Community Health Needs Assessment

2019 FINAL SUMMARY REPORT

SUBMITTED BY

Approved by the Board of Directors on June 27, 2019

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EXECUTIVE SUMMARY

Beginning in May 2018, the University of Maryland St. Joseph Medical Center (UM SJMC) undertook a comprehensive community health needs assessment (CHNA) to evaluate the health needs of individuals living in Baltimore County, Maryland. The aim of the assessment is to reinforce UM SJMC's commitment to the health of residents and align its health prevention efforts with the community's greatest needs. The assessment examined a variety of health indicators including chronic health conditions, access to health care and social determinants of health. UM SJMC contracted with Holleran Consulting (Holleran), a research firm based in Wrightsville, Pennsylvania, to execute this project.

The completion of the CHNA enabled UM SJMC to take an in-depth look at its community. The findings from the assessment were utilized by UM SJMC to prioritize public health issues and develop a community health implementation plan focused on meeting community needs. UM SJMC is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. This CHNA Final Summary Report serves as a compilation of the overall findings of each research component.

CHNA Components

- Secondary Data Profile
- Online Key Informant Survey
- Community Survey
- Focus Group Discussions

Key Community Health Issues

UM SJMC, in conjunction with community partners, examined the findings of the Secondary Data Profile, Online Key Informant Survey, Community Survey performed by UM SJMC, and Focus Group Discussions to select Key Community Health Issues pertinent to Baltimore County. Based on the insights received over the last three years, UMSJMC decided to continue their work on the same Key Community Health Issues and Health Priorities for the FY20-22 CHNA.

Prioritized Community Health Issues

Based on feedback from community partners, including health care providers, public health experts, health and human service agencies, and other community representatives, UM SJMC plans to remain focused on the community health improvement efforts on the following health priorities over the next three-year cycle:

- Access to Care
- Mental Health and Substance Abuse
- Chronic Disease – Cardiovascular Disease/Obesity
- Cancer
- Fall Prevention

Previous CHNA and Prioritized Health Issues

UM SJMC conducted a comprehensive CHNA in 2013 and again in 2016 to evaluate the health needs of individuals living in the hospital service area of Greater Baltimore. The purpose of the assessment was to gather information about local health needs and health behaviors. The assessment helped UM SJMC prioritize six health issues in 2013 and five health issues in 2016, and develop a community health implementation plan to improve the health of the surrounding community. The prioritized health issues and major outcomes from those priorities that were identified in the previous years include:

Prioritized Health Issues in 2013:

- Access to Health Care Services
- Diabetes
- Substance/Tobacco Abuse
- Heart Disease/Hypertension/Stroke
- Maternal/Child Health
- Cancer

Major outcomes from the 2013 priorities include:

- 8,029 free flu vaccines provided to the community
- 2,806 people received hypertension/stroke prevention and awareness education
- 5,161 community members received cancer education about early detection
- 301 women received free breast cancer screenings and education and another 90 women received screening for cervical cancer

Prioritized Health Issues in 2016:

- Access to Care
- Mental Health and Substance Abuse
- Chronic Disease- Cardiovascular Disease/Obesity
- Cancer
- Fall Prevention

Major outcomes from the 2016 priorities include:

- 7,815 free flu vaccines provided to the community
- Average of 450 attendees and 50 schools represented at Annual Powered By ME! Conference
- St. Clare diabetes patients average A1C has decreased from 7.47 (2016) to 7.30 (March 2019)
- 315 women received free breast cancer screenings (mammograms) and navigation of resources

The full list of outcomes from the 2016 prioritized health issues can be found in Appendix H.

Organization Overview

The University of Maryland St. Joseph Medical Center (UM SJMC) is a member of the University of Maryland Medical System, a not-for profit hospital system, and is located in Towson, Maryland. Driven by its mission of serving others with reverence, integrity, compassion and excellence, UM SJMC has provided compassionate care for generations of Baltimore families since 1864. UM SJMC is a 218 licensed bed, Catholic, acute care hospital with academic, community, and specialty services. Services are provided by more than 500 expert physicians that represent more than 50 medical specialties, and over 2,300 nurses, allied healthcare professionals and staff. The state-of-the-art medical technologies make UM SJMC one of the nationally ranked healthcare providers and a top performer in patient satisfaction.

> **Mission:** UM St. Joseph Medical Center will be guided by our Catholic health care tradition of loving service and compassionate care. As an integral member of University of Maryland Medical System, we provide access to a full spectrum of health care services that improves the health of the communities we serve.
>
> **Vision:** UM St. Joseph Medical Center, guided by our Catholic health care values, will be known for our ability to deliver the highest quality, innovative and coordinated care for the communities we serve.

Community Overview

For purposes of this assessment, "community" is defined as the current service area based on an analysis of the geographic area where individuals utilizing its hospital services reside. This definition of community is based upon county lines, which is similar to the market definition of Primary Service Area (PSA). The target population of the assessment reflects an overall representation of the community served by this hospital facility.

UM SJMC's primary service area is considered Baltimore County, Maryland. Baltimore County is the third most populous of the 24 Maryland counties, with an estimated population of 825,666. Additional demographics are summarized in this report. A map of the primary service area is presented below.

Source: US Courthouses – Maryland

Research Components Methodology and Background:

The CHNA was comprised of both quantitative and qualitative research components. A brief synopsis of the research components methodology with further details related to the background is provided.

- A Statistical Secondary Data Profile uses existing local-level data with state and national comparisons of demographic and health data, also known as "secondary data." The specific data sources depicting population and household statistics, education and economic measures, morbidity and mortality rates, incidence rates, and other health statistics for the Greater Baltimore hospital service area, or Baltimore County, were compiled and compared to state and national level data, where applicable. Demographic and health indicator statistics have been collated to portray the current health status of Baltimore County. It should be noted that in some cases, local-level data may be limited or dated. This is an inherent limitation with secondary data. The most recent data are used whenever possible. When available, state and national comparisons were also provided as benchmarks for the regional statistics. National comparisons include United States data and Healthy People 2020 (HP 2020) goals when available. For all of the statistics provided, the most recently published data at the county level are utilized and resources can be found in Appendix A.
- An Online Key Informant Survey was conducted with key informants residing in Baltimore County during July and August 2018. Key informants were defined as community stakeholders with expert knowledge, including public health and health care professionals, social service providers, non-profit leaders, business leaders, faith-based organizations, and other community leaders. Holleran worked closely with UM SJMC to identify the key informant participants. The survey was designed to assess pressing health issues in their community, missing resources/services, health care access, underserved populations, and community assets and opportunities. The survey took approximately 10 to 15 minutes to complete. A total of 56 key informants completed the survey with the largest percentage of informants being affiliated with Health Care/Public Health Organizations. The purpose of the key informant survey was to gather a combination of quantitative ratings and qualitative feedback through closed and open-ended questions. A copy of the survey tool can be found in Appendix B and the Key Informants who completed the survey can be found in Appendix C.
- A Community Health Survey was conducted by UM SJMC with individuals residing in Baltimore County between October 3, 2018 and January 30, 2019. The survey was designed to assess the important health-related, social environment, mental health, and access to care problems that affect the health status of individuals in the community. The survey consisted of five demographic questions, four health-related questions for the community, and one question asking for suggestions or ideas to improve the health in the community. A copy of the survey tool created by UM SJMC can be found in Appendix F. A total of 779 resident surveys were completed throughout Baltimore County to promote geographical and ethnic diversity among respondents. The purpose of the community survey was to gather a combination of quantitative ratings and qualitative feedback from community residents.

  The respondents who completed the community health survey were mostly female (65%) and between the ages of 50 to 64 years (36%). An additional 20% of all respondents were between the ages of 65 and 74 years. Over three-quarters of respondents identify themselves as White

(78%). The next largest population is the Black or African-American race, at 11% of survey participants. About 12% of all respondents identify themselves as Latino/Hispanic, including majority (59%) of the "Other/more than one race (please specify)" specified Hispanic or Latino.

- Three community Focus Group Discussions were conducted on behalf of UM SJMC in November, 2018. The focus groups conducted on Wednesday, November 7, involved two sessions with twelve participants in the first session, and ten participants in the second session. A third session was conducted on Monday, November 12 with twelve participants. In total, feedback was received from 34 community members across the three sessions, including Spanish-speaking individuals, seniors, and the general community. The purpose of the focus groups was to gather qualitative feedback regarding the health needs of Baltimore County area residents, and to dig deeper into and triangulate the findings from the other research components.

  Holleran created the discussion guide in consultation with UM SJMC, consisting of eight questions designed to elicit responses and group discussion around the chosen health topics. The chosen health topics include; access to health care services, personal health and wellness, and chronic diseases. Every discussion was audio-taped in order to make sure that each participant's viewpoints are accurately represented in the report. A signature was obtained from all participants prior to the focus group discussion consenting to be recorded. A copy of the discussion guide can be found in Appendix E.

Research Partner

UM SJMC contracted with Holleran, an independent research and consulting firm located in Wrightsville, Pennsylvania, to conduct research in support of the CHNA. The firm collected, analyzed, and interpreted data both from the online community survey and the focus groups, and prepared all reports. Holleran has over 25 years of experience in conducting public health research and community health assessments. The firm provided the following assistance;

- Collected, analyzed, and interpreted data from the statistical secondary data profile;
- Collected, analyzed, and interpreted data from the online key informant survey;
- Conducted, collected, and interpreted data from the three focus group sessions;
- Analyzed and interpreted data from the community survey; and
- Prepared all reports.

Community Representation

Community engagement and feedback were an integral part of the CHNA process. UM SJMC sought community input through focus group discussions with community residents, a community member survey available to Baltimore County residents, and a key informant survey with community leaders and partners. It is important to note that the results reflect the perceptions of some community leaders and residents, but may not represent all community perspectives. Public health and health care professionals shared knowledge and expertise about health issues, and leaders and representatives of non-profit and

community-based organizations provided insight on the community, including the medically underserved, low income, and minority populations.

Research Limitations

As with all research efforts, there are some limitations related to this study's research methods that should be acknowledged. Data based on self-reports should be interpreted with particular caution. In some instances, the key informant survey participants, community member survey participants, and focus group discussants may over- or under-report behaviors and illnesses based on fear of social stigma, depending on the health outcome of interest or misunderstanding the question being asked. In addition, respondents may be prone to recall bias where they may attempt to answer accurately, but remember incorrectly.

In addition, timeline and other restrictions may have impacted the ability to survey all community stakeholders. UM SJMC sought to mitigate limitations by including representatives of diverse and underserved populations throughout the research components.

Prioritization of Needs

Following the completion of the CHNA research, UM SJMC prioritized community health issues in collaboration with community leaders and partners, and developed an implementation plan to address prioritized community needs.

Based on feedback from community partners, including health care providers, public health experts, health and human service agencies, and other community representatives, UMSJMC decided to continue their work on the same health priority areas for the FY20-22 CHNA. UM SJMC plans to remain focused on community health improvement efforts in the following health priority areas over the next three-year cycle:

Prioritized Health Issues in 2019:

- Access to Care
- Mental Health and Substance Abuse
- Chronic Disease – Cardiovascular Disease/Obesity
- Cancer
- Fall Prevention

SOCIO-DEMOGRAPHIC STATISTICS OVERVIEW

Demographic and health indicator statistics have been collated to portray the current health status of Baltimore County. For all of the statistics provided, the most recently published data at the county level are utilized. It is also important to note that social determinants such as income and education can significantly impact health status, health behaviors, and health outcomes. Research has shown that lower educational attainment, poverty, and race/ethnicity are risk factors for certain health conditions. For this reason, local demographic information is included in the report for reference.

Population Characteristics

Between 2012 and 2016, the population of the UM SJMC service area, Baltimore County, experienced slightly slower growth when compared to Maryland and the nation. The female to male population in Baltimore County remains similar when compared to the nation. However, Baltimore County has a slightly higher percentage of females than the nation.

Table 1. Overall Population (2010; 2012 – 2016)

	U.S.	Maryland	Baltimore County
Population (2012 - 2016)	318,558,162	5,959,902	825,666
Population Growth from 2010	3.2%	3.2%	2.6%
Male (share of population)	49.2%	48.4%	47.4%
Female (share of population)	50.8%	51.6%	52.6%

Source: U.S. Census Bureau

As evidenced by the median age, Baltimore County has a slightly older population compared to the state of Maryland and the nation. The median age is nearly one full year older as compared to the state and the nation. Consequently, Baltimore County also has a larger proportion of residents aged 75 years and older (7.4%) than the state (5.8%) and the nation (6.2%), according to the U.S. Census Bureau.

Figure 1. Median Age, 2012 – 2016

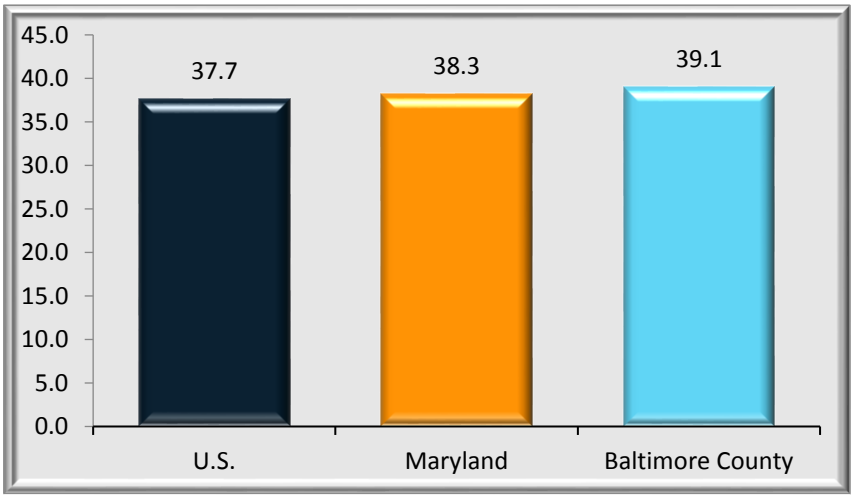


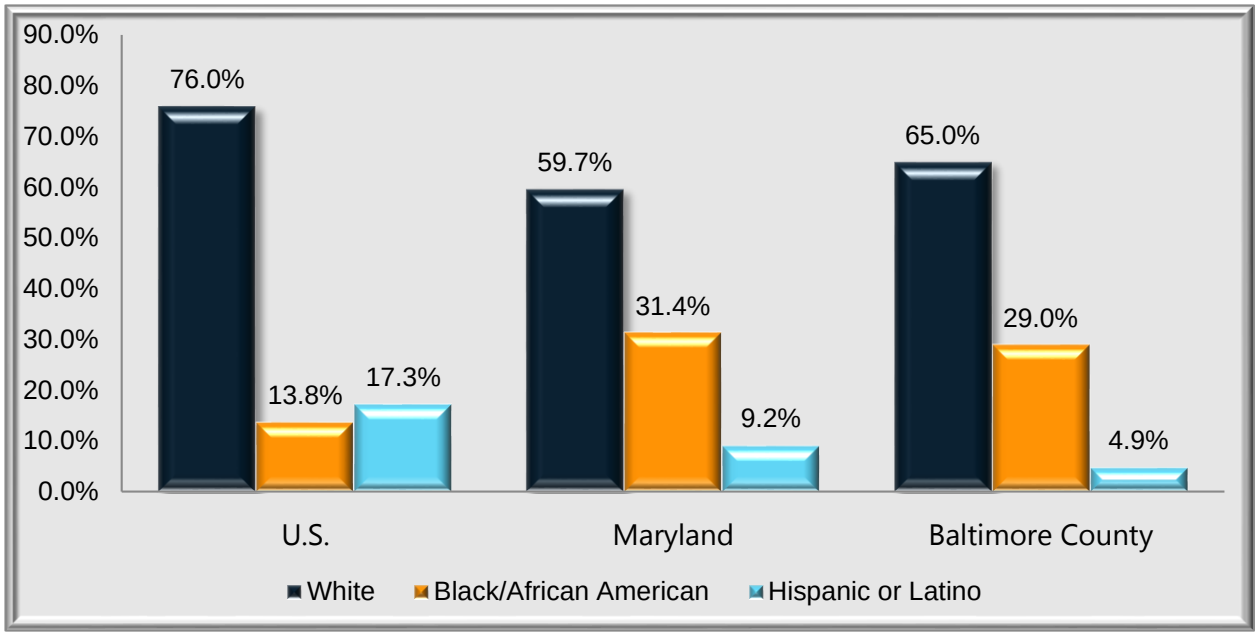
Table 2. Population by Age (2012 – 2016)

	U.S.	Maryland	Baltimore County
Under 5 years	6.2%	6.2%	5.9%
5 to 14 years	12.9%	12.6%	12.0%
15 to 24 years	13.8%	13.3%	13.1%
25 to 44 years	26.4%	26.7%	26.0%
45 to 59 years	20.3%	21.6%	20.8%
60 to 74 years	14.2%	13.9%	14.7%
75 to 84 years	4.3%	4.0%	4.8%
85 years and over	1.9%	1.8%	2.6%
Median Age (Years)	**37.7**	**38.3**	**39.1**

Source: U.S. Census Bureau

Nearly two-thirds of the population in Baltimore County is White. This proportion is higher than the state but lower than the nation. Twenty-nine percent of the population is Black/African American, which is slightly lower than the state but higher than the nation. The Hispanic/Latino population living in Baltimore County is notably smaller than both Maryland and the nation. The racial breakdown provides a foundation for primary language statistics.

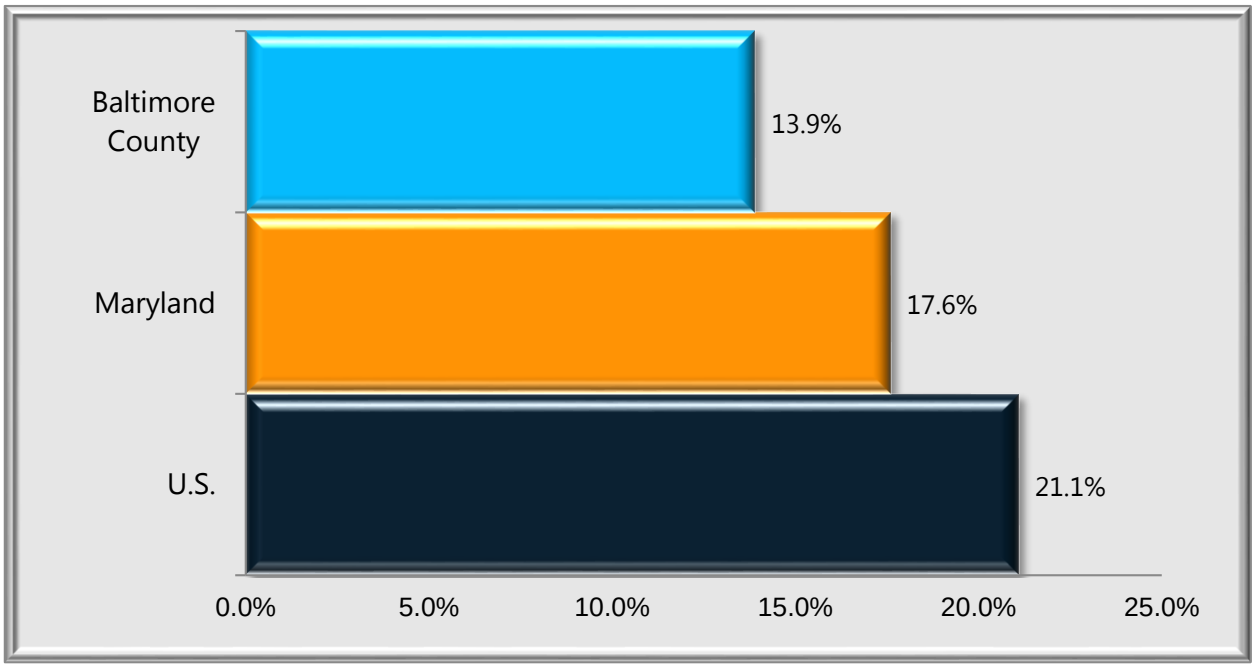
Figure 2. Racial Breakdown of the Three Major Races, 2012 – 2016



The percentage of individuals who speak a language other than English at home is lower in Baltimore County (13.9%) when compared to Maryland (17.6%) and the nation (21.1%). Residents who speak a

language other than English at home in Baltimore County are most likely to speak another Indo-European language (4.8%) or Spanish (4.0%). This is similar to the state, but much different than the nation where individuals most likely speak Spanish.

Figure 3. Population Speaking a Language Other Than English at Home, 2012 – 2016



Household Statistics

A review of U.S. Census data shows specific community highlights related to housing characteristics in UM SJMC's primary service area of Baltimore County. Housing is an important social determinant of physical and mental health. Affordable housing helps to alleviate the financial burden and makes more household resources available to pay for health care and healthy food, which leads to better health outcomes.

Baltimore County has a larger proportion of single-female householders (14.4%) when compared to the nation (12.9%). The percentage is similar to the state (14.3%). There is also a greater proportion of householders living alone who are 65 years or older in Baltimore County than in the state and the nation. Similarly, the percentage of grandparents responsible for their grandchildren is higher in Baltimore County (38.4%) than in the state (32.3%) and the nation (36.5%).

Table 3. Households by Type (2012 – 2016)

	U.S.	Maryland	Baltimore County
Total households	117,716,237	2,177,492	312,826
Average household size	2.64	2.67	2.57
Average family size	3.24	3.26	3.18
Family households	65.9%	66.9%	65.2%
Male householder, no wife	4.8%	4.9%	4.7%
Female householder, no husband	12.9%	14.3%	14.4%
Married-couple families	48.2%	47.7%	46.1%
Nonfamily households	34.1%	33.1%	34.8%
Householder living alone	27.7%	27.0%	28.6%
65 years and over	10.4%	9.8%	11.8%

Source: U.S. Census Bureau

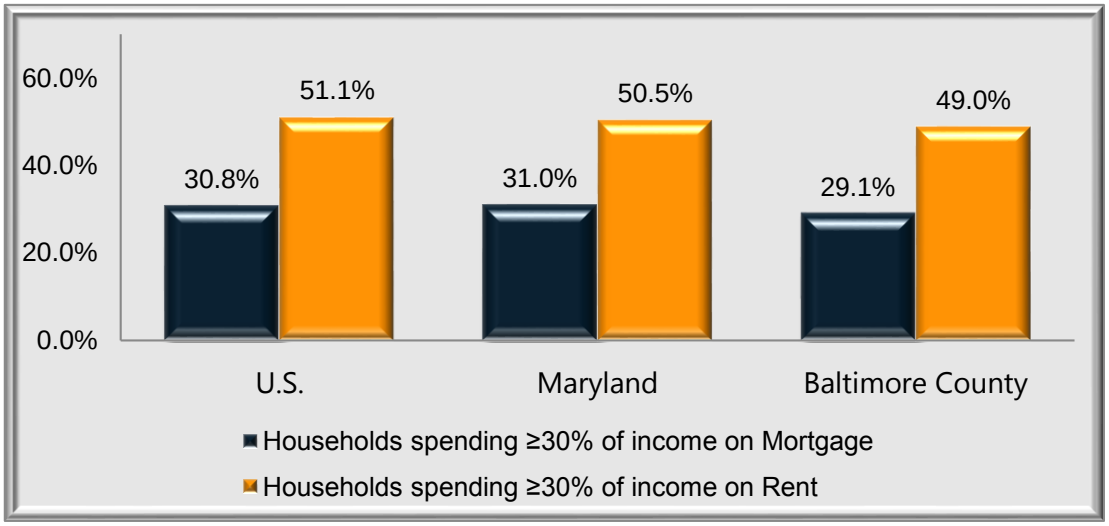
Table 4. Grandparents Responsible for Grandchildren (2012 – 2016)

	U.S.	Maryland	Baltimore County
Number of grandparents living with own grandchildren under 18 years	7,243,142	145,209	19,739
% of grandparents responsible for grandchildren	36.5%	32.3%	38.4%

Source: U.S. Census Bureau

A slightly lower proportion of residents in Baltimore County spend more than 30% of their income on mortgage (29.1%) when compared to residents across Maryland (31.0%) and the nation (30.8%). A slightly lower percentage of Baltimore County residents also spend more than 30% of their income on rent (49.0%) in comparison to the state (50.5%) and the nation (51.1%).

Figure 4. Households Spending More Than 30% of Income on Housing, 2012 – 2016



Income and Employment Statistics

Another indirect measure of health outcomes is household income as it provides a foundation for determining poverty status. A review of the U.S. Census Bureau data on income and employment statistics highlights the following statistics of Baltimore County. The median income for households and families is slightly higher in Baltimore County ($68,989 and $85,115) when compared to the nation but is lower when compared to the state. The median home value in Baltimore County ($246,900) is lower than that of Maryland ($290,400) but higher than the nation ($184,700). The median amount of dollars spent on housing rental is slightly lower in Baltimore County ($1,193) when compared to the state ($1,264) but is higher compared to the nation ($949).

Baltimore County has lower poverty rates for all families (6.1%), female-headed households (15.7%) and individuals (9.3%) when compared to the state and nation. The proportion of all households living below poverty level in Baltimore County (9.3%) is similar when compared to the state (9.9%), but is lower when compared to the nation (15.1%). Additionally, there is a lower percentage of households in Baltimore County receiving food stamps (10.3%), compared to what is found in Maryland (11.1%) and the nation (13.0%).

Table 5. Households with Supplemental Benefits in the Past 12 Months (2012 – 2016)

	U.S.	Maryland	Baltimore County
Population below poverty level	15.1%	9.9%	9.3%
Households with supplemental security income	5.4%	4.4%	4.7%
Mean supplemental security income	$9,523	$9,682	$10,226
Households with cash public assistance income	2.7%	2.5%	2.4%
Mean cash public assistance income	$3,336	$3,553	$3,928
Households with food stamp/SNAP benefits in the past 12 months	13.0%	11.1%	10.3%
Households below poverty level and receiving food stamps	50.3%	39.8%	33.9%
Households with one or more people 60 years and over receiving food stamps	29.2%	31.1%	32.2%
Households with children under 18 years receiving food stamps	53.0%	52.6%	54.5%

Source: U.S. Census Bureau

Baltimore County's unemployment rate is 4.3%. This percentage is similar to the state (4.1%) and the nation (4.4%). Residents of Baltimore County are more likely to be in the labor force (66.5%) when compared the nation (63.5%) and the percentages are similar to Maryland (68.2%).

Table 6. Employment Status, 16 Years Old and Older (2012 – 2016; 2017)

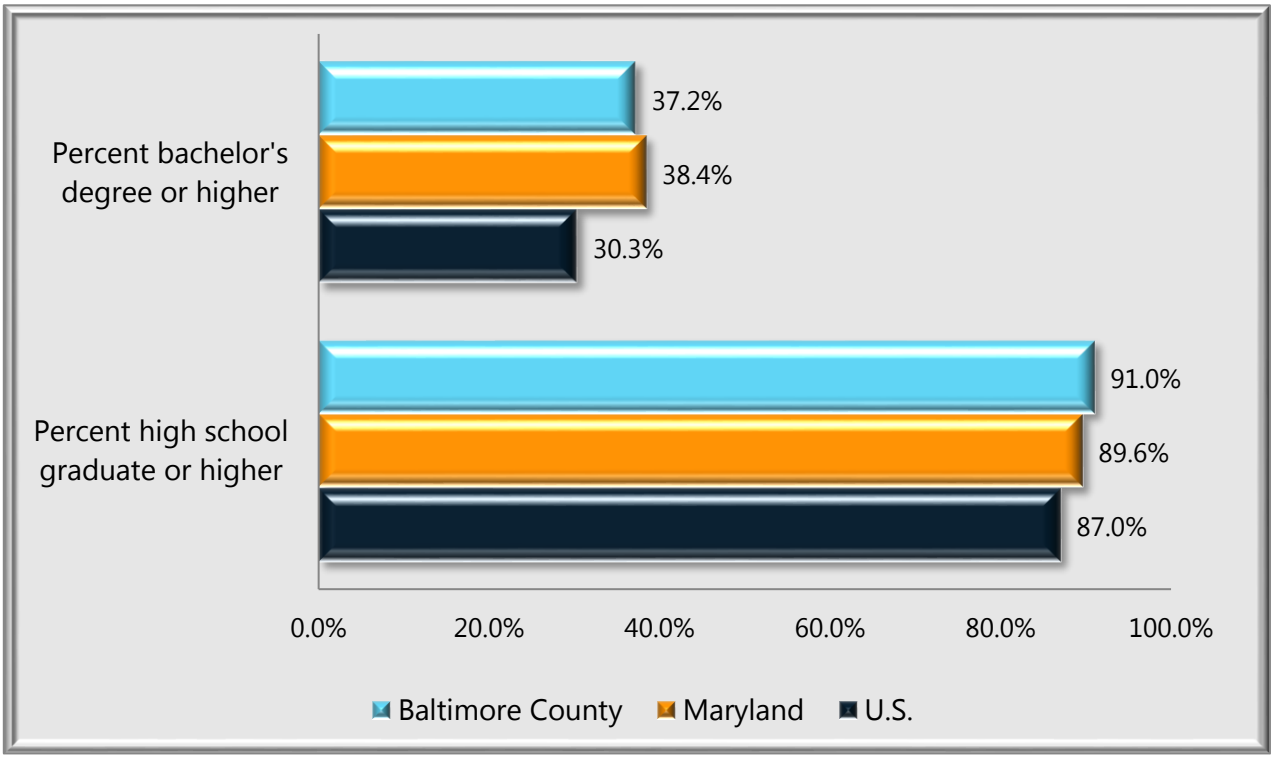
	U.S.	Maryland	Baltimore County
Population in labor force	160,818,740	3,249,911	444,124
% of population in labor force	63.5%	68.2%	66.5%
Civilian labor force	63.1%	67.6%	66.4%
Armed Forces	0.4%	0.6%	0.1%
% of population not in labor force	36.5%	31.8%	33.5%
Unemployed civilian labor force (2017 average)	**4.4%**	**4.1%**	**4.3%**

Sources: Bureau of Labor Statistics & U.S. Census Bureau

Education Statistics

Education is also an important social determinant of health. Anecdotal evidence indicates that individuals who are less educated tend to have poorer health outcomes. Residents aged 25 years and over in Baltimore County are just as likely to have graduated from high school as other Maryland state residents. However, they are slightly less likely to have attained a bachelor's degree compared to residents across the state. Both percentages are higher when compared to the nation.

Figure 5. Population with a High School Diploma or Bachelor's Degree or Higher (2012 – 2016)



COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Key Health Issues

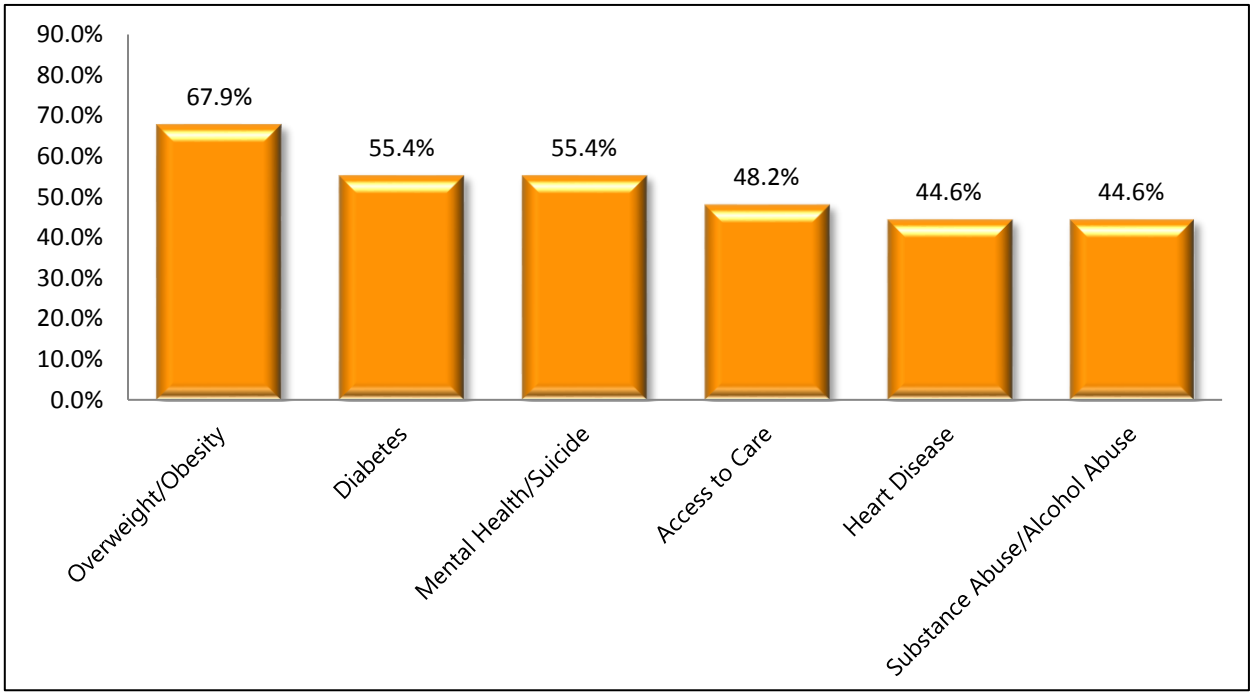
Key informants, members of the community, and focus group participants were all asked to identify the most pressing health issues in their community. The collective feedback clearly showcased an agreement of what issues were being experienced throughout Baltimore County.

Key Informant Feedback

Key informants were asked to rank the most pressing health issues in their community from a list of 13 focus areas identified in the survey. The issues of overweight/obesity, diabetes, mental health/suicide, access to care, heart disease, and substance abuse/alcohol abuse were ranked as the top six health issues. Dementia, arthritis, homelessness, infectious diseases, osteoporosis, socialization, and preventive care were additional topics mentioned by key informants as "other" key health issues commonly seen in the communities they serve. The chart in Figure 6 depicts the percentage of respondents who ranked the six most common health issues as a concern in their community.

Figure 6. "What are the top health issues you see in your community?"

Key Informant respondents could select more than one option, therefore the percentages may sum to more than 100.0%.



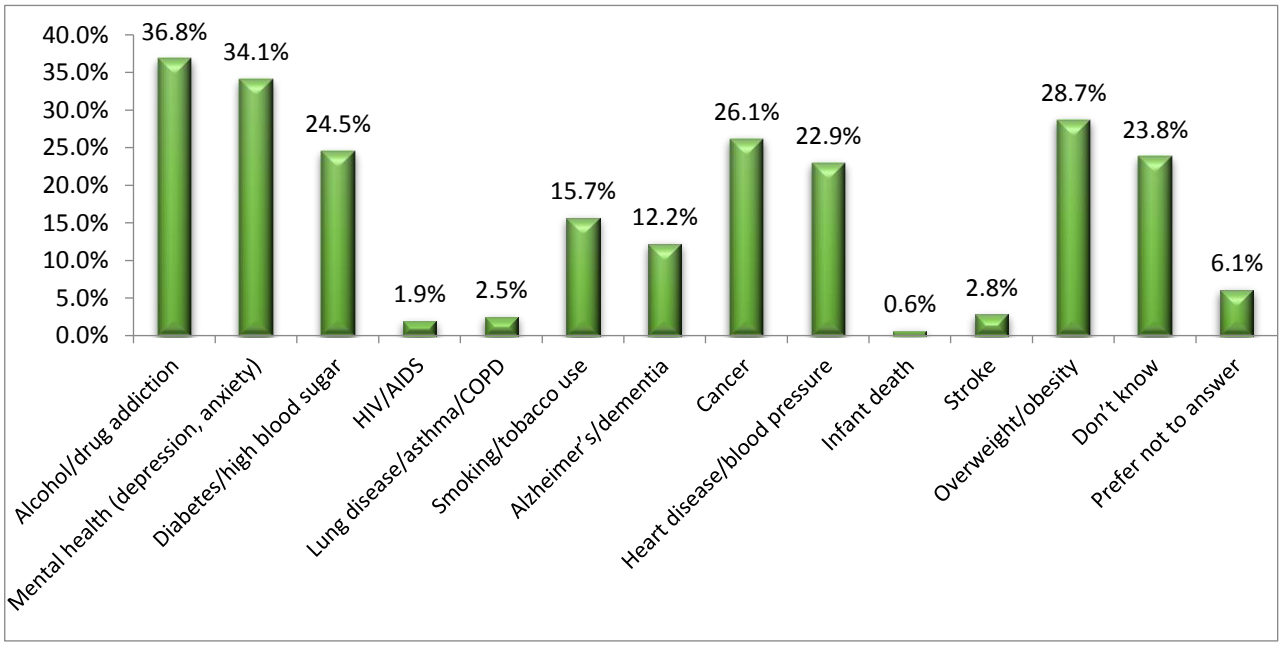
Respondents were also asked, of those health issues mentioned, which one issue was the most significant. About 23% and 18% of key informants selected access to care and overweight/obesity as being the most significant health issues, respectively. Mental health/suicide and substance abuse/alcohol abuse were each selected by nearly 13% of key informants as the most significant health issues in the community as well.

Key informant respondents were also given the opportunity to provide information regarding health issues and their reasons for selecting them. In general, many explained that overweight/obesity was chosen as a top health issue in the community as it is often an underlying factor for other chronic conditions. However, many key informants felt mental/behavioral health impacts other health indicators as well. Lack of insurance or being underinsured was often identified as a major barrier to care and often leads to overutilization of the Emergency Department. Additionally, difficulty understanding/navigating the health care system greatly impacts an individual's ability to access care.

Community Survey Findings

A community survey conducted by UM SJMC inquired about what community members believed to be the three most important health problems that affect the health of the community. Among these respondents (n=690), the three most common health problems reported were alcohol/drug addiction (36.8%), mental health including depression and anxiety (34.1%), and overweight/obesity (28.7%). A summary of the most important health problems as reported by the community respondents are shown in the figure below.

Figure 7. Community Survey - Most Important Health Problems in the Community (n=690)



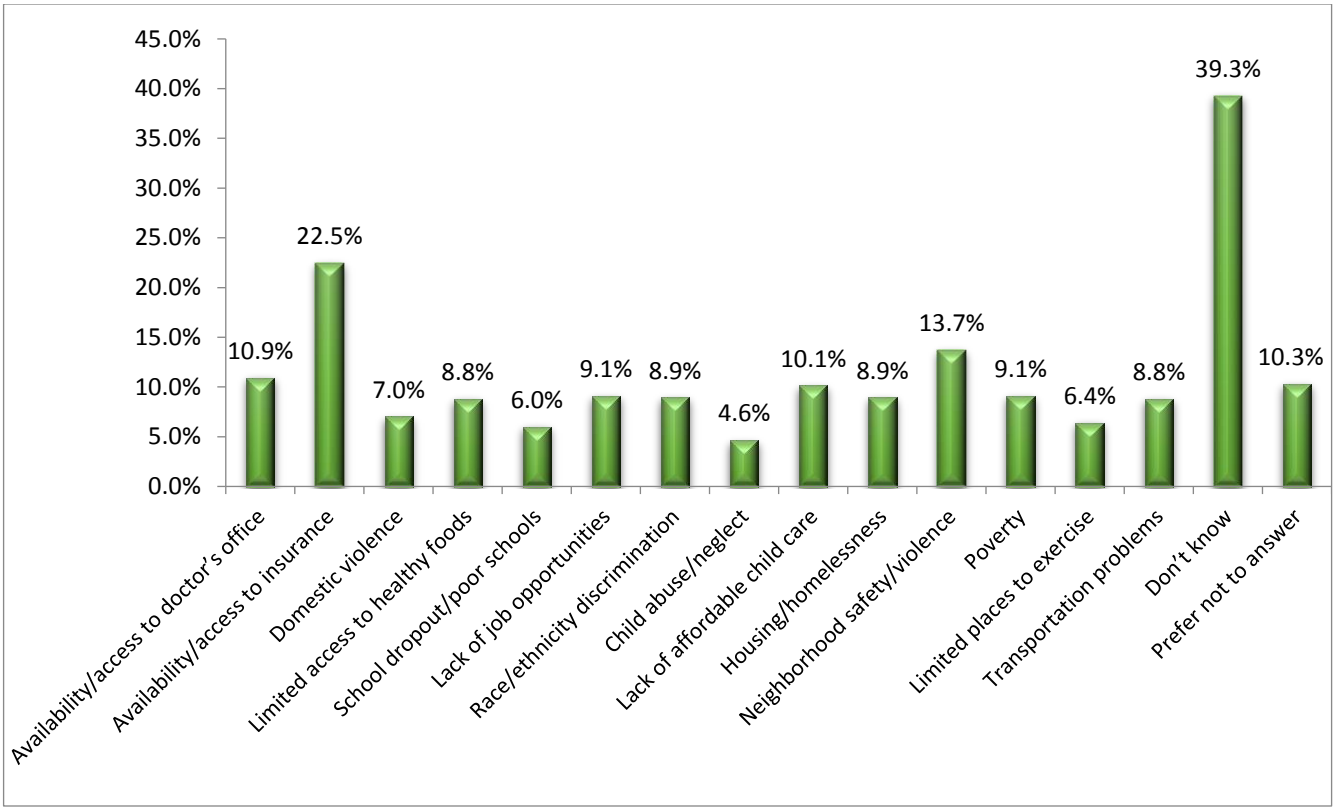
Respondents could select more than one option, therefore the percentages may sum to more than 100.0%.

Community members were also asked to select the three most important social/environmental problems that affect the health of the community. The top response by those who selected a problem from the list was availability/access to insurance, followed by neighborhood safety/violence.

Many respondents that felt there is not one specific social/environmental problem or said they do not know what affects the health of the community, when asked to identify which problem they think is

most important. Figure 8 displays the responses to the most important social/environmental problems affecting health in the community that were identified by the survey respondents.

Figure 8. Community Survey - Most Important Social/Environmental Problems in the Community (n=672)



Respondents could select more than one option, therefore the percentages may sum to more than 100.0%.

Finally, community members were asked to identify the number of poor mental health days they experienced during the last 30 days. The majority of respondents (76.5%) reported they had zero days, another 6.5% stated they didn't know and another 5.2% preferred not to answer. The majority of the remaining 11.8% (87 respondents) reported experiencing 1 to 10 days of poor mental health. Eight individuals reported 11 to 20 poor mental health days with another 11 respondents reporting 21 to 30 days of poor mental health.

Secondary Data Findings

Secondary data findings clearly support the feedback received from both the Key Informants as well as the Community Survey respondents. Based on the secondary data analysis, obesity, mental health/substance abuse, access to care, and heart disease issues continue to confirm health issues being experienced by Baltimore County residents. These findings are important because these issues can be

significant confounding factors for broader health issues and overall unhealthy lifestyle behaviors. The following secondary data highlights the key health issues mentioned above, in which the county differs notably from the state and nation.

Table 7. Crude Death Rates per 100,000 (2016)

	U.S.	Maryland	Baltimore County
Number of deaths	2,744,248	48,884	8,436
Death rate by race			
White	919.3	1027.7	1331.2
Black	732.3	765.7	695.9
Hispanic or Latino	327.6	177.2	170.5
Death Rate	**849.3**	**812.5**	**1015.1**

Sources: Centers for Disease Control and Prevention & Maryland Department of Health

The crude mortality rate per 100,000 in Baltimore County (1,015.1) is higher than both the state's rate of 812.5 and the nation's rate of 849.3. Additionally, the crude mortality rate for the White population in Baltimore County (1,331.2) is notably higher when compared to the White population in both Maryland (1,027.7) and the nation (919.3).

The top three causes of death in both Baltimore County and the state are diseases of the heart, cancer, and stroke. The top two causes of death are the same in the nation, but the third leading cause of death in the U.S. is accidents.

The crude death rate per 100,000 due to heart disease, cancer, stroke, diabetes, and influenza and pneumonia are all worse than rates in both the state and the nation. The crude death rate for accidents, chronic lower respiratory disease, Alzheimer's disease, nephritis, nephrotic syndrome and nephrosis is better than the nation, but both the county and nation's rates are worse compared to Maryland. The crude suicide rate per 100,000 in Baltimore County is lower (10.8) when compared to the nation (13.9) but is higher when compared to the state (9.7).

Table 8. Crude Death Rates by Selected Causes, All Ages per 100,000 (2016)

	U.S.	Maryland	Baltimore County
Diseases of heart	196.6	189.6	238.6
Malignant neoplasms (Cancer)	185.1	181.5	223.8
Accidents	49.9	37.9	46.2
Chronic lower respiratory disease	47.8	34.5	42.8
Cerebrovascular diseases (Stroke)	44.0	45.0	64.4
Alzheimer's Disease	35.9	19.6	25.1
Diabetes mellitus	24.8	22.6	26.7
Influenza and pneumonia	15.9	17.0	21.7
Nephritis, nephrotic syndrome and nephrosis	15.5	13.7	15.2
Suicide	13.9	9.7	10.8

Sources: Centers for Disease Control and Prevention & Maryland Department of Health

The overall age-adjusted cancer incidence rate per 100,000 is higher in Baltimore County (476.8) than the rate in the state (446.2) and the nation (441.2). Age-adjusted cancer incidence rates for breast, bladder, lung and bronchus, pancreas, melanoma, prostate, and uterine cancer are all higher in Baltimore County than the state and the nation. The overall age-adjusted cancer mortality rate per 100,000 in Baltimore County (162.7) is similar to the rate in Maryland (162.3). However, both are slightly better than the national rate of 163.5. The rate still falls short of the HP 2020 goal of 161.4. The age-adjusted cancer mortality rates for breast, bladder, and pancreatic cancer are all higher in Baltimore County than the state and the nation.

Table 9. Cancer Incidence by Site, per Age-Adjusted 100,000 (2011 - 2015)

	U.S.	Maryland	Baltimore County
Breast (female)	124.7	131.7	135.7
Bladder	20.3	21.2	24.4
Colon & Rectum	39.2	37.0	38.2
Lung & bronchus	60.2	57.4	64.5
Pancreas	12.6	13.1	13.8
Melanoma of the skin	21.3	22.4	29.0
Prostate	109.0	125.7	127.4
Cervix	7.5	6.4	6.3
Uterus	26.2	27.3	28.0
All sites	**441.2**	**446.2**	**476.8**

Source: National Cancer Institute

Table 10. Average Annual Cancer Mortality by Site, per Age-Adjusted 100,000 (2011 - 2015)

	HP 2020	U.S.	Maryland	Baltimore County
Breast (female)	20.7	20.9	22.4	22.6
Bladder	N/A	4.4	4.8	5.0
Colon & Rectum	14.5	14.5	14.2	14.3
Lung & bronchus	45.5	43.4	41.5	43.6
Pancreas	N/A	10.9	11.6	12.0
Cervix	2.2	2.3	2.0	1.9
Prostate	21.8	19.5	20.1	17.2
Melanoma of the skin	2.4	2.6	2.3	2.8
Uterus	N/A	4.6	5.5	5.4
All sites	**161.4**	**163.5**	**162.3**	**162.7**

Sources: National Cancer Institute & Healthy People 2020

Focus Group Feedback

During the focus group sessions participants were asked if they had a chronic condition, what barriers, if any, have they experienced in managing their disease. Often with chronic conditions, individuals find it takes discipline and time to properly manage their chronic condition. It can also take seeing several providers to treat their disease and symptoms, which can feel like a daunting task. The majority agreed that a serious lack of communication, as well as, a lack of understanding of the condition were their biggest barriers. Additional barriers discussed in managing a chronic disease include:

- Lack of awareness and communication in knowing what to expect and understanding to know what questions to ask
- Time constraints in committing to manage the chronic illness well
- Increased stress of financial burden associated with managing the condition

Health Care Access

Secondary Data Findings

Residents of Baltimore County are more likely to have health insurance (92.6%) when compared to residents in Maryland (91.9%), and the nation (88.3%). It is important to note, these findings as compared to the Community survey and Focus Group feedback does not reflect the experience and/or perception of the community.

According to the Behavioral Risk Factor Survey, approximately 12% of residents in Baltimore County could not afford to see a doctor in the past 12 months. This rate is similar to the nation (12.1%) but worse than the state (10.8%). A higher percentage of adults in Baltimore County have received a routine checkup within the past year (78.1%) than adults across the state (76.2%) and across the nation (70.2%).

Table 11. Health Insurance Coverage (2012 - 2016)

	U.S.	Maryland	Baltimore County
With health insurance coverage	276,875,891	5,389,007	757,187
% of population with health insurance coverage	88.3%	91.9%	92.6%
With private health insurance	66.7%	74.1%	75.2%
With public coverage	33.0%	29.8%	30.4%
% of population without health insurance	11.7%	8.1%	7.4%

Source: U.S. Census Bureau

Table 12. Health Care Access (2015)

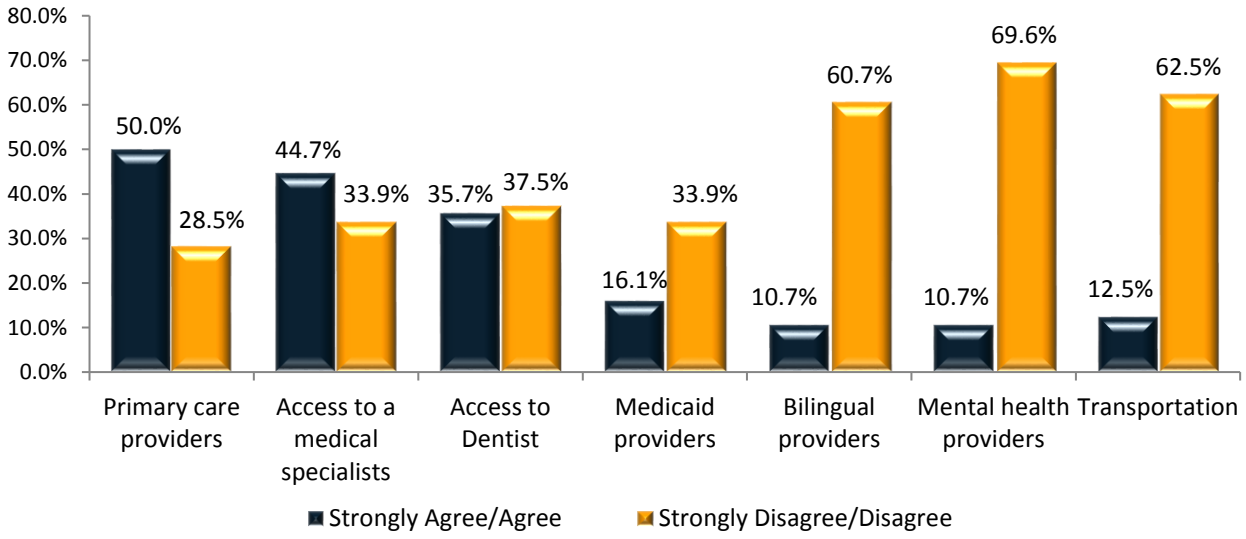
	U.S	Maryland	Baltimore County
Could not afford to see a doctor in the past 12 months	12.1%	10.8%	12.3%
Visited a doctor for a routine checkup within the past year	70.2%	76.2%	78.1%

Sources: Centers for Disease Control and Prevention & Maryland Behavioral Risk Factor Surveillance System

Key Informant Feedback

Key Informants were asked to identify the ability of local residents to access health care services, such as primary care providers, medical specialists, dentists, bilingual providers, mental/behavioral health providers, Medicaid/Medical Assistance providers, and transportation. Respondents rated their agreement with these statements on a scale of 1 (Strongly Disagree) through 5 (Strongly Agree). Figure 9 depicts the percentage of respondents who responded as "Strongly Agree or Agree" as compared to those who "Strongly Disagree or Disagree" with the factors.

Figure 9. Key Informant - Ratings of Health Care Access



Only half of key informants "Strongly Agree" or "Agree" that residents can easily access primary care in the service area. A few less key informants (45%) felt that medical specialists are easy to access in the area. Additionally, just a little more than a third felt residents could easily access a dentist. While these statements about access to care did not receive an overwhelming number of positive responses from key informants, they fared better than the other access to care statements regarding Medicaid/Medical Assistance, bilingual and mental/behavioral health providers.

The availability of bilingual providers and the availability of mental/behavioral health providers received the worst ratings with only about 11% of respondents who "Strongly Agree" or "Agree" with these statements. Additionally, approximately 16% of key informants felt there are sufficient numbers of providers accepting Medicaid/Medical Assistance. Notably, 50% of key informants neither agreed nor disagreed with the availability of Medicaid/Medical Assistance providers in the area indicating that there may be a lack of information on this topic. Lastly, transportation for medical appointments also received a very low rating with only about 13% of key informants who "Strongly Agree" or "Agree" that it is available in the area.

Barriers to Health Care Access

After rating health care access issues facing the local service area, the informants were asked about the most significant barriers that keep people in the community from accessing health care when they need it. The top five barriers that were selected most frequently include:

- Inability to Pay Out-of-Pocket Expenses (Co-pays, Prescriptions, etc.)
- Lack of Transportation
- Inability to Navigate Health Care System
- Lack of Health Insurance Coverage
- Availability of Providers/Appointments

Table 13 shows a combined result of the number and percent of respondents who selected each barrier and the percent of respondents who selected it as the most significant barrier. Barriers are ranked from top to bottom based on the frequency of participants who selected the barrier.

Among health care access barriers, about 26% of respondents rated inability to pay out-of-pocket expenses as the most significant barrier for residents in accessing care. This was followed closely behind by inability to navigate the health care system, which was selected by nearly a quarter of key informants.

Table 13. Key Informant - Ranking of Barriers to Health Care Access

Key Health Barrier	Count	Percent of respondents who selected the issue*	Percent of respondents who selected the issue as the most significant
Inability to Pay Out-of-Pocket Expenses (Co-pays, Prescriptions, etc.)	40	71.4%	26.4%
Lack of Transportation	40	71.4%	13.2%
Inability to Navigate Health Care System	38	67.9%	24.5%
Lack of Health Insurance Coverage	32	57.1%	13.2%
Availability of Providers/Appointments	29	51.8%	7.5%
Time Limitations (Long Wait Times, Limited Office Hours, Time off Work)	23	41.1%	5.7%
Language/Cultural Barriers	21	37.5%	3.8%
Basic Needs Not Met (Food/Shelter)	18	32.1%	5.7%
Lack of Trust	16	28.6%	0.0%
Lack of Child Care	11	19.6%	0.0%
Other	1	1.8%	0.0%
None/No Barriers	0	0.0%	0.0%

**Respondents could select more than one option, therefore the percentages may sum to more than 100.0%.*

Key informants also shared additional information regarding barriers to health care access. A selection of their responses and comments related to barriers to health care is provided below.

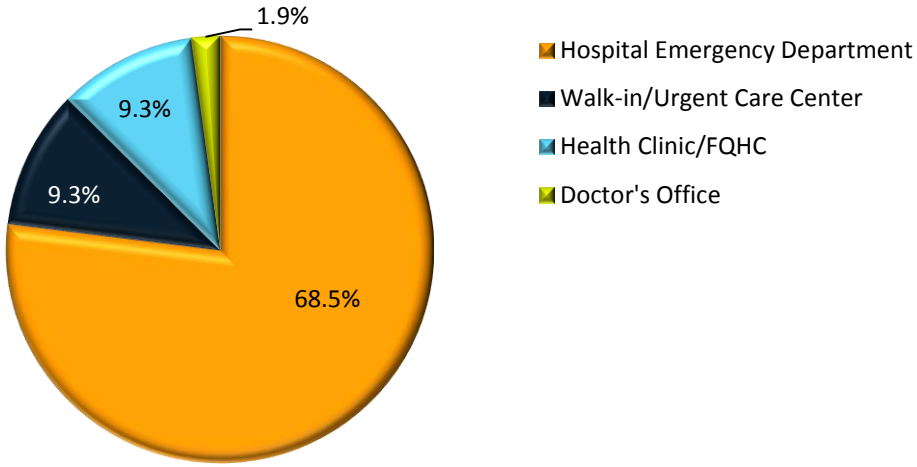
- "If patients have insurance and is auto assigned a provider they do not want to see, they have no idea how to navigate that. Different insurance have different rules for pre-auth or specialist referrals. Some cannot even see a cardiologist or vascular without seeing a PCP. The PCP cannot see them on a timely manner - typically 2 months out, and to align that with cardiology or pulmonologist after to get a referral, patient would have been readmitted 4X already to a hospital. The whole system is unfavorable to patients."
- "Individuals do not seek primary prevention services when they don't know how they are going to pay the rent. It isn't a priority for them due to the lack of basic needs being met. The Baltimore area is fortunate in the availability of providers. However, there are some specialists that have long waiting lists (dermatology) or have limited appointments (child psychiatrist)."
- "Patients, especially undocumented immigrants and uninsured, have difficulty and are unable to navigate the healthcare system. They often wait until the illness is severe and then seek care in the ED. They do not have a primary care provider."
- "There are community resources out there but right hand and left hand don't know it. Patients have no reference list that's easy to use, nor do their providers."

Informants were asked whether there are specific populations who are not being adequately served by local health services. The majority of key informants (71%) felt there are underserved populations in the community. The 37 respondents who felt there are specific populations that are not being adequately served in the community were then asked to identify which populations they think are underserved.

Nearly 60% of respondents felt that uninsured/underinsured individuals are underserved. Hispanic/Latino and low-income/poor populations groups were also considered underserved by approximately 57% of key informants. Additionally, about 54% of respondents thought Immigrant/Refugee populations and Senior/Aging/Elderly populations are also underserved in the community.

Key informants were also asked to identify where uninsured/underinsured individuals go to access health care. Over 68% of respondents indicated the Hospital Emergency Department is the primary place for uninsured/underinsured individuals to seek medical care. Key informant opinions regarding this issue are summarized in Figure 10.

Figure 10. Key Informant - Opinions Regarding Uninsured/Underinsured Individuals



NOTE: "Don't Know" and "Other" responses are not reported.

Focus Group Feedback

Focus group participants were asked to identify the greatest challenge faced when navigating health care services in the county. Concerns of a lack of awareness of services available in the community were shared during the group discussions. Participants identified an absence of understanding for how and where to access health care services in the community. The overwhelming majority of participants agree that many individuals have difficulty navigating the available resources in the health care system.

Another common theme that was discussed in all sessions is the clear communication gap between patients and providers. Participants reflected on general lack of awareness of services available in the community. Overcrowding of Emergency Departments in the health care system could be a part of the problem. Emergency Departments tend to be associated with longer wait times and an increased

number of non-emergent visits. The participants identified these concerns as a major barrier. One participant shared their negative experience during an Emergency Department visit and felt there was a lack of involvement and communication during their visit. As the participant put it, "I was just told that this was an emergency, and they better start it {the blood transfusion}, but there were these gaps of time where nothing was going on. Why did it take six hours to go from point A to point B, and why wasn't anyone coming in to tell me what was going on or that we were very busy. I was just being totally ignored." However, not all participants had experienced the Emergency Department in a negative light.

Obtaining a timely appointment for a non-urgent matter at one's primary care provider office was identified as a significant issue. One participant explained, "They tell you that you have to get the, "OK," from your primary before you can go see someone else, and that's the problem because then you have to make an appointment to see who he suggested and that's a wait time and in the mean time you're hurting." This issue often correlated to longer waiting times, especially depending on the type of care/specialty needed.

Participants also expressed concern for the inability to make timely appointments with a specialty provider. A participant mentioned, "I was supposed to see Neurology in a couple of weeks with an anticipated stroke from when I was here and it was 3 months before I could get in to see somebody." From these discussions, it was gathered that many participants did not have secure and timely access to providers, primary care or specialists.

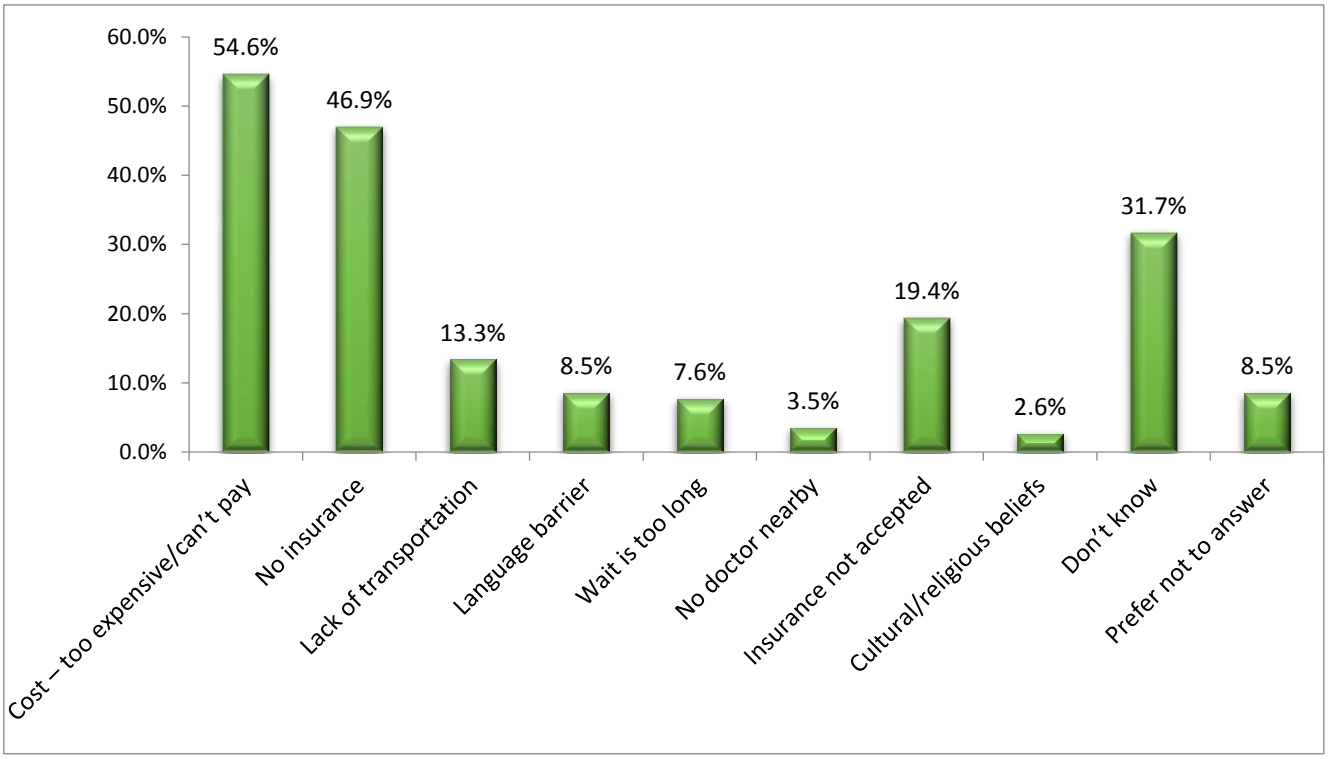
Participants also reported their desire for a meaningful and sustained relationship with a primary care provider. It was evident the participants found their physicians to be professional in nature and excellent care is being provided. However from the discussions, it was concluded many patients experienced a common barrier of communication with providers when attempting to access health care services. Lack of timely and effective communication with providers was a substantial challenge in navigating health care services. Many agreed the need for timely and effective communication could not be more emphasized.

The other theme that emerged was that participants felt significant barriers regarding their insurance or lack thereof. Participants who had insurance found their coverage to be confusing and overwhelming. Participants felt that the general information regarding insurance coverage was a very challenging and often unclear. The point was made that individuals did not understand their health insurance. One community member suggested that the providers should explain it better to their patients, and not just using medical terms.

Community Survey Findings

Community members were asked to identify the three most important reasons people in the community do not receive health care. About 55% of respondents reported cost, too expensive and/or can't pay, as the number one reason people in the community cannot get health care. No insurance (47%) was reported second, followed by Don't know (32%) and Insurance not accepted (19%).

Figure 11. Community Survey - Most Important Health Problems in the Community (n=682)



Respondents could select more than one option, therefore the percentages may sum to more than 100.0%.

Missing Resources/Services

Key Informant Findings

Respondents were asked to identify key resources or services they felt were missing in the community. Free/Low Cost Medical Care and Free/Low Cost Dental Care topped the list with nearly 62% and 60% of key informants selecting these resources, respectively. Mental health services and transportation were also identified as missing by approximately 58% of key informants. A summary of responses is given in Table 14.

Table 14. Key Informant - Listing of Missing Resources/Services in the Community

Missing Resources /Services	Count	Percent of respondents who selected the issue*
Free/Low Cost Medical Care	32	61.5%
Free/Low Cost Dental Care	31	59.6%
Mental Health Services	30	57.7%
Transportation	30	57.7%
Bilingual Services	25	48.1%
Substance Abuse Services	24	46.2%
Health Education/Information/Outreach	20	38.5%
Prescription Assistance	20	38.5%
Medical Specialists	11	21.2%
Health Screenings	10	19.2%
Primary Care Providers	9	17.3%
Other	2	3.8%
None	0	0.0%

**Respondents could select more than one option, therefore the percentages may sum to more than 100.0%.*

Focus Group Feedback

The focus group participants were asked, "Do you feel that people in the community are fully aware of the healthcare services/options that are available to them? Why? Why not?" While the majority of participants in all of the sessions conveyed that information regarding healthcare services is widely available in the community, most felt it should be the individual's personal responsibility to obtain the information. However, it is important to note there was hesitation as to whether the individual would actually obtain the appropriate information. It was suggested that having access to the information in a central location or an individual to address what resources and services are available would be the ideal situation.

There was a general consensus that the elderly and Spanish-speaking populations were not aware of the resources available in the community. Participants felt that seniors generally become aware of services either by word of mouth or when the service is taken to them in a senior living community. A barrier for the older adult population that was discussed is only having information available online.

Participants expressed that the Spanish-speaking population became aware of services either by members of their church community or when given information and resources at the St. Clare Medical Outreach and Hope Clinic. These participants felt that language is a common barrier regarding healthcare services and resources available in the community for the Spanish-speaking population

The decreased presence of translation assistance was commonly discussed as well. One participant stated, "When one needs a translator, they get annoyed … and the doctor doesn't like it either." The lack of interpreter services for patients resulted in longer wait times and overall visit times. Participants suggested the need for medical interpreters and bilingual medical staff was essential to facilitate

efficient communication and improve patient engagement. Many of the Spanish-speaking population expressed concerns of the lack in language services in the local clinics and hospitals.

In general, the session participants ultimately agreed that the number of specialty providers in the area was acceptable. However, some participants pointed out a few specialty areas were deficient including gynecology, dentistry, and ophthalmology.

Challenges to Maintaining a Healthy Lifestyle

Key Informant Feedback

"People in the community often have difficulties affording nutritious foods and understanding how to determine what to eat."

Respondents were asked, "What challenges do people in the community face in trying to maintain healthy lifestyles like exercising and eating healthy and/or trying to manage chronic conditions like diabetes or heart disease?" A variety of challenges were discussed by key informants. Notably, financial limitations, education, awareness, support, and access rose to the forefront as the main themes surrounding key informant concerns. Income and cost of services was an issue that cut across many aspects of health. Affordable healthy foods and exercise opportunities were mentioned most frequently; however, cost of prescription medications and cost of medical care were also concerns. If an individual is struggling to meet basic needs, their health may not be a priority. Cost was compounded by the need for residents to be able to physically access affordable healthy food options as well as other health resources in the community.

Key informants also felt there was a lack of knowledge and education regarding healthy lifestyles and preventing chronic conditions. A lack of education and awareness about available resources in the community was also discussed. Lack of support for those dealing with chronic conditions, both personally and professionally, was also a concern.

Safety, particularly pedestrian safety, was often cited as a barrier to engaging in physical activity in the community. At an individual level, key informants also felt there was often a lack of motivation to engage in healthy behaviors, and that lifestyle change can be challenging. Many key informants suggested that recommendations on healthy lifestyles should be tailored to take into account an individual's busy lifestyle and potential financial barriers.

Focus Group Feedback

Many of the participants felt that it is an individual's personal responsibility to take control of their health and wellbeing. They were mixed in their responses to the challenges and motivators of being physically active and eating healthy foods. Quite a few barriers and challenges were discussed in the sessions, as well as some motivating factors that were suggested to assist individuals in maintaining a healthy lifestyle.

Participants were asked, "What are the biggest challenges you face in being physically active and eating healthy foods?" The participants discussed a multitude of barriers to being physically active and eating healthy foods such as cost, time, exhaustion, and lack of will power. One participant mentioned working too much and lack of time as a major barrier. Several other participants discussed additional challenges faced in being physically active and eating healthy foods. These included:

- The expense involved in eating healthy foods
- Scheduling more physical activity into already busy day
- Lack of education in how to cook healthy foods
- Constant temptation to eat unhealthy foods

The participants expounded on how the lack of will power can be one of the major barriers to being physically active and eating healthy foods. Not surprisingly, many of the participants explained similar challenges that rested on the busyness of their individual schedules. Due to the considerable time constraint barrier, most participants agreed and shared similar stories of long busy days that caused exhaustion. One participant explained, "I leave the house early, at 8:00, and get back to the house at 5:30. I come home tired and then I have to cook food to feed everyone, so then I feel that at the time I am very tired."

The participants felt some motivating factors influenced them to be more physically active and maintain a healthy lifestyle such as support, self-esteem, and utilizing the resources available. Majority felt that support was critical in motivating an individual to be more physically active and eat healthier foods. Many participants felt that family and children were strong motivators as well. Since chronic conditions are issues individuals face long-term, many participants felt that more access to and availability of various resources would be beneficial. One participant elaborated on a personal medical situation, acknowledging that losing 25 pounds would improve the condition in a substantial way. The participants agreed that if resources such as free wellness classes and groups would become available, that they would utilize them to maintain a healthy lifestyle.

As mentioned earlier in the report, participants in the focus group discussions were also asked if they had a chronic condition and what barriers, if any, were experienced in managing their disease. Often with chronic conditions, individuals find it takes discipline and time to properly manage their chronic condition. It can also take seeing several providers to treat their disease and symptoms, which can feel like a daunting task. The majority agreed that a serious lack of communication, as well as a lack of understanding of the condition were their biggest barriers. Additional barriers discussed in managing a chronic disease include:

- Lack of awareness and communication in knowing what to expect and understanding to know what questions to ask
- Time constraints in committing to manage the chronic illness well
- Increased stress of financial burden associated with managing the condition

Secondary Data Findings

Secondary data, too, showcased the challenges that arise in maintaining a healthy lifestyle, such as exercising, eating healthy, and/or managing a chronic condition for Baltimore County residents.

Table 15. Weight Classifications (2015)

	U.S.	Maryland	Baltimore County
Healthy Weight (BMI 18.5 - 24.9)	32.7%	35.0%	31.0%
Overweight (BMI 25.0 - 29.9)	35.5%	36.1%	36.0%
Obese (BMI 30.0 and above)	29.8%	28.9%	32.9%

Sources: Centers for Disease Control and Prevention & Maryland Behavioral Risk Factor Surveillance System

Baltimore County has a lower percentage of adults at a healthy weight (31.0%) when compared to both the state (35.0%) and the nation (32.7%). Furthermore, Baltimore County has a higher percentage of adults at an obese weight when compared to the state and the nation.

There were a higher proportion of individuals in Baltimore County who had ever been told by a doctor that they had the following chronic conditions when compared to the proportion in the state and the nation: angina or coronary heart disease, an anxiety disorder, a depressive disorder, and diabetes.

Table 16. Chronic Conditions (2015)

	U.S	Maryland	Baltimore County
Ever been told by a doctor or other health professional that you had:			
Angina or coronary heart disease	3.9%	3.7%	4.6%
Asthma	14.3%	13.9%	14.3%
Anxiety disorder	N/A	13.5%	16.7%
Depressive disorder	19.0%	16.3%	19.8%
Diabetes	9.9%	10.4%	11.9%
Heart attack	4.2%	3.7%	4.3%
Stroke	3.0%	2.8%	N/A

Sources: Centers for Disease Control and Prevention & Maryland Behavioral Risk Factor Surveillance System

Baltimore County ranked near the top half of all 24 counties in Maryland, according to the County Health Rankings. There are a few measures that Baltimore County performs better than both the state and the National Benchmark. One of those measures is access to exercise opportunities is higher in Baltimore County (94%) when compared to the state (93%) and the National Benchmark (91%). There are also a few measures that Baltimore County could improve upon in comparison to Maryland and the National Benchmark in order to increase the county's rank. Some of the notable measures needing improvement include that Baltimore County residents reported a slightly higher rate of poor mental health days in the past month (3.7) when compared to the National Benchmark (3.1). As well as, injury deaths per 100,000 in Baltimore County (77) are higher compared to the state (64) and the National Benchmark (55).

Health and Quality of Life

Key Informant Feedback

Key informants were asked, "What's being done well in the community in terms of health and quality of life?" Collaboration among health systems in the area, as well as with other community partners, was mentioned most frequently by key informants. While key informants acknowledged collaboration and partnerships between organizations have increased, there is always still room to improve. Additionally, key informants felt community health events, such as health screenings, and outreach occur often in the community. Community-based programs offered through libraries, senior centers, and churches were also seen as a community asset. Key informants agreed that there are resources and services available across the community, but the challenge is ensuring individuals are aware of these resources and that they are affordable. The following text box highlights select feedback given by participants.

- "County and State health departments are working with HCPs to coordinate strategies and care around shared community health objectives. Like-minded partners are beginning to work together more effectively to identify and solve common health issues. Local and State agencies are collaborating more too."
- "Libraries, senior centers and churches offer safe places to go and appropriate programming IF people can get there."
- "Local organizations, health care providers and hospitals are attempting to breakdown the silo and work alongside each other to address the same population - but it's a long road ahead."
- "Members of the community that attend Senior Centers are learning, growing and improving their quality of life. Senior Housing is adding additional supports and programming."
- "National Diabetes Prevention Program offerings within the County. Hospital wellness classes and specific disease classes open to the public. Walking trails at Baltimore County recs and parks locations and elsewhere."
- "Senior Centers provide a wide array of prevention and chronic disease self-management programs as well as healthy foods. More people need to be encouraged to take advantage of the offerings."
- "There are a lot of grass roots organizations that are trying to help including introducing things like community gardening and exercise programs. Many of these grass roots efforts don't receive the profile or support they need and run on shoe string budgets, but they actively reach out to younger people. I think if we want to stress prevention of health problems, we need to devote more resources to the 15-30 age group."
- "There are many services and programs, but either they are on brochures that cannot be read, they are given in locations that are convenient for the organizers but not for the participants. You need to identify key community members and build upon relationships that already exist, within groups that can support one another. Offer transportation."

Key Informants were also asked to identify existing resources available to members of the community who were navigating available resources. The list of available resources identified can be found in Appendix D.

Other Suggestions and Recommendations

Key Informant Feedback

Key informants were asked to provide suggestions or recommendations to improve health and quality of life in their community. A variety of suggestions were provided by respondents, but the majority wanted to see continued and expanded collaboration and coordination among organizations in the community. Increasing access to free and/or low cost health care services was also frequently mentioned by key informants.

In terms of access, transportation was cited as a barrier. Key informants suggested offering free transportation options and improving public transportation. The need for professional support to help individuals navigate the health care system was also emphasized.

Additionally, key informants felt more of an emphasis needs to be placed on prevention efforts. Ensuring individuals are being educated on healthy lifestyles and providing them access to preventive health services. This includes making sure that available resources are effectively advertised to all segments of the population. Additionally, one idea to encourage an individual to take advantage of preventive services was to offer incentives. Some key informants emphasized senior centers as a great resource for older adults in the community.

Community Survey Feedback

Respondents were asked to provide ideas or suggestions that they felt would be helpful in addressing the health needs of the community. The participants shared thoughts regarding how UM SJMC could support community members in improving their overall health. Consistently, participants suggested providing affordable health care to the community; a universal health insurance made available to all; and additional education services.

KEY FINDINGS

Each of the individual research components from the CHNA reveal a unique perspective on the health status of residents living in Baltimore County. A number of overlapping health issues are worthy of attention for UM SJMC and its partners; however, it is important to undertake a process that pulls key themes from each component and prioritizes the community needs. The following list highlights the key themes that stood out across all the research components of the CHNA.

- **Access to Care:** Overall insurance coverage appears to be favorable as evidenced through the secondary data analysis. However, the inability to pay out-of-pocket expenses and the lack of health insurance coverage is perceived to be significant barriers for Baltimore County residents. Difficulty navigating the health care system was also mentioned as one of the top barriers in the key informant survey and was a common theme in the focus group discussions. Services that were seen as missing or insufficient in the county were free/low cost medical and dental care. Focus group participants also identified difficulty establishing effective primary care provider relationships, as well as getting a timely appointment with primary care providers. According to focus group participants, increasing customer services from physician office staff, improving translation services and more specialist providers could curb some of these barriers.
- **Most Pressing Health Issues:** Overweight/obesity, heart disease, cancer, and diabetes were some of the most common health problems in the county based on secondary data analysis and survey responses. Also of note, respondents identified drug/alcohol abuse and addiction, blood pressure, and mental health (depression, anxiety) and suicide as being the most pressing health issues in their community.
- **Mental Health:** The issue of mental health and substance/alcohol abuse was shared as a health concern among survey and focus group participants. Along these lines, the need for mental health services and providers was commonly voiced. However, the majority of community survey participants reported zero days of poor mental health in the past 30 days, but identified alcohol/drug addiction and mental health as the most pressing health issues in the community.
- **Lack of awareness of existing resources:** Focus group and survey participants mentioned that they lack awareness of resources that are available to the community. This notion was corroborated by the community survey participants that responded with not knowing the most pressing social/environmental issues in the community, as well as not knowing how to access resources and care in the community.
- **Healthy Behavior Motivators:** Focus group participants identified cost, time, lack of knowledge, and temptation of unhealthy choices as barriers to eating healthy foods and exercising. Key informants mentioned efforts for improvement such as community health events, health screenings, and outreach in the community. The focus group participants felt some motivating factors influenced them to be more physically active and maintain a healthy lifestyle such as support, self-esteem, and utilizing the resources available.

IDENTIFICATION OF COMMUNITY HEALTH NEEDS

Prioritization Session

The Prioritization and Implementation Strategy session were hosted on April 25, 2019 at UM St. Joseph Medical Center.

Process

After a group welcome, there was a review of data and common themes identified in the 2019 Community Health Needs Assessment. Discussion followed on whether these findings were consistent with what the session participants observed in the community. A post-it activity allowed participants to indicate which issues should be targeted to make the greatest impact in community health. A summary of the ranked priority areas was read back to session participants for confirmation and final thoughts. Participants then discussed current approaches by UM SJMC and other local agencies in the community to address these areas of concern. Additional suggestions were offered for programs and partnerships. Based on the insights received and review of data, UM SJMC decided to continue their work on the same health priorities for the FY20-22 CHNA.

A full list of Prioritization and Implementation Strategy session participants can be found in Appendix G.

Key Community Health Issues

- Access to Care
- Cancer
- Care Coordination
- Chronic Disease – Cardiovascular Disease, Obesity, Stroke, Diabetes
- Disparities
- Fall Prevention
- Healthy Food Access
- Isolation and Loneliness
- Low Health Literacy and Language Barriers
- Lack of Transportation
- Mental Health
- Physical Activity
- Substance Abuse
- Tobacco Use

Identified Health Priorities

- Access to Care
- Mental Health and Substance Abuse
- Chronic Disease – Cardiovascular Disease/Obesity
- Cancer
- Fall Prevention

COMMUNITY HEALTH IMPLEMENTATION STRATEGY

Strategies to Address Community Health Needs

UM SJMC developed an Implementation Strategy to illustrate the hospital's specific programs and resources that support ongoing efforts to address the identified community health priorities. This work is supported by community-wide efforts and leadership from the Executive Team and Board of Directors. The goal statements, suggested objectives, key indicators, intended outcomes and initiatives, and inventory of existing community assets and resources for each priority area listed below.

Prioritized Health Issue #1: Access to Care

Goal: Reduce the number of uninsured ED visits.

Objective: Increase the number of people with a usual primary care provider.

Key Indicators: number of St. Clare patients, number of TCC patients, number of HCAM appointments, transportation services, translation services, workforce development

Existing Community Resources: St. Clare Medical Outreach, UM SJMC Transitional Care Center, Healthcare Access Maryland, Humanim, GEDCO, Lyft

Prioritized Health Issue #2: Mental Health and Substance Abuse

Goal: Reduce emergency department visits related to mental health conditions.

Objective: Increase screening and referrals for mental health conditions and substance abuse.

Key Indicators: number of screenings, number of trainings, number of community events, increased resources, decreased stigma

Existing Community Resources: UM SJMC Behavioral Health Center, Sheppard Pratt/Mosaic Community Services, The Bergand Group, BCDH Peer Recovery Specialists

Prioritized Health Issue #3: Chronic Disease – Cardiovascular Disease/Obesity

Goal: Reduce the mortality rate from heart disease and stroke.

Objective: Increase prevention, early detection and treatment efforts for hypertension and diabetes.

Key Indicators: number of evidence-based programs, number of screenings, healthy food access, opportunities for physical activity

Existing Community Resources: American Heart Association, MAC Inc., Hungry Harvest, Meals on Wheels of Central Maryland, Baltimore County Department of Aging, Baltimore County Department of Health, Y of Central Maryland, Towson University

Prioritized Health Issue #4: Cancer

Goal: Reduce the cancer mortality rate.

Objective: Increase early detection through screening and education.

Key Indicators: number of screenings, number of participants, number of cancers detected

Existing Community Resources: Baltimore County Prevent Cancer Program, Nueva Vida, Maryland Cancer Collaborative, GBMC Screenings

Prioritized Health Issue #5: Fall Prevention

Goal: Reduce the fall-related death rate.

Objective: Increase participation in evidence-based fall prevention programs.

Key Indicators: number of programs, number of sites, number of participants, falls/injuries

Existing Community Resources: Baltimore County Department of Aging, Baltimore County Department of Health, Maryland Society for Sight, Van Dyke & Bacon Shoes, MD Falls Free Coalition, MAC Inc.

Appendix A. Secondary Data Profile References

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Appendix B. Key Informant Survey Tool

Key Informant Online Questionnaire

INTRODUCTION: As part of its ongoing commitment to improving the health of the communities it serves, University of Maryland St. Joseph Medical Center is spearheading a comprehensive Community Health Needs Assessment.

You have been identified as an individual with valuable knowledge and opinions regarding community health needs, and we appreciate your willingness to participate in this survey.

The survey should take about 10-15 minutes to complete. Please be assured that all of your responses will go directly to our research consultant, Holleran Consulting, and will be kept strictly confidential. Please note that while your responses, including specific quotations, may be included in a report of this study, your identity will not be directly associated with any quotations.

When answering the questions, please consider the community and area of interest to be Baltimore County.

KEY HEALTH ISSUES

1. What are the top **5** health issues you see in your community? (CHOOSE 5)

☐ Access to Care	☐ Overweight/Obesity
☐ Cancer	☐ Sexually Transmitted Diseases
☐ Dental Health	☐ Stroke
☐ Diabetes	☐ Substance Abuse/Alcohol Abuse
☐ Heart Disease	☐ Tobacco
☐ Maternal/Infant Health	☐ Uninsured
☐ Mental Health/Suicide	☐ Other (specify):

2. Of those health issues mentioned, which **1** is the most significant? (CHOOSE 1)

☐ Access to Care	☐ Overweight/Obesity
☐ Cancer	☐ Sexually Transmitted Diseases
☐ Dental Health	☐ Stroke
☐ Diabetes	☐ Substance Abuse/Alcohol Abuse
☐ Heart Disease	☐ Tobacco
☐ Maternal/Infant Health	☐ Uninsured
☐ Mental Health/Suicide	☐ Other (specify):

3. What resources are available in the community to address the top health issues you identified?

4. Please share any additional information regarding these health issues and your reasons for ranking them this way in the box below:

ACCESS TO CARE

5. On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about **Health Care Access** in the area.

	Strongly Disagree←→Strongly Agree
Residents in the area are able to access a primary care provider when needed. (Family Doctor, Pediatrician, General Practitioner)	☐1 ☐2 ☐3 ☐4 ☐5
Residents in the area are able to access a medical specialist when needed. (Cardiologist, Dermatologist, Neurologist, etc.)	☐1 ☐2 ☐3 ☐4 ☐5
Residents in the area are able to access a dentist when needed.	☐1 ☐2 ☐3 ☐4 ☐5
There are a sufficient number of providers accepting Medicaid and Medical Assistance in the area.	☐1 ☐2 ☐3 ☐4 ☐5
There are a sufficient number of bilingual providers in the area.	☐1 ☐2 ☐3 ☐4 ☐5
There are a sufficient number of mental/behavioral health providers in the area.	☐1 ☐2 ☐3 ☐4 ☐5
Transportation for medical appointments is available to area residents when needed.	☐1 ☐2 ☐3 ☐4 ☐5

6. What are the most significant barriers that keep people in the community from accessing health care when they need it? (Select all that apply)

☐ Availability of Providers/Appointments
☐ Basic Needs Not Met (Food/Shelter)
☐ Inability to Navigate Health Care System
☐ Inability to Pay Out of Pocket Expenses (Co-pays, Prescriptions, etc.)
☐ Lack of Child Care
☐ Lack of Health Insurance Coverage
☐ Lack of Transportation
☐ Lack of Trust
☐ Language/Cultural Barriers
☐ Time Limitations (Long Wait Times, Limited Office Hours, Time off Work)
☐ None/No Barriers
☐ Other (specify):

7. Of those barriers mentioned, which **1** is the most significant? (CHOOSE 1)

☐ Availability of Providers/Appointments
☐ Basic Needs Not Met (Food/Shelter)
☐ Inability to Navigate Health Care System
☐ Inability to Pay Out of Pocket Expenses (Co-pays, Prescriptions, etc.)
☐ Lack of Child Care
☐ Lack of Health Insurance Coverage
☐ Lack of Transportation
☐ Lack of Trust
☐ Language/Cultural Barriers
☐ Time Limitations (Long Wait Times, Limited Office Hours, Time off Work)
☐ None/No Barriers
☐ Other (specify):

8. Please share any additional information regarding barriers to health care in the box below:

9. Are there specific populations in this community that you think are not being adequately served by local health services?

__ Yes __ No

10. **If yes**, which populations are underserved? (Select all that apply)

☐ Black/African-American
☐ Children/Youth
☐ Disabled
☐ Hispanic/Latino
☐ Homeless
☐ Immigrant/Refugee
☐ Low-income/Poor
☐ Seniors/Aging/Elderly
☐ Uninsured/Underinsured
☐ Young Adults
☐ None
☐ Other (specify):

11. In general, where do you think MOST uninsured and underinsured individuals living in the area go when they are in need of medical care? (CHOOSE 1)

☐ Doctor's Office
☐ Health Clinic/FQHC
☐ Hospital Emergency Department
☐ Walk-in/Urgent Care Center
☐ Don't Know
☐ Other (specify):

12. Please share any additional information regarding Uninsured/Underinsured Individuals & Underserved Populations in the box below:

13. Related to health and quality of life, what resources or services do you think are missing in the community? (Select all that apply)

☐ Bilingual Services
☐ Free/Low Cost Dental Care
☐ Free/Low Cost Medical Care
☐ Health Education/Information/Outreach
☐ Health Screenings
☐ Medical Specialists
☐ Mental Health Services
☐ Prescription Assistance
☐ Primary Care Providers
☐ Substance Abuse Services
☐ Transportation
☐ None
☐ Other (specify):

CHALLENGES & SOLUTIONS

14. What challenges do people in the community face in trying to maintain healthy lifestyles like exercising and eating healthy and/or trying to manage chronic conditions like diabetes or heart disease?

15. In your opinion, what is being done ***well*** in the community in terms of health and quality of life? (Community Assets/Strengths/Successes)

16. What recommendations or suggestions do you have to improve health and quality of life in the community?

CLOSING

17. Which one of these categories would you say BEST represents your community affiliation? (CHOOSE 1)

☐	Business Sector
☐	Community Member
☐	Education/Youth Services
☐	Faith-Based/Cultural Organization
☐	Government/Housing/Transportation Sector
☐	Health Care/Public Health Organization
☐	Mental/Behavioral Health Organization
☐	Non-Profit/Social Services/Aging Services
☐	Other (specify):

18. University of Maryland St. Joseph Medical Center and its partners will use the information gathered through this survey in guiding their community health improvement activities. Please share any other feedback you may have for them below:

Thank you! That concludes the survey.

Appendix C. Key Informant Participants

Name	Organization
Lisa Beauvois	UM SJMC - St. Clare Medical Outreach
Donna Bilz	Baltimore County Department of Aging
Erin Browning	Arbutus Senior Center
Alice Chan	UM SJMC
Kristine Chmyr	UM SJMC- Transitional Care Center
Donna Costa	UM SJMC
Steve Crawford	UM SJMC
Laura Culbertson	Baltimore County Department of Health
Gail Cunningham	UM SJMC
Bill Deloriers	UM SJMC
Neeta Deshpande	UM SJMC- Transitional Care Center
Marie Dix	Liberty Senior Center
Barbara Franke	Jacksonville Senior Center
Cindy Gerhard	St. Elizabeth Hall
Shavise Glascoe	Towson University
Angela Gottesfeld	UM SJMC
Amy Greensfelder	ProBono Counseling
Kathy Haduch	Rosedale Senior Center
Nader Hanna	UM SJMC
Ruth Heltne	Y in Central Maryland
Kim High	Bureau of Community Health Services
Bettye Holt-Haskins	Hereford Senior Center
Mary Jo Huber	UM SJMC- St. Clare Medical Outreach
Judy Hvisc	UM SJMC
Julia Johnson	UM SJMC
Ann Marie Labin	St. Joseph Parish
Della Leister	Baltimore County Department of Health
Julie Lynn	Bykota Senior Center
Grace McDowell	Edgemere Senior Center
Patti McGraw	UM SJMC
Michelle Mills	Baltimore County Department of Aging
Cynthia Mingo	Fleming Senior Center
Nicolette Morris	UM SJMC
Kathy Mulford	Towson Orthopaedic Associates
Wayne Nelson	Towson University
Betsy Niehoff	UM SJMC- St. Clare Medical Outreach
Constance Notaro	Baltimore County Department of Health
Sam Pacamarra	St. Joseph School

Bonnie Riehl	Parkville Senior Center
Ann Marie Riehl	Victory Villa Senior Center
Laura Riley	Baltimore County Department of Aging
David Riley	Knollwood Community
Kelly Roberts	St. Michael the Archangel School
Collan Rosier	Maxim Healthcare Services
Mark Saba	UM SJMC
Nicole Schaefer	UM SJMC- Transitional Care Center
Vicki Schmelz	Padonia International Elementary School
Grace Serafini	UM SJMC
Anne Marie Smouse	UM SJMC
Sandra Villa de Leon	Nueva Vida
Michael Wainwright	UM SJMC
Niya Werts	Towson University
John Worden	Baltimore County Police Department
Maria Yansen	ACAC
Dan Young	Baltimore County Department of Health

Appendix D. Existing Resources to Address Health Issues by Key Informants

The following is a detailed listing of available resources identified by key informants to help address key health issues in the community.

- Baltimore County Health Department
- MD Diagnosis & Treatment Program for Breast, Cervical and Colon Cancer for people with proof of MD residency
- FQHP (charge on a sliding scale)
- ACAC Physician Referred Exercised Program (P.R.E.P.)
- Diabetes prevention program
- Giant food nutritionist services
- Behavioral Health Center at UM SJMC
- Mosaic and other clinics are out in the community
- Cancer Association
- Area hospitals
- Bone Health Center at TOA
- Cardiac Rehab screenings
- Department of Aging
- Baltimore County Department of Aging's Maryland access point
- Churches
- Maryland Department of Health
- Doctor's offices
- Chronic disease self-management courses
- Edgemere has one local physician and Bayview is the closest hospital
- Health presentations
- Two medical facilities in Phoenix, MD
- Jacksonville Senior Center resource
- Senior centers (speakers)
- Libraries
- Several resources available for heart disease within the UM SJMC
- Baltimore City and County Clinics for routine care and immunizations
- Program available that provides Narcan to anyone willing to attend a basic training session
- Open source information

- Health club memberships
- Access to healthy foods and recreation
- Outpatient treatment
- Physicians and pharmacy
- Roi
- Screening programs
- High-risk clinics
- Awareness programs
- Outpatient diabetes self-management education and medical nutrition therapy at UM SJMC
- Diabetes supports groups through local hospitals
- Maryland ADA Chapter
- Various internet sites: ADA, AADE, NDEP, CDC, AHA
- Some clinics
- Some inpatient beds
- Paucity of medically assisted treatment for addiction to opioids
- St. Clare Clinic
- The Pro Bono Counseling Project
- Healthcare Access Maryland
- Some IOP / partial day programs, but usually AA is the only program people are aware about
- Limited resources for the uninsured in Baltimore County for health care
- Limited access for mental health services resulting in use of the Emergency Department to serve as a primary provider
- Towson University Wellness Center
- Maryland Addiction Recovery Center
- Sheppard Pratt Health System Rehab Treatment
- Diabetes educator that is accessible only if the patient has insurance. Community health worker is available for patient education regarding diabetes management along with office visits. Nurse case manager and pharmacist provide diabetes education during office visits.
- Weight Watchers

Appendix E. Focus Group Discussion Guide Tool

Community Health Needs Assessment

19 Focus Group Discussion Guic

UNIVERSITY of MARYLAND
ST. JOSEPH MEDICAL CENTER

SUBMITTED BY
HOLLERAN
COMMUNITY ENGAGEMENT RESEARCH & CONSULTING

November 2018

Thank you for taking the time to participate in this Focus Group as part of a Community Health Needs Assessment for the University of Maryland Saint Joseph Medical Center. This is a group discussion to discover how local residents are managing their health. My name is _____ with Holleran, an independent consulting firm based in Wrightsville, PA.

I expect the session will last about an hour. Your identity and your comments will be kept confidential, so I ask that you be open in your responses and share your honest opinions.

I'd like to go over the ground rules to help the group run smoothly. First, the session is being audio taped. I am taping the session to make sure I report everyone's feedback and opinions accurately. Second, it's important that we have one person speaking at a time. You may be making some very valid points, but if you're sharing them with the person next to you while someone else is talking, your insight will be lost. I also ask that you respect every person's right to his or her own opinion. The point of having focus groups is to collect all points of view. Lastly, we would like everyone to provide their feedback based on your personal experience of being a health care consumer.

My responsibility is to guide the group. There may be some areas that we could talk about for hours, but we have a number of questions that I want to get your feedback on, so I may need to cut some discussions and move on.
Before we get started, does anyone have any questions?

Group Discussion

1. What was your experience like last time you tried to access medical care for yourself and your family members?
   Probes: *availability of providers, ability to get doctor's appointment soon, and understanding/empathy of providers*

2. What is the greatest challenge you face when navigating health care services in the county?

3. What do you think are some changes in healthcare that need to be made to improve the health of people living in the area?
   Probes: *More specialists and staff, friendlier staff and translators, decrease waiting*

4. Do you feel that people in the community are fully aware of the healthcare services/options that are available to them? Why? Why not?

5. What are the biggest challenges you face in being physically active and eating healthy foods?

6. What motivates you (or would motivate you) to be more physically active and maintain a healthy lifestyle?

7. If you have a chronic condition, what barriers, if any, have you experienced in managing your disease?
   Probes*: Education, emotional/social needs, physical limitations, time, money, etc.*

8. What do you think University of Maryland Saint Joseph Medical Center could do to support community members in improving their overall health?
   Probes*: Education, outreach, Wellness programming.*

Closing

Those are all the questions I have for the group. Is there anything you thought we would talk about that we didn't? Is there anything else you'd like to add that could be helpful for University of Maryland Saint Joseph Medical Center as they work to provide programs and services that meet your needs?

Thank you again for your participation. I appreciate your candid responses. Your feedback is valuable and will help University of Maryland Saint Joseph Medical Center tremendously.

Appendix F. Community Survey Tool

UNIVERSITY of MARYLAND
ST. JOSEPH MEDICAL CENTER

Community Health Needs Assessment

Your responses to this optional survey are anonymous and will inform how hospitals and agencies work to improve health in Baltimore County. Thank you!

Instructions: You must be 18 years or older to complete this survey. Please answer all questions and return the survey as indicated. For questions about this survey, contact University of Maryland St. Joseph Medical Center's Community Health Department at 410-337-1479.

1. What is your ZIP code? *Please write 5-digit ZIP code.* _____

2. What is your sex? *Please check one.*

☐ Male ☐ Female ☐ Transgender
☐ Other *specify*_____ ☐ Don't know ☐ Prefer not to answer

3. What is your age group (years)? *Please check one.*

☐ 18-29 ☐ 40-49 ☐ 65-74 ☐ 75+
☐ 30-39 ☐ 50-64 ☐ Don't know ☐ Prefer not to answer

4. Which one of the following is your race? *Please check all that apply.*

☐ Black or African American ☐ White ☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ American Indian or Alaska Native
☐ Other/more than one race *specify*_____
☐ Don't know ☐ Prefer not to answer

5. Are you Hispanic or Latino/a? *Please check one.*

☐ Yes ☐ No ☐ Don't know ☐ Prefer not to answer

6. 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.*

_____ **days** ☐ Zero days ☐ Don't know ☐ Prefer not to answer

7. What are the three most important health problems that affect the health of your community? *Please check only three.*

☐ Alcohol/drug addiction
☐ Mental health (depression, anxiety)
☐ Diabetes/high blood sugar
☐ HIV/AIDS
☐ Lung disease/asthma/COPD
☐ Smoking/tobacco use
☐ Don't know
☐ Alzheimer's/dementia
☐ Cancer
☐ Heart disease/blood pressure
☐ Infant death
☐ Stroke
☐ Overweight/obesity
☐ Prefer not to answer

8. What are the three most important social/environmental problems that affect the health of your community? *Please check only three.*

☐ Availability/access to doctor's office
☐ Availability/access to insurance
☐ Domestic violence
☐ Limited access to healthy foods
☐ School dropout/poor schools
☐ Lack of job opportunities
☐ Race/ethnicity discrimination
☐ Don't know
☐ Child abuse/neglect
☐ Lack of affordable child care
☐ Housing/homelessness
☐ Neighborhood safety/violence
☐ Poverty
☐ Limited places to exercise
☐ Transportation problems
☐ Prefer not to answer

9. What are the three most important reasons people in your community do not get health care? *Please check only three.*

☐ Cost – too expensive/can't pay
☐ No insurance
☐ Lack of transportation
☐ Language barrier
☐ Don't know
☐ Wait is too long
☐ No doctor nearby
☐ Insurance not accepted
☐ Cultural/religious beliefs
☐ Prefer not to answer

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

_____
_____
_____

☐ Don't know ☐ Prefer not to answer

Thank you for completing this survey!

Community survey tool was created and conducted by the University of Maryland St. Joseph Medical Center.

Appendix G. Prioritization & Implementation Strategy Session Participants

Name	Title	Organization
Aarika Subah	RN in Transitional Care Center	UM SJMC
Adam Conway	Director of Population Health	GBMC
Amabely Garcia	Outreach Volunteer	Nueva Vida
Amanda Subino	Peer Outreach Worker	Baltimore County Dept of Health
Ann Marie Labin	Faith Community Nurse	St. Joseph Parish Cockeysville
Brian Perez	Operations Manager	Towson Sports Medicine
Camisha Coke	Program Manager	Maxim Healthcare
Claire McMillan	Rehab Manager	UM SJMC
Craig Lippens	Director of Community Outreach	Bergand Group
David Riley	Community Member	Knollwood Association
Della Leister	Deputy Health Officer	Baltimore County Dept of Health
Donna Bilz	Program Coordinator	Baltimore County Dept of Aging
Frances Parks	Health and Wellness Center	McCormick
Grace Serafini	Director, Psychiatry & MCH	UM SJMC
Karlayne Parker	Ombudsman	Baltimore County Dept of Aging
Laura Culbertson	Quality Improvement Chief	Baltimore County Dept of Health
Laura Riley	Director	Baltimore County Dept of Aging
Michael Wainwright	CV Fitness Manager	UM SJMC
Nicole Schaefer	Nurse Care Manager	UM SJMC
Paula Cope	Referral Coordinator	UM SJMC
Rachelle Cook	Intern	Baltimore County Dept of Aging
Ruth Heltne	VP of Strategic Partnerships	Y of Central Maryland
Sarah Fogler	Senior Director of Pop Health	GBMC
Shavise Glascoe	Wellness Center Director	Towson University
Stephanie Archer-Smith	Executive Director	Meals on Wheels, Central MD
Sue Koerber	Community Member	N/A
Ted Gross	Chief Program Officer	GEDCO
Cheryl Slaski	Volunteer Coordinator	UM SJMC

Appendix H. 2016 Implementation Strategy Outcomes

University of Maryland St. Joseph Medical Center

Implementation Strategy Outcomes

FY 2017 – 2019

Priority Area/CHNA Goal 1: Access to Care

Priority Area #1: Access to Care

Goals:

1. Increase the percentage of adults who are vaccinated against influenza annually.
2. Increase the percentage of people with a usual primary care provider.
3. Decrease emergency visits related to mental health conditions.

Objective	Strategy & Action	Target Population	Measure
Increase the number of free flu vaccinations provided to the community.	Provide seasonal flu vaccinations to the community through free community flu vaccination clinics offered onsite and at various offsite locations and times by increasing the number of sites and clinics where flu vaccinations are offered.	General population	# of free flu clinics hosted ▪ 2017 = 22 clinics ▪ 2018 = 19 clinics ▪ 2019 = 20 clinics # of individuals vaccinated ▪ 2017=2,729 vaccinated ▪ 2018=2,371 vaccinated ▪ 2019=2,715 vaccinated
Increase access to healthcare in the uninsured population at St. Clare Medical Outreach.	Continue monthly intake of new patients as program allows by monthly interviews for potential eligible patients (if eligible schedule appointment with primary care provider and if not eligible provide resources for health care access).	Undocumented population	# of new patients per month ▪ 2017=235 new patients (3,282 total visits) ▪ 2018=167 new patients (4,384 total visits) ▪ 2019, as of February=50 new patients (2,779 total visits) **In FY19 there has been a lack of providers.*

Build strong partnerships with UM St. Joseph Medical Group Primary Care Providers and specialists in order to provide timely access to service.	Create referral coordinator role to assist with appointment scheduling by developing protocols to improve timely communication and better handoffs from providers and working with physicians to open capacity for new patients in need of care. - In 2018, a rapid process improvement workshop dedicated to access to care in PCP offices using a LEAN approach worked to identify and improve inefficiencies. Changes were made to the scheduling system, patient registration, and communication methods among staff to streamline work processes. A significant change in efficiency, wait time, and staff satisfaction was observed.	Patients of the Medical Group Providers of the Medical Group General population	# of new patients seen within the network ▪ 2017=3,676 ▪ 2018=3,315 ▪ As of February 2019=1,790 Total=8,781 % of new patient appointments made/kept No shows among new patients: ▪ 2017=901 ▪ 2018=638 ▪ As of February 2019=318 Decrease # of no-show appointments ▪ 2017=10,247 ▪ 2018=8,619 ▪ 2019, as of February=4,860
Develop after hours and extended hours care to meet the growing health needs of the community.	Extended the three PCP office location (Towson, Dundalk and Jacksonville) hours to evenings and weekends to accommodate a variety of patients and enhance partnership with ChoiceOne Urgent Care Center. - *Towson ChoiceOne on Joppa Road relocated to Northern Parkway.*	General population	# of new sites opened by the end of 2017 ▪ A fourth location opened in December 2017, ChoiceOne Urgent Care Rotunda in Baltimore 21211 # of patients seen during extended hours *Tracking patients has been limited as different EMRs are being used*
Create more pathways in the community for Behavioral Health patients.	Open a Behavioral Health Center as part of the Post Discharge Center that can help at risk patient's transition back into the community and encourages counseling and medication adherence.	Patients of primary care Patients of behavioral health High-risk medical patients	% of hospital PAU, readmission, and utilization rates ▪ 30 day readmission =3.5% o No show group=10.8% ▪ 90 day readmission=9.0% o No show group=21.6% ▪ 180 day readmission=17.2% o No show group=30.7% # of patients seen

			▪ 2018=240 patients seen
Plan and open a Post Discharge Center that helps high-risk patient's transition back into the community.	Open a center for high risk patients discharged from UM SJMC with 3 disciplines (physician provider, pharmacist and case manager) to follow up on high risk patients discharged from UM SJMC and transition them back into the community.	High-risk and high utilizer UM SJMC patients	% of hospital PAU, readmission, and utilization rates ▪ 30 day readmission=6% o No show group=12.4% ▪ 90 day readmission=16.7% o No show group=26.2% ▪ 180 day readmission=22.7% o No show group=33.3% # of patients seen ▪ 2016-2018=672 patients seen
Further enhance partnership with Maxim Transition Assist to help high-risk patient's transition back into the community ensuring proper follow up and psychosocial needs are met.	Community Health Workers (CHW) will provide non-clinical in-home services to high risk UM SJMC discharged patients to assist with transportation needs, follow up appointments, psychosocial needs, and report conditions to providers.	High-risk medicine or behavioral health patients	% of hospital PAU, readmission, and utilization rates ▪ 30 day readmission=6% o Patients not in program=16% ▪ 90 day readmission=25% o Patients not in program=33% ▪ 180 day readmission=38% o Patients not in program=40% # of patients seen ▪ 2018=593 patients completed the program
Invest in Transition Nurse Navigators (TNN) to help with targeted patient populations.	Increase telephone post discharge follow up to high-risk medical and behavioral health patients to make arrangements and assist or augment discharge plans by connecting patients to CHW, Post Discharge Center or Behavioral Health Center in addition to community providers.	High-risk patients High utilizer medical patients Behavioral health patients	% of hospital PAU, readmission, and utilization rates ▪ 2016-2018=Average of 10% readmission for patients in TNN program compared to the national average of 20%

Increase awareness on important considerations for health literacy when interacting with patients (written and verbal).	Educate employees about health literacy by incorporating UMMS Health Literacy videos into annual HealthStream training for employees. Present UMMS Health Literacy videos to providers. Use a 5th grade reading level in health literature and forms by revising screening forms and handouts to improve readability.	UM SJMC Employees UM SJMC Providers General population	# of employees/providers educated ▪ A health literacy video was developed for training purposes in 2016 and became a required competency for all UM SJMC staff for one year. # of forms revised ▪ Simplified participant form for biometric screenings was revised # of handouts revised ▪ Shock Trauma Prevention Matters publications were developed/adopted by UMMS hospitals as a collaborative effort to share information on issues including violence, water safety, distracted driving, etc. through social media, news articles, and flyers. Brightly colored with graphics, simple language, and available for each topic. ▪ Resource with drug facts listed in chart form with pictures and local drop box locations shared with our ED, Pharmacy, and Behavioral Health. ▪ Stroke magnet revised with bigger font and more pictures to help individuals identify associated signs and symptoms widely distributed at health fairs, festivals, and partner organizations.

Priority Area/CHNA Goal 2: Mental Health and Substance Abuse

Priority Area #2: Mental Health and Substance Abuse

Goals:

1. Decrease the rate of emergency department visits related to substance abuse disorders.
2. Decrease the percentage of adults who currently smoke.

Objective	Strategy & Action	Target Population	Measure
Increase the number of individuals who are screened and referred for depression.	Increase the knowledge and education of patients on depression and psychosocial issues post cardiac events by engaging patients on healthy lifestyles through education lectures and handouts, psychology referrals (1:1 consult), PCP referrals, and Pre & Post Assessments. Increase education of individuals at Cardiac Speaker Support Group.	Patients in Cardiac Rehab	Pre & Post Assessment including: PhQ9 Index Outcomes: % change in PhQ9 Index ▪ 2017=44% ▪ 2018=39% ▪ 2019=32% # of participants requiring a psychology referral ▪ 2017=24 patients ▪ 2018=12 patients ▪ 2019=12 patients
Provide culturally appropriate access to mental health.	Increase staff knowledge of common mental health disorders. - Presentation mental disorders/ case studies - Discuss and define diagnosis and treatment options - Identify barriers to treatment - Collect feedback from staff	Staff of St. Clare Medical Outreach	# of individuals educated ▪ 34 healthcare professionals/partners trained at 2 sponsored Mental Health First Aid trainings # of presentations presented to staff ▪ 3 presentations

Promote medication management and raise awareness on the dangers of over the counter drug addiction.	Develop and deliver a presentation on substance abuse and sleep (present information on how medications affect the brain and sleep, as well as interventions and treatment). Offer brown bag medication reviews.	General population Senior citizens	# of presentations ▪ 14 presentations ▪ Pharmacist presented at Stepping On and available for questions at Stepping On reunions in 2017–2019 ▪ Pharmacist available for questions at annual heart health events in 2017, 2018, and 2019 # of attendees ▪ 119 participants ▪ Ask the Pharmacist at the Y o March 2018=25 participants o March 2019=60 participants
Decrease the number of cardiac rehab adults who are using tobacco products.	Provide education & information on smoking cessation management by guest speakers using PowerPoint lectures to engage target population on healthy lifestyles through tobacco cessation counseling, education lectures and handouts, referral to county department of health quit smoking program, and Pre & Post Assessments.	Patients currently enrolled in the Cardiac Rehab Program	Pre & Post Assessment including: # of cigarettes/tobacco usage ▪ 2017=4 patients ▪ 2018=5 patients ▪ 2019=2 patients Outcomes: % changes in tobacco usage ▪ 2017=22 participants/12 quit (2 classes) ▪ 2018=24 participants/4 quit (2 classes) ▪ 2019=insufficient attendance to continue regular classes with BCDH # of people who quit during program ▪ 2017=2 quit ▪ 2018=1 quit ▪ 2019=1 quit
Prevent tobacco use and substance abuse in adolescents.	Present information and provide educational material on the dangers of tobacco use and substance abuse at the Annual Powered by ME! Conference and follow up with high schools who attended.	High school students High school staff/administrators	# of post conference evaluations completed *Unfortunately evaluation attempts did not yield many responses* # of attendees at annual event ▪ Average of 450 attendees at each annual conference

			# of schools represented at annual event ▪ About 50 schools represented at each annual conference
Educate youth of Baltimore County and City on issues regarding mental health.	Present information and provide educational material on signs/symptoms of mental health issues and appropriate treatment options at the Annual Powered by ME! Conference and follow up with high schools who attended.	High school students High school staff/administrators	# of post conference evaluations completed *Unfortunately evaluation attempts did not yield many responses* # of attendees at annual event ▪ Average of 450 attendees at each annual conference # of schools represented at annual event ▪ About 50 schools represented at each annual conference
Educate youth of Baltimore county and city on the dangers of performance enhancing drug use.	Present information and provide educational material on negative effects of PED use and appropriate treatment options for PED use and/or abuse at the Annual Powered by ME! Conference and follow up with high schools who attended. - Each of these topics was targeted through a variety of approaches within the conference (keynote addresses, speaker presentations, written material and resources) - Partners: Shock Trauma, Sheppard Pratt, One Love Foundation, Taylor Hooton Foundation	High school students High school staff/administrators	# of post conference evaluations completed *Unfortunately evaluation attempts did not yield many responses* # of attendees at annual event ▪ Average of 450 attendees at each annual conference # of schools represented at annual event ▪ About 50 schools represented at each annual conference

Additional Priority Area (Mental Health and Substance Abuse) Strategies and Actions:

- In September 2016, a bilingual family health nurse practitioner from St. Clare Medical Outreach completed an 18-month certification program in mental health counselling and began piloting a new culturally appropriate mental health counselling program. Four office hours a week are now devoted to Mental Health in the clinic.
- In 2017, St. Clare initiated a free Emotional Support Group for Latina Women that met regularly at a local church through 2018.

- Peer Recovery Specialists are now available to assist Emergency Department patients through a partnership with Baltimore County Health Dept.
- Over the past three years, the University of Maryland Medical System (UMMS) has hosted four Mental Health conferences to address multiple issues that reside in our Baltimore communities. These include topics relating to depression and anxiety, addiction and substance abuse, various mental health disorders/conditions, as well as suicide prevention and resilience. The speakers range from clinical professionals to those who have had personal experiences with mental health issues. We welcome people from the community, as well as UMMS employees and partners to attend these community conversations. UMMS will continue to discuss issues of mental health with our communities and have scheduled our next conference, which will be held in June 2019 to focus on Adverse Childhood Experiences (ACEs).
- UM SJMC received smoking cessation resources through the Community Tobacco Education Program from the Baltimore County Department of Health. These resources were widely distributed to community members and partners.
- UM SJMC Community Health developed a brief tobacco and nicotine presentation that was delivered to 200 students K-8.

Priority Area/CHNA Goal 3: Chronic Disease – Cardiovascular Disease/Obesity

Priority Area #3: Chronic Disease – Cardiovascular Disease/Obesity

Goals:

1. Reduce the age adjusted mortality rate of heart disease.
2. Increase the proportion of adults who are at a healthy weight.
3. Increase the number of people who are physically active.

Objective	Strategy & Action	Target Population	Measure
Increase the proportion of cardiac rehab adults who are at a healthy weight.	Provide education and information on the importance on healthy eating, heart healthy shopping, nutritional importance for weight loss, hypertension to engage the target population on healthy lifestyles through education lectures and handouts, heart healthy recipes, nutrition fair, measurement of abdominal girths and daily weights, dietician referrals (1:1 Consult), Pre & Post Assessments, and Cardiac Speaker Support Group	Patients currently enrolled in the Cardiac Rehab Program	Pre & Post Assessment including: -Rate your Plate (Heart) -Blood Pressure pre & post exercise -Abdominal Girth -Weight Outcomes: % change in RYP ▪ 2017=5% positive change in RYP ▪ 2018=3% positive change in RYP ▪ 2019=5% positive change in RYP % of change in weight loss ▪ 2017=3% positive change in weight loss ▪ 2018=3% positive change in weight loss ▪ 2019=2% positive change in weight loss % of change in abdominal girth ▪ 2017=1% positive change in abdominal girth ▪ 2018=1% positive change in abdominal girth ▪ 2019=1% positive change in abdominal girth % of participants with normal blood pressure (BP) post-exercise program ▪ 2017=87% patients with normal BP at discharge ▪ 2018=87% patients with normal BP at discharge

			▪ 2019=89% patients with normal BP at discharge # of participants who require dietician referral ▪ 2017=3 patients required dietician referrals ▪ 2018=3 patients required dietician referrals ▪ 2019=1 patient required dietician referral
Monitor and maintain diabetes patients AIC to be at goal.	Engage with each diabetic patients to lower or maintain A1C - Establishing individualized A1C and blood glucose goals - Monitor A1C and blood glucose to ensure patients are monitoring blood glucose at home - Provide education on diabetes - Encourage patients to be involved in care and treatment	Patients of St. Clare Medical Outreach	Monitor A1C and blood glucose at each visit Average A1Cs ▪ 2016=7.47 ▪ 2017=7.38 ▪ 2018=7.83 ▪ 2019, as of March=7.30
Increase awareness on the importance of blood pressure management and the signs and symptoms of stroke.	Distribute educational materials and provide information on risks of hypertension and stroke through: - Blood Pressure Screenings - Cholesterol Screenings - Stroke/AAA Screenings - F.A.S.T. educational material	General population	# of screenings *BP Screenings* ▪ 2017=342 (38 referred) ▪ 2018=211 (62 referred) ▪ 2019, as of March=163 (72 at risk) *Stroke/AAA Screenings* ▪ 2017=32 (2 at risk) ▪ 2018=29 (3 at risk) ▪ 2019=28 *Cholesterol Screenings* ▪ 2017=121 (8 referred) ▪ 2018=83 (13 referred) ▪ 2019, as of March=102 (16 referred) # of individuals educated ▪ 2018=211 individuals attended stroke lectures ○ 115 completed surveys following the lecture and about 96% of respondents indicated that they could identify the

			F.A.S.T. signs/symptoms of stroke after compared to 69% before the lecture ○ Increased % of attendees who knew the risk factors of stroke following the lecture
Highlight connection between diabetes and resulting complications (high blood pressure).	Expand/continue evidence-based diabetes education opportunities through support groups and health fairs.	Diabetic patients General population	# of individuals educated ▪ 2017=122 ▪ 2018=96 ▪ 2019, as of April=110
Promote healthy weight loss and management.	Continue to offer free body composition analysis, which identifies individual body fat percentage, muscle mass, total body water, visceral fat, basal metabolic rate, and BMI, as well as provide education on healthy lifestyles and resources. Provide resources, support, and education to St. Clare patients seeking to lose weight and maintain healthy habits - Identify patients with high BMI and track weight - Provide one on one coaching/education for weight loss and healthy eating and follow up coaching sessions with phone counseling - Provide information in Spanish on weight loss, healthy eating, and stress reduction in Spanish - Provide presentations to patients on healthy lifestyles and weight management - Provide educational videos in waiting area on weight management/healthy lifestyles - Encourage patients to stay active and establish exercise routines	General population Patients of St. Clare Medical Outreach	# of participants ▪ 2017=474 (235 referred) ▪ 2018=392 (201 referred) ▪ 2019, as of March=224 (122 referred) # of patients educated ▪ 2017=410 ▪ 2018=415 ▪ 2019, as of March=210

Increase the number of individuals who engage in regular physical activity and stress management.	Continue and expand free yoga classes to be offered weekly to the public. Additional physical activity initiatives from 2016 to 2019: - A St. Clare walking/biking group was initiated in 2018. Towson Sports Medicine in partnership with UM SJMC adopted The Healthy Kids Running Series in 2017, a 5-week running program for children pre-K to 8th grade. Two series are hosted at local high schools each year.	General population	# of classes ▪ 2017=88 classes ▪ 2018=99 classes ▪ 2019, as of March=70 classes # of participants ▪ 2017=592 pts ▪ 2018=844 pts ▪ 2019, as of March=740 participants # of participants 27 unique walkers 34 unique riders # of participants FY17- 247 registered runners FY18- 324 registered runners
"BeMore Fit N Fun" Program: Educate youth of Baltimore County on the importance of a balanced diet and exercise. Promote active healthy lifestyles and effect change in a family/community.	A free one week camp for youth age 6-12 focusing on proper nutrition and consistent exercise by engaging the targeted population on healthy lifestyles through education lectures and handouts, healthy snacking, daily weights, dietician referrals, PCP referrals, and Pre & Post Assessments. Educational material and presentations on exercise, nutrition, goal setting, communication, team building.	General population	Pre & Post Assessment # of 2/4/6 week follow ups ▪ 2017=22 participants ▪ 2018=12 participants ▪ 2019=12 participants Follow-up survey responses were insufficient to provide outcome data. Despite multiple attempts to host the program at different locations, attendance was low and the program was discontinued.

Priority Area/CHNA Goal 4: Cancer

Priority Area #4: Cancer

Goals:

1. Raise awareness of cancer screening guidelines in community.
2. Maintain/add to disease specific cancer screening programs, focus on disparities.

Objective	Strategy & Action	Target Population	Measure
Educate primary care physicians about cancer screening guidelines.	Collaborate with the Physician Liaison Office for physician liaisons to provide cancer screening guidelines to PCP practices for their patients. Annual Cancer Symposium	Primary Care Physicians	# of physicians/professionals educated ▪ 2017=110 providers (182 total professionals) ▪ 2018=50 providers (138 total professionals) ▪ 2019=78 providers (136 total professionals)
Improve early cancer detection in community with a focus on disparities.	Collaborate with UM SJMC Employee and Community Health, Health Department, and community organizations to: - Active Participation in Baltimore County Cancer Coalition - Active Participation in Maryland State Cancer Collaborative and Cancer Plan Steering Committee - Active Participation on Leadership Team of DHMH Patient Navigation Network	Residents of Baltimore County Metro-area Employees	# of community members screened (by race, ethnicity and insurance status) ▪ Attend Quarterly Meetings to establish collaboration with Baltimore County Cancer Protection Program from monthly participation at the Breast Cancer Screenings at UMSJMC, which educates participants about cancer prevention and register participants for Cervical or Colorectal Cancer Screenings if eligible. ▪ Participate in all Conference Call Planning Meetings and Active on Patient Navigation Network Leadership Team Meetings and June Conference 2016 – 2018
Implement Colorectal Cancer Screening program for Employees.	Implement screening, track metrics, and collaborate with GI Physicians, Employee Health, and DDC.	Employees	# of employee colonoscopies performed ▪ 2017=32 screenings ▪ 2018=26 screenings ▪ 2019=39 screenings

Continue Community Breast Cancer Screening Program.	Implement screening, track metrics, and collaborate with Cancer Institute/Breast Center and Community Health.	Women in the general population	# of women having screening mammogram ▪ 2017=28 ▪ 2018=27 ▪ 2019=35
Continue One Voice Breast Cancer screening program for Uninsured.	Implement screening programs, navigate women to appropriate resources, track metrics, and collaborate with Advanced Radiology, Cancer Institute/ Breast Center and Community Organizations.	Uninsured women in the general population	# of uninsured women receiving screening mammogram and navigation ▪ 2017=99 ▪ 2018=124 ▪ 2019, as of March=92
Continue Community Prostate Cancer Screening.	Implement screening, track metrics, and collaborate with Cancer Institute, Community Health, and GU physicians.	Men in the general population	# of men having prostate exam, DRE and PSA ▪ 2017=26 screenings ▪ 2018=32 screenings ▪ 2019=27 screenings
Continue Cervical Cancer Screening.	Implement screening, track metrics, and collaborate with Community Health, Cancer Institute and Women's Health Associate.	Women in the general population (focus on disparities)	# women screened for cervical cancer ▪ 2017=32 screenings ▪ 2018=30 screenings ▪ 2019=42 screenings
Explore possibility of skin cancer screening program.	Meetings with Cancer Institute, Dermatologists, Community Health and Administration to determine feasibility.	Men in the general population Women in the general population	Identify other opportunities for screening and education ▪ New physician champion identified, skin cancer screening scheduled for 4/24- 38 were screened ▪ Partnered with About Faces to provide education to their employees. In FY18, 45 staff members were educated at four store locations. Also partnered with Claire Marie Foundation to raise awareness on pediatric melanoma at 2018 Women's Conference.

Priority Area/CHNA Goal 5: Fall Prevention

Priority Area #5: Fall Prevention

Goals:

1. Decrease the rate of fall related deaths among the elderly.

Objective	Strategy & Action	Target Population	Measure
To support better balance in adults.	Increase Stepping On (a 7 week evidence-based program that incorporates balance and strength exercises with education on home safety, medications, footwear, vision, and assistive devices) Program to twice a year.	General population over age 65 years	# of programs offered ▪ 2017=3 programs (funded instructor) ▪ 2018=3 programs ▪ 2019=5 programs # of participants ▪ 2017=42 completers ▪ 2018=27 completed ▪ 2019=48 completed to date
To promote bone health in adults.	Continue with bone density screenings that are offered through an ultrasound of the heel bone and counsel participants on their risk and give information on protecting bone health. Ensure those identified as high-risk are advised to speak with their health care provider about a DEXA scan.	General population over age 18 years	# of individuals screened for bone density ▪ 2017=339 (160 referred) ▪ 2018=270 (136 referred) ▪ 2019, as of April=127 (60 referred)
To increase fall prevention awareness in the community.	Provide educational material on ways to reduce fall risk by incorporating into bone density screenings and distributing at the Senior Expo.	General population	# of individuals who receive education ▪ Approximately 500 individuals received educational materials at the Senior Expo

Appendix I. Full List of Outcomes from the 2013 CHNA

University of Maryland St. Joseph Medical Center

Implementation Strategy

Priority Area: CHNA Goal 1 - Access to Health Care

Priority Area: Access to Health Care Services

Goals: Bring screenings, vaccinations and health education to people who otherwise would not receive any health care interventions.

1. Increase the number of patients receiving free flu shots
2. Increase the number of patients receiving health screenings

Objective	Strategy & Action	Population	Measure
Increase the number of patients who receive free flu shots --------	Community Health will provide over 3,000 free seasonal flu vaccinations to the community through open clinics offered onsite and at various offsite locations in surrounding areas of need (Cockeysville, White Marsh, Owings Mills, Hereford, etc.) from October through December.	General population	Number of community members who receive vaccinations ▪ FY14 2617 vaccinated 18 clinics total, 13 offsite ▪ FY15 3013 vaccinated 20 clinics total, 14 offsite ▪ FY16 2399 vaccinated 20 clinics total, 14 offsite ▪ Zip codes served: 21204, 21093, 21030, 21218, 21236, 21120, 21202, 21201, 21231 Four community flu clinics hosted every year at UM SJMC on a weekday, a Friday evening, a Saturday, and a Sunday. Clinics are also held offsite at different locations in Baltimore County from 12-7pm (White Marsh Mall, Greetings & Readings Hunt Valley, Kenilworth Mall, St. Joseph Parish Cockeysville). Other areas of need are targeted in Baltimore City (Marian House, Esperanza Center, Weinberg Center, Lexington Market). Vaccine Information Sheets and consent forms are provided in Spanish if needed (over 20% of

Increase the number of patients receiving health screenings	Community Health will offer free monthly bone density screening to help individuals evaluate osteoporosis risk and to provide resources to support bone health. Over 150 individuals will be screened and educated. Community Health will offer free bone density screenings at all 20 Baltimore County Senior Centers in 2013. Over 200 seniors will be screened and educated.	General population Senior Citizens	the individuals vaccinated at St. Joseph Parish in Cockeysville are Hispanic). Free flu shots are also offered in couples attending childbirth class in the fall. Number of patients who participate in screenings ▪ FY14- 205 screened (72 referred for follow-up) ▪ FY15- 242 screened (79 referred for follow-up) ▪ FY16- 199 screened to date (70 referred for follow-up) Number of screenings/education accomplished. ▪ FY14- 317 screened (156 referred for follow-up) ▪ FY15- 258 screened (125 referred for follow-up) ▪ FY16- 169 screened to date (78 referred for follow-up) Two health educators and a nurse completed training in Stepping On for Better Balance, an evidence-based fall prevention program. Four series were hosted with 45 total participants.

Priority Area: CHNA Goal 2 - Diabetes

Priority Area: Diabetes
Goals:
1. Increase the number of patients served by Diabetes Education/Outreach
2. Increase the emphasis in Diabetes Education on obesity education and high blood pressure awareness as a consequence of diabetes
3. Maintain and enhance diabetes education for Hispanic patients at St. Clare Medical Outreach

Objective	Strategy & Action	Target Population	Measure
Increase patients seen in Diabetes Education -------- Highlight connection between diabetes and resulting complications, especially high blood pressure for patients receiving diabetes education --------	Continue and expand evidence-based diabetes education opportunities	Patients diagnosed with diabetes	Maintain current program enrollment and increase as needed ▪ FY14- 518 clinic visits ▪ FY15- 930 clinic visits ▪ FY16- 576 clinic visits (year to date) An endocrinologist was hired for FY15, resulting in increased patient volumes. In February 2015, the endocrinologist left and an educator's FTE was changed. ▪ FY14- 24 visits for free diabetes support groups ▪ FY15- 61 visits for free diabetes support groups ▪ FY16- 46 visits for diabetes support groups (year to date) ▪ Two health educators were trained as instructors in Stanford's Living Well Chronic Disease Self-Management program. Three series were hosted in FY16 with 32 total participants.

Increase diabetes compliance by patients at St. Clare Medical Outreach ----------	Maintain collaboration between hospital-based diabetes educators and staff of St. Clare Medical Outreach	Patients of St. Clare Medical Outreach	Maintain current obesity awareness and nutrition initiatives at St. Clare Medical Outreach, monitoring outcomes. Continue to monitor A1C levels for progressive improvement ▪ FY 14 –Tracked only monthly average of A1Cs, Monthly average ranged from 7.3-8.3 o Yearly average – 7.78. ▪ FY 15- Monthly A1Cs ranged from 7.5-8.4 o Yearly average A1C–7.87 o 42.7 % of patients had an A1C of 7 or below 29% had an A1C of 7.1–8.9 o 28% had an A1C of 9 or greater ▪ FY16- New Medical Director = A1C tracking was performed differently o 45% patients have an A1C of 7 or below o 40% patients have an A1C of 7.5-8.4 o 15% of patients have an A1C of 9 or greater o Monthly average A1Cs range from 6.99-8.8, year to date average A1C is 7.52
Increase body composition awareness and the implications	Community Health will offer free monthly body composition analysis to help individuals evaluate weight, body fat, and muscle mass on an ongoing basis and to provide resources to support individual weight loss efforts. Over 250 individuals will have their body composition analyzed and explained at onsite and offsite events.	General population	St. Clare received a grant from BGE for education. St. Clare was able to purchase booklets in Spanish for patients on healthy styles and replicas of food. A grant from the Hoffberger Foundation was awarded to St. Clare to purchase strips for glucometers and medication for diabetics. Number of people screened ▪ FY14- 217 screened ▪ FY15- 433 screened ▪ FY16- 419 screened to date ▪ UM SJMC hosted an educational series including screening parts of the HBO documentary Weight of the Nation theweightofthenation.hbo.com/ and discussion with a panel of experts. A healthy meal and educational material on nutrition was provided. There were 225 participants.

			▪ UM SJMC hosted a monthly weight management support group for six months. Support group was discontinued.

Priority Area: CHNA Goal 3 – Substance/Tobacco Abuse

Priority Area: Substance/Tobacco reduction/cessation
Goals: Increase the number of patients using screening and primary care outreach opportunities
1. Bring smoke cessation education to high school age students
2. Increase the number of people who participate in one of our multi-week, smoking cessation courses
3. Increase the number of participants in a Powered by Me! event

Annual Objective	Strategy & Action	Population	Measure
Increase the number of people who receive substance/tobacco cessation interventions through UM-SJMC (Fresh Start classes and Powered by Me!)	Smoking cessation resources will be provided to all cardiovascular and cancer screening participants.	Patients already who are screened for cardiovascular disease or cancer	Numerical increase in people offered substance/tobacco cessation assistance. ▪ FY14- 340 ▪ FY15- 2740 ▪ FY16- 1053 (year to date) ▪ Beginning in FY15, smoking cessation resources were included in heart education booklets provided to cardiac rehab patients
	Tobacco awareness will be offered as a topic for secondary school health fair requests including Calvert Hall	High School students	Numerical increase in number of people who participate in substance/tobacco cessation opportunities at UM-SJMC

	College High School and Rosedale Alternative School. Maintain Powered by Me! Involvement in sports programs	 Student athletes, coaches, parents, school administrators	▪ UM SJMC host Freedom from Smoking course on two separate occasions, but registration/ attendance was insufficient to complete the course. ▪ In FY16 Stroke III: Advanced Topics in Risk Reduction was added as an opportunity for nursing education. 255 nurses participated. http://poweredbymemd.org/ ▪ FY14- 527 attended conference ▪ FY15- conference cancelled due to riots ▪ FY16- 471 attended conference ▪ Student athletes, coaches, and administrators from 51 public and private high schools in Baltimore County, Baltimore City, Howard County, Harford County, Prince Georges County, Anne Arundel County

Priority Area: CHNA Goal 4 – Heart Disease/Hypertension/Stroke

Priority Area: Heart disease/hypertension/stroke **Goals:** 1. Raise awareness of risk factors for stroke, stroke symptoms and appropriate response to symptoms			
Annual Objective	**Strategy & Action**	**Population**	**Measure**
To provide education regarding stroke prevention, signs of stroke	Provide stroke education on the topics of signs and symptoms of stroke, activating EMS, risk factors, and prevention to 500 people in the local community in fiscal year 2014. Create an annual internal May Stroke Awareness Month campaign based on the F.A.S.T. public education materials, with a target audience of visitors and nonclinical staff, to launch on May 1, 2013.	General population Hospital visitors, UM-SJMC non-clinical staff	Numbers of community members educated ▪ FY14- 912 ▪ FY15- 890 ▪ FY16- 1004 (to date) F.A.S.T. posters and tabletop tents were distributed throughout public and restricted areas in UM SJMC. F.A.S.T. messaging on public television monitors in hospital. Partnered with Marketing for blog posts, Facebook posts, and articles for local newspapers and UM SJMC Health Matters magazine. Annual Health Stream stroke education module mandated

			for all clinical employees. A series of stroke education classes were initiated for nurses. About 300 nurses participate each year.

Priority Area: CHNA Goal 5 – Maternal/Child Health

Priority Area: Maternal/Infant Health
Goals:
1. To educate pregnant women and women of childbearing age of the dangers of poor nutrition, diabetes (gestational and chronic), high blood pressure, substance/tobacco use during pregnancy
2. To educate women who are pregnant and those of childbearing age how they can enhance their own health and the health of their unborn child
3. To educate target populations how protect themselves and the baby from severe, long-term negative health outcomes
4. 4. To educate women about low/very low birth weight, its causes, its prevention, long-term consequences of low/very low birth weight

Annual Objective	Strategy & Action	Population	Measure
To include education about healthy lifestyle practices into all women's services encounters --- To include education about the long-term effects of low/very low birth weight	Bilingual educational materials will be available to all providers of women's health services at UM-SJMC. All providers will be asked to include education on the relationship between healthy lifestyle/nutrition	Women who are pregnant, women of childbearing age who are not pregnant	Consistency of including healthy lifestyle education in patient encounters and in high school health education visits ▪ Patients at Women's Health Associates (WHA) receive verbal education on healthy lifestyle practices at each visit ▪ FY14- 9,315 patient visits ▪ FY15- 10,527 patient visits

into all women's services encounters ----------	into their regular patient visits. These materials will be available to providers at UM-SJMC's Women's Health Associates, our Perinatal Center.		▪ FY16- 7,778 patient visits (year to date) Need to reorder educational material. ▪ The majority of pregnant patients at WHA receive written educational material in English or Spanish as preferred by the patients.
To include education about low/very low birth weight into all high school health education opportunities	Community Health Outreach will include education on low/very low birth weight in high school classes	High school students	Number of students ▪ FY14- 190 students ▪ FY15- 290 students ▪ FY16- 184 students to date Education delivered at Catholic High- an inner city school

Priority Area: CHNA Goal 6 – Cancer

Priority Area: Cancer **Goal:** 1. Increase number of patients screened for various types of cancer 2. Increase cancer screenings in minority communities 3. Increase number of patients diagnosed w/cancer and moved to treatment			
Annual Objective	**Strategy & Action**	**Population**	**Measure**
			NOTE: FY 2013 – April 2016 Metrics
Develop strategic plan to implement cancer prevention and early detection education in the community with an emphasis on reaching underserved members of community	Partnerships included: ▪ Hopkins Community Advisory Group –East Baltimore ▪ UM SJMC Community Health Program 2013, 2014, 2015 ▪ ACS, One Voice Grant 2102, 2013 ▪ One Voice Program , culturally sensitive collaborative prevention & early detection	Underserved populations African American women and Latina women PCP & Health Care Professionals	Metrics for measuring outreach program effectiveness: # Community education programs ▪ FY 2014= 30 cancer prevention programs ▪ FY 2015= 16 cancer prevention programs ▪ FY 2016 thru April 2016 cancer prevention programs=8 ▪ Total= 54

----------	program with Advanced Radiology, Nueva Vida, Cancer Institute, Breast Center 2013, 2014, 2015 ongoing ▪ Sister's Network 2012,2013 for African American and Nueva Vida Latina Women 2013, 2014, 2015 ▪ Maryland Cancer Collaborative Primary Prevention and Disparities Committee 2013, 2014 ▪ Member Patient Navigation Network Leadership Team 2015 ▪ Member Cancer Collaborative Steering Committee 2015 ▪ Baltimore County Cancer Coalition 2013. 2014, 2015 ▪ Baltimore City Cancer Coalition 2013, 2014, 2015 ▪ Susan G. Komen ▪ Govan's Ecumenical Development Corporation GEDCO ▪ Educational Activities Provided: Cancer Prevention programs are consistent with evidence based national guidelines and evidence based interventions; ACS, Association of Breast Surgeons and NCI national guidelines Action Examples: ▪ American Cancer Society CPS 3 Cancer Prevention Study: 9/17/13 ;SJMC host site enrolled 67 people ▪ St. Stephen's AME Church Essex 9/14/13 CPEDE Zip 21221 ▪ Marian House for Homeless Women 10/2/13 CPEDE &Resources CPEDE Zip 21218 ▪ Senior Expo 10/9/13 CPEDE Zip 21093		# Community members educated ▪ FY 2014= 3,002 ▪ FY 2015= 1,555 ▪ FY 2016= 604 ▪ Total= 5,161 # PCP/ Health Care Professionals Educated ▪ FY 2014= 225 ▪ FY 2015= 95 ▪ FY 2016= 220 ▪ Total= 540

	▪ New Psalmist Baptist Church, 10/12/13 Breast Cancer Awareness CPEDE Zip 21215 ▪ Oak Crest Employee Health Expo 10/16/13 CPEDE Zip 21234 ▪ MD Health Connection Speaker 10/15/13 Access to Care at UM SJMC ▪ B'More Healthy, UMMS Event at Convention Center 3/1/14 CPEDE Zip 21201 ▪ Mt. Calvary AME Church Biggest Loser Health Event 3/8/14 CPEDE Zip 21286 ▪ Komen Finding Your Path to Breast Health, New Psalmist Baptist Church 3/8/14 CPEDE Zip 21215 ▪ Colorectal Cancer Awareness Day at UM SJMC 4/16/14 ▪ Why Women Cry Event, University of Baltimore Mt Royal Ave 4/21/16 CPEDE Zip 21201 ▪ Baltimore County Housing & Self Sufficiency Program, Baltimore County Health Department Drumcastle 4/26/14 CPEDE Zip 21212 ▪ Mt. Calvary AME Church 5/10/14 CPEDE Zip 21286 ▪ Archdiocese Health Day 5/15/14 CPEDE Zip 21201 ▪ Women's Health Conference at UM SJMC 5/17/14 CPEDE ▪ WJZ Ask the Expert Call In 6/5/14 at WJZ TV Station Zip 21211 ▪ Up In Smoke Smoking Cessation Classes 6/23 & 6/30 at UMSJMC NOTE: currently refer patients to Baltimore County Smoking Cessation Programs throughout county ▪ Primary Care Physician Outreach/Education, Cancer Institute Annual Symposiums at Sheppard Pratt Conference Center Zip 20204		

	▪ Cervical Cancer Awareness 1/14/15 at UM SJMC ▪ Leadership Baltimore, 2/9/15 at UMSJMC CPEDE ▪ Cancer Prevention Awareness at UM SJMC 2/18/15 ▪ Colon Cancer Awareness at UM SJMC 3/18/15 ▪ WJZ Ask the Expert 3/26/15 ▪ Towson Y High Risk Breast Screening Education 3/30/15 Zip 21204 ▪ Mc Cormick Employee Event 5/11/15 CPEDE Zip 21131 ▪ Archdiocese Health Event 5/16/15 CPEDE Zip 21201 ▪ 4th Annual Women's Conference at UM SJMC 5/16/15 CPEDE ▪ Patient Navigation Conference ▪ 9/16/16 at Sheppard Pratt Conference Center participants representing State of MD ▪ UM SJMC Employee Wellness Event 10/8/16 ▪ Colorectal Cancer Screening Initiative for Employees/Education and Screening 2/18/16, 2/24/16,/2/24/16 for Sedexo, 3/5/16 screening, 3/19/16 screening, 4/9/16 screening ▪ Heart health Employee Wellness Event- Colorectal Cancer Screening Guidelines		
Foster Breast Screenings and Breast Health Education ----------	Community Cancer Screenings scheduled in partnership with SJMC Community Health and continuation of monthly 100 free Screening Mammogram program with our original One Voice partner, Nueva Vida, thru April 2016 Self-breast exam education is included in the monthly ongoing screening ----------	Community women Hispanic women Uninsured women ----------	Numbers of women screened ▪ FY2014 = 101 women ▪ (29 community, 10/5/13 + 72 One Voice) • 65 Hispanic • 84 uninsured ▪ FY 2015 = 89 women (29 Community, 10/11/14 + 60 One Voice) • 58 Hispanic • 67 Uninsured

	▪ Participation in the Baltimore City Cancer Coalition ▪ Baltimore County Cancer Coalition ▪ Maryland Cancer Collaborative State Coalition Steering Committee ▪ Maryland Patient Navigation Network Leadership Team ▪ American Cancer Society ▪ Nueva Vida ▪ Luekemia & Lymphoma Society ▪ Pancreatic Action Network ▪ Hopkins Community Advisory Group ▪ UM SJMC Community Health and Wellness Wise Committee	Women and men	▪ FY 2016 thru April 2016 = 111 women (21 community, 10/10/15 + 90 One Voice) • 82 Hispanic • 97 Uninsured ▪ Total = 301 Active participation in listed Coalitions/organizations # ▪ 2014= 8 ▪ 2015= 7 ▪ 2016=8
Continue cervical cancer screenings ----------	2 Cervical Cancer Screenings scheduled in partnership with Community Health	Women	Number of women screened for Cervical Cancer ▪ FY 2014 = 28 11/12/13 ▪ FY 2015 = 31 3/7/15 ▪ FY 2016= 31 3/12/16 ▪ Total= 90
Continue prostate cancer screenings ----------	3 Prostate Screenings scheduled in partnership with Community Health	Men	Number of men screened for Prostate cancer ▪ FY 2014 = 28 9/25/13 ▪ FY 2015 = 16 9/20/14 ▪ FY 2016= 26 9/16/15 ▪ Total = 70
Continue skin cancer screenings ----------	2 Skin Screenings scheduled in partnership with Community Health	Men and Women	Number of people screened for Skin Cancer ▪ FY 2014 = 42 5/8/14 ▪ FY 2015 = 32 9/20/14 ▪ FY 2016= 0 ▪ Total = 74
Colon Cancer Employee Screening Initiative Signed ACS 80% by 2018 pledge to increase colorectal cancer screenings	3 Colorectal Cancer Screenings 3/5/16, 3/19/16, 4/9/16	Men and Women	Number of people screened for Colorectal Cancer ▪ FY 2016 = 30+ meeting on 5/10/16 to report final metrics