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: Sheppard Pratt	◉	○	
Your hospital's ID is: 4000	◉	○	
Your hospital is part of the hospital system called N/A	◉	○	
The primary Narrative contact at your hospital is Thomas Glenn	◉	○	
The primary Narrative contact email address at your hospital is tglenn@sheppardpratt.org	◉	○	
The primary Financial contact at your hospital is PRIMARY FINANCIAL NAME	○	◉	Sabrina Grega
The primary Financial email at your hospital is mmiddleton@sheppardpratt.org	○	◉	sabrina.grega@sheppardpratt.org

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

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

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

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

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

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

This question was not displayed to the respondent.

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

☐ 20701	☐ 20776	☐ 21062	☑ 21146
☐ 20711	☐ 20778	☐ 21076	☑ 21225
☐ 20714	☐ 20779	☐ 21077	☐ 21226
☐ 20724	☐ 20794	☐ 21090	☐ 21240
☐ 20733	☑ 21012	☐ 21106	☑ 21401
☐ 20736	☐ 21032	☐ 21108	☐ 21402
☐ 20751	☐ 21035	☑ 21113	☑ 21403
☐ 20754	☑ 21037	☑ 21114	☐ 21404
☐ 20755	☐ 21054	☑ 21122	☐ 21405
☐ 20758	☐ 21056	☐ 21123	☑ 21409
☐ 20764	☑ 21060	☐ 21140	☐ 21411
☐ 20765	☑ 21061	☑ 21144	☐ 21412

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

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

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

☐ 21013	☐ 21092	☐ 21156	☐ 21225
☐ 21020	☑ 21093	☐ 21161	☐ 21227

- [ ] 21022
- [ ] 21023
- [ ] 21027
- [x] 21030
- [ ] 21031
- [ ] 21043
- [ ] 21051
- [ ] 21052
- [ ] 21053
- [ ] 21057
- [ ] 21065
- [ ] 21071
- [ ] 21074
- [ ] 21082
- [ ] 21085
- [ ] 21087
- [ ] 21094
- [ ] 21102
- [ ] 21104
- [ ] 21105
- [ ] 21111
- [x] 21117
- [ ] 21120
- [ ] 21128
- [ ] 21131
- [x] 21133
- [ ] 21136
- [ ] 21139
- [ ] 21152
- [ ] 21153
- [ ] 21155
- [ ] 21162
- [ ] 21163
- [x] 21204
- [x] 21206
- [x] 21207
- [ ] 21208
- [x] 21209
- [ ] 21210
- [ ] 21212
- [x] 21215
- [ ] 21219
- [x] 21220
- [x] 21221
- [x] 21222
- [ ] 21224
- [ ] 21228
- [ ] 21229
- [x] 21234
- [ ] 21235
- [ ] 21236
- [ ] 21237
- [x] 21239
- [ ] 21241
- [x] 21244
- [ ] 21250
- [ ] 21252
- [ ] 21282
- [ ] 21284
- [ ] 21285
- [x] 21286

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.

- [ ] 21048
- [ ] 21074
- [ ] 21102
- [ ] 21104
- [x] 21136
- [ ] 21155
- [x] 21157
- [ ] 21158
- [ ] 21757
- [ ] 21771
- [ ] 21776
- [ ] 21784
- [ ] 21787
- [ ] 21791
- [ ] 21797

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.

- [ ] 20842
- [ ] 20871
- [x] 21701
- [x] 21702
- [x] 21703
- [ ] 21704
- [ ] 21705
- [ ] 21710
- [ ] 21719
- [ ] 21727
- [ ] 21754
- [ ] 21755
- [ ] 21757
- [ ] 21758
- [ ] 21759
- [ ] 21762
- [ ] 21775
- [ ] 21776
- [ ] 21777
- [ ] 21778
- [ ] 21780
- [ ] 21783
- [ ] 21787
- [ ] 21788

- [ ] 21713
- [ ] 21714
- [ ] 21716
- [ ] 21717
- [ ] 21718
- [ ] 21769
- [ ] 21770
- [ ] 21771
- [ ] 21773
- [ ] 21774
- [ ] 21790
- [ ] 21791
- [ ] 21793
- [ ] 21798

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.

- [ ] 21001
- [ ] 21005
- [x] 21009
- [ ] 21010
- [ ] 21013
- [ ] 21014
- [ ] 21015
- [ ] 21017
- [ ] 21018
- [ ] 21028
- [ ] 21034
- [ ] 21040
- [ ] 21047
- [ ] 21050
- [ ] 21078
- [ ] 21082
- [ ] 21084
- [ ] 21085
- [ ] 21087
- [ ] 21111
- [ ] 21130
- [ ] 21132
- [ ] 21154
- [ ] 21160
- [ ] 21161

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

- [ ] 20701
- [x] 20723
- [ ] 20759
- [ ] 20763
- [ ] 20777
- [ ] 20794
- [ ] 20833
- [ ] 21029
- [ ] 21036
- [ ] 21041
- [x] 21042
- [x] 21043
- [x] 21044
- [x] 21045
- [x] 21046
- [x] 21075
- [ ] 21076
- [ ] 21104
- [ ] 21150
- [ ] 21163
- [ ] 21723
- [ ] 21737
- [ ] 21738
- [ ] 21765
- [ ] 21771
- [x] 21784
- [ ] 21794

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.

- [ ] 20058
- [ ] 20207
- [ ] 20707
- [ ] 20777
- [ ] 20783
- [ ] 20787
- [ ] 20810
- [ ] 20811
- [ ] 20812
- [ ] 20814
- [ ] 20815
- [ ] 20816
- [ ] 20817
- [ ] 20818
- [ ] 20824
- [ ] 20825
- [ ] 20827
- [ ] 20830
- [ ] 20832
- [ ] 20833
- [ ] 20837
- [ ] 20838
- [ ] 20839
- [ ] 20841
- [ ] 20842
- [ ] 20847
- [ ] 20848
- [ ] 20849
- [ ] 20850
- [ ] 20851
- [ ] 20852
- [ ] 20853
- [ ] 20854
- [ ] 20855
- [ ] 20857
- [ ] 20859
- [ ] 20860
- [ ] 20861
- [ ] 20862
- [ ] 20866
- [ ] 20868
- [ ] 20871
- [ ] 20872
- [ ] 20874
- [ ] 20875
- [ ] 20876
- [ ] 20877
- [ ] 20878
- [ ] 20879
- [ ] 20880
- [ ] 20882
- [ ] 20883
- [ ] 20884
- [ ] 20885
- [ ] 20886
- [ ] 20889
- [ ] 20891
- [ ] 20892
- [ ] 20894
- [ ] 20895
- [ ] 20896
- [ ] 20898
- [ ] 20899
- [ ] 20901
- [ ] 20902
- [ ] 20903
- [ ] 20904
- [ ] 20905
- [ ] 20906
- [ ] 20907
- [x] 20910
- [ ] 20911
- [ ] 20912
- [ ] 20913
- [ ] 20914
- [ ] 20915
- [ ] 20916
- [ ] 20918
- [ ] 20993
- [ ] 21770
- [ ] 21771
- [ ] 21797

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

  Count of patient discharges by ZIP code in FY2021. ZIP codes are ranked by total number of discharges, and those accounting for up to and including 60% of total discharges are counted as the CBSA.

- [ ] Other. Please describe.

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

https://www.sheppardpratt.org/why-sheppard-pratt/mission-values/

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

Sheppard Pratt is a specialty hospital and therefore draws patients from a larger geographic area, which includes the entire Central Maryland region and beyond. However, the CBSA was defined by the counties from which the greatest number of inpatient discharges originate. While the market areas for the Towson, Ellicott City, and Baltimore Washington hospitals overlap, each has areas from which they have a greater concentration of patients. The Towson campus has a higher concentration of patients from Baltimore City and County, while Ellicott City and the Baltimore Washington campuses have a greater concentration of patients from Anne Arundel and Howard Counties.

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)

05/10/2019

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

https://www.sheppardpratt.org/chna/

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

Sheppard Pratt Community Health Needs Assessment - Towson Campus.pdf
1.1MB
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)	☐	☐	☑	☐	☑	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Board of Directors or Board Committee (facility level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Board reviewed and approved the 2019 CHNA
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Board of Directors or Board Committee (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (facility level)	☐	☐	☑	☑	☐	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Population Health Staff (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Population Health Staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☐	☑	☑	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Community Benefit staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	

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

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

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

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

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

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Workers								X			
Hospital Advisory Board		X									
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: Sinai Hospital (Child Abuse Center)	X	X					X						X	
Local Health Department -- Please list the Local Health Departments here: Baltimore County Department of Health, Anne Arundel Department of Health, Harford County Health Department	X	X	X	X			X						X	
Local Health Improvement Coalition -- Please list the LHICs 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
Maryland Department of Health	☑	☑	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐
Other State Agencies -- Please list the agencies here: Maryland Behavioral Health Administration	☑	☑	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	☑	☐
Local Govt. Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Faith-Based Organizations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
School - K-12 -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
School - Colleges, Universities, Professional Schools -- Please list the schools here: Johns Hopkins Bloomberg School of Public Health	☑	☑	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	☑	☐

	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: Anne Arundel County Mental Health Agency, Howard County Mental Health Authority	☑	☑	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	☑	☐

	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: The Listening Place, Child Advocacy Center, Maryland Coalition of Families, Maryland Children's Alliance, Family Network - Pathfinders for Autism,Tuerk House	☑	☑	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	☑	☐

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

11/15/2019

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

https://www.sheppardpratt.org/files/resources/2019-implementation-plan-final.pdf

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

Sheppard Pratt Community Health Needs Implementation Plan - Towson Campus.pdf
672.5KB
application/pdf

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

This question was not displayed to the respondent.

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

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

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

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

Our previous CHNA (2016) focused on mental health education, increasing access to and utilization of behavioral health, mental health services delivered in an integrated care model, stigma reduction, and expansion of outpatient services for the child and adolescent population. Our most recent CHNA (2019), includes these priorities and has expanded the number and scope of the initiatives, with a renewed emphasis on care coordination between inpatient and outpatient providers, increasing Mental Health First Aid training in our community, and expanding hours at our Psychiatric Urgent Care clinic.

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				
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.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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.

This question was not displayed to the respondent.

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	Psychiatric Urgent Care	Expand access to crisis care by offering walk-in clinic for behavioral health assessment and triage	6,048 encounters	PUC volumes
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.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

	Health Conditions - Sensory or Communication 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				

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.

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

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

	Health Behaviors - Drug and Alcohol Use Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

	Health Behaviors - Preventive Care Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Free discharge medications	Ensure patients have access to medication continuity following discharge	2,863 prescriptions filled	Number of free discharge prescriptions filled at both campuses
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.

	Health Behaviors - Violence Prevention Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				

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

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

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

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

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

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

This question was not displayed to the respondent.

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

	Populations - LGBT 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				

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.

	Populations - Parents or Caregivers 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				

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

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

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

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

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

	Populations - Workforce 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				

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.

	Settings and Systems - Health Care Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Integrated Care with GBMC	Improve access to behavioral healthcare by partnering with local primary care practice	6,124 visits	GBMC primary care behavioral health volumes
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

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

	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.

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

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

	Settings and Systems - Transportation Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Free Transportation for Clinical Services	Ensure Patients have access to transportation for clinical services	3,342 free rides	community benefit eligible free transportation via ambulance, taxi, or rideshare service
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.

	Social Determinants of Health - Education Access and Quality Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Free Continuing Medical Education	Provide accessible CME for behavioral health in an accessible virtual format	2088 credits earned by Non-SPHS employees	CME credits using Ethos system
Initiative B	Positive Behavioral Interventions & Supports training	Provide training on PBIS to community members	2074 PBIS participants	Number of PBIS participants
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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				
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.

This question was not displayed to the respondent.

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

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

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

	Other 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				

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

- (●) Yes
- ( ) No

Q131.
In your most recently completed CHNA, the following community health needs were identified:
Health Conditions - Addiction, Health Conditions - Dementias, Health Conditions - Mental Health and Mental Disorders, Health Conditions - Sensory or Communication Disorders, Health Behaviors - Child and Adolescent Development, Health Behaviors - Drug and Alcohol Use, Health Behaviors - Health Communication, Health Behaviors - Nutrition and Healthy Eating, Health Behaviors - Preventive Care, Health Behaviors - Tobacco Use, Health Behaviors - Violence Prevention, Populations - Adolescents, Populations - Children, Populations – LGBT, Populations - Men, Populations - Older Adults, Populations - Parents or Caregivers, Populations - People with Disabilities, Populations - Women, Populations - Workforce, Settings and Systems - Community, Settings and Systems - Health Care,

Settings and Systems - Hospital and Emergency Services, Settings and Systems - Housing and Homes, Settings and Systems - Schools, Settings and Systems - Transportation, Social Determinants of Health - Economic Stability, Social Determinants of Health - Education Access and Quality, Social Determinants of Health - Health Care Access and Quality, Social Determinants of Health - Social and Community Context, Other (specify)
Other: Care coordination, Access to family therapy

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.

Sheppard Pratt tracks volumes and outcomes related to its large number of mental health, substance use, special education, developmental disability, and social services. Health disparities are tracked and reported as a component of the triennial community health needs assessment process.

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

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

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

Q60. Section III - CB Administration

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

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

Q246. Please describe the third party audit process used.

This question was not displayed to the respondent.

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

- ◉ Yes
- ○ No

Q63. Please describe the community benefit narrative audit process.

Reviewed by internal group to ensure accuracy and completeness

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

- ○ Yes
- ● No

Q65. Please explain:

The financial spreadsheet is reviewed and approved for submission by the Chief Financial Officer.

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

- ○ Yes
- ● No

Q67. Please explain:

The narrative report is reviewed and approved for submission by the Vice President and Chief Strategy Officer.

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.

Sheppard Pratt operates many services designed to address community-identified needs, and it aims to enhance access to these services by developing its integrated continuum of care and leveraging data to ensure effectiveness.

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

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

Q135.
Section IV - Physician Gaps & Subsidies

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

- ○ No
- ◉ Yes

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

	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	○	○	
Medical Genetics	○	○	
Neurological Surgery	○	○	
Neurology	○	○	
Obstetrics & Gynecology	○	○	
Oncology-Cancer	○	○	
Ophthamology	○	○	
Orthopedics	○	○	
Otololaryngology	○	○	
Pathology	○	○	
Pediatrics	○	○	
Physical Medicine & Rehabilitation	○	○	
Plastic Surgery	○	○	
Preventive Medicine	○	○	
Psychiatry	◉	○	Physician recruitment to meet community need
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.

The health system subsidizes hospital-based physician salaries when they are negatively impacted by charity care or low reimbursement rates. This approach has been adopted in order to continue to offer mental health specialty services to the community as well as to insure full physician coverage without any gaps in the availability of psychiatric specialists.

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.

Financial Assistance Policy.pdf
175.8KB
application/pdf

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

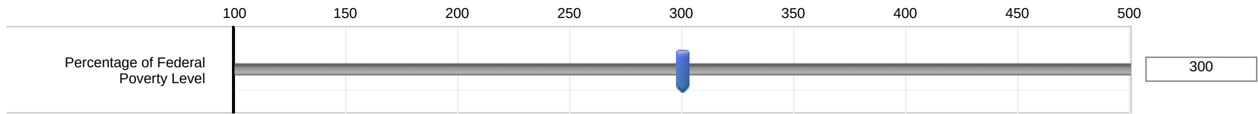
https://www.sheppardpratt.org/financial-assistance-policy/

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: Revision to clarify income thresholds

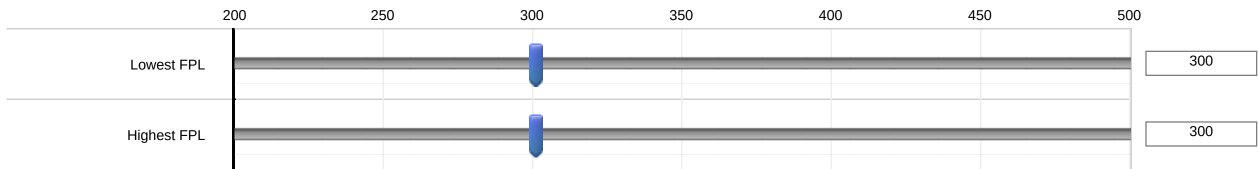
Q143. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



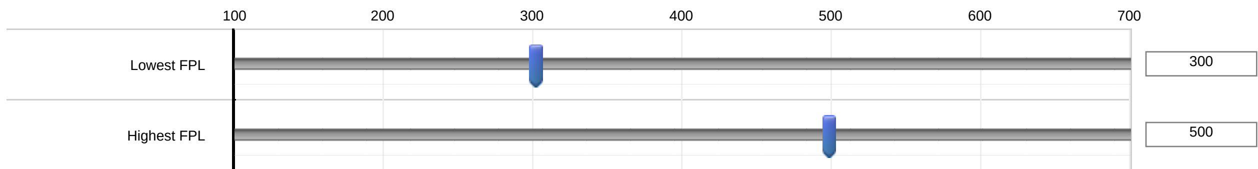
Q144. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

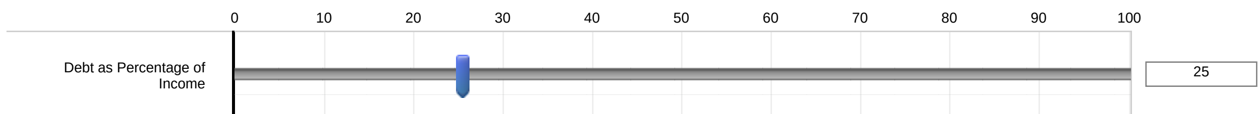


Q145. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health 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)

- ☑ Federal corporate income tax
- ☑ State corporate income tax
- ☐ State sales tax
- ☐ Local property tax (real and personal)

☐ Other (Describe) ____

Q150. Summary & Report Submission

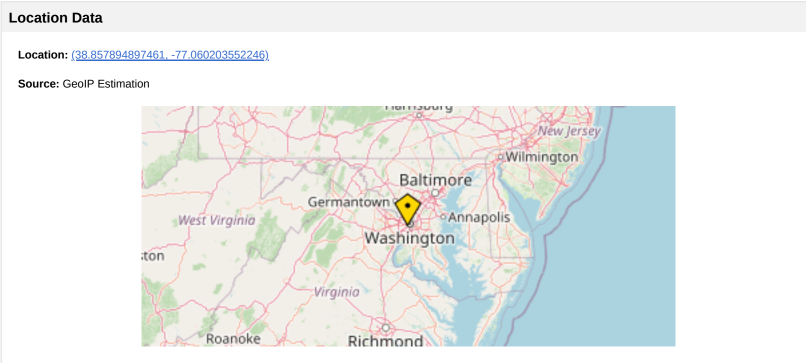
Q151.

Attention Hospital Staff! IMPORTANT!

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

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

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



Community Health Needs Assessment

For

Sheppard Pratt Hospital – Towson Campus

May 10, 2019

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Sheppard Pratt Community Health Needs Assessment Outline

Introduction

The purpose of this document is to summarize the research conducted to support the development of the Community Health Needs Assessment document for Sheppard Pratt Hospital – Towson Campus. The document helps Sheppard Pratt better understand needs in its service area.

This document contains the following sections:

- Hospital profile
- Outreach activities since the previous CHNA
- Methodology summary and service area profile
- Service areas
- Secondary research profile
  - Demographic factors (population, gender, race and ethnicity, and age)
  - Social and physical environment factors (educational attainment, income, and poverty)
  - Risk and protective lifestyle behaviors (access to care, overweight/obesity, and physical activity)
- Health status profile
  - General health status
  - Mortality – Leading causes of death
  - Morbidity - Leading causes of illness
  - Behavioral health condition incidence
- Primary research
  - Focus group discussions and interviews
  - List of focus group participants and interviewees
- Community needs to be considered for prioritization;
- Prioritized list of community needs
- Community health resources list (included as a separate document)

Sheppard Pratt Hospital Profile

Sheppard Pratt Health System, a private non-profit health system was founded in Baltimore, Maryland, to provide compassionate solutions to help those suffering from mental illness recover and get back to their lives. With hospital facilities in Towson and Ellicott City, the organization offers a full range of mental health, substance use, and special education services for people throughout Maryland, to meet the needs of children, adolescents, adults, and older adults.

A patient-centered treatment approach, combined with a legacy of clinical excellence, sets Sheppard Pratt apart from other health systems, on both a local and national level. As a free-standing system focused solely on mental health treatment, healing, and recovery, we are able to provide our patients with the specialized care they need in a supportive and compassionate environment.

A History of Community Focus

Sheppard Pratt Health System has been improving the quality of life in our community by providing mental health, special education, and substance use services for more than 100 years. While our treatments and therapies have always been modern and ahead of their time, our patient-centered approach and compassionate care has remained the same since we first opened our doors in 1891. Our founder, Moses Sheppard, envisioned an institution that treated patients with respect and dignity, with a window in each room and soothing grounds to look at through that window.

This vision was also shared by Enoch Pratt, a wealthy merchant and philanthropist who left an endowment for The Sheppard Asylum upon his death in 1896.

More than 100 years later, Sheppard Pratt Health System continues to carry out Sheppard's dream to provide compassionate care to help people with mental illness heal. Today, Sheppard Pratt is Maryland's largest provider of mental health, special education, and substance use services, helping more than 70,000 individuals annually.

Mission & Values

Our Mission: To improve the quality of life of individuals and families by compassionately serving their mental health, addiction, special education, and community support needs.

Our Values Statement: Since our founding in 1853, Sheppard Pratt Health System has remained loyal to our Quaker heritage. The Quaker testimonies of simplicity, peace, integrity, community, and equality drive not only our core values, but our guiding principles, as well.

Our Core Values:

- **To Meet a Need** - to work toward recovery of health and quality of life for people we serve
- **To Lead** - to continually seek and create more effective ways to serve individuals
- **To Care** - to employ the highest standards of professionalism, with compassion, at all times
- **To Respect** - to recognize and respond to the human dignity of every person

Our Guiding Principles:

- **Quality -** We will meet professional standards in our field and continuously improve all aspects of our work.
- **Empowerment** - We will encourage the autonomy of our consumers and staff using teamwork to achieve individualized goals.
- **Integrity** - We will conduct ourselves in an ethical, honest, and forthright manner.
- **Innovation -** We will use the expertise of our staff, as well as the latest scientific advancements, to create a system that is a model for others.
- **Community -** We will work to reduce stigma to increase access to mental health services and to increase awareness of the benefits of treatment.
- **Learning -** We will enhance professional knowledge and skills through inquiry, teaching, learning, and research.
- **Value -** We will assure that the cost of our services reflects their value and we will operate in a cost-efficient way.
- **Safety** - We will provide a safe environment for consumers, volunteers, staff, and visitors.

- **Diversity** - We will foster an environment that embraces the diversity of all of our constituents.
- **Charity** - We will meet our charitable responsibilities to serve the community and to honor the intent of our donors.
- **Caring** - We will provide all of our services with compassion and sensitivity.

Outreach Activities Since the Previous CHNA

Through its programs and services, as well as its affiliate and partner relationships, Sheppard Pratt Health System has been active in providing the community with a continuum of care that can include inpatient hospitalization, partial hospitalization, intensive outpatient treatment, outpatient referrals, and housing and rehabilitation services, as needed. Some of the highlights since its last community assessment include:

- Engaged 400 people in its 2018 "Stride" community walk event in Towson benefiting individuals with serious mental illness. The event raised over $ 25,000 to support patients and students.
- Provided a broad continuum of care to those who rely on Medical Assistance. In FY '18 our payor mix was over 31% Medical Assistance.
- Served as one of the largest private providers of special education services in Maryland with schools throughout the state.
- Contributed over $4.6 million in charity health care in the past year alone.
- Fielded 11,818 calls through our Therapy Referral Service in the past year.
- Maintained an Autism Specialty page as part of Sheppard Pratt's Virtual Resource Center. This specialty page has received more than 1,500 views in FY 2018.
- Provided a Parent Lecture Series with 997 individuals attending in FY 2018.
- Operated the Positive Behavioral Intervention System (PBIS). This program engages teachers and school systems staff in professional educational opportunities that better prepare them to identify student with mental health needs. A total of 117 training events were held, training 6,766 school staff in PBIS in FY '18.
- Operated the Life Space Crisis Program. This program provides school staff with an intensive experiential training which integrates evidenced-based practices related to prevention and integration, behavioral management and modification which results in positive student relationships with school staff. In FY 2018, 1,000 school staff received training.
- Provided Crisis Services: In FY 2018:
  - 4,570 individuals utilized the Crisis Walk In Clinic
  - 715 individuals utilized the Urgent Assessment, Scheduled Crisis Intervention and Bridge programs
- Operated the Crisis Referral Outpatient Program – 1,449 individuals served in FY 2018.
- Provided Tele-psychiatry Services.
  - 2,101 encounters were provided to active clients at 9 centers, including
  - 471 initial evaluations and 1,630 medication management sessions

- Provided Professional Education – “Wednesday Lecture Series” – 3,181 people attended the series in FY 2018.
- Provided services to low income or underinsured individuals.
    - 1,261 individuals were provided with Financial Assistance
    - 225 individuals were provided with assistance in accessing insurance and other support programs
- Opened a new observation unit in FY ’17, the Behavioral Observation Service, with the intention of reducing hospital emergency department referrals for patients presenting for co-occurring (mental health & addictions care) as well as inpatient admissions for such care. After being medically stabilized in observation status, patients can be evaluated to determine the most appropriate level of care. In FY ’18 104 patients were treated by this service.
- Developed and implemented a collaborative care project with GBMC in 2017. The goals were to create more capacity for mental health services in alliance with somatic care providers, reduce the stigma often associated with seeking mental health treatment, and reduce ED visits related to mental health conditions. In FY ’18 there were 2,031 patients seen in the 10 primary care medical homes operated by GBMC, with a total of 5,875 visits.

Methodology Summary and Service Area Profile

The ACA requires all U.S. not-for-profit hospitals to complete a Community Health Needs Assessment (CHNA) every three years. The purpose of the CHNA is to help identify prioritized community needs that can confirm and/or help focus hospital outreach programs. CHNAs are required to contain the following components:

- Definition of the Primary Service Area (PSA) market served
- Description of the methodology used to collect a comprehensive list of community needs from people representing a broad range of community interests – especially those of underserved populations
- A prioritized list of community health needs and a description of the methodology used to prioritize them
- A summary of activities conducted since the prior CHNA
- Description of the community resources potentially available to address significant health needs as identified in the CHNA
- NOTE: Each hospital – Towson and Ellicott City – is required to submit its own CHNA document and draft its own Implementation Plan (in response to the IRS Schedule 990H requirements). However, for hospitals that jointly conduct their CHNA research, common activities and/or data "may be substantively identical."

Sheppard Pratt used a multi-modal approach to conduct the research for the 2019 CHNA. The CHNA for each hospital included the following:

- Demographic and other secondary research
- Focus group discussions with key stakeholders – many of whom serve underserved populations (including public health officials)[1]
- One-on-one telephone interviews with key stakeholders
- Discussions with hospital leaders
- Needs prioritization activities

[1] A list of stakeholders who participated in the leadership groups and one-on-one interviews is included in the appendix.

Service Areas

The market areas for the Towson hospital and the Ellicott City hospital overlap, but each have areas in which they have greater concentrations of patients.

Towson location patients are more highly concentrated in Baltimore County and Baltimore City while Ellicott City has a greater concentration of patients from Anne Arundel County and Howard Counties. Ellicott City also has a higher percent of patients coming from other counties in Maryland than the Towson facility.

Table 1: Percent of 2018 In-Patient Population by Sheppard Pratt Service Area

Area	Population	Percent of Maryland Population	Percent of 2018 Towson In-patient Population	Percent of 2018 Ellicott City In-patient Population
Anne Arundel County	564,600	9.4%	10.7%	24.9%
Baltimore County	828,637	13.8%	19.2%	15.1%
Baltimore City	619,796	10.3%	31.2%	18.3%
Howard County	312,495	5.2%	5.6%	9.4%
Harford County	250,132	4.2%	5.4%	2.8%
All other Maryland counties	N/a	N/a	19.4%	25.6%
Non-Maryland	N/a	N/a	8.5%	3.8%
Total			100.0%	100.0%

Data Source: US Census Bureau, American Community Survey. 2013-17. Source geography: Tract

- Sheppard Pratt, in general, and the Towson location in particular have an outstanding reputation and tend to draw patients from a relatively wide geography, as one in three (27.9%) inpatients at the Towson location reside in Maryland counties other than those listed above or from other states. Approximately one-third of Ellicott City patients (29.4%) reside in other areas.
- Approximately one-third (31.2%) of in-patient patients at the Towson facility reside in Baltimore City. Followed by 19.2% in Baltimore County.
- For the Ellicott City facility, a disproportionately high percentage of patients come from Anne Arundel County (24.9% of patients) and other Maryland counties (25.6%).

The Sheppard Pratt Hospital – Ellicott City Campus CHNA will be addressed in a separate report. However, due to the proximity of both service areas, demographics, and other key quantifiable data for the Ellicott City service area is included in the Towson report where helpful.

Secondary Research Profile

During the secondary research phase of the project, data was collected from four domains:

- Demographics
- Social and Physical Environment Factors
- Risk and Protective Lifestyle Behaviors
- Health Status

As a summary of the secondary research, the Towson service area is diverse in respect to race, income, lifestyle factors, and others. The overall population of the service area is stable, yet the Baltimore City population is contracting while Baltimore County and Harford County is increasing. However, the challenging characteristics of Baltimore City are reflected in community needs, as identified in the research.

The Ellicott City service area is characterized by increasing population, higher income and educational attainment, and healthier lifestyles compared to the Towson service area. Though some demographic and environmental factors are favorable for Howard and Anne Arundel Counties, research respondents identified a clear list of community health needs.

In the following sections that present demographic and other data, information is shown for the Towson and Ellicott City service areas; the Ellicott City data is presented for comparison purposes. The following tables highlight data that provides a profile of the primary areas served by each hospital.

Demographic Factors

There are over 1.44 million people in Baltimore County and Baltimore City and approximately 1.7 million people in the primary Sheppard Pratt service area.

Table 2: Population by County

Towson Facility Service Area			Ellicott City Facility Service Area		
Area	Population	Percent Change since 2000	Area	Population	Percent Change since 2000
Baltimore County	828,637	6.73%	**Anne Arundel County**	564,600	9.8%
Baltimore City	619,796	-4.64%	**Howard County**	312,495	15.83%
Harford County	250,132	12.0%			
Maryland	5,996,079	9.01%			

Source: US Census Bureau, Decennial Census. 2000 - 2010. Source geography: Tract.

- From 2000 to 2015, there was a shift in population out of the most urban area (Baltimore City) to other areas.
- Growth was especially strong in Howard and Harford counties where the population grew over 15.83% and 12.0%, respectively.

The population in each facility's service area includes slightly more females than males. However, for the Towson location service area, the difference is more pronounced. Men and women may have different disease prevalence and healthcare needs.

Table 3: Gender by County

Towson Facility Service Area			Ellicott City Facility Service Area		
Area	**Perfect Male**	**Percent Female**	**Area**	**Perfect Male**	**Percent Female**
Baltimore County	47.42%	52.58%	**Anne Arundel County**	49.52%	50.48%
Baltimore City	47.01%	52.99%	**Howard County**	48.91%	51.09%
Harford County	48.91%	51.09%			
Maryland	48.47%	50.77%			

Data Source: US Census Bureau, American Community Survey. 2013-17. Source geography: Tract

- The population in Baltimore County and Baltimore City is nearly 53% female. The Ellicott City service area and Harford County split is more even – 51% female; 49% male.
- Anne Arundel County has the highest percentage of males.

The Towson service area is highly diverse, especially in Baltimore City where over 62% of the population is African American. The Ellicott City service area is largely white with pockets of diversity. Harford County has the least diversity in the Sheppard Pratt service area.

Table 4: Race and Ethnicity by County

Towson Facility Service Area					Ellicott City Facility Service Area				
Area	**% Afri. Amer.**	**% White**	**% Hispanic**	**% Lang. Other than English**	**Area**	**% Afri. Amer.**	**% White**	**% Hispanic**	**% Lang. Other than English**
Baltimore County	27.94%	62.07%	5.12%	2.77%	**Anne Arundel County**	31.21%	58.28%	7.31%	1.86%
Baltimore City	62.80%	30.29%	4.96%	2.26%	**Howard County**	18.48%	58.69%	6.51%	2.87%
Harford County	13.47%	79.40%	4.24%	0.88%					
Maryland	29.72%	56.62%	17.60%	3.35%					

Data Source: US Census Bureau, American Community Survey. 2013-17. Source geography: Tract

- Nearly two of three (62.80%) Baltimore City residents are African American while about three of ten (30.29%) are white. Within the Towson service area, Baltimore County has the opposite racial makeup.
- Harford County has the least racial diversity with approximately 80% of the population identifying as white.

Baltimore County, Anne Arundel County, and Howard County each have a median age similar to the Maryland average while the median age is lower (35.0 years) in Baltimore City. Harford County has the oldest median age at 40.6 years.

Table 5: Median Age and Age Groups by County

Towson Facility Service Area					Ellicott City Facility Service Area				
Area	**Median Age**	**% under 25**	**% 25 to 64**	**% 65 and older**	**Area**	**Median Age**	**% under 25**	**% 25 to 64**	**% 65 and older**
Baltimore County	39.2	30.81%	39.59%	16.10%	**Anne Arundel County**	38.5	31.40%	41.97%	13.76%
Baltimore City	35.0	31.39%	43.41%	12.79%	**Howard County**	38.7	32.69%	41.96%	12.55%
Harford County	40.6	31.23%	39.96%	14.94%					
Maryland	38.5	31.70%	41.09%	14.16%	**United States**	37.8	32.62%	52.50%	14.87%

Data Source: US Census Bureau, American Community Survey. 2013-17. Source geography: Tract

- The median age in Baltimore City is relatively low (35.0 years). It is substantially lower than Baltimore County (39.2), the state of Maryland (38.5) and the U.S. total (37.8).
- The median age of residents in the Ellicott City facility service area and Baltimore County are near the Maryland state average.
- About one in three people in both service areas are age 25 or younger.
- Baltimore County (16.10%) and Harford County (14.94%) have the highest percentage of individuals 65 years and old. Seniors often have different needs than children and younger adults.

Social and Physical Environment Factors

The high school graduation rates are similar in each facility's service area. However, the percentage of those with college degrees is substantially higher in the Ellicott City service area.

Table 6: Educational Attainment by County

Towson Facility Service Area						Ellicott City Facility Service Area					
Area	% No H.S. Diploma	% H.S. Grad	% with Some College	% College Grad	% Advanced Degree	Area	% No H.S. Diploma	% H.S. Grad	% with Some College	% College Grad	% Advanced Degree
Baltimore County	8.37%	23.44%	18.83%	21.63%	16.89%	**Anne Arundel County**	7.44%	21.02%	19.77%	23.25%	17.46%
Baltimore City	15.38%	24.54%	18.95%	15.95%	15.14%	**Howard County**	4.28%	12.40%	13.91%	29.80%	32.68%
Harford County	6.70%	24.15%	21.65%	20.93%	14.75%						
Maryland	9.59%	22.12%	18.70%	20.89%	18.91%	**United States**	12.29%	23.00%	20.52%	19.60%	12.18%

Source: ACS 2010-2014.

- Nearly two of five (39.92%) Baltimore City adults have only a high school diploma (24.54%) or less (15.38%).
- About five of seven people (68%) in the Ellicott City service area have at least some college (including those with a degree).
- Howard County is the most educated county with over 62% of the population having at least a bachelor's degree.
- Approximately 50% of the population in Baltimore City has at least some college or a degree while over 57% of the population in Harford County has at least some college or a degree.

The Ellicott City service area has a substantially higher household income than the Towson location and is higher than the state median. In the respective service areas, there is also a dramatic difference in the percentage of children aged 0-17 who are living in households with income below the Federal Poverty Level (FPL).

Table 7: Income and Poverty by County

Towson Facility Service Area					Ellicott City Facility Service Area				
Area	**Median HH Income**	**% under 100% FPL**	**% Children under 100% FPL**	**% HH Income $100,000+**	**Area**	**Median HH Income**	**% under 100% FPL**	**% Children under 100% FPL**	**% HH Income $100,000+**
Baltimore County	$71,810	9.10%	11.46%	34.1%	**Anne Arundel County**	$94,502	6.07%	7.35%	47.1%
Baltimore City	$46,641	22.43%	32.90%	20.0%	**Howard County**	$115,576	5.16%	5.79%	58.0%
Harford County	$83,445	7.47%	9.24%	41.2%					
Maryland	$78,916	9.68%	12.89%	39.1%	**United States**	$57,652	14.58%	20.31%	26.2%

Data Source: US Census Bureau, American Community Survey. 2013-17. Source geography: Tract

- Nearly one-third (32.90%) of children in Baltimore City live under 100% of the FPL.
- More than 34% of Baltimore County households earn annual income of over $100,000 – nearly double the rate of Baltimore City.
- Over 40% of Harford County residents earn a household income over $100,000, which is the highest in the Towson service area and over twice the rate of Baltimore City.
- More than half (58%) of Howard County households earn over $100,000.

Risk and Protective Lifestyle Behaviors

This indicator reports the number of providers per 100,000 population. The ratios of providers – PCP, dental, and mental health – in Harford County and Anne Arundel County are lower (worse) than the state average.

Table 8: Provider Rates per 100,000 Population by County

Towson Facility Service Area				Ellicott City Facility Service Area			
	Rate per 100,000 population				Rate per 100,000 population		
Area	Primary Care Physicians[2]	Mental Health Care	Dental Care	Area	Primary Care Physicians	Mental Health Care	Dental Care
Baltimore County	119.72	251.00	73.27	**Anne Arundel County**	74.09	153.80	66.47
Baltimore City	176.62	372.70	64.32	**Howard County**	207.58	251.90	81.68
Harford County	63.17	146.20	61.53				
Maryland	104.50	216.00	74.20	**United States**	87.80	202.80	65.60

Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2015.

- Baltimore City has the highest ratio of population to mental health providers in the combined service areas meaning there are an above average number of mental health providers in the city. Baltimore City has more mental health providers than both the state and national average.
- Harford County has the lowest ratio of primary care, mental health, and dental providers than any of the other counties in both service areas. Harford County has nearly half the primary care providers than the state average.

[2] Note: This indicator reports the population per provider. Primary care doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs and General Pediatrics MDs.

- Anne Arundel County has slightly more providers than Harford County, but has the lowest ratio of providers in the Ellicott City service area. Both Anne Arundel and Harford Counties are geographically more rural, and the United States is currently facing a physician shortage in rural areas[3].

Overall, the health status measures that indicate an overweight population in each facility's service area are similar to the state and the nation. However, the percentage for Baltimore City in the Towson service area is higher whereas the percentage is substantially lower in Howard County. Obesity is a major risk factor for chronic diseases, such as diabetes and heart disease[4].

Table 9: Obesity and Physical Activity by County

Towson Facility Service Area			Ellicott City Facility Service Area		
Area	**BMI of 30 or more**	**% with no leisure physical activity**	**Area**	**BMI of 30 or more**	**% with no leisure physical activity**
Baltimore County	30.7%	21.8%	**Anne Arundel County**	28.8%	18.4%
Baltimore City	33.2%	24.7%	**Howard County**	23.9%	15.4%
Harford County	29.8%	21.9%			
Maryland	30.0%	20.6%	**United States**	28.3%	21.6%

Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2015.
Source geography: County

- In Baltimore City, one in three adults have a BMI over 30; and one in four (24.7%) have no leisure physical activity.
- Howard County residents have the lowest percentage of people with BMI over 30 (23.9%) and percent with no leisure physical activity (15.4%).
- Baltimore County, Harford County, and Anne Arundel County rates are similar to the state averages.

[3] Warshaw R. Health disparities affect millions in rural U.S. communities. AAMCNews. https://news.aamc.org/patient-care/article/health-disparities-affect-millions-rural-us-commun/
[4] https://www.cdc.gov/obesity/adult/causes.html

Health Status Profile

General Health Status

The Towson service area has a higher percentage of adults age 18 and older self-report having poor or fair health in response to the question "Would you say that in general your health is excellent, very good, good, fair, or poor?" This indicator is relevant because it is a measure of general poor health status. The self-reported measure for mental health status is also above the state.

Table 10: Health Status of Residents by County

Towson Facility Service Area				Ellicott City Facility Service Area			
Area	% Poor or Fair Health	Poor Physical Health Days	Poor Mental Health Days	Area	% Poor or Fair Health	Poor Physical Health Days	Poor Mental Health Days
Baltimore County	13%	3.1	3.7	**Anne Arundel County**	11%	3.0	3.4
Baltimore City	19%	3.7	4.1	**Howard County**	9%	2.4	2.9
Harford County	13%	3.3	3.6				
Maryland	14%	3.1	3.5				

Source: 2019 County Health Rankings.

- The Towson and Ellicott City services areas differ in that – consistent with some demographic and lifestyle indicators – Baltimore County, Harford County, and Baltimore City have generally poorer health and poorer physical and mental health days, especially Baltimore City.

Mortality – Leading Causes of Death

In nearly all cases, the most common causes of death in respective services areas for each facility are consistent with those of the U.S. as a whole: Diseases of the Heart, Cancer (Malignant Neoplasms), Cerebrovascular Diseases, and Chronic Lower Respiratory Disease. However, the rates in the Towson service are higher, driven in large part by the heart disease rates in Baltimore City.

Table 11: Leading Cause of Death by County

Towson Facility Service Area		Ellicott City Facility Service Area	
Area	Deaths per 100,000[5]	Area	Deaths per 100,000[6]
Baltimore County	**763.8**	**Anne Arundel County**	**713.4**
Diseases of the Heart	179.3	Diseases of the Heart	158.5
Malignant Neoplasms	167.8	Malignant Neoplasms	153.9
Cerebrovascular Diseases	43.6	Cerebrovascular Diseases	45.8
Accidents / Unintentional Poisoning	39.6	Chronic Lower Respiratory Disease	36.7
Chronic Lower Respiratory Disease	32.0	Accidents / Unintentional Poisoning	33.1
Suicide	9.7	Suicide	12.1
Baltimore City	**1033.3**	**Howard County**	**525.0**
Diseases of the Heart	241.4	Malignant Neoplasms	117.6
Malignant Neoplasms	201.9	Diseases of the Heart	106.2
Cerebrovascular Diseases	54.8	Cerebrovascular Diseases	32.7
Accidents / Unintentional Poisoning	49.7	Accidents / Unintentional Poisoning	24.4
Chronic Lower Respiratory Disease	37.5	Chronic Lower Respiratory Disease	17.8
Suicide	8.3	Suicide	8.0
Harford County	**745.0**	**Maryland**	**715.3**

[5] 2011 – 2013 age adjusted death rates for leading causes, per 100,000 population
[6] 2011 – 2013 age adjusted death rates for leading causes, per 100,000 population

Towson Facility Service Area		Ellicott City Facility Service Area	
Area	Deaths per 100,000[5]	Area	Deaths per 100,000[6]
Diseases of the Heart	167.1	Diseases of the Heart	166.4
Malignant Neoplasms	164.1	Malignant Neoplasms	154.5
Cerebrovascular Diseases	36.6	Cerebrovascular Diseases	39.3
Chronic Lower Respiratory Disease	39.0	Accidents / Unintentional Poisoning	34.3
Accidents / Unintentional Poisoning	34.6	Chronic Lower Respiratory Disease	30.4
Suicide	10.7	Suicide	9.3

Source: Neall RR. And Hurt SL. Maryland Vital Statistics Annual Report 2017. Retrieved March 29, 2019, from https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2017annual.pdf.

Suicide Rates

Suicide is a serious public health problem that can have lasting effects on individuals, families, and communities. Suicide is highly correlated with mental health and substance abuse disorders. The State Health Improvement Process[7] (SHIP) indicates that approximately 500 lives are lost each year in the state to this preventable cause of death.

The SHIP provides a framework for accountability, local action, and public engagement in order to advance the health of Maryland residents. The SHIP measures for improvement are aligned with the Healthy People (HP) 2020 objectives established by the Department of Health and Human Services. State and county level data on critical health measures is also provided through the SHIP.

[7] SHIP Accessed March 2019: http://dhmh.maryland.gov/ship/Pages/home.aspx

During the measurement period 2014-2016, the statewide rate of completed suicides was 9.2 people per 100,000. The Maryland rate of suicide is already below the national Healthy People 2020 goal of 10.2. All racial groups in Maryland were at, or below, this rate except for non-Hispanic whites where the rate was 12.8, which increased since 2007.

Figure 1: Suicide Rates by Race and Ethnicity for Maryland, 2014-2016

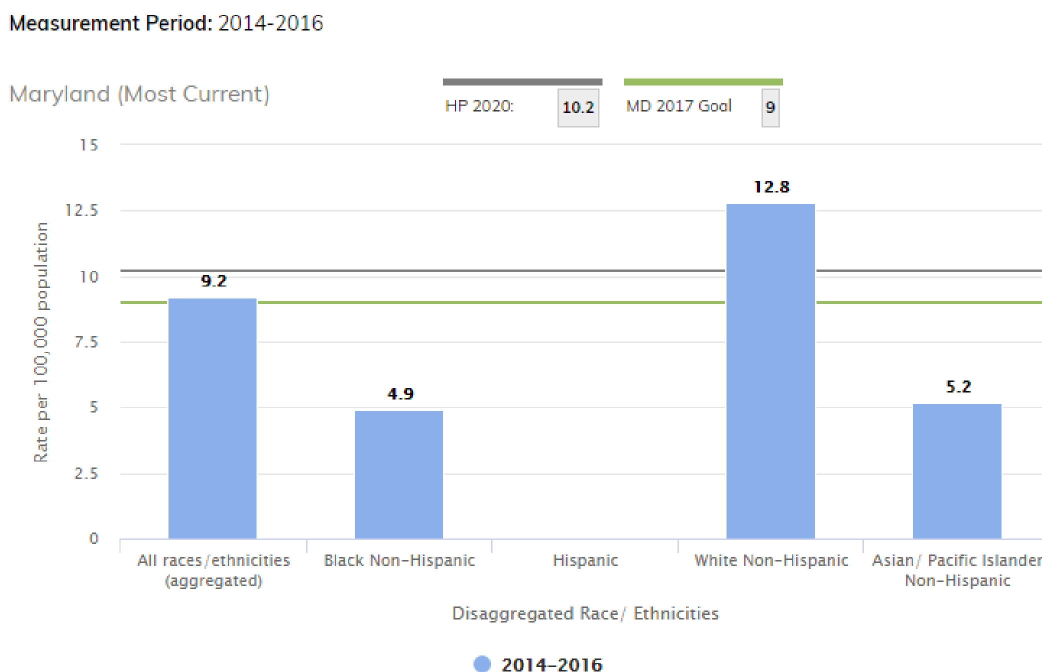
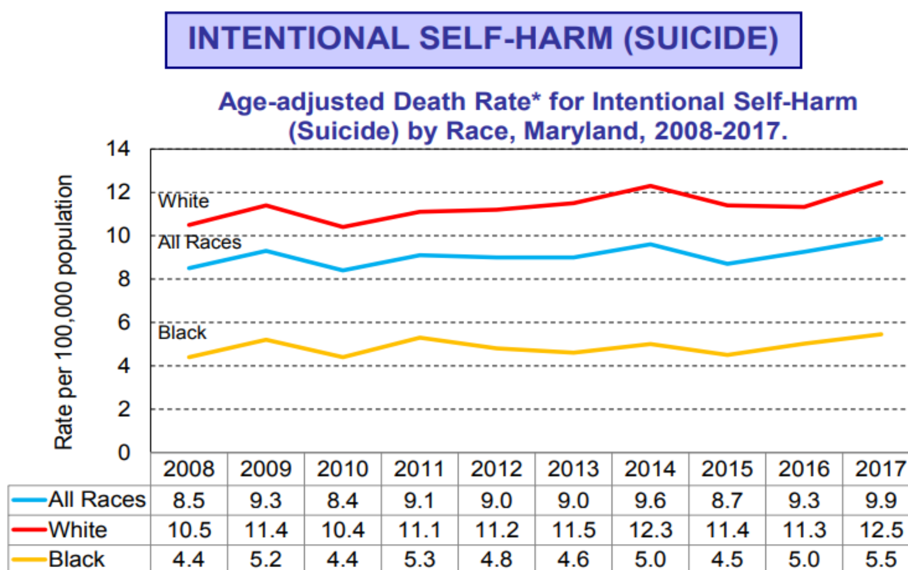


Figure 2: Suicide Age-adjusted Death Rate by Race for Maryland, 2008-2017

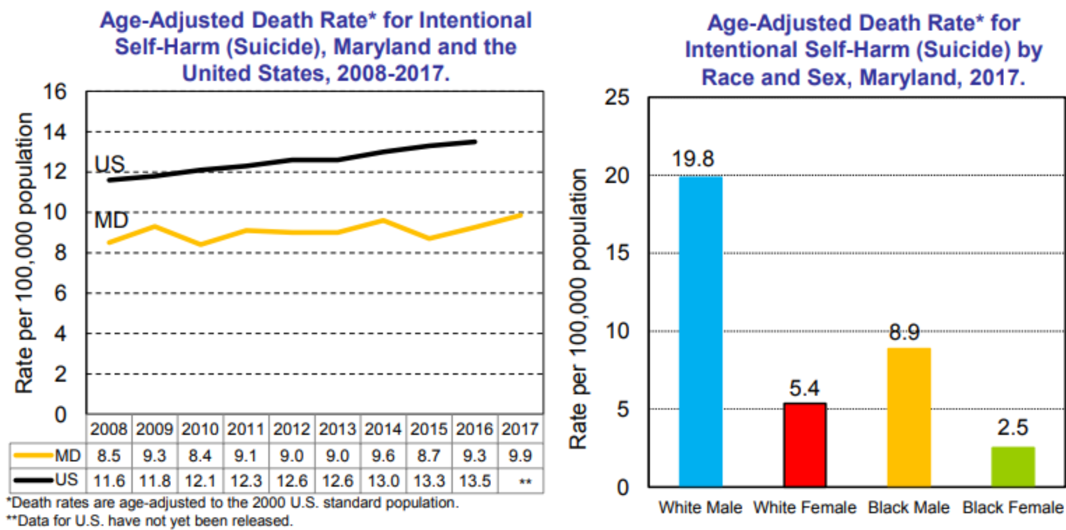


	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
All Races	8.5	9.3	8.4	9.1	9.0	9.0	9.6	8.7	9.3	9.9
White	10.5	11.4	10.4	11.1	11.2	11.5	12.3	11.4	11.3	12.5
Black	4.4	5.2	4.4	5.3	4.8	4.6	5.0	4.5	5.0	5.5

Source: Neall RR. And Hurt SL. Maryland Vital Statistics Annual Report 2017. Retrieved March 29, 2019, from https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2017annual.pdf.

- The suicide rates in Maryland peaked in 2009 and then reached an all-time low in 2010. Since 2010, the age-adjusted death rate for suicide has steadily climbed for all races before dipping again in 2015. Once again, the death rate for suicide is increasing for all races.
- White people have the highest age-adjusted death rate for suicide, which is over twice that of black people.

Figure 3: Age-adjusted Death Rate for Suicide



- Age-adjusted death rate for suicide is significantly higher in white males than white females and black males and females.

Morbidity

According to the CDC, six in ten adults in the United States have at least one chronic disease. Chronic diseases, such as heart disease, cancer, and diabetes are the leading causes of death and disability in the U.S. Howard County residents have the lowest incidences of cancer, diabetes, and asthmas; whereas, Harford County has some of the highest incidence rates.

Table 12: Percent of the Adult Population with Select Chronic Conditions

Chronic Condition	Baltimore County	Baltimore City	Anne Arundel County	Harford County	Howard County	Maryland
Arthritis	28.2%	23.1%	23.7%	30.7%	18.6%	23.5%
Asthma	14.3%	17.5%	11.4%	15.3%	13.2%	13.9%
Cardiovascular Disease (angina or coronary disease)	4.6%	3.8%	3.3%	4.0%	2.7%	3.7%
COPD	6.2%	7.6%	5.0%	ND	ND	6.1%
Diabetes	11.9%	10.9%	9.4%	10.8%	7.8%	10.4%
Cancer – Rate per 100,000 Population (all sites)[8]	135.7	124.2	134.2	137.0	132.4	131.7

Data Source: Maryland Department of Health. 2015 Maryland BRFSS.
https://phpa.health.maryland.gov/ccdpc/Reports/Documents/MD-BRFSS/2015_MD_BRFSS_County_Level_Data_Tables.pdf

- Chronic disease incidence rates in Baltimore County and Baltimore City are generally slightly higher than the state average.
- Ellicott City service area counties rates are lower than the state average except for cancer.

[8] Data Source: State Cancer Profiles. 2011-15

Behavioral Health Condition Incidence

Depression and Anxiety Disorder Prevalence

There is a greater concentration of residents in Harford County diagnosed with Depressive Disorders than the other counties and Maryland. Baltimore County has a higher percentage of residents with Depressive Disorders and Anxiety Disorders than Baltimore City.

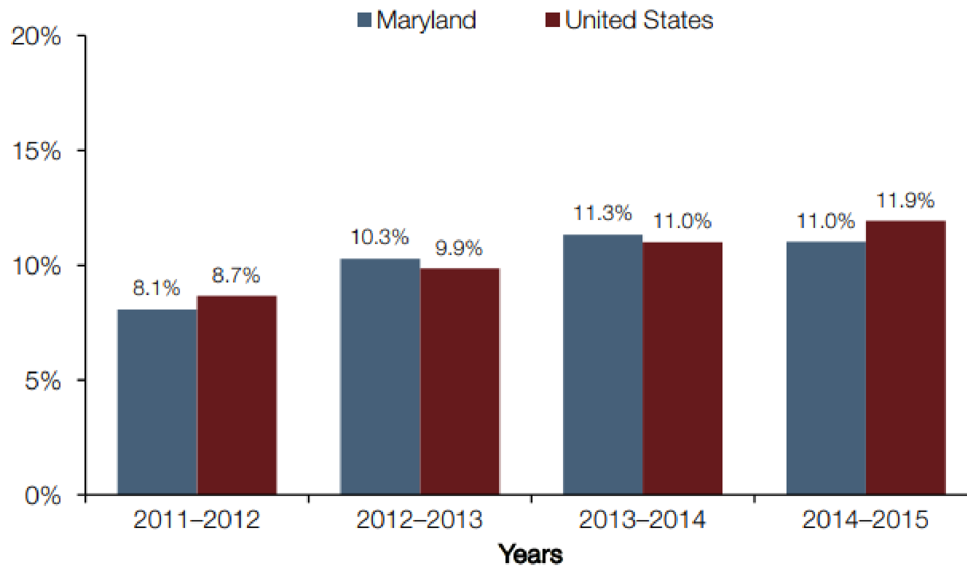
Table 13: Adult Depression and Anxiety Disorder Prevalence by County

Towson Facility Service Area			Ellicott City Facility Service Area		
Area	**% Depressive Disorder**	**% Anxiety Disorder**	**Area**	**% Depressive Disorder**	**% Anxiety Disorder**
Baltimore County	19.8%	16.7%	**Anne Arundel County**	14.3%	8.7%
Baltimore City	18.7%	11.6%	**Howard County**	14.5%	16.7%
Harford County	23.1%	ND			
Maryland	16.3%	13.5%			

Data Source: Maryland BRFSS, 2015.

- Harford County has the highest percentage of residents (23.1%) with Depressive Disorder with Baltimore County coming in second at 19.8%.
- The Ellicott City service area has the lowest concentration of residents with Depressive Disorders, but Howard County is tied with Baltimore County for the highest percentage of residents with Anxiety Disorders (16.7%).
- Baltimore City has the highest percentage of residents with a Depressive Disorder, but a lower percentage of residents with an Anxiety Disorder compared to the state.

Figure 4: Youth (12 -17 years) Major Depressive Episode Diagnosed in Past Year, 2013-2014



Data Source: Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer – Maryland Vol. 4. Rockville MD: Substance Abuse and Mental Health Services Administration, 2015. https://www.samhsa.gov/data/sites/default/files/Maryland_BHBarometer_Volume_4.pdf

- From 2014-2015, 11.0% (50,000) adolescents in Maryland between the ages of 12 – 17 years of age were diagnosed with a Major Depressive Episode in the past year, which is down by 0.3% from 2013-2014. Maryland is below the national percentage of 11.9%.
- Of the adolescents aged 12 -17 with a past year Major Depressive Event, 44.4% (20,000) received treatment for their depression. The national percentage for 2011 to 2015 was 38.9%. Over half (55.6%) did not receive treatment for depression[9].
- Approximately 64.0% of Maryland children under 18 who were treated or served in the public mental health system reported improved functioning. The national rate of improved functioning was 71.6%[10].

[9] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer – Maryland Vol. 4. Rockville MD: Substance Abuse and Mental Health Services Administration, 2015. https://www.samhsa.gov/data/sites/default/files/Maryland_BHBarometer_Volume_4.pdf

[10] Ibid.

Incidence of Excessive Alcohol Consumption

Ellicott City service area has both the highest percent of adult excessive drinking (Anne Arundel County) and the lowest percent (Howard County). Baltimore City has the highest percent of adult binge drinking in the Towson service area while Baltimore County and Harford County are above the state average.

Table 14: Adult Alcohol Consumption by County

Towson Facility Service Area			Ellicott City Facility Service Area		
Area	**% Adult Excessive Drinking**	**% Adult Excessive Drinking Age-Adjusted**	**Area**	**% Adult Excessive Drinking**	**% Adult Excessive Drinking Age-Adjusted**
Baltimore County	15.8%	16.5%	**Anne Arundel County**	18.7%	19.2%
Baltimore City	17.1%	17.7%	**Howard County**	15.4%	15.2%
Harford County	15.8%	16.2%			
Maryland	15.4%	15.7%	**United States**	16.4%	16.9%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12. Source geography: County

- Anne Arundel County has the highest age-adjusted percent of adult excessive drinking (19.2%); whereas, Howard County has the lowest (15.2%).
- Baltimore County, and Harford County fall below the national average (16.9%) and above the Maryland average (15.7%) for age-adjusted percent of adult excessive drinking.
- Approximately 12.1% (55,000) of Maryland young people between the ages of 12-17 years of age reported drinking alcohol within the month prior to being surveyed, which is similar to previous years[11].

[11] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer – Maryland Vol. 4. Rockville MD: Substance Abuse and Mental Health Services Administration, 2015. https://www.samhsa.gov/data/sites/default/files/Maryland_BHBarometer_Volume_4.pdf

Incidence of Illicit Drug Use

Although fewer than five percent of people in Baltimore County and Baltimore City used cocaine or non-medical pain medications in the past year, there is a sizable concentration of drug-related intoxication deaths that have occurred.

Table 15: Behavioral Health Measures for Baltimore-Towson Metropolitan Statistical Area (MSA) among Persons Aged 12 and Older

Drug	Baltimore-Towson[12]	Maryland	United States
Substance Use in Past Year			
Any Illicit Drug	14.3%	12.6%	14.7%
Marijuana	10.2%	9.1%	10.7%
Pain Relievers (Nonmedical)	4.4%	3.7%	4.9%
Substance Use or Mental Disorder in Past Year			
Substance Use Disorder	10.4%	8.4%	9.0%
Major Depressive Episode (Aged 18 or Older)	6.7%	5.5%	6.6%
Substance Use in Past Month			
Cigarettes	24.2%	20.7%	24.1%
Binge Alcohol	22.3%	20.1%	23.2%

Data Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2005 and 2006 to 2010 (revised March 2012).

- Residents in the Baltimore-Towson MSA have reported using any illicit drug (14.2%) above the Maryland average (12.6%), but below the national average (14.7%).
- The Baltimore-Towson MSA has a higher percentage of residents with a Substance Use Disorder (10.4%) and Major Depressive Episode (6.7%) than both the state and national averages.
- Approximately one in four residents of the Baltimore-Towson MSA have reported using cigarettes (24.2%) and binge alcohol (22.3%) in the past month.

[12] The Baltimore-Towson MSA consists of Anne Arundel County, Baltimore County, Carroll County, Harford County, Howard County, Queen Anne's County, and Baltimore City.

Table 16: Selected Drug Use, Past Year Substance Use Disorder and Treatment, and Past Year Mental Health Measures in Maryland by Age Group

Measure	12 - 17	18 - 25	26+
Illicit Drugs			
Past Month Illicit Drug Use	9.05%	28.26%	9.70%
Past Year Marijuana Use	13.76%	39.47%	12.00%
Past Month Marijuana Use	7.13%	26.24%	8.71%
Past Year Cocaine Use	0.35%	6.20%	1.69%
Past Year Heroin Use	0.05%	1.03%	0.52%
Past Year Methamphetamine Use	0.09%	0.32%	0.26%
Past Year Misuse of Pain Relievers	3.05%	7.32%	3.47%
Alcohol			
Past Month Alcohol Use	9.48%	59.08%	57.41%
Past Month Binge Alcohol Use	4.63%	39.58%	23.53%
Tobacco Products			
Past Month Tobacco Product Use	4.45%	26.10%	19.69%
Past Month Cigarette Use	2.68%	19.79%	16.56%
Past Year Substance Use Disorder and Treatment			
Illicit Drug Use Disorder	2.73%	8.01%	1.99%
Pain Reliever Use Disorder	0.47%	0.78%	0.58%
Alcohol Use Disorder	1.44%	10.46%	5.04%
Substance Use Disorder	3.45%	16.84%	6.52%
Past Year Mental Health Issues			
Serious Mental Illness	ND	6.48%	3.51%
Any Mental Illness	ND	23.18%	15.99%
Received Mental Health Services	ND	15.15%	14.04%
Had Serious Thoughts of Suicide	ND	9.04%	3.23%
Major Depressive Episode	12.91	12.93%	6.02%

Data Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016 and 2017.

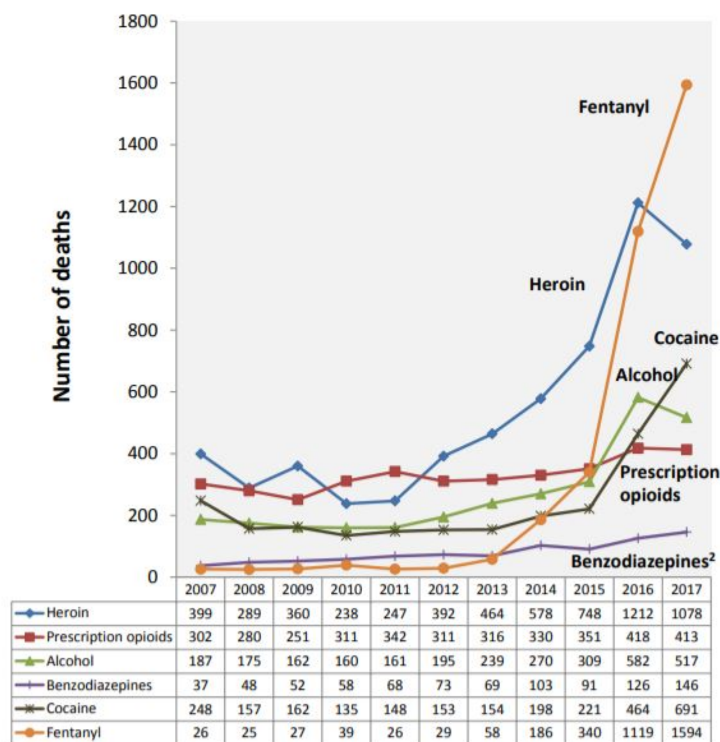
- Young people aged 18 to 25 have a significantly higher illicit drug use rates than people ages 12 to 17 and 26 and over, especially for cocaine, heroin, and misuse of pain relievers.

- Tobacco product use is higher in the 18 to 25 age group than the 12 to 17 and 26 and over age groups.
- Young people aged 18 to 25 have significantly higher illicit drug use disorder (8.01%), Alcohol Use Disorder (10.46%), and Substance Use Disorder (16.84%) than the other two age groups.
- Approximately one in four young adults aged 18 to 25 has had a mental illness in the past year compared to approximately one in six adults aged 26 and over.

Opioid-Related Data

Overall, the number of drug- and alcohol-related deaths have steadily increased from 2007 to 2017 with some decrease in death rates for selected substances in the past year.

Figure 5: Number of Drug- and Alcohol-Related Deaths by Selected Substance in Maryland, 2007-2017



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Heroin	399	289	360	238	247	392	464	578	748	1212	1078
Prescription opioids	302	280	251	311	342	311	316	330	351	418	413
Alcohol	187	175	162	160	161	195	239	270	309	582	517
Benzodiazepines	37	48	52	58	68	73	69	103	91	126	146
Cocaine	248	157	162	135	148	153	154	198	221	464	691
Fentanyl	26	25	27	39	26	29	58	186	340	1119	1594

[1]Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum to the total number of deaths.
[2]Includes deaths caused by benzodiazepines and related drugs with similar sedative effects.

Data Source: Maryland Department of Health. Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland Annual Report, 2017.
https://bha.health.maryland.gov/OVERDOSE_PREVENTION/Documents/Drug_Intox_Report_2017.pdf

- The number of drug- and alcohol-related deaths in Maryland have increased since 2007, especially in Fentanyl, Heroin, Cocaine, and prescription opioids.
- As of March 19, 2019, Anne Arundel County has experienced 29 fatal opioid-related overdoses with 28% involving Fentanyl and 21% involving a Cocaine/Fentanyl mix. There was a total of 177 overdoses in 2019, which is a 25.6% decrease from 238 overdoses YTD 2018[13].
- In 2018, Howard County experienced 225 total (fatal and non-fatal) opioid overdoses, which is up slightly from 2017.[14]
- In 2017, Baltimore City had 692 opioid-related deaths[15]. As of September 30, 2018, the citywide Staying Alive program has trained over 34,644 individuals on Narcan treatment and dispensed 3,891 naloxone kits across the city. There are 904 reversals reported in 2018[16].

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[13] Anne Arundel County Department of Health. Opioid-Related Data. https://www.aahealth.org/opioid-related-data/.
[14] Howard County Department of Health. Howard County Opioid Scorecard. https://www.howardcountymd.gov/LinkClick.aspx?fileticket=inW6R5vr-_M%3d&tabid=2851&portalid=0
[15] Maryland Department of Health. Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland Annual Report, 2017. https://bha.health.maryland.gov/OVERDOSE_PREVENTION/Documents/Drug_Intox_Report_2017.pdf
[16] Baltimore City Department of Health. Substance Use Disorder. https://health.baltimorecity.gov/programs/substance-abuse

Sheppard Pratt Patient Profile

Diagnoses – Top 7 Diagnoses FY18 by discharge[17]

The top five most frequent diagnoses at discharge in FY18 were the same in both SPHS facility service areas with only slight variations in overall rank and order.

Table 17: Top 7 FY18 Diagnoses by Discharge Data by Sheppard Pratt Service Area

Townson Facility Service Area			Ellicott City Facility Service Area		
Rank	**Diagnoses**	**Number of Discharges**	**Rank**	**Diagnoses**	**Number of Discharges**
1	Major Depressive Disorders	1,925	1	Major Depressive Disorders	933
2	Bipolar Disorders	997	2	Bipolar Disorders	759
3	Schizoaffective disorders	485	3	Schizoaffective disorders	308
4	Eating Disorders	263	4	Mood Disorders	268
5	Adjustment Disorders	48	5	Adjustment Disorders	35
6	Anxiety Disorders	40	6	Anxiety Disorders	29
7	Mood Disorders	3	7	Eating Disorders	4
	All others diagnoses	1,871		All others diagnoses	222
	TOTAL	5,632		TOTAL	2,558

- The Towson campus provided treatment to over twice as many individuals than the Ellicott City campus.
- There were twice as many patients discharged with the diagnosis of Major Depressive Disorder (from the Towson campus than the Ellicott City campus.
- Across both SPHS campuses, Major Depressive Disorders and Bipolar Disorders were the top two recurring diagnoses at discharge in FY2018.

[17] SPHS Diagnosis at Discharge, FY18

Digital / Social Media Data Analysis

Over four billion people across the globe use the internet with approximately 3.2 billion using social media in 2018.[18] The internet and social media has become a powerful channel to share information at home and around the world.

Approximately two-thirds of all U.S. adults (68%) are Facebook users and 75% of those users access Facebook at least daily. YouTube, while not considered a traditional social media platform, has increased in popularity in the recent years with 73% of U.S. adults reported using the platform[19]. Google continues to be the top search engine with 70% of all search market share.

With an abundance of information at an individual's fingertips, one in three Americans have searched online to figure out a medical condition.[20] Of those who seek medical information online, 46% of the individuals sought attention from their medical provider. Reviewing online search interest and social media can help identify the most common, emerging, and surging healthcare-related issues in the local community.

Approach:

As noted, Crescendo deployed data analysis and reporting techniques based on digital communications resources such as the following:

- Facebook Business Manager
- Meltwater Social Media Insight
- Google Analytics and Trend Analysis

Goal:

To Better understand community members' interest in mental health and substance use disorder topics by identifying the most common, emerging, and/or surging mental health and substance use disorder issues included in publicly available online discussions.

Digital tools, such as Google Trends, Meltwater Services, and others can help identify mental health and substance use disorder issues that are increasingly pertinent in online discussions across social media and the internet.

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[18] We Are Social. *Digital in 2018: World's Internet User Pass the 4 Billion Mark*. https://wearesocial.com/blog/2018/01/global-digital-report-2018

[19] Pew Research Center. *Social Media Use in 2018*. http://www.pewinternet.org/2018/03/01/social-media-use-in-2018/

[20] Pew Research Center. Health Online 2013. http://www.pewinternet.org/2013/01/15/health-online-2013/

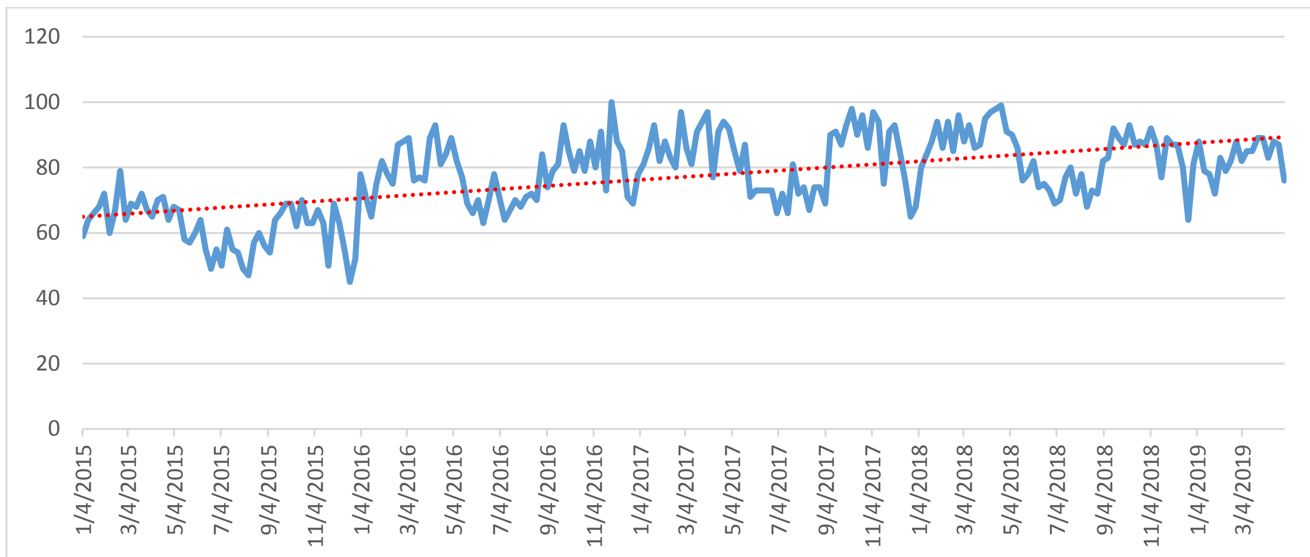
About Google Trends

Google Trends is a search trends feature from Google that shows how frequently a given search term is entered into Google's search engine relative to the site's total search volume over a given time period. Google uses a relative score to measure the index of search activity. The maximum value, or peak popularity, is 100. For example, if the value for "Baltimore" is 100 and the value for "donut" is 50, the number of searches for "donut" is half as popular as "Baltimore." A score of 0 means there was not enough data for the term.

The following charts depict the search interest for mental health issues in the Baltimore area over a specific time period.

Mental Health Search Interest Overview

Figure 6: Google Search Interest Over Time for Mental Health



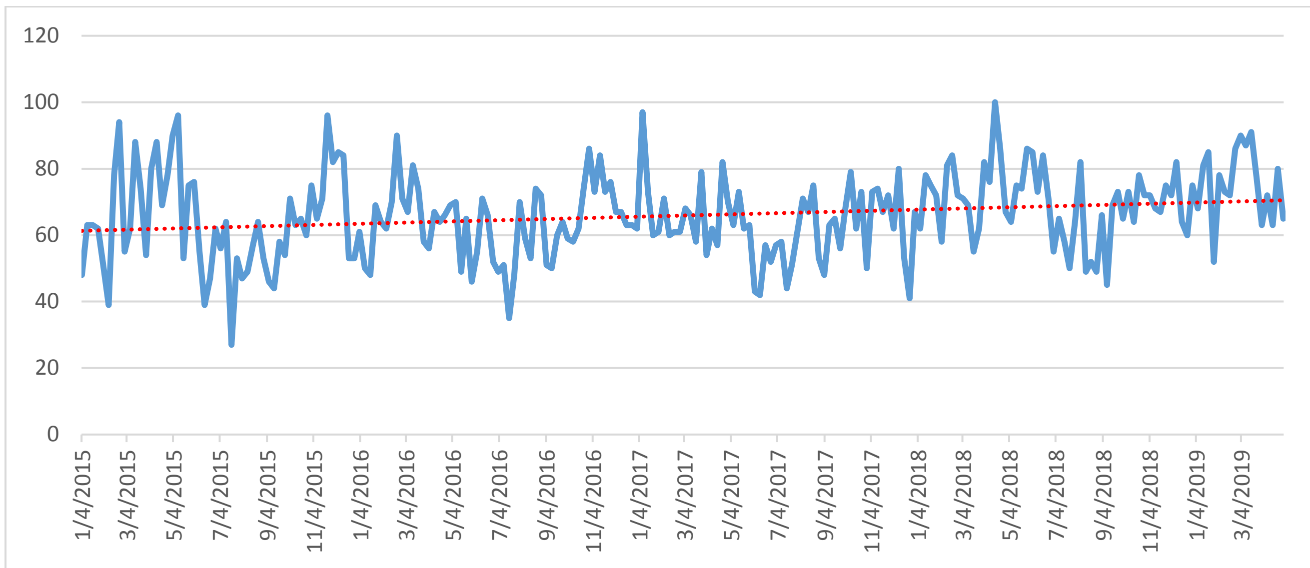
- From January 1, 2015 through April 30, 2019, search interest for "Mental Health" increased approximately 42%, which is above the national increase of 29% for mental health.
- Top search queries for mental health include anxiety, depression, autism, bipolar, and ADHD. The top rising search term, which is the term with the biggest increase in search frequency since January 1, 2015 is "psychiatrist near me."

Mental Health Disorders Google Search Interest

Approximately 35% of U.S. adults have reported they have gone online to try to figure out what medical condition they or someone else might have.[21] Search interest for mental health in the Greater Baltimore area has increased above the national trend since the 2015 Community Health Needs Assessment in 2015. Search interest for anxiety has increased above the national average while search interest in substance abuse has decreased slightly during the same time period.

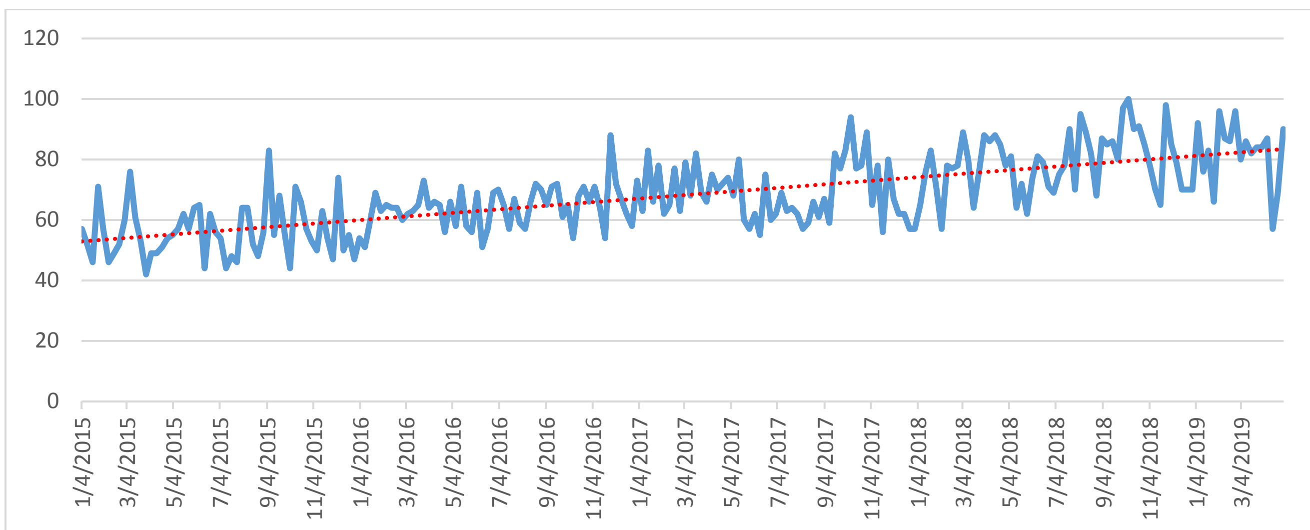
[21] Pew Research Center. Health Online 2013. http://www.pewinternet.org/2013/01/15/health-online-2013/

Figure 7:Google Search Interest Over Time for Depression



- Search interest for Depression increased approximately 17% from January 1, 2015 through April 30, 2019, which is below the national increase of 22%.
- Depression as a search term was most popular in Stevensville, Towson, Pasadena, Lake Shore, and Catonsville.
- Top search terms for Depression include depressions, anxiety, depression symptoms, and bipolar. The top two rising search terms are ketamine and bupropion.

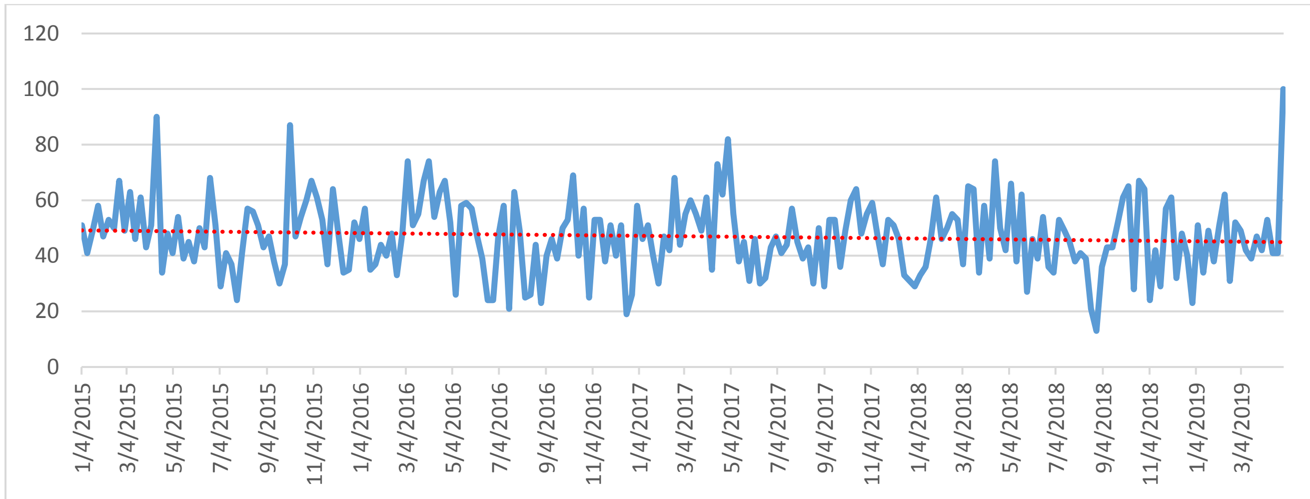
Figure 8: Google Search Interest Over Time for Anxiety



- From January 1, 2015 through April 30, 2019, search interest for Anxiety increased 63% in the Baltimore area. The Baltimore area is slight above the national increase rate of 57% during the same time period.
- Anxiety has a search term was most popular in Bel Air, Towson, White Marsh, Bel Air North, and Arnold.

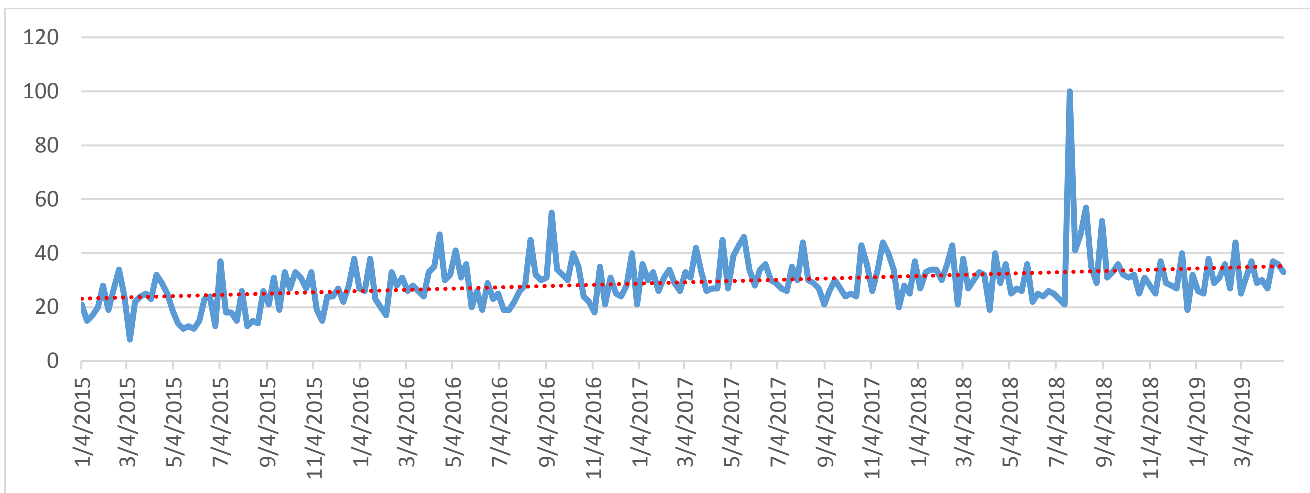
- The top search terms include anxiety symptoms, social anxiety, depression, anxiety medication, and anxiety attack.
- The top rising search terms include CBD oil, medical cannabis, and weighted blanket indicating that people are researching alternative treatment options for anxiety.

Figure 9: Google Search Interest Over Time for Substance Abuse



- Search interest for Substance Abuse decreased by approximately 8% overall from January 1, 2015 through April 30, 2019 although there is great variability in search interest.
- Search interest was highest in Towson, Baltimore, Catonsville, and Columbia where a high percentage of substance abuse services are location in the region.

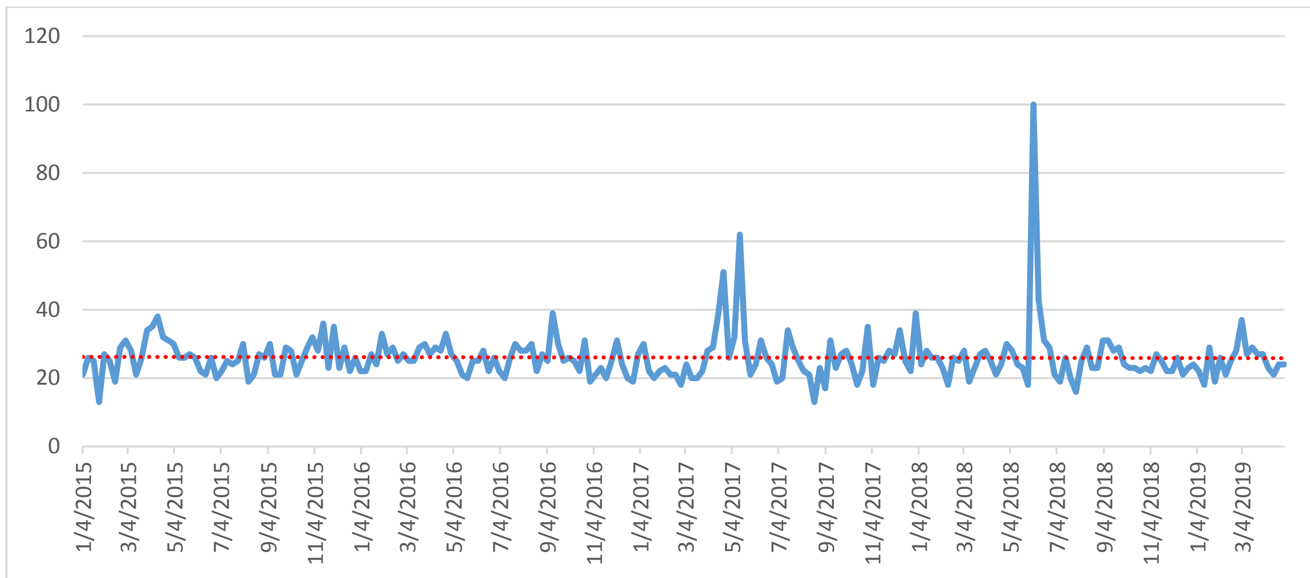
Figure 10: Google Search Interest Over Time for Drug Overdose



- From January 1, 2015 through April 30, 2019, search interest for drug overdose increased approximately 64%.

- Search interest reached an all-time high during the week of July 22, 2018 due to the high-profile Heroin overdose of the popstar, Demi Lovato.
- Search interest for the term "drug overdose" was highest in Bel Air South, Glen Burnie, Westminster, Catonsville, and Baltimore.
- The top search terms include overdose, drug overdose, heroin overdose, fentanyl, and Demi Lovato.

Figure 11: Google Search Interest Over Time for Suicide



- Search interest for Suicide has remained relatively flat from January 1, 2015 through April 30, 2019 following similar national trends.
- Search interest for the term "suicide" reached peaks around May 2017 and June 2018. The May 2017 peak is due to the release of the movie The Suicide Squad. The June 2018 peaks are due to the high-profile suicides of Kate Spade and Anthony Bourdain.
- Top search terms include suicidal, suicide hotline, suicide prevention, and suicide.

Summary

The digital analysis of Google search interest trends in the Greater Baltimore area reveals some positive correlations between mental health disorder Google searches and diagnoses. Since the previous Community Health Needs Assessment in 2015, Google search interest for anxiety has increased 63%, which is higher than the national trend. Search interest for depression has also increased during the same time period, but below the national trend. Interestingly, search interest popularity for both depression and anxiety are highest in cities mainly in Baltimore and Harford Counties.

The positive correlation between Google search increase for anxiety and depression may indicate two things: 1) awareness has increased and more individuals are searching for symptoms and prevention information, and 2) mental health stigma may be preventing individuals from seeking treatment and information from their medical providers and are thus turning to the internet for information especially in more affluent suburban areas. For example, top search terms for anxiety included alternative treatment methods like CBD oil and weighted blankets.

Google Trends data can also help Public Health departments monitor search interest for specific diseases or lifestyle behaviors and develop strategies and programs to address the public health issue. For example, new research recently published in the Journal of the American Academy of Child & Adolescent Psychiatry discovered a significant increase in monthly suicide rates among U.S. youth aged 10 to 17 years after the release of the Netflix show, 13 Reasons Why, in 2017.[22] Public health officials can watch trend data to help develop targeted campaigns to curb harmful behaviors or to create awareness campaigns around mental health stigma.

[22] Bridge JA et al. Association Between the Release of Netflix's 13 Reasons Why and Suicide Rates in the United States: An Interrupted Times Series Analysis. Journal of the American Academy of Child & Adolescent Psychiatry, Volume 0, Issue 0. https://www.jaacap.org/article/S0890-8567(19)30288-6/fulltext

Primary Research

Research Approach

Primary research for the Sheppard Pratt Hospital CHNAs included six focus group discussions and 15 one-on-one interviews with key stakeholders from the target service areas. Public health officials, sub-sector specific experts, directors of service organizations engaging the underserved populations, and others were included in the research.

Focus Group Discussions

The purpose of the focus groups was to gather the insights and perspectives from a diverse set of key stakeholders in the Towson and Ellicott City services areas. Discussions were designed to explore topics such as the following:

- Behavioral health needs that they see most frequently in their professional setting, and in general
- Structural, system-level, and policy issues that impact behavioral health
- High priority community needs that Sheppard Pratt may be able to have an impact on

Key Stakeholder Interviews

The one-on-one interviews provided the opportunity for more in-depth discussion of behavioral health and substance use issues with local experts. In many instances, interviewees were able to provide granular insight regarding health needs such as identifying counties in which the need is most acute, population sub-groups most highly impacted by particular behavioral health issues, and insight regarding effectiveness and operational aspects of current programs. Interviewees were able to speak of their perceived needs in both Sheppard Pratt hospital service areas.

The results of the focus groups and the one-on-one interviews include comments about, and lists of, high priority behavioral health – as well as observations about structural aspects of community health. The research approached allowed Sheppard Pratt to "cast a wide net" and include experts' insights on a range of behavioral health and needs issues.

Initial Qualitative Research Findings and Comments

In many cases, insights and comments could be attributed to specific service areas (i.e., Towson or Ellicott City); however, in others, participants' feedback referred to the combined region. The material below includes the summary of high-level system and contextual observations from focus group discussions and interviews, and a review of detailed needs as identified by participants. Based on this material, the service area's highest priority needs are listed below.

Top Three Categories of Prioritized Community Needs
Access to appropriate care • Expanded capacity in select services. • Enhanced transitions of care and "warm handoffs" to help improve the perceived quality of care. • Increased support for programs that involve a patient's family or social network. • Support for logistics and other issues impacting the ability of patients to take advantage of existing services (e.g., transportation, finances, convenient hours of operation, and others).
Enhanced crisis service options • Greater availability of crisis service providers. • More widely available information required to access services. • Enhanced efficiency of the referral networks or points to get initial help.
Awareness and prevention • Expanded knowledge of Sheppard Pratt and community service provider locations, capabilities, and access information (e.g., hours of operation, insurances accepted, types of care offered, etc.). • Increased health system leadership and policy leadership. • Increased efforts to reduce stigma.

The following section provides some greater detail – along with illustrative quotes – for the needs categories noted in the table above.

Access to Appropriate Care

Access to Care

There is a perceived need for more providers especially those with specialized skills.

One of the most frequently identified and urgent health needs in the Towson service area is related to system capacity (an "access to care" component) – especially for children and adolescents. Many (but not all) focus group participants and individual interviewees indicated that there is a broad-based need for more mental health and substance use disorder (SUD) professionals. However, many also suggest that there is a greater need for service providers able to provide specialized care in areas such as trauma-informed care, traumatic brain injury, and services for individuals with dual diagnosed mental health and behavioral health disorders. One interviewee stated that "there are enough providers, but not enough that have the right education" when referring to the need for more trauma-informed care (TIC) trained providers to meet the needs of children living in Baltimore City. Some illustrative comments supporting this observation follow.

- *"[The total Sheppard Pratt service area] would benefit from more therapists who are trained in trauma-informed care. They are not evidence based trained."*
- *"There is a need for expanded service for people suffering from traumatic brain injury."*
- *"I wish that there were more neuropysch beds for kids with co-occurring behavioral health and mental health diagnosis. There is such as shortage in the state."*
- *"For children with ADHD, OCD, depression, and Down Syndrome, access to mental health services is difficult for children with dual-diagnosed mental health and behavioral health disorders. There are not enough providers trained or willing to see this population."*

In some cases, insurance regulations are hampering treatment for children.

Additionally, one focus group of parents and caregivers of children with mental health issues discussed why their children were discharged after 10 days of inpatient treatment at the Towson facility. One parent had to abandon her child at the hospital, so her child could receive the care she needed. Focus group participants were unsure if it was an insurance or hospital policy to discharge patients after 10 days of hospitalization.

- *"Why do our children get 'kicked out' of the hospital after 10 days? Is it due to an insurance policy? We had to abandon our daughter so she could stay at the hospital for three months because we knew she wouldn't be safe at home and we couldn't get 24/7 in-house care for her."*

Mental Health Treatment Options

Treatment options lag the increasing needs for services among children and adolescents.

Many focus group participants and stakeholders recognized the vast number of treatment options Sheppard Pratt offers in both in-patient and out-patient settings in the Towson service area. However, there is a perceived gap in available treatment options for children. One stakeholder noted that more and more children are being diagnosed with mental health and substance abuse issues, but the healthcare system has not caught up with the new trend.

- *"Kids are getting diagnosed with SA and MH issues younger, but services haven't caught up yet, so we don't have places for them."*
- *"We need intervention and treatment services for youth with behavioral and mental health needs. We find that teens and pre-teens with poor behaviors often get dumped out of society and they begin a cycle of poor behaviors going forward in life."*
- *"ACE and Trauma-informed care need to be infused throughout the healthcare system – especially among those coming into frequent contact with youth."*

Increased quality of care and more consistent use of best practices (region-wide) is needed to better meet patients' needs.

Many stakeholders spoke positively about the high quality of care that many area organizations (including Sheppard Pratt) provide for their clients, yet several mentioned some specific areas for improvement.

- *"Sheppard Pratt offers DBT treatment, but they don't always get the opportunity to provide it. In some cases, patients are just held for stabilization without being able to receive the full benefits of DBT or other forms of care."*
- *"There may be an opportunity for Sheppard Pratt to better coordinate care and referrals with other area hospitals. For example, different hospitals have different psychology beliefs. I had a client who was displaying dissociate disorder issues. We went to John Hopkins who turned her away because they didn't believe in dissociate disorders. A stronger linkage between Hopkins and Sheppard Pratt may have helped my client get quicker care."*
- *"There needs to be an infusion of evidence-based best practices into schools, businesses, public safety, families, and providers. There are lots of good people trying to do great things, yet there is a lack of uniform, validated, consistent approaches."*

Care Coordination (Capacity)

Transitions of care and "warm handoffs" help improve the perceived quality of care.

Several focus group participants and stakeholders indicated that more coordination and post-discharge programs would help reduce readmissions and support integrated and continuity of care goals across Sheppard Pratt and community partners. For example, a parent of a child with mental health issues said that increased post-inpatient discharge contact from a Sheppard Pratt provider would help enable better guidance to the next stage of care and improve adherence to the child's treatment plan.

- *"Although inpatient quality of care is good, additional follow-up after discharge would help KEEP my child out of the hospital and help keep her healthy."*
- *"Increased focus on a "team approach" to care and working in a more integrated way with community service provider partners would benefit outcomes."*
- *"Increased coordination of care and 'warm handoffs' would better engage downstream providers in the community leading to lower readmissions and healthier patients."*

Addiction Treatment (Capacity)

There is a continuing, growing, need for services designed to address substance misuse issues.

The opioid crisis and other substance misuse issues were big concerns for most focus group participants and community stakeholders. First identified in the 2015 Community Health Needs Assessment as one of the most urgent health needs in the service area, the need for addiction treatment for opioid dependency and other substance use disorders (SUDs) continues to be a top identified need in the Towson service area. Many of the comments from the community revolved around the need for more services and providers.

- *"There are a few detox centers in the City for mostly alcohol and benzos. Many people will try to detox at home, but in the end, they give up because it's hard."*
- *"We should increase more community-based Opioid Use Disorder (OUD) services."*
- *"There are not enough Substance Abuse providers in Harford County, so there is a big wait list. Many have to go to Eastern Maryland or Baltimore City for services."*

- *"We need to provide training for first responders around the opioid and broader substance misuse issue."*

Public policy and the generational impact of substance misuse presents ongoing health challenges and heightens the need for system-level attention to structural issues affecting community mental health and substance misuse.

Many stakeholders indicate that they recognize that the opioid epidemic is a much larger regional and national issue that needs to be addressed from a public health viewpoint. Substance misuse has a major impact not only on the individual, but also their families and the community.

- *"We view addiction as a juridical issue, not a public health issue."*
- *"The opioid epidemic is by far the greatest issue facing the area – maybe the entire nation's Public Health biggest challenge, too. Sheppard-Pratt should have a large outpatient opioid treatment center on the Sheppard Pratt campus."*
- *"Parental substance use has a major impact on the parents, but a longer term impact on kids and the community."*
- *"The entire conversation about ACEs [i.e., Adverse Childhood Experiences] is getting more attention. There is still a big opportunity to education school systems, first responders, and even direct care providers about ACE and how to help patients wrestling with related issues."*
- *"Trauma, poverty, and racism is the main issue in Baltimore City. This leads to ACEs and we all know that people who experience ACEs as a child will have longer health outcomes as an adult."*

Increased support for programs that involve a patient's family or social network may help improve overall care and outcomes.

In focus group discussions and stakeholder interviews, participants recognized the importance of providing services to the family and other important social network members – not just the individual. Many community partners identified the need for additional family services, such as increased family counseling during crisis.

- *"[It would be beneficial for hospitals to more] fully engage and coordinate services with DSS. Hospitals tend to focus on the patient [and to some extent on the family], but a smoother transition of care to DSS or other community partners would help address ongoing family issues."*
- *"[Mental health providers] need to increase clinical efforts to address family issues – even if only one member is the patient."*
- *"We were only offered family counseling once during my daughter's hospitalization. I wish we could do it more."*
- *"The whole opioid epidemic is severe in Baltimore City and Baltimore County. For our work, we see maltreated children and neglected children who are the result of parent use of drugs, especially opioids. Especially with children this is truly a 'family' issue."*

Financial / Insurance Reimbursement (Logistics)

Financial and health insurance issues were often cited as major contributors to access to care challenges.

Participants indicated that private insurance coverage is not as extensive as medical assistance and many providers, especially those in Baltimore City, do not accept private insurance. Medicare is also perceived by some as having limited coverage for services for issues such as substance use disorders.

- *"Medicare does not reimburse for some substance use disorder care services."*
- *"Private insurance doesn't cover a lot of services. There are not enough providers in Baltimore City that take private insurance. Some do offer a sliding scale, though."*
- *"It is an interesting situation – difficult for many – where if you have insurance including Medicaid but no money [i.e., low household income], you can receive mental health care from providers AND supporting services from DSS. If you have insurance and a decent household income, you can get mental health care from providers BUT NO supporting services from DSS – even though some in this category can't afford deductibles and co-pays. Third, if you have no insurance, you are in dire straits because you can get neither mental health care from providers NOR supporting services from DSS."*

Transportation (Logistics)

Transportation to mental health and SUD treatment services away from more urban areas is a challenge.

Qualitative research participants indicate that transportation is a challenge for many people in need of mental health and SUD treatment services – especially those living further away from more urban areas (e.g., where public transportation, ride sharing, and proximity to services is better) or those in crisis.

- *"We live in Howard County. If my child is in crisis, I have to bring him to the Towson facility. I'm scared to drive him there as he could hurt himself or me on the way."*
- *"People who struggle to receive treatment often struggle with housing and transportation needs."*
- *"Private insurance doesn't pay for transportation to medical appointments, but Medicaid and Medicare will for most people."*
- *"Transportation is a big issue, especially in a rural county."*

Housing (Logistics)

Qualitative research participants state that additional continuity of care options and more efficient transitions of care would improve outcomes and reduce hospital readmissions.

Affordable housing is often cited as one of the top needs in the local community by focus group participants and community stakeholders. Specialized housing, like recovery and transitional housing, is lacking in many areas of the Towson service area.

- *"Housing – there's an eight year waiting list for affordable housing in Baltimore City."*
- *"We do have a few recovery-type homes in Harford County, but none accept pregnant woman or allow women to stay with their children."*

Enhanced Crisis Service Options

Walk-In Clinic

The Sheppard Pratt Walk-in Clinic is perceived as beneficial, yet additional resources and operational adjustments would enhance its ability to meet patient needs.

The Sheppard Pratt Walk-In Clinic was one of the outcomes from the 2015 Community Health Needs assessment, and most focus group participants and community participants spoke positively about its creation and availability to serve the public. The most frequently mentioned way to further improve the usefulness of its services is to expand hours and add providers.

- *"A 'Quick Clinic' is a great idea but is challenging due to hours of operation. If there is not an immediate opening, kids wind up going to the ED, which, in itself, can be traumatic."*
- *"The Walk-in Clinic provides needed services, but it is understaffed. Its capacity needs to be expanded to better meet the [growing] needs."*
- *"We need expanded hours at the walk-in clinic. I was in the clinic all day with my daughter waiting for an appointment but was unable to be seen."*
- *"We've had several families try to go to the walk-in clinic. It is a good resource, but because some families were needing services for their child with Autism, they had to go to the hospital ED instead."*

Crisis Services

Increased capacity of mental health and/or SUD crisis services is an ongoing need.

One of the most urgent needs identified by almost all focus group participants and community stakeholders was the need for additional or expanded crisis services in the service area. In both Sheppard Pratt service areas, qualitative research respondents indicate that crisis services currently exist but are often overtaxed, understaffed, and underfunded. They say that response times can be slow due to staffing and sometimes insurance type can affect access to the service for some individuals.

- *"Crisis services exist, but they are overtaxed. More capacity is needed."*
- *"Only Baltimore City has crisis services tailored to children and youth. We have services in our county, but they [i.e., crisis service providers] might not be knowledgeable about the unique needs of kids in crisis."*
- *"BCAR and BCRI currently offer crisis services [in Baltimore City]. BCAR only has six people so the wait time can be up to 24 hours. Sometimes insurance is an issue and can delay response."*
- *"There are not enough crisis services. The City has no 24/7 or urgent care clinic in the City, which is a major access point for many."*
- *"Harford County doesn't have a 24/7 mobile crisis unit that can address the needs of people around the clock yet. [Supposedly, some are] working on putting together a crisis center that opens this summer to help divert people from the ED."*

Awareness and Prevention

Service Awareness and System-level Support

There is opportunity for Sheppard Pratt to take a leadership role in driving care coordination initiatives in the Towson service area and the State of Maryland.

One of the more consistent observations noted among focus group participants and stakeholder interviewees was that there is a need for a coordinating body to help inform or align area services. Most note that there is a wealth of areas services (though some gaps exist, as previously mentioned), but there is not a unified source that can serve as a central point of information about community service site capabilities. For example, many community mental health providers indicate that they do not have a full understanding of the services provided by other sites. As such, when they refer a client to another provider for care, they do not feel confident that they have a full understanding of the best options for the client. Similarly, many community members indicate that when they have the need to seek care for health-related issues, they are unsure about where and how to initially seek help.

- *"My granddaughter needed some help; she was depressed and thought about hurting herself. When she was eventually ready to get some help, she didn't really know where to start, and she's a smart, well-educated person! She started with her regular doctor who suggested medication and a counselor. After six weeks, she got in to see a counselor, but the counselor wasn't the right fit. The counselor wasn't sure where else to send her, so she sent her to Sheppard Pratt. The hospital helped her get through her immediate issues. She is still trying to find the right fit, though, for her outpatient work."*
- *"We [at a public health agency] think that we know all of the services providers in the area and their capabilities. We also know that we are wrong! There are so many providers – many doing good things that we don't even know about – that it is hard to stay current. It would be great if there was either a central point of information or some form of coordinating body where we [community service providers] could easily see what others are doing."*
- *"The Baltimore area is home to numerous organizations, providers, and services. However, awareness of available resources is not always known by consumers and providers. While some community partners and health departments have resource guides available, not many people are aware of the resource guide until they are in crisis."*
- *"In some instances, community providers work very well together. However, much more is needed. The restructuring of the state's Mental Health System resulted in different groups competing for limited resources, or at least, unsure about which organizations should take leadership roles or drive initiatives. There is a vacuum or some sort."*
- *"A regular luncheon, meeting, or other QUARTERLY event where disparate service providers could come together and learn about what each other does would be very helpful. Sheppard Pratt would be a perfect host organization. Everyone knows them, they are a de facto partner in community care already, and they would have the ability to help lead and coordinate care. This would be an important*

leadership role, but I don't think that Sheppard Pratt would have to necessarily DO everything, but their ability to lead and organize others would fill an important vacuum that currently exists."

Stigma (Awareness)

In focus groups and interviews, participants recognized that individuals seeking treatment for mental health and substance use disorders often may not seek help because of stigma-related issues.

Qualitative research respondents indicate that stigma can take many different forms: "internal" stigma in which the person in need feels that he or she is weak because of the need for help, or that she or he should be able to "pick myself up by my bootstraps." Many people say that they also may face "externally-based stigma" which often stems from feeling embarrassed or overly concerned about how others may perceive the need for help. Additionally, there is added stigma for those with Autism that can hinder their quality of care. As one of the leading behavioral health hospitals in the county, Sheppard Pratt has the opportunity to lead the discussion on mental health and substance use issues to reduce stigma in the local community.

- *"Neighborhoods and families are very close. The downside is that there is a greater than usual sense of 'what happens in the family, stays in the family.' This can be counterproductive and hinder early intervention and other interventions."*
- *"Stigma is very much an issue amongst substance use addiction and mental health."*
- *"We are unforgiving to people who have addiction issues. Even in AA or NA, we teach them that they are an addict. 'Hi, I'm Joe and I'm an addict.' Even after 25 years of recovery. I'm not sure that that is a good premise!"*
- *"Greater outreach by Sheppard Pratt to the African American community would be a great benefit to some of the higher need neighborhoods in our community."*
- *"Stigma is rampant – especially among youth."*
- *"There is a severe lack or training and stigma in the medical field when it comes to Autism. Many providers don't understand Autism and often blame other health and mental health issues on Autism when in fact it is another co-occurring mental health issue."*
- *"Sheppard Pratt can be a behavioral health leader that can help the city, the county, and the state address the core issues impacting suicide and mental health."*

Summary

Based on the qualitative research (i.e., focus group discussions, stakeholder interviews, and leadership meetings), secondary data analysis, and the digital and social media research, community needs were identified and categorized as access to appropriate care, enhanced crisis service options, and prevention and awareness. The needs identified during the CHNA research process were used in the needs prioritization process in the following section.

Needs Prioritization

The needs prioritization process was a two-stage initiative that included (Stage 1) an online quantitative and qualitative survey followed by leadership group meeting and a second quantitative survey (Stage 2).

Leading up to the Stage 1 survey, the results of the secondary data research and the qualitative research from the focus group discussions and stakeholder interviews led to a list of 35 discreet or overlapping needs. Six Sheppard Pratt Health System employees who were part of the leadership group took part in an online survey in which they were asked to rate each of the 35 needs on a 7-point scale (with 7 = the greatest need for more focus). They were also asked to provide qualitative feedback on the needs in the community.

Stage 1: Prioritization of Needs

Analysis of the Stage 1 survey identified three categories of needs:

- Access to appropriate care
- Enhanced crisis service options
- Prevention and awareness

Respondents were asked to rate the 35 needs within three categories of needs. The median scores of the full list of needs evaluated in the Stage 1 survey appear in Appendix C. Expanding access to primary care and increasing awareness of existing services and community organizations tied as the top need.

Stage 2: Prioritization of Needs

Stage 2 of the prioritization process included an in-depth workshop-style meeting with the six members of the leadership group. Prior to the meeting, analysis of the Stage 1 survey (as well as the prior secondary and primary research) led to the categorization of needs into a rank order list (below) and three general categories, (i.e., Access to appropriate care, enhanced crisis service options, and prevention and awareness). The workshop-style Stage 2 meeting embedded activities designed to evaluate the three categories, review individual community needs, and – importantly – help develop tactical initiatives by which higher-priority needs can be addressed.

Prioritized Needs

Based on input from the Leadership Group meetings; analysis of local, State of Maryland, and federal quantitative data; community input; and, the needs evaluation process, the prioritized list of community needs is shown in the table below.

Top Community Needs – Towson	
Rank	**Community Needs**
1	Improve care coordination between inpatient and outpatient providers
2	Increase Mental Health First Aid training to first responders, schools, public safety, and others
3	Expand hours at the Crisis Walk-in Clinic
4	Improve provider information on provider network directory lists
5	Increase Sheppard Pratt's regional leadership role by coordinating disparate community services
6	Improve regulation around addiction counseling
7	Create a parent support group for parents with children with SMI
8	Increase residential options for teens with co-occurring mental health and behavioral issues
9	Increase awareness of services offered at what SPHS locations
10	Provide Narcan and Evzio training to key community members (i.e., police, fire, schools)
11	Engage in system-level / regulatory / policy change advocacy
12	Increase access to family therapy for families
13	Decrease stigma around mental health and substance use disorders

Implementation Strategy Considerations

Also, during a Sheppard Pratt Leadership meeting, participants worked collaboratively to build the foundation for Implementation Plan activities (to be conducted after from this CHNA). Group members undertook efforts to identify an initial list of activities designed to address high priority need categories and several detailed opportunities for improvement. A summary of potential next steps to support development of the Implementation Plan is listed below.

- Develop a list of existing programs and how they impact (or are impacted by) higher-priority needs.
- Develop a criterion by which Sheppard Pratt can evaluate which community needs to address (and how) and which ones to not address (and the rationale to support the decision).
- Establish a small workgroup that can evaluate each of the community needs based on the evaluation criteria and develop specific strategies to include in the Implementation Plan.
- Draft the Implementation Plan according to requirements and then work to further implement strategies to better meet community members' needs.

Appendix

- Appendix A: Sheppard Pratt Leadership Group
- Appendix B: Stakeholder Interview Participants
- Appendix C: List of 35 community needs
- Appendix D: Resource Guide

Appendix A: Sheppard Pratt Leadership Group

The Sheppard Pratt Leadership Group consisted of key staff members of the Sheppard Pratt Health System. The Leadership Group provided insights during two group discussions and the needs prioritization process.

Sheppard Pratt Leadership Group	
Name	**Position**
Jennifer Wilkerson	VP and Chief Strategy Officer
Laura Lawson	VP and Chief Nursing Officer
Jeff Grossi	Chief of Government Relations
Dr. Ben Borja	Medical Director, Crisis Services & Residency Training
Armando Colombo	Executive VP and Chief Operating Officer
Jeff Richardson	VP and Chief Operating Officer, Sheppard Pratt Community Services
Antonio DePaolo	Chief Transformation Officer

Appendix B: Community Stakeholder Participants

Fifteen community stakeholders participated in stakeholder interviews to provide valuable insights into the health needs of their local communities and populations their organizations serve in the Greater Baltimore area.

Community Stakeholder Participants	
Name	**Organization**
Dr. Gregory W. Branch	Baltimore County Department of Health
Billie Penley	Anne Arundel Department of Health
Lt. Michelle Denton	The Listening Place
Jane Gehring	Child Advocacy Center
Ann Geddes	Maryland Coalition of Families
Barbara J. Bazron, PhD	Maryland Behavioral Health Administration
Susan B. Hansell	Maryland Children's Alliance
Adrienne Mickler	Anne Arundel County Mental Health Agency
Rebecca Rienzi	Family Network – Pathfinders for Autism
Adam Rosenberg	Child Abuse Center
Dr. Joshua Sharfstein	John Hopkins Hospital
Roe Rodgers-Bonaccorsy	Howard County Mental Health Authority
Crista Taylor	Baltimore City Behavioral Health System
Mallory Canami	Harford County Health Department
Bernard Gyebi-Foster	Tuerk House

Appendix C: Community Needs

The following table is the results of the first round of the Needs Prioritization survey containing the score and rank of the 35 identified community needs.

Rank	Community Need	Score
1	Improve care coordination between inpatient and outpatient providers	6.75
2	Increase Mental Health First Aid training to first responders, schools, public safety, and others	6.75
3	Expand hours at the Crisis Walk-in Clinic	6.50
4	Create a parent support group for parents with children with SMI	6.50
5	Improve provider information on provider network directory lists	6.50
6	Improve regulation around addiction counseling	6.25
7	Increase residential options for teens with co-occurring mental health and behavioral issues	6.20
8	Increase awareness of services offered at what SPHS locations	6.00
9	Provide Narcan and Evzio training to key community members (i.e., police, fire, schools)	6.00
10	Engage in system-level / regulatory / policy change advocacy	6.00
11	Increase access to family therapy for families	5.75
12	Decrease stigma around mental health and substance use disorders	5.75
13	Provider greater support for community efforts to increase general awareness of services available in the community	5.75
14	Provide advocacy around mental health and substance use disorders (i.e., opioid epidemic)	5.50
15	Increase approved patient data sharing across all providers	5.50
16	Increase access to outpatient services for people in rural areas	5.50
17	Expand wrap-around services for the chronically mentally ill	5.50
18	Increase the consistency and thoroughness of inpatient discharge follow-up	5.25
19	Increase the number of therapists trained in trauma-informed care	5.25
20	Develop a trauma-informed care training program for providers in Maryland	5.25
21	Increase number of mental health-trained providers in hospital Emergency Departments across the state	5.25
22	Work with community service providers and Sheppard Pratt sites to increase awareness of services available at county health departments	5.25
23	Increase number of peer support specialists in hospital and outpatient settings	5.25
24	Create a mobile crisis response team	5.00
25	Increase access to outpatient Dialectical Behavioral Therapy (DBT) for children and adolescents	4.75
26	Increase the number of providers who accept Medicaid clients	4.75
27	Provide expanded detox center capacity in Baltimore and Baltimore County	4.75
28	Increase coordination between Sheppard Pratt and Department of Social Services (DSS)	4.75
29	Increase accessibility to the Way Station program	4.50
30	Provide additional parent education classes at non-traditional hours for working families	4.50
31	Provide safe transportation to Towson facility for children in crisis	4.50
32	Improve medication management education for older adults	4.50
33	Increase services for new moms with substance use disorders	4.50
34	Increase the number of providers who accept private insurance clients	4.25
35	Create services to reduce senior isolation	3.75

Appendix D: Resource Guide

Sheppard Pratt's Resource Guide is available online at https://www.sheppardpratt.org/for-patients-supports/.

Sheppard Pratt
HEALTH SYSTEM

Community Health Needs Assessment

Implementation Plan

Towson Campus

August 2019

Background

The Community Health Needs Assessment (CHNA) and the Implementation Plan are required by federal agencies. Specifically, the Affordable Care Act of 2010 requires all U.S. not-for-profit hospitals to complete a CHNA and Implementation Plan every three years.

- In 2019, Sheppard Pratt Health System (SPHS) leadership worked with community leaders, underserved populations receiving services in the community, and others to complete its CHNA and identify 35 community health-related needs or service gaps.
- SPHS prioritized the list using qualitative and quantitative approaches.
- The following Implementation Plan indicates which of the prioritized needs the health system will address (and how) and which ones it will not address (and why not).

Requirements

The CHNA and the Implementation Plan are separate but linked requirements.

- CHNA Requirements
  - Define the community served by SPHS
  - Describe the quantitative and qualitative methodology used to identify and prioritize community needs
  - Include a comprehensive list of community health or health-related resources
  - List the activities conducted since the prior CHNA in order to address the identified needs
  - Prioritize the list of community health needs to be included in the Implementation Plan

The CHNA document (available on the website) clearly addresses each of these issues.

- Implementation Plan Requirements
  - Identify which community needs the hospital will address (and how)
  - Identify which community needs the hospital will not address (and why not)

This document summarizes the Implementation Plan results.

Methodological Focus Areas

- Each hospital is required to conduct and publish its own CHNA and Implementation Plan, yet hospitals are encouraged to collaborate on the CHNAs – especially where service lines and/or service areas overlap.
- For each Sheppard Pratt hospital, CHNA and Implementation Plan activities were jointly conducted in order to maximize the efficiency of the research and the effectiveness of emerging strategies.
- The strategic approach establishes the basis for shared operational plans to address needs.

NOTE: Details of the strategic approach are contained in the Appendix.

Implementation Plan Approach

- Implementation Plan activities [i.e., actions taken to identify which community health needs will be addressed (and how)], include the following:
  - Conducting in-depth discussions with the SPHS Project Leadership team to review the needs list and identify ones generally outside of SPHS's purview to impact
  - Developing a matrix that identified existing programs or activities that positively impact one or more of the 35 identified, prioritized community needs
  - Working with the Project Leadership team to define for each of the 35 needs the "degree of control that SPHS has to enact change" and a "potential timeline on which positive change could reasonably be made to address the need"
  - Creating this summary document that addresses the project requirements including clear recognition of activities within the hospital's purview to address and (if so), how the hospital can best address the need

The full, prioritized list of 35 community needs (from the CHNA) is included on the next slide.

The Total List of Prioritized Needs

1. Improve care coordination between inpatient and outpatient providers
2. Increase Mental Health First Aid training to first responders, schools, public safety, and others
3. Expand hours at the Crisis Walk-in Clinic
4. Create a parent support group for parents with children with Severe Mental Illness
5. Improve provider information on provider network directory lists
6. Improve regulation around addiction counseling
7. Increase residential options for teens with co-occurring mental health and behavioral issues
8. Increase awareness of services offered at SPHS locations
9. Provide Narcan and Evzio training to key community members (i.e., police, fire, schools)
10. Engage in system-level / regulatory / policy change advocacy
11. Increase access to family therapy
12. Decrease stigma around mental health and substance use disorders
13. Provide greater support for community efforts to increase general awareness of services available in the community
14. Provide advocacy around mental health and substance use disorders (i.e., opioid epidemic)
15. Increase approved patient data sharing across all providers
16. Increase access to outpatient services for people in rural areas
17. Expand wrap-around services for the chronically mentally ill
18. Increase the consistency and thoroughness of inpatient discharge follow-up
19. Increase the number of therapists trained in trauma-informed care
20. Develop a trauma-informed care training program for providers in Maryland
21. Increase the number of mental health-trained providers in hospital Emergency Departments across the state
22. Work with community service providers and SPHS sites to increase awareness of services available at county health departments
23. Increase the number of peer support specialists in hospital and outpatient settings
24. Create a mobile crisis response team
25. Increase access to outpatient Dialectical Behavioral Therapy (DBT) for children and adolescents
26. Increase the number of providers who accept Medicaid clients
27. Provide expanded detox center capacity in Baltimore and Baltimore County
28. Increase coordination between SPHS and Department of Social Services (DSS)
29. Increase accessibility to Way Station programs
30. Provide additional parent education classes at non-traditional hours for working families
31. Provide safe transportation to Towson facility for children in crisis
32. Improve medication management education for older adults
33. Increase services for new moms with substance use disorders
34. Increase the number of providers who accept private insurance clients
35. Create services to reduce senior isolation

Evaluation Criteria and Definitions

SPHS has a long-standing commitment to the community. As such, through existing or new programs, the hospital expects to be able to address – to some degree – the majority of identified needs. In some instances, SPHS may help facilitate and partner with other organizations to address the need.

- The degree to which the hospital can address the needs is based on the following criteria:
  - The CHNA-based priority of the need
  - Resources within an existing program or initiative which can be deployed
  - Opportunities for collaboration with community partners
  - The degree to which the need is within the hospital's purview to address

NOTE: Definition of a "need:" A service gap – or, an **unmet** health issue – that could benefit from additional support from SPHS or affiliated organizations. For example, many chronic disease states or specific mental health conditions such as heart disease, diabetes, depression, and others – while highly important, ongoing community health issues – may not be listed as **unmet** needs **IF** the hospital and others are already highly engaged in these critically important areas: The need for the service may always exist, but if hospitals and others are providing capacity and access to quality care, there may not be an **unmet** need.

Categorization of the 35 Community Needs Identified in the CHNA

- For each of the 35 needs, SPHS examined its current programs, outreach efforts, and collaborations, and considered new initiatives such that each of the 35 needs were assigned to one of the following categories:
  - Needs for which SPHS will enhance existing programs or establish new ones: The hospital has current activities that may be able to be modified or expanded to address the community health need; or, newly created activities or initiatives may be required to do so.
  - Needs SPHS is addressing through existing programs and activities: The hospital is already actively providing services to address the community health need and may focus efforts on building awareness of existing programs and services.
  - Needs that SPHS will not address: The need is either not within the SPHS purview or beyond its ability to readily impact.
- The following pages show Implementation Plan SUMMARY results – "needs that the hospital will address (and how) and which ones it will not address (and why not)" – by category, (i.e., the three primary categories noted above).

Needs for Which SPHS will Enhance Existing Programs or Establish New Ones

- SPHS Project Leadership team members reviewed each of the needs for which SPHS has, or may establish, programs to address on two scales:
  - The degree of local control (i.e., the amount of influence SPHS may possess to affect needs).
  - Timeline (i.e., the expected amount of time it would take to impact the need)
- Based on the analysis, SPHS identified a highly focused list of program focus areas that does the following:
  - (1) addresses the highest priority needs,
  - (2) exists within SPHS's ability to control, and,
  - (3) provides positive impact in the "one-year," "two- to three-year," and "four years or longer" time frames.
- Results are shown on the following slides.

In the "Within One-Year" Timeline, Focus is on Expanded Hours and Trained Mental Health Professionals

- "Within 1 Year" High priority need focus areas:
  - Increase Mental Health First Aid training to first responders, schools, public safety, and others (Rank: 2)
  - Expand capacity at the Crisis Walk-in Clinic (Rank: 3)
  - Decrease stigma around mental health and substance use disorders** (e.g., many of the SPHS programs and educational outreach activities are designed to explicitly or implicitly fight stigma), (CHNA Rank: 12)
  - Increase the number of providers who accept Medicaid clients (e.g., where possible, SPHS will continue to expand Medicaid access to care), (CHNA Rank: 26)

** Note that SPHS currently has plans to enhance substance abuse disorder programs. Ongoing review and enhancement of those plans and capabilities will continue, as needed.

Needs for Which SPHS will Enhance Existing Programs or Establish New Ones

In the "Two- to Three-Year" Timeline, Focus is on Care Coordination and Access to Care

- "Two to three-year timeline for positive impact" High priority need focus areas:
  - Improve care coordination between inpatient and outpatient providers (Rank: 1)
  - Create a parent support group for parents with children with Severe Mental Illness (e.g., by engaging potential participants, learning their insights regarding important needs / group content information, and offering additional group meeting times / days), (Rank: 4)
  - Increase access to family therapy, (e.g., by offering additional group meeting times / days / locations), (Rank: 11)
  - Increase approved patient data sharing across all providers (Rank: 15)
  - Increase consistency and thoroughness of inpatient discharge follow-up (e.g., through electronic, telephonic, care coordination, or other means), (Rank: 18)
  - Increase access to outpatient Dialectical Behavioral Therapy (DBT) for children and adolescents (Rank: 25)
  - Increase services for new moms with substance use disorders (Rank: 33)

Needs for Which SPHS will Enhance Existing Programs or Establish New Ones

In the "Four Years or Longer" Timeline, Focus is on Community-Based Education and Change

- "Four years or longer timeline for positive impact" High priority needs:
  - Provide Narcan and Evzio training to key community members (i.e., police, fire, schools) (Rank: 9)
  - Engage in system-level / regulatory / policy change advocacy (Rank: 10). [Note that although this need has been an ongoing focus for SPHS, and it is likely that some positive effects will be seen within one year, continuing work and additional progress will be required over a longer time frame.]
  - Review or increase the number of peer support specialists in hospital and outpatient settings (Rank: 23)

Needs SPHS Will Not Directly Address

While SPHS has existing programs and activities that address a majority (30, or 86%) of the 35 needs identified in the Community Health Needs Assessment, the following eight needs are not currently being addressed by programs and activities at SPHS. Although, SPHS is open to supporting initiatives that address these needs, the following list represents prioritized community needs that are either not within the SPHS purview or are beyond the organization's ability to readily impact.

- (CHNA Rank: 5) Improve information on provider network directory lists (e.g., lists of other SPHS services or non-affiliated community service providers that may be helpful to the patient).
- (CHNA Rank: 20) Develop a trauma-informed care training program for providers in Maryland
- (CHNA Rank: 31) Provide safe transportation to Towson facility for children in crisis
- (CHNA Rank: 32) Improve medication management education for older adults
- (CHNA Rank: 34) Increase the number of providers who accept private insurance clients

Summary: Focus Areas and Needs by Time Frame

- **"Within One-Year" Impact Expectation – Focus areas include:**
  - Expanding Hours at the Walk-In Clinic and mental health training for the community
  - Comment: Needs (enumerated earlier) in this category are largely in SPHS's control yet may be further strengthened with community partnership, where possible.
- **"Two to Three-Year" Impact Expectation – Focus areas include:**
  - Care Coordination and access to specialized mental health care and services
  - Comment: Although ***impact*** would be expected within two to three years, new or enhanced programs may need to start sooner.
- **"Four years or longer" Impact Expectation – Focus areas include:**
  - Community-based mental health training and policy changes
  - Comment: Programs and activities addressing these needs will be more effective when working with community partners.

Note that SPHS will continue to address a broad range of other prioritized community needs, as well as respond to urgent or emerging needs, if they arise.

Summary: Existing Programs and Activities Addressing Community Needs

- Of the 35 community needs identified from the Community Health Needs Assessment, existing programs and activities already address 86% (30 of 35) to some extent.
  - For some of the 30 needs already being addressed, SPHS is a facilitator or partner with a community service organization while for others, it takes more of a leadership role.
  - For most of these needs, SPHS programs and activities will remain largely unchanged. However, SPHS may modify existing programs, as needed or as additional opportunities present themselves.
- The following pages list the ranked needs and the number of existing SPHS programs and activities impacting them.
- The appendices include a more detailed list of programs and activities addressing the needs.

Appendix A: Description of Joint Efforts

The following slides highlight the strategic approach to the joint efforts by Sheppard Pratt, Towson Campus and Sheppard Pratt, Ellicott City Campus to conduct the CHNA and the Implementation Plan, and, more importantly, establish shared operational plans to address needs.

CHNA and Implementation Plan

Effectiveness and Operational Efficiency

Meeting the requirement for each facility to submit its own CHNA and Implementation Plan

- Each hospital – Towson location and Ellicott City location – is required to conduct and publish their own CHNA and Implementation Plan.
- Hospitals are encouraged to collaborate on the CHNAs – especially where service lines and/or service areas overlap.

CHNA and Implementation Plan

Effectiveness and Operational Efficiency

Improving the ability to meet service area needs by jointly conducting research efforts

- Given the overlapping service areas and the collaborative nature of the operations between the two Sheppard Pratt Health System sites, CHNA and Implementation Plan activities were jointly conducted in order to maximize the efficiency of the research and the effectiveness of strategies emerging from the work.

CHNA and Implementation Plan

Effectiveness and Operational Efficiency

Conducting research to comprehensively evaluate total service area needs and unique aspects based on location

- During the joint CHNA research for the two hospitals, particular attention was given to identify differences that may or may not exist between the two overlapping service areas.
- The results of the CHNAs identified an identical set of approximately 35 community needs with very little variation in the ranked priority based on location.

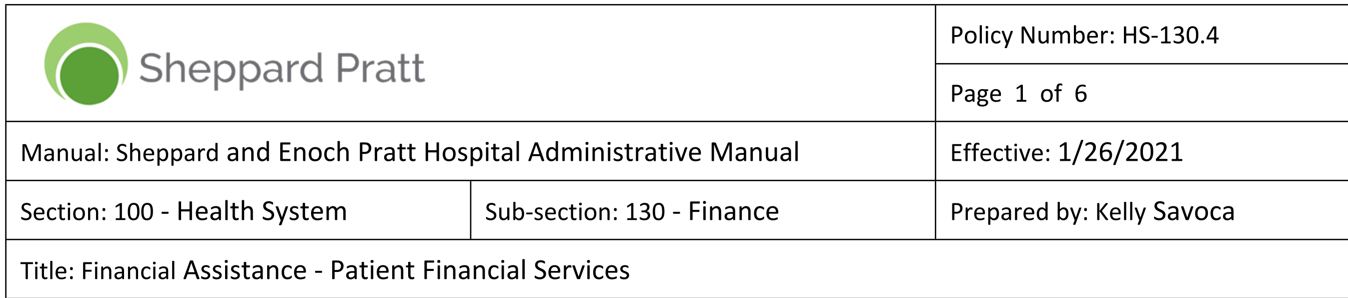
Effectiveness and Operational Efficiency

Producing CHNAs and Implementation Plans that can direct operational plans while meeting regulatory requirements.

- Each hospital has its own CHNA and Implementation Plan; however, they are identical for both Sheppard Pratt hospitals.
- This methodology effectively supports operational plans to address identified needs in each market – and even the administration of services, in some cases – that will be centrally managed, maximize patient care, improve operational efficiency, and better focus Sheppard Pratt's efforts to meet the highest priority service area needs.

Appendix B: Existing SPHS Programs Addressing Priority Community Needs

See separate document



Sheppard Pratt		Policy Number: HS-130.4
		Page 1 of 6
Manual: Sheppard and Enoch Pratt Hospital Administrative Manual		Effective: 1/26/2021
Section: 100 - Health System	Sub-section: 130 - Finance	Prepared by: Kelly Savoca
Title: Financial Assistance - Patient Financial Services		

POLICY:

Sheppard Pratt Health System ("Health System") is dedicated to providing patients with the highest quality of care and services. To assist our patients, financial assistance will be provided to patients who are unable to pay for services rendered and who meet the criteria established in this financial assistance policy ("FAP") regardless of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information or on the basis of disability.

PURPOSE:

To establish the eligibility criteria and process for application/approval of charitable assistance for Health System clients.

PROCEDURE:

1. Definitions

Amounts Generally Billed or AGB: The amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care, as further explained in Section 3 herein.

Code Section 501(r): Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder, as amended from time to time.

Emergency Care: Immediate care that is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts.

Gross Charges: The full amount charged by the Health System for items and services before any discounts, contractual allowances, or deductions are applied.

Household: In determining the family/household income of a patient, a household shall consist of the patient and any of the following individuals: (i) a spouse, regardless of whether the patient and spouse expect to file a joint federal or state tax return; (ii) biological children, adopted children, or stepchildren; and (iii) 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 shall consist of the child and the following individuals: (i) biological parents, adopted parents, or stepparents or guardians; (ii) biological siblings, adopted siblings; or (iii) stepsiblings; and (iii) Anyone for whom the patient's parents or guardians claim a personal exemption in a federal or state tax return.

Medically Necessary Care: Services or care that is determined to be medically necessary following a determination of clinical merit by the admitting physician or other licensed physician.

Patient: Those persons who receive emergency or medically necessary care at the Health System and the person who is financially responsible for the care of the patient.

Presumptive Eligibility: The process by which the Health System may use previous eligibility determinations and/or information from sources other than the individual to determine eligibility for financial assistance.

Uninsured: Patients with no insurance or third-party assistance to help resolve their financial liability to healthcare providers.

Underinsured: Patients who have limited healthcare coverage, or coverage that leaves the patient with an out of pocket liability and therefore may still require financial assistance.

Responsible Party: With respect to services provided by the Health System, the patient, account guarantor or other person(s) responsible for paying for such services.

2. Financial Assistance Eligibility

A. General Criteria

Services eligible for financial assistance include: emergency care, services deemed medically necessary care by the Health System, and in general, care that is non-elective and needed in order to prevent death or adverse effects to the patient's health.

Certain services that are not otherwise considered emergency or medically necessary care, as determined by the Health System at its sole discretion, are not eligible for financial assistance under this FAP. Excluded services include, but are not limited to, elective services, Education Program(s), the Retreat, and the Ruxton House, as well as any ancillary services relating to the aforementioned categories.

In addition, the Quaker population may be eligible for separate and/or additional assistance under the Health System's separate Quaker Financial Assistance Policy. For further information regarding the Quaker Financial Assistance Policy, please contact the Patient Financial Services Department.

Absent extenuating circumstances, as determined by the Health System, financial assistance provided by the Health System under this FAP is secondary to all other third parties and financial resources available to the patient, including but not limited to worker's compensation insurance, Medicaid, and other local, state, or federal programs ("Third Party Assistance"). Any patient who fails or refuses to provide requested information to the Health System may be deemed ineligible for financial assistance under this FAP at the Health System's sole discretion. Similarly, a patient who furnishes false or misleading information in connection with this FAP may be deemed ineligible for financial assistance under this FAP at the Health System's sole discretion.

B. Financial Criteria

Patients who are uninsured or underinsured may be eligible for assistance based on certain financial criteria, limitations, and exceptions, as provided below:

- Patients who have a household income at or below 300% of the Federal Poverty Guidelines may receive free care (a 100% discount).
- Patients who have a household income below 500% of the Federal Poverty Guidelines and who are also experiencing a financial hardship may also receive a 50% discount as Reduced-Cost Care. For purposes of this provision, a financial hardship means medical debt (out-of-pocket expenses, excluding copayments, coinsurance, and deductibles, for medical costs billed by a hospital) incurred by a family over a 12-month period that exceeds 25% of family income.

Notwithstanding the criteria above, Patients who have accumulated assets of $10,000 per individual or $25,000 per household (as adjusted for inflation annually beginning October 1, 2020 in accordance with the Consumer Price Index) may only be eligible for 50% assistance. For purposes of this asset test, the following assets shall be excluded from the aforementioned threshold: (i) equity in a primary residence not to exceed $150,000; (ii) retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement

account, including, but not limited to, deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred-compensation plans; (iii) one (1) motor vehicle used for the transportation needs of the patient or any family member of the patient; (iv) any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act; and (v) prepaid higher education funds in a Maryland 529 Program account.

A patient whose income and assets exceed the established eligibility guidelines but state they are unable to pay all or part of their account balance(s) may be further evaluated on a case-by-case basis. Eligibility for full or partial financial assistance will be determined after giving consideration to the patient's total financial situation as well as a consideration of extenuating circumstances. Additional criteria used to determine eligibility status includes employment status, future earnings capacity, and other financial resources. Patients who have a household income between 300% and 500% of the Federal Poverty Guidelines shall be eligible for a payment plan pursuant to the Health System's separate billing and collections policy (See Section 9 below) in accordance with the Health System's mission and service area.

When determining patients' eligibility, the Health System does not take into account a patient's citizenship or immigration status. Furthermore, the Health System will not withhold financial assistance or deny a financial assistance application on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or disability.

C. <u>Eligibility Determination Process</u>

When reviewing a submitted financial assistance application, the Health System shall: (i) determine whether the patient has health insurance; (ii) determine whether the patient is presumptively eligible for free or reduced-cost care under Maryland law; (iii) determine whether uninsured patients are eligible for public or private health insurance; (iv) to the extent practicable, offer assistance to uninsured patients if the patient chooses to apply for public or private health insurance; (v) to the extent practicable, determine whether the patient is eligible for other public programs that may assist with health care costs; and (vi) use information in the possession of the Health System, if available, to determine whether the patient is qualified for free or reduced-cost care under the hospital's financial assistance policy.

3. Determining the Financial Assistance Amount

Once eligibility for financial assistance is established, the Health System will not charge patients who are eligible for financial assistance more than the amounts generally billed, or AGB, to insured patients for emergency or medically necessary care (the "AGB limitation"). To the extent applicable, the maximum patient payment for Reduced-Cost Care shall be no greater than an amount equal to the Health System's charges less the Health System's mark-up for such care (see next paragraph for information concerning mark-up).

Pursuant to Maryland law, the charges to which a discount will apply are set by Maryland's rate regulation agency known as the Health Services Cost Review Commission ("HSCRC") and are the same for all payers. Thus, to the extent applicable, AGB is determined under the prospective method and is based on the rates established by HSCRC for the Health System. Furthermore, the Health System does not apply a mark-up or other fee on the rates established by HSCRC.

4. Applying for Financial Assistance

Determinations for financial assistance eligibility will require patients, including responsible parties, to submit a complete financial assistance application including all supporting documentation required by the application and may require appointments or discussion with a representative of the Health System's Patient Financial Services Department. Patients will be required to provide necessary information and documentation when applying for financial assistance. The information required is specified in the application and instructions thereto.

Financial assistance applications on file at the Health System may be used for a period of up to 12 months after the date of submission if financial circumstances have not changed.

Applications are accepted for financial assistance at any point in the billing cycle, including after placement with a collection agency or other third party. However, patients who have, or are eligible for, Third Party Assistance must first apply for and exhaust such Third Party Assistance before an application for financial assistance under this FAP will be processed/considered, as determined at the sole discretion of the Health System.

5. Notification of Approval or Denial for Assistance

The Patient Financial Services department will notify the patient in writing within 14 days of the receipt of a completed financial assistance application as to whether the application was approved or denied. If the application was approved, the letter will include the amount of assistance approved. If the application was denied, the denial reason will be provided in this letter. For incomplete applications, patients will be provided with a list in writing of the information and/or documentation still needed to complete the financial assistance application and where to submit the missing information.

Reasons for denial include:

- Incomplete application information.
- Excess income or resources.

6. Appeals

All patients determined to be not eligible for financial assistance or eligible for less than the most generous amount of assistance (100%) available under this Financial Assistance Policy (FAP) will be given 30 days to submit an appeal to request further financial assistance. The patient can present additional information at this time to support his or her request.

The Maryland Health Education and Advocacy Unit (HEAU) is available to assist patients in filing and mediation of a reconsideration request. The HEAU contact information is:

HEAU Hotline:
Mon-Fri 9am-4:30pm
410-528-1840
Toll free: 1-877-261-8807
FAX: 410-576-6571
heau@oag.state.md.us
www.marylandattorneygeneral.gov/pages/cpd/heau/default.aspx

Complaints concerning alleged violations of Maryland Code Sec. 19-214.1 or 19-214.2 can be filed by a patient or her/his authorized representative jointly with the HSCRC (Health Services Cost Review Commission) and the HEAU (Health Education and Advocacy Unit) via email at hscrc.patient-complaints@maryland.gov.

7. Presumptive Eligibility

In certain circumstances deemed reasonable and understandable, the lack of a financial assistance application and supporting documentation will not necessarily result in a denial for assistance. If a patient fails to supply sufficient information to support financial assistance eligibility, the Health System may refer to or rely on external sources and/or other program enrollment resources to determine if the patient qualifies for presumptive eligibility. Except as provided below, presumptive eligibility shall only cover the patient's specific date of service. A determination of presumptive eligibility will be based on the following criteria:

- Medicaid Eligible Patients. Balances for a patient who is currently eligible for full Medicaid coverage, but was not on the date of service.
- Patient is homeless.
- Patient with an adverse credit report or other third-party financial information.
- Deceased patient with no estate assets.
- Patient with out of state Medicaid eligibility currently residing outside of Maryland.

In addition, a patient who is not eligible for the Maryland Medical Assistance Program or Maryland Children's Health Program will qualify for presumptive eligibility if any of the following criteria apply:

- Lives in a household with children enrolled in the free and reduced-cost meal program.
- Receives benefits through the federal Supplemental Nutrition Assistance Program.
- Receives benefits through the State's Energy Assistance Program.
- Receives benefits through the federal Special Supplemental Food Program for Women, Infants, and Children.
- Receives benefits from any other social service program as determined by the Maryland Department of Health and the HSCRC.

8. Publication of Financial Assistance Policy

The Health System's FAP, financial assistance application, and plain language summary (including translations) are available to patients upon request and free of charge. In addition, translation services for Spanish, Russian, Korean, Mandarin (Chinese), Tagalog, Urdu, Vietnamese, and French, as well as other languages can be requested for patients in need of language assistance (subject to availability and scheduling).

The FAP, financial assistance application form, and the plain language summary are available upon request in the following Health System locations:

- Patient Registration and Admission Locations
- Crisis Walk-in Clinic
- Patient Financial Services Department (Towson, Maryland)

During patient registration for inpatient hospital services, patients receive a packet with the plain language summary of the FAP.

The FAP, financial assistance application, and the plain language summary are distributed by mail when requested by telephone at the following numbers:

- Patient Financial Services Department – (410)-938-3370 or toll free at 1-(800)-264-0949
- Each collection agency with which the Health System places accounts

Patients can also find the FAP, the financial assistance application, and the plain language summary online at the Health System web site:

- www.sheppardpratt.org/patient-care-and-services/resources/financial-support/

In addition, the Health System communicates the availability of financial assistance in the following ways:

- Notification on all patient billing statements
- Signage posted in registration and admission areas
- Signage posted in the Crisis Walk-in Clinic
- Patient brochures summarizing the FAP and how to apply for assistance offered at hospitalization
- Additional public engagement efforts

9. Actions in the Event of Non-Payment

The collection actions the Health System may take if a financial assistance application and/or payment are not received are described in a separate billing and collections policy. In brief, the Health System will make certain efforts to provide patients with information about the FAP before certain actions are taken to collect a bill. Balances placed with a collection agency are still eligible for a financial assistance reduction if eligibility criteria are met. The billing and collections policy (including translations) can be obtained as in the same manner and the same locations provided in Section 7 above.

10. Eligible Providers

In addition to care delivered by the Health System, emergency and medically necessary care delivered by the providers listed below in the hospital facility is also covered by this FAP:

- Sheppard Pratt Physicians, P.A.

References:

HS-130.11 Patient Financial Assistance - Plain Language Summary

Attachments:

Revised Dates:

2/14, 6/18, 7/18, 11/19, 2/20, 11/20, 1/21

Reviewed Dates:

12/05, 5/08, 10/11, 3/14, 6/18, 7/18, 11/19, 2/20, 11/20, 1/21

Signatures:

Harsh Trivedi: 1/26/21
Kelly Savoca: 1/12/21