Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission (HSCRC or Commission) is required to collect community benefit information from individual hospitals in Maryland and compile into an annual statewide, publicly available report. The Maryland General Assembly updated §19-303 of the Health General Article in the 2020 Legislative Session (HB1169/SB0774), requiring the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments. The reporting is split into two components, a Financial Report and a Narrative Report. This reporting tool serves as the narrative report. In response to the legislation, some of the reporting questions have changed for FY 2021. Detailed reporting instructions are available here: https://hscrc.maryland.gov/Pages/init_cb.aspx

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

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

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

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

	Is this information correct? Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: MedStar Union Memorial Hospital	◉	○	
Your hospital's ID is: 210024	◉	○	
Your hospital is part of the hospital system called MedStar Health.	◉	○	
The primary Narrative contact at your hospital is Meghan Monpremier	◉	○	
The primary Narrative contact email address at your hospital is Meghan.A.Monpremier@medstar.net	◉	○	
The primary Financial contact at your hospital is Beth Kelly	◉	○	
The primary Financial email at your hospital is Beth.e.Kelly@medstar.net	◉	○	

Q4. The next group of questions asks about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

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

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

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

The hospital utilizes a wide variety of metrics including hospital patient utilization data, disease incidence and prevalence, density of underserved or low-income residents and evidenced health disparities, and presence of existing programs and partnerships.

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

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

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

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

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

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

- [x] Other. Please describe.

CBSAs were selected based on hospital patient utilization data; elevated disease incidence and prevalence; a high density of underserved or low-income residents and evidenced health disparities; proximity to the hospital; and/or an existing presence of programs and partnerships.

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

https://www.medstarunionmemorial.org/our-hospital/mission-vision-and-values/

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

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

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

- (●) Yes
- ( ) No

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

This question was not displayed to the respondent.

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

6/30/2021

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

https://ct1.medstarhealth.org/content/uploads/sites/16/2021/06/MedStar_Health_2021_CHNA_Report.pdf?opt_id=oeu1621883455916r0.6943780776403146&_ga=2.115508992.786991321.1626111019-573208838.1621883457

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

Medstar Health 2021 CHNA Report.pdf
19.7MB
application/pdf

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

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

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

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

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

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

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

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (system level)	☐	☐	☐	☐	☑	☐	☐	☐	☑	☐	
Physician(s)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Nurse(s)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Social Workers	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hospital Advisory Board	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	
Other (specify)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	

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

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

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

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

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

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - K-12 -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - Colleges, Universities, Professional Schools -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Behavioral Health Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Social Service Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Post-Acute Care Facilities -- please list the facilities here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Community/Neighborhood Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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

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

- (●) Yes
- ( ) No

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

6/30/2021

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

https://ct1.medstarhealth.org/content/uploads/sites/16/2021/06/MedStar_Health_2021_CHNA_Report.pdf?opt_id=oeu1621883455916r0.6943780776403146&_ga=2.115508992.786991321.1626111019-573208838.1621883457

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

Medstar Health 2021 CHNA Report.pdf
19.7MB
application/pdf

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

This question was not displayed to the respondent.

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

- [x] Health Conditions - Addiction
- [x] Health Behaviors - Drug and Alcohol Use
- [x] Populations - Women

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

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

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

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

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

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

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

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

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

	Health Conditions - Addiction Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Screening, Brief Intervention and Referral to Treatment (SBIRT) Program	To deliver evidence-based behavioral health programs and services targeting the identification of substance abuse and linkage to treatment services among high-risk individuals in MedStar Union Memorial Hospital's CBSA.	In FY21, 36,770 patients were screened for substance abuse. Of those, 7,331 screened positive for substance use. PRCs provided 1,092 brief interventions with patients including 472 referrals to treatment, of which 176 were confirmed to have linked with those services.	Number of SBIRT screens annually; Number of positive SBIRT screens annually; Number of brief interventions completed annually; Number of referrals to treatment provided annually; Number of patients linked to treatment annually.
Initiative B				
Initiative C				
Initiative D				

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

Initiative J				
All Other Initiatives				

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

	Health Conditions - Overweight and Obesity Initiative Details

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

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

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

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

Initiative I				
Initiative J				
All Other Initiatives				

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

	Settings and Systems - Transportation Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Uber Program	To address the barrier of transportation to medical and health services and programs among individuals who identify transportation as a social unmet need.	In FY21, more than 2,200 rides were provided through Uber for more than $36,860 in transportation assistance.	Number of transportation rides facilitated.
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

	Social Determinants of Health - Health Care Access and Quality Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes

Initiative A	Social Determinants of Health Screenings (SDOH)	To conduct social needs screenings and support linkages to social need services as part of care delivery and chronic disease self-management programming.	In FY21, 142 social needs screenings were completed. Participants reported food insecurity (59%); transportation barriers (55%); need for employment assistance (12%); need for utility assistance (13%); need for housing assistance (83%); and financial strain (53%); education (3%); safety concerns (100%); mental health (62%); stress (37%).	Number of social needs screenings completed.
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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

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

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

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

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

This question was not displayed to the respondent.

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

- [x] Yes
- [ ] No

Q131.
In your most recently completed CHNA, the following community health needs were identified:
Health Conditions - Addiction, Health Conditions - Cancer, Health Conditions - Diabetes, Health Conditions - Heart Disease and Stroke, Health Conditions - Mental Health and Mental Disorders, Health Conditions - Overweight and Obesity, Health Behaviors - Drug and Alcohol Use, Health Behaviors - Nutrition and Healthy Eating, Health Behaviors - Physical Activity, Health Behaviors - Preventive Care, Health Behaviors - Tobacco Use, Populations - Men, Populations - Older Adults, Populations - Women, Settings and Systems - Community, Settings and Systems - Health Insurance, Settings and Systems - Housing and Homes, Settings and Systems - Transportation, Social Determinants of Health - Economic Stability, Social Determinants of Health - Health Care Access and Quality, Social Determinants of Health - Neighborhood and Built Environment, Social Determinants of Health - Social and Community Context
Other:

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

This question was not displayed to the respondent.

Q132. Why were these needs unaddressed?

This question was not displayed to the respondent.

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

MedStar Health is committed to serving diverse communities and creating a diverse workplace where people feel a sense of belonging and accomplishment. MedStar Health strives to be bold in addressing health inequities that affect the communities we serve. We believe it is our duty to promote justice for marginalized communities and to identify and address racism across the spectrum of bias and discrimination. MedStar Health tracks health disparities in quality and safety measures in the hospital and ambulatory setting to inform priority areas for improvement in patient care. MedStar Health also tracks disparities in the communities we serve and uses this information to inform decision making surrounding community health programming, among other things. As a leader in health care, we recognize the value in evolving our organization by bringing unique, multi-dimensional perspectives together to make an impact on patient care. We are taking steps to ensure our culture supports a safe environment for all, including developing awareness, education and training for the workforce to minimize and overcome biases, ensuring leadership and workforce populations reflect the communities we serve, and ensuring diversity of external Supply Chain partners. This work is spearheaded by a systemwide Equity, Inclusion and Diversity Steering Committee.

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

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

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

Q60. Section III - CB Administration

Q61. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

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

Q246. Please describe the third party audit process used.

This question was not displayed to the respondent.

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

- [x] Yes

- ◯ No

Q63. Please describe the community benefit narrative audit process.

The internal review of the Community Benefit Report is performed by the Administrative Director, Population Health, the Financial Services Manager, and the CFO. The CFO provides oversight of the CBISA reporting function, auditing process and approval of Community Benefit funding. The CEO's and CFO's signature is obtained through an attestation letter supporting their approval of the Community Benefit Report. The MedStar Health Corporate Office also conducts a review/audit of the hospital's Community Benefit Report annually.

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

- ◉ Yes
- ◯ No

Q65. Please explain:

This question was not displayed to the respondent.

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

- ◉ Yes
- ◯ No

Q67. Please explain:

This question was not displayed to the respondent.

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

- ◉ Yes
- ◯ No

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

MedStar Health's vision is to be the trusted leader in caring for people and advancing health. As part of MedStar Health's fiscal year 2021-2025 system strategic plan (which acts as the umbrella plan for all MedStar Health entities, including its hospitals), community health and community benefit initiatives and tactics ladder up to the Develop Care Management Capabilities strategy focus area. This strategy provides guidance and context for the community health needs assessments, priorities and initiatives for each MedStar Health hospital.

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

Q133. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- ☑ Diabetes - Reduce the mean BMI for Maryland residents
- ☑ Opioid Use Disorder - Improve overdose mortality
- ☐ Maternal and Child Health - Reduce severe maternal morbidity rate
- ☐ Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17

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

Q135. Section IV - Physician Gaps & Subsidies

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

- ○ No
- ◉ Yes

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

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	○	◉	
Anesthesiology	○	◉	
Cardiology	○	◉	
Dermatology	○	◉	
Emergency Medicine	○	◉	
Endocrinology, Diabetes & Metabolism	○	◉	
Family Practice/General Practice	○	◉	
Geriatrics	○	◉	
Internal Medicine	◉	○	Non-resident house staff and hospitalists
Medical Genetics	○	◉	
Neurological Surgery	○	◉	
Neurology	○	◉	
Obstetrics & Gynecology	○	◉	
Oncology-Cancer	○	◉	
Ophthamology	○	◉	
Orthopedics	○	◉	
Otololaryngology	○	◉	
Pathology	○	◉	
Pediatrics	◉	○	Coverage of emergency department call
Physical Medicine & Rehabilitation	○	◉	
Plastic Surgery	○	◉	
Preventive Medicine	○	◉	
Psychiatry	○	◉	
Radiology	○	◉	
Surgery	○	◉	
Urology	○	◉	
Other. (Describe)	○	◉	

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

Internal Medicine - This is necessary for the provision of inpatient care since they perform a clinical function not met by community physicians. However, the amount the internal medicine specialists are reimbursed by insurers for their services falls short of providing these services. For this reason, the hospital must subsidize. Pediatrics - This is necessary for the provision of inpatient care since they perform a clinical function not met by community physicians. However, the amount the on- call emergency pediatrics specialists are reimbursed by insurers for their services falls short of providing these services. For this reason, the hospital must subsidize.

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

Q140. Section VI - Financial Assistance Policy (FAP)

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

MedStar Health Corporate Financial Assistance Policy_12.2020 Final.pdf
1.1MB
application/pdf

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

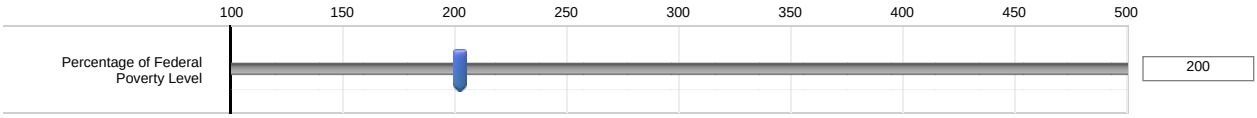
https://www.medstarhealth.org/mhs/patients-and-visitors/medstar-health-financial-assistance/

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

- ○ No, the FAP has not changed.
- ◉ Yes, the FAP has changed. Please describe: Yes, changes include removal of a patients' citizenship status to determine eligibility, further enhancements to and distribution of the Patient Information Sheet, defined timeframe for completed application determinations, further definition on who is included in calculating family income, an appeals process for denials that include the contact information for the Health Education and Advocacy Units, offer payment plans to uninsured patients between 201-500% of FPL, further exclusions in the evaluation of patient's financial resources, and additions of programs to be included in presumptive eligibility.

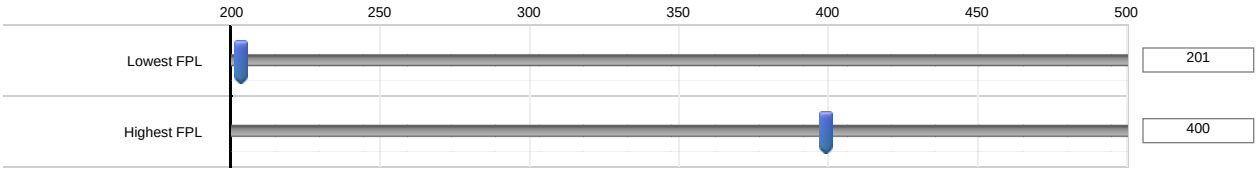
Q143. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



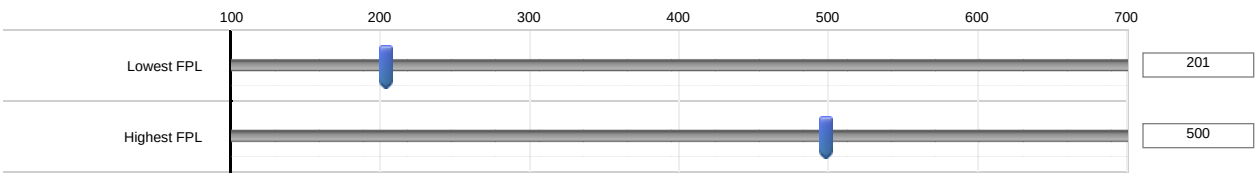
Q144. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

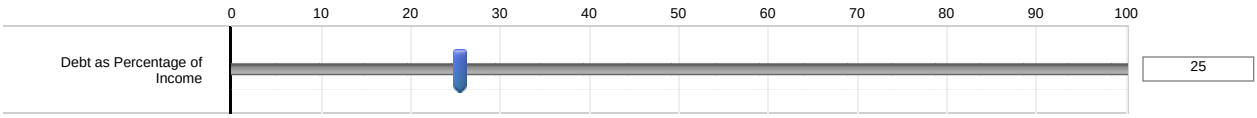


Q145. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

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



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



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

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

Q150. Summary & Report Submission

Q151.

Attention Hospital Staff! IMPORTANT!

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

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

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

Location Data

Location: (38.920806884766, -77.036003112793)

Source: GeoIP Estimation

2021 Community Health Needs Assessment

It's how we treat people.

MedStar Health

2021 Community Health Needs Assessment

Table of Contents

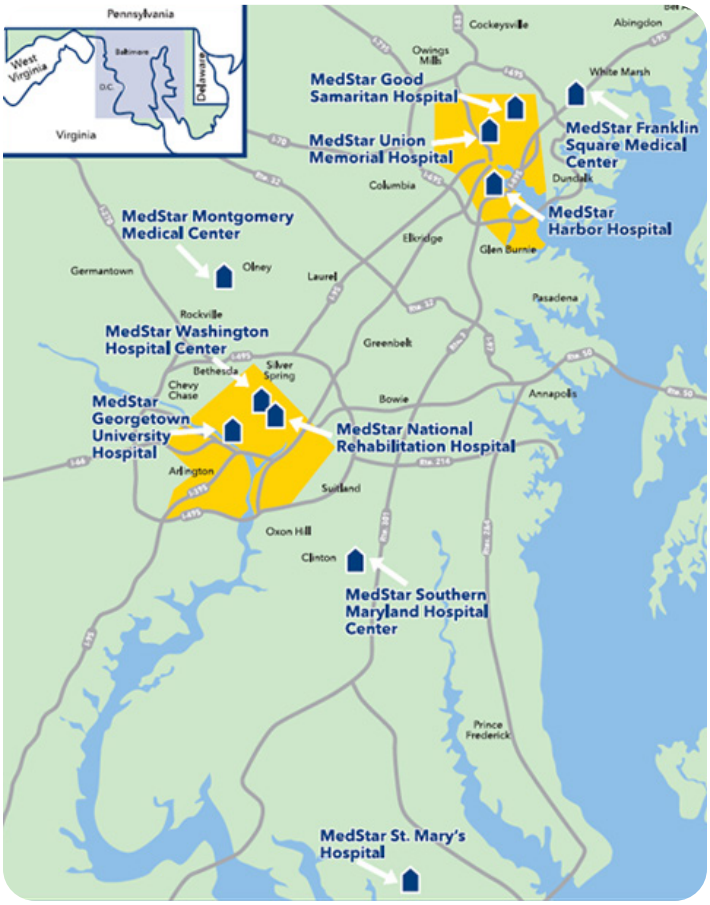
Executive summary

MedStar Health is a not-for-profit health system dedicated to caring for people in Maryland and the Washington, D.C., region, while advancing the practice of medicine through education, innovation, and research. Serving our communities is at the heart of what we do every day.

MedStar Health operates more than 120 entities. We serve patients across our 10 hospitals, ambulatory and urgent care locations, and through telehealth and home care services. Thanks to technological advancements, enhanced access options, and new approaches to the care experience, we continue evolving the many ways we serve our communities. We recognize that a person's health is shaped by the health of the community in which they live. As a healthcare leader in the region, we play a significant role in advancing health and partnering with others to facilitate community health improvement. Our efforts are primarily guided by the results of our Community Health Needs Assessment (CHNA), which we perform every three years.

The CHNA allows MedStar Health to better understand local health needs, informing our strategies and partnerships to benefit community health and advance our mission. It is an organized, formal, and systematic approach to identify and address the needs of underserved communities across our geographic footprint. The CHNA guides the development and implementation of a comprehensive plan to improve health outcomes for those disproportionately affected by disease. This CHNA also informs the creation of a strategy for future community health programming and community benefit resource allocation for fiscal years 2022–2024 across the 10 MedStar Health hospitals. As a not-for-profit organization, our CHNAs align with guidelines established by the Affordable Care Act and comply with Internal Revenue Service (IRS) requirements.

MedStar Health Location Map



Committed to our communities

Whether we see you at a MedStar Health facility or a program in your neighborhood, as a not-for-profit health system, we are committed to the health and wellness of the communities we serve. After all, many of our associates live in the same communities we serve.

MedStar Health mission and vision

Our vision: To be the trusted leader in caring for people and advancing health.
Our mission: To serve our patients, those who care for them, and our communities.

CHNA approach

Our CHNA is an organized, systematic approach, bringing hospital leaders together with individuals representing a diverse cross-section of the community to identify the needs.

Using both public health and healthcare utilization data, each hospital identifies communities or geographic areas of focus. The CHNA will serve as a roadmap for targeted health promotion strategies conducted in each Community Benefit Service Area (CBSA). The impact of the hospitals' efforts in their respective CBSAs will be tracked and evaluated over the three-year cycle. The CHNA process included the involvement of local residents, community partners, and stakeholders. Each hospital's CHNA was led by an Advisory Task Force (ATF) that included community activists, residents, faith-based leaders, hospital representatives, public health leaders, and other stakeholders. Task Force members used population-level data, community health needs survey findings, and feedback from community input sessions to create recommendations for each hospital's health priorities, potential implementation strategies, and to identify key partners.

Through a partnership with Georgetown University's Department of Health Systems Administration, community health data was compiled, synthesized, and analyzed. The assessment of health data along with the community feedback were used to inform Task Forces' recommendations regarding health priority identification and appropriate level of hospital engagement in the areas identified.

The final CHNA implementation strategies were endorsed by each hospital's Board of Directors and approved by MedStar Health's Board of Directors.

Priorities and implementation strategies

The CHNA process identified three overarching categories: health and wellness, access to care and services, and social determinants of health.

As part of the assessment process, hospital ATFs determined the level of engagement each hospital should take to address priority needs. The three different levels of engagement—leader, partner, and supporter—were based on factors such as hospital strengths and assets, community expertise, and current programming. Each hospital developed implementation strategies for the identified priorities.

Evaluation

Over the next three years, the hospitals will execute the implementation strategies. Plans will focus on the execution of programming for identified priority areas, systematic measurement and tracking of program effectiveness, as well as reporting progress and outcomes relative to internal measures, and local and national public health goals. Progress and impact of hospital's strategies will be assessed annually and shared with ATF members and each hospital's Board of Directors.

Health and wellness

- Chronic disease prevention and management
- Behavioral health: Substance use disorders and mental health
- Maternal and child health
- Aging and older adult health

Access to health care and services

- Access to affordable health care and insurance
- Fear/mistrust of providers
- Transportation

Social determinants of health

- Housing and homelessness
- Employment
- Food insecurity
- Neighborhood safety and community violence
- Racial discrimination

CHNA process

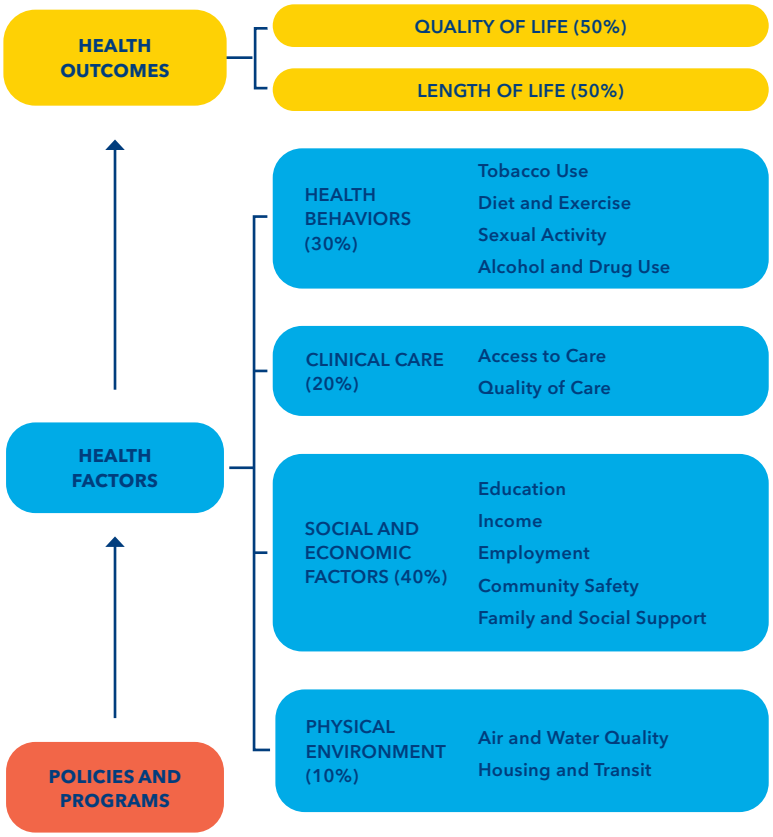
The Community Health Department oversees and coordinates the process and deliverables to improve health outcomes through the system's service areas. The department uses evidence-based methodologies to leverage internal and external stakeholder relationships and resources to target health-related disparities and address physical, social, and economic contributors to health. These efforts focus primarily on improving the health of underserved populations and addressing health disparities with the goal of achieving health equity.

Our Health Equity approach
Racial Justice and Health Equity serve as the foundation from which our community health team operates. These priorities serve as the guiding principle of our CHNA approach, including through the implementation of initiatives, partnerships, and methods of evaluation directed at tracking and addressing health disparities in our community.

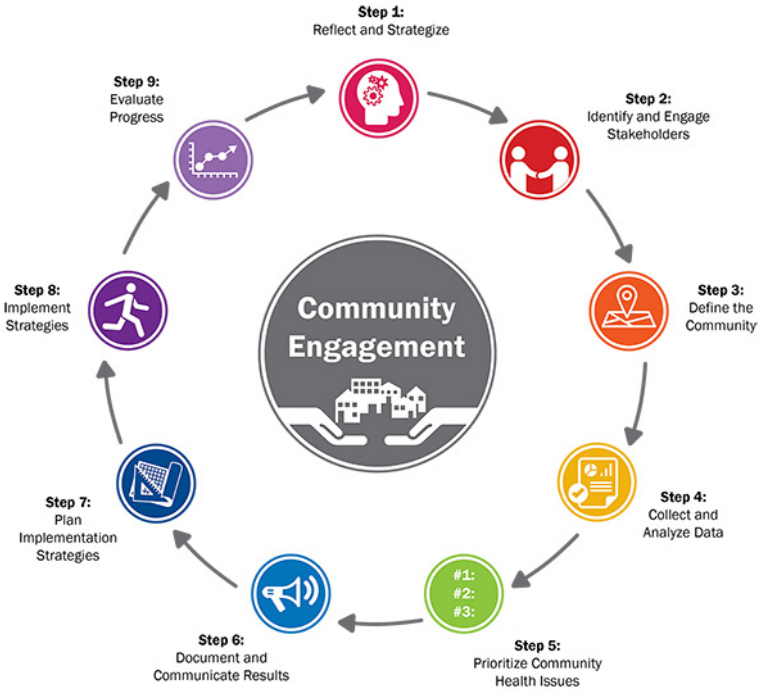
EQUALITY	The assumption is that everyone benefits from the same supports. This is equal treatment.
EQUITY	Everyone gets the individual supports they need. This is "affirmative action."
JUSTICE	Inequities are addressed so all systemic barriers are removed.

Guiding principles and framework

The guiding framework for the CHNA was adopted from the Robert Wood Johnson Foundation's County Health Rankings Model and incorporates best practice standards that have been published by nationally recognized leaders in the healthcare field. The model provides an understanding of what contributes to the health of communities, how assets and strengths should be identified and leveraged as part of community program development. The systemwide process leveraged hospitals and partners' existing strengths and expertise to complete the CHNA.



The Association for Community Health Improvement's model was reviewed as it offers a nine-step pathway for conducting a CHNA and developing implementation strategies. Making community engagement a central component of the assessment process is mutually beneficial to hospitals and communities.



healthycommunities.org/assesstoolkit

Community Benefit Service Areas (CBSAs)

Each hospital identified a community or target population of focus, called a Community Benefit Service Area (CBSA). These CBSAs were selected based on hospital patient utilization data, elevated disease incidence and prevalence; a high density of underserved or low-income residents and evidenced health disparities; proximity to the hospital; and existing presence of programs and partnerships.

The CHNA will serve as a roadmap for targeted health promotion strategies conducted in the CBSA. The impact of the hospitals' efforts in their respective CBSAs will be tracked and evaluated over the three-year cycle.

MedStar Health	CBSA ZIP Codes
MedStar Franklin Medical Center	21220, 21221
MedStar Georgetown University Hospital	20011, 20002, 20019
MedStar Good Samaritan Hospital	21239, 21206
MedStar Harbor Hospital	21225
MedStar Montgomery Medical Center	20906
MedStar National Rehabilitation Hospital	Residents with disabilities in the Greater D.C. area.
MedStar St. Mary's Hospital	20653
MedStar Southern Maryland Hospital Center	20748
MedStar Union Memorial Hospital	21213, 21218
MedStar Washington Hospital Center	20011, 20010, 20019

As previously noted, the CHNA involved a wide range of organizations, hospital leaders, community leaders, and community members. These included:

Community Health team at MedStar Health
Established the CHNA methodology for all hospitals; assisted in identifying strategic partners; provided expertise and technical support as needed; designed CHNA survey tools and reviewed findings; ensured that processes, deliverables, and deadlines complied with the IRS mandate.

Hospital Advisory Task Force
Reviewed secondary public health data; designed CHNA survey tool and reviewed findings; recommended the hospital's CBSA, health priorities, and associated strategies. Task Force members included hospital leaders, grassroots activists, community residents, faith-based leaders, hospital representatives, public health leaders, and other stakeholder organizations, such as local health department representatives.

Hospital leadership executive sponsors
Served as liaisons between ATFs and hospital executive leadership to ensure the hospital's selected priorities and implementation strategy plans aligned with the strengths of the organization, its population health management strategies, and clinical priorities.

CHNA survey respondents, Telephone Town Halls, and community input session participants
More than 4,770 people completed the CHNA survey, and nearly 4,000 participated in Telephone Town Halls and input sessions. Diverse groups of community stakeholders—including residents and organizations, civic and faith-based leaders, public health officials, and government agencies—and hospital leadership were engaged to garner information about the most pressing issues across the communities targeted.

Methodology

The data sources for the CHNA included quantitative secondary population-level data, hospital healthcare utilization data, a CHNA community survey, and qualitative community Telephone Town Halls/virtual input sessions. Data were used to broaden the types of information gathered and engage a diverse group of internal and external stakeholders to inform the CHNA process and deliverables.

The types of information gathered for each data source were as follows:

- **Secondary data**: To provide consistency and allow comparison with the previous CHNA, the 2021 CHNA builds upon the prior report and includes additional measures in the priority areas of disease prevalence, mortality and morbidity rates, health disparities, and associated social determinants.
- **Hospital utilization data**: Patient healthcare utilization and charity care data (a proxy for economic status) were used to identify each hospital's CBSAs and geographic areas of focus for needs assessment and strategy implementation.
- **CHNA community survey**: Questions about healthcare access, health equity, health condition concerns, and social determinants of health were asked in a community questionnaire distributed by the hospitals in their CBSAs.
- **Community input sessions**: Hospitals facilitated nine community discussions with diverse community stakeholders to identify the most critical community health issues. Guided discussion areas included topics related to community health and wellness, access to care and services, and social determinants of health.

4,700+
questionnaires were completed

4,000
participants attended town halls/ input sessions

Over **4,700** questionnaires were completed and **13** community input sessions and **2** Telephone Town Halls were conducted with nearly **4,000** participants to identify priority areas and develop targeted implementation strategies across each of the 10 hospitals' CBSAs.

To reach our diverse populations, the community survey was available online in **four languages**: English, Spanish, Korean, and Amharic. Paper surveys were also available in an additional **five languages**: French, Arabic, Swahili, Kinyarwanda, and Tigrinya.

Data collection for all four data sources was used to:

1. Prioritize identified needs.
2. Determine the appropriate hospital role in addressing the health issues prioritized for each hospital.
3. Establish system-, region-, and hospital-specific approaches and outcome measures.

This information was then used to develop each hospital's implementation strategies and evaluation plans to be executed over the next three years.

Prioritization process and criteria

Identification of priorities was first shaped by an understanding of the public health priorities, local community needs, existing partnerships and programming, and each hospital's strengths within the context of the system's priorities.

The ATFs participated in interactive online prioritization exercises that involved grouping and ranking identified needs, as well as discussions regarding initiatives and partnership opportunities.

Priorities and hospital role

MedStar Health hospitals are unable to address all of the health needs identified in the CHNA. Given this, each of the 10 hospitals determined appropriate roles to play in addressing their identified priorities.

Hospital role

Once the identified community health needs were prioritized, each hospital ATF team determined the appropriate hospital role to address the prioritized needs. The determination was primarily based on hospital and community strengths, assessment finding, and priorities selected. The following types of hospital roles were established:

LEADER ROLE (FOCUS AREA)	Areas that MedStar Health is well-positioned to take a leadership role in addressing.
PARTNER ROLE (COLLABORATION AREA)	Areas in which MedStar Health is best positioned to serve as a collaborator with other leading organizations.
SUPPORTER ROLE (PARTICIPATION AREA)	Areas that MedStar Health recognizes as significant contributors to health but are beyond the scope of its organizational strengths.

MedStar Health partnered with the Georgetown University Department of Health Systems Administration to capture, analyze, and synthesize data. The partnership was critical to ensuring the CHNA advances health equity and population health for individuals, families, and communities. The work was led by Dr. Christopher King, whose expertise is at the intersection of healthcare, public health, and racial equity.

Overview of regional and nationwide related statistics

This section outlines data collected on various health topics in the United States, Maryland, and Washington, D.C.

Health and wellness

Chronic disease prevention and management

Measure	United States	Maryland	District of Columbia
Age-adjusted death rate due to diseases of the heart (per 100,000)[1]	**165** (2016-2018)	**164** (2016-2018)	**195** (2016-2018)
Age-adjusted death rate due to stroke (deaths/100,000)[1]	**37** (2016-2018)	**40** (2016-2018)	**37** (2016-2018)
Age-adjusted death rate due to cancer (deaths/100,000)[2,3]	**149** (2018)	**155** (2015-2017)	**156** (2018)
Age-adjusted death rate due to diabetes (deaths/100,000)[5]	**21** (2018)	**20** (2018)	**20** (2016-2018)
% of adults who are obese[6,7]	**42** (2017-2018)	**31** (2016)	**25** (2018)

Addiction and substance use disorders

Measure	United States	Maryland	District of Columbia
% of adults reporting binge or heavy drinking[5]	**13** (2017)	**17** (2017)	**27** (2017)
% of adults who currently smoke[5]	**14** (2017)	**14** (2017)	**16** (2017)
% of adolescents who use tobacco products[3,8]	**8** (2018)	**14** (2016)	**11** (2017)
% of alcohol-impaired driving deaths[9]	**11** (2014-2018)	**29** (2014-2018)	**29** (2014-2018)
Opioid prescriptions dispensed (per 100 persons)[10]	**51** (2018)	**45** (2018)	**25** (2018)
Drug overdose deaths (per 100,000)[10,11]	**21** (2018)	**37** (2016-2018)	**40** (2016-2018)
# of opioid-related intoxication related deaths[11,12]	**46,802** (2018)	**2,143** (2018)	**191** (2018)
% of population impacted by opioid-related deaths*	**0.014** (2018)	**0.035** (2018)	**0.027** (2018)
# of heroin-related intoxication related deaths[11,12]	**14,996** (2018)	**830** (2018)	**79** (2018)
% of population impacted by heroin-related deaths*	**0.005** (2018)	**0.014** (2018)	**0.011** (2018)
# of fentanyl-related intoxication related deaths[11,12]	**28,400** (2018)	**1,888** (2018)	**162** (2018)
% of population impacted by fentanyl-related deaths*	**0.009** (2018)	**0.031** (2018)	**0.023** (2018)

*The number of opioid-, heroin-, and fentanyl-related deaths taken as a percentage of the total population.

Access to care

Cost of healthcare

Measure	United States	Maryland	District of Columbia
% of adults with health insurance[13,14,15,16]	**92** (2019)	**92** (2018)	**96** (2018)
% of children with health insurance[15,16]	**95** (2018)	**97** (2018)	**98** (2018)
% of adults who have had a routine checkup[5,13,17]	**71** (2017)	**90*** (2015)	**77** (2017)
% of adults unable to afford to see a doctor[5,13,17]	**13*** (2014)	**11*** (2015)	**10** (2017)

Social determinants of health (SDOH)

Housing

Measure	United States	Maryland	District of Columbia
% of owner-occupied housing[18,19]	**64** (2014-2018)	**66** (2013-2017)	**42** (2014-2018)
% of renters spending 50% or more on rent[15,20]	**25** (2018)	**14** (2014-2018)	**18** (2014-2018)

Education

Measure	United States	Maryland	District of Columbia
% of adults with a high school diploma or higher[15,21]	**90** (2019)	**91** (2019)	**91** (2014-2018)
% of adults with a bachelor's or more advanced degree[15,18,22]	**35** (2018)	**40** (2019)	**58** (2014-2018)

Economics and employment

Measure	United States	Maryland	District of Columbia
% of unemployed adults[23,24]	**4** (2019)	**4** (2019)	**6** (2019)
Median household income[14,15,25]	**$63,179** (2018)	**$83,100** (2018)	**$82,604** (2018)
% of persons living in poverty*[14,15,18]	**12** (2018)	**9** (2018)	**17** (2018)

*Poverty status calculated as an average within the past 12 months in 2018.
*Last updated 8/9/2020

Community engagement

This section includes a high-level overview of key findings from the CHNA survey. Issues that are unique to a specific hospital, community, or region are not presented in this system summary section, however, they will be noted in each hospital's report. It should be noted that questions are based on what respondents observe in their community, not their personal experiences.

MedStar Health is committed to conducting the CHNA with input from persons who represent the broad interests of the community, including those with special knowledge of or expertise in public health. We solicit and take into account input received from all members of the public, including:

- Leaders from the local public health department,
- Members of medically underserved, low-income, and minority populations in the community,
- Individuals or organizations serving or representing the interests of vulnerable populations.
- The CHNA development process is community driven, with multiple areas of outreach including:
  - Community surveys
  - Telephone Town Hall events
  - Community input sessions
  - Advisory task force participation

These outreach activities provide the community the opportunity to provide advice, insight, as well as solutions to the local community health needs.

COVID-19

In 2020 during the onset of COVID-19, lockdowns and social distancing guidelines drastically changed the way the community survey could be delivered. MedStar Health coordinated efforts with local public health departments in Baltimore and Washington, D.C. cities, and Baltimore, Montgomery, Prince George's, and St. Mary's counties in Maryland to develop and distribute a community survey.

Following social distancing guidelines, this CHNA included an array of engagement opportunities, including:

- email distribution
- touchless QR codes
- promotional fliers
- postcards
- paper and online surveys
- text messages with survey links
- virtual meetings and community input sessions
- MedStar Health marketing campaigns and website promotion

Working closely with each hospital's ATF, we partnered with community organizations to promote the CHNA. Many of them assisted us with outreach, including:

- Local churches
- YMCAs
- Food banks
- Local health departments
- Local community-based organizations

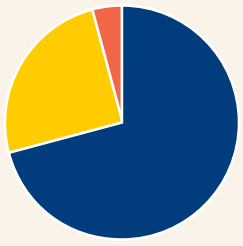
Through the collaborative efforts, we gathered input from underserved and at-risk populations and gained general perspectives about social and environmental issues and health and wellness. Due to the timing of the survey, we asked relevant questions about COVID-19 and social justice and its community impact.

More than **50,000 text messages** were sent to communities in Montgomery, Prince George's, and St. Mary's counties, and the District of Columbia.

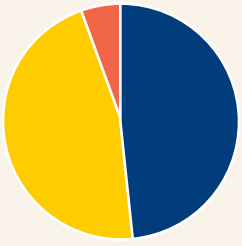
System-wide survey results

As part of the 2021 MedStar Health CHNA primary data collection process, 4,702 individuals age 18 and older completed the survey.

- 72% of respondents were between ages 30-64.
- 17% had annual household incomes less than $20,000.
- Nearly 45% did not have a college degree. 54% worked full-time and nearly 5% were not working due to COVID-related termination or furlough.
- 94% had health insurance; 16% were covered by Medicaid; 16% covered by Medicare.



71% of the total population identify as female, **25%** male. 4% did not self-identify.



Black people represented **45%** of the sample. Whites represented **43%**. **5%** of participants were Hispanic/Latino.

Health and wellness
The top five leading health problems that affect people in their communities are:
- Addiction/substance use disorders
- Diabetes
- High blood pressure
- Mental health
- Obesity/weight gain

Access to care
The top five reasons people do not get the healthcare they need at the right time include:
- Cost
- No insurance or limited coverage
- Had to wait too long for an appointment
- Finding a doctor who accepts my insurance
- No/limited transportation

Despite high insurance rates, the cost of healthcare continues to be a barrier. This is likely due to co-payments, medication costs, and other services that may not be covered, such as dental procedures and mental health services.

While the majority of respondents (84%) obtain health information from a doctor or health professional, some respondents cite a lack of provider diversity as a key driver of distrust or hesitancy.

Social determinants of health
The most important issues that affect quality of life include:
- Housing and homelessness
- Limited access to doctors
- Lack of job opportunities
- Safety and community violence

High costs of housing and limited access to grocery stores in some communities were documented as significant barriers to health.

Social justice
The leading social justice issues affecting respondents' communities include:
- Substance use disorders
- Racial inequality
- Limited access to quality care
- Poverty
- Homelessness

Among those who cited these issues, significant racial disparities were not observed. Community policing was referenced as a potential solution.

76% indicated "law enforcement is not responsive to the concerns of my community" and **10%** cited a **negative experience** with law enforcement.

COVID-19
All respondents expressed concern about someone in their household being infected with the virus. At the time of the survey, 42% of respondents knew someone who had been infected with COVID-19. Twenty-seven percent (27%) have sought financial assistance, 23% needed food assistance, and 15% needed energy/utility assistance. Among all racial groups, Black people reported higher incidences of need across all three categories. Respondents also expressed concern about the short- and long-term psychological effect of social isolation—particularly among seniors.

Delaying care due to either mixed messages from providers, fear of contracting the virus, or change in insurance status due to COVID-19 were commonly cited.

Limitations and key considerations

As findings are interpreted, there are noteworthy limitations and considerations. Males were underrepresented and only account for 29% of the sample. Asian American, Native Hawaiian/Pacific Islanders, and American Indian/Alaska natives were also underrepresented. Heterogeneity exists within racial groups; Black classifications may include Jamaican, Haitian, Ethiopian, Somalian, and others. Due to data collection limitations, these residents are captured as Black unless otherwise noted.

Five percent (5%) of the total number of respondents were Hispanic or Latino. Persons with annual household incomes greater than $100,000 represented the largest income category of the sample (29%).

As a result of the COVID-19 pandemic, many respondents were likely to endure temporally unique challenges associated with social isolation, unemployment, mixed messages from healthcare providers, and fear of contracting the virus.

Key community partners are listed in each hospital section, but this is not an exhaustive list of all of our partners.

Community input data review

This section includes a high-level overview of key findings from 13 community input sessions (n=191). Issues that are unique to a specific hospital, community, or region are not presented and can be found in individual hospital summaries.

Health and wellness

Barriers	Potential solutions
Healthy food priority areas/poor diet	Make healthy foods affordable and more accessible; establish nutrition programs using a peer support method.
Alcohol/substance use disorders and mental health: A key driver for poor health behaviors (e.g., depression, stress, trauma, abuse)	Explore ways to end the mental health stigma; increase access to mental health/wellness support services; develop strategic partnerships with faith-based organizations.

Access to care

Barriers	Potential solutions
Delaying or avoiding care due to mixed messages from providers and/or fear of COVID-19	Providers should work in partnership with public health officials to achieve consistency in messaging; conduct community-based virtual education sessions.
Cultural or linguistic insensitivity; fear; distrust	Employ racially and ethnically diverse lay extenders (e.g., community health workers, patient navigators) as key agents of healthcare delivery models; ensure materials are in plain language and linguistically appropriate; implement tactics to cultivate a diverse pipeline of providers who reflect the communities served.
Lack of transportation	Explore unconventional modalities (e.g., Uber Health, LYFT).
Long wait times for primary care and specialty appointments; limited provider hours; lack of access to dental, mental health, and medication services due to cost	Advocate for coverage expansion; expand provider hours of operation to include evenings and/or weekends; deliver care at the neighborhood level; explore mobile units; expand virtual visits. As virtual visits become more common, special accommodations are necessary for seniors and those without reliable internet connectivity.
Insurance plans not accepted by providers; difficulty navigating health care system	Explore partnerships with Federally Qualified Health Centers (FQHCs) and other safety-net providers; advocate for reimbursement parity (e.g., Medicaid vs. commercial); Simplify instructions; ensure information is linguistically appropriate; employ patient navigators.

Social determinants of health

Barriers	Potential solutions
Limited employment options; wages not keeping up with inflation	More jobs with livable wages are needed within proximity of low-income communities; expand access to alternative training/education programs that target those with a high school diploma; advocate for livable wage.
High costs of housing = instability	Incentives are needed to make housing more affordable.
Wages not keeping up with inflation	Advocate for livable wage compensation.
Healthy foods unaffordable or unattainable	Incentives are needed for grocery stores in low-income communities; expand frequency and geography of pop-up food markets.
Low literacy/health literacy	Advocate for health education in public schools; employ lay extenders (e.g., patient navigators); simplify health information.
Distrust of police	Normalize community policing; retrain officers; triage emergency response to the most appropriate professionals (social worker, mental health professional, etc.).
Racial inequities	Invest in marginalized communities of color; increase access to quality resources (e.g., schools, medical providers, fitness centers, jobs with livable wages, job training, and pipeline development programs, etc.).

Key themes from community engagement activities

Health and wellness
There is continued need for education, prevention, and management programs and services focused on chronic disease in the areas of alcohol and substance use disorders, mental health conditions, diabetes, heart disease, obesity, and cancer. Communities lack awareness of resources available and how to access existing wellness, prevention, and management services.

Access to care and services
Increased collaboration between MedStar Health and community-based health providers and organizations will assist with strategy execution and bring health education and prevention services directly into communities. Transportation services as well as access to behavioral health and social needs services were routinely identified as areas of priority.

Social determinants of health
Meeting community needs around social determinants is an essential component of delivering quality, comprehensive care for patients. MedStar Health's community partners will play a critical role in helping to address the social determinants of health.

Our new Telephone Town Halls were successful in Baltimore County—more than **2,300 households joined**. Almost 1,000 participants stayed on the call, and several dozen asked questions or participated in live polling. In the Baltimore City Hospital Collaborative Telephone Town Hall, nearly **4,100 community members joined the call**, over 2,800 stayed on the call, and nearly 100 asked questions.

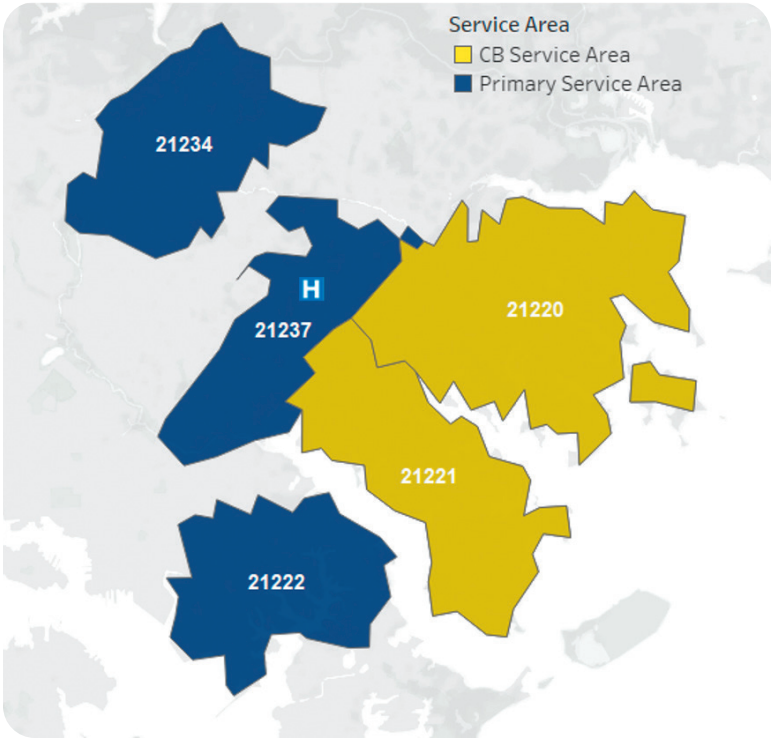
Community Health Needs Assessment

History
In 1969, MedStar Franklin Square Medical Center opened as a four-story, 305-bed hospital located in Rosedale in eastern Baltimore County. Today, it's the third largest hospital in Maryland. MedStar Franklin Square offers a diverse array of specialties and advanced technologies not traditionally found at community hospitals.
It is recognized for its expertise in medicine, surgery, oncology, cardiology, obstetrics and gynecology, behavioral health, and ambulatory services. With more than 3,500 employees, it is one of the largest employers in Baltimore County.

The community
MedStar Franklin Square has a long history of reaching out to its communities for feedback, collectively identifying local health care needs and building partnerships to meet those needs. Our Advisory Task Force Committee is comprised of community residents as well as representatives from the local health department, community college, federally qualified health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): Southeast Baltimore County, MD
MedStar Franklin Square's CBSA includes residents living in ZIP codes 21220 and 21221. This geographic area was selected as MedStar Franklin Square's CBSA based on hospital utilization data and secondary public health data, as well as the longstanding collaborative partnership with the Baltimore County Southeast Area Network (Southeast Network) for its community benefit efforts.

MedStar Franklin Square Medical Center



Identified health needs:

Health and wellness
Turn to page 16 for goals and initiatives

- Chronic disease prevention and management
- Behavioral health: Substance use disorders and mental health
- Maternal and child health

Access to health care and services
Turn to page 19 for goals and initiatives

- Transportation
- Access to affordable health care and insurance

Social determinants of health
Turn to page 20 for goals and initiatives

- Housing and homelessness
- Employment
- Racial discrimination

Demographics

ZIP Code 21220

39,199 Total population[41]

37 Median population by age[41]

36 Male median age[41]

38 Female median age[41]

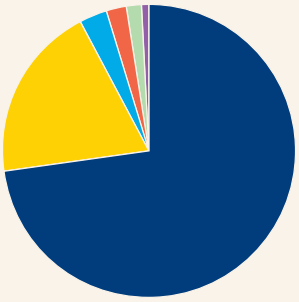
52% Female[41]

48% Male[41]

Educational attainment (those 25+ years)[41]

<High school diploma	**16%**
High school graduate	**62%**
Associate's degree	**7%**
Bachelor's degree	**9%**
Master's degree	**4%**
Professional degree	**<1%**
Doctorate degree	**<1%**

Race[41]



- WHITE (73%)
- BLACK (19%)
- AM. INDIAN OR ALASKAN NATIVE (1%)
- ASIAN (2%)
- NATIVE HAWAIIAN/ PAC. ISLANDER (0%)
- OTHER RACES (2%)
- TWO OR MORE RACES (3%)

Average household income in 2018: $57,381[41]

ZIP Code 21221

42,154 Total population[42]

38 Median population by age[42]

37 Male median age[42]

39 Female median age[42]

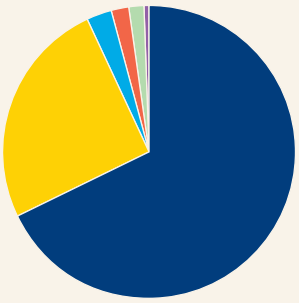
52% Female[42]

48% Male[42]

Educational attainment (those 25+ years)[42]

<High school diploma	**16%**
High school graduate	**65%**
Associate's degree	**6%**
Bachelor's degree	**9%**
Master's degree	**3%**
Professional degree	**<1%**
Doctorate degree	**<1%**

Race[42]



- WHITE (68%)
- BLACK (25%)
- AM. INDIAN OR ALASKAN NATIVE (<1%)
- ASIAN (2%)
- NATIVE HAWAIIAN/ PAC. ISLANDER (0%)
- OTHER RACES (2%)
- TWO OR MORE RACES (3%)

Average household income in 2018: $50,533[42]

Health and wellness

Chronic disease prevention and management

Baltimore County's heart disease and stroke death rates are worse than the state and nationwide averages, and more than 30% of adults in Baltimore County are obese. Prevention is important because it helps encourage healthier lifestyles which, in turn, can reduce obesity and risk factors for heart disease and stroke. MedStar Franklin Square prioritized keeping people healthy and empowering communities to choose healthy behaviors. This priority is consistent with Maryland Total Cost of Care priorities (diabetes), the Maryland State Health Improvement Plan (healthy communities, healthy living, quality preventative care), and the Baltimore County Health Improvement Plan (disease/chronic conditions).

Goals

- Improve health and quality of life for those living with diabetes and heart disease while seeking to prevent such chronic conditions through obesity and diabetes prevention.
- Improve screening rates for diabetes, HbA1c, cancer, BMI, and controlled blood pressure.
- Promote obesity reduction through nutrition and fitness programs.

Initiatives

- Host and offer chronic disease and diabetes education programs.
- Host and provide access to wellness services, nutrition education, and fitness programs.
- Partner with Sodexo, MD Food Bank, and Meals on Wheels to support access to and use of fresh, healthy foods with local farmers, food distribution, and food preparation demonstrations.
- Improve awareness of prediabetes and gestational diabetes and provide appropriate interventions.

Heart disease and stroke

- Baltimore County has a heart disease death rate of 179 per 100,000 people, compared to 164 per 100,000 people in Maryland and 165 per 100,000 nationwide.
  - This is an improvement from 2018 in which Baltimore County had a heart disease death rate of 256 per 100,000 people.[1]
- On the contrary, the statewide heart disease death rate has increased since 2018, from 129 per 100,000 to 164 per 100,000 in 2021.[1]
- Baltimore County has a stroke death rate of 45 per 100,000 people, compared to 40 per 100,000 people in Maryland, and 37 per 100,000 nationwide.[1]

Diabetes and obesity

- 31% of adults in Baltimore County are obese, compared to 42% of adults nationwide.[6,7]

At 18 diabetes-related deaths per 100,000 people, Baltimore County has **slightly fewer diabetes deaths on average** than Maryland (20 per 100,000) and the nation (21 per 100,000).[1]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

- Number of participants
- Number of events
- Number of screenings
- Number of participants, weight loss, physical activity increase, and BMI change

Key partners

- American Diabetes Association
- Baltimore County Department of Health
- Community Assistance Network
- Eastern Interfaith Outreach
- Family Crisis Center
- Hungry Harvest
- Maryland Department of Health
- Maryland Food Bank
- Meals on Wheels of Central Maryland
- Sodexo
- Southeast Network
- United Way
- Y of Central Maryland

Maternal and child health

The health of mothers and children is integral to the health of our communities. At MedStar Health, we're dedicated to supporting initiatives that promote healthy moms and babies, reduce inequalities, improve outcomes, and promote healthy moms and babies. These priorities are consistent with Maryland Total Cost of Care priorities (maternal and child health) and the Maryland State Health Improvement Plan (healthy beginnings).

Goals

- Promote positive birth outcomes, reduce low birth weight, and increase breastfeeding practices for mothers and their families in Baltimore County.
- Improve access to prenatal care services including screening, health promotion, and interventions that enable women with quality maternal and infant health services and support.
- Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women.

Initiatives

- Support new mothers with education, lactation assistance, and support groups.
- Provide maternal and child health education and link to social service resources.
- Support and promote county resources for immunization, Well Child clinics, and Infant and Toddlers programs.

- Southeast Baltimore County has an infant mortality rate of 6 per 1,000 live births, which is equal to the state and nationwide rates.[7]
- Southeast Baltimore County has 14 teen births per 1,000 females ages 15-19.
  - This is below the statewide rate of 17 per 1,000 and almost equal to the nationwide rate of 13 per 1,000.[7]
- 27% of survey respondents indicated that a lack of affordable childcare is one of the most important issues affecting quality of life in their community.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

- Number of participants in maternal health programs
- Number of maternal education events

Key partners

- Abilities Network
- Baltimore County Department of Health
- Baltimore County Public Library
- Baltimore County Women, Infants and Children (WIC) program
- Harford County Department of Health
- Harford County Women, Infants and Children (WIC) program
- Healthy Babies Collaborative

100% of survey respondents said that members of their household becoming infected was their **biggest worry** related to COVID-19. **74%** said emotional health was their biggest concern, and **65%** of respondents said they worry for the health of their community as the pandemic continues.*

*Surveys were conducted August-September 2020.

Behavioral health and substance use disorders

Substance use and behavioral health disorders affect communities throughout Baltimore County. MedStar Franklin Square prioritized initiatives to respond to these issues—especially addressing opioid use—with the goal of improving access to services. This priority is consistent with Maryland Total Cost of Care priorities (opioids), the Maryland State Health Improvement Plan (quality preventative care), and the Baltimore County Health Improvement Plan (behavioral health).

Goals

- Reduce stigma about prevention and treatment of behavioral health disorders and addiction-related conditions among priority populations; improve access and referrals to services.
- Improve early identification, access, and referrals of mental health and addiction services.
- Promote engagement in care for those with mental health and substance use disorders.

Initiatives

- Conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT) in ER, women's services, and ambulatory sites supported by Peer Recovery Coaches.
- Provide virtual and in-person smoking cessation programming.
- Provide trauma-informed care delivery training for frontline ER clinicians.
- Provide mental health training for community service providers.
- Provide behavioral health community education, screenings, and support groups; sponsor events or walks for behavioral health.
- Engage as a member of Greater Baltimore Regional Integrated Crisis (GBRICS) to expand mental heath and crisis services.

Addiction/substance use disorders

- 46% of MedStar Franklin Square CHNA survey respondents indicated that addiction and substance use disorders affect quality of life in their community.
- Addiction and substance use were ranked the top priority for MedStar Franklin Square CHNA survey respondents with a household income of $20,000 to $34,999; it was ranked the #2 priority for respondents with a household income less than $20,000.
- Baltimore County had 50 drug overdose deaths per 100,000 people, compared to 37 in Maryland and 21 nationwide.[10,11]

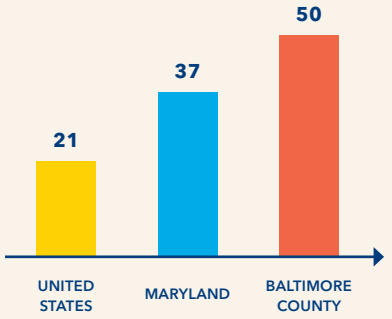
Alcohol

- 17% of adults in Baltimore County report binge drinking, compared to 13% nationwide.[5]
- 26% of driving deaths in Baltimore County between 2014 and 2018 were related to alcohol impairment, compared to 11% nationwide.[5]

Opioids

Baltimore County dispenses 53 opioid prescriptions per 100 people, compared to 45 prescriptions dispensed per 100 people in Maryland, and 51 per 100 nationwide.[10]

Baltimore County has a drug overdose death rate of 50 per 100,000 people, compared to 37 per 100,000 people in Maryland, and 21 per 100,000 nationwide.[10,11]



Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Substance use disorders and mental health

- Number of SBIRT screenings, referrals, and linkages to treatment
- Number of referrals and linkages to treatment and support services
- Number of participants enrolled in smoking cessation programming
- Number of trainings offered

Key partners

- Baltimore County REACH program
- Behavioral Health Systems of Baltimore
- Dundalk Medication Assisted Treatment Clinic
- Helping Up Mission
- Ideal Option Treatment Center
- Maryland Quit Now
- MedMark Treatment Center
- Mental Health Association of Maryland
- Mosaic Group
- NAMI Metro Baltimore–National Alliance for Mental Illness

Access to health care and services

Access to quality care and services is a key issue in Baltimore County. It is important for promoting and maintaining health, preventing and managing disease, and achieving health equity for all. For this reason, MedStar Franklin Square prioritized initiatives such as expanding health care access and providing financial assistance. These priorities are consistent with the Maryland State Health Improvement Plan (access to health care) and the Baltimore County Health Improvement Plan (access to health care).

Goals

- Improve and expand community access to comprehensive, quality health care providers and programs, as well as medical and non-medical services.
- Support innovative medical care delivery methods designed to lower the cost of health care.
- Eliminate barriers to access health care, including transportation and financial resources, and expand community access to medical and non-medical services.

Initiatives

- Navigate patients to insurance access through Patient Financial Advocates and Community Health Workers.
- Provide screenings, referrals, and linkage to community resources and health insurance through hospital-based Community Health Workers, Navigators, and Peer Recovery Coaches.
- Expand access to primary care and behavioral health services for the uninsured and underinsured through residency safety net clinics.
- Expand services through virtual care.
- Provide support to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs.

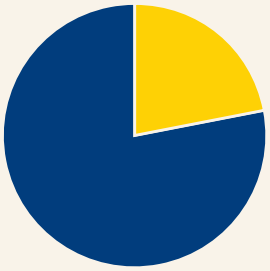
Access to health care and services

- 93% of adults in Baltimore County have health insurance, slightly above the statewide average of 92%.[15,16]
- 57% of MedStar Franklin Square CHNA survey respondents said their health insurance is provided through their employer.
- 97% of children in Baltimore County have health insurance, equal to the statewide proportion of children with health insurance.[15,16]

Baltimore County has a **330:1 population to mental health provider ratio.** This is below Maryland's average of 390:1.[12]

Economics, housing, and food insecurity

- 4% of adults in Baltimore County are unemployed.
  - This is consistent with the state and nationwide adult unemployment rates.[23,24]
- The median household income in Baltimore County is $75,800, lower than the statewide median household income of $83,100.[14,25]
- 10% of people in Baltimore County live in poverty, compared to 12% nationwide.[14,18]

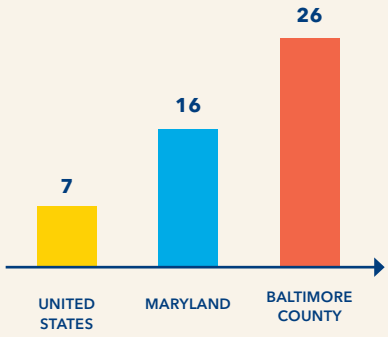


78% of MedStar Franklin Square CHNA survey respondents indicated the **cost of health care** is the most common reason why people in their community **do not get care when they need it.**

- Though Baltimore County has a higher proportion of people living in poverty and households with children experiencing food insecurity, the proportion of households with children receiving public assistance or SNAP benefits, which is 12%, is much lower than the proportion of households nationwide receiving these benefits, which is 31%.[15]
- 11% of households in Baltimore County experience food insecurity.
  - This is equal to the state and nationwide proportions of households experiencing food insecurity.[26,27]

Economics, housing, and food insecurity continued...

26% of households with children in Baltimore County experience food insecurity. This is much higher than the national average of 7% of households with children that experience food insecurity, and 16% of Maryland households.[26,27]



Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented and relevance to external public health goals.

Access to healthcare professionals
- Number of residents and fellows enrolled in Graduate Medical Education programs
- Number of participants in healthcare navigation programs

Access to affordable health care and insurance
- Number of clients and encounters
- Number of linkages to insurance and social resources
- Number of events
- Number of social needs screenings

Key partners

- Baltimore County Department of Health Bureau of Community Health Services
- Aunt Bertha
- Baltimore County Department of Social Services
- Community Assistance Network
- United Way of Central Maryland
- HealthCare Access Maryland
- Uber Health

Social determinants of health

To make Baltimore County more accessible for all, MedStar Franklin Square has developed a series of initiatives to address needs such as housing, employment, anti-discrimination, and transportation. For this reason, MedStar Franklin Square prioritized initiatives such as expanding health care access and providing financial assistance. These priorities are consistent with the Maryland State Health Improvement Plan (healthy communities) and the Baltimore County Health Improvement Plan (impact of social determinants of health).

Goals

- Promote health equity that aims to address social determinants of health, improve health outcomes, and reduce disparities.
- Address the barrier of transportation to medical and health services among individuals who identify transportation as an unmet social need.
- Support a robust transportation system.
- Promote work pipeline opportunities with community, schools, and business partners.
- Support workforce development programs.
- Recognize housing instability and homelessness as a public health issue.
- Support eligible homeless individuals and families in receiving health and social services.
- Advocate to improve Baltimore County and State of Maryland response to individuals and families experiencing homelessness.

Initiatives

- Screen patients for transportation needs; partner with Uber Health, taxi companies, rideshare companies, and local transit agencies to provide transportation.
- Develop pipeline of job opportunities through intern and practicum experiences in the field of medicine for high school and college-level students.
- Execute system-wide Equity, Inclusion, and Diversity strategy which focuses on recruitment, retention, and culture change to address the spectrum of discrimination.
- Partner with Baltimore JOBS to employ Community Health Workers and Peer Recovery Coaches.
- Employ diverse workforce for the next generation of clinicians.
- Support basic home maintenance education for renters and homeowners; promote Safer at Home senior programs.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Access to transportation
- Number of transportation rides facilitated

Employment
- Number of events
- Number of participants

Racial discrimination
- Number of participants trained in cultural competency and implicit bias

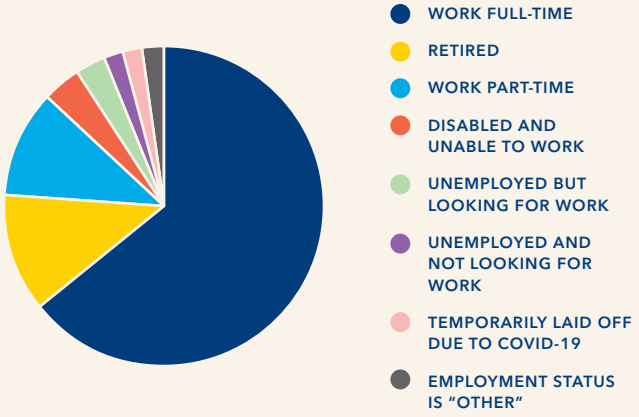
Housing
- Number of enrollees in housing services

Education
- 91% of adults in Baltimore County have a high school diploma or more.[15,21]
- 39% of adults in Baltimore County have a bachelor's or more advanced degree.[22,23]

Social justice
- 52% of MedStar Franklin Square CHNA survey respondents indicated that addiction is one of the issues that affects their community most.
- 38% of respondents indicated that racial inequality is one of the issues that affects their community most.

Baltimore County has **greater residential segregation** between Black and white county residents than the United States overall. **The racial segregation index in Baltimore County is 58**, while the nationwide index is **53**. Higher values indicate greater segregation between Black and white county residents.[15]

Jobs statuses of MedStar Franklin Square CHNA survey respondents



Key partners

- Baltimore Alliance for Careers in HealthCare
- Baltimore County Communities for the Homeless
- CASH Campaign of Maryland
- Community College of Baltimore County
- Stevenson University
- Towson University
- University of Maryland

4,700+
questionnaires were completed systemwide

715
came from MedStar Franklin Square

The 23-question survey was conducted from late August to the end of October 2020.

Survey was distributed in person and online.

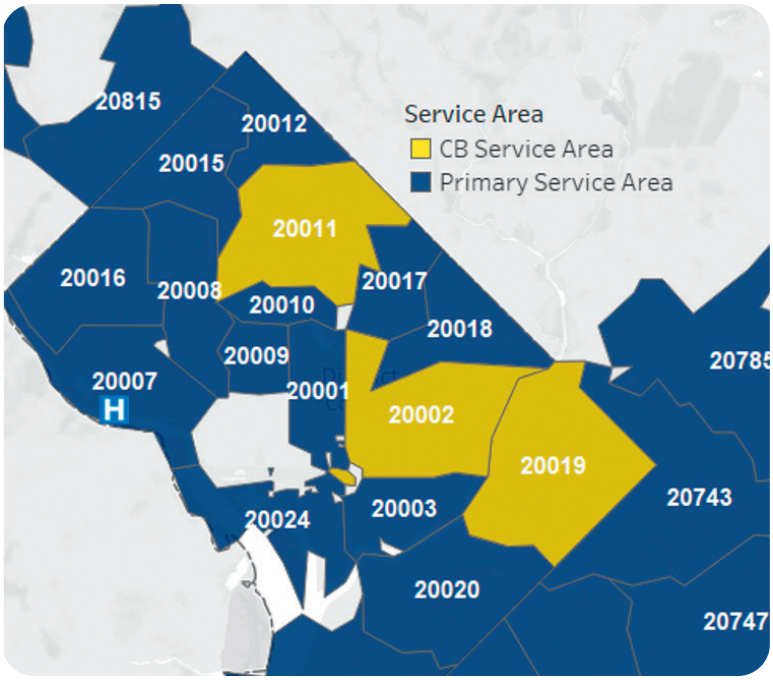
Community Health Needs Assessment

MedStar Georgetown University Hospital

History
MedStar Georgetown University Hospital is an acute care teaching and research hospital with 609 beds located in Northwest Washington, D.C. Founded in the Jesuit principle of *cura personalis*—caring for the whole person—MedStar Georgetown centers of excellence include neurosciences, transplants, cancer, and gastroenterology.

The community
MedStar Georgetown has a long history of reaching out to its communities for feedback, collectively identifying local health care needs and building partnerships to meet those needs. Our Advisory Task Force Committee (ATF) is comprised of community residents as well as representatives from the local health department, university, federally qualified health centers, social service programs, faith-based and community-based organizations.

Community Benefit Service Area (CBSA): Washington, D.C.
The MedStar Georgetown CBSA includes residents living in ZIP codes 20011, 20002, and 20019. We also support citywide efforts to improve services in 20020 and 20032 (east of the river). This geographic area was selected as the MedStar Georgetown CBSA based on hospital utilization data and secondary public health data, with the goal of expanding services and programs.



Identified health needs:

Health and Wellness
Turn to page 24 for goals and initiatives

- Chronic disease prevention and management
- Behavioral health: Substance use disorders and mental health

Access to health care and services
Turn to page 27 for goals and initiatives

- Access to providers, affordable health care, and insurance
- Transportation

Social determinants of health
Turn to page 28 for goals and initiatives

- Employment
- Housing and homelessness
- Racial discrimination

Demographics

ZIP Code 20011

58,536 Total population[43]

39 Median population by age[43]

37 Male median age[43]

40 Female median age[43]

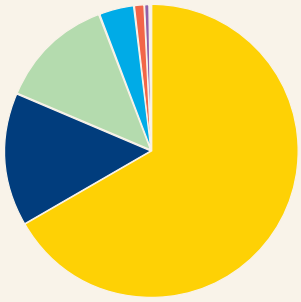
53% Female[43]

47% Male[43]

Educational attainment (those 25+ years)[43]

<High school diploma	**16%**
High school graduate	**46%**
Associate's degree	**4%**
Bachelor's degree	**18%**
Master's degree	**11%**
Professional degree	**4%**
Doctorate degree	**2%**

Race[43]



Average household income in 2018: $67,645[43]

ZIP Code 20002

52,370 Total population[44]

35 Median population by age[44]

35 Male median age[44]

35 Female median age[44]

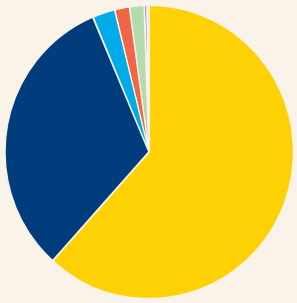
52% Female[44]

48% Male[44]

Educational attainment (those 25+ years)[44]

<High school diploma	**14%**
High school graduate	**35%**
Associate's degree	**3%**
Bachelor's degree	**24%**
Master's degree	**16%**
Professional degree	**5%**
Doctorate degree	**3%**

Race[44]



Average household income in 2018: $89,289[44]

ZIP Code
20019

54,358 Total population[45]

35 Median population by age[45]

32 Male median age[45]

38 Female median age[45]

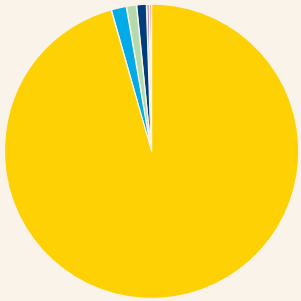
56% Female[45]

44% Male[45]

Educational attainment (those 25+ years)[45]

<High school diploma	**19%**
High school graduate	**63%**
Associate's degree	**4%**
Bachelor's degree	**8%**
Master's degree	**5%**
Professional degree	**<1%**
Doctorate degree	**<1%**

Race[45]



Average household income in 2018: $40,554[45]

Health and wellness

Chronic disease prevention and management

Because heart disease and cancer death rates are higher in Washington, D.C. than state and nationwide rates, MedStar Georgetown prioritized initiatives that improve quality of life for those with chronic diseases and encourage prevention, detection, and accessible treatment. This priority is consistent with Community Health Improvement Process objectives (health literacy) and D.C. Healthy People objectives (quality preventative care, healthy living).

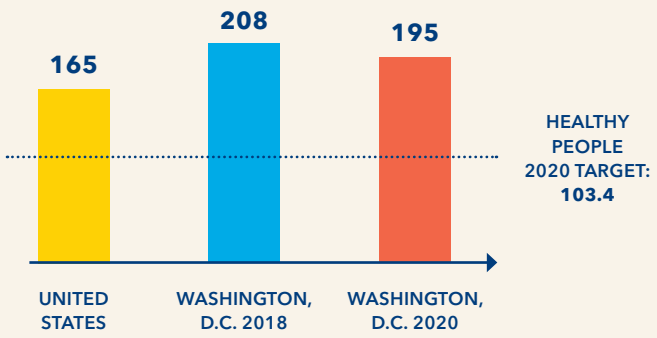
Goals

- Reduce overall risk of chronic diseases; provide appropriate care by facilitating prevention strategies, affordable care, and educational engagement tools.
- Improve health and quality of life through prevention, detection, and treatment of risk factors for chronic diseases.
- Improve diabetes care and prevention through clinical and education programs.
- Improve health and quality of life through prevention, detection, and treatment of risk factors for cancer.
- Improve screening rates for cervical, colorectal, and breast cancer.

Initiatives

- Promote and provide chronic disease prevention education, wellness activities, and support groups.
- Launch Produce Rx program to provide nutrition education, lifestyle changes classes, and access to fresh, healthy foods.
- Provide free breast, cervical, and colon cancer screening programs through community partnership.

Heart disease and stroke



Washington, D.C. has a heart disease death rate of **195 per 100,000 people**. This is an improvement from 2018, which had a death rate of 208 per 100,000 people. However, this is worse than the nationwide rate of 165 per 100,000 people.[1]

Cancer

- Washington, D.C. has a cancer death rate of 156 per 100,000 people, compared to 149 per 100,000 nationwide.[2,3,4]

Diabetes and obesity

- 25% of adults in Washington, D.C. are obese, compared to 42% of adults nationwide.[6,7]
- Washington, D.C. is almost equal to the state and national average for diabetes deaths, at 20 per 100,000 people.[5]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Cancer

- Number of chronic disease management screenings
- Number of prediabetes screenings
- Number of participants
- Number of programs
- Number of participants at educational and wellness events

Key partners

- Bridging the Gap
- Capital Area Food Bank
- D.C. Department of Health
- D.C. Greens
- D.C. Primary Care Association
- Health Alliance Network
- MedStar Diabetes Institute
- MedStar Washington Hospital Center
- Ronald McDonald Charities of Greater Washington, D.C.

46% of survey respondents in ZIP codes 20011, 20002, and 20019 reported knowing someone outside of their family who **had been diagnosed with COVID-19**.*

*Surveys were conducted August-September 2020.

Behavioral health and substance use disorders

Community members in Washington, D.C. have expressed a need for improved mental health care and additional resources to combat substance use. For these reasons, MedStar Georgetown prioritized initiatives that seek to improve behavioral health access, support services, treatment, and education for mental health and substance use. These priorities are consistent with Community Health Improvement Process objectives (mental health).

Goals

- Reduce stigma about prevention and treatment of behavioral health disorders and addiction-related conditions among priority populations.
- Improve early identification and referrals of mental health and addiction services.
- Promote engagement in care for those with mental health and substance use disorders.

Initiatives

- Conduct Screening, Brief Intervention and Referral to Treatment (SBIRT) and Overdose Survivors Outreach Program in ER supported by Peer Recovery Coaches.
- Continue participation in Access Helpline: D.C. area 24/7 phone line and mobile crisis team.
- Engage in School Mental Health WISE Center support at 32 D.C. public schools.

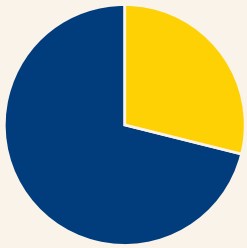
Addiction/substance use disorders

- 32% of MedStar Georgetown CHNA survey respondents indicated that addiction and substance use disorders affect people in their community, compared to 57% of respondents overall.
- 16% of adults in Washington, D.C. smoke, compared to 14% nationwide.[5]
- 11% of adolescents in Washington, D.C. use tobacco products, compared to 8% nationwide.[3,8]

Alcohol

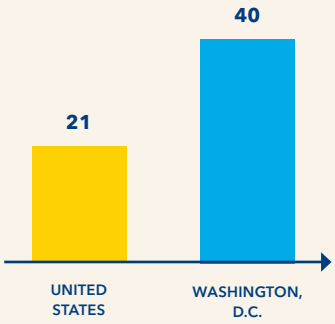
- 27% of adults in Washington, D.C. report binge drinking, compared to 13% nationwide.[5]

29% of driving deaths in Washington, D.C. between 2014 and 2018 were **related to alcohol impairment**, compared to 11% nationwide.[9]



Opioids

Washington, D.C. has **40 drug overdose deaths per 100,000 people** compared to 21 per 100,000 people nationwide.[10,11]



- Washington, D.C. dispenses 25 opioid prescriptions per 100 people, compared to 51 per 100 people nationwide.[11]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Substance use disorders and mental health

- Number of SBIRT screenings, referrals, and linkages to treatment
- Number of referrals and linkages to treatment and support services
- Number of trainings offered
- Number of participants

Key partners

- Children's Law Center
- Children's National Health System
- D.C. Collaborative for Mental Health in Pediatric Primary Care
- D.C. Department of Behavioral Health
- D.C. Hospital Association
- D.C. Public Schools
- Early Childhood Innovation Network
- McClendon Center
- Mosaic Group
- Parent Watch
- SE Family Strengthening
- Spaces in Action
- Total Family Care Coalition
- WISE Center

Access to health care and services

Paired with the proportion of people living in poverty, the high cost of living in Washington, D.C. has led to inequalities in access to care and services. For this reason, MedStar Georgetown prioritized initiatives that improve access, reduce costs, and provide education. These priorities are consistent with D.C. Healthy People objectives (access to health services, healthy communities).

Goals

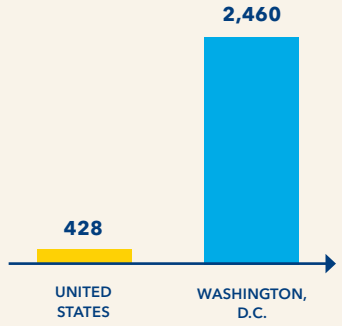
- Improve access to comprehensive, quality health care providers and programs, as well as medical and non-medical services.
- Support innovative medical care delivery methods designed to lower health care costs.
- Eliminate barriers to accessing health care, including transportation and financial resources, and expand community access to medical and non-medical services.
- Address the barrier of transportation to medical and health services among individuals who identify transportation as an unmet social need.

Initiatives

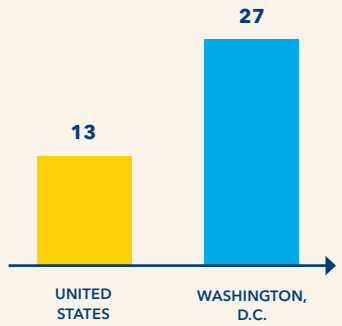
- Host and offer Training Physicians in the Community, which provides healthcare providers with strategic safety net community partners offering healthcare services.
- Engage Family Medicine Residency with Unity Health Care at East of the River Health Center for clinical experiences partnerships.
- Host and offer D.C. Safe Babies, Safe Moms education and health services program.
- Provide healthcare and education through mobile vehicle based clinics and Kids Mobile Medical Clinic/Ronald McDonald Mobile and FITNESS mobile program with D.C. public schools.
- Expand services through virtual care.
- Provide homecare services to support homebound patients through MGUH HomeCare Nurse Practitioner Program.
- Provide support to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs.
- Conduct social needs screenings, referrals, and linkages to community resources through hospital-based non-medical resources, MedStar Social Needs Tool, D.C. Find Help online resources, and the Health Justice Alliance program.
- Address the barrier to transportation to medical and health services.

Access to health care and services

- Washington, D.C. has a 210:1 ratio of population to mental health providers, compared to the nationwide ratio of 290:1.[12]
- 96% of adults in Washington, D.C. have health insurance, compared to 92% nationwide.[13,14,15,16]
- 10% of adults in Washington, D.C. cannot afford to see a doctor, compared to 13% nationwide.[5,13,17]
- 50% of respondents said their health insurance is provided through their employer.
- 26% of respondents indicated that limited availability or access to doctors is one of the most important issues affecting quality of life in their community. Limited availability or access to health insurance was the next most selected issue.



Washington, D.C. has an **HIV prevalence of 2,460 per 100,000 people**, compared to 428 per 100,000 nationwide.[28,29]



Washington, D.C. has **27 teen births per 1,000 females ages 15-19**. This is higher than the nationwide rate of 13 per 1,000 females.[7]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Access to healthcare professionals
- Number of residents and fellows enrolled in Graduate Medical Education
- Number of participants
- Number of mobile programs

Access to affordable health care and insurance
- Number of uninsured linked to a financial navigator
- Number of participants in residency safety net clinics

Access to transportation
- Number of transportation rides facilitated

Key partners

- Catholic Charities
- Children and Family Services Administration
- Community of Hope
- Breathe D.C.
- D.C. Safe Babies, Safe Moms
- East of River Health Center
- FITNESS mobile program
- Fort Lincoln Medicine Center
- Kids Mobile Medical Clinic/Ronald McDonald Mobile
- Mamatoto Village
- MedStar Georgetown University Hospital HomeCare NP Program
- Unity Clinic
- Uber Health
- Unity Health Care

Social determinants of health

Addressing social determinants of health is important for improving health and reducing health disparities. For this reason, MedStar Georgetown supports initiatives for affordable and safe housing, provide health services to residents of local homeless shelters, provide discrimination education, and more. These priorities are consistent with Community Health Improvement Process objectives (care coordination) and D.C. Healthy People objectives (healthy communities).

Goals

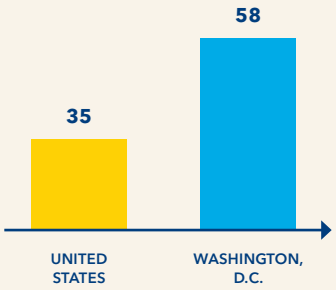
- Recognize housing instability and homelessness as a public health issue.
- Support eligible homeless individuals and families receiving health and social services.
- Advocate for improving city response to individuals and families experiencing homelessness.
- Promote health equity that addresses social determinants of health, improves health outcomes, and reduces disparities.
- Improve cultural competency and racial disparities education/trainings to health professionals.
- Improve primary care workforce distribution in underserved areas and increase diversity in health care professions.

Initiatives

- Provide health services for residents of the Triumph Shelter through the HOYA Clinic.
- Provide health services, assessments, footwear, and care packages for residents of the Harriet Tubman Homeless Shelter.
- Provide cultural competency and implicit bias trainings.
- Host and expand the Ask a Healthcare Provider series in the community.
- Improve data collection and evaluation addressing disparity gaps.

Education

- 91% of adults in Washington, D.C. have a high school diploma or more, nearly equal to the nationwide proportion of 90%.[15,21]



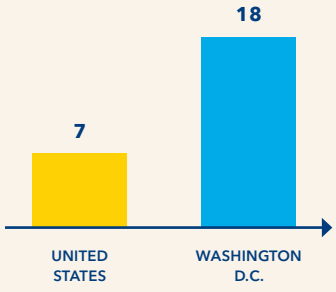
58% of adults in Washington, D.C. **have a bachelor's or more advanced degree**. This is higher than the nationwide proportion of 35%.[15,18,21]

Employment

- 6% of adults in Washington, D.C. are unemployed, compared to 4% nationwide. [23,24]
- 17% of people in Washington, D.C. live in poverty, slightly more than the nationwide percentage of 12%.[14,15,18]
- The median household income in Washington, D.C. is $82,604. This is higher than the nationwide median of $63,179.[14,15,25]
  - Paired with the proportion of people living in poverty, this indicates the high cost of living in Washington, D.C.
- 56% of MedStar Georgetown CHNA survey respondents said they work full-time. 14% are retired. 8% work part-time. 5% are disabled and unable to work. 6% are not employed but looking for work, while 4% said they are unemployed and not looking for work.

Food insecurity

- 11% of households in Washington, D.C. experience food insecurity.
  - This is equal to the nationwide proportion of households experiencing food insecurity.[26,27]



18% of households with children in Washington, D.C. **experience food insecurity**. This is higher than the nationwide proportion of **7%**.[26,27]

  - 42% of households with children in Washington, D.C. receive public assistance or SNAP benefits.[15,30]

Social justice

- 46% of survey respondents indicated that racial inequality is one of the social justice issues that affects their community most.
- 50% of respondents indicated that their law enforcement agency is somewhat responsive to the concerns of their community.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Housing and homelessness

- Number of residents served through the HOYA clinic

Racial discrimination

- Number of participants trained in cultural competency and implicit bias

Key partners

- Bread for the City
- Community of Hope
- Health Justice Alliance
- HOYA Foot Clinic at Harriet Tubman Homeless Shelter
- N Street Village
- So Others Might Eat
- The Georgetown University
- The Talking Drum Incorporated
- Triumph Shelter

4,700+
questionnaires were completed systemwide

547
came from MedStar Georgetown

The 23-question survey was conducted from late August to the end of October 2020.

Survey was distributed in person and online.

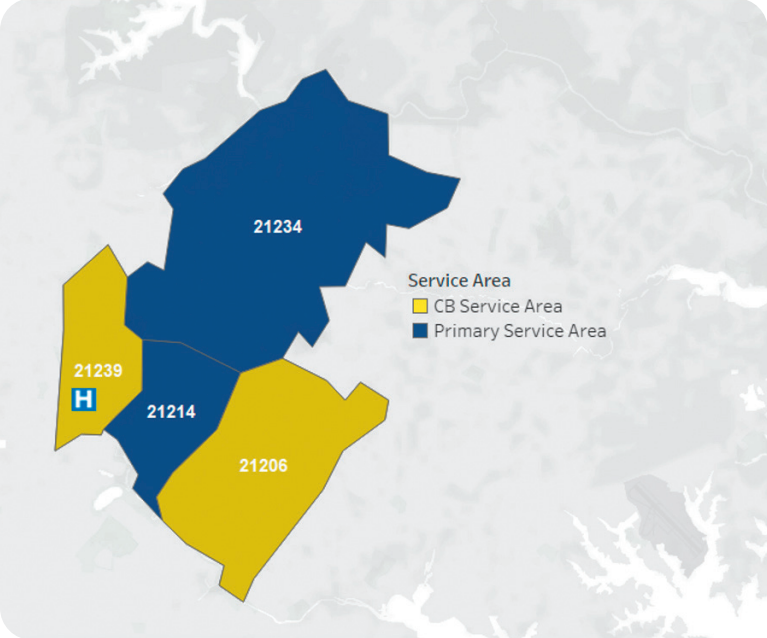
Community Health Needs Assessment

History
MedStar Good Samaritan Hospital is a 201-bed adult care community teaching hospital founded in 1968 through a gift from local merchant and philanthropist Thomas J. O'Neill. Today, its anchor services include cancer care, diabetes care, emergency medicine, geriatrics, hyperbaric medicine and wound healing, inpatient rehabilitation, interventional radiology, orthopedics, vascular care, and wellness.

The community
MedStar Good Samaritan has a long history of reaching out to its communities for feedback, collectively identifying local health care needs, and building partnerships to meet those needs. Our Advisory Task Force (ATF) Committee is comprised of community residents as well as representatives from local health departments, universities, federally qualified health centers, social service programs, faith-based and community-based organizations.

Community Benefit Service Area (CBSA): Baltimore City
MedStar Good Samaritan's CBSA includes residents living in ZIP codes 21239 and 21206. This geographic area was selected as MedStar Good Samaritan's CBSA based on hospital utilization data and secondary public health data, as well as its proximity to the hospital and an opportunity to build upon longstanding programs and services.

MedStar Good Samaritan Hospital



Identified health needs:

Health and wellness
Turn to page 32 for goals and initiatives

- Chronic disease prevention and management
- Behavioral health: Substance use disorders and mental health
- Aging and older adult health

Access to health care and services
Turn to page 35 for goals and initiatives

- Access to affordable health care and insurance
- Transportation

Social determinants of health
Turn to page 37 for goals and initiatives

- Food insecurity
- Neighborhood safety/ community violence
- Employment

Demographics

ZIP Code 21239

28,793 Total population[46]

36 Median population by age[46]

32 Male median age[46]

39 Female median age[46]

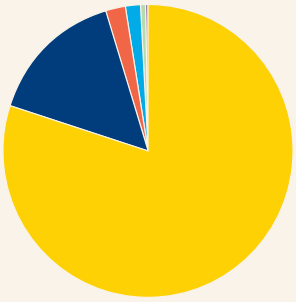
56% Female[46]

44% Male[46]

Educational attainment (those 25+ years)[46]

<High school diploma	**14%**
High school graduate	**56%**
Associate's degree	**3%**
Bachelor's degree	**14%**
Master's degree	**9%**
Professional degree	**2%**
Doctorate degree	**1%**

Race[46]



- WHITE (15%)
- BLACK (80%)
- AM. INDIAN OR ALASKAN NATIVE (<1%)
- ASIAN (2%)
- NATIVE HAWAIIAN/ PAC. ISLANDER (0%)
- OTHER RACES (<1%)
- TWO OR MORE RACES (2%)

Average household income in 2018: $46,161[46]

ZIP Code 21206

50,846 Total population[47]

35 Median population by age[47]

34 Male median age[47]

37 Female median age[47]

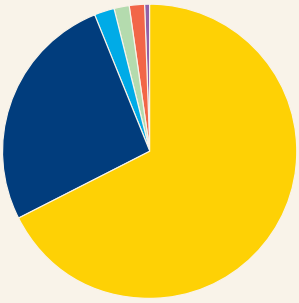
54% Female[47]

46% Male[47]

Educational attainment (those 25+ years)[47]

<High school diploma	**15%**
High school graduate	**63%**
Associate's degree	**5%**
Bachelor's degree	**11%**
Master's degree	**6%**
Professional degree	**1%**
Doctorate degree	**<1%**

Race[47]



- WHITE (27%)
- BLACK (68%)
- AM. INDIAN OR ALASKAN NATIVE (<1%)
- ASIAN (2%)
- NATIVE HAWAIIAN/ PAC. ISLANDER (0%)
- OTHER RACES (<1%)
- TWO OR MORE RACES (2%)

Average household income in 2018: $42,735[47]

Health and wellness

Chronic disease prevention and management

Baltimore City's heart disease, stroke, and cancer death rates are worse than the state and nationwide averages. For these reasons, MedStar Good Samaritan prioritized measures to prevent, detect, and treat chronic diseases and empower communities to choose healthy behaviors. These priorities are consistent with Maryland Total Cost of Care priorities (diabetes), the Maryland State Health Improvement Plan (healthy communities, healthy living, quality preventative care), and Healthy Baltimore 2020 priorities (Chronic Disease Prevention).

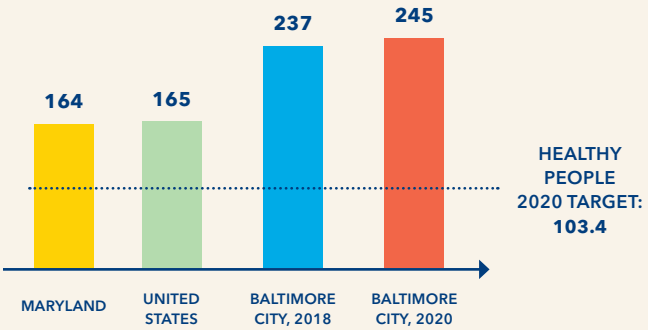
Goals

- Improve health and quality of life through prevention, detection, and treatment of risk factors for chronic diseases.
- Improve screening rates for diabetes, HbA1c, cancer, BMI, and controlled blood pressure.
- Improve the health and quality of life for those living with diabetes and heart disease while seeking to prevent such chronic conditions through obesity and diabetes prevention.

Initiatives

- Host and provide diabetes community education (CDC Diabetes Prevention Program) online risk assessment, and support groups.
- Host and provide access to wellness services and education.
- Participate in and/or lead local heart disease community activities and provide community education.
- Develop and launch Food Rx Program on campus to provide nutrition education, lifestyle change classes, and access to fresh, healthy foods.
- Launch first regional Collaborative Care Center for medically complex patients with chronic illness.
- Improve awareness of prediabetes and gestational diabetes.
- Offer breast, cervical, and colon cancer screening programs through MedStar Cancer Network.

Heart disease and stroke



Baltimore City has a heart disease death rate of 245 per 100,000 people.
This is an increase from 2018, which had a death rate of 237 per 100,000 people. It is also worse than the state and nationwide rates of 164 per 100,000 people and 165 per 100,000 people, respectively.[1]

- Baltimore City has a stroke death rate of 54 per 100,000 people.[1]
  - This is worse than the state and nationwide rates of 40 per 100,000 people and 37 per 100,000 people, respectively.
  - The Healthy People target stroke death rate is 34.8 per 100,000 people.[31]

Cancer

- Baltimore City has a cancer death rate of 202 per 100,000 people.[2,3,4]
  - This is worse than the state and nationwide rates of 155 per 100,000 people and 149 per 100,000 people, respectively. However, this is an improvement from the 2018 rate of 228 per 100,000 people. [2,3,4]
- The Healthy People target cancer death rate is 153 per 100,000 people.[31]

Diabetes and obesity

- 35% of adults in Baltimore City are obese, slightly more than the statewide percentage of 31%.[6,7]
  - This is better than the nationwide percentage of 42%. However, it is worse than the Healthy People 2020 target of 31%.[6,7,31]
- Baltimore City has a diabetes-related death rate of 34 per 100,000 people.[11]
  - This is worse than the state and nationwide rates of 20 per 100,000 people and 21 per 100,000 people, respectively.[11]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

- Number of participants enrolled in diabetes educational and clinical interventions initiatives
- Number of participants at wellness events
- Number of participants served through Food Rx Program
- Number of patients served at Collaborative Care Center
- Number of referrals

Aging and older adult health

At MedStar Health, we are committed to honoring the dignity and well-being of older adults in Baltimore City. We're prioritizing initiatives that promote healthy, successful aging. This priority is consistent with the Maryland State Health Improvement Plan (healthy communities, healthy living, quality preventative care).

Goals

- Improve the health and quality of life of older adults by offering medical and non-medical supports to aging with dignity.
- Improve access to senior healthcare services.

Initiatives

- Serve as regional hub for geriatric medical services on both campuses through MedStar Center for Successful Aging.
- Partner with local hospital skilled nursing facilities to improve transitions of care and quality between hospital and nursing home community.
- Host and provide wellness services, fall prevention, smoking cessation, and other health offerings to seniors.
- Serve as hub for MedStar House Call program, expanding access to primary care within communities.

Older adult health
- 27% of older adults in Baltimore City report no physical activity.[6,7]

Aging
- 17% of survey respondents indicated that aging and older adult issues affect people in their community.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

- Participant weight loss, physical activity increase, and BMI change
- Number of participants served
- Number of participants enrolled

Key partners

- American Heart Association
- Baltimore City Health Department
- BCHD Department of Aging
- MedStar Center for Successful Aging
- Enoch Pratt Libraries
- GEDCO
- Hampden Family Center
- Joy Wellness Center
- Keswick Wise and Well
- Maryland Department of Health
- Maryland Medicaid
- MedStar House Call program
- Weinberg YMCA

Behavioral health and substance use disorders

Addiction and substance use disorders were reported as the top concern of MedStar Good Samaritan CHNA survey respondents with an income of $20,000 to $49,999. For this reason, MedStar Good Samaritan developed initiatives to expand resources, education, and programming that seeks to reduce harmful behaviors. These priorities are consistent with Maryland Total Cost of Care priorities (opioids), the Maryland State Health Improvement Plan (quality preventative care), and Healthy Baltimore 2020 priorities (behavioral health).

Goals

- Reduce stigma about prevention and treatment of behavioral health disorders and addiction-related conditions among priority populations.
- Improve early identification, access, and referrals of mental health and addiction services.
- Improve behavioral health, including mental health and substance use disorder services, by expanding access and serving as a leader in addressing the opioid epidemic.

Initiatives

- Conduct Screening, Brief Intervention, Referral to Treatment (SBIRT) in ER and ambulatory sites supported by Peer Recovery Coaches.
- Conduct Opioid Survivor Outreach Program, allowing opioid overdose survivors to receive harm reduction tools and connection to treatment.
- Serve as a health hub for behavioral health resources, education, overdose preventions, and peer-to-peer support.
- Provide in-person and/or virtual smoking cessation programming.
- Engage as a member of Greater Baltimore Regional Integrated Crisis to expand mental health and crisis services.
- Provide behavioral services such as intensive outpatient and inpatient programs, psychiatry and therapy clinics, CRISIS teams, and Partial Hospitalization Program.

Addiction/substance use disorders

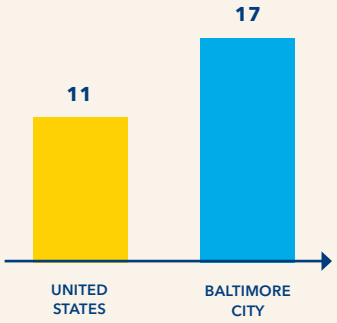
- 52% of MedStar Good Samaritan CHNA survey respondents indicated that addiction and substance use affect people in their community.
- Addiction and substance use disorders were ranked the top priority for MedStar Good Samaritan CHNA survey respondents with a household income of under $20,000 to $49,999.
- 20% of adults in Baltimore City currently smoke, compared to 14% nationwide.[5]

Did you know? 19% of adolescents in Baltimore City use tobacco products, compared to 14% in the state of Maryland and 8% nationwide.[3,8]

Alcohol

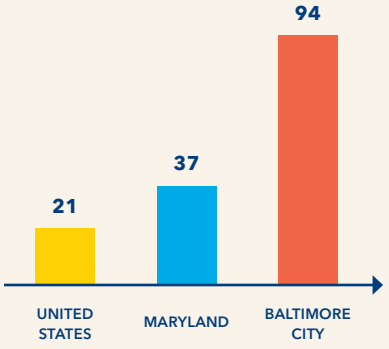
- 19% of adults in Baltimore City report binge drinking.[5]
  - This is worse than the state and nationwide percentages of 17% and 13%, respectively.

17% of deaths in Baltimore City between 2014-2018 were **related to alcohol impairment**.[9] This is worse than the nationwide percentage of **11%**.



Opioids

Baltimore City has 94 drug overdose deaths per 100,000 people, compared to 37 per 100,000 people in Maryland, and 21 per 100,000 nationwide.[10,11]



- There are 42 opioid prescriptions dispensed per 100 people in Baltimore City, lower than the nationwide rate of 51 per 100 people.[10]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

- Number of SBIRT screenings, referrals, and linkages to treatment
- Number of referrals and linkages to treatment and support services
- Participants in smoking cessation program

Key partners

- American Cancer Society
- Baltimore Alliance Healthcare Careers
- Baltimore City Hospital Coalition
- Behavioral Health Systems of Baltimore
- Greater Baltimore Regional Integrated Crisis Services (GBRICS)
- Maryland Quit Now
- Mosaic Group
- NAMI Metropolitan Baltimore–National Alliance for Mental Illness
- Turnaround Tuesday

Equal proportions of survey respondents (36%) in ZIP codes 21239 and 21206 said they either didn't know anyone personally who had been diagnosed with COVID-19 or that they know someone who was diagnosed with COVID-19.*

*Surveys were conducted August-September 2020.

Access to health care and services

Access to quality care and services is a key issue in health care. And at MedStar Health, we strive to make world-class health care convenient and accessible for everyone. This priority is now consistent with Maryland Total Cost of Care priorities (access to health care) and Healthy Baltimore 2020 priorities (life course and core services).

Goals

- Improve and expand community access to comprehensive, quality health care providers and programs, as well as medical and non-medical services.
- Support innovative medical care delivery methods designed to lower costs.
- Eliminate barriers to health care, including transportation and financial resources, and expand community access to medical and non-medical services.
- Address transportation barriers to medical and health services among individuals who identify transportation as an unmet social need.
- Support a robust transportation system (public, rideshares, bikes, sidewalks, street safety).

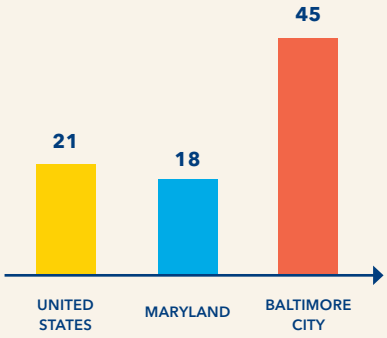
Initiatives

- Assist patients in need of insurance through screenings, referrals, and linkage to community resources through hospital-based Community Health Workers, navigators, and Peer Recovery Coaches.
- Provide medical and non-medical services, testing the intersection of health and housing through partnership at the J. Van Story Health and Wellness Hub.
- Provide support to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs, including those without U.S. documentation status.
- Continue strategic, legacy partnership with Shepherd's Clinic and Joy Wellness Center to expand access to primary care and behavioral health services for the uninsured and underinsured.
- Expand services through virtual care.
- Screen patients for transportation needs; partner with Uber Health; offer vouchers/tokens to provide transportation to patients without adequate financial resources.

Access to health care and services

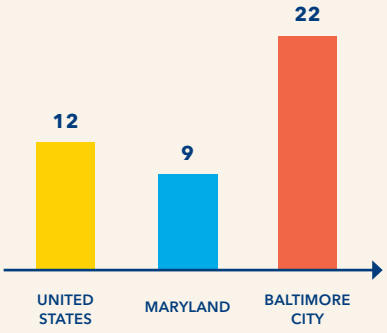
- Baltimore City has a 210:1 ratio of population to mental health providers, compared to the state and nationwide ratios of 390:1 and 290:1, respectively.[12]
- 91% of adults in Baltimore City have health insurance, almost equal to the state and nationwide averages.[14,16]
- 47% of MedStar Good Samaritan CHNA survey respondents said their health insurance is provided through their employer. Medicare or Medicare supplement and Medicaid were the next highest proportions.
- 72% of MedStar Good Samaritan CHNA survey respondents indicated that cost is one of the most common reasons people in their community do not get care when they need it. 53% selected no insurance as one of the most common reasons.

45% of the Baltimore City population is enrolled in the Medicaid/CHIP program. This is much higher than the state and nationwide percentages of 18% and 21%, respectively.[4,30]



Economics, housing, and food insecurity

22% of people in Baltimore City live in poverty. This is worse than the state and nationwide percentages of 9% and 12%, respectively.[14,18]



- The median household income in Baltimore City is $50,500, lower than the state and nationwide median of $83,100 and $63,179, respectively.[14,25]
- 21% of households in Baltimore City experience food insecurity.[26,27]
  - This is worse than the state and nationwide percentage of 11%.
- Did you know: 32% of households with children in Baltimore City receive public assistance or SNAP benefits.[15]
  - This is higher than the statewide percentage and almost equal to the nationwide percentage of 12% and 31%, respectively.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

- Number of social screenings completed
- Number of patients connected to J Van Story Health and Wellness Hub services
- Number of social needs referrals and connections to community resources
- Number of participants served at Joy Wellness Center programs
- Number of transportation rides facilitated

Key partners

- Aunt Bertha
- Baltimore City Health Department
- Baltimore City transit system
- Central Baltimore Partnership
- Community Housing Partners
- Johns Hopkins Medicine
- Joy Wellness Center
- Keswick Wise and Well
- Metro Access
- Shepherd's Clinic
- Sheppard Pratt
- Uber Health
- United Way of Central Maryland
- University of Maryland School of Nursing

Social determinants of health

Baltimore City residents reported that addiction, racial inequality, poverty, food insecurity, and violence are some of the issues that affect the quality of life in their communities the most. For these reasons, MedStar Good Samaritan prioritized initiatives that address these concerns through community-based screenings, support, services, partnership development, advocacy, and much more. This priority is consistent with the Maryland State Health Improvement Plan (healthy communities) and the Healthy Baltimore 2020 (violence prevention).

Goals

- Reduce inequities caused by lack of access to food by promoting expansion of food access.
- Improve access to employment by deploying strategies to hire local residents, create more pipelines to increase diversity, and remove systemic barriers to entering workforce.
- Improve cultural competency and racial disparities education/training to health professionals.
- Reduce community violence through community partnerships and employing a trauma-informed approach to care.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

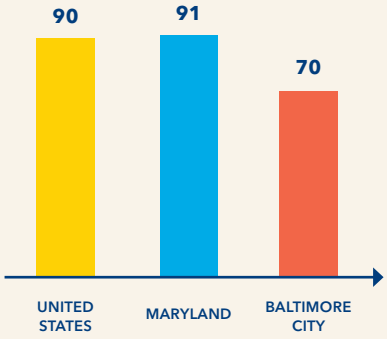
- Number of social needs screenings completed
- Number of participants in Food Rx program
- Number of Safe Streets participants; events held
- Number of trauma-informed care delivery training participants

Initiatives

- Continue screening patients for food insecurity and focus on creating solutions for food access in partnership with community-based partners.
- Develop and launch a Food Rx Program on campus.
- Participate in coalitions, support and provide referrals for medically tailored meals, seek evidence-based programs, offer nutrition counseling, and advocate for policy change.
- Develop job opportunities through intern and practicum experiences in medicine, focused on students of color.
- Execute system-wide strategy for Equity, Inclusion, and Diversity, focusing on recruitment, retention, and culture change to address the spectrum of discrimination, including race, LGBTQ+, gender, disabilities, etc.
- Through Baltimore JOBS, continue workforce development programs to employ Peer Recovery Coaches and Community Health Workers; implement career ladder opportunities.
- Partner with Safe Streets; connect perpetrators or those experiencing violence to wrap-around services through a trauma-informed care approach.
- Participate in violence prevention advocacy and community events to reduce neighborhood violence.
- Develop and launch trauma-informed care delivery training for frontline ER clinicians.

Education

70% of adults in Baltimore City have a high school diploma or more. This is **lower than the state and nationwide percentages** of 91% and 90%, respectively.[15,21]



- 31% of adults in Baltimore City have a bachelor's or more advanced degree.[18,22]
  - This is lower than the state and nationwide percentages of 40% and 35%, respectively.

Social justice

- When compared with all counties in Maryland, Baltimore City has the highest level of resident segregation.[15]
- Substance use disorders, racial inequality, and poverty were the top social justice issues that MedStar Good Samaritan CHNA survey respondents indicated affect their community most.
- 51% of respondents indicated that addiction is one of the issues that affects their community most.
- 37% of respondents indicated that racial inequality is one of the issues that affects their community most.
- 36% of respondents indicated that poverty is one of the issues that affects their community most.
- 40% of respondents identified neighborhood safety/ community violence as one of the most important issues affecting quality of life in their community.

Jobs

- 5% of adults in Baltimore City are unemployed, almost equal to the state and nationwide percentage.[23,24]
- 46% of survey respondents indicated they work full-time.
- 24% of survey respondents indicated that a lack of job opportunities is one of the most important issues affecting their community.

Key partners

- Baltimore Alliance Healthcare Careers
- Baltimore City Police Department
- Baltimore City Safe Streets
- Cristo Rey
- HealthCare Access Maryland
- Hungry Harvest
- Maryland Food Bank
- Safe Streets
- Meals on Wheels of Central Maryland
- Mercy High School
- Morgan State University
- Moveable Feast
- Vivien T. Thomas Medical Arts Academy

4,700+
questionnaires were completed systemwide

469
came from MedStar Good Samaritan

The 23-question survey was conducted from late August to the end of October 2020.

Survey was distributed in person and online.

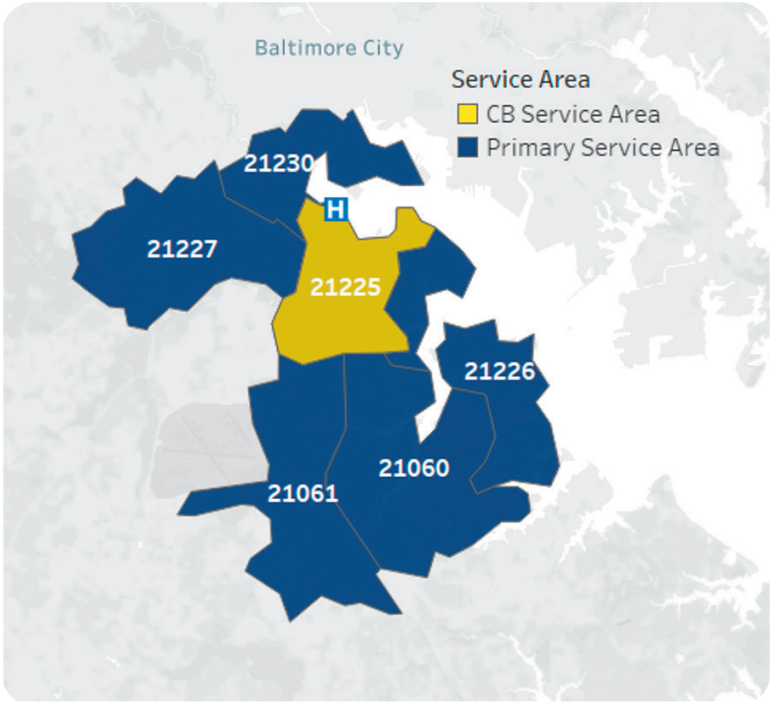
Community Health Needs Assessment

History
MedStar Harbor Hospital serves patients from Baltimore City and Anne Arundel County. Minutes from downtown Baltimore, MedStar Harbor offers comprehensive medical care, treatment, and technology in many areas, including inpatient and outpatient behavioral health, cardiology, emergency care, pediatrics, orthopedics, and women's services.

The community
MedStar Harbor has a long history of reaching out to its communities for feedback, collectively identifying local health care needs and building partnerships to meet those needs. Our Advisory Task Force Committee is comprised of community residents as well as representatives from the local health department, federally qualified health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): Baltimore, MD
The MedStar Harbor CBSA includes residents living in ZIP code 21225. This geographic area was selected based on hospital utilization data and secondary public health data as well as its proximity to the hospital.

MedStar Harbor Hospital



Identified health needs:

Health and wellness
Turn to page 40 for goals and initiatives

- Chronic disease prevention and management
- Behavioral health: Substance use disorders and mental health
- Maternal and child health

Access to health care and services
Turn to page 44 for goals and initiatives

- Access to affordable health care and insurance
- Fear/mistrust of providers
- Transportation

Social determinants of health
Turn to page 46 for goals and initiatives

- Housing and homelessness
- Food insecurity
- Neighborhood safety and community violence

Demographics

ZIP Code
21225

33,545 Total population[48]

32 Median population by age[48]

31 Male median age[48]

32 Female median age[48]

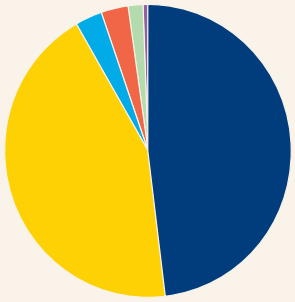
53% Female[48]

47% Male[48]

Educational attainment (those 25+ years)[48]

<High school diploma	**25%**
High school graduate	**60%**
Associate's degree	**6%**
Bachelor's degree	**7%**
Master's degree	**1%**
Professional degree	**<1%**
Doctorate degree	**<1%**

Race[48]



Average household income in 2018: $38,259[48]

Health and wellness

Chronic disease prevention and management

Due to higher-than-average heart disease, stroke, and cancer death rates in ZIP code 21225, MedStar Harbor prioritized measures to prevent, detect, and treat chronic diseases and empower communities to choose healthy behaviors. These priorities are consistent with Maryland Total Cost of Care priorities (diabetes), the Maryland State Health Improvement Plan (healthy communities, healthy living, quality preventative care), and Healthy Baltimore 2020 priorities (chronic conditions).

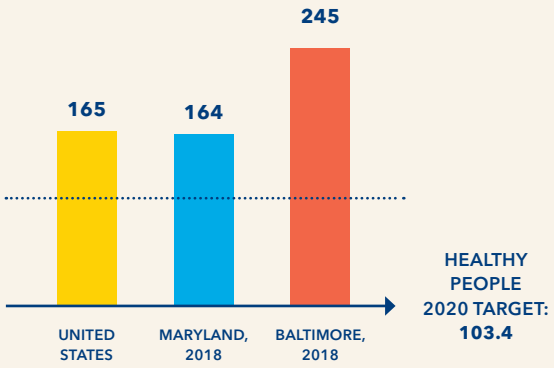
Goals

- Improve the health and quality of life for those living with diabetes and heart disease while seeking to prevent such chronic conditions through obesity and diabetes prevention.
- Improve screening rates for diabetes, HbA1c, cancer, BMI, and controlled blood pressure.

Initiatives

- Host and provide community diabetes education, CDC Diabetes Prevention Program, support groups, online prediabetes risk assessments; and actively support local diabetes prevention activities.
- Host and provide access to wellness services and education, including but not limited to yoga and fitness activities.
- Participate or lead local heart disease community activities and provide community education.
- Develop and launch Food Rx Program on campus designed to provide nutrition education, lifestyle change classes, and access to fresh, healthy foods.
- Provide primary care services through MedStar Mobile Health Center to address risk factors of chronic disease and refer community members to specialty care, if needed.
- Improve awareness of prediabetes and gestational diabetes.
- Offer breast, cervical, and colon cancer screening programs through MedStar Cancer Network.

Heart disease and stroke



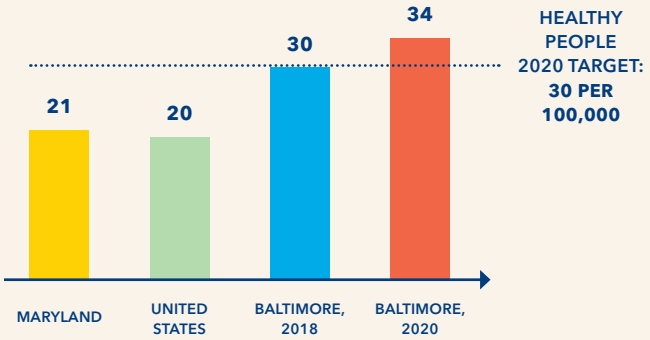
ZIP code 21225 has a heart disease death rate of 245 per 100,000 people. This is an increase from 2018, in which the rate was 237 per 100,000 people. This is worse than the nationwide rate of 165 per 100,000 people.[1]

- ZIP code 21225 has a stroke death rate of 54 per 100,000 people, above the nationwide rate of 37 per 100,000.[1]

Cancer

- ZIP code 21225 has a cancer death rate of 202 per 100,000 people. This is above the nationwide rate of 165 per 100,000.[2,3,4]

Diabetes and obesity



ZIP code 21225 is **above the state and national average for diabetes deaths**, at 34 per 100,000 people, compared to a rate of 20 per 100,000 statewide and 21 per 100,000 nationwide. This is an increase from 2018's rate of 30 per 100,000 people.[11]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Obesity

- Number of participants
- Number of events
- Participant weight loss, physical activity increase and BMI change

Diabetes

- Number of participants
- Number of events
- Number of prediabetes screenings

Key partners

- American Heart Association
- Anne Arundel County Health Department
- Arundel Elementary
- Baltimore City Health Department
- Black Yield Institute
- Brooklyn Park Library
- Cherry Hill Economic Development Corporation
- Cherry Hill Senior Manor
- Cherry Hill Tenant Association
- Greater Baybrook Alliance
- Lakeland STEAM Center
- Maryland Department of Health
- Maryland Medicaid
- North County Recreational Center
- The Well
- Transformation Center
- Westport Academy

Maternal and child health

The health of mothers and children is integral to the health of our community. At MedStar Health, we're dedicated to supporting initiatives that reduce inequities, improve outcomes and promote healthy moms and babies. This priority is consistent with Maryland Total Cost of Care priorities (maternal and child health).

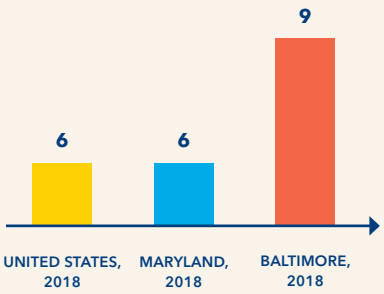
Goals

- Improve health outcomes related to maternal and child health.
- Serve as a connector to resources and services to address maternal morbidity and mortality with local and state agencies.

Initiatives

- Support new mothers with education, lactation assistance, support groups, and weekly MOMS luncheons.
- Join and participate in B'more for Healthy Babies Collaborative to reduce infant mortality through community mobilization and behavioral change.
- Conduct Screening, Brief Intervention, Referral to Treatment (SBIRT) in inpatient labor and delivery and outpatient OB practices supported by Peer Recovery Coaches.
- Provide community-based medication-assisted therapy support group for expecting mothers through MedStar Fetal Assessment Center.

ZIP code 21225 has an infant mortality rate of 9 per 1,000 live births. This is higher than the state and nationwide rate of 6 per 1,000 live births.[7]



Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

- Number of participants in maternal health programs
- Number of maternal education events and support groups

Key partners

- Anne Arundel County Health Department
- Baltimore City Health Department
- B'more for Healthy Babies
- Enoch Pratt Libraries
- HealthCare Access Maryland
- Women, Infant & Children (WIC)

Behavioral health and substance use disorders

Addiction and substance use disorders were reported as the top concern of MedStar Harbor CHNA survey respondents. For this reason, MedStar Harbor developed initiatives to expand resources, education, and programming that seeks to reduce harmful behaviors. These priorities are consistent with Maryland Total Cost of Care priorities (opioids), the Maryland State Health Improvement Plan (quality preventative care), and the Baltimore County Health Improvement Plan (behavioral health). These priorities are consistent with Maryland Total Cost of Care priorities (opioids), the Maryland State Health Improvement Plan (quality preventative care), and Healthy Baltimore 2020 priorities (behavioral health).

Goals

- Reduce stigma about prevention and treatment of behavioral health disorders and addiction-related conditions among priority populations.
- Improve early identification and referrals of mental health and addiction services.
- Promote engagement in care for those with mental health and substance use disorders.
- Improve behavioral health, including mental health and substance use services, by expanding access and serving as a leader in addressing the opioid epidemic.

Initiatives

- Conduct Screening, Brief Intervention, Referral to Treatment (SBIRT) in ER, women's services, and ambulatory sites supported by Peer Recovery Coaches.
- Conduct Opioid Survivor Outreach Program, allowing for opioid overdose survivors to receive harm reduction tools and connection to treatment.
- Serve as a health hub for behavioral health resources, education, overdose prevention, and peer-to-peer support.
- Provide smoking cessation programming.
- Provide behavioral services such as intensive outpatient and inpatient programs, psychiatry and therapy clinic, CRISIS Teams, Partial Hospitalization Program, and therapeutic and educational groups.
- Conduct free, universal HIV testing screening services in ER.
- Engage as a member of Greater Baltimore Regional Integrated Crisis to expand mental health and crisis services.

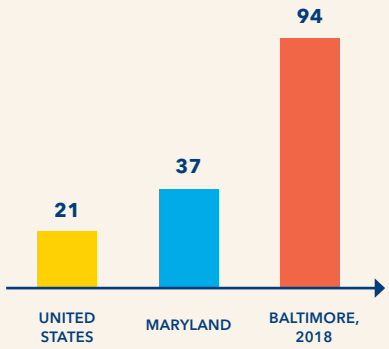
Addiction/substance use disorders

73% of MedStar Harbor CHNA survey respondents **indicated that addiction and substance use disorders** affect people in their community.

Alcohol

- 19% of adults in ZIP code 21225 report binge drinking, which is higher than the statewide percentage of 17%.[5]
- 17% of driving deaths in ZIP code 21225 between 2014 and 2018 were related to alcohol impairment, compared to 29% statewide and 11% nationwide.[9]

Opioids



ZIP code 21225 has 94 drug overdose deaths per 100,000 people compared to 37 per 100,000 people statewide and 21 per 100,000 nationwide.[10,11]

- ZIP code 21225 dispenses 42 opioid prescriptions per 100 people, compared to 45 per 100 people statewide and 51 per 100 people nationwide.[10]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Substance use disorders and mental health

- Number of SBIRT screenings, referrals, and linkages to treatment
- Number of referrals and linkages to treatment and support services
- Number of participants enrolled in smoking cessation and Opioid Survivor Outreach
- Number of trainings offered

Key partners

- Anne Arundel County Health Department
- Baltimore City Health Department
- Behavioral Health Systems of Baltimore
- Cherry Hill Family Health Center
- Mosaic Group
- NAMI Metropolitan Baltimore–National Alliance for Mental Illness

42% of MedStar Harbor CHNA survey respondents said they **needed financial assistance** as a result of COVID-19, **35% required food assistance,** and **24% required energy assistance.***

*Surveys were conducted August-September 2020.

Access to health care and services

Cost and mistrust of providers are reported as common reasons people in ZIP code 21225 do not get health care when they need it. For this reason, MedStar Harbor prioritized initiatives to expand health care, transportation, and other services in the community. These priorities are consistent with Maryland Total Cost of Care priorities (access to health care) and Healthy Baltimore 2020 priorities (life course and core services).

Goals

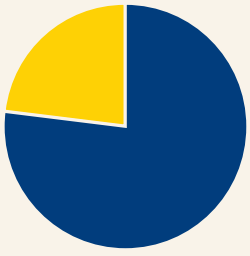
- Improve systemic barriers related to trust in medical providers through training experiences that bridge understanding of vulnerable and marginalized populations.
- Improve access to transportation for vulnerable populations related to cost and systemic barriers to access public transportation.
- Eradicate barriers to accessing health care, including transportation, and financial resources; expand community access to medical and non-medical services.

Initiatives

- Develop and launch community health rotation for internal medicine residents to expose the next generation of clinicians to community challenges.
- Execute system-wide strategy for Equity, Inclusion, and Diversity, which focuses on recruitment, retention, and culture change to address the spectrum of discrimination, including race, LGBTQ+, gender, disabilities, etc.
- Develop and launch trauma-informed care delivery training for frontline ER clinicians to ensure staff is adequately equipped to care for patients.
- Develop pipelines of job opportunities focused on students of color to promote diversity of frontline clinical and non-clinical providers.
- Assist patients in need of insurance through screenings, referrals, and linkage to community resources through hospital-based Community Health Workers, Navigators, and Peer Recovery Coaches.
- Provide primary care services without the need for insurance through MedStar Mobile Health Center.
- Provide support to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs.
- Expand services through virtual care.
- Serve as lead and finish design plan for bike and pedestrian pathway that connects Gywnns Falls Trail and BWI Trail.
- Conduct free HIV testing screening services in the ER, given the correlation between substance use and HIV prevalence in south Baltimore City.

Access to health care and services

- ZIP code 21225 has a 220:1 ratio of population to mental health providers, compared to the nationwide ratio of 290:1.[12]
- 91% of adults in ZIP code 21225 have health insurance, compared to 92% statewide and nationwide.[14,16]
- 48% of respondents said their health insurance is provided through their employer.
- 32% of respondents indicated that limited availability or access to doctors is one of the most important issues affecting quality of life in their community.



77% of respondents indicated that **cost is one of the most common reasons** people in their community **do not get health care** when they need it.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Fear/mistrust of providers

- Number of participants
- Number of trainings offered
- Diversity and inclusion programs developed
- Number of students enrolled in experiences

Access to affordable health care and insurance

- Number of screenings, referrals, linkage to resources
- Number of patients served through MedStar Mobile Health Center

Access to transportation

- Number of rides
- Completion of bicycle and pedestrian path along The Gwynns Falls Trail

Key partners

- Anne Arundel County Department of Transportation
- Arundel Elementary
- Baltimore City Department of Transportation
- Brooklyn Park Library
- Cherry Hill Tenant Association
- Greater Baybrook Alliance
- HealthCare Access Maryland
- Lakeland STEAM Center
- North County Recreational Center
- The Well
- Transformation Center
- Uber Health
- Westport Academy

Social determinants of health

Those living in ZIP code 21225 reported that housing and homelessness, food insecurity, and racial inequality are some of the issues that affect the quality of life in their communities the most. For these reasons, MedStar Harbor prioritized initiatives that address these concerns through community-based support, opportunities, advocacy, and more. These priorities are consistent with the Maryland State Health Improvement Plan (healthy communities) and Healthy Baltimore 2020 priorities (life course and core services).

Goals

- Reduce inequities caused by lack of access to food by promoting the expansion of food access.
- Reduce inequities caused by affordable housing, or housing conditions by promoting the intersection of housing and health care.
- Reduce community violence through community partnerships and employing a trauma-informed approach to care delivery.

Initiatives

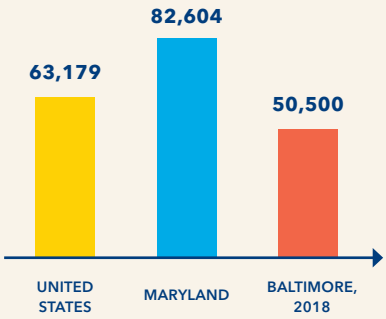
- Provide social needs screenings for food insecurity; provide fresh produce prescriptions through Community Health Workers while focusing on long-term sustainability for food access to community-based partners.
- Participate in coalitions, support, and referrals to medically tailored meals; seek evidence-based programs; offer nutrition counseling; and advocate for policy change.
- Utilize Baltimore City Continuum of Care membership to advocate and act on specific opportunities to address homelessness, including referring patients to housing agencies.

Economics, housing, and food insecurity

43% of survey respondents indicated that **housing problems and homelessness are among the most important issues that affect quality of life in their community**. Poverty was the next most selected issue.

- 5% of adults in ZIP code 21225 are unemployed, which is above the state and nationwide rates of 4%.[23,24]
- 22% of people in ZIP code 21225 live in poverty. This is higher than the statewide percentage of 9% and the nationwide percentage of 12%.[14,18]

Economics, housing, and food insecurity continued...



The median household income in ZIP code 21225 is $50,500. This is below the statewide median of $82,604 and nationwide median of $63,179.[14,25]

- 21% of households in ZIP code 21225 experience food insecurity, which is higher than the state and nationwide proportions of 11%.[26,27]
- 16% of households with children in ZIP code 21225 experience food insecurity.
  - This is equal to the statewide proportion and above the nationwide proportion of 7%.[26,27]
  - 32% of households with children in ZIP code 21225 receive public assistance or SNAP benefits. This is equal to the statewide proportion and below the nationwide proportion of 31%.[15]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Food insecurity
- Social needs screenings completed
- Number of participants in Food Rx program
- Patients served

Housing and homelessness
- Number of enrollees in housing services

Key partners

- Anne Arundel County Health Department
- Baltimore City Health Department
- Baltimore City Mayor's Office of Homeless Services
- Baltimore City Office of Food Planning
- Baltimore City Police Department
- Black Yield Institute
- Hungry Harvest
- Maryland Food Bank
- Maryland Medicaid
- Meals on Wheels of Central Maryland
- Safe Streets

4,700+
questionnaires were completed systemwide

479
came from MedStar Harbor

The 23-question survey was conducted from late August to the end of October 2020.

Survey was distributed in person and online.

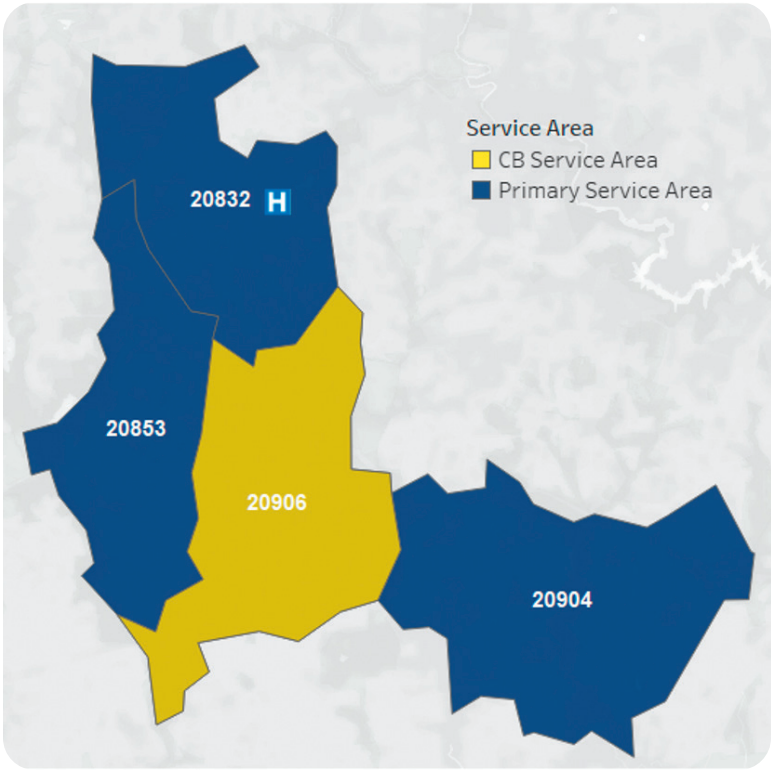
Community Health Needs Assessment

MedStar Montgomery Medical Center

History
MedStar Montgomery Medical Center is located in Olney, Maryland. It was founded in 1919 by Jacob Wheeler Bird, MD, and became part of MedStar Health in 2008. MedStar Montgomery is a Joint Commission-certified Primary Stroke Center, a member of the American Academy of Sleep Medicine, and has received the Gold Plus Performance Achievement Award from the American Heart/American Stroke Association. It is also a member of the American College of Surgeons (ACS), the American Society for Metabolic and Bariatric Surgery (ASMBS), and the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSQIP). Its bariatric program provides comprehensive weight loss care to patients in Montgomery County and the surrounding areas.

The community
MedStar Montgomery has a long history of reaching out to its communities for feedback, collectively identifying local health care needs and building partnerships to meet those needs. Our Advisory Task Force Committee is comprised of community residents as well as representatives from the local health department, public school system, federally qualified health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): Montgomery County, MD
The MedStar Montgomery County CBSA includes residents living in ZIP code 20906. This geographic area was selected based on hospital utilization and secondary public health data as well as its proximity to the hospital, coupled with a high density of low-income residents.



Identified health needs:

Health and wellness
Turn to page 49 for goals and initiatives

- Chronic disease prevention and management
- Behavioral health: Substance use disorders and mental health
- Aging and older adult health

Access to health care and services
Turn to page 53 for goals and initiatives

- Access to affordable health care and insurance

Social determinants of health
Turn to page 54 for goals and initiatives

- Food insecurity

Demographics

ZIP Code
20906

64,696 Total population[49]

40 Median population by age[49]

37 Male median age[49]

43 Female median age[49]

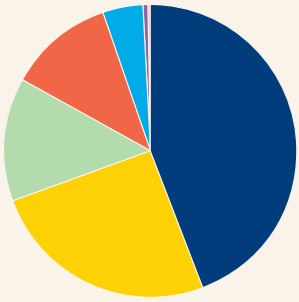
54% Female[49]

46% Male[49]

Educational attainment (those 25+ years)[49]

<High school diploma	**18%**
High school graduate	**40%**
Associate's degree	**5%**
Bachelor's degree	**20%**
Master's degree	**11%**
Professional degree	**3%**
Doctorate degree	**3%**

Race[49]



Average household income in 2018: $61,715[49]

Health and wellness

Chronic disease prevention and management

While residents of Montgomery County have lower heart disease, stroke, diabetes, and cancer death rates than the state and nationwide rates, MedStar Montgomery is prioritizing health initiatives that help support the overall well-being of community members. These priorities are consistent with Maryland Total Cost of Care priorities (diabetes) and the Maryland State Health Improvement Plan (healthy communities, healthy living, quality preventative care) as well as the Healthy Montgomery Community Health Improvement Plan (chronic disease).

Goals

- Improve the health and quality of life through prevention, detection and treatment of risk factors for chronic diseases.
- Improve the health and quality of life for those living with diabetes and heart disease while seeking to prevent such chronic conditions through obesity and diabetes prevention.

Initiatives

- Host and provide access to healthy lifestyle education programs, wellness activities, and support groups.
- Host and provide obesity prevention fitness and nutrition programs.
- Collaborate and offer free breast, cervical, and colon cancer screening programs through MedStar Cancer Network.

Heart disease and stroke

- Montgomery County has a heart disease death rate of 102 per 100,000 people, compared to 164 per 100,000 people statewide and 165 per 100,000 nationwide.[1]
  - This is an improvement from 2018, in which the rate was 111 per 100,000 people.
  - The Healthy People 2020 target goal for heart disease is 103.4 per 100,000 people.[31]
- Montgomery County has a stroke death rate of 25 per 100,000 people, below the state and nationwide rates of 40 per 100,000 and 37 per 100,000, respectively.[1]
  - The Healthy People 2020 target goal for stroke deaths is 34.8 per 100,000 people.

Cancer

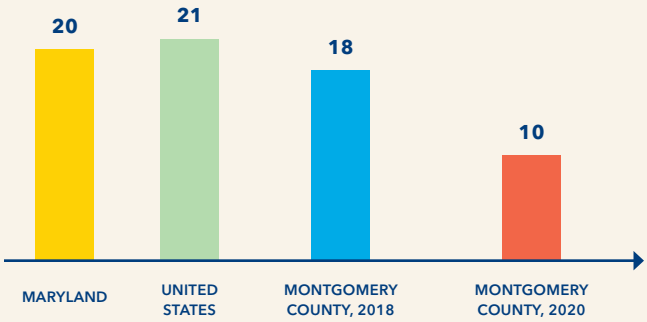
- Montgomery County has a cancer death rate of 115 per 100,000 people, compared to 155 per 100,000 statewide and 149 per 100,000 nationwide.[2,3,4]

Diabetes and obesity

- 20% of adults in Montgomery County are obese, compared to 31% of adults statewide.

Smoking

- 8% of adults in Montgomery County smoke, compared to 14% statewide and nationwide.[5]
- 10% of adolescents in Montgomery County use tobacco products, compared to 14% statewide and 8% nationwide.[3,8]



Montgomery County is **well below the state and national average for diabetes deaths**, at **10 per 100,000** people, compared to a rate of 20 per 100,000 statewide and 21 per 100,000 nationwide. This is a decrease from 2018 in which the rate was 18 per 100,000 people.[11,12]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

- Number of participants enrolled in chronic disease prevention and management programs
- Number of participants at wellness events
- Number of screenings

Key partners

- African American Health Program
- American Diabetes Association
- Asian American Health Initiative
- Eat Well Be Active Partnership
- Giant Nutrition Tours
- Latino Health Initiative
- Manna Food Center
- MedStar Cancer Network
- MedStar Heart and Vascular Institute
- Montgomery County Department of Health and Human Services
- Primary Care Coalition of Montgomery County

Aging and older adult health

At MedStar Health, we are committed to honoring the dignity and well-being of older adults in Montgomery County. We're prioritizing initiatives that promote healthy, successful aging. This priority is consistent with the Maryland State Health Improvement Plan (healthy living, healthy communities, quality preventative care).

Goals

- Promote healthy aging; offer medical and non-medical supports to aging with dignity.
- Improve the health, function, and quality of life of older adults.
- Increase older adults' engagement in light, moderate leisure-time social and physical activities.

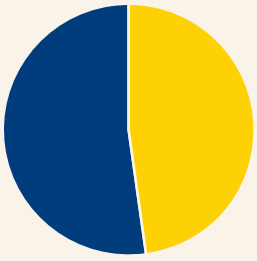
Initiatives

- Host and offer Age Friendly senior wellness services, virtual and in-person health education programs; fall prevention; wellness clinics/ exercise classes.
- Participate in health fairs and provide screenings.
- Host and offer fall prevention programs with our Geriatrics providers.
- Partner with local skilled nursing facilities to improve transitions of care and quality between hospital and nursing home community.
- Participate in county Age Friendly-Home & Community Based Services and Dementia Friendly workgroups.

Older adult health

- 16% of adults in Montgomery County report that they get no physical activity.[5,6,7]

Aging



48% of survey respondents indicated that **aging/older adult issues** affect people in their community.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

- Number of programs
- Number of participants

Key partners

- Adventist Healthcare Centers
- Holy Cross Hospitals
- Jewish Council of Aging
- Leisure World
- Maryland Department of Aging
- Nexus Montgomery Skilled Nursing Facilities Alliance
- Nexus Montgomery
- Olney Home for Life Services
- Maryland Senior Call Check program
- Suburban Hospital
- 36 facilities in Montgomery and Prince Georges counties

Behavioral health and substance use disorders

Addiction, substance use disorders, and behavioral health disorders affect communities throughout Montgomery County. MedStar Montgomery prioritized initiatives to improve the response to these issues. These priorities are consistent with Maryland Total Cost of Care priorities (opioids) and the Maryland State Health Improvement Plan (quality preventative care) as well as the Healthy Montgomery Community Health Improvement Plan (behavioral health).

Goals

- Reduce stigma about prevention and treatment of behavioral health disorders and addiction-related conditions among priority populations and improve access and referrals.
- Improve early identification and referrals of mental health and addiction services.

Initiatives

- Conduct screening, Brief Intervention and Referral to Treatment (SBIRT) in ER supported by Peer Recovery Coaches.
- Serve as a health hub for behavioral health resources, education, overdose prevention, and peer-to-peer support.
- Host and offer smoking/vaping cessation programs.
- Engage as a member of Nexus Montgomery Regional Behavioral Health Partnership by centralizing crisis services ecosystem, expanding mobile crisis delivery, and offering same day access services.

Addiction/substance use disorders

- 24% of MedStar Montgomery CHNA survey respondents indicated that addiction and substance use affect quality of life in their community.

Alcohol

- 16% of adults in Montgomery County report binge drinking, which is almost equal to the statewide proportion but higher than the nationwide percentage of 13%.[5]
- 23% of driving deaths in Montgomery County between 2014 and 2018 were related to alcohol impairment, compared to 29% statewide and 11% nationwide.[9]

Opioids

- Montgomery County has 11 drug overdose deaths per 100,000 people compared to 37 per 100,000 people statewide and 21 per 100,000 nationwide.[10,11]
- Montgomery County dispenses 27 opioid prescriptions per 100 people, compared to 45 per 100 people statewide and 51 per 100 people nationwide.[10]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Substance use disorders and mental health

- Number of participants
- Number of SBIRT screenings, referrals, and linkages to treatment
- Number of programs
- Number of referrals and linkages to treatment and support services

Key partners

- American Cancer Society
- Cornerstone Montgomery
- EveryMind
- Family Services Inc.
- Maryland Quit Now
- Mental Health Association of Montgomery County
- Montgomery County Fire and Rescue Services
- Mosaic Group
- Nexus Montgomery Regional Behavioral Health Partnership
- Sheppard Pratt Health System

53% of survey respondents in ZIP code 20906 reported knowing someone outside of their family who had been **diagnosed with COVID-19**.*

*Surveys were conducted August-September 2020.

Access to health care and services

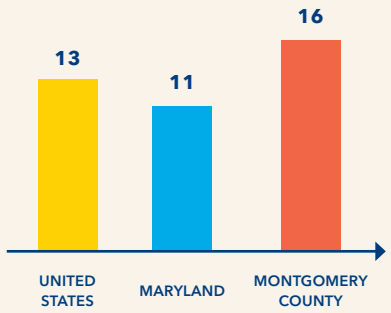
Access to quality care and services is a key issue for some residents of Montgomery County. For this reason, MedStar Montgomery prioritized initiatives such as expanding health care access and prioritized initiatives designed to expand health care access and lower health care costs. These priorities are consistent with the Maryland State Health Improvement Plan (access to care).

Goals

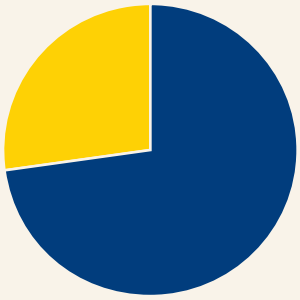
- Improve and expand community access to comprehensive, quality health care providers and programs, as well as medical and non-medical services.
- Support innovative medical care delivery methods designed to lower the cost of health care.
- Eliminate barriers to accessing health care, including transportation and financial resources; expand community access to medical and non-medical services.

Initiatives

- Assist patients in need of insurance through screenings, referrals, and linkage to community resources through hospital-based programs and hospital-based Community Health Workers and Peer Recovery Coaches.
- Continue strategic, legacy partnership with Projecto Salud to expand access to primary care services for uninsured and underinsured patients.
- Expand services through virtual care.
- Provide support to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs.



16% of adults in Montgomery County **cannot afford to see a doctor**, compared to 11% statewide and 13% nationwide.[5,13,17]



73% of respondents indicated that cost is one of the **most common reasons** people in their community **do not get health care when they need it**.

Access to health care and services

- Montgomery County has a 320:1 ratio of population to mental health providers, compared to the nationwide ratio of 290:1. The state ratio is 390:1.[12]
- 91% of adults in Montgomery County have health insurance, compared to 92% state and nationwide.[13,14,15,16]
- 36% of respondents indicated that limited availability or access to doctors is one of the most important issues affecting quality of life in their community.
- Montgomery County has an HIV prevalence of 397 per 100,000 people, compared to 643 per 100,000 people statewide and 428 per 100,000 nationwide.[28,29]

Access to transportation

- 20% of survey respondents indicated that limited pedestrian and bike safety is one of the most important issues that affects quality of life in their community. 18% of respondents selected limited access to transportation.

Economics and housing

- 3% of adults in Montgomery County are unemployed, which is almost equal to the state and nationwide rates of 4%.[23,24]
- 7% of people in Montgomery County live in poverty.
  - This is below the state and nationwide percentages of 9% and 12%, respectively.[14,15,18]
- The median household income in Montgomery County is $107,800.
  - This is above the state and nationwide medians of $83,000 and $63,000, respectively.[14,15,25]
- 43% of survey respondents indicated that housing problems/homelessness is one of the most important issues that affects quality of life in their community. Poverty was the next most selected issue.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Access to affordable health care and insurance

- Number of social screenings completed
- Number of patients connected to Projecto Salud or other county safety net clinics
- Number of participants
- Number of referrals, linkages to resources

Access to transportation

- Number of transportation rides facilitated

Key partners

- Healthy Montgomery
- Latino Health Initiative
- Linkage to Learning
- Montgomery County Department of Health and Human Services
- Montgomery County Public Schools
- Primary Care Coalition
- Projecto Salud
- Uber Health

Social determinants of health

Food insecurity is one of the issues that affects some Montgomery County residents. In response, MedStar Montgomery developed initiatives to address this and make healthy lifestyles more accessible. These priorities are consistent with the Maryland State Health Improvement Plan (healthy communities).

Goals

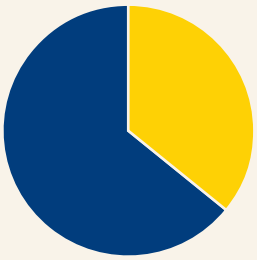
- Support social and physical environments that promote good health for all.
- Reduce inequities caused by lack of access to food by working to promote the expansion of food access.
- Expand and collaborate with Food is Medicine partners to provide direct and indirect support to assist those in need.

Initiatives

- Provide social needs screenings for food insecurity .
- Participate in Healthy Montgomery Transforming Community Initiative to reduce barriers to accessing healthy foods in vulnerable communities.
- Host Olney Farmers Market.
- Host and provide nutrition and culinary skills education, support emergency preparedness plans, and referrals to medically tailored meals.

Food insecurity

- 6% of households with children in Montgomery County experience food insecurity. This is below the state and nationwide proportions of 16% and 7%, respectively.[26,27]
- 6% of households with children in Montgomery County receive public assistance or SNAP benefits.[15,30]



36% of children enrolled in public school in Montgomery County are **eligible for free or reduced lunch**.[32]

Social justice

52% of survey respondents indicated that racial inequality is one of the social justice issues that **affects their community most**.

Jobs

- 40% of survey respondents said they work full-time. 11% work part-time. 39% are retired. 2% are disabled and unable to work. 2% are not employed but looking for work.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Food insecurity

- Social needs screenings completed
- Number of participants
- Number of programs

Key partners

- Capital Area Food Bank
- Community Reach of Montgomery County
- Food is Medicine Coalition
- Healthy Montgomery Transforming Community Initiative
- Manna Food Center
- Meals on Wheels of Central Maryland
- Montgomery County Food Council
- Olney Chamber of Commerce
- Olney Farmers Market

4,700+

questionnaires were completed systemwide

243

came from MedStar Montgomery

The 23-question survey was conducted from late August to the end of October 2020.

Survey was distributed in person and online.

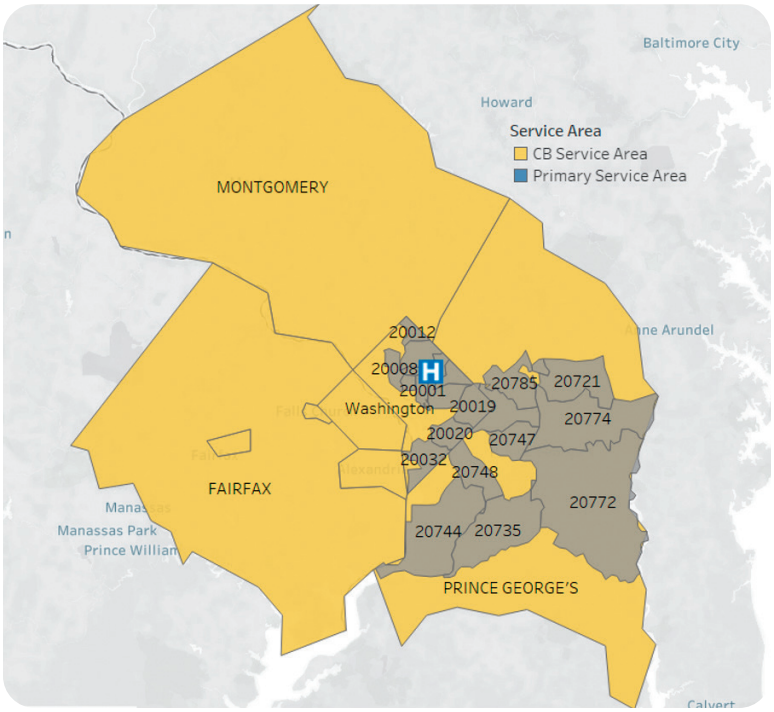
Community Health Needs Assessment

History
MedStar National Rehabilitation Hospital (NRH) has treated adults and children with disabling illness or injury for more than 30 years. MedStar NRH is MedStar National Rehabilitation Network's flagship hospital, offering inpatient, day treatment, and outpatient services in Washington, D.C., and the surrounding areas.

The community
MedStar NRH has a long history of reaching out to its communities for feedback, collectively identifying local health care needs and building partnerships to meet those needs. Our Advisory Task Force Committee is comprised of community residents as well as representatives from the local health department, disability networks, federally qualified health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): Greater D.C.
The MedStar NRH CBSA includes residents with disabilities living in the Greater D.C. area, which includes all of Washington, D.C., Montgomery and Prince George's counties in Maryland, and Arlington and Fairfax counties in Virginia. This geographic area was selected based on hospital utilization and secondary public health data and its proximity to the hospital.

MedStar National Rehabilitation Hospital



Identified health needs:

Health and wellness
Turn to page 58 for goals and initiatives

- Chronic pain
- Injury prevention; wellness and health education for people with disabilities
- Behavioral health: Substance use disorders and mental health

Access to health care and services
Turn to page 60 for goals and initiatives

- Access to affordable health care and insurance
- Fear/mistrust of providers
- Transportation

Social determinants of health
Turn to page 62 for goals and initiatives

- Racial discrimination
- Employment

Washington, D.C.

692,817 Total population[33]

11.6% Population with a disability[33]

44% Those with a disability who are male[33]

56% Those with a disability who are female[33]

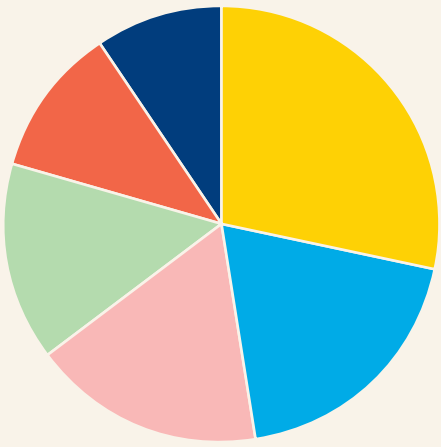
Percent of disabled population (by age)[33]

Under 5	**1.6%**
5 to 17	**4.5%**
18 to 34	**5.1%**
35 to 64	**13.7%**
65 to 74	**25.5%**
75+	**50.4%**

Race

Prevalence of disability among working-age individuals ages 21 to 64.[33]

This represents a portion of the total disabled population.



Maryland

10.4% Male disabled population[34]

10.9% Female disabled population[34]

Employment

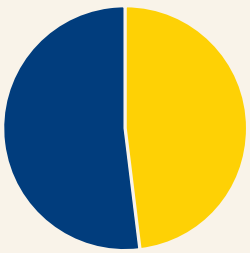
42.4% employment rate among working-age individuals[34]

Poverty

21.1% poverty rate among working-age individuals[34]

Age

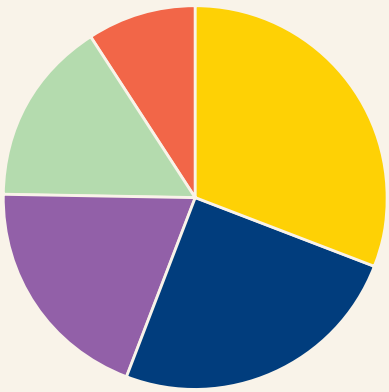
Prevalence of disability was 48.1% for persons ages 75+[34]



Race

Prevalence of disability among working-age individuals ages 21 to 64[34]

This represents a portion of the total disabled population.



Virginia

10.8% Male disabled population[35]

11.3% Female disabled population[35]

Employment

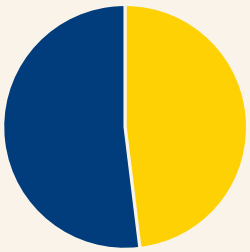
36.8% employment rate among working-age individuals[35]

Poverty

25.1% poverty rate among working-age individuals[35]

Age

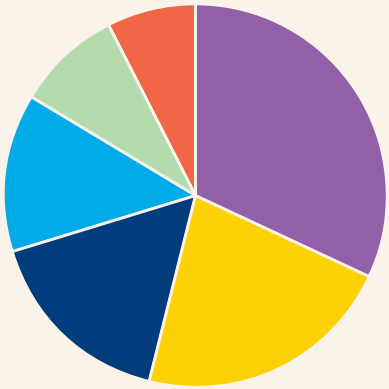
Prevalence of disability was 48.1% for persons ages 75+[35]



Race

Prevalence of disability among working-age individuals ages 21 to 64[35]

This represents a portion of the total disabled population.



Six types of disabilities

Hearing | Visual | Cognitive | Ambulatory | Self-care | Independent living

Health and wellness

Chronic pain, injury prevention, and behavioral health

Chronic pain, arthritis, substance use disorders, and mental health were reported as top concerns of those with disabilities in the Greater D.C. region. For these reasons, MedStar NRH prioritized initiatives to improve the quality of life for residents with chronic pain and expand support for mental health and substance use disorders. These priorities are consistent with Community Health Improvement Process objectives (mental health, health literacy) and D.C. Healthy People objectives (disability services, quality preventative care).

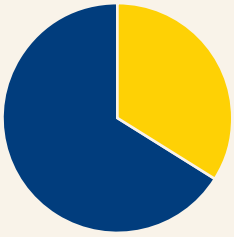
Goals

- Improve the health, function, and quality of life for those with chronic pain.
- Reduce chronic pain and misuse of prescription pain relievers.
- Improve the health and well-being of people with disabilities.
- Expand illness and injury prevention education programs.
- Reduce stigma about prevention and treatment of behavioral health disorders and addiction-related conditions.
- Improve early identification and referrals of mental health and addiction services.
- Promote engagement in care for those with mental health and substance use issues.
- Provide increased access to mental health treatment/services.

Initiatives

- Host and provide chronic pain, SCI, amputee, cardiac, and stroke support groups and community activities.
- Host and provide adaptive Sports & Fitness programming.
- Engage Sports Medicine Program Athletic Trainers for community safety education, injury prevention trainings, and community events.
- Host Think First bike safety and helmet classes; YMCA programs and classes.
- Host and offer Behavioral Health community education, screenings, support groups, and sponsored events.

Chronic pain



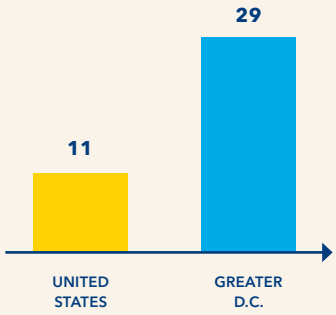
34% of survey respondents indicated that **chronic pain and arthritis** are among the health problems that affect people most in their community.

Injury prevention; wellness and health education for people with disabilities

- 18% of survey respondents indicated that having limited places to exercise is one of the most important issues affecting quality of life in their community.
- The Maryland 2015 Disability Status Report indicates that among people of all ages in Maryland, 5.9% reported an ambulatory disability, 4.6% reported an independent living disability, and 2.2% reported a self-care disability.[34]
- The Virginia 2013 Disability Status Report indicates that among people of all ages in Virginia, 6.1% reported an ambulatory disability, 4.8% reported an independent living disability, and 2.3% reported a self-care disability.[35]
- 20% of adults in the Greater D.C. region report no physical activity.[3,7,17]

Behavioral health and substance use disorders

- Equal proportions of survey respondents (37%) indicated that addiction, substance use, and mental health are among the most important health problems affecting people in their community.
- 31% of survey respondents indicated that addiction is one of the social justice issues affecting their community most.
- The Greater D.C. region reports a drug overdose rate of 40 per 100,000 people.
  - This is much higher than the nationwide rate of 21 per 100,000 people.[10,11]
- The Greater D.C. region has a 210:1 ratio of population to mental health providers , compared to the nationwide ratio of 290:1.[12]
- 27% of adults in the Greater D.C. region report heavy or binge drinking.[5]
  - This is much higher than the nationwide percentage of 13%.



29% of driving deaths in the Greater D.C. region are related to **alcohol impairment**. This is much higher than the nationwide percentage of **11%**.[9]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Health and wellness
- Number of participants
- Number of events
- Number of participants reporting improved pain management

Injury prevention; wellness and health education for people with disabilities
- Number of adaptive sports and fitness classes held; participants; pre/post evaluations
- Number of people served by ATCs
- Number of traumatic injury prevention classes held; participants
- Number of support group sessions held; participants

Behavioral health services

- Number of health education events

Key partners

- Academy of Spinal Cord Professionals
- American Spinal Injury Association
- Brain Injury Association of D.C. (BIADC)
- D.C. Department of Parks & Recreation (DPR)
- DPI Adaptive Fitness
- Maryland–National Capital Park & Planning Commission (M-NCPPC)
- MedStar Capital Iceplex
- Think First
- United Spinal Association
- YMCA of Metropolitan Washington

54% of survey respondents with disabilities in the Greater D.C. area reported knowing someone outside of their family who had been **diagnosed with COVID-19**.*

*Surveys were conducted August-September 2020.

Access to health care and services

Access to quality health care is a key issue for those with disabilities in the Greater D.C. region. For this reason, MedStar NRH prioritized initiatives that expand access to health insurance, medical care, and transportation. These priorities are consistent with D.C. Healthy People objectives (access to health services).

Goals

- Improve and expand community access to comprehensive, quality health care providers and programs, as well as medical and non-medical services.
- Eliminate barriers to accessing health care, including transportation and financial resources; expand community access to medical and non-medical services.
- Improve access to transportation for vulnerable populations related to cost and address the barrier of transportation to medical and health services.
- Support a robust transportation system (public, rideshares, bikes, sidewalks, street safety).

Initiatives

- Host and offer Spinal Cord Injury and Pathway to Primary Care Program.
- Expand access to essential health services through virtual care.
- Provide support to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs.
- Host and provide accessible driving education and support through the MNRH Driving Program.

Access to health insurance

- In 2015, 93.4% of working-age people with disabilities in Maryland had health insurance.[34]
- In 2013, 81.9% of working-age people with disabilities in Virginia had health insurance.[35]
- 76% of survey respondents indicated that cost is one of the most common reasons people in their community do not get health care when they need it. The next most selected reason was no insurance, selected by 48% of respondents.
- 34% of survey respondents indicated that limited access to health insurance is one of the most important issues affecting quality of life in their community.
- In 2015, 70.2% of working-age people in Maryland without disabilities reported that their health insurance coverage was provided by a current or former employer or union (theirs or a family member's). Only 43.6% of working-age people in Maryland with disabilities reported that their health insurance coverage was provided by a current or former employer or union (theirs or a family member's).[34]
- In 2013, 66.6% of working-age people in Virginia without disabilities reported that their health insurance coverage was provided by a current or former employer or union (theirs or a family member's). Only 36.9% of working-age people in Virginia with disabilities reported that their health insurance coverage was provided by a current or former employer or union (theirs or a family member's).[35]

Access to health care professionals

- 62% of survey respondents indicated that the internet is one of their top three sources for health information.
- 21% indicated that worry or discomfort about talking to a healthcare professional was a common reason they don't get care when they need it, and 18% selected fear or mistrust of providers.

Access to transportation

- 25% of survey respondents indicated that limited access to transportation is one of the most important issues affecting quality of life in their community.
- 30% of survey respondents indicated that limited transportation is one of the most common reasons people in their community do not get health care when they need it.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Access to health care professionals

- Number of participants
- Number of programs

Fear/mistrust of providers

- Number of participants trained in cultural competency and implicit bias
- Number of programs
- Number of participants

Access to transportation

- Number of patients served through driving education

Key partners

- MedStar NRH Driving Program
- MetroAccess
- Mobility Works
- Uber Health

Social determinants of health

Racial discrimination and employment were reported as some of the most important issues affecting the quality of life in the Greater D.C. region. For this reason, MedStar NRH prioritized initiatives that promote health equity, employment opportunities, and anti-discrimination education. These priorities are consistent with Community Health Improvement Process objectives (care coordination) and D.C. Healthy People objectives (healthy communities).

Goals

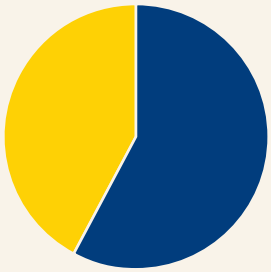
- Improve systemic barriers related to trust in medical providers through training experiences that bridge understanding of vulnerable populations.
- Develop Healthy Communities outreach opportunities; promote "in the field" experiences such as Ask a Doc, volunteers at service agencies, or provide screening opportunities.
- Support social and physical environments that promote good health for all.
- Improve health equity that aims to address social determinants of health, improve health outcomes, and reduce disparities.
- Improve access to job opportunities by deploying strategies to hire local residents and creating more pipelines to increase diversity and remove systemic barriers to entering workforce.

Initiatives

- Expand and host Ask a Doc series.
- Execute system-wide strategy for Equity, Inclusion, and Diversity which focuses on recruitment, retention, and culture change to address the spectrum of discrimination, including race, LGBTQ+, gender, disabilities, etc.
- Develop pipeline of job opportunities through intern and practicum experiences in the field of medicine for high school and college-level students.

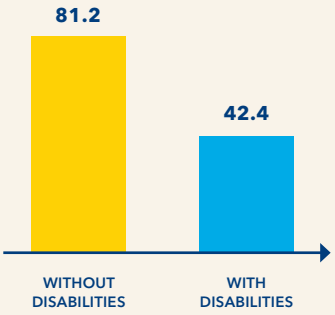
Racial discrimination

58% of survey respondents indicated that **racial inequality** is one of the social justice issues that **affects their community most**.

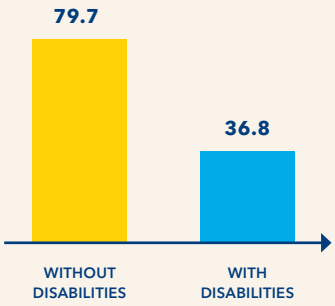


- In 2015, 10.1% of working-age Black people in Maryland reported a disability. The next largest proportion was those who were white, with 8.8% reporting a disability.[34]
- In 2013, 17.1% of working-age people in Virginia who identified as Native American reported a disability. The next largest proportion was those who were Black, with 12.1% reporting a disability.[35]

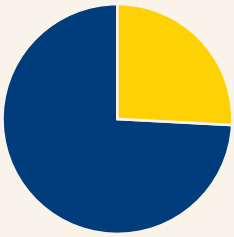
Employment



In 2015, the employment rate for working-age people **without disabilities in Maryland was 81.2%**. The employment rate for working-age people **with disabilities was 42.4%**.[34]

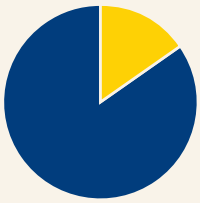


In 2013, the employment rate for working-age people **without disabilities in Virginia was 79.7%**. The employment rate for working-age people **with disabilities was 36.8%**.[35]



26% of survey respondents indicated that a **lack of job opportunities** is one of the most important issues affecting quality of life in their community. **6%** of adults in the Greater D.C. region are unemployed.[23,24]

Out of the six types of disabilities, Maryland's employment rate was **highest for those with a hearing disability, at 60%**. The employment rate was **lowest for those with an independent living disability, at 20.5**%.[34]



Out of the six types of disabilities, Virginia's employment rate was **highest for those with a hearing disability, at 56.4%**. The employment rate was **lowest for those with a self-care disability, at 15.5%**.[35]

- In 2015, 10.2% of working-age people with a disability in Maryland were not working but actively seeking work.[3]
- In 2013, 9.7% of working-age people with a disability in Virginia were not working but actively seeking work.[35]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Employment
- Number of events
- Number of participants

Racial discrimination
- Number of programs
- Number of participants

4,700+
questionnaires were completed systemwide

212
came from MedStar NRH

The 23-question survey was conducted from late August to the end of October 2020.

Survey was distributed in person and online.

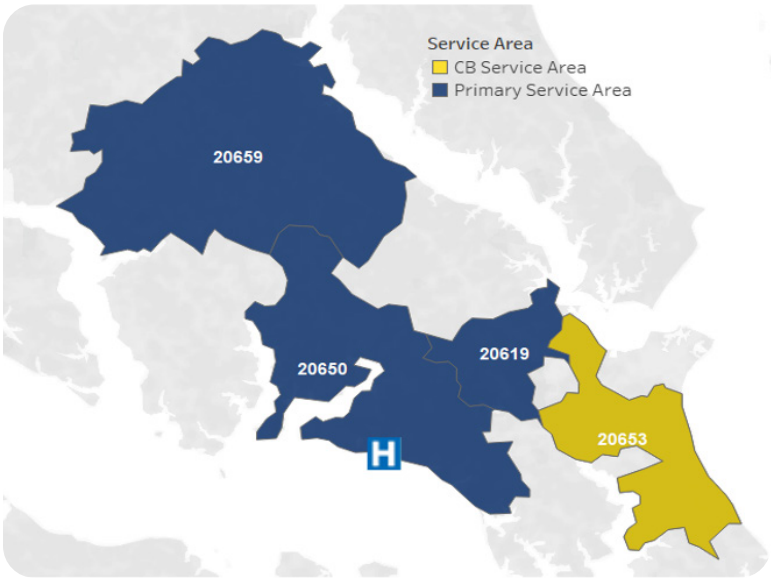
Community Health Needs Assessment

History
Nestled in the waterside community of Leonardtown, MD, MedStar St. Mary's Hospital is a full-service hospital delivering state-of-the-art emergency and acute inpatient and outpatient care.

The community
MedStar St. Mary's has a long history of reaching out to its community for feedback, collectively identifying local health care needs and building partnerships to meet those needs. Our Advisory Task Force Committee is comprised of community residents as well as representatives from the local health department, school system, federally qualified health centers, social service programs, and community and faith-based organizations.

Community Benefit Service Area (CBSA): St. Mary's County, MD
The MedStar St. Mary's CBSA includes residents living in ZIP code 20653. The Lexington Park community was selected based on hospital utilization and secondary public health data.

MedStar St. Mary's Hospital



Identified health needs:

Health and wellness
Turn to page 66 for goals and initiatives

- Chronic disease prevention and management
- Behavioral health: Substance use disorders and mental health

Access to health care and services
Turn to page 69 for goals and initiatives

- Access to affordable health care and insurance
- Transportation

Social determinants of health
Turn to page 70 for goals and initiatives

- Housing and homelessness
- Employment

Demographics

ZIP Code
20653

24,481 Total population[50]

31 Median population by age[50]

30 Male median age[50]

31 Female median age[50]

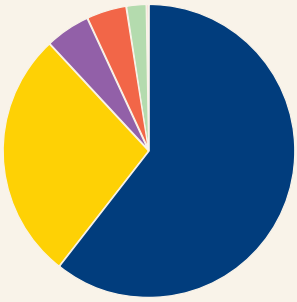
51% Female[50]

49% Male[50]

Educational attainment (those 25+ years)[50]

<High school diploma	**11%**
High school graduate	**50%**
Associate's degree	**7%**
Bachelor's degree	**20%**
Master's degree	**10%**
Professional degree	**1%**
Doctorate degree	**1%**

Race[50]



Average household income in 2018: $63,676[50]

Health and wellness

Chronic disease prevention and management

ZIP code 20653 is above the state and national averages for diabetes deaths. MedStar St. Mary's prioritized initiatives to provide accessible chronic disease prevention, detection, and treatments. These priorities are consistent with Maryland Total Cost of Care priorities (diabetes) and the Maryland State Health Improvement Plan (healthy communities, healthy living, quality preventative care), as well as Healthy St. Mary's Partnership priorities (chronic disease).

Goals

- Reduce overall risk of chronic disease and provide appropriate care by facilitating prevention strategies, affordable care, and educational engagement tools.
- Improve health and quality of life through prevention, detection, and treatment of risk factors for chronic diseases.
- Promote healthy lifestyle through nutrition, wellness, and exercise programs.
- Improve screening rates for diabetes, HbA1c, cancer screenings, BMI, and controlled blood pressure.
- Improve the health and quality of life for those living with diabetes and heart disease while seeking to prevent such chronic conditions through obesity and diabetes prevention.

Initiatives

- Host and provide community diabetes education (CDC Diabetes Prevention Program, Living Well classes, and referrals to MedStar Diabetes Boot Camp).
- Host and offer access to wellness services and education, health screenings, online and in-person risk assessments, and support groups, and actively support local diabetes prevention activities.
- Expand and improve awareness of nutrition and health education programming and support groups in the community.
- Expand and offer Totally Linking Care–Diabetes Prevention Regional Program; offer in-person/ virtual diabetes education, provider education, social needs screenings, and linkages to community resources.

Heart disease and stroke

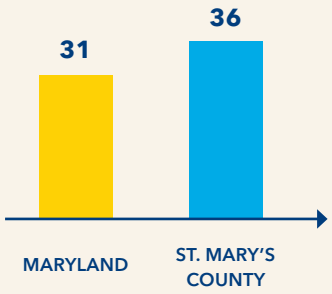
- ZIP code 20653 has a heart disease death rate of 161 per 100,000 people, compared to 164 per 100,000 people statewide, and 165 per 100,000 nationwide.[1]
  - This is above the Healthy People 2020 target goal for heart disease, 103.4 per 100,000 people.[31]
- ZIP code 20653 has a stroke death rate of 30 per 100,000 people, which is below the state and nationwide rates of 40 per 100,000 and 37 per 100,000, respectively.
  - This is below the Healthy People 2020 target goal for stroke deaths, 34.8 per 100,000 people.[1,31]

Cancer

- ZIP code 20653 has a cancer death rate of 165 per 100,000 people, compared to 155 per 100,000 statewide, and 149 per 100,000 nationwide.[2,3,4]

Diabetes and obesity

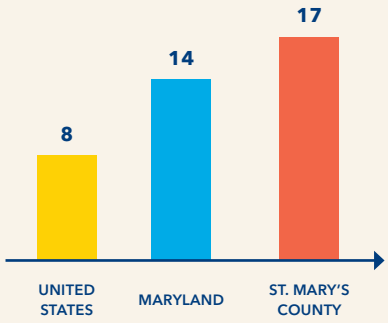
36% of adults in ZIP code 20653 are obese, compared to **31%** of adults statewide.[6,7]



- ZIP code 20653 is above the state and national averages for diabetes deaths, at 38 per 100,000 people, compared to a rate of 20 per 100,000 statewide and 21 per 100,000 nationwide.
  - This is an increase from 2018 in which the rate was 18 per 100,000 people.[11]

Smoking

- 15% of adults in ZIP code 20653 smoke, compared to 14% statewide and nationwide.[5]



17% of adolescents in ZIP code 20653 **use tobacco products**, compared to 14% statewide and 8% nationwide.[3,8]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Chronic disease prevention and management

- Number of participants
- Number of programs
- Number of events

Key partners

- American Cancer Society
- American Diabetes Association
- Centers for Disease Control and Prevention
- Chronic Disease Action Team
- East Run Medical Center
- Healthy St. Mary's Partnership
- Maryland Department of Health
- MedStar Diabetes Institute
- Minority Outreach Coalition
- Sodexo
- St. Mary's College of Maryland
- St. Mary's County Health Department
- Totally Linking Care–Maryland
- University of Maryland Cooperative Extension

Behavioral health and substance use disorders

A majority of MedStar St. Mary's CHNA survey respondents indicated that addiction and substance use disorders affect the quality of life in their community. Additionally, there is a need for mental health support services because St. Mary's County has far fewer mental health providers than the state and nationwide averages. For these reasons, MedStar St. Mary's prioritized initiatives that expand prevention, education, and treatment. These priorities are consistent with Maryland Total Cost of Care priorities (opioids), the Maryland State Health Improvement Plan (quality preventative care), and Healthy St. Mary's Partnership priorities (behavioral health).

Goals

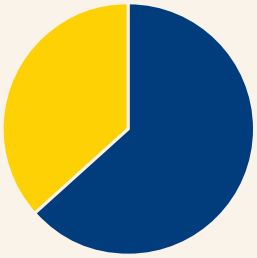
- Reduce stigma about prevention and treatment of behavioral health disorders and addiction-related conditions among priority populations and improve access and referrals to services.
- Improve early identification and referrals of mental health and substance use disorder services.
- Promote engagement in care for those with mental health and substance use issues.

Initiatives

- Conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT) supported by Peer Recovery Coaches and Overdose Survivor Outreach Program (OSOP).
- Support opioid overdose survivors to receive harm reduction tools and connection to treatment.
- Offer Mindoula® care coordination program.
- Support Healthy St. Mary's Partnership behavioral health efforts through the Violence, Injury, and Trauma Action Team.
- Provide smoking cessation programming and referrals to MD Quit Now.
- Host and offer behavioral health community education, screenings, support groups, and sponsor events or walks for behavioral health.
- Plan with partners to expand Medication Assisted Treatment (MAT) services; plan to establish buprenorphine clinic with partners.

Addiction/substance use disorders

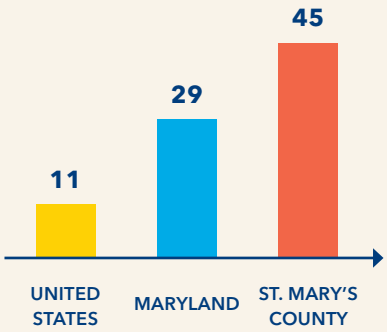
64% of MedStar St. Mary's CHNA survey respondents indicated that **addiction is one of the social justice issues** affecting their community most.



Alcohol

- 19% of adults in ZIP code 20653 report binge drinking, higher than the state and nationwide percentages of 17% and 13%, respectively.[5]

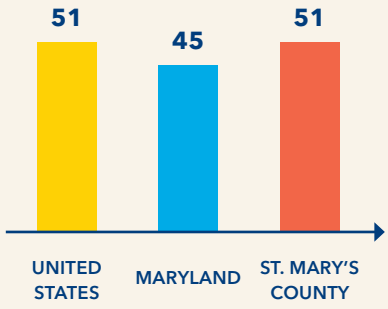
45% of driving deaths in ZIP code 20653 between 2014 and 2018 were **related to alcohol impairment**, compared to 29% statewide and 11% nationwide.[9]



Opioids

- ZIP code 20653 has 28 drug overdose deaths per 100,000 people, compared to 37 per 100,000 people statewide and 21 per 100,000 nationwide.[10,11]

ZIP code 20653 **dispenses 51 opioid prescriptions per 100 people**, equal to the nationwide volume, compared to 45 per 100 people statewide.[10]



Mental health

- ZIP code 20653 has an 870:1 ratio of population to mental health providers, compared to the nationwide ratio of 290:1. The state ratio is 390:1.[12]

48% reported knowing someone outside of their family who had been **diagnosed with COVID-19**.*

*Surveys were conducted August-September 2020.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Substance use disorders and mental health

- Number of SBIRT screenings, referrals and linkages to treatment
- Number of referrals and linkages to treatment and support services
- Number of patients served
- Number of participants enrolled in Mindoula programming

Key partners

- American Foundation for Suicide Prevention
- Healthy St. Mary's Partnership
- Maryland Quit Now
- Mindoula Health, Inc.
- Minority Outreach Coalition
- Mosaic Group
- NAMI Southern Maryland–National Alliance for Mental Illness
- Outlook Recovery
- Project Chesapeake
- Pyramid Walden
- Southern Maryland Continuum of Care Program
- Southern Maryland Tri-County Council
- St. Mary's County Health Department
- St. Mary's County Public Schools

Access to health care and services

Access to quality care and services is a key issue in health care. And at MedStar Health, we strive to make world-class health care convenient and accessible. These priorities are consistent with the Maryland State Health Improvement Plan (access to care).

Goals

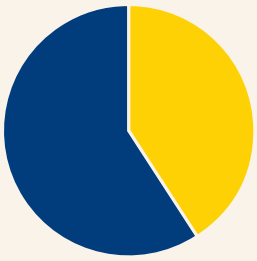
- Improve and expand community access to comprehensive, quality health care providers and programs, as well as medical and non-medical services.
- Support innovative medical care delivery methods designed to lower the costs of health care.
- Eliminate barriers to access health care, including transportation and financial resources, and expand community access to medical and non-medical services.
- Improve access to transportation for medical and health services among individuals who identify transportation as a social unmet need.

Initiatives

- Assist patients in need of insurance through screenings, referrals, and linkage to community resources through hospital-based Patient Financial Advocates, Community Health Workers, and Peer Recovery Coaches.
- Expand services through virtual care.
- Provide access to safety-net dental providers.
- Engage transitional care nurses and Community Health Workers to assist identified patients with finding appropriate primary care providers and specialists in region.
- Provide support to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs.
- Screen patients for transportation barriers in electronic medical record through standardized Social Determinants of Health screening.
- Partner with community providers, including Uber Health and Wheels to Wellness to provide transportation.

Access to health care and insurance

- 94% of adults in ZIP code 20653 have health insurance, compared to 92% statewide and nationwide.[13,14,15,16]
- 46% of survey respondents indicated that their health insurance is provided through their employer.
- 5% of adults in ZIP code 20653 cannot afford to see a doctor, compared to 11% statewide and 13% nationwide.[5,13,17]
- 75% of survey respondents indicated that cost is one of the most common reasons people in their community do not get health care when they need it.



41% of survey respondents indicated that **limited availability or access to doctors** is one of the most important issues affecting quality of life in their community.

Access to transportation

- 4% of the population living in ZIP code 20653 identify as both low income and do not live near a grocery store.[26]
- 29% of survey respondents indicated that limited access to transportation is one of the most important issues that affects quality of life in their community.
- 35% of survey respondents indicated that limited transportation is one of the most common reasons why people in their community do not get health care when they need it.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Access to transportation

- Number of transportation rides facilitated

Access to health care and insurance

- Number of referrals
- Number of participants
- Number of screenings
- Number of uninsured linked to a financial advocate
- Number of events

Key partners

- Department of Aging and Human Services
- Department of Social Services
- Health Partners, Inc.
- MedStar Shah Medical Group
- Minority Outreach Coalition
- St. Mary's County Health Department

Social determinants of health

Employment concerns and housing problems are two of the main issues reported in ZIP code 20653. MedStar St. Mary's prioritized initiatives to provide work opportunities, living wages, and safe, affordable housing. These priorities are consistent with the Maryland State Health Improvement Plan (healthy communities).[38]

Goals

- Advocate for and support social and physical environments that promote good health for all.
- Recognize housing instability and homelessness as a public health issue.
- Support eligible homeless individuals and families receiving health and social services.
- Advocate to improve county response to individuals and families experiencing homelessness.
- Reduce inequities caused by lack of affordable housing and housing conditions by working to promote the intersection of housing and healthcare.
- Improve access to job opportunities by deploying strategies to hire local residents and creating more pipelines to increase diversity and remove systemic barriers to entering workforce.
- Improve cultural competency and racial disparities education to health professionals.
- Promote workforce development and pipeline opportunities with community, schools, and business partners.

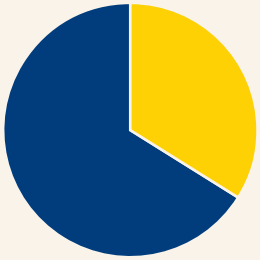
Initiatives

- Support community housing/homelessness initiatives by connecting individuals with local resources through Community Health Workers..
- Develop pipeline of job opportunities through work training programs, intern, and volunteer experiences in the field of medicine for high school and college-level students.
- Execute system-wide Equity, Inclusion, and Diversity strategy which focuses on recruitment, retention, and culture change.
- Provide workforce development for frontline associates in roles of Community Health Workers and Peer Recovery Coaches.

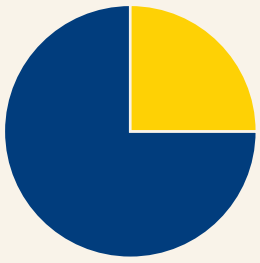
Economics and employment

- 7% of adults in ZIP code 20653 are unemployed. This is slightly higher than the state and nationwide rates of 4%.[23,24]
- 8% of people in ZIP code 20653 live in poverty. This is below the state and nationwide percentages of 9% and 12%, respectively.[14,15,18]
- 24% of survey respondents indicated that the fear of losing their job if time is taken off from work is one of the most common reasons people in their community do not get health care when they need it.
- 32% of adults in ZIP code 20653 have a bachelor's or more advanced degree. This is below the state and nationwide proportions of 40% and 35%, respectively.[15,18,22]

Housing and homelessness



34% of survey respondents indicated that **housing problems/ homelessness** is one of the social justice issues that affects their community most.



25% of survey respondents indicated that **housing inequality** is one of the social justice issues affecting their community most.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Employment

- Number of events
- Number of participants

Housing and homelessness

- Number of patients connected to housing resources

4,700+
questionnaires were completed systemwide

506
came from MedStar St. Mary's

The 23-question survey was conducted from late August to the end of October 2020.

Survey was distributed in person and online.

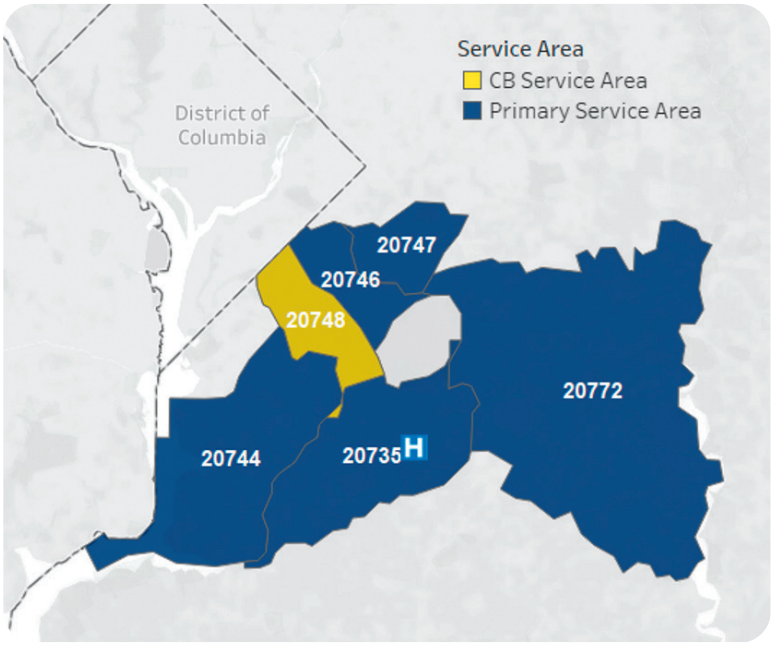
Community Health Needs Assessment

History
MedStar Southern Maryland Hospital Center is a 182 bed, full-service acute care facility with more than 49,000 emergency department visits and nearly 12,000 admissions each year. Investing in talented clinicians, education, and technology allows MedStar Southern Maryland to offer clinical services typically reserved for academic medical centers.

The community
MedStar Southern Maryland has a long history of reaching out to its communities for feedback, collectively identifying local health care needs, and building partnerships to meet those needs. Our Advisory Task Force Committee is comprised of community residents as well as representatives from the local health department, community college, faith-based communities, federally qualified health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): Prince George's County, MD
The MedStar Southern Maryland CBSA includes Prince George's County residents living in ZIP code 20748. This area was selected based on hospital utilization and secondary public health data.

MedStar Southern Maryland Hospital Center



Identified health needs:

Health and wellness
Turn to page 74 for goals and initiatives

Chronic disease prevention and management

Behavioral health: Substance use disorders and mental health

Access to health care and services
Turn to page 77 for goals and initiatives

Access to affordable health care and insurance

Transportation

Social determinants of health
Turn to page 79 for goals and initiatives

Employment

Demographics

ZIP Code
20748

38,792 Total population[51]

38 Median population by age[51]

36 Male median age[51]

40 Female median age[51]

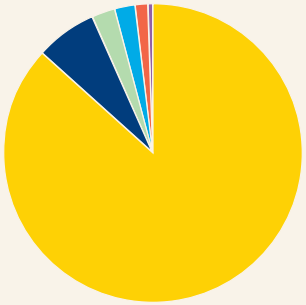
54% Female[51]

46% Male[51]

Educational attainment (those 25+ years)[51]

<High school diploma	**10%**
High school graduate	**63%**
Associate's degree	**6%**
Bachelor's degree	**14%**
Master's degree	**5%**
Professional degree	**<1%**
Doctorate degree	**<1%**

Race[51]



- WHITE (7%)
- BLACK (87%)
- AM. INDIAN OR ALASKAN NATIVE (<1%)
- ASIAN (1%)
- NATIVE HAWAIIAN/ PAC. ISLANDER (0%)
- OTHER RACES (3%)
- TWO OR MORE RACES (2%)

Average household income in 2018: $51,396[51]

Health and wellness

Chronic disease prevention and management

A majority of MedStar Southern Maryland CHNA survey respondents reported that diabetes and high blood sugar greatly affect people in their community. For this reason, MedStar Southern Maryland prioritized strategies to reduce diabetes risks and provide prevention and treatment for diabetes and other chronic diseases. These priorities are consistent with Maryland Total Cost of Care priorities (diabetes) and the Maryland State Health Improvement Plan (healthy communities, healthy living, quality preventative care).

Goals

- Reduce overall risk of chronic disease, especially diabetes; provide appropriate care by facilitating prevention strategies, affordable care, and educational engagement tools.
- Improve screening rates for diabetes, HbA1c, cancer, BMI, and uncontrolled blood pressure.
- Improve health and quality of life through prevention, access to fresh, nutritious food, and environments that promote good health, wellness and active living.

Initiatives

- Host and provide access to wellness services and education, screenings, online risk assessments, and support groups, and be active in supporting local prevention activities.
- Expand and offer Totally Linking Care—Diabetes Prevention Regional Program; offer in-person/virtual diabetes education, provider education, social needs screenings, and linkages to community resources.
- Increase presence among Spanish-speaking population by offering bilingual health education programming.
- Partner to support access to and use of fresh, healthy foods with local farmers markets, food distributions, health education, and food preparation demonstrations.
- Improve awareness of prediabetes and gestational diabetes and implement practice mechanisms to assure referral of patients to interventions.
- Host and offer senior wellness and screening programs.
- Improve care and well-being through screenings, fall prevention, Walk with Ease, and educational programs.
- Link community with cancer support and prevention services and improve quality of life for those living with cancer.

Heart disease and stroke

- ZIP code 20748 has a heart disease death rate of 168 per 100,000 people, compared to 164 per 100,000 people statewide and 165 per 100,000 nationwide.[1]
  - This is above the Healthy People 2020 target goal for heart disease, 103.4 per 100,000 people.[31]
- ZIP code 20748 has a stroke death rate of 44 per 100,000 people, which is above the state and nationwide rates of 40 per 100,000 and 37 per 100,000, respectively.[1]
  - This is above the Healthy People 2020 target goal for stroke deaths, 34.8 per 100,000 people.[31]

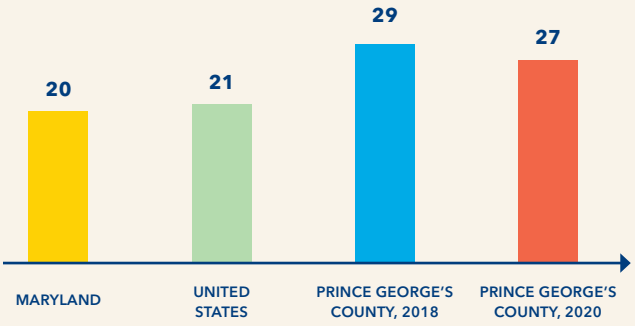
Cancer

- ZIP code 20748 has a cancer death rate of 158 per 100,000 people, compared to 155 per 100,000 statewide and 149 per 100,000 nationwide.[2,3,4]

Diabetes and obesity

- 37% of adults in ZIP code 20748 are obese, compared to 31% of adults statewide and 42% nationwide.[6,7]

72% of survey respondents indicated that **diabetes/high blood sugar** is one of the health problems that affects people in their community most.



ZIP code 20748 is **above the state and national average for diabetes deaths**, at **27 per 100,000 people**, compared to a rate of 20 per 100,000 statewide and 21 per 100,000 nationwide. However, this is a **decrease from 2018**, in which the rate was 29 per 100,000 people.[11]

Smoking

- 12% of adults in ZIP code 20748 smoke, compared to 14% statewide and nationwide.[5]
- 11% of adolescents in ZIP code 20748 use tobacco products, compared to 14% statewide and 8% nationwide.[3,8]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Chronic disease prevention and management

- Number of programs
- Number of attendees
- Number of outreach events
- Number of screenings

Diabetes

- Number of programs
- Number of attendees
- Number of outreach events
- Number of screenings
- Number of referrals and linkages to resources

Key partners

- American Cancer Society
- American Diabetes Association
- Arthritis Foundation
- Beth Shalom AME Church
- Capital Area Food Bank
- Centers for Disease Control and Prevention
- Charles County Health Department
- D. Leonard Health Center-Clinton
- Food & Friends
- Giant Foods
- HEAL workgroup
- Hope Connections
- Meals on Wheels of Central Maryland
- MedStar Cancer Network
- MedStar Diabetes Institute
- Other faith-based organizations
- Prince George's Health Action Coalition
- Prince George's County Health Department
- Quitline
- Sodexo
- Totally Linking Care Maryland
- YMCA Prince George's County

51% reported knowing someone outside of their family who had been **diagnosed with COVID-19**.*

*Surveys were conducted August-September 2020.

Behavioral health and substance use disorders

Residents in ZIP code 20748 indicated a need for more accessible prevention and treatment of mental health and substance use disorders. For this reason, MedStar Southern Maryland prioritized initiatives that focus on improving and expanding access to mental health and substance use disorder services. These priorities are consistent with Maryland Total Cost of Care priorities (opioids) and the Maryland State Health Improvement Plan (quality preventative care).

Goals

- Reduce stigma about prevention and treatment of behavioral health disorders and addiction-related conditions among priority populations.
- Improve early identification and referrals of mental health and substance use disorder services.
- Ensure access to quality behavioral health and substance use disorder services.

Initiatives

- Provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) with support of Peer Recovery Coaches in ER and women's services sites.
- Provide Overdose Survivor Outreach Program (OSOP), allowing for overdose survivors to receive harm reduction tools and connection to treatment.
- Offer Mindoula® care coordination program.
- Be a leader and participant in the Totally Linking Care Behavioral Health Crisis Service by centralizing the crisis service ecosystem and expanding mobile crisis delivery and same-day access services.
- Host and offer behavioral health community education, overdose prevention, and support groups and sponsor events or walks.

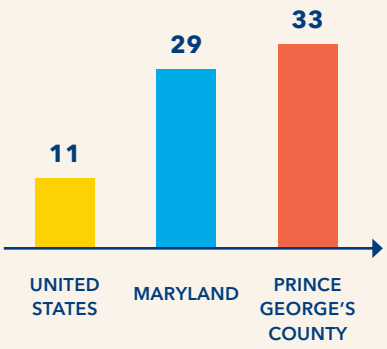
Addiction/substance use disorders

- 30% of MedStar Southern Maryland CHNA survey respondents indicated that addiction and substance use disorders affect quality of life in their community.
- 36% of MedStar Southern Maryland CHNA survey respondents indicated that addiction is one of the social justice issues affecting their community most.

Alcohol

- 14% of adults in ZIP code 20748 report binge drinking, lower than the state percentage of 17% and just above the nationwide percentage of 13%.[5]

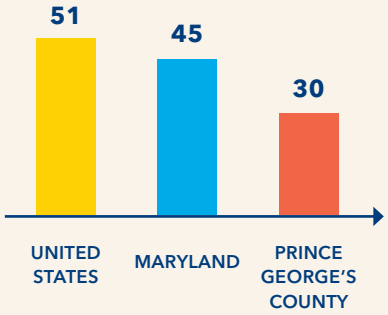
33% of driving deaths in ZIP code 20748 between 2014 and 2018 were **related to alcohol impairment**, compared to 29% statewide and 11% nationwide.[9]



Opioids

- ZIP code 20748 has 16 drug overdose deaths per 100,000 people compared to 37 per 100,000 people statewide and 21 per 100,000 nationwide.[10,11]

ZIP code 20748 dispenses **30 opioid prescriptions per 100 people**, below the state and nationwide volumes of 45 per 100 people and 51 per 100 people, respectively.[10]



Mental health

1 in 5 adults in America experience a mental illness. This is equal to about **140,000 Prince George's County residents**.[55]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Substance use disorders and mental health

- Number of SBIRT screenings, referrals, and linkages to treatment
- Number of referrals and linkages to treatment and support services
- Number of participants enrolled in smoking cessation and Overdose Survivor Outreach

Key partners

- Behavioral Health Administration
- Bridging the Gap
- Diamond Healthcare
- Hope Connections
- Hope House
- Mindoula
- Mosaic Group
- NAMI Southern Maryland–National Alliance for Mental Illness
- Faith-based organizations
- VIT (Violence, Injury, and Trauma) action teams

Access to health care and services

MedStar Southern Maryland CHNA survey respondents indicated that health care costs and limited access to insurance prevent people from getting the care they need and affect quality of life. For these reasons, MedStar Southern Maryland prioritized initiatives that improve access to care and contribute to lower health care costs. These priorities are consistent with the Maryland State Health Improvement Plan (access to care).[38]

Goals

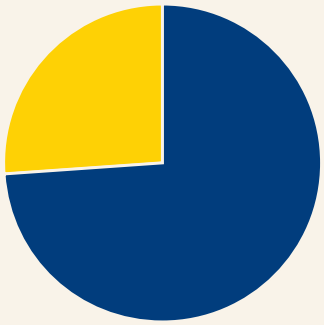
- Improve and expand community access to comprehensive, quality health care providers and programs, as well as medical and non-medical services.
- Eliminate barriers to health care access, including transportation and financial resources; expand community access to medical and non-medical services.
- Address the barrier of transportation to medical and health services among individuals who identify transportation as an unmet social need.

Initiatives

- Assist patients in need of insurance through screenings, referrals, and linkage to community resources through hospital-based Community Health Workers, Navigators, and Peer Recovery Coaches.
- Provide support to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs.
- Expand services through virtual care.
- Screen patients for transportation barriers in electronic medical records through standardized SDOH screening.
- Partner with Uber Health to provide transportation.

Access to affordable health care and insurance

- 30% of survey respondents indicated that limited access to a doctor's office is one of the most important issues affecting quality of life in their community.
- 27% of survey respondents indicated that mistrust of providers is one of the most common reasons people in their community do not get health care when they need it.
- 86% of adults in ZIP code 20748 have health insurance, compared to 92% statewide and nationwide.[13,14,15,16]
- 97% of children in ZIP code 20748 have health insurance. This is equal to the statewide proportion and just above the nationwide proportion of 95%.[15,16]
- 60% of survey respondents indicated that their health insurance is provided through their employer.
- 15% of adults in ZIP code 20748 cannot afford to see a doctor, compared to 11% statewide and 13% nationwide.[5,13,17]



74% of survey respondents indicated that **cost** is one of the most common reasons people in their community **do not get health care when they need it**. No insurance was the next most common reason.

Survey respondents selected **limited access to health insurance as the most important issue** affecting quality of life in their communities.

- 38% of respondents indicated that limited access to health care is one of the social justice issues affecting their community most.

Access to transportation

- 27% of survey respondents indicated that limited access to transportation is one of the most important issues that affect quality of life in their community.
- 30% of survey respondents indicated that limited transportation is one of the most common reasons why people in their community do not get health care when they need it.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Access to affordable health care and insurance

- Number of screenings, referrals, linkage to resources
- Number of participants

Access to transportation

- Number of transportation rides facilitated

Key partners

- HealthCare Access Maryland
- Maryland Medicaid Organizations
- Maryland Health Benefit Exchange
- Metro Access
- Prince George's County Healthcare Action Coalition
- Prince George's County Health Department
- Uber Health

Social determinants of health

Prince George's County indicated a need for additional local employment opportunities. For this reason, MedStar Southern Maryland prioritized initiatives that provide work experience to community members.

Goals

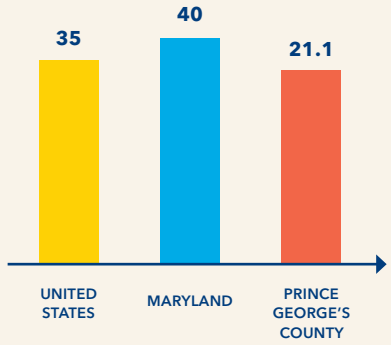
- Improve access to job opportunities by deploying strategies to hire local residents and creating more pipelines to increase diversity and remove systemic barriers to entering the workforce.
- Improve cultural competency and racial disparities education/trainings to health professionals.

Initiatives

- Implement pipeline of job opportunities through intern and practicum experiences in medicine for high school and college-level students.
- Execute on system-wide Equity, Inclusion, and Diversity strategy.
- Support pipeline opportunities to provide health care work experience and networking opportunities for health care professionals in training.

Economics and employment

- 8% of people in ZIP code 20748 live in poverty. This is below the state and nationwide percentages of 9% and 12%, respectively.[14,15,18]
- 22% of survey respondents indicated that the fear of losing their job if time is taken off from work is one of the most common reasons people in their community do not get health care when they need it.
- 90% of adults in ZIP code 20748 have a high school diploma or more. This is nearly equal to the state and nationwide proportions of 91% and 90%, respectively.[15,21]



21.1% of adults in ZIP code 20748 have a **bachelor's or more advanced degree**. This is below the state and nationwide proportions of 40% and 35%, respectively.[15,18,22]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Employment

- Number of events
- Number of participants

4,700+
questionnaires were completed systemwide

317
came from MedStar Southern Maryland

The 23-question survey was conducted from late August to the end of October 2020.

Survey was distributed in person and online.

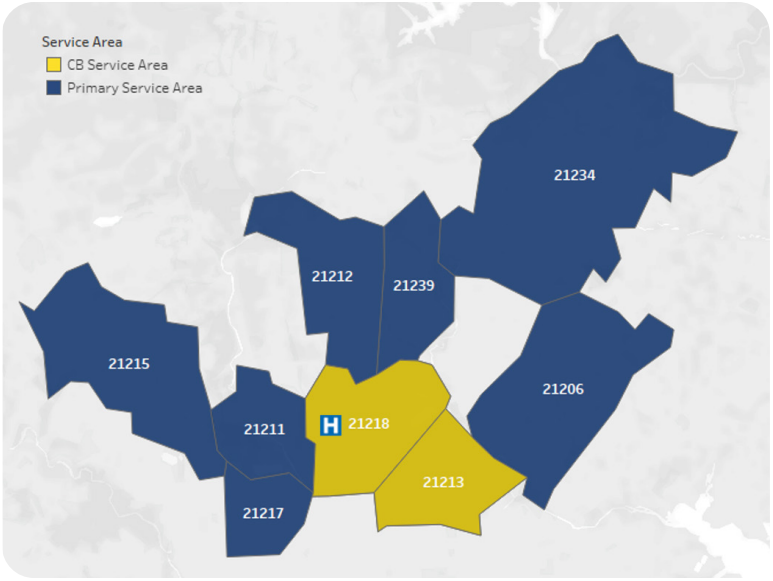
Community Health Needs Assessment

MedStar Union Memorial Hospital

History
MedStar Union Memorial Hospital is a not-for-profit, 223-bed acute care teaching hospital with a strong emphasis on cardiac care, orthopedics, and sports medicine. As one of the region's top specialty hospitals, MedStar Union Memorial has been caring for members of the community for more than 160 years.

The community
MedStar Union Memorial has a long history of reaching out to its communities for feedback, collectively identifying local health care needs and building partnerships to meet those needs. Our Advisory Task Force Committee is comprised of community residents as well as representatives from the local health department, universities, federally qualified health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): Baltimore City, MD
The MedStar Union Memorial CBSA includes residents living in ZIP codes 21213 and 21218. This geographic area was selected based on hospital utilization and secondary public health data as well as its close proximity to the hospital, coupled with a high density of low-income residents, high rates of chronic disease prevalence, and hospital utilization information.



Identified health needs:

Health and wellness
Turn to page 82 for goals and initiatives

- Chronic disease prevention and management
- Behavioral health: Substance use disorders and mental health
- Aging and older adult health

Access to health care and services
Turn to page 85 for goals and initiatives

- Access to affordable health care and insurance
- Transportation

Social determinants of health
Turn to page 87 for goals and initiatives

- Neighborhood safety and community violence
- Employment
- Food insecurity

Demographics

ZIP Code 21213

32,733 Total population[52]

36 Median population by age[52]

32 Male median age[52]

38 Female median age[52]

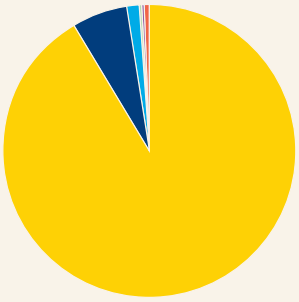
55% Female[52]

45% Male[52]

Educational attainment (those 25+ years)[52]

<High school diploma	**22%**
High school graduate	**63%**
Associate's degree	**4%**
Bachelor's degree	**7%**
Master's degree	**3%**
Professional degree	**<1%**
Doctorate degree	**<1%**

Race[52]



Average household income in 2018: $34,258[52]

ZIP Code 21218

49,796 Total population[53]

33 Median population by age[53]

32 Male median age[53]

34 Female median age[53]

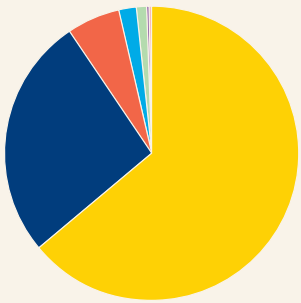
52% Female[53]

48% Male[53]

Educational attainment (those 25+ years)[53]

<High school diploma	**16%**
High school graduate	**48%**
Associate's degree	**5%**
Bachelor's degree	**15%**
Master's degree	**10%**
Professional degree	**4%**
Doctorate degree	**3%**

Race[53]



Average household income in 2018: $64,610[53]

Health and wellness

Chronic disease prevention and management

Several chronic diseases, such as heart disease, stroke, and cancer are prevalent among Baltimore City residents. To address these health issues, MedStar Union Memorial Hospital prioritized measures to prevent, detect, and treat chronic diseases and empower communities to choose healthy behaviors. These priorities are consistent with Maryland Total Cost of Care priorities (diabetes), the Maryland State Health Improvement Plan (healthy communities, healthy living, quality preventative care), and Healthy Baltimore 2020 priorities (chronic disease prevention).

Goals

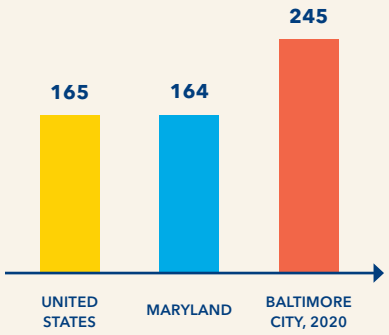
- Improve the health and quality of life for those living with diabetes and heart disease while seeking to prevent such chronic conditions through obesity and diabetes prevention.
- Improve screening rates for diabetes, HbA1c, cancer, BMI, and uncontrolled blood pressure.
- Reduce overall risk of chronic diseases and provide appropriate care by facilitating prevention strategies, affordable care, access to healthy foods, and educational tools.

Initiatives

- Host and provide diabetes prevention education.
- Host and provide access to wellness services and education.
- Participate in and/or lead local heart disease community activities and provide community education.
- Develop and launch Food Rx program to provide nutrition education, lifestyle change classes, and access to fresh, healthy foods.
- Improve awareness of prediabetes and gestational diabetes; implement practice mechanisms to assure patients' referral to interventions through MedStar Diabetes Institute.

Heart disease and stroke

Baltimore City has a heart disease death rate of 245 per 100,000 people. This is worse than the state and nationwide rates of 164 per 100,000 people and 165 per 100,000 people.[1]



- Baltimore City has a stroke death rate of 54 per 100,000 people.[1]
  - This is worse than the state and nationwide rates of 40 per 100,000 people and 37 per 100,000 people, respectively.
  - The Healthy People target stroke death rate is 34.8 per 100,000 people.[31]

Cancer

- Baltimore City has a cancer death rate of 202 per 100,000 people.[2,3,4]
- This is worse than the state and nationwide rates of 155 per 100,000 people and 149 per 100,000 people, respectively.[2,3,4]
- However, this is an improvement from the 2018 rate of 228 per 100,000 people.
- The Healthy People target cancer death rate is 153 per 100,000 people.[31]

Diabetes and obesity

- 35% of adults in Baltimore City are obese, slightly more than the statewide percentage of 31%.[6,7]
- This is better than the nationwide percentage of 42%. However, it is worse than the Healthy People 2020 target of 31%.[6,7,31]
- Baltimore City has a diabetes-related death rate of 34 per 100,000 people.[11]
- This is worse than the state and nationwide rates of 20 per 100,000 people and 21 per 100,000 people, respectively.[11]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Chronic disease prevention and management
- Number of participants enrolled in diabetes educational and clinical initiatives
- Number of participants at wellness events
- Number of participants served through Food Rx program
- Number of patients served at Collaborative Care Center
- Number of referrals

Aging and older adult health

MedStar Union Memorial is committed to honoring the dignity and well-being of older adults in Baltimore City. We're prioritizing initiatives that promote healthy, successful aging.

Goals

- Promote healthy aging.
- Improve health and quality of life through prevention, detection, and treatment of risk factors for chronic diseases.
- Improve access to senior health care services.

Initiatives

- Serve as a regional hub of clinical services through MedStar Center for Successful Aging and the MedStar House Call program.
- Partner with local hospital skilled nursing facilities to improve transitions of care and quality between hospital and nursing home community.
- Host and provide wellness services, fall prevention, smoking cessation, and other health offerings to seniors.

Older adult health
- 27% of older adults in Baltimore City report no physical activity.[6,7]

Aging
- 17% of survey respondents indicated that aging and older adult issues affect people in their community.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

- Number of patients served
- Number of participants enrolled in senior wellness service
- Number of programs

Key partners

- Baltimore City Department of Aging
- Baltimore City Health Department
- Enoch Pratt Libraries
- GEDCO
- Hampden Family Center
- Joy Wellness Center
- Keswick Wise and Well
- Maryland Medicaid
- Maryland Department of Health
- MedStar Center for Successful Aging
- MedStar House Call program
- Weinberg YMCA

Behavioral health and substance use disorders

Addiction and substance use disorders were reported as the top concern of MedStar Union Memorial CHNA survey respondents. For this reason, MedStar Union Memorial developed initiatives to expand resources, education, and programming that seeks to reduce harmful behaviors. These priorities are consistent with Maryland Total Cost of Care priorities (opioids) and Healthy Baltimore 2020 priorities (behavioral health).[38,39]

Goals

- Reduce stigma about prevention and treatment of behavioral health disorders and addiction-related conditions among priority populations.
- Improve early identification, access, and referrals of mental health and addiction services.
- Promote engagement in care for those with mental health and substance use disorders.
- Improve behavioral health, including mental health and substance use disorder services, by expanding access and serving as a leader in addressing the opioid epidemic.

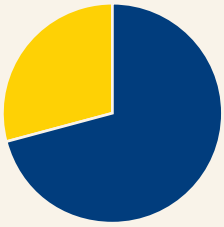
Initiatives

- Conduct Screening, Brief Intervention, Referral to Treatment (SBIRT) in ER and ambulatory sites supported by Peer Recovery Coaches.
- Conduct Opioid Survivor Outreach Program, allowing opioid overdose survivors to receive harm reduction tools and connection to treatment.
- Serve as a health hub for behavioral health resources, education, overdose preventions, and peer-to-peer support.
- Provide in-person and/or virtual smoking cessation programming.
- Engage as a member of Greater Baltimore Regional Integrated Crisis to expand mental health and crisis services.

Addiction/substance use disorders

- 53% of Baltimore City survey respondents indicated that addiction and substance use affect people in their community.

71% of survey respondents indicated that **addiction** is one of the social justice issues that **affects their community most**.



- 20% of adults in Baltimore City currently smoke, compared to 14% nationwide.[5]

Did you know: **19% of adolescents in Baltimore City use tobacco products**, compared to 14% in the state of Maryland and 8% nationwide. [3,8]

Alcohol

- 19% of adults in Baltimore City report binge drinking. This is worse than the state and nationwide percentages of 17% and 13%, respectively.[5]
- 17% of deaths in Baltimore City between 2014-2018 were related to alcohol impairment. This is worse than the nationwide percentage of 11%.[9]

Opioids

Baltimore City has **94 drug overdose deaths** per 100,000 people.[10,11]

- This is significantly worse than the state and nationwide rates of 37 per 100,000 people and 21 per 100,000, respectively.[10,11]
- There are 42 opioid prescriptions dispensed per 100 people in Baltimore City, lower than the nationwide rate of 51 per 100 people.[10]

Key partners

- American Cancer Society
- Behavioral Health Systems of Baltimore
- Greater Baltimore Regional Integrated Crisis Services (GBRICS)
- Maryland Quit Now
- MedMark Treatment Centers
- Mosaic Group
- NAMI Metropolitan Baltimore–National Alliance for Mental Illness
- Powell Recovery
- Tuerk House, Inc
- Turnaround Tuesday

59% of survey respondents in ZIP codes 21213 and 21218 reported that they **didn't know anyone personally** who had been diagnosed with COVID-19. However, **50%** of respondents reported **needing food assistance** due to COVID-19, and **20%** reported **needing financial assistance**.*

*Surveys were conducted August-September 2020.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

- Number of SBIRT screenings, referrals, and linkages to treatment
- Number of referrals and linkages to treatment and support services
- Participants in smoking cessation program

Access to health care and services

Cost is reported as one of the most common reasons people in Baltimore City do not get health care when they need it. For this reason, MedStar Union Memorial prioritized initiatives to expand health, transportation, and other services to patients in need. These priorities are consistent with Maryland Total Cost of Care priorities (access to health care) and Healthy Baltimore 2020 priorities (life course and core services).[38,39]

Goals

- Improve and expand community access to comprehensive, quality health care providers and programs, as well as medical and non-medical services.
- Support innovative medical care delivery methods designed to lower costs.
- Eradicate barriers to accessing health care, including transportation and financial resources.
- Address transportation barriers to medical and health services among individuals who identify transportation as an unmet social need.
- Support a robust transportation system (public, rideshares, bikes, sidewalks, street safety).

Initiatives

- Assist patients in need of insurance through screenings, referrals, and linkage to community resources through hospital-based Community Health Workers, Navigators, and Peer Recovery Coaches.
- Provide medical and non-medical services, testing the intersection of health and housing through partnership at the J. Van Story Health and Wellness Hub.
- Provide support to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs, including those without U.S. documentation status.
- Continue strategic, legacy partnership with Shepherd's Clinic and Joy Wellness Center to expand access to primary care and behavioral health services for the uninsured and underinsured.
- Expand services through virtual care.
- Participate in legislative advocacy to improve public health transportation system in Baltimore City.
- Screen patients for transportation needs, partner with Uber Health, and offer vouchers/tokens to provide transportation to patients without adequate financial resources.

Access to health care and services

- 91% of adults in Baltimore City have health insurance, almost equal to the state and nationwide percentages.[14,16]
- 62% of Baltimore City survey respondents said their health insurance is provided through their employer. Medicare or Medicare supplement and Medicaid were the next highest proportions.

80% of Baltimore City survey respondents indicated that **cost is one of the most common reasons people in their community do not get care when they need** it. **71%** selected **no insurance** as one of the most common reasons.

Did you know: **45%** of the Baltimore City population is **enrolled in the Medicaid/CHIP program**. This is **much higher** than the state and nationwide percentages of 18% and 21%, respectively.[4,30]

- The HIV prevalence in Baltimore City is 2,151 per 100,000 people, compared to 643 per 100,000 statewide and 428 per 100,000 people nationwide.[28,29]

Access to transportation

- 25% of survey respondents indicated that limited access to transportation is one of the most important issues that affects quality of life in their community.
- 30% of survey respondents indicated that limited transportation is one of the main reasons people in their community do not get health care when they need it.

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Access to affordable health care and insurance

- Number of screenings completed
- Number of patients connected to specialty services
- Number of SDOH connections
- Number of participants served at Joy Wellness Center programs

Access to transportation

- Number of transportation rides facilitated

Key partners

- Aunt Bertha
- Baltimore City Health Department
- Baltimore City transit system
- Central Baltimore Partnership
- HealthCare Access Maryland
- J Van Story Health and Wellness Hub
- Johns Hopkins Medicine
- Joy Wellness Center
- Keswick Wise and Well
- Maryland Department of Transportation
- Shepherd's Clinic
- Sheppard Pratt
- Uber Health
- United Way of Central Maryland

Social determinants of health

Baltimore City residents reported that addiction, racial inequality, poverty, food insecurity, and violence are some of the issues that affect the quality of life in their communities the most. For these reasons, MedStar Union Memorial prioritized initiatives that address these concerns through community-based screenings, support, opportunities, advocacy, and more. These priorities are consistent with the Maryland State Health Improvement Plan (healthy communities) and Healthy Baltimore 2020 priorities (life course and core services).[38,39]

Goals

- Reduce inequities caused by lack of access to food by promoting expansion of food access.
- Improve employment access by deploying strategies to hire local residents, create more pipelines to increase diversity, and remove systemic barriers to entering workforce.
- Improve cultural competency and racial disparities education/training to health professionals.
- Recognize and support crime reduction programs.
- Support Safe Streets/Community Violence Intervention Teams.
- Reduce community violence through community partnerships and employing a trauma-informed approach to care.

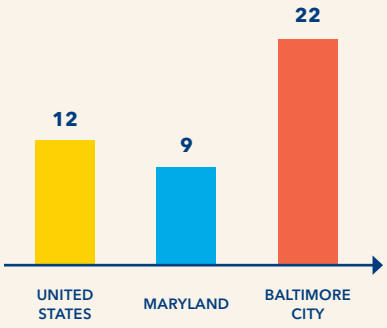
Initiatives

- Continue screening patients for food insecurity and provide fresh produce prescriptions; focus on long-term sustainability for food access to community-based partners.
- Develop and launch a Food Rx program.
- Participate in coalitions, support and provide referrals for medically tailored meals, seek evidence-based programs, offer nutrition counseling, and advocate for policy change.
- Develop job opportunities through intern and practicum experiences in medicine for high school and college level students.
- Execute system-wide strategy for Equity, Inclusion, and Diversity, focusing on recruitment, retention, and culture change to address the spectrum of discrimination, including race, LGBTQ+, gender, disabilities, etc.
- Provide additional workforce development training to frontline staff.
- Through Baltimore JOBS, continue workforce development programs to employ Peer Recovery Coaches and Community Health Workers; implement career ladder opportunities.
- Partner with Safe Streets; connect victims and perpetrators of violence to wrap-around services through a trauma-informed care approach.
- Participate in violence prevention advocacy and community events to reduce neighborhood violence.
- Develop and launch trauma-informed care delivery training for frontline ER clinicians.

Food insecurity
- 21% of households in Baltimore City experience food insecurity. This is below the state and nationwide proportions.[26,27]
- 16% of households with children in Baltimore City experience food insecurity. This is equal to the statewide proportion.[26,27]
- 32% of households with children in Baltimore City receive public assistance or SNAP benefits.[15]
- 47% of children enrolled in public school in Baltimore City are eligible for free or reduced lunch.[32]

Economics and employment
- 5% of adults in Baltimore City are unemployed, higher than the state and nationwide rates of 4%.[23,24]

22% of people in Baltimore City live in poverty. This is **above the state and nationwide percentages** of 9% and 12%, respectively.[14,18]



- 70% of adults in Baltimore City have a high school diploma or more. This is below the state and nationwide proportions of 91% and 90%, respectively.[15,21]
- 31% of adults in Baltimore City have a bachelor's or more advanced degree. This is below the state and nationwide proportions of 40% and 35%, respectively.[18,22]

Community safety and violence
- 55% of survey respondents indicated that violence is one of the health problems affecting their community most.
- 53% of survey respondents indicated that neighborhood safety and community violence are some of the most important issues impacting quality of life in their community.
- 38% of survey respondents answered "Not at all" when asked if their law enforcement agency is responsive to the concerns of their community.
- 34% of respondents described their personal experience with law enforcement as "bad."

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

Food insecurity
- Number of food insecurity screenings completed
- Number of participants in Food Rx program
- Number of patients served

Employment
- Number of students served, enrolled
- Number of Equity, Inclusion, and Diversity trainings offered

Violence
- Number of Safe Streets participants
- Number of trauma-informed care delivery training participants

Key partners

- Baltimore Alliance Healthcare Careers
- Baltimore City Office of Food Planning
- Baltimore City Police Department
- Cristo Rey
- HealthCare Access Maryland
- Hungry Harvest
- Maryland Food Bank
- Meals on Wheels of Central Maryland
- Mercy High School
- Morgan State University
- Moveable Feast
- Safe Streets
- Vivien T. Thomas Medical Arts Academy

4,700+
questionnaires were completed systemwide

456
came from MedStar Union Memorial

The 23-question survey was conducted from late August to the end of October 2020.

Survey was distributed in person and online.

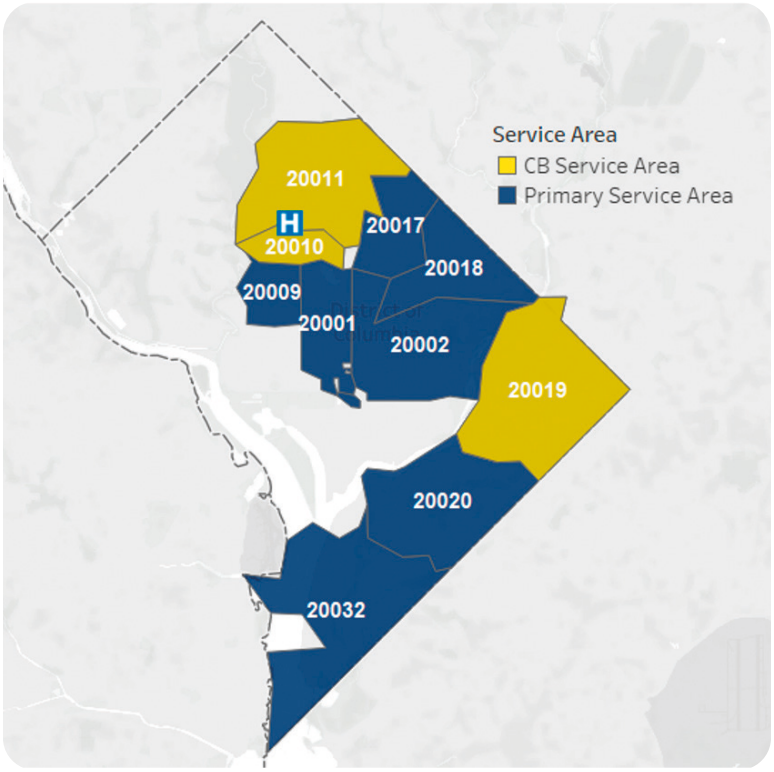
Community Health Needs Assessment

History
MedStar Washington Hospital Center is a not-for-profit, 912-bed academic medical center in the center of the nation's capital. It is the busiest and largest hospital in Washington, D.C. and the surrounding area—and serves as a referral center and the central hub for the region's most advanced acute medical care. In 2019 alone, nearly 444,000 inpatients and outpatients walked through its doors.

The community
MedStar Washington has a long history of reaching out to its communities for feedback, collectively identifying local health care needs, and building partnerships to meet those needs. Our Advisory Task Force (ATF) Committee is comprised of community residents as well as representatives from local health departments, universities, federally qualified health centers, social service programs, and community-based organizations.

Community Benefit Service Area (CBSA): Washington, D.C.
MedStar Washington's CBSA includes residents living in ZIP codes 20011, 20010, and 20019. This geographic area was selected as MedStar Washington's CBSA based on hospital utilization data and secondary public health data, as well as its proximity to the hospital and an opportunity to build upon longstanding programs and services.

MedStar Washington Hospital Center



Identified health needs:

Health and wellness
Turn to page 91 for goals and initiatives

- Chronic disease prevention and management
- Behavioral health: Substance use disorders and mental health

Access to health care and services
Turn to page 94 for goals and initiatives

- Access to affordable health care and insurance
- Transportation
- Fear/mistrust of providers

Social determinants of health
Turn to page 96 for goals and initiatives

- Housing and homelessness
- Food insecurity

Demographics

ZIP Code 20011

58,536 Total population[43]

39 Median population by age[43]

37 Male median age[43]

40 Female median age[43]

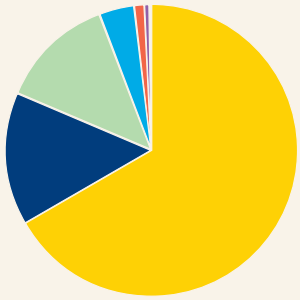
53% Female[43]

47% Male[43]

Educational attainment (those 25+ years)[43]

<High school diploma	**16%**
High school graduate	**46%**
Associate's degree	**4%**
Bachelor's degree	**18%**
Master's degree	**11%**
Professional degree	**4%**
Doctorate degree	**2%**

Race[43]



Average household income in 2018: $67,645[43]

ZIP Code 20010

30,138 Total population[54]

32 Median population by age[54]

32 Male median age[54]

32 Female median age[54]

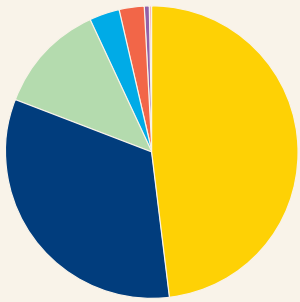
52% Female[54]

48% Male[54]

Educational attainment (those 25+ years)[54]

<High school diploma	**18%**
High school graduate	**28%**
Associate's degree	**2%**
Bachelor's degree	**24%**
Master's degree	**19%**
Professional degree	**6%**
Doctorate degree	**3%**

Race[54]



Average household income in 2018: $73,560[54]

ZIP Code
20019

54,358 Total population[45]

35 Median population by age[45]

32 Male median age[45]

38 Female median age[45]

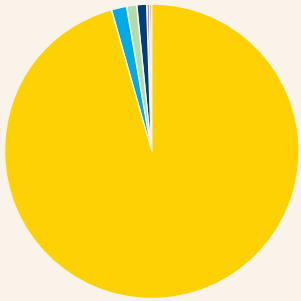
56% Female[45]

44% Male[45]

Educational attainment (those 25+ years)[45]

<High school diploma	**19%**
High school graduate	**63%**
Associate's degree	**4%**
Bachelor's degree	**8%**
Master's degree	**5%**
Professional degree	**<1%**
Doctorate degree	**<1%**

Race[45]



Average household income in 2018: $40,554[45]

Health and wellness

Chronic disease prevention and management

The communities surrounding MedStar Washington have higher death rates for heart disease and cancer compared to nationwide. For this reason, MedStar Washington prioritized initiatives that promote improved chronic disease management and care. This priority is consistent with Community Health Improvement Process objectives (health literacy) and D.C. Healthy People objectives (quality preventative care, healthy living).[31,40]

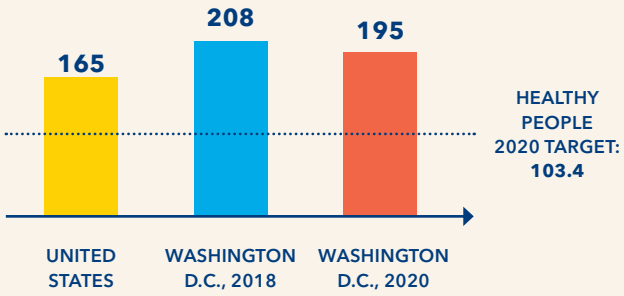
Goals

- Reduce overall risk of diabetes, cardiovascular disease, cancer, and obesity; provide appropriate care by facilitating prevention strategies, affordable care, and educational engagement tools.
- Improve health and quality of life through prevention, detection, and treatment of risk factors for chronic diseases.
- Improve screening rates for diabetes, HbA1c, cancer, BMI, and uncontrolled blood pressure.
- Improve the health, function, and quality of life of people with chronic pain.

Initiatives

- Host and provide health education classes for chronic disease self-management and prevention, nutrition education, and exercise.
- Host and provide wellness services and screenings in the community.
- Offer Ask a Doc series to community residents to provide health education.
- Host programs with emergency preparedness skills such as Stop the Bleed and care safety.
- Provide Colorectal Cancer in the Neighborhood prevention, education, and access to screenings.
- Awareness of diabetes care and prevention through clinical and education.
- Host and offer a bariatric/obesity clinic and support group; help patients by providing clinical care, nutrition education, and ongoing support groups.
- Support patients with the Million Hearts® initiative by assisting with chronic disease management and social needs.

Heart disease and stroke



The Washington, D.C. area has a heart disease death rate of 195 per 100,000 people.
This is an improvement from 2018, which had a death rate of 208 per 100,000 people; however, this is worse than the nationwide rate of 165 per 100,000 people.[1]

- The Washington, D.C. area has a stroke death rate of 37 per 100,000 people, equal to the nationwide rate.[1]

Cancer

- The Washington, D.C. area has a cancer death rate of 156 per 100,000 people.[2,3,4]
- This is an improvement from 2018, which had a death rate of 179 per 100,000 people.
- However, this is worse than the nationwide rate of 149 per 100,000 people.[2,3,4]

Did you know? The Healthy People target cancer death rate is 153 per 100,000 people.[31]

Diabetes and obesity

- 25% of adults in the Washington, D.C. area are obese, compared to the nationwide average of 42% and the Healthy People 2021 target of 31%.[6,7]
- There are 20 diabetes-related deaths per 100,000 people in the Washington, D.C. area, nearly equal to the 2018 rate and the nationwide rate.[11]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

- Number of programs
- Number of participants
- Number of screenings

Key partners

- D.C. Health
- D.C. Million Hearts program
- D.C. Office on Aging
- D.C. Senior Wellness Centers
- East River Family Strengthening Collaborative, Inc. (ERFSC)
- Martha's Table
- MedStar Cancer Network
- MedStar Diabetes Institute
- MedStar Heart and Vascular Institute
- Mt Sinai Baptist Church
- Sorogi
- YMCA

54% of MedStar Washington Hospital Center survey respondents reported needing financial assistance due to COVID-19, **39%** reported needing energy assistance, **36%** reported needing food assistance, and **33%** reported needing housing assistance.*

*Surveys were conducted August-September 2020.

Behavioral health and substance use disorders

Substance use disorders and mental health issues are a top priority in the communities served by MedStar Washington. To address these issues, MedStar Washington Hospital Center has developed initiatives aimed at improving access to mental health and substance abuse resources in the community. These priorities are consistent with Community Health Improvement Process objectives (mental health).[40]

Goals

- Reduce stigma about prevention and treatment of behavioral health disorders and addiction-related conditions among priority populations.
- Improve early identification and referrals to mental health and addiction services.
- Promote engagement in care for those with mental health and substance use disorders.
- Provide increased access to mental health treatment and services.
- Reduce violence and create a support system that can lead to long-term change; provide referrals and linkage to community resources.
- Improve the health, function, and quality of life of people with chronic pain.

Initiatives

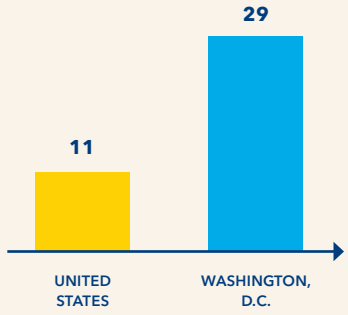
- Conduct Screening, Brief Intervention and Referral to Treatment (SBIRT) in ER supported by Peer Recovery Coaches.
- Conduct Opioid Survivor Outreach Program, allowing for opioid overdose survivors to receive harm reduction tools and connection to treatment.
- Expand Community Violence Intervention Program.

Addiction/substance use disorders

- 22% of MedStar Washington Hospital Center CHNA survey respondents indicated that addiction and substance use disorders affect quality of life in their community, compared to 57% of respondents overall.
- Addiction and substance use disorders were ranked the top priority for MedStar Washington CHNA survey respondents with a household income of under $20,000 to $49,999.

Alcohol

- 27% of adults in the Washington, D.C. area reported binge drinking, compared to the nationwide rate of 13%.[5]



29% of deaths in the Washington, D.C. area between 2014-2018 were **related to alcohol impairment,** compared to the nationwide rate of **11%.**[10]

Opioids

- The Washington, D.C. area has 40 drug overdose deaths per 100,000 people, higher than the nationwide rate of 21 per 100,000.[10,11]
- The Washington, D.C. area dispenses 25 opioid prescriptions per 100 people, lower than the nationwide rate of 51 per 100 people.[10]

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

- Number of SBIRT screenings
- Number of referrals and linkages to treatment and support services
- Number of participants served in Community Violence Intervention Program

Key Partners

- Cure the Streets
- District of Columbia Hospital Association
- Mamatoto Village
- McClendon Center
- MedStar Georgetown Family Medicine and Pediatrics
- Mosaic Group
- NAMI D.C.–National Alliance on Mental Illness
- Office of Neighborhood Safety and Engagement
- SAMSHA
- So Others Might Eat Inc.
- Unity Clinic

Access to health care and services

Limited access to health care and services in Washington, D.C. was prioritized as a key issue by survey respondents. We have developed initiatives to address this issue in the communities served by MedStar Washington Hospital Center. These priorities are consistent with D.C. Healthy People objectives (access to health services, healthy communities).[31]

Goals

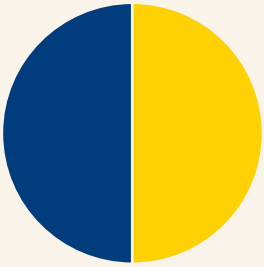
- Eliminate barriers to access health care, including transportation and financial resources.
- Improve access to comprehensive, quality health care providers and services.
- Expand access to essential health services through virtual care, community partnerships, mobile clinics, educational seminars, screenings, and vaccination programs.
- Reduce ER visits for acute or non-emergent care.
- Support Medicaid expansion programs and collaborate with Maryland Medicaid organizations to educate the community on healthcare coverage and benefits.
- Support innovative medical care delivery methods designed to lower healthcare costs.
- Develop and launch Healthy Communities outreach opportunities; promote "in the field" experiences such as Ask a Doc, volunteers at service agencies, or provide screening opportunities.
- Address transportation barriers to medical and health services among individuals who identify transportation as an unmet social need.
- Support a robust transportation system.
- Improve cultural competency and racial disparities education/trainings to health professionals.

Initiatives

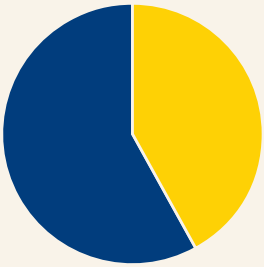
- Assist patients in need of insurance through screenings, referrals, and linkage to community resources through hospital-based Community Health Workers, Navigators, and Peer Recovery Coaches.
- Increase access to health care providers and community resources for parents and children through D.C. Safe Babies, Safe Moms initiative.
- Expand access to essential health services through virtual care.
- Provide medical and non-medical services to people living with HIV through the Ryan White HIV program.
- Improve health through prevention, referrals, and linkage to community resources.
- Provide support to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs.
- Screen patients for transportation needs, partner with Uber Health, and offer vouchers/tokens to provide transportation to those without adequate financial resources.
- Offer Ask a Doc series to community residents to provide health education and foster the provider-to-community relationship.
- Execute system-wide strategy for Equity, Inclusion, and Diversity.
- Expand Ask a HealthCare Professional series.

Access to health care and services

- The Washington, D.C. area has a 210:1 ratio of population to mental health providers, compared to the nationwide ratio of 290:1.[12]
- 96% of adults in the Washington, D.C. area have health insurance, compared to 92% nationwide.[13,14,15,16]
- 10% of adults in the Washington, D.C. area cannot afford to see a doctor, compared to 13% nationwide.[15,16]
- 32% of respondents said their health insurance is provided through their employer.



50% of respondents indicated that **limited availability or access to doctors** is one of the most important issues affecting quality of life in their community.



42% of households with children in the MedStar Washington, D.C. area **receive public assistance** or SNAP benefits.[15,30]

Transportation

- 6% of survey respondents indicated that a lack of transportation is one of the most important issues affecting quality of life in their community.
- 21% of survey respondents indicated that limited access to transportation is one of the top 5 most common reasons why people in their community do not get health care when they need it.

Fear/mistrust of providers

- 30% of survey respondents indicated that fear or mistrust of doctors is one of the top 5 most common reasons why people in their community do not get health care when they need it.

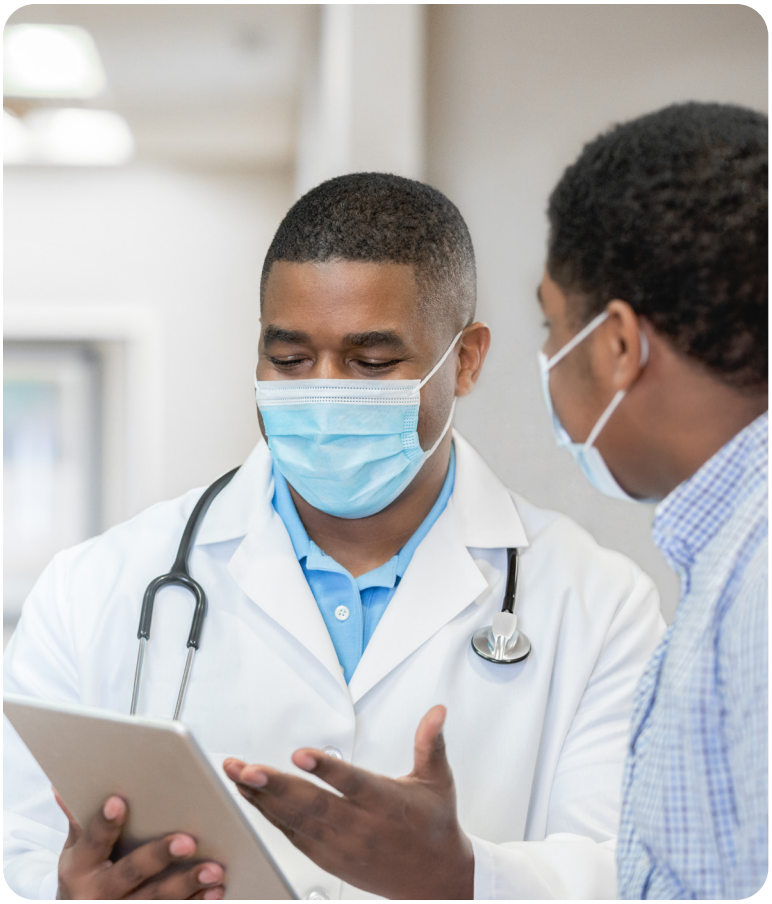
Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

- Number of participants
- Number of programs
- Number of referrals, linkages to care
- Number of transportation rides facilitated

Key partners

- Community of Hope D.C.
- D.C. Safe Babies, Safe Moms
- Mamatoto Village
- MedStar Georgetown Family Medicine and Pediatrics
- Primary Care Association
- Uber Health
- Whitman Walker Health



Social determinants of health

To make Washington, D.C. more accessible for all, MedStar Washington has developed a series of initiatives to address needs such as education, social justice, and employment. These priorities are consistent with Community Health Improvement Process objectives (care coordination).[40]

Goals

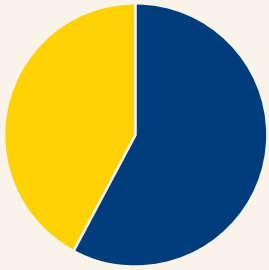
- Reduce inequities caused by lack of access to food by working to promote the expansion of food access.
- Provide health promotion, access, and nutrition opportunities to help reduce household food insecurity and reduce hunger.
- Recognize housing instability and homelessness as a public health issue.
- Connect eligible homeless individuals and families to social services in the community.
- Advocate to improve city response to individuals and families experiencing homelessness.

Initiatives

- Screen patients for food insecurity in electronic medical record through standardized SDOH screening.
- Refer and link community members to resources for food access, meal delivery, and supplemental financial support.
- Provide meal boxes and meal vouchers for community members in need.
- Support the community by providing assistance and referrals to housing resources.
- Participate in housing collaboratives and partnerships with community organizations and coalitions.
- Execute systemwide strategy for Equity, Inclusion, and Diversity, which focuses on recruitment, retention, and culture change to address the spectrum of discrimination, including race, LGBTQ+, gender, disabilities, etc.

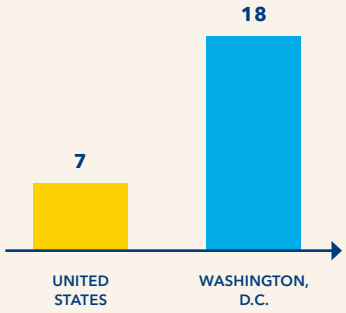
Education

58% of adults in the Washington, D.C. area have a bachelor's or more advanced degree; this is **significantly higher** than the nationwide percentage of 35%.[15,18,22]



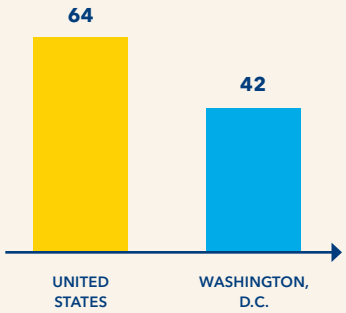
Food insecurity

- 11% of households in the Washington, D.C. area experience food insecurity. This is equal to the state and nationwide proportions.[26,27]



18% of households with children in the Washington, D.C. area **experience food insecurity**. This is above the nationwide proportion of 7%.[26,27]

Housing and homelessness



42% of those in the Washington, D.C. **area own their homes**, compared to **64%** nationwide.

- 18% of those in the Washington, D.C. area spend 50% or more of their income on rent. This is lower than the nationwide average of 25% of people spending 50% or more of their income on rent.
- 25% of survey respondents indicated that housing problems/homelessness is one of the most important issues affecting quality of life in their community

Program-specific metrics

Key factors will be tracked to determine the impact of programs and services implemented, and relevance to external public health goals.

- Number of screenings and referrals; linkages to resources
- Number of pantry visits; number of meals provided; number of vouchers distributed
- Number of SDOH connections
- Number of participants

Key partners

- Bread for the City
- Capital Area Food Bank
- D.C. Food is Medicine Coalition
- D.C. Housing and Authority
- D.C. Shelters
- Food and Friends
- Martha's Table
- Sodexo
- So Others Might Eat, Inc.
- Ward 8 Health Council
- Washington Urban League

4,700+
questionnaires were completed systemwide

779
came from MedStar Washington

The 23-question survey was conducted from late August to the end of October 2020.

Survey was distributed in person and online.

References

1. Interactive Atlas of Heart Disease and Stroke. Centers for Disease Control and Prevention. https://nccd.cdc.gov/DHDSPAtlas/?state=State.

2. Cancer Data and Statistics. Centers for Disease Control and Prevention. https://www.cdc.gov/cancer/dcpc/data/index.htm. Published July 29, 2020.

3. Maryland State Health Improvement Process. SHIP Lite Home. https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx. Published May 8, 2020.

4. Health Status. Kaiser Family Foundation. https://www.kff.org/state-category/health-status/.

5. CDC - BRFSS. Centers for Disease Control and Prevention. https://www.cdc.gov/brfss/. Published August 31, 2020.

6. U.S. Diabetes Surveillance System. Centers for Disease Control and Prevention. https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html.

7. CDC - NCHS - National Center for Health Statistics. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/index.htm.

8. Adolescent Health. OPA Office of Population Affairs. https://www.hhs.gov/ash/oah/adolescent-development/substance-use/drugs/tobacco/index.html.

9. Fatality Analysis Reporting System (FARS). NHTSA. https://www.nhtsa.gov/research-data/fatality-analysis-reporting-system-fars. Published March 26, 2021.

10. Opioid Overdose. Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/index.html. Published March 30, 2021.

11. CDC WONDER. Centers for Disease Control and Prevention. https://wonder.cdc.gov/controller/datarequest/D76.

12. Centers for Medicare and Medicaid Services (CMS), National Provider Identification. 2019. https://download.cms.gov/nppes/NPI_Files.html.

13. Behavioral Risk Factor Surveillance System. Maryland Department of Health. https://phpa.health.maryland.gov/ccdpc/Reports/Pages/brfss.aspx.

14. Berchick ER, Barnett JC, Upton RD. Health Insurance Coverage in the United States: 2018. The United States Census Bureau. https://www.census.gov/library/publications/2019/demo/p60-267.html. Published November 8, 2019.

15. American Community Survey (ACS). 2014-2019. United States Census Bureau. https://data.census.gov/cedsci/.

16. SAHIE. Small Area Health Insurance Estimates (SAHIE). https://www.census.gov/data-tools/demo/sahie/#/.

17. DC Health. DC.gov. https://dchealth.dc.gov/.

18. QuickFacts-United States. The United States Census Bureau. https://www.census.gov/quickfacts/fact/table/US/PST045219.

19. County Demographics - Baltimore County. https://www.baltimorecountymd.gov/Agencies/economicdev/meet-baltimore-county/stats-and-figures/county-demographics.html. Published June 19, 2019.

20. America's Rental Housing 2020. Joint Center for Housing Studies of Harvard University. https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_Americas_Rental_Housing_2020.pdf.

21. 2020 Maryland School Report Card. Maryland State Department of Education. https://reportcard.msde.maryland.gov.

22. Current Population Survey (CPS). The United States Census Bureau. https://www.census.gov/programs-surveys/cps.html. Published November 23, 2020.

23. U.S. Bureau of Labor Statistics. https://www.bls.gov/.

24. Local Area Unemployment Statistics (LAUS) - Workforce Information & Performance. Maryland Department of Labor. https://www.dllr.state.md.us/lmi/laus/.

25. Bureau USC. SAIPE State and County Estimates for 2018. The United States Census Bureau. https://www.census.gov/data/datasets/2018/demo/saipe/2018-state-and-county.html. Published January 12, 2021.

26. USDA ERS - Data Products. USDA ERS. https://www.ers.usda.gov/data-products/.

27. Feeding America. https://www.feedingamerica.org/.

28. AtlasPlus. Centers for Disease Control and Prevention. https://gis.cdc.gov/grasp/nchhstpatlas/main.html?value=atlas.

29. HIV Surveillance Reports. Centers for Disease Control and Prevention. https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published February 3, 2021.

30. 2018 Maryland Poverty Profiles. Maryland Alliance for the Poor. https://mda.maryland.gov/about_mda/Documents/SNAB/Maryland-Poverty-Profiles_2018_1-15-2018_T.pdf.

31. Healthy People 2020. https://www.healthypeople.gov/2020/.

32. National Center for Education Statistics (NCES) Home Page, part of the U.S. Department of Education. National Center for Education Statistics (NCES) Home Page, a part of the U.S. Department of Education. https://nces.ed.gov/.

33. American Community Survey (ACS). 2018. United States Census Bureau. https://data.census.gov/cedsci/.

34. Yang KL, Tan HE. 2015 Disability Status Report-Maryland. Yang-Tan Institute on Employment and Disability at the Cornell University ILR School. www.Disabilitystatistics.org.

35. Yang KL, Tan HE. 2013 Disability Status Report-Virginia. Yang-Tan Institute on Employment and Disability at the Cornell University ILR School. www.Disabilitystatistics.org.

36. Health and Human Services 8 Priority Focus Areas: Prince George's County, MD. Prince George's County, MD. https://www.princegeorgescountymd.gov/2472/HHS-8-Priority-Focus-Areas.

37. DC Health Matters. https://www.dchealthmatters.org/.

38. State Health Insurance Assistance Program. https://pophealth.health.maryland.gov/Pages/SHIP.aspx.

39. Local Health Improvement Coalition. Baltimore County Government. https://www.baltimorecountymd.gov/boards-commissions/health/local-health-improvement#:~:text=The%20LHIC%20has%20created%20a,behavioral%20health%20and%20chronic%20disease.

40. DC Healthy People 2020. DC Health. https://dchealth.dc.gov/page/dc-healthy-people-2020.

41. ZIP Code 21220. ZIP Code 21220 Map, Demographics, More for Middle River, MD. https://www.unitedstateszipcodes.org/21220/.

42. ZIP Code 21221. ZIP Code 21221 Map, Demographics, More for Essex, MD. https://www.unitedstateszipcodes.org/21221/.

43. ZIP Code 20011. ZIP Code 20011 Map, Demographics, More for Washington, DC. https://www.unitedstateszipcodes.org/20011/.

44. ZIP Code 20002. ZIP Code 20002 Map, Demographics, More for Washington, DC. https://www.unitedstateszipcodes.org/20002/.

45. ZIP Code 20019. ZIP Code 20019 Map, Demographics, More for Washington, DC. https://www.unitedstateszipcodes.org/20019/.

46. ZIP Code 21239. ZIP Code 21239 Map, Demographics, More for Baltimore, MD. https://www.unitedstateszipcodes.org/21239/.

47. ZIP Code 21206. ZIP Code 21206 Map, Demographics, More for Raspeburg, MD. https://www.unitedstateszipcodes.org/21206/.

48. ZIP Code 21225. ZIP Code 21225 Map, Demographics, More for Brooklyn, MD. https://www.unitedstateszipcodes.org/21225/.

49. ZIP Code 20906. ZIP Code 20906 Map, Demographics, More for Silver Spring, MD. https://www.unitedstateszipcodes.org/20906/.

50. ZIP Code 20653. ZIP Code 20653 Map, Demographics, More for Lexington Park, MD. https://www.unitedstateszipcodes.org/20653/.

51. ZIP Code 20748. ZIP Code 20748 Map, Demographics, More for Temple Hills, MD. https://www.unitedstateszipcodes.org/20748/.

52. ZIP Code 21213. ZIP Code 21213 Map, Demographics, More for Baltimore, MD. https://www.unitedstateszipcodes.org/21213/.

53. ZIP Code 21218. ZIP Code 21218 Map, Demographics, More for Baltimore, MD. https://www.unitedstateszipcodes.org/21218/.

54. ZIP Code 20010. ZIP Code 20010 Map, Demographics, More for Washington, DC. https://www.unitedstateszipcodes.org/20010/.

55. Mental Health Facts in America. NAMI—National Alliance on Mental Illness. https://www.nami.org/nami/media/nami-media/infographics/generalmhfacts.pdf

MedStar Health

MedStarHealth.org

MedStar Health

Corporate Policies

Title:	**Corporate Financial Assistance Policy**	**Section:**	
Purpose:	To ensure uniform management of the MedStar Health Corporate Financial Assistance Program across all MedStar Health Hospitals and Hospital-based Physician Practices.	**Number:**	
Forms:		**Effective Date:**	**12/01/2020**

Policy

1. As one of the region's leading not-for-profit healthcare systems, MedStar Health is committed to ensuring that uninsured and underinsured patients meeting eligibility criteria; and patients determined eligible for presumptive eligibility within the communities we serve who lack financial resources have access to emergency and medically necessary hospital services. MedStar Health hospitals and hospital based-physician practices will:

   1.1 Treat all patients equitably, with dignity, respect, and compassion.
   1.2 Serve the emergency health care needs of everyone who presents to our MedStar Health hospitals and hospital-based physician practices regardless of a patient's ability to pay for care.
   1.3 Assist those patients who are admitted through our admission process for non-urgent, medically necessary care who cannot pay for the care they receive.
   1.4 Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep its hospitals' doors open for all who may need care in the community.

2. MedStar Health will not withhold financial assistance or deny a patient's application for financial assistance on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or on the basis of disability. In addition, MedStar Health will not use a patient's citizenship or immigration status as an eligibility requirement for financial assistance.

Scope

1. In meeting its commitments, MedStar Health hospitals and hospital-based physician practices will work with their patients seeking emergency and medically necessary care to gain an understanding of each patient's financial resources. Based on this information and eligibility determinations as described below, MedStar Health hospitals and hospital-based physician practices will provide financial assistance to patients who reside within the communities that we serve in one or more of the following ways:

   1.1 Assist with enrollment in publicly-funded entitlement programs (e.g., Medicaid).
   1.2 Refer patients to State or Federal Insurance Exchange Navigator resources.
   1.3 Assist with consideration of funding that may be available from other charitable organizations.
   1.4 Provide financial assistance according to applicable policy guidelines.
   1.5 Provide financial assistance for payment of MedStar Health hospital and hospital-based physician practice charges using a sliding-scale based on the patient's household income and financial resources.
   1.6 Offer payment plans to assist patients with financing their healthcare services.

Definitions

1. **Free Care**

   100% Financial Assistance for medically necessary care provided to uninsured patients with household income between 0% and 200% of the federal poverty level (FPL).

2. **Reduced Cost-Care**

   Partial Financial Assistance for medically necessary care provided to uninsured patients with household income between 201% and 400% of the FPL.

3. **Underinsured Patient**

   An "Underinsured Patient" is defined as an individual who elects third party insurance coverage with high out of pocket insurance benefits or a patient with Medicare coverage resulting in large patient account balances.

4. **Financial Hardship**

   Medical debt, incurred by a household over a 12-month period, at the MedStar Health hospitals and hospital-based physician practices that exceeds 25% of the family household income. This means test is applied to uninsured and underinsured patients with income up to 500% of the Federal Poverty Guidelines.

5. **MedStar Health Uniform Financial Assistance Application**

   A uniform financial assistance data collection document. The Maryland State Uniform Financial Assistance Application will be used by all MedStar Health hospitals and hospital-based physician practices regardless of the hospital or practice geographical locations.

6. **MedStar Health Patient Information Sheet**

   A plain language summary that provides information about MedStar Health's Financial Assistance Policy, and a patient's rights and obligations related to seeking and qualifying for free or reduced cost medically necessary care. The Maryland State Patient Information Sheet format, developed through the joint efforts of Maryland Hospitals and the Maryland Hospital Association, will be used by all MedStar Health hospitals and hospital-based physician practices regardless of the hospital or practice geographical locations.

7. **AGB – Amount Generally Billed**

   Amounts billed to patients who qualify for Reduced-Cost Sliding Scale Financial Assistance.

8. **Medical Debt**

   "Medical debt" means out-of-pocket expenses, excluding co-payments, coinsurance, and deductibles, for medical costs billed by a hospital.

Responsibilities

1. MedStar Health will widely publicize the MedStar Health Financial Assistance Policy by:

1.1 Providing access to the MedStar Health Financial Assistance Policy, Financial Assistance Applications, and MedStar Health Patient Information Sheet on all hospital websites and patient portals.

1.2 Providing hard copies of the MedStar Health Financial Assistance Policy, MedStar Health Uniform Financial Assistance Application, and MedStar Health Patient Information Sheet to patients upon request.

1.3 Providing hard copies of the MedStar Health Financial Assistance Policy, MedStar Health Uniform Financial Assistance Application, and MedStar Health Patient Information Sheet to patients upon request by mail and without charge.

1.4 Providing notification and information about the MedStar Health Financial Assistance Policy by:

1.4.1 Offering copies as part of all registration or discharges processes and answering questions on how to apply for assistance.
1.4.2 Providing written notices on billing statements.
1.4.3 Displaying MedStar Health Financial Assistance Policy information at all hospital registration points.
1.4.4 Translating the MedStar Health Financial Assistance Policy, MedStar Health Uniform Financial Assistance Application, and the MedStar Health Patient Information Sheet into primary languages of all significant populations with Limited English Proficiency.

1.5 MedStar Health will provide public notices yearly in local newspapers serving all hospital target populations.

1.6 Providing samples documents and other related material as attachments to this Policy:

1.6.1 Appendix #1 – MedStar Health Uniform Financial Assistance Application
1.6.2 Appendix #2 – MedStar Health Patient Information Sheet
1.6.3 Appendix #3 – Translated language listing for all significant populations with Limited English Proficiency (documents will be available upon request and on hospital websites and patient portals)
1.6.4 Appendix #4 – Hospital Community Served Zip Code listing
1.6.5 Appendix # 5 – MedStar Health Financial Assistance Data Requirement Checklist
1.6.6 Appendix #6 – MedStar Health Financial Assistance Contact List and Instructions for Obtaining Free Copies and Applying for Assistance
1.6.7 Appendix #7 – MedStar Health FAP Eligible Providers

1.7 The MedStar Health Patient Information Sheet shall be provided to the patient, the patient's family, or the patient's authorized representative:

1.7.1 Before discharge;
1.7.2 With the hospital bill;
1.7.3 On request; and
1.7.4 In each written communication to the patient regarding collection of the hospital bill.

2. MedStar Health will provide a financial assistance probable and likely eligibility determination to the patient within two business days from receipt of the initial financial assistance application.

2.1 Probable and likely eligibility determinations will be based on:

2.1.1 Receipt of an initial submission of the MedStar Health Uniform Financial Assistance Application.

2.2 The final eligibility determination will be made and communicated to the patient based on receipt and review of a completed application.

2.2.1 Completed application is defined as follows:

2.2.1.a All supporting documents are provided by the patient to complete the application review and decision process.
- See Appendix #5 – MedStar Health Financial Assistance Data Requirement Checklist.

2.2.1.b Application has been approved by MedStar Health Leadership consistent with the MedStar Health Adjustment Policy as related to signature and dollar limits protocols.

2.2.1.c Pending a final decision for the Medicaid application process.

2.3 On receipt of a completed application, MedStar Health will make a final eligibility determination within 14 days. During this period, any billing and collection actions will be suspended.

3. MedStar Health believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Financial assistance and periodic payment plans available under this policy will not be available to those patients who fail to fulfill their responsibilities. For purposes of this policy, patient responsibilities include:

3.1 Comply with providing the necessary financial disclosure forms to evaluate their eligibility for publicly-funded healthcare programs, charity care programs, and other forms of financial assistance. These disclosure forms must be completed accurately, truthfully, and timely to allow MedStar Health's facilities to properly counsel patients concerning the availability of financial assistance.

3.1.1 All patients must provide proof of residency within the defined hospital service area. Proof of residency documentation would include gas and electric bills, pay stubs, bank statements, rent statements, etc. Patient must first apply for Medical Assistance, Medical Assistance Emergency Services, and other coverage program(s) eligibility.

3.2 Working with MedStar Health hospital Patient Advocates and Patient Financial Services staff to ensure there is a complete understanding of the patient's financial situation and constraints.

3.3 Making applicable payments for services in a timely fashion, including any payments made pursuant to deferred and periodic payment schedules.

3.4 Providing updated financial information to MedStar Health hospital Patient Advocates or Customer Service Representatives on a timely basis as the patient's financial circumstances may change.

3.5 It is a patient's responsibility, during their 12-month eligibility period, to notify MedStar Health of their existing household eligibility for free care, reduced cost-care, and/or eligibility under financial hardship provisions for medical necessary care received during the 12-month eligibility period.

3.6 In the event a patient fails to meet these responsibilities, MedStar Health reserves the right to pursue additional billing and collection efforts. In the event of non-payment billing, and collection efforts are defined in the MedStar Health Billing and Collection Policy. A free copy is available on all hospital websites and patient portals via the following URL: **www.medstarhealth.org/FinancialAssistance**, or by call customer service at 1-800-280-9006.

4. Patients of MedStar Health's hospitals and hospital-based physician practices may be eligible for full financial assistance or partial sliding-scale financial assistance as set forth under this policy. The Patient Advocate and Patient Financial Services staff will determine eligibility for full financial assistance and partial sliding-scale financial assistance based on review of income for the patient and their family (household), other financial resources available to the patient's family, family size, and the extent of the medical costs to be incurred by the patient.

5. **ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE**

5.1 Federal Poverty Guidelines. Based on household income and family size, the percentage of the then-current Federal Poverty Level (FPL) for the patient will be calculated.

5.1.1 Free Care: Free Care (100% Financial Assistance) will be available to uninsured and underinsured patients with household incomes between 0% and 200% of the FPL. FPL's will be updated annually.

5.1.2 Reduced Cost-Care: Reduced Cost-Care will be available to uninsured and underinsured patients with household incomes between 201% and 400% of the FPL. Reduced Cost-Care will be available based on a sliding-scale as outlined below. Discounts will be applied to amounts generally billed (ABG). FPL's will be updated annually.

5.1.3 In determining the family income of a patient, a hospital shall apply a definition of household size that consists of the patient and, at a minimum, the following individuals:

5.1.3.a A spouse, regardless of whether the patient and spouse expect to file a joint federal or State tax return;
5.1.3.b Biological children, adopted children, or stepchildren; and
5.1.3.c Anyone for whom the patient claims a personal exemption in a federal or State tax return.

For a patient who is a child, the household size shall consist of the child and the following individuals:

5.1.3.d Biological parents, adopted parents, or stepparents or guardians;
5.1.3.e Biological siblings, adopted siblings, or stepsiblings; and
5.1.3.f Anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.

5.2 Basis for Calculating Amounts Charged to Patients: Free Care or Reduced-Cost Care Sliding Scale Levels:

	Financial Assistance Level Free / Reduced-Cost Care	
Adjusted Percentage of Poverty Level	**HSCRC-Regulated Services**	**Washington Hospitals, Hospital-Based Physician Practices, and non-HSCRC Regulated Services**
0% to 200%	100%	100%
201% to 250%	40%	80%
251% to 300%	30%	60%
301% to 350%	20%	40%
351% to 400%	10%	20%
more than 400%	no financial assistance	no financial assistance

5.3 **MedStar Health Hospitals and Hospital-Based Physician Practices** will comply with IRS 501(r) requirements on limiting the amounts charged to uninsured patients seeking emergency and medically necessary care.

5.3.1 The MedStar Health calculation for AGB will be the amount Medicare would allow for care, including amounts paid or reimbursed and amounts paid by individuals as co-payments, co-insurance, or deductibles.

5.3.2 Amounts billed to patients who qualify for Reduced-Cost Sliding Scale Financial Assistance will not exceed the AGB.

Example:

GROSS CHARGES	MEDICARE ALLOWABLE AGB AMOUNT	**PATIENT ELIGIBLE FOR SLIDING SCALE ASSISTANCE	FINANCIAL ASSISTANCE AMOUNT APPROVED AS A % OF THE MEDICARE ALLOWABLE AGB AMOUNT	PATIENT RESPONSIBILITY
$1,000.00	$800.00	40%	$320.00	$480.00
**Sliding Scale % will vary per Section 5.2 - Basis for Calculating Amounts Charge Patients in this Policy				

6. **FINANCIAL ASSISTANCE: ADDITIONAL FACTORS USED TO DETERMINE ELIGIBILITY FOR MEDICAL ASSISTANCE: FINANCIAL HARDSHIP.**

6.1 MedStar Health will provide Reduced-Cost Care to patients, both uninsured and underinsured, with household incomes between 201% and 500% of the FPL that, over a 12-month period, have incurred medical debt at the same hospital or hospital-based physician practice in excess of 25% of the patient's household income. Reduced Cost-Care will be available based on a sliding-scale as outlined below.

6.2 A patient receiving reduced-cost care for Financial Hardship and the patient's immediate family members shall receive/remain eligible for Reduced Cost medically necessary care when seeking subsequent care for 12 months beginning on the date that the reduced-care was received. It is the responsibility of the patient to inform the MedStar Health hospital and hospital-based physician practice of their existing eligibility under a Financial Hardship during the 12-month period.

6.3 If a patient is eligible for Free Care / Reduced-Cost Care, and Financial Hardship, the hospital and hospital-based physician practice will employ the more generous policy to the patient.

6.4 Financial Hardship Reduced-Care Sliding Scale Levels:

	Financial Assistance Level – Financial Hardship	
Adjusted Percentage of Poverty Level	**HSCRC-Regulated Services**	**Washington Hospitals, Hospital-Based Physician Practices, and non-HSCRC Regulated Services**
201% to 500%	**Not to Exceed 25% of Household Income**	**Not to Exceed 25% of Household Income**

EXAMPLE: Financial Hardship Calculation		
12 - Month Medical Debt (A)	Annual Household Income	% Medical Debt to Annual Household Income
$25,000	$50,000	50%
25% Annual Household Income / Patient Responsibility (B)		
$12,500		
Financial Hardship Allowance = (A) less (B)		
$12,500		

7. **METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE: INCOME AND ASSET DETERMINATION.**

7.1 Patients may obtain a Financial Assistance Application and other informational documents:

7.1.1 On Hospital Websites and Patient Portals via the following URL: **www.medstarhealth.org/FinancialAssistance**;
7.1.2 From MedStar Health hospital Patient Advocates and/or Admission / Registration Associates; or
7.1.3 By contacting Patient Financial Services Customer Service.
- See Appendix #6 – Financial Assistance Contact List and Instruction for Obtaining Free Copies and How to Apply for Assistance.

7.2 MedStar Health will evaluate the patient's financial resources **EXCLUDING**:

7.2.1 The first $250,000 in equity in the patient's principle residence.
7.2.2 Retirement assets for which the IRS has granted preferential treatment as a retirement account, including deferred-compensation plans qualified under the Internal Revenue Code or non-qualified deferred-compensation plans
7.2.3 The first $10,000 in monetary assets e.g., bank account, stocks, CD, etc.
7.2.4 One motor vehicle used for the transportation needs of the patient or any family member of the patient.
7.2.5 Any resources excluded in the determining financial eligibility under Medical Assistance Programs under the Social Security Act.
7.2.6 Prepaid higher education funds in a State specific 529 Program account.

7.3 MedStar Health will use the MedStar Health Uniform Financial Assistance Application as the standard application. MedStar Health will require the patient to supply all documents necessary to validate information to make eligibility determinations.

7.4 Financial assistance applications and support documentation will be applicable for determining program eligibility one (1) year from the application date. Additionally, MedStar Health will consider for eligibility all accounts (including bad debts) 240 days prior to the application date.

7.5 Patients to whom discounts, payment plans, or financial assistance are extended have continuing responsibility to provide accurate and complete financial information. In the event a patient fails to meet these continuing responsibilities, the patient will be financially responsible for the original amount owed, less any payments made to date.

8. PRESUMPTIVE ELIGIBILTY

8.1 Patients already enrolled in certain means-tested programs are deemed eligible for free care on a presumptive basis. Examples of programs eligible under the MedStar Health Financial Assistance Program include but are not limited to:

8.1.1 Federal Supplemental Nutrition Assistance Program (SNAP);
8.1.2 Maryland Temporary Cash Assistance (TCA);
8.1.3 All Dual eligible Medicare / Medicaid Program – SLMB QMB;
8.1.4 All documented Medicaid Spend Down amounts as documented by Department of Social Services;
8.1.5 Patients living in a household with children enrolled in the free or reduced-cost meal program;
8.1.6 State's Energy Assistance Program;
8.1.7 Federal Special Supplemental Food Program for Women, Infants, and Children (WIC);
8.1.8 Patients receiving benefits from any other social service program as determined by the Department and the Commission; and
8.1.9 Out of State Medicaid Programs.

MedStar Health will continually evaluate any publicly-funded programs for eligibility under the Presumptive Eligibility provision of this policy.

8.2 Additional presumptively eligible categories will include with minimal documentation:

8.2.1 Homeless patients as documented during the registration/clinical intake interview processes.
8.2.2 Deceased patients with no known estate based on medical record documentation, death certificate, and confirmation with Registrar of Wills.
8.2.3 MedStar Health will utilize automated means test scoring campaigns and databases to determine presumptive financial assistance eligibility. Patients determined to have income scoring up to 200% of the FPL will be deemed presumptively eligible for free care.

8.3 Patients found to be eligible for Presumptive Eligibility, as defined in Sections 8.1 and 8.2 of this policy, are automatically waived from Program Exclusions as defined in the Exclusion section of this policy.

9. MEDSTAR HEALTH FINANCIAL ASSISTANCE APPEALS

9.1 In the event a patient is denied financial assistance, the patient will be provided the opportunity to appeal the MedStar Health denial determination.

9.2 Patients are required to submit a written appeal letter to the Director of Patient Financial Services with additional supportive documentation. Contact information for submission an appeal will be found on the MedStar Health denial determination letter sent to the patient.

9.3 Appeal letters must be received within 30 days of the financial assistance denial determination.

9.4 Financial assistance appeals will be reviewed by a MedStar Health Appeals Team. Team members will include the Director of Patient Financial Services, Assistance Vice President of Patient Financial Services, and the hospital's Chief Financial Officer.

9.5 Denial reconsideration decisions will be communicated, in writing, within 30 business days from receipt of the appeal letter.

9.6 The patient or the patient's authorized representative may request the assistance of the Health Education and Advocacy Unit's (HEAU) in filing and mediation of reconsideration requests. Requests for assistance should be directed to:

Health Education and Advocacy Unit
200 St Paul Place
Baltimore, Maryland 21202
Email - heau@aog.state.md.us

Telephone Number: (410) 528-1840, or 1 (877) 261-8807
Fax Number: (410) 576-6571

HEAU Website: https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx

9.7 If the MedStar Health Appeals Panel upholds the original denial determination, the patient will be offered a payment plan in order to facilitate payment.

10. PAYMENT PLANS

10.1 MedStar Health will make available payment plans to uninsured or underinsured patients with household income above 200% of the Federal Poverty Guidelines who do not meet eligibility criteria for the MedStar Health Financial Assistance or Financial Assistance Programs.

10.2 Patients to whom discounts, payment plans, or financial assistance are extended have continuing responsibilities to provide accurate and complete financial information. In the event a patient fails to meet these continuing responsibilities, MedStar Health will pursue collections of open patient balances per the MedStar Health Corporate Billing and Collection Policy. MedStar Health reserves the right to reverse financial assistance account adjustments and pursue payment for original balances owed.

11. **BAD DEBT RECONSIDERATIONS AND REFUNDS**

11.1 In the event a patient who, within a two (2) year period after the date of service was found to be eligible for free care on that date of service, MedStar Health will initiate a review of the account(s) to determine the appropriateness for a patient refund for amounts collected exceeding $25.

11.2 It is the patient's responsibility to request an account review and provide the necessary supportive documentation to determine free care financial assistance eligibility.

11.3 If the patient fails to comply with requests for documentation, MedStar Health will document the patient's non-compliance. The patient will forfeit any claims to a patient refund or free care assistance.

11.4 If MedStar Health obtains a judgment or reports adverse information to a credit reporting agency for a patient who was later to be found eligible for financial assistance, MedStar Health will seek to vacate the judgment or strike the adverse information.

Exclusions

1 **PROGRAM EXCLUSIONS**

The MedStar Health Financial Assistance Program excludes the following from financial assistance eligibility:

1.1 Patients seeking non-medically necessary services, including cosmetic procedures.

1.2 Patients residing outside a hospital's defined zip code service area, except that certain waivers may be made for:

1.2.1 Patient referrals within the MedStar Health System.
1.2.2 Patients arriving for emergency treatment via land or air ambulance transport.

1.3 Patients who are non-compliant with enrollment processes for publicly-funded healthcare programs, charity care programs, and other forms of financial assistance.

****

This Page Intentionally Left Blank

****

Policy and Procedure Clarification

MedStar Health Corporate Financial Assistance Policy

The following section headings of this document are considered the MedStar Health Corporate Financial Assistance Policy for external publication and reference by the general public.

- Policy
- Scope
- Definitions
- Responsibilities
- Exceptions

The following section headings of this document are considered internal procedural requirements, as related to the MedStar Health Corporate Financial Assistance Policy, for internal use and not subject to external publication or reference.

- What Constitutes Non-Compliance
- Consequences for Non-Compliance
- Explanation and Details/Examples
- Requirements and Guidelines for Implementing the Policy
- Related Policies
- Procedures Related to Policy
- Legal Reporting Requirements
- Reference to Laws or Regulations of Outside Bodies
- Right to Change or Terminate Policy
- Approval by
- Related Signatures

What Constitutes Non-Compliance

Actions or conduct by MedStar Health employees or contracted employees in violation of this Policy.

Consequences of Non-Compliance

Violations of this Policy by any MedStar Health employee or contract employee may require the employee to undergo additional training and may subject the employee to disciplinary action, including, but not limited to, suspension, probation or termination of employment, as applicable.

Explanation and Details/Examples

N/A

Requirements and Guidelines for Implementing the Policy

N/A

Related Policies

N/A

Procedures Related to Policy

Admission and Registration
Financial Self Pay Screening
Billing and Collections
Bad Debt
MedStar Health Corporate Adjustment Policy
MedStar Health Corporate Payment Plan Policy

Legal Reporting Requirements

HSCRC Reporting as required – Maryland Hospitals Only
Year End Financial Audit Reporting
IRS Reporting

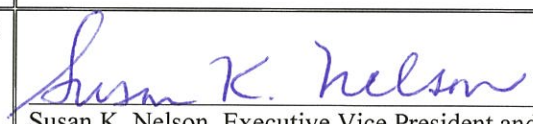
Reference to Laws or Regulations of Outside Bodies

Maryland House Bill 1420 Section 19-214.1 and 19-214.3 – Maryland Hospitals Only
Maryland Senate Bill 328 Chapter 60 – Maryland Hospitals Only
COMAR 10.37.10 Rate Application and Approval Procedures – Maryland Hospitals Only
IRS Regulations Section 501(r)

Right to Change or Terminate Policy

Any change to this Policy requires review and approval by the Legal Services Department.
Proposed changes to this Policy will be discussed with all affected parties at both the Business Unit and Corporate levels of the Organization.

The Corporation's policies are the purview of the Chief Executive Officer (CEO) and the CEO's management team

Reference:	
Approved By:	 Susan K. Nelson, Executive Vice President and CFO
Additional Signature Information:	