UNIVERSITY of MARYLAND MEDICAL CENTER

Community Health Needs Assessment & Implementation Plan

Executive Summary

FY2019-FY2021

Approved by: Community Engagement Committee, Board of Directors
6/4/18

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Executive Summary

Overview

The University of Maryland Medical Center (UMMC) serves Baltimore City and the greater metropolitan region, including patients with in-state, out-of-state, and international referrals for tertiary and quaternary care. UMMC is a private, non-profit acute care hospital and is the flagship academic medical center of the University of Maryland Medical System. It is the second leading provider of healthcare services in Baltimore City and the state of Maryland and has served the state's and city's populations since 1823.

In FY2017, UMMC provided care for 28,727 inpatient admissions, 7,750 outpatient surgical cases, 322,914 outpatient visits, and 57,568 emergency department visits. The University of Maryland Medical Center is licensed for 767 acute care beds. Beyond the Medical Center's facilities in FY2017, the Community Health Improvement Team provided over 65 health fairs in local faith-based organizations, schools, and community centers, led two health promotion grants from the Baltimore City Health Department and co-sponsored five major UMMS health fairs/screening events with 25,015 encounters in the community. In addition, the Medical Center provides a community outreach section on the UMMC public web site to announce upcoming community health events and activities in addition to posting the annual Community Benefit Report and triennial Community Health Needs Assessment (CHNA). https://www.umms.org/ummc/community-health

Our Mission

University of Maryland Medical Center is the academic flagship of the University of Maryland Medical System. Its mission is to provide health care services on its two campuses for the Baltimore community, the State of Maryland and the nation. In partnership with the University of Maryland School of Medicine and the University of Maryland health professional schools, we are committed to:

- Delivering superior health care
- Training the next generation of health professionals

- Discovering ways to improve health outcomes worldwide

Our Vision:

UMMC will be known for providing high value and compassionate care, improving health in Maryland and beyond, educating future health care leaders and discovering innovative ways to advance medicine worldwide.

Source: https://www.umms.org/ummc/about/mission-vision

Our Commitment to Excellence:

Pillars We Focus on Every Day

Our Community Health Improvement Mission:

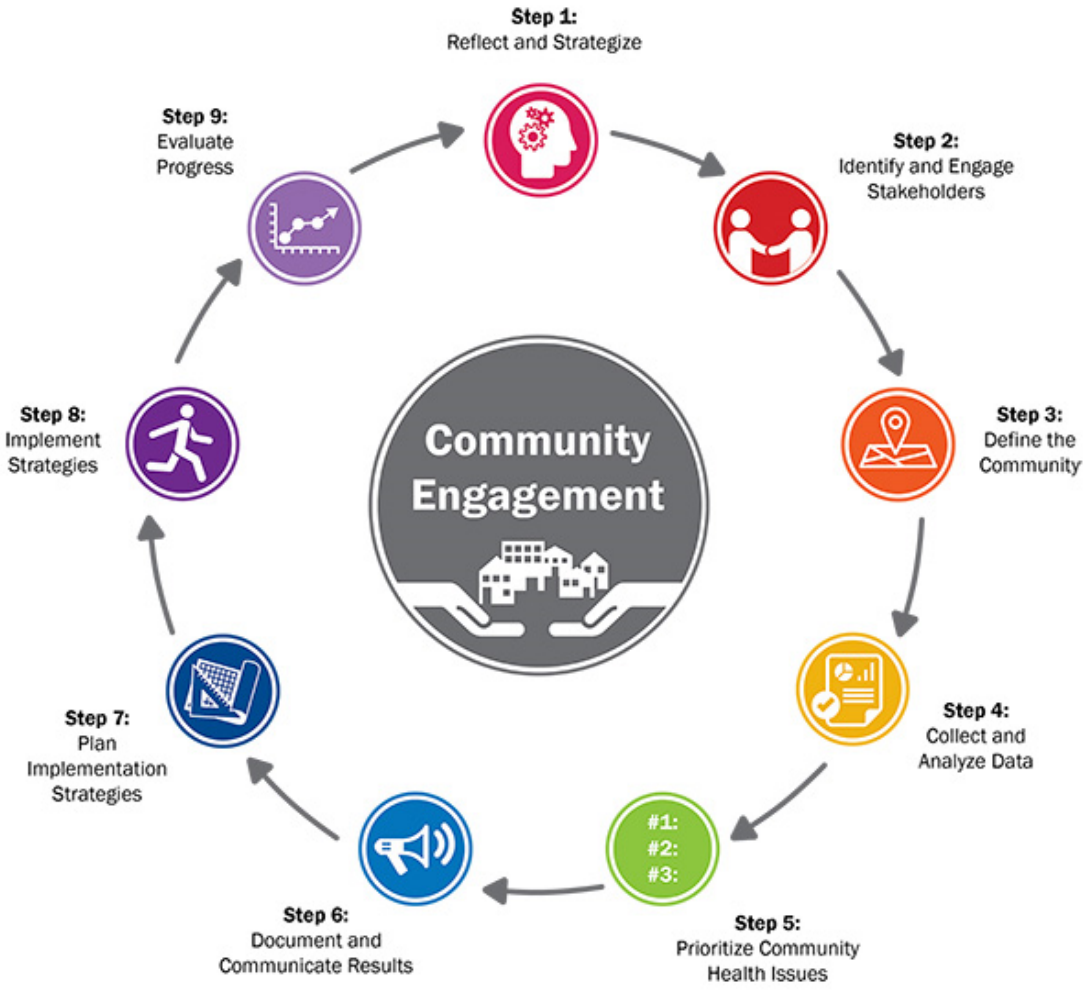
To empower and build healthy communities

Process

I. Establishing the Assessment and Infrastructure

To complete a comprehensive assessment of the needs of the community, the Association for Community Health Improvement's (ACHI) 9-step Community Health Assessment Process was utilized as an organizing methodology. The UMMC Community Health Improvement Team (CHI Team) served as the lead team to conduct the Community Health Needs Assessment (CHNA) with input from other University of Maryland Medical System Baltimore City-based hospitals, community leaders, the academic community, the public, health experts, and the Baltimore City Health Department. The UMMC CHI Team adopted the following ACHI 9-step process (See Figure 1) to lead the assessment process and the additional 5-component assessment (See Figure 2) and engagement strategy to lead the data collection methodology.

Figure 1 - ACHI 9-Step Community Health Assessment Process



According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a community health needs assessment either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and beginning in 2013, perform an assessment at least every three years thereafter. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public. For the purposes of this report, a community health needs assessment is a written document developed by a hospital facility (alone or in conjunction with others) that utilizes data to establish community health priorities, and includes the following: (1) A description of the process used to conduct the assessment;(2) With whom the hospital has worked; (3) How the hospital took into account input from community members and public health experts; (4) A description of the community served; and (5) A description of the health needs identified through the assessment process.

Figure 2 – 5-Step Assessment & Engagement Model

Data was collected from the five major areas outlined above to complete a comprehensive assessment of the community's needs. Data is presented in Section III of this summary and includes primary and secondary sources of data. The University of Maryland Medical Center participates in a wide variety of local coalitions including, several sponsored by the Baltimore City Health Department, Cancer Coalition, Tobacco Coalition, Influenza Coalition as well as partnerships with many community-based organizations like the American Heart Association (AHA), American Cancer Society (ACS), Susan G. Komen Foundation, Ulman Foundation, American Diabetes Association (ADA), B'More Healthy Babies, Donate Life, and Safe Kids to name a few. This assessment report was approved by the UMMC CHI Team in May, UMMC Executive Leadership in May, and the Board of Directors in June 4, 2018.

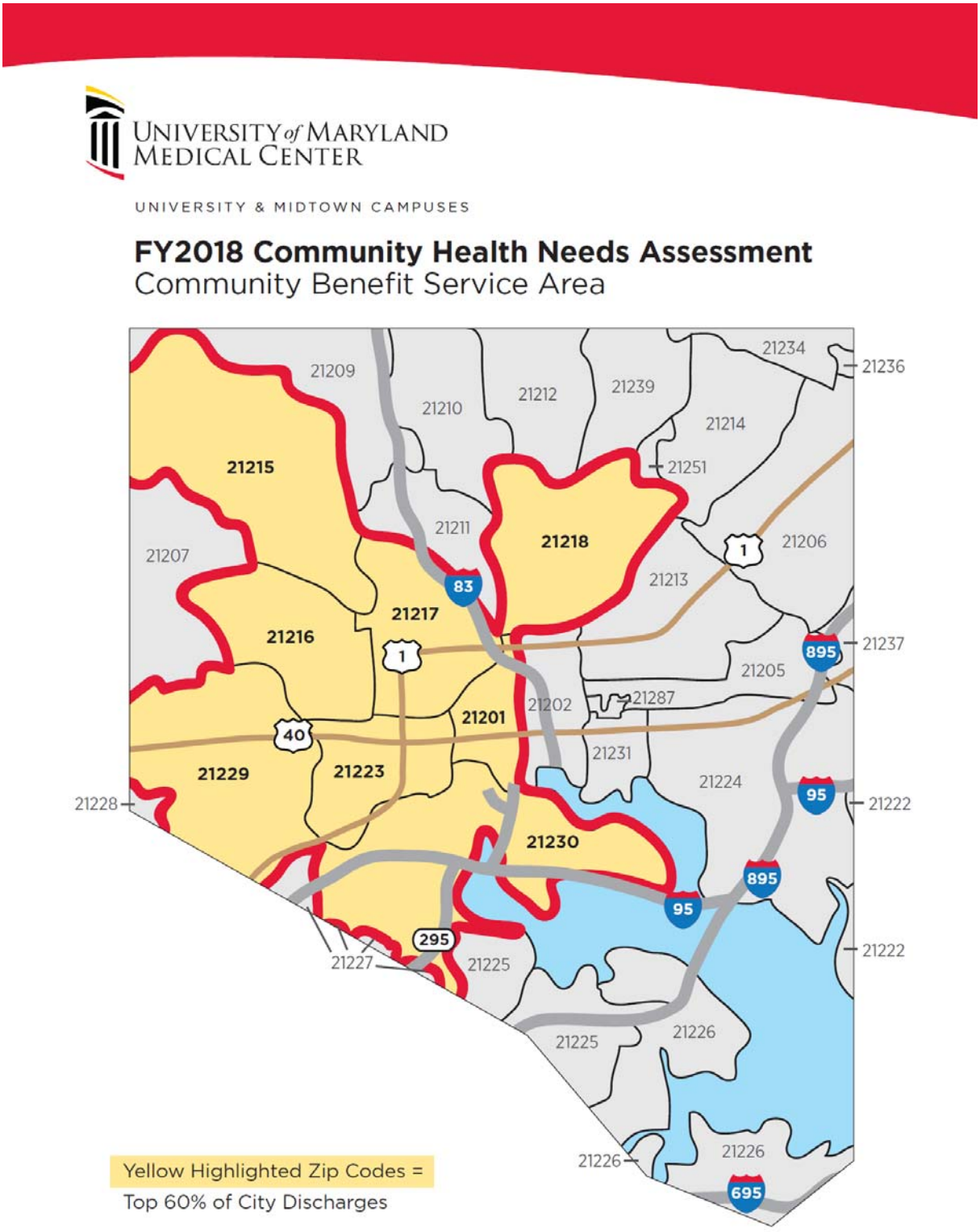
II. Defining the Purpose and Scope

Primary Community Benefit Service Area

Despite the larger regional patient mix of UMMC from the metropolitan area, state, and region, for purposes of community benefits programming and this report, the Community Benefit Service Area (CBSA) of UMMC is within Baltimore City.

The top seven zip codes within Baltimore City displayed in Figure 3 represent the top 60% of all Baltimore City admissions in FY'17. These seven targeted zip codes (21201, 21215, 21216, 21217, 21223, 21229, and 21230) are the primary community benefit service area (CBSA) and comprise the geographic scope of this assessment. See Figure 3.

Figure 3 – Top Baltimore City FY'17 Admissions to UMMC by Zip Code



III. Collecting and Analyzing Data

Using the above frameworks (Figures 1 & 2), data was collected from multiple sources, groups, and individuals and integrated into a comprehensive document which was utilized at a retreat on January 22, 2018 of the UMMC Downtown/Midtown Campuses' Community Health Improvement (CHI) Team. During that strategic planning retreat, priorities were identified using the collected data and an adapted version of the Catholic Health Association's (CHA) priority setting criteria. The identified priorities were also validated by a panel of UM Clinical Advisors and UMB Campus experts.

UMMC used primary and secondary sources of data as well as quantitative and qualitative data and consulted with numerous individuals and organizations during the CHNA, including other University of Maryland Medical System (UMMS) Baltimore City-based hospitals (University of Maryland Medical Center Midtown Campus, University of Maryland Rehabilitation and Orthopedic Institute, community leaders, community partners, the University of Maryland Baltimore (UMB) academic community, the general public, local health experts, and the Baltimore City Health Department.

Additionally, for the first time in the city's history, all local Baltimore City hospitals joined together in fiscal year 2018 to collaborate on several key data collection strategies for a joint community health needs assessment. UMMC partnered with Johns Hopkins Hospital, Sinai Hospital (Lifebridge), Medstar Health, St. Agnes Health System, and Mercy Medical Center. All of the above hospitals/health systems had been collaborating on several initiatives prior to the CHNA year and agreed that it would be beneficial to work on a more detailed level on a joint city-wide CHNA. This multi-hospital collaborative worked on the following data collection components together:

- Public survey of Baltimore City residents
- Key stakeholder interviews
- Key population focus groups

- Key community partner focus groups

After the data was collected and analyzed jointly, each individual hospital used the collected data for their respective community benefit service areas to identify their unique priorities for their communities. The collaborating hospitals/health systems did agree to jointly focus on mental health as a key city-wide priority.

The following describes the individual data collection strategies with the accompanying results.

A) Community Perspective

The community's perspective was obtained through one survey offered to the public using several methods throughout Baltimore City. A 6-item survey queried Baltimore City residents to identify their top health concerns and their top barriers in accessing health care. (See Appendix for the actual survey)

Methods

6-item survey distributed in FY2018 using the following methods:

- Conducted from late September through November 2017
- All hospitals participated in data collection throughout the city
- Distributed in person and offered online
- Offered in English, Spanish, and Russian
- Collected 4,755 surveys
- All Baltimore City zip codes represented

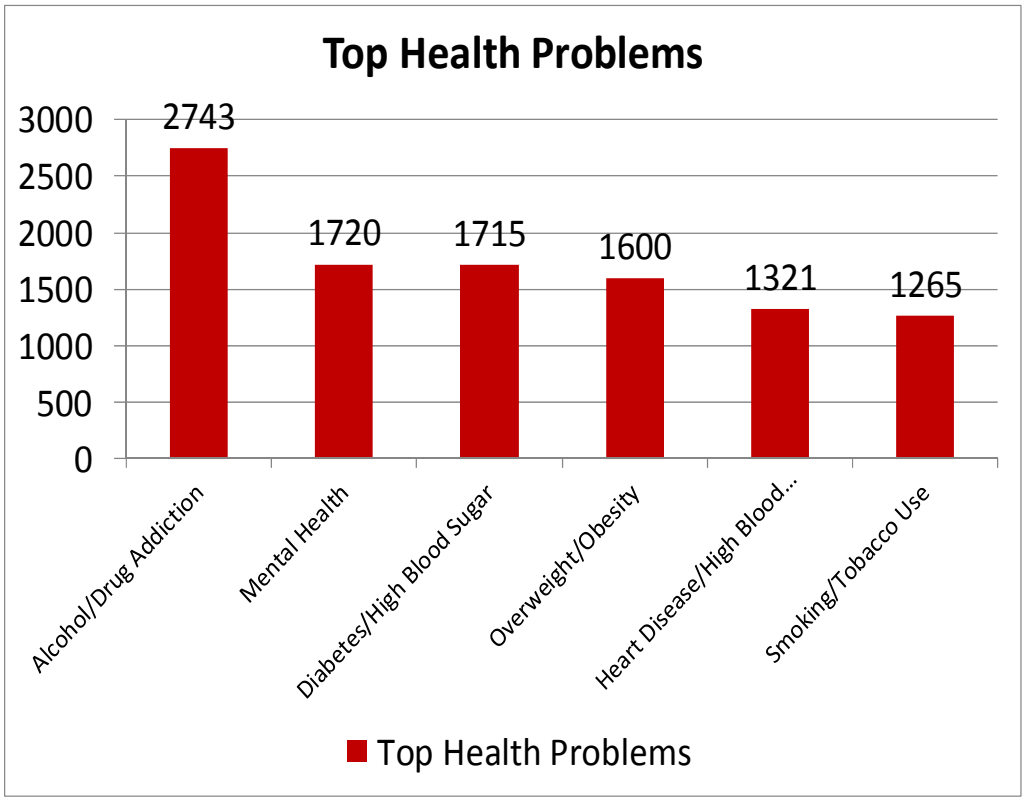
Results

- ❑ Top 6 Health Concerns: (See Chart 1 below)
    - ❑ Alcohol/Drug Addiction
    - ❑ Mental Health
    - ❑ Diabetes/High Blood Sugar
    - ❑ Overweight/Obesity
    - ❑ Heart Disease/High Blood Pressure
    - ❑ Smoking/Tobacco Use

Analysis by CBSA targeted zip codes revealed the same top health concerns and top health barriers with little deviation from the overall Baltimore City data. The sample size was 4,755 for all of Baltimore City and 1,324 for residents from the identified UMMC CBSA.

Chart 1 - Community's Top Health Concerns (All Baltimore City)

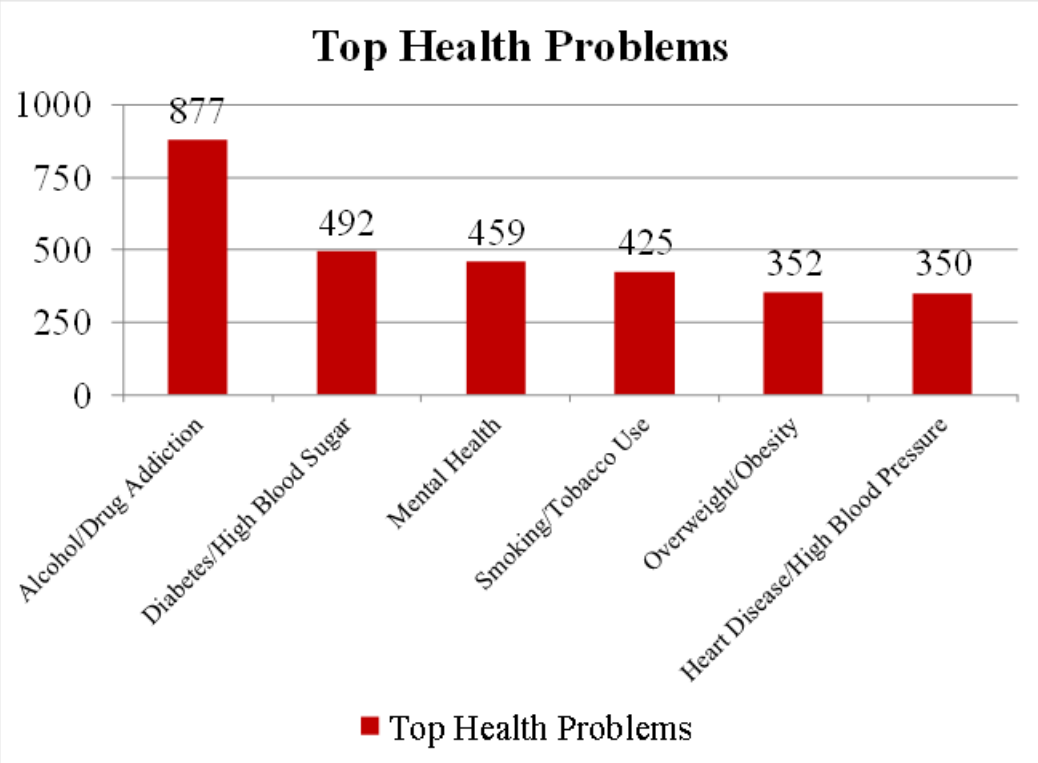
- ❑ Alcohol/Drug Addiction
- ❑ Mental Health
- ❑ Diabetes/High Blood Sugar
- ❑ Overweight/Obesity
- ❑ Heart Disease/High Blood Pressure
- ❑ Smoking/Tobacco Use



(N=4,755)

Chart 1A - UMMC's Community Benefit Service Area Top Health Concerns

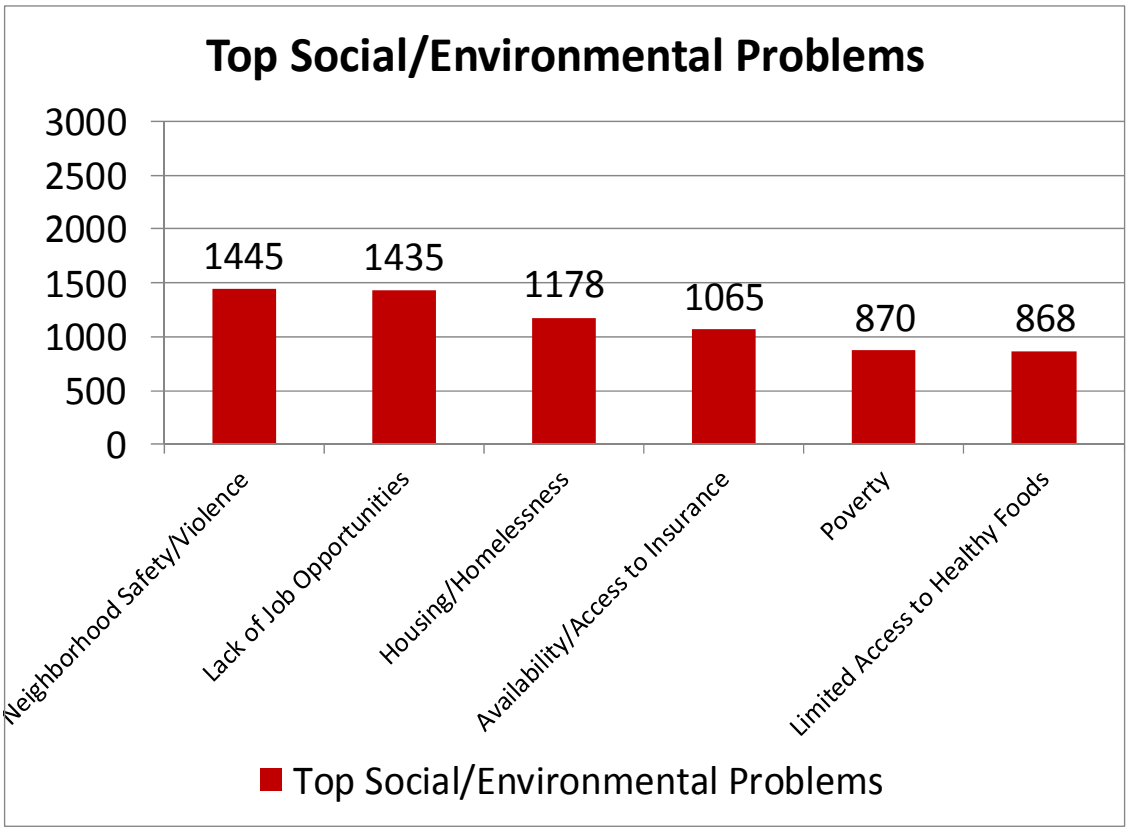
- ❑ Alcohol/Drug Addiction
- ❑ Diabetes/High Blood Sugar
- ❑ Mental Health
- ❑ Smoking/Tobacco Use
- ❑ Overweight/Obesity
- ❑ Heart Disease/High Blood Pressure



N= 1,324 in CBSA

Chart 2 - Community's Top Social/Environmental Issues (All Baltimore City)

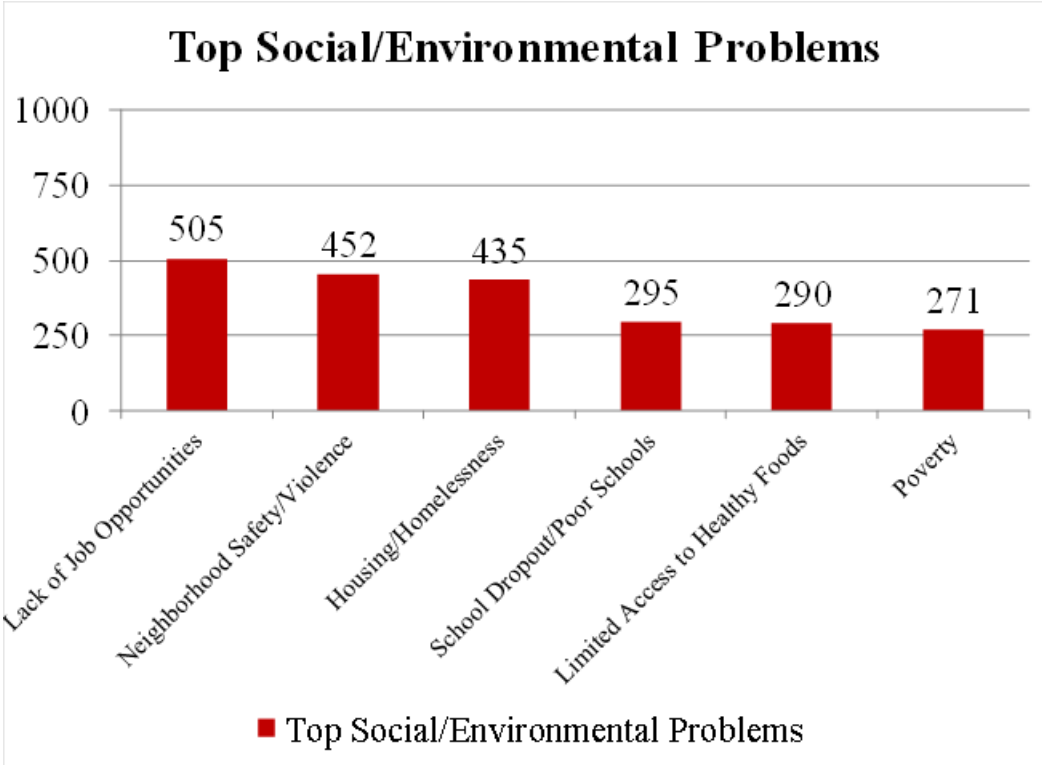
- ❑ Neighborhood Safety/Violence
- ❑ Lack of Job Opportunities
- ❑ Housing/Homelessness
- ❑ Availability/Access to Insurance
- ❑ Poverty
- ❑ Limited Access to Healthy Foods



N= 4,755

Chart 2A - UMMC's Community Benefit Service Area Top Social/Environmental Issues

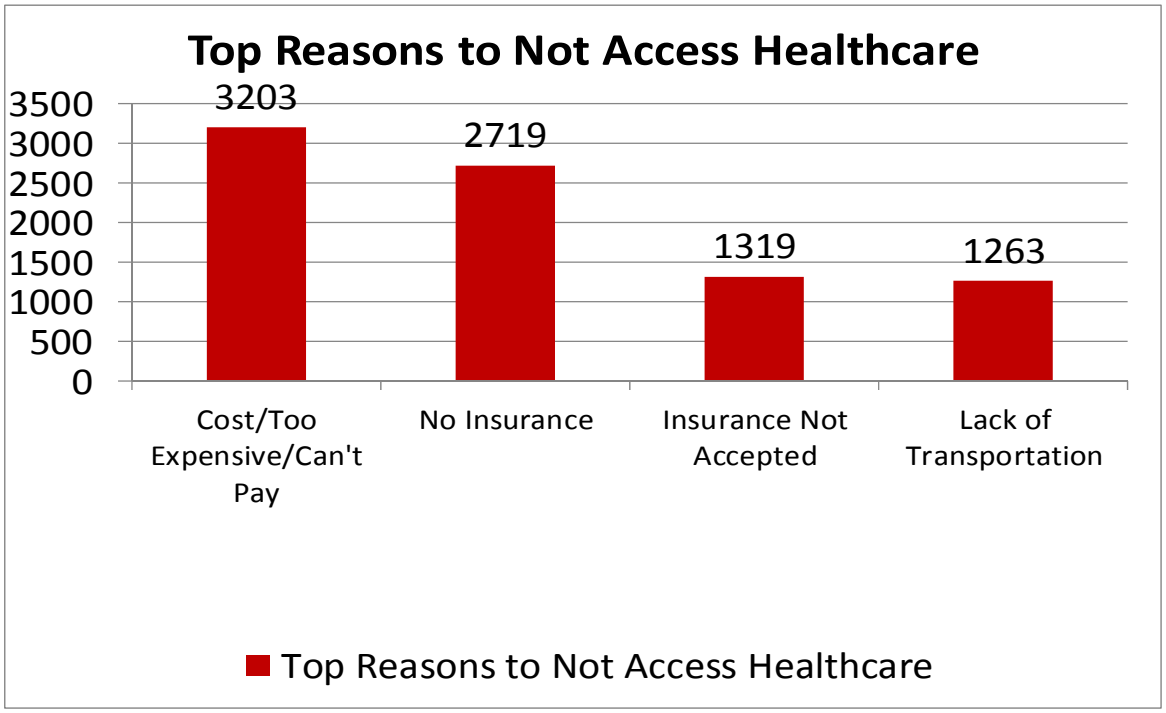
- ❑ **Lack of Job Opportunities**
- ❑ **Neighborhood Safety/Violence**
- ❑ **Housing/Homelessness**
- ❑ **School Dropout/Poor Schools**
- ❑ **Access to Healthy Foods**
- ❑ **Poverty**



N = 1,324 in CBSA

Chart 3 – Community's Top Barriers to Healthcare (All Baltimore City)

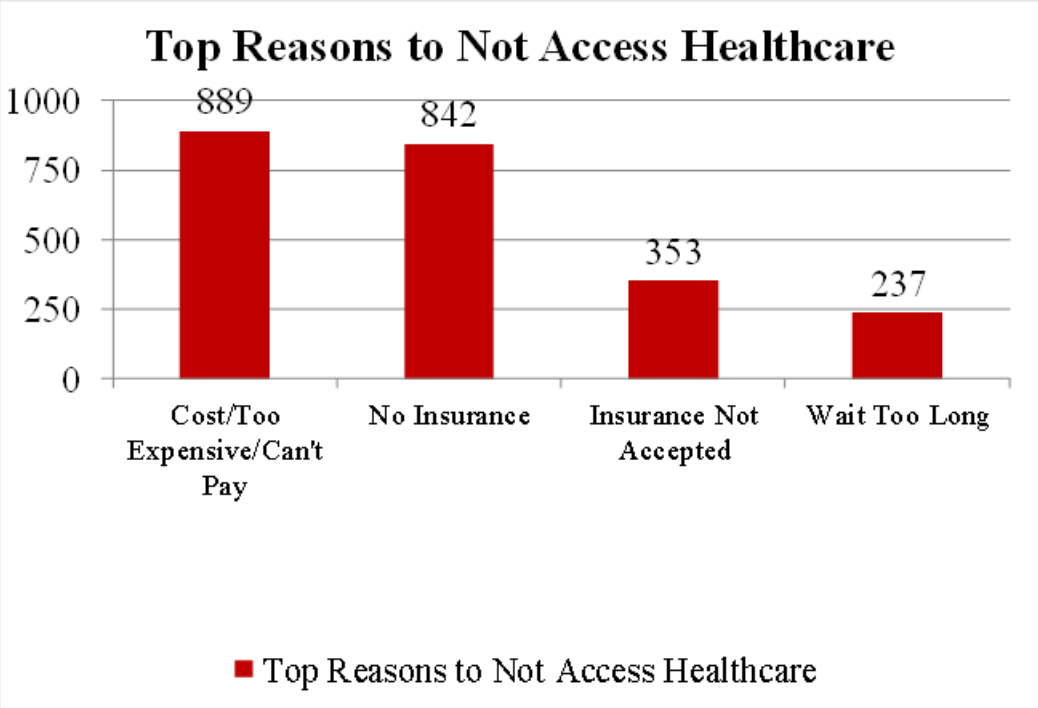
- ❑ Cost/Too Expensive/Can't Afford
- ❑ No Insurance
- ❑ Insurance not Accepted
- ❑ Lack of Transportation



N = 4,755

Chart 3A - UMMC's Community Benefit Service Area Top Barriers to Healthcare

- ❑ Cost/Too Expensive/Can't Afford
- ❑ No Insurance
- ❑ Insurance not Accepted
- ❑ Lack of Transportation



N = 1,324 in CBSA

B) Health Experts

Methods

- Reviewed & included National Prevention Strategy Priorities, Maryland State Health Improvement Plan (SHIP) indicators, and Healthy Baltimore 2020 plan from the Baltimore City Health Department
- Reviewed Healthy Baltimore 2020: A blueprint for health
- Reviewed Baltimore City Health Department's 2017 Community Health Assessment
- Conducted campus-wide stakeholder retreat in January 2018, including University of Maryland Schools of Medicine, Nursing, Social Work and UMB Community Affairs office

Results

- National Prevention Strategy – 7 Priority Areas

- Tobacco Free Living
- Preventing Drug Abuse and Excessive Alcohol Use
- Healthy Eating
- Active Living
- Injury and Violence Free Living
- Reproductive and Sexual Health
- Mental and Emotional Well Being

- SHIP: 39 Objectives in 5 Vision Areas for the State, includes targets for Baltimore City
  - While progress has been made since 2012, measures within Baltimore City have not met identified targets; Even wider minority disparities exist within the City
- Healthy Baltimore 2020: Four Priority Areas for Baltimore City
  1) Strategic Priority 1: Behavioral Health
  2) Strategic Priority 2: Violence Prevention
  3) Strategic Priority 3: Chronic Disease Prevention
  4) Strategic Priority 4: Life Course Approach and Core Services
- Health Expert UMB Campus Panel Focus Group Top Action Items included:
  - ❑ Continue collaborative work from the UMMC/UMB Strategic Community Plan
  - ❑ Improve communication and synergy across campus schools and UMMC
  - ❑ Identify ways to partner and support each other

Figure 4 - Comparison of Federal, State, and Local Health Priorities

National Prevention Strategy: 2011 Priority Areas	Maryland State Health Improvement Plan (SHIP) 2014	Healthy Baltimore 2020
Tobacco Free Living	Healthy Beginnings	Behavioral Health
Preventing Drug Abuse & Excessive Alcohol Use	Healthy Living	Violence Prevention
Healthy Eating	Healthy Communities	Chronic Disease Prevention
Active Living	Access to Healthcare	Life Course Approach & Core Services
Injury & Violence Free Living	Quality Preventive Care	
Reproductive & Sexual Health		
Mental & Emotional Well-Being		

C) Community Leaders

Methods

- Hosted two focus groups in collaboration with the other Baltimore-based hospitals for community-based organization partners to share their perspectives on health needs (November 2017)

Results

- Consensus reached that social determinants of health (and "upstream factors") are key elements that determine health outcomes
- Top needs and barriers were identified as well potential suggestions for improvement and collaboration (See Appendix 4 for details)
- Top Needs:
  - Health Literacy
  - Employment/Poverty
  - Mental/Behavioral Health
  - Cardiovascular Health (obesity, hypertension, stroke, & diabetes)
  - Maternal/Child Health – focusing on promoting a healthy start for all children

- Top Barriers:
  - Focusing on the outcome and not the root of the problems (i.e. SDoH)
  - Lack of inter-agency collaboration/working in silos

- Suggestions for Improvement:
  - Leverage existing resources
  - Increase collaboration
  - Focus on Social Determinants of Health
  - Enhance behavioral health resources

D) Social Determinants of Health (SDoH)

Defined by the World Health Organization as: ….the conditions in which people are born, grow, live, work and age…

Methods

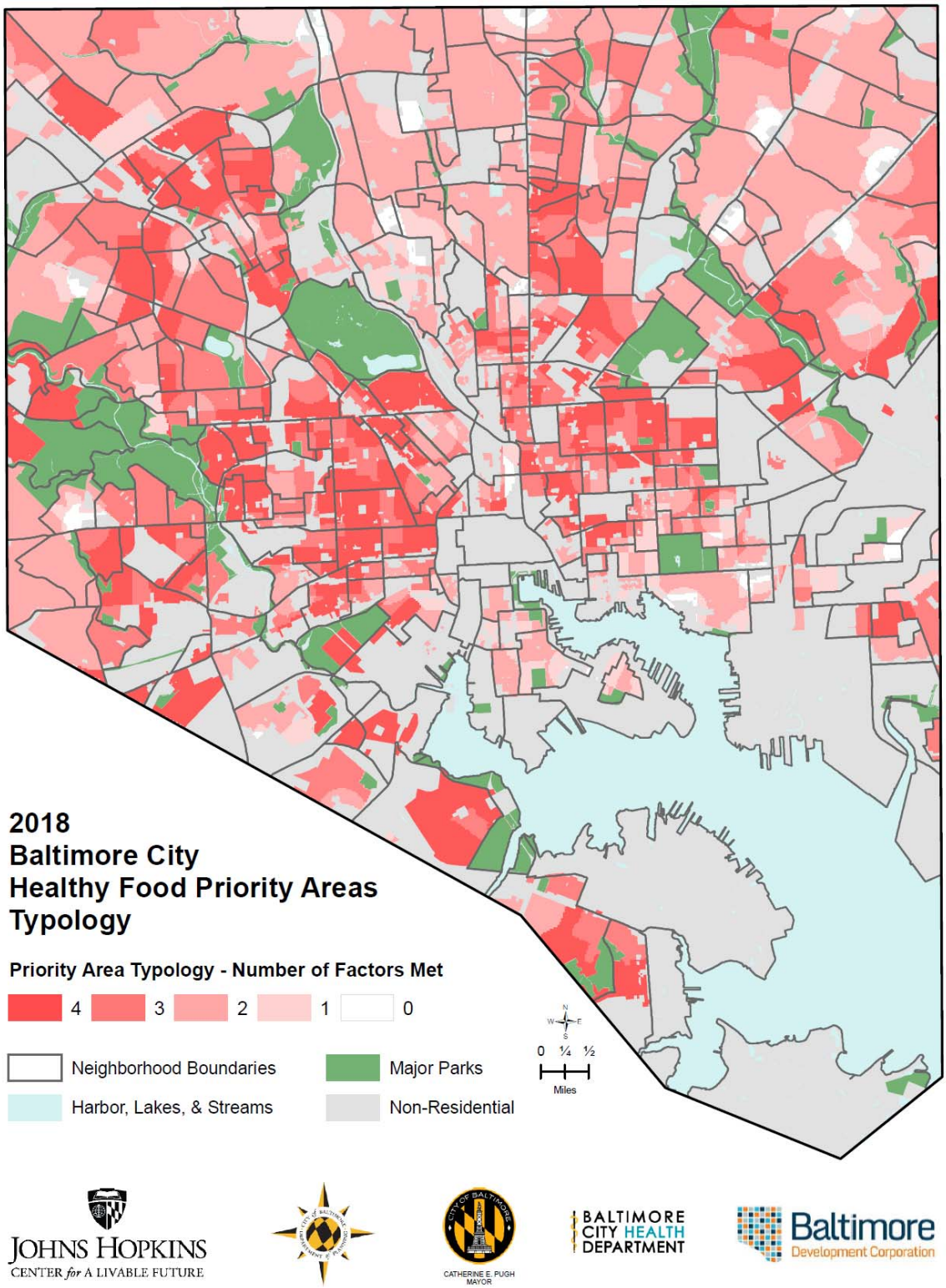
- Reviewed data from Baltimore Neighborhood Indicator Alliance (Demographic data and SDoH data)
- Reviewed data from identified 2011 Baltimore City Health Department's Baltimore City Neighborhood Profiles,
- Reviewed Baltimore City Food Desert Map (See Figure 5)

Results

- Baltimore City Summary of CBSA targeted zip codes (See Appendix 2)
- Top SDoHs:
  - Low Education Attainment (52.6% w/ less than HS degree)

- High Poverty Rate (15.7%)/High Unemployment Rate (11%)
- Violence
- Poor Food Environment (See Figure 5 below)
- Housing Instability

Figure 5 – Baltimore City Food Environment Map



E) Health Statistics/Indicators

Methods

Review annually and for this triennial survey the following:

Local data sources:

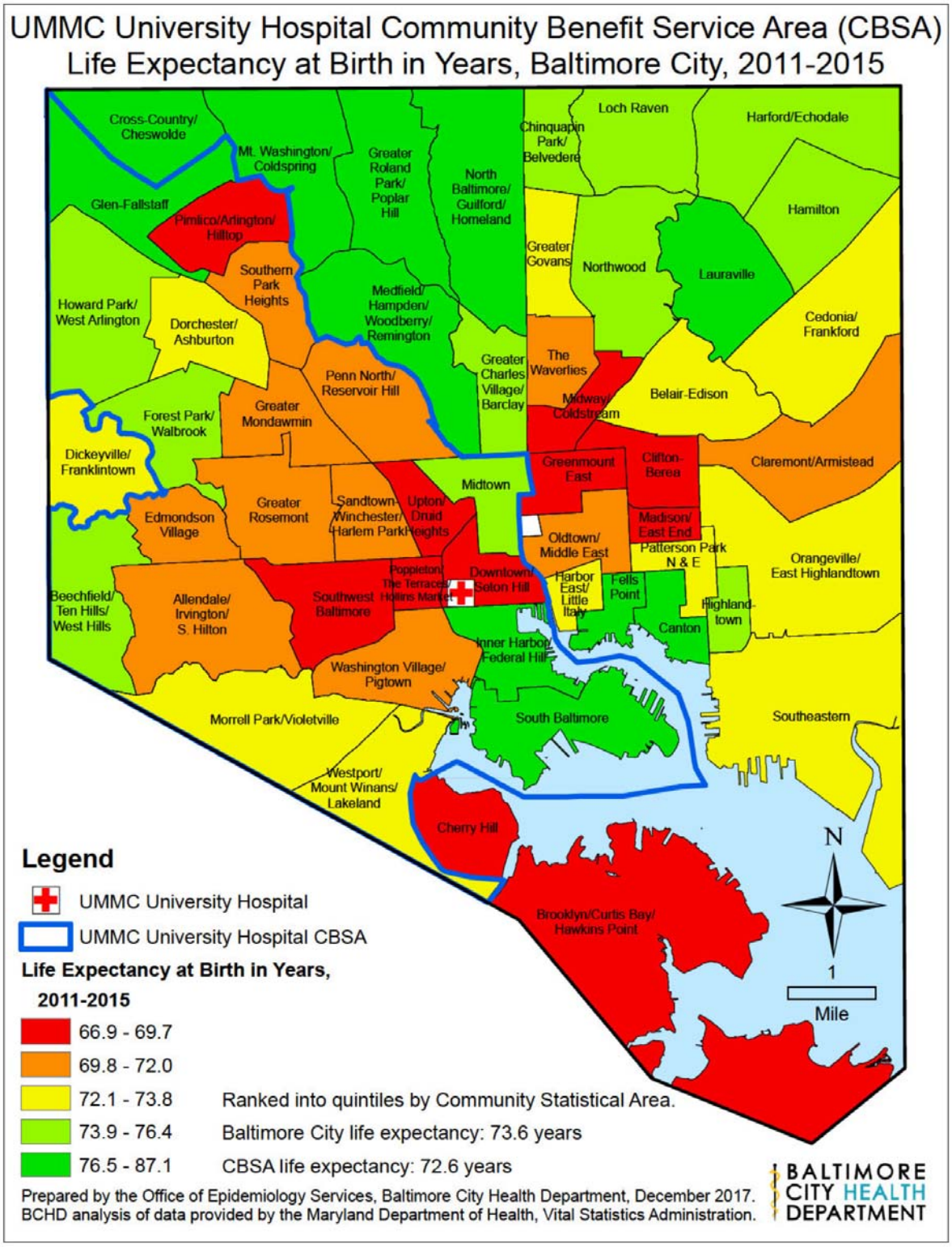
- Baltimore City Health Status Report
- Baltimore Health Disparities Report Card
- Baltimore Neighborhood Health Profiles
- DHMH SHIP Biennial Progress Report 2012-2014

National trends and data:

- Healthy People 2020
- County Health Rankings
- Centers for Disease Control reports/updates

Results

- Baltimore City Health Outcomes Summary for CBSA-targeted zip codes (See Appendix 2)
- Top 3 Causes of Death in Baltimore City in rank order:
  - Heart Disease
  - Cancer
  - Stroke
- Cause of Pediatric Deaths
  - High Rate of Infant Mortality


UMMC University Hospital Community Benefit Service Area (CBSA)
Life Expectancy at Birth in Years, Baltimore City, 2011-2015
Cross-Country/ Cheswolde
Mt. Washington/ Coldspring
Greater Roland Park/ Poplar Hill
North Baltimore/ Guilford/ Homeland
Loch Raven
Chinquapin Park/ Belvedere
Harford/Echodale
Hamilton
Glen-Fallstaff
Pimlico/Arlington/ Hilltop
Southern Park Heights
Medfield/ Hampden/ Woodberry/ Remington
Greater Govans
Northwood
Lauraville
Howard Park/ West Arlington
Dorchester/ Ashburton
Cedonia/ Frankford
Penn North/ Reservoir Hill
Greater Charles Village/ Barclay
The Waverlies
Midway/ Coldstream
Belair-Edison
Forest Park/ Walbrook
Greater Mondawmin
Dickeyville/ Franklintown
Greenmount East
Clifton-Berea
Claremont/Armistead
Midtown
Edmondson Village
Greater Rosemont
Sandtown-Winchester/ Harlem Park
Upton/ Druid Heights
Madison/ East End
Oldtown/ Middle East
Patterson Park N & E
Orangeville/ East Highlandtown
Beechfield/ Ten Hills/ West Hills
Allendale/ Irvington/ S. Hilton
Poppleton/ The Terraces/ Hollins Market
Southwest Baltimore
Downtown/ Seton Hill
Harbor East/ Little Italy
Fells Point
Canton
Highland-town
Inner Harbor/ Federal Hill
Washington Village/ Pigtown
Morrell Park/Violetville
South Baltimore
Southeastern
Westport/ Mount Winans/ Lakeland
Cherry Hill
Brooklyn/Curtis Bay/ Hawkins Point
N
1
Mile
Legend
UMMC University Hospital
UMMC University Hospital CBSA
Life Expectancy at Birth in Years, 2011-2015
66.9 - 69.7
69.8 - 72.0
72.1 - 73.8
73.9 - 76.4
76.5 - 87.1
Ranked into quintiles by Community Statistical Area.
Baltimore City life expectancy: 73.6 years
CBSA life expectancy: 72.6 years
Prepared by the Office of Epidemiology Services, Baltimore City Health Department, December 2017.
BCHD analysis of data provided by the Maryland Department of Health, Vital Statistics Administration.
BALTIMORE CITY HEALTH DEPARTMENT

IV. Selecting Priorities

Analysis of all quantitative and qualitative data described in the above section identified these top five areas of need within Baltimore City. These top priorities represent the intersection of documented unmet community health needs and the organization's key strengths and mission. These priorities were identified and approved by the UMMC/Midtown CHI Team and validated with the health experts from the UMB Campus Panel:

1) Mental Health (in collaboration with City hospitals)
2) Substance Abuse
3) Chronic Disease Management (CVD, Diabetes, HIV)
4) Maternal/Child Health
5) Violence Prevention
6) Workforce Development

V. Documenting and Communicating Results

The completion of this community health needs assessment marks a milestone in community involvement and participation with input from community leaders, the academic community, the general public, UMMS Baltimore City-based hospitals, and health experts. This report will be posted on the UMMC website under the Community Outreach webpage at https://www.umms.org/ummc/community-health. Highlights of this report will also be documented in the Community Benefits Annual Report for FY'18. Reports and data will also be shared with our community partners and community leaders as we work together to make a positive difference in our community by empowering and building healthy communities.

VI. Planning for Action and Monitoring Progress

A) Priorities & Implementation Planning

Based on the above assessment, findings, and priorities, the Community Health Improvement Team has incorporated our identified priorities with the Maryland's State Health Improvement Plan (SHIP) since the first needs assessment in FY'12. Using the SHIP as a framework, the following matrix was created to show the integration of our identified priorities and their alignment with the SHIP's Vision Areas (See Table 1). UMMC will also track the progress with long-term outcome objectives measured through the Maryland's Department of Health & Mental Hygiene (DHMH). Short-term programmatic objectives, including reach and outcome measures will be measured annually by UMMC for each priority areas through the related programming. Adjustments will be made to annual plans as other issues emerge or through our annual program evaluation.

In addition to the identified strategic priorities from the CHNA, UMMC employs the following prioritization framework which is stated in the UMMC Community Outreach Plan. Because the Medical Center, serves the region and state, priorities may need to be adjusted rapidly to address an urgent or emergent need in the community, (i.e. disaster response or infectious disease issue). The CHNA prioritized needs for the

Sustained and Strategic Response Categories and the Rapid and Urgent Response Categories' needs will be determined on an as-needed basis.

UMMC will provide leadership and support within the communities served at variety of response levels. Rapid and Urgent response levels will receive priority over sustained and strategic initiatives as warranted.

- **Rapid Response -** Emergency response to local, national, and international disasters, i.e. civil unrest, weather disasters – earthquake, blizzards, terrorist attack
- **Urgent Response -** Urgent response to episodic community needs, i.e. H1N1/ Flu response
- **Sustained Response -** Ongoing response to long-term community needs, i.e. obesity and tobacco prevention education, health screenings, workforce development
- **Strategic Response -** Long-term strategic leadership at legislative and corporate levels to leverage relationships to promote health-related policy or reform and build key networks

Future Community Health Needs Assessments will be conducted every three years and strategic priorities will be re-evaluated then. Programmatic evaluations will occur on an ongoing basis and annually, and adjustments to programs will be as needed. All community benefits reporting will occur annually to meet state and federal reporting requirements.

B) Unmet Community Needs

Several additional topic areas were identified by the Community Health Improvement Team during the CHNA process including: Behavioral/mental health, safe housing, transportation, and substance abuse. While the Medical Center will focus the majority of our efforts on the identified strategic programs outlined in the table below, we will review the complete set of needs identified in the CHNA for future collaboration and work. These areas, while still important to the health of the community, will be met through either existing clinical programs (i.e. Methadone clinics, Residential Psychiatric program) or through collaboration with other health care organizations as needed. Additionally, substance abuse programming is already integrated into existing programs – Stork's Nest and Violence Prevention programs. The additional unmet needs not addressed by UMMC will also continue to be addressed by key Baltimore City governmental agencies and existing community-based organizations.

The UMMC identified core priorities target the intersection of the identified community needs and the organization's key strengths and mission. The following table summarizes the programs either currently in use or to be developed to address the identified health priorities.

Table 1 - UMMC Strategic Programs and Partners
FYs '19-'21

Maryland SHIP Vision Area	UMMC Priorities	UMMC Strategic Community Programs	UMMC Partners
Healthy Beginnings & Quality Preventive Care	**Maternal/Child Health**	Stork's Nest	March of Dimes, Zeta Phi Beta Sorority, Inc., B'More Healthy Babies
		Breathmobile	Baltimore City Health Dept, Kohl's Cares Foundation, Baltimore City Public Schools
Healthy Communities	**Mental Health**	Mental Health Conference, MH Screenings, MHFA	Mosaic Group, UMMC Dept of Psychiatry, UMMS Hospitals
	Trauma/Violence Prevention	Violence Prevention Program, Bridge Prgm, PHAT, My Future, My Career	Baltimore City Health Dept., Roberta's House, MIEMSS, Baltimore City Police, UMB Campus, Juvenile Services
	Safe Kids	Safe Kids (Helmets, Fire Safety, Car Seats)	Safe Kids, Baltimore City Fire Dept, Maryland Car Seat Safety Program
Quality Preventive Care	**Substance Abuse**	Drug Facts campaign, Provider education on prescribing practices, SBIRT, Naloxone	UMMC Pharmacy Dept, UMMC Opioid Steering Committee, Baltimore City Health Dept., Maryland Poison Control Ctr.
Healthy Living & Quality Preventive Care	**Cardiovascular Disease/ Obesity/Diabetes/HIV**	Farmer's Market, Kids to Farmer's Market, Maryland Healthy Men Program, Mobile Market, BMI screenings, BP Screenings, DPP Program, A1C screenings, Nutrition education, Living Well workshops (HTN, Chronic Disease, Diabetes, & HIV) HIV/HCV Screenings	AHA, ADA, UMB Campus, MAC, CDC, UMMS, Farmers' Market Association, Hungry Harvest, Lexington Market, JACQUES, UMMC Center for Infectious Diseases, various Baltimore City Health Dept and other City agencies
Access to Healthcare & Healthy Communities	**Workforce Development**	Project Search, BACH Fellows, Youthworks, NAHSE, Healthcare Career Alliance, Urban Alliance	Baltimore City Public Schools, Baltimore Healthcare Career Alliance, Center for Urban Families, Dept. of Social Services, Mayor's Office of Employment Development

FY 19-21 Community Health Improvement Implementation Plan – Mental Health

Priority Area: Mental Health

Long Term Goals Supporting Maryland SHIP:

1) **Reduce the Suicide Rate – Balto City (2016) = 8.5/100,000 population; ➢ MD 2017 Goal: 9/100,000 & HP 2020 Goal: 10.2/100,000**
2) **Reduce the Emergency Department Visits related to Mental Health– Balto City = 6,782/100,000 population; ➢ MD 2017 Goal: 3,152.6/100,000**

Annual Objective	Strategy	Target Population	Actions Description	Performance Measures	Resources/Partners
Reduce the suicide rate Reduce the ED visit rate r/t mental health Increase awareness in the community of mental health	Provide education and information to community members on identifying mental health problems using the evidence-based program: **Mental Health First Aid (MHFA)**	<u>Community Training</u> - Faith Leaders, Health Ministry Leaders, Community members (adults & youth) in West Baltimore <u>Staff Training</u> - Healthcare providers & staff	Mental Health First Aid (MHFA) is a course for lay public which assists the public in identifying someone experiencing a mental health or substance use-related crisis. Participants learn risk factors and warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help. Trauma Informed-Care/Specific Interventions – Utilizing evidence-based programs to address specific needs identified in partner schools in West Baltimore. Co-sponsor annual Mental Health Conference annually for the community at large.	<u>Reach:</u> 1) # of MHFA classes 2) # educated with MHFA 3) # of students assisted through programs in partner schools 4) # attending annual mental health conference <u>Outcomes:</u> 1) Participants' self-reported learning from post-test 2) # of referrals to care 3) Participant evaluations of conference	UMMC Department of Psychiatry, Mosaic Services, Faith Based Partners, UMSON (Dr. Lori Edwards)
Increase the number of individuals	Provide mental health screenings in the community with	West Baltimore	Provide free mental health screenings using the PHQ2 (then PHQ9 if +) tool in the community. Provide education and	<u>Reach:</u> 1) # of people screened in the community	UMMC Dept of Psychiatry

referred to appropriate mental health resources	referrals as needed		information about mental health with information on resources.	Outcomes: 1) # of positive screens 2) # of referrals	
Partner with Baltimore City Hospitals on one mental health initiative annually	Year 1 - Implement SBIRT fully in all Emergency Depts	Baltimore City	Review data from Mosaic Group/CRISP to look for: - Health disparities -Ability to share treatment plan across institutions	TBD	Johns Hopkins Hospital, Sinai Hospital, St. Agnes Hospital, Mercy, Medstar, Mosaic Group, CRISP

FY 19-21 Community Health Improvement Implementation Plan – Substance Abuse

Priority Area: Substance Abuse

Long Term Goals Supporting Maryland SHIP:

1) **Reduce the Drug-induced Death Rate – Balto City = 57.4/100,000 population; ➢ MD 2017 Goal: 12.6/100,000 ➢ HP 2020 Goal: 11.3/100,000**

Annual Objective	Strategy	Target Population	Actions Description	Performance Measures	Resources/Partners
Reduce the Drug-induced death rate	Provide education and information to community members on identifying substance abuse issues in the community	Faith Leaders, Health Ministry Leaders, Community members in West Baltimore, Partner Schools, Parent groups	Develop and utilize Drug Facts campaign to educate and inform West Baltimore City residents about identification of substance abuse behavior and community resources	Reach: 5) # of events with Drug Facts info 6) # educated with Drug Facts info Outcomes: 4) # of referrals made to addiction treatment resources	UMMC Department of Psychiatry, UMMC Opioid Stewardship Task Force, UMMC Midtown Center for Addiction Medicine, UMMC Pharmacy Dept.
	Provide education to licensed providers on scope of opioid crisis and appropriate prescribing practices	Licensed, prescribing healthcare providers	Provide free provider education on scope of opioid crisis and relevant prescribing practices utilizing Centers for Disease Control and/or American Hospital Association best practices standards. Work with commercial insurers to reduce Co-pay for Narcan Link SBIRT program to increase referrals	Reach: 1) # of providers educated Outcomes: 1) Pre and post test results of reported knowledge	Above and Community healthcare providers

FY 19-21 Community Health Improvement Implementation Plan - Maternal Child Health

Priority Area: Maternal/Child Health

Objectives Supporting Maryland SHIP:

1) **Reduce the percentage of births that are low birth weight (LBW): Balto City = 11.7% ➢ MD 2017 Goal: 8.0% & HP 2020 Goal: 7.8%**
2) **Increase the proportion of pregnant women starting prenatal care in the 1st trimester: Balto City (2016) = 59.6% ➢ MD 2017 Goal: 66.9% & HP2020 Goal: 77.9%**
3) **Reduce the ED visit rate due to asthma: Balto City (2016) = 224.8/10,000 ➢ MD 2017 Goal: 62.5/10,000**
4) **Reduce the pedestrian injury rate on public roads: - Balto City (2016) = 181.7/100,000 ➢ MD 2017 Goal: 35.6/100,000 & HP2020 Goal: 20.3/100,000**

Annual Objective	Strategy	Target Population	Actions Description	Performance Measures	Resources/Partners
Increase the percentage of babies born >37 weeks gestation Reduce the percentage of births that are low birth weight Increase the percentage of women breastfeeding upon discharge	Provide education and information on healthy pregnancies, breastfeeding, and early infant care through engaging, evidence-based program: **Stork's Nest Community** **Breastfeeding Support Group**	Women in West Baltimore Communities delivering at UMMC	Stork's Nest prenatal education program is a free, points-based incentive program for pregnant women and their partners. Women earn points when they complete prenatal classes and keep prenatal visit appointments. Implement 10 Steps best practices to support successful breastfeeding throughout the continuum of care. Offer community breastfeeding support groups to provide an additional resource postpartum for sustained success.	<u>Reach:</u> 7) # of women enrolled <u>Outcomes:</u> 5) % of babies born> 37 wks gestation 6) % of babies born > 2500 grams 7) % of women initiating breastfeeding	UMMC Department of OB/GYN, UMMC Family Medicine, March of Dimes, Zeta Phi Beta Sorority, Faith Based Partners

Decrease the ED visit rate due to asthma (pediatric) Decrease hospitalizations due to asthma Decrease missed school days due to asthma	Provide primary care and health education through evidence-based program: **Breathmobile**	School-age children in Baltimore City Schools, primarily West Baltimore	The Breathmobile is a free, mobile primary care clinic focusing on pediatric asthma. The Breathmobile visits Batlimore City Schools during the school year providing care, treatment, and health education to children with asthma.	Reach: 2) # of site visits 3) # of individual students seen 4) # of total visits Outcomes: 2) # of ED visits 3) # of Hospitalizations 4) # Missed school days	UMMC Dept of Pediatrics, Baltimore City Public Schools, Baltimore City Health Dept, and Kohl's
Decrease number of fire-related deaths to children under 14 years of age Decrease the pedestrian injury rate on public roads Increase the percentage of correctly installed child safety seats Increase in participants' knowledge and awareness of fire safety, pedestrian safety, and child passenger seat safety	Provide education and information on child passenger safety, fire safety, pedestrian safety, and distracted pedestrian awareness through engaging programs: **Safe Kids**	Pre-school and school-age children and their families in Baltimore City, primarily West Baltimore	Safe Kids strives to reduce unintentional injury to children through free education and training on fire safety, pedestrian safety, and child passenger safety. This program also provides child passenger seat testing and provides smoke detectors and helmets through its programming.	Reach: 1) # of encounters with children and/or families Outcomes: 1) # of Fire-related deaths of children under 14 yrs in Balto City 2) # of Pedestrian injuries 3) Car seat misuse rate identified & corrected at seat check events 4) Increase in knowledge using parent survey questions for child passenger safety events 5) # of car seats distributed to families in need via low cost program	UMMC Dept of Pediatrics, Baltimore City Public Schools, Baltimore City Health Dept., Baltimore City Fire Dept., MDH, MIEMSS Child Passenger Programs

FY 19-21 Community Health Improvement Implementation Plan – Chronic Disease Prevention

Priority Area: Chronic Disease – Cardiovascular Disease/Obesity

Long-Term Goals Supporting Maryland State Health Improvement Plan (SHIP):
1) Increase the proportion of adults who are <u>not</u> overweight or obese: Balto City (2016) : 33.5% ➢ 2017 MD Target: 36.6%; HP 2020 Target:33.9%
2) Reduce the proportion of adolescents (ages 12-19) with obesity: Balto City (2014): 17.1% ➢ 2017 MD Target: 10.7%; HP 2020 Target: 16.1%
3) Age adjusted mortality rate from heart disease: Balto City (2016): 236.3/100,000 age-adjusted 2017 MD Target ➢ 166.3/100,000; HP 2020 Target: 152.7/100,000
4) Reduce emergency department visit rate due to hypertension: Balto City (2014): 658.9/100,000 ➢ 2017 MD Target: 234/100,000

Annual Objective	Strategy	Target Population	Actions Description	Performance Measures	Resources/Partners
Increase the proportion of adults who are at a healthy weight Reduce the proportion of youth who are obese Reduce emergency department visit rate due to hypertension	Provide education & information on the importance of heart healthy lifestyle through engaging, evidence-based programs: **Know Your Numbers, Hypertension Screening & Outreach Program, Living Well with Hypertension, Living Well with Chronic Disease, Maryland Healthy Men, BP Hubs**	Adults & Youth in Priority Targeted Zips	Engage targeted communities on healthy lifestyles through the sponsorship or provision of: - Community-wide education - Store Tours - Cooking Classes/Demos/Tastings - Community Screenings & Referrals (Blood pressure, BMI/Weights, & Cholesterol) - Exercise Demonstrations Provide Living Well with Hypertension class monthly to community members Provide Living Well w/ Chronic Disease Workshop twice/annually Develop resource guide (pdf) to be used on website and for community events Provide info on healthy weight resources at every major outreach event: - Fall Back to Good Health - B'More Healthy Expo	<u>Reach:</u> 1) # of campaigns 2) # of events featuring information 3) # of people attending events 4) # of classes 5) # of people attending classes <u>Outcomes:</u> 1) # of people screened 2) % of referrals for abnormal findings 3) % followed through for follow-up 4) % of participants with normal BPs after referrals/ intervention 6)Self-reported knowledge/ awareness through Pre/Post Participant Survey	Dr. Wallace Johnson, MD, UMMC Nutrition Dept., UMMC/Midtown Nursing, UMB Campus, ADA, AHA, Shopper's Food Warehouse, Buy-Rite, Giant, Hungry Harvest, Planet Fitness, Local Barber/Beauty Shops, Faith Communities, Lexington Market

			- Lexington Market Monthly Health Fair - Mobile Market -All Diabetes-related Events Deploy Blood Pressure Hubs in the community in barber/beauty shops and churches Continue the Maryland Healthy Men hypertension program with 50 men/yr		

Increase the variety of fruits & vegetables to the diets of the population aged 2 yrs and older Increase healthy food access	Through engaging, evidence-based programs, 1) Improve access to variety of fruits & vegetables: **Farmer's Market, UMMC Mobile Market** 2) Promote awareness of healthy ways to prepare fruits & vegetables: **Kids to Farmer's Market, Fruits & Vegetables Prescription Program (pilot), Mobile Market**	Adults & Children	Sponsor UMMC Farmer's Market: - Maintain WIC and SNAP voucher acceptance by vendors - Pilot prescription program promoting consumption of fruits & vegetables purchased at Farmer's Market - Explore additional Farmer's market and food access options for West Baltimore - Provide educational opportunity for local school children to attend Farmer's Market as a field trip - Provide support for local legislation supporting healthy food options and access to fresh fruits and vegetables Mobile Market - Provide access to healthy produce in West Baltimore food deserts by using Mobile Van & Hungry Harvest in West Baltimore sites weekly - Provide educational materials to encourage use and purchasing of fresh produce	<u>Reach:</u> 1) # of Farmer's Markets held 2) # of vendors accepting WIC & SNAP vouchers 3) # of educational materials distributed 4) # of schools and children attending Kids to Farmer's Market Program 5) # of F & V Prescriptions distributed 6) # of Mobile Markets held 7) # of produce bags purchased 8) Track zip codes of Mobile Market recipients and report utilization in benefit service area <u>Outcomes:</u> 1) $ amount spent through WIC/SNAP benefits at FM & zip codes of purchasers 2) # of F & V prescriptions redeemed 3) $ of matching funds for F & V Prescription Program 3) # of children trying a new healthy food item at FM tour 4) Self-reported knowledge in students participating in FM program 5) Self-reported servings of produce/day through survey of Mobile Market	UMB Campus, BCPSS, UM BioPark, MTA, UM Dept of Family Medicine, Hungry Harvest, UM Rehab

Priority Area: Chronic Disease – HIV/HCV Prevention

Long Term Goal Supporting Maryland SHIP:
1) Reduce the incidence of HIV infection: Balto City (2016) = 53.7 /100,0000 ➢ MD 2017 Goal: 26.7/100,000
Goals of the **National HIV and AIDS Strategy (NHAS) and National Viral Hepatitis Strategic Plan**
1. Reduce New HIV/HCV Infections
2. Increase Access to Care and Improving Health Outcomes for People Living with HIV and HCV
3. Reducing HIV-Related Health Disparities
4. Achieve a Coordinated Response to the HIV Epidemic

Annual Objective	Strategy	Target Population	Actions Description	Performance Measures	Resources/Partners
Reduce new HIV/HCV infections	1a. Identify high risk HIV negative individuals and refer to campus-based HIV Prevention (Pre-Exposure Prophylaxis - PreP) programs	Individuals at high risk for HIV per the CDC PreP guidelines[1]	Provide PrEP information and referrals at various community events	Reach: # of community members referred to PrEP clinics	Institute of Human Virology, STAR TRACK Adolescent HIV Clinic, University of Maryland PreP Taskforce, Baltimore City Health Department
	1b. UMMC University and Midtown Campuses will coordinate community outreach activities in collaboration with IHV and the UMB Office of Community Engagement in order to provide HIV and complementary services in areas within the university's strategic area	Adults & Adolescents in targeted West Baltimore Zip codes	Offer free HIV/ HCV education and screenings in churches, seniors centers, and various community sites including use of the UMMC Community Health Mobile Van within various West Baltimore targeted zip codes	# of community members screened for HIV annually # of community members screened for HCV annually	Institute of Human Virology, UMMC and UMMC Midtown CHEC, UMB Office of Community Engagement, DHMH, BCHD
Increase access to care and improve outcomes for people living with HIV and HCV	2a. Identify community members with HIV/HCV who are not engaged in care and refer to CID clinic or JACQUES Linkage to Care Navigators for immediate access to medical and psychosocial services 2b.Offer 1 Cohort of LW w/ HIV class during 1st year and 2 Cohorts during 2nd year	Patients newly diagnosed or not engaged in HIV/HCV care within the last six (6) months	Provide counseling, education, and referral to those identified as HIV-positive or HCV-positive Provide Living Well with HIV Infection classes to the community	Outcomes: # of community members HIV positive referred to treatment/care # of community members HCV positive referred to care	Institute of Human Virology, UMMC and UMMC Midtown, UMB Office of Community Engagement, DHMH, BCHD

[1] Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2014 Clinical Practice Guidelines (2014). Accessible at http://www.cdc.gov/hiv/pdf/prepguidelines2014.pdf

Priority Area: Chronic Disease – Diabetes Prevention **Long-Term Goals Supporting Maryland Health Improvement Plan (SHIP):** **1) Increase the proportion of adults who are <u>not</u> overweight or obese: Balto City (2016) : 33.5% ➢ 2017 MD Target: 36.6%; HP 2020 Target:33.9%** **2) Maryland SHIP #27 – Reduce diabetes-related emergency department visits: Balto City (2014): 548.9/100,000 ➢ 2017 MD Target: 186.3/100,000**					
Annual Objective	**Strategy**	**Target Population**	**Actions Description**	**Process Measures**	**Resources/Partners**
Increase diabetes awareness and healthy lifestyles to prevent and manage diabetes.	Engage the church in a variety of year around activities to improve health of church members living with diabetes and their families.	Adults & Youth in six church communities within the targeted Zip	Offer six educational workshops, then a support group 1x/month for 9 months following the workshop series. Each workshop is 1-1.5 hours Content areas: Diabetes Basics, Fitness, healthy eating, Heart health, Diabetes prevention for children	<u>Reach:</u> 1) # host churches 2) # participants recruited 3) # support groups held 4) # people attending <u>Outcomes:</u> 1) Attrition rate of attendees from seminar 1-6 2) Self-reported learning from Pre& Post/survey 3) #High risk identified and screened for diabetes	ADA, Churches, UMMC, UMSOM, UMSOP
Increase the awareness of diabetes and heart disease.	Empower individuals with T2DM to know their heart disease risk. Encourage people with T2DM to take action to improve health outcomes	Adults, providers, LIP in the community within the target zips	Provide peer to peer provider education Leverage UMMS professional experts to participate in local educational activities for the community (Ask the Expert)	<u>Reach:</u> 1) # educational activities 2) # Participants of seminar 3) # social media hits 4) # website hits 5) # adults with completing the risk tool 6) #Cardiology referral	SOM,UMMC,UMCDE
Reduce diabetes-related emergency department visits by 5%	Educate the community signs and symptoms of diabetes along with prevention and treatment of hypoglycemia and hyperglycemia	Adults & Children	Engage targeted communities on hypo/hyperglycemia: - Participate in diabetes awareness - Advocacy - Community seminars on Diabetes Provide info on diabetes resources at outreach activities.	<u>Reach:</u> 1) # of participants 2) # of materials distributed per event and totals	UMSON, ADA, Bethel AME, Z-HAP, DHMH,UMMC, Faith Based Partners

Increase the proportion of adults who are at a healthy weight Provide three cohorts of DPP/annually	**CDC Diabetes Prevention Program (DPP)**	Adults & Youth in Priority Targeted Zips	Offer the CDC National Diabetes Prevention Program: for people at risk with diabetes 16 week program & a monthly post core follow-up	Reach: 1) #of participants enrolled Outcomes: 1) # of participants that achieve 7% weight loss 2) # of participants that achieve ≥150 minutes of physical activity per week 3) # of participants that complete 16 week program	UMCDE,UMMC, ADA, AHA, JDRF, ST. MARK'S UNITED METHODIST CHURCH,HOPKINS,BCHD, UMMC, CDC
	Educate & engage community on the importance of daily physical activity guidelines using evidence-based research & programs	Adults and Children	Participate in outreach activities and distribute physical activity guidelines and resources with the promotion of activity at every major event: • JDRF WALK • Waxter Center Heart Health Day • Dance Off Diabetes (Adult) • Children's Diabetes Dance • Step Out ADA walk • Annual Emancipation Day 5k Run/Walk	Reach: 1) # of participants 2) # of materials given out on the health benefits of physical activity Outcomes: 1) # of miles/steps/time spent for activity	St. Mark's United Methodist Church, ADA, BCHD, Faith Based parters, UMMC
Increase the variety of fruits & vegetables to the diets of the population aged 2 yrs and older Increase healthy food access	Improve access to variety of fruits & vegetables Promote awareness of healthy ways to prepare fruits & vegetables	Adults & Children	Zeta Healthy Aging Partnership (Z-HAP) Spring series on Fruits & Veggies Matters with the on-site farmers market. The goal of this series is to increase intake of produce of the participants.. Each seminar will identify fruit and vegetables of the season and feature a recipe will be provided. The participants will be challenged to try a new fruit & or vegetable and create a new recipe.	Reach: 1) # of participants per seminar 2) # of lbs of food distributed 3) # of nutrition series held Outcome: 1) % participants that increased fruit consumption 2) % participants that increased vegetable consumption	Z-HAP Zeta Center, UMCDE, Urban Farmers, Gather Baltimore

FY 19-21 Community Health Improvement Implementation Plan – Violence Prevention

Priority Area: Violence Prevention Program

Long Term Goals Supporting Maryland SHIP:
Reduce the domestic violence rate: Baltimore City= 678.5 in 2015 ➢ MD 2017 Goal: 445/100,000; Baltimore City Goal: 610.7/100,000

Long Term Goal Supporting Healthy People 2020:
Reduce homicides: Baltimore City= 55.6 in 2017 ➢ 2021 Target: Decrease by 10%=50.0/100,000 (National Goal 5.5/100,000)
Reduce firearm-related deaths: Maryland= 11.9/100,000 in 2015 ➢ 2021 Target: Decrease by 10%=10.7/100,000 (National Goal 9.3/100,000)
Maintain the low rate of recidivism for VIP participants due to violent injury. (VIP FY17 Performance = ≤ 1.3% ➢ 2021 Target: < 1%)

Annual Objective	Strategy	Target Population	Actions Description	Performance Measures	Resources/Partners
Reduce the rate of recidivism due to violent injury and domestic violence.	Provide education and information through access to evidence-based programs: **Violence Intervention Program (VIP)** and **Bridge Program** Replicate evidence-based	Patients admitted to UM Shock Trauma Center due to violence > 15 yrs. Participants include victims of assault, intimate partner violence, gunshot wounds, and domestic violence related incidents. Patients admitted to UMMC Midtown	**VIP program** provides structured support and education to prevent repeated violence in the community. • Case workers enroll patients of violent injury at the bedside. • Participants are offered weekly support group meetings after discharge. • Participants receive services to help with employment, housing, mental health, substance abuse, and interpersonal skills. **Bridge Program** provides structured support and education to prevent repeated violence in the community. • 24/7 response to victims seeking treatment in the hospital • Safety planning and case management • Individual counseling services and support groups • Court accompaniment and advocacy • Participants receive services to help with employment, housing, mental	Reach: 1) Number of patient encounters 2) Number of participants enrolled 3) Number of participants completing program Outcomes: 1) Re-injury rate (based on the Trauma Registry and state-reported criminal activity) 2) Self-reported re-injury and self-reported criminal activity 3) VIP Survey/ Bridge Survey and Program Evaluation Survey Additional Metrics: 1) Hours spent doing Violence Prevention	School of Nursing School of Social Work Community Engagement Center University Of Maryland Medical Center-Midtown Campus Baltimore City Police Department and several community partners : • Department of Juvenile Services • Department of Parole and Probation • Community organizations Maryland Network Against Domestic

	programs on the UMMC Midtown Campus	due to violence. Participants include victims of assault, intimate partner violence, gunshot wounds, and domestic violence related incidents.	health, substance abuse, safety planning, and interpersonal skills.	Related Activities 2) Number of hires resulting from Turnaround Tuesdays a. Number of hires retained through 6 month probation period	Violence Marriott Inner Harbor at Camden Yards Arden House (Anne Arundel County) Baltimore City Family Crimes
Promote violence prevention and education in youth populations • Provide education to at least 250 youth in the community	Provide education on the importance of violence prevention through five programs: **Promoting Healthy Alternatives for Teens (PHAT)** **My Future My Career (MFMC)** **Healthy Teen Dating Relationships (#DatingGoals)** **Violence Prevention Program-Saving Maryland's At Risk Teens (VPP-SMART)**	Middle and high school students in Baltimore City within two partner high schools.	***Promoting Healthy Alternatives for Teens (PHAT)*** is held at the Shock Trauma Center or an on-site location as a single session workshop designed to expose youth to the consequences associated with poor decision-making, goal setting, and career planning. ***My Future – My Career*** is held at the Shock Trauma Center as a 6 week program, designed to engage youth who are at risk for either becoming victims and/or victimizing others. Students focus on goals for higher education and career opportunities. ***Healthy Teen Dating Relationships (#DatingGoals)*** is held in the classroom setting. This one hour presentation provides an overview of dating violence, its effects, and resources available to victims. It promotes discussion among the students and helps them explore the differences between healthy and unhealthy relationships **Violence Prevention Program-Saving Maryland's At Risk Teens (VPP-SMART)** is a new program in development that will be held at the Shock Trauma Center as a single session workshop. It is designed to	Reach: 1) Number of PHAT, MF-MC, #DatingGoals, VPP-SMART program requests/inquiries 2) Number of PHAT, MF-MC, #DatingGoals, VPP-SMART program presentations 3) Number of PHAT, MF-MC, #DatingGoals, VPP-SMART program attendees 4) Number of Art Against Violence submissions Outcomes: 1) Increase in knowledge using pre and post-tests regarding teen dating violence 2) Identification of a PHAT or MF-MC Champion. A "graduate" of the program willing to come back and share their experience	Baltimore City Public Schools, Promise Heights Community Department of Juvenile Justice Services Teen Court

			expose youth who have been involved in aggressive or violent activity to the consequences associated with their actions. It promotes discussion among the youth as to the reasons they are engaging in violent behavior and alternative ways to solve problems. This is a new venture the combines the use of a credible messenger with the clinical background of a trauma nurse. **Art Against Violence** Annual event in March offered to all Baltimore City school students to open the discussion about youth violence through art.		Memorial Episcopal Church Baltimore City Public Schools
Provide Stop the Bleed education to at least 1,000 individuals in the community	Disseminate information regarding violence prevention at health fairs though **Prevention Matters**	West Baltimore Community City of Baltimore	**Stop the Bleed** is a new program designed to educate the public on how to stop bleeding in a person with trauma. Developed by the American College of Surgeons and the Hartford Consensus, this 2-hour session includes lecture, demonstration, and skills practice. **Prevention Matters** is a monthly public service awareness campaign spearheaded by the Center for Injury Prevention and Policy. Each month, a fact sheet will be developed to inform the community about the prevention topic and it will be accompanied by an article in the Baltimore Times. CIPP will also host a table monthly to highlight the topic of the month in the Weinberg Atrium and at Lexington Market's Health and Wellness Day at the Market	Reach: 1) Number of people attended Outcomes: 1) Number of people certified Reach: 1) Number of hits to the Prevention Matters website, downloads of materials, referrals to UMMC services 2) Number of visitors to the monthly tables	Baltimore Times Lexington Market

References

[1] Maryland State Health Improvement Process website: http://ship.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship12

[2] Calculated from 342 deaths in 2017 (1F)

[3] https://www.healthypeople.gov/2020/data/map/4768?year=2015

FY19-21 Community Health Improvement Implementation Plan – Workforce Development

Priority Area: Workforce Development
Goal Supporting Maryland Health Improvement Plan (SHIP):
1) **To address Maryland's unemployment rate of 9.9% among youth ages 16-24 (16-19: 16.2%) and (20-24: 7.7%)**
2) **To address hiring into three of Maryland's top 10 projected growth occupations (Nursing, Nursing Assistant, and Clerical jobs)**

Annual Objective	Strategy	Target Population	Actions Description	Performance Measures	Resources/Partners
To hire 50 job seekers annually from a diverse populations connected to community partners with work readiness and technical training programs	Focus on entry-level high demand positions and act as a liaison between community partners to pipeline potential candidates	The unemployed and underemployed within West Baltimore Returning Citizens Displaced and/or dislocated adults/and youth	• **Information Sessions (UMB CEC)** ▪ Food Service Opportunities ▪ Environmental Service Opportunities ▪ Safety Observation Tech ▪ Security ▪ **Humanim (Admin. Asst. Prog)** • Prescreen Candidates • Engage in Mock Interviews • Facilitate an Information Session • Have resumes reviewed by recruiters • **ItWorks (PCT Training Program)** • Prescreen Candidates for Training • Present How To Be A Success • Facilitate class on Presenting Yourself on paper in person • Provide Clinical • Have recruiters schedule interviews for graduates • **Surgical Technician Trainee (BACH)** • BACH will vet through ESOL candidates to consider for this program. Participants will be interviewed by Surgical Tech Committee • 2 Candidates will be considered for participation (13 month) Apprenticeship Program • **HSCRC (CHW/PRS)**	<u>Reach:</u> # of people served from West Baltimore <u>Outcomes:</u> # hired from the program	Center for Urban Families Marian House Mayors Office of Employment Development Department of Social Services Helping Up Mission Catholic Charities Sinai Hospital Turn Around Tuesday Southwest Partnership Humanim UMB CEC BUILD BAHEC

			• Candidates who successfully complete their training will be considered for an interview for hire • **SBLC Tour (Biomedical)** o Provide Tours For Adults seeking a high school diploma to expose them to opportunities that are in healthcare upon receipt of a diploma **Referrals from Community Partners**		
To pipeline up to 5 students annually from any of these programs	Partner with local colleges, high schools, and faith leaders to pipeline qualified applicants into the medical center	• Baltimore City Public High School Students • Youth and Young Adults who reside in the West Baltimore targeted zip codes • Local Colleges and University students	• **Edmondson High School** (Clinical Exp.) o Provide High School Seniors majoring in CNA and Surgical Tech programs hands on clinical opportunities to qualify them to take their board exams and pipeline them into our workforce. • **The Connect/Ingoma Foundation** o Receive referral from organization serving displaced	Reach: 1) # of people served from West Baltimore Outcomes: # hired from the program	Baltimore City Public Schools Faith Leaders within the West Baltimore Targeted Zip codes Local colleges and universities within __ radius Edmondson High School Vivien T. Thomas Art Academy
	Leverage strategic partnerships and build a workforce pipeline that leads to career opportunities for the youth of West Baltimore through 7 programs: Project Search, YouthWorks, NAHSE, BACH Fellows,	1)18-21 year old Baltimore City at risk youth 2) Underemployed and unemployed populations 3) Individuals currently receiving	Provide essential skills training, career coaching, internships attend career days, and tours for program participants through 7 key programs: **Project Search** – One-year academic and internship program for Baltimore City high school seniors with disabilities **YouthWorks** – Summer jobs program, sponsored by the Mayor's Office, for Baltimore	Reach: 1) # of students enrolled in programs Outcomes: 1) # hired from the program	National Association of Health Service Executives Project Search (Annie E. Casey Foundation) Baltimore Alliance for Careers in Healthcare Mayor's Office of

	Building Steps, Urban Alliance, Cristo Rey	public assistance	City Youth. The program provides a 6 week internship for youth 14-21 years of age. **NAHSE** – Eight-week internship program for minority undergraduate and graduate students. Interns with an interest in health administration, health information technology, finance, marketing and human services are afforded the opportunity to gain meaningful experience at the hospital. **Building Steps** - Helps minority high school students become science and technology professionals, internships and tours are provided for student to explore their career options **BACH Fellows** – Provides rising high school seniors a six-week, career-building workshop and paid work experience in a hospital setting. **Urban Alliance** – Provide students with internships in professional settings such as law firms, banks, hospitals, financial institutions and non-profit organizations. **Cristo Rey** – Provide high school students with an interest in healthcare the opportunity to learn and grow through entry-level jobs in STC.		Employment Development Ingoma Foundation

2017 Baltimore Health Needs Survey

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

Instructions: You must be 18 years or older to complete this survey. Please answer all questions and return the survey as indicated. For questions about this survey, contact 667-234-2102 or 1-800-492-5538.

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

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

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

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

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

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

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

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

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

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

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

PLEASE TURN OVER FOR NEXT PAGE

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

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

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

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

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

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

10. What ideas or suggestions do you have to improve health in your community? _____
_____
_____
_____ ☐ Don't know ☐ Prefer not to answer

Thank you for completing the survey!

Appendix 2
Social Determinants of Health (SDoH) Summary
UMMC - CHNA FY2018

imore City	Upton/ Druid Hts (21201)	SW Balto (21223)	Mondawmin (21216 & 21217)	Pimlico/ Arlington/ Hilltop (21215)	Allendale/ Edmondson (21229)	Wash Vill./ Morrell Park (21230)	Inner Harbor/ S. Balto (21230)
1,819 ↑	$15,950 ↑	$24,946 ↓	$38,655 ↑	$32,410 ↑	$35,958/36,648 ↑	$48,175/38,210 ↑ ↓	$88,854/88,487 ↑
3.1 ↓	22.3 ↑	20.4 ↑	19.0 ↑	17.1 ↑	20.0/18.4 ↑	16.4/13.1 ↑	5.4/6.0 ↑
8.8 ↑	60.1 ↑	45.9 ↑	28.4 ↑	28.4 ↑	35.1/28.1 ↑	33.6/13.3 ↑	17.0/5.6 ↑
51	82*	76*	62	61	64/54	56/61	16/17
7.6 ↑	74.0 ↑	69.1 ↑	83.6 ↑	80.9 ↑	88.2/87.0 ↑	94.0/80.7 ↑	90.0/90.5 ↑
7.2	60.3	65.6	57.9	66.2	56.9/56.8	41.5/68.5	20.3/22.2
3.8 ↑	3.9 ↓	8.9 ↓	3.2 ↓	1.7 ↓	4.3/1.3 ↓ →	3.6/2.2 ↓	4.7/3.1 →

Community Social Environment	Balto City	Upton/ Druid Hts	SW Balto	Mondawmin	Pimlico/ Arlington/ Hilltop	Allendale/ Edmondson	Wash Vill./ Morrell Park	Inner Harbor/ S. Balto
Homicide Rate – all ages (#of homicides/10,000)	3.9 ↓	7.7 ↓	8.2 ↓	7.3 ↓	7.4 ↓	5.3/4.8 ↓	5.5/1.1 ↓	1.2/0.0 ↓ →
Youth Homicide-under 25 (# of homicides/ 100,000)	31.3	61.0	52.9	46.7	56.8	38.5/29.1	33.7/15.5	6.8/0.0
Housing								
Vacant Building Density (#of buildings/10,000 housing units)	562.4 ↓	1,136.1 ↓	2,477.9 ↑	1,039.8 ↑	1,097.3 ↑	469.6/276.4 ↑	618.6/184.4 ↓	36.2/43.6 ↓
Demographics								
No health insurance 18 and older	11.7	11.7	18.5	12.2	13.7	11.2/16.6	11.0/14.8	4.9/7.3
Food Environment (# of/10,000 people)								
Fast Food Density	2.5 ↑	2.9 ↑	2.8 ↑	4.3 ↓	0.8 ↑	1.2/0 →	5.5/5.5 ↑	5.5/7.8 ↑
Carryout Density	11.4 ↓	16.4 →	17.3 ↓	12.9 ↑	14.4 ↓	5.6/1.3 ↓ →	27.3/13.2 ↑	22.6/9.4 ↑ →
Corner Store Density	14.1 ↑	23.2 ↑	35.2 ↑	15.0 ↑	18.6 ↑	11.7/8.8 ↑ ↓	38.2/12.1 ↑	6.2/7.8 ↑
Supermarket Proximity* (by Car in min.)	3.7	1	2	3	2	3/.69	8/5	4/1
Supermarket Proximity* (by Bus in min.)	12.3	1	8	11	8	8/29	22/11	11/3

Supermarket Proximity* (by Walking in min.)	16.6	1	9	12	9	15/43	26/22	18/8
Health Food Availability Index (HFAI) 0-25	10.3							

Source: Baltimore City Health Department (2017). 2017 Neighborhood Health Profile Report. [Neighborhood Health Profile Reports | Baltimore City Health Department]

Legend:
↑- Increase in prevalence compared to 2015 data
↓ - Decrease in prevalence compared to 2015 data
→ - No change in prevalence compared to 2015 data
If data was not marked, then comparative data was not available in 2015 profile data

*Upton/Druid Heights – 2nd worst Hardship Rating in the City
*Sandtown – 4th worst Hardship Rating in the City
*SW Baltimore – 5th worst Hardship Rating in the City

Appendix 3
Health Outcomes Summary
UMMC CHNA FY2018

Health Outcomes	Baltimore City	Upton/ Druid Hts (21201)	SW Balto (21223)	Mondawmin (21216 & 21217)	Pimlico/ Arlington/ (21215)	Allendale/ Edmondson (21229)	Wash Vill./ Morrell Park (21230)	I. Harbor/ S. Balto (21230)
Life Expectancy at Birth (in years)	73.6 ↓	68.2 ↑	68.0 ↑	70.4 ↑	68.2 ↑	70.9/71.8 ↑	70.1/73.6 ↑	79.2/76.7 ↑
Causes of Death (% of Total Deaths)								
1 – Heart Disease	24.4 ↓	28.1 ↑	21.2 ↓	23.0 ↓	23.9 ↓	24.8/23.9 ↓	25.6/21.6 ↓	24.9/21.3 →
2 – Cancer	21.3 ↑	18.9 ↑	19.8 ↓	20.1 ↑	19.5 ↑	20.4/21.9 ↑ ↓	15.3/18.6 ↓	26.1/20.9 ↑ ↓
Lung	5.9 ↓	5.7 ↑	5.9 ↓	6.3 ↑	5.5 →	5.9/7.3 ↓ ↑	3.8/5.5 ↓	8.2/5.2 ↑ ↓
Colon	2.0 ↓	1.0 ↓	1.7 ↑	1.7 ↓	1.9 ↓	1.2/2.4 ↓	1.5/1.1 ↓	2.2/3.3 ↑
Breast	1.5 ↓	0.3 ↓	0.9 ↓	1.5 ↓	1.4 ↓	1.1/1.1 ↓	1.9/0.8 ↑ ↓	2.9/1.9 ↑ ↓
Prostate	1.1 ↓	1.3 ↓	1.2 ↓	0.9 ↓	1.3 ↓	1.7/1.1 ↓	0.0/0.2 →	1.2/0.5 ↓
3 – Stroke	4.9 ↑	3.1 ↓	5.8 ↑	6.5 ↓	4.4 ↓	5.1/7.1 ↓ ↑	2.7/5.2 ↓ ↑	4.3/5.2 ↑
4 – HIV/AIDS	1.8 ↓	2.8 ↓	2.9 ↓	3.9 ↑	2.3 ↓	1.7/2.2 ↓	4.6/1.4 ↑ ↓	0.2/0.0 ↓
5 – Chronic Lower Respiratory Disease	3.5 →	3.6 ↑	3.7 ↑	3.0 ↑	4.0 ↑	3.7/3.9 ↑	5.7/7.4 ↑ →	3.9/5.7 ↓
6 - Homicide	3.5 ↑	5.6 ↑	4.5 ↑	5.3 ↑	5.3 ↑	5.3/3.9 ↑	4.2/0.8 ↑	1.4/0.0 ↑ →
7 – Diabetes	3.0 ↓	3.3 ↓	3.3 →	3.6 ↑	5.2 ↑	3.3/3.2 ↑	2.3/2.5 ↓ ↑	2.7/1.4 ↓
8 – Septicemia	2.7 ↓	1.8 ↓	2.4 ↓	2.6 ↓	2.0 ↓	1.8/2.8 ↓ ↑	1.5/2.9 ↓ →	2.9/0.9 ↓
9 – Drug Induced Death	4.5 ↑	5.7 ↑	7.1 ↑	4.1 ↑	3.5 ↑	4.0/2.2 ↑	8.4/4.3 ↑	3.9/5.2 ↑

10 - Injury	3.5 ↑	2.8 ↑	4.3 ↑	2.6 ↑	3.7 ↑	3.0/2.8 ↓ ↑	5.3/3.8 ↑	5.1/1.9 ↑
Maternal & Child Health								
Infant Mortality Rate (per 1,000 live births)	10.4 ↑	10.0 ↓	13.9 ↑	5.2 ↓	20.0 ↑	10.6/9.8 ↓	4.6/8.2 ↓ ↑	3.3/1.5 ↓
Low Birthweight % (LBW < 5 lbs, 8 oz)	11.5 ↓	13.5 ↓	12.4 ↓	12.6 ↓	15.6 ↑	14.0/13.8 ↓	11.1/7.1 ↓	6.8/6.2 ↑
%Prenatal Care 1st Tri.	54.7 ↓	48.9 ↓	45.9 ↓	51.9 ↓	47.8 ↓	50.7/54.1 ↓	57.4/58.9 ↓	71.8/73.5 →
% Births to Mothers Who Smoke	10.7 ↑	15.9 ↑	18.9 ↑	12.1 ↑	12.7 ↑	10.9/9.9 ↑	13.4/23.1 ↓ ↑	3.7/6.6 ↑

Source: Baltimore City Health Department (2017). 2017 Neighborhood Health Profile Report. [Neighborhood Health Profile Reports | Baltimore City Health Department]

Legend:
↑- Increase in prevalence compared to 2015 data
↓ - Decrease in prevalence compared to 2015 data
→ - No change in prevalence compared to 2015 data
If data was not marked, then comparative data was not available in 2015 profile data

Appendix 4
Community Partner Focus Groups

Baltimore City-wide CHNA 2017
Focus Group: Key Community Stakeholders
Date/Time: 11/10/17, 1:30pm and 11/15/17, 11am
Location/Host: Mercy Medical Center and Forest Park Senior Center
# of attendees: 16 and 7
Attendee Profile: Attendees were invited by members of the city-wide CHNA Project Team, and represented a variety of organizations throughout the city. They were chosen for their knowledge of specific communities, focus areas or disease states that were important for getting a full picture of community needs. See list of attendees at end of document.
Facilitators: Lane Levine, Sinai Hospital, and Anne Williams, University of Maryland Medical System

Identified Priority Health Concerns
Alcohol and drug addiction
Mental Health
Chronic disease (generally)

Identified Priority Environmental Concerns
Safety, violence and trauma
Older adults*
Housing

Identified Priority Health Care Access Problems
Accessibility/availability of medical services and facilities in neighborhoods
Health literacy
Caregiver needs

*The meetings attracted a high proportion of people in aging services fields – however, people not strictly in these fields also touched heavily on problems concerning older adults.

Notes:
Health Concerns

- **Alcohol and drug addiction (top item)**
  - Drug addiction affects all ages (even babies) and tends to impact physical health, mental health and lead to stroke, heart disease, cancer, and Alzheimer's disease.
  - Lack of employment leads to substance abuse.
- **Mental Health (top item)**
  - Mental health is often not talked about and is rarely ever seen as a health problem.
  - Mental health issues are on the rise and there is a lack of adequate health care to address the problem; more resources and providers are necessary.
  - It permeates all ages and it is often difficult for people to manage the symptoms of their illness and becomes a barrier to living a healthy life.

- Depression and anxiety are two major issues and it was noted that the two mental illnesses can arise from being exposed to violence and being immobile. Outcomes include isolation and loneliness, which can lead to alcohol and drug addiction.
- People are often unreceptive to references to mental health that include words they are not familiar with: “trauma is not the word they use”.

- **Chronic Diseases (top item)**
  - Obesity: Stems from poor diet, sedentary lifestyles (often due to inability to exercise), and genetic predispositions.
  - Diabetes: There is a very high rate of diabetes across the board
  - COPD: Becoming increasingly prevalent in older adults
  - Heart disease, high blood pressure, and cancer: leading cause of death for most adults
- Pregnancy complications
  - Infant mortality is a huge issue: “If we allow babies to die, then we’re not taking care of the health of the community as a whole”
  - Preterm birth is often overlooked. Although there has been a lot of progress, it is still an issue that drives a lot of costs.
  - Women with high blood pressure or drug/alcohol addiction can contribute to preterm birth
- Mental health problems can prevent mothers from receiving care.
- Tobacco use
  - “HIV/AIDS gets more attention in LGBT population, but cigarettes and tobacco will kill 6x more people that HIV/AIDS will in one year”
- Inaccessible spaces for those with disabilities
- Alzheimer’s and Dementia
  - People generally feel helpless and it impacts caregivers
- ADHD/Autism
- Lack of oral hygiene
- Hearing impairment
- HIV/Aids
- Asthma

Social/Environmental Factors

- **Safety, violence and trauma (top item)**
  -Murder rate is rising
  Effects on youth:
    - Violence is a leading cause of death for Baltimore kids
    - Children encounter violence before they even encounter school
    - Teen violence is on the rise
    - Abused and neglected kids
    - Violence has a lifelong effect on their long-term outcomes

  Effects on the community:
    - Even if housing is available and accessible, community violence can prevent people from moving into the community.
    - Healthy food initiatives in conjunction with corner stores are jeopardized if safety to and from the stores is an issue.

Community Building
    - Conflict resolution training is critical
    - "Community members need to be empowered to feel like they can work through issues instead of hurting or violating others to get what they want."

- **Older adults (top item)**
  - Abuse of older adults is increasing
  - Housing is a major problem that older adults face. Not only is cost a problem, but infrastructure that ensures safety is a problem too (i.e. lack of sturdy railings).
  - There is not enough access to resources in general for older adults.
  - Isolation, their inability to manage daily living, and basic gaps (such as lack of hearing aids to use phones to get help) are also major issues.

- **Housing (top item)**
  - Homelessness and children
    - Children are affected because of lack of stable meals and switching schools, which manifests in poor education outcomes.
    - Mental health deteriorates because living with multiple different people: "don't have own space, can't get homework done, can't sleep because there are 6 people in their room"
    - They cannot establish a community because they are always moving.
  - Accessibility and affordability
    - There is a need for more affordable housing with less discrimination against disabilities.
    - "Home based setting vs institutional housing for people with developmental disabilities leads to improved outcomes"
  - Quality Issues
    - Lead paint poisoning is a major problem: "had some homes where builders start stripping it and it goes to other homes affecting neighbors"
    - Safe infrastructure
    - Rat and roach infestation is a hindrance to health: "Roaches bring asthma, rats bring depression, lead brings depression"
    - 1/3 of house are vacant or boarded up – attracts rodents and illegal activities
    - Mold

- Law enforcement
  - Drug dealers are ignored by police
  - Over policing is meant to reduce violence, but it does the exact opposite. It creates a strong divide: police vs. community
  - "Police used to live in communities they serve and knew people there; now they are assigned to a block and know no one there"
- Green space
  - Green space is necessary for health, mental and physical.
  - "Patterson park ensues violence at a certain time at night. A beautiful space tainted by sex trafficking."

- Parental guidance
  - Parent stress levels are high because they do not know how to address certain issues that arise with their children
- Lack of crisis intervention

- Employment
  - Frequent lack of opportunities and benefits (days off for medical care and lack of or ever-changing health insurance)
  - A sense of autonomy and self-determination is critical to health
  - Income: “Working 3 jobs to be able to afford the necessities”
- Education: lack of services in schools and resources
  - There is a lack of services and resources: “are they getting appropriate education?”
  - There is also a lack of leadership in Baltimore City Schools
  - Schools are underfunded: “the community cannot be supported by the schools we have”
- Food
  - Food deserts and lack of healthy food
- Institutionalized racism
  - Redlining
  - Lack of ability to accumulate wealth, have sustained environments, poverty
  - Inequities we see are a direct result of racism in the US
  - We can address the symptoms but need to get to the underlying cause
  - Hospitals can have a role in addressing it, but many initiatives get started in the Baltimore area but are not sustained

Access to Health Care:

- **Medical care accessibility (top item)**
  - “Just having health presence in the community reduces crime rate “
  - There needs to be not just access, but quality access.
- Cost
    - The cost of health care is one of the main issues.
    - “If it continues to rise at the same rate, then the amount of funds available for community health programs will not be sufficient”.
- Transportation
    - Getting to locations for care is difficult, especially for older adults
- Physicians
    - Availability of physicians in the community is an issue.
    - There are also language and communication barriers: “Could be we’re all speaking the same language, but things are not being explained in a way that’s understandable”
    - Continuity of care is usually an issue because there is not a doctor or health system nearby. In addition, there is a lack of care management. Information is dispersed, but follow ups are rare.
    - There is a need for a smoother transition between pediatric and adult services.

- Health literacy
  - "Health insurance literacy – people do not understand how to navigate their insurance, how to use it to address their needs"
  - Unfamiliar terminology prohibits understanding
- Pharmacy deserts and unaffordable prescriptions
- Caregiver resources
  - Caregivers are often stressed because of the lack of resources they have, which effects patient care.
- Dental Care and Vision
  - Although important, dental care and vision are rarely a priority.

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Appendix 5
Priority Setting Strategy/Process

Priorities were voted on by all members of the UMMC Community Health Improvement Team using Poll Everywhere with the following questions:

1) What are the top three health problems in rank order that we need to address in Baltimore?
2) What are the top three social/environmental issues in rank order that we need to address in Baltimore?

Team members were asked to consider the following criteria when voting:

- Problem is greater in the City compared to the State or region
- Impact on vulnerable populations is significant
- Cost to the community can be achieved by addressing this problem/aligned with population health
- Major improvements in the quality of life can be made by addressing this problem
- Issue can be addressed with existing leadership and resources
- Progress can be made on this issue in the short term

Appendix 6
Community Health Improvement Team

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Appendix 7
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