

Housekeeping

- Please type your name and organization in the chat.
- Please stay muted during the presentation. If you have any questions, please use the chat function.
- During the discussion portion of the session, we encourage participant engagement, respectful discourse, open hearts, and curious minds.
- This session is being recorded for future viewing purposes.



Building a Healthier Maryland State Health Improvement Plan (SHIP) Implementation Kickoff

November 13, 2025



Welcome & Opening Remarks



Meg Sullivan, MD, MPH
Deputy Secretary of Public Health Services
Maryland Department of Health

Agenda

- I. **SHIP Overview** - 20 minutes
- II. **SHIP Implementation & Working Together** - 25 minutes
- III. **Breakout Rooms & Discussion** - 20 minutes
- IV. **Reconvene & Next Steps** - 5 minutes
- V. **Closing Remarks** - 5 minutes

If you have any questions during our session today, please use the chat function and our team will follow up with responses to all questions when we send out the recording.

Meet the *Building a Healthier Maryland* Team



Meg Sullivan, MD, MPH
Deputy Secretary, PHS



Katherine Feldman, DVM, MPH
MDH Chief Performance Officer



Laura Lee Wight
Strategic Initiatives &
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Performance & Quality Improvement Program
Manager



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PHS Strategy & Performance Manager



Hana Bekele, MBA
Public Health Improvement Coordinator

SHIP Overview

What is the SHA and the SHIP?

The State Health Assessment (SHA) and State Health Improvement Plan (SHIP) provide a structured, community owned framework to improve community health and address disparities across sectors.

State Health Assessment (SHA)

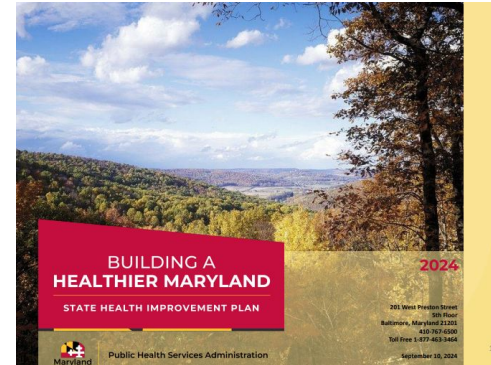
Systematic approach to collecting, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve the public's health.



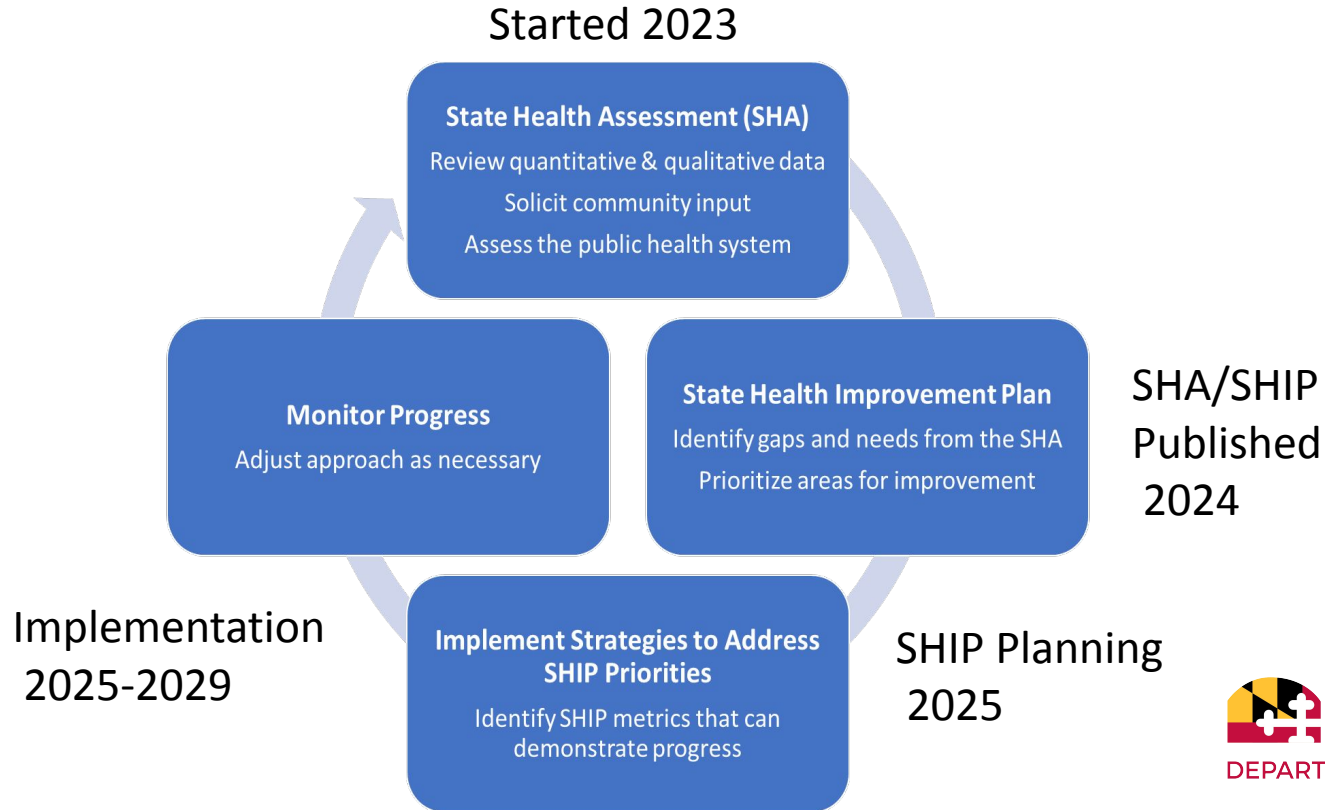
State Health Improvement Plan (SHIP)

Long-term plan to address issues identified in the SHA. Describes how the state health department, its cross-sectoral partners and the communities it serves will work together to improve the health of the population.

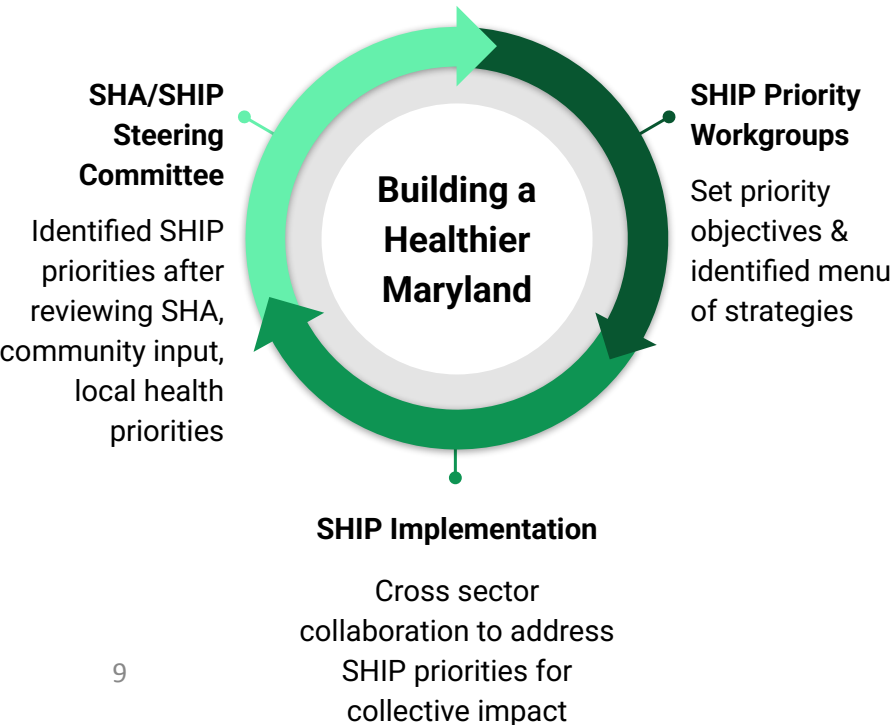
Building a Healthier Maryland Initiative



SHA / SHIP Cycle



Building a Healthier Maryland Steering Committee & SHIP Development



Maryland Department of Health

- Office of the Secretary
- Public Health Services
- Behavioral Health Administration
- Health Care Financing
- Office of Minority Health and Health Disparities
- Prevention and Health Promotion Administration

Maryland State Agencies

- Department of Labor
- Department of Housing & Community Development
- Department of Human Services
- Department of Aging
- Department of Transportation
- State Department of Education
- Department of the Environment

Local Health Officers

- Baltimore City
- Montgomery County
- Somerset County
- Washington County

Partner & Community Organizations

- Maryland Hospital Association
- Maryland Rural Health Association
- Maryland State Medical Society
- Mid-Atlantic Association of Community Health Centers

Local Health Improvement Coalitions

- Baltimore County LHIC
- Garrett County LHIC
- Howard County LHIC
- St. Mary's County LHIC

Key Concepts of the SHIP

The State Health Improvement Plan (SHIP):

- Provides a **broad picture of statewide health priorities** and serves as an **organizing framework** for the state and for local jurisdictions
- Puts forward a **shared language and vision**, including a menu of strategies to address priority areas for **collective impact**.
- **Leverages statewide data from the SHA** to provide information and direction to the areas that need the most attention
- Contributes to decision making:
 - Prioritization of activities
 - Allocation of resources
 - Informs strategic planning

SHA/SHIP Facts

- SHA/SHIP cycles are 5 years
- SHA/SHIPs are informed by local Community Health Assessments (CHAs) and local Community Health Improvement Plans (CHIPs), which focus on a specific geographic population

Purpose of the SHIP

The SHIP leads community health improvement by providing:

Data

Provides state & jurisdictional data to support CHAs, CHIPs, and strategic planning and to monitor progress

Evidence-Based Strategies

Provides a menu of strategies to address statewide health priorities for agencies and local partners to use for action

Funding Justification

Serves as a point of reference and offers core data, objectives, and strategies for grants & proposals

Advocacy Framework

Helps organizations promote policy, systems, & environmental change

State Health Improvement Plan: 5 Health Priority Areas



Chronic Disease



Access to Care



Women's Health

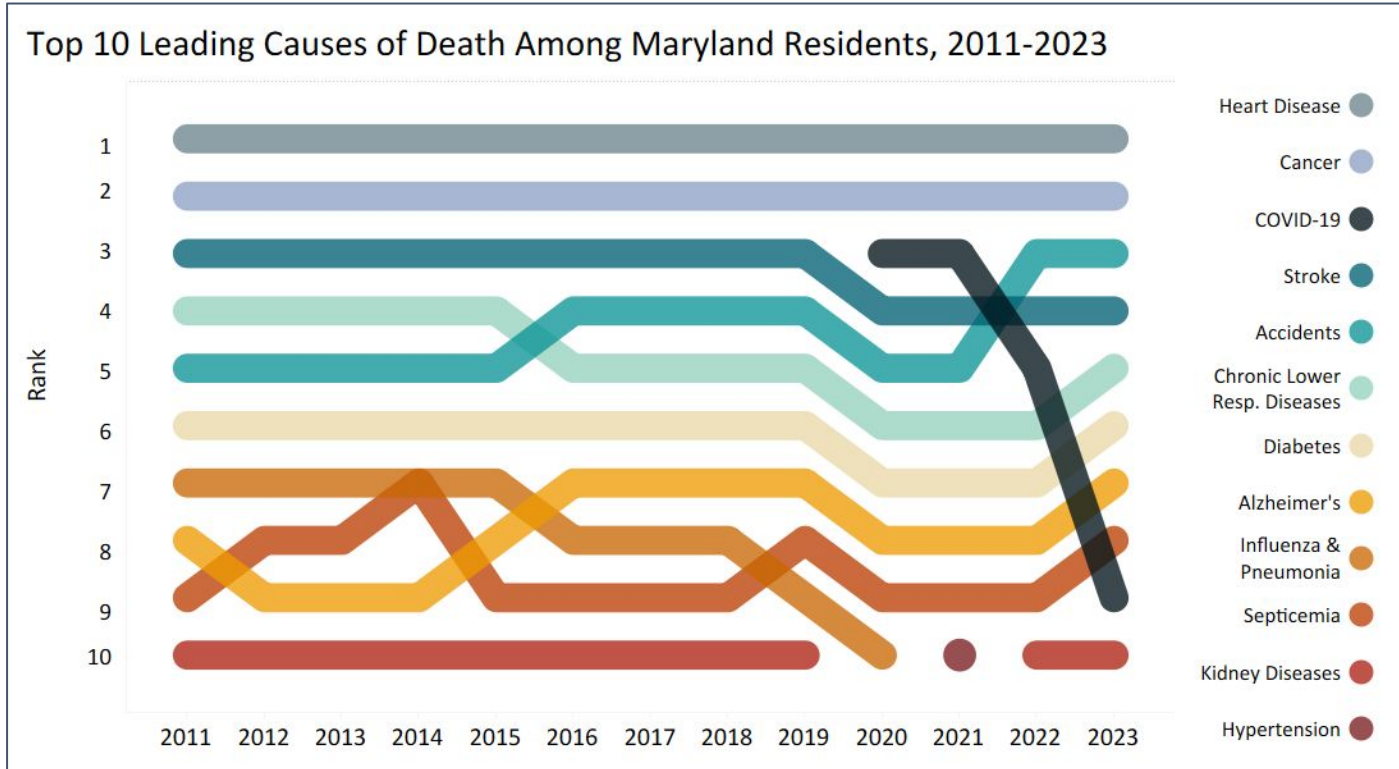


Violence

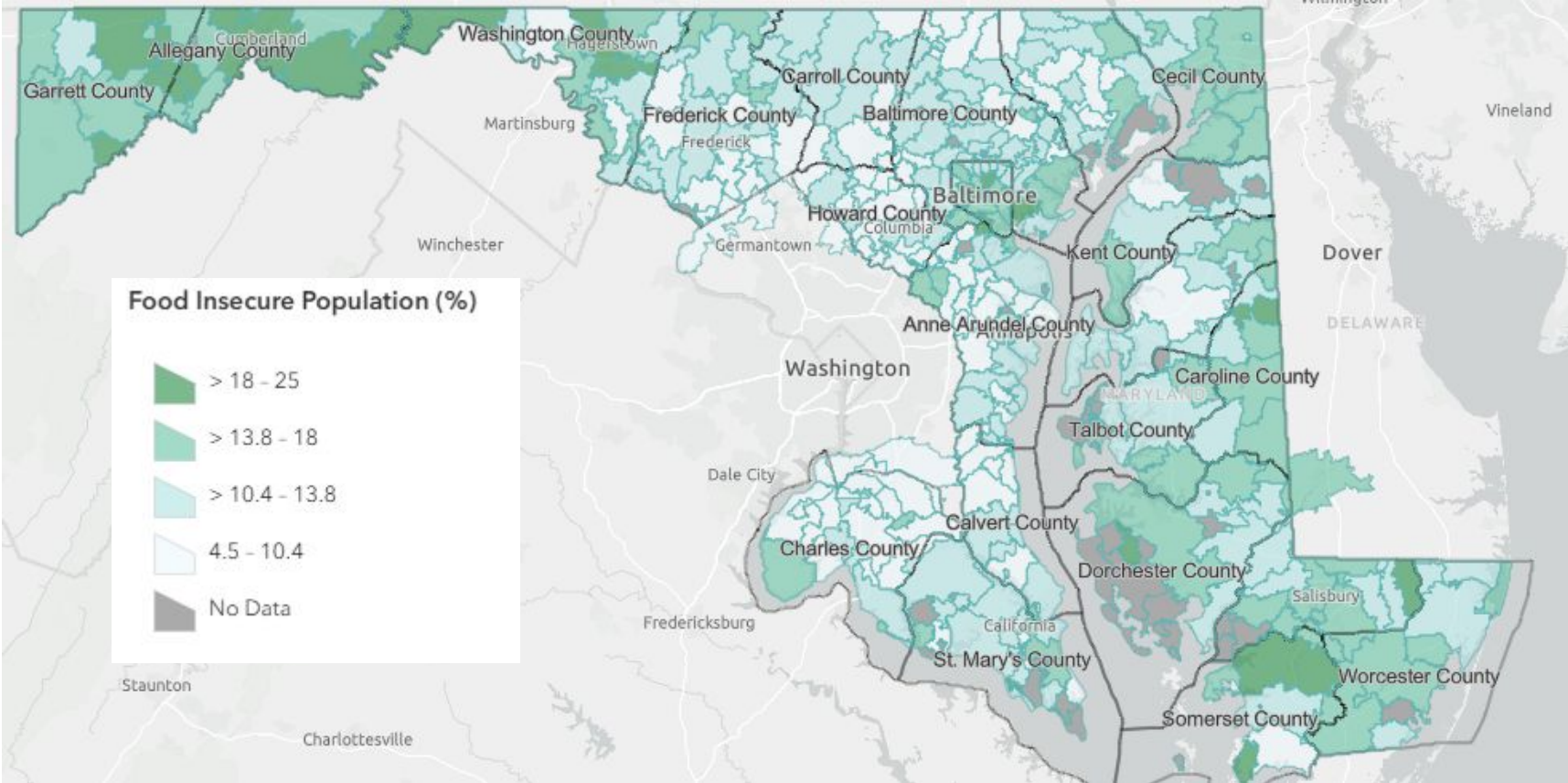


Behavioral Health

Leading Causes of Death, Maryland, 2011-2023



% of Population that is Food Insecure by Zip Code, Maryland, 2022





Priority 1: Chronic Disease

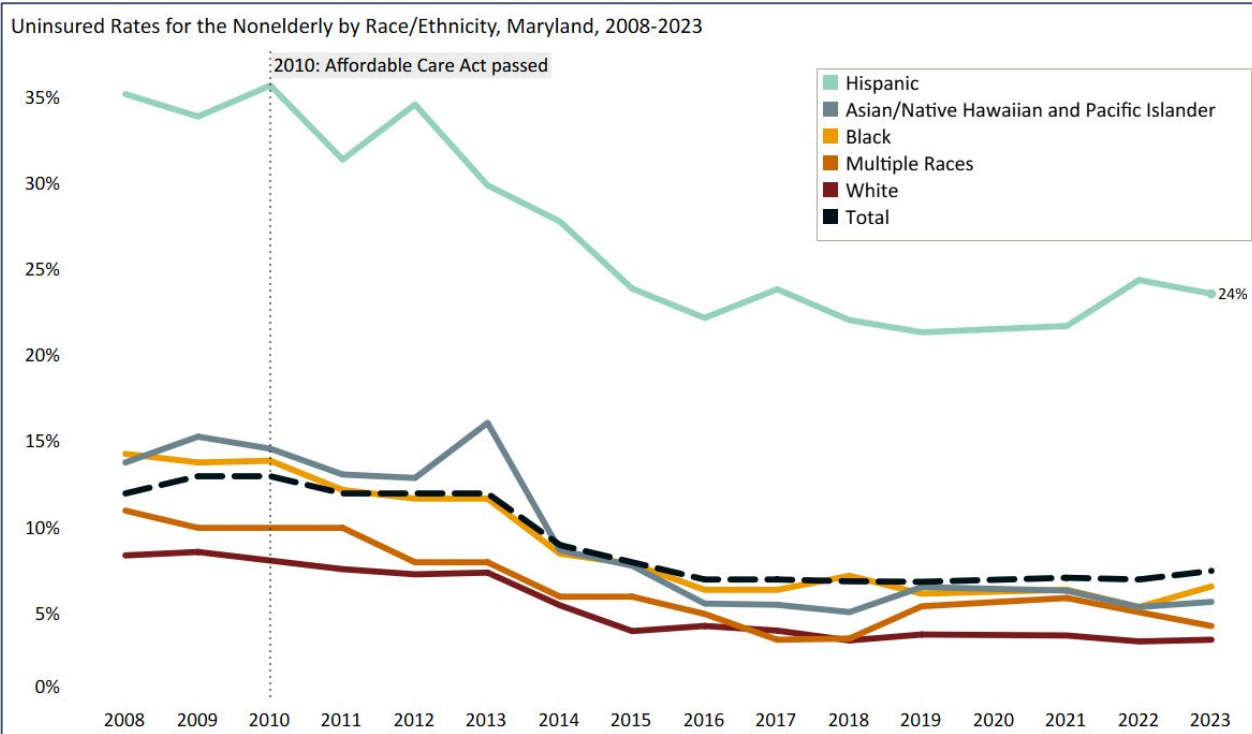
Goal 1 Enhance primary prevention of chronic disease

- **Objective 1.1.1:** By 2029, lower the percentage of households experiencing food insecurity due to resource limitations from 9.5% to 8.3%
- **Objective 1.1.2:** By 2029, decrease the percentage of adults reporting no physical activity or exercise other than their regular job in the past 30 days from 21.2% to 17.5%

Goal 2 Enhance Screening, treatment, and care for chronic illness

- **Objective 1.2.1:** By 2029, increase the percentage of adults ages 45-75 who reported receiving one or more of the recommended colorectal cancer screening tests within the recommended time interval from 71.8% to 75.3%
- **Objective 1.2.2:** By 2029, increase the percentage of high risk populations receiving lung cancer screenings from 2.9% to 4.5%
- **Objective 1.2.3:** By 2026, reduce the rate of emergency room visits for asthma among children from 7.8 per 1,000 to 5.3 per 1,000, and for Black children from 19 per 1,000 to 9 per 1,000
- **Objective 1.2.4:** By 2029, reduce the proportion of adults with diabetes who have an A1c value above 9% from 33.9% to 11.6%
- **Objective 1.2.5:** By 2029, increase the proportion of adults 18–85 years of age who have a diagnosis of hypertension and whose blood pressure was adequately controlled to 18.9%

Health Coverage, Maryland, 2008-2023



As of 2023, about **8%** of Maryland residents were without health insurance. This is down from 12% in 2008, prior to the introduction of the ACA. Racial disparities persist, particularly for Hispanic Marylanders, 24% of whom were uninsured in 2023.

Non-citizen immigrants account for 38% of the uninsured, though they only account for 7.2% of the state population (2021).





Priority 2: Access to Care

Goal 1 Enhance care delivery models to meet the needs of different populations

- **Objective 2.1.1:** By 2029, increase the proportion of statewide behavioral health outpatient service recipients who receive services via telehealth from 59.1% to 67%
- **Objective 2.1.2:** By 2029, increase the total percentage of students enrolled in School Based Health Centers from 35% to 70% at that school

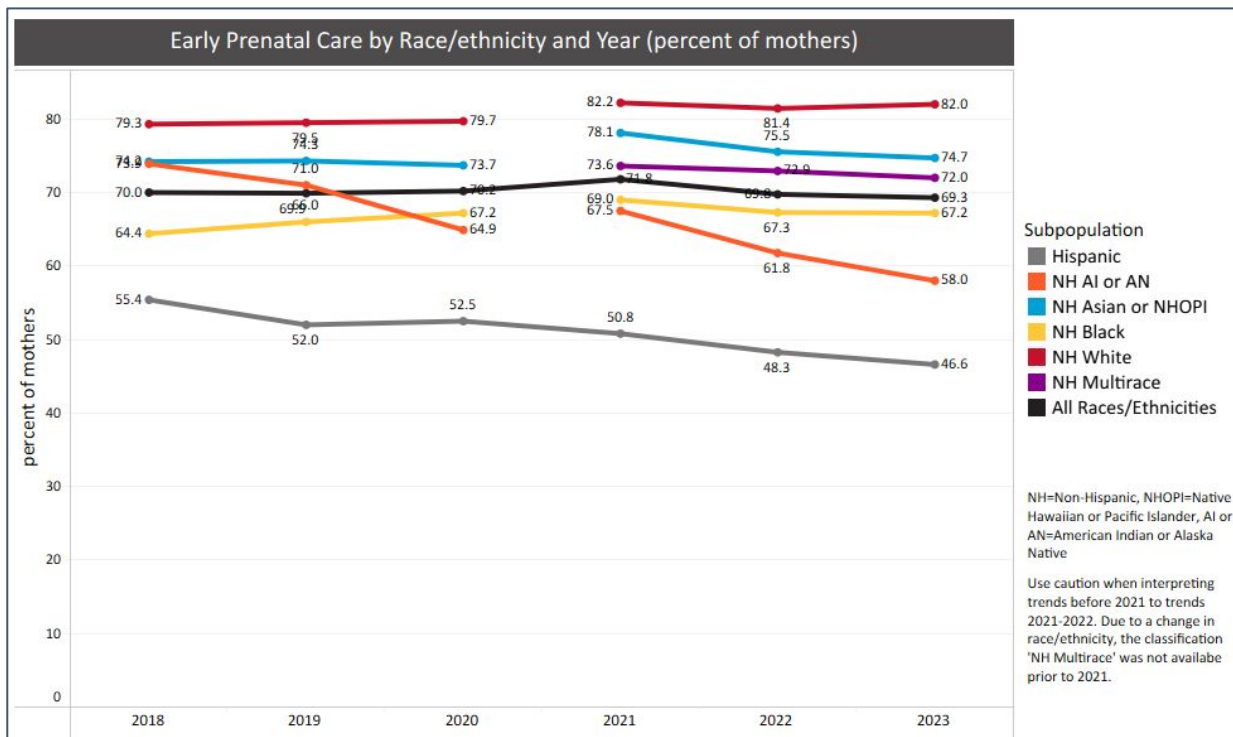
Goal 2 Recruit and retain high quality healthcare and public health workforce

- **Objective 2.2.1:** By 2029, reduce the average wait time for primary care first appointment

Goal 3 Reduce barriers to care

- **Objective 2.3.1:** By 2029, reduce the total proportion of individuals not covered by private or public health insurance from 7% to 5.5%

Early Prenatal Care by Race/Ethnicity, Maryland, 2016-2022

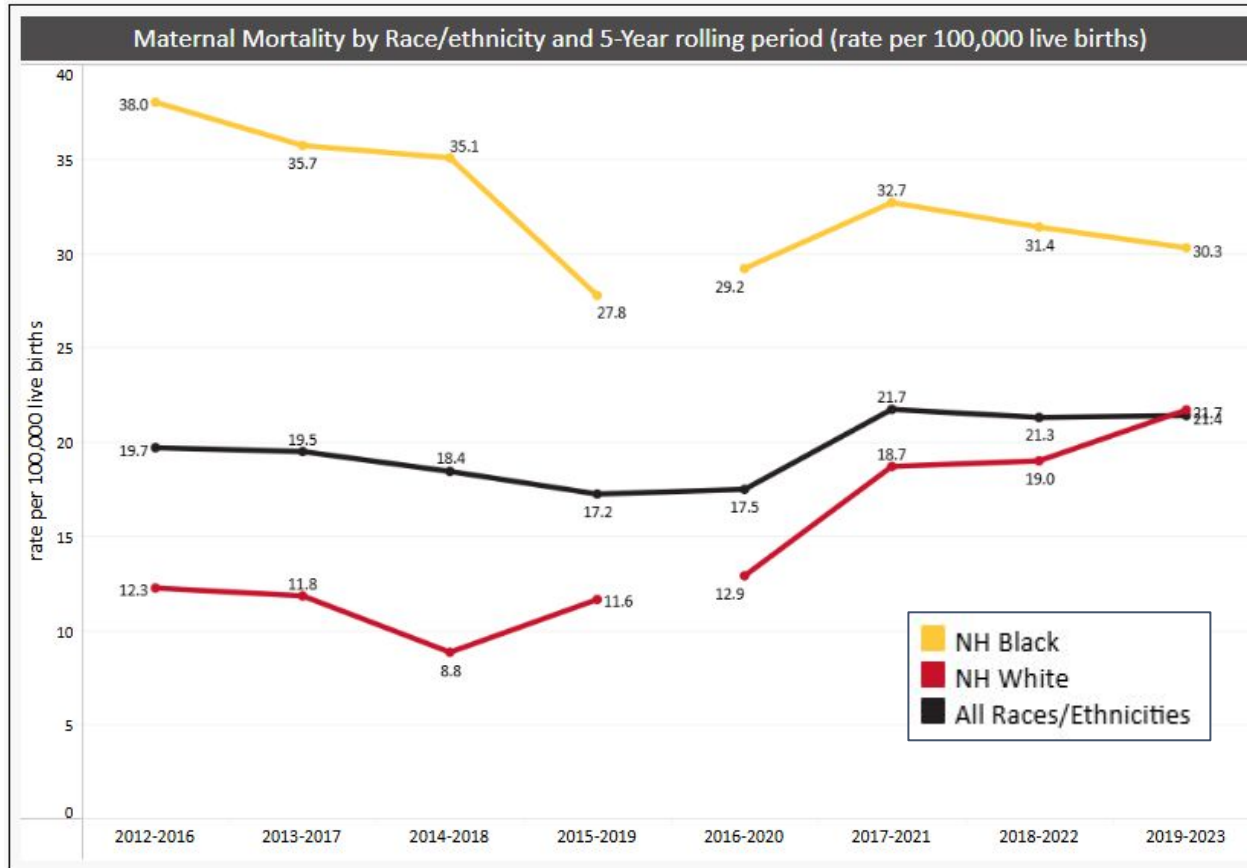


Maryland Vital Statistics Administration, [VSA Data 2010-2020](#), 2021, 2022 and 2023 by request. Available on the [Women's Health Dashboard](#)

Note: The 'multirace' classification was introduced in 2021. Prior, individuals who identify as 'multirace' would have been classified as one of the single-race designations. For this reason, use caution when interpreting trends before 2021 to trends 2021-22.



Maternal Mortality by Race/Ethnicity, Maryland, 2012-2023



Data Source: CDC WONDER

Note: Data points where numerators are small are suppressed and are not shown. Small subpopulation sizes can make rates fluctuate dramatically. Subpopulations for which all years are suppressed are not displayed



Priority 3: Women's Health

Goal 1 Improve maternal health outcomes through improved maternal care before, during and after pregnancy

- **Objective 3.1.1:** By 2029, reduce the rate of preterm births from 10.7% to 9.4%
- **Objective 3.1.2:** By 2029, reduce the infant mortality rate from 6.5 per 1,000 live births to 5.2 per 1,000 live births
- **Objective 3.1.3:** By 2029, reduce the percentage of babies born with low birth weight from 8.5%
- **Objective 3.1.4:** By 2029, reduce unintended pregnancy rate from 42% to 36.5%, with a focus on addressing health disparities
- **Objective 3.1.5:** By 2029, increase the percentage of deliveries in which individuals were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care
- **Objective 3.1.6:** By 2029, reduce the total maternal mortality rate from 21.7 to 17.2 per 100,000 live births, and for Black women from 30.7 to 19.2 per 100,000 live births
- **Objective 3.1.7:** By 2029, increase the percentage of pregnant women who receive prenatal care beginning in the first trimester from 78.1% to 82%



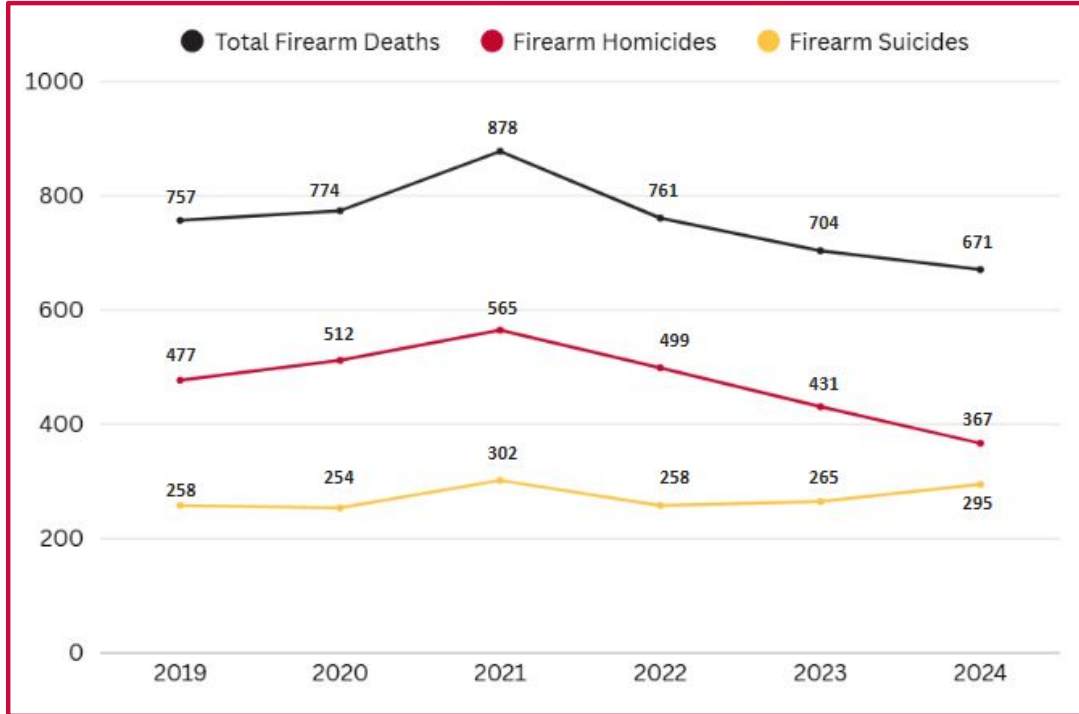
Priority 3: Women's Health

Goal 2 Increase breast and cervical cancer prevention, screening, and care

- **Objective 3.2.1:** By 2029, increase the number of women receiving a breast cancer screening for which one is indicated from 83.2% to 87%
- **Objective 3.2.2:** By 2029, increase the proportion of adolescents ages 13-17 who are up to date on HPV vaccine from 72% to 80%
- **Objective 3.2.3:** By 2029, increase the proportion of females who receive a cervical cancer screening based on the most recent guidelines from 79.3% to 82.5%



Firearm-Related Fatalities, Maryland, 2019-2024



- Gun fatality rates rose sharply from 2020 to 2021, but have fallen significantly each year since
- Total firearm fatalities have decreased by 24% since the peak in 2021
- The decrease has been driven by a 35% decrease in firearm homicides since 2021
- Firearm suicide fatalities have fluctuated, with a 14% increase from 2019 to 2024

*2024 data is provisional and subject to change



Priority 4: Violence

Goal 1 Reduce firearm-related suicides, homicides, and injuries

- **Objective 4.1.1:** By 2029, reduce the age-adjusted rate of firearm-related suicides from 4.7 to 2 per 100,000
- **Objective 4.1.2:** By 2029, reduce the age-adjusted rate of firearm-related homicides from 10.3 to 6.6 per 100,000

Goal 2 Reduce the rates of, and harms associated with, intimate partner and sexual violence (IPV/SV)

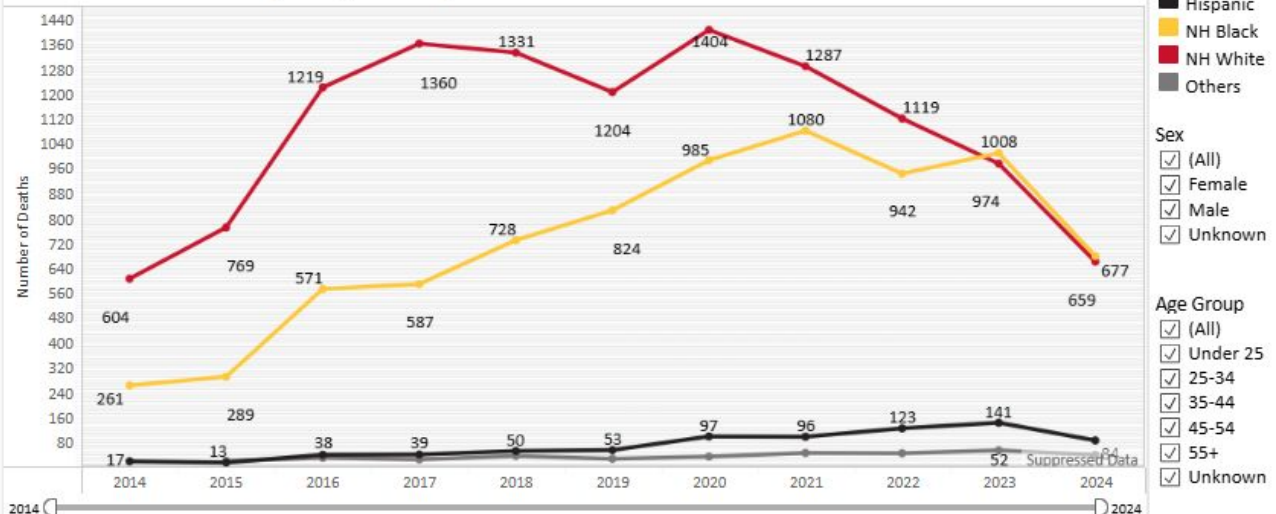
- **Objective 4.2.1:** By 2029, reduce emergency department visits related to intimate partner violence (IPV)

Fatal Overdose: Historic Trends

The Fatal Overdose dashboard contains counts of unintentional drug- and alcohol-related intoxication deaths occurring in Maryland from 2014 to date. Data are sourced from the Maryland Vital Statistics Administration (VSA) and the Office of the Chief Medical Examiner (OCME). **Counts for 2022-2024 are preliminary and subject to change as OCME death investigations are finalized.** Preliminary counts are often incomplete and causes of death may be pending investigation resulting in an underestimate relative to final counts. Incident County and Incident ZIP Code on the dashboard indicates the Place of Occurrence. Per NCHS, counts are suppressed for values <10 and rates for values with numerators <20. These suppressed values are represented with **. See "About Data" page for more details.

Incident County:
 Incident Zip:
 Substances Involved:
 Count: Rate:

Total Overdose Deaths by Race/ Ethnicity Over Time



TIP: Drag the ends of the slider to select the time period you wish to view

Note. Counts by race/ ethnicity are provided for Hispanic, Non-Hispanic Black, Non-Hispanic White, and a broader "Other" category of specific races with too few decedents to represent (Non-Hispanic American Indian/Alaska Native, Asian/Pacific Islander, Multi-Race, Unknown). The Hispanic category includes all persons of Hispanic origin of any race. Subject to change as new data emerges.





Priority 5: Behavioral Health

Goal 1 Expand access to, and utilization of, behavioral health services

- **Objective 5.1.1:** By 2029, reduce the rate of emergency department visits for mental health conditions from 4,510 per 100,000
- **Objective 5.1.2:** By 2029, reduce the rate of suicides from 9.9 per 100,000 to 9.1 per 100,000
- **Objective 5.1.3:** Increase the number of youth substance use treatment providers by 2% each year
- **Objective 5.1.4:** By 2026, increase utilization of public behavioral health services by 4%

Goal 2 Reduce disparities in mental health outcomes

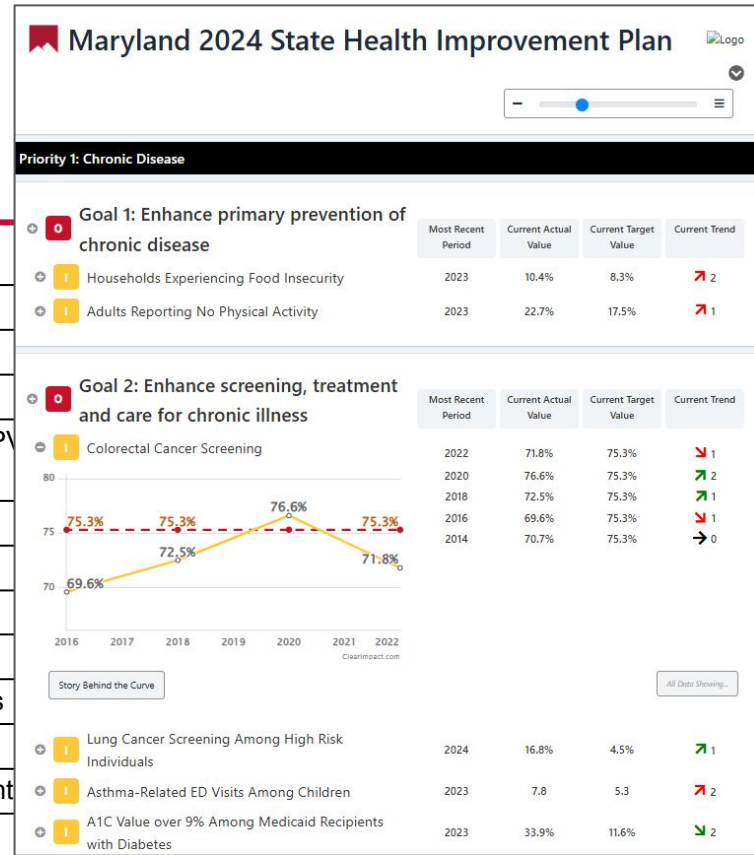
- **Objective 5.2.1:** By 2029, reduce the percentage of students who felt sad or hopeless most days for more than 2 weeks in the past 12 months from 42% for all students, and from 64.6% for LGBTQ students
- **Objective 5.2.2:** By 2029, increase availability of affordable housing from 46.1% as a way to improve health outcomes, including mental health

Goal 3 Reduce overdose and the negative health outcomes associated with substance use

- **Objective 5.3.1:** By 2029, reduce the opioid fatality rate by 20%
- **Objective 5.3.2:** By 2029, reduce emergency department visits related to addictions-related conditions

2024 SHIP Metrics

1.1.1	Households Experiencing Food Insecurity	3.1.6	Maternal Mortality Rate
1.1.2	Adults Reporting No Physical Activity	3.1.7	Prenatal Care in First Trimester
1.2.1	Colorectal Cancer Screening	3.2.1	Breast Cancer Screening
1.2.2	Lung Cancer Screening Among High Risk Individuals	3.2.2	Adolescents with Up-to-Date HPV Vaccination
1.2.3	Asthma-Related ED Visits Among Children	3.2.3	Cervical Cancer Screening
1.2.4	Diabetics with A1c Value over 9%	4.1.1	Firearm-Related Suicide Rate
1.2.5	Prevalence of Diagnosed Hypertension	4.1.2	Firearm-Related Homicide Rate
2.1.1	Telehealth Utilization Among PBHS recipients	4.2.1	IPV-Related ED Visits
2.1.2	School-Based Health Center Enrollment	5.1.1	Mental Health-Related ED Visits
2.2.1	Avg Wait Time for Primary Care First Appt	5.1.2	Suicide Rate
2.3.1	Uninsured Rate	5.1.3	Number of Youth SUD Treatment
3.1.1	Pre-Term Birth Rate	5.1.4	PBHS Utilization Rate
3.1.2	Infant Mortality Rate	5.2.1	Students Feeling Sad or Hopeless
3.1.3	Babies with Low Birth Weight	5.2.2	Affordable Housing
3.1.4	Unintended Pregnancy Rate	5.3.1	Opioid Fatality Rate
3.1.5	Postpartum Depression Screening	5.3.2	Addictions-Related ED Visits



SHIP scorecard available at <https://embed.clearimpact.com/Scorecard/Embed/88362>

Participant Engagement Time!

Where do you see opportunity for improving health in Maryland?



Word cloud generated by participants during meeting

SHIP Implementation

Collective Impact Model

The SHIP drives towards **collective impact** across sectors by aligning communities, organizations and institutions with a common agenda and leveraging health indicator data to monitor progress.

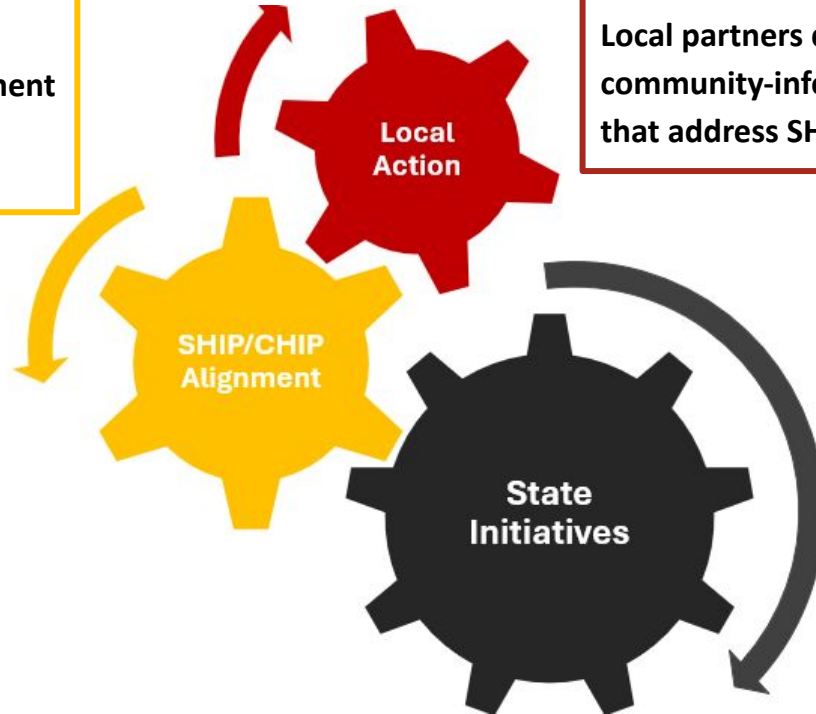
The SHIP encourages and supports mutually reinforcing activities across MDH programs, other state agencies, local health departments and health improvement coalitions, partner associations, community-based organizations, and health systems to ultimately **benefit all Marylanders**.



Local and State Activities Inform and Build Off of Each Other

SHIP provides a unifying framework that aligns local Community Health Improvement Plans (CHIPs) with statewide goals and measures.

Local partners drive action by implementing community-informed and evidence-based strategies that address SHIP priorities that are also local priorities



State implementation supports alignment by coordinating resources, sharing data, and fostering partnerships that amplify local efforts and build towards collective impact

Synergy in Local and State Implementation

At the State Level:

- **Coordinate Strategy & Resources:** Align SHIP priorities with statewide programs and funding streams.
- **Provide Data & Guidance:** Deliver state and jurisdictional health indicators to inform planning and decision-making.
- **Lead Statewide Initiatives:** Advance programs and policies that address SHIP priorities across Maryland.
- **Support Collective Action:** Foster partnerships across agencies, partners and sectors to drive systems-level change.
- **Monitor Progress:** Track statewide outcomes and share learnings to guide continuous improvement.

At the Local Level:

- **Localize SHIP Priorities:** Integrate SHIP focus areas into Community Health Assessments (CHAs), Community Health Improvement Plans (CHIPs), and other strategic efforts.
- **Drive Action Through Collaboration:** Leverage local partnerships with CBOs, healthcare systems, and residents.
- **Align Efforts for Impact:** Use SHIP as a framework for programmatic initiatives, grants, and advocacy.
- **Contribute to Statewide Goals:** Report progress and insights to support collective statewide success.

Health Priority Workgroups

- Workgroups will roll out incrementally, starting with Chronic Disease.
- All workgroups will be activated by the end of 2026



First Chronic Disease Workgroup meeting December 15, 2025

Health Priority Workgroups

- Champion and oversee the implementation of evidence-based and community-informed initiatives
- Serve as connectors across sectors and lift up existing work whenever possible
- Leverage existing partnerships to drive collective action and shared outcomes
- Integrate work with current initiatives to avoid duplication and maximize impact

Workgroup participants include:

- LHD and LHIC representatives
- SHIP development workgroup members
- MDH subject matter experts
- Representatives from other key coalitions, councils, advisory groups
- Internal and external stakeholders, including other state agencies

Health Priority Workgroups - Activities

Workgroups will develop action plans that could include, but are not limited to:

- **Environmental scan of related programs/initiatives:** Conduct environmental scans of current programs, initiatives, and activities that address the SHIP priority
- **Policy recommendations:** Create systemic change by advancing policy recommendations that relate to SHIP objectives
- **Develop toolkits and resources:** Create practical toolkits, guidance documents, and resource packages to support partners in adopting, implementing, and sustaining strategies aligned with SHIP objectives.
- **Expand, amplify, or implement evidence-based programs or initiatives:** Identify opportunities for alignment of resources and amplification and expansion of programs to more broadly implement evidence-based strategies that address SHIP objectives

Tracking Progress & Strengthening Collaboration

Annual Report

- Document and communicate statewide progress, milestones, and outcomes.

Annual Convening

- Bring together multi-sector stakeholders, including the BAHM Steering Committee, local health departments, and SHIP workgroup participants.
- Showcase model programs, best practices, and innovations that advance SHIP priorities.
- Promote statewide initiatives and facilitate knowledge exchange across sectors.
- Strengthen partnerships among health, education, social services, housing, business, academia, and community organizations to advance shared health and equity goals.

Break Out Rooms & Discussion

Break Out Rooms Instructions

1. Join Your Breakout Room

- You'll be automatically placed into groups of 8–10 participants.
- Discussion questions will be on the whiteboard, group will self-facilitate the discussion.

Time: 20-25 minutes

Up next: Review Next Steps & Closing

2. Open the Canva Whiteboard

- The link is in the chat, please click it now.
- Once in Canva, find the whiteboard labeled with your breakout room number (e.g., "Room 1," "Room 2," etc.).

3. Discuss & Capture Ideas

- Using the discussion questions, record your thoughts, key points, and takeaways on the whiteboard.
- Everyone is encouraged to contribute.

4. Technical Help

- Team members will move between rooms to provide technical support if needed.

November 13th SHIP Kick Off Breakout Rooms

Instructions: Click on your assigned room below.
The hyperlink will take you to your whiteboard

[Room 1](#)

[Room 2](#)

[Room 3](#)

[Room 4](#)

[Room 5](#)

[Room 6](#)

[Room 7](#)

[Room 8](#)

[Room 9](#)

[Room 10](#)

[Room 11](#)

[Room 12](#)

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[Room 19](#)

[Room 20](#)

[Room 21](#)

[Room 22](#)

[Room 23](#)

[Room 24](#)

[Room 25](#)

START HERE

Instructions

- 1) As a group, discuss each question.
- 2) Use the sticky notes, arrows, and reactions to capture your answers.
- 3) We will collect your whiteboard and share the final product with the group at a later date.

Helpful Tips

- 1) Consider electing one person in the group to share their screen.
- 2) Consider having a designated scribe to help capture ideas.
- 2) Zoom in and out to better see the sections.

Breakout Room Participants

Write down the names and organization of the Break Out Room participants below.

Room 1

SHIP Kick Off Breakout Room Discussions

Question 1: What is one thing that stood out to you from today's overview of the SHIP- its priorities, objective, or collective impact approach?

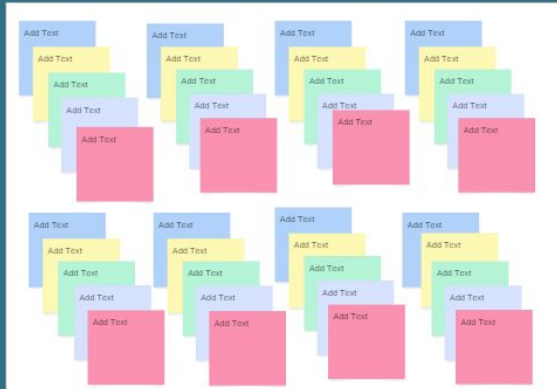
Question 2: How do the SHIP priorities connect to existing work, partnerships, coalitions, or initiatives in your organization or community?

Question 3: How could SHIP workgroups best support you – through data sharing, networking, capacity building, or policy alignment?

Notes, Questions, Ideas!!!

White Board Resources

Use sticky notes to add ideas, notes and questions. Click and drag the sticky notes to where you want to leave a note, double click to add text.



Click & drag the icons below to emphasize and connect ideas.



Discussion Questions

1. What is one thing that stood out to you from today's overview of the SHIP- its priorities, objective, or collective impact approach?
2. How do the SHIP priorities connect to existing work, partnerships, coalitions, or initiatives in your organization or community?
3. How could SHIP workgroups best support you — through data sharing, networking, capacity building, or policy alignment?

Next Steps

How to Get Involved

Read and share the updated SHIP

Sign up for a Health Priority Workgroup

Tell us about the services your organization provides

Stay informed about opportunities for engagement

Next Steps: Read & Share the Updated SHIP

The 2025 updated SHIP will include:

- Updated health indicator data
- New section on how to use the SHIP for community health improvement efforts
- Expanded list of evidence-based interventions and strategies for each SHIP objective

The updated SHIP will be posted to the ***Building a Healthier Maryland*** website and sent to partners via our newsletter

Next Steps: SHIP Workgroup Participation

Sign up for a SHIP Health Priority workgroup

<https://forms.gle/74YvLZsh3zWdDCkT7>

Or use the QR code below.



Next Steps: Complete the PHSA

If you are a new partner, please complete the Public Health Systems Assessment (PHSA). The goal is to gather information regarding the types of services your organization provides, the populations you serve, the health concerns you address, and your community building efforts. Click the link below or scan the QR code.

<https://forms.gle/3Tv9Rzsf6PHysRLS6>



Next Steps: Stay Informed

Stay informed about SHIP activities, progress, and opportunities for engagement through the SHIP Health Action Newsletter. Subscribe to the newsletter using the link below!

<https://public.govdelivery.com/accounts/MDDHMH/subscriber/new?preferences=true>

If you have stories of model programs, community engagement efforts, or initiatives that relate to SHIP priorities, please consider submitting them to be highlighted in our newsletter.

Email: mdh.bahm@maryland.gov

Closing Remarks

Appendix

SHIP Kickoff Attending Organizations

Maryland Department of Health

MDH- Medicaid
 MDH- Center for Chronic Disease Prev. & Contr.
 MDH- Center for Firearm Violence Prevention and Intervention
 MDH- Community Health Resources Commission
 MDH-Behavioral Health Administration
 MDH-Center for Tobacco Prevention and Control
 MDH-Office Care Transformation
 MDH-Office of the Secretary
 MDH-Office of Population
 MDH-Prevention and Health Promotion Administration
 MDH-Public Health Services
 MDH-State Office of Rural Health
 MDH- Office of the Deputy Secretary for Public Health Services

State Agency Partners

Maryland Department of Aging
 Maryland Department of Disabilities
 Maryland Department of Education
 Maryland Department of Housing and Community Development
 Maryland Department of Human Services
 Maryland Department of Labor
 Maryland Department of the Environment
 Maryland Department of Transportation
 Maryland Insurance Administration
 Maryland Wellness/ Maryland Rural Health Association
 State Council on Child Abuse and Neglect

Local Government Agencies

Allegany County Human Resources and Development Commission
 Baltimore County Department of Aging
 Baltimore Metropolitan Council
 Carroll County Government
 DCRS, OAI, SCHIP
 Garrett County Government
 Howard County Government
 Howard County Government Office on Aging & Independence
 Office on Aging and Independence
 Washington County Department of Social Services

SHIP Kickoff Attending Organizations

Local Health Departments

Allegany County Health Department	Harford County Health Department
Anne Arundel Department of Health	Howard County Health Department
Baltimore City Health Department	Kent County Health Department
Baltimore County Department of Health	Montgomery County Health Department
Calvert County Health Department	Queen Anne's County Department of Health
Caroline County Health Department	Somerset County Health Department
Carroll County Health Department	St. Mary's County Health Department
Charles County Department of Health	Talbot County Health Department
Dorchester County Health Department	Washington County Health Department
Frederick County Health Department	Wicomico County Health Department
Garrett County Health Department	Worcester County Health Department

Education Institutions

Anne Arundel Community College
Anne Arundel County Public Schools
Carroll Community College
Carroll County Public Schools
Hilltop Institute at UMBC
Howard County Public Schools
UMES School of Pharmacy
UMMS
University of Maryland School of Public Health

SHIP Kickoff Attending Organizations

Community Based Organizations		
AACF	Connected Communities For Behavioral Wellness	Partnership Development Group Inc
AACo AAA Area Agency on Aging Advisory Council	CRISP Shared Services	Reclaiming Health Learning Lab
Accessible Resources for Independence, Inc. Center for Independent Living	Food & Friends	Roots in Wellness, Inc.
Advancing Synergy	Health Care for the Homeless	Special Olympics Maryland
African Immigrants Dream Inc.	Home Helpers of Westminster	SPHC Foundation
AGR	Horizon Foundation	The Healthy Church
AHEC West	I-Matter, LLC	The Hilltop Institute
Allegany County HRDC	Illuminated Paradigm Counseling and Healing, LLC	The Horizon Foundation
Anne Arundel Mental Health Agency	James' Place Inc.	The Partnership Development Group, Inc.
Audacity of Hope	Maryland Children's Alliance	UnitedHealthcare Community Plan
BACC	Maryland Children's Alliance	Univ. of Maryland Extension, Baltimore County
Baltimore Safe Haven	Maryland Health Care Commission	University of Maryland Extension - SNAP-Ed
Catastrophic Health Planners	Meals on Wheels of Central Maryland	Unraveling Obesity Inc.
CENTER OF HELP	MedStar Healthy Babies Collaborative	Western Maryland Food Bank
Chesapeake Children's Museum	Method Fitness and Wellness	
Child Advocacy Center of Frederick County	Moveable Feast	

SHIP Kickoff Attending Organizations

Healthcare Entities	
Accessible Resources for Independence	LifeBridge Health
Annapolis Women's Clinic	LifeBridge Health- Northwest Hospital
August Rose Health Center	Maryland Physicians Care
CareFirst	Medpsych Health Services
CareFirst BlueCross BlueShield	Meritus Health/ Meritus School of Osteopathic Medicine
Carroll Hospital	Mountain Laurel Medical Center
Chase Brexton Health Care	MSB Counseling Services LLC
Columbia Community Care	Preshon Clinical Services
CRISP	TidalHealth
Elevate Recovery Centers	UM Baltimore Washington Medical Center
Garrett Regional Medical Center	Uneo Health
GBMC	United Healthcare
Health Tech Alley	UnitedHealthcare Community Plan of Maryland
Holy Cross Health	UPMC Western Maryland
Johns Hopkins Howard County Hospital	West Cecil Health Center
Johns Hopkins Howard County Medical Center- Population Health	Western Maryland Health Care Corporation
5 Johns Hopkins Howard County Medical Center: Community care team	Western Maryland Healthcare Corporation, d/b/a Mountain Laurel Medical Center

***Building a Healthier Maryland* Communications Resources**

- **Visit** the [Building a Healthier Maryland webpage](#) to access the SHA & SHIP documents & metrics
 - [2024 State Health Assessment \(SHA\)](#)
 - [2024 State Health Improvement Plan \(SHIP\)](#)
 - [SHIP Scorecard](#)
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