



Mt. Washington Pediatric Hospital



Community Health Needs Assessment and Action Plan

Executive Summary

FY2015

June 2015

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Executive Summary

Introduction

Overview of Mt Washington Pediatric Hospital

Mt. Washington Pediatric Hospital is a comprehensive, sub-acute-care facility serving children with special medical and rehabilitative needs. This small, nonprofit children's hospital is located off a quiet, verdant street in one of the Baltimore City's nicest neighborhoods. From this enclave, the hospital provides rehabilitation and medical care for patients from neonatal to young adult. Over 79% of children treated are from financially disadvantaged families and consider the facility a home away from home. Our workforce includes 604 people. Mt Washington Pediatric Hospital was named as one of the "Best Places to Work in Baltimore" by Baltimore Magazine in February 2012.

Our History

In 1922, a medical social worker named Hortense Kahn Eliasberg sought to open a home where children could safely recover from illness and surgery. Thanks to her efforts, the Happy Hills Convalescent Home for Children opened later that year in Northwest Baltimore. It has since evolved into the Mt. Washington Pediatric Hospital, a leader in local pediatric specialty care. Today, those who work at Mt. Washington Pediatric Hospital remain committed to the mission Hortense Kahn Eliasberg established so many years ago - improving the health and well-being of all children who are ill, injured, or in need of help. Our **mission** is clear; we are forever dedicated to maximizing the health and independence of the children we serve. It is our **vision** that Mt Washington Pediatric Hospital will continue to be a premier leader in providing specialty health care for children, as distinguished by our:

- Quality of care
- Service excellence
- Innovation
- Multidisciplinary approach
- Family focus
- Outstanding workforce

MWPH is a licensed pediatric specialty inpatient, outpatient, and day hospital program that serves Baltimore City, Prince Georges County and the greater metropolitan region, including patients with in-state and out of state referrals. This is MWPH's second Community Health Needs Assessment (CHNA) and reporting these activities is our way of being accountable to the Greater Baltimore community and demonstrating the value and impact of our many community-based services and partnership.

Our Mission

Mt. Washington Pediatric Hospital is dedicated to maximizing the health and independence of the children we serve.

Our Vision

Mt Washington Pediatric Hospital will be a premier leader in providing specialty health care for children, as distinguished by our:

- Quality of Care
- Service excellence
- Innovation
- Multidisciplinary approach
- Family focus
- Outstanding workforce

Our Values

Mt Washington Pediatric Hospital will act in a manner consistent with these values:

- Quality - Adhere to the highest standards of care in a safe environment
- Integrity – Act with honesty and truthfulness in all patient care and business activities
- Respect – Treat all individuals with compassion, dignity, and courtesy
- Education – Promote lifelong learning

In 2010, the Community Advocacy and Injury Prevention Program began October 2010, thanks to the generous support from the MWPH foundation. This was an effort to increase community engagement at the hospital as well as responsiveness to those needs demonstrated by people in our community, Northwest Baltimore and its surrounding counties. Since starting the program MWPH has impacted nearly 51,000 families and formed a network of collaboration with several local and regional organizations.

Our Community Advocacy & Injury Prevention Program:

- **Mission:** To meet the needs of the public by establishing and maintaining relationships with community leaders and government agencies so as to promote programs and activities that advocate for safety and prevent injury for children.
- **Vision:** Increase the visibility and outreach of Mt. Washington Pediatric Hospital and Foundation by helping children and their families reduce death and disability through education and programs on preventing injury.
- **Purpose:** To provide a proactive approach to injury prevention and safety by educating families, providers, and communities on safety and best practices, while fostering coalitions, changing organizational practices and influencing policy and legislation.

Demographic data

MWPH is a regional leader in pediatric specialty care and is a jointly owned corporate affiliate of the University of Maryland Medical Systems (UMMS) and Johns Hopkins Health System (Hopkins). The majority of MWPH patients are residents of Baltimore city.

According to the American Community Survey 2010, African Americans or Blacks make up 63% of Baltimore City's population. Respectively, Whites are 32.6% of the population followed by Hispanics/Latinos with 2.8%. The remaining 4% racial make-up is comprised of Asian, American Indian, and Native Hawaiian/Pacific Islanders.

MWPH patient race demographics reflect those of Baltimore city. Last year, 48% of our patients were Black or African American, 39% were Caucasian, 4% of patients were Latino or Hispanic and 4% were identified as Asian. Approximately 3% were identified as Other/Biracial, with a total of 6,936 unique patients served.

| Demographics | Baltimore City | Maryland |
|--|----------------|-----------|
| Total Population | 620,961 | 5,773,552 |
| Age*, % | | |
| Under 5 years | 6.6% | 6.3% |
| Under 18 years | 21.5% | 23.4% |
| 65 Years and Older | 11.7% | 12.3% |
| Race/Ethnicity*,% | | |
| White | 29.6% | 58.2% |
| Black | 63.7% | 29.4% |
| Native American | 0.4% | 0.4% |
| Asian | 2.3% | 5.5% |
| Hispanic or Latino | 4.2% | 8.2% |
| Median Household Income** | \$39,113 | \$70,017 |
| Households in Poverty | 21.2% | 12.1% |
| Pop. 25+ Without H.S. Diploma**,% | 21.7% | 12.1% |
| Pop. 25+ With Bachelor's Degree or Above**,% | 25.2% | 35.6% |

MWPH is a specialty pediatric facility and our patients come from all over the state of Maryland, and in many cases from out of state. We are a small, family-focused hospital with approximately 604 employees. Where many hospitals define their Community Benefit Service Area (CBSA) by their discharges or by the community of which they reside, MWPH is slightly different. MWPH is located in the Mt Washington area of Baltimore City which according to the 2011 Baltimore City Health Department Healthy Neighborhood Profiles is one of the healthiest neighborhoods in the city, however surrounding this neighborhood, are several of the unhealthiest neighborhoods in the city and state, according their health outcomes and social determinants of health.

As previously stated, MWPH is located in the northwest quadrant of Baltimore City, serving both its immediate neighbors and others from throughout the Baltimore City and County region. The neighborhoods surrounding MWPH are identified by the Baltimore Neighborhood Indicators Alliance (BNIA) as Southern Park Heights (SPH), Upton Druid Heights (UDH) and Pimlico/Arlington/Hilltop (PAH). Together they constitute an area that is predominately African American with a below average median family income, but above average rates for unemployment, and other social determinants of poor health.

BNIA's statistical information for Baltimore City and its neighborhoods indicates SPHs' median household income was \$27,635, UDH's was \$13,388, and PAH's \$29,031. It should be noted that nearly 50% of the people living in the UDH neighborhood meet the federal poverty guideline. This is compared to Baltimore City's median household income of \$30,078, which by comparison is significantly lower than the median income of other counties in the state of Maryland.

The percent of families earning less than the federal self-sufficiency standard in SPH was 56% for married couples with 1-5 children and 85% for "other" families with 1-5 children; in PAH these indicators were 59% for married couples and 83% for "other" families. The unemployment rate for Baltimore City was 15.7 % while UDH had an unemployment rate of 17.5% and PAH 17.0%.

Since MWPH's last CHNA there has been an increase of patients coming from other parts of the city that are not in the northwest quadrant of Baltimore city. This is not necessarily atypical because, as aforementioned MWPH is a specialty hospital and does receive patients from all across the city, its surrounding counties, and states. It should also be noted that this may also be a result of MWPH's co-affiliation with Johns Hopkins Hospitals and University of Maryland Medical Systems that our largest patient admissions are from different parts of the city.

Specifically speaking the largest increase was seen in two neighborhoods that have equally disparaging health outcomes, Clifton-Berea (CFB) and Southwest Baltimore (SWB). According to the Baltimore Healthy Neighborhood Profiles CB's the percent of families earning less than the federal self-sufficiency standard in CFB and SWB was 18.4% and 26.2% respectively. The unemployment rate for both neighborhoods is around 20%, and all of these neighborhoods have homicide rates nearly 30% or more with CFB leading at 61% (# Of homicides/per 10,000 people).

The six zip codes that represent the largest number of admissions to the hospital in calendar year 2011 are, in descending order of admissions 21215, 21217, 21207, 21216, 21223, 21206. The Baltimore City Health Department uses Neighborhood Health Profiles (NHP) when analyzing health outcomes and risk factors. The NHPs are based on census tract data and do not follow zip code boundaries. In the chart

below we have identified the NHP that are contained within the zip codes of the primary service area for MWPH. Two of the zip codes (21207 and 21208) span city/county lines (see footnotes below chart). Baltimore County does not provide NHP's.

The data provided in the chart below for the primary racial composition, median income and households below poverty level was obtained from the US Census Bureau, based on census data from 2010. The life expectancy data, unless otherwise noted, was obtained from the Baltimore City Health Department's 2011 neighborhood health profiles.

| Community Statistical Area | Baltimore City | Upton/Druid Heights (21217) | Southwest Baltimore (21223) | Mondawmin (21216 & 21217) | Pimlico/Arlington/Hilltop (21215) | Howard Park/ W. Arlington (21207) | Southern Park Heights (21215) | Clifton-Berea (21206) |
|----------------------------------|----------------|-----------------------------|-----------------------------|---------------------------|-----------------------------------|-----------------------------------|-------------------------------|-----------------------|
| Life Expectancy (In Years) | 71.8 | 62.9 | 65 | 69.6 | 66.8 | 72.9 | 66.7 | 64.9 |
| Median Income | \$37,395 | \$13,388 | \$27,158 | \$34,438 | \$29,031 | \$36,622 | \$27,635 | \$24,696 |
| % households below poverty level | 15.7% | 48.8% | 26.2% | 12.2% | 21.3% | 15.2% | 25.9% | 18.4% |
| Infant Mortality | 12.1 | 15.0 | 13.6 | 18.5 | 14.9 | 7.8 | 15.6 | 18.3 |
| Avertable Deaths | 36.1% | 63.1% | 31.5% | 31.9% | 45.7% | 21.8% | 50.9% | 45.9% |
| Unemployment | 15.2% | 17.5% | 11.2% | 10.2% | 17.0% | 11.2% | 17.5% | 20.0% |

***The life expectancy provided for the 21207 zip code is not for the entire zip code, but for the CBSA Howard Park/W. Arlington, the city segment of that zip code. Life expectancy is not available at the zip code level in Baltimore County.**

The racial composition and income distribution of these zip codes reflect the segregation and income disparity characteristics of the Baltimore metropolitan region. As indicated above, those zip codes that have a predominantly African American population reflect the racial segregation and poverty with regard to health disparities and poor health outcomes that are reflective of Baltimore City. This is in direct contrast to neighboring Baltimore City/Baltimore County zip codes (21208 & 21209) in which the hospital is located. The median household income 2.5 times higher, and in the population is predominantly white.

Process

I. Establishing the Assessment and Infrastructure

To complete a comprehensive assessment of the needs of the community, the Association for Community Health Improvement's (ACHI) 6-step Community Health Assessment Process was utilized as an organizing methodology. The University of Maryland Medical Systems (UMMS) Community Benefit Team (CBT) served as the lead team to conduct the Community Health Needs Assessment (CHNA) with input from other University of Maryland Medical System Baltimore City-based hospitals, community leaders, the academic community, the public, health experts, and the Baltimore City Health Department. MWPH adopted the following ACHI 6-step process (See Figure 1) to lead the assessment process and the additional 5-component assessment (See Figure 2) and engagement strategy to lead the data collection methodology.

Figure 1 - ACHI 6-Step Community Health Assessment Process



According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a community health needs assessment either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and beginning in 2013, perform an assessment at least every three years thereafter. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public.

For the purposes of this report, a community health needs assessment is a written document developed by a hospital facility (alone or in conjunction with others) that utilizes data to establish

community health priorities, and includes the following:

1. A description of the process used to conduct the assessment.
2. Who the hospital has collaborated with to complete the assessment
3. How the hospital took into account input from community members and public health experts
4. A description of the community served
5. A description of the health needs identified through the assessment process.

Figure 2 – 5-Step Assessment & Engagement Model



Data was collected from the five major areas illustrated above to complete a comprehensive assessment of the community’s needs. Data is presented in **Section III** of this summary. The MWPH participates in a wide variety of local coalitions including, several sponsored by the Baltimore City Health Department, Cancer Coalition, Baltimore Healthy Start Program, Kids in Safety Seats (KISS), Coalition to End Lead Poisoning, as well as partnerships with many community-based organizations like Children’s Hospital Association (CHA), Traumatic Brain Injury Society, Injury Free Coalition for Kids, Greater Baltimore Asthma Alliance (GBAA), American Diabetes Association (ADA), American Heart Association (AHA), B’More Healthy Babies, Text4baby, and Safe Kids to name a few.

II. Defining the Purpose and Scope

Primary Community Benefit Service Area

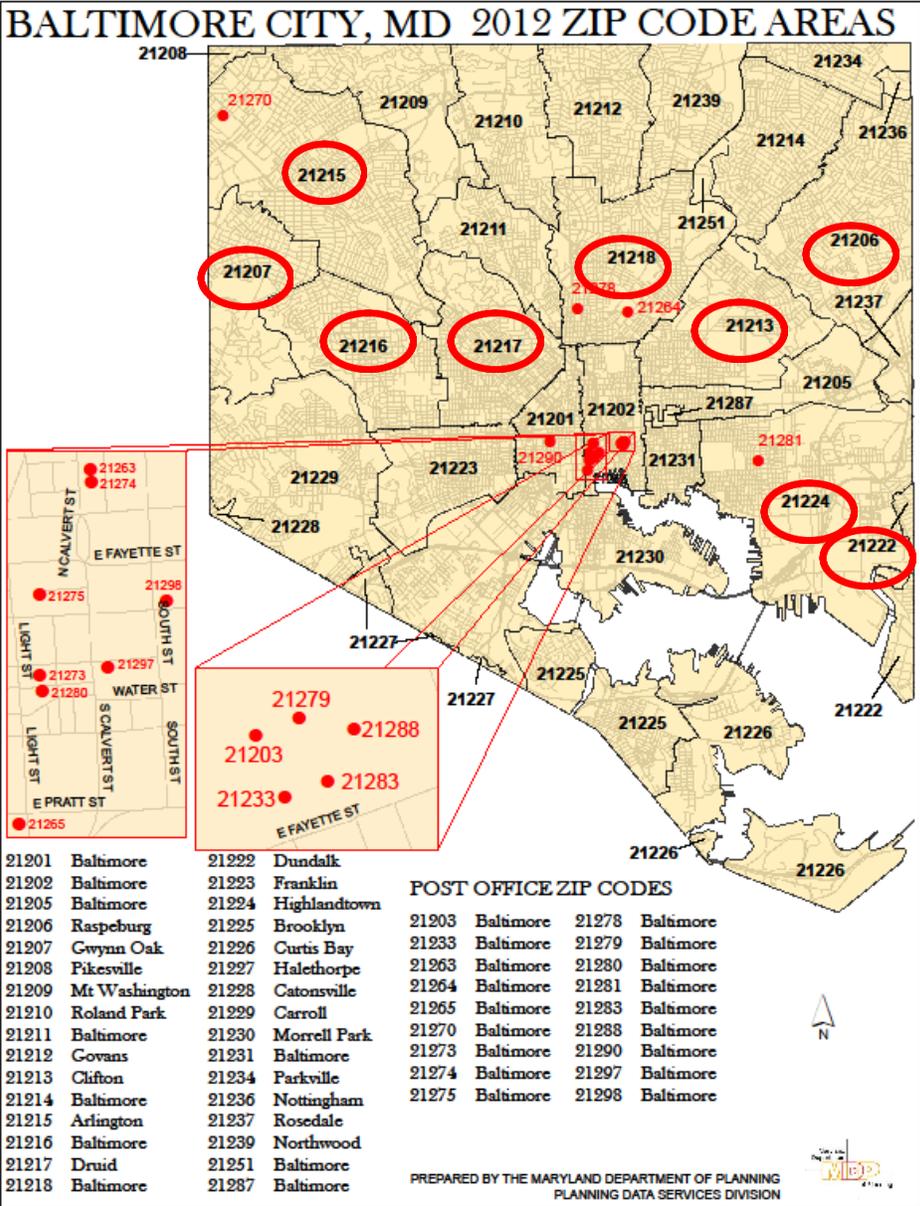
To effectively reach its mission, MWPH conducted a formal community health needs assessment (CHNA) during FY 2015. Despite the larger regional patient mix of MWPH, for purposes of community benefits programming and this report, the Community Benefit Service Area (CBSA) of

MWPH is within Baltimore City.

The Mt Washington Pediatric Hospital serves a large portion of Baltimore County and Baltimore City; we draw 59% of our discharges from a defined market area with four sub-areas within the Baltimore County and Baltimore City. Our core market is defined as 13 contiguous ZIP codes in Baltimore City from which we draw 54% of our discharges. These 13 targeted zip codes are the primary community benefit service area. (CBSA) and comprise the geographic scope of this assessment.

| Bed Designation: | Inpatient Admissions: | Primary Service Area Zip Codes: | All other Maryland Hospitals Sharing Primary Service Area: | Percentage of Uninsured Patients, by County: | Percentage of Patients who are Medicaid Recipients, by County: |
|--|------------------------------|--|---|---|--|
| <p>102</p> <p>Type</p> <p>86- Pediatric Specialty</p> <p>16-CARF Accredited Rehabilitation</p> <p>Location</p> <p>84-West Rogers (Baltimore) Campus</p> <p>15- Prince George’s Hospital Center</p> | 801 | 21215 | UMD | 0% | <p>79.11% of all Patients were Medicaid recipients</p> <p>Baltimore City 40%</p> <p>Baltimore County 29%</p> <p>Anne Arundel County 12%</p> <p>Prince Georges County 8.3%</p> <p>Harford County 6.1%</p> <p>Howard County 4.4%</p> <p>Montgomery County .2%</p> |
| | | 21223 | St. Joseph’s | Uninsured Patients | |
| | | 21213 | Mercy | | |
| | | 21217 | Johns Hopkins | | |
| | | 21206 | St. Agnes | | |
| | | 21061 | Union Memorial | | |
| | | 21218 | UMD Midtown | | |
| | | 21222 | Northwest | | |
| | | 21136 | GBMC | | |
| | | 21224 | Kennedy Krieger | | |
| | | 21207 | Prince Georges Community Hospital | | |
| | | 21244 | Sinai | | |
| | | 21040 | | | |

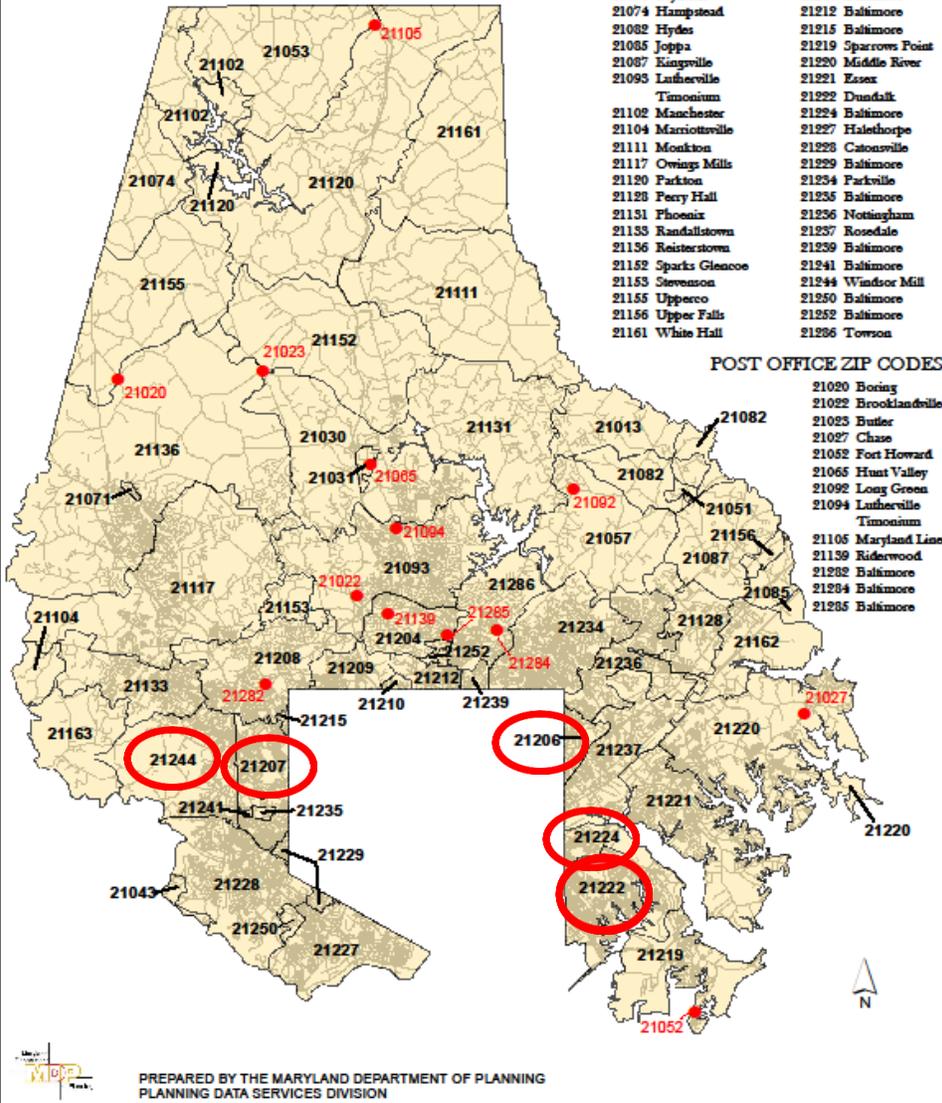
RED= Zip codes in
Top 60% of
Admissions FY'15



BALTIMORE COUNTY, MD 2012 ZIP CODE AREAS

- | | |
|----------------------|----------------------|
| 21013 Baldwin | 21162 White Marsh |
| 21030 Cockeysville | 21163 Woodstock |
| 21031 Hunt Valley | 21204 Towson |
| 21043 Ellicott City | 21206 Baltimore |
| 21051 Fock | 21207 Gwynn Oak |
| 21053 FreeLand | 21208 Pikesville |
| 21057 Glen Arm | 21209 Baltimore |
| 21071 Glyndon | 21210 Baltimore |
| 21074 Hampstead | 21212 Baltimore |
| 21082 Hydes | 21215 Baltimore |
| 21085 Joppa | 21219 Sparrows Point |
| 21087 Kingville | 21220 Middle River |
| 21095 Lutherville | 21221 Essex |
| Timonium | 21222 Dundalk |
| 21102 Manchester | 21224 Baltimore |
| 21104 Marriottsville | 21227 Halethorpe |
| 21111 Monkton | 21228 Catonsville |
| 21117 Owings Mills | 21229 Baltimore |
| 21120 Parkton | 21234 Parkville |
| 21128 Ferry Hall | 21235 Baltimore |
| 21131 Phoenix | 21236 Nottingham |
| 21133 Randallstown | 21257 Rosedale |
| 21136 Reisterstown | 21259 Baltimore |
| 21152 Sparks Glencoe | 21241 Baltimore |
| 21153 Stevenson | 21244 Windsor Mill |
| 21155 Upperco | 21250 Baltimore |
| 21156 Upper Falls | 21252 Baltimore |
| 21161 White Hall | 21286 Towson |

RED= Zip codes in
Top 60% of
Admissions FY'15

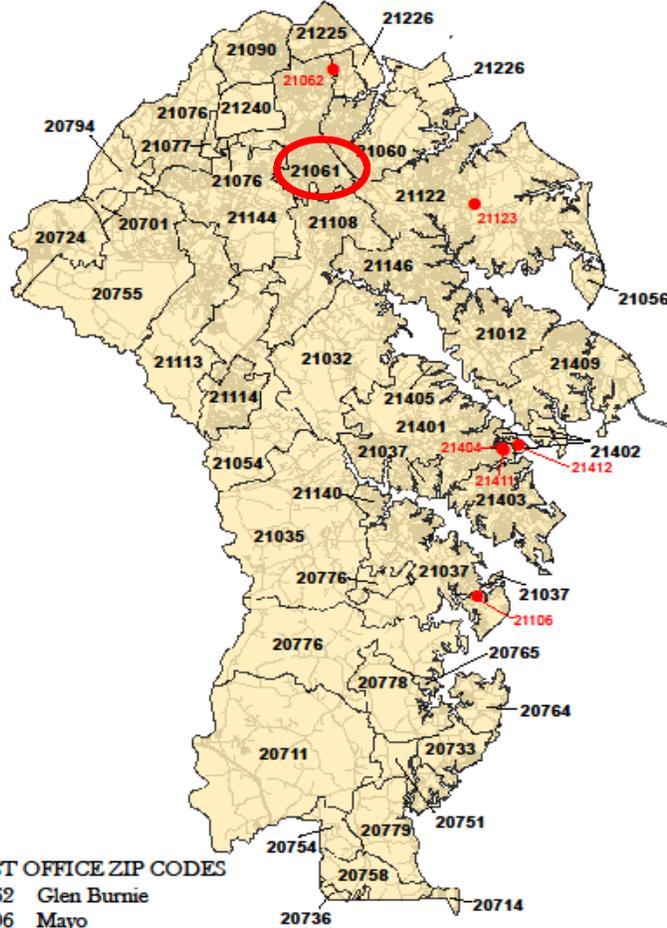


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ANNE ARUNDEL COUNTY, MD 2012 ZIP CODE AREAS

RED= Zip codes in
Top 60% of
Admissions FY'15

- 20701 Annapolis Junction
- 20711 Lothian
- 20714 North Beach
- 20724 Laurel
- 20733 Churchton
- 20736 Owings
- 20751 Deale
- 20754 Dunkirk
- 20755 Fort George G Meade
- 20758 Friendship
- 20764 Shady Side
- 20765 Galesville
- 20776 Harwood
- 20778 West River
- 20779 Tracys Landing
- 20794 Jessup
- 21012 Arnold
- 21032 Crownsville
- 21035 Davidsonville
- 21037 Edgewater
- 21054 Gambrells
- 21056 Gibson Island
- 21060 Glen Burnie
- 21061 Glen Burnie
- 21076 Hanover
- 21077 Harmans
- 21090 Lanthicum Heights
- 21108 Millersville
- 21113 Odenton
- 21114 Crofton
- 21122 Pasadena
- 21140 Riva
- 21144 Severn
- 21146 Severna Park
- 21225 Brooklyn
- 21226 Curtis Bay
- 21240 BWI Airport
- 21401 Annapolis
- 21402 Naval Academy
- 21403 Eastport
- 21405 Sherwood Forest
- 21409 Annapolis



POST OFFICE ZIP CODES

- 21062 Glen Burnie
- 21106 Mayo
- 21123 Pasadena
- 21404 Annapolis
- 21411 Annapolis
- 21412 Annapolis



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III. Collecting and Analyzing Data

Community Perspective

The community's perspective was obtained through two surveys offered to the public during health fairs throughout Baltimore City. A 6-item survey asked respondents to identify their top health concerns and their top barriers in accessing health care. A longer survey was also created and posted online on the public website.

Methods

- 3-item survey distributed to the public at a variety of outreach events in FY'15 (Short Form) and made available in Maryland Matters publication. N=1,212
- 25-item online survey posted to the survey monkey and www.umm.edu website for community to complete (Long Form)
- Attended neighborhood meetings hosted by Baltimore City Health Department and other local community organizations.

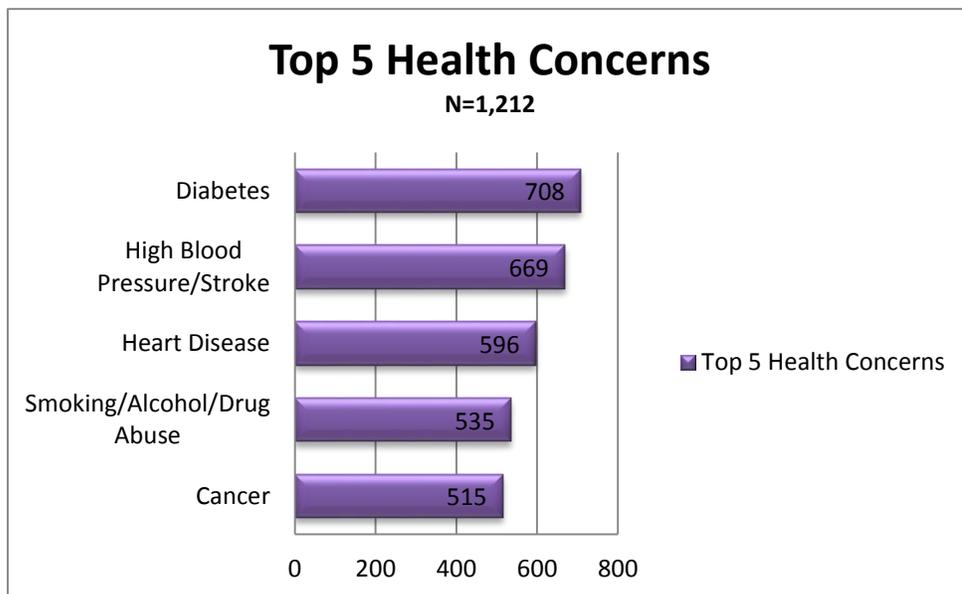
Results

- Top 5 Health Concerns (See Chart 1 Below)
 - Diabetes
 - High Blood Pressure/Stroke
 - Heart Disease
 - Smoking/Alcohol/Drug Abuse
 - Cancer

Analysis by CBSA targeted zip codes revealed the same top health concerns and top health barriers with little deviation from the overall Baltimore City data.

Chart 1 - Community's Top 5 Health Concerns (All Baltimore City)

Frequency Selected

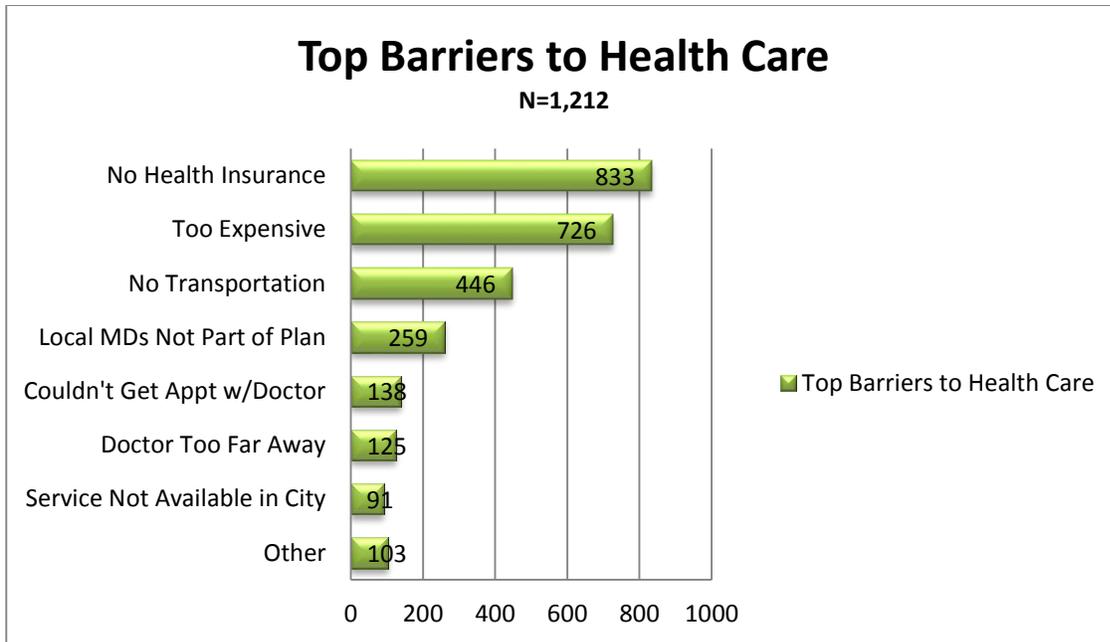


Top 5 Barriers to Health Care: (See Chart 2 below)

- No Health Insurance
- Too Expensive
- No Transportation
- Local MDs Not Part of Plan
- Couldn't get an appointment with Doctor

- Doctor too far away.
- (Medical) service not available in the city

Chart 2 – Community’s Top Barriers to Healthcare (All Baltimore City)



Analysis by CBSA targeted zip codes identified very similar health concerns and top health barriers with little to no deviation from overall Baltimore City data, or the MWPH CHNA completed in 2012.

B) Health Experts

Methods

- Facilitated focus group meetings to include specialty clinical staff; Outpatient (Psychology, Weigh Smart, Social Work) [October 7, 2014], Traumatic Brain Injury & Recreational Therapy [September 29, 2014] as well as MWPH employees who engage in community affairs and MWPH Family Advisory Council [October 24, 2014].
- Interview Baltimore City Health Dept. Director of Chronic Disease Prevention
- Review and include National Prevention Strategy Priorities, State Health Improvement Plan (SHIP) indicators, and Healthy Baltimore 2015 plan from BCHD

Results

- National Prevention Strategy – 7 Priority Areas
- SHIP: 39 Objectives in 6 Vision Areas for State, includes targets for Baltimore City
- Healthy Baltimore 2015: 10 Priority Areas

Methods

Interviewed Laura Fox, MPH, Director, Office of Chronic Disease Prevention, Baltimore City Health Department (2/17/15)

Results

Identified the **top 4 health problems** per Baltimore City Mayor’s health priorities:

1. Cardiovascular Disease (CVD) – Decrease premature mortality (as defined as death prior to 75 years)
2. Asthma – With a concentration on pediatrics specifically
3. Heroin Use – while a priority, no major initiatives to date
4. Diabetes – as related to CVD as a co-morbidity

Top Barriers to Health

- Knowledge deficit with respect to health insurance
 - ✓ People don’t know how to use (navigate) the system- need care connectors and/or health navigators
 - ✓ People aren’t sure what MCO’s will accept them
 - ✓ Limited minutes on phone limits calls for assistance
- General Education/Literacy (SDoH)

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

| National Prevention Strategy: 2011 Priority Areas | Maryland State Health Improvement Plan (SHIP) 2011 | Healthy Baltimore 2015 |
|---|--|---|
| Tobacco Free Living | Healthy Babies | Promote Access to Quality Health Care for All |
| Preventing Drug Abuse & Excessive Alcohol Use | Healthy Social Environments | Be Tobacco Free |
| Healthy Eating | Safe Physical Environments | Redesign Communities to Prevent Obesity |
| Active Living | Infectious Diseases | Promote Heart Health |
| Injury & Violence Free Living | Chronic Diseases | Stop the Spread of HIV & Other ST Infections |
| Reproductive & Sexual Health | Healthcare Access | Recognize & Treat Mental Health Needs |
| Mental & Emotional Well-Being | | Reduce Drug Use & Alcohol Use |
| | | Encourage Early Detection of Cancer |
| | | Promote Healthy Children & |
| | | Create Health Promoting Neighborhoods |

C) Community Leaders

Methods

- Participated in Park Heights Community Partner Focus Group (October 2014)

Results

- #1 Serious Problem identified: 44.8% reported the need for Health Literacy (See Chart 3)
- #2 Serious Problem identified: 35.7% reported the issue of Violence
- Top 3 Moderate Problems in rank order:
 - Behavioral/Mental Illness
 - Heart Disease
 - Diabetes

- 86.7% of community get their health information from family & friends, 63%
- from Internet, 60% from church
- Top 3 Action Items:
 - Mobile Unit – Screenings, Health Education, Community Engagement
 - Set up a “Green” Neighborhood as a Model
 - Mental Health

D) Social Determinants of Health (SDoH)

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

Methods

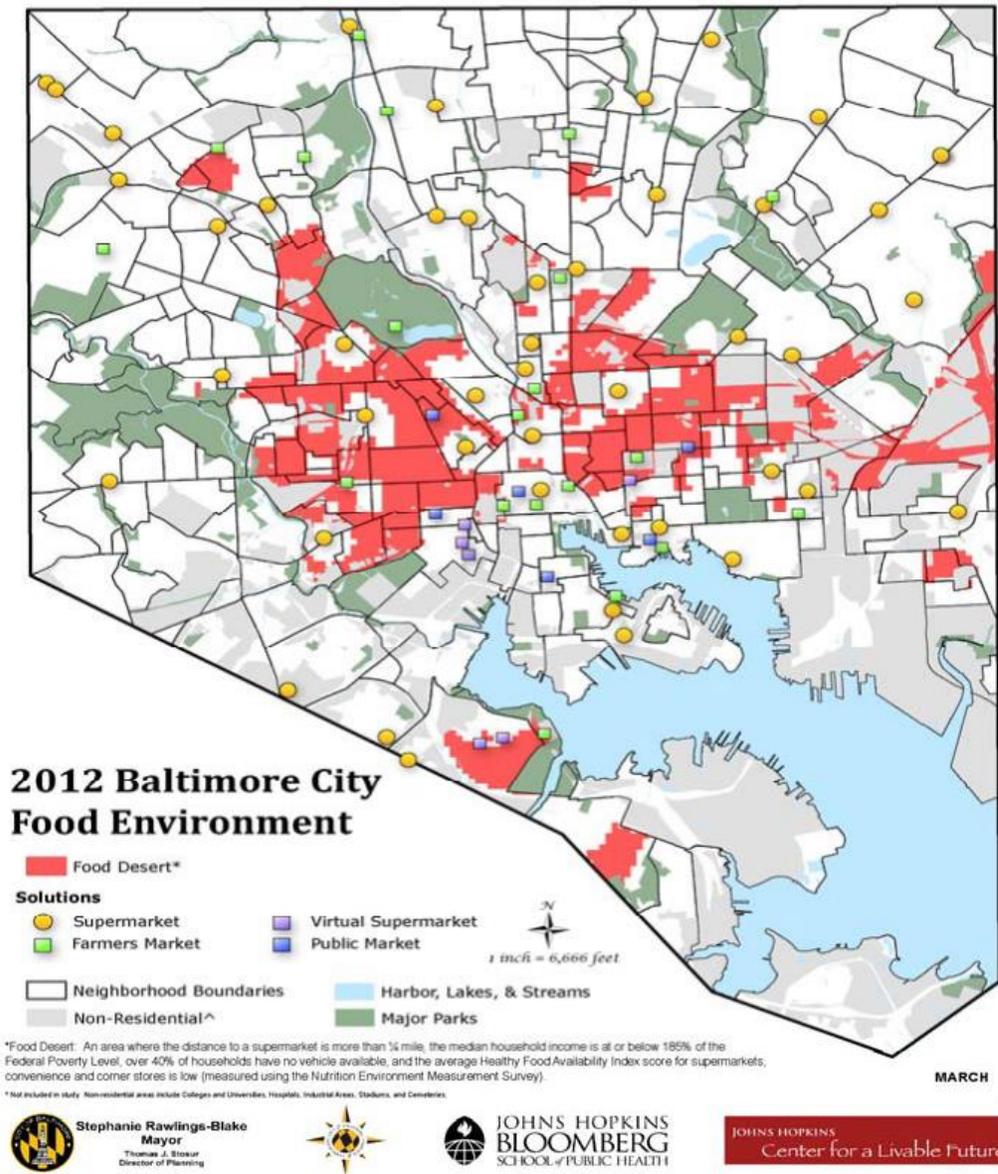
- Reviewed data from identified 2011 Baltimore City Health Department’s Baltimore City Neighborhood Profiles, Baltimore City Food Desert Map (See Figure 5)

Results:

- Baltimore City Summary of CBSA targeted zip codes (See Appendix 1)

- Top SDoHs:
 - Low Education Attainment (52.6% w/ less than HS degree)
 - High Poverty Rate (15.7%)/High Unemployment Rate (11%)
 - Violence
 - Poor Food Environment (See Figure 5 below)

Figure 5 – Baltimore City Food Environment Map



E) Health Statistics/Indicators

Methods:

- Regularly review the following local data sources:
 - Baltimore City Health Status Report
 - Baltimore Health Disparities Report Card
 - Baltimore Neighborhood Profiles

- Regularly review national trends and data:
 - Healthy People 2015
 - Centers for Disease Control reports/updates
 - F as in Fat: Executive Summary (RWJF)

Results:

Baltimore City Health Outcomes Summary for CBSA-targeted zip codes (See Appendix 2):

- Top 3 Causes of Death in Baltimore City in rank order:
 - Heart Disease
 - Cancer
 - Stroke

- Cause of Pediatric Deaths
 - High rate of Infant Mortality

IV. Selecting Priorities

Analysis of all quantitative and qualitative data described in the above section identified these top six areas of need within Baltimore City. These top priorities represent the intersection of documented unmet community health needs and the organization's key strengths and mission. These priorities were identified and approved by the MWPH Community Empowerment Team and validated with the health experts from the Baltimore City Department of Health, local schools medicine, and nursing, rehabilitation, social work and MWPH employees who engage in community affairs.

A prioritization meeting was held on April 30, 2015 with a cross section of clinicians, community stakeholders/activists, as well as community health educators. Participants were provided all the data collected for the fiscal year CHNA which included the community perspective, health experts/focus groups/interviews, as well as national and local health prevention strategies. The group was charged with prioritizing the health needs of the CBSA using the following criteria:

- Magnitude: the number of people impacted by the problem
- Severity: the risk of morbidity and mortality with the problem

- Historical trends
- Alignment of the problem with the MWPB's strengths and priorities
- Impact of the problem on the vulnerable populations of the CBSA
- Importance of the problem in the community
- Relationship of the problem to other community issues
- Feasibility of change, availability of tested approaches
- Value if immediate intervention vs. any delay, especially for long-term or complex threats.

Participants were asked to select six priorities based on this criteria where 1 is the most important/significant and 6 is not as urgent an need. As a result there were 15 different priorities identified. A matrix was then utilized (see chart below) to better identify in what order we would prioritize our services and/or programming and the feasibility of having so many.

| CHNA Priority Setting Matrix FY 2015 | | | | | | | | | | | | |
|---|------------------------------|----------------------------------|-------------------------------|-------------------------|-------------------|---------------------------|----------------------------------|----------------------|-----------|------------------|----------------------|-------|
| | CVD/ Diabetes/ Obesity | Health Literacy/ Education | Maternal & Child Health | Access to Healthcare | Lead Poisoning | Maternal/ Child Health | Mental/ Behaviorial Health | Injury Prevention | Asthma | Health Policy | Workforce Dvlpmnt | TOTAL |
| Problem is greater in the city compared to the state or region. | 70 | 64 | 63 | 73 | 70 | 59 | 66 | 8 | 9 | 10 | 60 | 552 |
| Impact on vulnerable populations is significant. | 66 | 66 | 60 | 67 | 62 | 60 | 66 | 10 | 59 | 11 | 2 | 529 |
| Cost to the community can be achieved by addressing this problem/aligned with Pop Health. | 61 | 68 | 60 | 64 | 61 | 63 | 60 | 66 | 6 | 20 | 9 | 538 |
| Major improvements in the quality of life can be made be addressing this problem. | 60 | 66 | 60 | 67 | 62 | 63 | 62 | 6 | 5 | 11 | 4 | 466 |
| Issue can be addressed with existing leadership and resources. | 63 | 63 | 57 | 55 | 37 | 51 | 59 | 8 | 3 | 2 | 3 | 396 |
| Progress can be made on this issue in the short term. | 61 | 64 | 52 | 53 | 36 | 49 | 60 | 10 | 3 | 3 | 2 | 393 |
| TOTAL | 381 | 391 | 352 | 379 | 328 | 345 | 373 | 108 | 85 | 57 | 80 | |

MWPB priorities were identified as follows:

- 1) Education/Health Literacy/Outreach
- 2) Access to Health Care
- 3) Chronic Disease/Obesity/Diabetes
- 4) Maternal and Child Health
- 5) Lead Poisoning
- 6) Asthma
- 7) Injury Prevention

V. Documenting and Communicating Results

The completion of this community health needs assessment marks a milestone in community involvement and participation with input from community leaders, the academic community, the general public, UMMS Baltimore City-based hospitals, Johns Hopkins University hospitals (JHUH) and

health experts. This report will be posted the MWPB website under the Community Advocacy & Injury Prevention Program. Highlights of this report will also be documented in the Community Benefits Annual Report for FY'15. Reports and data will also be shared with our community partners and community leaders as we work together to make a positive difference in our community by empowering and building healthy communities.

VI. Planning for Action and Monitoring Progress

A) Priorities & Implementation Planning

Based on the above assessment, findings, and priorities, the MWPB agreed to incorporate our identified priorities with Maryland's State Health Improvement Plan (SHIP). Using the SHIP as a framework, the following matrix was created to show the integration of our identified priorities and their alignment with the SHIP's Vision Areas (See Table 1). MWPB will also track the progress with long-term outcome objectives measured through the Maryland's Department of Health & Mental Hygiene (DHMH).

Short-term programmatic objectives, including process and outcome measures will be measured annually by MWPB for each priority areas through the related programming. Adjustments will be made to annual plans as other issues emerge or through our annual program evaluation. MWPB will provide leadership and support within the communities served at sustained and strategic response levels.

- **Sustained Response** - Ongoing response to long-term community needs, i.e. obesity and injury prevention education, health screenings.
- **Strategic Response** - Long-term strategic leadership at legislative and corporate levels to leverage relationships to promote health-related policy or reform and build key networks

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

**Table 1 - MWPB Community Needs Assessment Priorities & Outcomes
FYs '15-18**

| Maryland SHIP Vision Area | MWPB Priorities | SHIP Outcome Objectives |
|---|--|---|
| Healthy Beginnings | Maternal/Child Health Lead Poisoning | 1) Reduce low birth weight (LBW) & very low birth weight (VLBW) 2) Reduce sudden unexpected infant deaths (SUIDS) 3) Increase the proportion of pregnant women starting prenatal care in the first trimester. 4) Increase the proportion of children who receive blood lead screenings |
| Healthy Social Environments Healthy Living | Childhood Obesity/Chronic Disease/CVD/Diabetes Injury/Trauma/Violence Prevention | 1) Reduce the % of children who considered obese 2) Increase life expectancy 3) Decrease rate of alcohol-impaired driving fatalities 4) Decrease rate of distracted driving fatalities 5) Reduce rate of recidivism due to violent injury |
| Safe Physical Environments Healthy Communities | Injury/Trauma/Violence Prevention Lead Poisoning Childhood Obesity/Chronic Disease/CVD/Diabetes | 1) Decrease fall-related deaths 2) Reduce pedestrian injuries on public roads 3) Increase access to healthy foods (See below: Obesity) 4) Reduce child maltreatment 5) Reduce the % of young children with high blood levels 6) Decrease fall related deaths |
| Access to Health Care | Health Literacy/Education/Outreach Access to Health Care | 1) Increase the proportion of persons with health insurance 2) Increase general health literacy and the general populations ability to navigate the healthcare system |

| | | |
|------------------------|--|---|
| Chronic Disease | Obesity/Heart Disease/ Diabetes | <ol style="list-style-type: none"> 1) Increase the proportion of adults who are at a healthy weight 2) Reduce the proportion of children & who are considered obese 3) Increase access to healthy foods 4) Reduce deaths from heart disease 5) Reduce diabetes-related emergency room visits |
|------------------------|--|---|

B) Unmet Community Needs

Several additional topic areas were identified by the MWPH during the CHNA including: mental health, safe housing, transportation, and substance abuse. While the MWPH will focus the majority of our efforts on the identified priorities outlined in the table above, we will review the complete set of needs identified in the CHNA for future collaboration and work. These areas, while still important to the health of the community, will be met through other health care organizations with our assistance as available. The unmet needs not addressed by MWPH will also continue to be addressed by key Baltimore City governmental agencies and existing community- based organizations.

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

**Table 2 - MWPH Strategic Programs and Partners
FYs ‘15-18**

| Maryland SHIP Vision Area | MWPH Priorities | MWPH Strategic Community Programs | MWPH Partners |
|--|--|--|---|
| Healthy Babies | Maternal/Child Health | Prenatal & Postnatal Education | B’More Healthy Babies Stork’s Nest, Text4Baby, |
| Healthy Social Environments | Reduce child maltreatment | Violence Intervention Program (VIP) | Baltimore City Health Dept., The Family Tree, Roberta’s House, House of Ruth |
| Safe Physical Environments | Trauma Prevention Reduce Pedestrian Injuries Reduce Blood Lead Levels | Trauma Prevention B’More Safe Safe Kids Programming (Helmets, Fire Safety, Car Seats) B’More Prepared | Traumatic Brain Injury Society, Johns Hopkins School of Public Health Injury Prevention Program Safe Kids, Baltimore City Fire Dept, Maryland Car Seat Safety Program |

| | | | |
|--------------------------|---|--|--|
| Chronic Disease | Reduce childhood obesity Reduce diabetes-related emergency room visits Reduce death from heart disease | Weigh Smart, Weigh Smart Jr., Healthy Living Academy, Nutritional Rehabilitation Program | AHA, ADA, UMB Campus, UMMS City Hospitals, various Baltimore City Agencies, Mt Washington Elementary, Arlington Elementary, AHA Cooking with Heart Kitchen, Klein's Shop Rite grocery stores |
| | | | |
| Healthcare Access | Workforce Development Health Literacy/ Outreach & Education | Camp NOAH Grow Your Own | Balto City Public Schools, ARC Baltimore, Dress for Success |

Appendix 1 - Social Determinants of Health (SDoH) Summary Baltimore City 2011

| SDoH | Baltimore City | Upton/Druid Hts | SW Balto | Mondawmin | Pimlico/Arlington/Hilltop | Howard Park/W. Arlington | Southern Park Heights | Clifton-Berea |
|--|-----------------------|------------------------|-----------------|----------------------------|----------------------------------|---------------------------------|------------------------------|----------------------|
| Socioeconomic Characteristics | | (21217) | (21223) | (21216 & 21217) | (21215) | (21207) | (21215) | (21206) |
| Median Income | \$37,395 | \$13,388 | \$27,158 | \$34,438 | \$29,031 | \$36,622 | \$27,635 | \$24,696 |
| Unemployment (% Unemployed) | 11.0 | 17.5 | 19.6 | 10.2 | 17.0 | 11.2 | 17.5 | 20.0 |
| Families in Poverty % | 15.7 | 48.8 | 26.2 | 12.2 | 21.3 | 15.2 | 25.9 | 18.4 |
| Education | | | | | | | | |
| Kindergarten Readiness % "Fully Ready" | 65 | 55.1 | 61.2 | 65.9 | 76.8 | 65.8 | 46.4 | 71.0 |
| Adults w/ HS Degree or less - % | 52.6 | 72.2 | 70.2 | 61.6 | 69.5 | 51.9 | 69.6 | 78.5 |
| Community Built Environment | | | | | | | | |
| Alcohol Store Density (#stores/10,000 people) | 4.6 | 6.2 | 11.2 | 51.4 | 5.9 | .9 | 4.5 | 8.1 |
| Tobacco Retail Density (#stores/10,000 people) | 21.8 | 39.0 | 51.4 | 27.8 | 32.2 | 7.4 | 20.3 | 49.6 |
| Community Social Environment | | | | | | | | |
| Homicide Rate (#of homicides/10,000) | 20.9 | 37.9 | 44.2 | 31.1 | 27.9 | 15.6 | 43.7 | 61.8 |
| Domestic Violence (# of incidents/1,000) | 40.6 | 55.0 | 66.3 | 52.8 | 51.8 | 34.7 | 54.1 | 58.2 |

| Housing | Balto City | Upton/ Druid Hts | SW Balto | Mondawmin | Pimlico/ Arlington/ Hilltop | Howard Park/ W. Arlington | Southern Park Heights | Clifton-Berea |
|---|-------------------|---------------------------------|---------------------|------------------|--|--------------------------------------|----------------------------------|----------------------|
| Energy Cut-off Rate (# per 10,000/month) | 39.1 | 45.2 | 79.6 | 62.6 | 73.2 | 61.9 | 20.9 | 61.2 |
| Vacant Building Density (#of buildings/10,000 housing units) | 567.2 | 1,380.5 | 2,081.5 | 844.9 | 918.7 | 128.2 | 1202.9 | 2722.8 |
| Food Environment (# of/10,000 people) | | | | | | | | |
| Fast Food Density | 2.4 | 2.1 | 2.2 | 5.4 | 0 | 0.9 | 1.5 | 3.0 |
| Carryout Density | 12.7 | 16.4 | 24.0 | 11.8 | 18.6 | 9.2 | 7.5 | 13.2 |
| Corner Store Density | 9.0 | 12.3 | 25.7 | 10.7 | 12.7 | 1.8 | 6.0 | 17.2 |
| Supermarket Proximity (by Car in min.) | 3.7 | 1 | 2 | 3 | 2 | 4.0 | 3.0 | 4.0 |
| Supermarket Proximity (by Bus in min.) | 12.3 | 1 | 8 | 11 | 8 | 22 | 8.0 | 10.0 |
| Supermarket Proximity (by Walking in min.) | 16.6 | 1 | 9 | 12 | 9 | 2.3 | 18.0 | 14 |

Source: Baltimore City Health Department (2011). 2011 Neighborhood Health Profile Report. www.baltimorehealth.org

Appendix 2 - Health Outcomes Summary Baltimore City 2011

| Health Outcomes | Baltimore City | Upton/ Druid Hts (21201) | SW Balto (21223) | Mondawmin (21216 & 21217) | Pimlico/ Arlington/ (21215) | Howard Park/ W. Arlington (21207) | Southern Park Heights (21215) | Clifton – Berea (21206) |
|--|----------------|--------------------------|------------------|---------------------------|-----------------------------|-----------------------------------|-------------------------------|-------------------------|
| Life Expectancy at Birth (in years) | 71.8 | 62.9 | 65 | 69.6 | 66.8 | 72.9 | 66.7 | 64.9 |
| Causes of Death (% of Total Deaths) | | | | | | | | |
| 1 – Heart Disease | 25.8 | 26.5 | 26.4 | 24.9 | 26.8 | 21.8 | 32.2 | 30.7 |
| 2 – Cancer | 20.8 | 17.5 | 20.2 | 19.5 | 18.9 | 19.2 | 24.6 | 31.3 |
| Lung | 6.3 | 5.5 | 7.0 | 4.3 | 5.5 | 5.1 | 9.3 | 7.9 |
| Colon | 2.1 | 1.8 | 1.6 | 2.1 | 3.2 | 2.0 | 2.8 | 2.5 |
| Breast | 3.2 | 1.5 | 2.7 | 4.6 | 2.6 | 2.3 | 1.6 | 4.3 |
| Prostate | 2.5 | 2.8 | 2.2 | 3.0 | 3.2 | 4.0 | 3.4 | 3.0 |
| 3 – Stroke | 4.7 | 3.6 | 3.6 | 6.8 | 4.8 | 4.5 | 7.3 | 7.3 |
| 4 – HIV/AIDS | 3.5 | 7.4 | 4.0 | 3.8 | 4.8 | 4.5 | 7.2 | 7.2 |
| 5 – Chronic Lower Respiratory Disease | 3.5 | 1.4 | 2.6 | 2.4 | 2.1 | 3.2 | 4.8 | 2.3 |
| 6 – Homicide | 3.4 | 5.0 | 4.3 | 4.3 | 3.4 | 5.5 | 7.0 | 8.7 |
| 7 – Diabetes | 3.2 | 4.4 | 3.3 | 3.5 | 3.1 | 2.6 | 5.1 | 3.7 |
| 8 – Septicemia | 3.1 | 3.6 | 3.1 | 2.9 | 4.3 | 4.3 | 5.4 | 4.4 |
| 9 – Drug Induced Death | 2.8 | 4.1 | 5.0 | 3.3 | 2.5 | 2.3 | 3.4 | 5.3 |
| 10 – Injury | 2.5 | 2.3 | 2.9 | 2.4 | 2.0 | 3.4 | 2.9 | 3.3 |
| Maternal & Child Health | | | | | | | | |
| Infant Mortality (per 1,000 live births) | 12.1 | 15.0 | 13.6 | 18.5 | 14.9 | 7.8 | 15.6 | 18.3 |
| Low Birth weight % (LBW < 5 lbs, 8 oz) | 12.8 | 14.1 | 13.8 | 18.0 | 14.4 | 9.3 | 18.0 | 14.4 |
| %Prenatal Care 1 st Tri. | 77.3 | 71.4 | 71.6 | 68.4 | 72.2 | 74.8 | 71.1 | 71.8 |
| % Births to Mothers Who Smoke | 8.8 | 10.4 | 17.0 | 11.3 | 10.0 | 4.7 | 11.4 | 12.2 |

Source: Baltimore City Health Department (2011). 2011 Neighborhood Health Profile Report. www.baltimorehealth.org

Appendix 3 -

Community Advocacy Program Strategic Implementation and Action Plan
Priority Area: Maternal/Child Health
Long Term Goal:

- 1) **Maryland SHIP#3: Reduce the percentage of births that are low birth weight (LBW). (Balto City Baseline: 12.8% » 2017 Target: 8.5%)**
- 2) **Maryland SHIP#4: Reduce sudden unexpected infant deaths (SUIDS)**
- 3) **Maryland SHIP#6: Increase the proportion of pregnant women starting prenatal care in the 1st trimester. (Balto City Baseline: 75% » 2017 Target: 84.2%)**

| Annual Objective | Strategy | Target Population | Actions Description | Process Measures | Resources/ Partners |
|---|--|--|--|--|---|
| Reduce the percentage of births that are low birth weight | Support evidenced-based innovative Pre-natal programs that reduce LBW in West Baltimore Communities | Pre and Post-natal women in West Baltimore zip codes: | Provide safety baby showers to B'More Healthy Babies, Baltimore Healthy Start Programs and Promise Heights Program Provide materials on proper nutrition, physical activity, and stress management to encourage healthy full term pregnancies | Enroll 50 additional women in the program Enroll 75 additional women in the Centering Prenatal care Program | B'More Healthy Babies Baltimore Healthy Start Program, Baltimore City Head Starts and other Early Child Hood Centers Community Advocacy Department |
| Increase the proportion of pregnant women seeking prenatal care starting within the 1st Trimester | Educate women in West Baltimore to navigate the health care system to utilize resources in the community that promotes healthy pregnancies | 21215 21223 21213 21217 21206 21208 21218 21207 | Create innovative patient education materials to educate women on importance and benefits of starting prenatal care within 1st Trimester materials to empower women to seek care ASAP via health fairs, MCOs, and MWPH communication channels | 3 types of educational materials/campaigns developed | |

Community Advocacy Program Strategic Implementation and Action Plan

| Priority Area: Violence Prevention Program | | | | | |
|---|---|---|--|---|--|
| Long Term Goal: Reduce the rate of recidivism due to violent injury. (Balto City Baseline: █ 2014 Target: Decrease by 10%) | | | | | |
| Annual Objective | Strategy | Target Population | Actions Description | Process Measures | Resources/Partners |
| Reduce the rate of recidivism due to child maltreatment | Provide talks on behavior management, appropriate toys/play, baby signing, and a resource guide to parents of free resources in the community to provide parents with skills and tools required to be better and more engaged parents | Parents in West Baltimore ZIP codes 21215 | Provide talks once a month as a community benefit. Print resource guide and edit and evaluate after 6 months to ensure accuracy. | Reach: <ul style="list-style-type: none"> • 200 copies of materials distributed • 50 active clients • 25 people attending group weekly | Infant Education Development Team: Rehabilitation Therapists Community Outreach Coordinator Child Life Specialists Physical Therapists Psychologist |
| | Educate community youth on the importance of violence prevention | Middle school teens in Balto City | Present Healthy Self Image Curriculum to program at Baltimore City middle and high schools that is focused of positive self esteem and identifying bullying behaviors Attend community events | <ul style="list-style-type: none"> • 1,000 copies of materials distributed • 40 Events attended • 4,000 people attending events | |

Community Empowerment Action Plan

Priority Area: Lead Poisoning

Long Term Goal:
1) Maryland SHIP#13: To reduce blood lead levels in children (Balto City Baseline: 37.4% 2017 MD Target: 61.5%)

| Annual Objective | Strategy | Target Population | Actions Description | Process Measures | Resources/Partners |
|---|--|---|--|--|---|
| increase awareness of the risks of lead poisoning | Encourage all parents to have their children treated and to treat those children with lead poisoning by educating them about the various dietary and environmental modifications they can make to improve their condition. | Adults & Children in targeted West Baltimore Zips | <p>Provide talks to schools, Elementary Parent Teacher Associations/ Organizations, Head Start Health Advisory Committees West Baltimore targeted zip codes.</p> <p>Provide information on prevention and most up-to-date information regarding Lead legislation.</p> <p>Partner with Baltimore City Health Dept/ Coalition to End Lead Poisoning to provide most recent information community locations.</p> <p>Obtain materials from DHMH and Centers for Disease Control (CDC) on the importance of lead poisoning prevention for distribution in churches, senior centers, website, and community sites.</p> | <p>Incidence of blood lead level poisoning in specific west Baltimore ZIP codes.</p> <p># of materials distributed</p> <p># of events attended</p> <p># of materials distributed</p> | <p>Coalition to End Lead Poisoning</p> <p>MWPH Lead Program Coordinator</p> <p>Community Outreach Coordinator</p> |

| | | | | | |
|--|---|----------------------------|--|---|------------------------------------|
| | | | <p>Develop & distribute healthy food information at EJP Day at the (Northeast) Market</p> <p>Provide info on healthy weight resources at every major outreach event:</p> <ul style="list-style-type: none"> - Take a Loved One Event - Spring into Health Event | | |
| | <p>Educate & engage community on the importance of daily physical activity guidelines using evidence- based research & programs</p> | <p>Adults and Children</p> | <ul style="list-style-type: none"> - B'More Healthy Expo - Diabetes Rally Week - Healthy City Days - Nurses' Week Lexington Market Fair <p>Healthy Living Academy (HLA)</p> <p>Provide (HLA) to at least 3 elementary and middle schools annually</p> <p>Provide pedometers to key community physicians for children 10-18 yrs</p> <p>Develop & distribute physical activity guidelines and resource info at every major outreach event:</p> <ul style="list-style-type: none"> - Take a Loved One Event - Spring into Health Event - B'More Healthy Expo - Diabetes Rally Week - Healthy City Days | <p># of pedometers distributed</p> <p># of students participating</p> | <p>Weigh Smart Program Manager</p> |

Community Advocacy Program Strategic Implementation and Action Plan

Priority Area: Healthcare Access – Health Literacy/Education/Outreach

Long-Term Goals:

- 1) Reduce the utilization of preventable emergency room visits for adults and children.
- 2) Improve the proportion of adults in Northwest Baltimore who are Health Literate

| Annual Objective | Strategy | Target Population | Actions Description | Process Measures | Resources/Partners |
|---|---|-------------------|--|--|--|
| Improve the health literacy in for adults in West Baltimore | Create training program for clinical and non-clinical personnel focused on motivational interviewing | Adults | Review all materials that are provided to patients for literacy levels. Create Health Stream module that promotes cultural sensitivity and training on how to provide motivational interviewing and identifying a patient with low literacy | # of employees who successfully complete the training. # of documents reviewed and reissued with lower literacy levels | University of Medical Systems Maryland Physicians Care Amerigroup United Health Care Maryland Health Care access |
| Reduce the utilization of preventable emergency room visits due to poor or low health literacy skills | Create incentives that provide pictures and or low-literacy techniques to help families better understand how to navigate the health care system. | Adults | Provide information at every major outreach event: - Take a Loved One Event - Spring into Health Event - B'More Healthy Expo - Healthy City Days Develop resource guide to be used on website and for smaller community events as handout | Reach: # of materials distributed per event and totals # of campaigns # of events featuring information # of people attending events # of web page hits | Baltimore City Health Department |

| | | | | | |
|--|---|-------------------|--|--|--|
| | Support community health care workers that provide education on navigating the health care system | Adults & Children | Partner with CBOs to provide education, funding & support of joint missions. | Amount of financial resources provided in \$ # of joint events/activities sponsored | |
|--|---|-------------------|--|--|--|

Community Advocacy Program Strategic Implementation and Action Plan

Priority Area: Workforce Development

Long Term Goal:

1) Increase the number of minority allied health care professionals, specifically pediatric nurses.

| Annual Objective | Strategy | Target Population | Actions Description | Process Measures | Resources/Partners |
|--|--|--|--|---|--|
| <p>Increase the number of minority allied health care professionals, specifically pediatric nurses. number of minority allied health care</p> | <p>CAMP NOAH- to spark interest in nursing and allied health in the high school students of Baltimore City opportunities for underserved residents of West Baltimore</p> | <p>2)Disabled youth/young adults pursuing high school completion degrees</p> <p>2) High School students currently enrolled in healthcare related vocational training</p> | <p>Provide training, coaching and employment for program participants</p> <p>Provide participants with experience and the opportunity to observe care practices working directly with premature infants, toddlers & adolescents, under the guidance of respiratory therapists, and child life specialists.</p> <p>High school students to interact with health care professionals while gaining real world experiences.</p> <p>All students receive education in First Aid & CPR, nursing observation experiences, and all necessary equipment such as stethoscopes, scrubs, and breakfast and lunch provided by the hospital.</p> | <p>Internship will lead to higher employment rates of these minority groups</p> | <p>Baltimore City Public Schools</p> <p>Baltimore Alliance for Careers in Healthcare</p> <p>Nursing Education Department</p> |

Appendix 4
MWPH Community Advocacy Program
Team Members

Sheldon Stein
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Thomas Paullin
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Mary Miller
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Clinical Expert Advisors

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Lead Poisoning Program Nurse Manager
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Michelle Demuele
Weigh Smart Program Manager
mdemeule@mwph.org

Appendix 5 -- Community Health Needs Assessment Partners

University of Maryland School of Medicine

Yvette Rooks, MD, Family & Community Medicine

Renee Fox, MD, MWPH Foundation Board, Pediatrician, Neurology & NICU

UMMS Baltimore-City Based Hospitals

Anne Williams, DNP, RN, Senior Manager, Community Empowerment & Health Education

Donna Jacobs, Senior Vice President Government and Regulatory Affairs, UMMS

Stacy Stephens, Director, B'more Healthy Babies Upton Druid Heights Clinical Instructor

Claire Myer, KISS (Kids In Safety Seats)

Karen Hardingham, University of MD Medical Systems Safe Kids Baltimore

Kevin Williams, Baltimore City Fire Department Inspector
Detector Program

David Skinner, Community & Outreach Associate Green & Healthy Homes Initiative

Alma Roberts, President and CEO, Baltimore Healthy Start Program

Rebecca S Dineen, Bureau of Maternal and Infant Care,
Maternal and Infant Care Program

Anne Langley,
Johns Hopkins School of Medicine
Director of Health Policy Planning

Angela Ginn, R.D., LDN, CDE
Education Coordinator for UMCDE
University of Maryland Midtown Campus

Patricia Barger, Community Outreach Director, The Family Tree Program

Appendix 6

Community Partner Focus Group Attendees - October 30, 2014

| Company | Contact | Title | Telephone | Email | Attending | Notes |
|---|------------------------------|---|----------------------|--|-----------|---|
| MD HZE | Joan D. Plisko, PhD | Technical Director | (410) 706-2107 | jplisko@som.umaryland.edu | 0 | NOT ATTENDING |
| American Cancer Society (ACS) | Kira Eyring | Representative for Hospitals | (410) 931-6850 | kira.eyring@cancer.org | 1 | Sending Suzi Ford, suzi.ford@cancer |
| American Diabetes Association (ADA) | Kathy (Katherine) Rogers | Executive Director, MD Area | (410) 265-0075 x4672 | karogers@diabetes.org | 1 | May need to leave early |
| Associate Black Charities | Diane Bell-McCoy | President & CEO | (410) 659-0000 X1202 | DMcCoy@abc-md.org | 1 | Adar Ayira (AAyira@abc-md.org) attending / Valencia King (VKing@abc-md.org) Valencia is not available |
| Baltimore City Health Department | Dr. Jacquelyn Duval-Harvey | Interim Commissioner of Health | (410) 396-3835 | Jacquelyn.Duval-Harvey@baltimorecity.gov | 1 | Sending Shannon Mace Heller, JD, MPH, Director, Office of Policy and Planning. |
| Bmore Healthy Babies, Upton/Druid Heights Program, School of Social Work | Stacey Stephens | Program Director | (410) 396-0882 X1097 | sstephens@ssw.umaryland.edu | 1 | |
| Center for Urban Families | Joe (Joseph) Jones | Founder, President & CEO | (410) 367-5691 | jjones@cfuf.org | 1 | |
| Coppin School of Nursing | Dr. Tracey Murray | Interim Dean, College of Health Prof. | (410) 951-3971 | tmurray@coppin.edu | 1 | Sending Ms. Sharon Darden, Associate Director of CSU Community Health Center, sdarden@coppin.edu |
| Green and Healthy Homes | Ruth Ann Norton | President & CEO | (410) 534-6447 | ranorton@ghhi.org | 1 | |
| Health Enterprise Zone (HEZ), Bon Secours Health System | Novella Tascoe, JD, MSHA | Health Policy, Advocacy & Proj Mgmt Spec | (410) 362-3183 | NOVELLA_TASCOE@bshsl.org | 1 | |
| Health Enterprise Zone (HEZ), Bon Secours Health System | Tiffany Tate | | | tiffany_tate@msn.com | 1 | |
| Institute for Healthiest Maryland, University of Baltimore | Renee Ellen Fox, MD | Executive Director | (410) 706-5279 | rfox@umaryland.edu | 1 | |
| LIGHT Health and Wellness Comprehensive Services, Inc | Debbie J. Rock, MSW | Executive Director | (443) 524-0220 | drock@lighthealth.org | 1 | |
| Michelle Gourdine & Associates | Dr. Michelle Gourdine | CEO | (443) 801-7932 | drgourdine@gmail.com | 1 | |
| Mosaic Community Services | Lori Doyle, ED | Chief Operating Officer | (410) 453-9553 x1150 | Lori.Doyle@mosaicinc.org | 1 | Sending Timothy Allen, Director, Outreach Services Div., Timothy.Allen@mosaicinc.org |
| Power to End Stroke & American Heart Association | Kimberly Mays | Senior Director, Community & Multicultural Health | (410) 685-7074 | kimberly.mays@heart.org | 1 | |
| Safe Kids Baltimore/MD CARES Program, Univ of MD Hospital Children's Hosp | Karen Hardingham | Clinical Program Coordinator | (410) 328-7532 | khardingham@umm.edu | 1 | Maybe a little late |
| Total Health Care, Inc. | Faye Royale-Larkins, RN, MPH | Chief Executive Officer | (410) 728-4090 | Froyale-larkins@totalhealthcare.org | 1 | sending Nedra Beulah, Director of Community and School-Based Programs, NBeulah@totalhealthcare.org |
| University of Maryland Baltimore School of Nursing | Jane M. Kirschling, PhD, RN | Dean and Professor, DEAN | (410) 706-6741 | jkirschling@son.umaryland.edu | 1 | Sending Pat McLaine, DrPH, MPH, RN, Aast Prof, UMSON, Dept of Family & Community Health, Pat.McLaine |
| Violence Intervention Program in Shock Trauma (VIP) | Tara Reed Carlson MS, RN | Business Development Manager | (410) 328-7347 | tcarlson@umm.edu | 1 | |
| Baltimore City Schools | Naomi Gubernick | Chief of Staff | (410) 396-8805 | NGubernick@bcps.k12.md.us | | |
| Baltimore Medical System | Jay Wolvovsky | President | (410) 732-8800 | jay.wolvovsky@bmsi.org | | |
| Chase Brexton Health Care | Richard Larison | Chief Executive Officer | (410) 837-2050 | rlarison@chasebrexton.org | | |
| Department of Mental Health & Hygiene | Josh (Joshua) Sharfstein | Secretary | (410) 767-4639 | joshua.sharfstein@maryland.gov | | |
| Donate Life | Elizabeth (Libby) Wolfe | Executive Director | (410) 242-7000 | LWolfe@DonateLifeMaryland.org | | |
| Healthcare Access Maryland | Kathleen Westcoat, MPH | President and CEO | (443) 451-4050 | kwestcoat@hcmaryland.org | | |
| Healthy Start | Alma Roberts | President & CEO | (410) 396-7318 | Alma.Roberts@baltimorecity.gov | | |
| Komen | Sarah Cordi | Development Manager | (410) 938-8990 | scordi@komenmd.org | | |
| NAACP - Baltimore City Branch | Tessa Hill-Aston | President | (410) 366.3300 | tessanzacc@yahoo.com | | |
| Sisters Together & Reaching, Inc. | Rev. Debra Hickman | | (410) 276-8969 | debbie7rev@aol.com | | |
| United Way | Mark Furst | President & CEO | (410) 547-8000 | mark.furst@uwcm.org | | |
| | | | | | 19 | Total Invited Guest |
| Hosts | | | | | | |
| Jeff Jones | | | | | 1 | |
| Donna Jacobs | | | | | 1 | |
| Anne Williams | | | | | 1 | |
| Melissa Stokes | | | | | 1 | |
| | | | | | 4 | Total Host |
| | | | | | 23 | Grand Total |



MWPH Community
Empowerment Team
Members

| | | |
|--|---|---|
| <p>Sheldon Stein President & CEO Kevin A. Hollins Board Member Kyra Crafton Community Advocacy Assistant</p> | <p>Tom Paullin VP Development Matthew Cohen Board Member Jill Feinberg Public Relations Director</p> | <p>Renee Fox, M.D. Board Member Melissa Beasley Community Advocacy Manager Yehudis Scheter Internal Communications Coordinator Monica Atkinson Senior Manager Human Resources</p> |
| <p>Paula Bragg Director of Philanthropy</p> | <p>Tammany Buckwalter Director of Events & Provider Relations</p> | <p>Michelle Hanover Family Liaison Denise Pudinski VP Social Work Steve Band, M.D. Pediatric Psychology</p> |
| <p>Justina Starobin VP Outpatient Services Erica Jones Infection Control Nurse Mgr Linda Morrison Health Professionals and Nursing Education</p> | <p>Jenny Bowie VP Nursing Sally DeArruda Language Services Manager Lois Bower Manager Recreational Therapy</p> | <p>Sajid Manzoor Respiratory Therapy/ Diversity Council Chair Michele Demeule Weigh Smart Program Mgr David Kravitz Green & Healthy Homes Initiative</p> |
| <p>Angel Bivens Poison Control/Baltimore Safe Kids Cardell Payne Outpatient Services Manager Jimmy Payne Arlington Elementary School</p> | <p>Richard Katz, M.D. Chief Medical Officer</p> <p>Sonya Johnson-Branch Healthy Living Academy David Skinner Green & Healthy Homes Initiative</p> | <p>Susan Dubroff CARF Surveyor/ VP Rehabilitation Therapy</p> |
| <p>Barbara Moore Nurse Manger Lead Program</p> | <p>Sharon Meadows Nursing Education</p> | |

Appendix 8- Focus Group Notes

Community Partner Focus Group 10/30/14

Needs

- Asthma → Healthy Homes
- Mental Health → stress & stress management w/ crises
- Addictions → lack if integrated systems
- Health literacy (twice)
- Health education for teens
- People living in crisis lifestyle
- Lack of coordinated services for integrated care/ Care Coordination
- Access to primary care → integrated w/ primary care medical home
- Access to health resources → physical fitness
- Prenatal & first 100 days → focus on children
- Infant mortality → complications in women's health/healthy women
- Sufficient employment to support families
- Restrictive hiring policies – for people who have a criminal record, can't get healthcare jobs

Barriers

- Wrong focus- focus on outcome and not the root of the problem
- Bureaucracy – measures of success haven't changed
- Working in silos
- Shared vision with community partners
- Our vision of a healthy community (how the community defines healthy as opposed to outsiders)
- Interagency collaboration (Lack of)
- Lack of community voice
- Trust

- Resistance to change → making something a belief
- Organizations' missions/conflict
- Funding allocation – real vs. perceived
- Misalignment of incentives/payment structures
- Too much talking and not enough action
- Misinformation in the community

Resolutions- "What Can We Do About It?"

- Shore up mental health/behavioral health with community benefit dollars → generate savings from preventative readmissions
- Behavioral health should not be separate from public health
- Invest in social economic determinates. Add civil/legal attorney
- Leverage existing resources, use expertise to seamlessly address issues.
- Leverage partnerships in connecting to w/our community partners
- Fund the root causes
- Use more Community Health Workers
- Use community-based organizations for grant writing
- Can't spread resources too thin → prioritization is critical
- Join/align policy advocacy issues

Appendix 9-

MWPH (Specialty) Focus Group Notes SUMMARIZED

On the status of pediatric health and wellness in Baltimore city:

- Very divergent by income; health determined by income
- Pimlico and Park heights are not wealthy; have poor health outcomes; there is a correlation between race, income and those outcomes.
- Access to healthcare
 - Access to good employment, role models, and schools—Neighborhood have lost their core.

Maryland is very good at providing coverage → other social issues prevent positive health outcomes. Providing connections to these (social) services for children is hard. It seems as if there are more social issues other than number of physicians available.

GAPS & DISPARITIES

- With behavioral health, the law requires that patients must receive services in a regulated facility before reimbursement can be made. In most cases, there are no incentives in the community for behavioral health.
- There is not a strong presence of two-parent households. This can affect child care and income. Recently in primary care there has been an increase of father involvement. Despite the fact they did are not married, their involvement makes a difference.
- The epidemic of substance abuse in Baltimore City plays a role in healthcare and child care.
- The gaps in care when a woman becomes pregnant. It usually takes usually 6-8 weeks to be eligible for insurance. This delays women in receiving care until their second trimester.
- Some parents think that Pre-K is not necessary for their children. Educating parents on the importance of education will help as well.
- Many parents do not meet the income requirements for early education programs/aftercare such as Head Start

Access to care as relates to the community

- Barriers in transportation, language, and services necessary for care
 - For example, shuttle is not wheelchair accessible. Try to accommodate this by vouchers. Sometimes the voucher did not work.
 - Access to child care for training at MWPH.

- Lack of quality child care can be barrier to health. If they cannot find reliable transportation or child care, family will miss sessions and reschedule appointments.

RECOMMENDATIONS

- MWPH can visit more neighborhood child care and provide education about health and development.
 - Family Fun—allow families to visit the hospital for training, education, and availability for other matters
- MWPH provide more services to the community and improve services to the community
- Add UMMS shuttle and stop to Mondawmin Mall to improve access to MWPH
- Expansion of shuttle to Bayview area. Patients from Dundalk, Rosedale, and Essex can travel to MWPH.
- Making the shuttle more accessible for disabilities (this was addressed within the disability plan.)
- Creating support programs (support groups)
 - Opportunity for therapist to act as a guide for the parents within the support group.
 - Despite historically experiencing low attendance, MWPH can find ways to provide support and increase engagement from the community.
 - Issue: Creating child care option for parents during the support group.
- Using the locals schools as resources
- Providing behavioral services to the parents
- Create partnerships with adult behavioral services
- Provide support and assistance for parents
- Dual services for child and family
- Affiliated Partners (Expand and utilize partnership by MWPH)
- Parent-to-parent respite care
- Encourage parents to build relationship with other parents in similar situations, facilitate positive relationship such as with “Happy Hour”
- Expansion of Recreational therapy
 - Collaborating with weight smart for programs with toddlers and pre-schoolers
 - Adaptable programs such as sports in the community for pediatrics
 - UMMS Rehab Network Partnership

- Walk clinic
- Safety issues change for the children as they get older. Recommends addressing injury prevention forums for older children safety prevention
- Need for preparedness for disaster
- Provide age-appropriate materials to educate families about disaster preparedness
- A series of education sessions dedicated to preparing for life scenarios (i.e. strong winter)
- Specific programs to address matters like electronically dependent children
- Assist families in understanding how to navigate through healthcare services
- Identify staff who best understand what benefits are available for outpatient families
- Creating a program for the target areas for food dessert areas.
- Using collaborations and partnerships within the community and more community-base programming
- Involve interested parents to facilitate the programs (as well as neighborhood association) to engage the community.

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