Community Health Needs Assessment

2016 FINAL SUMMARY REPORT

SUBMITTED BY

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EXECUTIVE SUMMARY

Beginning in January 2016, the University of Maryland St. Joseph Medical Center (St. Joseph) undertook a comprehensive community health needs assessment (CHNA) to evaluate the health needs of individuals living in Baltimore County, Maryland. The aim of the assessment is to reinforce St. Joseph's commitment to the health of residents and align its health prevention efforts with the community's greatest needs. The assessment examined a variety of health indicators including chronic health conditions, access to health care and social determinants of health. The University of Maryland St. Joseph Medical Center contracted with Holleran Consulting, a research firm based in Lancaster, Pennsylvania, to execute this project.

The completion of the CHNA enabled University of Maryland St. Joseph Medical Center to take an in-depth look at its community. The findings from the assessment were utilized by St. Joseph to prioritize public health issues and develop a community health implementation plan focused on meeting community needs. St. Joseph is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. This CHNA Final Summary Report serves as a compilation of the overall findings of each research component.

CHNA Components

- Online Community Survey
- Key Informant Surveys
- Prioritization Session
- Implementation Plan

Key Community Health Issues

The University of Maryland St. Joseph Medical Center, in conjunction with community partners, examined the findings of the Online Community Survey and Focus Group Discussions to select Key Community Health Issues pertinent to Baltimore County. The following issues were identified (presented in alphabetical order):

- Access to care
  - Lack of primary care and specialty care providers
  - Long wait times
  - Home care
  - Resource awareness
  - Price of medication and insurance deductibles
- Care Coordination
- Chronic Disease – Cardiovascular disease, Obesity, Stroke, Diabetes
- Disparities
- Low Health literacy and Language barriers
- Lack of transportation
- Mental health
- Substance abuse
- Tobacco use

Prioritized Community Health Issues

Based on feedback from community partners, including health care providers, public health experts, health and human service agencies, and other community representatives, St. Joseph plans to focus community health improvement efforts on the following health priorities over the next three-year cycle:

- Access to Care
- Mental Health and Substance Abuse
- Chronic Disease- Cardiovascular Disease/Obesity
- Cancer
- Fall Prevention

Previous CHNA and Prioritized Health Issues

St. Joseph Medical Center conducted a comprehensive CHNA in 2013 to evaluate the health needs of individuals living in the hospital service area within Greater Baltimore. The purpose of the assessment was to gather information about local health needs and health behaviors. The assessment helped St. Joseph prioritize six health issues and develop a community health implementation plan to improve the health of the surrounding community. The prioritized health issues include:

- Access to Health Care Services
- Diabetes
- Substance/Tobacco Abuse
- Heart Disease/Hypertension/Stroke
- Maternal/Child Health
- Cancer

Major outcomes from the 2013 priorities include:

- 8,029 free flu vaccines provided to the community
- 744 bone density screenings provided to local seniors and an additional 646 screenings provided to the general population
- 2,024 diabetic visits received education about diabetes
- 4,133 people offered substance/tobacco cessation assistance
- 2,806 people received hypertension/stroke prevention and awareness education
- 27,620 visits where women received education regarding healthy lifestyle practices
- 5,161 community members received cancer education about early detection
- 301 women received free breast cancer screenings and education and another 90 women received screening for cervical cancer

The full list of outcomes can be found in Appendix C.

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Organization Overview

The University of Maryland St. Joseph Medical Center is a member of the University of Maryland Medical System, a not-for-profit hospital system, and is located in Towson, Maryland. Driven by its Catholic health mission of serving others with reverence, integrity, compassion and excellence, St. Joseph has provided compassionate care for generations of Baltimore families for more than 150 years. Services provided by more than 1,100 expert physicians and over 2,300 nurses, allied healthcare professionals and staff, and a state-of-the-art medical technology make St. Joseph one of the nationally ranked healthcare providers and a top performer in patient satisfaction.

Methodology and Background

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

- An Online Community Survey was conducted with individuals residing in Baltimore County between January 29 and March 18, 2016. The survey was designed to assess their health status, health risk behaviors, preventive health practices and needs, health care access primarily related to chronic diseases, and community assets and opportunities. The survey took approximately 10 to 15 minutes to complete. A total of 924 resident surveys were completed throughout Baltimore County to promote geographical and ethnic diversity among respondents.
- Focus Group Discussions: two Key Informant focus groups were conducted at St. Joseph Medical Center on February 10 and February 17, 2016. There were 12 participants in the first session and 11 participants attended the second session. The purpose of the focus groups was to gather expert-level qualitative feedback from a variety of health and social service providers, with an active role and a broad understanding of the health care system and health needs of Baltimore County residents.

Research Partner

University of Maryland St. Joseph Medical Center contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. The firm collected, analyzed and interpreted data both from the online community survey and the focus groups, and prepared all reports. Holleran has 23 years of experience in conducting public health research and community health assessments.

Community Representation

Community engagement and feedback were an integral part of the CHNA process. The University of Maryland St. Joseph Medical Center sought community input through key informant focus group discussions with community leaders and partners and an online community member survey available to all Baltimore County residents, and inclusion of community leaders in the prioritization and implementation planning process. Public health and health care professionals shared knowledge and expertise about health issues, and leaders and representatives of non-profit and community-based

organizations provided insight on the community, including the medically underserved, low income, and minority populations.

Research Limitations

As with all research efforts, there are some limitations related to this study's research methods that should be acknowledged. Data based on self-reports should be interpreted with particular caution. In some instances, community member survey participants may over- or underreport behaviors and illnesses based on fear of social stigma depending on the health outcome of interest or misunderstanding the question being asked. In addition, respondents may be prone to recall bias where they may attempt to answer accurately, but remember incorrectly.

In addition, timeline and other restrictions may have impacted the ability to survey all community stakeholders. St. Joseph sought to mitigate limitations by including representatives of diverse and underserved populations through the online community member survey.

Previous Study Done by St. Joseph

St. Joseph conducted an independent community health survey the previous year. The survey sought to gather information around the most salient health issues in Baltimore County and identify the common barriers that keep people from seeking medical care. Some notable similarities were observed in the findings between the current CHNA and the study St. Joseph conducted.

Prioritization of Needs

Following the completion of the CHNA research, St. Joseph prioritized community health issues in collaboration with community leaders and partners, and developed an implementation plan to address prioritized community needs.

COMMUNITY MEMBER SURVEY OVERVIEW

Socio-Demographic Statistics Overview

The demographic profile of the respondents who completed the online survey is depicted in Tables 1-3. In general, there was a good representation of zip codes in the survey and participants were well spread out throughout the county. Nearly 40% of all respondents reside in zip codes 21234, 21093, 21236, 21286, 21204, 21030 and 21212.

As depicted in Table 1, of the total 924 respondents, the majority of respondents were female (81%) and between the ages of 55 to 64 years (24%). An additional 22% of all respondents were between the ages of 65 and 80 years. Over three-quarters of respondents identify themselves as White (79%). The next largest population is the Black/African-American race, at 13% of survey participants. About 8% of all respondents identify themselves as Latino/Hispanic. The most common "Other" race mentioned was "mixed."

In regard to educational attainment, a little more than a quarter of respondents (27.0%) have attained an undergraduate degree or higher. Another 24% of survey participants have a graduate or professional-level degree. The majority of respondents in the "Other" category indicated they have a nursing diploma. The survey also showed that a greater share of respondents (44%) had an annual household income of $75,000 or more and about 10% of respondents fall in the lowest income brackets, with an annual household income of less than $20,000.

Table 1. Demographic Information

Demographics	
Gender	
Male (n=179)	19.4%
Female (n=745)	80.6%
Age	
18 – 24 (n=29)	3.3%
25 – 34 (n=140)	15.7%
35 – 44 (n=122)	13.7%
45 – 54 (n=157)	17.6%
55 – 64 (n=209)	23.5%
65 – 80 (n=196)	22.0%
81+ (n=38)	4.3%
Race/Ethnicity	
White (n=716)	78.9%
Black/African American (n=119)	13.1%
American Indian/Alaska Native (n=3)	0.3%
Asian/Pacific Islander (n=27)	3.0%
Hispanic/Latino - *can be of any race, for example, White Hispanic* (n=70)	7.7%

Other (n=42)	4.6%

Access to Care

This section illustrates the health coverage status of residents in Baltimore County and highlights the barriers related to access to health care that contribute to poor health.

Health Insurance Coverage

Health insurance coverage can have a significant influence on health outcomes. Respondents were asked to indicate whether or not they have health care coverage, including insurance, prepaid plans, or government plans, such as Medicaid or Medical Assistance. Seventy-one percent of respondents reported they predominately obtain their health care coverage through their own or someone else's employer sponsored plans. About 5% of respondents cited they were currently uninsured.

Approximately 86% of survey participants in Baltimore County have at least one person who they think of as their personal doctor. In other words, at least 12% are without a medical home.

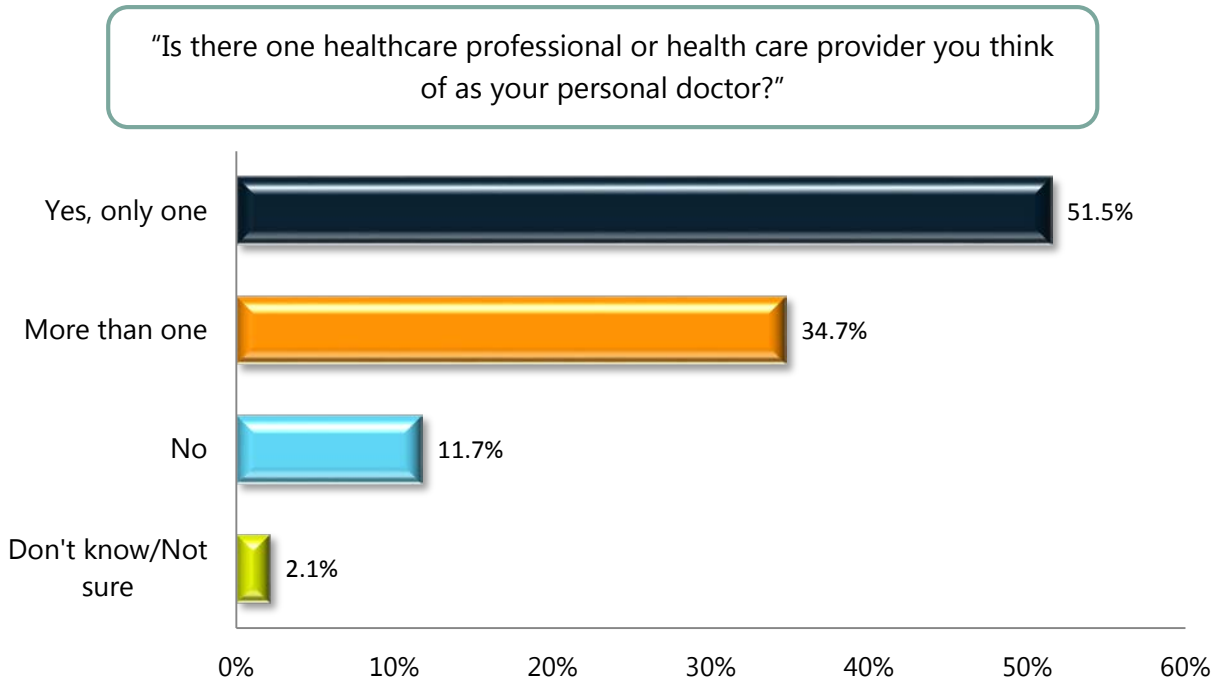


Figure 1. Percentage of individuals with or without personal healthcare provider

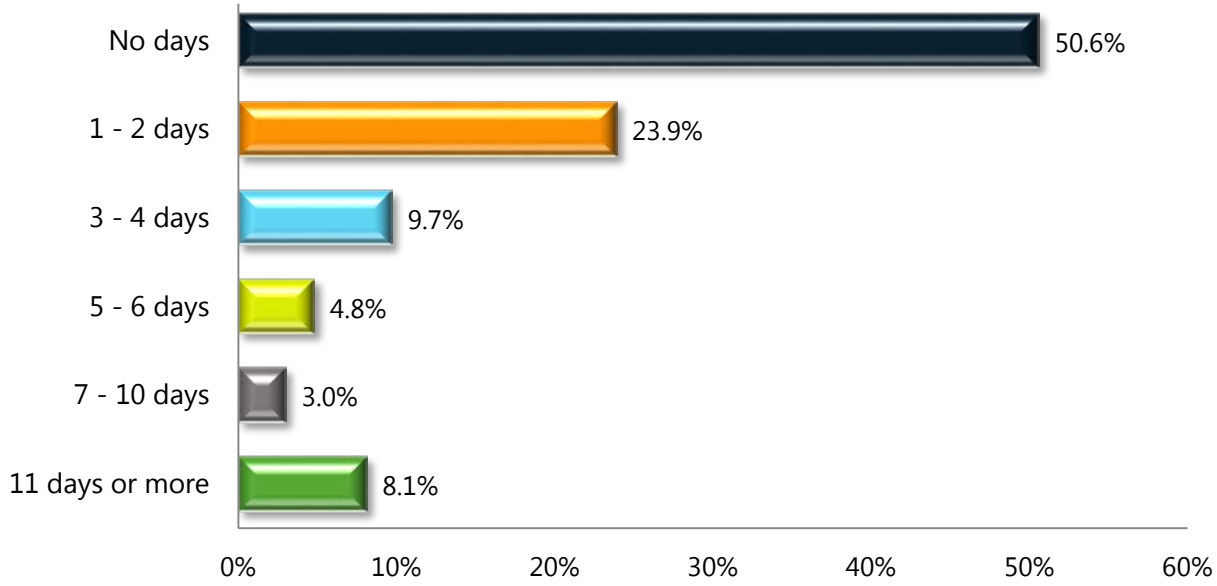
Key Health Issues

Overall Physical Health Status

Survey participants were asked to rate their overall health. In general, self-reported measures of health are favorable among respondents. Over one-half of respondents (53%) reported having very good or excellent overall health. Approximately 14% of respondents reported having fair or poor health. In addition, approximately half of the respondents reported not suffering from physical illness or injury during the previous 30 days. However, nearly a quarter (24%) reported having one to two days of poor

physical health and 10% reported having three to four days of poor physical health. The following chart depicts survey participants' self-reported poor physical health days.

Figure 2. Poor Physical Health in the past 30 days



Inability to work due to poor physical health was also measured in the survey. A strong majority of respondents in Baltimore County (78%) reported there were no days they were unable to work due to poor health. In contrast, about 6% of respondents reported being unable to work for 11 days or more in the past month because of poor physical health.

Chronic Health Issues

Some chronic conditions are of concern in Baltimore County. High blood pressure was the most cited health issue respondents encounter (44%). High cholesterol was ranked second with about 39% of respondents selecting the issue and was followed by arthritis with approximately 31% of respondents identifying it as a health concern they have been diagnosed with.

Table2. Top Seven Chronic Condition Diagnoses

Rank	Chronic Condition	Count	%*
1	High blood pressure	295	43.7%
2	High cholesterol	265	39.3%
3	Arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia	210	31.1%
4	Cancer	159	23.6%
5	Anxiety disorder	153	22.7%
6	Depressive disorder	152	22.5%
7	Asthma	121	17.9%

* Respondents could select more than one option, therefore the percentages may sum to more than 100.0%.

Survey participants were also asked in a different set of questions if they have ever been diagnosed with cancer, to which about 22% (N=189) reported that they have. Among these respondents, the most

common types of cancer reported by respondents were breast cancer (36%) and skin cancer other than melanoma (22%).

The other set of survey questions dealt with identifying the most pressing health issues facing Baltimore County residents. Overweight/Obesity topped the list with close to 60% of respondents selecting the issue as one of the top five most pressing health issues facing their county. Cancer and Drug Abuse/Alcohol Abuse were also health concerns shared by 53% and 43% of respondents respectively. The fourth most pressing health issue was Heart Disease, with a 42% rating, and Diabetes was ranked 5th with a rating of 37%. The following table highlights the rankings of the top ten health issue as selected by respondents.

Table 3. Ranking of the Top Ten Most Pressing Health Issues by Community Residents

Rank	Key Health Issue	Count	%*
1	Overweight/Obesity	506	59.1%
2	Cancer	457	53.4%
3	Drug Abuse/Alcohol Abuse	371	43.3%
4	Heart Disease	356	41.6%
5	Diabetes	319	37.3%
6	High Blood Pressure	291	34.0%
7	Alzheimer's Disease/Aging Issues	283	33.1%
8	Access to Care/Uninsured	253	29.6%
9	Mental Health/Suicide	241	28.2%
10	Tobacco Use/Smoking	158	18.5%

* Respondents could select more than one option, therefore the percentages may sum to more than 100.0%.

Health Risk Behaviors

Preventative Care

Generally, routine check-ups look favorable among respondents. Approximately 88% of survey respondents visited a doctor for a routine physical exam or check-up within the past two years; 72% visited a doctor within the past year.

Tobacco and Alcohol Use

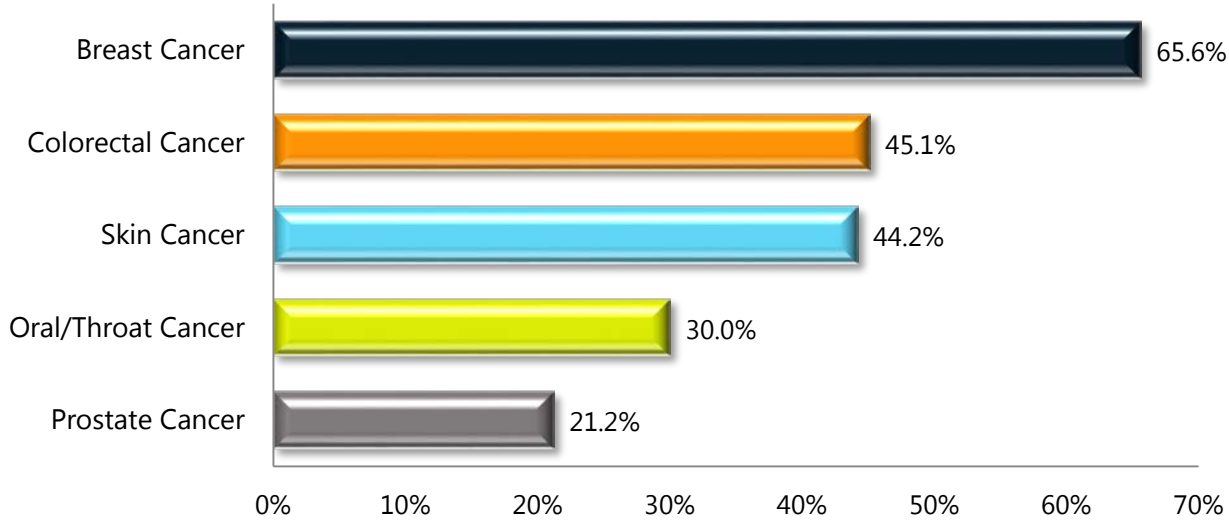
Risky behaviors related to tobacco use were measured as part of the survey. About 93% of respondents reported not smoking at all, while 7% indicated smoking either every day or some days. In regard to alcohol use, more than three-fourths of respondents did not have an alcoholic beverage during the past 30 days. Among respondents who did drink an alcoholic beverage, 14% participated in binge drinking one to two times during the past month. Only a very small percentage of respondents (approximately 8%) participated in binge drinking three or more times during the past month. Binge drinking is defined as four drinks or more on one occasion for women and five drinks or more on one occasion for men.

Cancer Screening

Online community survey participants were asked if they have routine screenings for skin cancer, breast cancer, prostate cancer, oral/throat cancer and colorectal cancer. Nearly two-thirds of female

respondents had routine screenings for breast cancer, followed by 45% of respondents reporting a routine screening for colorectal cancer. The following graph highlights survey participants' responses.

Figure 3. Routine Cancer Screenings



Prenatal Care

Women respondents that disclosed being pregnant at any time between June 2013 and February 2016 (N=70; 10%) were asked if they received prenatal care during their pregnancy to which all of them, except for one individual, answered affirmatively. In addition, 94% of these women confirmed that a doctor, nurse or other health care worker had talked with them about ways to prepare for a healthy pregnancy and baby.

Barriers to Accessing Health Services

Understanding the perceived barriers to accessing health services can be very eye-opening as it often gets to the less obvious reasons people avoid or delay seeking health care. By far, the most commonly encountered barrier among survey participants was the inability to pay insurance co-pays and deductibles (75%), distantly followed by lack of health insurance coverage (59%). Difficulty to understand/navigate health care system (39%), being unable to find a doctor or get an appointment (37%), and struggles to make ends meet (30%) were ranked as the 3rd, 4th and 5th most significant barriers facing Baltimore County residents respectively.

However, when asked if they had delayed needed medical care in the past 12 months, about 70% of respondents reported not delaying or needing medical care in the past 12 months. Of those who did delay medical care, 10% stated they couldn't afford the out-of-pocket costs. Another 6% indicated they could not get an appointment soon enough. Responses such as the following were common when providing reasons for delaying needed medical care:

> *"Costs don't match service provided. Too costly for preventive medicine, since [I] have very high deductible. Paying high health insurance for little benefit to me."*

"Didn't feel like dealing with the co-pay."

"Do not have enough time to miss from work for the surgery."

Resources Needed to Improve Access

Free/low cost medical and dental care services top the list for most needed services to improve health in Baltimore County (48%). Free/low cost eye care was the third most needed service, closely followed by mental health services that respondents felt were missing in the community.

Table 4. Top Ten Resources Needed in the Community

Rank	Key Health Issue	Count	%*
1	Free/Low Cost Medical Care – Tied	404	47.5%
2	Free/Low Cost Dental Care – Tied	404	47.5%
3	Free/Low Cost Vision/Eye Care	325	38.2%
4	Mental Health Services	306	36.0%
5	Health Education/Information/ Outreach	280	32.9%
6	Prescription Assistance	266	31.3%
7	Health Screenings	244	28.7%
8	Substance Abuse Services – Tied	224	26.4%
9	Elder Care/Senior Services – Tied	224	26.4%
10	Access to Affordable Fresh Fruits & Vegetables	221	26.0%

* Respondents could select more than one option, therefore the percentages may sum to more than 100.0%.

In addition, respondents indicated through an open-ended question a variety of resources and services that they felt were missing. The text box below highlights some of the verbatim comments.

Select Comments Regarding Resources Missing in the Community:

- "Direct contact with live receptionist on phone to navigate the health system."
- "Exercise facilities or parks not dedicated to competitive ball sports only."
- "Good primary care providers."
- "Not being aware of resources that exist."
- "Preventive, holistic, natural, alternative, therapies."
- "Safe streets, safe neighborhoods, places for children to play."
- "Smoking cessation included in substance abuse services; education on appropriate use of EMS and ED services."

Suggestions and Recommendations

To round out the feedback from survey participants, respondents were asked to provide suggestions/recommendations that they felt would be helpful in addressing the health needs of

Baltimore County residents. Most survey participants expressed the need for providing affordable health care and insurance plans, especially for seniors, and free/affordable mental health/substance abuse services. Respondents also pointed out the need for more health education and outreach in regard to nutrition, physical exercise, and chronic disease management.

FOCUS GROUP DISCUSSIONS OVERVIEW

Background

This section gives an overview of the finding of two Key Informant focus groups conducted on February 10 and February 17, 2016. Both focus groups were conducted at St. Joseph Medical Center. Each group involved a small number of individuals, with 12 participants attending in the first session and 11 participants in the second session, in order to hold a constructive and participatory dialogue with each participant. The participants represented a variety of health and social service sectors, with an active role and a broad understanding of the health care system and health needs of Baltimore County residents. A list of attendees for both sessions can be found in Appendix A.

Access to Care

Focus group participants were asked to discuss barriers related to accessing health care services in Baltimore County. The following themes emerged from the discussions in both sessions.

Lack of Specialty Care Providers and Long Wait Times

Lack of specialty care providers was commonly voiced as a significant barrier in both sessions. This issue often correlated with longer wait periods to see a specialist. The waiting period mentioned by participants ranged from 3 months to 7 months depending on the type of care needed. One participant mentioned "I'd like to see an increase in the availability of certain specialties so that patients aren't waiting 6 to 7 months to be seen, especially Neurology, Endocrinology, and Dermatology."

The point was also made that the massive increase in the number of people with insurance is creating an unprecedented imbalance in the health care system where demand exceeds capacity. From these discussions, it was gathered that many patients did not have assured and timely access to primary care providers or to specialists.

Insurance Deductibles and Price of Medications

The cost to obtain health care, particularly related to copays and deductibles, was cited as a barrier for Baltimore County residents. People with chronic conditions need advanced care and close follow-up to help them effectively manage their conditions. However, inability to afford high deductibles often pose a significant challenge and create a chain reaction where those who can't afford their medications or regular appointments often end up having a medical emergency situation and find themselves back in the hospital or the ER.

On the same line of thought, the price of medications was also mentioned by both groups as being a significant barrier. One participant described a situation where while many people might be able to find

affordable care, the "after care" costs deter them from following through with their medical care regiment and they won't go back for a follow-up.

Lack of Transportation

Transportation was also a shared concern among participants in both sessions and was identified as a major barrier, particularly for older adults. As one participant put it, "They [older adults] don't drive anymore and have to rely on family and friends or the MTM and it is often not a reliable system."

Another participant echoed that transportation often poses a huge problem for cancer patients who have to attend medical appointments for active treatments and follow-ups on a regular basis.

Lack of Awareness of Available Resources

Participants shared that a general understanding of how and where to access resources and connect with them is a persistent issue in the community. Participants also acknowledged that even they, as providers, are not fully aware of existing resources in the community. Key factors that were mentioned as determining one's ability to research these resources included access to a computer and the internet, one's ability to devote time to explore what's out there, which often is time consuming, and the literacy level of the individual.

In general, participants seemed to agree that there are plenty of resources available; coordinating these resources to provide a consistent method or path for residents to follow and creating awareness among providers so they know where to refer patients were recommended as an effective strategy to curb this issue.

Lack of Mental Health Providers and Stigma

Mental health services, particularly child and geriatrics psychiatric services were also a shared concern among participants. The wait period to see a psychiatrist was also noted to be overwhelmingly long, and could take anywhere between 3 to 9 months to get in. One physician expanded on this issue as follows:

> *"I had a lady in the office an hour ago who had seen her counselor and needs a psychiatrist and finally got an appointment with a psychiatrist in April* [2 months wait period]*, so she came by my office for medication so I can bridge her over that amount of time, and that was the soonest she could get in."*

The other theme that emerged as overlapping with mental health was the issue of substance abuse and prescription drug abuse. One participant described a sad recurring incident where opioid addiction was becoming commonplace in senior living/retirement homes. Participants also unanimously agreed that resources were acutely scarce when it comes to mental health/behavioral health and substance abuse services.

Bilingual Providers

Lack of bilingual providers and translators was also mentioned as a barrier, particularly for illegal immigrants and asylum seekers.

Major Areas of Opportunity

Focus group participants were then asked to discuss major areas of opportunity that they felt were important to improve access to care in the county.

Care Coordination

Care coordination appears to be the most needed piece in the health delivery process in Baltimore County to facilitate residents' interactions with the health care system and improve their health outcomes. It was noted that there were not many individuals in the county that were dedicated to handling comprehensive care coordination – just fragmented case management given in a disbanded manner.

Participants also talked about community health workers and their potential to successfully engage patients and spur them in the right direction of self-care. According to participants, these health workers serve as social workers in a way, but have the advantage of actually getting the trust of community members because they emanate from the communities that they serve. It was further discussed that patients do not generally trust providers because of the education barrier, and community health workers can overcome that barrier and get patients engaged and integrated in the system by building an ongoing relationship.

Case Managers

It was acknowledged that patients interact with any number of care providers across multiple settings. It would make it easier for patients to get better and stay healthy if they could have case managers who help streamline their different care and assist them with navigating the health system. The difficulty to navigate the health care system was again mentioned as a barrier.

Training Caregivers

Caregivers were mentioned as an important existing force in the service delivery process. Educating these caregivers to better understand the medical needs of the people they are caring for was mentioned as a plausible alternative to ultimately improve the health outcome of patients. Many agreed that the health system should provide more support to these caregivers who may have their hands full with a full time job and caring for their loved ones by teaching them about the available local resources to take care of the patients, as well as themselves.

Specialty Clinics

One participant mentioned that it could be a good idea to have specialty clinics, such as a Neurology Clinic or a Rheumatology Clinic somewhere at St. Joseph's Medical Center or in the suburban areas which would be manned by residency students or someone who is trained in that specialty. According to the participant, the physician may not need to be there the whole time, but those mid-level providers could be a great resource for residents in helping them access much-needed specialty services.

Community Involvement, Advocacy and Partnership

Focus group participants were then asked, "What do you think could encourage more community involvement, advocacy, and partnership around health issues that would benefit the public/your clients as it pertains to your organization's services?"

Coalition

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

Outreach (Community Paramedicine)

The overwhelming majority of participants seemed to agree that many people have difficulty getting to health care facilities and suggested the need for being proactive in rethinking the current health care delivery system so to get providers out in the neighborhoods and communities where people reside. This was believed to potentially enhance access to primary care, especially for medically underserved populations. Seniors/elderly individuals were mentioned to be at a disadvantage because most of these individuals no longer drive and are dependent on public transportation, which makes it difficult for them to attend medical appointments in a timely manner. Other population groups mentioned as potentially benefiting from such an outreach included homeless individuals and the general working population, who usually can't get off work.

Volunteers

The value volunteers bring to health care delivery was discussed extensively in both focus groups. One participant mentioned that there are a lot of residents, particularly baby boomers, who want to stay engaged and use some of their experiences and knowledge. Another participant discussed how using students in the health discipline (medical students, nursing students) proved to be an effective way to bring health education to the different parts of Baltimore County.

Challenges Facing Providers when helping people navigate health care services

Focus group participants were then asked, "From your perspective, what is the greatest challenge you face when helping people navigate health care services in the county?"

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

Lack of specialty care providers was brought up again as posing an enormous challenge and providers often struggle where to send patients for further diagnosis. Availability of after-hour services was also an issue in Baltimore County. Having a nurse or a resource person available to answer questions and provide information was suggested as a plausible solution. The over-utilization of Emergency Rooms was also discussed along these lines as being a leeway for folks who believe their case is emergency and think that they are going to get in and out of the ER quicker. Thus, having a nurse or a resource person available to answer questions and provide information could unburden the ER for truly emergency cases.

Underserved Populations

Focus group participants were then asked to discuss if there were specific populations in the county that they thought were not being adequately served by local health services. Illegal immigrants, refugees, cash-paid workers, and seniors were among the population groups that participants mentioned as being inadequately served by the local health system.

Major Chronic Illnesses

Several health conditions were mentioned by the two groups as being the biggest health problems in the community, including: Hypertension, Diabetes, COPD, Coronary Artery Disease/Vascular Disease, Overweight/Obesity and Substance Abuse/Addiction. However, most participants seemed to agree that the issue of overweight was rather cultural where "in some cultures what somebody considers overweight or a high BMI in some cultures it's acceptable."

Participants noted that while there may be resources available to treat chronic diseases and helping sick people, there is "a big void for focus on prevention" and a need to proactively think of preventive measures so these diseases do not occur in the first place.

Managing Chronic Illnesses

When asked what people in the community do to prevent and manage their chronic illnesses, participants seemed to be divided on the issue of exercise. While some suggested that people generally exercise to stay healthy, others noted that the likelihood of people to regularly exercise depends on their socioeconomic backgrounds and cultural orientation. Participants also pointed out that people go to their primary doctor to prevent and manage their chronic illnesses.

Participants offered a number of insightful suggestions when discussing what would motivate county residents to be more physically active and maintain a healthy lifestyle. The following bullet points summarize the core points discussed.

- Results: Seeing other people that were successful in losing weight through exercise and healthy diet could motivate folks to do the same.
- Family members putting pressure on each other.
- Providing evidence based programs for older adults in exercise programs. One participant offered, "It's not saying you need to go out and exercise, it's not saying you need to lose weight, but for older adults, it's do you want to be able to carry groceries, do you want to be able to lift a grandchild."
- Support groups: Being a part of a network where people are trying to achieve the same goal and try to encourage each other. The importance of building relationships, where one had peers to confide in was very stressed by many discussants.
- Reward: Giving monetary reward or reducing insurance premiums for achieving goals or being a part of a wellness plan.
- Healthy competition: Putting information online where people can compare themselves to other people that are exercising and achieving similar goals. A participant further offered, "you could expand that and jump to digital devices and provide that to other ethnic groups. Use mobile phones apps to track your steps."

- The primary care doctor should be the one to motivate people to engage in preventative medicine such as vaccinations, nutritional programs, healthy eating, physical activity, and screening tests.

Key Informants' Final Thoughts

When asked what the primary priority of the community should be to improve the health of those who live and work in Baltimore County, participants seemed to unanimously agree that building up the primary care network by taking the primary care services where the community lives and works would improve some of the issues related to access to care.

Networking with other providers and agencies who have cross-cutting goals was also mentioned as an important step. The use of technology to make those connections was again mentioned as an important tool, where providers could use technology gadgets such as video conferences or webinars for health promotion. Another most frequently mentioned priority was mental health and substance abuse. The need to attract more into the county, and enabling residents to access it and afford it was underlined.

Participants were also asked what St. Joseph Medical Center could do to support them or their organization in improving the overall health of the community. One participant suggested that St. Joseph should take part in community health fairs. Another participant brought up the idea of opening up a sub specialty center for the county so people have an option to find medical care nearby as opposed to going to Johns Hopkins.

It was also suggested that St. Joseph's affiliate Urgent Care centers such as Choice One could offer more lines of health care services than just medical surgical services, where they would house mental health therapists at least once a week to promote mental health and substance abuse and utilize the facilities within the community efficiently.

ST. JOSEPH'S INDEPENDENT STUDY OVERVIEW

As mentioned elsewhere in the report, St. Joseph conducted an independent community health survey the previous year. The survey sought to gather information around the most salient health issues in Baltimore County and identify the common barriers that keep people from seeking medical care. Notwithstanding the different methodologies used in the current CHNA and the survey St. Joseph undertook, some notable similarities were observed in the findings between the two studies. The finding is highlighted as follows:

- **Biggest health problems:** The majority of survey participants identified obesity as being the biggest health problem in the community, followed by drugs/tobacco/alcohol abuse. Diabetes, heart problems, and mental health were ranked as the 3rd, 4th, and 5th major health problem facing residents in the community. When asked to identify the top health problems in the community, survey participants mentioned obesity and drugs/tobacco/alcohol abuse as such.

- **Barriers to accessing health care:** The most common barrier that was identified as keeping people in the community from getting needed health care was cost, followed by transportation, lack of specialists in the area, and language barrier.

CONCLUDING THOUGHTS

Each of the research components from the CHNA reveal specific points of feedback that are worthy of attention from St. Joseph Medical Center and its partners. However, it is important to undertake a process that pulls key themes from each component and prioritizes the community needs. Select highlights from both components of the CHNA are listed below.

- **Cost of health care:** Overall insurance coverage appears to be favorable as evidenced through the community survey and key informant discussions. However, the inability to pay insurance co-pays, deductibles, and prescription medications was found to be a significant barrier for Baltimore County residents. Key informants noted that patients with chronic illnesses often fail to follow through with their medical care regiment because of their inability to afford out-of-pocket expenses.

- **Most pressing health issues:** Hypertension, overweight/obesity, cancer, and substance abuse were some of the most pressing health issues mentioned by both the community survey and key informant focus group participants.

- **Mental Health:** The issue of mental health and substance abuse was also a shared concern among participants. Along these lines, the need for mental health services and a shorter wait period to see mental health providers was commonly voiced.

- **Lack of awareness of existing resources:** Community survey participants mentioned through an open-ended question that they lack awareness of resources that are available to the community. This notion was corroborated by key informant focus group participants that even they, as providers, struggle with how and where to access existing resources when trying to connect patients with these resources.

IDENTIFICATION OF COMMUNITY HEALTH NEEDS

Prioritization Session

The prioritization session was hosted the morning of Friday, May 13th at UM St. Joseph Medical Center.

Process

After group introductions, there was a review of data and common themes identified in the 2016 Community Health Needs Assessment. Discussion followed on whether these findings were consistent with what the session participants observed in the community. Participants then discussed current approaches by UM St. Joseph Medical Center and other local agencies to address these areas of concern. Additional suggestions were offered for programs and partnerships. A summary of the discussion and priorities was read back to session participants for confirmation and final thoughts.

Key Community Health Issues

- Access to care
  - Lack of primary care and specialty care providers
  - Long wait times
  - Home care
  - Resource awareness
  - Price of medication and insurance deductibles
- Care Coordination
- Chronic Disease – Cardiovascular disease, Obesity, Stroke, Diabetes
- Disparities
- Low Health literacy and Language barriers
- Lack of transportation
- Mental health

- Substance abuse
- Tobacco use

Identified Health Priorities

- Access to Care
- Mental Health and Substance Abuse
- Chronic Disease- Cardiovascular Disease/Obesity
- Cancer
- Fall Prevention

Appendix A. Key Informant Focus Groups Participants

Session I

1. George Larocco, MD
2. Lin Romano
3. Barbara K. Anderson
4. Keith Jacobs
5. Christine Woods
6. William S. Queale, MD
7. Ruth Heltne
8. Kara Barlow RN
9. Julia Johnson
10. Della J. Leister, RN
11. Mary Jo Huber, RN
12. Wayne Brannock

Session II

1. Monica Fulton
2. Angelica Sfakianoudis
3. Donna Bilz
4. Ted Gross
5. Mary (Kathy) Mulford, CRNP
6. Steve Adelsberger
7. Nicolette Morris, MD

8. Aileen McShea Tinney
9. Kirsten Krummel-McCracken, RN
10. Matt Goldstein
11. Julie Vaughn, MD

Appendix B. Prioritization Session Participants

Name	Title	Agency
Jackie Sims	Community Member	Patient Advisory Council
Robert Breschi	Community Member	Patient Advisory Council
Donna Bilz	Healthscope Coordinator	Maryland Department of Aging
Irena Koyfman, CRNP	Director of Transitional Care	Maxim
Ita Cremen	Program Manager	Maxim
Laura Culbertson, RN	Public Health Administrator	Baltimore County Department of Health
Alice Chan	Population Health Manager	UM St. Joseph Medical Center
Michael Wainwright, MS, ACSM, CEP	Supervisor Cardiovascular Fitness Department	UM St. Joseph Medical Center
Kellie Edris	Senior Director of Marketing, Communications and Community Health	UM St. Joseph Medical Center
Mary Jo Adams, RN	Nurse Coordinator Community Health	UM St. Joseph Medical Center

Kristen Artes, MS, CHES	Community Health Specialist	UM St. Joseph Medical Center
Donna Costa, MA, MHS	Oncology Community Outreach Manager	UM St. Joseph Medical Center
Mary Jo Huber, RN	Nurse Manager St. Clare Medical Outreach	UM St. Joseph Medical Center

Appendix C. Full List of Outcomes from the 2013 CHNA

Implementation Strategy

Priority Area: CHNA Goal 1 - Access to Health Care

Priority Area: Access to Health Care Services

Goals: Bring screenings, vaccinations and health education to people who otherwise would not receive any health care interventions.

1. Increase the number of patients receiving free flu shots
2. Increase the number of patients receiving health screenings

Objective	Strategy & Action	Population	Measure
Increase the number of patients who receive free flu shots	Community Health will provide over 3,000 free seasonal flu vaccinations to the community through open clinics offered onsite and at various offsite locations in surrounding areas of need (Cockeysville, White Marsh, Owings Mills, Hereford, etc.) from October through December.	General population	Number of community members who receive vaccinations ▪ FY14 2617 vaccinated 18 clinics total, 13 offsite ▪ FY15 3013 vaccinated 20 clinics total, 14 offsite ▪ FY16 2399 vaccinated 20 clinics total, 14 offsite ▪ Zip codes served: 21204, 21093, 21030, 21218, 21236, 21120, 21202, 21201, 21231 Four community flu clinics hosted every year at UM SJMC on a weekday, a Friday evening, a Saturday, and a Sunday. Clinics are also held offsite at different locations in Baltimore County from 12-7pm (White Marsh Mall, Greetings & Readings Hunt Valley, Kenilworth Mall, St. Joseph Parish Cockeysville). Other areas of need are targeted in Baltimore City (Marian House, Esperanza Center, Weinberg Center, Lexington Market). Vaccine Information Sheets and consent forms are provided in

Increase the number of patients receiving health screenings	Community Health will offer free monthly bone density screening to help individuals evaluate osteoporosis risk and to provide resources to support bone health. Over 150 individuals will be screened and educated.	General population	Spanish if needed (over 20% of the individuals vaccinated at St. Joseph Parish in Cockeysville are Hispanic). Free flu shots are also offered in couples attending childbirth class in the fall. Number of patients who participate in screenings ▪ FY14- 205 screened (72 referred for follow-up) ▪ FY15- 242 screened (79 referred for follow-up) ▪ FY16- 199 screened to date (70 referred for follow-up)
	Community Health will offer free bone density screenings at all 20 Baltimore County Senior Centers in 2013. Over 200 seniors will be screened and educated.	Senior Citizens	Number of screenings/education accomplished. ▪ FY14- 317 screened (156 referred for follow-up) ▪ FY15- 258 screened (125 referred for follow-up) ▪ FY16- 169 screened to date (78 referred for follow-up)
			▪ Two health educators and a nurse completed training in Stepping On for Better Balance, an evidence-based fall prevention program. Four series were hosted with 45 total participants.

Priority Area: CHNA Goal 2 - Diabetes

Priority Area: Diabetes
Goals:
1. **Increase the number of patients served by Diabetes Education/Outreach**
2. **Increase the emphasis in Diabetes Education on obesity education and high blood pressure awareness as a consequence of diabetes**
3. **Maintain and enhance diabetes education for Hispanic patients at St. Clare Medical Outreach**

Objective	Strategy & Action	Target Population	Measure
Increase patients seen in Diabetes Education -------- Highlight connection between diabetes and resulting complications, especially high blood pressure for patients receiving diabetes education --------	Continue and expand evidence-based diabetes education opportunities	Patients diagnosed with diabetes	Maintain current program enrollment and increase as needed ▪ FY14- 518 clinic visits ▪ FY15- 930 clinic visits ▪ FY16- 576 clinic visits (year to date) An endocrinologist was hired for FY15, resulting in increased patient volumes. In February 2015, the endocrinologist left and an educator's FTE was changed. ▪ FY14- 24 visits for free diabetes support groups ▪ FY15- 61 visits for free diabetes support groups ▪ FY16- 46 visits for diabetes support groups (year to date) ▪ Two health educators were trained as instructors in Stanford's Living Well Chronic Disease Self-Management program. Three series were hosted in FY16 with 32 total participants.

Increase diabetes compliance by patients at St. Clare Medical Outreach ----------	Maintain collaboration between hospital-based diabetes educators and staff of St. Clare Medical Outreach	Patients of St. Clare Medical Outreach	Maintain current obesity awareness and nutrition initiatives at St. Clare Medical Outreach, monitoring outcomes. Continue to monitor A1C levels for progressive improvement ▪ **FY 14** –Tracked only monthly average of A1Cs. Monthly average ranged from 7.3- 8.3 Yearly average – 7.78. ▪ **FY 15-** Monthly A1Cs ranged from 7.5-8.4 Yearly average A1C–7.87 42.7 % of patients had an A1C of 7 or below 29% had an A1C of 7.1 – 8.9 28% had an A1C of 9 or greater ▪ **FY16-** with a New Medical Director A1C tracking was performed differently 45% patients have an A1C of 7 or below 40% patients have an A1C of 7.5-8.4 15% of patients have an A1C of 9 or greater Monthly average A1Cs range from 6.99 - 8.8, year to date average A1C is 7.52
Increase body composition awareness and the implications	Community Health will offer free monthly body composition analysis to help individuals evaluate weight, body fat, and muscle mass on an ongoing basis and to provide resources to support individual weight loss efforts. Over 250 individuals will have their body composition analyzed and explained at onsite and offsite events.	General population	St. Clare received a grant from BGE for education. St. Clare was able to purchase booklets in Spanish for patients on healthy styles and replicas of food. A grant from the Hoffberger Foundation was awarded to St. Clare to purchase strips for glucometers and medication for diabetics. Number of people screened ▪ FY14- 217 screened

			▪ FY15- 433 screened ▪ FY16- 419 screened to date ▪ UM SJMC hosted an educational series including screening parts of the HBO documentary Weight of the Nation theweightofthenation.hbo.com/ and discussion with a panel of experts. A healthy meal and educational material on nutrition was provided. There were 225 participants. ▪ UM SJMC hosted a monthly weight management support group for six months. The support group was discontinued due to low attendance.

Priority Area: CHNA Goal 3 – Substance/Tobacco Abuse

Priority Area: Substance/Tobacco reduction/cessation

Goals: Increase the number of patients using screening and primary care outreach opportunities

1. **Bring smoke cessation education to high school age students**
2. **Increase the number of people who participate in one of our multi-week, smoking cessation courses**
3. **Increase the number of participants in a Powered by Me! event**

Annual Objective	Strategy & Action	Population	Measure
Increase the number of people who receive substance/tobacco cessation interventions through UM-SJMC (Fresh Start classes and Powered by Me!)	Smoking cessation resources will be provided to all cardiovascular and cancer screening participants. Tobacco awareness will be offered as a topic for secondary school health fair requests including Calvert Hall College High School and Rosedale Alternative School.	Patients already who are screened for cardiovascular disease or cancer High School students	Numerical increase in people offered substance/tobacco cessation assistance. ▪ FY14- 340 ▪ FY15- 2740 ▪ FY16- 1053 (year to date) ▪ Beginning in FY15, smoking cessation resources were included in heart education booklets provided to cardiac rehab patients Numerical increase in number of people who participate in substance/tobacco cessation opportunities at UM-SJMC

	Maintain Powered by Me! Involvement in sports programs	Student athletes, coaches, parents, school administrators	▪ UM SJMC attempted to host the Freedom from Smoking course on two separate occasions, but registration/ attendance was insufficient to complete the course. ▪ In FY16 Stroke III: Advanced Topics in Risk Reduction was added as an opportunity for nursing education. The course covers material on how to help patient quit smoking including the science of nicotine addiction, motivational interviewing techniques, and smoking cessation resources. 255 nurses participated. http://poweredbymemd.org/ ▪ FY14- 527 attended conference ▪ FY15- conference cancelled due to Baltimore City riots ▪ FY16- 471 attended conference ▪ Student athletes, coaches, and administrators from 51 public and private high schools in Baltimore County, Baltimore City, Howard County, Harford County,

			Prince Georges County, Anne Arundel County

Priority Area: CHNA Goal 4 – Heart Disease/Hypertension/Stroke

Priority Area: Heart disease/hypertension/stroke **Goals:** **1. Raise awareness of risk factors for stroke, stroke symptoms and appropriate response to symptoms**			
Annual Objective	**Strategy & Action**	**Population**	**Measure**

To provide education regarding stroke prevention, signs of stroke	Provide stroke education on the topics of signs and symptoms of stroke, activating EMS, risk factors, and prevention to 500 people in the local community in fiscal year 2014. Create an annual internal May Stroke Awareness Month campaign based on the F.A.S.T. public education materials, with a target audience of visitors and nonclinical staff, to launch on May 1, 2013.	General population Hospital visitors, UM-SJMC non-clinical staff	Numbers of community members educated ▪ FY14- 912 ▪ FY15- 890 ▪ FY16- 1004 (to date) F.A.S.T. posters and tabletop tents were distributed throughout public and restricted areas in UM SJMC. F.A.S.T. messaging on public television monitors in hospital. Partnered with Marketing for blog posts, Facebook posts, and articles for local newspapers and UM SJMC Health Matters magazine. Annual Health Stream stroke education module mandated for all clinical employees. A series of stroke education classes were initiated for nurses. About 300 nurses participate each year.

Priority Area: CHNA Goal 5 – Maternal/Child Health

Priority Area: Maternal/Infant Health

Goals:

1. To educate pregnant women and women of childbearing age of the dangers of poor nutrition, diabetes (gestational and chronic), high blood pressure, substance/tobacco use during pregnancy

2. To educate women who are pregnant and those of childbearing age how they can enhance their own health and the health of their unborn child

3. To educate target populations how protect themselves and the baby from severe, long-term negative health outcomes

4. To educate women about low/very low birth weight, its causes, its prevention, long-term consequences of low/very low birth weight

Annual Objective	Strategy & Action	Population	Measure
To include education about healthy lifestyle practices into all women's services encounters	Bilingual educational materials will be available to all providers of women's health services at UM-SJMC.	Women who are pregnant, women of childbearing age who are not pregnant	Consistency of including healthy lifestyle education in patient encounters and in high school health education visits ▪ Patients at Women's Health Associates (WHA) receive verbal education on healthy lifestyle practices at each visit ▪ FY14- 9,315 patient visits ▪ FY15- 10,527 patient visits ▪ FY16- 7,778 patient visits (year to date) Need to reorder educational material. ▪ The majority of pregnant patients at WHA receive written educational material in English or Spanish as preferred by the patients.
To include education about the long-term effects of low/very low birth weight into all women's services encounters	All providers will be asked to include education on the relationship between healthy lifestyle/nutrition into their regular patient visits. These materials will be available to providers at UM-SJMC's Women's Health Associates, our Perinatal Center.		
To include education about low/very low birth weight into	Community Health Outreach will include education on low/very	High school students	Number of students ▪ FY14- 190 students

all high school health education opportunities	low birth weight in high school classes		▪ FY15- 290 students ▪ FY16- 184 students to date Education delivered at Catholic High- an inner city school

Implementation Strategy

Priority Area: CHNA Goal 6 – Cancer

Priority Area: Cancer **Goal:** **1. Increase number of patients screened for various types of cancer** **2. Increase cancer screenings in minority communities** **3. Increase number of patients diagnosed w/cancer and moved to treatment**			
Annual Objective	**Strategy & Action**	**Population**	**Measure**
			NOTE: FY 2013-April 2016 Metrics
Develop strategic plan to implement cancer prevention and early detection education in the community with an emphasis on reaching underserved members of community	**Partnerships included:** ▪ Hopkins Community Advisory Group –East Baltimore ▪ UM SJMC Community Health Program 2013, 2014, 2015 ▪ ACS, One Voice Grant 2102, 2013 ▪ One Voice Program , culturally sensitive collaborative prevention & early detection program with Advanced Radiology, Nueva Vida, Cancer Institute, Breast Center 2013, 2014, 2015 ongoing	▪ Underserved populations ▪ African American women and Latina women ▪ PCP & Health Care Professionals	Metrics for measuring outreach program effectiveness: # Community education programs ▪ FY 2014= 30 cancer prevention programs ▪ FY 2015= 16 cancer prevention programs ▪ FY 2016 thru April 2016 cancer prevention programs=8 ▪ **Total= 54** # Community members educated ▪ FY 2014= 3,002 ▪ FY 2015= 1,555

	▪ Sister's Network 2012,2013 for African American and Nueva Vida Latina Women 2013, 2014, 2015 ▪ Maryland Cancer Collaborative Primary Prevention and Disparities Committee 2013, 2014 ▪ Member Patient Navigation Network Leadership Team 2015 ▪ Member Cancer Collaborative Steering Committee 2015 ▪ Baltimore County Cancer Coalition 2013. 2014, 2015 ▪ Baltimore City Cancer Coalition 2013, 2014, 2015 ▪ Susan G. Komen ▪ Govan's Ecumenical Development Corporation GEDCO ▪ Educational Activities Provided: Cancer Prevention programs are consistent with evidence based national guidelines and evidence based interventions; ACS, Association of Breast Surgeons and NCI national guidelines **Action Examples:** ▪ American Cancer Society CPS 3 Cancer Prevention Study:		▪ FY 2016= 604 ▪ **Total= 5,161** # PCP/ Health Care Professionals Educated ▪ FY 2014= 225 ▪ FY 2015= 95 ▪ FY 2016= 220 ▪ **Total= 540**

	9/17/13 ;SJMC host site enrolled 67 people ▪ St. Stephen's AME Church Essex 9/14/13 CPEDE Zip 21221 ▪ Marian House for Homeless Women 10/2/13 CPEDE &Resources CPEDE Zip 21218 ▪ Senior Expo 10/9/13 CPEDE Zip 21093 ▪ New Psalmist Baptist Church, 10/12/13 Breast Cancer Awareness CPEDE Zip 21215 ▪ Oak Crest Employee Health Expo 10/16/13 CPEDE Zip 21234 ▪ MD Health Connection Speaker 10/15/13 Access to Care at UM SJMC ▪ B'More Healthy, UMMS Event at Convention Center 3/1/14 CPEDE Zip 21201 ▪ Mt. Calvary AME Church Biggest Loser Health Event 3/8/14 CPEDE Zip 21286 ▪ Komen Finding Your Path to Breast Health, New Psalmist Baptist Church 3/8/14 CPEDE Zip 21215 ▪ Colorectal Cancer Awareness Day at UM SJMC 4/16/14 ▪ Why Women Cry Event, University of Baltimore Mt Royal Ave 4/21/16 CPEDE Zip 21201		

	▪ Baltimore County Housing & Self Sufficiency Program, Baltimore County Health Department Drumcastle 4/26/14 CPEDE Zip 21212 ▪ Mt. Calvary AME Church 5/10/14 CPEDE Zip 21286 ▪ Archdiocese Health Day 5/15/14 CPEDE Zip 21201 ▪ Women's Health Conference at UM SJMC 5/17/14 CPEDE ▪ WJZ Ask the Expert Call In 6/5/14 at WJZ TV Station Zip 21211 ▪ Up In Smoke Smoking Cessation Classes 6/23 & 6/30 at UMSJMC NOTE: currently refer patients to Baltimore County Smoking Cessation Programs throughout county ▪ Primary Care Physician Outreach/Education, Cancer Institute Annual Symposiums at Sheppard Pratt Conference Center Zip 20204 ▪ Cervical Cancer Awareness 1/14/15 at UM SJMC ▪ Leadership Baltimore, 2/9/15 at UMSJMC CPEDE ▪ Cancer Prevention Awareness at UM SJMC 2/18/15 ▪ Colon Cancer Awareness at UM SJMC 3/18/15 ▪ WJZ Ask the Expert 3/26/15		

	▪ Towson Y High Risk Breast Screening Education 3/30/15 Zip 21204 ▪ Mc Cormick Employee Event 5/11/15 CPEDE Zip 21131 ▪ Archdiocese Health Event 5/16/15 CPEDE Zip 21201 ▪ 4th Annual Women's Conference at UM SJMC 5/16/15 CPEDE ▪ Patient Navigation Conference ▪ 9/16/16 at Sheppard Pratt Conference Center participants representing State of MD ▪ UM SJMC Employee Wellness Event 10/8/16 ▪ Colorectal Cancer Screening Initiative for Employees/Education and Screening 2/18/16, 2/24/16,/2/24/16 for Sedexo, 3/5/16 screening, 3/19/16 screening, 4/9/16 screening ▪ Heart health Employee Wellness Event- Colorectal Cancer Screening Guidelines		
Foster Breast Screenings and Breast Health Education	Community Cancer Screenings scheduled in partnership with SJMC Community Health and continuation of monthly 100 free Screening Mammogram program with our original	Community Women Hispanic women Uninsured women	**Numbers of women screened** ▪ FY2014 = 101 women ▪ (29 community, 10/5/13 + 72 One Voice) • 65 Hispanic • 84 uninsured

	One Voice partner, Nueva Vida, thru April 2016 Self-breast exam education is included in the monthly ongoing screening		▪ FY 2015 = 89 women (29 Community 10/11/14 + 60 One Voice) • 58 Hispanic • 67 Uninsured ▪ FY 2016 thru April 2016 = 111 women (21 community 10/10/15 + 90 One Voice) • 82 Hispanic • 97 Uninsured **Total = 301**
	▪ Participation in the Baltimore City Cancer Coalition ▪ Baltimore County Cancer Coalition ▪ Maryland Cancer Collaborative State Coalition Steering Committee ▪ Maryland Patient Navigation Network Leadership Team ▪ American Cancer Society ▪ Nueva Vida ▪ Luekemia & Lymphoma Society ▪ Pancreatic Action Network ▪ Hopkins Community Advisory Group ▪ UM SJMC Community Health and Wellness Wise Committee	Women and men	**Active participation in listed Coalitions/organizations #** • 2014= 8 • 2015= 7 • 2016=8
Continue cervical cancer screenings	2 Cervical Cancer Screenings scheduled in partnership with Community Health	Women	**Number of women screened for Cervical Cancer** ▪ FY 2014 = 28 11/12/13 ▪ FY 2015 = 31 3/7/15 ▪ FY 2016= 31 3/12/16

			▪ **Total= 90**
Continue prostate cancer screenings	3 Prostate Screenings scheduled in partnership with Community Health	Men	**Number of men screened for Prostate cancer** ▪ FY 2014 = 28 9/25/13 ▪ FY 2015 = 16 9/20/14 ▪ FY 2016= 26 9/16/15 ▪ **Total = 70**

Continue skin cancer screenings	2 Skin Screenings scheduled in partnership with Community Health	Men and Women	**Number of people screened for Skin Cancer** ▪ FY 2014 = 42 5/8/14 ▪ FY 2015 = 32 9/20/14 ▪ FY 2016= 0 ▪ **Total = 74**
Colon Cancer Employee Screening Initiative Signed ACS 80% by 2018 pledge to increase colorectal cancer screenings	3 Colorectal Cancer Screenings 3/5/16, 3/19/16, 4/9/16	Men and Women	**Number of people screened for colorectal cancer** ▪ **FY 2016 = 30+ meeting on 5/10/16 to report final metrics**