Development

Sports, Recreation and the Arts

The county public school system offers arts programming through its magnet programs in the Performing and Visual Arts (PVA). PVA is available at Wiley H. Bates and Brooklyn Park Middle Schools, and Annapolis and Broadneck High Schools. Maryland Hall for the Creative Arts, the Chesapeake Arts Center, the Annapolis Children's Museum and several non-profit organizations offer after school and summer arts programs. However, for low income students, the lack of any transportation out of their neighborhood makes participation difficult.

Many participants in this needs assessment lamented the lack of sports and recreation opportunities for children and youth across the county, especially the removal of middle school sports from the curriculum in public schools. Participation in a school sports team is tied to academic achievement. When students have failing grades they cannot participate in sports. While this is supposed to act as an incentive to improve grades, according to participants it most often acts as a disincentive to attend school.

Parents from every race, ethnicity and income level decried the lack of "active things to do" for children and youth. While some communities have a recreation center for youth, many do not. One parent and county resident recalled the importance of inter-neighborhood sports during his childhood:

"When I was young we had our own community sports and associations and we played against the other communities. So there was great investment within those communities for young people; we played against Pumphrey, and Pumphrey played against Freetown, Freetown played against Magothy. Now we have the recreation leagues that are pulling youth out of their communities - it's not community driven."

School personnel also noted the importance of sports and the need for more recreation centers in low income neighborhoods where youth struggle with transportation needs as well as the negative outcomes associated with poverty. As one noted:

"We need rec-centers. Only the families who can afford to sign up their kids for sports can engage in them. I tell everyone I'm a product of community center, rec-center, I went to summer camp there, I went to Head Start there. It was the catch-all."

Career and Work Opportunities

There are three institutions of higher education within county boundaries. Anne Arundel Community College is a two-year institution with three campuses, and had an enrollment of 18,734 full-time credit students in fall of 2018. St. John's College, a four-year liberal arts college in Annapolis had an enrollment of 513 in the same year. The county is also home to the United States Naval Academy, a four year institution with an enrollment of 4,495 in fall of 2018.

Several participants in this needs assessment commented on the lack of apprenticeship and career opportunities for those students who are not college bound. School system officials recognize that for some students who may successfully graduate, there is no formal path forward. As one school official asked:

"What can we be doing, the community college and others in the county, for those students that aren't going off to college and are really seeking some marketable career skills as they leave us in the K-12 system and go into the workforce?"



Anne Arundel Community College recently announced plans to expand its skilled trades program by 2021. The college plans to construct a new Center for Innovation and Skilled Trades on its Arnold campus. The center will initially offer certification for forklift operation and general contracting with plans to expand to training in plumbing, electrical, HVAC and welding.¹¹

Summary

The successful development of youth in our county begins during early childhood. The birth to five year period may be the most important in terms of future social, emotional and academic development. It is in these years that gaps in achievement related to income, race, ethnicity and special needs begin. Participants commented overwhelmingly on the rapid increase in behavioral and mental health issues for this age group, a problem that county leaders must struggle with. Mental health and substance abuse issues for older youth should also be made a priority. There should be increased collaboration between the public school system, community college and workforce development to ensure that our youth have work options.

Needs and Gaps in Services

- The need for behavioral supports for young children continues to grow. The public school system needs additional community support as it grapples with this problem.
- Anxiety and depression, including increased suicidal ideation among public school students, requires a huge increase in mental and emotional health services inside and outside of the school system.
- Mentoring programs continue to be high on everyone's list of needs, especially for financial literacy and soft skills, but also for adults who can act as role models and support for youth who have little parental supervision and those who are unaccompanied. **There has been almost no increase in mentoring programs since this gap was highlighted in the 2015 needs assessment.**
- Youth recreation and support centers within low income communities are desperately needed. The lack of transportation for low income parents and their children makes this need even greater.
- Participants from every income level commented that we need **"something for our kids to do after school, a place to be."**
- While the public school system does an excellent job feeding children, there are gaps on weekends and during semester breaks. This need is greatest in North and South counties.
- The lack of consistent career education in the school system has not changed since 2015.
- The need for coordinated employment services for those youth who are not college bound is growing as the job market grows.
- Many parents, at every income level, are struggling with raising children. While some are single, low income parents, all parents who took part in this needs assessment were battling the impact of social media. The lack of parenting programs in the county continues to be a significant area of need.

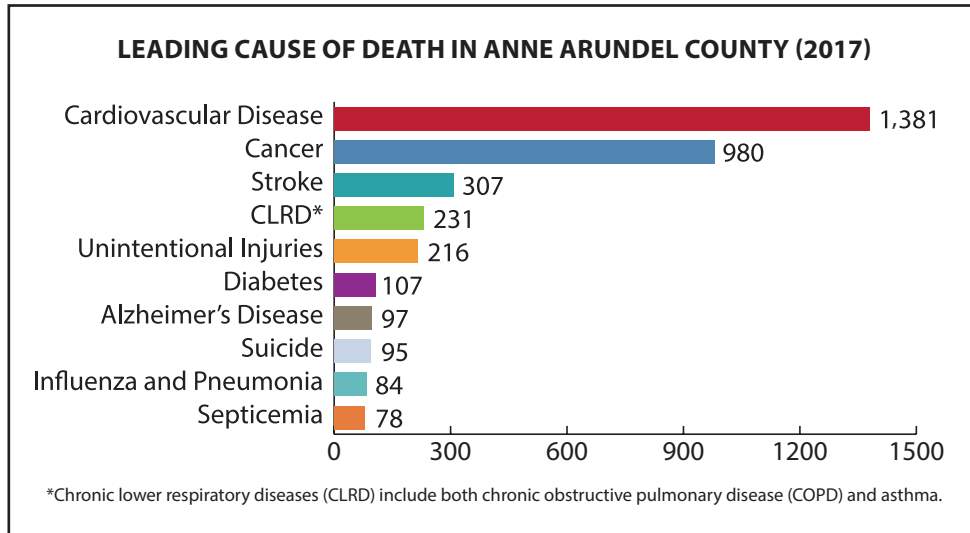
¹¹ Lauren Lumpkin, *AACC receives \$1M gift to fund skilled trades program*, The Capital, January 29, 2019.

Chapter 4 | Health

Health

In 2017, there were 4,461 deaths in Anne Arundel County, and life expectancy was 79.6 years. Cardiovascular disease was the leading cause of death in the county, followed by cancer. Accidental deaths (unintentional injury) were the fifth leading cause of death, primarily driven by increases in opioid overdose deaths. That number has risen almost 10 percent since 2013 (Figure 18).

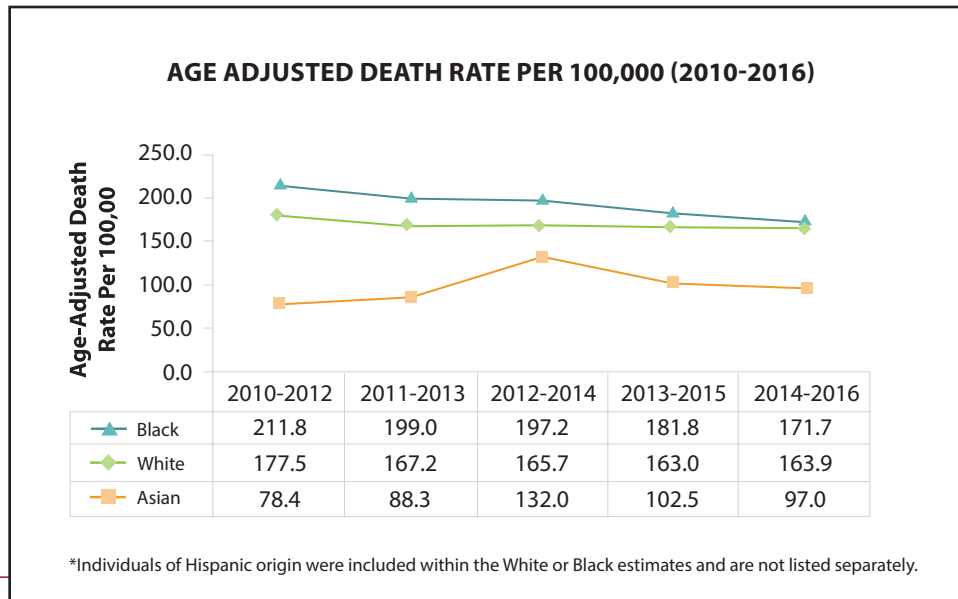
Figure 18



Maryland Department of Health, Vital Statistics Administration, 2018

Age-adjusted death rates for coronary heart disease decreased for Blacks and Whites between 2013 and 2016. While Blacks still have the highest death rates in the county per 100,000 residents, that number decreased by 18 percent in just three years. The decrease for Whites was only 8 percent (Figure 19).

Figure 19



Centers for Disease Control and Prevention, 2016



Births

Many factors affect pregnancy and childbirth including the mother’s pre-pregnancy health status, the mother’s age at birth, access to health care and socioeconomic status.¹ In 2017, there were 6,985 births in Anne Arundel County. Of those births, 4,242 were non-Hispanic White, 1,273 were non-Hispanic Black and 936 were Hispanic (Table 26).

Table 26

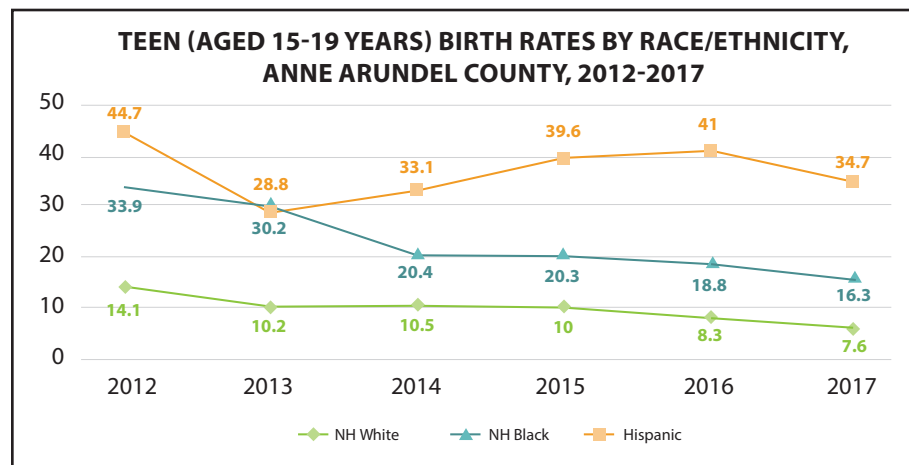
Anne Arundel County Births by Race and Ethnicity (2013-2017)					
	2013	2014	2015	2016	2017
Total	6,814	6,968	6,924	6,994	6,985
NH*White	4,399	4,483	4,383	4,357	4,242
NH Black	1,204	1,236	1,259	1,291	1,273
Hispanic	827	866	847	896	936

Maryland Department of Health, Vital Statistics Administration, 2013-2017 Annual Reports.

Adequate prenatal care access is a concerning issue in the county. The Hispanic population is showing the greatest increase in births, approximately 15 percent, yet there is low utilization of available OB-GYN services. The county Health Department reports since 2012, there has been an overall decrease in pregnant women seeking prenatal care during their first trimester. In 2016, less than half of Hispanic mothers received prenatal care during their first trimester of pregnancy and 10.5 percent of Hispanic mothers received late or no prenatal care.²

The teen birth rate has dropped for all races/ethnicities since 2013, although the Hispanic rate has shown an uptick since 2013. The Black teen birth rate has dropped by almost half since 2012 (Figure 20).

Figure 20



Maryland Department of Health, Vital Statistics Administration, 2012-2017 Annual Reports

¹ Anne Arundel County Department of Health, 2018.

² Ibid.

Infant Mortality

Infant mortality measures deaths during the first year of life. In 2017, there were 28 infant deaths in Anne Arundel County, with an overall infant mortality rate of 4.1 per 1,000 live births, lower than the state and the nation. A significant disparity continues to exist between white and black infant mortality. In 2017, non-Hispanic black infants in Anne Arundel County had a mortality rate of 7.9 per 1,000 live births, significantly higher than for non-Hispanic white infants. The same disparity is seen at the state and national levels (Table 27).

Table 27

Infant Mortality Rate Comparison, 2013-2017					
	2013	2014	2015	2016	2017
Infant Mortality- All Races per 1,000 Live Births					
Anne Arundel	5.6	5.7	5.1	5.6	4.1
Maryland	6.6	6.5	6.7	6.5	6.5
United States	6.0	5.8	5.9	5.9	5.9
Infant Mortality- Non-Hispanic White per 1,000 Live Births					
Anne Arundel	3.9	3.8	3.6	5.3	2.8
Maryland	4.6	4.4	4.0	4.3	4.0
United States	5.1	4.9	4.9	5.0	5.0
Infant Mortality- Non-Hispanic Black per 1,000 Live Births					
Anne Arundel	10.8	12.9	9.5	10.1	7.9
Maryland	10.6	10.7	11.3	10.5	11.2
United States	11.1	10.9	11.3	10.8	10.8
Infant Mortality- Hispanic (Any Race) per 1,000 Live Births					
Anne Arundel	7.3	**	**	**	5.3
Maryland	4.7	4.4	5.5	4.3	4.7
United States	5.0	5.0	5.0	5.0	5.0

** Rate not calculated, fewer than 5 deaths.

Maryland Department of Health, *Vital Statistics Administration, 2013-2017 Annual Reports*.

U.S. Department of Health and Human Services, *Healthy People 2020*.



Low Birthweight

Low birthweight is a term used to describe babies who are born weighing less than 2,500 grams (five and a half pounds). In contrast, the average newborn weighs about 8 pounds. Risk factors for low birthweight include using street drugs and abusing prescription drugs, exposure to air pollution or lead, low socioeconomic status and domestic violence.³ Low birthweight infants run the risk of developing health issues, hyperactivity disorders and developmental issues, especially those developmental issues related to school achievement. In Anne Arundel County, the percentage of low birthweight babies is dropping slowly and is less than the state average at 7.4 percent (Table 28).

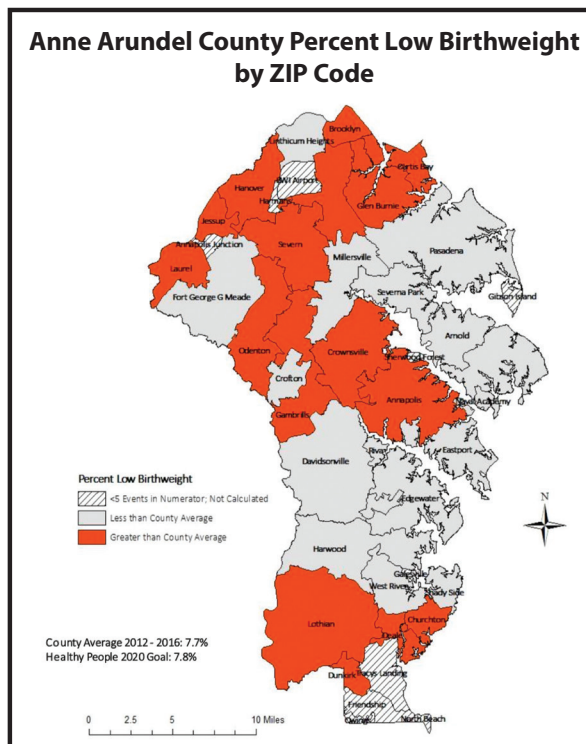
Table 28

Percentage of Babies Born of Low Birthweight, 2014 & 2016			
Percentage of Low Birthweight (<2500 g) Babies	Anne Arundel	Maryland	United States
2014	7.5%	8.5%	8.0%
2016	7.4%	8.6%	8.2%

Anne Arundel County Department of Health, 2018

There are several ZIP Codes concentrated in the northern part of the county where the percentage of low birthweight infants is much higher than 7.5 percent (Figure 21).

Figure 21



Anne Arundel County Department of Health, 2018

³ March of Dimes, *Low Birthweight*, 2018.

Health Care Access

The Affordable Care Act (ACA) continues to increase county residents’ access to health care. Under the ACA, persons whose income is up to 138 percent of the poverty level are eligible for Medicaid. Persons whose income is above 138 percent but below 400 percent of the poverty level have the option to purchase health insurance through the Maryland Health Connection (the state’s insurance marketplace/exchange). However, access issues remain. As one respondent commented:

“People believe they have access to healthcare via Medicaid but there are many providers who do not accept Medicaid; that’s a real barrier to access. Also, many people who have high-deductible health insurance plans can’t afford the deductible.”

A small percentage of county residents such as undocumented persons, those not enrolled in Medicaid despite being eligible, and persons opting to pay the annual penalty instead of purchasing insurance, still remain uninsured. However, the percentage of uninsured residents in Anne Arundel County continued to decline in 2018, reaching a low of six percent of residents.⁴

The number of Medicaid enrollments increased ten percent, from 84,616 in 2014 to 93,425 in May 2018 (Table 29). Access to specialist care is limited for the Medicaid and uninsured populations. While primary care may be accessible through community health clinics, finding specialists who will take referrals without private insurance is difficult. As one provider noted:

“We can use preventive primary care – there’s no problem with that, but if someone needs cardiology or oncology and they are uninsured, not all specialists will see them or do payment plans – that’s an access to care issue.”

Table 29

Medicaid Enrollment by Age, Sex and Race/Ethnicity, Anne Arundel County (May 2018)			
		Medicaid Enrollment 2014	Medicaid Enrollment 2018
Total Enrollment		84,616	93,425
Age	Under 20 Years	37,843	44,572
	21 to 64 Years	43,040	44,216
	65 Years and Over	3,733	4,637
Sex	Male	37,186	42,133
	Female	47,430	51,292
Race/ Ethnicity	White, NH	39,793	35,824
	Black, NH	25,193	22,718
	Hispanic, Any Race	6,349	920
	Asian	3,829	4,274

Maryland Department of Health, 2018

⁴ Anne Arundel County Department of Health, 2018.



Access to Outpatient Care

Access to outpatient care is a continuing problem in the county. Having a primary care provider reduces non-financial barriers to obtaining care, facilitates access to services, and increases the frequency of contacts with health care providers. Without a primary care provider, people have more difficulty obtaining prescriptions and attending necessary appointments. According to county health rankings, the patient to primary care physician ratio in Anne Arundel is lower than the state of Maryland average and that of the U.S. top performing counties which are among the 90th percentile in ranking. The actual number of primary care physicians in the county has increased by only five since 2014 (Table 30).

According to one provider:

“The percentage of primary care doctors is still low and that’s a problem. Primary care doctors do have large caseloads and that is hard on folks. We need to make primary care more attractive to medical schools.”

Similarly, the patient to dentist and mental health provider ratios in Anne Arundel County are worse than in Maryland and the U.S. top performing counties.

Table 30

Primary Care Physicians, Dentists and Mental Health Providers Anne Arundel County (2018)				
	Anne Arundel County Total	Anne Arundel County Ratio	Maryland Ratio	Top U.S. Counties (90th percentile)
Primary Care Physicians (2018)	386	1,450:1	1,140:1	1,030:1
Dentists (2018)	378	1,480:1	1,320:1	1,280:1
Mental health providers (2018)	861	650:1	460:1	330:1

Anne Arundel County Department of Health, 2018

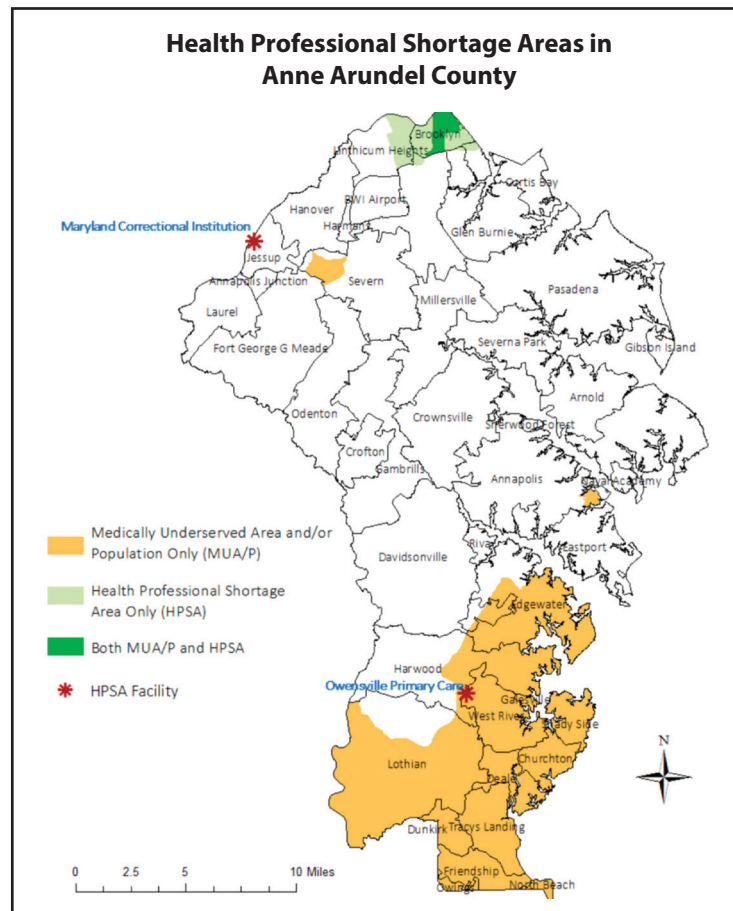
Health Professional Shortage Areas

Health Professional Shortage Areas (HPSAs) are designated by the federal Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers and may be geographic or facility-based. In Anne Arundel County there is currently one designated Primary Care HPSA facility (Owensville Primary Care), One Dental HPSA facility (Owensville Primary Care) and two Mental Health HPSA facilities (Owensville Primary Care and Maryland Correctional Institution, Jessup).

Medically Underserved Areas

Medically Underserved Areas (MUA) are designated based on four variables: ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. There are 11 census tracts in Anne Arundel County that are designated as medically underserved areas or populations. Approximately 54,700 (10 percent) of the county's population lives in these 11 census tracts. Brooklyn Park in North County is both an HPSA and an MUA (Figure 22).

Figure 22

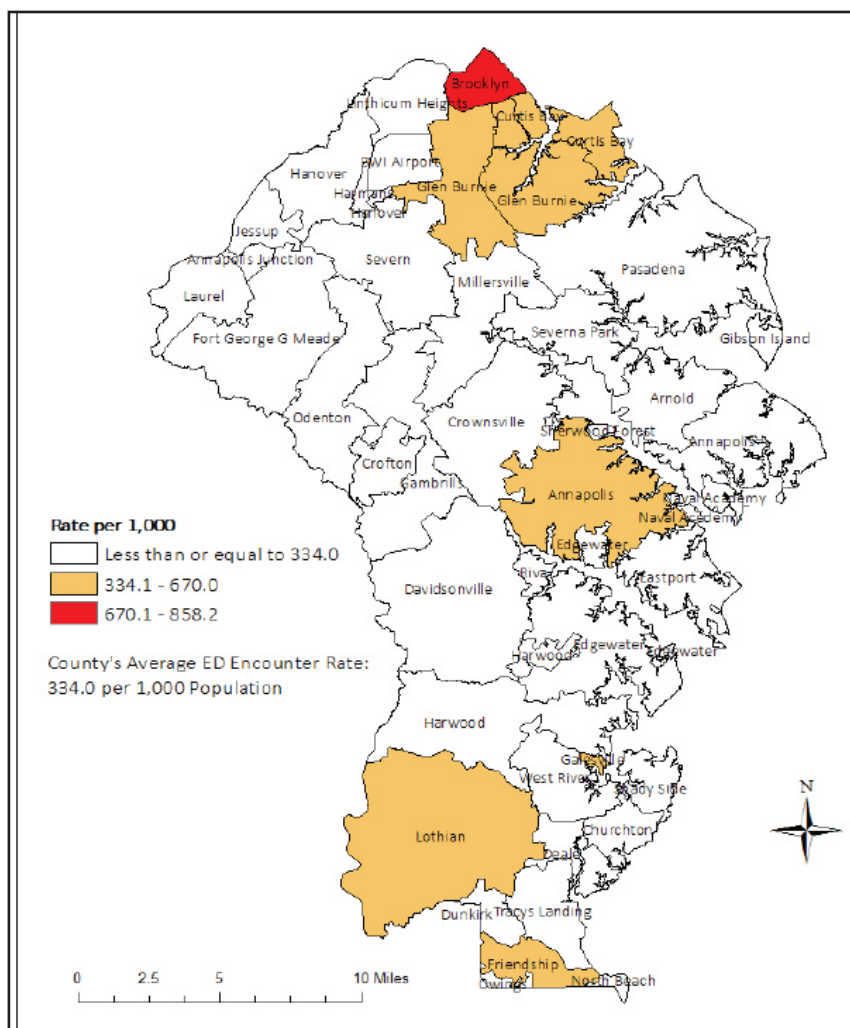


Anne Arundel County Department of Health, 2018



In 2017, 9.6 percent of Emergency Department visits were by uninsured residents. Although not all visits to the Emergency Department are avoidable, care in lower level settings for some conditions, such as diabetes and hypertension, can potentially reduce the number of visits, thereby reducing costs and increasing the quality of care.⁵ The rate of Emergency Department visits increases for those residents living in Medically Underserved and Health Professional Shortage Areas (Figure 23).

Figure 23 Emergency Department Encounters per 1,000 Population by ZIP Code, Anne Arundel County, 2017



Anne Arundel County Department of Health, 2018

⁵ Anne Arundel County Department of Health, 2018.

Hospital Admissions

In 2017 there were 59,277 hospital stays in Anne Arundel County, a rate of 104.3 stays per thousand (Table 31). The hospitalization rate increased with age from 68.7 hospitalizations per 1,000 population among 0–18 year olds, to 262.5 hospitalizations per 1,000 population among those age 65 years and over. (Note: This data only includes Anne Arundel County residents admitted to hospitals in Maryland.)

Table 31

Inpatient Hospitalizations in Anne Arundel County (2017)		
	Number	Rate per 1,000
Total Hospitalizations	59,277	104.3
Age		
0 to 18 Years	9,763	68.7
19 to 39 Years	12,917	83.3
40 to 64 Years	16,607	84.9
65 Years and Over	19,990	262.5
Sex		
Male	25,656	92.7
Female	33,621	118.8
Race/Ethnicity		
White, NH	38,719	96.9
Black, NH	11,747	132.5
Asian, NH	1,271	62.1
Hispanic (Any Race)	3,368	84.7

Anne Arundel County Department of Health, 2018



ZIP codes are another way to track hospitalizations. The ZIP Code containing Brooklyn Park has the highest rate of hospitalization at 163.9 per 1,000 residents. The Glen Burnie rates are also notable when population density is considered (Table 32).

Table 32

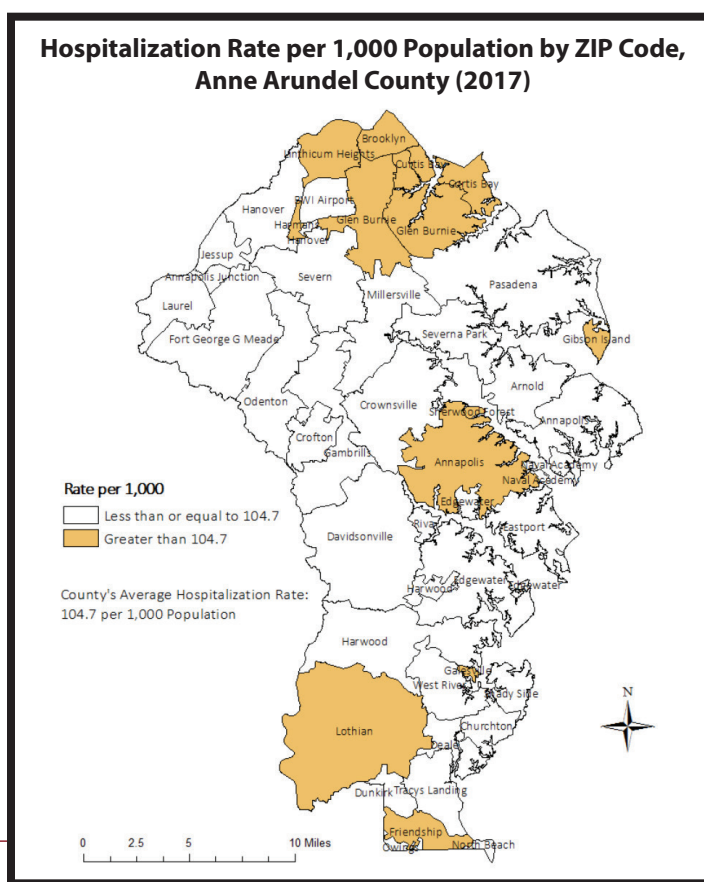
Inpatient Hospitalizations by ZIP Code, Anne Arundel County (2017)			
Town	Zip Code	Number	Rate per 1,000
Brooklyn	21225	2,396	163.9
Curtis Bay	21226	555	16.4
Friendship	20758	66	155.3
Galesville	20765	53	147.2
Glen Burnie (East)	21060	4,307	133.9
Glen Burnie (West)	21061	6,717	123.8

Anne Arundel County Department of Health, 2018

Lack of access to primary care, multiple health issues presenting at the same time, poverty, unhealthy food and lack of medication management were reasons given for the high rates. As one provider noted:

“We have seen a huge increase in the acuity of our patients... they have multiple issues; congestive heart failure, renal failure and diabetes... many patients with very complex and multiple issues along with poor social determinants of good health.”

Figure 24



Anne Arundel County Department of Health, 2017

Chapter 4 | Health

The Social Determinants of Health

Many factors determine the state of a person's overall wellness. The social determinants of health include income level, especially for those who live in poverty, access to healthy food, emotional stability, the cleanliness and safety of the environment, and access to health services. Although Anne Arundel County has a high standard of living overall, there are pockets of poverty and health access issues found in areas of high population density in North County, Annapolis, and in some of the rural areas of South County. Many focus group participants commented on the intractable nature of the pockets of poverty and distress, and a multiplication of the negative social determinants of a healthy life for some families. As one primary care provider commented:

“Back pain, headaches, insomnia; all the symptoms of stress. You start digging into the socio-economic factors – there are reasons for those things. They're behind on the rent, they could get evicted, they haven't had money to buy food. Sometimes there is a job loss involved.”

The majority of negative social and health indicators continue to polarize North and South County and Annapolis (Table 33). In South County, access to health care is very limited and there are few primary care doctors. Those residents with transportation often travel to Glen Burnie to access primary care. Owensville Primary Care is inaccessible to those residents who live in areas like Deale and have no transportation. Brooklyn Park (North County) is both a Medically Underserved and a Health Shortage Area and continues to have the highest indicators of need, as does Glen Burnie (Table 33).

Table 33

Rising Demographic, Socioeconomic, and Health Indicators by Zip Code, Anne Arundel County, 2017								
Zip Code	Area	Poverty Percentage	Percent without High School Diploma	Percent of Households on Snap	ED Visit Rate per 1,000	Percent Low Birthweight Infants	Preventable Hospitalization Rate per 1,000	Minority Population
20711	Lothian	11.7%	13.2%	23.4%	389.7	8.4%	6.8	25.6%
20714	North Beach	10.6%	7.5%	8.6%	285.0	8.9%	<11	12.4%
20724	Laurel	3.8%	9.1%	4.2%	234.6	9.3%	2.4	64.6%
20751	Deale	10.8%	8.7%	5.4%	233.1	9.2%	4.6	7.1%
20758	Friendship	7.1%	3.9%	0.0%	562.4	8.8%	<11	7.1%
20765	Galesville	14.7%	20.2%	9.6%	352.8	6.3%	<11	22.5%
20776	Harwood	10.8%	7.6%	8.8%	293.1	4.4%	6.0	15.5%
20794	Jessup	7.9%	20.6%	11.8%	220.4	11.3%	2.9	52.5%
21060	Glen Burnie (East)	7.9%	13.7%	12.6%	406.5	8.0%	6.9	29.8%
21061	Glen Burnie (West)	9.2%	13.6%	12.8%	441.9	8.0%	5.5	45.0%
21090	Linthicum Heights	7.5%	10.1%	5.1%	270.5	6.9%	5.6	10.8%
21144	Severn	7.9%	8.2%	10.4%	289.2	9.2%	3.5	51.7%
21225	Brooklyn	27.3%	20.1%	32.6%	858.2	9.9%	8.9	59.4%
21226	Curtis Bay	16.6%	15.8%	16.8%	509.6	8.7%	6.6	26.9%
21401	Annapolis	7.9%	7.2%	8.9%	364.5	7.7%	5.4	31.5%
21403	Eastport	6.9%	9.8%	6.9%	331.8	7.5%	4.4	37.5%
Anne Arundel County		6.1%	8.1%	7.0%	340.0	7.7%	4.6	29.7%

U.S. Census Bureau, American Community Survey, 5-year Estimates 2012-2016. Maryland Health Services Cost Review Outpatient Files, 2017

Red = Higher than County Average



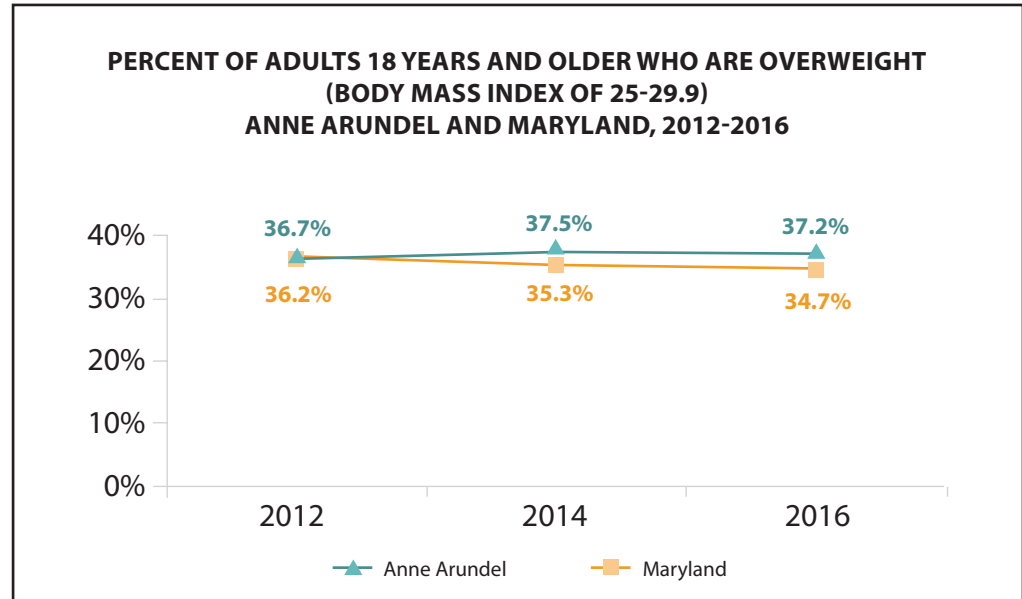
Overweight and Obesity

Overweight and obesity continue to create health issues for county residents. Many factors play a role in weight including low income, lifestyle, surrounding environment, access to healthy food, genetics and certain diseases. Overweight and obesity are determined using weight and height to determine a BMI or “body mass index” measure. Between 2012 and 2016, the percent of overweight adults (Body Mass Index of 25 to 29.9) 18 years and older in Anne Arundel County rose slightly from 36.7 percent to 37.2 percent while the state average fell (Figure 25).

The percent of residents who are classified as obese (Body Mass Index 30 and over) also rose from 27 to 31 percent and the state average also rose (Figure 26).

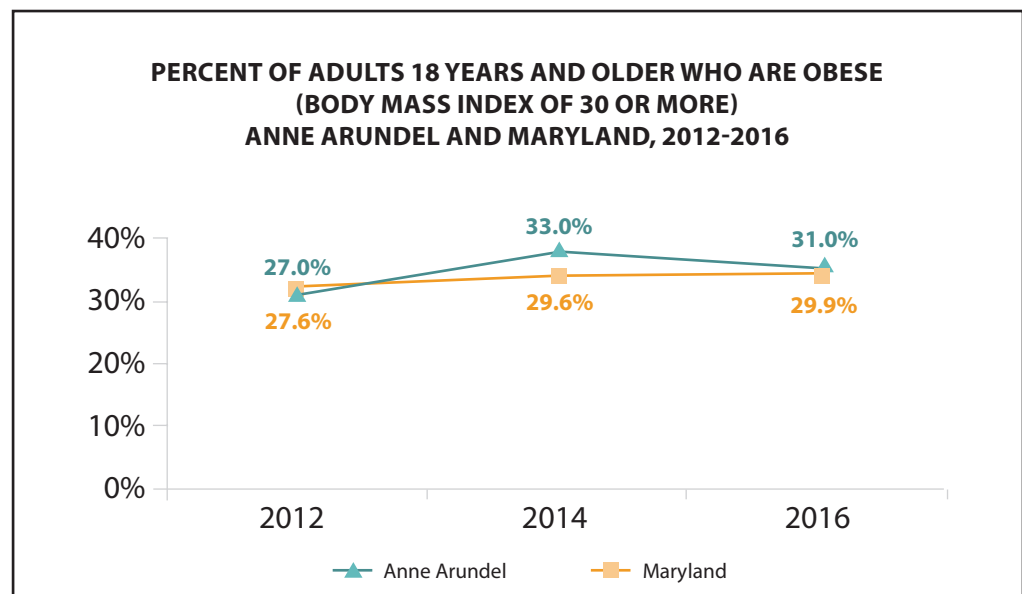
Obesity is prevalent in low income families in the county for a variety of reasons: their neighborhoods often lack full-service grocery stores and farmers’ markets, healthy food can be more expensive, there is no transportation to get to a supermarket, there is a greater availability of fast food restaurants selling cheap, filling food, and there are fewer recreational facilities for exercise. The streets may be unsafe and there is little for children to do.

Figure 25



Anne Arundel County Department of Health, 2018, (Maryland BFSS)

Figure 26



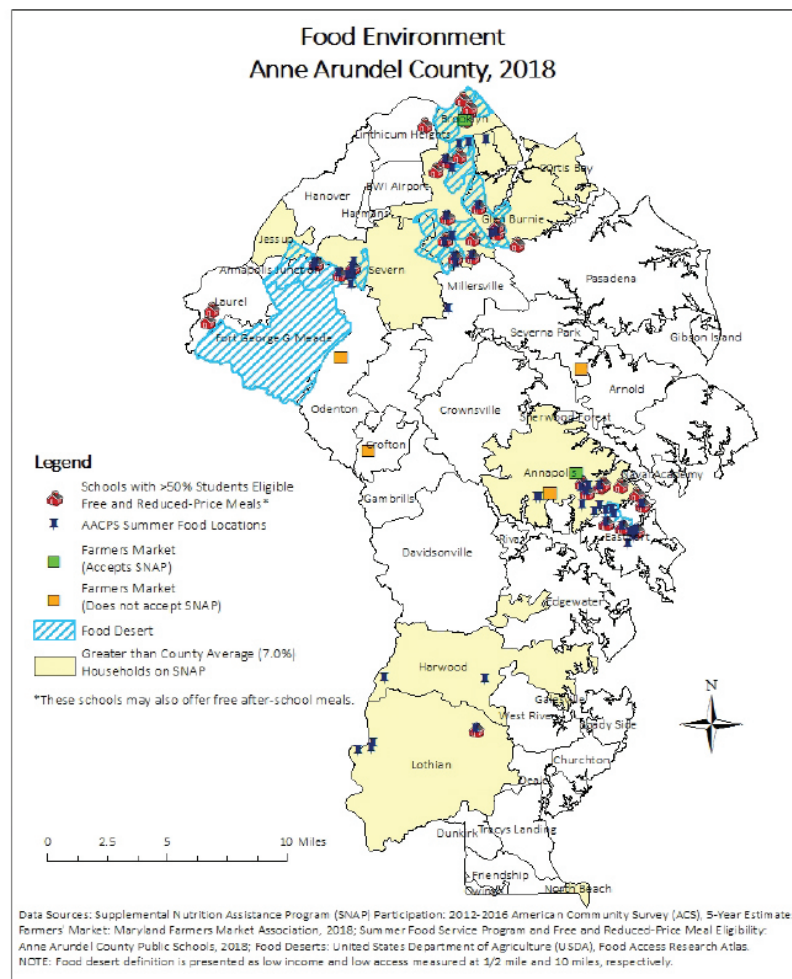
Anne Arundel County Department of Health, 2018, (Maryland BFSS)

Access to Healthy Food

In 2018, over 13 percent or 74,522 county residents resided in a food desert, up from 12 percent in 2015. Food deserts are defined by the United States Department of Agriculture (USDA) as urban neighborhoods and rural towns without ready access to fresh, healthy and affordable food. Several of the county's low income communities are also mapped as food deserts (Figure 27). They do not have access to healthy food and they have no transportation to get to supermarkets. Unhealthy food is cheap and filling, an important asset for large families managing with few means. As one health provider noted:

“Many people don’t have access. They may have medical transportation to get to a doctor but they don’t have the transportation to get to a grocery store. If they get to the grocery store and are on the SNAP program, or whatever, they see apples are \$2.99 a pound, but the ramen noodles are 10 packs for \$1.”

Figure 27



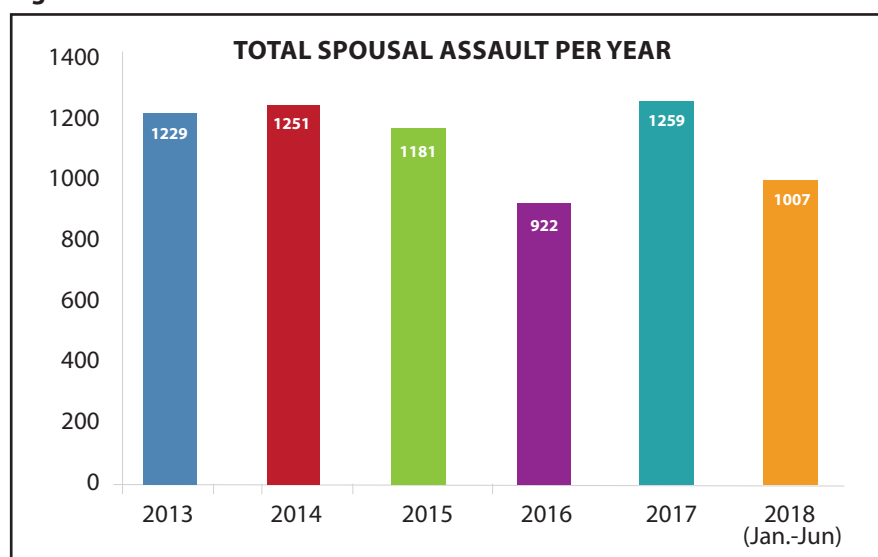
Anne Arundel County Department of Health, 2018.



Domestic Violence

The Anne Arundel County Police Department tracks domestic violence by year and police district, including physical assaults with hands or fists, guns, and knives. Figure 28 shows all Domestic Violence incidents in the county from 2013 through the first six months of 2018. The data shows an upward trend although there was a dip in numbers for the 2015-2016 year. The statistics for the early 2018 year are alarming. The numbers for the six month period are almost as high as for the previous 12 months. These statistics confirm anecdotal data from police, schools and hospital personnel, who all reported a notable increase in domestic violence over the same period.

Figure 28



Anne Arundel County Police Department, 2018

Child Physical and Sexual Abuse

In 2018, the county's Child Advocacy Center investigated 326 sexual abuse cases, of which seven were for sexual assault.⁶ Respondents noted a large increase in the number of child on child sexual assaults that are being reported by the school system and others. One commented that:

“Children are looking at pornography on their parent’s phones and tablets. It used to be that the child was the victim and the adults the perpetrators, but that’s not always the case now. Now we have five and six year olds doing inappropriate things. Kids are watching pornography at early ages.”

All child sexual assault and sexual abuse cases must go to the police department prior to a hand-off to social services. This process, and the limited number of police specialists, can cause back ups of over three months and then there may be 95 to 100 cases at a time sent to Department of Social Services (DSS). As one provider noted:

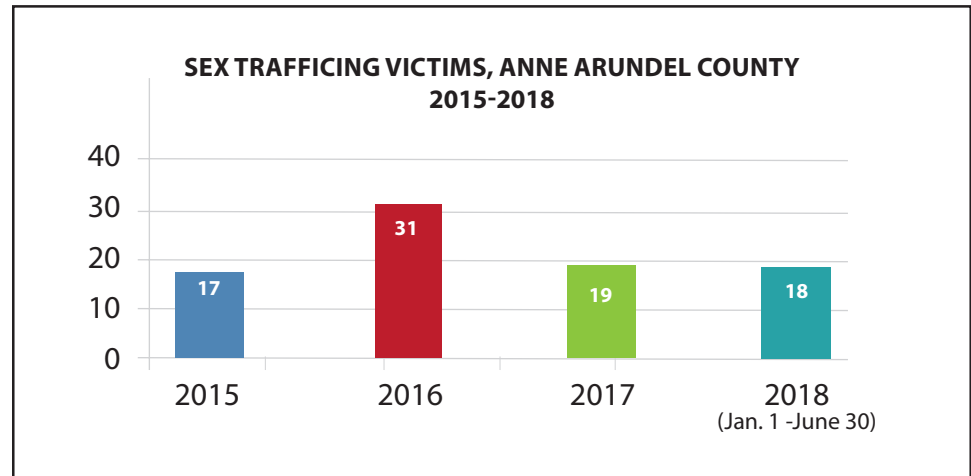
“Every report has to go through these guys before it comes to DSS. We’re often cold calling three months later.”

⁶ Anne Arundel County Department of Social Services, 2018.

Sex Trafficking Victims

Anne Arundel County is in the top five jurisdictions in Maryland for sex trafficking.⁷ The 50-mile radius surrounding BWI airport is becoming known as the third-most-lucrative area in the state for trafficking in people.⁸ Anne Arundel County Police Department tracks the number of sex trafficking incidents for the county (Figure 29). While the numbers were stable between 2015 and 2017, data for the first 6 months of 2018 are showing an almost 100% increase in cases. There are only two detectives fully dedicated to human trafficking.

Figure 29



Anne Arundel County Police Department, 2018

Social Media as a Public Health Issue

Social media, including the active use of smart phones and tablets, is a major concern for residents and professionals in every area of the county. The constant access to electronic information is impacting every age group and demographic:

Early Childhood. Focus group participants reported babies as young as 12 months are regularly observed holding cell phones and tablets. One early childhood provider described this as ‘soothing by cell phone.’ Another commented:

“I hate to blame technology but youngsters at a very early age are being babysat by electronics, usually it’s an iPad or a cell phone. Then we’re asking them to sit quietly in a circle and say their ABCs.”

Many focus group participants commented on the number of parents with their eyes on their own cell phone rather than creating any interaction or eye contact with their children. Several suggested that the ease of electronic access to pornography for very young children is linked to rising child on child sexual abuse within the school system.

Youth. Increases in bullying, suicide and suicidal ideation for youth have been linked to the constant use of social media ‘apps’ such as Instagram and Snapchat. As one educator noted:

“Students will turn one another in: ‘look what she wrote online about me’ or ‘look what he posted online’ – it’s a disruption of the school day.”

Youth in low income communities are emulating international gang members, their colors and lifestyles by following their on-line presence. Body language, eye contact and social behavior of every kind is now lessened by the isolation caused by cell phone use. Several focus group participants noted that video-games are replacing outdoor play and recreation for many children.

⁷ A. Rubenstein and N. Carr, *Child Sex Trafficking Victims Initiative Child Sex Trafficking in Maryland: January 2017*. University of Maryland School of Social Work, 2017

⁸ Maryland Human Trafficking Taskforce, *Trafficking in Maryland*, 2018.



Adults. All focus group participants commented on the increase in the use of social media by adults. Some commented on the isolation it causes and the need to look at every experience through the lens of a photo for Facebook. As one professional commented:

“People spend way too much time looking at other people’s activity on social feeds – how many likes did you get or not get? Let’s make sure we take some pictures so we can post them. How about enjoying the event you’re going to?”

Others linked the use of social media and rapid electronic communication with rising rates of drug use, depression and anxiety. As a faith community member commented:

“People are feeling more and more isolated because you can be surrounded by 500 friends (on social media) but you’re in your room by yourself.”

Limited English Proficient Residents

The numbers of Limited English Proficient residents are growing, especially in North County. Anecdotal information suggest their health needs are being served in community health clinics. While the numbers of bi-lingual health care professionals appear to be growing slowly, there is a lack of interpreters who understand medical terminology. As one provider recounted:

“We have a patient who saved months for his neurological care, to see a neurosurgeon for follow up; cost was \$715 for the visit which he knew ahead of time; and he and his wife scrimped and saved and they went to the appointment. The wife had to translate, she has no medical knowledge whatsoever and the patient left with no idea what the doctor said.”

Summary

Overall, the physical health of county residents and their access to health services have improved since 2014. However, in the densely populated areas of Glen Burnie and Brooklyn Park (Health Professional Shortage and Medically Underserved Areas), costs are being driven up by emergency room visits and increased hospitalization rates.

Needs

- Increased numbers of community health clinics, especially in Medically Underserved Areas
- A plan to recruit primary care physicians
- Translation services for limited English Proficient residents
- Access to specialist services for the uninsured and the Medicaid population
- Healthy living and preventative health care to avoid hospitalization
- Greater awareness of importance of prenatal care for pregnant women
- Increased focus on areas of high need and few resources: Brooklyn Park, Glen Burnie, and South County
- A plan to address the social determinants of health

Chapter 5 | Behavioral Health

Mental Health

The rise in behavioral health issues for every age group, and the lack of appropriate services and service providers, were major concerns for all participants in this needs assessment. Providers who don't accept Medicaid and Medicare, and patients with inadequate health insurance, or no insurance, exacerbate the issue. Overall there has been a 70 percent increase in Anne Arundel County residents seeking mental health services since 2012; 16,348 residents were served by the county mental health agency in 2018 (Table 34). The two highest increases in residents served since 2016 are the early childhood population and those over age 65. Participants in this needs assessment shared many opinions as to why mental health issues are increasing, including poverty, isolation, social media, increasing societal violence and hostility, the fast pace of a technological world, and the reduction of stigma regarding mental health services. Several commented on the intergenerational and socio-economical nature of mental health issues. As one provider noted:

"I think you go back to the families that are struggling in poverty who are multi-generational and living together; it's the hereditary piece. It's the third generation bipolar schizophrenic whose child is showing ADHD acting out behaviors where we know we worked with mom or the grandmother 10 years ago. We're dealing with more at an even younger age; you're talking first and second graders."

Table 34

Individuals Served in the Public Mental Health System (2012 – 2018)							
Age Range	FY 2012	FY 2016	FY 2017	2016 - 2017 % Change	FY 2018*	2017 - 2018 % Change	2012-2018 % Increase
Early Child (0-5)	392	460	492	7.0%	548	11.4%	40%
Child (6-12)	1,821	2,596	2,774	6.9%	2,999	8.1%	65%
Adolescent (13-17)	1,388	1,923	1,929	0.3%	2,128	10.3%	55%
Transitional (18-21)	586	792	884	11.6%	926	4.8%	58%
Adult (22 to 64)	5,351	8,520	9,036	6.1%	9,628	6.6%	80%
Elderly (65 and over)	59	92	105	14.1%	119	13.3%	102%
TOTAL	9,597	14,383	15,220	5.8%	16,348	7.4%	70%

* Based on claims paid through September 30, 2018.
Anne Arundel County Mental Health Agency, 2018



The county's hospital emergency departments are often the receiving facilities for behavioral health issues. In 2017, there were 12,446 behavioral health encounters; mood disorders accounted for 26.3 percent of those and over 20 percent were alcohol related (Table 35).

Table 35

ED Encounters for Behavioral Health Conditions in Anne Arundel County (2017)			
	Condition	Frequency	Percent
1	Mood Disorders	3,277	26.3%
2	Alcohol-Related Disorders	2,546	20.8%
3	Substance-Related Disorders	2,212	17.8%
4	Anxiety Disorders	1,654	13.3%
5	Suicide and Intentional Self-Inflicted Injuries	724	5.8%
6	Schizophrenia and Other Psychotic Disorders	655	5.3%
7	Attention-Deficit Conduct and Disruptive Behavior Disorders	379	3.1%
8	Delirium Dementia and Amnestic and Other Cognitive Disorders	348	2.8%
9	Adjustment Disorders	295	2.4%
10	Miscellaneous Mental Health Disorders	112	0.9%
	Total	12,446	

Anne Arundel County Department of Health, 2018

Access to Care

The Affordable Care Act continues to increase access to mental health services through expanded Medicaid services. The total numbers served in the county public mental health system have increased 13 percent in two years, from 14,383 in 2016 to 16,348 in 2018 (Table 36). Those with private insurance struggle the most to access care due to limited coverage, high deductibles, time limits, and providers who will not accept private insurance. As one provider noted:

“To receive clinical mental health services, the co-pays and deductibles in the new insured world will break your back. If you're living paycheck to paycheck and you need a 30 dollar co-pay once a week, for the next six weeks, that probably isn't going to happen.”

Chapter 5 | Behavioral Health

Table 36

Three Year Comparison for Medicaid Insured and Uninsured Individuals					
	Persons Served				
	FY 2016	FY 2017	2016 -2017 % Change	FY 2018	2017 - 2018 % Change
Medicaid	13,824	14,626	5.8%	15,694	7.3%
Medicaid State Funded	1,923	2,342	21.8%	2,591	10.6%
Uninsured	746	488	-34.6%	642	31.6%
Total	14,383	15,220	5.8%	16,348	7.4%

Anne Arundel County Mental Health Agency, 2018

The number of out-patient mental health providers in the county continues to grow, an increase of 4.6 percent from 366 in 2014, to 383 in 2018. However, the ratio of mental health providers to residents in the county is much lower than the state (Table 37).

The county lacks psychiatrists and geriatric psychiatrists, especially for those residents with dementia and Alzheimer's disease. There is one Spanish-speaking psychiatrist in the entire county available to the Hispanic uninsured population. There are very few Spanish speaking mental health counselors.

Table 37

Mental Health Providers in Anne Arundel County, Maryland (2018)				
	Anne Arundel County Total	Anne Arundel County Ratio	Maryland Ratio	Top U.S. Counties (90th percentile)
Mental health providers	861	650:1	460:1	330:1

Anne Arundel County Department of Health, 2018



Residential services are a growing and urgent need. In Anne Arundel County, there are only 24 crisis temporary beds and only one inpatient psychiatric unit with 24 beds. The beds are almost always full. There are 263 beds for the chronically mentally ill scattered throughout the county. There are no residential services for adolescents. Both hospitals are currently expanding their mental health services to meet the community demand. University of Maryland Baltimore Washington Medical Center (UM-BWMC) recently added ten beds to their inpatient psychiatric unit, which will allow them to serve 650 more residents per year. Anne Arundel Medical Center (AAMC) broke ground on a new mental health hospital in 2018 that will add 16 inpatient beds and serve an estimated 900 patients when it opens in 2020. The need is overwhelming. As one provider noted:

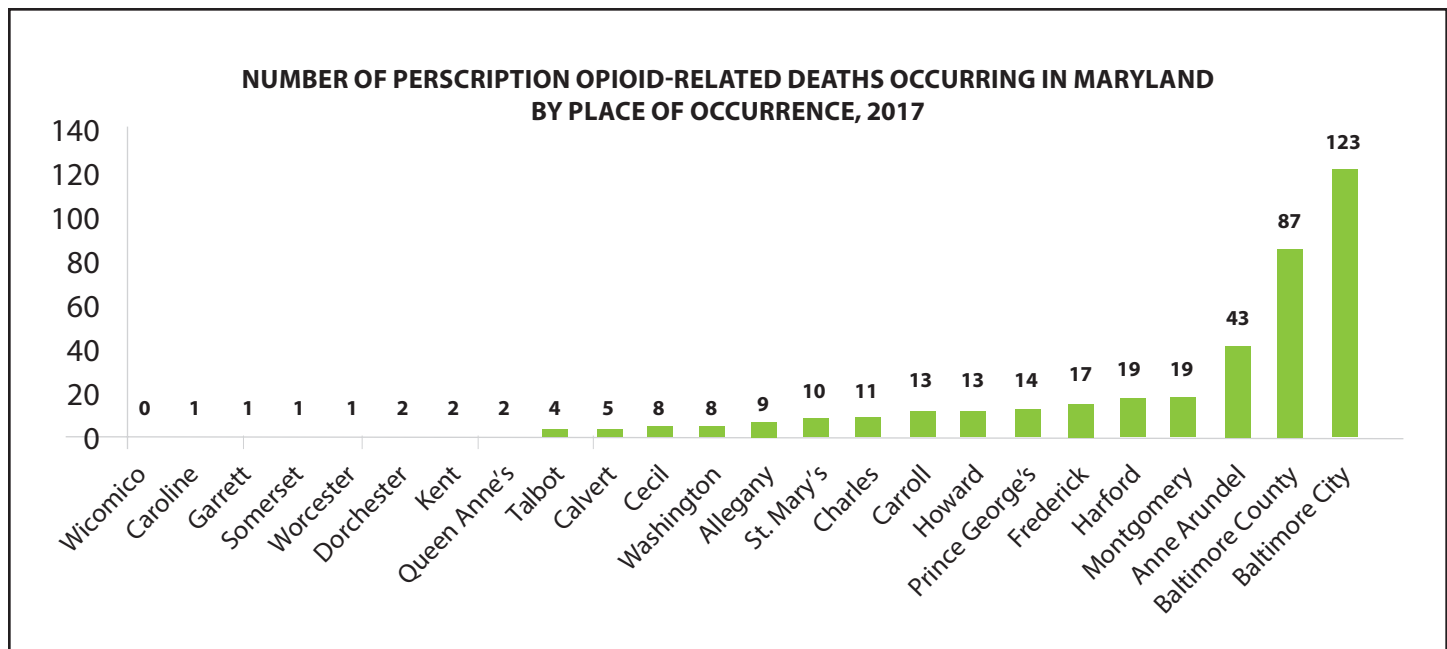
“So if you come to our campus with a broken bone, there are 30 orthopedists who want to fix your bone. But if you come to our hospital with a broken soul, we’ve got two psychiatrists, only one of them on this campus.”

The Opioid Epidemic

Prescription Opioids

Prescription opioid addiction is now a major public health crisis. Although Anne Arundel County is the fifth largest county in the state in terms of population, it had the third highest rate of prescription opioid related deaths as of 2017 (Figure 30).

Figure 30



Maryland Department of Health, 2018

Chapter 5 | Behavioral Health

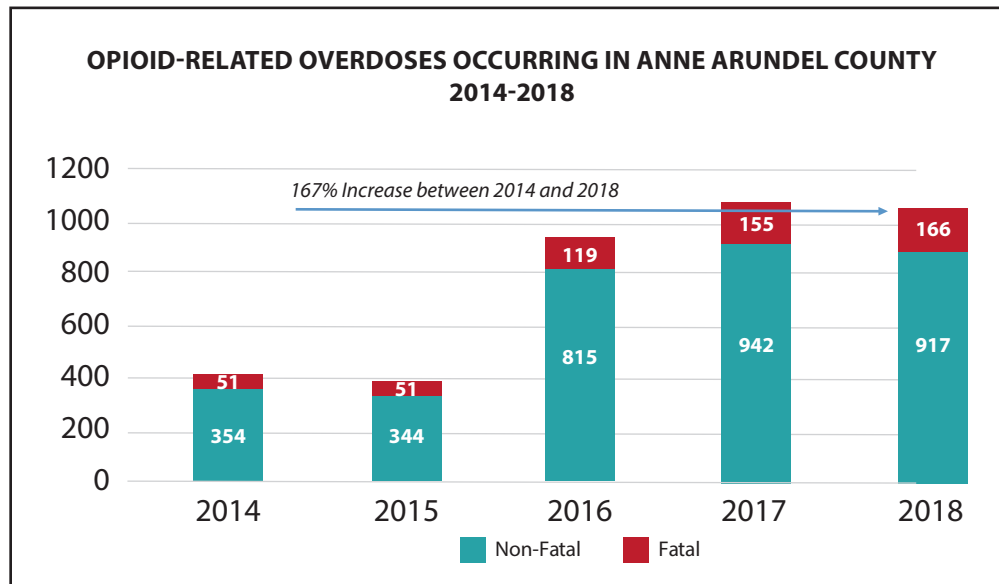
County health professionals acknowledge that while opioids are helpful to patients in extreme pain, opioid addiction is a major issue. The medical community has tightened regulations and behaviors regarding opioids, and 2017 saw the first decrease in prescription overdose use since 2013, from 48 to 43 deaths.¹ According to one provider, it is important to manage pain but at the same time make sure excess supply is diminished:

“We don’t want to withhold pain medicine from patients (who need it) but decrease the excess supply that is sitting out there in everyone’s medicine cabinets.”

Opioid/Heroin Overdoses

In 2018, Anne Arundel County police reported almost 1,100 opioid-related overdoses occurring within the county, a 167 percent increase since 2014 (Figure 31).

Figure 31



Anne Arundel County Police Department, 2018. **Note:** In 2018, there were 116 Persons with 2 or more overdoses.

In 2018, there were 1,083 total overdoses year to date, a 1.3 percent decrease from 1,097 in 2017 (Figure 31). Several county initiatives have contributed to that reduction including the very successful Safe Stations program. However, the rate of fatal overdoses continues to increase, driven by the introduction of fentanyl into the community. Fentanyl-related deaths in the county have increased significantly since 2013 and surpassed heroin related deaths in 2018. Also, in 2018 there were 166 fatal overdoses compared to 155 in 2017, a 7.1 percent increase.

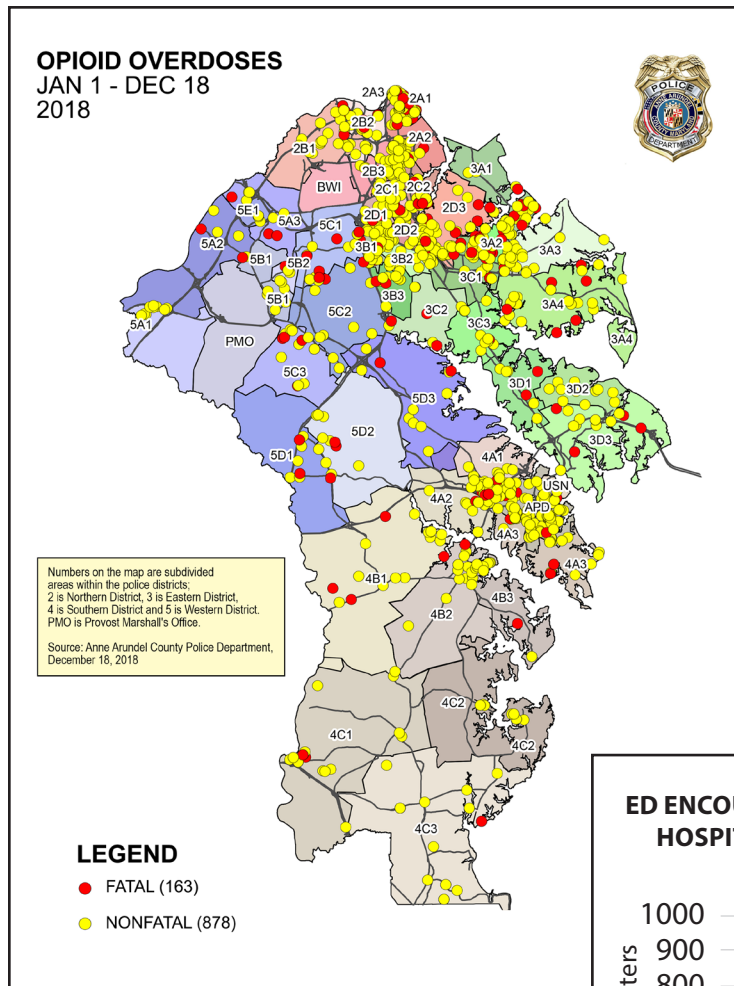
¹ Maryland Department of Health, *Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2017*.



As with other county issues, geography plays a part. The majority of overdoses occur in North County and Annapolis. Several participants pointed to Glen Burnie as the number one area for opioid availability. As one provider noted:

“I would like to see more suboxone providers in Glen Burnie because we know that this is a heroin saturated zip code and there are very few docs that prescribe suboxone.”

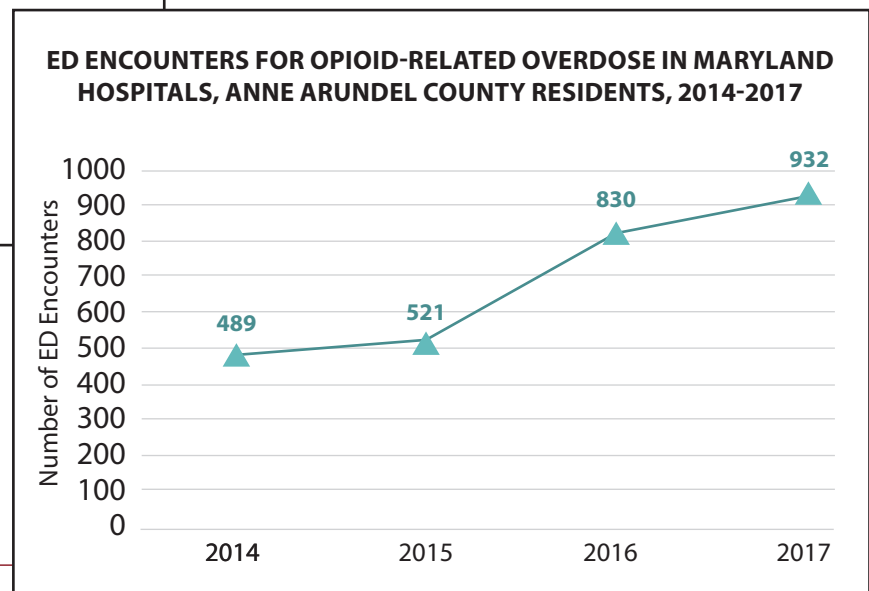
Figure 32



Anne Arundel County
Police Department, 2018

Opioid related overdoses are also causing capacity issues for hospital emergency departments. The rate of emergency department opioid overdose encounters for Anne Arundel County residents has risen 91 percent since 2014 from 489 to 932 (Figures 32 and 33). The percentages are uneven for the two county hospitals. The University of Maryland Baltimore Washington Medical Center accounted for 45 percent of the hospital encounters for opioid related diagnoses through October 2018, whereas Anne Arundel Medical Center accounted for 19 percent.

Figure 33



Anne Arundel County Department of Health, 2018

Secondary Victims of the Opioid Crisis

The current opioid crisis has many victims. The number of newborns assessed positive for substances in their systems, including methadone, has risen 144 percent since 2014 from 74 to 181.² Grandparents and great-grandparents are raising children with little governmental help. Many are on fixed incomes and have health and other issues to contend with. As one participant pointed out:

“We need support for these grandparents. I have an 85 year old client who is a retired nurse raising a second grader. It’s actually her great-grandchild. She came to a meeting with a notebook like I had, trying to keep track of the systems and how to navigate them.”

According to all participants, the children of opioid victims are traumatized and ashamed. Several suggested we need narcotics support groups for teen family members. Young children born into homes where heroin is used may be neglected, may have spent periods homeless or living in a tent, as was the case of an 18 month old Glen Burnie child in 2017. Participants in this needs assessment cited numerous examples of very young children left alone or strapped into a car seat 24 hours a day. As one provider noted:

“Sometimes we’re not seeing these kids ‘til kindergarten or coming into pre-k, but when they were two years old, dad was a heroin addict and put the kid in the closet.”

Participants in this needs assessment also explained that many teens who have an addicted single mother or father, or who are living with grandparents, are taking care of their siblings, finding places to sleep, selling drugs for rent, and visiting food pantries. As one participant commented:

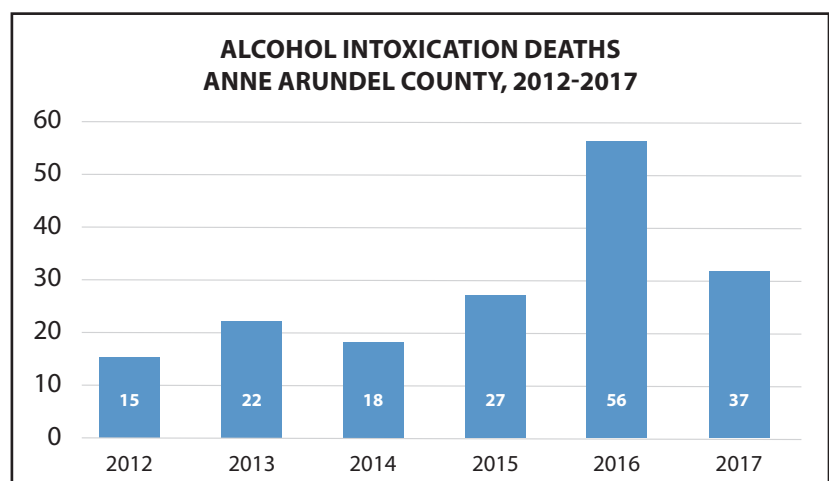
“Like the 17 year-old who finds her mom dead of an overdose in a hotel and goes to school the next day and begs the school for help. This epidemic is not going away...every family is impacted so what are we doing with that? You’ve got fathers, mothers, aunts, and uncles who are dying. What are we doing with that?”

Other Substance Use

Alcohol

Alcohol use continues to be an acceptable social norm in the county. The number of alcohol related deaths increased by 273 percent between 2012 and 2016, from 15 to 56 deaths. In 2017, the number of alcohol-related deaths declined to 37 (Figure 34). According to the Maryland Department of Health 2016 High School Youth Risk Behavior Survey, the number of students who acknowledged driving a car, or driving within a car with someone who had been using alcohol, has reduced significantly since 2014.

Figure 34



Maryland Department of Health, 2018

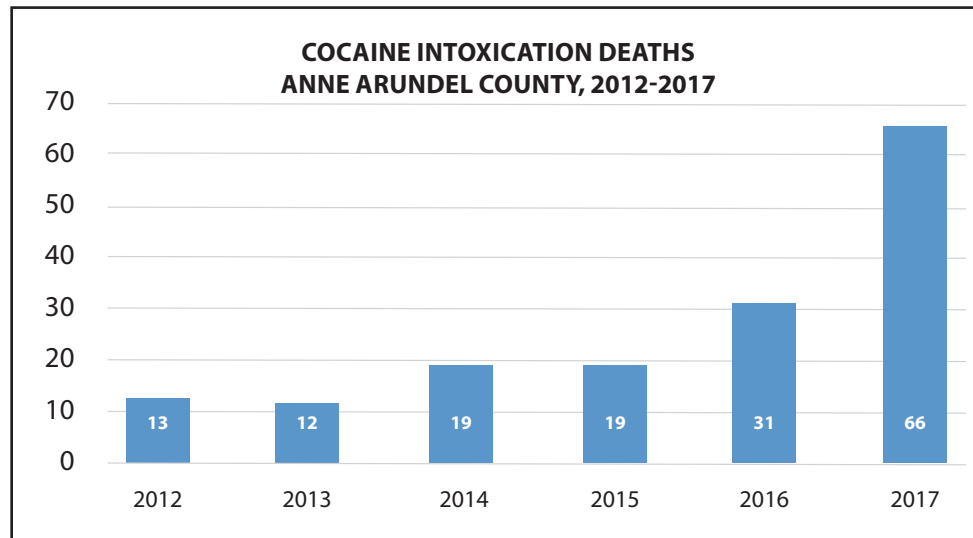
² Anne Arundel County Department of Social Services, 2018.



Other Drugs

Several participants noted a rise in the use of 'street drugs' such as PCP, crystal meth and cocaine. Anne Arundel County was third in the state in 2017 for cocaine ingestion deaths with a 400 percent increase between 2012 and 2017, from 13 deaths to 66 deaths³ (Figure 35). The first quarter of 2018 showed a similar trend with 23 deaths from cocaine use. Many participants noted the use of cannabis in students as young as 11, and the intergenerational use of street drugs.

Figure 35



Maryland Department of Health, 2018

Summary

Behavioral Health issues are a major worry for participants in this needs assessment. Mental health issues at either end of the age scale, early childhood and seniors, are rising very rapidly. For the senior population, these issues may be co-occurring with senility or dementia.

Everyone who participated in this needs assessment acknowledged the enormous efforts made by the county and county hospitals to manage the opioid/heroin crisis, yet the progress is little and slow.

Needs and Gaps:

- More providers of psychiatric, geriatric-psychiatric, counseling and substance abuse services, especially Spanish speaking services
- Residential mental health and substance abuse beds, especially for the adolescent population
- Further support for the Anne Arundel County Mental Health Agency's very successful Crisis Intervention system and the Safe Stations program
- Integration of social and behavioral health services
- Crisis beds for immediate response and to relieve the emergency departments
- Support for seniors with co-occurring mental health issues and dementia

³ Maryland Department of Health, *Unintentional Drug-and Alcohol-Related Intoxication Deaths in Maryland, 2017*.

Chapter 6 | Senior Population

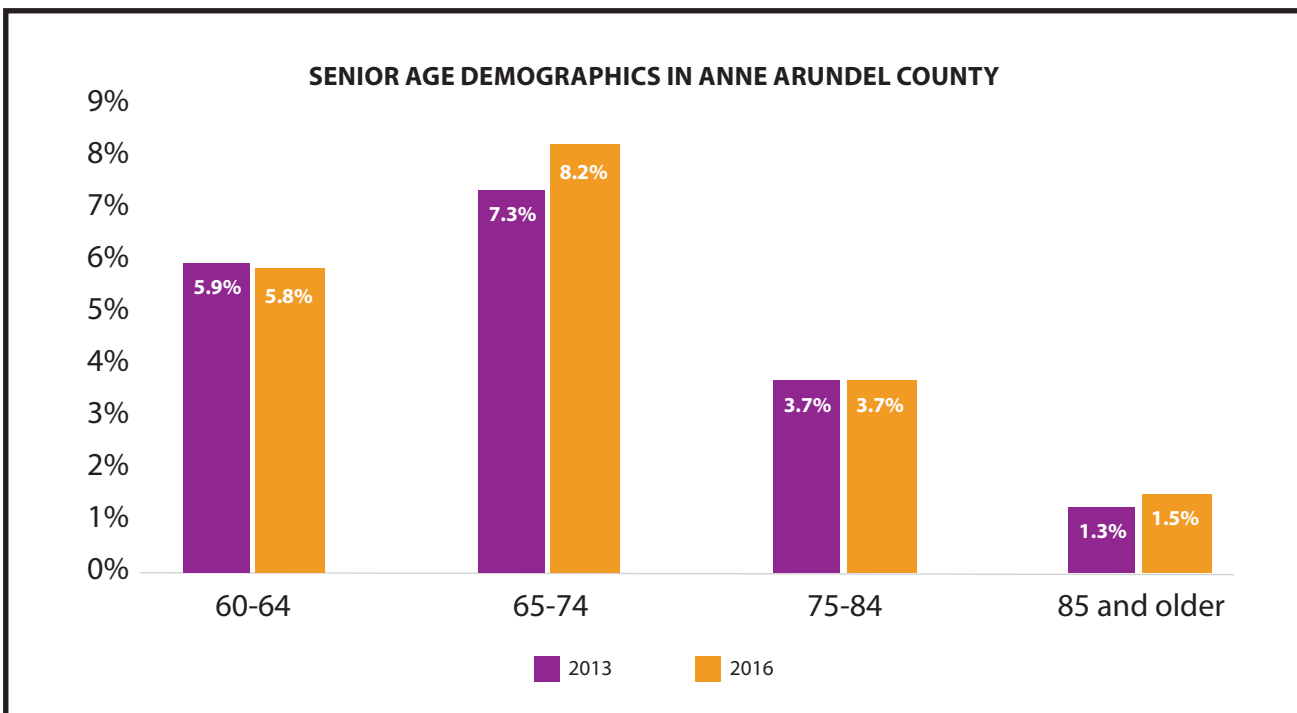
Senior Population

The number of Americans over the age of 60 is increasing. The large demographic of Baby Boomers (those born between 1946 and 1964) is now defining the aging population; 10,000 people in the nation turn 65 every day.¹ Seniors are also living longer through advanced medical care, early diagnosis and treatment of diseases, and better nutrition.

'Senior' is a very broad term for a group that now spans almost four decades. Service providers see the aging population in three distinct groups: 55-70 years of age, 70-85 years of age, and 85 and older. Each group has very distinct needs emotionally, physically and psychologically, yet they tend to get treated as one large demographic.

Since 2013, the number of Anne Arundel County residents over age 60 has grown from 99,084 to 107,523, an increase of 8.6 percent. The largest increase is seen in the 65-74 year old age group, with a smaller increase for the 85 and older group. (Figure 36). As each group continues to age, their requirements for support and services increase.

Figure 36



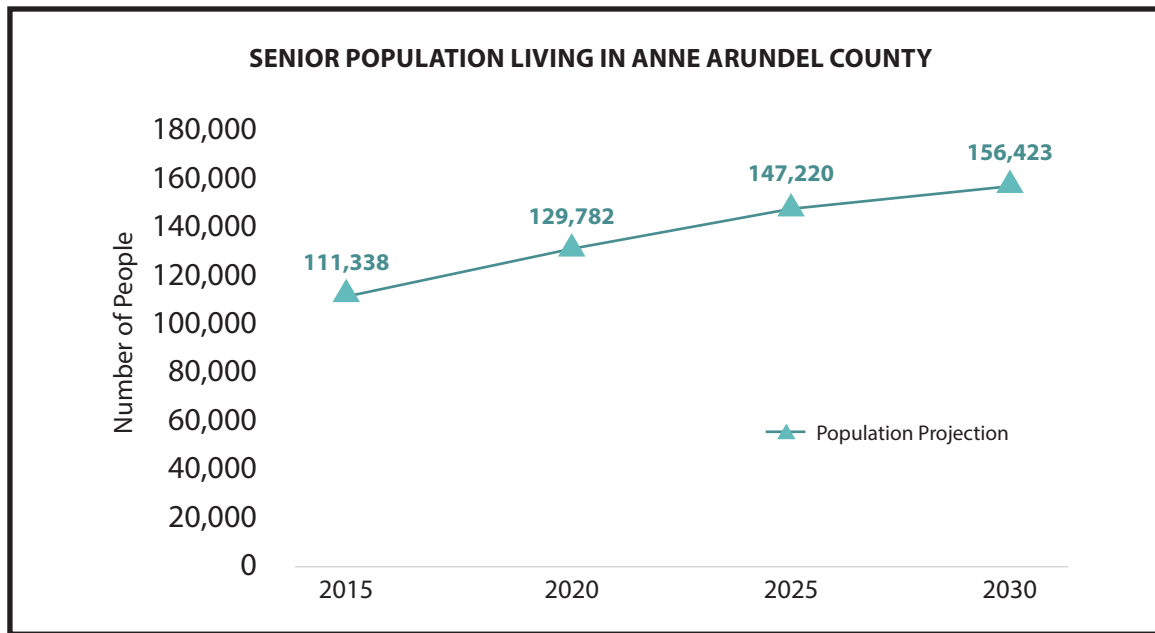
U.S. Census Bureau, American Community Survey, 2016 Estimates

The county's senior population is expected to continue rapid growth until 2030 when the trend line begins to dip (Figure 37). The Maryland Department of Aging State Plan (2017) predicts there will be a 40.49% increase in seniors living in Anne Arundel County during this period from 111,000 seniors to over 150,000 in 2030.

¹ U.S. Department of Health & Human Services, *Aging*, 2018.



Figure 37



Maryland Department of Aging, 2017

Economics

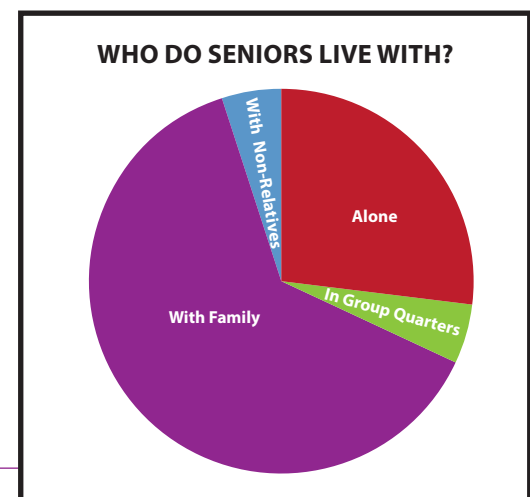
Households headed by people ages 65 and over reported a median income of \$58,559 nationally in 2016, according to the Administration on Aging Administration for Community Living (AAACL). More than 85 percent of people 65 and older receive Social Security. The average Social Security income for all retired workers in 2018 is \$1,404 per month, a \$44 increase over 2017. Among elderly Social Security beneficiaries, 50 percent of married couples and 71 percent of unmarried persons receive 50 percent or more of their income from Social Security. Generally, women receive less from Social Security due to work breaks to raise children and lower earnings over time.²

In Anne Arundel County, the median income for the 65 and older population was \$47,976 in 2016. Just over six percent of county seniors (almost 5,000) are living below 100 percent of the poverty line, lower than the national average of 9.3 percent.³

Housing

Affordable and appropriate housing is one of the biggest challenges seniors face in Anne Arundel County. Twenty-seven percent of seniors live alone, and 72 percent of those are single females. The majority of seniors live with family members, either because they are financially and/or physically unable to live alone, or because their adult children cannot find affordable housing in the county (Figure 38). Sometimes three and four generations of family members find it necessary to live together. According to 2016 U.S. Census estimates, there are 9,212 county households where three generations of family members live together in the same house. Residents from the sandwich generation (those managing children and seniors) often become unpaid caregivers. Twenty-seven percent of them have stopped working to care for a loved one according to the Genworth Cost of Care Survey (2018).

Figure 38



Source: Census.gov

² Social Security Administration, *Social Security is Important to Women*, 2018.

³ Administration on Aging Administration for Community Living, *Aging and Disability in America*, 2018.

Chapter 6 | Senior Population

There are some subsidized housing options under which the renter pays 30 percent of total adjusted income (including income from assets). Waiting lists are maintained by the Housing Commission of Anne Arundel County, the Annapolis Housing Authority, and privately managed Section 8 complexes. There are 1,142 elderly families on the county's public housing wait list. The average wait time is 685 days.⁴ Monthly costs for every type of assisted care in the Baltimore area are very high (Table 38) ranging from \$1,880 per month for adult day care to \$10,585 per month in a private room.

Table 38

Average Monthly Cost of Long Term Care Services in Maryland			
Care Type		Baltimore Area, MD	National Average Cost
Adult Day Care	Weekdays only	\$1,880	\$1,492
Assisted Living		\$4,250	\$3,600
Homemaker Services	44 hours per week	\$4,004	\$3,813
Home Health Care	44 hours per week	\$3,813	\$3,813
Nursing Home	Semi-Private (double occupancy room for one person)	\$9,733	\$6,692
	Private (single occupancy room for one person)	\$10,585	\$7,604

Genworth Cost of Care Survey, 2018

Participants from the medical community commented on the number of seniors who are admitted to the hospital, often through the emergency room, who have no home to return to. Some take up hospital beds for months at a time, at a very high cost, until guardianship can be determined and a place found for them. According to providers, guardianship programs for seniors have increased fourfold since 2014. As one participant explained:

“Sometimes there is family but they’re estranged, or they might just be far away and feel like they don’t want to take on the responsibility; all sorts of reasons for it. But the cases are very complex; many of the folks have very little means, some of them have some assets and income, but sometimes it’s very hard to place them. It can be very hard to find appropriate housing.”

There is a long waiting list for Senior Care, a program operated by the County Department of Aging and Disabilities, that helps seniors age in place. The program costs \$300-600 per month, as opposed to thousands of dollars for nursing home care. Seniors often need assisted living as they age, which is difficult to afford on a fixed income.

⁴ Housing Commission of Anne Arundel County, 2018.



Health

Most seniors have at least one chronic health condition, and many have multiple conditions. The top five conditions seniors suffer from are hypertension, hyperlipidemia, arthritis, ischemic heart disease, and diabetes.⁵ According to participants in this needs assessment, urinary tract infections are common, largely due to decreased fluid intake in the elderly. Sepsis and pneumonia are also common, especially during a hospital stay.

Multiple participants noted the over-prescription of medications to seniors. Many prescriptions are multiples of the same kind of medicine and do not react well together. Seniors often have issues remembering to take pills at the right time and in the right dose. As one participant noted:

“We’ve asked seniors how many medications they are on; some are on as many as 20 medications, including 3 or 4 for high blood pressure.”

The number of Medicare beneficiaries is rising in the county as a result of the growing senior population. The county has served almost 3,000 new beneficiaries in the last three years. The number of people who are also eligible for Medicaid due to low income rose from 10.9 percent to 11.3 percent in three years (Table 39). Half of all people on Medicare have incomes less than \$26,200.⁶

Table 39

Medicare Beneficiaries in Anne Arundel County 2013 - 2016 Comparison		
Beneficiary Demographic Characteristics	2013 (Number or Percentage)	2016 (Number or Percentage)
Beneficiaries with Part A & Part B	75,607	78,529
Fee-for-service Beneficiaries	69,420	70,606
Medicare Advantage (MA) Beneficiaries	6,187	7,923
Average Age	72 years	72 years
Female	56.2%	56.5%
Male	43.8%	43.5%
White, NH	82.2%	81.5%
Black	31.1%	12.5%
Hispanic, Any Race	1.3%	1.6%
Eligible for Medicaid	10.9%	11.3%

Anne Arundel County Department of Health, 2018

⁵ Administration on Aging Administration for Community Living, *Aging and Disability in America*, 2018.

⁶ Jacobson, G; Griffin, S.; and Neuman T. *Income and Assets of Medicare Beneficiaries, 2016-2035*. Kaiser Family Foundation, 2017.

Chapter 6 | Senior Population

Behavioral Health

Demand for mental health services has risen more steeply for those age 65 and older than for any other demographic, increasing 102% since 2012 (see chart on page 55).⁷

Loneliness and isolation often results in anxiety and depression. As seniors live longer, an increasing number develop dementia or Alzheimer's disease. There are no mental health services for seniors in the county that accept Medicare and very few geriatric psychiatrists. There are very few in-home services that offer evaluations for those with mental health issues and/or dementia. Those that do exist don't accept Medicaid or Medicare. According to participants, in times of real crisis, Medicare eligible seniors may be referred as far away as Georgia for mental health care. There are many elderly couples in the county who are caring for each other. When one or both become too frail, they are often separated in nursing homes or acute care facilities. Currently there are no nursing facilities that allow senior couples to stay together. As one participant noted:

"You've got couples that live into their 90's and one has dementia and one doesn't. We put them in the hospital or in assisted living and separate them which causes an increase in loneliness and despair... There's no reason why two people who have been married for 60 years can't be in the same room together."

Substance abuse also occurs in the elderly. According to participants, seniors become addicted to pain medication through pain clinics and prescriptions from primary care providers. They are often prescribed medication for anxiety and depression. There are no substance abuse treatment services through Medicare. As one provider commented:

"We're also seeing quite a bit of benzo addiction and people prescribed Xanax, and unfortunately we are dealing with opioid addictions. We have 67 year old heroin addicts right now because of opioid addiction."

Transportation

As seniors age, they may be physically unable to drive, or prefer not to. They depend on public transportation services to take them from Point A to Point B. There are only two forms of transportation for the elderly population: Medicaid medical transportation for those eligible and the county's 'on demand' partial transit system. The age for the latter service has been increased to 65 and the number of available vans has been decreased to twelve. Many respondents commented on the need for transportation for seniors: to the grocery store, a hairdresser's appointment or a visit to the local senior center. These activities help address the loneliness and isolation experienced by our aging population. As one participant noted:

"Now it's going to be even tougher when it comes to things like medications, groceries and other everyday needs, they just don't get them. 'I couldn't get there so I didn't buy them.'"

⁷ Anne Arundel County Mental Health Agency, 2018.



Kinship & Guardianship

Kinship caregivers are those grandparents, relatives and friends who agree, formally and informally, to raise their grandchildren and other children when parents are no longer able to. The number of grandparents raising grandchildren in the county has increased over 34 percent between 2014 and 2017. The opioid and heroin crisis may be partly responsible for the increase, as parents overdose or fall into addiction. There are few formal supports for kinship families and many issues to struggle with. When kinship caregivers do not have legal guardianship they may be unable to sign for medical and other care for the children in their charge. Legal guardianship procedures can take months. Many kinship caregivers are on a fixed or limited income. As one provider noted:

“It’s the grandparents and great-grandparents caring for babies or school-aged children that they don’t have a clue what to do with. They do not have the financial assistance that they need to take care of them and they don’t have the room. They are depleting their savings, they are on a fixed income and that population is growing tremendously. Almost 50 percent of our calls for help are from kinship families.”

Needs and Gaps

- Aging in place is the preferred method of care. As seniors age they are likely to develop a need for some assistance with daily living. Affordable assisted living is a huge need for this demographic.
- Mental health services and especially geriatric psychiatry are a gap in services for senior residents, especially those that rely on Medicare and/or Medicaid.
- The over-prescription of every type of medication was commented on many times during this needs assessment. Some medical facilities have a pharmacist review medications when patients enter, but seniors may see several medical and mental health providers, all of whom may prescribe medication for a specific issue without looking at the entire picture of a patient’s medications.
- The number of kinship caregivers who are also seniors is growing in the county. There is a huge need for financial and other supports for such families. Without formal legal guardianship their ability to act in the place of the parent is sorely limited.
- As more seniors age, demand will increase for transportation services to help with daily living.

Needs Assessment Summary

Anne Arundel County is a wonderful place to live for most residents. In 2018, there is low unemployment, high median household income, a good public school system, cultural diversity and acres of natural resources for recreation. Most residents are able to access healthcare services. The growing need for behavioral health services for all ages requires attention from county health leaders. The consequences of increased social media use are causing negative health and behavioral problems throughout the community. Increasing aggression and violence in schools, hospitals and other systems should be a huge concern to county leadership.

Deep and stubborn pockets of poverty in North and South County and in the city of Annapolis require focused attention and effective collaborative solutions. Low income families, youth and seniors regularly encounter barriers to progress.

The three big needs in the county—transportation, affordable housing and affordable quality child care—remain unchanged since 2009. Public and private investments are needed to advance progress for all.



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About the Community Foundation of Anne Arundel County

In 1998 a group of community leaders gathered to consider how they might make a substantial and long-term difference in our community. Their vision was to create a Community Foundation, a permanent charitable foundation that would provide funds needed to create a better quality of life for all residents in Anne Arundel County for as long as the foundation exists. Under their leadership, the Community Foundation of Anne Arundel County (CFAAC) was born and is now one of more than 800 community foundations across the country. CFAAC is certified for operational and legal excellence and accountability with the National Standards for U.S. Community Foundations. CFAAC currently holds 126 funds and manages more than \$14 million in assets.

CFAAC is a 501(c)3 nonprofit organization that seeks to elevate philanthropy in the county. We help donors meet their financial and philanthropic goals through donor advised funds while helping to build and sustain community through grant making. CFAAC is a significant contributor to philanthropic community leadership in the county by helping to harness the power of collective giving to address persistent community needs today and for generations to come. We partner with donors to maximize the impact of their philanthropic investments for the long-term and make it easy, effective and accessible to everyone.

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Anne Arundel County

Community Health Needs Assessment (CHNA) **2019**

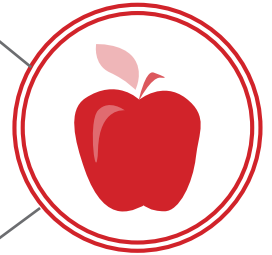
A Collaboration With:

Anne Arundel Medical Center
University of Maryland Baltimore Washington Medical Center
Anne Arundel County Department of Health
Anne Arundel County Mental Health Agency
Community Foundation of Anne Arundel County
Annapolis and Anne Arundel County YWCA
Anne Arundel County Partnership for Children, Youth and Families



The **highest percentage of poverty** is in the **Brooklyn Park** ZIP Code at **27.3%**

74,522 county residents currently reside in a **food desert**



An average of **444 children per month** were **abused or neglected** from March 2016 through February 2017

The number of **free lunches** served daily to students has increased **7%** in four years



The number of **crisis interventions** in the public school system for **social and emotional issues** **doubled** since 2013

Overall there has been a **70% increase** in residents seeking **mental health services** since 2012

The **percent of uninsured residents** in Anne Arundel County continued to decline, reaching a low of **5.3%**

The rate of **emergency department opioid overdose** encounters for County residents has **risen 91%** since 2014



Anne Arundel County

Community Health Needs Assessment
2019

Preface

The Context of Health Care in Maryland and Anne Arundel County.

The health care landscape in Anne Arundel County, Maryland, and the United States has been rapidly changing over the past several years and will continue to evolve. Health system reforms in public health, health care, insurance and other sectors are resulting in dramatic changes to both financing and service delivery. These changes include improving the efficiency and effectiveness of health organizations and services, as well as increasing connections and collaborations among public health, health care, and other sectors. (Source: CDC, <http://www.cdc.gov/stltpublichealth/program/transformation/index.html>)

Maryland, in particular, is a leader in health system transformation. Since January, 2014, Maryland's hospitals, guided by an innovative agreement with the Centers for Medicare & Medicaid Services, have been making progress toward the Institute for Healthcare Improvement's Triple Aim of Health Care: to reduce costs, improve the health of communities and improve the experience of care for patients. Maryland is the only state in the nation that sets the rates hospitals can charge for their services. Rates are the same for all patients for the same service in the same hospital, whether they have Medicare, Medicaid, private health insurance, or pay out of their own pocket. The Maryland Medicare waiver or "All-Payer" model was modernized to better reflect the current state of health care – a trend toward more outpatient care and prevention, and less inpatient care. The new waiver agreement aligns with the goals of the Triple Aim of Health Care — less expensive care, better experiences for patients, and healthier communities. The new agreement requires hospitals and the state to achieve specific cost and quality targets. (Source: <http://www.mhaonline.org/docs/default-source/advocacy/legislative/md-general-assembly/Priorities/leave-behinds/waiver-101.pdf?sfvrsn=2>)

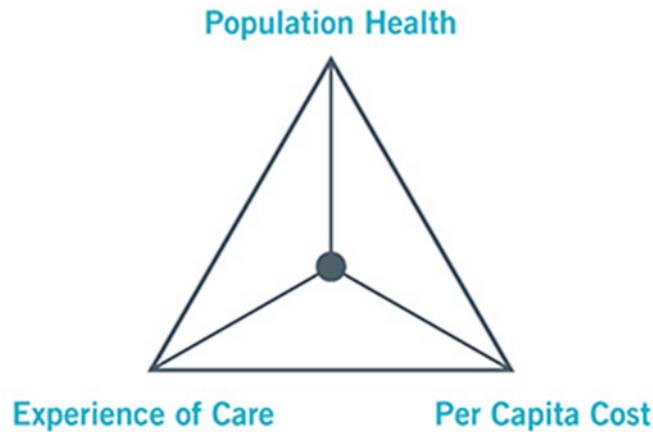
All of Maryland's hospitals now operate under fixed annual budgets that shift incentives from volume to value. This is a model where hospitals are not rewarded based on how many patients they treat, but rather on how successful they are in keeping their patients and communities healthy. The result; hospitals are keeping costs down by trimming unnecessary use of hospital services, improving quality, and working to keep members of their communities healthier and out of the hospital. To do this, hospitals have moved care beyond their walls and into communities by expanding preventive care and collaborating with others to make sure care does not stop after a patient leaves the hospital. (Source: <http://www.mhaonline.org/docs/default-source/advocacy/legislative/md-general-assembly/Priorities/leave-behinds/waiver-101.pdf?sfvrsn=2>) New models of care are being developed that include care coordination and navigation services, community health workers, non-traditional settings of care and unique partnerships. There is an increased awareness of the need to address the socioeconomic determinants of health through these new care models.

Starting in January, 2019, Maryland's hospitals will operate under a new contract with the federal government, designed to test whether the improvements hospitals have made under the All-Payer Model can be expanded to all health care providers. Rather than focusing on how hospitals alone can deliver efficient, high-quality care, physicians, skilled-nursing facilities, home health providers, and others, will be incentivized to improve how they coordinate care for patients and how they address societal health problems such as diabetes, heart disease, and opioid use disorders. In doing so, Maryland's entire health care system will work to ensure that patients receive the right care, at the right time, in the right setting. (Adapted from/source: <https://www.mhaonline.org/transforming-health-care/tracking-our-all-payer-experiment>)

At the same time, due to the expansion of Medicaid and the decrease in uninsured patients, many public health departments are reducing the direct clinical services they provide. Increasingly, health departments are focusing their efforts on prevention and education, helping newly insured and others access health care services, and convening community stakeholders in coalitions to improve community health. Other governmental agencies are also increasingly being tasked with helping to keep the communities they serve healthier and able to live more productive lives. All of these changes have placed an increased emphasis on public-private partnerships, coalition building and advocacy for community health improvements. There is increased collaboration between health systems, community hospitals, insurance companies, physician practices, long-term care and other providers, as well as community-based organizations, public health departments, and patients and consumers. These collaborations will only continue to grow and mature.

Anne Arundel County is fortunate that it has many strong, existing partnerships to improve the health and well-being of Anne Arundel County residents.

The IHI Triple Aim



Foreword

The summative (quantitative) data contained in this needs assessment was gathered from a variety of local, state and national sources. Population and socio-economic statistics were compiled using data from the United States (U.S.) Census Bureau’s Population Estimates Program and the American Community Survey 1-Year and 5 Year Estimates. These data should be considered less reliable due to the gap of eight years since the last full census. All data here are based on census estimates. Birth and death data files were obtained from the Maryland Department of Health and Mental Hygiene, Vital Statistics Administration. The emergency department and inpatient hospital discharge data files were obtained from the Maryland Health Services Cost Review Commission for topics like birth, mortality and hospital utilization. Other data sources used for this report were: Maryland Vital Statistics Annual Reports, Maryland Department of Health and Mental Hygiene’s Annual Cancer Reports, Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention’s CDC WONDER Online Database, Centers for Medicare and Medicaid Services, National Vital Statistics Reports and County Health Rankings, and a variety of local databases. The specific data sources are listed throughout the report.

The 2019 CHNA draws on qualitative data gathered from 26 key informants and 11 focus groups. Focus group areas included emergency department personnel, low income youth, behavioral health providers, Hispanic residents, advocates, domestic violence victims and a host of others representing a total of 185 participants. A full list of focus groups and key informants can be found below. Interviews and conversations were recorded, with the permission of participants, and transcribed verbatim. The author thanks Lisa Kovacs, Administrative Coordinator at the Anne Arundel County Partnership for Children, Youth and Families, for the hours of transcription time spent ensuring this CHNA accurately represents the voices of our community. The data was read and reread until dominant themes emerged which became the subtext of the report. All participants gave permission for their words to be used in the final report, although their identities are protected.

The 2019 CHNA draws on qualitative data gathered from 26 key informants as follows:

- CEO, Anne Arundel Medical Center (AAMC)
- CEO, University of Maryland Baltimore Washington Medical Center
- Anne Arundel County Health Officer
- Executive Director, Anne Arundel County Mental Health Agency
- Director, Anne Arundel County Crisis Response
- Clinical Director, Anne Arundel County Mental Health Agency
- Domestic Violence Coordinator, AAMC
- County legislative leader
- Director, Department of Social Services

Schools Superintendent
Middle School Ambassador
Three Domestic Violence victims
Director, Anne Arundel County Department of Aging and Disabilities
Hispanic Community leader
Anne Arundel County Chief of Police
Anne Arundel County Transportation Director
County Executive
County Administrative Officer
Faith leader
Public housing resident
Formally homeless youth
Executive Director, Community Health Agency
Executive Director, YWCA
Executive Director of Alternate Education for the public school system

Eleven focus groups contributed to the report as follows:

AAAMC and UMBWMC Emergency Department and Emergency Response (14).
Low-Income Youth from Public Housing (32).
Behavioral Health Providers (40)
Domestic Violence and Sexual Assault Victims (7)
Seniors (10)
Hispanic Community (5)
Human services providers and advocates (14)
Early childhood advocates (10)
Community Health providers (4)
Aging and Disabilities providers (7)
Pupil Personnel Workers (20)
Anne Arundel County Health Department senior staff (12)
Criminal justice representatives (5)

Information Gaps in the Data

- The last full US Census of the population was completed in 2010. All census data used in this report is based on summary estimates completed each year since then.
- The mental health secondary data in this report reflects the public mental health system only.
- Numbers for heroin and other opiate addictions rely on police reports and emergency room data. There is no accurate count for the number of heroin addicts in the county.
- Domestic violence numbers are unreliable. Many incidences go unreported, reflect those seeking medical attention, or who seek support through a domestic violence provider or the court system.
- Opinions from youth consumers of mental health services were not captured in this report.
- There is no accurate count of the number of undocumented residents in the county
- Homeless family numbers are unreliable. They reflect only those families who have been served in a shelter or by a homeless service provider.

About the Author

Dr. Pamela Brown is currently the Executive Director of the Anne Arundel County Partnership for Children, Youth and Families. She completed her Ph.D. in Educational Leadership at Florida Atlantic University. Her dissertation focused on the importance of community partnerships in diverse neighborhoods. She is a University Research Reviewer and Dissertation Chair for the University of Phoenix specializing in qualitative case study methods. She is certified to conduct ethical research through the Collaborative Institutional Training Initiative at the University of Miami. She has been conducting community needs assessments for over 20 years.

The 2019 Anne Arundel County Community Health Needs Assessment (CHNA) is the result of an extended collaboration between the following partners: Anne Arundel Medical Center, University of Maryland Baltimore Washington Medical Center, Anne Arundel County Department of Health, Anne Arundel County Mental Health Agency, Community Foundation of Anne Arundel County, Anne Arundel County Partnership for Children, Youth and Families and the YWCA of Annapolis and Anne Arundel County. All organizations throughout Anne Arundel County, including community-based organizations, non-profits, faith-based organizations, government and businesses are encouraged to use the CHNA findings.

Summary of Principal Findings

Population: The Anne Arundel County population has grown 14.3 percent since 2000 to 559,737 residents. The county’s population is aging. Those over 65 have increased by 11 percent since 2014 while the percentages of those 19 and under have decreased slightly.

Hispanic Population: The Hispanic population is growing more significantly than all races/ethnicities and is now at 7.9 percent or 39, 402 residents, still lower than the state average of 9.8 percent. The County has the fourth largest Hispanic population by percentage among Maryland counties. The distribution of the Hispanic population is uneven in the county with a high of 20.3 percent in the City of Annapolis.

Health: Life expectancy for the county has risen to 79.6 years. Cancer remains the leading cause of death, although the numbers have seen a 1 percent decrease since 2013. Accidental (unintentional injury) deaths have risen to the fourth leading cause of death, driven most likely by increases in opioid overdose deaths. Heart disease accounts for 22 percent or 974 of all county deaths as of 2016. That number has risen almost 10 percent since 2013.

Overweight and Obesity: Overweight and obesity continue to create health issues for county residents. Between 2012 and 2016, the percent of overweight adults (Body Mass Index of 25 to 29.9) 18 years and older in Anne Arundel County rose slightly from 36.7 percent to 37.2 percent. The percent of county residents who are classified as obese (Body Mass Index 30 and over) also rose from 27 to 31 percent.

Mental Health: There has been a 70 percent increase in residents seeking mental health services since 2012; 16,343 residents were served by the county mental health agency in 2018. The two highest increases in numbers served are the early childhood population and those over 65. Increased mental health and behavioral issues in the birth to five early childhood population are causing widespread concern in every system.

Substance Abuse: In 2017, Anne Arundel County police reported almost 1,100 opioid-related overdoses occurring within the county, a 171 percent increase since 2014. Fentanyl-related deaths in the county have increased significantly since 2013 and surpassed heroin related deaths through currently reported data for 2017. The current opioid crisis has many victims. The number of newborns assessed positive for substances in their systems, including methadone, has risen 144 percent since 2014 from 74 to 181. Grandparents and great grandparents are raising children with little governmental help.

Domestic Violence: The data since 2015 shows an upward trend. The statistics for the 2018 year are alarming. The numbers for the six month period are almost as high as for the previous 12 months. These statistics confirm anecdotal data from police, schools and hospital personnel who all reported a notable increase in domestic violence over the same period.

Child Physical and Sexual Abuse: In 2018, the county’s Child Advocacy Center investigated 326 sexual abuse cases, of which seven were for sexual assault. Respondents noted a large increase in the number of child on child sexual assaults that are being reported by the school system and other agencies.

Sex Trafficking Victims: Anne Arundel County is in the top five jurisdictions in Maryland for sex trafficking. While the numbers were stable between 2015 and 2017, data for the first 6 months of 2018 are showing an almost 100 percent increase in cases.

Emergency Departments: The two county hospital emergency departments at AAMC and UMBWMC have become the ‘catch all’ for somatic and behavioral health treatment. As one provider noted ‘we are the new church door’ for many of the socio-economic issues in the county. They are often the receiving facilities for behavioral health issues. In 2017, there were 12,446 behavioral health encounters; mood disorders accounted for 26.3 percent of those.

The Environment: The 2016 State of the Bay Report from the Chesapeake Bay Foundation showed that each of the three indicator categories—pollution, habitat, and fisheries have improved since 2014. However, despite many efforts by federal, state, and local governments and other interested parties, pollution in the Bay does not meet existing water quality standards. All of the county’s waterways are considered “impaired” because of excessive levels of major contaminants, which are largely a result of untreated storm water runoff.

Transportation: The lack of public transportation continues to be a major issue for the county. The majority of county residents (80 percent) drive to work alone in their cars every day; 7.7 percent car pool; 2 percent walk; and 2 percent take a bus. There are now five regional transit routes, eight Annapolis routes, four local bus routes and four commuter bus routes. Additionally there are two pilot bus routes in South County. There are large areas of the county that are underserved or not served at all, including North and West County.

Homelessness: Homelessness is a continuing issue for individuals and families in the county. The county served 1,684 homeless individuals in 2017, including 269 families. There are still only three homeless shelters in the county and three rapid rehousing programs. In 2018, 1,260 homeless youth were identified in the county public school system. North County schools accounted for 337 of the homeless children, triple the amount for 2016

Social Media: The use of social media, including the active use of smart phones and tablets, is a major concern for residents and professionals in every area of the county. The constant access to electronic information is impacting every age group and demographic. Babies as young as 12 months have been observed in the county holding iPhones and tablets. One early childhood provider described this as “soothing by cell phone.”

Geography: The majority of negative social and health indicators continue to polarize in North and South County and Annapolis. In South County, access to health care is very limited and there are few primary care doctors. Those residents with transportation often travel to Glen Burnie to access primary care. Owensville Health Center is inaccessible to those residents who live in areas like Deale and have no transportation. Brooklyn Park (North County) is both a Medically Underserved and a Health Shortage Area and continues to have high indicators of need, as does Glen Burnie.

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Introduction

County Overview

Anne Arundel County is the fifth largest county in the state covering 415 square miles. It has 534 miles of natural shoreline. For the majority of residents the county is a wonderful place to live. Most recent household median income estimates stand at \$91,918 (US Census estimates, 2016.) The unemployment rate (as of January 2018) is 3.9 percent, lower than the state average of 4.6 percent. However, there are 32,368 Anne Arundel County residents (5.8 percent) living below the poverty level. The rate of poverty for children is much higher, at 9.3 percent. Single female head of household numbers are even higher and there are racial disparities; 14.8 percent of White and 19.3 of African American single female head of households are at or below the poverty level. Economic distress is spread unequally throughout the county with pockets of low income and poverty level families clustered in North and South County areas and in Annapolis.

In 2018, residents are most concerned about the heroin/opioid crisis, gun violence, behavioral issues among the very young, and the impact of social media on every facet of our lives and the lives of our children. Participants in this needs assessment cited lack of transportation as the biggest barrier to success, from accessing appropriate medical care to acquiring and retaining employment. The lack of quality, affordable child care and the scarcity of affordable housing are continuing barriers for poverty level and low-income families as they try to move towards self-sufficiency.

Anne Arundel County is served by two major hospitals: Anne Arundel Medical Center in Annapolis and the University of Maryland Baltimore Washington Medical Center in Glen Burnie (Figure 1.) Due to their location, residents living in the northern part of county often choose to be served by MedStar Harbor Hospital, in Baltimore City. Residents in the southern part of the county often seek medical care in Calvert and Prince George’s counties.

Figure 1: Anne Arundel County Hospital Locations



Anne Arundel County Department of Health, 2018

Physical and behavioral health services are available at three Federally Qualified Health Centers (FQHCs) and at the Anne Arundel County Department of Health (six clinic sites.) Medicaid recipients and other low-income, uninsured residents can obtain a wide variety of quality mental health services through The Anne Arundel County Mental Health Agency, Inc. (AACMHA).

There are eight options for primary care community clinics in Anne Arundel County. The clinics serve newborns to geriatrics, and work with those who are low-income, uninsured, or have other means of Medical Assistance, such as Medicaid. Self-pay patients are charged for services based on gross household income and number of household dependents.

Population Demographics

The most recent census estimates on the diversity of the county illustrate a diminishing White, Caucasian population. The Hispanic population has grown over 205.4 percent since the year 2000 (Table 3.) The most common foreign languages in Anne Arundel County are Spanish (26,124 speakers), Tagalog (2,810 speakers), and Korean (2,751 speakers.) Compared to other places, Anne Arundel County has a relative high number of Greek (737 speakers), Korean (2,751 speakers), and African Languages (2,387 speakers.)

Table 3: Anne Arundel County Ethnic and Racial Composition (2000-2016)

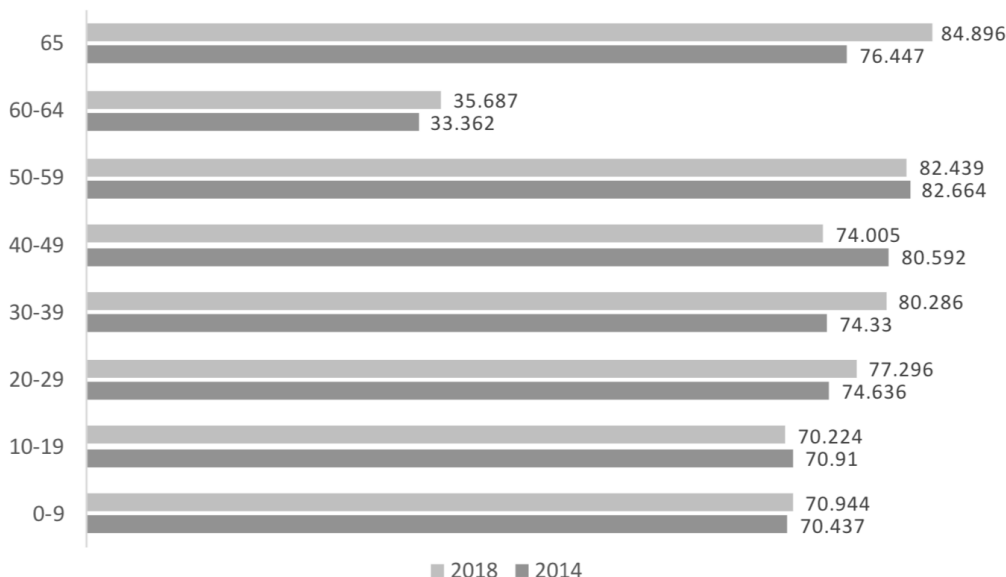
Ethnic/Racial Composition in Anne Arundel County, 2000-2016							
	2000		2010		2016		Percent Change 2010 - 2016
	Amount	%	Amount	%	Amount	%	%
Total	489,656	100	537,656	100	559,737	100	14.3
Non-Hispanic Whites	390,519	79.8	405,456	75.4	393,514	70.3%	0.8
Other Races:	99,137	20.2	132,200	24.6	126,821	22.7%	27.9
Hispanic or Latino	12,902	2.6	32,902	6.1	39,402	7.9%	205.4
Black/African- American	65,755	13.4	83,484	15.5	87,090	15.6%	32.4
Other*	20,480	4.2	15,814	3	39,731	7.1%	94

* Includes: "American Indian and Alaskan Native", "Asian", "Native Hawaiian or other Pacific Islander", "Some other race", or "Two or more races". Therefore, the "White" and "Black" figures are those who were counted as "White alone" or "Black alone."

U.S. Census Bureau, American Community Survey, 2016

Anne Arundel County has an aging population. Those over 65 have increased by 11 percent since 2014 while the percentages of those 19 and under have decreased slightly. (Figure 2.)

Figure 2: Anne Arundel County Age Distribution (2014-2018)



Anne Arundel County Economic Development Corporation, 2018

The Hispanic Community

While the White Caucasian population of the county continues to diminish, the Hispanic population is growing more significantly than all races/ethnicities and is now at 7.9 percent (still lower than the state average of 9.8 percent.) The County has the fourth largest Hispanic population by percentage among Maryland counties. The distribution of the population is uneven in the county with a high of 20.3 percent Hispanic in the City of Annapolis. The largest sector of the Hispanic population is from Central American countries, including a growing population from El Salvador. This is significantly different from the overall U.S. Hispanic population, which is overwhelmingly Mexican (63 percent.)

Traditional governmental systems, from the city and county police departments, to the public schools and health systems, are struggling to adequately respond to this growing Spanish speaking population. Only seven Annapolis police officers speak Spanish as do nine percent of full-time civilian personnel, and only nine county police officers speak Spanish, (City of Annapolis Police Department, 2017.) The public school system has a shortage of teachers for English Language Learners (Anne Arundel County Public Schools, 2018) and the county mental health agency reports a woeful lack of Spanish speaking counselors. There is only one Spanish speaking psychiatrist in the entire county (Anne Arundel County Mental Health Agency, 2018.)

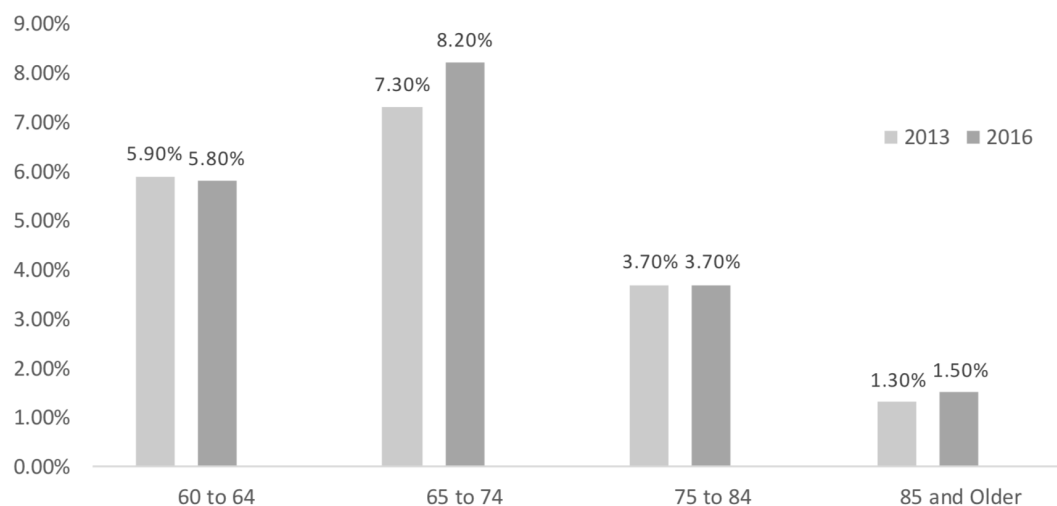
Senior Population

The number of Americans over the age of 60 is continuing to increase. The large demographic of Baby Boomers (those born between 1946 and 1964) is now defining the aging population; 10,000 people in the nation turn 65 every day (U.S. Health and Human Services, 2018.) Seniors are also living longer through advanced medical care, early diagnosis and treatment, and better nutrition.

'Seniors' is a very broad term for a group that now spans almost four decades. Service providers see the aging population in three quite distinct groups; 55- 69 years of age, 70-84 years of age and 85 and older. Each group has very distinct needs emotionally, physically and psychologically.

In Anne Arundel County there has been an increase since 2013 in those residents over 60 from 18.2 percent to 19.2 percent. The largest increase is in the 65-74 age group with a smaller increase for the 85 and older group (Figure 3.) As each group continues to age, their requirements for supports and services increase.

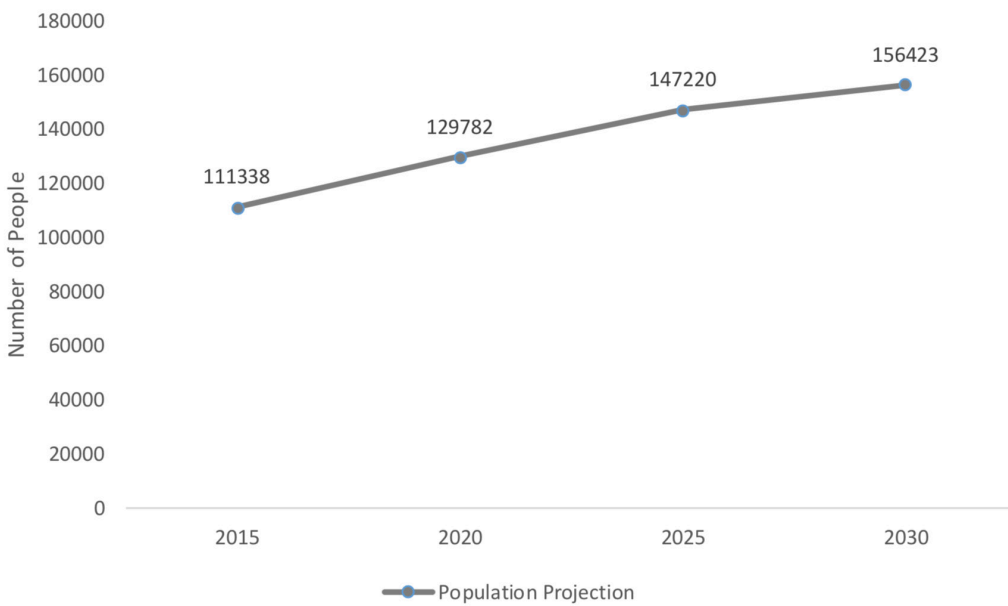
Figure 3: Senior Age Demographics in Anne Arundel County (2013, 2016)



U.S. Census Bureau, American Community Survey, 2016 Estimates

The county's senior population is expected to continue rapid growth until 2030 when the trend line begins to dip (Figure 4.) The Maryland Department of Aging State Plan (2017) predicts there will be a 40.49 percent increase in seniors living in Anne Arundel County during this period from 80,000 seniors to over 150,000 in 2030.

Figure 4: Maryland’s 60+ Population Projections for Anne Arundel County (2015-2030)



Maryland Department of Aging, 2017

Income

The gap between rich and poor continues to widen. The number of resident households with an income above \$200,000 has grown by over 38 percent. Those households with an income below \$25,000 have shrunk, but only slightly (Table 4.) Anne Arundel County Economic Development Corporation offers more recent income estimates than census data suggesting that in 2018, the median household income for the county is now standing at \$99,652; 19 percent more than the state and 65 percent more than the nation.

Table 4: Estimated Annual Household Income Numbers for Anne Arundel County (2010, 2016)

Estimated Annual Household Income Numbers 2010 and 2016					
Totals	2010:		2016:		Percent Change
Per household	Number	%	Number	%	
Less than \$25,000	20,819	10.7	20,439	10.0	-1.80%
25,000-34,999	12,201	6.2	10,875	5.3	-10.90%
35,000-49,999	19,077	9.7	18,775	9.2	-1.60%
50,000-74,999	34,853	17.7	32,573	15.9	-6.50%
75,000-99,999	29,982	15.3	29,148	14.2	-2.80%
100,000-199,999	61,569	31.0	68,734	33.6	11.60%
200,000 and above	17,498	9.0	24,285	11.9	38.80%

US Census Bureau American Community Survey, 2016 estimates

Poverty

Poverty is defined in different ways. The official United States poverty rate is decided by the Federal government. As of 2018, a family of four (two adults, two children) with an annual income below \$25,100 is living in poverty. There are 32,368 Anne Arundel County residents (5.8 percent) living below the poverty level (Table 5), a slight dip from the 2016 level of 33,618 (6.1 percent) although the trend line is still up slightly since 2014. There are 31,377 households led by single parents, of which 22,565 have a female as the head of household. Economic well-being for households headed by a single parent can be fragile. Estimates suggest 14.7 percent of the single parent households in the county make an income that is below the federal poverty level.

Table 5: Poverty Status, Anne Arundel County (2014-2017)

Poverty Status, Anne Arundel County, 2014-2017								
	2014		2015		2016		2017	
	Below poverty level	Percent below poverty level	Below poverty level	Percent below poverty level	Below poverty level	Percent below poverty level	Below poverty level	Percent below poverty level
Population below poverty level	31,573	5.9%	31,573	5.9%	33,168	6.10%	32,368	5.8%
Age								
Under 18 years	8,846	7.1%	8,359	6.7%	8,923	7.10%	9,024	7.1%
18 to 64 years	8,377	6.8%	19,571	5.7%	20,126	5.80%	18,585	5.3%
65 years and over	3,563	5.2%	3,643	5.1%	4,119	5.60%	4,759	6.0%
Race and Ethnicity								
White, not Hispanic or Latino	18,365	4.6%	18,875	4.7%	18,237	4.70%	18,367	4.5%
Black or African American alone	8,608	10.5%	8,622	10.3%	8,153	9.70%	9,417	10.7%
Asian alone	1,744	9.1%	1,524	7.8%	1,423	7.20%	787	3.7%
Hispanic or Latino origin (of any race)	3,165	8.9%	3,018	8.2%	3,643	9.50%	5,491	12.5%

US Census Bureau, American Community Survey, 2016 Estimates

Poverty continues to be concentrated in the North and South of the county (Table 6.) The highest percentage of poverty is in the ZIP Code that contains Brooklyn Park at a staggering 27.3 percent followed by Curtis Bay; both areas border Baltimore City. North Beach and Deale (South County) have almost twice the level of poverty as the county average.

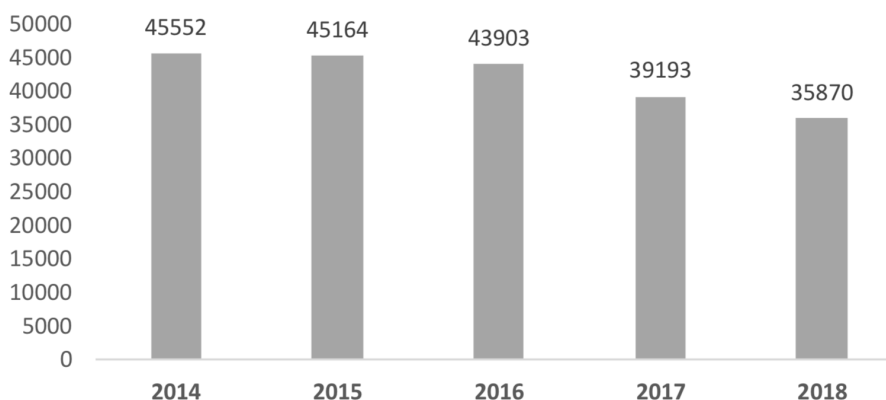
Table 6: Anne Arundel County Selected Poverty Percentages by ZIP Code (2016)

Selected Poverty Percentages by ZIP Code, 2016 Anne Arundel County		
ZIP Code	Area	Poverty Percentage
21225	Brooklyn Park	27.3%
21226	Curtis Bay	16.6%
21060	Glen Burnie (East)	7.9%
21061	Glen Burnie (West)	9.2%
20714	North Beach	10.6%
20751	Deale	10.8%
	Anne Arundel County	5.8% (2017 estimates)

US Census Bureau, American Community Survey, 2016 and 2017 Estimates

Low income residents can also be measured by the numbers receiving what used to be called food stamps and is now the Supplemental Nutrition Assistance Program (SNAP). Snap participation is down 21 percent since peaking in 2014 at 45,552 (Figure 5.) This is partly due to reinstated work requirements and a decrease in adult eligibility, as well as the improving economy.

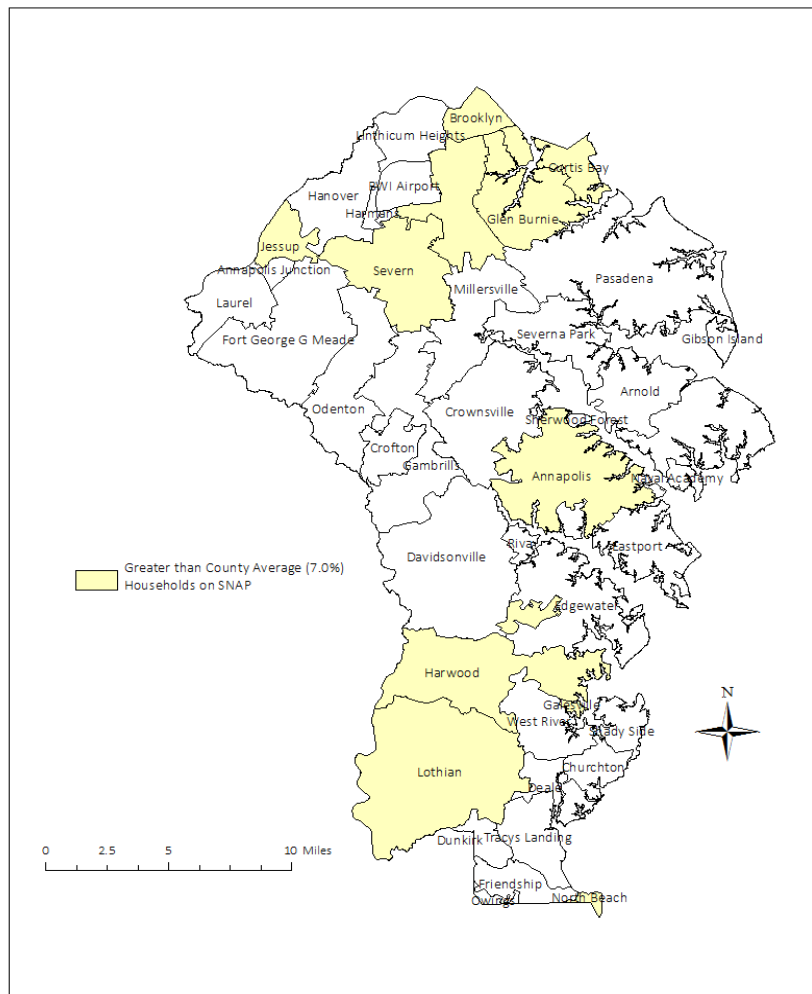
Figure 5: Anne Arundel County SNAP Recipients (2014-2018)



*Anne Arundel County
Department of Social Services,
2018*

According to 2016 US Census American Community Survey estimates, SNAP recipients are spread unevenly across the county (Figure 6) with the largest number in North and South County areas and Annapolis.

Figure 6: Anne Arundel County SNAP recipients (2016)



US Census Bureau American Community Survey, 2016 Estimates

Child Maltreatment

According to the Center for Disease Control (2018) high poverty and concentrated neighborhood disadvantage increases the likelihood that a child will suffer abuse and neglect. In Anne Arundel County, an average of 444 children per month were abused or neglected from March 2016 through February 2017, an increase of almost 13 percent since 2014.

Table 7: Counties in Maryland with the Highest Number of Child Maltreatment Reports (2017)

Counties in Maryland with the Highest Number of Child Maltreatment Reports, 2017	
	Monthly Average from March 2016-February, 2017
Montgomery	526
Baltimore City	554
Prince George's	748
Anne Arundel	444
Baltimore County	414

Maryland Department of Human Resources, 2017

The numbers of Anne Arundel County families receiving in-home services from county social services has risen every year since 2014. Child protective investigations for abuse and neglect were decreasing until 2018. Most alarming, the numbers of newborns exposed to illegal substances has increased 158 percent since 2014 (Table 8.)

Table 8: Anne Arundel County Child Welfare Key Indicators (2014-Present)

Anne Arundel County Child Welfare Key Indicators 2014 - Present					
	2014	2015	2016	2017	2018 (September)
Families Receiving in Home Services	483	607	662	753	625
New Children Receiving in Home Services	1005	1016	1139	1429	1196
New CPS Accepted Investigations	2400	2154	2161	2185	2243
New Substance Exposed Newborn Assessments	74	169	197	174	191

Anne Arundel County Department of Social Services, 2018

The Environment

Anne Arundel County is a place of natural beauty that can be enjoyed through two state and 70 county parks linked by an extensive network of recreation and transportation trails. With 534 miles of linear coastline, the county ranks second for waterfront in the state and second in the nation when compared to other counties. The county has a wealth of waters, including the Magothy River, the Upper Patuxent River, the Rhode River, the Severn River, the South and West Rivers and the Patapsco River.

The Chesapeake Bay is perhaps Anne Arundel County’s most treasured natural resource, constituting the largest estuary in the United States. Many Anne Arundel communities are within one mile of the Bay shoreline. The 2016 State of the Bay Report from the Chesapeake Bay Foundation shows that each of the three indicator categories; pollution, habitat, and fisheries, have improved since 2014 (Table 1.) However, despite many efforts by federal, state, and local governments and other interested parties, pollution in the Bay does not meet existing water quality standards.

According to the Anne Arundel County Department of Public Works, all of Anne Arundel County’s waterways are considered “impaired” because of excessive levels of major contaminants, which are largely a result of untreated storm water runoff. All storm water runoff ends up in nearby streams, rivers and eventually the Chesapeake Bay, without prior treatment. Since storm water comes into contact with litter, gasoline, oils, brake pad dust from cars, pesticides, waste from pets and many other toxins along its journey, storm water is a significant source of pollution to the county waterways.

Table 1: Chesapeake Bay Health Indicators, 2014 to 2016 Comparison

	Indicator	2016	2014	Grade
Pollution	Nitrogen	17	+1	F
	Phosphorus	28	+3	D
	Dissolved Oxygen	40	+3	C
	Water Clarity	20	+2	D-
	Toxins	28	0	D
Habitat	Forested Buffers	57	-1	B
	Wetlands	42	0	C
	Underwater Grasses	24	+2	D-
	Resource Lands	32	0	D+
Fisheries	Rockfish	66	+2	
	Blue Crabs	55	+10	B
	Oysters	10	+2	F
	Shad	11	+2	F

Chesapeake Bay Foundation, 2017

The Anne Arundel County Department of Health (2018) identified five potential groundwater problem areas for water quality within the county due to saltwater intrusion, volatile organic compounds (VOCs) and elevated levels of nitrate, radium, arsenic and cadmium. The areas are Annapolis Neck, Gambrills Area, Northern Anne Arundel County (generally all areas north of U.S. Route 50), Fort Meade/Odenton Area and the Annapolis/Edgewater Peninsula.

Lead in School Buildings

As of August, 2018, 19 public schools had unacceptable levels of lead in their drinking water. Although the Center for Disease Control does not set an unsafe level of lead, the U.S. Environmental Protection Agency recommends water be shut off at any faucet where lead levels exceed 20 parts per billion. Children are especially susceptible to lead poisoning. It can result in an array of negative health affects including reduced IQ, impaired growth, hearing loss and severe neurological problems. At Glen Burnie High School, 71 water outlets tested above that level. Of the elementary schools, 18 had at least one faucet at the unacceptable for lead level (Table 2.)

Table 2: Anne Arundel County Public Schools with Unacceptable Lead Levels

Schools with faucets above 20 parts per billion for lead	Number of faucets
Brooklyn Park Elementary School	23
Sunset Elementary	14
Hilltop Elementary	13
High Point Elementary	13
Overlook Elementary	10
Park Elementary	10
Belle Grove Elementary	8
Linthicum Elementary	5
Solley Elementary	5
Oakwood Elementary	3
Marley Glen Special Elementary	4
George Cromwell Elementary	2
Glendale Elementary	2
Richard Henry Lee Elementary	2
Woodside Elementary	2
Ferndale Elementary	1
North Glen Elementary	1
Point Pleasant Elementary	1

Maryland Department of the Environment, 2018

Air quality is another issue for the county. Anne Arundel was given an F by the American Lung Association in 2018 for an average of 13 high ozone days, a reduction from the 2013 rate of 23 days. High ozone causes respiratory harm (e.g. worsened asthma, worsened COPD, inflammation,) can cause cardiovascular harm (e.g. heart attacks, strokes, heart disease, congestive heart failure) and may cause harm to the central nervous system.

Summary

In 2018, Anne Arundel County is still a land of plenty. Low unemployment, high median household income, growing cultural diversity and acres of natural beauty make the county a desirable place to live. However, deep and stubborn pockets of poverty to the South and North of the county and in the City of Annapolis, require focused attention. As one administrator noted:

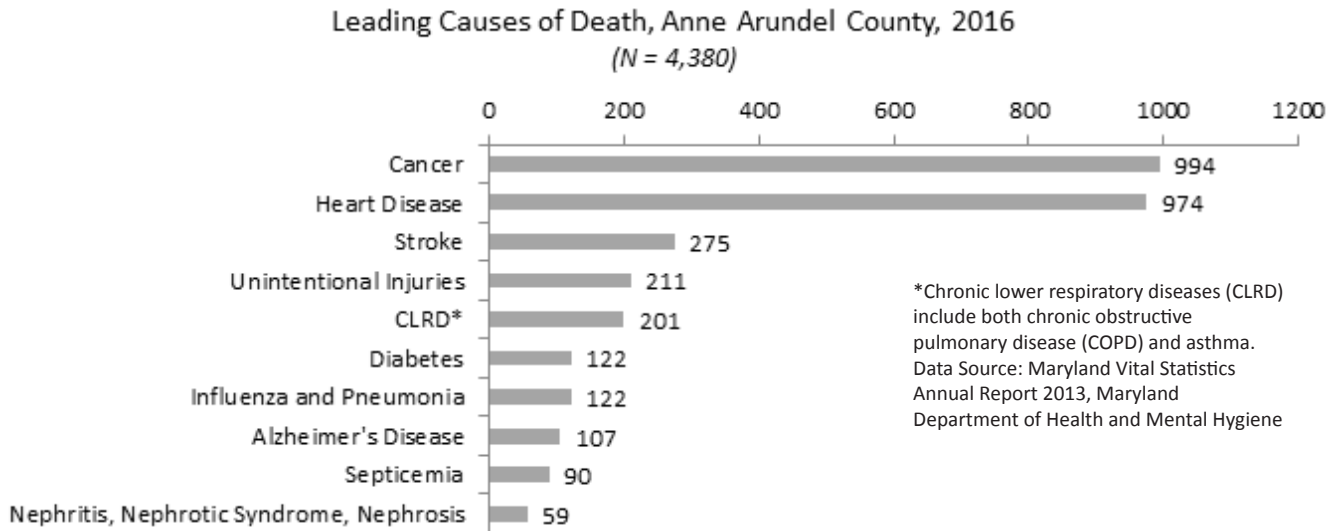
There is a lot of suffering, there are a lot of people with challenges in this community and as good a job as we're doing, these problems are not going to be solved overnight.

While our bay and watersheds are improving, air quality is still an issue for vulnerable residents. Newly required testing for lead pollution in the drinking water at public schools points to the need for public action, especially at the elementary level when children are most susceptible.

Chapter 1 - Somatic Health

In 2016, there were 4,380 deaths in Anne Arundel County, and life expectancy was 79.6 years. Accidental (unintentional injury) deaths rose to the fourth leading cause of death driven by increases in opioid overdose deaths. Cancer was the leading cause of death, although these number have seen a 1 percent decrease since 2013 (Figure 7.) Overweight and obesity continue to drive poor health outcomes for the county, including secondary issues such as diabetes.

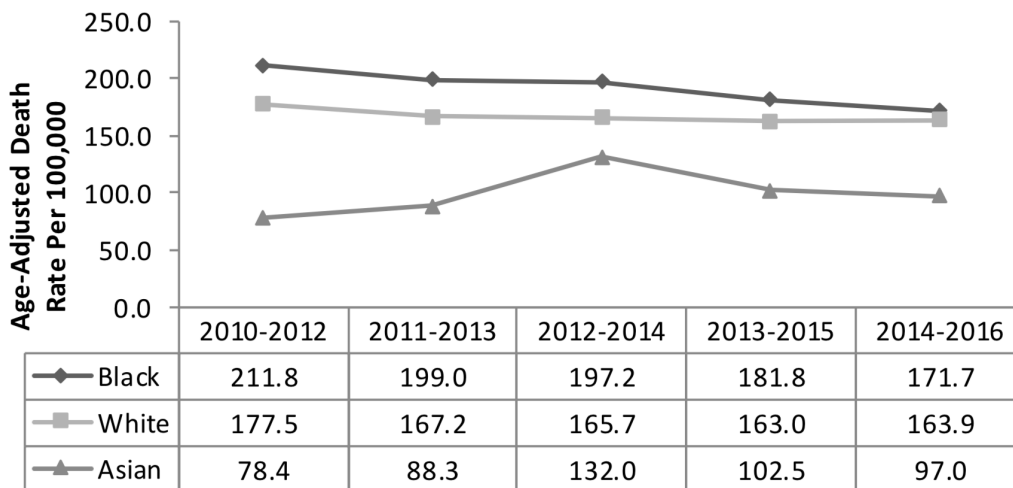
Figure 7: Leading Causes of Death, Anne Arundel County (2016)



Maryland Department of Health, Vital Statistics Administration, 2016

Heart disease accounts for 22 percent or 974 of all county deaths as of 2016. That number has risen almost 10 percent since 2013. Age-adjusted death rates for coronary heart disease decreased for Blacks and Whites between 2013 and 2016. While Blacks still have the highest death rates in the county per 100,000 residents, that number decreased by 18 percent in just three years. The decrease for Whites was only 8 percent (Figure 8.)

Figure 8: Age Adjusted Death Rate per 100,000 (2010-2016)



Centers for Disease Control and Prevention, 2016

*Individuals of Hispanic origin were included within the White or Black estimates and are not listed separately.

Births

Many factors affect pregnancy and childbirth including the mother’s pre-pregnancy health status, the mother’s age at birth, access to health care and socioeconomic status (Anne Arundel County Department of Health, 2018.) In 2016, there were 6,994 births in Anne Arundel County. Of those births, 4,357 were non-Hispanic White, 1,251 were non-Hispanic Black and 896 were Hispanic. The Hispanic population is showing the greatest increase, at 15 percent, yet, according to participants, there is a lack of affordable OBGYN services for this population.

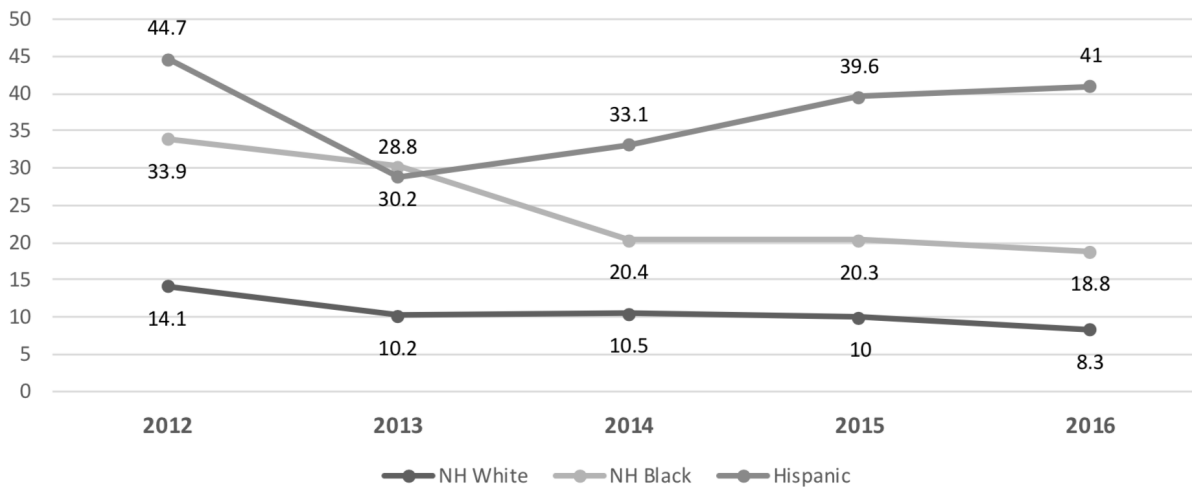
Table 9: Anne Arundel County Births by Race and Ethnicity (2012-2016)

Anne Arundel County Births by Race and Ethnicity 2012 - 2016					
	2012	2013	2014	2015	2016
Total	6,852	6,814	6,968	6,924	6,994
NH*White	4,514	4,399	4,483	4,383	4,357
NH Black	1,195	1,204	1,236	1,259	1,291
Hispanic	782	827	866	847	896

Anne Arundel County Department of Health, 2018

The teen birth rate has dropped for all races/ethnicities since 2012, although the Hispanic rate has shown an uptick since 2013. The Black teen birth rate has dropped by almost half since 2012 (Figure 9.)

Figure 9: Teen Birth Rates by Race/Ethnicity for Anne Arundel County (2012-2016)



Maryland Department of Health, Vital Statistics Administration, 2012-2016 Annual Reports

Infant Mortality

Infant mortality measures deaths during the first year of life. In 2016, there were 39 infant deaths in Anne Arundel County, with an overall infant mortality rate of 5.6 per 1,000 live births, lower than the State and the Nation (Table 10.) A significant disparity continues to exist between white and black infant mortality. In 2016, non-Hispanic black infants in Anne Arundel County had a mortality rate of 10.5 per 1,000 live births, double that for non-Hispanic white infants. The same disparity is seen at the state and national levels (Table 10.)

Table 10: Infant Mortality Rate Comparison (2012-2016)

Infant Mortality Rate Comparison, 2012 - 2016					
	2012	2013	2014	2015	2016
Infant Mortality- All Races per 1,000 Live Births					
Anne Arundel	6.4	5.6	5.7	5.1	5.6
Maryland	6.3	6.6	6.5	6.7	6.5
United States	6.0	6.0	5.8	5.9	5.9
Infant Mortality- Non-Hispanic White per 1,000 Live Births					
Anne Arundel	5.3	3.9	3.8	3.6	5.3
Maryland	3.8	4.6	4.4	4.0	4.3
United States	5.0	5.1	4.9	4.9	5.0
Infant Mortality- Non-Hispanic Black per 1,000 Live Births					
Anne Arundel	8.4	10.8	12.9	9.5	10.1
Maryland	10.4	10.6	10.7	11.3	10.5
United States	11.2	11.1	10.9	11.3	10.8
Infant Mortality- Hispanic (Any Race) per 1,000 Live Births					
Anne Arundel	7.7	7.3	**	**	**
Maryland	5.5	4.7	4.4	5.5	5.4
United States	5.1	5.0	5.0	5.0	5.0

** Rate not calculated, fewer than 5 deaths.

Maryland Department of Health, Vital Statistics Administration, 2012-2016 Annual Reports

U.S. Department of Health and Human Services, Healthy People 2020

Low Birthweight

Low birthweight is a term used to describe babies who are born weighing less than 2,500 grams (five and a half pounds.) In contrast, the average newborn weighs about 8 pounds. Risk factors for low birthweight include using street drugs and abusing prescription drugs, exposure to air pollution or lead, low socioeconomic status and domestic violence (March of Dimes, 2018.) Low birth weight infants run the risk of developing health issues, hyperactivity disorders and developmental issues, especially those developmental issues related to school achievement. The pre-conception and pre-birth health of the mother are contributing factors, often related to limited access to health and pre-natal care.

In Anne Arundel County, the percentage of low birth weight babies is dropping slowly and is less than the state average at 7.4 percent (Table 11.)

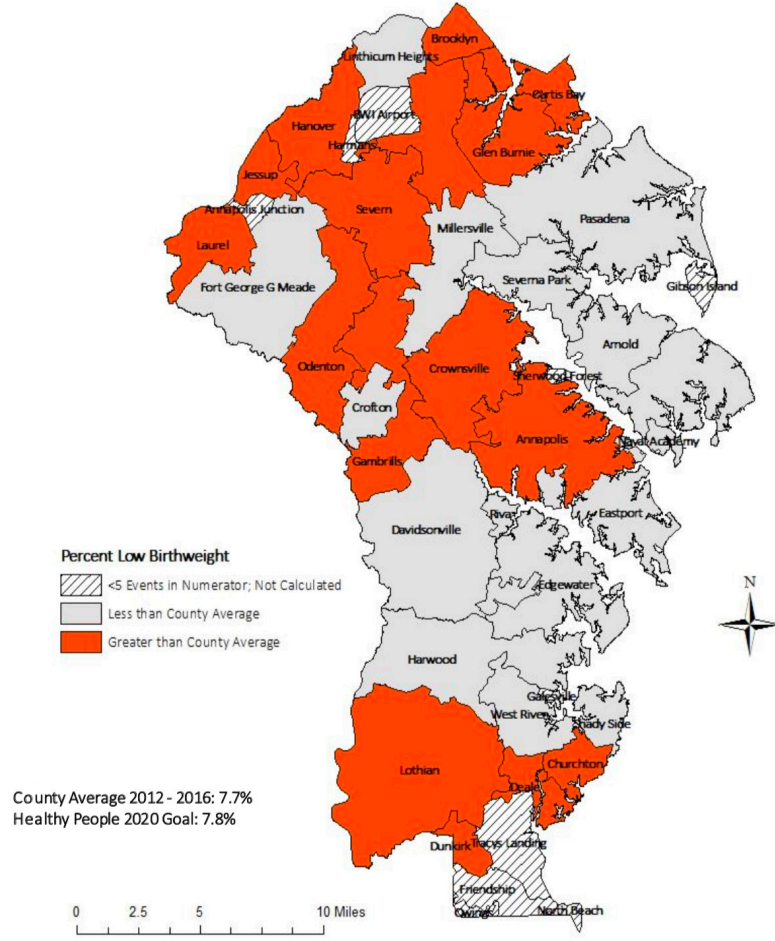
Table 11: Percentage of Babies Born of Low Birth Weight (2016)

Percentage of Babies Born of Low Birth Weight, 2016			
Percentage of Low Birth Weight (<2500 g) Babies	Anne Arundel	Maryland	United States
2014	7.5%	8.5%	8.0%
2016	7.4%	8.6%	8.2%

Anne Arundel County Department of Health, 2018

There are several ZIP Codes concentrated in the northern part of the county where the percentage of low birth weight infants is much higher than 7.5 percent, especially in the North of the County (Figure 10.)

Figure 10: Anne Arundel County Percent Low Birth Weight by ZIP Code



Anne Arundel County Department of Health, 2018

Health Care Access

The Affordable Care Act (ACA) continues to increase county residents’ access to health care. Under the ACA, persons whose income is up to 138 percent of the poverty level are eligible for Medicaid. Persons whose income is above 138 percent but below 400 percent of the poverty level have the option to purchase health insurance through the Maryland Health Connection (the state’s insurance marketplace/exchange). However, access issues remain. As one respondent commented:

People believe they have access to healthcare on the Medicaid side but there’s so many that do not accept Medicaid and that’s a real barrier to access and then people who have the high deductible health plans can’t make their deductible

A small percentage of county residents such as undocumented persons, those not enrolled in Medicaid despite being eligible, and persons opting to pay the annual penalty instead of purchasing insurance, still remain uninsured. However, the percent of uninsured residents in Anne Arundel County continued to decline, reaching a low of 5.3 percent of residents in 2018.

The number of Medicaid enrollments increased from 84,616 in 2014 to 93,425 in May 2018, a ten percent increase (Table 12.) Specialist care is an access issue for the Medicaid and uninsured populations. While primary care may be accessible through community health clinics, finding specialists who will take referrals without private insurance is difficult. As one provider noted:

We can use preventive primary care – there’s no problem with that, but if someone needs cardiology or oncology and they are uninsured, not all specialists will see them or do payment plans – that’s an access to care issue

Table 12: Medicaid Enrollment by Age, Sex and Race/Ethnicity, Anne Arundel County (May 2018)

Medicaid Enrollment by Age, Sex and Race/Ethnicity Anne Arundel County, May 2018		
	Medicaid Enrollment 2014	Medicaid Enrollment 2018
Total Enrollment	84,616	93,425
Age		
Under 20 Years	37,843	44,572
21 to 64 Years	43,040	44,216
65 Years and Over	3,733	4,637
Sex		
Male	37,186	42,133
Female	47,430	51,292
Race/Ethnicity		
White, NH	39,793 (47%)	35,824
Black, NH	25,193 (30%)	22,718
Hispanic, Any Race	6,349 (8%)	920
Asian	3,829 (5%)	4,274

Maryland Department of Health, 2018

Access to Outpatient Care

Access to outpatient care is a continuing issue in the county. Having a primary care provider reduces nonfinancial barriers to obtaining care, facilitates access to services, and increases the frequency of contacts with health care providers. Without a primary care provider, people have more difficulty obtaining prescriptions and attending necessary appointments. According to county health rankings, the patient to primary care physician ratio in Anne Arundel (1,450:1) is worse than in Maryland (1,140:1) and the U.S. top performing counties which are among the 90th percentile in ranking (1,030:1). The actual number of primary care physicians in the county has increased by only five since 2014 (Table 13.) As one provider noted:

The percentages (primary care doctors) are still low and that's still a problem. I think primary care docs do have large caseloads and that is hard on folks. But I just think we need to make primary care more attractive to medical schools.

Similarly, the patient to dentist and mental health providers' ratio in Anne Arundel is worse than in Maryland and the U.S. top performing counties.

Table 13: Primary Care Physicians, Dentists and Mental Health Providers in Anne Arundel County (2018)

Primary Care Physicians, Dentists and Mental Health Providers Anne Arundel County, Maryland				
	Anne Arundel County Total	Anne Arundel County Ratio	Maryland Ratio	Top U.S. Counties (90th percentile)
Primary Care Physicians (2018)	386	1,450:1	1,140:1	1,030:1
Dentists (2018)	378	1,480:1	1,320:1	1,280:1
Mental health providers (2018)	861	650:1	460:1	330:1

County Health Rankings, Anne Arundel County Department of Health, 2018

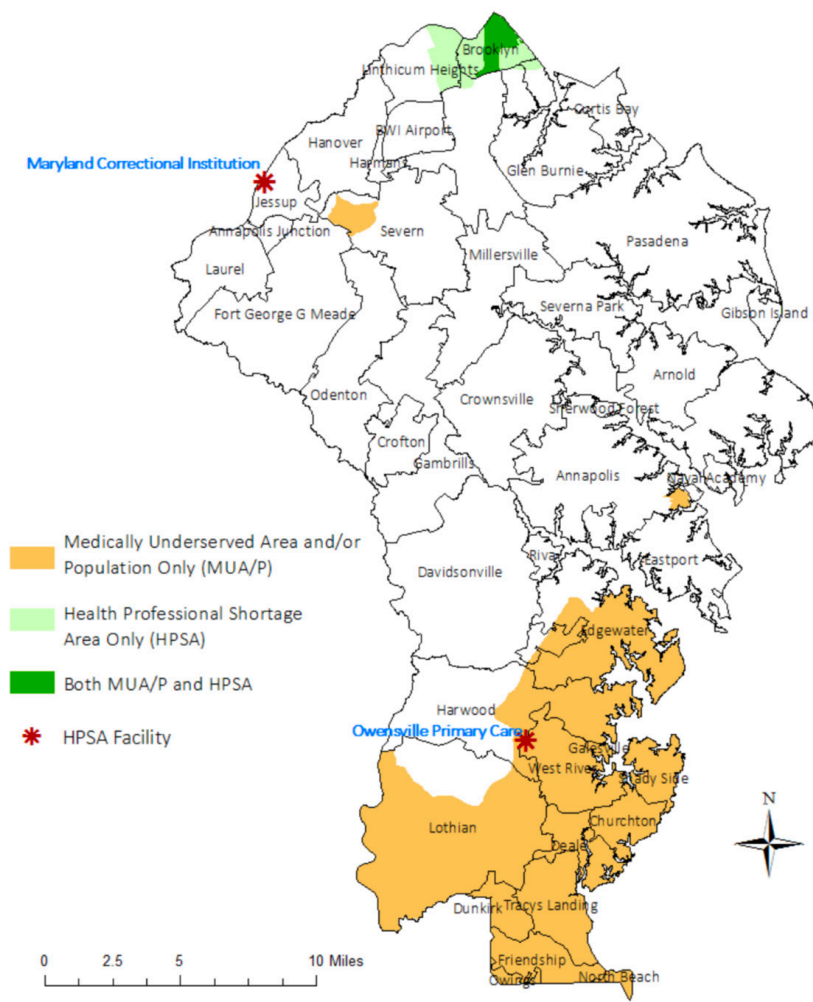
Health Professional Shortage Areas

Health Professional Shortage Areas (HPSAs) are designated by Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers and may be geographic or facility-based. In Anne Arundel County there is currently one designated Primary Care HPSA facility (Owensville Primary Care), 1 Dental HPSA facility (Owensville Primary Care) and 2 Mental Health HPSA facilities (Owensville Primary Care and Maryland Correctional Institution, Jessup.)

Medically Underserved Areas

Medically Underserved Areas (MUA) are designated based on four variables: ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. There are 11 census tracts in Anne Arundel County which are designated as medically underserved areas or populations. Approximately 54,700 (10 percent) of the county's population lives in these 11 census tracts. Brooklyn Park in North County is both an HPSA and an MUA.

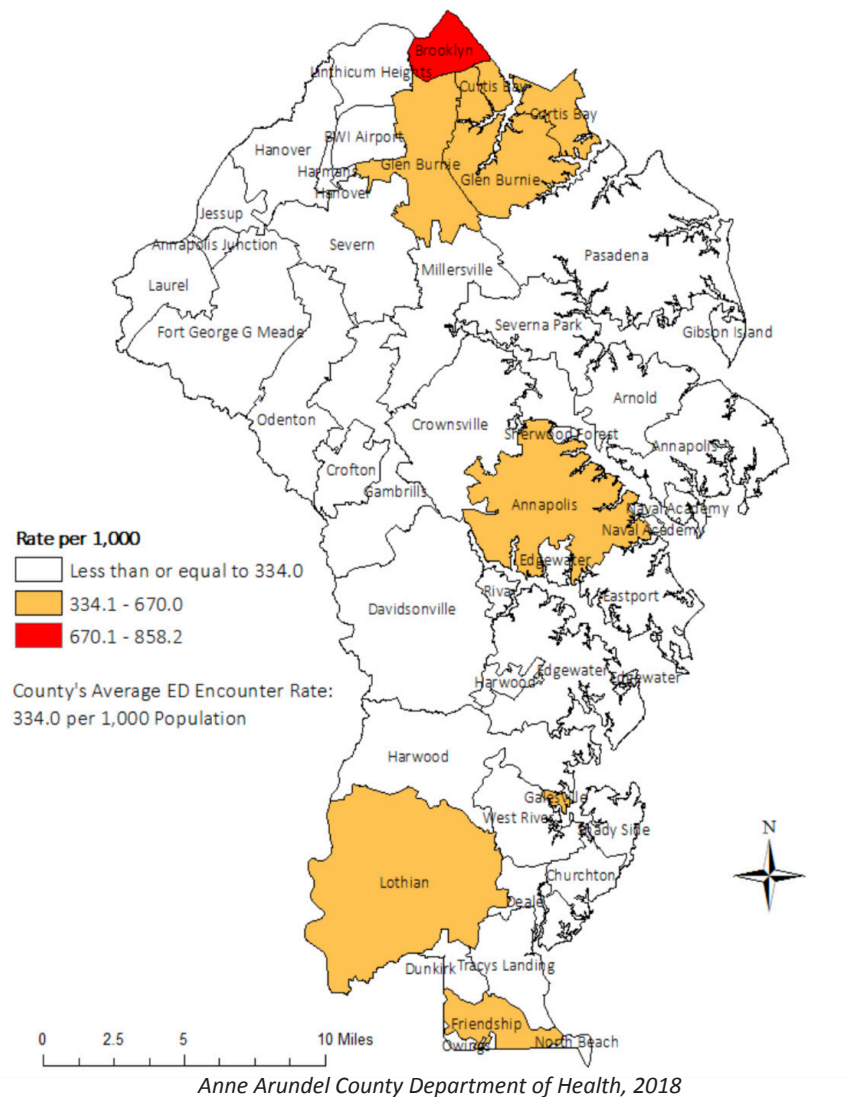
Figure 11: Health Professional Shortage Areas in Anne Arundel County



Anne Arundel County Department of Health, 2018

In 2016, 9.6 percent of Emergency Department visits were by uninsured residents. Although not all visits to the Emergency Department are avoidable, care in lower level settings for some conditions, such as diabetes and hypertension, can potentially reduce the number of visits, thereby reducing costs and increasing the quality of care. (Anne Arundel County Department of Health, 2018.) The rate of Emergency Department visits increases for those residents living in Medically Underserved and Health Professional Shortage Areas (Figure 12.)

Figure 12: Emergency Department Encounters per 1,000 Population by ZIP Code, Anne Arundel County, 2017



Senior Health

Most seniors have at least one chronic health condition, and many have multiple conditions. The top five conditions seniors suffer from are hypertension, hyperlipidemia, arthritis, ischemic heart disease and diabetes (Administration on Aging Administration for Community Living, 2018.) According to participants, chronic health issues are often created by such social determinants of health as poverty and the lack of caring friends and relatives; both increasingly common in the Medicare population.

Multiple participants noted that the seniors they served are prescribed a lot of different medications for health and behavioral health issues as they age. Many prescriptions are multiples of the same kind of medicine, some of which do not react well together. Often seniors have issues remembering to take pills at the right time and in the right dose. As one participant noted:

We've had some seniors on 26 different medications. The truth of the matter is that there's 10 in their purse, 10 different ones in their cabinets, there's a couple on their night stands, they don't know where one is, maybe they couldn't afford the other one and it's still sitting at the pharmacy.

The number of Medicare beneficiaries is rising in the county as a result of the growing senior population. The county has served almost 3,000 new beneficiaries in the last three years. The number who are also eligible for Medicaid, due to low income, rose from 10.9 percent to 11.3 percent in three years (Table 14.) Half of all people on Medicare have incomes less than \$26,200 (Jacobson, Griffin and Neuman (2017).)

Table 14: Medicare Beneficiaries in Anne Arundel County, 2013-2016 Comparison

Medicare Beneficiaries in Anne Arundel County 2013 - 2016 Comparison		
Beneficiary Demographic Characteristics	2013 (Number or Percentage)	2016 (Number or Percentage)
Beneficiaries with Part A & Part B	75,607	78,529
Fee-for-service Beneficiaries	69,420	70,606
Medicare Advantage (MA) Beneficiaries	6,187	7,923
Average Age	72 years	72
Female	56.2%	56.5%
Male	43.8%	43.5%
White, NH	82.2%	81.5%
Black	31.1%	12.5%
Hispanic, Any Race	1.3%	1.6%
Eligible for Medicaid	10.9%	11.3%

Anne Arundel County Department of Health, 2018

Hospital Admissions

In 2017 there were 59,277 hospital stays in Anne Arundel County; a rate of 104.3 stays per thousand (Table 15.) The hospitalization rate increased with age from 68.7 hospitalizations per 1,000 population among 0–18 year olds, to 262.5 hospitalizations per 1,000 population among those aged 65 years and over. (Note: This data only includes Anne Arundel County residents admitted to hospitals in Maryland.)

Table 15: Inpatient Hospitalizations in Anne Arundel County (2017)

Inpatient Hospitalizations Anne Arundel County 2017		
	Number	Rate per 1,000
Total Hospitalizations	59,277	104.3
Age		
0 to 18 Years	9,763	68.7
19 to 39 Years	12,917	83.3
40 to 64 Years	16,607	84.9
65 Years and Over	19,990	262.5
Sex		
Male	25,656	92.7
Female	33,621	118.8
Race/Ethnicity		
White, NH	38,719	96.9
Black, NH	11,747	132.5
Asian, NH	1,271	62.1
Hispanic (Any Race)	3,368	84.7

Anne Arundel County Department of Health, 2017

The rate changes depending on ZIP code. The ZIP Code containing Brooklyn Park has the highest rate of hospitalization at 163.9 per 1,000 residents. The Glen Burnie rates are also notable when population density is considered (Table 16.)

Table 16: Inpatient Hospitalizations by ZIP Code, Anne Arundel County, 2017

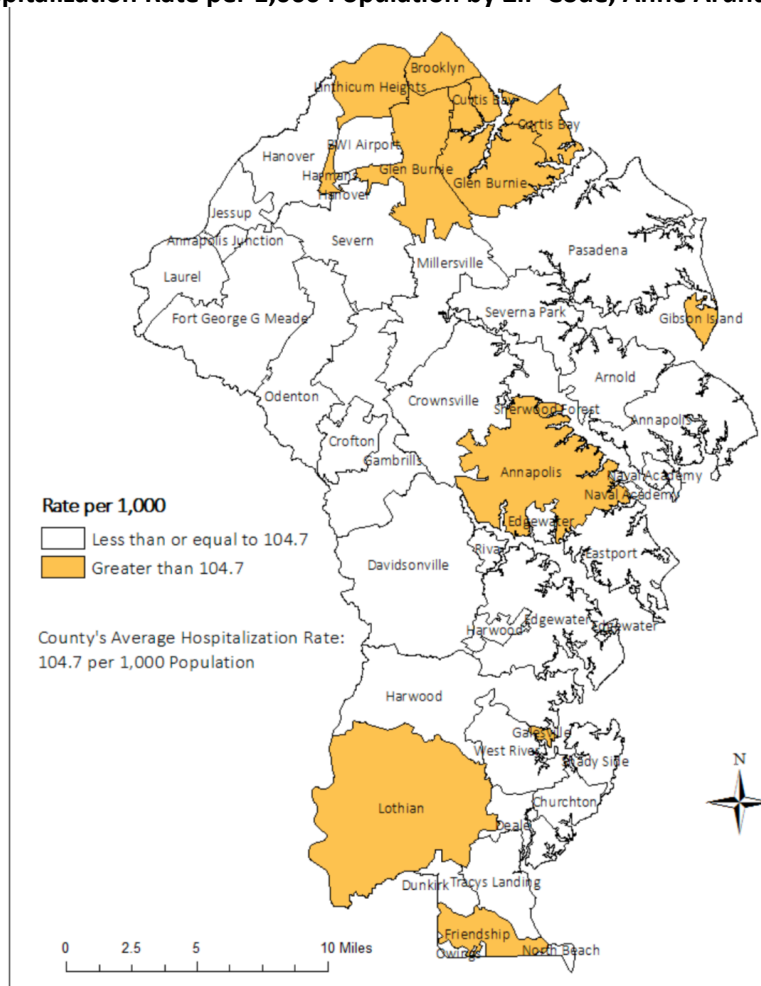
Inpatient Hospitalizations by ZIP Code Anne Arundel County 2017			
Town	Zip Code	Number	Rate per 1,000
Brooklyn	21225	2396	169.3
Curtis Bay	21226	555	126.4
Friendship	20758	66	155.3
Galesville	20765	53	147.2
Glen Burnie (East)	21060	4307	133.9
Glen Burnie (West)	21061	6717	123.8

Anne Arundel County Department of Health, 2018

Lack of access to primary care, multiple health issues presenting at the same time, poverty, unhealthy food and lack of medication management were reasons given for the high rates. As one provider noted:

We have seen a huge increase in the acuity of our patients... they have multiple issues; congestive heart failure and renal failure and diabetes not just one. A number of patients with very complex and multiple issues along with poor social determinants of good health.

Figure 13: Hospitalization Rate per 1,000 Population by ZIP Code, Anne Arundel County (2017)



Anne Arundel County Department of Health, 2017

Limited English Proficient Residents

The numbers of Limited English Proficient residents are growing, especially in North County. Hospitals are required to serve such residents and provide translation services. Several participants noted a rise in the population. Anecdotal information suggest their health needs are also being served in community health clinics. While the numbers of bi-lingual health care professionals appear to be growing slowly, there is a lack of interpreters who understand medical terminology. As one provider recounted:

We have a patient who saved months for his neurological, to see a neurosurgeon for follow up; \$715 a visit which he knew ahead of time, and he and his wife scrimped and saved and they went in. The wife had to translate, she has no medical knowledge whatsoever. And the gentlemen left with no idea what the guy said.

Summary

Overall, the physical health of county residents and their access to health services have improved since 2014. However, in the densely populated areas of Glen Burnie and Brooklyn Park, (Health Professional Shortage and Medically Underserved Areas) costs are being driven up by emergency room visits and increased hospitalization rates. Environmental issues continue to put the Chesapeake Bay, its shoreline, and county rivers at risk.

Needs

- Increased numbers of community health clinics, especially in Medically Underserved Areas
- A plan to recruit primary care physicians.
- Limited English Proficient services
- Access to specialist services for the uninsured and the Medicaid population
- Medication management for Seniors
- Healthy living and preventative health care to avoid hospitalizations
- A plan to address the social determinants of health.
- Increased focus on areas of high need and few resources; Brooklyn Park and Glen Burnie, Annapolis and South County.

Chapter 2 - Behavioral Health

Mental Health

The rise in behavioral health issues for every age group, and the lack of appropriate services and service providers, were the major concerns for all participants in this needs assessment. These issues are exacerbated by providers who don't accept Medicaid and Medicare, and patients with inadequate health insurance, or no insurance at all. Overall there has been a 70 percent increase in residents seeking public mental health services since 2012; 16,343 residents were served by the county mental health agency in 2018 (Table 17.) The two highest increases in residents served are the early childhood population and those over 65. Participants in this needs assessment shared many opinions as to why mental health issues are increasing including, poverty, isolation, social media, increasing societal violence, the fast pace of a technological world and the reduction of stigma around mental health services. Several commented on the intergenerational and socio economical nature of mental health. As one provider noted:

I think you go back to the families that are struggling in poverty who are multi-generational and living together; it's the hereditary piece. It's the third generation bipolar schizophrenic whose child is showing ADHD acting out behaviors where we know we worked with Mom 10 years prior or the Grandmother. We're dealing with more at an even younger age, you're talking first and second grade.

Table 17: Individuals Served in the Public Mental Health System (2012-2018)

Individuals Served in the Public Mental Health System 2012 - 2018							
Age Range	FY 2012	FY 2016	FY 2017	% Change	FY 2018	% Change	% Increase 2012-2018
Early Child (0-5)	392	460	492	7.0%	548	11.4%	40%
Child (6-12)	1,821	2,596	2,774	6.9%	2,999	8.1%	65%
Adolescent (13-17)	1,388	1,923	1,929	0.3%	2,128	10.3%	55%
Transitional (18-21)	586	792	884	11.6%	926	4.8%	58%
Adult (22 to 64)	5,351	8,520	9,036	6.1%	9,628	6.6%	80%
Elderly (65 and over)	59	92	105	14.1%	119	13.3%	102%
TOTAL	9,597	14,383	15,220	5.8%	16,348	7.4%	70%

* Based on claims paid through September 30, 2018.

Anne Arundel County Mental Health Agency, 2018

The County's hospital Emergency Departments are often the receiving facilities for behavioral health issues. In 2017, there were 12,446 behavioral health encounters; mood disorders accounted for 26.3 percent of those and over 20 percent were alcohol related (Table 18.)

Table 18: ED Encounters for Behavioral Health Conditions in Anne Arundel County (2017)

ED Encounters for Behavioral Health Conditions, Anne Arundel County 2017			
	Condition	Frequency	Percent
1	Mood Disorders	3,277	26.3
2	Alcohol-Related Disorders	2,546	20.8
3	Substance-Related Disorders	2,212	17.8
4	Anxiety Disorders	1,654	13.3
5	Suicide and Intentional Self-Inflicted Injuries	724	5.8
6	Schizophrenia and Other Psychotic Disorders	655	5.3
7	Attention-Deficit Conduct and Disruptive Behavior Disorders	379	3.1
8	Delirium Dementia and Amnestic and Other Cognitive Disorders	348	2.8
9	Adjustment Disorders	295	2.4
10	Miscellaneous Mental Health Disorders	112	0.9
	Total	12,446	

Anne Arundel County Department of Health, 2018

Access

The Affordable Care Act continues to increase access to mental health services through expanded Medicaid services. The total numbers served in the county public mental health system have increased 13 percent in two years from 14,383 in 2016 to 16,348 in 2018 (Table 17.) Those with private insurance struggle the most to access care due to limited coverage, high deductibles, time limits and providers who will not accept private insurance. As one provider noted:

The clinical mental health services, the co-pays and deductibles in the new insured world will break your back. If you're pay check to pay check and you need a 30 dollar co-pay once a week, for the next six weeks, that probably isn't going to happen

Table 19: Three Year Comparison for Medicaid Insured and Uninsured Individuals

Three Year Comparison Medicaid/Uninsured					
	Persons Served				
	FY 2016	FY 2017	% Change	FY 2018	% Change
Medicaid	13,824	14,626	5.80%	15,694	7.30%
Medicaid State Funded	1,923	2,342	21.80%	2,591	10.60%
Uninsured	746	488	-34.60%	642	31.60%
Total	14,383	15,220	5.80%	16,348	7.40%

Anne Arundel County Mental Health Agency, 2018

The number of out-patient mental health providers in the county continues to grow; an increase of 4.6 percent from 366 in 2014 to 383 in 2018. However, the ratio of mental health providers to residents in the county is much lower than the state (Table 20.)

The county lacks psychiatrists and geriatric psychiatrists, especially for those residents with dementia and Alzheimer's. According to public mental health providers there is one Spanish-speaking psychiatrist in the county available to the Hispanic uninsured population. There are very few Spanish speaking mental health counselors.

Table 20: Mental Health Providers in Anne Arundel County, Maryland 2018

Mental Health Providers Anne Arundel County, Maryland				
	Anne Arundel County Total	Anne Arundel County Ratio	Maryland Ratio	Top U.S. Counties (90th percentile)
Mental health providers (2018)	861	650:1	460:1	330:1

Anne Arundel County Department of Health, 2018

Residential services are a growing and urgent need. In Anne Arundel County, there are only 24 crisis temporary beds and only one inpatient psychiatric unit with 24 beds which is located in Northern Anne Arundel County. Those beds are virtually always full. There are 263 beds for the chronically mentally ill scattered throughout the county. There are no residential services for adolescents. Both hospitals are currently expanding their mental health services as a result. University of Maryland Baltimore Washington Medical Center (UMBWMC) just added ten beds to their in-patient psychiatric unit which will allow them to serve 650 more residents per year. Anne Arundel Medical Center (AAMC) broke ground on a new mental health hospital in 2018 which will add 16 beds and serve 900 patients. The need is overwhelming. As one provider noted:

So if you come to our campus with a broken bone, I've got 30 orthopedists who want to fix your bone. But if you come to our hospital with a broken soul, we've got [few psychiatrists].

Mental Health and Behavioral Issues in Early Childhood

Increased mental health and behavioral issues in the birth to five early childhood population are causing widespread concern in every system. Behavioral problems in children as young as two years old are disrupting child care facilities including Early Head Start and Head Start. They are causing consternation for parents and increasing stress for preschool and kindergarten teachers. Hospital personnel described young children in the emergency room as “totally out of control” and physically assaulting staff who try to calm them. Parents are described as “exhausted and desperate - looking for a place they can keep their child safe.” As one provider commented:

The shift is more and more towards the younger set. It used to be that when five, six, and seven year olds came in we thought they just needed better parenting. We don't say that anymore because a lot of these kids are really sick. About 50% of them need to be hospitalized

Professionals are divided as to the cause of this increase but they all agree that this is a new phenomenon unrelated to income. Many suggested the use of social media by parents and young children is leading to huge deficits in social and emotional skills. It is no longer surprising to see young children “biting, scratching,” and even “throwing chairs” in kindergarten classrooms. Children as young as two are being diagnosed with Attention Deficit Disorder and medicated accordingly.

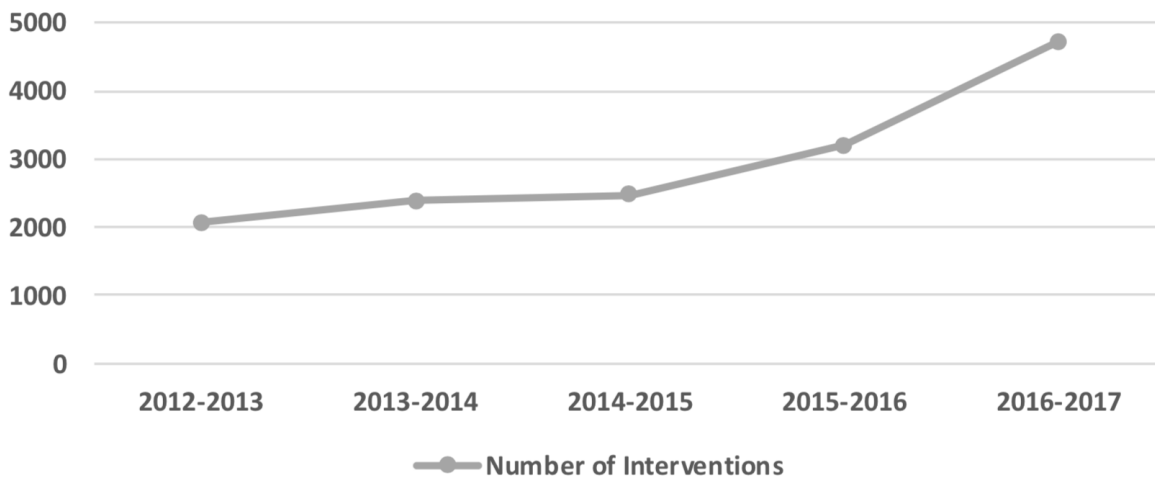
Some serious mental health issues are surfacing earlier; often co-occurring with developmental issues such as autism. As one professional commented “we've seen some kids with even psychotic issues at a very young age.” According to the Anne Arundel County Mental Health Agency (2018) the birth to five population is showing another large increase in use of mental health services, a rise of 11.4 percent in one year (Table 17.) Yet there is a huge lack of resources inside the public school system and within the community for this age group. According to participants from hospitals and schools, suicidal ideation and “cutting” behaviors are becoming more and more common at the elementary school level. Pediatricians are attempting to manage the crisis, usually with medications. Many professionals commented that for the 0- 5 population, parents are the most important piece of the picture. As one noted:

If you took the child out of the environment would we still see the behavior? It is not just the traditional (intergenerational poverty) environments, it is truly parents. Even if you have an environment that feels or looks okay you may have a parent who is not skilled. We obviously have more vulnerable families who have issues with opioids. There may be kids acting out, but when you see the parenting up close ...

Mental Health and Older Youth

The Anne Arundel County Department of Health provides school health services to all public school students through school health assistants and nurses. The nurses' work with school system guidance counselors to address students' physical and mental health issues as they are identified and coordinate interventions as needed. The number of crisis interventions in the public school system for social and emotional issues has doubled since 2013 (Figure 14.)

Figure 14: Number of Crisis Interventions for Social/Emotional Problems in Anne Arundel County Public Schools (2012-2017)

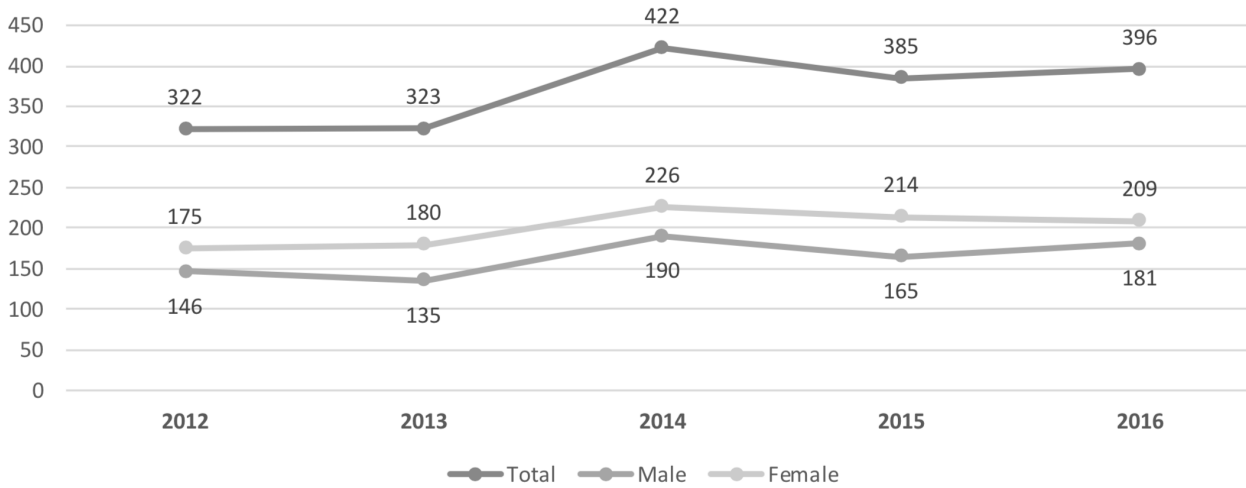


Anne Arundel County Department of Health, 2018

As of 2016, the Anne Arundel County youth suicide rate was 7.8 per 100,000, an increase compared to the rate of 5.3 per 100,000 in 2012. The Centers for Disease Control and Prevention (CDC) estimates that for each youth suicide, there are 25 suicide attempts. Between 2012 and 2016, there were 1,306 Emergency Department encounters in Maryland hospitals for suicide attempts by Anne Arundel County youth aged 10 to 24 years, an average of 261 per year. Similar to the completed suicides among this age group, there were more Emergency Department encounters for suicide attempts between 2012-2016 (compared to the previous report for 2008-2012,) costing Emergency Departments an estimated \$1.1 million (Anne Arundel County health Department, 2016.). According to the 2016 High School Youth Risk Behavior Survey, the percentage of Anne Arundel County high school students who felt so sad or hopeless almost every day for 2 weeks in a row that they stopped doing some usual activities, increased significantly between 2014 and 2016.

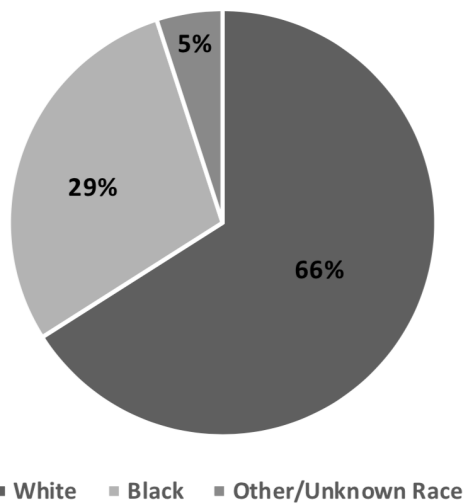
The number of Emergency Evaluations by county police for juvenile suicidal or out of control behavior has been steadily rising since 2012 (Figure 15.) County police performed over 1,800 emergency evaluations for juveniles (ages 17 years and under) for suicidal or out of control behavior from 2012 through 2016. Two thirds of the juveniles were White, 29 percent Black (Figure 16.)

Figure 15: Emergency Evaluations Reported by Anne Arundel County Police for Juvenile Suicidal or Out of Control Behavior by Sex (2012-2016)



Anne Arundel County Department of Health, 2016

Figure 16: Emergency Evaluations Reported by Police for Suicidal or Out of Control Behavior by Race (2012 – 2016)



Anne Arundel County Police Department, 2016

Participants emphasized the growing mental health issues for youth throughout the school system. Cutting behaviors, depression and anxiety are increasing. There has been an over ten percent rise in mental health services for those youth 6-12 years since 2016 and an 8.1 percent rise in those age 12-17 years. Educators stressed that many children are impacted by trauma, poverty and substance abuse issues at home. As one noted:

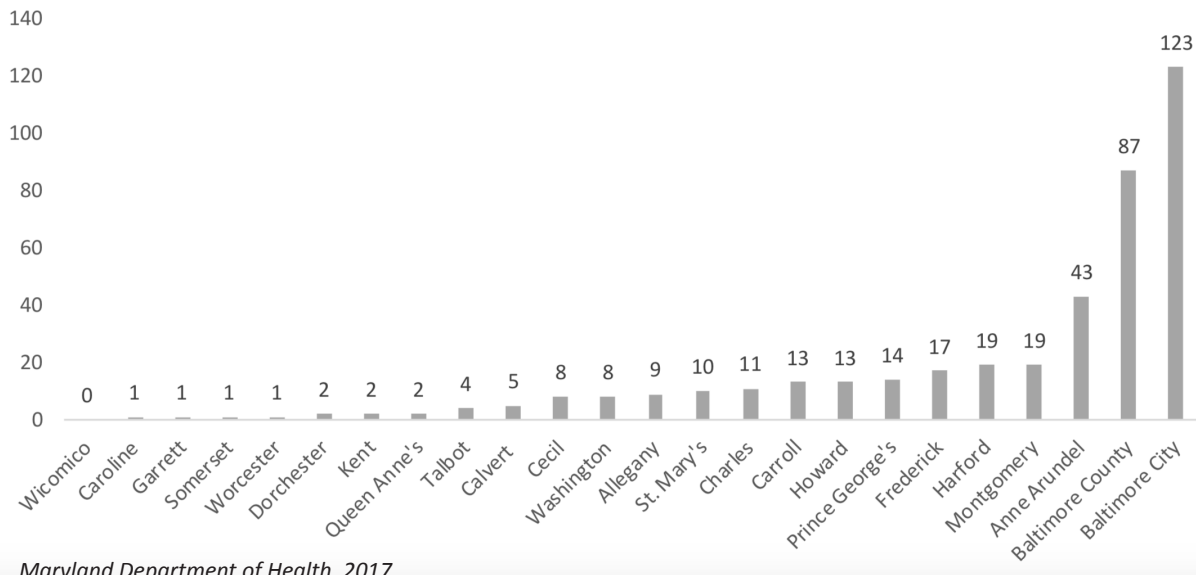
We have kids that are totally out of control. It's coming from a multitude of factors, and lack of parenting is a huge piece of it. The worst three cases I can think of we had parents who were on pills, one experiencing homelessness and one about to be evicted.

The Opioid Crisis

Prescription Opioids

Prescription opioid addiction is now a major public health crisis. Although Anne Arundel County is the fifth largest county in the state in terms of population, it has the third highest rate of prescription opioid related deaths as of 2017 (Figure 17.)

Figure 17: Number of Prescription Opioid-Related Deaths Occurring in Maryland by Place of Occurrence (2017)



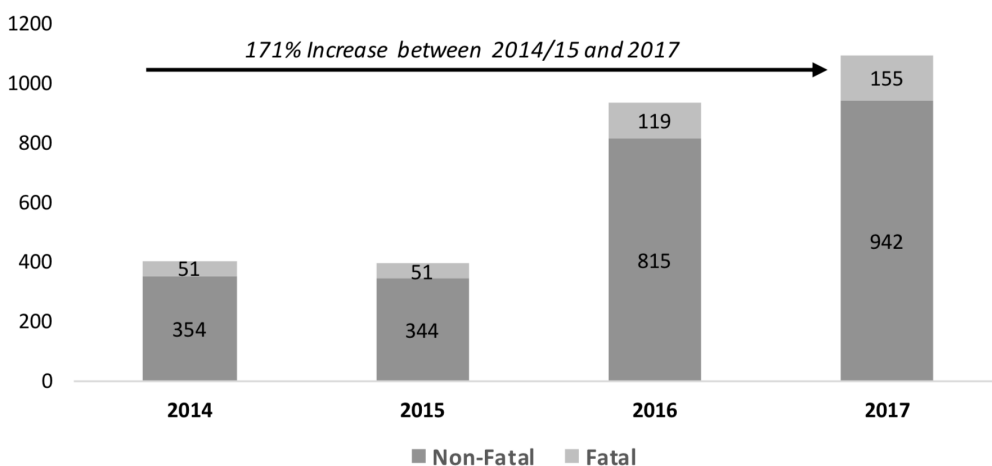
County health professionals acknowledge that, while opioids are helpful to patients with extreme pain issues, opioid addiction is a major issue. The medical community has tightened regulations and behaviors around opioids and 2017 saw the first decrease in prescription overdose use since 2013, from 48 to 43 deaths (Maryland Department of Health, 2018.) According to one provider, it is important to manage pain but at the same time make sure excess supply is diminished:

We don't want to withhold pain medicine from patients (who need it) but decrease the excess supply that is sitting out there in everyone's medicine cabinets.

Opioid/Heroin Overdoses

In 2017, Anne Arundel County police reported almost 1,100 opioid-related overdoses occurring within the county, a 171 percent increase since 2014 (Figure 18.)

Figure 18: Opioid-Related Overdoses Occurring in Anne Arundel County (2014-2017)



Note: In 2017, there were 117 Persons with 2 or more overdoses.

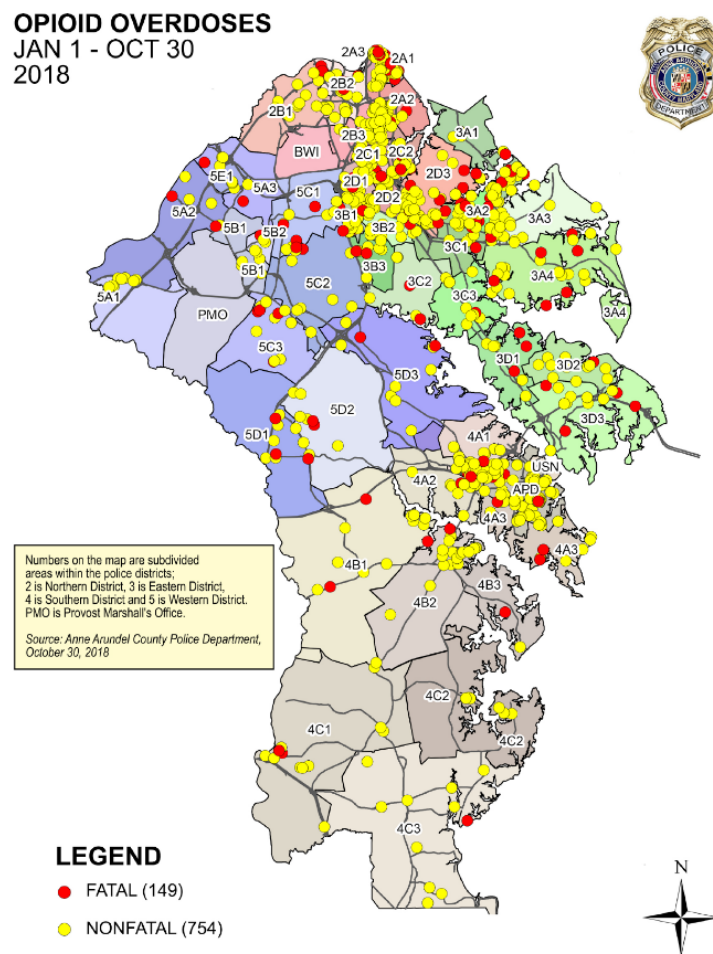
Anne Arundel County Police Department, 2018

As of October 30, 2018, there were 903 total overdoses year to date, a 1.4 percent decrease from 916 in 2017 (Figure 19.) Several county initiatives have contributed to that reduction including the very successful Safe Stations program. As of April 20th, 2017, every police and fire department in the City of Annapolis and Anne Arundel County is designated as a safe environment for those suffering from heroin/opioid addiction. Substance can ask for help 24 hours a day and are offered recovery services.

However, the rate of fatal overdoses continues to increase, driven by the introduction of fentanyl into the community. Fentanyl-related deaths in the county have increased significantly since 2013 and surpassed heroin related deaths through currently reported data for 2017. Year to date 2018 there have been 149 fatal overdoses as opposed to 2017, a 13.7 percent increase. As with other county issues, geography plays a part. The majority of overdoses occur in North County and Annapolis. Several participants pointed to Glen Burnie as the number one area for opioids. As one provider noted:

I would like to see more suboxone providers in Glen Burnie because we know that this is a heroin saturated zip code and there are very few docs that prescribe suboxone.

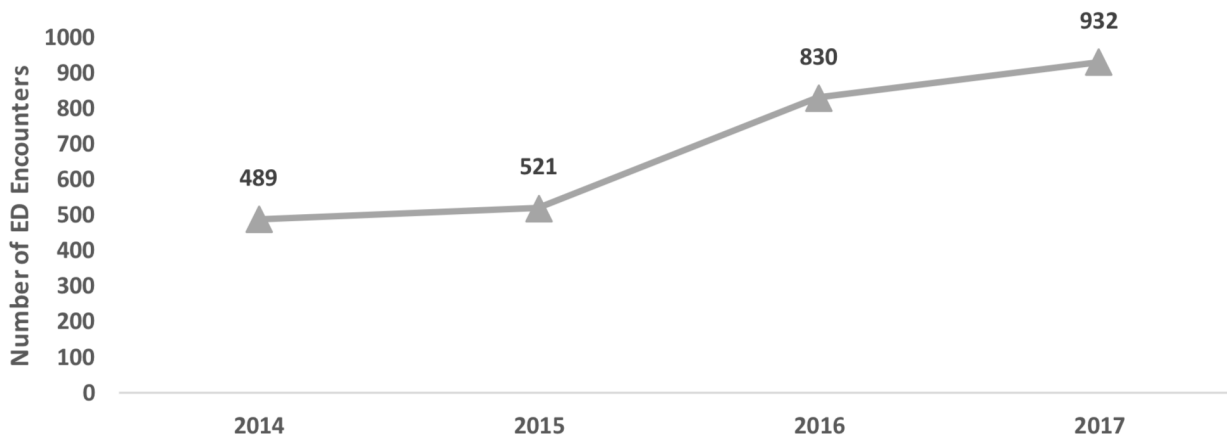
Figure 19: Opioid Overdoses January to October 2018 in Anne Arundel County



Anne Arundel County Police Department, 2018

Opioid related overdoses are also causing issues for hospital emergency departments. The rate of emergency department opioid overdose encounters for Anne Arundel County residents has risen 91 percent since 2014 from 489 to 932 (Figure 20.) The percentages are uneven for the two county hospitals. UMBWMC accounted for 45 percent of the hospital encounters for opioid related diagnoses in 2018, year to date, whereas AAMC accounted for 19 percent.

Figure 20: ED Encounters for Opioid-Related Overdose in Maryland Hospitals, Anne Arundel County Residents (2014-2017)



Anne Arundel County Department of Health, 2018

Secondary Victims of the Opioid Crisis

The current opioid crisis has many victims. The number of newborns assessed positive for substances in their systems, including methadone, has risen 144 percent since 2014 from 74 to 181 (Department of Social Services, 2018.) Grandparents and great grandparents are raising children with little governmental help. Many are on fixed incomes and have health and other issues to contend with. As one participant pointed out:

We need support for these grandparents. I have an 85 year old who is a retired nurse raising a second grader. It's actually her great grandchild. She came to a meeting with a notebook like I had, trying to keep track of the systems and how to navigate them.

According to all participants, the children of opioid victims are traumatized and ashamed. Several suggested we need narcotics support groups for teen family members. Young children born into homes where heroin is used may be neglected, may have spent periods homeless or living in a tent, as with the case of an 18 month old in Glen Burnie in 2017. There were numerous examples of very young children left alone or strapped into a car seat 24 hours a day. As one provider noted:

Sometimes we're not seeing these kids 'til kindergarten or coming in to pre-k, but when they were two Dad was a heroin addict and put the kid in the closet.

According to the participants in this needs assessment, teens who have an addicted single mother or father, or who are living with grandparents, are taking care of their siblings, finding places to sleep, selling drugs for rent and visiting food pantries. As one participant commented:

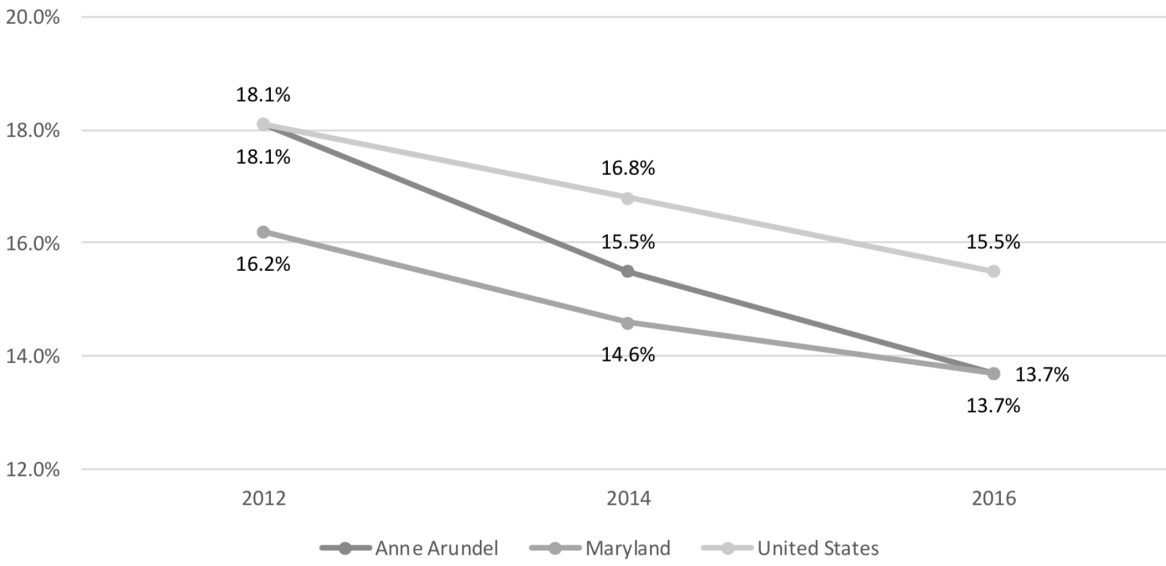
Like the 17 year old who finds her Mom dead of an overdose in a hotel and goes to school the next day and begs the school for help. This epidemic is not going away...every family is impacted so what are we doing with that? You've got fathers, and mothers, and aunts, and uncles who are dying. What are we doing with that?

Other Substance Use

Tobacco

Smoking is associated with an increased risk of heart disease, stroke, lung and other types of cancers, and chronic lung diseases (Centers for Disease Control, 2018.) The rate of adult tobacco use has continued to drop in the county and is now equal to the state and less than the nation (Figure 21.) According to the 2016 Middle School Risk Behavior Survey, cigarette smoking by Anne Arundel Middle School students is trending significantly downwards. However, many participants commented on the increased use of e-cigarettes and vaping, in and outside of the school gates.

Figure 21: Percent of Adults 18 Years and Older Who are Current Cigarette Smokers: Anne Arundel, Maryland and U.S. (2012-2016)

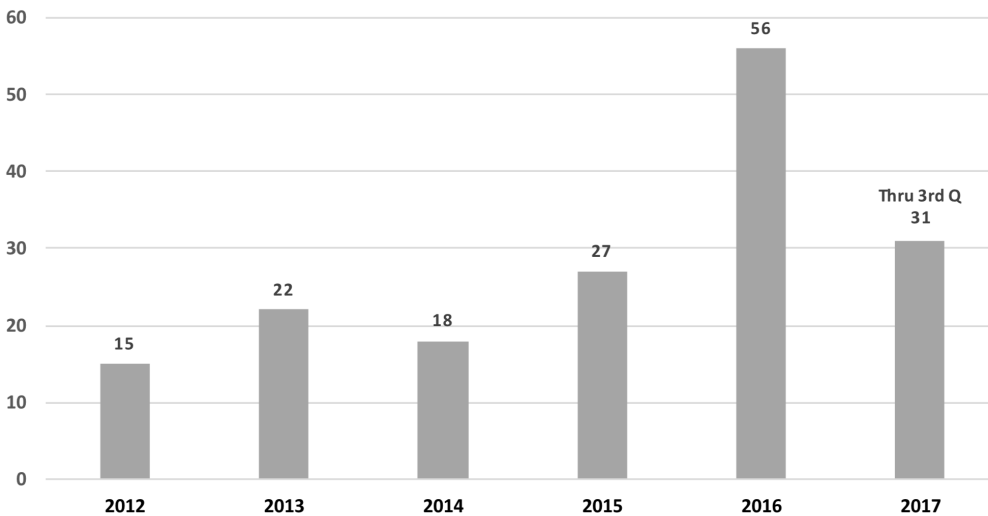


Behavioral Risk Factor Surveillance System (BRFSS), 2012-2016

Alcohol

Alcohol continues to be an acceptable social norm in the county. The number of alcohol related deaths increased by 273 percent between 2012 and 2016, from 15 to 56 deaths. 2017 data is only through the third quarter but continues to follow the trend upwards (Figure 22.) According to the 2016 High School Youth Risk Behavior Survey, the number of students who acknowledged driving a car, or driving within a car with someone who had been using alcohol, has reduced significantly since 2014.

Figure 22: Anne Arundel County Alcohol Intoxication Deaths (2012-2017)

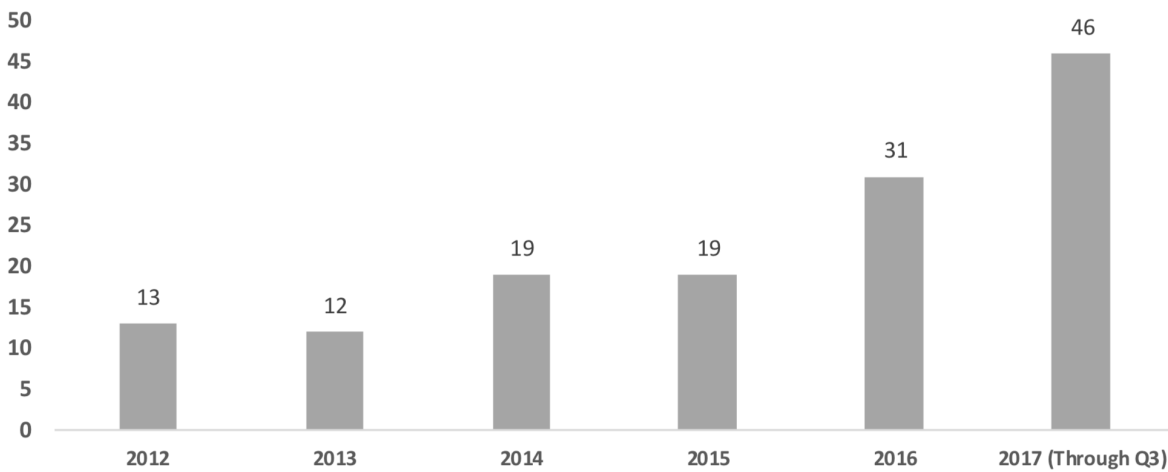


Maryland Department of Health, 2017

Other Drugs

Several participants noted a rise in the use of ‘street drugs’ such as PCP, crystal meth and cocaine. Anne Arundel County was third in the State in 2017 for cocaine ingestion deaths rising 400 percent between 2012 and 2017, from 13 deaths to 66 deaths (Maryland Department of Health, 2018.) The first quarter of 2018 showed a similar trend with 23 deaths from cocaine use. Many participants noted the use of cannabis in students as young as 11 and the intergenerational use of street drugs.

Figure 23: Cocaine Intoxication Deaths in Anne Arundel County (2012-2017)



Anne Arundel County Department of Health, 2018

Behavioral Health and Seniors

Demand for mental health services has risen more steeply for those age 65 and older than any other demographic (see Table 17 on page 22.) Loneliness and isolation often results in anxiety and depression. As seniors live longer, an increasing number develop dementia or Alzheimer’s disease. According to Department of Aging and Disabilities personnel, there are no mental health services for seniors in the county that accept Medicare and very few geriatric psychiatrists. There are very few in-home services that can offer evaluations for those with mental health issues and/or dementia. Those that do exist don’t accept Medicaid or Medicare. According to participants, in times of real crisis Medicare eligible seniors may be referred as far away as Georgia. There are many elderly couples in the county who are caring for each other. When one or both become too frail, they are often separated in nursing homes or acute care facilities. Currently there are no facilities that allow seniors to stay together. As one participant noted:

You’ve got couples that live into their 90’s and one has dementia and one doesn’t. We put them in the hospital or in assisted living and separate them which causes increase in loneliness and despair... There’s no reason why two people who have been married for 60 years can’t be in the same room together.

Substance abuse also occurs in the elderly. According to participants, seniors become addicted to pain medication through pain clinics and prescriptions from primary care providers. They are often prescribed medication for anxiety and depression. There are no substance abuse services through Medicare. As one provider commented:

We’re also seeing quite a bit of benzo addiction and people prescribed Xanax, and unfortunately still the opioid addictions. We have 67 year old heroin addicts right now because of opioid addiction.

Summary

Behavioral health issues are the major concern for participants in this needs assessment. Mental health issues at either end of the age scale (early childhood and seniors) are rising very rapidly. For the senior population, these issues may be co-occurring with senility or dementia. Everyone who participated in this needs assessment acknowledged the enormous efforts made by county agencies and hospitals to manage the opioid/heroin crisis yet the progress is little and slow.

Needs

- More providers of psychiatric, geri-psychiatric, counseling and substance abuse services, especially Spanish speaking services.
- Higher rates of reimbursement to help recruit health and behavioral health providers.
- Residential mental health and substance abuse beds, especially for the adolescent population
- Further support for the Mental Health Agency's very successful Crisis Intervention system and the Safe Stations program
- Increase in mental health and behavioral services for all childhood populations but especially the 0-5 group
- Integration of social and behavioral health services
- Crisis beds for immediate response and to relieve the emergency departments
- School based assessments of mental health and substance abuse
- Support for Seniors with co-occurring mental health issues and dementia

Chapter 3 - The Social Determinants of Health

Many factors determine the state of a person’s overall wellness. The social determinants of health include income level (especially for those who live in poverty,) access to healthy food, emotional stability, the cleanliness and safety of the environment and access to health services. Although Anne Arundel County has a high standard of living overall, there are pockets of poverty and health access issues to be found in areas of high density in North County, Annapolis, and in some of the rural areas of South County. Many participants commented on the intractable nature of the pockets of poverty and distress and a multiplication of the negative social determinants of a healthy life for some families. As one primary care provider commented:

Back pain, headaches, insomnia; all the things that go along with stress. You start digging into the soci-economic factors – there are reasons for those things. They’re behind on the rent, they could get evicted, they haven’t had money to buy food, and husband lost his job.

The majority of negative social and health indicators continue to polarize in North and South County and Annapolis (Table 21.) In South County, access to health care is very limited and there are few primary care doctors. Owensville Health Center is inaccessible to those residents who live in areas like Deale and have no transportation. Those residents with transportation often travel to Glen Burnie to access primary care. Brooklyn Park (North County) is both a Medically Underserved and a Health Shortage Area and continues to have the highest indicators of need, as does Glen Burnie.

Table 21: Rising Demographic, Socioeconomic, and Health Indicators by ZIP Code, Anne Arundel County (2017)

Rising Demographic, Socioeconomic, and Health Indicators by ZIP Code Anne Arundel County, 2017								
ZIP Code	Area	Poverty Percentage	Percent without High School	Percent of Households on Snap	ED Visit Rate per 1,000	Percent Low Birth Weight Infants	Preventable Hospitalization Rate per 1,000	Minority Population
20711	Lothian	11.7%	13.2%	23.4%	389.7	8.4%	6.8	25.6%
20714	North Beach	10.6%	7.5%	8.6%	285.0	8.9%	<11	12.4%
20724	Laurel	3.8%	9.1%	4.2%	234.6	9.3%	2.4	64.6%
20751	Deale	10.8%	8.7%	5.4%	233.1	9.2%	4.6	7.1%
20758	Friendship	7.1%	3.9%	0.0%	562.4	8.8%	<11	7.1%
20765	Galesville	14.7%	20.2%	9.6%	352.8	6.3%	<11	22.5%
20776	Harwood	10.8%	7.6%	8.8%	293.1	4.4%	6.0	15.5%
20794	Jessup	7.9%	20.6%	11.8%	220.4	11.3%	2.9	52.5%
21060	Glen Burnie (East)	7.9%	13.7%	12.6%	406.5	8.0%	6.9	29.8%
21061	Glen Burnie (West)	9.2%	13.6%	12.8%	441.9	8.0%	5.5	45.0%
21090	Linthicum Heights	7.5%	10.1%	5.1%	270.5	6.9%	5.6	10.8%
21144	Severn	7.9%	8.2%	10.4%	289.2	9.2%	3.5	51.7%
21225	Brooklyn	27.3%	20.1%	32.6%	858.2	9.9%	8.9	59.4%
21226	Curtis Bay	16.6%	15.8%	16.8%	509.6	8.7%	6.6	26.9%
21401	Annapolis	7.9%	7.2%	8.9%	364.5	7.7%	5.4	31.5%
21403	Eastport	6.9%	9.8%	6.9%	331.8	7.5%	4.4	37.5%
	Anne Arundel	6.1%	8.1%	7.0%	340.0	7.7%	4.6	29.7%

* Gray = Higher than County Average

US Census American Community Survey 5 year estimates, 2012-2016; Maryland Health Services Cost Review Outpatient Files, 2017

Hospitalization and Emergency Department Patterns related to Social Determinants

When patterns of hospitalization and Emergency Department visits are examined by ZIP code (Figures 24 and 25) they generally reflect the social determinants illustrated in Table 21 above. ZIP code 21225, which contains Brooklyn Park, has the highest hospitalization and emergency department visit rate of anywhere else in the county.

Figure 24: Hospitalization Rate per 1,000 Population by ZIP Code, Anne Arundel County, 2017

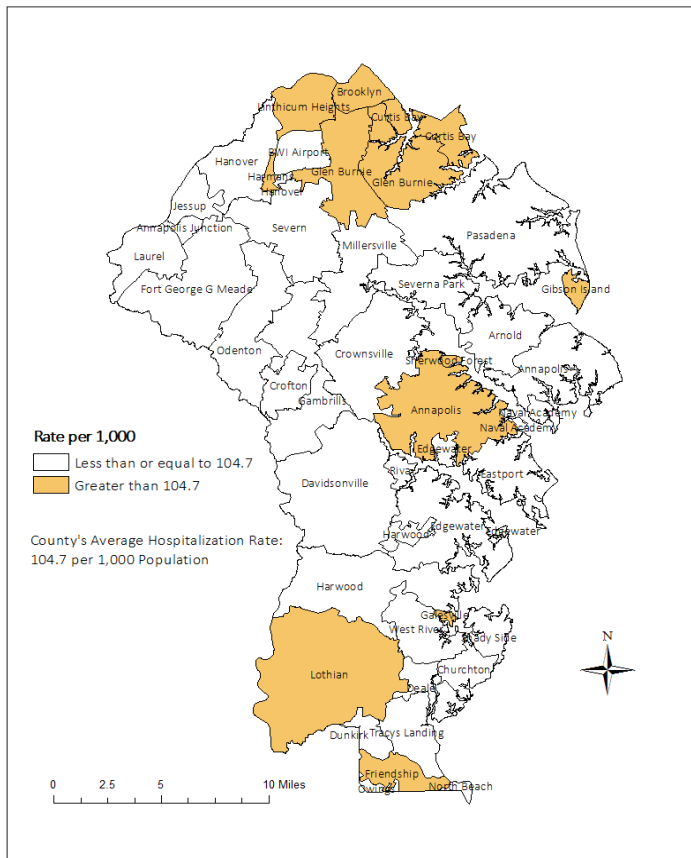
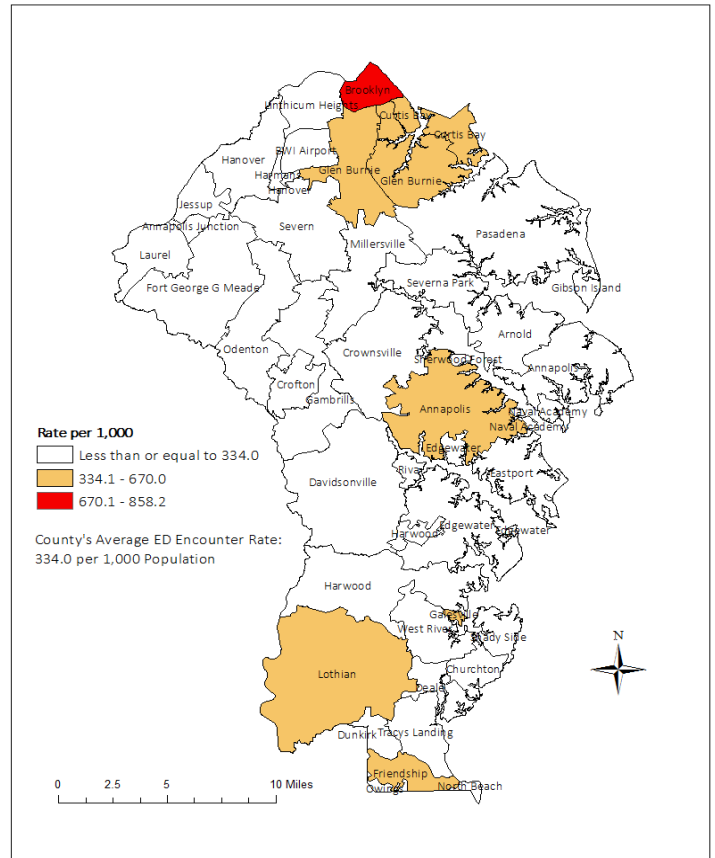


Figure 25: Emergency Department Encounters per 1,000 Population by ZIP Code, Anne Arundel County, 2017



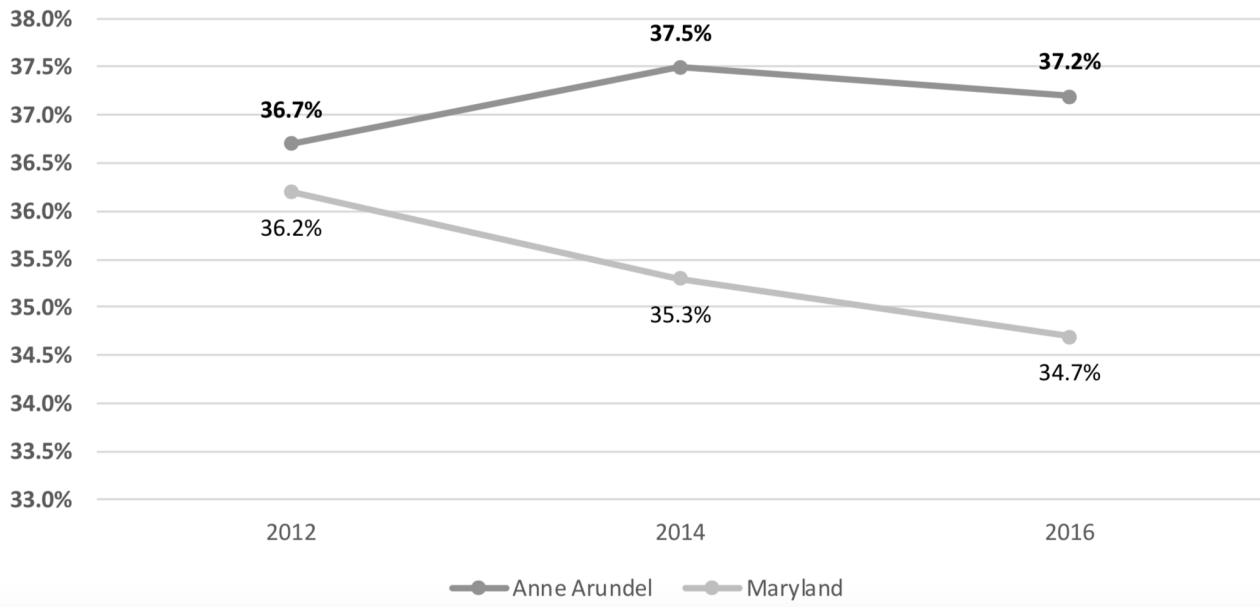
Anne Arundel County Department of Health, 2018

Overweight and Obesity

Overweight and obesity continue to create health issues for county residents. Many factors play a role in weight including low income, lifestyle, surrounding environment, access to healthy food, genetics and certain diseases. Overweight and obesity are determined using weight and height to determine a BMI or “body mass index” measure. Between 2012 and 2016, the percent of overweight adults (Body Mass Index of 25 to 29.9) 18 years and older in Anne Arundel County rose slightly from 36.7 percent to 37.2 percent while the state average fell (figure.) The percent of county residents who are classified as obese (Body Mass Index 30 and over) also rose from 27 to 31 percent, as did the state average.

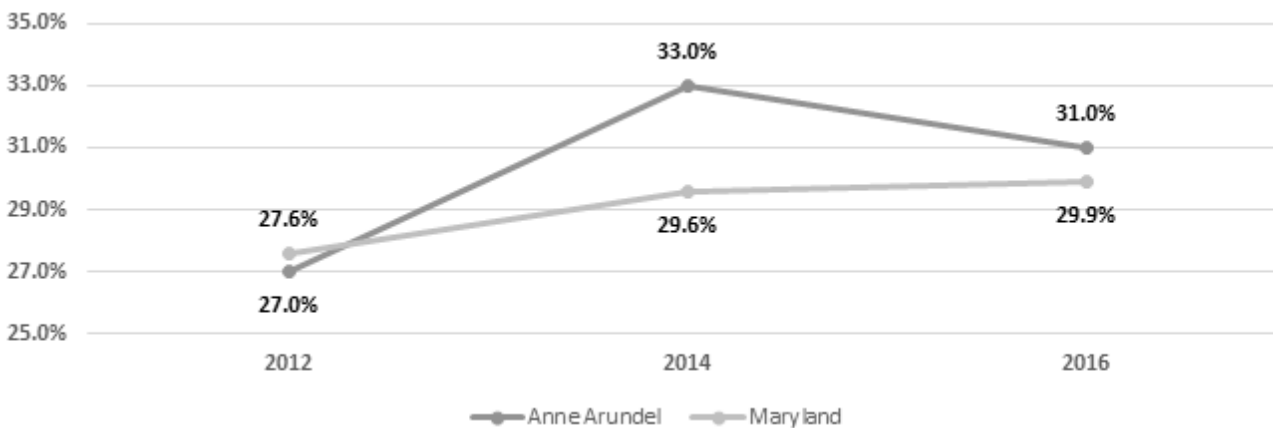
Obesity is prevalent in low income families in the county for a variety of reasons; their neighborhoods often lack full-service grocery stores and farmers’ markets, healthy food can be more expensive, there is no transportation to get to a supermarket, there is a greater availability of fast food restaurants selling cheap, filling food, and there are fewer recreational facilities for exercise. The streets may be unsafe and there is little for children to do.

Figure 26: Percent of Adults 18 Years and Older Who Are Overweight (BMI of 25 to 29.9), Anne Arundel County and Maryland (2012-2016)



Anne Arundel County Department of Health, 2018

Figure 27: Percent of Adults 18 Years and Older Who Are Obese (BMI of 30 or More), Anne Arundel County and Maryland (2012-2016)



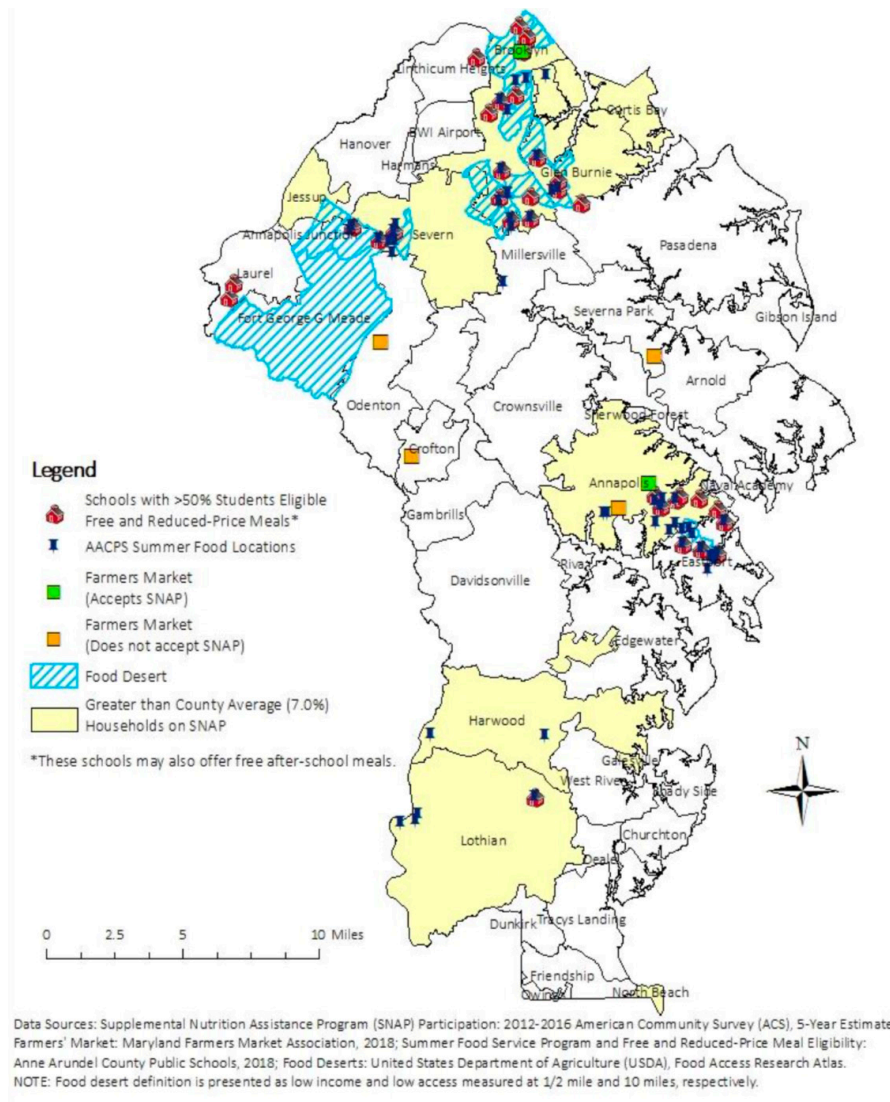
Anne Arundel County Department of Health, 2018

Access to Healthy Food

In 2018, over 13 percent or 74,522 county residents currently reside in a food desert, up from 12 percent in 2015. Food deserts are defined by the United States Department of Agriculture (USDA) as urban neighborhoods and rural towns without ready access to fresh, healthy and affordable food. Several of the County’s low income communities are also mapped as food deserts (Figure 28.) They do not have access to healthy food and they have no transportation to get to supermarkets. Unhealthy food is cheap and filling; an important asset for large families managing with few means. As one health provider noted:

A lot of times they don’t have access. They may have medical transportation to get to a doctor, they’re not going to have the transportation to get to a grocery store, and then you get to the grocery store and you’re on the SNAP program, or whatever it is you’re on, and then you go and you look and the apples are 2.99 a pound, right but the ramen noodles are 10 packs for a \$1.

Figure 28: Anne Arundel County Food Environment (2018)



Anne Arundel County Department of Health, 2018

Hungry Children

In several research studies, childhood hunger has been associated with significantly poorer cognitive functioning, decreased school attendance, and diminished academic achievement. Participants in this needs assessment, from school personnel to the faith community, noted that they are seeing more hungry children than ever before. As one school administrator noted:

They haven't eaten at home and they barely have a sofa to sleep on. There are things happening that they don't get a good night's sleep so when they come and don't do their homework it's really the least of your worries at that time. We have to ask what's happening at home and how can we help?

While there are volunteer back pack programs, church food pantries, and SNAP (food stamps) programs for those eligible, there are many gaps in services, particularly for those children living with grandparents, relatives and friends. As one faith community member noted "these kids are hungry, just hungry. They go to school hungry." The free breakfast and lunch program within the public school system has seen a persistent increase in the number of children registering for and receiving free breakfast and lunch. The number of free breakfasts received by children in the county has risen from 1,666,339 in 2014, to 2,007,167 in 2018, an almost 21 percent increase in four years. An added concern is that breakfasts were served on only 181 days of the year, just over half of the potential days for a child to eat breakfast. The number of free lunches served daily to students has increased from 14,351 in 2014 to 15,216 in 2018; a seven percent increase.

Housing

There is very little affordable housing in the county. As of September, 2018, the median home sale price was \$345,000, an increase of 10 percent or \$30,000 compared to last year. There has been a decrease of 9 percent in the numbers of houses sold in 2018 versus 2017.

The average rent for a two-bedroom apartment in the county is \$1,658 per month. Renters account for 26.4 percent or 52,948 of the 203,336 households in the county. Of those renters, 24,172 or 45 percent are overburdened. Renters are considered overburdened when they pay more than thirty percent of their gross income in rent.

According to the 2016-2020 Consolidated Plan for Anne Arundel County, 66 percent of extremely low income renters and 72 percent (4,645) of extremely low income homeowners are paying more than 50 percent of their income for housing. If an emergency, such as sudden unemployment, seasonal lay-off, unexpected medical event, or other difficulties occurs, these households risk losing their homes and becoming homeless. Single parent families, the elderly, and those with disabilities who are dependent on one paycheck or on a fixed income, are also at risk of homelessness.

There is a decreasing amount of public and subsidized housing in the county. There were 10,278 county families on the waiting list for Housing Choice Vouchers as of 2017 (Table 22.) There are 17,683 families on the waiting list for public housing (Anne Arundel County Housing Commission, 2018.) There are 1,514 families on the Annapolis public housing list. (Housing Authority of the City of Annapolis, 2018.)

Table 22: Anne Arundel County Housing Choice Voucher List (2017)

Anne Arundel County Housing Choice Voucher List 2017			
	# of Families	% of total families	Average Days Waiting
Waiting list total	10,278		966
Extremely low income (<=30% but <=50% AMI)	7,414	72.1%	
Very low income (>50% but 80% AMI)	1,836	17.9%	
Low income (>50% but 80% AMI)	746	7.3%	
Over limit for low income (>80% AMI)	282	2.7%	
Families with Children	9,079	88.3%	
Elderly Families	296	2.9%	
Families with disabilities	498	4.9%	
White	1,442	14.0%	
African American	2,998	29.1%	
Amer. Indian/Alaskan Native	13	0.1%	
Asian	80	0.7%	
Native Hawaiian/Other Pacific Islander	6	0.1%	
Not Assigned	5,749	55.9%	

Housing Commission of Anne Arundel County, 2018

Homelessness

The county served 1,684 homeless individuals in 2017, an increase of 13 percent since 2015 (table 23.) The family homelessness count is only of those families who were served in a shelter program. Many families are doubled up or staying in their cars. Anecdotal estimates suggest family homelessness is far higher in the county due to the lack of affordable housing.

Table 23: Anne Arundel County Homeless Served (2015-2017)

Anne Arundel County Homeless Served 2015-2017			
	2015	2016	2017
Single Adult	1138	1215	1290
Veteran	44	41	37
Youth Under 21	15	19	4
Family	256	274	269
Senior 62+	17	40	43
Chronic	46	82	41
Total Served	1516	1671	1684

Anne Arundel County Department of Social Services, 2018

There are still only three homeless shelters in Anne Arundel County and three rapid rehousing programs. 308 people needing housing services attended the 2018 Anne Arundel County Homeless Resource Day. Of those, only 34 percent were in a shelter or receiving some kind of resident services.

Table 24: Anne Arundel County Homeless Resource Day Attendance Totals 2018

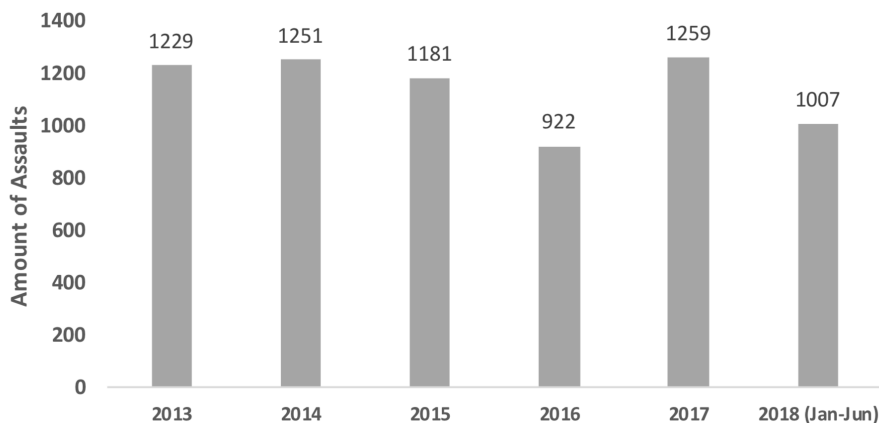
Anne Arundel County Homeless Resource Day Attendance Totals 2018		
Guests	Numbers	Percent
Attended	307	
Shelters	64	21%
Residential Programs/Halfway Houses	40	13%
Staying with Family	40	13%
Staying with Friends	40	13%
Renting their own apartment	40	13%
Living in a place not meant for habitation	31	10%
Other	52	17%

Anne Arundel County Department of Social Services, 2018

Domestic Violence

The Anne Arundel County Police Department tracks domestic violence by year and police district including physical assaults with hands or fists, guns, and knives. Figure 29 shows all Domestic Violence incidents in the county from 2013 to the first six months of 2018. The data shows an upward trend although there was a dip in numbers for the 2015-2016 year. The statistics for the 2018 year are alarming. The numbers for the six month period are almost as high as for the previous 12 months. These statistics confirm anecdotal data from police, schools and hospital personnel who all reported a notable increase in domestic violence over the same period.

Figure 29: Total Spousal Assaults Per Year (2013 – June 2018)



Anne Arundel County Police Department, 2018

Child Physical and Sexual Abuse

In 2018, the county’s Child Advocacy Center investigated 326 sexual abuse cases, of which seven were for sexual assault (Anne Arundel County Department of Social Services, 2018.) Respondents noted a large increase in the number of child on child sexual assaults that are being reported by the school system and other agencies. One commented that:

Children are looking at pornography on their parent’s phones and tablets. It used to be that the child was the victim and the adults the perpetrators but that’s not always the case now. Now we have five and six year olds doing inappropriate things. Kids are watching pornography at early ages.

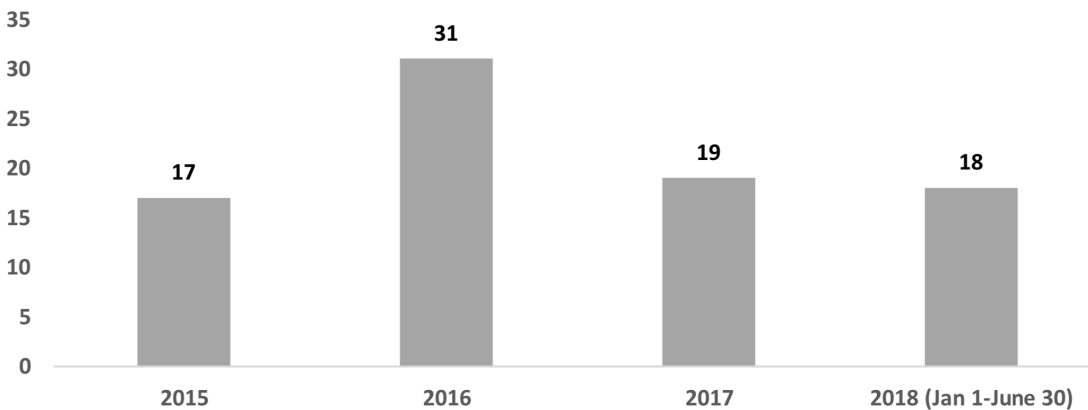
All child sexual assault and sexual abuse cases must go to the police department prior to a hand-off to social services. This process, and the limited number of police specialists, can cause back up of over three months and then there may be up to 100 cases at a time sent to the Department of Social Services. As one provider noted:

Every report has to go through these guys before it comes to DSS. We’re often cold calling three months later.

Sex Trafficking Victims

Anne Arundel County is in the top five jurisdictions in Maryland for sex trafficking. (Rubenstein and Carr, 2017.) The 50-mile radius surrounding BWI airport is becoming known as the third-most-lucrative area in the nation for trafficking in people (Maryland Human Trafficking Taskforce, 2018.) Anne Arundel County Police Department tracks the number of sex trafficking incidents for the county (Figure 30). While the numbers were stable between 2015 and 2017, data for the first 6 months of 2018 are showing an almost 100 percent increase in cases. There are only two Anne Arundel County Police detectives fully dedicated to human trafficking.

Figure 30: Sex Trafficking Victims, Anne Arundel County 2015-2018



Anne Arundel County Police Department, 2018

Transportation

The lack of public transportation continues to be a major issue for the county. Since 2014, the county has developed a transportation division and there have been improvements. There are now five regional transit routes, eight Annapolis routes, four local bus routes and four commuter bus routes. Additionally there are two pilot bus routes in South County. Nonetheless, public transportation continued to be a major concern for all participants in this needs assessment. There are large areas of the county that are underserved or not served at all, including North and West County. Low income residents who have no car or share a car, have major issues getting to work, to college, to the hospital, even to the nearest grocery store. As one provider noted:

I've got a family who relocated to Severn. She works at Brightview right by Rolling Knolls. It's a three hour commute via MTA; that's what you have to do for connections. What about transportation in West County? You're in Sarah's house but you are from Annapolis and you want to come back, you work here, forget it, you can't.

Sports and Recreation

Many participants in this needs assessment lamented the lack of sports and recreation opportunities for children, youth and adults across the county, especially the removal of middle school sports from the curriculum in public schools. Parents from every race, ethnicity and income level decried the lack of "active things to do" for children and youth. While some communities have a recreation center for youth, many do not. One parent and resident recalled the importance of inter-neighborhood sports:

When I was young we had our own community sports and associations and we played against the other communities. So there was great investment within those communities for young people; we played against Pumphrey, and Pumphrey played against Freetown, Freetown played against Magothy. Now we have the recreation leagues that are pulling youth out of their communities - it's not community driven.

Participants also noted the importance of sports and the need for more recreation centers in low income neighborhoods where youth struggle with transportation needs as well as the negative outcomes associated with poverty. As one noted:

We need rec-centers. Only the families who can afford to sign up their kids for sports can engage in them. I tell everyone I'm a product of a community center, a rec-center, I went to summer camp there, I went to Head Start there. It was the catch all.

Social Media as a Public Health Issue

Social media, including the active use of smart phones and tablets, is a major concern for residents and professionals in every area of the county. The constant access to electronic information is impacting every age group and demographic:

Early Childhood

Babies as young as 12 months have been observed in the county holding iPhone and tablets. One early childhood provider described this as "soothing by cell phone." Another commented:

I hate to blame technology but youngsters at a very early age are being babysat by electronics. Whether it be an iPad or a cell phone. Then we're asking them to sit quietly in a circle and say their ABC's

Many participants commented on the number of parents with their eyes on their own cell phone rather than creating any interaction or eye contact with their children. Several suggested that the ease of electronic access to pornography for very young children is linked to rising child on child sexual abuse within the school system.

Youth

Increases in bullying, suicide and suicidal ideation for youth, have been linked to the constant use of social media 'apps' such as Instagram and Snapchat. As one educator noted:

Students will turn one another in- 'look what she wrote on-line about me' or 'look what he posted on line' – it's a disruption of the school day.

Youth in low income communities are emulating international gang members, their colors and lifestyles by following their on-line presence. Body language, eye contact and social behavior of every kind is now lessened by the isolation of cell phone use. Video-gaming is replacing outdoor sports and recreation, and it is addictive.

Adults

All participants commented on the increase in the use of social media for adults. Some commented on the isolation it causes and the need to look at every experience through the lens of a photo for Facebook. As one professional said:

People spend way too much time looking at other people's activity on social feeds – 'how many likes did you get or didn't get? Let's make sure we take some pictures so we can post them.' How about enjoying the event you're going to?

Others linked the use of social media and rapid electronic communication with rising rates of drug use, depression and anxiety. As a faith community member commented:

People are feeling more and more isolated because you can be surrounded by 500 friends (on social media) but you're in your room by yourself.

Increase in Violence

Many participants commented on the increase in violence within agencies and facilities. Teachers are getting bitten and punched; nursing staff are physically assaulted. Anecdotally there appears to be growing anger at many levels.

Gang Violence

For some youth and young adults in Anne Arundel County, informal gangs (neighborhood crews) or legitimate, international gangs such as Mara Salvatrucha (MS-13,) provide the consistency, safety, and security usually provided by the family. The sense of belonging and purpose has been described, eloquently, by gang members. The Annapolis Collaborative for Change, a cross sector partnership on gun and gang violence, has inventoried at least ten identifiable neighborhood crews in Annapolis alone, and four sects of MS-13 across the county. Neighborhood crews appear to have developed from the rivalries or neighborhood 'beefs' in low income and public housing communities. Thirty years ago these natural turf wars, waged fiercely on a sunny Saturday afternoon, were most often settled with a cross-community get together or cook-out on the same evening. As one ex-resident of a public housing complex noted:

The neighborhood was like a family – everyone looked after everyone's kids. I grew up with a single parent who warned against ever having a cop knocking on the door. We were all raised as brothers and sisters. Even the drunk on the corner would threaten to tell your Mom if you were up to no good.

In 2018, young people get involved in gangs to belong. They sell drugs to be perceived as successful and entrepreneurial, to buy tennis shoes, and sometimes to buy food or pay rent for the family. It is a local cottage industry described by a community member as "a pyramid scheme and no-one wants to stop the flow." Arguments over drug territory and sales have become entangled with the old neighborhood rivalries. As another resident noted, "there are territories. They are controlling territories so they can do drug transactions."

MS-13, an international criminal gang that originated in Los Angeles, California, in the 1980s, has an organized presence in the county. Members are searching for young recruits. According to one Hispanic resident:

They are active in schools in Annapolis, Arnold and Glen Burnie. Some elementary school children are very familiar with MS-13. They are second generation – their parents are gang members. Children as young as 13 in Annapolis have been invited in. No-one wants to 'snitch.'

Since the 2015 needs assessment, youth violence has increased in the public school system, both in amount and intensity. As one professional noted:

What they are being disciplined for is qualitatively different ... fights were fights, and now fights involve weapons. Aggression was aggression but now the aggression is more dangerous, more volatile, having more serious repercussions in terms of injuries and the like.

Summary

Low-income youth, families and seniors continue to face access issues. The three big needs; transportation, affordable housing and affordable quality childcare, remain unchanged since 2009. The consequences of expanding social media are negative health and behavioral issues at every level of the community. Increasing aggression and violence in schools, hospitals, and other systems should be a huge concern to county leadership.

Needs

- Access to transportation continues to be a huge issue, especially for low income residents and seniors living in areas of North and South County
- Affordable housing is non-existent in most parts of the county creating stress, and worst of all homelessness, for low income families
- Quality childcare is cost prohibitive for those parents on low-income trying to get into the job market
- Access to recreational and social opportunities for low-income youth within their own communities
- Acknowledgement and education about the negative impact of social media on health and behavioral health
- Access to healthy food for low income families

Chapter 4 - Service Delivery Issues

Many of the issues and needs raised by participants in this needs assessment originate in the processes used to deliver health and behavioral health care. Care is often delivered in silos of specialization. Many agencies may be involved in the wellness of each individual yet there are barriers to communication between those agencies.

Emergency Departments - the new “Church Door”

Emergency Departments (ED) provide a significant source of medical and social care in Anne Arundel County. The two county hospital emergency departments at AAMC and UMBWMC have become the ‘catch all’ for somatic, behavioral health and social issues. As one provider noted ‘we are the new church door’ for many of the socio-economic issues in the county. The Emergency Department is a trusted venue and one of the main “front doors” not just for primary care but for difficult societal issues.

Table 25: ED Encounters by Age, Sex, and Race/Ethnicity (2013 and 2017)

ED Encounters by Age, Sex, and Race/Ethnicity, 2013 and 2017				
	2013 Number	2013 Rate per 1,000	2017 Number	Rate per 1,000
Total Encounters	186,124	334.9	189,819	334.0
Age				
0 to 18 Years	39,455	312.0	40,301	283.6
19 to 39 Years	68,342	415.9	64,700	417.0
40 to 64 Years	58,087	301.9	57,566	294.4
65 Years and Over	20,240	279.0	27,251	357.8
Sex				
Male			84,147	304.0
Female			105,656	373.5
Race/Ethnicity				
White, NH	98,617	250.3	103,908	260.1
Black, NH	48,507	554.0	59,167	667.3
Asian, NH	1,454	71.7	2,066	101.0
Hispanic (Any Race)	8,552	223.0	13,110	329.5

Anne Arundel County Department of Health, 2018

The overall numbers of county Emergency Department encounters increased by only 2 percent between 2013 and 2017. However, when the numbers are disaggregated by race/ethnicity and age, the percentage increases are startling. Visits increased by 34 percent for those over 65 years of age, 22 percent for Blacks, and 48 percent for Hispanics.

Service Delivery Issues in the Emergency Department

When parents and/or caregivers of the elderly lack the ability or the dollars to care for an aging family member, the Emergency Department may be the only option to achieve some respite. Seniors may have been admitted to hospital but now require 24 hour care in an assisted living setting. When family members are unable to care for their relative, or are absent or non-existent, some entity or professional has to become the guardian for that person. Some elderly people in the county have become homeless, with no caretaker, and with medical issues. Seniors may be admitted to the hospital from the Emergency Department only because there is no place to be discharged to. One provider told the story of a senior with a tracheotomy who was homeless. She was admitted to the Emergency Department because there was nowhere else to house her. As one provider noted:

We’re seeing a lot more respite care. We’re seeing a lot more care management cases where a person may be in the Emergency Department for weeks on end. We’ve seen guardianship cases when patients are in the hospital for months, taking up a bed for no reason when there is no medical indication that they need to be here, but they need to be somewhere safe.

Hospital and Emergency Department employees may apply for guardianship of the patient so that decisions can be made about their living arrangements and future care, although the process to obtain guardianship through the court system can take months. As one provider noted:

That's the other thing that's dramatically increased is that hospitals are initiating the guardianship process more and more. We have a very close relationship with the court system here but that's even straining due to the rate at which we are having to do this.

Hospitals have no financial streams to pay for patients who have nowhere else to go, so the stay becomes "uncompensated care." For the person who is retained in the hospital the outlook is poor. Visitation is limited and contact with the outside world is almost non-existent. As one provider noted:

There are times they walk down to the gift shop once a week if they have good behavior...I take them out for field trips in the parking lot, it's awful.

Developmentally/Intellectually Disabled Youth and Adults

There are over 68,000 developmentally disabled adults in Anne Arundel County, many of whom are low income (Anne Arundel County Community Development Services, 2018.) Persons with Developmental Disabilities may have Deafness/Severe Hearing Impairment, Orthopedic Impairment, Autism Spectrum Disorder, Behavioral Problems, Blindness/Severe Visual Impairment, Cerebral Palsy, Epilepsy/Seizure Disorder, Head Injury, Mental Disorder, intellectual disability, Speech/Language Impairment, and other Neurological Impairment (Maryland Department of Developmental Disabilities, 2018.)

The Centers for Disease Control and Prevention (2018) estimates that Autism Spectrum Disorder (ASD) affects one in 59 US children. Boys are four times more likely to be identified with ASD than girls; one in 38 boys and one in 152 girls. The overall rate in Maryland is one in 50 children: one in 31 boys and one in 139 girls. On average, medical expenditures for children and adolescents with ASD were 4.1 to 6.2 times greater than for those without ASD. In addition to medical costs, intensive behavioral interventions for children with ASD cost \$40,000 to \$60,000 per child, per year.

Developmentally disabled youth and adults, some with co-occurring mental health issues, arrive in the Emergency Department when parents are exhausted and have run out of options for their care. Providers estimate that at any given time Emergency Departments may have six to eight developmentally disabled patients who actually need case management rather than emergency health care. The parents may be exhausted especially now they are dealing with a young adult rather than a child. Sometimes the caregiver parent has become isolated from other family members. As a provider commented:

Mom (more often than not,) or whoever the parent is, has been isolated from the rest of their family (they come to the Emergency Department, ill themselves but with their adult child.) Either one of them may not have family, so here's a sick patient with an adult child, what do I do with this adult child? So, in that case we admit both of them.

The Developmental Disabilities Agency (DDA) has increased services for youth and adults but the services are hard to access, especially given the length of time it takes to fill out, and process the individual applications for assistance.

Communication Issues

Most hospital providers noted the improvement in communication since the institution of care alerts within the CRISP (Chesapeake Regional Information System for Patients) electronic system in the hospitals. The alerts allow personnel to share information related to patients. Entry and discharge for Emergency Departments, hospitals and other systems were highlighted as still problematic, especially for high risk patients. Often several specialists and outside agencies may be working with one patient and yet there is not one person in a coordinating role for all of the services and professionals. As one provider noted:

We have high risk programs that contract with the county and with the Coordinating Center for community care management. We're bumping into each other a little bit. So instead of having seven people from seven different programs call a patient, I would like to be able to work on some place or person who knew everyone who was working with a patient.

The hospital system expects primary care to be the gatekeeper when patients are discharged but some providers commented that there is a gap in communication between the two. Hospital staff may not hear any information about a discharged patient until they are readmitted.

Required Speed of Service Delivery

A payment overhaul for Maryland Hospitals began in 2014. Each hospital has a global budget that is regulated by the state that incentivizes efficient care and the reduction of "potentially avoidable utilization" through improvement in quality, safety and population health management. A particular emphasis has been placed on reducing preventable hospital admissions through improved care management and post-acute medical and non-medical supports.

Although many innovative payment models and pay-for-performance models are being introduced in the non-hospital, regulated outpatient setting, traditional fee for service models are prevalent. This model, combined with decreasing reimbursement rates for many services, encourages providers to see more patients, which can reduce the time they have available for individual patients. As one provider commented:

I feel like we're pushed to see patients so quickly and to turn them around and when, sometimes I'll be driving home and I'm like I hope they are alright, I hope they're alright, yeah I've got them out in 102 minutes, did I do everything I needed to do?

Impact of Social Media ("Don't confuse your google search with my medical degree.")

Many professionals commented on the amount of medical information readily available to patients through the Internet, advertisements on television and other social media. Patients (and their families and friends) may arrive having diagnosed themselves and expecting a certain level of care, medication and/or admission to the hospital. One provider noted:

It's consumer driven medicine. 'I looked this up on WebMD, you should be doing xyz.'

Summary

Some of the social issues in the community, including the increase in behavioral issues, and the lack of options for the growing group of seniors and Developmentally Disabled adults and older youth, are negatively impacting waiting room times, hospital beds available, and speed of patient care for hospitals. At the same time, the Maryland hospital payment system incentivizes the medical community to decrease hospital admissions. This appears to be a lose/lose proposition for patients and professionals, especially because it adds a level of anxiety and haste to services.

Needs

- Information sharing and coordination among hospitals, primary care and human services agencies who are following up with discharged patients.
- Low cost assisted living and nursing homes for the uninsured and those with no end of life plan.
- One patient navigator/coordinator for high risk patients inside and outside of the hospital setting.
- One stop shops for health, behavioral health and social services, especially for the aging and disabled populations.

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Community Health Needs Assessment Implementation Plan

FY2019-FY2021



Approved, Board of Trustees

May 21, 2019

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EXECUTIVE SUMMARY

Anne Arundel Medical Center (AAMC) is pleased to provide the FY2019 through FY2021 Community Health Needs Assessment (CHNA) and Implementation plan. This report is designed to describe the process of collecting information and ascertaining the community needs, prioritizing those needs and a description of AAMC’s action plan to address those needs to improve health. For the purpose of this report, the community is defined as Anne Arundel County since the majority of patient discharges reside in this area. The Board of Directors approved this plan on (INSERT DATE) in accordance with IRS regulations.

Key Findings: The CHNA data was compiled from secondary data sources and qualitative information obtained from key informant interviews and several focus groups of diverse community members. It outlined over 50 health needs in the Anne Arundel County community. While a singular entity or hospital does not have the capacity or resources to address all of the needs, AAMC intends to collaborate with partners and address many of the needs to better the health of the community. AAMC’s senior leadership and select patient advisors prioritized the 50 needs and selected 4 health needs. The results and correlating action plans are included in Table 1.

Table 1

Priority	Action Plans
Senior Health	Build age-friendly programs around the 4Ms (Medication, Mentation, Mobility, what Matters), with additional focus in ambulatory care settings
Youth Behavioral Health/ In-Crisis	Engage community stakeholder to identify gaps in services and implement programs to increase education on risk and warning signs for mental health for adults and adolescents.
Social Determinants of Health	Create a systemic screening process for patients to address social determinants of health. Engage community partners to expand referrals.
Assessing Needs in Prince George’s & Queen Anne’s Counties	Year 1 – Integrate and participate in Prince George’s County and Eastern shore health department(s) community coalitions. Year 2 – Select 1 health need from findings from Year 1 and develop and focused implementation plan.

INTRODUCTION

During Fiscal Year 2019, AAMC conducted its third three-year Community Health Needs Assessment (CHNA) in collaboration with University of Maryland, Baltimore Washington Medical Center (UMBWMC), the Anne Arundel County Department of Health (AADOH), the Anne Arundel County Mental Health Agency, and the Anne Arundel County Partnership for Children, Youth and Families pursuant to the requirements of Section 501(c)(3) of the Internal Revenue Code (“Section 501(r)”). The FY2019 CHNA covers the fiscal years 2019, 2020 and 2021. The CHNA findings and corresponding Implementation Plan was approved by Board in INSERT DATE, also required by Section 501(r), and made available on the hospital website.

The report outlined more than 50 health needs with input from secondary data analysis and community input (focus groups and key informant interviews). One hospital, alone, does not have the resources necessary to address the fifty needs identified in the CHNA.

Collaboration with community partners (county and city governments, local non-profits, faith based organizations, employer groups, payor groups, etc.) will be paramount to improving health and addressing the needs of county residents. AAMC is committed to improving the health of the patients we serve, and as a result, the priorities and plan outlined in this report represent what our leadership has determined we can impact. This will provide part of the foundation in which to allocate resources for the next three years.

ABOUT ANNE ARUNDEL MEDICAL CENTER

We are a regional health system headquartered in Annapolis, Md., serving an area of more than one million people. Founded in 1902, AAMC includes a not-for-profit hospital, a medical group, imaging services, a substance use treatment center, and other health enterprises. In addition to a 57-acre Annapolis campus, AAMC has outpatient pavilions across Anne Arundel County, and physician practices on the Eastern shore and in Prince George’s County. A new mental health hospital, the McNew Family Hospital, will open in the Spring, 2020. With more than 1,200 medical staff members, 4,800 employees and 900 volunteers, AAMC consistently receives awards for quality, patient satisfaction and innovation.

AAMC's mission is *to enhance the health of the people it serves. It is also guided by its core principles of compassion, trust, dedication, quality, innovation, diversity and collaboration.*

That means that the care that AAMC provides is centered on the patient. We operate beyond the walls of the hospital and serve a broad geography and diverse population of patients.

Our work builds on partnerships, relationships and connectivity. We hold shared accountability among patients, physicians, hospital, employees and community. We are driven by standards based on evidence and outcomes while remaining viable, cost-effective, and responsible.

In FY2016, AAMC engaged in a multi-year project to reduce health disparity and create a culture of health equity for providers and employees, patients, families and the community we serve. The program is multi-dimensional and includes improving language access for better communication between provider and patient, on-going cultural competency education for physicians and staff, and identifying programs that narrow disparity and foster equity. Our work will continue to focus on strengthening a system of equity, recruiting and hiring a diverse workforce, improved training for staff and physicians, and using a health equity lens as we approach health needs of the community.

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS AND METHODOLOGY

The summative (quantitative) data contained in this needs assessment was gathered from a variety of local, state and national sources. Population and socio-economic statistics were compiled using data from the United States (U.S.) Census Bureau's Population Estimates Program and the American Community Survey 1-Year and 5 Year Estimates. These data should be considered less reliable due to the gap of eight years since the last full census. All data here are based on census estimates. Birth and death data files were obtained from the Maryland Department of Health and Mental Hygiene, Vital Statistics Administration. The emergency department and inpatient hospital discharge data files were obtained from the Maryland Health Services Cost Review Commission for topics like birth, mortality and hospital utilization. Other data sources used for this report were: Maryland Vital Statistics Annual Reports, Maryland Department of Health and Mental Hygiene's Annual Cancer Reports, Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention's CDC WONDER Online Database, Centers for Medicare and Medicaid Services,

National Vital Statistics Reports and County Health Rankings, and a variety of local databases. The specific data sources are listed throughout the report.

The FY2019 CHNA draws on qualitative data gathered from 26 key informants and 11 focus groups. Focus group areas included emergency department personnel, low income youth, behavioral health providers, Hispanic residents, advocates, domestic violence victims and a host of others representing a total of 185 participants. Key informants included law-makers, hospital CEOs, and leaders from health department, police, schools, faith organizations, and community residents – representing 26 individuals. A full list of focus groups and key informants can be found in the CHNA (NOTE WEBSITE).

PRIORITIZING COMMUNITY HEALTH NEEDS

We followed provided an unbiased process to narrow more than 50 community health needs to 4. While many of the needs overlap or are needs we currently address, it is important to prioritize needs to support a strategic framework, maximize resources, and have an impact. First, a visual model (infographic—Appendix A) of the CHNA was developed to condense the document into a workable tool. Executive council, service line leaders, and patient advisors were convened to review the model and review the findings of the CHNA. The Council was asked to rank their top needs. These recommendations were collected and present to the Population Health Task Force. The task force included executive leaders and ambulatory leaders who were charged with developing a robust and focused implementation plan. The task force re-validated the recommendations from the Executive Council and reviewed/ included additional focus areas for consideration. Approximately 8-10 community needs were discussed. Members of the Population Health Task Force further narrowed and ranked the needs based on the following criteria:

- Community importance
- AAMC's ability to impact change
- Need aligns with AAMC's strategic priorities
- Impact on vulnerable populations or disparity

The following list includes the prioritized needs as determined above.

-
1. Somatic Health: Senior Health (inclusive of chronic conditions, dementia, mental health, polypharmacy, and loneliness/social isolation)
 2. Social Determinants: Strengthen partnerships to address social determinants
 3. Behavioral Health: Youth Crisis Intervention/Youth Suicide
 4. Expand Community Needs into primary service including Prince George's and Queen Anne's Counties.

IMPLEMENTATION STRATEGY

See the following for a detailed plan.

SOMATIC HEALTH: SENIOR HEALTH

Individuals over the age of 65 are on the rise in our community. Furthermore, chronic diseases account for 75% of all healthcare spending,ⁱ and almost 90% of seniors have at least one chronic condition, with a quarter of them having four or more.ⁱⁱ With the outsized impact senior citizens have on healthcare utilization and spending, addressing their unique characteristics and needs plays a vital role not only in controlling costs but in providing the best care possible to this patient population. As an *Age-Friendly Health System*, AAMC is committed to meeting the needs of the elderly population – in the acute care setting, in the outpatient setting and in the community at large.

Objectives	Actions	Metrics	Community Partners
Reduce harmful medication interactions	Pilot and expand Beers Criteria Alarm in AAMC practices to warn prescribers about interactions and inform patients	Establish baseline for Beers Criteria assessment and set goal for Year 2, 3	<ul style="list-style-type: none"> Anne Arundel County Department of Aging & Disabilities Skilled Nursing Facilities
Improve mobility	Increase mobility screening via “Timed up and Go” programs and refer patients to physical therapy	Establish baseline for Timed Up and Go assessment and set goal for Year 2, 3	
Increase the number of patients with “What Matters” conversations with providers	Educate providers and increase What Matters screenings to increase the number of documented conversations about patient goals Implement Wellness visits into AAMC practices	Increase the number of patients with documented patient goals in patient medical record (including end of life wishes and documents) Increase the number of patients with a Wellness visit on the Eastern shore.	
Reduce social isolation	Implement social isolation screening tool; increase the number of programs patients are referred to for home visits and interaction	Establish screening tool, establish baseline for social isolation and set goal for Year 3	
Increase awareness of link between chronic disease and dementia.	Explore the connection between Type 2 Diabetes and vascular dementia.	Establish screening tool, establish baseline and set goal for Year 3	

BEHAVIORAL HEALTH: YOUTH CRISIS & SUICIDE

Between 2012 and 2016, suicide was the second leading cause of death for 10-24 year olds in Anne Arundel Countyⁱⁱⁱ. During this period, Anne Arundel County has also seen a 97% increase in female youth suicide attempts in just six years (2011- 348, 2016 – 433)^{iv}. The number of crisis interventions for social and emotional problems has more than doubled since 2013^v. Anne Arundel County high school students report higher rates of feeling sad or hopeless and seriously considering attempting suicide compared to the state of Maryland^{vi}.

Objectives	Actions	Metrics	Community Partners
Engage Community stakeholders to identify barriers related to gaps in screening, access to care, continuity of treatment, community resources Increase education and awareness about risk factors for mental health/ crisis in youth among adults and youth Expand outreach and grassroots programs in schools	Implement programs that address gaps related to screening, access to care	Increase the number of programs implemented; increase the number of individuals referred to care	<ul style="list-style-type: none"> • Anne Arundel County Public Schools Anne Arundel County Mental Health Agency • American Academy for Pediatrics • National Alliance on Mental Illness • National Foundation for Suicide Prevention • Student led grassroots awareness and advocacy groups(e.g., Our Minds Matter, Burgers and Bands, Ellie’s Bus)
	Implement programs for adult Mental Health First Aid training and Youth and Adult Resiliency program.	Increase the number of individuals trained in mental health and resiliency	
	Collaborate with Anne Arundel County Public Schools and the Department of Health to educate staff and suicide prevention, screening and resources.	Increase the number of Anne Arundel County Public Schools staff trained in mental health; increase the number of students referred for programs.	
	Collaborate with Anne Arundel County Public Schools and pediatricians to implement programs and campaigns to raise awareness and reduce stigma around mental health and youth.	Improve screening and referral process for youth accessing mental health care.	
	Implement Intensive Outpatient Psychiatric (IOP)	Increase the number of youth in care	

SOCIAL DETERMINANTS OF HEALTH: STRENGTHENING PARTNERSHIPS

Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes.^{vii} These conditions are known as social determinants of health (SDOH). Many factors determine the state of a person’s overall wellness. The social determinants of health include income level, especially for those who live in poverty, access to healthy food, emotional stability, the cleanliness and safety of the environment, and access to health services. Although Anne Arundel County has a high standard of living overall, there are pockets of poverty and health access issues found in areas of high population density in North County, Annapolis, and in some of the rural areas of South County. Transportation, affordable housing, childcare, and access to healthy food remain as needs for county residents.¹

Objectives	Actions	Metrics	Community Partners
Create a systemic screening process for patients to address social determinants of health. Engage community partners to expand referrals.	Implement systematic screening/ screening tool of social determinants of health in all AAMC primary Care Practices (FY19)	Increase the number of patients who are screened for social determinants of health.	<ul style="list-style-type: none"> • 211/ United Way • Other local resources such as Department of Aging and Disabilities, Department of Health, Department of Social Services, etc.)
	Develop and implement a multi-layered referral process (FY20)	Increase the number of referrals to community resources.	
	Develop and communicate a comprehensive resource list, including partnerships and programs (e.g., UWCM 211) (FY20)	Establish and communicate resource list.	
	Provide education to physicians, medical assistants, patient panel coordinators, etc. (FY20)	Increase the number of providers and staff educated about social determinants of health to increase screenings referrals to services	
	Identify top 2-3 SDOH needs that impact patient care and develop partnerships and plans to address SDOH, including resource allocation (FY20-21)	Determine resource allocation expense (community benefit) to address needs.	

EXPANSION INTO GEOGRAPHIC SERVICE AREA

AAMC serves a growing number patients and residents in areas of Prince George’s and Queen Anne’s Counties. It is imperative that the Implementation Plan address the health needs in those communities. For example, Prince George’s County is home to more than 900,000 diverse residents and includes urban, suburban, and rural areas. In contrast, Queen Anne’s County is one of the twenty-four counties in Maryland with a rural designation. The populations are unique and diverse across the counties and we are committed to providing the right care in the right place.

Objectives	Actions	Metrics	Partners
<p>Focus on integration and full participation with the Prince George’s County and Eastern Shore health departments and community coalitions.</p> <p>Select one category of need specific to each geography and develop a focused plan to impact needs.</p>	<p>Attend community coalition meetings to determine outcomes of FY19-FY20 CHNA</p>	<p>Increase the number of meetings attended and partners identified.</p> <p>Outcome measures are to be determined based on plan.</p>	<ul style="list-style-type: none"> • AAMC practices and providers in Prince George’s County and Eastern Shore Counties • Prince George’s County Department of Health • Prince George’s County Public Schools • Prince George’s County Department of Aging and Disabilities • City of Bowie • Chamber(s) of Commerce • Queen Anne’s County Department of Community Services • Queen Anne’s County on Aging – Maryland Access Point • Rural Health Collaborative
	<p>Align partnerships in geographic areas to establish strategic plans to address needs</p>		
	<p>Develop plans and identify actions, resources and outcome metrics for FY20, 21</p>		

FINAL NOTES

The implementation plan will be incorporated into the strategic planning process for the next three years to ensure that adequate resources are allocated to the projects. Activities will be monitored and the progress will be communicated. A copy of this report and a complete report of the CHNA can be found on our website at www.aahs.org

Appendix A

FY19 Community Health Needs Assessment (CHNA) Gap Analysis



References

- ⁱ Healthy Aging Facts: National Council on Aging.
- ⁱⁱ *The Future of Home Health Care: A Strategic Framework for Optimizing Value*. Home Health Care Management and Practice Journal. October 5, 2016.
- ⁱⁱⁱ Anne Arundel County Department of Health. 2018, March. Trends in youth suicide in Anne Arundel County 2012-2016. Found at <https://www.aahealth.org/wp-content/uploads/2018/07/YouthSuicideReport2012-2016.pdf>
- ^{iv} Anne Arundel County Department of Health. 2014, September. Youth Suicide; an assessment of youth suicide behavior in Anne Arundel County 2008-2012. Found at <https://www.aahealth.org/youth-suicide-report-september-2014/>
- ^v Anne Arundel County Department of Health. 2018, March. Trends in youth suicide in Anne Arundel County 2012-2016. Found at <https://www.aahealth.org/wp-content/uploads/2018/07/YouthSuicideReport2012-2016.pdf>
- ^{vi} Maryland Department of Health. 2014. Maryland youth risk behavior survey high school summary tables, Anne Arundel County. Found at <https://phpa.health.maryland.gov/ccdpc/Reports/Documents/2014YRBSReports/YRBS0HighSchoolSummaryByCounty.pdf>
- ^{vii} <http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health>

ADM1.1.91 - Patient Financial Services – Hospital Financial Assistance, Billing & Collection

Dates Previously Reviewed/Revised: N/A Newly Reviewed By: F&A 9/2012, BOT 9/2012, HPRC 1/2015, BOT 6/2019, BOT6/2020, BOT 1/2021 Approval Date: 1/2021 Effective Date: 1/2021	Owner: Director, Patient Financial Services
Approver Title: Chief Financial Officer On file <hr style="width: 40%; margin-left: 0;"/> Approval Signature	

Scope:

This Luminis Health policy applies to hospital services provided at Anne Arundel Medical Center (AAMC), Doctors Community Medical Center (DCMC), J. Kent McNew Medical Center (MMC) and Pathways (collectively hospitals) only. Other providers, including all physicians who deliver emergency and medically necessary care at AAMC, DCMC, MMC and Pathways are not covered by this policy.

Policy Statement:

To promote access to all for medically necessary services regardless of an individual's ability to pay, to provide a method of documenting uncompensated care and to ensure fair treatment of all applicants and applications.

Purpose:

- To assure the hospital communicates patient responsibility amounts in a fair and consistent manner.
- To provide opportunity to resolve questions regarding charges or insurance benefits paid.
- To assure the hospital meets the requirements of Maryland standards for hospital billing and collection practices.
- To provide opportunity to resolve questions regarding charges or insurance benefits paid.
- To define the hospital's decision-making process for referral for collection or legal action.
- To assure the hospital meets the requirements of Maryland standards for hospital billing and collection practices.

Definitions: None

Policy/Procedure:

Financial Assistance:

- A patient's payment for reduced-cost care shall not exceed the amount generally billed (AGB) as determined by the Health Services Cost Review Commission's (HSCRC) approved rates.
- Patients may apply for Financial Assistance by the methods listed below.
 - By calling AAMC at 443-481-6500 or DCMC at 301-552-8093
 - Patients may apply in person at the Financial Advocacy Office which is located in the Ambulatory Care Pavilion on the first floor of AAMC's main campus between 8:30 a.m. and 4:00 p.m., Monday through Friday or at 7404 Executive Place, 3rd floor, Room 300A, Lanham, Maryland 20706

- The Financial Advocacy Office will mail a free copy of Luminis Health's financial assistance policy and financial assistance application to any patient who requests those documents
- Patients may apply on the internet at:
<https://luminis.health/aamc-fa-application> for AAMC or MMC
<https://luminis.health/dcmc-fa-application> for DCMC
- Applications are available in English and en Español
- The following two-step process shall be followed when a patient or a patient's representative requests or applies for financial assistance, Medical Assistance, or both:
 - Step One: Determination of Probable Eligibility. Within two business days following the initial request for financial assistance, application for Medical Assistance, or both, Luminis Health shall: (1) make a determination of probable eligibility, and (2) communicate the determination to the patient and/or the patient's representative. In order to make the determination of probable eligibility, the patient or his/her representative will be required to provide information about family size, insurance, assets and income, and the determination of probable eligibility will be based solely on the information provided by the patient or patient's representative. No application form, verification or documentation of eligibility will be requested or required for the determination of probable eligibility.
 - Step Two: Final Determination of Eligibility. Following a determination of probable eligibility, Luminis Health will make a final determination of eligibility for Financial Assistance, which (except as otherwise provided in this Policy) will be based on a completed Uniform Financial Assistance Application and supporting documentation of eligibility.
- Once a request for financial assistance has been approved, dates of service twelve months before the approval and twelve months after the approval shall be included in the adjustment. Service dates outside this twenty-four-month window may be included if approved by a Supervisor, Manager, or Director of the Patient Financial Services Department.
- **PROVIDERS NOT COVERED BY FINANCIAL ASSISTANCE POLICY**
Unless otherwise specified, the Luminis Health Financial Assistance Policy does not apply to physicians or certain other medical providers who care for you while you are in the hospital. This includes emergency room doctors, anesthesiologists, radiologists, hospitalists, pathologists, and other providers. These doctors will bill you separately from the hospital bill. This policy does not create an obligation for the hospital to pay for the services of these physicians or other medical providers. The public may obtain a copy of this list by printing from the link below or contacting the Luminis Health Financial Counseling office.

[Providers excluded from the Luminis Health Financial Assistance policy \(PDF\)](#)

- **PROVIDERS COVERED BY FINANCIAL ASSISTANCE POLICY**
This policy applies to services provided by Luminis Health (facility charges) only. Medical professionals who care for you in the hospitals will bill you separately for their services (professional charges). Each of these medical professionals has their own policy and their bills are not covered by this Financial Assistance Policy.

Eligibility Criteria:

- Luminis Health provides 100% financial assistance to individuals with household income at or below 300% of the US Poverty guideline but deemed ineligible for any County, State or Federal Medicaid or other funding program.
- Luminis Health provides 100% financial assistance to individuals enrolled in a means-tested State or Local program. Patients who provide proof of enrollment in one of these programs do not have to complete an application or submit supporting documentation of income to be approved for financial assistance.

- A patient that has qualified for Medical Assistance (Medicaid) is deemed to automatically qualify for financial assistance under this policy. The amount due from a patient on these accounts may be written off to financial assistance with verification of Medicaid eligibility. Standard documentation requirements are waived.
- A patient of Luminis Clinical Enterprises who has been approved for financial assistance by that organization automatically qualifies for financial assistance under this policy at the same percentage of charges discount. The patient does not have to complete a separate application to be eligible under this policy. Some service exclusions may apply.
- Luminis Health provides a sliding fee scale for individuals with household income at or below 350% of the US poverty guideline but deemed ineligible for any County, State or Federal Medicaid or other funding program. The sliding scale provides 50% financial assistance to individuals up to 350%.
- Luminis Health provides financial assistance not only to the uninsured but to patients with a demonstrated inability to pay their deductibles, copayments and balance after insurance.
- Luminis Health recognizes that a portion of the uninsured or under insured population may not engage in the traditional financial assistance application process. If the required information is not provided by the patient, Luminis Health may employ an automated, predictive scoring tool to qualify patients for financial assistance. The patient's score predicts the likelihood of a patient to qualify for Financial Assistance based on publicly available data sources. Approval through the automated scoring method applies only to accounts where obtaining an application is not feasible as determined by the Patient Financial Services Department.
- For all income levels, Luminis Health will consider special circumstances such as the amount of the bill compared to income and cumulative impact of all medical bills from the hospitals. The guidelines in Maryland regulation regarding financial hardship will be followed to determine if a special circumstance is valid.
- AAMC developed an initiative with the Anne Arundel (AA) County Department of Health to help provide free prenatal diagnostic testing for uninsured unregistered immigrants. These individuals are not eligible for any Medicaid program.
- AAMC participates with an AA County specific program (REACH) administered through the AA County Department of Health to provide free care to low income uninsured or under-insured individuals (below 200% of the US Poverty Guideline). These individuals come to AAMC on an elective basis and are prescreened by the local Department of Social Services.
- Diagnostic and Treatment services are provided free of charge to referrals from the AAMC Outreach Free Clinic initiative located in downtown Annapolis.
- Payment plans are interest-free. Payment plans greater than four months will be handled by an external vendor. Payment plans are available to patients regardless of their household income.

Exclusions from Eligibility:

- Services not charged and billed by a Luminis Health Facility listed within this policy are not covered by this policy.
- Cosmetic, other elective procedures, convenience and/or Luminis Health facility services which are not medically necessary, are excluded from this policy.

- The Hospitals exclude assets such as:
 - Equity in the patient's primary residence
 - The first \$15,000 of monetary assets
 - The value of transportation necessary to generate an income
 - Certain retirement benefits such as a 401k where the IRS has granted preferential tax treatment as a retirement account including but not limited to deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans where the patient would pay taxes and/or penalties by cashing in the benefit
- Patients who chose to become voluntary self-pay patients do not qualify for Financial Assistance for the amount owed on any account where they have elected to be self-pay.

Appealing an Unfavorable Decision

- Patients who feel they have been denied financial assistance inappropriately under this policy may contact the Health Education and Advocacy Unit of the Maryland Attorney General's Office.
- Email heau@oag.state.md.us
- Telephone 410-576-6300; En español 410-230-1712
- Address 200 St. Paul Place 16th Floor, Baltimore, MD 21202-2021
- Fax 410-576-6571
- Website <https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx>

Billing:

Patient Statement of Charges:

- A Summary Bill of charges, formally referred to as the Uniform Summary Bill is mailed to every inpatient within 15 days of discharge from the hospital. This contains information on the insurance company billed as well as how to contact the Patient Financial Services office for questions or assistance.
- Uninsured patients receive this Summary as well.
- Each bill for outpatient services includes detail charge information on the first request for payment.
- At any time, the patient may request a copy of their detailed itemized bill.
- The HSCRC required Patient Billing Information sheet data is printed on the Uniform Summary Bill and the back of all patient billing statements.
- A representative list of services and charges is available to the public on the hospital's website and in written form. The website will be updated quarterly with the most recent average charge per case for each of the services.
- Requests and inquires for current charges for specific procedures/services will be directed to the ACP Financial Coordinator or if applicable the specific department Financial Coordinator. The Coordinator will communicate with the patient and the patient's provider of care to provide the best possible estimate of charges. Using the CPT code, service description and/or other supply/hospitalization time charge estimates are based on, a) review of the charge master for the CPT code/service description, and/or b) review of cost of similar surgical procedures/treatments/hospital stays. The patient will be informed cost quotes are estimates and could vary based on the actual procedure(s) performed, supplies used, hospital stay/OR time & changes in HSCRC rates. If the Coordinator requires guidance or additional information to provide the estimate, he/she will contact the Reimbursement Department. Every effort will be made to respond to the request for charges within 2 business days depending on information needed to fulfill the patient's request.

Patient Balance Billing:

- From the point in which it is known that the patient has a balance for which they are responsible the hospital begins billing the patient to request payment.
- Each patient receives a minimum of 4 requests for payment over a 120-day period.
- Each patient bill includes contact information for financial assistance and states where to call to request a payment plan.
- Each bill informs the patient they may receive bills from physicians or other professionals.
- Short- and Long-term interest free payment plans are available. The hospital considers the balance of the bill and the patient's financial circumstances in determining the appropriate agreement.
- Should the patient contact Patient Financial Services Customer Service unit regarding inability to pay – financial assistance is offered, and the financial assistance screening process begins.
- Patients who have made payments to Luminis Health in excess of \$25 and later become eligible for financial assistance on those dates of service will be entitled to a refund of the amount paid.
- Patient complaints about the billing or collection agency process should be directed to the Patient Financial Services general telephone number.

Collection Agency process:

- If there is no indication from the patient or a representative that they cannot pay and no attempt at payment or reasonable payment arrangements is made, the account is referred to a collection agency.
- The collection agency referral would typically occur between 120 – 150 days from the first request to the patient to pay assuming the patient made no attempt to work out payment arrangements or indicated financial need.
- The final statement to the patient communicates the account will be referred to an external agency if the balance is not satisfied.

Collections:

- The Director of Patient Financial Services oversees the hospital's business relationship with the Collection Agency. The Patient Financial Services Department is responsible for determining that reasonable efforts have been made to determine whether an individual is eligible for financial assistance before initiating extraordinary collection actions (ECAs).
- Luminis Health permits the following ECAs:
 - Reporting adverse information about an individual to credit agencies
 - Commencing a civil action against an individual**
- Luminis Health does not allow the following ECAs:
 - Selling an individual's debt to a third party
 - Deferring, or denying, or requiring a payment before providing medically necessary care because of non-payment of one or more bills for previously provided care
 - Placing a lien on an individual's property
 - Foreclosing on an individual's real property
 - Attaching or seizing an individual's bank account or other personal property
 - Causing an individual's arrest

- Causing an individual to be subject to a writ of body attachment
- Garnishing an individual's wages

** Commencing civil action against an individual is not the normal course of collection, however, Luminis Health reserves the right to pursue collections through civil action in extraordinary circumstances, at the discretion of senior management, to include, but not limited to:

- When a patient's receivable is \geq \$5,000 and the patient's ability to pay has been verified
 - When an insurance company confirms payment has been made directly to the patient or patient representative
- If a financial assistance application is received within 240 days of the first post-discharge billing statement, and the account is with a collection agency, the agency will be notified to suspend all ECAs until the application and all appeal rights have been processed.
 - Luminis Health does utilize a credit reporting bureau.
 - Luminis Health does not charge interest to patients.
 - The Luminis Health Business Office staff reviews each case before being referred for legal action.
 - The collection agency is educated on how to make referrals to Luminis Health's financial counseling departments for individuals indicating they have an inability to pay.
 - The collection agency will establish payment arrangements in compliance with Luminis Health's interest free commitment.

Hospital Financial Assistance Communications:

- The Financial Assistance Signage is conspicuously displayed in English & Spanish in each hospital's Emergency Department, Cashiering & Financial Counseling office. Patients desiring to discuss financial assistance in another language may call the contact numbers in this policy and interpretive services will be provided.
- The Financial Assistance Policy as well as a printable Uniform Financial Assistance Application is posted on the hospitals' websites.
- Financial Assistance information is included in each patient guide located in the inpatient rooms.
- Registration staff and Financial Coordinators are trained on how to refer patients for financial assistance.
- The Uniform Financial Assistance Application is available at all registration points in each hospital, including the Emergency Department.
- A brochure "Patient Information Sheet" is available at every patient access point in each hospital and is posted on the Luminis Health website. This brochure includes information regarding financial assistance/contact points and is available in English/Spanish.
- Individual notice regarding the Financial Assistance Policy shall be provided at the time of admission or preadmission to each person who seeks services in the hospital. It is mandatory that all inpatients receive the "Patient Information Sheet" brochure as part of the admission packet.

- Information is available through the patient access/registration staff to provide to the uninsured or any individual concerned about paying their hospital bill directing them to the hospital's Financial Counseling office for assistance.
- Hospital Patient Financial Service staff receive extensive training on the revenue cycle and are incentivized to obtain AAHAM Technical (CRCS) certification to demonstrate their expertise in billing and revenue cycle requirements.

References: Patient Protection and Affordable Care Act statutory section 501 (r)
IRS Notice 2015-46
Department of Treasury, Internal Revenue Service, Additional Requirements for Charitable Hospitals; Volume 77, No. 123, Part II, 26 CFR, Part 1
Maryland Health General Article § 19-214.2

Cross References: None

From: [Crabbs, Christine B](#)
To: [Hilltop HCB Help Account](#)
Subject: RE: Clarification Required - Anne Arundel Medical Center FY 21 Community Benefit Narrative
Date: Thursday, June 9, 2022 3:37:06 PM

[Report This Email](#)

Hello, to answer your question, yes Lowest FPL 301%, Highest FPL 500%, Debt as a Percentage of Income 25%. For reference, in last year's report the hospital answered with Lowest FPL 330%, Highest FPL 500%, Debt as a Percentage of Income 25%.

Thank you.

Christine Crabbs
Director, Community Health

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From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Thursday, May 19, 2022 4:31 PM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>; Crabbs, Christine B <ccrabbs@luminishealth.org>
Subject: Clarification Required - Anne Arundel Medical Center FY 21 Community Benefit Narrative

⚠CAUTION: This email originated from outside of Luminis Health. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Thank you for submitting the FY 2021 Hospital Community Benefit Narrative report for Anne Arundel Medical Center. In reviewing the narrative, we encountered a few items that require clarification.

The responses to Questions 145 and 146 on page 30 of the attached indicate that financial hardship assistance is offered to households up to 300% FPL who have medical debt equal to 50% of household income, whereas the FAP document contains this sentence: *"The guidelines in Maryland regulation regarding financial hardship will be followed to determine if a special circumstance is valid."* As stated in the question, *"Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) 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 confirm that the correct answers to questions 145 and 146 should be Lowest FPL 301%, Highest FPL 500%, Debt as a Percentage of Income 25%. For reference, in last year's report the hospital answered with Lowest FPL 330%, Highest FPL 500%, Debt as a Percentage of Income 25%.

Please provide your clarifying answers as a response to this message.