MedStar Health

Community Health Needs Assessment

2018

Knowledge and Compassion
Focused on You

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Executive Summary

MedStar Health is a not-for-profit health system dedicated to caring for people in Maryland and the Washington, D.C., region, while advancing the practice of medicine through education, innovation and research. MedStar's nearly 30,000 associates, 6,000 affiliated physicians, 10 hospitals, numerous ambulatory care and urgent care centers and the MedStar Health Research Institute are recognized regionally and nationally for excellence in medical care. As the medical education and clinical partner of Georgetown University, MedStar trains more than 1,100 medical residents annually. MedStar's patient-first philosophy combines care, compassion and clinical excellence to advance health in the region.

At MedStar Health we recognize that a person's health is interwoven with the health of the community in which they live. We work to help our patients thrive under our care, as well as outside our hospital and clinic walls. A person's health is dependent on many different factors, including physical, social and economic factors such as access to housing, transportation, and employment. As a healthcare leader in the region, we play an important and significant role in advancing health and partnering with others to facilitate community health improvement. Our efforts are guided in large part by the results of our Community Health Needs Assessment (CHNA), which we perform every three years.

MedStar's CHNA utilizes an organized, systematic approach to identify and address the needs and assets of underserved communities across MedStar's geographic footprint. The CHNA guides the development and implementation of a comprehensive plan to improve health outcomes for those disproportionately affected by disease as well as social, environmental and economic barriers to good health. The CHNA also informs the creation of a strategy for future community health programming and how to allocate community benefit resources for fiscal years 2019–2021 across the 10 MedStar hospitals. As a not-for-profit organization, MedStar is required by the Internal Revenue Service (IRS) to conduct a CHNA every three years. Our CHNAs align with guidelines established by the Affordable Care Act and comply with IRS requirements.

PRIORITY HEALTH AREAS

While each hospital identified its own community needs and priority health areas, several conditions were listed as top priorities systemwide. They included:

- **Health and Wellness**
  - Chronic disease prevention and management
  - Behavioral health
- **Access to Care and Services**
  - Addiction and mental health services
  - Social need services
  - Transportation
- **Social Determinants of Health**
  - Housing
  - Employment

CHNA Approach

Using both public health and healthcare utilization data, each hospital identified communities or geographic areas of focus, called a Community Benefit Service Area (CBSA). The CBSA served as the geographic target area for the health needs assessment and for the execution of the strategies to address health needs identified. In addition, the above data were used to identify specific populations to assess and target for programmatic efforts. The CHNA will serve as a roadmap for targeted health promotion strategies conducted in the CBSA. The impact of the hospitals' efforts in their respective CBSAs will be tracked and evaluated over the next three-year cycle.

The CHNA process involved local residents, community partners and stakeholders, along with hospital leadership. Each hospital's CHNA was led by an Advisory Task Force (ATF) that included hospital leaders, community activists, residents, faith-based leaders, hospital representatives, public health leaders and other stakeholders. Task Force members used population-level data, community health needs survey findings and feedback from community input sessions to create recommendations for each hospital's health priorities, potential implementation strategies, and to identify key partners. Through a partnership with Georgetown University, public health and CHNA data were compiled, synthesized, and analyzed. Nearly 3,500 people were involved in the CHNA process, including 3,345 survey respondents and 150 people who participated in community input sessions.

Each ATF used the health needs survey data, along with information elicited through the community input sessions, to make recommendations regarding health priority areas and the appropriate level of hospital engagement in addressing these areas, and potential strategies to address the identified needs. The final CHNA implementation strategies were endorsed by each hospital's Board of Directors and approved by MedStar Health's Board of Directors.

Priorities and Implementation Strategies

The CHNA process identified three overarching categories of need across all 10 MedStar hospitals: health and wellness, access to care and services and social determinants of health. Within the health and wellness domain, chronic disease and prevention (diabetes, heart disease, obesity and cancer) and behavioral health (alcohol and drug addiction and mental health conditions) were identified as systemwide priorities.

Under access to care and services, increased access to behavioral health services for addiction and mental health were identified as systemwide priorities. Access to specific social services such as housing and jobs, as well as transportation to or from health-related services were the most frequently identified social needs. Several of these same areas were listed as priorities under social determinants of health, including housing and homelessness, affordable child care and lack of jobs.

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

Evaluation

Progress and impact of hospital's strategies will be assessed annually and shared with ATF members and each hospital's Board of Directors.

02 CHNA Approach and Process

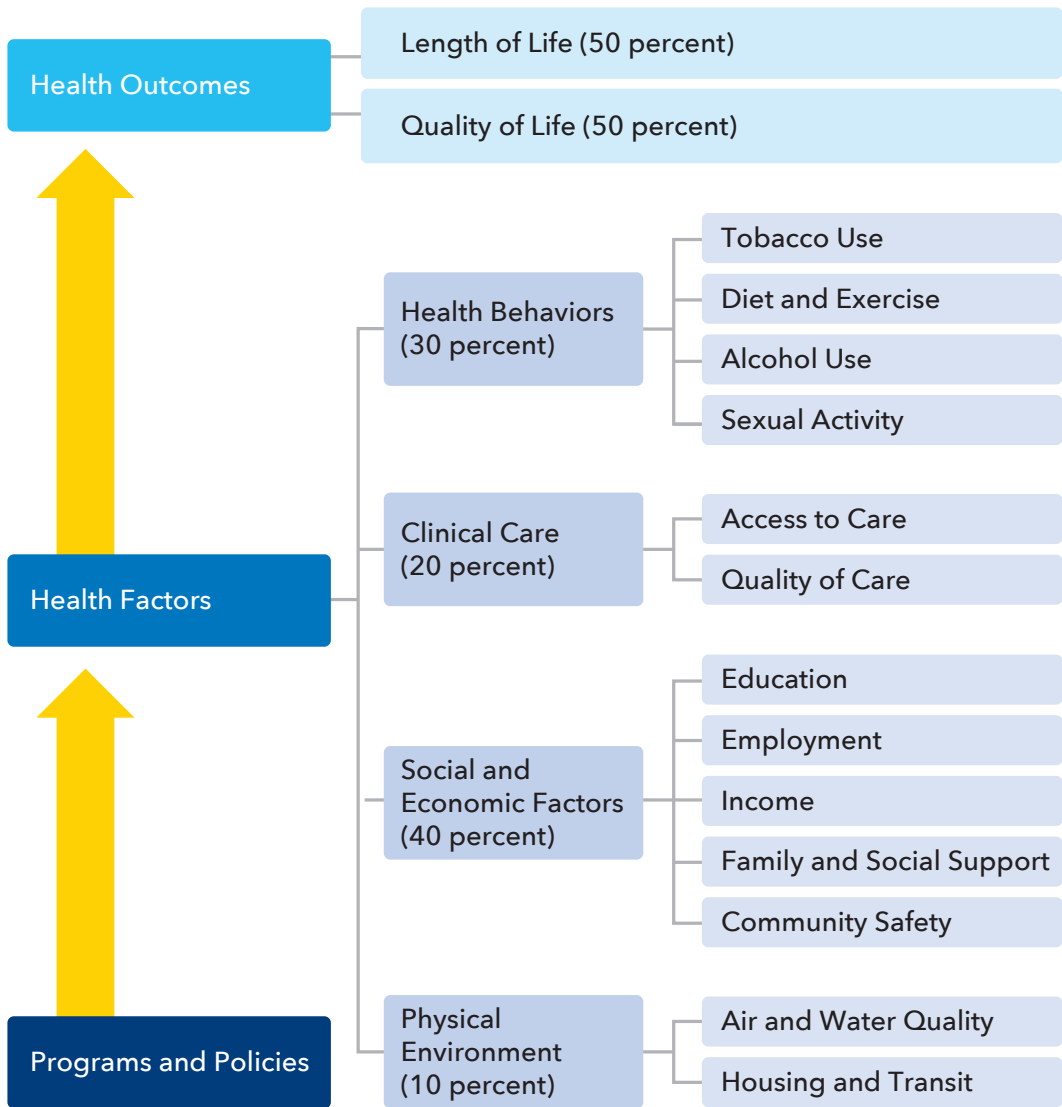## Community Health Needs Assessment (CHNA) Planning and Implementation

The Community Health Department at MedStar Health oversees and coordinates the CHNA process and deliverables to improve health outcomes throughout the system's service areas. The department drives CHNA program implementation and evaluation and community benefit reporting to the community and regulatory bodies. The department uses evidence-based methodologies to leverage internal and external stakeholder relationships and resources to target health-related disparities and address physical, social and economic contributors to suboptimal health. These efforts focus primarily on improving the health of underserved populations and addressing health disparities with the goal of achieving health equity.

CHNA Guiding Principles and Frameworks

The four guiding models for the CHNA were the Robert Wood Johnson Foundation's County Health Rankings Model,[21] Centers for Disease Control and Prevention's Reaching for Health Equity Model,[22] the Asset-Based Community Development Institutes's Asset-Based Community Development Framework,[23] and the National Center for Disease and Health Promotion's Social Ecological Model.[24] These models build upon a vast evidence-base and incorporate best practice standards that have been published by nationally recognized leaders in the healthcare field.

Equality

Equity

Equity means we all have the tools that we need to live a healthy, successful life.

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Health Outcomes
- Length of Life (50 percent)
- Quality of Life (50 percent)

Health Factors

Health Behaviors (30 percent)
- Tobacco Use
- Diet and Exercise
- Alcohol Use
- Sexual Activity

Clinical Care (20 percent)
- Access to Care
- Quality of Care

Social and Economic Factors (40 percent)
- Education
- Employment
- Income
- Family and Social Support
- Community Safety

Physical Environment (10 percent)
- Air and Water Quality
- Housing and Transit

Programs and Policies

County Health Rankings model ©2018 UWPHI

The models provide an understanding of what contributes to the health of communities, how assets and strengths of communities should be identified and leveraged as part of community program development. They also help identify the most effective ways to address individual, organizational, community and policy-level contributors to health in order to realize health equity. These models frame MedStar's community benefit efforts to improve the health status of people in MedStar's CBSAs.

During fiscal year 2018, each MedStar hospital used a multi-pronged approach to gather insights on their respective community health issues, determine health focus areas and develop targeted implementation strategies to address the issues prioritized. This included convening hospital ATFs to oversee the process and development of implementation strategies through formal review and approval.

Key CHNA Contributors and Participant Groups

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

- **Community Health Department at MedStar Health:** Established the CHNA methodology for all hospitals; assisted in identification of strategic partners; provided expertise and technical support as needed; ensured that processes, deliverables and deadlines comply with the IRS mandate.

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

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

- **CHNA Survey Respondents and Community Input Session Participants:** Nearly 3,500 people completed the CHNA survey and contributed to the community input sessions as part of the CHNA process. Diverse groups of community stakeholders—including CBSA residents and organizations, civic and faith-based leaders, public health officials and government agencies—and hospital leadership were engaged to garner information about the most pressing issues across CBSAs.

CHNA Methodology and Data Collection

The data sources for the CHNA included quantitative secondary population-level data, hospital healthcare utilization data, a CHNA community survey and qualitative community group input sessions. These data were used to broaden the types of information gathered and to engage a diverse group of internal and external stakeholders to inform the CHNA process and deliverables. The types of information gathered for each data source were as follows:

- **Secondary Data:** National, state, local health and disparity data, public health priorities and community health improvement plans. County-level ZIP code and neighborhood level data (when available).

- **Hospital Utilization Data:** Patient healthcare utilization and charity care data (a proxy for economic status) were used to identity each hospital's CBSAs and geographic areas of focus for needs assessment and strategy implementation.

- **CHNA Community Survey:** Open and closed-ended questions about healthcare access, health equity, health condition concerns, social determinants and community strengths and assets were asked in a community questionnaire disseminated by the hospitals in their CBSAs.

- **Community Input Session Discussions:** Hospitals facilitated nine community discussions with a diverse group of community stakeholders to identify the most important community health issues. Guided discussion areas included topics related to community health and wellness, access to care and services and the social determinants of health.

Combined information from all of the above sources was used to:

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

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

Prioritization Process and Criteria

Identification of health priorities was shaped by an understanding of the public health priorities, needs assessment data and each hospital's strengths within the context of the system's priorities. Additionally, when selecting final targeted health priorities, MedStar considered additional criteria such as availability of evidence-based approaches and existing partnerships and programming. These components were used to identify priority areas. The ATFs participated in a comprehensive prioritization exercise that involved grouping and ranking identified needs and assets, as well as discussions about what existing and new initiatives and partners should be included in a hospital's three-year implementation plans. The purpose was to determine how to best support the highest prioritized needs, while leveraging identified community assets and resources.

Hospital Strengths/ Priorities

Importance Identified by Community/ Community Assets

Magnitude of Health Issue

Availability of Evidence-Based Approaches

Priority Determination

Severity of Health Issue

Potential Impact of Strategy

Disparity/ Equity-focused

Existing/ Potential Partnerships

Hospital Role in Identified Priority Areas

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

- **Focus (Leader) Role:** MedStar is well-positioned to take a leadership role in addressing identified focus areas. Strategies to address these areas are included in each hospital's CHNA.

- **Collaboration (Partner) Role:** MedStar will partner with other leading organizations in which it is best positioned to serve as a collaborator. Hospitals' strategies will include the local organizations who are leading this work and MedStar's role as a partner.

- **Participation (Supporter) Role:** MedStar will play a supporter role in areas it recognizes as significant contributors to health, but are beyond the scope of its organizational strengths. MedStar will participate as a supporter or advocate in these areas. Accordingly, the three-year plan will reference local organizations leading efforts in those areas.

Community Benefit Service Areas (CBSAs)

Each hospital's Advisory Task Force identified a geographic or target area to serve over the next three-year Community Health Needs Assessment cycle. These CBSAs were selected based on hospital patient utilization data; elevated disease incidence and prevalence; a high density of underserved or low-income residents and evidenced health disparities; proximity to the hospital; and/or an existing presence of programs and partnerships.

Systemwide Priorities and Implementation Strategies

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This report provides an overview of systemwide assessment findings, identified priorities as well as detailed information of the CHNA priorities and strategies for each hospital.
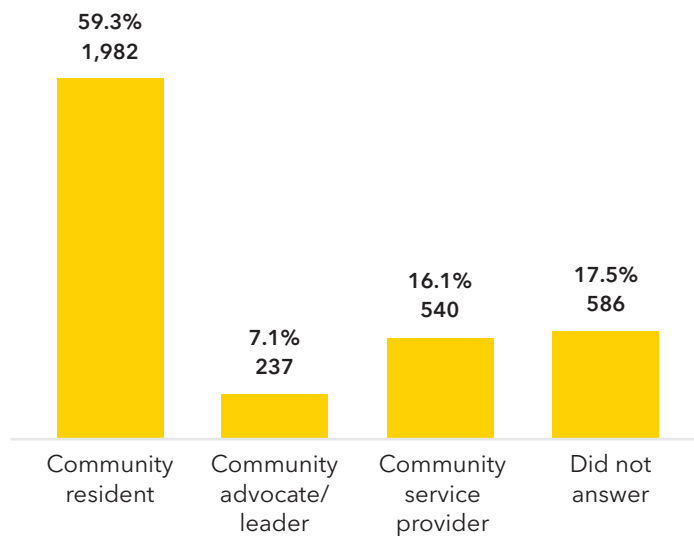
Assessment domains included examination of health needs in three areas:

- Health and wellness
- Access to care and services
- Social determinants of health

A. Survey Results

MedStar Health sought the input of various community stakeholders through a combination of community input sessions and the CHNA survey. As part of the CHNA process, 3,345 people age 18 and older completed the survey tool, and a majority of respondents were community residents.

SURVEY RESPONDENT ROLE IN THE COMMUNITY

Role	Percentage	Count
Community resident	59.3%	1,982
Community advocate/leader	7.1%	237
Community service provider	16.1%	540
Did not answer	17.5%	586

Domain 1: Health and Wellness

Chronic disease prevention and management emergedas a key health priority within the health and wellness domain across all 10 hospitals. More specifically, the following chronic conditions were prioritized as focus areas for the hospitals' implementation strategies.
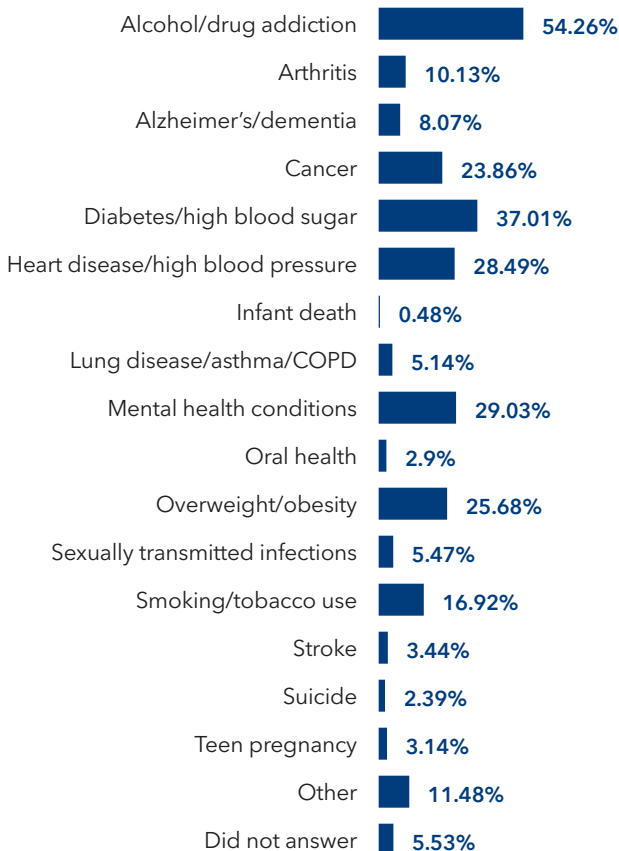
- Chronic Disease Prevention and Management
  - Diabetes
  - Heart Disease
  - Obesity
  - Cancer

Behavioral health was also identified as a priority across the 9 acute MedStar hospitals.

- Behavioral Health
  - Alcohol and drug addiction
  - Mental health conditions

HEALTH AND WELLNESS

The top health problems identified across MedStar communities were alcohol and drug addiction, diabetes, heart disease, mental health conditions and obesity.

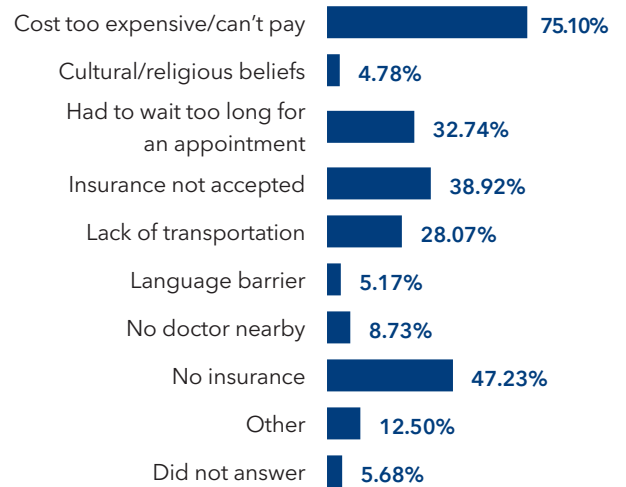|	
Alcohol/drug addiction	54.26%
Arthritis	10.13%
Alzheimer's/dementia	8.07%
Cancer	23.86%
Diabetes/high blood sugar	37.01%
Heart disease/high blood pressure	28.49%
Infant death	0.48%
Lung disease/asthma/COPD	5.14%
Mental health conditions	29.03%
Oral health	2.9%
Overweight/obesity	25.68%
Sexually transmitted infections	5.47%
Smoking/tobacco use	16.92%
Stroke	3.44%
Suicide	2.39%
Teen pregnancy	3.14%
Other	11.48%
Did not answer	5.53%

Domain 2: Access to Care and Services

Within the Access to Care and Services domain, most MedStar hospitals listed specific strategies and outcome targets to address these needs:

1. Increased access to mental health and addiction services
2. Increased access to social needs services
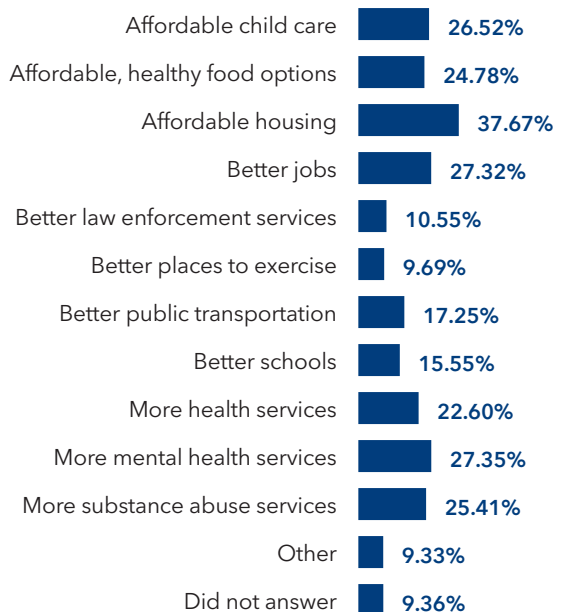3. Improved access to transportation to and from health-related services

ACCESS TO CARE

The top healthcare access issues identified across MedStar communities were cost, no insurance insurance not accepted, appointment wait times, and transportation.

Cost too expensive/can't pay	75.10%
Cultural/religious beliefs	4.78%
Had to wait too long for an appointment	32.74%
Insurance not accepted	38.92%
Lack of transportation	28.07%
Language barrier	5.17%
No doctor nearby	8.73%
No insurance	47.23%
Other	12.50%
Did not answer	5.68%

ACCESS TO SERVICES

Specific services identified across MedStar communities included greater access to substance abuse services, mental health services, housing, and employment.

Affordable child care	26.52%
Affordable, healthy food options	24.78%
Affordable housing	37.67%
Better jobs	27.32%
Better law enforcement services	10.55%
Better places to exercise	9.69%
Better public transportation	17.25%
Better schools	15.55%
More health services	22.60%
More mental health services	27.35%
More substance abuse services	25.41%
Other	9.33%
Did not answer	9.36%

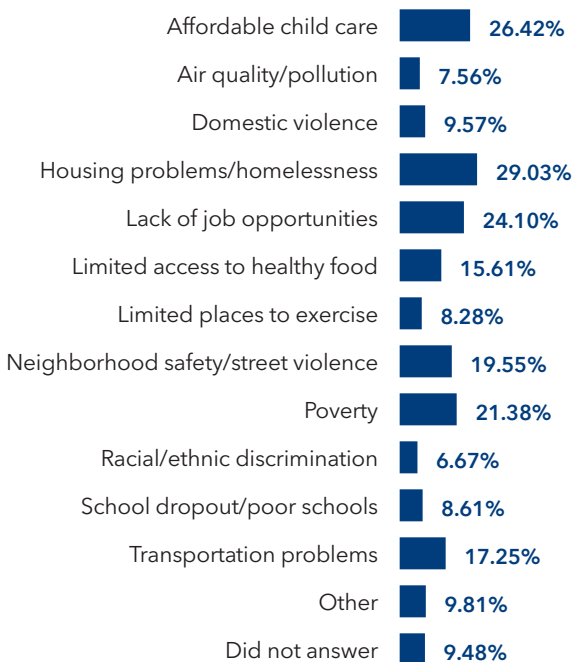## Domain 3: Social Determinants of Health

MedStar understands and recognizes that the social and physical environments in which people live can have significant effects on the development and progression of disease and associated health status. Societal and physical environment can directly affect individual behaviors and health outcomes. Addressing such factors is essential to achieving improved health and health equity. In addition, social determinants such as housing and employment instability , can directly impact healthcare costs. They are significant drivers of how often and what type of healthcare services people use. Key social determinants identified to address were:

- Affordable housing and homelessness
- Affordable child care
- Better job opportunities

Within this domain, MedStar prioritized increased employment and workforce development as collaboration areas. MedStar's three-year implementation plan will include efforts in this space. In addition, MedStar will serve in a supporter role to address community issues around housing and homelessness.

SOCIAL DETERMINANTS OF HEALTH

The top social issues contributing to community health across MedStar communities were identified as housing, childcare, employment, poverty, and neighborhood violence/safety.

Category	Percent
Affordable child care	26.42%
Air quality/pollution	7.56%
Domestic violence	9.57%
Housing problems/homelessness	29.03%
Lack of job opportunities	24.10%
Limited access to healthy food	15.61%
Limited places to exercise	8.28%
Neighborhood safety/street violence	19.55%
Poverty	21.38%
Racial/ethnic discrimination	6.67%
School dropout/poor schools	8.61%
Transportation problems	17.25%
Other	9.81%
Did not answer	9.48%

Community Strengths and Assets

In alignment with the Asset-Based Community Development Framework, the approximate 3,500 people involved in the CHNA process helped identify current strengths and assets in their community, as well as how those strengths could be used to address identified health issues and achieve health equity.

Respondents indicated that they had access to good medical providers and good overall health care services that could be leveraged to address local health issues while also helping to shrink the health equity gap. The fact that their communities offered many community involvement opportunities was also viewed as a strength. Respondents also identified local organizations that would be particularly suited to helping address community health issues in partnership with local health care providers.

Based on the assets identified, respondents identified several critical collaborators to support MedStar's priority areas. These included:

- Local health departments
- Community healthcare providers and organizations
- Social service agencies
- Pharmacies
- Faith-based institutions
- Schools
- Homeless shelters
- Employment Agencies
- Food Banks
- Community-based organizations

B. Community Input Sessions: Key Themes

At the qualitative community input sessions, community members identified the health issues most important to them. These issues fell into three overarching topic areas: health and wellness, access to care and services and social determinants of health.

Domain 1: Health and Wellness

There is a continued need for prevention and management programs and services focused on chronic disease in the areas of drug and alcohol addiction, mental health conditions, diabetes, heart disease, obesity and cancer. Communities lack awareness of the health-related resources available and how to access existing wellness, prevention and management services. Numerous community assets and resources are underutilized due to lack of awareness and social determinant barriers such as housing instability, lack of transportation and financial instability stemming from lack of employment.

Domain 2: Access to Care and Services

Increased collaboration between MedStar and community-based health providers and organizations will assist with strategy execution and bringing health education and prevention services directly into communities, which will decrease barriers to access and appropriate use of healthcare services. Transportation services as well as access to behavioral health and social needs services were routinely identified as areas of priority.

Domain 3: Social Determinants of Health

There is a documented link between social determinants of health and their impact on health care use and costs. Basic needs such as affordable housing, child care and employment need to be met in order to improve physical and mental health and generate overall improved health status in the community. Many people overusing healthcare services, particularly emergency care, have social issues that are not being addressed. Meeting community needs around social determinants is an essential component of delivering quality, comprehensive care for patients. MedStar's community partners will play a critical role in helping to address the social determinants of health.

Evaluation

Over fiscal years 2019-2021, the hospitals will execute the approved implementation strategies. Plans will focus on evidence and outcomes based strategies that align with assessment findings and hospitals' population health management efforts. Evidence-based programming for identified priority areas, systematic measurement and examination of program effectiveness, as well as progress and outcomes relative to program metrics and local public health goals, will be tracked as part of the evaluation. Strategy progress and impact will be shared with hospitals' ATF and Board of Directors.

Priorities and Hospital Role

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

SYSTEM-WIDE PRIORITIES BY HOSPITAL ROLE

FOCUS AREAS

Chronic disease prevention and management

Access to behavioral health services

Identification of social needs and linking to community social services

COLLABORATION AREAS

Transportation

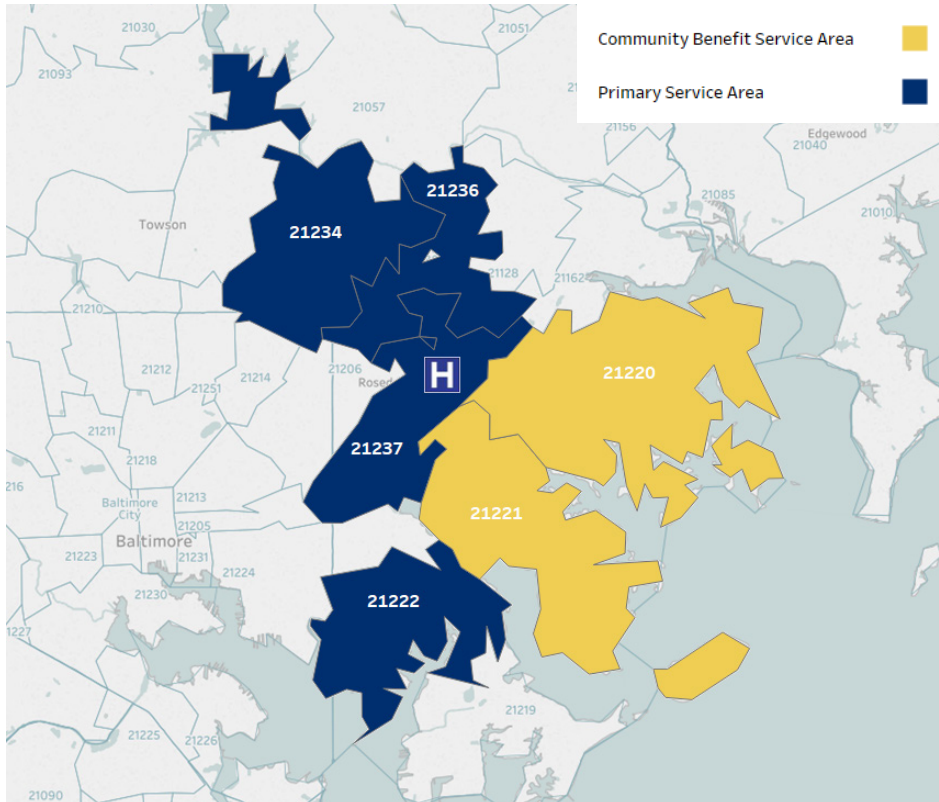Employment and workforce development

PARTICIPATION AREAS

Housing

Individual Hospital Community Health Needs Assessments and Strategies

MedStar Franklin Square Medical Center

Community Benefit Service Area
Primary Service Area

Community Health Needs Assessment

Health and Wellness

CHRONIC DISEASE

Chronic Disease Objectives
- Deliver evidence-based, outcome-focused chronic disease management and prevention programs and services in, or targeting individuals living in, MedStar Franklin Square Medical Center's Community Benefit Service Area (CBSA)
- Prevent the onset of type 2 diabetes through a 12-month lifestyle change program
- Increase awareness and the intention to quit among smokers
- Provide stroke survivors and their family caregivers an opportunity to support each other as they strive to rebuild their lives and promote health, independence, and well-being

COMMUNITY BENEFIT SERVICE AREA (CBSA): SOUTHEAST BALTIMORE COUNTY

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

COMMUNITY HEALTH PRIORITIES
- **Health and Wellness**
  - Chronic Disease Prevention and Management
  - Behavioral Health
  - Maternal and Child Health

- **Access to Care and Services**
  - Mental Health Services and Substance Use Services
  - Linkage to Social Need Resources and Services
  - Transportation

- **Social Determinants of Health**
  - Employment
  - Housing

Chronic Disease Secondary Data

DIABETES

- Diabetes is the sixth leading cause of death in Baltimore County.[27]
- The death rate for diabetes in Baltimore County is 19.6 per 100,000 people, compared to 19.2 per 100,000 in Maryland and to 21.0 per 100,000 in the US.[27, 28]

HEART DISEASE AND STROKE

- Heart disease is the leading cause of death in Baltimore County and Maryland.[27]
- Stroke is the third leading cause of death in Baltimore County and Maryland.[27]
- Baltimore County has a heart disease death rate of 176.8 per 100,000 people in Baltimore County, compared to 166.9 per 100,000 statewide.[27]
- In Baltimore County, the stroke death rate was 43.9 per 100,000 people in Baltimore County, compared to 38.4 per 100,000 statewide.[27]

OBESITY

- 30.0 percent of adults in Baltimore County report a BMI of 30 or more.[11]

SMOKING

- 15.0 percent of adults in Baltimore County are current smokers.[13]

CANCER

- Cancer is the second leading cause of death in both Baltimore County and the state of Maryland.[27]
- Baltimore County has a cancer death rate of 171.0 per 100,000, higher than the state cancer death rate of 157.4 per 100,000.[27]
- Baltimore County has a cancer death rate of 171.0 per 100,000, compared to 157.4 per 100,000 for the state.[27]

Chronic Disease Strategies

- Conduct Living Well Chronic Disease Self- Management Program
- Conduct Diabetes Prevention Program
- Conduct Smoking Cessation Program
- Conduct Stroke Support Group

Chronic Disease Anticipated Outcomes

- Increased participation in chronic disease prevention and management programs and services
- Increased retention rates among program participants
- Improved health behaviors and health outcomes among program participants
- Increased identification of social unmet needs and linkages to social need services among chronic disease management program participants
- Improved healthcare utilization patterns among program participants

Chronic Disease Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Living Well Program**
  - Percentage of program completers who report improved quality of life
  - Percentage of program completers reporting increased physical activity
  - Percentage of program completers who have decreased blood pressure and weight loss
  - Percentage of people who screened positive for social needs and were linked to services at intake and post program completion
  - Percentage of completers who do not readmit to emergency department (ED) after the program ends
  - Potentially Avoidable Utilizations (PAU) and readmission rates among program completers
  - Percentage of program completers who successfully complete follow-up assessments

- **Diabetes Prevention Program**
  - Number of Diabetes Prevention Program (DPP) programs conducted annually
  - Retention rates among DPP participants
  - Number of participants who meet weight loss goal of five percent
  - Number of participants who meet physical activity goal of 150 minutes per week

- **Smoking Cessation: Cancer Prevention**
  - Percentage of completers who report quitting after program participation
  - Quit rate of program completers

- **Stroke Support**
  - Number of support groups held annually
  - Number of participants in support groups annually

From January to March 2017, there were **550 drug and alcohol overdose-related deaths** in Maryland, including 372 fentanyl-related deaths.[9]

PUBLIC HEALTH METRICS

- Age-adjusted death rates for heart disease, stroke, cancer, and diabetes
- Prevalence rates of obesity among adults
- Emergency department visits and hospitalization rates due to hypertension, heart disease, stroke, cancer, obesity, and diabetes
- Prevalence rates of diabetes among adults
- Percentage of adults who smoke
- Percentage of adolescents using tobacco products

KEY PARTNERS: CHRONIC DISEASE

American Cancer Society

American Stroke Association

Baltimore County Department of Aging

Baltimore County Department of Health

Centers for Disease Control and Prevention (CDC)

Maintaining Active Citizens, Inc.

Maryland Department of Aging

Maryland Department of Health

St. Stephens AME Church

BEHAVIORAL HEALTH

Behavioral Health Objectives: Substance Use Disorders

- Deliver evidence-based behavioral health programs and services targeting the identification of substance abuse and linkage to treatment services among high-risk individuals in MedStar Franklin Square's CBSA

Behavioral Health Secondary Data

ALCOHOL ABUSE

- 16 percent of adults in Baltimore County report excessive drinking.[11]
- Percentage of driving deaths in Baltimore County with alcohol involvement: 26 percent.[11]
- Percentage of Baltimore County adults reporting binge drinking: 16 percent.[11]

OPIOID ABUSE

- Baltimore County saw the largest increase in drug-related deaths in 2017, where 176 people died in the first quarter of 2017, compared to 113 people in the first quarter of 2016.[9]
- From January to March 2017, there were 550 drug and alcohol overdose-related deaths in Maryland, including 372 fentanyl-related deaths.[9]

Behavioral Health Strategies

- Implement the Screening, Brief Intervention, and Referral to Treatment (SBIRT) strategy in emergency department and primary care settings
- Embed Peer Recovery Coaches on hospital care teams to assist with improving access to substance use treatment and social service linkage, and support community education efforts

Behavioral Health Anticipated Outcomes

- Improved identification of high-risk substance use behaviors and access to substance abuse treatment, education, and social services

Behavioral Health Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- Number of emergency department (ED) SBIRT screens annually
- Number of positive SBIRT screens annually
- Number of brief interventions completed annually
- Number of referrals to treatment provided annually
- Number of patients linked to treatment annually
- ED readmission and potentially avoidable utilization (PAU) rates of patients who receive brief interventions and/or linkage to treatment
- Number of substance abuse or addiction support groups promoted and held in MedStar Franklin Square CBSA annually

PUBLIC HEALTH METRICS

- Percentage of individuals reporting a substance abuse disorder
- Percentage of adults reporting excessive drinking
- Percentage of hospitalizations due to a substance abuse or alcohol abuse disorder
- Number of driving deaths involving alcohol
- Age-adjusted death rate due to opioid overdose
- Age-adjusted drug and alcohol related death rate
- Drug and alcohol related emergency department visits

KEY PARTNERS: BEHAVIORAL HEALTH

Baltimore County Department of Health

Mosaic Group

Substance Abuse and Mental Health Services Administration (SAMSHA)

MATERNAL AND CHILD HEALTH

Maternal and Child Health Objectives

- Promote positive birth outcomes and increased breastfeeding practice for mothers and their families in Southeast Baltimore County

Maternal and Child Health Secondary Data

- In Baltimore County, nine percent of infants are born with low birth weight. This is higher than the rate for Maryland (8.5 percent) and the United States (7.8 percent).
- For every 1,000 live births in Baltimore County, there are six infant deaths per year.[11]
- The infant mortality rate for black mothers in Baltimore County is 11 per 1,000 live births.[11]

Maternal and Child Health Strategies

- Support and coordinate the Healthy Babies Collaborative

Maternal and Child Health Anticipated Outcomes

- Increased number of babies being born healthy and being raised in safe and stable families and communities in southeast Baltimore County
- Improved access to breastfeeding education and services in southeast Baltimore County

Maternal and Child Health Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- Number of support group meetings held annually
- Number of participants in support group meetings annually
- Percentage of infants being "fully formula-fed"

PUBLIC HEALTH METRICS

- Percentage of babies with low birth weight
- Percentage of babies exclusively breastfed
- Percentage of infants being "fully formula-fed"
- Infant mortality rate
- Maternal mortality rate
- Child mortality rate

Access to Care and Services

Access to Care and Services Objectives

- Increase access to mental health services as part of the primary care model
- Improve appropriate healthcare utilization practices and health outcomes of high-need, high-risk patients by identifying social unmet needs and linkage to community social needs resources at point of care using the Aunt Bertha tool

Access to Care and Services Secondary Data

- In Baltimore County, there are 400 mental health providers for every one patient.[11]
- Seven percent of the Baltimore County population under the age of 65 do not have health insurance.[11]
- The ratio of the population to primary care physicians in Baltimore County is 990:1.[11]
- 12.0 percent of children in Baltimore County are living in poverty; among black children, the rate is 16.0 percent; among Latino children, the rate is 22.0 percent; among white children, the rate is seven percent.[11]

Access to Care and Services Strategies

- Provide mental health services as part of a primary care model
- Conduct social needs screenings and support linkages to social need services as part of care delivery and chronic disease self-management programming

Access to Care and Services Anticipated Outcomes

- Increased access to mental health services in primary care settings
- Increased use of uniform social needs screener in MedStar Franklin Square care delivery sites and as part of the Living Well Program
- Improved identification of patients' unmet social needs and service linkage at point of care
- Improved health care utilization among individuals linked to social need services, transportation services or mental health services

Access to Care and Services Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Mental Health Services**
  - Number of people who receive mental health treatment services in program primary care setting annually
  - Number of people screened for selected mental health conditions (substance use, depression, and anxiety) annually
  - Number of people with positive mental health screening annually
  - Number of people who screen positively for mental health conditions that are referred or linked to services annually
  - ED readmission and PAU rates of people with positive mental health screening that were referred or linked to services

- **Social Need Services**
  - Number of social needs screenings conducted annually
  - Number of positive social needs screens annually
  - Number of people referred to services annually
  - Number of people linked to services annually
  - ED readmission and PAU rates of people with positive social needs screenings that are referred or linked to services

PUBLIC HEALTH METRICS

- Depression and anxiety disorder prevalence rates
- Percentage of adults unemployed
- Percentage of households experiencing food insecurity
- Percentage of uninsured individuals

- Number of individuals reporting avoiding medical care due to cost
- Percentage of individuals living below the poverty line

Collaboration Areas

Collaboration areas were identified as social determinant areas in which the hospital will serve as a partner with outside organizations.

TRANSPORTATION

Transportation Objectives
- Address the barrier of transportation to medical and health services and programs among individuals who identify transportation as a social unmet need

Transportation Secondary Data
- 28 percent of MedStar Franklin Square CHNA survey respondents identified lack of transportation as a barrier to accessing care.

Transportation Strategies
- Implement MedStar Health UBER program

Transportation Anticipated Outcomes
- Increased number of available rides to and from medical and health services and community health programs
- Decreased no-show rates among participants

Transportation Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **MSH UBER Program**
  - Number of rides supported annually
  - Number of people who receive rides annually

19 percent of youth ages 16 to 24 are classified as "disconnected youth" (neither in school nor working).[21]

- ED readmission and PAU rates of people who receive rides
- Medical appointment no show rates
- Percentage of people who identify transportation as a barrier

PUBLIC HEALTH METRICS
- Percentage of the population with access to public transportation
- Percentage of population who have delayed getting medical care due to lack of transportation

EMPLOYMENT

Employment Objectives
- Hire individuals from underserved communities as Community Health Advocates (CHA) and Peer Recovery Coaches (PRC) to contribute to MedStar Health's population health management efforts in the Baltimore region through the Baltimore Population Health Workforce Support for Disadvantaged Areas Program (PHWSDA)
- Prepare local underserved students for healthcare-related collegiate studies and careers through an established pipeline internship program

Employment Secondary Data
- 4.5 percent of the population in Baltimore County over the age of 16 is unemployed and seeking work.[11]
- The Baltimore County unemployment rate is five percent, which is the same as the US, but higher than the unemployment rate in Maryland (four percent).[21]
- In Baltimore County, the high school graduation rate is 89.9 percent. Racial disparities exist in high school graduation rates in Maryland. White students graduation rate is 90.0 percent compared to 77.0 percent and 73.0 percent among black and Hispanic students, respectively.[26]

- 19.0 percent of Baltimore County youth ages 16 to 24 are classified as "disconnected youth" (neither in school nor working)[21]

Employment Strategies
- Conduct PHWSDA program
- Conduct the Rx for Success Pipeline Summer Internship Program for underserved high school students

Employment Anticipated Outcomes
- Increased number of CHAs and PRCs hired and trained by 2019
- Increased number of underserved, racial and ethnic minority interns in the Rx for Success summer internship at MedStar Franklin Square annually
- Improved satisfaction rates among student interns, intern supervisors, and school partner leadership annually
- Improved pipeline processes to increase employment opportunities post-internship for eligible students

Employment Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Population Health Workforce Support for Disadvantaged Areas "Jobs" Program**
  – Number of individuals trained from MedStar Franklin Square's CBSA
  – Number of individuals hired from MedStar Franklin Square's CBSA
  – Retention rates of hired associates
  – Number of patients or clients assisted by these positions
  – Average caseload for positions
  – Average length of patient engagement by positions
  – Number of patients screened for social needs and number of those referred or linked to services
  – Readmission rates among patients assigned to CHAs or PRCs
  – ED utilization among patients assigned to CHAs or PRCs

- **Rx for Success Pipeline Summer Internship Program**
  – Number of students who apply to the internship annually
  – Number of students selected or placed in the internship annually
  – Number of student interns from MedStar Franklin Square's CBSA annually
  – Graduation rates of interns
  – Number of seniors who complete the internship and pursue a health-related college major
  – Number of seniors who complete the internship and are employed in a health-related position within MedStar Health
  – Student, supervisor, and community partner satisfaction rate
  – Type of intern placements within MedStar Franklin Square

PUBLIC HEALTH METRICS
- Unemployment rate
- High school graduation and completion rate
- Percentage of new hires to healthcare fields[25]

KEY PARTNERS: EMPLOYMENT

Baltimore Alliance for Careers in Healthcare (BACH)

Baltimoreans United in Leadership Development (BUILD)

Eastern Technical High School

Project SEARCH–Arc of Baltimore

Turnaround Tuesday

Other local health systems

Participation Areas

Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.
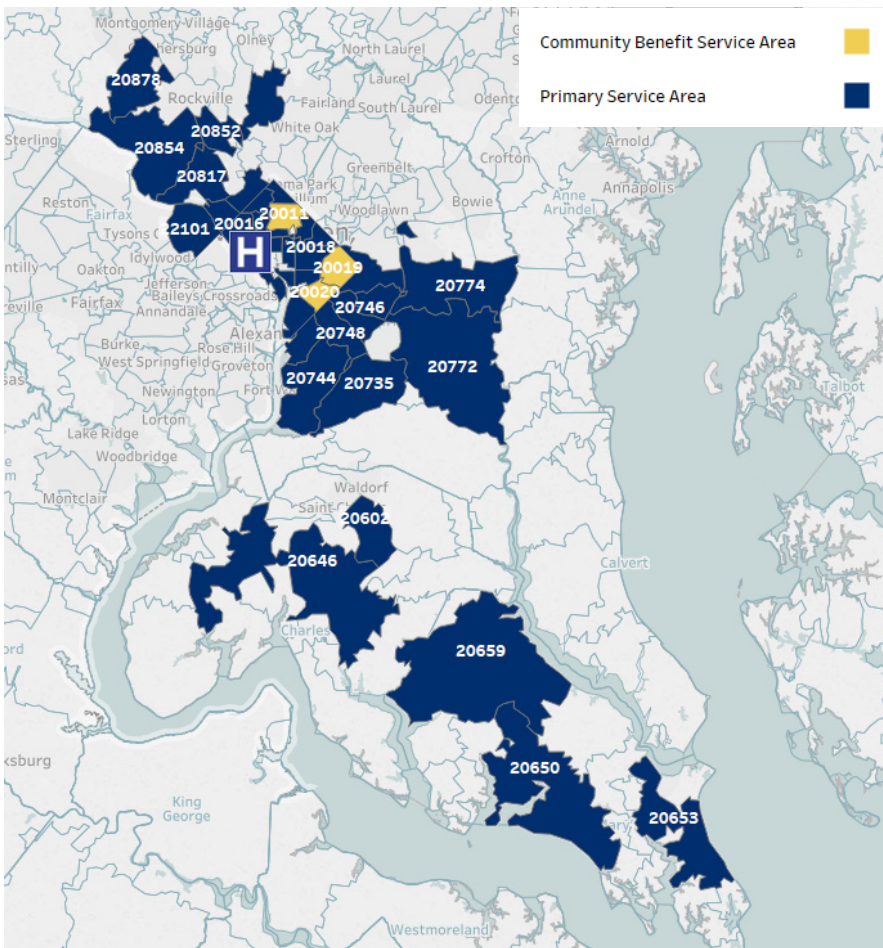
PARTICIPATION
- Housing

KEY PARTNERS: PARTICIPATION

Baltimore County Communities for the Homeless

Baltimore County Department of Planning

Health Care for the Homeless

Neighbor to Neighbor

United Way of Central Maryland

MedStar Georgetown University Hospital

Community Benefit Service Area
Primary Service Area

Community Health Needs Assessment

Health and Wellness

CHRONIC DISEASE

Chronic Disease Objectives

- Deliver evidence-based and outcome-focused chronic disease management and prevention programs and services in, or targeting at-risk, high-need individuals living in, MedStar Georgetown University Hospital's Community Benefit Service Area (CBSA)

COMMUNITY BENEFIT SERVICE AREA (CBSA): 20011, 20019, 20020 (WITH EMPHASIS ON WARDS 7 AND 8)

MedStar Georgetown University Hospital's CBSA includes residents in Washington, DC zip codes 20011, 20019, and 20020. This geographic area was selected based on hospital utilization and secondary public health data with the goal of expanding services and programs to underinsured, uninsured, and low income people.

COMMUNITY HEALTH PRIORITIES

- **Health and Wellness**
  - Chronic Disease Prevention and Management
  - Behavioral Health

- **Access to Care and Services**
  - Mental Health and Substance Use Services
  - Linkage to Resources and Services—Schools
  - Transportation

- **Social Determinants of Health**
  - Food Access
  - Employment
  - Housing

- Increase access to health care and support services by providing patient visits to children and adolescents living in the underserved communities of DC, who are at risk or have poor access to comprehensive pediatric health care services

Chronic Disease Secondary Data

DIABETES
- Diabetes was the sixth leading cause of death in DC, with 127 deaths in 2016 (and a mortality rate of 19.8).[32]
- In 2014, one in eleven (or 9.1 percent) DC residents had diabetes. In 2013, diabetes was the ninth leading cause of hospitalization in DC, with 1,572 visits.[6]
- In DC, emergency department (ED) visits related to diabetes were over six times higher African-Americans than for Whites.[6]
- An analysis of ED records found that up to 30 percent of visits for diabetes, asthma, and other chronic conditions were potentially preventable with better access to effective primary and preventive care.[6]

HEART DISEASE AND STROKE
- Heart disease is the leading cause of death among DC residents, with 1,375 deaths in 2016 (and a mortality rate of 211.7).[32]
- Heart disease in DC can be attributed to preventable factors like obesity, poor physical activity, heavy drinking, eating unhealthy foods, and not keeping blood pressure and cholesterol under control.
- The hospitalization rate for heart disease in DC was 41.9 per 1,000 Medicare beneficiaries.
- Heart disease is the top reason for hospitalization in DC.
- Stroke is the fourth leading cause of death in DC, with 252 deaths in 2016 (and mortality rate of 38.4).[32]

OBESITY
- In DC, 26.2 percent of adults are obese. DC has the second lowest adult obesity rate in the nation.[36]

- More than one-third (33.8 percent) of 10-12 year-olds in DC are obese.[36]
- DC ranks 11th among all states for obesity rates among kids ages 10-12.[36]

CANCER
- Cancer is the second leading cause of death among DC residents, with 1,044 deaths in 2016 (and a mortality rate of 160.1).[32]
- The crude death rate of deaths from cancer in Ward 7 is about 22.0 percent higher than the DC-wide rate, and 26.0 percent higher than the nation.[35]
- DC has the highest liver cancer rates in the country, with 15 deaths per 100,000 men, and five such deaths per 100,000 women.[35]

Chronic Disease Strategies
- Conduct Living Well – Chronic Disease Self-Management Program
- Deliver Mobile Health Clinics: Kids Mobile Medical Clinic & Mobile FITNESS Program

Chronic Disease Anticipated Outcomes
- Increased participation in chronic disease prevention and management programs and services
- Increased retention rates among program participants
- Improved health behaviors and health outcomes among program participants
- Increased identification of social unmet needs and linkages to social need services among chronic disease management program participants
- Improved healthcare utilization patterns among program participants
- Increased number of children and adolescent patients at mobile health clinics
- Increased children and adolescent body mass index (BMI) screenings

Chronic Disease Metrics

PROGRAM-SPECIFIC METRICS

- **Living Well Program**
  - Percentage of program completers who report improved quality of life
  - Percentage of program completers reporting increased physical activity
  - Percentage of program completers who have decreased blood pressure and weight loss
  - Percentage of people who screened positive for social needs and were linked to services at intake and program completion
  - Percentage of completers who do not readmit to the ED
  - Potentially avoidable utilizations (PAU) and readmission rates among program completers
  - Percentage of program completers who successfully complete follow-up assessments

- **Pediatric Health Care Services**
  - Number of patient visits completed annually
  - Number of unique patients annually
  - Number of patients screened for BMI annually
  - Number of patients (or students) served or reached annually
  - Number of participants reached through fitness programs and events (including Build Our Kids Success program) annually

PUBLIC HEALTH METRICS

- Age-adjusted death rate from diabetes, heart disease, stroke, and cancer
- Emergency department visit rates and hospitalizations due to hypertension, diabetes, heart disease, stroke and cancer
- Prevalence of diabetes in DC
- Incidence and prevalence of heart disease and stroke in DC
- Percentage of adults at a healthy weight or BMI
- Percentage of adults participating in recommended levels of physical activity
- Percentage of adults who are obese

> DC's mortality rate for opioid-related **overdose deaths is among the highest in the nation.**[37]

- Percentage of children and adolescents who are obese or overweight

KEY PARTNERS: CHRONIC DISEASE

Build Our Kids Success (BOKS)

DC Department of Aging and Human Services

DC Department of Family Services

DC Health

DC Public Schools

Maintaining Active Citizens, Inc.

Maryland Department of Aging

Ronald McDonald House Charities of Greater Washington, DC

Schools (Barnard Elementary School, KIPP D.C. AIM Academy, KIPP DC Heights Academy, and Neval Thomas Elementary School)

Share Our Strength's Cooking Matters Program

The NHLBI's We Can! (Ways to Enhance Children's Activity & Nutrition) and Healthy Kids Challenge

BEHAVIORAL HEALTH

Behavioral Health Objectives

- Deliver evidence-based behavioral health programs and services targeting the identification of substance abuse and linkage to treatment services among high-risk individuals in MedStar Georgetown University Hospital's CBSA

Behavioral Health Secondary Data

SUBSTANCE ABUSE

- Nationally, over 20 million adults have a substance use disorder.
- In 2016, there were more than 63,600 drug overdose deaths in the United States.[41]
- The rate of drug overdose deaths in DC in 2016 was 38.8 per 100,000 population.[41]
- More DC residents report use of illicit drugs (12.3 percent) than the national rate, 8.8 percent.[30]

ALCOHOL ABUSE

- 28.0 percent of adults in DC report binge drinking compared to 18.0 percent nationally.[11]
- In DC, the percentage of driving deaths with alcoho involvement was 25 percent compared to 33.0 percent nationally.[11]

- The percentage of driving deaths with alcohol involvement in DC increased from 43.0 percent in 2015 to 74.0 percent in 2016.[5]
- White adults were more than twice as likely to report as binge drinkers compared to Black adults (35.0 percent and 14.0 percent, respectively).[5]
- The percent of adults reporting as binge drinkers varied significantly by ward, with the highest percentages in Wards 1 (42.0 percent) and 2 (30.0 percent) and lowest in Wards 4 (16.0 percent) and 7 (18.0 percent).[5]

OPIOID ABUSE
- DC's mortality rate for opioid-related overdose deaths is among the highest in the nation, with a 2016 rate of 30 deaths per 100,000 people (or 209 deaths). The national rate is 13.3 per 100,000 people.[37]

Behavioral Health Strategies
- Conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program

Behavioral Health Anticipated Outcomes
- Improved identification of high-risk substance use behaviors and access to substance abuse treatment, education, and social need services

Behavioral Health Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- Number of SBIRT screens annually
- Number of positive SBIRT screens annually
- Number of brief interventions completed annually
- Number of referrals to treatment provided annually
- Number of patients linked to treatment annually
- ED readmission and PAU rates of patients who receive brief interventions and/or linkage to treatment
- Number of substance abuse and addiction support groups held in Medstar Georgetown University Hospital's CBSA annually

PUBLIC HEALTH METRICS
- Percentage of individuals reporting a substance abuse disorder

- Percentage of adults reporting excessive drinking
- Percentage of adults and adolescents who report alcohol use and binge drinking
- Percentage of hospitalizations due to a substance abuse or alcohol abuse disorder
- Number of driving deaths involving alcohol
- Number of hospitalizations due to opioid overdose
- Age-adjusted death rate due to opioid overdose
- Age-adjusted drug and alcohol related death rate
- Drug- and alcohol-related ED visits

Access to Care and Services

Access to Care and Services Objectives
- Increase access to mental health services as part of the primary care model
- Improve appropriate healthcare utilization practices and health outcomes of high-need, high-risk patients by identifying social unmet needs and linkage to community social needs resources at point of care using the Aunt Bertha tool

Access to Care and Services Secondary Data
MENTAL HEALTH SERVICES
- In 2014, approximately 18.0 percent of DC adults had ever been told they had a depressive disorder.[5]
- Rates of reported depression were highest in Ward 8 (30.0 percent), Ward 1 (22.0 percent), and Ward 7 (18.0 percent).[5]
- Areas of Wards 7 and 8 were designated by the Health Resources and Services Administration (HRSA) as mental health professional shortage areas in 2015.[5]
- In 2014, the second most common inpatient hospital discharge among all DC residents was for mood disorders (3.9 percent).[5]

SOCIAL NEEDS SERVICES

- 93.0 percent of adult residents and 96.0 percent of children have insurance coverage in DC. It is the second highest coverage rate in the nation.[5]
- Residents in Wards 7 and 8 had the lowest coverage amongst all wards (90.0 percent and 91.0 percent, respectively).[5]
- Health insurance coverage was lowest among Hispanic/Latino residents (78.0 percent) compared to 91.0 percent coverage among Black residents and 97.0 percent coverage among White residents.[5]
- DC-wide, 10.0 percent of adults reported that they had delayed getting medical care because they could not get an appointment soon enough.[5]

Access to Care and Services Strategies

- Provide mental health services as part of the primary care model
- Conduct social needs screening and support linkages to social need services as part of care delivery and chronic disease self-management programming

Access to Care and Services Anticipated Outcomes

- Increased access to mental health services in primary care settings
- Increased use of uniform social needs screener in MedStar Georgetown University care delivery sites and as part of the Living Well program
- Improved identification of patients' social unmet needs and service linkage at point of care
- Improved healthcare utilization among individuals linked to social need services, transportation services or mental health services

Access to Care and Services Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Mental Health Services**
  - Number of people who receive or are referred to mental health treatment services in primary care settings annually
  - Number of people screened for selected mental health conditions (substance use, depression, and anxiety) annually

DC-wide, **10 percent** of adults reported that they had delayed getting medical care because they could not get an appointment soon enough.[5]

  - Number of people with positive mental health screenings annually
  - Number of people who screen positively for mental health conditions that are referred or linked to services annually
  - ED Readmission and PAU rates of people with positive mental health screening that were referred or linked to services

- **Social Needs Services**
  - Number of social needs screenings conducted annually
  - Number of positive social needs screened annually
  - Number of people referred to services annually
  - Number of people linked to services annually
  - ED Readmission and PAU rates of people with positive social needs screening that were referred or linked to services

PUBLIC HEALTH METRICS

- Depression and anxiety disorder prevalence rates
- Percentage of adults unemployed
- Percentage of households experiencing food insecurity
- Percentage of uninsured individuals
- Number of individuals reporting avoiding medical care due to cost
- Percentage of individuals living below the poverty line
- Percentage of people reporting unmet healthcare needs in the past 12 months
- Percentage of people reporting they could not afford to see a doctor in the past 12 months

Collaboration Areas

Collaboration areas were identified as social determinant areas in which the hospital will serve as a partner with outside organizations.

TRANSPORTATION

Transportation Objectives
- Address the barrier of transportation to medical and health services and programs among individuals who identify transportation as a social unmet need

Transportation Secondary Data
- Lack of transportation is cited as having a significant impact on access to health care services and is a determinant of a person's ability to access basic resources that can affect quality of life.[5]
- In DC, many characterize public transportation as expensive and unreliable.[5]
- Metro stations in DC are concentrated in the central region (Wards 2 and 6) and are lacking in other areas, especially in Wards 4, 7 and 8.[5]
- 19.0 percent of MedStar Georgetown University Hospital's CHNA survey respondents identified lack of transportation as a barrier to accessing care.

Transportation Strategies
- Implement MedStar Health UBER program

Transportation Anticipated Outcomes
- Increased number of available rides to and from medical and health services and community health programs
- Decreased no-show rates among participants

Transportation Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **MSH UBER Program**
  - Number of rides supported annually
  - Number of people who receive rides annually
  - ED readmission and PAU rates of people who receive rides
  - No show rates among program participants
  - Percentage of people who identify transportation as a barrier

PUBLIC HEALTH METRICS
- Percentage of the population with access to public transportation
- Percentage of population who have delayed getting medical care due to lack of transportation

EMPLOYMENT

Employment Objectives
- Prepare local underserved students for healthcare-related collegiate studies and careers through an established pipeline internship program

Employment Secondary Data
- In 2015, 14.0 percent of DC families lived in poverty. In Wards 7 and 8, 75.0 percent more families live in poverty, at 25.0 percent and 29.0 percent respectively, compared to the DC benchmark.[5]
- DC's unemployment rate has decreased since 2011, but the rate varies from ward to ward. Compared to the national rate, unemployment was two times higher in Ward 7 and three times higher in Ward 8 in 2016.[5]
- Compared to the national average, as of June 2016, unemployment is two times higher in Ward 7 and three times higher in Ward 8.[5]
- DC's income inequality ratio is 7.0 percent (ratio of household income at the 80th percentile to income at the 20th percentile).[5]
- Income and employment status are closely linked to morbidity, mortality, and overall well-being; lower than average life expectancy is highly correlated with low-income status.[5]

Employment Strategies

- Conduct the Rx for Success Pipeline Summer Internship Program for underserved high school students

Employment Anticipated Outcomes

- Increased number of underserved, racial and ethnic minority interns in the Rx for Success summer internship at MedStar Georgetown University Hospital's annually
- Improved satisfaction rates among student interns, intern supervisors and school partner leadership annually
- Improved pipeline processes to increase employment opportunities post-internship for eligible students

Employment Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Rx for Success Pipeline Summer Internship Program**
  - Number of students who apply to the internship annually
  - Number of students selected and placed in the internship annually
  - Number of student interns from MedStar Georgetown University Hospital's CBSA annually
  - Graduation rates of interns
  - Number of seniors who complete the internship and pursue a health-related college major
  - Number of seniors who complete the internship and are employed in a health-related position within MedStar Health
  - Student, supervisor and community partner satisfaction rate
  - Type of intern placements within MedStar Georgetown University Hospital

PUBLIC HEALTH METRICS

- Unemployment rate
- Percentage of adults who are unemployed and seeking work (unemployment rate)
- High school graduation and completion rate
- Percentage of new hires to healthcare fields

13 percent of the population in DC reports food insecurity, or insufficient access to healthy food, compared to 10 percent nationally.[5]

FOOD ACCESS

Food Access Objectives

- Improve access to healthy food among individuals who identify food insecurity as a social need

Food Access Secondary Data

- 29.0 percent of MedStar Georgetown University Hospital's CHNA respondents identified healthy food options as a community need.
- Residents in Wards 7 and 8 have reported they struggled to afford the cost of healthy produce.[5]
- 13.0 percent of the population in DC reports food insecurity, or insufficient access to healthy food, compared to 10.0 percent nationally.[5]

Food Access Strategies

- Conduct Food & Friends Meal Referral Program

Food Access Anticipated Outcomes

- Increased number of people with positive social needs screened for food insecurity that are referred or linked to food-related services
- Increased number of annual MedStar Georgetown University Hospital-supported meals

Food Access Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Food and Friends Meal Referral Program**
  - Number of referrals to Food & Friends annually
  - Number of people linked to food services annually
  - Number of meals supported annually
  - ED readmission and PAU rates of people linked to food services

PUBLIC HEALTH METRICS

- Percentage of food insecure households
- Percentage of population lacking access to healthy food

> **KEY PARTNERS: FOOD ACCESS**
>
> Food & Friends
> Capital Area Food Bank

SCHOOL-BASED HEALTH CENTERS

School-Based Health Centers Objectives
- Improve access to health care services for adolescents living in the underserved areas of DC

School-Based Health Centers Secondary Data
- There are eight school-based health centers in DC, and DC Health oversees seven of them.[39]
- A SBHC can serve as a student's primary health care provider or supplement the services they would normally receive.[39]
- Each SBHC offers medical, oral, social and mental health services, and education to enrolled students, and to the children of enrolled students.[39]

School-Based Health Centers Strategies
- Provide health care services through the school-based health centers at Roosevelt Senior High School and Anacostia Senior High School

School-Based Health Centers Anticipated Outcomes
- Improved health outcomes among program participants

School-Based Health Centers Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- Number of students served annually
- Number of patient visits completed annually

PUBLIC HEALTH METRICS

- Emergency department visit rates due to asthma for children ages 5–14

> **KEY PARTNERS: EMPLOYMENT**
>
> Anacostia Senior High School
> Anacostia Wellness Clinic
> Roosevelt Senior High School
> DC Health
> DC Public Schools
> Health Justice Alliance
> Mary's Center Inc.
> MWHC TAPP program
> National Alliance to Advance Adolescent Health
> New Heights Program

Participation Areas

Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.

PARTICIPATION

- Housing

> **KEY PARTNERS: PARTICIPATION**
>
> Central Union Mission
> Coalition for the Homeless
> DC Department of Human Services—Family Services Administration
> DC Health
> District of Columbia Primary Care Association (DCPCA)—DC Positive Accountable Community Transformation (DC PACT)
> Housing and Urban Development
> Pathways to Housing

MedStar Good Samaritan Hospital
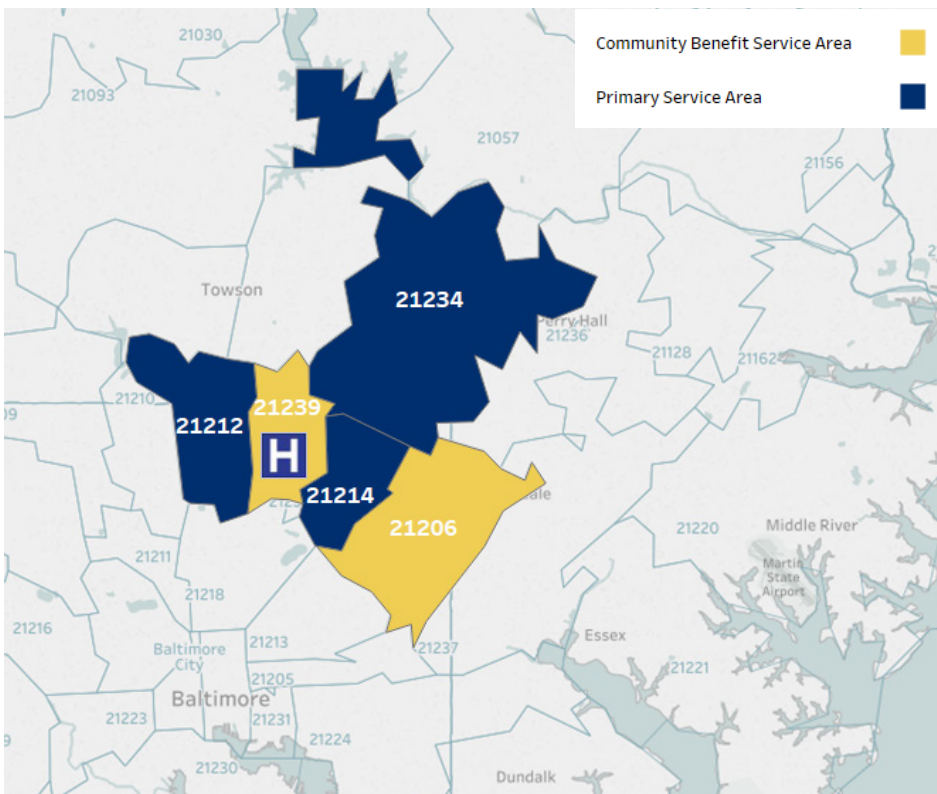
Community Health Needs Assessment

Health and Wellness

CHRONIC DISEASE

Chronic Disease Objectives

Deliver evidence-based, outcome-focused chronic disease management and prevention programs and services in, or targeting individuals living in, MedStar Good Samaritan Hospital's Community Benefit Service Area (CBSA)

- Prevent the onset of type 2 diabetes through a 12-month lifestyle change program
- Increase awareness and the intention to quit among smokers
- Provide stroke survivors and their family caregivers an opportunity to support each other as they strive to rebuild their lives and promote health, independence and well-being

COMMUNITY BENEFIT SERVICE AREA (CBSA): GOVANS AREA
MedStar Good Samaritan Hospital's CBSA includes residents in zip codes 21206 and 21239. This geographic area was selected based on hospital utilization and secondary public health data as well as its close proximity to the hospital, coupled with a high density of residents with low incomes.

COMMUNITY HEALTH PRIORITIES
- **Health and Wellness**
  – Chronic Disease Prevention and Management
  – Behavioral Health

- **Access to Care and Services**
  – Mental Health Services
  – Linkage to Resources and Services
  – Transportation

- **Social Determinants of Health**
  – Employment
  – Neighborhood Violence and Street Safety
  – Housing

Chronic Disease Secondary Data

DIABETES
- Diabetes is the sixth leading cause of death in Baltimore City and Maryland.[27]
- The prevalence of diabetes in Baltimore City is 13.65 percent.[11]
- The prevalence of diabetes among African Americans (18.58 percent) is more than twice as high as the prevalence among Whites in Baltimore City (7.44 percent).[11]

HEART DISEASE AND STROKE
- Heart disease is the leading cause of death in Baltimore City and Maryland.[27]
- Stroke is the third leading cause of death in Baltimore City and Maryland.[27]
- 145 out of 100,000 people die prematurely due to cardiovascular disease (CVD).[2]
- In 2014, the CVD premature death rate among Black residents was about 1.6 times the same rate among White residents.[2]
- Baltimore City has the highest stroke death rate per 100,000 people in Maryland at a rate of 108.4 per 100,000 individuals.[4]

OBESITY
- 34.0 percent of adults in Baltimore City report a body mass index (BMI) of 30 or higher, compared to 26.0 percent for the top US performers.[11]

CANCER
- Cancer is the second leading cause of death in Maryland and Baltimore City has the highest cancer mortality rate among all Maryland jurisdictions.[8]
- Baltimore City has a cancer death rate of 213.9 per 100,000, higher than the state cancer death rate of 157.4 per 100,000.[19, 27]

SMOKING
- 20.0 percent of adults smoke in Baltimore City, compared to 15.5 percent of adults nationally in 2016.[11]

Chronic Disease Strategies
- Conduct Living Well – Chronic Disease Self-Management Program
- Conduct Diabetes Prevention Program
- Conduct Smoking Cessation Program
- Conduct Stroke Support Group

Chronic Disease Anticipated Outcomes
- Increased participation in chronic disease prevention and management programs and services
- Increased retention rates among program participants
- Improved health behaviors and health outcomes among program participants
- Increased identification of social unmet needs and linkages to social need services among chronic disease management program participants
- Improved healthcare utilization patterns among program participants

Chronic Disease Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Living Well Program**
  - Percentage of program completers who report improved quality of life
  - Percentage of program completers reporting increased physical activity
  - Percentage of program completers who have decreased blood pressure and weight loss
  - Percentage of people who screened positive for social needs and were linked to services at intake and post program completion
  - Percentage of completers who do not readmit to emergency department (ED) after program ends
  - Potentially avoidable utilizations (PAU) and readmission rates among program completers
  - Percentage of program completers who successfully complete follow-up assessments

- **Diabetes Prevention Program**
  - Number of Diabetes Prevention Program (DPP) programs conducted annually
  - Retention rates among DPP participants
  - Number of participants who meet weight loss goal of five percent
  - Number of participants who meet physical activity goal of 150 minutes per week

- **Smoking Cessation Program**
  - Percentage of completers who report quitting after program participation
  - Quit rate of program completers

- **Stroke Support Group**
  - Number of support groups held annually
  - Number of participants in support groups annually

PUBLIC HEALTH METRICS

- Age-adjusted death rates for heart disease, stroke, cancer, and diabetes
- Prevalence rates of obesity among adults
- ED visits and hospitalization rates due to hypertension, heart disease, stroke, cancer, obesity, and diabetes
- Prevalence rates of diabetes among adults
- Percentage of adults who smoke
- Percentage of adolescents using tobacco products

KEY PARTNERS: CHRONIC DISEASE

American Cancer Society

American Stroke Association

Baltimore City Department of Aging

Baltimore City Health Department

Centers for Disease Control and Prevention (CDC)

Maintaining Active Citizens, Inc.

Maryland Department of Aging

Maryland Department of Health

BEHAVIORAL HEALTH

Behavioral Health Objectives: Substance Use Disorders

- Identify people with at-risk and dependent substance and/or alcohol use behaviors, and provide brief early intervention services to those who screen positively for risky drug and alcohol use
- Empower community members and stakeholders to save lives in response to an opioid overdose through naloxone training
- Identify people with at-risk and dependent substance abuse behaviors and provide community navigation and support services through the Opioid Survivor Outreach Program

Behavioral Health Secondary Data

ALCOHOL ABUSE

- Percentage of driving deaths with alcohol involvement in Baltimore City: 20.0 percent.[1]
- Percentage of Baltimore City adults reporting binge drinking: 18.0 percent.[11]
- Substance Abuse: Total number of drug- and alcohol-related intoxication deaths in Maryland increased from 1,259 in 2015 to 2,089 in 2016.[10]

OPIOID ABUSE

- Number of prescription opioid-related intoxication deaths increased from 61 in 2010 to 113 in 2016.[10]

Behavioral Health Strategies

- Implement the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program
- Embed Peer Recovery Coaches on hospital care teams to assist with improving access to substance use treatment and social service linkage, and support community education efforts
- Offer naloxone training to community
- Develop and implement Opioid Survivor Outreach Program (OSOP) to provide support and resources to opioid survivors that visit hospital-based emergency departments

Behavioral Health Anticipated Outcomes

- Improved identification of high-risk substance use behaviors and access to substance abuse treatment education, and social need services

Behavioral Health Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **SBIRT Program**
  - Number of SBIRT screens annually
  - Number of positive SBIRT screens annually
  - Number of brief interventions completed annually
  - Number of referrals to treatment provided annually
  - Number of patients linked to treatment annually
  - ED readmission and PAU rates of patients who receive brief interventions and/or linkage to treatment
  - Number of substance abuse and addiction support groups held in MGSH CBSA annually

- **Naloxone Training and OSOP**
  - Number of naloxone administration trainings offered at the hospital or CBSA annually
  - Number of community members trained to administer naloxone annually
  - Number of referrals to treatment annually
  - Number of suspected overdoses annually
  - Number of referrals to OSOP peer recovery coaches annually
  - Number of patients successfully contacted by OSOP recovery coach annually

- Number of OSOP patients referred to treatment monthly
- Number of OSOP patients linked to recovery support groups annually
- Number of naloxone kits provided to OSOP patients annually
- Number of naloxone prescriptions provided to OSOP patients annually
- Number of known OSOP deaths annually

PUBLIC HEALTH METRICS
- Percentage of individuals reporting a substance abuse disorder
- Percentage of adults reporting excessive drinking
- Percentage of adults and adolescents who report alcohol use and binge drinking
- Percentage of hospitalizations due to a substance abuse or alcohol abuse disorder
- Number of driving deaths involving alcohol
- Number of hospitalizations due to opioid overdose
- Age-adjusted death rate due to opioid overdose
- Age-adjusted drug and alcohol related death rate
- Drug- and alcohol-related ED visits

KEY PARTNERS: BEHAVIORAL HEALTH

Baltimore City Health Department

Community substance abuse and mental health treatment service organizations

Mosaic Group

Substance Abuse and Mental Health Services Administration (SAMHSA)

Access to Care and Services

Access to Care and Services Objectives
- Increase access to mental health services as part of the primary care model
- Improve healthcare utilization practices and health outcomes of high-need, high-risk patients by identifying social unmet needs and linkage to community social needs resources at point of care using the Aunt Bertha tool
- Ensure access to health care services and health education for the Hispanic/Latino and immigrant communities

Access to Care and Services Secondary Data

HEALTH CARE
- In Baltimore City, there is one primary care physician for 1,060 people (ratio 1060:1).[11]
- In 2014, 10.0 percent of survey respondents in Baltimore City reported being unable to get the medical care they needed in the past 12 months[1]
- Mental Health.
- One out of 5 (110,468) Baltimoreans will experience a mental illness each year.[3]
- One out of 20 (24,093) Baltimore City adults have a serious mental illness such as major depressive disorder, bipolar disorder, or schizophrenia.[3]
- One out of 25 (19,275) Baltimore City adults need both mental health and substance abuse treatment.[3]
- 20.0 percent of Baltimoreans with serious mental illness lack health insurance.[3]

HEALTH EQUITY AND DISPARITIES
- While Baltimore's overall population diminished by 4.6% between 2000-2010, the Hispanic/Latino population grew dramatically by 134.7%.[42]

Access to Care and Services Strategies
- Provide mental health services as part of the primary care model
- Conduct social needs screenings and support linkages to social needs services as part of care delivery and chronic disease self-management programming

Access to Care and Services Anticipated Outcomes
- Increased access to mental health treatment services and education services for hospital primary care patients
- Increased access to community mental health education opportunities
- Improved identification of patients' social unmet needs and service linkage at point of care
- Improved healthcare utilization among individuals linked to mental health, social need or transportation services
- Increased health education courses in Hispanic/Latino and immigrant communities

Access to Care and Services Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Mental Health Services**
  - Number of people who receive mental health treatment services in program primary care setting annually
  - Number of people screened for selected mental health conditions (substance use, depression, and anxiety) annually
  - Number of people with positive mental health screening annually
  - Number of people who screen positively for mental health conditions that are referred or linked to services annually
  - ED readmission and PAU rates of people with positive mental health screening that were referred or linked to services

- **Social Needs Services**
  - Number of social needs screenings conducted annually
  - Number of positive social needs screen annually

- Number of people referred to services annually
- Number of people linked to services annually
- ED readmission and PAU rates of people with positive social needs screening that were referred or linked to services

- **Health Equity and Disparities**
  - Number of lay leaders from Hispanic/Latino and immigrant communities trained annually
  - Number of participants from Hispanic/Latino and immigrant communities in health education courses annually
  - Number of health education courses delivered in Hispanic/Latino and immigrant communities annually

PUBLIC HEALTH METRICS
- Percentage of people reporting unmet health care needs in the past 12 months
- Percentage of people reporting they could not afford to see a doctor in the past 12 months
- Percentage of people diagnosed with mental illness that are uninsured
- Percentage of adults unemployed
- Percentage of households living in poverty
- Percentage of households experiencing food insecurity

Collaboration Areas

Collaboration areas were identified as social determinant areas in which the hospital will serve as a partner with outside organizations.

TRANSPORTATION

Transportation Objectives
- Address the barrier of transportation to medical and health services and programs among individuals who identify transportation as a social unmet need

Transportation Secondary Data
- 28 percent of MedStar Good Samaritan Hospital CHNA survey respondents identified lack of transportation as a barrier to accessing care.

Transportation Strategies
- Implement MedStar Health UBER program

Transportation Anticipated Outcomes
- Increased number of available rides to and from medical and health services and community health programs
- Decreased no-show rates among participants

Transportation Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **MedStar Health UBER Program**
  - Number of rides supported annually
  - Number of people who receive rides annually
  - ED readmission and PAU rates of people who receive rides

  - No show rates among program participants
  - Percentage of people who identify transportation as a barrier

PUBLIC HEALTH METRICS
- Percentage of the population with access to public transportation
- Percentage of population who have delayed getting medical care due to lack of transportation

EMPLOYMENT

Employment Objectives
- Hire individuals from underserved communities as community health advocates (CHAs) and peer recovery coaches (PRCs) to contribute to MedStar Health's population health management efforts in the Baltimore region through the Baltimore Population Health Workforce Support for Disadvantaged Areas Program (PHWSDA)
- Prepare local underserved students for health care-related collegiate studies and careers through an established pipeline internship program

Employment Secondary Data
- 28.8 percent of Baltimore City families live in poverty.[11]
- 19.0 percent of youth between the ages of 16-24 are classified as disconnected youth (neither in school nor working), compared to 13.0 percent in Maryland and 10.0 percent for the top US performers.[11]
- 70.0 percent of Baltimore City high schoolers graduate within four years, compared to 87.0 percent in Maryland and 95.0 percent among the top US performers.[11]

Employment Strategies
- Conduct PHWSDA program
- Conduct the Rx for Success Pipeline Summer Internship Program for underserved high school students
- Provide educational opportunities, skills training, professional mentorship and internship opportunities to local high school students.

Employment Anticipated Outcomes
- Increased number of CHAs and PRCs hired and trained by 2019
- Increased number of underserved, racial and ethnic minority interns in the Rx for Success summer internship at MedStar Good Samaritan Hospital annually
- Improved satisfaction rates among student interns, intern supervisors and school partner leadership annually
- Improved pipeline processes to increase employment opportunities post-internship for eligible students

Employment Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **PHWSDA "Jobs" Program**
  - Number of individuals trained from MedStar Good Samaritan Hospital CBSA
  - Number of individuals hired from MedStar Good Samaritan Hospital CBSA
  - Retention rates of hired associates
  - Number of patients or clients assisted by these positions
  - Average caseload for positions
  - Average length of patient engagement by positions
  - Number patients screened for social needs and number of those referred or linked to services
  - Readmission rates among patients assigned to CHAs or PRCs
  - ED utilization among patients assigned to CHAs or PRCs

- **Rx for Success Pipeline Summer Internship Program**
  - Number of students who apply to the internship annually
  - Number of students selected and placed in the internship annually
  - Number of student interns from MedStar Good Samaritan Hospital's CBSA annually
  - Graduation rates of interns
  - Number of seniors who complete the internship and pursue a health-related college major
  - Number of seniors who complete the internship and are employed in a health-related position within MedStar Health
  - Student, supervisor, and community partner satisfaction rate

- Type of intern placements within MedStar Good Samaritan Hospital

- **FUTURE OF HEALTH Program**
  - Number of students who apply to the cohorts annually
  - Number of students selected and placed in the cohorts annually
  - Number of students from MedStar Good Samaritan Hospital's CBSA annually
  - Graduation rates of students in cohorts
  - Number of seniors who complete the experience and pursue a health related-college major
  - Number of seniors who complete the experience and are employed in a health-related position within MedStar Health

PUBLIC HEALTH METRICS
- Unemployment rate
- High school graduation and completion rate
- Percentage of new hires to health care fields

KEY PARTNERS: EMPLOYMENT
Baltimore Alliance for Careers in HealthCare
BUILD - Baltimoreans United in Leadership Development
Mercy High School
Mission Integration and Volunteer Services
NACA Freedom and Democracy Academy
Turnaround Tuesday
Vivien T. Thomas Medical Arts Academy

Participation Areas

Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.

Participation
- Neighborhood Violence and Street Safety
- Housing

KEY PARTNERS: PARTICIPATION
American Heart Association
BUILD - Baltimoreans United in Leadership Development
Habitat for Humanity
Healthcare for the Homeless
Penn North - UTURNS/SAMHSA
Safe Streets
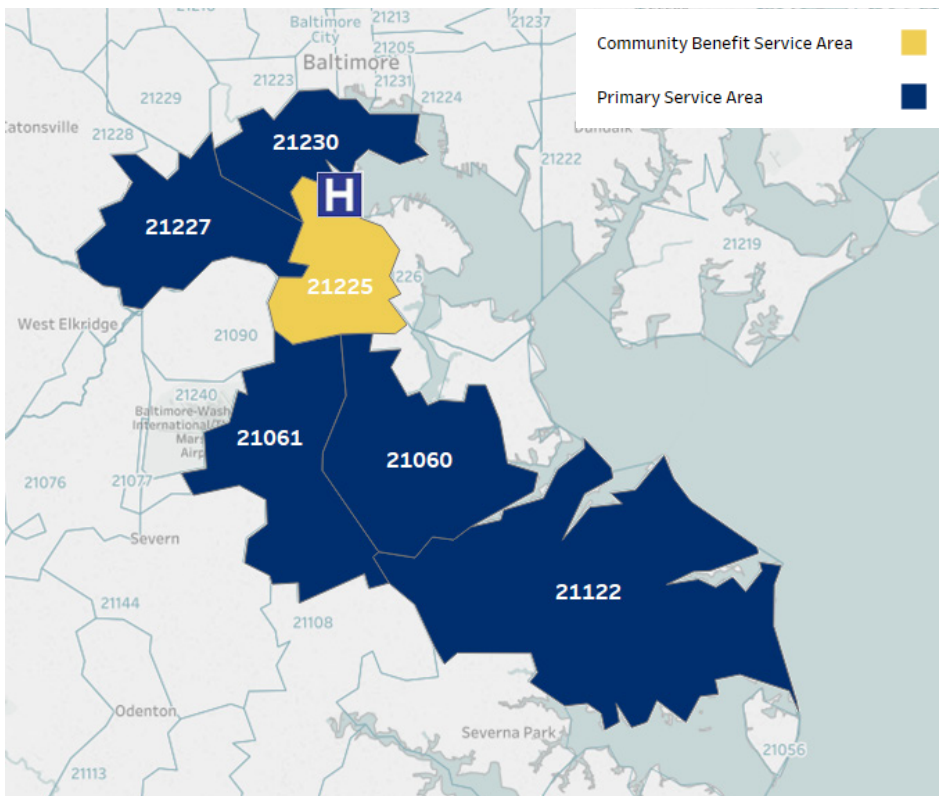
MedStar Harbor Hospital

Community Health Needs Assessment

Health and Wellness

CHRONIC DISEASE

Chronic Disease Objectives
Deliver evidence-based, outcome-focused chronic disease management and prevention programs and services targeting at-risk, high-need individuals living in MedStar Harbor Hospital's Community Benefit Service Area (CBSA)

- Prevent the onset of type 2 diabetes through a 12-month lifestyle change program
- Increase awareness and the intention to quit among smokers
- Detect breast, cervical, and colon cancer through screening for those that may not be able to afford the screening services on their own

COMMUNITY BENEFIT SERVICE AREA: SOUTHERN BALTIMORE CITY AND NORTHERN ANNE ARUNDEL COUNTY

MedStar Harbor Hospital's CBSA includes all residents of the hospital's zip code, 21225. This area covers Southern Baltimore City and Northern Anne Arundel County, and includes four neighborhoods: Brooklyn, Brooklyn Park, Cherry Hill, and Pumphrey. In particular, the hospital will focus on the Cherry Hill community. This geographic area was selected based on hospital utilization data and secondary public health data as well as its high poverty rate and proximity to the hospital.

COMMUNITY HEALTH PRIORITIES

- **Health and Wellness**
  - Chronic Disease Prevention and Management
  - Behavioral Health

- **Access to Care and Services**
  - Mental Health
  - Linkage to Resources and Services
  - Transportation

- **Social Determinants of Health**
  - Employment
  - Food Access and Insecurity
  - Housing

> Cancer is the second leading cause of death in Maryland, and Baltimore City has the **highest cancer mortality rate among all Maryland jurisdictions.**[8]

Chronic Disease Secondary Data

DIABETES

- Diabetes is the sixth leading cause of death in Baltimore City and Maryland.[27]
- The prevalence of diabetes in Baltimore City is 13.65 percent.[11]
- The prevalence of diabetes among African Americans (18.58 percent) is more than twice as high as the prevalence among Whites (7.44 percent) in Baltimore City.[11]

HEART DISEASE AND STROKE

- Heart disease is the leading cause of death in Baltimore City and Maryland.[27]
- Stroke is the third leading cause of death in Baltimore City and Maryland.[27]
- 145 out of 100,000 people in Baltimore City die prematurely due to cardiovascular disease (CVD).[2]
- In 2014, the CVD premature death rate among Black residents of Baltimore City was about 1.6 times the same rate among White residents.[2]
- Baltimore City has the highest stroke death rate per 100,000 people in Maryland at a rate of 108.4 per 100,000 individuals.[4]

OBESITY

- 34 percent of adults in Baltimore City and 29 percent of adults in Anne Arundel County report a body mass index (BMI) of 30 or higher report, compared to 26 percent for the top US performers.[11]

CANCER

- Cancer is the second leading cause of death in Maryland, and Baltimore City has the highest cancer mortality rate among all Maryland jurisdictions.[8]
- Baltimore City has a cancer death rate of 213.9 per 100,000, higher than the state cancer death rate of 157.4 per 100,000.[19, 27]

SMOKING

- 20 percent of adults in Baltimore City smoke, compared to 15.5 percent of adults nationally in 2016.[11]

Chronic Disease Strategies

- Conduct Living Well – Chronic Disease Self-Management Program
- Conduct Diabetes Prevention Program
- Conduct Smoking Cessation Program
- Conduct Cancer Screening Program

Chronic Disease Anticipated Outcomes

- Increased participation in chronic disease prevention and management programs and services
- Increased retention rates among program participants
- Improved health behaviors and health outcomes among program participants
- Increased identification of social unmet needs and linkages to social need services among chronic disease management program participants
- Improved health care utilization patterns among program participants

Chronic Disease Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Living Well Program**
  - Percentage of program completers who report improved quality of life
  - Percentage of program completers reporting increased physical activity
  - Percentage of program completers who have decreased blood pressure and weight loss
  - Percentage of people who screened positive for social needs and were linked to services at intake and post program completion
  - Percentage of completers who do not readmit to emergency department (ED) after the program ends
  - Potentially avoidable utilizations (PAU) and readmission rates among program completers
  - Percentage of program completers who successfully complete follow-up assessments

- **Diabetes Prevention Program**
  - Number of Diabetes Prevention Program (DPP) programs conducted annually
  - Retention rates among DPP participants
  - Number of participants who meet weight loss goal of five percent
  - Number of participants who meet physical activity goal of 150 minutes per week

- **Smoking Cessation: Cancer Prevention**
  - Percentage of completers who report quitting after program participation
  - Quit rate of program completers

- **Cancer Screening Programs**
  - Number of breast and cervical cancer screenings annually
  - Number of colon cancer screenings annually
  - Number of patients referred to treatment from screenings annually
  - Number of cancer support groups offered at hospital annually

PUBLIC HEALTH METRICS
- Age-adjusted death rates for heart disease, stroke, cancer, and diabetes
- Prevalence rates of obesity among adults
- Emergency department visits and hospitalization rates due to hypertension, heart disease, stroke, cancer, obesity, and diabetes
- Prevalence rates of diabetes among adults
- Percentage of adults who smoke
- Percentage of adolescents using tobacco products

KEY PARTNERS: CHRONIC DISEASE

Baltimore City Breast and Cervical Cancer Screening Program

Baltimore City Department of Aging

Baltimore City Department of Health and Human Services

Baltimore City Health Department

Centers for Disease Control and Prevention (CDC)

Maintaining Active Citizens, Inc.

Maryland Department of Aging

Maryland Department of Health

Behavioral Health Objectives: Substance Use Disorders

- Deliver evidence-based behavioral health programs and services targeting the identification of substance abuse and linkage to treatment services among high-risk individuals in MedStar Harbor Hospital's CBSA
- Empower community members and stakeholders to save lives in response to an opioid overdose
- Identify people with at-risk and dependent substance abuse behaviors and provide community navigation and support services
- Provide educational programs to ensure individuals and families experiencing, or impacted by, mental illness get the support and information needed

Behavioral Health Secondary Data

SUBSTANCE ABUSE
- The total number of drug- and alcohol-related intoxication deaths in Maryland increased from 1,259 in 2015 to 2,089 in 2016.[10]

ALCOHOL ABUSE
- Percentage of driving deaths with alcohol involvement: 20 percent in Baltimore City and 36 percent in Anne Arundel County.[11]
- Percentage of adults reporting binge drinking: 18 percent in Baltimore City and 20 percent in Anne Arundel County.[11]

OPIOID ABUSE
- The number of prescription opioid-related intoxication deaths in Maryland increased from 61 in 2010 to 113 in 2016.[10]

Behavioral Health Strategies

- Provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) program and peer recovery coaches
- Offer Naloxone training to community
- Develop and implement Opioid Survivor Outreach Program (OSOP) to provide support and resources to opioid survivors that visit hospital-based emergency departments

- Provide National Alliance on Mental Illness (NAMI) Basics Class–geared to parents and family caregivers of children and adolescents who have been diagnosed with a mental health condition
- Provide Peer to Peer Class–peer recovery education course open to anyone experiencing a mental health challenge
- Host an annual Mental Health Forum

Behavioral Health Anticipated Outcomes
- Improved identification of high-risk substance use behaviors and access to substance abuse treatment, education, and social need services.

Behavioral Health Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **SBIRT Program**
  - Number of ED SBIRT screens annually
  - Number of positive SBIRT screens annually
  - Number of brief interventions completed annually
  - Number of referrals to treatment provided annually
  - Number of patients linked to treatment annually
  - ED readmission and PAU rates of patients who receive brief interventions and/or linkage to treatment
  - Number of substance abuse and addiction support groups promoted and held in MedStar Harbor Hospital's CBSA annually

- **Naloxone Training and OSOP**
  - Number of naloxone administration trainings offered at the hospital or community partner locations annually
  - Number of community members trained to administer naloxone annually
  - Number of referrals to treatment annually
  - Number of suspected overdoses annually
  - Number of referrals to OSOP peer recovery coaches annually
  - Number of patients successfully contacted by OSOP recovery coach annually
  - Number of OSOP patient referred to treatment monthly
  - Number of OSOP patients linked to recovery support groups annually

  - Number of naloxone kits provided to OSOP patients annually
  - Number of naloxone prescriptions provided to OSOP patients annually
  - Number of known OSOP deaths annually

- **NAMI Educational Program**
  - Number of education programs and events held on campus or in the CBSA annually
  - Number of attendees or participants per educational program

PUBLIC HEALTH METRICS
- Percentage of individuals reporting a substance abuse disorder
- Percentage of adults reporting excessive drinking
- Percentage of adults and adolescents who report alcohol use and binge drinking
- Percentage of hospitalizations due to a substance abuse or alcohol abuse disorder
- Number of driving deaths involving alcohol
- Number of hospitalizations due to opioid overdose
- Age-adjusted death rate due to opioid overdose
- Age-adjusted drug and alcohol related death rate
- Drug- and alcohol-related ED visits

KEY PARTNERS: BEHAVIORAL HEALTH

Community mental health and substance use treatment service organizations

Mosaic Group

National Alliance on Mental Illness

Substance Abuse and Mental Health Services Administration (SAMSHA)

Access to Care and Services

Access to Care and Services Objectives
- Increase access to mental health services as part of the primary care model
- Improve appropriate healthcare utilization practices and health outcomes of high-need, high-risk patients by identifying social unmet needs and linkage to community social needs resources at point of care using the Aunt Bertha tool

Access to Care and Services Secondary Data

- One out of five (110,468) Baltimoreans will experience a mental illness each year.[3]
- One out of 20 (24,093) Baltimore City adults have a serious mental illness such as major depressive disorder, bipolar disorder, or schizophrenia.[3]
- One out of 25 (19,275) Baltimore City adults need both mental health and substance abuse treatment.[3]
- 14 percent of Americans with serious mental illness lack health insurance coverage.[31]
- In Baltimore City, 31 percent of children under the age of 18 live in poverty.[11]

Access to Care and Services Strategies

- Provide mental health services as part of a primary care model
- Conduct social needs screening and support linkages to social need services as part of care delivery and chronic disease self-management programming

Access to Care and Services Anticipated Outcomes

- Increased access to mental health services in primary care settings
- Increased use of uniform social needs screener in MedStar Harbor Hospital's care delivery sites and as part of the Living Well Program
- Improved identification of patients' unmet social needs and service linkage at point of service
- Improved healthcare utilization among individuals like to social need services, transportation services, or mental health services

Access to Care and Services Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Mental Health Services**
  - Number of people who receive mental health treatment services in program primary care setting annually
  - Number of people screened for selected mental health conditions (substance use, depression, and anxiety) annually
  - Number of people with positive mental health screening annually
  - Number of people who screen positively for mental health conditions that are referred or linked to services annually
  - ED readmission and PAU rates of people with positive mental health screening that were referred or linked to services

- **Social Needs Services**
  - Number of social needs screenings conducted annually
  - Number of positive social needs screen annually
  - Number of people referred to services annually
  - Number of people linked to services annually
  - ED readmission and PAU rates of people with positive social needs screening that are referred or linked to services

PUBLIC HEALTH METRICS

- Percentage of people reporting unmet healthcare needs in the past 12 months
- Percentage of people reporting they could not afford to see a doctor in the past 12 months
- Percentage of people diagnosed with mental illness that are uninsured
- Percentage of adults unemployed
- Percentage of households living in poverty
- Percentage of households experiencing food insecurity

KEY PARTNERS: ACCESS TO CARE

Aunt Bertha, Inc.

Family Health Centers of Baltimore

Collaboration Areas

Collaboration areas were identified as social determinant areas in which the hospital will serve as a partner with outside organizations.

TRANSPORTATION

Transportation Objectives
- Address the barrier of transportation to medical and health services and programs among individuals who identify transportation as a social unmet need

Transportation Secondary Data
- In 2014, about 29 percent of households in Baltimore City did not own a car and many of these households relied on public transportation for commuting.[14]
- 29 percent of MedStar Harbor Hospital CHNA survey respondents identified lack of transportation as a barrier to accessing care.

Transportation Strategies
- Implement MedStar Health UBER program

Transportation Anticipated Outcomes
- Increased number of available rides to and from medical and health services and community health programs
- Decreased no-show rates among participants

Transportation Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **MedStar Health UBER Program**
  - Number of rides supported annually
  - Number of people who receive rides annually
  - ED readmission and PAU rates of people who receive rides
  - No show rates among program participants
  - Percentage of people who identify transportation as a barrier

PUBLIC HEALTH METRICS

- Percentage of the population with access to public transportation
- Percentage of population who have delayed getting medical care due to lack of transportation

KEY PARTNERS: TRANSPORTATION

Aunt Bertha, Inc.

Uber Technologies, Inc.

EMPLOYMENT

Employment Objectives
- Hire individuals from underserved communities as community health advocates (CHAs) and peer recovery coaches (PRCs) to contribute to MedStar Health's population health management efforts in the Baltimore region through the Baltimore Population Health Workforce Support for Disadvantaged Areas Program (PHWSDA).
- Prepare local underserved students for health care-related collegiate studies and careers through an established pipeline internship program.

Employment Secondary Data
- The unemployment rate in Baltimore city is 13.1 percent.[11]

- 19 percent of Baltimore City youth between the ages of 16-24 are classified as "disconnected youth" (neither working nor in school).[11]
- 28.8 percent of families live in poverty in Baltimore City.[11]

Employment Strategies
- Conduct PHWSDA program
- Conduct the Rx for Success Pipeline Summer Internship Program for underserved high school students

Employment Anticipated Outcomes
- Increased number of CHAs and PRCs hired and trained by 2019
- Increased number of underserved, racial and ethnic minority interns in the Rx for Success summer internship at MedStar Harbor Hospital annually
- Improved satisfaction rates among student interns, intern supervisors and school partner leadership annually
- Improved pipeline processes to increase employment opportunities post-internship for eligible students

Employment Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **PHWSDA "Jobs" Program**
  - Number of individuals trained from MedStar Harbor Hospital CBSA
  - Number of individuals hired from MedStar Harbor Hospital CBSA
  - Retention rates of hired associates
  - Number of patients or clients assisted by these positions
  - Average caseload for positions
  - Average length of patient engagement by positions
  - Number patients screened for social needs and number of those referred or linked to services
  - Readmission rates among patients assigned to CHAs or PRCs
  - ED utilization among patients assigned to CHAs or PRCs

- **Rx for Success Pipeline Summer Internship Program**
  - Number of students who apply to the internship annually
  - Number of students selected and placed in the internship annually

- Number of student interns from MedStar Harbor Hospital's CBSA annually
- Graduation rates of interns
- Number of seniors who complete the internship and pursue a health-related college major
- Number of seniors who complete the internship and are employed in a health-related position within MedStar Health
- Student, supervisor, and community partner satisfaction rate
- Type of intern placements within MedStar Harbor Hospital

PUBLIC HEALTH METRICS
- Percentage of individuals unemployed yet seeking employment
- Unemployment rate
- High school graduation and completion rate
- Percentage of new hires to health care fields

KEY PARTNERS: EMPLOYMENT

Baltimore Alliance for Careers in HealthCare

Baltimore Population Health Workforce Collaborative (BPHWC) "Jobs" Program

Baltimore Youth Works

Start on Success–Humanim

Vivien T. Thomas Medical Arts Academy

FOOD ACCESS

Food Access Objectives
- Address food insecurity among individuals who identify food insecurity as a social unmet need in MedStar Harbor Hospital's CBSA

Food Access Secondary Data
- 24 percent of MedStar Harbor Hospital CHNA respondents identified access to affordable, healthy food as a community need.

Food Access Strategies
- Provide access to affordable healthy foods through the Baltimarket community-based food access program with the Baltimore City Health Department

Food Access Anticipated Outcomes
- Improved access to healthy and affordable foods in MedStar Harbor Health's CBSA

Food Access Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- Number of people who participate in education and cooking demonstrations annually
- Number of nutritional education and cooking demonstrations provided to the community on-site at corner stores in MedStar Harbor Health's CBSA annually

PUBLIC HEALTH METRICS

- Percentage of households experiencing food insecurity

KEY PARTNERS: FOOD ACCESS

American Heart Association

Baltimore City—Baltimarket

Baltimore South Gateway Partnership

Cherry Hill Town Center—Community Action Partnership

Maryland Food Bank

United Way of Central Maryland

Participation Areas

Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.

Participation

- Housing

KEY PARTNERS: PARTICIPATION

Baltimore City government agencies

Greater Baybrook Alliance

Habitat for Humanity/Baltimore South Gateway Partnership

Healthcare for the Homeless

Public housing associations in East Baltimore

MedStar Montgomery Medical Center

Legend:
- Community Benefit Service Area
- Primary Service Area

Community Health Needs Assessment

Health and Wellness

CHRONIC DISEASE

Chronic Disease Objectives
- Deliver evidence-based, outcome-focused chronic disease management and prevention programs and services in, or targeting individuals living in, MedStar Montgomery Medical Center's CBSA

Chronic Disease Secondary Data

DIABETES
- Among adults in Montgomery County, 7.4 percent have been diagnosed with diabetes.[7]

COMMUNITY BENEFIT SERVICE AREA (CBSA): ASPEN HILL/BEL PRE
MedStar Montgomery Medical Center's CBSA includes residents in the Aspen Hill/Bel Pre neighborhoods of Montgomery County, Maryland (zip codes 20906 and 20853). This geographic area was selected based on hospital utilization and secondary public health data as well as its close proximity to the hospital, coupled with a high density of low-income residents.

COMMUNITY HEALTH PRIORITIES
- **Health and Wellness**
  - Chronic Disease Prevention and Management
  - Behavioral Health

- **Access to Care and Services**
  - Emergency and Primary Care
  - Mental Health Services
  - Transportation
  - Medication Adherence

- **Social Determinants of Health**
  - Employment
  - Housing

- In Montgomery County, there are 11.6 hospitalizations per 10,000 people aged 18+ years due to diabetes.[7]
- There also are 11.6 deaths per 100,000 people in the county due to diabetes.[7]

HEART DISEASE
- In Montgomery County, there are 107.5 deaths per 100,000 people due to heart disease.[7]

OBESITY
- Nearly 53 percent of Montgomery County adults have been told they are overweight,[11] and more than one in five adults report a body mass index (BMI) of 30 or above.[7]

CANCER
- Montgomery County's age-adjusted mortality rate due to cancer is 118.7 deaths per 100,000 people.[7]

Chronic Disease Strategies
- Conduct Living Well – Chronic Disease Self-Management Program
- Deliver Senior Strength and Balance Program

Chronic Disease Anticipated Outcomes
- Increased participation in chronic disease prevention and management programs and services
- Increased retention rates among program participants
- Improved health behaviors and health outcomes among program participants
- Increased identification of social unmet needs and linkages to social need services among chronic disease management program participants
- Improved health care utilization patterns among program participants

Chronic Disease Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Living Well Program**
  – Percentage of program completers who report improved quality of life
  – Percentage of program completers reporting increased physical activity

  – Percentage of program completers who have decreased blood pressure and weight loss
  – Percentage of people who screened positive for social needs and were linked to services at intake and post program completion
  – Percentage of completers who do not readmit to emergency department (ED) after the program ends
  – Potentially avoidable utilizations (PAU) and readmission rates among program completers
  – Percentage of program completers who successfully complete follow-up assessments

- **Senior Strength and Balance Program**
  – Number of participants screened annually
  – Number of participants registered annually
  – Number of participants who report improvements in blood pressure reading after the program ends
  – Number of participants who report improvements in cholesterol reading after the program ends
  – Number of participants who report improvements in glucose HbA1c reading after the program ends
  – Number of participants who report weight loss improvements after the program ends
  – Percentage of participants who report zero ED visits during the past 12 months
  – Percentage of participants who report being admitted to a hospital overnight or longer

PUBLIC HEALTH METRICS
- Age-adjusted death rate from heart disease, diabetes, and cancer
- Percentage of adults at a healthy weight (BMI < 25 kg/m2)
- Prevalence rates of diabetes, heart disease, and cancer among adults
- Emergency department admission rates for diabetes, heart disease, cancer, and hypertension in Montgomery County

KEY PARTNERS: CHRONIC DISEASE

Longwood Community Center

Maintaining Active Citizens, Inc.

Maryland Department of Aging

Mid-County Community Center

Montgomery County Department of Aging and Human Services

Montgomery County Recreation

> In 2016, **102 drug- or alcohol-related intoxication deaths occurred** in Montgomery County.[16]

Behavioral Health Objectives: Substance Use Disorder

- To deliver evidence-based behavioral health programs and services targeting the identification of substance abuse and linkage to treatment services among high-risk individuals in MedStar Montgomery Medical Center's CBSA

Behavioral Health Secondary Data

SUBSTANCE ABUSE

- Among youth (12 and up) and adults in Montgomery county, 70,363 (8.2 percent) have substance abuse disorders; 70 percent are age 26 or older.[15]

ALCOHOL ABUSE

- In Montgomery County, 15 percent of adults report excessive drinking.[11]
- In Montgomery County, 33 percent of driving deaths involve alcohol.[11]
- Some 7.4 hospitalizations per 10,000 adults in Montgomery County are due to alcohol abuse.[15]

OPIOID ABUSE

- In 2016, 102 drug- or alcohol-related intoxication deaths occurred in Montgomery County, of which 26 were related to prescription opioids (including prescribed fentanyl), 48 were related to heroin, and 43 were related to either prescribed or illicit fentanyl.[16]
- The number of heroin-related ED visits in Montgomery County tripled between 2009 and 2014. However, Montgomery County still has the second lowest rate of ED visits related to heroin in the state.[16]

Behavioral Health Strategies

- Conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program

Behavioral Health Anticipated Outcomes

- Improved identification of high-risk substance use behaviors and access to substance abuse treatment, education, and social need services

Behavioral Health Metrics

PROGRAM-SPECIFIC METRICS

- Number of SBIRT screens annually
- Number of positive SBIRT screens annually
- Number of brief interventions completed annually
- Number of referrals to treatment provided annually
- Number of patients linked to treatment annually
- ED readmission and PAU rates of patients who receive brief interventions and/or linkage to treatment
- Number of substance abuse and addiction support groups promoted and held in MedStar Montgomery Medical Center's CBSA annually

PUBLIC HEALTH METRICS

- Percentage of individuals reporting a substance abuse disorder
- Percentage of adults reporting excessive drinking
- Percentage of adults and adolescents who report alcohol use and binge drinking
- Percentage of hospitalizations due to a substance abuse or alcohol abuse disorder
- Number of driving deaths involving alcohol
- Number of hospitalizations due to opioid overdose
- Age-adjusted death rate due to opioid overdose
- Age-adjusted drug- and alcohol-related death rate
- Drug and alcohol related ED visits

> **KEY PARTNERS: BEHAVIORAL HEALTH**
>
> Maryland Department of Health and Mental Hygiene - Behavioral Health Administration
>
> Substance Abuse and Mental Health Services Administration (SAMSHA)

Access to Care and Services

Access to Care and Services Objectives

- Increase access to medical and social need services and hospital community-based health programs for individuals in MedStar Montgomery Medical Center's CBSA
- Improve access to mental health services and reduce ED utilization among behavioral health patients
- Connect uninsured and underserved self-pay patients to primary and specialty care services
- Identify and connect high-need, high-risk individuals with social unmet needs to community resources

- Improve healthcare utilization practices and health outcomes of high-need, high-risk patients by identifying social unmet needs and linkage to social needs resources at point of care using the Aunt Bertha tool

Access to Care and Services Secondary Data
- In Montgomery County, 87.4 percent of adults have had a routine check-up in the last two years.[7]
- Over eight percent of Montgomery County residents cannot afford to see a doctor.[7]
- The number of people in Montgomery County who don't have insurance has dropped from 22 percent in 2010 to 12.5 percent in 2014 and 10 percent in 2017.[11]
- While the Affordable Care Act (ACA) has made insurance and health care more affordable, Montgomery County residents are having trouble signing up for health insurance plans, understanding their coverage, and using services.[7]
- More than three-quarters of Montgomery County adults (77.4 percent) said they experienced two or fewer days of poor mental health in the past month.[7]

Access to Care and Services Strategies
- Provide Mindoula Behavioral Health Program
- Implement Emergency Department-Primary Care Connect Program
- Conduct social needs screenings and support linkages to social need services as part of care delivery and chronic disease self-management programming

Access to Care and Services Anticipated Outcomes
- Increased access to mental health treatment services and education services for hospital primary care patients
- Improved health care utilization among individuals linked to transportation, mental health and social need services
- Improved identification of patients' social unmet needs and service linkage at point of care
- Increased access to community social needs resources

Access to Care and Services Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevant to external public health goals.

- **Mental Health Services**
  - Number of patients enrolled in program annually
  - Number of referrals to treatment provided annually
  - Number of patients linked to treatment annually
  - ED readmission and PAU rates of people who receive case management and/or clinical mental health services

- **Primary and Specialty Care Services**
  - Number of patients served annually
  - Number of uninsured patients identified annually
  - Number of referrals made to safety net clinics annually
  - Number of patients who schedule a primary care follow-up visit annually
  - Number of patients referred who are CBSA residents annually

- **Social Needs Services**
  - Number of social needs screenings conducted annually
  - Number of positive social needs screen annually
  - Number of people referred to services annually
  - Number of people linked to services annually
  - ED Readmission and PAU rates of people with positive social needs screening that were referred or linked to services

PUBLIC HEALTH METRICS
- Ratio of primary care providers to the general population
- Ratio of mental health care providers to the general population
- Percentage of uninsured adults

KEY PARTNERS: ACCESS TO CARE AND SERVICES
Aunt Bertha, Inc.

Community-based social services organizations

Holy Cross Aspen Hill Community Clinic

Mindoula Behavioral Health

Montgomery County Safety-Net Clinics

Proyecto Salud Community Clinic

Collaboration Areas

Collaboration areas were identified as social determinant areas in which the hospital will serve as a partner with outside organizations.

TRANSPORTATION

Transportation Objectives
- Address the barrier of transportation to medical and health services and programs among individuals who identify transportation as a social unmet need

Transportation Secondary Data
- An estimated 3.6 million Americans lack a car or access to public transportation or can't afford taxis or Ubers. Missed appointments and resulting delays in care cost the health system an extra $150 billion a year.[7]
- 28 percent of MedStar Montgomery Medical Center CHNA survey respondents identified lack of transportation as a barrier to accessing care.

Transportation Strategies
- Implement Olney Home for Life and Manor Connections Transportation programs

Transportation Anticipated Outcomes
- Increased number of available rides to and from medical and health services and community health programs
- Decreased no-show rates among participants

Transportation Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Olney Home for Life and Manor Connections Transportation Program**
  - Number of rides supported annually
  - Number of people who receive rides annually
  - ED readmission and PAU rates of people who receive rides
  - No show rates among program participants
  - Percentage of people who identify transportation as a barrier

PUBLIC HEALTH METRICS
- Percentage of the population with access to public transportation

- Percentage of population who have delayed getting medical care due to lack of transportation

> **KEY PARTNERS: TRANSPORTATION**
> Aunt Bertha, Inc.
> Manor Connections
> Olney Home for Life

EMPLOYMENT

Employment Objectives
- Prepare local underserved students for health care-related collegiate studies and careers through an established pipeline internship program

Employment Secondary Data
- 11.0 percent of Montgomery County residents live in poverty.[7]
- 3.3 percent of county residents are unemployed.[11]
- 89.0 percent of county residents graduate high school.[11]
- 77.0 percent of county residents have had some college.[11]

Employment Strategies
- Conduct the Rx for Success Pipeline Summer Internship Program for underserved high school students

Employment Anticipated Outcomes
- Increased number of underserved, racial and ethnic minority interns in the Rx for Success summer internship at MedStar Montgomery Medical Center annually
- Improved satisfaction rates among student interns, intern supervisors, and school partner leadership annually
- Improved pipeline processes to increase employment opportunities post-internship for eligible students

Employment Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine:
1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Rx for Success Pipeline Summer Internship Program**
    - Number of students who apply to the internship annually
    - Number of students selected and placed in the internship annually
    - Number of student interns from MedStar Montgomery Medical Center's CBSA annually
    - Graduation rates of interns

- Number of seniors who complete the internship and pursue a health-related college major
- Number of seniors who complete the internship and are employed in a health-related position within MedStar Health
- Student, supervisor, and community partner satisfaction rate
- Type of intern placements within MedStar Montgomery Medical Center

PUBLIC HEALTH METRICS
- Unemployment rate
- High school graduation and completion rate
- Percentage of new hires to health care fields

> **KEY PARTNERS: EMPLOYMENT**
> John F. Kennedy High School

MEDICATION ADHERENCE

Medication Adherence Objectives
- Improve medication adherence, ensure proper medication administration, and decrease drug interactions among MedStar Montgomery Medical Center patients

Medication Adherence Secondary Data
- 29.0 percent of MedStar Montgomery Medical Center CHNA respondents identified lack of taking prescribed medication as a community need and identified the need for more medication adherence services and resources.

Medication Adherence Strategies
- Provide bedside delivery of medications to patients at MedStar Montgomery Medical Center prior to discharge
- Provide discounted medications to discharged patients who cannot afford the cost, in partnership with Giant Pharmacy

Medication Adherence Anticipated Outcomes
- Increased medication adherence rates among patients discharged from MedStar Montgomery Medical Center

Medication Adherence Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- Number of patients who receive bedside medication delivery and education prior to hospital discharge
- Number of patients who receive discounted medications through MedStar Montgomery Medical Center's partnership with Giant Pharmacy

PUBLIC HEALTH METRICS
- Medication adherence rate

> **KEY PARTNERS: MEDICATION ADHERENCE**
> Giant Pharmacy
> Family and Nursing Care

Participation Areas

Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.
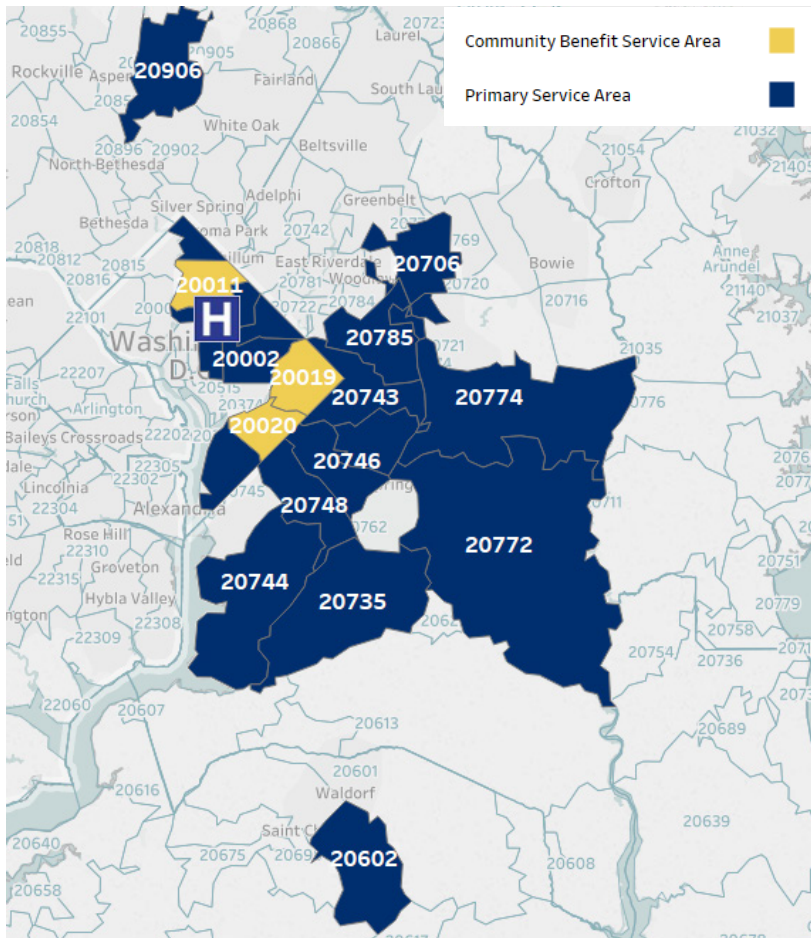
Participation
- Housing

> **KEY PARTNERS: PARTICIPATION**
> Department of Health and Human Services
> Housing Opportunities Commission

MedStar National Rehabilitation Hospital

Legend:
- Community Benefit Service Area
- Primary Service Area

Community Health Needs Assessment

Health and Wellness

CHRONIC DISEASE

Chronic Disease Objectives

- To deliver evidence-based, outcome-focused chronic disease management and prevention community-based programs and services targeting at-risk, high need individuals living in MedStar National Rehabilitation Hospital's Community Benefit Service Area (CBSA)

COMMUNITY BENEFIT SERVICE AREA (CBSA): 20011, 20019, 20020 (WITH EMPHASIS ON WARDS 5, 7, AND 8)

MedStar National Rehabilitation Hospital's CBSA includes residents living with disabilities in Washington, DC zip codes 20011, 20019, and 20020. This geographic area was selected based on hospital utilization and secondary public health data as well as the hospital's strengths and primary service area.

COMMUNITY HEALTH PRIORITIES

- **Health and Wellness**
  - Chronic Disease Prevention and Management

- **Access to Care and Services**
  - Linkage to Resources and Services
  - Transportation
- **Social Determinants of Health**
  - Food Access and Insecurity
  - Employment
  - Housing

Chronic Disease Secondary Data

DIABETES

- Diabetes was the sixth leading cause of death in Washington, DC, with 127 deaths in 2016 (and a mortality rate of 19.8).[32]
- In 2014, one in eleven (or 9.1 percent) DC residents had diabetes. In 2013, diabetes was the ninth leading cause of hospitalization in DC, with 1,572 visits.[6]
- In DC, emergency department (ED) visits related to diabetes were over six times higher African Americans than for Whites.[6]
- An analysis of ED records found that up to 30 percent of visits for diabetes, asthma, and other chronic conditions were potentially preventable with better access to effective primary and preventive care.[6]

HEART DISEASE AND STROKE

- Heart disease is the leading cause of death among DC residents, with 1,375 deaths in 2016 (and a mortality rate of 211.7).[32]
- Heart disease in DC can be attributed to preventable factors like obesity, poor physical activity, heavy drinking, eating unhealthy foods, and not keeping blood pressure and cholesterol under control.
- The hospitalization rate for heart disease in DC was 41.9 per 1,000 Medicare beneficiaries.[5]
- In DC, 29.4 percent of adults have been told they have high blood pressure. Of those, 74.4 percent were taking blood pressure control medication.[5]
- Stroke is the fourth leading cause of death in DC, with 252 deaths in 2016 (and mortality rate of 38.4).[32]

OBESITY

- In DC, obesity rates for adults with disabilities are significantly higher than adults without disabilities.[43]
- In DC, 26.2 percent of adults are obese, up from 20.1 percent in 2000 and 14.4 percent in 1990.
- DC has the second lowest adult obesity rate in the nation.[36]
- More than one-third (33.8 percent) of 10-12 year-olds in DC are obese.[36]
- DC ranks 11th among all states for obesity rates among children ages 10-12.[36]

CANCER

- Cancer is the second leading cause of death among DC residents, with 1,044 deaths in 2016 (and a mortality rate of 160.1 per 100,000).[32]

- The crude death rate of deaths from cancer in Ward 7 is about 22.0 percent higher than the DC-wide rate, and 26.0 percent higher than the nation.[35]
- DC has the highest liver cancer rates in the country, with 15 deaths per 100,000 men, and five such deaths per 100,000 women.[35]
- Women with disabilities are less likely to receive mammogram than women without disabilities.[44]
- Cigarette smoking is significantly higher among adults with disabilities compared to adults without disabilities.[45]

DISABILITY

- Among DC residents, 11.1 percent have some type of disability.[38]
- Among the six types of disabilities identified, the highest prevalence rate was for ambulatory disability (6.8 percent). The lowest prevalence rate was for self-care disability, 2.2 percent.[38]
- In 2016, 75,100 of the 674,300 individuals of all ages in DC reported one or more disabilities.[38]
- In Ward 8, 17.0 percent of residents have a disability.[38]
- Studies show that individuals living with disabilities are more likely to report poor health, less access to healthcare, as well as smoking and physical inactivity.[46]

Chronic Disease Strategies

- Implement the Living Well Chronic Disease Self Management Program for adults living with physical disabilities

Chronic Disease Anticipated Outcomes

- Increased participation in chronic disease prevention and management programs and services
- Increased retention rates among program participants
- Improved health behaviors and health outcomes among program participants
- Increased identification of social unmet needs and linkages to social need services among chronic disease management program participants
- Improved healthcare utilization patterns among program participants

Chronic Disease Metrics

PROGRAM-SPECIFIC METRICS

- **Living Well Program**
  - Percentage of program completers who report improved quality of life
  - Percentage of program completers reporting increased physical activity

- Percentage of program completers who have decreased blood pressure and weight loss
- Percentage of people who screened positive for social needs and were linked to services (Aunt Bertha) at intake and post program completion
- Percentage of completers who do not readmit to emergency department (ED) after the program ends
- Potentially avoidable utilizations (PAU) and readmission rates among program completers
- Percentage of program completers who successfully complete follow-up assessments

PUBLIC HEALTH METRICS

- Age-adjusted death rate from diabetes, heart disease, and cancer
- Emergency department visit rate due to hypertension, heart disease, stroke, diabetes, and cancer
- Prevalence of diabetes in DC
- Incidence and prevalence of heart disease and stroke in DC
- Percentage of adults at a healthy weight or body mass index (BMI)
- Percentage of adults who are obese
- Percentage of adults who participate in the recommended levels of physical activity

KEY PARTNERS: CHRONIC DISEASE

DC Department of Aging and Human Services

DC Department of Family Services

DC Health

Maintaining Active Citizens, Inc.

Maryland Department of Aging

PHYSICAL ACTIVITY AND FITNESS

Physical Activity and Fitness Objectives

- Delivery quality fitness programs designed specifically for individuals with physical disabilities living in MedStar National Rehabilitation Hospital CBSA.

Physical Activity Secondary Data

- Of the adult population in DC over the age of 20, 17.0 percent reports no leisure-time physical activity.[5]
- 23.0 percent of adults report a BMI of 30 or more.[5]
- Rates of obesity were highest in Wards 8 (37.0 percent), 7 (34.0 percent), and 5 (26.0 percent).[5]
- By race and ethnicity, 34.0 percent of Black residents were obese, compared to 20.0 percent of Hispanic residents and 10.0 percent of White residents.[5]

Physical Activity Strategies

- Provide adapted fitness classes for individuals with physical disabilities in MedStar National Rehabilitation Hospital's CBSA

Physical Activity Anticipated Outcomes

- Improved access to physical fitness classes and activities for physically disabled people in the community

Physical Activity Metrics

PROGRAM-SPECIFIC METRICS

- Number of adapted fitness classes held annually
- Number of participants in adapted fitness classes annually
- Number of participants in adapted fitness classes from CBSA
- Percentage of participants who report physical progress after each class
- Percentage of participants who report weekly physical activity

PUBLIC HEALTH METRICS

- Percentage of adults living with disabilities reporting a BMI of 30 or more
- Percentage of adults living with disabilities reporting no leisure-time physical activity

> **KEY PARTNERS: PHYSICAL ACTIVITY AND FITNESS**
> DC Health
> DC Parks & Recreation
> Division of Program Integrity Fitness

Access to Care and Services

Access to Care and Services Objectives

- Improve appropriate healthcare utilization practices and health outcomes of high need, high risk patients by identifying social unmet needs and linkage to community social needs resources at point of care using the Aunt Bertha tool

Access to Care and Services Secondary Data

- Among DC residents, 11.1 percent have some type of disability.[37]
- Four percent of the population under the age of 65 is uninsured.[5]

- Health insurance coverage was lowest among Hispanic/Latino residents (78.0 percent) compared to 91.0 percent coverage among Black residents and 97.0 percent coverage among White residents.[5]
- Residents in Ward 7 and Ward 8 had the lowest coverage amongst all wards (90.0 percent and 91.0 percent, respectively).[5]
- DC-wide, 10.0 percent of adults reported that they had delayed getting medical care because they could not get an appointment soon enough. Rates were highest in Ward 1 (14.0 percent), Ward 6 (12.0 percent), and Ward 2 (11.0 percent).[5]

Access to Care and Services Strategies

- Conduct social needs screening and support linkages to social need services as part of care delivery and chronic disease self-management programming

Access to Care and Services Anticipated Outcomes

- Increased use of uniform social needs screener in MedStar National Rehabilitation Hospital care delivery sites and as part of the Living Well program
- Improved identification of patients' social unmet needs and service linkage at point of care
- Improved healthcare utilization among individuals linked to social need services and transportation services

Access to Care and Services Metrics

PROGRAM-SPECIFIC METRICS

- Number of social needs screenings conducted annually
- Number of positive social needs screen annually
- Number of people referred to services annually
- Number of people linked to services annually
- ED readmission and PAU rates of people with positive social needs screening that are referred or linked to services

PUBLIC HEALTH METRICS

- Percentage of uninsured adults
- Percentage of adults reporting avoiding medical care due to high cost
- Percentage of adults with disabilities

> **KEY PARTNERS: ACCESS TO CARE AND SERVICES**
> Aunt Bertha Inc.
> Community-based social services

Collaboration Areas

Collaboration areas were identified as social determinant areas in which the hospital will serve as a partner with outside organizations.

TRANSPORTATION

Transportation Objectives
- Address the barrier of transportation to medical and health services and programs among individuals who identify transportation as a social unmet need.

Transportation Secondary Data
- Lack of transportation is cited as having a significant impact on access to health care services and is a determinant of a person's ability to access basic resources that can affect quality of life.[5]
- In DC, many characterize public transportation as expensive and unreliable. Metro stations in DC are concentrated in the central region (Wards 2 and 6) and are lacking in other areas, especially in Wards 4, 7 and 8.[5]

Transportation Strategies
- Implement MedStar Health UBER program

Transportation Anticipated Outcomes
- Improved access to transportation for individuals identifying transportation as a social need
- Increased number of available rides to and from medical and health services and community health programs
- Decreased no-show rates among participants

Transportation Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **MSH UBER Program**
  - Number of rides supported annually
  - Number of people who receive rides annually
  - ED readmission and PAU rates of people who receive rides
  - No show rates among program participants
  - Percentage of people who identify transportation as a barrier

PUBLIC HEALTH METRICS
- Percentage of the population with access to public transportation
- Percentage of population who have delayed getting medical care due to lack of transportation

KEY PARTNERS: TRANSPORTATION

Aunt Bertha, Inc.

Uber Technologies, Inc.

EMPLOYMENT

Employment Objectives
- Prepare local underserved students for healthcare-related collegiate studies and careers through an established pipeline internship program

Employment Secondary Data
- In 2015, 14.0 percent of DC families lived in poverty. In Wards 7 and 8, 75.0 percent more families live in poverty, at 25.0 percent and 29.0 percent respectively, compared to the DC benchmark.[5]
- DC's unemployment rate has decreased since 2011, but the rate varies from ward to ward. Compared to the national rate, unemployment was two times higher in Ward 7 and three times higher in Ward 8 in 2016.[5]
- Compared to the national average, as of June 2016, unemployment is two times higher in Ward 7 and three times higher in Ward 8.[5]
- DC's income inequality ratio is 7.0 percent (ratio of household income at the 80th percentile to income at the 20th percentile).[5]
- Income and employment status are closely linked to morbidity, mortality, and overall well-being; lower than average life expectancy is highly correlated with low-income status.[5]

Employment Strategies

- Conduct the Rx for Success Pipeline Summer Internship Program for underserved high school students

Employment Anticipated Outcomes

- Increased number of underserved, racial and ethnic minority interns in the Rx for Success summer internship at MedStar National Rehabilitation Hospital annually
- Improved satisfaction rates among student interns, intern supervisors and school partner leadership annually
- Improved pipeline processes to increase employment opportunities post-internship for eligible students

Employment Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Rx for Success Pipeline Summer Internship Program**
  - Number of students who apply to the internship annually
  - Number of students selected and placed in the internship annually
  - Number of student interns from MedStar National Rehabilitation Hospital's CBSA annually
  - Graduation rates of interns
  - Number of seniors who complete the internship and pursue a health-related college major
  - Number of seniors who complete the internship and are employed in a health-related position within MedStar Health
  - Student, supervisor and community partner satisfaction rate
  - Type of intern placements within MedStar National Rehabilitation Hospital

PUBLIC HEALTH METRICS

- Unemployment rate
- Percentage of adults who are unemployed and seeking work (unemployment rate)
- High school graduation and completion rate
- Percentage of new hires to health care fields

> **KEY PARTNERS: EMPLOYMENT**
> Eastern High School
> Companies for Causes

FOOD ACCESS

Food Access Objectives

- Improve access to healthy food among individuals with physical disabilities who identify food insecurity as a social need

Food Access Secondary Data

- 30.0 percent of MedStar National Rehabilitation Hospital CHNA respondents identified healthy food options as a community need.
- Residents in Wards 7 and 8 have reported they struggled to afford the cost of healthy produce.[5]
- Among DC residents, 13.0 percent report food insecurity, or insufficient access to healthy food, compared to 10.0 percent nationally.[5]

Food Access Strategies

- Conduct Food and Friends Meal Referral Program

Food Access Anticipated Outcomes

- Increased number of people with positive social needs screened for food insecurity that are referred or linked to food-related services
- Increased number of annual MedStar National Rehabilitation Hospital-supported meals

Food Access Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Food and Friends Meal Referral Program**
  - Number of referrals to Food & Friends annually
  - Number of people linked to food services annually
  - Number of meals supported annually
  - ED readmission and PAU rates of people linked to food services

PUBLIC HEALTH METRICS

- Percentage of food insecure households
- Percentage of population lacking access to healthy food

KEY PARTNERS: FOOD ACCESS

Food & Friends

Capital Area Food Bank

Participation Areas

Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.

Participation

- Housing

KEY PARTNERS: PARTICIPATION

Central Union Mission

Coalition for the Homeless

DC Department of Human Services–Family Services Administration

District of Columbia Primary Care Association (DCPCA)– DC Positive Accountable Community Transformation (DC PACT)

Housing and Urban Development Pathways to Housing

MedStar St. Mary's Hospital

Community Benefit Service Area ▢ (yellow)

Primary Service Area ▢ (dark blue)
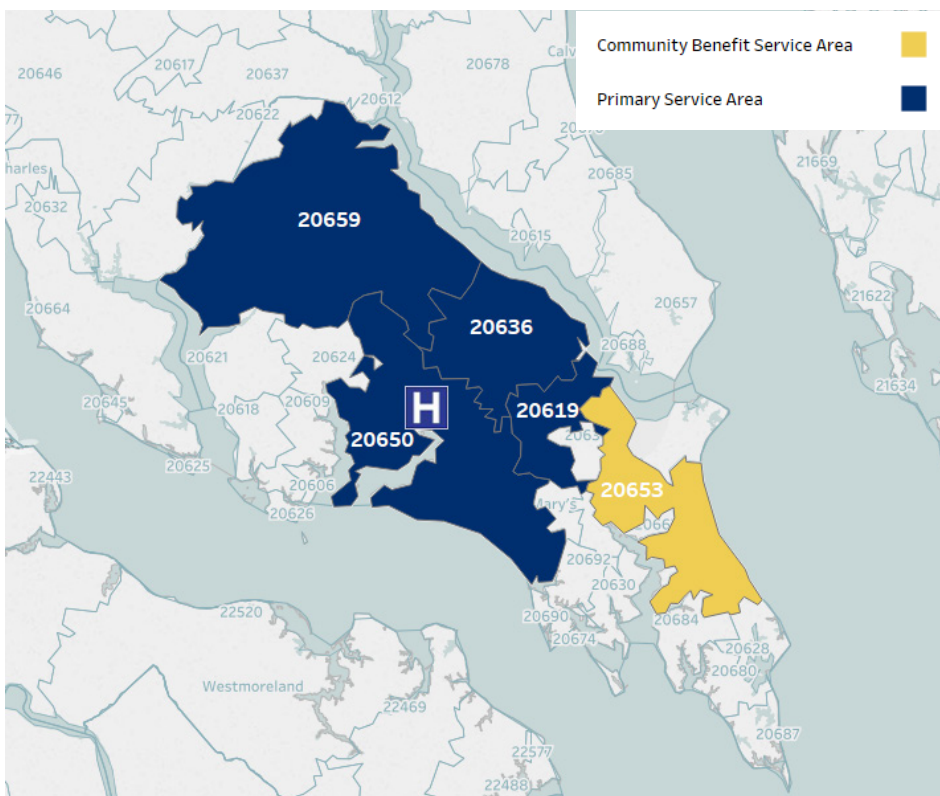
Community Health Needs Assessment

Health and Wellness

CHRONIC DISEASE

Chronic Disease Objectives
- Deliver evidence-based, outcome-focused chronic disease management and prevention programs and services in, or targeting individuals living in, MedStar St. Mary's Hospital's Community Benefit Service Area (CBSA)
- Prevent the onset of type 2 diabetes through a 12-month lifestyle change program
- Provide Health Connections classes and programs at the East Run Center

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COMMUNITY BENEFIT SERVICE AREA (CBSA): LEXINGTON PARK

MedStar St. Mary's Hospital's CBSA includes residents of St. Mary's County, Maryland, with a focus on the Lexington Park community (zip code 20653). The Lexington Park community was selected based on hospital utilization and secondary public health data as well as the fact that it has the greatest number of medically underserved citizens in the area, with approximately 9.1 percent of the population living below the federal poverty level.

COMMUNITY HEALTH PRIORITIES
- **Health and Wellness**
  - Chronic Disease Prevention and Management
  - Behavioral Health

- **Access to Care and Services**
  - Mental Health Services
  - Dental, Primary Care, and Behavioral Health Services
  - Transportation

- **Social Determinants of Health**
  - Employment
  - Housing

Chronic Disease Secondary Data

DIABETES
- Diabetes is the sixth leading cause of death in St. Mary's County.[12]
- The percentage of adults ever diagnosed with diabetes in St. Mary's County increased from 7.2 percent in 2004 to 10.4 percent in 2013.[12]

HEART DISEASE AND STROKE
- Heart disease is the leading cause of death in St. Mary's County and in Maryland.[12]
- Stroke is the third leading cause of death in Maryland.[27]

OBESITY
- In St. Mary's County, 32.0 percent of adults report a body mass index (BMI) over 30.0 vs. 29.0 percent of adults in Maryland overall.[11]
- 24.0 percent of St. Mary's adults get little or no exercise, partly because they have less access to exercise opportunities than others in Maryland (62.0 percent compared to 93.0 percent).[11]

CANCER
- Cancer is the second leading cause of death in St. Mary's County.[12]
- In St. Mary's County, the 2014 cancer mortality rate was 184.4 per 100,000 people, compared to Maryland's 162 per 100,000 people.[12]

SMOKING
- Cigarette smoking is the leading cause of preventable disease and death in the United States.
- In 2016, more than 16 million Americans lived with a smoking-related disease.
- In St. Mary's County, 15.0 percent of adults report smoking, which is on par with the national average of 15.5 percent.[11]

Chronic Disease Strategies
- Conduct the Living Well Chronic Disease Self-Management Program
- Deliver the Diabetes Prevention Program (DPP)
- Deliver Health Connections classes and programs, including Parents to Be, support groups, and diabetes and nutrition programs

Chronic Disease Anticipated Outcomes
- Increased participation in chronic disease prevention and management programs and services
- Increased retention rates among program participants
- Improved health behaviors and health outcomes among program participants
- Increased identification of social unmet needs and linkages to social need services among chronic disease management program participants
- Improved health care utilization patterns among program participants

Chronic Disease Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Living Well Program**
  - Percentage of program completers who report improved quality of life
  - Percentage of program completers reporting increased physical activity
  - Percentage of program completers who have decreased blood pressure and weight loss
  - Percentage of people who screened positive for social needs and were linked to services at intake and post program completion
  - Percentage of completers who do not readmit to the emergency department (ED)
  - Potentially avoidable utilizations (PAU) and readmission rates among program completers
  - Percentage of program completers who successfully complete follow-up assessments

- **Diabetes Prevention Program**
  - Number of DPP programs conducted annually
  - Retention rates among DPP participants
  - Number of participants who achieve an average weight loss goal of five percent
  - Number of participants who meet physical activity goal of 150 minutes per week

- **Health Connections Programs**
  - Number of participants registered in each program annually
  - Number of no shows annually
  - Number of participants citing barriers to attending programs annually
  - Number of participants demonstrating pre and post program improvement on basic knowledge questionnaire for diabetes and nutrition programs

- Number of new participants in support groups annually
- Number of returning participants in support groups annually
- Number of Parents to Be program participants indicating improved knowledge post-delivery

PUBLIC HEALTH METRICS
- Age-adjusted death rate from diabetes, heart disease, and cancer
- Percentage of adults at a healthy weight (BMI < 25 kg/m2)
- ED visits due to diabetes, heart disease, cancer, and hypertension

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KEY PARTNERS: CHRONIC DISEASE

Centers for Disease Control and Prevention

Maintaining Active Citizens Inc.

Maryland Department of Aging

Maryland Department of Health

St. Mary's County Department of Aging and Human Services

St. Mary's County Health Department

BEHAVIORAL HEALTH

Behavioral Health Objectives: Substance Use Disorders
- To deliver evidence-based behavioral health programs and services targeting the identification of substance abuse and linkage to treatment services among high-risk individuals in MedStar St. Mary's Hospital's CBSA

Behavioral Health Secondary Data

ALCOHOL ABUSE
- 18 percent of St. Mary's residents report excessive drinking, compared to a 13 percent rate for the top US performers.[11]
- 38 percent of driving deaths in St. Mary's involved alcohol impairment.[11]

OPIOID ABUSE
- In St. Mary's County, 59 per 100,000 population died from drug overdose in 2014-2016. This is compared to 24 per 100,000 during the same time period in the rest of the state.[10]
- The drug overdose rate for top US performers was 10 per 100,000.[10]
- In 2016, there were nine heroin-related deaths in St. Mary's County.[10]

Behavioral Health Strategies
- Implement the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program

Behavioral Health Anticipated Outcomes
- Improved identification of high-risk substance use behaviors and access to substance abuse treatment education and social need services

Behavioral Health Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- SBIRT Program
  - Number of SBIRT screens annually
  - Number of positive SBIRT screens annually
  - Number of brief interventions completed annually
  - Number of referrals to treatment provided annually
  - Number of patients linked to treatment annually
  - ED readmission and PAU rates of patients who receive brief interventions and/or linkage to treatment
  - Number of substance abuse and addiction support groups promoted and held in MedStar St. Mary's Hopsital's CBSA annually

PUBLIC HEALTH METRICS
- Percentage of individuals reporting a substance abuse disorder
- Percentage of adults reporting excessive drinking
- Percentage of adults and adolescents who report alcohol use and binge drinking
- Percentage of hospitalizations due to a substance abuse or alcohol abuse disorder
- Number of driving deaths involving alcohol
- Number of hospitalizations due to opioid overdose
- Age-adjusted death rate due to opioid overdose
- Age-adjusted drug and alcohol related death rate
- Drug- and alcohol-related ED visits

KEY PARTNERS: BEHAVIORAL HEALTH

Maryland Department of Health and Mental Hygiene - Behavioral Health Administration

Mosaic Group

Substance Abuse and Mental Health Services Administration (SAMSHA)

Access to Care and Services

Access to Care and Services Objectives
- Improve access to mental health services and reduce ED utilization among behavioral health patients
- Expand access to dental care, basic primary care, and behavioral health services in MedStar St. Mary's Hospital's CBSA
- Improve health care utilization practices and health outcomes of high need, high risk patients by identifying social unmet needs and linkage to community social needs resources at point of care using the Aunt Bertha tool

Access to Care and Services Secondary Data
- Five percent of the St. Mary's population under the age of 65 is without health insurance.[11]
- Ratio of mental health providers in St. Mary's County is one for every 1,000 people.[11]
- Ratio of dentists in St. Mary's County is one for every 1,940 people, compared to 1,280:1 for the top US performers.[11]

Access to Care and Services Strategies
- Conduct Mindoula Health Behavioral Health program
- Deliver behavioral health services through MedStar Behavioral Health at East Run
- Deliver primary care services via MedStar St Mary's Hospital Primary Care at East Run program
- Provide dental care services at the Dental Clinic at East Run
- Conduct social needs screenings and support linkages to social need services as part of care delivery and chronic disease self-management programming

Access to Care and Services Anticipated Outcomes
- Increased access to mental health treatment and education services
- Growth in primary care, psychiatric, and dental practice patient base
- Improved identification of patients' social unmet needs and service linkage at point of care
- Improved health care utilization among individuals linked to social need, transportation, mental health, primary care, behavioral health, and dental services

Access to Care and Services Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Mental Health Services**
  - Number of patients enrolled in the program annually
  - Number of referrals to treatment provided annually

- Number of patients linked to treatment annually
- ED readmission and PAU rates of people who receive case management and/or clinical mental health services

- **Primary Care, Behavioral Health, and Dental Services**
  - Number of new patients in each practice annually
  - ED utilization for new patients in each practice annually
  - Readmission and PAU rates for new patients in primary care and behavioral health practices
  - Quality measures for primary care as reported to Medicare

- **Social Needs Services**
  - Number of social needs screenings conducted annually
  - Number of positive social needs screen annually
  - Number of people referred to services annually
  - Number of people linked to services annually
  - ED readmission and PAU rates of people with positive social needs screening that were referred or linked to services

PUBLIC HEALTH METRICS
- Ratio of primary care, behavioral health, and dental health care providers to population
- Percentage of households living in poverty
- Percentage of households experiencing food insecurity
- Percentage of uninsured adults

KEY PARTNERS: ACCESS TO CARE AND SERVICES

Aunt Bertha, Inc.

Community-based social services organizations

Dental Schools

HealthShare

Mindoula Health

Missions of Mercy

St. Mary's County Health Department

Collaboration Areas

Collaboration areas were identified as social determinant areas in which the hospital will serve as a partner with outside organizations.

Transportation Objectives
- Address the barrier of transportation to medical and health services and programs among individuals who identify transportation as a social unmet need

Transportation Secondary Data
- 34.0 percent of MedStar St. Mary's Hospital CHNA survey respondents identified lack of transportation as a barrier to accessing care.

Transportation Strategies
- Provide transportation to medical services via the AccessHealth program and a Tri-County Council transportation grant

Transportation Anticipated Outcomes
- Increased transportation services to and from medical and health services and community health programs
- Decreased no-show rates among participants

Transportation Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Transportation Services**
  - Number of rides supported annually
  - Number of people who receive rides annually
  - ED readmission and PAU rates of people who receive rides
  - No show rates among program participants
  - Percentage of people who identify transportation as a barrier
  - Number of participants utilizing transportation options to attend programs annually

PUBLIC HEALTH METRICS
- Percentage of the population with access to public transportation
- Percentage of population who have delayed getting medical care due to lack of transportation

EMPLOYMENT

Employment Objectives

- Prepare local underserved students for health care-related collegiate studies and careers through an established pipeline internship program

Employment Secondary Data

- In St. Mary's County, 4.1 percent of the population over the age of 16 is unemployed and looking for work.[11]
- In St. Mary's, 11.0 percent of teens between the ages of 16-24 are classified as disconnected youth (neither working nor in school).[11]

Employment Strategies

- Conduct the Rx for Success Pipeline Summer Internship Program for underserved high school students

Employment Anticipated Outcomes

- Increased number of underserved, racial and ethnic minority interns in the Rx for Success summer internship at MSMH annually
- Improved satisfaction rates among student interns, intern supervisors, and school partner leadership annually
- Improved pipeline processes to increase employment opportunities post-internship for eligible students

Employment Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Rx for Success Pipeline Summer Internship Program**
  - Number of students who apply to the internship annually
  - Number of students selected and placed in the internship annually
  - Number of student interns from MedStar St. Mary's Hospital's CBSA annually
  - Graduation rates of interns
  - Number of seniors who complete the internship and pursue a health-related college major
  - Number of seniors who complete the internship and are employed in a health-related position within MedStar Health
  - Student, supervisor, and community partner satisfaction rate
  - Type of intern placements within MedStar St. Mary's Hospital

PUBLIC HEALTH METRICS

- Unemployment rate
- High school graduation and completion rate
- Percentage of new hires to health care fields

Participation Areas

Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.
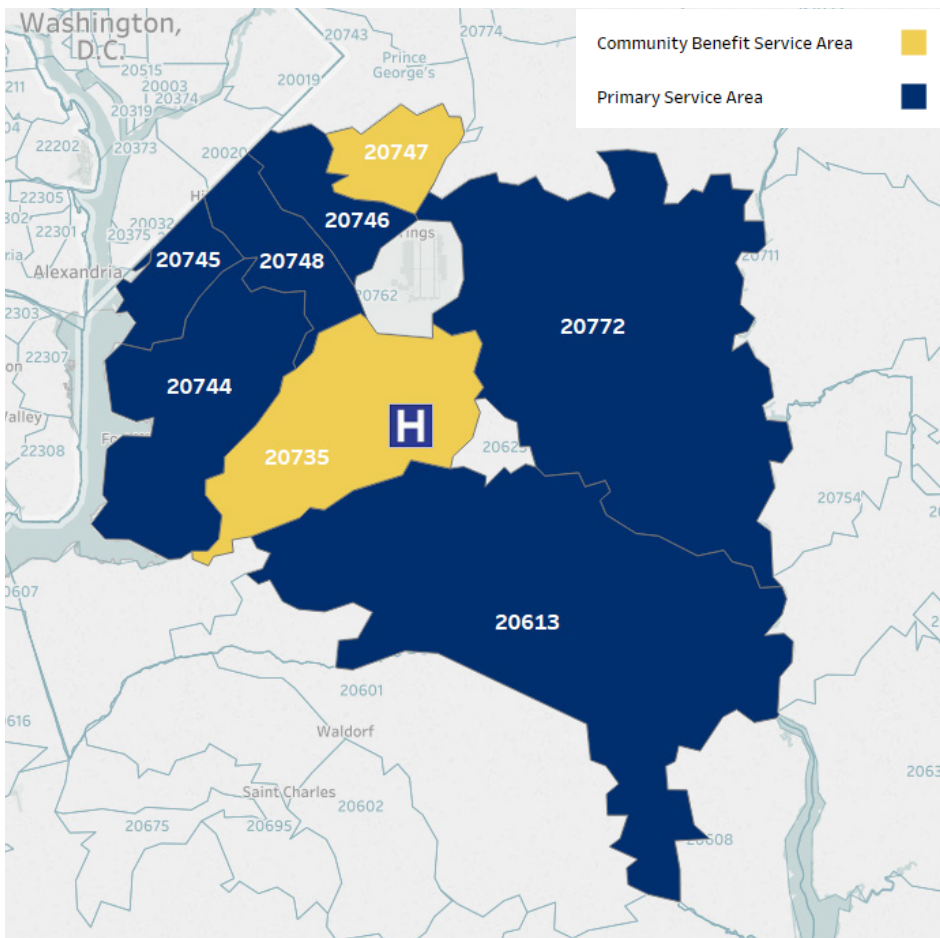
Participation

- Housing

MedStar Southern Maryland Hospital Center

Legend:
- Community Benefit Service Area (yellow)
- Primary Service Area (navy)

Community Health Needs Assessment

Health and Wellness

CHRONIC DISEASE

Chronic Disease Objectives
- Deliver evidence-based, outcome-focused chronic disease management and prevention programs and services in, or targeting individuals living in, MedStar Southern Maryland Hospital Center Community Benefit Service Area (CBSA)
- Increase awareness and the intention to quit among smokers

COMMUNITY BENEFIT SERVICE AREA (CBSA): SOUTHERN PRINCE GEORGE'S COUNTY

MedStar Southern Maryland Hospital Center's CBSA includes residents of Southern Prince George's County (zip codes 20735 and 20747). This geographic area was selected based on hospital utilization and secondary public health data as well as its proximity to the hospital.

COMMUNITY HEALTH PRIORITIES
- **Health and Wellness**
  - Chronic Disease Prevention and Management
  - Behavioral Health

- **Access to Care and Services**
  - Mental Health
  - Linkage to Resources and Services
  - Transportation
- **Social Determinants of Health**
  - Employment
  - Housing

Chronic Disease Secondary Data

DIABETES
- Two percent of adults in Prince George's County have diabetes.[11]

HEART DISEASE
- Heart disease (24.6 percent) and cancer (25.0 percent) are responsible for half of all deaths in the county.[17]

OBESITY
- In Prince George's County, 33.0 percent of adults are obese.[11]

CANCER
- In Prince George's County, there were 1,417 deaths due to cancer in 2014. The cancer mortality rate was 168.6 per 100,000 people.[8]

SMOKING
- Cigarette smoking is the leading cause of preventable disease and death in the United States.
- In 2016, more than 16 million Americans lived with a smoking-related disease.
- In Prince George's County, 12.0 percent of adults smoke compared to 15.0 percent nationally.[11]

Chronic Disease Strategies
- Conduct the Living Well Chronic Disease Self Management Program
- Conduct the Smoking Cessation Program

Chronic Disease Anticipated Outcomes
- Increased participation in chronic disease prevention and management programs and services
- Increased retention rates among program participants
- Improved health behaviors and health outcomes among program participants
- Increased identification of social unmet needs and linkages to social need services among chronic disease management program participants
- Improved health care utilization patterns among program participants

Chronic Disease Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Living Well Program**
  - Percentage of program completers who report improved quality of life
  - Percentage of program completers reporting increased physical activity
  - Percentage of program completers who have decreased blood pressure and weight loss
  - Percentage of people who screened positive for social needs and were linked to services at intake and post program completion
  - Percentage of completers who do not readmit to emergency department (ED) after the program ends
  - Potentially avoidable utilizations (PAU) and readmission rates among program completers
  - Percentage of program completers who successfully complete follow-up assessments

- **Smoking Cessation Program**
  - Percentage of completers who report quitting after program participation
  - Quit rate of program completers

PUBLIC HEALTH METRICS
- Age-adjusted death rate for diabetes, heart disease, stroke, and cancer
- ED visits and hospitalization rates due to hypertension, heart disease, stroke, cancer, obesity, and diabetes
- Percentage of adults at a healthy weight (body mass index < 25 kg/m2)
- Percentage of adults participating in the recommended levels of physical activity
- Prevalence rates of obesity among adults
- Prevalence rates of diabetes among adults
- Percentage of adults who smoke

KEY PARTNERS: CHRONIC DISEASE
American Cancer Society

Maintaining Active Citizens, Inc.

Maryland Department of Aging

Prince George's County Department of Aging and Human Services

Prince George's County Health Department

BEHAVIORAL HEALTH

Behavioral Health Objectives

- Identify people with at-risk and dependent substance and/or alcohol use behaviors, and provide brief early intervention services to those who screen positively for risky drug and alcohol use

Behavioral Health Secondary Data

ALCOHOL ABUSE

- In Prince George's County, 15.0 percent of residents report excessive drinking.[11]
- 34.0 percent of driving deaths in Prince George's County involved alcohol.[11]
- 26.2 percent of ED visits in Prince George's County are from alcohol-related disorders.[18]

SUBSTANCE ABUSE

- Prince George's County has a 10.0 percent drug overdose death rate.[18]

Behavioral Health Strategies

- Conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program

Behavioral Health Anticipated Outcomes

- Improved identification of high-risk substance use behaviors and access to substance abuse treatment, education, and social need services

Behavioral Health Metrics

PROGRAM-SPECIFIC METRICS

- Number of SBIRT screens annually
- Number of positive SBIRT screens annually
- Number of brief interventions completed annually
- Number of referrals to treatment provided annually
- Number of patients linked to treatment annually
- ED readmission and PAU rates of patients who receive brief interventions and/or linkage to treatment
- Number of substance abuse and addiction support groups promoted and held in CBSA annually

PUBLIC HEALTH METRICS

- Percentage of individuals reporting a substance abuse disorder
- Percentage of adults reporting excessive drinking
- Percentage of adults and adolescents who report alcohol use and binge drinking
- Percentage of hospitalizations due to a substance abuse or alcohol abuse disorder

- Number of hospitalizations due to opioid overdose
- Age-adjusted death rate due to opioid overdose
- Age-adjusted drug and alcohol related death rate
- Drug- and alcohol-related ED visits

KEY PARTNERS: BEHAVIORAL HEALTH

Community substance abuse and mental health treatment service organizations

Maryland Department of Health and Mental Hygiene - Behavioral Health Administration

Mosaic Group

Substance Abuse and Mental Health Services Administration (SAMHSA)

Access to Care and Services

Access to Care and Services Objectives

- Improve access to mental health services and reduce ED utilization among behavioral health patients
- Improve appropriate healthcare utilization practices and health outcomes of high-need, high-risk patients by identifying social unmet needs and linkage to community social needs resources at point of care using the Aunt Bertha tool

Access to Care and Services Secondary Data

MENTAL HEALTH SERVICES

- 27.0 percent of Prince George's County high school students reported they stopped their normal activities for two weeks or more due to feeling sad or hopeless, and 14.7 percent reported they have seriously considered suicide.[17]
- 3.3 percent of Prince George's County residents report having poor mental health days.[17]
- In Prince George's County, the ratio of mental health providers to the population is 890:1, compared to 460:1 for the top US performers[17]

26.2 percent of ED visits in Prince George's County are from alcohol-related disorders.[18]

Access to Care and Services Strategies

- Conduct Mindoula Behavioral Health Program
- Conduct social needs screenings and support linkages to social need services as part of care delivery and chronic disease self-management programming

Access to Care and Services Anticipated Outcomes

- Increased number of eligible patients who complete Mindoula mental health assessment annually
- Increased number of patients with selected mental health diagnoses who are referred to treatment annually
- Improved use of uniform social needs screener in MedStar Southern Maryland Hospital Center's care delivery sites and as part of the Living Well Program
- Improved identification of patients' unmet social needs and service linkage at point of care
- Improved healthcare utilization among individuals liked to social need services, transportation or mental health services

Access to Care and Services Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Mental Health Services**
    - Number of patients enrolled in the program annually
    - Number of referrals to treatment provided annually
    - Number of patients linked to treatment annually
    - ED readmission and PAU rates of people who receive case management and/or clinical mental health services

- **Social Needs Services**
    - Number of social needs screenings conducted annually
    - Number of positive social needs screen annually
    - Number of people referred to services annually
    - Number of people linked to services annually
    - ED readmission and PAU rates of people with positive social needs screening that were referred or linked to services

PUBLIC HEALTH METRICS

- Percentage of uninsured adults
- Adults reporting delaying access to medical care due to high cost
- Percentage of adults with mood disorders
- Ratio of mental health providers to the general population

Collaboration Areas

Collaboration areas were identified as social determinant areas in which the hospital will serve as a partner with outside organizations.

TRANSPORTATION

Transportation Objectives

- Address the barrier of transportation to medical and health services and programs among individuals who identify transportation as a social unmet need

Transportation Secondary Data

- In 2014, 23.5 percent of adults in Prince George's County indicated they had delayed medical care mainly due to a lack of transportation, lack of timely appointments, and long wait times to see a provider.[17]
- 24.0 percent of MedStar Southern Maryland Hospital Center CHNA survey respondents identified lack of transportation as a barrier to accessing care.

Transportation Strategies

- Implement MedStar Health UBER program

Transportation Anticipated Outcomes

- Increased number of available rides to and from medical and health services and community health programs
- Decreased no-show rates among participants

Transportation Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **MedStar Health UBER Program**
  - Number of rides supported annually
  - Number of people who receive rides annually
  - ED readmission and PAU rates of people who receive rides
  - No show rates among program participants
  - Percentage of people who identify transportation as a barrier

PUBLIC HEALTH METRICS

- Percentage of the population with access to public transportation
- Percentage of population who have delayed getting medical care due to lack of transportation

> **KEY PARTNERS: TRANSPORTATION**
>
> Aunt Bertha, Inc.
>
> Uber Technologies, Inc.

EMPLOYMENT

Employment Objectives

- Prepare local underserved students for health care-related collegiate studies and careers through an established pipeline internship program
- Improve access to local employment opportunities within the community

Employment Secondary Data

- In Prince George's County, over four percent of the population (ages 16 and older seeking work) is unemployed.[11]
- 79.0 percent of Prince George's County high school students graduate within four years.[11]
- 14.0 percent of Prince George's County teens ages 16-24 are neither working nor in school.[11]

Employment Strategies

- Conduct the Rx for Success Pipeline Summer Internship Program for underserved high school students
- Conduct semi-annual career fairs at MedStar Southern Maryland Hospital Center

Employment Anticipated Outcomes

- Increased number of underserved, racial and ethnic minority interns in the Rx for Success summer internship at MedStar Southern Maryland Hospital Center annually
- Improved satisfaction rates among student interns, intern supervisors, and school partner leadership annually
- Improved pipeline processes to increase employment opportunities post-internship for eligible students
- Increased employment opportunities available in Prince George's County

Employment Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Rx for Success Pipeline Summer Internship Program**
  - Number of students who apply to the internship annually
  - Number of students selected and placed in the internship annually
  - Number of student interns from MedStar Southern Maryland Hospital Center's CBSA annually
  - Graduation rates of interns
  - Number of seniors who complete the internship and pursue a health-related college major
  - Number of seniors who complete the internship and are employed in a health-related position within MedStar Health
  - Student, supervisor, and community partner satisfaction rate
  - Type of intern placements within MedStar Southern Maryland Hospital Center

- **Annual Career Fairs**
  - Number of participants who apply to positions during the career fair annually
  - Number of participants selected and placed into open positions annually
  - Number of participants from MedStar Southern Maryland Hospital Center's CBSA annually
  - Number of people hired from MedStar Southern Maryland Hospital Center's CBSA

PUBLIC HEALTH METRICS

- Unemployment rate
- High school graduation and completion rate
- Percentage of new hires to health care fields

KEY PARTNERS: EMPLOYMENT

Community-based providers

Health-focused employment seekers in Prince George's County

Health-focused high schools in Prince George's County

Participation Areas

Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.

Participation

- Housing

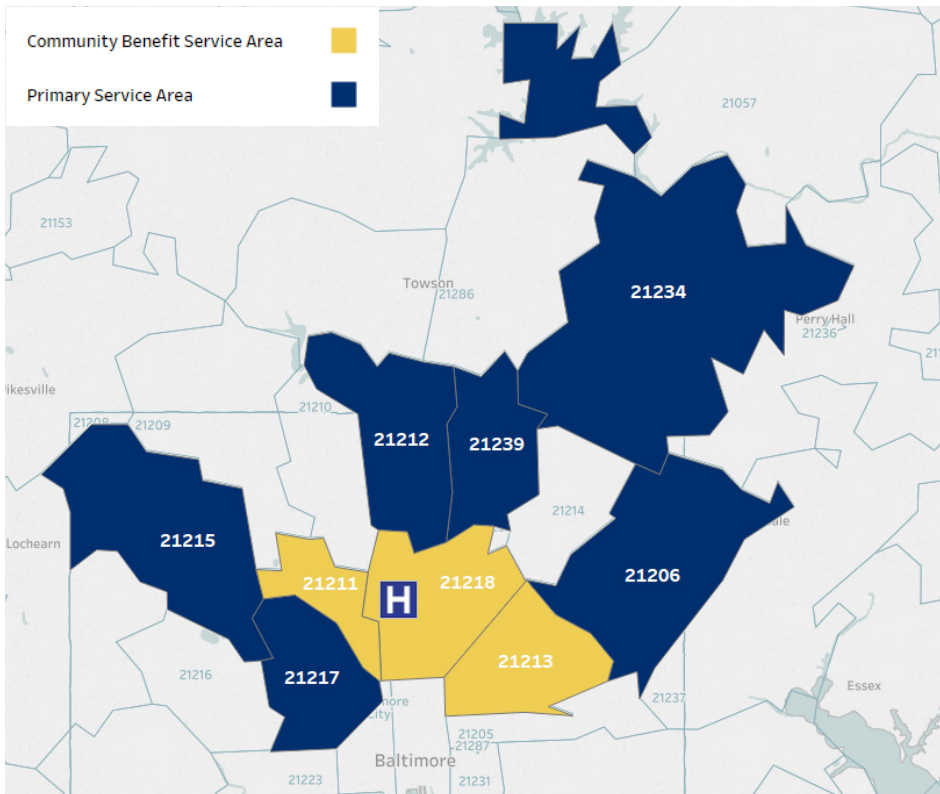**KEY PARTNERS: PARTICIPATION**

Catholic Charities

Prince George's County Chamber of Commerce

Prince George's County Department of Planning and Development

Prince George's County Department of Social Services

MedStar Union Memorial Hospital

Community Benefit Service Area
Primary Service Area

Community Health Needs Assessment

Health and Wellness

CHRONIC DISEASE

Chronic Disease Objectives
- To deliver evidence-based, outcome-focused chronic disease management and prevention community-based programs and services targeting at-risk, high-need individuals living in MedStar Union Memorial Hospital's CBSA

Chronic Disease Secondary Data

DIABETES
- Diabetes is the sixth leading cause of death in Baltimore City and Maryland.[27]
- The prevalence of diabetes in Baltimore City is 13.65 percent.[11]

COMMUNITY BENEFIT SERVICE AREA (CBSA): NORTH CENTRAL BALTIMORE CITY

MedStar Union Memorial Hospital's CBSA includes residents in Baltimore City zip codes 21211, 21213, and 21218. This geographic area was selected based on hospital utilization and secondary public health data as well as its close proximity to the hospital, coupled with a high density of low-income residents, high rates of chronic disease prevalence, and hospital utilization information.

COMMUNITY HEALTH PRIORITIES

- **Health and Wellness**
  - Chronic Disease Prevention and Management
  - Behavioral Health

- **Access to Care and Services**
  - Mental Health Services and Substance Use Services
  - Transportation

- **Social Determinants of Health**
  - Employment
  - Neighborhood Violence and Safety
  - Housing

- The prevalence of diabetes among African Americans (18.58 percent) is more than twice as high as the prevalence among Whites (7.44 percent).[11]

HEART DISEASE AND STROKE
- Heart disease is the leading cause of death in Baltimore City and Maryland.[27]
- Stroke is the third leading cause of death in Baltimore City and Maryland.[27]
- 145 out of 100,000 people in Baltimore City die prematurely due to cardiovascular disease (CVD).[2]
- In 2014, the CVD premature death rate among Black residents of Baltimore City was about 1.6 times that of White residents.[2]
- Baltimore City has the highest stroke death rate per 100,000 people in Maryland at a rate of 108.4 per 100,000 individuals.[4]

OBESITY
- 34.0 percent of adults in Baltimore City report a body mass index (BMI) of 30 or higher report, compared to 26.0 percent for the top US performers.[11]

CANCER
- Cancer is the second leading cause of death in Maryland, and Baltimore City has the highest cancer mortality rate among all Maryland jurisdictions.[8]
- Baltimore City has a cancer death rate of 213.9 per 100,000, higher than the state cancer death rate of 157.4 per 100,000.[19, 27]

SMOKING
- Cigarette smoking is the leading cause of preventable disease and death in the United States.
- In 2016, more than 16 million Americans lived with a smoking-related disease.
- 20.0 percent of adults in Baltimore smoke, compared to 15.5 percent nationally (2016).[11]

Chronic Disease Strategies
- Conduct Living Well – Chronic Disease Self-Management Program
- Conduct Diabetes Prevention Program (DPP)
- Conduct smoking cessation Programs
- Conduct breast, cervical, and colon cancer screenings
- Embed community health advocates (CHAs) in hospital care teams and in the CBSA to assist with chronic disease management and education efforts

Chronic Disease Anticipated Outcomes
- Increased participation in chronic disease prevention and management programs and services
- Increased retention rates among program participants
- Improved health behaviors and health outcomes among program participants
- Increased identification of social unmet needs and linkages to social need services among chronic disease management program participants
- Improved health care utilization patterns among program participants

Chronic Disease Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Living Well Program**
  - Percentage of program completers who report improved quality of life
  - Percentage of program completers reporting increased physical activity
  - Percentage of program completers who have decreased blood pressure and weight loss
  - Percentage of people who screened positive for social needs and are linked to services at intake and post program completion
  - Percentage of completers who do not readmit to emergency department (ED) after program ends
  - Potentially Avoidable Utilizations (PAU) and readmission rates among program completers
  - Percentage of program completers who successfully complete follow-up assessments

- **Diabetes Prevention Program**
  - Number of DPP programs conducted annually
  - Retention rates among DPP participants
  - Number of participants who meet weight loss goal of 5 percent
  - Number of participants who meet physical activity goal of 150 minutes per week

- **Smoking Cessation Program**
  - Percentage of completers who report quitting after program participation
  - Quit rate of program completers

- **Cancer Screenings**
  - Numbers of breast, cervical, and colon cancer screenings annually
  - Number of patients referred to treatment from screenings annually
  - Number of cancer support groups offered in MedStar Union Memorial Hospital CBSA annually

PUBLIC HEALTH METRICS

- Age-adjusted death rate for diabetes, heart disease, and cancer
- ED visits and hospitalization rates due to hypertension, heart disease, cancer, obesity, and diabetes
- Percentage of adults at a healthy weight or BMI
- Percentage of adults who participate in the recommended levels of physical activity
- Prevalence rates of obesity among adults
- Prevalence rates of diabetes among adults
- Percentage of adults who smoke

KEY PARTNERS: CHRONIC DISEASE

American Cancer Society

Baltimore City Breast and Cervical Cancer Screening Program

Baltimore City Department of Aging

Baltimore City Health Department

Centers for Disease Control & Prevention

Maintaining Active Citizens, Inc.

Maryland Department of Aging

Maryland Department of Health

BEHAVIORAL HEALTH

Behavioral Health Objectives: Substance Use Disorders

- To deliver evidence-based behavioral health programs and services targeting the identification of substance abuse and linkage to treatment services among high-risk individuals in MedStar Union Memorial Hospital's CBSA

Behavioral Health Secondary Data

SUBSTANCE ABUSE

- The total number of drug- and alcohol-related intoxication deaths in Maryland increased from 1,259 in 2015 to 2,089 in 2016.[10]

> The total number of drug and alcohol-related intoxication deaths in Maryland **increased from 1,259 in 2015 to 2,089 in 2016.**[10]

ALCOHOL ABUSE

- Percentage of driving deaths with alcohol involvement: 20.0 percent in Baltimore City compared to 13.0 percent for the top US performers.[11]
- Percentage of adults reporting binge drinking: 18.0 percent in Baltimore City compared to 13.0 percent for the top US performers.[11]

OPIOID ABUSE

- In Maryland, the number of prescription opioid-related intoxication deaths increased from 61 in 2010 to 113 in 2016.[10]

BEHAVIORAL HEALTH STRATEGIES

- Implement the Screening, Brief Intervention, and Referral to Treatment (SBIRT) strategy in ED and primary care settings.
- Embed peer recovery coaches (PRCs) on hospital care teams to assist with improving access to substance use treatment and social service linkage, and support community education efforts.
- Offer Naloxone trainings in the community.
- Develop and implement Opioid Survivor Outreach Program (OSOP) to provide support and resources to opioid survivors that visit hospital-based emergency departments.

Behavioral Health Anticipated Outcomes

- Improved identification of high-risk substance use behaviors and access to substance abuse treatment education, and social need services

Behavioral Health Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- Number of SBIRT screens annually
- Number of positive SBIRT screens annually
- Number of brief interventions completed annually
- Number of referrals to treatment provided annually
- Number of patients linked to treatment annually
- ED readmission and PAU rates of patients who receive brief interventions and/or linkage to treatment
- Number of substance abuse and addiction support groups held in MedStar Union Memorial Hospital CBSA annually

- **Naloxone Training and OSOP**
  - Number of naloxone administration trainings offered at the hospital or CBSA annually
  - Number of community members trained to administer naloxone annually
  - Number of referrals to treatment annually
  - Number of suspected overdoses annually
  - Number of referrals to OSOP peer recovery coaches annually
  - Number of patients successfully contacted by OSOP recovery coach annually
  - Number of OSOP patients referred to treatment monthly
  - Number of OSOP patients linked to recovery support groups annually
  - Number of naloxone kits provided to OSOP patients annually
  - Number of naloxone prescriptions provided to OSOP patients annually
  - Number of known OSOP deaths annually

PUBLIC HEALTH METRICS

- Percentage of individuals reporting a substance abuse disorder
- Percentage of adults reporting excessive drinking
- Percentage of adults and adolescents who report alcohol use and binge drinking
- Percentage of hospitalizations due to a substance abuse or alcohol abuse disorder
- Number of driving deaths involving alcohol
- Number of hospitalizations due to opioid overdose
- Age-adjusted death rate due to opioid overdose
- Age-adjusted drug and alcohol related death rate
- Drug- and alcohol-related emergency department visits

KEY PARTNERS: BEHAVIORAL HEALTH

Baltimore City Health Department

Mosaic Group

Substance Abuse and Mental Health Services Administration (SAMSHA)

Access to Care and Services

Access to Care and Services Objectives
- Increase access to medical and social need services and hospital community-based community health programs for individuals in MedStar Union Memorial Hospital's CBSA
- Increase access to mental health services and education
- Improve health care utilization practices and health outcomes of high-need, high-risk patients by identifying social unmet needs and linkage to community social needs resources at point of care using the Aunt Bertha tool
- Ensure access to health care services and health education for the Hispanic/Latino and immigrant communities

Access to Care and Services Secondary Data

ACCESS TO CARE
- In 2014, only 10.0 percent of respondents reported being unable to get the medical care they needed in the past 12 months, compared to 22.0 percent in 2009.[1]
- Eight percent of Baltimore city residents are uninsured.[11]
- In Baltimore, the ratio of residents to mental health providers is 270:1.[11]

HEALTH DISPARITIES
- While Baltimore's overall population diminished by 4.6% between 2000-2010, the Hispanic/Latino population grew dramatically by 134.7%.[42]

Access to Care and Services Strategies
- Provide mental health services as part of the primary care model
- Conduct social needs screenings and support linkages to social need services as part of care delivery and chronic disease self-management programming using CHAs and PRCs
- Deliver health education courses in Hispanic/Latino and immigrant communities to improve healthcare access

Access to Care and Services Anticipated Outcomes
- Increased access to mental health treatment services and education services for hospital primary care patients
- Increased access to community mental health education opportunities
- Increased use of uniform social needs screener in MedStar Union Memorial Hospital care delivery sites and as part of the Living Well program
- Improved identification of patients' social unmet needs and service linkage at point of care
- Improved health care utilization among individuals linked to mental health, social need or transportation services
- Increased health education courses in Hispanic/Latino and immigrant communities

Access to Care and Services Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Mental Health Services**
  - Number of people who receive or are referred to mental health treatment services in program primary care setting annually
  - Number of people screened for selected mental health conditions (substance use, depression, and anxiety) annually
  - Number of people with positive mental health screening annually
  - Number of people who screen positively for mental health conditions that are referred or linked to services annually
  - ED readmission and PAU rates of people with positive mental health screenings that are referred or linked to services

- **Social Need Services**
  - Number of social needs screenings conducted annually
  - Number of positive social needs screen annually
  - Number of people referred to services annually
  - Number of people linked to services annually
  - ED readmission and PAU rates of people with positive social needs screenings that are referred or linked to services

- **Health Equity and Disparities**
  - Number of lay leaders from Hispanic/Latino and immigrant communities trained annually
  - Number of participants from Hispanic/Latino and immigrant communities in health education courses annually
  - Number of health education courses delivered in Hispanic/Latino and immigrant communities annually

PUBLIC HEALTH METRICS
- Percentage of people reporting unmet healthcare needs in the past 12 months

- Percentage of people reporting they could not afford to see a doctor in the past 12 months
- Percentage of people diagnosed with mental illness that are uninsured
- Percentage of adults unemployed
- Percentage of households living in poverty
- Percentage of households experiencing food insecurity

> **KEY PARTNERS: ACCESS TO CARE AND SERVICES**
>
> Aunt Bertha, Inc.
>
> Community-based addiction and mental health services organizations
>
> Esperanza Center
>
> Greater Baybrook Alliance
>
> Immigration Outreach Service Center
>
> Shepherd's Clinic

Collaboration Areas

Collaboration areas were identified as social determinant areas in which the hospital will serve as a partner with outside organizations.

TRANSPORTATION

Transportation Objectives
- Address the barrier of transportation to medical and health services and programs among individuals who identify transportation as a social unmet need

Transportation Secondary Data
- Lack of transportation is cited as having a significant impact on access to health care services and is a determinant of a person's ability to access basic resources that can affect quality of life.[5]
- 25 percent of MedStar Union Memorial Hospital CHNA survey respondents identified lack of transportation as a barrier to accessing care.

Transportation Strategies
- Implement MedStar Health UBER program

Transportation Anticipated Outcomes
- Increased number of available rides to and from medical and health services and community health programs
- Decreased no-show rates among participants

Transportation Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **MedStar Health UBER Program**
  - Number of rides supported annually
  - Number of people who receive rides annually
  - ED readmission and PAU rates of people who receive rides
  - No show rates among program participants
  - Percentage of people who identify transportation as a barrier

PUBLIC HEALTH METRICS
- Percentage of the population with access to public transportation
- Percentage of population who have delayed getting medical care due to lack of transportation

> **KEY PARTNERS: TRANSPORTATION**
>
> Aunt Bertha, Inc.
>
> Uber Technologies, Inc.

EMPLOYMENT

Employment Objectives
- Hire individuals from underserved communities as CHAs and PRCs to contribute to MedStar Health's population health management efforts in the Baltimore region through the Baltimore Population Health Workforce Support for Disadvantaged Areas Program (PHWSDA)
- Prepare local underserved students for health care-related collegiate studies and careers through an established pipeline internship program

Employment Secondary Data
- The current unemployment rate is 6.4 percent in Baltimore, compared to 3.2 percent for the top US performers.[20]
- 19.0 percent of youth between the ages of 16-24 are classified as disconnected youth (neither in school nor working), compared to 13.0 percent in Maryland and 10.0 percent for the top US performers.[11]

- 70.0 percent of high schoolers graduate within four years, compared to 87.0 percent in Maryland and a 95.0 percent rate for the top US performers.[11]

Employment Strategies
- Conduct PHWSDA program
- Conduct the Rx for Success Pipeline Summer Internship Program for underserved high school students

Employment Anticipated Outcomes
- Increased number of CHAs and PRCs hired and trained by 2019
- Increased number of underserved, racial and ethnic minority interns in the Rx for Success summer internship at MedStar Union Memorial Hospital annually
- Improved satisfaction rates among student interns, intern supervisors, and school partner leadership annually
- Improved pipeline processes to increase employment opportunities post-internship for eligible students

Employment Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **PHWSDA "Jobs" Program**
  - Number of individuals trained from MedStar Union Memorial Hospital CBSA
  - Number of individuals hired from MedStar Union Memorial Hospital CBSA
  - Retention rates of hired associates
  - Number of patients or clients assisted by these positions
  - Average caseload for positions
  - Average length of patient engagement by positions
  - Number patients screened for social needs and number of those referred or linked to services
  - Readmission rates among patients assigned to CHAs or PRCs
  - ED utilization among patients assigned to CHAs or PRCs

- **Rx for Success Pipeline Summer Internship Program**
  - Number of students who apply to the internship annually
  - Number of students selected and placed in the internship annually
  - Number of student interns from MedStar Union Memorial Hospital's CBSA annually

- Graduation rates of interns
- Number of seniors who complete the internship and pursue a health-related college major
- Number of seniors who complete the internship and are employed in a health-related position within MedStar Health
- Student, supervisor, and community partner satisfaction rate
- Type of intern placements within MedStar Union Memorial Hospital

PUBLIC HEALTH METRICS
- Unemployment rate
- High school graduation and completion rate
- Percentage of new hires to healthcare fields

KEY PARTNERS: EMPLOYMENT

Baltimore Alliance for Careers in HealthCare

BUILD - Baltimoreans United in Leadership Development

Mercy High School

Mission Integration and Volunteer Services

NACA Freedom and Democracy Academy

Other local health systems

Project SEARCH – Arc of Baltimore

Turnaround Tuesday

Vivien T. Thomas Medical Arts Academy

Participation Areas

Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.
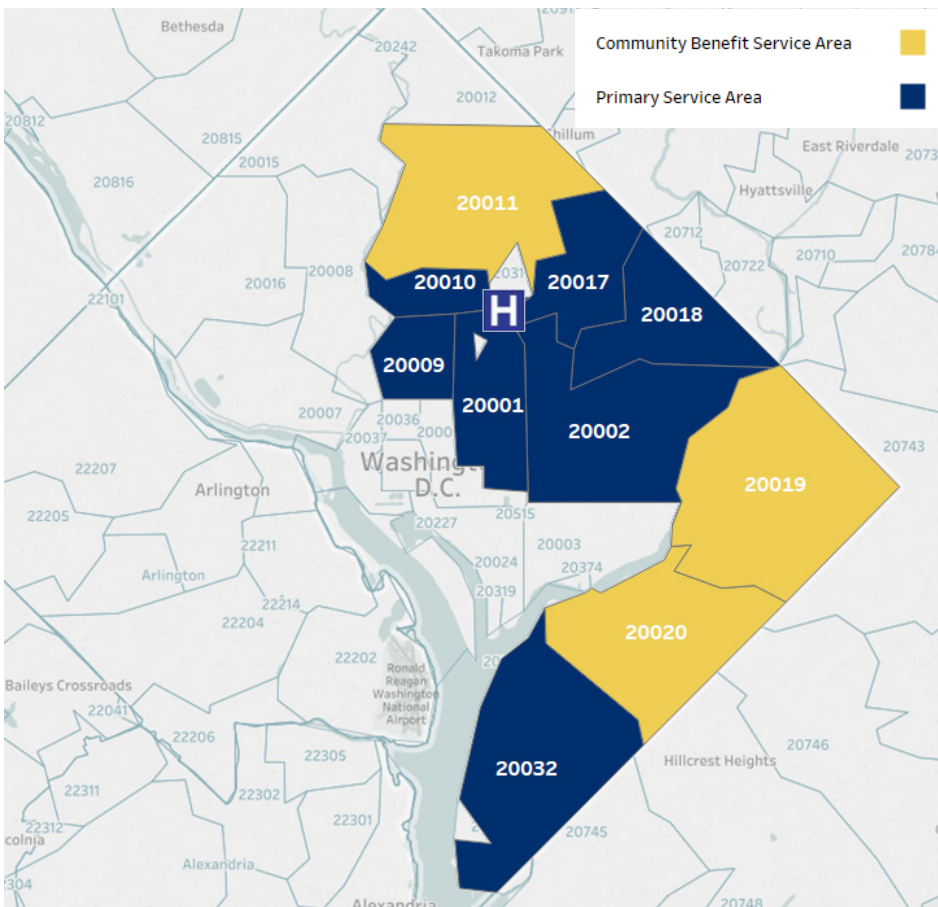
Participation
- Neighborhood Violence and Street Safety
- Housing

KEY PARTNERS: PARTICIPATION

Baltimore City governmental agencies

BUILD – Baltimoreans United in Leadership Development

Central Baltimore Partnership

Habitat for Humanity

Healthcare for the Homeless

Penn North - UTURNS

SAFE Streets

MedStar Washington Hospital Center

COMMUNITY BENEFIT SERVICE AREA (CBSA): 20011, 20019, 20020 (WITH EMPHASIS ON WARDS 7 AND 8)

MedStar Washington Hospital Center's CBSA includes residents in Washington, DC zip codes 20011, 20019, 20020. This geographic area was selected based on hospital utilization and secondary public health data as well as its close proximity to the hospital, coupled with an opportunity to build upon longstanding programs and services.

COMMUNITY HEALTH PRIORITIES

- **Health and Wellness**
  - Chronic Disease Prevention and Management
  - Behavioral Health

- **Access to Care and Services**
  - Mental Health
  - Linkage to Resources and Services
  - Transportation

- **Social Determinants of Health**
  - Food Access
  - Employment
  - Housing

Community Health Needs Assessment

Health and Wellness

CHRONIC DISEASE

Chronic Disease Objectives

- Deliver evidence-based, outcome-focused chronic disease management and prevention programs and services in, or targeting individuals living in, MedStar Washington Hospital Center Community Benefit Service Area (CBSA).

> Diabetes was the **sixth leading cause of death** in DC, with 127 deaths in 2016 (and a mortality rate of 19.8).[32]

Chronic Disease Secondary Data

DIABETES

- Diabetes was the sixth leading cause of death in Washington, DC, with 127 deaths in 2016 (and a mortality rate of 19.8).[32]
- In 2014, one in eleven (or 9.1 percent) DC residents had diabetes. In 2013, diabetes was the ninth leading cause of hospitalization in DC, with 1,572 visits.[6]
- In DC, emergency department (ED) visits related to diabetes were over six times higher for African Americans than for Whites.[6]
- An analysis of ED records found that up to 30 percent of visits for diabetes, asthma, and other chronic conditions were potentially preventable with better access to effective primary and preventive care.[6]

HEART DISEASE AND STROKE

- Heart disease is the leading cause of death among DC residents, with 1,375 deaths in 2016 (and a mortality rate of 211.7).[32]
- Heart disease in DC can be attributed to preventable factors like obesity, poor physical activity, heavy drinking, eating unhealthy foods, and not keeping blood pressure and cholesterol under control.
- The hospitalization rate for heart disease in DC was 41.9 per 1,000 Medicare beneficiaries.
- Heart disease is the top reason for hospitalization in DC
- Stroke is the fourth leading cause of death in DC, with 252 deaths in 2016 (and mortality rate of 38.4).[32]

OBESITY

- In DC, 26.2 percent of adults are obese. DC has the second lowest adult obesity rate in the nation.[36]
- More than one-third (33.8 percent) of 10-12 year-olds in DC are obese.[36]
- DC ranks 11th among all states for obesity rates among children ages 10-12.[36]

CANCER

- Cancer is the second leading cause of death among DC residents, with 1,044 deaths in 2016 (and a mortality rate of 160.1 per 100,000).[32]
- The crude death rate of deaths from cancer in Ward 7 is about 22 percent higher than the DC-wide rate, and 26 percent higher than the nation.[35]
- DC has the highest liver cancer rates in the country, with 15 deaths per 100,000 men, and five such deaths per 100,000 women.[35]

Chronic Disease Strategies

- Conduct Living Well Chronic Disease Self-Management Program

Chronic Disease Anticipated Outcomes

- Increased participation in chronic disease prevention and management programs and services
- Increased retention rates among program participants
- Improved health behaviors and health outcomes among program participants
- Increased identification of social unmet needs and linkages to social need services among chronic disease management program participants
- Improved healthcare utilization patterns among program participants

Chronic Disease Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Living Well Program**
  - Percentage of program completers who report improved quality of life
  - Percentage of program completers reporting increased physical activity
  - Percentage of program completers who have decreased blood pressure and weight loss
  - Percentage of people who screen positive for social needs and are linked to services at intake and post program completion
  - Percentage of completers who do not readmit to the ED after program ends
  - Potentially Avoidable Utilizations (PAU) and readmission rates among program completers
  - Percentage of program completers who successfully complete follow-up assessments

PUBLIC HEALTH METRICS

- Age-adjusted death rate from diabetes, heart disease, stroke, and cancer
- ED visit rates and hospitalizations due to hypertension, diabetes, heart disease, stroke, and cancer
- Prevalence of diabetes in DC
- Incidence and prevalence of heart disease and stroke in DC
- Percentage of adults at a healthy weight or body mass index (BMI)
- Percentage of adults who are obese
- Percentage of adults participating in recommended levels of physical activity

KEY PARTNERS: CHRONIC DISEASE

DC Department of Aging and Human Services

DC Department of Family Services

DC Health

Maintaining Active Citizens, Inc.

Maryland Department of Aging

BEHAVIORAL HEALTH

Behavioral Health Objectives: Substance Use Disorders

- Deliver evidence-based behavioral health programs and services targeting the identification of substance abuse and linkage to treatment services among high-risk individuals in MedStar Washington Hospital Center's CBSA

Behavioral Health Secondary Data

SUBSTANCE ABUSE

- Nationally, over 20 million adults had a substance use disorder in 2014.[40]
- In 2016, there were more than 63,600 drug overdose deaths in the United States.[41]
- The rate of drug overdose deaths in DC in 2016 was 38.8 per 100,000 population.[41]
- More DC residents report use of illicit drugs (12.3 percent) than the national rate, 8.8 percent.[30]

ALCOHOL ABUSE

- 28.0 percent of adults in DC report binge drinking compared to 18.0 percent nationally.[11]
- In DC, the percentage of driving deaths with alcohol involvement was 25.0 percent compared to 33.0 percent nationally.[11]

- The percentage of driving deaths with alcohol involvement in DC increased from 43.0 percent in 2015 to 74.0 percent in 2016.[5]
- White adults were more than twice as likely to report as binge drinkers compared to Black adults (35.0 percent and 14.0 percent, respectively).[5]
- The percent of adults reporting as binge drinkers varied significantly by ward, with the highest percentages in Wards 1 (42.0 percent) and 2 (30.0 percent) and lowest in Wards 4 (16.0 percent) and 7 (18.0 percent).[5]

OPIOID ABUSE

- DC's mortality rate for opioid-related overdose deaths is among the highest in the nation, with a 2016 rate of 30 deaths per 100,000 people (or 209 deaths). The national rate is 13.3 per 100,000 people.[37]

Behavioral Health Strategies

- Conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program

Behavioral Health Anticipated Outcomes

- Improved identification of high-risk substance use behaviors and access to substance abuse treatment, education and social need services

Behavioral Health Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- Number of SBIRT screens annually
- Number of positive SBIRT screens annually
- Number of brief interventions completed annually
- Number of referrals to treatment provided annually
- Number of patients linked to treatment annually
- ED readmission and PAU rates of patients who receive brief interventions and/or linkage to treatment
- Number of substance abuse and addiction support groups promoted and held in MedStar Washington Hospital Center's CBSA annually

PUBLIC HEALTH METRICS

- Percentage of individuals reporting a substance abuse disorder
- Percentage of adults reporting excessive drinking
- Percentage of adults and adolescents who report alcohol use and binge drinking

- Percentage of hospitalizations due to a substance abuse or alcohol abuse disorder
- Number of driving deaths involving alcohol
- Number of hospitalizations due to opioid overdose
- Age-adjusted death rate due to opioid overdose
- Age-adjusted drug and alcohol related death rate
- Drug- and alcohol-related ED visits

KEY PARTNERS: BEHAVIORAL HEALTH

Community-based addiction and mental health services organizations

DC Health

Maryland Department of Health and Mental Hygiene - Behavioral Health Administration

Mosaic Group

Substance Abuse and Mental Health Services Administration (SAMSHA)

Access to Care and Services

Access to Care and Services Objectives

- Increase access to mental health services as part of the primary care model
- Improve appropriate healthcare utilization practices and health outcomes of high-need, high-risk patients by identifying social unmet needs and linkage to community social needs resources at point of care using the Aunt Bertha tool

Access to Care and Services Secondary Data

MENTAL HEALTH SERVICES

- In 2014, approximately 18.0 percent of DC adults had ever been told they had a depressive disorder.[5]
- Rates were highest in Ward 8 (30.0 percent), Ward 1 (22.0 percent), and Ward 7 (18.0 percent).[5]
- Areas of Wards 7 and 8 were designated by the Health Resources and Services Administration (HRSA) as mental health professional shortage areas in 2015.[5]
- In 2014, the second most common inpatient hospital discharge among all DC residents was for mood disorders (3.9 percent).[5]

SOCIAL NEEDS SERVICES

- 93.0 percent of adult residents and 96.0 percent of children have insurance coverage in DC. It is the second highest coverage rate in the nation.[5]
- Residents in Wards 7 and 8 had the lowest coverage amongst all wards (90.0 percent and 91.0 percent, respectively).[5]
- Health insurance coverage was lowest among Hispanic/Latino residents (78.0 percent) compared to 91.0 percent coverage among Black residents and 97.0 percent coverage among White residents.[5]
- DC-wide, 10.0 percent of adults reported that they had delayed getting medical care because they could not get an appointment soon enough.[5]

Access to Care and Services Strategies

- Provide mental health services as part of the primary care model
- Conduct social needs screening and support linkages to social need services as part of care delivery and chronic disease self-management programming

Access to Care and Services Anticipated Outcomes

- Increased access to mental health services in primary care settings
- Increased use of uniform social needs screener in MedStar Washington Hospital Center care delivery sites and as part of the Living Well program
- Improved identification of patients' social unmet needs and service linkage at point of care
- Improved health care utilization among individuals linked to social need, transportation services or mental health services

Access to Care and Services Metrics

PROGRAM-SPECIFIC METRICS

- **Mental Health Services**
  - Number of people who receive or are referred to mental health treatment services in primary care settings annually
  - Number of people screened for selected mental health conditions (substance use, depression and anxiety) annually
  - Number of people with positive mental health screenings annually
  - Number of people who screen positively for mental health conditions that are referred or linked to services annually
  - ED readmission and PAU rates of people with positive mental health screening that were referred or linked to services

- **Social Needs Services**
  - Number of social needs screenings conducted annually
  - Number of positive social needs screened annually
  - Number of people referred to services annually
  - Number of people linked to services annually
  - ED readmission and PAU rates of people with positive social needs screening that were referred or linked to services

PUBLIC HEALTH METRICS

- Percentage of people reporting unmet healthcare needs in the past 12 months
- Percentage of people reporting they could not afford to see a doctor in the past 12 months
- Depression and anxiety disorder prevalence rates
- Percentage of adults unemployed
- Percentage of households experiencing food insecurity
- Percentage of uninsured individuals
- Number of individuals reporting avoiding medical care due to cost
- Percentage of individuals living below the poverty line
- Percentage of adults with disabilities

> **KEY PARTNERS: ACCESS TO CARE AND SERVICES**
>
> Aunt Bertha, Inc.
>
> Community-based addiction and mental health services organizations
>
> Community-based social services organizations

Collaboration Areas

Collaboration areas were identified as social determinant areas in which the hospital will serve as a partner with outside organizations.

TRANSPORTATION

Transportation Objectives
- Address the barrier of transportation to medical and health services and programs among individuals who identify transportation as a social unmet need

Transportation Secondary Data
- Lack of transportation is cited as having a significant impact on access to health care services and is a determinant of a person's ability to access basic resources that can affect quality of life.[5]
- In DC, many characterize public transportation as expensive and unreliable.[5]
- Metro stations in DC are concentrated in the central region (Wards 2 and 6) and are lacking in other areas, especially in Wards 4, 7, and 8.[5]
- 19 percent of MedStar Washington Hospital Center CHNA survey respondents identified lack of transportation as a barrier to accessing care.

Transportation Strategies
- Implement MedStar Health UBER program

Transportation Anticipated Outcomes
- Increased number of available rides to and from medical and health services and community health programs
- Decreased no-show rates among participants

Transportation Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **MedStar Health UBER Program**
  - Number of rides supported annually
  - Number of people who receive rides annually
  - ED readmission and PAU rates of people who receive rides
  - No show rates among program participants
  - Percentage of people who identify transportation as a barrier

PUBLIC HEALTH METRICS
- Percentage of the population with access to public transportation
- Percentage of population who have delayed getting medical care due to lack of transportation

> **KEY PARTNERS: TRANSPORTATION**
> Aunt Bertha, Inc.
> Uber Technologies, Inc.

EMPLOYMENT

Employment Objectives
- Prepare local underserved students for healthcare-related collegiate studies and careers through an established pipeline internship program

Employment Secondary Data
- In 2015, 14.0 percent of DC families lived in poverty. In Wards 7 and 8, 75.0 percent more families live in poverty, at 25.0 percent and 29.0 percent respectively, compared to the DC benchmark.[5]

- DC's unemployment rate has decreased since 2011, but the rate varies from ward to ward. Compared to the national rate, unemployment was two times higher in Ward 7 and three times higher in Ward 8 in 2016.[5]
- Compared to the national average, as of June 2016, unemployment is two times higher in Ward 7 and three times higher in Ward 8.[5]
- Income and employment status are closely linked to morbidity, mortality, and overall well-being; lower than average life expectancy is highly correlated with low-income status.[5]

Employment Strategies
- Deliver the Rx for Success Pipeline Summer Internship Program for underserved high school students

Employment Anticipated Outcomes
- Increased number of underserved, racial and ethnic minority interns in the Rx for Success summer internship at MedStar Washington Hospital Center annually
- Improved satisfaction rates among student interns, intern supervisors, and school partner leadership annually
- Improved pipeline processes to increase employment opportunities post-internship for eligible students

Employment Metrics

PROGRAM-SPECIFIC METRICS
Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Rx for Success Pipeline Summer Internship Program**
  - Number of students who apply to the internship annually
  - Number of students selected and placed in the internship annually
  - Number of student interns from MedStar Washington Hospital Center's CBSA annually
  - Graduation rates of interns
  - Number of seniors who complete the internship and pursue a health-related college major
  - Number of seniors who complete the internship and are employed in a health-related position within MedStar Health
  - Student, supervisor and community partner satisfaction rate
  - Type of intern placements within MWHC

PUBLIC HEALTH METRICS
- Unemployment rate
- Percentage of adults who are unemployed and seeking work (unemployment rate)
- High school graduation and completion rate
- Percentage of new hires to healthcare fields

KEY PARTNERS: EMPLOYMENT

Eastern High School

Companies for Causes

FOOD ACCESS

Food Access Objectives
- Improve access to healthy food among individuals who identify food insecurity as a social need

Food Access Secondary Data
- 21.0 percent of Medstar Washington Hospital CHNA respondents identified healthy food options as a community need.
- Residents in Wards 7 and 8 have reported they struggled to afford the cost of healthy produce.[5]
- 13.0 percent of the population of DC reports food insecurity, or insufficient access to healthy food, compared to 10.0 percent nationally.[5]

Food Access Strategies
- Conduct Food & Friends Meal Referral Program

Food Access Anticipated Outcomes
- Increased number of people with positive social needs screened for food insecurity that are referred or linked to food-related services
- Increased number of annual MedStar Washington Hospital Center-supported meals

Food Access Metrics

PROGRAM-SPECIFIC METRICS

Key factors will be tracked to determine: 1) impact of programs and services implemented; and 2) relevance to external public health goals.

- **Food & Friends Meal Referral Program**
  – Number of referrals to Food & Friends annually
  – Number of people linked to food services annually
  – Number of meals supported annually
  – ED readmission and PAU rates of people linked to food services

- **Food Access Public Health Metrics**
  – Percentage of food insecure households
  – Percentage of population experiencing food insecurity[11]

KEY PARTNERS: FOOD ACCESS

Food & Friends

Capital Area Food Bank

Participation Areas

Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.

Participation
- Housing

KEY PARTNERS: PARTICIPATION

Central Union Mission

Coalition for the Homeless

DC Department of Housing and Urban Development

DC Department of Human Services – Family Services Administration

DC Health

District of Columbia Primary Care Association (DCPCA)- DC Positive Accountable Community Transformation (DC PACT)

Pathways to Housing

References

1 Baltimore City Health Department. (2017). Community Health Assessment. Retrieved from https://health.baltimorecity.gov/sites/default/files/health/attachments/Baltimore%20City%20CHA%20-%20Final%209.20.17.pdf.

2 Baltimore City Health Department. (2011). Healthy Baltimore 2015. Retrieved from http://health.baltimorecity.gov/healthy-baltimore-2015.

3 Baltimore City Mental Health Systems. Mental Health in Baltimore City. Retrieved from http://www.bhsbaltimore.org/site/wp-content/uploads/2013/08/Mental-Health-in-Baltimore-City-Fact-Sheet.pdf.

4 Centers for Disease Control and Prevention. Interactive Atlas of Heart Disease and Stroke. Retrieved from https://nccd.cdc.gov/DHDSPAtlas/.

5 Government of the District of Columbia Department of Health. (2017). District of Columbia Health Systems Plan. Retrieved from https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/DC%20Health%20Systems%20Plan%202017_0.pdf.

6 Government of the District of Columbia, Health Regulation and Licensing Administration. (2016). Impacts of Pharmaceutical Marketing on Healthcare in the District of Columbia: Diabetes in the District of Columbia. Retrieved from https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Impacts%20Report%202016%20-%20Diabetes.pdf.

7 Healthy Montgomery. Community Health Improvement Plan. Retrieved from http://www.healthymontgomery.org.

8 Maryland Department of Health. (2017) Cancer Data: Cigarette Restitution Fund Program. Retrieved from https://phpa.health.maryland.gov/cancer/SiteAssets/Pages/surv_data-reports/2017_CRF_Cancer_Report_(20170827).pdf.

9 Maryland Department of Health. (2017). First quarter fatal overdose data. Retrieved from https://health.maryland.gov/newsroom/Pages/Maryland-Department-of-Health-releases-2017-first-quarter-fatal-overdose-data.aspx.

10 Maryland Department of Health and Mental Hygiene. (2017). Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2016. Retrieved from https://bha.health.maryland.gov/OVERDOSE_PREVENTION/Documents/Maryland%202016%20Overdose%20Annual%20report.pdf.

11 The Robert Wood Johnson Foundation. (2018). County health rankings. Retrieved from http://www.countyhealthrankings.org/.

12 St. Mary's County Health Department. (2015). County Health Status Report: St. Mary's County, Maryland. Retrieved from http://www.smchd.org/wp-content/uploads/SMCountyHealthStatusReport_FINAL.pdf.

14 Baltimore City Department of Planning. Data & Demographics. Retrieved from https://planning.baltimorecity.gov/planning-data#Housing%20&%20Transportation.

15 Office of Legislative Oversight. (2015). Behavioral Health in Montgomery County. Retrieved from http://www.montgomerycountymd.gov/OLO/Resources/Files/2015_Reports/OLO%20Report%202015-13%20Behavioral%20Health%20in%20Montgomery%20County.pdf.

16 Office of Legislative Oversight. (2017). Prescription Opioids: Prescriber Education and the Maryland Prescription Drug Monitoring Program. Retrieved from http://www.montgomerycountymd.gov/OLO/Resources/Files/2017%20Reports/OLO%20Report%202017%20-11%20Prescription%20Opioids.pdf.

17 Prince George's County Health Department. (2016). Health Report. Retrieved from https://www.princegeorgescountymd.gov/ArchiveCenter/ViewFile/Item/290.

18 Prince George's County Health Department. (2016). Community Health Needs Assessment. Retrieved from https://www.princegeorgescountymd.gov/ArchiveCenter/ViewFile/Item/2884.

19 Big Cities Health Coalition. Data Platform. Retrieved from http://bchi.bigcitieshealth.org/cities/94/18360.

20 Maryland Department of Labor, Licensing & Regulation. Local Area Unemployment Statistics (LAUS) - Workforce Information & Performance. Retrieved from https://www.dllr.state.md.us/lmi/laus/.

21 The Robert Wood Johnson Foundation. (2016). County Health Rankings Model. Retrieved from http://www.countyhealthrankings.org/county-health-rankings-model.

22 Centers for Disease Control and Prevention. Health Equity. Retrieved from https://www.cdc.gov/chronicdisease/healthequity/index.htm.

23 Asset-Based Community Development Institute, DePaul University. Asset-Based Community Development Framework. Retrieved from https://resources.depaul.edu/abcd-institute/Pages/default.aspx.

24 Centers for Disease Control and Prevention. The Social-Ecological Model: A Framework for Prevention. Retrieved from https://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html.

25 Bureau of Labor Statistics. (2014). Healthcare: Millions of jobs now and in the future. Retrieved from https://www.bls.gov/careeroutlook/2014/spring/art03.pdf.

26 Open Data Network. "High School Graduation Rates: Baltimore County, MD." https://www.opendatanetwork.com/entity/0500000US24005/Baltimore_County_MD/education.graduation_rates.percent_high_school_graduate_or_higher?year=2016.

27 Maryland Department of Health, "Maryland Vital Statistics Annual Report," 2016. https://health. maryland.gov/vsa/documents/2016_annualreport. webversion.pdf.

28 Centers for Disease Control and Prevention, National Center for Health Statistics, "Stats of the State of Maryland," https://www.cdc.gov/nchs/pressroom/ states/maryland/maryland.htm, accessed May 9, 2018.

29 Centers for Disease Control and Prevention, National Center for Health Statistics. https://www.cdc.gov/nchs/ pressroom/sosmap/cancer_mortality/cancer.htm, accessed May 9, 2018.

30 DC Department of Health. Appendix A. SUBSTANCE ABUSE-RELATED DATA FOR THE DISTRICT OF COLUMBIA. Retrieved from https://doh.dc.gov/sites/ default/files/dc/sites/doh/publication/attachments/ appendix_a.pdf.

31 Kaiser Family Foundation. "Fact Sheet: Faciltitating Access to Mental Health Services." 2016. https://www. kff.org/medicaid/fact-sheet/facilitating-access-to-mental-health-services-a-look-at-medicaid-private-insurance-and-the-uninsured/.

32 Centers for Disease Control and Prevention, National Center for Health Statistics. "Stats of the District of Columbia" https://www.cdc.gov/nchs/pressroom/ states/DC/DC.htm, accessed May 25, 2018.

33 Centers for Disease Control and Prevention, National Center for Health Statistics. "Smoking and Tobacco Use State Highlights: District of Columbia" https://www. cdc.gov/nchs/pressroom/states/DC/DC.htm, accessed May 25, 2018.

34 Campaign for Tobacco Free Kids. "The Toll of Tobacco in Washington, DC." https://www.tobaccofreekids.org/ problem/toll-us/dc accessed May 25, 2018.

35 Government of the District of Columbia Department of Health. "District of Columbia Community Health Needs Assessment, Vol. 1. Revised 3/15/13. https://doh. dc.gov/sites/default/files/dc/sites/doh/page_content/ attachments/2nd%20Draft%20CHNA%20(v4%202)%20 06%2004%202013%20-%20Vol%201.pdf accessed May 25, 2018.

36 Trust for America's Health and the Robert Wood Johnson Foundation. "The State of Obesity in Washington, D.C." https://stateofobesity.org/states/dc/ accessed May 25, 2018.

37 National Institute on Drug Abuse. "Washington, D.C. Opioid Summary." https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/washington-dc-opioid-summary. Accessed May 25, 2018.

38 Yang-Tan Institute on Employment and Disability at the Cornell University ILR School. "2016 Disability Status Report: District of Columbia." http://www. disabilitystatistics.org/StatusReports/2016-PDF/2016-StatusReport_DC.pdf?CFID=9349108&CFTOKE N=5b38219cd4b17542-BA623FD8-F365-3A57-546F004C2F2C4301, accessed May 25, 2018.

39 DC Public Schools. "School-Based Health Center Program: Fact Sheet." https://dcps.dc.gov/sites/ default/files/dc/sites/dcps/publication/attachments/ SBHC-Fact-Sheet.pdf, accessed May 25, 2018.

40 Substance Abuse and Mental Health Services Administration (SAMHSA). "Substance Use Disorders." https://www.samhsa.gov/disorders, accessed May 26, 2018.

41 Centers for Disease Control and Prevention, National Center for Health Statistics. "Drug Overdose Deaths in the United States, 1999-2016. https://www.cdc. gov/nchs/products/databriefs/db294.htm, accessed May 26, 2018.

42 City of Baltimore Hispanic Commission. Demographics. Retrieved from https://hc.baltimorecity.gov/hc-demographics

43 Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report. State-Specific Prevalence of Obesity Among Adults with Disabilities. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/ mm5136a1.htm

44 Centers for Disease Control and Prevention. Women with Disabilities and Breast Cancer Screening. Retrieved from https://www.cdc.gov/ncbddd/ disabilityandhealth/breast-cancer-screening.html#ref

45 Centers for Disease Control and Prevention. Cigarette Smoking Among Adults with Disabilities. Retrieved from https://www.cdc.gov/ncbddd/disabilityandhealth/ smoking-in-adults.html

46 Centers for Disease Control and Prevention. Disability and Health: Information for Health Care Providers. Retrieved from https://www.cdc.gov/ncbddd/ disabilityandhealth/hcp.html

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