Sheppard Pratt

Community Health
Needs Assessment

2025

crescendo cg

Contents

Introduction

Sheppard Pratt is the nation's largest private, nonprofit provider of mental health, substance use, special education, and social services, serving over 80,000 people annually. For over 170 years, Sheppard Pratt has delivered care across hospitals, schools, clinics, and homes. Sheppard Pratt also conducts research on areas of study including major depressive disorder, bipolar disorder, autism, and schizophrenia and offers professional education and training for providers, students, and the community.

Learn more: https://www.sheppardpratt.org/

Mission

To improve the quality of life of individuals and families by compassionately serving their mental health, addiction, special education, and community support needs.

Vision

To be the preeminent provider of mental health services in the nation—leading innovation and delivering compassionate, expert care when and where people need it.

Values

Since our founding in 1853, Sheppard Pratt has remained loyal to our Quaker heritage. The Quaker testimonies of simplicity, peace, integrity, community, and equality drive not only our core values, but our guiding principles, as well.

Core Values

To Meet a Need.
To work toward recovery of health & quality of life for people we serve

To Lead.
To continually seek & create more effective ways to serve individuals

To Care.
To employ the highest standards of professionalism, with compassion, at all times

To Respect.
To recognize & respond to the human dignity of every person

Between December 2024 and May 2025, Crescendo Consulting Group worked in collaboration with Sheppard to conduct a Community Health Needs Assessment. A combination of quantitative and qualitative research methods was used to evaluate perspectives and opinions of community stakeholders. A Community Health Needs Assessment (CHNA) is a comprehensive process that identifies the health needs, barriers to accessing care, and the Social Drivers of Health (SDoH) in a community. Intentional outreach was made to include the voices and lived experiences of the community's most vulnerable populations that may not have historically participated in this process in prior years. The Community Health Needs Assessment is a requirement of all non-profit hospitals to complete every three years as part of the Patient Protection and Affordable Care Act (the ACA) and codified under IRS Section 501(r)(3).

A Community Health Needs Assessment:

- Establishes a profile of a community.
- Determines the needs in a community that can be addressed and the population that is most impacted by the need.
- Includes both quantitative and qualitative data to assist in identifying needs in the community.

CHNA Work Group

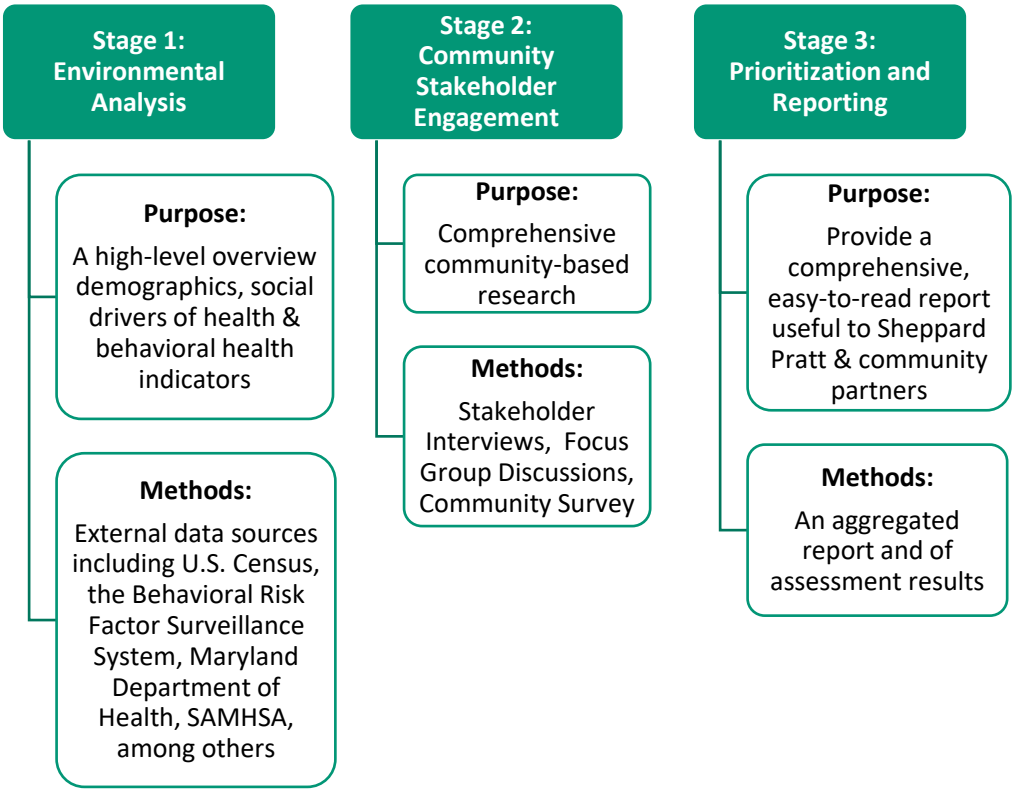
Name	Title
Brian Lynch	Vice President and Chief Human Resources Officer
Bryan Mroz	Vice President and Chief Operating Officer, Hospitals
Carrie Etheridge	Director of Social Work
Claudia Keenan	Vice President and Chief Development Officer
Harsh K. Trivedi, MD, MBA	President and Chief Executive Officer
Holly Young	Executive Director, Baltimore/Washington Campus
Jeffrey Grossi, JD	Chief of Government Relations
Jennifer Coyne, JD	General Counsel
Jennifer Weiss Wilkerson, MHSA, FACHE	Senior Vice President and Chief Strategy Officer
Kathy Flannery, Med	Vice President and Chief of Schools
Kelly Savoca, CPA, MBA	Senior Vice President and Chief Financial Officer
Marshall D. Henson	Vice President and Chief Operating Officer, Community Services
Megha Kachalia	Chief of Strategic and Business Planning
Paula Bostwick, RN, MSN, CENP	Chief Nursing Officer
Stephen (Steve) Merz, MHSA, FACHE	Vice President and Chief Operating Officer, Sheppard Pratt Solutions
Thomas D. Hess, MBA, MEd	Chief of Staff
Todd Peters, MD	Senior Vice President and Chief Medical Officer

Outreach Activities Since the Previous CHNA

In progress

Methodology

Sheppard Pratt and Crescendo Consulting Group prioritized inclusivity and intentionality in their community engagement efforts to ensure that the voices of the communities served by Sheppard Pratt were actively included. They aimed to provide opportunities for community members to participate in ways that suited their comfort levels, ensuring their perspectives were heard and considered. The Community Health Needs Assessment (CHNA) was conducted using a three-stage process:



Environmental Analysis provided a critical insight into the demographics of the service area, social drivers of health, and behavioral health-related measures, among many others.

Qualitative Research included eight one-on-one stakeholder interviews and six focus groups.

A **Community Survey** was conducted via SurveyMonkey and paper copies in two languages to evaluate and address behavioral health care and other needs, gaps, and resources in the community. A total of 80 valid responses were collected and analyzed.

The **Needs Prioritization Process** was conducted with the Sheppard Pratt CHNA workgroup members. The process consisted of a pre-prioritization survey using a modified Hanlon Method, a review of high-level findings from both quantitative search, qualitative research, and a discussion focused on identified needs.

Service Area

Sheppard Pratt cares for patients from all over Maryland and across the United States. For this report, data was collected for our hospital's primary service area (PSA), the geographical region from which Sheppard Pratt draws 80% of hospital patients. Our PSA is comprised of six Maryland counties including Anne Arundel County, Baltimore County, Baltimore City, Howard County, Montgomery County, and Prince George's County.

EXHIBIT 1: SHEPPARD PRATT SERVICE AREA BY COUNTY POPULATION

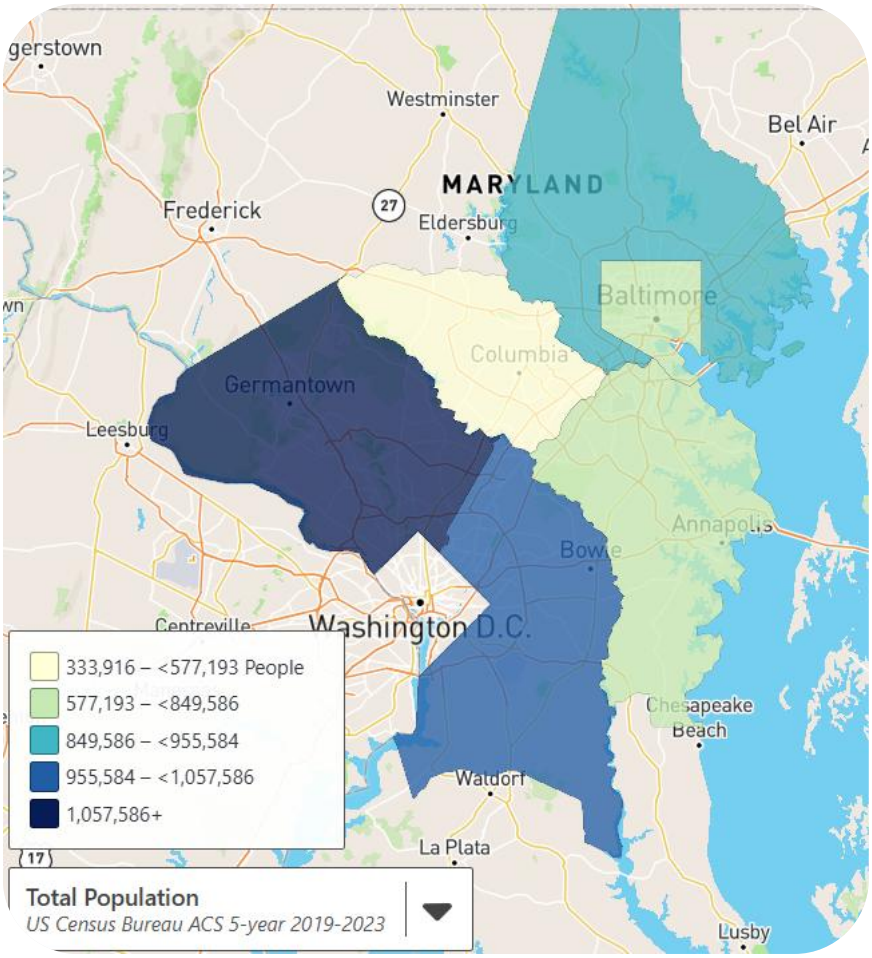


EXHIBIT 2: PRIMARY SERVICE AREA

Patient County	Discharges	% of Total Discharges	Cumulative % of Total
Baltimore County	1,946	26.4%	26.4%
Baltimore City	1,256	17.1%	43.5%
Anne Arundel County	833	11.3%	54.8%
Howard County	719	9.8%	64.6%
Montgomery County	700	9.5%	74.1%
Prince George's County	404	5.5%	79.6%

Qualitative Research

The qualitative primary research stage of this Community Health Needs Assessment included one-to-one interviews and focus group discussions with stakeholders and community members within the Sheppard Pratt service area.

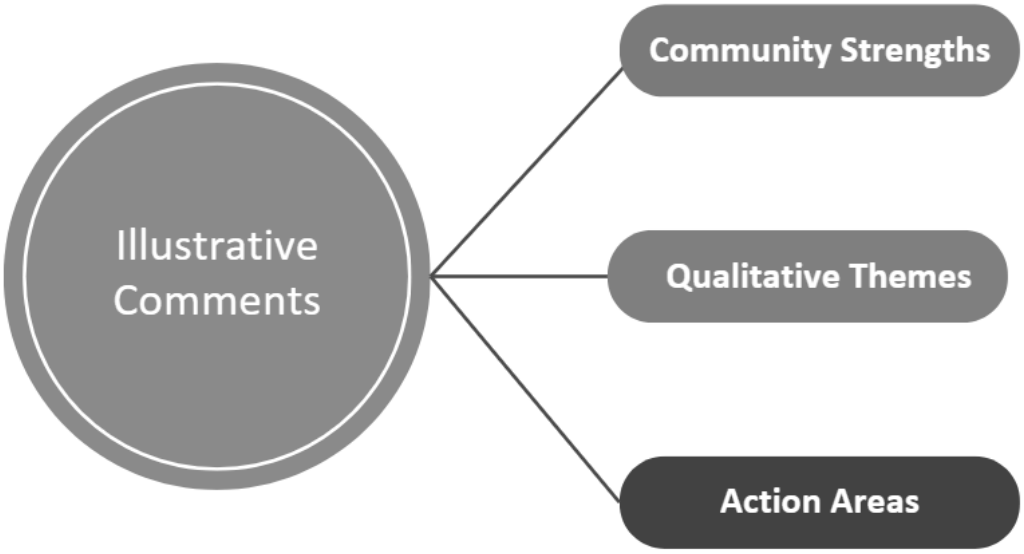
The interviews provided an opportunity to have an in-depth discussion about community needs, physical and mental health care, and service issues with community leaders and professionals. The focus groups enabled the participants to highlight areas of consensus and to compare differences as to what they see as the biggest behavioral healthcare needs facing the community.

Participation

The interviews and focus group discussions covered participants' broad perceptions of community needs, as well as more detailed areas of need. In total, across both qualitative research stages, individuals provided input from the following segments and others. Please note that these categories are not mutually exclusive for some individuals.

- Department of Health
- National Alliance on Mental Illness
- Behavioral Healthcare Organizations
- Community Leaders
- Community Partners
- Sheppard Pratt leaders and staff

Qualitative data instruments can be found in Appendix B and C.



Community Strengths

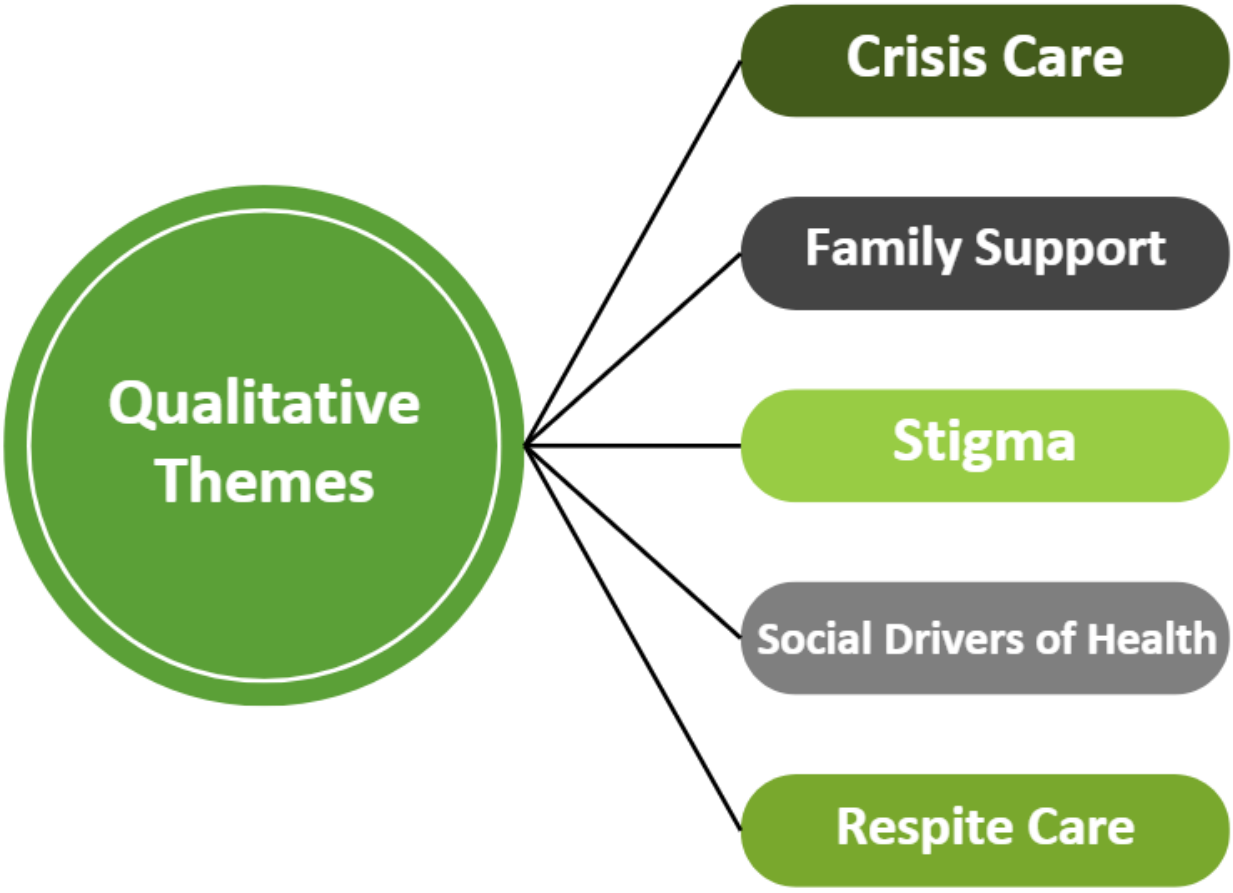
The combination of qualitative individual interviews and focus group discussions provided information on the **Community Strengths** of the Sheppard Pratt service area. For this Community Health Needs Assessment, it is important to highlight the strengths that residents see in their community and to recognize programs and services that have seen success in addressing community needs.

- "My favorite thing about my community is the ability to fix problems for people and being able to bring people to the table."
- "Baltimore is special because people really care ad want to make a positive change and are really dedicated to the city. It's not the easiest city because we have a lot of issues and pay very high taxes. We just lack the resources to get where we want to go."
- "There's a great deal of resources available such as hospitals, colleges, and programs to meet the needs of people who have a behavioral health need. It's not perfect, but there are a lot of resources for people who need support and services."
- "It's really nice to be doing work at the local level because it's easier to see results and easier to build relationships with other community leaders whose support you need for various activities."
- "The department of health is a great place to work. We have our ups and downs, and you don't always agree with management, but it's a mission-driven place to be and to work."
- "I have the opportunity to work to make a difference in the county from a population level and look at trends to come up with solutions. Most of our private providers and county agencies are unusually collaborative."
- "Behavioral health is valued throughout the community. Where's there a meeting where behavioral health isn't at, someone will say 'hey where are they?' We always have a seat at the table."

Qualitative Themes

The qualitative discussions also resulted in several themes about areas of need, described as **Qualitative Themes.** Each of these themes cuts across and impacts subsequent **Action Areas,** which are representative of respondents' consensus perspectives. In some cases, the observations highlight examples of potential intervention.

A combination of qualitative research methods results in five themes:



Crisis Care

Community stakeholders shared that there are not enough crisis services, and existing services are not fully effective.

- "We created legislation, the Greater Baltimore Regional Integrated Crisis System (GBRICS) Partnership project[1], a four-county pilot in Maryland with hospitals, first responders, and behavioral health providers to figure out how to ease the burden on emergency rooms of people in mental health crises. It didn't go as well as planned, it was supposed to be a five-year pilot. I think it's an ongoing problem."
- "Our police are more educated, knowing that these people don't need to go to jail, so what do they do with them? There are big gaps in crisis services."
- "Through a crisis center walk-in, staff would link people to appropriate services that have been identified. We need a place to go when people need more than a quick visit, but don't need a bed, they need to be linked to ongoing services."
- "There is a lack of service providers, which exacerbates crisis situations. There is a lack of crisis beds because there are few community-based services. When people reach the point of crisis, there's nowhere for them to go other than hospital boarding."

Family Support

People with lived experience as well as behavioral healthcare providers cited the need for more support and education around the entire family unit, not just the patient.

- "For a lot of the units at Sheppard Pratt, family support is something were really lacking. If we could give families more support, we could get more patients at home with their families and not have some of these issues. All we can do is tell them to call NAMI. We are not doing what we could. If they were support people would feel more confident."
- "At Sheppard Pratt, years ago, they used to have family education groups before visitation, and it was very supportive, and families used to love it. Families who have come back are asking for it and saying they need it."

[1] Central Maryland Regional Crisis System. https://www.bhsbaltimore.org/learn/central-md-regional-crisis-system/

- "It would be helpful to have information on what to expect from visiting the behavioral healthcare system. You're going into a locked place and there's trauma in that."
- "Families are typically on board with wanting to help when their child is discharged, but the problem is more what we do is discussing the discharge plan and what aftercare looks like, but a lot of families don't understand their child's illness and what could a be trigger and what symptoms look like. We can give the education to supportive parents, but then I don't know if they have the education to fully help them."

Stigma

Stigma around accessing behavioral health services crosses all age groups, races, and ethnicities, according to community stakeholders.

- "Depression and anxiety are 25% of all mental illness, but even if people don't suffer from severe depression or anxiety, they understand what that could feel like. Psychosis is different, and not everyone might know what that feels like; there's not enough education around it. People just can't relate. Especially the way the media portrays mental illness. Every time there's a mass shooting; everyone talks about what mental illness they had."
- "The elderly have access to care, but stigma gets in the way. They need anti-stigma education because the stigma prevents them from seeking help."
- "Stigma is still an incredibly big barrier. There are populations of different races and ethnicities that are not comfortable seeking support. Providers need to acknowledge the role of peer support in eradicating stigmas."
- "Stigma kills, and it will until people are on an anti-stigma campaign in Baltimore County."
- "There's some school-based mental healthcare, but there's stigma around parents not wanting or believing their child has a mental health condition or fear that if they talk to somebody, will their peers find out?"
- "A lot of high schoolers who are struggling with mental health are afraid, and they think they will receive poor treatment. They don't want to get reported to the counselor. There's a hiding of symptoms because they are afraid.

Sometimes they don't want to get behind on schoolwork and want to be present at school. For people who don't struggle with mental health as much, there would be a little bit of negative talk. It's mostly fear of reaching out."

- "People living with a mental health condition never recover or experience recovery. Providers see it as if we're stagnant and can't be helped, and resources are being wasted on us."

Social Drivers of Health

Housing and transportation were identified as major barriers to accessing behavioral healthcare services.

- "For housing for people with mental illness, there are certain restrictions out there, and there's barely any housing in general. There's very little to no supportive housing. Housing continues to be something that bubbles up."
- "Affordable housing for people who need more support, who may not be able to keep full-time jobs. People leaving detention center programs need housing, and that housing may be coupled with behavioral healthcare, and we don't have a lot of those resources. That is a stressor for people, and when they don't have various different things they need and when they cycle out of different treatment programs, they have higher needs because their basic needs aren't being met."
- "I have found that there is no supportive housing in Howard County, and we've had to shift my granddaughter around. There's only one shelter in the county, and then Sheppard Pratt."
- "Transportation is also a barrier for a lot of people. We're a typical suburban community that relies on people having cars. The public bus system is pretty inadequate. When you get to rural areas of the state, there are limited providers and it's a bigger issue and you have people coming from the shores into Baltimore because there isn't anyone in Alleghany County."
- "Often, people with mental health conditions don't have access to transportation, so if they have to travel a long distance from home or if they have physical disability, they're not able to access mental health services."

- "I was talking to a mom who wanted her child to do the day program, but it requires transportation. Sheppard Pratt sometimes provides transportation based on a variety of factors, but this family lives over an hour away, and mom can't provide transportation, so we had to say no."

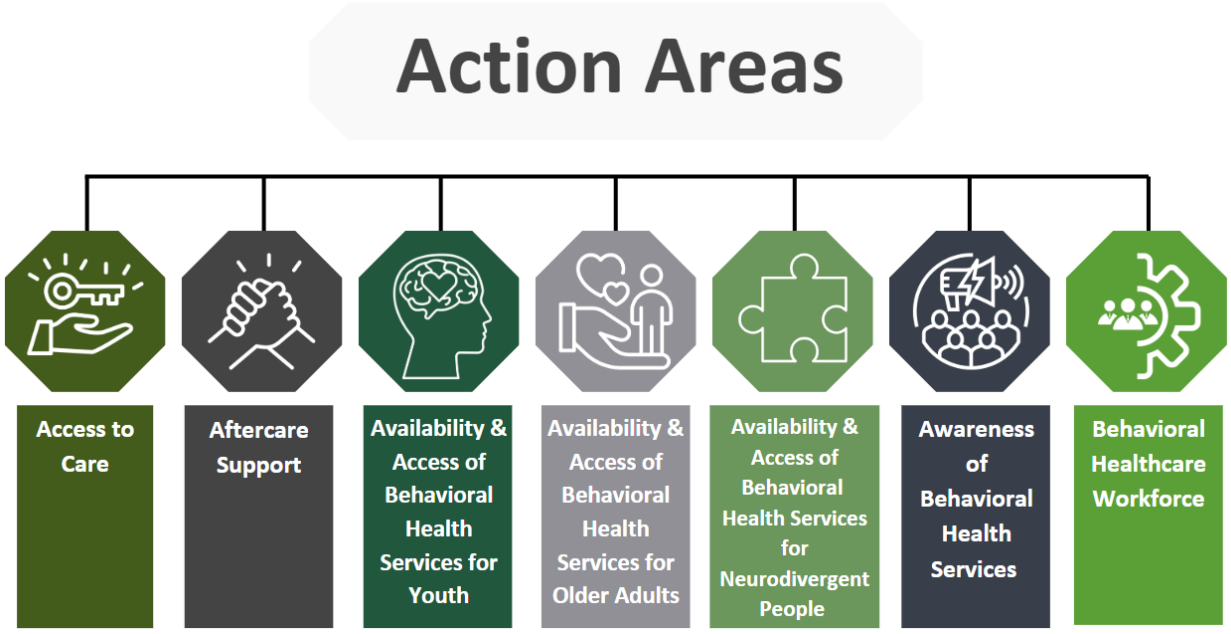
Respite Care

Respite care was identified as a service lacking in the service area and the state overall.

- "For families with access to waivers in the state, there are theoretical respite services available. We have an autism waiver that takes the payment burden off the family, but there's an eight-year waitlist to get the waiver, and once the wait time is up, you have to wait until there are providers available. For families without waiver services, it comes back to 'do you have money to pay for it?'"
- "Our public behavioral healthcare program covers a lot of things, so there's actually more access if you have Medicaid versus private insurance. Private insurance doesn't cover respite and wrap-around care."

Action Areas

The following **action areas** were derived from the qualitative themes that arose as a result of stakeholder interviews and focus group discussions. Each action area includes an overview of the subject, de-identified illustrative observations gathered during the qualitative research process and supporting quantitative secondary research. **The illustrative observations are representative of respondents' consensus perspectives.**



Access to Care

Community stakeholders reported that while there are numerous hospitals in the service area, navigating the healthcare system remains complex. As a result, emergency rooms are frequently used for behavioral health crises, indicating gaps in appropriate crisis care. Access to care is perceived as under-resourced and ineffectively managed. One of the primary barriers to accessing care is insurance coverage, both Medicaid and commercial insurance. Behavioral healthcare providers expressed concerns about the declining number of providers accepting Medicaid, making it increasingly difficult for patients to find care. Additionally, even individuals with commercial insurance face challenges, as fewer providers accept insurance at all. These issues contribute to disruptions in the continuity of care, limiting individuals' ability to receive consistent and comprehensive behavioral health services.

- “A lot of mental health providers don’t accept Medicare, and a lot of people living with mental health conditions are on disability.”
- “Mosaic is only taking Medicaid, not commercial insurance. If Sheppard Pratt had an outpatient service that accepts commercial insurance, it would be better for patients. Patients lose the connection to the hospital easily, and there is no continuity of care.”
- “Sometimes we want to be able to offer more resources, but insurance is a barrier. If we're trying to get in-home services for a patient waiting for residential services, it can be hard to find a place that accepts their insurance or has availability.”
- “On the co-occurring unit, the challenge is weighing between clinical readiness for discharge from this acute setting versus acceptance into a substance rehab program. We have to weigh insurance coverage while they are here. Insurance offers more substance use-based treatment over mental health treatment. If someone has a co-occurring substance use disorder, often providers decide whether they’re going to treat substance use or the mental health diagnoses, but they don’t always treat both simultaneously.”
- “With Medicaid, there are not a lot of specialty providers that take medical assistance. A lot of times, we will have a patient with severe trauma or OCD who needs specialty service like an intensive DBT skills group, and a lot of the time these specialists don’t accept state insurance. If a patient comes in with private insurance, they have a lot more options.”
- “With Medicare, some things are just unaffordable. The prescription companies want to push certain medications to patients, and then the insurance won't approve the medication.”

- “If you don’t have the right coverage, services can be very limited. Medicaid is the only payor in many circumstances, so if you don’t have Medicaid, you are at a disadvantage. Sometimes it’s about service matching that’s difficult. I want to be in-person, close to home, and have services that take my insurance. There are high co-pays and high-deductible plans for people with commercial insurance. Even when people have benefits, they don’t understand their mental health benefits.”
- “The cost aspect of it, the ones that are available from the small pool are pay as you go or don’t take insurance. You need to find a therapist and then determine what they cover through insurance, it's all fine print. You prefer in-person, and most therapists with specialties have a certificate or a degree.”
- “If it’s an access issue, you are forced to go to someone you don’t connect with or pay more because you do connect with a provider. We ended up changing insurance companies just to get a portion of my child’s sessions covered.”
- “I’ve seen a lot of private practice providers stop taking commercial insurance. They can be so difficult; you can either rely on big companies to navigate the reimbursement process, or it falls to the patient because they are out of network, and that can be overwhelming for people who are struggling.”
- “People have private insurance, and they have a list of providers, and a lot of providers won’t take insurance because the health insurance system is such a mess, so most providers will do self-pay only.”

Culturally Competent Behavioral Health Services

Cultural competency in health care enables systems to deliver patient-centered care by addressing diverse values, beliefs, and behaviors. It involves recognizing cultural influences, assessing cross-cultural relations, expanding knowledge, and adapting services to meet unique needs. This approach is key to reducing racial and ethnic health disparities.

American Hospital Association

Access to care is exacerbated by a significant number of the service area population who have difficulties finding culturally competent care. For example, one stakeholder shared that in their community, there is a “fairly large Korean population”, which was identified as “a very closed community in a different way compared to the Hispanic/Latino community. For the Hispanic/Latino community, there is a fear of accessing services, and in the Black/African American community, historical stigma exists, and there is the level of trauma that makes this population harder to reach and serve.

- “The Hispanic/Latino community is vulnerable and underserved, especially with this new administration. It will be incredibly hard.”
- “We lack bilingual providers who can adequately serve. When you talk about the struggles of finding an English-speaking therapist, think about finding someone who speaks Spanish.”
- “In the Black/African American community, there is a distrust of the medical system, and getting over systemic racism is a challenge. Then, finding culturally competent providers compounds the issue as well.”
- “There’s a big barrier when people don’t speak English as their primary language. They try to push a computerized interpreter service, but it’s not in every unit. From nine a.m. to seven p.m., there's a live interpreter; after that it's video.”
- “There is a shortage of cultural competence and multi-lingual providers, and we’re a very diverse community. It can be hard to talk to someone about certain things when they don’t look like you. We hear all the time of the need that people need providers who look and talk like them. It's not just cultural competence – it's beyond that. It would increase comfort and usage.”
- “Putting someone in front of a population that looks like them and can share their lived experience of mental health or substance use disorder can break down barriers and allow someone to feel safe in seeking services. Having culturally competent providers is something we lack. The number of black or black male or Latino providers is really slim.”

After inpatient behavioral health treatment, aftercare ensures a smooth transition to daily life through ongoing support, relapse prevention, and sustained recovery. It includes intensive outpatient programs, partial hospitalization, counseling, therapy, support groups, and medical interventions. A personalized plan addresses individual needs, reinforcing coping skills and managing relapse triggers.

The Recovery Village, Continuum of Care in Addiction Recovery

Aftercare Support

Aftercare programs, a vital part of the behavioral health continuum care, are a step in the recovery process for individuals who have completed residential treatment, an intensive outpatient program, hospitalization, or a crisis. It encompasses a set of supportive and therapeutic services designed to help individuals maintain their sobriety and navigate the challenges of life after completing primary addiction treatment programs. The Institute of Medicine's continuum of care categorizes behavioral health services into four areas: promotion, prevention, treatment, and recovery. It provides a structured framework for addressing substance misuse across various stages of care, ensuring comprehensive support for individuals and communities.[2] Finding adequate aftercare support in the community presents several challenges. Individuals with lived experience reported a lack of follow-up resources and aftercare support following a mental health crisis. Meanwhile, providers expressed frustration over patients not following through with scheduled or referred aftercare services. Another significant barrier is the availability of providers. Patients are often referred to providers with limited capacity or those who do not accept their insurance, making it difficult to access necessary care. Both community members and behavioral healthcare providers emphasized that being referred to providers who cannot accommodate patients is not only frustrating but also detrimental to their recovery and overall well-being.

- "At Mosaic Community Services (within Sheppard Pratt) a lot of people come in wanting to get connected because they had a good experience inpatient and want to continue with outpatient care, and we can't get them an appointment. I had a patient tell me that there was an outpatient Sheppard Pratt Center near where they lived. In practice, I don't know if that's going to be a thing."
- "Sometimes it can be hard to get families to buy into the aftercare plan. Either the patient refuses to go and we can't make them go, or the families will schedule an appointment with us, and they just don't show up - they don't follow through. We don't typically communicate with them after discharge, but sometimes they contact us for

[2] SAMHSA, The Institute of Medicine's Continuum of Care. https://www.samhsa.gov/resource/sptac/institute-medicines-continuum-care

medications, but we don't do that. We set up an appointment for them with a psych provider, but they didn't show up. It happens once or twice a month."

- "After I was stabilized, I was released from the hospital to the street, which meant I was homeless for a couple of years. When somebody is in crisis, stabilized, and released to the street, they don't have the means to find another therapist, and they don't know what programs are out there. Sometimes they run into someone who can help them pro bono, but they stay lost for a while."
- "People are referred to providers that have no ability to see you. People just give up trying eventually if they've called ten places. This is more stressful and just adds to their mental health problems."
- "I would think that they (providers) would ensure that people with serious mental illnesses are being followed up on. For instance, when people are given a referral after being released from the hospital, there's no follow-up at all. There needs to be a better discharge plan and more follow-up. They make recommendations, we call, the place says no, and now we've got someone who is in a serious condition with no medication and no plan moving forward."
- "There is a poor compliance rate that people who come from the hospital to outpatient care. Getting the patient to engage in follow-up care from the hospital referral system is difficult."
- "In the thought disorders unit, I do notice that when patients are involuntarily here, the state of Maryland emphasizes the dangerousness of the person over mental health status. If they go to a hearing and the judge deems them not dangerous, it's a rush for us to discharge. Wait times for residential housing placement are long, but if the patient wants to leave, then we will get the same patient six months later."
- "Sheppard Pratt has never invested in outpatient services. They've never put money into their outpatient programs, so it's nearly impossible to get outpatient therapists through Sheppard Pratt."
- "Sheppard Pratt used to have outpatient mental health centers throughout the state, but they ended up making it so administration-heavy, the funds they were pulling in from treatment weren't enough, so they closed them down."

Availability and Access of Behavioral Health Services for Youth

Community stakeholders shared that since the COVID-19 pandemic, children have needed a lot more support, and many children and young adults are feeling "pressured and despair." According to the 2022 Maryland Youth Risk Behavior Survey, the percentage of students who self-report feeling sad or hopeless almost every day for two weeks or more during the past year increased between 2018 and 2022 in Prince George's County, Howard County, Baltimore County, Baltimore City, and the state of Maryland. Additionally, in 2022, over 14% of high school students in all counties in the service area seriously considered suicide, and over 10% of high school students created a plan to commit suicide.

- "With the pandemic (the class of 2019/2022), kids have been untethered and have needed a lot of support. Parents are using their best skills, and these are educated individuals. Parents are racing against the clock with young people."
- "There is a lot of talk about the difficulty of discharging teens from hospitals to community residential opportunities. The kid piece becomes more complicated when there's aggression involved, and we've seen this across the nation. We saw acuity increase post-COVID, so there are no more people needing care, but the level of acuity is becoming higher."
- "A lot of the patients are coming in not believing in the standard therapy that we offer, so they are not compliant. A lot of young adults are just in denial that they need this kind of treatment, so we see a lot of re-admissions for the exact same reasons. It's just been a steady theme throughout the past couple of years."
- "Maryland lowered the age of consent for seeking behavioral health services a few years ago from age 16 to age 12. This means just talking to a counselor, there was a lot of pushback from conservative members, and it was a very ugly floor fight. Children are their people even when they are 12 and don't have to tell their parents."
- "We need more youth-serving providers and beds, as well as open services. We don't have a lot of resources available, but there are some. There are various programs we have across the lifespan, but there are pockets of people we can do a better job with."
- "There are no beds for children in Anne Arundel County, so that's an issue. You have places you can walk in to get help, but you need to go out of the county to get help. The providers that are accessible want appointments for children at 10 a.m. on Tuesday, but the child is in school. The number of youth inpatient beds in the state is abysmal."

- “Youth are held in emergency rooms for extreme amounts of time. Trying to find psychiatrists or anyone with credentials to see youth is really hard. Long waitlists, not enough youth-focused resources. Shortage of child psychiatrists, and stabilization beds for children.”
- “Howard County just expanded a physical wing for adults and maybe children, and Sheppard Pratt opened an Elkridge campus, and there’s less of a bed shortage because of that but I think in general it helped. Children would be waiting for days for a residential placement and an assessment.”
- “Kids in the transitional age group (age 18-25) are a hard group to serve. They’re less likely to want to answer services, and they sort of aren’t interested until they’re older.”
- “The legalization of recreational marijuana is a whole new ball game. We legalized recreational marijuana, and now I feel like I smell it everywhere. Figuring out what to do with that will be hard. Vaping is a huge issue, and it's so unregulated and addictive.”
- “There isn’t a lot for adolescents between 12 and 20. It has been very hard for my 18-year-old to find a place that fits in. She's been to Sheppard Pratt three times, and it seems that there are not enough beds when these people are in crisis.”

Stakeholders also shared that although school-based services do exist, there is a need for additional services.

- “In schools in Howard County, every school has a child psychologist in its elementary middle, and high schools, it helped a lot of kids who don’t have access outside of school but still more is needed the schools are doing as much as they do with the staff that they have – were lucky here in Howard County. They are spread thin throughout. Howard County has had a challenge around overcapacity in schools; even if there are providers, they aren’t available.”
- “We need more school-based services. It's inconsistent among schools. There are several providers for the school system – Sheppard Pratt being among them. So some schools get these services and others don’t. If schools do have a counselor or psychiatrist, it's shared between multiple locations, so it's not that effective.”

Availability and Access to Behavioral Health Services for Older Adults

Providers shared that there has been a noticeable increase in older adults seeking behavioral health care, and community Stakeholders cited unique challenges in providing behavioral healthcare services to the older adult population within communities. Providers specifically cited challenges finding treatment for older adults with mobility issues, exacerbated by the challenges that come with Medicaid.

- "For older people, accompanying physical age is hard. Residential programs that serve these people don't provide both psychiatric care and mobility assistance. They deal with so much loss of autonomy and the loss of a spouse. We need to keep seniors connected to the community and keep them useful."
- "With older adults, they are using substances at an age where the type of use is changing a lot. People are going to different locations to use, and to older adults, the thought of open use spaces was not talked about, so they use in isolated areas, so the overdose rate is higher for them."
- "For geriatrics, we don't have enough Medicare providers, a lot of outpatient providers won't take Medicare because of the rates. There is supposed to be a geriatric RRP that doesn't take patients with ambulation issues, which is ridiculous – just within Sheppard Pratt itself, there are issues servicing our patients."
- "Our day hospitals here don't want to take geriatric patients because they are hard of hearing. I have referred patients to day hospitals that have been kicked out because providers need to speak louder or have patients sit closer, and they aren't willing to do that. We used to have a geriatric day hospital, which closed years ago because we weren't getting enough referrals, but they didn't put enough effort into it."
- "The van that they encourage us to use at Sheppard Pratt doesn't take our geriatric patients because they need help moving in and out of the vehicle. They don't want us to use their van services; the services exist."
- "We have noticed in the last year we've had a lot of incoming admissions from nursing homes, and it would be for things that were very quickly resolved here, like being back on medications to decrease aggression, and we learn the nursing home just discharged them. There are programs with placements with older adults, especially if they have health needs (bathing, meal prep), that the community support waiver has a wait list for a year, so all we have for a placement for them is social security."

- “We have people coming in in their late 60s who have $30 in social security per month and are wheelchair bound, and you can't find a placement for them. There’s been an influx of nursing home referrals, and they don’t accept them back. Sometimes aggression is understandable, but then there’s just no communication, there’s a lack of information we need. We've had older adults stay with us for three to six months.”
- “Especially on the thought disorders unit at Sheppard, we are becoming a geriatric program.”
- “Older adults with dementia are increasing. When the emergency departments get backed up, it’s geriatric and kids - those are the populations that back up the emergency department. There are areas where there are not enough services and resources.”

Availability and Access of Behavioral Health Services for Neurodivergent People

According to community stakeholders, there are several challenges in accessing care for individuals with Autism Spectrum Disorder (ASD) and Intellectual and Developmental Disabilities (IDD), based on input from community stakeholders and providers. Individuals with IDD often struggle to obtain high-quality behavioral health services, further compounding the challenges they face in receiving appropriate care. Stakeholders shared that there is a provider shortage and workforce training gap, as there is a lack of healthcare providers who feel confident or adequately trained to work with individuals with ASD and IDD, particularly those with limited communication and cognitive delays. There are greater barriers for non-verbal individuals as community stakeholders report that non-verbal individuals with ASD face even more difficulties accessing care than those who can communicate verbally. While Sheppard Pratt’s Center for Autism provides services, stakeholders feel that the available resources are insufficient to meet the needs of the community. Individuals with ASD are frequently kept in emergency rooms for extended periods while awaiting inpatient care, sometimes for months. There are also severe challenges with Maryland’s Developmental Disabilities Administration (DDA), as stakeholders shared that the complexity of the waiver system and prolonged approval processes create significant barriers to care. Providers describe interactions with the DDA as frustrating, sometimes requiring months to years of persistent effort.

- “Services for people with autism spectrum disorder get harder as people age. When people age out of services, it's harder to find something comparable for adults.”
- “I have seen an increase in IDD/ASD, I can see that there’s not enough education where it can come off as a thought disorder. It’s unaddressed ASD without proper intervention. There are no behavioral health issues and no medication changes. It feels like group homes just want a break.”
- “If you have autism and you have suicidal ideations, the autism is what the therapist hears, and they don’t know how to treat autism, so they don’t treat the suicidal ideations.”
- “When you’re on an emergency room bed waiting for an inpatient one to open up, any person who doesn’t have autism will get the bed and that’s illegal - no hospital system will admit to that.”
- “Our most underserved population with ASD in the community is those who are non-verbal. There are more challenges when entering an emergency room setting or any setting when there are communication challenges.”
- “Autism is a spectrum, and we see a lot of discrimination with people who are verbal and independent but still have challenges. Those are the people we see walking into a crisis enter saying that they feel suicidal, and those are the ones who are turned away. These are people who can have a job but have other challenges exacerbated by mental health issues or social anxiety, and that’s the population that we see unable to access appropriate support.”
- “I advise families not to disclose the autism diagnosis and focus on the mental health stuff because otherwise they’ll be turned away because of the autism, but you can’t do that with individuals who are nonverbal.”
- “Applied behavior analysis is the most frequently asked type of service, which is a type of therapy many parents have utilized, which is extremely limited and not usually covered by insurance.”
- “Applied behavior analysis in the community through regular insurance stops at 18, some stop at 21, so the parents are sent home with nothing by psych follow-up, so managing day to day is insurmountable, especially if parents need to work. Even when DDA gets involved, there is a funding problem and a lack of resources, such as available providers, to help with in-home behavioral challenges. Clients do better in residential settings because they get what they need, but families want to keep them home.”

- “People with ASD really do not have any issues with substance use disorder treatment because they are nonverbal and very low functioning. I have some resources, but they are few and far between.”
- “Luckily, we have a clinic here at Sheppard, a lot of our providers have a lot of experience, but it can be very difficult at times, depending on where the clients live, to find treatment. We get a lot of patients from southern and western Maryland, where there are very few resources, let alone for patients with special needs.”
- “It’s hard to find outpatient providers with experience with people with IDD. When providers find out what some of their challenges are, like aggression, what we find now is a lot of providers want to treat them virtually because they don’t want them in the offices. Some of our providers will do both, but some patients can't even tolerate sitting in front of a screen.”
- “If we have families that are taking care of patients with challenging behaviors, not connected with Maryland’s Developmental Disabilities Administration (DDA), there’s nothing to help their families. They are assaulting their families, and this is baseline behavior, and it takes a very long time to get connected to the DDA.”
- “Patients are frequently abandoned on my unit. We identify a provider, but patients will sit here six months to a year, even when we have a place for them to go. We get turned into respite care and residential care. There needs to be respite resource providers so there is somewhere to go to wait. I’ve had patients here for two years, DDA considers them safe, so families just leave them here.”
- “No one should live in a hospital. For patients who are very low functioning and low verbal, you don’t get outside often - there is no quality of life living in a hospital unit. The IDD section is a lot smaller, and this population likes to pace, and they need space. They start to decompensate because of the environment they are living in it’s a broken system. Sometimes they have funding for emergency respite care, but that seems very infrequent, and it’s only for 30 days.”

Awareness of Behavioral Health Services

Providers of behavioral healthcare services shared that there needs to be more public health campaigns around behavioral healthcare services. For example, the 988 Lifeline, which helps people access mental health services, is often associated with crises only, not a way to discover local behavioral healthcare resources. Community stakeholders expressed the need for additional community outreach around local behavioral healthcare services.

- "There's no centralized clearinghouse where you can get info about what's out there. A lot of people call NAMI, and we know a lot of resources, but we don't know everything. We need an info clearinghouse more than just going on the SAMHSA Locator online and a lot of people don't even know about that."
- "We have a lot of good resources, but typically folks aren't aware of what's available or how to access them or whether they're eligible for a program, so that contributes to the dilemma, and that's been a perennial issue for decades."
- "For those who have experience in the behavioral health system, it's easier to access services but if you've never interacted with the system, it's hard to know where to start which is why we see so much activity in the emergency department for behavioral health and in the criminal justice system."
- "988 has been a great improvement and the campaign has improved access. I don't think people understand they can call that number to get resources, they think it's a crisis line."
- "The marketing strategy doesn't work in the nonprofit world because the budget doesn't exist for it. For example, nobody pays attention to services for seniors, which could be plastered everywhere, until mom breaks a hip but it's not on your radar if you don't need it. People aren't paying attention to things they don't need until they need them."
- "We have a robust network of providers in Anne Arundel County and most people don't understand how many because when you need something, and you don't know where to turn you think there's nothing. We have way more services than what most people are aware of."
- "There is not a lot of outreach or education for people with mental health conditions as far as what to do, or how to maintain recovery, what recovery is, etc."
- "There needs to be a clearinghouse of information and an active campaign of education, about what mental health is, what mental illness is, that it's recoverable, it's nothing to

be afraid of, and people with serious mental illnesses are not to be feared. There needs to be a big push for education, and I think public awareness will come with that.

- "Community education should be a number one priority. Community education is a low-hanging fruit. It's not very expensive, just requires outreach."

Behavioral Healthcare Workforce

Behavioral healthcare providers who participated in the qualitative data collection process shared challenges working in the field, including the increasing acuity of patients and current reimbursement rates. The provider shortage plays directly into the heightened acuity of patients, as, according to stakeholders, people frequently must wait to see a provider for a lengthy amount of time, further exacerbating behavioral health issues. As one provider shared, people may feel like they are in crisis, but according to the behavioral health system, they may not be.

- "The retention rate is an issue, among the social workers who have been here for over ten years, but outside of that, the general time frame is about two years. They are trying to improve that with pay, which has been helpful."
- "I do see with inpatient care that there's a shortage of support staff who are front lines. Sometimes you do have to go hands-on on and there's a shortage of that kind of staffing. They expect the mental health worker to do that, and there are not enough mental health workers in the unit. As an LWCS, I try not to go hands-on, but sometimes I need to assist because there are not enough mental health workers and nurses."
- "If they want to increase retention rates, they really need to increase the pay for entry-level, not only for LCSWs but for mental health workers. They don't find out they are required to go hands-on until they are in the building."
- "For holidays, we have to use PTO. There are days when I could be remote and be effective in case management."
- "If you're taking medication, you need a psychiatrist to prescribe, a psychiatrist doesn't do talk therapy with you, so you need to see a psychologist or counselor – you just can't get them both at the same place often, but the best practice is med management and mental health counseling. People will always pick the meds, but you need the real hard work, which is the deep dive into mental health counseling."
- "A lot of times we also hear in the support groups that being able to make an appointment with someone is so difficult. It can be very hard because everyone's so booked up, there's just a crisis out there. Now with everything happening, there will be

even more crises. While people are waiting to get a therapist, they have nothing else to go to except support groups through NAMI."

- "Assertive community treatment already has a waitlist because of the shortage of providers. Keeping staff on those teams is difficult, and half of the positions are licensed positions that are hard to fill."
- "We are currently struggling to find folks who will work in the field. There is a critical shortage of LCSWs, paraprofessionals, psychiatrists, and nurses. Even before the pandemic, there was a need, and since the pandemic, it's been very difficult for provider programs to find staff. People don't want to enter the field and that has an impact on our ability to deliver services because providers are struggling to find staff to meet the need. I don't think it's getting better."
- "Fewer people are going into the field based on what we know. This makes it harder for people working in the field because they have to do extra shifts, cover more cases, and that leads to burnout. People are leaving the field. People who are receiving treatment are harder to treat than ever before."
- "There are certain types of programs that we need more of and resources that can meet the needs of people that we don't currently have in the system, like a crisis response center. We have some capacity to treat people with SUD in a residential program, but we could increase capacity. We have a limited number of services that help people, like if you need to go to the hospital for some time, we have limited availability of step-down programs if you're not ready to go home or are still working on things. We have some crisis beds but there isn't enough of that resource. I don't know if our capacity for certain services has matched the growth of the need."
- "We have peer support specialists, which is a plus, but there's a shortage of them. We don't have as many as we need; they are hard to come by. They are looking at hopefully bringing them in under a lower threshold, like getting certified within two years of employment, compared to having certification coming in."
- "Providers are going to be very hesitant to engage in new things right now because of funding. You can't start something and not finish it because that ruins trust."
- "There's a problem with obtaining psychiatrists and there's a long wait time to be seen by psychiatrists, and during that time, people go into crisis, and that's when they end up calling us."

Community Survey

The purpose of the community survey was to enable a greater share of people living and working in Sheppard Pratt's service area to share their perspectives on access to behavioral health care and the greatest needs affecting their community.

Methodology

The community survey was made available online and via print copies in English and Spanish. The questionnaire included closed-ended, need-specific questions, open-ended questions for community members to provide input, and demographic questions. Invitations to participate were distributed through Sheppard Pratt's social media channels.

There were **80** valid survey responses included in this analysis, the majority of which (98.8%; n = 79) were to the English language version of the survey, and one (1.3%) was to the Spanish language version of the survey.

Response validity was adjusted based on the respondent's completion of one or more non-demographic survey questions. Special care was exercised to minimize the amount of non-sampling error through the assessment of design effects (e.g., question order and wording). The survey was designed to maximize accessibility in evaluating respondents' insights regarding an array of potential community needs.

While the survey served as a practical tool for capturing insights of individuals in Sheppard Pratt's service area, this was not a random sample. Findings should not be interpreted as representative of the full population.

Additionally, sample sizes of demographic subpopulations were not large enough to consider samples to be representative of the broader populations from which responses were received. Differences in responses have not been tested for statistical significance as part of this assessment.

See Appendix D for the survey instrument.

Respondent Demographics

The most frequently reported county of residence was Baltimore County (32.5%), followed by Howard County (21.3%) and Baltimore City (16.3%).

EXHIBIT 3: SURVEY RESPONDENT RESIDENCE

COUNTIES OF RESIDENCE	PERCENT OF RESPONDENTS
Baltimore County	32.5%
Howard County	21.3%
Baltimore City	16.3%
Anne Arundel County	8.8%
Montgomery County	5.0%
Prince George's County	0.0%
Other	16.3%

Community roles of respondents included **persons with lived experience** (31.6%), **Sheppard Pratt leadership or staff** (29.1%), and **general community members** (24.1%). A variety of other roles and professions were also represented by respondents.

EXHIBIT 4: SURVEY RESPONDENT ROLE IN COMMUNITY

ROLES IN COMMUNITY	PERCENT OF RESPONDENTS
Person with Lived Experience	31.6%
Sheppard Pratt Leadership or Staff	29.1%
General Community Member	24.1%
Non-profit Organization	19.0%
Parent / Family Member of Person(s) in Services	17.7%
Other	16.5%
Licensed Community Mental Health Provider	12.7%
Educator	8.9%
Local/County Government	6.3%
Case Manager	2.5%
State Government Official	1.3%

Almost all respondents (93.8%) had a degree in higher education, including technical or trade schools, associate or bachelor's degrees, and graduate or professional degrees. Notably, no respondents (0.0%) had less than a high school degree or an equivalent degree (e.g., GED).

The median household income reported by respondents falls in the $100,000 to $149,999 range, which is like the median household income estimated for the state of Maryland ($101,652).[3]

EXHIBIT 5: SURVEY RESPONDENT EDUCATION LEVEL AND HOUSEHOLD INCOME

DEMOGRAPHIC VARIABLE	PERCENT OF RESPONDENTS
EDUCATION (HIGHEST LEVEL ATTAINED)	
Less than high school or equivalent	0.0%
High school diploma or equivalent	4.2%
Some college	2.1%
Technical or Trade schools	2.1%
Associate degree	6.3%
Bachelor's degree	20.8%
Graduate or professional degree	64.6%
I prefer not to say	0.0%
HOUSEHOLD INCOME	
Less than $10,000	0.0%
$10,000 to $14,999	4.2%
$15,000 to $24,999	2.1%
$25,000 to $34,999	4.2%
$35,000 to $49,999	8.3%
$50,000 to 74,999	6.3%
$75,000 to $99,999	8.3%
$100,000 to $149,000	27.1%
$150,000 to $199,999	8.3%
$200,000 or more	18.8%
I prefer not to answer	12.5%

[3] U.S. Census Bureau American Community Survey Five-year Estimates, 2019-2023.

Four in five respondents (81.3%) identified as female. A small portion of respondents (2.1%) identified as being a member of the LGBTQIA+ community. The majority of respondents (93.4%) identify as White or Caucasian. With regards to age, two in five respondents (42.2%) clustered in the 45 to 64 age group.

EXHIBIT 6: SURVEY RESPONDENT GENDER IDENTITY AND LGBTQIA+ STATUS

DEMOGRAPHIC VARIABLE	PERCENT OF RESPONDENTS
GENDER	
Female	81.3%
Male	16.7%
Non-Binary	2.1%
I prefer not to say	0.0%
LGBTQIA+ STATUS	
Member of LGBTQIA+ community	2.1%
Not a member of LGBTQIA+ community	95.7%
I prefer not to say	2.1%

All respondents identified as White/Caucasian, Black/African American, or both, with most respondents (89.4%) identifying as White or Caucasian. With regards to age, one in two respondents (50.0%) clustered in the 45 to 64 middle-aged group.

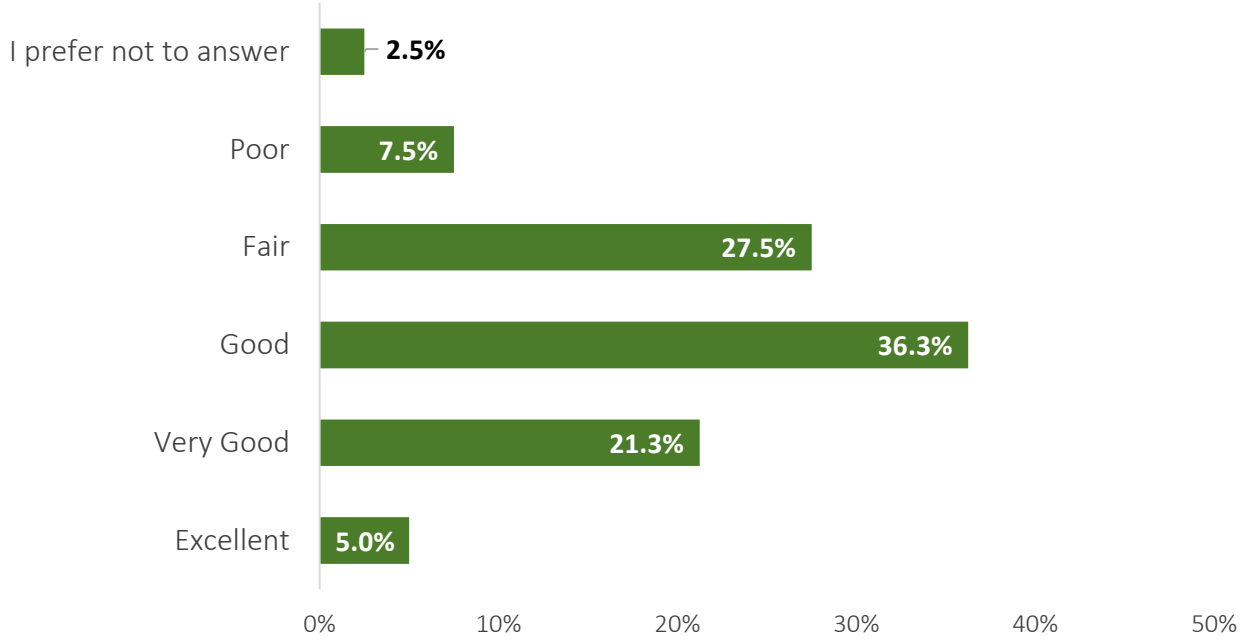
EXHIBIT 7: SURVEY RESPONDENT DEMOGRAPHICS

DEMOGRAPHIC VARIABLE	PERCENT OF RESPONDENTS
RACE AND/OR ETHNICITY	
White or Caucasian	89.4%
Black or African American	14.9%
I prefer not to answer	0.0%
AGE	
Under 18	0.0%
18-24	0.0%
25-34	10.4%
35-44	14.6%
45-54	33.3%
55-64	16.7%
65 and Over	22.9%
I prefer not to answer	2.1%

Findings

Respondents' self-reported mental health status varied, with the most frequent response (36.3%) rating their mental health status as **good**. Only 5.0% of respondents rated their mental health status as **excellent** (the highest possible rating); a slightly larger portion of respondents (7.5%) rated their mental health status as **poor** (the lowest possible rating).

EXHIBIT 8: RESPONDENT SELF-REPORTED MENTAL HEALTH STATUS

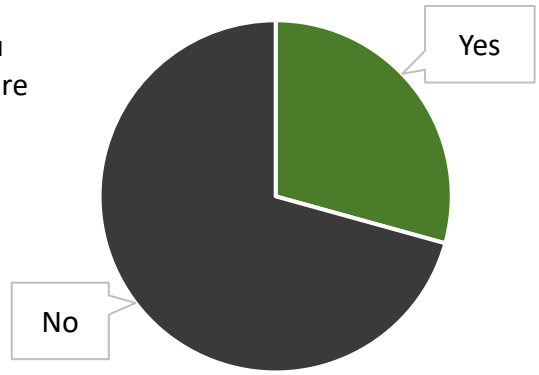


Access to Behavioral Health Care

Almost one in three respondents (29.3%) reported needing, but being unable to access, behavioral health care in the past year.

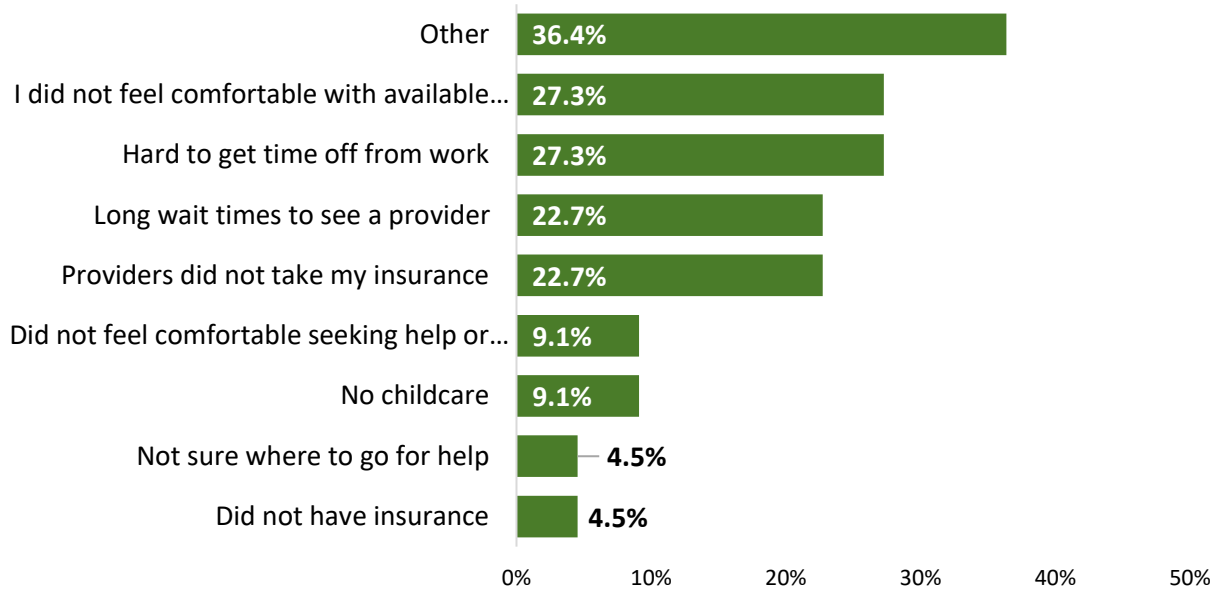
EXHIBIT 9: RESPONDENTS EXPERIENCING DIFFICULTIES GETTING NEEDED BEHAVIORAL HEALTH CARE

Was there a time in the **past 12 months** when you needed mental health care but did NOT get the care you needed?



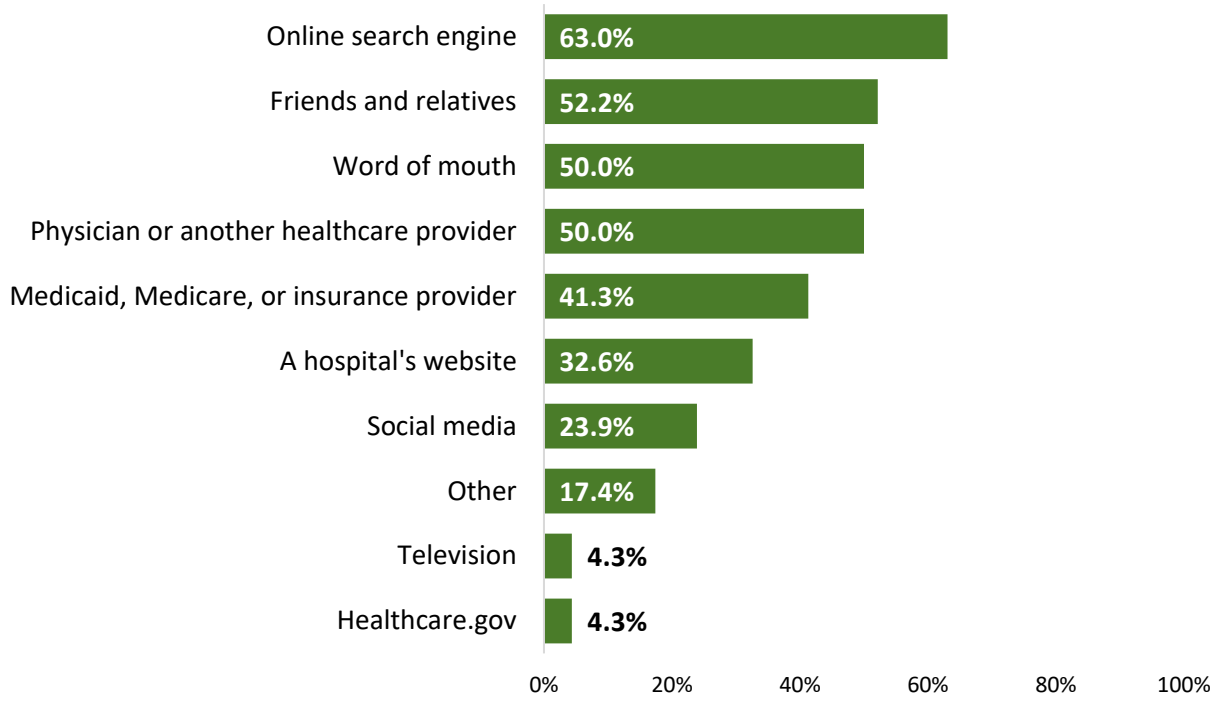
Top barriers to accessing behavioral health care included: **lack of comfort with providers** (27.3%), **difficulty taking time off from work** (27.3%), **long wait times for providers** (22.7%), and **insurance not accepted** (22.7%). In the open-ended Other answer option, respondents noted frustrations with processes including not wanting to start over with a new therapist or only being offered virtual appointments.

EXHIBIT 10: BARRIERS TO ACCESSING BEHAVIORAL HEALTH CARE



Respondents most frequently reported using **online search engines** (63.0%) to find out about behavioral health care, followed by learning from **friends and relatives** (52.2%). One in two respondents reported finding out from **healthcare providers** (50.0%) and/or via **word of mouth** (50.0%).

EXHIBIT 11: SOURCES FOR FINDING OUT ABOUT BEHAVIORAL HEALTH CARE



Access to Child/Adolescent Behavioral Health Care

The majority of respondents (71.8%) reported having no children under the age of 18 currently living at home, with the minority of respondents (28.2%) reported having one or more children.

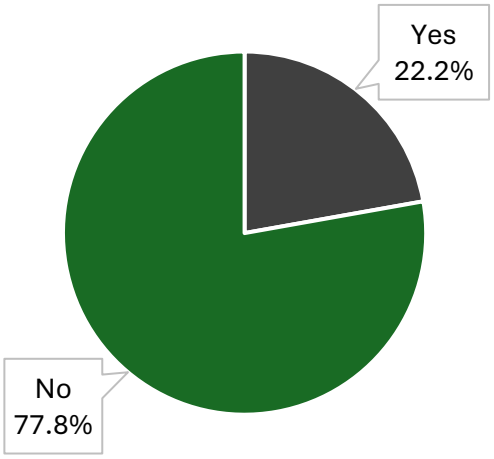
EXHIBIT 12: SURVEY RESPONDENT DEMOGRAPHICS

DEMOGRAPHIC VARIABLE	PERCENT OF RESPONDENTS
None	71.8%
1 child	14.1%
2 children	11.3%
3 children	1.4%
4 children	0.0%
5 children	1.4%
6 or more children	0.0%

Among the respondents who reported having one or more children under age 18 currently living at home, one in five respondents (22.2%) reported needing, but being unable to access, behavioral health care for their child(ren) in the past year.

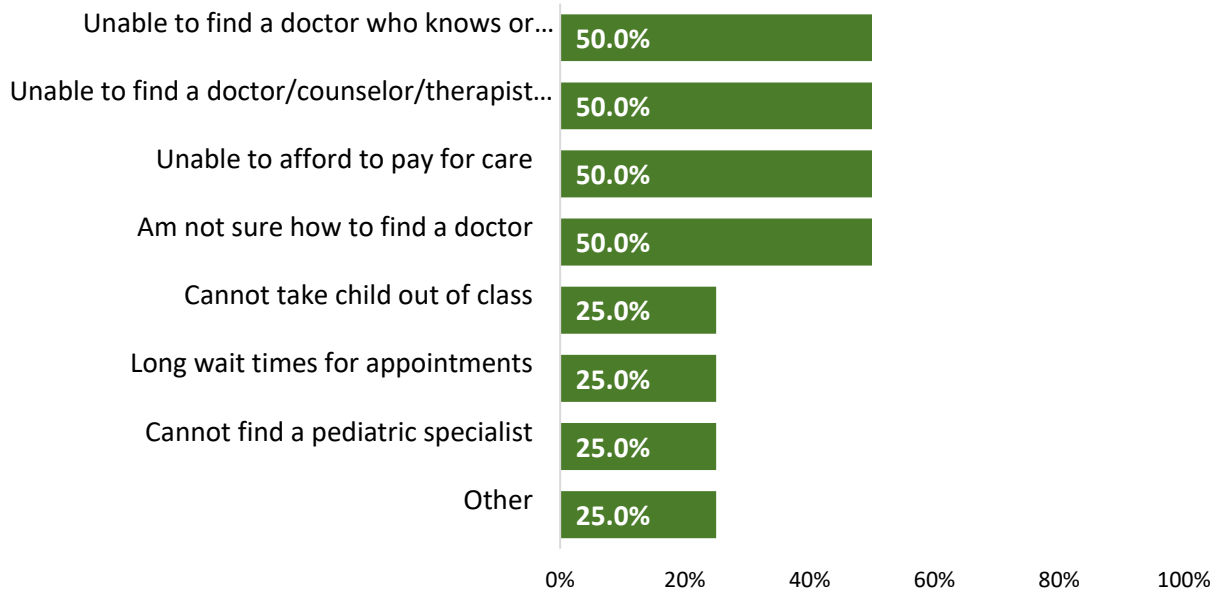
EXHIBIT 13: RESPONDENTS EXPERIENCING DIFFICULTIES GETTING NEEDED BEHAVIORAL HEALTH CARE FOR THEIR CHILDREN

Was there a time in the **past 12 months** when children in your home needed mental and/or behavioral health care but did NOT get the care they needed?



Top barriers specific to accessing child/youth behavioral health care included: **uncertainty about how to find a doctor** (50.0%), **unaffordability of care** (50.0%), **insurance not accepted** (50.0%), and **difficulty finding providers who know or understand** (50.0%). Answers to the open-ended. Other answer options included differences in the parents' opinion regarding whether the child needed treatment.

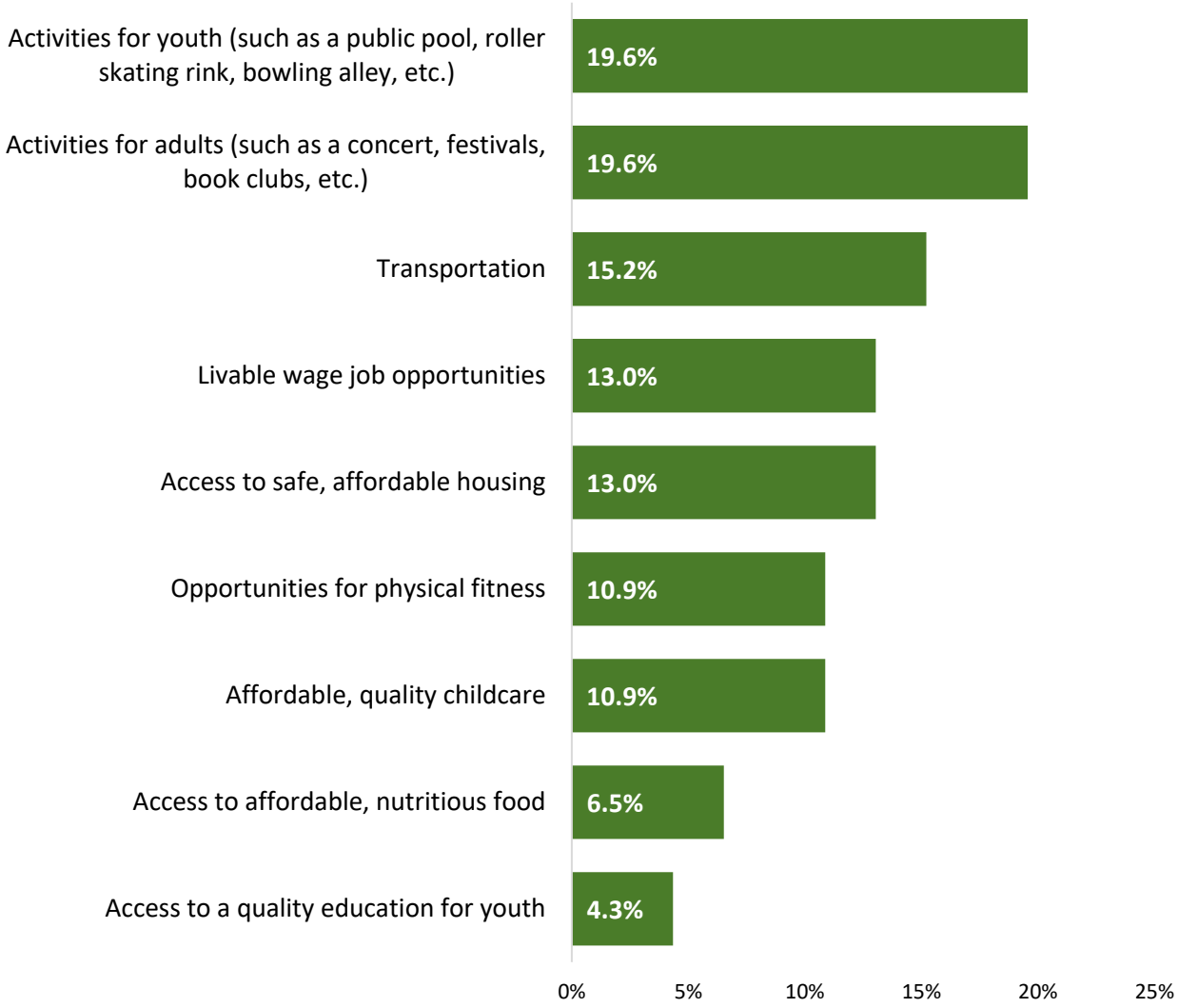
EXHIBIT 14: BARRIERS TO ACCESSING CHILD/ADOLESCENT BEHAVIORAL HEALTH CARE



Basic Needs and Community Resources

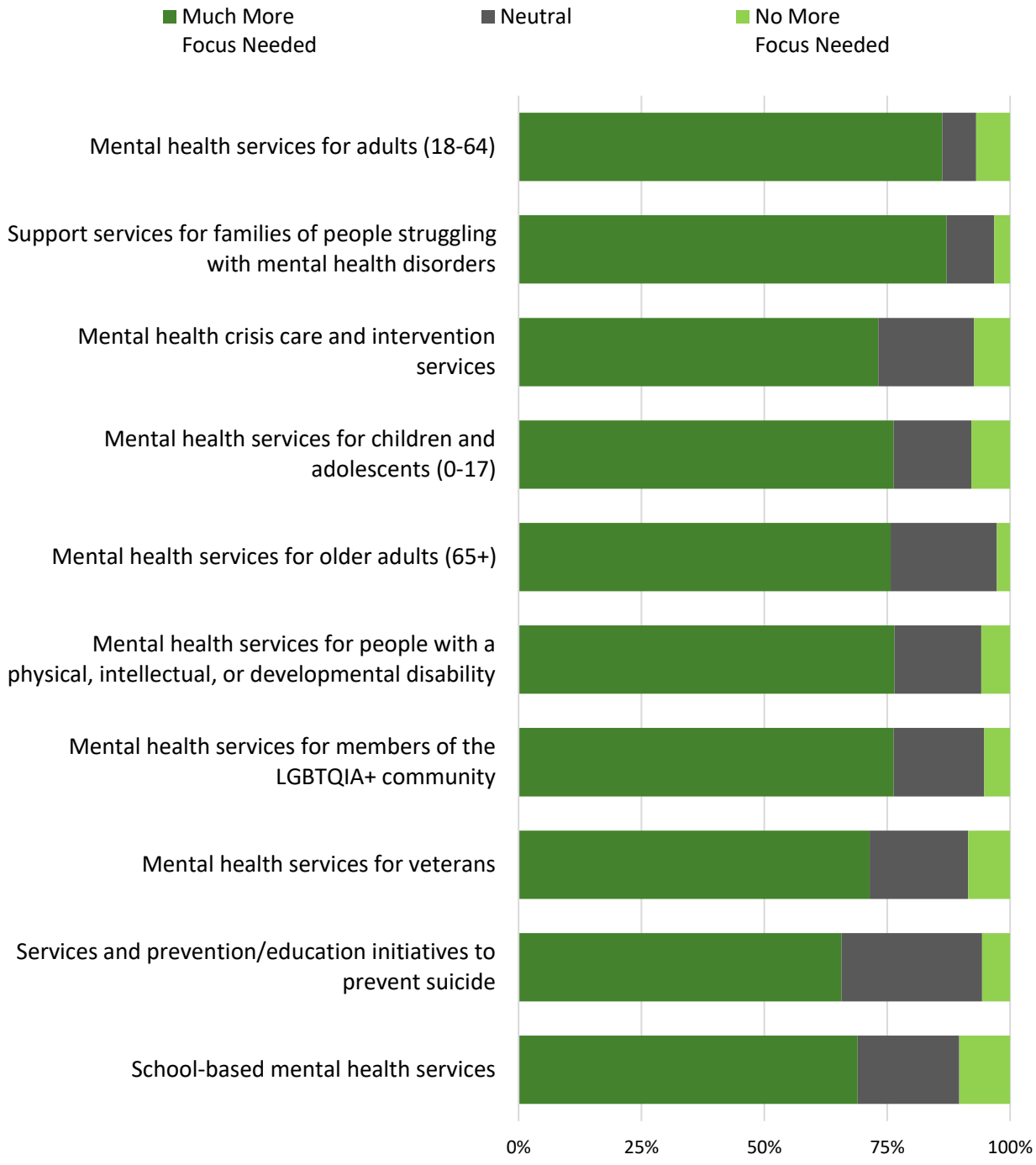
When asked which needs respondents struggled with in the past 12 months, **activities** for **youth** (19.6%) and **adults** (19.6%) rose to the top.

EXHIBIT 15: IDENTIFIED CURRENT NEEDS OF SURVEY RESPONDENTS



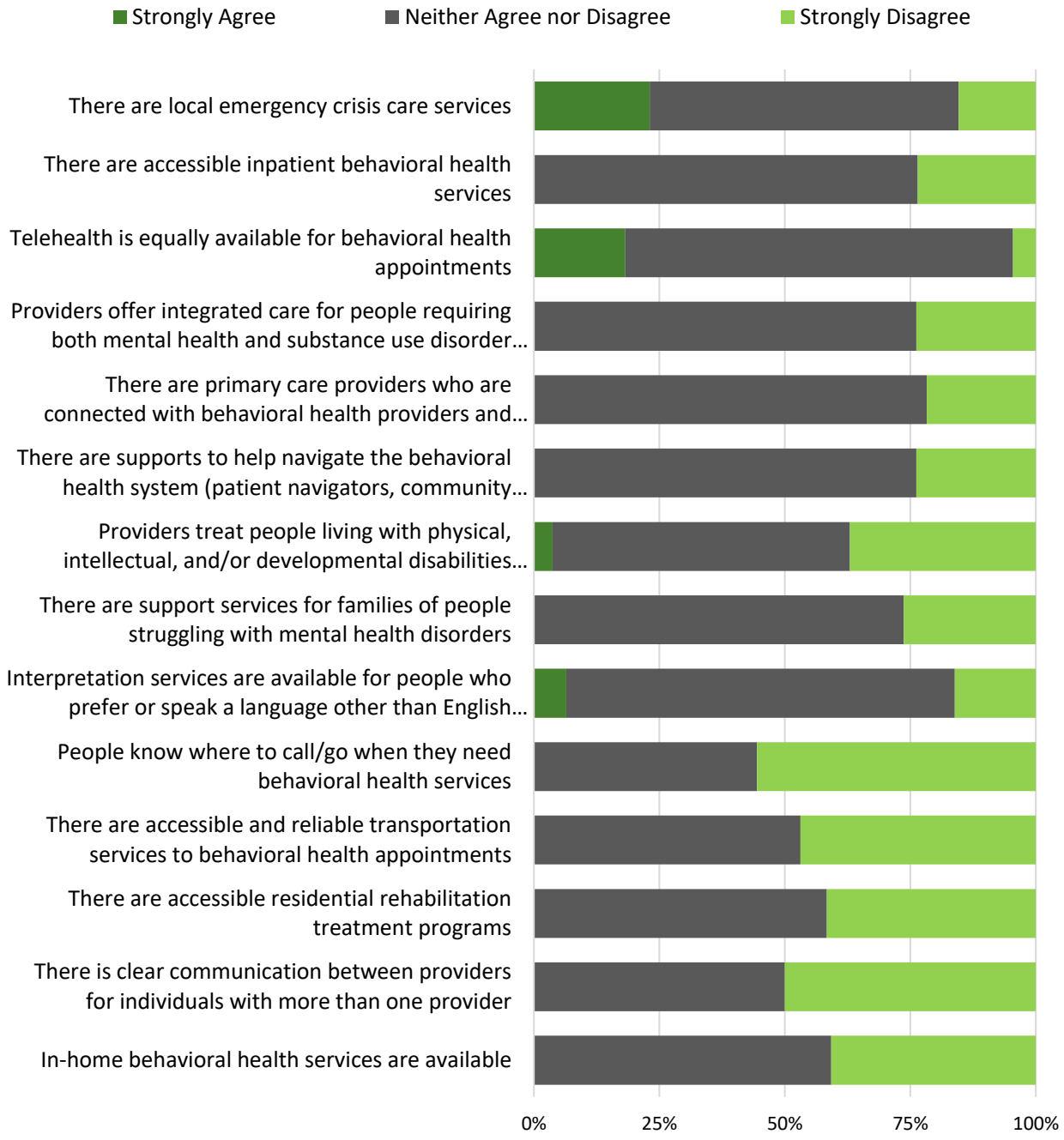
Respondents identified **mental health services for adults 18-64 years old** (85.7%) as the top mental health-related challenge requiring either much more focus or more focus in the community. **Support services for families** (79.2%) were also identified as a top mental health-related challenge requiring either much more focus or more focus in the community.

EXHIBIT 16: NEED FOR MORE FOCUS ON MENTAL HEALTH-RELATED CHALLENGES



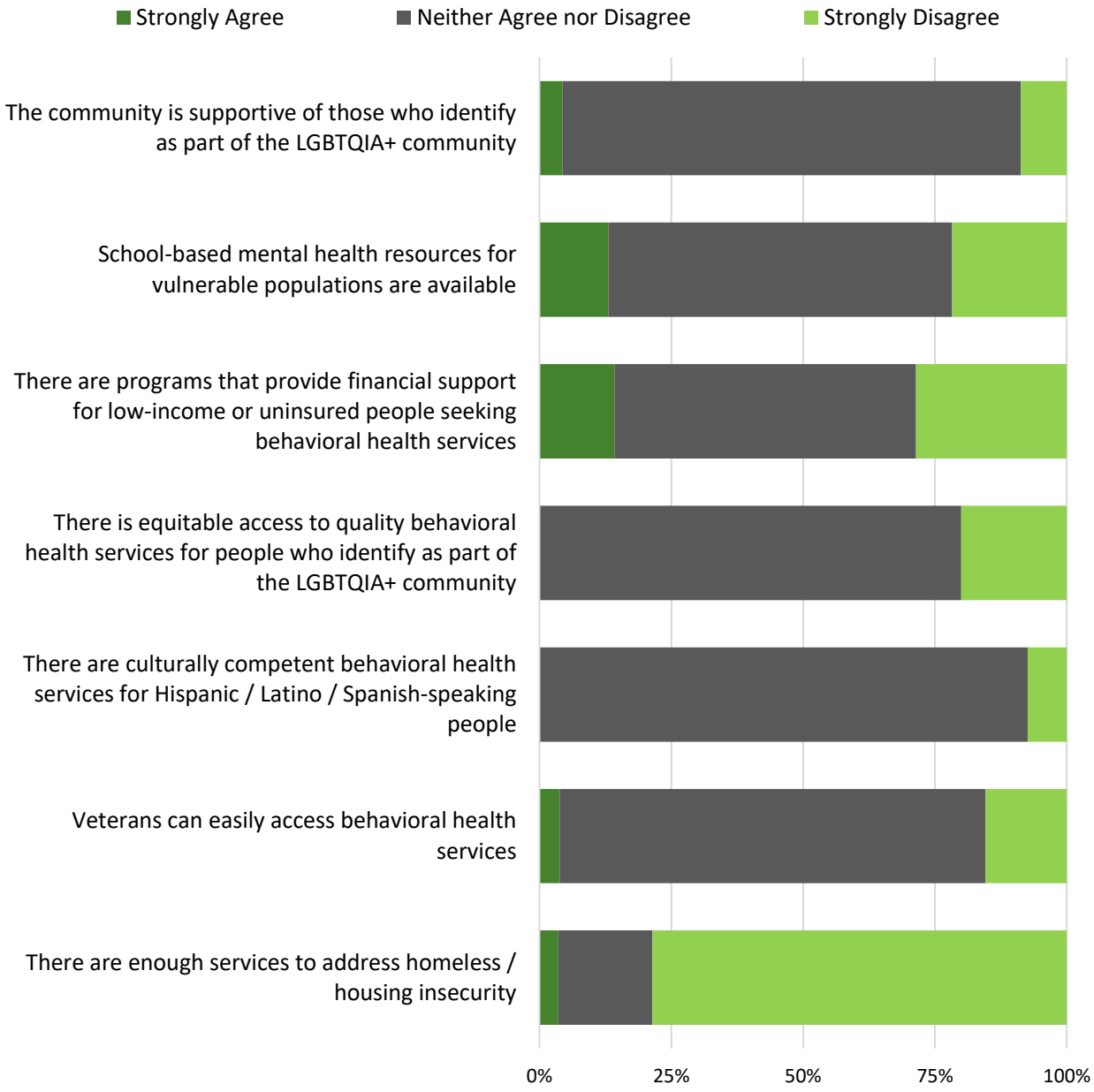
Overall, a notably smaller portion of respondents either agreed or strongly agreed that there is adequate access to in-home behavioral health care services (6.4%), providers clearly communicate with one another (6.4%), and there are readily available interpretation services (6.8%). These results suggest that access to **in-home behavioral health care services, improved communication between providers**, and **readily available interpretation services** are areas for improvement within the community.

EXHIBIT 17: RESPONDENT PERCEPTIONS OF COMMUNITY RESOURCE AVAILABILITY



Respondents most frequently agreed or strongly agreed that the community **supports members of the LGBTQIA+ community** (37.0%) and **provides school-based mental health for vulnerable populations** (23.9%). None of the resources for vulnerable populations received a majority of respondents agreeing or strongly agreeing. This suggests a need for improvements in all vulnerable population services mentioned, especially for services to address homelessness/housing instability, and veteran-specific behavioral health services received the least amount.

EXHIBIT 18: RESPONDENT PERCEPTIONS OF COMMUNITY RESOURCES FOR VULNERABLE POPULATIONS



Environmental Analysis

Secondary data provides an essential framework for better understanding the fabric of the community. This analysis highlights sociodemographic factors, social determinants of health, behavioral health risk factors, and other key indicators to guide the development of effective strategies further to meet evolving needs. The following data were primarily gathered from the United States Census Bureau American Community Survey Five-year Estimates, the Behavioral Risk Factor Surveillance System, the Maryland Department of Health, among others.

For additional, more in-depth data, please see the data tables in Appendix A. The following pages show key findings and high-level summary data.

American Community Survey: Five-year Estimates

There is an intentional purpose in using five-year data estimates compared to one-year data estimates.

Five-year estimates are derived from data samples gathered over several subsequent years and provide a more accurate estimate of measures, especially among numerically smaller high-risk populations or subgroups, compared to one-year estimates, which are based on more limited samples with greater variance.

Source: *https://www.census.gov/data/developers/data-sets/acs-5year.html*

The Social Vulnerability Index

The Social Vulnerability Index (SVI), developed by the CDC, identifies vulnerable populations using population data. It helps to improve well-being and mobility relative to county and state benchmarks and guides disaster preparedness and emergency response. During public health crises like pandemics, SVI data supports targeted interventions—such as multilingual messaging, financial aid, and mobile units for high-risk groups—helping address specific community needs, build resilience, and reduce health disparities.[4]

The SVI measures are grouped into four major categories:

SOCIOECONOMIC STATUS	Population Living in Poverty Unemployed Population Population with No High School Diploma
HOUSEHOLD COMPOSITION & PEOPLE LIVING WITH A DISABILITY	Age 65 & Over Age Below 18 Population Living With a Disability Single-Parent Households
MINORITY POPULATION & LANGUAGE	Minority Population Population Who Speaks English Less than Very Well
HOUSING & TRANSPORTATION	Multi-Unit Housing Structures Mobile Homes Crowding Population With No Vehicle

[4] Agency for Toxic Substances & Disease Registry, CDC/ATSDR Social Vulnerability Index.

EXHIBIT 19: SOCIAL VULNERABILITY INDEX

	Indicator	United States	Maryland	Anne Arundel County	Baltimore County	Baltimore City	Howard County	Montgomery County	Prince George's County
Socioeconomic Status	Living in Poverty	12.4%	9.3%	5.5%	10.0%	20.1%	5.1%	7.1%	10.2%
	Unemployment Rate	5.2%	4.9%	4.0%	5.0%	6.6%	3.6%	4.8%	6.4%
	Median Household Income	$78,538	$101,652	$120,324	$90,904	$59,623	$146,982	$128,733	$100,708
	No High School Diploma	10.6%	9.0%	6.2%	8.3%	12.8%	4.7%	8.8%	13.3%
	Uninsured	8.6%	6.2%	4.6%	5.5%	5.8%	4.0%	6.8%	11.2%
Household Composition and Disability	Under 18	22.2%	22.3%	22.7%	21.9%	20.9%	24.0%	22.9%	22.2%
	65 and Older	16.8%	16.3%	15.6%	17.8%	14.9%	14.8%	16.6%	14.4%
	Living with a Disability[5]	13.0%	11.4%	10.7%	11.8%	16.5%	8.4%	9.1%	10.1%
	Single-parent Households	24.9%	25.7%	20.0%	27.8%	49.8%	16.9%	20.1%	32.5%
Minority Status and Language	Minority Population[6]	41.8%	52.6%	73.8%	37.3%	47.7%	53%	59.6%	88.9%
	Limited or No English Proficiency	8.4%	7.8%	4.3%	4.3%	5.4%	8.1%	15.8%	14.2%
Household Type and Transportation	Multi-unit Housing Structures[7]	26.9%	26.3%	18.0%	28.7%	35.0%	26.3%	35.1%	3.2%
	Housing Cost-burdened[8]	30.7%	30.9%	27.1%	31.0%	39.7%	25.9%	31.6%	36.4%
	Mobile Homes	5.7%	1.3%	1.2%	0.8%	0.2%	0.8%	0.2%	0.6%
	No Vehicle	8.3%	8.7%	3.9%	8.0%	26.6%	3.9%	8.2%	9.2%
	Overcrowded Housing Units[9]	3.4%	2.5%	1.9%	2.2%	1.8%	1.8%	3.4%	5.1%
	Group Quarters[10]	2.4%	2.0%	1.8%	2.3%	3.7%	0.8%	0.8%	1.9%

Source: U.S. Census Bureau, 2019-2023 American Community Survey Five-year Estimates

[5] The percentage of civilian noninstitutionalized population living with a disability. The Census Bureau defines the civilian noninstitutionalized population as including "all U.S. civilians not residing in institutional group quarters facilities such as correctional institutions, juvenile facilities, skilled nursing facilities, and other long-term care living arrangements.

[6] The percentage of Black, Indigenous, and People of Color.

[7] The percentage of housing units that are in buildings containing two or more housing units.

[8] The percentage of occupied housing units whose selected monthly costs as a percentage of household income is greater than 30%. This is a combination of both owner-occupied and renter-occupied housing units.

[9] The percentage of all occupied housing units with more than one person per room.

[10] Group quarters are places where people live or stay, in a group living arrangement, that is owned or managed by an entity or organization providing housing and/or services for the residents.

Demographics

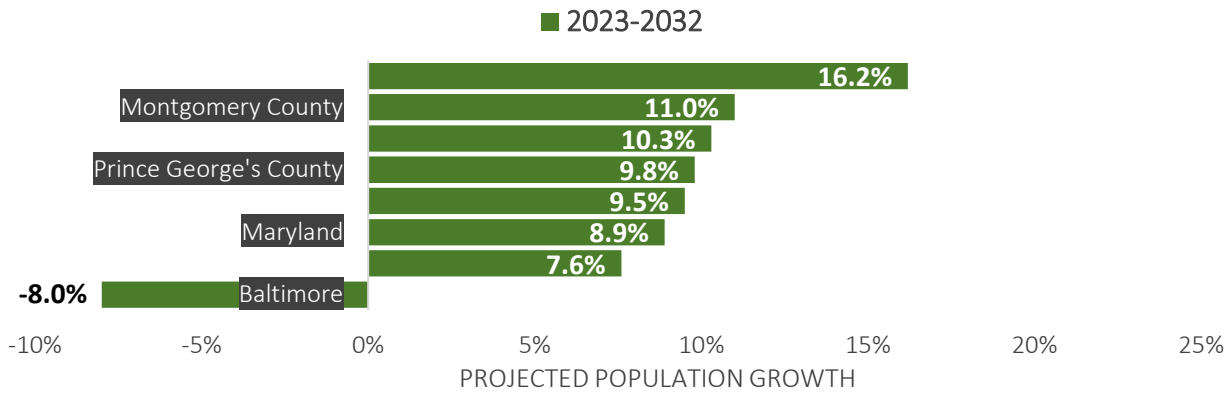
According to population comparisons from the U.S. Census Bureau American Community Survey, Five-year Estimates, Howard County's population grew by nearly 20%, the highest growth in the service area. By 2032, Howard and Montgomery counties are expected to grow by over 10%. Baltimore City is expected to decrease by at least eight percent.

EXHIBIT 20: POPULATION GROWTH

	2006-2010	2019-2023	Total Population Change	Percent Change
United States	303,965,272	332,387,540	+28,422,268	+9.4%
Maryland	5,696,423	6,170,738	+474,315	+8.3%
Anne Arundel County	527,020	590,936	+63,916	+12.1%
Baltimore City	620,538	577,193	-43,345	-7.0%
Baltimore County	799,195	849,586	+50,391	+6.3%
Howard County	279,366	333,916	+54,550	+19.5%
Montgomery County	947,230	1,057,586	+110,356	+11.7%
Prince George's County	854,722	955,584	+100,862	+11.8%

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

EXHIBIT 21: PROJECTED POPULATION GROWTH



	Projected 2032 Population
United States	364,066,358
Maryland	6,721,149
Anne Arundel County	651,799
Baltimore City	531,143
Baltimore County	914,467
Howard County	388,105
Montgomery County	1,174,055
Prince George's County	1,049,677

Source: U.S. Census Bureau American Community Survey

EXHIBIT 22: CHILD POPULATION

	Under 5	5 - 9	10 - 19	Under 18
United States	5.7%	6.0%	13.0%	22.2%
Maryland	5.8%	6.1%	12.8%	22.3%
Anne Arundel County	6.0%	6.2%	12.4%	22.7%
Baltimore County	5.8%	6.2%	12.8%	21.9%
Baltimore City	6.1%	5.5%	12.0%	20.9%
Howard County	5.5%	6.4%	14.5%	24.0%
Montgomery County	5.8%	6.2%	13.1%	22.9%
Prince George's County	6.2%	6.2%	12.6%	22.2%

Source: U.S. Census Bureau, 2019-2023 American Community Survey Five-year Estimates

EXHIBIT 23: ADULT POPULATION

	20 - 24	25 - 34	35 - 54	55 - 64	65 +
United States	6.5%	13.7%	25.4%	12.8%	16.8%
Maryland	6.0%	13.3%	26.2%	13.5%	16.3%
Anne Arundel County	5.7%	13.8%	26.9%	13.3%	15.6%
Baltimore County	6.1%	13.1%	25.0%	13.4%	17.8%
Baltimore City	6.3%	18.2%	24.4%	12.5%	14.9%
Howard County	5.6%	11.9%	28.4%	13.0%	14.8%
Montgomery County	5.5%	12.1%	27.5%	13.2%	16.6%
Prince George's County	6.3%	14.0%	26.9%	13.4%	14.4%

Source: U.S. Census Bureau, 2019-2023 American Community Survey Five-year Estimates

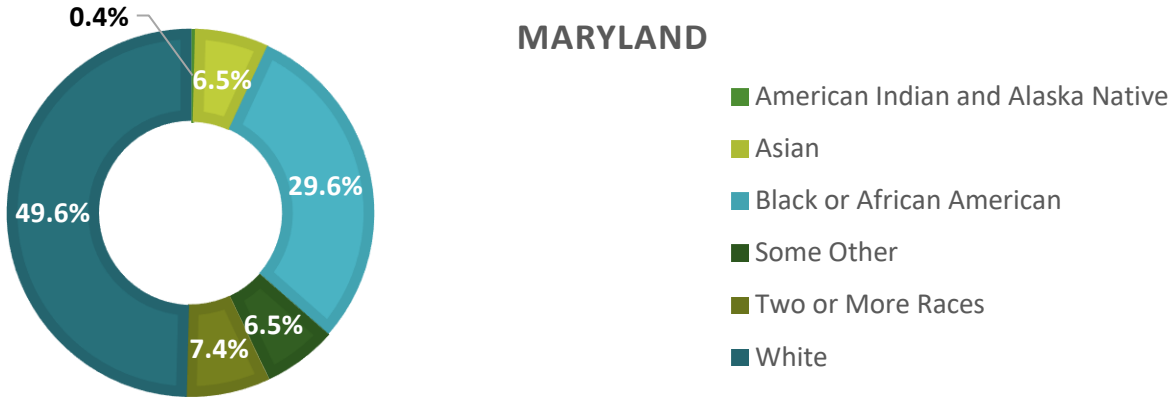
EXHIBIT 24: LANGUAGES SPOKEN

	Total Population Age Five and Older	English only	Language other than English	Speak English less than very well
United States	313,447,641	78.0%	22.0%	8.4%
Maryland	5,811,398	79.4%	20.6%	7.8%
Anne Arundel County	555,190	86.4%	13.6%	4.3%
Baltimore County	800,332	84.4%	15.7%	5.4%
Baltimore City	541,888	88.3%	11.7%	4.3%
Howard County	315,420	73.2%	25.9%	8.1%
Montgomery County	996,009	57.5%	42.4%	15.8%
Prince George's County	896,150	69.9%	30.0%	14.2%

Source: U.S. Census Bureau, 2019-2023 American Community Survey Five-year Estimates

EXHIBIT 25: RACE[11]

	American Indian and Alaska Native	Asian	Black or African American	Native Hawaiian and Other Pacific Islander	Some Other	Two or More Races	White
United States	0.9%	5.8%	12.4%	0.2%	6.6%	10.7%	63.4%
Maryland	0.4%	6.5%	29.6%	0.0%	6.5%	7.4%	49.6%
Anne Arundel County	0.6%	4.1%	17.7%	0.0%	4.5%	8.0%	65.1%
Baltimore County	0.3%	6.0%	30.3%	0.0%	3.4%	5.9%	54.1%
Baltimore City	0.4%	2.5%	60.0%	0.0%	4.4%	5.2%	27.4%
Howard County	0.3%	18.8%	20.0%	0.0%	3.5%	8.5%	48.9%
Montgomery County	0.5%	15.2%	18.6%	0.0%	11.1%	10.1%	44.4%
Prince George's County	0.6%	4.0%	59.8%	0.0%	15.6%	6.9%	13.2%



Source: U.S. Census Bureau, 2019-2023 American Community Survey Five-year Estimates

EXHIBIT 26: ETHNICITY

	Hispanic or Latino of Any Race
United States	19.0%
Maryland	12.1%
Anne Arundel County	10.0%
Baltimore County	7.4%
Baltimore City	7.9%
Howard County	8.4%
Montgomery County	20.6%
Prince George's County	21.7%

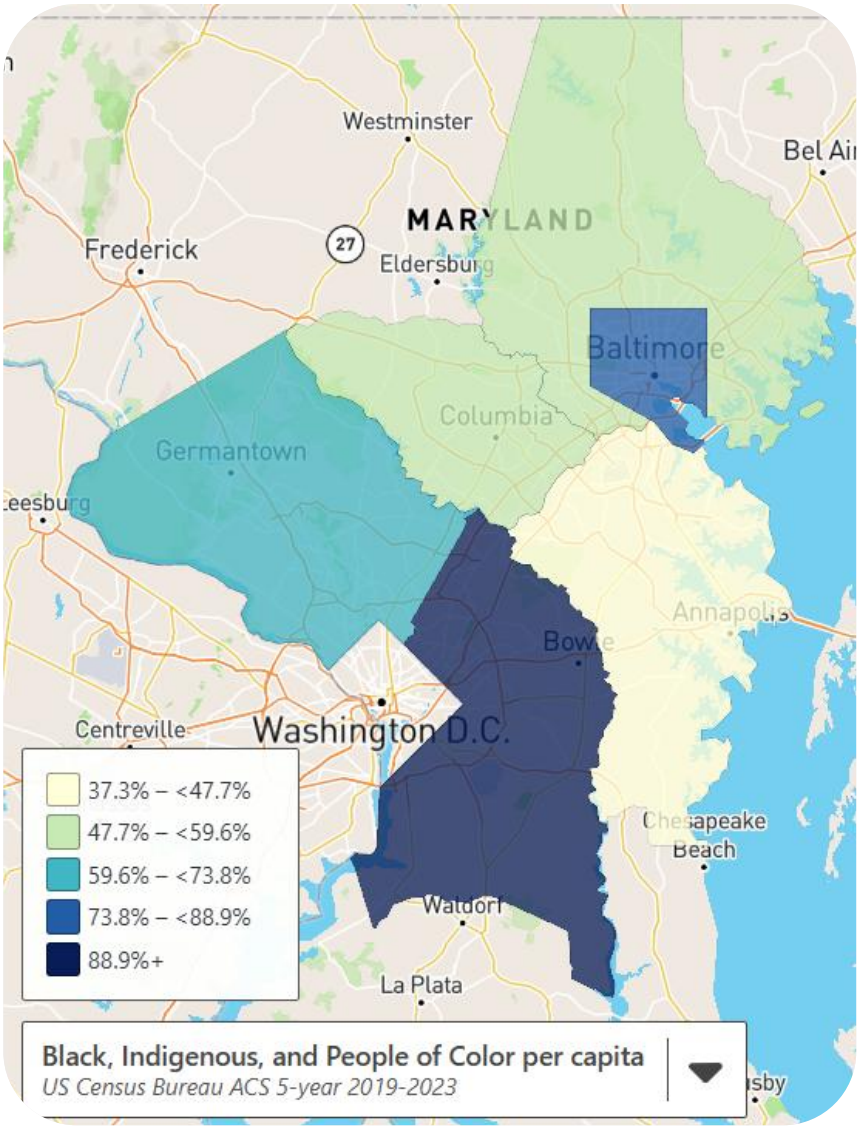
Source: U.S. Census Bureau, 2019-2023 American Community Survey Five-year Estimates

[11] Race alone are those "people who responded to the question on race by indicating only one race are referred to as the race alone population, or the group who reported only one race. https://www.census.gov/glossary/?term=Race+alone

Racial/ethnic minorities often suffer from poor mental health outcomes due to multiple factors, including inaccessibility of high-quality mental health care services, cultural stigma surrounding mental health care, discrimination, and overall lack of awareness about mental health.[12]

The map below represents Black, Indigenous, and People of Color (BIPOC). The data values were calculated by taking the total population minus the white (not Latino, not Hispanic) population. Approximately 89% of the population in Prince George's County is considered a minority population.

EXHIBIT 27: MINORITY POPULATION

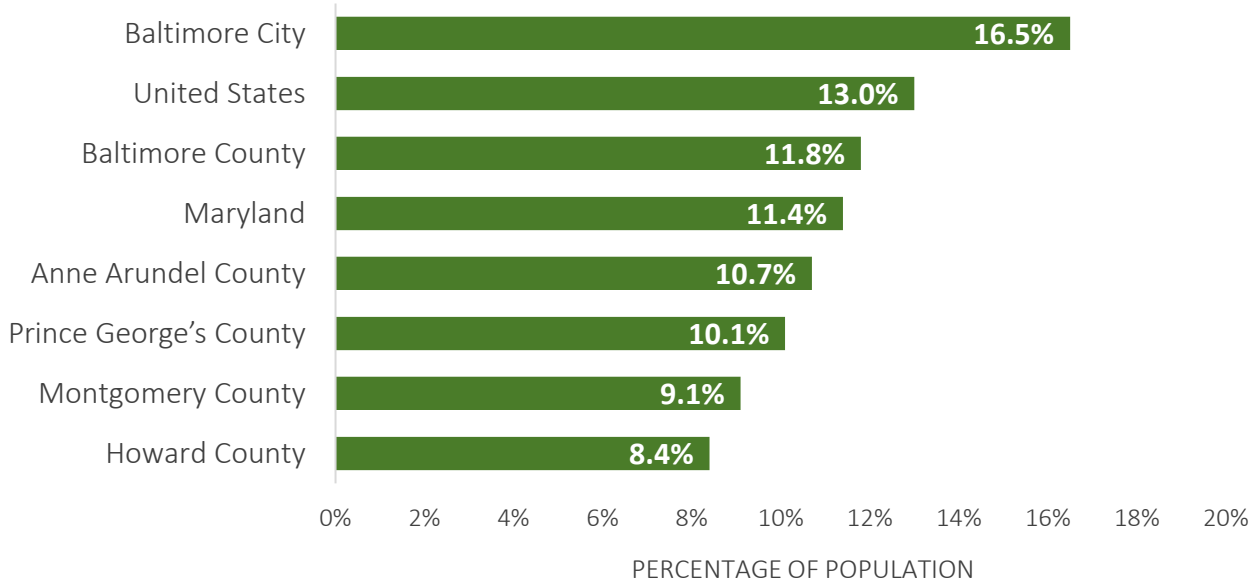


[12] American Psychiatric Association, Mental Health Disparities: Diverse Populations. https://www.psychiatry.org/psychiatrists/diversity/education/mental-health-facts

Population Living with a Disability

People living with seen and unseen disabilities face elevated mental health concerns and are more likely to utilize mental health services compared to non-disabled individuals. Yet, this population experiences higher unmet mental health needs and barriers to accessing care.[13]

EXHIBIT 28: POPULATION LIVING WITH A DISABILITY[14]



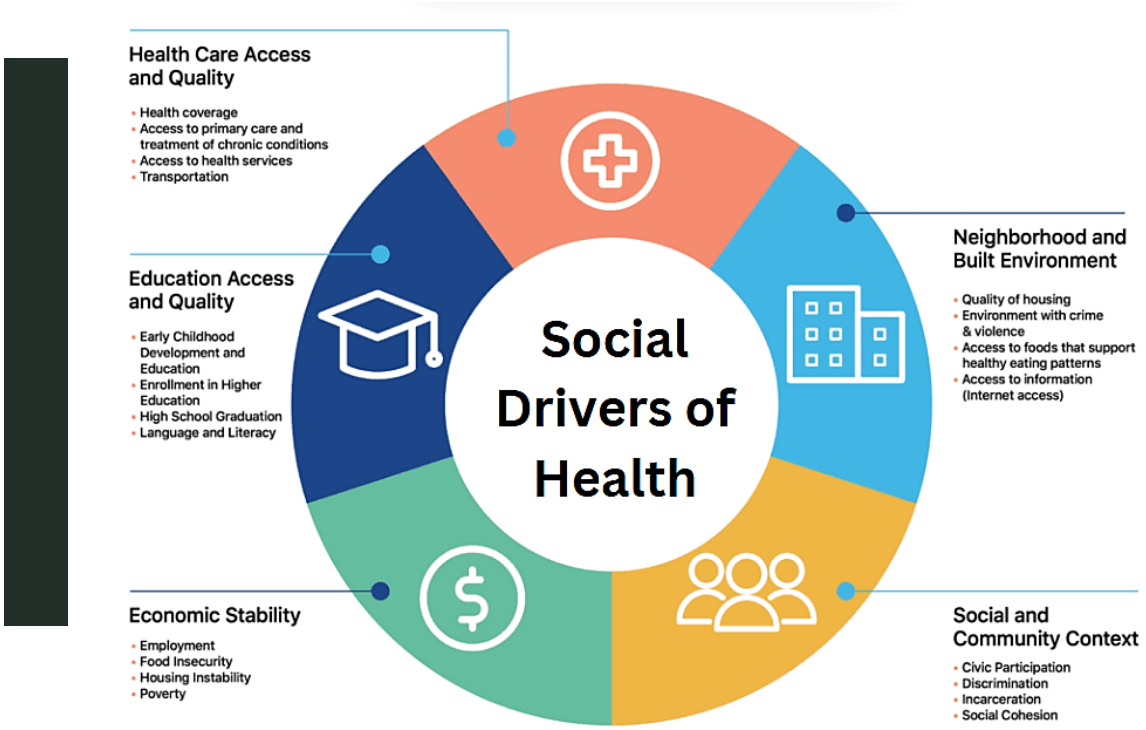
Nearly 17% of Baltimore City's population is living with a disability, the highest rate in the Sheppard Pratt service area.

[13] Yale School of Medicine, Ableism cited as major barrier to mental health care for people with disabilities (2024). https://medicine.yale.edu/news-article/ableism-cited-as-major-barrier-to-mental-health-care-for-people-with-disabilities/#:~:text=People%20with%20disabilities%20(PWD)%20make,and%20barriers%20to%20accessing%20care.

[14] Percentage of the civilian noninstitutionalized population living with a disability. The civilian population excludes persons residing in institutions. Such institutions consist primarily of nursing homes, prisons, jails, mental hospitals, and juvenile correctional facilities. Link: https://www.census.gov/programs-surveys/popest/about/glossary/national.html#:~:text=Civilian%20Noninstitutionalized%20Population,hospitals%2C%20and%20juvenile%20correctional%20facilities

Social Drivers of Health Key Findings

Social drivers of health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. They also contribute to wide health disparities and inequities. The framework has been championed by the U.S Centers for Disease Control and Prevention (CDC) and other governmental agencies and is integrated into the Healthy People 2030 goals.[15] Social Drivers are also known as social determinants. "Determinants" suggest that nothing can be done to change our health fate. By using the term "drivers," we can reframe the conversation that social factors don't force health to be fated or destined, but rather something that people and communities can change. The following secondary research sections include key findings related to Social Drivers of Health in the Sheppard Pratt Service Area.



About the Data

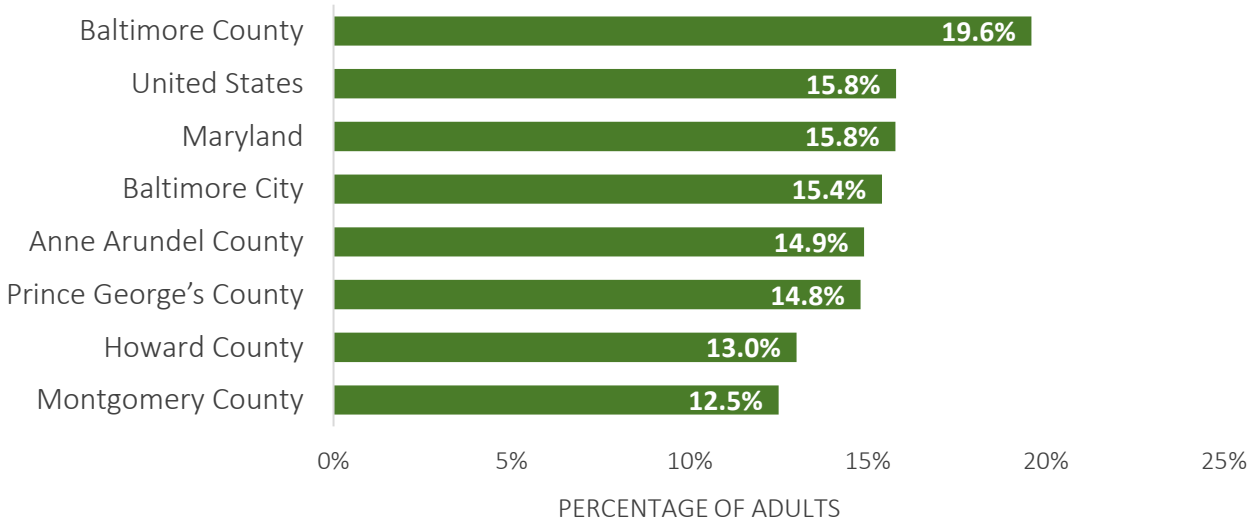
PLACES provides health and health-related data using small-area estimation for counties, incorporated and census designated places, census tracts, and ZIP Code Tabulation Areas (ZCTAs) across the United States. PLACES estimates chronic disease and other health-related measures at various geographic levels of the United States using a small area estimation methodology. Data are derived from Behavioral Risk Factor Surveillance System data, Census population data, and American Community Survey data.

[15] Healthy People 2030. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health

Behavioral Health

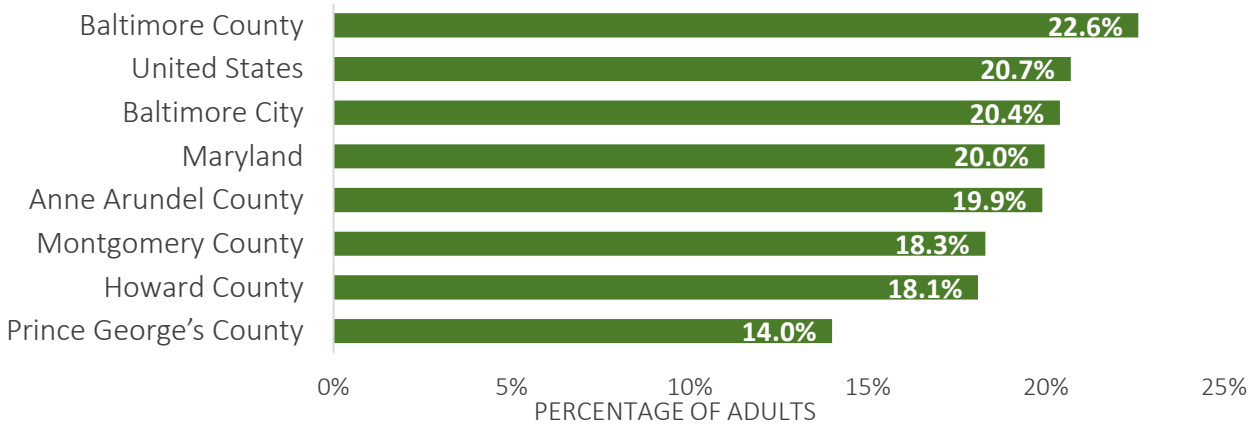
Over 10% of adults[16] in all counties in the service area, self-reported experiencing 14 or more poor mental health days during the past 30 days, and over 14% of adults in all counties self-reported having ever been told by a doctor, nurse, or other health professional that they had depressive disorder. Baltimore County has the highest estimated annual prevalence rate of poor mental health days and depression.

EXHIBIT 29: SELF-REPORTED POOR MENTAL HEALTH DAYS



Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. PLACES, 2022

EXHIBIT 30: SELF-REPORTED DEPRESSION[17]



Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. PLACES, 2022

[16] Aged 18 and over.

[17] Estimated annual prevalence rate of adults aged 18 and over who report having ever been told by a doctor, nurse, or other health professional that they had depressive disorder.

***"Mental health diagnosis"** includes all mental health diagnoses, which is up to three diagnoses reported for each individual. For this reason, the numbers may not sum to total.

****"Other mental disorders"** includes all other mental health diagnoses & diagnoses not included in another diagnostic category; it excludes alcohol/substance-related diagnoses.

EXHIBIT 31: TREND OF MENTAL HEALTH DIAGNOSIS IN MARYLAND

	2016	2017	2018	2019	2021	2022
Male	45.3%	46.1%	46.0%	45.6%	43.3%	42.4%
Female	54.7%	53.9%	54.0%	54.4%	56.7%	57.6%
Mental Health Diagnosis*						
Trauma and Stressor-Related Disorders	16.7%	17.3%	18.0%	18.3%	17.5%	17.7%
Anxiety Disorders	17.3%	18.3%	19.6%	20.4%	18.7%	21.6%
Attention-Deficit/Hyperactivity Disorder	16.0%	15.7%	15.7%	15.6%	13.4%	13.6%
Bipolar	13.4%	13.0%	13.0%	12.9%	12.7%	12.7%
Depressive Disorders	28.3%	28.6%	29.0%	29.8%	28.7%	28.9%
Schizophrenia and Other Psychotic Disorders	8.6%	8.1%	7.9%	7.6%	7.3%	6.8%
Other Mental Health Disorders**	13.8%	13.5%	13.1%	12.8%	9.3%	9.0%

Source: SAMHSA. Mental Health Annual Report Use of Mental Health Services: National Client-Level Data, 2022

The coexistence of both a mental health disorder and a substance use disorder (SUD) is referred to as co-occurring disorders. Co-occurring disorders may include any combination of two or more SUDs and mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR). Importantly, no specific combinations of mental and substance use disorders are uniquely defined as co-occurring disorders.[18]

EXHIBIT 32: CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS

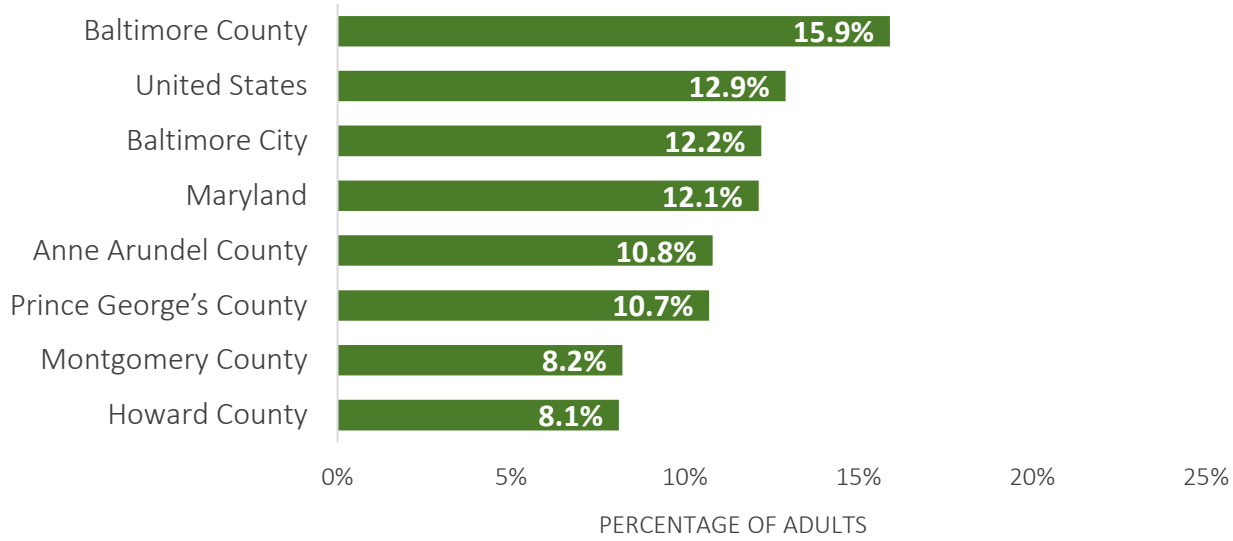
	United States		Maryland	
	2019	**2023**	**2019**	**2023**
Adults	28%	28%	25%	40%
Children	5%	7%	28%	2%

Source: SAMHSA Uniform Reporting System. State Mental Health Measures

[18] SAMHSA, Co-Occurring Disorders and Other Health Conditions. https://www.samhsa.gov/substance-use/treatment/co-occurring-disorders

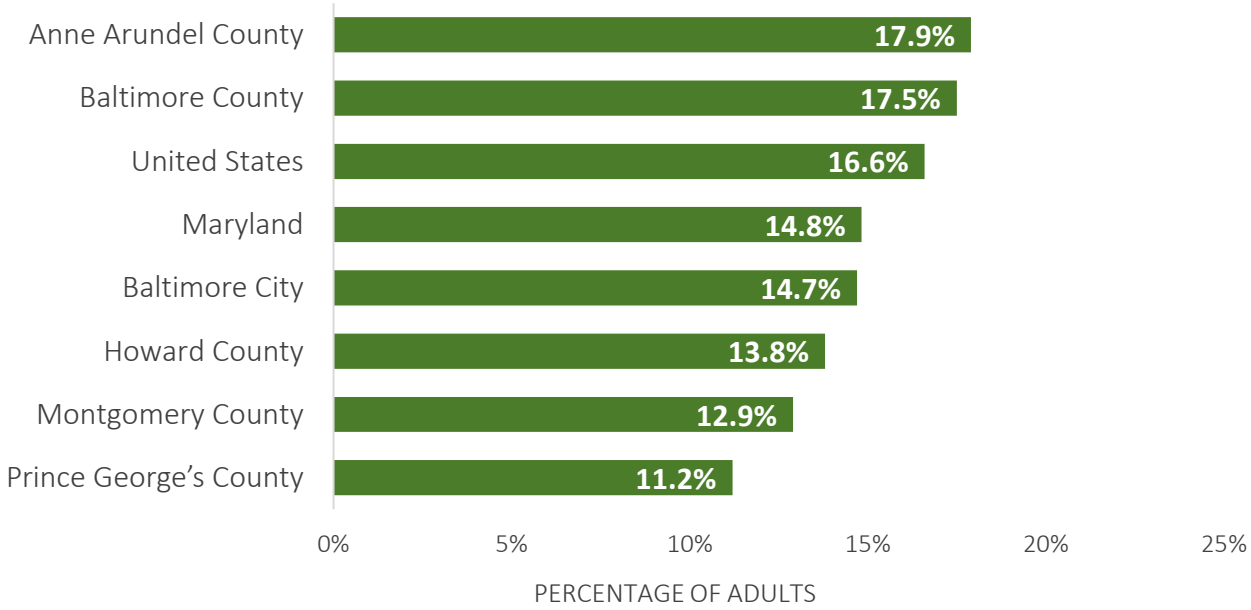
Over 15% of adults self-reported smoking 100 or more cigarettes in their lifetime and currently smoke every day or some days in Baltimore County. The estimated annual prevalence rate of adults who report having five or more drinks for men or four or more drinks for women on an occasion in the past 30 days is highest in Anne Arundel and Baltimore counties (over 17% of adults).

EXHIBIT 33: SELF-REPORTED CURRENT CIGARETTE SMOKING



Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. PLACES, 2022

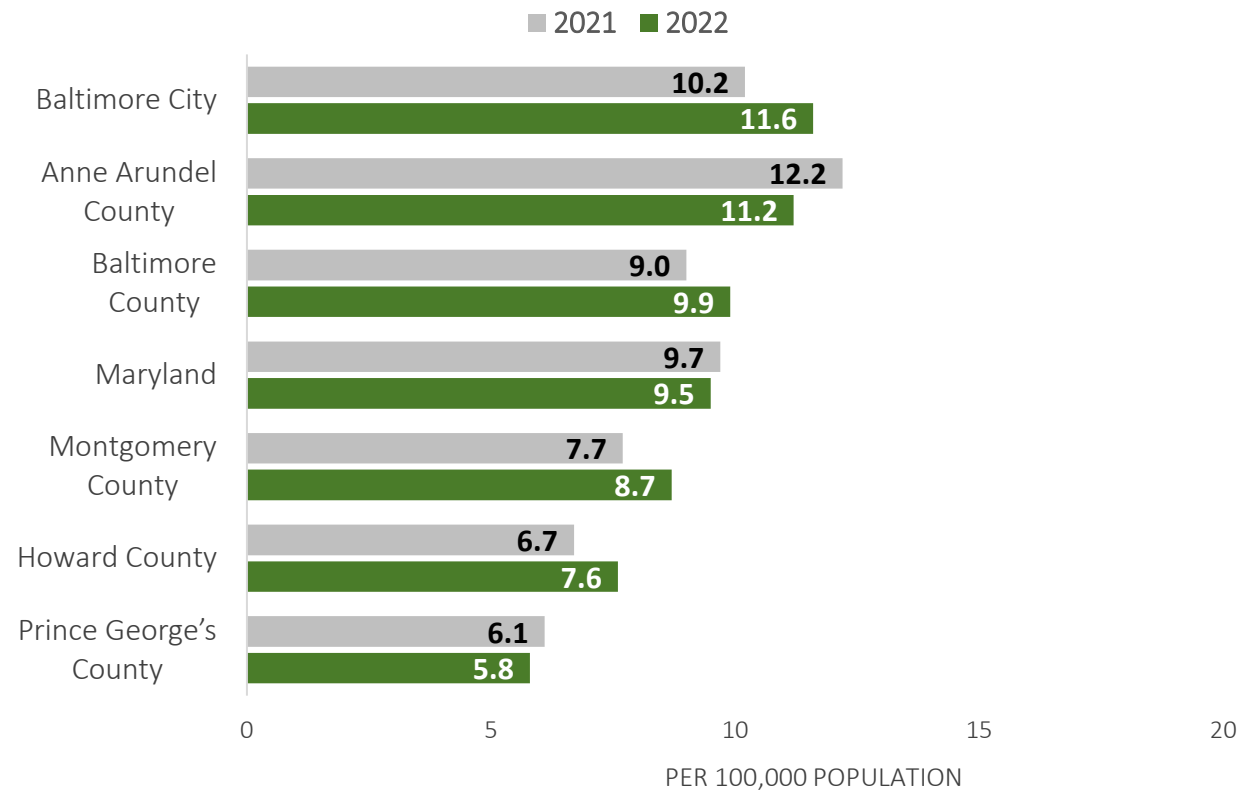
EXHIBIT 34: SELF-REPORTED BINGE DRINKING



Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. PLACES, 2022

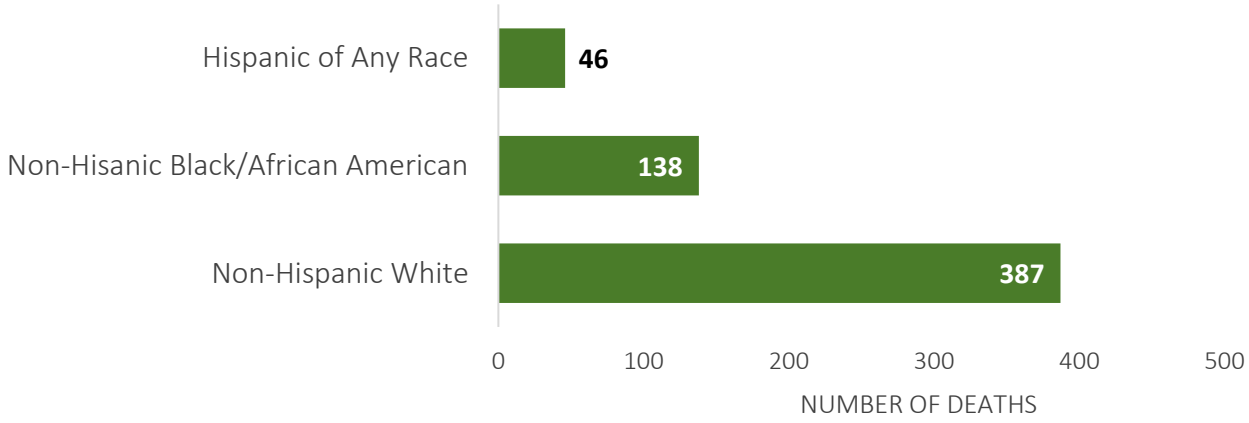
According to the Maryland Vital Statistics Annual Report, between 2021 and 2022, the age-adjusted suicide rate increased by at least 10% in Baltimore City, Baltimore County, Montgomery County, and Howard County.

EXHIBIT 35: AGE-ADJUSTED SUICIDE RATE



Source: Maryland Department of Health. Maryland Vital Statistics Annual Report, 2021 and 2022

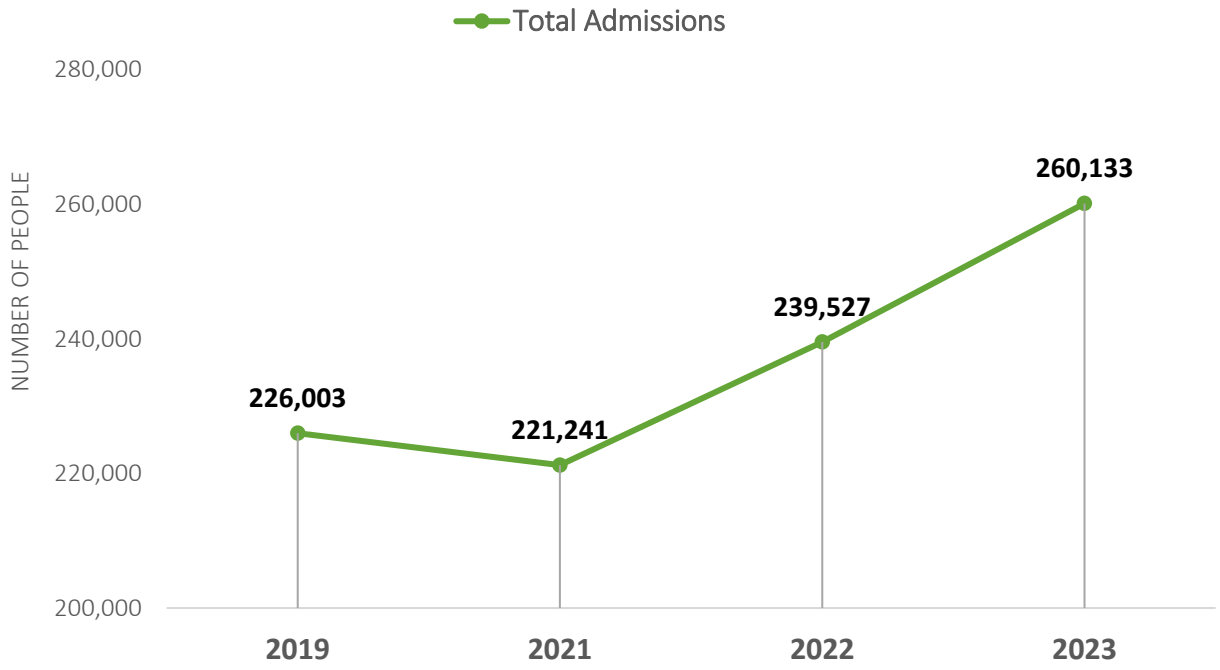
EXHIBIT 36: NUMBER OF DEATHS CAUSED BY SUICIDE IN MARYLAND BY RACE/ETHNICITY IN MARYLAND



Source: Maryland Department of Health. Maryland Vital Statistics Annual Report, 2022

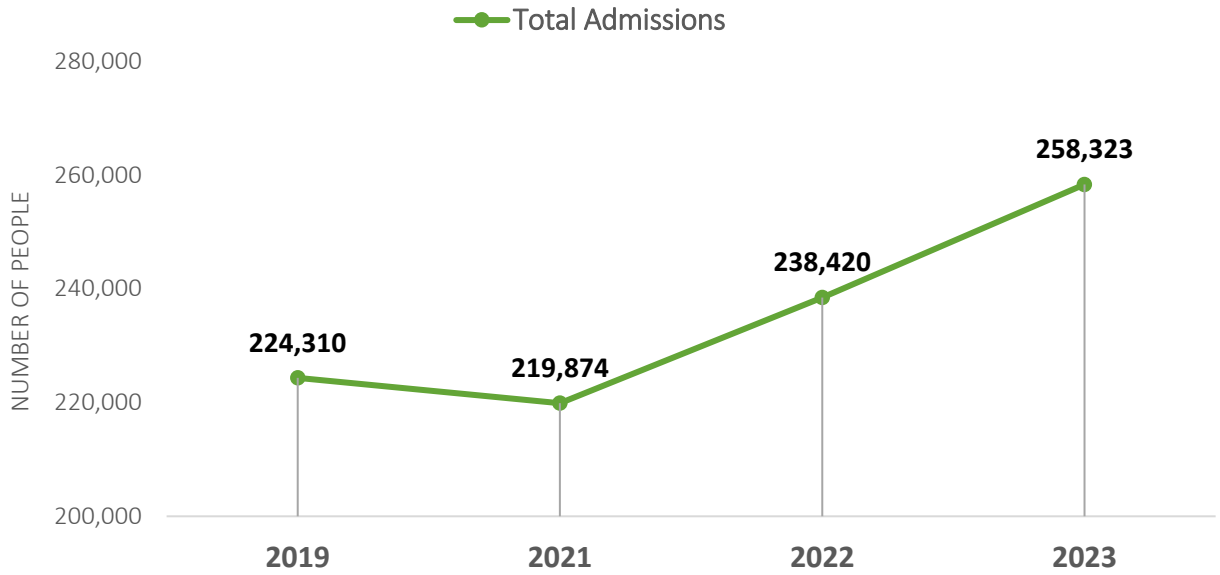
The number of individuals served by Maryland's state mental health authority and community mental health programs have been rising since 2021, coinciding with the COVID-19 pandemic. Between 2021 and 2023, total admissions into state mental health authorities increased by 17.6%, while total admissions to community mental health programs increased by 17.4%.

EXHIBIT 37: POPULATION SERVED BY THE STATE MENTAL HEALTH AUTHORITY IN MARYLAND



Source: Substance Abuse and Mental Health Services Administration. Maryland Uniform Reporting System Output Tables

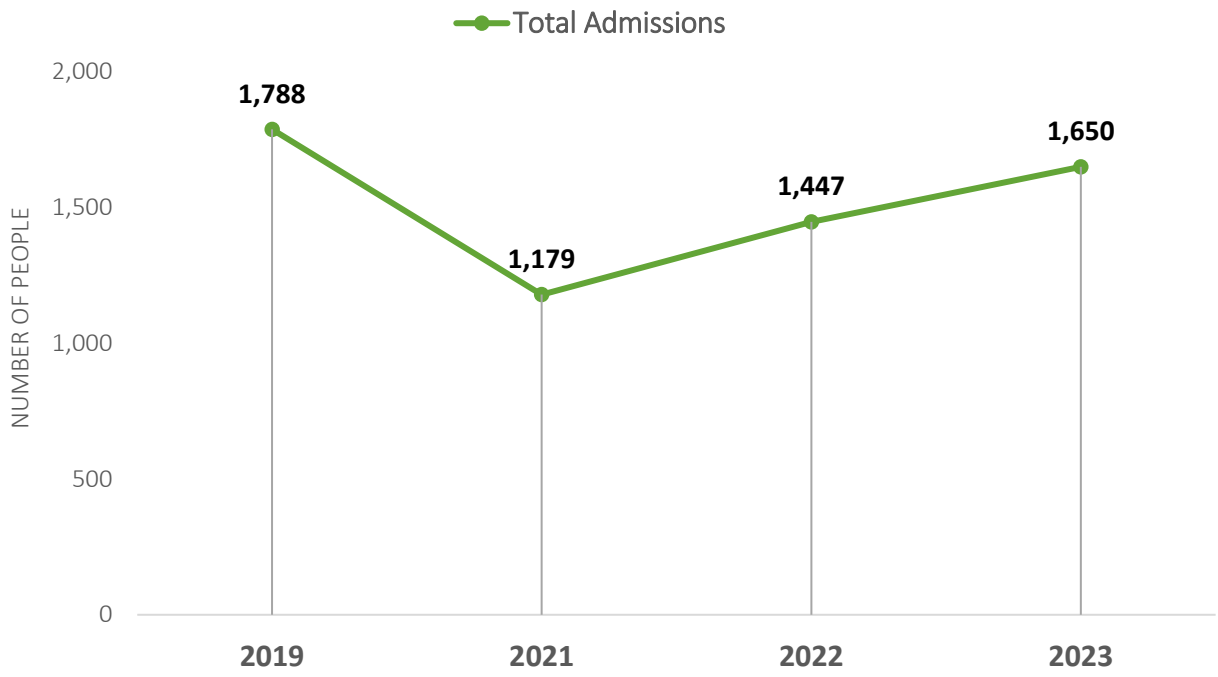
EXHIBIT 38: SERVED IN COMMUNITY MENTAL HEALTH PROGRAMS



Source: Substance Abuse and Mental Health Services Administration. Maryland Uniform Reporting System Output Tables

Between 2019 and 2021, the total number of people served in state psychiatric hospitals decreased by 34%, however, between 2021 and 2023, this figure increased by approximately 40%,

EXHIBIT 39: PEOPLE SERVED IN STATE PSYCHIATRIC HOSPITALS



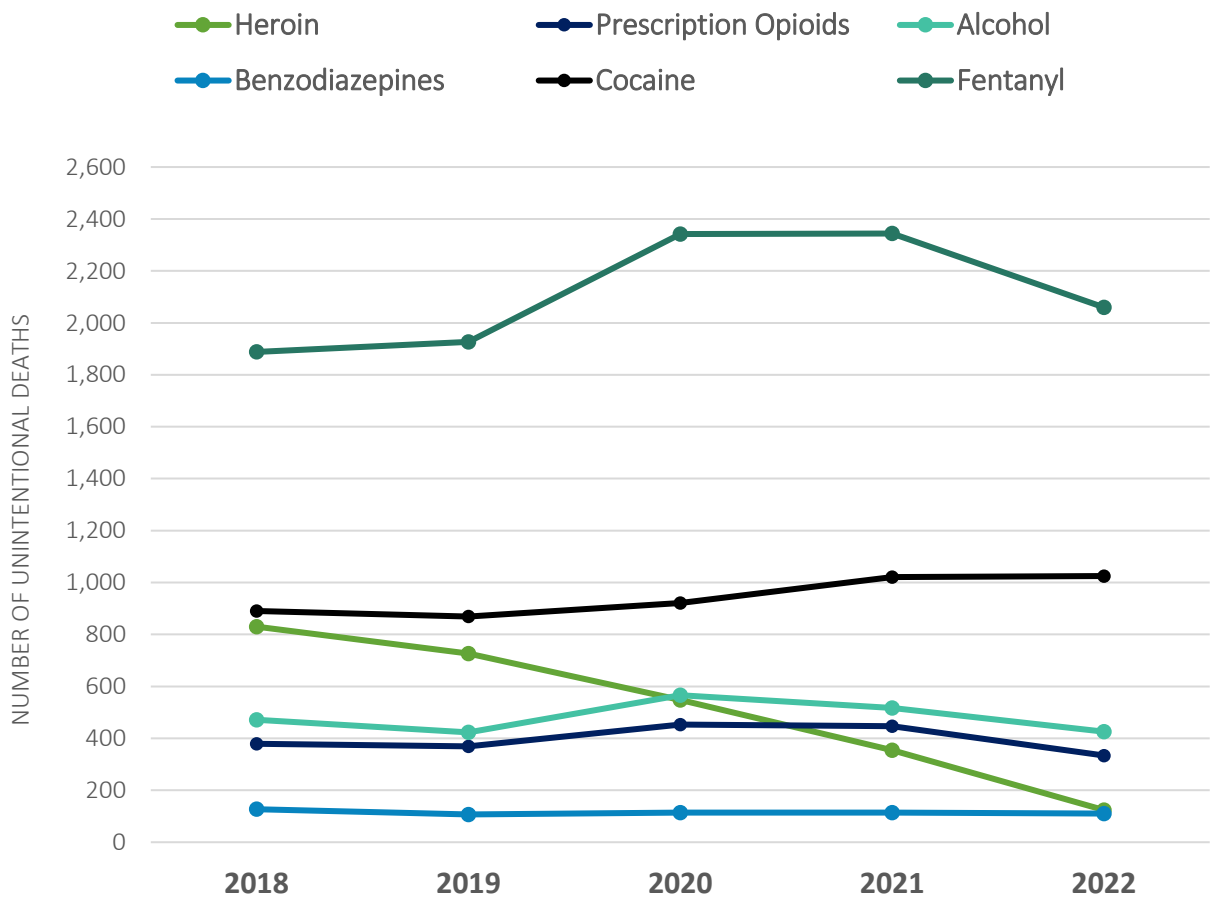
Source: Substance Abuse and Mental Health Services Administration. Maryland Uniform Reporting System Output Table

Substance Use

Between 2018 and 2022,

- Heroin overdoses decreased by 85%
- Prescription Opioid overdoses decreased by 12%
- Alcohol overdoses decreased by 9.7%
- Benzodiazepines overdoses decreased by 13.4%
- Cocaine overdoses increased by 15%
- Fentanyl overdoses increased by 9.7%

EXHIBIT 40: ANNUAL TREND OF UNINTENTIONAL OVERDOSE DEATHS IN MARYLAND

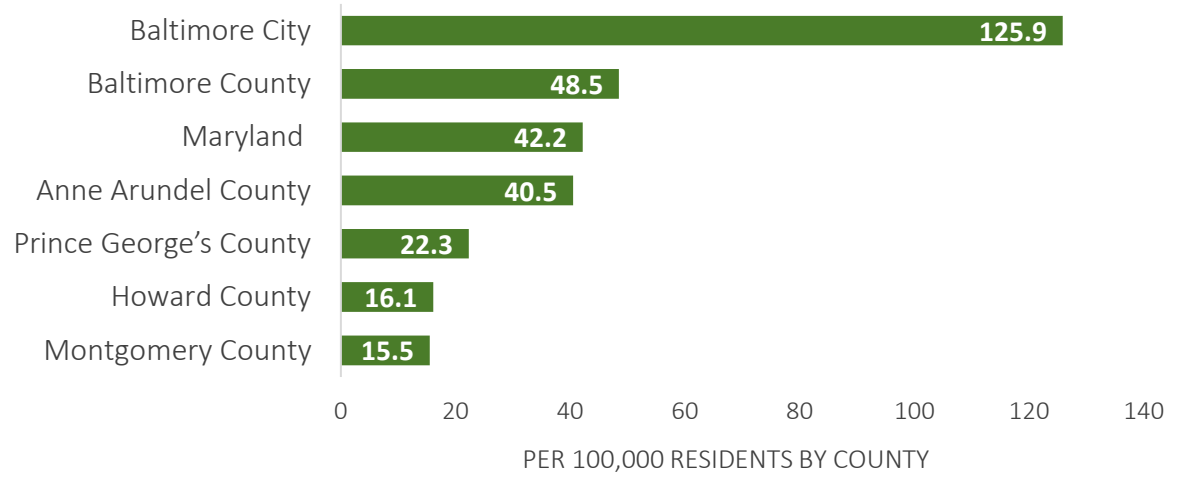


	2018	2019	2020	2021	2022
Heroin	830	726	548	354	124
Prescription Opioids	379	369	453	447	334
Alcohol	472	423	566	517	426
Benzodiazepines	127	107	114	114	110
Cocaine	891	869	921	1,021	1,025
Fentanyl	1,888	1,927	2,342	2,344	2,060

Source: Maryland Department of Health Vital Statistics. Unintentional Drug and Alcohol-Related Intoxication Deaths Annual Report

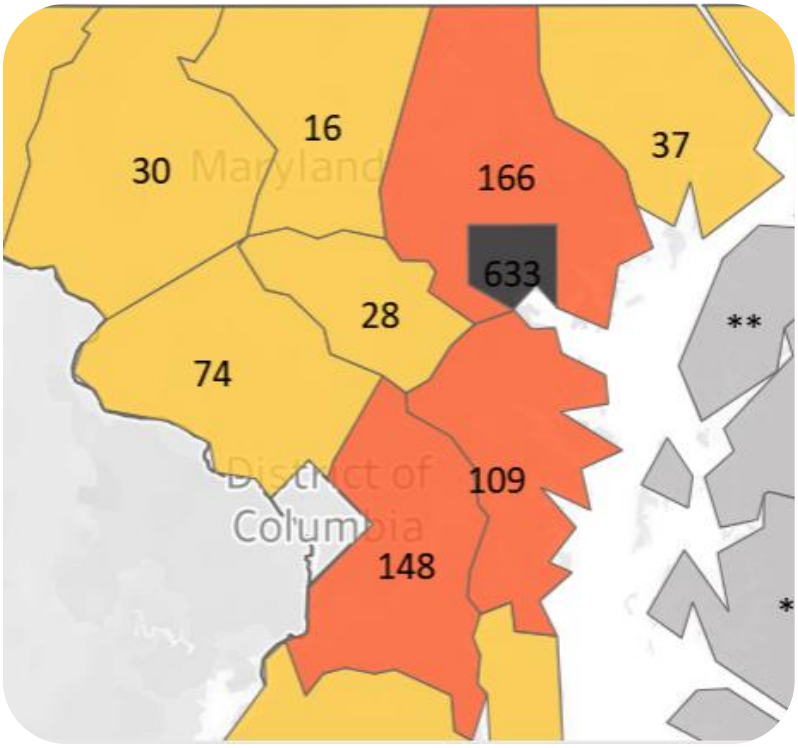
Maryland's 2022 Unintentional Drug and Alcohol-Related Intoxication Deaths Annual Report shows that Baltimore City and Baltimore County had the highest rates of age-adjusted unintentional drug and alcohol related deaths by county within the service area. These rates are also higher compared to the state of Maryland.

EXHIBIT 41: AGE-ADJUSTED MORTALITY RATE FOR UNINTENTIONAL DRUG-AND ALCOHOL-RELATED DEATHS BY PLACE OF RESIDENCE



Source: Maryland Department of Health Vital Statistics. Unintentional Drug and Alcohol-Related Intoxication Deaths Annual Report, 2022

EXHIBIT 42: NUMBER OF OVERDOSE DEATHS BY COUNTY



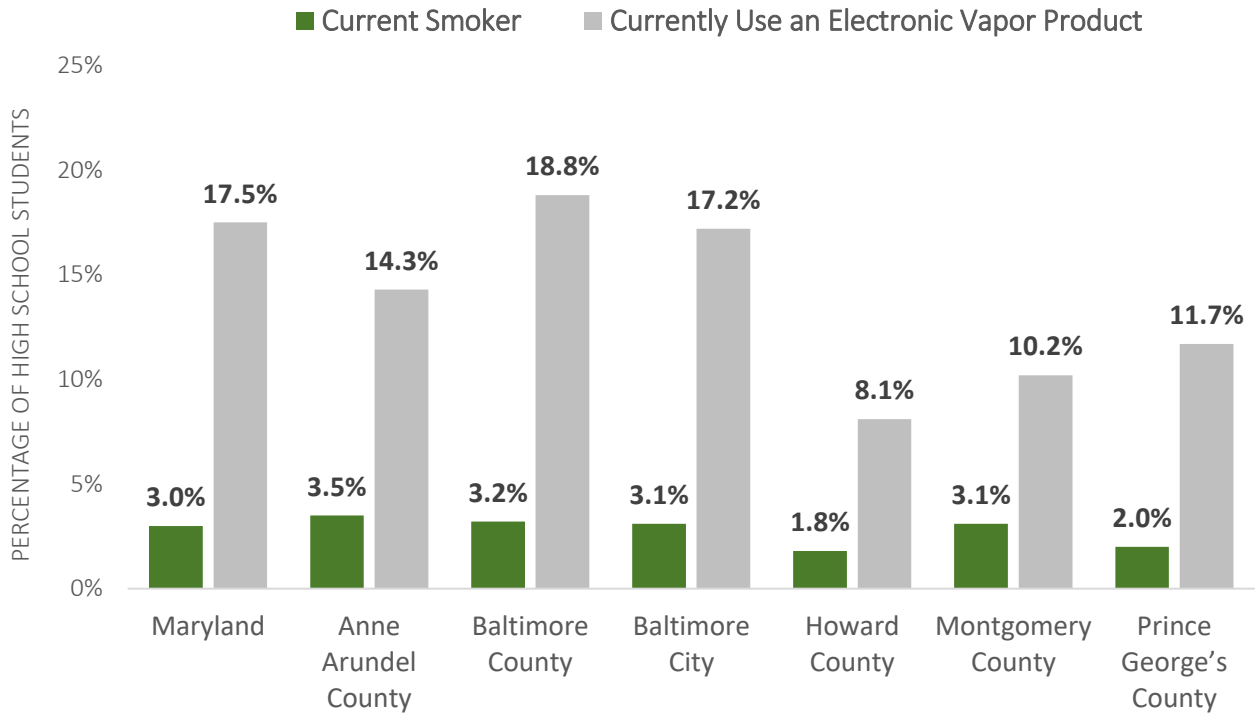
Between March 2024 and February 2025, Baltimore City recorded the highest number of overdose deaths in the service area (633).

Source: Maryland Department of Health Overdose Data Portal, March 2024 – February 2025

Youth Behavioral Health

Nearly 18% of high school students in Maryland self-reported current electronic vapor product use. Within the service area, over 15% of high school students self-reported using these products in Baltimore City and Baltimore County.

EXHIBIT 43: SELF-REPORTED CURRENT TOBACCO USE BY HIGH SCHOOL STUDENTS[19]



Source: Maryland Youth Risk Behavior Survey, 2022

[19] **Current Smoker:** Percentage of students who currently smoked cigarettes (on at least 1 day during the 30 days before the survey). **Currently Use an Electronic Vapor Product**: Percentage of students who currently used an electronic vapor product (including e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods [such as JUUL, SMOK, Suorin, Vuse, and blu], on at least 1 day during the 30 days before the survey)

Between 2018 and 2022, self-reported substance use by high school students decreased across all substances.

EXHIBIT 44: SELF-REPORTED LIFETIME SUBSTANCE USE BY HIGH SCHOOL STUDENTS

2018	Marijuana[20]	Pain Medicine[21]	Cocaine	Heroin	Methamphetamines	Ecstasy (MDMA)
Maryland	6.4%	14.6%	4.8%	3.7%	3.7%	4.9%
Anne Arundel County	6.4%	14.2%	5.4%	4.4%	4.8%	5.8%
Baltimore County	5.7%	15.1%	4.0%	3.7%	3.0%	4.3%
Baltimore City	13.8%	21.0%	9.2%	8.7%	8.2%	9.7%
Howard County	3.7%	12.0%	3.2%	2.1%	1.9%	2.9%
Montgomery County	3.8%	11.4%	3.2%	2.0%	1.8%	3.2%
Prince George's County	7.4%	19.0%	5.6%	4.3%	5.2%	5.7%

2022	Marijuana	Pain Medicine	Cocaine	Heroin	Methamphetamines	Ecstasy (MDMA)
Maryland	4.3%	11.1%	1.8%	1.3%	1.4%	2.0%
Anne Arundel County	4.1%	10.9%	1.8%	1.3%	1.6%	2.4%
Baltimore County	5.1%	12.2%	1.6%	1.2%	1.4%	1.8%
Baltimore City	6.3%	13.1%	2.1%	1.8%	1.6%	2.6%
Howard County	1.7%	9.1%	1.6%	1.2%	1.1%	1.3%
Montgomery County	2.1%	7.8%	0.7%	ND	0.4%	0.8%
Prince George's County	5.0%	13.6%	1.4%	1.0%	1.0%	1.5%

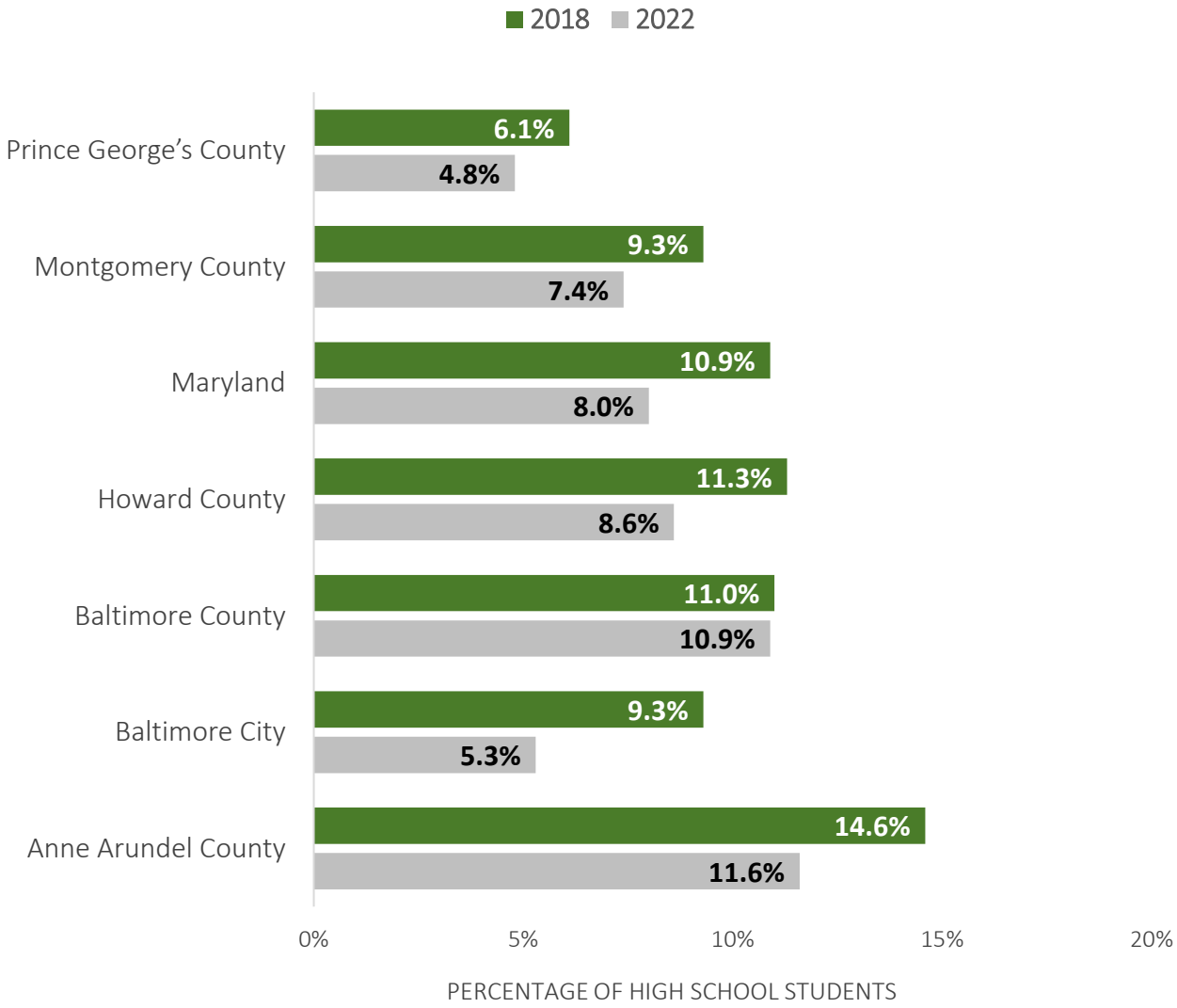
Source: Maryland Youth Risk Behavior Survey

[20] Percentage of students who tried marijuana for the first time before age 13 years.

[21] Percentage of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life).

The percentage of high school students who self-report binge drinking decreased in all service areas between 2018 and 2022.

EXHIBIT 45: SELF-REPORTED BINGE DRINKING[22] BY HIGH SCHOOL STUDENTS

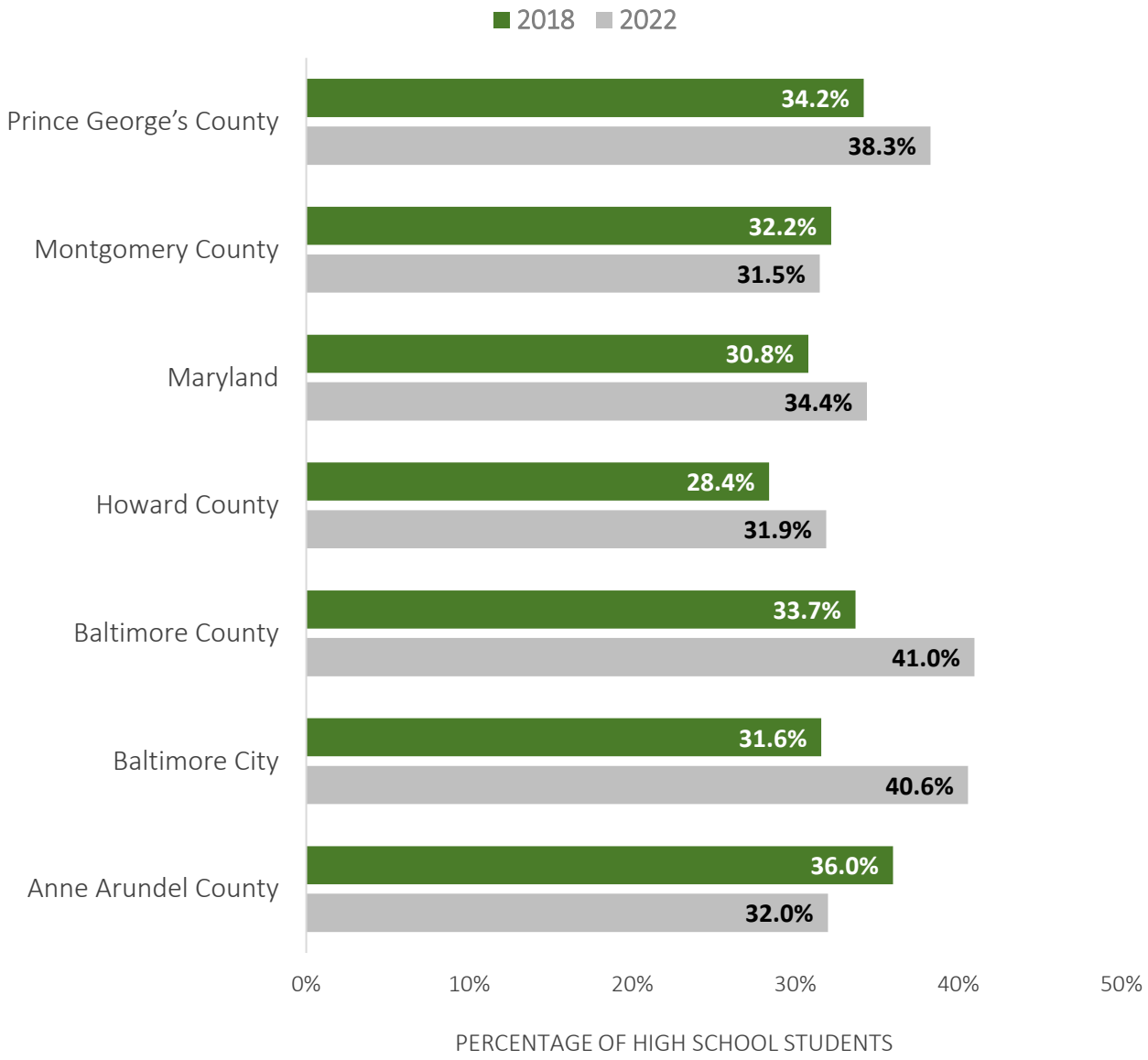


Source: Maryland Youth Risk Behavior Survey

[22] Percentage of students who currently were binge drinking (had four or more drinks of alcohol in a row if they were female or five or more drinks of alcohol in a row if they were male, within a couple of hours, on at least 1 day during the 30 days before the survey).

The percentage of students who self-report feeling sad or hopeless almost every day for two weeks or more during the past year increased between 2018 and 2022 in Prince George's County, Howard County, Baltimore County, Baltimore City, and the state of Maryland.

EXHIBIT 46: SELF-REPORTED FEELING SAD OR HOPELESS BY HIGH SCHOOL STUDENTS[23]

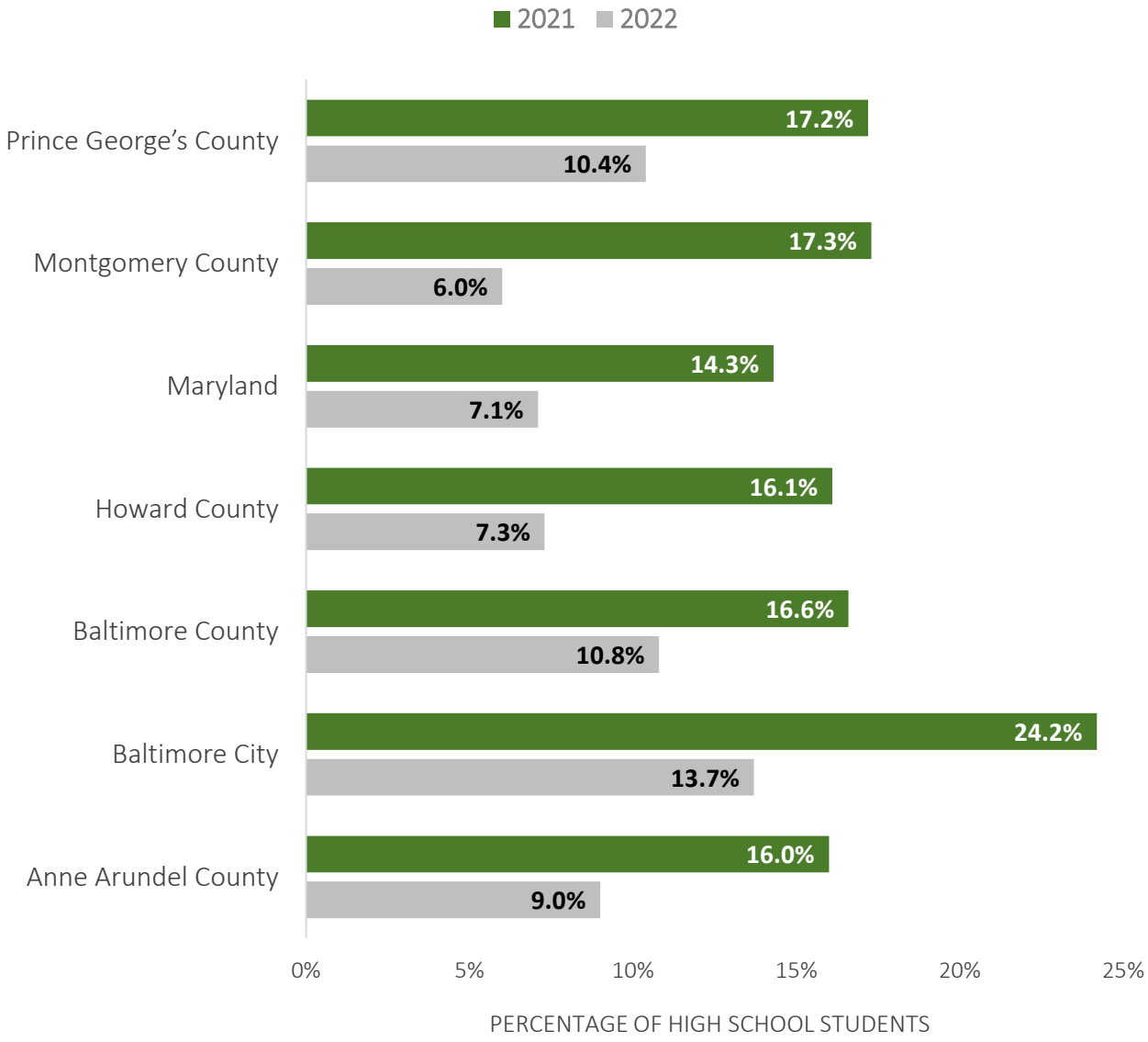


Source: Maryland Youth Risk Behavior Survey

[23] The percentage of students self-reporting feeling sad or hopeless almost every day for two weeks or more during the past year.

Compared to 2021, fewer high school students self-reported attempted suicide in the past year in 2022.

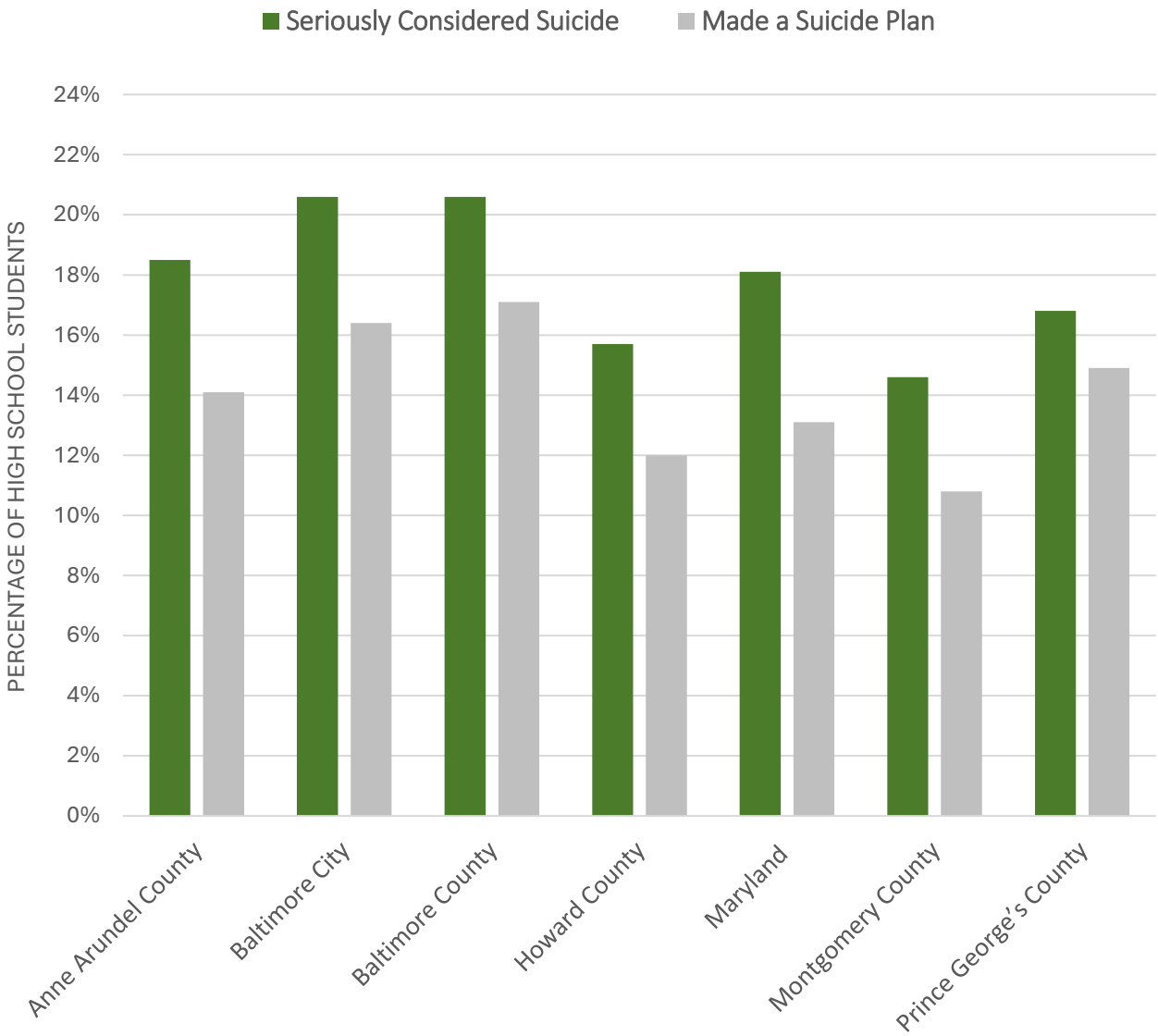
EXHIBIT 47: SELF-REPORTED SUICIDE ATTEMPT IN THE PAST YEAR BY HIGH SCHOOL STUDENTS



Source: Maryland Youth Risk Behavior Survey

Over 14% of high school students in all counties in the service area seriously considered suicide, and over 10% of high school students created a plan to commit suicide.

EXHIBIT 48: HIGH SCHOOL STUDENT SUICIDALITY IN THE PAST YEAR



	Seriously Considered Suicide	Made a Suicide Plan
Maryland	18.1%	13.1%
Anne Arundel County	18.5%	14.1%
Baltimore City	20.6%	16.4%
Baltimore County	20.6%	17.1%
Howard County	15.7%	12.0%
Montgomery County	14.6%	10.8%
Prince George's County	16.8%	14.9%

Source: Maryland Youth Risk Behavior Survey, 2022

Behavioral Healthcare Workforce

A recent report found that Maryland employs about 50% of the necessary behavioral health workforce to meet the behavioral health needs of the State. The need is concentrated mainly in six behavioral health occupation categories: social and human services assistants (includes peer recovery specialists, outreach workers, and unlicensed case managers); counselors/therapists; psychiatric aides (help patients with daily tasks); social workers; psychologists; and psychiatrists. The number of people graduating with degrees in behavioral-health-related fields has declined compared to 2019 levels. Between 2014 and 2022, 70% of graduates of social work, clinical, and counseling psychology programs in Maryland work in other industries in Maryland, are employed out of state, or were not working one year after degree completion. The report found that the behavioral health workforce is insufficient to meet the State's demand for behavioral health services and that there is both high job turnover and low job satisfaction among many occupations, and the university pipeline, which would supply more behavioral health candidates in Maryland, has been increasingly less productive.[24]

EXHIBIT 49: BEHAVIORAL HEALTHCARE PROVIDER RATIOS

Ratio of People Per One Provider	Mental Health Provider	Clinical Social Workers
Maryland	742	753
Anne Arundel County	894	983
Baltimore City	336	325
Baltimore County	645	652
Howard County	619	680
Montgomery County	631	595
Prince George's County	1,201	1,377

Source: U.S. Centers for Medicare and Medicaid Services. National Plan and Provider Enumeration System, 2024

Maryland Health Care Commission

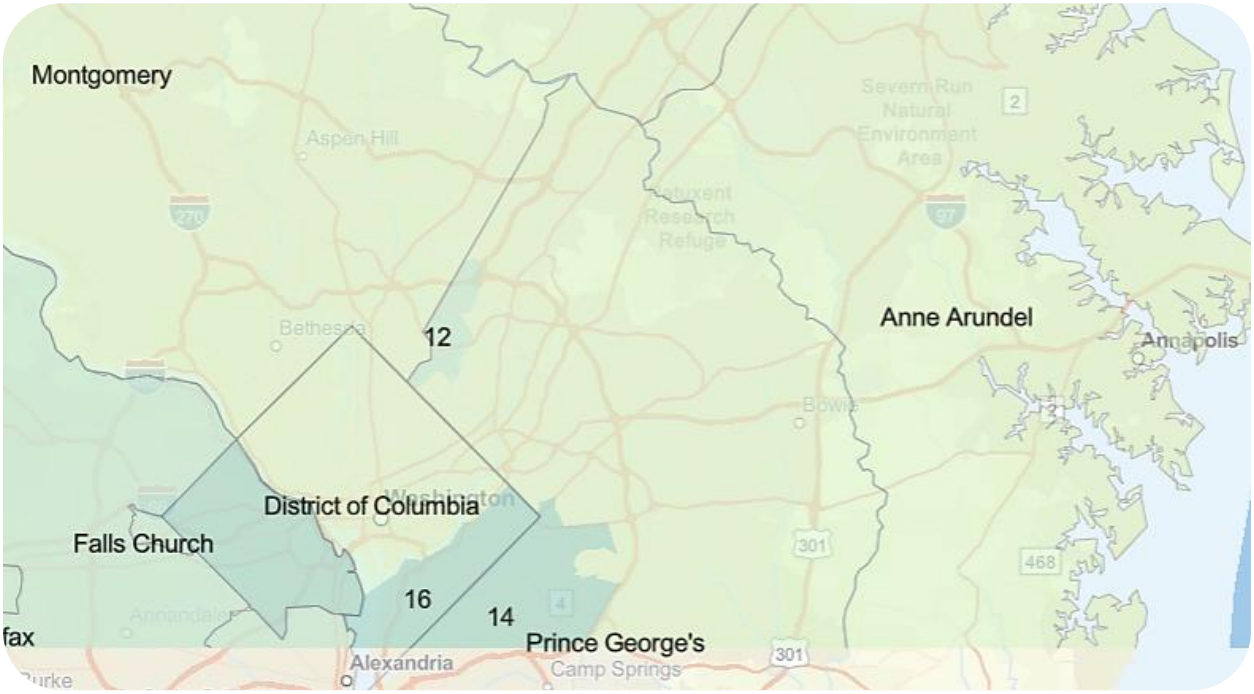
Six Strategies to Strengthen the Behavioral Health Workforce in Maryland

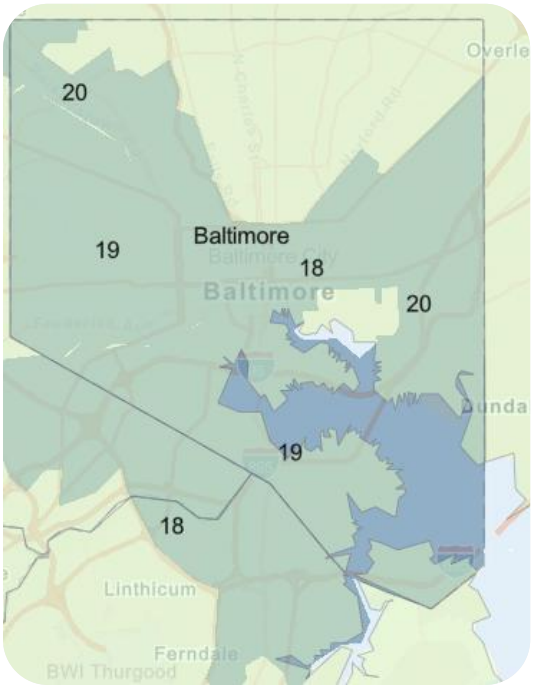
- Provide Competitive Compensation
- Increase Awareness of Behavioral Health Careers
- Support Paid Education and Training
- Promote Timely and Effective Licensing
- Invest in Job Quality
- Expand Impact of Current Workforce

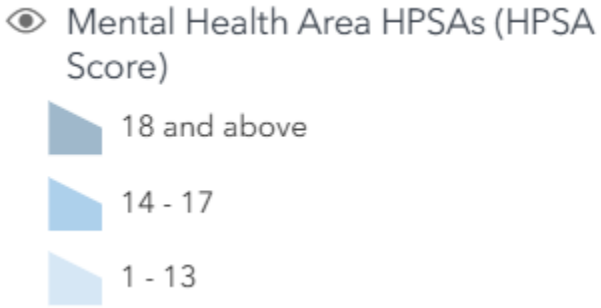
[24] Maryland Health Care Commission, Investing in Maryland's Behavioral Health Talent (2024) Link: https://marylandmatters.org/wp-content/uploads/2024/11/Full-Report_Maryland-BH-Workforce-Assessment-_Final-Oct-2024.pdf

Health Professional Shortage Areas are geographic areas, populations, or facilities with a shortage of primary, dental, or mental health care providers. The HPSA tool can be utilized to identify counties and states with the most severe provider shortages for a select variety of health care disciplines. **Scores range from 0 to 26, with a higher score indicating a greater need.** There are several locations, primarily centralized around Baltimore, with high HPSA scores.

EXHIBIT 50: MENTAL HEALTH PROFESSIONAL SHORTAGE AREAS





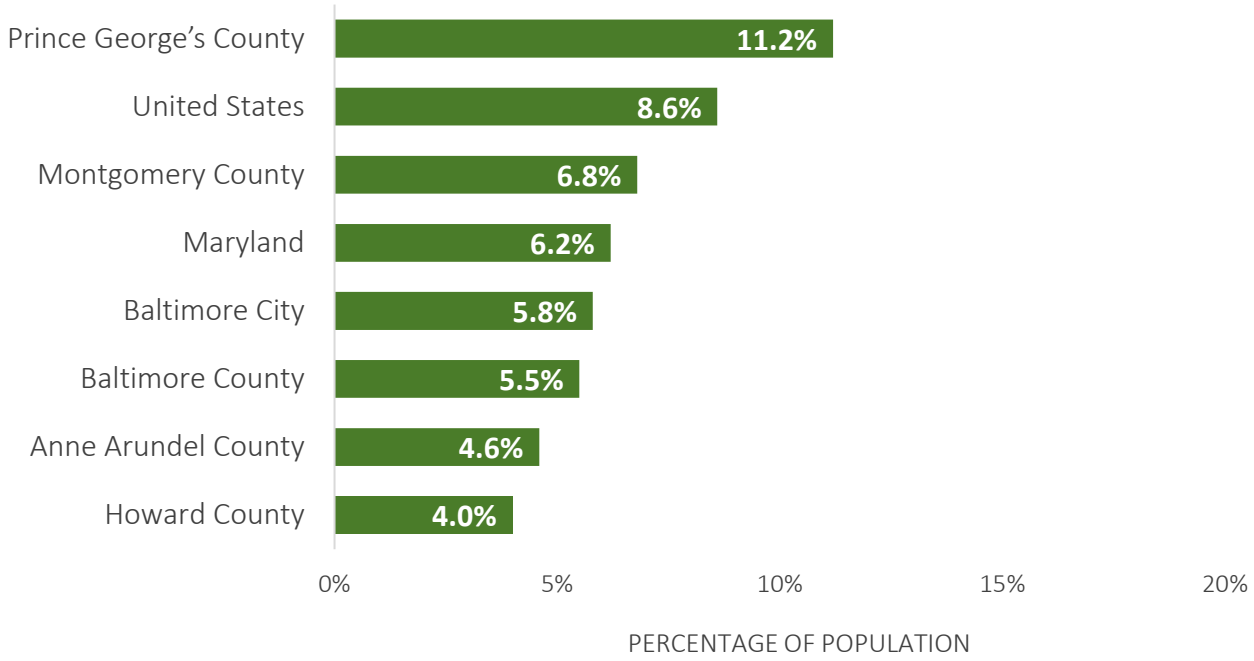


Source: Health Resources and Services Administration, 2/1/2025

Health Care Access and Quality

High cost-sharing and expenses not covered by insurance leave some with expensive medical bills. Many adults face additional barriers to accessing needed healthcare. Long appointment wait times, difficulty finding in-network providers and challenges traveling to providers at convenient times may lead some to delay or skip care. Even with insurance, people face difficulties finding a doctor who accepts insurance, finding an available appointment, getting to the provider or clinic when they are open and travel times to the provider.[25] Within the Sheppard Pratt service area, over 296,520 people are without health insurance coverage. In Prince George's County alone, over 106,140 people do not have health insurance.

EXHIBIT 51: POPULATION WITHOUT HEALTH INSURANCE



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

[25] Peterson-KFF Health System Tracker. Beyond cost, what barriers to health care do consumers face? 2024 https://www.healthsystemtracker.org/chart-collection/beyond-cost-what-barriers-to-health-care-do-consumers-face/#Percent%20of%20adults%20who%20delay%20or%20did%20not%20get%20health%20care,%20by%20type%20of%20care,%202022

EXHIBIT 52: POPULATION BY INSURANCE TYPE

	Total Population	With health insurance coverage	With private health insurance	With public coverage
United States	332,387,540	91.4%	67.3%	36.3%
Maryland	6,170,738	93.8%	73.4%	34.2%
Anne Arundel County	590,936	95.4%	81.2%	28.9%
Baltimore County	849,586	94.5%	73.4%	36.0%
Baltimore City	577,193	94.2%	58.5%	46.8%
Howard County	333,916	96.0%	83.4%	25.0%
Montgomery County	1,057,586	93.2%	76.0%	29.6%
Prince George's County	955,584	88.8%	66.5%	34.9%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

About the Data

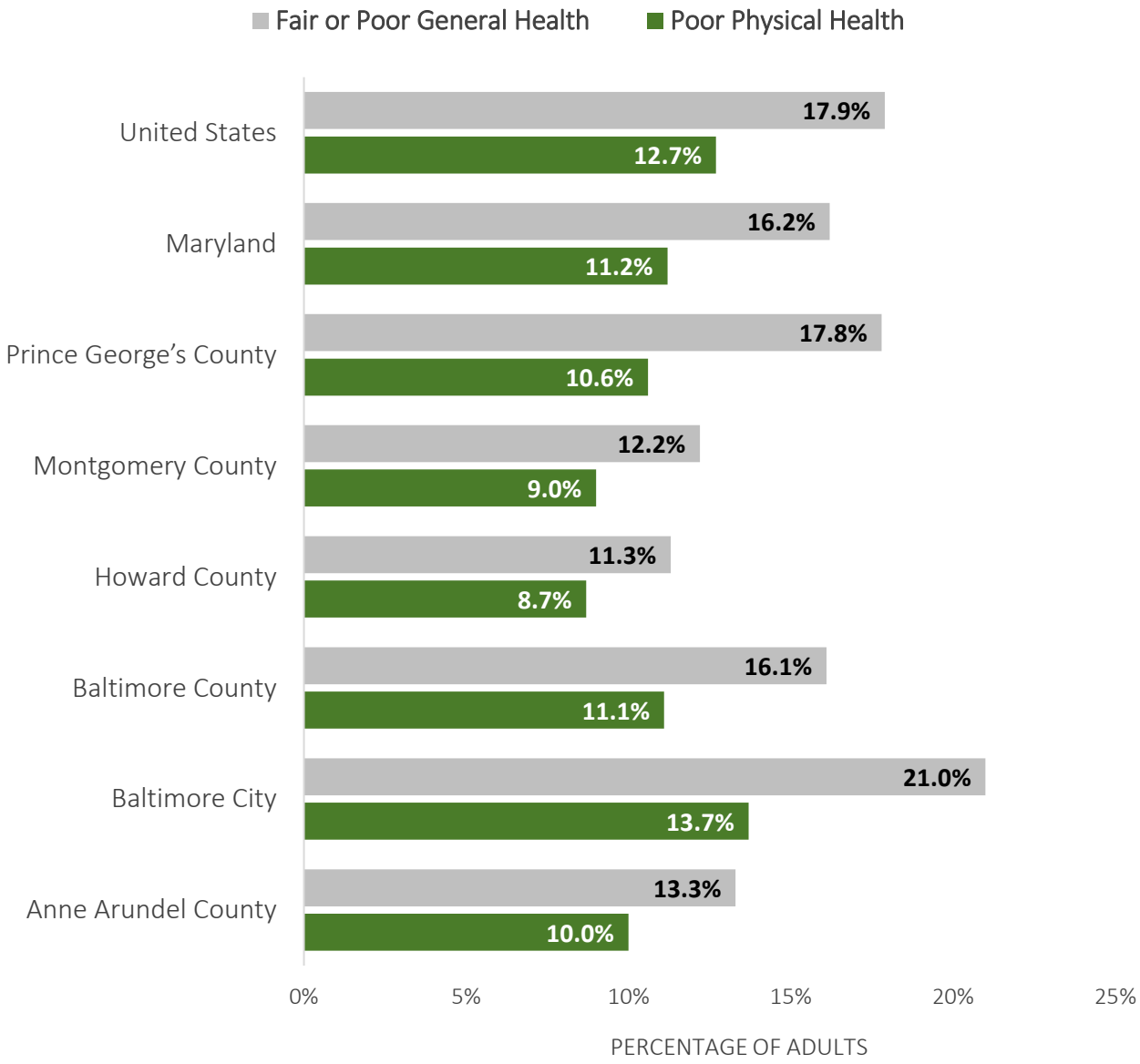
Private health insurance is a plan provided through an employer or union, a plan purchased by an individual from a private company, or TRICARE or other military health care.

Public coverage includes the federal programs Medicare, Medicaid, and VA Health Care (provided through the Department of Veterans Affairs); and the Children's Health Insurance Program (CHIP).

Health Status

Fair or Poor General Health: Estimated annual prevalence rate of adults aged 18 and over who report their general health status as "fair" or "poor". Poor Physical Health: Estimated annual prevalence rate of adults aged 18 and over who report 14 or more days during the past 30 days during which their physical health was not good.

EXHIBIT 53: SELF-REPORTED HEALTH STATUS[26]



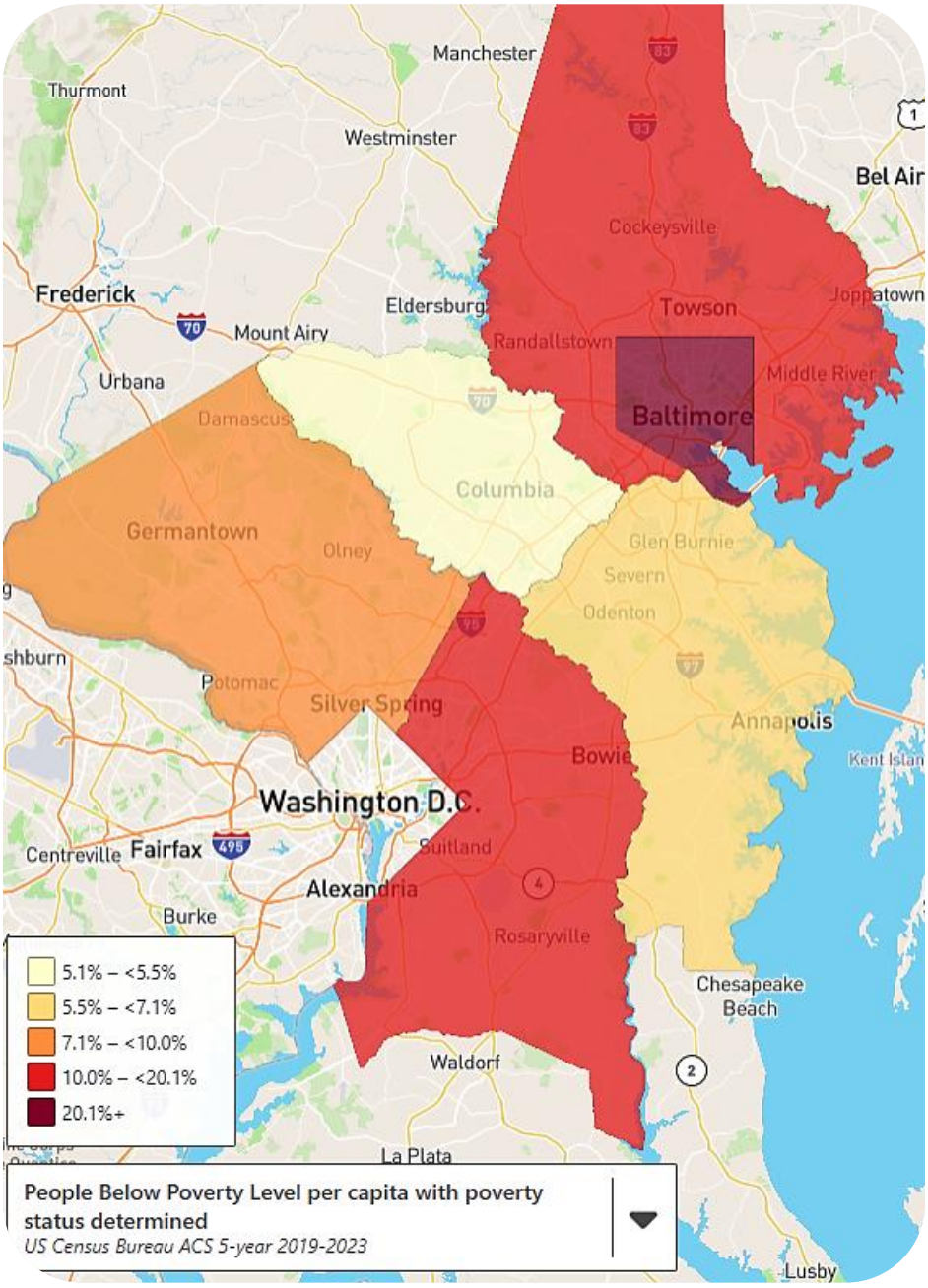
Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. PLACES, 2022

[26] **Fair of Poor General Health**: Estimated annual prevalence rate of adults aged 18 and over who report their general health status as "fair" or "poor". **Poor Physical Health:** Estimated annual prevalence rate of adults aged 18 and over who report 14 or more days during the past 30 days during which their physical health was not good.

Economic Stability

People with steady employment are less likely to live in poverty and more likely to be healthy, but many people have trouble finding and keeping a job. People with disabilities, injuries, or conditions like arthritis may be especially limited in their ability to work. In addition, many people with steady work still don't earn enough to afford the things they need to stay healthy.[27]

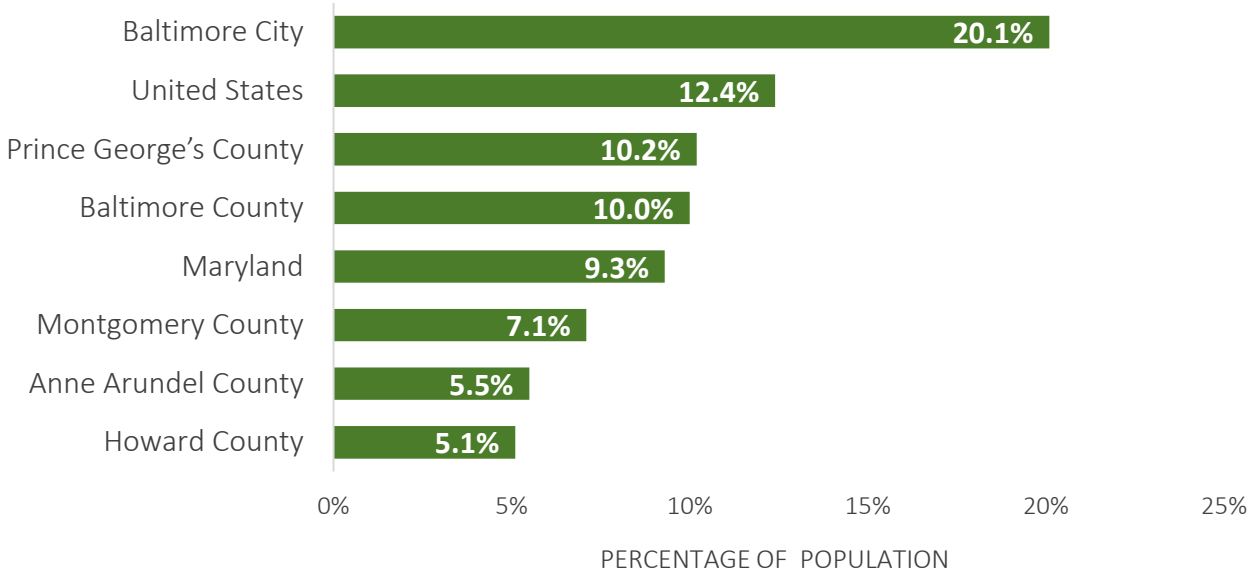
EXHIBIT 54: POPULATION LIVING IN POVERTY



[27] U.S. Department of Health and Human Services. Healthy People 2030. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability

Poverty and mental health are deeply interconnected, with poverty both contributing to and resulting from mental illness. Social, economic, and environmental factors shape mental well-being, requiring a multifaceted approach to support those affected and break the cycle between poverty and mental health challenges.[28]

EXHIBIT 55: POPULATION LIVING IN POVERTY



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

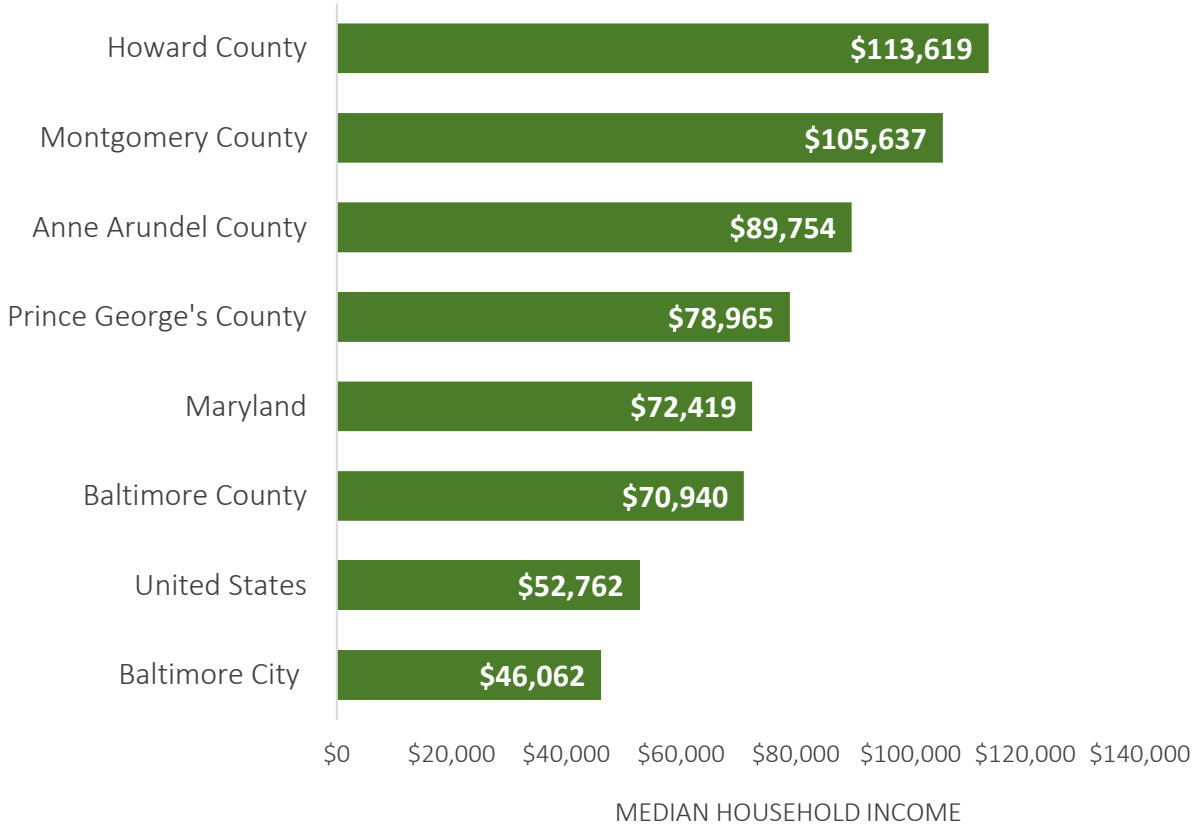
EXHIBIT 56: HOUSEHOLDS LIVING IN POVERTY, 2010-2023 PERCENT CHANGE

	2010	2023	2010-2023 Percent Change
United States	13.1%	12.5%	-5.2%
Maryland	8.4%	9.6%	+13.8%
Baltimore City	20.0%	20.3%	+1.8%
Baltimore County	7.8%	9.9%	+27.0%
Anne Arundel County	4.9%	5.6%	+13.7%
Howard County	4.0%	5.0%	+25.6%
Montgomery County	5.8%	7.1%	+22.4%
Prince George's County	7.1%	9.7%	+35.1%

U.S. Census Bureau American Community Survey One-year Estimates

[28] Mental Health Foundation, Poverty and mental health. https://www.mentalhealth.org.uk/explore-mental-health/publications/poverty-and-mental-health

EXHIBIT 57: MEDIAN HOUSEHOLD INCOME



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 58: MEDIAN HOUSEHOLD INCOME, 2010-2023 PERCENT CHANGE

	2010	2023	2010-2023 Percent Change
United States	$52,762	$77,719	+47.3%
Maryland	$72,419	$98,678	+36.3%
Anne Arundel County	$89,754	$117,650	+31.1%
Baltimore City	$46,062	$59,579	+16.0%
Baltimore County	$70,940	$87,056	+89.0%
Howard County	$113,619	$141,159	+24.2%
Montgomery County	$105,637	$125,371	+18.7%
Prince George's County	$78,965	$98,027	+24.1%

Source: U.S. Census Bureau American Community Survey One-year Estimates

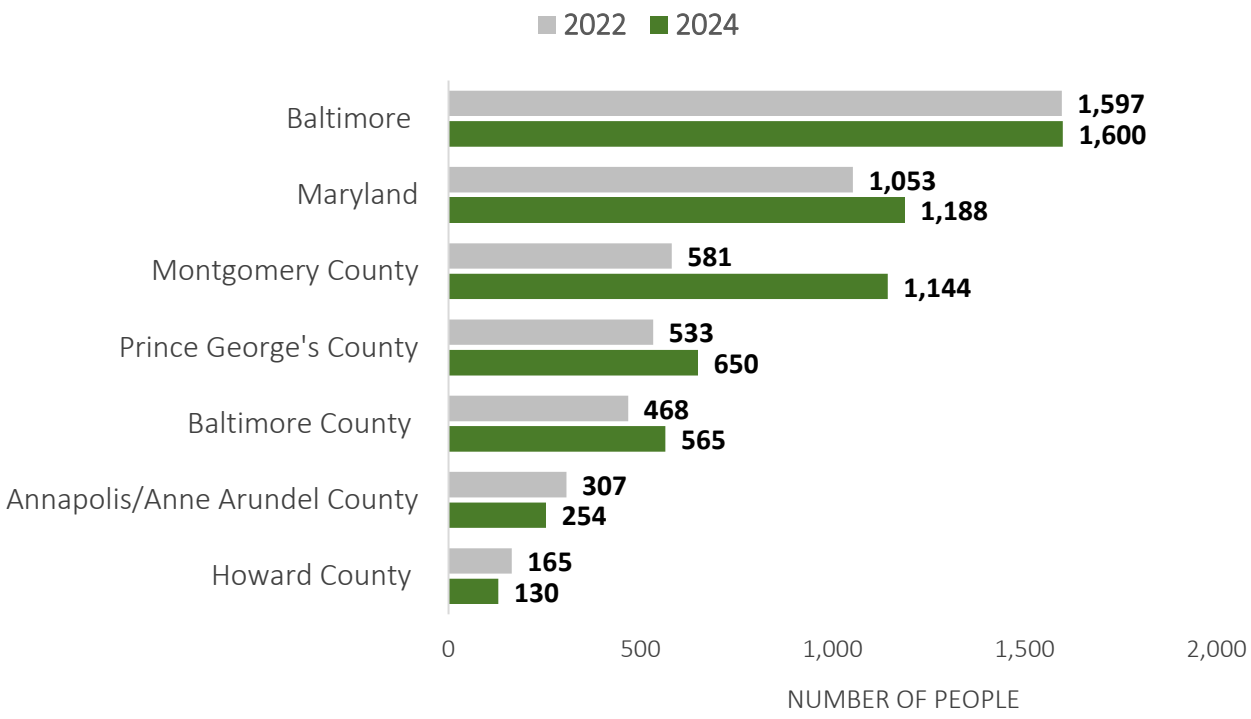
Neighborhood and Physical Environment

The neighborhoods people live in have a major impact on their health and well-being. The physical environment includes housing and transportation, parks and playgrounds, and the chances for recreational opportunities. [29] Neighborhood quality is shaped in part by how well individual homes are maintained, and widespread residential deterioration in a neighborhood can negatively affect the mental health of residents.[30]

Housing Insecurity

Lack of safe, affordable housing increases health risks by limiting access to necessities like food, medication, and transportation. High rent causes financial strain, while unsafe neighborhoods elevate injury risk and stress levels, impacting long-term health. Many affordable housing areas also lack grocery stores, contributing to obesity and diabetes, and have underfunded schools, affecting children's education.[31]

EXHIBIT 59: ANNUAL POINT-IN-TIME COUNTY BY CONTINUIM OF CARE LOCATION



Source: U.S. Department of Housing and Urban Development, HUD Exchange. CoC Homeless Populations and Subpopulations Reports, 2022 and 2024

[29] Kaiser Family Foundation. Beyond Healthcare: The Role of Social Determinants in Promoting Health & Health Equity, 2018. Link: https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

[30] U.S. Department of Health and Human Services. Healthy People 2030. Social Determinants of Health Literature Summaries: Quality of Housing. Link: https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/quality-housing

[31] University Health, Institute for Public Health. Impact of Housing Instability on Health. https://www.universityhealth.com/public-health/factors-shaping-health/economic-stability/housing

EXHIBIT 60: POINT-IN-TIME COUNTY BY POPULATION

	Severely Mentally Ill	Chronic Substance Abuse	Veterans	HIV/AIDS	Victims of Domestic Violence	Unaccompanied Youth	Parenting Youth
Maryland	238	154	84	3	129	45	12
Annapolis/Anne Arundel County	34	31	10	1	7	6	0
Baltimore	479	243	127	36	41	58	13
Baltimore County	78	32	15	8	11	14	3
Howard County	22	8	5	1	18	2	1
Montgomery County	30	25	5	1	10	8	0
Prince George's County	80	5	19	9	39	70	7

Source: U.S. Department of Housing and Urban Development, HUD Exchange. CoC Homeless Populations and Subpopulations Reports, 2024

Social and Community Context

People's relationships and interactions with family, friends, co-workers, and community members can have a major impact on their health and well-being. Many people face challenges and dangers they can't control — like unsafe neighborhoods, discrimination, or trouble affording the things they need. This can have a negative impact on health and safety throughout life.[32] Community violence happens between unrelated individuals, who may or may not know each other, generally outside the home. Examples include assaults or fights among groups and shootings in public places, such as schools and on the streets.[33]

In Maryland, protective orders—similar to restraining orders—require one person to avoid certain actions toward another. Between January 2021 and 2024, protective orders statewide rose by 75%. Baltimore County saw a 17.6% increase, Montgomery County nearly 11%, while Baltimore City (-16.4%) and Howard County (-14.1%).

EXHIBIT 61: DOMESTIC VIOLENCE PROTECTIVE ORDER

	January 2021				January 2024			
	Men	**Women**	**Unknown**	**Total**	**Men**	**Women**	**Unknown**	**Total**
Maryland	73.2%	24.7%	2.0%	**1,187**	72.2%	26.5%	1.3%	**2,079**
Anne Arundel County	76.3%	21.6%	2.2%	**139**	68.6%	30.7%	0.7%	**140**
Baltimore County	73.1%	25.2%	1.7%	**238**	73.2%	23.6%	3.2%	**280**
Baltimore City	67.7%	27.2%	5.2%	**232**	68.6%	30.9%	0.5%	**194**
Howard County	75.0%	23.4%	1.6%	**64**	80.0%	20.0%	0.0%	**55**
Montgomery County	77.7%	24.4%	0.9%	**220**	73.0%	27.0%	0.0%	**244**
Prince George's County	70.9%	26.5%	2.6%	**426**	73.4%	24.0%	2.6%	**459**

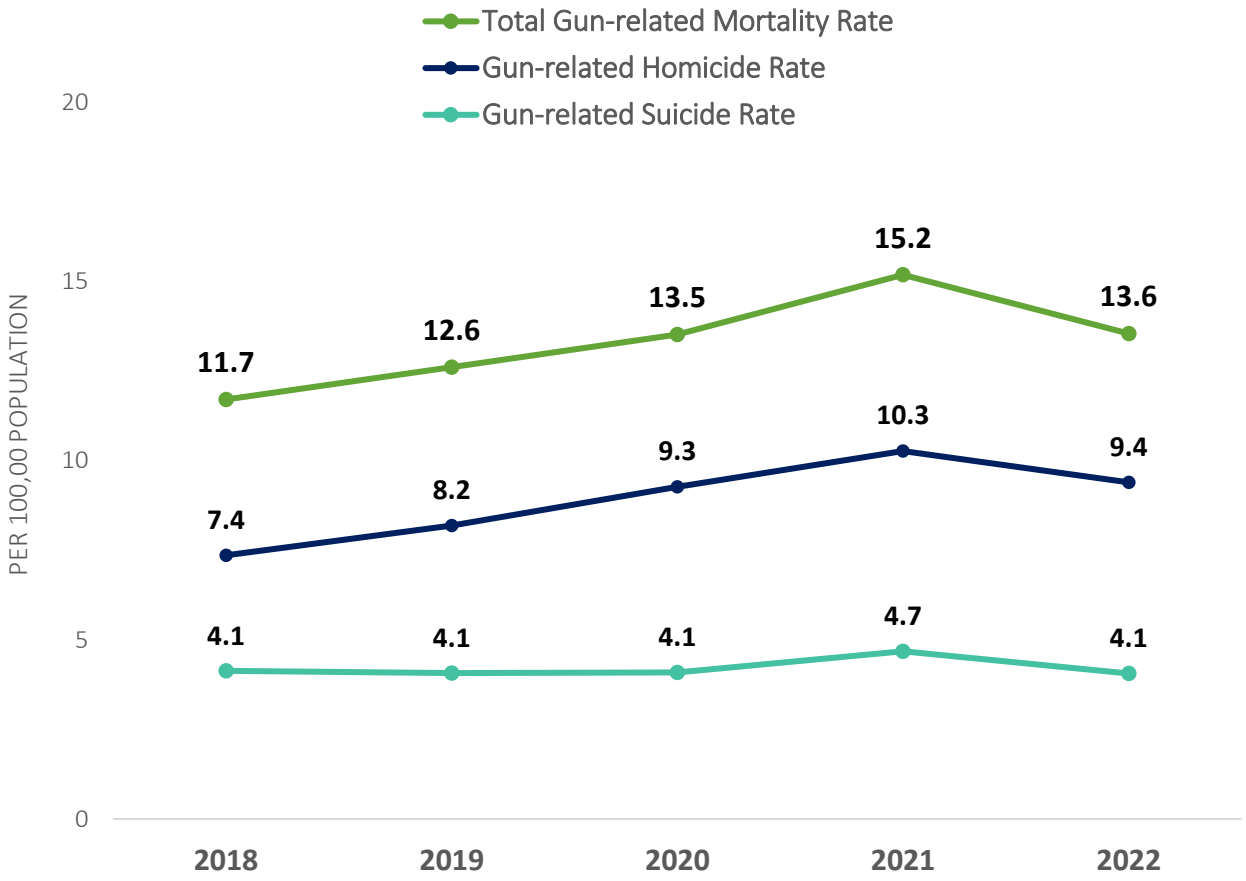
Source: State of Maryland. Administrative Office of the Courts, Domestic Violence Monthly Summary Reporting

[32] U.S. Department of Health and Human Services. Healthy People 2030. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/social-and-community-context

[33] U.S. CDC. National Center for Injury Prevention and Control, About Community Violence. https://www.cdc.gov/community-violence/about/index.html#cdc_behavioral_basics_what_cdc_is_doing-what-cdc-is-doing

Maryland had the 9th highest gun homicide rate in the country in 2022. Young people aged 15 to 34 accounted for 53% of all gun deaths in 2022. Firearms were the leading cause of death among children and teens ages 1-17 in 2022.[34]

EXHIBIT 62: GUN-RELATED MORTALITY RATES IN MARYLAND

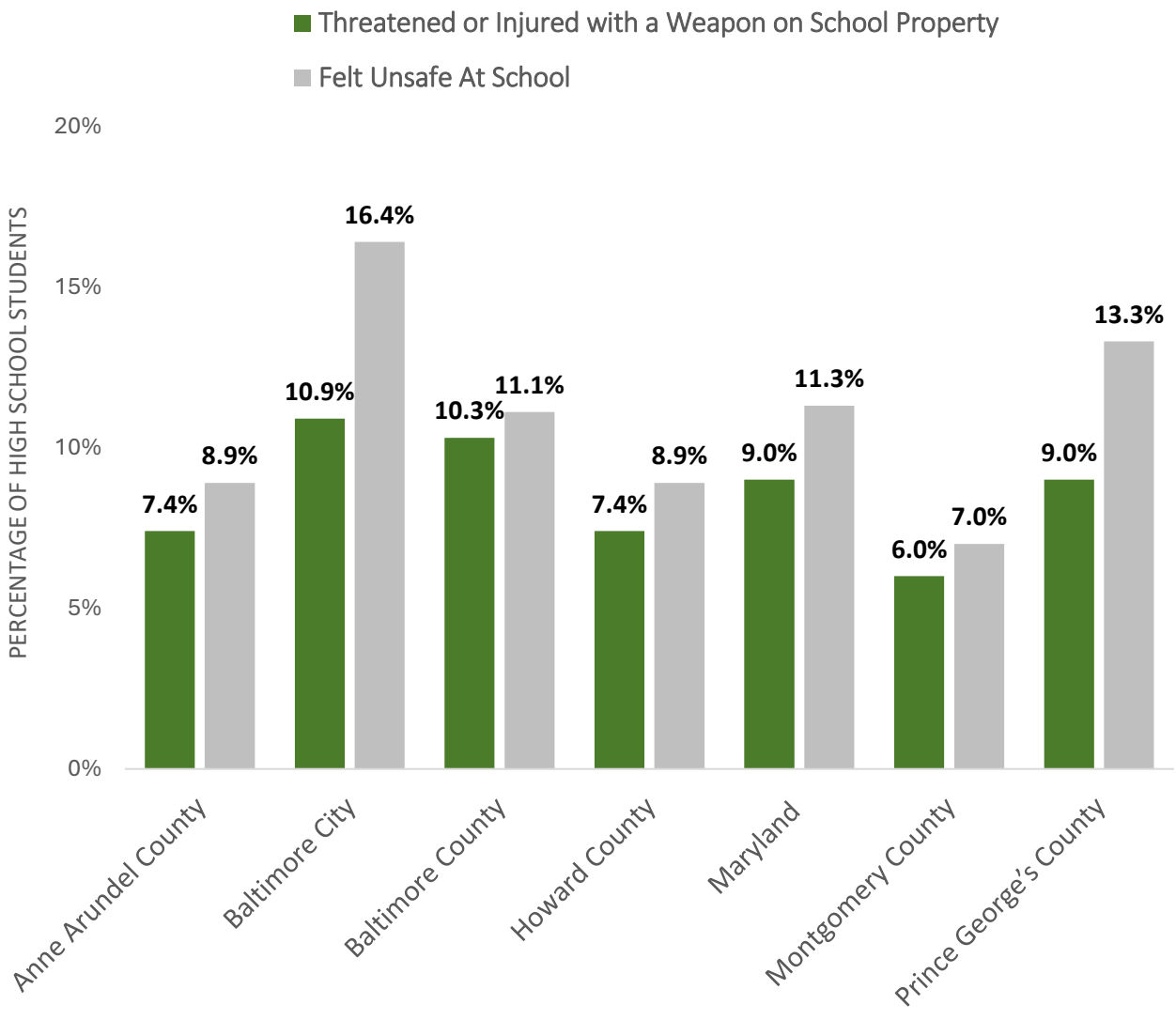


Source: Johns Hopkins Bloomberg School of Public Health, Center for Gun Violence Solutions

[34] Johns Hopkins University Center for Gun Violence Solutions. Gun Violence in the U.S. 2022: Examining the Burden Among Children and Teens. https://publichealth.jhu.edu/center-for-gun-violence-solutions/maryland

The data below indicates the percentage of high school students who were threatened or injured with a weapon on school property in the past year, as well as high school students' self-reported feeling unsafe at school in the past year in 2022.

EXHIBIT 63: YOUTH SCHOOL SAFTEY



Source: Maryland Youth Risk Behavior Survey, 2022

Needs Prioritization Process

The needs prioritization is a critical final step in the Community Health Needs Assessment process. The CHNA team analyzed the quantitative and qualitative research, and **17** community needs were identified. The following list outlines the community needs identified in the 2025 Community Health Needs Assessment for the Sheppard Pratt service area. **These needs are presented in alphabetical order, without prioritization.**

- Culturally responsive behavioral healthcare services for diverse populations, including access to interpreter services
- Develop and implement strategies to improve the retention of the behavioral healthcare workforce
- Enhance aftercare support services for patients following inpatient treatment
- Expand access to behavioral health crisis services for individuals in urgent need of care
- Expand access to family education and support programs
- Healthcare coverage to address gaps for uninsured individuals
- Implement behavioral healthcare outreach programs tailored for immigrant and non-English-speaking communities
- Improve access to behavioral healthcare services, including reducing wait times and increasing provider availability
- Increase access to behavioral health respite services
- Increase access to behavioral healthcare services tailored to the needs of neurodivergent individuals
- Increase access to behavioral healthcare services tailored to the needs of older adults
- Increase access to behavioral healthcare services tailored to the needs of youth
- Increase availability of behavioral healthcare services within schools
- Increase awareness of behavioral healthcare services
- Programs to reduce stigma associated with seeking behavioral healthcare services
- Quality, affordable, supportive housing for post-behavioral healthcare treatment
- Reliable, affordable, and accessible transportation options to behavioral healthcare facilities and other essential services

A vital part of the prioritization process included a pre-session survey using a modified Hanlon Method. Sheppard Pratt's CHNA work group were asked to rank each community need on a scale for magnitude, severity, and feasibility. **A priority score was calculated for each community need.**

EXHIBIT 64: INITIAL RANKING BASED ON WORK GROUP SURVEY

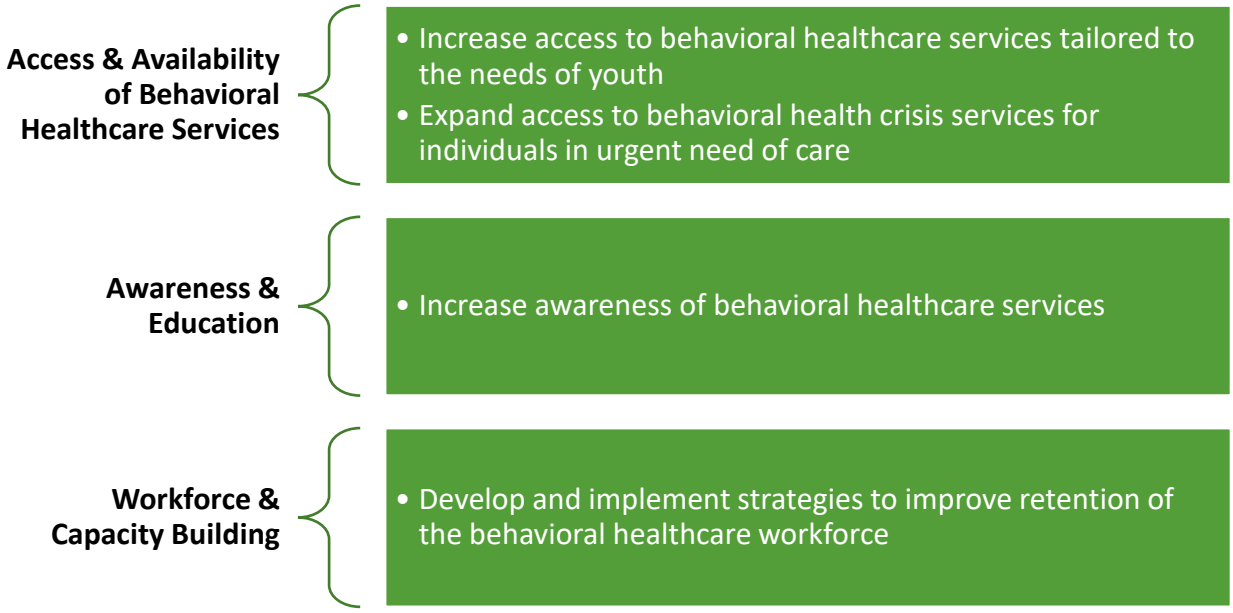
Rank	Need	Score
1	Increase access to behavioral healthcare services tailored to the needs of youth	11.0
2	Expand access to behavioral health crisis services for individuals in urgent need of care	12.0
3	Improve access to behavioral healthcare services, including reducing wait times and increasing provider availability	12.9
4	Develop and implement strategies to improve the retention of the behavioral healthcare workforce	12.9
5	Increase availability of behavioral healthcare services within schools	14.5
6	Increase awareness of behavioral healthcare services	15.6
7	Quality, affordable, supportive housing for post-behavioral healthcare treatment	15.7
8	Increase access to behavioral healthcare services tailored to the needs of neurodivergent individuals	17.2
9	Expand access to family education and support programs	17.7
10	Enhance aftercare support services for patients following inpatient treatment	18.0
11	Reliable, affordable, and accessible transportation options to behavioral healthcare facilities and other essential services	20.0
12	Healthcare coverage to address gaps for uninsured individuals	20.3
13	Programs to reduce stigma associated with seeking behavioral healthcare services	20.6
14	Increase access to behavioral healthcare services tailored to the needs of older adults	21.0
15	Increase access to behavioral health respite services	21.6
16	Culturally responsive behavioral healthcare services for diverse populations, including access to interpreter services	23.5
17	Implement behavioral healthcare outreach programs tailored for immigrant and non-English-speaking communities	24.3

*Please note that the lowest scores indicate the highest priority.

Final List of Needs

To conduct the final prioritization, Sheppard Pratt's leadership team met virtually on April 18, 2025. During the meeting, they reviewed high-level findings from both quantitative and qualitative research, discussed the identified community health needs, and participated in an open discussion. This discussion provided an opportunity for the leadership team to highlight any needs they found surprising, identify any gaps in the list of needs, and consider factors such as the magnitude and severity of each need, potential barriers to addressing them, and opportunities for collaboration with community partners.

Through this process, the Sheppard Pratt leadership team highlighted **three** priority areas to focus on within the next three years. These priorities will serve as the foundation for future community health improvement strategies.



Appendices

Appendix A: Supplementary Secondary Research

Appendix B: Stakeholder Interview Guide

Appendix C: Focus Group Moderator's Guide

Appendix D: Community Survey

Appendix A: Supplementary Secondary Research

Demographics

EXHIBIT 65: POPULATION GROWTH

	2006-2010	2019-2023	Percent Change
United States	303,965,272	332,387,540	+9.4%
Maryland	5,696,423	6,170,738	+8.3%
Anne Arundel County	527,020	590,936	+12.1%
Baltimore City	620,538	577,193	-7.0%
Baltimore County	799,195	849,586	+6.3%
Howard County	279,366	333,916	+19.5%
Montgomery County	947,230	1,057,586	+11.7%
Prince George's County	854,722	955,584	+11.8%

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

EXHIBIT 66: POPULATION BY GENDER

	Male	Female
United States	49.5%	50.5%
Maryland	48.7%	51.3%
Anne Arundel County	49.5%	50.5%
Baltimore County	47.6%	52.4%
Baltimore City	46.6%	53.4%
Howard County	49.3%	50.7%
Montgomery County	48.7%	51.3%
Prince George’s County	48.4%	51.6%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 67: MEDIAN AGE

	Median Age
United States	38.7
Maryland	39.3
Anne Arundel County	39.0
Baltimore County	39.5
Baltimore City	36.1
Howard County	39.4
Montgomery County	39.3
Prince George’s County	38.5

Source: U.S. Census Bureau, 2019-2023 American Community Survey Five-year Estimates

EXHIBIT 68: U.S. CITIZENSHIP

	Naturalized U.S. citizen	Not a U.S. citizen
United States	7.3%	6.6%
Maryland	8.8%	7.4%
Anne Arundel County	5.7%	4.1%
Baltimore County	7.5%	5.3%
Baltimore City	4.2%	4.7%
Howard County	14.7%	7.5%
Montgomery County	19.2%	14.2%
Prince George's County	10.7%	14.1%

Source: U.S. Census Bureau, 2019-2023 American Community Survey Five-year Estimates

Population Living with a Disability

EXHIBIT 69: DISABILITY BY TYPE

	Ambulatory Difficulties	Cognitive Difficulties	Hearing Difficulties	Vision Difficulties	Independent Living Difficulties	Self-Care Difficulties
United States	6.3%	5.1%	3.6%	2.4%	4.5%	2.4%
Maryland	5.4%	4.5%	2.7%	1.9%	3.9%	2.1%
Anne Arundel County	4.9%	4.2%	2.9%	1.4%	3.4%	1.7%
Baltimore County	5.6%	4.6%	2.8%	2.1%	4.3%	2.1%
Baltimore City	8.6%	7.0%	2.6%	3.0%	5.5%	2.9%
Howard County	3.5%	3.4%	2.1%	1.3%	3.2%	1.8%
Montgomery County	4.0%	3.5%	2.5%	1.5%	3.3%	1.8%
Prince George's County	5.4%	3.7%	1.9%	1.8%	3.5%	1.9%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 70: POPULATION LIVING WITH A DISABILITY BY AGE

	Under 5	5 to 17	18 to 34	35 to 64	65 to 74	75 and Over
United States	0.7%	6.1%	7.7%	12.4%	24.0%	46.5%
Maryland	0.5%	5.6%	7.0%	10.4%	20.9%	42.8%
Anne Arundel County	0.4%	6.1%	6.3%	9.6%	20.1%	40.6%

Baltimore County	0.4%	5.5%	7.3%	10.7%	19.5%	43.6%
Baltimore City	0.4%	7.9%	9.1%	18.6%	33.6%	50.7%
Howard County	0.5%	4.9%	5.7%	6.4%	14.4%	41.2%
Montgomery County	0.6%	4.5%	6.0%	6.8%	15.7%	40.5%
Prince George's County	0.5%	4.3%	5.6%	9.9%	21.8%	42.1%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 71: POPULATION LIVING WITH A DISABILITY BY RACE

	American Indian and Alaska Native	Asian	Black or African American	Native Hawaiian and Other Pacific Islander	Some Other	Two or More Races	White
United States	15.7%	7.9%	14.5%	12.7%	10.0%	10.9%	13.9%
Maryland	12.1%	7.1%	12.3%	9.6%	5.8%	9.5%	12.3%
Anne Arundel County	6.5%	5.0%	10.7%	9.4%	7.1%	8.6%	11.6%
Baltimore County	13.9%	7.5%	19.0%	19.2%	8.8%	13.9%	13.5%
Baltimore City	24.3%	6.4%	10.4%	5.1%	6.9%	10.5%	13.5%
Howard County	17.8%	5.4%	8.8%	0.0%	5.2%	7.2%	9.9%
Montgomery County	8.2%	7.8%	9.1%	3.3%	5.6%	8.3%	10.6%
Prince George's County	14.5%	9.5%	11.3%	24.1%	4.3%	9.2%	12.4%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 72: POPULATION LIVING WITH A DISABILITY BY ETHCNITY

	Hispanic or Latino
United States	9.9%
Maryland	6.8%
Anne Arundel County	6.6%
Baltimore County	7.5%
Baltimore City	7.9%
Howard County	7.1%
Montgomery County	7.1%
Prince George's County	5.0%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

Education

EXHIBIT 73: EDUCATIONAL ATTAINMENT

	Less than 9th Grade	9th to 12th Grade, No Diploma	High School Degree	Some College No Degree	Associate's Degree	Bachelor's Degree	Graduate Degree
United States	4.7%	5.9%	26.2%	19.4%	8.8%	21.3%	13.7%
Maryland	4.0%	5.0%	23.7%	17.7%	6.9%	22.5%	20.3%
Anne Arundel County	2.3%	3.9%	22.0%	19.5%	7.1%	25.1%	20.1%
Baltimore City	4.1%	8.7%	27.9%	18.4%	5.5%	18.1%	17.3%
Baltimore County	3.3%	5.0%	24.2%	18.7%	7.4%	23.1%	18.3%
Howard County	2.6%	2.2%	12.4%	12.5%	5.9%	30.7%	33.8%
Montgomery County	5.1%	3.6%	13.5%	12.1%	5.4%	27.2%	33.1%
Prince George's County	7.8%	5.5%	25.3%	19.0%	6.4%	20.3%	15.8%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 74: BACHELOR'S DEGREE OR HIGHER BY RACE

	American Indian and Alaska Native	Asian	Black or African American	Native Hawaiian and Other Pacific Islander	Some Other	Two or More Races	White
United States	16.2%	57.0%	24.7%	19.0%	15.6%	28.2%	37.7%
Maryland	23.6%	64.7%	33.4%	41.7%	17.0%	44.1%	47.7%
Baltimore City	19.1%	73.3%	20.0%	19.2%	17.3%	48.4%	62.2%
Baltimore County	18.8%	57.4%	34.3%	62.9%	19.0%	39.0%	44.5%
Anne Arundel County	30.6%	55.0%	38.8%	34.0%	25.6%	46.0%	47.4%
Howard County	38.2%	71.9%	55.0%	52.1%	33.9%	57.8%	67.8%
Montgomery County	28.5%	68.6%	46.3%	45.4%	19.6%	53.1%	72.5%
Prince George's County	17.7%	56.8%	37.1%	41.7%	10.2%	35.5%	49.9%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 75: BACHELOR'S DEGREE OR HIGHER BY ETHNICITY

	Hispanic or Latino
United States	19.9%
Maryland	25.4%
Anne Arundel County	33.4%
Baltimore City	31.3%
Baltimore County	29.0%
Howard County	42.3%
Montgomery County	28.8%
Prince George's County	13.6%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

Economic Stability

EXHIBIT 76: POPULATION LIVING IN POVERTY BY AGE

	Under Five	Under 18	18-64	65 and Older
United States	17.6%	16.3%	11.6%	10.4%
Maryland	12.1%	11.5%	8.6%	9.0%
Anne Arundel County	5.4%	5.8%	5.3%	5.8%
Baltimore City	25.5%	26.4%	17.8%	20.9%
Baltimore County	13.9%	12.9%	8.9%	10.1%
Howard County	6.2%	5.5%	5.0%	4.9%
Montgomery County	9.6%	8.4%	6.5%	7.2%
Prince George's County	12.7%	13.7%	9.3%	8.8%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 77: POPULATION LIVING IN POVERTY BY RACE

	American Indian and Alaska Native	Asian	Black or African American	Native Hawaiian and Other Pacific Islander	Some Other	Two or More Races	White
United States	21.8%	9.9%	21.3%	17.2%	18.2%	14.7%	9.9%
Maryland	11.8%	7.6%	13.0%	9.6%	15.2%	9.9%	6.5%
Anne Arundel County	11.7%	6.6%	8.4%	23.9%	11.4%	6.3%	4.1%
Baltimore City	12.6%	21.2%	23.6%	1.0%	25.2%	16.3%	12.1%
Baltimore County	11.9%	10.2%	11.8%	6.8%	18.1%	13.7%	8.1%
Howard County	10.7%	3.7%	11.7%	0.0%	7.7%	4.1%	3.0%
Montgomery County	9.1%	6.0%	11.4%	10.9%	13.0%	7.7%	4.0%
Prince George's County	14.4%	14.4%	8.8%	16.2%	15.1%	10.8%	9.2%

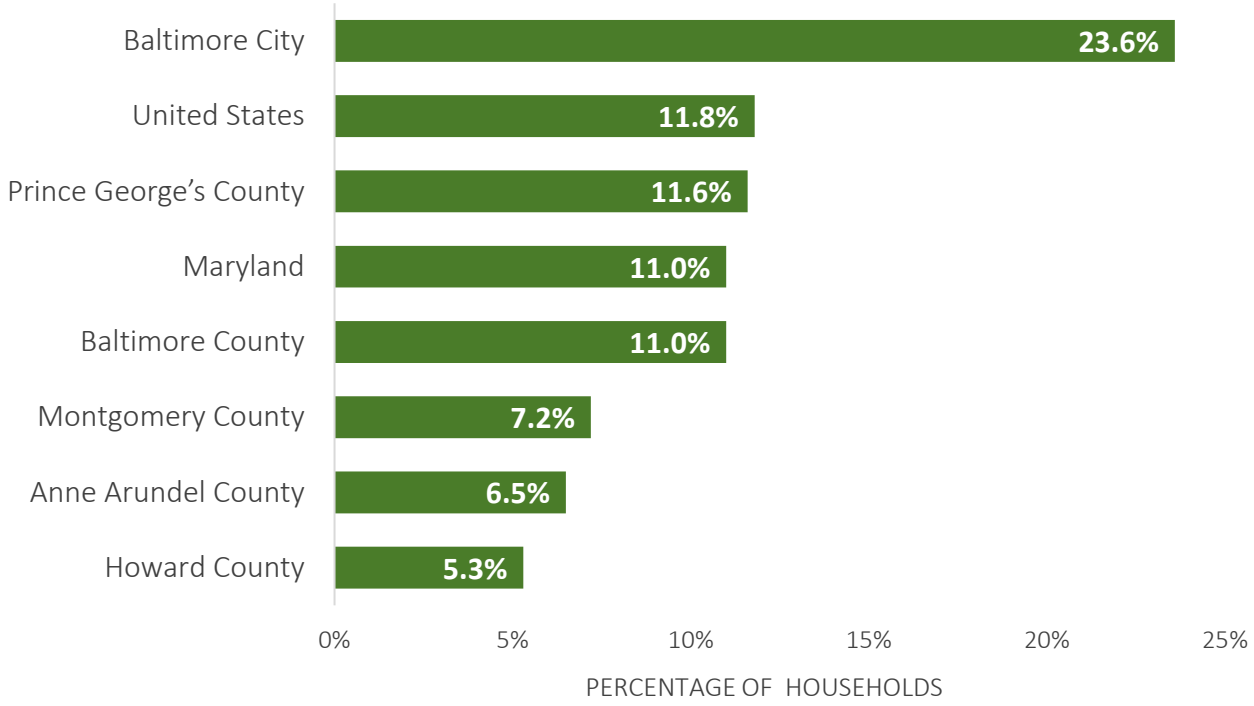
Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 78: POPULATION LIVING IN POVERTY BY ETHNICITY

	Hispanic or Latino
United States	16.9%
Maryland	12.3%
Anne Arundel County	7.8%
Baltimore City	19.7%
Baltimore County	15.3%
Howard County	6.0%
Montgomery County	10.7%
Prince George's County	13.9%

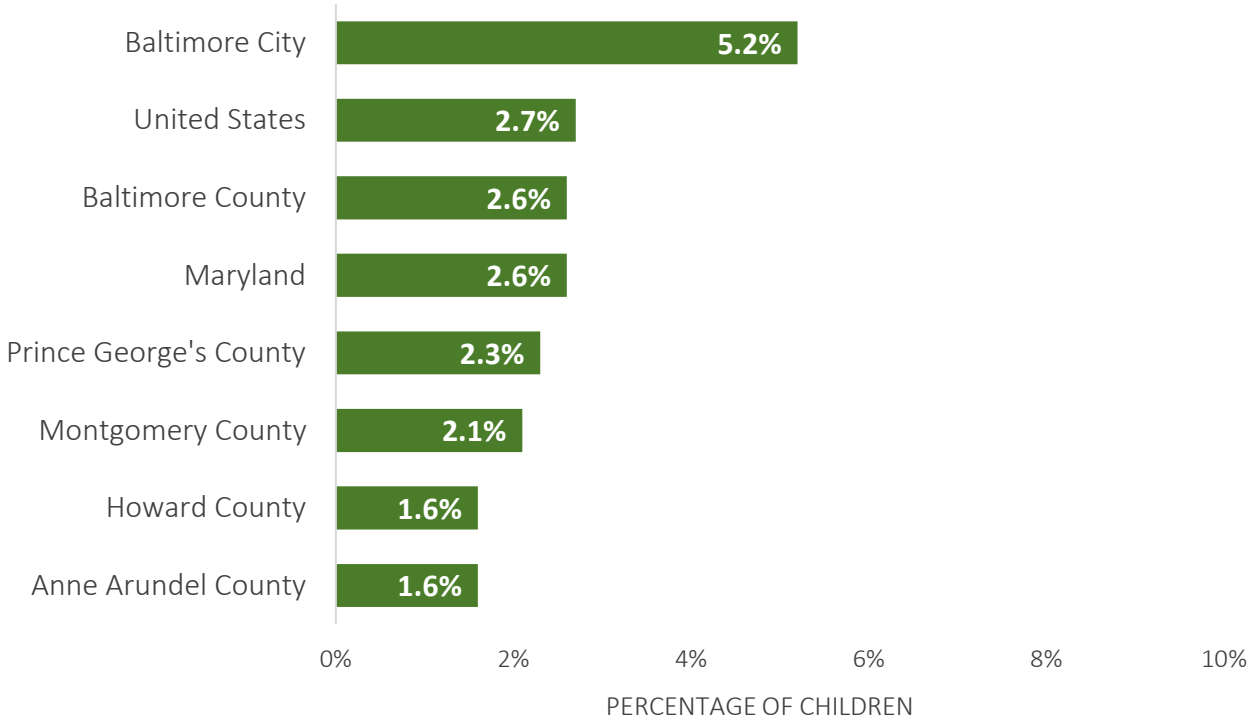
Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 79: HOUSEHOLDS RECEIVING FOOD STAMPS/SNAP



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 80: CHILDREN IN HOUSEHOLDS RECEIVING PUBLIC ASSISTANCE INCOME



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 81: MEDIAN HOUSEHOLD INCOME BY RACE

	American Indian and Alaska Native	Asian	Black or African American	Native Hawaiian and Other Pacific Islander	Some Other	Two or More Races	White
United States	$59,393	$113,106	$53,444	$78,640	$65,558	$73,412	$83,784
Maryland	$74,577	$130,232	$81,904	$113,706	$81,821	$103,920	$113,334
Baltimore City	$39,079	$72,125	$47,464	$112,610	$52,159	$68,765	$93,316
Baltimore County	$60,893	$105,544	$77,905	$237,045	$62,104	$87,934	$100,199
Anne Arundel County	$88,790	$124,179	$103,235	$NA	$96,641	$123,982	$127,576
Howard County	ND	$176,094	$115,632	$NA	$87,508	$129,580	$158,829
Montgomery County	$105,952	$144,493	$89,362	$142,589	$83,317	$118,278	$159,895
Prince George's County	$51,806	$110,359	$100,334	$80,474	$89,449	$103,273	$110,160

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

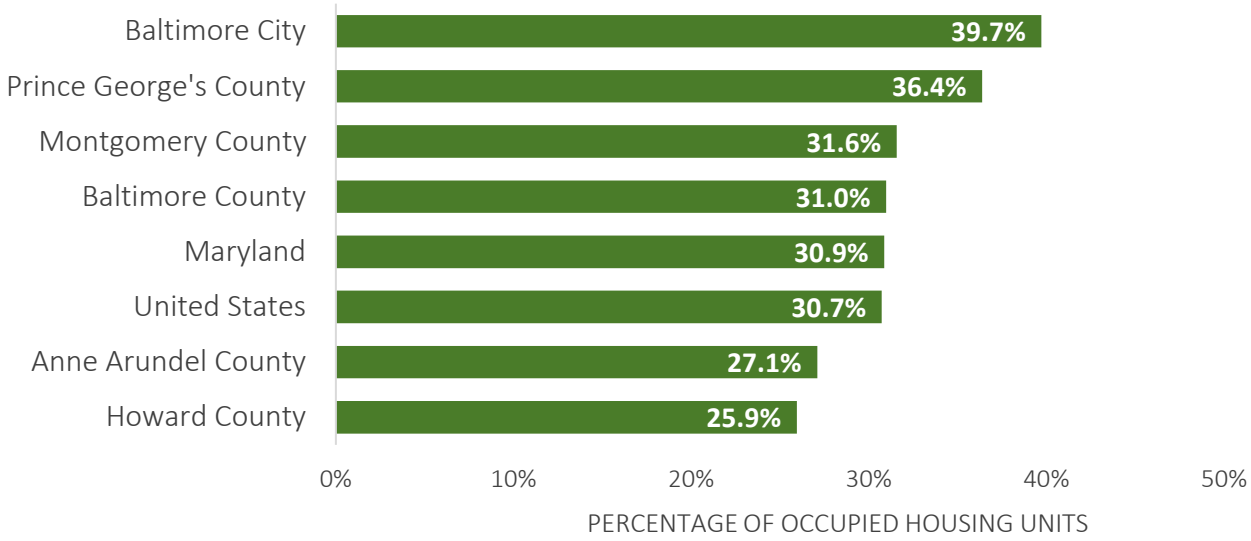
EXHIBIT 82: MEDIAN HOUSEHOLD INCOME BY ETHNICITY

	Hispanic or Latino
United States	$68,890
Maryland	$90,334
Baltimore City	$58,840
Baltimore County	$79,688
Anne Arundel County	$108,601
Howard County	$112,425
Montgomery County	$94,619
Prince George's County	$90,083

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

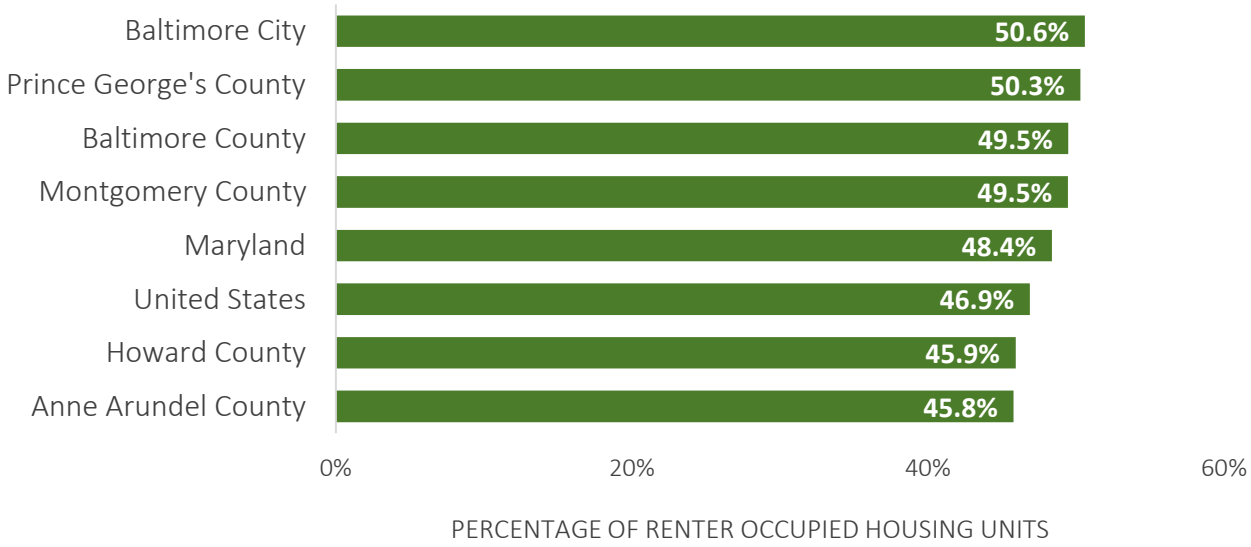
Neighborhood and Physical Environment

EXHIBIT 83: HOUSING COST-BURDENED[35]



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 84: RENTER EXCESSIVE HOUSING COSTS[36]



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

[35] **Housing Cost Burdened**: Percentage of occupied housing units whose selected monthly costs as a percentage of household income is greater than 30%. This is a combination of both owner-occupied and renter-occupied housing units.
[36] **Renter Excessive Housing Costs:** Percentage of renter occupied housing units whose selected monthly costs as a percentage of household income is greater than 30%.

EXHIBIT 85: HOUSEHOLD COMPOSITION

	Household with Children	Households with Grandparents Responsible for Grandchildren	Single Householder Family with Children
United States	29.9%	1.3%	8.5%
Maryland	31.0%	1.3%	8.8%
Baltimore City	22.6%	1.6%	11.0%
Baltimore County	29.3%	1.1%	9.0%
Anne Arundel County	32.2%	0.8%	7.8%
Howard County	37.1%	1.0%	7.3%
Montgomery County	33.9%	0.7%	7.2%
Prince George's County	31.3%	2.1%	10.7%

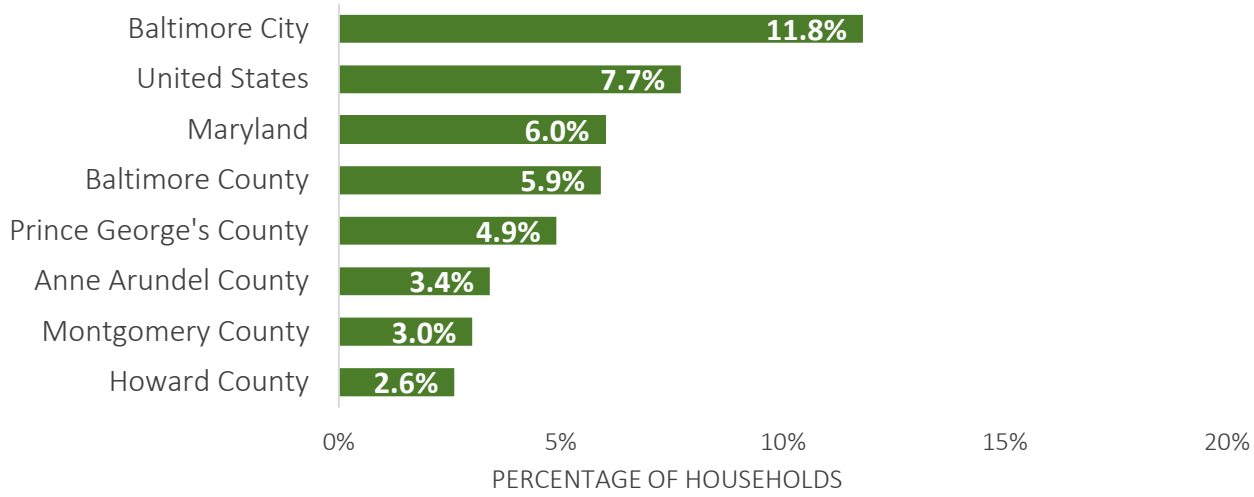
Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 86: TRANSPORTATION INDICATORS

	No Vehicles Available per Household	Mean Travel Time to Work (in minutes)	Commute Transportation by Public Transit	Commute Transportation by Drive Alone
United States	8.3%	26.6	3.5%	70.2%
Maryland	8.7%	31.5	4.9%	66.3%
Baltimore City	3.9%	29.4	11.5%	56.8%
Baltimore County	8.0%	28.3	3.0%	71.4%
Anne Arundel County	26.6%	29.4	1.9%	72.1%
Howard County	3.9%	28.8	1.9%	67.4%
Montgomery County	8.2%	32.4	8.5%	54.2%
Prince George's County	9.2%	35.5	8.6%	61.2%

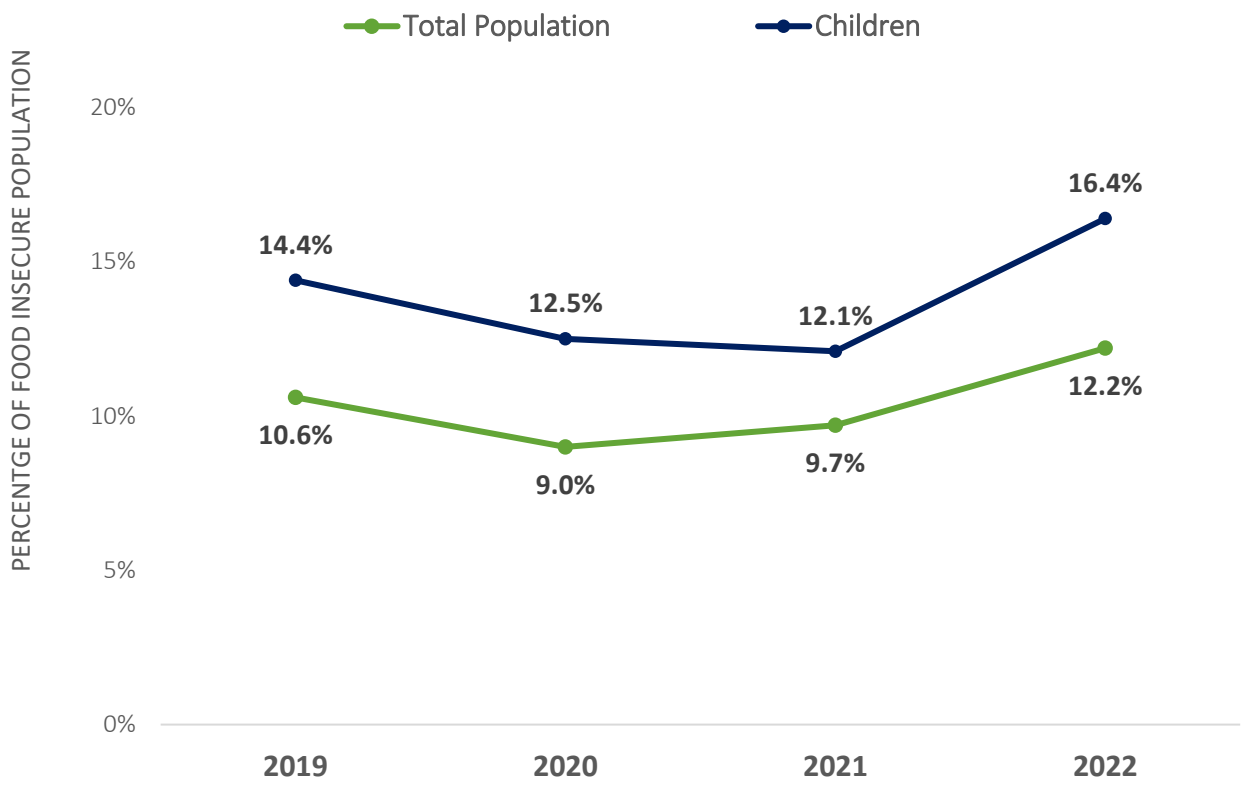
Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 87: HOUSEHOLD WITHOUT INTERNET ACCESS



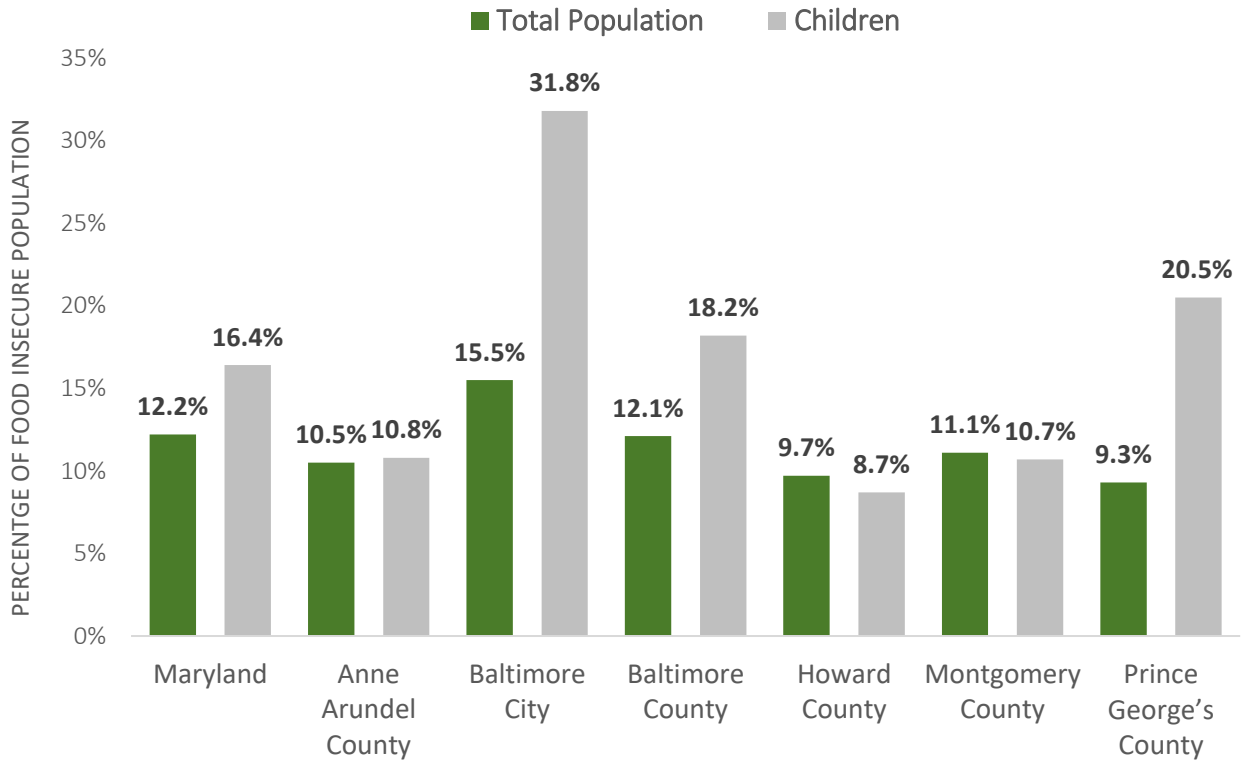
Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 88: TREND OF FOOD INSECURITY IN MARYLAND



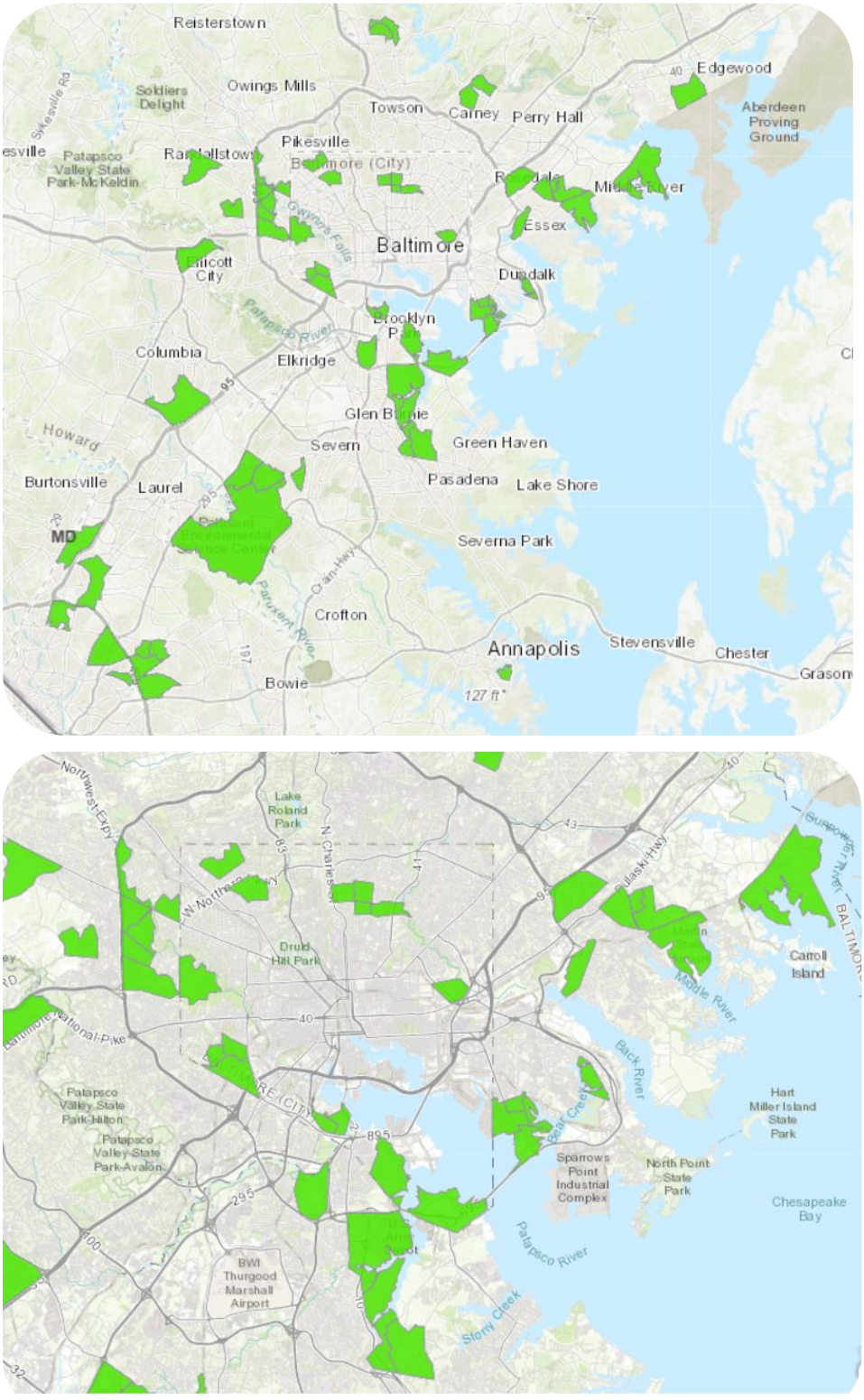
Source: Feeding America

EXHIBIT 89: FOOD INSECRUITY



Source: Feeding America, 2022

EXHIBIT 90: FOOD DESERTS[37]



Source: U.S. Department of Agriculture, Economic Research Services. Food Access Research Atlas, 2023

[37] The Food Access Research Atlas indicates low-income census tracts where a substantial number or share of residents is more than one mile (urban) or 10 miles (rural) from the nearest supermarket. The green shaded areas on the map indicate food deserts.

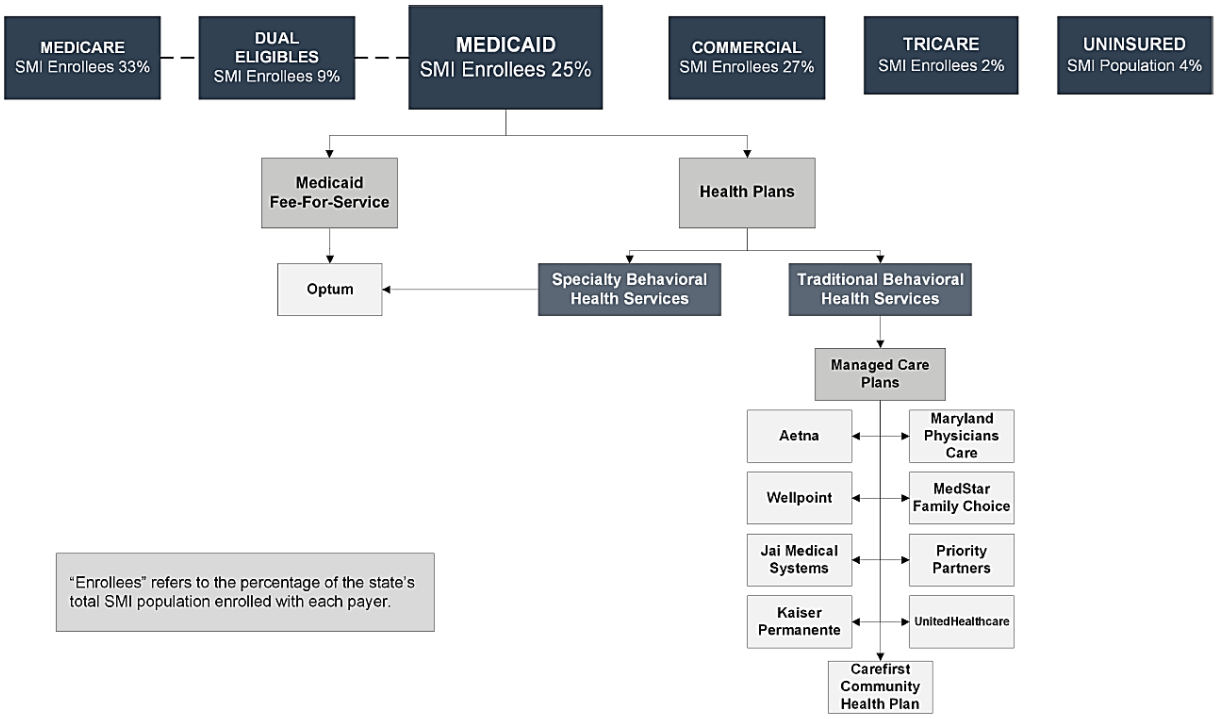
Health Care

EXHIBIT 91: POPULATION WITHOUT HEALTH INSURANCE BY AGE

	Under 6	6 to 18	19 to 64	65 and Over
United States	4.5%	5.8%	12.0%	0.8%
Maryland	3.8%	4.4%	8.4%	1.0%
Anne Arundel County	2.1%	4.6%	7.7%	0.6%
Baltimore County	4.4%	5.1%	7.0%	0.9%
Baltimore City	2.6%	2.2%	6.6%	0.7%
Howard County	2.6%	3.0%	5.3%	0.9%
Montgomery County	3.0%	3.6%	9.7%	1.6%
Prince George's County	6.4%	8.7%	14.6%	1.8%

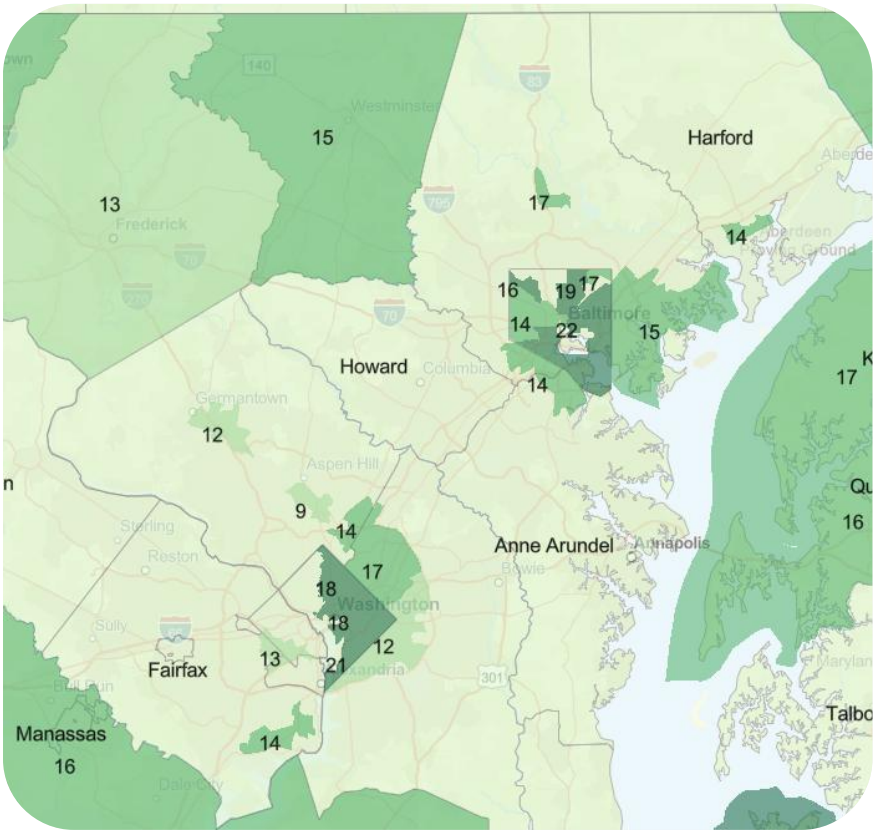
Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

EXHIBIT 92: MARYLAND BEHAVIORAL HEALTH CARE COVERAGE BY PAYER



Source: Maryland Behavioral Health System: An OPEN MINDS State Profile, 2024

EXHIBIT 93: PRIMARY CARE HEALTH PROFESSIONAL SHORTAGE AREAS



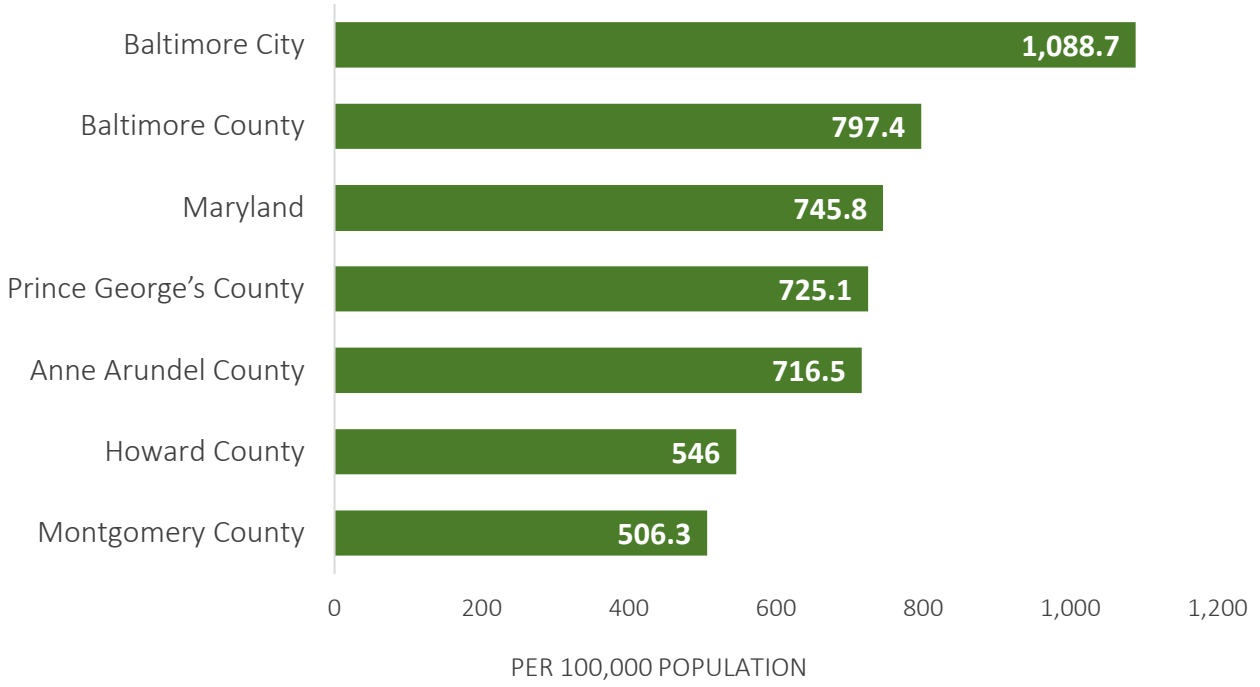
Source: Health Resources and Services Administration, 2/1/2025

Health Professional Shortage Areas

(HPSAs) are geographic areas, populations, or facilities with a shortage of primary, dental, or mental health care providers. The HPSA tool can be utilized to identify counties and states with the most severe provider shortages for a select variety of health care disciplines. **Scores range from 0 to 26, with a higher score indicating a greater need.**

Health Status

EXHIBIT 94: AGE-ADJUSTED MORTALITY RATE



Source: Maryland Department of Health. Maryland Vital Statistics Annual Report, 2022

EXHIBIT 95: AGE-ADJUSTED LEADING CAUSES OF DEATH

Per 100,000 Population	Heart Disease	Cancer	COVID-19	Cerebrovascular Diseases	Accidents
Maryland	155.8	136.7	40.1	43.7	48.7
Anne Arundel County	143.8	134.2	39.7	57.9	44.4
Baltimore County	171.2	149.5	43.0	43.2	50.8
Baltimore City	224.6	178.0	48.2	58.4	102.7
Howard County	100.7	111.6	24.7	40.8	29.9
Montgomery County	101.9	101.2	26.2	28.5	27.1
Prince George's County	151.3	128.6	41.9	47.0	41.5

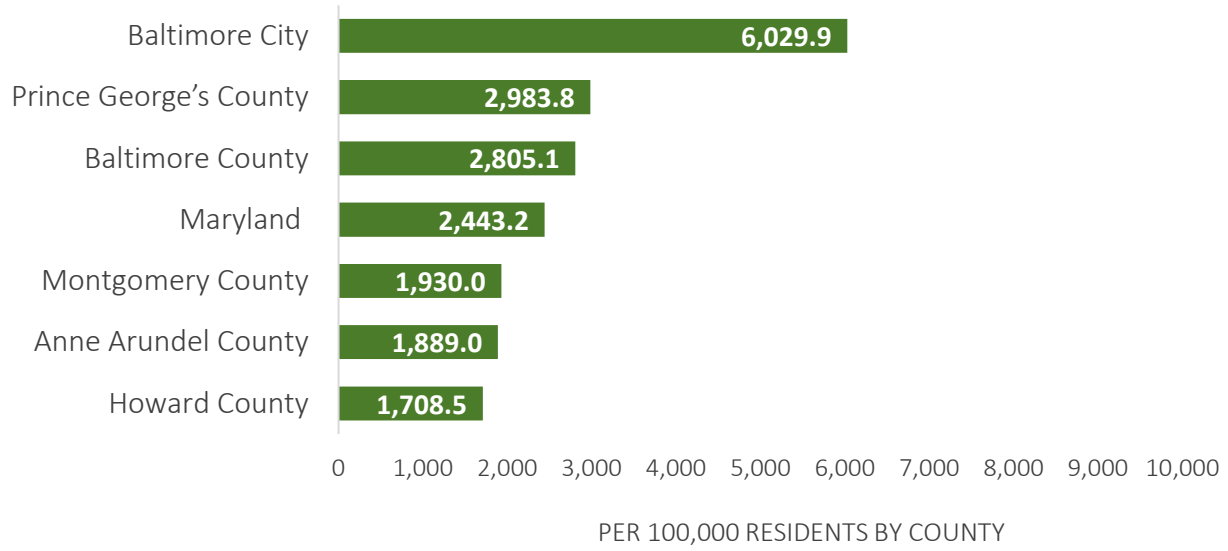
AGE-ADJUSTED LEADING CAUSES OF DEATH CONTINUED

Per 100,000 Population	Chronic Lower Respiratory Disease	Diabetes	Alzheimer's Disease	Septicemia	Nephritis, Nephrotic Syndrome, and Nephrosis
Maryland	24.4	23.1	15.5	12.7	9.7
Anne Arundel County	40.3	31.7	19.5	10.7	7.9
Baltimore County	26.7	21.4	15.6	13.3	8.8
Baltimore City	32.5	32.4	12.8	22.3	13.7
Howard County	11.9	15.5	10.7	10.7	7.9
Montgomery County	11.8	12.4	13.4	9.2	6.6
Prince George's County	15.4	31.7	19.0	13.1	13.5

Source: Maryland Department of Health. Maryland Vital Statistics Annual Report, 2022

Social and Community Context

EXHIBIT 44: CRIME RATES



Per 100,000 Residents by County	Violent Crime Rate	Property Crime Rate
Maryland	459.0	1,984.3
Anne Arundel County	324.7	1,564.3
Baltimore City	1,704.5	435.4
Baltimore County	2,805.1	2,364.4
Howard County	148.2	1,560.3
Montgomery County	209.0	1,721.0
Prince George's County	474.5	2,509.4

Source: Governor's Office of Crime Prevention and Policy, Crime Dashboard 2023

Appendix B: Stakeholder Interview Guide

Community Health Needs Assessment Stakeholder Interview Guide

Greetings,

As you know, Sheppard Pratt is conducting a Community Health Needs Assessment (CHNA) to help gain insights for identifying strengths, community resources, and additional ideas for improving Behavioral Health services. Your perspectives are important, and we appreciate your taking the time to speak with us. Although I will be taking notes, interview comments will not be attributed to specific individuals in the report. Please consider our conversation confidential. The discussion will include questions from a few broad categories and will take less than 30 minutes. Do you have any questions for me before we begin?

Introduction

Please tell me a little bit about yourself. How long have you been living and/or working in the area?

What do you like most about living and/or working in the community? PROBE: Strengths

Access to Care and Delivery of Services

Thinking broadly about COMMUNITY health, please tell me what first comes to mind when I say Behavioral Health in the area?

At a high level, how would you describe the current availability of mental health and substance use disorder services in the area? PROBE STAFF AND SERVICES: Psychiatrists and other providers such as therapists and psychologists, Autism specialists, anxiety/depressions, etc. Outpatient services, transitional housing, integrated care/primary care, crisis services, wait times, etc.

ADDITIONAL PROBES FOR SPECIFIC MENTIONED SERVICES INCLUDE:

- Is follow-up care provided after CRISIS stabilization?
- Is there good access for both virtual/telemedicine and face-to-face?
- Do patients/clients need to drive far for services? Do you think they are willing to drive to access services or do they not have an option?

Current Systems of Care and Service Needs

In general, how easy is it for people to get the care they need?

When you think of barriers to care, what comes to mind? PROBE: Transportation, insurance/finance, wait times, language barriers, cultural issues.

What are the three biggest behavioral health challenges facing your community, your friends, or your family? [For professionals, ask what conditions do you see most?] PROBE: Schizophrenia, anxiety, depression, bipolar, Trauma, substance use disorder, Eating Disorders, Intellectual disabilities, Autism, etc.

Is school-based mental health care available in schools for children and adolescents?

Is respite care available in the community? (For example, is housing and other services available for someone who is experiencing homelessness after they are discharged from the hospital?)

Population Subgroups, Awareness, and Communications

What populations are especially vulnerable and/or underserved in your community? PROBE: with follow-ups from longer guide when participant names

• People Living with a Disability

• Children and Adolescents – what is access to inpatient care / hospital for children and adolescents?

• New Americans/Minority Populations

• Older Adults

Generally, what are the challenges [insert identified population above] experience when accessing and receiving behavioral health services in the community?

How do individuals generally learn about access to and availability of services in the area? PROBE: Social media, Text WhatsApp, word of mouth, etc.

Community Health Equity, Stigma, Social Determinants and Pandemic Issues

When thinking broadly about Behavioral Health, which of the following seems to be the MOST pressing community issue people are facing?

- Stigma
- Equitable Services for Marginalized or Hard-To-Reach Populations
- Housing and Other Costs of Living Issues
- Transportation
- Remaining Pandemic Issues

What are some of the community-level actions that can be done to address [MOST PRESSING ISSUE NAMED ABOVE]?

Are there any 'low-hanging fruit' opportunities that could be addressed quickly?

Magic Wand Question

If there was one issue that you could personally change about behavioral health in the community with the wave of a magic wand, what would it be?

Appendix C: Focus Group Moderator's Guide

Community Health Needs Assessment Focus Group Moderator's Guide

My name is [Crescendo staff name] from Crescendo Consulting Group [if two staff are present, both introduce themselves]. We are working with Sheppard Pratt to conduct community health needs assessments to identify strengths, service gaps, and needs in the community, especially regarding behavioral health needs and potential ways to address them.

- **General purpose and approach of the discussion:** The purpose of this discussion is to learn more about the strengths and resources in the community, as well as to collect your insights to help improve Behavioral Health prevention and treatment services in the community. For today Behavioral Health means mental health, substance use disorders, and services for people with intellectual and developmental disabilities. The discussion will include questions from a few broad categories and will last approximately 60 minutes.

  Your honest opinions are the key to this process. **There are no right or wrong answers** to the questions I'm going to ask. I'd like to hear from each of you and learn more about your opinions, both positive and negative.

- **Ground rules:** We have some ground rules to consider before we start our conversation today. **It is essential that this is a safe place**, free from abusive words and actions, threats, and disrespectful behaviors. That includes words and behaviors directed towards us, your facilitators, or anyone else.

- **Moderator's role**: As a facilitator, I am here to help keep the conversation moving so we can get to all the questions. Sometimes I may interject in a rich conversation. Please don't take anything personally if I suggest we need to move on to the next topic.

- **Necessity for notetaking, or online recording, and confidentiality:** We will be taking notes so that we can remember the important points shared in today's discussion. We will be describing our discussion in a written report; however, your name will not be. **Please consider what you hear here to be confidential.**

- **Protocol for those who have not been to a focus group before:** Have any of you been in a discussion group like this before? I will be asking the whole group questions. Please feel free to speak up. I'd encourage you to respond directly to the comments other people make. If you don't understand the question, please let me know. We want everyone to participate, listen, and share.

- **Logistics and Questions**

Introduction

Please tell us your name a little bit about yourself and what you like most about living and/or working in the community.

Access to Care and Delivery of Services

- Thinking broadly about COMMUNITY health, please tell me what first comes to mind when I say Behavioral Health in [service area]?
- At a high level, how would you describe the current availability of mental health and substance use disorder prevention and treatment services in [service area]?

Examples: Psychiatrists, Eating Disorders and Autism specialists, services for children, outpatient services, transitional housing, integrated care/primary care, crisis services, etc.

Additional Follow-up for specific mentioned services include:

- Is follow-up care provided after crisis stabilization?
- What is the prevalence of developmental/cognitive disability? Dual diagnosis and co-occurring?

Current Systems of Care and Service Needs (Process of seeking behavioral health care)

- In general, how do people obtain the care they need? In other words, if a friend or family member needed help, what would you suggest they do?

  Examples: Type of services they seek, the number to call, the organization they first think about

  Examples of Services: Intake, Crisis, Intensive Outpatient Programs, Outpatient to Inpatient

- Where do you seek mental health services for children today?
  - Which provider comes to mind when you seek mental health services for children?
- What is your knowledge about Sheppard Pratt's services?
- When you think of barriers to care, what comes to mind?

  Examples: Transportation, insurance/finance, wait times, language barriers, cultural issues

- What would you say are the three biggest behavioral health challenges facing your community, your friends, or your family? (For professionals, ask what conditions you see most).

  Examples: Schizophrenia, depression, bipolar, Trauma, Medicated Assisted Treatment, Eating Disorders, Intellectual disabilities, Autism, etc.

Population Subgroups, Awareness, and Communications

- What populations are especially vulnerable and/or underserved in your community?

  Examples: People living with a disability, children and adolescents, new Americans, older adults

- How do individuals generally learn about access to and availability of services in the area?

  Examples: Preferred language, social media, text/WhatsApp, word of mouth, etc.

Community Health Equity, Stigma, and Social Drivers

- When thinking broadly about behavioral health, which of the following seems to be the most pressing community issues impacting people's behavioral health?

  Examples: Stigma, equitable services for marginalized or hard-to-reach populations,

  housing, and other costs of living issues remaining pandemic issues

- What are some ways to address stigma in the community? Do different cultures perceive mental health differently? If so, how do you approach addressing stigma differently in different cultures?

Closing Question

- If there was one issue that you could personally change about behavioral health in the community, what would it be?

Appendix D: Community Survey

Sheppard Pratt Community Health Needs Assessment

Community Survey

Sheppard Pratt is conducting this survey as part of a Community Health Needs Assessment for its Towson and Baltimore/Washington campuses. The results from this survey will be used to evaluate and address behavioral health and other community needs, gaps, and resources. The survey will close on Sunday, 2/16 at 5:00 PM. All survey responses will be kept confidential.

We appreciate you sharing your thoughts to help improve our services.

What county do you live in?

- ☐ Anne Arundel County
- ☐ Baltimore County
- ☐ Baltimore City
- ☐ Howard County
- ☐ Mongomery County
- ☐ Prince George's County
- ☐ Other (please specify):

What is your role in the community? (Check all that apply)

- ☐ General community member
- ☐ Case Manager
- ☐ Licensed Community Mental Health Provider
- ☐ Educator
- ☐ Law Enforcement
- ☐ Non-profit Organization
- ☐ Juvenile Justice Services
- ☐ Local/County Government
- ☐ Sheppard Pratt Leadership or Staff
- ☐ Parent / Family Member of Person(s) in Services
- ☐ State Government Official
- ☐ Person With Lived Experience
- ☐ Other (please specify):

Thinking about your mental health, which includes stress, depression, and problems with emotions, how would you rate your overall mental health? (Choose one)

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ I prefer not to answer

Access

Was there a time in the PAST 12 MONTHS when you needed mental health care but did NOT get the care you needed?

- ☐ Yes
- ☐ No

What are some reasons that kept you from getting mental health care? (Check all that apply)

- ☐ Did not have insurance
- ☐ Having insurance but even with it, could not afford it
- ☐ Providers did not take my insurance
- ☐ No childcare
- ☐ Not sure where to go for help
- ☐ Hard to get time off from work
- ☐ I did not feel comfortable with available providers
- ☐ Providers did not speak my language
- ☐ Concern about my immigration status
- ☐ Lack of transportation
- ☐ Did not feel comfortable seeking help or worried that others will find out about it
- ☐ Long wait times to see a provider
- ☐ Other (please specify):

Children's Access

Do you have children (under 18)?

- ☐ Yes
- ☐ No

Was there a time in the PAST 12 MONTHS when children in your home needed mental and/or behavioral health care but did NOT get the care they needed?

- ☐ Yes
- ☐ No

What are some reasons that kept you from getting mental health care? (Check all that apply)

- ☐ Am not sure how to find a doctor
- ☐ Unable to afford to pay for care
- ☐ Cannot find a pediatric specialist
- ☐ Long wait times for appointments
- ☐ Cannot take time off work
- ☐ Unable to find a doctor/counselor/therapist who takes my insurance
- ☐ Cannot take child out of class
- ☐ Do not have insurance to cover medical care
- ☐ Doctor's office does not have convenient hours
- ☐ Transportation challenges
- ☐ Unable to find a doctor who knows or understands
- ☐ My culture, identity, or beliefs
- ☐ Unable to schedule an appointment when needed
- ☐ Other (please specify):

Behavioral Health Challenges

Thinking about your community, which mental health-related challenges do you feel need more focus on? Please answer using the scale below.

	1 No More Focus Needed	2	3 Neutral	4	5 Much More Focus Needed	I Do Not Know
Mental health services for children and adolescents (0-17)						
Mental health services for adults (18-64)						
Mental health services for older adults (65+)						
Mental health services for veterans						
Mental health services for members of the LGBTQIA+ community						
Mental health services for people with a physical, intellectual, or developmental disability						
Mental health crisis care and intervention services						
Support services for families of people struggling with mental health disorders						
School-based mental health services						
Services and prevention/education initiatives to prevent suicide						

Thinking about your community, which substance use disorder-related challenges do you feel need more focus on? Please answer using the scale below.

	1 No More Focus Needed	2	3 Neutral	4	5 Much More Focus Needed	I Do Not Know
Substance use services for children and adolescents (0-17)						
Substance use services for adults (18-64)						
Substance use services for older adults (65+)						
Medication-assisted treatment services (suboxone, buprenorphine, methadone, naltrexone, etc.)						
Substance use services for veterans						
Substance use services for members of the LGBTQIA+ community						
Substance use services for people with a physical, intellectual, or developmental disability						
Support services for families of people struggling with substance use disorder						
School-based early intervention for substance use						
School-based substance use prevention education						
Detox centers for people working to recover from substance use issues						
Local programs to help support those in recovery						
Transitions of care services for people moving from one level of care to another						
Housing options for people in recovery (sober-living facilities, transitional housing, permanent supportive housing)						

Of all the challenges listed above, what do you think are the community's top two greatest behavioral health challenges? *(open-ended)*

1.

2.

Your Community

Thinking about your community, to what degree do you agree or disagree with the statements below?

In My Community,	1 Strongly Disagree	2 Disagree	3 Neither agree nor disagree	4 Agree	5 Strongly Agree
There are accessible inpatient behavioral health services					
There are supports to help navigate the behavioral health system (patient navigators, community health workers)					
There are accessible residential rehabilitation treatment programs					
There are support services for families of people struggling with mental health disorders					
In-home behavioral health services are available					
Providers offer integrated care for people requiring both mental health and substance use disorder treatment					
There are accessible and reliable transportation services to behavioral health appointments					
Providers treat people living with physical, intellectual, and/or developmental disabilities and mental health and/or substance use disorder					
People know where to call/go when they need behavioral health services					
Telehealth is equally available for behavioral health appointments					
Interpretation services are available for people who prefer or speak a language other than English seeking behavioral health services					
There are local emergency crisis care services					

In My Community,	1 Strongly Disagree	2 Disagree	3 Neither agree nor disagree	4 Agree	5 Strongly Agree
There are primary care providers who are connected with behavioral health providers and services					
There is clear communication between providers for individuals with more than one provider					

Thinking about vulnerable populations in your community, rate the statements below.

In My Community,	1 Strongly Disagree	2 Disagree	3 Neither agree nor disagree	4 Agree	5 Strongly Agree
There are culturally competent behavioral health services for Hispanic / Latino / Spanish-speaking people					
There are enough services to address homeless / housing insecurity					
School-based mental health resources for vulnerable populations are available					
Veterans can easily access behavioral health services					
There is equitable access to quality behavioral health services for people who identify as part of the LGBTQIA+ community					
The community is supportive of those who identify as part of the LGBTQIA+ community					
There are programs that provide financial support for low-income or uninsured people seeking behavioral health services					

Social Drivers of Health

In the past 12 months, have you struggled with any of the following? (Check all that apply)

- ☐ Access to affordable, nutritious food
- ☐ Transportation
- ☐ Affordable, quality childcare
- ☐ Access to a quality education for youth
- ☐ Access to safe, affordable housing
- ☐ Livable wage job opportunities
- ☐ Opportunities for physical fitness
- ☐ Activities for adults (such as a concert, festivals, book clubs, etc.)
- ☐ Activities for youth (such as a public pool, roller skating rink, bowling alley, etc.)

Which of the following sources do you normally use to find out about behavioral health care? (Check all that apply)

- ☐ A hospital's website
- ☐ Friends and relatives
- ☐ Healthcare.gov
- ☐ Medicaid, Medicare, or insurance provider
- ☐ Physician or another healthcare provider
- ☐ Social media
- ☐ Television
- ☐ Word of mouth
- ☐ Online search engine
- ☐ Other (please specify):

About You

The following questions are used to sort and compare groups of responses and **will not** be used to identify individual respondents.

To which gender identity do you most identify?

- ☐ Man/Male
- ☐ Woman/Female
- ☐ Transgender Woman/Female
- ☐ Transgender Man/Male
- ☐ Non-Binary
- ☐ Use another term (please specify):
- ☐ I prefer not to answer

How old are you?

- ☐ Under 18
- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 and over
- ☐ I prefer not to answer

What is your highest level of education?

- ☐ Less than high school or GED
- ☐ High school diploma or equivalent
- ☐ Some college
- ☐ Technical or Trade school
- ☐ Associate degree
- ☐ Bachelor's degree
- ☐ Graduate or professional degree
- ☐ I prefer not to share

What is your race and/or ethnicity? (Check all that apply)

- ☐ White or Caucasian
- ☐ Black or African American
- ☐ Middle Eastern or North Africa
- ☐ Asian
- ☐ Native American or Alaska Native
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Hispanic, Latino, or other Spanish origin
- ☐ Another race/ethnicity (please specify):
- ☐ I prefer not to answer

Are you a member of the LGBTQIA+ community?

- ☐ Yes
- ☐ No
- ☐ I prefer not to answer

Which of the following best describes your total annual household income in the past year?

- ☐ Less than $10,000
- ☐ $10,000 to $14,999
- ☐ $15,000 to $24,999
- ☐ $25,000 to $34,999
- ☐ $35,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $149,999
- ☐ $150,000 to $199,999
- ☐ $200,000 or more
- ☐ I prefer not to answer