Community Health Needs Assessment & Implementation Plan

FY2022- FY2024

Mt. Washington Pediatric Hospital

APPROVED BY THE BOARD OF DIRECTORS • JUNE 24, 2021

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Executive Summary

Located in Baltimore, Maryland, Mt. Washington Pediatric Hospital (MWPH) has provided specialty rehabilitative and transitional medical care to children for nearly 100 years. MWPH is a specialty care hospital serving newborns to young adults with a variety of medical and rehabilitative needs. With 102 beds and a workforce of nearly 700, MWPH is a recognized leader in pediatric specialty care, treating more than 8,500 patients annually. As a jointly owned corporate affiliate of the University of Maryland Medical System (UMMS) and Johns Hopkins Medicine, MWPH provided more than $5.4 million in community benefit services in fiscal years 2022-2024.

In FY2020 alone the Community Benefit team attended 32 health fairs, provided nearly 2000 pediatric health assessments, 600 hearing and vision screenings, 400 car seat installations and education and incorporated strategies to reduce the impact of COVID19 on vulnerable communities in our region.

The following report outlines the process by which the MWPH Community Health Needs Assessment (CHNA) was conducted for FY 2022 – FY 2021 and the implementation strategies that will be adopted to meet these needs.

Mission

MWPH proud to lead the way in improving the lives of children and young adults with complex medical needs. Its mission is to maximize the health and independence of the children they serve.

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

Source: https://www.mwph.org/about-us/mission-vision-values

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

Community Health Improvement Mission

As an affiliate of UMMC, we share in their community health improvement mission to empower and build healthy communities.

Process

From July 2020 to May 2021, MWPH undertook a comprehensive community health needs assessment (CHNA) to evaluate the health needs of children with special health care needs in Baltimore City, Maryland. The aim of the assessment was to reinforce MWPH's commitment to the health of residents and align its health prevention efforts with the community's greatest needs. The assessment examined several health indicators including chronic health conditions, access to health care, and Social Determinants of Health (SoDH).

The MWPH Community Health Improvement Team served as the lead team to conduct the CHNA. MWPH worked with the Baltimore City Hospital Community Benefit Collaborative (BCHCBC) where local Baltimore City hospitals joined together (initially in 2014), to collaborate on several key data collection strategies for a joint community health needs assessment.

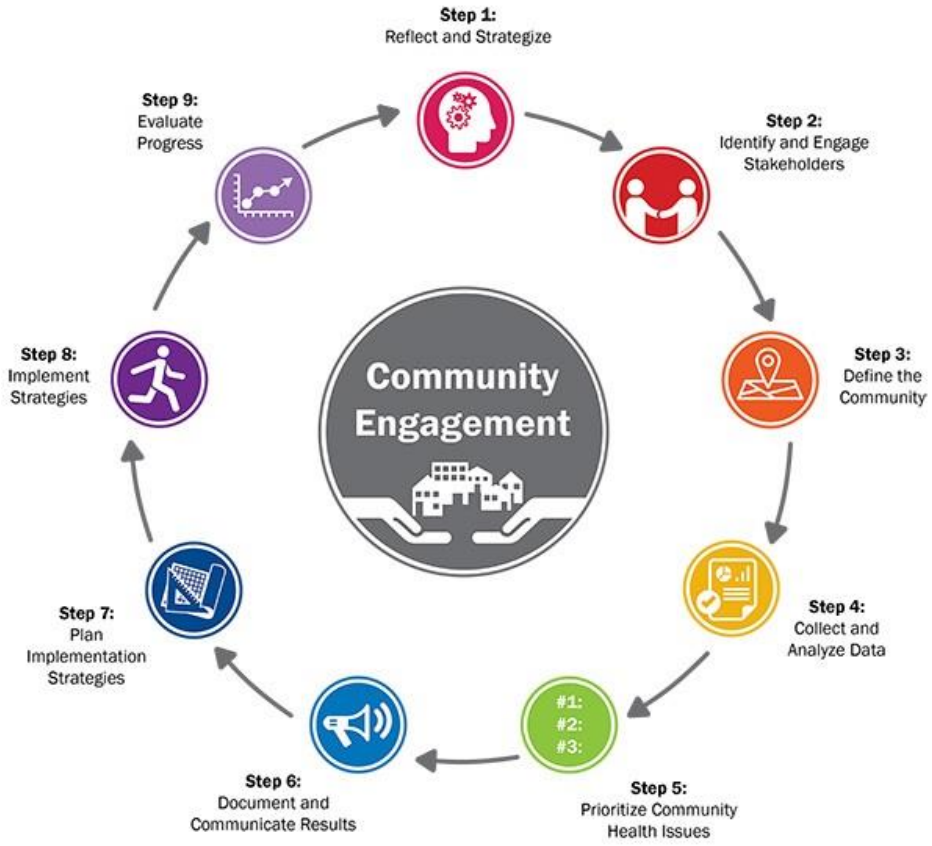
For the 2018 CHNA, MWPH continued to partner with BCHCBC to include, University of Maryland Medical Systems (UMMC), Johns Hopkins Hospital, Sinai Hospital Lifebridge Health, MedStar Health, St. Agnes Health System, and Mercy Medical Center. All of the above hospitals/health systems had been collaborating on several initiatives prior to the CHNA year and agreed that it would be beneficial to work on a more detailed level on a joint city-wide CHNA.

Baltimore City Hospital Community Health Collaborative (BCHCHC)

- University of Maryland Medical System
- Johns Hopkins Health
- MedStar Health
- Mercy Medical
- Lifebridge Health
- St. Agnes Hospital

To complete a comprehensive assessment of the needs of the community, the Association for Community Health Improvement's (ACHI) 9-step Community Health Assessment Process and was utilized as an organizing methodology (Figure 1).

Figure 1 – ACHI 9-Step Community Health Assessment Process



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

I. Reflect, Establish Infrastructure, and Strategize

Before beginning a new assessment cycle, MWPH reflected on its previous CHNA to identify what elements worked well, areas for process improvement and whether the implementation strategies had their desired impact. Below outline outlines the previous CHNA priorities and the needs met.

Previous CHNA and Prioritized Health Issues**:** MWPH conducted a comprehensive CHNA in 2018 to evaluate the health needs of individuals living in the hospital service area within Greater Baltimore. The purpose of the assessment was to gather information about local health needs and health behaviors. The assessment provided guidance to MWPH to prioritize six health issues and develop a community health implementation plan to improve the health of the surrounding community. The prioritized health issues were:

Figure 2 – Previous CHNA Priorities 2018-2020

Previous CHNA Outcomes:

- 42,123 families received education on preventable injures
- 2,053 Families received education about lead poisoning through Health Education and Outreach
- 1736 households (in-person and virtual) reached through Parenting from the Heart health literacy and mental health seminars.
- 1,674 family assistance bags distributed
- 1,809 ht/wt/body-mass assessments conducted
- 742 families received car seat installation, education and refresher
- 505 participants in 36 Safety Baby Showers receiving education on preventable injuries such as scalding/burns, traumatic brain injury as a result of poor child passenger safety, falls, furniture tip-overs, child maltreatment, poisoning, and sudden infant death syndrome
- 492 vision screenings and 237 eye glasses provided
- 401 patient families provided with transportation assistance
- 309 Discharge assistance provided
- 316 children participated in bully prevention education
- 211 hearing screenings conducted

During the implementation of the identified strategies, the Nation was faced with an unprecedented Covid-19 pandemic. Mt. Washington Pediatric Hospital Community Benefit team quickly reassessed the Implementation Strategies in place to cater to the severely hit communities while keeping focus on the determined FY2019-Fy2021 priorities. The following outcomes were achieved.

COVID-19 Pandemic Related Outcomes:

- 265,000 meals provided to families in need
- 3,626 diapers, wipes, baby families
- 2,653 adult and children's masks distributed
- 26 food distributions/community pantries supported

II. Identify and Engage Stakeholders

The Community Advocacy Team continues to establish robust, trusting relationships with community stakeholders and foster a welcoming and inclusive environment, creating a stronger sense of joint ownership of the CHNA process. Including, several sponsored by the Baltimore City Health Department, Tobacco Coalition, and Safe Kids. In addition, many community –based organizations such as, B'More Health Babies, Y of Central Maryland and St. Vincent de Paul Head Starts, Baltimore City Public School System, Park Heights Renaissance, Baltimore City Homeless Children, Jewish Volunteers Connections, Baltimore City Police Department, Weekend Backpack for Homeless Children, American Red Cross, and multiple family and youth organizations supporting the underserved communities in Baltimore City.

III. Defining the Community Benefit Service Area

Despite the larger regional patient mix (Figure 3) of MWPH from the metropolitan area, state, and region, for purposes of community benefits programming and this report, the Community Benefit Service Area (CBSA) of MWPH is within the 21215, 21216 and 21217 zip code areas.

To specify the geographic focus and population characteristics for the scope of the assessment and implementation strategies, MWPH accessed data by zip code (top 60% of admissions/outpatient visits), and the Baltimore City Health Department Neighborhood Profile data was utilized (please note that no update to 2017 data was made by the Baltimore Neighborhood Indicator Alliance (BNIA), therefore, per Baltimore City Health Department, 2017 BNIA was utilized.) The team also connected with the parents of children with special health care needs through virtual focus groups and hospital support groups to truly understand their concept of community.

MWPH serves children, adolescents, and young adults from primarily from Maryland, but also many States in the Northeast region. MWPH has three location locations, in Northwest Baltimore City, Prince Georges County at UM Capital Regional Hospital and an outpatient site in Harford County. Data analyzed during the last three fiscal years---2019, 2020, and 2021---indicate that 93% of all inpatients and outpatients served by the MWPH are Maryland residents, with patients from nearly every county.

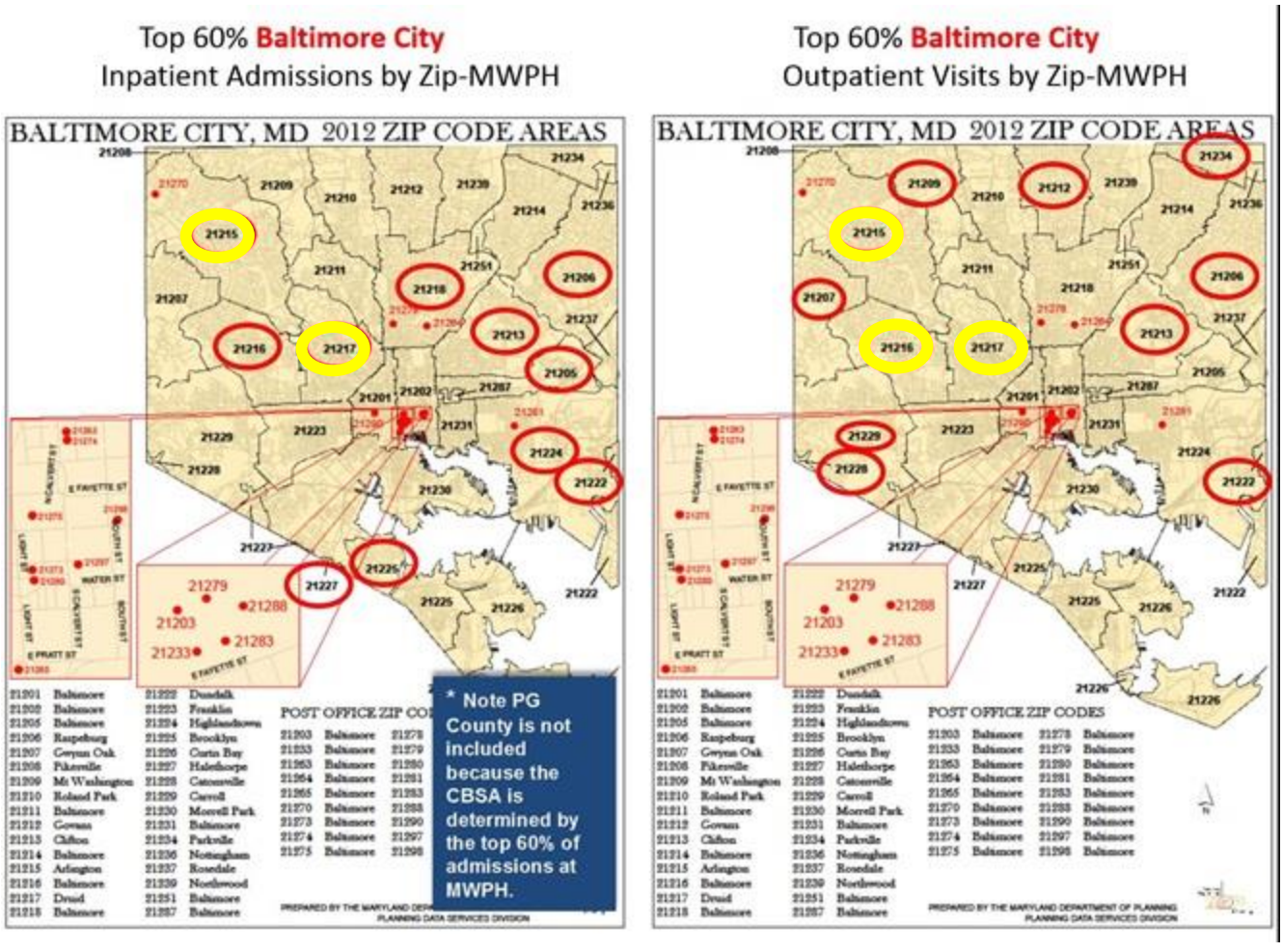
MWPH also receives patients from across the State due to limited access to pediatric specialists in rural parts of Maryland. According to the 2020 Maryland Parent Survey, 73% of parents reported driving 25 or more miles for pediatric specialty care, with 25% reporting that they had to drive 100+ miles roundtrip. In order to make our community programming as impactful, MWPH further defined its community by looking at the top 60% of inpatient admissions and outpatient visits from Baltimore City and Baltimore County. Medicaid patients accounted for 79.11% of the total MWPH admissions in FY20 and 5% of these Medicaid patients live in the 21215 and 21217 zip code which is a target area of the hospital's community benefit service area (CBSA).

All of the in-patient and outpatient service area zip codes outlined in figure 3 do not necessarily determine eligibility for community benefit services, because MWPH is a specialty pediatric facility, our patient's residence span the state of Maryland and many more from out of state. Therefore, MWPH determined that the specific zip codes of 21215, 21216 & 21217 define the hospital's Community Benefit Service Area (CBSA) and constitute an area that is predominantly African American with below average median family income, but above average rates for unemployment, and other SoDH of poor health.

Relying on data from the American Community Survey[1], SPH's median household income was $26,015 and PAH's median household was $32,410. This is compared to Baltimore City's median household income of $41,819 in 2017. The percentage of families with incomes below the federal poverty guidelines[2] in SPH was 46.4%, in PAH, 28.4% of rates for SPH and PAH, were 23.6% and 17.1% respectively while the Baltimore City unemployment rate recorded in 2017 was 13.1%.[3]

The racial composition and income distribution of the zip codes described above reflect the segregation and income disparity characteristic of the Baltimore metropolitan region. As indicated above, those zip codes that have a predominantly African American population, including 21215, reflect the racial segregation and poverty representative of Baltimore City. This is in contrast to neighboring Baltimore County zip codes (21208 & 21209) in which the hospital is located, the median household income is much higher, and in which the population is predominately white.

Figure 3. Top 60% Inpatient Admissions/Outpatient Visits by Zip FY20 for Baltimore City and Community Benefit Service Areas



IV. Collect and Analyze Data

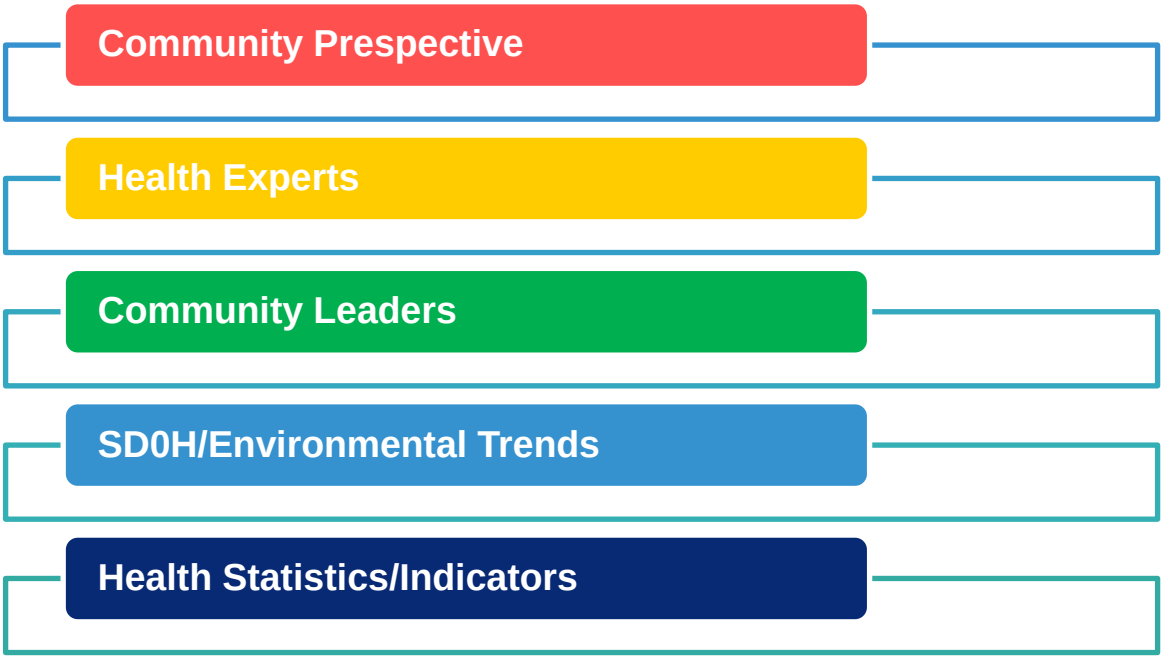
The below 5- component assessment (See Figure 2) and engagement strategy was used to lead the data collection methodology.

Table I. General Hospital Demographics

Bed Designation:	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:
102 *Type* 86- Pediatric Specialty 16-CARF Accredited Rehabilitation *Location* 84-West Rogers(Baltimore) Campus 15- Prince George's Hospital Center	21222 21220 21206 21215 21213 21061 21221 21205 21217 21224 21227 21225 21037	UMD St. Joseph's Mercy Johns Hopkins St. Agnes Union Memorial UMD Midtown Northwest GBMC Kennedy Krieger UM Capital Regional Hospital Sinai	0% Uninsured Patients	81% of all Patients were Medicaid recipients Baltimore City 56% Baltimore County 19% Prince Georges County 9% Anne Arundel County 8 % Harford County 4% Howard County 2% St. Mary's County 2%

In collaboration with BCHCBC, data was collected from the five major areas outlined above to complete a comprehensive assessment of the community's needs (figure 4). Including, online and in-person paper surveys, telephone town hall phone interviews, of Baltimore City and Baltimore County residents, focus groups with community state holders and patient families, key informant interviews of community leaders and stakeholders and quantitative data analysis of secondary, and published data from multiple sources. *Please note that no update to 2017 data was made by the Baltimore Neighborhood Indicator Alliance (BNIA), therefore, per Baltimore City Health Department, 2017 BNIA was utilized.*

Figure 4 – 5-Step Assessment & Engaement Model



The findings from the assessment were utilized by MWPH to prioritize public health issues and develop a community health implementation plan focused on meeting community needs. This CHNA targets the needs of children and young adults with developmental disabilities and other disorders in Baltimore City as well as their families. This CHNA Final Summary Report serves as a compilation of the overall findings of each research component.

Please note: Due to the COVID-19 pandemic and the limitations on in-person gatherings, the number of surveys, focus groups and other engagement strategies were challenged. However, every effort was made to ensure quality and quantity of engagement and data collection.

Using the above frameworks (Figures 1 & 2), data was collected from multiple sources, groups, and individuals and integrated into a comprehensive document which was utilized at a retreat on March 29, 2021 with the MWPH Community Health Advisory Board (CHAB) along with several other community organizations, faith-based leaders, elected officials, patient families, hospital leadership. During that strategic planning retreat, priorities were identified using the collected data and an adapted version of the Catholic Health Association's (CHA) priority setting criteria.

The identified priorities were also validated by a panel of MWPH clinical experts. MWPH used primary and secondary sources of data as well as quantitative and qualitative data and consulted with numerous individuals and organizations during the CHNA. Including, University of Maryland Medical Center Midtown Campus, University of Maryland Hospital for Children, Johns Hopkins Health, other BCHCHC hospitals, community leaders, community partners, the University of Maryland Baltimore (UMB) academic community, the general public, patient families, local health experts, and the Baltimore City Health Department.

MWPH also joined together to collaborate on several key data collection strategies for a joint community health needs assessment. This effort was initially launched in 2014 and (as mentioned previously) was identified as the Baltimore City Hospital Community Health Collaborative. In addition to UMMS and JHH, BCHCHC included multiple Baltimore based health systems/hospitals. Including, Sinai Hospital Lifebridge Health, MedStar Health, St. Agnes Health System, and Mercy Medical Center. All of the above hospitals/health systems had been collaborating on several initiatives prior to the CHNA year and agreed that it would be beneficial to work on a more detailed level on a joint city-wide CHNA.
This multi-hospital collaborative worked on the following data collection components together:
- Public survey of Baltimore City residents
- Key stakeholder interviews
- Key population focus groups
- Key community partner focus groups for Implementation Strategy (asthma, mental health, children's health)

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

A) Community Perspective – Surveys

The community's perspective was obtained through one survey offered to the public using several methods throughout Baltimore City. Due to the COVID-19 pandemic, routine methods of collecting responses to the survey posed a great challenge. MWPH and BCHCHC was unable to distribute as many surveys as majority of the community events were canceled. However, MWPH worked closely with community partners, hospital staff (associates, leadership and physicians), Baltimore City Health Department and other stakeholders to distribute the surveys electronically and in-person at COVID relief efforts (food pantries, clothing drive, virtual job fairs and via social media platforms). See Appendix for the actual survey.

Methods

6-item survey distributed in FY2020 using the following methods:
- Conducted from late September through November 2020
- All hospitals participated in data collection throughout the city
- Distributed in person and offered online
- Offered in English, Spanish
- Collected 2, 475 surveys
- All Baltimore City zip codes represented

Results

Top 5 Health Concerns:
(See Chart 1 below)

- Alcohol
- Mental Health
- Diabetes/High Blood Sugar
- Heart Disease/High Blood Pressure

- Overweight/Obesity

Analysis by CBSA targeted zip codes revealed the same top health concerns and top health barriers with little deviation from the overall Baltimore City data. The sample size was 2,475 for all of Baltimore City and 889 for residents from the identified MWPH CBSA.

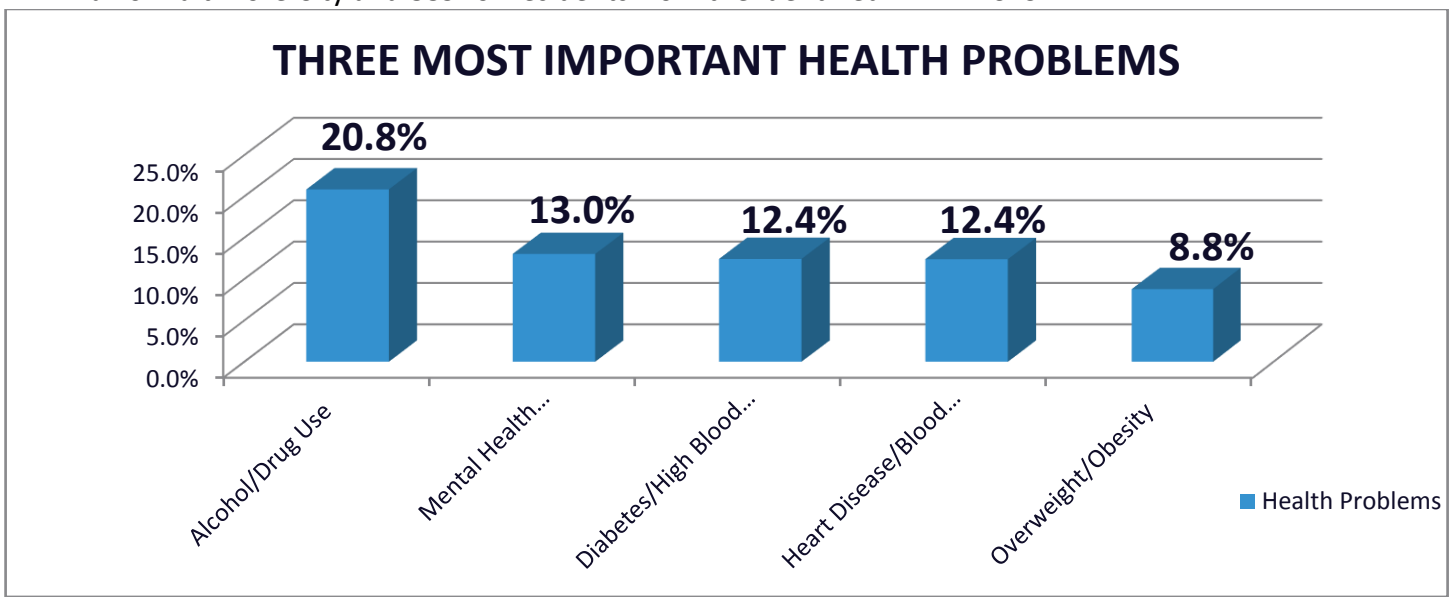


Chart 1A – MWPH's Community Benefit Service Area Top Health Concerns
N=889 MWPH CBSA

- **Mental Health – 24.6%**
- **Overweight/Obesity – 20.3%**
- **Alcohol/Drug Use – 17.0%**
- **Heart Disease/High Blood Pressure – 11.8%**
- **Diabetes/High Blood Sugar – 9.3%**

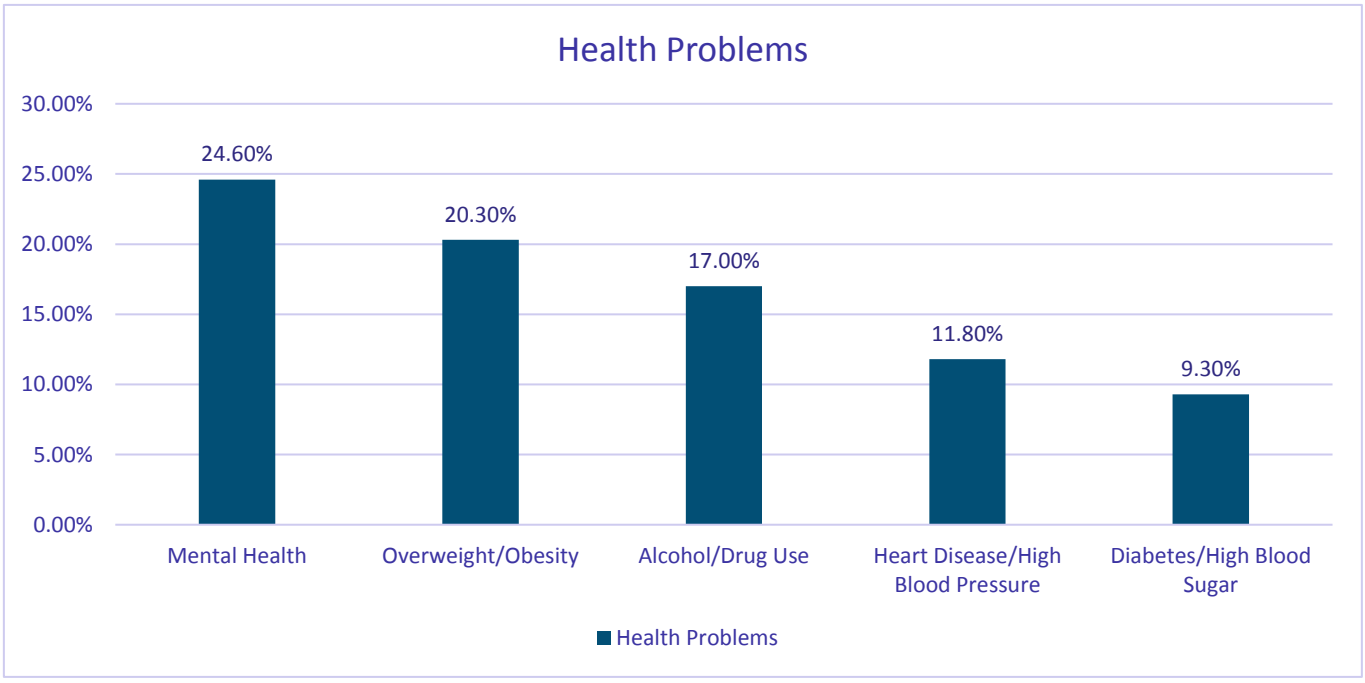


Chart 2 - Community's Top Social/Environmental Issues (All Baltimore City)

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

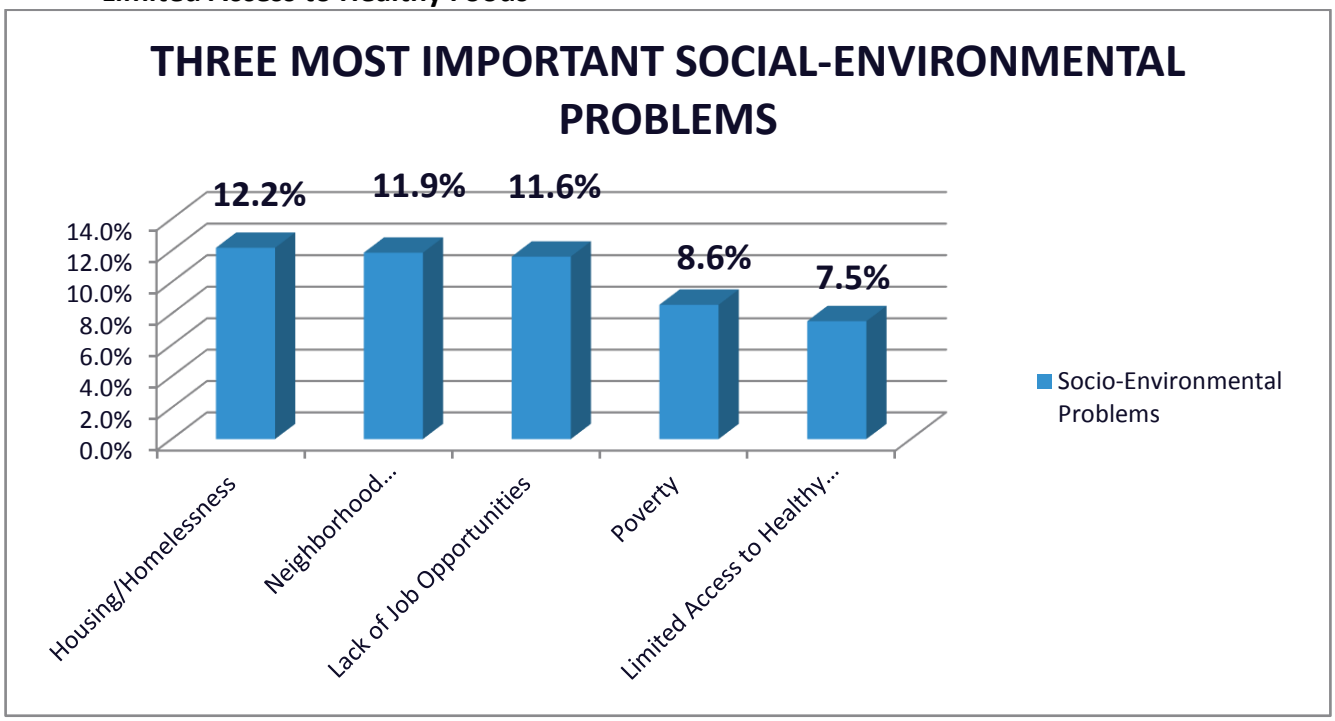


Chart 2A - MWPH's Community Benefit Service Area Top Social/Environmental Issues
N=889 MWPH CBSA

- **Limited Access to Healthy Foods – 16.5%**
- **Neighborhood Safety/Violence – 13.6%**
- **Poverty – 11.2%**
- **Availability/Access to Doctor's Office – 9.9%**
- **Lack of Job Opportunities- 6.3%**

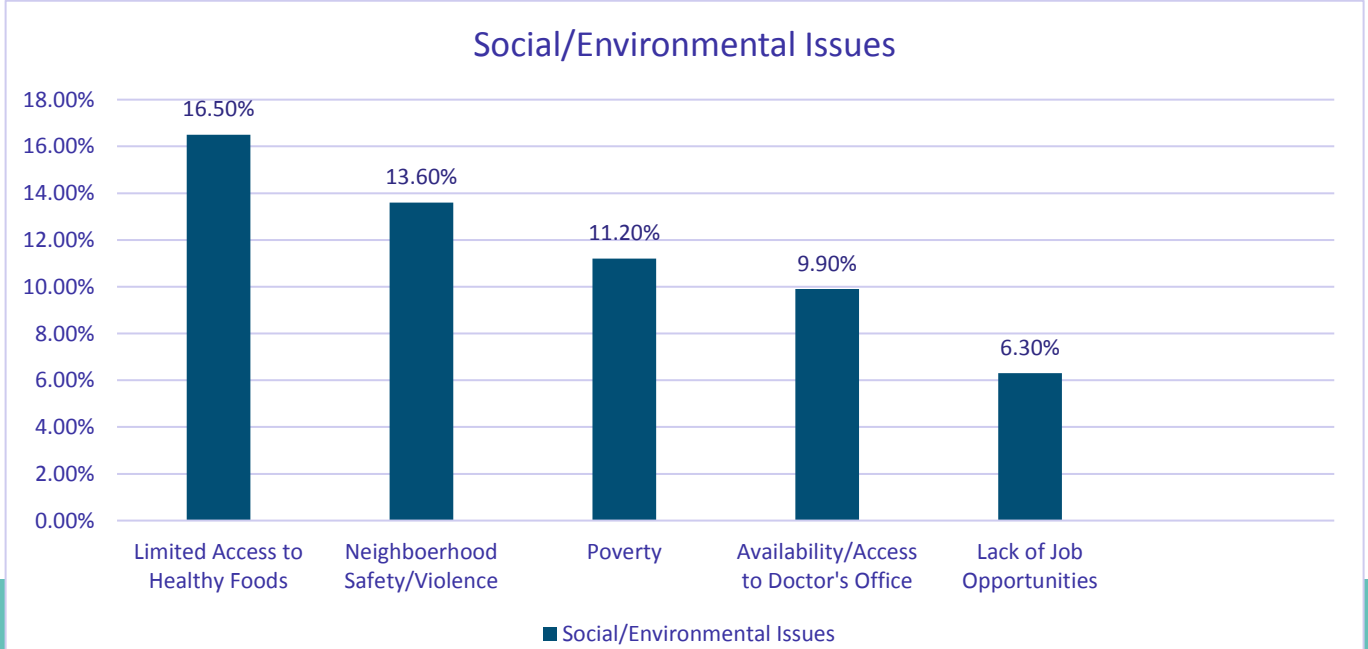


Chart 3 – Community's Top Barriers to Healthcare (All Baltimore City)

- **Cost/Too Expensive/Can't Afford**
- **No Insurance**
- **Lack of Transportation**
- **Insurance Not Accepted**
- **Fear or Mistrust of Doctors**

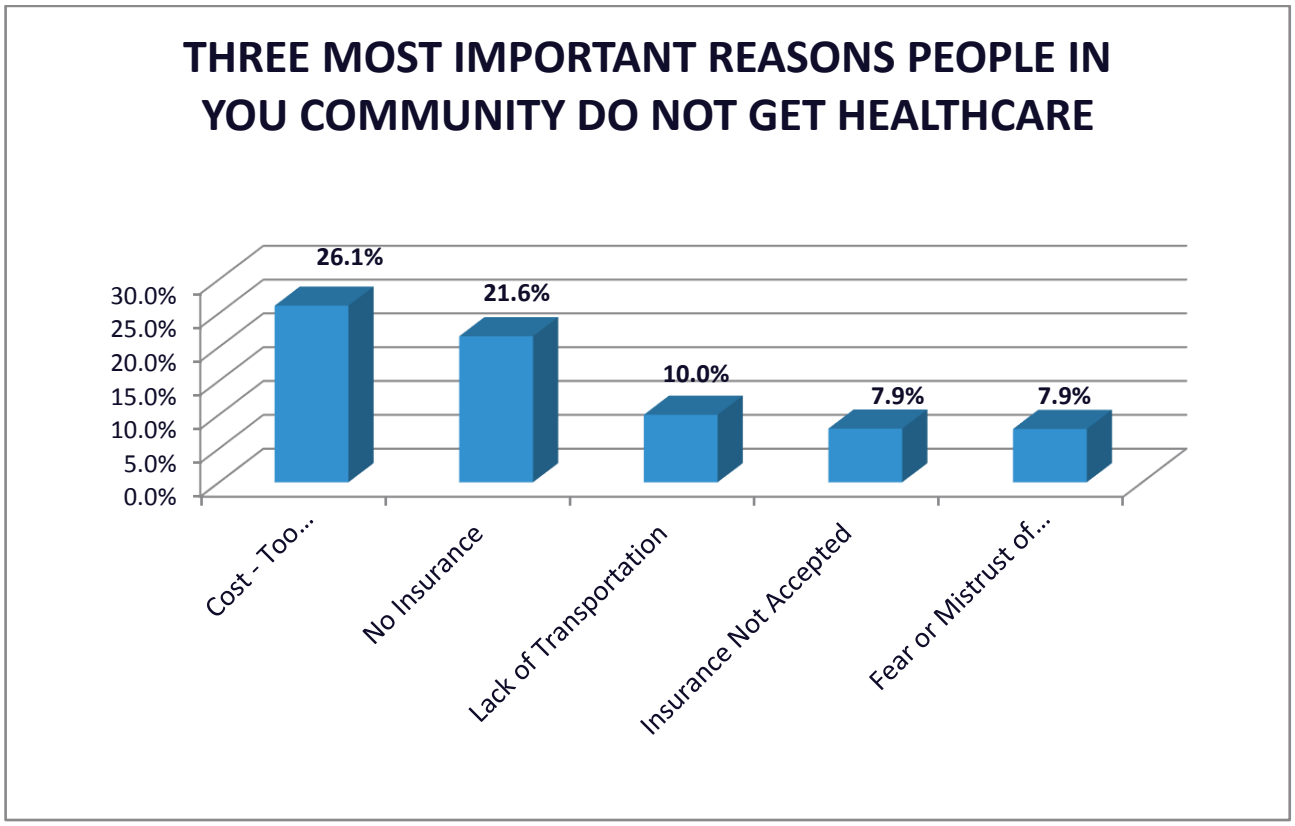
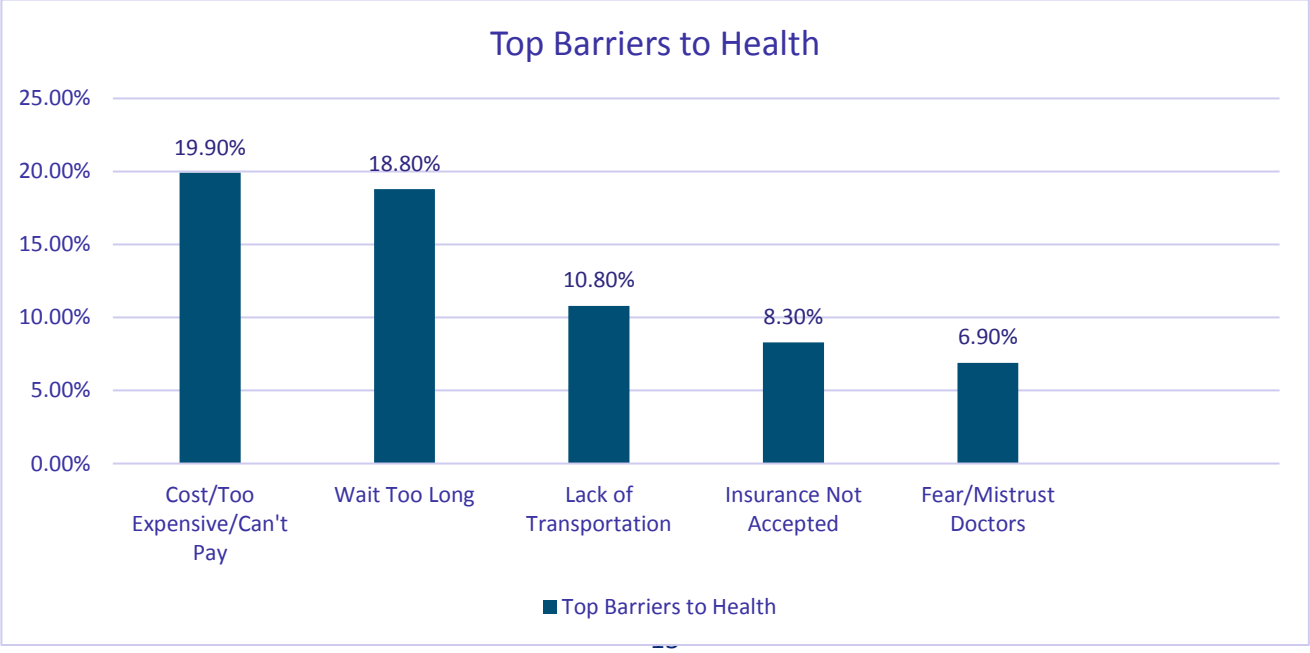


Chart 3A – MWPH's Community Benefit Service Area Top Barriers to Healthcare
Cost/Too Expensive/Can't Pay- 19.9%
Wait Too Long- 18.8%
Lack of Transportation- 10.8%
Insurance Not Accepted 8.3%



A) Community Perspective – Telephone Town Hall

COVID-19 pandemic significantly restricted face-to-face and large group interactions, MWPH with the hospitals in BHCHC participated in Telephone Town Halls were conducted by the Sexton Group (see appendix for full report). The purpose of the town halls were to reach a broader community perspective since limited numbers of surveys were collected. Sexton Group utilized their database of both mobile and landline records of residents in Baltimore City based on CBSA zip codes for all BHCHC hospitals. Those in attendance were explained the purpose of the town hall. The town halls were short and asked three questions focusing on the biggest health problem facing the community, SoDH impacting the community and barriers to obtaining health.

Following format was used for the Tele-town hall

1. Invitation to participate is sent to selected number of participants in a specific zip codes: BHCHC CBSA zip codes were selected.
2. At the top of the call, callers were asked about three areas related to the health of their communities: medical services; social needs; access to care.
3. Tell them that we will provide examples in each category and then will provide time for their comments on any other issues they may have.
4. Starting with medical/health services and do the same for the other categories. Say "here are some examples of healthcare services – which do you think are needed, in order of importance?" Give about 5 examples of our choice. Callers can then vote electronically on them.
5. When voting is done, ask callers if there are other health issues they are concerned about. Their line will be released ad their response recorded.
6. Do the same for the other areas (social services and access).
   The whole town hall is recorded.

Total 6,913 attended the town hall, with 4,163 staying less than a minute to listen and 2,749 staying more than a minute.

Number of Attendees Who Answered the Call

People reached on outbound calls	11942	100% answered
People that hung up w/o answering	5174	43.3%
People that attended	6768	56.7%

How Long Did the Attendees Stay

Stayed on over 60 seconds	2749	39.8%
Pressed 0 to ask a question	96	1.4%
Recorded their question	28	0.4%
Spoke live to whole meeting	12	0.2%
Chose to be transferred	0	0.0%
Left message at end of meeting	0	0.0%
Stayed less than minute	4164	60.2%
Total Attendees	6913	

Response to Q1: Major Health Concern

Health Concern	Number Selected As a Concern	% of All Answers
Substance Abuse	36	27.9%
Chronic Disease	34	26.4%
Senior Health	22	17.1%
Overweight	19	17.4%
Mental Health	18	14.0%
Total Answers	129	100.0%

Response to Q2: Barriers to Health Care

Barrier	Number Selected As a Concern	% of All Answers
Cost	12	66.7%
Transportation	3	16.7%
Language	1	5.6%
Fear	1	5.6%
No doctor	1	5.6%
Total Answers	18	100.0%

Response to Q3: Social Environmental

Reason	Number Selected As a Concern	% of All Answers
Neighborhood	18	40.9%
Social isolation	9	20.5%
Access	8	18.2%
Healthy foods	6	13.6%
Housing	3	6.8%
Total Answers	44	100.0%

Baltimore City Collaborative Telephone Town Hall Audio link
COLO.PLAYMYFILE.COM/PLAYMP3/M5417_4_337763048182250658424600937O.MP3
Report link
https://townhalllogin.com/thmeetingreports.wr?id=3100011022761464860733378212899O

B) Health Experts

Methods

- Reviewed & included National Prevention Strategy Priorities, Maryland State Health Improvement Plan (SHIP) indicators, and Healthy Baltimore 2020 plan from the Baltimore City Health Department (please note: due to the pandemic no new data is available/previous data was used).
- Reviewed Healthy Baltimore 2020: A blueprint for health
- Reviewed Baltimore City Health Department's 2017 Community Health Assessment
- Conducted two focus groups including patient families, families who have children with medically complex needs and MWPH CHAB.
- Conducted stakeholder retreat in March 2020, with community partners, hospital leadership, patient families and foundation board members.

Results

- National Prevention Strategy – 7 Priority Areas
  - Tobacco Free Living
  - Preventing Drug Abuse and Excessive Alcohol Use
  - Healthy Eating
  - Active Living
  - Injury and Violence Free Living
  - Reproductive and Sexual Health
  - Mental and Emotional Well Being

- SHIP: 39 Objectives in 5 Vision Areas for the State, includes targets for Baltimore City – (While progress has been made since 2018, measures within Baltimore City have not met identified targets; Even wider minority disparities exist within the City)
- Healthy Baltimore 2020: Four Priority Areas for Baltimore City
  1) Strategic Priority 1: Behavioral Health
  2) Strategic Priority 2: Violence Prevention
  3) Strategic Priority 3: Chronic Disease Prevention
  4) Strategic Priority 4: Life Course Approach and Core Services

National Prevention Strategy: 2020 Priority Areas	Maryland State Health Improvement Plan (SHIP) 2020	Healthy Baltimore 2020 (updated 2021)
Tobacco Free Living	Healthy Beginnings	Behavioral Health
Preventing Drug Abuse & Excessive Alcohol Use	Healthy Living	Violence Prevention
Active Living	Access to Healthcare	Life Course Approach & Core Services
Injury & Violence Free Living	Quality Preventive Care	
Reproductive & Sexual Health		
Mental & Emotional Well-Being		

C) Community Leaders

Two focus groups were conducted. List of names of attendees and dates are listed in the Appendix.

This section gives an overview of the clinical, medical, and public health experts' focus groups conducted in December 2019, March 2020 and April 2020 (one focus group was divided in two sessions due to attendee availability.

Access to Care

Focus group attendees were asked to discuss barriers related to accessing health care services for CYSHCN in Baltimore City. The following themes emerged from the discussions in the sessions

Lack of Specialty Care Providers and Long Wait Times

Lack of specialty care providers was commonly voiced as a significant barrier in these sessions. This issue often correlated with longer wait periods to see a specialist. Four issues related to access to specialists were cited repeatedly:

1) Families reported problems getting needed specialist care, especially Children or Youth with Special Health Care Needs (CYSCHN) with emotional, behavioral, or developmental (EBD) issues.
2) Families reported long wait times for specialist appointments especially for diagnostics or mental health services.
3) For families who reported their health insurance was not adequate, they also said that their child did not see a specialists in the last 12 months.
4) Most families reported getting referrals, but a small sub-section (about 10%) reported they had problems getting referrals when needed.

Insurance Deductibles and Price of Durable Medical Equipment (DME) and Medications for CYSHCN

Difficulties with access to care, dealing with insurance coverage and piecing together needed services from a fragmented system takes its toll on families at MWPH raising CYSHCN. The toll is both emotional and financial. Families are frustrated by the impact the fragmented system has on their ability to parent all of their children.
For families whose children utilize DME such as wheel chairs, braces orthotics, diapers, and even special glasses, problems with adequacy of coverage were noted.

In some cases, families stated that health plans simply provided no coverage for needed equipment, other times there were dollar limits that did not match the actual cost of items. Approval processes were reported as difficult and time consuming. As noted earlier in this CHNA, 17.7% of families reported out of pocket expenses for DME 10.4% of that on diapers for their child with special health care needs.

Again, the severity of the child's health care needs related to out of pocket costs with 26.6% of the children who parent's rated their problems as severe having families reported spending over $1,000 out of pocket in the past year. Families with private insurance or a combination of public and private were more likely to have higher out of pocket expenses.

CYSHCN have chronic conditions that require advance care and close follow-up to help their parents effectively manage their conditions. However the inability to afford high deductibles often pose a significant challenge and create a chair reaction where those who can't afford their medications or regular appointments often end of having a medical emergency.

Fragmentation of Health Care System/Care Coordination

The issue of lack of coordination of services and supports for CYSHCN was a frequent theme in group discussions with families. Overall 7603% of CYSHCN had parents who reported that services and supports did not receive care in a well-functioning system. And even higher percentage (81.1%) of parents with children rated as having the most severe conditions and the highest needs reported that the system was not easy to use. Children with family incomes of 100-199% of the federal poverty level had even more parents who were having difficulty using the system (89.3%).

Families reported that finding services were difficult, time consuming and the processes and forms were overwhelming. It was reported that at times there was a lack of coordination within the same institution or agency. For example, in hospitals some departments participated in a health plan and others in the same hospital did not. Families were perplexed by this and felt they could not understand how to access covered care. For CYSHCN, they might have to go to one hospital for that care, yet be unable to access other aspects of health care at that same institution. There were concerns that there is no reimbursement to health care providers for care coordination needed to support families in dealing with the fragmented system. At the same time, families noted that children who were involved with multiple public programs might have more than one care coordination, yet there was no integration of those services.

Lack of Transportation

Transportation was the most discussed area of concern in all focus groups at MWPH, from executive level staff, clinical content experts, and parents of CYSHCN the like, transportation was identified as a major barrier. As one participant put it "I don't drive, so I have to rely on family and friends or Medicaid Transportation and it is often an unreliable system. I have utilized the free shuttle service, problem is… the shuttle doesn't always work with Mass Transportation schedules for the bus… one time I had to walk over 2 hours because the shuttle service made me miss the last bus. Also because I am a single parent, if I don't have child care I can't keep my appointment. Medicaid Transportation will only transport myself and the child who is receiving treatment. Several participants (and later staff) echoed that transportation posed a huge problem for children who are severely delayed, autistic, or have severe aggressive behavior diagnoses.

Lack of Mental Health Providers and Stigma

When parents were asked if there were certain health care related services for CYSHCN were delayed or not received in the past 12 months, participants overwhelmingly identified therapies, mental health services, and behavioral supports as the most frequently delayed or not received services.

In addition, almost one third of families reported a delay in their own health care or a family member's care due to the child's special needs (31%). Slightly more than six in ten parents (61%) reported anxiety problems in their children during the past year. Other frequently reported behavioral issues included anger/conflict management, depression, and an increase in problem behaviors. For each behavior cited, parents sough help between 67%-96% of the time (PPMS Parent Calls); ye the majority of parents reported accessing the help they needed was either somewhat difficult or very difficult. The chart bellows identifies each reported behavioral issue and the difficulty in getting help.

Table II. Unmet Needs Based on Child Behavioral Health Issue

Unmet Needs Based on Child Behavioral Health Issue	
BEHAVIORAL HEALTH ISSUE	**% OR REPORTING DIFFICULTY IN GETTING HELP**
Anxiety	60.6%
Suicidal Thoughts/Behaviors	44.7%
Increase in Problem Behaviors	51.2%
Depression	50.5%
Anger/Conflict Management	50.4%
Bullying	40.4%
Drug/Alcohol Abuse	35.7%

Other needs identified by parents included finding therapies, child care, psychiatrists and other mental providers or services, Applied Behavior Analysis (ABA) therapies, camps and general financial assistance for middle income parents. In most cases, parents had sought help from someone in getting this need or service but many found this difficult to obtain.

Impact on Family Well Being

Families reported that the burden of the out of pocket costs can have an impact on the financial status of the family. In addition, the time spent dealing with insurance issue seeking and coordinating care and providing care for their children has resulted in some parents having to reduce or give up employment.

Less visible is the financial impact on families of the time spent providing, coordinating, and arranging care for their children and youth with special health care needs. Because of care for their CYSHCN. Because of the time needed to provide, arrange or coordinate care, some parents had to alter their employment status provides additional financial impact on the families. Others report that they avoided changing jobs because of concern about their child's health coverage. 51% reported either cut hours, stopped working, or avoided changing jobs because of their child's care.

37% of parents of CYSHCN and 34.7% of parents of children with EBD felt aggravation from parenting. Many parents stated that they were receiving no emotional help parenting their child and expressed not coping very well with the demand of raising a child with special health care needs.

Nearly 40% of parents with CYSHCN and EBD stated that they sometimes, usually, or always feel angry with their child. As in this parent's statement "We're parents. We all want to everything we can so our children can reach their potential. But none of us signed up to be parents of children with additional needs—it's just so much harder for our kids. So we want to make sure in every way we know how, that our kid has everything they need. And you're a great mom or dad for doing that, that's something we don't do enough for each other, tell each other that."

Where the need mental health services for CYSHCN is clearly documented for various sources of data, what is often overlooked is the well-being, health care, and mental health of the caregiver/parent.

Case Managers
It was acknowledged that MWPH patients interact with any number of care providers across multiple settings it would make it easier for patient families to get better and be healthier if they could have case managers who help streamline their different care and assist with navigating the health system. The difficulty to navigate the health care system again was mentioned as a barrier. This would also help to improve the health outcome of Spanish speaking families if they had access to a bilingual case manager or advocate to assist in access of health care services and care coordination

Training Caregivers
Parents were mentioned as an important existing force in the service delivery process. Educating these caregivers to better understand the medical needs of their CYSHCN was mentioned as the best alternative to improve the health outcome of patients. Many agreed that the health system should provide more support to these parents who typically have their hands full with full time jobs, other children and their needs, and caring for their CYSHCN by teaching them about available local resources to take care of the patient-child, as well as themselves.

Community Involvement, Advocacy and Partnership
Focus group participants were then asked, "What do you think could encourage more community involvement, advocacy, and partnership around health issues that would benefit the public/your child as it pertains to your organizations services?"

Coalition
The need to coalesce around cross-cutting causes and objectives was emphasized in the discussions, to this end, an active convener that would help partners to form coalitions was cited as a potentially useful resource.

Outreach (Community Paramedicine/Telemedicine)
The overwhelming majority of participants seemed to agree that many people have difficulty getting to pediatric specialty services and suggested the need for being proactive in rethinking the current health care system of delivery so to get providers out in the neighborhoods and communities where people reside. This need was significantly intensified during the COVID-19 pandemic. Additionally, this was believed to potentially enhance access to care, especially for medically underserved populations in rural areas. CYSHCN are at a high disadvantage because their transportation depends on the availability of parent's work schedule, other appointments, and access to means of transportation, which makes it difficult for them to attend medical appointments in a timely matter, or often at all.

MWPH's telemedicine service is growing. Many families have provided positive feedback about its availability as a convenience and a recommended solution for dealing with the barriers of transporting a CYSHCN to several appointments.

Volunteers
The value of volunteers bring to health care delivery was discussed extensively in all focus groups. One participant mentioned that there are a lot of parents, who want to become

more engaged and enhance their training and knowledge. Another participant recommended using students in the health discipline (community health educators, nursing, medical, etc.) was an effective way to bring health education to different parts of Baltimore City.

Challenges Facing Providers when helping people navigate health care services
Focus group participants were then asked, "From your perspective, what is the greatest challenge you face when helping people navigate health care services at MWPH?"

Participants noted that helping patients understand and navigate the health benefits exchange was very challenging because even after people have insurance coverage, they didn't know how to use it. "It's a time and system issue and in some aspects it's a language issue… We have a whole new market of people out there who have insurance and don't know how to access it or don't know why they should access it or don't know why they should access it."

Lack of specialty providers was brought up again as posing an enormous challenge and providers often struggle where to send patients for further diagnosis. Specifically speaking, psychiatry and physiatrist.

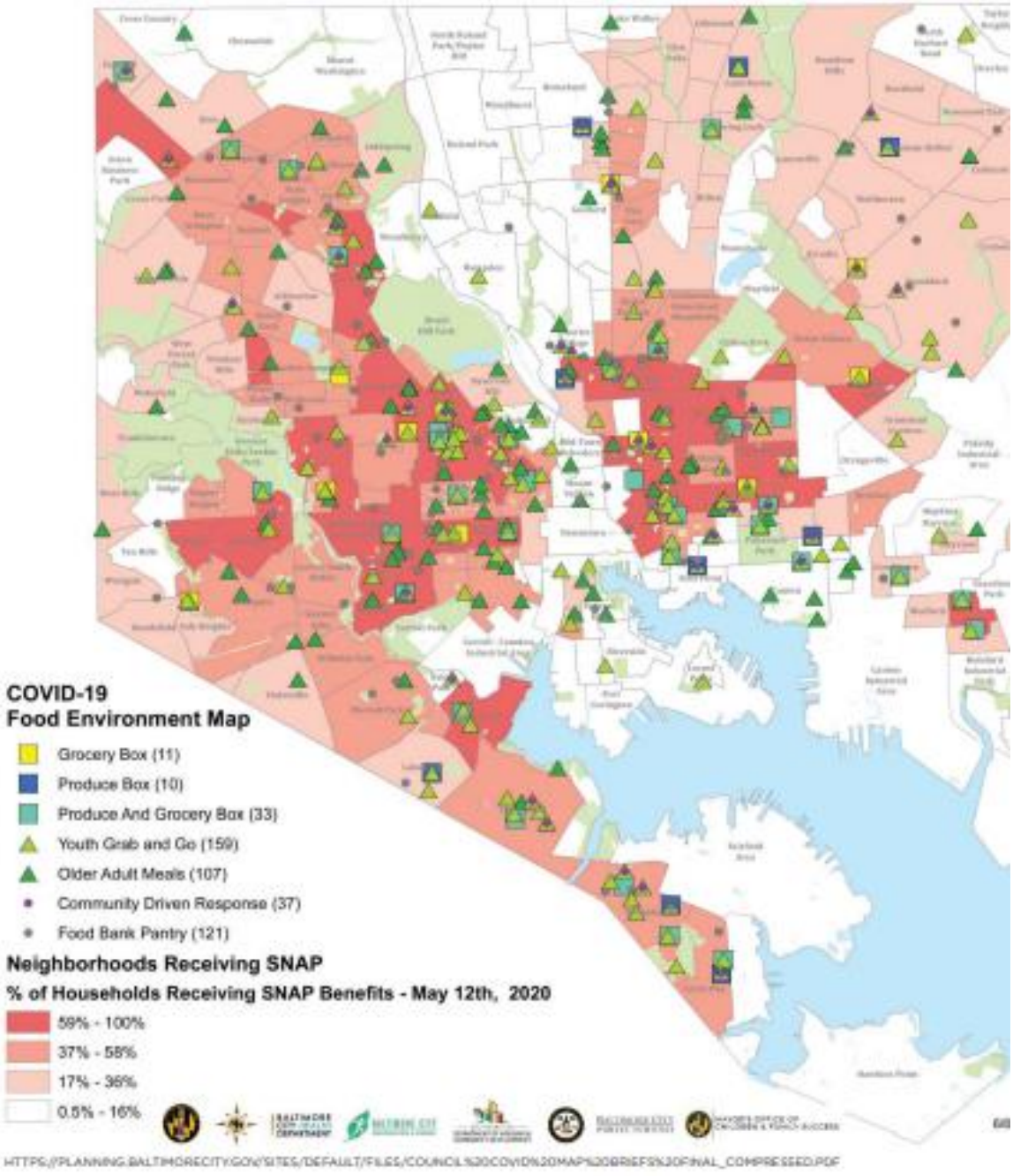
Stakeholders Retreat
Stakeholder retreat was conducted in March 2021 to select and vote on priorities. All quantitative and qualitative health needs, social determinants of health and barriers to health were shared. Below are the top priorities section outlines the priorities.

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 ν Reviewed data from Baltimore Neighborhood Indicator Alliance (Demographic data and SDoH data)

- Reviewed data from identified 2011 Baltimore City Health Department's Baltimore City Neighborhood Profiles,
- Reviewed Baltimore City Food Desert Map – Please note that data available was from 2018-No new data from 2020 is available and previous data was utilized per BCHD. (See Figure 4) Results
- Baltimore City Summary of CBSA targeted zip codes (See Appendix 2)
- Top SDoHs: Low Education Attainment (52.6% w/ less than HS degree)
  High Poverty Rate (15.7%)/High Unemployment Rate (11%)
- Violence
- Poor Food Environment (See Figure 5)
- Housing Instability

Figure 5 Baltimore City Healthy Food Priority Areas



E) Health Statistics/Indicators

Methods

Utilized/reviewed the following data:

City and State trends and data sources:

- Baltimore City Health Department State of Health in Baltimore
- MD HSCRC Statewide Integrated Health Improvement Strategy Proposal
- Maryland Department of Health Vital Statistics

National trends and data sources:

- Healthy People 2030
- County Health Rankings
- Centers for Disease Control Reports/Updates

Results

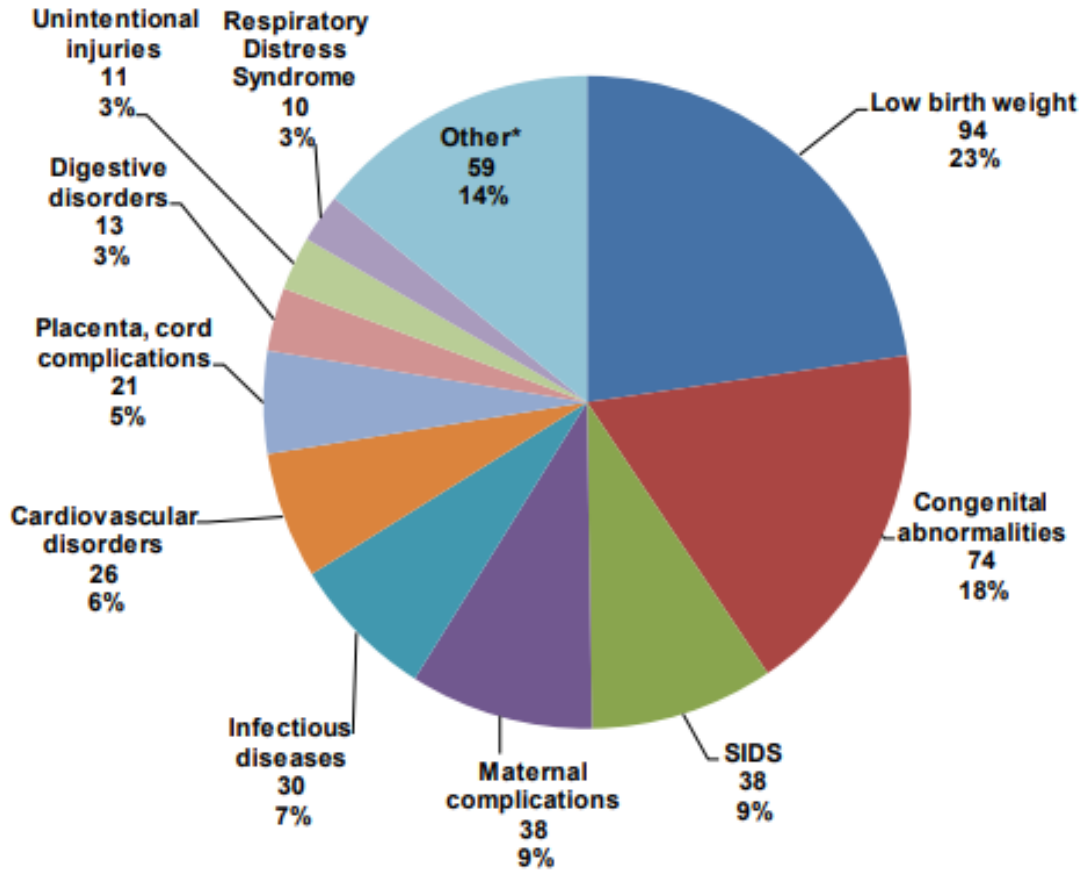
- Baltimore City Health Outcomes Summary (See Appendix)
- Baltimore City Health Rankings (See Appendix)
- Top 3 Causes of Death in Baltimore City in rank order:
  -Heart Disease
  -Cancer
  - Stroke
- Maternal Morbidity Rate (figure 6)
- Cause of Pediatric Deaths
  -High Rate of Infant (figure 7)

Severe Maternal Morbidity Rates/10,000 Delivery Hospitalizations, Disaggregated by Race and Ethnicity

Population	Baseline (2018)	2023	2026	Absolute change	Relative Percentage Change
Total	**242.5**	**219.3**	**197.1**	**45.4**	**19%**
White NH	183.6	169.8	156.1	27.5	15%
Black NH	328.5	295.7	262.8	65.7	20%
Asian NH	241.9	217.7	193.5	48.4	20%
Hispanic	236.9	213.2	189.5	47.4	20%
Other	227.3	204.6	181.8	45.5	20%

Source: https://hscrc.maryland.gov/DOCUMENTS/MODERNIZATION/SIHIS%20PROPOSAL%20-%20CMMI%20SUBMISSION%2012142020.PDF

Leading Cause of Death in Infants, Maryland 2019



Source: https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Infant%20Mortality/Infant_Mortality_Report_2019.pdf

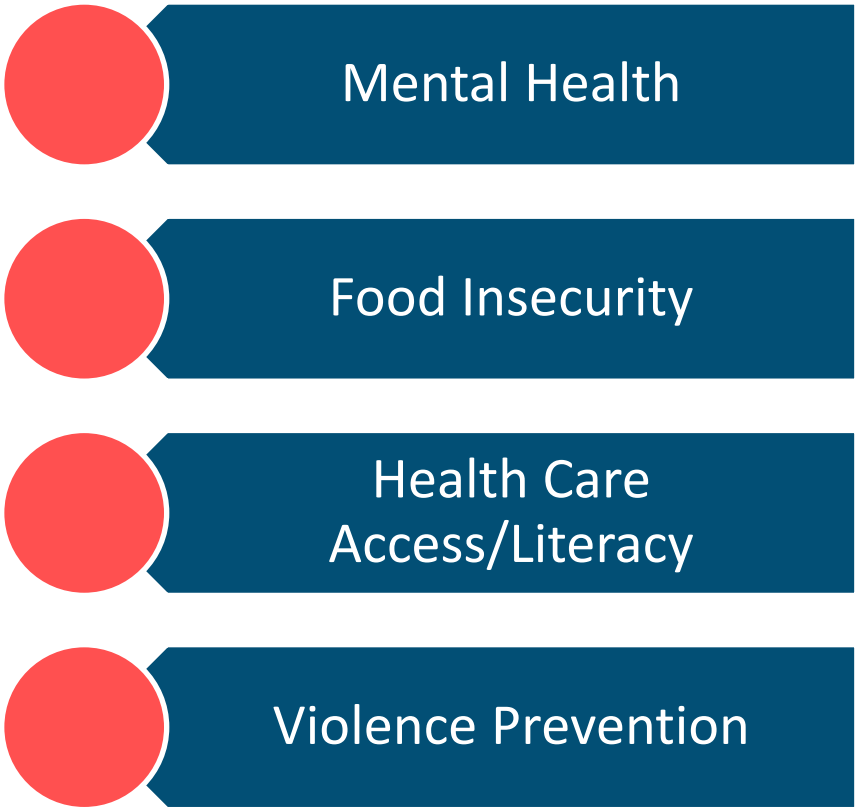
IV. Selecting Priorities

On March 29, 2021 a community stakeholder meeting was held with the MWPH Community Health Advisory Board (CHAB), community partners and patient families to determine the most pressing community health needs. Attendees included community members, community leaders (including Baltimore City elected officials) hospital management and executive board, and members of the hospital and foundation board.

The Criteria for Prioritization:

- Magnitude of the problem
- Severity of the problem
- Need among vulnerable populations
- Ability to have a measurable impact on the issue
- Existing interventions focused on the issue
- Whether the issue is a root cause of other problems
- Trending health concerns in the community
- Alignment with MWPH's exiting priorities and whether finances/resources to address the health concern
- Potential barriers or challenges to addressing the need

Results/Priorities identified:



V. Documentation 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/JHH Baltimore City-based hospitals, and health experts. Hospital Foundation Board approved CHNA on May 20, 2021and Hospital June 24, 2021.

This report will be posted on the MWPH website under the Community Outreach webpage at https://www.mwph.org/community/community-health-needs-assessment-and-reports Highlights of this report will also be documented in the Community Benefits Annual Report for FY'21. 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

Based on the above assessment, findings, and priorities, the Community Health Improvement Team will incorporate the identified priorities with the SHIP priorities and create a matrix that outlines programs to meet the unmet community needs in the MWPH CBSA.

VII. Implementation Strategy FY 2022-2024

The following Implementation Strategy is required and presented to meet the needs of the community served by Mt. Washington Pediatric Hospital Pediatric Hospital (MWPH) based on the findings in the 2018 Community Health Needs Assessment (CHNA). MWPH will track the progress with long-term outcome objectives measured through the Maryland's Department of Health (MDH).

Short-term programmatic objectives, including process and outcome measures will be measured annually by MWPH for each priority areas through the related programming. Adjustments will be made to annual plans as priorities emerge in the community, or through our annual program evaluation. MWPH 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. 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.

Maryland SHIP Vision Area	MWPH Priorities	MWPH Strategic Community Programs	MWPH Partners
Healthy Beginnings & Quality Preventive Care	Access to Healthcare Mental Health	Patient Education Materials (literacy level/language), Patient Resource Guide, Prenatal and Postnatal Education, Community Events Clinical Education Program	Baltimore City Health Dept. Baltimore County Health Dept. MDH, Head Start Programs (Y of Central Maryland/Catholic Charities), Baltimore City Public Schools MWPH Leadership/Associates
Healthy Communities	Violence Prevention Mental Health	Safe Streets Program Peace in the Streets Program Bully Prevention Program Child Passenger Safety Car Seat Program Safety Baby Showers PREP Program, Car Seat Safety Program Mental Health Conference, MH Screenings, MHFA	Baltimore City Health Dept., The Family Tree, Roberta's House, House of Ruth Safe Kids, Baltimore City Fire Department, Maryland Car Seat Safety Program, KISS, Maryland Physicians Care, Amerigourp, United Health UMMS/MWPH Psychiatry/Psychology, Child Life, Baltimore City Public Schools
Quality Preventive Care	Mental Health	Pimlico Elem/Middle piolet school-based mental health program Strategy, Parent Education Groups, Provider and Patient	MWPH/UMMS Dept of Psychiatry, Baltimore City Police Dept., Community Healthcare Providers, Faith-based Organizations (local churches synagogues)

		Education on Prescribing Practices	
Healthy Living & Quality Preventive Care	Health Literacy	Safety Baby Showers Parenting from the Heart Seminar Series Hearing Screenings Vision Screenings Lead Blood Level Testing	Share Baby, Safe Kids, Baltimore City Fire Department, Maryland Car Seat Safety Program, KISS, Maryland Physicians Care, Amerigourp, United Health
Access to Healthcare & Healthy Communities	Access to Healthy Foods	Weigh Smart/Weigh Smart Jr, Farmer's Markets, Community Gardens, WIC Presentations, School-based health, BMI and Blood Pressure Screenings, Chronic Disease Prevention Education, Parenting from the Heart Virtual Seminar Series, Safety Baby Showers (inpatient and community)	Baltimore City Public Schools, WIC, Local Farmer's Markets

Priority Area: Access to Healthcare Long-Term Goals: 1) Reduce the utilization of adult and child emergency room visits for preventable injuries 2) Improve the proportion of adults in Northwest Baltimore who are Health Literate					
Annual Objective	Strategy	Target Population	Actions Description	Process	Resources/Partners
Improve the health literacy in for adults in West Baltimore	Create training program for clinical and nonclinical personnel focused on motivational interviewing	Adults/Children	Review all materials that are provided to patients for literacy levels.	Improve the health literacy in for adults in West Baltimore	Create training program for clinical and nonclinical personnel focused on motivational interviewing
Reduce the proportion of adults emergency room and physician visits due to poor and/or low health literacy skills	Create incentives that provide infographic and or low-literacy techniques to help families better understand how to navigate the health care system Support community Health care workers that provide education on navigating the health care system	Adults/Children Adults & Children	Provide information at every major outreach event: - Fall Back to Health Event at Mondomin Mall - B'More Healthy Expo - Healthy City Days Develop resource guide to be used on website and for smaller community events as handout Partner with CBOs to provide education, funding & support of joint missions.	Reach: # of materials distributed per event and totals # of campaigns # of events featuring information # of people attending events # of web page hits Amount of financial resources provided in dollars # of joint events/activities sponsored	Children's Hospital Association Maryland Hospital Association Baltimore City Health Department Baltimore County Health Dept. MDH, Head Start Programs (Y of Central Maryland/Catholic Charities), Baltimore City Public Schools

Priority Area: Violence– Encourage safe physical environment for children 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	Resources/Partners
Reduce the rate of preventable harm to children and youth in West Baltimore	Continuations and expansion of the Car Seat Program (include – installation, education, low-cost car seat program and car seat distribution) External: Provide education and information at community events, with partners and events on behavior management, appropriate toys/play, baby signing, and a resource guide to parents of free resources in the community to provide parents	Parents in West Baltimore ZIP codes 21215, 21216, 21217 Elementary and middle school youth and teens in Baltimore City MWPH parents/families/ caregivers	Provide talks once a month as a community benefit. Print resource guide and edit and evaluate after 6 months to ensure accuracy Present Healthy Self Image Curriculum to program at Baltimore City elementary and middle schools that is focused of positive self-esteem and identifying bullying behaviors Attend community events	Reach: # copies of materials distributed # of active clients # of people attending group weekly # of events	Baltimore City Police Department Baltimore City Fire Department Safe Kids/Kids in Safety Seats Changing Lives Ministries Office of Mayor – Baltimore City Baltimore City Public Schools Y of Central Maryland St. Vincent de Paul/Catholic Charities Inpatient: Rehabilitation Therapists

	with skills and tools required to be better and more engaged parents Provide materials on proper nutrition, physical activity, and stress management to assist in copying strategies Inpatient: Provide safety baby showers to women and/or their families of active patients to educate them about injury prevention topics such as medication administration, lead poisoning safety, choking, poisoning, child passenger safety, burning/scalding, infant sleep safety, falls and other residential injuries.				Community Outreach Coordinator Child Life Specialists Physical Therapists Psychologist Baltimore City Health Dept., The Family Tree, Roberta's House, House of Ruth Infant Education Development Team

	Educate community youth on the importance of violence prevention				

Priority Area: Mental Health Long Term Goals Supporting Maryland SHIP: 1) Reduce the Suicide Rate – Balt. City (2016) = 8.5/100,000 population; ¬ MD 2017 Goal: 9/100,000 & HP 2020 Goal: 10.2/100,000 2) Reduce the Emergency Department Visits related to Mental Health– Balt. City = 6,782/100,000 population; ¬ MD 2017 Goal: 3,152.6/100,000					
Annual Objective	Strategy	Target Population	Actions Description	Process	Resources/Partners
Reduce the rate of suicides in the targeted serving area Increase mental health awareness in the community and with patients Connect individuals needing mental health services to appropriate resources Partner with surrounding Baltimore County and City hospitals on one mental health initiative	Provide education and information to community members on identifying mental health problems using the evidence-based program: Mental Health First Aid (MHFA) Provide mental health screenings in the community and refer to appropriate resources as needed	West Baltimore Adults & Youth Community Training – Schools, faith leaders, health ministry leaders, community members in Providers/staff/patients and family members training	Baltimore City Trauma Informed Care Task Force through the Mayor's Office of Children and Family Success. Participate in advocacy events on State and Local levels/support policies and bills meeting the objectives Mental Health First Aid (MHFA) is a course for lay public which assists the public in identifying someone experiencing a mental health or substance use-related crisis. Participants learn risk factors and warning signs for mental health	Reach: # of students assisted through programs in part schools # attending annual mental health conference Outcomes: # of referrals to care # of participants in MHFA program Reach: # of people screened in the community Outcomes:	Children's Hospital Association UMMC Department of psychiatry MWPH Behavioral health services Baltimore City Public Shcools MWPH psychologists Johns Hopkins Hospital, Sinai Hospital, St. Agnes Hospital, Mercy, MedStar, Mosaic Group, CRISP

			and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help. Trauma Informed-Care/Specific Interventions – Utilizing evidence-based programs to address specific needs identified in partner schools in West Baltimore. Co-sponsor two semi-annual Mental Health Conferences for the community at large. Provide free mental health screenings using the PHQ2 (then PHQ9 if +) tool in the community. Provide education and information about mental health	# of positive screens # of referrals	

Priority Area: Obesity & Access to Healthy Foods
Long Term Goals:
Healthy People NWS 9 (LHI) – Reduce the proportion of adults who are obese Healthy People 2020 NWS 10 (LHI)

- Reduce the proportion of children and adolescents who are obese Healthy People 2020 NWS 14 & 15
- Increase the variety & contribution of fruits & vegetables to the diets of the population aged 2 yrs and older Healthy People 2020 PA 2.4
- Increase the proportion of adults who meet the objectives for aerobic physical activity and for muscle- strengthening activity

1) Maryland SHIP # 30 – Increase the proportion of adults who are at a healthy weight (Balto City Baseline: 33.1% » 2017MD Target: 35.7%)
2) Maryland SHIP #31 – Reduce the proportion of youth (ages 12-19) who are obese (Balto City Baseline: 17.4% » 2017 MD Target: 11.3%) 3) Maryland SHIP #25 – Reduce deaths from heart disease (Deaths/100,000 age-adjusted) (Balto City Baseline: 259.7 » 173.4)
4) Maryland SHIP #27 – Reduce diabetes-related emergency department visits (Balto City Baseline: 823.7 » 2017 MD Target: 330.0) who met the demographic

Annual Objective	Strategy	Target Population	Actions Description	Process	Resources/Partners
Increase the proportion of adults who are at a healthy weight Reduce the proportion of youth who are obese	Weigh Smart/Weigh Smart Jr. and Healthy Living Academy Start and sustain school-based and community gardens School-based Bi-yearly BMI/Ht/Wt screenings Monthly community cooking	Adults and children in property targeted zip codes	Nutritional Rehabilitation Program- A coordinated holistic approach to management of diagnoses that have a nutritional component. Program is for children with food allergies and developmental issues such as cerebral palsy Engage targeted communities on healthy lifestyles: - Sponsor community meetings	Reach: # of materials distributed per event and totals # of people attending events Pre/Post participant survey results # of pedometers distributed	MWPH Nutrition Dept./Diabetes Program/Weight Smart Program Manager & Team WIC Local Farmers

	demos through Park Heights School Educate & engage community on the importance of daily physical activity guidelines using evidence- based research & programs Collaborate with WIC and other partners in offering Farmers Market in targeted areas with food deserts		- Advocacy - Food Label Sessions - Cooking Demos/Tastings Develop & distribute healthy food information at EJP Day at the (Northeast) Market Provide info on healthy weight resources at every major outreach event: - Fall Back to Health Event Weigh Smart/Weigh Smart Jr. and Healthy Living Academy (HLA) Provide (HLA) to at least 3 elementary and middle schools annually Provide pedometers (similar resources) to key community physicians for children 10-18 yrs Develop & distribute physical activity guidelines and resource info at every major outreach event: -	# of students participating	

Priority Area: Health Literacy Long Term Goal: 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	Resources/Partners
Reduce the utilization of preventable emergency and physician visits due to poor or low health literacy skills	Improve health care access by bringing care to the community (at frequently accessed locations- i.e. schools/community centers/faith-based organizations) Create incentives that provide pictures and or low-literacy techniques to help families better understand how to navigate the health care system. Support community healthcare workers that provide	Adults Adults & Children	Provide information at every major outreach event: - Back-to-School events, community/resource fairs, community gatherings and food drives. Develop resource guide to be used on website and for smaller community events as handout Partner with CBO's to provide education, funding and support of joint missions	Reach: # of materials distributed per event and totals # of campaigns # of events featuring information # of people attending events # of web page hits Amount of financial resources provided in dollars # of joint events/activities sponsored	Baltimore City Health Department Baltimore City Public Schools Community organizations from MWPH Community Health Advisory Board (CHAB) Local and State Elected Officials Faith-based Organizations University of Maryland Medical System Maryland Physicians Care Amerigroup United Health Care Maryland Health Care Access

	education on navigating the healthcare system				

Appendix 1
Public Survey
2020 Baltimore Health Needs Survey

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

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

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

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

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

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

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

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

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

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

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

6. Do you have health insurance? ☐Yes ☐No

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

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

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

☐ Alcohol / Drug addiction ☐ Overweight / Obesity
☐ Mental health (depression, anxiety) ☐ Cancer
☐ Diabetes / High blood sugar ☐ Heart disease / High blood pressure
☐ HIV/AIDS ☐ Infant death
☐ Lung disease / Asthma / COPD ☐ Stroke
☐ Smoking / Tobacco use ☐ Don't know or prefer not to answer
☐ Sexually Transmitted Infections ☐ Other_____

☐ Alzheimer's / Dementia

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

☐ Availability / Access to doctor's office
☐ Availability / Access to insurance
☐ Domestic violence
☐ Limited access to healthy foods
☐ School dropout / Poor schools
☐ Lack of job opportunities
☐ Racial / Ethnicity discrimination
☐ Social isolation / Loneliness
☐ Don't know or prefer not to answer
☐ Child abuse / Neglect
☐ Lack of affordable child care
☐ Housing / Homelessness
☐ Neighborhood safety / Violence
☐ Poverty
☐ Limited places to exercise
☐ Transportation problems
☐ Other: _____

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

☐ Cost – Too expensive / Can't pay
☐ No insurance
☐ Lack of transportation
☐ Language barrier
☐ Worried about immigration status
☐ Fear or mistrust of doctors
☐ Don't know or prefer not to answer
☐ No doctor nearby
☐ Insurance not accepted
☐ Cultural / Religious beliefs
☐ Child care
☐ Wait is too long
☐ Other: _____

<u>COVID-19 QUESTIONS</u>

11. Which of the following apply to you? Check all that apply.

☐ I have been diagnosed with the Coronavirus
☐ A household member has been diagnosed with the Coronavirus
☐ A family member outside my household has been diagnosed with the Coronavirus
☐ A friend or someone I know outside of my family has been diagnosed with the Coronavirus
☐ I don't know anyone personally who has been diagnosed with the Coronavirus
☐ Prefer not to say

12. As a result of COVID19, have you needed any of the following? Check all that apply.

☐ Financial assistance
☐ Food assistance
☐ Rental assistance
☐ Translation/Interpretation Services
☐ None
☐ Energy assistance
☐ Wi-Fi / Internet assistance
☐ Housing/shelter
☐ Childcare
☐ Other: _____

When it comes to COVID-19 what are you most concerned about right now?

Rank the following options in order of importance (1 = most important to 4 = least important).

_____ Members of my household becoming infected
_____ The health of my community as the pandemic continues
_____ The emotional health of my household

_____ Financial hardship

What ideas or suggestions do you have to improve health in your community?

_____

_____ __☐ Don't know or prefer not to answer

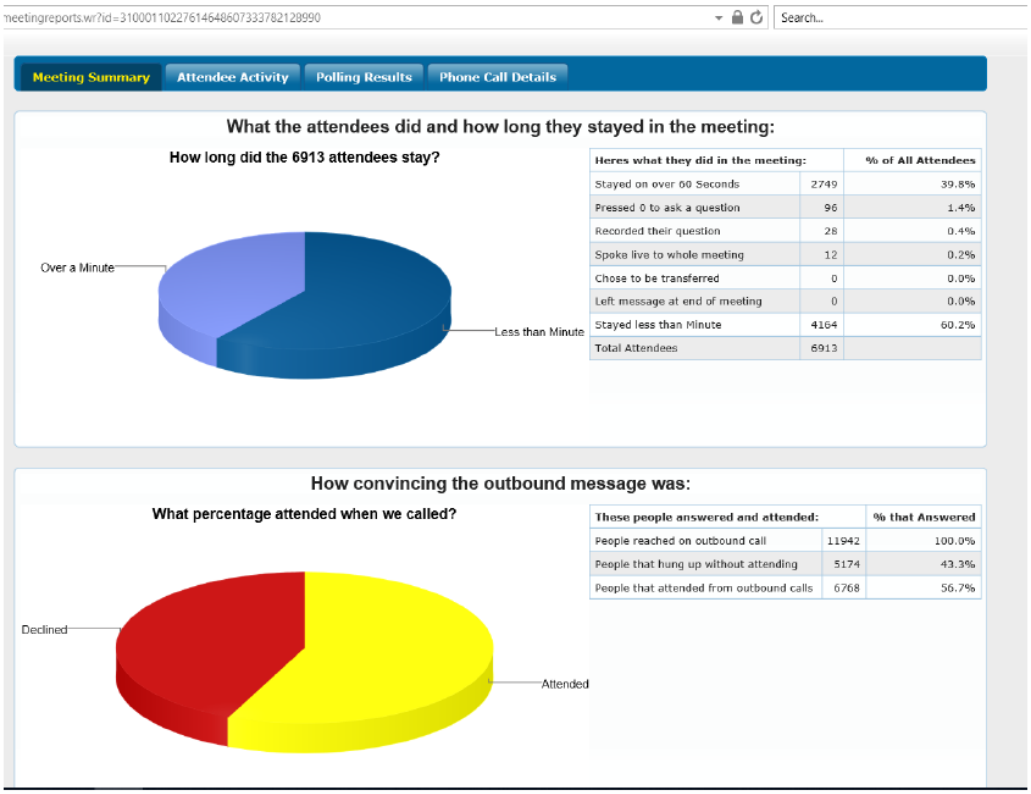
Thank you for completing the survey!

Appendix 2 - Telephone Town Hall Data

Baltimore City Collaborative Telephone Town Hall
October 22 – 3pm

Audio link
COLO.PLAYMYFILE.COM/PLAYMP3/M5417_4_337763048182250658424600937O.MP3

report link
https://townhalllogin.com/thmeetingreports.wr?id=3100011022761464860733378212899O



Jaimey Sexton
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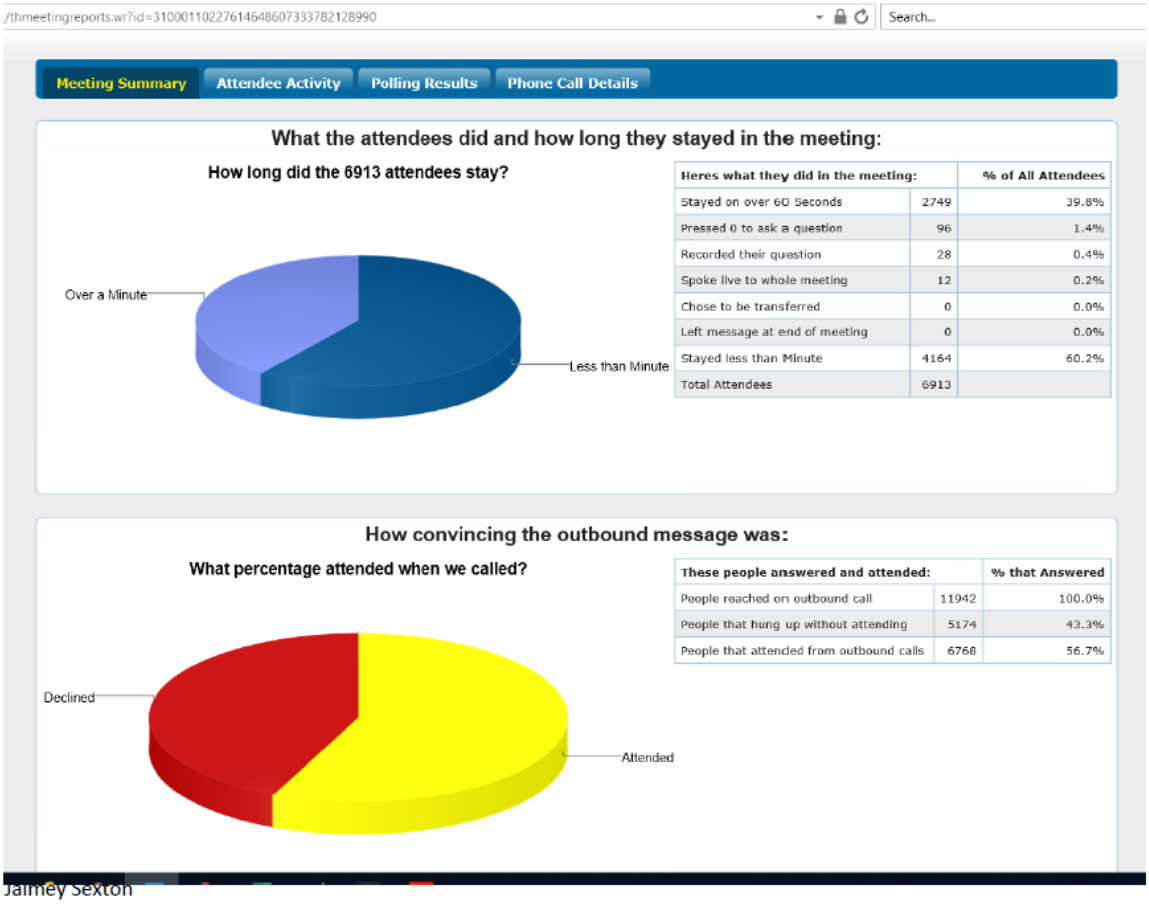

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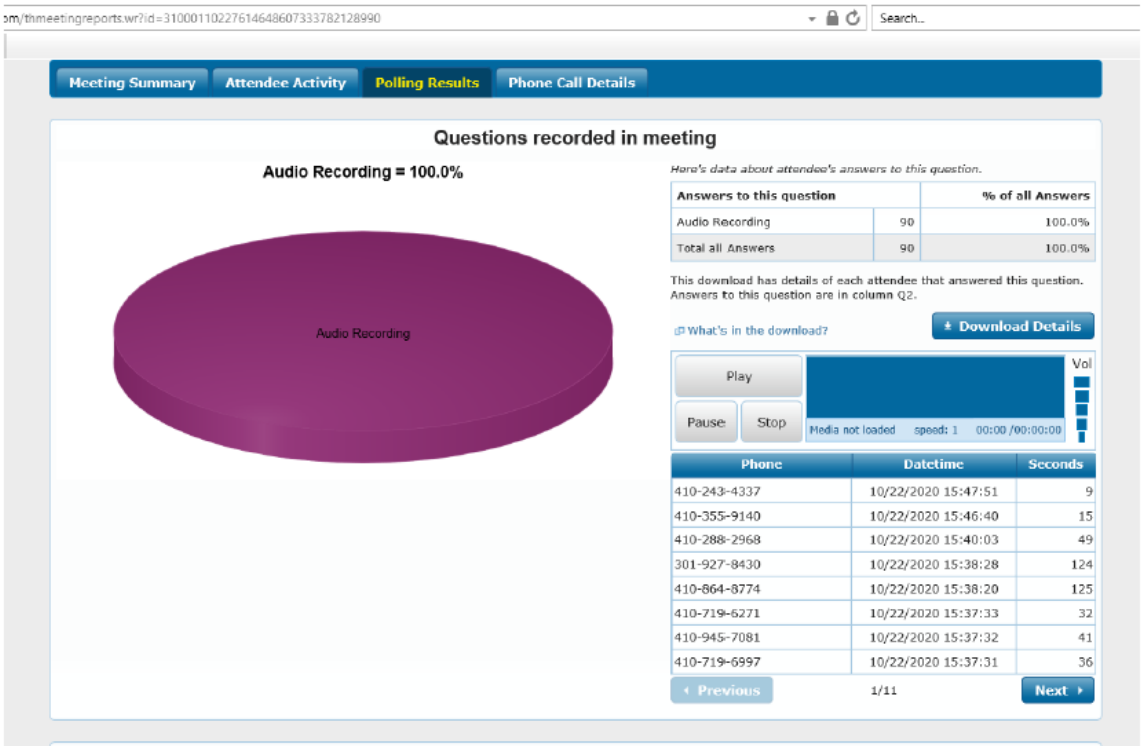
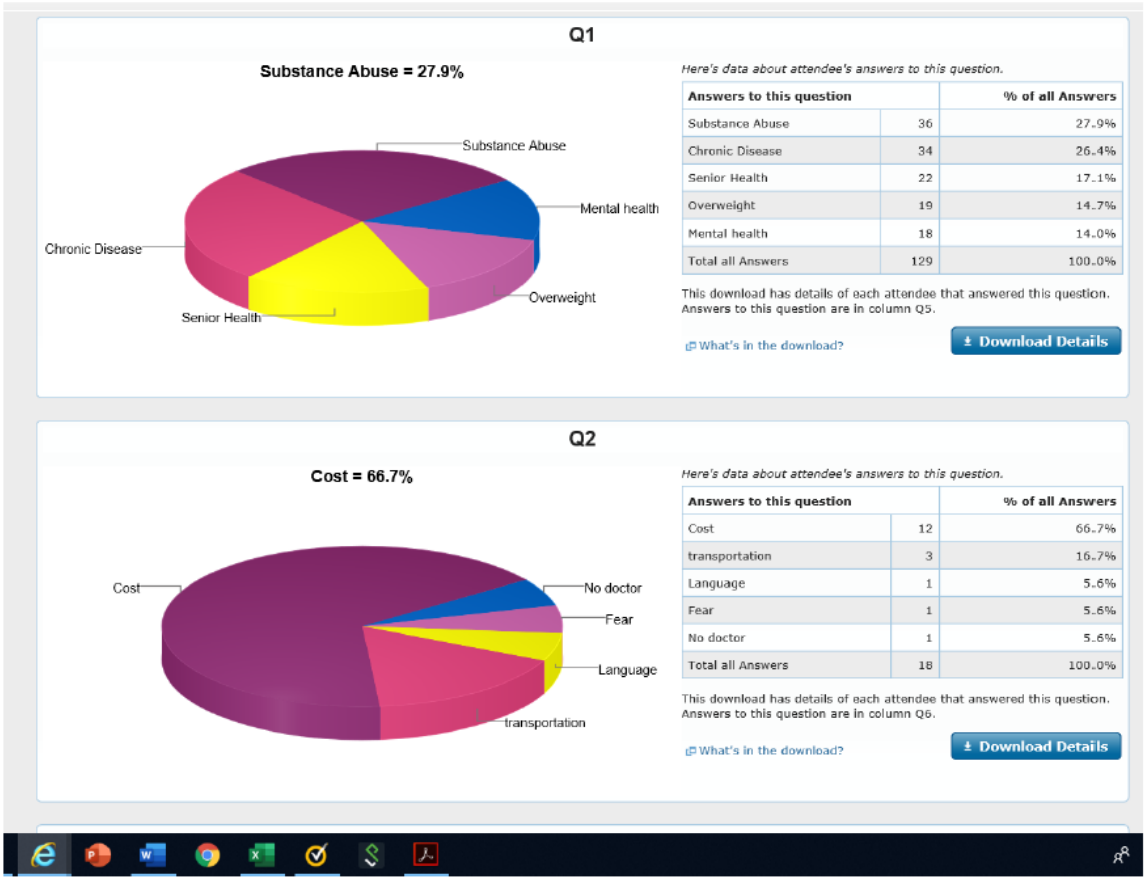


Jaimey Sexton
The Sexton Group



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Appendix 3 – Socioeconomic Characteristics Data

Table III. CBSA Socioeconomic Characteristics*

Community Benefit Service Area(CBSA)[4] Target Population (by sex, race, ethnicity, and average age)			
CBSA Zip Codes	**21215 21206 21216 21213 21222**		
Total Population within the CBSA	144,744		
Sex	***Male***		66,766
	Female		77,977
Age	***0-17 yrs.***	43,423	30%
	18-24 yrs.	62,830	4.3%
	25-44 yrs.	38,024	10.6%
	45-64 yrs.	38,625	15.9%
	65+yrs.	20,471	13.4%
Race/Ethnicity	***White Non-Hispanic***	5,604	3.9%
	Black Non-Hispanic	135,480	93.6%
	Hispanic	1,530	1.05%
	Asian and Pacific Islander non-Hispanic	703	0.5%
	All others	2,150	1.5%

(Table III Cont.) CBSA Community Characteristics Socioeconomic				
Baltimore City Neighborhood	**Zip Code**	**Median Household Income**	**% of households with incomes below federal poverty**	**Unemployment**
Baltimore City		$41,819	28.8%	13.1%
Pimlico/Arlington/Hilltop	**21215**	$32,410	28.4%	17.1%
Southern Park Heights	**21215**	$26,015	46.4%	23.6%
Clifton Berea	**21206**	$25,738	30.2%	17.4%
Upton /Druid Heights	**21217**	$15,950	60.1%	22.3%
Dorchester/ Ashburton	**21216**	$36,870	31.6%	21.9%
Greater Mondawmin	**21216**	$38,655	28.4%	19.0%
Dundalk	**21222**	$30,597	16.5%	19.0%

[4] **Baltimore Neighborhood Health Profiles 2017**

Belair-Edison	**21213**	$38,906	29.1%	16.2%

Education				
Baltimore City Neighborhood	**Zip Code**	**% of Kindergartners "ready to learn**	**% of High School Students missing 20+ days**	**% of residents with a high school diploma or less**
Baltimore City		77.6%	38.7%	47.2%
Pimlico/Arlington/Hilltop	**21215**	80.9%	46.4%	66.2%
Southern Park Heights	**21215**	63.2%	43.6%	69.0%
Clifton Berea	**21206**	79.0%	46.9%	63.3%
Upton /Druid Heights	**21217**	74.0%	46.0%	60.3%
Dorchester/ Ashburton	**21216**	58.9%	32.6%	55.6%
Greater Mondawmin	**21216**	83.6%	34.7%	57.9%
Dundalk	**21222**	93.8%	44.9%	61.0%
Belair/Edison	**21213**	75.3%	37.5%	5.7%

Access to Healthy Foods			
Baltimore City Neighborhood	**Zip Code**	**Corner Store Density (# of corner stores per 10,000 residents)**	**Carryout Density (# of carryouts per 10,000 residents)**
Baltimore City		14.1	11.4
Pimlico/Arlington/Hilltop	**21215**	18.6	14.4
Southern Park Heights	**21215**	11.3	6.0
Clifton-Berea	**21206**	20.3	12.2
Upton/Druid Heights	**21217**	23.2	16.4
Dorchester/Ashburton	**21216**	11.9	9.3
Greater Mondawmin	**21216**	15.0	12.9
Dundalk	**21222**	14.4	12.8
Belair Edison	**21213**	11.5	6.9

(Table III Cont'd) Housing				
Baltimore City Neighborhood	**Zip Code**	**Vacant Building Density (# vacant buildings/10,000 units)**	**Hardship Index* (*Description Below*)**	**Lead Paint Violation Rate (# of violations per year/10,000 residents)**
Baltimore City		562.4	51	9.8
Pimlico/Arlington/Hilltop	**21215**	1,097.3	61	12.8
Southern Park Heights	**21215**	1,374.5	73	20.9
Clifton-Berea	**21206**	2,649.3	61	48.7
Dorchester/ Ashburton	**21216**	224.1	61	10.7
Greater Mondawmin	**21216**	1039.8	62	17.9
Upton/ Druid Heights	**21217**	1136.1	82	16.2
Dundalk	**21222**	105.6	69	1.2
Belair-Edison	**21213**	276.8	55	9.9

**The Hardship Index combines indicators of public health significance from six socioeconomic indicators- housing, poverty, unemployment, education, income, and dependency. The Index ranges from 100=most hardship to 1= least hardship. This composite score of socioeconomic hardship within a CSA, relative to other CSAs and to Baltimore City.*

Community Built and Social Environment				
Baltimore City Neighborhood	**Zip Code**	**Liquor Store Density Rate (# stores/10,000 residents)**	**Youth Homicide Incidence Rate (#homicides/ 100,000 residents <25 years old**	**Infant Mortality Rate (# reported incidents/10,000 residents)**
Baltimore City		3.8	31.3	10.4
Pimlico/Arlington/Hilltop	**21215**	1.7	56.8	20.0
Southern Park Heights	**21215**	4.5	48.9	15.5
Clifton-Berea	**21206**	6.1	107.0	14.8
Dorchester/ Ashburton	**21216**	1.7	70.7	6.4
Greater Mondawmin	**21216**	3.2	46.7	5.2
Upton/Druid Heights	**21217**	2.1	27.9	49.6
Dundalk	**21222**	3.2	9.5	8.9
Belair-Edison	**21213**	2.3	42.3	10.1

Life Expectancy & Mortality			
Baltimore City Neighborhood	**Zip Code**	**Life Expectancy at birth (in years)**	**Percentage of Live Births Occurring Preterm (less than 37 wks gestation)**
Baltimore City		73.6	12.4%
Pimlico /Arlington/Hilltop	**21215**	68.2	15.0%

Southern Park Heights	**21215**	70.1	13.4%
Clifton-Berea	**21206**	66.9	14.7%
Dorchester/ Ashburton	**21216**	73.4	14.5%
Greater Mondawmin	**21216**	70.4	15.1%
Upton/Druid Heights	**21217**	68.1	13.5%
Dundalk	**21222**	72.7	11.3%
Belair-Edison	**21213**	72.0	16.1%

(Table I Cont'd) Percentage of Uninsured people by County within the CBSA (Baltimore City)				
Health Insurance Coverage	Estimate	Margin of Error (+/-)	Percent	Margin of Error (+/-)
With health insurance coverage	646,300	10,414	90.6%	0.8
With private health insurance coverage	564,262	11,439	79.1%	1.2
With public health coverage	186,337	7,005	26.1%	1
No health insurance coverage	66,699	6,013	9.4%	0.8

Life Expectancy, Infant Deaths, Low Birth Weights, Sudden Infant Death, Child Maltreatment, by County within the CBSA (Baltimore City[5])					
Measure Description	**Baltimore City Baseline**	**Baltimore City Update**	**Maryland Update**	**Race/Ethnicity City Update**	**Race/Ethnicity State Update**
Life Expectancy **(at birth)**	72.9	73.6	79.3	Black-- 71.5 White-- 76.5	Black-- 76.4 White-- 80.2
Infant Mortality **(per 1,000 births)**	12.3	10.4	6.7	Black-- 15.8 Non-Hispanic (NH) White-- 5.3	Black-- 11.8 Hispanic-- 4.1 NH White-- 4.2
Low Birth Weight **(percentage)**	12.3%	12.4%	8.8%	API-- 8.9%* Black-- 14.8% Hispanic-- 6.4% White—8.0%	API-- 8.9% Black-- 12.1% Hispanic-- 7.0% NH White-- 6.9%
Sudden Infant Death Syndrome **(per 1,000 births)**	2.07	2.10	0.93	***	NH Black—1.68 NH White—0.69
Child Maltreatment **(per 1,000 children <18 yrs. With cases reported to social services)**	13.8	13.8	5.3	N/A	4.8

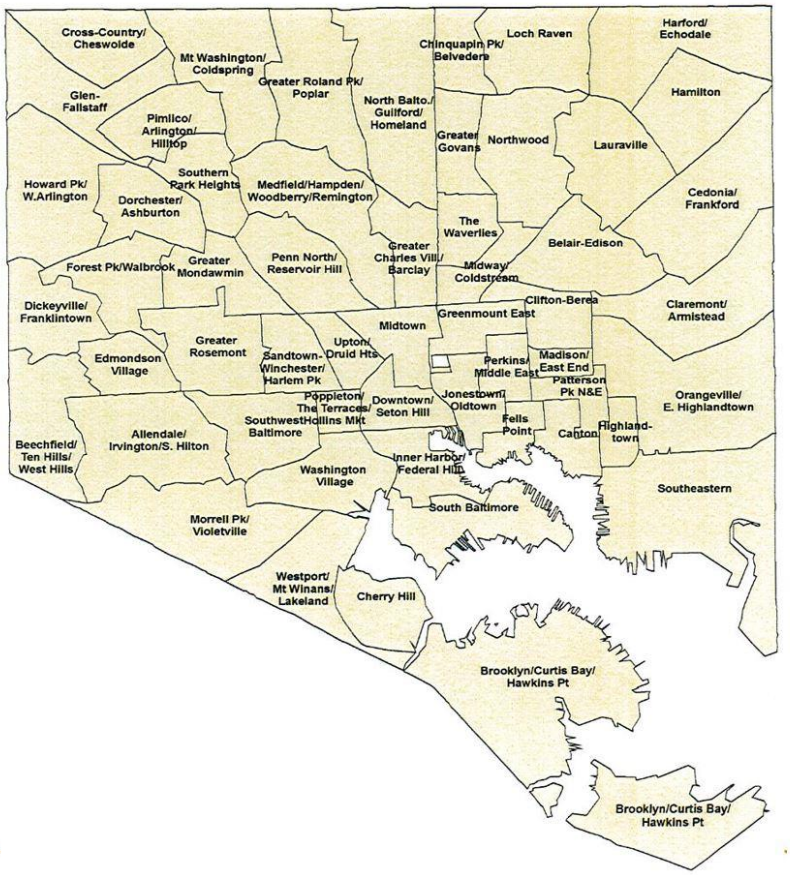
Appendix 4– Baltimore City and County Maps

The racial composition and income distribution of the zip codes described below reflect the segregation and income disparity characteristic of the Baltimore metropolitan region. As indicated above, those zip codes that have a predominantly African American population, including 21215, reflect the racial segregation and poverty representative of Baltimore City. This is in contrast to neighboring Baltimore County zip codes (21208 &21209) in which the hospital is located, the median household income is much higher, and in which the population is predominately white.

The Baltimore City Health Department uses the Community Statistical Areas (CSA) when analyzing health outcomes and risk factors. The CSAs represent clusters of neighborhoods based on census track data rather than zip code and were developed by Baltimore City Planning Department based on recognizable city neighborhood perimeters. In the chart below, we represent the community benefit activities at MWPH. One zip code (21207) spans city and county lines (see footnote below chart). Baltimore County does not provide CSAs. In Baltimore, health disparity lines are more predetermined by the neighborhood where one resides than their zip code. MWPH has adopted the guidance set by the Baltimore City Health Department that defines the community benefit service area with neighborhoods rather than simply zip code (Figure 3).

Baltimore City and County Maps

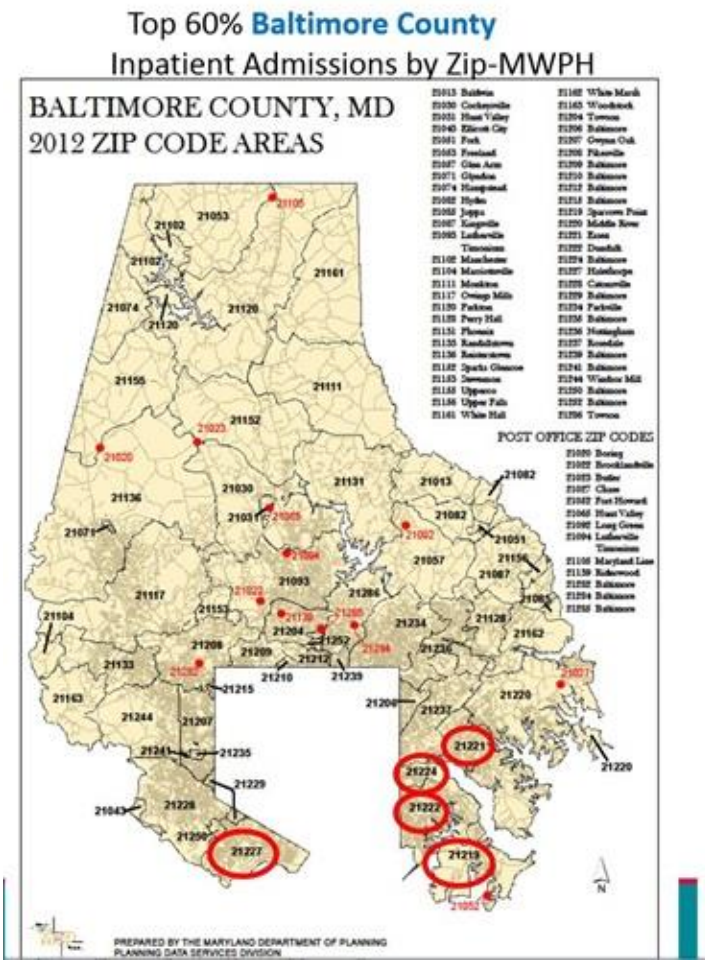
Baltimore Neighborhood Map



The presence of health disparities as well as social determinants of health are a major key factor in determining what the target population for our CBSA and how MWPH might serve it best as a pediatric specialty hospital. Unlike most other hospitals that share one or more of our primary service area zip codes and because of the specialty services we provide, patients come to MWPH

from all over the state of Maryland and Pennsylvania. MWPH is also located within the 21209 zip code that is a part of Mt Washington/Coldspring CSA that is one of the most wealthy and healthy neighborhoods in the city of Baltimore. Interestingly enough, MWPH is within walking distance from the 21215 zip code and Pimlico/Arlington /Hilltop neighborhood which as the aforementioned data demonstrate had several health disparities: poverty and vulnerable populations.
MWPH realizes that population health improvement requires focusing beyond the healthcare clinical space and moving into the innovative non-medical healthcare space to comprehensively address all factors that determine health.

Top 60% Inpatient Admissions/Outpatient Visits by Zip FY20 for Baltimore County



Appendix 5-Baltimore City Health Outcomes Data

Health/Social Indicator	Baltimore City current prevalence 2019	Maryland current prevalence 2019	Race prevalence			
			Black	White	Asian/ Hispanic/ Other	
Life expectancy[3,4]	72.8 ↓	79.2				
Heart disease[3]	5.0% ↓	3.1%	5.2%	6.4%	ND	
Stroke[3]	5.6% ↑	3.1%	7.3%	3.9%	ND	
Hypertension[3]	40.5% ↑	34.9%	46.2%	34.3%		
Diabetes[3]	11.8% ↓	11.0%	13.6%	8.8%		
Asthma[3]	19.3 ↑	14.6%	21.6%	12.2%		
Cancer (All)[3]	8.9% →	11.2%	7.5%	12.1%		
Obesity Adults[3]	40.5% ↑	32.9%	46.5%	31.4%		
Days Mental Health Not Good (past 30 days)[3]	54.6% ↓	62.0%				
Food environment Index[4]	7.2	8.7				
Households living under federal poverty level[1]	19,244	84,800				
Vacant Housing[1]	55,180	243,540				
25 years and older w/o HS diploma[1]	62,652	402,152				

Health/Social Indicator	Baltimore City current prevalence 2019	Maryland current prevalence 2019	Race prevalence			
			Black	White	Asian/ Hispanic/ Other	
Low Birthweight[2]	12% →	9%	15%	7%	9%	8%
Infant Mortality Rate[2]	8.8 ↓	5.9	28% Leading cause	4.4		6.3
Infant Death[2]	68 ↓ 3	414	51	9		6
Children in poverty[4]	31%	12%	38%	10%	21%	31%

Community Social Environment	Balto City	Upton Druid Hts (21201)	SW Balto (21223)	Mondawmin (21216 & 21217)	Pimlico/ Arlington/ Hilltop (21215)	Allendale/ Edmondson (21229)	Washington Vill/ Morell Park (21230) Inner Harbor/ S. Baltimore (21230)
Homicide Rate – all ages (#of homicides)[5]	298 50 ↓	8 3 ↓	33 7 ↓	46 20 ↓	31 8 ↓	34 16 ↑	12 →
Youth Homicide - under 25 (# of homicides)[5]	110 12 ↓	3 1 ↓	10 2 ↓	16 4 ↓	9 6 ↓	22 14 ↑	4 →

Legend:

↓ Prevalence declined, but needs to increase

↓ Prevalence declined

→ Prevalence remained the same

↑ Prevalence increased

↑ Prevalence increase significantly

[1] CENTERS FOR DISEASE CONTROL. (2019). IN ATLASPLUS CHARTS. RETRIEVED FROM HTTPS://GIS.CDC.GOV/GRASP/NCHHSTPATLAS/CHARTS.HTML

[2] MARYLAND DEPARTMENT OF HEALTH. (2019). IN MARYLAND VITAL STATISTICS INFANT MORTALITY IN MARYLAND, 2019. RETRIEVED FROM HTTPS://HEALTH.MARYLAND.GOV/VSA/DOCUMENTS/REPORTS%20AND%20DATA/INFANT%20MORTALITY/INFANT_MORTALITY_REPORT_2019.PDF

[3] MARYLAND DEPARTMENT OF HEALTH. (2021, APRIL). IN WELCOME TO MD-IBIS - MARYLAND'S PUBLIC HEALTH DATA RESOURCE. RETRIEVED FROM MD-IBIS: DATASET QUERY SYSTEM.

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Appendix 6
Focus Group Attendees/Comments
Special Families Unite/CHAB/Family Health Advisory/Community Stakeholders

Special Families Unite	MWPH Community Health Advisory Board/ Stakeholders/Community Partners/CHAB and Individual Interviews	Family Advisory Council
Angela Sittler Nicole McFadden Danielle Tinsley Jessica Salmond Carlin Elie	Dr. Ed Perl- Medical Director/CHAB/Foundation Board Andrea Brown- Foundation Board Member Asia Williams – Chief of Staff Del. Tony Bridges Councilman Isaac Yitzy Schleifer Eli Getzoff- Psychologist Jameliah Blount – GBT Tabernacle Church Valerie Matthews – Catherine's Family & Youth Services Kaliq Simms – Park Heights Renaissance Pastor Troy Randall – At the House/Park Heights Neighborhood Association Jimmy Mitchell- Arlington Elem Brianna Dorsey-Pimlico Elem/Middle Malkia Pipkin-Baltimore City Homeless Children's Health	Ashlee Watts-Page Ugochi Wogu Adrienne Owens Tonya Paige Brenda Dwyer Will & Vicki Dekroney Donte Ricks

	Alan Taylor – Weekend Backpack for Children Food Program **Will McCabe – Hungry Harvest Foods** **Trina Adams – Free Tree/Baltimore City Police** **Kisha McRay – Y of Central Maryland Baltimore City Head Start** **Monique Norris – Baltimore City Public Schools** **Camelia Clark – Zeta Phi Beta Sorority, Inc.** **Valerie Dudley-Baltimore City Health Department** **Emily Paterson** **Maryland Poison Control** **Laura Doherty** **Baltimore Curriculum Project** **Emily Hunter** **Arlington Elem** **Nneka Barnnette** **Pimlico Elem/Middle**	

Focus Groups Feedback

What is your perception of the most serious health issues facing this community?
Addition/Substance Abuse

Chronic Disease – Which one?
Overweight/Obesity
Mental Health
- Don't go to the doctors a lot… - copays
Transportation
- access to stores not being close to us.

Mental Health – stigma attached to mental health… being judge… dishonest programs.
Treatment/providing.
Distrust with the providers.

- Parents with disabilities who have children with disabilities. Not a lot of programs out here
NO other parenting class
- Nothing around to help them reunification … transitioning your child back, how do you change WIC locations etc.…

a. lack of food
b. access to food
c. virtual learning for children with complex medical condition and special needs…. access to

Does anyone have any suggestions as ways to combat these issues?

Improve transportation
Improve virtual learning platforms for special needs children

Barriers to receiving healthcare? What are reasons people in the community do not get healthcare when they need it?

Area – health insurance in the area .. providers..

Providers in the area don't accept your insurance
Fear of trusting doctors
Lack of health insurance
Undocumented

- **Cost- too expensive/Can't pay**
- **No doctor nearby**
- **Fear or mistrust of doctors**
- **Lack of transportation**
- **Language barrier**

Does anyone have any suggestions as ways to combat these issues? healthcare for all despite
Transportation

4. What are common environmental/ or social conditions that negatively affect quality of life in your community?

- **Access to doctor's office**
- **Limited access to healthy foods**
- **Social Isolation/Loneliness**
- **Neighborhood safety**
- **Housing/Homelessness**

- safety
- access to food markets
- housing
- race impact on wages
- drug activities
- police presence and lack of

Does anyone have any suggestions as ways to combat these issues?

6. What do you think hospital systems can do to improve health and quality of life in your community?

Quality of hand sanitizer for outpatient..
Change in staff.. Turnover rate
Friendliness of the staff

MWPH to get companies to partners with them to have job listing that are willing to go give people a chance…

CHAB/Individual Prioritization Retreat Notes

1. Obesity/Access to Healthy Foods
    - Due to the pandemic, the community has had the opportunity to have fresh produce distributed at local community centers.
    - More people are able to have health foods in their diet, without the typical obstacles (ie: money for the produce, transportation to get the produce, etc.).
    - There have been many food desert initiative but ParkHeights remains to be desolate. There are many convenience stores and liquor stores in the neighborhood and only one supermarket.
2. Mental Health
    - Due to the pandemic, mental health providers have been seeing more patients using telehealth.
    - Telehealth has made it easier for patient to make and keep their appointment times, while eliminating barriers like transportation, child care, scheduling conflicts.
    - The pandemic has increase mental health concerns of many and also intensified the mental health issues of those who were suffering prior to the pandemic (ie: adverse trauma; latest news reports of 15 year old killing another 15 year old).
    - Park Heights Community is in need of trauma counseling program for the children and caregivers.

- Oasis was a trauma program based in Martin Luther King Elementary School. It has been put on hold, because the elementary school has been closed down. Oasis program is in need of a new home base. Can Pimlico Elementary/Middle School house the program?
- Per Dr. Getzoff, Lindsay Gavin (MWPH) has a background in trauma counseling and maybe interested in overseeing the Oasis program out of the Pimlico Community Health Suite.
- Pastor Randall is working with DHR to build a program for trauma counseling for the whole family and caregivers in the home.
- Dr. Getzoff fears that once the community opens up from quarantine, telehealth appointments and health equity will decrease.

3. Neighborhood Violence and Safety
    - Concern for safety in the Park Heights Community. Per Pastor Randall, he has to coordinate times for the Police and members of Safety Streets to come to the neighborhoods, just so that children and the elderly can sit outside or visit the community garden.
    - Many have been terrorized by the drug dealers and gang members in the neighborhood. Pastor Randall wants to create a safe space for the community so they can enjoy being outside without having to experience or witness violence.
    - Safe Streets has been a huge support in the schools and in the community when it comes to deescalating arguments and mediation.
4. Healthy Environment/Health Care Education and Access
    - Per Asia, there is a need to grow more plants and trees to combat the pollution in the air and waterways.
    - Improving air quality will help improve breathing issues for the residents of the area. Many resident suffer from asthma, COPD and is the leading cause of death among adults.
    - By educating children and improving air quality, we can decrease the impact of the breathing issues by the time the child reaches adulthood.
    - Mr. Mitchell shared that Arlington Elementary with be starting an environmental studies program for children this summer that educates them about the Maryland Water Shed System and gardening plants the purify the air.
    - Baltimore constantly has had problem with their water quality and air quality.

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