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?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Northwest Hospital Center, Inc.	◉	○	
Your hospital's ID is: 210040	◉	○	
Your hospital is part of the hospital system called LifeBridge Health	◉	○	
The primary Narrative contact at your hospital is Sharon McClernan	◉	○	
The primary Narrative contact email address at your hospital is smcclernan@lifebridgehealth.org	◉	○	
The primary Financial contact at your hospital is UNKNOWN	○	◉	Julie Sessa
The primary Financial email at your hospital is jsessa@lifebridgehealth.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.

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

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

Northwest Hospital Utilizes the following data sources: -The Robert Wood Johnson Foundation's County Health Rankings and Roadmaps (https://www.countyhealthrankings.org/) - Maryland Department of Health's Vital Statistics and Reports https://health.maryland.gov/vsa/Pages/reports.aspx) - The University of Wisconsin School of Medicine and Public Health's Neighborhood Atlas/Area Deprivation Index Map (https://www.neighborhoodatlas.medicine.wisc.edu/) - Data from the Healthy Communities Institute and can be found at https://healthycarroll.org/lifebridge/

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

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

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

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

☐ 21074	☐ 21152	☐ 21221	☐ 21284
☐ 21082	☐ 21153	☐ 21222	☐ 21285
☐ 21085	☐ 21155	☐ 21224	☐ 21286
☑ 21087			

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

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

  Please view full narrative in "Other" section that follows.

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

  Please view full narrative in "Other" section that follows.

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

  Please view full narrative in "Other" section that follows.

- [x]

Other. Please describe.

Description of Community Served by Northwest Hospital Northwest Hospital (herein referred to as Northwest), is a hospital in northwest Baltimore County with a unique geographic construct, that splits it communitybased footprint across northwest Baltimore City and the suburbs of Baltimore, Carroll and Howard counties. Owned and operated byLifeBridge Health, Northwest is full service, with an emergency room and surgical facilities located at the intersection of Old Court Road and Carlson Lane, west of Liberty Road. Northwest Hospital offers services that range of clinical services that care for medical, surgical, behavioral health, rehabilitative and hospice patients. Its unique facilities have been designed around the Friesen concept, with nursing at the center of care delivery, allowing nurses to spend more time with their patients. Founded in 1964 by Baltimore County residents, as a community hospital, Northwest functions by working to create an environment conducive to caring for its patients and neighbors. As a not-for-profit organization, Northwest Hospital continues its commitment to creating and maintaining an environment where exceptional quality care and service is achieved and recognized by our patients and their families, members of the medical and allied health staffs, employees, volunteers and the communities that it serves. It remains steadfast in its mission to improve the well-being of the community it serves by nurturing relationships between the hospital, medical staff and our patients and their families. Northwest Hospital is located in the Randallstown (21133) community of Baltimore County, serving both its immediate neighbors and others from throughout the Baltimore County region. The community served by Northwest Hospital can be defined by its (a) Primary Service Area (PSA) and (b) Community Benefit Service Area (CBSA), the area targeted for community health improvement. a) The Primary Service Area (PSA) is comprised of zip codes from which the top 60% of patient discharges originate 2. Listed in order from largest to smallest number of discharges for FY 2013, Northwest’s PSA includes the following zip codes: 21133 (Randallstown), 21244 (Windsor Mill), 21207 (Gwynn Oak), 21117 (Owings Mills), and 21208 (Pikesville). The Community Benefit Service Area (CBSA) is comprised of zip codes, or geographic areas, targeted for Community Benefit programming due to the area’s demonstration of need. The five zip codes of Northwest Hospital’s Primary Service Area make up Northwest Hospital’s CBSA. There are significant demographic characteristics and social determinants impacting the health of the community served by Northwest Hospital. Northwest Hospital’s Community Benefit activities fit into the hospital strategic plan as well as the hospital Strategic Transformation Plan. In 2016, LifeBridge Health added a new pillar in its updated strategic plan, focusing on managing the total cost of care. Strategies within this pillar include “prioritizing population health and the continuum of care.” Northwest Hospital’s Community Benefit activities are administered by departments and staff within the Department of Population Health, and are considered crucial to this pillar of the hospital strategic plan.

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

https://www.lifebridgehealth.org/Northwest/AboutNorthwest1.aspx

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

Q37. Section II - CHNAs and Stakeholder Involvement Part 1 - Timing & Format

Q38.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- (●) Yes
- ( ) No

Q39. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q40. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

06/30/21

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

https://www.lifebridgehealth.org/Uploads/Public/Documents/Population%20Health/Northwest%20Hospital%20and%20Baltimore%20County%20CHNA%202020-2021.pdf

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

Northwest Hospital and Baltimore County CHNA 2020-2021.pdf
2MB
application/pdf

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

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

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

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

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										
	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 initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
CB/ Community Health/ Population Health Director (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☐	☐	☐	

	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 initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☑	☑	☑	☑	☑	☐	☐	☐	
Board of Directors or Board Committee (facility level)	☐	☐	☑	☑	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (system level)	☐	☐	☑	☑	☐	☐	☐	☐	☐	☐	
Clinical Leadership (facility level)	☐	☐	☑	☑	☑	☐	☐	☐	☐	☐	
Clinical Leadership (system level)	☐	☐	☑	☑	☑	☐	☐	☐	☐	☐	
Population Health Staff (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Population Health Staff (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Community Benefit staff (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Community Benefit staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Physician(s)	☐	☐	☑	☑	☑	☐	☐	☐	☐	☐	
Nurse(s)	☐	☐	☑	☑	☑	☐	☐	☐	☐	☐	

	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 initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Workers	☐	☐	☑	☑	☑	☐	☐	☐	☐	☐	
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

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

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

Refer to the FY 2021 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is optional for FY 2021, but will be mandatory for FY 2022.

	Level of Community Engagement						Recommended Practices							
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals -- Please list the hospitals here: Greater Baltimore Medical Center, Franklin Square Hospital Northwest Hospital, University of Maryland- St. Joseph Medical Center and Sheppard Pratt	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☐	☐
Local Health Department -- Please list the Local Health Departments here: Baltimore County Health Department	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☐	☐
Local Health Improvement Coalition -- Please list the LHICs here: Baltimore County LHIC	☑	☑	☑	☑	☑	☐	☑	☐	☐	☑	☐	☑	☐	☐

	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
Maryland Department of Health	[x]	[x]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Other State Agencies -- Please list the agencies here:	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Local Govt. Organizations -- Please list the organizations here:	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Faith-Based Organizations	[x]	[x]	[x]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
School - K-12 -- Please list the schools here:	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
School - Colleges, Universities, Professional Schools -- Please list the schools here: Towson University	[x]	[x]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[x]	[ ]	[ ]	[ ]	[ ]	[ ]

	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, 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
Behavioral Health 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
Social Service 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
Post-Acute Care Facilities -- please list the facilities here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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

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

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

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

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

- (●) Yes
- ( ) No

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

6/30/2021

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

https://www.lifebridgehealth.org/Uploads/Public/Documents/Population%20Health/NWH%20Implementation%20Plans%20(July%202021)%20.pdf

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

NWH Implementation Plans (July 2021) .pdf
1.4MB
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.

- [x] Health Conditions - Addiction
- [ ] Health Conditions - Arthritis
- [ ] Health Conditions - Blood Disorders
- [x] Health Conditions - Cancer
- [ ] Health Conditions - Chronic Kidney Disease
- [ ] Health Conditions - Chronic Pain
- [ ] Health Conditions - Dementias
- [x] Health Conditions - Diabetes
- [ ] Health Conditions - Foodborne Illness
- [ ] Health Conditions - Health Care-Associated Infections
- [x] Health Conditions - Heart Disease and Stroke
- [ ] Health Conditions - Infectious Disease
- [x] Health Conditions - Mental Health and Mental Disorders
- [ ] Health Conditions - Oral Conditions
- [ ] Health Conditions - Osteoporosis
- [ ] Health Conditions - Overweight and Obesity
- [ ] Health Conditions - Pregnancy and Childbirth
- [ ] Health Behaviors - Drug and Alcohol Use
- [ ] Health Behaviors - Emergency Preparedness
- [ ] Health Behaviors - Family Planning
- [x] Health Behaviors - Health Communication
- [ ] Health Behaviors - Injury Prevention
- [ ] Health Behaviors - Nutrition and Healthy Eating
- [ ] Health Behaviors - Physical Activity
- [x] Health Behaviors - Preventive Care
- [ ] Health Behaviors - Safe Food Handling
- [ ] Health Behaviors - Sleep
- [ ] Health Behaviors - Tobacco Use
- [x] Health Behaviors - Vaccination
- [x] Health Behaviors - Violence Prevention
- [ ] Populations - Adolescents
- [ ] Populations - Children
- [ ] Populations - Infants
- [ ] Populations – LGBT
- [ ] Populations - Women
- [x] Populations - Workforce
- [ ] Settings and Systems - Community
- [ ] Settings and Systems - Environmental Health
- [ ] Settings and Systems - Global Health
- [ ] Settings and Systems - Health Care
- [x] Settings and Systems - Health Insurance
- [ ] Settings and Systems - Health IT
- [ ] Settings and Systems - Health Policy
- [x] Settings and Systems - Hospital and Emergency Services
- [x] Settings and Systems - Housing and Homes
- [ ] Settings and Systems - Public Health Infrastructure
- [ ] Settings and Systems - Schools
- [x] Settings and Systems - Transportation
- [ ] Settings and Systems - Workplace
- [ ] Social Determinants of Health - Economic Stability
- [ ] Social Determinants of Health - Education Access and Quality

☐ Health Conditions - Respiratory Disease	☐ Populations - Men	☑ Social Determinants of Health - Health Care Access and Quality
☐ Health Conditions - Sensory or Communication Disorders	☐ Populations - Older Adults	☐ Social Determinants of Health - Neighborhood and Built Environment
☐ Health Conditions - Sexually Transmitted Infections	☐ Populations - Parents or Caregivers	☐ Social Determinants of Health - Social and Community Context
☐ Health Behaviors - Child and Adolescent Development	☐ Populations - People with Disabilities	☐ Other (specify)

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.

Q58. Section II - CHNAs and Stakeholder Involvement Part 6 - Initiatives

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.

	Health Conditions - Addiction Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	SBIRT Program	Peer recovery coaches connect SUD patients with treatment and community resources.	500 patients a month	# of interventions, # of referrals to treatment; rate of bup. induction while in the ED
Initiative B	Buprenorphine induction program	Initiate buprenorphine induction in the ED		
Initiative C	Alcohol and drug use screening during primary care visits	Routinely screen patients at primary care visits for alcohol and drug use.		
Initiative D	GBRICS - Greater Baltimore Regional Integrated Crisis System	Provide alternative to ED for individuals in crisis; includes call line.		
Initiative E	Prescription drug take-back	Publicize/provide ability to safely dispose of unused prescription drugs.		
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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	Center for Breast Health	Provide high quality full spectrum breast health services.	Approx 2,600 patient visits per year (NW and Carroll)	Number of patients seen; number of surgeries.
Initiative B	Mammothon - breast cancer screening event			Number of people getting mammograms
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.

This question was not displayed to the respondent.

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	Diabetes Medical Home Extender Program	Provide comprehensive care coordination for patients with chronically unmanaged diabetes and help resolve psychosocial barriers preventing patients from utilizing primary care. Ensure patients have appropriate medications, transportation, and home support services.		
Initiative B	Diabetes wellness education	Focus on Diabetes Wellness and Prevention throughout LBH service areas; partnership with Diabetes Resource Centers and Local ADA chapter		
Initiative C	Diabetes Wednesdays educational calls	Weekly series with classes with Diabetes Educator on various subjects pertinent to managing diabetes		
Initiative D	Endocrinologist-led Webinar education series for Primary Care Providers: Diabetes best practice management	Endocrinologists educate LBH primary and specialty care providers on best practice for diabetes pt management.	20-40 providers attending each of the 6 Endocrinologist-led webinars	Primary care provider attendance
Initiative E	Diabetes Patient Guide (new) developed and distributed	Ensure individuals with diabetes have knowledge to best manage diabetes and their overall health	Guidebooks distributed to LifeBridge primary care offices throughout Baltimore City and County.	
Initiative F	Community Mobile Health Clinic	Mobile health initiative reaches traditionally underserved communities that face a variety of access and other SDOH barriers. Groups are typically at higher risk for chronic disease and potentially avoidable hospital utilization.		Referrals to providers and social resources.
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	Telemonitoring Program	To improve the quality of care, patient outcomes, and reduce hospital utilization for patients with chronic diseases by improving patient-provider communication, improving coordination of care, and improving time of follow up with PCP		Hospital utilization pre and post implementation of telemonitoring program.
Initiative B	Cardiologist-led Webinar education series for Primary Care Providers: Heart Failure best practice management	Cardiologists educate LBH primary and specialty care providers on best practice for cardiac pt management.	30-45 providers attending each of the 6 Cardiologist-led webinars	Primary care provider attendance
Initiative C	Heart Failure Patient Guide (new) developed and distributed	Ensure individuals with diabetes have knowledge to best manage heart failure and their overall health	Guidebooks distributed to LifeBridge primary care offices throughout Baltimore City and County.	
Initiative D	Community Mobile Health Clinic	Mobile health initiative reaches traditionally underserved communities that face a variety of access and other SDOH barriers. Groups are typically at higher risk for chronic disease and potentially avoidable hospital utilization.		Referrals to providers and social resources.
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.

This question was not displayed to the respondent.

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	Screening for Depression in Primary Care	Identify depression during primary care appointments and provide follow-up if needed.		% of primary care patients screened with PHQ-2/9 annually.
Initiative B	GBRICS - Greater Baltimore Regional Integrated Crisis System	Improve access to appropriate support for individuals in behavioral health crisis.		
Initiative C	ED Navigation	Reduce readmission rates by seeing patients who are frequent utilizers of ER defined by at least 3 times in 4 months; and those who are likely to come back to ER within 30 days and be admitted to hospital	Approx. 300-400 patients per month.	Performing short term case management; patients who do not return to ER within 30 days of contact, also that patients were linked to medical PCP or specialist
Initiative D	Ambulatory Care Management	Care management services for high-risk community members. Collaboration with internal and external mental health practices; referrals to community resources	More than 10,000 patients worked with per year.	Successful linkage to resources and compliance with engagement with resource.
Initiative E	Integrated Behavioral Health Services with Primary Care Providers	As part of MDPCP program, working to identify a network of providers who will work with LBH Clinically Integrated Network for behavioral health services.		
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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

This question was not displayed to the respondent.

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.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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	Community Health Education Team	Prioritizing health education needs in the community and providing Health, Wellness, and Prevention education events, classes and risk assessments; connecting participants to resources to maintain health, and with medical providers and/or other programs.	929 in-person attendees. 793 via telelearning.	Attendance, Behavior change, knowledge gained (self-report), also healthcare system engagement
Initiative B	PPE and IP/IC Education/Training	Facility/staff PPE training, IP/IC site assessments, and centralized training for MDH/MHA.	Over 1,000 trained.	Increased rate of transmission-based precautions and reduced staff/patient positivity. HSCRC LTC metrics and ad-hoc assessments with county/city Departments of Health.
Initiative C	Live Life Healthy	Cover various health topics in an innovative way to include elements of game shows, quizzes, and health talks	123 participants since Oct 2020.	attendance, lifestyle change, engagement with health care system
Initiative D	Mental Health Mondays	Partnership with Mental Health practitioners in the area as well as LBH staff to offer classes on various mental health topics, created at the request of community members and faith leaders in our service areas.	166 participants since Oct 2020.	attendance, lifestyle change, engagement with health care system
Initiative E	TeleLearning - Faith Edition	Education on various topics geared towards faith leaders in our communities to aid in forming congregational plans, wellness ministries, and health-related activities in faith-based organizations.		attendance, lifestyle change, engagement with health care system
Initiative F	Work Out Wednesdays	TeleLearning program focused on physical activity with instructions for various types of exercises		attendance, lifestyle change, engagement with health care system
Initiative G	Community Pastoral Outreach	Community Pastoral Outreach provides nurturing and supportive leadership with members of the faith community within LifeBridge Health's catchment area and beyond. Specifically, Community Pastoral Outreach is the resident faith liaison for the hospital system; assists congregations (all faiths) with developing health and wellness ministries; provide community pastoral care with participants of established programs of Community Initiatives (spiritual advisement, prayer, encouragement); help faith communities develop workshops, seminars, classes in relation to faith and health along with specific health concerns; explore opportunities for partnership with faith communities and LifeBridge Health; engage in faith relations (local governments, nonprofits, colleges & Universities, etc) througout LBH service areas.	143 participants for Sinai area in FY2020; 43 via telelearning	attendance, lifestyle change, engagement with health care system
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.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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	Community Health Screening Events	Provide screenings and risk assessments at mutiple locations throughout the LBH service areas, reaching all outreach markets, working with local businesses and organizations based on prioritized needs. Collaborating with LBH call center to provide follow-up, also providing real time nurse consultations.	89 individuals screened in NW service area	Attendance, number of people reached for follow-up by call center, decrease in ER visits
Initiative B	Post-Acute COVID Testing	Community-based clinical touches covering COVID testing. Vaccinations, chronic disease prevention and identification, and various other use cases for LBH Mobile Health.	Up to 150/week in-facility	
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.

This question was not displayed to the respondent.

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	LBH Mobile Health	Clinical mobile health initiative reaches traditionally underserved communities that face a variety of access and other SDOH barriers. Groups are typically at higher risk for chronic disease and potentially avoidable hospital utilization.		
Initiative B	Live Chair barbershop/salon partnerships	Live Chair is a business partner that works with a network of barbershops and salons in the Baltimore area to support increased health screenings, prevention, and better access to health care for traditionally underserved populations.		
Initiative C	Population Health Community Vaccination	Community-based clinical touches covering COVID vaccinations, testing, and various use cases for LBH Mobile Health		
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	Hospital Domestic Violence Response	The Domestic Violence Program at Northwest Hospital (DOVE), the only domestic violence program in Northwest & Western Baltimore County, receives referrals of domestic violence victims from the hospital, individuals and organizations in the community and Baltimore County Police. Connects survivors of domestic violence to shelter, counseling, legal services, and case management.	1,500 annually; 346 nights of shelter; 1,000+ legal services	number of clients; feedback; future ACE/Resilience/Hope assessment.
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.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

	Populations - Workforce Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Northwest Academy for Health Professions	Supports community workforce development in health professions.		
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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.

This question was not displayed to the respondent.

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	Insurance Counseling	Assist patients with insurance signups through the Maryland Health Benefit Exchange.		
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 Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	SBIRT Program	Peer Recovery Coaches support patients with substance use disorder to promote recovery and connect patients to community resources (OSOP included) and treatment options (BUP included)	Approximately 300-400 patients per month served at Northwest	Number of patients served.
Initiative B	ED Navigation	Reduce readmission rates by seeing patients who are frequent utilizers of ER defined by at least 3 times in 4 months; and those who are likely to come back to ER within 30 days and be admitted to hospital	Approximately 300-400 patients per month served at Northwest	Number of short term case management services performed; patients who do not return to ER within 30 days of contact; patients linked to medical PCP or specialist
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.

	Settings and Systems - Housing and Homes Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Housing Upgrades to Benefit Seniors (HUBS)	Improve living conditions to reduce injuries and chronic disease exacerbations (e.g., grab bars, air conditioners, address mold, lead paint, radon)	75 First Time Clients a Year. 200+ repairs/services provided a year.	
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

	Settings and Systems - Transportation Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Ambulatory Care Management	Care management services to address social needs for high-risk community members, including coordination of transportation to medical appointments and social services.		Successful linkage to resources and compliance with engagement with resource.
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				

Initiative J				
All Other Initiatives				

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.

	Social Determinants of Health - Health Care Access and Quality Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Ambulatory Care Management	Care management services for high-risk community members. Collaboration with internal and external mental health practices; referrals to community resources; coordination of transportation to medical appointments and Social Services.		Successful linkage to resources and compliance with engagement with resource.
Initiative B	Collaboration with community faith-based organizations	Partnering with community faith-based groups to improve residents' access to health education and services.		
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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.

This question was not displayed to the respondent.

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 - Addiction, Health Conditions - Cancer, Health Conditions - Diabetes, Health Conditions - Heart Disease and Stroke, Health Conditions - Mental Health and Mental Disorders, Health Behaviors - Health Communication, Health Behaviors - Preventive Care, Health Behaviors - Vaccination, Health Behaviors - Violence Prevention, Populations - Workforce, Settings and Systems - Health Insurance, Settings and Systems - Hospital and Emergency Services, Settings and Systems - Housing and Homes, Settings and Systems - Transportation, Social Determinants of Health - Health Care Access and Quality
Other:

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

This question was not displayed to the respondent.

Q132. Why were these needs unaddressed?

This question was not displayed to the respondent.

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

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.

- [x] Yes, by the hospital's staff
- [x] 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.

The community benefit narrative is reviewed regularly by the health system's Community Benefit Committee that makes recommendation for approval of the Community Benefit Report by the LifeBridge Health Community Mission Committee of the LifeBridge Health Board.

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.

The Community Health Needs Assessment results are prioritized by community leaders and system leadership. A Community Benefit plan is created from this prioritization process. The community benefit plan is used to identify needs and priorities for the organizational strategy.

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.

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

This question was not displayed to the respondent.

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.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q140. Section VI - Financial Assistance Policy (FAP)

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

LBH Financial Assistance Policy English 012821.pdf
277.4KB
application/pdf

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

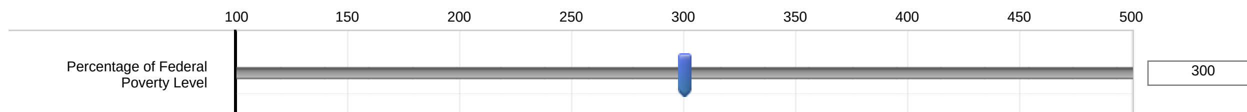
https://www.lifebridgehealth.org/Main/LifeBridgeHealthFinancialAssistance.aspx

Q147. Has your FAP changed within the last year? If so, please describe the change.

- (selected) No, the FAP has not changed.
- Yes, the FAP has changed. Please describe:

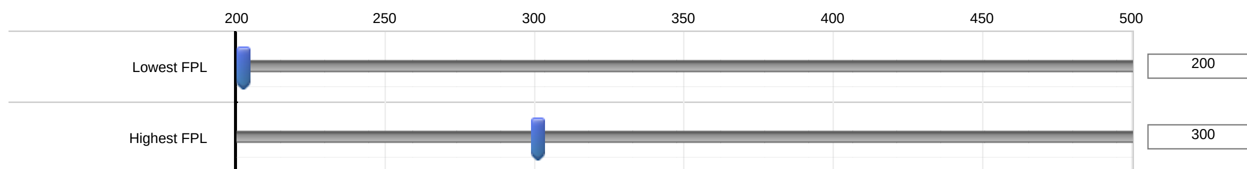
Q143. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



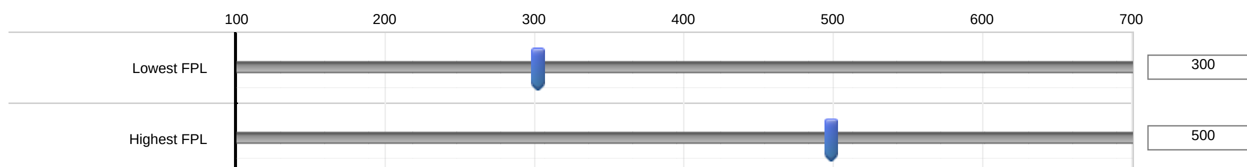
Q144. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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



Q145. 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 select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship.



Q146. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.

Debt as Percentage of Income	25

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)

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

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.

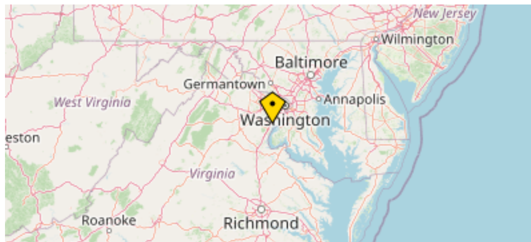
We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can 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: (38.658294677734, -77.248100280762)

Source: GeoIP Estimation



LifeBridge Health

Northwest Hospital

Community Health Needs Assessment

2021

EXECUTIVE SUMMARY

Located in Randallstown, Northwest Hospital is a 253-bed facility licensed in the state of Maryland providing acute, primary and specialty care services to residents of communities across the north and west sides of Baltimore City and Baltimore County as well as Carroll and Howard counties. In addition, Northwest Hospital has built nearby facilities that offer convenient outpatient surgery, adult day care and physical rehabilitation services.

Northwest Hospital is part of LifeBridge Health, Inc. which also includes Grace Medical Center in southwest Baltimore, Sinai Hospital and Levindale Hebrew Geriatric Center and Hospital in Baltimore City, and Carroll Hospital in Carroll County.

2021 Community Health Needs Assessment

Approach and Methodology

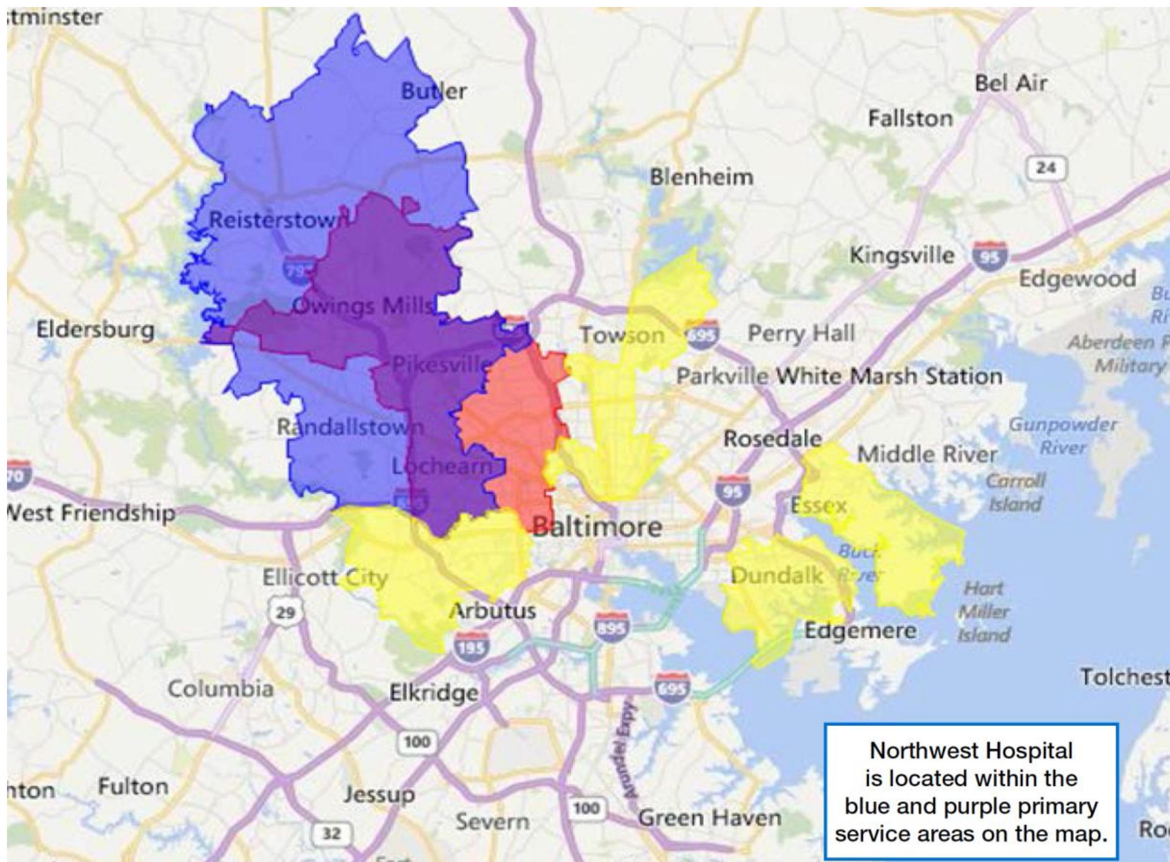
Northwest Hospital (Northwest) participated in a collaborative Community Health Needs Assessment (CHNA) for Baltimore County in 2020-21. The Baltimore County Department of Health, Northwest Hospital of LifeBridge Health, Sheppard Pratt, Greater Baltimore Medical Center, University of Maryland St. Joseph Medical Center, and MedStar Franklin Square made up the “Collaborative”, and representatives from each of these organizations worked together as the CHNA Steering Committee to guide the development of this CHNA.

These organizations provided the focus group and survey data that are further analyzed in this report. The CHNA process examines the overall health needs of the residents of Baltimore County and allows the county to continuously evaluate how best to improve and promote the health of the community. The Collaborative utilized the services of Ascendient Consulting to gather secondary data and analyze survey and focus group input. Several inputs and analyses captured responses particular to the Northwest service area. They are referenced in this Executive Summary.

Description of Community Served

Northwest Hospital's CHNA service area includes the following zip codes: 21207, 21208, 21117, 21133, 21244, and 21087. (represented by the blue and purple areas of the following map).

Northwest Hospital Service Area



Demographic Highlights

Category	Northwest Service Area	Baltimore County, US Census Bureau 2019
Population	2010 Census: 205,888 2016 Census: 219,106 2019 Census: 218,526	2019: 827,370
Gender	Female: 54% Male: 46%	Female: 53% Male: 47%
Race	Black/African American: 62% White: 26% Asian: 4.5% Multiple Races: 2.1%	Black/AA: 30% White: 60% Asian: 6.3% Multiple Races: 2.6%
Ethnicity	Hispanic/Latinx: 5.0%	Hispanic/Latinx: 5.8%
Age	Under 18: 21.0% 18 to 64: 62.4% 65 and Older: 16.6%	Under 18: 27.5% 18 to 64: 54.9% 65 and Older: 17.6%

The population of the service area for Northwest Hospital has grown by 6.13 percent over the past decade, while the population of Baltimore County as a whole has grown by only 2.77 percent. Northwest's service area has a significantly greater percentage of Black/African-American residents compared to the County, and a smaller percentage of "Under 18" population when compared to the county-wide demographic.

Impact of 2018 – 2020 Northwest Hospital Implementation Strategy

Category: Health Concerns; ***Prioritized Need***: Chronic Disease

In response to the prioritized need of chronic disease, the Office of Community Health Improvement implemented the Diabetes Wellness Series. This education series offered education on the treatment strategies and self-management of Diabetes for patients and

family members. Also included in the curriculum is information on pre-diabetes, medication management, food, physical activity and healthy lifestyle choices. We partnered with various community organizations, American Diabetes Association, Maryland Department of Health, Baltimore County Department of Health and Human Services, Northwest Hospital's Diabetes Resource Center, and many others. Between July 2017 and March 2020, there were 50 in-person classes offered serving 116 people. 96% of attendees surveyed indicated that they would institute lifestyle changes and behavioral changes based on the information heard and received during events.

Category: Health Concerns; ***Prioritized Need***: Chronic Disease

In response to the prioritized need of chronic disease, the Office of Community Health Improvement continued the Changing Hearts Program (through June 2019) to maintain and improve behavioral and biometric outcomes connected to heart disease. 172 total community members were served. Various aspects of the program continued after June 2019 through March 2020. Components included but were not limited to providing on-going support to facilitate lifestyle change; improve quality of life, smoking status, healthy eating practices and physical activity. The program also held regular education sessions and shared materials to improve biometric elements such as blood pressure, fasting blood sugar, body mass index, and cholesterol levels. We partnered with many organizations throughout the communities including the American Heart Association, Baltimore County Department of Health and Hunan Services, Baltimore County Department of Recreation and Parks, Baltimore Department of Aging, and Baltimore County Public Library. 72% of program participants presented with either pre-hypertension and either Stage One or Stage Two Hypertension as defined by the American Heart Association. Of those completing the program, 46% demonstrated an improvement in their blood pressure compared to the beginning measurement. 85% presented as overweight or obese and after completing the program 14% had an improvement in their BMI compared to the beginning measurement. 74% of participants presented as pre-diabetic or diabetic according to their fasting blood glucose measurements. 30% demonstrated improvement in their fasting blood sugar upon completion of the program. 62% presented with cholesterol numbers that were above normal, with 14% of individuals demonstrating an improvement in cholesterol levels upon program completion. 96% of program participants reported making healthier lifestyle choices regarding diet, activity, communication with healthcare providers and smoking status (28% began smoking cessation programs). Upon conclusion of the Changing Hearts Program, in-person screening and risk assessment activities continued (June 2019-March 2020) serving 446 people during which time 98% of those surveyed committed to and/or reported making healthier lifestyle choices based on the results of their assessment and education provided.

Category: Access to Health Care; ***Prioritized Need***: Health Education/Knowledge of Available Resources

In response to the prioritized needs of health education and the knowledge of available resources the Office of Community Health Improvement increased staff to expand reach into surrounding communities. The addition of the Community Pastoral Outreach Coordinator (Nov. 2017) and additional Health Educators (July 2017-June 2019 and Jan. 2020-present) allowed for the increase in health events and expansion of topics. In addition to illness and prevention related topics, information was added on the connection between faith and health; and the inclusion of more information on community resources facilitated more access. Staff hours for workshops FY18-FY20 (health fairs and other in-person events through March 2020) increased by 51% compared to the previous CHNA cycle (FY15-FY17). The overall number of people receiving health education increased by 34% during the same timeframe (including a 12% increase in the faith-based partners) compared to the previous cycle. Coalition building saw an increase of 98% as our Community Pastoral Outreach Coordinator facilitated better, more collaborative relationships with our surrounding faith communities.

Key Findings and Analysis for Baltimore County

Secondary data collection included the analysis of over 100 data indicators at the county-level. Data were collected from numerous sources, including:

- Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings (63)
- Maryland Department of Health, State Health Improvement Process (SHIP) (28)
- Maryland Department of Health, Maryland Youth Risk Behavior Survey & Youth Tobacco Survey (YRBS/YTS) (2)
- MedStar Health, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting (13)
- The Opportunity Atlas, U.S. Census Bureau, Harvard University, and Brown University (1)

Forty-six (46) key informant surveys and seventeen (17) focus groups were conducted throughout the county, and 1,755 resident surveys were completed.

The CHNA identified nine areas whose data, focus group input, stakeholder interviews, and survey responses generated the weighted average need. Those conditions in order of importance are – Physical Health, Safety, Substance Use disorders, Food Security,

Access to Care, Income, Mental Health, Built Environment, and Transportation Options and Transit.

Key Secondary Data Findings

Chronic Disease

- The age-adjusted death rate due to stroke per 100,000 for Baltimore County was 45.0 compared to the Maryland wide rate of 40.0
- The mortality rate for heart disease per 100,000 for Baltimore County was 179.3 versus 166.4 for Maryland
- The age-adjusted death rate due to cancer per 100,000 for Baltimore County was 168.0 compared to the Maryland wide rate of 155.0

Safety

- Injury mortality per 100,000 population (95.0 in Baltimore County, 76.0 in Maryland)
- Juvenile arrests per 1,000 (41.0 in Baltimore County, 29.0 in Maryland)
- Violent crime rate per 100,000 population (511.0 in Baltimore County, 459.0 in Maryland)

Substance Use Disorders

- Drug overdose deaths per 100,000 (50.0 in Baltimore County, 37.0 in Maryland)
- Opioid prescriptions dispensed per 100 persons (53.0 in Baltimore County, 45.0 in Maryland)

Food Security

- Percentage of households with children experiencing food insecurity (26% in Baltimore County, 16% in Maryland)

Income

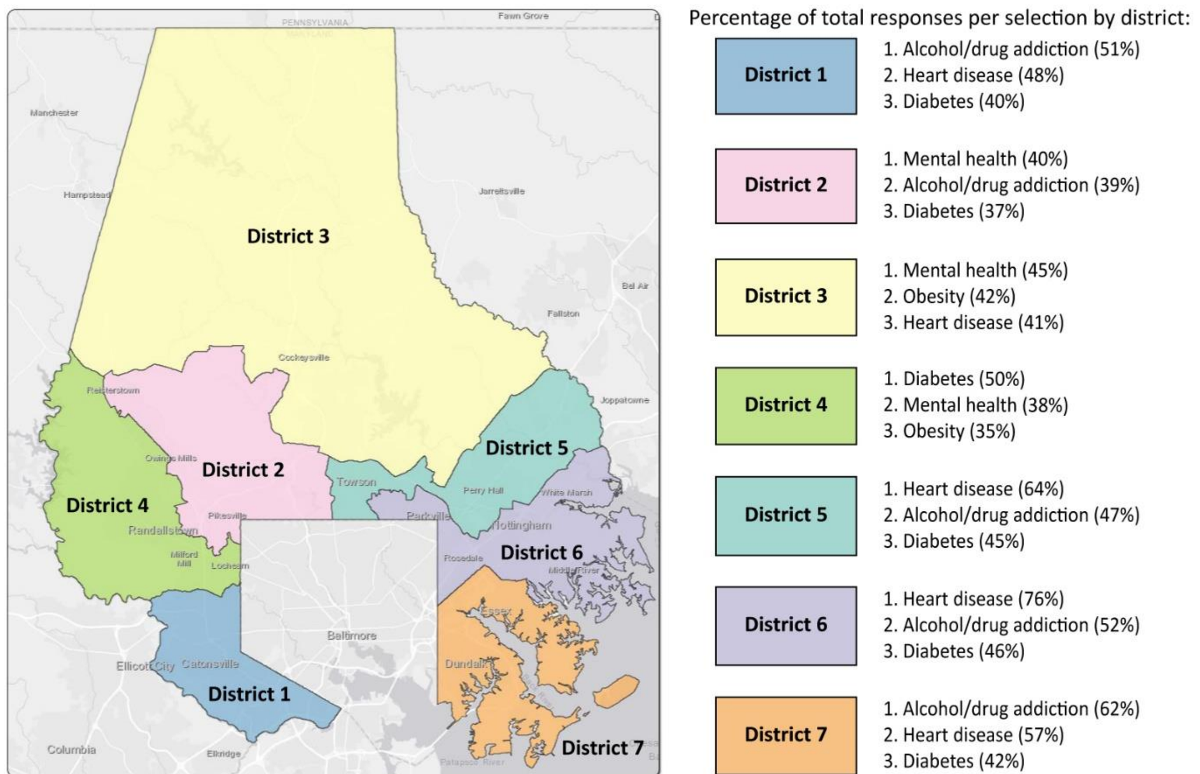
- Percentage of children in poverty (13% in Baltimore County, 12% in Maryland)

Transportation Options and Transit

- Percentage of the workforce that drives alone to work (79% in Baltimore County, 74% in Maryland)

Health Disparities

Several health disparities by geography and by race across Baltimore County were reflected in the county-wide survey. A mapping by geographic District of responses to the survey question "What are the three **most important health problems** affecting the health of your community?", is shown below. Districts 2 and 4 primarily reflect the service area of Northwest Hospital. Diabetes, Mental Health, Alcohol and Drug addiction, and Obesity received the most responses.



When survey participants from the various geographic districts were asked "What are the three most important **social/environmental problems** affecting the health of your community?", respondents from Districts 2 and 4 listed most frequently – Lack of Job Opportunities, Neighborhood Safety, Race/ethnicity discrimination, Access to Physician offices, and Poverty.

When the Baltimore County survey responses were analyzed by race, the most significant concerns for Black/African-American respondents were Lack of Job Opportunities, Neighborhood safety, and Availability or Access to Insurance. For White respondents the priorities were Insurance, Neighborhood Safety, and Affordable Child Care (see table below).

Top 5 Responses	Black/African American	White	Other, No Answer	Total
Neighborhood safety/violence	32%	24%	25%	27%
Availability/access to insurance	26%	25%	21%	24%
Lack of job opportunities	33%	16%	20%	21%
Availability/access to doctor's office	24%	16%	24%	20%
Lack of affordable child-care	21%	20%	17%	19%
Count	437	921	335	1,693

Focus Groups and Stakeholder Involvement

In addition to the key informant surveys and focus groups across Baltimore County, Northwest Hospital and its companion LifeBridge Health facilities conducted focus groups as well as conversations with key stakeholders within the primary service areas. Representatives included community leaders, associations, as well as expressed demographic groups – those with disabilities, re-entry residents, and Spanish-speaking employees. Four stakeholder interviews and four focus groups were conducted between August 2020 and November 2020.

Participants highlighted the following themes as **top health concerns**:

- High Blood Pressure, Diabetes, and High Cholesterol
- Mental Health and Illness, Depression, Loneliness
- Drug and Alcohol Addiction, Substance Abuse

The leading **social and environmental barriers** referenced were:

- Unemployment, Poverty, as well as Crime and Trash
- Lack of Transportation
- Safety across the community
- Lack of open space, recreation, and a sense of community
- Language barriers

The top **reasons for not accessing healthcare** services included:

- Lack of Insurance, and underlying lack of funds
- A distrust in the healthcare system and corresponding misinformation and perceived discrimination
- Delays in receiving care, more timely care needed
- Lack of education
- Lack of transportation and distance from doctors

Survey Responses

A web-based and hardcopy survey instrument was distributed in 2020 to collect information from Baltimore City residents regarding their health and social needs. Two hundred seventy-seven respondents were from the Northwest service area. Sixty-four percent (64%) were female and eighty percent (80%) were Black/African-American.

The most important problems that affect the health of the community are:

- Alcohol/Drug addiction – 58 percent of respondents
- Mental Health (Depression/Anxiety) – 43 percent
- Diabetes/High Blood Sugar – 31 percent

The most important social/environmental problems that affect the health of the community are:

- Lack of Job Opportunities – 35 percent of respondents
- Housing/Homelessness – 29 percent
- Poverty – 18 percent

Northwest Hospital Identified Health Needs and Priorities

In 2018, Northwest Hospital identified and prioritized the following health needs in the community:

- Behavioral Health/Substance Abuse
- Chronic Disease, Diabetes
- Chronic Disease, Cardiovascular
- Workforce Development
- Community Health Education
- Access to Insurance

In 2021, the six needs (above) remained as **Identified Needs** of the community, and six additional needs (in green boxes below) were added.

Identified Needs of Community Served

Behavioral Health Substance Abuse	Chronic Condition, Cardiovascular	Chronic Condition, Diabetes
Community Health Education	Access to and Cost of Insurance	Workforce Development, Income
Mental Health and Depression	Safety	Health Disparities
Food Insecurity	Built Environment	Transportation

The Northwest Hospital CEO and CHNA leadership met with representatives of the Northwest Hospital Board, Leadership team, key community stakeholders, and the LifeBridge Health Community Mission Committee members on April 26, 2021, to review findings of the CHNA and to seek recommendations to prioritize the identified needs

above. Following review of secondary and survey data, as well as findings of the interviews and conducted focus groups, the participants were asked to select those identified needs for which there was **"High Need"** (significance and prevalence) and **"High Feasibility"** (ability to impact).

The following Identified Needs were selected as **Priorities** for Northwest Hospital and will be included in the 2021 – 2024 Implementation Plan:

1. Chronic Heart Disease
2. Mental Health and Depression
3. Community Health and Wellness Education
4. Diabetes
5. Health Disparities

Northwest Hospital leadership anticipates the 2021 – 2024 Implementation Plan will address these needs in conjunction with both LifeBridge Health resources and with well-established community partners and organizations.

Northwest Hospital will also support the work of Baltimore County agencies as well as the CHNA Collaborative health systems and community organizations to address and advocate for solutions to additional Identified Needs not prioritized in its Implementation Plan.

Baltimore County

2020-2021

Community Health Needs Assessment

Healthy people living, working, and playing in Baltimore County

ACKNOWLEDGEMENTS

This Community Health Needs Assessment (CHNA) represents the culmination of work completed by multiple individuals and groups. The Baltimore County Department of Health (BCDH) and local health systems including Northwest Hospital of LifeBridge Health, Sheppard Pratt, Greater Baltimore Medical Center Healthcare (GBMC), the University of Maryland St. Joseph Medical Center (UM SJMC), and MedStar Franklin Square Medical Center (MedStar Franklin Square) have served an integral role in making this comprehensive assessment possible and will be referred to as the Collaborative throughout this CHNA. The Collaborative would like to extend its gratitude to all the focus groups participants, key community health leaders, and community members who provided information used in the development of this assessment. In addition, the Collaborative would specifically like to thank the following members of the CHNA Steering Committee who provided their time and knowledge throughout the entirety of this process:

Name	Title	Organization
D'Ambra Anderson	Population Health Data Analyst	GBMC
Kristen Artes	Community Outreach Manager	The University of Maryland St. Joseph Medical Center
Laura Culbertson	Chief, Office of Quality Improvement	Baltimore County Department of Health
Sarah Fogler	Senior Director of Population Health	GBMC
Dorothy L. Fox	Executive Director and CEO	LifeBridge Health
Thomas B. Glenn	Director of Strategy and Business Development	Sheppard Pratt
Leah Gutermuth	Population Health Program Manager	GBMC
Patricia Isennock	Administrative Director of Population and Community Health	MedStar Franklin Square
Della Leister	Deputy Health Officer	Baltimore County Department of Health
Sharon McClernan	Vice President of Clinical Integration	LifeBridge Health

Additionally, the Collaborative would like to recognize Ascendient Healthcare Advisors for its efforts in directing this process and drafting the content of this Community Health Needs Assessment.

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INTRODUCTION

Background

To further illustrate its commitment to the health and well-being of the community, the Collaborative completed this assessment to understand and document the greatest health needs currently faced by its residents. BCDH, Northwest Hospital of LifeBridge Health, Sheppard Pratt, GBMC, UM SJMC, and MedStar Franklin Square make up the Collaborative, and representatives from each of these organizations worked together as the CHNA Steering Committee to guide the development of this CHNA. These organizations provided the focus group and survey data that are further analyzed in this report. In addition, MedStar Franklin Square provided some existing data from their FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting that are utilized in this report. The CHNA process examines the overall health needs of the residents of Baltimore County and allows the county to continuously evaluate how best to improve and promote the health of the community. While each of these organizations has historically assessed the health needs of the community and responded accordingly, this CHNA is a more formal and collaborative approach by community partners to proactively work together to identify and respond to the needs of Baltimore County residents.

Process Overview

A significant amount of information has been reviewed during this planning process, and the CHNA Steering Committee has been careful to ensure that a variety of sources were used to deliver a truly comprehensive report. Assessment methods included both existing (secondary) data as well as new (primary) data that were collected directly from the community throughout this process. It is also important to note that, although unique to Baltimore County, the sources and methodologies used to develop this report comply with the current standards and measures of the Public Health Accreditation Board (PHAB) and IRS requirements for nonprofit hospital organizations.

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

- Identify the health needs of Baltimore County residents.
- Understand racial and geographic health disparities that exist in Baltimore County.
- Understand the challenges residents face when trying to maintain and/or improve their health.
- Understand where underserved populations turn for services needed to maintain and/or improve their health.
- Understand what is needed to help residents maintain and/or improve their health.
- Prioritize the needs of the community and clarify/focus on the highest priorities.

There are ten phases in the CHNA process. Results of the first seven phases are discussed throughout this assessment and the development of community health action plans and subsequent phases will take place in the near future.

Report Structure

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

1) *Evaluation of Prior CHNA Implementation Strategies* **–** This chapter provides a reflective summary on the progress made towards addressing the priority health needs identified in the previous CHNAs developed by the organizations that make up the Collaborative.

2) *Methodology* – The methodology chapter provides an overall summary of how the priority health need areas were selected as well as how information was collected and incorporated into the development of this CHNA, including study limitations.

3) *County Health Profile* **–** This chapter details the demographic data (such as age, gender, and race) and socioeconomic data of Baltimore County residents.

4) *County Priority Health Need Areas* – This chapter describes each identified priority health need area for Baltimore County and summarizes the new and existing data that support these prioritizations. This chapter also describes the impact of health disparities among racial and geographic sub-groups in Baltimore County.

5) *Health Resource Inventory* – This chapter documents existing health resources currently available to the Baltimore County community.

6) *Next Steps* **–** This chapter briefly summarizes the next steps that will occur to address the priority health need areas discussed throughout this document.

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

1) *County Demographic and Socioeconomic Data* – Information regarding the population characteristics (such as age, gender, and race) as well as the Community Need Index rankings of Baltimore County are presented in Appendix 1.

2) *Detailed Summary of Existing (Secondary) Data Measures and Findings* – Existing data measures and findings used in the prioritization process are presented in Appendix 2.

3) *Detailed Summary of New (Primary) Findings* – Summaries of new data findings from community and key community health leader surveys as well as focus groups are presented in Appendix 3.

Summary Findings: Baltimore County Priority Health Need Areas

To achieve the study objectives, both new and existing data were collected and reviewed. New data included information from internet-based surveys and focus groups; various local organizations, community members, and health service providers within Baltimore County participated. Existing data included information regarding the demographics, health and healthcare resources, behavioral health, disease trends, and county rankings of Baltimore County. The data collection and analysis process began in June 2020 and continued through to the development of this document.

Given the size of Baltimore County, both in geography and population, significant variations in demographics and health needs exist within the county. At the same time, consistent needs are present across the whole county and thus serve as the foundation for determining priority health needs at the county level. This document will discuss the priority health need areas for Baltimore County, as well as how the severity of those needs might vary across racial and geographic sub-groups based on the information obtained and analyzed during this process.

Through the prioritization process discussed in this document, the CHNA Steering Committee identified Baltimore County's priority health need areas from a list of over 100 potential health needs. Please note that the final priority need areas were not ranked in any hierarchical order of importance and all will be addressed by the Collaborative and the Local Health Improvement Coalition (LHIC). After analysis of all relevant data and discussions with the CHNA Steering Committee, the following three focus areas have been identified as county-wide priorities for the 2020-2021 CHNA:

Priority Health Need Areas

- Behavioral Health, including Mental Health and Substance Use Disorders
- Physical Health
- Health Disparities

The process used to prioritize findings in this assessment are discussed later in the report. It is important to note that health, healthcare, and associated community needs rarely exist in a vacuum. Instead, they are very much interrelated with each other, with improvements in one driving advancements within another. As such, although it was necessary for this process to separate the various areas for purposes of measuring need, the interrelationship should be acknowledged as improvement initiatives are considered going forward.

Further, many health needs are the result of underlying societal and socioeconomic factors. Many studies show that factors such as income, education, and the physical environment affect the health status of individuals and communities. This CHNA acknowledges that linkage and focuses on identifying and documenting the greatest health needs as they present themselves today. As strategic and health improvement plans are developed to address these needs, it is clear that the Collaborative's goal is to work with other community organizations to address more systemic factors that have the potential for long-term improvements to the population's health.

CHAPTER 1 | EVALUATION OF PRIOR CHNA IMPLEMENTATION STRATEGIES/ACTION PLANS

A Community Health Needs Assessment (CHNA) is an ongoing process that begins with the evaluation of the previous CHNA. Previously, each organization making up the Collaborative completed its own assessment process and report. Below is a summary evaluation of each Collaborative organization's implementation plan from its prior assessment. To avoid the development of multiple CHNAs and the duplication of efforts among various agencies, the organizations making up the Collaborative decided that the development of a joint 2020-2021 CHNA and expansion of existing efforts to work together to impact priority need areas would be most efficient moving forward.

Baltimore County Department of Health

BCDH's FY2021 Community Health Improvement Plan (CHIP) addresses the following priority areas: access to care, behavioral health, and chronic disease. Due to challenges related to the COVID-19 pandemic, some planned action items have not yet been conducted. However, BCDH has successfully increased access to care through expanded use of bilingual staff and enhanced cultural competencies in surveys and focus groups. To address behavioral health concerns, BCDH has held Narcan trainings (including virtual trainings) and provided access to Narcan kits, developed new peer case manager positions, and tracked the number of clients placed in behavioral health treatment programs. As part of its strategy related to chronic disease, BCDH and the Fetal and Infant Mortality Community Action Team (FIMR CAT) have conducted case reviews to promote healthy pregnancies and birth outcomes.

Northwest Hospital of LifeBridge Health

Northwest Hospital's 2018-2020 implementation plan addressed the following priority areas: chronic disease, health education/knowledge of available resources, medical insurance, workforce development, and its relationship with Chase Brexton Primary Care. To address these respective issues, the Office of Community Health Improvement has implemented the Diabetes Wellness Series, continued the Changing Hearts Program, increased staff to expand reach into surrounding communities, trained staff to assist patients with navigating and applying for Medicaid health insurance, utilized Sinai Hospital of Baltimore's vocational services and workforce readiness program (VSP) for training and workforce development services, and strengthened existing partnerships with Chase Brexton to increase access for patients needing behavioral health services.

Sheppard Pratt

Sheppard Pratt's 2019 Implementation Plan addresses priority areas related to behavioral health including mental health and substance use disorders. Sheppard Pratt Leadership met to determine which identified needs fall within its purview to impact as a behavioral health provider and to discuss which of the organization's programs could be expanded upon to meet community needs more effectively. The system has taken steps to serve the community by expanding access to its urgent psychiatric care clinic, improving care coordination with local health system partnerships, implementing mental health training programs for providers, developing a hub-and-spoke opioid treatment program, and advocating for policy change to better support community behavioral health.

Greater Baltimore Medical Center Healthcare

GBMC's 2020-2022 implementation plan addresses the following priority areas: behavioral health/substance use disorders, access to care, and obesity. To address issues related to behavioral health/substance use disorders, GBMC expanded Mental Health First Aid Training and continues to support the GBMC Sexual Assault Forensic Examination (SAFE) Program. Relative to access to care, GBMC has facilitated connections to meet the needs of underserved populations through the Elder Medical Care program, the Complex Care Clinic, and the Moveable Feast program. To reduce risk factors contributing to obesity, GBMC has encouraged community weight loss as a means of diabetes prevention and partnered with Hungry Harvest for Produce in a SNAP initiative.

University of Maryland St. Joseph Medical Center

UM SJMC's FY2020-2022 implementation plan addresses the following priority areas: access to care, chronic health conditions, cancer, fall prevention, and mental health and substance abuse. Although the COVID-19 pandemic created challenges related to care access, UM SJMC formed new partnerships with local schools and community organizations to distribute needed resources including COVID-19 wellness kits, vaccine education and registration support, and flyers for programs and resources. UM SJMC also successfully transitioned many programs to virtual offerings and the St. Clare Medical Outreach team continued serving underserved communities through telehealth visits.

To address chronic health conditions, UM SJMC adopted the National Diabetes Prevention Program and partnered with the Baltimore County Department of Health to plan and deliver education about the dangers of vaping to local schools and youth organizations. UM SJMC also opened the Wellness and Support Center to provide a variety of support services for cancer survivors. Programs focused on fall prevention have also been expanded through the adoption of the "Tai Ji Quan: Moving for Better Balance" program which has also been offered virtually throughout the pandemic. The University of Maryland Health System has led several webinar series on mental health and health literacy topics that have been shared widely across system hospitals.

MedStar Franklin Square Medical Center

MedStar Franklin Square's 2018 implementation plan addresses the following priority areas: health and wellness, access to care and services, and social determinants of health. The hospital conducts many programs and support groups related to chronic disease including its Living Well Chronic Disease Self-Management Program, a Diabetes Prevention Program, a Smoking Cessation Program, and a Stroke Support group. To address behavioral health issues, MedStar Franklin Square has implemented the Screening, Brief Intervention, and Referral to Treatment (SBIRT) strategy in emergency department and primary care settings and embedded Peer Recovery Coaches on hospital care teams. Relative to maternal and child health, the hospital has supported and coordinated the Healthy Babies Collaborative. To better provide access to care and services, MedStar Franklin Square has included mental health services as part of its primary care model and conducted social needs screenings and support linkages as part of care delivery. It has partnered with outside organizations to address social determinants of health related to transportation and employment, including implementing the MedStar Health UBER program, conducting the PHWSDA program, and conducting the Rx for Success Pipeline Summer Internship Program for underserved high school students.

CHAPTER 2 | METHODOLOGY

Study Design

A multi-step process was used to assess the community needs, challenges, and opportunities for Baltimore County. Multiple sources, including new and existing sources, were incorporated throughout the study to paint a more complete picture of Baltimore County's health needs. While the CHNA Steering Committee viewed the new and existing data equally, there were instances where one provided more compelling evidence of community health needs than the other. In these instances, the health needs identified were discussed based on the applicable data gathered. Multiple methodologies, including analysis of data, content analysis of community feedback, and stakeholder engagement, were utilized to identify key areas of need.

Specifically, the following data types were collected and analyzed:

New (Primary) Data

Community engagement and feedback was obtained through community internet-based surveys, key community health leader internet-based surveys, and seventeen unique community focus groups, as well as significant input and direction from the CHNA Steering Committee. Leveraging these sources, the CHNA Steering Committee was able to incorporate input from over 4,000 Baltimore County residents.

Existing (Secondary) Data

Key sources for existing data on Baltimore County included data made available by participating organizations and numerous public data sources related to demographics, social and economic determinants of health, environmental health, health status and disease trends, mental/behavioral health trends, and modifiable health risks. Key information sources leveraged during this process included:

- *County Health Rankings*, developed in partnership by Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute
- Maryland Department of Health's State Health Improvement Process (MD SHIP)
- Data provided by CHNA Steering Committee Members and affiliated organizations, including data from MedStar Franklin Square's FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting
- The Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS)
- *The Opportunity Atlas*, developed in partnership by the U.S. Census Bureau, Harvard University, and Brown University

For more information regarding data sources and data time periods, please refer to Appendix 2.

Comparisons

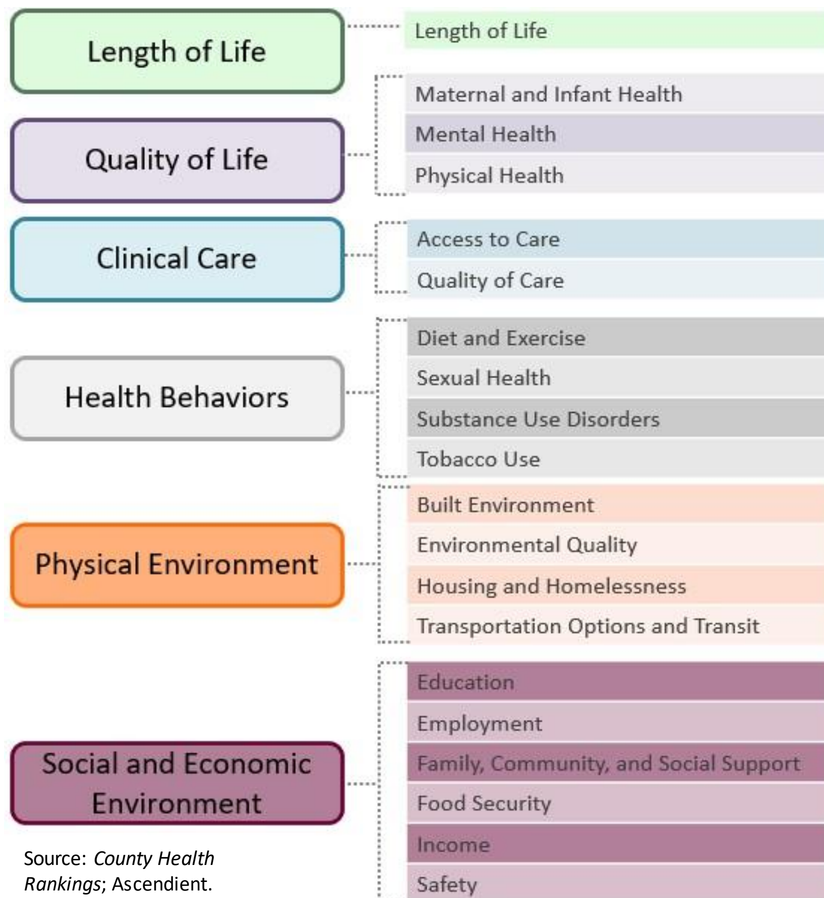
The existing data collected throughout the process are only relevant if compared to a benchmark, goal, or comparative geography. In other words, without the ability to compare Baltimore County with an outside measure, it would be impossible to determine how the county is performing. For the 2020-2021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

- *County Health Rankings* Top Performers: This is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute that ranks counties across the nation by various health factors.

- State of Maryland: As part of the process, the Steering Committee determined that comparisons with the state of Maryland in total would be appropriate. While certain differences exist, the geographic overlap creates similarities that increase the meaningfulness of comparisons.

Prioritization Process Overview and Results

The process of determining the priority health needs for the 2020-2021 CHNA began with the collection and analysis of hundreds of data points. All individual data measures from both new and existing sources were gathered, analyzed, and interpreted. In order to combine data points into more easily discussable categories, all individual data measures were grouped into six categories and twenty corresponding focus areas based on "common themes."



Source: *County Health Rankings*; Ascendient.

Given the large number of individual data measures that were collected, analyzed, and interpreted throughout this process to develop the twenty categories, it was not feasible to make each of them a priority. To help determine which health needs should be priorities, the CHNA Steering Committee developed a prioritization matrix to estimate the need areas that are of greatest concern.

The prioritization matrix included findings from the analysis of the new and existing data. Each type of data offers unique insights into the health needs of Baltimore County residents. To ensure that the prioritization process accounts for these various perspectives, existing data were weighted 50 percent in the prioritization matrix. To account for the numerous methods of new data collection, community survey findings were weighted 10 percent while focus group data and key community health leader survey findings were weighted 20 percent, respectively.

In order to draw conclusions about the existing data, Baltimore County's performance on each data measure were compared to targets/benchmarks. If Baltimore County's performance was more than five percent worse than the comparative benchmark, it was concluded that improvements are needed to better the health of Baltimore County residents. Conversely, if Baltimore County performed more than five percent better than the benchmark, it was concluded that the need for improvement is less acute. For each data measure that was deemed high need, the corresponding focus area received a value of one. Focus areas were then ranked based on the number of data measures within the focus area that were flagged as high need and corresponding percentages of total high need counts were calculated. This percentage was then multiplied by the assigned weight for existing data (50 percent) to become part of each focus area's weighted percentage score. For example, the Transportation Options and Transit focus area contained two data measures determined to be high need. Thirty-two data measures were flagged as high need across all focus areas, so the Transportation Options and Transit focus area's percentage of high need was 6.25 percent (2 ÷ 32).

Conclusions from the new data were drawn based on the frequency in which each focus area was discussed in focus groups or selected in survey responses. If a topic was discussed or selected with high frequency, then it was determined to be more of a need than those that were mentioned fewer times. Each focus area was ranked based on the number of mentions within each data collection method (focus groups, community surveys, key community health leader surveys) and corresponding percentages of total mentions were then calculated. This percentage was then multiplied by the assigned weight (20 percent for focus group data, 10 percent for community survey data, and 20 percent for key community health leader survey data) to become part of each focus area's weighted percentage score.

Please refer to the appendices for detailed descriptions of the methodologies used to analyze and determine the need level for each data component.

The preliminary priority scores for each of the various focus areas are provided in the following table.

Focus Area	Preliminary Score
Physical Health	3.0
Safety	1.9
Substance Use Disorders	1.7
Food Security	1.6
Access to Care	1.5
Income	1.5
Mental Health	1.4
Built Environment	1.4
Transportation Options and Transit	1.1

*Focus areas excluded from the table due to preliminary scores below 1.0 were Family, Community and Social Support, Diet and Exercise, Housing and Homelessness, Tobacco Use, Quality of Care, Environmental Quality, Length of Life, Employment, Maternal and Infant Health, Sexual Health, and Education.

Though the prioritization matrix serves as a useful tool in identifying high need areas, additional input from the CHNA Steering Committee on February 12, 2021 was considered to identify which high need areas would be defined as priority health need areas in the 2020-2021 CHNA. Please note that although Mental Health and Substance Use Disorders were viewed separately through the data collection process, the CHNA Steering Committee decided to combine these two focus areas as a single priority (Behavioral Health) for Baltimore County overall and will view these together for purposes of action planning and implementation. In addition, given the size of Baltimore County, it can be expected that health needs will not be uniform for all residents. As research was conducted for this CHNA, several health disparities were identified and discussed with the Steering Committee. So important is the need to understand these inequalities that the Steering Committee decided to make Health Disparities a priority area in this CHNA. Chapter 4 discusses the findings related to each of the priority areas in detail, including the key racial and geographic health disparities that emerged in the information obtained and analyzed during this process. The final priority need areas were not ranked in any hierarchical order of importance and all will be addressed by the Collaborative. The following three focus areas were identified as the top priority health need areas in Baltimore County to be addressed over the next three years:

Priority Health Need Areas

- Behavioral Health, including Mental Health and Substance Use Disorders
- Physical Health
- Health Disparities

Study Limitations

The development of a CHNA is a lengthy and time-consuming process. As such, more recent data may have been made available after the collection and analysis period of this process. Existing data are typically available at a lag time of one to three years from the data occurrence. One limitation in the data analyses process is the staleness of the data which may not depict the most recent occurrences

experienced within the community. Given the staleness of existing data, the CHNA Steering Committee attempted to compensate for these limitations through the collection of new data, including focus groups, internet-based community surveys, and internet-based key community health leader surveys. Existing data are also limited regarding availability by demographic cohorts such as gender, age, race, and ethnicity.

Given the size of Baltimore County in both population and geography, this study was limited in its capacity to fully capture health disparities and health needs across racial and ethnic lines. While efforts were made to include a diverse group of community members to participate in surveys, roughly two-thirds of all survey respondents were white individuals. Although survey respondents were given the option of selecting from numerous race categories – including but not limited to Asian, American Indian/Alaskan Native, and Native Hawaiian/Other Pacific Islander – limited responses were received from these racial groups. Because of these data limitations, race was categorized as one of three groups for the survey analysis: White, Black, or Other/Prefer Not to Answer. The Other/Prefer Not to Answer group includes responses from those who selected Asian, American Indian/Alaskan Native, Native Hawaiian/Other Pacific Islander, or other. This limited the ability to assess health needs and disparities for other racial/ethnic minority groups in the community.

Additionally, gaps in information for particular sub-segments of the population exist. Many of the available data sets do not necessarily isolate historically underserved populations including the uninsured, low-income persons, and/or certain minority groups. However, in an effort to capture a more holistic and culturally competent view of the need in Baltimore County despite the lack of available data, attempts were made to include underserved sub-segments of the greater population through the new data gathered throughout the CHNA process. By way of example, the CHNA Steering Committee chose to focus on the non-English-speaking members of the community by developing an internet-based community survey that was available in Spanish. Paper surveys were also distributed in an effort to reach as much of the community as possible.

Future assessments can expand upon such efforts to include additional underserved communities whose needs are not specifically discussed throughout this assessment due to limitations in the ability to gather data and input during this CHNA cycle. Of note and of example, residents within the disabled and deaf and hard-of-hearing communities can be a focus of future new data collection methods. Additionally, more input from both patients and providers of substance use disorder services would also be beneficial in future assessments.

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

CHAPTER 3 | COUNTY PROFILE

Baltimore County occupies 612 square miles — plus an additional 28 square miles of water — in the geographic center of Maryland. With a population in excess of 825,000 persons, the county is the largest jurisdiction in the Central Maryland Metropolitan Area.

Population figures discussed throughout this chapter were obtained from the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute's *County Health Rankings*. Baltimore County's total population has remained relatively constant over recent years, however, the 65 and older age cohort has grown at an annual rate of 2.1 percent.

Total Population – Baltimore County			
	2014	2018	CAGR*
Below 18	178,621	178,931	0.0%
Between 18 and 65	517,521	507,190	-0.5%
65 and older	130,783	142,310	2.1%
Total	826,925	828,431	0.0%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.
*Compound Annual Growth Rate

As compared to Maryland, Baltimore County has a slightly older population with a higher percentage of the population over the age of 65.

2018 Population – Age Distribution		
	Baltimore County	Maryland
Percentage below 18	21.6%	22.2%
Percentage between 18 and 65	61.2%	62.4%
Percentage 65 and older	17.2%	15.4%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

The population distribution by gender is similar between Baltimore County and the state of Maryland.

2018 Population – Gender Distribution		
	Baltimore County	Maryland
Female	52.6%	51.5%
Male	47.4%	48.5%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Baltimore County and the state of Maryland have similar racial distributions, but Baltimore County has a smaller Hispanic population when compared to Maryland. Overall, Baltimore County is slightly less diverse than Maryland as a whole.

2018 Population – Racial Distribution		
	Baltimore County	Maryland
White	64.2%	62.8%
Black	29.0%	29.8%
Asian	6.3%	6.7%
American Indian/Alaskan Native	0.4%	0.6%
Native Hawaiian/Other Pacific Islander	0.1%	0.1%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

2018 Population – Ethnic Distribution		
	Baltimore County	Maryland
Hispanic	5.7%	10.4%
Non-Hispanic	94.3%	89.6%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

In addition to demographic data, socioeconomic factors in the county such as income, poverty, and unemployment play a significant role in identifying healthcare needs. The median household income in Baltimore County is higher than the national benchmark but roughly 10 percent lower than the median household income in Maryland.

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

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

To understand how Baltimore County compares regarding other key socioeconomic factors, see the Community Need Index discussion in Chapter 4 and Appendix 1.

CHAPTER 4 | PRIORITY NEED AREAS

This chapter looks at each of the three priority areas in more detail and discusses the data that supports each priority. As mentioned previously, these priority needs areas are not listed in any hierarchical order of importance and all will be addressed by the Collaborative.

Priority Need: Behavioral Health

The Behavioral Health priority includes mental health conditions (like depression and Alzheimer's) and access to psychiatric and/or behavioral health services, as well as alcohol, opioid, and illegal drug use and data related to overdoses. Although Mental Health and Substance Use Disorders were viewed separately through the data collection process, the CHNA Steering Committee decided to combine these two focus areas as a single priority (Behavioral Health) for Baltimore County overall. Both the Mental Health and Substance Use Disorders focus areas were identified as areas of high need for Baltimore County after considering new and existing data. Due to the overlap in contributing factors and prevalence of dual diagnoses, the Steering Committee ultimately decided to combine them for purposes of action planning and implementation and defined the single priority area as Behavioral Health. Each focus area is discussed in more detail below.

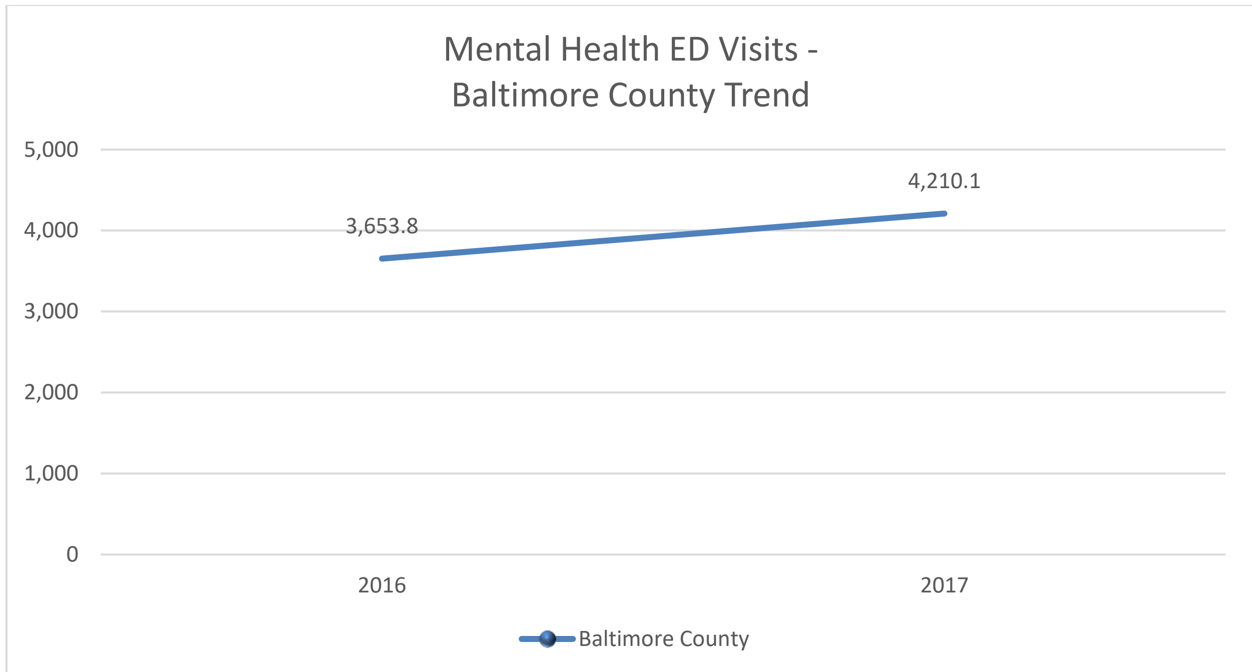
Mental Health

Mental Health, including dementia and depression, as well as access to psychiatric and/or behavioral health services, was identified as a high need area based on new and existing data. Additional input from the CHNA Steering Committee on February 13, 2021 was considered to include Mental Health as part of the Behavioral Health priority need area in this assessment. This priority aligns with the state's initiative to improve behavioral health crisis services over the next five years through the Greater Baltimore Regional Integrated Crisis System (GBRICS) partnership. Findings that support the identification of Mental Health as a priority area in Baltimore County include:

Existing Data

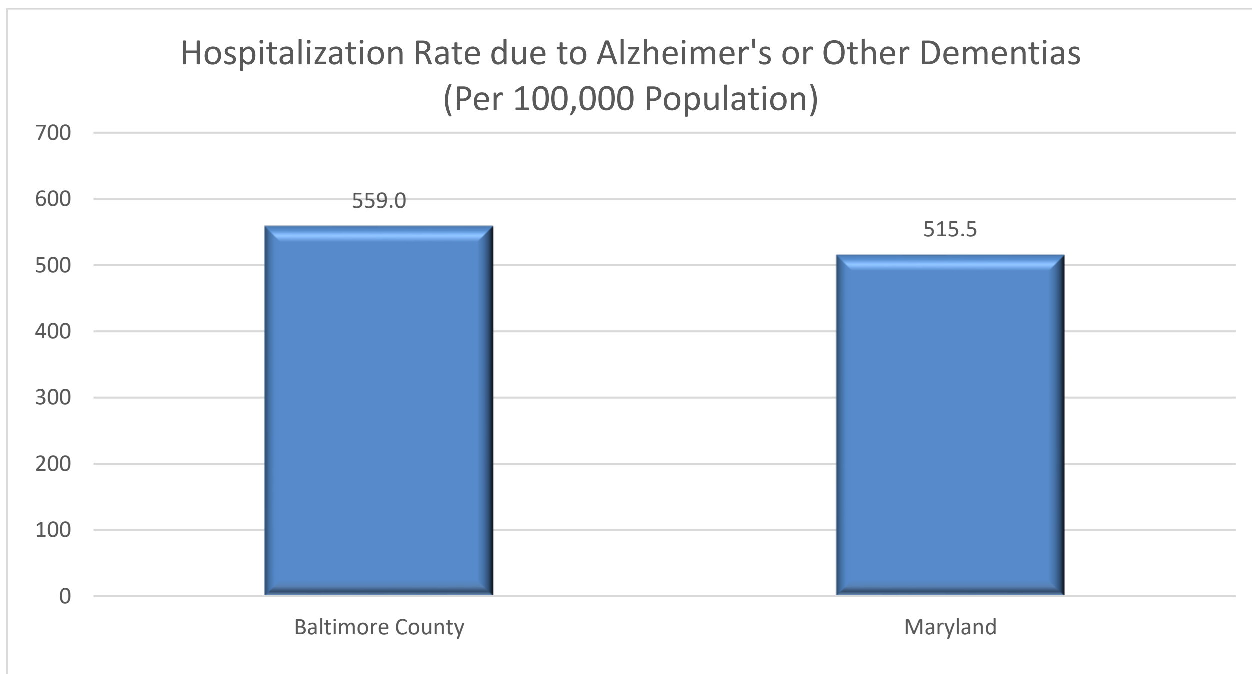
As shown in Appendix 2, existing data reveal that Baltimore County's performance varies when compared to Maryland and national top performers. Although Baltimore County has improved over recent years on some measures, performance on most measures has worsened.

According to MD SHIP, mental health problems place a heavy burden on the healthcare system, especially when people in crisis use emergency departments instead of other sources of care when available. Existing data, illustrated in the chart below, shows that while Baltimore County's rate of mental health ED visits is slightly lower than the Maryland target (4,291.5 per 100,000 population), the county is trending in the wrong direction.



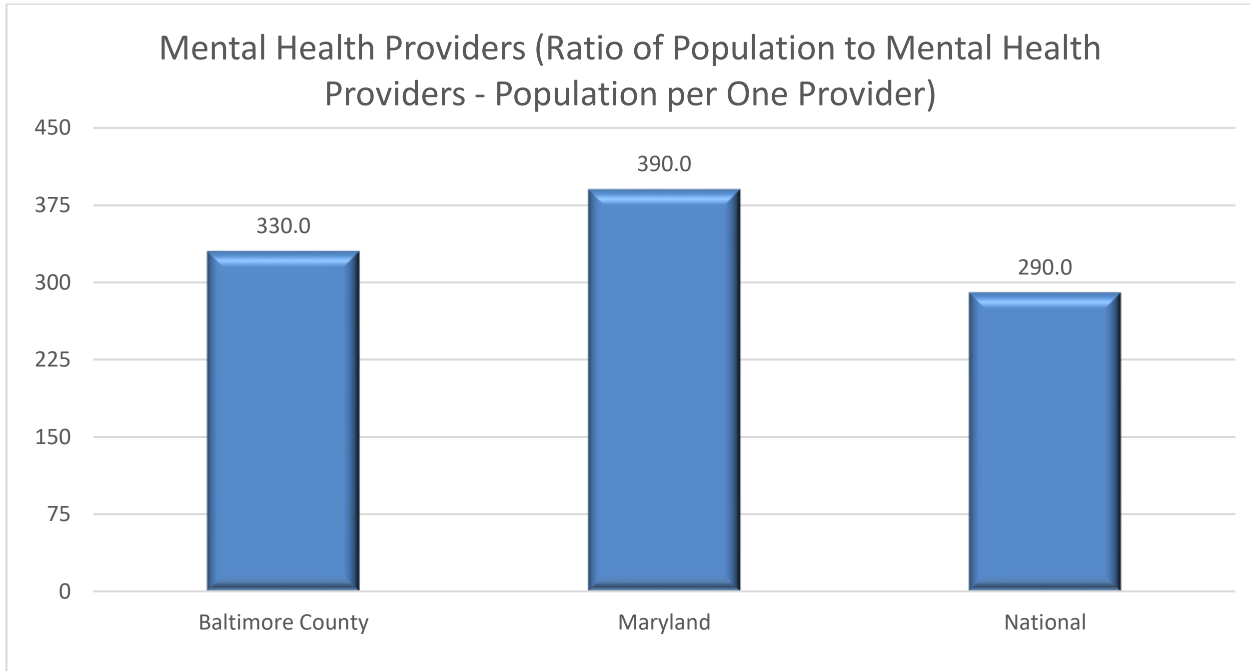
Source: Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.

Further, as Baltimore County's population ages, certain neurological disorders such as Alzheimer's and dementia become more common. According to MD SHIP data, the hospitalization rate due to Alzheimer's or other dementias in Baltimore County is 8 percent greater than Maryland's benchmark (515.5 hospitalizations per 100,000 population).



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

Existing data show that while Baltimore County has a lower ratio of population to mental health providers than the state of Maryland, it has a higher ratio when compared to the national benchmark. According to *County Health Rankings*, lower ratios are desired to ensure adequate access to mental health services. Although there has been some improvement over recent years, feedback from surveys and focus groups supports that there is still more work to be done.



Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Focus Group Findings

Mental Health was identified by seven of 17 focus groups as a community need, with depression, anxiety, and stress discussed as a concern in most focus groups. Focus group participants also mentioned the increased prevalence of mental and behavioral health conditions within the past five years. Of note, focus group participants reported that isolation during the COVID-19 pandemic had worsened mental health conditions and challenged access to mental health services. Mental health needs were seen as a dominant problem faced by the community as a whole.

Community and Key Community Health Leader Survey Results

40 percent of community survey respondents indicated mental health conditions, such as anxiety and depression, as one of the most important health problems affecting Baltimore County residents. Further, approximately one in three community respondents (32 percent) reported experiencing six or more poor mental health days in the last month, and 18 percent of community respondents reported 11 or more poor mental health days in the last month. Additionally, 78 percent of key community health leaders surveyed chose Mental Health as one of the top three areas of need.

As discussed throughout this document, health disparities are present across Baltimore County. For information regarding disparities across racial and geographic sub-groups, please refer to the Health Disparities Priority Need section of this report.

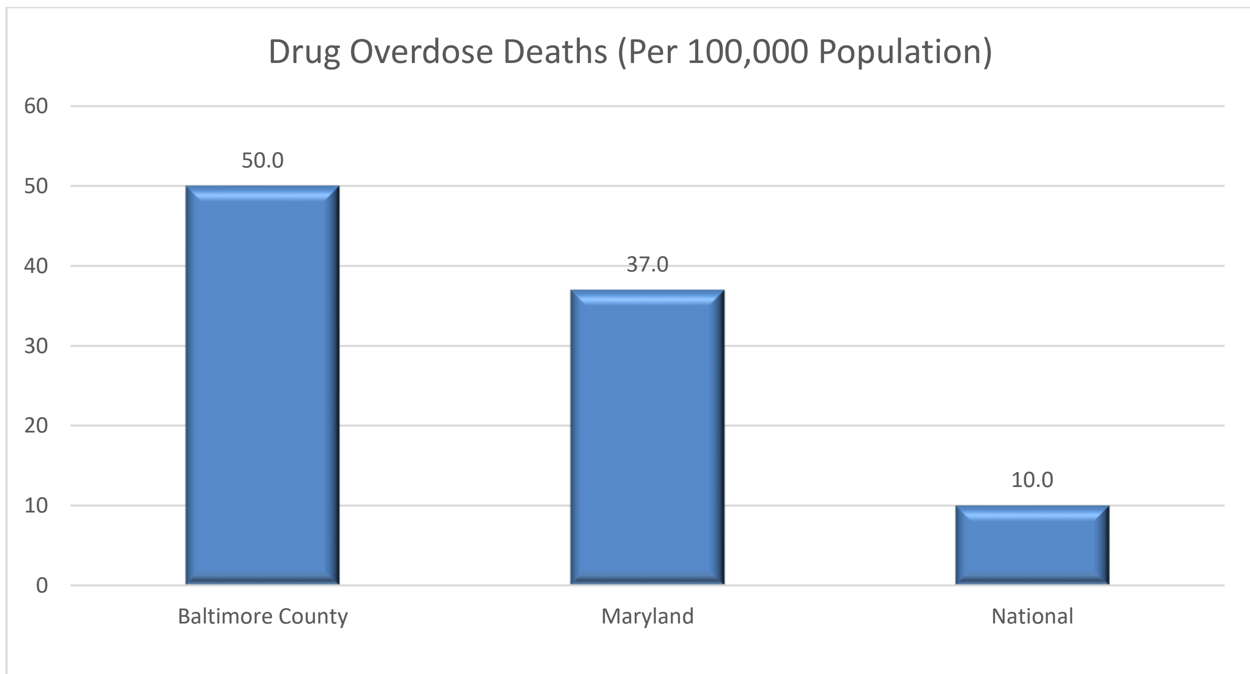
Substance Use Disorders

Substance Use Disorders were identified as an area of high need for Baltimore County after considering new and existing data. Additional input from the CHNA Steering Committee on February 13, 2021 was considered to include Substance Use Disorders as part of the Behavioral Health priority need area in this assessment. Findings that support the identification of Substance Use Disorders as a priority area in Baltimore County include:

Existing Data

As shown in Appendix 2, existing data reveal that Baltimore County is performing worse than Maryland and the nation overall in many areas related to Substance Use Disorders. Recent trends in high need areas vary in Baltimore County with fewer adolescents using tobacco products but increased drug-induced deaths.

According to data analyzed by *County Health Rankings*, Baltimore County experiences more drug-induced deaths (50 per 100,000 population) than both the Maryland and national targets (37 per 100,000 population and 10 per 100,000, respectively). Further, the number of drug-induced deaths in Baltimore County has risen significantly in recent years.

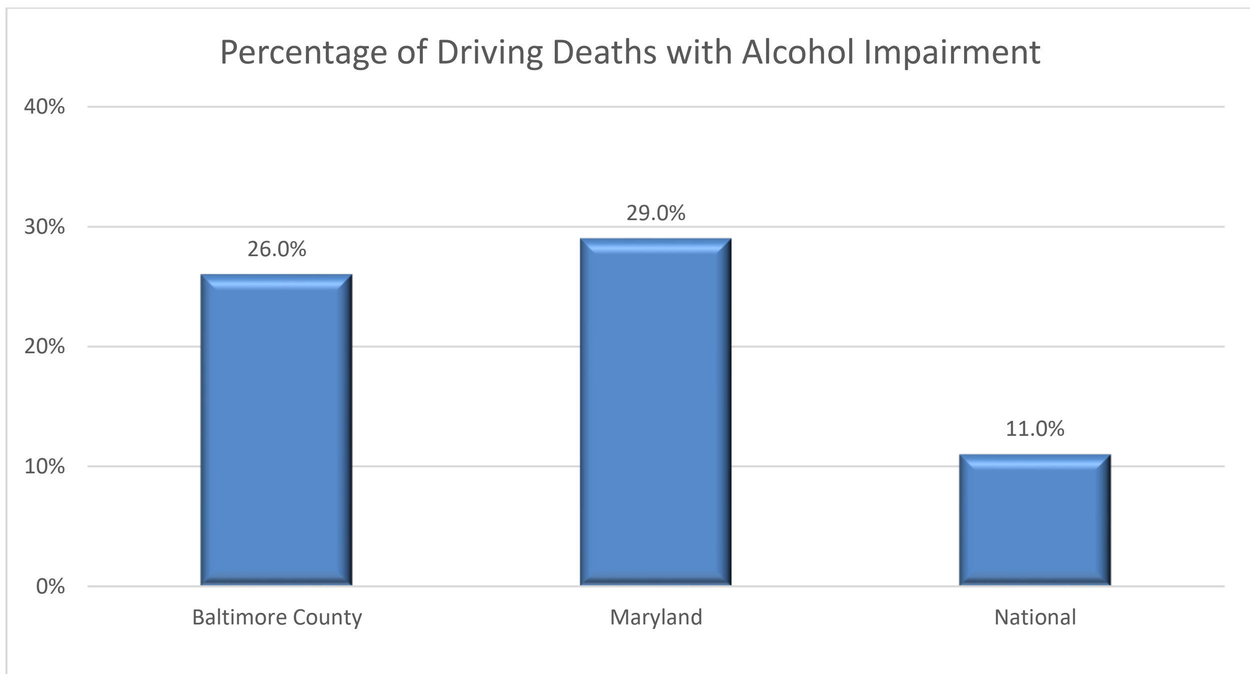


Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

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

- Percentage of population impacted by fentanyl-related deaths (0.04 percent in Baltimore County, 0.01 percent nationally)
- Percentage of population impacted by opioid-related deaths (0.04 percent in Baltimore County, 0.01 percent nationally)
- Opioid prescriptions dispensed per 100 persons (53.0 in Baltimore County, 45.0 in Maryland)

Additionally, as shown in the chart below, *County Health Rankings* indicate that 26 percent of all driving deaths in Baltimore County involve alcohol impairment, exceeding the national benchmark of 11 percent. Moreover, according to the most recent data available from the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute's *County Health Rankings*, nearly one in five adults in Baltimore County report excessive drinking.



Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Community and Key Community Health Leader Survey Results

Substance use disorders, including drug and alcohol abuse, were indicated as one of the most important health problems affecting Baltimore County by 28 percent of community survey respondents. Further, 61 percent of key community health leaders selected substance use disorders as one of the top three need areas, with 30 percent of key community health leaders indicating that there are not enough substance use treatment providers available to meet the community's needs.

As discussed throughout this document, health disparities are present across Baltimore County. For information regarding disparities across racial and geographic sub-groups, please refer to the Health Disparities Priority Need section of this report.

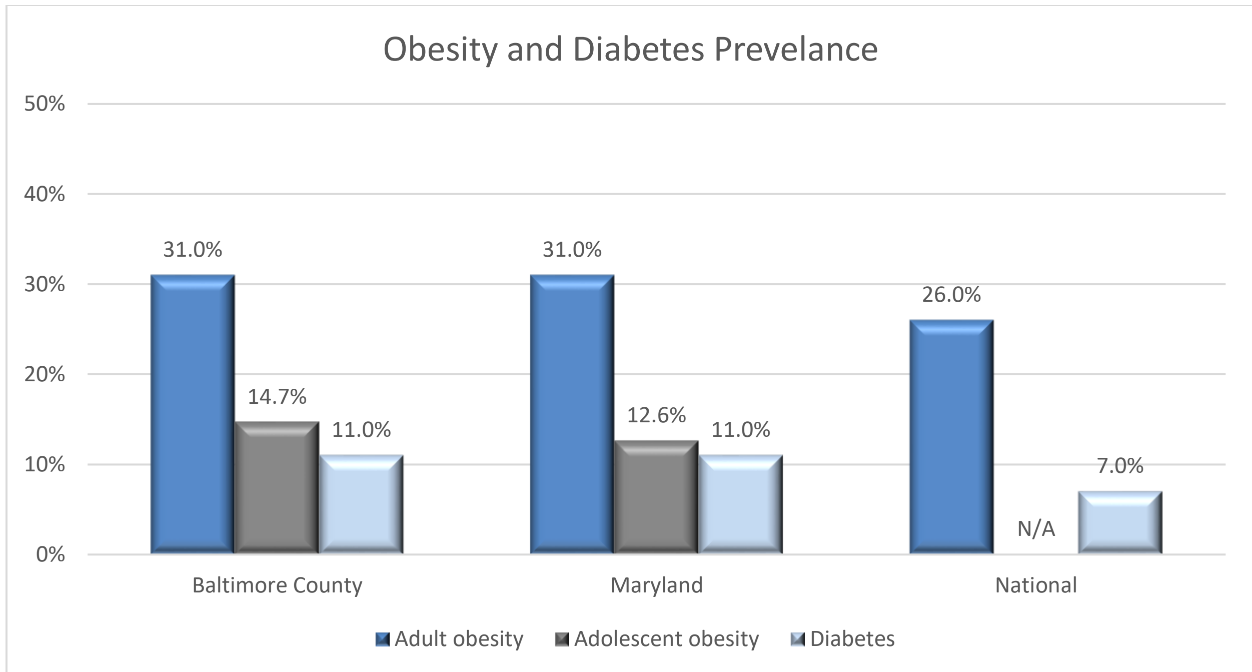
Priority Need: Physical Health

Physical Health, including diabetes, hypertension, heart disease, obesity, and cancer, as well as access to health services, particularly during the COVID-19 pandemic, has been identified as a top priority need area in this CHNA. As shown in Chapter 2 of this report, Physical Health was identified as an area of high need for Baltimore County after considering new and existing data, and the additional input gathered from the CHNA Steering Committee on February 13, 2021 identified Physical Health as a priority need. The Steering Committee also discussed more narrowly defining Physical Health as a specific condition or illness but decided to make the broader category of Physical Health the priority, which will then allow each partner organization to define how that relates to their local community as they develop implementation and action plans. Findings that support the identification of Physical Health as a priority area in Baltimore County include:

Existing Data

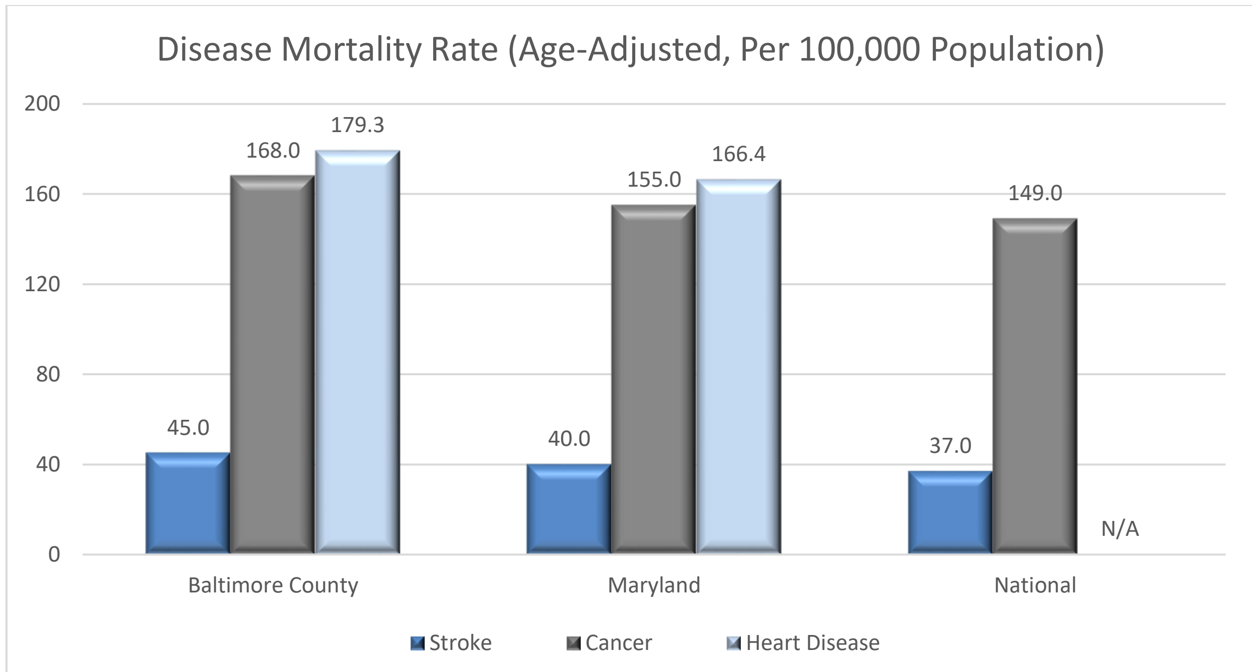
As shown in Appendix 2, existing data reveal that Baltimore County is performing worse than Maryland and the nation overall in many areas related to Physical Health. In addition, Baltimore County is improving in some of these high need areas but getting worse in others.

According to data available from *County Health Rankings*, the percentage of obese adults is five percentage points greater in Baltimore County than the national benchmark for adult obesity (26 percent). National benchmark data were not available for those under 20 years of age, but MD SHIP data indicates that 14.7 percent of adolescents are obese in Baltimore County, as compared to the 12.6 percent in Maryland. Baltimore County also has a greater prevalence of adults diagnosed with diabetes (11 percent) than the national benchmark (7 percent).



Sources: Maryland Department of Health, State Health Improvement Process (SHIP). Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Baltimore County performs worse than national and Maryland benchmarks on mortality rates related to stroke, cancer, and heart disease. According to data provided by MedStar Franklin Square, deaths due to stroke are higher in Baltimore County (45 stroke-related deaths per 100,000 population) than both the national and Maryland benchmarks (37 and 40 stroke-related deaths per 100,000, respectively). In addition, Baltimore County has the highest cancer-related deaths among comparative geographies per 100,000 (168 in Baltimore County, 155 in Maryland, and 149 nationally). Deaths related to heart disease are also more common in Baltimore County (179.3 per 100,000 population) than Maryland (166.4 per 100,000 population).



Sources: MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.

Focus Group Findings

Although Physical Health was only ranked as a top health need in three of the 17 focus groups, existing data and community surveys support that more progress can be made in this area. Focus group participants believed that diabetes, cancer, obesity, hypertension, and heart disease were significant community concerns. Educational sessions, particularly for those who are at increased risk of these conditions, were identified as a much-needed resource by focus group members.

Community and Key Community Health Leader Survey Results

When aggregated, Physical Health was considered the greatest community health problem by both community members and key community health leaders. When asked to choose the three most important health problems that affect the health of their community, physical health problems such as heart disease, hypertension, and stroke were identified by 48 percent of respondents. In addition, 37 percent of respondents chose obesity, and 42 percent of respondents chose diabetes.

As discussed throughout this document, health disparities are present across Baltimore County. For information regarding disparities across racial and geographic sub-groups, please refer to the Health Disparities Priority Need section of this report.

Priority Need: Health Disparities

There are many contributing factors that can either positively or negatively influence an individual's health. The Collaborative recognizes this fact and believes that in order to portray a complete picture of the health-related status of the county it first must address the factors contributing to the health of the community. According to the Centers for Disease Control and Prevention, factors contributing to an individual's health status can include the following:

Five Determinants of Health

1. Biological – sex, age, and genetics
2. Behavioral – alcohol use, drug abuse, smoking, and nutrition
3. Social – discrimination, income, and gender
4. Physical environment – where a person lives and crowding conditions
5. Availability of health services – access to quality healthcare and whether or not a person has health insurance

As seen in the examples above, many of the factors that contribute to health are either not controllable or are societal in nature. As such, healthcare providers need to consider many underlying factors that may impact an individual's health and not simply their current health conditions.

It is widely acknowledged that those with lower income, lower social status and lower levels of education have more difficulty obtaining healthcare services than their counterparts in the community. The inability to access healthcare services contributes to poor health status. Further, members of impoverished communities can also function under high levels of day-to-day stress which contributes to worse health outcomes, particularly as it relates to mental and behavioral health.

One area of particular importance that was repeatedly mentioned and discussed throughout the process of gathering new data was the limited financial resources available to residents of Baltimore County. Community members, key community health leaders, and focus group participants all voiced that the lack of health insurance or other financial resources is a primary reason residents do not seek medical attention. Lack of health insurance significantly influences one's ability to access healthcare services particularly if there are not many providers who offer services on a sliding fee scale. In fact, some participants mentioned that in order to receive care they have to travel into Baltimore City or even out of state since they believe these areas have more resources available than the county. However, due to fiscal hardship or transportation issues, this may not be a feasible alternative. Further, many stated that medical attention was delayed due to the difficult decision of choosing between the necessities of day-to-day life, including electricity and food, and medical care and medications. For many, the consensus was that when faced with these choices, members of the community would choose not to seek medical attention or fill their prescriptions in favor of spending their limited financial resources on other necessities deemed more immediate and critical.

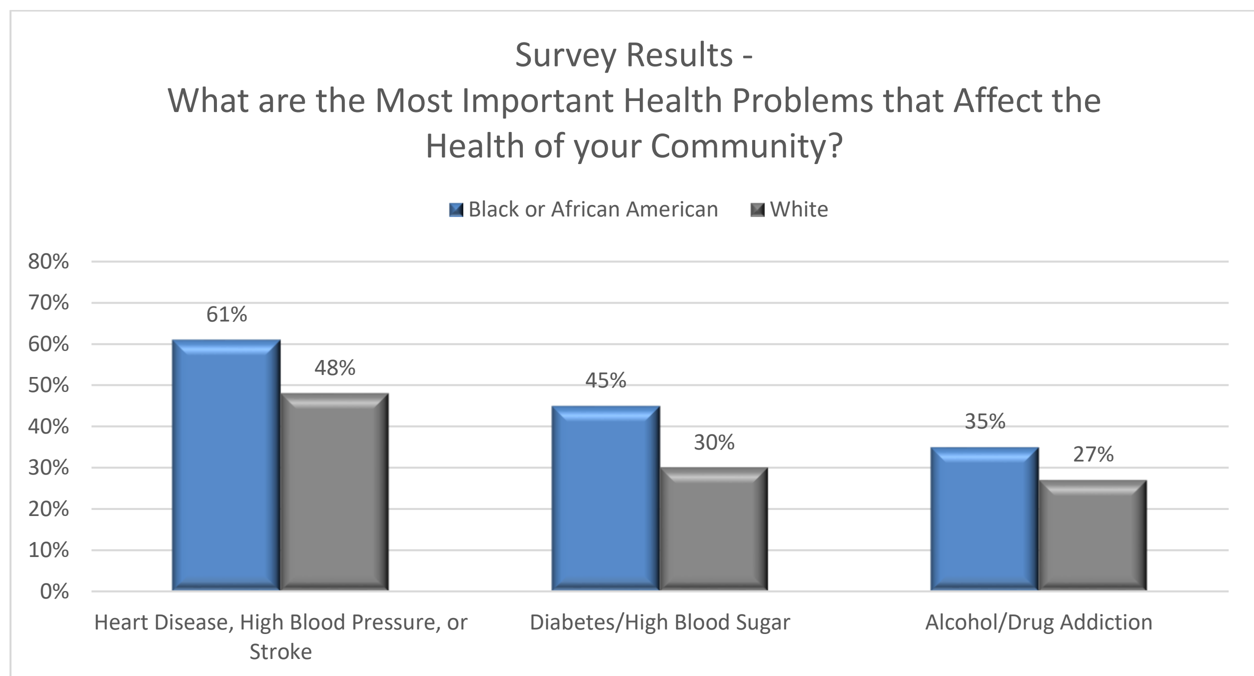
Additionally, the high cost of prescription medications was discussed. Without health insurance coverage, many residents are unable to afford their prescription medications. Even for those with health insurance coverage that extends to cover the cost of medications, there is still difficulty associated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

conveniently located pharmacy that will accept certain forms of insurance. As a result, many simply go without their medication which often worsens their health condition.

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

Racial Disparities

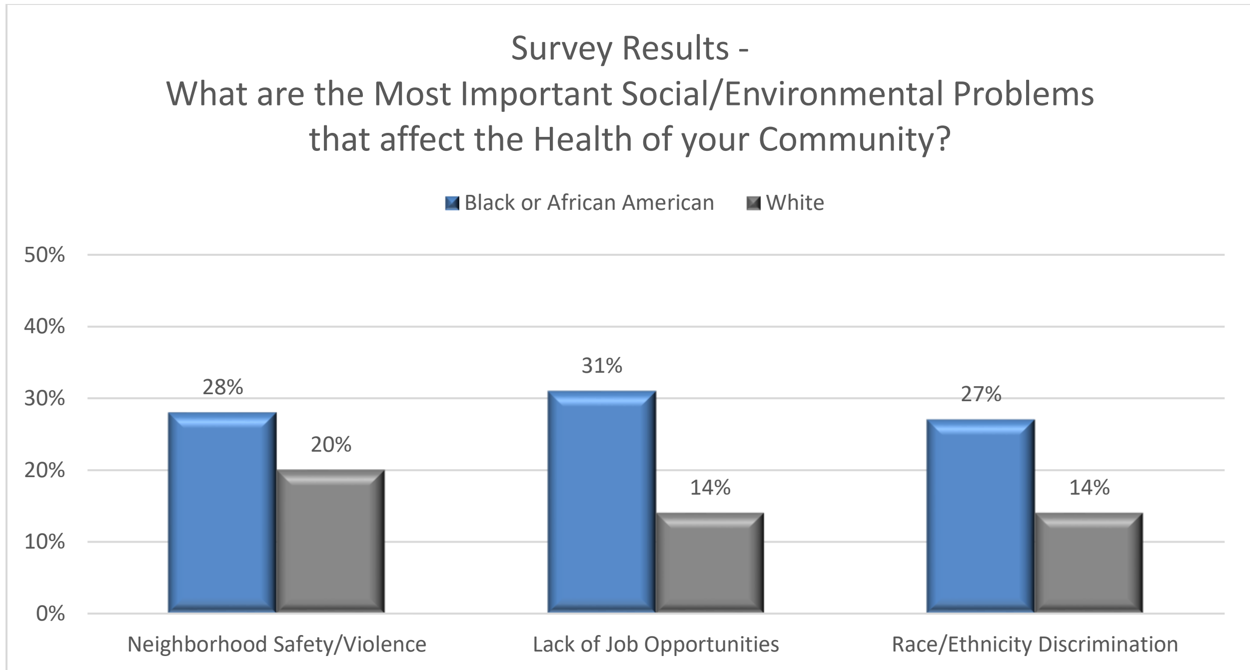
Health-related racial disparities exist in many communities. The new data gathered throughout the CHNA process demonstrates these disparities in Baltimore County, particularly regarding the perceived priority needs of the community and access to healthcare. Due to the racial composition of the respondents of the community internet-based surveys, the following discussion centers on the comparison of results between White and Black or African American respondents. There were slight differences in perceived needs and the prioritization of those needs among the two groups.



Source: Data compiled from community surveys.

As shown in the chart above, opinions varied when respondents were asked to identify the most important health problems affecting their community. 61 percent of all Black or African American respondents indicated heart disease, hypertension, or stroke as opposed to 48 percent of all White respondents. Additionally, 45 percent of all Black or African American respondents indicated diabetes and high blood sugar as opposed to 30 percent of all White respondents. Substance use disorders, such as alcohol and drug addiction, were noted by 35 percent of all Black or African American survey respondents and 27 percent of all White respondents.

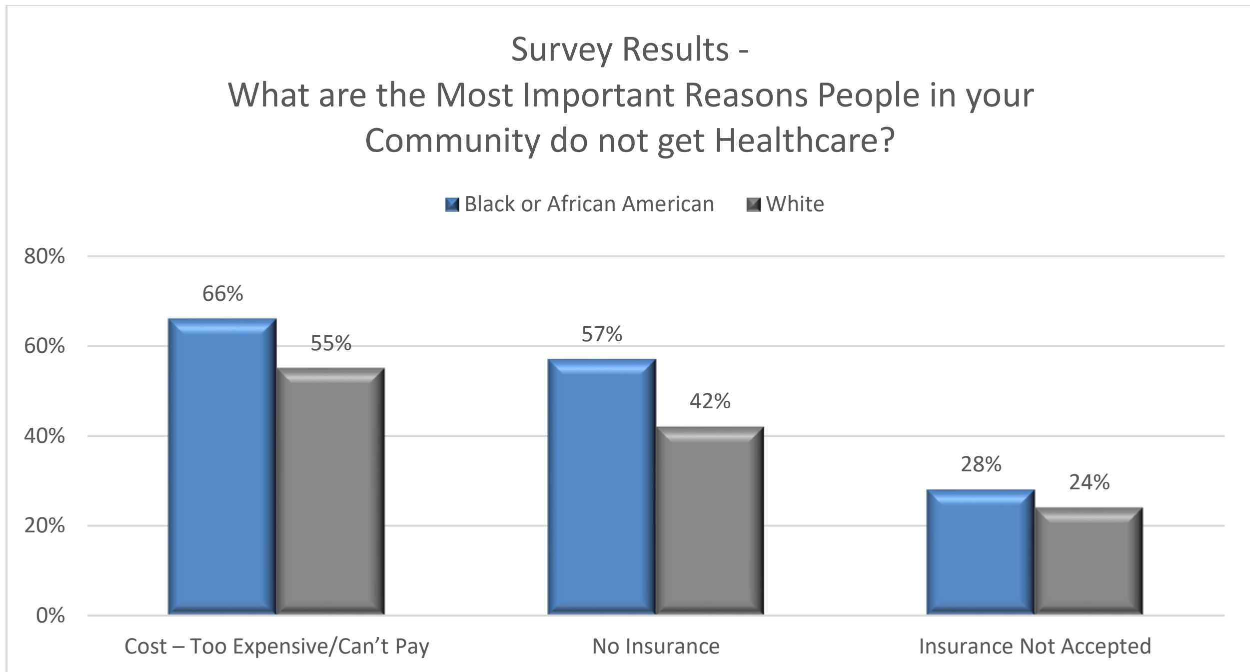
As demonstrated in the chart below, differences were also present in the perceived social/environmental problems facing the community.



Source: Data compiled from community surveys.

28 percent of all Black or African American respondents and 20 percent of all White respondents specified neighborhood safety/violence as a major issue. 31 percent of all Black or African American respondents believe that a lack of job opportunities is one of the most important social/environmental problems affecting the health of the community, while only 14 percent of White respondents indicated the same concern. Further, 27 percent of Black or African American survey respondents selected racial/ethnic discrimination as one of the most important social/environmental problems affecting the health of the community, as compared to approximately 14 percent of all White respondents.

Community survey respondents were also asked to choose the most important reasons why they believe people in the community do not get healthcare. As shown in the chart below, the responses collected demonstrate a notable consensus across racial groups, with the majority of respondents in both groups selecting high costs, lack of insurance, and denial of insurance as the top reasons people in the community do not get healthcare. However, there were slight differences that are illustrated in the chart below.



Source: Data compiled from community surveys.

Cost (too expensive/can't pay) was selected by 66 percent of all Black or African American survey respondents and only 55 percent of all White respondents. Lack of insurance was chosen by 57 percent of all Black or African American survey respondents as opposed to 42 percent of all White respondents. Insurance (not accepted) was the most similar across racial groups, indicated by 28 percent of all Black or African American respondents and 24 percent of all White respondents.

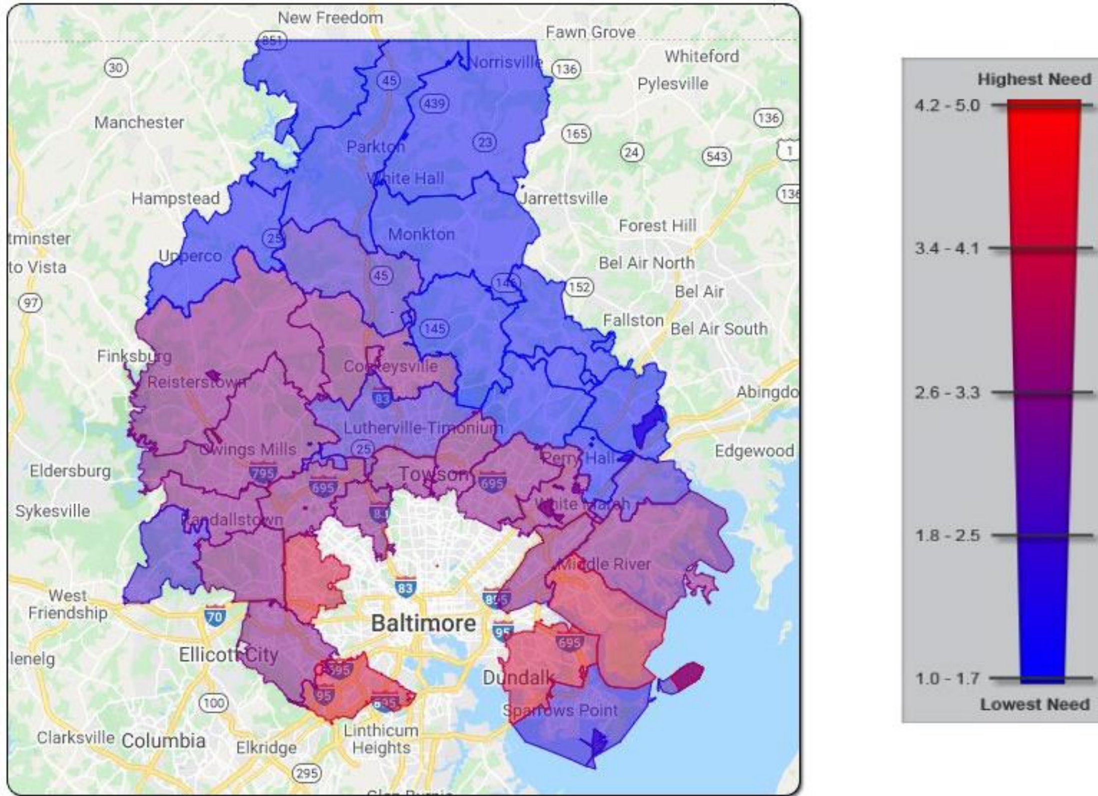
Geographic Disparities

As discussed throughout this document, health needs can vary based on many factors. One resource that is helpful in demonstrating need variation among geographies is the Community Need Index (CNI) developed by Dignity Health and Truven Health Analytics. The CNI identifies the severity of health disparity at the ZIP code level and demonstrates the link among community need, access to care, and healthcare utilization. Rather than relying solely on public health data, the CNI accounts for the underlying economic and structural barriers that affect overall health including social determinants of health. The CNI identifies five prominent barriers that make it possible to quantify healthcare access in communities across the nation. These barriers include those related to income, culture/language, education, insurance, and housing.

Using data related to these barriers, a score is assigned to each barrier condition (with one (1) representing less community need and five (5) representing more community need). The scores are then aggregated and averaged for a final CNI score (each barrier receives equal weight in the average). A score of 1.0 indicates a ZIP code with the lowest socioeconomic barriers, while a score of 5.0 represents a ZIP code with the most socioeconomic barriers. Although Baltimore County received an overall CNI score of 2.3, there is significant variability within the county as half of the county's ZIP codes fall into the mid to mid-high CNI score range indicating the presence of socioeconomic barriers to health and healthcare for the population in those areas. As shown on the map below, areas of greatest need are located in the

southern portion of the county. Please note that since the CNI is based on ZIP code, some of the highlighted areas extend beyond the county borders.

Community Need Index



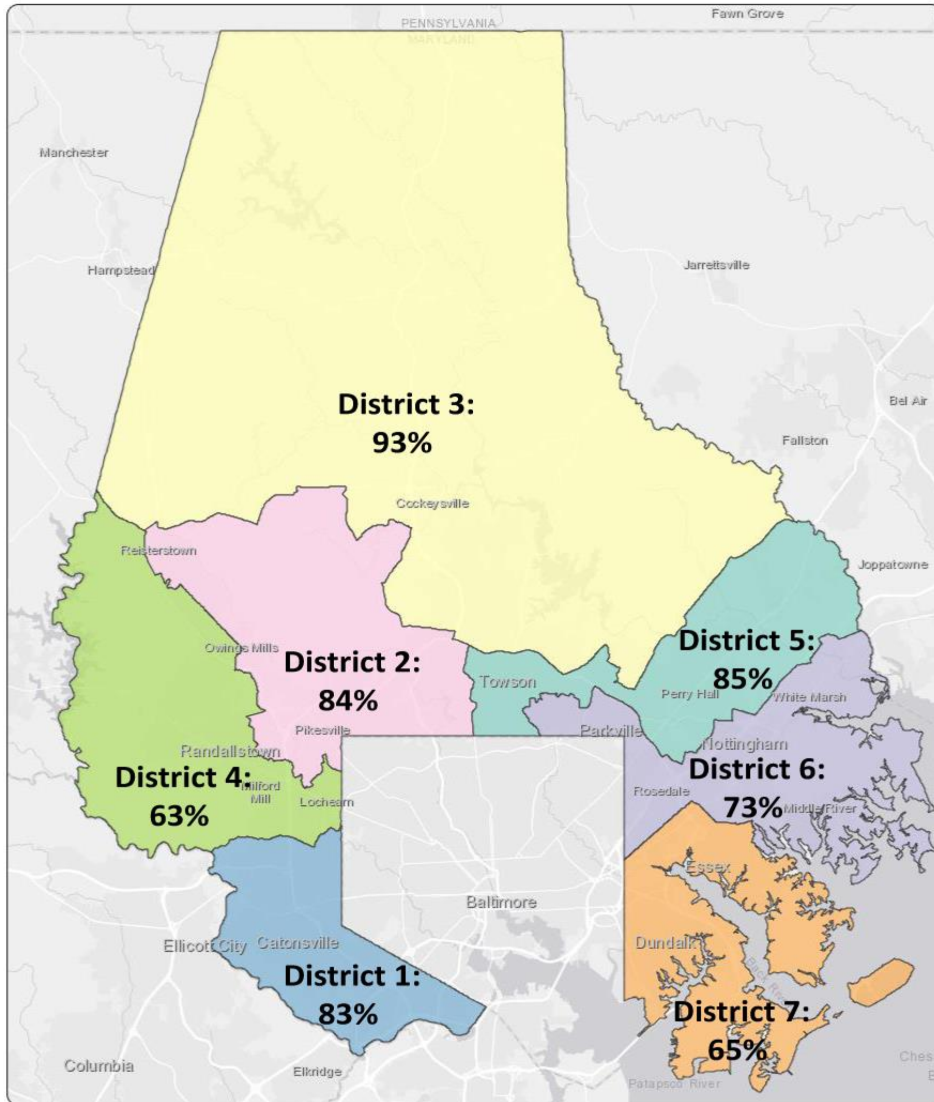
Source: Dignity Health and Truven Health Analytics, Community Need Index. Data accessed December 2020.

The CHNA Steering Committee also analyzed ZIP code level data corresponding to each of the seven Councilmanic districts when aggregating the community survey data to further understand how the severity of need might vary by location. Two of the survey questions highlighted significant need disparity across Baltimore County and are illustrated in the maps on the following pages.

Community Survey Findings

Do you have the ability to find healthy foods around where you live? (By Councilmanic District)

Percentage of total respondents per district that answered "Yes"

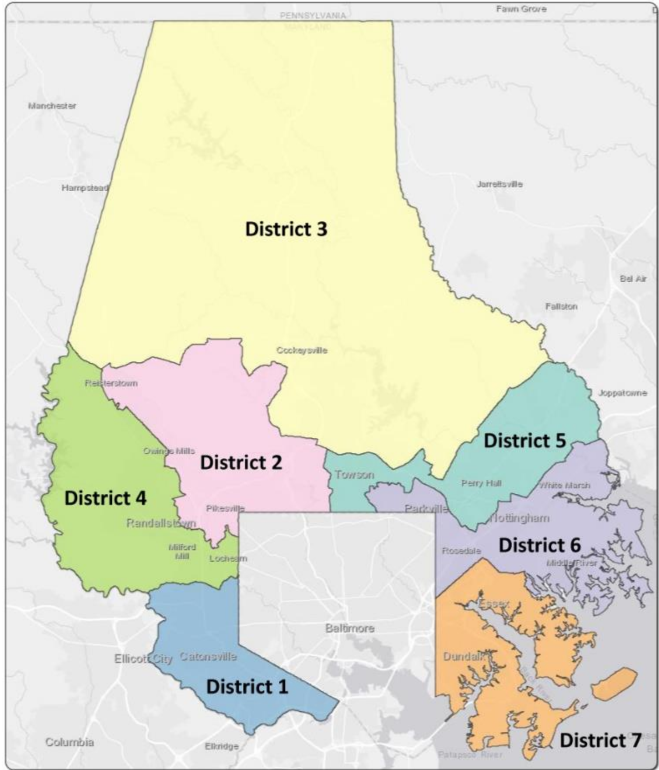


Source: Data compiled from community surveys.

The information shown in the map above highlights the significance of the gap and differences within Baltimore County with 93 percent of community survey respondents in District 3 stating they had the ability to find healthy foods where they lived, whereas only approximately 65 percent of respondents in Districts 4 and 7 reported having that ability.

Community Survey Findings

What are the three most important health problems that affect the health of your community?



Percentage of total responses per selection by district:

District 1
1. Alcohol/drug addiction (51%)
2. Heart disease (48%)
3. Diabetes (40%)

District 2
1. Mental health (40%)
2. Alcohol/drug addiction (39%)
3. Diabetes (37%)

District 3
1. Mental health (45%)
2. Obesity (42%)
3. Heart disease (41%)

District 4
1. Diabetes (50%)
2. Mental health (38%)
3. Obesity (35%)

District 5
1. Heart disease (64%)
2. Alcohol/drug addiction (47%)
3. Diabetes (45%)

District 6
1. Heart disease (76%)
2. Alcohol/drug addiction (52%)
3. Diabetes (46%)

District 7
1. Alcohol/drug addiction (62%)
2. Heart disease (57%)
3. Diabetes (42%)

Source: Data compiled from community surveys.

The perceived priority needs of the community differed significantly across districts. Districts 1 and 7 reported alcohol/drug addiction as the most important health need affecting the community. In addition, Districts 2, 5 and 6 ranked addiction as the second highest health need, while Districts 3 and 4 did not consider it to be one of the most important issues at all. Similarly, mental health was highly ranked in Districts 2, 3 and 4, but it was not considered to be one of the most important issues in the remaining districts.

Given the size of Baltimore County, both in population and geography, it can be expected that health needs will not be uniform for all residents. The Community Need Index and survey data demonstrate that there are significant geographic disparities in Baltimore County, particularly regarding socioeconomic factors and the perceived needs of the community.

CHAPTER 5 | HEALTH RESOURCE INVENTORY

The following section details existing resources, facilities, and programs throughout Baltimore County.

Health Resources

The list of resources below is representative of the services available in Baltimore County; however, this list is not exhaustive. Additionally, while the resources, facilities, and programs listed in this section have been categorized into common groups, these organizations and programs may offer additional services as well. Please note that while the county overall may be adequately served by existing capacity in some areas, not every area of the county is equally served, and the need for additional resources may be greater in one geography as compared to another.

As shown, this health resource inventory was compiled based on input and information from all Collaborative partners and have been categorized into the following areas, including Healthcare Facilities, Home-based Health Services, Other Healthcare Services, and Community Services.

Healthcare Facilities

- Baltimore County Department of Health – Offers a variety of health services for the general public and specialty groups, including general health services, children's health services, senior health services, uninsured health services, and women's health services.
- Northwest Hospital of LifeBridge Health – 231-bed hospital offering a variety of services at its hospital location as well as nearby outpatient facilities offering service such as outpatient surgery, adult day care, and physical rehabilitation.
- Sheppard Pratt – Provider of mental health, substance use, special education, developmental disability, and social services offering services in inpatient, outpatient, and virtual settings.
- Greater Baltimore Medical Center Healthcare – 342-bed medical center offering a variety of services at its hospital and main campus medical office buildings as well as primary care offices throughout the community. GBMC also provides and operates integrated behavioral health services, The Geckle Diabetes and Nutrition Center, and the Bariatric Surgery and Comprehensive Obesity Management Program.
- University of Maryland St. Joseph Medical Center – 218-bed hospital offering a variety of services at its hospital and associated practices. UM SJMC also offers many community programs to support families, chronic disease and pain management, physical activity and fall prevention. Additionally, the Barbara Posner Wellness and Support Center offers many support services for cancer patients. St. Clare Medical Outreach is a devoted team that provides primary care and health education to those who have no access to healthcare.
- MedStar Franklin Square Medical Center – 338-bed hospital offering a variety of services at its hospital location as well as primary care, family health, diabetes prevention, nutrition, and smoking cessation services in outpatient settings. Additionally, MedStar Health operates numerous Diabetes Institute locations, the MedStar Health Research Institute, and various behavioral health and outpatient psychiatry services. MedStar Health also offers numerous support groups including those focused on living well with chronic pain, diabetes, and stroke.

Home-based Health Services

Organization	Example Service Offerings
Affiliated Santé Group's Baltimore County Mobile Crisis Team	Dispatches to assist in crisis events related to mental health
Baltimore County Department of Aging	Many evidence-based programs such as Stepping On Fall Prevention, BeCAUSE, senior meals
Baltimore County Department of Health	In-home aide services, Community Health Workers, Nurse home visiting
Baltimore County Department of Social Services	In-home Aides and Case management for specific populations, Guardianship unit
Meals on Wheels of Central Maryland	Home-delivered meals, Grocery Assistance Program
Sheppard Pratt	In-home medication management

Other Healthcare Services

Other healthcare services are offered by the following organizations.

Organization
Baltimore County Department of Health
Baltimore County Department of Social Services
Baltimore County Public Schools
Baltimore Medical Systems
Center for Family Success
Chase Brexton
County shelters
Gilchrist
House of Ruth
Maryland Department of Health
Nueva Vida
Planned Parenthood
St. Clare Medical Outreach
Total Health Care
Towson University Institute for Well Being

Community Services

Additional community services are offered by the following organizations.

Organization
Alzheimer's support group
American Cancer Society
American Diabetes Association
American Heart Association
Assistance Center of Towson Churches

Organization
Baltimore County Communities for the Homeless
Baltimore County Public Library
Baltimore County Recreation and Parks
Baltimore County Senior Centers
Baltimore Hunger Project
Baltimore Jobs Program
BCPS Allied Health Magnets
CCBC
Community Assistance Network
Epiphany Community Services
Food distribution sites (various)
Gilchrist Grief Counseling and Support Resources
Harbel Prevention and Recovery Center
Healthy Babies Collaborative
Healthcare Access Maryland
Healthcare for the Homeless
Humanim
Hungry Harvest
League for People with Disabilities
MD Food Bank
Mental Health Association of Maryland
Mosaic Community Services
Moveable Feast
NAMI
Pro Bono Counseling
Shining Star Baptist
Southeast Network
St. Stevens AME
Streets of Hope
Student Support Network
United Way
Y of Central Maryland

CHAPTER 6 | NEXT STEPS

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

APPENDICES

APPENDIX 1 | COUNTY DEMOGRAPHIC AND SOCIOECONOMIC DETAIL

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

County Demographics

Age and Total Population

The tables below show the change in population in Baltimore County and Maryland by age cohort.

Total Population by Age – Baltimore County			
	2014	2018	CAGR
Below 18	178,621	178,931	0.0%
Between 18 and 65	517,521	507,190	-0.5%
65 and older	130,783	142,310	2.1%
Total	826,925	828,431	0.0%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Total Population by Age – Maryland			
	2014	2018	CAGR
Below 18	1,350,668	1,341,483	-0.2%
Between 18 and 65	3,800,995	3,770,656	-0.2%
65 and older	824,744	930,579	3.1%
Total	5,976,407	6,042,718	0.3%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Gender

The tables below show the change in population in Baltimore County and Maryland by gender.

Total Population by Gender – Baltimore County			
	2014	2018	CAGR
Female	435,789	435,755	0.00%
Male	391,136	392,676	0.10%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Total Population by Gender – Maryland			
	2014	2018	CAGR
Female	3,077,850	3,112,000	0.28%
Male	2,898,557	2,930,718	0.28%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Race

The tables below show the change in population in Baltimore County and Maryland by race.

Total Population by Race – Baltimore County			
	2014	2018	CAGR
White	549,503	531,501	-0.8%
Black	224,627	240,203	1.7%
Asian	48,675	52,462	1.9%
American Indian/Alaskan Native	3,500	3,637	1.0%
Native Hawaiian/Other Pacific Islander	620	628	0.3%
Total	826,925	828,431	0.0%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Total Population by Race – Maryland			
	2014	2018	CAGR
White	3,807,063	3,792,775	-0.1%
Black	1,749,444	1,801,327	0.7%
Asian	380,168	405,682	1.6%
American Indian/Alaskan Native	33,413	36,188	2.0%
Native Hawaiian/Other Pacific Islander	6,319	6,746	1.6%
Total	5,976,407	6,042,718	0.3%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Ethnicity

The tables below show the change in population in Baltimore County and Maryland by ethnicity.

Total Population by Ethnicity – Baltimore County			
	2014	2018	CAGR
Hispanic	41,346	47,221	3.38%
Non-Hispanic	785,579	781,210	-0.14%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Total Population by Ethnicity – Maryland			
	2014	2018	CAGR
Hispanic	555,806	628,443	3.12%
Non-Hispanic	5,420,601	5,414,275	-0.03%

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Socioeconomic Detail

Income

The table below shows the median household income in 2018 for Baltimore County, Maryland, and the nation overall.

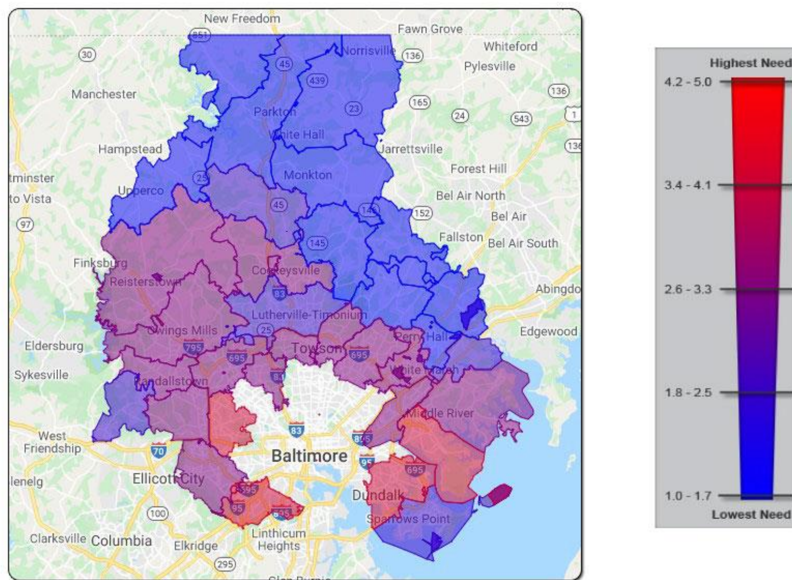
2018 Median Household Income			
	Baltimore County	Maryland	National
Income	$75,800	$83,100	$69,000

Source: Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.

Community Need Index

One resource that is helpful in demonstrating need variation among geographies is the Community Need Index (CNI) developed by Dignity Health and Truven Health Analytics. The CNI identifies the severity of health disparity at the ZIP code level and demonstrates the link among community need, access to care, and healthcare utilization. Rather than relying solely on public health data, the CNI accounts for the underlying economic and structural barriers that affect overall health including social determinants of health. The CNI identifies five prominent barriers that make it possible to quantify healthcare access in communities across the nation. These barriers include those related to income, culture/language, education, insurance, and housing.

Using data related to these barriers, a score is assigned to each barrier condition (with one (1) representing less community need and five (5) representing more community need). The scores are then aggregated and averaged for a final CNI score (each barrier receives equal weight in the average). A score of 1.0 indicates a ZIP code with the lowest socioeconomic barriers, while a score of 5.0 represents a ZIP code with the most socioeconomic barriers. As shown on the map below, areas of greatest need are



located in the southern portion of the county. Please note that since the CNI is based on ZIP code, some of the highlighted areas extend beyond the county borders.

Although Baltimore County received an overall CNI score of 2.3, there is significant variability within the county as half of the county's ZIP codes fall into the mid to mid-high CNI score range indicating the presence of socioeconomic barriers to health and healthcare for the population in those areas.

Baltimore County		
ZIP Code	**CNI Score**	**City**
21227	3.8	Halethorpe
21207	3.6	Gwynn Oak
21221	3.6	Essex
21222	3.6	Dundalk
21250	3.4	Baltimore
21030	3.2	Cockeysville
21234	3.2	Parkville
21237	3.2	Rosedale
21031	3.0	Hunt Valley
21136	3.0	Reisterstown
21204	3.0	Towson
21220	3.0	Middle River
21244	3.0	Windsor Mill
21252	3.0	Towson
21117	2.8	Owings Mills
21236	2.8	Nottingham
21286	2.8	Towson
21133	2.6	Randallstown
21208	2.6	Pikesville
21209	2.6	Baltimore
21228	2.6	Catonsville
21219	2.4	Sparrows Point
21153	2.0	Stevenson
21162	2.0	White Marsh
21052	1.8	Fort Howard
21071	1.8	Glyndon
21093	1.8	Lutherville Timonium
21152	1.8	Sparks Glencoe
21156	1.8	Upper Falls
21163	1.8	Woodstock
21128	1.6	Perry Hall
21053	1.4	Freeland
21057	1.4	Glen Arm
21120	1.4	Parkton
21131	1.4	Phoenix
21155	1.4	Upperco

Baltimore County		
ZIP Code	**CNI Score**	**City**
21013	1.2	Baldwin
21082	1.2	Hydes
21087	1.2	Kingsville
21111	1.2	Monkton
21161	1.2	White Hall
21051	1.0	Fork

APPENDIX 2 | DETAILED EXISTING (SECONDARY) DATA FINDINGS

Many individual existing data measures were analyzed as part of the CHNA process. These data provide detailed insight into the health status and health-related behavior of residents in the county. These existing data are based on statistics of actual occurrences, such as the incidence of certain diseases, as well as statistics related to social determinants of health.

Methodology

All individual existing data measures were grouped into six categories and 20 corresponding focus areas based on “common themes.” In order to draw conclusions about the existing data, Baltimore County’s performance on each data measure were compared to targets/benchmarks. If Baltimore County’s performance was more than five percent worse than the comparative benchmark, it was concluded that improvements are needed to better the health of Baltimore County residents. Conversely, if Baltimore County performed more than five percent better than the benchmark, it was concluded that the need for improvement is less acute. The most recently available Baltimore County data were compared to these targets/benchmarks in the following order (as applicable):

- Maryland
- National Benchmark/University of Wisconsin Population Health Institute’s County Health Rankings Top Performers Benchmark

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

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

Data Sources

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

Access to Care

Measure	Description	Data Source	Most Recent Data Year(s)
Uninsured (percent of population < 65 without health insurance)	Percentage of the population under age 65 without health insurance coverage.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Primary Care (ratio of population to primary care physicians - population per one provider)	Ratio of the population to primary care physicians. Primary care physicians include practicing non-federal physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. The ratio represents the number of individuals served by one physician in a county, if the population was equally distributed across physicians. Prior to the 2013 County Health Rankings, primary care physicians were defined only as M.D.s. In 2013, D.O.s were incorporated into the definition of primary care physicians and obstetrics/gynecology was removed as a primary care physician type.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Dentists (ratio of population to dentists - population per one dentist)	Ratio of the population to dentists. The ratio represents the population served by one dentist if the entire population of a county was distributed equally across all practicing dentists.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2018
Uninsured adults (ages 18 to 64)	Percentage of the population ages 18 to 64 that has no health insurance coverage in a given geography.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Uninsured children (ages under 19)	Percentage of the population under age 19 that has no health insurance coverage.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Other primary care providers (ratio of population to other primary care providers -	Ratio of the county population to the number of other primary care providers. Other primary care providers include nurse practitioners	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County	2019

Measure	Description	Data Source	Most Recent Data Year(s)
population per one provider)	(NP), physician assistants (PA), and clinical nurse specialists. Please note that the methods for calculating this measure changed in the 2017 Rankings.	Health Rankings. Data accessed December 2020.	
Children receiving dental care (ages 0 to 20)	This indicator reflects the percentage of children (aged 0-20 years) enrolled in Medicaid (320+ days) who received at least one dental visit during the past year.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
ED visit rate due to addiction-related conditions	This indicator shows the rate of emergency department visits related to substance use disorders (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
ED visit rate due to asthma	This indicator shows the rate of emergency department visits due to asthma (per 10,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
ED visit rate due to diabetes	This indicator shows the emergency department visit rate due to diabetes (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
ED visit rate due to hypertension	This indicator shows the rate of emergency department visits due to hypertension (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
ED visit rate due to dental problems	This indicator shows the emergency department visit rate related to dental problems (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Persons with a usual primary care provider	This indicator shows the percentage of people who reported that they had one person they think of as their personal doctor or healthcare provider.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Uninsured ED visits	This indicator shows the percentage of persons without health (medical) insurance.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Persons unable to afford physician visits	Percentage of adults unable to afford to see a doctor.	MedStar Franklin Square, FY21 Community Health	2015

Measure	Description	Data Source	Most Recent Data Year(s)
		Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	

Built Environment

Measure	Description	Data Source	Most Recent Data Year(s)
Food environment index (index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best))	The Food Environment Index measures the quality of the food environment in a county on a scale from 0 to 10. The Food Environment Index is comprised of two variables: Limited access to healthy foods from the USDA's Food Environment Atlas estimates the percentage of the population who are low income and do not live close to a grocery store. Living close to a grocery store is defined differently in rural and nonrural areas: in rural areas, it means living less than 10 miles from a grocery store whereas in nonrural areas, it means less than 1 mile. Low income is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size. Food insecurity from Feeding America estimates the percentage of the population who did not have access to a reliable source of food during the past year. The two variables are scaled from 0 to 10 (zero being the worst value in the nation, and 10 being the best) and averaged to produce the Food Environment Index. In 2016, the average value for counties was 7.0 and most counties fell between about 5.4 and 8.3.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2015, 2017
Access to exercise opportunities (percent of the population with adequate access to locations for physical activity)	Percentage of individuals in a county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities. Individuals are considered to have access to exercise	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2010, 2019

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

Diet and Exercise

Measure	Description	Data Source	Most Recent Data Year(s)
Physical inactivity (percent of adults that report no leisure time physical activity)	Percentage of adults ages 20 and over reporting no leisure-time physical activity in the past month. Examples of physical activities include running, calisthenics, golf, gardening, or walking for exercise. The method for calculating Physical	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016

Measure	Description	Data Source	Most Recent Data Year(s)
	Inactivity changed. Data for Physical Inactivity are provided by the CDC Interactive Diabetes Atlas which combines 3 years of survey data to provide county-level estimates. In 2011, BRFSS changed their methodology to include cell phone and landline participants. Previously only landlines were used to collect data. Physical Inactivity is created using statistical modeling.		
Physical Activity (percentage)	This indicator shows the percentage of persons who reported at least 150 minutes of moderate physical activity or at least 75 minutes of vigorous physical activity per week.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017

Education

Measure	Description	Data Source	Most Recent Data Year(s)
High school graduation (percent of ninth grade cohort that graduates in four years)	Percentage of the ninth-grade cohort in public schools that graduates from high school in four years. Please note this measure was modified in the 2011, 2012, and 2014 Rankings.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016-2017
Some college (percent of adults aged 25-44 years with some post-secondary education)	Percentage of the population ages 25-44 with some post-secondary education, such as enrollment in vocational/technical schools, junior colleges, or four-year colleges. It includes individuals who pursued education following high school but did not receive a degree as well as those who attain degrees. The numerator is the number of adults ages 25-44 who have obtained some level of post-secondary education. The denominator is the population ages 25-44 in a county.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Reading Scores	Average grade level performance for 3rd graders on English Language Arts standardized tests.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016

Measure	Description	Data Source	Most Recent Data Year(s)
Math Scores	Average grade level performance for 3rd graders on math standardized tests.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016
Students entering kindergarten ready to learn	This indicator shows the percentage of students who enter Kindergarten ready to learn.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Percentage of adults with a high school diploma or higher	Percentage of adults with a high school diploma or higher.	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2014-2018
Percentage of adults with a bachelor's or more advanced degree	Percentage of adults with a bachelor's or more advanced degree.	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2014-2018

Employment

Measure	Description	Data Source	Most Recent Data Year(s)
Unemployment rate (percent of population age 16+ unemployed)	Percentage of a county's workforce that is not employed. The numerator is the number of individuals over age 16 in a county who are seeking work but do not have a job. The denominator is the total labor force, which includes all individuals over age 16 who are actively searching for work and unemployed plus those who are employed. Unemployment estimates are modeled.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2018

Environmental Quality

Measure	Description	Data Source	Most Recent Data Year(s)
Air pollution (avg daily measure of fine particulate matter in micrograms per cubic meter)	Average daily density of fine particulate matter in micrograms per cubic meter. Fine particulate matter is defined as particles of air pollutants with an aerodynamic	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County	2014

Measure	Description	Data Source	Most Recent Data Year(s)
	diameter less than 2.5 micrometers (PM2.5). Air Pollution is modeled. For 2017, County Health Rankings is using data provided by the EPHT Network. From 2013-2016 the County Health Rankings used data provided by the NASA Applied Sciences Program, which used a similar methodology but also incorporates satellite data. For 2012 and prior years of the County Health Rankings, data were obtained from the EPHT Network, but the measures of air quality differed from the current measure: County Health Rankings reported the average number of days annually that both PM2.5 and ozone pollution were reported to be over the accepted limit.	Health Rankings. Data accessed December 2020.	

Family, Community, and Social Support

Measure	Description	Data Source	Most Recent Data Year(s)
Percentage of children that live in single-parent household	Percentage of children (less than 18 years of age) in family households that live in a household headed by a single parent. The single parent could be a male or female and is without the presence of a spouse. Foster children and children living in non-family households or group quarters are not included in either the numerator or denominator.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Social associations (number of membership associations per 10,000 population)	Number of organizations per 10,000 population in a county. The numerator is the number of organizations or associations in a county. Associations include membership organizations such as civic organizations, bowling centers, golf clubs, fitness centers, sports organizations, political organizations, labor organizations, business organizations, and professional organizations. The denominator is the population of a county. Social Associations does not measure all of	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017

Measure	Description	Data Source	Most Recent Data Year(s)
	the social support available within a county. Data and business codes are self-reported by businesses in a county. We use the primary business code of organizations, which in some cases may not match up with our notion of what should be labeled as a civic organization. This measure does not take into account other important social connections offered via family support structures, informal networks, or community service organizations, all of which are important to consider when understanding the amount of social support available within a county.		
Disconnected youth	Percentage of teens and young adults ages 16-24 who are neither working nor in school.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Residential segregation - black/white	Degree to which two or more groups live separately from one another in a geographic area. The index of dissimilarity is a demographic measure of the evenness with which two groups (black and white residents, in this case) are distributed across the component geographic areas (census tracts, in this case) that make up a larger area (counties, in this case). The index score can be interpreted as the percentage of either black or white residents that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Residential segregation - non-white/white	Degree to which two or more groups live separately from one another in a geographic area. The index of dissimilarity is a demographic measure of the evenness with which two groups (non-white and white residents) are distributed across the component geographic areas (census tracts, in this case) that make up a larger area (counties, in this case).	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018

Measure	Description	Data Source	Most Recent Data Year(s)
	The index score can be interpreted as the percentage of white or non-white that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area.		
Percentage not proficient in English	Percentage of population that is not proficient in English.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018

Food Security

Measure	Description	Data Source	Most Recent Data Year(s)
Percentage of households experiencing food insecurity	Percentage of the population who did not have access to a reliable source of food during the past year. This measure was modeled using information from the Community Population Survey, Bureau of Labor Statistics, and American Community Survey. More detailed information can be found here. This is one of two measures that are used to construct the Food Environment Index.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Limited access to healthy foods	Percentage of population who are low-income and do not live close to a grocery store.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2015
Children eligible for free or reduced-price lunch	Percentage of children enrolled in public schools, grades PK - 12, eligible for free (family income less than 130 percent of federal poverty level) or reduced price (family income less than 185 percent of federal poverty level) lunch.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017-2018
Percentage of households with children receiving public assistance or SNAP benefits	Percentage of households with children receiving public assistance or SNAP benefits	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2018
Percentage of households with children	Percentage of households with children experiencing food insecurity	MedStar Franklin Square, FY21 Community Health	2018

Measure	Description	Data Source	Most Recent Data Year(s)
experiencing food insecurity		Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	
Food Insecurity Among Middle School Students: All races/ethnicities	Percentage of students who, when asked, said they were worried that their food money would run out before they could buy more, and/or if the food their family bought did not last and they did not have money to get more.	The Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS). Data accessed December 2020.	2018
Food Insecurity Among High School Students: All races/ethnicities	Percentage of students who, when asked, said they were worried that their food money would run out before they could buy more, and/or if the food their family bought did not last and they did not have money to get more.	The Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS). Data accessed December 2020.	2018

Housing and Homelessness

Measure	Description	Data Source	Most Recent Data Year(s)
Severe housing problems (percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities)	Percentage of households with one or more of the following housing problems: Housing unit lacks complete kitchen facilities; Housing unit lacks complete plumbing facilities; Household is severely overcrowded; or Household is severely cost burdened. Incomplete kitchen facilities is defined as a unit which lacks a sink with running water, a range or a refrigerator. Incomplete plumbing facilities is defined as lacking hot and cold piped water, a flush toilet, or a bathtub/shower. Severe overcrowding is defined as more than 1.5 persons per room. Severe cost burden is defined as monthly housing costs (including utilities) that exceed 50 percent of monthly income. The numerator is the number of households in a county with at least one of the above housing problems and the denominator is the number of total households in a county.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2012-2016

Measure	Description	Data Source	Most Recent Data Year(s)
Percentage of owner-occupied housing	Percentage of occupied housing units that are owned.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Percentage of people spending more than 50 percent of their income on rental housing	Number of renter-occupied housing units spending 50 or more percent of household income on rent as a percentage of total renter-occupied housing units.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Affordable Housing (percentage)	This indicator shows the percentage of housing units sold that are affordable on the median teacher's salary.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2016

Income

Measure	Description	Data Source	Most Recent Data Year(s)
Children in poverty (percent of children under age 18 in poverty)	Percentage of children under age 18 living in poverty. Poverty status is defined by family size and income and is measured at the household level. If a household's income is lower than the poverty threshold for a household of their size, they are considered to be in poverty. Poverty thresholds differ by household size and geography. For more information on how poverty thresholds are calculated please see the Census poverty page. Children in Poverty estimates are modeled.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2018
Median household income	Income where half of households in a county earn more and half of households earn less. Income, defined as "Total income", is the sum of the amounts reported separately for: wage or salary income; net self-employment income; interest, dividends, or net rental or royalty income or income from estates and trusts; Social Security or Railroad Retirement income; Supplemental Security Income (SSI); public assistance or welfare payments;	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2018

Measure	Description	Data Source	Most Recent Data Year(s)
	retirement, survivor, or disability pensions; and all other income. Receipts from the following sources are not included as income: capital gains; money received from the sale of property (unless the recipient was engaged in the business of selling such property); the value of income "in kind" from food stamps, public housing subsidies, medical care, employer contributions for individuals, etc.; withdrawal of bank deposits; money borrowed; tax refunds; exchange of money between relatives living in the same household; gifts and lump-sum inheritances, insurance payments, and other types of lump-sum receipts.		
Income inequality (ratio of household income at the 80th percentile to income at the 20th percentile)	Ratio of household income at the 80th percentile to that at the 20th percentile, i.e., when the incomes of all households in a county are listed from highest to lowest, the 80th percentile is the level of income at which only 20 percent of households have higher incomes, and the 20th percentile is the level of income at which only 20 percent of households have lower incomes. A higher inequality ratio indicates greater division between the top and bottom ends of the income spectrum.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Percentage of individuals living in poverty	Number of people living below poverty level as percent of total population.	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2018
Household Income ($, 000s) - All	Average annual household income in 2014-2015 for children (now in their mid-30s) who grew up in this area.	The Opportunity Atlas, developed in partnership by the U.S. Census Bureau, Harvard University, and Brown University. Data accessed December 2020.	2014-2015

Length of Life

Measure	Description	Data Source	Most Recent Data Year(s)
Premature Death (years of potential life lost before age 75 per 100,000 population age-adjusted)	Number of events (i.e., deaths, births, etc.) in a given time period (three-year period) divided by the average number of people at risk during that period. Years of potential life lost measures mortality by giving more weight to deaths at earlier ages than deaths at later ages. Premature deaths are deaths before age 75. All of the years of potential life lost in a county during a three-year period are summed and divided by the total population of the county during that same time period-this value is then multiplied by 100,000 to calculate the years of potential life lost under age 75 per 100,000 people. These are age-adjusted.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016-2018
Life expectancy	Average number of additional years t hat someone at a given age would be expected to live if current mortality conditions remaine d constant throughout their lifetime. Based on life expectancy at birth. State data are a single year while county data are a three-year aggregate. Data were not reported in the County Health Book prior to 2013.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016-2018
Child mortality	Number of deaths among children under age 18 per 100,000 population	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2015-2018

Maternal and Infant Health

Measure	Description	Data Source	Most Recent Data Year(s)
Low birthweight (percent of live births with birthweight < 2500 grams)	Percentage of live births where the infant weighed less than 2,500 grams (approximately 5 lbs., 8 oz.). The numerator is the number of low birthweight infants born over a 7-year time span, while the denominator is the total number of births in a county during the same time.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2012-2018
Infant mortality	Number of all infant deaths (within 1 year), per 1,000 live births.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2012-2018

Mental Health

Measure	Description	Data Source	Most Recent Data Year(s)
Poor mental health days (avg number in past 30 days age-adjusted)	Average number of mentally unhealthy days reported in past 30 days. This measure is based on responses to the Behavioral Risk Factor Surveillance System (BRFSS) question: “Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” The value reported in the County Health Rankings is the average number of days a county’s adult respondents report that their mental health was not good. Poor Mental Health Days is age-adjusted. Prior to the 2016 County Health Rankings, the CDC’s BRFSS provided the County Health Rankings with county-level estimates that were constructed from seven years of responses from participants who used a landline phone. However, even with multiple years of data, these did not provide reliable estimates for all counties, particularly those with smaller	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017

Measure	Description	Data Source	Most Recent Data Year(s)
	respondent samples. In 2016, the CDC began producing single-year estimates at the county level using a combination of BRFSS data and a multilevel modeling approach based on respondent answers and individual characteristics such as age, sex, and race/ethnicity, along with county-level poverty and county and state-level contextual effects. Poor Mental Health Days estimates are created using statistical modeling.		
Mental health providers (ratio of population to mental health providers - population per one provider)	Ratio of the population to mental health providers. Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and mental health providers that treat alcohol and other drug abuse, as well as advanced practice nurses specializing in mental healthcare. The ratio represents the number of individuals served by one mental health provider in a county, if the population were equally distributed across providers. In 2015, marriage and family therapists and mental health providers that treat alcohol and other drug abuse were added to this measure.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2019
Frequent mental distress	Percentage of adults who reported ≥14 days in response to the question, "Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
ED visit rate due to mental health conditions	This indicator shows the rate of emergency department visits related to mental health disorders (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Suicide Rate	This indicator shows the suicide rate per 100,000 population.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2014-2017

Measure	Description	Data Source	Most Recent Data Year(s)
Hospitalization rate due to Alzheimer's or other dementias	This indicator shows the rate of hospitalizations related to Alzheimer's or other dementias (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017

Physical Health

Measure	Description	Data Source	Most Recent Data Year(s)
Poor or fair health (percent of adults reporting fair or poor health age-adjusted)	Percentage of adults in a county who consider themselves to be in poor or fair health. This measure is based on responses to the Behavioral Risk Factor Surveillance Survey (BRFSS) question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" The value reported in the County Health Rankings is the percentage of respondents who rated their health "fair" or "poor." Poor or Fair Health is age-adjusted. Prior to the 2016 County Health Rankings, the CDC's BRFSS provided the County Health Rankings with county-level estimates that were constructed from seven years of responses from participants who used a landline phone. However, even with multiple years of data, these did not provide reliable estimates for all counties, particularly those with smaller respondent samples. In 2016, the CDC began producing single-year estimates at the county level using a combination of BRFSS data and a multilevel modeling approach based on respondent answers and individual characteristics such as age, sex, and race/ethnicity, along with county-level poverty and county and state-level contextual effects. Poor or Fair Health estimates are created using statistical modeling.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Poor physical health days (avg number of unhealthy days in past 30 days, age-adjusted)	Average number of physically unhealthy days reported in past 30 days. This measure is based on responses to the Behavioral Risk	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County	2017

Measure	Description	Data Source	Most Recent Data Year(s)
	Factor Surveillance System (BRFSS) question: "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?" The value reported in the County Health Rankings is the average number of days a county's adult respondents report that their physical health was not good. Poor Physical Health Days is age-adjusted. Prior to the 2016 County Health Rankings, the CDC's BRFSS provided the County Health Rankings with county-level estimates that were constructed from seven years of responses from participants who used a landline phone. However, even with multiple years of data, these did not provide reliable estimates for all counties, particularly those with smaller respondent samples. In 2016, the CDC began producing single-year estimates at the county level using a combination of BRFSS data and a multilevel modeling approach based on respondent answers and individual characteristics such as age, sex, and race/ethnicity, along with county-level poverty and county and state-level contextual effects. Poor Physical Health Days estimates are created using statistical modeling.	Health Rankings. Data accessed December 2020.	
Adult obesity (percent of adults that report a BMI >= 30)	Based on responses to the Behavioral Risk Factor Surveillance Survey (BRFSS) and is the percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2. Participants are asked to self-report their height and weight. From these reported values, BMIs for the participants are calculated. The method for calculating Adult Obesity changed. Data for Adult Obesity are provided by the CDC Interactive Diabetes Atlas which combines 3	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016

Measure	Description	Data Source	Most Recent Data Year(s)
	years of survey data to provide county-level estimates. In 2011, BRFSS changed their methodology to include cell phone and landline participants. Previously only landlines were used to collect data. Adult Obesity is created using statistical modeling.		
Frequent physical distress	Percentage of adults who reported ≥14 days in response to the question, "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?"	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Diabetes prevalence	Prevalence of diagnosed diabetes in a given county. Respondents were considered to have diagnosed diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016
Insufficient Sleep	Percentage of adults who report fewer than 7 hours of sleep on average.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016
Adolescents who are obese	This indicator shows the percentage of adolescent public high school students who are obese.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2016
Sudden unexpected infant death rate	This indicator shows the rate of sudden unexpected infant deaths (SUIDs) per 1,000 live births. Sudden unexpected infant deaths (SUIDs) include deaths from Sudden Infant Death Syndrome (SIDS), unknown cause, accidental suffocation and strangulation in bed.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2013-2017
Adults who are not overweight or obese (percentage)	This indicator shows the percentage of adults who are not overweight or obese.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017

Measure	Description	Data Source	Most Recent Data Year(s)
Cancer mortality rate	This indicator shows the age-adjusted mortality rate from cancer (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2012-2016
Age-Adjusted Mortality Rate from Heart Disease	This indicator shows the age-adjusted mortality rate from heart disease (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2014-2017
Age-adjusted Death Rate due to Diabetes (per 100,000 population)	Age-adjusted Death Rate due to Diabetes (per 100,000 population).	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2019
Age-adjusted Death Rate due to Stroke (per 100,000 population)	Age-adjusted Death Rate due to Stroke (per 100,000 population).	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2019
Age-adjusted Death Rate due to Cancer (per 100,000 population)	Age-adjusted Death Rate due to Cancer (per 100,000 population).	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2019

Quality of Care

Measure	Description	Data Source	Most Recent Data Year(s)
Preventable hospital stays (rate for ambulatory sensitive conditions per 1,000 Medicare enrollees)	Hospital discharge rate for ambulatory care-sensitive conditions per 1,000 fee-for-service Medicare enrollees. That means it looks at people who were discharged from the hospital for conditions that, with appropriate care, can normally be treated without the need for a hospital stay. Examples of these conditions include convulsions, chronic obstructive pulmonary disease, bacterial pneumonia, asthma, congestive heart failure, hypertension, angina, cellulitis, diabetes, gastroenteritis, kidney/urinary infection, and	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017

Measure	Description	Data Source	Most Recent Data Year(s)
	dehydration. Preventable hospital stays are measured among fee-for-service Medicare enrollees and is age-adjusted.		
Mammography screening (percent of female Medicare enrollees)	Percentage of female Medicare enrollees ages 67-69 that received at least one mammogram during the last two years. The numerator is women ages 67-69 on Medicare who have received at least one mammogram during the past year. The denominator is all women ages 67-69 on Medicare in a specific geography.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Children and adults who are vaccinated annually against seasonal influenza	Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Children receiving blood lead screening	This indicator reflects the percentage of children (aged 12-35 months) enrolled in Medicaid (90+ days) screened for lead in their blood.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Children with elevated blood lead levels	Number of children (0-72 months old) with blood lead levels > 10 µg/dL divided by the Total Number of Children (0-72 months old) tested.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Early prenatal care	This indicator shows the percentage of pregnant women who receive prenatal care beginning in the first trimester.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017

Safety

Measure	Description	Data Source	Most Recent Data Year(s)
Violent crime rate per 100,000 population	Number of violent crimes reported per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between a victim and a perpetrator, including homicide, rape, robbery, and aggravated assault. Information for this measure comes from the FBI's Uniform Crime Reporting (UCR) Program. Crimes are counted where they are committed rather than based on the residence of people involved.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014, 2017
Injury mortality per 100,000 population	Number of deaths from planned (e.g., homicide or suicide) and unplanned (e.g., motor vehicle deaths) injuries per 100,000 population. This measure includes injuries from all causes and intents over a 5-year period. Deaths are counted in the county of residence for the person who died, rather than the county where the death occurred.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Motor vehicle crash deaths	Number of deaths due to traffic accidents involving a motor vehicle per 100,000 population. Motor vehicle crash deaths include traffic accidents involving motorcycles; 3-wheel motor vehicles; cars; vans; trucks; buses; street cars; ATVs; industrial, agricultural, and construction vehicles; and bicyclists or pedestrians when colliding with any of the previously listed motor vehicles. Deaths due to boating accidents and airline crashes are not included in this measure. In prior years, non-traffic motor vehicle accidents were included in this definition. ICD10 codes included are V02-V04 (.1, .9), V09.2, V12-V14 (.3-.9), V19 (.4-.6), V20-V28 (.3-.9), V29-V79 (.4-.9), V80 (.3-.5), V81.1, V82.1, V83-V86 (.0-.3), V87 (.0-.8), and V89.2.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2012-2018

Measure	Description	Data Source	Most Recent Data Year(s)
Homicides	Number of deaths from assaults, defined as ICD-10 codes X85-Y09, per 100,000 population	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2012-2018
Firearm fatalities	Number of deaths due to firearms, defined as ICD-10 codes W32-W34, X72-X74, X93-X95, Y22-Y24, and Y35.0, per 100,000 population.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Juvenile arrests	Rate of delinquency cases per 1,000 juveniles.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Child maltreatment rate	This indicator shows the rate of children who are maltreated per 1,000 population under the age of 18.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Fall-related death rate	This indicator shows the rate of fall-related deaths per 100,000 population.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2014-2017
Pedestrian injury rate on public roads	This indicator shows the rate of pedestrian injuries on public roads per 100,000 population.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017
Domestic Violence	Number of domestic violence crimes divided by total population.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017

Sexual Health

Measure	Description	Data Source	Most Recent Data Year(s)
Sexually transmitted infections (chlamydia rate per 100,000)	Number of newly diagnosed chlamydia cases per 100,000 population	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Teen birth rate (per 1,000 females ages 15-19)	Number of births to females ages 15-19 per 1,000 females	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2012-2018
HIV prevalence	Number of diagnosed cases of HIV for persons aged 13 years and older in a county per 100,000 population.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016
HIV incidence rate	This indicator shows the rate of adult/adolescent cases (age 13+) diagnosed with HIV (per 100,000 population).	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2017

Substance Use Disorders

Measure	Description	Data Source	Most Recent Data Year(s)
Excessive drinking	Percentage of adults that report either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than one (women) or 2 (men) drinks per day on average. Please note that the methods for calculating this measure changed in the 2011 Rankings and again in the 2016 Rankings. Excessive Drinking estimates are created using statistical modeling.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Alcohol-impaired driving deaths	Percentage of motor vehicle crash deaths which had alcohol involvement. The National Highway Traffic Safety Administration defines a fatal crash as alcohol-related or	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County	2014-2018

Measure	Description	Data Source	Most Recent Data Year(s)
	alcohol-involved if either a driver or a non-motorist (usually a pedestrian or bicyclist) had a measurable or estimated blood alcohol concentration of 0.01 grams per deciliter or above. Alcohol-Impaired Driving Deaths are measured in the county of occurrence.	Health Rankings. Data accessed December 2020.	
Drug overdose deaths	Number of deaths due to drug poisoning per 100,000 population. ICD-10 codes used include X40-X44, X60-X64, X85, and Y10-Y14. These codes cover accidental, intentional, and undetermined poisoning by and exposure to: 1) nonopioid analgesics, antipyretics and antirheumatics, 2) antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, 3) narcotics and psychodysleptics [hallucinogens], not elsewhere classified, 4) other drugs acting on the autonomic nervous system, and 5) other and unspecified drugs, medicaments and biological substances.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2016-2018
Opioid prescriptions dispensed (per 100 persons)	Opioid prescriptions dispensed (per 100 persons).	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2018
Percentage of population impacted by fentanyl-related deaths	Percentage of population impacted by fentanyl-related deaths (Number of related deaths taken as a percentage of the total population).	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2018
Percentage of population impacted by heroin-related deaths	Percentage of population impacted by heroin-related deaths (Number of related deaths taken as a percentage of the total population).	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce Kickoff Meeting. Data accessed December 2020.	2018
Percentage of population impacted by opioid-related deaths	Percentage of population impacted by opioid-related deaths (Number of related deaths taken as a percentage of the total population).	MedStar Franklin Square, FY21 Community Health Needs Assessment Advisory Taskforce	2018

Measure	Description	Data Source	Most Recent Data Year(s)
		Kickoff Meeting. Data accessed December 2020.	

Tobacco Use

Measure	Description	Data Source	Most Recent Data Year(s)
Adult smoking	Percentage of the adult population that currently smokes every day or most days and has smoked at least 100 cigarettes in their lifetime. Please note that the methods for calculating this measure changed in the 2016 Rankings. Adult Smoking estimates are created using statistical modeling.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2017
Adolescents who use tobacco products	This indicator shows the percentage of adolescents (public high school students) who used any tobacco product in the last 30 days.	Maryland Department of Health, State Health Improvement Process (SHIP). Data accessed December 2020.	2016

Transportation Options and Transit

Measure	Description	Data Source	Most Recent Data Year(s)
Driving alone to work (percent of the workforce that drives alone to work)	Percentage of the workforce that usually drives alone to work. The numerator is the number of workers who commute alone to work via a car, truck, or van. The denominator is the total workforce.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Long commute/driving alone (among workers who commute in their car alone, the percentage that commute more than 30 minutes)	Percentage of workers who drive alone (via car, truck, or van) with a commute longer than 30 minutes. The numerator is the number of workers who drive alone for more than 30 minutes during their commute. The denominator is the number of workers who drive alone during their commute.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2014-2018
Traffic volume	Average traffic volume per meter of major roadways in the county.	Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute, County Health Rankings. Data accessed December 2020.	2018

Complete Data by Focus Area

When viewing the existing data summary tables, please note that the following color shadings have been included to identify how Baltimore County compares to Maryland/the national benchmark.

Existing Data Summary Table Color Comparisons

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

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

Access to Care

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Uninsured (percent of population <65 without health insurance)	6.0%	7.0%	6.0%	2017	Trending in Correct Direction	-14.1%
Primary Care (ratio of population to primary care physicians - population per one provider)	1,030.0	1,140.0	990.0	2017	Trending in Wrong Direction	0.5%
Dentists (ratio of population to dentists - population per one dentist)	1,240.0	1,290.0	1,340.0	2018	Trending in Correct Direction	-0.6%
Uninsured adults (ages 18 to 64)	7.0%	8.0%	7.0%	2017	Trending in Correct Direction	-15.9%
Uninsured children (ages under 19)	3.0%	4.0%	3.0%	2017	Trending in Correct Direction	-12.0%
Other primary care providers (ratio of population to other primary care providers - population per one provider)	665.0	937.0	916.0	2019	Trending in Correct Direction	-9.3%
Children receiving dental care (ages 0 to 20)	NA	63.7	62.9	2017	Trending in Correct Direction	0.1%
ED visit rate due to addiction-related conditions	NA	2,017.0	1,689.0	2017	Trending in Correct Direction	-2.7%
ED visit rate due to asthma	NA	68.4	68.0	2017	Trending in Correct Direction	-4.8%
ED visit rate due to diabetes	NA	243.7	224.6	2017	Trending in Wrong Direction	12.8%
ED visit rate due to hypertension	NA	351.2	340.7	2017	Trending in Wrong Direction	11.1%
ED visit rate due to dental problems	NA	362.7	281.1	2017	Trending in Correct Direction	-45.6%

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Persons with a usual primary care provider	NA	83.2%	88.2%	2017	Trending in Correct Direction	2.2%
Uninsured ED visits	NA	8.6	7.9	2017	Trending in Correct Direction	-15.4%
Persons unable to afford physician visits	13.0%	11.0%	11.0%	2015	NA	NA

Built Environment

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Access to exercise opportunities (percent of the population with adequate access to locations for physical activity)	91.0%	93.0%	96.0%	2010, 2019	Trending in Correct Direction	0.0%
Food environment index (index of factors that contribute to a healthy food environment)	8.6	9.0	8.4	2015, 2017	Trending in Correct Direction	1.2%

Diet and Exercise

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Physical inactivity (percent of adults that report no leisure time physical activity)	20.0%	22.0%	24.0%	2016	Trending in Correct Direction	-1.0%
Physical Activity (percentage)	NA	50.6%	49.7%	2017	Trending in Correct Direction	0.7%

Education

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
High school graduation (percent of ninth grade cohort that graduates in four years)	96.0%	88.0%	89.0%	2016-2017	Trending in Correct Direction	2.1%
Some college (percent of adults aged 25-44 years with some post-secondary education)	73.0%	70.0%	70.0%	2014-2018	Trending in Correct Direction	0.0%
Students entering kindergarten ready to learn	NA	45.0%	47.0%	2017	Trending in Wrong Direction	-2.0%
Percentage of adults with a high school diploma or higher	90.0%	91.0%	91.0%	2014-2018	NA	NA
Percentage of adults with a bachelor's or more advanced degree	35.0%	40.0%	39.0%	2014-2018	NA	NA
Reading scores	3.4	3.1	3.1	2016	NA	NA
Math scores	3.4	3.0	3.1	2016	NA	NA

Employment

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Unemployment rate (percent of population age 16+ unemployed)	2.6%	3.9%	4.0%	2018	Trending in Correct Direction	-10.4%

Environmental Quality

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Air pollution (avg daily measure of fine particulate matter in micrograms per cubic meter)	6.1	9.6	10.9	2014	Trending in Correct Direction	-2.5%

Family, Community and Social Support

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Percent of children that live in single-parent household	20.0%	33.0%	34.0%	2014-2018	Trending in Correct Direction	-1.4%
Social associations	18.4	9.0	8.4	2017	Trending in Correct Direction	0.6%
Disconnected youth	4.0%	6.0%	5.0%	2014-2018	Trending in Correct Direction	-19.7%
Residential segregation - Black/White	23.0	62.0	58.0	2014-2018	Trending in Correct Direction	-0.8%
Residential segregation - non-White/White	14.0	55.0	50.0	2014-2018	Trending in Correct Direction	-1.0%
Percentage not proficient in English	NA	3.0P	2.0%	2014-2018	Trending in Wrong Direction	0.0%

Food Security

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Percentage of households experiencing food insecurity	9.0%	11.0%	11.0%	2017	Trending in Correct Direction	-4.1%
Percentage of households with children receiving public assistance or SNAP benefits	31.0%	12.0%	12.0%	2018	NA	NA
Percentage of households with children experiencing food insecurity	7.0%	16.0%	26.0%	2018	NA	NA
Limited access to healthy foods	2.0%	3.0%	3.0%	2015	Trending in Correct Direction	-3.1%
Children eligible for free or reduced-price lunch	32.0%	46.0%	49.0%	2017-2018	Trending in Wrong Direction	4.7%

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Food Insecurity Among Middle School Students: All races/ethnicities	NA	25.2%	28.5%	2018	NA	NA
Food Insecurity Among High School Students: All races/ethnicities	NA	28.0%	30.1%	2018	NA	NA

Housing and Homelessness

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Percentage of owner-occupied housing	81.0%	67.0%	66.0%	2014-2018	Trending in Wrong Direction	0.0%
Percentage of renters spending 50 percent or more on rent	7.0%	14.0%	14.0%	2014-2018	Trending in Correct Direction	-6.7%
Severe housing problems (percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities)	9.0%	16.0%	16.0%	2012-2016	Trending in Wrong Direction	0.0%
Affordable Housing (percent)	NA	48.1%	64.1%	2016	Trending in Wrong Direction	-0.4%

Income

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Children in poverty (percent of children under age 18 in poverty)	11.0%	12.0%	13.0%	2018	Trending in Wrong Direction	0.0%
Income Inequality	3.7	4.5	4.2	2014-2018	Trending in Wrong Direction	0.6%
Socioeconomics - Median HH Income	$69,000.0	$83,100.0	$75,800.0	2018	Trending in Correct Direction	2.8%
Percentage of persons living in poverty	12.0%	9.0%	10.0%	2018	NA	NA
Household Income ($, 000s) - All	$60.0	$81.9	$49.0	2014-2015	NA	NA

Length of Life

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Life expectancy	81.1	79.1	78.1	2016-2018	Trending in Wrong Direction	-0.3%
Premature Death (years of potential life lost before age 75 per 100,000 population age-adjusted)	5400.0	7100.0	8100.0	2016-2018	Trending in Wrong Direction	4.5%
Child mortality	40.0	50.0	50.0	2015-2018	Trending in Wrong Direction	0.0%

Maternal and Infant Health

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Infant mortality	4.0	6.0	6.0	2012-2018	Trending in Correct Direction	-2.5%
Low birthweight (percent of live births with birthweight < 2500 grams)	6.0%	9.0%	9.0%	2012-2018	Trending in Wrong Direction	0.0%

Mental Health

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Mental health providers (ratio of population to mental health providers)	290.0	390.0	330.0	2019	Trending in Correct Direction	-7.5%
Poor mental health days (avg number in past 30 days age-adjusted)	3.4	3.8	3.8	2017	Trending in Wrong Direction	1.7%
ED visit rate due to mental health conditions	NA	4291.5	4210.1	2017	Trending in Wrong Direction	15.2%
Hospitalization rate due to Alzheimer's or other dementias	NA	515.5	559.0	2017	Trending in Correct Direction	-6.6%
Suicide Rate	NA	9.3	9.7	2014-2017	Trending in Correct Direction	-2.0%
Frequent mental distress	11.0%	12.0%	12.0%	2017	Trending in Wrong Direction	6.3%

Physical Health

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Adult obesity (percent of adults that report a BMI >= 30)	26.0%	31.0%	31.0%	2016	Trending in Wrong Direction	2.6%
Poor or fair health (percent of adults reporting fair or poor health age-adjusted)	12.0%	15.0%	14.0%	2017	Trending in Wrong Direction	0.0%
Poor physical health days (avg number of unhealthy days in past 30 days, age-adjusted)	3.1	3.4	3.2	2017	Trending in Correct Direction	-0.6%
Adults who are not overweight or obese (percentage)	NA	32.6%	31.9%	2017	Trending in Wrong Direction	-1.1%
Adolescents who are obese	NA	12.6	14.7	2016	Trending in Wrong Direction	2.7%

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Sudden unexpected infant death rate	NA	0.5	0.5	2013-2017	Trending in Correct Direction	-4.5%
Age-adjusted Death Rate due to Diabetes (per 100,000 population)	21.0	20.0	8.0	2019	Trending in Correct Direction	-23.7%
Age-adjusted Death Rate due to Stroke (per 100,000 population)	37.0	40.0	45.0	2019	Trending in Correct Direction	-4.7%
Age-adjusted Death Rate due to Cancer (per 100,000 population)	149.0	155.0	168.0	2019	Trending in Wrong Direction	0.8%
Frequent physical distress	9.0%	10.0%	10.0%	2017	Trending in Wrong Direction	3.6%
Diabetes prevalence	7.0%	11.0%	11.0%	2016	Trending in Wrong Direction	2.4%
Insufficient sleep	27.0%	36.0%	34.0%	2016	Trending in Correct Direction	-5.4%
Cancer Mortality Rate	NA	154.5	167.8	2014-2017	Trending in Correct Direction	-0.1%
Age-Adjusted Mortality Rate from Heart Disease	NA	166.4	179.3	2014-2017	Trending in Wrong Direction	1.1%

Quality of Care

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Children and adults who are vaccinated annually against seasonal influenza	53.0%	50.0%	53.0%	2017	Trending in Correct Direction	3.9%
Mammography screening (percent of female Medicare enrollees)	50.0%	41.0%	45.0%	2017	Trending in Wrong Direction	-7.2%
Preventable hospital stays (rate for ambulatory sensitive conditions per 1,000 Medicare enrollees)	27.6	45.5	51.7	2017	Trending in Correct Direction	-0.6%
Children receiving blood lead screening	NA	65.7	69.4	2017	Trending in Correct Direction	0.5%
Children with elevated blood lead levels	NA	0.3	0.2	2017	Trending in Wrong Direction	0.0%
Early prenatal care	NA	69.6%	69.0%	2017	Trending in Correct Direction	1.0%

Safety

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Injury mortality per 100,000 population	58.0	76.0	95.0	2014-2018	Trending in Wrong Direction	8.9%
Violent crime rate per 100,000 population	63.0	459.0	511.0	2014, 2017	Trending in Correct Direction	-1.8%
Child maltreatment rate	NA	7.1	6.4	2017	Trending in Correct Direction	-6.8%
Domestic Violence	NA	537.1	1146.7	2017	Trending in Wrong Direction	9.9%
Fall-related death rate	NA	10.1	14.1	2014-2017	Trending in Wrong Direction	6.6%

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Pedestrian injury rate on public roads	NA	53.5	54.4	2017	Trending in Wrong Direction	4.5%
Motor vehicle crash deaths	9.0	9.0	8.0	2012-2018	Trending in Correct Direction	-2.3%
Homicides	2.0	8.0	7.0	2012-2018	Trending in Wrong Direction	3.1%
Firearm fatalities	8.0	11.0	11.0	2014-2018	Trending in Wrong Direction	6.9%
Juvenile arrests	NA	29.0	41.0	2017	NA	NA

Sexual Health

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Sexually transmitted infections (chlamydia rate per 100,000)	161.4	552.1	538.0	2017	Trending in Wrong Direction	10.3%
Teen birth rate (per 1,000 females ages 15-19)	13.0	17.0	14.0	2012-2018	Trending in Correct Direction	-9.5%
HIV incidence rate	NA	20.4	15.9	2017	Trending in Correct Direction	-3.1%
HIV prevalence	41.0	643.0	461.0	2016	Trending in Wrong Direction	0.4%

Substance Use Disorders

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Alcohol-impaired driving deaths (proportion of driving deaths with alcohol impairment)	11.0%	29.0%	26.0%	2014-2018	Trending in Correct Direction	-3.5%
Excessive drinking (percent of adults who report heavy or binge drinking)	13.0%	17.0%	17.0%	2017	Trending in Wrong Direction	1.2%
Opioid prescriptions dispensed (per 100 persons)	51.0	45.0	53.0	2018	NA	NA
Percentage of population impacted by fentanyl-related deaths	0.01%	0.03%	0.04%	2018	NA	NA
Percentage of population impacted by heroin-related deaths	0.01%	0.01%	0.01%	2018	NA	NA
Percentage of population impacted by opioid-related deaths	0.01%	0.04%	0.04%	2018	NA	NA
Drug overdose deaths	10.0	37.0	50.0	2016-2018	Trending in Wrong Direction	25.7%

Tobacco Use

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Adult smoking (percent of adults that report smoking >= 100 cigarettes and currently smoking)	14.0%	14.0%	13.0%	2017	Trending in Correct Direction	-5.2%
Adolescents who use tobacco products	NA	14.4%	16.5%	2016	Trending in Correct Direction	-8.3%

Transportation Options and Transit

Measure	Univ. of Wisconsin Top Performer Benchmark	Maryland	Baltimore County, MD	Most Recent Data Year	Baltimore County, MD Trend	CAGR
Driving alone to work (percent of the workforce that drives alone to work)	72.0%	74.0%	79.0%	2014-2018	Trending in Wrong Direction	0.0%
Long commute/driving alone (among workers who commute in their car alone, the percentage that commute more than 30 minutes)	16.0%	50.0%	47.0%	2014-2018	Trending in Wrong Direction	1.1%
Traffic volume	NA	578.0	718.0	2018	NA	NA

APPENDIX 3 | DETAILED NEW (PRIMARY) DATA FINDINGS

New data were collected through focus groups, internet-based community surveys, and internet-based key community health leader surveys.

Methodologies

The methodologies varied based on the type of new data being analyzed. The following section describes the various methodologies used to analyze the new data.

Focus Groups

17 focus groups were conducted throughout the county with the following groups:

- Local Health Improvement Coalition
- Diabetes Prevention Program SJMC
- Behavioral Health Advisory Council
- Baltimore Hebrew Congregation Brotherhood
- Homeless Roundtable
- Chase Brexton LGBT Resource Center, FreeState Justice, PFLAG
- Court Appointed Special Advocates – Towson (CASA)
- Interfaith
- Mount Olive Baptist Church
- Veterans
- North East Towson Improvement Association
- Towson University – BCDA Age Friendly Survey
- Patient Family Advisory Council
- Homebound Clients
- Hispanic Cycle/Walking Group
- Community Input FSMC
- FSMC Telephone Town Hall

Responses to the following question were analyzed to identify the issues most important to participants at each focus group:

- What are the biggest problems facing this community?

Responses were then assigned to the 20 focus areas based on similarities and common themes. The following methodology was used to assign a need level to each response topic:

- If mentioned in 7 or more groups = High Need
- If mentioned in 4-6 groups = Medium Need
- If mentioned in 0-3 groups = Low Need

Focus Group Findings	
Focus Area	**Health Need**
Length of Life	Low Need
Maternal and Infant Health	Low Need
Mental Health	High Need
Physical Health	Low Need
Access to Care	High Need
Quality of Care	Low Need
Diet and Exercise	Low Need
Sexual Health	Low Need
Substance Use Disorders	Low Need
Tobacco Use	Low Need
Built Environment	High Need
Environmental Quality	Low Need
Housing and Homelessness	Low Need
Transportation Options and Transit	Low Need
Education	Low Need
Employment	Low Need
Family, Community, and Social Support	Low Need
Food Security	Low Need
Income	Low Need
Safety	Low Need

The feedback from the focus groups was diverse, but several key themes emerged, including:

Access to Care:
- Access to Care was mentioned in 11 of 17 focus groups, with high cost or lack of/insufficient insurance being the most frequent barriers to accessing care

Built Environment:
- Built Environment was identified by 9 of 17 focus groups as a community need, with accessible home modifications, AED availability, food delivery for seniors, offices where Spanish speaking translators are available, and more mentioned

Mental Health:
- Mental Health was identified by 7 of 17 focus groups as a community need, with depression, anxiety, and stress mentioned

Additional comments related to priority needs identified in this CHNA include:

Physical Health:
- Diabetes Prevention Program SJMC: Issues of lack of exercise, obesity, smoking/tobacco use
- Interfaith Council: More dental care needed for older adults
- FSMC Telephone Town Hall: Issue of chronic disease

Community Surveys

A total of 4,276 internet-based surveys were completed by individuals whose self-reported ZIP code is located within Baltimore County. Surveys were available in both English and Spanish. Paper versions of surveys were made available upon request.

Survey responses were assigned to the 20 focus areas based on similarities and common themes. The focus areas to which each statement/response option was assigned is denoted in bold parenthesis next to the statement/response. Focus areas that were mentioned most frequently were categorized as High Need, while focus areas that were mentioned least frequently were categorized as Low Need. For all questions, non-responses and responses of unsure/do not know were not factored into the assigned need level.

Responses to the following questions were analyzed to identify the issues most important to the respondents of the community survey:

- On how many days during the past 30 days was your mental health not good? Mental health includes stress, depression, and problems with emotions. *Please write number of days.* **(Mental Health)**

- What are the three most important health problems that affect the health of your community? *Please check only three.*
  a. Alcohol/drug addiction **(Substance Use Disorders)**
  a. Alzheimer's/dementia **(Mental Health)**
  b. Mental health (depression, anxiety) **(Mental Health)**
  c. Cancer **(Physical Health)**
  d. Diabetes/high blood sugar **(Physical Health)**
  e. Heart disease/blood pressure **(Physical Health)**
  f. HIV/AIDS **(Sexual Health)**
  g. Infant death **(Maternal and Infant Health)**
  h. Lung disease/asthma/COPD **(Physical Health)**
  i. Stroke **(Physical Health)**
  j. Smoking/tobacco use **(Tobacco Use)**
  k. Overweight/obesity **(Physical Health)**
  l. Don't know
  m. Prefer not to answer

- What are the three most important social/environmental problems that affect the health of your community? *Please check only three.*
  a. Availability/access to doctor's office **(Access to Care)**
  b. Child abuse/neglect **(Safety)**
  c. Availability/access to insurance **(Access to Care)**
  d. Lack of affordable child care **(Family, community, and social support)**
  e. Domestic violence **(Safety)**
  f. Housing/homelessness **(Housing and Homelessness)**
  g. Limited access to healthy foods **(Food security)**
  h. Neighborhood safety/violence **(Safety)**
  i. School dropout/poor schools **(Education)**
  j. Poverty **(Income)**
  k. Lack of job opportunities **(Employment)**
  l. Limited places to exercise **(Diet and Exercise)**
  m. Race/ethnicity discrimination **(Family, community, and social support)**
  n. Transportation problems **(Transportation Options and Transit)**
  o. Don't know
  p. Prefer not to answer

- What are the three most important reasons people in your community do not get healthcare? *Please check only three.* **(Access to Care)**
  a. Cost – too expensive/can't pay
  b. No Insurance
  c. Insurance not accepted
  d. Lack of transportation
  e. Cultural/religious beliefs
  f. Language barrier
  g. No doctor nearby
  h. Wait is too long
  i. Don't know
  j. Prefer not to answer

- Do you have the ability to find healthy foods around where you live? **(Food Security)**

- Do you have access to a dentist or dental services? **(Access to Care)**

Community Survey Findings	
Focus Area	**Health Need**
Length of Life	Low Need
Maternal and Infant Health	Low Need
Mental Health	Medium Need
Physical Health	High Need
Access to Care	High Need
Quality of Care	Low Need
Diet and Exercise	Medium Need
Sexual Health	Low Need
Substance Use Disorders	High Need
Tobacco Use	Low Need
Built Environment	Medium Need
Environmental Quality	Low Need
Housing and Homelessness	Medium Need
Transportation Options and Transit	Low Need
Education	Low Need
Employment	Low Need
Family, Community, and Social Support	High Need
Food Security	Low Need
Income	Low Need
Safety	High Need

Several key themes emerged, including:

Physical Health:

- 48 percent of respondents identify heart disease/blood pressure as an important health problem that impacts the community
- 34 percent of respondents identify diabetes/high blood sugar as an important health problem that impacts the community

Substance Use Disorders:

- 46 percent of respondents identify alcohol/drug addiction as an important health problem that affects the community

Family, Community, and Social Support:

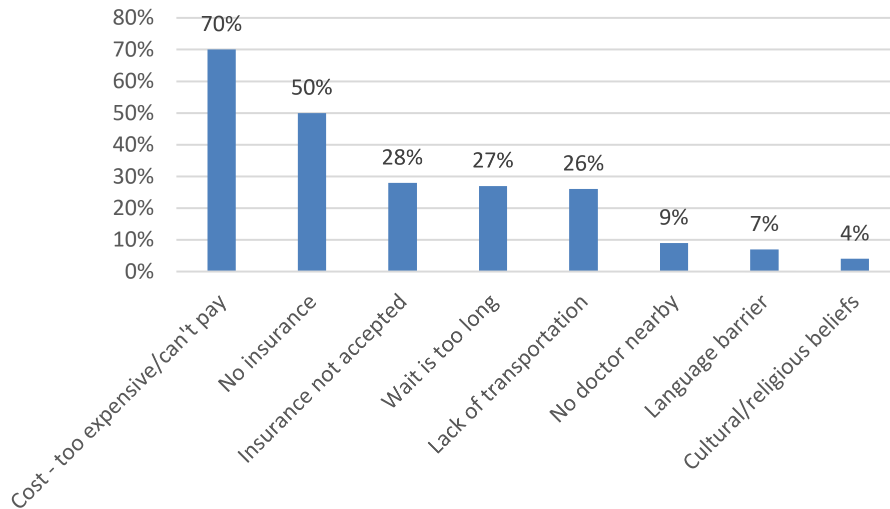
- 15 percent of community survey respondents listed lack of affordable childcare as one of the three most important social/environmental problems affecting the community

Safety:

- 22 percent of respondents identify neighborhood safety/violence as an important social/environmental problem that impacts the community
- 7 percent of respondents identify domestic violence as an important social/environmental problem that impacts the community
- 5 percent of respondents identify child abuse/neglect as an important social/environmental problem that impacts the community

Access to Care

- Most important reasons people don't get healthcare, by percent of respondents:



Additional comments related to priority needs identified in this CHNA include:

Mental Health:

- 40 percent of respondents believe mental health is an important health problem in their community
- 18 percent of respondents experienced 11 or more poor mental health days in the past month
- 32 percent of respondents experienced 6 or more poor mental health days in the past month

Built Environment:

- 11 percent of respondents identify limited places to exercise as an important social/environmental problem that impacts the community
- 14 percent of respondents identify limited access to healthy foods as an important social/environmental problem that impacts the community

Food Security:

- 14 percent of respondents identify limited access to healthy foods as an important social/environmental problem that impacts the community

Income:

- 70 percent of respondents identify cost as one of the most important reasons people don't receive healthcare
- 18 percent of respondents identify poverty as an important social/environmental problem that affects the health of the community

Transportation Options and Transit:

- 26 percent of respondents listed lack of transportation as an important reason people don't receive healthcare
- 15 percent of respondents listed transportation problems as an important social/environmental problem that impacts the community

Key Community Health Leader Surveys

45 key community health leaders representing the following organizations were surveyed:

- Arbutus United Methodist Church (1)
- Baltimore County Department of Aging (4)
- Baltimore County Department of Health (4)
- Baltimore County Department of Social Services (1)
- Baltimore County Government (1)
- Baltimore County Head Start (1)
- Baltimore County Health and Human Services (2)
- Baltimore County Local Management Board (1)
- Baltimore County Police Department (1)
- Baltimore County Public Library (1)
- Baltimore County Public Schools (3)
- Chase Brexton (2)
- Chase United Methodist Church (1)
- Christus Victor Lutheran Church (1)
- DABS Consulting, LLC (1)
- GBMC HealthCare (2)
- Jewish Community Services (1)
- Johns Hopkins Bayview Medical Center (1)
- Knollwood Association (1)
- Lansdowne Alliance Church (1)
- Loch Raven High School (1)
- Maryland Department of Health (1)
- Meals on Wheels of Central Maryland (1)
- MedStar Franklin Square Medical Center (1)
- New Psalmist Baptist Church (1)
- Sheppard Pratt (1)
- St. Michael Lutheran Church (1)
- The League for People with Disabilities (1)
- The Tabernacle at GBT (1)

- Towson University (2)
- University of Maryland – St. Joseph Medical Center (3)

Survey responses were assigned to the 20 focus areas based on similarities and common themes. The focus areas to which each question/response option was assigned is denoted in bold parenthesis next to the question/response. In instances of open-ended questions, frequently used key words and phrases were used to identify commonly mentioned focus areas. In order to assign a need level to each response topic, the following methodology was used to score the issues mentioned as areas of need:

- If mentioned in 32 or more responses = High Need
- If mentioned in 16-31 responses = Medium Need
- If mentioned in 0-15 responses = Low Need

Responses to the following questions were analyzed to identify the issues most important to the respondents of the key community health leader survey:

- How do you believe the health of your community has changed over the past 3 years?

- From the list provided, please select the top five community health needs of Baltimore County.
  a. Access to Care **(Access to Care)**
  b. Cancer **(Physical Health)**
  c. Dental Health **(Physical Health)**
  d. Diabetes **(Physical Health)**
  e. Heart Disease and Stroke **(Physical Health)**
  f. Maternal/Infant Health **(Maternal and Infant Health)**
  g. Mental Health/Suicide **(Mental Health)**
  h. Primary and Preventive Healthcare **(Physical Health)**
  i. Obesity **(Physical Health)**
  j. Sexually Transmitted Disease **(Sexual Health)**
  k. Substance Use/Alcohol Use **(Substance Use Disorders)**
  l. Tobacco and Electronic Smoking Devices **(Tobacco Use)**
  m. Housing **(Housing and Homelessness)**
  n. Uninsured **(Access to Care)**
  o. Other

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

j. Time limitations
k. None/no barriers

- What is missing or represents a gap in your community for its residents?
- What challenges do older adults face in your community?
- In terms of places to get regular exercise, are there enough in your community? **(Built Environment)**

Key Community Health Leader Survey Findings	
Focus Area	**Health Need**
Length of Life	Low Need
Maternal and Infant Health	Low Need
Mental Health	High Need
Physical Health	High Need
Access to Care	High Need
Quality of Care	Low Need
Diet and Exercise	Medium Need
Sexual Health	Low Need
Substance Use Disorders	Medium Need
Tobacco Use	Low Need
Built Environment	Medium Need
Environmental Quality	Low Need
Housing and Homelessness	High Need
Transportation Options and Transit	High Need
Education	Low Need
Employment	Low Need
Family, Community, and Social Support	Low Need
Food Security	Medium Need
Income	Low Need
Safety	Low Need

Several key themes emerged, including:

Mental Health:
- 78 percent of respondents listed mental health as a community health need

Physical Health:
- 63 percent of respondents identify Diabetes, Obesity, or Heart Disease as a community health need

Access to Care:
- 59 percent of respondents listed access to care as a community health need

Housing and Homelessness:

- 43 percent of respondents listed housing as one of the top five health needs in the community

Transportation Options and Transit:

- 70 percent of respondents listed lack of transportation as a significant barrier keeping people in the community from accessing healthcare when they need it

Additional comments related to priority needs identified in this CHNA include:

Substance Use Disorders:

- 61 percent of respondents identify Substance/Alcohol Abuse as a community health need
- 54 percent of respondents strongly disagree with the following statement: “There are enough substance use treatment providers”
- 30 percent of respondents somewhat disagree to the above statement

Food Security:

- 52 percent of respondents believe their communities basic needs (food/shelter) not being met are a barrier to accessing healthcare services

Built Environment:

- 44 percent of respondents said there weren’t enough places to get regular exercise in the community

Income:

- 13 percent of respondents noted that low-income populations were not being adequately served by local health services

Implementation Plans for
Northwest Hospital Prioritized Needs
2021-2024

The following Identified Needs were selected as **Priorities** for Northwest Hospital and will be included in the 2021 – 2024 Implementation Plan:

1. Chronic Heart Disease
2. Diabetes
3. Mental Health, Depression, and Substance Use Disorder
4. Community Health and Wellness Education
5. Health Disparities

Northwest Hospital will also work on plans to improve these additional needs identified by the community:

- Food Insecurity
- Community Safety
- Workforce Development

Specific implementation Plans for each of these areas are described in the following pages.

Northwest Hospital will also address these remaining identified needs:

- Transportation
- Built Environment
- Improved Access to Health Insurance

CHRONIC HEART DISEASE - IMPLEMENTATION PLAN

July 2021

Northwest Plan Point Person: Dr. Chaitanya Ravi

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Provider adherence to latest cardiac disease management guidelines.	• CIN Heart Failure Pathway implementation (e.g., consistent use of HF order set in hospital). • Cardiologists update LBH primary and specialty care providers on best practice management for Ischemic Heart Disease, Heart Failure (i.e., via series of CME webinars). • Define, measure, and improve use of Guideline-Directed Medical Therapy for pts with Ischemic Heart Disease, Heart Failure. • Define expectations, criteria, and process to assess for and refer eligible patients to Palliative/Supportive Care. • Implement training (e.g., clinical, medication reconciliation, use of SDOH tools, etc.) to keep care providers up to date on optimal approaches for care of this population. • Develop reporting to track progress on performance measures.	- Usage of HF order set. - Cardiologist-led webinars for Primary Care Providers completed; number of participants. - % patients on ACE/ARB, Beta Blocker, Statin - # of palliative/ supportive care consultations.
Reliable transition planning and communication at discharge.	• Follow-up appt with PCP set, prior to hospital discharge, for within 7 days post-discharge. • Med Rec completed, Rx filled prior to discharge. Med Rec includes assessment of meds patient already has at home. • Communicate discharge summary with primary care provider within 2 days of discharge. • Follow-up call to patient within 2 days of discharge (preferably by RN).	- % of follow-up phone calls to patients completed within 2 days of discharge. - % of discharges with clinic visits within 7 days. - Number of medication issues identified post-discharge. - Track and document standard categories of social issues identified, i.e., financial, health literacy/ numeracy issues.
Regular access to primary care and cardiologists.	• Utilize mobile clinics and/or community partnerships to improve health care access for cardiovascular patients in communities. • Outreach to established patients who haven't been seen in primary care in last year. • Monitor/improve screening for heart disease in primary care. • Explore expansion of home/remote monitoring (e.g., BP cuff, scales) • Regularly screen to identify and address depression. • Increase annual visits with cardiac specialists.	- % of Ischemic Heart Disease, Heart Failure pts with 1+ primary care/ cardiologist visits per year. - % of CVD, HF pts screened for depression and action taken if depressed.

CHRONIC HEART DISEASE - IMPLEMENTATION PLAN

July 2021

Northwest Plan Point Person: Dr. Chaitanya Ravi

Improvement Drivers	Tactics	Metrics to Assess Progress
Identify, address social barriers to better health management.	• Regularly screen this population to identify Social Determinants of Health (SDOH). • Refer patients with social needs to support programs. • Assess for, then create and implement strategies for patient health literacy/numeracy issues. • Caretaker – Ask patient if they have someone who helps them manage; invite that person to encounters. • Review and teach clinicians/community health workers best practices on how to conduct SDOH assessments and enhance patient self-reporting.	% of SDOH pts with completed referrals to social support programs. - Create strategies to target/track specific patients for more individualized/focused support.
Community/ Patient education and engagement on prevention and self-management.	• Regular educational calls, webinars, screenings for community members, focused on high-risk populations. • Create and distribute comprehensive Heart Failure patient self-management guide. • Utilize mobile clinics and/or community partnerships to improve health care access for cardiovascular patients in communities. • Identify/establish healthy, affordable recipe resources, including recipes that are culturally relevant. • Identify/establish grocery store partnerships on nutrition, medication support. • Support physical activity resources and opportunities for this population (e.g., walking groups, 'Fitness Fridays,' LBH Health and Fitness).	# of PCP pts, caretakers referred to education sessions. # of pts, caretakers participating in education programs. # of pts with improved meds adherence, diet or exercise habits, reduced tobacco usage.
Partner with American Heart Association.	• Work with American Heart Assn. to identify and implement relevant AHA resources/tools to support this population.	- AHA programs/ tools implemented.

DIABETES – IMPLEMENTATION PLAN

July 2021

Northwest Plan Point Person: Dr. Chaitanya Ravi

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Provider adherence to latest diabetes disease management guidelines.	• CIN Diabetes Pathway implementation (e.g., update and implement inpatient Diabetes order set) • Endocrinologists update LBH primary and specialty care providers on best practice management for Diabetes (i.e., via series of CME webinars). • Monitor and improve guideline-directed medical therapy for pts with Diabetes. • Assess for and refer eligible patients to Palliative/Supportive Care. • Develop reporting to track progress on performance measures.	- Consistent use of Diabetes order set - Webinars completed, number of participants - # of palliative/ supportive care consultations
Reliable transition planning and communication at discharge.	• Follow-up appt with PCP set, prior to hospital discharge, for within 7 days post-discharge. • Med Rec completed, Rx filled prior to discharge. Med Rec includes assessment of meds patient already has at home. • Communicate discharge summary with primary care provider within 2 days of discharge. • Follow-up call to patient within 2 days of discharge (preferably by RN).	- % of follow-up phone calls completed within 2 days of discharge. - % of discharges with clinic visits in 7 days. - # of meds issues identified post-discharge. - Track and document standard categories of social issues identified that can impact health outcomes, i.e., financial, health literacy/ numeracy issues.
Improve healthy food availability in priority areas	• Implement Diabetes Regional Partnership grant (with St. Agnes): zips 21229, 21223, 21216, 21215, 21207. - Improve access to healthy food	
Improve access to care. Regular primary care visits; endocrinologist visits when needed.	• Primary Care reaches out to patients with Diabetes and A1c≥7 for regular testing (3x a year). • Outreach to established patients who haven't been seen in primary care in last year. • Monitor/improve screening for pre-diabetes in primary care. • Utilize mobile clinics and/or community partnerships to improve health care access for diabetes patients in communities. • Regularly screen for and address depression. • Refer to Endocrinologist pts with Type 1 diabetes or poorly controlled Type 2 diabetes.	- % of pts with new primary care access. - % of diabetic pts w/ A1c test 3x annually. - % of Diabetic pts screened for depression and action taken if depressed.

DIABETES – IMPLEMENTATION PLAN

July 2021

Northwest Plan Point Person: Dr. Chaitanya Ravi

Improvement Drivers	Tactics	Metrics to Assess Progress
Identify, address social barriers to better health management.	• Regularly screen this population to identify Social Determinants of Health (SDOH). • Refer patients with social needs to support programs. • Assess for, then create and implement strategies for patient health literacy/numeracy issues. • Review and teach clinicians/community health workers best practices on how to conduct SDOH assessments and enhance patient self-reporting.	- % of SDOH pts with completed referrals to social support programs. - Create strategies to target/track specific patients for more individualized/focused support.
Community/Patient education and engagement focused on prevention and mgmt.	• Regular educational calls, webinars, screenings for community members focused on high-risk populations. • Create and distribute comprehensive Diabetes patient self-management guide. • Implement Diabetes Regional Partnership grant (with St. Agnes): zips 21229, 21223, 21216, 21215, 21207. - Improve healthy behaviors with focus on pre-diabetes • Utilize mobile clinics and/or community partnerships to improve health care access for diabetic patients in communities. • Identify/establish healthy, affordable recipe resources, including recipes that are culturally relevant. • Identify/establish grocery store partnerships on nutrition, medication support. • Support physical activity resources and opportunities for this population (e.g., walking groups, 'Fitness Fridays,' LBH Health and Fitness).	- Pts participating in education programs. - Pts with improved medication adherence, diet or exercise habits, reduced tobacco usage.
Partner with American Diabetes Association.	• Work with ADA to identify and implement relevant ADA resources/tools for this population.	- ADA programs/ tools implemented.

MENTAL HEALTH AND SUBSTANCE USE DISORDER – IMPLEMENTATION PLAN

July 2021

Northwest Plan Point Person: Cynde McCallum

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Develop crisis response alternatives to ED for Mental Health/SUD.	• GBRICS Program (including a centralized call center)	- GBRICS call volumes and related data.
Peers counsel patients into SUD treatment	• SBIRT Program with Peer Counselors based in Emergency Departments	- # of SBIRT/OSOP referrals - # of SBIRT/OSOP Referrals kept.
Screen/refer patients with substance abuse disorder	• Implement universal screening questionnaire in Cerner for outpatient practices.	- # of LBH internal referrals received from PCPs.
Screen/refer patients with depression/anxiety	• Implement universal screening questionnaire in Cerner for outpatient practices.	- # of LBH internal referrals received from PCPs.
Expand availability/access to non-crisis behavioral health services: e.g., walk-in, virtual behavioral health services, resources	• Reassess need for community-based clinics along NWH corridor. • Explore use of Mosaic Community Services to improve rapid accessibility to mental health services. • Explore Telehealth/TelePsych as a mode of improving access.	- Readmission data - ED visit data Market analysis
Stigma reduction campaign	• Explore stigma reduction campaign opportunities with County government.	

COMMUNITY HEALTH & EDUCATION – IMPLEMENTATION PLAN

July 2021

Northwest Plan Point Person: Kimberly Davis

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Education on prevention of chronic disease	• Develop and implement educational initiatives in communities about preventing chronic disease (e.g., preparation of healthy foods, transportation to supporting resources/activities). • When appropriate, connect at-risk individuals identified to mental health and social determinant resources. • Explore referral 'bonus' for referring family and friends to education programs.	-# of patients participating in programs - # of patients demonstrating decreased risk factors based on pre and post measurements
Targeted education/support on diabetes management	• Implement Diabetes Regional Partnership grant (with St. Agnes): zips 21229, 21223, 21216, 21215, 21207. - Improve healthy behaviors through education and support with focus on pre-diabetes • Create and distribute comprehensive Diabetes and Heart Failure patient self-management guides. • Implement regular educational calls, webinars, screenings for community members focusing on high-risk populations. • Explore expansion of remote monitoring to improve diabetes management. • Consider use of Mobile Clinic to assist with education in community.	-# of pts participating in education programs. - # of pts with improved medication adherence, diet or exercise habits, reduced tobacco usage.
Reliable transition planning and communication at discharge	• Med Rec completed, Rx filled prior to discharge. Med Rec includes assessment of meds patient already has at home. Ensure patient/family member understanding of medication regimen (e.g., use "teach back") • Follow-up call to patient within 2 days of discharge (preferably by RN). Provide education to support self-management. • Communicate discharge summary with primary care provider within 2 days of discharge. • Explore implementation of a Community Pastoral Outreach process for spiritual needs of hospitalized patients and to reach individuals who have been discharged.	- Number of medication issues identified post-discharge. - Track and document categories of social issues identified that can impact health
Target disease processes with specific disease management education	• Education offerings that focus on living in a community of limited resources and managing disease • Education offerings that focus on resources that are available both during crisis and when patient may just need something small • Explore marketing and public relations initiatives to educate/benefit community members	-Decrease in ED visits -Increase in the use of other resources (e.g., 24 hr nurse line)

HEALTH DISPARITIES REDUCTION – IMPLEMENTATION PLAN

July 2021

Northwest Plan Point Person: Dr. Sam Smith

Goal: Reduce disparities, especially for communities of color in targeted areas compared to white population at baseline. In addition, reduce disparities for non-English speaking populations and LGBTQ communities.

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Build trust in health care services by linking to existing community relationships	• Work with Faith-Based Organizations in prioritized communities to better provide community residents with education, information about maintaining health. • Work with Barbershops/Salons in prioritized communities to better provide community residents with education, information about maintaining health and accessing care resources.	- # of pts participating in education programs, screenings. - # of new pts referred to LBH providers.
Reduce implicit bias in provision of health care services	• Explore implementation of training for health care providers on what implicit bias is and how to recognize and address it.	- # of health care workers trained
Bring health care access closer to where people are	• Deploy Mobile Clinic to communities of opportunity. • Work with Barbershops/Salons in prioritized communities to increase access/referrals to health care services. • Explore expansion of behavioral health care access in community. • Explore partnerships with school-based health centers (e.g., on topics such as healthy behaviors, telehealth, obesity, depression).	- COVID vaccination uptake among communities of color. - # of pts referred to LBH providers.
Expand non-traditional access to primary health care	• Use Mobile Clinic to reach underserved neighborhoods. • Explore options to expand telehealth access in communities. • Explore implementation of a 24-hour nurse line.	- # of telehealth visits in priority communities. - # of calls to 24-hour nurse line.
Improve patients' skills to manage their chronic conditions	• Implement regular educational calls, webinars, community screenings to support better patient understanding and self-management of their chronic conditions. • Update and distribute comprehensive chronic condition patient self-management guides (e.g., diabetes, heart failure).	- # of ED visits of pts with diabetes, chronic heart disease. - Change in # of primary care visits among priority populations. - # of participants in educational events, screenings.
Identify and address Health Literacy, Numeracy, Cultural, Language differences	• Implement screening for patient health literacy/numeracy across the care continuum. • Develop recommendations for care team on ways to assist patients with low health literacy/numeracy. • Create/update patient education materials, instructions that take into account potential health literacy and numeracy barriers.	-# of patients screened for health literacy/numeracy. -Sharing of health literacy/ numeracy status among health care team (e.g., in electronic medical record)

HEALTH DISPARITIES REDUCTION – IMPLEMENTATION PLAN

July 2021

Northwest Plan Point Person: Dr. Sam Smith

Goal: Reduce disparities, especially for communities of color in targeted areas compared to white population at baseline. In addition, reduce disparities for non-English speaking populations and LGBTQ communities.

Improvement Drivers	Tactics	Metrics to Assess Progress
Reduce Food Insecurity, Expand access to healthier food	• Diabetes Regional Partnership grant (with St. Agnes): zips 21229, 21223, 21216, 21215, 21207. ○ Improve access to healthier food • Partner with local organizations, businesses, and/or government to explore improvements to access to healthy, affordable food choices. • Advocate policy changes with City, County, State governments.	- # of healthy food initiatives/ access points established in priority communities. - # of community members served by new food initiatives.

FOOD INSECURITY – IMPLEMENTATION PLAN

July 2021

Northwest Plan Point Person: Sharon Hendricks

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Healthy Food Availability (quality, quantity, variety, price, location)	• Partner with community organizations working to enhance healthy food availability and/or delivery. • Explore partnership with community organizations working to establish/expand urban vegetable gardens. • Explore creation of farmers market on or near Northwest facilities. • Diabetes Regional Partnership grant (with St. Agnes): zips 21229, 21223, 21216, 21215, 21207 to improve access to healthy food for residents at risk for diabetes.	- # of individuals served through programs. - Sales at farmers' market. - Community testimony.
Access (transportation, income, social support, time, priorities)	• Explore Hungry Harvest program implementation for Northwest (farmers market; tailored food delivery (e.g., diabetic friendly)) – Sinai has MOU • Explore ongoing area Food Waste Reduction initiatives for potential to redirect/repurpose food. • Explore implementation of Healthy Food as Medicine programs (e.g., providers can provide vouchers for vegetables; pilot framework exists; implemented in Philadelphia, DC). • Explore opportunities with Maryland Food Bank on access points and delivery. • Explore partnerships with schools on access to and distribution of healthy food. • Explore partnerships with schools to provide teaching on nutrition for health.	- # of individuals served through programs. - # of new initiatives launched. - Community testimony.
Utilization (food literacy, cooking ability, cooking facilities, time)	• Diabetes Regional Partnership Program – Food Project – meal preparation classes planned. Identify/create/adapt healthy recipe book. Consider food preferences, especially re: cultural needs (e.g., Passover). • Identify and refer patients to cooking demonstrations for healthy/affordable/culturally relevant meals. • Explore collaboration with American Heart Association, American Diabetes Association to improve access to healthy meal options. • Explore opportunities through 4H Extension offices – curriculum geared around healthy meal preparation in city and county.	- # of individuals served through programs. - # of cooking demonstrations held. - Community testimony
Stability (Availability and Access at all times)	• Explore sustainability of farmers markets at or near Northwest Hospital. • Identify/develop and make accessible to LifeBridge care managers and social workers a list of active food pantries in area and their schedules. • Explore funding to provide food vouchers to community residents at Northwest (e.g., to get meals at hospital cafeteria, etc.)	- # of multi-year food access initiatives launched/underway.

COMMUNITY SAFETY – IMPLEMENTATION PLAN

July 2021

Northwest Plan Point Person: Mike DeCarlo

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Improve economic opportunity for youth and adults (e.g., job opportunity, job placement)	• Work with community elementary/middle schools to assist with training in workforce expectations and career skills. • Support local training programs to develop Community Health Workers. • LBH Talent Acquisition works to hire candidates from community organizations that provide job training.	- # of completed trainings/ initiatives at community elementary/middle schools. - # of students participating in training. - Funding/resources expended to support CHW training. -# of individuals hired by LBH through community organizations that provide job training.
Address mental health, stress, depression/anxiety	• Connect referred community residents to case managers and victim advocates • Incorporate trauma training into mental health treatment • Partnership with the National Alliance on Mental Illness (NAMI) to focus on support for adults in our community	-# of completed referrals to mental health support. -% improvements in Hope & Resiliency scores
Build a strong social network; support a robust socio-cultural environment to counter community trauma and promote healing and connection	• Promote community violence prevention education & awareness • Implement youth mentoring programs. • Build/Foster neighborhood support groups.	-# of people trained/benefiting from prevention/awareness programs. -# of neighborhood support groups created/supported.
Address Adverse Childhood (abuse, neglect, household dysfunction) **& Adverse Community Experiences** (witness to violence, poverty, foster care)	• Screening in practices, ED, and various points of entry • Improve internal LBH education & awareness	-% improvements in Hope & Resiliency scores
Provide a coordinated system of response and care to suspected abuse, intrapersonal violence, and trauma	• Operate accredited advocacy centers in coordination with partners in law enforcement, social services, prosecution	Satisfaction survey results of partner agencies

WORKFORCE DEVELOPMENT – IMPLEMENTION PLAN

July 2021

Northwest Plan Point Person: Richard Finger

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Provide training in in-demand job skills.	• Support local training programs to develop Community Health Workers.	- Funding/resources expended to support CHW training.
Provide training and guidance in career management and development.	• Partner with community elementary/middle/high schools to assist with training in workforce expectations and skills.	- # of completed trainings/ initiatives at community elementary/middle/high schools. - # of students participating in training.
Facilitate connections between trainees and potential employers.	• LBH Talent Acquisition works to hire candidates from community organizations that provide job training. • Partner with “Turnaround Tuesday” community organization.	-# of individuals hired by LBH through community organizations that provide job training.

Header Information

Participating Organization's: Sinai Hospital, Northwest Hospital, Carroll Hospital, Levindale Hebrew Geriatric Center and Hospital, Grace Medical Center
Policy Category: Finance
Subject: Hospital Financial Assistance
Department Responsible for Review: Revenue Cycle Division
Policy Owner: Senior Vice President and Chief Revenue Officer

I. POLICY

A. Purpose. The purposes of this Policy are to (a) set forth eligibility criteria for receiving Financial Assistance; (b) outline circumstances and criteria under which each hospital will provide free or discounted care for Eligible Services to eligible patients who are Uninsured, Underinsured, patients ineligible for public or government assistance or who are otherwise unable to pay for Eligible Services, (c) set forth the basis and methods of calculation for charging any discounted amounts to such patients, and (d) state the measures to widely publicize this Policy within the communities to be served by the hospital. LifeBridge Health expects that patients will comply fully with the terms of this Policy in the determination of their eligibility for, and any receipt of, Financial Assistance and discounts. LifeBridge Health further expects its patients to apply for Medicaid and other governmental program assistance when appropriate, and to pursue any payments from third parties who may be liable to pay for the patient's care as the result of personal injury or similar claims. LifeBridge Health also encourage individuals to obtain health insurance to the extent such individuals are financially able to do so.

B. Scope. This policy applies to LifeBridge Health State of Maryland regulated hospital affiliates specifically Carroll Hospital, Grace Medical Center, Levindale Hebrew Geriatric Center and Hospital, Northwest Hospital and Sinai Hospital (collectively known for this policy as "LifeBridge Health")

C. Policy. It is the policy of LifeBridge Health to provide medically necessary health care services to all patient's without regard to the patient's ability of pay or Protected Class as defined in MD Code, Health-General §19-214.1, at each applicable hospital location (as defined below). Each hospital also provides, without discrimination, care for Emergency Medical Conditions (as defined below) to individuals without regard to such individual's eligibility for Financial Assistance, as more specifically set forth in LifeBridge Health's separate Emergency Medical Treatment & Labor Act (EMTALA) Policy, a copy of which can be obtained free of charge from any one of the sources or locations listed in Section III. K. of this Policy.

D. Adoption of Policy. The Board of Directors of LifeBridge Health and each of its applicable tax-exempt affiliates that provides medically necessary hospital services, has adopted the following policies and procedures for the provision of Financial Assistance.

E. Frequency of Review. This policy is to be reviewed and approved every two years.

II. DEFINITIONS

For purposes of this Policy, the terms below shall be defined as follows:

A. **"AGB"** means the amounts generally billed as defined by IRS Section 501(r)(5) for hospital emergency and other Medically Necessary care to individuals who have insurance covering that care, and calculated in accordance to the State of Maryland Health Services Cost Review Commission (HSCRC).

B. **"Application"** has the meaning set forth in Section III. B. below which shall comply with the HSCRC uniform financial assistance application requirements.

C. **"Assets"** means assets and resources (and the values thereof) of an individual, that would be taken into account and valued in accordance with the Code of Maryland Regulations in determining eligibility specifically excluding such individual's (a) primary personal residence not to exceed an assessed value of $150,000, (b) retirement assets or plans as qualified or nonqualified by the Internal Revenue Service including one or more retirement plans which shall include, without limitation, an individual retirement account (traditional or Roth), profit-sharing plan, defined benefit pension plan, 401(k) plan, 403(b) plan, nonqualified deferred compensation plan, money purchase pension plan, or other retirement plan equivalent to any of the foregoing, (c) one motor vehicle owned by the patient or any family member used for necessary transportation needed, (d) prepaid education assets or plans as defined by the State of Maryland or Internal Revenue Service which include, without limitation, Education Savings Account or 529 plans, (e) any assets expressly excluded in determining eligibility for a Federal or State financial or medical assistance program or plan which include, but not limited to, the Federal Supplemental Nutrition Assistance Program (SNAP), the Maryland Medical Assistance Program, State Energy Assistance Program, or Supplemental Food Program for Women, Infants, and Children, (f) burial space or plot, funds or prepaid burial contracts, and (g) household goods and personal effects.

D. **"CMO"** means Chief Medical Officer at a LifeBridge Health hospital or Chief Physician Executive.

E. **"Eligible Services"** means the services (and any related products) provided by a LifeBridge Health hospital that are eligible for Financial Assistance under this Policy, which shall include: (1) emergency medical services provided in an emergency room setting, (2) non-elective medical services provided in response to life-threatening circumstances that are other than emergency medical services in an emergency room setting, and (3) Medically Necessary Services as defined in this policy.

F. **"Emergency Medical Conditions"** has the same meaning as such term is defined in section 1867 of the Social Security Act, as amended (42 U.S.C. 1395dd) and as stated:

> "A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious

jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions: (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child."

G. **"Family Member"** means a member of a group of two (2) or more individuals who reside together and who are related by birth, marriage, or adoption, including, without limitation, any individual claimed as a dependent by any such individual on his or her federal income tax return.

H. **"Family Income"** means the gross income of an individual and all of his or her Family Members, including, without limitation, compensation for services (wages, salaries, commissions, etc.), interest, dividends, royalties, capital gains, annuities, pension, retirement income, Social Security, public or government assistance, rents, alimony, child support, business income, income from estates or trusts, survivor benefits, scholarships or other educational assistance, annuity payments, payments under or from a reverse mortgage, fees, income from life insurance or endowment contracts, and any other gross income or remuneration, from whatever source derived, all on a pre-tax basis.

I. **"Federal Poverty Guidelines"** means poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services in effect at the time of such determination.

J. **"Financial Assistance"** means any financial assistance in the form of free or discounted care granted to an eligible individual pursuant to this Policy.

K. **"Financial Hardship"** means an Uninsured or Underinsured patient of a LifeBridge Health hospital who (1) after payment by all third-party payers, is financially obligated to a LifeBridge Health hospital for an amount in excess of twenty-five percent (25%) of such patient's gross annual income and (2) has Assets that total value of which is less than the amount of "Assets", as amended from time to time.

L. **"Hospital Cost Review Commission (HSCRC)"** means an independent agency of the State of Maryland with broad regulatory authority to establish rates to promote cost containment, access to care, financial stability and accountability; including guidelines that govern hospital financial assistance.

M. **"Hospital"** means a facility (whether operated directly or through a joint venture arrangement) that is required by the State of Maryland to be licensed, registered, or similarly recognized as a

hospital. "Hospital" means collectively, more than one Hospital Facility. As it relates to this Policy, applicable locations include:

- Carroll Hospital,
- Grace Medical Center
- Levindale Hebrew Geriatric Center and Hospital
- Northwest Hospital,
- Sinai Hospital

N. **"Medically Necessary"** shall have the same meaning as such term is defined for Medicare (services or its reasonable and necessary for the diagnosis or treatment of illness or injury), or for disputed or less clear cases referred to the CMO or designee to render a decision.

O. **"Policy"** means this "Financial Assistance Policy" of a LifeBridge Health hospital, as amended from time to time.

P. **"Protected Class"** shall comply with the Code of Maryland Regulation specifically representing race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, disability, citizenship status, or any other class, ethnicity or designation not otherwise specified.

Q. **"Provider"** means a LifeBridge Health hospital employed physician, advanced clinical practitioner or licensed professional recognized and granted authority by the State of Maryland to provide health care services.

R. **"Uninsured"** means a patient of a LifeBridge Health hospital who has no level of insurance, third party assistance, medical savings account, or claims against one or more third parties covered by insurance, to pay or assist with such individual's payment obligations for the provision of Eligible Services.

S. **"Underinsured"** means a patient of LifeBridge Health hospital who has some level of insurance, third party assistance, medical savings account, or claims against one or more third parties covered by insurance, to pay or assist with such individual's payment obligations for provision of Eligible Services, but who nevertheless remains obligated to pay out-of-pocket expenses for the provision of Eligible Services that exceed such individual's financial abilities.

III. GUIDELINES

A. Eligibility. Upon a determination of financial need and eligibility in accordance with this Policy, a LifeBridge Health hospital will provide Financial Assistance for Eligible Services to or for Uninsured patients, Underinsured patients, patients who are ineligible for public or government assistance, or who are otherwise unable to pay for Eligible Services. Financial Assistance

pursuant to this Policy shall be based on a determination of financial need for each individual, regardless of race, sex, age, disability, national origin or religion, or other Protected Class.

B. Application for Financial Assistance. Except as otherwise provided in this Policy, a LifeBridge Health authorized representative will review all information requested and set forth in an application for Financial Assistance (a copy of which can be obtained free of charge from any one of the sources or locations listed in Section III. K. below of this Policy), an in any and all documentation therein requested and provided (the application and such documentation, collectively, an "Application"), as well as any one or more items of the following information, in determining whether an individual will be eligible for and receive Financial Assistance:

1. Publicly available data that provides information about an individual's ability to pay (e.g. credit reports, scores, or ratings; Federal Poverty Guidelines, relevant published federal or state guidelines, bankruptcy filings or orders);
2. Insurance eligibility for public or private health insurance including qualification for other public programs that may cover health care costs;
3. Information relating to such individual's participation or enrollment in, or receipt of benefits from or as part of, (a) any state or federal assistance program enrollment (e.g., Supplementary Security Income, Medicaid, Food Stamps/SNAP, Women, Infants, and Children (WIC) programs, AFDC, Children's Health Insurance Program (CHIP), low-income housing, disability benefits, unemployment compensation, subsidized school lunch, or (b) any free clinic, indigent health access programs, or Federally Qualified Health Center (FQHC).
4. Information substantiating the total gross Family Income and assets owned or held by the individual and liabilities or other obligations of the individual;
5. Information substantiating that such individual is or has been homeless, disabled, declared mentally incompetent or otherwise incapacitated, so as to adversely affect such individual's financial ability to pay; and/or
6. Information substantiating that such individual has sought or is seeking benefits from all other available funding sources for which the individual is eligible, including insurance, Medicaid or other state or federal programs.

It is preferred, but not required, that an individual request Financial Assistance prior to Eligible Services being provided. Any Application may be submitted prior to, upon receipt of Eligible Services, or during the billing and collection process. The information that an individual requesting Financial Assistance has provided will be re-evaluated, verified, and required to be updated at each subsequent time Eligible Services are provided that is more than twelve (12) months after the time such information was previously provided. If such information does change or additional information is discovered relevant to the patient's eligibility for Financial Assistance, it is the patient's responsibility to notify Customer Service at (800)788-6995. Applications will be made available, free of charge, at any hospital Patient Access or Customer Service. Requests for Financial Assistance will be processed promptly, and the hospital will determine eligibility within two (2) business days for probable determination or 14 (fourteen) days for final determination after receipt of a completed Application, submission of all required

information, and make all reasonable efforts to provide written notification to the patient or applicant of its determination within thirty (30) days. Such notification may be in the form of a billing statement which shows the amount of Financial Assistance applied to the patient's account(s), and if the patient is granted 100% Financial Assistance or denied, written notice will be sent in the form of a letter delivered to the patient's or guarantor's mailing address on file.

A LifeBridge Health hospital may deny or reject any Application and/or may reverse any previously provided discounts or Financial Assistance, if it determines in good faith, that information previously provided was intentionally false, incomplete or misleading. Moreover, a LifeBridge Health hospital may, at its sole discretion, pursue any and all legal remedies or actions, including criminal charges, against any person who knowingly misrepresented their financial condition including, without limitation, the amount or value of Family Income and/or Assets.

C. Appeals and Complaints. Patients or Guarantors with applications denied for Financial Assistance covered under this Policy may appeal such decisions or file a complaint.
   1. Appeals must be in writing and describe the basis of reconsideration, including any supporting documentation. Appeals must be submitted to Customer Service within fourteen (14) calendar days of the application decision or otherwise the decision shall be upheld and considered final. Customer Service will make every effort to notify Patients or Guarantors of the appeal decision within thirty (30) calendar days.
   2. Complaints regarding this Policy can be received by mail, email or phone. All complaints are to be reported to LifeBridge Health Compliance Department for monitoring and reporting. Customer Service will respond to each complaint, contact the individual who filed the complaint and notify the LifeBridge Health Compliance Department of the complaint's outcome.

   Patients or Guarantors may also file a complaint with Maryland Health Education and Advocacy Unit using the following contact information:

   Office of the Attorney General
   Health Education and Advocacy Unit
   200 St. Paul Place, 16th Floor
   Baltimore, MD 21202
   Phone: (410)528-1840
   Fax: (410)576-6571
   Email: HEAU@oag.state.md.us

D. Presumptive Financial Assistance. In some cases or circumstances a patient or applicant may appear eligible for Financial Assistance, but either has not provided all requested information or otherwise non-responsive to the application process. In such cases or circumstances, an authorized representative of a LifeBridge Health hospital may complete the Application on the patient's behalf and research evidence of eligibility for Financial Assistance from available

outside sources to determine the patient's estimated income and potential discount amounts or may utilize other sources of information to make an assessment of financial need. As a result of such information, the patient may be eligible for discounts up to 100% of the amounts owed for Eligible Services. In such circumstances, a patient is presumed eligible to receive Financial Assistance for Eligible Services if the patient meets one or more of the following criteria:

1. Eligible for the Maryland Medical Assistance program or Maryland Children's Health Program and:
    i. Lives in a household with children enrolled in the free and reduced-cost meal program;
    ii. Receives benefits through the federal Supplemental Nutrition Assistance Program;
    iii. Receives benefits through the State's Energy Assistance Program;
    iv. Receives benefits through the federal Special Supplemental Food Program for Women, Infants, and Children; or
    v. Receives benefits from any other social service program as determined by the Maryland Department of Health and Mental Hygiene (MD DHMH) and the State of Maryland HSCRC.
2. Residence in low income or subsidized housing;
3. Unfavorable credit history, based on the patient's credit report (high risk, low medical score, delinquent accounts);
4. Utilization of third-party predictive modeling based on public record databases and calibrated historical approvals statistically matched to this Policy. Such technology will be deployed prior to bad debt assignment in an effort to screen all patients for financial assistance prior to collection agency placement or pursuing any extraordinary collection actions.
5. Homeless or received care from a homeless shelter, free clinic;
6. Mentally incompetent as declared by a court or licensed professional; or
7. Deceased with no known estate.

E. <u>Eligibility Criteria and Amounts Charged to Patients.</u> Patients who are determined to be eligible, shall receive Financial Assistance in accordance with such individual's financial need, as determined by referring to the Federal Poverty Guidelines as published annually in the Federal Register.
    1. Notwithstanding anything in this Policy to the contrary, no patient who is eligible to receive Financial Assistance for Eligible Services will be charged more than allowed by the State of Maryland HSCRC pricing or AGB for emergency or other Medically Necessary care.
    2. The basis for determining and calculating the amounts billed an Uninsured or Underinsured patient who is eligible for Financial Assistance is as follows:
        i. Any Uninsured or Underinsured patient eligible for Financial Assistance will first receive the Financial Assistance discount for either 100% of billed charges or a reduced billed amount for those with Family income above 300% of the Federal Poverty Guidelines.

ii. Uninsured or Underinsured patients eligible for Financial Assistance whose yearly Family Income is equal to or less than 300% of the Federal Poverty Guidelines and whose total Assets do not exceed amounts allowed will receive a discount of 100% of their remaining account balance.

iii. Any Uninsured with Family Income above 300%, but less than 500% of the Federal Poverty Guidelines may qualify for a Financial Hardship discount. To qualify total Assets must be less than allowed provided total outstanding medical expenses minus co-payments, coinsurance and deductibles exceed 25% of annual Family Income. The amount of the Financial Hardship discount is any amount that exceeds 25% of annual Family Income. Thus, remaining balance owed excluding co-payments, coinsurance and deductibles if applicable after discount does not exceed 25% of Family Income.

F. Excluded Services. The following healthcare services are not eligible for Financial Assistance under this Policy:

1. Purchases from retail operations, including gift shops, retail pharmacy, durable medical equipment, cafeteria purchases;
2. Services provided by non-LifeBridge Health entities or professional services from physicians or advanced practice providers during hospital visits;
3. Elective procedures or treatments that are not Medically Necessary including cosmetic surgery, bariatric surgery, venous ablation.
4. Services provided at Levindale Nursing, Rehabilitation and Adult Day Care locations and any amounts deemed by Medicaid as patient liability.
5. Existing or pre-established programs to assist patients with defined coverage of services similar to Best Beginnings for undocumented women needing prenatal care or Access Carroll for free clinic care to uninsured and underinsured patient populations in Carroll County.

G. Communication of Information about the Policy to Patients and the Public. LifeBridge Health hospitals will take measures to inform and notify patients and visitors and the residents of the community at large served by the hospital, of this Policy in a manner that, at a minimum, will notify the listener and reader that the hospital offers Financial Assistance and informs individuals about how and where to obtain more information about this Policy. Such measures will include the following:

1. Clearly and conspicuously post signage to advise patients and visitors of Financial Assistance availability including Emergency Department, admission areas and billing departments
2. Make this Policy, the Application, and a plain language summary of this Policy widely available on its website www.lifebrigehealth.org.
3. Make paper copies of this Policy, the Application, and a plain language summary of this Policy available upon request, without charge, in public locations in each hospital including Emergency Department, admission areas, billing department and by mail or e-

mail. Furthermore, Patient Access and Customer Service representatives will notify and inform individuals upon admission or discharge of Financial Assistance and offer a paper copy of a plain language summary of the Financial Assistance Policy.

4. List all Providers, as referenced as Addendum I, whether employed or not employed by the hospital, covered by this Policy and will make widely available on its website www.lifebridgehealth.org.
5. Referral of patients for Financial Assistance may be made by any member of LifeBridge Health staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors.
6. A request for Financial Assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws and limitations.
7. Any and all written or printed information concerning this Policy, including the Application, will be made available in each of the languages spoken by the lesser of 1,000 individuals or 5% of the community served by the hospital or the population likely to be encountered or affected by the hospital. The hospital will take reasonable efforts to ensure that information about this Policy and its availability is clearly communicated to patients who are not proficient in reading and writing and/or who speak languages other than those for which information about this Policy are printed or published.

H. <u>Document Retention Procedures.</u> The hospital will maintain documentation in accordance with retention policies sufficient to identify each patient determined to be eligible for Financial Assistance including the patient's Application, any information obtained or considered in determining such patient's eligibility for Financial Assistance (including information about such patient's income and assets), the method used to verify patient's income, the amount owed by the patient, the method and calculation of any Financial Assistance for which such patient was eligible and in fact received, and the person who approved the determination of such patient's eligibility for Financial Assistance.

I. <u>Relationship to Billing and Collections Policy.</u> For any patient who fails to timely pay all or any portion of amount(s) owed, the hospital will follow guidelines set forth in its separate Billing and Collections Policy; provided that, the hospital will not commence or institute any extraordinary collection actions (including garnishments, liens, foreclosures, levies, attachments or seizures of assets, commencing civil or criminal actions, sales of debts to third parties, reporting adverse information to credit reporting agencies or credit bureaus) against any patient for failure to timely pay all of any portion of patient's account, without first, making reasonable efforts to determine whether the patient is eligible for Financial Assistance. Reasonable efforts are set forth in the separate Billing and Collections Policy, including those relating to patient communications and required actions, time periods, and notices of complete or incomplete Application for Financial Assistance. A copy of the Billing and Collection Policy may be obtained free of charge from any one of the sources or locations listed in Section III.K. below.

J. <u>No Effect on Other Policies; Policy Subject to Applicable Law.</u> This Policy shall not alter or modify other policies regarding efforts to obtain payment from third party payers, transfers or emergency care. This Policy and the provision of any Financial Assistance will be subject to all applicable federal, state, and local law.

K. <u>Sources of and Locations for Information.</u> Copies of this Policy, the Application, the Billing and Collections Policy, and the EMTALA Policy, may be obtained from or at any one or more of the following sources or locations:

1. Any Customer Service, Patient Access, or Patient Registration areas;
2. Emergency Department, admission areas or billing department;
3. By calling Customer Service at (800)788-6995; and
4. LifeBridge Health's website at www.lifebridgehealth.org.

From:	David Baker
To:	Hilltop HCB Help Account
Cc:	Sharon McClernan
Subject:	UPDATED: Clarification Required - Northwest Hospital Center FY 21 Community Benefit Narrative
Date:	Wednesday, June 8, 2022 2:55:51 PM
Attachments:	Outlook-pzy03a5f.png

Report This Email

Please see additional responses added below in **red** (there was not a place to document them in the Supplemental Survey form).

David R. Baker, DrPH, MBA
Executive Director, Population Health

LifeBridge Health
410.469.5170 office | dbaker@lifebridgehealth.org
Assistant: Cheryl Ebaugh, chebaugh@lifebridgehealth.org

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Thursday, May 19, 2022 9:13 AM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>; Sharon McClernan <smcclernan@lifebridgehealth.org>
Subject: Clarification Required - Northwest Hospital Center FY 21 Community Benefit Narrative

LBH SECURITY ALERT: This email is from an external source. Do not click on any links or open attachments unless you recognize the sender and know the content is safe. Never provide your username or password.

Thank you for submitting the FY 2021 Hospital Community Benefit Narrative report for Northwest Hospital Center, Inc. In reviewing the narrative, we encountered a few items that require clarification:

- In your response to Question 34 on page 5 of the attached, one sentence reads, “The five zip codes of Northwest Hospital’s Primary Service Area make up Northwest Hospital’s CBSA.” However, 21087 was also selected in Question 13 on pages 2-3. Please clarify how 21087 was determined to be part of your hospital’s CBSA.

  21087 should *not* be included in Northwest Hospital’s CBSA.

- Please provide responses to Questions 244, 218, 219, and (if applicable) 139 using the following supplemental survey: https://umbc.co1.qualtrics.com/jfe/form/SV_0wUxZ4JF1tNuvmm?Q_CHL=gl&Q_DL=0SJwNVhKbuecgdB_0wUxZ4JF1tNuvmm_MLRP_3dtAvJIlbgV2gFE

Please complete the supplementary survey linked above and provide all other clarifying answers as a response to this message.

Responses to these questions have been submitted via the survey.

- *We request that all hospitals who report physician subsidies complete Questions 218 and 219, as well as Question 139 if applicable.*

Q218: Please describe the initiatives addressing populations – LGBT.
The hospital has an LGBTQ+ Employee Resource Group devoted to LGBTQ+ patient and employee concerns and support. Part of this support includes LGBTQ+ Cultural Competency virtual trainings. The Human Rights Campaign Foundation honored the hospital as a LGBTQ Healthcare Equality Top Performer.

Q219: Please describe the initiatives addressing populations – Men.
The hospital routinely offers telephonic, video, and in-person community education and screening events targeting men's health, including events focused on prostate cancer.

CONFIDENTIALITY NOTICE This e-mail transmission, and any documents, files, or previous e-mail messages attached to it, may contain information that is confidential. If you are not the intended recipient, or a person responsible for delivering it to the intended recipient, you are hereby notified that you must not read this transmission and that any disclosure, copying, printing, distribution or use of any of the information contained in or attached to this transmission is STRICTLY PROHIBITED! If you have received this transmission in error, please immediately notify the sender by telephone or return e-mail and delete the original transmission and its attachments without reading or saving in any manner.

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

To track health disparities in the communities it serves, the hospital collects patient-level information about race, gender, zip code, Area Deprivation Index, and social determinants of health. To reduce health disparities in the communities it serves, the hospital prioritizes outreach to neighborhoods with higher economic and social disparities in its service area. To help address traditional barriers to health care access among these communities, the hospital brings health care resources to where people live through Mobile Health Clinic and other health promotion events in priority neighborhoods--including events focused on chronic disease management and COVID-19 vaccinations. To further its reach and better capture residents in most need of services, the hospital regularly partners with trusted neighborhood-based entities, including churches, synagogues, community associations and centers, and public libraries.

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:

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

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	○	○	
Anesthesiology	●	○	Non-resident house staff and hospitalists
Cardiology	○	○	
Dermatology	○	○	
Emergency Medicine	●	○	Coverage of emergency department call
Endocrinology, Diabetes & Metabolism	○	○	
Family Practice/General Practice	○	○	
Geriatrics	○	○	
Internal Medicine	●	○	Non-resident house staff and hospitalists
Medical Genetics	○	○	
Neurological Surgery	○	○	
Neurology	○	○	
Obstetrics & Gynecology	○	○	
Oncology-Cancer	○	○	
Ophthamology	○	○	
Orthopedics	○	○	

Otololaryngology	◯	◯	
Pathology	◯	◯	
Pediatrics	◯	◯	
Physical Medicine & Rehabilitation	◯	◯	
Plastic Surgery	◯	◯	
Preventive Medicine	◯	◯	
Psychiatry	◯	◯	
Radiology	◯	◯	
Surgery	◯	◯	
Urology	◯	◯	
Other, (Describe)	◯	◯	

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.

Physician subsidies have become necessary to ensure that all patients requiring anesthesia, behavioral health, radiology and general medicine care have the access they need both on an inpatient and outpatient basis, including 24/7 coverage. Northwest Hospital provides coverage in each of these areas through contracted physicians, House Staff or Hospitalists and allocates a significant amount of resources to sustain these programs. To help ease the effects of uncompensated care on physicians and address the gap in care for our patients, Northwest Hospital contracts with various specialists to ensure 24/7 coverage in the ED. Hospital-employed physicians are required to see medical underserved, uninsured, Medicare and Medicaid patients.

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

Location Data

Location: (39.3407, -76.6753)

Source: GeoIP Estimation