MedStar Health

MedStar Franklin Square Medical Center • MedStar Georgetown University Hospital
MedStar Good Samaritan Hospital • MedStar Harbor Hospital
MedStar Montgomery Medical Center • MedStar National Rehabilitation Network
MedStar St. Mary's Hospital • MedStar Union Memorial Hospital
MedStar Washington Hospital Center

Community Health Assessment 2012

MedStar Franklin Square Medical Center

Full Report

Knowledge and Compassion
Focused on You

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Executive Summary

MedStar Health conducted its first Community Health Assessments (CHA) as a system for each of the nine MedStar hospitals in fiscal year 2012 (July 1, 2011-June 30, 2012). This new systemwide effort was borne out of the need to create a more organized, formal and systematic approach to meeting the needs of underserved communities. This opportunity is especially relevant in light of growing momentum and increased scrutiny around how hospitals are making a measurable contribution to the health of the communities they serve. MedStar Health's CHAs comply with the new Internal Revenue Service (IRS) mandate requiring not-for-profit hospitals to conduct community health needs assessments once every three years.

MedStar Health's approach to the CHA is based on guidelines established by the IRS. The approach also incorporates best practice standards that have been published by nationally recognized leaders in the field, such as the Catholic Health Association,[1] the Association for Community Health Improvement[2] and the American Public Health Association.[3] The CHA allows hospitals to better understand the health needs of vulnerable or underserved populations; and subsequently, develop a plan that will guide future community benefit programming. MedStar Health hospitals will advance their work in the community by deploying community benefit resources to support a documented plan with measurable objectives.

The involvement of local residents, community partners, and stakeholders was a cornerstone of the CHA. Each hospital's assessment was led by an Advisory Task Force (ATF), which was comprised of a diverse group of individuals, including grassroots activists, community residents, faith-based leaders, hospital representatives, public health leaders and other stakeholder organizations, such as representatives from local health departments. ATF members reviewed quantitative and qualitative data and provided recommendations for the hospital's health priorities, specifically as they relate to the needs of underserved and low-income communities.

The findings from extensive data analyses were corroborated by stakeholder and community input. Heart disease was consistently identified as a priority for all of MedStar's acute hospitals. Diabetes and obesity were also high priorities for most hospitals. In addition to heart disease, diabetes and obesity, two of the acute hospitals identified unique priorities based on their needs assessment, coupled with existing goals or efforts with community partners. MedStar St. Mary's Hospital selected substance abuse to align with existing county priorities. MedStar Franklin Square Medical Center identified substance abuse and asthma due to its existing partnership with the Southeastern Network Collaborative and Baltimore County Public Schools. MedStar National Rehabilitation Hospital, MedStar's only free-standing specialty hospital, identified prevention of subsequent stroke among persons who speak Spanish as a primary language as an underserved population in the rehab community.

Each hospital identified a Community Benefit Service Area (CBSA) – a specific community or target population of focus, a very important aspect of the needs assessment. The impact of the hospitals' work in the CBSA will be tracked over time. Implementation strategies were developed and will serve as a roadmap for how the hospital will use its resources and collaborate with strategic partners to address the priorities.

Implementation strategies were endorsed by the hospital's Board of Directors and the Strategic Planning Committee of the MedStar Health Board of Directors. The MedStar Health Board of Directors approved each hospital's implementation strategy on June 20, 2012.

IRS Requirements for Tax Exempt Status:
Community Health Assessments

In 2006, the Internal Revenue Service (IRS) initiated a study that examined the community benefit reporting methodologies of more than 500 not-for-profit hospitals. There were three key findings: 1) there were discrepancies in how hospitals were defining and reporting community benefit; 2) there was no standardized approach in determining how to use community benefit resources to best meet the needs of the community; and 3) some hospitals' community benefit contributions were not commensurate with their tax exempt status.[4] These findings have informed a national argument for developing more consistent community benefit reporting expectations for all not-for-profit hospitals.

On March 23, 2010, Congress approved the Patient Protection and Affordable Care Act (PPACA). The Act included a Community Health Assessment (CHA) mandate for not-for-profit hospitals. According to the mandate, the CHA must be conducted once every three years and it must include input from persons who represent the broad interests of the community, as well as those with public health expertise. Furthermore, an implementation strategy must be developed by the hospital and approved by its Board of Directors. The implementation strategy must be publicly available within the same tax year the CHA is conducted.[5]

Systemwide Approach to the Community Health Assessment

MedStar Health hospitals conducted their CHAs in accordance with a framework established by the Corporate Community Health Department (CCHD). The CCHD provided project oversight and technical assistance to the hospital throughout the CHA process. The scope of the assessment included: determining key stakeholder roles and responsibilities; establishing data collection and data analyses methodologies; determining a Community Benefit Service Area (CBSA) and developing health priorities, implementation strategies and outcome measures.

Roles and Responsibilities

- *Corporate Community Health Department* - Establish a CHA methodology for all hospitals; identify strategic partners; provide expertise and technical support as needed; ensure that processes, deliverables and deadlines comply with the IRS mandate.
- *Executive Sponsor* – Serve as liaison to the senior leadership team; ensure the hospital's selected priorities are aligned with the strengths of the organization.
- *Hospital Lead* – Serve as internal resource on existing community health programs and services; facilitate and document all activities associated with the assessment.
- *Advisory Task Force* – Review quantitative data; design data collection tool and review findings; recommend the hospital's Community Benefit Service Area and community benefit health priorities. *Task force members included grassroots activists, community residents, faith-based leaders, hospital representatives, public health leaders and other stakeholder organizations, such as representatives from local health departments.*
- *Hospital Boards* – Review and endorse the hospital's Community Benefit Service Area health priorities and implementation strategy.
- *Strategic Planning Committee of the MedStar Health Board* - Review and endorse each hospital's Community Benefit Service Area, health priorities and implementation strategy.
- *MedStar Health Board of Directors*– Approve each hospital's implementation strategy.

Data Collection and Review

Advisory Task Force members analyzed quantitative and qualitative data to identify and confirm health priorities. In an effort to promote consistency in data collection and analysis among all hospitals, MedStar Health partnered with the Healthy Communities Institute (HCI) [6] and Holleran Consulting.[7]

Quantitative Data
The HCI provided a dynamic web-based platform that included over 130 Community Health indicators pulled from over 40 reputable sources. The platform allowed Advisory Task Force members to identify the most pressing health priorities in their service areas. Members were also able to identify health disparities based on varying health conditions.

HCI data were available by county or city and some measures were available by census track. If more localized data were available, the CCHD facilitated efforts to ensure they were accessible to Advisory Task Force members. *Baseline data for indicators that were not available, but deemed important by some hospitals, will be determined as a FY13 implementation action step.*

Qualitative Data

MedStar Health engaged Holleran, a public health consulting firm, to help each Advisory Task Force: 1) develop a community input tool; 2) conduct face-to-face community input sessions; 3) analyze findings and undergo a prioritization process; and 4) develop an approach to an implementation strategy.

Each ATF developed a community input survey that was disseminated to the residents and stakeholders of its CBSA. The tool included approximately 30 questions that allowed respondents to rate their perception of the level of importance around issues related to wellness and prevention, access to care and quality of life. Open-ended questions allowed them to offer suggestions on the hospital's role in addressing some of the community's most severe health issues. The majority of respondents completed the survey online. Hard copies were also available and respondents had the option to complete the survey over the phone. The survey was available in Spanish for hospitals that targeted Spanish speaking populations.

Over 900 surveys were completed systemwide. In an effort to capture a snapshot of the respondent population, demographic variables were collected for each respondent and aggregated in the hospital's final report. Variables included race, highest level of education, household annual income and health insurance status.

Face-to-face input sessions were open to residents and stakeholders of the targeted communities. Each hospital's session lasted 90 minutes. During the session, participants were asked the same questions that were included in the community input survey. However, respondents contributed their input through keypad technology, which allowed for more efficient prioritization of health concerns. The session concluded with breakout sessions that allowed participants to engage in guided conversations related to critical issues that impact the health of their community. The dialogue allowed facilitators to identify important trends and issues that would inform the hospital's approach to its implementation strategy.

In addition to face-to-face input sessions for the community at-large, another community input session was held with public health leaders in two jurisdictions where MedStar Health has more than one hospital – Baltimore City and the District of Columbia. There were 23 participants in the session held in the District of Columbia and 7 participants in the Baltimore City session. Participants included representatives from the Department of Health, federally qualified health centers, community clinics, the United Way, the Catholic Health Association, schools of public health and healthcare coalitions.

Local, State and National Health Goals

In addition to reviewing primary and secondary data, Advisory Task Force members reviewed city, state and national health goals. For example, Maryland hospital task force members reviewed the priorities outlined in Maryland's State Health Improvement Process;[8] Baltimore City task force members reviewed Healthy Baltimore 2015;[9] and all task force members reviewed Healthy People 2020[10] targets. Awareness of these targets helped task force members understand the context of national, state and local jurisdiction health goals as they prioritized health issues.

As part of the assessment, all MedStar hospitals collaborated with or received input from their local health departments. For example, Baltimore City hospital presidents had a series of meetings with the Baltimore City Health Commissioner to explore opportunities to align the city's lead health priority, heart disease, with hospital activities.

Summary of Systemwide Key Findings

Although Community Health Needs Assessments were specific to each hospital, all hospitals identified heart disease as a key health priority. All MedStar hospitals in Baltimore City and MedStar Georgetown University Hospital and MedStar Washington Hospital Center in the District of Columbia identified diabetes as a priority. Priorities were selected by quantitative data analyses and corroborated by stakeholder and community input.

Key Finding: A high prevalence of heart disease with noteworthy gender and racial disparities in some jurisdictions.

Washington Hospitals

- *District of Columbia:* The age adjusted death rate due to coronary heart disease is 184.1 per 100,000. Compared to all US counties, this figure falls within the range of the worst quartile. The rate is also significantly higher than the Healthy People 2020 target (100.8/100,000).[11] The age adjusted death due to coronary heart disease is significantly higher in Blacks/African Americans (228.1/100,000) compared to Whites (116.0/100,000).[11] It is also significantly higher in men (247.2/100,000) than women (140.3/100,000).[11]

- *St. Mary's County:* The age adjusted death rate due to heart disease is 234.4 per 100,000.[12] Compared to all Maryland counties, this figure falls within the range of the worst quartile.[12]

- *Montgomery County:* 38.7% of Montgomery County residents age 18 and older have high cholesterol. This percentage is higher than the state average and ranks within the 25th to 50th percentile of all Maryland counties. It also exceeds the Healthy People 2020 target (13.5%).[13]

Baltimore City Hospitals

- *Baltimore City:* The age adjusted death rate due to heart disease is 262.9/100,000.[12] Compared to all Maryland counties, this figures falls within the worst quartile.[12] The death rate is significantly higher in men (339.1/100,000) than women (209.9/100/000).[12]

- *Baltimore County:* 33.8% of Baltimore County residents age 18 and older have hypertension.[13] This percentage is higher than the state average and ranks among the worst quartile of all Maryland counties. It also exceeds the Healthy People 2020 target (26.9%).[13] The prevalence of hypertension is also higher in Blacks/African American (48%) than Whites (31.7%).[13]

- *Anne Arundel County:* The age adjusted death rate due to heart disease is 196.8 per 100,000. Compared to all Maryland counties, this figure falls within the range of the worst quartile.

Key Finding: A high prevalence of diabetes with noteworthy racial disparities in the District of Columbia and Baltimore City.

District of Columbia

10.9% of District of Columbia residents age 18 and older have been diagnosed with diabetes.[14] Compared to all US states, this percentage is within the worst quartile.[14] The prevalence of diabetes is significantly higher in Blacks/African Americans (17.5%) than Whites (3.6%).[14]

Baltimore City

12.9% of Baltimore City residents age 18 and over have diabetes[13] and the age adjusted death rate due to diabetes in Baltimore City is 31.9/100,000.[12] Compared to all Maryland counties, these figures rank among the worst quartile.[13] The prevalence of adults with diabetes is higher in Blacks/African Americans (15%) than Whites (9.6%) and the age adjusted death rate in Blacks/African Americans is higher (39.0/100,000) than whites (21.7/100,000).

Heart Disease Statistics

Measure	District of Columbia	St. Mary's County	Montgomery County	Baltimore City	Baltimore County	Anne Arundel County	Healthy People 2020
Age adjusted death rate due to heart disease (per 100,000)	184.1	234.4	131.0	262.9	196.6	198.8	N/A
% of adults with high blood pressure	26.1	24.0	24.5	**36.7***	**33.8***	**28.5***	26.9
% of adults with high cholesterol	**34.6***	**33.4***	**38.7***	**36.1***	**36.2***	**34.9***	13.5

**percentage exceeds Healthy People 2020 goal*

Key findings from surveys and community input sessions

Over 900 surveys were completed throughout region and nine community input sessions were conducted. The following opportunities were consistently identified across the system:

Wellness and Prevention: Respondents expressed an ongoing need for programs and services that address heart disease, overweight/obesity, diabetes and cancer. Efforts to increase awareness of existing wellness and prevention services were also suggested.

Access to Care: Respondents recommended that providers bring health services directly into the communities that need them most. Increasing the accessibility of specialty care providers for the underinsured and uninsured and enhancing access to convenient and affordable transportation for medical visits were also high priorities.

Quality of Life: Respondents suggested comprehensive efforts to improve the quality and safety of neighborhoods to promote physical activity and healthy living. Increasing access to affordable healthy foods was also identified as a need.

Community Benefit Service Areas and Priorities

Community Benefit Service Areas

Each hospital's Advisory Task Force identified a Community Benefit Service Area (CBSA) – which is defined as a geography or target population that will serve as the hospital's priority for future community benefit programming. CBSAs were determined based on the following key considerations: 1) a high density of residents who are low-income or underserved; 2) the CBSA's proximity to the hospital; and 3) an existing presence of effective programs and partnerships.

The CBSA will benefit from an increased or expanded presence of community health services sponsored by the hospital and supported by its partners. Potential best practices will be piloted in the CBSA and existing evidence-based programs will be replicated in other CBSAs throughout the system. Services in the CBSA will include formal and more extensive data collection and tracking of outcomes to demonstrate a change in knowledge, skill, behavior or health status of persons impacted. Demographic variables, such as race/ethnicity, language, culture and insurance status will also be collected. Findings will support efforts to continuously improve services to ensure cultural and linguistic relevance. These efforts will contribute to local and national health disparity goals.

Common Priorities

The terminology used to depict each priority was determined by the hospital's Advisory Task Force and based on what was preferred and resonated most with the community. For example, community members preferred the term "heart disease" over "cardiovascular disease" and some hospitals selected heart disease as a priority, while others selected a risk factor for heart disease as a priority. MedStar Georgetown University Hospital will focus on the reduction of hypertension in its service area and MedStar St. Mary's Hospital will implement activities aimed to reduce the percentage of obese or overweight residents in its service area. The majority of acute hospitals identified diabetes as a priority. While the terminology may be unique, many of the educational and preventive activities for heart disease, diabetes, obesity and hypertension are interrelated.

Unique Priorities

Quantitative and qualitative findings, coupled with pre-existing partnerships allowed some hospitals to identify unique priorities. MedStar St. Mary's Hospital selected substance abuse based on quantitative data and alignment with a pre-determined county priority. MedStar Franklin Square Medical Center selected substance abuse and asthma due to a pre-existing partnership with the Southeastern Network Collaborative and Baltimore County Public Schools, respectively. MedStar National Rehabilitation Hospital identified prevention of recurrent stroke among persons who speak Spanish as a primary language as a unique and underserved population in the rehab community.

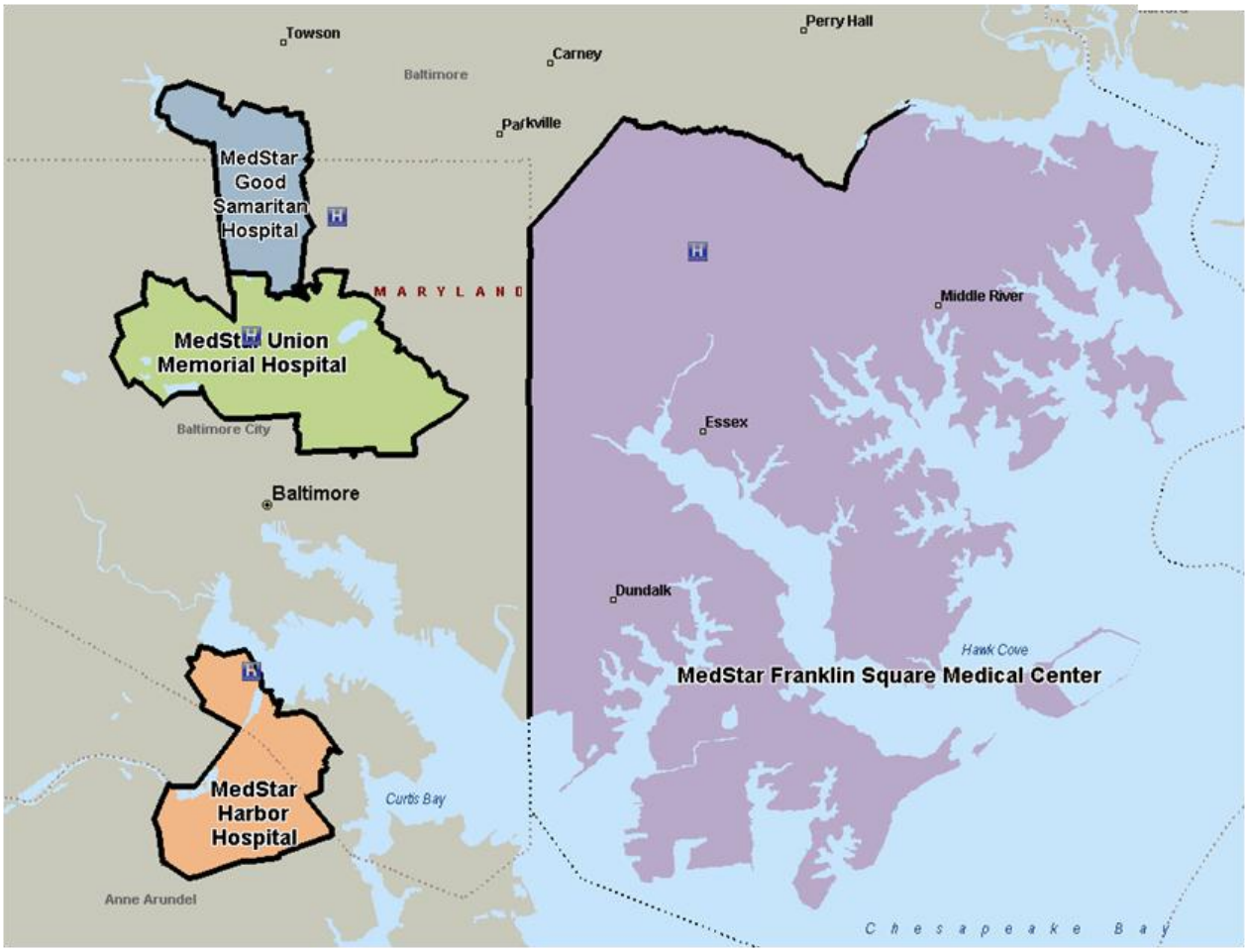
Services Provided Outside of the CBSA

MedStar hospitals have a history of contributing to the health of the region by providing services outside of their CBSAs. These programs and services address health awareness, education, early detection and prevention of disease. Hospitals will continue to maintain a presence in these areas; however, the CBSA will serve as the population of focus. Activities within the CBSA will be evaluated or refocused for more rigorous outcomes tracking. Promising practices will be piloted and evidence-based programs will be replicated in the CBSA.

Overview of Individual Hospital Community Benefit Service Areas and Health Priorities

Baltimore Hospitals

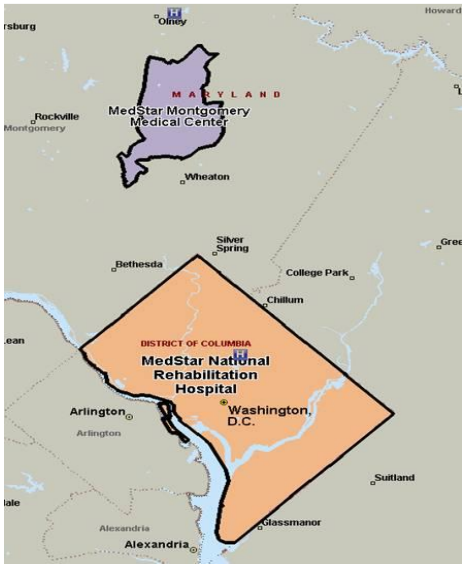
	MedStar Franklin Square Medical Center	MedStar Good Samaritan Hospital	MedStar Harbor Hospital	MedStar Union Memorial Hospital
Heart Disease	X	X	X	X
Diabetes		X	X	X
Substance Abuse	X			
Asthma	X			
Community Benefit Service Area	Southeast Baltimore County	Greater Govans	Cherry Hill / Brooklyn Park	North Central Baltimore City



Washington Hospitals

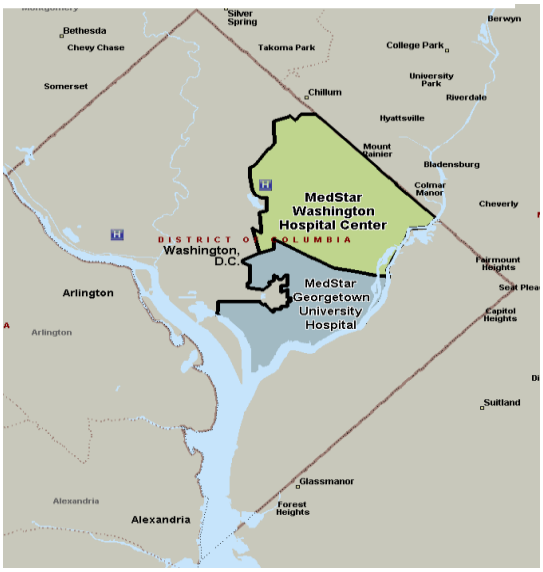
	MedStar Georgetown University Hospital	MedStar Montgomery Medical Center	MedStar National Rehabilitation Hospital	MedStar St. Mary's Hospital	MedStar Washington Hospital Center
Heart Disease	X	X		X	X
Diabetes	X			X	X
Obesity	X			X	X
Substance Abuse				X	
Stroke			X	X	
Community Benefit Service Area	Ward 6	Aspen Hill / Bel Pre	Spanish speaking stroke survivors and their caregivers	St. Mary's County with emphasis on Lexington Park	Ward 5

MedStar Montgomery Medical Center
MedStar National Rehabilitation Hospital



MedStar St. Mary's Hospital

MedStar Georgetown University Hospital
MedStar Washington Hospital Center



Implementation Strategy Approach

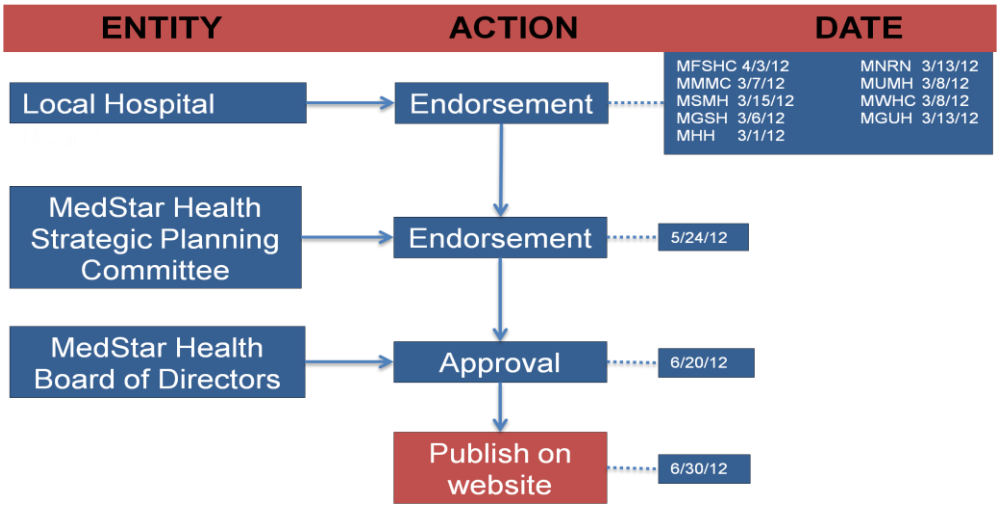
The Implementation Strategy serves as a roadmap for how community benefit resources will address the health priorities and contribute to the health of the communities served. In an effort to improve outcomes and measure progress over time, the activities are few and focused. The programming component of the Implementation Strategy is based on:

- Including specific short- and long-term measurable outcomes.
- Refining or expanding existing programs and services that are aligned with health priorities.
- Sustaining, enhancing or identifying new partners.
- Focusing on the expansion of services directly into communities of need.
- Identifying and testing promising practices for replication throughout the system.
- Developing common programming to support heart disease, the system priority.
- Leveraging expertise throughout the system.
- Sharing and using existing human and operating resources to support priorities.

The activities documented in the Implementation Strategy will undergo extensive evaluation. Process evaluations will support continuous quality improvement efforts to enhance how the activity is delivered and outcome evaluations will assess for a change in knowledge, skill or health status among persons impacted. In an effort to support local and national health disparity goals, mechanisms for more robust demographic data collection will be established. Examples include but are not limited to: race/ethnicity, primary language, culture and religious affiliation.

Each hospital's Implementation Strategy was written by the Hospital Lead and supported by the Executive Sponsor. The strategy was endorsed by the hospital's Board of Directors and the MedStar Health Board of Directors' Strategic Planning Committee, and approved by the MedStar Health Board of Directors.

IMPLEMENTATION STRATEGY ENDORSEMENT AND APPROVAL PROCESS



Institutionalizing Performance

Corporate Community Health Department (CCHD)
The CCHD Department will provide systemwide leadership to optimize the outcomes of the hospital's implementation strategy. The Department will manage the activities of a Community Benefit Workgroup, identify a common platform for tracking and measuring performance, and identify new partners and sustain relationships with existing partners who support a systemwide strategy. The Department will also work with Hospital Leads to support the execution of implementation strategies and convene groups to support the replication of evidence-based programs across the system.

- Community Benefit Workgroup
  The Community Benefit Workgroup is comprised of Hospital Leads and other internal community health associates. The workgroup convenes quarterly and meetings are designed to promote information exchange, disseminate new guidelines and performance measures, ensure consistency in documentation and data collection, and advance the knowledge, skills and abilities of individual team members.

- Tracking and Measurement
  The Corporate Community Health Department will identify, develop and implement a common platform for documenting demographics and change in knowledge, skills or health status of persons impacted. The department will provide guidelines and provide technical support to promote consistency across all hospitals.

- Partnerships
  Heart disease is a systemwide priority for MedStar Health. Activities to prevent heart disease and promote healthy living among persons with heart disease are included in each hospital's implementation strategy. The CCHD Department will lead efforts to cultivate partnerships that will expand the hospitals' capacity to contribute to the reduction of heart disease in vulnerable populations. The CCHD will also explore opportunities to expand MedStar Health's partnership with the Department of Health and Human Services as a member of the Million Hearts Campaign.

Hospital Leadership
Senior leaders who oversee the hospital's community benefit activities will support efforts to identify resources that can be allocated or reorganized to support the priorities and activities documented in the implementation strategy. Hospitals leaders will also identify and support opportunities to integrate community benefit activities with the relevant requirements of each hospital's accreditation or certification programs.

Advisory Task Force, Board Leadership and Community Updates
Annual updates on the progress of the implementation strategy will be provided to the hospital's Advisory Task Force, the Board of Directors and the MedStar Health Strategic Planning Committee. Updates will also be available to the community and stakeholders through the MedStar Health corporate website.

Resources

[1] http://www.chausa.org/Assessing_and_Addressing_Community_Health_Needs.aspx
[2] http://www.communityhlth.org/
[3] http://www.apha.org/
[4] http://www.irs.gov/pub/irs-tege/frepthospproj.pdf
[5] http://housedocs.house.gov/energycommerce/ppacacon.pdf
[6] http://www.healthycommunitiesinstitute.com/
[7] http://www.holleranconsult.com/
[8] http://dhmh.maryland.gov/ship/SitePages/Home.aspx
[9] http://www.baltimorehealth.org/healthybaltimore2015.html
[10] http://www.healthypeople.gov/2020/default.aspx
[11] http://wonder.cdc.gov/ucd-icd10.html
[12] http://www.dhmh.state.md.us/
[13] http://www.marylandbrfss.org/
[14] http://apps.nccd.cdc.gov/brfss/

For more information on MedStar Health's Community Health Assessment, please contact the Corporate Community Health Department
410-772-6693 or Jessica.Roach@medstar.net

MedStar Franklin Square Medical Center
Community Health Assessment FY2012

1. Define the hospital's Community Benefit Service Area (CBSA) and identify the hospital's community benefit priorities.

MedStar Franklin Square Medical Center's (MFSMC) Community Benefit Service Area (CBSA) includes residents of zip codes 21206, 21219, 21220, 21221, 21222, 21224, and 21237. This region was selected due to the hospital's pre-existing partnership with the Baltimore County Southeast Area Network – a volunteer community organization that monitors and works to improve the health of residents in the southeastern portion of Baltimore County. Based on quantitative and qualitative findings, asthma management among children, awareness of resources concerning alcohol and substance abuse and heart health have been identified as the MedStar Franklin Square Medical Center's community benefit priorities.

2. Provide a description of the CBSA.

The total population of the seven ZIP codes that make up the MedStar Franklin Square's CBSA is 271,230. The majority of the population is white (67.0%), followed by Black/African American (26.8%), Asian (1.6%), other (1.5%), American Indian/Alaskan Native (0.7%) and Native Hawaiian/Pacific Islander (0.1%). An additional 2.4% of people identify with two or more races/ethnicities. Adults ages 18-44 account for 37.0% of the population, while those younger than 18 represent 22.8% of the population and those over the age of 65 represent 14.1%. The weighted average annual household income in Southeast Baltimore County is $47,241, as compared to $63,279 in Baltimore County as a whole (Claritas, 2011).

3. Identify community health assessment program partners and their expertise or contribution to the process.

Holleran is a public health research and consulting firm with 20 years of experience in conducting community health assessments. The firm provided the following support: 1) assisted in the development of a community health assessment survey tool; 2) facilitated the community health assessment face-to-face group session; and 3) facilitated an implementation planning session.

The **Healthy Communities Institute** provided quantitative data based on 129 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

4. State who was involved in the decision-making process.

The community benefit priorities were recommended by an Advisory Task Force, which consisted of Baltimore County representatives from the Health Department, Department of Social Services, Local Management Board, Office of Planning and MedStar Franklin Square representatives from Community Outreach, Community Medicine, Senior Management, Board, Patient Advocacy, Marketing, Family Practice, and Healthcare for the Homeless.
The Advisory Task Force reviewed local secondary data, coupled with state and federal community health goals. Task Force members also reviewed the Medical Center's

operating plan, the outcomes of prior community health assessments and current community benefit programs and services. In partnership with Holleran, the team developed and helped disseminate a community health assessment tool around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life. The Advisory Task Force invited key local partners, including area non-profit service providers and representatives from the Maryland State Department of Education**,** Baltimore County Public Schools and the Department of Aging to a community benefit planning forum to evaluate the survey results, identify priorities, and plan collaborative action steps.

In addition to quantitative and qualitative findings, the Task Force considered the hospital's strengths as well as local, regional and/or state health goals. Based on findings, the Task Force made a recommendation on the priorities, which were then approved by the MedStar Franklin Square Medical Center's President, endorsed by the MFSMC Board of Directors and the MedStar Health Board of Director's Strategic Planning Committee and approved by the MedStar Health Board of Directors.

Advisory Task Force Members

Name	Title	Organization
Janet Rafky	Sr. Dir, Patient Advocacy	MedStar Franklin Square
Tricia Isennock, MS, RN-BC, MCHES	Community Outreach Mgr.	MedStar Franklin Square
Trina Adams	AVP Marketing	MedStar Franklin Square
Nick D'Alesandro	Community Liaison	Baltimore County Social Services
Gregory Branch, MD	County Health Officer	Baltimore County Department of Health
Terri Kingeter	Sector Coordinator	Baltimore County Planning Office
Caryn Koterwas	Marketing Specialist	MedStar Franklin Square
Scott Krugman, MD	Community Medicine Service Line Director	MedStar Franklin Square
Patricia Norman	Board Member	MedStar Franklin Square
Sally Rixey. MD, MEd	FHC Chief of Family Practice	MedStar Franklin Square
Karen Robertson-Keck	VP, Human Resources	MedStar Franklin Square
Don Schlimm	Acting Executive Director	Baltimore County Local Management Board
Kelechi Uduhiri. MD, MPH, MS	Medical Director	Healthcare for the Homeless - Baltimore County
Rene Youngfellow, RN	Division Chief, Clinical Services-Center Based Services	Baltimore County Department of Health

Key Community Partners in Community Benefit Planning

Name	Title	Organization
Donna Bilz	Healthscope Director	Baltimore County Department of Aging
Wendy Freeman	PartnerSHIP Program Director	Baltimore County Department of Health
Susan Hahn	Parent Support Services	Baltimore County Public Schools
Diane Kretzschmar, RN, PNP, CCE, PN	Parish Nurse Coordinator	MedStar Franklin Square
Mike Mason	Specialist Physical Education	Maryland State Department of Education
Joanne McAuliffe	Oncology Service Line Director	MedStar Franklin Square
Karen Polite-Lamma RN, BS, BSN, CCE, MCHES	Education Specialist	MedStar Franklin Square
Laura Riley	Deputy Director, CountyRide	Baltimore County Department of Aging
Kristin Scilipoti	Health Educator	MedStar Franklin Square

5. Justify why the hospital selected its community benefit priorities.

a) Community Asthma Management	
Quantitative Evidence	• At 21.9%, the percentage of children diagnosed with asthma is higher than any surrounding county and higher than the state percentage (16.4%). This statistic translates into missed days of school, limitations on daily activities, visits to the emergency department for treatment of asthma symptoms, and hospitalizations. • MedStar Franklin Square Medical Center CY2011 Asthma Statistics: - Pediatric ED visits: 449 - Admissions: 143 - Transferred to PICU: 13 • Baltimore County Public Schools (BCPS) 2010-11 (total enrollment 104,000 students): - 13,344 students with asthma diagnosis - 4,831 students had asthma medication orders at school
Qualitative Evidence	BCPS school nurses report increased nurse visits and 911 transfers of students from school to emergency room due to asthma
Hospital Strengths	Center of Excellence for Pediatric Asthma Management
Alignment with local, regional, state or national health goals	• Healthy People 2020 Respiratory objectives RD-1 through RD-7 • Maryland State Health Improvement Plan (MD SHIP): Child Health • BCPS stats • Southeast Network: Keeping children safe and healthy
Other justification	Resource access (spacers, management plans) is limited in this area due to economic status

b) Resource Awareness - Tobacco Use and Substance Abuse Prevention/Cessation	
Quantitative Evidence	• Registration for free tobacco cessation programs at MedStar Franklin Square is frequently so low that programs are cancelled • The current adult smoking rate in Maryland is 15.2% (MD BRFSS) • The current adult smoking rate in Baltimore County is 15.6% (MD BRFSS) • Tobacco use contributes to cancer, heart disease, and respiratory diseases (including emphysema, bronchitis, and chronic airway obstruction), premature birth, low birth weight, stillbirth, and infant death
Qualitative Evidence	• 70.3% (n=243) of Community Input Survey respondents think tobacco use is a “critical” or “very critical” issue • 27.3 (n=243) of Community Input Survey respondents “don’t know” that smoking cessation, prevention, education and support programs are available in Southeast Baltimore County • 28.3 (n=243) of Community Input Survey respondents “don’t know” that substance abuse prevention, education and support programs are available in Southeast Baltimore County • Only 41.4% (n=243) of Community Input Survey respondents “agreed” or “strongly agreed” that smoking cessation, prevention, education and support programs are available; 27.3% did not know; another 6.6% did not respond • Only 38.5% (n=243) of Community Input Survey respondents “agreed” or “strongly agreed” that substance abuse, prevention, education and support programs are available; 28.3% did not know; another 8.2% did not respond
Hospital Strengths	• Marketing department • Website • Partnerships – Southeast Network, Baltimore County Tobacco Coalition • Stop Smoking Today program (73% quit rate, N=5)
Alignment with local, regional, state or national health goals	• Healthy People 2020 TU-1 through TU-20; the HP2020 target is to reduce the proportion of adults who smoke to 12% • MD SHIP: Tobacco Use • Baltimore County plan: Tobacco Coalition
Other justification	N/A

c) Senior Heart Health	
Quantitative Evidence	• There are 195.4 deaths due to heart disease per 100,000 population in Baltimore County (MD DHMH & MD VSA, 2009) • There are 239.0 deaths due to heart disease per 100,000 population in Baltimore County (HSCRC, 2010) • Heart disease is the leading cause of death in Maryland, accounting for 25% of all deaths (MD SHIP) • 36.2% of people in Baltimore County report high cholesterol (MD BRFSS, 2009) • 33.8% of people in Baltimore County report high blood pressure (MD BRFSS, 2009) • Heart disease accounts for 26.5% of all deaths in Southeast Baltimore County (Community Needs Assessment, 2008)
Qualitative Evidence	• 81.8% (n=243) of Community Input Survey respondents rated heart disease to be “critical” or “very critical” • 73.4% (n=243) of Community Input Survey respondents rated stroke to be “critical” or “very critical”
Hospital Strengths	• Recipient of highest level of recognition for quality stroke care from the American Heart Association/American Stroke Association (AHA/AMA) • Relationship with Baltimore County Department of Aging
Alignment with local, regional, state or national health goals	• Healthy People 2020 HDS-1 through HDS-5 • MD SHIP: Reduce deaths from heart disease (Chronic Disease)
Other justification	N/A

6. Does the hospital currently have community benefit activities that support other key health needs that were identified as important in the Community Health Assessment?

Condition / Issue	Classification	Name of Program / Description of Service	Key Partner
Domestic Violence/Child Abuse	Quality of Life	Triple P (Positive Parenting Program) Child Protective Team	Baltimore County Local Management Board Child Protective Team
Obesity	Wellness & Prevention; Quality of Life	Fit Families Heart Smart Trail Mall Walking	MedStar Franklin Square Family Health Center Department of Natural Resources White Marsh Mall Eastpoint Mall Baltimore County Local Health Coalition
Diabetes	Wellness & Prevention	Diabetes support group	
Heart Disease	Wellness & Prevention; Access to Care	Blood pressure screenings Women's Health Navigator	White Marsh Mall Eastpoint Mall Target Various community sites
Cancer	Wellness & Prevention; Access to Care	Community screenings	Community sites - businesses
Stroke	Wellness & Prevention; Access to Care	Blood pressure screenings Risk screening	White Marsh Mall Eastpoint Mall Target Various community sites
Infant mortality	Wellness & Prevention	Reducing Adverse Perinatal Outcomes Sleep Safety	Blue Cross Blue Shield Baltimore County Local Health Coalition Various community sites
Homelessness	Wellness & Prevention; Access to Care	Healthcare for the Homeless – Baltimore County	Baltimore County Communities for the Homeless Baltimore County: Office of Planning, Department of Health, Department of Social Services Area shelters

7. List other health priorities that were identified in the CHNA and describe why the hospital did not select them?

Condition / Issue	Classification	Source	Explanation
Transportation	Access to Care	42.1% (n=243) of Community Input Survey respondents found the quality of transportation to be "fair," "poor" or "very poor"	MFSMC does not have the expertise or infrastructure to serve as a lead around this area of need
Housing	Quality of Life	53.1% (n=243) of Community Input Survey respondents found the quality of housing to be "fair," "poor" or "very poor"	MFSMC does not have the expertise or infrastructure to serve as a lead around this area of need

8. Describe how the hospital will institutionalize community benefit programming to support the Implementation Strategy.

The hospital's Implementation Strategy is a roadmap for how community benefit resources will be deployed and how outcomes will be reported. The Community Benefit Hospital Lead will oversee planning, programming, monitoring, and evaluation of outcomes. The Executive sponsor will support institutional efforts to re-organize or reallocate resources as needed. Annual progress updates will be provided to Advisory Task Force members and the hospital's Board of Directors. The progress report will also be publicly accessible via the hospital's website.

The MedStar Health Corporate Community Health Department (CCHD) will provide system-wide coordination and oversight of community benefit programming. The CCHD will oversee the agenda of the Community Benefit Workgroup, which is comprised of Community Benefit Hospital Leads and other community health professionals across the system. The purpose of the workgroup is to share best practices and promote consistency around data collection, tracking, and reporting that is consistent with internal policies and state and federal guidelines.

The CCHD will provide the MedStar Health Board of Director's Strategic Planning Committee with annual updates on the hospital's progress towards the goals documented in the Implementation Strategy.

Resources

- Claritas, 2011
- Healthy People 2020
- US Census 2010
- Maryland State Health Improvement Plan
- Maryland Vital Statistics Administration
- Maryland Department of Health and Mental Hygiene
- Maryland Health Services Cost Review Commission
- Maryland Behavioral Risk Factor Surveillance System
- Baltimore County Local Health Coalition
- Holleran Community Input Results – MedStar Franklin Square Medical Center

Implementation Strategy

Community Need: Asthma Care
Goal Statement: Improve the quality of asthma care for children in the fifty-one BCPS schools in the Community Benefit Service Area (CBSA) through standardized asthma management plans and spacer availability.
Target Population: Children who attend Deep Creek Elementary School, Golden Ring Middle School, and Kenwood High School

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	Baltimore County Public School (BCPS) RNs MedStar Franklin Square Community Asthma Team MedStar Grant Development Team MedStar Franklin Square Outpatient Pharmacy	Continue collaboration with BCPS and area school nurses through the Community Asthma Team.	Convene monthly meetings to identify challenges, opportunities and resources.	Determine number of 911 calls due to asthma in target schools	Decrease 911 calls by 10%[1] from the fifty-one BCPS schools in the Community Benefit Service Area (CBSA)	Baltimore County Public Schools Community Asthma Team	Community Asthma Team
2		Facilitate the use of a standardized, accessible management plan form for each elementary school child experiencing asthma.	Identify and implement a standardized form Identify and eliminate barriers Promote the use of a standardized form	Identify the current number of children with diagnosed asthma with completed asthma action plans in target schools	Increase by 10% the number of completed asthma action plans in targeted schools by November 2014[2]	Baltimore County Public Schools Community Asthma Team	Maryland Department of Health and Mental Hygiene Baltimore County Public Schools Community Asthma Team
3		Increase the availability of spacers for use in schools	Identify and mitigate obstacles to spacer access Identify funding source(s) for spacers Obtain and distribute spacers to schools	Obtain funding to supply ten spacers to each of the fifty-one BCPS schools in the CBSA	Provide ten spacers to each of the fifty-one BCPS schools in the CBSA by November 2014	Baltimore County Public Schools Community Asthma Team	MedStar Franklin Square Outpatient Pharmacy Baltimore County Public Schools Community Asthma Team

[1] According to the BCPS RN Director, there were 63 911 calls from BCPS schools in 2011.
[2] Baseline will be established in 2013.

Community Need: Resource Awareness
Goal Statement: Increase the awareness of the public, providers and policy makers in the Community Benefit Service Area (CBSA) about available tobacco and other substance abuse prevention, education and support programs resources.
Target Population: Adults who live and/or work in the CBSA

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
1	MedStar Franklin Square Community Health Education (CHE) Stop Smoking Today (smoking cessation program) Baltimore County Department of Health Tobacco Coalition American Cancer Society American Heart Association Holleran	Identify obstacles to resource awareness	Hold three community input sessions with the Southeast Network, other healthcare providers, and community members	Increased awareness of tobacco and other substance abuse resources as indicated by the re-execution of the Holleran community input survey at all the previous sites November 2014: Decrease number of "Don't Know" responses by 10%[1]	Increased number of Stop Smoking Today participants by 10%	Baltimore County Department of Health Baltimore County Department of Aging Baltimore County Office of Planning Baltimore County Public Schools Southeast Area Network	Community Outreach Manager
2		Increase publicity about tobacco and other substance abuse resources.	Utilize MedStar Franklin Square marketing opportunities to publicize smoking and substance abuse cessation prevention, education and support programs in the CBSA[2] Collaborate with Baltimore County and area resource providers in related publicity campaigns Send brochure electronically to BCDH and SEN to be distributed to all providers and clients	Determine baseline participation in One Voice Dundalk.			AVP MedStar Franklin Square Marketing

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	artnering Organizations	Responsible Party(ies)
3		Re-execution of the Holleran community input survey at all the previous sites	Distribute surveys	At least 250 community input surveys completed by November 2014	Increase participation in One Voice Dundalk by 10%		

[1] Holleran survey, Wellness and Prevention questions 4a (27.3%, n=243) and 4g (28.3%, n=243).
[2] Include information in the MedStar Health education calendar, MedStar Franklin Square website, and distribute 20 brochures in all MedStar physician offices and facilities in CBSA.

Community Need: Senior Cardiovascular Health
Goal Statement: Improve the quality of cardiovascular health for seniors attending the seven Baltimore County Department of Aging (BCDA) Senior Centers in the Community Benefit Service Area.
Target Population: Seniors attending the seven BCDA Senior Centers in the CBSA: Ateaze, Edgemere, Essex, Fleming, Overlea-Fullerton, Rosedale, and Victory Villa

#	Resources	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes	Partnering Organizations	Responsible Party(ies)
	Baltimore County Department of Aging • Senior Centers • Fitness Centers • CountyRide MedStar Franklin Square • Community Health Education • Food and Nutrition • Consumer Health Library • Pharmacy • Fitness Coordinator • Family Medicine Residency MedStar Health Cardiovascular Services • Nurse American Heart Association Million Hearts Initiative	Implement Healthy Heart club[1] in each targeted Senior Center: Ateaze, Edgemere, Essex, Fleming, Overlea-Fullerton, Rosedale, Seven Oaks, and Victory Villa	Recruit 10 participants at each senior center Assess each participant for baseline heart health indicators[2] Collect pertinent heart health medical information[3] from each participant Hold monthly meetings (Oct – May) to discuss hearth health topics[4] Reassess heart health indicators[2] and BRFSS questions at end of program	Determine number of blood pressures in therapeutic range Increased number of screening participants who are aware of personal blood pressure numbers by 10%[5] 10% increased awareness of blood pressure/stroke risk factors as indicated by pre- and post tests[5]	Blood pressures in therapeutic range increased by 10%[5] Decreased number of hospital/ED visits for hypertension by 10% by participants[5]	Baltimore County Department of Aging University of Maryland, Baltimore and Notre Dame of Baltimore Pharmacy students Eastpoint Mall White Marsh Mall	Health Educator Community Outreach Manager

[1] Name tentative
[2] Height, weight, blood pressure, body mass index (BMI), waist circumference, cholesterol, glucose
[3] Behavior Risk Factor Surveillance System (BRFSS) questions, current medications, any advance directives on file, emergency information, recent (within the past year) doctor/hospital/emergency department visits
[4] I.e., risk factor education, self-management techniques, resource navigation, health literacy
[5] Baseline will be established on first day of program.

Appendix: Community Input Results

Background and Methodology

Beginning in October 2011, staff from MedStar Health and Franklin Square Hospital Center partnered with Holleran to develop a questionnaire to gather feedback from community members. The purpose of the questionnaire was to garner feedback during "Community Input Sessions" and to distribute the questionnaire in the community via online and written data collection methodologies. Community members were also given the opportunity to complete the questionnaire over the telephone. The content of the questionnaire focused on perceptions of community needs and strengths across four key domains:

1. Access to healthcare services
2. Key health issues prominent in the community
3. Perceived quality of life
4. Availability of wellness and prevention initiatives

The hospital identified key area agencies and individuals to serve on the "Advisory Task Force." The purpose of the task force is to guide the efforts of the community assessment work and to serve as advisors with the hospital's community benefit planning. Holleran staff worked with the Franklin Square Hospital Center Advisory Task Force members to supplement core questions identified by MedStar Health with additional questions that were customized to their hospital's services and their specific community's needs.

On Monday, November 14, the Community Input Session was held. Eighteen individuals from the surrounding community offered feedback via the questionnaire. Representatives from Franklin Square Hospital Center and the Advisory Task Force were also in attendance at the session, but did not respond to the questionnaire.

Holleran facilitated Franklin Square Hospital Center's Community Input Session, which lasted approximately 90 minutes. The session was organized into a gathering of quantitative feedback via a wireless keypad technology and roundtable discussion groups aimed at stimulating qualitative feedback to the open-ended questions. In addition to the onsite Community Input Session, the hospital gathered nearly 226 additional completed surveys via online and written survey distribution. It is important to note that the number of completed surveys and limitations to the random sampling yield results that are directional in nature and may not necessarily represent the entire population within the hospital's service area.

The following report is a compilation of the responses from all community members, both those in attendance at the onsite meeting and those who completed the survey outside of the meeting. This summary, in conjunction with secondary data from Healthy Communities Institute, will serve as the foundation for Franklin Square Hospital Center's Implementation Planning and community benefit activities.

Overview of Quantitative Results

Respondent Demographics

A total of 244 individuals responded to the questionnaire, 18 during the Community Input Sessions and an additional 226 following the input session (online and written responses).The majority (62.4%) were residents in the community and an additional 15.9% represented area professionals, community leaders, and government officials. Seven out of ten were White and roughly 40% reported having a college degree or higher. The age groups were fairly evenly represented, with the 65+ demographic representing the largest proportion in the sample (33.2%). With respect to household income, 16% of the sample reported an income less than $25,000 and 18.4% reported a household income of $100,000 or greater. When asked about health insurance coverage, 6.7% indicated they do not currently have health insurance and an additional 2.9% have Medicaid for their coverage.

Access to health services

The initial set of questions focused on access to area healthcare and health services. Individuals were asked to respond to a series of statements whereby they agreed or disagreed with the corresponding statement (1=strongly disagree; 5=strongly agree). The highest level of agreement (average 3.9) was reflected in access to primary care and access to specialty care. The lowest level of agreement (average 2.8) was reflected in the number of bilingual physicians and other health care providers in Southeast Baltimore County.

On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements:

Factor	Mean Response	Corresponding Scale Response
Residents in the area are able to access a primary care physician or other health care provider (family doctor; general practitioner; internist; pediatrician).	3.9	Agree
Residents in the area are able to access a medical specialist (oncologist, cardiologist).	3.9	Agree
Residents in the area are able to access a dentist when needed.	3.4	Neutral
Residents in the area have access to transportation for medical appointments.	3.2	Neutral
There are a sufficient number of physicians and other health care providers accepting Medicaid or other forms of medical assistance.	3.4	Neutral
There are a sufficient number of bilingual physicians and other health care providers in Southeast Baltimore County.	2.8	Neutral
Health prevention, screening and wellness are promoted well in Southeast Baltimore County.	3.5	Agree

When looking at the specific number of individuals responding that they “strongly agree” with the statement, once again, access to primary care and specialty care were rated the highest with approximately 40% stating they “strongly agree.” The fewest “strongly agree” responses were garnered from access to bilingual health providers (5.5%), the number of physicians who accepting Medicaid or other forms of medical assistance (17.3%), and the availability of transportation for medical appointments (17.8%).

Key Health Issues
Again, individuals were asked to respond on a scale of 1 through 5 to identify the health issues they perceived as the most critical in the community (5=very critical issue; 1=not a critical issue). The table below outlines the average ratings on the 1 through 5 scale.

On a scale of 1 (not critical) through 5 (very critical), please rate how critical you believe the following are in your community:

Factor	Mean Response	Corresponding Scale Response
Diabetes	4.1	Critical
Cancer	4.2	Critical
Heart Disease	4.1	Critical
Stroke	3.9	Critical
Obesity	4.3	Critical
Mental/Behavioral Health	3.9	Critical
End of Life Care	3.6	Critical
Tobacco	4.0	Critical
Air/Environmental Hazards	3.7	Critical
Unintentional (accidental) Injuries	3.0	Neutral
Infant Mortality (death)	3.1	Neutral

The table above shows that obesity is of greatest concern among individuals in the community (average rating of 4.3). This is consistent with rising concerns statewide and nationally with the growing obesity epidemic. Other health issues rated among those greatest concern include cancer, diabetes, heart disease and tobacco use. The connection between all of these issues is noteworthy as well, with poor diabetes management, obesity, and tobacco use all being risk factors for heart disease and some cancers. While all issues were rated as being a critical issue of concern in the community, the two that were rated the lowest were accidental injuries/death and infant mortality (ratings of 3.0 and 3.1 respectively).

Wellness & Prevention
The awareness of and quality of area wellness and prevention services was assessed as well. Individuals were asked questions about services such as smoking cessation, diabetes prevention and education, cancer screenings, substance abuse programs, and cardiovascular disease prevention and support among others. As detailed in the summary tables below, the community members rated the availability of cancer screening, prevention and education services as the most prominent with respect to availability (rating of 3.8). This was followed by average ratings of 3.6 for smoking cessation and prevention support services and diabetes prevention and support programs in Southeast Baltimore County.

The lowest level of agreement was for aging-related services. Specifically, the question asked for feedback regarding the availability of services for aging in place at home. This garnered a rating of 3.1 on the five-point scale. It is also important to note that nearly 30% of the respondents responded to this question with a “don’t know” response, suggesting a lack of awareness about available services. Similarly, a large percentage of individuals (25% or greater) responded “don’t know” to the questions about breastfeeding support and programs, substance abuse prevention and programs, HIV/AIDS services, and smoking cessation programs.

On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements:

Factor	Mean Response	Corresponding Scale Response
Smoking cessation, prevention, education and support programs are available in Southeast Baltimore County.	3.6	Agree
Diabetes Prevention, education and support programs are available in Southeast Baltimore County.	3.6	Agree
Cancer screening, prevention, education and support programs (mammography, prostate exams) are available in Southeast Baltimore county.	3.8	Agree
Healthy Lifestyle (nutrition, exercise) education and support programs are available in Southeast Baltimore County.	3.5	Agree
Cardiovascular disease prevention, education and support programs are available in Southeast Baltimore County.	3.5	Agree

On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements:

Factor	Mean Response	Corresponding Scale Response
HIV/AIDS prevention, education and support programs are available in Southeast Baltimore County.	3.4	Neutral
Substance Abuse prevention, education and support programs are available in Southeast Baltimore County.	3.4	Neutral
Breastfeeding promotion and support programs are available in Southeast Baltimore County.	3.4	Neutral
Support for aging at home is available in Southeast Baltimore County.	3.1	Neutral

Quality of Life

The questionnaire was not limited to simply the clinical aspects of community health, but also garnered feedback on a number of the known social determinants of health, such as education, housing, and neighborhood safety. Similar to other sections on the questionnaire, individuals responded on a 1 through 5 scale with 1=very poor and 5=excellent.

Not surprisingly, the availability of area jobs and employment issues were rated the most negatively (rating of 2.7). Thirty-five percent (35%) of the individuals stated that the quality of the jobs and employment opportunities in the area is “poor” or “very poor.” Given the current economic situation nationally, this low rating was anticipated. The next two lowest rated issues (average of 3.2) were transportation and neighborhood safety. Only 38% of individuals perceive the area transportation services to be “excellent” or “good.” Transportation was also identified during the discussion groups as a key area of concern in the area.

When looking at the items rating higher by the individuals, the schools and education system in Southeast Baltimore were rated among the highest (3.8 average rating). A similar rating (3.7) was received for the availability of fresh produce and healthy foods for households in the Southeast Baltimore neighborhoods. Specifically, more than half (57%) of the respondents rated access to fresh produce as “excellent” or “good.”

On a scale of 1 (very poor) through 5 (excellent), please rate the quality of each in the community:

Factor	Mean Response	Corresponding Scale Response
Recreational activities	3.5	Good
Neighborhood safety	3.2	Fair
Fresh produce and other healthy foods	3.7	Good
Schools/Education	3.8	Good
Housing	3.5	Good
Transportation	3.2	Fair
Jobs/Employment	2.7	Fair

Qualitative Results

The qualitative results represent the feedback garnered from the roundtable discussions at the Community Input Session as well as responses from the open-ended questions on the online and written surveys.

Suggestions for improving access to quality health care services
When asked for specific suggestions about how area hospitals and public health agencies can improve access to quality health care services in the community, greater outreach, communication, education and marketing to rural communities was identified as an issues needing greater outreach. As one attendee from the input session stated, *"Bring the information to where people already are."* Related to the issue of access to care in rural areas was the difficulty of accessing transportation or transportation that is affordable. Suggestions were made to develop mobile treatment options, such as vans or buses that provide treatment at various locations and times in the Southeast part of the county.

While transportation issues were noted as concerns among those living in rural areas, transportation in general was noted as a concern for all. Suggestions were made to explore transportation options for certain populations such as the elderly and disabled. Attendees from the community input session and respondents on the questionnaire identified that transportation barriers can be a challenging issue to overcome, particularly given its tie to funding. However, suggestions were given for hospital officials to meet and work with local government officials to explore options to mitigate these issues with certain populations (again, seniors and the disabled). Others mentioned that there are a number of best practices for mobile clinics for either primary care or dental care, and that those options should be explored.

Feedback was also received for the hospital and public health agencies to strongly pursue prevention and treatment options through non-clinical partnerships, such as schools, area employers, and churches. If successful, these strategic partnerships can not only assist with providing outreach opportunities, but can also promote communications back home to families and community in a broader way than the hospital can do alone. It was perceived that there might be a greater awareness of what services, screenings, and educational opportunities already exist if communications are promoted through these avenues as well.

Related to awareness of existing screenings and prevention activities, many individuals do not appear to be aware of what is already offered through the hospital and public health agency. A number of suggestions were made to provide additional screenings, prevention programs, and educational activities. To an even greater extent, suggestions were made to better promote and advertise these offerings. The hospital and its partners are encouraged to fully explore whether the true issue is availability or awareness, or a combination of both. The conduct of the community health needs assessment was perceived to be a great opportunity to be a catalyst for this type of community dialogue and line of communication.

Additional suggestions to improve access to care included better management of the hospital emergency room for acute health needs versus primary care. Feedback was given that the emergency room is over-burdened with non-emergency related health issues that the true emergency needs of the community are not being met the way they should be. The community also perceived there to be a lack of coordination among area providers. Better communication between primary care providers and specialists was one of the strongest recommendations. Significant gaps exist with respect to the coordination among providers for pharmaceutical needs and the sharing of key health information and patients. Other suggestions included

greater availability of services for the un- and under-insured (more physicians accepting medical assistance, shorter wait times for appointments, etc.).

The final theme that emerged within this section related to services for seniors in the community. The need for better availability of services for home-bound seniors (primary care, meals, transportation) was noted. Specifically, community members note significant concern for seniors with dementia. These individuals appear to be largely overlooked with little support to the families in navigating "the system." This growing demographic group presents particular concern to the community and the demands it will place on the health and social service system.

Perception of top health priorities for the hospital and public health agency
There were some similar themes in this section of questioning and discussion as in the access to care needs in the community. It is also important to note that the quantitative results from the questionnaire very much aligned with the qualitative feedback from the open-ended discussion questions.

The primary health priority was obesity and the preventive measures related to healthy weight. The community shares significant concerns about the prominence of overweight and obesity in the area, among both adults and children. Again, the schools were suggested as potential avenues to better educate children on the importance of eating nutritionally and maintaining active lifestyles. In general, it is perceived that there continues to be too much focus on being reactive and treatment as opposed to prevention. Related to the obesity epidemic, several suggestions were made to work collaboratively to create and maintain "Healthy Communities" that focus on livable neighborhoods. This includes neighborhoods with free recreational opportunities (walking paths, bike paths, basketball courts, parks). It is also important to not only offer these things, but to ensure that the neighborhoods are safe for residents to access. A few individuals suggested policy work with local elected officials and planners to move these types of communities forward.

Often related to the obesity and overweight issue, heart disease and diabetes were noted as additional key health concerns in the community. Again, the focus was on prevention services and education as opposed to offering more for the treatment of these issues. Cancer prevention and early detection were two additional areas of priority.

Seniors were again singled out as a demographic group that should be the focus of increased services in the surrounding area. Dementia and Alzheimer's were specifically mentioned. It is perceived that area providers, from physicians to nurses to emergency personnel, need to be better trained in how to provide support for the elderly with cognitive impairments as well as their families.

While mentioned by significantly fewer individuals, additional health priorities included substance abuse, immunizations, mental illness, infant mortality, men's health, specific needs among the Hispanic/Latino community, and services for the homeless.

Most significant healthcare access barriers in Southeast Baltimore
When asked what the most significant health care access barriers in Southeast Baltimore County are, individuals again mentioned very similar themes. The most significant barriers included the following:

- Transportation
- Cost (medications, co-pays, cost of insurance)
- Too few providers for un- and under-insured (too few clinics, providers who accept medical assistance)
- Large number of individuals who lack of health and dental insurance
- Undocumented population (transient, need for more bilingual providers)

Navigating the system emerged as a serious barrier. Examples were given of the difficulty of managing more simple tasks such as calling to make appointments to the more complex tasks such as filling out paperwork for medical assistance and support services. The hospital emergency department is perceived as the one-stop shop for many individuals seeking primary care, mental health services, and even minor health needs. Participants felt strongly that better case management and oversight of care was needed, possibly via patient advocates or patient care navigators. The medical home concept was suggested as something that should be marketed.

Aside from barriers due to financial constraints and insurance issues, in general it was perceive that there is an overall lack of awareness and understanding of what services currently exist. This problem does not only appear to be present among community residents, but across agencies and organizations. A number of suggestions were made to better organize and promote what services are currently available to the public and to develop a system for effectively communicating these services to the community.

Coordination across agencies in Southeast Baltimore County
It should be noted that the majority of the feedback garnered to this open-ended question was from the community input session. The majority of individuals who responded to the questionnaire following the input session responded that they do not have the knowledge to know whether agencies in the area collaborative well. Therefore, quite a few responses of “I don’t know” were received.

Participants from the community input session shared strong feelings regarding how well the agencies in Southeast Baltimore County work together to improve overall health. Some stated that the agencies are pretty resourceful given the limited funding and staffing challenges. Communication was again emphasized as potential areas of opportunity. While agencies often work together on a number of outreach initiatives and services, many in the public are not aware of this collaboration. This is evidenced by the few number of questionnaire responded who were able to comment on this topic.

There was some feedback received that silos do continue to exist, which causes some natural barriers along lines of communication. The government sector, the private sector and the public sector tend to each function and communicate differently, which can lead to a fragmented system. A few individuals mentioned that the local chamber of commerce does not seem to

exert a significant influence connecting the business sector with the healthcare community. Schools were once again mentioned as an important partner in the community. Interestingly, session participants felt that there may be a fear of reaching out to the unknown and opening a *"Pandora's box."* It was suggested felt that agencies should consider *"how will it benefit all of us?"* and begin to think and plan strategically with initiatives that might be out of an organization's natural *"comfort zone."*

Concluding Thoughts

Some clear patterns emerged from the community input session and completion of the online and written questionnaires. Clearly, obesity and related health issues (diabetes, heart disease) is perceived to be the highest priority need in the greater community. The individuals who provided feedback strongly feel that more collaborative efforts need to be focused on ensuring that people live healthy lifestyles, know how to lives these types of lives, and are given the tools to this type of quality of life. Those tools include not only knowledge, but also access to affordable and nutritional foods, and safe neighborhoods that promote healthy living.

While the barriers to care are numerous, transportation was clearly noted as the most prominent hindrance to access healthcare. This was noted as problematic for those living in rural areas, but also for specific populations such as the elderly and disabled. The cost of transportation, whether it be owning a vehicle or paying for a bus or taxi service, was the key driver with this issue. Not a new or surprising cost issue barrier continues to be a lack of health insurance and the ability to obtain services in the area if you do not have health insurance. For those with medical assistance, the availability is also limited with too few clinics and physicians available to offer services. As is the case in most communities throughout the county, the hospital emergency department is often the safety net for these individuals.

As next steps, it is suggested that Franklin Square Hospital Center and its partners examine the key health priorities and barriers, evaluate the scope of these issues and determine its greatest ability to impact for change.

Questionnaire

ACCESS TO CARE/SERVICES

1. On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements:

	Strongly disagree←→Strongly agree
HEALTHCARE	
a) Residents in the area are able to access a primary care physician or other health care provider (family doctor; general practitioner; internist; pediatrician).	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
b) Residents in the area are able to access a medical specialist (oncologist, cardiologist).	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
c) Residents in the area are able to access a dentist when needed.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
d) Residents in the area have access to transportation for medical appointments.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
e) There are a sufficient number of physicians and other health care providers accepting Medicaid or other forms of medical assistance.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
f) There are a sufficient number of bilingual physicians and other health care providers in Southeast Baltimore County.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
g) Health prevention, screening and wellness are promoted well in SE Baltimore County.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know

KEY HEALTH ISSUES

2. On a scale of 1 (not so critical) through 5 (very critical), please rate how critical you believe the following are in your community:

	Not so critical← →Very critical
a) Diabetes	☐1 ☐2 ☐3 ☐4 ☐5
b) Cancer	☐1 ☐2 ☐3 ☐4 ☐5
c) Heart Disease	☐1 ☐2 ☐3 ☐4 ☐5
d) Stroke	☐1 ☐2 ☐3 ☐4 ☐5
e) Obesity	☐1 ☐2 ☐3 ☐4 ☐5
f) Mental/Behavioral Health	☐1 ☐2 ☐3 ☐4 ☐5
g) End of Life Care	☐1 ☐2 ☐3 ☐4 ☐5
h) Tobacco	☐1 ☐2 ☐3 ☐4 ☐5
i) Air/environmental hazards	☐1 ☐2 ☐3 ☐4 ☐5
j) Unintentional (accidental) injuries	☐1 ☐2 ☐3 ☐4 ☐5
k) Infant mortality (death)	☐1 ☐2 ☐3 ☐4 ☐5

QUALITY OF LIFE

3. On a scale of 1 (very poor) through 5 (excellent), please rate the quality of each in the community.

	Very poor ←→ Excellent
NEIGHBORHOOD/ENVIRONMENT	
a) Availability of recreational activities	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
b) Neighborhood safety	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
c) Availability of fresh produce and other healthy foods	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
d) Schools/Education	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
e) Housing	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
f) Transportation	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
g) Jobs/Employment	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know

WELLNESS & PREVENTION

4. On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements:

	Strongly disagree← →Strongly agree
a) Smoking cessation, prevention, education and support programs are available in Southeast Baltimore County.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
b) Diabetes prevention, education and support programs are available in Southeast Baltimore County.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
c) Cancer screening, prevention, education and support programs (mammography, prostate) are available in Southeast Baltimore County.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
d) Healthy lifestyle (nutrition, exercise) education and support programs are available in Southeast Baltimore County.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
e) Cardiovascular disease prevention, education and support programs are available in Southeast Baltimore County.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
f) HIV/AIDS prevention, education and support programs are available in Southeast Baltimore County.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
g) Substance Abuse prevention, education and support programs are available in Southeast Baltimore County.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
h) Breastfeeding promotion and support programs are available in Southeast Baltimore County.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know
i) Support for aging at home is available in Southeast Baltimore County.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Don't know

ROUNDTABLE DISCUSSION QUESTIONS

1. What specific suggestions do you have for area hospitals and public health agencies to improve access to quality health care services in the community?

2. What are the top health priorities that the hospital or public health agencies can address in the community?

3. What are the most significant healthcare access barriers in Southeast Baltimore County?

4. How well do the agencies in Southeast Baltimore County work together to improve overall health?