Community Health Needs Assessment

2019 FINAL SUMMARY REPORT

SUBMITTED BY

HOLLERAN

COMMUNITY ENGAGEMENT RESEARCH & CONSULTING

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

Background

Greater Baltimore Medical Center (GBMC) undertook a comprehensive Community Health Needs Assessment (CHNA) to evaluate the health needs of individuals living in the hospital service area within Baltimore County in Maryland. The aim of the assessment is to reinforce GBMC's commitment to the health of residents and align its health prevention efforts with the community's greatest needs. The assessment examined a variety of health indicators including chronic health conditions, access to health care and social determinants of health. GBMC completed their last CHNA in June 2016.

Beginning in September 2017, GBMC started work to complete their 2019 CHNA by refreshing their secondary data and talking to key informants and their partners to glean community perspective on the health needs of individuals living in the community. From the 2016 CHNA, three priority areas were chosen including (1) Behavioral Health/Substance Abuse, (2) Access to Care, and (3) Obesity. Since the 2016 assessment, GBMC has held a series of community meetings to engage their partners in discussion of the needs within each priority area, as well as how to address and improve those issues within the community. GBMC contracted with Holleran Consulting (Holleran), a research firm based in Wrightsville, Pennsylvania, to execute their 2019 CHNA and Community Action Planning Sessions.

The first of the meetings occurred in September 2017. During this meeting, attendees were broken into three groups – one for each priority area. The groups discussed current resources in the community, what is missing, and suggestions to improve the priority area in the community. Several needs were identified, as well as ideas to help address these needs. GBMC then brought partners back together for a Community Action Planning Session in May 2018. Priority area groups worked together to translate the conversation and ideas generated in the September meeting into action. Therefore, each priority area group was charged with identifying three focus areas and action plans to address each focus area. Leaders for each priority area group were assigned and charged with convening their groups to work through their action plans over the next several months. To understand how each priority area group is doing and re-engage partners in a discussion around needs still existing in the community, GBMC again reunited their partners for a Community Action Planning Update meeting. This meeting gleaned additional insights from key informants/partners who have a broad understanding of community needs.

Based on the insights received over the last three years, GBMC decided to continue their work for the 2019-2021 CHNA. The completion of the 2019 CHNA enabled GBMC to take an in-depth look at its community through the lens of the most recent secondary data finding and by convening local community health experts based on their 2016 prioritized needs. The findings from the assessment will be utilized by GBMC to continue work on their community's key health issues and remain focused on their robust community health implementation plan. GBMC is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. This CHNA Final Summary Report serves as a compilation of the overall findings of each research component.

CHNA Components

- Secondary Data Research
- Community Perspective
    - Key Informant Action Planning Session

Previous CHNA and Prioritized Health Issues

Greater Baltimore Medical Center (GBMC) conducted a comprehensive CHNA in 2016 to evaluate the health needs of individuals living in the hospital service area within Baltimore County in Maryland. The purpose of the assessment was to gather information about local health needs and health behaviors. The assessment helped GBMC to identify health issues and develop a community health implementation plan to improve the health of the surrounding community. The prioritized health issues included:

- Behavioral Health/Substance Abuse
- Access to Care
- Obesity

2019 Prioritized Community Health Issues

Based on feedback from community partners, including health care providers, public health experts, health and human service agencies, and other community representatives, Greater Baltimore Medical Center (GBMC) plans to remain focused on the community health improvement efforts on the following health priorities over the next three-year cycle:

- Behavioral Health/Substance Abuse
- Access to Care
- Obesity

Major outcomes from the priority areas were defined at the Community Action Planning Update Meeting on October 26, 2018, and are included in Appendix G.

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Organization Overview

Greater Baltimore Medical Center (GBMC) is a non-profit health care organization, licensed and accredited by Joint Commission on Accreditation for Health Care Organizations (JCAHO). The 342-bed (acute and sub-acute care) medical center's main campus is located in Towson, Maryland. GBMC handles more than 23,000 admissions and approximately 52,000 emergency room visits annually.

The mission of GBMC is to provide medical care and service of the highest quality to each patient leading to health, healing, and hope. Since its founding in 1965, GBMC's accomplishments have validated the vision of its founders to combine the best of community and university-level medicine. Additionally, GBMC's Community Needs Advisory Committee strives to improve the health of the local community by focusing on outreach, education, and clinical services, as well as building partnerships with local organizations, businesses, and individuals, to promote good health and disease prevention.

GBMC employs approximately 3,900 individuals in clinical and non-clinical areas including 1,100 Medical Center nurses and more than 120 Hospice nurses. GBMC is one of the largest private sector organization employers in Baltimore County. The nearly 1,110 physicians that serve on GBMC's medical staff make it among the largest of any community hospital in the Mid-Atlantic region. More than 300 of its physicians are employed through GBMC Health Partners, a group of physician practices owned by GBMC. GBMC Health Partners features a diverse collection of practices including primary care providers, specialists, advanced practice clinicians and hundreds of support staff.

In addition to GBMC Health Partners, GBMC also owns and operates Gilchrist Hospice Care, a nationally recognized, nonprofit leader in serious illness and end-of-life care in central Maryland. Founded in 1987, the GBMC Foundation is a nonprofit organization established to centralize and coordinate fundraising efforts to benefit the organization. GBMC has been recognized for excellence on national, regional and local levels.

"*To every patient, every time, we will provide the care that we would want for our own loved ones.*"

Mission: The mission of GBMC is to provide medical care and service of the highest quality to each patient leading to health, healing and hope.

Vision: As our national healthcare system evolves, for GBMC to maintain its status as a provider of the highest quality medical care to our community, we must transform our philosophy and organizational structure, to develop a model system for delivering patient-centered care.

Community Overview

Greater Baltimore Medical Center (GBMC) defined its current service area based on an analysis of the geographic area where individuals utilizing its services reside. GBMC's primary service area is considered Baltimore County, Maryland. Baltimore County is the third most populous of the 24 counties including Baltimore City, with an estimated population of 825,666. Additional demographics are summarized in throughout this report.

Methodology

The CHNA was comprised of both quantitative and qualitative research components. A brief synopsis of the research components is included below with further details provided throughout the document:

- A Statistical Secondary Data Profile uses existing local-level data with state and national comparisons of demographic and health data also known as "secondary data." The specific data sources depicting population and household statistics, education and economic measures, morbidity and mortality rates, incidence rates, and other health statistics for the GBMC service area, or Baltimore County, were compiled and compared to state and national level data, where applicable.

- Community Perspective – Action Planning Sessions were conducted in 2017 and 2018 with key stakeholders representing diverse interests in the community. From the 2016 CHNA, three priority areas were chosen including (1) Behavioral Health/Substance Abuse, (2) Access to Care, and (3) Obesity. GBMC held a series of community meetings to engage their partners in discussion of the needs within each priority area, as well as how to address and improve those issues within the community.

Research Partner

Greater Baltimore Medical Center (GBMC) contracted with Holleran, an independent research and consulting firm located in Wrightsville, Pennsylvania, to conduct research in support of the CHNA. Holleran has over 25 years of experience in conducting public health research and community health assessments. The firm provided the following assistance:

- Collected and interpreted data from secondary data sources
- Collected, analyzed and interpreted data from community perspectives
- Prepared all reports including Final Summary Report
- Assisting GBMC with Community Meetings and Action Planning Sessions
- Reporting assessments to community at Action Planning Sessions

Community Representation

Community stakeholders and partner engagement and feedback were an integral part of the CHNA process. Greater Baltimore Medical Center (GBMC) sought community input through inclusion of community leaders and partners in the prioritization and implementation planning process as well as in follow up community meetings over the past two years. Public health and health care professionals shared knowledge and expertise about health issues, and leaders and representatives of non-profit and community-based organizations provided insight on the community, including the medically underserved, low income, and minority populations.

Research Limitations

As with all research efforts, there are some limitations related to this study's research methods that should be acknowledged. Data based on self-reports should be interpreted with caution. In particular, respondents may be prone to recall bias where they may attempt to answer accurately, but remember incorrectly.

In addition, timeline and other restrictions may have impacted the ability for all community stakeholders to be involved in the community action planning sessions. GBMC sought to mitigate limitations by including representatives of diverse and underserved populations throughout the research components.

Prioritization of Needs

Greater Baltimore Medical Center (GBMC) has elected to continue their work of the prioritized community health issues and developed an updated implementation plan to address the prioritized community needs. The identified needs of the community are:

- Behavioral Health/Substance Abuse
- Access to Care
- Obesity

SOCIO-DEMOGRAPHIC STATISTICS OVERVIEW

Population Characteristics

Between 2012 and 2016, the population of the GBMC service area, Baltimore County, experienced slightly slower growth when compared to Maryland and the nation. Yearly there are nearly 51,069 births and 41,280 Deaths, which without the migration produces a continuous population growth of 9,789 people, according to Maryland State Records.

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

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

Source: U.S. Census Bureau

Female Share of Population

Baltimore County has experienced a higher percentage of females when compared to Maryland and the nation. The female share of the population from the 2010 Census was 52.9% and from the 2000 Census was 53.4% in Baltimore County. Table 2, below, depicts the age group variations from females and males across the nation, state, and county. The proportion of females slightly varies across other various demographic indicators throughout the report. In addition, the in combination with one or more of the other races is listed, so the numbers may add to more than the total population and the percentages may add to more than 100 percent because individuals may report more than one race.

Table 2. Female and Male Share of Population by Age Groups (2010)

	U.S.		Maryland		Baltimore County	
	Male	Female	Male	Female	Male	Female
Under 18 years	25.0%	23.1%	24.7%	22.2%	23.7%	20.4%
18 to 64 years	63.6%	62.3%	64.6%	64.1%	63.7%	63.2%
65 years and over	11.4%	14.6%	10.7%	13.7%	12.6%	16.4%

Source: U.S. Census Bureau

Table 3. Female and Male Share of Population by Race and Hispanic or Latino (2010)

	U.S.		Maryland		Baltimore County	
	Male	Female	Male	Female	Male	Female
Total population	**151,781,326**	**156,964,212**	**2,791,762**	**2,981,790**	**380,409**	**424,620**
White	113,178,585	116,218,887	1,670,459	1,737,544	251,699	272,370
Black/African American	18,522,552	20,352,073	794,340	907,563	94,390	114,597
Hispanic or Latino (of any race)[a]	25,732,491	25,007,598	248,107	225,614	17,502	16,488

Source: U.S. Census Bureau

[a] Hispanic/Latino residents can be of any race, for example, White Hispanic or Black/African American Hispanic.

Older Adult Population Estimates

As evidenced by the median age, Baltimore County has a slightly older population compared to the state of Maryland and the nation. The median age is nearly one full year older as compared to the state and the nation as seen in Table 3. Consequently, Baltimore County also has a larger proportion of residents aged 75 years and older (7.4%) than the state (5.8%) and the nation (6.2%).

The population in Baltimore County is notably older. In 2016, the older adult population (aged 65 years and over) in Baltimore County accounted for 15.8% of the total population. Between 2015 and 2030, Maryland is anticipated to increase the population aged 60 years and over by 40%, on the other hand Baltimore County is only projected to increase by 25%. The booming aging population will place an exceptional demand on health, social services, the workforce, and housing accommodations. However, the Baltimore County Department of Health provides a number of services through the Bureau of Community Health Services to assist and support residents to age in their homes.

Table 4. Population by Age (2012 – 2016)

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

Source: U.S. Census Bureau

Figure 1. Median Age (2012 – 2016)

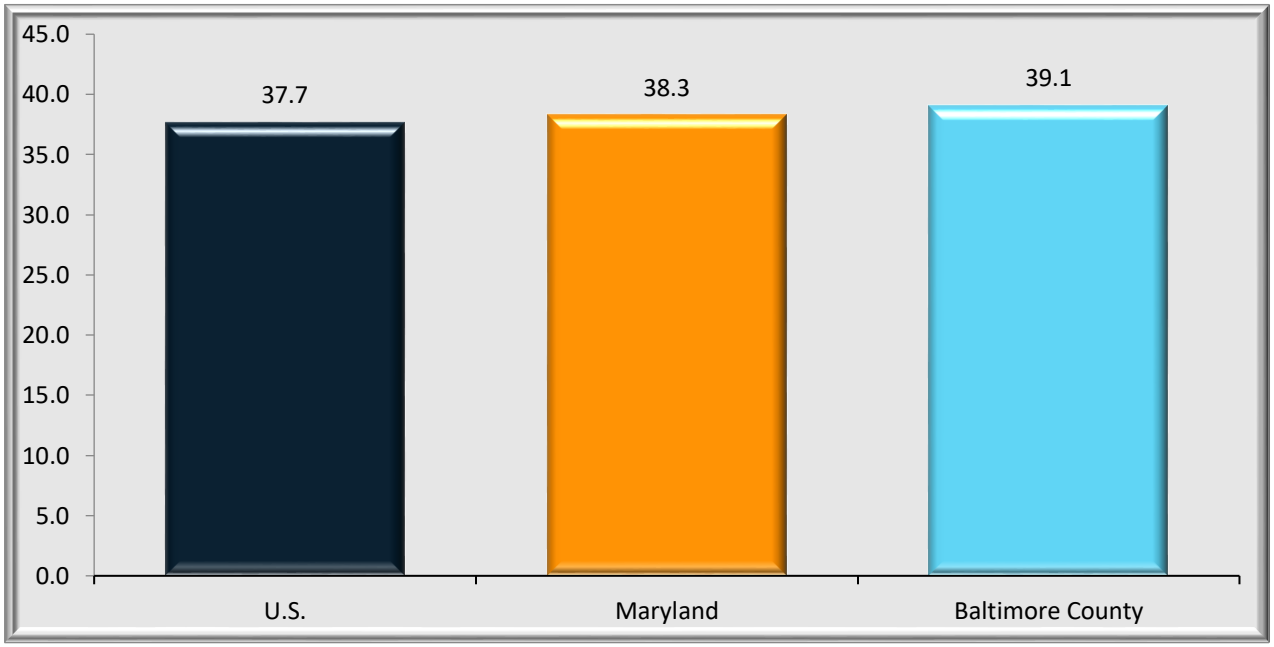


Table 5. Population Aged 65 Years and Over by Sex and Select Race/Ethnicity (2012 – 2016)

	U.S.	Maryland	Baltimore County
Male (share of population)	44.0%	48.4%	41.7%
Female (share of population)	56.0%	51.6%	58.3%
White	83.9%	70.0%	78.5%
Black or African American	8.8%	23.0%	17.0%
Hispanic or Latino Origin (of any race)	7.7%	2.9%	1.4%

Source: U.S. Census Bureau

Table 6. Older Adult Population Age Groups by Race and Hispanic or Latino (2012 – 2016)

	U.S.	Maryland	Baltimore County
75 to 84 years			
White	11,654,445	168,225	31,580
Black/African American	1,166,978	52,970	6,154
Hispanic or Latino (of any race)[a]	1,034,915	6,282	566
85 years and over			
White	5,286,053	84,752	19,301
Black/African American	435,901	18,076	1,876
Hispanic or Latino (of any race)[a]	376,448	2,471	201

Source: U.S. Census Bureau

[a] Hispanic/Latino residents can be of any race, for example, White Hispanic or Black/African American Hispanic.

The proportion of older adults in Baltimore County seems larger, however the distribution of percentages across all age categories in Table 4 shows the younger population is truly smaller. These findings correspond to a higher number of premature deaths that are reported in Baltimore County when compared to Maryland and the National Benchmark.

Table 7. Premature Mortality: Years of Potential Life Lost Before Age 75 per 100,000 (2016; 2018)

	National Benchmark[a]	Maryland	Baltimore County
Premature death (2018)	5,300	6,500	6,700
Premature death (2016)	5,200	6,400	6,500

Source: County Health Rankings[b]

[a] National benchmark represents the 90th percentile, i.e., only 10% are better.

[b] Rank is based on all 24 counties within Maryland State. A ranking of "1" is considered to be the healthiest.

There are also a higher number of drug poisoning deaths per 100,000 in Baltimore County (33) in comparison to the state (24) and the National Benchmark of 10, according to the County Health Rankings in 2018. The largest age group in both the United States and Maryland reported among drug overdose deaths are the 25 to 35 year olds. Additional findings may be contributing to the different proportion of age groups in Baltimore County; however, these findings listed above indicate a higher premature death and unevenly distributing a higher percentage to the older population.

Race & Ethnicity

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

Table 8. Race Alone or in Combination with One or More Other Races (2012 - 2016)

	U.S.	Maryland	Baltimore County
White	76.0%	59.7%	65.0%
Black/African American	13.8%	31.4%	29.0%
American Indian/Alaska Native	1.7%	1.0%	0.9%
Asian or Pacific Islander	6.2%	7.1%	6.6%
Native Hawaiian and Pacific Islander	0.4%	0.2%	0.1%
Some Other Race	5.3%	4.1%	1.2%
Hispanic or Latino *(of any race)*[a]	17.3%	9.2%	4.9%

Source: U.S. Census Bureau

[a] Hispanic/Latino residents can be of any race, for example, White Hispanic or Black/African American Hispanic.

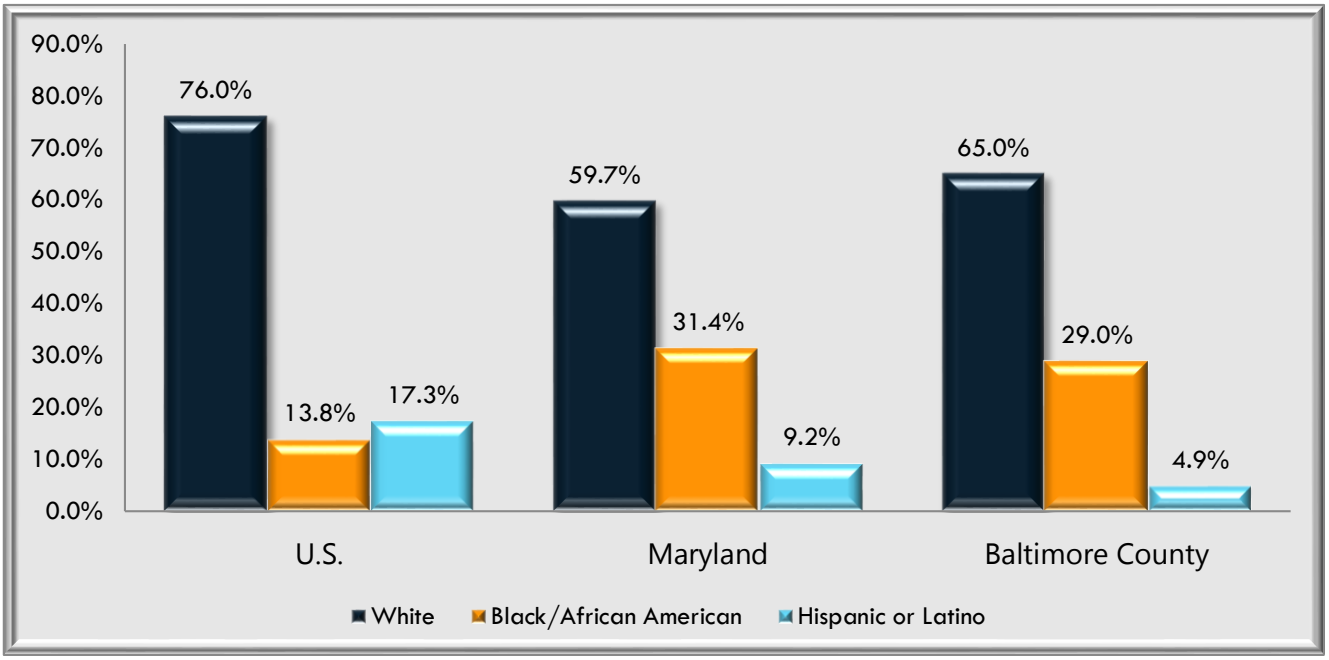
Table 9. Race Alone or in Combination with One or More Other Races (2010 - 2014)

	U.S.	Maryland	Baltimore County
White	76.3%	60.4%	65.8%
Black/African American	13.7%	31.1%	28.2%
American Indian/Alaska Native	1.7%	1.0%	0.8%
Asian or Pacific Islander	5.9%	6.8%	6.2%
Native Hawaiian and Pacific Islander	0.4%	0.2%	0.1%
Some Other Race	5.2%	3.8%	1.5%
Hispanic or Latino *(of any race)*[a]	16.9%	8.8%	4.6%

Source: U.S. Census Bureau

[a] Hispanic/Latino residents can be of any race, for example, White Hispanic or Black/African American Hispanic.

Figure 2. Racial Breakdown by Three Major Races (2012 – 2016)



Language Diversity

Certain groups are at a higher risk for having limited English language skills and low literacy, such as individuals who do not speak English at home, immigrants, and individuals with lower levels of education. Data from the 2012 – 2016 American Community Survey indicated the percentage of individuals who speak a language other than English at home is lower in Baltimore County (13.9%) than in Maryland (17.6%) and the nation (21.1%). Residents who speak a language other than English at home in Baltimore County are most likely to speak another Indo-European language (4.8%) or Spanish (4.0%). This is similar to the state, but much different from the nation where individuals most likely speak Spanish. Having limited English proficiency in the United States can be a barrier to accessing health care services and understanding health information.

Table 10. Language Spoken at Home, 5 Years Old and Older (2012 – 2016)

	U.S.	Maryland	Baltimore County
English only	78.9%	82.4%	86.1%
Language other than English	21.1%	17.6%	13.9%
Speak English less than "very well"	8.5%	6.5%	5.1%
Spanish	13.1%	7.5%	4.0%
Speak English less than "very well"	5.4%	3.3%	1.7%
Other Indo-European languages	3.6%	4.4%	4.8%
Speak English less than "very well"	1.1%	1.2%	1.5%
Asian and Pacific Islander languages	3.4%	3.7%	3.0%
Speak English less than "very well"	1.6%	1.5%	1.3%
Other languages	1.0%	2.1%	2.0%
Speak English less than "very well"	0.3%	0.5%	0.5%

Source: U.S. Census Bureau

Table 11. Language Spoken at Home, 5 Years Old and Older by Year (2010 – 2014; 2012 – 2016)

	U.S.		Maryland		Baltimore County	
	2010 - 2014	2012 – 2016	2010 - 2014	2012 – 2016	2010 - 2014	2012 – 2016
English only	79.1%	78.9%	83.1%	82.4%	86.9%	86.1%
Language other than English	20.9%	21.1%	16.9%	17.6%	13.1%	13.9%

Source: U.S. Census Bureau

Table 12. Language Spoken at Home by Race and Hispanic or Latino (2012 – 2016)

	U.S.	Maryland	Baltimore County
Speak only English	**235,519,143**	**4,608,065**	**668,992**
White	186,334,144	2,884,773	447,187
Black/African American	34,116,892	1,485,868	193,131
Hispanic or Latino (of any race)[a]	13,361,272	117,504	11,391
Speak a language other than English	**63,172,059**	**984,286**	**107,567**
White	34,142,193	343,768	46,006
Black/African American	3,331,777	166,694	18,429
Hispanic or Latino (of any race)[a]	36,707,265	372,084	24,594

Source: U.S. Census Bureau

[a] Hispanic/Latino residents can be of any race, for example, White Hispanic or Black/African American Hispanic.

Household, Income, and Employment Statistics

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

Household Statistics

The table below shows household types in Baltimore County have a larger proportion of single-female householders with no husband present (14.4%) when compared to the nation (12.9%). The percentage is similar to the state (14.3%). There is also a greater proportion of householders living alone who are 65 years or older in Baltimore County than in the state and the nation.

Table 13. Households by Type (2010 – 2014; 2012 – 2016)

	U.S.		Maryland		Baltimore County	
	2010 - 2014	2012 – 2016	2010 - 2014	2012 – 2016	2010 - 2014	2012 – 2016
Family households	66.2%	65.9%	67.1%	66.9%	65.1%	65.2%
Male householder, no wife	4.8%	4.8%	4.8%	4.9%	4.6%	4.7%
Female householder, no husband	13.0%	12.9%	14.6%	14.3%	14.4%	14.4%
Married-couple families	48.4%	48.2%	47.7%	47.7%	46.1%	46.1%
Nonfamily households	33.8%	34.1%	32.9%	33.1%	34.9%	34.8%
Householder living alone	27.6%	27.7%	26.9%	27.0%	28.9%	28.6%
65 years and over	10.0%	10.4%	9.2%	9.8%	11.3%	11.8%

Source: U.S. Census Bureau

Figure 3. Householder living alone, 65 years and over (2012 – 2016)

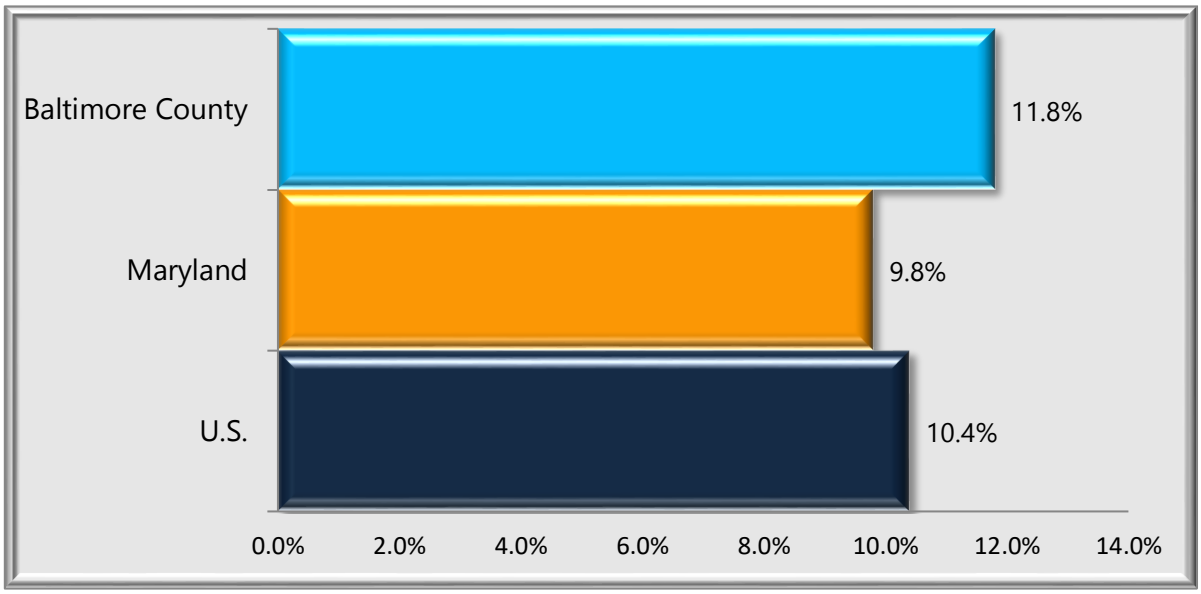


Table 14. Household Type of Female Householder by Race and Hispanic or Latino (2012 – 2016)

	U.S.	Maryland	Baltimore County
Female householder, no husband			
White	60.4%	38.0%	45.1%
Black/African American	26.8%	53.4%	48.8%
Hispanic or Latino (of any race)[a]	19.4%	7.8%	4.4%

Source: U.S. Census Bureau

[a] Hispanic/Latino residents can be of any race, for example, White Hispanic or Black/African American Hispanic.

Table 15. Population 65 Years and Older Living Alone by Race and Hispanic or Latino (2010)

	U.S.	Maryland	Baltimore County
65 and older Living Alone			
White	9,519,930	141,836	29,680
Black/African American	1,025,198	40,771	4,281
Hispanic or Latino (of any race)[a]	506,987	2,746	278

Source: U.S. Census Bureau

[a] Hispanic/Latino residents can be of any race, for example, White Hispanic or Black/African American Hispanic.

A higher percentage of grandparents responsible for their grandchildren are occurring as well in Baltimore County (38.4%) in comparison to the state (32.3%) and the nation (36.5%). Children may live with and/or be financial responsibility of their grandparents for a number of reasons. Being responsible for a grandchild can put a financial and physical strain on grandparents.

Table 16. Grandparents Responsible for Grandchildren (2010 – 2014; 2012 – 2016)

	U.S.	Maryland	Baltimore County
Grandparents responsible for grandchildren (2010 – 2014)	38.0%	33.4%	38.7%
Grandparents responsible for grandchildren (2012 – 2016)	36.5%	32.3%	38.4%

Source: U.S. Census Bureau

Table 17. Grandparents Responsible for Grandchildren by Race and Hispanic or Latino (2012 – 2016)

	U.S.	Maryland	Baltimore County
Grandparents responsible for grandchildren			
White	64.9%	45.1%	52.3%
Black/African American	21.9%	46.0%	43.5%
Hispanic or Latino (of any race)[a]	20.2%	6.5%	3.3%

Source: U.S. Census Bureau

[a] Hispanic/Latino residents can be of any race, for example, White Hispanic or Black/African American Hispanic.

Income Statistics & Poverty Status

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

is slightly lower in Baltimore County ($1,193) when compared to the state ($1,264) but is higher compared to the nation ($949).

When looking at housing costs in Baltimore County, a slightly lower proportion of residents spend more than 30% of their income on a mortgage (29.1%) when compared to residents across Maryland (31.0%) and the nation (30.8%). The same is true for residents spending more than 30% of their income on rent. The percentage in Baltimore County (49.0%) is lower than the state (50.5%) and the nation (51.1%).

Research establishes a concrete link between low socio-economic status and poor health, but understanding how and why individuals in poverty are at a greater risk for disease is more complex. Baltimore County data shows lower poverty rates for all families, female-headed households, and individuals when compared to the state and nation. The proportion of all households living below poverty level in Baltimore County is similar to the state, but is lower than the nation.

Table 18. Poverty Status of Families and People in the Past 12 Months (2012 – 2016)

	U.S.	Maryland	Baltimore County
All families	11.0%	6.8%	6.1%
With related children under 18 years	17.4%	10.6%	9.8%
With related children under 5 years	17.2%	10.2%	9.9%
Married couple families	5.5%	2.9%	2.9%
With related children under 18 years	7.9%	3.6%	3.8%
With related children under 5 years	6.3%	3.0%	4.0%
Female-headed households, no husband present	29.9%	18.9%	15.7%
With related children under 18 years	39.7%	26.3%	23.0%
With related children under 5 years	45.0%	29.9%	28.0%
All people	15.1%	9.9%	9.3%
Under 18 years	21.2%	13.3%	12.0%
18 years to 64 years	14.2%	9.2%	8.9%
65 years and over	9.3%	7.7%	7.2%

Source: U.S. Census Bureau

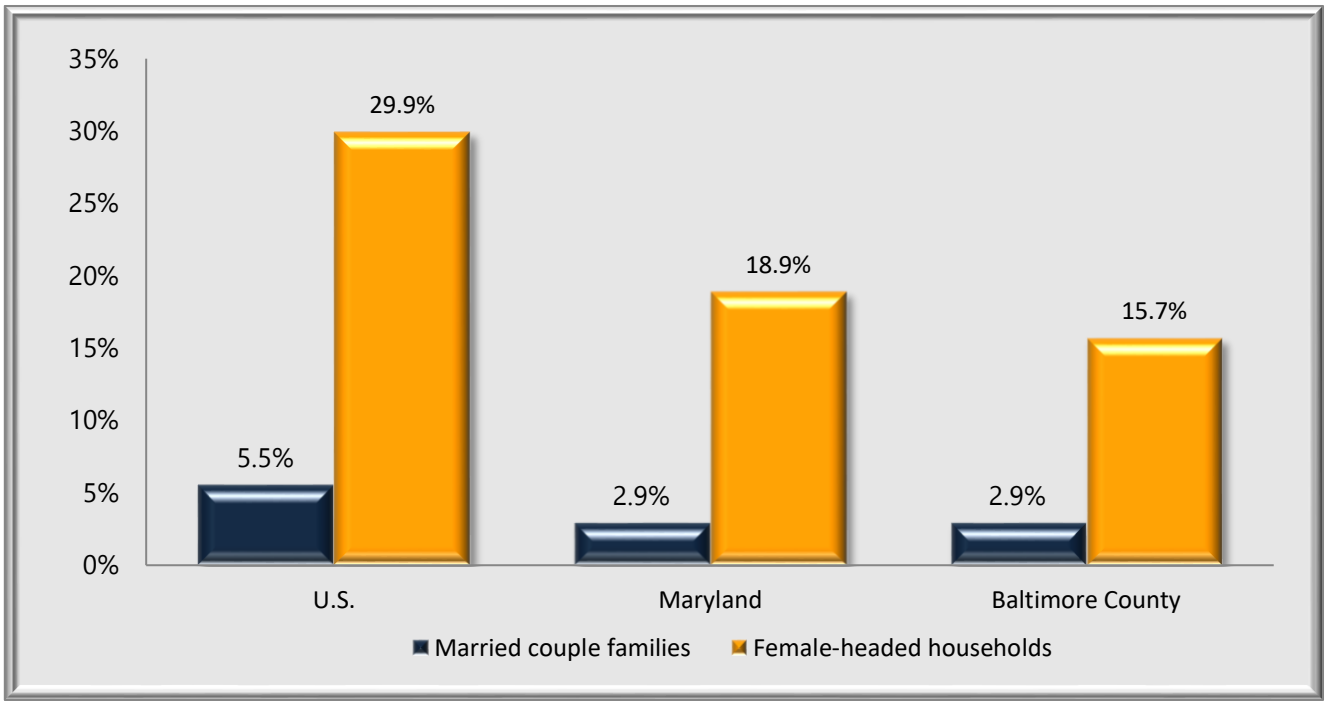
Table 19. Families Below the Poverty Level by Race and Hispanic or Latino (2012 – 2016)

	U.S.	Maryland	Baltimore County
White	8.6%	4.4%	4.5%
Black/African American	22.3%	11.6%	9.0%
Hispanic or Latino (of any race)[a]	20.9%	11.5%	13.5%

Source: U.S. Census Bureau

[a] Hispanic/Latino residents can be of any race, for example, White Hispanic or Black/African American Hispanic.

Figure 4. Percentage of families below the poverty level by household type (2012 – 2016)



Additionally, there are lower percentages of households in Baltimore County receiving food stamps (10.3%) when compared to Maryland (11.1%) and the nation (13.0%).

Table 20. Households with Supplemental Benefits in the Past 12 Months (2012 – 2016)

	U.S.	Maryland	Baltimore County
Households with food stamps/SNAP benefits in the past 12 months	13.0%	11.1%	10.3%
Households below poverty level and receiving food stamps	50.3%	39.8%	33.9%
Households with one or more people 60 years and over receiving food stamps	29.2%	31.1%	32.2%
Households with children under 18 years receiving food stamps	53.0%	52.6%	54.5%

Source: U.S. Census Bureau

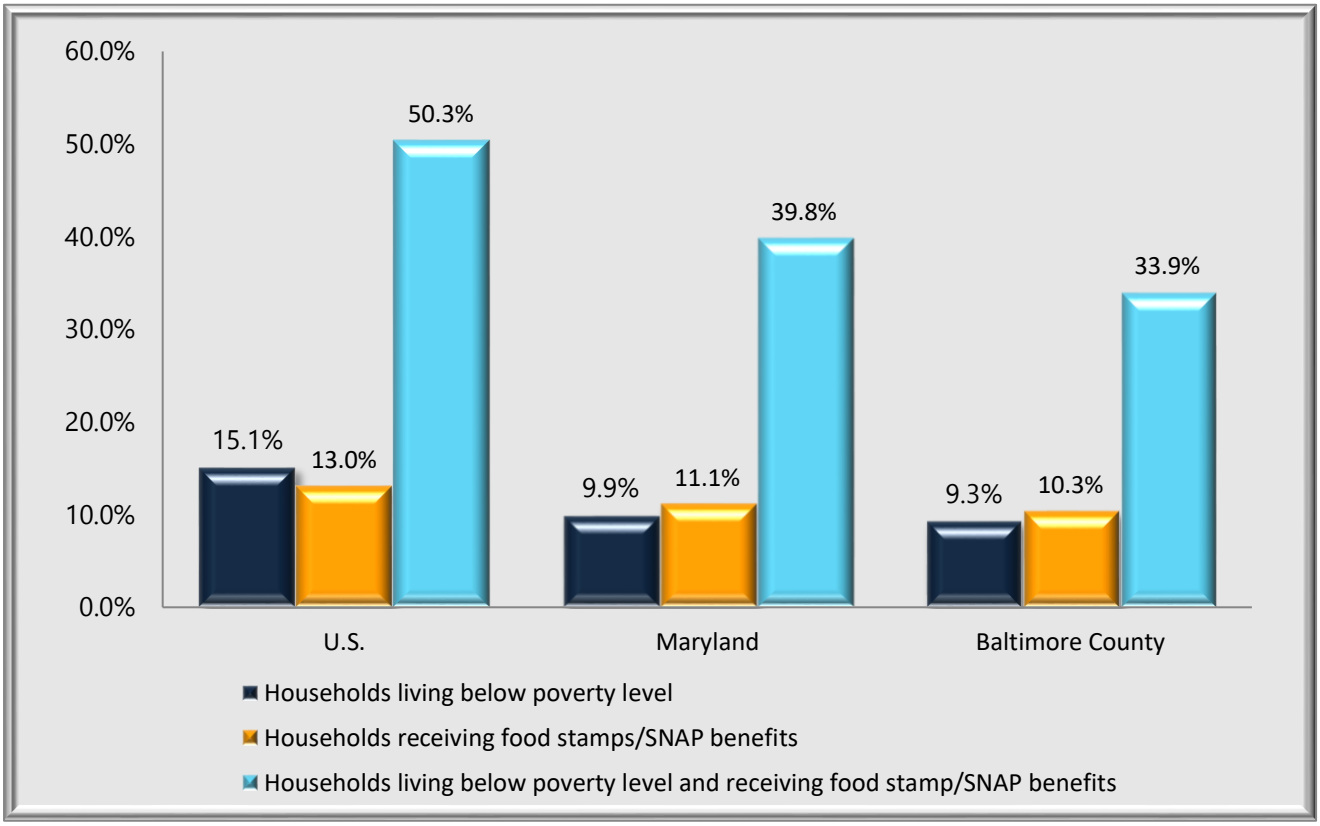
Table 21. Households with Food Stamps/SNAP Benefits by Race and Hispanic or Latino (2012 – 2016)

	U.S.	Maryland	Baltimore County
White	60.6%	37.9%	48.7%
Black/African American	26.1%	52.8%	43.0%
Hispanic or Latino (of any race)[a]	21.4%	8.4%	5.5%

Source: U.S. Census Bureau

[a] Hispanic/Latino residents can be of any race, for example, White Hispanic or Black/African American Hispanic.

Figure 5. Households below poverty level and receiving food stamps (2012 – 2016)



Education Statistics

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

Table 22. Educational Attainment, Population 25 Years and Over (2012 – 2016)

	U.S.	Maryland	Baltimore County
Less than high school diploma	13.0%	10.4%	9.0%
High school graduate (includes equivalency)	27.5%	25.4%	27.2%
Some college, no degree	21.0%	19.4%	19.5%
Associate's degree	8.2%	6.4%	7.0%
Bachelor's degree	18.8%	20.7%	21.4%
Graduate or professional degree	11.5%	17.7%	15.8%
Percent high school graduate or higher	**87.0%**	**89.6%**	**91.0%**
Percent bachelor's degree or higher	**30.3%**	**38.4%**	**37.2%**

Source: U.S. Census Bureau

Figure 6. Population with a high school diploma or bachelor's degree or higher (2012 – 2016)

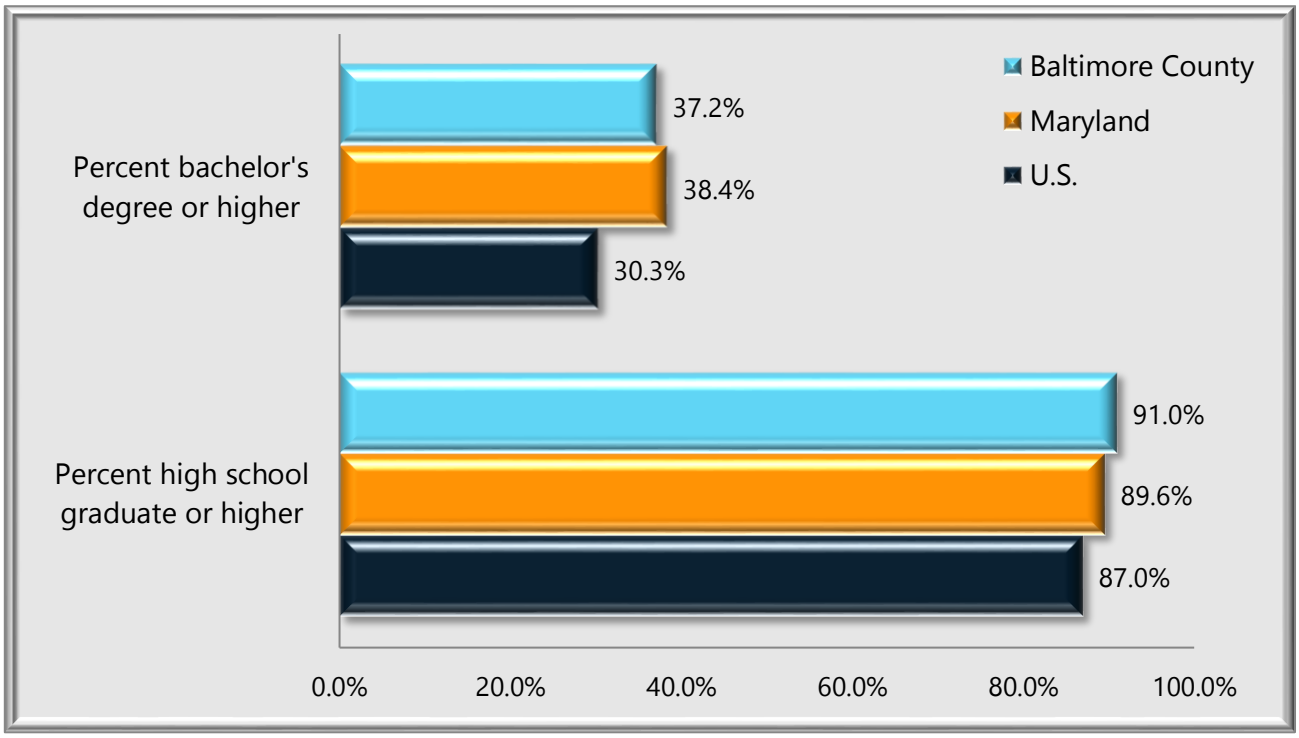


Table 23. Educational Attainment by Race and Hispanic or Latino (2012 – 2016)

	U.S.	Maryland	Baltimore County
High school graduate or higher			
White	88.9%	91.6%	91.0%
Black/African American	84.3%	89.3%	92.5%
Hispanic or Latino (of any race)[a]	65.7%	64.0%	71.4%
Bachelor's degree or higher			
White	31.6%	42.2%	38.4%
Black/African American	20.0%	27.8%	30.4%
Hispanic or Latino (of any race)[a]	14.7%	21.4%	22.8%

Source: U.S. Census Bureau

COMMUNITY MEETING OVERVIEW

Following the completion of the 2016 CHNA, GBMC began the work to create new opportunities to facilitate greater community collaboration and conversation by orchestrating action planning sessions with organizations located in Baltimore County who are actively working to improve the health of the community. Community Action Planning Meetings took place in September 2017, as well as in May and October 2018.

On September 15, 2017, GBMC convened a 4-hour meeting with approximately 40 stakeholders representing diverse interests in the community. Stakeholders represented a variety of different sectors in the community including, but not limited to, health care organizations, long-term care providers, higher education institutions, for-profit businesses (such as fitness centers and grocery stores), and social service organizations. A full list of attendees can be found in Appendix E. The meeting consisted of three main components:

- Review of the 2016 CHNA research findings for each focus area including Behavioral Health/Substance Abuse, Access to Care, and Obesity. Data was reviewed at a broad level to give context and background to the rest of the day's discussion.
- Panel discussion with experts from each of the focus areas. Panelists shared their day-to-day experiences, what they are currently doing to address the priority area, and what gaps still remain.
- Small group roundtable discussions around each of the priority areas. Meeting attendees were able to discuss their perspective on each of the priority areas and brainstorm how to address some of the issues.

On May 18, 2018, GBMC held a 3-hour meeting with approximately 32 stakeholders/key informants representing diverse interests in the community. Stakeholders represented a variety of different sectors in the community including, but not limited to, health care organizations, long-term care providers, higher education institutions, and social service organizations. A full list of attendees can be found in Appendix D. The meeting consisted of:

- A recap of the September 2017 community meeting including an overview of the data and a reminder of ideas generated for each priority area.
- Breakout action planning sessions for each priority area in which focus areas were brainstormed and action items were solidified.

Each breakout group was tasked with choosing three focus areas for their priority. Action plans were then put into place to identify how each focus area would be accomplished in the community. Action plans needed to contain:

- Actions – what specific activities will be done to accomplish the area of focus?
- Responsible parties/partners – who will be doing each action?
- Timeline – when will the action be completed?

- Measurable outcomes – how will you show the action has been completed?

To build upon GBMC's collaborative community impact to the 2016 CHNA priorities, GBMC's 2019 CHNA was comprised of a combination of secondary data as well as an onsite Community Action Planning Session held on October 26, 2018. GBMC held a 3-hour meeting with approximately 40 stakeholders representing diverse interests in the community. Stakeholders represented a variety of different sectors in the community including, but not limited to, health care organizations, long-term care providers, higher education institutions, and social service organizations. A full list of attendees can be found in Appendix C. The meeting consisted of:

- A recap of the September 2017 Community Meeting and the May 2018 Community Action Planning Session.
- An overview of the progress of each priority area group provided by the leaders of each group.
- A breakout into priority area groups to review and update action plans as well as engage in a discussion around gaps and needs that still need to be addressed.

Each breakout group walked through their action plans and discussed:

- What has been accomplished?
- What do we still want to accomplish (expanded focus areas or new focus areas)?
- What new action items should be added to the plan?

Each breakout group also engaged in a broader discussion around needs, barriers, and gaps that still exist in the community in order to glean additional insight. Specifically, each group discussed the following questions:

- What are we missing? What gaps still exist that have not yet been addressed?
- What underserved groups exist in the community? How do we reach them?
- What are the biggest barriers in the community for this priority area?

PRIORITY HEALTH ISSUES

The leading causes of death in Baltimore County are heart disease, cancer, stroke, accidents, and chronic lower respiratory disease. While the top two leading causes of death are consistent with the state and the nation. Of particular concern, the age-adjusted death rate due to heart disease, cancer, and stroke is much higher than both the state and the nation. The overall age-adjusted death rate per 100,000 in 2016 for Baltimore County (1,015.1) is worse than the state (812.5) and the nation (849.3). However, the age-adjusted death rate for whites in Baltimore County is even more notable as the rate (1,331.2) is much worse than both the state (1,027.7) and the nation (849.3).

Table 24. Deaths by Selected Causes, All Ages per 100,000 (2014; 2016)

	U.S.		Maryland		Baltimore County	
	2014	2016	2014	2016	2014	2016
Diseases of heart	192.7	196.6	186.3	189.6	225.3	238.6
Malignant neoplasms (Cancer)	185.6	185.1	180.0	181.5	200.1	223.8
Accidents (Unintentional Injuries)	46.1	49.9	31.9	37.9	35.9	46.2
Chronic lower respiratory disease	42.6	47.8	28.0	34.5	34.0	42.8
Cerebrovascular diseases (Stroke)	41.7	44.0	41.3	45.0	54.9	64.4
Alzheimer's disease	29.3	35.9	15.6	19.6	18.7	25.1
Diabetes mellitus	24.0	24.8	21.8	22.6	22.7	26.7
Influenza and pneumonia	17.3	15.9	17.1	17.0	21.0	21.7
Suicide (Intentional Self-Harm)	15.1	15.5	12.6	13.7	14.8	15.2
Nephritis, nephrotic syndrome and nephrosis	13.4	13.9	10.1	9.7	10.5	10.8

Source: Centers for Disease Control and Prevention

The following sections provide a more detailed discussion of the priority health issues that were determined to be significant in Baltimore County.

Behavioral Health/Substance Abuse

Based on the primary and secondary data analysis, mental health and substance abuse issues continue to emerge as a health concern for Baltimore County Residents. This finding is important because these issues can be significant confounding factors for broader health issues and overall unhealthy lifestyle behaviors.

Secondary Data Findings

Suicide/Major Depressive Disorders

The crude death rate due to suicide per 100,000 in Baltimore County is lower when compared to the nation, but is still higher than the suicide rate across Maryland. However, data from the Behavioral Risk

Factor Surveillance System (BRFSS) showed that there is a higher proportion of individuals diagnosed with an anxiety disorder compared to the state; the same is true for those diagnosed with a depressive disorder.

Table 25. Crude Death Rates per 100,000 Due to Suicide (2014; 2016; 2017)

	U.S.			Maryland			Baltimore County		
	2014	2016	2017	2014	2016	2017	2014	2016	2017
Total suicide	13.4	13.9	14.5	10.1	9.7	10.4	10.5	10.8	10.3

Source: Centers for Disease Control and Prevention

Table 26. Anxiety and Depression (2014; 2015)

	U.S.		Maryland		Baltimore County	
	2014	2015	2014	2015	2014	2015
Ever been told by a doctor or other health professional that you had:						
Anxiety disorder	N/A	N/A	13.9%	13.5%	14.4%	16.7%
Depressive disorder	18.7%	19.0%	15.9%	16.3%	13.9%	19.8%

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

Alcohol Abuse

In terms of substance abuse, data from BRFSS shows the percentages of binge drinkers and chronic drinkers are both lower than the national percentages of 16.3% and 5.9%, respectively. The percentage of binge drinkers is lower than the state and the percentage of chronic drinkers is similar.

Table 27. Alcohol Abuse (2015)

	U.S	Maryland	Baltimore County
Binge drinker [a]	16.3%	14.2%	12.9%
Chronic drinker [b]	5.9%	4.9%	5.0%

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

[a] Males having 5 or more and females having 4 or more drinks per occasion

[b] Men having more than 2 drinks and females 1 drink per day

Deaths Related to Substance Use

Total intoxication deaths were reported for Maryland and Baltimore County in 2016 and the number of heroin-related deaths was significantly higher for both state and county when compared to the number of prescription opioid-related deaths.

Table 28. Intoxication Deaths^ by Place of Occurrence (2016)

	Maryland	Baltimore County
Total intoxication deaths	2,089	336
Number of heroin-related deaths	1,212	208
Number of prescription-opioid-related deaths	418	67

Source: Maryland Department of Health

^Death that was a result of recent ingestion or exposure to alcohol or another type of drug

Tobacco Use

County Health Rankings data show that the percentage of adults who smoke is the same when Baltimore County is compared to the state and the nation. Adult smoking status is one factor that contributes to this ranking.

County Health Rankings rank the health of nearly every county in the nation. A ranking of "1" is considered to be the healthiest. Based on this data, Baltimore County ranked in the top half of all 24 Maryland Counties in regard to health factors (ranked 11), health behaviors (ranked 8), and clinical care (ranked 8).

Data from the Maryland Behavioral Risk Factor Surveillance System (BRFSS) demonstrated that Baltimore County has a lower percentage of current smokers when compared to the state and the nation. The percentage of former smokers in Baltimore County is similar to the nation and both are higher than the state of Maryland. Baltimore County has a higher percentage of adults who never smoked when compared to the state and the nation.

Table 29. Alcohol and Tobacco (2015)

	U.S	Maryland	Baltimore County
Current smoker	17.1%	15.1%	12.8%
Former smoker	25.1%	23.4%	25.2%
Never smoked	56.5%	61.5%	62.1%

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

Key Informant/Community Perspective

During the first CHNA Community Meeting hosted by GBMC in September of 2017, three main overarching issues that could be improved were discussed in regard to behavioral health/substance abuse. First, there is a misallocation of resources with an over-focus on the hospital stages of treatment. It was referenced that the community needs to work to build more relational bridges rather than building more beds. Additionally, there is an apparent disconnect between treatment providers due to a lack of provider communication. However, the concept of "warm handoffs" has been implemented over the past year and should be continued. This can be accomplished by helping to make appointments and connections for patients. Lastly, there is a bias against medications.

Integration of Behavioral Health/Substance Abuse services at GBMC was discussed with a focus on Patient Centered Medical Homes (PCMH) and Mosaic Community Services in the Emergency Department (ED) and Inpatient Units. A Health Services Cost Review Commission (HSCRC) Grant has been used to support the addition of Sheppard Pratt Behavioral Health and Substance Use staff to provide assessment/brief treatment at the PCMH. Additionally, Mosaic Community Services provides a full-time Resource Specialist to assist with inpatient and ED clients.

Gaps in current services included confidentiality/privacy protections, uncertainty of staffing adequacy, physical space constraints, and billing. Potential considerations for future program development included access to wraparound services, sustainability of PCMH model, reimbursement by Medicare, and use of virtual or tele-behavioral services for certain populations.

In May of 2018, another collective meeting was hosted by GBMC in order to identify action plans around each priority area of focus from the 2016 CHNA. During that meeting, the Behavioral Health/Substance Abuse priority team identified their overarching goal was to increase education/awareness of behavioral health/substance abuse in the community and improve delivery of services. The focus areas include:

1. Establish a universal assessment tool and discuss platforms for sharing information
2. Expand Mental Health Aid Training
3. Establish a County-Wide Provider Council

During the October 2018 Community Action Planning Meeting, Lynn Flanigan, Sheppard Pratt, provided a brief update on each focus area of the Behavioral Health/Substance Abuse priority team. Those updates were:

- Discussion continues regarding both PHQ-9 and other no cost measures for a universal assessment tool.
- Two Mental Health First Aid Trainings were held at Broadmead since the May meeting, and they have opened up the training to others as well. Additionally, GBMC hosted a "Time for Me" presentation on October 16th. This was focused on "When to Ask for Help" and was presented by Catherine Harrison-Restelli, MD, and Lynn Flanigan, RN, LCSW-C and was attended by about 50 community members.
- Both Tom Bond at Helping Up and Ann Patterson at Broadmead offered to host a provider council meeting once council members are established.

After the update was provided, the priority teams met to review what gaps and barriers still exist that have not yet been addressed. Gaps and barriers identified by the priority team included:

- The lack of a standardized screening tool makes it difficult for providers to understand who is being served in the community.
- There is a shortage of psychiatric physicians in the community.
- There is a need for a centralized resource that identifies providers and their specific services to the county.
- Limited medication assisted treatment and physician reluctance to receive the training to provide the resource.
- Stigma associated with mental health.
- Isolation due to mental health issues.

Lastly, the group was asked to identify community members who might be underserved. The focus group identified the Rehab population, the older population, as well as individuals who are being released from detention centers.

Access to Care

Access to care was identified as another priority area, based on both the primary and secondary data analysis. As the needs of the community grow and change, it is important for GBMC to evolve and identify ways easing access to care and the barriers that residents face when seeking care.

Secondary Data Findings

Health Insurance Coverage

Health insurance coverage can have a significant influence on health outcomes. Based on data from the U.S. Census Bureau (2012 – 2016), residents in Baltimore County are more likely to have health insurance when compared to residents in Maryland and the nation. This may be a contributing factor to the BRFSS data finding that shows that there are a higher percentage of residents who could not afford to see a doctor in the past year when compared to residents across Maryland. This percentage is similar to the nation. Baltimore County has two service areas that have been designated as Medically Underserved Areas, including Middle River and Landsdown/Highlands.

Table 30. Health Care Access (2015)

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

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

Health Care Provider

Based on data from BRFSS, there is a higher percentage of residents in Baltimore County who have received a routine check-up within the past year than residents across the state and the nation. This may be related to the fact that, according to County Health Rankings data, the primary care physician density in Baltimore County is better than both the state and the National Benchmark. However, ratio of dentists and mental health providers falls short of the National Benchmark. The following tables summarize these findings.

Table 31. Clinical Care Rankings[a] – Health Care Provider Density (2016; 2018)

	National Benchmark[b]	Maryland	Baltimore County
Clinical Care Rank (2018)			**8**
Primary care physician density	1,030:1	1,140:1	990:1
Dentist density	1,280:1	1,320:1	1,350:1
Mental health provider density	330:1	460:1	400:1
Clinical Care Rank (2016)			**10**
Primary care physician density	1,040:1	1,120:1	970:1
Dentist density	1,340:1	1,360:1	1,370:1

Mental health provider density	390:1	530:1	450:1

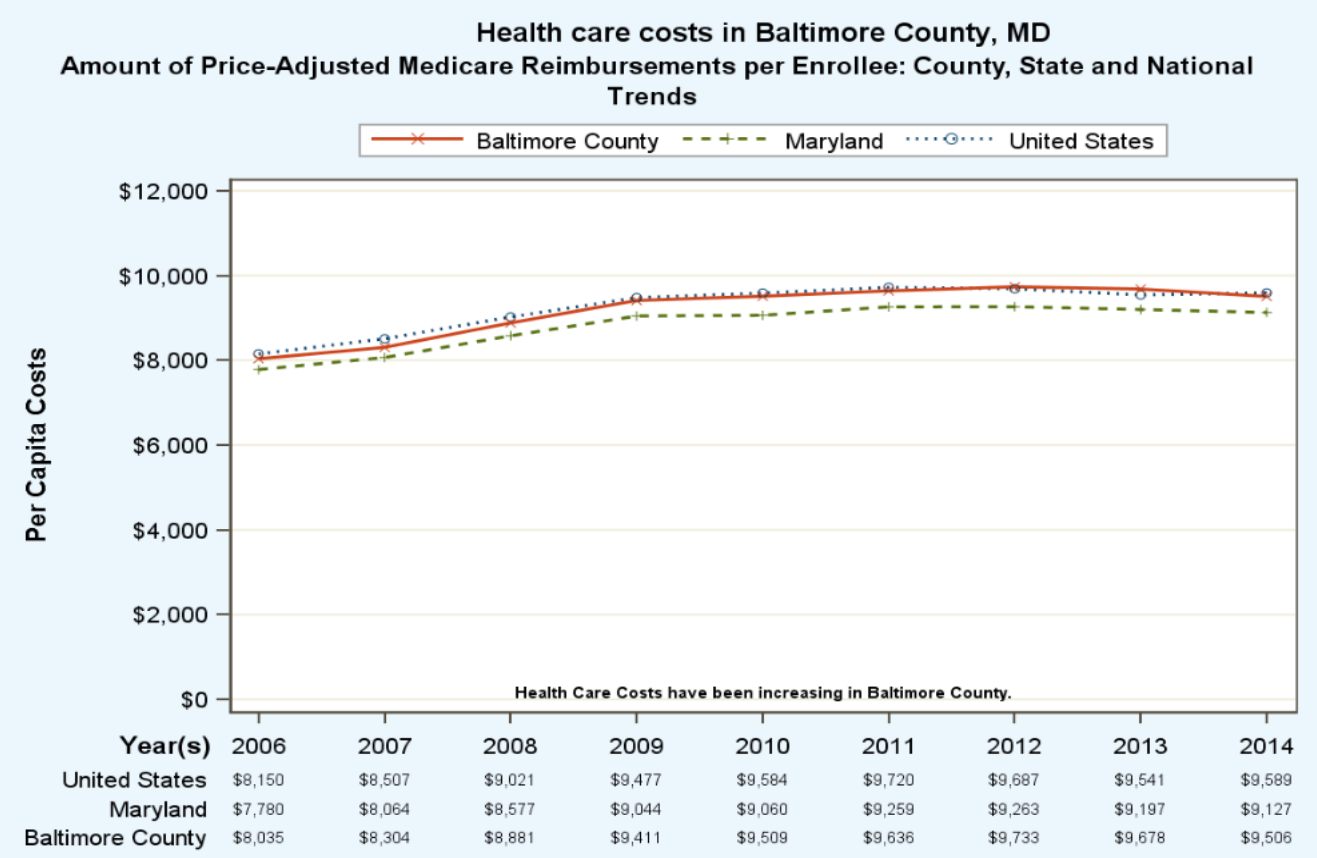
Source: County Health Rankings

[a] Rank is based on all 24 counties within Maryland State. A ranking of "1" is considered to be the healthiest.

[b] National Benchmark represents the 90th percentile, i.e., only 10% are better.

Health Care Costs

An overarching theme surrounding the healthcare industry is cost. Baltimore County consistently has a higher cost of health care per person than Maryland. However, Baltimore County tends to mimic the national statistic. Healthcare costs can be a deterrent for residents accessing care.



Source: County Health Rankings

Key Informant/Community Perspective

During the fall Community Meeting in 2017, Dr. Robin Motter-Mast, Medical Director of Primary Care, GBMC, and Dr. W. Anthony Riley, Chief Medical Director of Gilchrist, GBMC, discussed the patient population and the services GBMC offers to the community. The majority of the patient population (60 - 80%) is healthy and can be delivered care through the Advanced Primary Care PCMH. The next largest percentage of the patient population is those with chronic diseases (15 - 30%), who are best served through the Medical Neighborhood, PCMH, and specialists. Lastly are those that have complex illness, advanced illness, and are dying (5%). These patients are provided care through Medical and Surgical Hospital Care, Gilchrist Hospice Care, and the Support Our Elders Program of Gilchrist Greater Living.

The GBMC Primary Care Practice connects patients to an entire health network to make staying healthy more convenient. This fosters more team-based care and collaboration. Data was shared showing positive trends in post-hospital follow-up visits and a decrease in emergency department visits. Additional data showed that a high percentage of high-utilizers had a mental health diagnosis, so the care team was adapted for behavioral health as well. With this change, data revealed lower than average no-show rates for BHC and psychiatry visits.

In terms of gaps, Community Benefit Service is spread thin meeting only "tip of the iceberg" needs. There is a lack of a system to help access social and economic services. Psychiatric care is limited, both office and home-based. Additionally, family caregiver education about hands-on care and resources, psychological support, and respite care are lacking in the community. Considerations for future program development include more access to geriatric assessment and consultation – "Harry Potter Sorting Hat" role. More affordable in-home respite care is needed, especially for caregivers with family members suffering from advanced dementia. Lastly, focused services for those on the waiting list for low income housing should also be considered.

During the Community Action Planning session held at GBMC in May of 2018, the Access to Care priority team identified their overarching goal was to increase access to quality care for all residents by identifying underserved populations and simplifying the process for accessing services and resources. To accomplish that goal they established three focus areas:

1. Create seamless transitions between care settings.
2. Improve information sharing among providers.
3. Identify needs of the underserved populations and facilitate connections to meet needs.

In the Access to Care priority groups' most recent meeting held in October 2018, Leana Hoover, GBMC, updated the attendees regarding their progress by reporting the following:

- GBMC and University of Maryland St. Joseph Medical Center (UMSJMC) health networks have met regularly since May. They will be working to establish data and quality measures to be submitted quarterly. A shared patient has been identified between the two health systems. The workgroup has also agreed upon standard data to be shared and next steps will be to establish means of communication, leveraging utilization of EPIC: Care Alerts and meeting with EPIC stakeholders to determine which aspects of EPIC are being utilized.
- Both GBMC and UMSJMC have Care Managers/Patient Navigators in the service area who focus on uninsured/underinsured populations (in GBMC Patient Centered Medical Home, UMSJMC High Risk Clinic and the inpatient settings of both health systems). UMSJMC has been successful in their High Risk Clinic in identifying patients that are not eligible for Social Security numbers and might be undocumented. Similar concepts can be applied throughout the community in different care settings. A social media group/website to share resources/support among Care Managers is continuing to be explored.
- The group is trying to identify populations in need by collecting social/economic determinant data. This will help to trend any specific barriers to accessing care. In November, GBMC EPIC is launching a questionnaire specifically designed to capture social/economic determinants. This

screening will be completed in all areas of the organization including both inpatient and ambulatory care settings and is proposed to be collected every six months. EPIC is partnering with *Aunt Bertha* to supply a centralized place to connect patients with community resources.

- Details about two community outreach efforts, the Health Equity Pilot Program and Working on Partnerships to build a stronger, ongoing relationship with the Latino Community, were also shared.

After the update was provided, the priority teams met to review what gaps and barriers still exist that have not yet been addressed. Gaps and barriers identified by the priority team included:

- Limited education about the continuum of care,
- The need for additional information and communication regarding services offered through Palliative Care,
- Better communication and standardization needed among clinicians,
- Financial barriers associated with both getting to the appointments as well as the appointment cost itself,
- Timely access to services,
- Difficulty navigating the healthcare system,
- Transportation challenges.

Finally, the group was asked to identify community members who might be underserved. The focus group identified the undocumented population, the Hispanic population, individuals who are uninsured or underinsured, low to middle income populations and lastly, the homeless population.

Obesity

Obesity was identified as a final priority area, based on both the primary and secondary data analysis. Obesity is often the result of an overall energy imbalance due to poor diet and limited physical activity. Being overweight or obese is a concern as it can be a contributing factor to a variety of other health conditions including Diabetes and heart disease.

Secondary Data Findings

Overweight/Obesity

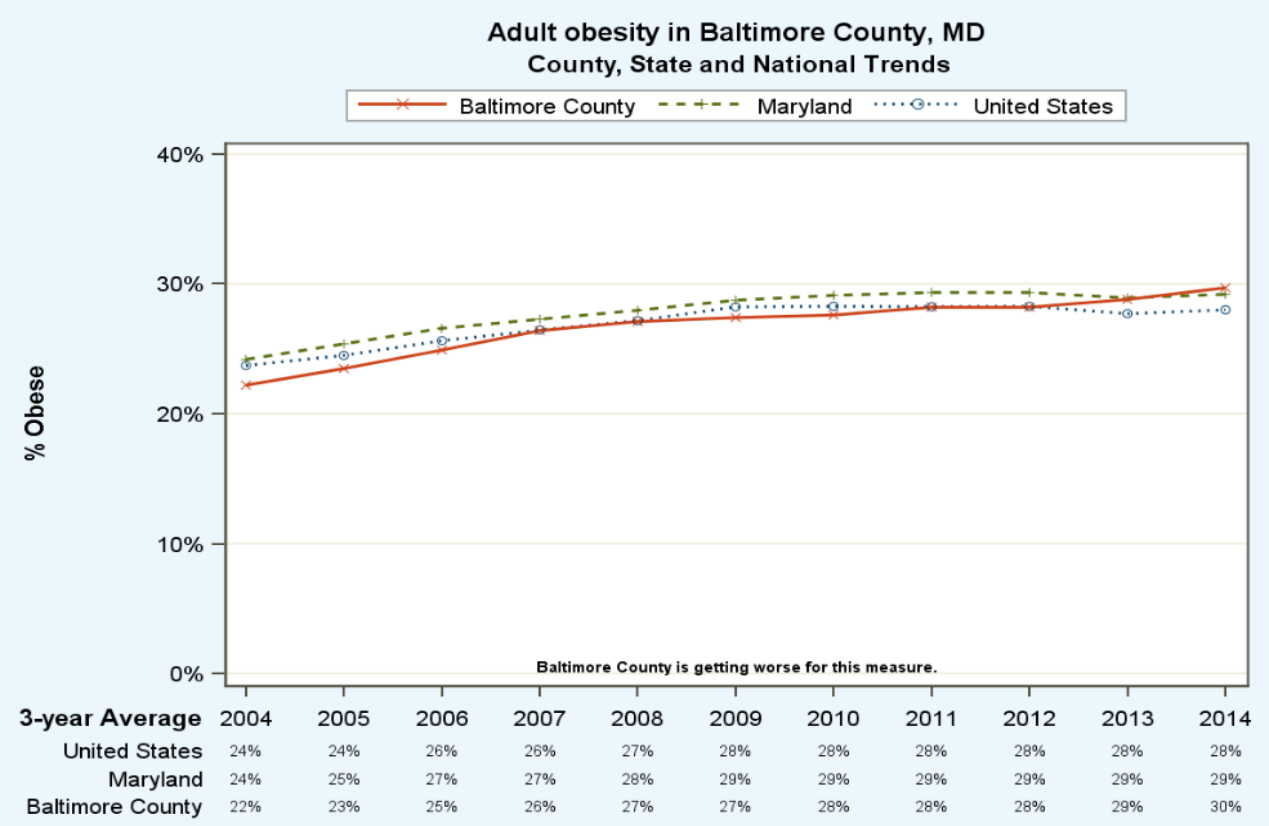
Adult Obesity studies help measure diet and exercise in a county. Data from the Maryland Behavioral Risk Factor Surveillance System (BRFSS) demonstrated that Baltimore County has a higher percentage of residents that are overweight/obese when compared to the state and the nation (when both Overweight and Obese percentages are combined). Consequently, the percentage of adults at a healthy weight is lower in Baltimore County compared to both Maryland and the nation. The top states in the nation report obesity at 26% or lower.

Table 32. Weight Classifications (2013; 2015)

	U.S.	Maryland	Baltimore County

	2013	2015	2013	2015	2013	2015
Healthy Weight (BMI 18.5 - 24.9)	35.2%	32.7%	35.9%	35.0%	35.0%	31.0%
Overweight (BMI 25.0 - 29.9)	35.4%	35.5%	35.9%	36.1%	65.0%	36.0%
Obese (BMI 30.0 and above)	29.4%	29.8%	28.3%	28.9%		32.9%

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



Source: County Health Rankings

Dietary and Exercise Behaviors

Regular physical activity combined with healthy eating is widely supported as the best way to prevent certain health concerns such as obesity, Diabetes, heart disease and many others. Baltimore County ranked in the top half of all 24 Maryland Counties in regard to health factors (11), health behaviors (8), and clinical care (8) in 2018. There are a few measures that Baltimore County performs better than both the state and the National Benchmark. The one measure includes that Baltimore County residents have better access to exercise opportunities (94%) than residents across Maryland (93%) and compared to the National Benchmark (91%).

Based on data from County Health Rankings, there is a slightly higher percentage of adults aged 20 and older in Baltimore County that report no leisure time physical activity (24%) when compared to the state (22%) and the National Benchmark (20%). This is despite the population in Baltimore County actually having slightly better access to exercise opportunities compared to Maryland and the National Benchmark.

In terms of healthy eating, Baltimore County has a similar food environment index (8.3) compared to both Maryland (9.1) and the National Benchmark (8.6). This index takes two variables into account – the percentage of the population who are low income and do not live close to a grocery store and the percentage of the population who did not have access to a reliable source of food during the past year.

Table 33. Food Environment Index (2018)

	National Benchmark[b]	Maryland	Baltimore County
Food Environment Index (2018)	8.6	9.1	8.3
Food Environment Index (2016)	8.3	8.1	8.0

Source: County Health Rankings

[a] Rank is based on all 24 counties within Maryland State. A ranking of "1" is considered to be the healthiest.

[b] National Benchmark represents the 90th percentile, i.e., only 10% are better.

Key Informant/Community Perspective

During the Community meeting held in September 2017, attendees were educated on the topic of obesity in Baltimore County by Dr. Elizabeth Dovec, Medical Director and Bariatric Surgeon, GBMC's Comprehensive Obesity Management Program; Ellen Wallace, RN – Certified Diabetes Educator and Clinical Coordinator of Geckle Center, GBMC; and Rebecca Denison, RD, LDN, Doctor of Integrated Medicine – Geckle Diabetes and Nutrition Educator, GBMC.

The expert panel began by reflecting on the statistics and the cost of obesity to the healthcare system and that the system for addressing obesity is broken. It was emphasized obesity can be tied back to many things in one's life including relationships, decisions, and emotions. Obesity is linked to a number of chronic health conditions, which can begin to pile up on an individual and be difficult to control. For someone to be a good candidate for weight loss surgery, they need to have a new relationship with food, exercise, and a new mindset. An individual always needs to understand their "why" before taking the next steps. In order to address gaps and the broken system, it was suggested to build an effective and comprehensive medical weight loss center.

The Geckle Diabetes and Nutrition Center was highlighted and shared how their staff works to address obesity. This includes the Diabetes Self-Management Education Program, Medical Nutrition Therapy, Quarterly Prediabetes classes, Weight Management 12-week class series, CDC Diabetes Prevention Program, and through multiple community venues. Additionally, the Geckle Center collaborates with GBMC through Lunch and Learns, the Wound Center, rotation offered to MD residents, and partnership with GBMC Gastroenterology.

In May of 2018 the priority team for the obesity topic determined their overarching goal would be to reduce risk factors that contribute to obesity and improve access to wellness resources and healthy foods. In order to accomplish that goal they identified three focus areas:

1. Explore opportunities to create "Healthy Baltimore County"
2. Increase access to healthy foods

3. Pilot a comprehensive weight management program with GBMC health system

During the October 2018, Community Meeting, Cate O'Connor-Devlin, GBMC, provided an update regarding the accomplishments the Obesity Priority group had accomplished since May, 2018. It included the following:

- Participants in the group expanded from three to ten.
- Connections were made with both Giant and ShopRite. Giant is reaching out through community events for seniors and offering help with the ordering and delivery of food. ShopRite has completed research in the area on food deserts, but currently has not used the data to implement any programs.
- The group is working with Giant to increase usage of their in-house nutritionist through physician's office practices and GBMC EHS.
- GBMC EHS and HR have been included in the workgroups to develop programs for just the GBMC community.
- The group is working with GBMC COMP to have a booth at their Reveal party in December and will be looking at NuTri as a possible product for the GBMC wellness program. An overview of NuTri and a video from the Reveal party were shared.
- The group is currently working with Sodexo on healthy options for the staff reward program in the cafeteria.

After the update was provided, the priority teams met to review what gaps and barriers still exist that have not yet been addressed. Gaps and barriers identified by the priority team included:

- Provision of alternatives to Bariatric surgery, such as support groups and resources for Overeaters Anonymous,
- The need to create an Aunt Bertha Resource toolkit,
- Healthy Eating education for children,
- Improvement of Fit and Healthy Program at GBMC,
- Transportation challenges,
- Affordability of foods,
- Lack of communication regarding available resources,
- Limited transportation to parks in Baltimore County.

As the group wrapped up their time together, they were asked to identify community members who might be underserved. The focus group identified the older adult population, individuals who do not qualify for Bariatric surgery and the Hispanic population.

CONCLUSION

While each community priority area group has worked diligently on the three topic areas, it is clear there is still much work to be done. It is for that reason that GBMC remains committed to working with the local community to impact how Baltimore County residents experience challenges associated with Behavioral Health/Substance Abuse, Access to Care, and Obesity.

COMMUNITY HEALTH IMPLEMENTATION PLAN

Strategies to Address Community Health Needs

GBMC believes that actions focused on improvement in the persistent three prioritized areas will have the greatest impact on the community's health. As GBMC developed an Implementation Strategy on May 17, 2019 to illustrate the hospital's specific programs and resources that support ongoing efforts to address the identified multi-faceted community health problems. A full list of attendees can be found in Appendix B. This work is supported by community-wide efforts and leadership from the Executive Team and Board of Directors. The goal statements, suggested objectives, key indicators, intended outcomes and initiatives, and inventory of existing community assets and resources for each of the priority areas are listed below.

Prioritized Health Issue #1: Behavioral Health/Substance Abuse

Goal: Increase education/awareness of behavioral health/substance abuse in the community and improve delivery of services

Objective:

- Establish a universal screening tool and discuss platforms for sharing information
- Expand Mental Health First Aid Training
- Establish a County-Wide Provider Council

Key Indicators:

- Create an email list of Behavioral Health Workgroup participants.
- Share and review ideas of assessment tools and information sharing platforms among email list.
- Hold a meeting of Behavioral Health Workgroup participants and other key organizations to establish a universal assessment tool and discuss platform sharing options.
- Train organization staff on how to use the universal assessment tool moving forward.
- Establish plans to reconvene group to make a decision on platform sharing options.
- Research mental health apps and the potential tie to universal assessment tools.
- Determine what organizations provide Mental Health First Aid training classes in the area.
- Host Mental Health First Aid training at each organization in the Behavioral Health Workgroup.
- Investigate opportunities to offer community-wide Mental Health First Aid training and consider partnering with local colleges.
- Identify an organization to spearhead Provider Council.
- Recruit community stakeholders to participate in the Provider Council.

- Conduct initial meeting of Provider Council to discuss Behavioral Health resources available in the community.
- Create and maintain an online directory of available Behavioral Health resources.

Outcomes:

- # of participants included on email list
- # of participants providing input, # of assessment tools and platforms identified
- # of participants at meeting, Identification of universal assessment tool, # of organizations committed to using universal assessment tool
- # of organizations using universal assessment tool, # of staff trained, # of individuals screened through universal assessment tool
- # of organizations invited to participate in discussion
- # of mental health apps identified, # of ideas generated to link to assessment tool
- # of organizations providing Mental Health First Aid training classes in the area, # of organizations hosting training classes, # of people trained
- # of organizations interested in participating in Mental Health First Aid training, # of individuals trained, # of training hours conducted
- # of organizations identified to spearhead Council, Selection of one spearheading organization
- # of community stakeholders recruited for Council, # of attendees at initial meeting, # of resources identified
- Creation of 1 online directory, # of resources listed in directory, # of page views of online directory, # of updates to directory – updated at least quarterly

Existing Community Resources: Greater Baltimore Medical Center (GBMC), University of Maryland St. Joseph Medical Center (UMSJMC), Sheppard Pratt, Kolmac, Manor Care, Towson University, Catholic Charities, Gilchrist – Hospice/Geriatric/Home Health Care, Chesapeake Regional Information System for our Patients (CRISP), Maryland Prescription Data Management Program (MPDMP), Mosaic Community Services, Santa Services, Baltimore County Department of Health

Prioritized Health Issue #2: Access to Care

Goal: Increase access to quality care for all residents by identifying underserved populations and simplifying the process for accessing services and resources.

Objective:

- Increase connections to meet needs and coordination of care
- Decrease barriers to receiving care
- Increase a seamless transition and coordination of care between care settings and providers
- Improve residents' awareness of available resources to utilize health care options
- Increase access by identifying populations in need
- Increase number of care managers/patient navigators/community health workers who report support from a social media group/website

Key Indicators:

- Conduct meetings of providers in the GBMC and UM SJMC health networks and other community partners

- Establish a Community Access Network (CAN) to help address needs/barriers identified
- Create a standard set of information to be collected from patients upon admission and discharge that will be utilized across all care settings and among providers
- Identify populations in need of care by collecting social determinants via a standard tool
- Determine and connect patients to resources during the discharge process
- Establish a social media group/website for patient navigators and community health workers to share resources and offer support

Outcomes:

- # of meetings held, # of providers in attendance at meetings
- # of participants in attendance, # of partners participating in network, # of needs addressed
- Outline a standard data set or measuring tool: # of care settings informed about the standard data set, # of care settings utilizing the standard data set
- Outline a standard process: # of care settings providing outline of standard process
- # of underserved populations identified, # of connections made with organizations serving underserved populations
- # of care settings connecting patients to resources at discharge, # of individuals utilizing resources identified in repository
- # of patient navigators/community health workers identified, # of patient navigators/community workers participating in a social media group/website, # of posts/page views on the social media group/website, #/% of patient navigators/community workers that feel support and resources from the group/website is helpful

Existing Community Resources: Greater Baltimore Medical Center (GBMC), University of Maryland St. Joseph Medical Center (UMSJMC), Health Network Providers, Procare Ambulance of Maryland, Johns Hopkins Home Care Group, Gilchrist – Hospice/Geriatric/Home Health Care, Friendship Circle of Baltimore, Baltimore County Department of Health, Care Managers/Patient Navigators/Community Health Worker, High Risk Clinic, Aunt Bertha, Chesapeake Regional Information System for our Patients (CRISP)

Prioritized Health Issue #3: Obesity

Goal: Reduce risk factors that contribute to obesity and improve access to wellness resources and healthy foods

Objective:

- Explore opportunities to create "Healthy Baltimore County"
- Increase access to healthy foods
- Pilot a comprehensive weight management program with GBMC health system
- Improve collaborative efforts with chronic disease management specialists

Key Indicators:

- Reach out to community stakeholders including Baltimore County Health Department, Giant Registered Dietician, Department of Aging, Towson University, American Heart Association, YMCA, and Parks and Recreation
- Reach out to Healthy Howard for Best Practices

- Convene a meeting of all Obesity Workgroup members and expand stakeholder group
- Create an inventory of wellness resources in the community
- Create partnership with "Healthy Harvest" program and University of Maryland St. Joseph Medical Center that includes health education
- Create a partnership between Towson University and older adults in community to help with grocery shopping
- Create a partnership between grocery stores and senior housing to bring produce onsite
- Identify opportunities with "Moveable Feast" that could support patients upon discharge with healthy meals
- Connect with GBMC Leadership to discuss ideas for comprehensive weight management program
- Create a list of recommendations of weight loss resources in the community for individuals that don't qualify for surgery
- Pilot a comprehensive weight management program, featuring the list of recommendations of weight loss resources with GBMC staff
- Partner with GBMC's food management provider to identify healthy choices and calorie awareness in café's and cafeterias
- Partner with PCP providers to determine patients who are food insecure and create programing to assist those families
- Refine chronic disease management process to enhance patient care through a multi-specialty approach
- Pilot a program utilizing GBMC interns to track potential new hires within the health system who are hypertensive
- Create process to identify and educate patients who are admitted with Type II Diabetes and have an A1C of 9 or higher

Outcomes:

- # of meetings held, # of providers/organizations in attendance at meetings
- # of participants in attendance, # of partners participating in committee work , # of needs addressed
- # of new ideas, # of opportunities to expand existing programs
- # of underserved populations identified, # of connections made with organizations serving underserved populations
- # of care settings connecting patients to resources at discharge, # of individuals utilizing resources identified in repository
- # of patients who are food insecure and # of interventions
- # of weight loss goals being obtained, # of individuals whose weight is in a healthy range,
- # of patients served, # of patients who are now within healthy ranges for blood lipid levels and glucose levels

Existing Community Resources:

Greater Baltimore Medical Center (GBMC), University of Maryland St. Joseph Medical Center (UMSJMC), Health Network Providers, Baltimore County Health Department, Bayada Home Health Care ,Giant Food Stores, Healthy Harvest, Active Life and Sports PT, Brick Bodies, Department of

Aging, Towson University, American Heart Association, American Diabetes Association, YMCA, Parks and Recreation, Marquis Health Services/Orchard Hill Rehab

Appendix A. Secondary Data Sources

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Appendix B. Implementation Strategy Attendees – May 17, 2019

Name (Last, Frist)		Organization	Priority Area
Anglin	Lisa	Greater Baltimore Medical Center	Access to Care
Balzerzak	Barbara	JHHCG	Access to Care
Boone	Charles	Procare Ambulance of Maryland	Access to Care
Carl	Kimberly	JHHCG	Access to Care
Chan	Alice	UM SJMC	Access to Care
Conway	Adam	GBMC	Mental Health/Substance Abuse
Cool	Judy	JHHCG	Access to Care
Davenport	Kim	GBMC Marketing	Mental Health/Substance Abuse
Falbo	Melissa	HCR ManorCare	Mental Health/Substance Abuse
Ferreira	Courtney	Active Life And Sports PT	Obesity/Diabetes
Flanigan	Lynn	Sheppard Pratt Health System	Mental Health/Substance Abuse
Fogler	Sarah	GBMC	Mental Health/Substance Abuse
Hamel	Catherine	GBMC	Access to Care
Hoover	Leana	GBMC/ Gilchrist	Access to Care
Lomelino	Fabio	Gilchrist/GBMC	Mental Health/Substance Abuse
Melanson	Dawn	Manor Care	Mental Health/Substance Abuse
Millard	Melissa	Johns Hopkins Home Care Group	Access to Care
Motter	Robin	GBMC	Access to Care
O'Connor-Devlin	Cate	GBMC	Obesity/Diabetes
Palughi	Donald	Friends Circle	Access to Care
Parr	Joann	GBMC	Access to Care
Selby	Erin	UM St. Joseph Medical Center	Obesity/Diabetes
Serafini	Grace	UM SJMC	Mental Health/Substance Abuse
Soyke	Sandy	Catholic Charities -Jenkins Senior Campus	Mental Health/Substance Abuse
Thompson	Monique	GBMC Continuing Care	Access to Care
Achiro	Janet	Employee Health-GBMC	Access to Care
Chan	Meghan	GBMC	Obesity/Diabetes
Rosell-Missler	Felicity	Johns Hopkins	Access to Care

Appendix C. Action Planning Meeting Attendees – October 26, 2018

Name	Organization	Priority Area
D'Ambra Anderson	GBMC	Behavioral Health/Substance Abuse
Crystal Andre Smith	Brick Bodies	Obesity
Kristen Artes	UM St. Joseph Medical Center	Access to Care
Charles Boone	Procare Ambulance of Maryland Inc.	Access to Care
Carolyn Candiello	GBMC	Obesity
Kim Carl	John Hopkins Home Care Group	Access to Care
Meghan Chan	GBMC	Obesity
Alice Chan	UM St. Joseph Medical Center	Access to Care
Danielle Clifford	American Heart Association	Obesity
Judy Cool	John Hopkins Home Care Group	Access to Care
Elizabeth Dovec	GBMC	Obesity
Ahmed Elsayed-Ahmed	GBMC	
Anne Evans	Gilchrist	Obesity
Melissa Falbo	Manor Care	Behavioral Health/Substance Abuse
Lynn Flanigan	Sheppard Pratt Health System	Behavioral Health/Substance Abuse
Sarah Fogler	GBMC	
Simon Freyou	GBMC	Obesity
Nikki Gachot	Marquis Health Services/Orchard Hill Rehab	Obesity
Jennifer Gerlach	Genesis Healthcare	Access to Care
Mark Guindon	Bayada Home Health Care	Obesity
Catherine Hamel	Gilchrist/GBMC	
Leana Hoover	Gilchrist	Access to Care
Trisha Kendall	Gilchrist	Obesity
Kiara King	GBMC	Obesity
Kimberly Mays	American Heart Association	Obesity
Dawn Melanson	Manor Care	Behavioral Health/Substance Abuse
Melissa Millard	John Hopkins Home Care Group	Access to Care
Melanie Miller	GBMC	Access to Care
Robin Motter	GBMC	Access to Care
Linda Mulkern	Bayada Home Health Care	Access to Care
Cate O'Connor-Devlin	GBMC	Obesity
Yolanda Pitts	Gilchrist	Access to Care
Joann Parr	GBMC	Obesity
Debbie Saraullo	Inhome Advantage	Access to Care
Vanessa Stinson	GBMC	Obesity
Lisa Stone	Stella Maris, Inc.	Access to Care
Airial Turner	GBMC	
Ellen Wallace	GBMC	Obesity
Mimi Walsh-Wehberg	Kolmac/ GBMC	Behavioral Health
Alex White	Brick Bodies	Obesity

Appendix D. Action Planning Meeting Attendees – May 18, 2018

Name	Priority Area
John Adamovich	Access to Care
MaryJo Adams	Behavioral Health/Substance Abuse
Kristen Artes	Access to Care
Maria Baxter	Access to Care
Tom Bond	Behavioral Health/Substance Abuse
Tina Brown	Access to Care
Tracee Brown	Access to Care
Carolyn Candiello	Obesity
Alice Chan	Access to Care
Phyllis Chapman-Gregory	Behavioral Health/Substance Abuse
Carrie Davis	Access to Care
Anne Evans	Obesity
Melissa Falbo	Behavioral Health/Substance Abuse
Lynn Flanigan	Behavioral Health/Substance Abuse
Yolanda Green	Access to Care
Joseph Hart	Access to Care
Leana Hoover	Access to Care
Becky Horner	Behavioral Health/Substance Abuse
Kiara King	Behavioral Health/Substance Abuse
Fabio Lomelino	Behavioral Health/Substance Abuse
Kim Mays	Access to Care
Melanie Miller	Access to Care
Robin Motter-Mast	Access to Care
Danny O'Brien	Access to Care
Cate O'Connor Devlin	Obesity
Pamela Parham	Obesity
Ann Patterson	Behavioral Health/Substance Abuse
Debbie Saraullo	Access to Care
Paul Spence	Access to Care
Kay Sullivan	Behavioral Health/Substance Abuse
Mary Walsh-Wehberg	Behavioral Health/Substance Abuse
Alexis Weller	Access to Care

Appendix E. Community Meeting Attendees – September 15, 2017

Name	Organization
Laurie Adams	Bayada Home Health
Debbie Aliff	ProCare
Crystal Andre	Brick Bodies
Ranee Appleby	Brick Bodies
Kristen Artes	St. Joseph Medical Center
Alice Chan	St. Joseph's Population Health Staff
Catherine Clark	Towson University
Rebecca Denison	Greater Baltimore Medical Center
Dr. Elizabeth Dovec	Greater Baltimore Medical Center
Cyrus Engineer	Towson University
Melissa Falbo	Manor Care Ruxton/Towson
Lynn Flanigan	Sheppard Pratt
Ryan Gadow	YMCA
Cindy Hatfield	Walgreen's
Dawn Hohl	John Hopkins Home Care
Becky Horner	Manor Care Ruxton/Towson
Mandy Katz	Giant
Dr. George Kolodner	Kolmac
Lisa LaBoard	Maryland Masonic Homes
Nikki Majewski	MHCC/Telehealth
Lieta Manistre	GBMC
Sierra Marty	GBMC- Patient Experience
Mary McSweeney-Feld	Towson University
Dawn Melanson	Manor Care Ruxton/Towson
Beth Merryman	Towson University
Michelle Middleton	Sheppard Pratt
Dr. Robin Motter-Mast	Greater Baltimore Medical Center
Danny O'Brien	Avila Homecare
Ann Patterson	Broadmead
Macall Perez	Communicare
Dr. W. Anthony Riley	Greater Baltimore Medical Center - Gilchrist
Stacey Sedesse	Maryland Masonic Homes
Yeong-Tae Song	Towson University
Molly Stryker	ShopRite
Michael Wah	GBMC
Ellen Wallace	Greater Baltimore Medical Center
Alexis Weller	CommuniCare

Appendix F. Community Resources

The following were identified at the September 15, 2017, CHNA Community Meeting as resources that already exist in Baltimore County.

Behavioral Health/Substance Abuse
Inpatient units at hospitals
Partial level (3 - 6 hours)
Outpatient
Community Health (Mosaic)
Adult day care
"Chronic illness" – Addiction → PCP
Short-term inpatient
Residential Treatment
Access to Care
Primary care offices
Great hospitals
Specialty Care
Gilchrist Services
Behavioral Health
Sheppard Pratt
St. Joseph's
GBMC
PC Office Culture
Obesity
RDs in grocery stores
Exercise facilities
Geckle
RN Care Manager/Care Coordinators (warm handoffs)

Appendix G. Updated Priority Area Action Plans – October 26, 2018

Priority Area #1: Behavioral Health/Substance Abuse

Focus Area #1: Establish a universal assessment tool and a platform for sharing information

Actions	Responsible Parties/Partners	Timeline	Measures/Outcomes
Create an email list of Behavioral Health Workgroup participants.	Sheppard Pratt – Lynn Flanigan Kolmac – Mimi Walsh-Wehberg	June 2018	• # of participants included on email list
Share and review ideas of assessment tools and information sharing platforms among email list.	All Workgroup Participants	June 2018	• # of participants providing input • # of assessment tools and platforms identified
Hold a meeting of Behavioral Health Workgroup participants and other key organizations to establish a universal assessment tool and discuss platform sharing options.	All Workgroup Participants	July 2018	• # of participants at meeting • Identification of universal assessment tool • # of organizations committed to using universal assessment tool
Train organization staff on how to use the universal assessment tool moving forward.	All Workgroup Participants	Spring 2019	• # of organizations using universal assessment tool • # of staff trained • # of individuals screened through universal assessment tool
Establish plans to reconvene group to make a decision on platform sharing options.	Sheppard Pratt – Lynn Flanigan Kolmac – Mimi Walsh-Wehberg	Spring 2019	• # of organizations invited to participate in discussion
Research mental health apps and the potential tie to universal assessment tools.	Manor Care – Melissa Falbo	January 2019	• # of mental health apps identified • # of ideas generated to link to assessment tool

Focus Area #2: Expand Mental Health First Aid Training

Actions	Responsible Parties/Partners	Timeline	Measures/Outcomes
Determine what organizations provide Mental Health First Aid training classes in the area.	All Workgroup Participants	June 2018	• # of organizations providing Mental Health First Aid training classes in the area
Host Mental Health First Aid training at each organization in the Behavioral Health Workgroup.	All Workgroup Participants	December 2018	• # of organizations hosting training classes • # of people trained
Investigate opportunities to offer community-wide Mental Health First Aid training and consider partnering with local colleges.	All Workgroup Participants, Towson University	Spring 2019	• # of organizations interested in participating in Mental Health First Aid training • # of individuals trained • # of training hours conducted

Focus Area #3: Establish a County-Wide Provider Council

Actions	Responsible Parties/Partners	Timeline	Measures/Outcomes
Identify an organization to spearhead Provider Council.	All Workgroup Participants, GBMC	Spring 2019	• # of organizations identified to spearhead Council • Selection of one spearheading organization
Recruit community stakeholders to participate in the Provider Council.	Spearheading Organization, All Workgroup Participants	Spring 2019	• # of community stakeholders recruited for Council
Conduct initial meeting of Provider Council to discuss Behavioral Health resources available in the community.	Spearheading Organization, Provider Council	Spring 2019	• # of attendees at initial meeting • # of resources identified
Create and maintain an online directory of available Behavioral Health resources.	Spearheading Organization, Provider Council	Spring 2019	• Creation of 1 online directory • # of resources listed in directory • # of page views of online directory • # of updates to directory – updated at least quarterly

Priority Area #2: Access to Care

Focus Area #1: Create seamless transitions between care settings

Actions	Responsible Parties/Partners	Timeline	Measures/Outcomes
Conduct quarterly meetings of providers in the GBMC and University of Maryland St. Joseph Medical Center (UM SJMC) health networks.	GBMC - Leana Hoover, UM SJMC - Alice Chan, Health Network Providers	August 2018	• # of meetings held • # of providers in attendance at meetings
Create a standard set of information to be collected from patients upon admission and discharge that will be utilized across all care settings.	GBMC - Leana Hoover, UM SJMC - Alice Chan, Health Network Providers	August 2018	• Outline a standard data set • # of care settings informed about the standard data set
Create a standard process for communicating the admission/discharge information between care settings.	GBMC - Leana Hoover, UM SJMC - Alice Chan, Health Network Providers	August 2018	• Outline a standard process • # of care settings providing outline of standard process
Launch a standard data set and process for communicating information between care settings.	GBMC - Leana Hoover, UM SJMC - Alice Chan, Health Network Providers	January 2019	# of care settings using a standard set • # of care settings utilizing a standard process • Best practice evaluation of how care has been impacted

Focus Area #2: Improve information sharing among providers and coordination of care

Actions	Responsible Parties/Partners	Timeline	Measures/Outcomes
Identify patient navigators in the service are that focus on uninsured/underinsured populations.	GBMC - Melanie Miller, UM SJMC - contact to be identified	August 2018	• # of patient navigators identified
Hold a forum for patient navigators.	GBMC - Melanie Miller, UM SJMC - contact to be identified	January 2019	• # of patient navigators in attendance at forum
Establish a social media group/website for patient navigators to share resources and offer support.	GBMC - Melanie Miller, UM SJMC - contact to be identified	January 2019	• Creation of a patient navigator social media group/website • # of patient navigators participating in a social media group • # of posts/page views on the social media group/website • #/% of patient navigators that feel the group is helpful

Additional resources identified to help with this focus area: Howard County, Baltimore County Provider Council, Assistance Center of Towson Churches (ACTC), Maryland Senior Resource Network (MSRN), United Churches Assistance Network (UCAN)

Focus Area #3: Identify needs of underserved populations and facilitate connections to meet needs

Actions	Responsible Parties/Partners	Timeline	Measures/Outcomes
Identify populations in need of care specifically the Hispanic, uninsured/underinsured, low/middle income and homeless.	GBMC - Dr. Robin Motter-Mast	August 2018	• # of underserved populations identified • # of connections made with organizations serving underserved populations
Collect social determinants to identify barriers to accessing care.	GBMC - Dr. Robin Motter-Mast	November 2018	• Social determinants collected from individuals • # of barriers identified
Determine if scores from the screening risk/predictive tools can be weighted to factor in the social determinants screening to create a more accurate risk score for patients.	GBMC - Dr. Robin Motter-Mast	Spring 2019	• # of patients with risk scores weighted to include social determinants screening
Establish a Community Access Network (CAN) to help address needs/barriers identified.	GBMC - Dr. Robin Motter-Mast	January 2019	• # of partners participating in network • # of needs addressed through Community Access Network
Create a repository (care navigator guide) of community resources available to improve access to services.	GBMC – Dr. Robin Motter-Mast	December 2019	• Creation of a community resource repository • # of resources included in repository • # of individuals utilizing resources identified in repository

Focus Area #4: Identify transportation resources available in the community to improve access to services

Actions	Responsible Parties/Partners	Timeline	Measures/Outcomes
Determine transportation resources available in the community.	TBD	January 2019	• # of transportation resources identified
Explore mobile integrated healthcare options.	GBMC – Leana Hoover ProCare	January 2019	• # of options identified

Priority Area #3: Obesity

Focus Area #1: Explore opportunities to create "Healthy Baltimore County"

Actions	Responsible Parties/Partners	Timeline	Measures/Outcomes
Reach out to community stakeholders including Baltimore County Health Dept., Giant Registered Dietitian, Department of Aging, Towson University, American Heart Association, YMCA, and Parks and Recreation.	All Workgroup Participants	July 2018	• # of stakeholders contacted
Reach out to Healthy Howard for best practices.	Gilchrist – Anne Evans	July 2018	• # of best practices identified
Convene a meeting of all original Obesity Workgroup members and additional stakeholders.	All Workgroup Participants	August 2018	• # of meeting attendees
Create an inventory of wellness resources in the community (i.e. parks, transportation) both in and out of Baltimore County.	GBMC – Cate O'Connor-Devlin, All Workgroup Participants	Spring 2019	• # of resources identified on inventory

Focus Area #2: Increase access to healthy foods

Actions	Responsible Parties/Partners	Timeline	Measures/Outcomes
Explore opportunities to raise awareness and expand the "Healthy Harvest" program.	GBMC – Meghan Chan	August 2018	• # of new ideas • # of opportunities identified to expand Healthy Harvest program
Create a partnership between Towson University students and older adults in the community to help with grocery shopping.	GBMC – Carolyn Candiello, Towson University	August 2018	• # of older adults served by students • # of college students partnered
Create a partnership between grocery stores and senior housing to bring produce on-site.	GBMC – Cate O'Connor-Devlin, Shop-Rite, Giant, Other Grocery Stores	August 2018	• # of senior housing communities participating • # of seniors served
Explore opportunities to bring Healthy Harvest to GBMC and UM SJMC so staff and surrounding communities gain access to food.	GBMC UM SJMC	Spring 2019	• # of individuals taking advantage of Healthy Harvest

Focus Area #3: Pilot a comprehensive weight management program with GBMC health system

Actions	Responsible Parties/Partners	Timeline	Measures/Outcomes
Connect with GBMC Leadership to discuss idea for comprehensive weight management program.	GBMC	October 2018	• # of conversations with leadership
Create a list of recommendations of weight loss resources in the community for individuals that don't qualify for surgery.	GBMC	Spring 2019	• Creation of list of weight loss resources • # of resources identified
Work with Sodexo to review food served at GBMC.	GBMC, American Heart Association, Sodexo	Spring 2019	• # of healthy food alternatives provided
Pilot the comprehensive weight management program, featuring the list of recommendations of weight loss resources, with GBMC staff.	GBMC	Summer 2019	• # of GBMC staff provided the list/participating in program • # of GBMC staff reaching weight loss goals using recommendation list
Assess the success of the pilot comprehensive weight management program to determine if the program should be expanded.	GBMC	Summer 2019	• %/# of participants that lost weight/within a healthy range • % of participants with blood lipid levels w/in a healthy range • % of participants w/ blood glucose w/in a healthy range • # of participants that have made healthy lifestyle changes

Appendix H. 2016 Implementation Strategy Outcomes

Greater Baltimore Medical Center 2016-2017 Implementation Strategy

Priority Area: Overweight/Obesity with Focus on Prevention of Chronic Diseases (Diabetes & Heart Disease)			
Goal	**Objective**	**Key Indicators**	**Outcome Measure**
Reduce risk factors for chronic disease and prevalence of overweight and obesity among community residents through education, screenings and promotion of healthy lifestyle choices.	Increase the number of residents who access educational resources related to obesity and chronic disease prevention programming.	• All patients seen in the PCMH have a BMI Screening	% of patients seen with a BMI calculated. % of patients seen in the PCMH meeting ACO measure Prev 9, BMI Screening and Follow-up
Priority Area: Mental Health Services for patients with or without chronic diseases			
Improve access to quality care for patients living with chronic disease and mental health issues	Integrate behavioral health services into the Patient Centered Medical Home (PCMH)	Number of patients seen in the PCMH with a mental health diagnosis with or without chronic disease (diabetes, hypertension, obesity) • Total # of PCMH patients screened for depression	%of patients in the PCMH with a mental health diagnosis with or without chronic disease (diabetes, hypertension, obesity) seen by a behavioral health specialist. %of patients seen in a PCMH who have had screening for clinical depression and a follow-up plan documented as defined by the ACO Prev12 measure.