University of Maryland St. Joseph Medical Center

This is the hospital specific implementation strategy for the University of Maryland St. Joseph Medical Center (UM SJMC) and addresses the community health needs identified through a collaborative community health needs assessment (CHNA) process conducted with local and regional partners. This document outlines plans for UM SJMC to support specific community benefit efforts as part of a larger community-wide and system plan.

Our Community and Key Partners

University of Maryland St. Joseph Medical Center

The University of Maryland St. Joseph Medical Center (UM SJMC) has been a treasured community resource dating back to our founding in 1864 by the Sisters of St. Francis of Philadelphia who opened the St. Joseph German Hospital to serve the sick and needy in downtown Baltimore.

This mission to care for a broad community has continued at UM SJMC in Towson since our move to Northern Baltimore in 1965. This charge is why one of the main tenants of our True North philosophy is "Our Community." We work closely with many community partners to accomplish this and continue to develop new, innovative alliances with organizations across our service area.

Although UM SJMC is well known for our large, annual free flu shot campaign, one of our very active relationships is with The Orokawa Y in Towson, where we offer free blood pressure screenings, support their Red Cross blood drives, offer a Stroke Support Group, and participate in their many health fairs. Stroke is an important health issue in our community. In our collaboration with the Baltimore County Stroke Smart Program, we have expanded stroke presentations into local senior centers, universities, and churches. We have a team trained through the Self-Management Resource Center for programs related to chronic disease management, which have been presented at several community settings.

UM SJMC is proud of our well-established community-based programs that serve a diverse population in age, ethnicity and income. For example, this is the 20th anniversary of our St. Clare Medical Outreach Program, which provides primary care to a low-income, working, uninsured population that is mainly Hispanic. Located in Lutherville, St. Clare served more than 1,100

patients this year, as well as referring to donated specialty care generously provided by UM SJMC specialists.

Community Health Needs Assessment

Process and Product

The University of Maryland St. Joseph Medical Center's Community Health Needs Assessment (CHNA) was conducted in partnership with the Baltimore County Health Department, Greater Baltimore Medical Center Healthcare, Medstar Franklin Square Medical Center, and Northwest Hospital of LifeBridge Health. The CHNA helps health leaders evaluate the health and wellness of the community they serve and identify gaps and challenges that should be addressed through new programs, services, and policy changes. This report was created in compliance with the Public Health Accreditation Board's Standards & Measures for Initial Accreditation, Version 2022, as well as Internal Revenue Service requirements for not-for-profit hospitals.

This written report describes:

- The community served
- Community demographics
- Existing health resources in the community available to respond to needs
- How data was collected in the assessment process
- The priority health needs of the community
- Health needs and issues of uninsured, low-income, and minority groups
- The process for identifying and prioritizing community needs and services required
- The process for consulting with persons representing the community's interests
- Information gaps that limit the hospital facility's ability to assess the community's health needs

PRIORITY HEALTH NEEDS & HOW THEY WERE ESTABLISHED

Prioritization Process

Process & Criteria

Secondary (existing) data is an important piece of the CHNA process. More than 100 data indicators were chosen for analysis from data sources like the Robert Wood Johnson Foundation County Health Rankings, the University of North Carolina Health Literacy Data Map, and the Centers for Disease Control and Prevention. Secondary data measures were gathered into six categories and 20 detailed sub-categories based on common themes. Each data measure was also compared to state or national benchmarks to identify areas of specific concern for Baltimore County. Top community needs identified through secondary data analysis included social determinants of health, access to healthcare, behavioral health, and health equity.

Primary (new) data was collected through community-based focus groups and web-based surveys for community members and key community leaders and included feedback from more than 2,200 people who live, work, or receive healthcare in Baltimore County. Key leaders most frequently represented nonprofit organizations, but participants also included government, health, and faith leaders among others. A total of 13 focus groups were conducted, either virtually or in person, with a variety of community members from different backgrounds, age groups and life experiences. Primary data identified access to healthcare, food insecurity, and transportation as top needs that impact the health and wellbeing of people living in Baltimore County.

The CHNA Steering Committee worked together to identify the priorities the county should focus on over the following three-year period. Leaders evaluated the primary and secondary data collected throughout the process to identify needs based on the size and scope, severity, the ability for hospitals or health departments to make an impact, associated health disparities, and importance to the community. Although it was not possible for every single area of potential need to be identified as a priority, the CHNA Steering Committee selected three top priority health needs (Behavioral health, Physical health and Access to care).

Identified Priorities

The following priority health issues are the final community-wide priorities, in no particular order, that were selected through the process described above:

Baltimore County*:*

- **Priority 1: Behavioral Health**- behavioral health describes conditions related to both mental health and substance use

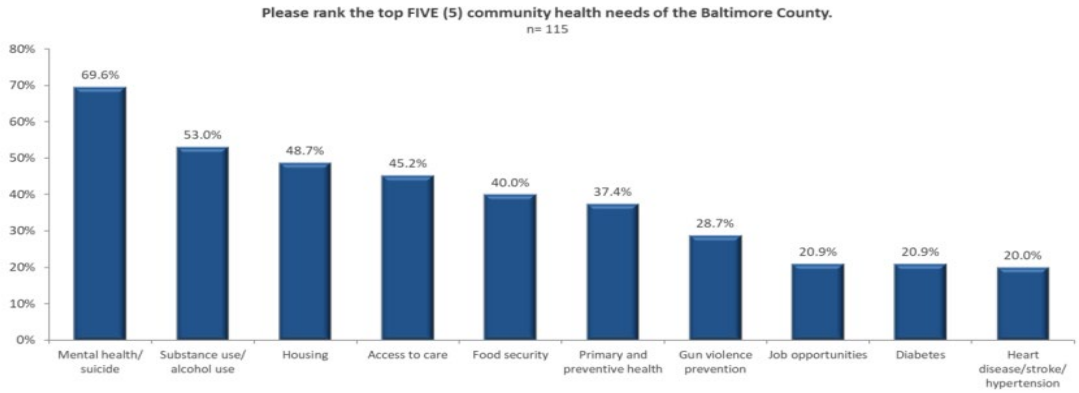
Table 4.1: Behavioral Health Indicators				
Indicator	Baltimore County	Baltimore City	Maryland	United States
Drug Overdose Deaths per 100,000	51	124	41	23
Percent of Population Experiencing Frequent Mental Distress	15%*	16%	13%	14%
Number of Poor Mental Health Days in the Past Month	4.5*	5.4	4.1	4.4
Percent of Adults Reporting Excessive Drinking	17%	18%	15%	19%

Source: Robert Wood Johnson Foundation, County Health Rankings 2023
*Indicates areas of high need

When compared to the previous CHNA, which was conducted in 2020, each of these statistics have increased. The population experiencing frequent mental distress increased from 12% in 2020 to 15% in 2023. The average monthly number of poor mental health days reported by residents increased as well, from 3.8 to 4.5 days. In 2023, 4.9% of residents in Baltimore County reported visiting a mental health provider, slightly higher than the state average of 4.7%, and the national average of 4.5%.

More than 2,000 people who live, work, or receive healthcare in Baltimore County responded to the community member survey. When asked to identify the top five community health needs in Baltimore County, mental health was identified as a top concern by 57.4% of respondents, and 41.6% identified alcohol and drug addiction.

Key leaders surveyed during the CHNA process identified mental health/suicide and substance or alcohol use as the top two health issues impacting residents of Baltimore County. Among 115 key leaders from various organizations who responded to the survey, 69.6% identified mental health and suicide as a top community health need in Baltimore County. Substance and alcohol use ranked second in the survey and was identified as a top concern by 53% of respondents.



- **Priority 2: Physical Health-** physical health is the monitoring and maintenance of the human body. There are many factors involved in an individual's overall physical health status, such as disease prevention, timely access to primary and preventive healthcare, exercise, and maintaining a healthy diet. Physical health can also involve the management of chronic health conditions.

  Baltimore County performed worse than the state of Maryland in nearly all physical health indicators.

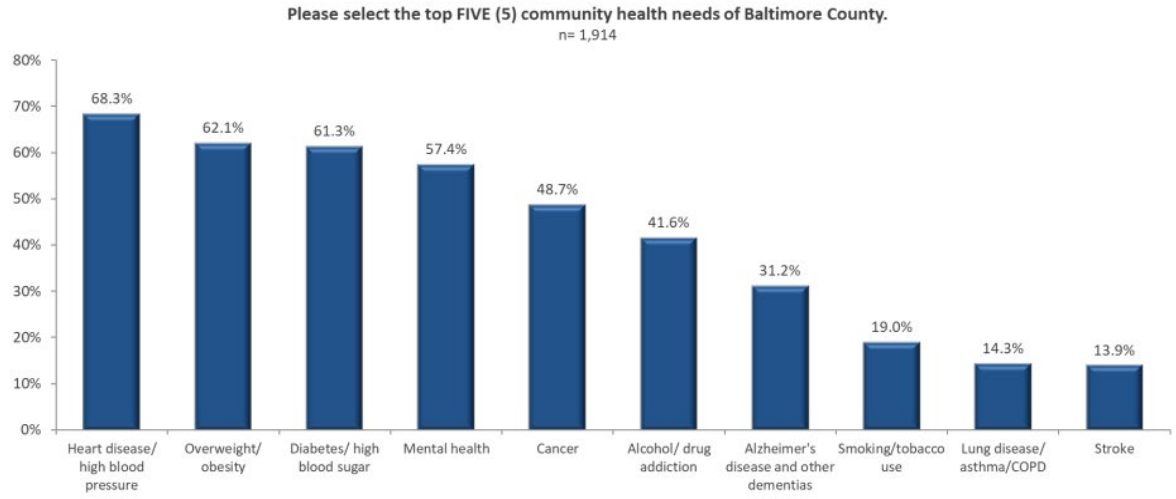
Table 4.2: Physical Health Indicators				
Indicator	Baltimore County	Baltimore City	Maryland	United States
Percentage of Population Experiencing Frequent Physical Distress	8%	10%	7%	9%
Number of Poor Physical Health Days in the Last 30 Days	2.5	3.3	2.5	3
Percentage of Population Reporting Poor or Fair Health	12%	17%	11%	12%
Percent of Population Reporting Insufficient Sleep	34%	40%	34%	33%
Adult Diabetes Prevalence	9%	13%	9%	9%
Adult Obesity Prevalence	32%	37%	31%	32%

  When compared to the state overall, Baltimore County had measurably worse rates of hospitalization for Alzheimer's disease or other dementias, as well as higher rates of mortality due to stroke, heart disease and cancer.

  Baltimore County also underperformed relative to the state in several health behaviors that have an impact on physical health. Baltimore County residents had higher rates of physical inactivity and smoking – both of which have been shown to increase the risk of various chronic health conditions. Despite having a higher rate of physical inactivity than the state, Baltimore County does have a higher proportion of its population with access to exercise opportunities. Food insecurity was also a concern for Baltimore County residents, which is notable due to the impact diet has on overall physical health.

Table 4.3: Health Behavior and Food Security Indicators				
Indicator	Baltimore County	Baltimore City	Maryland	United States
Percent of Physically Inactive Adults	22%	25%	21%	22%
Percent of Adult Smokers	14%	19%	11%	16%
Food Environment Index	8.3	7.5	8.7	7
Percent of Population with Access to Exercise Opportunities	97%	99%	92%	84%
Percent of Population Experiencing Food Insecurity	10%	16%	9%	12%
Percent with Limited Access to Healthy Foods	4%	2%	4%	6%
Percent of Children Eligible for Free or Reduced Lunch	52%	66%	45%	53%

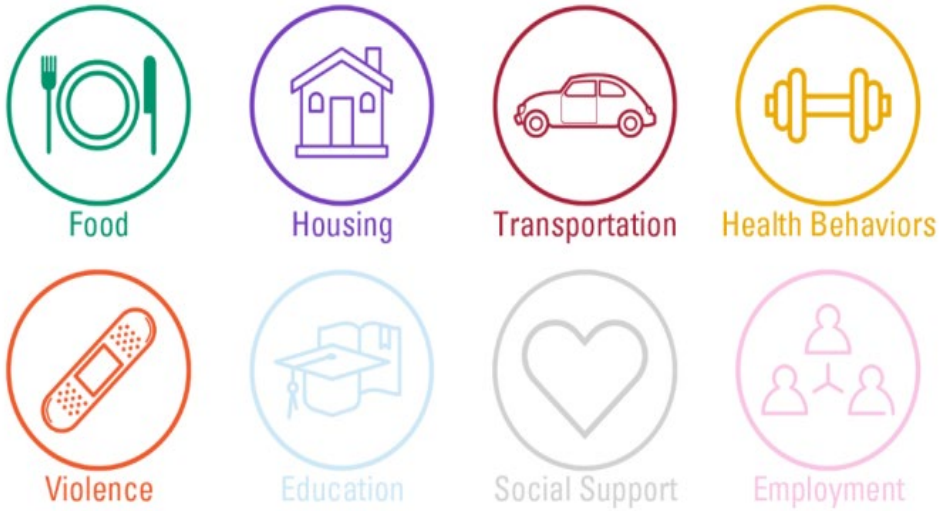
In Baltimore County, heart disease and high blood pressure were identified as the top community health need overall, having been selected by 68.3% of respondents. Overweight and obesity was identified as the second highest need by 62.1% of respondents, while diabetes and high blood sugar ranked third (61.3%). Other physical health conditions were also ranked among the top ten community health needs, including cancer (48.7%), Alzheimer's disease and other dementias (31.2%), lung conditions (14.3%) and stroke (13.9%). In addition, nearly one in five respondents identified smoking or tobacco use as a primary concern, which can also have significant health impacts resulting from tobacco exposure.



- **Priority 3: Access to Care-** access to care means patients can get high quality, affordable healthcare in a timely fashion to achieve the best possible health outcomes. It includes several components, including a physical location where care is provided, the ability to receive timely care, and enough providers in the workforce as well as financial coverage (i.e., insurance).

  Access to care and overall community health are affected by Social Determinants of Health (SDoH), which have a critical impact on health needs and outcomes. SDoH are not experienced equally by all people and are often linked to one another. The impacts of SDoH on populations are profound, can persist across generations, and often drive health inequities based on race, ethnicity, or socioeconomic status. When health systems use their resources to address SDoH among patient populations, it can strengthen the quality of the care they provide while reducing health inequities.

Figure 4.7: Social Determinants of Health

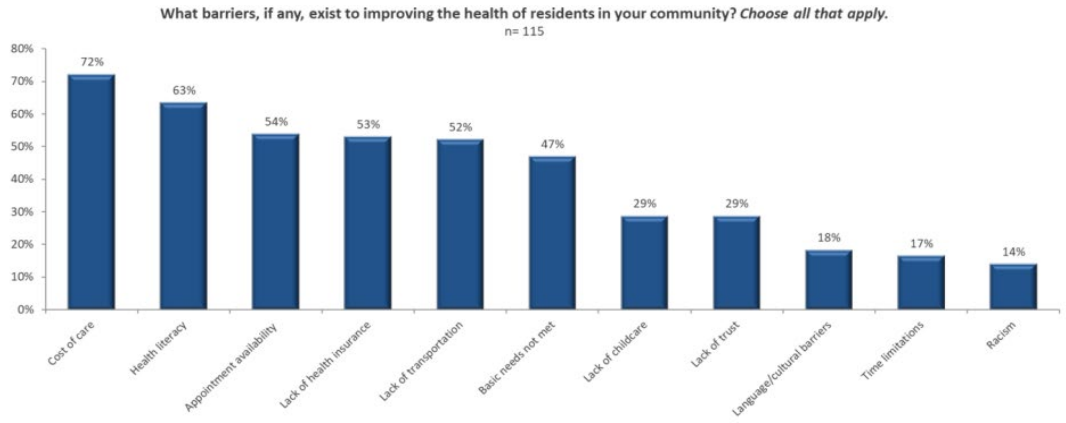


Source: American Hospital Association

While Baltimore County performed better than the state of Maryland on preventive health measures such as annual mammograms or flu vaccines for the Medicare population, it performed worse than the state for preventable hospital stays. A high rate of hospital stays for health conditions that are typically treated in an outpatient situation, such as diabetes, suggests that community members are not able to consistently access primary and or specialty care, which could help them manage their condition without being admitted to the hospital.

Table 4.4: Access to Care Indicators				
Indicator	Baltimore County	Baltimore City	Maryland	United States
Total Population per Primary Care Physician	1,100	800	1,130	1,310
Total Population per non-Physician Primary Care Provider	770	320	770	810
Total Population per Dentist	1,300	1,210	1,260	1,380
Total Population per Mental Health Provider	260	170	310	340
Annual Percentage of Medicare Enrollees Receiving Mammograms	41%	36%	37%	37%
Annual Percentage of Medicare Enrollees Receiving Flu Vaccines	59%	51%	55%	51%

Nearly three-quarters (72%) of respondents identified the cost of care as a top barrier to community health improvement. This was followed by health literacy (63%) and appointment availability (54%). Transportation was also noted as a barrier by more than half of respondents, underscoring the impact this particular SDoH has on health and well-being.

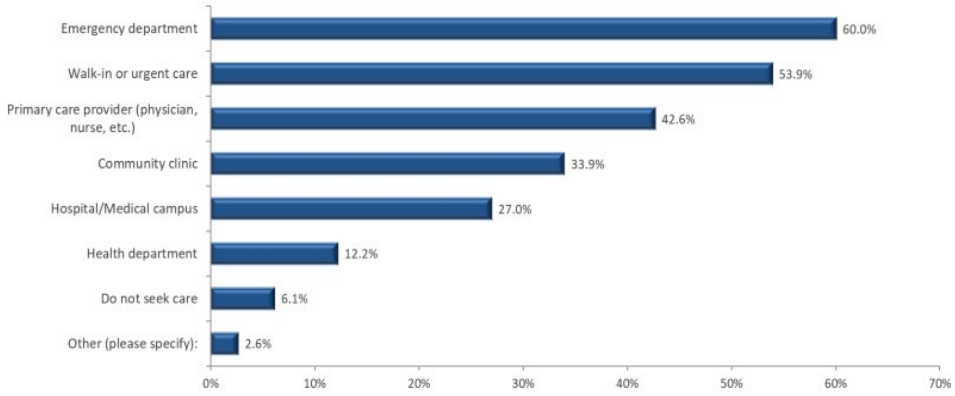


Key leaders were asked to identify the most common settings where community members seek care. Most respondents (60%) selected the emergency department as the most common location of care. The second most common was walk in/urgent care, at 53.9%. This aligns with community survey results that noted a lack of appointment availability and the high cost of care as major barriers. Individuals cannot be turned away at emergency departments for care, and many low-income individuals may not be able to see a primary care provider in a timely fashion or may lack health insurance to access primary care in the first place.

Figure 4.15

Members of your community typically seek medical care through... *Please select all that apply*

n= 115



HOW THIS IMPLEMENTATION STRATEGY WAS DEVELOPED

Engagement in a Community-Wide Plan

As a next step following the development of a community health needs assessment (CHNA), which includes prioritization of health needs, UM SJMC, collaborated with local public health experts and other key stakeholders to develop a written description of the activities that hospital facilities, public health agencies, and other local organizations plan to undertake collectively to address specific health needs in our community. This collaborative action planning process will result in the development of this hospital implementation strategy for our defined community through partnerships, which include the University of Maryland Medical Center, Baltimore County Health Department, Greater Baltimore Medical Center Healthcare, Medstar Franklin Square Medical Center, and Northwest Hospital of LifeBridge Health

IMPLEMENTATION STRATEGY DETAILS

Priority Health Issue #1: Behavioral Health

Desired Community Result:

UM SJMC's goal is to collaborate with community partners to create more pathways to care in the community for behavioral health patients, provide culturally appropriate access to and education on mental health, reduce the stigma around mental health and increase the number of adults screened and referred for support, reduce the drug-induced death rate, and increase the proportion of people with substance use disorder who are screened and referred to treatment.

Description of Community Need

Secondary data collected through the CHNA process identified behavioral health as an area of particular concern for residents of Baltimore County. In 2021, 20.7% of Baltimore County residents self-reported that a health professional has told them that they have a depressive disorder, higher than both the state of Maryland (16.6%) and the US (20.5%).17 Multiple mental health indicators in Baltimore County were higher than the state and national averages, with 15% of the population experiencing frequent mental distress (compared to 13% for the state and 14% nationally), and residents reporting an average of 4.5 poor mental health days per month (4.1 for state and 4.4 for national respectively). Drug overdoses in Baltimore County accounted for 51 deaths per 100,000 individuals, higher than the state rate (41 deaths 12 Source: SAMHSA (2023). Excessive drinking among adults was lower than the national rate, (17% vs. 19% respectively), but higher than the rate in Maryland (15%).

Partners

Community Behavioral Health Providers
Baltimore County Health Department
University of Maryland St. Joseph Medical Group
UMMS Population Health Service Organization
SJMG Behavioral Health Center
UMSJMG Primary Care
St. Clare Medical Outreach
Women's Health Associates
Pikesville OB practice
SJMC Emergency Department
SJMC 1W
UMSJMC Community Health
Cancer Institute Wellness and Support Center
UM SJMC Employee Health

Priority Area: Behavioral Health

Strategy: Collaborate with community partners to create more pathways to care in the community for behavioral health patients

Tactic	Action	Performance Measure
UM SJMG Behavioral Health Center	• Provide short-term behavioral health services with referral to community programs for extended care to patients discharged from UM SJMC or those affiliated with UM SJMG • Provide behavioral health services to patients self-referred from WHA & Pikesville OB with post-partum depression	• Patients served
UM SJMG St. Clare Medical Outreach Behavioral Health Provider	• Provide behavioral health services for undocumented patients being cared for by St. Clare Medical Outreach	• Patients served
FY 25 UM SJMC Emergency Dept.	• Behavioral Health Advocate, High Risk Case Manager, Social Worker - Collaborate to screen "at risk"/ high need" ED patients and refer to community resources	• TBD
GBRICS	• Support the initiative through monetary contribution • Distribute 988 resources at public health events	• Events attended
Cancer Institute Wellness & Support Center	• Support Mental Health and Wellness through referrals, to the support center, from the hospital, Cancer Institute, and UM SJMG	• Patients served
FY 25 Dementia Plan/Algorithm for evaluation & treatment	• Expand urgent access to Neurology • Partner with Assertive Community Treatment Teams • ODEPA ED Provider to obtain ACEP geriatric certification	• TBD

Strategy: Provide culturally appropriate access to and education on mental health

Tactic	Action	Metric
Health Fairs, Group Sharing, and Community Programs	• Support health literacy and close the disparity gap through participation in health fairs and group sharing utilizing community partners and diversity ambassadors to create trust • Support health literacy and minimize the stigma surrounding mental health through a Community Mental Health Awareness Program created in collaboration with our behavioral health community partners and Upper Chesapeake Hospital centered around health and wellness	• Events attended • Programs offered

	• Support health literacy through provider facilitated educational programs on chronic conditions and their impact on mental health	

Strategy: Reduce the stigma around mental health and increase the number of adults screened and referred for support

Tactic	**Action**	**Performance Measure**
UM SJMG Primary Care Behavioral Health Collaborative Care	• FY 25 in collaboration with UMMS PHSO to minimize the stigma associated with mental health will implement a collaborative care model in the primary care practice using a social worker for patients who screen mild to moderately positive on the depression screening tool	• Patients served

Strategy: Reduce the drug-induced death rate

Tactic	**Action**	**Performance Measure**
Baltimore County Overdose Prevention Task Force	• UM SJMC representation on the Task Force to align/create awareness of County initiatives	• Meetings attended
Statewide Targeted Overdose Prevention (STOP) Act:	• Partner with the Baltimore County Health Department to ensure compliance with the Statewide Targeted Overdose Prevention (STOP) Act	• Updated policies to support patients discharged after an opioid overdose

Strategy: Increase the proportion of people with substance use disorder who are screened and referred to treatment

Tactic	Action	Performance Measure
SBIRT Screening	• UM SJMG Primary Care and Emergency Department patients will receive SBIRT screening with referral to treatment programs for those that screen positive and agree to treatment	• Percent compliance with screenings
UM SJMC inpatient SDOH screen	• UM SJMC inpatient SDOH screen for all patients with referral to community resources for those that screen positive and agree to referral	• Percent compliance with screenings

Priority Health Issue #2: Physical Health

Desired Community Result

UM SJMC's goal is to collaborate with community partners to reduce the mortality rate of heart disease and stroke and reduce the rate of untreated hypertension, reduce current tobacco use, reduce the diabetes rate, reduce the rate of ED visits due to falls and increase the number of adults who do aerobic and muscle strengthening activity, increase healthy food access, reduce the cancer mortality rate, and increase the number of adults vaccinated against seasonal flu

Description of Community Need

Baltimore County performed worse than the state of Maryland in nearly all physical health indicators. This includes a higher percentage of residents experiencing frequent physical distress, or self-reporting poor or fair health status. Baltimore County also had slightly higher prevalence of diabetes and obesity among adults when compared to the state.

When compared to the state overall, Baltimore County had measurably worse rates of hospitalization for Alzheimer's disease or other dementias, as well as higher rates of mortality due to stroke, heart disease and cancer.

Baltimore County also underperformed relative to the state in several health behaviors that have an impact on physical health. Baltimore County residents had higher rates of physical inactivity and smoking – both of which have been shown to increase the risk of various chronic health conditions. Despite having a higher rate of physical inactivity than the state, Baltimore County does have a higher proportion of its population with access to exercise opportunities. Food

insecurity was also a concern for Baltimore County residents, which is notable due to the impact diet has on overall physical health.

Partners

Cancer Institute Wellness and Support Center
Um SJMG St. Clare Medical Outreach
Towson Sports Medicine
UM SJMC Community Health
Orokawa Y in Towson
UM SJMG Primary Care
UM SJMC Emergency Department/Stroke
UM SJMC Employee Health
Baltimore County Department of Health
Baltimore county Department of Aging

Priority Area: Physical Health

Strategy: Reduce mortality rate from heart disease and stroke and reduce the rate of untreated hypertension

Tactic	Action	Performance Measure
Stroke	• Support Baltimore County Stroke Smart proclamation and partner with the Baltimore County Health Department to increase awareness • FY 25 submit application for Stroke Smart Hospital • Stroke support group offered the 3rd Tuesday of each month at the Orokawa Y in Towson	• Events attended • Submission of application • Number
Health Fairs, Group Sharing, Screenings, and Community Programs	• Support health literacy and close the disparity gap through participation in Health Fairs and Group Sharing utilizing community partners, Spiritual Care, and diversity ambassadors to create trust • Community and hospital blood pressure screenings • Support health literacy through provider facilitated educational programs in the community "Hypertension, Stroke, and Physical Activity- importance of adherence and risks" • Chronic disease management programs	• Events attended • Screenings offered • Programs offered
Marketing health education that is UMMS branded to support health literacy	Social media • Quarterly community newsletter with specific health information related to time of year. (events and wellness tips that are inclusive of diverse populations with attention to health literacy) • Online risk assessments (Diabetes, Heart Aware, Lung Health) • Baltimore magazine (Stroke Smart, Urgent care vs ED)	• Mailings • Completed assessments
UM SJMC Wellness		• Programs

Wise		offered
UM SJMG Cardiology Bridge Program	• FY 25 UM SJMG Cardiology Bridge Program expansion to support post discharge follow and support patient transition from hospital to home	• Patients served
Cardiac Rehabilitation Phase I expansion	• Support health literacy through Cardiac Rehabilitation Phase I expansion with inclusion criteria to provide education on heart health for those diagnosis that don't necessarily qualify for Cardiac Rehabilitation	• Consults completed

Strategy: Reduce current tobacco use

Tactic	**Action**	**Performance Measure**
Smoking Cessation	• Cancer Institute to partner with Upper Chesapeake Hospital to offer smoking cessation program • Screen and refer to Baltimore County Health Department's Smoking Cessation Program • Screen and refer to CDC quit line • FY 25 Division of Pulmonology provider to obtain certification to facilitate smoking cessation classes	• Programs offered
Community Program	• To support health literacy, Vaping Education will be offered at health fairs	• Events attended

Strategy: Reduce the diabetes rate

Tactic	**Action**	**Performance Measure**
Community Program	To support health literacy and support self-management Community Health will offer CDC T2 program cohorts to the community	Cohorts offered
ADA Children's Camp	• UM SJMC participation ADA Children's Camp	• Attendance

Strategy: Reduce the rate of ED visits due to falls and increase the number of adults who do aerobic and muscle strengthening

Tactic	**Action**	**Performance Measure**
Community Programs, health fairs	• To support health literacy and improve strength balance in our geriatric population, Community Health will offer a Matter of Balance Program • Partner with Community Agencies to support/create awareness of their community programs that are offered	• Programs offered

	to address physical activity • Community/Virtual Yoga programs • Exercise physiologist/trainer presence at health fairs to perform physical activity assessments and offer recommendations. • Partner with Orokowa of Towson and Parkville YMCA to offer programs that improve health literacy	
FY 25 UM SJMC Bone density program	• Business plan created to expand our bone density program to create awareness, screenings, and treatment for those at risk	• Patients served
Encourage Exercise	• UM SJMG PCP smart phrase for AVS with exercise guidelines and physical activity education and program referral	•

Strategy: Increase healthy food access through partnerships

Tactic	**Action**	**Performance Measure**
Healthy food access	Increase healthy food access through partnerships • Hungry Harvest • Student Support network • Meal on Wheels • Maryland Food Bank • Gedco • First Fruits	• Number of events

Strategy: Reduce the cancer mortality rate

Tactic	**Action**	**Performance Measure**
State & County SJMC representation on Coalitions	• UM SJMC representation State Cancer Coalition • UM SJMC representation on Baltimore County Cancer and Tobacco Cessation Team	• Participation
One Voice	• Cancer Center partnership with Advanced Radiology to offer free cancer screenings to un or under-insured (mostly Hispanic)	• Patients served

Strategy: Increase the number of adults vaccinated against seasonal influenza

Tactic	Action	Performance Measure
Flu shot clinics	• Community Health flu shot clinics	• Number of clinics

Priority Health Issue #3: Access to Care

Desired Community Result

UM SJMC's goal is to collaborate with community partners to increase the number of adults with a primary care provider, reduce the number of uninsured emergency department visits, support health literacy and health resources awareness including the reduction of transportation and language barriers and identifying and addressing other barriers to care, and continuing to support internship programs to gain employment experience.

Description of Community Need

Baltimore County performs well on a number of access to care metrics, including the ratios of population to primary care physicians, non-physician primary care providers, and mental health providers. However, Baltimore County has several large hospitals and health systems located within its borders, so these ratios suggest that many people who reside outside the county travel there to receive care. Access to care may not be equitable across all county populations, particularly those with socioeconomic or transportation related challenges.

While Baltimore County performed better than the state of Maryland on preventive health measures such as annual mammograms or flu vaccines for the Medicare population, it performed worse than the state for preventable hospital stays. A high rate of hospital stays for health conditions that are typically treated in an outpatient situation, such as diabetes, suggests that community members are not able to consistently access primary care, which could help them manage their condition without being admitted to the hospital.

Partners

UM SJMG Primary Care
UM SJMG Transitional Care
UM Urgent Care
UM SJMG St. Clare Outreach
Baltimore County Health Department

Priority Area: Access to Care

Strategy: Increase the number of adults with a primary care provider

Tactic	Action	Performance Measure
UM SJMG Transitional Care Center	• Transitional care provided for patients of high need with multiple unmet social determinants of health, in need of timely follow up post discharge, without a primary care provider in need of transitional care until able to establish care with a primary care provider • Transitional care provided to patients refereed from UM Urgent Care until able to establish care with a primary care provider • "Fast track to specialty" for SJMG Primary Care and geographically located UM Urgent Care Facilities for patients needing urgent access	• Patients served
UM SJMG St. Clare Outreach	• Primary care services offered to undocumented patients	• Patients served
Marketing Strategies	• UM SJMG primary care cards with QR code for list of providers accepting new providers • Ability to self-schedule online • Participation with system initiative	• New patients
Promote specialty services within UMMS	• FY 25 partner to develop strategies for referrals to specialty services not provided at UM SJMC	

Strategy: Reduce the number of uninsured emergency department visits

Tactic	Action	Performance Measure
UM SJMG St. Clare partnership with UM Urgent Care	• Reinforcement on when to utilize lower acuity levels of care before resorting to an ED visit	• Number of patients served
UM SJMG St. Clare partnership with Baltimore County Health Department	• Refer patients for free or reduced cost services/screenings	• Number of patients referred
Expand access to "specialty" charity care	• FY 25 meet with CFO to understand charity care and align resources for Transitional care to be consistent with St. Clare	

Strategy: Support health literacy and health resource awareness including the reduction of transportation and language barriers and identifying and addressing other barriers to care

Tactic	Action	Performance Measure
Hospital discharge After Visit Summary	• Participate on system AVS workgroup to address improved language/health literacy	• Participation
Community Programs	• Offer community programs with virtual option and/or access via public transportation including Towson loop	• Programs offered
Lyft transportation	• Utilize Lyft ride transportation for transportation to medical appointments for high need patients while we work to connect them to resources	• Rides offered
Tele-health visits	• UM SJMG primary care to offer tele-health visits	• # of tele-health visits
UM SJMC Maternal Child Health (MCH)	• To support health literacy UM SJMC Maternal Child Health (MCH) will off prenatal and postpartum classes to support new families in the community	• Classes offered

Strategy: Offer internship programs to gain employment experience

Tactic	Action	Performance Measure
Internship programs	• Offer internship programs to gain employment experience	• Number of internships offered

NEXT STEPS

As part of the community health improvement process, the University of Maryland St. Joseph Medical Center, will continue to work with community partners in the development, implementation, and monitoring of our collaborative community health improvement plan (CHIP) that includes some of the hospital strategies outlined in this document. The next community health needs assessment (CHNA) will be conducted in 2026. As a note, this implementation is dynamic in nature and reflective of the communities that we serve and partners that we work with. Strategies may change in scope or fluctuate accordingly based on the aforementioned.