2024 Community Health Needs Assessment and Implementation Strategy

The Johns Hopkins Hospital
Johns Hopkins Bayview Medical Center

JOHNS HOPKINS MEDICINE
THE JOHNS HOPKINS HOSPITAL

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS BAYVIEW MEDICAL CENTER

Table of Contents

Introduction and Methodology

With the enactment of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, tax-exempt hospitals are required to conduct community health needs assessments (CHNA) and develop implementation strategies, which are approaches and plans to actively improve the health of communities served by health systems. These strategies provide hospitals and health systems with the information they need to deliver community benefits that can be targeted to address the specific needs of their communities. Coordination and management strategies based upon the outcomes of a CHNA, along with implementing strategies, can improve the impact of hospital community benefits.

To adhere to the requirements imposed by the Internal Revenue Service (IRS), tax-exempt hospitals and health systems must:

- Conduct a CHNA every three years.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how they are addressing the needs identified in the CHNA and provide a description of needs that are not being addressed, with the reasons why.

The Department of the Treasury and the IRS require a CHNA to include:

- A description of the community served by the hospital facility and how the description was determined.
- A description of the process and methods used to conduct the assessment.
- A description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs.
- A description of information gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility.
- Identification of organizations that collaborated with the hospital/health system and an explanation of their qualifications.
- A description of how the hospital organization considered input from persons who represent the broad interests of the community served by the hospital. In addition, the report must identify any individual providing input who has special knowledge of or expertise in public health. The report must also identify any individual providing input who is a "leader" or "representative" of populations.
- A prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs.
- A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

- A description of the needs identified that the hospital intends to address, the reasons those needs were selected, and the means by which the hospital will undertake to address the selected needs.[1]

The CHNA process for The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC) included the collection and analysis of primary and secondary data. Both public and private organizations, such as faith-based organizations, government agencies, educational systems, and health and human services entities were engaged to assess the needs of the community.

In 2024, Johns Hopkins again collaborated with the Baltimore City Health Department (BCHD) and a coalition of all hospitals in Baltimore to produce a Baltimore City Needs Assessment. The JHH/JHBMC CHNA builds on the citywide data and focuses on the communities surrounding the hospitals located within the hospitals' Community Benefit Service Area (CBSA) [2].

Primary data for the JHH/JHBMC CHNA included a review of work done by the hospital in response to the previous CHNA and Implementation Strategy, a health needs survey, available online and in paper formats in both English and Spanish, eight focus groups conducted with specific vulnerable population representatives, and 54 Stakeholder interviews with individuals who represent a) broad interests of the community, b) populations of need, and/or c) persons with specialized knowledge in public health. (A full list of interview participants appears in Appendix E.)

Past assessments in 2021, 2018, 2016 and 2013 served as a baseline to provide a deeper understanding of the health as well as the social determinants of health needs of the community and emerging trends.

An interactive resource inventory was created to highlight available programs and services within JHH and JHBMC's CBSA. The inventory identifies organizations and agencies in the community that are serving the various target populations within each of the priority needs.

A secondary data profile was compiled with local, state, and federal figures to provide essential information, insight, and knowledge on a broad range of health and social issues. Collecting and examining information about different community aspects and behaviors can help identify and explain factors that influence the community's health.

Data collected encompassed socioeconomic information, health statistics, demographics, children's health, mental health issues, etc. This report is a summary of primary and secondary data collected throughout the CHNA.

The development of the CHNA was led by the Office of Government, Community and Economic Partnerships (Maria Tildon, Vice President), Dr. Redonda Miller (President of The Johns Hopkins Hospital), and Jennifer Nickoles (President of the Johns Hopkins Bayview Medical Center), and involved the contributions of over 600 individuals through direct interviews, surveys, and focus groups. Contributors included, but were not limited to, community residents, members of faith-based organizations, state and local public health department representatives, neighborhood association leaders, other nonprofit and community based organization leaders, academic experts, local government officials, local school district representatives, health care consumers and providers, health professionals, members of medically underserved, low-income and minority

[1] The outcomes from the CHNA will be addressed through an implementation planning phase.

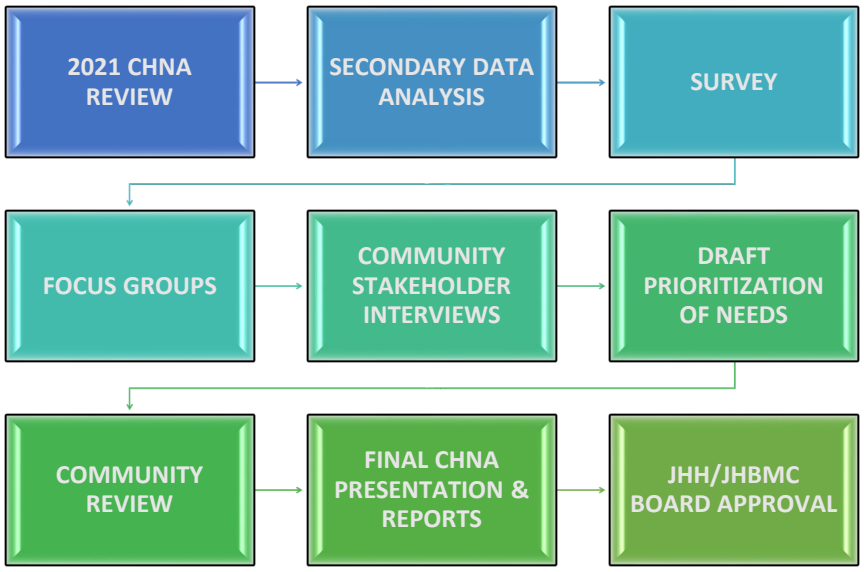
[2] The Community Benefit Service Area (CBSA) or the overall study area referenced in the report refers to the nine ZIP codes that defined the communities for JHH and JHBMC in the CHNA. The ZIP codes included are 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224 and 21231.

populations in the community served by the hospitals, Johns Hopkins Medicine leadership, and other experts, both internal and external to Johns Hopkins.

The 2024 CHNA presents the top five social determinants of health needs and top five health condition challenges as determined and prioritized by community representatives and residents. Over the eight-month CHNA process, 600 community residents and representatives shared their experiences and observations on the top community needs and priorities in East Baltimore. The information collected through surveys, interviews, and focus groups was reviewed in conjunction with collected secondary data. Representatives from Baltimore CONNECT, validated the review process and findings and participated in the prioritization of needs. During the review and discussion session, the community participants were asked to identify any oversights or weaknesses in the CHNA process and to ensure an appropriately diverse and representative group of CBSA residents contributed to the findings. Their final review, discussion and approval resulted in the list of needs as presented in this report.

The multiple steps in the yearlong CHNA process are depicted in the chart below. Additional information regarding each component of the project and the results can be found in Appendix A.

Chart 1: CHNA Process



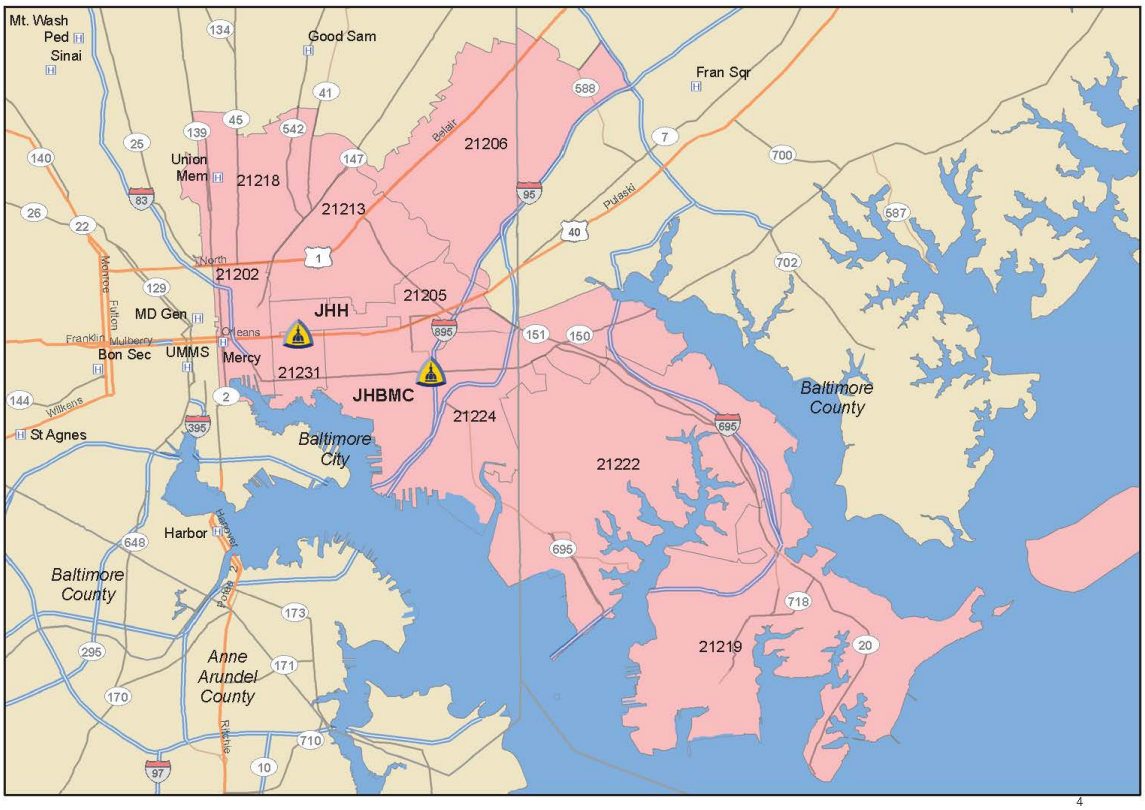
Community Benefit Service Area (CBSA)

In 2023-2024, a total of nine ZIP codes were analyzed by the Johns Hopkins Institutions. These ZIP codes represent the CBSA for JHH and JHBMC. The Johns Hopkins Institutions provide services to communities throughout Maryland, adjoining states, and internationally. The community health needs assessment focused on nine specific ZIP codes: 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, and 21231. This area reflects the population with the largest usage of the emergency departments and the majority of recipients of community benefit contributions and programming. Within the CBSA, JHH and JHBMC have focused on certain target populations such as the elderly, at-risk children and adolescents, uninsured individuals and households, and underinsured and low-income individuals and households.

The following map geographically depicts the community benefit service area by showing the communities that are shaded. (See Map 1).

Map 1: Overall Community Benefit Service Area – 2024 Study Area Map

The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center
Community Benefit Service Area



Between 2020 and 2024, the CBSA population has declined from 295,196 to 292,982, which represents a 0.7 percent drop. The CBSA population is expected to have an additional 1.0 percent decline from 2024 to 2029. With regard to income distribution, the CBSA continues to see the percentage of households earning less than $15,000 to be higher than the state average and the percentage of households earning over $100,000 lower than the state average, although there has been some improvement since the last CHNA. In terms of education level, the CBSA has a higher percentage of working age population with a high school degree, but lower percentages of residents with some college/associates degree and bachelor's degree or greater. (See Table 1).

Table 1: 2024 CBSA Demographic Snapshot

2024 Demographic Snapshot
jHH-JHBMC CBSA

Population	2024	2029	Pop. Change	% Change
Overall Population	**292,982**	**289,989**	**-2,993**	**-1.02%**

Population by Gender	2024	2029	Pop.Change	% Change
Female Population	152,681	150,737	-1,944	-1.27%
Male Population	140,301	139,252	-1,049	-0.75%
Total Population	**292,982**	**289,989**	**-2,993**	**-1.02%**

Age Distribution		
Age Group	2024 Population	% of Total
0-14	47,963	16.37%
15-17	9,980	3.41%
18-24	27,604	9.42%
25-34	55,796	19.04%
35-54	74,527	25.44%
55-64	33,230	11.34%
65-74	27,351	9.34%
75+	16,531	5.64%
Total	**292,982**	**100.00%**

Race Distribution		
Race	2024 Population	% of Total
American Indian / Alaska Native	2,056	0.70%
Asian	10,698	3.65%
Black / African American	122,097	41.67%
Multiple Races	22,325	7.62%
Native Hawaiian Islander / Pacific Islander	101	0.03%
Other	25,428	8.68%
White	110,277	37.64%
Total	**292,982**	**100.00%**

Household Income Distribution		
Income	2024 Households	% of Total
<15K	16,473	13.51%
15-25K	10,068	8.26%
25-50K	22,926	18.80%
50-75K	20,714	16.99%
75-100K	14,773	12.12%
100K+	36,970	30.32%
Total	**121,924**	**100.0%**

Ethnicity Distribution		
Ethnicity	2024 Population	% of Total
Hispanic (Any Race)	40,781	13.92%
Non-Hispanic (Any Race)	252,201	86.08%
Total	**292,982**	**100.00%**

Poverty Status Distribution		
Poverty Status	2024 Families	% of Total
At/Above Poverty	55,851	84.37%
Below Poverty	10,344	15.63%
Total	**66,195**	**100.00%**

Education Level Distribtion		
Adult Education Level	2024 Pop 25+	% of Total
Less than HS	8,830	4.26%
Some HS	18,584	8.96%
HS Degree	63,753	30.73%
Some College/Associates Degree	54,360	26.21%
BA or Higher	61,903	29.84%
Total	**207,430**	**100.00%**

Travel Time to Work Distribution		
Time	2024 Workers	% of Total
<5-19 Minutes	44,330	34.74%
20-44 Minutes	61,340	48.07%
45+ Minutes	21,947	17.20%
Total	**127,617**	**100.00%**

Language Distribtuion		
Language Spoken at Home	2024 Population	% of Total
French at Home	2,351	0.85%
Only English at Home	240,407	86.73%
Other Indo-European Lang at Home	5,098	1.84%
Other Lang at Home	2,692	0.97%
Spanish at Home	18,871	6.81%
All Others	7,786	2.81%
Total	**277,205**	**100.00%**

Source: Sg2 Market Demographics Tool

Developing a CHNA is a long and time-consuming process. Because of this, more recent data may have been made available after the collection and analysis timeframe. Existing data typically become available between

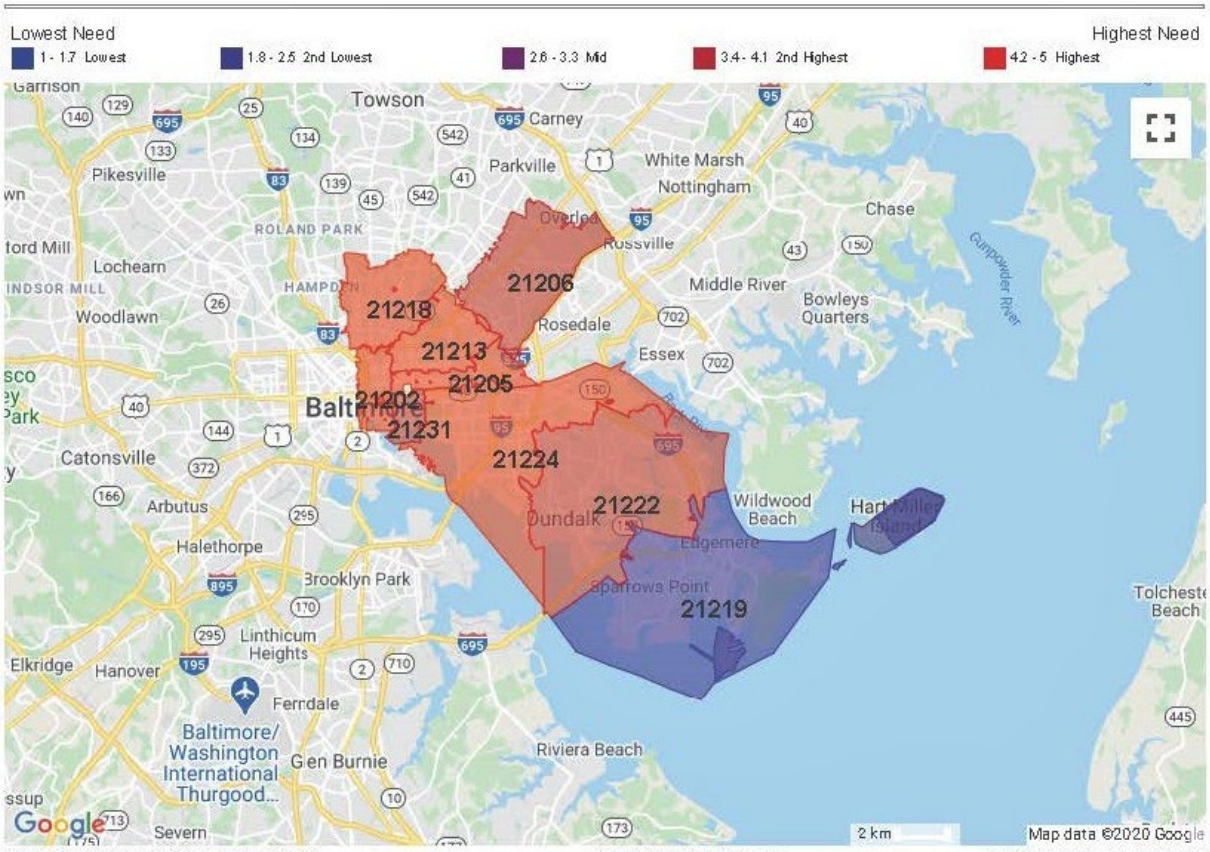
one and three years after the data is collected. This is a limitation, because the staleness of certain data may not depict current trends. For example, the U.S. Census Bureau's American Community Survey is a valuable source of demographic information; however, data for a particular year is not published until late the following year. This means 2022 data on community characteristics, such as languages spoken at home, did not become available until late fall 2023.

The Dignity Health Community Need Index (CNI) has been discontinued, but since the most recent score was from 2020, aspects of the CNI are still relevant. The CNI considers multiple factors that are known to impact health care access. The tool is useful in identifying and addressing the disproportionate and unmet health-related needs of neighborhoods. The five prominent socioeconomic barriers to community health quantified in the CNI are income barriers, cultural/language barriers, educational barriers, insurance barriers, and housing barriers. CNI scores are ranked from 1.0 to 5.0, with 1.0 representing the least need and 5.0 representing the highest barriers to accessing care.

In assessing the CNI scores for the overall study area or CBSA, the CNI score in 2020 of 4.1 has shown no improvement to barriers since 2017 when there was a small decrease from a score of 4.3 in 2015 to 4.1 in 2017. It is important to note that a low score (e.g., 1.0) does not imply that no attention should be given to that neighborhood; rather, hospital leadership should determine specifically what is working well to account for a low neighborhood score. CNI data from 2020 in the map below provides a geographic representation of the CNI scores for the CBSA. ZIP codes that have higher socioeconomic barriers (5.0) are represented in darker orange. As the socioeconomic scores decrease (i.e., improve), the coding color lightens, with blue representing the lowest barriers. As indicated in Map 2, there are concentrated areas within Baltimore City that clearly signify high socioeconomic barriers to care.

Map 2: Community Need Index (CNI) Study Area Map

Dignity Health.



Mean(zipcode): 4.1 / Mean(person): 4.2 | CNI Score Median: 4.4 | CNI Score Mode: 4,4.4,4.8

Zip Code	CNI Score	Population	City	County	State
21202	4.8	23893	Baltimore	Baltimore City, Md	Maryland
21205	4.8	15131	Baltimore	Baltimore City, Md	Maryland
21206	4	48203	Baltimore	Baltimore City, Md	Maryland
21213	4.8	30318	Baltimore	Baltimore City, Md	Maryland
21218	4.4	46813	Baltimore	Baltimore City, Md	Maryland
21219	2.4	9353	Sparrows Point	Baltimore	Maryland
21222	3.6	55968	Dundalk	Baltimore	Maryland
21224	4.4	49506	Baltimore	Baltimore City, Md	Maryland
21231	4	15984	Baltimore	Baltimore City, Md	Maryland

TRUVEN HEALTH ANALYTICS

Source: Dignity Health, 2020

Key Community Health Needs

The health status of a community depends on many factors, including quality of health care, social and economic determinants, individual behaviors, heredity, education, and the physical environment. Healthy People, coordinated by the Office of Disease Prevention and Health Promotion within the U.S. Department of Health and Human Services, identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being.

Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first 4 decades and creates targets for improving health status, promoting community health, and challenging individuals, communities, and professionals to take specific steps to ensure that good health, as well as long life, are enjoyed by all. Health is more than just the absence of disease. Social determinants of health (SDOH) contribute to health disparities and inequities. As reflected in Chart 2, SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

SDOH have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Air and water quality
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Simply promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

Chart 2: Social Determinants of Health

Socioeconomic status is a reflection of an individual's economic and social position in relation to others based on income, education, and occupation. The environment—in particular, where we work and live—as well as education, income, and age, play a significant role in an individual's socioeconomic status. It is well documented that residents who have limited education and limited financial resources often experience challenges such as poor housing, inadequate opportunities for employment advancement, and a low quality of life. All of these challenges ultimately affect their health outcomes.

Children attending schools in poor neighborhoods are likely to lack a rich educational infrastructure. Parents who struggle with employment opportunities are less likely to be able to offer their children educational resources such as computers, tutors, and books—materials typically needed for students to become successful.

Similarly, community residents living in neighborhoods that are underserved may face higher levels of stress if their community experiences high levels of crime, drug use and poverty. Furthermore, the social injustices and inequalities in a community can produce high levels of stress and contribute to all areas of direct health and social determinants of health challenges.

Residents in east Baltimore City and southeast Baltimore County are well aware of the health and social inequalities and disparities that exist. Addressing these disparities and working to reduce the socioeconomic gaps can bridge and provide sustainable support for those who have limited options. In the 2024 CHNA the impact of health equity on community health and wellness was a critical overarching consideration in reflecting the voice of the community throughout the prioritization of needs process.

The Johns Hopkins Institutions have significant strategies that are geared toward addressing the health and well-being of the community's marginalized youth and adult residents. As a major economic driver in the region, hospital leadership encouraged the health and well-being of the marginalized populations through their programs, community initiatives, economic development projects, and strategic partnerships.

The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center will continue to address the SDOH of their community residents with innovative and effective programs, community outreach efforts, and collaboration and partnerships with nonprofits and local organizations to reach vulnerable residents and those most affected by the health and social disparities across the city.

One of the objectives of the Patient Protection and Affordable Care Act (PPACA) is to identify ways to better coordinate health services to allow greater accessibility, while reducing health care costs for patients and caregivers. As a result, health care organizations are streamlining services and collaborating with community agencies and organizations to capitalize on the ability to share resources. By providing affordable health care insurance, a large portion of the previously uninsured population now has a pathway to affordable and accessible preventive services.

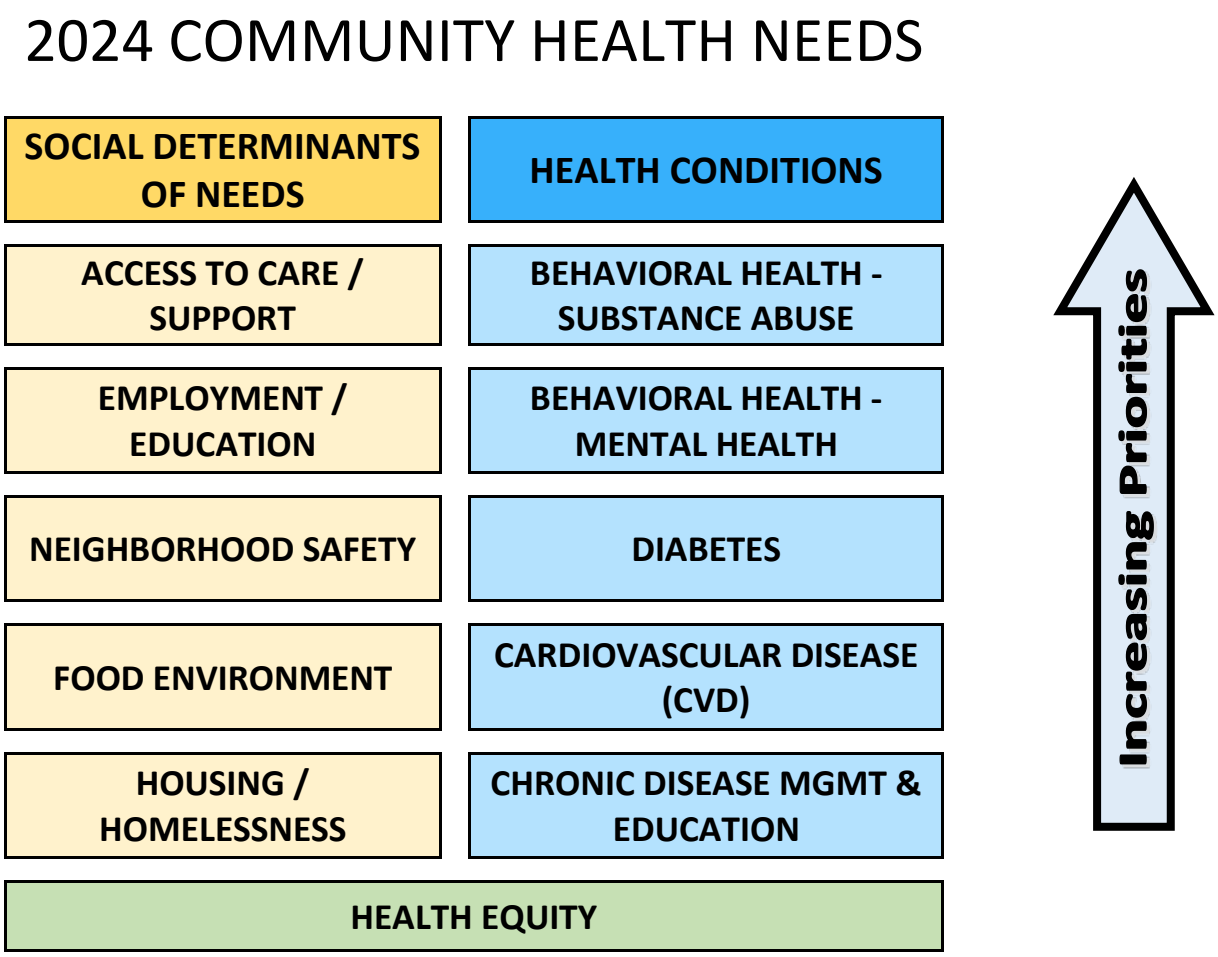
The key needs areas identified during the CHNA process through the gathering and analysis of primary and secondary data as described in the Introduction and Appendix A are depicted in Chart 3 below, in order of priority. Social Determinants of Needs are depicted in yellow and health conditions in blue.

In 2024, the identified social determinants of health needs in prioritized order are: access to care and support, employment and education, neighborhood safety, food environment and housing/ homelessness. Mirroring previous CHNAs, the two top health condition priorities are substance use and mental health. Diabetes, cardiovascular disease and chronic disease management and health education, follow to complete the list.

Please note that some of the CHNA community-identified needs encompass more than one commonly defined health or social need. For example, "chronic disease" not only includes health conditions such as cancer, arthritis, asthma, and obesity, but also health education and literacy to manage and/or prevent health issues. Also, employment/education includes job training and workforce education, which are essential to gainful employment with living wages and advancement opportunities, as well as K-12 education. Likewise, food environment includes access to healthy foods and nutrition education which could overlap with similar initiatives focused specifically on diabetes prevention and management. Starting in the 2021 CHNA, diabetes and cardiovascular disease were identified at a much higher priority than in previous assessments. Even though they are chronic diseases, they are presented in independent and distinct

categories. All identified key community needs are addressed either directly through designation as a prioritized key community need or incorporated as a component of a prioritized key community need.

Chart 3: JHH/JHBMC Prioritized Community Health Needs



Health Equity

Health equity is defined as a fair opportunity for individuals to attain their full health potential and that no one should be disadvantaged from achieving this potential. Health equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically, or by other means of stratification.[3] Equitable health systems are achieved by removing obstacles to health such as poverty, discrimination, and their consequences, including

[3] World Health Organization: WHO. (2021, July 7). *Health equity*. https://www.who.int/health-topics/health-equity#tab=tab_1

powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[4]

As previously mentioned, the CHNA is an opportunity to better understand the complex needs and stories of Baltimore. The information collected will be used to guide the practices and priorities of the Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center over the coming years. A recurring theme identified in interviews and surveys of residents of Baltimore was health equity. After review and careful consideration, a health equity lens is being applied to this year's CHNA. This lens allows for the identification of disparities and structural racism to craft effective interventions, and advance social justice within communities. It ensures that efforts to improve community health outcomes are equitable and inclusive, and helps prioritize resources to address the root causes of health disparities ultimately leading to healthier and more resilient communities for all.

Traditionally, the field of public health has focused on individual behaviors as determinants of good health. In recent years, the field has adopted the social determinants of health as key contributors of good health. Factors such as the area you work and live in, access to healthy food, clean air and water, quality education, adequate and stable housing are proven to impact health outcomes in a community.[5] Even within Baltimore, some communities have resources to have better health readily available to them, while others do not. These barriers are oftentimes a result of longstanding systems and policies created to discriminate against certain groups.[6]

Shifting the view of health from individual behavior to social determinants, allows for mitigating practices that result in health inequity. While health equity was not described as a specific need in this assessment, it is noted to show the significance equity plays in each health need in a community.

Health Outcomes

When examining health outcomes across all race and ethnic groups, disparities are apparent. For example, in Baltimore City the life expectancy at birth is 74.7 years for White babies but 68.4 years for Black babies – a gap of 6.3 years that has widened from 5.2 years in 2018. Similarly, the infant mortality rate for Baltimore City showed that there were 14.0 infant deaths per 1,000 live births for Black mothers versus 4.1 infant deaths per 1,000 live births for White mothers. The gap of 9.9 infant deaths has widened from 9.2 infant deaths in 2017.

Black women are more likely to give birth to low-birthweight infants, and their newborns experience higher infant death rates that are not associated with any biological differences, even after accounting for socioeconomic factors (Braveman, 2008; Hamilton et al., 2016; Mathews et al., 2015). Research data has

[4] *Glossary of Health Equity Transformation Terms | AHA*. (n.d.). Equity. https://equity.aha.org/glossary

[5] Stein, L. (2019, June 18). *Using community health needs assessments to promote health equity - Harder+Company Community Research*. Harder+Company Community Research. https://harderco.com/using-community-health-needs-assessments-promote-health-equity/

[6] UC Davis Medical Center. (2022). 2022 Community Health Needs Assessment. In *health.ucdavis.edu*. https://health.ucdavis.edu/media-resources/about/documents/pdfs/community-health-needs-assessment-2022.pdf

shown that in Maryland in 2021 the percentage of births to women receiving late or no prenatal care is higher for Black (6.8 percent) and Hispanic (12.8 percent) women when compared to White women (3.7 percent).

Chart 4: Baltimore City Life Expectancy

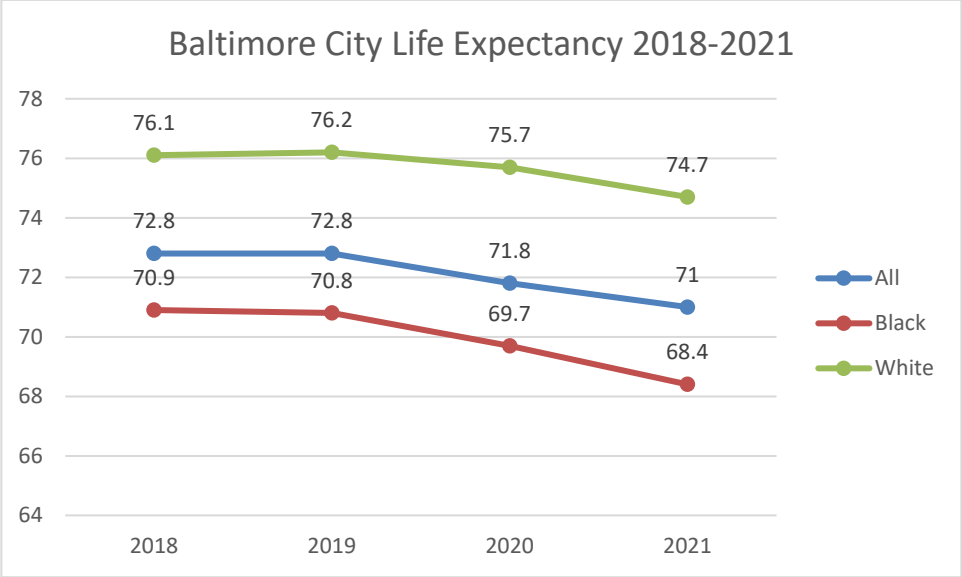


Chart 5: Baltimore City Infant Mortality Rate

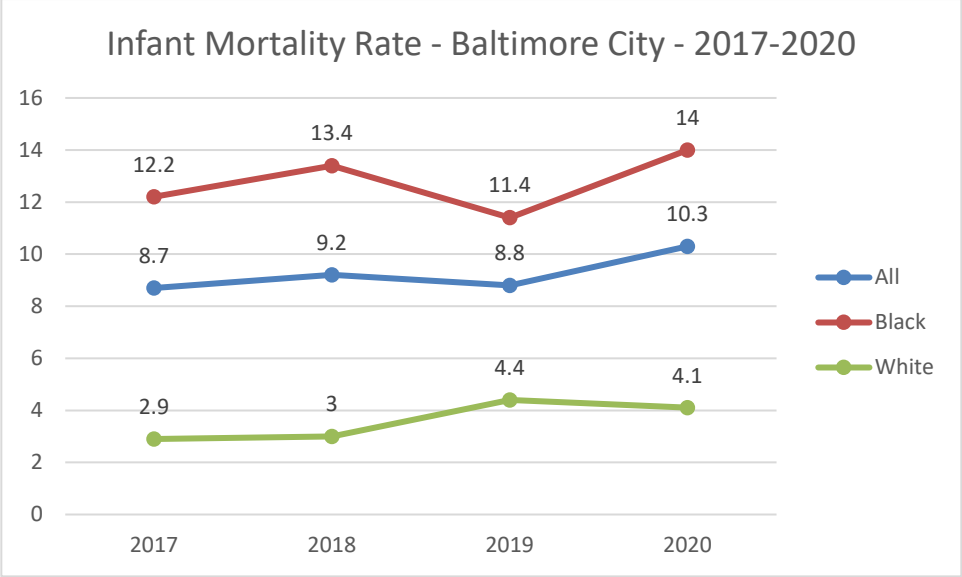
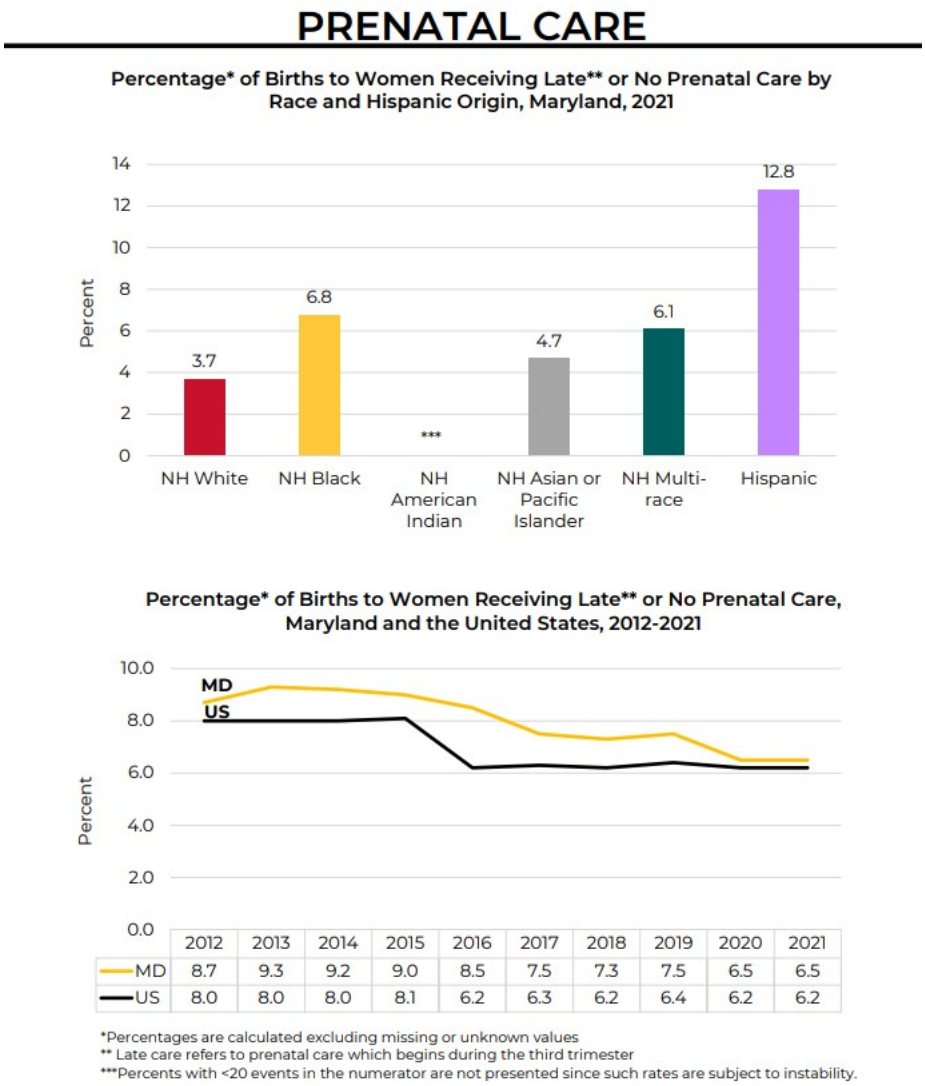
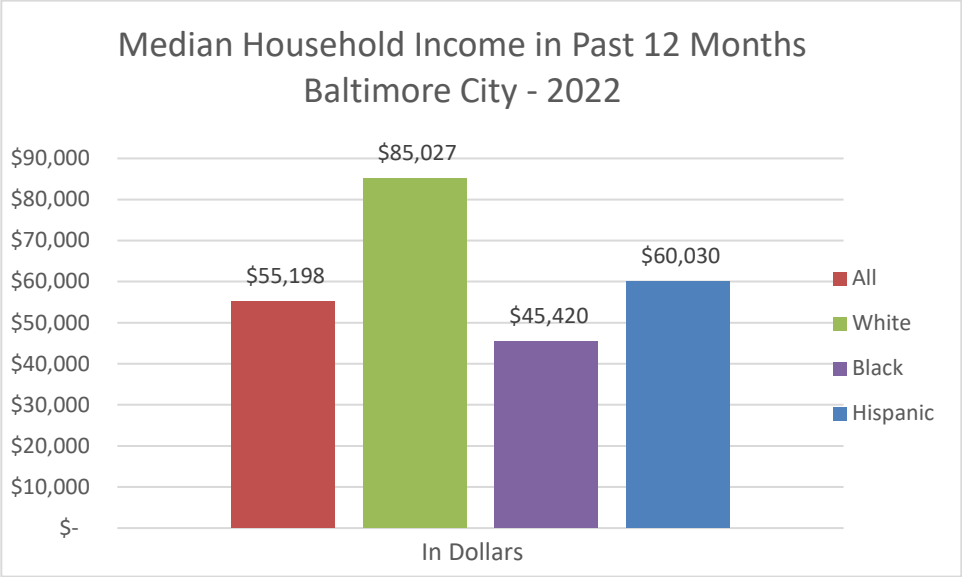


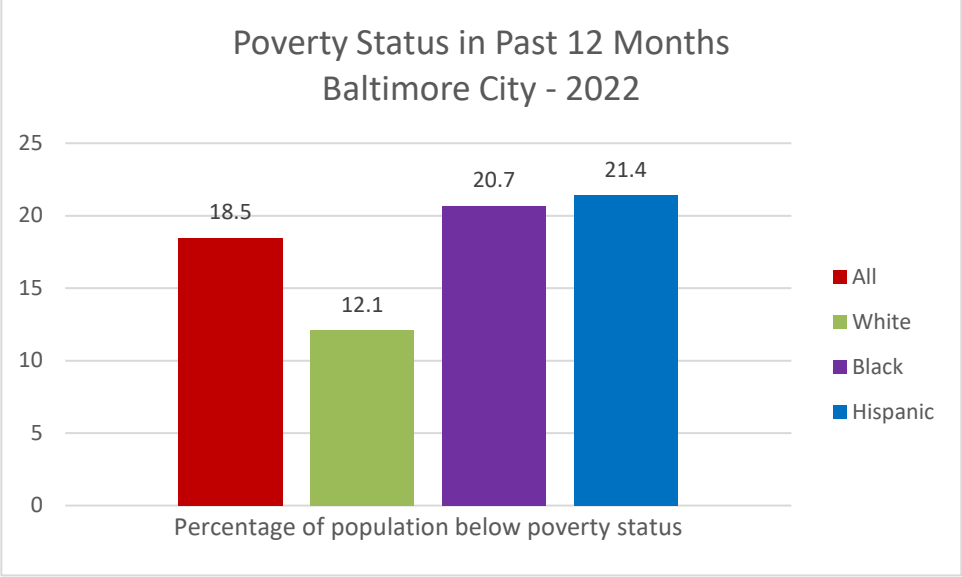
Chart 6: Maryland Prenatal Care



Inequities are also apparent in other factors that may directly or indirectly pertain to health outcomes, generally called Social Determinants of Health (SDOH) which have been discussed previously, such as median household income or poverty status when compared by race and ethnicity. In the next section, many of these socioeconomic factors and their impacts on health outcomes are discussed.

Chart 7: Baltimore City Household Income and Poverty Status





Improving Socioeconomic Factors

While biological makeup or genetics determine some health issues an individual will experience, socioeconomic factors, such as income, education, and employment opportunities, can shape how people make decisions related to their health as well as the access they have to health care services. There is both a direct and indirect relationship between community residents' overall health and low levels of educational attainment and the inability to secure employment. It is not uncommon for residents living in poverty to face multiple challenges related to high crime rates, poor home conditions, and low educational attainment. Often, individuals in these situations are focused on obtaining basic living needs (e.g., food, utilities, and

housing) for themselves and their families. Without access to higher education and associated employment opportunities, community residents will continue to struggle with these challenges.

The table below provides a snapshot from County Health Rankings and Roadmaps of where Baltimore City compares to Maryland, Baltimore County, and Howard County in 2024 in the categories of Health Outcomes, Health Factors, Clinical Care, Social & Economic Factors, and Physical Environment (see Table 2). The County Health Rankings no longer relies on a ranking scale comparing counties within Maryland.

Health Outcomes are measured through Length of Life and Quality of Life metrics. Health Factors are measured through Health Behaviors, such as adult smoking, adult obesity, excessive drinking, and teen births. Clinical Care is measured through uninsured rate, health provider ratios, preventable hospital stays, and screening and vaccination rates. Social & Economic Factors include high school completion, childhood poverty, income inequality, and injury death rate. Physical Environment is measure through air pollution, drinking water violations, severe housing problems, and commute time.

Table 2: 2024 County Health Rankings and Roadmaps - Comparison

	Maryland Remove Location	Baltimore City, MD Remove Location	Baltimore, MD Remove Location	Howard, MD Remove Location
Health Outcomes				
Length of Life	Maryland	Baltimore City, MD	Baltimore, MD	Howard, MD
Premature Death	7,900	15,600	8,600	4,400
Quality of Life	Maryland	Baltimore City, MD	Baltimore, MD	Howard, MD
Poor or Fair Health	13%	20%	14%	10%
Poor Physical Health Days	2.8	3.7	3.0	2.4
Poor Mental Health Days	4.4	5.8	4.9	4.0
Low Birthweight	9%	12%	9%	8%
Health Factors				
Health Behaviors	Maryland	Baltimore City, MD	Baltimore, MD	Howard, MD
Adult Smoking	10%	18%	13%	8%
Adult Obesity	34%	37%	37%	28%
Food Environment Index	8.8	7.7	8.4	9.1
Physical Inactivity	21%	28%	22%	16%
Access to Exercise Opportunities	92%	99%	97%	98%
Excessive Drinking	15%	17%	14%	14%
Alcohol-Impaired Driving Deaths	29%	21%	29%	29%
Sexually Transmitted Infections				
Teen Births	13	28	12	5

Clinical Care	Maryland	Baltimore City, MD	Baltimore, MD	Howard, MD
Uninsured	7%	7%	6%	4%
Primary Care Physicians	1,180:1	860:1	1,160:1	540:1
Dentists	1,240:1	1,170:1	1,260:1	1,110:1
Mental Health Providers	290:1	160:1	250:1	250:1
Preventable Hospital Stays	2,508	3,878	3,018	1,593
Mammography Screening	43%	43%	48%	49%
Flu Vaccinations	51%	48%	55%	59%
Social & Economic Factors	**Maryland**	**Baltimore City, MD**	**Baltimore, MD**	**Howard, MD**
High School Completion	91%	87%	92%	95%
Some College	71%	67%	71%	86%
Unemployment	3.2%	4.3%	3.3%	2.6%
Children in Poverty	12%	24%	15%	6%
Income Inequality	4.6	6.3	4.4	
Children in Single-Parent Households	26%	48%	29%	18%
Social Associations	8.8	10.3	8.3	8.7
Injury Deaths	92	216	113	47
Physical Environment	**Maryland**	**Baltimore City, MD**	**Baltimore, MD**	**Howard, MD**
Air Pollution - Particulate Matter	7.4	8.6	8.3	7.4
Drinking Water Violations		Yes	No	No
Severe Housing Problems	15%	21%	15%	13%
Driving Alone to Work	68%	58%	74%	71%
Long Commute - Driving Alone	49%	42%	45%	46%

Source: County Health Rankings & Roadmaps 2024. Blank values reflect unreliable or missing data.

Access to Care / Support

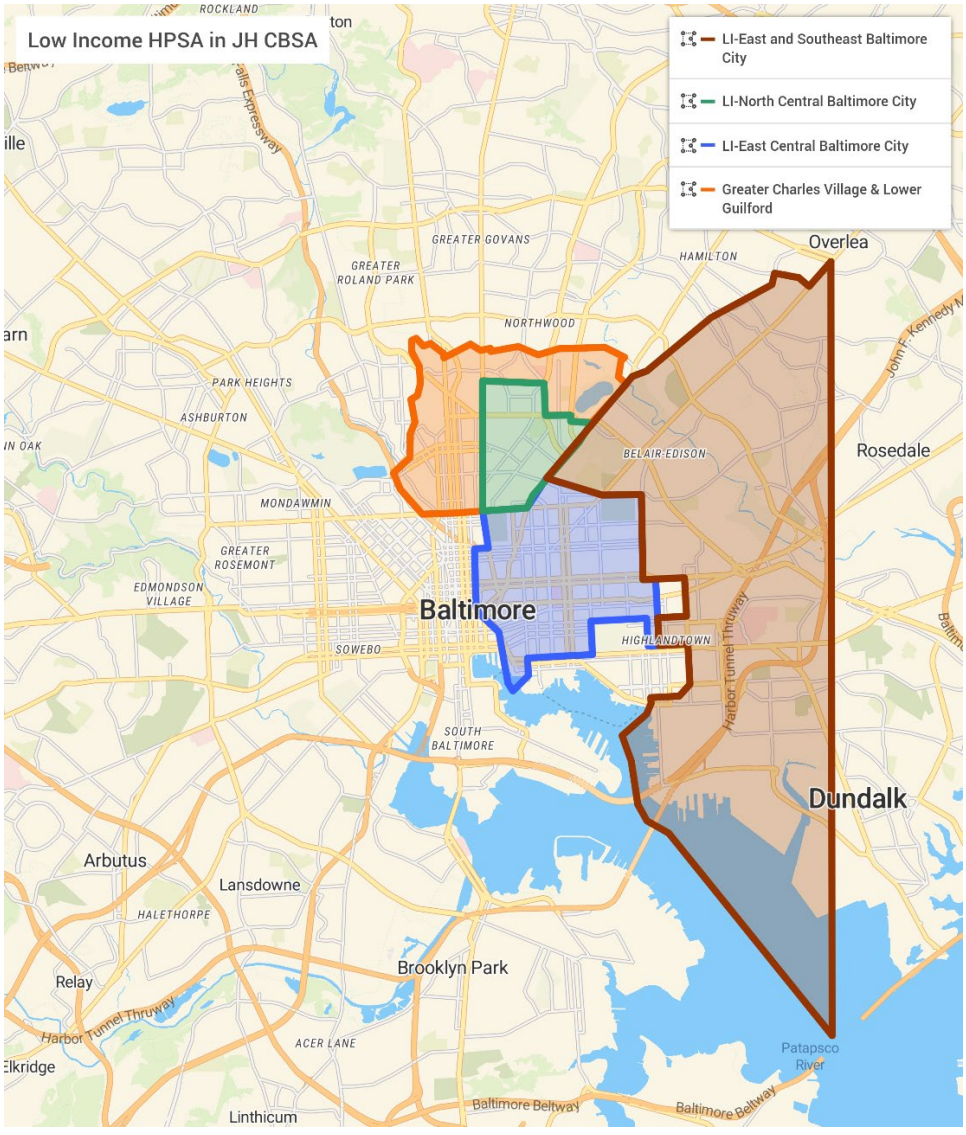
Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all Americans. Access to health care services is a recurring problem in the community. While this typically refers to the ability and ease with which people can obtain health care or use health care coverage, the residents in East Baltimore discussed a wide spectrum of barriers in connecting to care including physician shortages, excessive wait times, lack of transportation and/or childcare, fear and mistrust of doctors, language barriers, discrimination and racism among others.

In the CHNA key stakeholder interviews, the top barrier to healthcare was the difficulty in scheduling appointments due to a shortage of physicians, lack of available appointments or when a visit could be scheduled, the wait times were excessive. Also, Interview participants shared personal experiences of problematic access to care in emergency room visits that involved wait times of over 12 hours. Interviewees consistently responded that there is not enough primary care, specialty care, dental care and mental health care providers.

The second and third top barriers to care identified in the key stakeholder interviews were transportation and/or childcare and the prohibitive cost of insurance.

The Health Resources and Services Administration maintains designations for Health Professional Shortage Areas (HPSA)[7]. As of 2022, Baltimore City has several designations for HPSA. The West Baltimore City and West Central Baltimore census tracts are designated a Primary Care HPSA, with an estimated need of 3.25 HPSA FTEs and 24.66 HPSA FTEs, respectively. In the CBSA, there are also HPSA designations for Low Income Population HPSA. The Greater Charles Village and Lower Guilford census tracts have an estimated need of 2.25 HPSA FTEs, and the East Central Baltimore City census tracts have an estimated need of 7.21 HPSA FTEs. The East and Southeast Baltimore City census tracts have an estimated need of 10.27 HPSA FTEs; however, the opening of the BMS at Yard 56 clinic occurred after the most recent HRSA update.

Map 3 – Low Income Primary Care – Health Professions Shortage Area



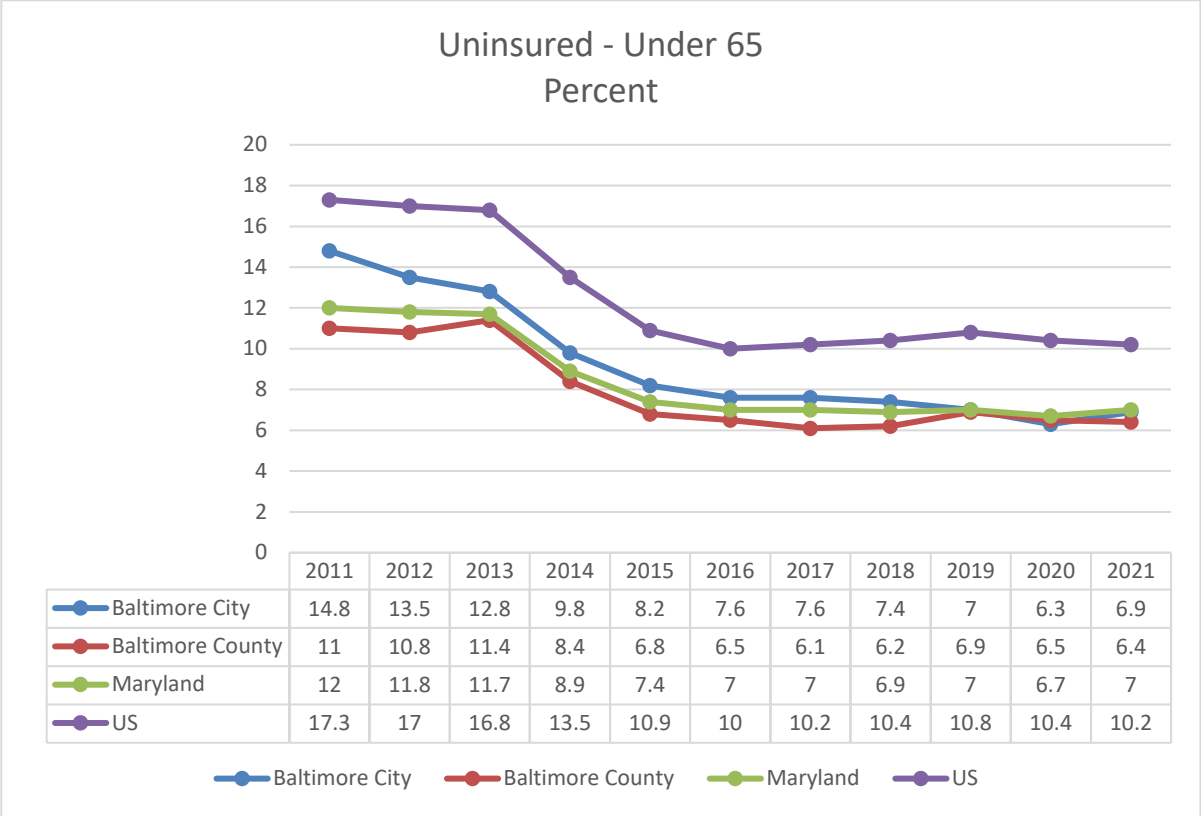
[7] https://data.hrsa.gov/tools/shortage-area

The availability of health care insurance is one of the most important elements in obtaining primary health care access. For many Americans, there remains a need to make it more available. The limitations in health care coverage affect the vulnerable, underserved, and low-income populations. Many factors influence the availability of health insurance, including economic factors, language, knowledge, citizenship, and ease of accessibility.

The Patient Protection and Affordable Care Act (PPACA) provides Americans with better health security by putting in place comprehensive health insurance reforms that expand coverage, hold insurance companies accountable, lower health care costs, guarantee more choice, and enhance the quality of care for all Americans. Although this legislation introduced historic reform, millions of Americans still find themselves unable to afford health insurance. Often forced to choose between meeting basic needs or paying health insurance premiums, too many Americans go without health insurance coverage, increasing the impact of injury and illness.

The availability and ease of use for insurance have increased with the passage of the PPACA. In 2018, the U.S. Census Bureau estimated that 6.9 percent of Marylanders, compared to 10.4 percent of the U.S. population, lives without any type of health care insurance. These numbers are a good indication of progress made, as 2011 levels were significantly higher with 12 percent of Marylanders and 17.3 percent of the U.S. population living without insurance coverage. The U.S. Census Bureau estimates on the county level from 2011 to 2021 show that Baltimore City and Baltimore County both lowered the percentage of uninsured population aged 18 to 64 years to 6.9 percent and 6.4 percent, respectively (See Chart 8). While the insurance coverage of community residents in Baltimore City is above the national rate, the uninsured population still remains vulnerable to the difficulty of obtaining health care services. Specifically, the Census estimates that for those with income below 400% of the federal poverty level the rate of uninsured rises to 10.2% for Baltimore City, 11.7% for Baltimore County and 13.8% for the state.

Chart 8: Uninsured Population Aged 18-64 years (2011 to 2021)



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Baltimore City	14.8	13.5	12.8	9.8	8.2	7.6	7.6	7.4	7	6.3	6.9
Baltimore County	11	10.8	11.4	8.4	6.8	6.5	6.1	6.2	6.9	6.5	6.4
Maryland	12	11.8	11.7	8.9	7.4	7	7	6.9	7	6.7	7
US	17.3	17	16.8	13.5	10.9	10	10.2	10.4	10.8	10.4	10.2

Source: U.S. Census Bureau, Small Area Health Insurance Estimates 2021

Based on a National Health Interview Survey in 2022 of 27.6 million people, Hispanic adults were most likely to lack health insurance coverage (27.6 percent), followed by non-Hispanic Black adults (13.3 percent). In the current CHNA survey in our catchment area, 76 percent of the respondents who identified as Hispanic/Latino indicated they did not have insurance. Many of these people were seeking free COVID-19 testing or health services from East Baltimore Medical Center or services from the Esperanza Center, both hubs for undocumented immigrants, so the results may not be representative of the overall Hispanic/Latino population in the JHH/JHBMC CBSA.

Table 3 shows a trend of the Community Needs Index (CNI) by ZIP code within the CBSA from 2014 through 2020 (refer to Appendix C for information on how CNI is calculated). The CNI score is an average of five different barrier scores that measure socioeconomic indicators: income, cultural/language, educational, insurance and housing barriers. Higher scores indicate more barriers. As shown in Table 3, ZIP codes 21202, 21205 and 21213 had the highest scores at 4.8, indicating that community residents in these specific neighborhoods experience the most barriers. Although the trend has been improving for most of the ZIP codes, the improvement has been marginal with some ZIP codes like 21206 and 21218 getting worse. The average score for the CBSA at 4.1 is worse than the city as a whole at 3.7 and much higher than Baltimore County at 2.9.

Table 3: CBSA CNI ZIP Codes and Scores: Specific Data and Measures

ZIP	County	City	2020 Population	% Population Increase/ (Decrease)	2014 CNI Score	2015 CNI Score	2017 CNI Score	2020 CNI Score	Increase/ (Decrease) 2017 to 2020
21202	Baltimore City	Baltimore	23,893	-2.8%	5.0	5.0	4.8	**4.8**	**0.0**
21205	Baltimore City	Baltimore	15,131	-5.3%	5.0	5.0	4.8	**4.8**	**0.0**
21206	Baltimore City / County	Baltimore	48,203	-4.2%	3.8	4.0	3.6	**4.0**	**0.4**
21213	Baltimore City	Baltimore	30,318	-4.7%	4.6	4.8	4.8	**4.8**	**0.0**
21218	Baltimore City	Baltimore	46,813	-4.4%	4.4	4.4	4.2	**4.4**	**0.2**
21219	Baltimore County	Sparrows Point	9,353	-3.9%	2.6	2.6	2.8	**2.4**	**-0.4**
21222	Baltimore City / County	Dundalk	55,968	-2.0%	3.6	3.4	3.6	**3.6**	**0.0**
21224	Baltimore City / County	Baltimore	49,506	-2.8%	4.6	4.6	4.4	**4.4**	**0.0**
21231	Baltimore City	Baltimore	15,984	-2.7%	4.8	4.6	4.2	**4.0**	**-0.2**
Overall Study Area			295,169	-3.5%	**4.2**	**4.3**	**4.1**	**4.1**	-
Baltimore City							**4.1**	**3.7**	
Baltimore County							**2.3**	**2.9**	

Source: Dignity Health, 2020

Community leaders believe there are a number of factors that affect insurance status within the community. Fear and a lack of trust were two consistent points that surfaced during community leader discussions.

Input from focus group sessions and surveys found that many residents do not have health insurance because they do not know how to obtain it or are undocumented. There was the belief that the process is difficult and that 'Obamacare' does not provide adequate, affordable coverage.

Some stated that they avoid seeking health services because they are not eligible, nor can they afford health insurance premiums or the costs associated with uninsured medical care. For many who were aware of health resources, there was a concern about the fear of doctors and the trustworthiness of information and services provided by these organizations. There is a need for this information to come from trusted community-based organizations and leaders.

Overall, the cost of care, insurance, and lack of community awareness are barriers to receiving health care. Many feel that payment for health care services is expensive, which includes out-of-pocket costs, prescription medications, and high deductibles. Several respondents commented that preventive health care services should be free, with fees for preventive services blocking participation for those who cannot afford basic needs.

Language barriers and fear of deportation are the main reasons the Hispanic/Latino population does not seek care. Language barriers create problems while scheduling appointments and communicating with providers during visits. While providing information is important, information to community residents must be basic and clearly understandable in order for residents to make appropriate and informed health decisions, even when a foreign language is not an issue.

Many people don't understand how to navigate the insurance and health care systems. Assistance programs are complicated and people don't know what is needed to apply. In the case of Hispanic/Latino participants, they feel information may not be held in confidence and could be used to deport them. Additionally, many reported they fear assistance programs are going away because of the previous federal administration.

Other concerns included transportation for groups that are not mobile, such as the disabled and older adults, and getting the prescriptions needed for care after leaving the health care facility. Increasing the number of community health workers was mentioned as a way to get services directly into the community, especially preventive measures and follow-up care.

In short, health services must be effective and relevant for community residents to be able to obtain them. Health insurance coverage can only go so far for those living in the community. There are a multitude of factors and barriers that prevent residents from obtaining care and services. These include affordability, health literacy, navigation through the health care system, the availability of providers, lack of culturally competent care, transportation, etc.

Employment/Education

The lack of job opportunities was ranked as the highest concern among CBSA residents at 33.5 percent of respondents in the current CHNA survey, up from 31 percent in the last CHNA where it ranked as the number two concern. In addition, 30 percent of survey respondents indicated poverty was their top social concern.

Adequate employment and income can provide a lifestyle that offers choices and options that influence health status and environmental factors such as housing, food, skill building for better employment opportunities, transportation, health care, and more. Data reveal that there are significant income disparities in the CBSA as compared to the state. Households below $25,000 represent 21.7% of CBSA households, and households below the federal poverty level represent 15.6% of CBSA households. By comparison, Maryland has a household rate of poverty of 9.6%, Baltimore County has a household poverty rate of 11%, and Baltimore City has a household rate of poverty of 19.6%.

Table 4 provides a detailed breakdown of median household income for the CBSA compared to Baltimore City, County, and Maryland statistics.

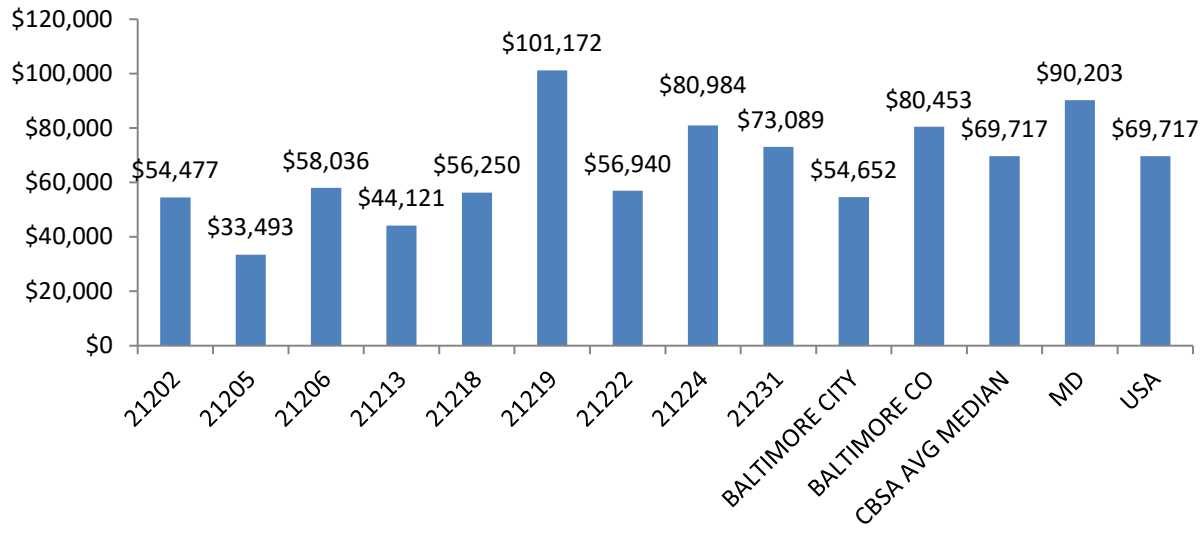
Table 4: Median Household Income Detail

	CBSA	Baltimore City	Baltimore County	Maryland
Median Income	$69,717	$54,652	$80,453	$90,203

Source: Census, American Community Survey, 2021

Providing a median household income snapshot across all ZIP codes, noting that ZIP codes 21205 and 21213 have the lowest median household incomes compared to their counterparts in the CBSA. Additionally, it is evident that the median household income in Baltimore City ($54,652) is significantly lower than that for Baltimore County ($80,453), Maryland ($90,203), and US ($69,717) (see Chart 9).

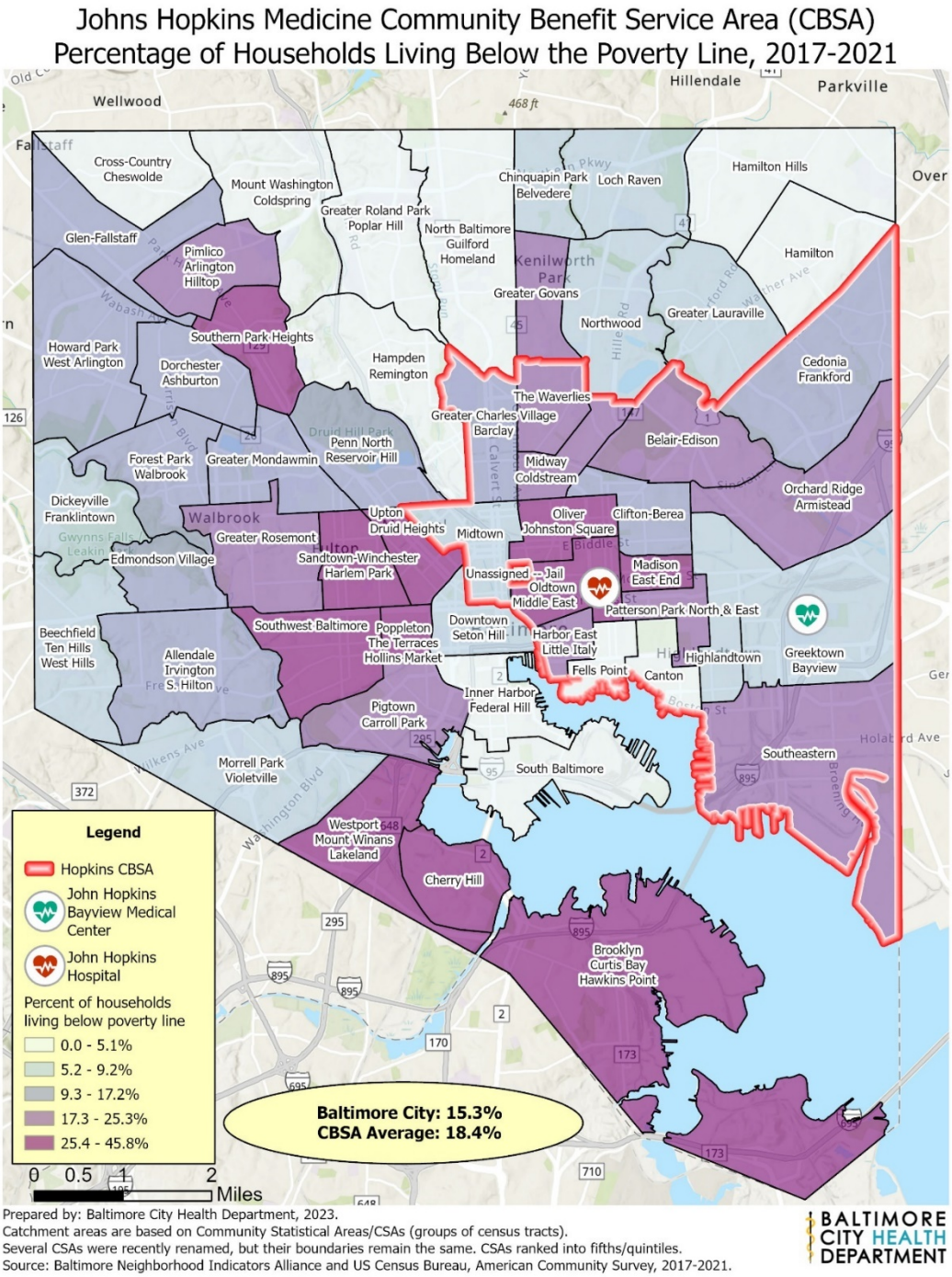
Chart 9: Median Household Income



Source: U.S. Census Bureau, American Community Survey, 2021 5-year Estimates

The Baltimore City Health Department mapped the percentage of households living below the poverty level in the CBSA, and the neighborhoods with the highest percentage of households in poverty included Oliver Johnstone Square, Oldtown Middle East, and Madison East End, where between 25 and 45 percent of households are in poverty. Other neighborhoods in the CBSA with high poverty between 17 and 25 percent of households include The Waverlies, Midway Coldstream, Belair-Edison, Orchard Ridge Armistead, Harbor East Little Italy, Patterson Park North & East, and Southeastern.

Map 4 – Percentage of Households Below Poverty Line – JH CBSA



Prepared by: Baltimore City Health Department, 2023.
Catchment areas are based on Community Statistical Areas/CSAs (groups of census tracts).
Several CSAs were recently renamed, but their boundaries remain the same. CSAs ranked into fifths/quintiles.
Source: Baltimore Neighborhood Indicators Alliance and US Census Bureau, American Community Survey, 2017-2021.

BALTIMORE CITY HEALTH DEPARTMENT

Community residents with a low household income can struggle to afford basic necessities such as food, shelter, and clothing. These community residents fare worse than those within a higher income bracket on many levels. Residents who are economically disadvantaged will continue to face significant life challenges affecting the ability to obtain resources and improve their living environment. Without good employment prospects and access to a sustainable living wage, these residents are more likely to engage in unhealthy behaviors, ignore mental health issues, not engage in preventive health practices, and fall victim to the generational cycle of living in poverty.

Reviewing CHNA discussions, community leaders are aware that employment opportunities for low-income residents can improve their quality of life on multiple levels. It is often necessary to provide training, education, workforce development, and resources to those in need.

The lack of employment opportunities for many community residents has not changed over the years, and the employment prospects for those with limited skills and those who have been incarcerated are bleak; thus, re-entry opportunities from businesses continue to provide hope. Community residents in the 2016 focus group cited extreme employment challenges due to multiple factors. Prior criminal history, lack of skills, and not being properly educated are some barriers that prohibit many from securing employment. While obtaining steady employment can be difficult, it is a goal many want to achieve.

From the 2016 CHNA study and continuing to the current study, focus group participants stated that they believed employment training or workforce development programs can assist those struggling to gain the skills and resources they need. It comes as no surprise that community residents who actively seek employment also cite the lack of transportation options as hindering their job prospects.

An individual's level of education affects their health status as it can dictate employment opportunities, workplace skills, and their career path. Educated individuals are more likely to have job security, are often better equipped to access and navigate through the services they need, and can understand the importance of taking preventive health measures and making healthy choices for themselves and their families. Educated residents typically are more aware of their own health status and the health status of their family. Being educated can mitigate some of the environmental factors that negatively affect the health status of disadvantaged populations by providing tools needed to better understand the environment and to take advantage of opportunities for life improvement.

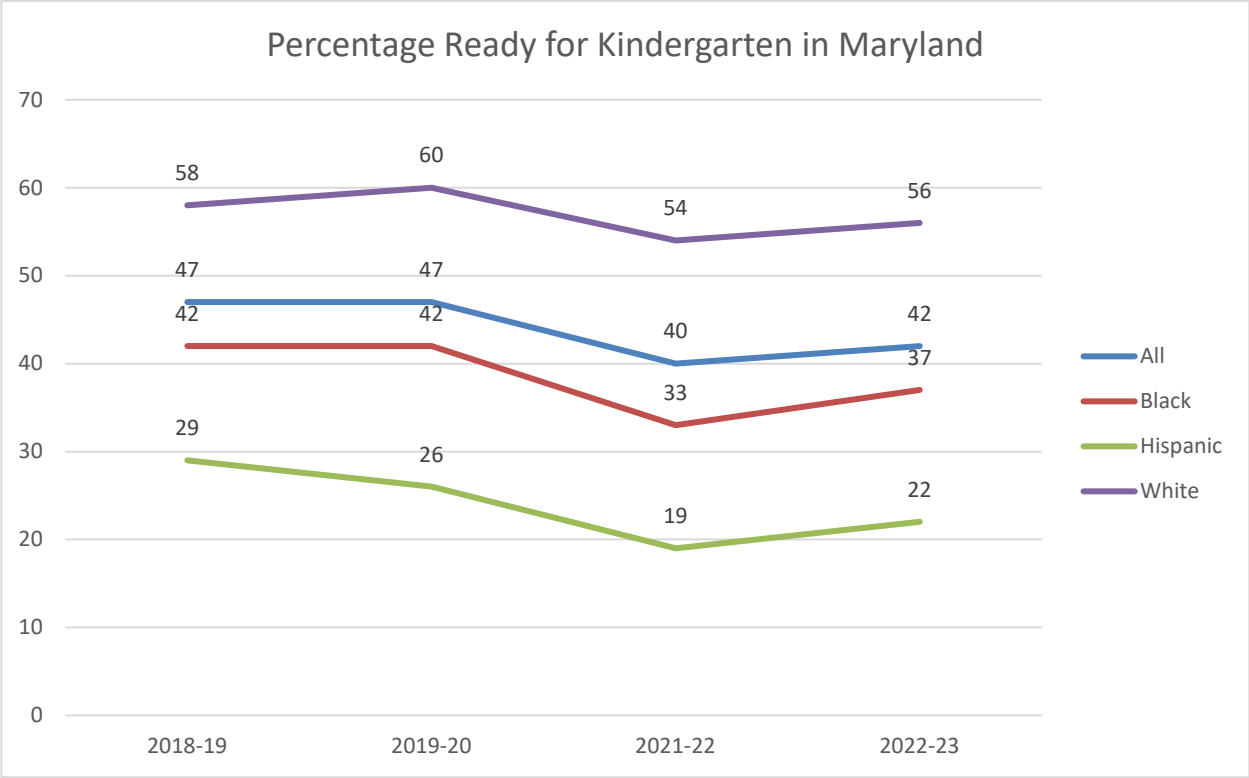
Students entering kindergarten ready to learn is an important indicator of the percentage of children who enter kindergarten ready in the domains of language and literacy, mathematics, social foundation, and physical development on the Maryland Model for School Readiness kindergarten assessment (KRA) for the school year ending in that year. Decades of research have demonstrated that the early years are critical to a child's social, emotional, and academic success, and children who start kindergarten ready are more likely to remain on track by the time they enter third grade and beyond.[8]

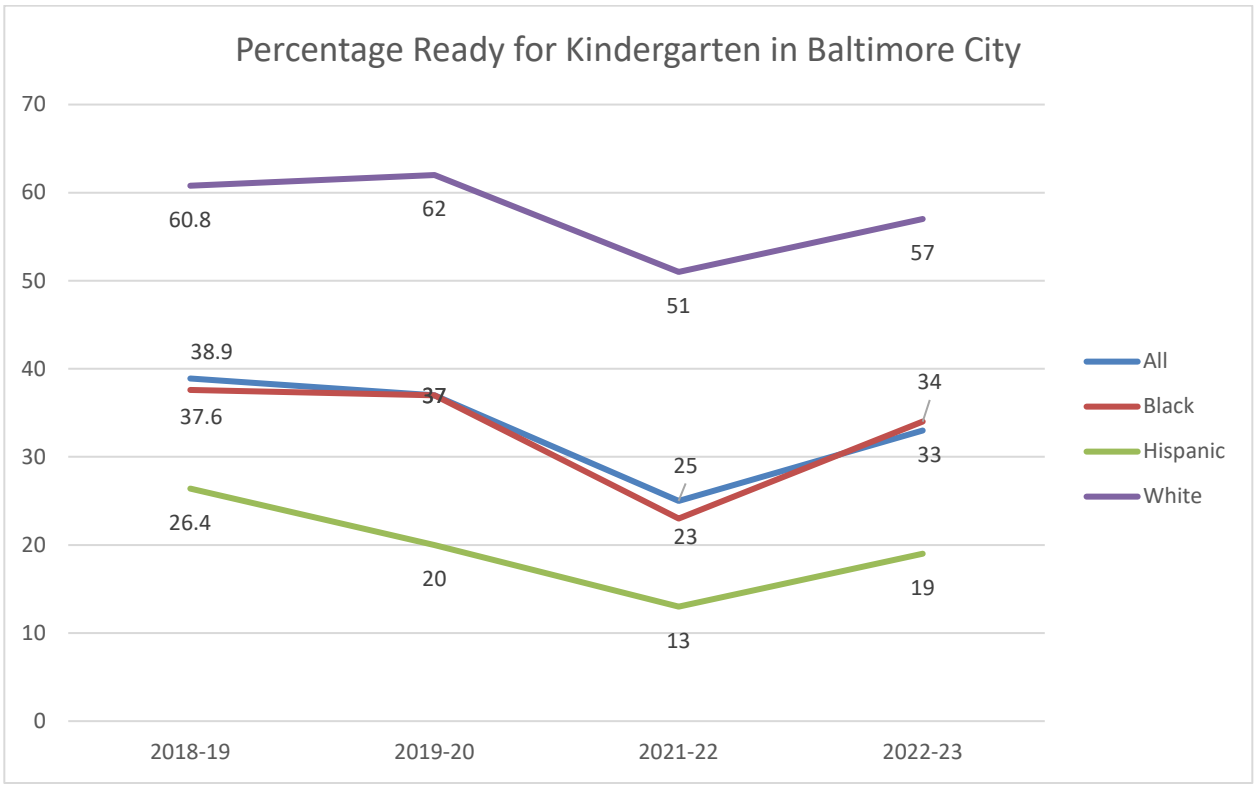
In 2022-2023, 42 percent of all kindergarteners were ready to learn in Maryland compared to 39 percent in Baltimore County and 33 percent in Baltimore City. Among White children, 56 percent were ready to learn in Maryland compared to 54 percent in Baltimore County and 57 percent in Baltimore City. For Black children, 37 percent were ready to learn in Maryland compared to 32 percent in Baltimore County and 34 percent in

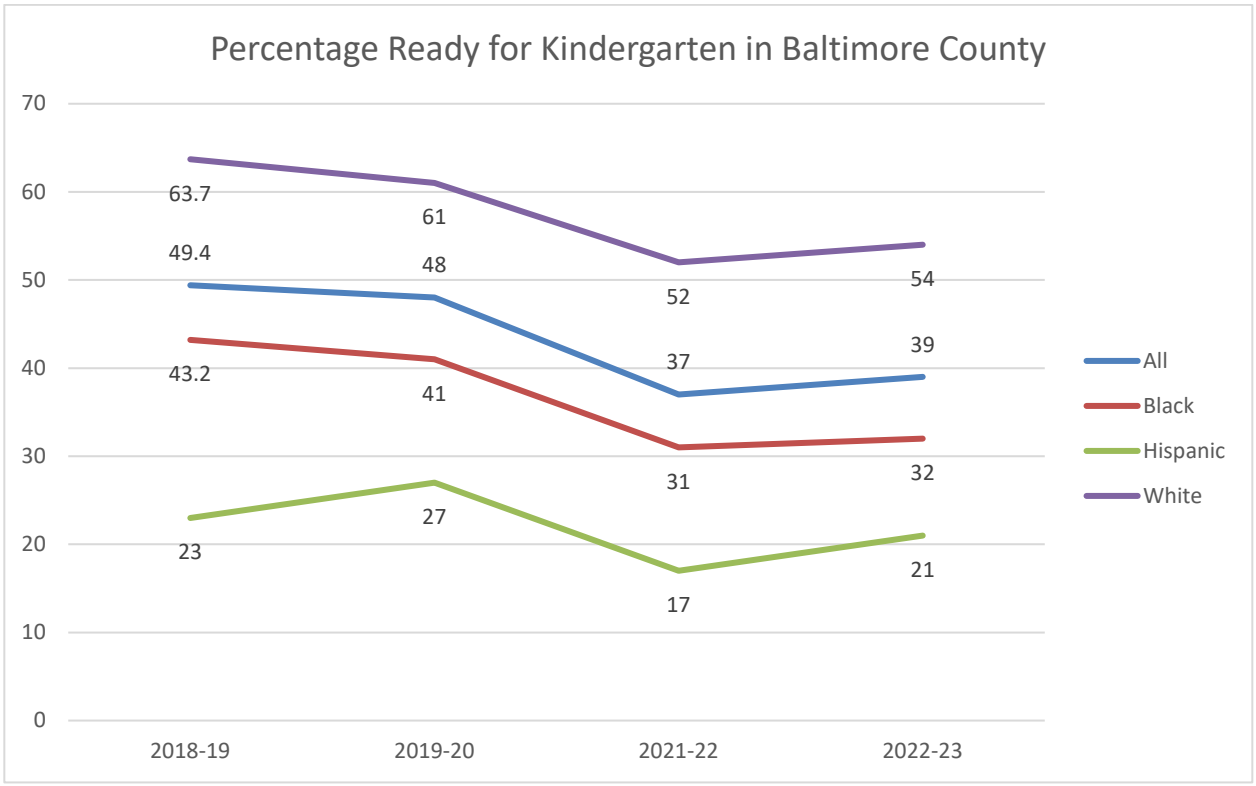
[8] Kindergarten Readiness Assessment Report, https://marylandpublicschools.org/about/Pages/DAAIT/Assessment/KRA/index.aspx

Baltimore City, and for Hispanic children, 22 percent were ready to learn in Maryland compared to 21 percent in Baltimore County and 19 percent in Baltimore City. Note: 2020-2021 KRA is not available due to the COVID-19 epidemic.

Chart 10: Percentage Children Ready for Kindergarten in Maryland, Baltimore and Baltimore County

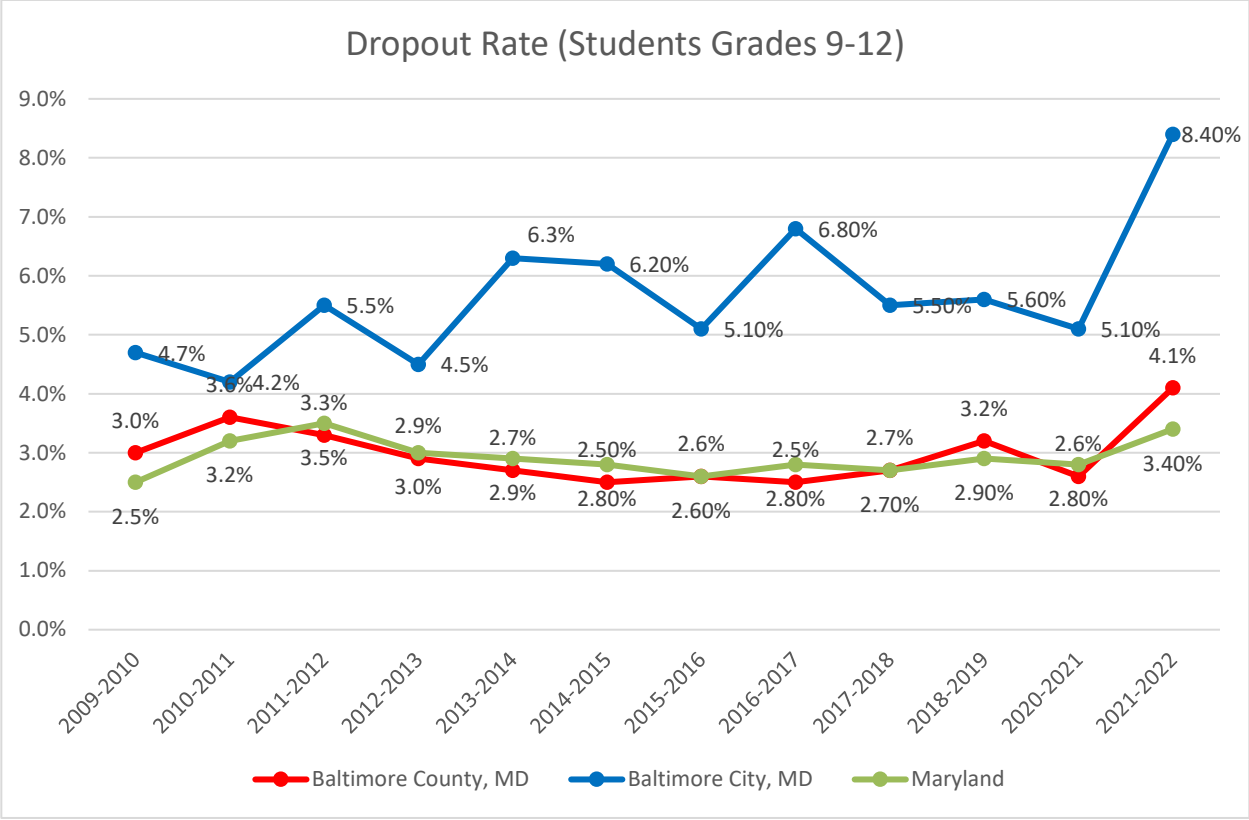



Percentage Ready for Kindergarten in Baltimore City
70
60
50
40
30
20
10
0
60.8
62
51
57
38.9
37
25
34
37.6
23
33
26.4
20
13
19
2018-19
2019-20
2021-22
2022-23
All
Black
Hispanic
White


Percentage Ready for Kindergarten in Baltimore County
70
60
50
40
30
20
10
0
63.7
61
52
54
49.4
48
37
39
43.2
41
31
32
23
27
17
21
2018-19
2019-20
2021-22
2022-23
All
Black
Hispanic
White

In 2024, Sg2 Market Demographics indicated a larger portion of residents age 25+ in the CBSA do not have a high school diploma, 13.2 percent, as compared to 10.0 percent for residents in the state of Maryland. Data from The Annie E. Casey Foundation highlight the dropout rate (see Chart 11). Baltimore City had a higher dropout rate (5.1 percent in 2020-2021) consistently over the years, nearly double that of the county and state for students in grades 9-12. Particularly concerning is the recent spike in the dropout rate in 2021-2022, with Baltimore City rising to 8.4% compared to 4.1% in the county and 3.4% in the state. Public health research has shown that high school dropouts are up to four times more likely to experience individual negative outcomes (being arrested, fired, or on government assistance, using illicit substances, having poor health) by age 27 and twenty-four times more likely compared to high school graduates to experience as many as four or more negative outcomes.[9] Both the Centers for Disease Control and Prevention and the American Public Health Association have advocated a reframing of school dropout as a public health issue because good health is predicted by good education, and health disparities are predicted by education disparities.

Chart 11: Dropout Rate (Students in Grades 9-12)



Source: Annie E. Casey Foundation, Kids Count, 2022. Profile for Maryland

[9] Lansford, JE, et al. J. Adolescent. Health, 2016, June 58(6): 652-658.

In 2024, CHNA community stakeholders spoke of the rise in behavioral health challenges in prekindergarten years. It was felt that most often community residents do not foresee or comprehend how education in the earliest years is linked to a pathway toward a healthier, more productive life.

Interview participants mentioned the need to emphasize the relationship between education and income as higher education enables community residents to expand their overall knowledge base, which in turn leads to a better understanding of their community, environment, and health.

Community leaders' concerns about employment opportunities were often communicated in conjunction with residents expressed need for affordable transportation. Improved transportation can increase employment opportunities for low-income residents. It was voiced that strong employment opportunities exist outside of the city; however, many residents struggle to secure reliable transportation due to limited and insufficient bus routes. Light rail trains and buses do not extend far enough to access employment opportunities in outlying areas.

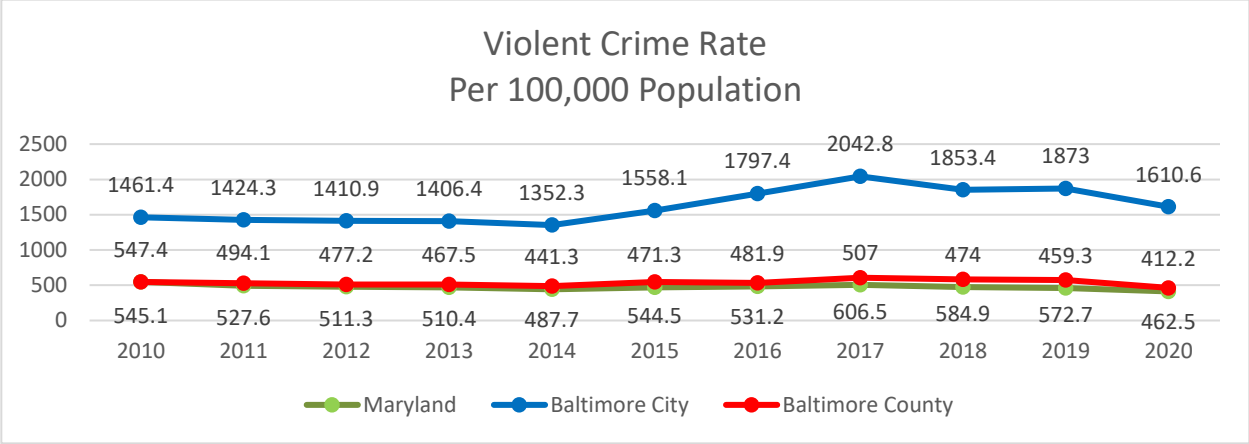
Having a strong, economically healthy community contributes to a healthier environment for residents and for neighborhoods overall. Community organizations and area agencies work diligently trying to connect residents to services and programs.

Neighborhood Safety

While many families and individuals live in a comfortable and safe environment, there are a large number of Baltimoreans who do not. Crime and safety factors significantly impact the ability of an individual to enjoy a full and productive life. The lack of a livable environment affects the ability of individuals to access adequate preventive health care services, engage in outdoor activities, and obtain other basic needs. Unfortunately, many city residents face the threat of crime each day.

In 2014, the overall rates of crime reached a low point in the State. Since then, following the 2015 Baltimore City unrest, overall crime rates in the City and the State have increased. Particularly problematic, the violent crime rate in Baltimore City has accelerated significantly. Data obtained from the FBI Uniform Crime Reports indicate that Baltimore City's violent crime rate of 1610 per 100,000 greatly exceeded that of Baltimore County (462) and the state (412) in 2020 (See Chart 12).

Chart 12: Violent Crime (per 100,000 Population)



Source: FBI Uniform Crime Reports 2008-2020

Most recent data from 2021 through 2023 is not available in a uniform way that compares the rate across Baltimore City, Baltimore County, and the state. Data from Baltimore City Police Department shows that the total reports of Violent Crime fell in 2020, possibly due to COVID-19 lockdowns, but increased in 2021 and 2022, before falling again in 2023. Anecdotally, as of April 2024, the violent crime year to date report has shown that the number of violent crimes reported as decreased by 6.1% versus April 2023.

Table 5 – Baltimore City Violent Crime Reports 2019-2023

Baltimore City Violent Crime	Violent Crimes Reported	Percentage Change from Previous Year
2019	12329	n/a
2020	10287	-16.50%
2021	10897	5.98%
2022	11707	7.43%
2023	11440	-2.28%

Source: Mayor's Office of Neighborhood Safety and Engagement, Public Safety Accountability Dashboard https://monse.baltimorecity.gov/baltimore-public-safety-accountability-dashboard

Data from the 2024 CHNA survey revealed neighborhood safety remains a top concern in the community. 26.8 percent of all respondents listed poor neighborhood safety as a high social/environmental concern and 31.9 percent of all respondents indicated violence was their top health concern. Crime, gun violence, domestic violence, lack of places for youth to gather and drugs were reasons why respondents did not feel safe in their neighborhood/community.

Focus group participants stated that residents are exposed to drugs, alcohol abuse, and violence in their neighborhoods on a regular basis. Domestic violence and other types of assaults were also mentioned as issues that the community deals with regularly. 22.4% of the participants identifying as Latino felt that domestic violence was a top critical need in their communities whereas 7.5% of Black or African American residents rated it similarly.

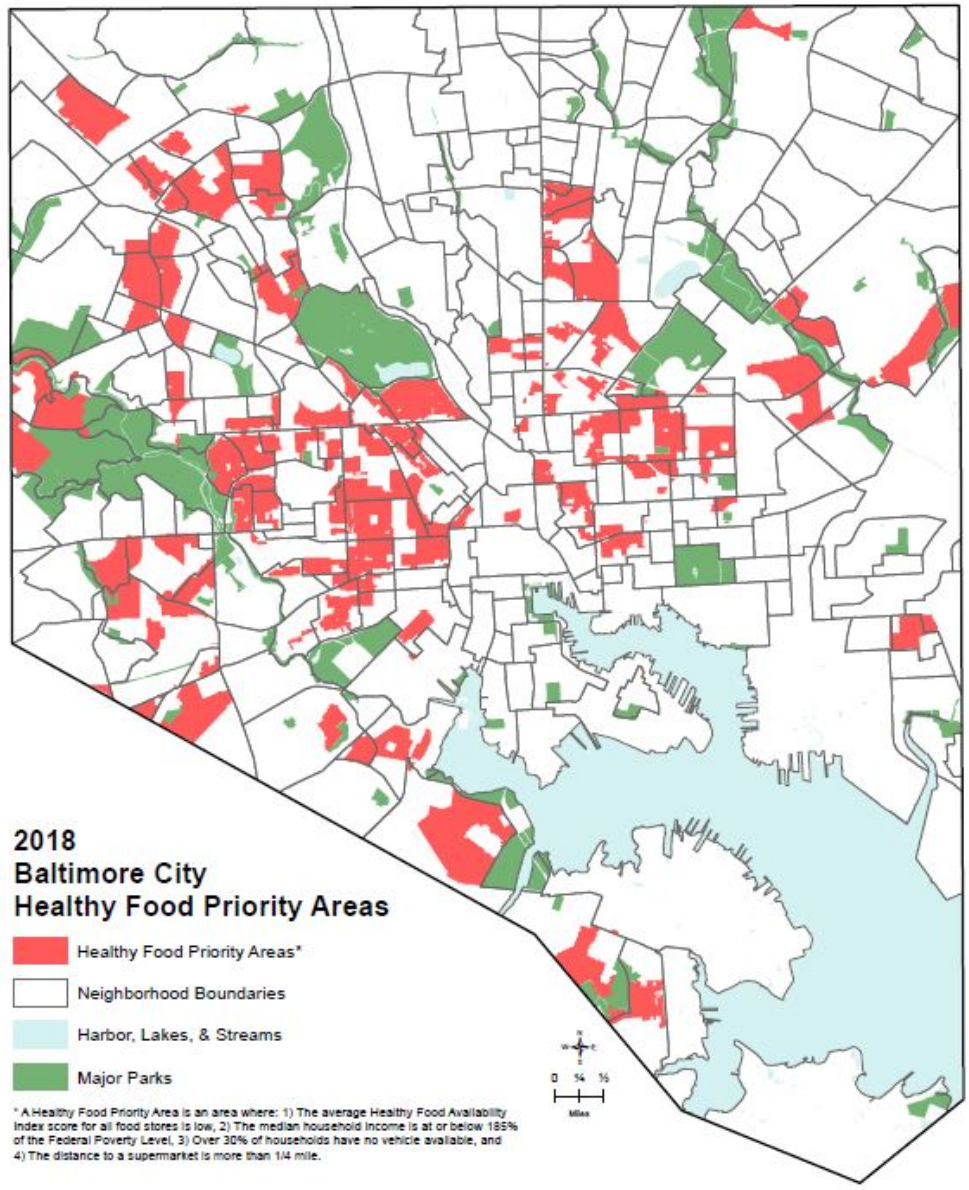
Reducing the crime rate and providing a safe environment requires participation from all city entities. Some would argue that improvements in law enforcement and more severe consequences could deter offenders, while others point out that this approach could lead to further disintegration of families. For residents of Baltimore City, crime is a significant part of their communities.

Food Environment

A healthy food environment ensures that residents have the ability to purchase nutritious foods and that those foods are affordable and conveniently located. The term “food desert” or “healthy food priority area” describes geographic regions where affordable, nutritious foods are typically difficult to obtain, especially for residents with limited transportation options. Healthy food choices, such as fresh fruits and vegetables, are often unavailable or too expensive in the small convenience-type stores characteristic of underserved and low-income areas. Food options found in such convenience stores are usually processed and high in calories and unhealthy fats. The unavailability of large grocery stores, supermarkets, and farmers’ markets, along with the convenience of junk foods, has contributed to the obesity epidemic. It is important to address the food environment as a way to reduce health disparities and improve patient management of chronic disease conditions such as obesity, high blood pressure, cardiovascular disease, and diabetes.

The most recent edition available of Baltimore City’s Food Environment Report (2018) provides insights into the issue of healthy food availability. Of a total city population of 621,000, about 146,000 people, or 23.5 percent, live in areas identified as Healthy Food Priority Areas, which qualify as meeting all four factors that are considered: supply of healthy food, household income, vehicle availability, and distance to a supermarket. These Priority Areas are located primarily in neighborhoods that are not close to either supermarkets or public markets and where residents rely primarily on convenience stores or small groceries and corner stores.

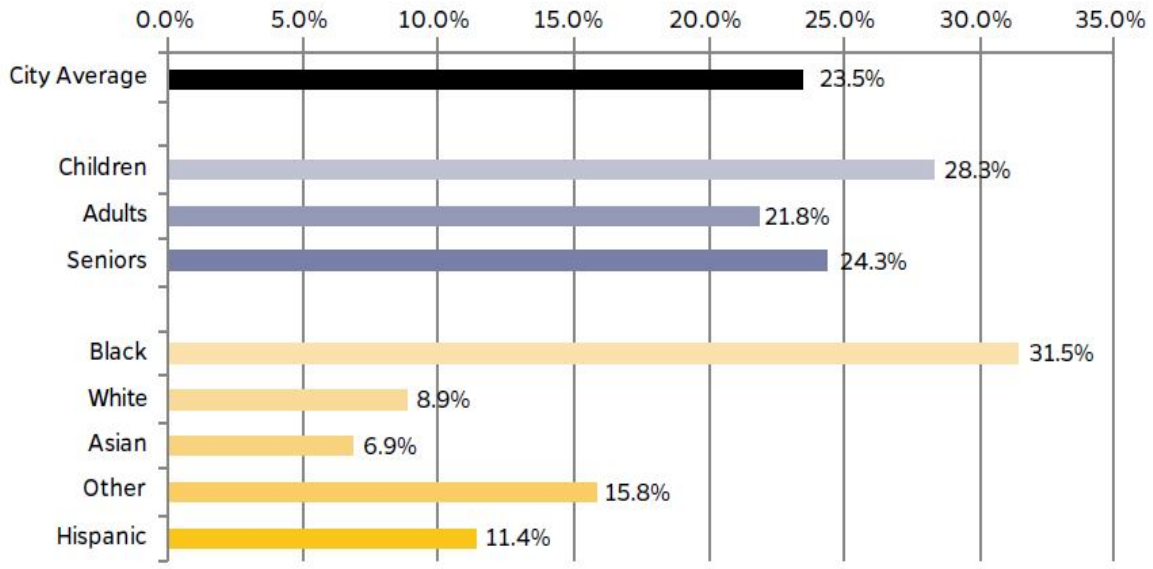
Map 5: Map of Healthy Food Priority Areas in Baltimore City



Source: 2018 Baltimore City Food Environment Report

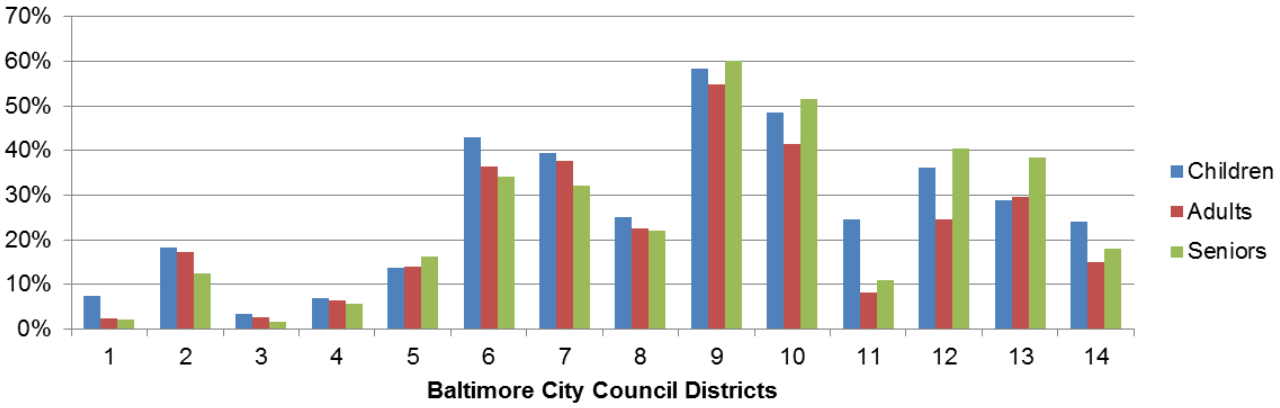
As indicated in Table 6, children are the more likely age group to live in a Priority Area. Black/African American residents of Baltimore are the most likely of any racial/ethnic group to live in a Priority Area – 31.5 percent in comparison to only 8.9 percent of White residents who live in a Priority Area. Since 2005, about 5,000 fewer residents in the CBSA live in a Healthy Food Priority Area due to the opening of a grocery store in the McElderry Park neighborhood.

Table 6: Percent of Population Groups Living in a Healthy Food Priority Area



Source: 2018 Baltimore City Food Environment Report

Chart 13: Percentage of Each Age Group Living in a Healthy Food Priority Area by District



Source: 2018 Baltimore City Food Environment Report

As shown in Chart 13 above, the districts of most concern in the JHH/JHBMC CBSA are districts 12 and 13 where close to 40 percent of seniors live in a food priority area, many with limited mobility. The percentage of children living in a food priority area is also high in these districts.

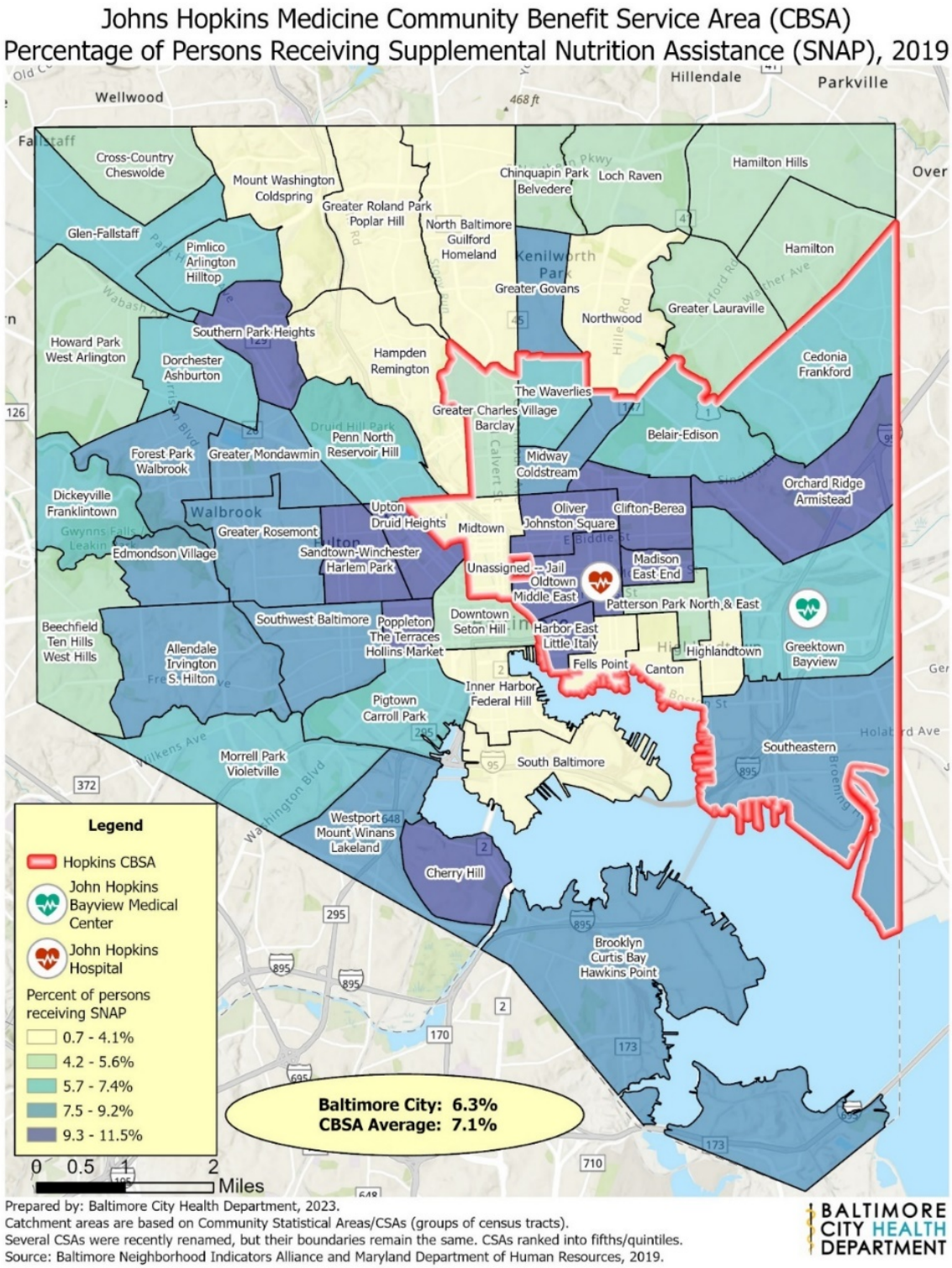
It was reported by the U.S. Census Bureau American Community Survey that more than one-third of Baltimore City residents (40.3 percent) live below 200 percent of the Federal Poverty Level (FPL); this is nearly twice the level of the state (21.6 percent) and higher than the U.S. (30.9 percent).[10] This indicator is relevant

[10] U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

because poverty creates barriers to access, including health services, healthy food, and other necessities that contribute to poor health status. The 2020 Annual Guidelines state that a family of four below 200 percent FPL has an average household income below $52,400.

Fortunately, the Supplemental Nutrition Assistance Program (SNAP) offers nutrition assistance to millions of eligible, low-income individuals and families and provides economic benefits to communities. This program is essential to many as it assists community residents with food options that allow them to be healthy and maintain their well-being. The U.S. Census Bureau reported for 2022 that Baltimore City had 26.3 percent of households receiving SNAP benefits in the past twelve months. This is more than twice the rate of households in Baltimore County (13.1 percent), Maryland (12 percent), and the U.S. (12.4 percent). The Baltimore City Health Department mapped the areas in the city where the percentage of residents receiving SNAP benefits is highest. In the CBSA, these neighborhoods are Oliver Johnstone Square, Clifton-Berea, Orchard Ridge Armistead, Oldtown Middle East, Madison East End, and Harbor East Little Italy.

Map 6 – Percentage of Persons Receiving SNAP – JH CBSA



Prepared by: Baltimore City Health Department, 2023.
Catchment areas are based on Community Statistical Areas/CSAs (groups of census tracts).
Several CSAs were recently renamed, but their boundaries remain the same. CSAs ranked into fifths/quintiles.
Source: Baltimore Neighborhood Indicators Alliance and Maryland Department of Human Resources, 2019.

BALTIMORE CITY HEALTH DEPARTMENT

Based on discussions from the current and previous CHNAs, community leaders are aware from the residents they serve that access to fresh, healthy foods is limited. Typically, residents have little access to grocery stores, yet fast foods and highly processed meals are easily accessible.

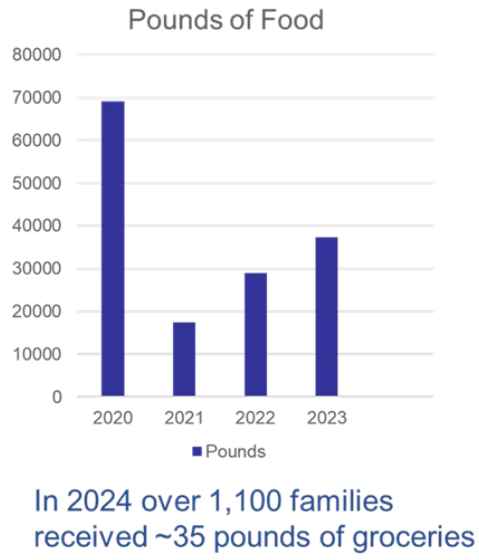
The inaccessibility of healthy food options paired with the absence of health education and the inability to participate in outdoor activities or in a structured physical exercise regimen creates an environment that perpetuates chronic health problems. Access to proper nutrition is vital to maintaining good health, according to focus group participants. There is general awareness regarding the connection between nutrition and making healthy food choices and the role both play in overall health.

Further complicating the problem is the need for education on nutrition and food preparation. Several food pantries distribute cooking instructions and recipes relevant to the food items being distributed and some hospitals and organizations host in-person cooking classes and demonstrations. The Johns Hopkins program "Food in the Marketplace" has been successful in providing live demonstrations at the Northeast Market in East Baltimore. Proper educational information on preparation and nutrition can assist those who want to eat healthy meals however, the availability of healthy food choices must be present.

In response to the urgent needs presented in 2020 as a result of the COVID-19 pandemic, Johns Hopkins has opened food pantries at five different clinics at JHH and JHBMC through the Hopkins Community Connection (HCC) program. In addition, HCC became an official Community Based Organization with the Maryland Department of Human Services to conduct SNAP outreach and application submission. HCC supported over 850 families with their applications for over $248,000 in critical food benefits.

As shown in Chart 14 below, the need for food has increased each year after the high point during the COVID-19 pandemic. For FY24, more than 1,000 unique families received groceries through the program. HCC also partnered with Hungry Harvest, a local farm to doorstep produce delivery service to deliver 6 months of fresh produce and eggs or bread to over 380 patients.

Chart 14: Food Pantry Needs



Source: Healthy Community Connection, 2024

Housing/Homelessness

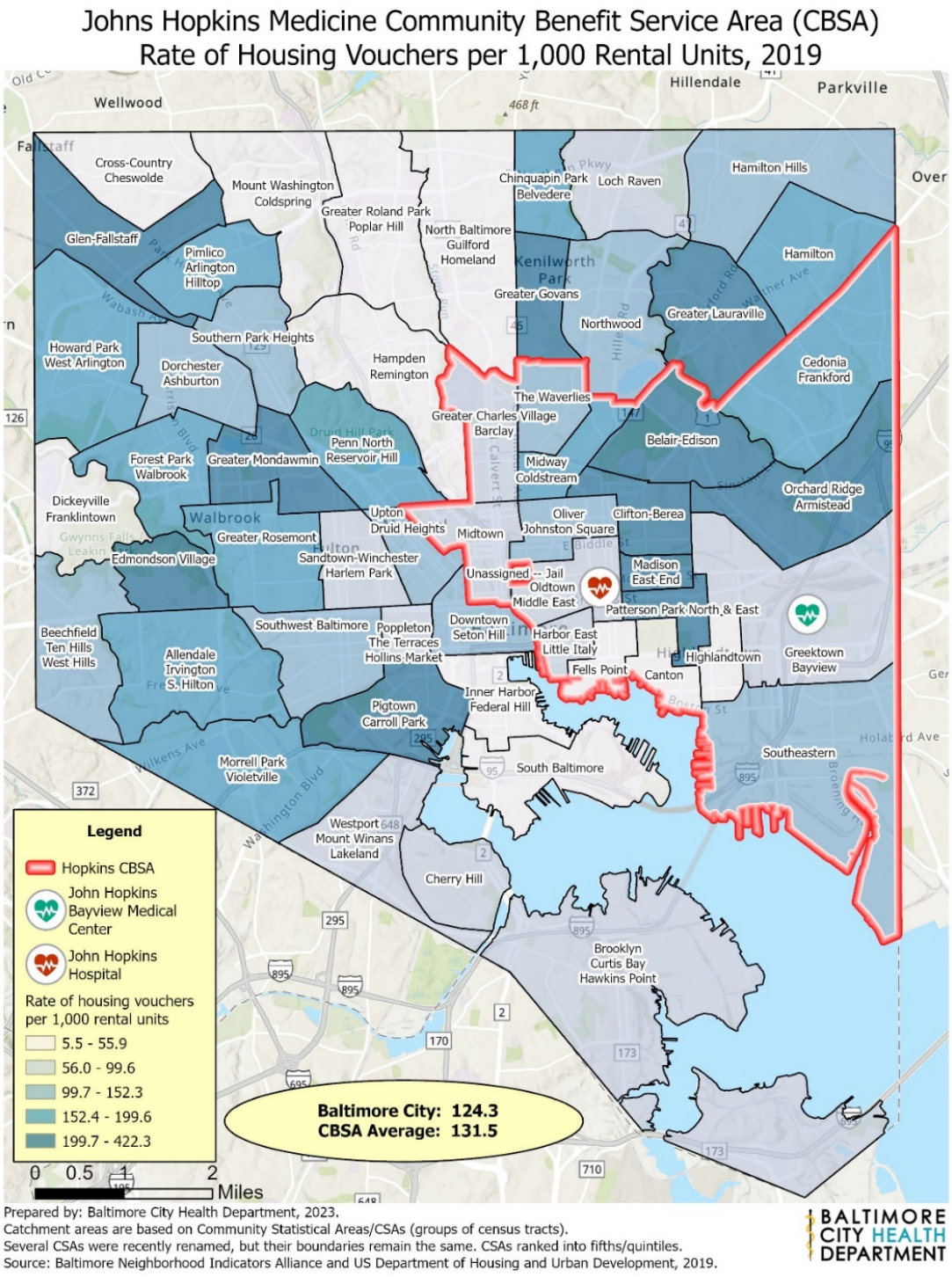
Another socioeconomic factor, a healthy or livable environment, refers to the surroundings in which one resides, lives, and interacts. A livable environment refers to the availability of safe, affordable, clean housing as well healthy food options, and low crime rates. A poor or unlivable environment can lead to poorer health outcomes, a shorter lifespan, and health disparities.

In the CBSA, safe and affordable housing is a critical environmental need. Outdated and unsafe infrastructures in many Baltimore City homes often present hazardous elements that can trigger and exacerbate chronic conditions.

As shown in Table 2 (pg 19) from the 2024 County Health Rankings & Roadmaps, Baltimore City had a much higher severe housing problem rate at 21 percent than did Baltimore County and the state at 15 percent. This means that 21 percent of households experienced at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.

Within the CBSA, 2019 housing data compiled by the Baltimore City Health Department in Map 7 shows that certain neighborhoods have a high rate of housing voucher usage in Baltimore City. Particularly, Belair-Edison, Clifton-Berea, Madison East End, Patterson Park North & East, and Orchard Ridge Armitage have a rate of housing voucher usage (199.7 to 422.3) that is higher than the Baltimore City (124.3) and CBSA (131.5) averages.

Map 7 – CBSA Rate of Housing Vouchers per 1,000 Rental Units



In the 2024 CHNA survey, more than one fourth of survey respondents (27.7 percent) identified affordable housing/homelessness as one of the highest social/environmental concerns among a list of available options.

Findings from primary data collected during the CHNA align with secondary data findings regarding housing problems in the City.

Affordable, clean, and safe housing was a common theme discussed in community stakeholder interviews. Public housing and rental properties are often in poor condition and can contain harmful elements that lead to respiratory conditions. Families are often unsure where to seek housing assistance. There are limited services and programs for residents who struggle with homelessness.

Health Conditions

The CHNA identified specific areas of focus regarding various health conditions include behavioral health services for substance abuse and mental health, diabetes, cardiovascular disease, and chronic disease management and health education.

Behavioral Health – Substance Use and Mental Health

During the CHNA process, access to behavioral health services, which includes substance abuse and mental health services, arose as a key priority in the study area. Secondary data, results from the survey, discussions with community leaders, and focus groups with vulnerable populations all highlighted the growing national and local need to increase access to behavioral health services. Behavioral health concerns, both substance abuse and mental health, were listed by focus group participants and survey respondents as their number one health concern.

The shortage of mental and behavioral health providers is recognized as a serious challenge for those struggling with mental and behavioral health issues. The loss of independence, the loss of a loved one, and the overall decline of health are also some contributing factors that make mental health a critical concern. Mental health is shaped in part by the socioeconomic factors and physical environment where people live. Primary and secondary data collected from the CHNA reinforced these statements.

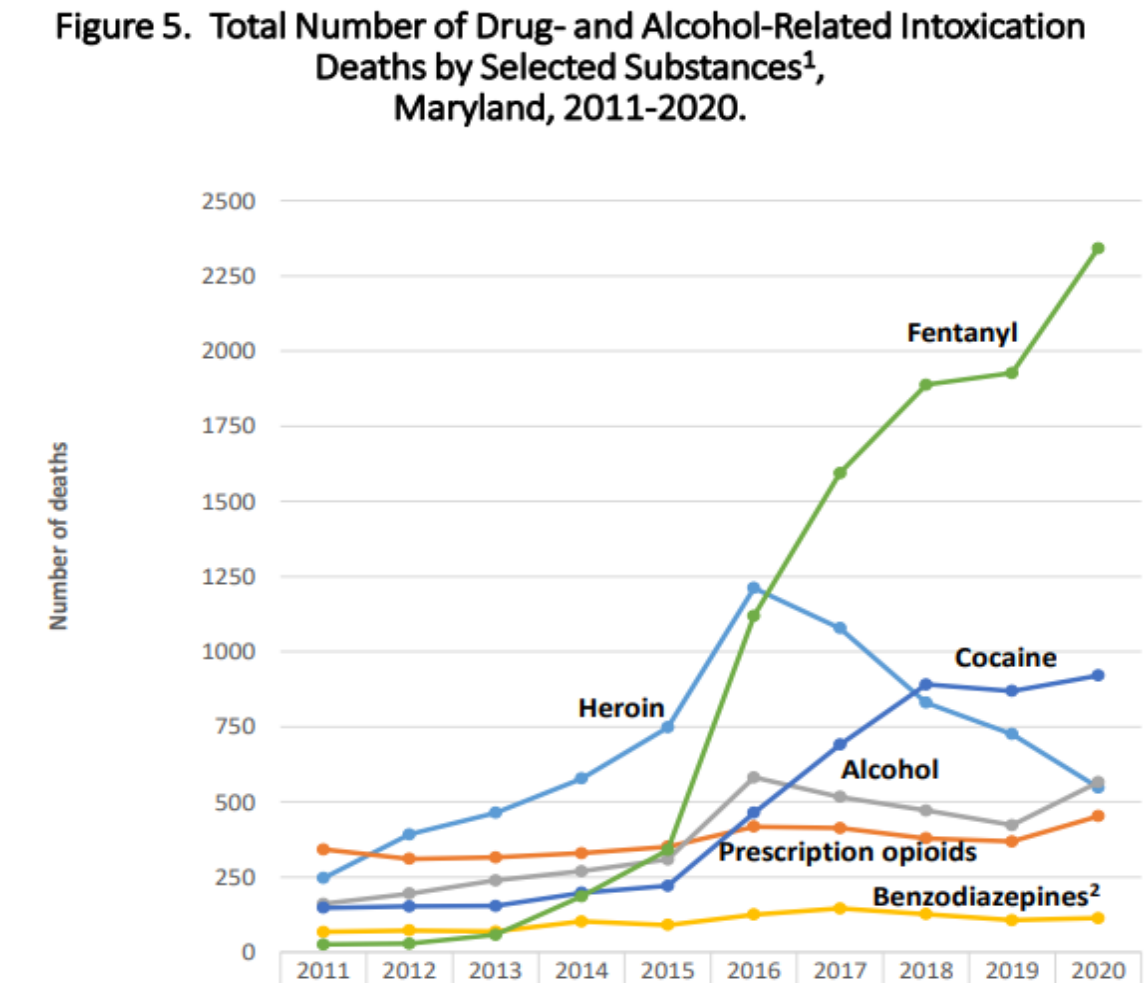
Substance Abuse

A major growing concern is substance abuse, which refers to the abuse of alcohol, the inappropriate use of prescription medicine, and the use of illegal drugs. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) 2022 National Survey of Drug Use and Health, 17.3 percent, or 48.7 million individuals aged 12 years or older, had a substance use disorder (SUD) in the past year. SUD was highest among adults aged 18-25 (27.8 percent), followed by age 12 or older (17.3 percent), and age 26 or older (16.6 percent). This included 29.5 million people who had an alcohol use disorder and 27.2 million who had a drug use disorder. More specifically, 19 million people had a marijuana use disorder, 5.6 million people had a prescribed pain reliever use disorder, and 0.9 million had a heroin use disorder.

Beginning with the 2022 National Survey of Drug Use and Health, people were classified as needing substance use treatment in the past year if they had an SUD or if they received substance use treatment in the past year. Based on this definition, 19.4 percent of people age 23 or older in 2022 (or 56.6 million people) needed substance use treatment in the past year, followed by adults aged 26 or older (17.7 percent or 41.4 million people), then by adolescents aged 12 to 17 (11.5 percent or 3.0 million people).

Maryland Department of Health's 2020 Report on Drug- and Alcohol-related Intoxication Deaths show that, like the nation, Maryland has seen a sharp increase in opioid-related deaths, primarily due to fentanyl and cocaine-related deaths and less as a result of prescription opioids and heroin (see Charts 15-17). The number of heroin-related deaths in Maryland increased five-fold between 2010 and 2016 but has since declined dramatically.

Chart 15: Drug- and alcohol-related intoxication deaths by selected substances, Maryland



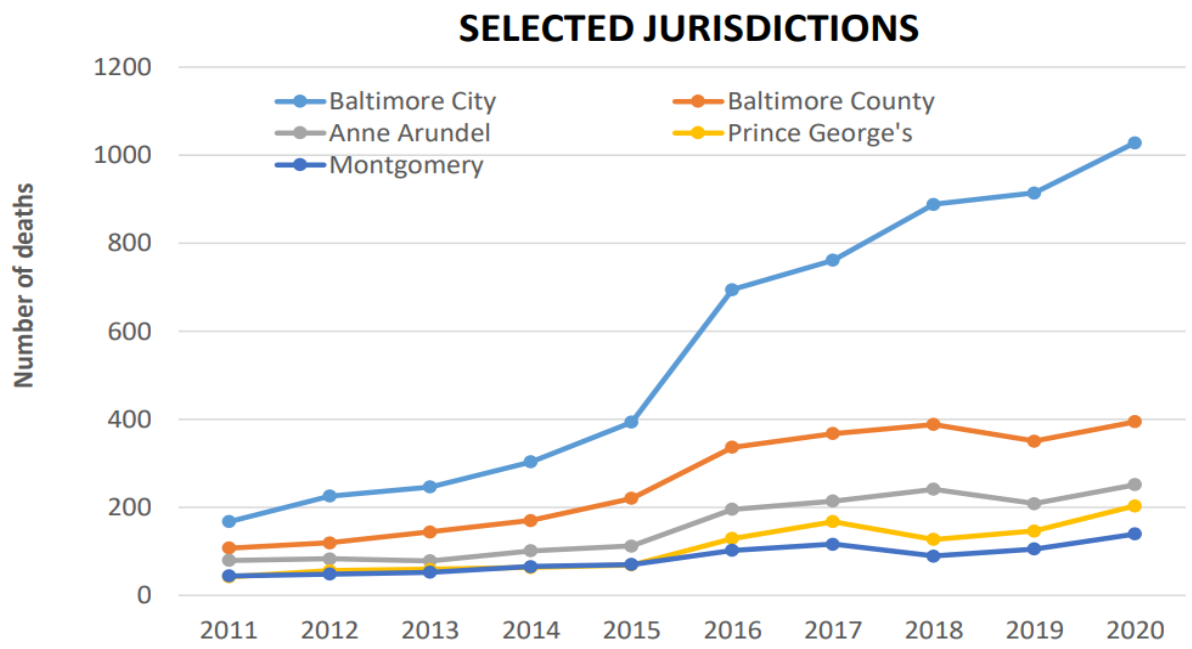
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Heroin	247	392	464	578	748	1212	1078	830	726	548
Prescription opioids	342	311	316	330	351	418	413	379	369	453
Alcohol	161	195	239	270	309	582	517	472	423	566
Benzodiazepines	68	73	69	103	91	126	146	127	107	114
Cocaine	148	153	154	198	221	464	691	891	869	921
Fentanyl	26	29	58	186	340	1119	1594	1888	1927	2342

[1]Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum to the total number of deaths.
[2]Includes deaths caused by benzodiazepines and related drugs with similar sedative effects.

Source: Maryland Department of Health Report on Drug- and Alcohol-related Intoxication Deaths (2020)

Baltimore City, in particular, has experienced large increases in fentanyl, cocaine, and alcohol-related deaths, followed by Baltimore County, Anne Arundel County, and Prince George's County.

Chart 16. Drug- and alcohol-related intoxication deaths by jurisdiction



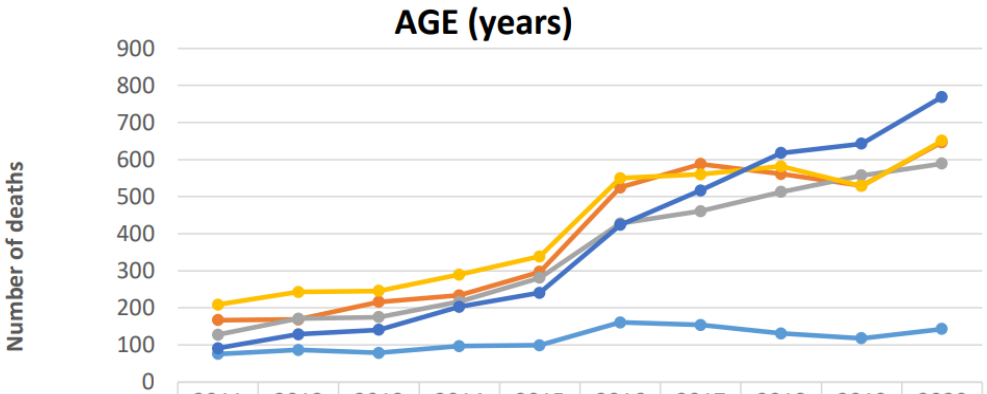
Source: Maryland Department of Health Report on Drug- and Alcohol-related Intoxication Deaths (2020)

In terms of demographics for drug- and alcohol-related intoxication deaths, although intoxication deaths have been increasing among all age groups, the increase has been greatest among individuals 55 years of age and above. The number of deaths among this age group increased more than eight-fold between 2011 and 2020, from 91 to 769. The number of deaths among Whites is about 50 percent higher than among Blacks in 2020. The number of deaths among Hispanics is at a relatively low level as compared to other groups; however, the number of deaths among this group have been steadily increasing since 2015 and has risen from 21 to 126 in 2020. Men are dying at a much higher rate than women 2.6:1.

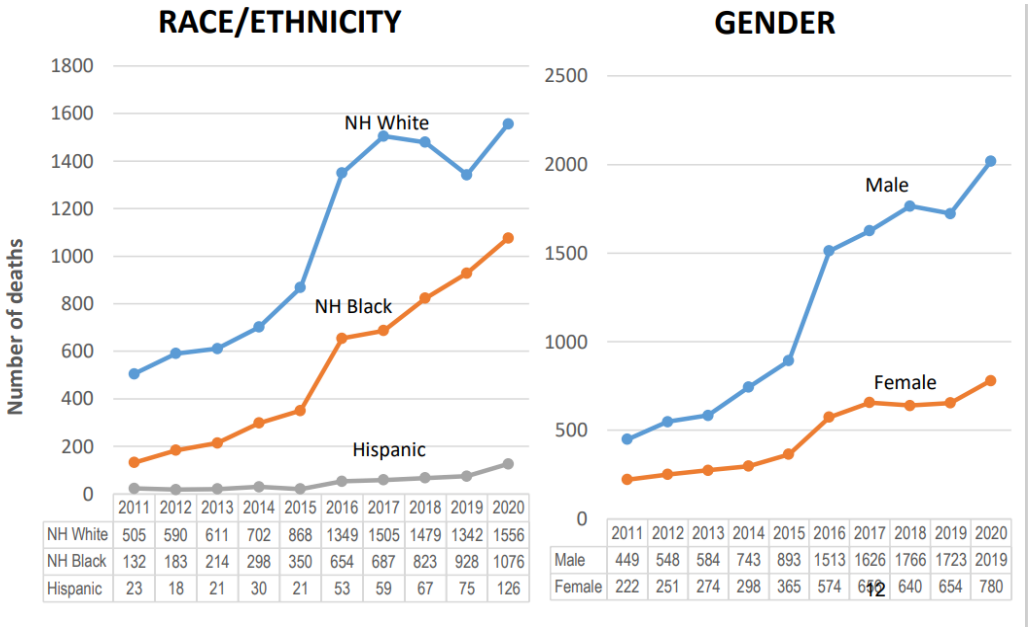
Chart 17. Drug- and alcohol-related intoxication deaths age group, race/ethnicity and gender in Maryland

Source: Maryland Department of Health Report on Drug- and Alcohol-related Intoxication Deaths (2020)

Figure 3. Total Number of Drug- and Alcohol-Related Intoxication Deaths Occurring in Maryland by Age Group, Race/Ethnicity and Gender, 2011-2020.



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
<25 years	76	87	79	97	99	161	154	131	118	143
25-34 years	167	169	216	234	297	525	588	561	530	647
35-44 years	128	171	175	217	281	428	461	513	557	589
45-54 years	209	243	246	290	339	550	560	582	529	651
55+ years	91	129	141	203	241	424	517	618	643	769

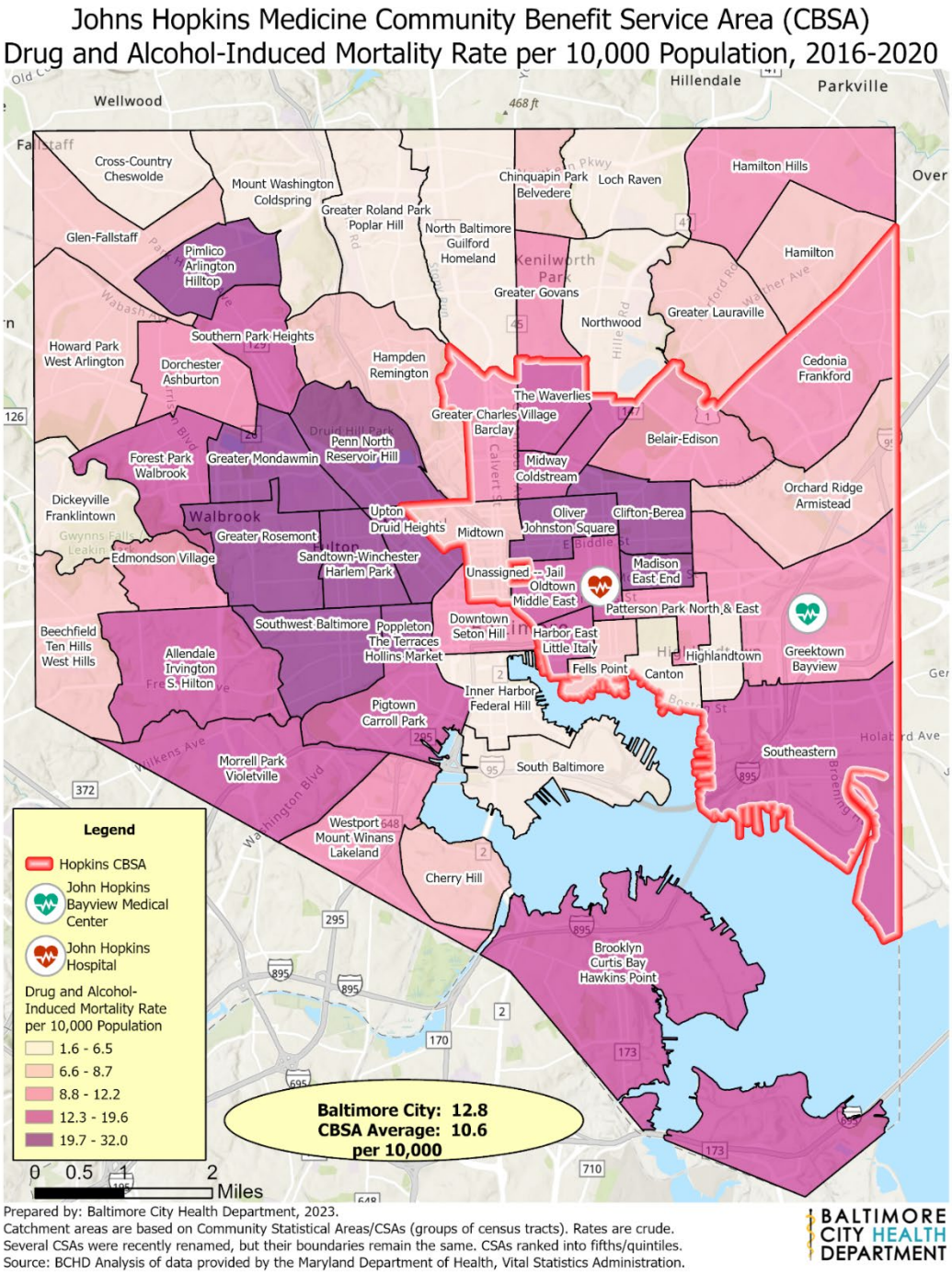


	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
NH White	505	590	611	702	868	1349	1505	1479	1342	1556
NH Black	132	183	214	298	350	654	687	823	928	1076
Hispanic	23	18	21	30	21	53	59	67	75	126

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Male	449	548	584	743	893	1513	1626	1766	1723	2019
Female	222	251	274	298	365	574	612	640	654	780

The Baltimore City Health Department mapped the drug and alcohol-induced mortality rate across the city, and the neighborhoods with the highest rate of drug and alcohol-induced mortality were Oliver Johnstone Square, Clifton-Berea, and Madison East End.

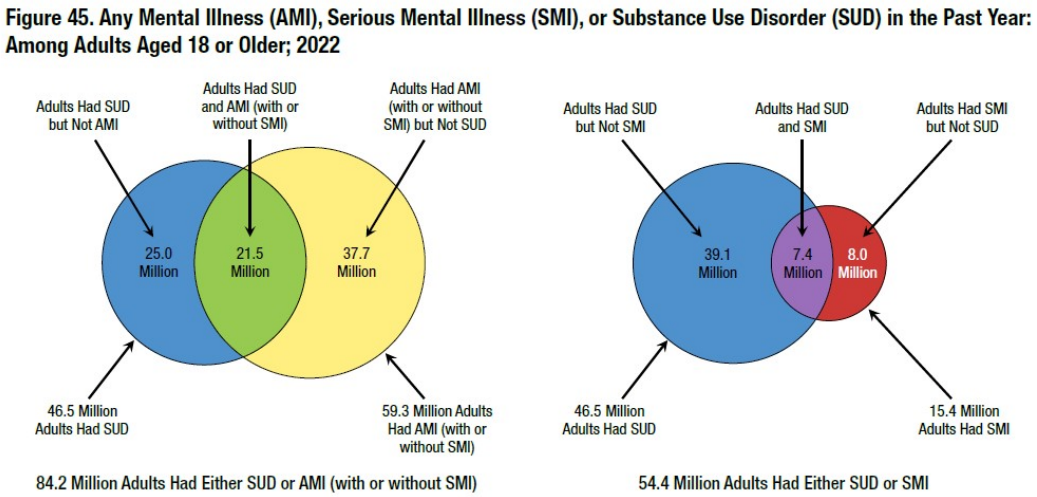
Map 8 – CBSA Drug and Alcohol-Induced Mortality Rate



Community residents recognize the dangers associated with drug and alcohol abuse. Results from the 2024 survey revealed that 54.4 percent of respondents indicated it one of their greatest health concerns. Discussions with community leaders echoed the concerns of survey respondents. Focus group participants expressed a strong need for more community resources and funding to combat the substance abuse problem, as well as a need for more mental and behavioral health programs.

Per the SAMHSA survey, an estimated 21.5 million adults aged 18 and older had co-occurring mental illness and substance use disorder in 2022, about half of whom did not receive either mental health care or specialty substance use treatment. Behavioral health disorders, which include mental illness and substance abuse, left undiagnosed and untreated, can lead to physical, emotional, and spiritual issues manifesting into larger health problems. Community residents dealing with behavioral health issues need access to adequate services and resources, as well as the knowledge of where to obtain care. Communities will suffer and face damaging effects if behavioral services and treatment options are not addressed.

Chart 18: Mental Illness or Substance Use Disorder in 2022



Source: SAMHSA, National Survey on Drug Use and Health, 2022

Mental Health

There are many factors linked to mental health including genetics, age, income, education, employment, and environmental conditions. As identified by primary and secondary data, mental health provider shortages, overall access issues, high rates of co-occurring mental disorders, and substance abuse issues all create significant concerns about the state of behavioral health issues and the need to bring additional focus on providing behavioral health services.

Community residents also struggle with environmental stress such as loss of or limited employment opportunities, poor living environments, and an overall sense of hopelessness creating feelings of depression and anxiety, all of which can impact the mental and spiritual well-being of the individual. The use and abuse

of drugs and alcohol are attractive avenues for community residents who struggle to face their mental health problems. In many cases, residents who have a mental health issue also are substance abusers.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), behavioral health is essential to overall health, with prevention and effective treatment measures allowing individuals to recover from mental health crises. Direct access to health professionals and health services for behavioral health problems enables community residents to obtain proper care and treatment leading to healthier lives.

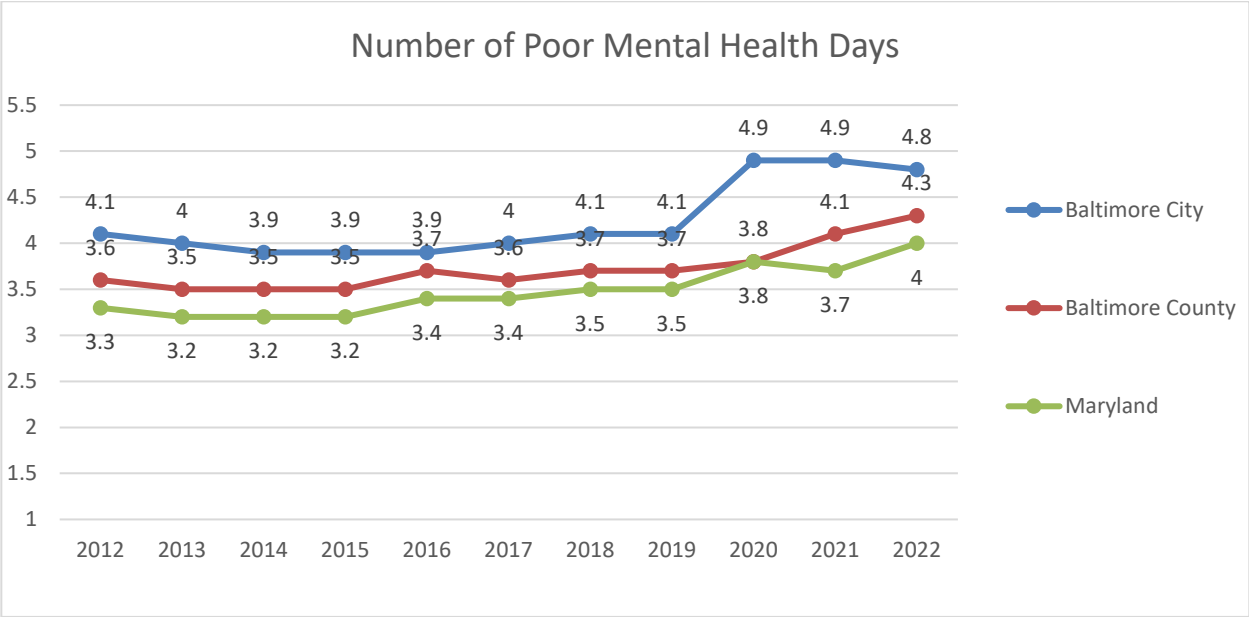
SAMHSA reported, based on the results of their 2022 national survey, that 19.5 percent of adolescents aged 12 to 17 (4.8 million people) and 8.8 percent of adults aged 18 or older (22.5 million people), had a major depressive episode (MDE) during the past year. Among adults 18 or older, the age category between 18 and 25 years of age had the highest rate of MDE at 20.1 percent. Among those adolescents and young adults who had a past year MDE, only 56.8 percent of adolescents aged 12 to 17 and 61.5 percent of adults 18 or older received mental health treatment for MDE in the past year.

Across the nation, mental illness continues to be a major issue for individuals and families. The Centers for Disease Control and Prevention (CDC) defines mental illness as "collectively all diagnosable mental disorders" or "health conditions that are characterized by alterations in thinking, mood, or behavior associated with distress and/or impaired functioning." According to the CDC, serious mental illness costs in the United States amount to $193.2 billion in lost earnings per year. In 2019, 19.2 percent of adults received mental health treatment in the past 12 months, including 15.8 percent who had taken prescription medication for their mental health and 9.5 percent who received counseling or therapy from a mental health professional. Women were more likely than men to receive treatment; non-Hispanic White adults (23 percent) were more 9likely than non-Hispanic Black/African American (13.6 percent) and Hispanic/Latino (12.9 percent) to receive treatment.

Data show roughly 60 percent of adults with mental illness received no mental health treatment within the last year, indicating a nationwide issue with individuals being able to receive proper mental health services and treatment. This is due, in part, to the lack of mental health providers across the U.S. According to the U.S. Department of Health and Human Services, nearly 122 million adults live in areas where shortages of mental health professionals make obtaining treatment difficult. As of April 2024, the KFF Health Database reports over 1.5 million people in Maryland live in a mental health professional shortage area (HPSA). This reflects an unmet need of approximately 80 psychiatrists Note: HPSA designations are based on available psychiatrists metrics. In some areas mental health services provided by other mental health providers such as clinical psychologists and clinical social workers, may be available.

From a local perspective, the CDC Behavioral Risk Factor Surveillance System reported that in 2022, Baltimore City residents had an average of 4.8 mentally unhealthy days in the past 30 days, which was higher than both Baltimore County and Maryland at 4.3 and 4.0 days (See Chart 19).

Chart 19: Average number of mentally unhealthy days reported in past 30 days (age-adjusted)



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2012- 2022

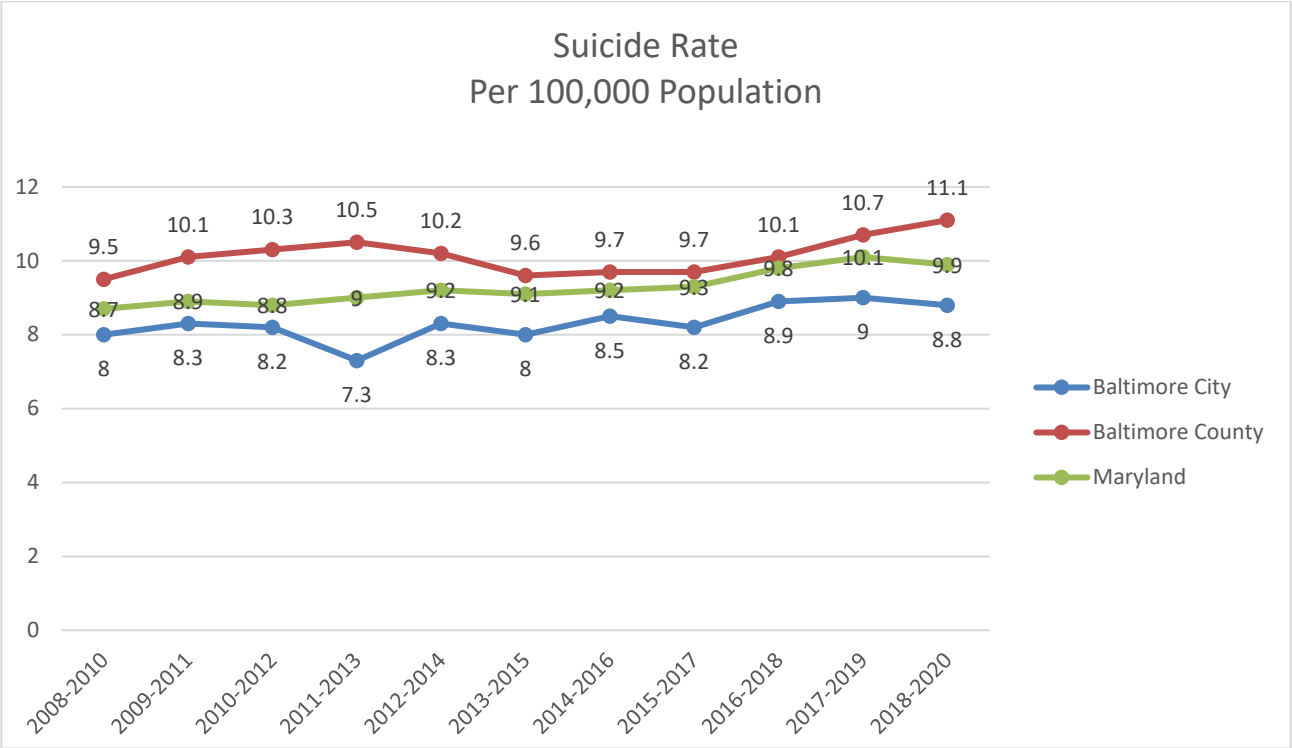
Information collected in the 2024 CHNA survey showed that community residents in the CBSA have an even greater need for mental health services. 53 percent of survey respondents indicated that their mental health was not well at some point within the past 30 days. 42 percent indicated the number of bad mental health days was 10 days or less, with more than half of those respondents saying they had 1 or 2 bad days.

Suicide is a serious public health problem and is a preventable cause of death. Residents who attempt suicide are typically depressed and/or face other significant mental health challenges for which they believe there are limited or no solutions. Suicide is the second leading cause of death among people aged 10-34 according to the National Institute of Mental Health and the CDC.

According to SAMHSA, in 2022 among adults aged 18 or older in the United States, 5.2 percent (or 13.2 million adults) had serious thoughts of suicide in the past year. Among adults aged 18 or older in 2022, 1.5 percent (3.8 million) made a suicide plan in the past year. In 2022, 3.4 million adolescents aged 12 to 17 (13.4 percent) had serious thoughts of suicide in the past year, 1.7 million (6.5 percent) made suicide plans.

The Maryland State Health Improvement Partnership from 2018-2020 reported 9.9 suicides per 100,000 population among Maryland residents (See Chart 20). This rate was higher in Baltimore County at 11.1 suicides and lower in Baltimore City at 8.8 suicides.

Chart 20: Suicide Rate, Maryland



Source: Maryland State Health Improvement Process 2020

Additional primary data collected from focus group participants reported mental health is a significant issue that affects all members of the community regardless of age or race. Barriers such as the lack of insurance coverage, social stigma, and lack of health education prevent individuals from seeking needed care. Educating community members on the signs and symptoms of depression and other mental health issues can enable them to be more aware of the disease in order to seek and obtain services.

In one focus group among Latino residents without legal status, participants expressed how they feel unsafe, unprotected and unseen. They spoke of experiencing fear, mistrust, loneliness, confusion, uncertainty. The feeling of being "unsafe, unprotected and unseen within their community, their homes and the healthcare system" has a direct impact to their mental health and wellbeing. Participants shared that a healthy community is where you can "feel at peace". No one felt they had achieved that goal.

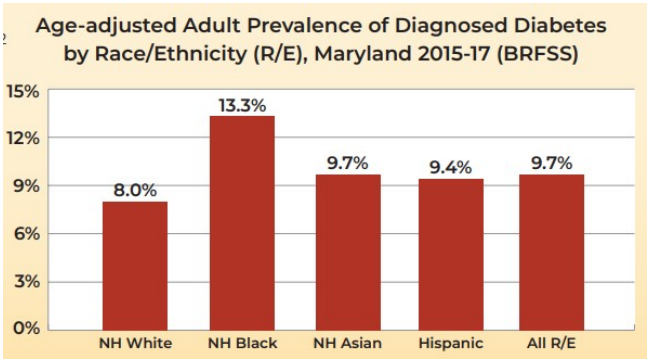
The need for mental health services in the schools was voiced in many key stakeholder interviews. In the 2021 CHNA the need for behavioral interventions in elementary schools was discussed. In 2024, several participants mentioned that now, three years later, elementary school is too late. Behavioral issues are increasingly developing in early childhood and are evident by the time a child goes to school. School based therapy sessions and other services are no longer thought of as a luxury but rather a necessity.

Diabetes

Diabetes is a widespread, chronic disease caused by the inability of the body to produce or properly use insulin. It is characterized by high blood sugar levels. Diabetes predisposes people to costly complications, including heart disease, kidney failure, hypertension, and stroke. Diabetes is the leading cause of new cases of blindness, end-stage renal failure, and non-traumatic lower extremity amputation. In 2017, the American Diabetes Association estimated the cost of diagnosed diabetes at $327 billion in medical costs and lost productivity.

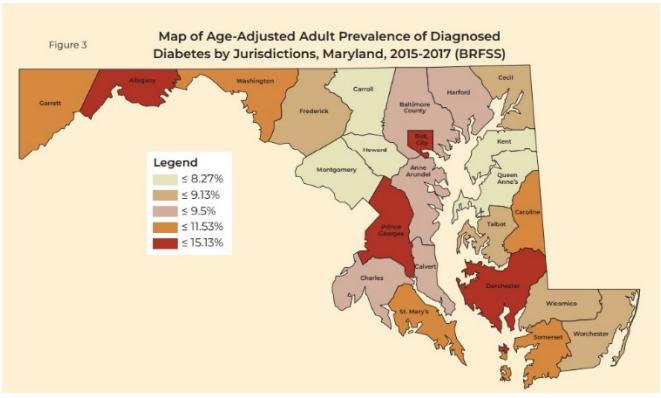
The Maryland Diabetes Action Plan[11] released in 2020 noted that an estimated 10.5 percent of the adult population in Maryland, or 488,942 adults have diabetes. Also, an estimated 34 percent of the adult population, or 1.6 million adults have prediabetes. The adult prevalence of diabetes is highest in non-Hispanic Blacks, followed by non-Hispanic Asians, Hispanics, and lowest in non-Hispanic Whites (see Chart 21).

Chart 21: Diabetes Prevalence by Race/Ethnicity



The geographic distribution of diabetes in Maryland shows that the counties which exceed the Maryland statewide prevalence rate of 10% are Dorchester, Allegany, Prince George's, Garrett, Washington, Somerset, and Caroline counties and Baltimore City.

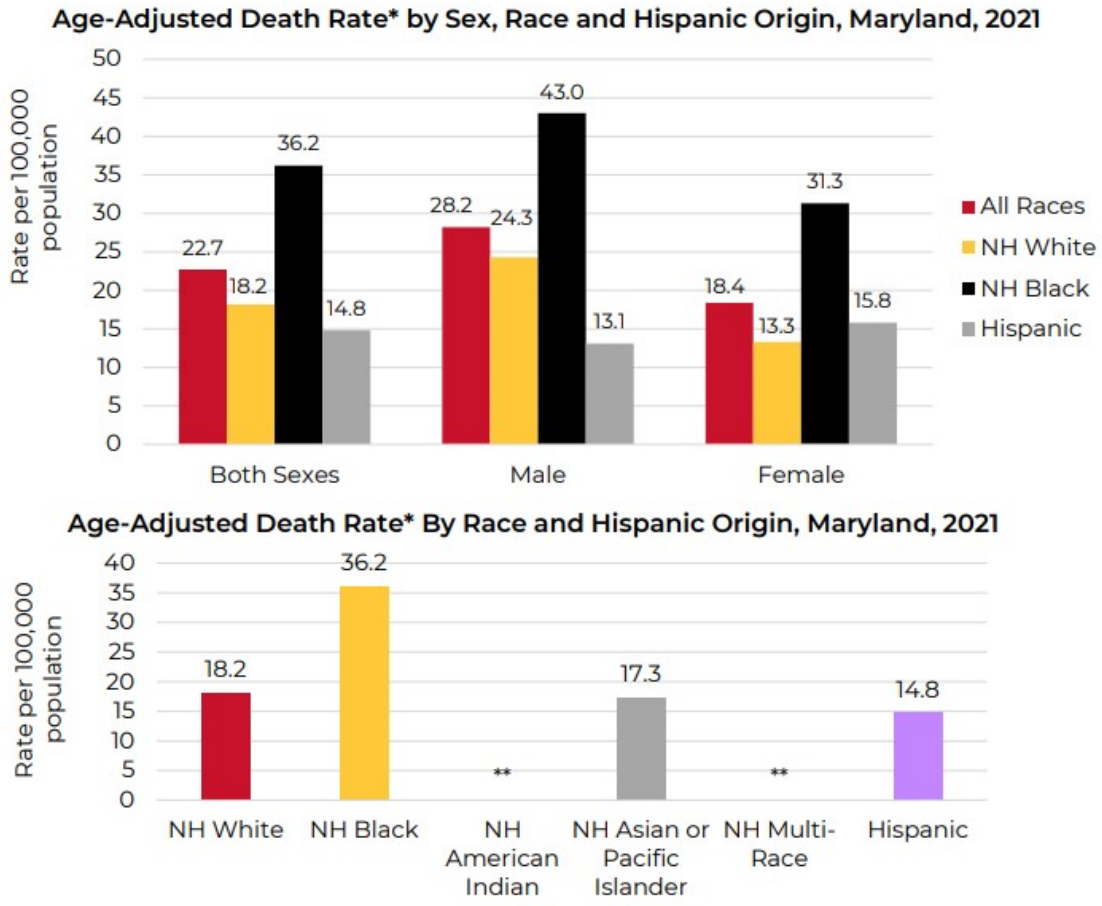
Map 9 – Diabetes Prevalence in Maryland



[11]https://health.maryland.gov/phpa/ccdpc/Documents/Diabetes%20Action%20Plan%20documents/Diabetes%20Action%20Plan%20June%201%202020.pdf

The Maryland Vital Statistics Annual Report for 2021 reported that diabetes was the seventh leading cause of death in the state. The 2021 age-adjusted mortality rate was 22.7, a 5 percent decrease compare to the 2020 rate of 23.9 per 100,000 population. However, the age-adjusted death rate from diabetes among non-Hispanic Blacks of 36.2 per 100,000 is twice that of non-Hispanic whites of 18.2 per 100,000.

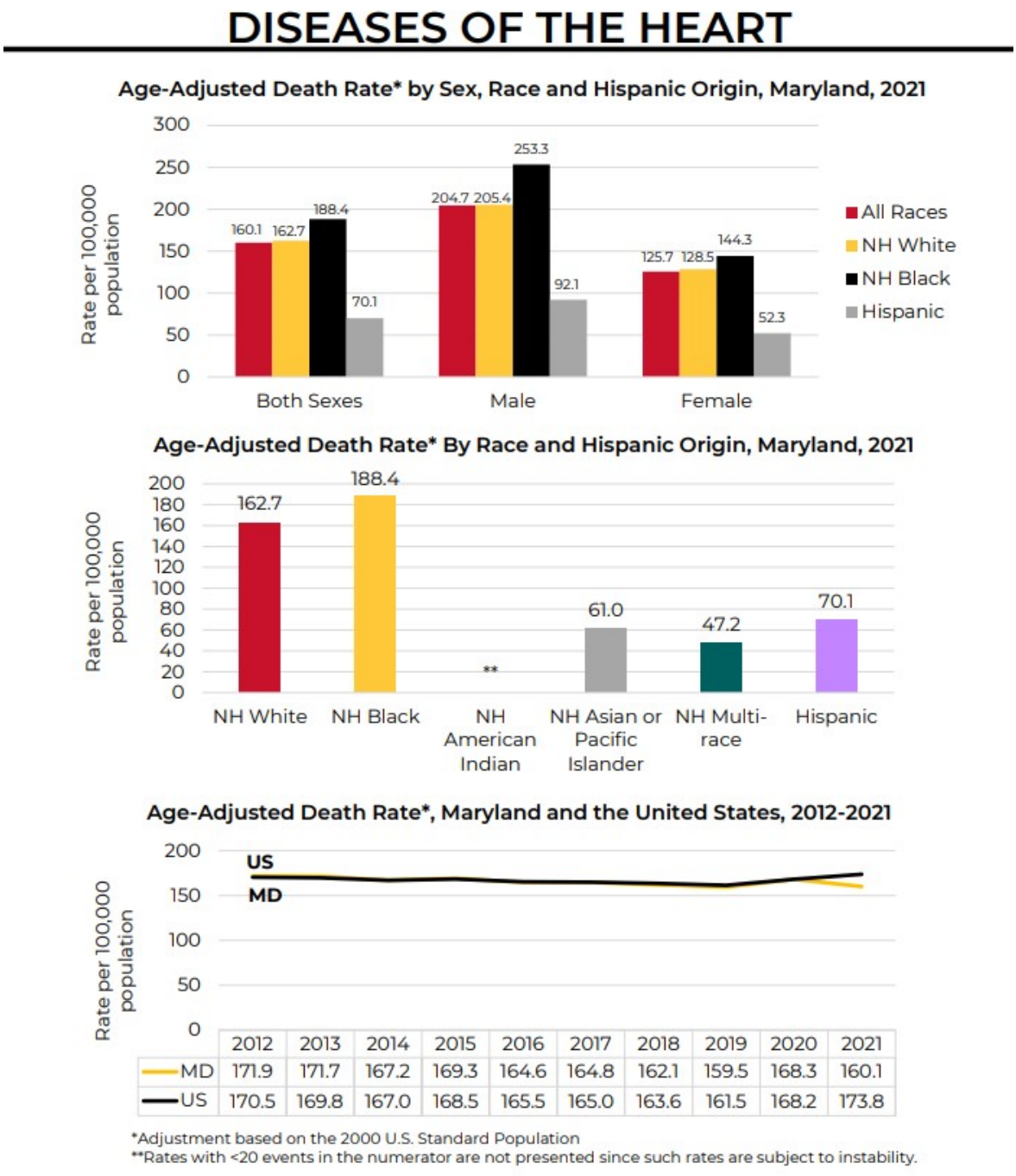
Chart 22: Age-adjusted Death Rate



Cardiovascular Disease (CVD)

Heart disease is the number one cause of death in Americans, killing more than 868,000 people each year, costing the health care system $214 billion annually, and causing $138 billion in lost productivity on the job. In Maryland, heart disease is the leading cause of death as well, and in 2021, it accounted for 20.8 percent of all deaths, and the age-adjusted mortality rate was 160.1 per 100,000 population.

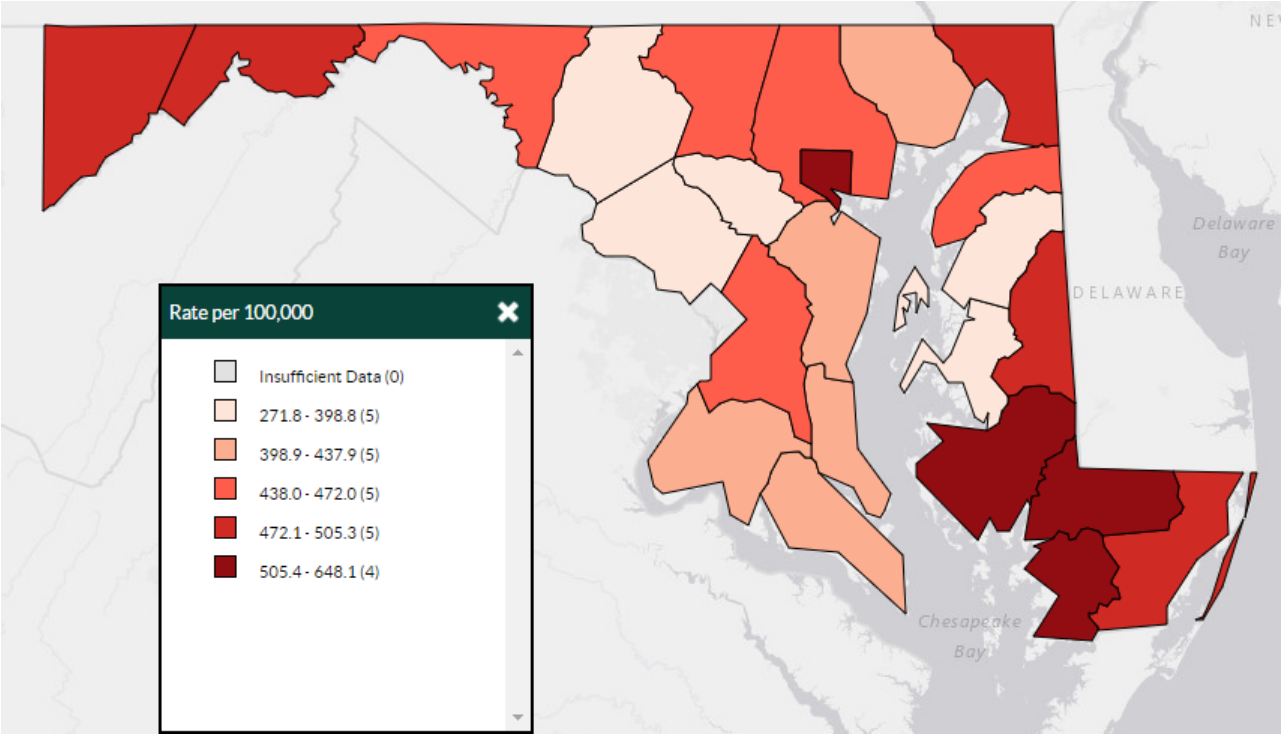
Chart 23 - Age-Adjusted Death Rate for Diseases of the Heart by Race and Hispanic Origin, Trend, and Race and Sex. Rate per 100,000 Population.



Source: Maryland Department of Health and Mental Hygiene Vital Statistics, 2021

As indicated in Map 10, the CDC reported that Baltimore City is a major hot spot within Maryland for deaths due to cardiovascular disease for those age 35 and older. The City has a death rate of 584.5 per 100,000 compared to Baltimore County at 461.3 per 100,000 and 422.3 per 100,000 for the U.S.

Map 10 - Total Cardiovascular Disease Death Rate per 100,000, 35+, in Maryland 2016-2018



Source: National Center for Chronic Disease Prevention and Health Promotion, 2021

Hypertension is one of the most common risk factors for diseases of the heart. The presence of hypertension doubles the risk of heart disease in men and triples the risk in women. It is documented that Blacks/African Americans have a greater risk than Whites for cardiovascular disease, due in part to more severe high blood pressure problems. Educating the broad community to understand the risks and signs of heart disease and stroke serves as the major impetus in the prevention and treatment of heart disease. The CDC reports that the adult hypertension prevalence in Maryland in 2021 was 35.2 percent compared with the prevalence in 2019 of 34.9 percent and in 2017 of 33.1 percent. Overall, the trend from 2011 to 2021 shows that the rate of adult hypertension has increased from 31.9 percent to 35.2 percent.

Smoking is a behavior that is highly linked to cardiovascular disease, stroke, and hypertension risk. In 2021 the adult smoking prevalence was 9.6 percent, which has declined significantly from 2011. The overall trend from 2011 to 2021 shows the adult smoking rate has decreased from 19.2 percent to 9.6 percent. Additionally, youth smoking prevalence has shown a marked decrease from 2007 to 2021 – from 16.8 percent in 2007 to 3.6 percent in 2021.

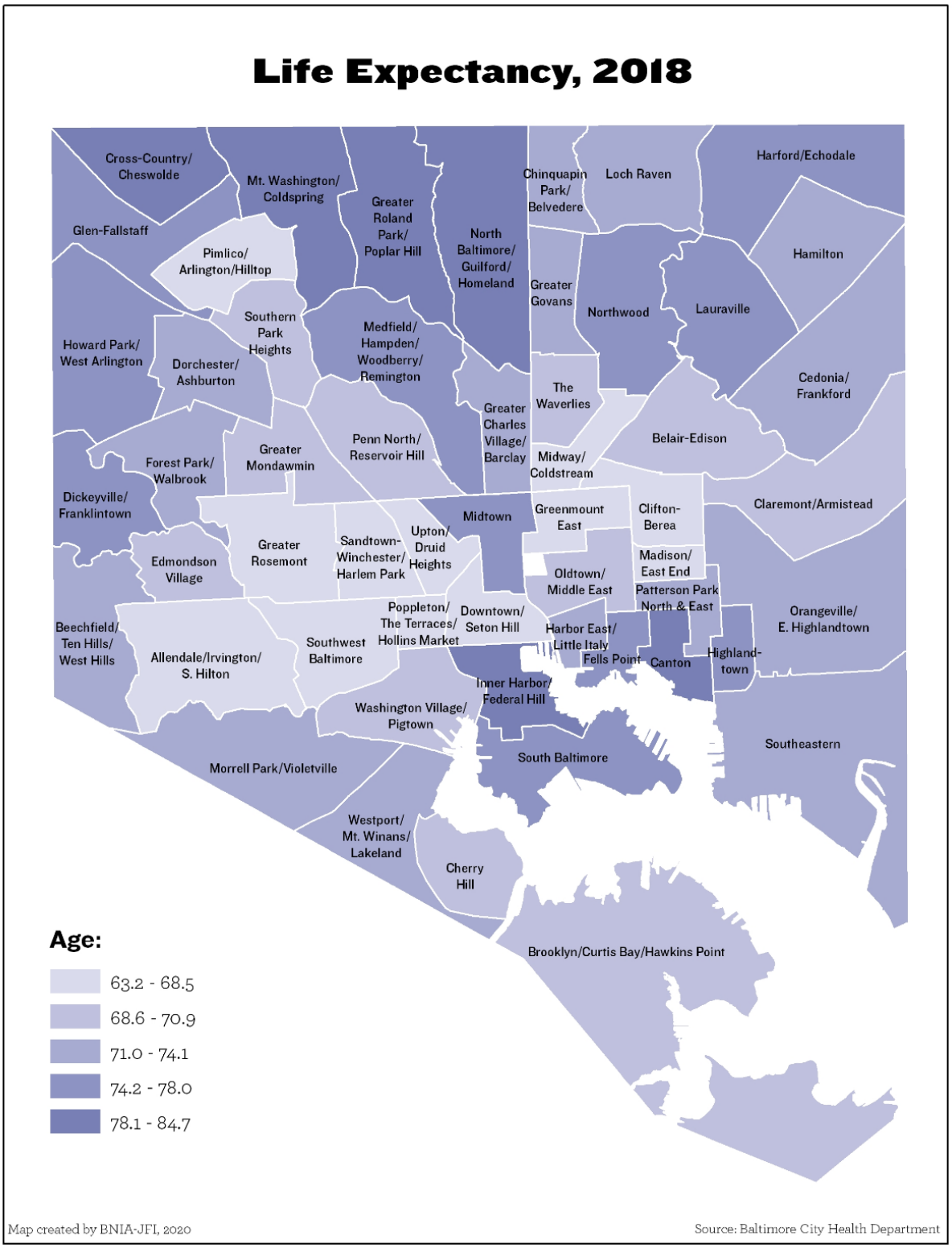
Chronic Disease Management & Education

According to the CDC, 90 percent of the nation's $3.8 trillion in annual health care expenditures are for treating people with chronic and mental health conditions. Although common, many of the chronic diseases diagnosed in community members are preventable. Living a healthy lifestyle by incorporating exercise, eating healthy foods, and avoiding tobacco and alcohol can reduce the risk of developing certain diseases. As mentioned above, both the adult and youth smoking prevalence have been on long-term declining trends. Other behaviors that are part of a healthy lifestyle include exercise and healthy eating. Over the 2011 to 2022 period, the CDC reported that adults who said they had exercised in the past 30 days increased from 73.8 percent to 78.8 percent. In terms of healthy eating, from 2015 to 2021, adults who reported eating fruit less than once per day increased from 36 percent to 37.1 percent – overall a decrease in healthy fruit intake. Whereas, for adult vegetable intake, from 2015 to 2021, adults who reported eating vegetables less than once per day decreased from 21.3 percent to 19.2 percent – overall an increase in health vegetable intake.

Maryland State Vital Statistics Annual Report (2021) stated that for an infant born in Maryland (2019-2021) they would have a life expectancy of 78.2 years and for Baltimore County 77.2 years, while for Baltimore City there would be dramatically lower life expectancy of 71.0 years. In Maryland over the 2019-2021 period, between White and Black groups at birth, life expectancy differs by nearly four years (3.9 years) – 78.7 for White life expectancy and 74.8 for Black life expectancy. This gap is wider at 6.3 years in Baltimore City – 74.7 for White life expectancy and 68.4 for Black life expectancy. Whereas for Baltimore County the gap is narrower at 3.1 years – 77.6 for White life expectancy and 74.5 for Black life expectancy.

Geographically, the map below shows how life expectancy is different across neighborhoods in Baltimore City in 2018, (the latest update available). The average life expectancy in Baltimore City in 2018 was 72.7 years. Life expectancy in our CBSA varies greatly from the high end at 80.8 years in Canton to the low end of 70.1 years in Belair-Edison, 68.4 in Madison/East End, and 67.4 in Clifton-Berea.

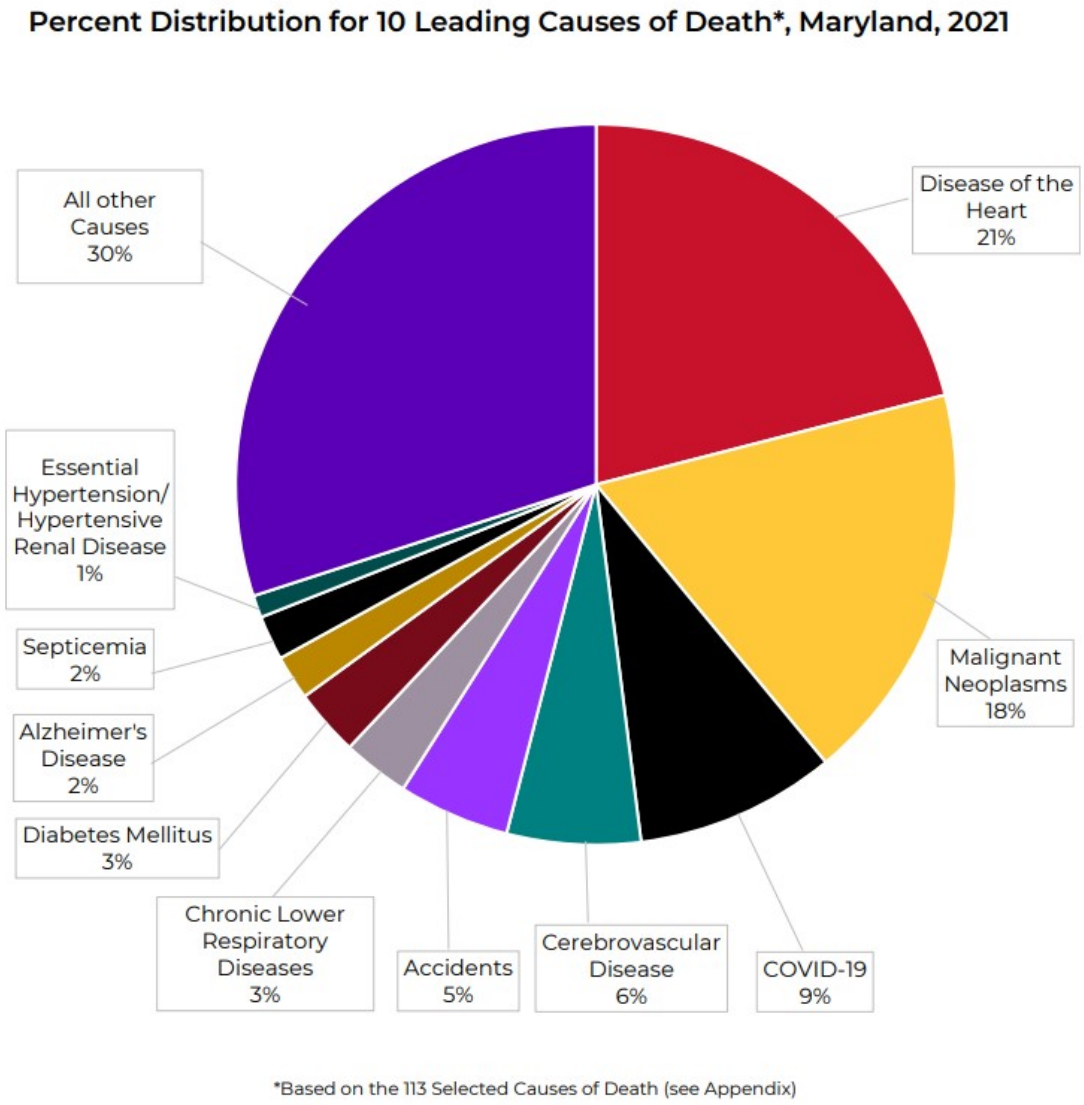
Map 11 - Life Expectancy, Baltimore City by Neighborhood, 2018



Source: Baltimore Neighborhood Indicators Alliance, 2020

Data obtained from the Maryland State Vital Statistics Annual Report (2021) identify the leading causes of death in Maryland as heart disease, cancer, COVID-19, stroke, accidents, chronic lower respiratory diseases, diabetes, Alzheimer's disease, septicemia, and primary hypertension.

Chart 24 - Ten Leading Causes of Death in Maryland



Source: Maryland Vital Statistics Annual Report, 2021

In Baltimore City and Baltimore County, the top five leading causes of death were similar - heart disease, cancer, COVID-19, accidents and stroke. These are also the top five leading causes of death for Maryland (See Tables 7-8).

Table 7: Top 10 Causes of Death in Baltimore City, 2021

	Percent of Total Deaths
Heart Disease	20.6
Cancer	15.9
COVID-19	8.0
Accidents	7.5
Stroke	5.5
Assault/Homicide	3.8
Diabetes	3.4
Chronic lower respiratory disease	2.6
Septicemia	1.6
Primary hypertension/hypertensive renal disease	1.4

Source: Maryland Vital Statistics 2021 Annual Report

Table 8: Top 10 Causes of Death in Baltimore County, 2021

	Percent of Total Deaths
Heart Disease	22.3
Cancer	17.3
COVID-19	9.1
Accidents	5.7
Stroke	5.4
Chronic lower respiratory disease	3.2
Diabetes	2.6
Alzheimer's disease	2.2
Septicemia	1.5
Primary hypertension/hypertensive renal disease	1.3

Source: Maryland Vital Statistics 2021 Annual Report

Cancer in some form affects more than 1.7 million people annually as reported by the American Cancer Society (ACS). The death rate from cancer in the U.S. has continued to decline. From 1991 to 2018, the cancer death rate has fallen 31 percent, including a 2.4 percent decline from 2017 to 2018. This is the largest one-year drop in the cancer death rate, and is mostly driven by the four most common cancers – lung, colorectal, breast, and prostate. Between 2012 and 2021, the cancer death rate has dropped by 1.6 percent per year. Unfortunately, cancer is still the second leading cause of all deaths. Declines since 1991 are mainly due to fewer people smoking, but also advances in early detection and treatment for some cancers.

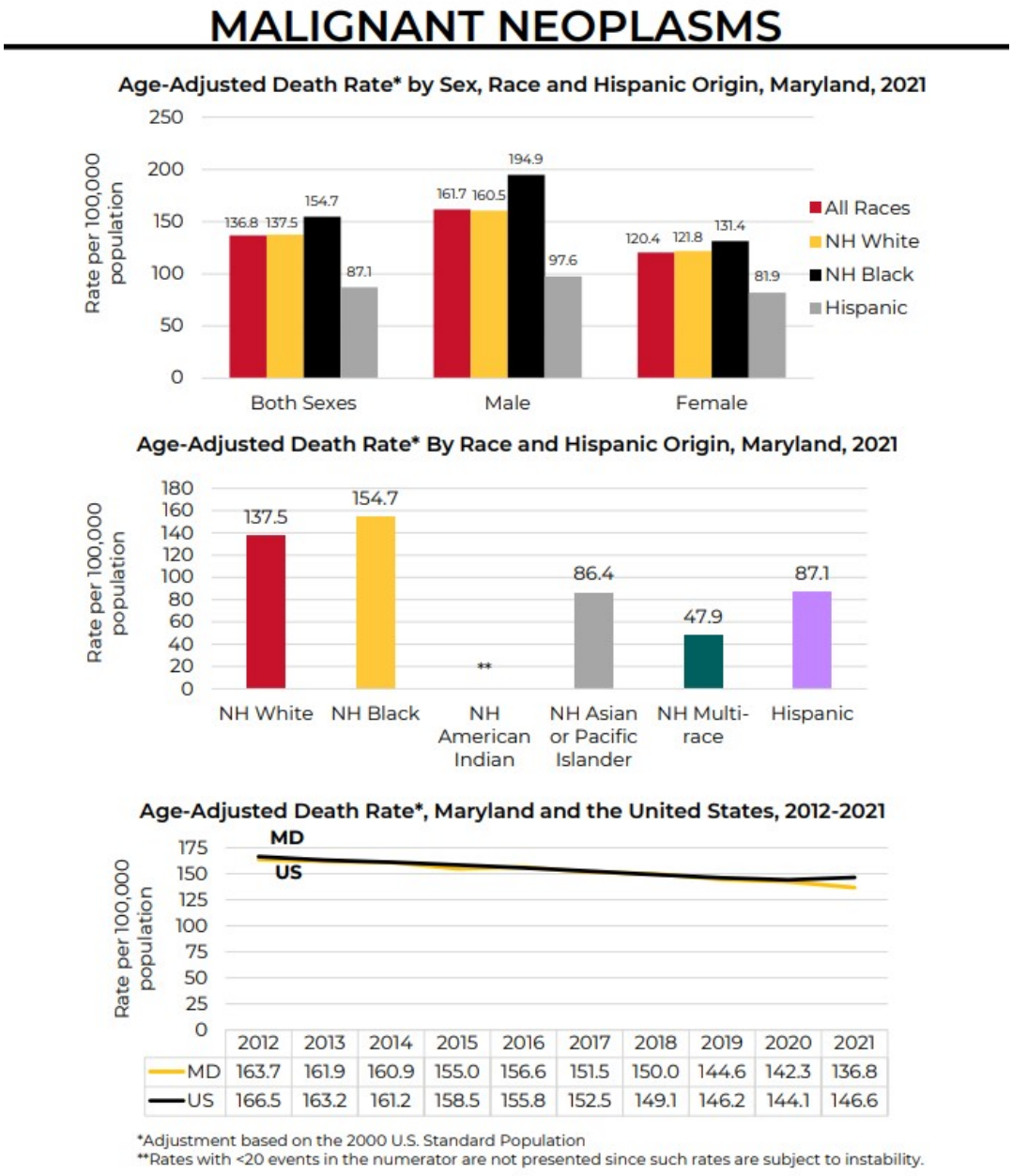
Between 2017 and 2021, cancer incidence rates have remained stable among men and women. During this period, eight of the nineteen most common cancers in men and nine of the twenty-one most common cancers in women showed statistically significant decreases in new cases. For both men and women, lung and bronchus cancer showed the greatest decreases. Over the past decade (2011 to 2021), the cancer

incidence rate, or the likelihood of developing cancer, increased slowly in women largely due to continued increases in breast and uterine cancers, and melanoma, offsetting declines in lung and colorectal cancers. In men, cancer incidence rates stabilized in recent years after declining from the mid-2000s until around 2013, largely driven by trends in prostate cancer, which have increased in recent years.[12]

Cancer (malignant neoplasms) is the second leading cause of death in Baltimore City, Baltimore County and the state of Maryland. The age-adjusted death rate of malignant neoplasms was higher among Blacks (154.7 per 100,000) as compared to Whites at (137.5 per 100,000) as shown in Chart 25. Both are significantly higher than the age-adjusted death rate for Hispanics/Latinos at 87.1 per 100,000. Over the last sixteen years, the age-adjusted death rate gap between Whites and Blacks in Maryland has declined. In 2008, the rate for Blacks was 212.8 per 100,000 versus 175.0 per 100,000 for Whites – an excess of 37.8 deaths per 100,000. In 2021 that gap, or excess deaths, has declined to 17.2 deaths per 100,000. To be sure, early detection and treatment have improved considerably, but likewise community health education and health equity efforts to improve health literacy have likely contributed to this.

[12] American Cancer Society, Cancer Facts & Figures 2024

Chart 25 - Maryland Cancer



Source: Maryland Department of Health and Mental Hygiene Vital Statistics, 2021 Annual Report

The American Cancer Society (ACS) noted that much of the suffering and death caused by cancer could be prevented by more systematic efforts to reduce underlying causes and to expand the use of established screening tests. Therefore, a greater emphasis should be placed on cancer screenings to provide early detection and public education and awareness to reduce the risk and prevent the various types of cancer.

Obesity, a growing national concern, has affected many communities and neighborhoods and shows no signs of waning. Communities are seeing children as young as two years old diagnosed as being overweight and/or obese. In the U.S., childhood obesity alone is estimated to cost $14 billion annually in direct health expenses. In 2017-18, 19.3 percent of kids ages 2 to 19 were obese according to the National Health and Nutrition Examination Survey. The adult obesity rate for ages 20+ was 42.4 percent for the same period. Since 1980, obesity rates among teens ages 12 to 19 quadrupled, from 5 percent to 20.6 percent.

In 2022, Maryland is reported as having the 36th highest adult obesity rate in the nation. Maryland's adult obesity rate is currently 31.5 percent, down from 32.3 percent in 2019, up from 29.9 percent in 2017, 19.6 percent in 2000 and 10.8 percent in 1990. Maryland was one of 29 other states where the adult obesity rate decreased in 2022.

More recent data from 2021-2022 showed that the rate of obesity in the 10 to 17 age group in Maryland has increased to 20.5 percent from 17.6 percent in 2019. Maryland ranks eighth in the U.S. for the rate of adolescent obesity.[13]

A new class of medications, called GLP-1 (glucagon-like peptide-1) agonists, originally designed to treat Type 2 diabetes have been approved for the treatment of obesity. These treatments produced by Novo Nordisk under the names Ozempic, Rybelsus, and Wegovy (semgalutide) and Eli Lilly under the name Mounjaro (tirzepatide) are highly effective weight loss agents. It remains to be seen how Medicaid coverage evolves for these drugs, but some states are taking steps to expand coverage of these drugs for weight loss. As well, new research has shown high correlations between GLP-1 related weight loss and a host of other diseases such as cardiovascular and kidney diseases. Additionally, the American Academy of Pediatrics guidelines now recommend pharmacotherapy obesity treatment in children age 12 and older.[14]

Physical inactivity is associated with a higher prevalence of risk for Type 2 diabetes and many other maladies, including cardiovascular diseases, hypertension, certain cancers, dementia, anxiety, and depression. According to the United Health Foundation, costs associated with physical inactivity account for more than 11 percent of total health care expenditures and are estimated at $117 billion annually. In their annual health rankings for 2020, 23.4 percent of Maryland adults reported no physical activity or exercise other than their regular job in the past 30 days. This compares to 26.4 percent for the United States. Individuals making less than $25K (40.7 percent), ages 65+ (29.6 percent), Native Americans (31.2 percent), and those with less than a high school education (44 percent) were the most inactive.

Obesity, continues to be discussed as a community epidemic. In past CHNA discussions, obesity was most often linked to Diabetes. In 2024, obesity was seen as connected to many health conditions including mental health, and should be talked about in the context of a chronic condition.

Chronic diseases can be managed, and many are preventable; however, generational attitudes along with the ability to obtain necessary health care services need to be addressed in order to allow community residents the opportunity to live healthier lives. Information gathered related to causes of death, high blood pressure, diabetes, etc. all point toward the need for community action. Education, information, improved access, and care management for those in the area can have a significant impact in reducing the chronic conditions of residents.

[13] https://stateofchildhoodobesity.org/demographic-data/ages-10-17/
[14] https://www.kff.org/policy-watch/medicaid-coverage-of-and-spending-on-new-drugs-used-for-weight-loss/

Conclusions and Recommendations

With the completion of the 2024 CHNA, The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC) will develop updated goals and strategies for the CHNA implementation phase. In this phase, the hospitals will leverage their strengths, resources, and outreach and work with community partners to identify ways to address their communities' health needs, thus improving overall health and addressing the critical health issues and well-being of residents in their communities. The Implementation Strategy will be completed and adopted by the hospitals' Board of Trustees in November, 2024. The community health needs assessment and implementation planning builds on the previous CHNA assessment and planning reports (2021, 2018, 2016 and 2013). The comprehensive CHNA addressed who was involved, what, where, and why, while the implementation planning phase will address how and when JHH and JHBMC will address the identified community health needs.

The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, partnering with community organizations and regional partners, understand that the CHNA document is not the last step in the assessment phase, but rather the first step in an ongoing evaluation process. Communication and continuous planning efforts are vital throughout the next phase of the CHNA. Information regarding the CHNA findings will be important to residents, community groups, leaders, and other organizations that seek to better understand the health needs of the communities surrounding JHH and JHBMC and how to best serve those needs.

In the assessment process, common themes and issues rose to the top as each project component was completed. The data collected from the overall assessment included feedback and input from community leaders and hard-to-reach, underserved, and vulnerable populations. The information collected provides JHH and JHBMC with a framework to begin identifying, evaluating, and addressing gaps in services and care, which will ultimately alleviate challenges for individuals living in the community.

Solidifying and reinforcing existing relationships and creating new associations must be paramount in order to address the needs of community residents. Expanding and creating new partnerships with multiple regional entities is vital to developing community-based strategies to tackle the region's key community health needs.

The key community health needs identified by JHH and JHBMC include improving social determinants of health factors (access to care/support, job opportunities including education and job training, neighborhood safety, food environment and housing/homelessness,) and improving access to direct health services (substance abuse, mental health, diabetes, cardiovascular disease and chronic disease management and education).

The collection and analysis of primary and secondary data provided the working group with an abundance of information, which enabled the group to identify key health services gaps. Collaborating with local, regional, statewide, and national partners, JHH and JHBMC understand the CHNA is one component of creating strategies to improve the health and well-being of community residents.

Implementation strategies will take into consideration the higher need areas that exist in regions that have greater difficulties obtaining and accessing services.

Action Steps:

Communicate the results of the CHNA process to staff, providers, leadership, boards, community stakeholders, and the community as a whole.

Use the inventory of available resources in the community to explore further partnerships and collaborations.

Implement a comprehensive grassroots community engagement strategy to build upon the resources that already exist in the community, including committed community leaders that have been engaged in the CHNA process.

Develop working groups to focus on specific strategies to address the top identified needs of the communities the health system serves and develop a comprehensive implementation plan.

Invite key community stakeholders to participate or be involved with working groups that will strategically address and provide expert knowledge on ways to address key community health needs.

Implementation Strategy

Introduction

The Community Health Needs Assessment (CHNA) is a report based on epidemiological, qualitative, and comparative methods that assess the health issues in a hospital organization's community in addition to how the community accesses services related to those issues. The Implementation Strategy is a list of specific actions and goals that demonstrate how The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC) plan to meet the CHNA-identified health needs of the residents in the communities surrounding the hospitals, i.e. the Community Benefit Service Area (CBSA). This Implementation Strategy was approved by the hospitals' Boards of Trustees for Johns Hopkins Bayview Medical Center (September 23, 2024) and for The Johns Hopkins Hospital (October 8, 2024).

Internal Revenue Service Requirements – Implementation Strategy

The Implementation Strategy developed and adopted by each hospital must address each of the needs identified in the CHNA. This can be done by either describing how the hospital plans to meet each need or explaining why a particular need will not be addressed by the hospital. Each need addressed must be tailored to that hospital's programs, resources, priorities, plans, and/or collaboration with governmental, non-profit, or other health care organizations. The hospital's board must approve the Implementation Strategy for the hospital.

Health Priorities

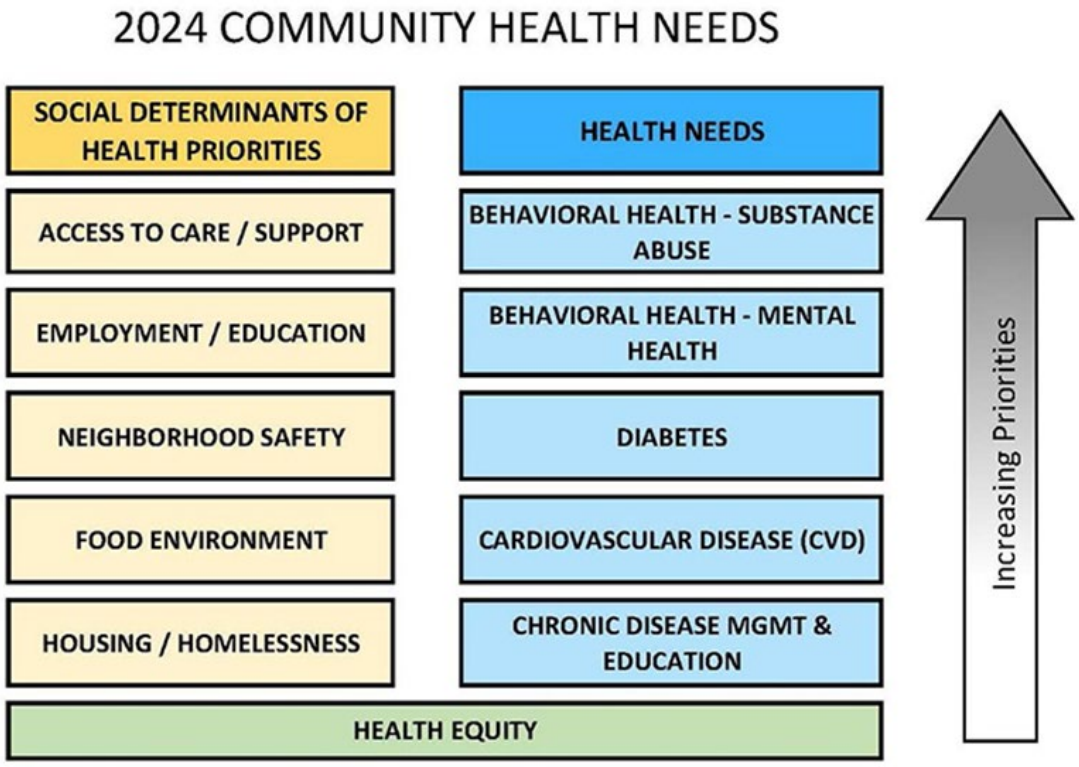
Based on the primary and secondary data collected and analyzed during the CHNA process, JHH and JHBMC's Implementation Strategy remains committed to the goals and strategies identified in the previous CHNA work sessions. While community feedback has shifted the priority of some focus areas, the overall needs remain relatively the same as reported in the 2021 CHNA. Data from focus groups, key informant interviews and a city-wide survey highlighted barriers to accessing care such as lack of transportation, physician shortages, language barriers and more. These barriers have played and continue to be contributing factors for communities in the hospital's CBSA. Community identified access to care along with employment/education and neighborhood safety as the three leading social determinants of health contributing to poor health outcomes. Behavioral health/substance abuse and mental health are the top direct health needs. Dental services were not identified as a need in the 2024 CHNA, but its importance to overall health will be addressed as appropriate under chronic disease management and education.

Johns Hopkins actively engages hundreds of programs to address the identified needs in their surrounding communities. The hospitals work to strategically allocate scarce resources to best serve the communities, partnering with community-based organizations (CBOs) whenever possible to expand the depth and breadth of resources. The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center share the same CBSA and as such are considered to be partners in delivering programs to local residents for the purposes of CHNA reporting regardless of the distinction of specific hospital funding sources.

The Implementation Strategy is the action plan of the CHNA that guides strategic planning on community engagement and planning. As noted in the CHNA, ten key need areas were identified through the gathering of primary and secondary data from local, state, and national resources, community stakeholder interviews,

surveys, focus groups with vulnerable populations, and a health provider inventory (highlighting organizations and agencies that serve the community). The identified community needs are depicted in order of priority in the graph below, with socioeconomic needs in orange and direct health needs in blue (See Chart 1). The following Implementation Strategy items outline action plans to address identified needs. Listed programs are examples and may change as resources become available or new needs arise.

Chart 1: JHH/JHBMC Key Community Health Needs



IMPROVING SOCIOECONOMIC FACTORS

SOCIOECONOMIC NEED 1: ACCESS TO CARE/SUPPORT			
Goal	**Strategies**	**What we are measuring**	**Potential Partner Organizations**
Improve access to healthcare services for residents across the JHH/ JHBMC CBSA	**Strategy 1:** Improve access to health care services and health education for immigrant communities.	• # of participants • # of collaborative vaccine clinics hosted • # Spanish speaking CHWs and peer recovery specialists (PRS)	• Centro SOL • Esperanza Center • Sacred Heart of Jesus Church
	Strategy 2: Improve ease of access to services and provide support to increase connection to care (e.g. transportation, financial assistance, pharmacy assistance etc.).	• # of patients linked to insurance and/or financial assistance • # of persons served in programs designed to improve physical access to care • # of transportation vouchers disbursed • # of patients receiving post discharge medication access	• Transportation services (Lyft/Uber etc.) • MDHD - MD Primary Care Program
	Strategy 3: Increase telehealth capacity to extend beyond the hospital walls to deliver care to more community members.	• # of sessions • # of programs • Expansion of care / # served	• Primary care physicians • Skilled Nursing Facilities (SNFs) • Office of Telemedicine

ACCESS TO CARE/SUPPORT INITIATIVE EXAMPLES:

Telehealth – Before the COVID pandemic, Telehealth services began opening new access to healthcare for many neighborhood residents unable to come to the hospital. Since March 2020, this system has revolutionized community outreach and continues to grow in importance as a key tool to address health

equity access. We continue to explore opportunities to partner with local organizations aimed at improving digital equity in East Baltimore.

Latino Outreach – Outreach to the Latino Community became a large focus for JHH and JHBMC during FY21. Addressing the high COVID-19 positivity rates in the community living in or around the Sacred Heart Church (21224 zip code), the hospitals set up a testing site and vaccination clinic outside the church. Support will continue and expand beyond the COVID initiatives.

After Care Clinic – Offers bridging care to patients (including behavioral health patients) returning to the community. Staff from Social Work, Case Management, Pharmacy, and Home Care screen patients for social determinants and link to services, in addition to providing care.

SOCIOECONOMIC NEED 2: EMPLOYMENT/EDUCATION			
Goal	**Strategies**	**What we are measuring**	**Potential Partner Organizations**
Increase employment and procurement opportunities to local and minority communities	**Strategy 1**: Increase youth and adult workforce training and education programs.	• # of participants in career development and mentoring programs • # of programs offered in vulnerable neighborhood locations	• Baltimore City Public Schools • Baltimore City Community College • Kaiser Permanente • Caroline Center • Turnaround Tuesday • University of Baltimore
	Strategy 2: Create new employment opportunities for underserved community residents including hires and/or recruitment and/or training to at risk populations i.e. justice involved, victims of violence and trauma.	• # of program participants and/or # of programs for at-risk populations • # of trade school or certification program placements # of hires from target populations	• BUILD • Baltimore's Promise • Caroline Center • Turnaround Tuesday
	Strategy 3: Support/contract with local, minority- and women-owned businesses and focus on hiring from underserved neighborhoods to improve the local economy.	• # of hires from underserved neighborhoods • Amount spent with local minority owned vendors	• BUILD • HopkinsLocal

EMPLOYMENT/EDUCATION INITIATIVE EXAMPLES:

HopkinsLocal – Johns Hopkins is leveraging its economic power to expand participation of local and minority-owned businesses in construction opportunities; increase our hiring of city residents, with a focus on neighborhoods in need of job opportunities; and enhance economic growth, employment, and investment in Baltimore through our purchasing activities.

BLocal BUILD College – BLocal partner companies have developed a program that provides training for small, local, minority-owned, women-owned, and/or disadvantaged businesses in design and construction industries. Training sessions focus on design, construction, and business-related topics to build key competencies and relationships for growth.

Turnaround Tuesday – A program offered through a partnership with BUILD to provide job training to returning citizens to increase basic job skills and qualifications for employment.

Summer Jobs Program – In conjunction with the Baltimore City Government and the State of Maryland, Johns Hopkins employs over 170 Baltimore City School students each summer through paid internships as

well as offering workforce education sessions. Student interns work at JHH and JHBMC as well as other departments in the Johns Hopkins Health System and the Johns Hopkins University.

P-TECH (Pathways in Technology Early College High Schools) – The P-TECH program is a partnership between the state of Maryland, Johns Hopkins University and Health System, Dunbar High School, the Baltimore City Community College (BCCC), University of Maryland (UMB) at Baltimore, and Kaiser Permanente. P-TECH is creating a school-to-industry pipeline by providing training from high school through community college and links Baltimore students to positions and mentors in the healthcare industry. The program is now working with its eighth cohort of students and mentors. Twenty-two students have graduated with an associate degree in general sciences, physical therapy, or respiratory therapy.

SOCIOECONOMIC NEED 3: CRIME AND NEIGHBORHOOD SAFETY			
Goal	**Strategies**	**What we are measuring**	**Potential Partner Organizations**
Enhance neighborhood safety and reduce violent encounters	**Strategy 1**: Identify and support violence reduction initiatives.	• Success rate of encounters to successful engagement of victims of blunt force intentional trauma (incl. gunshot wounds, stabbings) • # of participants linked to needed SDoH resources	• ROCA • UMB ROAR • Safe Streets • Baltimore City Health Department • Charm City Care Connection
	Strategy 2: Partner with community engagement outreach programs to identify local parks and recreation spaces that might benefit from attention/sprucing up in order to enhance after school offerings and reduce youth violence.	• # of youth participants in programs	• Baltimore City Police Department • Buddies Inc. • Patterson High School • John Ruhrah School • Mr. Mack Lewis Foundation

CRIME AND NEIGHBORHOOD SAFETY INITIATIVE EXAMPLES:

Burn Prevention Program – This intervention program, based at the JHBMC Burn Center, educates participants referred by the justice system on the severe consequences that could occur without proper fire prevention behavior. Additional sessions are conducted in local schools where students are taught emergency actions in case of fire.

Recreation facilities and programs – Johns Hopkins partners with the Department of Recreation and Parks as well as many community organizations to improve recreation facilities and opportunities in the CBSA. Some examples are 29th Street Recreation Center, the Craig Cromwell summer basketball league, and a new community basketball court in McElderry Park.

Operation P.U.L.S.E. (People United to Live in a Safe Environment) – Operation P.U.L.S.E. is a partnership between Johns Hopkins Medicine and CURE (Clergy United for Renewal in East Baltimore) that was established in 1992. This crime prevention ministry has trained over one thousand volunteers to conduct area security patrols and crime prevention programs for churches, senior groups, schools, outdoor community displays, and businesses.

Hospital Responders "Break the Cycle" Intervention Program – The Hospital Responders program follows the recent pilot program with the BCHD to hire and train intervention staff for emergency room response to victims of intentional blunt force trauma. Peer Recovery specialists contact each patient admitted to the hospital for intentional trauma (e.g. gunshot or stabbing) to engage in dialogue followed by participation in de-escalation and recovery programs.

SOCIOECONOMIC NEED 4: FOOD ENVIRONMENT (INCLUDING ACCESS & NUTRITION)			
Goal	**Strategies**	**What we are measuring**	**Potential Partner Organizations**
GOAL: Improve access to healthy food and healthy behaviors among youth and adults	**Strategy 1:** Provide resources to community residents with food insecurity.	• # of people served Amount of food distributed • # of programs etc.	• MD Food Bank (Hopkins Community Connection) • Civic Works (delivering food to seniors) • Let's Eat • Hungry Harvest • The Door
	Strategy 2: Expand program education on healthy eating and food preparation. (Nutrition / cooking etc.)	• # of people served # of programs etc. nutrition, zoom cooking classes, podcasts etc. • Measured increased skills/knowledge for healthy eating	• Days of Taste (Tastewise Kids Program) • Baltimore City Public Schools • American Heart Association

FOOD ENVIRONMENT INITIATIVE EXAMPLES:

JHBMC Community Food Pantry provides emergency food supply to individuals and families in need. In FY24, the pantry served 209 adults and 70 children, provided 98 individual bags and 83 family bags of food – totaling 3,834 pounds of food.

Vernon Rice Memorial Turkey Drive – Faculty, staff, and students join together with community organizations around JHH and JHBMC to distribute turkeys and produce boxes to families in need for the Thanksgiving holiday.

Days of Taste – A program connecting local chefs with 4th grade public school students for a series of sessions, including visiting a farm, sampling diverse foods, and culminating with the preparation of their own farm fresh salad with take home salad kits to share with their families.

Hopkins Community Connection – JHH/JHBMC supports four on-site desks for social services support including maintaining a food pantry for patients in need.

Active Lifestyle Outreach programs – Johns Hopkins Hospital and Bayview Medical Center support many programs to help residents maintain a healthy lifestyle. Among those are the "Stepping Out for Health" program, a network of walking programs with over 100 participants throughout the year.

Farmers Markets – JHH and JHBMC support community farmers markets with supported SNAP-EBT program benefits to encourage fresh food purchase for neighbors and staff.

SOCIOECONOMIC NEED 5: HOUSING/HOMELESSNESS			
Goal	**Strategies**	**What we are measuring**	**Potential Partner Organizations**
Increase access to housing and healthy homes in the CBSA	**Strategy 1**: Expand capacity to identify housing issues among low-income, uninsured, and homeless residents and connect to resources.	• # of encounters addressing housing issues • # of positive screenings and referrals to resources for housing issues	• Hopkins Community Connection • Health Care for the Homeless
	Strategy 2: Support aging in place initiatives for seniors.	• # of persons served Amount invested in home improvement partnerships	• Banner Neighborhoods • Civic Works • Southeast CDC • Habitat for Humanity • Meals on Wheels
	Strategy 3: Support community members recently discharged from a care facility.	• # of persons served • Amount invested in home improvement partnerships	• Banner Neighborhoods Civic Works • Southeast CDC • Habitat for Humanity • Meals on Wheels

HOUSING INITIATIVE EXAMPLES:

Helping Up Mission – Johns Hopkins is committing support to the Helping Up Mission to fund transitional housing space for homeless, discharged patients in need of continuing care.
Hopkins Community Connection – JHH/JHBMC supports four on-site desks for social services support (including housing) where patients are screened and referred to appropriate partner resources.
Transition Guides and Community Health Workers screen for social determinants needs and connect to resources, including housing support.
Habitat for Humanity – Johns Hopkins partners with Habitat for Humanity through financial contributions and direct employee volunteer efforts in our community.
Safe and Home Programs – JHH and JHBMC provide key support to area organizations which work to keep residents in their homes by assisting with home repairs, supplies and other resources. Organizations include: Banner Neighborhoods, Civic Works (a large subcontractor partner for the CAPABLE program), and Southeast Community Development Corporation.
Assistance in Community Integration Services (ACIS) – JHH and JHBMC partnered with the State of Maryland, Baltimore City, and other Baltimore City hospitals to deliver supportive services necessary to provide 300 housing opportunities for unhoused individuals and families with children. The program was renewed by CMS and will continue through 2026.

DIRECT HEALTH NEEDS

HEALTH NEED 1: BEHAVIORAL HEALTH/ SUBSTANCE ABUSE (SA)			
Goal	**Strategies**	**What we are measuring**	**Potential Partner Organizations**
Improve access to available substance abuse (SA) services	**Strategy 1**: Provide crisis services/substance use disorder treatment services to address opioid use disorder in local community.	• # served by community outreach crisis and/or treatment services • # of clients connected fulltime care	• Helping Up Mission • Dayspring Program • House of Ruth • Broadway Center for Addictions • Amazing Grace Lutheran Church • The Spot Mobile Clinic
	Strategy 2: Provide high-quality health care services in non-traditional settings, such as street-based medicine, to people who otherwise experience barriers to receiving care.	• # of people in these underserved populations who receive any health care service in a nontraditional setting • # of people in these underserved populations successfully connected to primary care (successfully meaning at least two visits to the same provider within 6 months) • # people with 3+ visits for any service within 6 months in the nontraditional setting (street-based medicine)	• Charm City Care Connection • Dee's Place

	Strategy 3: Design, test, launch, evaluate, and disseminate a campaign to reduce the stigma around addiction.	• # of JHH and JHBMC employees who sign The Words Matter Pledge	• Charm City Care Connection • Broadway Center for Addictions • The Mr. Mack Lewis Foundation • Amazing Grace Lutheran Church

SUBSTANCE ABUSE INITIATIVE EXAMPLES:

Rapid Response Team for Psychiatry/Substance Use – Expanded consultative services for Psychiatry and substance abuse to enable timely consultations (inpatient and ED) for patients requiring assessment and complex care planning.

Broadway "911" Center for Substance Abuse – Seen as a model for care across the country, the Broadway Center offers a full complement of addiction counseling and group classes, as well as medications to address opioid addiction (methadone, buprenorphine, and naltrexone).

Buprenorphine Treatment Services - Currently treating over 500 individuals with opiate use disorder using buprenorphine, plans are underway to expand services

Peer Recovery Specialists (PRS) – PRS are utilized in the hospital and community settings to assist clients in finding appropriate resources for SA treatment for long-term stability using their personal experiences of addiction and recovery to create a connection with the clients.

HEALTH NEED 2: BEHAVIORAL HEALTH/ MENTAL HEALTH			
Goal	**Strategies**	**What we are measuring**	**Potential Partner Organizations**
Improve access and coordination to mental health and behavioral health services	**Strategy 1**: Provide psychiatric consults for undocumented and/or uninsured community members.	• # of consults	• East Baltimore Medical Center • Behavioral Health System Baltimore • Baltimore City Health Department • Esperanza Center • Health Care for the Homeless • Chase Brexton Health Care
	Strategy 2: Provide outreach to individuals impacted by social isolation.	• # of people receiving outreach • # of events held in local senior centers by JHH and JHBMC staff	• Govans Ecumenical Development Corporation (GEDCO) • Senior centers • Baltimore City Health Department Community Depression Awareness Program (CDAP) • Adolescent Depression Awareness Program (ADAP)
	Strategy 3: Develop initiatives to improve mental health support and/or strengthen suicide prevention outreach.	• # of schools participating in program • # of children who receive services • # of adults who receive services • # of engagements addressing barriers to care for behavioral health care	• Baltimore City and County School Districts • Head Start Programs • Judy Center at Commodore John Rogers School • Helping Up Mission • Office of Behavioral Health Integration (OBHI)

MENTAL HEALTH INITIATIVE EXAMPLES:

Emergency Department (ED)-based Community Health Workers (CHW) - This service supports patients who could benefit from additional social work assistance after they leave the hospital or ED. The CHWs can help with housing, transportation, food, identification of multi-lingual providers, and other issues (including mental health services) potentially affecting a patient's ability to successfully manage on his/her own.
Bridge to Home - The Bridge to Home program is designed to help patients achieve a safe transition from hospital to home. Focused upon the critical aspects of self-care management, Bridge to Home offers

education about the “four pillars” of care transition, with a special emphasis upon understanding what to do, what to watch for (i.e., “red flags”), who to call, and who to see.

Behavioral Health Intervention Team - The Behavioral Health Consultation Team provides early identification and treatment for patients with behavioral health issues who have been admitted to non-psychiatry floors. The team reviews each day’s admissions and determines whether patients may benefit from some type of intervention, and then makes recommendations for comprehensive treatment plans with post-discharge follow-up and connecting with appropriate community resources.

Caring for the Community – In 2017, the JHH/JHBMC Department of Spiritual Care and Chaplaincy implemented a new social support network program for faith leaders in East Baltimore. Cohorts are limited to 20 participants for the six-week program. In FY23, eight local faith leaders received virtual online training.

Assertive Community Treatment (ACT) – Provides outpatient services to individuals with major mental illness who have repeatedly been hospitalized due to an inability to engage in out-patient care due to the severity of their mental illness.

Grandparents’ Day Celebration Events – A fun and engaging opportunity to celebrate seniors in our communities, by honoring them with a celebratory luncheon, games, music, various health screenings, and giveaways. The hospitals partner with various senior centers in Baltimore City to host these events.

HEALTH NEED 3: DIABETES			
Goal	**Strategies**	**What we are measuring**	**Potential Partner Organizations**
Increase access to and utilization of resources that address obesity and diabetes	**Strategy 1**: Increase physical activity and healthy lifestyle choice education to prevent the onset of Type 2 diabetes among adults and youth.	• # of education and exercise programs • # of participants # of community and school-based partners • Increase in % of healthy BMI measurements in patient visits	• Playworks (Baltimore City Youth Program) • American Heart Association
	Strategy 2: Increase access to the Diabetes Prevention Program (DPP) to people with an elevated BMI and high-risk for developing diabetes and/or Diabetes Self-Management Training (DSMT) and/or the DECIDE (Decision-making Education for Choices in Diabetes Everyday) Program for those with diabetes.	• # of people enrolled, referred, losing weight and/or completing the DPP/DECIDE from local communities • # of people screened at community-based outreach events • # of people initiating, engaged, and retained in DSMT/DECIDE	• Brancati Center • Maryland Health Department • Centro SOL • Esperanza Center • Baltimore Medical System at East Baltimore Medical Center • Highlandtown Healthy Living Center

DIABETES / OBESITY INITIATIVE EXAMPLES:

Diabetic Retinopathy Screening – Wilmer Institute performs free vision screenings for diabetic patients.
Healthy Lifestyle Programming – JHH and JHBMC support many healthy lifestyle programs including neighborhood sports leagues, after school active community programs, senior outreach (e.g. seated yoga) etc.

HEALTH NEED 4: CARDIOVASCULAR DISEASE (CVD)			
Goal	**Strategies**	**What we are measuring**	**Potential Partner Organizations**
Increase the awareness of CVD in the community, the factors contributing to heart disease and connection to care	**Strategy 1: Increase** access to specialty heart failure care and promote health equity in our community.	# of appointments to specialty care at the Heart Failure Bridge Clinic or to follow-up connections with a cardiologist within seven days of discharge	• Baltimore City Health Department • Esperanza Center • Health Care for the Homeless • Chase Brexton Health Care • Baltimore City Health Department
	Strategy 2: Provide blood pressure screenings and education sessions with community partners, senior centers, faith-based orgs and outreach to high-risk patients residing in the community.	• # of "train the trainer" sessions • # of blood pressure screenings and education sessions in community	• Called to Care • Baltimore CONNECT • Center for Urban Environmental Health • Baltimore City Senior Centers

CARDIOVASCULAR DISEASE INITIATIVE EXAMPLES:

Heart Failure Bridge Clinic – The Heart Failure Bridge Clinic helps patients manage their heart failure by providing a smooth transition home from the hospital. The transition combines interdisciplinary care, education, telemedicine and support services to engage patients in their own care.
Scales/Refrigerator Magnets – Scales are provided to high-risk heart failure patients for monitoring daily weights; magnets serve as a visual queue to reinforce self-management strategies.
Blood Pressure Screenings - Screenings are performed at various senior centers, living facilities and events in the community.
Smoking Cessation Education & COPD Screenings – Education and screening sessions are performed at locations and events in the community.

HEALTH NEED 5: CHRONIC DISEASE MANAGEMENT & EDUCATION			
Goal	**Strategies**	**What we are measuring**	**Potential Partner Organizations**
Share clinical expertise with community organizations to prevent, detect, and manage chronic diseases	**Strategy 1:** Increase prevention, care coordination and management of chronic diseases through outreach in partnership with community organizations, congregational health networks and individuals to reach residents via in-person contact and electronic media.	• # of health education/outreach encounters provided to community- based organizations and churches • # of participants in health events and number of screenings performed • # of vision screenings (retinopathy, glaucoma, testing in schools, etc.) • # of support groups / podcasts / programs	• Called to Care • Henderson-Hopkins School • John Ruhrah School • Baltimore CONNECT • Baltimore City Health Department • Centro SOL • Isaiah Wellness Center
	Strategy 2: Ensure high-risk patients with chronic disease receive access to coordinated health and support services, assistance with social determinants, medications, nutrition education and other resources to better manage their disease.	• # of visits Readmission rates • # of nutrition education sessions held with # of participants	• Baltimore City Health Department • Esperanza Center • Health Care for the Homeless • Chase Brexton Health Care • Support for People with Oral and Head and Neck Cancer (SPOHNC) • Debbie's Dream Foundation

CHRONIC DISEASE MANAGEMENT & EDUCATION INITIATIVE EXAMPLES:

After Care Clinic – This pilot program offers bridging care to patients returning to the community. Staff from Social Work, Case Management, Pharmacy, and Home Care screen patients for social determinants and link to services in addition to providing care.

Patient Access Line (PAL) - The Patient Access Line (PAL) is a post-discharge call service designed to help manage the critical transition from hospital to home. The team of experienced Hopkins nurses from a broad range of specialties call patients after they have gone home to review how they are doing and ensure they maintain follow-up appointments. The nurses also assess patients' ability to manage their own care and, where appropriate, engage additional support.

Transition Guides - The Transition Guide (TG) program is designed to support patients returning to the community who may not need or qualify for skilled home care, but who could benefit from additional teaching and assistance after they leave the hospital.
Remote Patient Monitoring – Technology able to transmit clinical data such as weight, BP, blood glucose, incentive spirometry via a wireless network to home care nurses to enable monitoring of patients in their homes.
Virtual Support Groups/Podcasts/Social Outreach – The COVID-19 response enabled the development of a new line of community support through more focused and sophisticated virtual health education and management services. Online (zoom) based support groups can provide companionship and socialization for community members with limited mobility from chronic conditions. Studies have shown reductions in readmissions

Note: For more information on community benefit programs and support please see the annual Community Benefit Report for each hospital available at https://gce.jhu.edu/community-benefit-reporting-cbr/ or contact the Johns Hopkins Office of Government, Community, and Economic Partnerships (GCE) at gce@jhu.edu .

Appendix A: Primary Data

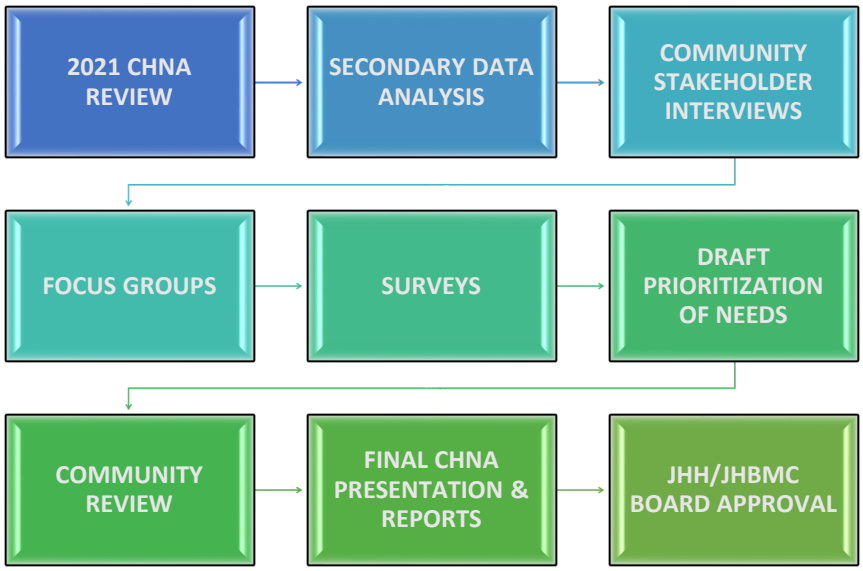
Process Overview

A comprehensive community-wide CHNA process was completed for The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC), connecting public and private organizations, such as health and human services entities, government officials, faith-based organizations, and educational institutions to evaluate the needs of the community. The 2024 assessment included primary and secondary data collection that incorporated public commentary, community stakeholder interviews, a resident survey, and focus groups.

Collected primary and secondary data led to the identification of key community health needs in the region. Johns Hopkins leadership will develop an Implementation Strategy that will highlight, discuss, and identify ways the health system will meet the needs of the communities they serve. The CHNA was approved by the JHBMC Board of Trustees on May 21,2024 and the JHH Board of Trustees on June 3, 2024. The Implementation Strategy will be approved by each board before the November 2024 IRS deadline.

As shown in Chart 26, the process of each project component in the CHNA is outlined.

Chart 26: CHNA Process



Previous CHNA Review (2021)

As part of the CHNA, The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center performed a public review on the methods, findings, and subsequent actions taken as a result of the previous CHNA and planning process. The 2021 CHNA process for JHH and JHBMC included the collection and analysis of primary and secondary data. Both public and private organizations, such as faith-based organizations, government agencies, educational systems, and health and human services entities were engaged to assess the needs of

the community. In total, the extensive primary data collection phase resulted in more than 1,700 responses from community stakeholders/leaders and community residents.

The JHH/JHBMC FY2021 CHNA Implementation Strategy addresses community identified direct health needs and SDoH areas including mental health, substance use, diabetes, cardiovascular disease, chronic disease management and health education, access to care and support, housing, neighborhood safety, job opportunities, and healthy food environment. Although the COVID-19 pandemic provided new challenges to in-person community programming, JHH and JHBMC continued to address the identified needs through over 250 community benefit activities including quickly transitioning a paid summer student intern program to a virtual platform for the summer 2020 session to avoid cancelling during the COVID lock down which would result in a loss of income for over 300 Baltimore students. Other JHH and JHBMC programs that addressed community needs identified in the 2021 CHNA included but were not limited to, comprehensive SDoH screenings, a food access program providing over a million meals to East Baltimore residents over three years, the launch of a new violence intervention program, a housing project with other Baltimore hospitals and public and private city partnership to provide housing and wrap-around services to homeless persons or those at-risk of becoming homeless and supporting a longtime supportive housing organization partner by providing over 18,000 bed nights to 280 individuals in treatment for substance use. JHH and JHBMC continue to support and collaborate with over 100 community organizations to deliver direct health services to community members based on the CHNA identified needs.

Community Stakeholder Interviews

Between October 2023 and March 2024, 57 individual community stakeholders were interviewed to better understand the changing health environment in East Baltimore. A complete list of interview participants appears in Appendix D.

The interview participants represented the broad interests of the community from a wide variety of professional backgrounds including: 1) public health expertise; 2) professionals with access to community health-related data; 3) representatives of underserved populations; 4) social services providers and leaders and members of a diverse group of community-based organizations and agencies. Chart 27 below, shows the wide spectrum of interests and expertise of participants who provided information and insights and based on their observations and experiences. The interviews offered community stakeholders an opportunity to provide feedback on the needs of the community, secondary data resources, and other information relevant to the study.

Chart 27: Interview participants

Each interview was conducted by Johns Hopkins, Community Health Investment staff and was approximately 30 to 60 minutes in duration. The interviews provided a platform for stakeholders to identify health issues and concerns affecting residents in their service area, as well as ways to address those concerns.

The qualitative data collected from community stakeholders are the opinions, perceptions, and insights of those who were interviewed as part of the CHNA process.

The common themes from the stakeholder interviews were (in no particular order):

- Access to Care – There are many barriers to receiving care for East Baltimore residents including a shortage of primary care and mental health providers, long wait times for appointments, lack of transportation and/or childcare services, discrimination, lack of employment or ability to pay for services, inability to navigate the health care system due to language challenges and complexity, etc.
- Mental Health and Substance Use – The need for more care, support and interventions for those suffering with behavioral health challenges
- Environment - crime/safety issues, the economy, housing, education and job training, employment availability, parks/recreation and systematic racism
- Chronic Disease Management and Health Education – diabetes, cardiovascular disease, obesity, cancer and other chronic diseases and conditions.
- Violence and Neighborhood Safety Interventions
- Social Isolation – even more important in th wake of the COVID-19 pandemic

Key suggestions (in no particular order):

- Transportation services and lower co-pays to assist with access issues

- Provide more health education information in hard copy and distribute to community partners. Include how to know when to go to a doctor, how to find a doctor and make an appointment etc.
- Increase Neighborhood Navigators and Community Health Workers (community based)
- School-based services (health clinics, social workers, mental health, full time nurse practitioners)
- Jobs with good pay/living wages
- Affordable and safe quality housing (including quality affordable rental properties - free of lead paint, mold, rodents, pests, in safe areas of the city)
- Access to healthy foods
- Replace vacant houses with community gardens
- Internal hospital community engagement training – learn how to welcome community members beyond taking some training on cultural competency or trauma informed care
- Free screenings at the hospital and in the community

Focus Groups

Between October and November 2023, Johns Hopkins facilitated eight focus groups with East Baltimore residents and leaders representing some of the most vulnerable populations. Johns Hopkins worked closely with community-based organizations and their representatives to schedule, recruit and facilitate focus groups within each of the at-risk communities. Several focus groups provided a cash incentive for participation. Table 9 below lists the focus group audiences and host community organization for each session.

Additionally, the Baltimore City coalition of hospitals conducted 25 other city-wide focus groups with participation from key leaders, non-profit partners, patients and community members. In total, over 300 people participated in the 33 Baltimore CHNA focus groups. The input from all groups was shared amongst the coalition hospitals for inclusion consideration in individual CHNAs.

The common themes from the focus group audiences were (in alphabetical order)

- Access to care - insurance coverage, lack of doctors, extreme wait times, mistrust of doctors, unable to navigate health care systems, etc.
- Chronic diseases
- Crime and safety
- Employment / job training
- Food environment
- Housing
- Isolation / loneliness
- Mental health / trauma
- Obesity
- Poverty

- Racism / discrimination
- Substance abuse
- Transportation

Table 9: East Baltimore Focus Group Audiences and host organization partners

FOCUS GROUP AUDIENCE:	HOST ORGANIZATION
Youth aged 18 -24	Eastside Yo!
Active substance users	Charm City Care Connection
Homeless women in supportive housing	Helping Up Mission
Seniors	Victory Village Senior Center
Latinos/Spanish-speaking	Esperanza Center
Latinos/Spanish-speaking group 1 of 2	CASA de Maryland
Latinos/Spanish-speaking group 2 of 2	CASA de Maryland
Faith-based leaders	Johns Hopkins Community Engagement

The following list of 33 focus group partners represents the total sessions convened for the Baltimore CHNA by members of the Baltimore Hospital Coalition and Baltimore City Health Department. These focus groups were conducted virtually, hybrid or in-person in October and November 2023. These groups included representation from key leaders, non-profit partners, patients and community members, and totaled more than 300 participants.

Baltimore City CHNA Focus Group Community partners

- Anchor Group
- Baltimore Medical System Case Managers
- BCHD HIV Services and Ryan White (two focus groups)
- BCHD Youth Advisory Council and Youth Ambassadors
- B'More for Healthy Babies
- CASA de Maryland (two focus groups)
- Catholic Charities' Esperanza Center
- Charm City Care Connection
- Druid Hill YMCA
- East Baltimore Faith Leaders
- Eastside Yo! (Historic East Baltimore Community Action Coalition)
- Health Care Access Maryland
- Health Care for the Homeless
- Healthy Start Father's Group
- Helping Up Mission
- J Van Story Branch Apartments
- MedStar Fetal Assessment Center
- Morgan State University's Nutrition in the Community Class

- Northeastern Community Organization
- Senior Network of North Baltimore
- Sinai Hospital Diabetes patients
- Sinai Hospital HIV Clinic patients
- Sinai Hospital Families with Children
- St. Agnes Community Council
- St. Agnes Patient Family Advisory Council
- The Mayor's Commission on Aging and Retirement Education
- UMMC Chronic Disease patients
- UMMC Cancer patients
- UMMC Community Engagement Committee
- Victory Village Senior Center
- Zeta Senior Center

Surveys

As part of a city-wide effort, Baltimore City hospitals and the Baltimore City Health Department collectively developed a survey in order to identify health risk factors and health needs in the community. The survey was similar to the 2021 instrument but it required a significant increase in responders' time due to the expanded scope and number of questions included in the 2024 edition. The survey was distributed by the hospitals through community-based organizations, community associations, faith-based organizations, local elected officials, FQHCs/clinics, blood drives, local shelters and social services providers. The survey was available in English and Spanish either online or in paper format.

Various social media avenues were utilized to solicit participation, including a targeted Facebook campaign to East Baltimore City residents, dedicated informational pages on the web sites of Johns Hopkins Medicine, Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC), along with an employee notice on the JHH digital information screens throughout the hospital.

Several community-based organizations assisted with paper surveys that were collected and entered into the online tool. Engagement of local community organizations was vital in the distribution process to vulnerable populations in the city. The information collected via the paper surveys ensured that some of the most vulnerable populations in East Baltimore were heard (non-English speakers, homeless persons in temporary housing and substance users, etc.)

In total, 2,282 surveys were collected. There were 653 surveys representing residents in the JHH/JHBMC CBSA that were used for analysis. Sixty-eight percent of survey respondents were female; two thirds of the respondents were under 50, sixteen percent were 60+; 35 percent identified as Black/African American, and 39 percent identified as Hispanic/Latino. Eleven percent of all surveys were completed in Spanish.

The information below represents key findings collected from the survey. Respondents were told to skip any question they did not want to answer. The percentages referenced below are based on the total number of respondents since respondents were able to choose more than one answer for several questions, including their top health and social concerns and reasons why they do not get health care.

Key Findings:

- Drug and alcohol addiction (54 percent), mental health/depression/anxiety (46 percent), diabetes/high blood sugar (38 percent), violence (31.9 percent), high blood pressure (30.2 percent), smoking/vaping/tobacco use (22.1 percent) and overweight/obesity (21.9 percent) were the top health concerns reported by survey respondents. Although the percentages changed, the order of concerns were roughly the same as during the last survey.
- The top social concerns were the lack of job opportunities (33.5 percent), no or limited access to health insurance (30.8 percent), poverty (30.2 percent), housing/homelessness (27.7 percent), discrimination (27.6 percent), poor neighborhood safety (26.8 percent), can't afford healthy foods (25.4 percent), gun violence (25 percent) and limited access to healthy foods (20.5 percent). These concerns took a significantly different order than during the last survey and discrimination didn't make the top responses in 2021.
- More than half of survey respondents (up from twenty-two percent in the last survey) indicated that within the past 30 days, they had a number of days when their mental health was not good. Over sixteen percent of people said they experienced 16 or more days of poor mental health including stress, depression and problems with emotions.
- Almost half of survey respondents indicated that within the past 30 days, they had a number of days when their physical health was not good. More than twelve percent of people said they experienced 16 or more days of poor physical health.
- Only sixty-two percent of respondents indicated they had health insurance coverage, a substantial decrease from the 2021 survey where eighty-five percent of respondents had health insurance. This number was impacted significantly by the Hispanic/Latino respondents who completed the survey, 76 percent of which did not have insurance coverage.
- The main reasons people in the community do not get health care are that it's too expensive (65.8 percent), no insurance (52.5 percent), lack of transportation (28.5 percent), not able to take time off work (27 percent), no appointments available or the wait is too long (26 percent), don't have a provider (23.9 percent) and language barriers (22.8 percent). These reasons remain relatively unchanged from the last survey.
- Eighty-two percent of people said they use digital applications without the need for assistance and sixty-six percent said they were willing to participate in telehealth services.
- The final question on the survey asked for any ideas or suggestions to improve health in the respondent's community. There were many comments referring to the long wait times in the emergency room. Additional comments and suggestions:
    - Clear information and access to services
    - Free basic preventative health care, low copays and prescriptions
    - Community health education starting in elementary schools
    - Help getting insurance
    - Funding of mental health resources
    - Transportation assistance
    - Free dental and eye care
    - Laboratory services in the same health center where treatment is provided

- Help with the cost of medications
- More clinics with Latino providers
- Raising awareness and eliminating discrimination and barriers to seeking care for Hispanic/Latino community members
- Having good interpreters and advocates available to be able to understand the doctor's instructions and follow-up needed.

Provider Resource Inventory

An inventory of programs and services available in the region was developed in 2016 and is updated regularly as appropriate. The provider inventory highlights available programs and services within the JHH/JHBMC CBSA. The inventory identifies the range of organizations and agencies in the community that are serving the various target populations within each of the priority needs. The inventory provides program descriptions and collects information about the potential for coordinating community activities and creating linkages among agencies.

An interactive link of the provider resource inventory is available on JHH's and JHBMC's website.

https://www.hopkinsmedicine.org/about/community_health/johns-hopkins-hospital/community_health_needs_assessment.html

https://www.hopkinsmedicine.org/about/community_health/johns-hopkins-bayview/health_needs_initiatives/community_health_needs_assessment.html

Prioritization of Needs

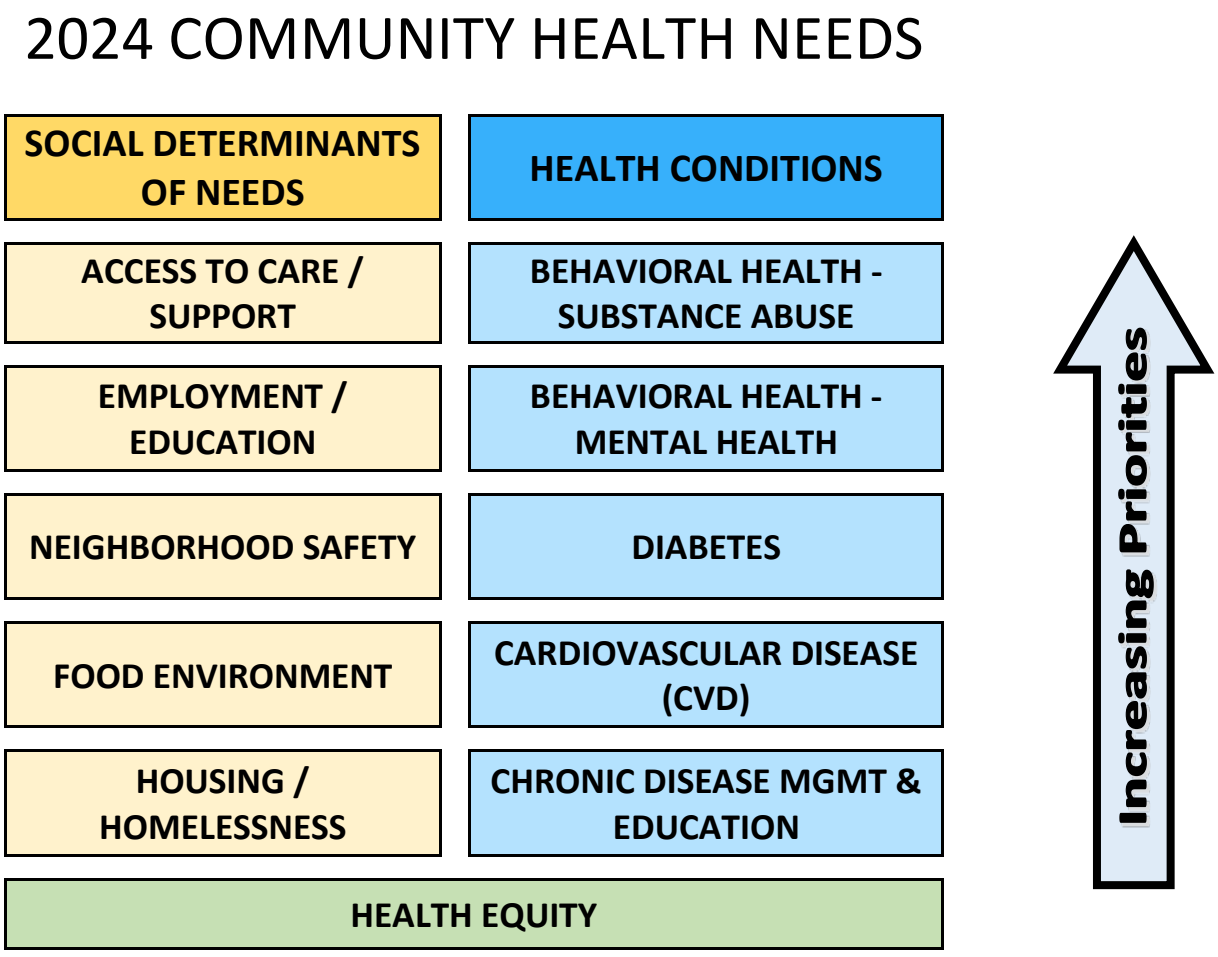
Based upon feedback and input from hospital leadership, community stakeholders, community residents, project leadership and extensive primary and secondary data research, ten CBSA needs were identified. To finalize the prioritization within the list, community partners affiliated with Baltimore CONNECT, a coalition of over 30 East Baltimore community organizations, were asked to review the process, the findings and participate in the prioritization. During the review and discussion session the community participants ensured an appropriately diverse group of residents from the CBSA contributed and were represented from the perspective of demographics and location of residence. The group was also asked to identify any oversights or weaknesses in the process. Their final review resulted in the list of needs as presented, shown below in Chart 28. For the first time Health Equity is specifically noted as the foundation through which the critical needs in East Baltimore must be viewed. It is presented graphically as a bar spanning and supporting the list containing the individual priorities.

The key community needs are grouped into broader areas (i.e., social determinants of health needs and health conditions). Please note that some of the CHNA community-identified needs encompass more than one commonly defined health or social need. For example, "Access to Care and Support" is a very large category encompassing all barriers to care that were identified by community participants. This includes, but is not limited to, shortage of physicians, difficulty making appointments, extreme wait times, discrimination, mistrust of doctors, lack of transportation and childcare services and/or not having health insurance or being underinsured. "Chronic Disease" not only includes health conditions such as cancer, arthritis, asthma, and oral health, but also health education and literacy to manage chronic health issues and promote general

health and wellbeing. Also, “Employment and Education” includes job training, formal education and lifelong learning, which are essential to gainful employment with living wages and advancement opportunities. Likewise, food environment includes access to healthy foods and nutrition education which could overlap with similar initiatives focused specifically on diabetes prevention and management. In the 2024 CHNA, diabetes and cardiovascular disease were again identified at a much higher priority than other chronic diseases. Therefore, they have been presented in independent and distinct categories. All identified key community needs are addressed either directly through designation as a prioritized key community need or incorporated as a component of a prioritized key community need.

The key need areas from the 2024 CHNA are depicted in the chart below (See Chart 28).

Chart 28: JHH/JHBMC Prioritized Key Community Health Needs



Implementation Planning

Based on the primary and secondary data collected and analyzed during the CHNA process, and the resulting prioritized list of community needs, JHH and JHBMC will begin developing an Implementation Strategy to address the concerns and priorities identified by community members and representatives. Although some of the focus areas have changed in their order of priority from the 2021 report per community feedback, the overall needs remain relatively the same as those reported previously. In the 2024 report, access to care and support escalated to the top concern among social determinants of needs for the first time. Job opportunities and neighborhood safety remained in the top three. As in every CHNA before, behavioral health (substance use and mental health) are the top direct health priorities.

Johns Hopkins is engaged in hundreds of programs addressing the identified needs in their surrounding communities. The hospitals work to strategically allocate scarce resources to best serve the communities, increase trust and build stronger community partnerships. The Implementation Strategy is the action plan component of the CHNA that guides strategic planning on community engagement.

Board of Trustees Approval

The 2024 Community Health Needs Assessment was presented to the Board of Trustees of The Johns Hopkins Hospital on June 3, 2024 and the Board of Trustees of Johns Hopkins Bayview Medical Center on May 21,2024 for approval and adoption.

Appendix B: Secondary Data Profile

Secondary Data Profile

Johns Hopkins collected and analyzed secondary data from multiple sources, including Baltimore City Health Department, Community Commons, County Health Rankings, Maryland Department of Health and Human Services, Governor's Office on Crime Control and Prevention, Neighborhood Health Profiles, Substance Abuse and Mental Health Services Administration, The Annie E. Casey Foundation and The Centers for Disease Control and Prevention (CDC), as well as other sources.

The secondary data profile includes information from multiple health, social and demographics sources utilized during the previous CHNAs and updated with current data from sources as available. The secondary data sources were used to compile information related to disease prevalence, socioeconomic factors and behavioral habits. Where applicable, data were benchmarked against state and national trends. ZIP code analysis was also completed to illustrate community health needs at the local level.

A robust secondary data report was compiled for JHH and JHBMC; select information collected from the report has been presented throughout the CHNA. Data specifically related to the identified needs were used to support the key health needs.

The Community Need Index (CNI) was obtained for the CHNA through Dignity Health and used to quantify the severity of health disparities for ZIP codes in The Johns Hopkins Hospital's and Johns Hopkins Bayview Medical Center's community benefit service area (CBSA). CNI considers multiple factors that are known to limit health care access. The tool is useful in identifying and addressing the disproportionate and unmet health-related needs of neighborhoods. The five prominent socioeconomic barriers to community health quantified in the CNI are income barriers, cultural/language barriers, educational barriers, insurance barriers and housing barriers.

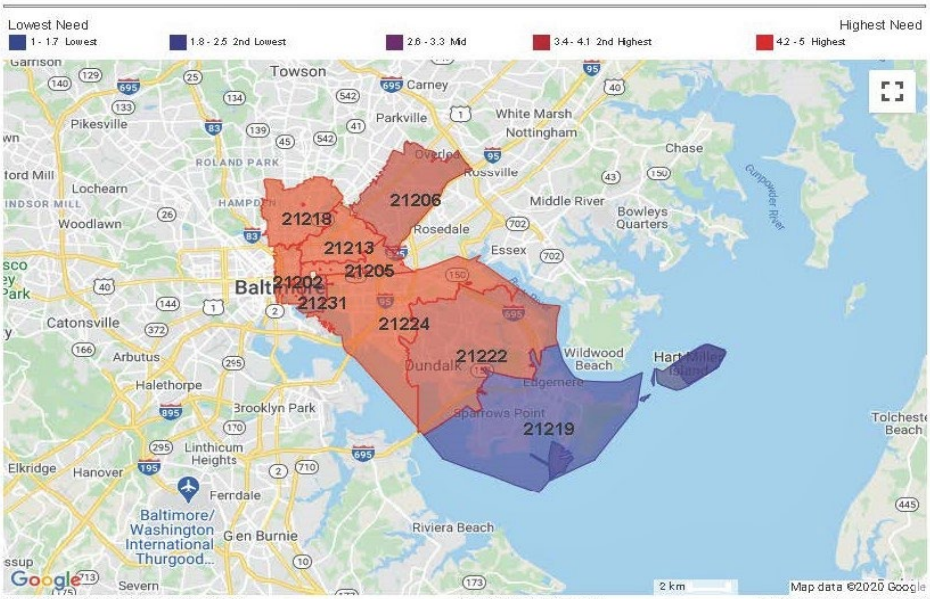
Dignity Health: Community Needs Index (CNI) Overview

Dignity Health and IBM Watson Health™ jointly developed a Community Need Index (CNI) in 2004 to assist in the process of gathering vital socioeconomic factors in the community. The CNI is strongly linked to variations in community health care needs and is a strong indicator of a community's demand for various health care services.

Based on a wide array of demographic and economic statistics, the CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need compared to the US national average (score of 3.0). The CNI is strongly linked to variations in community health care needs and is a good indicator of a community's demand for a range of health care services. Not-for-profit and community-based hospitals, for whom community need is central to the mission of service, are often challenged to prioritize and effectively distribute hospital resources. The CNI can be used to help them identify specific initiatives best designed to address the health disparities of a given community.

Map 12: Overall Community Benefits Service Area – 2020 Study Area CNI Map

Dignity Health.



Mean(zipcode): 4.1 / Mean(person): 4.2 CNI Score Median: 4.4 CNI Score Mode: 4, 4.4, 4.8

Zip Code	CNI Score	Population	City	County	State
21202	4.8	23893	Baltimore	Baltimore City, Md	Maryland
21205	4.8	15131	Baltimore	Baltimore City, Md	Maryland
21206	4	48203	Baltimore	Baltimore City, Md	Maryland
21213	4.8	30318	Baltimore	Baltimore City, Md	Maryland
21218	4.4	46813	Baltimore	Baltimore City, Md	Maryland
21219	2.4	9353	Sparrows Point	Baltimore	Maryland
21222	3.6	55968	Dundalk	Baltimore	Maryland
21224	4.4	49506	Baltimore	Baltimore City, Md	Maryland
21231	4	15984	Baltimore	Baltimore City, Md	Maryland

TRUVEN HEALTH ANALYTICS

Table 10: Community Needs Index Summary Trend by ZIP code 2014-2020

ZIP	County	City	2020 Population	% Population Increase/ (Decrease)	2014 CNI Score	2015 CNI Score	2017 CNI Score	2020 CNI Score	Increase/ (Decrease) 2017 to 2020
21202	Baltimore City	Baltimore	23,893	-2.8%	5.0	5.0	4.8	**4.8**	**0.0**
21205	Baltimore City	Baltimore	15,131	-5.3%	5.0	5.0	4.8	**4.8**	**0.0**
21206	Baltimore City / County	Baltimore	48,203	-4.2%	3.8	4.0	3.6	**4.0**	**0.4**
21213	Baltimore City	Baltimore	30,318	-4.7%	4.6	4.8	4.8	**4.8**	**0.0**
21218	Baltimore City	Baltimore	46,813	-4.4%	4.4	4.4	4.2	**4.4**	**0.2**
21219	Baltimore County	Sparrows Point	9,353	-3.9%	2.6	2.6	2.8	**2.4**	**-0.4**
21222	Baltimore City / County	Dundalk	55,968	-2.0%	3.6	3.4	3.6	**3.6**	**0.0**
21224	Baltimore City / County	Baltimore	49,506	-2.8%	4.6	4.6	4.4	**4.4**	**0.0**
21231	Baltimore City	Baltimore	15,984	-2.7%	4.8	4.6	4.2	**4.0**	**-0.2**
Overall Study Area			295,169	-3.5%	**4.2**	**4.3**	**4.1**	**4.1**	-
Baltimore City							**4.1**	**3.7**	
Baltimore County							**2.3**	**2.9**	

As shown in Table 10, the CNI analysis for the CBSA encompassed nine ZIP codes in the 2020 CHNA study. They include 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224 and 21231. Of the nine ZIP codes in The JHH and JHBMC study area:

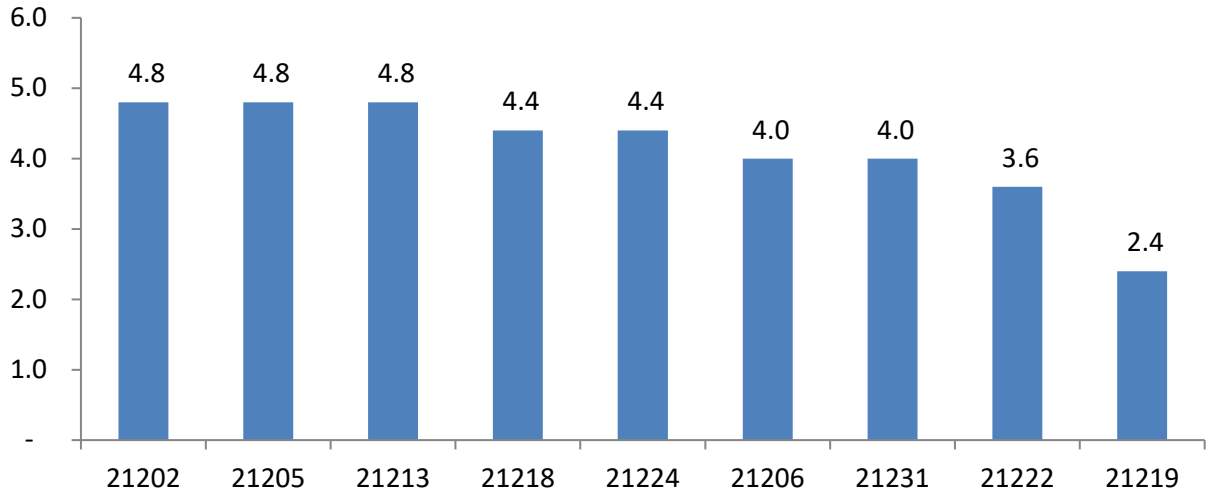
- CNI scores in green indicate a positive change in scores, showing a decrease in score from 2017 to 2020. Only 21219 and 21231 saw declines in CNI scores (reduced barriers to health care.)
- CNI scores in red indicate a negative change in scores, showing an increase in score from 2017 to 2020. ZIP codes 21206 and 21218 experienced rises in CNI scores (increased barriers to health care.)
- Five ZIP codes showed no improvement or degradation in score since 2017.

The CNI score for the CBSA in 2014 was 4.2, 2015 was 4.3, 2017 was 4.1 and 2020 was 4.1. While the CNI increased by +0.1 from 2014 to 2015, the CNI decreased in subsequent years to 4.1, indicating that the overall CBSA faces fewer barriers to accessing care. Even though the CBSA CNI has improved during this period, it is well behind the CNI of the overall city at 3.7 and Baltimore County at 2.9.

At the ZIP code level, the highest CNI score in the study area is 4.8 for the ZIP codes of 21202, 21205 and 21213. This indicates that these ZIP codes have the most barriers to accessing health care when compared to other ZIP codes in the study area.

The lowest CNI score in the study area was 2.4 in ZIP code 21219 (Sparrows Point). This ZIP code has the least barriers to health care access in the study area, but this does not imply that this area requires no attention. The median income for this ZIP code as shown previously in Chart 9 (pg 26) is $87,174, which is the highest in the CBSA. By comparison, the median income for 21205 was only $31,949.

Chart 29: Community Needs Index Overall Study Area Summary



Source: Dignity Health 2020

BALTIMORE CITY HEALTH DEPARTMENT (BCHD) - CHNA SECONDARY DATA COMPARISONS (2024)

Description of Focus Area Comparisons

When viewing the secondary data summary tables, please note that the following color shadings have been included to identify how Baltimore City compares to Maryland and the national benchmark. If both statewide Maryland and national data was available, Maryland data was preferentially used as the target/benchmark value.

Table11: BCHD CHNA Data Summary

Secondary Data Summary Table Color Comparisons

Color Shading	Priority Level	Baltimore City Description
	Low	Represents measures in which Baltimore City scores are **more than five percent better** than the most applicable target/benchmark and for which a low priority level was assigned.

	Medium	Represents measures in which Baltimore City scores are comparable to the most applicable target/benchmark scoring **within or equal to five percent**, and for which a medium priority level was assigned.
	High	Represents measures in which Baltimore City scores are **more than five percent worse** than the most applicable target/benchmark and for which a high priority level was assigned.

Note: Please see the methodology section of this report for more information on assigning need levels to the secondary data.

Please note that to categorize each metric in this manner and identify the priority level, the Baltimore City value was compared to the benchmark by calculating the percentage difference between the values, relative to the benchmark value:

(Baltimore Value – Benchmark Value)/(Benchmark) x 100 = % Difference Used to Identify Priority Level

For example, for the % Children Receiving Dental Care metric, the following calculation was completed:

(50.8-56.3)/(56.3) x 100% = -9.77% = Displayed as **High Priority Level**, Shaded in Red

This metric indicates that the percentage of children with access to dental care in Baltimore City is 9.8 percent worse than the percentage of children with access to dental care in the state of Maryland.

BCHD Report A4 Tables - Detailed Focus Area Benchmarks

Table A4.1: Access to Care

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Uninsured	10.0%	6.7%	5.9%	2021	Medium
Primary Care Physicians Ratio	1,310:1	1.133:1	804:1	2020	Low
Dentist Ratio	1,380:1	1,258:1	1,206:1	2021	Medium
Other Primary Care Provider Ratio	810:1	775:1	316:1	2022	Low
Children receiving dental care	N/A	56.3%	50.8%	2021	High
ED visits due to addiction-related conditions	N/A	2,017	1,689	2017	Low
ED visits due to asthma	N/A	68.4	68.0	2017	Medium
ED visits due to diabetes	N/A	243.7	224.6	2017	Low
ED visits due to hypertension	N/A	351.2	340.7	2017	Medium

ED visits due to dental care	N/A	362.7	281.1	2017	Low
Persons with usual primary care provider	N/A	87.3%	85.3%	2021	Medium
Uninsured ED visits	N/A	8.6	7.9	2017	Low

Table A4.2: Built Environment

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Food Environment Index	7.0	8.7	7.5	2019/2020	High
% with Access to Exercise Opportunities	84.0%	92.0%	98.8%	2020/2022	Low
Broadband Access	87.0%	90.0%	80.0%	2017-2021	High

Table A4.3: Diet and Exercise

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Physically Inactive	22.0%	20.6%	25.3%	2020	High

Table A4.4: Education

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Students entering kindergarten ready to learn	N/A	45.0%	47.0%	2017	Medium
School segregation	0.25	0.26	0.29	2021-2022	High
School funding adequacy	1,062	724	-7,285	2020	High

Table A4.5: Employment

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Unemployed	5.4%	3.8%	5.7%	2023	High

Table A4.6: Environmental Quality

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Average Daily PM2.5	7.4	7.4	8.6	2019	High

Table A4.7: Family, Community and Social Support

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Children in Single-Parent Households	25.0%	26.2%	49.2%	2017-2021	High
Social Association Rate	9.1	8.9	10.0	2020	Low
% Disconnected Youth	7.0%	6.0%	10.1%	2017-2021	High
Segregation Index – Black/White	63.0	63.5	67.6	2017-2021	High
% Not Proficient in English	14.0%	3.0%	1.6%	2017-2021	Low
Childcare Cost Burden	27.0%	22.0%	39.0%	2021/2022	High
Childcare Centers	7.0	6.0	6.0	2010-2022	Medium

Table A4.8: Food Security

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Food Insecure	12.0%	9.0%	15.5%	2020	High
% Limited Access to Health Foods	6.0%	3.6%	1.8%	2019	Low
% Eligible for Free or Reduced Lunch	53.0%	45.0%	66.1%	2020-2021	High
% Households with Children Receiving Public Assistance	24.4%	21.2%	47.7%	2020	High
Food Insecurity: Middle Schoolers	N/A	27.5%	41.8%	2021-2022	High
Food Insecurity: Middle Schoolers	N/A	27.5%	43.9%	2021-2022	High

Table A4.9: Housing and Homelessness

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Severe Housing Problems	17.0%	15.7%	21.4%	2015-2019	High
% Homeowners	65.0%	67.3%	47.9%	2017-2021	High
% Severe Housing Cost Burden	14.0%	14.0%	20.0%	2017-2021	High
% Affordable Housing	N/A	48.1%	91.9%	2016	Low

Table A4.10: Income

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Children in Poverty	17.0%	14.0%	33.8%	2021	High
Median Household Income	$69,700	$93,432	$55,224	2023	High

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Income Inequality	4.9	4.5	6.2	2017-2021	High
% Living in Poverty	12.8%	10.3%	23.0%	2017-2021	High
ALICE Households	28%	29%	53%	2021	High
Gender Pay Gap	0.81	0.87	0.93	2017-2021	Low

Table A4.11: Length of Life

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Years of Potential Life Lost Rate	7,300	7,547	14,844.8	2018-2020	High
Premature Age-Adjusted Mortality	360	360	683.6	2018-2020	High
Life Expectancy	78.5	78.6	71.8	2018-2020	High
Child Mortality Rate	50.0	48.5	90.0	2017-2020	High

Table A4.12: Maternal and Infant Health

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Low Birthweight	8.0%	8.7%	11.9%	2014-2020	High
Infant Mortality Rate	6.0	6.3	9.1	2014-2020	High

Table A4.13: Mental Health

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Mental Health Provider Ratio	340:1	315:1	170:1	2022	Low
Average No. of Mentally Unhealthy Days	4.4	4.1	5.4	2020	High
% Frequent Mental Distress	14.0%	12.7%	16.2%	2020	High
ED visits due to mental health conditions	N/A	4,291.5	4,210.1	2017	Medium
Hospitalization rate due to Alzheimer's or other dementias	N/A	515.5	559.0	2017	High

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Visited Mental Health Provider	N/A	4.7%	5.2%	2023	High
% Used Prescription Antidepressant Medications	N/A	6.7%	7.0%	2023	High
% Used Prescription Antianxiety Medications	N/A	7.6%	7.8%	2023	Medium
Depression rate	20.5%	16.6%	20.7%	2022	High
Suicide death rate	14.0	10.0	8.8	2016-2020	Low

Table A4.14: Physical Health

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Adults with Obesity	32.0%	30.9%	37.4%	2020	High
% Adults with Diabetes	9.0%	9.1%	13.4%	2020	High
% Frequent Physical Distress	9.0%	6.8%	10.1%	2020	High
% Insufficient Sleep	33.0%	34.1%	39.8%	2020	High
% Fair or Poor Health	12.0%	10.6%	39.8%	2020	High
Avg. No. of Physically Unhealthy Days	3.0	2.5	3.3	2020	High
Adolescents who are obese	N/A	15.9%	23.2%	2016	High
Adults who are not overweight or obese (%)	N/A	33.4%	33.9%	2021	Low
Age-Adjusted Death Rate from Heart Disease	N/A	163.3	226.7	2018-2020	High
Cancer Mortality Rate	N/A	145.5	187.9	2018-2020	High
Sudden unexpected infant death rate	N/A	0.8	2.0	2016-2020	High

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Age-adjusted Death Rate due to Stroke	38.8	42.5	55.9	2020	High

Table A4.15: Quality of Care

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Children/adults vaccinated annually against seasonal influenza	51.0%	55.0%	51.0%	2020	High
Mammography screening	37.0%	37.0%	36.0%	2020	Medium
Preventable hospital stays	28.1	26.5	40.9	2020	High
Children receiving blood lead screening	N/A	67.1	65.9%	2021	Medium
Children with elevated blood lead levels	N/A	0.2	0.2%	2020	Medium
Early prenatal care	N/A	70.2%	67.1%	2020	Medium

Table A4.16: Safety

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Firearm fatalities	12.0	12.3	43.7	2019	High
Homicides	6.0	9.1	43.2	2016-2020	High
Injury mortality	76.0	88.3	200.2	2016-2020	High
Juvenile arrests	24.0	27.1	25.3	2022	Low
Motor vehicle crash deaths	12.0	8.9	9.5	2014-2020	High
Child maltreatment rate	N/A	4.6	10.3	2018-2020	High
Domestic Violence	N/A	568.6	1,112.9	2020	High
Fall-related death rate	N/A	10.6	13.0	2017	High
Pedestrian injury rate on public roads	N/A	53.5	54.4	2020	Medium

Table A4.17: Sexual Health

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Teen Birth Rate	19.0	15.2	32.2	2014-2020	High
HIV Prevalence Rate	380.0	655.4	1,984.7	2020	High
HIV Incidence Rate	N/A	15.0	32.8	2021	High
Chlamydia Rate	481.3	535.9	1,181.8	2020	High

Table A4.18: Substance Use Disorders

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Drug Overdose Mortality Rate	23.0	41.1	123.7	2018-2020	High
% Excessive Drinking	19.0%	14.6%	17.9%	2020	High
% Driving Deaths with Alcohol	27.0%	28.3%	20.3%	2016-2020	Low
Opioid prescriptions dispensed	43.3	39.5	68.6	2020	High

Table A4.19: Tobacco Use

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
% Smokers	16.0%	11.1%	19.2%	2020	High
Adolescents who use tobacco products	N/A	14.4%	16.5%	2016	High

Table A4.20: Transportation Options and Transit

Measure	National Benchmark	Maryland Benchmark	Baltimore City Data	Most Recent Data Year	Baltimore City Need
Traffic Volume	505.0	695.2	1,443.3	2019	High
% Drive Alone to Work	73.0%	69.8%	42.9%	2017-2021	Low
% Long Commute – Drives Alone	37.0%	49.6%	58.2%	2017-2021	Low
% Car Ownership	N/A	89.8%	81.9%	2023	High
Mass Transit Spending	N/A	102.6	99.7	2023	Medium

Table 12: The table below include summaries of potential priority need areas, as identified by the secondary data analysis process, as well as priority areas of need identified by other state, local and national sources.

Priority Area	Secondary Data Findings	Mercy Medical 2021	MedStar Health 2021	Kennedy Krieger 2022	Sheppard Pratt 2022	Alive! Maryland 2022	Baltimore Medical 2020	Healthy People 2030
Social Determinants of Health	✓	✓	✓	✓	✓	✓	✓	✓
Access to Health Care	✓	✓	✓	✓	✓	✓	✓	✓
Mental Health and Behavioral Health/ Wellness	✓	✓	✓	✓	✓	✓	✓	
Health Equity		✓	✓	✓		✓	✓	✓
Substance Use	✓	✓	✓		✓		✓	
Health Literacy and Communication		✓	✓	✓	✓	✓	✓	✓
Specialty Care		✓	✓	✓		✓		
Childhood Support	✓	✓		✓			✓	
Chronic Disease	✓	✓	✓				✓	
Sexual Health	✓	✓				✓	✓	
Primary Care		✓	✓			✓	✓	
Obesity/Diabetes/Fitness/Nutrition	✓		✓				✓	
Staffing Support				✓	✓	✓		
Infant and Maternal Health	✓	✓					✓	

Appendix C: General Description of Johns Hopkins Medicine, The Johns Hopkins Hospital, and Johns Hopkins Bayview Medical Center

Johns Hopkins Medicine (JHM), headquartered in Baltimore, Maryland is an integrated global health enterprise and one of the leading health care systems in the United States. Johns Hopkins Medicine has six academic and community hospitals, four suburban health care and surgery centers, over 40 patient care locations, a home care group, and an international division, and it offers an array of health care services.

JHM's vision, "Together, we will deliver the promise of medicine," is supported by its mission to improve the health of the community and the world by setting the standard of excellence in medical education, research, and clinical care. Diverse and inclusive, JHM educates medical students, scientists, health care professionals and the public; conducts biomedical research, and provides patient-centered medicine to prevent, diagnose, and treat human illness.

Opened in 1889, The Johns Hopkins Hospital (JHH) has been consistently ranked by U.S. News & World Report as one of the top hospitals in the nation. JHH is a premier medical facility serving the health care needs of the greater Baltimore community, those in Maryland, nationally, and internationally. Training and educating researchers, scientists, health care professionals, and students are part of JHH's mission and tradition. The advancement of medicine, detection and treatment of diseases sets the standard in medical education and research. JHH has 1,162 licensed beds and over 2,400 full-time attending physicians. JHH is home to the Johns Hopkins Children's Center and the Johns Hopkins Kimmel Cancer Center, both of which are consistently ranked among the top in the nation by U.S. News & World Report.

Johns Hopkins Bayview Medical Center (JHBMC), committed to superior and innovative health care, education, and research, traces its history back to 1773. Since Johns Hopkins acquired Baltimore City Hospitals in 1984, more than $600 million has been invested to transform and modernize the campus. Uniting with The Johns Hopkins Hospital, the medical campus of JHBMC has been transformed to connect clinical care and medical education focusing on distinctive models of care in Johns Hopkins Centers of Excellence, including the Burn Center, Women's Center for Pelvic Health, Asthma & Allergy Center, and Memory and Alzheimer's Treatment Center. JHBMC's Geriatric Medicine and Rheumatology programs are consistently ranked highly by U.S. News & World Report. JHBMC has 455 licensed beds and over 680 attending physicians.

Appendix D: Community Stakeholder Interviewees

Johns Hopkins completed interviews with community stakeholders throughout the region to gain a better understanding of community health needs from the perspective of organizations, agencies, and government officials that have a deep understanding from their day-to-day interactions with populations in greatest needs.

Interviews and focus groups provided information about the community's health status, risk factors, service utilizations, and community resource needs, as well as gaps and service suggestions.

Listed below in alphabetic order by last name are the community stakeholders that participated in this CHNA.

Table 13: Community Stakeholder Interview Participants

NAME/TITLE	ORGANIZATION
Anne Langley	Charm City Care Connection
Anne Swett	Johns Hopkins Bayview Medical Center
Annie Weber	Henderson Hopkins School
Antoinette Maynard-Carter	Broadway Center for Addiction
Barbara Bates Hopkins	Bloomberg School of Public Health
Cara Goldstein	Office of Population Health JHM
Cesar Romero	Bayview Community Association
Charles Sheeler	Johns Hopkins Bayview Medical Center
Chauna Brocht	Behavioral Health Systems Baltimore
Zeke Cohen	Baltimore City Council
Courtney Speed	New Shiloh Baptist Church
Dan Hale	Depression Awareness Program
Danielle Darby	The Mix Church
Danielle McCray	Baltimore City Council
David Harris	McElderry Park Community Association
Barry Solomon	JH Community Connection
Dwayne Bruce	Dee's Place
Gary Dittman	Amazing Grace Lutheran Church
Gloria Nelson	Turner Station Conservation Team
Heather Nugent	Autumn Lake Healthcare
Jenny Hope	Historic East Baltimore Community Action Coalition (HEBCAC)
Karen Washington-Malone	JHHS Community Healthcare Provider
Katie Long	Friends of Patterson Park
Katie Vaselkiv	John Ruhrah Elementary/Middle School
Kerry Lessard	Native American Lifelines
Kevin Wenzel	Recovery program Maryland Treatment Center
Kristin Topel	JH Community Connection
Pamela Wilkerson	Helping Up Mission

Lauren Averella	Civic Works
Leon Purnell	Men and Families Center
Liam Davis	Greektown Neighborhood Assoc
Liz Kaylor	Baltimore Medical System
Maggie Fitzsimmons	Washington Hill Community
Marjorie Rodgers Cheshire	A&R Development
Mark Luckner	MD Community Health Resource Commission
Mary Ancinec	John Ruhrah Elementary/Middle School
Matthew Hart	Bayview Community Association
Matt Dolomore	Catholic Charities / Esperanza Center
Matt Hornbeck	Hampstead Hill Academy
Megan Lovely	Historic East Baltimore Community Action Coalition (HEBCAC)
Melvin Wilson	Turnaround Tuesday
Nina Bell	Eastside Yo!
Norma Karanek	Bloomberg School of Public Health
Odette Belcher	Daysprings
Pamela Wilkerson	Helping Up Mission
Randi Woods	Sisters Together and Reaching (STAR)
Robin Truiett Theodorson	Banner Neighborhoods
Rodney Toney	JH Supply Chain Sustainability Team
Rosalyn Stewart	Johns Hopkins Bayview Medical Center
Sam Zisow-McLean	Movable Feast
Shannon Campbell-Burroughs	Baltimore City Head Start
Sherese Moton	Patterson High School
Stella Karais	St. Nicholas Greek Orthodox Church
Taavon James, President	The Community Group
Tasha Gresham-James	Dundalk Renaissance Corporation
Tehma Wilson	The Door (Baltimore Urban Leadership Foundation)

Appendix E: Community Organizations and Partners

The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center came together to conduct a community health needs assessment (CHNA). As leading health care providers, JHH and JHBMC are dedicated to understanding community needs and offering and enhancing quality programs to address those needs and promote population wellness.

The primary data collected in the CHNA provided invaluable input and represents ongoing dedication to assisting JHH and JHBMC in identifying community health needs priorities and building a foundation upon which to develop strategies that will address the needs of residents in east Baltimore City and southeast Baltimore County.

Listed below are the community organizations that assisted JHH and JHBMC with the primary collection for the 2024 CHNA.

Table 14: Community Organization Partners in the 2024 CHNA

	Community Organizations and Partners
1.	A&R Development
2.	Amazing Grace Lutheran Church
3.	Anchor Group
4.	Ascension Saint Agnes
5.	Autumn Lake Healthcare
6.	B'More for Healthy Babies
7.	Baltimore City Council
8.	Baltimore City Head Start
9.	Baltimore City Health Department
10.	Baltimore City Health Department HIV Services
11.	Baltimore City Health Department Youth Advisory Council and Youth Ambassadors
12.	Baltimore CONNECT
13.	Baltimore Medical System, Inc.
14.	Banner Neighborhoods Community Corporation
15.	Bayview Community Association
16.	Bea Gaddy Family Center
17.	Behavioral Health Systems Baltimore
18.	CASA de Maryland
19.	Catholic Charities
20.	Charm City Care Connection
21.	Civic Works

	Community Organizations and Partners
22.	Dayspring Programs
23.	Dee's Place
24.	Druid Hill YMCA
25.	Dundalk Renaissance Corporation
26.	Eastside YO!
27.	Elmer A Henderson: A Johns Hopkins Partnership School
28.	Esperanza Center
29.	Friends of Patterson Park
30.	Greektown Neighborhood Association
31.	Hampstead Hill Academy
32.	Health Care Access Maryland
33.	Health Care for the Homeless
34.	Healthy Start Father's Group
35.	Helping Up Mission
36.	Historic East Baltimore Community Action Coalition, Inc.
37.	Israel Baptist Church
38.	J Van Story Branch Apartments
39.	John Ruhrah Elementary Middle School/The Judy Center
40.	Johns Hopkins Bayview Community Advisory Board
41.	Johns Hopkins Broadway Center for Addiction
42	Johns Hopkins Centro Sol
43.	Johns Hopkins Community Connection
44.	Johns Hopkins Health System
45.	Johns Hopkins Medicine Office of Population Health
46.	Johns Hopkins Supply Chain Sustainability Team
47.	Johns Hopkins University
48.	Johns Hopkins University Bloomberg School of Public Health Center for Environmental Health and Engineering
49.	Life Bridge Health
50.	Maryland Community Health Resources Commission
51.	Maryland Department of Health
52.	Maryland Treatment Centers
53.	McElderry Park Community Association
54.	Meals on Wheels

	Community Organizations and Partners
55.	MedStar Health
56.	Men & Families Center
57.	Mercy Medical Center
58.	Morgan State University
59.	Moveable Feast
60.	Mt Washington Pediatric Hospital
61.	Native American Lifelines of Baltimore
62.	New Shiloh Baptist Church
63.	Northeastern Community Organization
64.	Patterson High School
65.	Roberta's House
66.	Senior Network of North Baltimore
67.	Sinai Hospital
68.	Sisters Together and Reaching (STAR)
69.	South East Community Development Corporation
70.	St. Agnes / Ascension
71.	St. Nicholas Greek Orthodox Church
72.	The Community Group
73.	The Door Inc. (Baltimore Urban Leadership Foundation)
74.	The Dream Center/The Mix Church
75.	The Mayor's Commission on Aging and Retirement Education
76.	The Mix Church
77.	The Well Foundation
78.	Turnaround Tuesday
79.	Turner Station Conservation Teams
80.	University of Maryland Medical System
81.	Urban Health Institute
82.	Victory Village Senior Center
83.	Washington Hill Community Association
84.	Zeta Senior Center
85	Zion Baptist Church

Appendix F: Climate Change and Sustainability at Johns Hopkins

Hospitals, as critical infrastructure in healthcare systems, play a significant yet often overlooked role in addressing climate change and promoting sustainability. First, the healthcare sector is a substantial contributor to carbon emissions, with hospitals being among the largest energy consumers. Their constant demand for electricity, heating, and cooling, coupled with the extensive use of medical equipment and supplies, leads to considerable greenhouse gas emissions. Consequently, hospitals have a responsibility to mitigate their environmental impact by adopting energy-efficient technologies, optimizing resource utilization, and embracing renewable energy sources. Through initiatives like installing solar panels, improving building insulation, and implementing waste reduction strategies, hospitals can reduce their carbon footprint while simultaneously cutting operational costs.

Moreover, the intersection of hospitals and climate change extends beyond environmental concerns to encompass public health and resilience. Climate change amplifies the frequency and intensity of extreme weather events, posing direct threats to healthcare infrastructure and patient care. Hospitals must adapt to these challenges by enhancing their resilience and disaster preparedness strategies. Additionally, as climate change exacerbates certain health risks such as heat-related illnesses, respiratory diseases, and vector-borne illnesses, hospitals must adjust their healthcare delivery models to address emerging needs. By integrating climate resilience into their operations and promoting community health initiatives, hospitals can not only mitigate the adverse impacts of climate change but also foster healthier and more sustainable communities.

Though climate change and sustainability did not rise to the level of an identified community need in the 2024 CHNA, The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center have both championed sustainability in the operations and management of their facilities. Below are some highlights from each hospital on how Johns Hopkins has acted in a sustainable manner.

CHNA - JHH Sustainability Highlights 2024

Office Supply Swap: To celebrate America Recycles Day and Earth Month in November 2023 and March 2024 respectively, JHH hosted an Office Supply Swap. Prior to the event there multiple drop off days at varying locations throughout the hospital where staff could drop off their extra, unwanted office supplies that were held until swap day. On the day of the swap, staff were invited to come drop off supplies and shop around for any office supplies they needed. Supplies included binders, hanging folders, keyboards, labels, paperclips, highlighters, notebooks and more. Used writing utensils, batteries and toners were accepted for recycling and eyeglasses for donation.

The goal of the event is to redistribute office supplies throughout the hospital as needed. This decreases the amount of material being landfilled, particularly for products that are still in good condition. It also decreases the need to buy supplies new, decreasing the reliance on and demand for virgin materials. All items were packed up and stored after the November 2023 event for use at March 2024 office swap. Extra supplies from March's event were similarly packed and stored for future use at the next swap event, hopefully in November 2024.

Green Office Certification & Awards Luncheon: Offices and departments across the hospital can do their part to increase sustainability by participating in the Green Office Certification on April 3, 2024. After filling out a simple form to benchmark a department's sustainable performance, departments work throughout the year to complete the checklist and become Green Office Certified. After the first year of being certified, departments can participate in the re-certification process each year after, continuing their commitment to engaging in and promoting sustainable activities throughout the hospital. To become certified or re-certified, departments engage in sustainable activities such as turning off all the lights and electronics in their offices before leaving, setting printers to default double side printing

and instituting paperless meetings to decrease paper use, collecting batteries and writing utensils for recycling, and promoting sustainable program offered through the hospital such as the furniture reuse program and the Farmers Market. All certified and recertified offices are honored at our Green Office Awards & Luncheon each April in celebration of Earth Month.

Farmers Market: The Farmers Market has been a staple of JHH for well over a decade. The market focuses on providing local, fresh, and organic produce and lunch options to the staff and community of JHH. The market also features a Community Support Agriculture (CSA) Program provided by one of the farm vendors who follows organic and regenerative farm practices. The CSA program allows staff and community members to sign up and receive a box of fresh, locally grown produce weekly throughout the market season. The focus on local farm products and lunch offerings highlights the positive sustainable impact of supporting locally owned businesses.

Practice Greenhealth: The Johns Hopkins Hospital has been a member of Practice Greenhealth for almost a decade to drive positive, sustainable changes throughout the healthcare sector. We have been recognized with 22 sustainability awards since 2015, many of which are through this awards program and last year. In 2024 the hospital was awarded the Partner Recognition Award for our efforts during the 2023 calendar year. The application covers various sustainability questions and topics over all hospital operations and prepares a GAP analysis to determine where the hospital can improve. This also allows the hospital to benchmark itself against other healthcare organizations when it comes to climate impacts and sustainability.

Waste Diversion: As a part of Johns Hopkins Hospital commitment to sustainability, there are multiple programs that support waste diversion in everyday activities. In 2023, the hospital recycled over 1 million pounds of material including cardboard and paper, scrap metal, and cooking oil. Another hallmark program is the furniture repurposing program, in partnership with Re-form. Through this program, hospital staff can donate unwanted or unused furniture from their offices or departments which is then repurposed throughout the hospital or donated. In 2023 the program helped divert almost 5,530 pounds of furniture away from landfill.

Composting Food Waste: In a joint effort by the Facilities Department and Food and Culinary Services team, The Johns Hopkins Hospital began composting food waste in compliance with Maryland Department of the Environment Solid Waste Management – Organics Recycling and Waste Diversion – Food Residuals (COMAR 26.04.13). This aligns with Baltimore City's Waste-To-Wealth Initiative and Food Waste & Recovery Strategy that aims to grow local businesses and reduce waste. Composting helps our community be more resilient to climate change and promote biodiversity through the creation of nutrient-rich soil.

The composting program at The Johns Hopkins Hospital required the communication and collaboration between vendors, pest management, Food Services, and Environmental Care Services. Veteran Compost, a local veteran owned business based in Aberdeen, Maryland was selected as a vendor to manage all food residual waste. The composting efforts align with our commitment to the community as the reduction and diversion of waste is essential to improving public health and decreasing greenhouse gas emissions. Keiy Murofushi, the Executive Director of Food & Culinary Services says "Cultivating sustainability at Johns Hopkins Hospital's Food and Nutrition Department, our composting initiatives underscore our dedication to curbing methane emissions from waste management. By minimizing food waste, we are preserving resources and championing innovative solutions that revitalize our food supply chains. Our efforts reflect a proactive stance toward environmental stewardship and community well-being." The Johns Hopkins Hospital composts to be a more sustainable healthcare option by reducing our environmental impact through waste diversion efforts.

Appendix G: Reference List

1. Annie E. Casey Foundation, Kids Count, 2018. Profile for Maryland. http://datacenter.kidscount.org/data/tables/4467-dropout-rate?loc=22&loct=5#detailed/5/3300-3323/false/1648,1603,1539.1381,1246,1124,1021,909,857,105/any/10051,10050
2. Baltimore City Department of Planning. Food Environment Maps. https://planning.baltimorecity.gov/baltimore-food-policy-initiative/food-environment
3. Baltimore City Health Department Statistics and Data. http://health.baltimorecity.gov/
4. Baltimore City Neighborhood Health Profiles, 2018. http://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports
5. CARES Engagement Network. CHNA Report for Baltimore City and Maryland. https://www.engagementnetwork.org/
6. Centers for Disease Control and Prevention: CDC Mental Health Treatment Among Adults: United States, 2019. https://www.cdc.gov/nchs/products/databriefs/db380.htm
7. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. Retrieved from PLACES Project Data, 2020. https://www.cdc.gov/PLACES.
8. Centers for Disease Control and Prevention. National Center for Health Statistics. https://www.cdc.gov/nchs/fastats/hispanic-health.htm
9. Centers for Disease Control and Prevention. http://www.cdc.gov/chronicdisease/
10. County Health Rankings and Roadmaps, 2020. http://www.countyhealthrankings.org/app/maryland/2020/rankings/baltimore-city/county/outcomes/overall/snapshot
11. Dignity Health, Community Need Index, 2020. http://cni.dignityhealth.org/
12. Healthy Food Systems, Johns Hopkins Bloomberg School of Public Health. https://healthyfoodsystems.net/
13. Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 01/28/2021 from https://health.gov/healthypeople/objectives-and-data/social-determinants-health
14. Johns Hopkins Center for a Livable Future. Baltimore City's Food Environment Report: 2018 Report. https://clf.jhsph.edu/projects/baltimore-citys-food-environment
15. Kaiser Family Foundation Health Tracking Polls, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/
16. Maryland Department of Health and Human Services, Vital Statistics Jurisdictional Data. https://health.maryland.gov/vsa/Pages/jurisdictional.aspx

17. Maryland Department of Health Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2019. https://health.maryland.gov/vsa/Documents/Overdose/REV_Annual_2019_Drug_Intox_Report.pdf
18. Maryland Department of Health, State Health Improvement Process. https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx
19. Maryland Statistical Analysis Center (MSAC), Governor's Office of Crime Control and Prevention. https://opendata.maryland.gov/Public-Safety/Violent-Crime-Property-Crime-by-County-1975-to-Pre/jwfa-fdxs
20. National Alliance on Mental Illness, Mental Health by the Numbers. https://www.nami.org/mhstats
21. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/suicide
22. National Center for Health Statistics, Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2022 (cdc.gov)
23. Neighborhood Health Profile. 2017. http://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports
24. Proceedings of the National Academy of Sciences of the United States of America. https://www.pnas.org/content/118/5/e2014746118
25. Substance Abuse and Mental Health Services Administration (SAMHSA), Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey of Drug Use and Health. https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf
26. Substance Abuse and Mental Health Services Administration (SAMHSA); Behavioral Health Barometer, United States, Volume 6. 2020. https://www.samhsa.gov/data/report/behavioral-health-barometer-united-states-volume-6
27. The Baltimore Sun Media Group. https://homicides.news.baltimoresun.com/
28. The State of Childhood Obesity, 2020. Trust for America's Health and the Robert Wood Johnson Foundation. http://stateofchildhoodobesity.org
29. The U.S. Department of Health and Human Services. Health Professional Shortage Areas. https://data.hrsa.gov/topics/health-workforce/shortage-areas
30. The U.S. Department of Health and Human Services. https://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf
31. United Health Foundation, America's Health Rankings analysis of CDC, Behavioral Risk Factor Surveillance System, Accessed 2021. https://www.americashealthrankings.org/explore/annual/measure/Sedentary/state/MD
32. US Census Bureau, Small Area Health Insurance Estimates. https://www.census.gov/data-tools/demo/sahie/#/?s_statefips=24

Appendix H: CHNA Task Force/Working Group & Consulting Group Members

Members of the task force/working group were charged with the project components of the CHNA and report preparation. Members of the task force/working group are listed below.

Task Force/Working Group Members:

1. Dr. Redonda Miller, President, The Johns Hopkins Hospital
2. Jennifer Nickoles, President, Johns Hopkins Bayview Medical Center
3. Hosanna Asfaw-Means, Director of Community Health Investment, Government, Community and Economic Partnerships, Johns Hopkins Institutions
4. Sharon Tiebert-Maddox, Director, Strategic Initiatives and Community Health Improvement, Government, Community and Economic Partnerships, Johns Hopkins Institutions
5. Sherry Fluke, Senior Financial/Project Manager, Government, Community and Economic Partnerships, Johns Hopkins Institutions
6. William Wang, Associate Director, Government, Community and Economic Partnerships, Johns Hopkins Institutions

Consulting group members were advisory to the task force and brought in for review and consultation as needed during various phases of the CHNA development and needs prioritization. The members of the consulting group are listed below.

Consulting Group Members:

1. Maria Harris Tildon, Vice President, Government, Community and Economic Partnerships, Johns Hopkins Institutions
2. Shatabdi Patel, Economic Development Program Manager, Government, Community and Economic Partnerships, Johns Hopkins Institutions
3. Lindsay Hebert, DrPH, Director, Community Affairs and Engagement, Government, Community and Economic Partnerships, Johns Hopkins Institutions
4. Selwyn Ray, Director, Community Relations, Health and Wellness, Johns Hopkins Bayview Medical Center
5. Adrianna Moore, Senior Project Manager, Healthcare Transformation and Strategic Planning, Johns Hopkins Health System

Appendix I: 2023 Survey (English Version)

Dear Community Member,

We invite you to participate in the Baltimore City 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. This is not a research survey. It will take less than 10 minutes to complete. You will find the results of this survey, recent community health statistics, community member feedback, and updated community health priorities on Baltimore hospital and Baltimore City Health Department's websites in July 2024 (search for "Community Health Needs Assessment"). 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 **Ascendient Healthcare Advisors** at **(240) 358-1445.**

Thank you for your time and participation!

S

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

2. Which neighborhood do you live in?
Please select one of the options listed. ☐ Allendale/Irvington/S. Hilton
☐ Beechfield/Ten Hills/West Hills
☐ Belair-Edison
☐ Brooklyn/Curtis Bay/Hawkins Point
☐ Canton
☐ Cedonia/Frankford
☐ Cherry Hill
☐ Chinquapin Park/Belvedere
☐ Clifton-Berea
☐ Cross-Country/Cheswolde
☐ Dickeyville/Franklintown
☐ Dorchester/Ashburton
☐ Downtown/Seton Hill
☐ Edmondson Village
☐ Fells Point
☐ Forest Park/Walbrook
☐ Glen-Fallstaff
☐ Greater Charles Village/Barclay
☐ Greater Govans
☐ Greater Lauraville
☐ Greater Mondawmin
☐ Greater Roland Park/Poplar Hill
☐ Greater Rosemont
☐ Greentown/Bayview
☐ Hamilton
☐ Hamilton Hills
☐ Hampden/Remington
☐ Harbor East/Little Italy
☐ Highlandtown
☐ Howard Park/West Arlington
☐ Inner Harbor/Federal Hill
☐ Loch Raven
☐ Madison/East End
☐ Midtown
☐ Midway/Coldstream
☐ Morrell Park/Violetville
☐ Mount Washington/Coldspring
☐ North Baltimore/Guilford/ Homeland
☐ Northwood
☐ Oldtown/Middle East
☐ Oliver/Johnson Square
☐ Orchard Ridge/Armistead
☐ Patterson Park North & East
☐ Penn North/Reservoir Hill
☐ Pigtown/Carroll Park
☐ Pimlico/Arlington/Hilltop
☐ Poppleton/The Terraces/ Hollins Market
☐ Sandtown-Winchester/ Harlem Park
☐ South Baltimore
☐ Southeastern
☐ Southern Park Heights
☐ Southwest Baltimore
☐ The Waverlies
☐ Upton/Druid Heights
☐ Westport/Mount Winans/ Lakeland
☐ Other (please specify): _____
☐ Don't know
☐ Decline to answer

3. What is your age group (years)?
Please select one. ☐ 18-29
☐ 30-39
☐ 40-49
☐ 50-59
☐ 60-74
☐ 75+
☐ Don't know
☐ Decline to answer

4. What is your race?
Please select all that apply.
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ American Indian or Alaska Native
☐ White or Caucasian
☐ Asian
☐ Other, *specify*_____
☐ Don't know
☐ Decline to answer

5. Are you Hispanic or Latino/a?
Please select one. ☐ Yes
☐ No
☐ Don't know
☐ Decline to answer

6. Do you think of yourself as:
Please select one. ☐ Male
☐ Female
☐ Transgender man
☐ Transgender woman
☐ Gender queer/gender nonconforming, i.e., neither exclusively male nor female
☐ Additional gender category (or other) (*please specify)*: _____
☐ Don't know
☐ Decline to answer

8. Do you think of yourself as:
Please select one. ☐ Straight or heterosexual
☐ Lesbian or Gay
☐ Bisexual
☐ Queer
☐ Pansexual
☐ Questioning
☐ Something else (*please specify)*: _____
☐ Don't know
☐ Decline to answer

9. Do you have health insurance?
Please select one.
☐ Yes
☐ No
☐ Don't know
☐ Decline to answer

9.1. If you don't have health insurance, how confident do you feel about knowing how to sign up for health insurance coverage?
Please select one.
☐ I have health insurance
☐ Very confident
☐ Somewhat confident
☐ Not at all confident
☐ Don't know
☐ Decline to answer

10. Thinking about your physical health, which includes physical illness and injury, about how many days during the past 30 days was your physical health not good?
Please select one.
☐ None
☐ 1-2 days
☐ 3-5 days
☐ 6-10 days
☐ 11-15 days
☐ 16 or more days
☐ Don't know
☐ Decline to answer

11. Thinking about your mental health, which includes stress, depression, and problems with emotions, about how many days during the past 30 days was your mental health not good?
Please select one.
☐ None
☐ 1-2 days
☐ 3-5 days
☐ 6-10 days
☐ 11-15 days
☐ 16 or more days
☐ Don't know
☐ Decline to answer

12. **What do you think are the top 5 health issues that affect people the most in the neighborhood where you live?** *Please select up to five*

☐ Addiction/Substance use
☐ Alzheimer's Disease/dementia
☐ Cancer
☐ Children with illnesses
☐ Chronic pain & arthritis ☐ Diabetes/High blood sugar
☐ Falls
☐ Heart disease/Stroke
☐ High blood pressure
☐ HIV/AIDS
☐ Infant death
☐ Infectious disease (e.g., COVID, flu, hepatitis)
☐ Lung disease/Asthma/COPD
☐ Maternal health/Reproductive health
☐ Mental health (e.g., depression, anxiety, suicide, PTSD, trauma) ☐ Overweight / Obesity
☐ Preventable injuries
☐ Sexually transmitted infections
☐ Smoking/ Vaping/Tobacco use
☐ Social isolation / Loneliness ☐ Violence
☐ Other (*please specify):*

___

☐ None
☐ Don't know
☐ Decline to answer

13. **What do you think are the top 5 social/environmental problems that affect the health of people the most in the neighborhood where you live?** *Please select up to five.*

☐ No or limited access to a nearby doctor's office
☐ No or limited access to health insurance ☐ Domestic violence ☐ Limited knowledge about healthy foods
☐ Limited access to healthy foods
☐ Can't afford healthy foods
☐ Limited access to/can't afford any food
☐ School dropout/Poor schools ☐ Lack of job opportunities ☐ Racial/Ethnicity discrimination
☐ Social isolation/Loneliness
☐ Child abuse/Neglect
☐ Elder abuse/Neglect
☐ Lack of affordable childcare
☐ Housing problems/Homelessness ☐ Poor neighborhood safety
☐ Gun violence
☐ Poverty ☐ Limited places to exercise safely
☐ Limited places for youth to gather safely ☐ Transportation problems
☐ Other (*please specify):*

___

☐ None
☐ Don't know
☐ Decline to answer

14. **What are the top 5 reasons people in your neighborhood *do not get* health care when they need it?**
Please select up to five.

☐ Cost – Too expensive / Can't pay
☐ Don't have health insurance
☐ Insurance is not accepted
☐ Don't have a doctor/medical provider
☐ No doctor/medical provider nearby
☐ Don't know whom to call or how to make an appointment
☐ No appointments available when needed/Wait for an appointment is too long
☐ Lack of transportation
☐ Lack of / Limited childcare ☐ Language barrier
☐ Worried about immigration status
☐ Fear or mistrust of doctors
☐ Difficulty getting a referral to or appointment with a specialist
☐ Not able to take time off work/Afraid of losing job
☐ Worried or uncomfortable telling a health care provider about my health problem
☐ Cultural / Religious beliefs ☐ Other (*please specify):* ___
☐ People do not have any issues accessing health care
☐ None
☐ Don't know
☐ Decline to answer

15. What kind of help do you need managing your current health conditions (for example, heart conditions, high blood pressure, stroke, diabetes, asthma, cancer, COPD, congestive heart failure, arthritis, HIV, depression, anxiety, other mental health condition, etc.) to stay healthy?
Please choose all that apply.

☐ I don't have a current health condition to manage
☐ Help getting health insurance to cover the care I need
☐ Help finding a doctor
☐ Help making and keeping appointments with my doctor(s)
☐ Help understanding all the directions from my doctor(s)
☐ Help understanding how to take my medication(s)
☐ Help paying for my prescription(s)/medication(s) or medical equipment
☐ Health care in my home
☐ Help coordinating my overall care among multiple health care providers
☐ Access to healthy foods
☐ Access to places to exercise safely
☐ Transportation assistance
☐ Financial assistance for co-pays, deductibles
☐ Home modification assistance (for example, installing a wheelchair ramp or a handicapped-accessible shower)
☐ Other (*please specify*): _____
☐ None
☐ Don't know
☐ Decline to answer

16. If you visited an Urgent Care Center or Emergency Department in the past 12 months instead of going to your medical provider, what was your reason?
Please choose all that apply.
☐ Didn't visit Urgent Care or Emergency Dept in last 12 months
☐ Needed care after regular office hours
☐ Convenient locations and/or hours
☐ Wanted to be seen right away/No wait time for appointments
☐ I do not have a medical provider
☐ Couldn't get a timely appointment with my medical provider
☐ I do not have a mental health provider
☐ Couldn't get a timely appointment with my mental health provider
☐ I do not have health insurance
☐ More affordable/No cost
☐ Was traveling/Away from home
☐ Other (*please specify*): _____
☐ Don't know
☐ Decline to answer

17. I can use applications on my computer, cell phone, or another electronic device on my own without asking for help from someone else.
Please select one.
☐ Agree
☐ Disagree
☐ Don't have/use electronic devices
☐ Don't know
☐ Decline to answer

18. I am open to participating in "telehealth," i.e., having my health assessed and managed virtually through a phone and/or electronic device.
Please select one.
☐ Agree
☐ Disagree
☐ Don't have/use electronic devices
☐ Don't know
☐ Decline to answer

19. Did your child/ren (under 18 years old) have a yearly wellness visit with a medical provider in the past 12 months?
Please select one.
☐ Yes
☐ No
☐ At least one child, but not all
☐ I don't have any children under 18 years old
☐ Don't know
☐ Decline to answer

20. Did your child/ren (under 18 years old) receive a regular dental checkup at least once in the past 12 months?
Please select one.
☐ Yes
☐ No
☐ At least one child, but not all
☐ I don't have any children under 18 years old
☐ Don't know
☐ Decline to answer

21. In the past 12 months, did your child/ren (under 18 years old) need help from a doctor, therapist, counselor, or social worker for emotional or mental health problems or challenges such as feeling sad, depressed, angry or anxious?
Please select one.
☐ Yes
☐ No
☐ At least one child, but not all
☐ I don't have any children under 18 years old
☐ Don't know
☐ Decline to answer

22. What ideas or suggestions do you have to improve health in your community?
Please write your answer.
_____
_____
_____
_____
☐ Don't know
☐ Decline to answer

Thank you for completing the survey!

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS HEALTH SYSTEM

For more information contact:

Johns Hopkins Government, Community & Economic Partnerships

1101 W 33rd Street, Suite B301
Baltimore, MD 21218

(443) 997-5999

gce.jhu.edu | gce@jhu.edu