Ascension Saint Agnes Hospital

FY 21 Community Health Needs Assessment

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Summary

The three Community Health Need Priorities to be addressed by Ascension Saint Agnes (ASA) for the FY 2021 through FY 2024 cycle are:

- **Address mental health/substance use disorder;**
- **Prevent diabetes and improve health; and**
- **Build person-centered healthy neighborhoods to address social determinants of health.**

These priorities were defined with robust community input.

Introduction

Background

ASA is dedicated to the art of healing. We have a long history of providing exceptional holistic care to a diverse population of over 400,500 residents of the southwest segment of the Baltimore metropolitan area. We are a fully accredited, full-service 251 bed teaching hospital with residency programs in medical and surgical specialties. ASA offers emergency services and a wide variety of inpatient and outpatient services in addition to institutes and community-based offices including Saint Agnes Medical Group and Seton Imaging. Built on a strong foundation of excellent medical care and compassion, ASA and the physicians who practice here are committed to providing the best care for our patients for many years to come.

Maryland increasingly recognizes the many factors influencing health beyond traditional health care, and ASA is leading the way by creating new opportunities to be as relevant to our community when they are well as when they are sick. ASA is committed to achieving measurable improvements in health and the social determinants of health. ASA annually provides approximately $45 million in charitable giving and community benefit.

Since 2018, the ASA Health Institute has partnered with the community to keep individuals at their best health. The ASA Health Institute continually evolves to implement new initiatives, with a focus on community engagement, care management, chronic disease management, and behavioral health. ASA operates a robust Diabetes Prevention Program (DPP), and recently secured $5 million in new funding to support DPP. In 2020, ASA in partnership with Catholic Charities established a primary care clinic at My Brother's Keeper. Efforts to improve health outcomes and reduce health disparities traditionally sought to build care coordination services into clinical practice. The My Brother's Keeper clinic inverts that approach, by building clinical services into a trusted community anchor. To address patients' transportation needs, in 2020

ASA developed a new transportation model, building a network of volunteer chaperones to accompany older adults and adults with disabilities to and from medical appointments. Another ASA initiative is Food Rx, which addresses systemic inequities in access to healthy food and improves nutrition for chronically and medically complex patients.

ASA submits the Fiscal Year (FY) 2021 Community Health Needs Assessment (CHNA) amidst the ongoing COVID-19 pandemic. The effect of COVID-19 on the U.S. healthcare system and economy is unprecedented. Motivated by our mission, we've taken every precaution to keep our communities safe while caring for those who need us most.

Our Mission and Vision

Saint Agnes Hospital was founded in 1862 by the Daughters of Charity to meet the health needs of the poor. As a Catholic health care ministry and member of Ascension Health, ASA is dedicated to the art of healing to sustain and improve the lives of the individuals and communities we serve. Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving our entire community, with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually centered, holistic care which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words. Figure 1 shows ASA's core values.

Figure 1: ASA Core Values

Our community outreach programs continue to expand our mission. ASA has launched community initiatives to fight diabetes, cardiovascular disease, and obesity, improve access to primary care, and address social determinants of health such as access to nutritious food and transportation. Through expanding outreach and community integration services our dedicated team strives to enhance the social and physical environments that promote good health for all.

We envision a strong, vibrant Catholic health ministry in the United States which will lead to the transformation of healthcare. We will ensure service that is committed to health and well-being for our communities and that responds to the needs of individuals throughout the life cycle. We will expand the role of laity, in both leadership and sponsorship, to ensure a Catholic health ministry in the future.

CHNA Purpose and Scope

The ASA CHNA process is about improving health—the health of individuals, families, and communities. The objective of the assessment is to evaluate the health status of the people residing in the communities surrounding our hospital, to highlight the geographic regions and populations within the service area that have greater health needs, and to determine how ASA can best respond to health need priorities. In accordance with IRS requirements and Affordable Care Act, hospital facilities with a tax-exempt status are mandated to complete this assessment every three years, with the input of representatives from the community as well as local health jurisdictions. Hospital services and health improvement programs are to be linked to the needs identified in the assessment process. Improvements in community health are to be demonstrated through measurable outcomes, as impacted by hospital services and programs.

The assessment process involved both quantitative and qualitative components. See Figure 2. ASA engaged the participation of the public through a structured online survey and a series of focus groups. We presented findings to several groups of external stakeholders to solicit feedback from leaders among the communities we serve. Internal stakeholders representing clinical care, population health, care management, and pastoral care also provided input.

Figure 2: Community Health Needs Assessment Process

In the prior CHNA cycle, ASA adopted the following three priorities for FY 2018 through FY 2021:

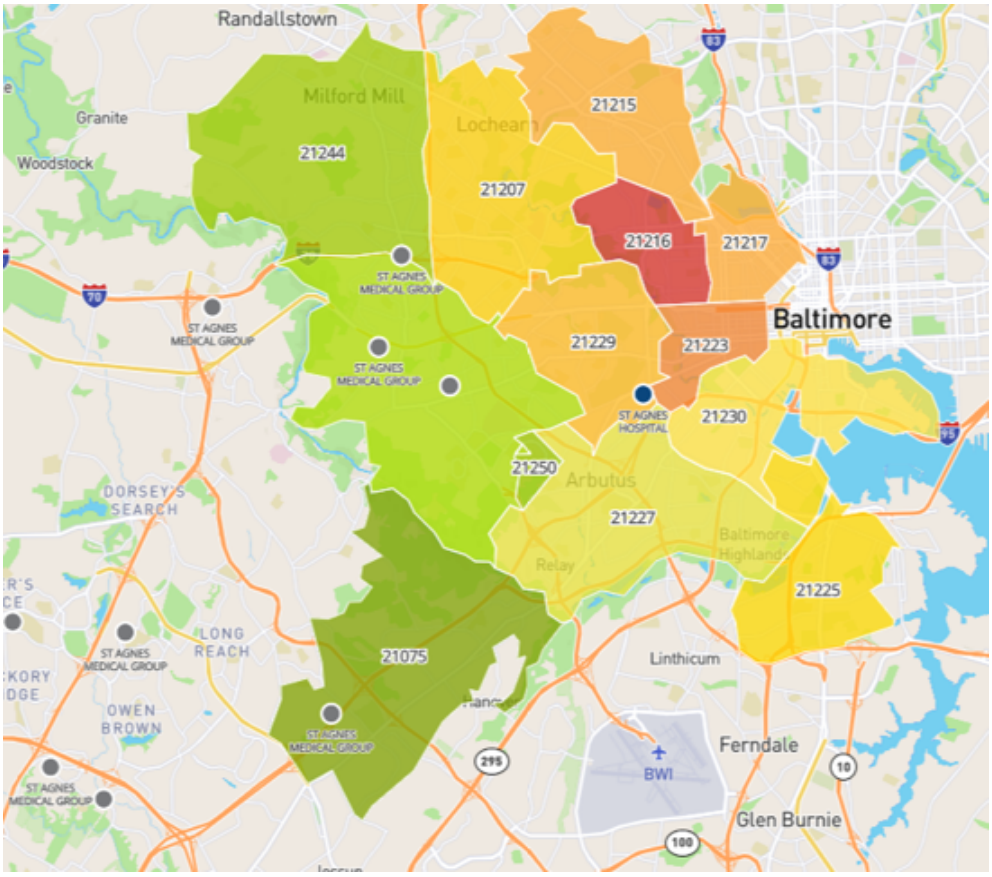
- Address mental health/substance abuse (shared priority with all Baltimore City hospitals);
- Reduce obesity and impact of chronic diseases; and
- Create person-centered healthy neighborhoods to address social determinants of health.

For FY 2021, ASA again conducted our CHNA collaboratively with other Baltimore City Hospitals. This facilitates the establishment of shared health need priorities as well as strategies to collectively address identified health needs. As the healthcare industry transitions to value-based based care across the continuum, a shared understanding and knowledge of community needs has become a more important aspect of the CHNA.

Community Benefit Service Area

The community benefit service area is comprised of the zip codes that account for 70% of ASA hospital discharges. The ASA service area changed between FY 2018 and FY 2021. The zip code 21226 Curtis Bay is no longer included; in FY 2018 it was the furthest south community in the ASA service area. New zip codes in FY 2021 include 21075 Elkridge, representing a southwestward expansion into Howard County, and 21244 Windsor Mill and 21250 Baltimore/UMBC. These represent a westward shift into Baltimore County. The ASA FY 2021 community benefit service area is shown in Figure 3. Within the service area, ASA has defined different communities. The communities are groupings of zip codes in with similar demographic characteristics and geographic boundaries. Details about each of the individual communities are in Appendix 1.

Figure 3: Ascension Saint Agnes Service Area by Zip Code



The needs of the ASA service area are highly variable from community to community. ASA focuses upon the needs where we can have the greatest impact on community health. This guides the allocation of resources and development of new healthcare programs.

Addressing the COVID-19 Pandemic

It is important to acknowledge the context of the COVID-19 pandemic as a backdrop to the FY 2021 CHNA. The social, economic, and health effects of COVID-19 have reverberated through our community. Given the requirement to eliminate non-emergency services for a period of months, hospital revenues plummeted. At the same time, hospitals faced increased costs for protective personal equipment (PPE), testing, ventilators, and infrastructure to implement telemedicine. ASA has taken steps to support our patients, health care partners, associates, and the community at large.

Patient Support

In addition to serving COVID-19 patients through the emergency department and on an inpatient basis, ASA focused on the provision of testing. We established a 24/7 COVID-19 hotline, where our nurses and care teams could guide patients with the most up-to-date screening information and best options for care and testing. We launched the availability of drive-by COVID-19 tests for qualified patients.

We took measures to address patients' hesitancy to seek medical care due to fear of COVID-19 exposure by rapidly expanding telemedicine services and enabling patients to access care

without leaving home. To date we've provided over 32,000 telemedicine visits. We also have provided prescription delivery to medically fragile patients.

Additional steps helped ensure the safety of our patients. This included the provision of remote monitoring tools and access to care team support for the daily status monitoring for COVID-19 positive patients and persons under investigation for COVID-19. Tracphones were provided for patients without phone access to facilitate remote management. We also provided shuttle rides home, and hoteling for COVID-19 patients in need of isolation from their households.

We provided a remote monitoring program for COVID positive patients identified as high risk of hospitalization by the ED or their PCP. These patients were provided with a pulse oxygen monitor, application for their phone, and care management support. Patients were asked to respond to questions on the mobile application three times per day describing signs and symptoms. Patients with specific responses triggered follow up by a nurse or physician. Patients who did not respond were contacted by the care management team, and if they were not able to connect with them, the local 911 was called and a wellness check was requested. Patients reported high satisfaction with this program.

Skilled Nursing Facility Support

Nationwide, skilled nursing facilities (SNFs) have been heavily impacted by COVID-19. ASA supported our post-acute network through the provision of PPE, testing supplies and staff for testing, weekly technical assistance and coordination calls, Medical Director support calls, and COVID-19 prevention messaging supplies. ASA contracted home health agencies and SNFs to serve underinsured patients with home health services, skilled nursing days, and home oxygen services.

Community Support

ASA implemented the following actions to mitigate vulnerabilities and disparities exacerbated by the COVID-19 crisis:

- Distributed over 42,000 pounds of produce to key community partners including churches, urban farming group, family homeless shelter, and a day resource center.
- Distributed over 27,000 pounds of produce to medically fragile patients.
- Distributed COVID-19 prevention messaging posters throughout the community.
- Provided 250 hygiene kits for seniors and families with infants distributed door-to-door and through community partners.

Vaccine Distribution

ASA has led the way in distributing COVID-19 vaccinations to our community, with a special focus on reaching vulnerable populations. We continue to coordinate with local health departments and other hospitals and health care providers to deliver vaccinations. By leveraging our well-established relationships with community partners, we are gaining insight into how best to target areas with extremely low vaccination rates. These partners are known and trusted in their communities and serve as the base of vaccine distribution operations. Our efforts include the following:

- Community-based vaccine clinics convened with our partners in underserved areas;

- A mobile vaccine team that brings vaccines to communities in need and homebound individuals to overcome transportation barriers; and
- Broad community educational efforts as well as in-person outreach by community health workers.

Associate Support

During the COVID-19 crisis, our ASA doctors, nurses, respiratory therapists, and other members of our care teams worked long shifts to meet patients' needs. Like other families across the country, our front-line healthcare workers had to balance the demands of work with the closure of their children's schools and childcare centers. National news of healthcare workers falling ill and even dying from COVID-19 was widespread prior to vaccine availability. Our front-line staff faced the daily potential risk of COVID-19 infection for themselves, and potential risk of transmission of the virus to their families—adding to physical and mental stress. In recognition of this, ASA provided support to our associates through financial assistance to address basic needs, $25,000 in meals to associates, organization and delivery of donated meals for our hospital teams, shuttle service and Lyft gift cards for associates, and peer support counseling.

Primary and Secondary Data Research and Analysis

Community Survey Overview

A consumer survey sought to gain a quantitative assessment to establish broad public input from the community. The survey was conducted in October 2020 in collaboration with other Baltimore City Hospitals. Due to COVID-19 restrictions, the survey was fielded solely electronically. The survey questions are included as Appendix 2. Like the prior CHNA cycle, the survey asked respondents to rate the community's three most important health problems, social/environmental problems, and barriers to accessing healthcare. The survey asked respondents about their mental health, given the prioritization of that issue. Respondents were provided an opportunity to state ideas and suggestions for improving the health of their community. In 2020, the survey also asked respondents about their concerns and needs related to the COVID-19 pandemic.

Through the collaboration among Baltimore City Hospitals, there were 3,170 respondents across Baltimore City with over 100 zip codes represented. As in the past, respondents are predominately female (63%) and African American (61%). Approximately half of respondents are age 50 or older (52%) and half are ages 18 through 49 (48%). Respondents who reside in zip codes within ASA's service area (referred to as ASA respondents throughout this report) accounted for 1,202 responses (38% of total responses). Their demographics are similar, but with a higher proportion of respondents who are African American (74%).

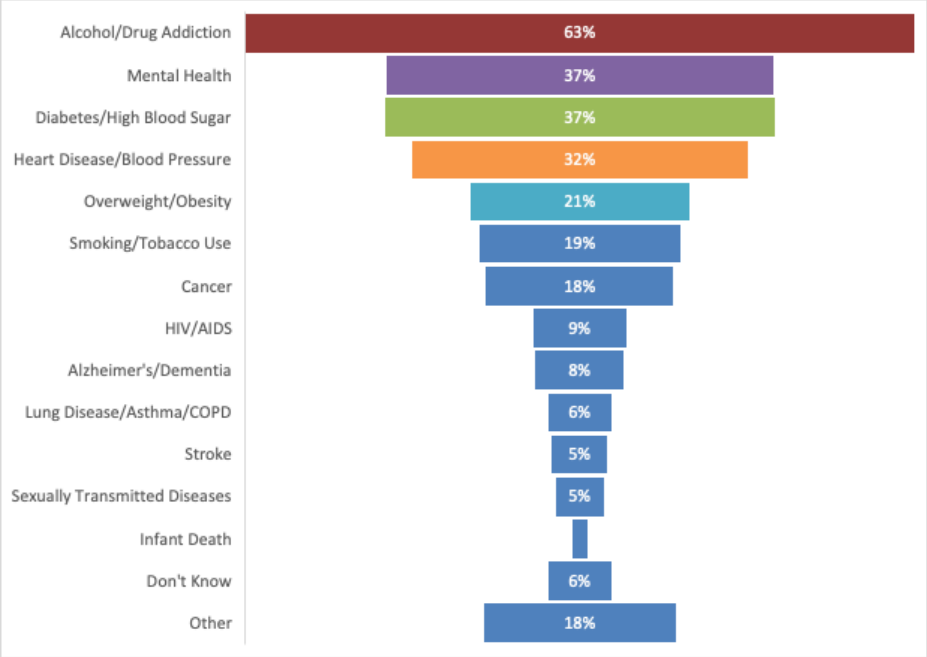
Community Survey – Top Health Concerns

Survey respondents identified the three most important health concerns facing their community from a list of health issues, including behavioral health problems such as

alcohol/drug abuse or tobacco use, mental health issues; chronic health conditions such as diabetes, hypertension, and overweight; and major diseases such as cancer, HIV, and Alzheimer's.

Results are shown in Figure 4. Among respondents residing in the ASA service area, the most named health concern was alcohol/drug addiction (named by 63%). This was followed by diabetes/high blood sugar and mental health (including depression and anxiety)—each were named by 37%). The next most named concern was heart disease/blood pressure (named by 32%).

Figure 4: Top Three Health Problems
Identified by Survey Respondents Residing in ASA Service Area



City-wide responses were similar, with alcohol/drug addiction named by 63%, followed by mental health (depression/anxiety) named by 36%, and diabetes/high blood sugar and heart disease/blood pressure each named by 34% of respondents City-wide. Overweight/obesity was

named by 21% of ASA respondents and 22% of respondents City-wide. Among those who responded “other,” the most common issue was chronic pain/arthritis, followed by violence (which is one of the choices for the question on social/environmental concerns).

Respondents were asked how many days during the past month their mental health not good. Among the 21% of ASA respondents who indicated they had days when their mental health was not good, the average number of days was approximately 11.

The top health concerns cited by ASA respondents—alcohol/drug addiction, diabetes/high blood sugar, and metal health—varied only slightly when segmented by different parameters. Figure 5 below shows the responses by neighborhood area, sex, race/ethnicity, and age. Male respondents ranked heart disease/blood pressure over mental health. Hispanic/Latino respondents and respondents under age 50 ranked heart disease/blood pressure over diabetes/ high blood sugar.

Figure 5: Top Health Problems by Area, Sex, Race/Ethnicity, and Age

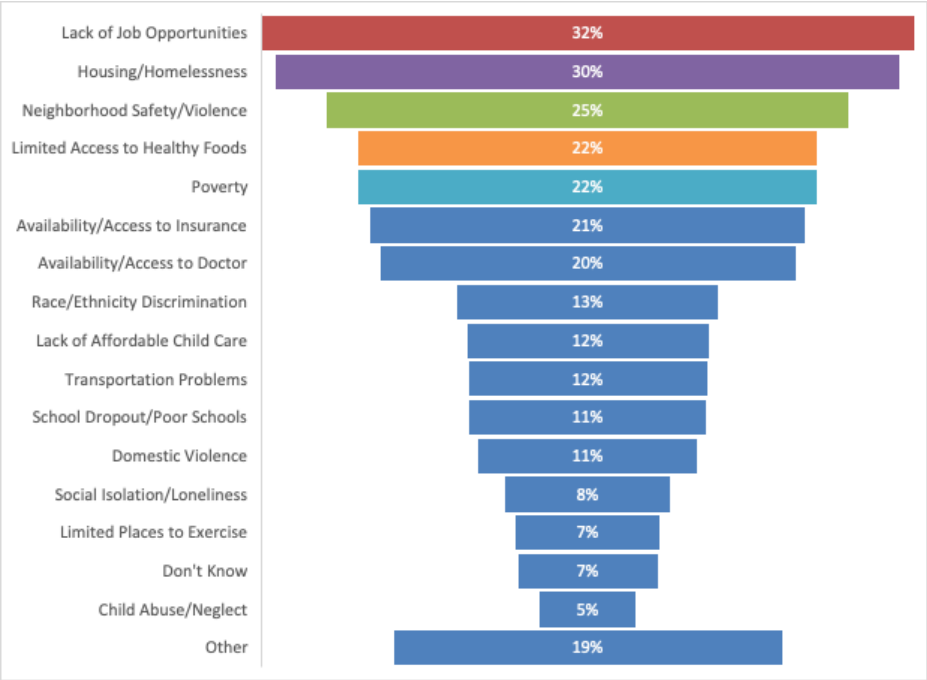
Most Important Health Problems	Total	Area		Sex		Race/Ethnicity				Age	
		City 91%	County 9%	Male 32%	Female 68%	African American 73%	White 18%	Multi/ Other 9%	Hispanic 4%	18-49 44%	50+ Years 56%
Alcohol/Drug Addiction	**63%**	**65%**	**46%**	**64%**	**63%**	**65%**	**62%**	**56%**	**53%**	**69%**	**59%**
Diabetes/High Blood Sugar	**37%**	**37%**	**39%**	**35%**	**38%**	**39%**	**30%**	**36%**	28%	29%	**43%**
Mental Health	**37%**	**37%**	**36%**	32%	**39%**	**38%**	**35%**	**36%**	**40%**	**41%**	**34%**
Heart Disease/ Blood Pressure	32%	32%	33%	**35%**	30%	33%	29%	**36%**	**40%**	**30%**	**34%**
Overweight/ Obesity	21%	20%	28%	18%	23%	20%	22%	30%	30%	23%	20%
Smoking/ Tobacco Use	19%	20%	12%	22%	18%	21%	11%	18%	6%	14%	22%
Cancer	18%	18%	21%	18%	19%	17%	22%	18%	15%	18%	18%
HIV/AIDS	9%	10%	2%	11%	8%	9%	7%	13%	19%	12%	7%
Alzheimer's/ Dementia	8%	8%	11%	6%	9%	8%	15%	4%	4%	7%	10%
Lung Disease/ Asthma/COPD	6%	6%	2%	6%	6%	6%	9%	4%	9%	5%	7%
Stroke	5%	5%	9%	6%	5%	6%	1%	8%	4%	4%	7%
Sexually Transmitted Diseases	5%	5%	0%	5%	5%	5%	3%	5%	4%	6%	4%
Infant Death	1%	2%	2%	1%	1%	2%	1%	1%	0%	2%	1%

Community Survey – Top Social/Environmental Concerns

The next portion of the survey asked about the three most important social or environmental problems affecting the health of respondents' communities, from a list of 15 issues. The results

are shown in Figure 6. Among ASA respondents, the top three most named issues were lack of job opportunities (32%), housing/homelessness (30%), and neighborhood safety/violence (25%). This is consistent with City-wide responses: housing/homelessness (32%), lack of job opportunities (30%), and neighborhood safety/violence (25%).

Figure 6: Top Three Social/Environmental Problems Identified by Electronic Survey Respondents Residing in ASA Service Area



Among those who responded "other," the most common issue was addiction/substance use, which is one of the choices for the question on health concerns. This was followed by food insecurity, which is related to but not the same as the choice limited access to healthy foods. Figure 7 shows how responses by neighborhood area, sex, race/ethnicity, and age.

Figure 7: Top Social/Environmental Problems by Area, Sex, Race/Ethnicity, and Age

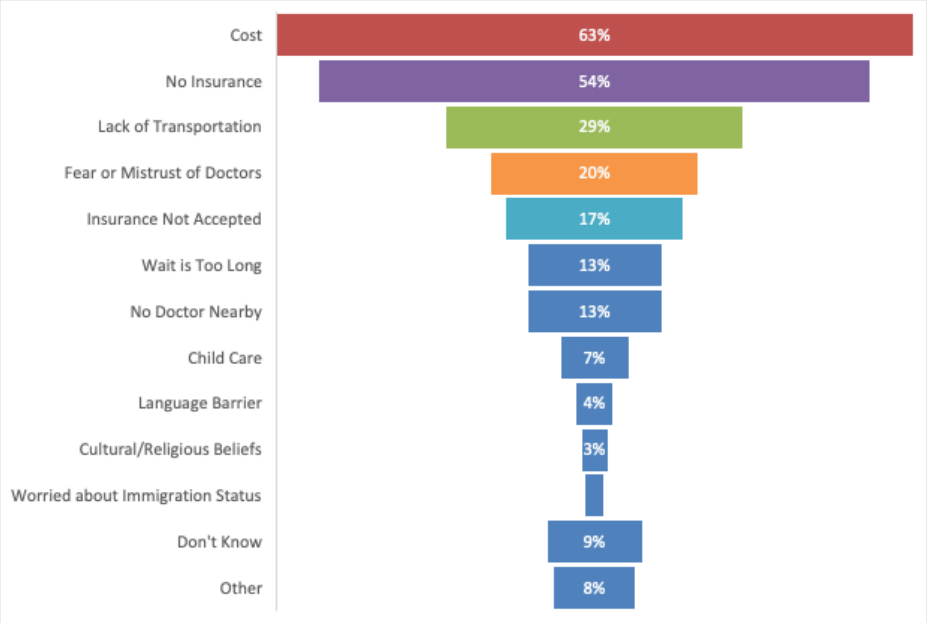
Most Important Social Problems	Total	Area		Sex		Race/Ethnicity				Age	
		City 91%	County 9%	Male 32%	Female 68%	African American 73%	White 18%	Multi/ Other 9%	Hispanic 4%	18-49 44%	50+ Years 56%
Lack of Job Opportunities	**32%**	**32%**	**30%**	**37%**	**29%**	**35%**	**23%**	25%	21%	**33%**	**30%**
Housing/ Homelessness	**30%**	**31%**	19%	**29%**	**30%**	**28%**	**35%**	**36%**	**38%**	**32%**	**29%**
Neighborhood Safety/Violence	**25%**	**26%**	**21%**	20%	**28%**	**26%**	19%	**28%**	**34%**	**25%**	**26%**
Limited Access to Healthy Foods	22%	22%	**22%**	21%	23%	22%	**23%**	23%	28%	19%	24%
Poverty	22%	23%	18%	**25%**	21%	22%	19%	**30%**	**40%**	**25%**	20%
Availability/ Access to Insurance	21%	21%	19%	21%	21%	20%	**23%**	24%	21%	24%	18%
Availability/ Access to Doctor's Office	20%	21%	16%	23%	18%	21%	18%	17%	28%	23%	18%
Race/ Ethnicity Discrimination	13%	12%	19%	11%	13%	11%	17%	17%	26%	15%	11%
Lack of Affordable Child Care	12%	12%	14%	10%	12%	10%	16%	16%	13%	16%	8%
Transportation Problems	12%	11%	13%	11%	12%	13%	10%	8%	0%	8%	14%
School Dropout/ Poor Schools	11%	12%	5%	11%	12%	13%	7%	9%	9%	12%	11%
Domestic Violence	11%	11%	8%	12%	10%	11%	10%	12%	9%	14%	8%
Social Isolation/ Loneliness	8%	8%	10%	6%	9%	8%	10%	5%	6%	5%	11%
Limited Places to Exercise	7%	6%	16%	5%	8%	7%	5%	8%	9%	4%	10%
Child Abuse/Neglect	5%	5%	3%	4%	5%	5%	3%	9%	9%	7%	3%

County residents and white respondents ranked limited access to healthy foods among their top three concerns. Male respondents, Hispanics/Latinos, multiracial, and younger respondents ranked poverty among their top three concerns.

Community Survey – Top Barriers to Accessing Healthcare

Survey respondents next chose from a list of 12 factors to identify the top three barriers to community members' healthcare access. Results are shown in Figure 8. Among ASA respondents, the most common reason cited was the cost of care (63%), followed by lack of insurance (54%). While most ASA respondents—86%—indicated that they have health insurance, their insured rate was lower than that of City-wide respondents (91%). Lack of transportation was also cited as a barrier (29%). Other reasons included fear or mistrust of doctors (20%) and insurance not being accepted (17%). The City-wide responses were similar, although insurance not being accepted was a more common response that fear or mistrust of doctors.

Figure 8: Top Barriers to Accessing Health Care
Identified by Electronic Survey Respondents Residing in ASA Service Area



Among those who responded "other," the most common issue was concern about job loss due to time taken off, followed by worry or discomfort about sharing their concerns with a doctor.

Figure 9 shows how results vary by neighborhood area and race/ethnicity. County residents and Hispanic/Latino respondents included fear or mistrust of doctors among their top three concerns.

Figure 9: Top Barriers to Accessing Health Care by Area, Sex, Race/Ethnicity, and Age

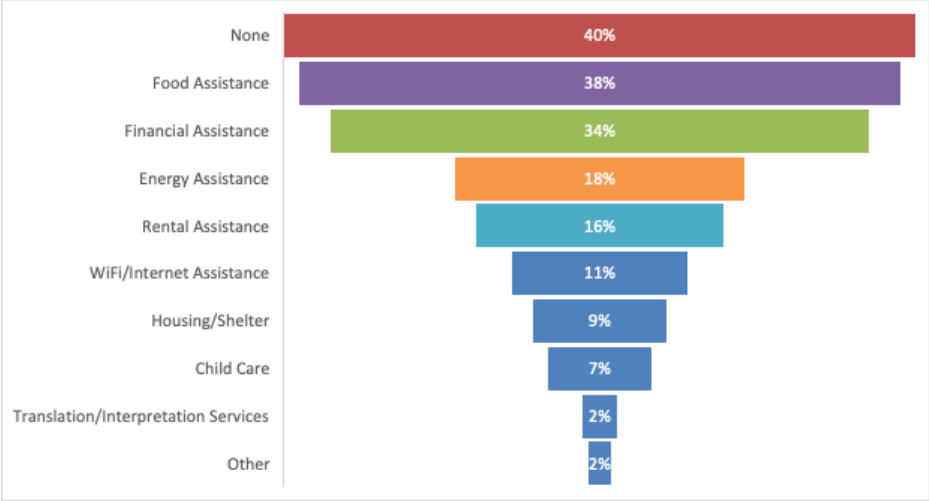
Barriers to Accessing Health Care	Total	Area		Sex		Race/Ethnicity				Age	
		City 91%	County 9%	Male 32%	Female 68%	African American 73%	White 18%	Multi/ Other 9%	Hispanic 4%	18-49 44%	50+ Years 56%
Cost - Too Expensive/ Can't Pay	**63%**	**63%**	**61%**	**55%**	**66%**	**62%**	**65%**	**65%**	**77%**	**67%**	**59%**
Lack of Insurance	**54%**	**55%**	**47%**	**52%**	**55%**	**55%**	**48%**	**48%**	**51%**	**57%**	**52%**
Lack of Transportation	**29%**	**30%**	24%	**28%**	**30%**	**30%**	**28%**	**28%**	15%	**29%**	**30%**
Fear or Mistrust of Doctors	20%	20%	**25%**	19%	21%	21%	18%	18%	**26%**	22%	19%
Insurance Not Accepted	17%	17%	19%	15%	19%	17%	18%	18%	19%	18%	18%
Wait is Too Long	13%	13%	13%	14%	13%	14%	11%	11%	19%	13%	13%
No Doctor Nearby	13%	14%	5%	16%	12%	13%	14%	14%	15%	13%	13%
Lack of Child Care	7%	6%	10%	7%	6%	7%	7%	7%	11%	10%	4%
Language Barrier	4%	4%	5%	4%	4%	3%	6%	6%	9%	5%	3%
Cultural/ Religious Beliefs	3%	3%	4%	2%	3%	3%	1%	1%	6%	2%	3%
Worried About Immigration Status	2%	2%	3%	2%	2%	2%	1%	1%	2%	2%	2%

Community Survey – COVID-19 Needs

The health needs survey included a new section of questions specific to COVID-19. Approximately 8% of ASA respondents indicated that they or a member of their household had been diagnosed with COVID-19. However, the social and economic effects of COVID-19 have been felt much more widely. Among ASA respondents, as a result of COVID-19, 38% have needed food assistance, 34% have needed financial assistance, and 18% have needed energy assistance. Approximately 40% indicated they needed no assistance due to COVID-19. The level of need among ASA respondents was somewhat higher than City-wide respondents (49% indicated no needed assistance). For both ASA and City-wide respondents, the greatest concern

related to COVID-19 was household members becoming infected, followed by financial hardship.

Figure 10: Top Needs Resulting from COVID-19 Pandemic
Identified by Electronic Survey Respondents Residing in ASA Service Area



Key Findings from the Community Survey

Since the FY 16 CHNA, substance use disorder and mental health concerns have continued their predominance as major community health concerns. Similarly, the top three social or environmental problems remain unchanged from the FY 18 CHNA survey results: lack of job opportunities, housing/homelessness, and neighborhood safety/violence. This indicates that ASA's FY 18 CHNA priority of creating person-centered health neighborhoods to address the social determinants of health remains relevant. The top barriers to accessing healthcare identified in this CNHA are also consistent with the FY 18 CHNA: cost of care, lack of insurance, and lack of transportation. The ASA Community Council has prioritized transportation as a foundational social determinant of health. It is also notable that one out of five respondents identified fear or mistrust of doctors as a major barrier to accessing health care.

While the health risks of COVID-19 are waning as vaccination becomes more widespread, the social and economic effects of the pandemic are longer lasting. Due to the pandemic, 60% of ASA respondents have required support to meet basic needs.

Focus Groups

To further understand community needs, qualitative input was gained from facilitated focus groups conducted by the Baltimore City hospital collaborative. Seventeen focus groups were held with leaders and members of community organizations, neighborhood associations, and faith-based organizations. Participants were recruited to understand the needs of vulnerable populations. Four of the groups focused on needs among older adults, three of the groups focused on needs among Baltimore's Latino/Hispanic community, and other groups focused on the needs of individuals with disabilities, individuals with prior justice system involvement, members of the LGBTQ community, individuals who have experienced homelessness, and individuals with a history of substance use disorder, among others.

Focus group members discussed the most serious health issues facing their communities. There were several health issues identified by multiple focus groups. These included needs related to mental health and substance use disorder; COVID-19 and the isolation resulting from the pandemic; and chronic diseases such as diabetes, heart disease, and chronic obstructive pulmonary disease (COPD). Additional health issues identified by at least one focus group included obesity, access to preventive care and family planning, cancer, vision impairment, and sexually transmitted infections.

There was overlap between what focus group members identified as the most serious health issues, and what they identified as the significant environmental or social factors affecting quality of life in their communities. Two major categories of social determinants of health were repeated across multiple focus groups: access to healthy food, and transportation—not just to access health care but also to access food and other needed resources. More generally, the affordability of basic needs, unemployment, and poverty were discussed, with particular emphasis on the effect of poverty on mental health. Among older adults, technology—the lack of access to it and the lack of knowledge of how to navigate it—was a significant issue. It was noted that the "digital divide" has been exacerbated by the COVID-19 pandemic. Other factors affecting quality of life were related to the physical environment. This included the need for safe housing, free from mold, pests, and trash; the need for safe, well-lit spaces to walk, exercise, and recreate; and the physical accessibility of streets, transportation, and hospital campuses, especially for older adults and individuals with disabilities. Another major topic identified was crime and violence, including violence and domestic violence.

Lastly, across multiple focus groups, the effects of systemic racism and discrimination were discussed as a key barrier to accessing health care. Focus group members described mistrust of the medical community due to historical experiences, exacerbated by the underrepresentation of people of color in health care professions. Focus group members perceived a lack of respect or sensitivity on the part of providers, or stigma assigned when not adhering to health care advise, for example to lose weight. Individuals experiencing a lifetime of poverty were described as living in survival mode, oriented away from preventive care. Moreover, some cultural preferences focus more on holistic practices instead of seeking out solutions from the health care establishment. Mistrust leads to a fear of revealing information to health care providers, particularly among undocumented immigrants.

The affordability of health care was also named as a key barrier to access. Dental services in particular were mentioned by older adults, and the time and cost to acquire or repair adaptive equipment was mentioned by individuals with disabilities. The complexity of navigating the health care system, the loss of historical providers due to insurance network requirements, and a general lack of awareness of resources were all barriers. Lastly, fear of exposure to COVID-19 acted as a deterrent to seeking out health care.

Focus group members offered suggestions for how hospital systems could help improve community health and quality of life. Communication between hospital systems and community organizations and businesses can help increase awareness of community needs and the resources available to meet them. A particular need was identified to address the stigma surrounding mental health. In addition to electronic communication, focus group members stated the need for information to be shared in print, and in other formats such as radio or television advertisements to reach community members with low literacy. Resources are needed in Spanish as well as English.

Two-way communication was suggested as a means of addressing the barrier presented by mistrust of the health care system due to racism. Ongoing conversations are needed to understand the needs of and advocate for lower income community members. Sensitivity training for health care workers can help foster more collaborative relationships among providers and patients. More representation of people of color in health care can also help.

Focus group members described strategies to help community members navigate the health care system. Roles such as advocates, community health workers, and case managers are needed to provide outreach, education, and follow-up for community members on the health resources available, how to access them, and understanding the management of health conditions. One idea was to hold regular resource fairs for health care staff, so they become aware of the resources available to patients and community members. There were multiple suggestions for how to reach community members where they are, for example by out-stationing mobile clinics, visiting nurses, and navigators to sites such as libraries, churches, and senior centers. A nurse call line was also mentioned as a valuable resource.

Other suggestions included incentives, such as free produce and healthy meals, to help engage community members in these efforts. Hospital systems could provide meeting space for community members to come together to address needs, or provide other resources for capacity-building. Hospital systems could also have a role in providing transportation to services.

In addition to the Baltimore City hospital collaborative focus groups, ASA conducted eight additional online focus groups with community leaders, local public health experts, and community members. These focus groups provided insight on key social determinants of health. The need for childcare and transportation were most often mentioned. Telehealth was viewed as a potential solution, but many community members lack reliable technology and connectivity. Provision of transportation or mobile clinics were additional solutions named.

Other issues include neighborhood safety, in particular to facilitate exercise and socialization, as well as concerns about the cost of accessing health care. The need for language interpretation and health literacy/health education was also mentioned. Outreach information on patient-specific due dates for health screenings would be valuable, although this can be challenging for populations that are transient. The focus groups noted that all social determinant of health needs have been exacerbated by the COVID-19 pandemic.

Key Findings from Focus Groups

The focus group discussions reinforced the results of the consumer survey. Mental health and substance use disorder are priority issues; they are exacerbated by both poverty and the economic effects and social isolation resulting from the COVID-19 pandemic. The need for transportation and access to healthy food were repeated themes. In addition, systemic racism, discrimination, and mistrust of the medical community create barriers to accessing health care.

Conduent Healthy Communities Institute Analysis

To gain further insight on the community ASA serves, Conduent Healthy Communities Institute was engaged to provide community health indicator data for Baltimore City and Baltimore County. Conduent provided Socio-Need Index Scores, Health and Quality of Life Topic Scores, and Indicator Scores for Baltimore City and Baltimore County.

SocioNeed Index Scores

Conduent develops SocioNeed Index Scores by incorporating measures of six different social and economic determinants of health associated with poor health outcomes. These six indicators include income, poverty, unemployment, occupation, education, and language. The indicators are standardized and averaged to create one composite index value for each zip code. Zip codes with higher values are estimated to have higher socio-economic need, which is correlated with poorer health. Figure 11 shows SocioNeed Index Scores for ASA zip codes, comparing FY 2021 results to FY 2018.

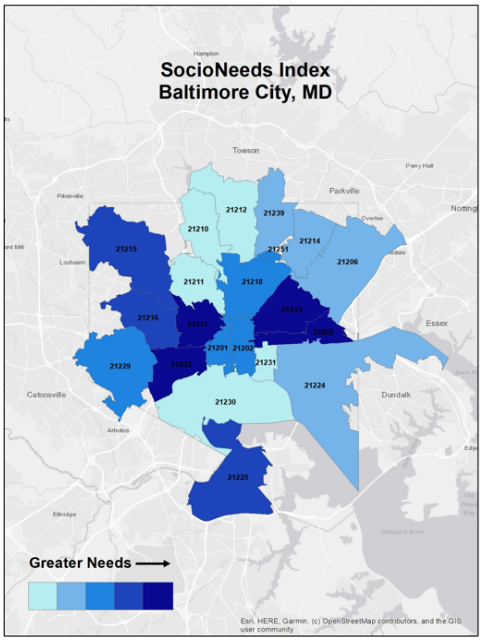
Figure 11: SocioNeed Index Scores for ASA Zip Codes

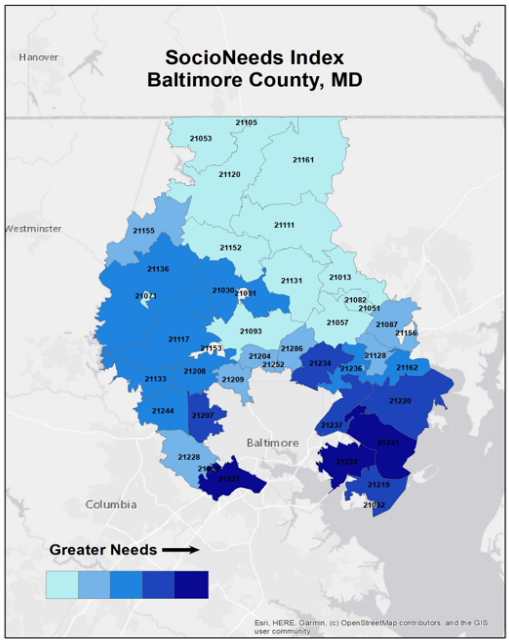
Zip Code	Community	2021 Score	2018 Score
21223	**South Baltimore City**	**97.9**	97.5
21250	Baltimore - UMBC	94.7	n/a
21217	West Baltimore City	93.7	94.9
21216	**West Baltimore City**	**90.9**	87.6
21225	Brooklyn – Linthicum	89.4	91.1
21215	West Baltimore City	85.8	87.1
21229	Southwest Baltimore City	74.7	79.6
21227	**Arbutus - Halethorpe**	**58.6**	54.7
21207	Gwynn Oak – Woodlawn	47.7	51.3
21244	Windsor Mill	24.4	n/a
21230	South Baltimore City	24.2	31.5
21228	Catonsville	11.5	11.5
21075	Elkridge	9.5	n/a

Approximately half of communities in the ASA service have SocioNeed Index Scores in the eighties and nineties, indicating a high level of need. While most communities' scores have improved or remained stable since FY 2018, there are three communities indicated in Figure 11 in bold that have experienced worsening scores—South Baltimore City 21223, West Baltimore

City 21216, and Arbutus—Halethorpe 21227. The wide range of need among zip codes is also notable, from a low score of 9.5 for Elkridge to a high score of 97.9 for South Baltimore City. Figure 12 shows the Scores mapped for Baltimore City and Baltimore County.

Figure 12: FY 2021 Baltimore City and Baltimore County Maps of SocioNeeds Index Scores





Indicator Scores and Health and Quality of Life Topic Scores

The Conduent Healthy Communities Institute provided Health and Quality of Life Topic Scores and Indicator Scores. This data scoring process involves several stages. Conduent collects data from over 25 secondary data sources, incorporating over 200 demographic, social, economic, and health indicators. Indicators are collected at the county level, to result in county-level scores.

For each indicator, a county is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0 through 3, where 0 indicates the best outcome and 3 the worst. Figures 13 and 14 below show Baltimore City and Baltimore County indicator scores that are 2.50 or higher, indicating high levels of unmet need. Baltimore City has 25 indicators meeting this threshold; these include indicators related to cancer, chronic disease, mental health, substance use disorder, and injuries. Baltimore County has seven indicators meeting this threshold; these include indicators related to mental health, substance use disorder, and cancer.

Source: Conduent Healthy Communities Institute 2021

Figure 13: Baltimore City Indicators with Scores of 2.50 and Above

Score	Indicator
2.83	Lung and Bronchus Cancer Incidence Rate
2.83	Chronic Kidney Disease: Medicare Population
2.83	Death Rate due to Drug Poisoning
2.83	Depression: Medicare Population
2.78	Cervical Cancer Incidence Rate
2.75	Age-Adjusted Death Rate due to Unintentional Injuries
2.75	Age-Adjusted Death Rate due to Drug Use
2.67	Alzheimer's Disease or Dementia: Medicare Population
2.61	Frequent Mental Distress
2.61	Diabetes: Medicare Population
2.61	Homeownership
2.61	People 65+ Living Below Poverty Level
2.61	Students Eligible for the Free Lunch Program
2.61	Asthma: Medicare Population
2.58	Chlamydia Incidence Rate
2.58	Age-Adjusted Death Rate due to Diabetes
2.56	Age-Adjusted Death Rate due to Prostate Cancer
2.53	Age-Adjusted Death Rate due to Stroke
2.53	High Blood Pressure Prevalence
2.53	Preterm Births
2.50	Child Food Insecurity Rate
2.50	Food Insecurity Rate
2.50	Persons with Disability Living in Poverty (5-year)
2.50	Hypertension: Medicare Population
2.50	Pedestrian Injuries

Figure 14: Baltimore County Indicators with Scores of 2.50 and Above

Score	Indicator
2.83	Depression: Medicare Population
2.83	Death Rate due to Drug Poisoning
2.67	Breast Cancer Incidence Rate
2.61	Cancer: Medicare Population
2.58	Age-Adjusted Death Rate due to Drug Use
2.50	Age-Adjusted Death Rate due to Falls
2.50	Liquor Store Density

Conduent categorizes indicators into topic areas and gives each topic area a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic. Figure 15 below shows the Health and Quality of Life Topic Scores for Baltimore County and Baltimore City. Prevention and Safety was the highest-ranked topic for both jurisdictions. Scores were higher for Baltimore City relative to Baltimore County, indicating more unmet need in Baltimore City.

Figure 15: Health and Quality of Life Topic Scores for Baltimore County and Baltimore City

Baltimore County

Health and Quality of Life Topics	Score
Prevention & Safety	2.11
Other Chronic Diseases	2.09
Older Adults & Aging	1.83
Public Safety	1.81
Substance Abuse	1.75
Mental Health & Mental Disorders	1.73
Transportation	1.72
Heart Disease & Stroke	1.71
Women's Health	1.70
Maternal, Fetal & Infant Health	1.68
Cancer	1.66
Environmental & Occupational Health	1.55
Diabetes	1.48
Respiratory Diseases	1.47
Oral Health	1.47
Children's Health	1.42
Immunizations & Infectious Diseases	1.40
Exercise, Nutrition, & Weight	1.39
Environment	1.38
Education	1.36
Access to Health Services	1.27
Social Environment	1.22
Teen & Adolescent Health	1.22

Baltimore City

Health and Quality of Life Topics	Score
Prevention & Safety	2.55
Diabetes	2.39
Maternal, Fetal & Infant Health	2.16
Economy	2.12
Cancer	2.03
Older Adults & Aging	2.00
Environmental & Occupational Health	1.97
Education	1.97
Mental Health & Mental Disorders	1.95
Social Environment	1.90
Respiratory Diseases	1.87
Women's Health	1.86
Heart Disease & Stroke	1.85
Public Safety	1.84
Substance Abuse	1.80
Children's Health	1.78
Teen & Adolescent Health	1.77
Immunizations & Infectious Diseases	1.76
Oral Health	1.62
Other Chronic Diseases	1.57
Environment	1.55
Exercise, Nutrition, & Weight	1.47
Transportation	1.27
Access to Health Services	1.25

Source: Conduent Healthy Communities Institute 2021

Key Findings from the Conduent Healthy Communities Institute Analysis

For many communities within the ASA service area, there is an extremely high level of unmet health and social determinant of health needs. Key health issues include mental health and substance use disorder, cancer, and chronic disease. Unmet needs exist in both Baltimore City and Baltimore County. However, Baltimore City experiences a more extreme level of need for a broader range of issues. Also, in Baltimore City, maternal and infant health is a more prevalent issue while in Baltimore County, issues related to aging are more prevalent.

Hospital Utilization Data

As part of the FY 2021 CHNA, ASA analyzed hospital utilization data. “Prevention Quality Indicators” or “PQIs” are nationally recognized measures that examine hospital utilization to help assess access to health care in the community. The ASA PQI rate (15.05) is very similar to the Statewide rate (14.45).[1] This indicates that relative to the rest of the State, patients of ASA do not disproportionately face barriers to accessing care in the community. ASA’s most common PQIs—measures that indicate a potential issue with access in the community—are heart failure,

[1] CY 2019 Risk Adjusted Rate: IP/OBS24+.

COPD or asthma in older adults, and diabetes (combined categories of short- and long-term complications).

Prevention Quality Indicators are also available specifically for the pediatric population. These are referred to as "PDIs." For the pediatric population, ASA's PDI rate is higher than the Statewide rate (2.07 versus 0.91).[2] The main category driving ASA's PDI rate is asthma.

Baltimore City Health Department Maps

The Baltimore City Health Department compiled maps to provide input to the CHNA. Figure 16 shows the all-cause mortality rate per 10,000 in Baltimore City over time. The map on the left includes data for the years 2014 through 2018. The map on the right shows data for the years 2011 through 2015. The all-cause mortality rate has increased between these two time periods.

Figure 16: Baltimore City All-Cause Mortality Rate

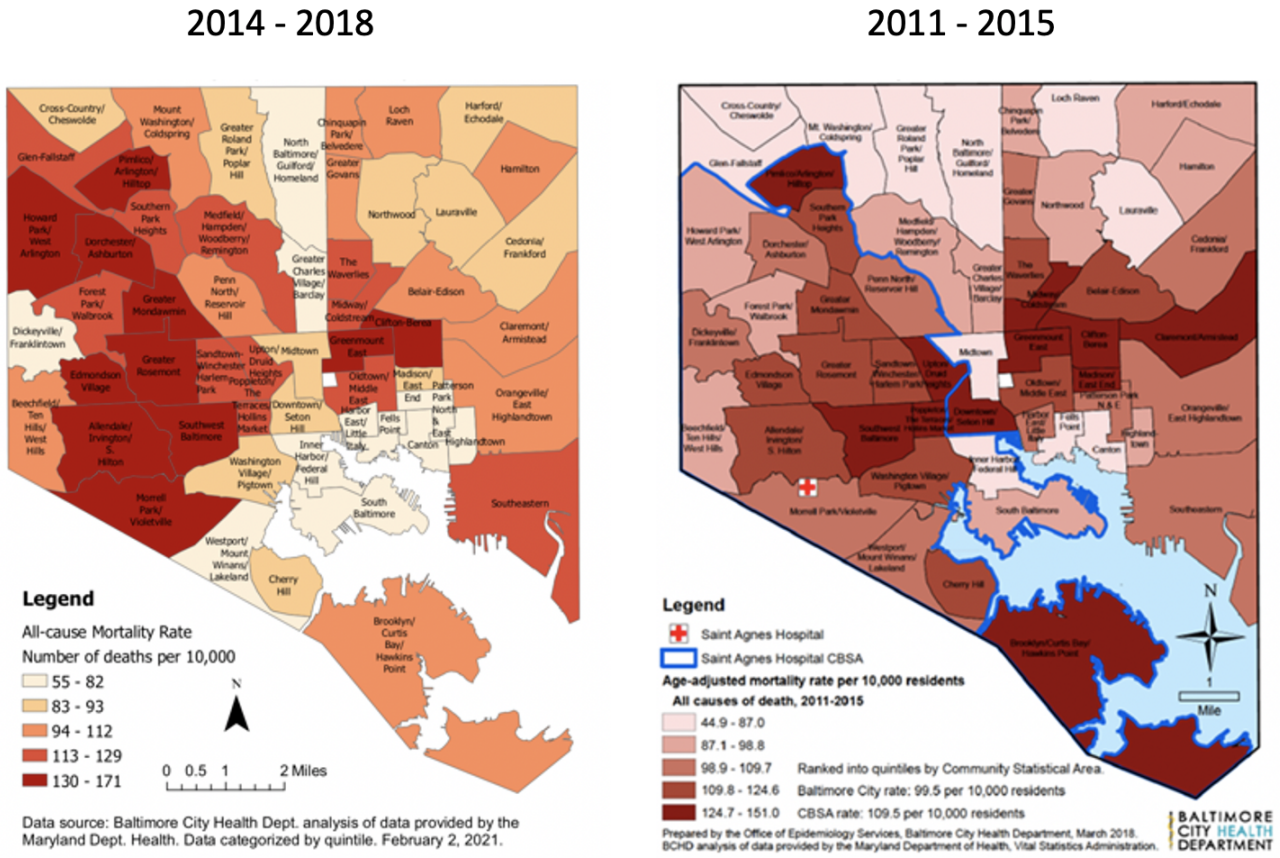
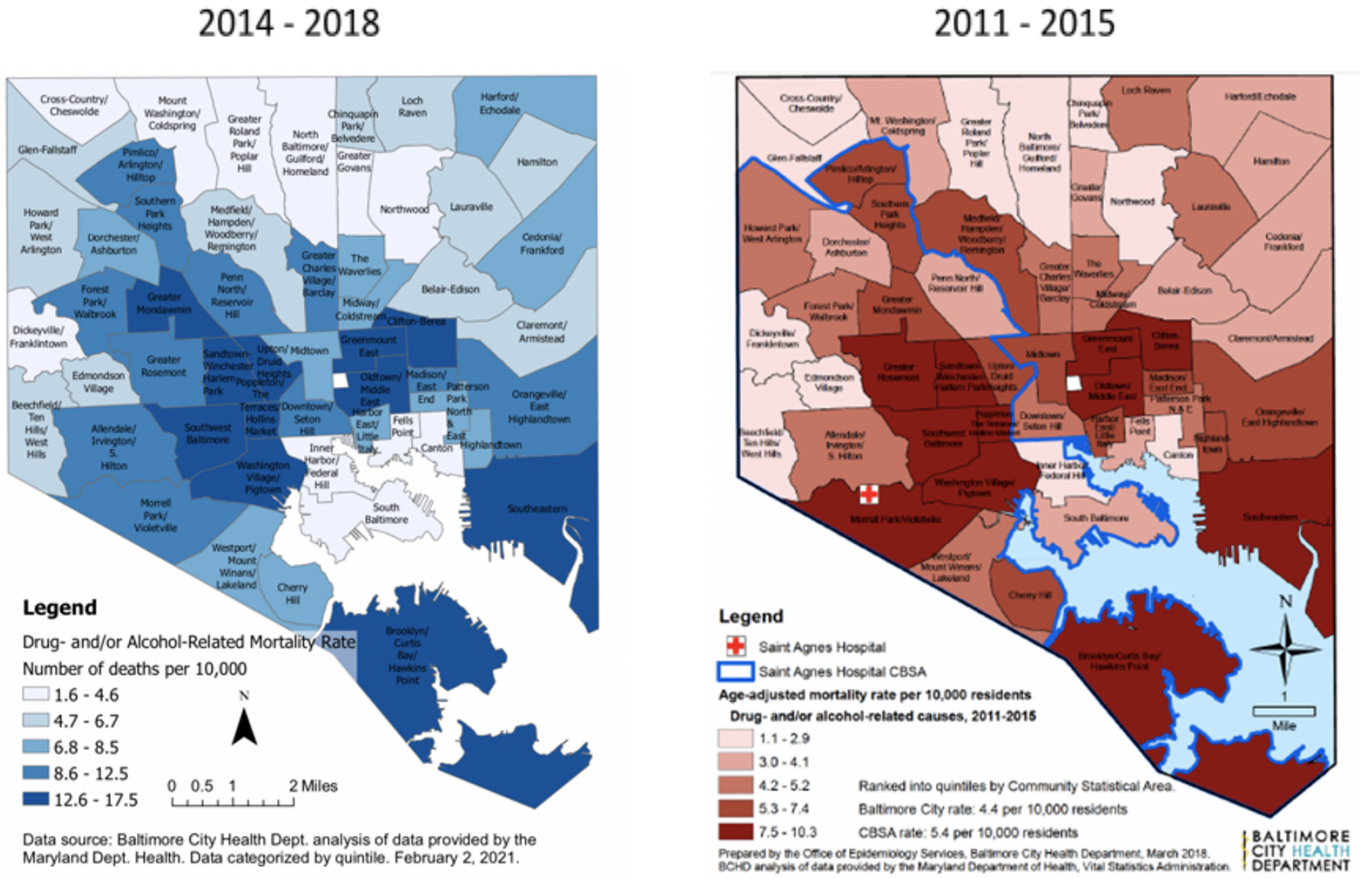


Figure 17 shows the drug- and/or alcohol-related mortality rate per 10,000 in Baltimore City over time. The map on the left includes data for the years 2014 through 2018. The map on the

[2] CY 2019 Risk Adjusted Rate IP/OBS24+

right shows data for the years 2011 through 2015. The drug- and/or alcohol-related mortality rate has increased between these two time periods.

Figure 17: Baltimore City Drug- and/or Alcohol-Related Mortality Rate



Conclusion of Primary and Secondary Data Research and Analysis

ASA sought a number of inputs to the CHNA to acquire meaningful community input. Through the survey, focus groups, Conduent analysis, hospital utilization data and information from the Baltimore City Health Department, was able to highlight the greatest unmet needs of the communities we serve. There was a high degree of correlation among the primary and secondary data findings. There was also consistency with the FY 2018 CHNA. Among the most significant health and social determinant of health needs are:

- Substance use disorder;
- Mental health;
- Chronic disease, including diabetes and heart disease;
- Economic opportunity;
- Affordable housing and safe neighborhoods;
- Affordable health care; and

- Transportation.

Stakeholder Input

ASA took multiple steps to gain stakeholder input on the findings of the primary and secondary data research and analysis. The findings were presented to three separate community groups, with the following questions posed:

- What about the findings resonates with you?
- What topics do you think are missing?
- What surprises you about the findings?
- What do you view as the major conclusions of the qualitative and quantitative analyses?

Additionally, stakeholders were asked questions and offered response choices similar to what was included in the community survey:

- What are the top health needs affecting the health of the community you serve?
- What are the top reasons people in the community you serve do not get health care?
- What are the top social/environmental concerns affecting the community you serve?

ASA Community Council

ASA renewed its commitment to community partnerships through the convening of its Community Council in August 2018. The Council's 25 members include a broad array of health care providers—including those with special knowledge of or expertise in public health, non-profit organizations, and other organizations devoted to addressing social determinants of health. The Community Council provides on ongoing forum for discussing the planning, implementation, and monitoring of ASA initiatives.

The qualitative and quantitative findings were presented to the Community Council to gain members' feedback on unmet needs in the ASA service area, and to directly hear from community members regarding allocation of community benefit resources.

Community Council members agreed that the findings of the primary and secondary data research and analysis accurately reflected the needs of the community. Discussion among the members largely focused on the significant effect of the COVID-19 pandemic on exacerbating existing needs. For example, members discussed the significance of substance use disorder and mental health, stating that the isolation resulting from the pandemic is having a major worsening effect. At the same time, fear of exposure to COVID-19 resulted in individuals with critical health needs delaying their care.

In terms of social/environmental concerns, members discussed the prevalence of job loss and inability of families to afford basic needs as a result of COVID-19. Other social determinants identified include housing/homelessness, lack of transportation, safety and violence, and the

significant digital divide. The school closures resulting from COVID-19 were highlighted as a major concern, as children are unable to engage in remote learning and are lost to the school system. Similarly, other community based organizations have but unable to engage and support their target populations throughout the pandemic. The economic and socially isolating footprint of COVID-19 is significant, with long term effects.

Members discussed a number of barriers to accessing healthcare, including affordability and lack of insurance, particularly for immigrants. The complexity of navigating the healthcare system can be significant, and even more so when there are language barriers. Members recognized the fear and mistrust of the healthcare system described by survey respondents and focus group participants. This acts as a barrier to COVID-19 vaccine uptake. As healthcare providers pivot to telehealth, some community members will be left behind due to a lack of access to technology and connectivity. The Community Council saw elevation of the role of community health workers as a strategy for overcoming barriers to healthcare and achieving long term health goals.

Community Associations

The qualitative and quantitative findings were presented to two separate Violetville associations to gain members' feedback on unmet needs and seek input on the allocation of community benefit resources. At these meetings, community association members agreed that the major issues from primary and secondary research were an accurate reflection of health and social needs and barriers to care.

One of the community associations primarily discussed mental health and substance use disorder as huge issues faced by the community. It is especially difficult to navigate the healthcare system for individuals who are dually diagnosed with a mental health condition and substance use disorder. Significant service gaps and fragmentation exist for this population, and there is a lack of support for patients and their families. Repeated failed attempts to navigate the system make it difficult to re-initiate with existing resources. Peer mentoring was described as valuable because it is a way to offer hope.

The other community association noted that based on the findings, many of the same needs extend across Baltimore City and Baltimore County; these challenges are not unique to the City. The group also discussed the need to identify solutions to overcome fear and mistrust of the healthcare system. They noted the implications this has for uptake of COVID-19 vaccines.

Conclusion of Stakeholder Input

Stakeholders overwhelmingly agreed with the findings with the primary and secondary research. They went on to emphasize how COVID-19 exacerbates the top health and social concerns:

- Worsening mental health and substance use;

- Difficult for community based organizations to engage clients;
- Digital divide is severe;
- Many more families require help with basic needs; and
- Fear and mistrust create barriers to vaccination.

Community Health Need Priorities

We presented research findings and stakeholder input to the ASA Board of Directors Mission Committee and the ASA Executive Team. We then engaged both groups to translate the top concerns into priorities for the ASA FY 2021 Community Health Needs Assessment. ASA's three Community Health Need Priorities approved by the Executive Team for the FY 2019 through FY 2021 cycle are:

- **Address mental health and substance use disorder;**
- **Prevent diabetes and improve health outcomes for individuals with diabetes; and**
- **Build person-centered healthy neighborhoods to address social determinants of health.**

ASA leadership believes in the importance of maintaining continuity with FY 2018 priorities,

Many of the needs identified in the FY 2016 and FY 2018 CHNAs remain significant. Given the scale and complexity of addressing these issues, ASA leadership believes in the importance of maintaining continuity around the priorities. Thus, there is continued focus on addressing mental health and substance use disorder. In addition, building person-centered healthy neighborhoods to address social determinants of health continues to reflect ASA's existing efforts and is aligned with our Catholic health mission of serving our community with a special focus on those who are poor or vulnerable. ASA leadership reoriented the FY 2018 priority to reduce obesity and the impact of chronic disease to focus on diabetes. This is consistent with State of Maryland health priorities. The ASA priorities continue to closely align with local, state and national priorities as found in Healthy Baltimore 2020, State of Maryland State Health Improvement Plan (SHIP) Vision Areas and Healthy People 2020. See Appendix 3.

Documenting and Communicating Results

The completion of this Community Health Needs Assessment marks a milestone in community involvement and participation, with input from the public, community leaders and health experts, and ASA administration. This report will be posted on the ASA website following ASA Board approval. Reports and data will also be shared with our community partners and community leaders as we work together to make a positive difference in our community by empowering and building healthy communities.

Planning for Action and Monitoring Progress

Using both primary and secondary research and stakeholder input—including those with special knowledge of or expertise in public health—the next step is to develop an implementation plan for the three identified priorities. The ASA Executive Leadership Team, Health Institute and Mission Integration will oversee the development of implementation strategies. The strategies will be shared with stakeholders for feedback and presented to the ASA Board by November 2021.

Appendix 1: Community Profiles

Arbutus (Zip Code 21227):
Arbutus is an older suburban community, located south of Caton and Wilkens Avenues, and has a population of 34,139. The traditionally blue collar community is part of the Baltimore County Health Jurisdiction. Saint Agnes Hospital is the primary hospital provider best positioned to address the specific health needs of this community.

Baltimore/UMBC (Zip Code 21250):
The 21250 zip code is home to the University of Maryland, Baltimore County (UMBC) campus, adjacent to Catonsville. UMBC enrolls approximately 13,500 students, one quarter of whom live on campus. On-campus health resources include University Health Services, which provides diagnosis and treatment of acute illnesses and injuries, treatment and monitoring of chronic illnesses, immunizations, preventative care, routine gynecological care, allergy shots, laboratory testing, and limited pharmacy services. The UMBC Counseling Center provides short-term individual and group counseling, and psychiatric services for students engaged in counseling.

Brooklyn-Linthicum (Zip Code 21225):
Brooklyn-Linthicum is an older urban/suburban community, located southeast of Caton and Wilkens Avenues, and has a population of 33,550. The industrial and blue collar community has seen an increase in the uninsured population and is part of both the Baltimore City and Baltimore County Health Jurisdictions. Harbor Hospital is the primary hospital provider best positioned to address the specific health needs of this community.

Catonsville (Zip Code 21228):
Catonsville is an older suburban community, located west of Caton and Wilkens Avenues, and has a population of 49,758, with a growing proportion of seniors. The traditionally white collar community is part of the Baltimore County Health Jurisdiction. ASA is the primary hospital provider best positioned to address the specific health needs of this community.

Elkridge (Zip Code 21075):
Elkridge is an older suburban community with historical and recreational areas. It located in Howard County, adjacent to Anne Arundel and Baltimore counties. Elkridge has a population of approximately 16,000, with higher incomes than other portions of the ASA service area. The median household income is approximately $66,000, and less than 3% of the population us under the poverty line. The population is over 80% white.

South Baltimore City (Zip Code 21223, 21230):
South Baltimore City is an older urban community, located east/southeast of Caton and Wilkens Avenues, and has a population of 59,923. The urban community is projected to experience population declines. South Baltimore City is part of the Baltimore City Health Jurisdiction. Baltimore Washington Medical Center and MedStar Harbor Hospital are the primary hospitals provider best positioned to address the specific health needs of this community.

Southwest Baltimore City (Zip Code 21229):
Southwest Baltimore City is an older urban community, located at Caton and Wilkens Avenues, and has a population of 44,537. Similar to other urban areas, Southwest Baltimore is projected to experience population declines. Southwest Baltimore City is part of the Baltimore City Health Jurisdiction. Saint Agnes Hospital is the primary hospital provider best positioned to address the specific health needs of this community.

West Baltimore City (Zip Code 21215, 21216, 21217):
West Baltimore City is an older urban community, located north of Caton and Wilkens Avenues, and has a population of 123,222. Similar to other urban areas, West Baltimore is projected to experience population declines. West Baltimore City is part of the Baltimore City Health Jurisdiction. Sinai Hospital, University of Maryland and Bon Secours Hospital are the primary hospital providers best positioned to address the specific health needs of this community.

Windsor Mill (Zip Code 21244):
Windsor Mill is a suburban community in Baltimore County, near Woodlawn. It has a population of approximately 34,000. Approximately 77% of the population is under 55 years of age. Median household income is $44,000.

Woodlawn (Zip Code 21207):
Woodlawn is a suburban community, located northwest of Caton and Wilkens Avenues, and has a population of 47,456, with a growing proportion of seniors. Woodlawn is part of the Baltimore County Health Jurisdiction. Northwest Hospital is the primary hospital provider best positioned to address the specific health needs of this community.

Appendix 2: Community Survey Questions

Question	Response Options
What is your zip code? (Please write 5-digit Zip code)	Open-Ended Response
What is your gender? (Please check one)	Female
	Male
	Transgender
	Other (please specify)
What is your age group? (Please check one)	18-29
	30-39
	40-49
	50-64
	65-74
	75+
Which one of the following is your race? (Please check all that apply)	Black or African American
	White or Caucasian
	Asian
	Native Hawaiian or Other Pacific Islander
	American Indian or Alaska Native
	Don't Know
	Prefer Not to Answer
	Other /More than one race (please specify)
Are you Hispanic or Latino/a? (Please check one)	Yes
	No
	Don't Know
	Prefer Not to Answer
Do you have health insurance?	Yes
	No
On how many days during the past 30 days was your mental health not good? (Mental health includes stress, depression, and problems with emotions)	Zero Days
	Don't Know
	Prefer Not to Answer
	(Please specify how many days here)
What are the three most important health problems that affect the health of your community? Please check only three.	Alcohol/Drug Addiction
	Mental Health (Depression/Anxiety)
	Diabetes/High Blood Sugar
	HIV/AIDS
	Lung Disease/Asthma/COPD
	Smoking/Tobacco Use
	Sexually Transmitted Diseases
	Alzheimer's/Dementia
	Cancer
	Heart Disease/Blood Pressure
	Infant Death
	Stroke
	Overweight/Obesity
	Don't Know or Prefer Not to Answer
	Other (please specify)

Continued on next page.

Question	Response Options
What are the three most important social/environmental problems that affect the health of your community? Please check only three.	Availability/Access to Doctor's Office
	Availability/Access to Insurance
	Domestic Violence
	Limited Access to Healthy Foods
	School Dropout/Poor Schools
	Lack of Job Opportunities
	Race/Ethnicity Discrimination
	Social Isolation/Loneliness
	Child Abuse/Neglect
	Lack of Affordable Child Care
	Housing/Homelessness
	Neighborhood Safety/Violence
	Poverty
	Limited Places to Exercise
	Transportation Problems
	Don't Know or Prefer Not to Answer
	Other (please specify)
What are the three most important reasons people in your community do not get health care? Please check only three.	Cost - Too Expensive/Can't Pay
	No Insurance
	Lack of Transportation
	Language Barrier
	Worried about Immigration Status
	Fear or Mistrust of Doctors
	Wait is Too Long
	No Doctor Nearby
	Insurance Not Accepted
	Cultural/Religious Beliefs
	Child Care
	Wait is Too Long
	Don't Know or Prefer Not to Answer
	Other (please specify)
Which of the following apply to you?	I have been diagnosed with the Coronavirus (COVID-19)
	A household member has been diagnosed with the Coronavirus
	A family member outside my household has been diagnosed with the Coronavirus
	A friend or someone I know outside my family has been diagnosed with the Coronavirus
	I don't know anyone personally who has been diagnosed with the Coronavirus
	Prefer not to say
As a result of COVID-19, have you needed any of the following? (Check all that apply)	Financial Assistance
	Food Assistance
	Rental Assistance
	Translation/Interpretation Services
	Energy Assistance
	WiFi/Internet Assistance
	Housing/Shelter
	Child Care
	None
	Other (please specify)
When it comes to COVID-19, what are you most concerned about right now? (Rank the following options in order of importance. 1 = Most important to 4 = Least important)	Members of my household becoming infected
	The health of my community as the pandemic continues
	The emotional health of my household
	Financial hardship
What ideas or suggestions do you have to improve the health in your community?	Open-Ended Response

Appendix 3: Alignment Among ASA, National, State, and City Priorities

ASA Community Health Needs Assessment Priorities	National Healthy People 2030 Goals	Maryland State Health Improvement Process[3]	Healthy Baltimore 2020[4]
Address Mental Health and Substance Abuse	● Improve mental health ● Reduce misuse of drugs and alcohol ● Reduce drug and alcohol addiction	● ED visits related to mental health conditions ● Suicide rate ● ED visits for addiction-related concerns ● Drug-induced death rate	● Close the male-female gap in students reporting periods of feeling sad/hopeless ● Close the gap, by ZIP code, in substance use-related ER visits ● Close the gap in overdose deaths between Baltimore and Maryland
Prevent Diabetes and Improve Health Outcomes for Individuals with Diabetes	● Reduce the burden of diabetes and improve quality of life for all people who have, or at risk for, diabetes	● ED visits due to diabetes ● Adults who are not overweight or obese ● Adolescents who have obesity ● Increase physical activity	● Close the Black-White gap in adult obesity ● Close the gap in food insecurity between Baltimore and Maryland
Build Person-Centered Healthy Neighborhoods to Address Social Determinants of Health	● Create neighborhoods and environments that promote health and safety ● Help people earn steady incomes that allow them to meet their health needs ● Increase educational opportunities and help children and adolescents do well in school ● Increase access to comprehensive, high-quality healthcare services ● Increase social and community support	● Life expectancy ● Affordable housing ● High school graduation rate ● Pedestrian injury rate on public roads ● Persons with usual source of primary care ● Uninsured ED visits	● Close the Black-White gap in life expectancy ● Close the Black-White gap in chronic high school absences ● Close the gap in youth homicides between Baltimore and Maryland

[3] https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx
[4] https://health.baltimorecity.gov/sites/default/files/HB2020%20-%20April%202017.pdf