Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission (HSCRC or Commission) is required to collect community benefit information from individual hospitals in Maryland and compile it into an annual statewide, publicly available report. The Maryland General Assembly updated §19-303 of the Health General Article in the 2020 Legislative Session (HB1169/SB0774), requiring the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments. The reporting is split into two components, a Financial Report and a Narrative Report. This reporting tool serves as the narrative report. Detailed reporting instructions have been distributed to your hospital's community benefit contacts, and additional copies can be requested at the email below.

In this reporting tool, responses are mandatory unless specifically marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCBHelp@hilltop.umbc.edu.

Q2. Section I - General Info Part 1 - Hospital Identification

Q3. Please confirm the information we have on file about your hospital for the fiscal year.

	Is this information correct?		If no, please provide the correct information here:
	Yes	No	
The proper name of your hospital is: Adventist HealthCare Fort Washington Medical Center	◉	○	
Your hospital's ID is: 210060	◉	○	
Your hospital is part of the hospital system called Adventist HealthCare.	◉	○	
The primary hospital community benefit (HCB) Narrative contact at your hospital is Gina Maxham.	◉	○	
The primary HCB Narrative contact email address at your hospital is gmaxham@adventisthealthcare.com	◉	○	
The primary HCB Financial report contact at your hospital is Jacqueline Pourahmadi, Sean Love	◉	○	
The primary HCB Financial report contact email at your hospital is JPourahm@adventisthealthcare.com; slove@adventisthealthcare.com	◉	○	

Q4. Please select the community health statistics that your hospital uses in its community benefit efforts.

- ☑ Median household income
- ☑ Percentage below federal poverty level (FPL)
- ☑ Percent uninsured
- ☑ Percent with public health insurance
- ☑ Percent with Medicaid
- ☐ Mean travel time to work
- ☑ Percent speaking language other than English at home
- ☑ Race: percent White
- ☑ Race: percent Black
- ☑ Ethnicity: percent Hispanic or Latino
- ☑ Life expectancy
- ☑ Crude death rate
- ☑ Other

Q5. Please describe any other community health statistics that your hospital uses in its community benefit efforts.

In addition to the areas above, we also take into account the prevalence, incidence, hospitalization, and ER utilization of different disease states.

Q6. Attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Q7. Section I - General Info Part 2 - Community Benefit Service Area

Q8. The next group of questions asks about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

Q9. Please select the county or counties located in your hospital's CBSA.

☐ Allegany County	☐ Charles County	☑ Prince George's County
☐ Anne Arundel County	☐ Dorchester County	☐ Queen Anne's County
☐ Baltimore City	☐ Frederick County	☐ Somerset County
☐ Baltimore County	☐ Garrett County	☐ St. Mary's County
☐ Calvert County	☐ Harford County	☐ Talbot County
☐ Caroline County	☐ Howard County	☐ Washington County
☐ Carroll County	☐ Kent County	☐ Wicomico County
☐ Cecil County	☐ Montgomery County	☐ Worcester County

Q10. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q11. Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q12. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q13. Please check all Baltimore County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q14. Please check all Calvert County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q15. Please check all Caroline County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q16. Please check all Carroll County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q17. Please check all Cecil County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q18. Please check all Charles County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q19. Please check all Dorchester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q20. Please check all Frederick County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q21. Please check all Garrett County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q22. Please check all Harford County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q23. Please check all Howard County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q24. Please check all Kent County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q25. Please check all Montgomery County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q26. Please check all Prince George's County ZIP codes located in your hospital's CBSA.

☐ 20233	☐ 20710	☐ 20742	☐ 20772
☐ 20389	☐ 20712	☐ 20743	☐ 20773
☐ 20395	☐ 20715	☑ 20744	☐ 20774
☐ 20588	☐ 20716	☑ 20745	☐ 20775
☐ 20599	☐ 20717	☐ 20746	☐ 20781
☐ 20601	☐ 20718	☐ 20747	☐ 20782
☐ 20607	☐ 20720	☑ 20748	☐ 20783
☐ 20608	☐ 20721	☐ 20749	☐ 20784
☐ 20613	☐ 20722	☐ 20750	☐ 20785
☐ 20616	☐ 20724	☐ 20752	☐ 20790
☐ 20623	☐ 20725	☐ 20753	☐ 20791
☐ 20703	☐ 20726	☐ 20757	☐ 20792
☐ 20704	☐ 20731	☐ 20762	☐ 20799
☐ 20705	☐ 20735	☐ 20768	☐ 20866
☐ 20706	☐ 20737	☐ 20769	☐ 20903
☐ 20707	☐ 20738	☐ 20770	☐ 20904
☐ 20708	☐ 20740	☐ 20771	☐ 20912
☐ 20709	☐ 20741		

Q27. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q28. Please check all Somerset County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q29. Please check all St. Mary's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q30. Please check all Talbot County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q31. Please check all Washington County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q32. Please check all Wicomico County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q33. Please check all Worcester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

- [ ] Based on ZIP codes in your Financial Assistance Policy. Please describe.
- [ ] Based on ZIP codes in your global budget revenue agreement. Please describe.
- [x] Based on patterns of utilization. Please describe.

  Fort Washington Medical Center identifies its CBSA using population health data captured via its electronic medical records system, which is CPSI. Data includes patient information from admissions and the emergency department such as a patient's demographic information, personal and family medical history, allergies, immunizations, medications, health conditions, contact, and insurance information. The demographic information is used to parse which communities utilize our services, how often, and the type of service(s)/care a patient most requires.

- [x] Other. Please describe.

  FWMC identifies its CBSA based on computer programs & systems (EMR/EHR)

Q35. Provide a link to your hospital's mission statement.

https://www.adventisthealthcare.com/about/mission/

Q36. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

Q37. Section II - CHNAs and Stakeholder Involvement Part 1 - Timing & Format

Q38.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- (●) Yes
- ( ) No

Q39. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q40. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

5/13/2019

Q41. Please provide a link to your hospital's most recently completed CHNA. Please provide the entire CHNA, not just an Executive Summary.

https://www.adventisthealthcare.com/app/files/public/17ea72a6-b9b6-4f28-8dd5-5c02d037159a/2020-CHNA-FWMC.pdf

Q42. Please upload your hospital's most recently completed CHNA. Please provide the entire CHNA, not just an Executive Summary.

FINAL2_ 2019 Prince Georges CHNA.pdf
6.1MB
application/pdf

Q43. Section II - CHNAs and Stakeholder Involvement Part 2 - Internal CHNA Partners

Q44. Please use the table below to tell us about the internal partners involved in the development of your most recent CHNA.

	CHNA Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
CB/ Community Health/Population Health Director (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
CB/ Community Health/ Population Health Director (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	

Clinical Leadership (facility level)	☐	☐	☐	☐	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Population Health Staff (facility level)	☐	☐	☐	☐	☐	☐	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Population Health Staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Community Benefit staff (facility level)	☐	☐	☐	☐	☑	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Community Benefit staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Physician(s)	☐	☐	☐	☐	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Nurse(s)	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Social Workers	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:

Q45. Section II - CHNAs and Stakeholder Involvement Part 3 - Internal Hospital Community Benefit Partners

Q46. Please use the table below to tell us about the internal partners involved in your community benefit activities during the fiscal year.

	Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (facility level)	☐	☐	☑	☐	☐	☐	☐	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (facility level)	☐	☐	☑	☑	☐	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Population Health Staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Community Benefit staff (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Physician(s)	☐	☐	☐	☑	☐	☐	☐	☑	☑	☐	
Nurse(s)	☐	☐	☐	☑	☑	☐	☐	☑	☑	☐	
Social Workers	☐	☐	☐	☑	☑	☐	☐	☑	☑	☐	
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Q47. Section II - CHNAs and Stakeholder Involvement Part 4 - Meaningful Engagement

Q48. Community participation and meaningful engagement is an essential component to changing health system behavior, activating partnerships that improve health outcomes and sustaining community ownership and investment in programs. Please use the table below to tell us about the external partners involved in your most recent CHNA. In the first column, select and describe the external participants. In the second column, select the level of community engagement for each participant. In the third column, select the recommended practices that each stakeholder was engaged in. The Maryland Hospital Association worked with the HSCRC to develop this list of eight recommended practices for engaging patients and communities in the CHNA process.

Refer to the FY 2023 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is mandatory for FY 2023.

	Level of Community Engagement						Recommended Practices							
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals -- Please list the hospitals here: Luminis Doctors Community Hospital, Prince George's Hospital Center, MedStar Southern Hospital	☐	☐	☑	☐	☐	☐	☑	☑	☑	☑	☐	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Departments -- Please list the Local Health Departments here: Prince George's County Health Department	☐	☐	☑	☐	☐	☐	☐	☑	☑	☑	☑	☐	☐	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Improvement Coalition -- Please list the LHICs here: Prince George's County Healthcare Action Coalition	☐	☐	☑	☐	☐	☐	☑	☐	☐	☑	☐	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Maryland Department of Health	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other State Agencies -- Please list the agencies here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Govt. Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Faith-Based Organizations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - K-12 -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - Colleges, Universities, Professional Schools -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Behavioral Health Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Social Service Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Post-Acute Care Facilities -- please list the facilities here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Community/Neighborhood Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other -- If any other people or organizations were involved, please list them here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q49. Section II - CHNAs and Stakeholder Involvement Part 5 - Follow-up

Q50. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (●) Yes
- ( ) No

Q51. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

6/30/2019

Q52. Please provide a link to your hospital's CHNA implementation strategy.

https://www.adventisthealthcare.com/app/files/public/e17cb0af-4fe8-4369-bdca-2e99fcc2166c/2020-CHNA-FWMC-ImplementationStrategy.pdf

Q53. Please upload your hospital's CHNA implementation strategy.

2020-CHNA-FWMC-ImplementationStrategy.pdf
400.9KB
application/pdf

Q54. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q55. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q56. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q57. Section II - CHNAs and Stakeholder Involvement Part 6 - Initiatives

Q58. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- ○ Yes
- ◉ No

Q59.
Using the checkboxes below, select the Community Health Needs identified in your most recent CHNA that were NOT addressed by your community benefit initiatives.

- ☐ Health Conditions - Addiction
- ☐ Health Conditions - Arthritis
- ☐ Health Conditions - Blood Disorders
- ☑ Health Conditions - Cancer
- ☐ Health Conditions - Chronic Kidney Disease
- ☐ Health Conditions - Chronic Pain
- ☐ Health Conditions - Dementias
- ☐ Health Conditions - Diabetes
- ☐ Health Conditions - Foodborne Illness
- ☐ Health Conditions - Health Care-Associated Infections
- ☐ Health Conditions - Heart Disease and Stroke
- ☑ Health Conditions - Infectious Disease
- ☐ Health Conditions - Mental Health and Mental Disorders
- ☐ Health Conditions - Oral Conditions
- ☐ Health Conditions - Osteoporosis
- ☐ Health Conditions - Overweight and Obesity
- ☐ Health Conditions - Pregnancy and Childbirth
- ☐ Health Conditions - Respiratory Disease
- ☐ Health Conditions - Sensory or Communication Disorders
- ☐ Health Conditions - Sexually Transmitted Infections
- ☐ Health Behaviors - Child and Adolescent Development
- ☐ Health Behaviors - Drug and Alcohol Use
- ☐ Health Behaviors - Emergency Preparedness
- ☐ Health Behaviors - Family Planning
- ☐ Health Behaviors - Health Communication
- ☐ Health Behaviors - Injury Prevention
- ☐ Health Behaviors - Nutrition and Healthy Eating
- ☐ Health Behaviors - Vaccination
- ☐ Health Behaviors - Violence Prevention
- ☑ Populations - Adolescents
- ☐ Populations - Children
- ☐ Populations - Infants
- ☐ Populations – LGBT
- ☐ Populations - Men
- ☐ Populations - Older Adults
- ☐ Populations - Parents or Caregivers
- ☐ Populations - People with Disabilities
- ☐ Populations - Women
- ☐ Populations - Workforce
- ☐ Settings and Systems - Community
- ☐ Settings and Systems - Environmental Health
- ☐ Settings and Systems - Global Health
- ☐ Settings and Systems - Health Care
- ☑ Settings and Systems - Health Insurance
- ☐ Settings and Systems - Health IT
- ☐ Settings and Systems - Health Policy
- ☐ Settings and Systems - Hospital and Emergency Services
- ☐ Settings and Systems - Housing and Homes
- ☐ Settings and Systems - Public Health Infrastructure
- ☐ Settings and Systems - Schools
- ☐ Settings and Systems - Transportation
- ☐ Settings and Systems - Workplace
- ☐ Social Determinants of Health - Economic Stability
- ☐ Social Determinants of Health - Education Access and Quality

- [x] Health Behaviors - Physical Activity
- [ ] Health Behaviors - Preventive Care
- [ ] Health Behaviors - Safe Food Handling
- [ ] Health Behaviors - Sleep
- [ ] Health Behaviors - Tobacco Use
- [ ] Social Determinants of Health - Health Care Access and Quality
- [ ] Social Determinants of Health - Neighborhood and Built Environment
- [ ] Social Determinants of Health - Social and Community Context
- [ ] Other Social Determinants of Health
- [ ] Other (specify)

Q60. Why were these needs unaddressed?

Adventist HealthCare Fort Washington Medical Center does not currently provide outreach and educational programs for the areas listed above due to limited financial resources and personnel. Rather than attempting to address every need and spreading resources too thin, we have prioritized the needs based on factors such as prevalence/incidence, inequities, gaps in the community, expertise, and partnerships, among others.

Q61. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

When completing the Community Health Needs Assessment process as much as is possible, all of the data collected is stratified by demographics such as race, ethnicity, sex, and age so that disparities are not masked by the aggregated data. Disparities identified are highlighted in the reports and taken into account when completing the prioritization process and developing the implementation strategy. As an example, as part of our grant giving program, our giving areas align with our CHNA priority areas. Applicants are asked to identify the disparities they will be addressing (within the priority areas) and how they have developed their programs to address those disparities. Whether they are addressing disparities in a meaningful way is one of the factors that determines if funding will be awarded. When evaluating programs, demographic data is also collected and utilized in the analysis. Patients receiving care at all of our locations are also asked to provide demographic data which is used to stratify metrics such as patient outcomes and patient experience.

Q62. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

- [x] None
- [ ] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program
- [ ] The COVID-19 Long-Term Care Partnership Grant
- [ ] The COVID-19 Community Vaccination Program
- [ ] The Population Health Workforce Support for Disadvantaged Areas Program
- [ ] Other (Describe)

Q63. (Optional) If you wish, you may upload a document describing your community benefit initiatives in more detail.

Q64. Section III - CB Administration

Q65. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- [x] Yes, by the hospital's staff
- [x] Yes, by the hospital system's staff
- [ ] Yes, by a third-party auditor
- [ ] No

Q66. Please describe the third party audit process used.

This question was not displayed to the respondent.

Q67. Does your hospital conduct an internal audit of the community benefit narrative?

- ( ) Yes
- (•) No

Q68. Please describe the community benefit narrative audit process.

This question was not displayed to the respondent.

Q69. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- ○ Yes
- ◉ No

Q70. Please explain:

The Adventist HealthCare Board of Trustees reviewed and approved the Community Health Needs Assessment and Implementation Strategy. Financial and executive leadership review and approve the financial spreadsheet.

Q71. Does the hospital's board review and approve the annual community benefit narrative report?

- ○ Yes
- ◉ No

Q72. Please explain:

The Adventist HealthCare Board of Trustees reviewed and approved the Community Health Needs Assessment and Implementation Strategy. The Board of Trustees only meets twice per year so they have not yet had a chance to review this report.

Q73. Does your hospital include community benefit planning and investments in its internal strategic plan?

- ◉ Yes
- ○ No

Q74. Please describe how community benefit planning and investments were included in your hospital's internal strategic plan during the fiscal year.

As part of Adventist HealthCare, Fort Washington Medical Center (FWMC) is dedicated to Community Benefit which aligns with the systems core mission and values. The Strategic Plan for FWMC as well as all of Adventist HealthCare (AHC) is based on our pillars of success: Bigger, Better (People; Quality and Safety; Experience; Finance), and Beyond. Each of the pillars are centered on measurable objectives and targets and is led by an overarching council with several committees reporting up to it. Population Health and community benefit efforts are all included within the Beyond pillar. The Community Benefit Steering Committee which oversees the CHNA and Implementation Strategy process as well as community benefit system-wide, reports to the Population Health Division Council. The strategic plan also outlines system-wide community benefit infrastructure and the areas of focus as determined by the CHNA process.

Q75. If available, please provide a link to your hospital's strategic plan.

Q76. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- ☑ Diabetes - Reduce the mean BMI for Maryland residents

  Diabetes Self-Management Program

- ☐ Opioid Use Disorder - Improve overdose mortality

- ☐

Maternal and Child Health - Reduce severe maternal morbidity rate

- [ ] Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17

- [ ] None of the Above

Q77. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q78. Section IV - Physician Gaps & Subsidies

Q79. (Optional) Please attach any files containing further information and data justifying physician subsidies at your hospital.

(This year, all information on physician gap subsidies is collected on the financials. However, if you have additional information on these subsidies to report, you may do so through attachments here.)

Q80. Section V - Financial Assistance Policy (FAP)

Q81. Upload a copy of your hospital's financial assistance policy.

AHC-FinancialAssistance-Policy - 2022.pdf
627.9KB
application/pdf

Q82. Provide the link to your hospital's financial assistance policy.

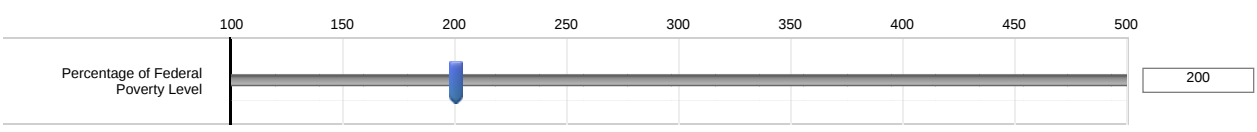
https://www.adventisthealthcare.com/app/files/public/cecfe073-900d-4040-99bf-98e381c6452d/AHC-FinancialAssistance-Policy.pdf

Q83. Has your FAP changed within the last year? If so, please describe the change.

- (●) No, the FAP has not changed.
- ( ) Yes, the FAP has changed. Please describe:

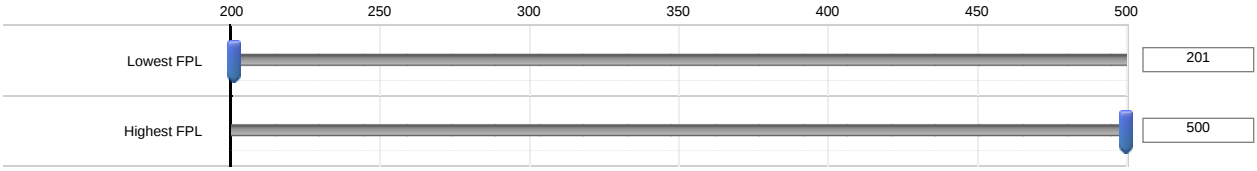
Q84. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

Please select the percentage of FPL below which your hospital's FAP offers free care.



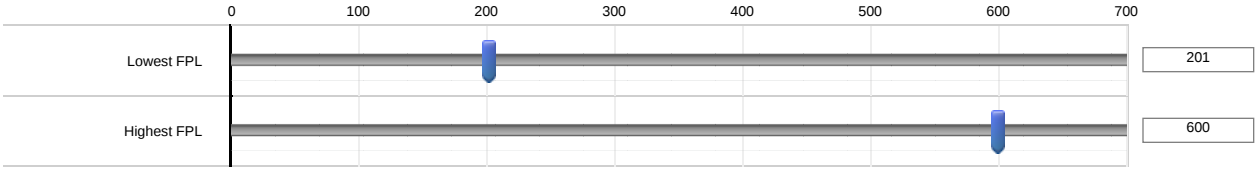
Q85. Maryland acute care and chronic care hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care.

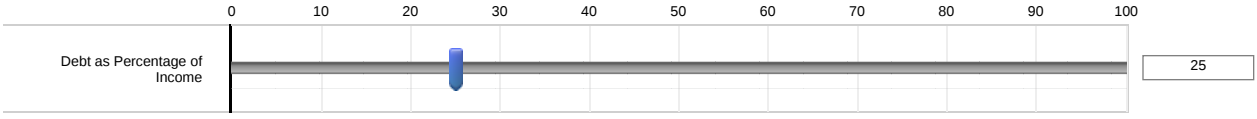


Q86. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3)(a) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship.



Q87. Please select the threshold for medical debt as a percentage of family income above which qualifies as a financial hardship.



Q88. Section VI - Tax Exemptions

Q89. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding taxable year (select all that apply)

- [x] Federal corporate income tax
- [x] State corporate income tax
- [x] State sales tax
- [x] Local property tax (real and personal)
- [ ] Other (Describe) _____

Q90. Summary & Report Submission

Q91.

Attention Hospital Staff! IMPORTANT!

You have reached the end of the questions, but you are not quite finished. Your narrative has not yet been fully submitted. Once you proceed to the next screen using the right arrow button below, you cannot go backward. You cannot change any of your answers if you proceed beyond this screen.

We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can use the Table of Contents feature to navigate to the appropriate section of the narrative.

Once you are fully confident that your answers are final, return to this screen then click the right arrow button below to officially submit your narrative.

Location Data

Location: (37.5538, -77.4603)

Source: GeoIP Estimation

2022
PRINCE GEORGE'S COUNTY

COMMUNITY HEALTH ASSESSMENT

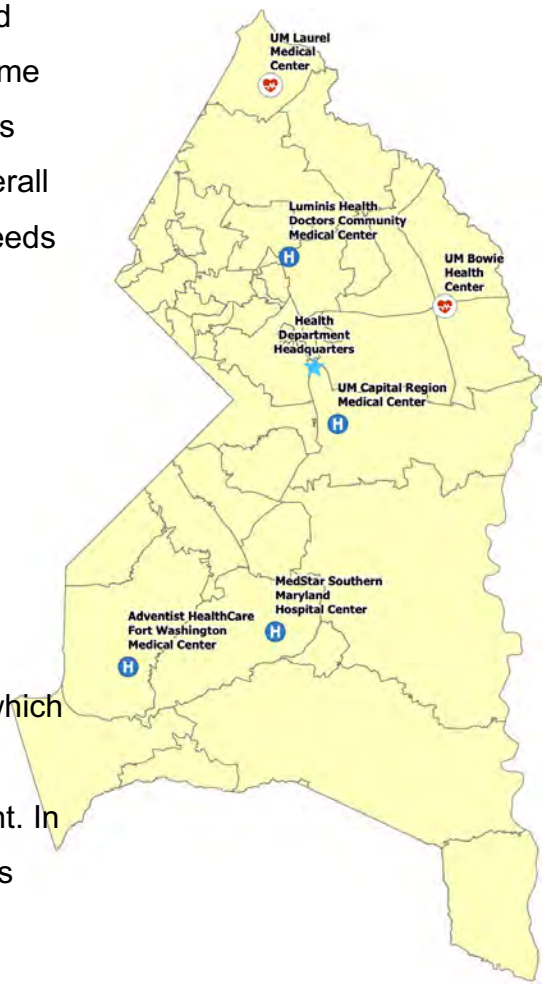
Prepared by:
Prince George's County Health Department
Office of Assessment and Planning
Health-OAP@co.pg.md.us

Approved and adopted by Adventist HealthCare October 2022

HEALTH DEPARTMENT
Prince George's County

INTRODUCTION

Prince George's County is located in the State of Maryland and is part of the Washington, D.C. metropolitan area. Home to nearly one million diverse residents, the County includes urban, suburban, and rural regions. The County, while overall considered affluent, has many communities with higher needs and poor health outcomes.



In 2015, the Prince George's County government and Maryland-National Capital Park and Planning Commission conducted a special study to develop a Primary Healthcare Strategic Plan[1] in preparation for enhancing the health care delivery network. A key recommendation from the plan was to "build collaboration among Prince George's County hospitals," which included conducting a joint community health assessment (CHA) with the Prince George's County Health Department. In 2016, the first inclusive CHA was completed. The hospitals and Health Department agreed to work collaboratively to update the 2016 CHA in 2019 and again in 2022.

CHA Core Team

Luminis Health Doctors Community Hospital
Adventist HealthCare Fort Washington Medical Center
MedStar Southern Maryland Hospital Center
Prince George's County Health Department
UM Capital Region Health

There are four hospitals located within the County: Luminis Health Doctors Community Hospital, Adventist HealthCare Fort Washington Medical Center, MedStar Southern Maryland Hospital Center, and UM Capital Region Medical Center with two freestanding emergency facilities in Laurel and Bowie. All four hospital systems and the Health Department appointed staff to facilitate the 2022 CHA process.

[1] http://www.pgplanning.org/Resources/Publications/PHSP.htm

PROCESS OVERVIEW

The CHA process was developed to 1) maximize community input, 2) learn from community experts, 3) utilize existing data, and 4) ensure a comprehensive prioritization process. Elements of the Mobilizing for Action through Planning and Partnerships (MAPP)[2] process were used in the 2022 CHA for inclusion of community perceptions of health and consideration of the local health system. At the start of the process, the Core Team reviewed the shared vision:

"A community focused on health and wellness for all."

The group agreed upon retaining the five shared values to provide focus, purpose, and direction for the CHA process:

- Collaboration
- Equity
- Trust
- Safety
- Prevention

The Core Team was also asked to review the previous survey tools and provide feedback and from this, questions about discrimination were included to reflect resident lived experiences. The effect of the COVID-19 pandemic was also discussed in depth, however much of the data available is only through 2020 and will not reflect the full effect of the pandemic, from exacerbation of the social determinants of health to potential poorer health outcomes due to missed screenings and timely treatment of a variety of health conditions.

The Health Department staff led the CHA process in developing the data collection tools and analyzing the results with input from the hospital representatives. The process included:

- A community resident survey available in English, Spanish, and French distributed by the hospitals and Health Department;
- Secondary data analyses that included the County demographics and population description through socioeconomic indicators, and a comprehensive health indicator profile;

[2] https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

- Hospital Service Profiles to detail the residents served by the Core Team;
- A community expert survey and key informant interviews; and
- A prioritization process that included the Core Team and Prince George's Healthcare Action Coalition leadership.

While the Core Team led the data gathering process, there was recognition that **health is a shared responsibility**. The community data collection strategies and the prioritization process were intentionally developed with this consideration and set the foundation for coordination moving forward.

Due to the pandemic, the Core Team determined to maintain the same priorities from 2019 since they are still relevant and much of the planned work from 2019 had to be suspended. The 2022 priorities will continue to be:

- the social determinants of health
- behavioral health
- obesity and metabolic syndrome
- cancer

The results of this process will guide the Health Department and hospitals in addressing the health needs of the County and pave the way for opportunities for further collaboration. The Core Team also acknowledged that due to the Maryland Department of Health's cyberattack in December 2020, much of the local data will need to be updated as it becomes available, which can provide further opportunities to address the priorities together.

KEY FINDINGS

Drivers of Poor Health Outcomes:

- **Social determinants of health drive many of our health disparities and were exacerbated further during the pandemic.**
    - Poverty, food insecurity, access to healthy food, affordable housing, inadequate financial resources, access to care, and a disparate built environment result in poorer health outcomes.
    - Growth in the County, while benefiting some, may harm others. Affordable housing was noted as a concern in the 2019 CHA and received even more focus in 2022. The median renter income in the County is estimated to be able to afford $1,460 for rent, but a two-bedroom apartment is estimated to cost $1,765 a month, well above what is affordable.
    - The County experienced substantial growth over the last decade, gaining more than 100,000 residents from 2010 to 2020. This has contributed to many of the social determinant issues, with not enough housing, need for more transportation, and need for more resources to address the social determinants.
- **Access to healthcare is still a leading issue in the County.**
    - Many residents still lack health insurance (some have not enrolled, some are not eligible); this disproportionately affects Hispanic residents.
    - Those with health insurance struggle to afford healthcare (such as co-pays, high premiums, and deductibles) and prescriptions, and have difficulty accessing care due to transportation challenges.
    - The County Health Assures program, which helps to provide healthcare for those without insurance or sufficient resources, was recognized as a positive step by both the community experts and key informants but it was noted that more of this resource is needed.
    - While advances in the County were made, such as the new UM Capital Region Medical Center and Luminis Behavioral Health facility, residents and community leaders noted that more was needed, which aligns with the need for more services due to population growth.

- **Residents desire more permanent solutions, not temporary resources.**
    - There are services available, but they are perceived as underutilized because residents do not know how to locate or use them, and their temporary nature contributes to this.
- **There is a perception that the County lacks quality healthcare providers.**
    - There is a great need for culturally competent and bilingual healthcare providers. This was noted in the 2019 CHA and further emphasized in 2022, in part due to the challenges that the pandemic brought to the forefront.
    - Surrounding jurisdictions are perceived to have better quality providers. Residents with resources often travel outside of the County for healthcare needs.
- **Lack of ability to access healthcare providers.**
    - There are limited transportation options available, and the supply does not meet the need. There is also a lack of transportation for urgent but non-emergency needs that cannot be scheduled in advance.
    - The distribution of providers is uneven in the County; some areas have a high geographic concentration of providers, while other areas have very few or no providers available nearby.
- **Disparities in health outcomes are complicated.**
    - Even though Black, non-Hispanic residents are more likely to be screened for cancer, they still have higher cancer mortality rates. The infant mortality rate for Black, non-Hispanic residents is significantly higher compared to other race/ethnic groups. It is challenging to determine how elements such as stress, culture, structural racism, and implicit bias contribute to health disparities along with the social determinants of health, healthcare access, and healthcare utilization.
    - Hispanic residents now comprise one out of every five County residents, but healthcare access remains a substantial challenge. If this pattern continues, new disparities could arise in the future as these residents age in the County.

Leading Health Challenges

- **Chronic conditions such as heart disease, diabetes, and stroke continue to lead in poor outcomes for many County residents.**
    - Behaviors that promote good health, such as healthy eating and active living, are not accessible to all residents and not all that do have access have adopted health lifestyles.
    - An estimated 71% of adults in the County are obese or overweight.
    - The lack of physical activity and increased obesity is closely related to residents with **metabolic syndrome**[3], which increases the risk for heart disease, diabetes, and stroke.
- **Behavioral health needs often overlap with other systems and can be exacerbated by other unmet needs such as housing.**
    - Hospitals, public safety, and the criminal justice system see many residents needing behavioral health services and treatment.
    - While the County has seen an increase in behavioral health resources, it is still not adequate to address the needs of our growing population.
    - One potential positive outcome from the pandemic is that behavioral health has been an area of focus and as a result, this has potentially reduced some of the stigma previously associated with it.
- While our population is growing, it is also aging.
    - The median age for Black and white, non-Hispanic residents is over 40 years
    - The need for more senior housing, aging in place services, and resources tailored more to seniors was identified.
- **While the trends for many health issues have improved in the County, we still have significant disparities. For example:**
    - **Cancer:** Black residents in the County had higher mortality rates for breast and prostate cancers despite having higher screening rates.
    - **HIV:** Prince George's County had the second highest rate of HIV diagnoses in the State in 2020 and had the highest number of actual cases in the State.

[3] Metabolic Syndrome is a group of risk factors that raises the risk of heart disease and other health problems such as diabetes and stroke. The risk factors include: a large waist; high triglycerides (fat in the blood); low HDL or "good" cholesterol; high blood pressure, and high blood glucose (sugar). Source: NIH, accessed on 6/1/16, http://www.nhlbi.nih.gov/health/health-topics/topics/ms

- **COVID-19**: Hispanic residents had an age-adjusted mortality rate more than twice as high as Black, non-Hispanic residents and over three times higher than white, non-Hispanic residents in 2020.
- **Substance Use:** White, non-Hispanic residents had a drug-related mortality rate nearly twice as high compared to Black, non-Hispanic residents between 2018 and 2020.
- **Teen Births:** The Hispanic teen birth rate was four times higher than Black, non-Hispanic teens and seventeen times higher than White, non-Hispanic teens in 2020.

Recommendations

- Leverage the attention COVID-19 has brought for health and other related issues to the public and leaders
  - Access to healthcare, the need for culturally and linguistically appropriate services, behavioral health, and the social determinants of health have all been areas of focus during the pandemic and now is the time to coordinate to address them.
- **Increase care coordination resources**
  - Trained community health workers were recognized as improving health outcomes for residents by navigating services and ensuring residents have the support and knowledge they need.
  - Residents need education about the available resources, and how to utilize and navigate them.
- **More funding and resources for health and support services**
  - Permanent funding is needed to strengthen the health safety net for those unable to access health insurance or unable to afford what is available.
  - There must be a focus on ensuring that basic needs are being met for residents experiencing vulnerabilities for them to manage their health.
- **Attract a culturally diverse quality healthcare workforce**
  - One in five residents in the County were born outside of the U.S. A diverse workforce would potentially help to address the cultural and language barriers experienced by residents.

- Plan now for the services needed for the seniors of the future, so residents can safely age upwards in our communities
- **Increased partnerships and collaborative efforts are needed**
    - Current coordinated efforts in the County were recognized as improving outcomes through care coordination and by addressing systemic issues in the County.

TABLE OF CONTENTS

COMMUNITY HEALTH ASSESSMENT

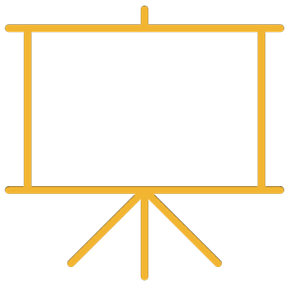
2022 EXECUTIVE SUMMARY

PRINCE GEORGE'S COUNTY HEALTH DEPARTMENT
Prepared by the Office of Assessment and Planning, June 14, 2022
Health-OAP@co.pg.md.us

HEALTH DEPARTMENT
Prince George's County

Community Health Assessment

OVERVIEW



1. WELCOME
2. CHA PROCESS
3. CHA RESULTS
4. NEXT STEPS

BASED ON MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIP (MAPP)

2019 Vision: A community focused on health and wellness for all.

2019 Values:

- Collaboration
- Equity
- Trust
- Safety
- Prevention

2022 CHA Components

- Demographics and Population Description
- Health Indicators
- Key Informant Interviews (N=15)
- Community Expert Survey (ongoing)
- Community Resident Survey (N=118)
- Asset and Resources Identification (ongoing)

2022 CHA Core Team

- Luminis Health Doctors Community Medical Center
- Adventist HealthCare Fort Washington Medical Center
- MedStar Southern Maryland Hospital Center
- UM Capital Regional Medical Center
- Prince George's Health Department
- Prince George's Healthcare Action Coalition Leadership

2022 PRIORITIES

Determined by consensus to retain the four priority areas:

- Social Determinants of Health
- Behavioral Health
- Obesity & Metabolic Syndrome
- Cancer

In 2019, it was acknowledged that these are challenging priorities that are already difficult to “move the needle.” In 2022, many of the notable disparities continue to exist with some further exacerbated by the COVID-19 pandemic. In addition to the disruptions caused by the COVID-19 pandemic, it is also uncertain what the far-reaching effects will be on the health and well-being of residents.

DATA LIMITATIONS

WE WILL NEED TO REVISIT SOME DATA SOURCES:

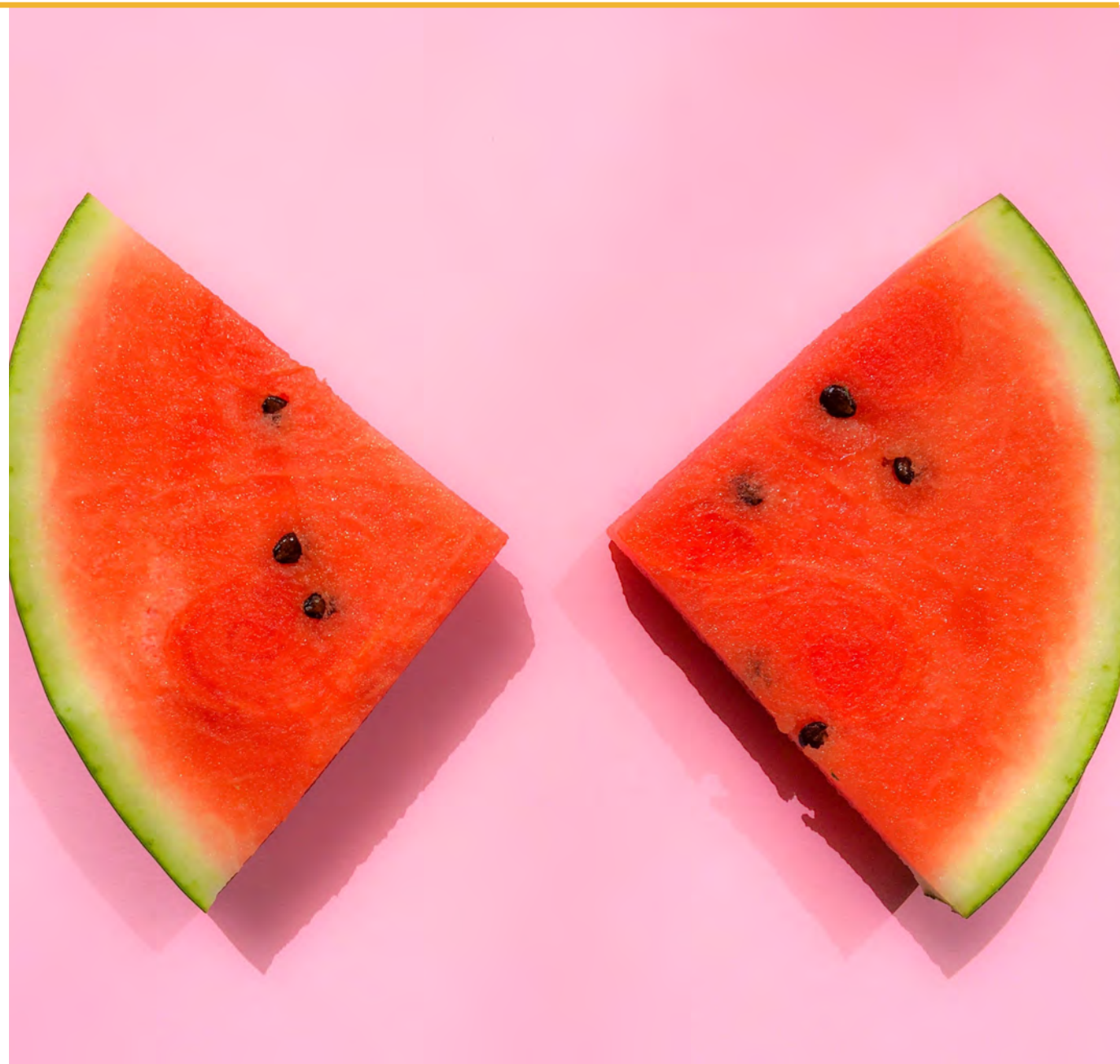
- **Census 2020:** We know our population grew much more than estimated.
  - 2019 American Community Survey Estimate: 909,327
  - 2020 Census: 967,201

- **Maryland Department of Health Cyberattack**
  - Still no Maryland Behavioral Risk Factor Surveillance System Data website
  - Moratorium on hospital discharge data
  - 2020 Vital Statistics data has not yet been released

The COVID-19 fallout is largely not included in the current data, including the effect of delayed screenings and diagnoses, prevention efforts that rely on in-person and event outreach, and the overall effect on individuals and households including the trauma and loss experienced by our community.

PRIORITY #1

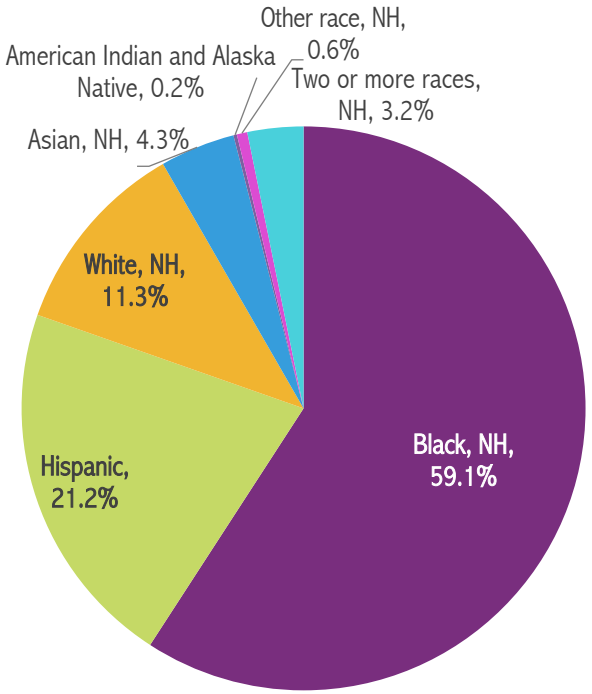
SOCIAL DETERMINANTS OF HEALTH

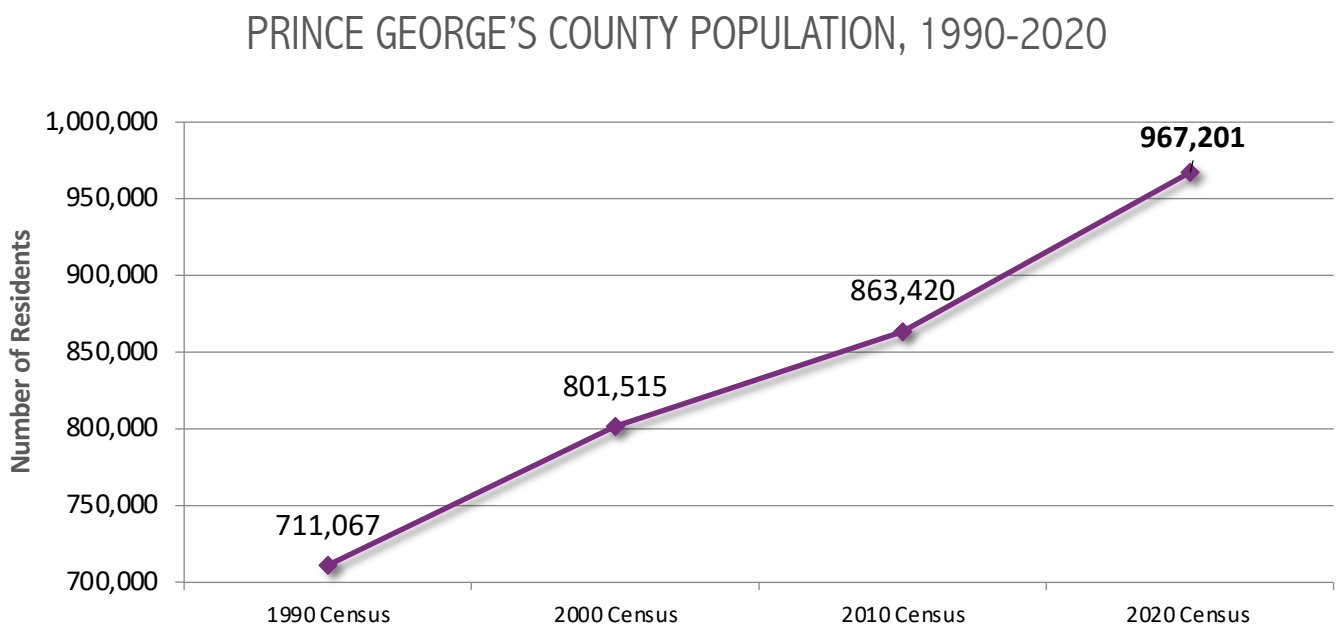


Population Changes

HIGHLIGHTS

- The Prince George's County population grew by 12% over the last decade, compared to only 7% for the State.
- County residents comprise 16% of the State.
- Residents identifying as Hispanic grew by nearly 60% between 2010 and 2020, now comprising 21.2% of residents, or more than one in five.





ACCESS TO CARE

Indicators

- Approximately 90% of residents have health insurance, with most covered through employer-based coverage
- Approximately 90,000 residents are estimated to lack insurance as of 2020 and nearly one in five residents ages 26-34 years were estimated to be uninsured
- By race and ethnicity, Hispanic residents are more likely to be uninsured (29%)
- Provider to Resident Ratios: 1 PCP to 1,890 residents, 1 dentist for every 1,570 residents, 1 mental health provider for every 550 residents
- Between March 2020 – June 2021, 39,143 residents enrolled for insurance through the COVID-19 Special Enrollment period (the most in Maryland)

RESIDENTS WITH HEALTH INSURANCE, 2016-2020

	PRINCE GEORGE'S	MARYLAND
Race/Ethnicity		
Black	93.8%	94.2%
Hispanic	70.7%	78.6%
White, non-Hispanic	96.0%	96.9%
Asian	92.8%	94.6%
Sex		
Male	87.9%	93.1%
Female	91.4%	94.9%
Age Group		
Under 19 Years	94.1%	96.5%
19 to 25 Years	85.7%	90.9%
26 to 34 Years	81.6%	88.8%
35 to 44 Years	82.0%	90.2%
45 to 54 Years	89.4%	93.5%
55 to 64 Years	93.1%	95.3%
65 Years and Older	97.6%	99.0%
Total	**89.7%**	**94.1%**

Data Source: 2016-2020 American Community Survey 5-Year Estimates, Table S2701

ACCESS TO CARE

Resident Surveys

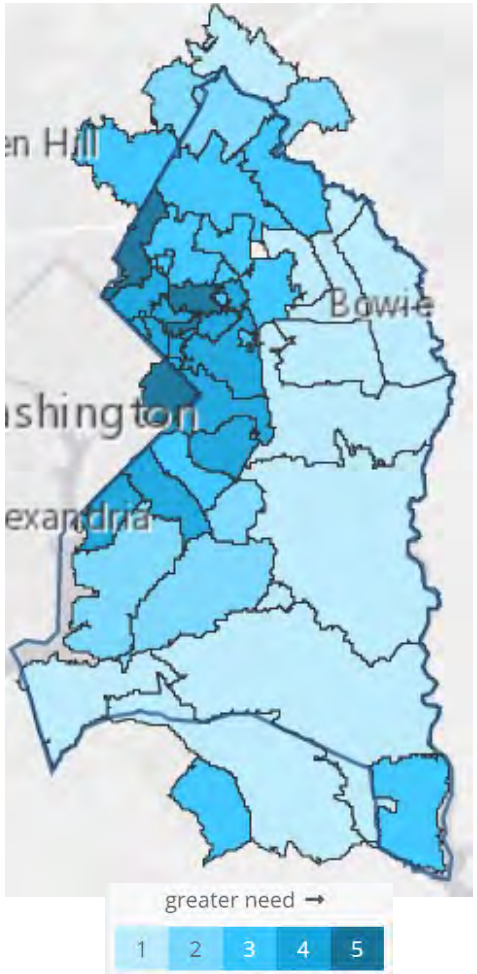
- Access to healthcare and related services was identified as the leading factor that defines a “healthy community”
- Nearly one-quarter are unsatisfied with the healthcare system in the County (same as 2019)
- Compared to 2019, fewer residents believed those in their community could not access a primary care provider (15%), about the same (one-third) indicated their community could not access a medical specialist, and more (42%) indicated their community could not access a mental health provider
- About a third indicated those in their community lacked transportation to medical appointments, and 43% indicated those in their community struggled to afford their medications
- Top barriers to care include money for co-pays or medications, no health insurance, time limitations (appointment availability, time off work), and childcare

Community Experts for Special Populations

- Echoed Resident Surveys about lack of healthcare providers/services, particularly specialists and mental health services
- Noted digital divide challenges, especially for seniors and veterans
- Health Insurance: some lack knowledge about resources, some do not qualify, more is needed to support both these groups
- Noted importance of culturally and linguistically appropriate provision of services, need for outreach and education for immigrant and refugee communities

Socioeconomic Factors

2022 SOCIONEEDS INDEX PRINCE GEORGE'S COUNTY



Source: www.PGCHealthZone.org

Indicators

- 12.6% of children are estimated to live in poverty in the County, similar to Maryland
- One-third of Hispanic, female head of household families live in poverty
- Unemployment declined in the County (5.5%, 2019) but remains higher for Black residents (6.5%); for residents with a disability the unemployment rate is 12.0%
- Median household income for the County was estimated as $86,290 in 2019, a 12% increase over five years
- An estimated 9.2% of County households do not have a vehicle

Resident Surveys

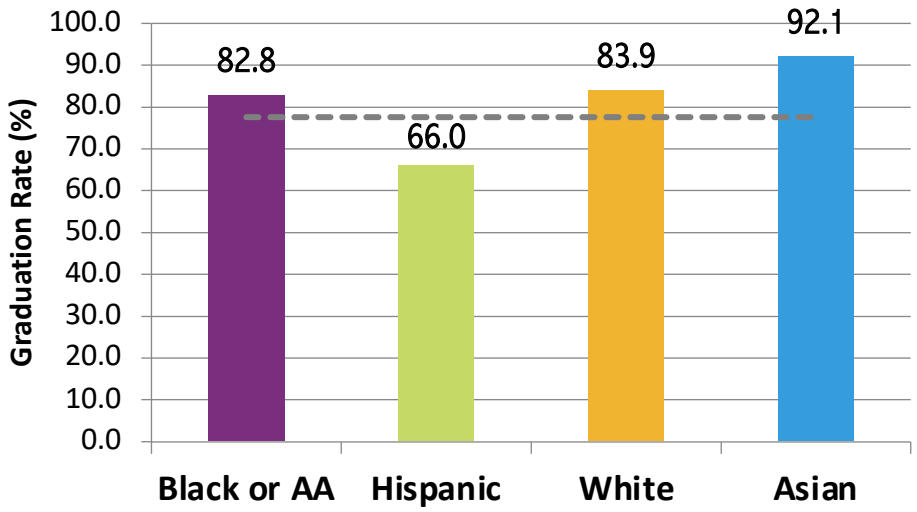
- 44% reported satisfaction with the economic opportunities in the overall County; 60% reported satisfaction the economy in their community
- Good jobs and a healthy economy were identified as the fifth most important factors for a healthy community
- One-third responded that transportation to medical appointments is not available to most in their community

Community Experts

- Similar to residents, economic stability was identified as one of the most important social determinants of health in the county
- Transportation was noted as a leading barrier to health and well-being

Education

2021 GRADUATION RATE BY RACE/ETHNICITY PRINCE GEORGE'S COUNTY PUBLIC SCHOOLS



Prince George's Graduation Rate: 77.6%
Maryland Graduation Rate: 87.2%

Source: 2021 Maryland Public Schools Report Card

Indicators

- 87% of residents 25+ years and older have at least a high school education, lower than state (90%)
- Nearly half of Hispanic residents have less than a high school education
- Only half of high school graduates enrolled in college, compared to 63% for the state; this drops to 30% for Hispanic graduates

Resident Surveys

- "Good schools" was identified as the third most important factor for a health community
- Approximately half indicated their community had a good schools.
- However, only 36% were satisfied with the County being a good place to raise children (down from half in 2019)

Community Experts

- Similar to residents, a little over a third thought those they serve felt the County is a good place to raise children
- About a third indicated the community they serve are treated differently due to their education or income level

Housing

2021 FAIR MARKET RENT

	PRINCE GEORGE'S	MARYLAND
		Fair Market Rent by Unit
Efficiency	$1,513	$1,125
One bedroom	$1,548	$1,247
Two bedroom	$1,765	$1,487
Three bedroom	$2,263	$1,927
Four bedroom	$2,742	$2,273
		Income Needed to Afford Fair Market Rent by Unit
Efficiency	$60,520	$45,013
One bedroom	$61,920	$49,860
Two bedroom	$70,600	$59,480
Three bedroom	$90,520	$77,065
Four bedroom	$109,680	$90,910
		Income of Renter
Estimated renter median income	$58,387	$53,894
Rent affordable for households earning the renter median income	**$1,460**	**$1,347**

Source: National Low Income Housing Coalition

Indicators

- An estimated 5.8% of housing units were vacant in 2019 in the County, lower than Maryland (9.9%)
- The average household size for renter-occupied units in the County was 2.70, larger than the state (2.46)
- Nearly one in five housing units in the County were estimated as having a severe housing problem (overcrowding, high housing cost, lack of kitchen or plumbing facilities)

Resident Surveys

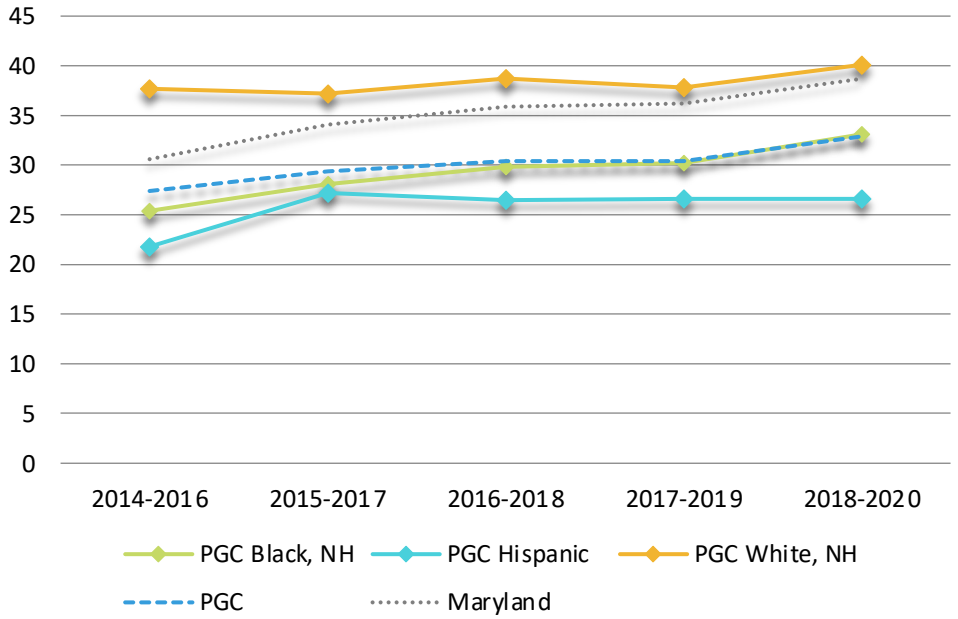
- "Affordable housing" was identified as the fourth most important factor for a healthy community
- Only 28% responded that their community has enough affordable housing

Community Experts

- Housing concerns such as affordability, quality, adaptability, and stability for school-age children were identified as a major barrier to health and well-being in the County

NEIGHBORHOOD & BUILT ENVIRONMENT

UNINTENTIONAL INJURY AGE-ADJUSTED MORTALITY RATE
2014-2020



Source: CDC Wonder

Indicators

- Estimated that 14.5% of County children are food insecure (2019); however, the County has one of the best food environment indexes in the State at 9.1 (10 is best).
- Both the County and the State have seen increases in the unintentional injury mortality rate; in the County unintentional injuries are one of the leading causes of death.

Resident Surveys

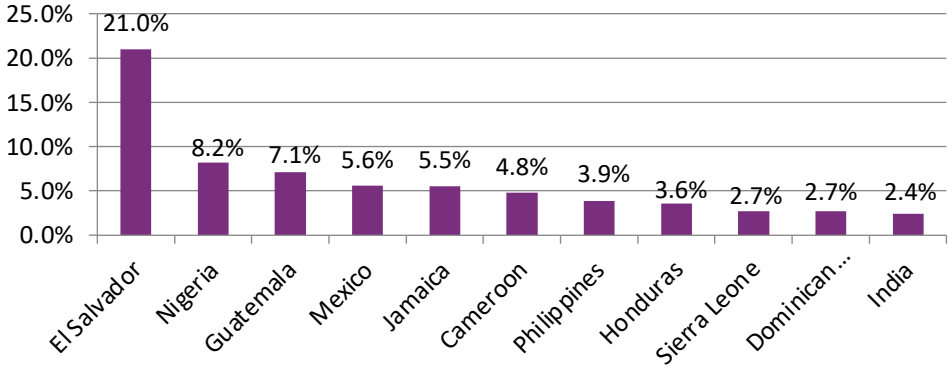
- 60% believe their community is a safe place to live, the same as in 2019
- Four out of five reported easy access to fresh food in their community, the same as in 2019
- Three-fourths reported parks as the places they go to most often in their community, followed by the library
- Aging within a community was identified as the fifth leading health issue

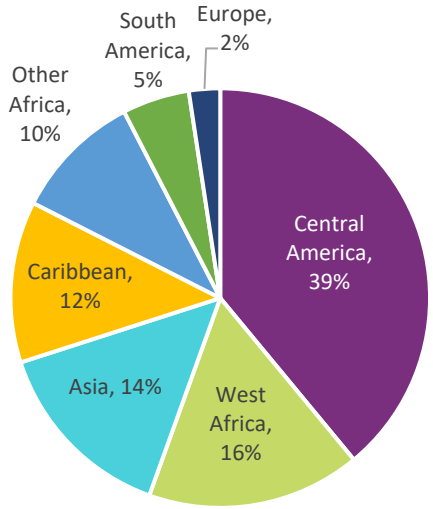
Community Experts

- One-third believed the residents they serve feel their community is a safe place to live
- Air quality and pollution noted as a concern

SOCIAL & COMMUNITY CONTEXT

LEADING COUNTRIES OF ORIGIN OF FOREIGN-BORN RESIDENTS
PRINCE GEORGE'S COUNTY, 2016-2020





Source: 2016-2020 American Community Survey 5-Year Estimates, Table B05006

Indicators

- An estimated 23.6% residents were born outside the United States
- As a world region, Central America accounts for nearly 40% of county foreign-born residents
- 42% of foreign-born households are naturalized U.S. citizens with a median household income of $87,993, compared to $71,670 for the 58% who are not U.S. citizens

Resident Surveys

- 56% are satisfied with the quality of life in Prince George's County
- Just under half identified their church as the place they go most often in the County
- 60% believe that an increase in community awareness and engagement would support health in their area (#1), followed by increased focus on health inequities in their community
- Nearly one-third indicated they have experienced being treated with less courtesy or respect at least a few times a month or more; for those that experienced this the most common reason for the experience was race or national origins

Community Experts

- Two-thirds believe the residents they serve are satisfied with the quality of life in the County

SDOH BIG PICTURE

What's happened since the last CHA?

- Updated RAND Report: Assessing Health and Human Services Needs
- PG Forward Taskforce
- Health Assures grew to $2.8m in 2020, covered 30,000 visits July – Dec 2021
- COVIDCare (started in 2020), sustained and evolved with Community Health Workers (CHWs) now serving residents in County libraries
- New Healthy Food Priority Area (HPSA) designation for Langley Park area
- Langley Park vaccination pod – looking at systemic models for a local strategy
- HPSA legislation for tax incentives
- 2021 Food Access and Equity Study

What's in the works?

- HD CHISS grant – expansion of 30 CHWs in community and 90 CHWs to be trained for state certification and COVID-19 certification; working on CWH pipeline
- HD HealthLeap - Healthy Literacy grant focusing on eight subpopulations to develop tailored interventions for delivery by providers and CHWs; HQI planning a dashboard to share cultural tailoring with physicians
- Pediatric Telehealth in PGCPS $4.1 million to build an infrastructure in school system
- New County equity officer position
- Pathways to Health Equity grants

Where do gaps/opportunities remain?

- New County Council members coming in 2022 who will need to be briefed
- Lack of adequate resources in the County (office/positions): Estimated County spending on health and human services departments is $39 per person, about one-third to one-seventh the per-person spending of surrounding Maryland counties.
- Create a *Health in All Policies* system
- Lack of community-based resources to support the level of need
- Need more information about digital divide as a barrier, opportunities for policies to create affordable housing, emerging foreign-born populations, the advocacy/policies needed to support aging population

PRIORITY #2

BEHAVIORAL HEALTH

MENTAL HEALTH

HEALTH INDICATORS & DISPARITIES

- White, NH residents have a suicide mortality rate of 16.0 per 100,000 residents, approximately 3 times higher than Black NH residents (5.5, 2018-2020)
- Almost one-third of high school students felt sad or hopeless impeding normal activity (past year); highest for Hispanic students
- Men have a suicide mortality rate of 10.4 per 100,000 (2018-2020), more than three times higher than women (2.8); it is highest for white NH men at 25.5

RISK FACTORS

- Gender (Female)
- Substance use disorder
- Family History
- No social and/or family support
- Trauma
- Abuse/Neglect

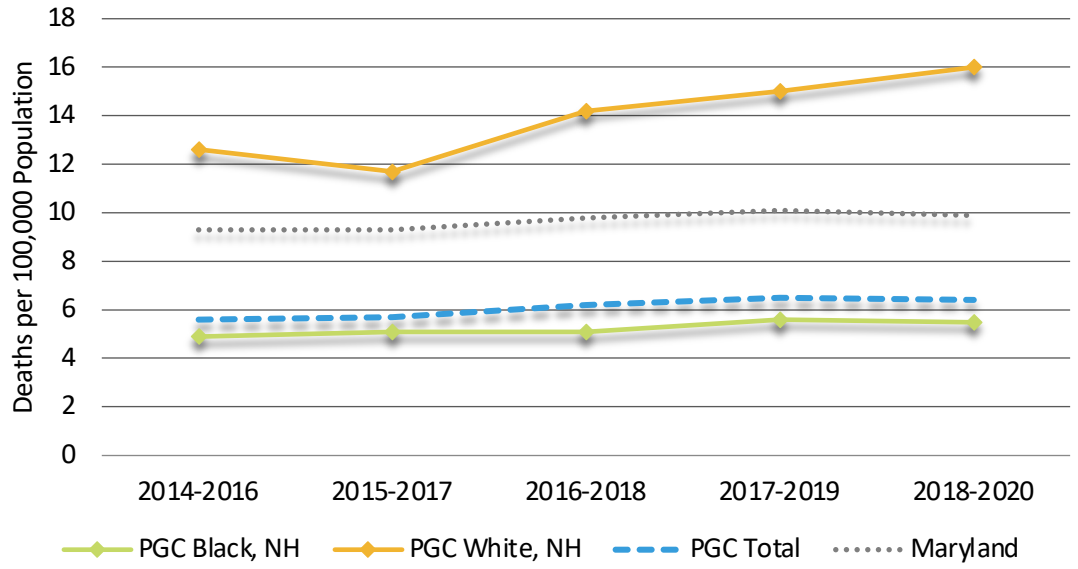
TRENDS (COMPARED TO 2019 CHA)

- Increase in MH providers to 550:1 in 2021 from 810:1 in 2018

- Almost one in five high school students indicated they had seriously considered suicide and 16% made a plan in 2018, similar to 2016
- Suicide mortality rate for Black, NH has remained between 5.0 - 5.5. per 100,000.

- Suicide mortality rate for White, NH increased from 11.7 per 100,000 in 2015-2017 to 16.0 in 2018-2020

SUICIDE AGE-ADJUSTED MORTALITY RATE, PRINCE GEORGE'S COUNTY, 2014-2020



Source: CDC Wonder Online Database; 2022 Community Health Assessment Resident and Community Expert Surveys, 2018 Maryland YRBS

COMMUNITY PERCEPTION

- Residents ranked as #2 top health issue
- Community experts ranked as #1 top health issue
- Identified as one of top 3 most important health issue facing the County by Key Informants

SUBSTANCE ABUSE

HEALTH INDICATORS & DISPARITIES

- White, NH residents have a drug-related mortality rate of 36.0 per 100,000 residents, approximately twice as high as the County at 18.7 (2018-2020)
- More than one in five white, NH adults reported binge drinking in the past month (22.8%, 2019), compared to 12.9% in the County
- Hispanic high school students were more likely to report using electronic vapor products in the past month (12.4%)

RISK FACTORS

- Mental health disorder
- Family history of addiction
- Age (younger use exposure more likely later SUIDs)
- No social and/or family supports

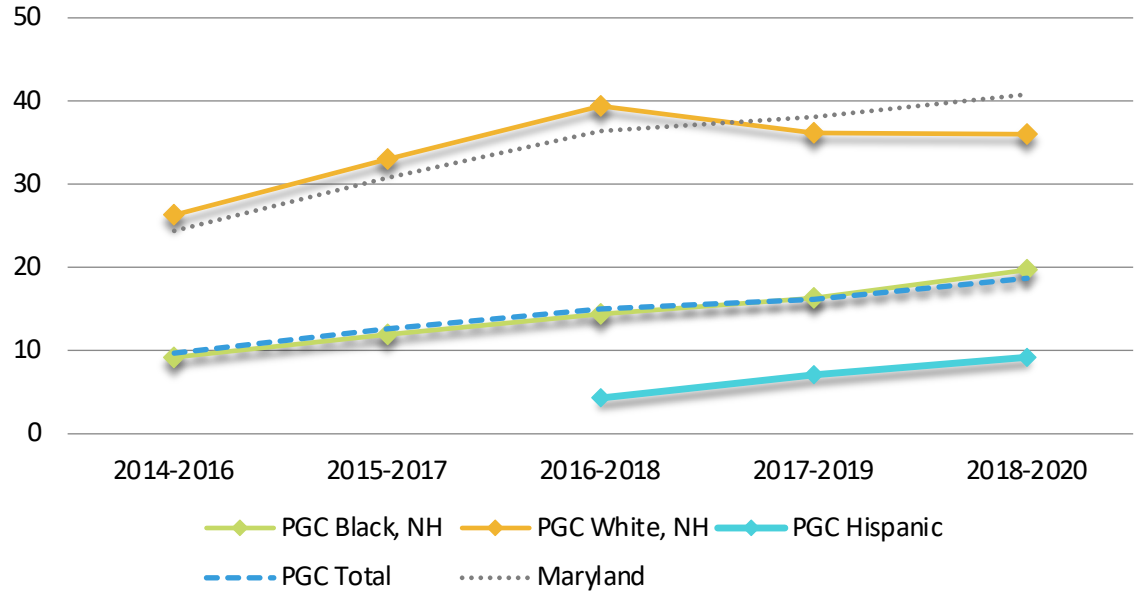
TRENDS (COMPARED TO 2019 CHA)

- Drug-related mortality rate for white NH residents has decreased from a high of 39.4 per 100,000 (2016-2018) to 36.0 (2018-2020)
- High school students who used tobacco products in the past month decreased to 9.5% in 2018, from 13.3% in 2013

- Overall, adults who binge drink remained steady, at 12.9% in 2019

- Drug-related mortality rate for the County and specifically Black NH and Hispanic residents has been steadily increasing
- Adults who reported binge drinking increased for both Black, NH and white, NH residents

DRUG-RELATED AGE-ADJUSTED MORTALITY RATE, PRINCE GEORGE'S COUNTY, 2014-2020



Source: CDC Wonder Online Database; 2022 Community Health Assessment Resident and Community Expert Surveys, 2018 Maryland YRBS

COMMUNITY PERCEPTION

- Residents ranked as #3 top health issue
- Community experts ranked as #6 top health issue
- Noted the need for early detection and treatment

BEHAVIORAL HEALTH BIG PICTURE

What's happened since the last CHA?

- Transition of UM Laurel Regional Hospital to UM Laurel Medical Campus that includes psychiatric emergency services, Intensive Outpatient Program, Partial Hospitalization, and the County's first Partial
- Opening of new UM Capital Region Health Medical Center in Largo in June 2021 including inpatient psychiatry unit
- Behavioral Health Professional Shortage Area Designation of Southeast Capital Beltway in August 2021
- Renovation of Behavioral Health Unit at MedStar Southern Maryland Hospital Center in May 2022
- Expansion of mobile crisis and response services
- Screening, Brief Intervention and Referral to Treatment (SBIRT) for substance use disorders and treatment including medication-assisted treatment (MAT) for opioid use disorders
- SBIRT including peer recovery specialists embedded at all local hospital emergency departments
- HSCRC Regional Partnership Catalyst grant

What's in the works?

- Luminis Behavioral Health Services Building scheduled to open in July 2022 on Doctors Community Medical Center Campus, including walk-in/urgent care behavioral health clinic, outpatient transitional care, substance use disorder intensive treatment, partial hospitalization program, a residential crisis program, and an inpatient unit in December 2022
- A pediatric telehealth network including BH within the public school system
- Crisis Receiving/Stabilization Center planned through the HSCRC Regional Catalyst Grant through TLC-MD
- Three-digit dialing of the National Suicide Prevention Lifeline (988) in July 2022
- 911 diversion pilot

Where do gaps/opportunities remain?

- Shortage of BH professionals to serve residents
- Lack of reimbursement availability for some
- Loan repayment/incentives for BH professionals not in HPSA-designated areas
- Culturally and linguistically sensitive services
- Commercial insurance barriers to access to behavioral health services at all levels of the continuum
- Lack of reimbursement for high acuity needs of uninsured individuals including undocumented individuals
- Prohibitive zoning regulations limiting the opening of certain behavioral health service types
- Opportunities through Maryland SIHIS

PRIORITY #3

OBESITY & METABOLIC SYNDROME

OBESITY

HEALTH INDICATORS & DISPARITIES

- Highest levels of obesity among Black, NH adults (40.2%)
- Adult females more likely to be obese (37.3%) than males (32.6%)
- Nearly four out of five residents ages 45-64 identified as overweight or obese (78.6%)
- One-third of Hispanic high school students identified as slightly or very overweight (2018)

RISK FACTORS

- Lack of physical activity
- Poor diet
- Age
- Race/ethnicity (Black and Hispanic)
- Gender (Women)
- Stress

TRENDS (COMPARED TO 2019 CHA)

- Decrease in adults who reported being obese from 42.0% in 2017 to 35.0% in 2019
- Decrease in adults who reported being obese or overweight from 73.5% in 2017 to 71.2% in 2019

- About half of adults reported engaging in regular physical activity in 2019, similar to 2017

- No negative trends identified

PERCENT OF ADULTS WHO ARE OBESE, PRINCE GEORGE'S COUNTY, 2019

	PRINCE GEORGE'S
Sex	
Male	32.6%
Female	37.3%
Race/Ethnicity	
Black, non-Hispanic	40.2%
Hispanic	23.2%
White, non-Hispanic	25.3%
Age	
18 to 44 Years	29.7%
45 to 64 Years	42.6%
Over 65 Years	36.1%
Total	35.0%

Source: 2020 CDC Wonder Online Database; 2022 Community Health Assessment Resident and Community Expert Surveys, 2019 Maryland BRFSS. 2018 Maryland YRBS

COMMUNITY PERCEPTION

- Residents ranked as #7 for top health issues
- Community experts ranked as #14 top health issue
- Concern for key informants as contributing to chronic diseases

HEART DISEASE

HEALTH INDICATORS & DISPARITIES

- #1 leading cause of death
- County mortality rate of 169.8 per 100,000 is higher compared to the state (163.2)
- Mortality rate for males is 225.6 per 100,000, compared to 128.7 for females
- White, NH residents have highest mortality rate (186.0 per 100,00)
- Black residents had the highest inpatient visit rate for heart failure (33.8 visits per 10,000 adults, 2017-2019)

RISK FACTORS

- Age
- Gender (Male)
- Obesity
- Poor diet
- Lack of physical activity
- Tobacco/Alcohol Use

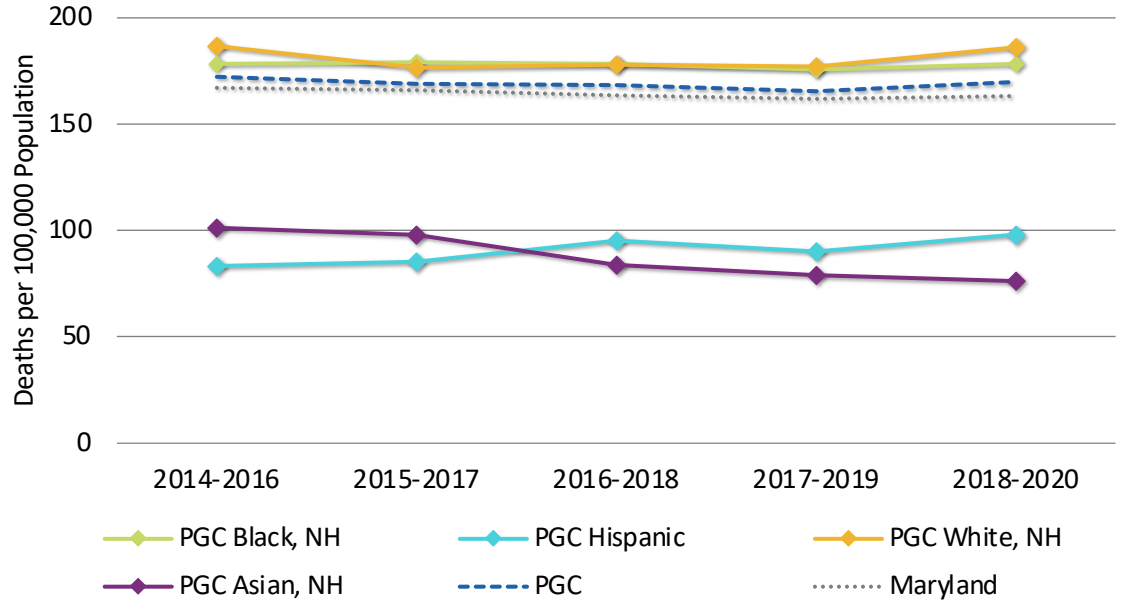
TRENDS (COMPARED TO 2019 CHA)

- Decrease in risk factor of adults who reported being obese from 42.0% in 2017 to 35.0% in 2019

- No neutral trends identified

- Increase in heart disease mortality across nearly all races/ethnicity
- Increase in residents on Medicare being treated for Heart Failure (14.7% in 2018 compared to 13.4% in 2015)

HEART DISEASE AGE-ADJUSTED MORTALITY RATE, 2014-2020



Source: 2020 CDC Wonder Online Database; 2022 Community Health Assessment Resident and Community Expert Surveys, 2016-2018 HSCRC

COMMUNITY PERCEPTION

- Residents ranked as #7 for top health issues
- Community experts ranked as #10 top health issue
- Overall chronic disease management was noted as a key issue in the County

DIABETES

HEALTH INDICATORS & DISPARITIES

- Nearly 14% of residents reported ever being diagnosed with diabetes (13.8%)
- #6 leading cause of death in the County
- Mortality rate (28.0) is higher than compared to Maryland (21.4)
- Mortality rate is highest for Black, NH residents (32.6 per 100,000)
- One in five residents ages 45-64 have diabetes

RISK FACTORS

- Overweight or obesity
- Age
- Race/ethnicity
- Hypertension
- No physical activity
- History of heart disease/stroke

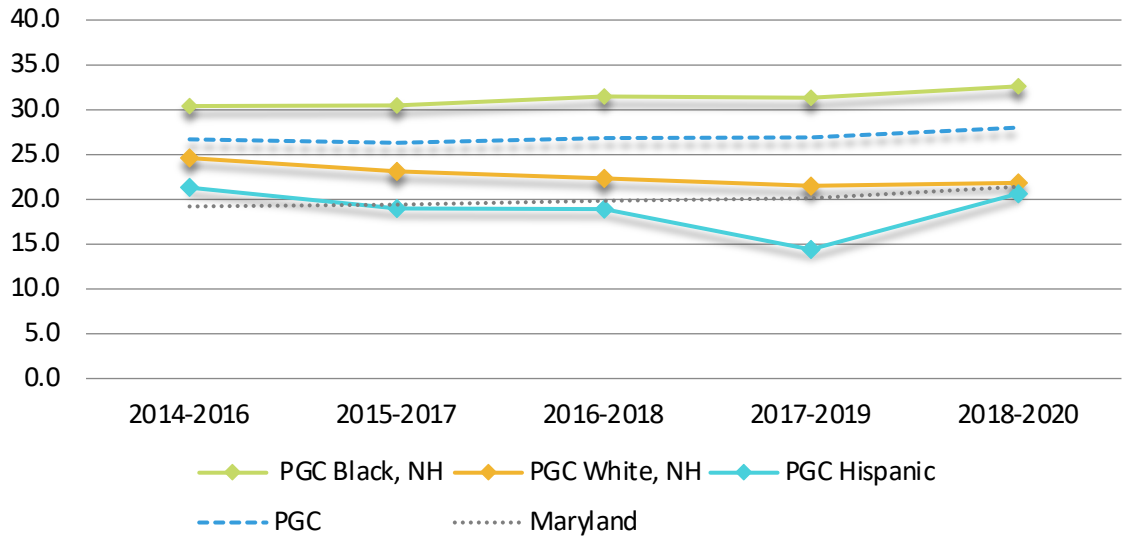
TRENDS (COMPARED TO 2019 CHA)

- No positive trends identified

- No neutral trends identified

- Increase in prevalence from 12.3% in 2017 to 13.8% in 2019
- Increase in inpatient visit rate due to diabetes (18.2 per 10,000, 2017-2019); highest for Black residents at 18.5
- Increase in diabetes mortality to 28.0 per 100,000 residents

DIABETES AGE-ADJUSTED MORTALITY RATE, PRINCE GEORGE'S COUNTY, 2014-2020



Source: 2018 Maryland BRFSS; 2020 CDC Wonder Online Database; 2022 Community Health Assessment Resident and Community Expert Surveys

COMMUNITY PERCEPTION

- Residents ranked as #3 top health issue
- Community experts tied as #1 top health issue
- Noted as a key chronic disease concern for key informant special populations

HYPERTENSION & STROKE

HEALTH INDICATORS & DISPARITIES

- Over one-third of residents reported a hypertension diagnosis (34.7%)
- Reported hypertension was highest for Black residents (37.5%)
- Black residents also had the highest inpatient visit rate due to hypertension (4.8 visits per 10,000 adults, 2017-2019)

RISK FACTORS

- Age
- Race (Black)
- Gender
- Tobacco/Alcohol Use
- Poor diet (sodium)
- No physical activity

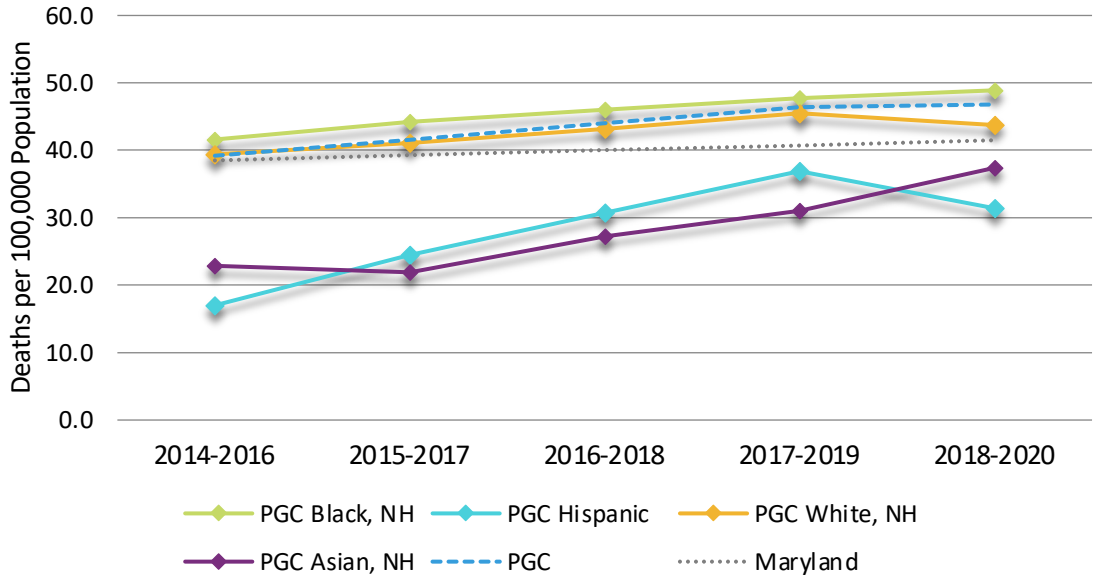
TRENDS (COMPARED TO 2019 CHA)

- No positive trends identified

- No neutral trends identified

- Overall increase in resident adults who have been told they have high blood pressure by a healthcare provider
- Increase in inpatient visit rate due to hypertension
- Increase in stroke mortality, from 39.2 in 2014-2016 to 46.8 in 2018-2020

STROKE AGE-ADJUSTED MORTALITY RATE, 2014-2020



Source: 2017 Maryland Annual Cancer Report; 2017 CDC Wonder Online Database; 2022 Community Health Assessment Resident and Community Expert Surveys

COMMUNITY PERCEPTION

- Stroke tied as #7 for top health issue by residents
- Stroke tied as #6 by community experts as top health issue
- Overall chronic disease management was noted as a key issue in the County

OBESITY & METABOLIC SYNDROME BIG PICTURE

What's happened since the last CHA?

- Implementation of 5-year HD grant (PreventionLink) that works with providers & pharmacists to address diabetes, high blood pressure, and heart disease.
- Transition to virtual options for National Diabetes Prevention Programs (DPP)
- Implementation of the Healthy Food Priority Areas
- Implementation of pilot programs including the Health Corner Store Initiative and Food As Medicine
- HSCRC Regional Partnership Catalyst Grant (TLC) for diabetes prevention
- Maryland SIHIS
- State law in 2022 requiring Medicaid to cover self-measures blood pressure monitoring devices

What's in the works?

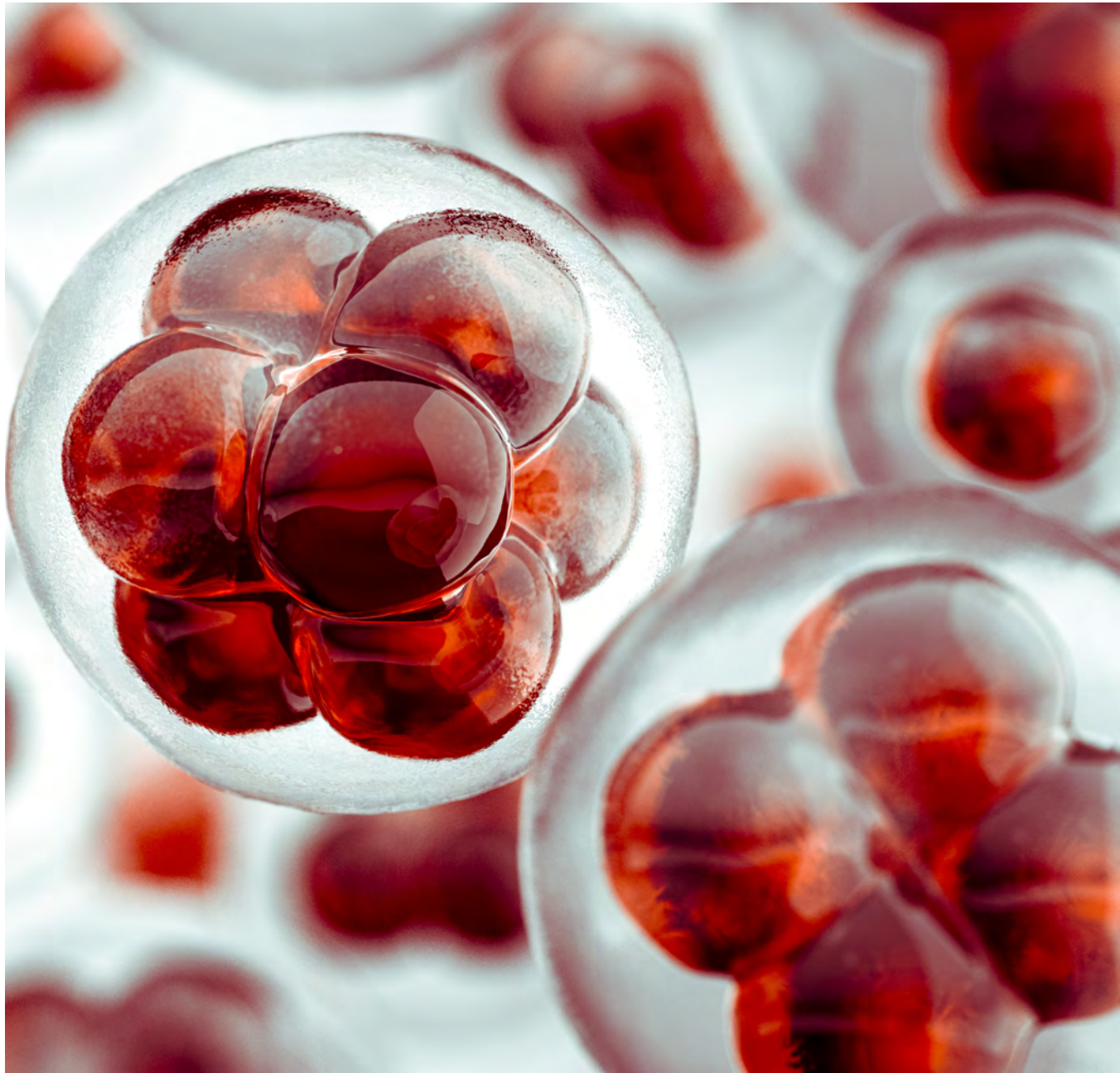
- Updating the Healthy Food Priority Areas methodology and data
- HD CHISS grant – CHWs to help obtain services for conditions that would lead to more severe covid including chronic diseases
- HD Remote Patient Monitoring pilot (PreventionLink)
- HD CHISS grant – expansion of 30 CHWs in community and 90 CHWs to be trained for state certification and COVID-19 certification; working on CWH pipeline
- HD HealthLeap - Healthy Literacy grant focusing on eight subpopulations to develop tailored interventions for delivery by providers and CHWs; HQI planning a dashboard to share cultural tailoring with physicians
- Pathways to Health Equity grants

Where do gaps/opportunities remain?

- Diabetes Self-Management Education and Support (DSMES) have high co-pays that can be a barrier
- Area DPP classes are often not full to capacity (except in bilingual classes which have been full for Luminis so more may be needed)
- Opportunities to ensure providers are making referrals for DPPs; foundation has been laid but have not reached wide-spread adoption yet
- Need for self-referral platform/process
- Opportunities to solidify outreach and referral network, but need to have services to direct residents too
- Opportunities through Maryland SIHIS

PRIORITY #4

CANCER



CANCER

HEALTH INDICATORS & DISPARITIES

- #2 leading cause of death in the County
- Men have the highest incidence rate (437.3 per 100,000, 2014-2018) and mortality rate (17.9 per 100,00, 2018-2020) compared to women (incidence rate 381.0, mortality rate 11.1)
- Black, NH residents have the highest mortality rate (150.7 per 100,000)
- By gender, race, and ethnicity Black, NH men have the highest mortality rate (182.0 per 100,000, 2018-2020) followed by white, NH men (173.8)

RISK FACTORS

- Tobacco use
- Age
- Family history
- Poor diet
- UV radiation
- Alcohol use
- Obesity

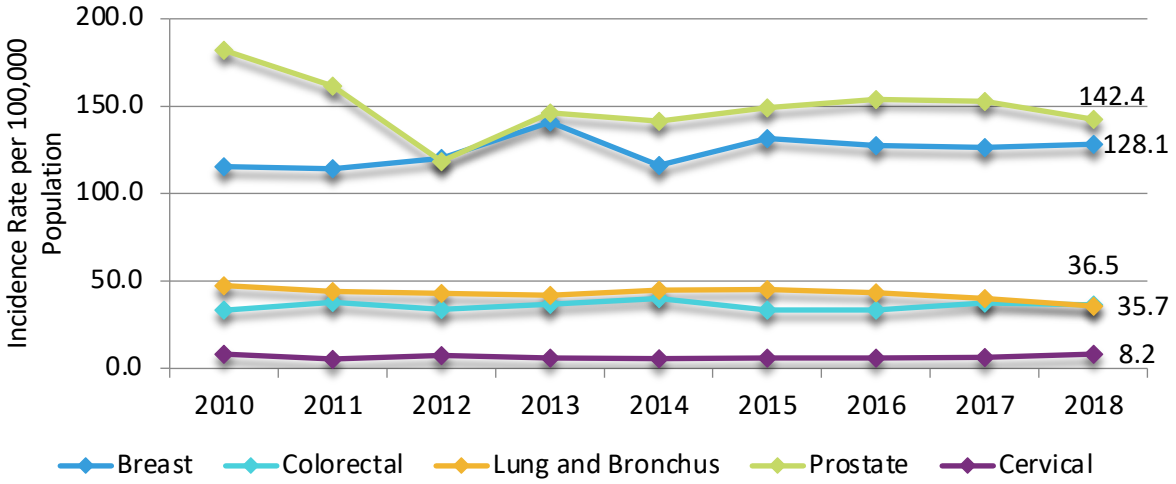
TRENDS (COMPARED TO 2019 CHA)

- Overall cancer mortality rate has declined over the last decade to a low of 141.7 per 100,000 (2018-2020), lower than Maryland (145.5)
- Decrease in incidence rate for Colorectal and Lung and Bronchus Cancers

- No neutral trends identified

- Mortality rate for Hispanic residents increased to 82.8 per 100,000 (2018-2020)
- Increase in incidence rate for breast and cervical cancer
- Increase in incidence rate for breast, colorectal, and lung and bronchus cancer for Black residents

CANCER AGE-ADJUSTED INCIDENCE RATES BY SITE, PRINCE GEORGE'S COUNTY, 2010-2018



Source: 2021 Maryland Annual Cancer Report; 2020 CDC Wonder Online Database; 2022 Community Health Assessment Resident and Community Expert Surveys

COMMUNITY PERCEPTION

- Residents ranked as #10 for top health issues
- Community experts ranked as #10 top health issue

BREAST CANCER

HEALTH INDICATORS & DISPARITIES

- Black, NH women have highest incidence rate (131.6 per 100,000, 2014-2018) and mortality rate (27.4 per 100,000, 2018-2020)
- Incidence Rate (125.9, 2014-2018) is lower than the state (130,8), but mortality rate is higher (PG 24.4, MD 20.7, 2018-2020)
- White, NH women reported lower mammogram screenings in the past 2 years (68.7%, 2018) compared to Black, NH women (90.5%)

RISK FACTORS

- Alcohol use
- Older age
- Obesity
- Inherited risk of breast cancer

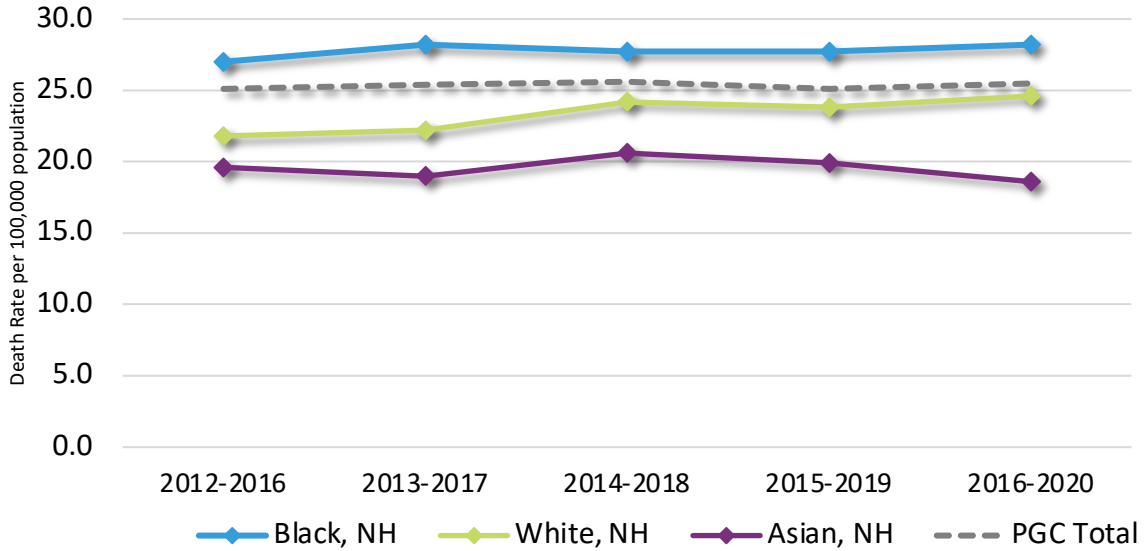
TRENDS (COMPARED TO 2019 CHA)

- Slight decrease in mortality rate for Black NH women, from 28.2 per 100,000 (2015-2017) to 27.4 (2018-2020)
- Increase in women (50+ years) who received a mammogram from 82.3% in 2016 to 86.2% in 2018

- Incidence rate has remained about the same from 2015-2018

- Slight increase in mortality rate for white NH women, from 22.4 per 100,000 (2015-2017) to 24.2 (2018-2020)

FEMALE BREAST CANCER 5-YEAR AGE-ADJUSTED MORTALITY RATE BY RACE/ETHNICITY, PRINCE GEORGE'S COUNTY, 2012-2020



Source: Maryland Annual Cancer Report; 2020 CDC Wonder Online Database; 2022 Community Health Assessment Resident and Community Expert Surveys, 2018 MD BRFSS

COMMUNITY PERCEPTION

- Residents ranked cancer in general as #10 for top health issues
- Community experts ranked cancer in general as #10 top health issue

PROSTATE CANCER

HEALTH INDICATORS & DISPARITIES

- Incidence Rate (147.9, 2014-2018) is higher than the state (126.3) and so is the mortality rate (PG 26.4, MD 19.9, 2018-2020)
- Incidence rate for Black men (178.0 per 100,000, 2014-2018) is nearly twice as high as white men (86.8)
- Mortality rate for Black NH men is 32.4 per 100,000 (2018-2020) compared to 18.4 for white NH men

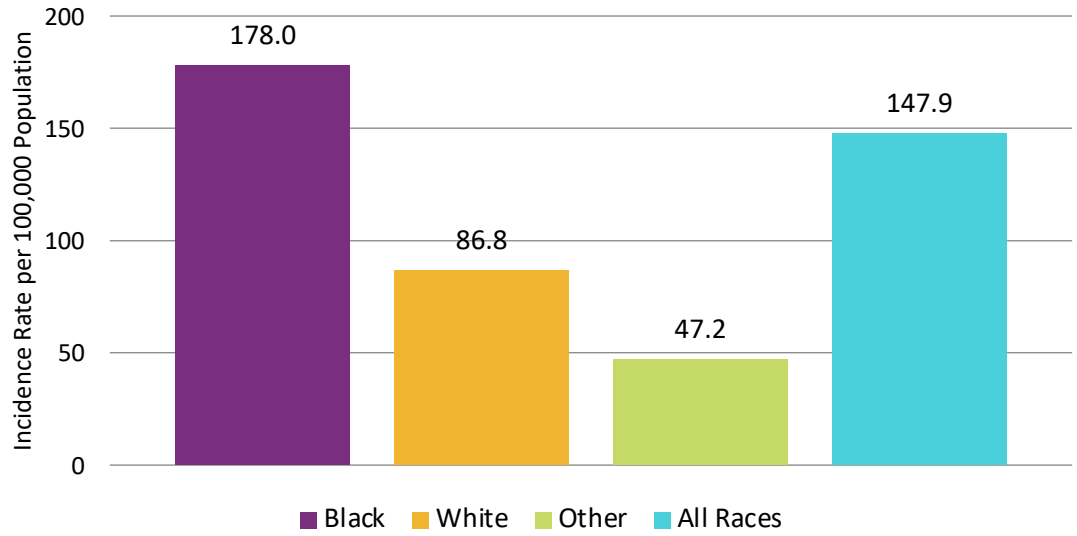
RISK FACTORS

- Older Age (50+ years)
- Race (Black)
- Family history of prostate cancer

TRENDS (COMPARED TO 2019 CHA)

- Decrease in mortality rate for Black NH men from 36.3 per 100,000 in 2015-2017 to 32.4 (2018-2020)
- Incidence rate overall and by race is about the same in 2014-2018 as it was 2019-2014
- Increase in mortality rate for white NH men from 16.5 per 100,000 in 2015-2017 to 18.4 (2018-2020)

PROSTATE CANCER AGE-ADJUSTED INCIDENCE RATE, PRINCE GEORGE'S COUNTY, 2014-2018



Source: Maryland Annual Cancer Report; 2020 CDC Wonder Online Database; 2022 Community Health Assessment Resident and Community Expert Surveys, 2018 MD BRFSS

COMMUNITY PERCEPTION

- Residents ranked cancer in general as #10 for top health issues
- Community experts ranked cancer in general as #10 top health issue

CANCER BIG PICTURE

What's happened since the last CHA?

What's in the works?

- New Regional Cancer Center at UMC CRH (opening in 2024)

Where do gaps/opportunities remain?

- Challenge in getting people to prioritize all their health needs, including cancer screenings, and having enough services available to get those behind caught up (same for overall health screenings)

ADDITIONAL AREAS OF INTEREST

HIV

HEALTH INDICATORS & DISPARITIES

- New HIV cases in Prince George's comprised 30% of all new cases in Maryland in 2020 (221 out of 724).
- Prince George's has the second highest HIV Incidence rate in the state (29.0 per 100,000) after Baltimore City; the state rate is 14.3
- 57% of new cases are between 20-39 years of age
- Over three-fourths of new cases are Black, non-Hispanic residents

RISK FACTORS

- Age (younger)
- MSM
- IV Drug Use
- Race/ethnicity (Black)

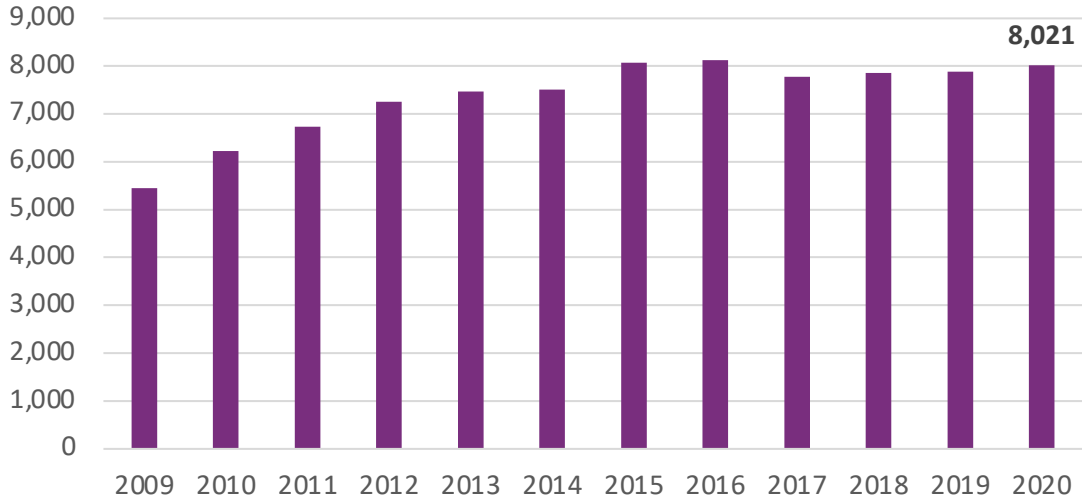
TRENDS (COMPARED TO 2019 CHA)

- Decrease in new cases from 332 in 2017 to 221 in 2020
- Decrease in new cases for residents under age 40 and those ages 60+

- The number of new cases for ages 40-59 stayed about the same for 2020 compared to 2017
- The percent of new cases linked to care within one month was 88.7% in 2020, about the same as 2017 (89.1%)

- Increase in mortality rate from 3.6 per 100,000 (2016-2018) to 4.3 (2018-2020)

CURRENT RESIDENTS LIVING WITH HIV, PRINCE GEORGE'S COUNTY, 2009-2020



Source: Prince George's and Maryland Annual HIV Epidemiological Reports; 2020 CDC Wonder Online Database; 2022 Community Health Assessment Resident and Community Expert Surveys

COMMUNITY PERCEPTION

- Not ranked by residents as a leading health problem in their community
- Community experts ranked as #15 top health issue

MATERNAL & INFANT HEALTH

HEALTH INDICATORS & DISPARITIES

- In 2020, the infant mortality rate fell to a low of 5.5 deaths per 1,000 live births in Prince George's, similar to Maryland at 5.7
- Infant mortality was highest for Black, non-Hispanic births at 8.0 per 1,000 (state is at 9.9)
- The teen birth rate in the County was 16.5 per 1,000 women ages 15-19 in 2020, but is more than doubled for Hispanic teens at 42.2
- Infants born at less than 37 weeks was highest for Black, non-Hispanic mothers (11.3%), and they also had highest percent of babies with low birth weight (<2500g, 10.9%)

RISK FACTORS

- Maternal health and behaviors
- Maternal age
- Low Birth Weight
- Prematurity

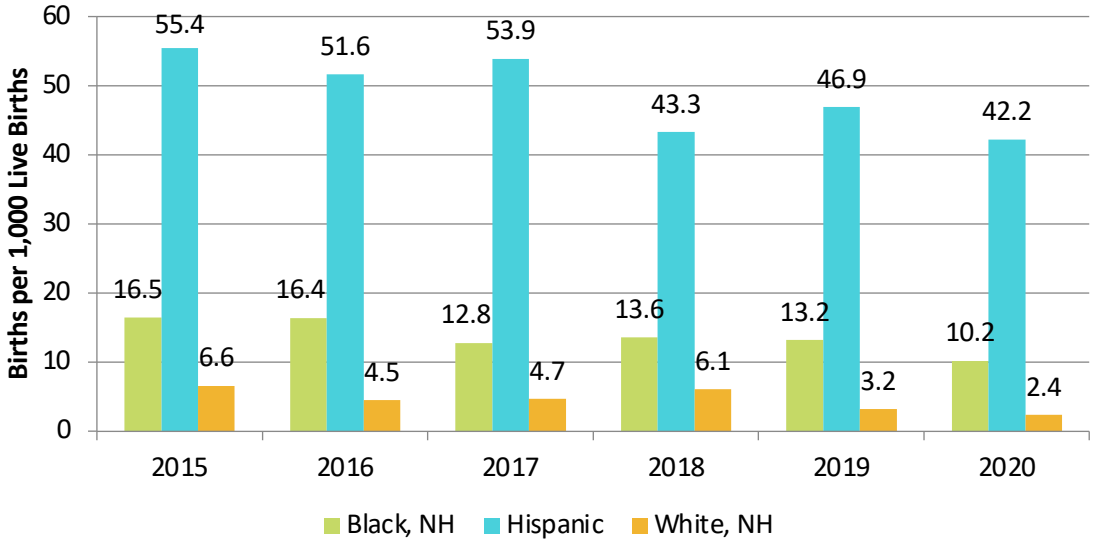
TRENDS (COMPARED TO 2019 CHA)

- Decrease in infant mortality rate from 8.2 in 2017 to 5.5 in 2020
- Decrease in teen birth rate from 19.3 in 2017 to 16.5 in 2020
- Decrease in low birth-weight infants from 9.8% in 2017 to 9.2% in 2020

- The percent of infants with late or no prenatal care in 2020 was 9.8%, similar to 2017 at 10.2%.

- No negative trends identified

TEEN BIRTH RATE (AGES 15TO 19) BY RACE AND ETHNICITY, PRINCE GEORGE'S COUNTY, 2015-2020



Source: Prince George's and Maryland Annual HIV Epidemiological Reports; 2020 CDC Wonder Online Database; 2022 Community Health Assessment Resident and Community Expert Surveys

COMMUNITY PERCEPTION

- Residents ranked cancer in general as #20 for top health issues
- Community experts ranked cancer in general as #13 top health issue

THEMES & NEXT STEPS

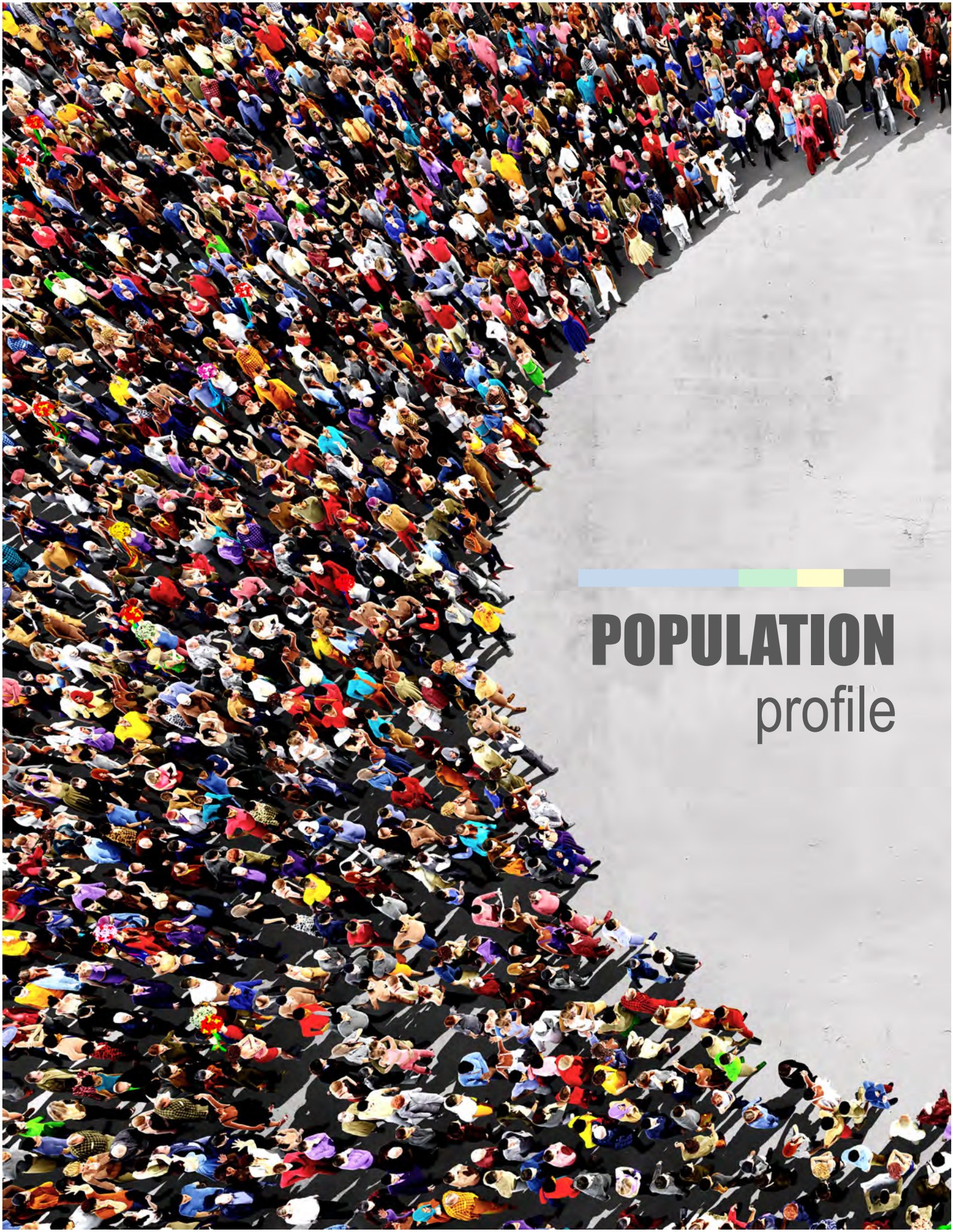
CHA EMERGENT THEMES

WHAT ROSE TO THE TOP?

- **There's progress, but** it's not enough to meet the demand (noted across multiple areas, especially for behavioral health)
- **Housing:** lack of enough affordable quality housing
- **Meetings the needs of foreign-born residents**: this was also a theme in 2019, but in addition to supporting uninsured residents, there was more of a focus on culturally and linguistically tailored services and programs, and more outreach and a visual presence of agencies providing services
- **Supporting Aging within Communities:** need for easily accessible services and transportation

NEXT STEPS

- Provide CHA Detailed Report
- Request for hospitals to present on Community Benefit plans at September 13 Prince George's Healthcare Action Coalition meeting
- Once additional data sources are available will identify timeline for updates
- Continuation of asset and resource identification, and opportunities for collaboration



POPULATION
profile

POPULATION PROFILE

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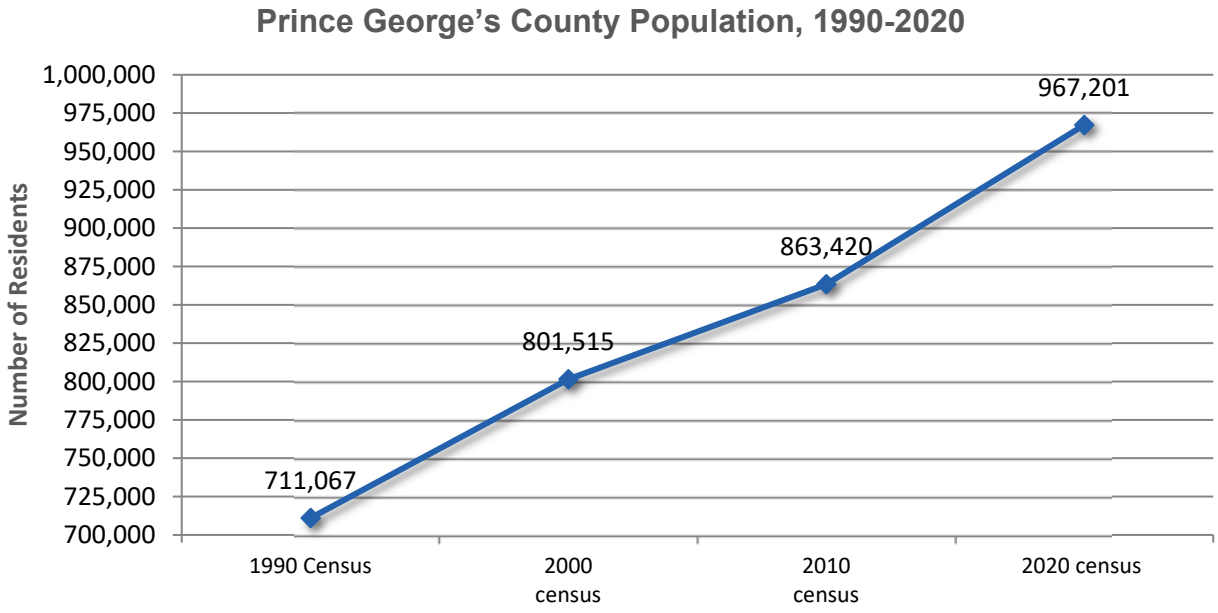
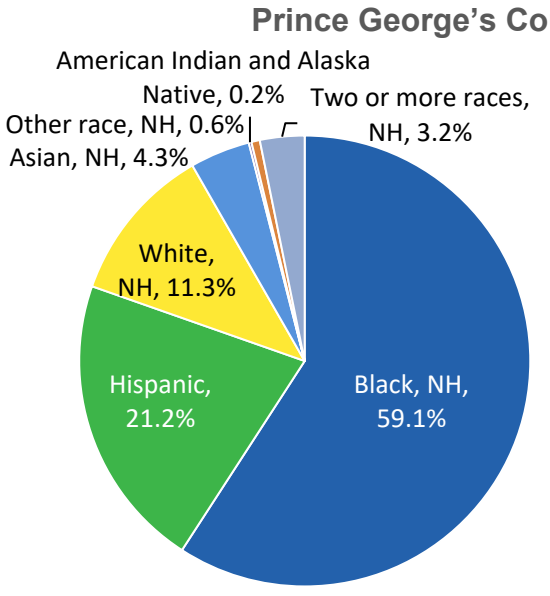
Overall Population

According to the 2020 U.S. Census, Prince George's County has the **second-largest population in Maryland at 967,201** accounting for nearly 16% of the State's residents. Prince George's County's population increased by over 100,000, or 12%, over the last decade, outpacing the State with an overall growth of only 7%.



Data Source: 2020 U.S. Census, Table P1



Data Source: 2020 U.S. Census, Table P2

The racial and ethnic composition of Prince George's County differs from Maryland and the United States. The Black, non-Hispanic population represents the majority of residents (59.1%), followed by Hispanic residents (21.2%). Since 2010, the Hispanic population grew by 60% in the County to over 205,000 residents and represents more than one out of every five residents in the County.

Population Demographics, 2020

2020 Estimates	Prince George's	Maryland	United States
Total Population	**967,201**	**6,177,224**	**331,449,281**
Race and Hispanic Origin			
Black, NH	571,866 (59.1%)	1,795,027 (29.1%)	39,940,338 (12.1%)
Hispanic (any race)	205,463 (21.2%)	729,745 (11.8%)	62,080,044 (18.7%)
White, NH	109,060 (11.3%)	2,913,782 (47.2%)	191,697,647 (57.8%)
Asian, NH	41,436 (4.3%)	417,962 (6.8%)	19,618,719 (5.9%)
American Indian/Alaskan Native, NH	1,887 (0.2%)	12,055 (0.2%)	2,251,699 (0.7%)
Two or more races, NH	31,408 (3.2%)	270,764 (4.4%)	13,548,983 (4.1%)
Other, NH	6,072 (0.6%)	37,889 (0.6%)	18,112,533 (0.7%)

Data Source: 2020 U.S. Census, Table P2

Over 59% of Prince George's County residents identify as Black, non-Hispanic, more than twice the percentage in Maryland (29.1%) and nearly five times higher than the U.S. (12.1%). Prince George's is home to nearly one-third of Black, non-Hispanic residents in Maryland, and to over one-fourth (28%) of Hispanic residents in Maryland.

Most of the 2020 U.S. Census data has not yet been released. For this report, the most recent data available is provided but may not match Census 2020 population figures.

Population Demographics, 2019

2019 Estimates	Prince George's	Maryland	United States
Population			
Total Population	**909,327**	**6,045,680**	**328,239,523**
Female	472,797 (52.0%)	3,117,667 (51.6%)	166,650,550
Male	436,530 (48.0%)	2,928,013 (48.4%)	161,588,973
Age			
Under 5 Years	59,374 (6.5%)	358,346 (5.9%)	19,404,835 (5.9%)
5-17 Years	142,088 (15.6%)	973,941 (16.1%)	53,562,950 (16.3%)
18-24 Years	85,570 (9.4%)	529,535 (8.8%)	30,373,170 (9.3%)
25-44 Years	253,852 (27.9%)	1,607,499 (26.6%)	87,493,320 (26.7%)
45-64 Years	242,190 (26.6%)	1,616,472 (26.7%)	83,331,220 (25.4%)
65 Years and Over	126,253 (13.9%)	959,887 (15.9%)	54,074,028 (16.4%)
Median Age (years)	37.8	39.0	38.5

Data Source: 2019 American Community Survey 1-Year Estimates, Table DP05; U.S. Census Population Estimates

Prince George's County, Median Age by Race and Ethnicity, 2019

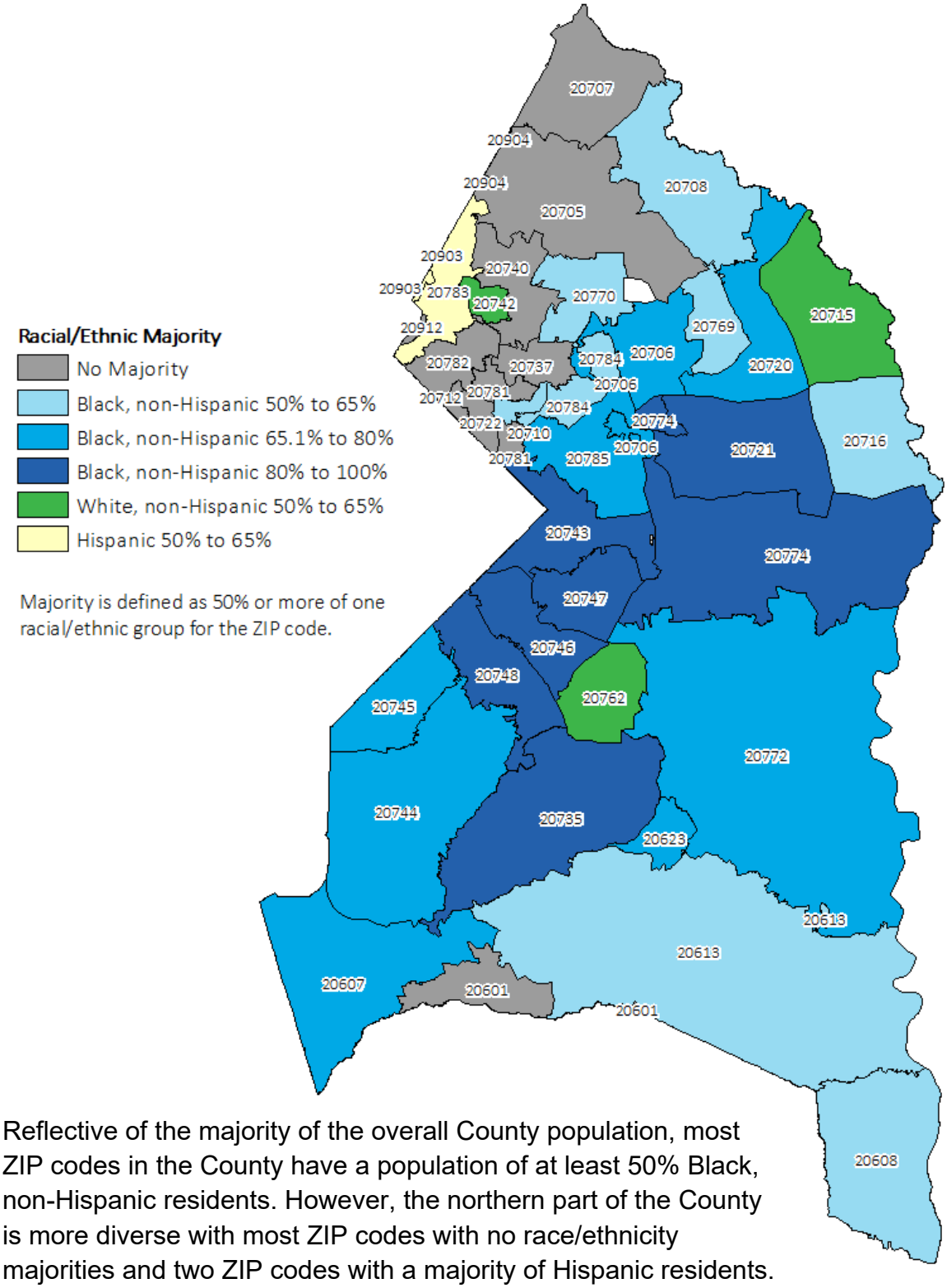
Race and Ethnicity	Median Age (yrs.)
Black	40.1
Hispanic, Any Race	28.8
White, NH	40.3
Asian	39.8

Data Source: 2019 American Community Survey 1-Year Estimates, Table B01002

As of 2019, the median age in the County was estimated as 37.8 years, an increase of 1.7 years compared to what was estimated five years ago in 2014. However, the median age of Maryland and the United States remains higher than the County (39.0 and 38.5 years, respectively). **The population of County residents ages 65 years and older is increasing**: In 2014, 11.3% of the overall population was over the age of 65 and in 2019, the 65 and older age group represented an estimated 13.8% of the population.

However, the median age varies substantially by race and ethnicity in the County. There is an 11.5-year difference between the median age of Hispanic residents (28.8 years) and white, non-Hispanic residents (40.3 years) in Prince George's County.

ZIP Codes by Population Racial and Ethnic Majority, Prince George's County, 2016-2020



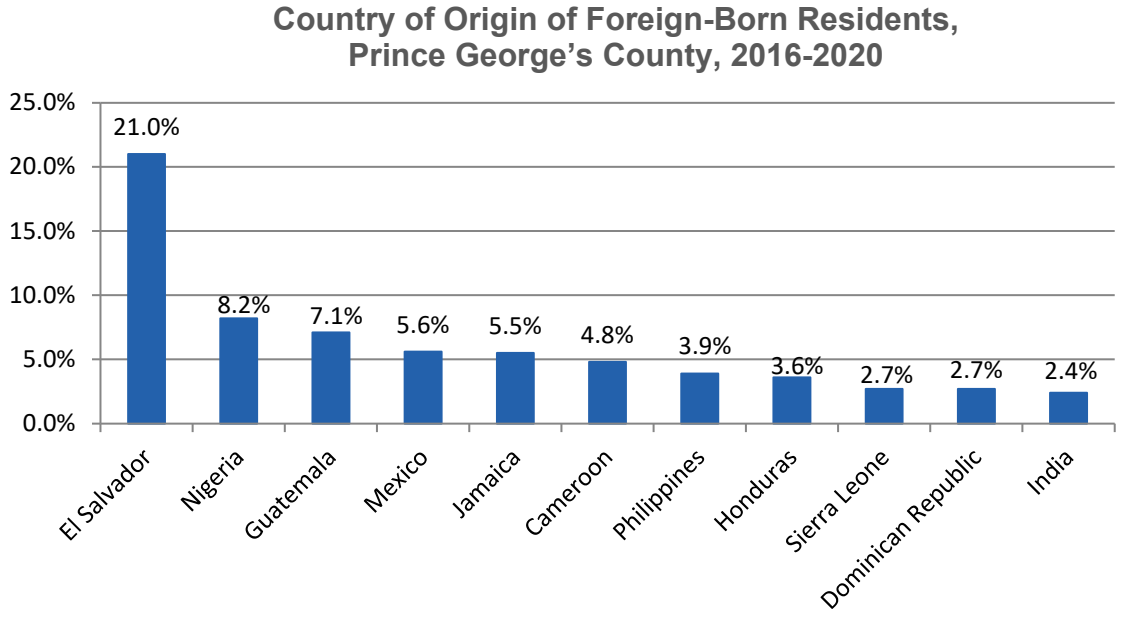
Reflective of the majority of the overall County population, most ZIP codes in the County have a population of at least 50% Black, non-Hispanic residents. However, the northern part of the County is more diverse with most ZIP codes with no race/ethnicity majorities and two ZIP codes with a majority of Hispanic residents.

Data Source: 2016-2020 American Community Survey 5-Year Estimates, Table B03002

Foreign-Born Residents

In Prince George's County, over 210,000 or more than one out of every five residents (23.6%)[1] are born outside the United States. The countries that contribute the most to the foreign-born population include El Salvador, Nigeria, Guatemala, Mexico, and Jamaica; these five countries account for nearly half of foreign-born residents. As a world region, Central America accounts for approximately 40% of County foreign-born residents. As a recent trend, residents from Cameroon have grown by an estimated 68% over the past five years with nearly 10,000 now calling Prince George's home.

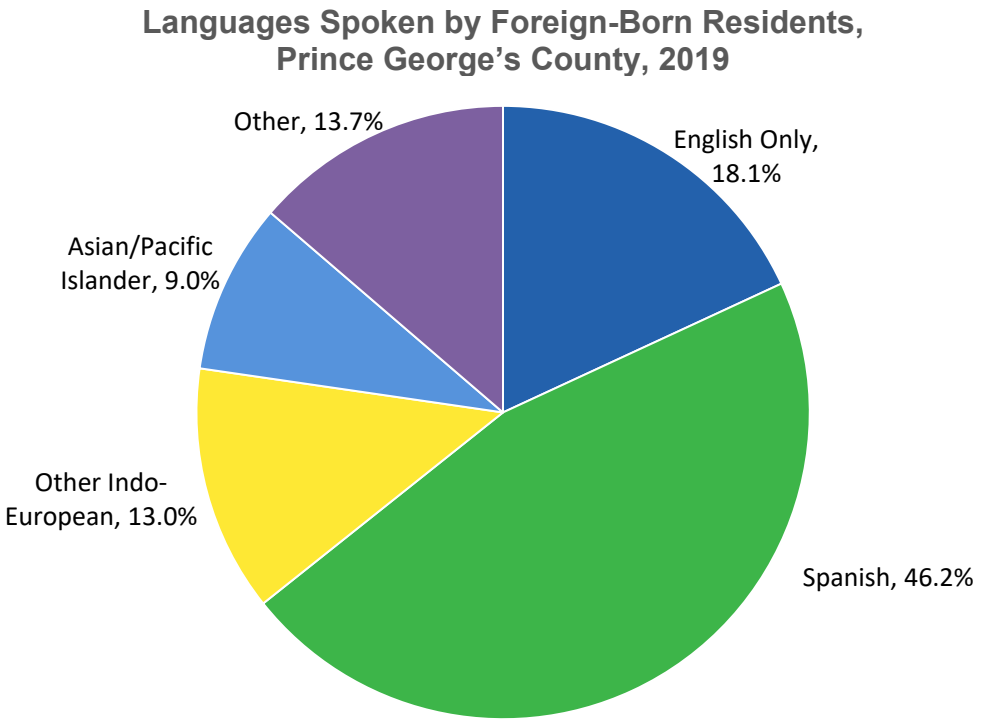
Forty-two percent of foreign-born households are naturalized U.S. citizens with a median household income of $87,993, compared to $71,670 for the 58% who are not U.S. citizens.[2]



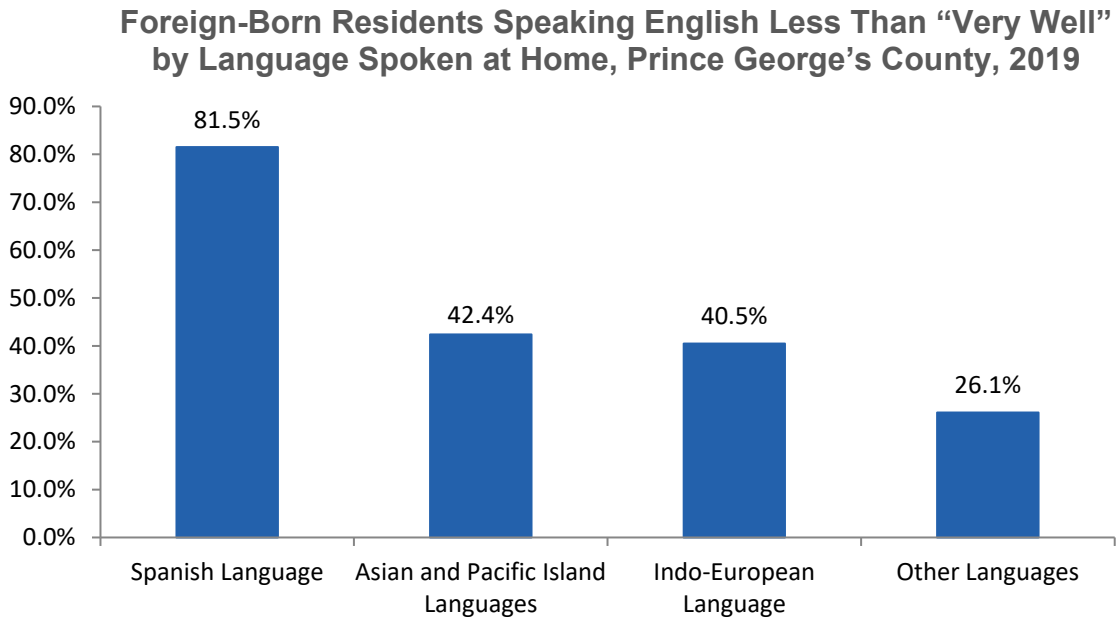
Data Source: 2016-2020 American Community Survey 5-Year Estimates, Table B05006

Approximately 18% of foreign-born residents speak only English as their primary language, and an additional 32% are estimated to speak English "very well." About half of foreign-born residents are estimated to speak English less than "very well', and of those, most speak Spanish as their primary language.[3]

[1] American Community Survey 5-year estimates, 2016-2020, Table S0501
[2] American Community Survey 1-year estimates, 2019, Table S0501
[3] American Community Survey, 1-year estimates, 2019, Table B06007



Data Source: 2019 American Community Survey 1-year estimates, Table C16005

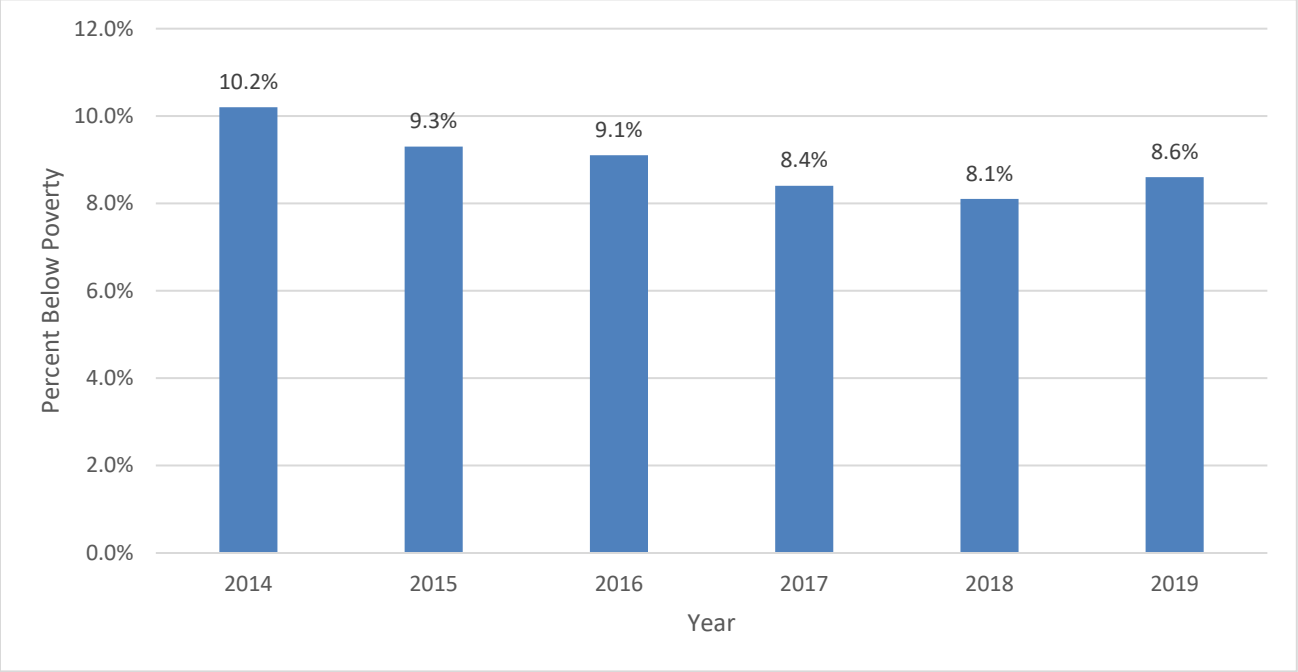


Data Source: 2019 American Community Survey 1-year estimates, Table C16005

Poverty

In 2019, the estimated proportion of individuals living in poverty in Prince George's County was 8.6%, a slight increase from a low of 8.1% in 2018.

Percentage of Residents Living Below the Poverty Level, Prince George's County, 2014 - 2019



Data Source: 2014-2019 American Community Survey 1-Year Estimates, Table S1701

The proportion of individuals living in poverty is lower in the County compared to Maryland and the U.S, but disparities continue to exist across several sociodemographic factors. Nearly one in ten females live in poverty in the County, compared to 7.6% of males. The proportion of residents with less than a high school education in poverty is four times higher compared to those with a bachelor's degree or more. Over twelve percent of children (under 18 years of age) in the County are estimated to live in poverty as of 2019. Poverty across individuals of different races and ethnicities also varies. About 11.5% of Hispanic residents in the County live in poverty, compared to 9.2% of white, non-Hispanic and 7.0% of black, non-Hispanic residents.

Individual Poverty Status in the Past 12 Months, Prince George's County, 2019

Indicators	Prince George's County N	Prince George's County % Poverty	Maryland % Poverty	U.S. % Poverty
Total individuals in poverty	75,954	8.6%	9.0%	12.3%
Male	32,125	7.6%	8.1%	11.1%
Female	43,829	9.5%	9.9%	13.5%
Age				
Under 18 years	24,772	12.6%	12.0%	16.8%
18 to 64 years	41,958	7.4%	8.3%	11.5%
65 years and over	9,224	7.4%	7.8%	9.4%
Race & Ethnicity				
Black	38,695	7.0%	12.9%	21.2%
Hispanic (of any race)	20,028	11.5%	11.7%	17.2%
White, non-Hispanic	9,363	9.2%	6.1%	9.0%
Asian	3,617	10.4%	7.4%	9.6%
Educational Attainment (population 25 years+)				
Less than high school	10,775	13.1%	18.3%	23.4%
High school graduate (or equivalent)	12,584	7.9%	11.4%	13.1%
Some college or Associate degree	11,058	6.6%	7.5%	9.1%
Bachelor's degree or higher	6,756	3.2%	3.2%	4.1%

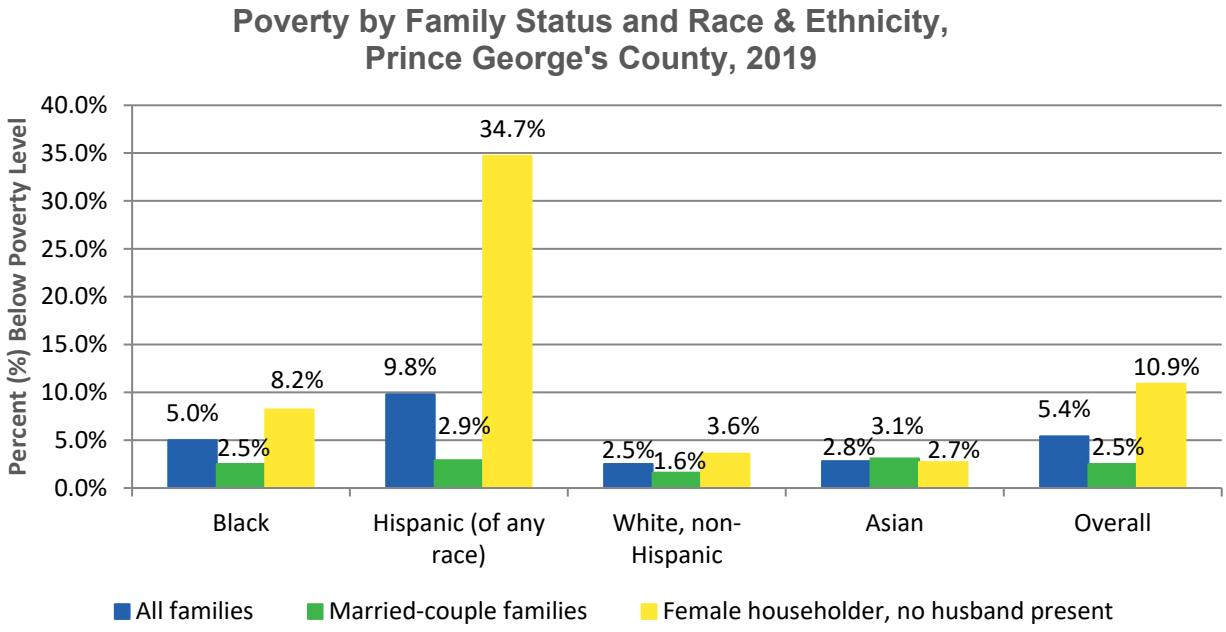
Data Source: American Community Survey 1-Year Estimates, 2019, Table S1701

Family Poverty Status in the Past 12 Months, 2019

	Prince George's County % Poverty	Maryland % Poverty	United States % Poverty
All families	5.4%	5.8%	8.6%
With related children under 18 years	9.0%	9.2%	13.8%
Married couple families	2.5%	2.7%	4.2%
With related children under 18 years	3.8%	3.6%	5.7%
Families with female householder, no husband present	10.9%	15.4%	24.1%
With related children under 18 years	17.2%	22.8%	33.5%

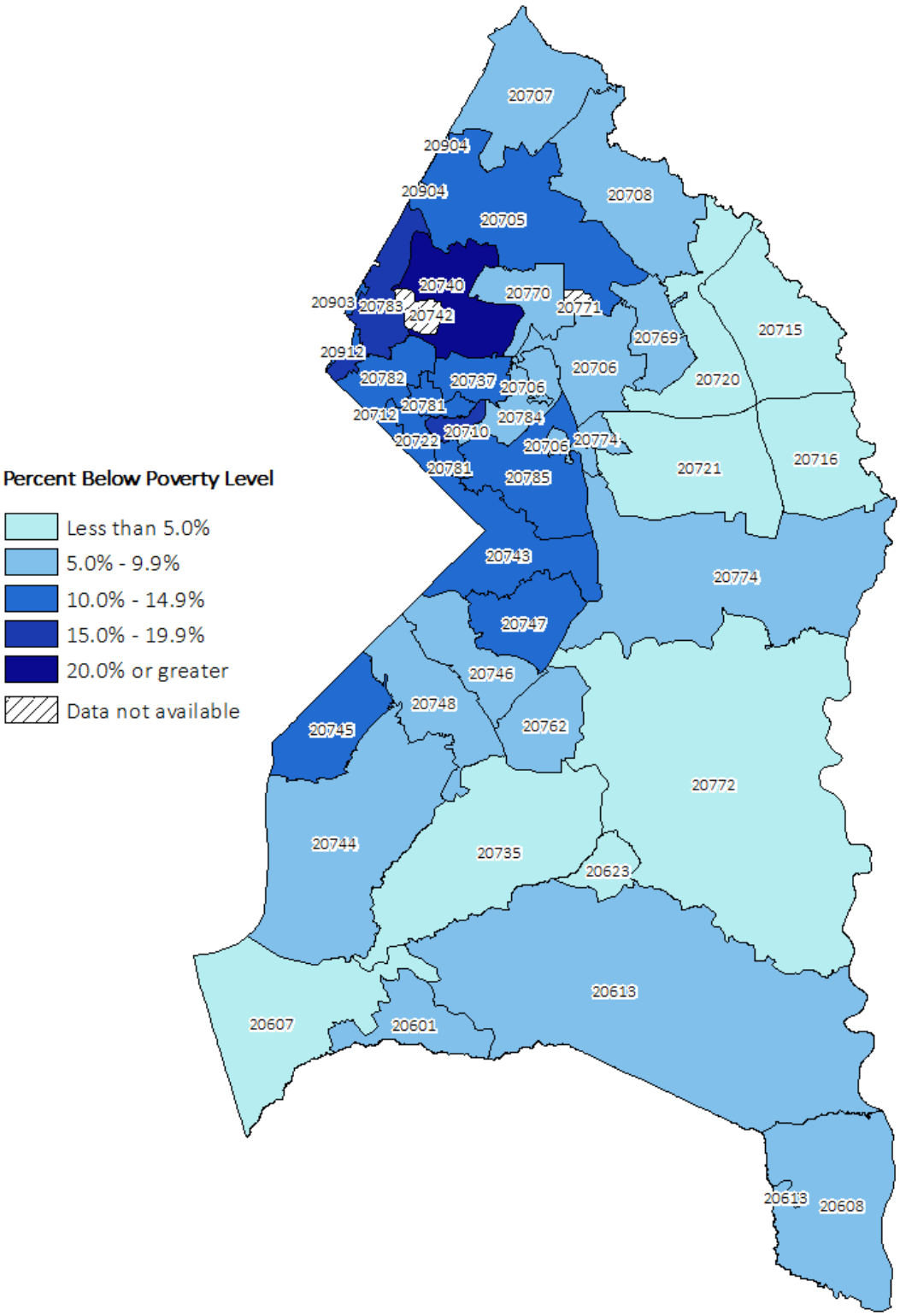
Data Source: 2019 American Community Survey 1-Year Estimates, Table S1702

Poverty status among families in Prince George's County decreased from an estimated 7% in 2014 to 5.4% in 2019, lower than both Maryland at 5.8% and the United States at 8.6%. However, over one in ten (10.9%) families with only a female head of household lives in poverty in the County, and this increases to 17.2% if the household has children under age 18. Over one-third of Hispanic families that include children under 18 years with only a female head of household lived in poverty in 2019, which is two times higher compared to single female households of other race/ethnicities.



Data Source: 2019 American Community Survey 1-Year Estimates, Table S1702

Percentage of Residents Living in Poverty by ZIP Code, Prince George's County, 2016-2020



Data Source: 2016-2020 American Community Survey 5-Year Estimates, Table S1701

Percentage of Residents Living in Poverty by ZIP Code, Prince George's County, 2016 - 2020

ZIP	Area	Poverty Percentage
20601	Waldorf	5.7%
20607	Accokeek	3.4%
20608	Aquasco	6.5%
20613	Brandywine	5.6%
20623	Cheltenham	1.2%
20705	Beltsville	7.7%
20706	Lanham	7.6%
20707	Laurel	7.9%
20708	Laurel	9.4%
20710	Bladensburg	10.7%
20712	Mount Rainier	7.6%
20715	Bowie	4.0%
20716	Bowie	3.0%
20720	Bowie	2.6%
20721	Bowie	2.9%
20722	Brentwood	8.2%
20735	Clinton	5.5%
20737	Riverdale	11.3%
20740	College Park	20.6%
20743	Capitol Heights	11.4%
20744	Fort Washington	5.9%
20745	Oxon Hill	10.2%
20746	Suitland	7.0%
20747	District Heights	9.8%
20748	Temple Hills	8.8%
20762	Andrews Air Force Base	4.8%
20769	Glenn Dale	5.4%
20770	Greenbelt	14.4%
20772	Upper Marlboro	4.1%
20774	Upper Marlboro	4.6%
20781	Hyattsville	8.3%
20782	Hyattsville	11.3%
20783	Hyattsville	17.9%
20784	Hyattsville	9.0%
20785	Hyattsville	12.9%
20903	Silver Spring	12.6%
20904	Silver Spring	8.7%
20912	Takoma Park	13.4%

Data Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates, Table DP03

Food Stamp/Supplemental Nutrition Assistance Program (SNAP) Benefits

Prince George's County had a lower proportion of households estimated to receive food stamp/SNAP benefits in 2019 (9.3%) compared to Maryland (9.8%) and the United States (10.7%). In the County, almost 44% of County residents receiving food stamps/SNAP have a disability and 49.7% have at least one person in the household over 60 years of age.

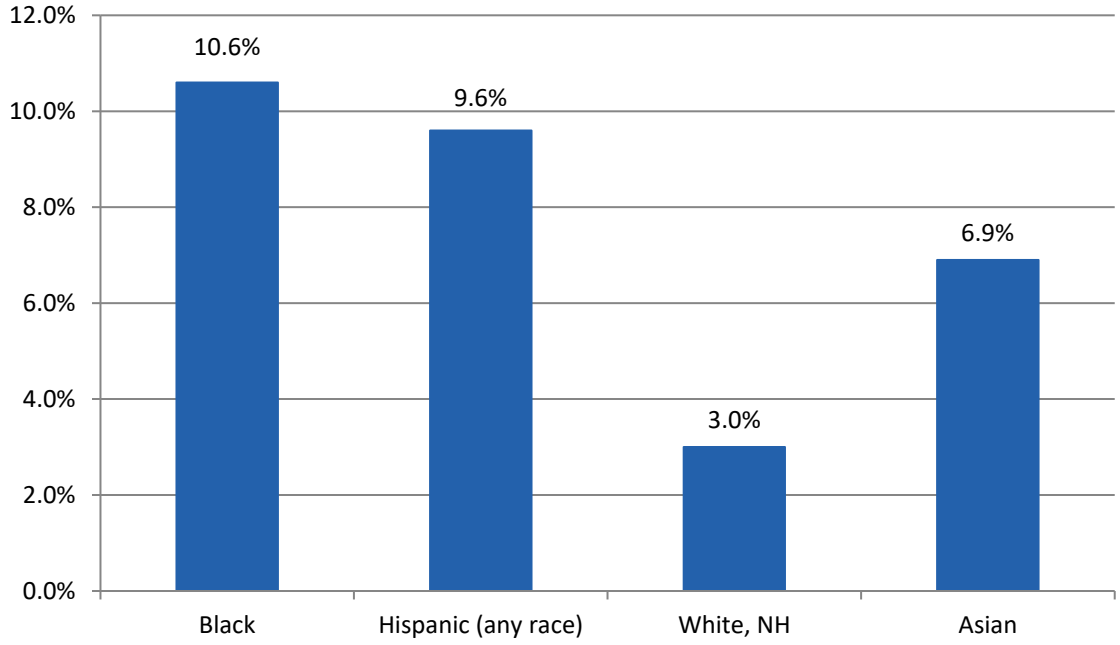
Percentage of Households with Food Stamp/SNAP Benefits, 2019

	Prince George's County	Maryland	United States
Households Receiving Food Stamps/SNAP	9.3%	9.8%	10.7%

Data Source: 2019 American Community Survey 1-Year Estimates, Table S2201

Approximately one in ten Black, non-Hispanic (10.6%) and Hispanic (9.6%) households received food stamps/SNAP in 2019, three times that of white, non-Hispanic households (3.0%). Households receiving food stamps/SNAP across County ZIP codes ranged from 2.4% (Andrews Air Force Base) to 19.5% (Bladensburg).

Percentage of Households Receiving Food Stamps/SNAP by Race and Ethnicity, Prince George's County, 2019



Data Source: 2019 American Community Survey 1-Year Estimates, Table B22005

Percentage of Households with Food Stamp/SNAP Benefits by ZIP Code, Prince George's County, 2016-2020

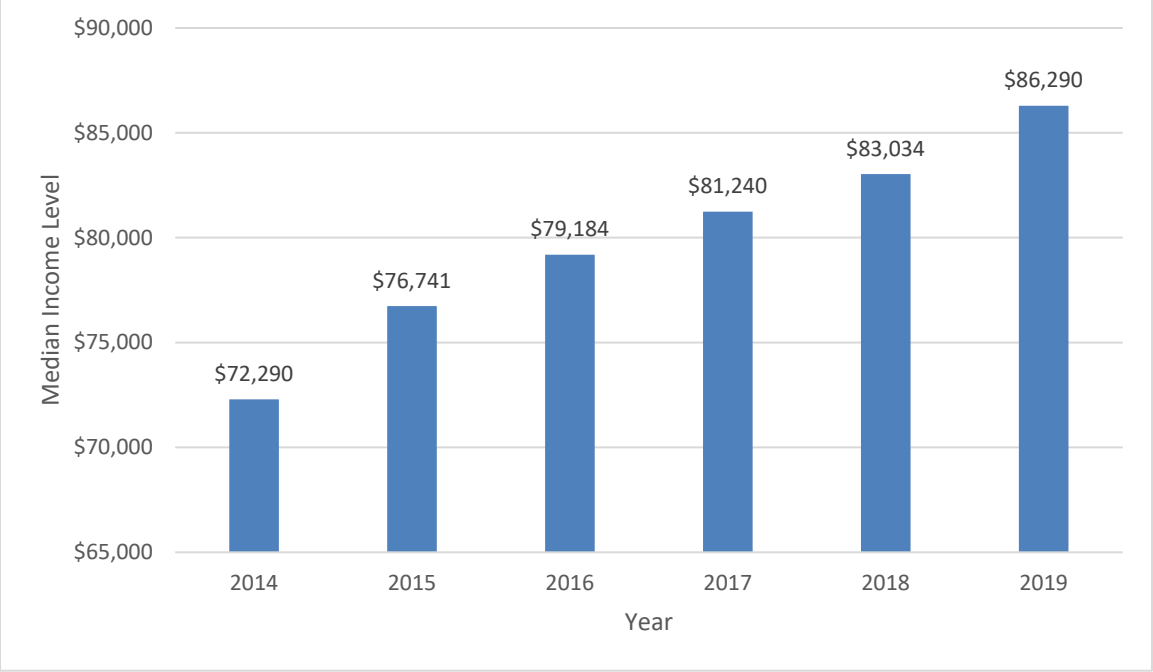
ZIP	Area	Percent of Households on SNAP
20601	Waldorf	6.7%
20607	Accokeek	4.9%
20608	Aquasco	3.4%
20613	Brandywine	5.5%
20623	Cheltenham	5.9%
20705	Beltsville	5.5%
20706	Lanham	8.5%
20707	Laurel	9.0%
20708	Laurel	12.8%
20710	Bladensburg	19.5%
20712	Mount Rainier	8.9%
20715	Bowie	3.4%
20716	Bowie	5.6%
20720	Bowie	4.2%
20721	Bowie	2.9%
20722	Brentwood	11.9%
20735	Clinton	6.5%
20737	Riverdale	12.5%
20740	College Park	7.1%
20743	Capitol Heights	18.3%
20744	Fort Washington	6.2%
20745	Oxon Hill	12.0%
20746	Suitland	11.5%
20747	District Heights	15.0%
20748	Temple Hills	12.6%
20762	Andrews Air Force Base	2.4%
20769	Glenn Dale	3.8%
20770	Greenbelt	8.0%
20772	Upper Marlboro	6.9%
20774	Upper Marlboro	5.4%
20781	Hyattsville	11.3%
20782	Hyattsville	9.5%
20783	Hyattsville	8.4%
20784	Hyattsville	10.6%
20785	Hyattsville	14.2%
20903	Silver Spring	9.8%
20904	Silver Spring	10.1%
20912	Takoma Park	9.3%

Data Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates, Table DP03

Income

The estimated median household income in Prince George's County has substantially risen over the past few years up to $86,290, similar to Maryland ($86,738) and over $20,000 more compared to the U.S. ($65,712).

Median Income Level for Households, Prince George's County, 2014 – 2019



Data Source: 2014-2019 American Community Survey 1-Year Estimates, Table S1901

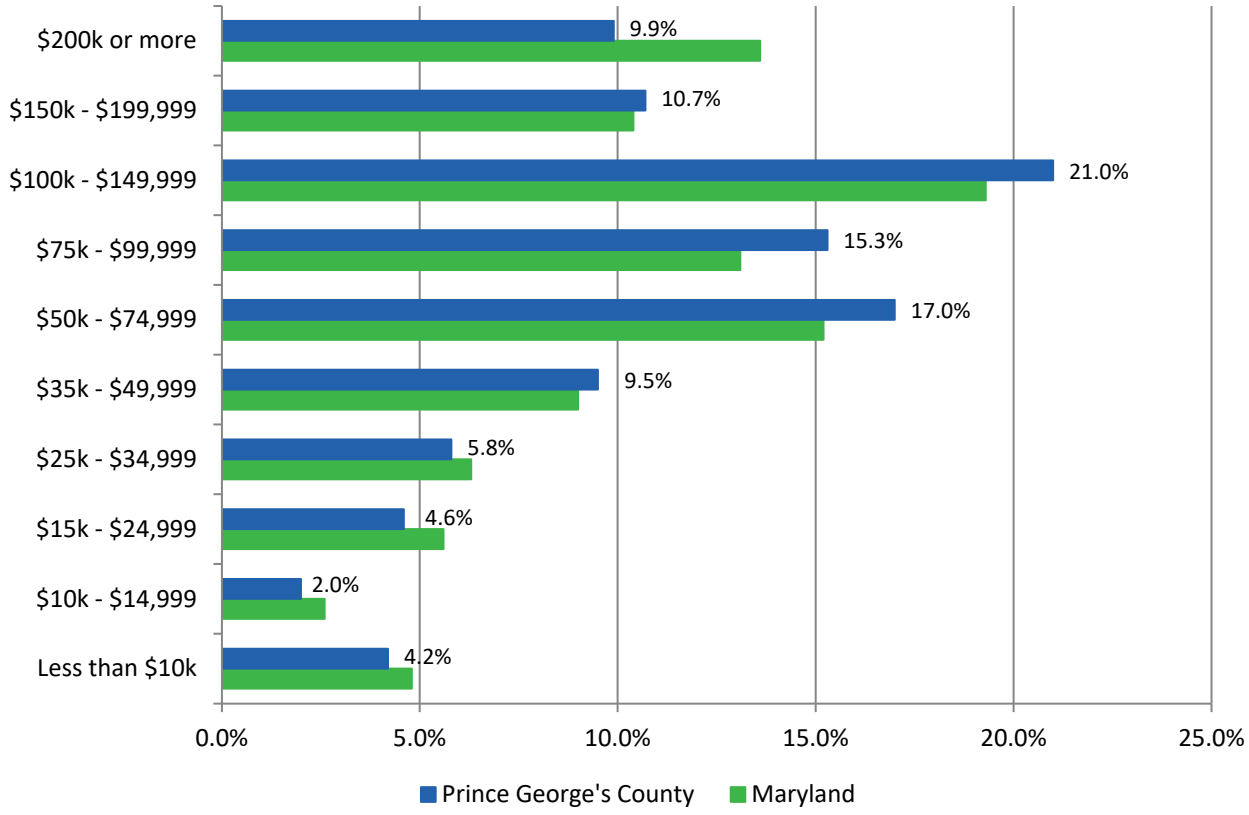
Income in the Past 12 Months (In 2019 Inflation-Adjusted Dollars)

	Prince George's County	Maryland	United States
Median household income	$86,290	$86,738	$65,712
Mean household income	$102,569	$114,089	$92,324
Median family income	$100,654	$105,679	$80,944
Mean family income	$118,396	$134,975	$108,587

Data Source: 2019 American Community Survey 1-Year Estimates, Table S1901

In 2019, over 40% of County households were estimated to have an income of more than $100,000 per year, similar to the state. While Maryland has more households with an income below $35,000 compared to the County, Maryland also has a higher percentage with an income above $200,000 (13.6%) compared to Prince George's (9.9%).

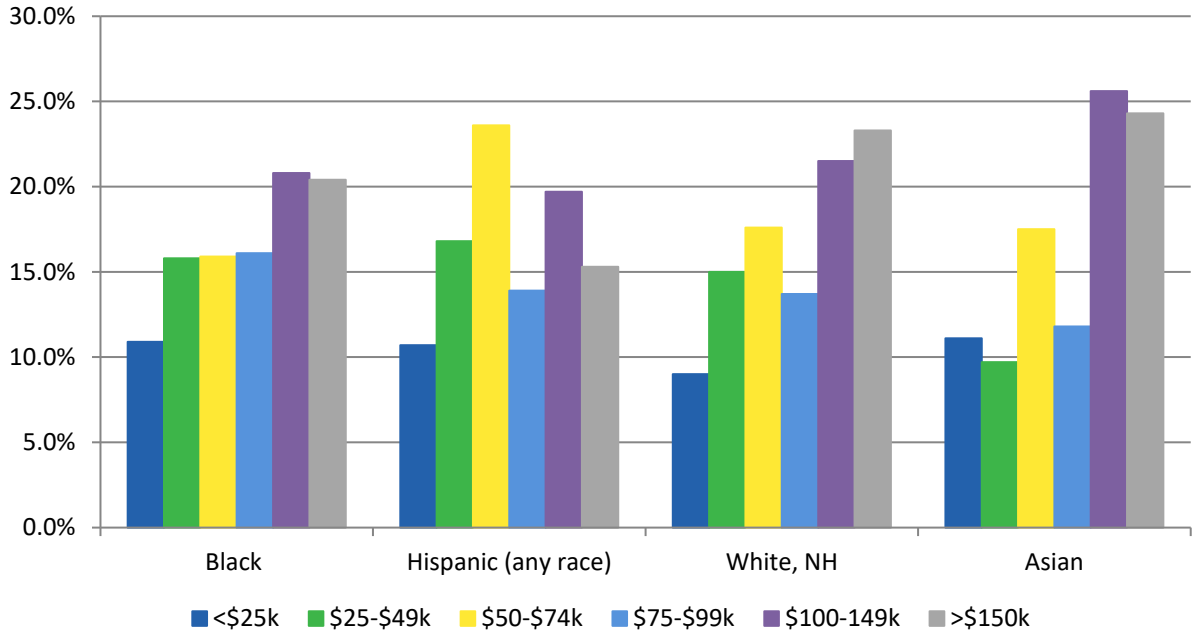
Household Income (In 2019 Inflation-Adjusted Dollars)



Data Source: 2019 American Community Survey 1-Year Estimates, Table S1901

Estimated income varies by race and ethnicity, with half of Asian households earning over $100,000, compared to only 35% of Hispanic households. Over half (51.1%) of Hispanic households earn less than $75,000 per year, while the majority of all other races and ethnicities earn more than $75,000.

Household Income (In 2019 Inflation-Adjusted Dollars) by Race and Ethnicity, Prince George's County



Data Source: 2019 American Community Survey 1-Year Estimates, Table B19001

Disability

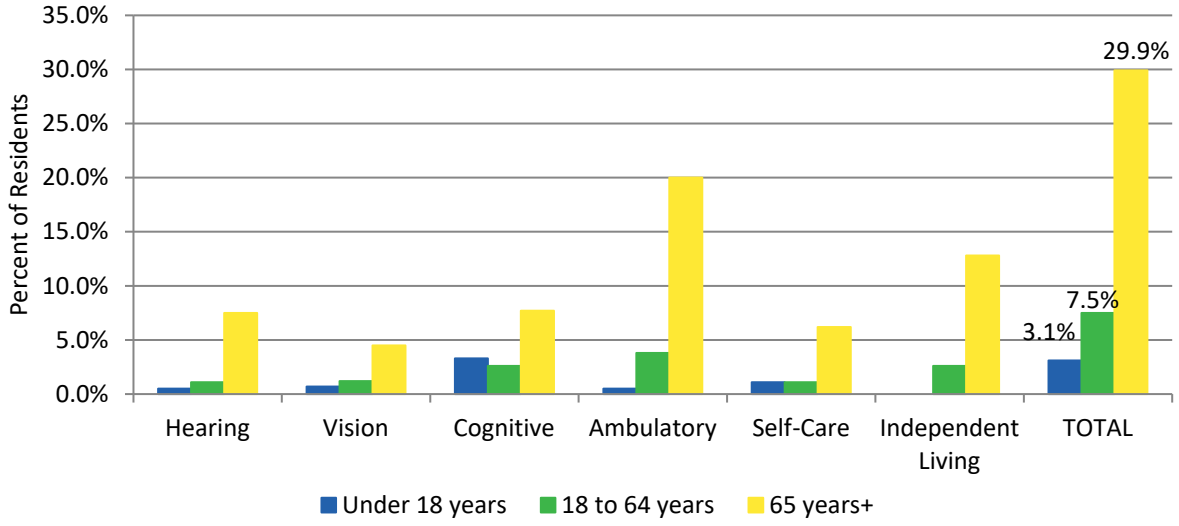
The definition of disability has changed over the past 40 years. In the 1960s and 1970s, a medical definition of disability was generally used, limited primarily to physical impairments. As time progressed, the definition expanded to include social and mental impairments as well as independence[4]. In 2019, about one in ten Prince George's County residents lives with a disability, lower than the state at 11.2% and the U.S. at 12.7%. However, one out of every five or about 20% of County residents over the age of 65 have an ambulatory disability, and overall nearly one-third of seniors live with a disability.

Percentage of Residents with a Disability, 2019

Indicators	Prince George's County	Maryland	U.S.
Total individuals with a disability	9.6%	11.2%	12.7%
Male	8.6%	10.7%	12.6%
Female	10.5%	11.6%	12.8%
Age Group			
Under 18 years	3.1%	4.2%	4.3%
18 to 64 years	7.5%	8.8%	10.3%
65 years and over	29.9%	30.3%	33.5%
Race/Ethnicity			
Black	10.7%	12.2%	14.1%
Hispanic (of any race)	3.3%	5.7%	9.1%
White, non-Hispanic	13.4%	12.2%	14.1%
Asian	8.9%	7.0%	7.2%

Data Source: 2019 American Community Survey 1-Year Estimates, Table S1810

Percentage of Residents by Disability and Age, Prince George's County, 2019



Data Source: 2019 American Community Survey 1-Year Estimates, Table S1810

[4] https://www.census.gov/topics/health/disability/about.html

Education

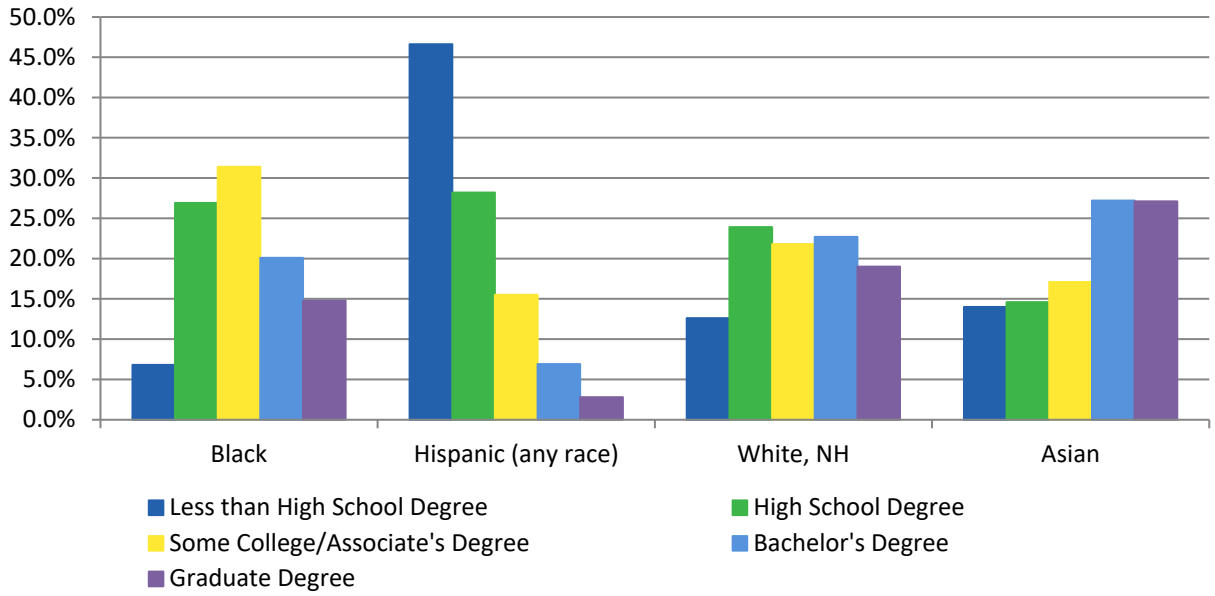
In 2019, about 87% of Prince George's County residents 25 years and older have at least a high school education, lower than Maryland (90.4%) and the U.S. (88.6%). One-third of County residents have at least a bachelor's degree or higher, similar to the country; however, this lags behind the state where over 40% have at least a bachelor's degree.

Percentage of Residents 25 Years and Older by Education, 2019

	Prince George's County (n=619,337)	Maryland (n=4,167,604)	United States (n=221,250,083)
Less than 9th Grade	7.2%	4.0%	4.8%
9th to 12th Grade, No Diploma	6.2%	5.6%	6.6%
High School Graduate	25.9%	24.6%	26.9%
Some College, No Degree	20.5%	18.0%	20.0%
Associate Degree	6.7%	6.9%	8.6%
Bachelor's Degree	19.2%	21.8%	20.3%
Graduate or Professional Degree	14.4%	19.1%	12.8%

Data Source: 2019 American Community Survey 1-Year Estimates, Table S1501

Percentage of Residents 25 Years and Older by Education and Race/Ethnicity, Prince George's County, 2019

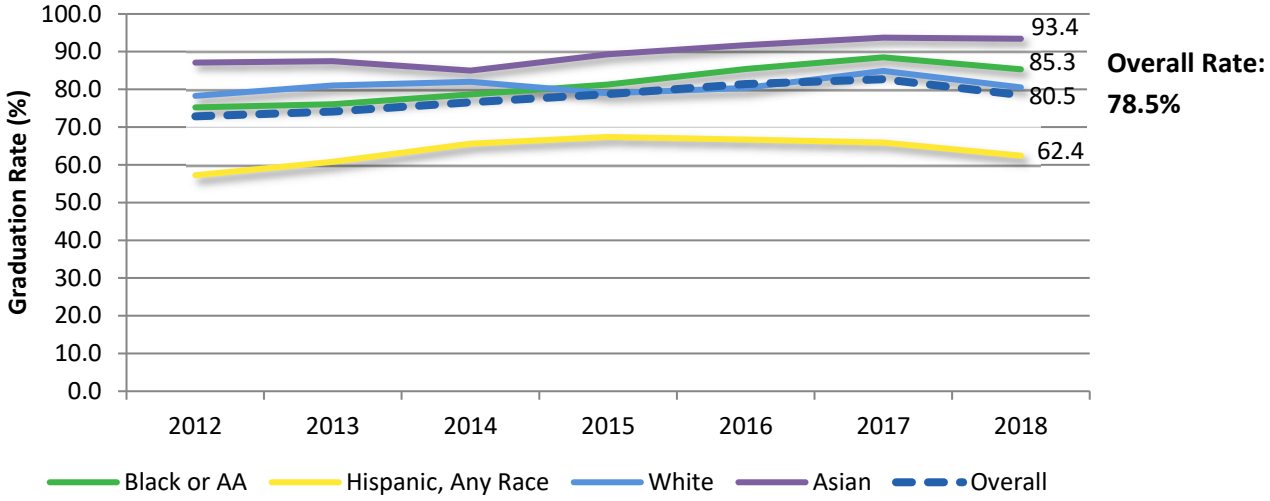


Data Source: 2019 American Community Survey 1-Year Estimates, Table B15002

Education attainment varies across races and ethnicity in Prince George's County. Almost half of County Hispanic residents 25 years and older do not have a high school degree and less than 10% have at least a bachelor's degree. Conversely, over half of Asian, non-Hispanic and over 40% of white, non-Hispanic residents 25 years and older have at least a bachelor's degree. Although most Black, non-Hispanic residents have at least a high school degree, less have at least a bachelor's degree compared to Asian, NH and white, NH residents.

In 2018, the overall rate of graduation in Prince George's County Public Schools was 78.5%. Hispanic students are much less likely than other race/ethnicities to complete high school in the County. Overall, the graduation rate in Prince George's County was lower compared to Maryland (86.9%) in 2018. Due to COVID-19, the 2019 and 2020 graduation rate data is not available.

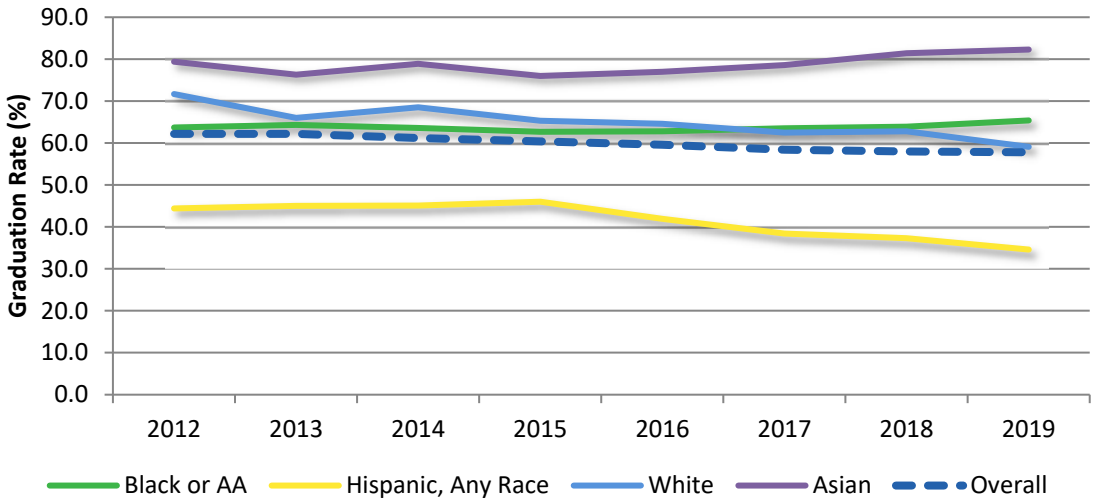
Graduation Rate by Race/Ethnicity, Prince George's County Public Schools



Data Source: 2012-2018 Maryland Report Card

College enrollment post high school also varies by race and ethnicity similar to the graduation rate with 82% of Asian student attending college compared to 34.6% of Hispanic students.

Nationwide College Enrollment 16 Months Post High School by Race/Ethnicity, Prince George's County Public Schools



Data Source: 2012-2019 Maryland Report Card

Percentage of Residents 25 Years and Older Without High School or Equivalent Education by ZIP Code, Prince George's County, 2016-2020

ZIP	Area	Percent Without High School or Equivalent
20601	Waldorf	6.8%
20607	Accokeek	6.5%
20608	Aquasco	9.2%
20613	Brandywine	7.1%
20623	Cheltenham	6.6%
20705	Beltsville	12.5%
20706	Lanham	15.0%
20707	Laurel	10.0%
20708	Laurel	9.3%
20710	Bladensburg	18.6%
20712	Mount Rainier	19.9%
20715	Bowie	4.4%
20716	Bowie	4.7%
20720	Bowie	5.0%
20721	Bowie	4.5%
20722	Brentwood	26.7%
20735	Clinton	6.2%
20737	Riverdale	35.3%
20740	College Park	15.0%
20743	Capitol Heights	13.7%
20744	Fort Washington	10.1%
20745	Oxon Hill	17.5%
20746	Suitland	10.2%
20747	District Heights	9.2%
20748	Temple Hills	8.0%
20762	Andrews Air Force Base	1.2%
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20772	Upper Marlboro	5.7%
20774	Upper Marlboro	4.3%
20781	Hyattsville	19.6%
20782	Hyattsville	23.1%
20783	Hyattsville	41.9%
20784	Hyattsville	21.8%
20785	Hyattsville	11.4%
20903	Silver Spring	34.9%
20904	Silver Spring	9.6%
20912	Takoma Park	15.9%

Data Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates, Table S1501

Employment

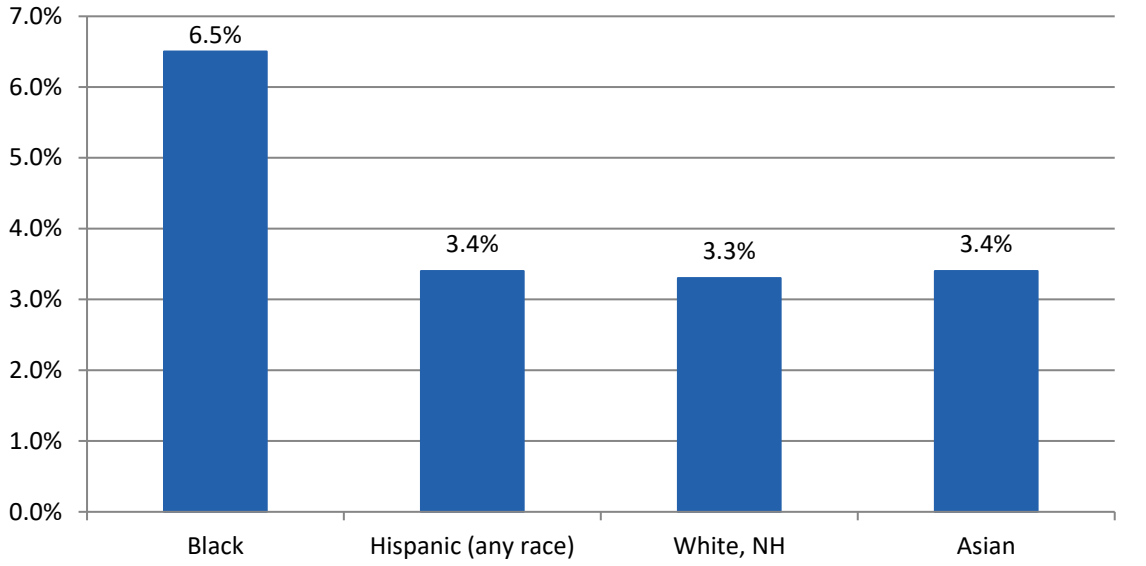
Unemployment in Prince George's County has decreased considerably; in 2014, an estimated 9.1% of residents were unemployed compared to 5.5% in 2019. However, the unemployment rate for the County remains slightly higher than Maryland (4.5%) and the U.S. (4.5%). The County unemployment rate varies by education, disability status, and race and ethnicity. Over 14% of those living in poverty are unemployed and 12% of residents with a disability are unemployed. By race and ethnicity, unemployment was highest among Black residents in 2019.

Unemployment Rate for Residents 16 Years and Older, 2019

	Prince George's County	Maryland	United States
Population 16 years and older	5.5%	4.5%	4.5%
Below Poverty Level	14.5%	21.5%	18.5%
With Any Disability	12.0%	10.8%	10.0%
Educational Attainment (Ages 25-64 Years)			
Less than High School	5.6%	7.0%	6.7%
High School Graduate	5.6%	4.7%	4.8%
Some College or Associate Degree	5.5%	4.2%	3.7%
Bachelor's Degree or Higher	2.8%	2.4%	2.3%

Data Source: 2019 American Community Survey 1-Year Estimates, Table S2301

Unemployment Rate, Prince George's County, 2019



Data Source: 2019 American Community Survey 1-Year Estimates, Table S2301

Housing

Estimated vacant housing units were at 5.8% in 2019 in Prince George's; vacancies in the County are lower than both Maryland (9.9%) and the U.S. (12.1%). There are fewer owner-occupied residences in the County (62.6%) compared to the state (66.8%) and the U.S. (64.1%), and about half (48.7%) of those owner-occupied housing units are married-couple family households.

Housing Characteristics, 2019

Indicators	Prince George's		Maryland		U.S.	
	N	%	N	%	N	%
Total Housing Units	**335,778**		**2,470,307**		**139,686,209**	
Vacancy						
Occupied Housing Units	316,361	94.2%	2,226,767	90.1%	122,802,852	87.9%
Vacant Housing Units	19,417	5.8%	243,540	9.9%	16,883,357	12.1%
For Rent	5,886		49,985		2,837,396	
Occupied Housing Units						
Owner-occupied	198,084	62.6%	1,488,168	66.8%	78,724,862	64.1%
Renter-occupied	118,277	37.4%	738,599	33.2%	44,077,990	35.9%
Owner-Occupied Units Household Type						
Married-couple family	96,554	48.7%	870,807	58.5%	46,847,633	59.5%
Male householder, no spouse present	10,412	5.3%	60,528	4.1%	3,411,043	4.1%
Female householder, no spouse present	34,233	17.3%	158,177	10.6%	7,104,998	9.0%
Nonfamily household	56,885	28.7%	398,656	26.8%	21,361,188	27.1%
Renter-Occupied Units Household Type						
Married-couple family	26,218	22.2%	180,512	24.4%	11,523,209	26.1%
Male householder, no spouse present	8,743	7.4%	46,400	6.3%	2,756,865	6.3%

Indicators	Prince George's		Maryland		U.S.	
	N	%	N	%	N	%
Female householder, no spouse present	26,816	22.7%	145,646	19.7%	7,950,522	18.0%
Nonfamily household	56,500	47.8%	366,041	49.6%	21,847,394	49.6%
Average Household Size						
Owner-occupied	2.89		2.74		2.70	
Renter-occupied	2.70		2.46		2.44	
Severe Housing Problems*		19%		16%		Unavailable

***Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.**

Data Source: 2019 American Community Survey 1-Year Estimates, Tables B25004, S2501, B25010; 2022 County Health Rankings

Fair Market Rent

About four in ten occupied housing units in Prince George's County are rentals. Renters in the County have a median income of $58,387, higher than the state at $53,894. Based on the fair market rent values in Prince George's County, the annual income needed to afford rent starts as $60,520 for an efficiency, $2,133 more than the median renter income.

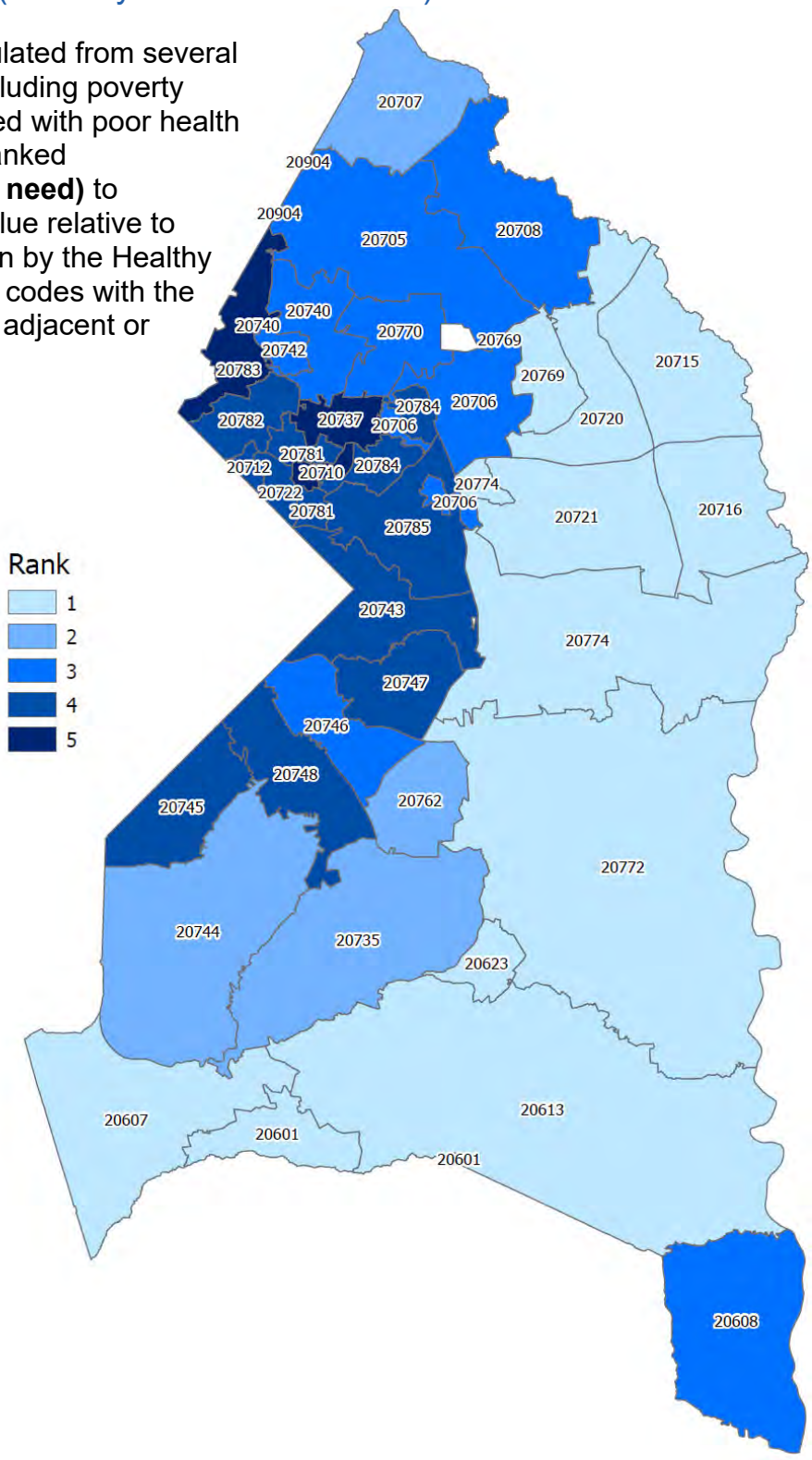
Fair Market Rent, 2021

	Prince George's County	Maryland
		Fair Market Rent by Unit
Efficiency	$1,513	$1,125
One bedroom	$1,548	$1,247
Two bedroom	$1,765	$1,487
Three bedroom	$2,263	$1,927
Four bedroom	$2,742	$2,273
	Income Needed to Afford Fair Market Rent by Unit	
Efficiency	$60,520	$45,013
One bedroom	$61,920	$49,860
Two bedroom	$70,600	$59,480
Three bedroom	$90,520	$77,065
Four bedroom	$109,680	$90,910
		Income of Renter
Estimated renter median income	$58,387	$53,894
Rent affordable for households earning the renter median income	$1,460	$1,347

Data Source: National Low Income Housing Coalition, www.nlihc.org

2021 Health Equity Index (formerly SocioNeeds Index)

The Health Equity Index is calculated from several social and economic factors, including poverty and education, that are correlated with poor health outcomes. The ZIP codes are ranked based on the index, from **1 (low need)** to **5 (high need)** based on their value relative to similar locations within the region by the Healthy Communities Institute[5]. The ZIP codes with the highest needs are concentrated adjacent or near to Washington, D.C.



[5] www.pgchealthzone.org


health
INDICATORS

HEALTH INDICATORS REPORT

Introduction

The following report includes existing health data for Prince George's County, compiled using the most current local, state, and national sources. This report was developed to inform and support a joint Community Health Assessment for the Health Department and area hospitals and was used as part of the Prioritization Process to determine area of focus for the next three years.

Methods

Much of the information in this report is generated through diverse secondary data sources, including: Maryland Health Services Cost Review Commission, Maryland Vital Statistics Annual Reports, Maryland Department of Health's (MDH) Annual Cancer Reports, Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention's CDC WONDER Online Database, Centers for Medicare and Medicaid Services, National Vital Statistics Reports, Maryland State Health Improvement Plan (SHIP), and the Prince George's County Health Department data website: www.pgchealthzone.org. Some of the data presented, specifically some birth and death data as well as some emergency room and hospitalization data, were analyzed by the Health Department using data files provided by MDH. The specific data sources used are listed throughout the report.

When available, national (noted as HP 2020) comparisons were provided as benchmarks. Most topics were analyzed by gender, race and ethnicity, age group, and include trends over time to study the burden of health conditions, determinants of health and health disparities.

Limitations

While efforts were made to include accurate and current data, data gaps and limitations exist. In December 2021, the MDH experienced a cyberattack that resulted in many datasets being unavailable, include vital statistics, hospital discharge data, and Maryland BRFSS results. The data presented is the most current available given this limitation. In addition, potential effects of the COVID-19 pandemic on health outcomes are not yet available for many data sources due to publication lag.

Another major limitation is that Prince George's County residents sometimes seek services in Washington, D.C., but because this is a different jurisdiction, the data for these services may be unavailable (such as Emergency Room visits and hospitalizations).

The diversity of the County is often not captured through traditional race and ethnicity. The County has a large immigrant population, but data specific to this population is often not available related to health issues.

Definitions

Crude Rate - The total number of cases or deaths divided by the total population at risk. Crude rate is generally presented as rate per population of 1,000, 10,000 or 100,000. It is not adjusted for the age, race, ethnicity, sex, or other characteristics of a population.

Age-Adjusted Rate - A rate that is modified to eliminate the effect of different age distributions in the population over time, or between different populations. It is presented as a rate per population of 1,000, 10,000 or 100,000.

Frequency - Often denoted by the symbol "n", frequency is the number of occurrences of an event.

Health Disparity - Differences in health outcomes or health determinants that are observed between different populations. The terms health disparities and health inequalities are often used interchangeably.

Health People 2020 (HP 2020) – Healthy People 2020 is the nation's goals and objectives to improve citizens' health. HP2020 goals are noted throughout the report as a benchmark.

Incidence Rate - A measure of the frequency with which an event, such as a new case of illness, occurs in a population over a period of time.

Infant Mortality Rate - Defined as the number of infant deaths per 1,000 live births per year. Infant is defined as being less than one year of age.

Maryland SHIP (MD SHIP) – Maryland's State Health Improvement Plan is focused on improving the health of the state; measures for the SHIP areas are included throughout the report as a benchmark.

Prevalence Rate - The proportion of persons in a population who have a particular disease or attribute at a specified point in time (point prevalence) or over a specified period of time (period prevalence).

Racial and Ethnic Groups:

Black or African American - A person having origins in any of the Black racial groups of Africa.

Hispanic or Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

White - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Vietnam, etc.

American Indian or Alaska Native - A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

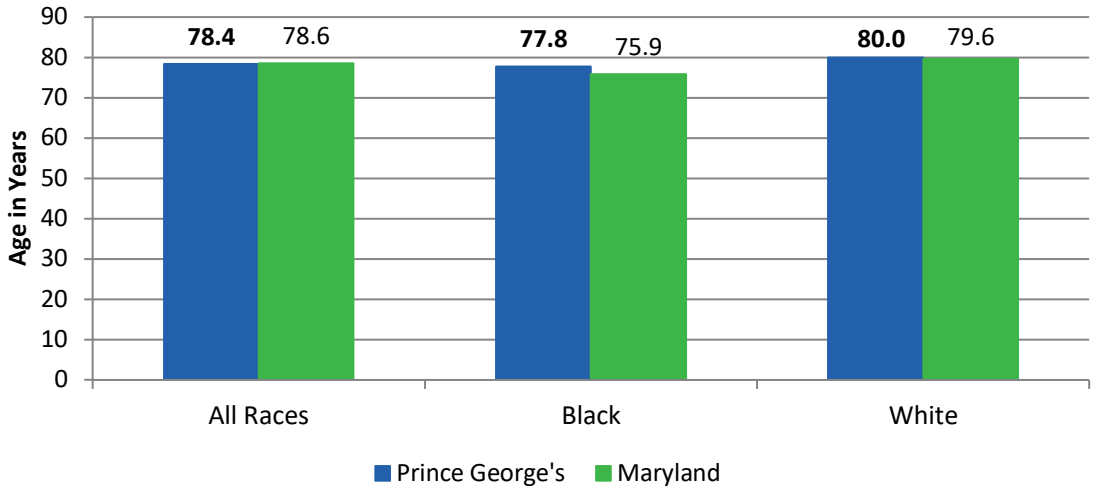
Table of Contents

Health Status Indicators

Life Expectancy

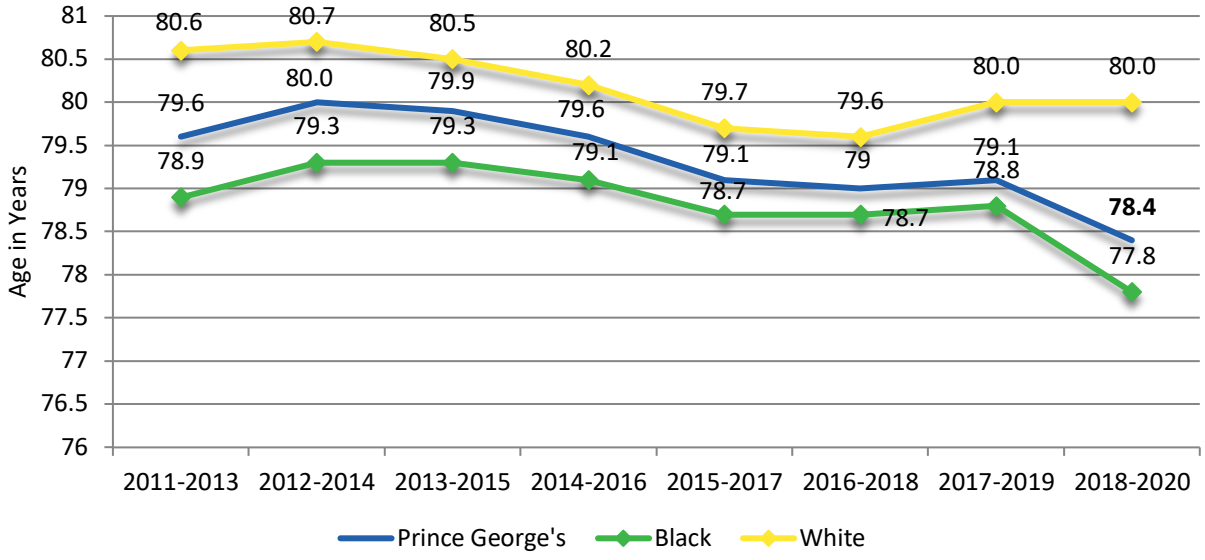
As of 2020, a Prince George's County resident is expected to live 78.4 years, similar to the 78.6 years for any Maryland resident. Life expectancy in the County and State has declined. At its peak the life expectancy for a County resident was 80.0 from 2012 to 2014. This is also a national trend, with a life expectancy in 2020 of 77.3 years, down from 78.9 years in 2014.

Life Expectancy at Birth by Race, 2018-2020



Data Source: Vital Statistics Rapid Release, Number 015, July 2021, National Vital Statistics System, National Center for Health Statistics; Maryland Vital Statistics Annual Report 2020, Maryland Department of Health, Vital Statistics Administration

Life Expectancy at Birth by Race, Prince George's County, 2011-2020



Data Source: Maryland Vital Statistics Annual Report 2013-2020, Maryland Department of Health, Vital Statistics Administration

Mortality

From 2018 to 2020, 20,953 deaths occurred among Prince George's County residents. Over 42% of all deaths in the County were due to heart disease or cancer, the two leading causes of death. Although COVID-19 just emerged in 2020, it became the third leading cause of death for County residents, with a mortality rate higher than both Maryland and the U.S. The County is also notably higher than Maryland and the U.S. for the age-adjusted death rate for heart disease, stroke, diabetes, septicemia, nephritis, homicide, and hypertension.

Leading Causes of Death, 2018-2020

Cause of Death	Prince George's County Deaths		Age-Adjusted Death Rates per 100,000 Population			Healthy People 2030 Target
	Number	Percent	Prince George's	Maryland	U.S.	
All Causes	**20,953**	**100%**	**749.8**	**747.0**	**758.7**	---
Heart Disease	4,755	22.7%	169.8	163.2	164.5	---
Cancer	4,177	19.9%	141.7	145.5	146.4	122.7
COVID-19	1,249	6.0%	43.8	27.4	28.8	---
Stroke	1,244	5.9%	46.8	41.5	37.6	33.4
Accidents	911	4.3%	32.9	38.7	51.6	43.2
Diabetes	813	3.9%	28.0	21.4	22.6	---
CLRD*	543	2.6%	19.6	29.3	38.1	---
Alzheimer's	404	1.9%	16.4	15.1	31.0	---
Nephritis	389	1.9%	14.1	10.6	12.8	---
Septicemia	373	1.8%	13.4	12.1	9.8	---
Influenza and Pneumonia	343	1.6%	12.6	12.4	13.4	---
Hypertension	336	1.6%	12.1	9.1	9.3	---
Homicide	320	1.5%	11.7	10.2	6.6	5.5

*CLRD=Chronic Lower Respiratory Disease, includes both chronic obstructive pulmonary disease and asthma
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Black non-Hispanic (NH) male residents have the highest age-adjusted death rate in the County followed by white male residents. Overall, males have a notably higher age-

adjusted mortality rate in the County than females, the same as the state and U.S., but lower than in Maryland and the U.S.

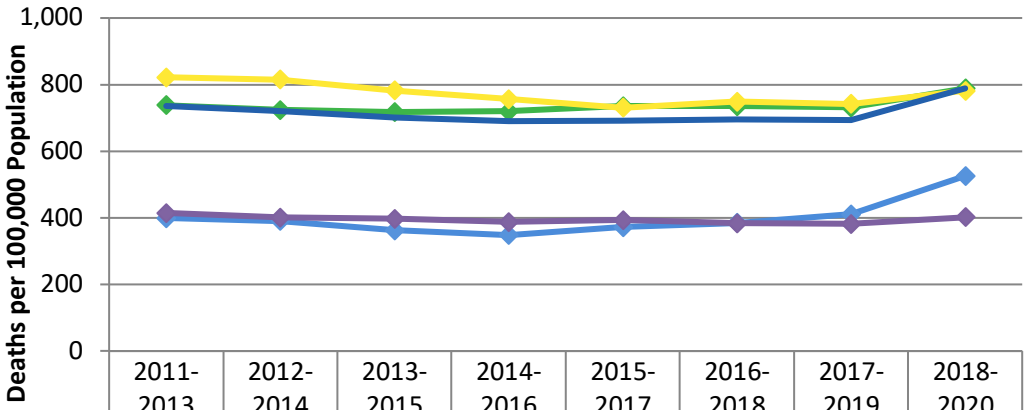
Age-Adjusted Death Rate per 100,000 by Race, Ethnicity, and Sex, 2018-2020

Race and Ethnicity	Prince George's County	Maryland	U.S.
Black, non-Hispanic	788.8	883.7	952.5
Male	997.1	1,128.3	1081.0
Female	638.4	707.2	778.7
Hispanic, any race	525.7	421.2	593.2
Male	614.5	501.2	727.1
Female	430.6	343.8	479.3
White, non-Hispanic	781.6	743.0	771.5
Male	957.2	874.0	907.0
Female	633.6	631.0	653.3
Asian, non-Hispanic	402.3	359.0	417.0
Male	485.1	435.0	500.6
Female	338.3	297.8	350.1
American Indian or Alaska Native, non-Hispanic	360.4	345.9	854.1
Male	468.2	382.5	1,020.6
Female	299.7	313.6	706.9
All Races and Ethnicities	749.8	747.0	758.7
Male	934.0	898.1	901.0
Female	609.4	622.8	636.8

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

The age-adjusted death rate increased across all races and ethnicity from 2018 to 2020 largely due to the deaths from COVID-19, which was the third leading cause of death in the County in 2020.

Age-Adjusted Death Rate per 100,000 for All Causes of Death by Race* and Ethnicity, Prince George's County, 2011-2020

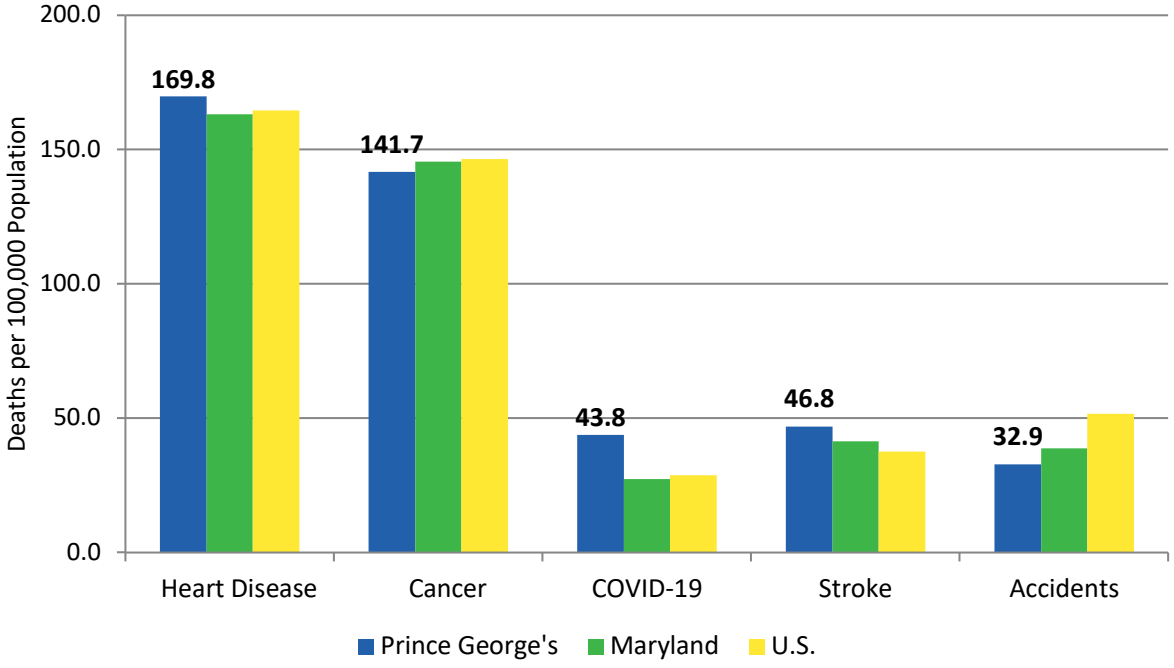


	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Black, NH	738.2	723.9	717.6	720.4	735.5	735.5	731.6	788.8
Hispanic	398.8	390.8	363.0	348.0	372.1	384.9	410.5	525.7
White, NH	822.2	815.1	782.1	756.4	730.4	749.2	741.8	781.6
Asian, NH	414.8	400.8	397.0	387.8	393.0	383.9	382.2	402.3
Prince George's	736.3	720.3	702.2	690.3	692.1	695.4	693.2	788.8

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

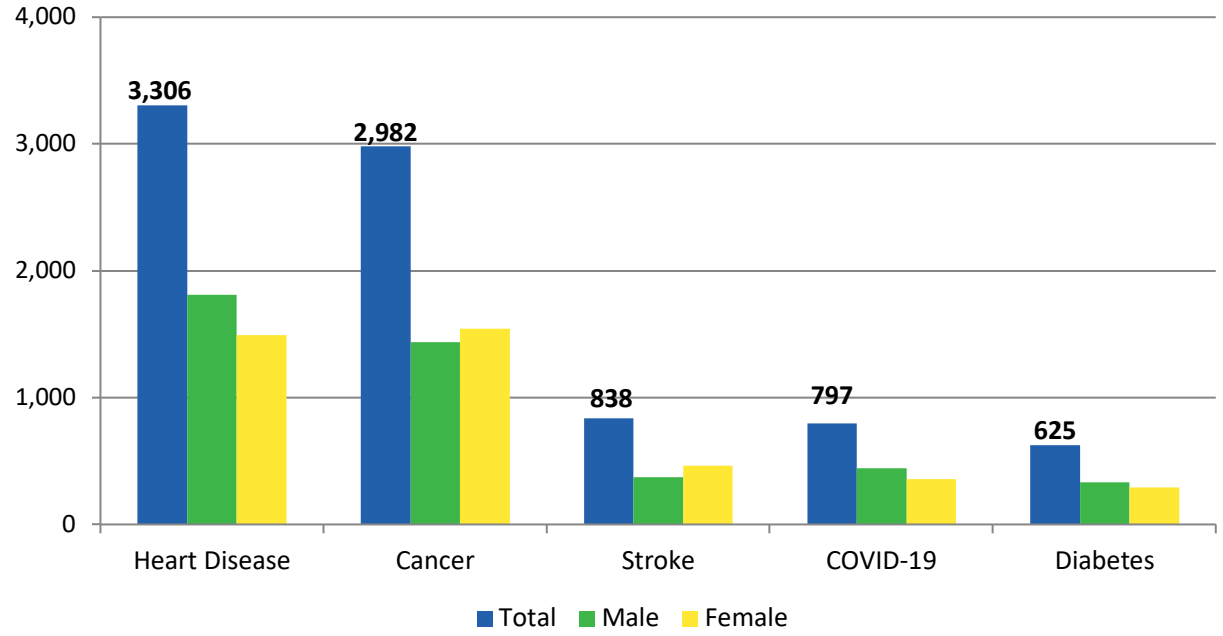
Out of the five leading causes of death in Prince George's, the County has a higher age-adjusted death rate compared to Maryland and the U.S. for heart disease, COVID-19, and stroke.

Leading Causes of Death, Age-Adjusted Rates, 2018-2020



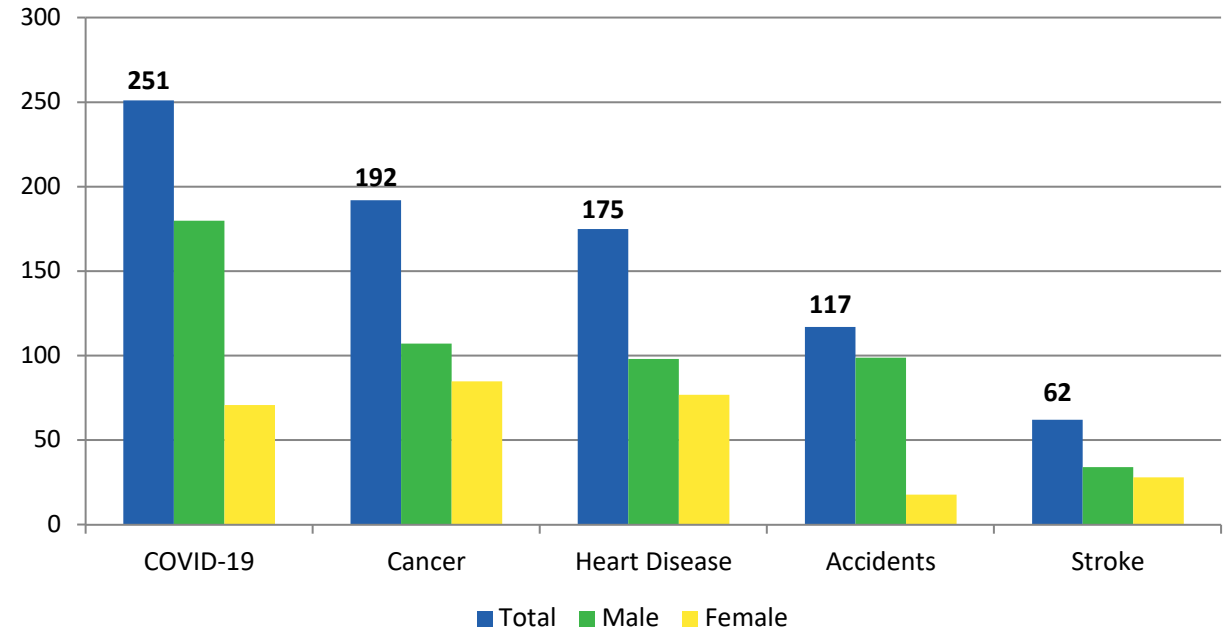
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Leading Causes of Death for Black Non-Hispanic Residents, Prince George's County, 2018-2020 (N=8,548)



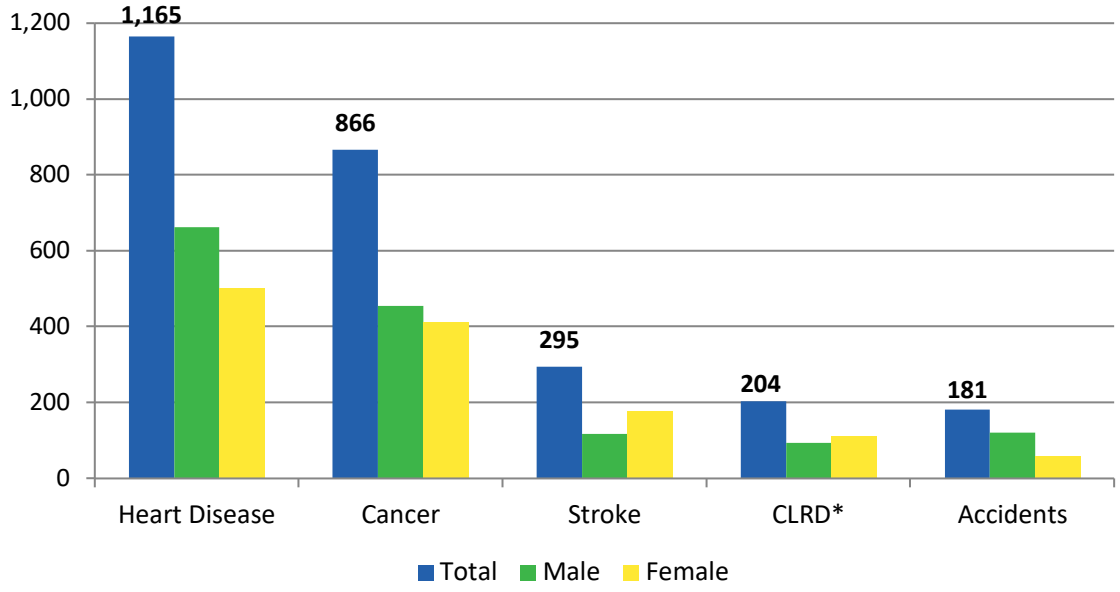
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Leading Causes of Death for Hispanic Residents (of Any Race), Prince George's County, 2018-2020 (N=797)



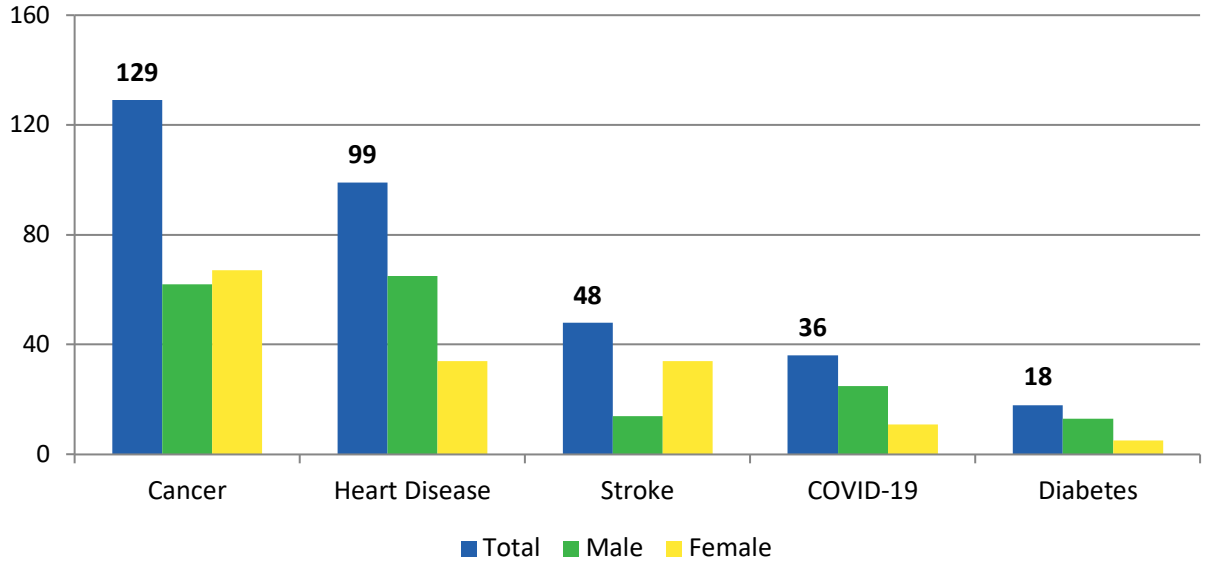
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Leading Causes of Death for White Non-Hispanic Residents, Prince George's County, 2018-2020 (N=2,711)



*CLRD=Chronic Lower Respiratory Disease, includes both chronic obstructive pulmonary disease and asthma
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Leading Causes of Death for Asian Non-Hispanic Residents, Prince George's County, 2018-2020 (N=330)



Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

While the leading cause of death by race and Hispanic ethnicity is consistently heart disease and cancer, there is variation for the remaining causes. For white, non-Hispanic (NH), Black NH, and Asian NH residents the third leading cause of death is stroke, but for Hispanic residents it is heart disease. Diabetes is a leading cause of death for both Black NH and Asian NH residents, while chronic lower respiratory diseases (CLRD) are included in the top five leading causes of death for white NH residents.

Access to Health Care

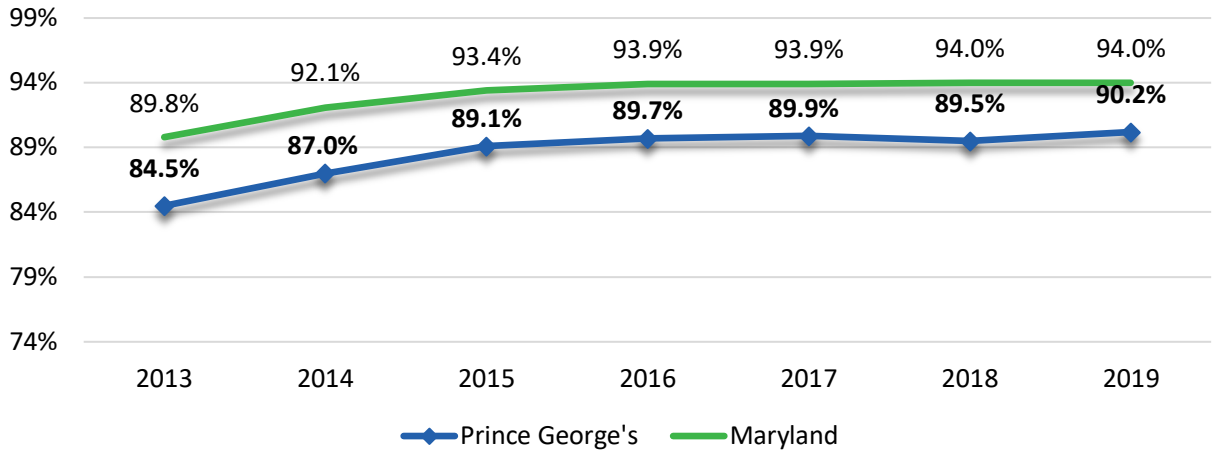
The percentage of residents with health insurance increased in Prince George's County following the implementation of the major provisions of the Affordable Care Act (ACA) in 2014. However, an estimated 92,790 residents remained uninsured as of 2020. By age, residents ages 26 to 44 years were least likely be insured with nearly one in five lacking health insurance. By race and ethnicity, Hispanic residents were less likely to be insured with nearly 30% lacking insurance.

Residents with Health Insurance, 2020

	Prince George's	Maryland
Race/Ethnicity		
Black	93.8%	94.2%
Hispanic	70.7%	78.6%
White, non-Hispanic	96.0%	96.9%
Asian	92.8%	94.6%
Sex		
Male	87.9%	93.1%
Female	91.4%	94.9%
Age Group		
Under 19 Years	94.1%	96.5%
19 to 25 Years	85.7%	90.9%
26 to 34 Years	81.6%	88.8%
35 to 44 Years	82.0%	90.2%
45 to 54 Years	89.4%	93.5%
55 to 64 Years	93.1%	95.3%
65 Years and Older	97.6%	99.0%
Total	**89.7%**	**94.1%**

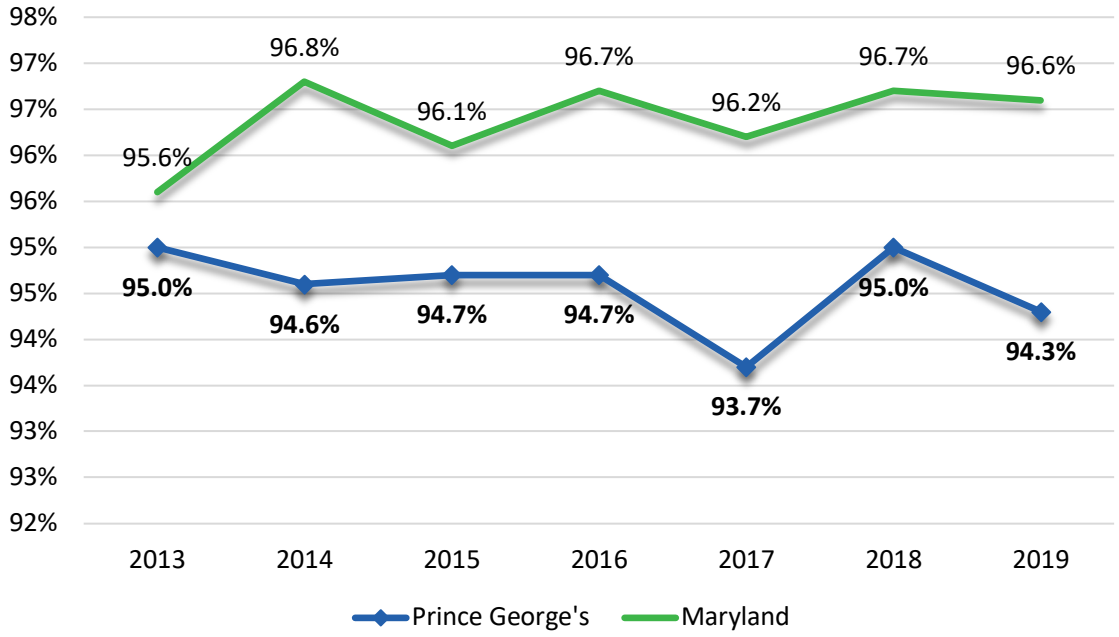
Data Source: 2016-2020 American Community Survey 5-Year Estimates, Table S2701

Residents with Health Insurance, 2013-2019



Data Source: 2019 American Community Survey 1-Year Estimates, Table S2701; 2020 1-Year estimates are unavailable

Children with Health Insurance, 2013-2019



Data Source: 2019 American Community Survey 1-Year Estimates, Table S2701

The estimated percentage of children with health insurance in the County decreased slightly in 2019 to 94.3%.

Adults who had a Routine Checkup Within the Last Year, 2017

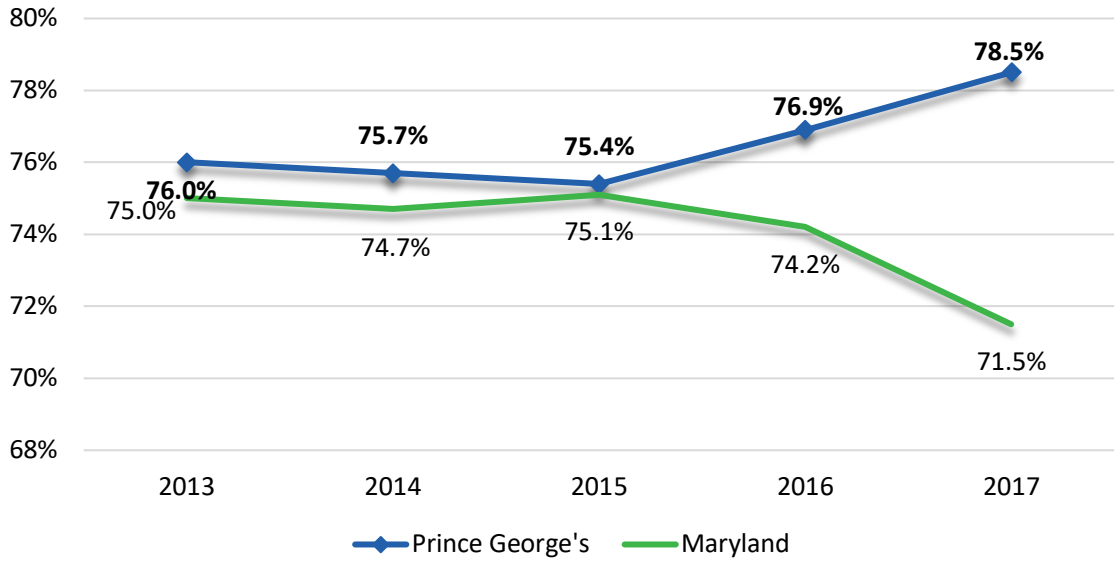
Demographic	Prince George's	Maryland
Race/Ethnicity		
Black, non-Hispanic	81.4%	79.0%
Hispanic	70.9%	62.6%
White, non-Hispanic	72.8%	67.4%
Sex		
Male	74.7%	67.6%
Female	82.9%	75.2%
Age Group		
18 to 44 Years	72.2%	63.3%
45 to 64 Years	83.6%	76.9%
Over 65 Years	89.2%	87.5%
Total	**78.5%**	**71.5%**

Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019; updated data not available

In 2017, more County adults reported having a routine checkup within the last year (78.5%) compared to Maryland (71.5%). By race, Black, NH residents were more likely to report having

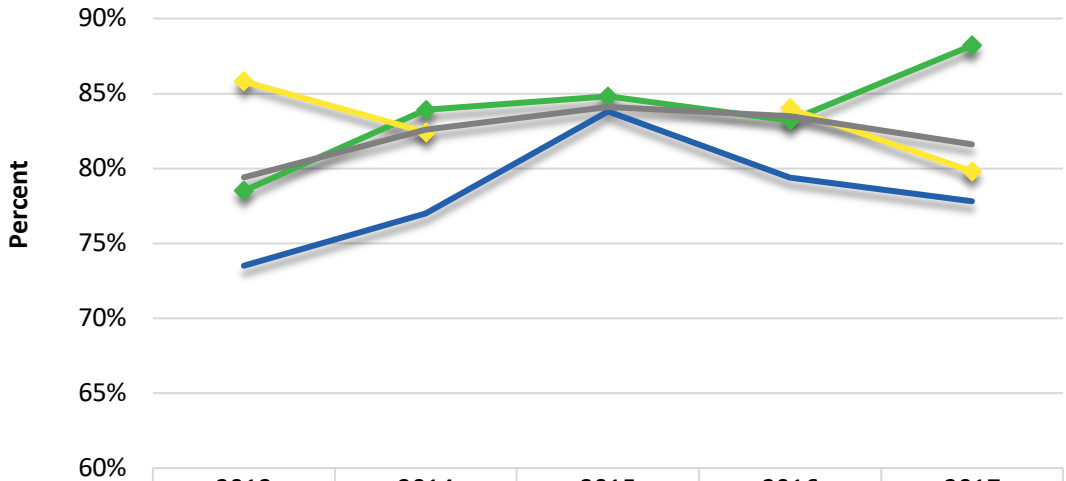
a routine checkup (81.4%) within the County. Due to the MDH cyberattack, more updated data was not available.

Adults who had a Routine Checkup Within the Last Year, 2013-2017



Data Source: 2013-2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019; updated data not available

Residents with a Usual Primary Care Provider, 2013-2017



	2013	2014	2015	2016	2017
PGC Black, NH	78.5%	83.9%	84.8%	83.2%	88.2%
PGC White, NH	85.8%	82.4%	**	84.0%	79.8%
PGC	73.5%	77.0%	83.8%	79.4%	77.8%
Maryland	79.4%	82.6%	84.1%	83.5%	81.6%

** White, NH data for 2015 not presented due to small number of events.
Data Source: 2013-2017 Maryland Behavior Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019, updated data not available

Prince George's County meets the national benchmark of 2,000 residents for every 1 primary care physician; however, the County has a much higher ratio compared to the state.

Resident to Provider Ratios

	Prince George's County Ratio	Maryland Ratio	Top U.S. Counties (90th percentile)
Primary Care Physicians	1,890:1	1,120:1	1,010:1
Dentists	1,570:1	1,260:1	1,210:1
Mental Health Providers	550:1	330:1	250:1

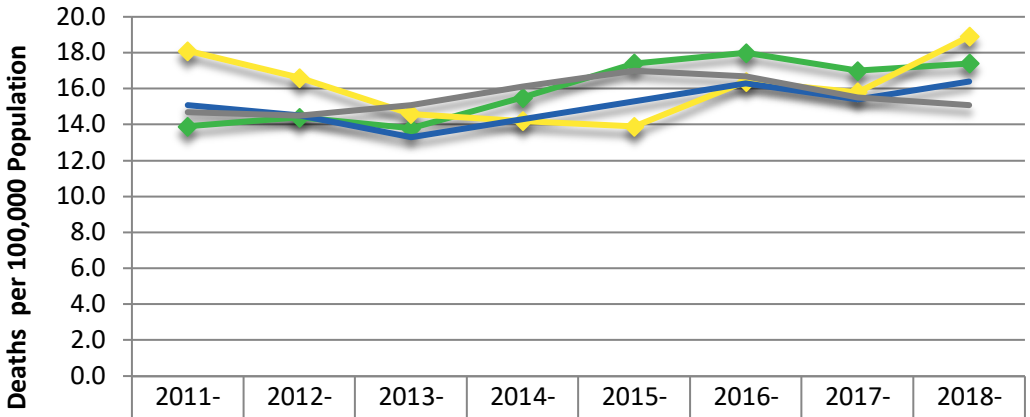
Data Source: 2022 County Health Rankings, www.countyhealthrankings.org

Diseases and Conditions

Alzheimer's Disease

In Prince George's County, the death rate for Alzheimer's Disease has increased since 2013 to 2015 with a rate of 13.3 deaths per every 100,000 population to 16.4 from 2018 to 2020.

Age-Adjusted Death Rate per 100,000 for Alzheimer's Disease 2013-2020



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
PGC Black, NH	13.9	14.4	13.8	15.5	17.4	18.0	17.0	17.4
PGC White, NH	18.1	16.6	14.6	14.2	13.9	16.4	15.8	18.9
PGC	15.1	14.5	13.3	14.3	15.3	16.3	15.4	16.4
Maryland	14.7	14.5	15.1	16.1	17.0	16.7	15.5	15.1

***** Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Cancer

Overview	
What is it?	Cancer is a term used for diseases in which abnormal cells divide without control and can invade other tissues; there are more than 100 kinds of cancer.
Who is affected?	In 2018, 4,025 residents were diagnosed with cancer in the County, and the cancer incidence rate was 399.1 per 100,000 residents. In 2020, there were 1,406 deaths from cancer in the County, which accounted for 17% of all deaths and was the second leading cause of death. Prostate and breast cancer are the most common types of cancer in the County, and in 2018 accounted for 35% of all new cancer cases. Overall, Black residents have the highest age-adjusted rate for new cancer cases and the highest age-adjusted death rate due to cancer. Prostate cancer has the highest age-adjusted death rate for County residents, followed by lung and bronchus cancer.
Prevention and Treatment	According to the CDC, there are several ways to help prevent cancer: • Healthy choices can reduce cancer risk, like avoiding tobacco, limiting alcohol use, protecting your skin from the sun, and avoiding indoor tanning, eating a diet rich in fruits and vegetables, keeping a healthy weight, and being physically active. • The human papillomavirus (HPV) vaccine helps prevent most cervical cancers and several other kinds of cancer. The hepatitis B vaccine can lower liver cancer risk. • Screening for cervical and colorectal cancers helps prevent these diseases by finding precancerous lesions so they can be treated before they become cancerous. Screening for cervical, colorectal, and breast cancers also helps find these diseases at an early stage, when treatment works best. Cancer treatment can involve surgery, chemotherapy, radiation therapy, targeted therapy, and immunotherapy.
What are the outcomes?	Remission (no cancer signs or symptoms), long-term treatment and care, and death.
Disparity	Overall, men had a higher age-adjusted cancer incidence rate per 100,000 (424.1) than women (386.7), and Black residents had a higher incidence rate (401.3) compared to White residents in 2018 (384.7). From 2018 to 2020, cancer mortality rates for Black, non-Hispanic (NH) residents was highest (150.7) compared to other race/ethnicities. By cancer site, Black residents in the County had higher incidence and mortality rates for breast and prostate cancers.
How do we compare?	Prince George's County's 2018 age-adjusted cancer incidence rate was 399.1 per 100,000 residents, much lower than the state at 445.9; other Maryland counties range from 372.1 (Montgomery) to 572.9 (Dorchester). The age-adjusted death rate for the County from 2018 to 2020 was 141.7, slightly lower compared to Maryland at 145.5.

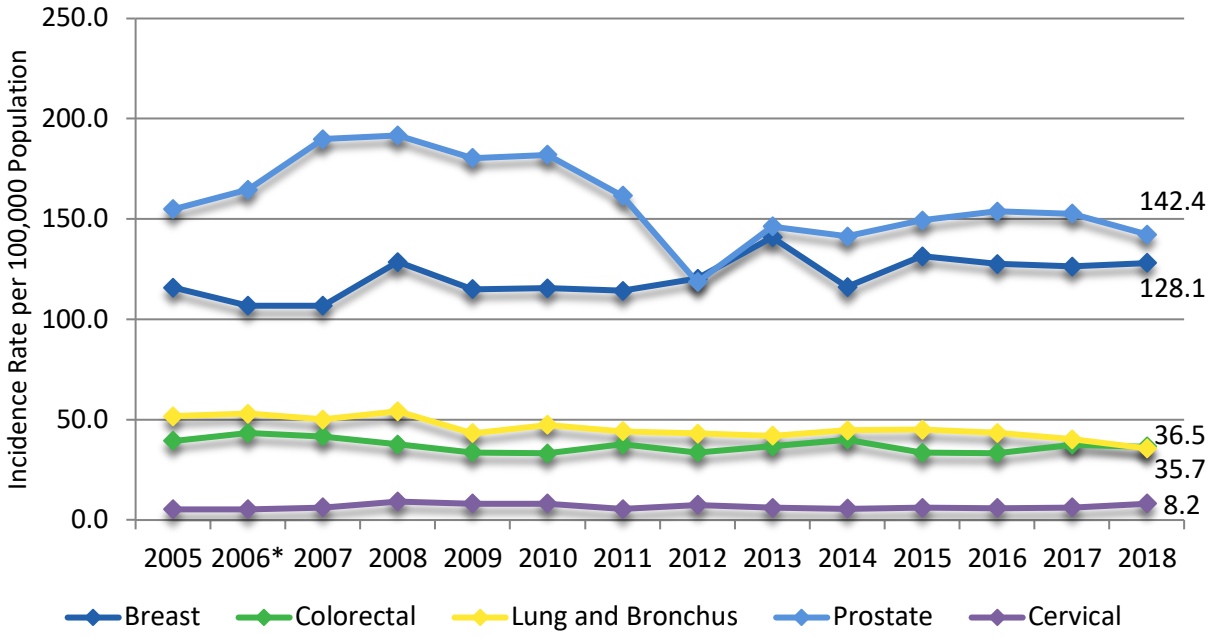
Overall, Prince George's County age-adjusted cancer incidence rate is less than Maryland and the U.S. for most leading types of cancer. Prostate cancer incidence remained higher in Prince George's County (147.9.4 cases per 100,000) compared to Maryland (126.3 cases per 100,000) and the U.S. (106.2) cases per 100,000).

Cancer Age-Adjusted Incidence Rates per 100,000 Population by Site, 2014-2018

Site	Prince George's	Maryland	United States
All Sites	401.6	446.1	448.6
Breast (Female)	125.9	130.8	126.8
Colorectal	36.1	36.1	38.0
Male	41.1	40.6	43.5
Female	32.4	32.5	33.4
Lung and Bronchus	41.6	54.1	57.3
Male	45.4	59.9	65.7
Female	38.7	49.9	50.8
Prostate	147.9	126.3	106.2
Cervical	6.4	6.6	7.7

Data Source: Maryland Department of Health, Annual Cancer Report, 2021; CDC National Center for Health Statistics, CDC WONDER Online Database

Cancer Age-Adjusted Incidence Rates by Site, Prince George's County, 2005-2018



*2006 incidence rates are lower than actual due to case underreporting

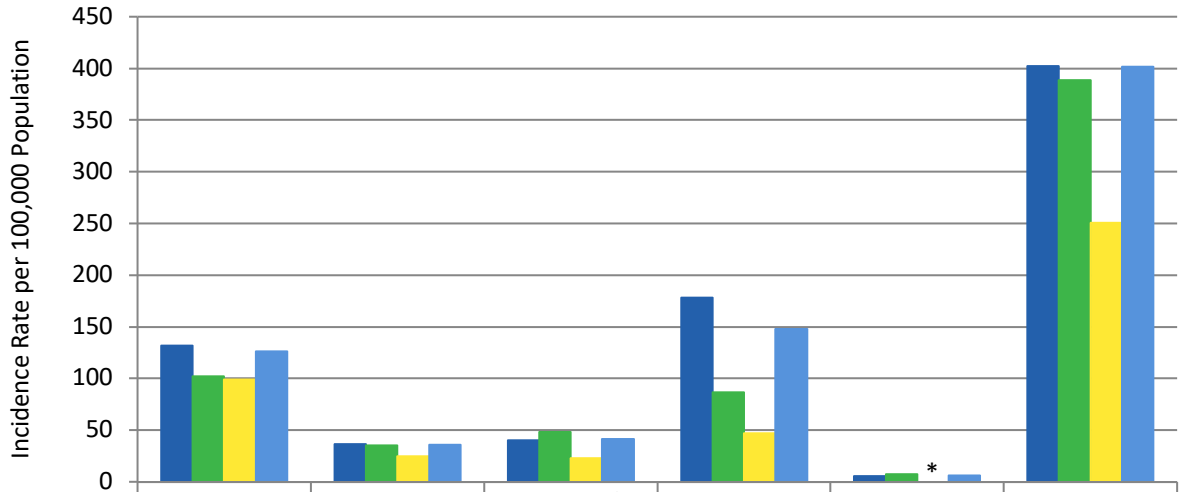
Data Source: Maryland Department of Health, Annual Cancer Reports

Cancer Age-Adjusted Incidence Rates by Site, Prince George's County, 2005-2018

Year	All Sites	Breast	Colorectal	Lung and Bronchus	Prostate	Cervical
2005	**386.3**	115.8	39.5	51.7	155.0	5.3
2006*	**364.4**	106.8	43.4	53.0	164.7	5.3
2007	**409.8**	106.8	41.7	50.1	189.9	6.3
2008	**429.1**	128.6	37.7	54.2	191.7	9.2
2009	**387.6**	115.0	33.7	43.3	180.4	8.2
2010	**403.5**	115.6	33.3	47.4	182.0	8.2
2011	**390.0**	114.2	37.7	44.2	161.7	5.4
2012	**376.7**	120.3	33.7	43.1	118.5	7.6
2013	**414.5**	140.9	36.8	42.0	146.3	6.1
2014	**397.0**	116.2	40.0	44.7	141.3	5.7
2015	**405.6**	131.5	33.6	45.0	149.3	6.1
2016	**399.7**	127.7	33.4	43.5	153.8	6.0
2017	**407.9**	126.3	37.6	40.2	152.7	6.2
2018	**399.1**	128.1	36.5	35.7	142.4	8.2

*2006 incidence rates are lower than actual due to case underreporting
Data Source: Maryland Department of Health, Annual Cancer Reports

Cancer Age-Adjusted Incidence Rates by Race, Prince George's County, 2014-2018

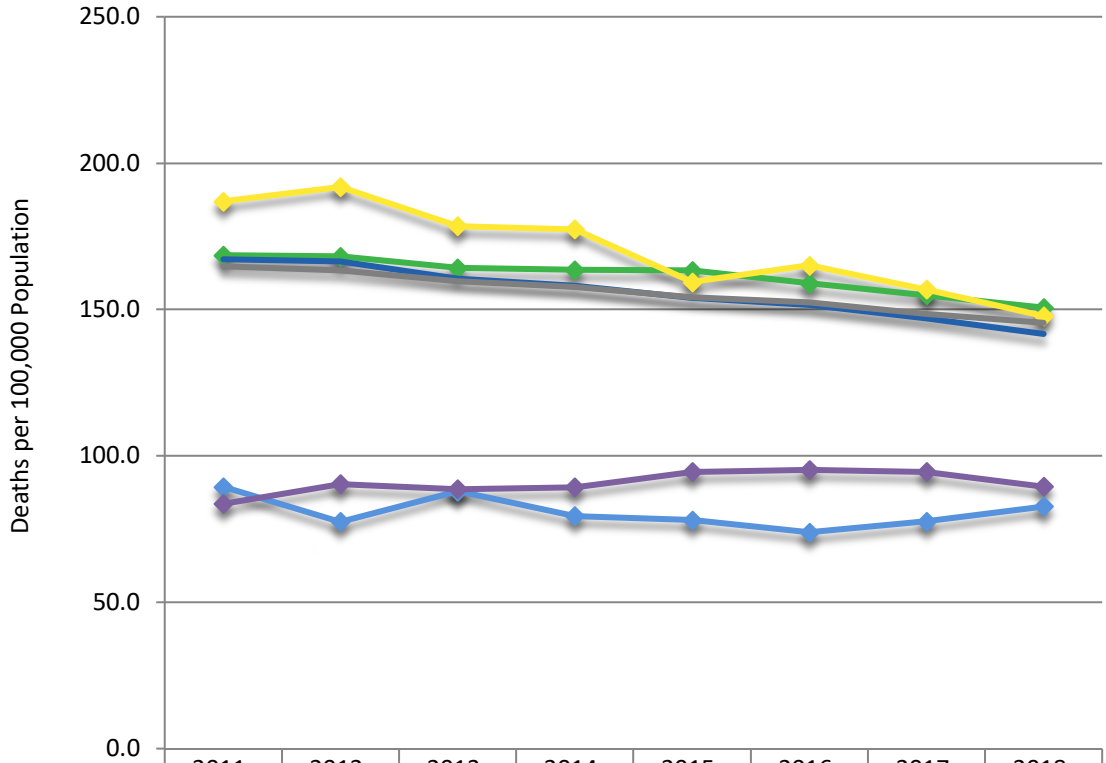


	Breast (Female)	Colorectal	Lung and Bronchus	Prostate	Cervical	All Sites
Black	131.6	36.3	39.9	178.0	5.6	402.1
White	102.3	35.2	48.0	86.8	7.6	388.8
Other	98.8	24.8	22.9	47.2	*	250.4
All Races	125.9	36.1	41.6	147.9	6.4	401.6

*Age-adjusted incidence rate unavailable due to small number of cases
Data Source: Maryland Department of Health, Annual Cancer Report, 2021
Individuals of Hispanic origin were included within the White or Black estimates and are not listed separately

Deaths due to cancer in the County decreased from 2011 to 2020, trending towards the Healthy People 2030 Goal of a cancer death rate of 122.7. In 2018-2020, Black, non-Hispanic (NH) residents had the highest age-adjusted death rate due to cancer at 150.7, followed by white, non-Hispanic (NH) residents at 147.8. Hispanic residents had the lowest death rate due to cancer in the County, at 82.8.

Age-Adjusted Death Rate per 100,000 for Cancer by Race and Ethnicity, Prince George's County, 2011-2020



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
PGC Black, NH	168.6	168.2	164.2	163.6	163.3	159.0	154.9	150.7
PGC Hispanic	89.5	77.6	88.0	79.6	78.1	74.0	77.7	82.8
PGC White, NH	187.0	191.9	178.5	177.5	159.4	165.1	156.9	147.8
PGC Asian, NH	83.7	90.5	88.7	89.4	94.6	95.3	94.6	89.6
PGC	167.2	166.4	160.5	158.2	154.1	151.6	147.0	141.7
Maryland	164.8	163.3	159.8	157.7	154.3	152.5	148.5	145.5

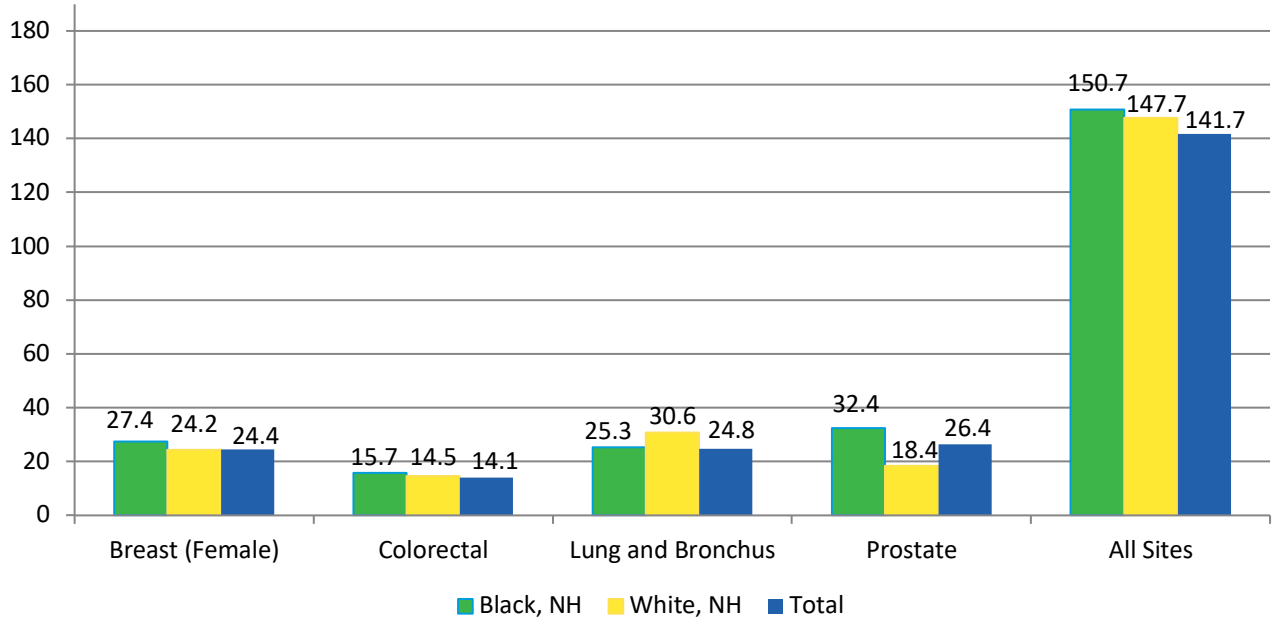
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Cancer Age-Adjusted Death Rates per 100,000 by Site and Sex, 2018-2020

Site	Prince George's	Maryland	United States	HP 2030 Goal
All Sites	**141.7**	145.5	146.4	122.7
Breast (Female)	**24.4**	20.7	19.4	15.3
Colorectal	**14.1**	13.3	13.1	8.9
Male	**17.9**	15.5	15.6	---
Female	**11.1**	11.5	11.1	---
Lung and Bronchus	**24.8**	31.3	33.4	---
Male	**30.5**	36.1	39.9	---
Female	**21.1**	27.8	28.1	---
Prostate	**26.4**	19.9	18.5	16.9
Cervical	**2.5**	2.1	2.2	---

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database; MDH Maryland SHIP http://ship.md.networkofcare.org/ph/; Healthy People 2020 https://www.healthypeople.gov/

Cancer Age-Adjusted Death Rates by Race* and Hispanic Origin, Prince George's County, 2018-2020



* Asian/Pacific Islander and Hispanic residents were not included due to insufficient numbers; Cervical cancer age-adjusted rates not shown by race due to insufficient numbers

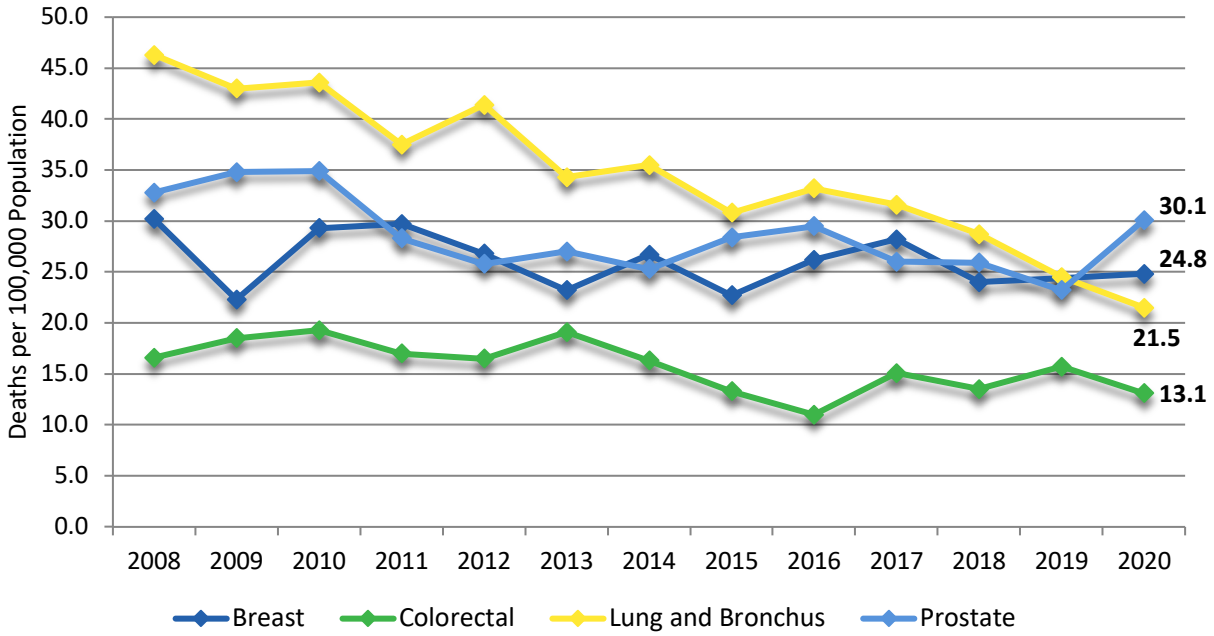
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Cancer Age-Adjusted Death Rates per 100,000 by Site*, Prince George's County, 2008-2020

Year	All Sites	Breast (Female only)	Colorectal	Lung and Bronchus	Prostate
2008	184.9	30.2	16.6	46.3	32.8
2009	178.8	22.3	18.5	43.0	34.8
2010	182.4	29.3	19.3	43.6	34.9
2011	171.3	29.7	17.0	37.5	28.3
2012	168.4	26.8	16.5	41.4	25.8
2013	162.1	23.2	19.1	34.3	27.0
2014	168.4	26.7	16.3	35.5	25.3
2015	151.3	22.7	13.3	30.8	28.4
2016	155.4	26.2	11.0	33.2	29.5
2017	155.7	28.2	15.1	31.6	26.0
2018	143.9	24.0	13.5	28.7	25.9
2019	141.7	24.4	15.7	24.5	23.2
2020	139.8	24.8	13.1	21.5	30.1

* Cervical cancer statistics not included due to insufficient numbers.
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Cancer Age-Adjusted Death Rates by Site, Prince George's County, 2008-2020

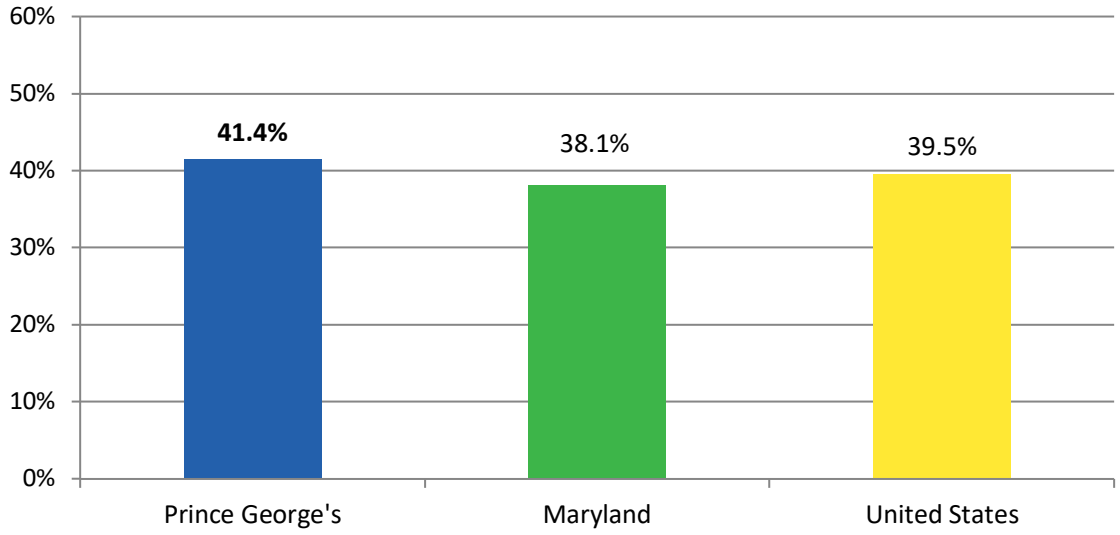


Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Cancer Screening

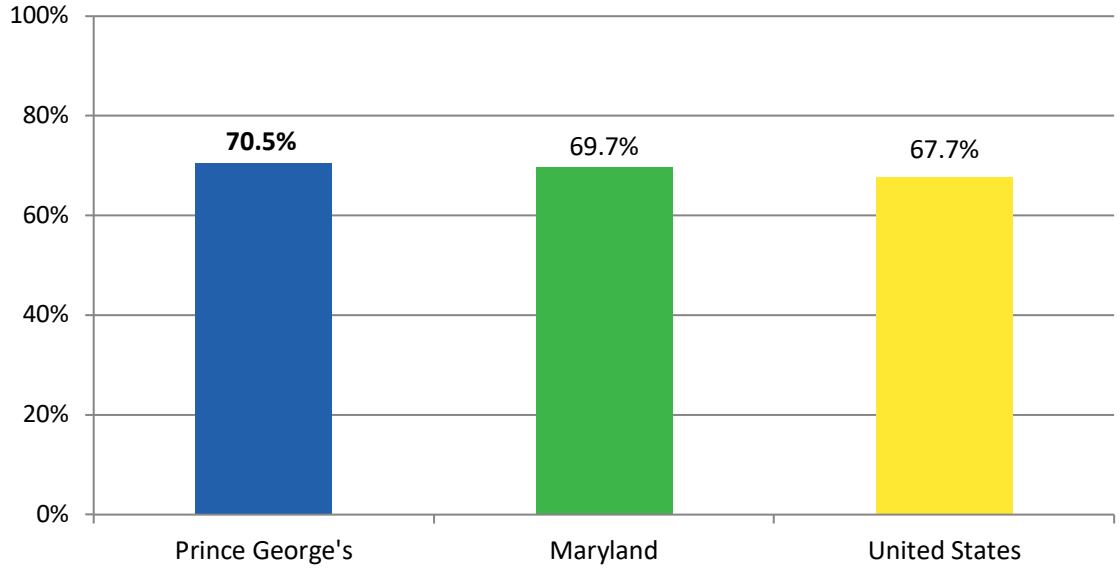
In 2016, Prince George's County had slightly higher cancer screening rates compared to the State and nation for prostate, colorectal, and breast cancers, and slightly lower screening rate for cervical cancer. Updated Maryland Behavioral Risk Factor Surveillance System data is not available due to the MDH cyberattack.

Men (40 years+) With a Prostate-Specific Antigen Test in the Past Two Years, 2016



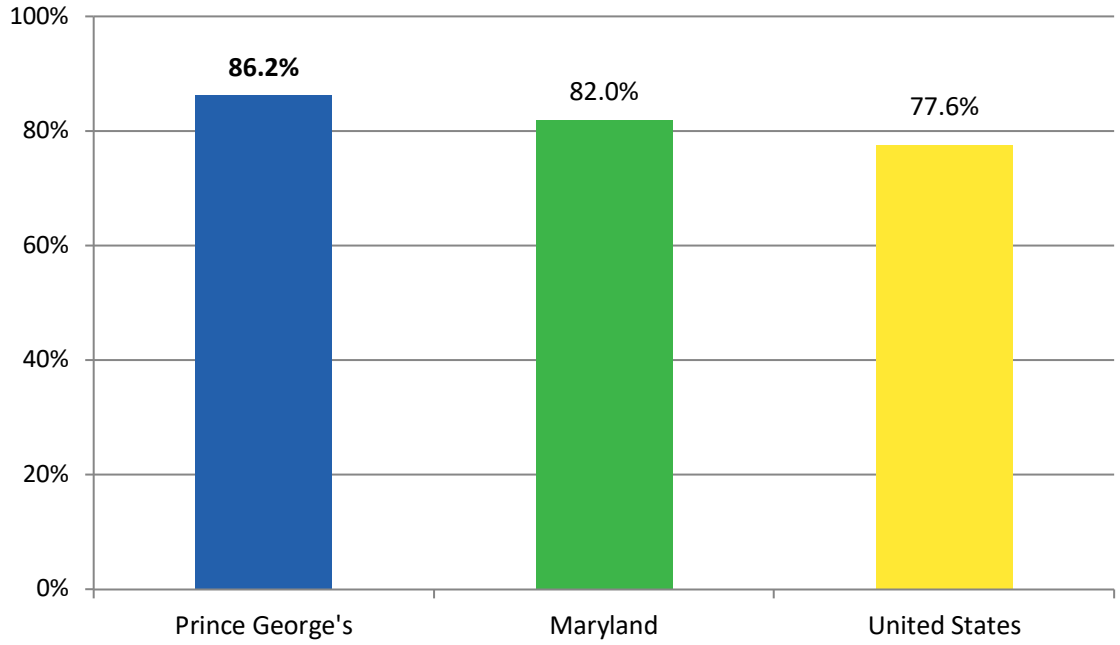
Data Source: 2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

Men and Women (50 – 75 years) Fully Meeting Colorectal Cancer Screening Recommendation, 2018



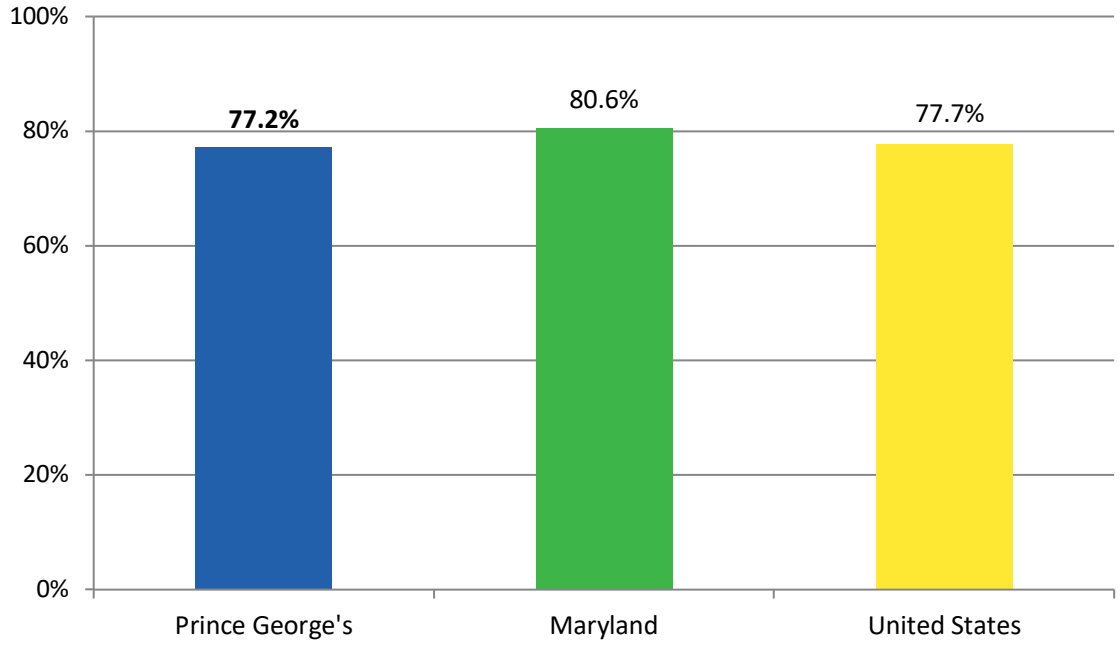
Data Source: 2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

Women (50+ years) who had a Mammography in the Past 2 Years, 2018



Data Source: 2018 Maryland Behavioral Risk Factor Surveillance System, accessed 5/15/2022 via www.pgchealthzone.org; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

Women (21-65 years) who had a Pap Smear in the Past Three Years, 2016



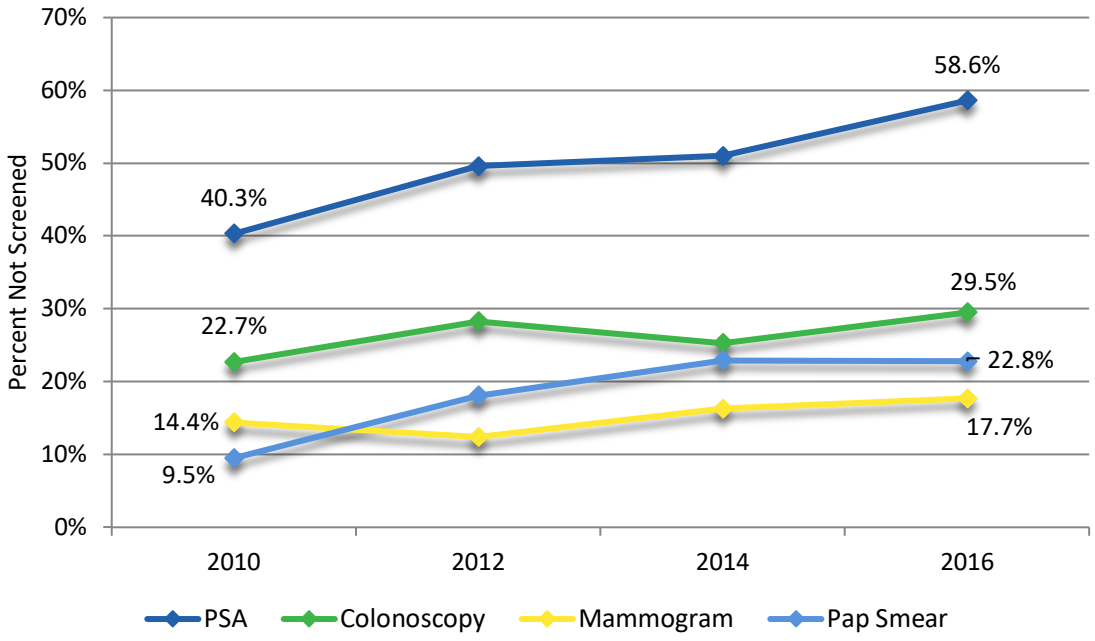
Data Source: 2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

Population Not Screened for Selected Cancer, Prince George's County, 2016

Cancer Screening	Target Group	Total Population	Percentage not Screened	Estimated Population not Screened
Prostate Specific Antigen (PSA) in past 2 years	Men 40 years and above	186,282	**58.6%**	**109,161**
Colorectal Cancer Screening	Men and women 50 - 75 years	251,357	**29.5%**	**74,150**
Mammography in past 2 years	Women 50 years and above	163,232	**17.7%**	**28,892**
Pap Smear in past 3 years	Women 21 - 65 years	291,708	**22.8%**	**66,509**

Data Source: 2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019; 2016 1-Year Estimates, U.S. Census Bureau, Table B01001 www.census.gov

Population Not Screened for Selected Cancers, Prince George's County, 2010-2016



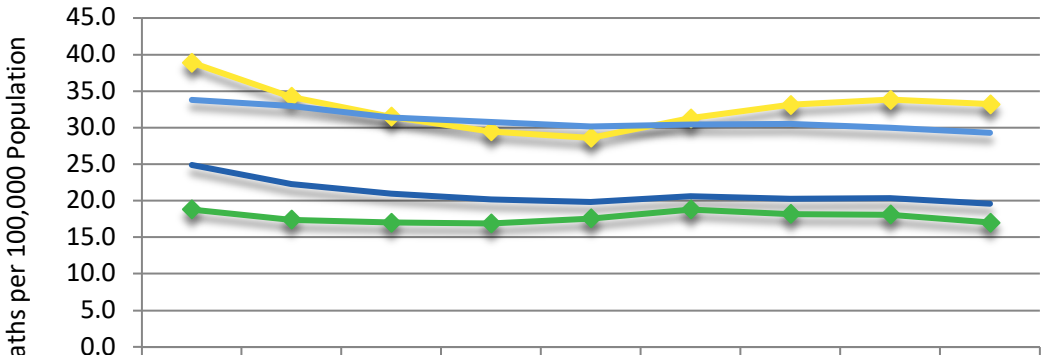
Data Source: 2010-2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Chronic Lower Respiratory Disease (CLRD)

CLRD are diseases that affect the lungs, which includes COPD (chronic obstructive pulmonary disease) and asthma. COPD consists of emphysema which means the air sacs in the lungs are damaged, and chronic bronchitis where the lining of the lungs are red and swollen and become clogged with mucus. Cigarette smoking is the main cause of COPD and is strongly associated with lung cancer. Asthma is a disease that also affects the lungs that is commonly is diagnosed in childhood. Asthma is described further below:

Asthma Overview	
What is it?	Asthma is a chronic disease involving the airways that allow air to come in and out of the lungs. Asthma causes airways to always be inflamed, they become even more swollen, and the airway muscles can tighten when something triggers your symptoms: coughing, wheezing, and shortness of breath.
Who is affected?	13.9% (of adults are estimated to have asthma (MD 2019 BRFSS) and 13.9% (33,294) of children are estimated to have asthma (MD 2013 BRFSS*).
Prevention and Treatment	Asthma cannot be prevented and there is no cure, but steps can be taken to control the disease and prevent symptoms: use medicines as your doctor prescribes and try to avoid triggers that make asthma worse. (NHLBI.NIH.gov; AAAAI.org)
What are the outcomes?	People with asthma are at risk of developing complications from respiratory infections like influenza and pneumonia. Asthma complications can be severe and include decreased ability to exercise, lack of sleep, permanent changes in lung function, persistent cough, trouble breathing, and death (NIH.gov).
How do we compare?	While 13.3% of adult County residents have asthma, other Maryland counties range from 5.9% to 22.3%; the state overall is 15.5% (2017 MD BRFSS) and the U.S. is at 14.2% (2017 BRFSS).

Age-Adjusted Death Rate per 100,000 for Chronic Lower Respiratory Disease (CLRD) by Race and Ethnicity, 2010-2020

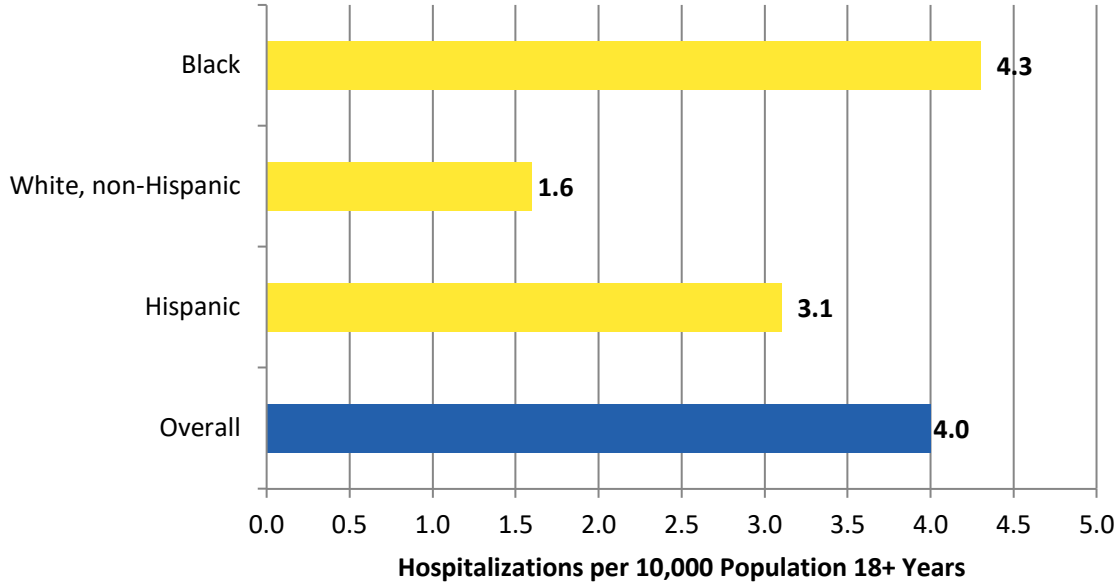


	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
PGC Black, NH	18.8	17.4	17.0	16.9	17.6	18.8	18.2	18.1	17.0
PGC White, NH	38.9	34.2	31.5	29.5	28.6	31.3	33.1	33.8	33.2
PGC	24.9	22.3	21.0	20.2	19.8	20.6	20.3	20.4	19.6
Maryland	33.8	33.0	31.4	30.8	30.2	30.4	30.5	30.0	29.3

***** Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

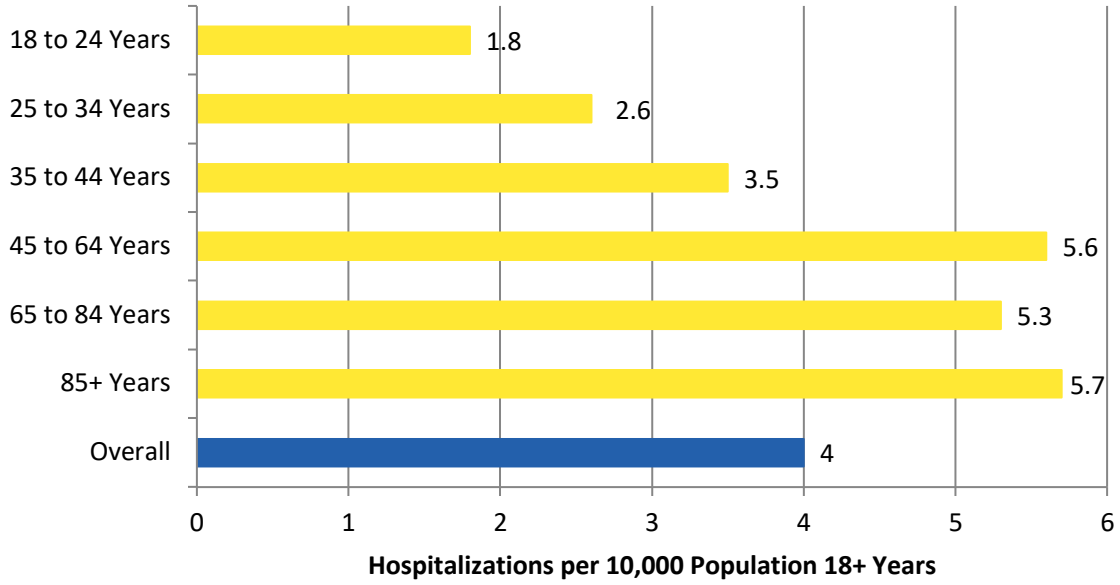
Adult Asthma

Age-Adjusted Hospital Inpatient* Visit Rate due to Adult Asthma by Race and Ethnicity, Prince George's County, 2017-2019



* Includes visits only to Maryland hospitals
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

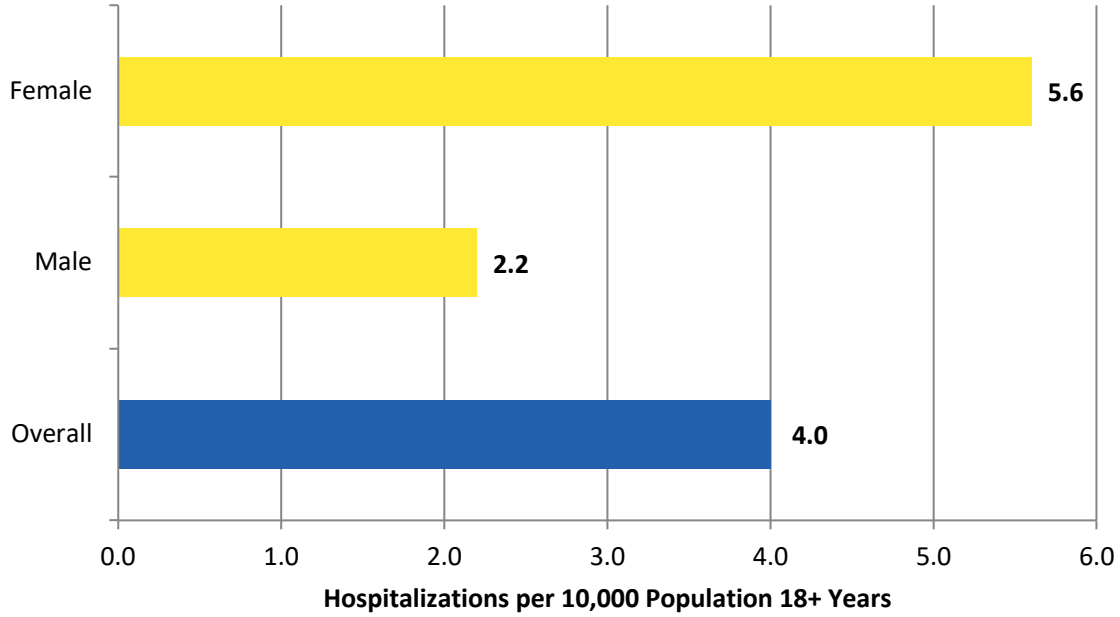
Age-Adjusted Hospital Inpatient* Visit Rate due to Adult Asthma by Age Group, Prince George's County, 2017-2019



* Includes visits to only Maryland hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Adult Asthma by Sex, Prince George's County, 2017-2019

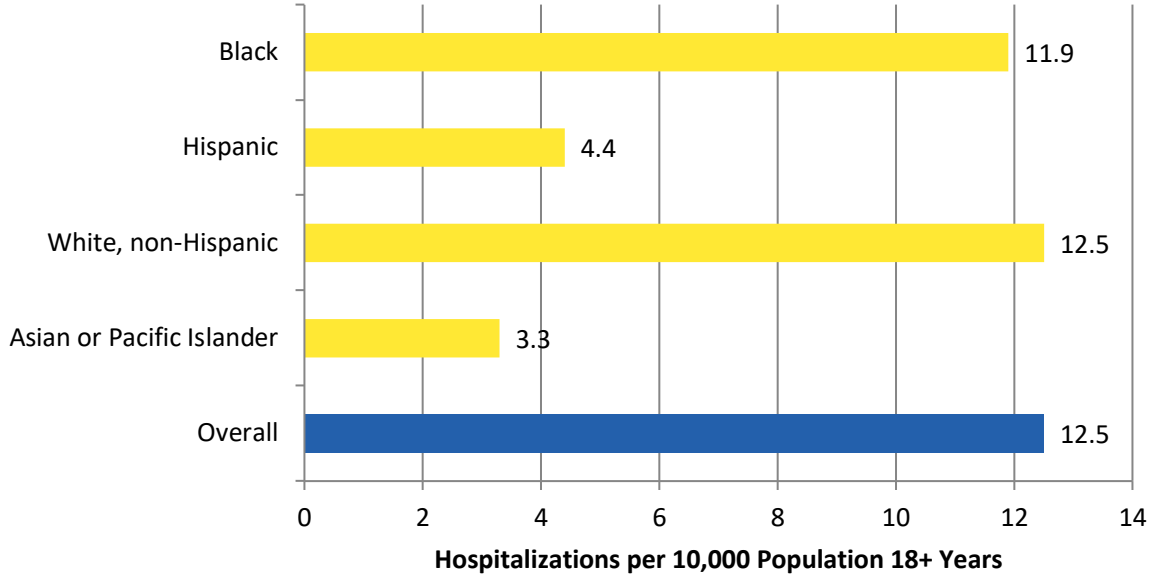


* Includes visits to only Maryland hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Chronic Obstructive Pulmonary Disease (COPD)

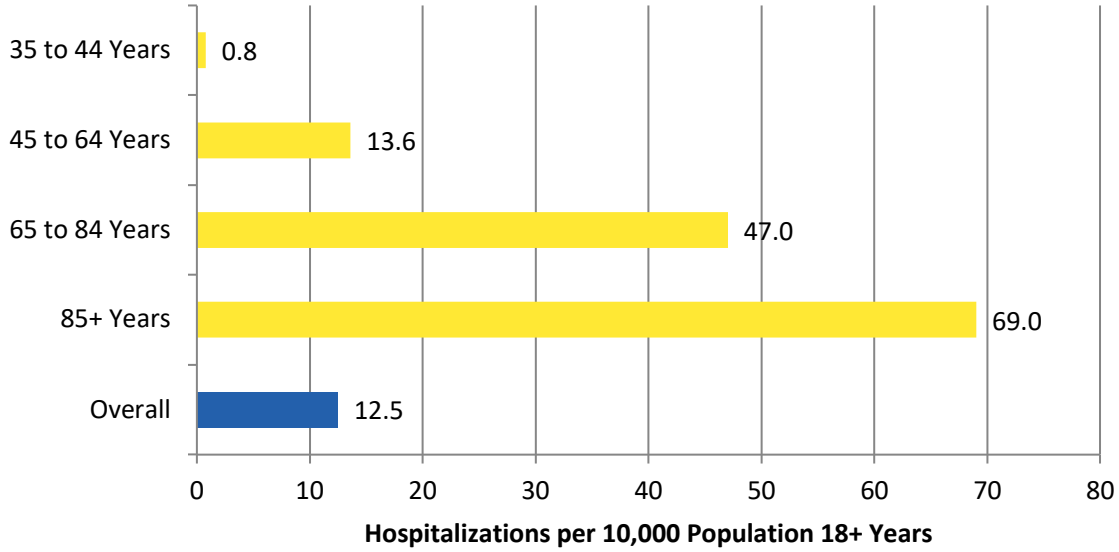
Age-Adjusted Hospital Inpatient* Visit Rate due to COPD by Race and Ethnicity, Prince George's County, 2017-2019



* Includes visits to only Maryland hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

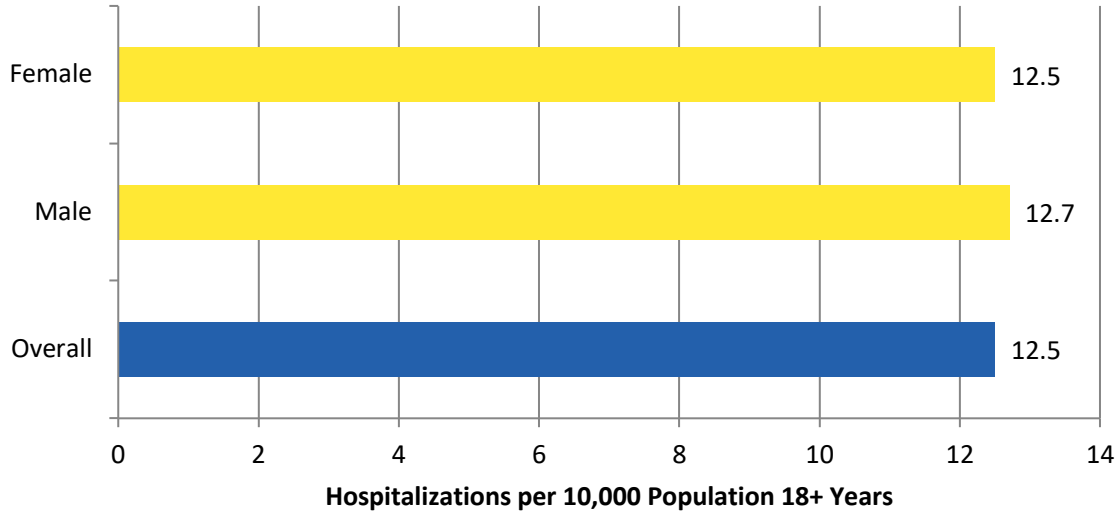
Age-Adjusted Hospital Inpatient* Visit Rate due to COPD by Age Group, Prince George's County, 2017-2019



* Includes visits to only Maryland hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to COPD by Sex, Prince George's County, 2017-2019



* Includes visits to only Maryland hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Diabetes

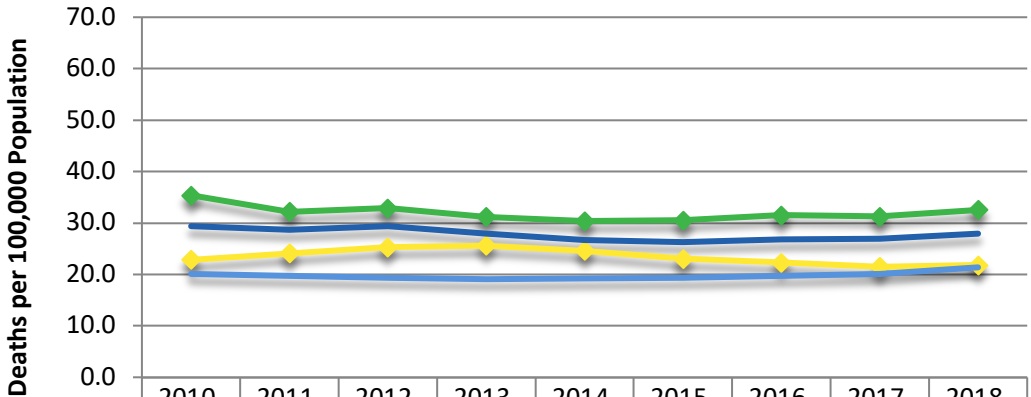
Overview	
What is it?	Diabetes is a condition in which the body either doesn't make enough of a hormone called insulin or can't use its own insulin, which is needed to process glucose (sugar) (Source: CDC).
Who is affected?	13.8% (97,685) of adults in the County are estimated to have diabetes. (2019 MD BRFSS). From 2018 to 2020, diabetes was the sixth leading cause of death in the County, with 813 or 3.9% of all resident deaths.
Prevention and Treatment	Diabetes can be prevented or delayed by losing a small amount of weight (5 to 7 percent of total body weight) through 30 minutes of physical activity 5 days a week and healthier eating. (Source: CDC Diabetes Prevention Program) The goals of diabetes treatment are to control blood glucose levels and prevent diabetes complications by focusing on nutrition, physical activity, and medication. (Source: Joslin Diabetes Center)
What are the outcomes?	Complications from diabetes include heart disease, kidney failure, lower-extremity amputation, and death.
Disparity	Black, non-Hispanic residents were more likely to die from diabetes from 2018 to 2020 (32.6 per 100,000) compared to White, non-Hispanic residents (21.8). More specifically, Black, non-Hispanic males had the highest death rate at 42.1 per 100,000, followed by white, non-Hispanic males at 28.7. Diabetes prevalence increases with age, with approximately one in three residents ages 65 and over estimated to have diabetes.
How do we compare?	Between 2018 and 2020, Prince George's County had one of the highest age-adjusted death rates due to diabetes (28.0 per 100,000). For the State, the diabetes death rate ranges from 12.2 (Montgomery County) to 37.1 (Washington County).

Percentage of Adults Who Have Ever Been Told By a Health Professional That They Have Diabetes, 2017 (Excludes Diabetes During Pregnancy)

	Prince George's County	Maryland
Sex		
Female	12.0%	8.9%
Male	13.0%	10.4%
Race/Ethnicity		
Black, non-Hispanic	13.6%	13.5%
Hispanic	16.7%	12.7%
White, non-Hispanic	10.5%	7.6%
Age Group		
18 to 34 Years	*	1.6%
35 to 49 Years	10.6%	7.2%
50 to 64 Years	19.3%	15.1%
Over 65 Years	28.7%	21.6%
Total	**12.3%**	**9.6%**

***** Individuals of Hispanic origin and ages 18-34 years were not included due to insufficient numbers
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

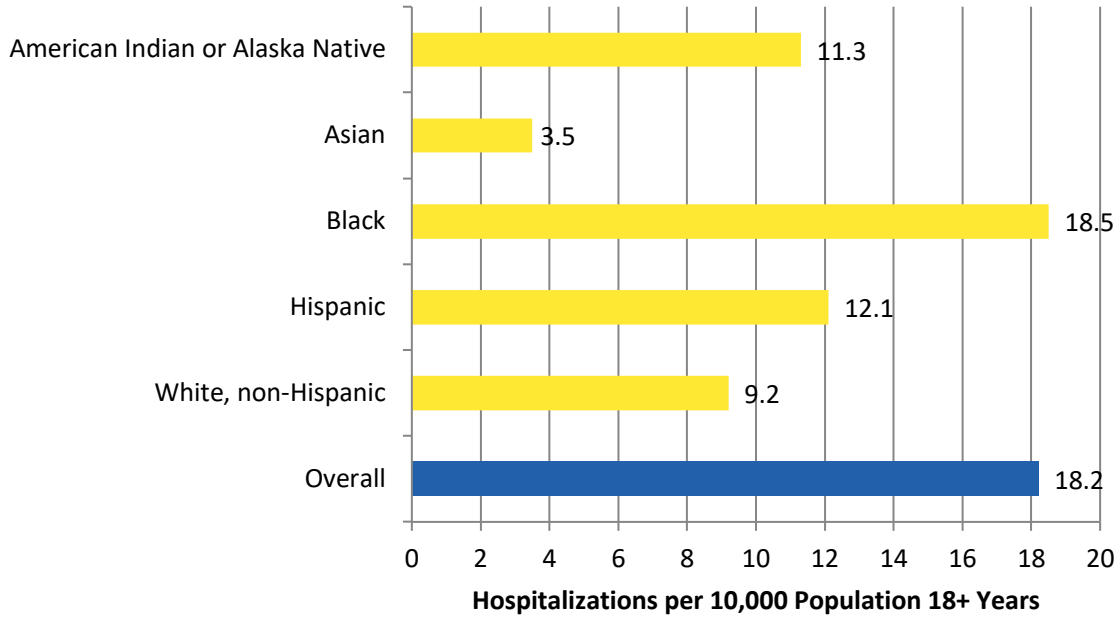
Age-Adjusted Death Rate per 100,000 for Diabetes, 2010-2020



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
PGC Black, NH	35.4	32.2	32.9	31.2	30.4	30.5	31.5	31.3	32.6
PGC White, NH	22.9	24.1	25.3	25.6	24.6	23.1	22.3	21.5	21.8
PGC	29.4	28.7	29.4	28.0	26.7	26.3	26.8	26.9	28.0
Maryland	20.1	19.8	19.4	19.1	19.2	19.4	19.8	20.1	21.4

***** Individuals of Hispanic origin and Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database;

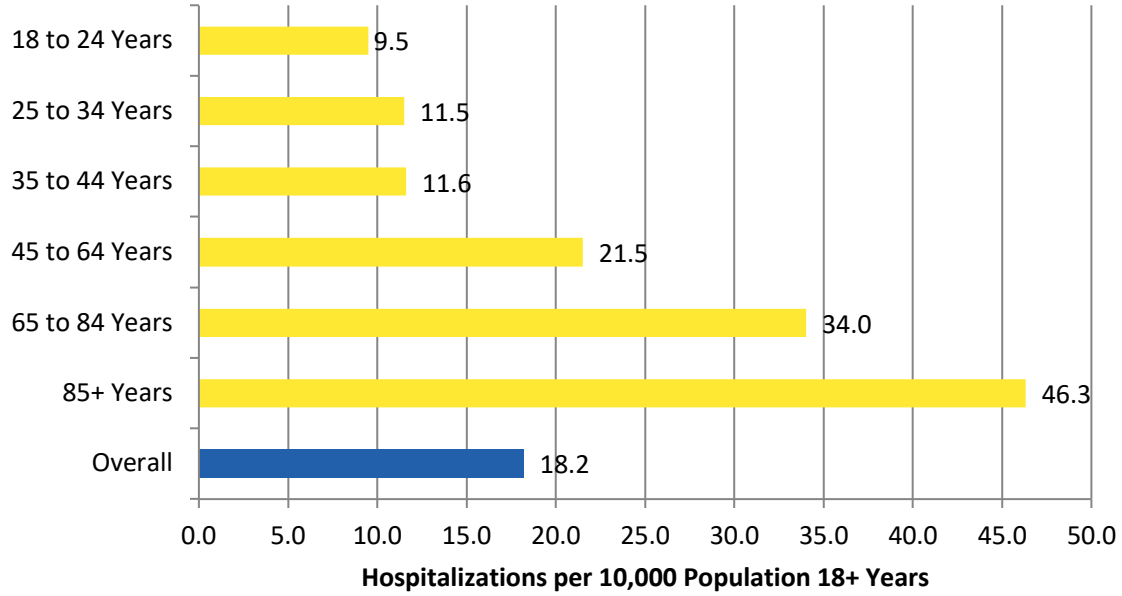
Age-Adjusted Hospital Inpatient* Visit Rate due to Diabetes by Race and Ethnicity, Prince George's County, 2017-2019



* Includes visits to only Maryland hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

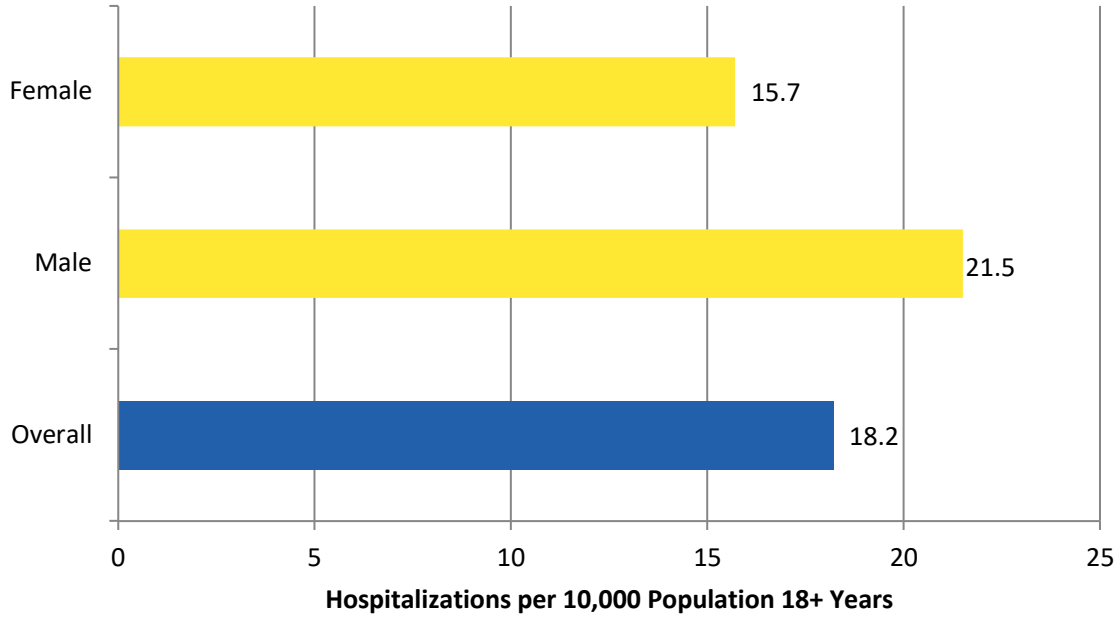
Age-Adjusted Hospital Inpatient* Visit Rate due to Diabetes by Age Group, Prince George's County, 2017-2019



* Includes visits to only Maryland hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Diabetes by Sex, Prince George's County, 2017-2019



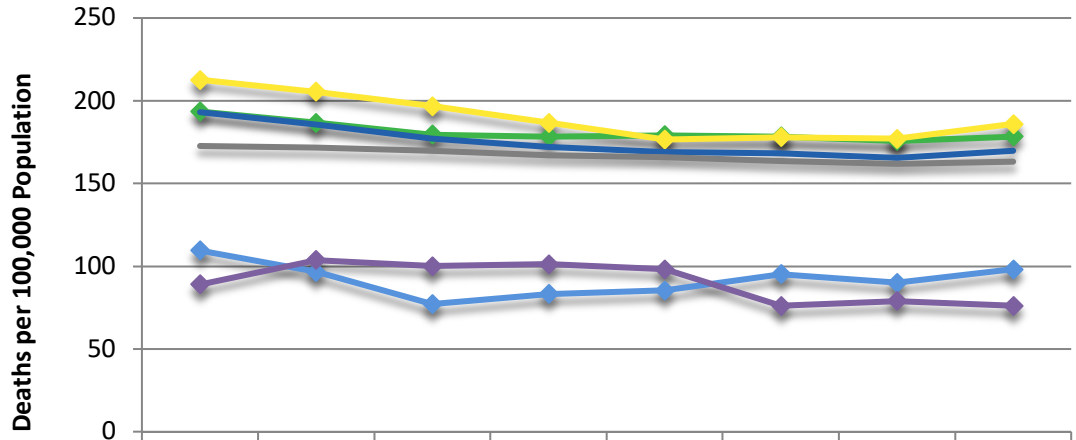
* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Heart Disease

Overview	
What is it?	Heart disease is a disorder of the blood vessels of the heart that can lead to a heart attack, which happens when an artery becomes blocked. Heart disease is one of several cardiovascular diseases.
Who is affected?	Heart disease was the leading cause of death in the County from 2018 to 2020, with 4,755 deaths (22.7%) of all resident deaths. However, the age-adjusted death rate from heart disease has decreased from 193.1 deaths per 100,000 from 2011 to 2013 to 169.8 deaths per 100,000 in 2018-2020 (Source: CDC Wonder).
Prevention and Treatment	Eating a healthy diet, maintaining a healthy weight, getting enough physical activity, not smoking, and limiting alcohol use can lower the risk of heart disease. (Source: CDC). The goals of heart disease treatment are to control high blood pressure and high cholesterol by focusing on eating healthier, increasing physical activity, quitting smoking, medication, and surgical procedures. (Source: CDC).
What are the outcomes?	Complications of heart disease include heart failure, heart attack, stroke, aneurysm, peripheral artery disease, and sudden cardiac arrest.
Disparity	White, non-Hispanic (NH) residents had the highest age-adjusted death rate in the County between 2018 and 2020 (186.0), followed by Black, NH residents (178.3). More specifically, White, NH males have the highest death rate in the County at 254.2, followed by Black, NH males (237.4).
How do we compare?	The age-adjusted death rate for heart disease for other Maryland counties ranged from 98.9 (Montgomery) to 291.3 (Somerset) deaths per 100,000 population from 2018 to 2020. The County rate of 169.8 is similar to Maryland overall at 163.2 deaths per 100,000 population, and the United States (164.5 per 100,000 population).

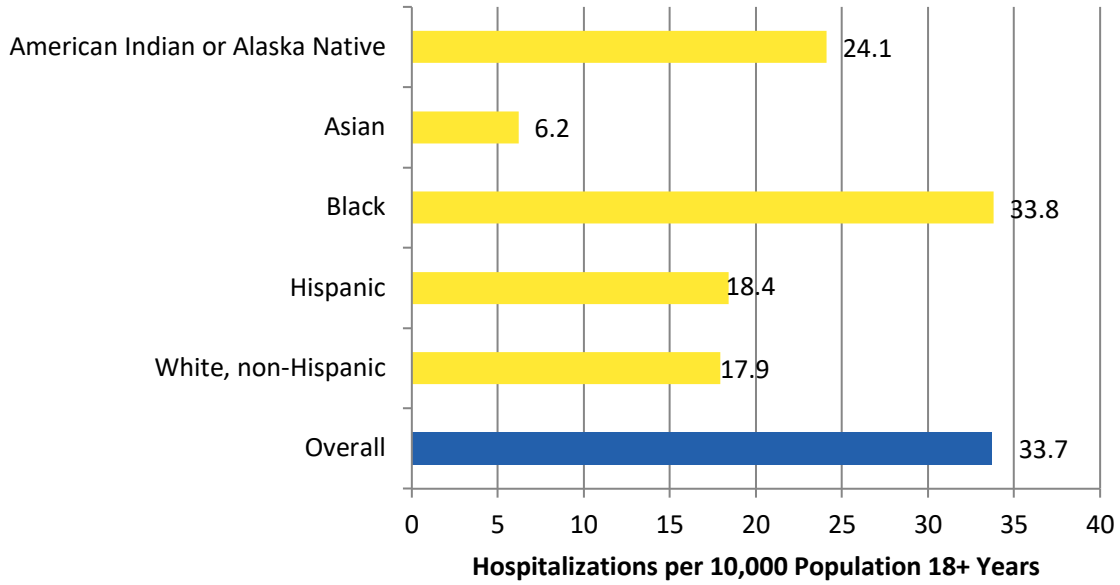
Age-Adjusted Death Rate per 100,000 for Heart Disease by Race and Ethnicity, 2010-2020



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
PGC Black, NH	193.5	186.7	179.6	178.3	179.1	178.3	175.7	178.3
PGC Hispanic	109.5	96.7	77.2	83.3	85.4	95.2	90.0	98.1
PGC White, NH	212.7	205.4	196.8	186.7	176.6	178.0	177.1	186.0
PGC Asian, NH	89.1	103.7	100.2	101.3	98.1	76.2	79.1	76.2
PGC	193.1	185.8	177.0	172.3	168.9	168.4	165.5	169.8
Maryland	172.7	171.6	169.9	167.1	166.0	163.5	161.9	163.2

Data Source: CDC, National Center for Health Statistics, CDC WONDER Online Database

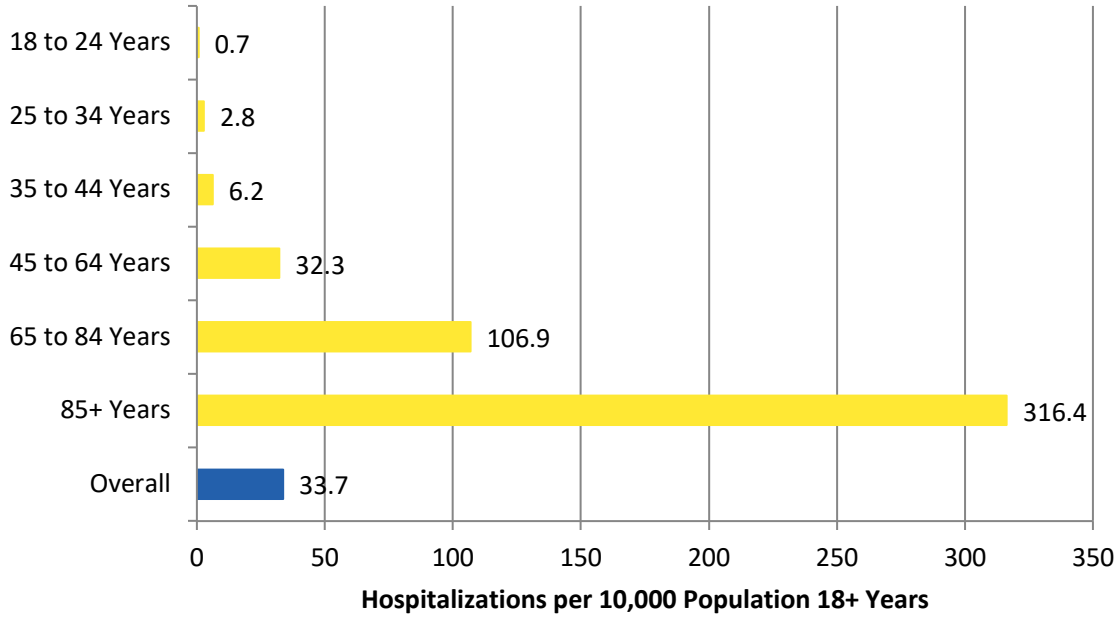
Age-Adjusted Hospital Inpatient* Visit Rate due to Heart Failure by Race and Ethnicity, Prince George's County, 2017-2019



* Includes visits to only Maryland hospitals

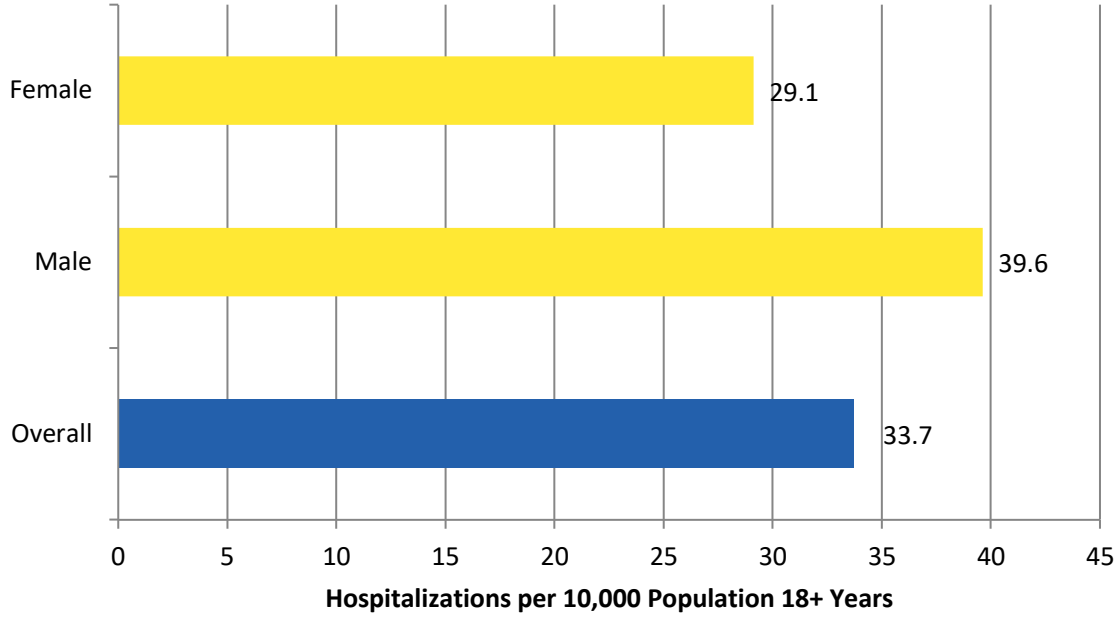
Data Source: www.pgchealthzone.org, Maryland Health Services Cost Review Commission; Maryland Health Care Commission;

Age-Adjusted Hospital Inpatient* Visit Rate due to Heart Failure by Age, Prince George's County, 2017-2019



* Includes visits to only Maryland hospitals
Data Source: www.pgchealthzone.org, Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Heart Failure by Sex, Prince George's County, 2017-2019

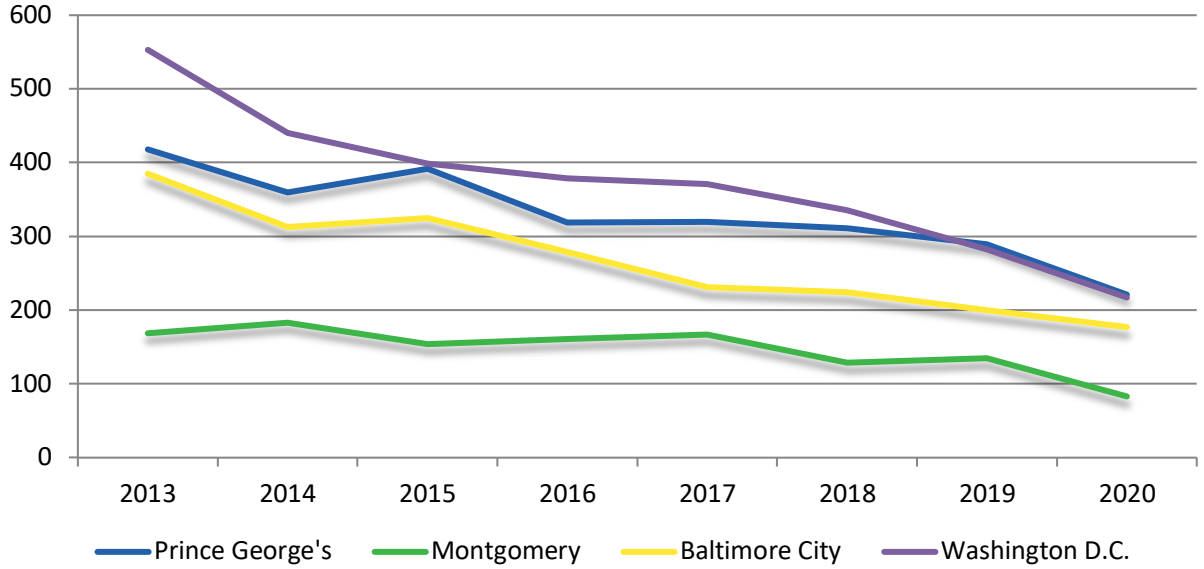


* Includes visits to only Maryland hospitals
Data Source: www.pgchealthzone.org, Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Human Immunodeficiency Virus (HIV)

Overview	
What is it?	HIV is a virus that attacks the body's immune system and can, over time, destroy the cells that protect us from infections and disease.
Who is affected?	In 2020, 221 County residents were diagnosed with HIV, a rate of 29.0 per 100,000 population. The total number of living HIV cases was 8,014, and over 44% of living HIV cases in Prince George's County are over the age of 50 years. Between 2018 and 2020, 133 residents died from HIV with an age-adjusted death rate of 4.3 per 100,000 population.
Prevention & Treatment	HIV can be prevented by practicing abstinence, limiting the number of sexual partners, using condoms the right way during sex, and never sharing needles. Medications are also available to prevent HIV. (Source: CDC) There is no cure for HIV but antiretroviral therapy (ART) is available which helps to control the virus so you can live a longer, healthier life and reduce the risk of transmitting HIV to others. (Source: AIDS.gov)
What are the outcomes?	HIV weakens the immune system leading to opportunistic infections (OIs). OIs are the most common cause of death for people with HIV/AIDS and can include Cryptococcus, cytomegalovirus disease, histoplasmosis, tuberculosis, and pneumonia. (Source: AIDS.gov)
Disparity	In 2020, approximately three out of every four new HIV cases occurred among Black, non-Hispanic residents, and seven out of every ten new HIV cases occurred among men. Nearly 60% of new HIV cases were among residents aged 20 to 39 years, and over half were among men who have sex with men.
How do we compare?	In 2020, Prince George's County had the second highest rate of HIV diagnoses (29.0 per 100,000 population) in the State after Baltimore City (35.5). In terms of the number of new cases, the County had the highest number of actual cases in the State, 221, followed by Baltimore City with 177. The rate of HIV diagnoses in other Maryland counties range from 0.0 (Garrett and Carroll counties) to 35.5 per 100,000 population (Baltimore City). The state overall had a rate of 14.3 per 100,000 population and the U.S. had a rate of 12.6 per 100,000 (2019).

New HIV Cases by Jurisdiction, 2013-2020



Data Source: 2020 County Annual HIV Epidemiological Profile for Prince George's County, MDH; 2021 HAHSTA Annual Epidemiology and Surveillance Report for Washington, D.C; 2020 Baltimore City Annual HIV Epidemiological Profile; 2020 Montgomery County Annual HIV Epidemiological Profile

Demographics of New HIV Cases, 2020

	Prince George's		Maryland	
	Number	**Rate***	**Number**	**Rate***
Sex at Birth				
Male	154	42.6	531	21.7
Female	67	16.7	193	7.3
Race/Ethnicity				
Black, non-Hispanic	170	35.3	520	33.9
Hispanic	33	24.8	85	17.4
White, non-Hispanic	6	6.2	87	3.3
Asian, non-Hispanic	3	9.0	10	2.9
Age				
13 to 19 Years	7	8.8	29	5.5
20 to 29 Years	70	56.3	233	30.1
30 to 39 Years	56	43.6	187	22.4
40 to 49 Years	52	44.2	125	16.6
50 to 59 Years	26	20.7	104	12.5
60+ Years	10	5.4	46	3.3
Country of Birth				
United States	146	25.9	500	12.0
Foreign-born	35	17.8	95	10.9
Total	**221**	**29.1**	**724**	**12.0**

*Rate per 100,000 Adult/Adolescents 13 years or older

Data Source: 2020 County Annual HIV Epidemiological Profile for Prince George's County, MDH; 2020 Maryland Annual HIV Epidemiological Profile

New HIV Cases by Exposure, 2020

	Prince George's		Maryland	
	Number	Percent	Number	Percent
Exposure				
Men who have Sex with Men (MSM)	115	51.9%	388	53.6%
Injection Drug Users (IDU)	10	4.5%	45	6.2%
MSM & IDU	2	0.8%	6	0.9%
Heterosexual	95	42.9%	285	39.4%
Perinatal	0	0.0%	0	0.0%
Total	**221**	**100.0**	**724**	**100.0**

Data Source: 2020 County Annual HIV Epidemiological Profile for Prince George's County, MDH; 2020 Maryland Annual HIV Epidemiological Profile

Demographics of Total Living HIV Cases, 2020

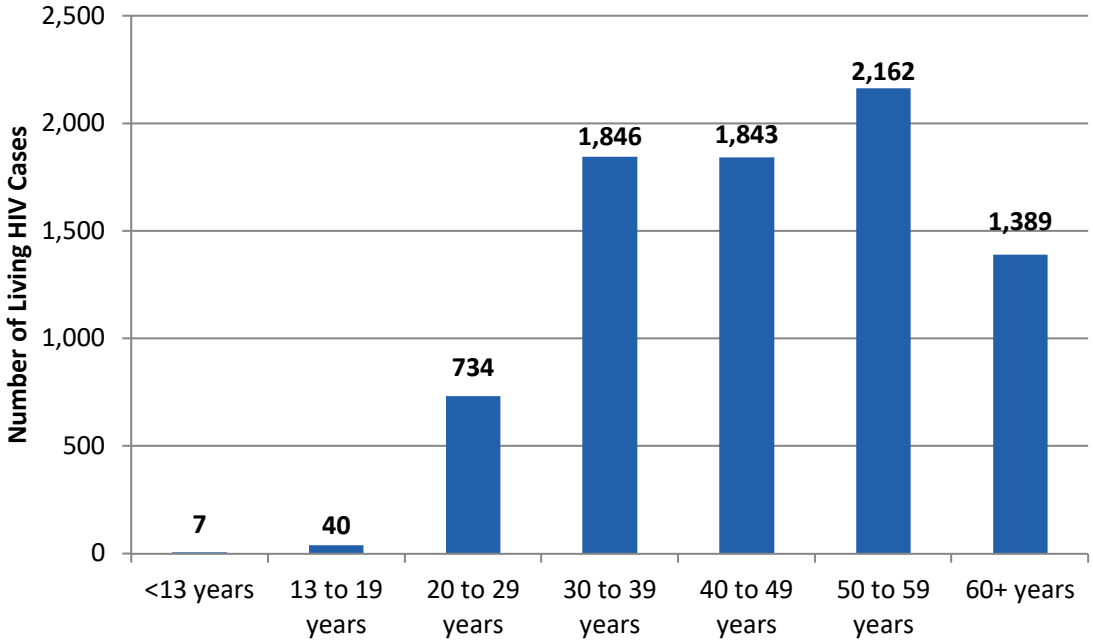
	Prince George's		Maryland	
	Number	Rate*	Number	Rate*
Sex at Birth				
Male	5,431	1,501.5	20,908	855.4
Female	2,583	645.4	10,768	405.6
Race/Ethnicity				
Black, non-Hispanic	6,630	1,375.0	23,554	1,537.6
Hispanic	646	484.5	2,233	457.2
White, non-Hispanic	315	323.0	3,879	148.2
Asian, non-Hispanic	42	125.5	249	72.1
Current Age				
13 to 19 Years	40	50.4	137	25.9
20 to 29 Years	734	590.7	2,455	317.6
30 to 39 Years	1,846	1,437.4	6,095	730.9
40 to 49 Years	1,843	1,568.1	6,307	837.0
50 to 59 Years	2,162	1,718.7	9,347	1,125.1
60+ Years	1,389	744.7	7,335	531.9
Country of Birth				
United States	6,585	1,167.8	26,887	643.1
Foreign-born	1,206	612.8	3,805	436.5
Total	**8,014**	**1,053.5**	**31,676**	**626.9**

*Rate per 100,000 Adult/Adolescents 13 years or older

Data Source: 2020 County Annual HIV Epidemiological Profile for Prince George's County, MDH; 2020 Maryland Annual HIV Epidemiological Profile

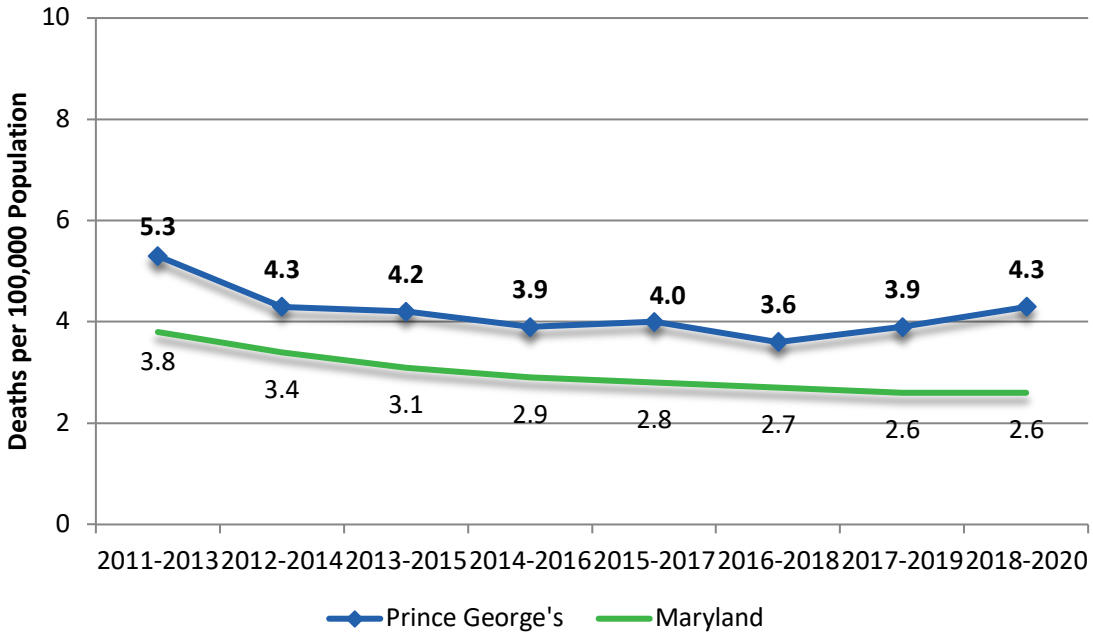
In Prince George's County, approximately one out of every 100 residents are living with HIV. The County's rate for living HIV cases (1,053.5 per 100,000 residents) is 68% higher compared to Maryland at 626.9.

Total Living HIV Cases by Current Age, Prince George's County, 2020



Data Source: 2020 County Annual HIV Epidemiological Profile for Prince George's County, MDH

HIV Age-Adjusted Mortality Rate, Prince George's County Compared to Maryland, 2011-2020



Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

The HIV age-adjusted death rate is higher in the County at 4.3 per 100,000 residents compared to Maryland (2.6).

Hypertension and Stroke

Overview	
What is it?	High blood pressure, or hypertension, is when the force of blood pumping through the arteries is too strong. Hypertension is a risk factor for stroke, which is when the flow of blood (and thus oxygen) to the brain is blocked.
Who is affected?	In the County, 31.9% (226,627) of adults are estimated to have hypertension (MD BRFSS 2017). In 2020, 438 County residents died from stroke, the fourth leading cause of death. Over two-thirds of County residents 65 years and older were hypertensive in 2017.
Prevention & Treatment	Hypertension and stroke can be prevented by eating a healthy diet, maintaining a healthy weight, exercising regularly, avoiding stress, and limiting alcohol and tobacco use (Source: CDC). The goal of stroke treatment is to maintain healthy blood pressure through proper nutrition, exercise, and medication (Source: American Heart Association).
What are the outcomes?	Complications from hypertension include damage to the heart and coronary arteries, stroke, kidney damage, vision loss, erectile dysfunction, angina, and death. (Source: American Heart Association).
Disparity	Black, non-Hispanic men have the highest age-adjusted death rate due to stroke at 54.2 per 100,000, followed by Asian, non-Hispanic women (45.8).
How do we compare?	Hypertension in other Maryland counties ranged from 21.6% (Kent County) to 57.2% (Somerset County). The 31.9% of Prince George's County residents with hypertension is similar to the state at 30.6% (MD BRFSS 2017) and the U.S. at 32.3% (BRFSS). Between 2018 and 2020, the County had a higher age-adjusted death rate due to stroke (46.8 per 100,000) compared to the State (41.5 per 100,000) and U.S (37.6 per 100,000).

Percentage of Adults Who Have Ever Been Told By A Health Professional They Have High Blood Pressure*, 2017

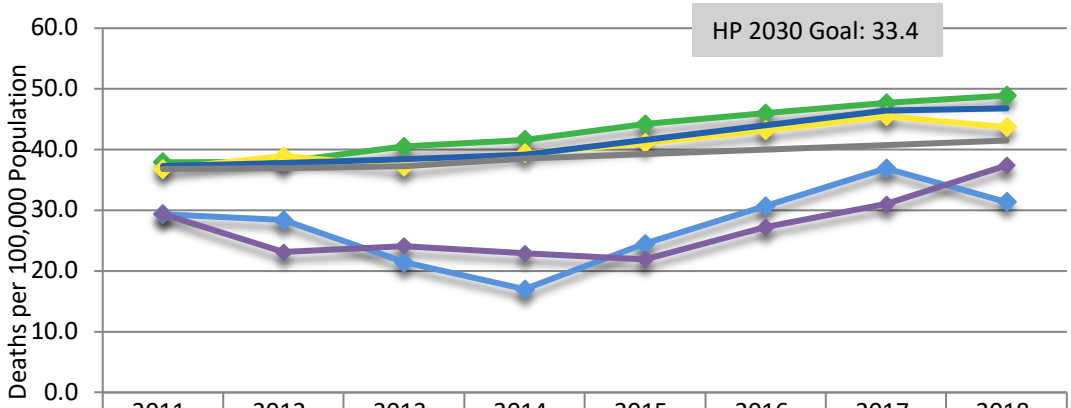
	Prince George's	Maryland
Sex		
Male	32.8%	33.0%
Female	31.1%	28.2%
Race/Ethnicity		
Black, non-Hispanic	34.2%	37.4%
Hispanic	34.6%	28.1%
White, non-Hispanic	28.3%	28.6%
Age Group		
18 to 34 Years	11.6%	10.9%
35 to 49 Years	19.2%	21.2%
50 to 64 Years	48.0%	45.4%
Over 65 Years	70.0%	63.6%
Total	**31.9%**	**30.6%**

*Excludes women told only during pregnancy and borderline hypertension

** Individuals of Hispanic origin and Asian/Pacific Islanders were not included due to insufficient numbers

Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System; https://ibis.health.maryland.gov, accessed 5/13/2019

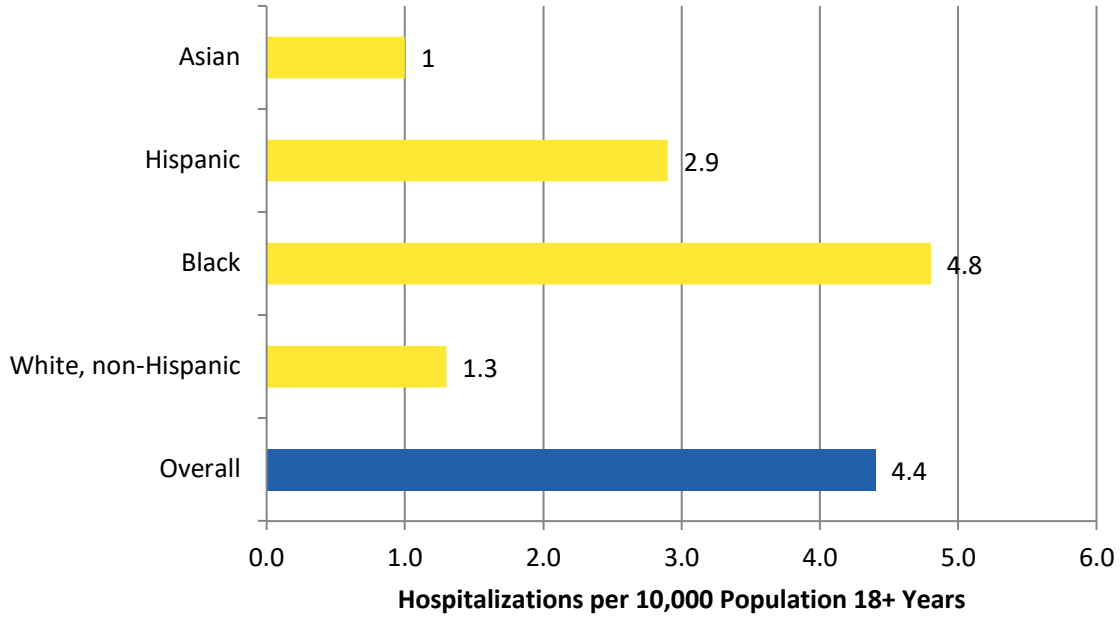
Age-Adjusted Death Rate per 100,000 for Stroke by Race and Ethnicity, Prince George's County, 2011-2020



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
PGC Black, NH	37.9	38.0	40.5	41.6	44.2	46.0	47.7	48.9
PGC Hispanic	29.4	28.4	21.4	17.0	24.5	30.7	36.9	31.4
PGC White, NH	36.8	38.9	37.2	39.4	41.1	43.2	45.5	43.7
PGC Asian, NH	29.4	23.1	24.1	22.9	21.9	27.2	31.0	37.4
PGC	37.3	37.8	38.4	39.2	41.6	44.0	46.4	46.8
Maryland	36.8	36.9	37.3	38.5	39.3	40.0	40.7	41.5

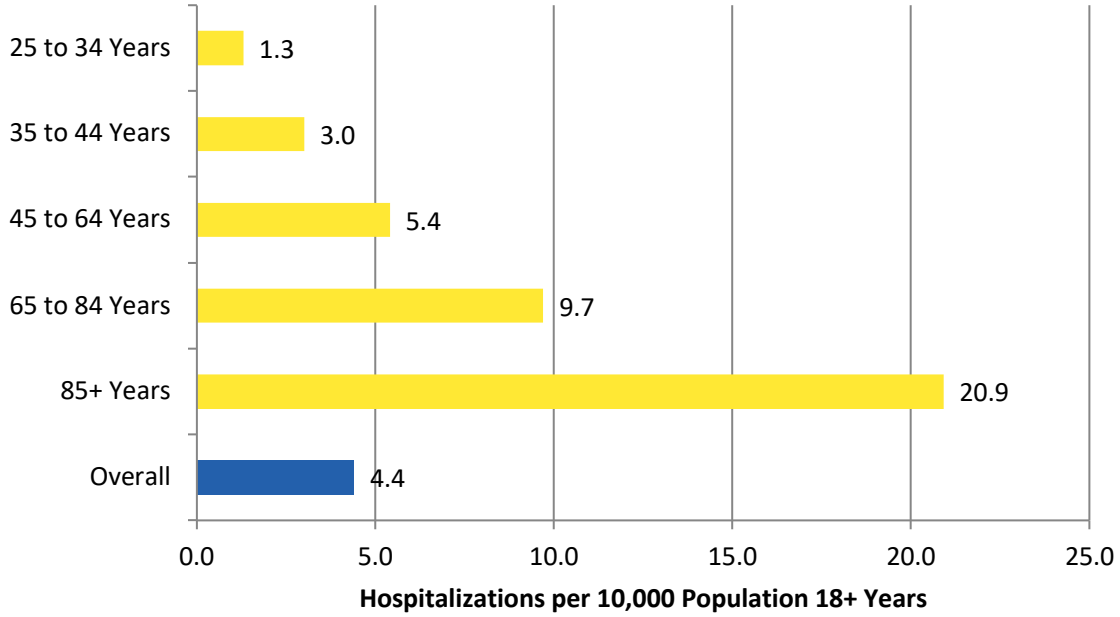
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Age-Adjusted Hospital Inpatient* Visit Rate due to Hypertension by Race and Ethnicity, Prince George's County, 2017-2019



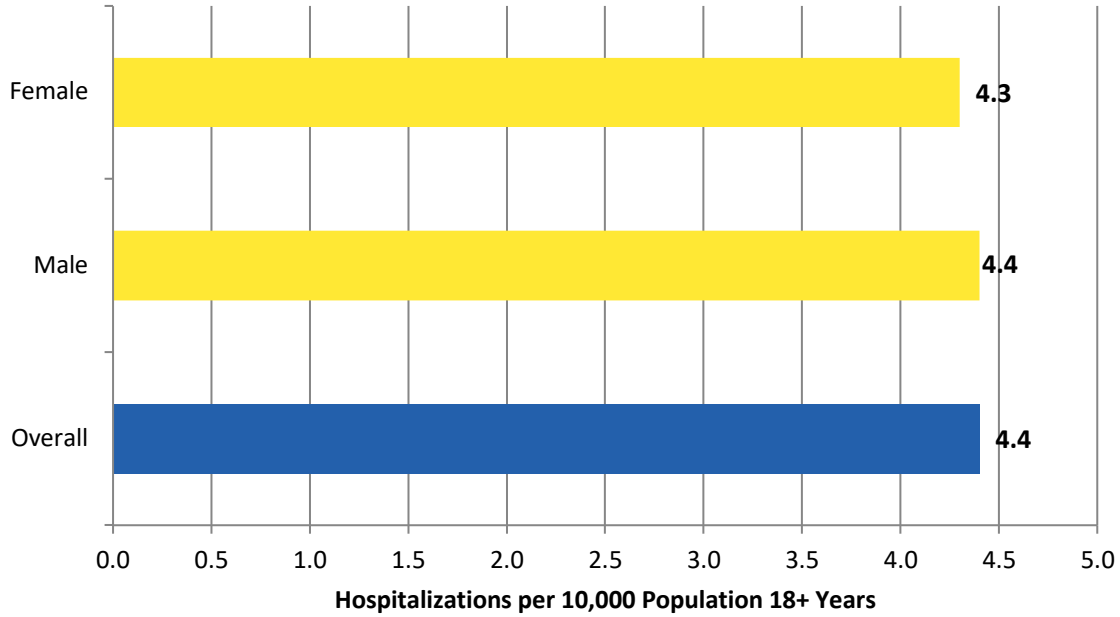
* Includes visits to only Maryland hospitals
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Hypertension by Age Group, Prince George's County, 2017-2019



* Includes visits to only Maryland hospitals
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Hypertension by Sex, Prince George's County, 2017-2019



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

Infectious Disease

Selected Reportable Disease, Prince George's County, 2016-2020

Morbidity	2016	2017	2018	2019	2020	5-Year Mean
Campylobacteriosis	42	58	62	57	59	56
H. influenza, invasive	40	11	8	16	13	18
Hepatitis A, acute	5	3	13	15	11	9
Legionellosis	23	41	53	39	27	37
Measles	0	1	0	0	0	0
Meningitis, viral	49	47	23	23	13	31
Meningitis, meningococcal	0	2	2	1	2	1
Pertussis	22	8	11	11	4	11
Salmonellosis	97	103	121	107	81	102
Shiga-toxin producing E.coli	4	10	26	31	18	18
Shigellosis	30	27	40	44	33	35
Strep Group B	68	80	79	78	54	72
Strep pneumonia, invasive	48	39	39	47	31	41
Tuberculosis	50	47	61	58	34	50
Animal-Related Illness						
Animal Bites	1,057	1,119	1,172	1,206	894	970
Animal Rabies	15	10	11	10	13	17

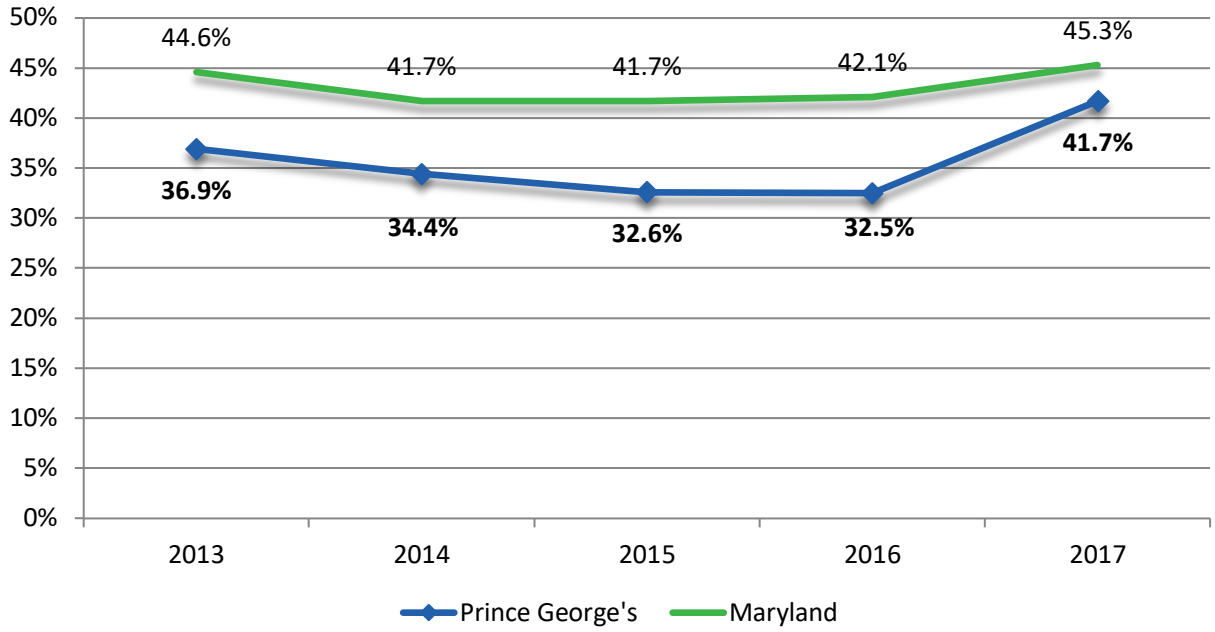
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, MDH

Percentage of Adults Who Had a Seasonal Influenza Shot or Influenza Vaccine Nasal Spray During the Past Year, 2017

	Prince George's	Maryland
Male	39.7%	42.3%
Female	44.3%	48.3%
Race/Ethnicity		
Black, non-Hispanic	38.2%	39.4%
Hispanic	41.5%	51.2%
White, non-Hispanic	49.8%	46.3%
Age Group		
18 to 34 Years	37.8%	34.1%
35 to 49 Years	38.9%	42.9%
50 to 64 Years	37.9%	48.3%
Over 65 Years	58.3%	66.8%
Total	**41.7%**	**45.3%**

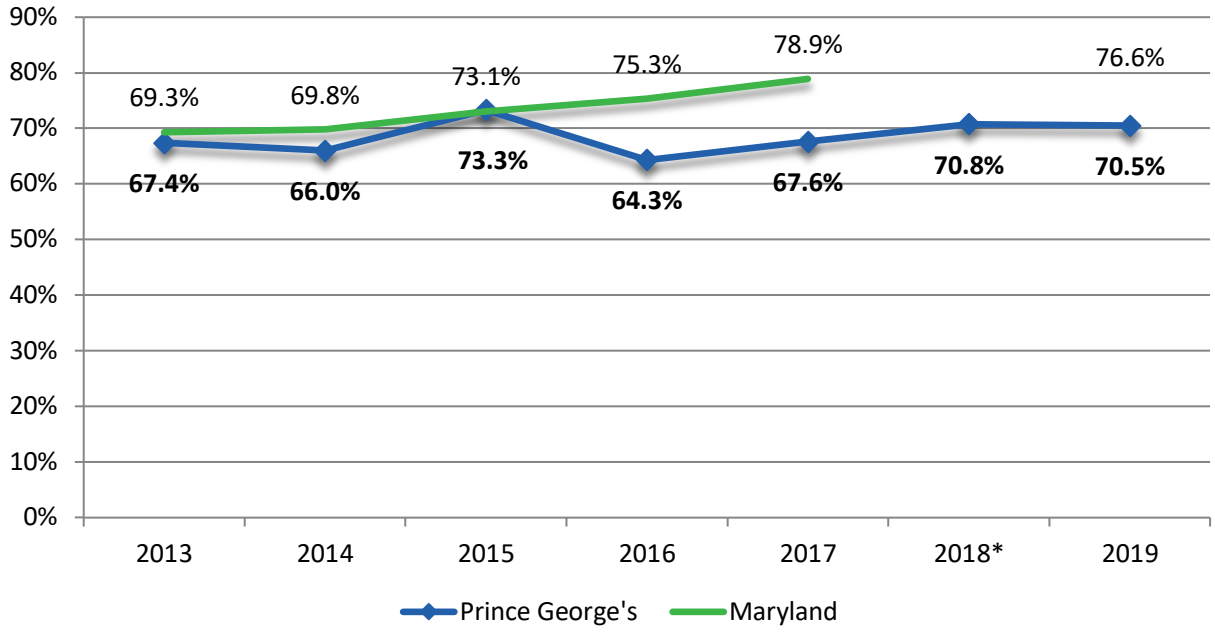
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Percentage of Adults Who Had a Seasonal Influenza Shot or Influenza Vaccine Nasal Spray During the Past Year, 2013-2017



Data Source: 2013-2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 3/8/2019

Percentage of Adults Age 65+ Who Ever Had a Pneumonia Vaccine, 2013-2019

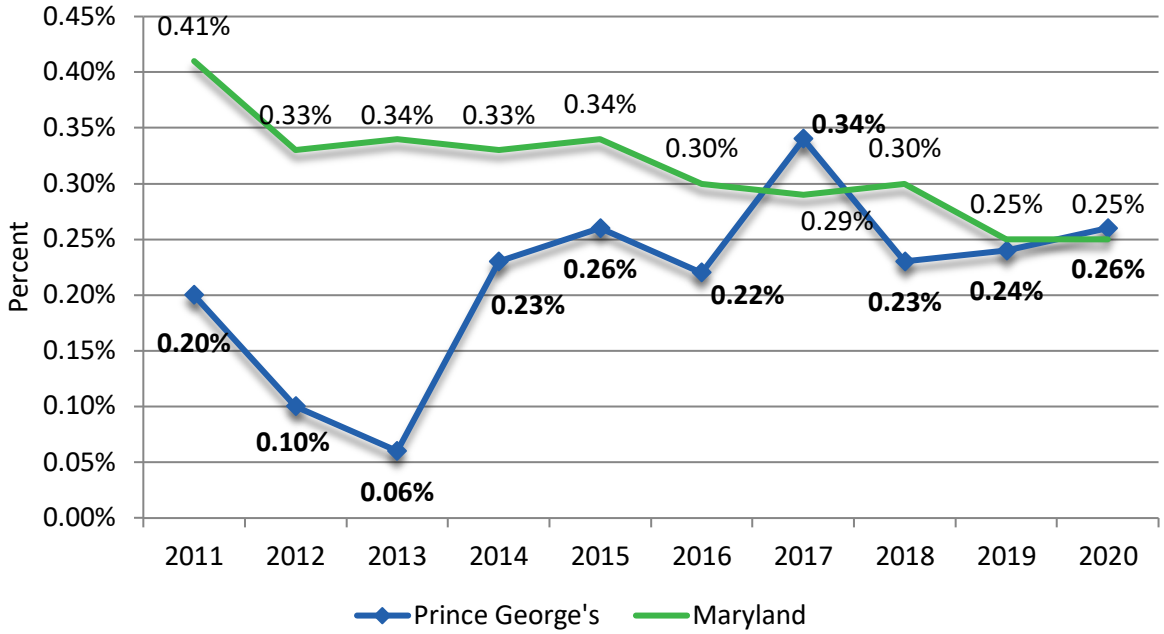


***** Maryland 2018 value unavailable
Data Source: 2013-2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Lead Poisoning

Children can be exposed to lead through lead-based paint and dust with lead in it. Although lead paint was banned in 1978, it can be found in homes built before then, and the deterioration of the paint results in the contaminated dust. Lead exposure often occurs without symptoms and can go unrecognized; however, lead can affect nearly every system in the body. There is no safe blood lead level in children, and action is recommended with levels above 5 micrograms per deciliter. Lead poisoning can result in damage to the brain, slowed development and growth, learning and behavior problems, and hearing and speech problems (Source: CDC).

Percentage of Children Age 0-72 Months Tested for Blood Lead who have 10 or More Micrograms/Deciliter of Lead in Blood, 2011 to 2020



Data Source: Maryland Department of the Environment

Maternal and Infant Health

Live Birth Rate per 1,000 Population, 2020

	Prince George's	Maryland	United States
Live Births per 1,000 Population	12.4	11.3	11.0

Data Source: Maryland Department of Health, Vital Statistics Administration, 2020 Annual Report; National Center for Health Statistics, National Vital Statistics Report, 2020

Number of Births by Race and Ethnicity of Mother, Prince George's County, 2020

Race/Ethnicity	Number of Live Births	Percent of Births	Birth Rate per 1,000 population
Black, NH	5,971	52.8%	10.4
Hispanic (any race)	3,845	34.0%	21.3
White, NH	980	8.7%	8.7
Asian, NH	428	3.8%	10.7
American Indian/Alaska Native, NH	18	0.2%	5.8
All Races	**11,308**	**100.0%**	**12.4**

Data Source: Maryland Department of Health, Vital Statistics Administration, 2020 Annual Report

Number and Percentage of Births by Age Group, 2020

		Prince George's	Maryland	United States
Age Group	**Number**	**Percent**	**Percent**	**Percent**
<15 years	9	0.1%	0.1%	0.0%
15 to 17 years	148	1.3%	1.0%	1.1%
18 to 19 years	320	2.8%	2.6%	3.3%
20 to 24 years	1,851	16.4%	13.7%	18.4%
25 to 29 years	3,014	26.7%	25.7%	28.3%
30 to 34 years	3,259	28.8%	33.0%	29.6%
35 to 39 years	2,076	18.4%	19.3%	16.2%
40 to 44 years	572	5.1%	4.3%	3.3%
45+ years	59	0.5%	0.4%	0.3%

Data Source: Maryland Department of Health, Vital Statistics Administration, 2020 Annual Report; National Center for Health Statistics, National Vital Statistics Report, 2020

Infant Mortality Rate*, 2020

	Prince George's	Maryland
Infant Mortality Rate per 1,000 Births	**5.5**	5.7

Data Source: Maryland Department of Health, Vital Statistics Administration, 2020 Annual Report

Infant Deaths, 2016-2020

	2016	2017	2018	2019	2020
Prince George's County Infant Deaths					
Black, non-Hispanic	67	82	73	46	48
Hispanic (any race)	22	19	17	23	12
White, non-Hispanic	2	1	2	1	2
Total Deaths	94	102	97	73	62
Infant Mortality Rate: All Races per 1,000 Live Births					
Prince George's	**7.6**	**8.2**	**8.0**	**6.2**	**5.5**
Maryland	6.5	6.5	6.1	5.9	5.7
Infant Mortality Rate: Black, non-Hispanic per 1,000 Live Births					
Prince George's	**9.7**	**12.0**	**10.9**	**7.3**	**8.0**
Maryland	10.5	11.2	10.2	9.3	9.9
Infant Mortality Rate: Hispanic (any race) per 1,000 Live Births					
Prince George's	**6.1**	**5.0**	**4.5**	**5.9**	**3.1**
Maryland	5.4	4.7	3.8	5.1	4.6
Infant Mortality Rate: White, non-Hispanic per 1,000 Live Births					
Prince George's	**	**	**	**	**
Maryland	4.3	4.0	4.1	4.1	3.3

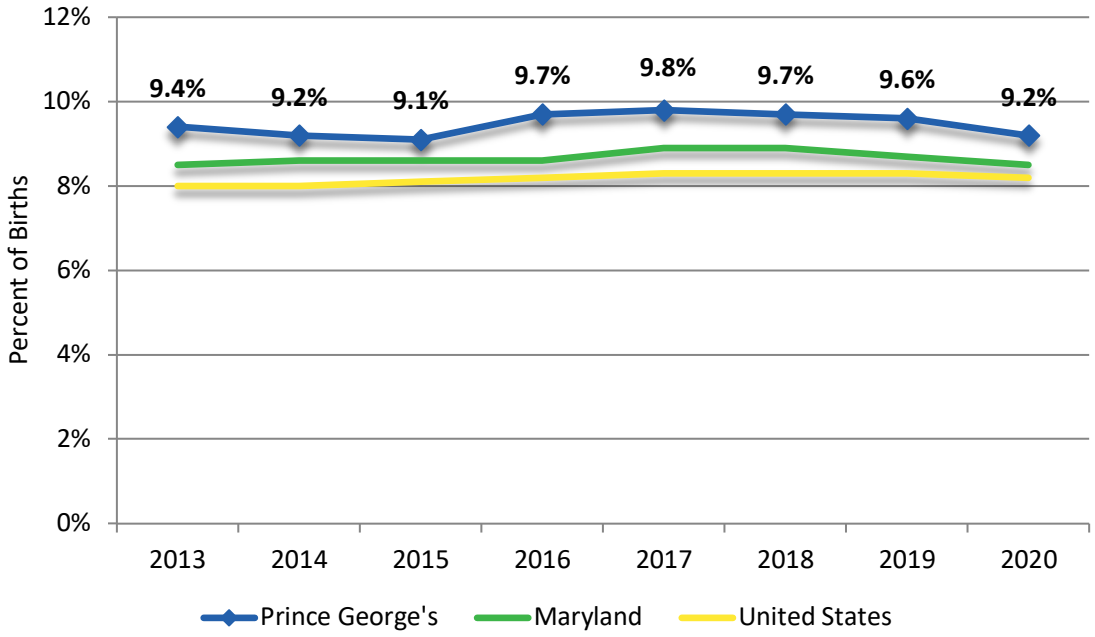
**Rates based on <5 deaths are not presented since they are subject to instability.
Data Source: Maryland Department of Health, Vital Statistics Administration, 2016-2020 Annual Infant Mortality Reports

Low Birth Weight (<2500g) by Race/Ethnicity and Age, 2020

	Prince George's	Maryland	United States
Race/Ethnicity			
Black, NH	10.9%	12.1%	14.2%
Hispanic (any race)	7.4%	7.1%	7.4%
White, NH	6.6%	6.4%	6.8%
Asian/PI	6.5%	8.3%	8.5%
Age Group			
Under 20 years	10.1%	10.1%	10.2%
20 to 24 years	9.0%	9.0%	8.6%
25 to 29 years	8.7%	8.4%	7.8%
30 to 34 years	8.5%	7.7%	7.7%
35 to 39 years	9.5%	8.4%	8.6%
40 + years	13.6%	12.1%	10.9%
Total	**9.2%**	**8.5%**	**8.2%**

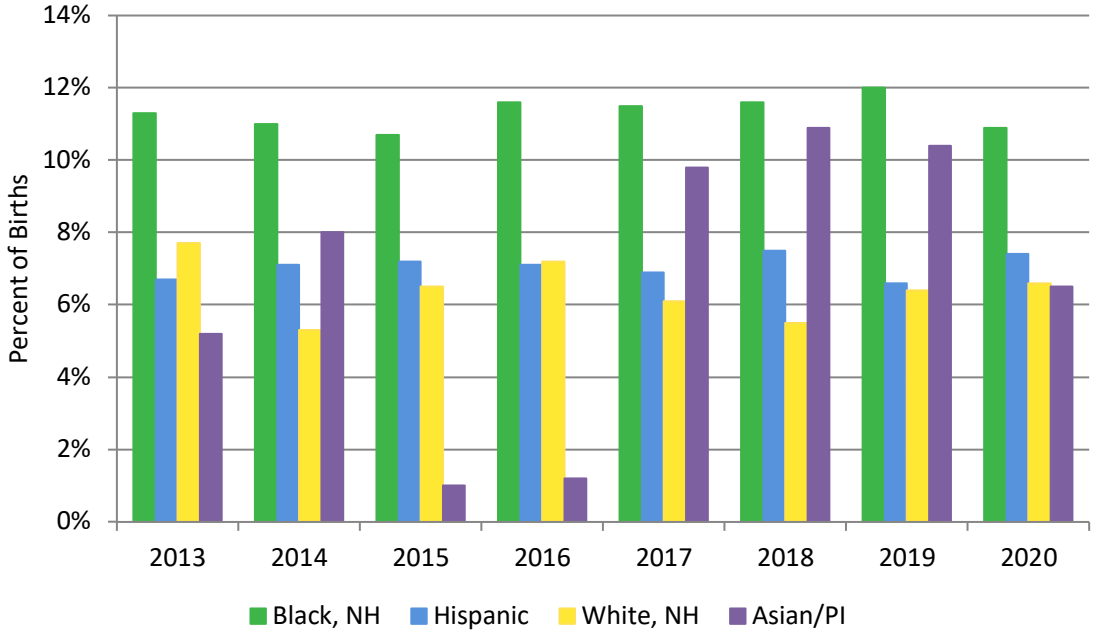
Data Source: Maryland Department of Health, Vital Statistics Administration, 2020 Annual Report; National Center for Health Statistics, Births Final Data for 2020

Percentage of Low Birth Weight Infants, 2013-2020



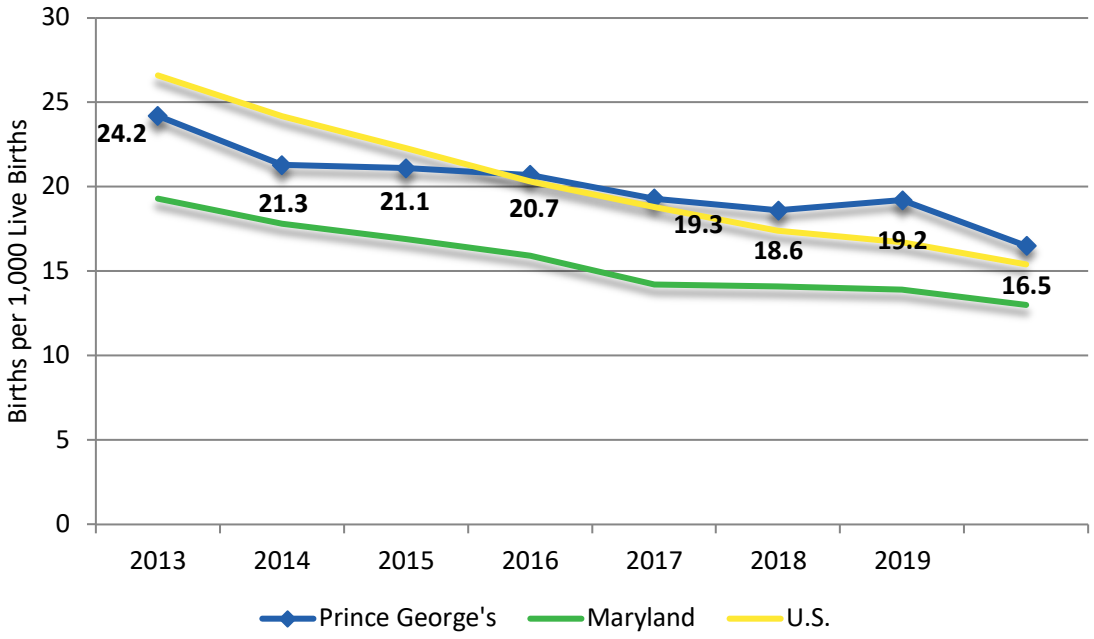
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2020 Annual Reports; National Center for Health Statistics, National Vital Statistics Report

Percentage of Low Birth Weight (<2500g) Infants by Race and Ethnicity, Prince George's County, 2013-2020



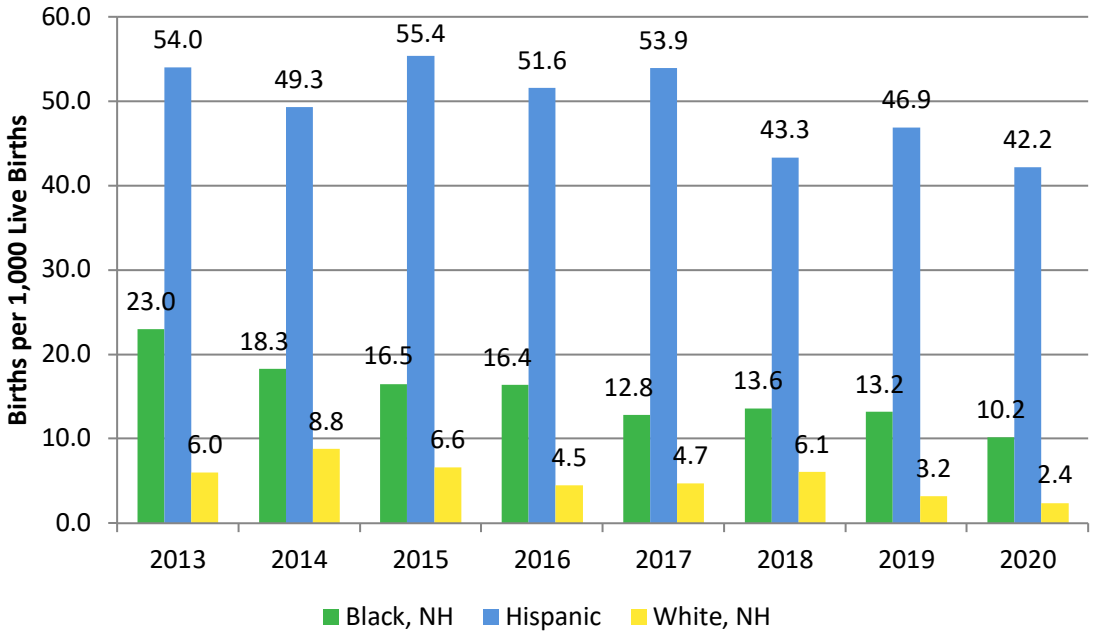
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2020 Annual Reports

Teen Birth Rate (Ages 15 to 19 Years), 2013-2020



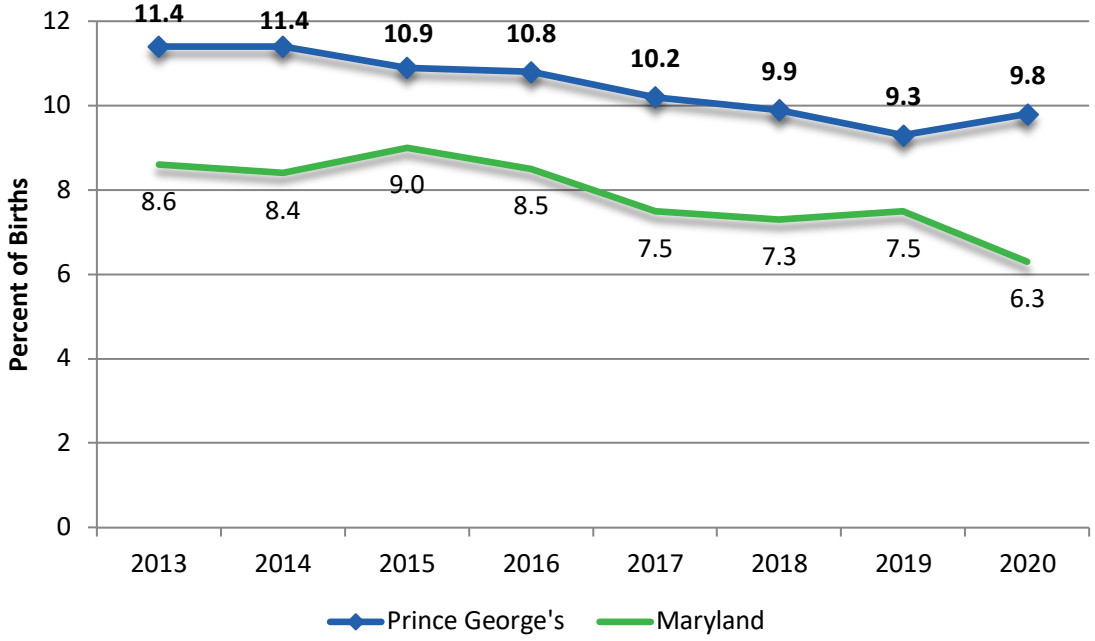
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2020 Annual Reports; National Center for Health Statistics, National Vital Statistics Report

Teen Birth Rate (Ages 15 to 19) by Race and Ethnicity, Prince George's County, 2013-2020



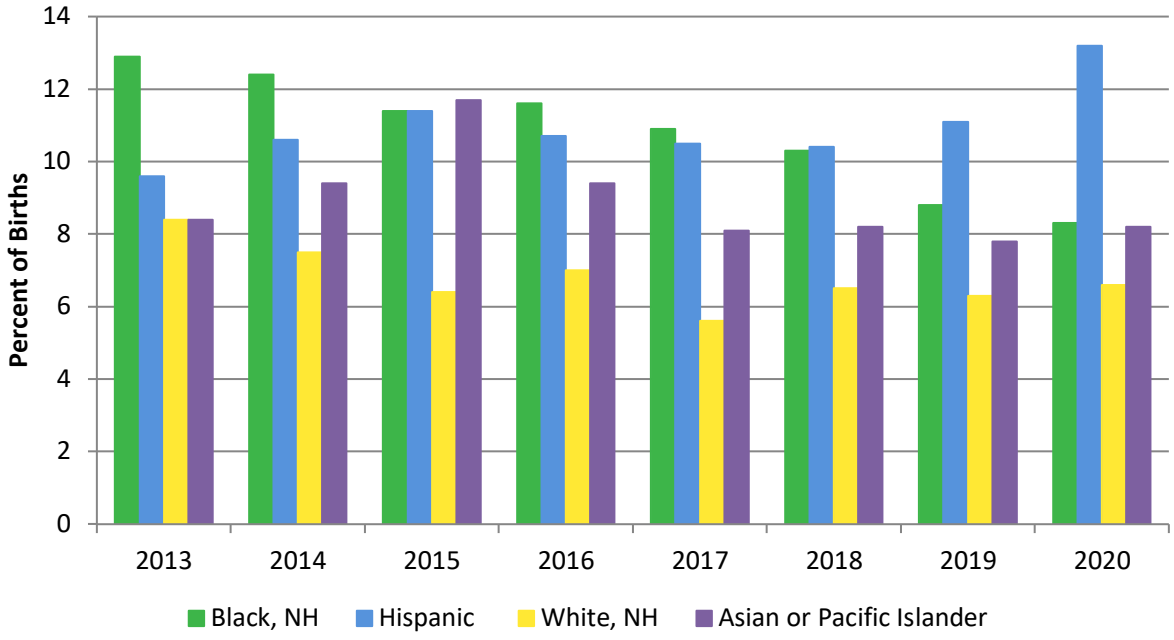
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2020 Annual Reports

Percentage of Births with Late or No Prenatal Care*, 2013-2020



*Late care refers to care beginning in the third trimester.
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2020 Annual Reports

Percentage of Births with Late or No Prenatal Care by Race and Ethnicity, Prince George's County, 2013-2020

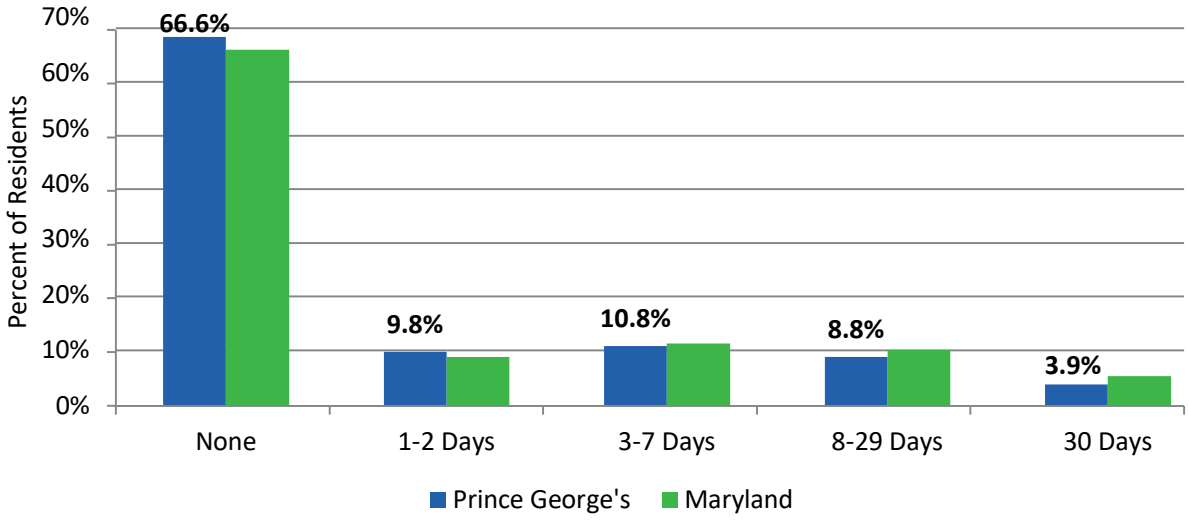


*Late care refers to care beginning in the third trimester.
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2020 Annual Reports

Mental Health

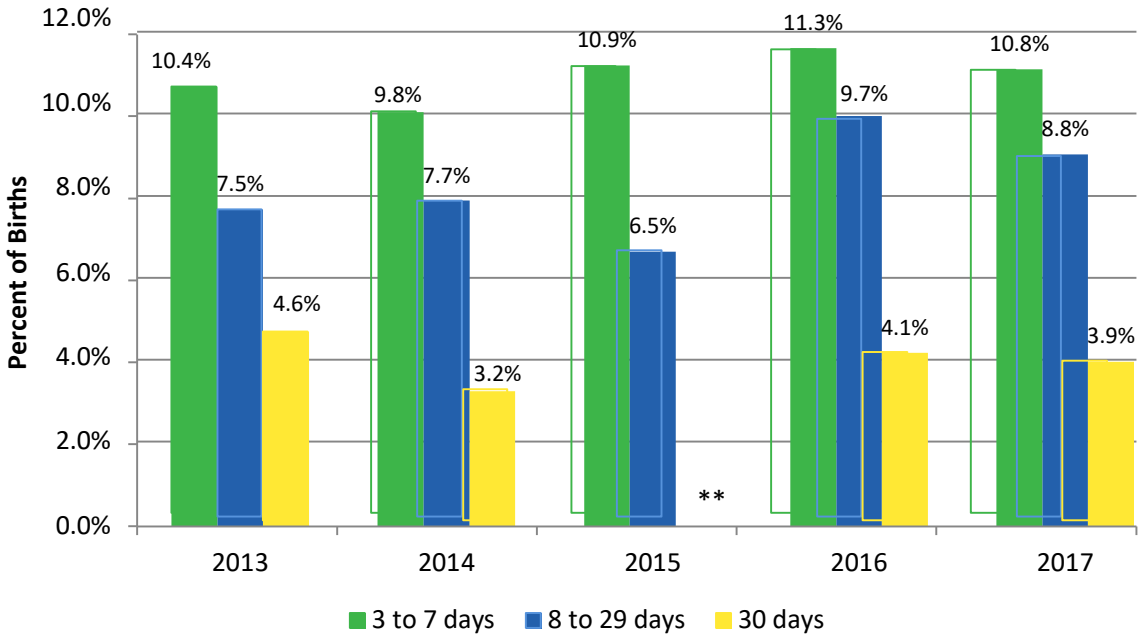
Overview	
What is it?	Mental health includes emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices.
Who is affected?	One in five adults in America experience a mental illness. For Prince George's County, this translates to nearly 150,000 County residents with mental health needs (Source: 2019 U.S. Census population estimates; NAMI). In addition, approximately 10,000 County youth (ages 12-17) are estimated to have experienced a major depressive episode, and one in five young people report that the pandemic had a significant negative impact on their mental health. (Source: NAMI). Overall in the County in 20**20,** there were **57** suicide deaths.
Prevention & Treatment	Both mental health prevention includes helping individuals develop the knowledge, attitudes, and skills they need to make good choices or change harmful behaviors (SAMHSA.gov). Mental health treatment includes psychotherapy, medication, case management, partial hospitalization programs, support groups, and peer support.
What are the outcomes?	Mental health covers a number of different conditions that can vary in outcomes. Early engagement and support are crucial to improving outcomes.
Disparity	The majority of suicides in the County are male, with an age-adjusted rate of 10.4 per 100,000 compared to 2.8 for females from 2018 to 2020. Specifically, White, non-Hispanic males have the highest suicide death rate at 25.5 per 100,000, nearly three times Black, non-Hispanic males at 9.2.
How do we compare?	Between 2018 and 2020, the County had the lowest suicide age-adjusted death rate in the state pf 6.4 per 100,000, compared to the highest of 17.5 for Cecil County. Maryland overall had a rate of 9.9 per 100,000.

Percentage of Residents with Poor Mental Health Days within a Month, 2017



Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Percentage of Residents with Poor Mental Health Days within a Month, 2013-2017



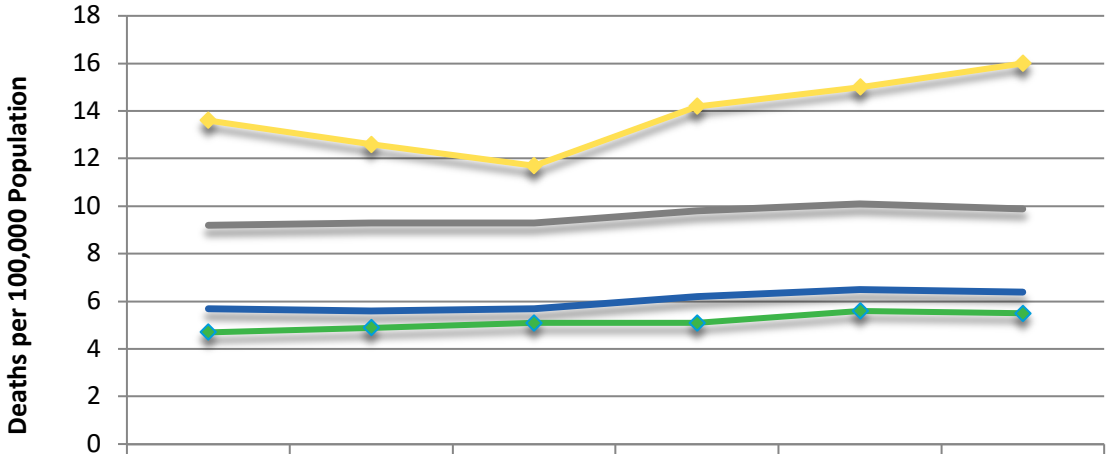
**Data not available; small number of observations.
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/31/2019

Percentage of High School Students Reporting Risk Factors for Suicide in the Past Year, Prince George's County, 2018

	Felt Sad or Hopeless 2+ Weeks or More	Seriously Considered Suicide	Made a Plan to Attempt Suicide
Male	27.6%	14.4%	14.6%
Female	41.1%	23.4%	22.1%
Race/Ethnicity			
Black, non-Hispanic	31.5%	19.2%	19.7%
Hispanic	38.8%	15.7%	15.1%
White, non-Hispanic	**	**	**
Age Group			
15 or younger	30.9%	19.3%	18.1%
16 or 17	35.9%	18.4%	19.5%
18 or older	42.6%	21.5%	17.6%
Total	**34.2%**	**19.0%**	**16.2%**

Data Source: 2018 Maryland Youth Risk Behavior Survey for Prince George's County

Age-Adjusted Suicide Rate per 100,000, 2010-2020

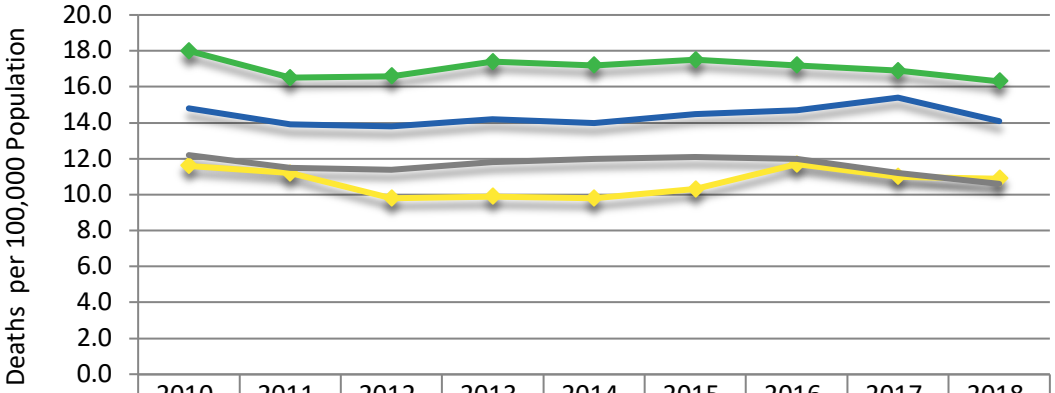


	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
PGC Black, NH	4.7	4.9	5.1	5.1	5.6	5.5
PGC White, NH	13.6	12.6	11.7	14.2	15.0	16.0
PGC Total	5.7	5.6	5.7	6.2	6.5	6.4
Maryland	9.2	9.3	9.3	9.8	10.1	9.9

* Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Nephritis (Chronic Kidney Disease)

Age-Adjusted Death Rate for Nephritis, 2010-2020



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
PGC Black, NH	18.0	16.5	16.6	17.4	17.2	17.5	17.2	16.9	16.3
PGC White, NH	11.6	11.2	9.8	9.9	9.8	10.3	11.7	11.0	10.9
Prince George's	14.8	13.9	13.8	14.2	14.0	14.5	14.7	15.4	14.1
Maryland	12.2	11.5	11.4	11.8	12.0	12.1	12.0	11.2	10.6

***** Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Obesity

Overview	
What is it?	Weight that is higher than what is considered a healthy weight for a given height is described as overweight or obese. Body Mass Index (BMI) is used as a screening tool for overweight or obesity that takes into consideration height and weight. Children and adolescents are measured differently based on their age and sex.
Who is affected?	In 2019, almost three-quarters of adults in the County were either obese (35.0%) or overweight (36.2%) (Source: www.pgchealthzome.org). Approximately half, or around 350,000 adults in the County do not reach at least 150 minutes of moderate physical activity or 5 minutes of vigorous activity.
Prevention and Treatment	The key to achieving and maintaining a healthy weight is not short-term dietary changes, but about a lifestyle that includes healthy eating and regular physical activity (Source: CDC.gov). Follow a healthy eating plan, focus on portion size, be active, reduce screen time and a sedentary lifestyle, and keep track of your weight (Source: NHLBI.NIH.gov).
What are the outcomes?	Obesity causes an increased risk of hypertension, type 2 diabetes, heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and breathing problems, some cancers, low quality of life, and mental illness (Source: CDC.gov).
Disparity	Black, NH adult residents (46.7%) were more likely to be obese than White, NH (29.9%) adult residents in the County; however, Hispanic (41.8%) and White, NH (35.8%) residents were more likely than Black, NH residents (29.8%) to be overweight in 2017. More adult females (44.5%) are estimated to be obese compared to males (40.0%), but fewer adult females (26.2%) were overweight compared to males (36.1%). Almost half of adults between the ages of 45 and 64 were overweight. Among high school students, one in five Hispanic students are overweight (20.2%) and an additional one in five are obese (19.4%).
How do we compare?	Obesity in Maryland was estimated at 31.1%, substantially lower than the 42.0% in Prince George's County (Source: 2017 MD BRFSS). 16.8% of high school students in the County were obese in 2018, higher than the State (12.8%).

How Obesity Is Classified

Body Mass Index (BMI)	Weight Status
Below 18.5	Underweight
18.5 – 24.9	Normal or Healthy Weight
25.0 – 29.9	Overweight
30.0 and Above	Obese

Data Source: Centers for Disease Control and Prevention

Percentage of Adults Who Are Obese, 2017

HP2030 Goal: 36.0%	Prince George's	Maryland
Sex		
Male	40.0%	30.1%
Female	44.5%	32.0%
Race/Ethnicity		
Black, non-Hispanic	46.7%	42.0%
Hispanic	34.5%	31.4%
White, non-Hispanic	29.9%	28.0%
Age		
18 to 44 Years	37.0%	27.7%
45 to 64 Years	49.3%	36.3%
Over 65 Years	39.8%	31.2%
Total	**42.0%**	**31.1%**

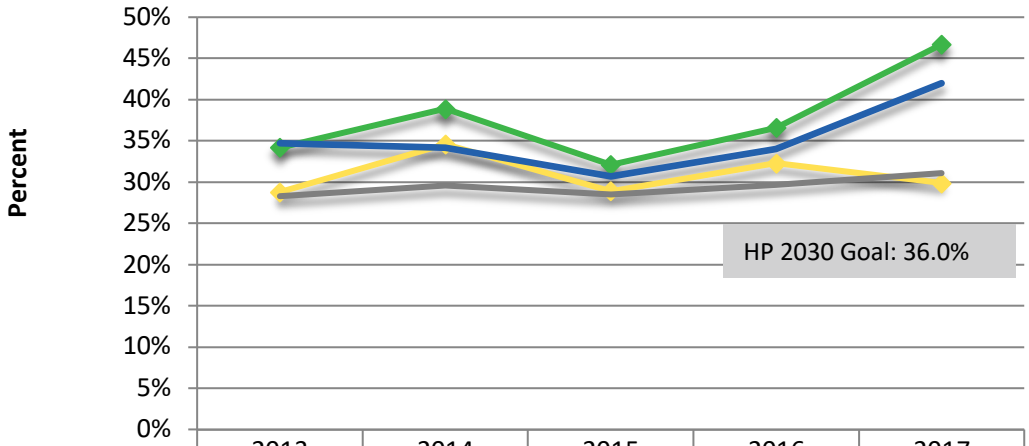
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Percentage of Adults Who Are Overweight, 2017

	Prince George's	Maryland
Sex		
Male	36.1%	40.5%
Female	26.2%	28.8%
Race/Ethnicity		
Black, non-Hispanic	29.7%	32.6%
Hispanic	41.8%	35.4%
White, non-Hispanic	35.8%	35.4%
Age		
18 to 44 Years	28.5%	32.8%
45 to 64 Years	33.7%	36.3%
Over 65 Years	38.6%	37.1%
Total	**31.5%**	**34.7%**

Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

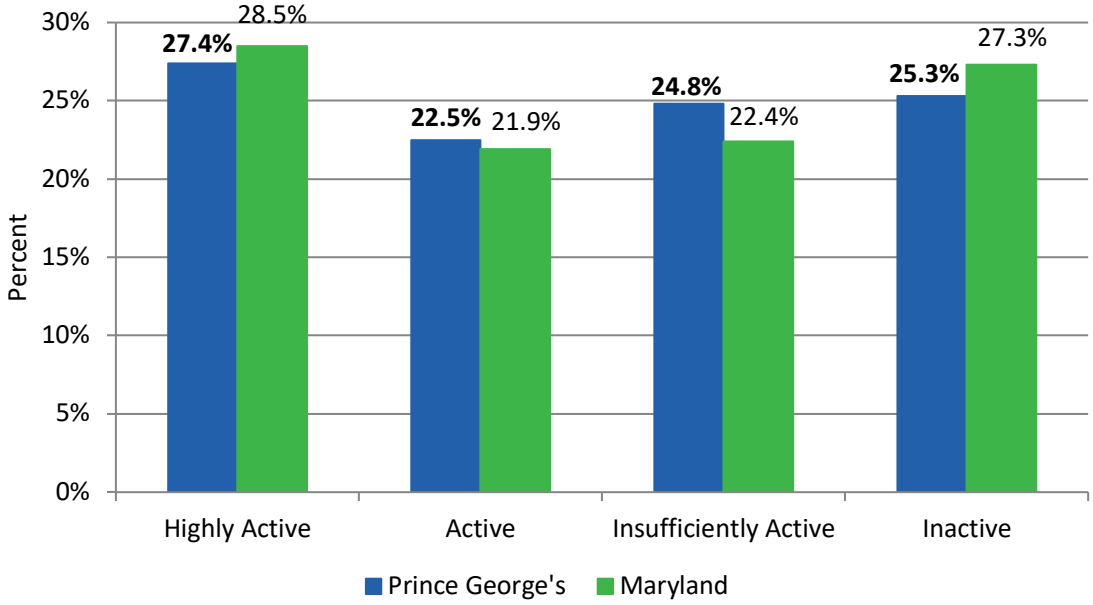
Percent of Adults Who Are Obese, 2013-2017



	2013	2014	2015	2016	2017
PGC Black, NH	34.2%	38.9%	32.1%	36.6%	46.7%
PGC White, NH	28.8%	34.6%	28.9%	32.3%	29.9%
Prince George's	34.7%	34.2%	30.7%	34.0%	42.0%
Maryland	28.3%	29.6%	28.5%	29.7%	31.1%

Data Source: 2013-2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Percentage of Adults by Physical Activity Level, 2017



Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Percentage of Adults Who Participated in at least 150 Minutes of Moderate Physical Activity or 75 Minutes of Vigorous Activity per Week, 2017

	Prince George's	Maryland
Sex		
Male	51.8%	52.7%
Female	49.3%	48.3%
Race/Ethnicity		
Black, non-Hispanic	50.5%	48.0%
Hispanic	43.4%	43.4%
White, non-Hispanic	51.3%	52.4%
Age Group		
18 to 44 Years	52.3%	48.6%
45 to 64 Years	50.9%	52.7%
Over 65 Years	43.1%	52.6%
Total	**50.1%**	**50.4%**

Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

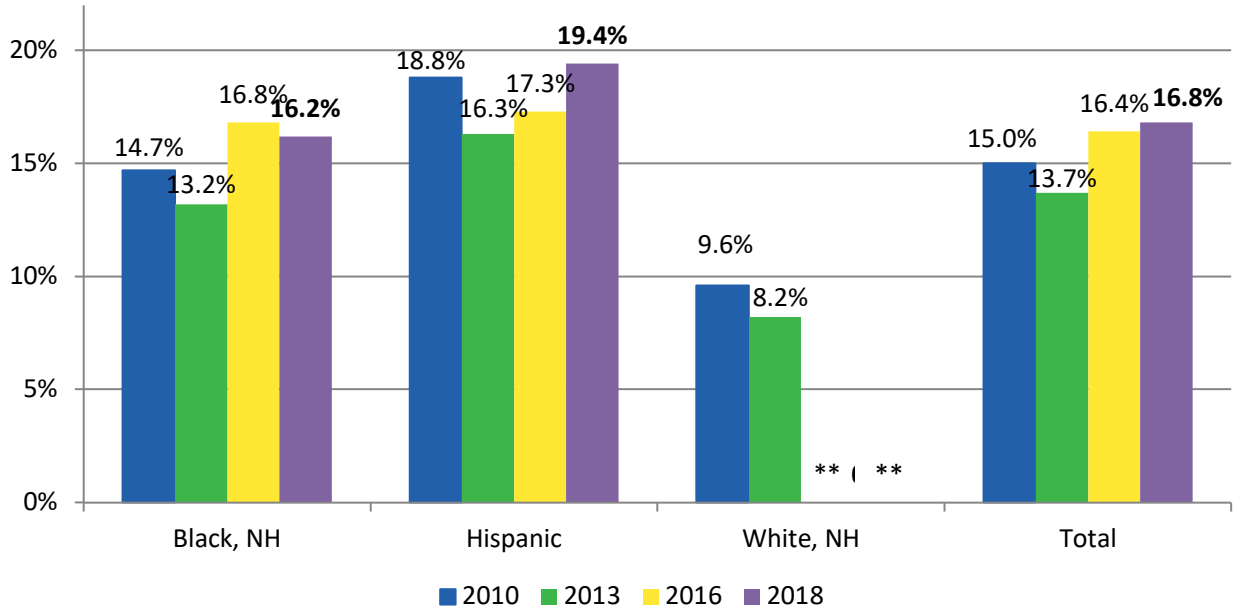
Percentage of High School Students Who are Obese, 2018

	Prince George's	Maryland
Sex		
Male	17.5%	14.6%
Female	16.0%	10.9%
Race/Ethnicity		
Black, non-Hispanic	16.2%	16.4%
Hispanic	19.4%	16.8%
White, non-Hispanic	**	9.7%
Age Group		
15 or Younger	16.7%	12.5%
16 or 17 Years	17.9%	13.0%
18 or Older	**	13.8%
Total	**16.8%**	**12.8%**

** Individuals of White, non-Hispanic origin were not included due to insufficient numbers

Data Source: 2018 Youth Risk Behavior Survey Report for Prince George's County and Maryland, MDH

Percentage of High School Students who are Obese, Prince George's County, 2010, 2013, 2016, and 2018



** Individuals of White, non-Hispanic origin were not included due to insufficient numbers
Data Source: 2013, 2016, and 2018 Youth Risk
Behavior Survey Report for Prince George's County and Maryland, MDH

Percentage of High School Students Who are Overweight, 2018

	Prince George's	Maryland
Sex		
Male	17.2%	14.5%
Female	19.2%	17.0%
Race/Ethnicity		
Black, non-Hispanic	17.8%	18.0%
Hispanic	20.2%	20.4%
White, non-Hispanic	**	12.9%
Age Group		
15 or Younger	16.7%	16.3%
16 or 17 Years	19.3%	15.4%
18 or Older	**	13.8%
Total	**18.2%**	**15.7%**

** Individuals of White, non-Hispanic origin were not included due to insufficient numbers
Data Source: 2018 Youth Risk Behavior Survey Report for Prince George's County and Maryland, MDH

Percentage of High School Students Who Ate Vegetables Three or More Times per day During the Past Week, 2018

	Prince George's	Maryland
Sex		
Male	12.0%	12.3%
Female	7.5%	11.2%
Race/Ethnicity		
Black, non-Hispanic	8.1%	10.2%
Hispanic	13.2%	13.0%
White, non-Hispanic	**	11.2%
Age Group		
15 or Younger	9.8%	11.3%
16 or 17 Years	9.5%	12.3%
18 or Older	**	14.0%
Total	**10.2%**	**11.9%**

** Individuals of White, non-Hispanic origin were not included due to insufficient numbers
Data Source: 2018 Youth Risk Behavior Survey Report for Prince George's County and Maryland, MDH

Percentage of High School Students who were Physically Active for a Total of at Least 60 Minutes per day on Five or More of the Past Week, 2018

	Prince George's	Maryland
Sex		
Male	29.6%	42.9%
Female	18.9%	30.4%
Race/Ethnicity		
Black, non-Hispanic	26.8%	30.7%
Hispanic	17.1%	27.4%
White, non-Hispanic	**	45.1%
Age Group		
15 or Younger	23.7%	40.5%
16 or 17 Years	24.5%	33.0%
18 or Older	**	33.9%
Total	**24.1%**	**36.5%**

** Individuals of White, non-Hispanic origin were not included due to insufficient numbers
Data Source: 2018 Youth Risk Behavior Survey Report for Prince George's County and Maryland, MDH

Oral Health

Percentage of Adults Who Visited a Dentist in the Past Year, 2016

	Prince George's	Maryland
Sex		
Male	60.9%	65.4%
Female	68.4%	70.8%
Race/Ethnicity		
Black, non-Hispanic	69.0%	63.4%
Hispanic	50.9%	57.6%
White, non-Hispanic	69.1%	73.3%
Age Group		
18 to 34 Years	61.2%	64.0%
35 to 49 Years	65.4%	69.3%
50 to 64 Years	69.6%	71.4%
Over 65 Years	66.2%	70.3%
Total	**64.9%**	**68.1%**

Data Source: 2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Percentage of High School Students Who Visited a Dentist in the Past Year, 2018

	Prince George's	Maryland
Sex		
Male	63.7%	75.4%
Female	69.0%	77.8%
Race/Ethnicity		
Black, non-Hispanic	65.3%	68.3%
Hispanic	68.9%	71.5%
White, non-Hispanic	**	84.5%
Age Group		
15 or younger	65.9%	77.5%
16 or 17	65.9%	76.6%
18 or older	**	64.5%
Total	**65.5%**	**76.3%**

** Individuals of White, non-Hispanic origin were not included due to insufficient numbers

Data Source: 2018 Maryland Youth Risk Behavior Survey

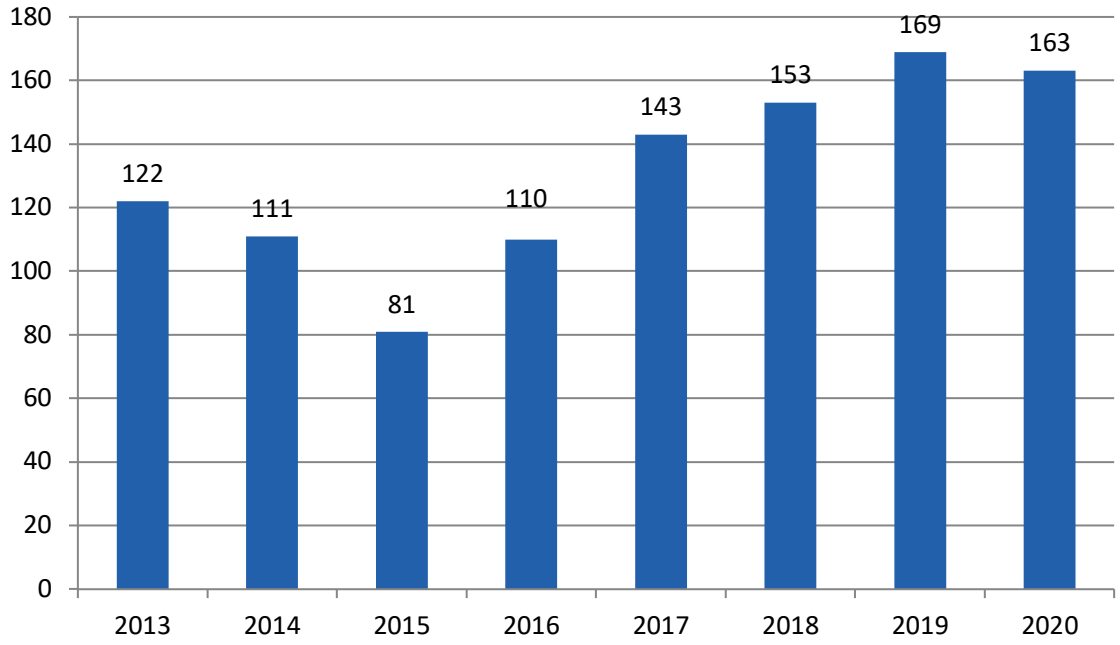
Sexually Transmitted Infections

Number of Sexually Transmitted Infections, Prince George's County

STI	2016	2017	2018	2019	2020	5-Year Mean
Chlamydia	6,752	7,365	8,013	8,262	6.974	6,080
Gonorrhea	1,832	2,001	2,020	2,195	2,406	2,091
Syphilis*	110	143	153	169	163	148

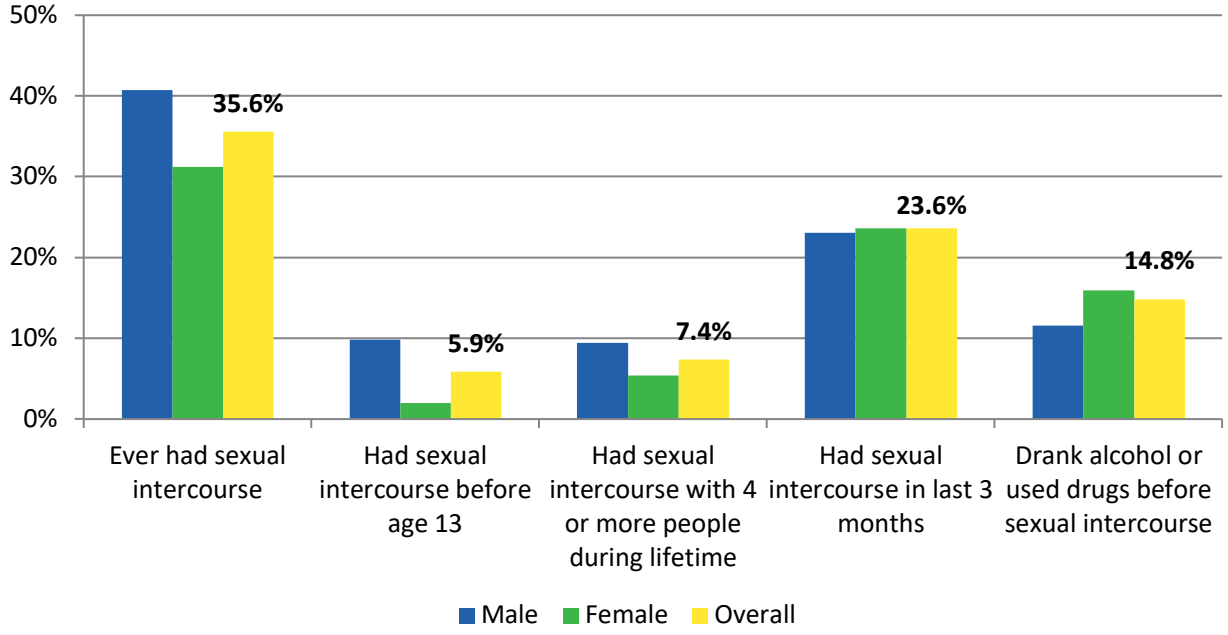
*Includes both Primary and Secondary Syphilis
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, MDH

Number of Primary/Secondary Syphilis Cases, Prince George's County, 2013-2020



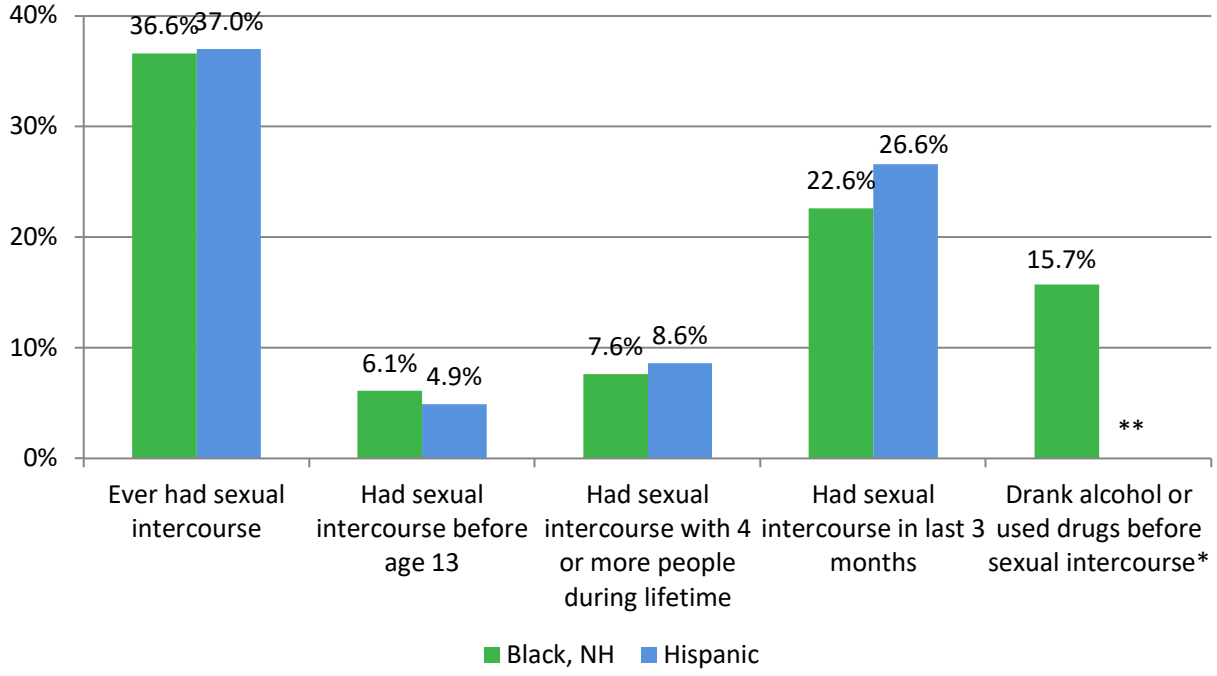
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, MDH

Sexual Behavior of High School Students by Sex, Prince George's County, 2018



Data Source: 2018 Youth Risk Behavior Survey, MDH

Sexual Behavior of High School Students by Race/Ethnicity, Prince George's County, 2018



*White, NH not displayed due to insufficient data
Data Source: 2018 Youth Risk Behavior, MDH

Substance Use Disorder

Overview	
What is it?	Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. (Source: SAMHSA.gov)
Who is affected?	In 2019, 12.9% of County residents reported binge drinking (four or more drinks for a woman in one time period and five or more drinks in one time period for a man). In 2018, 16.2% of adolescents reported using tobacco and nearly one-third reported using an electronic vapor product in the past month (2018). In 2020, there were 159 opioid-related deaths that occurred in Prince George's County, the majority (94%) of which were related to fentanyl.
Prevention & Treatment	Substance use prevention includes helping individuals develop the knowledge, attitudes, and skills they need to make good choices or change harmful behaviors (Source: SAMHSA.gov). Substance use treatment includes counseling, inpatient and residential treatment, case management, medication, and peer support.
What are the outcomes?	Substance use disorders result in human suffering for the individual consuming alcohol or drugs as well as their family members and friends. Substance use disorders are associated with lost productivity, child abuse and neglect, crime, motor vehicle accidents and premature death (Source: SAMHSA).
Disparity	White, non-Hispanic residents had a much higher drug-related death rate (36.0 per 100,000) compared to other County residents between 2018 and 2020. Specifically, white, non-Hispanic males have the highest drug-related death rate at 44.6, followed by Black non-Hispanic males at 34.2. A higher percentage of males and White, non-Hispanic residents binge drank in 2017 compared to other residents. Males were 3.5 times more likely to have an alcohol- or substance-related emergency department visit than females in 2017.
How do we compare?	Prince George's County had the 4th highest number of opioid-related deaths (by occurrence) in 2020, surpassed by Baltimore City, Baltimore County and Anne Arundel. However, Prince George's had the third lowest drug-related death rate in the State from 2018 to 2020. Fewer County adults smoke tobacco (8.6%) compared to Maryland (13.1%).

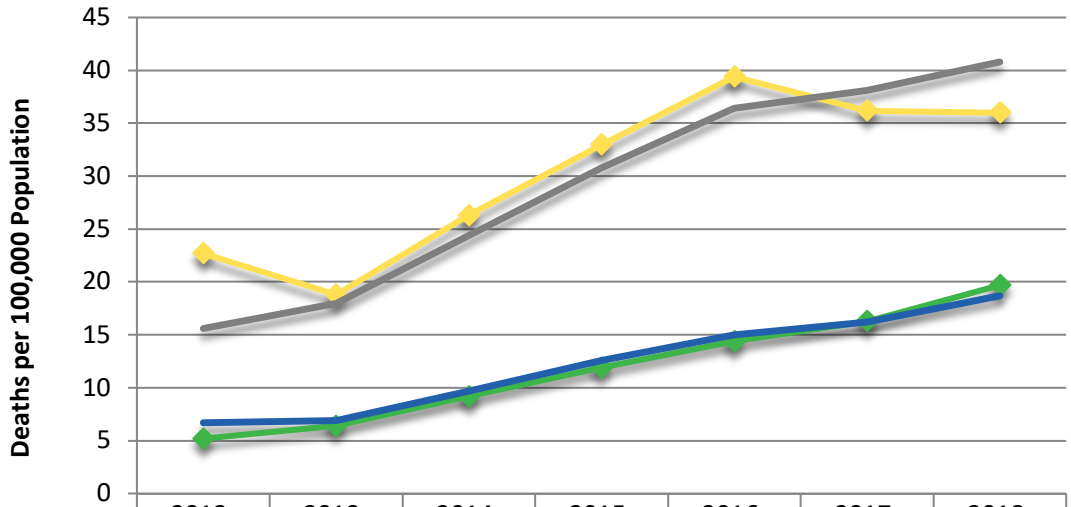
Emergency Department Visits* for Alcohol- and Substance-Related Conditions as the Primary Discharge Diagnosis, Prince George's County, 2017

	Number of ED Visits	Age-Adjusted ED Visit Rate per 100,000 Population
Sex		
Male	2,331	508.8
Female	696	144.5
Race/Ethnicity		
Black, non-Hispanic	1,551	265.1
Hispanic	587	353.4
White, non-Hispanic	440	371.0
Age		
Under 18 Years	54	26.6
18 to 39 Years	1,622	559.5
40 to 64 Years	1,218	402.5
65 Years and Over	133	113.7
Total	**3,027**	**320.7**

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County numbers and rate. As noted in the introduction, 2017 data is not comparable to the 2014 data used in the previous health needs assessment due to changes in ICD codes.

Data Source: Outpatient Discharge Data File 2017, Maryland Health Services Cost Review Commission; Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

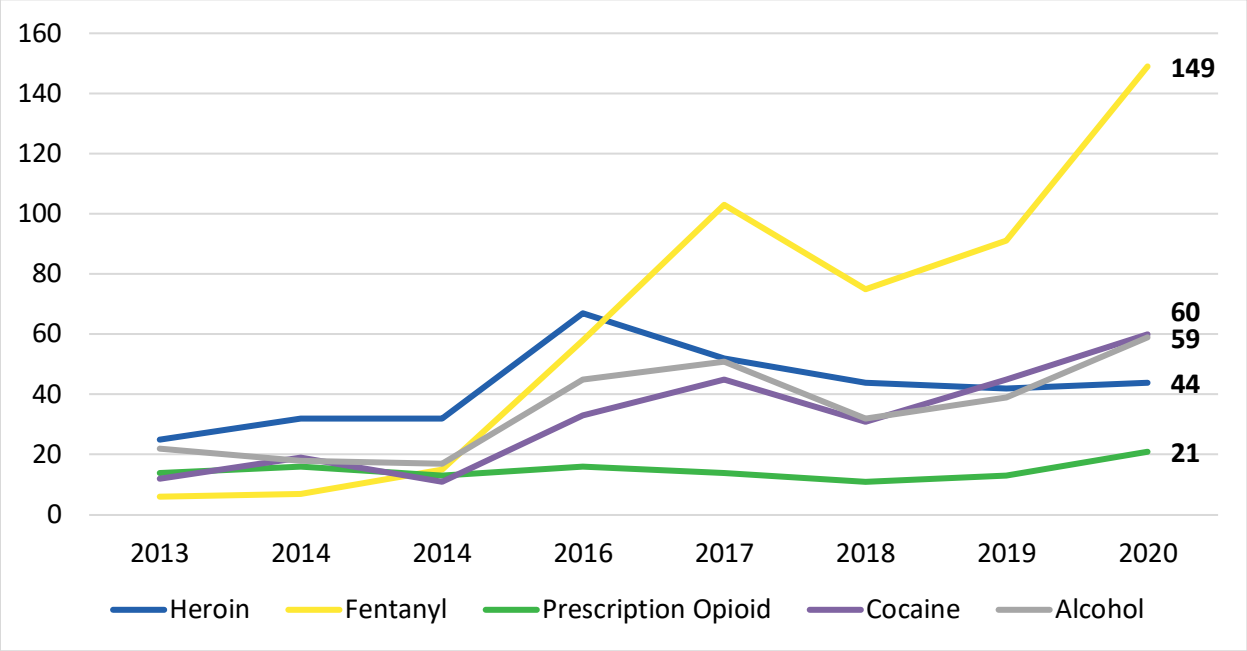
Drug-Related Age-Adjusted Death Rate per 100,000 Population, 2012 to 2020



	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
PGC Black, NH	5.2	6.4	9.2	11.9	14.4	16.3	19.7
PGC White, NH	22.7	18.8	26.3	33.0	39.4	36.2	36.0
PGC Total	6.7	6.9	9.7	12.6	15.0	16.2	18.7
Maryland	15.6	18.0	24.4	30.8	36.4	38.1	40.8

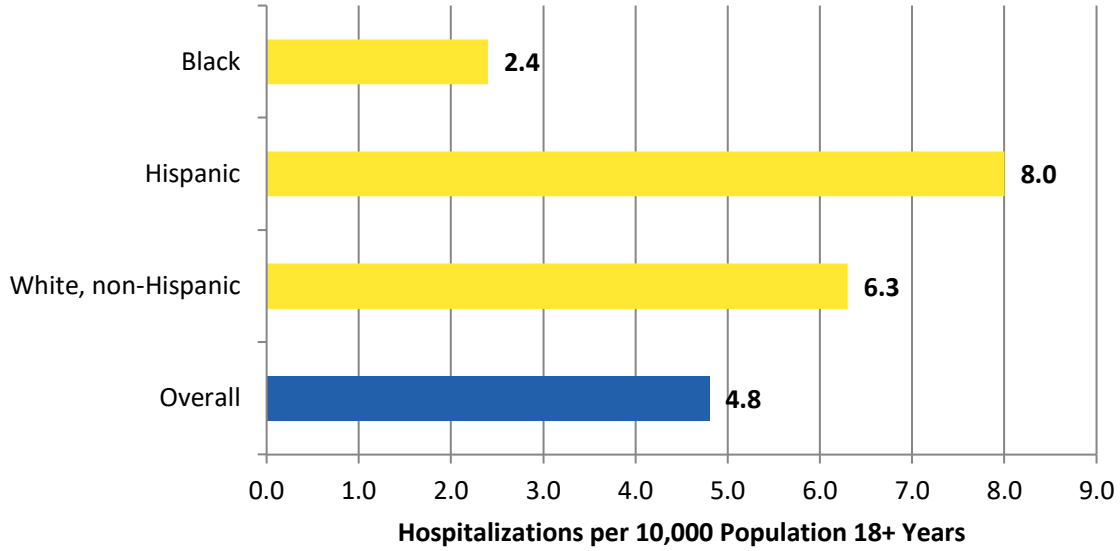
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Drug and Alcohol Intoxication Deaths by Place of Occurrence, Prince George's County, 2013-2020



Data Source: 2020 Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland Annual Report

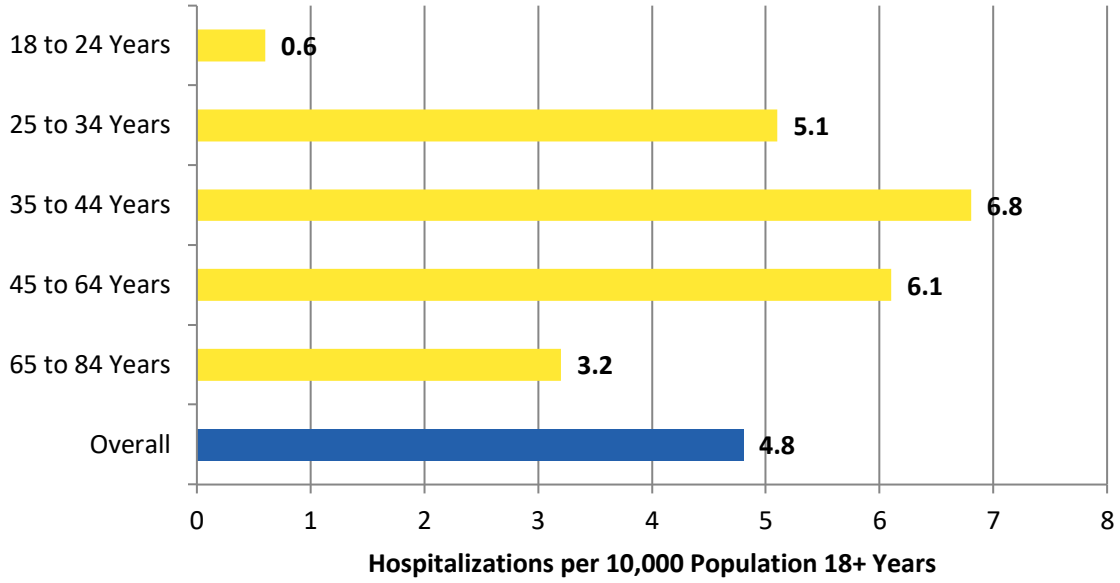
Age-Adjusted Hospital Inpatient* Visit Rate due to Alcohol Use by Race and Ethnicity, Prince George's County, 2017-2019



* Includes visits to only Maryland hospitals

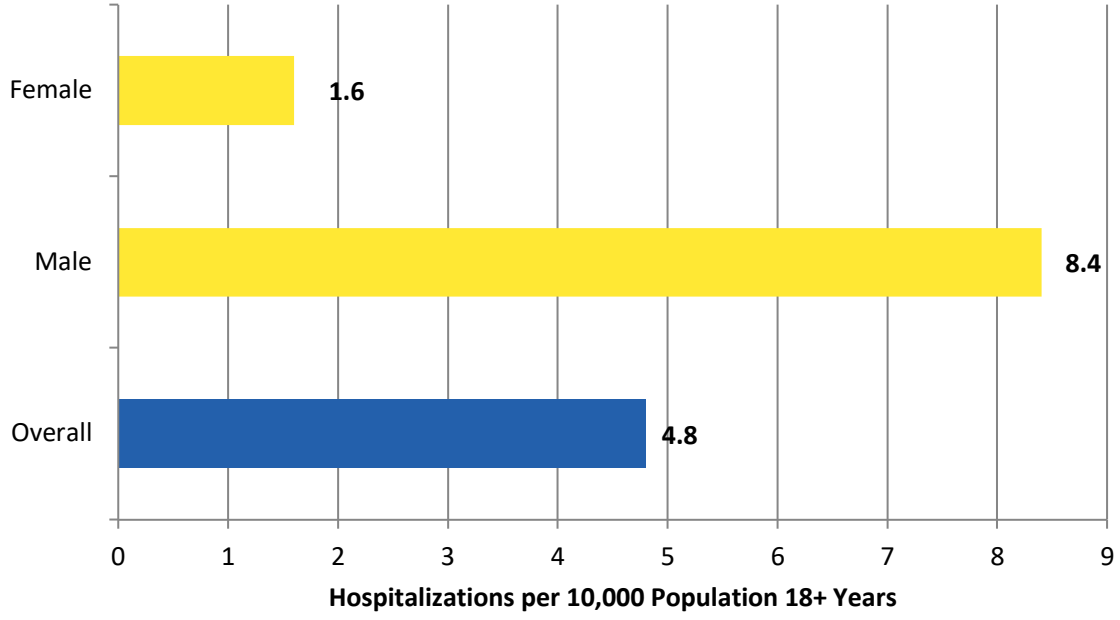
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Alcohol Use by Age Group, Prince George's County, 2017-2019



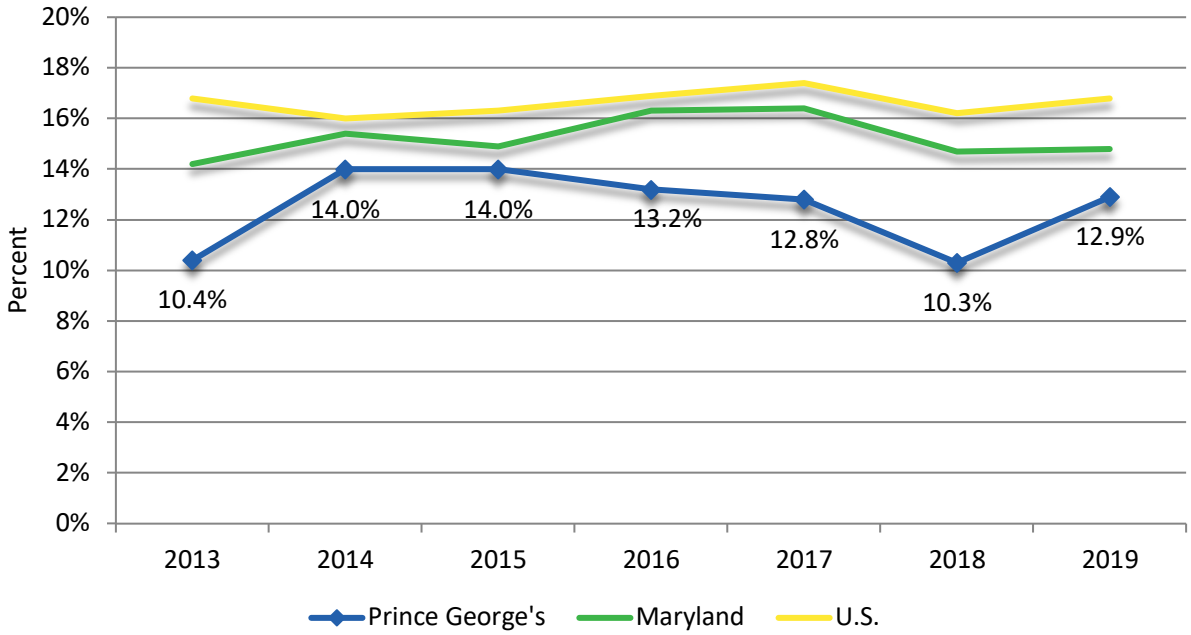
* Includes visits to only Maryland hospitals
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Alcohol Use by Sex, Prince George's County, 2017-2019



* Includes visits only to Maryland hospitals
Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Percentage of Adult Binge Drinkers* in the Past Month, 2013 to 2019



*Binge drinking is defined as males having five or more drinks on one occasion, females having four or more drinks on one occasion

Data Source: 2013-2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019, www.pgchhealthzone.org

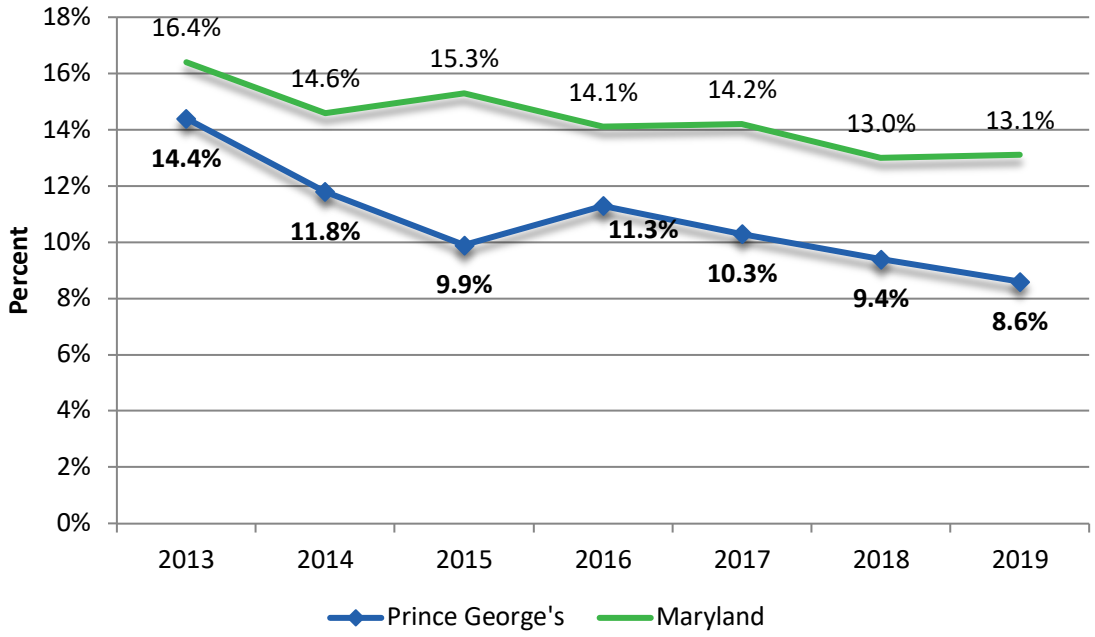
Percentage of Adults Who Currently Smoke, 2017

	Prince George's	Maryland
Sex		
Male	13.1%	16.4%
Female	7.0%	12.0%
Race/Ethnicity		
Black, non-Hispanic	9.0%	15.1%
Hispanic	20.7%	13.9%
White, non-Hispanic	13.8%	15.1%
Age Group		
18 to 34 Years	9.3%	15.4%
35 to 49 Years	10.4%	15.0%
50 to 64 Years	10.8%	15.4%
Over 65 Years	**	8.2%
Total	**10.3%**	**14.2%**

**Over 65 years not presented due to insufficient data

Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Percentage of Current Adult Smokers, 2013 to 2019



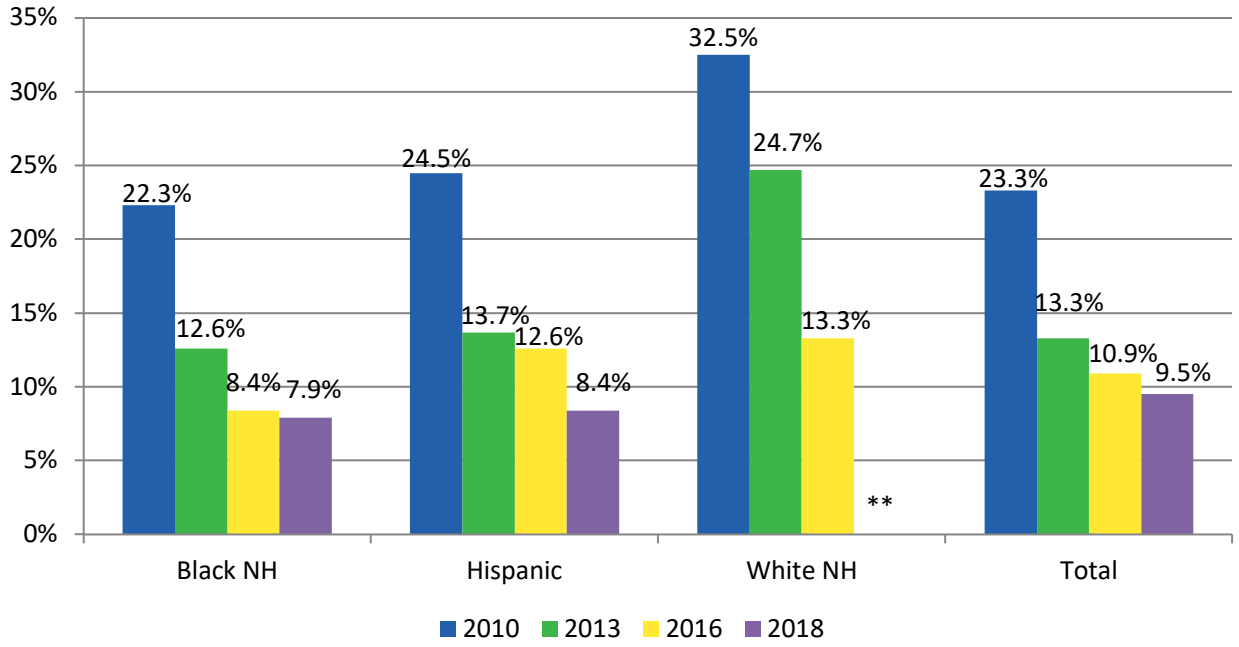
Data Source: 2013-2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019, www.pgchealthzone.org

Percentage of Students who Drank Alcohol During the Past Month, 2018

	Prince George's	Maryland
Sex		
Male	14.0%	21.0%
Female	21.6%	26.8%
Race/Ethnicity		
Black, non-Hispanic	17.9%	16.7%
Hispanic	16.2%	19.8%
White, non-Hispanic	**	32.3%
Age Group		
15 or Younger	17.0%	17.8%
16 or 17 Years	18.5%	28.9%
18 or Older	**	33.4%
Total	**18.3%**	**24.1%**

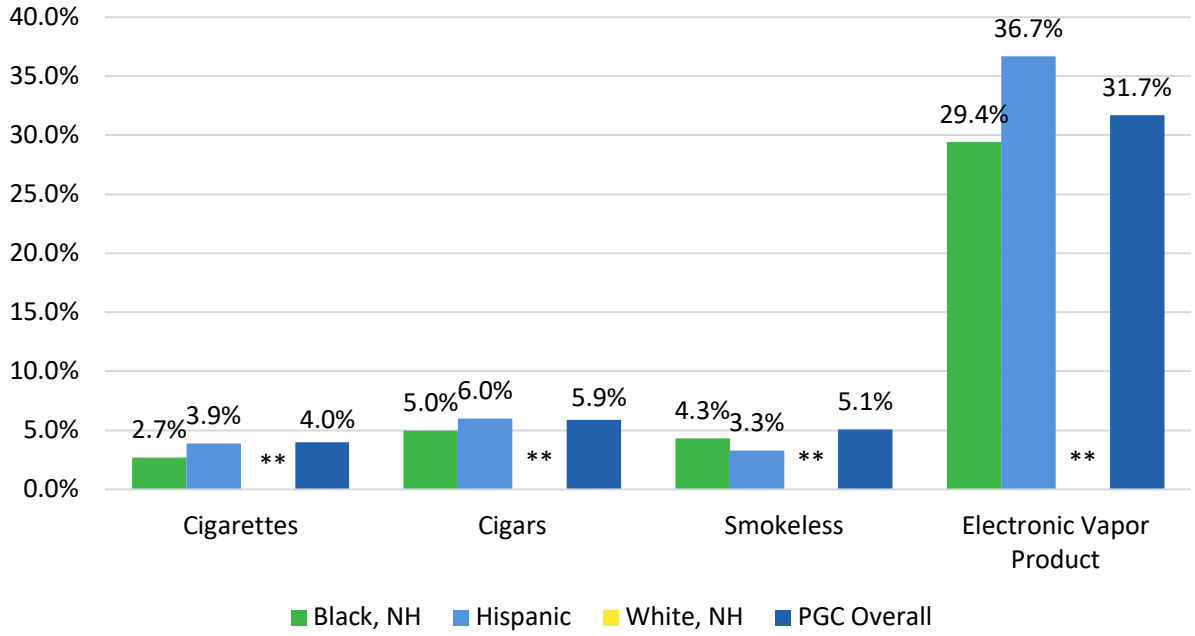
** White, non-Hispanic not presented due to insufficient data
Data Source: 2018 Youth Risk Behavior Survey Report for Prince George's County and Maryland, MDH

High School Students Who Used Tobacco Products During the Past Month, Prince George's County, 2010, 2013, 2016, and 2018



Data Source: 2010-2018 Youth Risk Behavior Survey Report for Prince George's County and Maryland, MDH

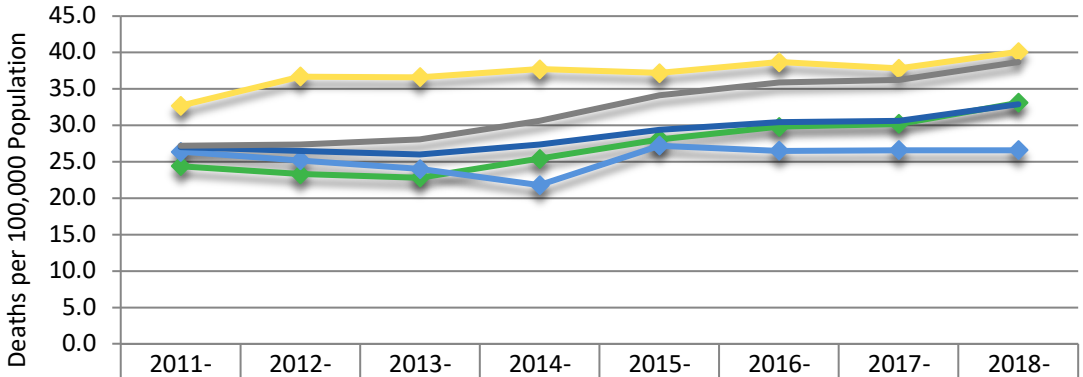
Tobacco Products Used by High School Students During the Past Month by Race/Ethnicity, Prince George's County, 2018



Data Source: 2018 Youth Risk Behavior Survey Report for Prince George's County and Maryland, MDH

Unintentional Injuries (Accidents)

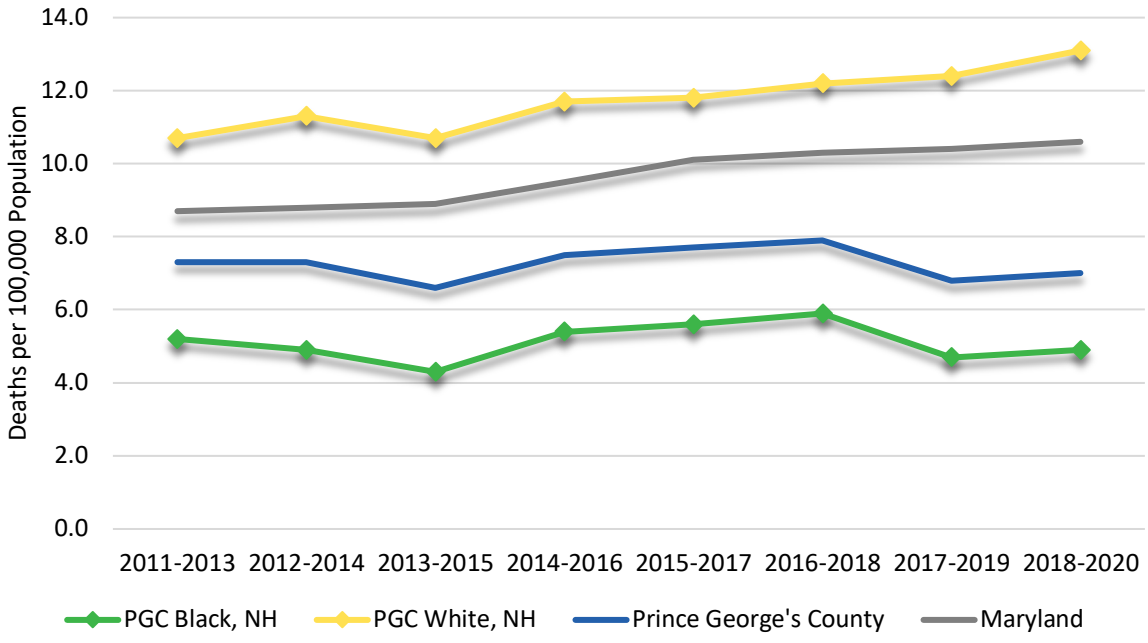
Age-Adjusted Death Rate per 100,000 for Unintentional Injuries, 2011-2020



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
PGC Black, NH	24.4	23.3	22.8	25.4	28.1	29.8	30.2	33.1
PGC Hispanic	26.4	25.2	24.0	21.8	27.2	26.5	26.6	26.6
PGC White, NH	32.7	36.7	36.6	37.7	37.2	38.7	37.8	40.1
PGC	27.0	26.5	26.0	27.4	29.4	30.4	30.6	32.9
Maryland	27.2	27.4	28.1	30.6	34.1	35.9	36.2	38.7

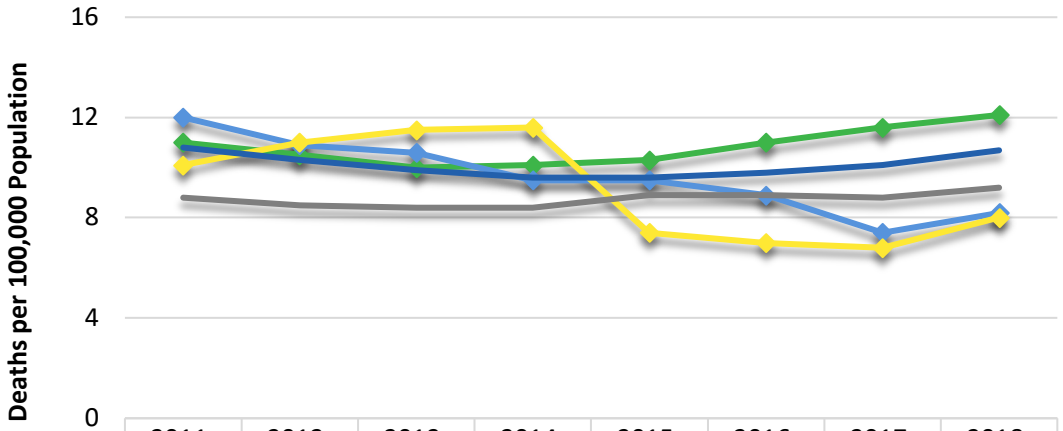
***** Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Age-Adjusted Fall-Related Death Rate, 2011 to 2020



***** Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database;

Age-Adjusted Death Rate due to Motor Vehicle Accidents, 2011-2020



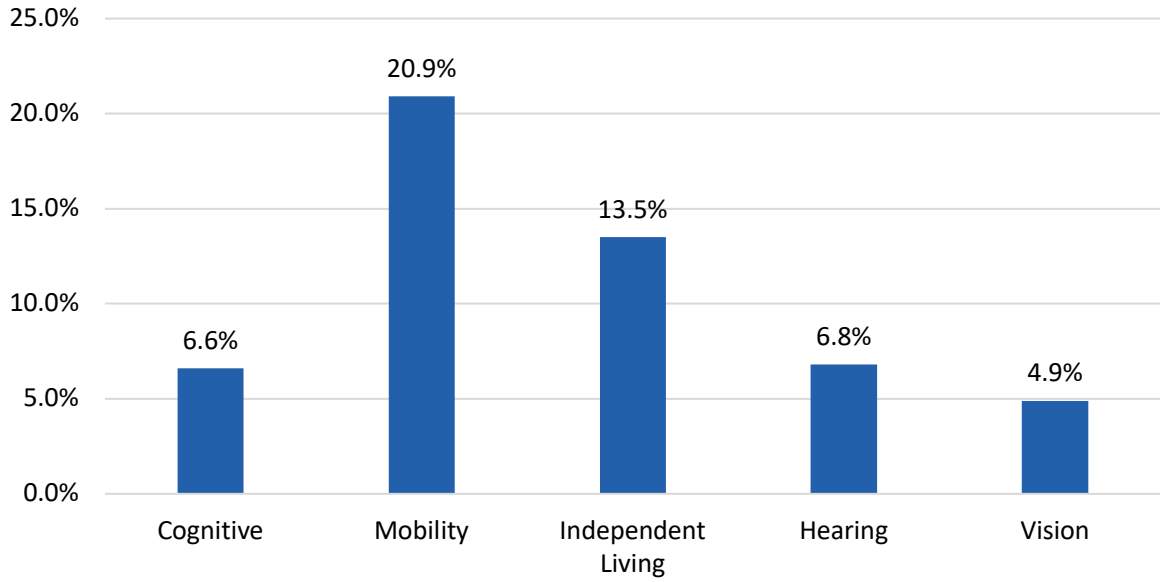
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2017	2017-2019	2018-2020
PGC Black, NH	11.0	10.5	10.0	10.1	10.3	11.0	11.6	12.1
PGC Hispanic	12.0	10.9	10.6	9.5	9.5	8.9	7.4	8.2
PGC White NH	10.1	11.0	11.5	11.6	7.4	7.0	6.8	8.0
PGC	10.8	10.3	9.9	9.6	9.6	9.8	10.1	10.7
Maryland	8.8	8.5	8.4	8.4	8.9	8.9	8.8	9.2

***** Asian/Pacific Island Residents were not included due to insufficient numbers

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database; Healthy People 2020 https://www.healthypeople.gov/

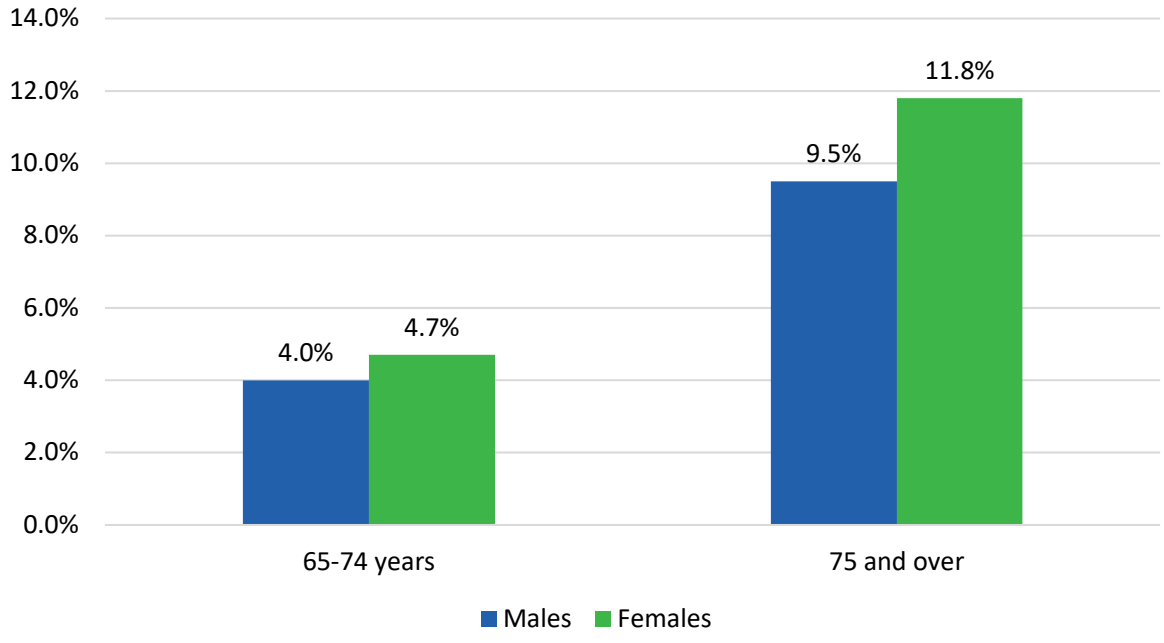
Senior Health

Percentage of Seniors (65+ Older) by Disability Type, Prince George's County, 2021



Data Source: 2021 American Community Survey, Table S1810

Percentage of Seniors (65+ Older) with a Self-Care Difficulty, 2021

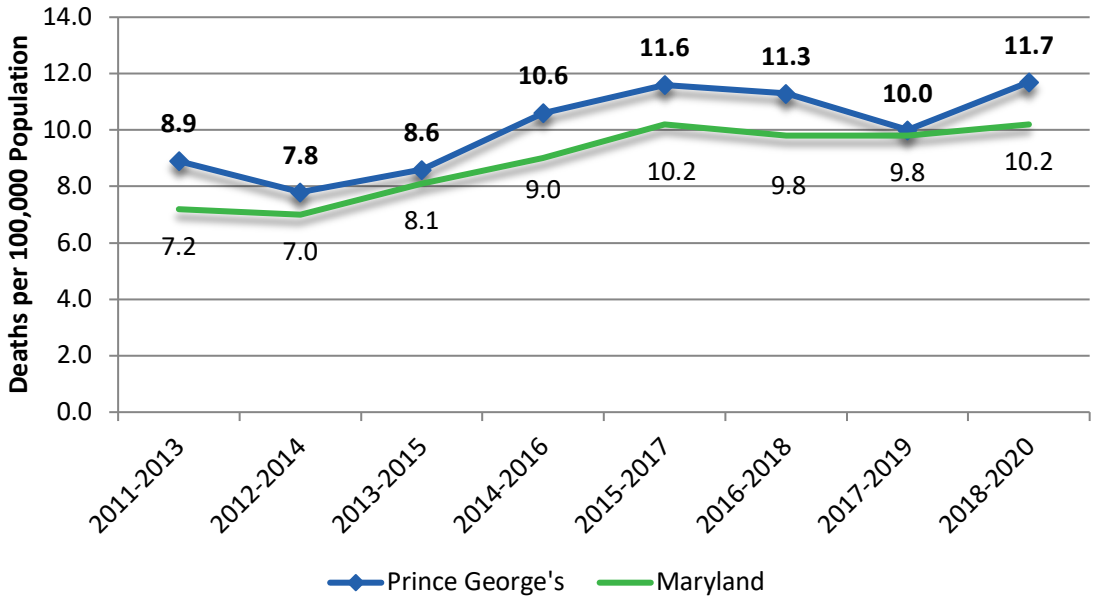


Data Source: 2021 American Community Survey, Table B18106

Violence and Domestic Violence

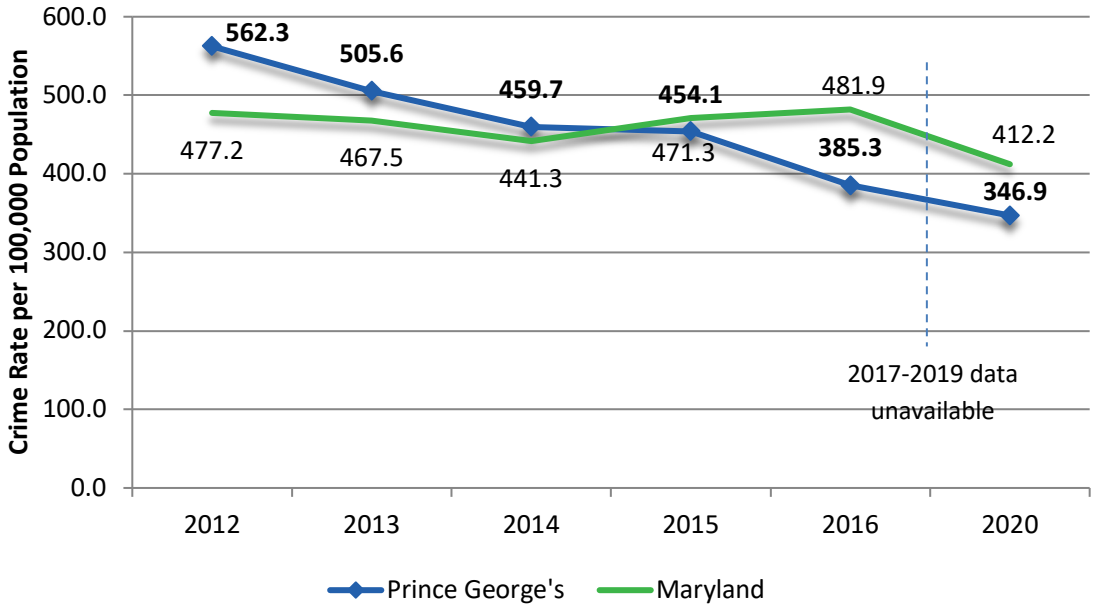
Overview	
What is it?	Violence affects all stages of life and includes child abuse, elder abuse, sexual violence, homicides, and domestic violence. Domestic violence is a pattern of abusive behavior including willful intimidation, physical assault, battery, and sexual assault used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can happen to anyone regardless of age, economic status, race, religion, sexual orientation, nationality, sex, or educational background (Source: National Coalition Against Domestic Violence).
Who is affected?	There were 3,161 violent crimes (includes homicide, rape, robbery, and aggravated assault) in 2020, and 138 residents in the County died by homicide. In 2020, there were 1,802 domestic-related crimes in the County and 12 domestic violence-related deaths. (Source: Maryland Network Against Domestic Violence).
Prevention and Treatment	Domestic violence prevention efforts depend on the population and include: • Prevent domestic violence before is exists (primary prevention). • Decrease the start of a problem by targeting services to at-risk individuals and addressing risk factors (secondary prevention). • Minimize a problem that is clear evidence and causing harm (tertiary prevention) (Source: Maryland Network Against Domestic Violence).
What are the outcomes?	Apart from deaths and injuries, domestic violence is associated with adverse physical, reproductive, psychological, social, and health behaviors. (Source: CDC.gov).
Disparity	No data is currently available about disparities for violence and domestic violence. However, anyone can experience domestic violence. Women generally experience the highest rates of partner violence compared to males. Teenaged, pregnant, and disabled women are especially at risk. (Source: MD Network Against Domestic Violence).
How do we compare?	The County's age-adjusted death rate due to homicide from 2018 to 2020 was 11.7, compared to the State overall at 10.2 and the U.S. at 6.6 per 100,000 population. The County's violent crime rate in 2020 was 346.9, below the State rate of 412.2 per 100,000. (Source: MD Governor's Office of Crime Control and Prevention).

Age-Adjusted Death Rate for Homicide, 2011-2020



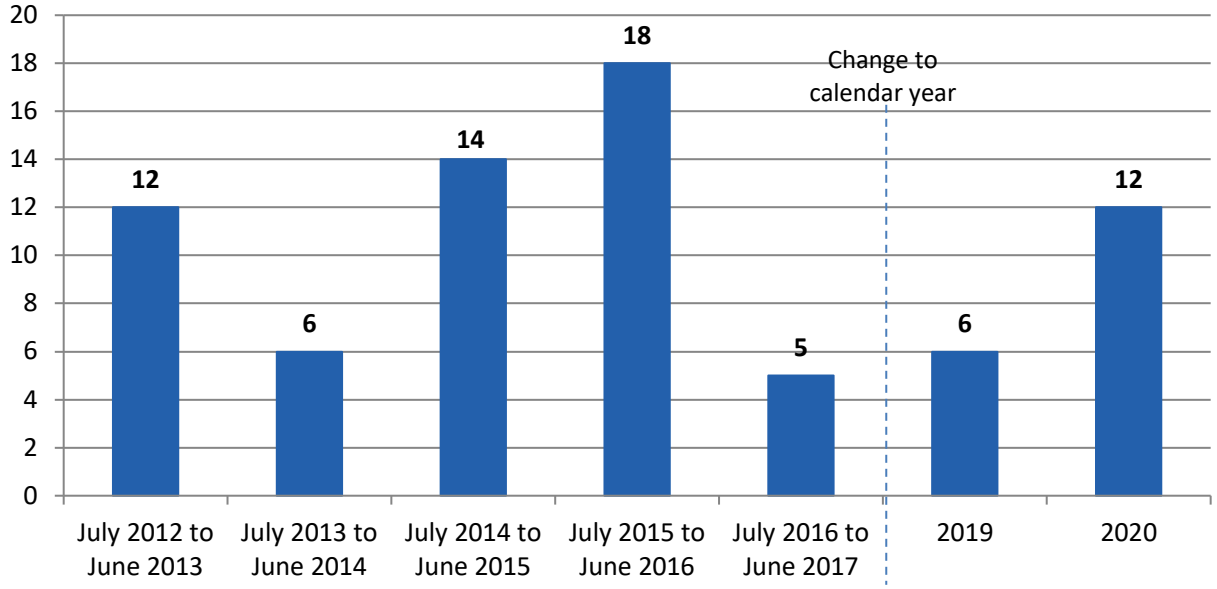
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Violent Crime* Rate, Prince George's County Compared to Maryland, 2012-2020



*Violent crimes include homicide, rape, robbery, and aggravated assault.
Data Source: Maryland Uniform Crime Report, 2020 Maryland Crime Dashboard

Domestic Violence-Related Deaths in Prince George's County, 2012-2020



Data Source: Maryland Network Against Domestic Violence, DV Homicide Prevention Report

KEY INFORMANT INTERVIEWS

Introduction

As part of the 2022 Community Health Assessment conducted in partnership with the County's hospitals, the Prince George's County Health Department (PGCHD) conducted key informant interviews with 16 County leaders drawn from diverse backgrounds with varying perspectives on health in the County. The key informant interviews were utilized as an opportunity to include perspectives from populations that may be under-represented through other collection methods and have a need for different or increased resources to achieve their best health. The special populations represented included veterans, seniors, those experiencing homelessness or housing insecurity, immigrants, refugees, and the Hispanic and Filipino communities.

This report summarizes the approach to the interviews and the findings.

Key Findings

- The most important health issues facing the County are (1) behavioral health, (2) chronic disease, (3) access to care, and (4) issues surrounding healthy eating and active living (i.e., food insecurity and food deserts). These leading issues remained the same from the 2019 Community Health Assessment key informants.
- The most important social determinants of health in the County are (1) economic stability, (2) transportation, (3) adequate and affordable housing, and (4) access to healthy food.
- The most important barriers relative to the health and well-being of residents are (1) lack of adequate mental health services, (2) lack of awareness about health programs and resources, (3) limited primary care access/specialists, (4) health literacy, (5) lack of transportation, (6) housing concerns, and (7) issues exacerbated by the pandemic effects.
- The leading physical health concerns are (1) access to available resources and care, (2) the role that lack of health insurance and health literacy contribute towards health issues, and (3) chronic disease and the incidence and prevalence of chronic disease, including cardiovascular disease, hypertension, Type 2 diabetes, as well as contributing factors such as obesity and physical health management.
- Several issues surrounding behavioral health are of heightened concern for Prince George's County residents. Residents expressed a clear need for: (1) earlier detection and treatment of behavioral health issues, (2) better affordability and access to behavioral health services, (3) more culturally and linguistically appropriate providers and specialists who can address and treat behavioral health issues, and (4) more

specialized behavioral health providers.

- Residents were concerned with both the natural environment (i.e., air quality, respiratory issues caused by pollen and transportation) and the built environment (i.e., poor walking environmental conditions, lack of adequate housing, lack of walkable communities, and need for more beautification efforts and clean neighborhoods).

- One challenge facing County leadership is that although there are several different initiatives addressing health that are active in the County, there is still a sense amongst residents that there is a lack of resources and services to address all of the concerns. **Residents do not want to see temporary fixes**. **They want to see and experience a permanent change in the County regarding health outcomes**. Although some are optimistic about future directions, residents must be made aware of what transformative changes are taking place in the County and what role they can also play in making hopeful changes into realities.

- Visible and sustainable partnerships and collaborations are needed in the County to address many of the identified health issues. Residents and leaders of County organizations, systems, and businesses need to have more opportunities to collaborate and plan to increase "buy-in" on various community and evidence-based health approaches in the County.

- Overall, more needs to be done to address issues surrounding an aging population, transportation, housing, undocumented individuals and families, chronic diseases and chronic disease management, and behavioral health issues.

Methodology

Sample: Twenty-nine individuals were identified by area hospitals and PGCHD as key informants to represent special populations in the County, including veterans, seniors, those experiencing homelessness or housing insecurity, immigrants, refugees, and the Hispanic and Filipino communities, as well as organizations such as educational institutions that may serve more than one population. The individuals identified as key informants were either members of or directly serve these special populations. Of the 29 potential respondents, 16 individuals completed the interviews. Despite multiple attempts to schedule interviews, it is recognized that some organizations/individuals were not included due to a lack of response and/or time limitations. However, efforts were made to include representation in the Community Expert Survey for under-represented populations to ensure inclusion in the Community Health Assessment process.

Appendix A presents the list of persons who completed the interviews.

Interview Protocol: The comprehensive interview guide developed for the 2016 and 2019 Community Health Assessment was utilized for consistency (see **Appendix B**), which consisted of 17 open-ended questions with related probes. The guide addressed the following focus areas: assets and barriers relative to health promotion in the County, opinions

on the leading health threats currently facing the County, specific priorities in the areas of physical, behavioral, and environmental health, and emerging threats to residents' health. Interviews were conducted by the Prince George's County Health Department's Office of Assessment and Planning.

Implementation: The interviewers conducted all the interviews via Zoom with each interview ranging from 30 to 75 minutes in duration. The opened-ended questions provided informants the opportunity to respond without limitations. All interviews were conducted between March 15-April 11, 2022.

Analysis: Preliminary analysis of the interview data occurred after each data collection activity. Each interviewer identified and recorded first impressions and highlights. The second stage of analysis consisted of the three interviewers meeting to discuss and identify common categories and overarching themes which emerged as patterns in the data. In the presentation of the interview findings, key patterns are reported along with supportive quotes.

Question-by-Question Analysis

1. ***What is your organization/ program's role relative to the health and well-being of County residents?***

See **Appendix A** for a list of participants.

2. ***How long has your organization/ program played this role?***

The key informant sample was drawn to reflect special populations of interest and concern in the County and included our veterans, seniors, those experiencing homelessness or housing insecurity, immigrants, refugees, and the Hispanic and Filipino communities. We also interviewed two individuals who represented organizations that served thousands of individuals from multiple communities in the County and had a deeper insight into many of the concerns of the special populations of focus. The respondents represent over 235 years of active service in the County.

3. ***In your opinion has the health of County residents improved, stayed the same, or declined over the past few years? What makes you say that?***

Over 30% (N=5) of the respondents believed that the health of the residents had improved over the past few years. An equal number of respondents reported that they believed that the health of residents had stayed the same, 20% of the respondents believed that the health of the residents had declined, while 13.3% shared that based on their knowledge, they were uncertain of the County's status because although some indicators had improved others had declined. Respondents shared that they believed that the health of the County was improving based on the visible increase in programs that are being offered to seniors and residentially challenged individuals.

"I will say it has improved because the programs have expanded. When I first started with the County, there was just one program (Senior Care) that provided services to seniors in the County, and that that program is still in existence (…) now there are several more programs, yes there is always a need for more slots, so we can serve more residents, but for the most part, these residents have more programming and resources so I can say "yes, it has improved".

Some respondents shared that they believed that the pandemic catalyzed a much-needed increase in programs for residents in the County.

"The pandemic has definitely had an impact, especially on mental health support!"

"It has improved (but) post pandemic-only!"

For those who felt that the health of the County had either stayed the same or were unsure, many expressed that health insurance issues (i.e., lack of access, undocumented individuals without access, and individuals who were unable to maximize its use) were still issues that were prevalent and of concern for County residents.

"The County has changed in demographics, pockets of the county are resource poor due to variation of individuals in areas, opportunity to improve exists, however there are currently not enough funds (general dollars) to support health."

Community experts also shared that mental illness-related issues appeared on the rise, and the number of individuals who suffered from the pandemic and co-related chronic diseases was also areas of concern for residents in the County, especially for those who lacked access to resources.

"There are lots of ups and downs related to health care...lots of ups and downs, but one thing that has stayed the same unfortunately is that if a family is undocumented, they are not eligible for any of the health services that exist."

"For obvious reasons, with the pandemic in mind, the pandemic truly brought to light challenges that our community was already facing (…) many of the challenges were just exacerbated but already existed prior to COVID."

"(I) haven't seen any great indicators suggesting that the people are any better off socially or physically. There's the same level of problems as prior to the pandemic."

4. ***What are the County's three most important assets/strengths relative to the health and well-being of (name the group that the person has been selected to represent)?***

When questioned about the important assets and strengths of the County relative to the health and well-being of the residents, the most common responses pertained to (1) the collaboration and communication among the various County organizations, (2) the available services and resources for County residents, and (2) the physical location of the County.

(i) *Collaboration and Communication*: Many respondents shared that they believed the collaboration between local organizations and non-profits was impressive and something that they hope would remain. Several respondents shared that during the height of the pandemic they appreciated knowing what was going on and that the County Executive and their team were always sharing information.

"I applauded Prince George's especially in the early phases of the pandemic when they were trying to get information out in a timely manner - Prince George's was putting out things in French right away, and I couldn't say the same for even the CDC. I could find things in Spanish."

"There is an active health department, active coalition, a clear strategic plan, and a collaborative approach to health (in the County)"

"The leadership and their teams are a strength to this County, there is collective thinking around how to address major diseases. There is also the PGHAC (Prince George's County Healthcare Action Coalition)."

(ii) *Available Services and Resource:* Several of the informants were able to share key resources that were available for their respective populations

"There are several resources for our veterans such as the military installation at the Joint Andrews Medical Facility where veterans receive medical treatment, the Office of Veteran Affairs and there are churches who offer services also"

"There are a significant number of nurses (in the County), multiple clinics and hospitals that provide services."

"There are shelter hotlines, a continuum of care, and community partners who provide community resources such as food."

"Parks and Planning-they help with physical activity, the health center in Largo, and several outreach efforts that are made to serve all communities that are represented in the County."

(iii) *The Physical Location of the County:* In several interviews, the actual physical location of the county relative to Washington D.C., and Annapolis was repeatedly reported as a strength for the County. It represented strength, access, and influence.

5. What are the County's three most important barriers relative to the health and well-being of residents?

The Community experts were equally concerned about the barriers relative to the health and

well-being of the County's residents as they were about the strengths. The most important barriers relative to the health and well-being of residents are (1) Lack of adequate mental health services, (2) Lack of awareness about health programs and resources, (3) Limited primary care access/specialists, (4) Health literacy, (5) Lack of transportation, (6) Housing concerns, and (7) The post-COVID-19 effects. Some quotes are provided below to highlight some of the sentiments associated with the above-mentioned concerns.

(i) Lack of Adequate Mental Health Services

"There is not enough primary care or understanding of health disparities for underserved populations)."

"There is a lack of readily accessible intermediate care."

"It is difficult to find social support."

(ii) Lack of Awareness About Health Programs and Resources

"There is a lack of awareness relative (about the) health and well-being of veterans; not enough tailored promotion and advertisement of organizations able to help veterans."

"There needs to be a map where programs are physically happening, a map of communities where (individuals) can actively participate."
"There are language barriers, we need more cultural sensitivity and civic participation."

(iii) Limited Primary Care Access/Specialists

"There is a lack of community primary care providers and support of health alliances."

"It is unfortunate, I have seen uninsured residents using pharmacy clinics for primary care when their needs were much more extensive."

(iv) Health Literacy

"There are issues surrounding the digital divide, especially pertaining to seniors and veterans"
"A lot of information is being put online, however there are still access challenges that ranges across SES and other demographics."

(v) Lack of Transportation: Repeatedly community experts shared that transportation was a serious concern for County residents. Informants shared that although there may be services in the County, often they are either far apart or they are unevenly distributed with a concentration in some areas while other areas lack adequate access. Many shared that to get around the County and experience the best that the County has to offer; transportation is a must. Respondents also stated that the existing transportation system was not extensive enough to meet the need of the residents.

"Lack of transportation is definitely an issue, especially in the southern part of the County"

"Transportation is more than just getting from one place to another but also being able to connect to other parts of your community, such as clinics, etc., our infrastructure does not support community engagement."

"Transportation is definitely an issue, especially with our older residents."

(vi) Housing Concerns: The identified key housing issues included: affordability, adaptability, differing quality and standards of housing across the County, and concerns surrounding the lack of stability for some school-aged children.

(vii) Post-COVID-19 Effects: Some respondents shared that they felt that the County is presently dealing with chronic diseases and mental health concerns that are related to COVID-19 and that this would be an issue that will continue to be of concern for some time.

"The COVID 19 effects are a serious issue, badly managed chronic diseases that end up as complications and being an emergency-we know that medical debt is a problem not only for uninsured individuals but for everyone."

6. ***What do you think are the three most important social determinants of health in the County? (Social determinants of health are factors related to the social environment, physical environment, health services, and structural and societal characteristics.)***

The most important social determinants of health in the County are (i) economic stability (ii) transportation, (iii) adequate and affordable housing, and (iv) access to healthy food.

(i) Economic Stability- The cost of living in the County and economic stability was identified as the most important social determinant of health in the county and seemed to be related to many other social determinants of health that were mentioned such as healthcare access and quality care.
"Making sure people have the ability to provide for themselves either through work or benefits (income)."

(ii) Transportation: Transportation was seen as another key social determinant of health in the County as it appeared to be essential to several of the components that were needed to be healthy and for an individual's well-being in the County. Many key informants reported that this was an urgent issue that has transpired for several years and needed to be addressed. One respondent summarized the transportation issue by stating:
"We just don't have enough of it!"

(iii) Housing: Economic stability seemed to be related to housing concerns (i.e., affordability and access). It was noted by many informants that some of the best affordable, quality places to live in the County are inaccessible to "too many" people.
"The cost (for housing) is simply too high!"
"There is not enough housing."

(iv) Healthy Food Access: It is important to note that several informants also shared that they believed that housing and healthy food access were related and a component of what *"adequate housing"* entailed. Many shared complaints about the *"excessive access to fast-food businesses"* that existed in many parts of the County. Many felt that this was an immediate concern that needed to be addressed as it related to many other components of a resident's well-being.

7. What do you think are the three most important physical health needs or concerns of County residents?

The leading physical health concerns for the key informants were (i) accessibility to available resources and care, (ii) health insurance and health literacy concerns in terms of how they impact physical health, and (iii) chronic disease and the incidence and prevalence of chronic disease, including cardiovascular disease, hypertension, Type 2 diabetes, as well as contributing factors such as obesity and physical health.

(v) Accessibility to Available Resources and Care: Several respondents shared that they felt that transportation needs were also related to the physical health needs of residents. One respondent shared:

"*You need to have accessibility of services to stay healthy."*

Another key informant shared that transportation was a concern related to many individuals' ability to meet their physical needs including access to affordable housing and healthy food options.

"*Individuals in the County are worried about not being able to take care of themselves."*

(vi) Health Insurance and Health Literacy: Key informants mentioned several health insurance and health literacy concerns that they believed were related to physical health in the County such as "*a lack of knowledge about health care resources, low health literacy, and health insurance limitations."*

Informants also shared some ideas about how to address this issue by suggesting "*more health programming and/or more information about existing programming."* Budgetary concerns were expressed for some existing health programs, especially in the context of resources dependent on pandemic-related funding.

(iii) Chronic disease concerns: Type 2 diabetes, cardiovascular disease, obesity, and hypertension were mentioned by over 80 percent of the participants. All respondents were concerned about the overall physical health of County residents. Support systems for individuals with chronic disease (especially seniors) were also mentioned as a concern.

8. What do you think are the three most important behavioral/mental health needs facing the County?

All respondents expressed concern about the rising incidence of behavioral health problems among adults and children. Several issues surrounding behavioral health are of heightened concern, including a clear need for (i) earlier detection and treatment of behavioral health issues, (ii) better affordability and access, (iii) more culturally and linguistically appropriate individuals who can address and treat behavioral health issues, and (iv) more specialized behavioral health providers

(i) Early Detection and Treatment: The four main issues that key informants mentioned related to early detection needs were: *(a) alcoholism, (b) depression, (c) suicide, and (d) anxiety.*

"Mental health disorders occur a lot earlier in life than we recognize, often in adolescence. We do not have a lot of ways to detect these behaviors as early as they need to be and thus there is a lack of mental health usage by patients that need it (i.e. Parents getting help for their children or even teachers making reports about their students) we have to change that."

(ii) Affordability and Access: Many respondents shared that a better understanding of health insurance and its offerings would also be beneficial.

"Assistance in finding qualified mental health providers in the County could help demystify how the system actually works."

(iii) More Culturally and Linguistically Appropriate Providers: All the respondents agreed that having culturally and linguistically appropriate individuals to assist with the mental health challenges that adults and children faced would be ideal.

"The ability to speak to someone without needing an interpreter in a mental health setting really changes the dynamic. A certain amount of trust and closeness and relationship between the provider and the patient and you just cannot do that, I think, in a mental health setting- an interpreter in the middle, I think it just kind of breaks down that relationship, altogether, and then that cultural piece like I was saying is a really important for understanding individuals."

Other respondents shared that although it was not ideal, the County was moving in the right direction.

"Many of the community clinics, I think, do a good job with this, the fact that you have many bilingual staff many times that are immigrants themselves… like I can relate, often with the communities that we serve thinking back to when you know I first emigrated to the United States, I did not have medical interpreters, we do a pretty good job I mean it's still never ideal but it's a decent enough".

(iv) More specialized behavioral health providers: All the respondents shared that they believed that the County needed more mental health providers who offered quality and trustworthy services. Some specialized issues that were mentioned by respondents were: "*stress management and domestic violence."*

9. ***What do you think are the three most important health-related environmental concerns facing the County?***

The responses expressed concern about both the natural environment including air quality, and respiratory issues caused by pollen and transportation and the built environment including poor walking environmental conditions, lack of adequate housing, lack of walkable communities, and the need for more beautification efforts and clean neighborhoods.

Natural Environment:

Air Quality: The quality of the air in the County was a concern to some of the respondents, alluding to the possible relationship between physical health conditions (e.g., asthma, allergies) and air quality. Another respondent also shared that they felt that poor air quality existed because the County is a strong commuter County.

Built Environment:

(i) Beautification Efforts: Respondents had varying concerns related to the need for more beautification efforts and increased clean neighborhoods. One respondent shared that there was a glaring lack of community gardening spaces in the County:

"We couldn't find any space {to create a community garden}and there were too many obstacles, so we dropped the idea."

(ii) Other Issues of Concerns: The majority of the respondents mentioned the following issues as concerns related to the built environment and the well-being of our residents such as lack of adequate housing (substandard apartments and leaving conditions), which could lead to overcrowding and an increased risk of the transmission of viruses, poor walkable conditions, and co-morbid effects.

10. ***Now if you had to prioritize and select the three most important health issues facing the County from among those you just mentioned what would they be?***

Nearly all respondents mentioned behavioral health (especially related to trauma), housing, and transportation. Several respondents expressed that the reputation of the County will be based on our ability to address the aforementioned issues. All agreed that intentional discussions and action plans surrounding these issues were essential.

Although the following issues were not in the "top 3", they were mentioned frequently:

(a) Finding solutions for the uninsured and the underinsured is needed. In an attempt to express the gravity of this issue, one respondent shared:

"Sometimes individuals rely on home remedies rather than seeking medical care because of

access (lack of time, lack of funding), home remedies that have either been passed down from generation to generation or other family and friends have shared, because they have no other option".

(b) Chronic Disease Management was also mentioned frequently, especially on issues such as diabetes, cardiovascular disease, kidney disease, and HIV.

Many respondents agreed that the County should continue to put health at the center of all its planning, including economic development, education, housing, and transportation.

11. In what way does your organization/program address each of the three issues you just mentioned?

Efforts to address the myriad of health problems and concerns raised by the respondents fell into three main categories: direct services, community health education, advocacy and outreach, and partnerships and collaborations.

Direct Services: All the direct service providers reported working at capacity and still being unable to meet the demand. Many predict that the demand for services will continue to rise, given the significant proportion of consumers who increasingly demand high-quality services, especially since COVID-19 became a challenge. All noted that in addition to the provider shortage, there was a need to know more about the non-profit sector, particularly in the area of supportive services.

Education and Outreach: Many respondents felt that one of the most important roles that they had was to provide community health education, advocacy, and outreach to (and for) residents. Several respondents expressed they wished to do more; however, their organizations were already at capacity and needed to expand to be better equipped to provide needed resources to additional residents in Prince George's County.

Partnerships and Collaborations: Several respondents reported having partnerships with various local, state, and national organizations and were passionate about the importance of collaborating with others for the benefit of the residents, they felt that COVID "forced them to do so" and there is a hope that those collaborations will remain and even strengthen moving forward.

12. How well is the County as a whole responding to these issues?

All the respondents shared that they believe that progress is being made, however many expressed that they feared that the progress was not enough to meet the growing demands and needs of residents. Some respondents believed that some needs are dire.

"There is a need for more adequate housing for our seniors. As I said, I've seen in fact three different senior housing communities that have been built in the County. The third one that I've seen is in Suitland Maryland seems to be the most affordable. It is scary to see what some seniors who do not have the income will have to afford just to have adequate housing. There is a need to provide adequate housing for our seniors. Hopefully, more will come because I am getting older too."

"The County does have a pilot program (Health Assures) to support the clinics, but I think we need to go above and beyond that. I think it's a good start, but I think you know when we just need to do more to support residents in having access to a provider."

"We need a program for undocumented individuals in this County."

All the respondents shared that the issues could not be easily solved, and it would take an "all-hands-on-deck" attitude to remedy many of these challenges. One respondent summarized it quite succinctly:

"Genuine efforts are being made. The issues are complex. The issues go beyond what the County government can do."

13. What more needs to be done and by which organizations/ programs?

While many of the responses indicated the responsibility of the Health Department and the County government to lead the effort, every respondent noted that the Health Department and the County government would need the support of local organizations and residents to implement the programs and changes. Many respondents referenced the COVID-19 efforts and the role that they played in working with their respective communities and shared that commitment and collaboration would be essential again to implement other initiatives.

Several key actions were shared by the respondents covering a variety of initiatives:

"More funding for the Health Department and Department of Family Services and Social Services because they departments work so closely together and provide most of the services for our seniors."

"A lot more community outreach and education- especially with immigrant and refugee communities who are taking on so many new things you know, trying to find a job and trying to find housing and you know school enrollments and I think it's just so challenging. Their lists are so long and cumbersome BUT knowing and understanding that there are services that even if they cannot get to them now….they are available and that they can tap into them someday is helpful."

"Increase health literacy and community outreach and education-they are currently doing a lot with the ACA."

"The County needs to invest in its population (resources, work development, etc.)."

"The school system is doing their best with contracting mental health clinicians but they can still do… better."

"*Improve technology literacy."*

"Increase funding for aging services and family support."

"Expand the multi-service centers to other areas of the County."

All the respondents agreed that more funding needs to be distributed to organizations and agencies that worked for the betterment of the residents of Prince George's County. The majority of respondents strongly suggested that two entities that could benefit from more funding would be the Health Department and the Department of Social Services because of their dedication to the County and the fact that they desperately need more resources to address the increasing needs of the residents. Capacity building was also mentioned as a need for local organizations, especially after surviving the complexities of COVID, but respondents did not identify who should deliver the proposed capacity building or how it would be funded.

14. What resources are needed but not available to address each of the three issues?

The majority of the responses centered around housing, transportation, the economy (e.g., sources of funding and the workforce), and health and human services as essential resources needed to address the current key health issues. The majority of the respondents reiterated their concerns about housing (detailed discussion in questions 5, 6, and 10) and transportation (detailed discussion in questions 5, 6, 7, 9,10, and 11).

Many respondents shared the need to see more collaboration and bidirectional partnerships with local organizations and the County government.

"The County should engage in more routine and regular dialogue with agencies at the executive level."

and that there should be better tracking of health actions and implementation:

"We need more funding and someone to lead and monitor actions and implement bidirectional partnership amongst organizations in the County. We need to create more authentic partnerships."

An appeal was made by all the respondents to increase the availability of all services such as primary care for undocumented residents, veterans, and seniors, train and hire more bilingual and trilingual staff and increase telehealth services and capacities, especially in areas and for individuals who have accessibility challenges.

15. What are the 3 most important <u>emerging</u> threats to health and well-being in the County?

There were several issues of concern for emerging threats to health and well-being in the County. The most common concerns were mental health conditions, housing, life with COVID and its after-effects, employment concerns, and lack of cultural and linguistic ongoing health delivery.

(i) Mental Health: Many respondents shared their opinions about the cyclical nature of these conditions and made a connection between the high levels of mental health concerns, such as stress and depression, and the behaviors that individuals may engage in to reduce the stress, such as consuming substances and the lack of physical activity, thus making them vulnerable to chronic diseases. They were also concerned with access to mental health care and treatment. An emerging concern was for senior residents in the County:
"We also are seeing a lot of seniors with more mental health issues than before, maybe it is because we are paying more attention to those behaviors at this time but it is very concerning."

(ii) Housing: Housing concerns have been mentioned extensively throughout this report. This should be interpreted not as being merely repetitive but as an issue that appears to transcend many of the issues that respondents have discussed.

(iii) Life With Covid-19/The lasting effects of COVID-19. Many respondents shared that they felt that we still had not seen all of the lasting effects of COVID, physically, mentally, emotionally, or socially, and felt we needed to keep increased funding available to be able to accommodate for this possible reality, in addition to pre-COVID health challenges.
"All of the challenges that the community had prior to the pandemic, they still have them and those resources are still needed. There is also no need to put up a program that the community did not ask for."

"The effects of kids in the school system and the pandemic, we still don't know the full effect it will have on them."

(iv) Employment Concerns: Several respondents mentioned that members of their respective community need to be re-trained or newly trained to better function in the "new" employment space (whether it be spaces to work remotely or skills to find new employment as their jobs may have been lost as a result of the pandemic).
"Many will need vocational training-workforce development-many people lost their jobs and many do not want to go back to such uncertain jobs."

(v) Language barriers/Cultural and linguistic diversity: Respondents shared that the "face" of the County is changing and that we need to be able to accommodate this for the benefit of the County as a whole.

16. How is your organization/program addressing these emerging threats?

Aside from sharing information where appropriate to their respective targeted population, respondents uniformly agreed that, although they can identify several threats, their organizations are not able to address all of them because they are too occupied with responding to current needs. In addition, some respondents believe that the identified threats require a uniform, comprehensive approach and not siloed actions undertaken by individual organizations, especially in areas such as emergency preparedness, advocacy, and outreach. Some respondents shared that whenever possible, they do their best to join organizations, coalitions, or task forces. Others addressed emerging threats through lobbying activities, advocacy, strategic communication, providing information on available resources and services, tailoring existing funds to meet emerging needs, integrating health into other activities, helping individuals to see all aspects of health as being important to one's overall well-being, and creating networks.

17. Do you have any other comments to add relative to health and the County?

The respondents' closing remarks centered on ensuring that as a County we address the top needs that they had shared about the various aspects of health. Many respondents shared that we can only address the current, emerging, and future challenges if organizations and governments collectively organize, strategize and implement programs and policies that will benefit our residents. Finally, all respondents shared that our County is resilient, and we have overcome several obstacles, especially over the last few years with the COVID-19 pandemic, and that we need to maintain our relationships and take our "lessons learned" and "press forward" to address and overcome new challenges. Overall, all the respondents were ready to see (and continue to work towards) significant change in the County.

Appendix A: List of Key Informants

NAME	ORGANIZATION	POPULATION
Michelle LaRue	Representative from CASA	Immigrant and Refugee
Alison Flores	Prince George's County Executive Latino Affairs Liaison	Hispanic
Patricia Chiancone	Prince George's County Public Schools International Student Admissions and Enrollment	Immigrant and Refugee
Lisa Walker	Hyattsville Aging in Place	Seniors
Tisa Holley	Prince George's County Public Schools, McKinney Vento Program	Homeless/Housing Insecurity
Patricia Fletcher	AERS Program	Seniors
James Dula	Office of Veterans Affairs, Department of Family Services	Veteran
Anthony Smith	Office of Veterans Affairs, Department of Family Services	Veteran
Stacey Little	University of Maryland Capital Region Health	Affiliated/Supporting Groups Business
Dushanka Kleinman	University of Maryland, College Park, School of Public Health	Affiliated/Supporting Groups Higher Education
Norberto Martinez	Langley Park Civic Association	Hispanic
Guy Merritt	Department of Corrections	Homelessness/Housing Insecurity
Anna Cazes	Fort Washington Medical Center	Filipino
Col. Jimmy Slade	Community Ministries	Homelessness/Housing Insecurity
Jean Drummond	HCDI, Inc	Affiliated/Supporting Groups Business
Andre Pittman	First Baptist Church of Glenarden Military Care Ministry:	Veteran

Appendix B: Community Health Assessment

Key Informant Interview Protocol

1. What is your/your organization's (program's) role relative to the health and well-being of County residents?

2. How long have you/ your organization/ program played this role?

3. In your opinion has the health of County residents of (name the group that the person has been selected to represent) improved, stayed the same, or declined over the past few years? What makes you say that?

4. What are the County's three most important assets/strengths relative to the health and well-being of ((name the group that the person has been selected to represent) residents?

5. What are the County's three most important barriers relative to the health and well-being of *(name the group that the person has been selected to represent)* residents?

6. What do you think are the three most important social determinants of health in the County for (name the group that the person has been selected to represent)? (Social determinants of health are factors related to the social environment, physical environment, health services, and structural and societal characteristics.)

7. What do you think are the three most important physical health needs or concerns of (name the group that the person has been selected to represent) County residents?

8. What do you think are the three most important behavioral/mental health needs that (name the group that the person has been selected to represent) face in the County?

9. What do you think are the three most important health-related environmental concerns (name the group that the person has been selected to represent) face in the County?

10. Now if you had to prioritize and select the three most important health issues facing the (name the group that the person has been selected to represent) in the County from among those you just mentioned what would they be?

11. In what way does your organization/ program address each of the three issues you just mentioned?

12. How well is the County as a whole responding to these issues?

13. Based on your experience and expertise, what else needs to be done in the County and by which organizations/ programs to address the needs of (name the group that the person has been selected to represent) in Prince George's County?

14. What resources are needed but not available to address each of the three issues?

15. What are the 3 most important emerging threats to health and well-being in the County for (name the group that the person has been selected to represent)?

16. How is your organization/program addressing these emerging threats?

17. Do you have any other comments to add relative to health and the County pertaining to (name the group that the person has been selected to represent)?


COMMUNITY EXPERT
survey

COMMUNITY EXPERT SURVEY

Introduction

Prince George's County is diverse, and our growing population has a wide range of needs, disparities, and perceptions about health. The Community Expert Survey was developed as a strategy that complements the overall Community Health Assessment (CHA) goal of identifying the health needs and issues among the County's different populations, through providers, community-based organizations, local governments, and population representatives that can speak for the communities they serve.

Methodology

The Core CHA team provided lists of community-based partners and representatives to be included in the survey such as the membership of the Prince George's County Health Action Coalition, as well as and community leaders, and representatives of specific populations. The survey was developed based on existing community surveys with some modifications specific to the County. Efforts were made to ensure the survey questions corresponded with the Community Resident Survey which was also part of CHA data collection efforts. An email request was sent to approximately 100 participants by the Prince George's County Health Department in April 2022, and hospital partners were also provided with the survey link to share with their community experts.

The survey questions included multiple choice, yes/no, and open-ended responses. Each multiple-choice question is presented as a simple descriptive statistic. Not all participants responded to every question; each question includes the number (N) of participants who did respond. Open-ended response questions were initially reviewed for content analysis, which was used to identify common categories and overarching themes that emerged as patterns in the data. Each response was then reviewed and analyzed according to the categories and themes, with summary responses presented to capture the participants' information.

Participation

Surveys were submitted by 27 participants though not all participants responded to every question. Participants represented knowledge bases from across the County geography. Participants represented a variety of organizations (question 20): government organizations (50%), non-profits (22.2%), public health organizations (16.7%), healthcare providers (11.1%), faith-based organizations (11.1%), social service organizations (5.6%), mental/behavioral health organizations (5.6%), and education/youth services (5.6%); participants also worked with a variety of populations in the County (question 22).

Key Findings

- ***Healthy community***: Access to healthcare, healthy behaviors and lifestyles, affordable housing, and good jobs/healthy economy were the most important factors defining a "healthy community" identified by community experts. All survey participants (20 responses) believe that the overall health of the community they serve is unhealthy, and over half believe the communities they serve are either unsatisfied or very unsatisfied with the healthcare system.

- ***Discrimination:*** Two new questions were added to the 2022 survey about discrimination. Participants indicated that the people they serve experience the following at least several times per year: treated with less courtesy compared to others (60%), receive poorer service at restaurants and stores (35%), and being treated as if they are not smart (20%). Participants identified for those they serve the leading reasons for these experiences were race (55%), education or income level (45%), and ancestry or national origin (20%).

- ***Leading health issues***: Similar to 2019, chronic disease and related issues including diabetes and poor diet, as well as mental health, aging problems, and dental health, led as the most pressing issues for the overall County. Other issues of concern were stroke/high blood pressure, alcohol and drug abuse, COVID, heart disease, physical inactivity, and cancer. By ranking, diabetes, mental health, and issues associated with aging were the most important health issues identified by participants.

- ***Access to healthcare***: Participants were more likely to disagree or somewhat disagree that most residents could access providers in the County, including mental health providers (85%), medical specialists (80%), dentists (85%), and primary care providers (55%). Almost half of survey participants disagreed or somewhat disagreed that providers incorporate cultural competency and health literacy into their practice, and over 60% disagreed or somewhat disagreed that providers accept Medicaid or provide services for residents who do not qualify for insurance. Nearly three-fourths of survey participants disagreed or somewhat disagreed that transportation is available to the majority of residents for medical appointments, and 80% disagreed or somewhat disagreed residents can afford their medication.

- ***Leading barriers****:* The most significant barrier to accessing healthcare in the County identified by participants was the inability to pay out of pocket expenses, followed by lack of insurance coverage, the inability to navigate the healthcare system, basic needs not met, and availability of providers/appointments.

- ***Resources to improve access:*** Survey participants identified key areas of resources that are needed to improve health care access in the County (those with at least 4 responses):

    - *Better health navigation, education, and information* – increased community health worker capacity, increased communication, engagement, and outreach services, add health literacy to the education system, countywide marketing of where to gather information

    - *More providers and access to providers* – more providers across all disciplines, need medical personnel to be at community centers and senior centers, need providers who reflect the populations they serve

    - *Affordable healthcare* – financial support directly or through expanded reimbursement, County funded programs for specialty healthcare access and services for the low income and uninsured populations, more trauma informed healthcare and behavioral health providers that are affordable for the immigrant population and the poorest among us, co-pay assistance and lower prescription costs

    - *Primary language considerations* – increasing provider access to translation services by phone and during appointments, bilingual staff in offices

- ***Underserved populations***: The populations that were selected as most underserved were immigrants, Latinos, seniors, and low-income minorities, similar to those identified in the 2019 Community Health Assessment.

- ***Primary barriers to accessing healthcare for underserved populations*:**

    - *Lack of financial and basic resources* – having to take time off work, low income and live in rural communities, no County subsidized program for medical specialty care access, lack affordable healthcare options and ability to earn a living wage to cover basic needs

    - *Cultural/language barriers* – lack of bilingual providers and staff, limited resources for non-English speakers, limited education and language, cultural competency

    - *Access to care* – lack of access to primary and specialty care, lack of access to providers who will see patients regardless of insurance status, not enough hospital beds, not enough providers that understand the needs of the residents they serve

- *Engagement and awareness of services and resources* – lack of awareness of resources and providers, lack of knowledge and experience with innovative technology, inability of agencies to understand how to saturate the community with quality messaging that resonates and triggers action, availability of appropriate services

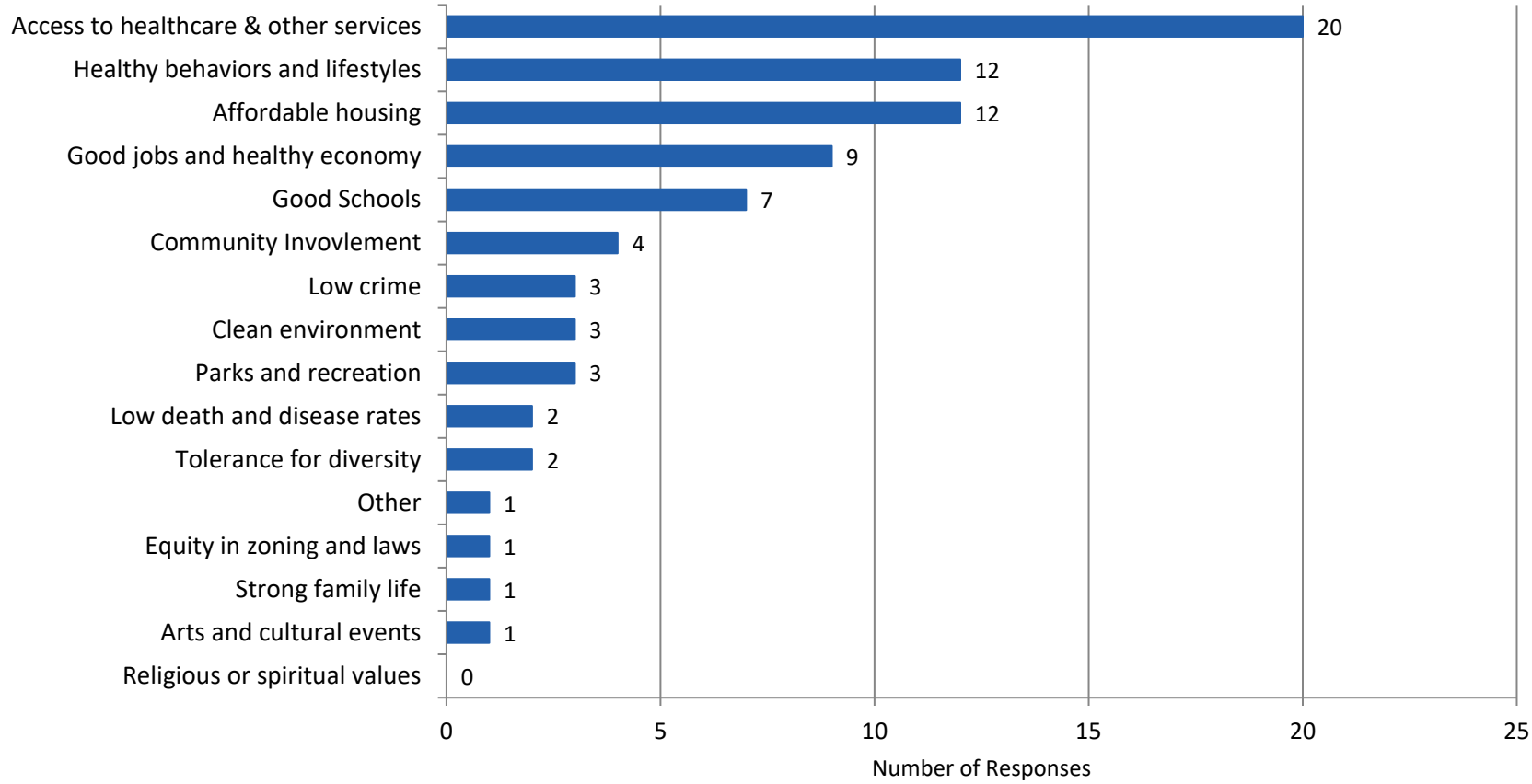
- *Lack of trust* – fear of identification consequences among the undocumented and immigrant populations, little trust in the system

- ***Recommendations to improve health:*** An increased focus on health inequities and increased communication and awareness were the most frequent recommendations to encourage and support community involvement around health issues in the county. Open-ended responses from participants included increasing and improving access to providers and clinics in the County, health education and outreach, and increase health funding.

- ***What is working well:*** Similar to the 2019 survey, participants reported that collaboration and partnerships among healthcare providers, hospitals, health department, and community-based services and programs continues to work well. Participants identified that several County agencies are contributing towards better health outcomes, with the County Health Department and Federally Qualified Health Centers (FQHCs) being mentioned the most. Programs focused on specific communities and community outreach and education were also viewed positively. As far as healthcare systems, the construction of the new hospital (UM Capital Region Medical Center) was positively mentioned by several participants, as well as the implementation of community/population health initiatives in the hospital systems.

Results

Question 1: What do you think are the **three** most important factors that define a "healthy community" (what most affects the quality of life in a community) for the community you serve in Prince George's County? (N=27 responses)

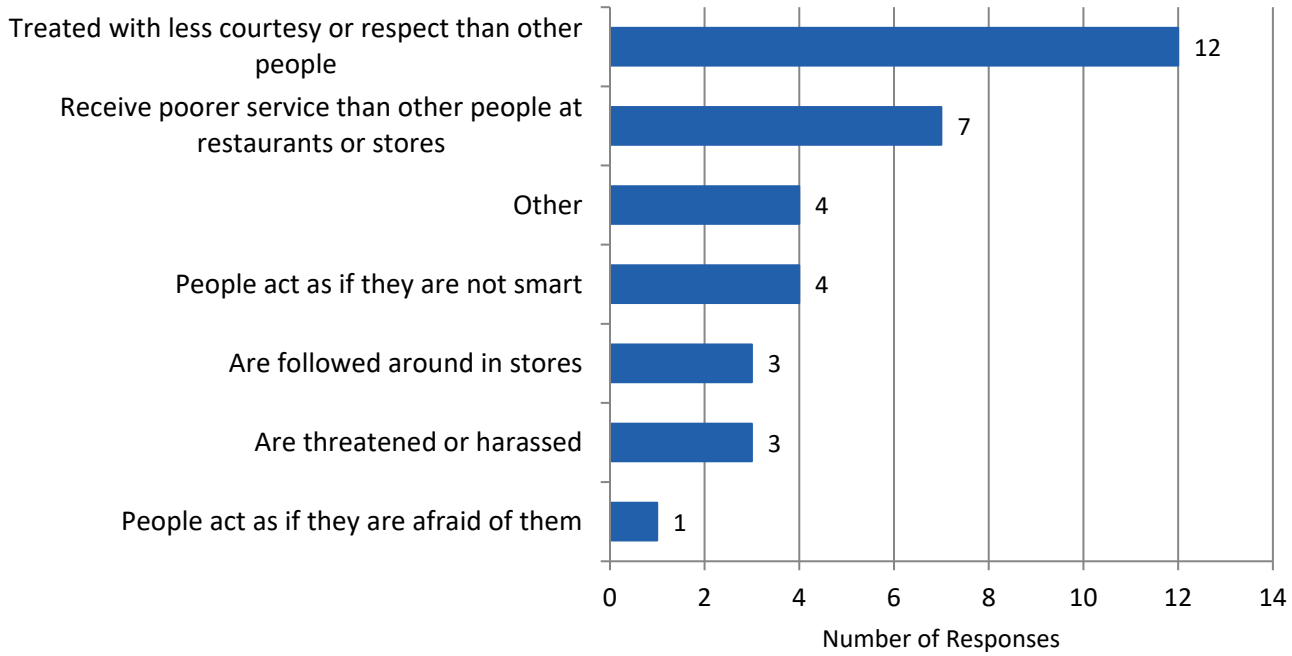


"Other" Included: improvements in collaboration between health care system and the community at large

Question 2: How satisfied do you think the Prince George's County communities you serve are with the following? (N=27 responses)

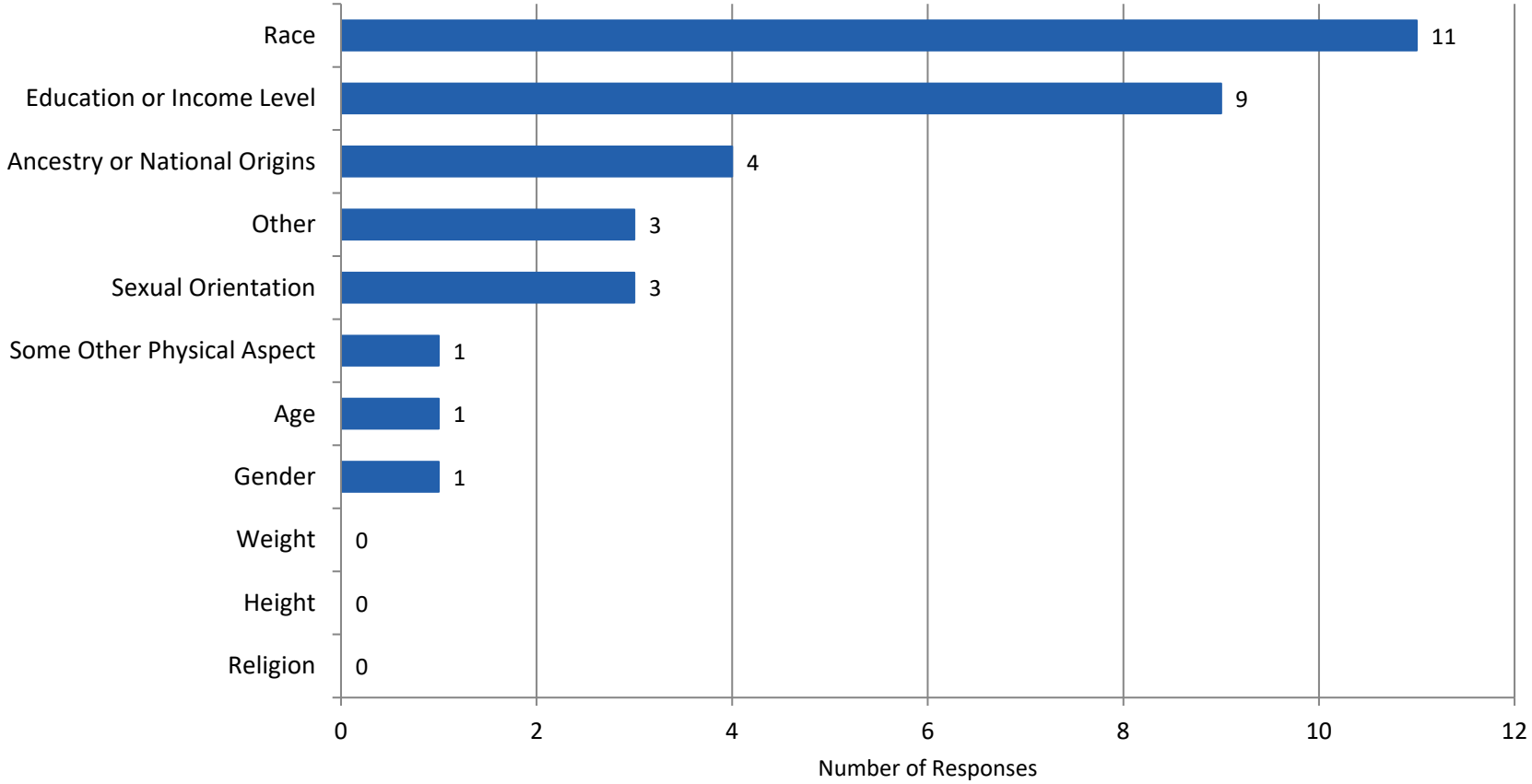
	Very Unsatisfied	Somewhat Unsatisfied	Neutral	Somewhat Satisfied	Very Satisfied
The quality of life	2 (7.4%)	4 (14.8%)	4 (14.8%)	15 (55.6%)	2 (7.4%)
The health care system	6 (22.2%)	9 (33.3%)	3 (11.1%)	9 (33.3%)	0 (0.0%)
A good place to raise children	4 (14.8%)	6 (22.2%)	7 (25.9%)	9 (33.3%)	1 (3.7%)
Economic opportunity	2 (7.4%)	6 (22.2%)	10 (37.0%)	7 (25.9%)	2 (7.4%)
A safe place to live	4 (14.8%)	6 (22.2%)	8 (29.6%)	7 (25.9%)	2 (7.4%)
The quality of the environment	2 (7.4%)	7 (25.9%)	4 (14.8%)	14 (51.9%)	0 (0.0%)

Question 3: Do the community members you serve experience any of the following at least a few times per year? (N=20 responses)



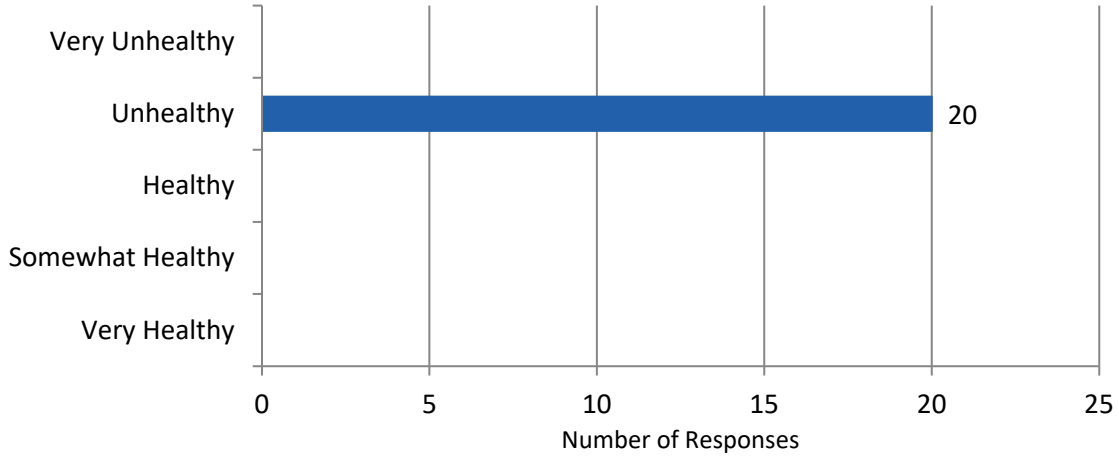
"Other" Included: Inequities in access to healthcare and education and housing, lack of access to specialty healthcare services

Question 4: If you selected any of the responses in the question above (question 3), what do you think is the main reason for these experiences? Please select all that apply. (N=20 responses)

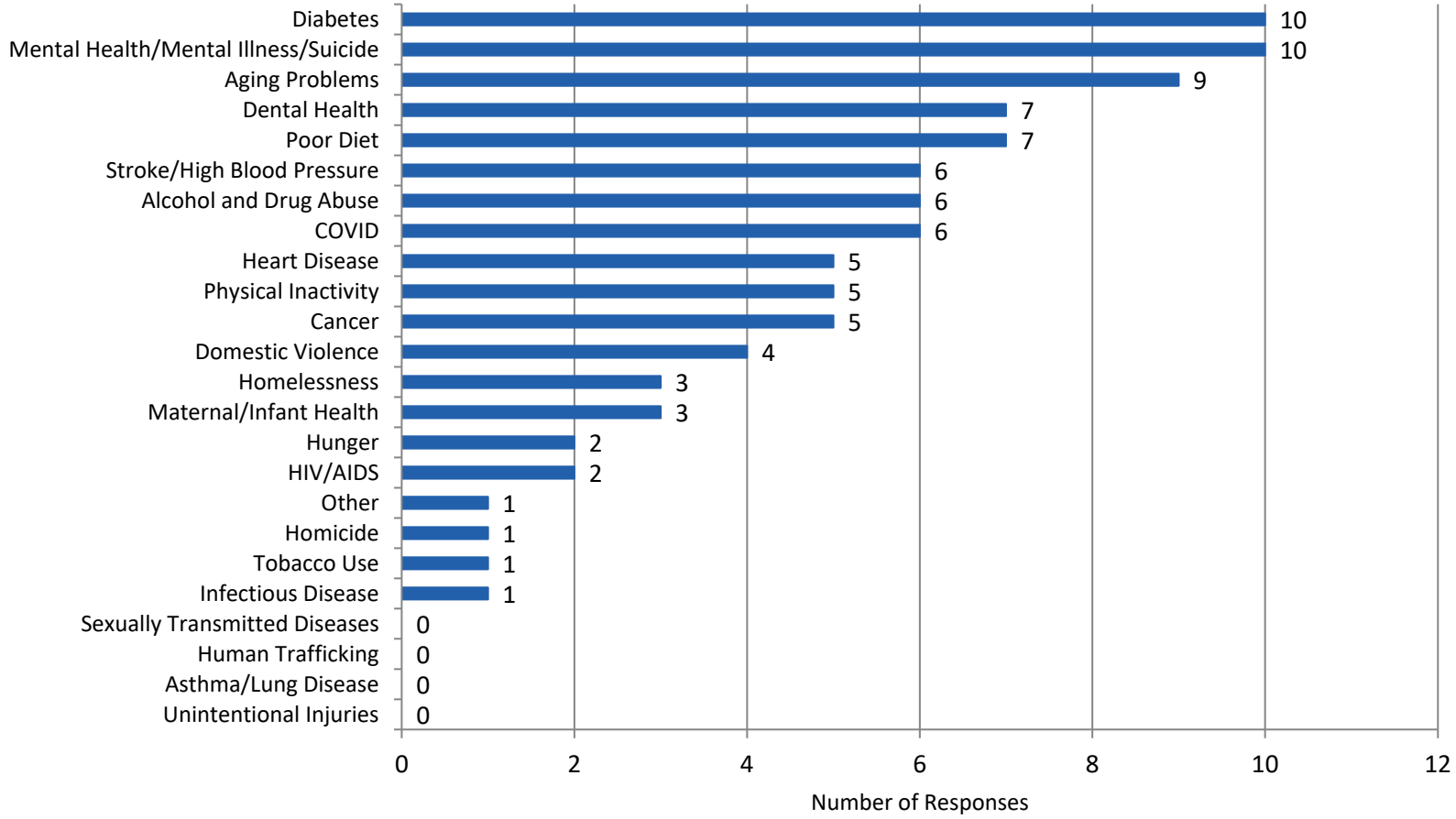


"Other" Included: ZIP code, county does not have programs to support access to specialty healthcare services for the low-income/uninsured populations

Question 5: How would you rate the overall health of the community you serve in Prince George's County? (N=20 responses)



Question 6: What are the leading health problems that impact the community you serve in Prince George's County? Please select up to five from the list below. (N=20 responses)



"Other" Included: affordable housing, financial stresses, health literacy

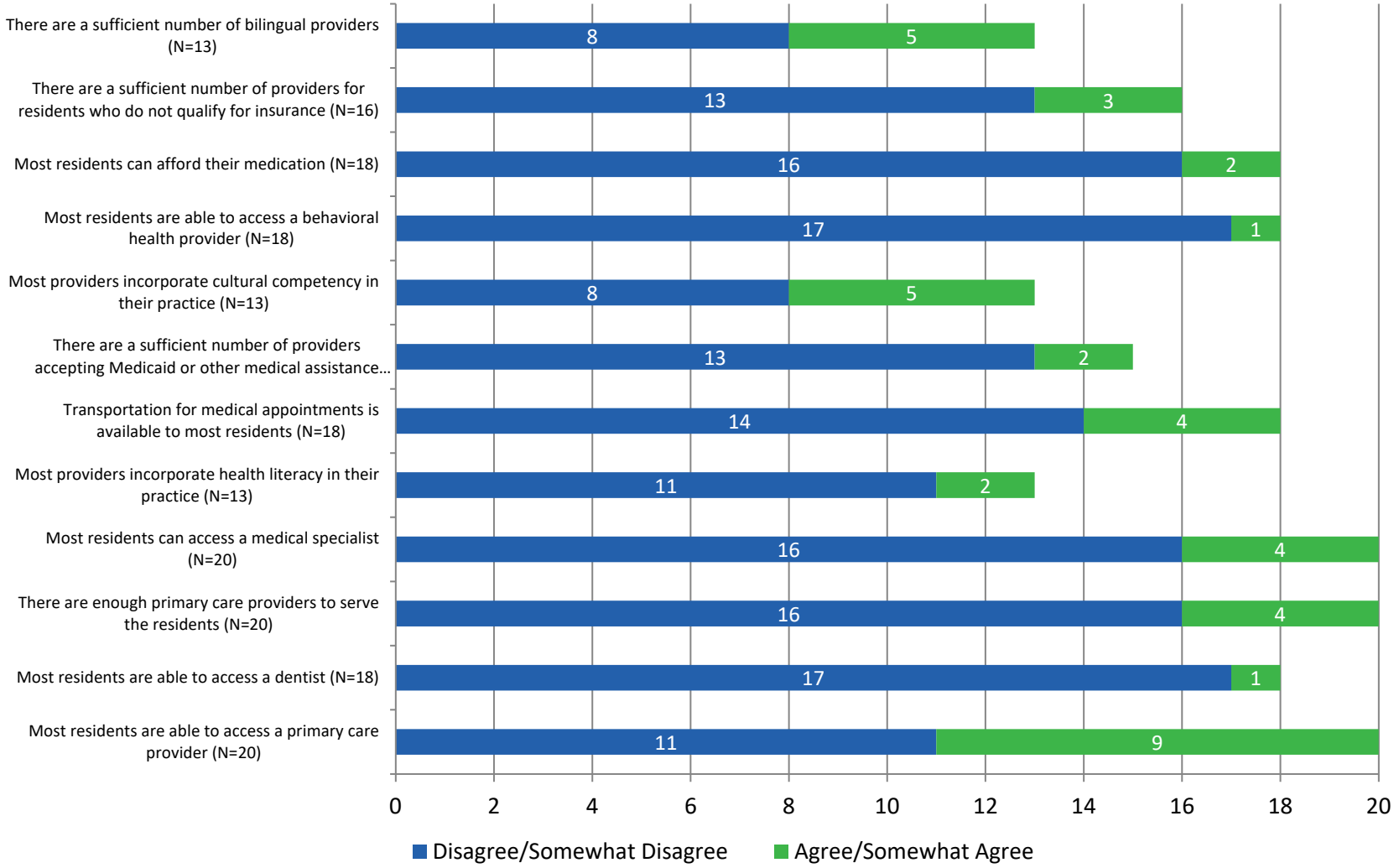
Question 7: Respondents were asked to share any additional information about health issues in the County in an open-ended response (N=5 responses). The responses are summarized in the table

Issues mentioned	Number of Responses	Summary of Responses
Specific Health Issues	3	Diabetes, dental health, stroke/high blood pressure are of highest concern. Many health issues are interrelated.
Lack of Insurance/Healthcare Challenges	1	Many residents lack insurance or are unable to afford co-pays. Challenges with navigating the healthcare system and residents don't know how to utilize services. More bilingual providers to address behavioral health issues.
Lack of Collaboration and Resources	1	Too many systems operating in silos and the lack of appropriate/adequate distribution of resources.
Lack of Affordable Healthcare	1	Community lacks affordable healthcare insurance programs for underinsured people.

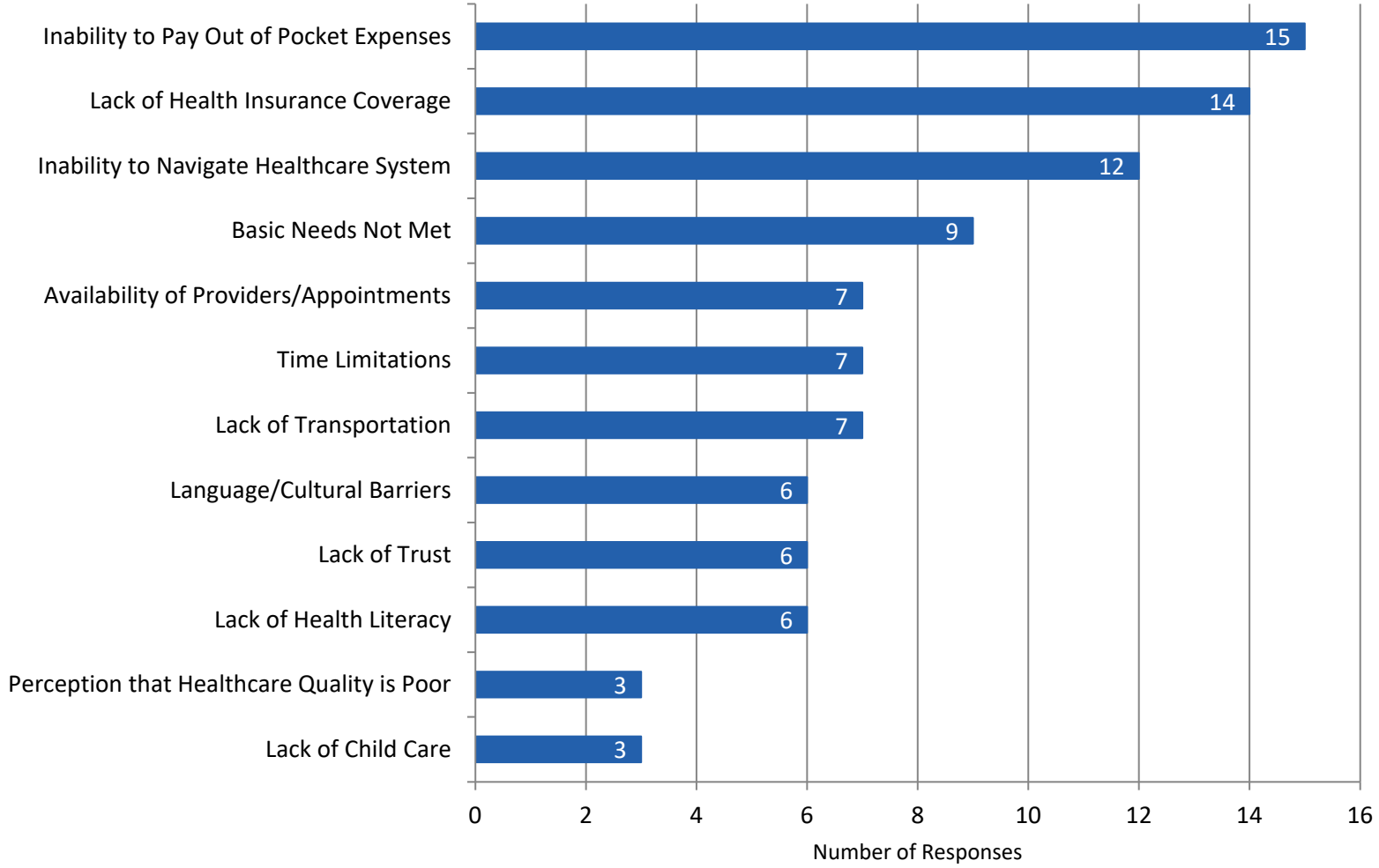
Question 8: Please rate the following statements about healthcare access in Prince George's County for the community you serve based on the scale below. (N=20 responses)

	Disagree	Somewhat Disagree	Somewhat Agree	Agree	No Opinion/ Don't Know
Most residents are able to access a primary care provider.	6 (30.0%)	5 (25.0%)	9 (45.0%)	0 (0.0%)	0 (0.0%)
There are enough primary care providers to serve the residents.	9 (45.0%)	7 (35.0%)	4 (20.0%)	0 (0.0%)	0 (0.0%)
Most residents are able to access a medical specialist.	9 (45.0%)	7 (35.0%)	4 (20.0%)	0 (0.0%)	0 (0.0%)
Most residents can access a behavioral health provider (such as for mental health or substance use treatment).	12 (60.0%)	5 (25.0%)	1 (5.0%)	0 (0.0%)	2 (10.0%)
Most residents are able to access a dentist.	9 (45.0%)	8 (40.0%)	1 (5.0%)	1 (5.0%)	1 (5.0%)
Transportation for medical appointments is available to most residents.	10 (50.0%)	4 (20.0%)	4 (20.0%)	0 (0.0%)	2 (10.0%)
Most residents can afford their medication.	11 (55.0%)	5 (25.0%)	2 (10.0%)	0 (0.0%)	2 (10.0%)
There are a sufficient number of providers accepting Medicaid or other forms of medical assistance.	6 (30.0%)	7 (35.0%)	2 (10.0%)	0 (0.0%)	5 (25.0%)
There are a sufficient number of providers for residents who do not qualify for insurance.	9 (45.0%)	4 (20.0%)	3 (15.0%)	0 (0.0%)	4 (20.0%)
There are a sufficient number of bilingual providers.	6 (30.0%)	2 (10.0%)	4 (20.0%)	1 (5.0%)	7 (35.0%)
Most providers incorporate cultural competency in their practice.	5 (25.0%)	3 (15.0%)	4 (20.0%)	1 (5.0%)	7 (35.0%)
Most providers incorporate health literacy in their practice.	5 (25.0%)	6 (30.0%)	2 (10.0%)	0 (0.0%)	7 (35.0%)

Question 8: Please rate the following statements about healthcare access in Prince George's County. (N=20 responses)



Question 9: From the list below, please select up to 5 leading barriers that keep the community you serve in Prince George's County from accessing healthcare. (N=20 responses)



Question 10: Respondents were asked to name two key resources or services that are needed to improve access to healthcare for County residents in an open-ended response (N=19 responses). The responses are grouped and summarized in the table below. Some responses included statements about multiple issues.

Key Resources	Number of Responses	Summary of Responses
More Providers and Access to Providers	8	Need for: more providers across all disciplines, need medical personnel to be at community centers and senior centers, providers who reflect the populations they serve, centers specially equipped to manage underserved populations, high speed broadband for access to telehealth, better access to mental health services, particularly for children
Affordable Healthcare/Health Insurance	7	Need for: financial support directly or through expanded reimbursement, County funded programs for specialty healthcare access and services for the low income and uninsured populations, more trauma informed healthcare and behavioral health providers that are affordable for the immigrant population and the poorest among us, co-pay assistance and lower prescription costs, provide a more robust safety net system, have social services help people with medical insurance, health insurance for all
Health Navigation, Education, and Information	5	Need for: increased community health worker capacity; increased communication, engagement, and outreach services; add health literacy to the education system beginning in middle school; county wide marketing of where to gather information
Primary Language Considerations	4	Need for: increasing provider access to translation services by phone during appointments; bilingual staff in offices
Transportation	3	Need for: more transportation; improved access to transportation
Improved Healthcare Quality	3	Need for: providers that are culturally competent; better care coordination and case management for patients; improve service quality
Basic Needs (housing, food, employment)	2	Need for: increased healthy eating options around the County, childcare

Question 11: Respondents were asked what population they think is most underserved for health-related services in Prince George's County in an open-ended response (N=20 responses). The responses are summarized in the table below.

Populations mentioned	Number of Responses	Summary of Responses
Immigrants	4	Immigrants, those with limited English proficiency
Minorities	4	Latinos, Blacks and Latinos, Black men
Low income	4	Lower income minorities, unemployed and underemployed residents, homeless individuals, and no access to a computer
Seniors	3	Seniors, African American seniors
Rural	1	Residents living in rural areas
Behavioral Health	1	Those with behavioral health
Transgender	1	Transgenders
Children	1	Children
Working class	1	Working class

Question 12: Respondents were asked what the primary barriers are for the populations listed in question 11 in an open-ended response (N=20 responses). The responses are grouped and summarized in the table below. Many responses included statements about multiple issues.

Primary Barriers	Number of Responses	Summary of Responses
Access to Care	9	Lack of access to primary and specialty care, lack of access to providers who will see patients regardless of insurance status, not enough hospital beds, not enough providers that understand the needs of the residents they serve, no County subsidized program for medical specialty care access, lack of affordable healthcare options, availability of appropriate services
Cultural/Language Barriers	7	Lack of bilingual providers and staff, limited resources for non-English speakers, limited education and language, cultural competency
Engagement and Awareness of Services and Resources	6	Lack of awareness of resources and providers, lack of knowledge and experience with innovative technology, inability of agencies to understand how to saturate the community with quality messaging that resonates and triggers action, lack of information available to understand and navigate behavioral health resources
Lack of Financial and Basic Resources	6	Having to take time off work, low income and live in rural communities, unable to earn a living wage to cover basic needs, low access to healthy foods
Lack of Trust	4	Fear of identification consequences among the undocumented and immigrant populations, little trust in the system
Lack of Insurance	3	Those ineligible for insurance will have unmet health needs, primarily undocumented immigrant populations, ineligibility for Medicare/Medicaid
Transportation	2	Need for more transportation options
Health Literacy	1	Inadequate resources to provide community-based education and healthy literacy where residents live, work, and play
Mental Health	1	Stigma of behavioral health and continuous criminalization of mental illness

Other responses: racism in all its forms

Question 13: Respondents were asked what is being done well in Prince George's County within communities to improve health and well-being and by whom in an open-ended response (N=15 responses). The responses are grouped and summarized in the table below. Many responses included statements about multiple activities and contributing organizations.

Agencies/Organizations	Number of Responses	Specific Program/Service/Action
Prince George's County Health Department	5	County Health Officer is determined to improve the quality of life and quality of healthcare for all residents, health education, COVID Cares Program, Health Assures program
Federally Qualified Health Centers	4	Variety of services under one roof - simplifying navigation for the most vulnerable
Prince George's County Parks and Recreation	1	Parks and Planning maintain a good number of community centers, playgrounds, trails, and other facilities that residents use to stay active
Hospital System	1	Building of the medical center
Prince George's County Council	1	Council members delivering food on a weekly or biweekly basis
Prince George's Department of Social Services	1	Provides excellent services to eligible residents to access health coverage
University of Maryland School of Public Health Center for Health Equity	1	Provides much needed health information to customers (i.e. barbershop & salons program)

Other organizations mentioned (without specified programs or services): Capital Area Food Bank, Brighter Bites

Some respondents listed programs and services occurring in the county without association to a specific agency or organization:

Other Areas of Action	Number of Responses	Specific Program/Service/Action
Collaboration and Partnerships	5	This community health assessment, COVID-19 response, passage of Blueprint for Excellence, educating the community about COVID-19 and getting people vaccinated, including and partnering with other organizations to improve the health of the community
Community-Based Services and Programs	5	Programs to connect qualifying residents to medical insurance, having bilingual centers and personnel to address community needs, COVID testing, hosting free healthcare events
Navigating Resources	2	Individuals doing their best to navigate the available resources they know about, sharing of resources
Healthy Lifestyles	2	Food insecurity initiatives are improving access to food for many residents, food distribution centers
Healthcare Access	2	Increasing number of providers, school-based clinics

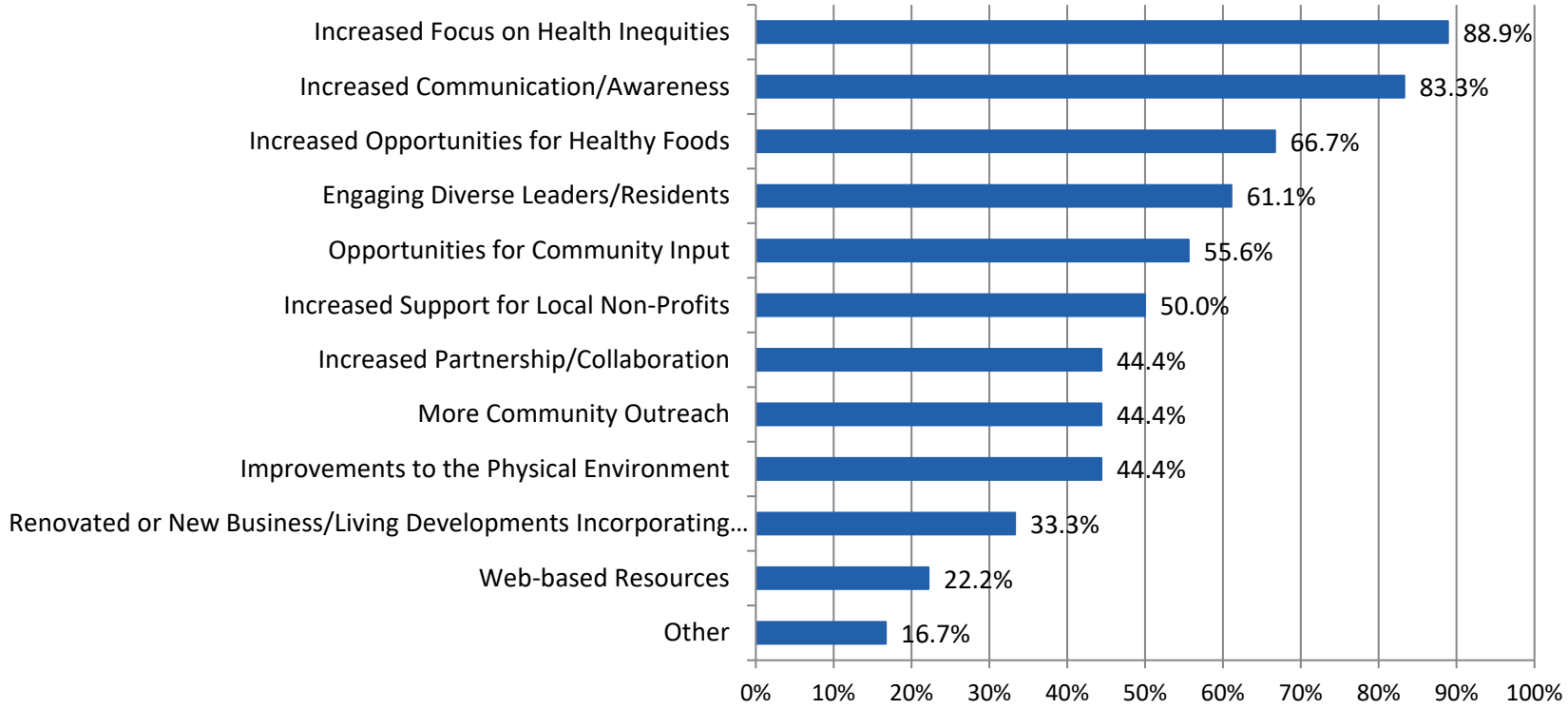
Question 14: Respondents were asked what is being done well by the healthcare systems in Prince George's County to improve health and well-being and by whom in an open-ended response (N=13 responses). The responses are grouped and summarized in the table below.

Areas of Action	Number of Responses	Specific Program/Service/Action
Improving Hospital Quality and Facilities	6	New systems in the County (Capital Region Health, MedStar, Luminus Health), improved quality of inpatient care with the new hospital, hospitals are investing more in the County, new hospital is addressing cancer and mental health, capacity expansions for the local healthcare systems, creating more facilities near public transportation
Education and Outreach	4	More advertisement in the community letting residents know of the services available to them, public notice of resources, getting information into the community, hospital community benefit programs are reaching a lot more residents based on lessons learned from COVID
Funding	2	Funding for Health Assures, Health Assures program is a start but should be amended, expanded, and retooled to address affordability, portability, and sustainability
Access to Providers and Clinics	1	Hospitals should be working closer with FQHCs to improve care, keep patients in their medical homes and out of the ER, and provide more access to specialists and diagnostics

Question 15: Respondents were asked what recommendations or suggestions they have to improve the health and quality of life in Prince George's County in an open-ended response (N=15 responses). The responses are grouped and summarized in the table below. Some responses included multiple recommendations.

Recommendations	Number of Responses	Summary of Responses
Increase and Improve Access to Providers & Clinics	8	Identify and eradicate barriers to establishing healthcare practices in the County, increased number of providers and beds with a greater need to expand certain specialties such as behavioral health providers, reduce the number of residents who resort to using emergency medical services or emergency departments for non-emergency matters, work to decriminalize behavioral health and implement a 911 diversion program for residents with behavioral health concerns, improve access to primary care appointments and scale, expand school-based clinics; more services to the northern part of the County
Health Education, Outreach and Navigation	4	Help residents navigate healthcare in the County through a centralized user-friendly hub of terminology and community resources, cultural competency, integrate health literacy in schools, appeal personally to residents
Increase Public Health and Healthcare Funding	4	Develop a clear vision for the Health Department and provide necessary funding, increase salaries to be more competitive to avoid turn over in the health department and social services agencies, use community benefit money to sustain innovations emerging from the pandemic response, advocate for a more robust program that include funding for specialty care and medications
Affordable Healthcare	3	Continue funding and expanding services/programs for those who cannot obtain care through insurance, assisting residents with or without insurance at a reasonable rate, universal insurance program
Basic Needs	3	Improve social economic conditions so all residents have access to a living wage, affordable housing, healthy food, education, and transportation, address food insecurity, look at a holistic approach that includes a living wage so they can afford healthcare in addition to rent, childcare, and food
Collaboration	2	Link clinical and social care, bring the entire system together in collaboration instead of working in silos
Support Healthy Lifestyles	2	Improve access to healthy food for all residents, healthier eating and food options
Community Engagement	2	Engage community members to fight for and demand more resources to improve the health care system, engagement from schools, churches, municipalities, and civic associations

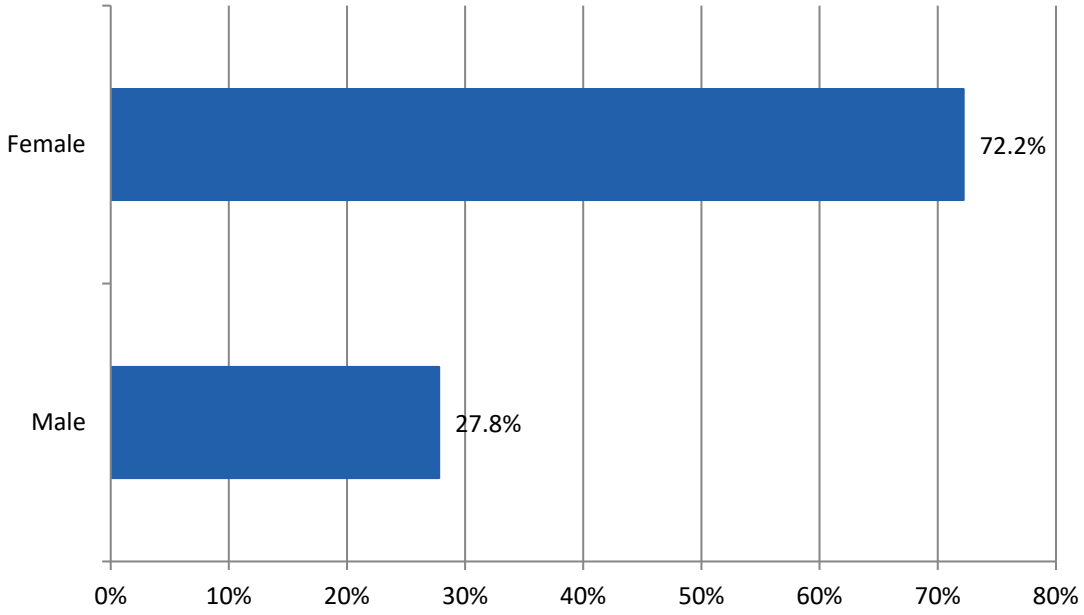
Question 16: What do you think could encourage and support more community involvement to improve health and well-being in Prince George's County (select all that apply)? (N=18 responses)



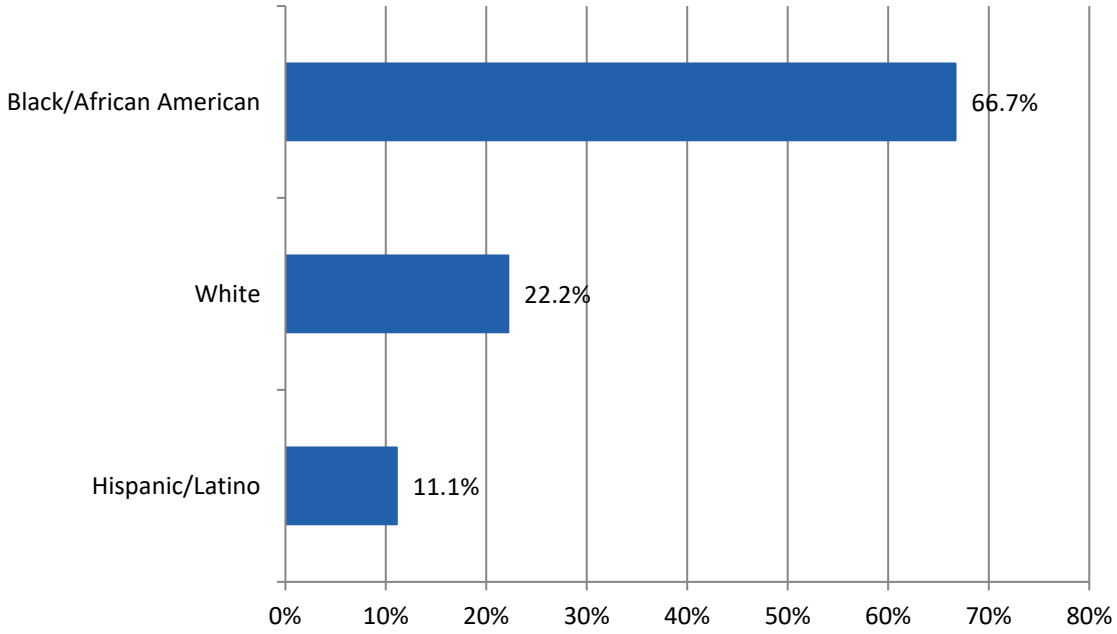
"Other" Included: all tactics would improve the health and well-being of residents, keep up with the Zoom Townhalls and working groups, pay the full amount it would take to fully fund Assures year-round as the Universal Primary Care program is retooled to address affordability, portability, and sustainability

Participant Profile

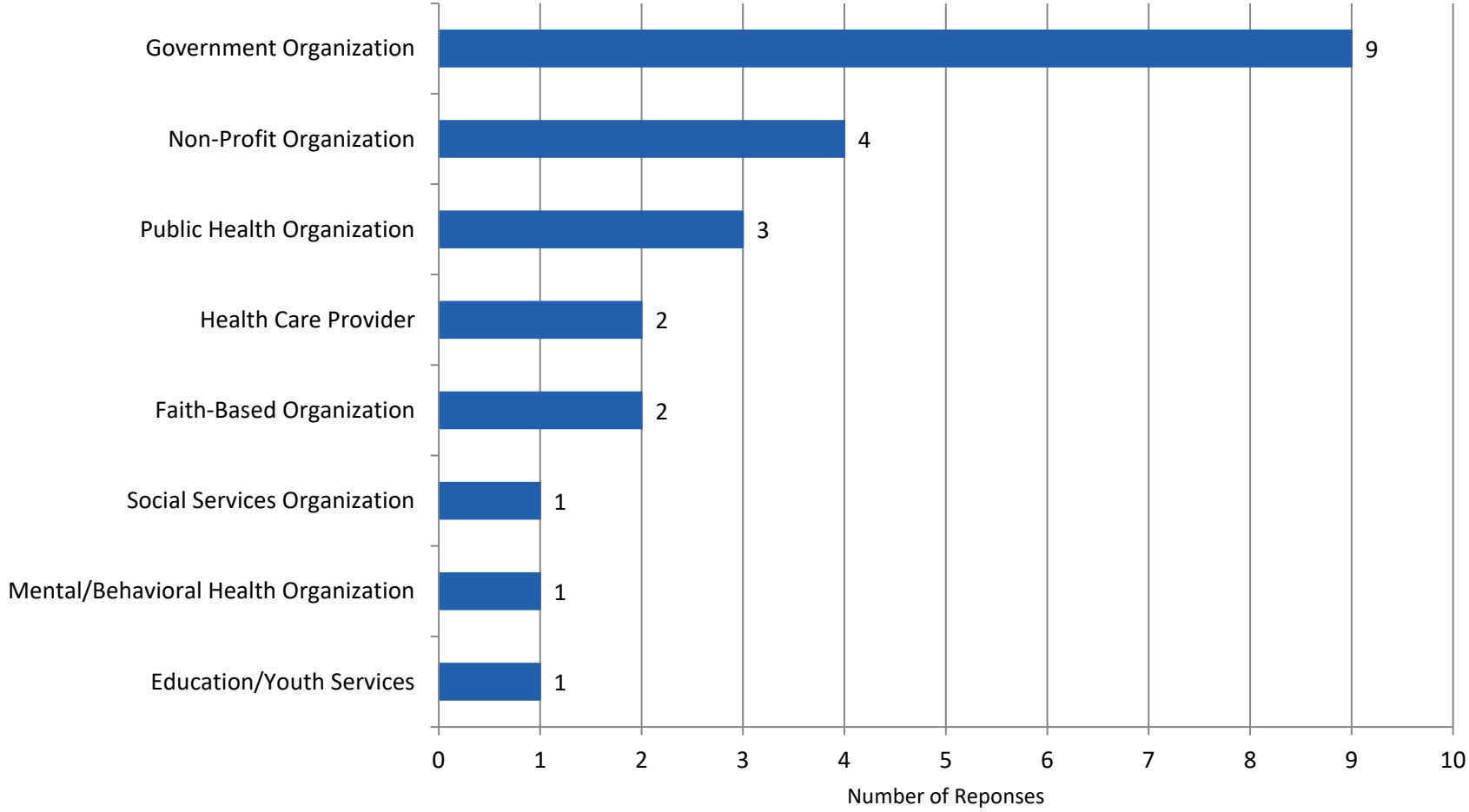
Question 18: What is your gender (N=18 responses)



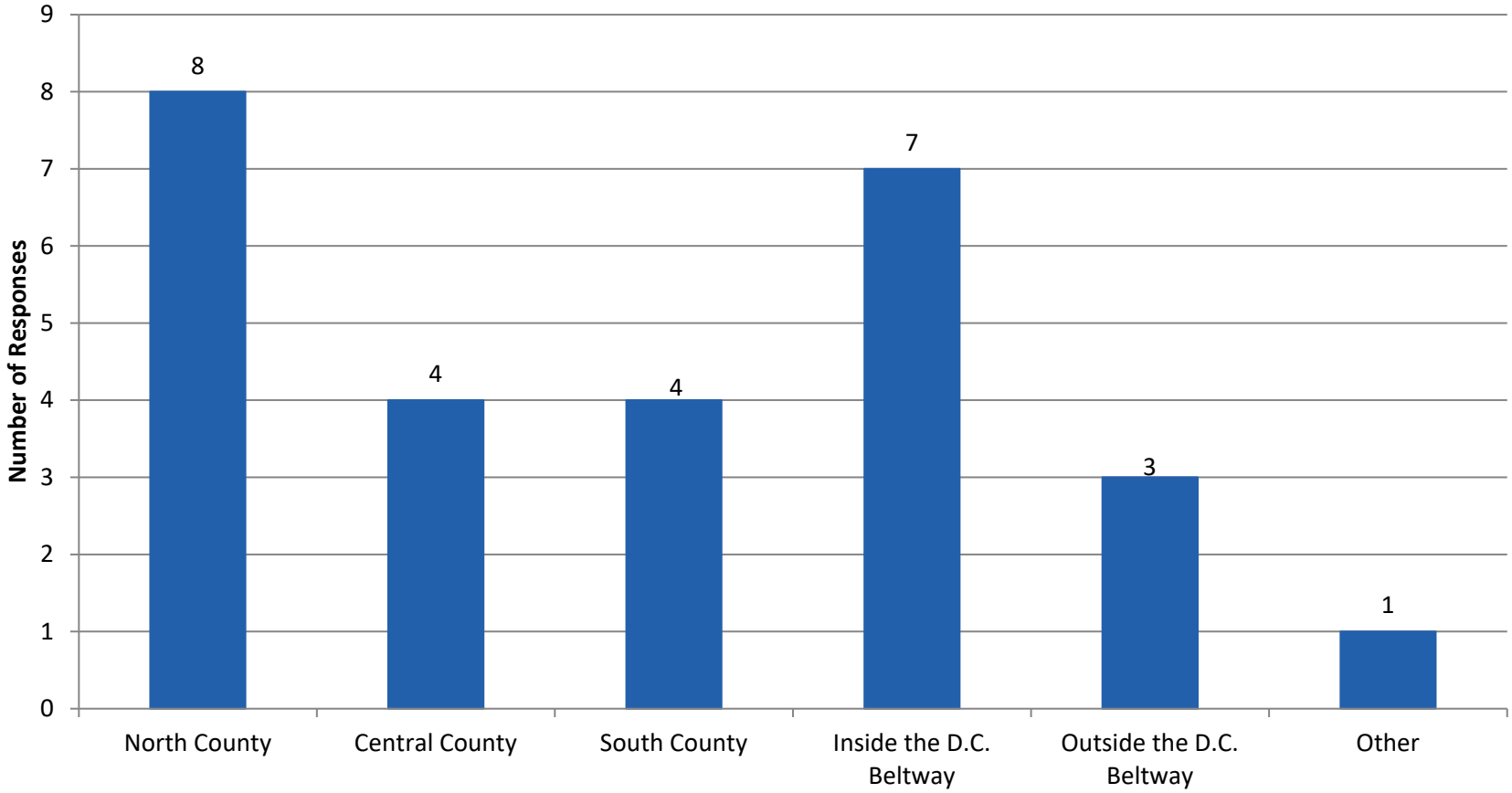
Question 19: What race/ethnicity best identifies you? (N=18 responses)



Question 20: Which of these categories would you say best represents your community affiliation? Participants were asked to select all that apply. (N=18 responses)

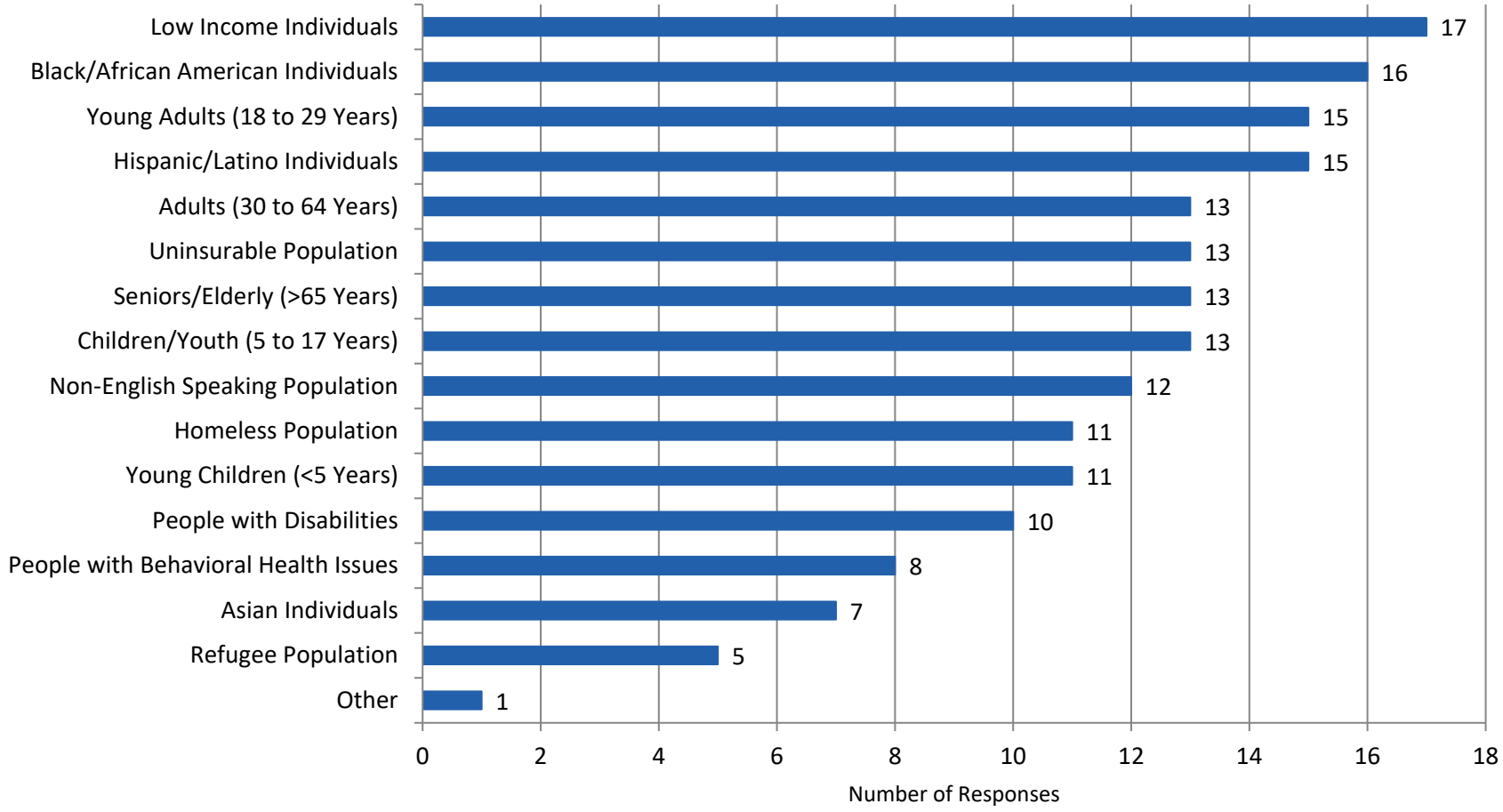


Question 21: In what geographic part of Prince George's County are you most knowledgeable about the population? Participants were asked to select all that apply. (N=18 responses)



"Other" included: knowledge across the entire County

Question 22: Please indicate the populations you serve or represent in Prince George's County through either personal, professional, or volunteer roles. Participants were asked to select all that apply. (N=18 responses)

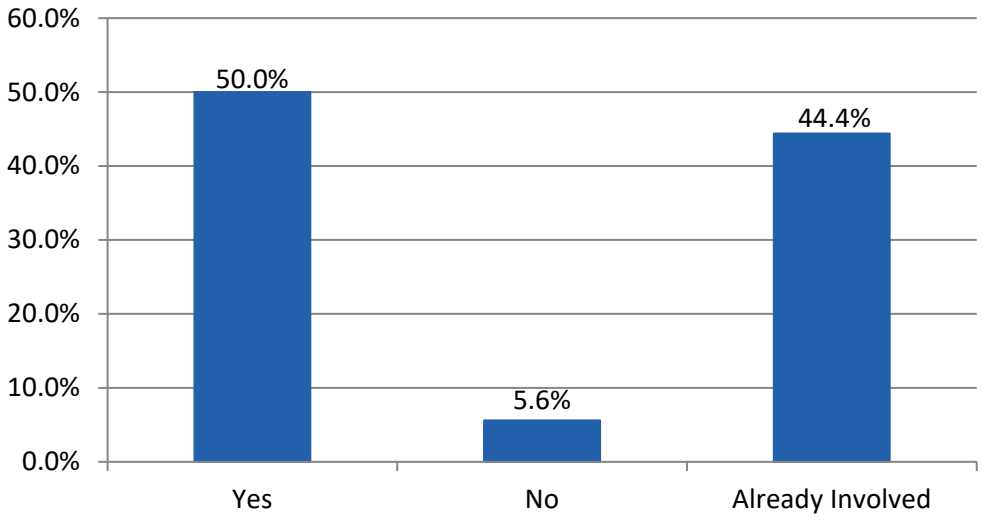


"Other" included: all the above

Question 23: Respondents were asked to share the most pressing needs of the populations they serve based on their experience (N=18 responses). The responses are grouped and summarized in the table below. The majority of these responses reiterated information that had already been provided in previous questions.

Additional Information	Number of Responses	Summary of Responses
Basic Needs	9	Improving the health and well-being and overall quality of life for County residents, ensuring all residents have access to a living wage, affordable housing, healthy food, education, and transportation, support to those experiencing homelessness
Healthcare Access	8	Increase number of providers and beds, behavioral health; over-reliance on emergency services, improved access to primary care, lack of access to medical specialty care
Healthy Environment	5	Lower crime, healthier food options, fewer liquor and tobacco stores, and higher paying jobs in the area, accessibility of healthy lifestyle practices (parks, trails, pools, etc.), managing the social needs that ultimately exacerbate overall physical and mental health status
County Services and Funding	4	Crisis response, services for the most vulnerable populations, additional funding for social programs, funding for specialty care and medications
Affordable Healthcare	4	Healthcare affordability, health insurance
Health Literacy and Health Education	2	Cultural competency, health literacy education
Cultural and Language Considerations	2	Education for Spanish population on services, support, and working on the gap for trust, people do not trust the system
Immigration Issues	2	Legal status, re-entry services
Better Education Outcomes	1	Lack of education
Care coordination and information	1	Resources and options

Question 24: Would you be interested in becoming more involved in local health initiatives? (N=18 responses)



RESIDENT
survey

COMMUNITY RESIDENT SURVEY

Introduction

Prince George's County is home to over 967,000 residents and growing, with a wide range of health needs and disparities. The Community Resident Survey was a strategy developed to complement the overall Community Health Assessment (CHA) goal of identifying the health needs and issues for the County's diverse population by hearing directly from our residents.

Methodology

The 2022 Community Resident Survey was modified from the 2019 Community Resident Survey, with any adaptations based on the Community Health Status and Assessment recommendations of the Mobilizing for Action Through Planning and Partnerships (MAPP) framework[1]. Efforts were made to ensure the survey questions corresponded with the Community Expert Survey, another key assessment of the MAPP framework. The survey questions included mostly multiple choice and rating scales with a few open-ended responses for demographics and an option for writing in a response if the participant answered with "other."

The survey was translated into Spanish (the most common language spoken in the County after English) and was made available online and through printed copies. Due to time limitations, the survey was distributed as a convenience sample. The Health Department made the survey available by website, social media, and through provided services at department locations; the survey link was also posted electronically by the County government. Survey distribution began in March 2022 and ended on May 11, 2022.

For analysis, each multiple choice and rating scale question is presented as a simple descriptive statistic. Because the surveys were collected as a convenience sample, the results were intended as an additional method of gaining community input in support of the overall process, while acknowledging the lack of an adequate sample size to statistically represent the County. Responses from the English survey were excluded if the participant indicated they were not a County resident or if residency information was completely missing to make that determination. All responses in the Spanish surveys were included in the final analysis, regardless of residency information; the results are presented separate from the English responses for most questions. Each question includes the number (N) of responses.

[1] https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

Participation

Surveys were completed by 118 participants: 106 in English and 12 in Spanish. Nearly all areas of the County were represented by the participants except for some of the most southern part of the County (a map of representation is available with Question 19). Over four-fifths of survey participants were female, which is higher than the County. However, survey participation by race and ethnicity was similar to the County population. Spanish survey participants were younger and all between the ages of 25-44 years, while English survey participants were more evenly distributed by age. Over 70% of all survey participants had a college degree or higher; however, 80% of the Spanish survey participants did not have higher than a high school degree. Although English survey participants reported a wide range of annual household incomes, all Spanish participants reported an annual household income of less than $49,999.

Key Findings

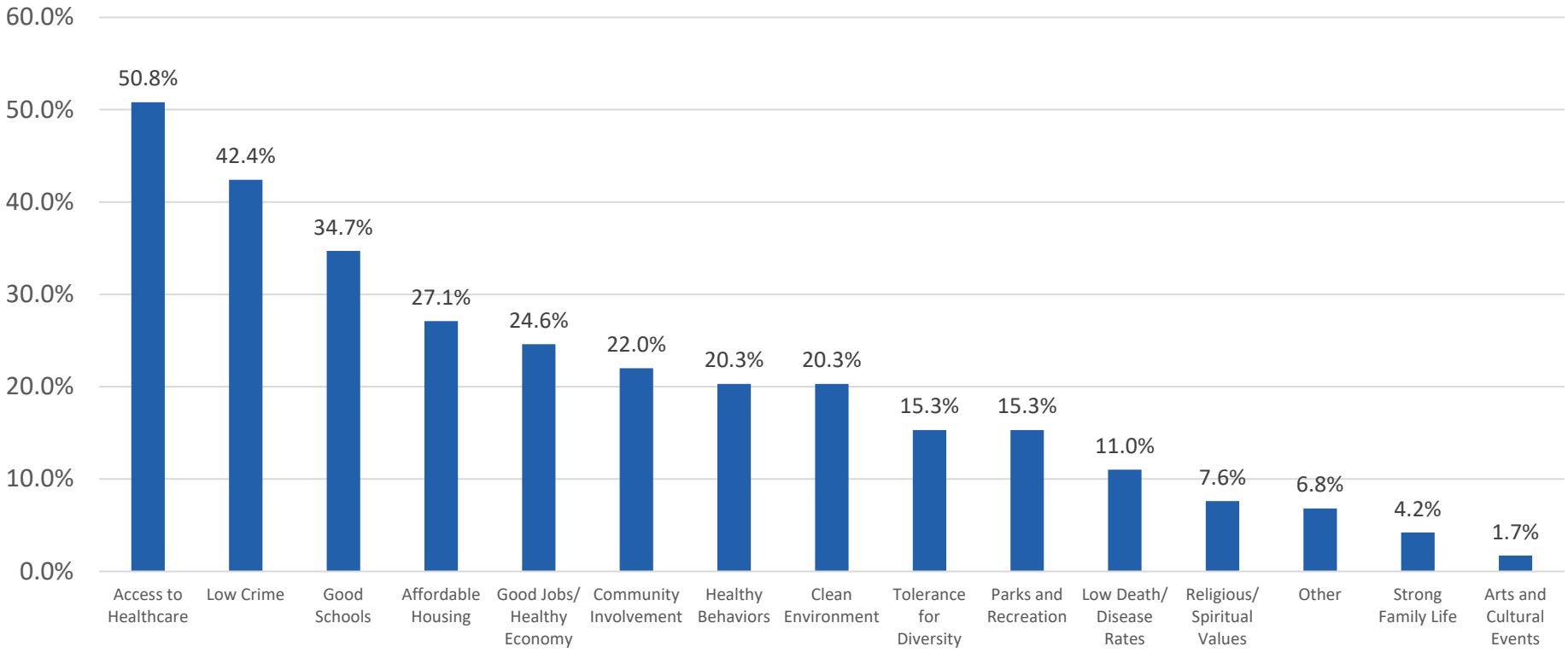
- ***Healthy Community***: Over half of all survey participants said that access to healthcare was one of the most important factors defining a "healthy community," followed by low crime, good schools, and affordable housing. Spanish survey participants also considered good jobs/healthy economy as one of the most important factors, while English survey participants said community involvement and healthy behaviors also defined a healthy community. Compared to the 2019 survey, low crime and affordable housing were leading indicators of a healthy community, while in the 2019 survey good jobs and a healthy economy were of higher importance. Four-fifths of all survey participants reported that parks were the places they went most frequently in Prince George's County, followed by libraries and rivers/lakes/woods.
- ***Community Determinants of Health:*** Almost half of survey respondents (48.1%) agreed that their community has easy access to fresh fruits and vegetables; however, this was much lower (37.5%) among the Spanish participants. Over half (60.4%) of English and 87.5% of Spanish survey participants disagreed or somewhat disagreed that there is enough affordable housing in their community, higher than the 2019 survey. Spanish survey respondents were more likely (87.5%) than English survey respondents (32.6%) to disagree or somewhat disagree that their community was safe with little crime.
- ***Discrimination:*** Over 30% of all survey participants reported that a few times a month or more they are treated with less courtesy or respect than other people. Notably, 100% of Spanish survey participants reported this happening a few times a month or more, compared to just 25% of English survey participants. Nearly 16% of English survey participants and 57% of Spanish survey participants reported receiving poorer service than other people at restaurants or stores a few times a month or more. When asked about the main reason for these experiences, nearly 60% of all participants reported their race as a reason followed by their gender (33%). Ancestry and age were also listed as main reasons for these experiences by over 20% of all participants.
- ***Leading health issues***: COVID-19, mental illness, and diabetes, as well as substance use (alcohol, drug, and tobacco) led as the major health problems identified by survey

participants. For Spanish survey participants, homelessness and homicide were also identified as leading issues while for English survey participants aging problems and poor diet were identified.

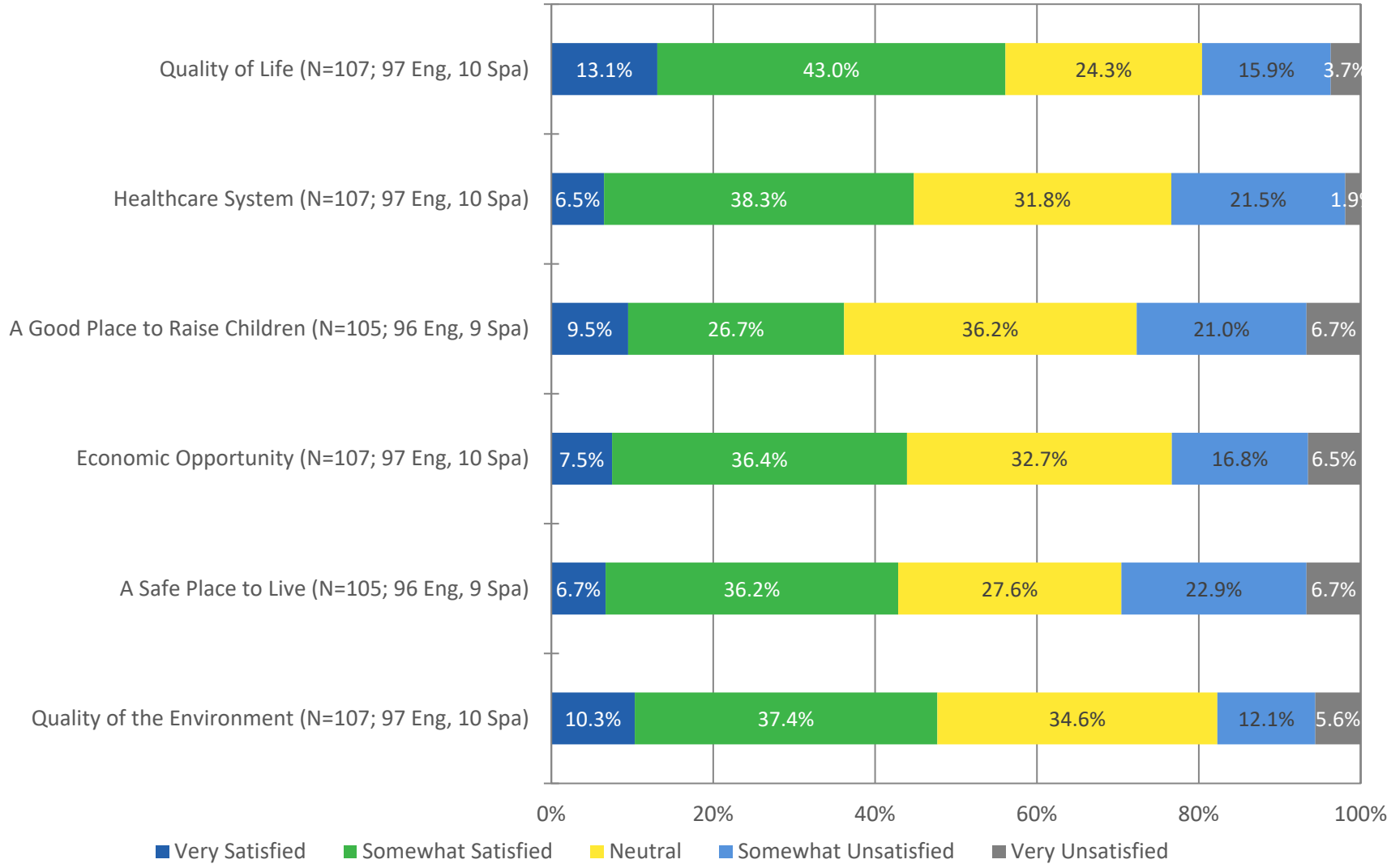
- ***Access to healthcare***: Over 65% of English survey participants and 80% of Spanish survey participants agreed or somewhat agreed that residents in their community could access a primary care provider, slightly higher compared to 2019 survey responses. However, less survey participants agreed or somewhat agreed that there are enough providers for the number of residents in their community, that most residents are able to access medical specialists in their community and that most residents can access a mental health provider in their community. Although 55% of English survey participants said most residents in their community could access a dentist, only 20% of Spanish survey participants felt the same. More participants disagreed or somewhat disagreed that most residents can afford their medication in their community.
- ***Leading barriers****:* Overall, lack of money for co-pays and prescriptions, time limitations, and lack of health insurance coverage were indicated as the leading barriers to accessing healthcare in the County. For English survey participants, 56% also reported that lack of childcare was a major or moderate problem, while over three quarters (80%) of Spanish survey participants reported lack of transportation as a barrier to accessing care.
- ***Health Care:*** Overall, 79.8% of survey participants reported having some type of insurance and most (92.1%) reported seeing a primary care doctor in the past year. However, among the Spanish survey participants, 60% did not have health insurance and 20% did not see a primary care doctor in the past year. Almost 20% of both English and Spanish survey participants reported being unable to access needed medical care in the past year, primarily due to the wait time being too long. Lack of transportation and childcare were also barriers for those unable to get care in the past year.
- ***Health Communication:*** Both English (94%) and Spanish (80%) survey participants said that doctors were the most trusted source of health and lifestyle information in their community. Following doctors, English participants reported health screenings (57.8%) as trusted sources of health information, followed by counseling. Spanish survey participants said that health fairs were trusted sources of health information (40%) followed by phone counseling. Regarding the dissemination of health information, both English participants (73.8%) and Spanish participants (80%) were most likely to prefer e-mail. Following this nearly half of overall participants preferred to receive health information in person or through a website. For Spanish survey participants, two-thirds indicated they preferred texting.
- ***Recommendations to improve health:*** Overall, all survey participants recommended increased communication and awareness followed by increased focus on health inequities to encourage and support more community involvement around health issues in Prince George's County. Among Spanish survey participants, an increased number of healthcare practitioners and more community-specific outreach were also important factors in community health.

Results

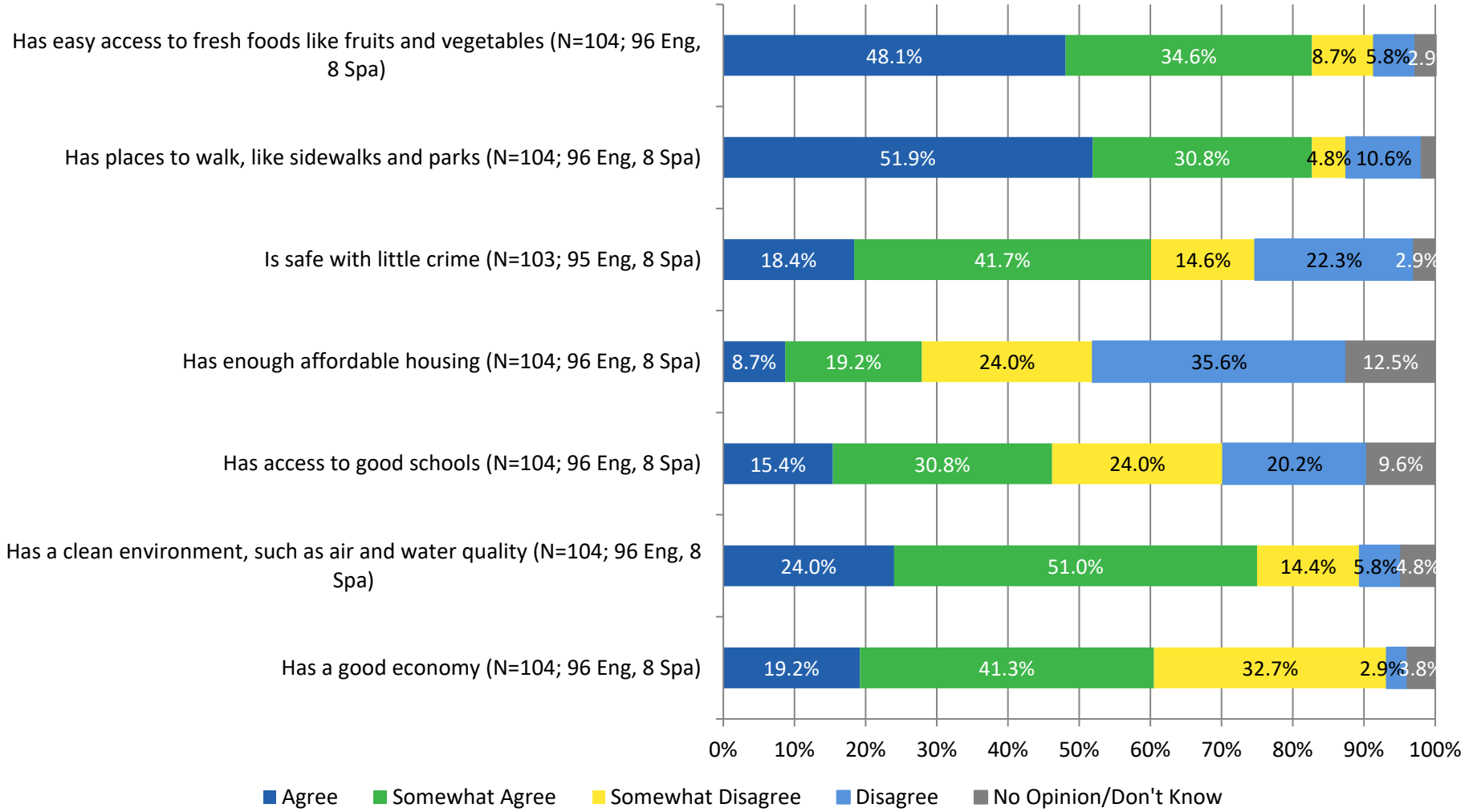
Question 1: What do you think are the three most important factors that define a “Healthy Community” (what most affects the quality of life in a community)? (N=118 responses; 106 English, 12 Spanish)



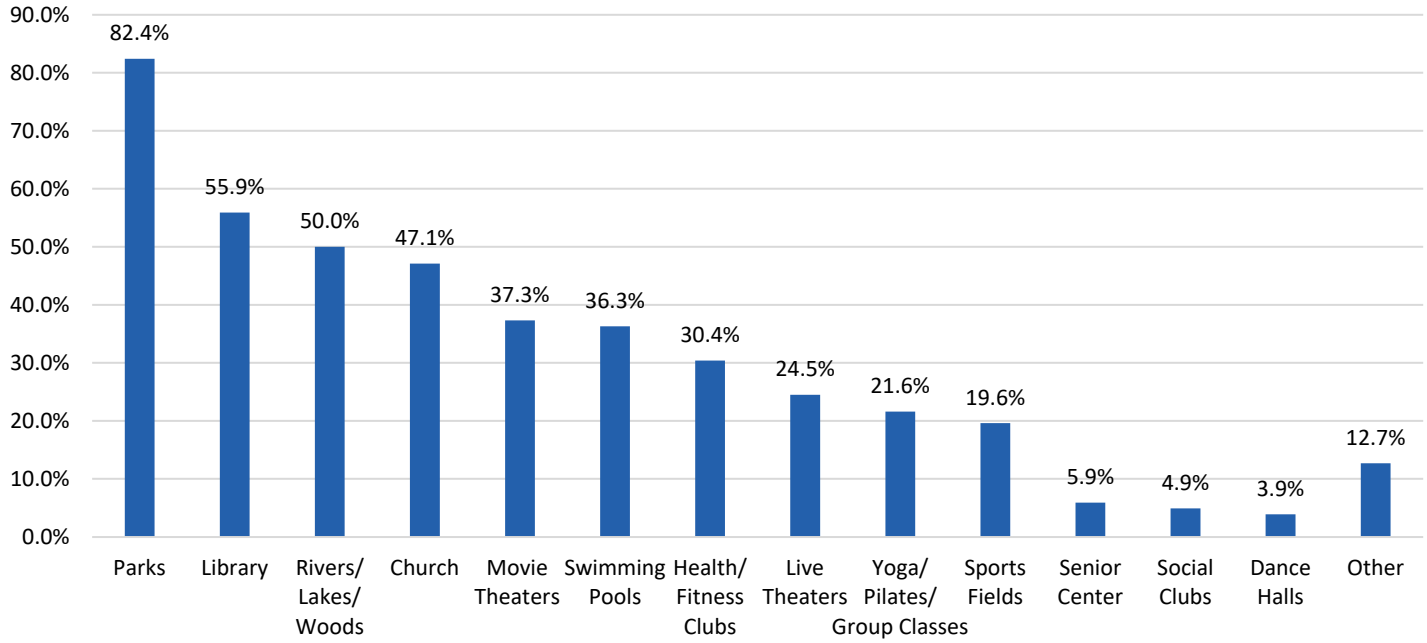
Question 2: How satisfied are you with the following in Prince George's County?



Question 3: Please rate each of the following statements for your community.

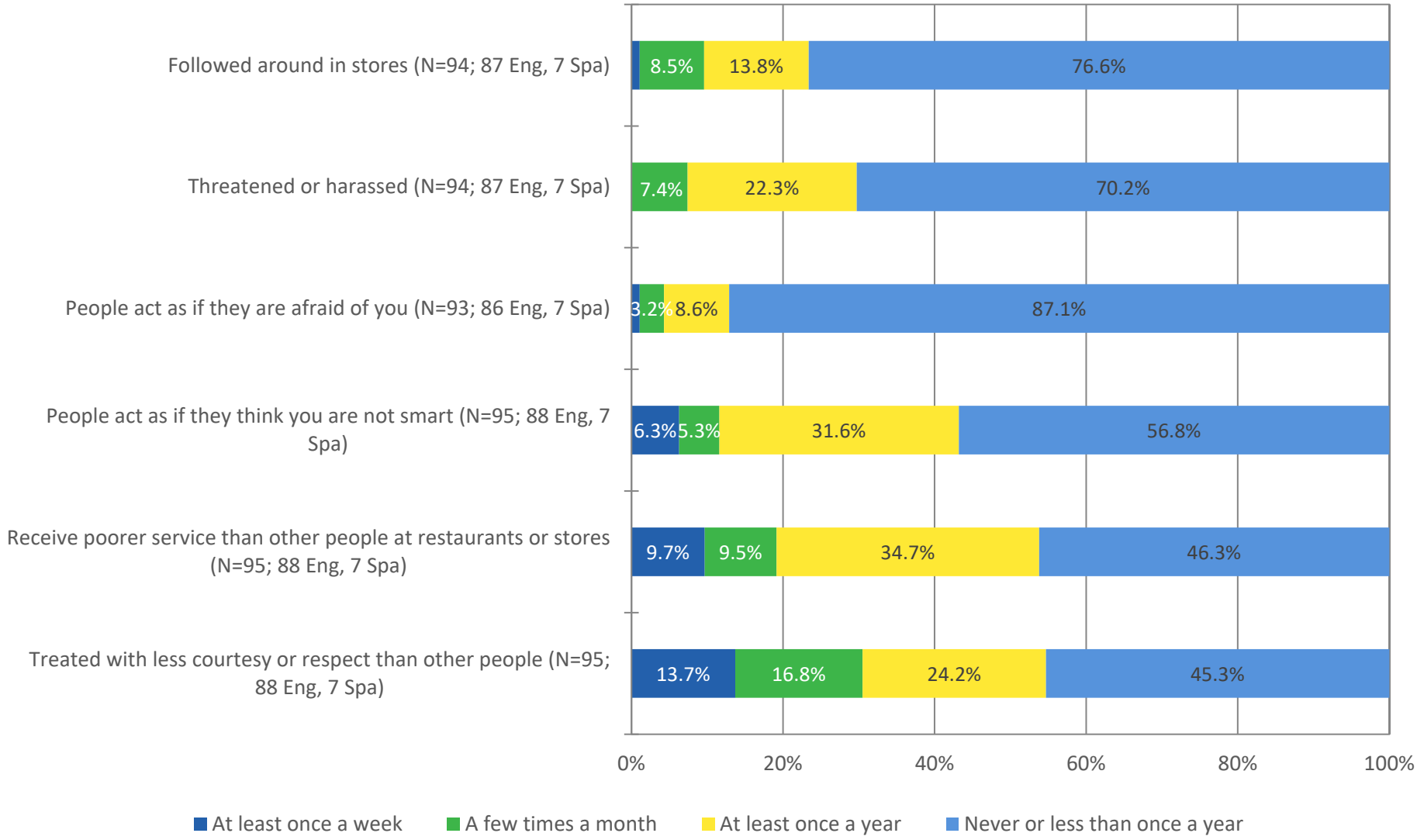


Question 4: The places where I go in my community most often in Prince George's County are (select all that apply). If you changed your activities due to COVID, please include the places you are likely to return to in the future. (N=102 responses; 95 English, 7 Spanish)

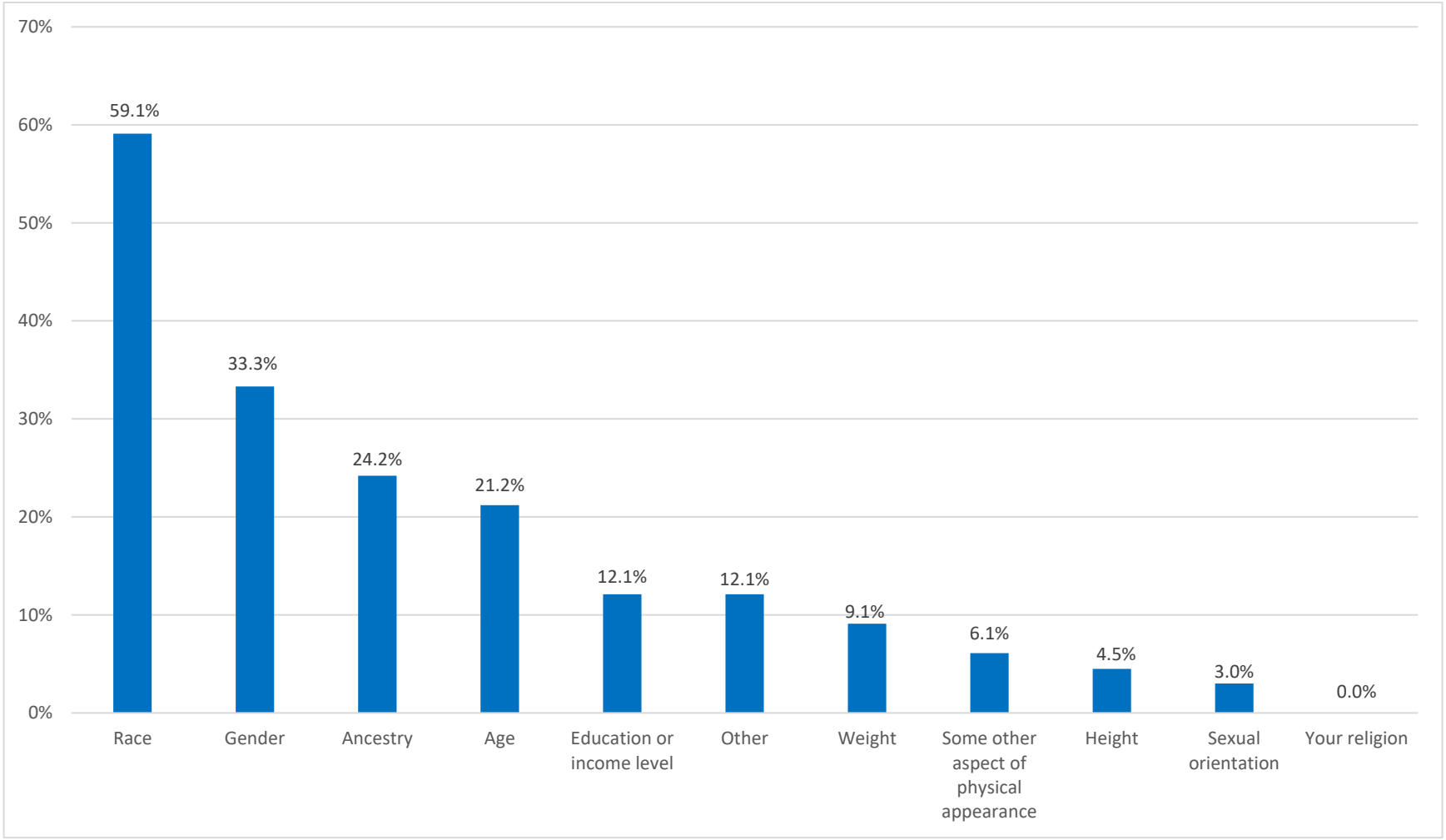


"Other" included**:** restaurants, grocery store, work, community center, ice skating, gymnasiums, markets, malls, tennis courts, recreational centers

Question 5: In your day-to-day life, how often have any of the following things happened to you?

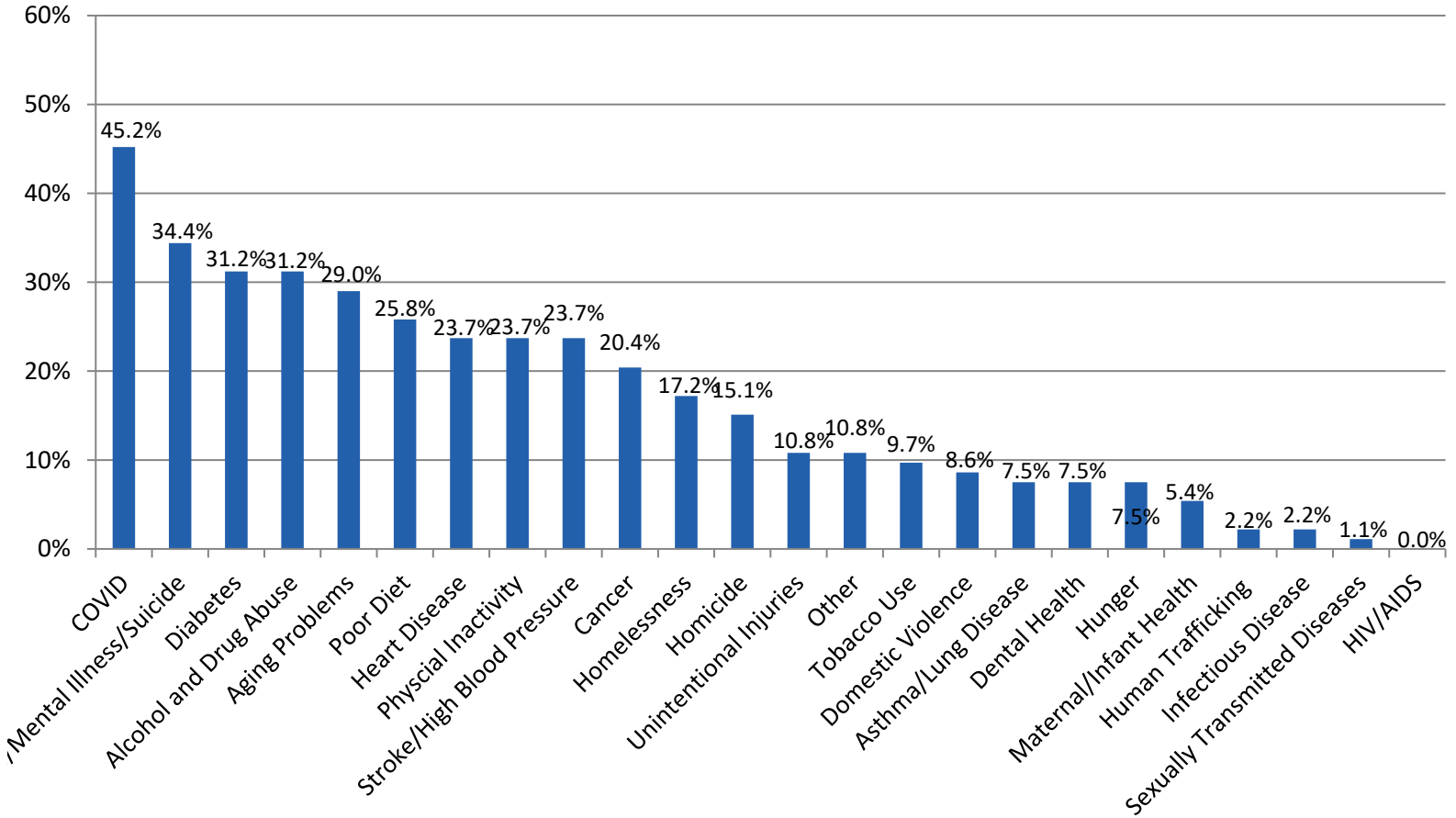


Question 6: If you answered at least once a year or more for any question above (in question 5), what do you think is the main reason for these experiences? Please select all that apply. (N=66 responses; 60 English, 6 Spanish)



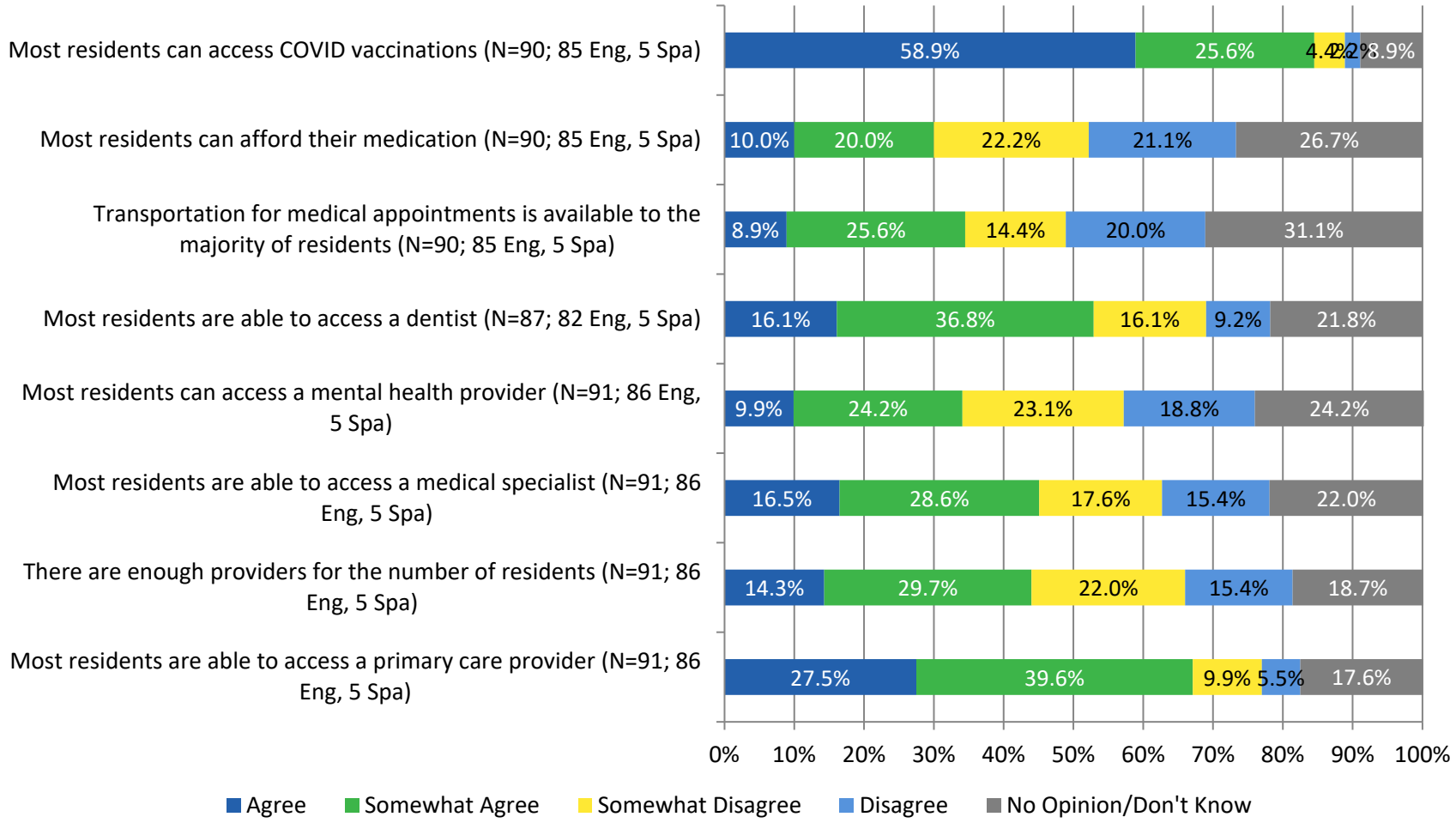
"Other" included**:** obliviousness, people having a bad day, ignorance, and I don't know

Question 7: What are the leading health problems that impact your neighborhood or community? Please select up to five from the list below. (N=93 responses; 87 English, 6 Spanish)

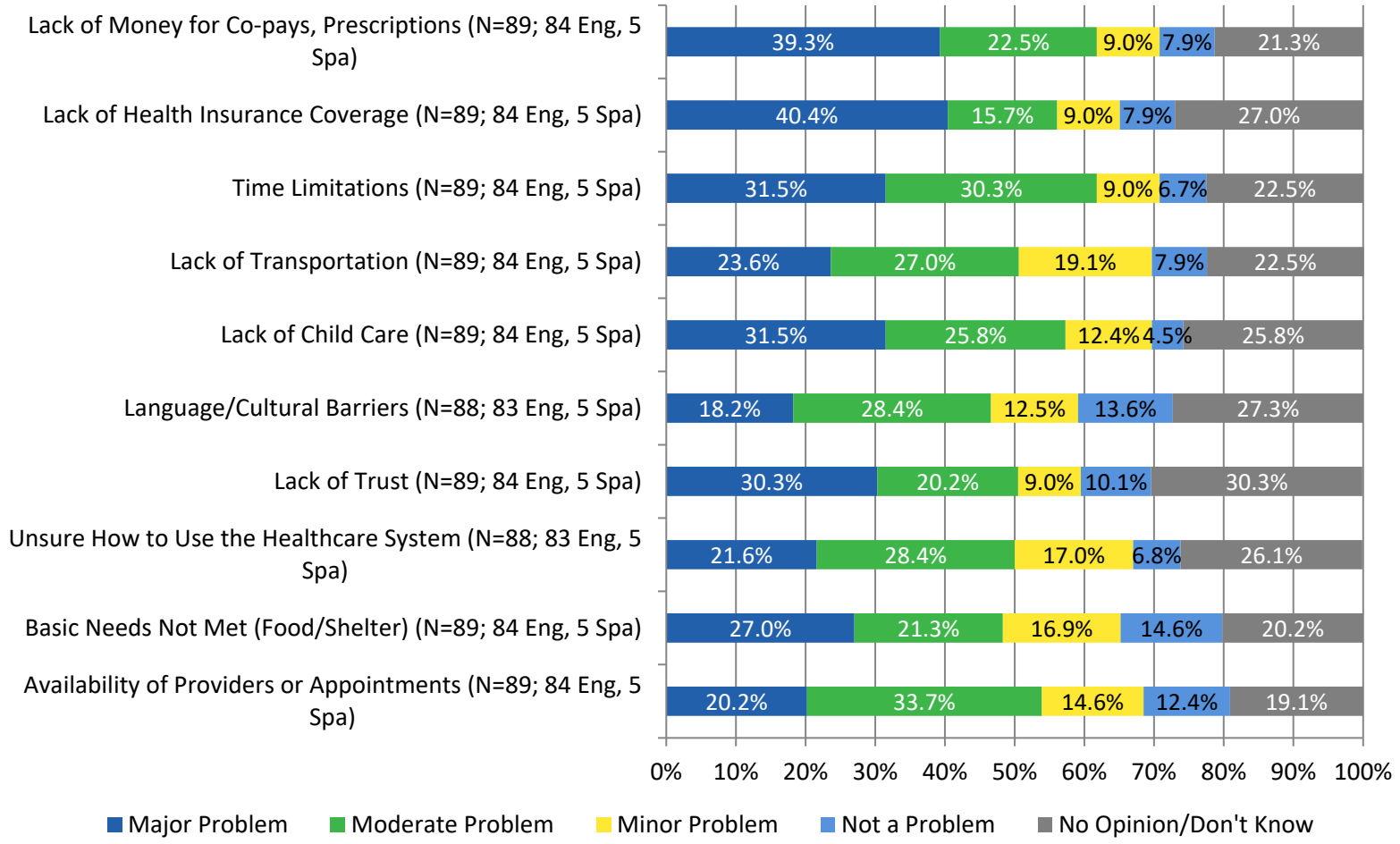


"Other" included**:** need more transportation, marijuana use, Isolation, lack of access to healthy and nutritious foods at local restaurants, crime, and chronic kidney disease

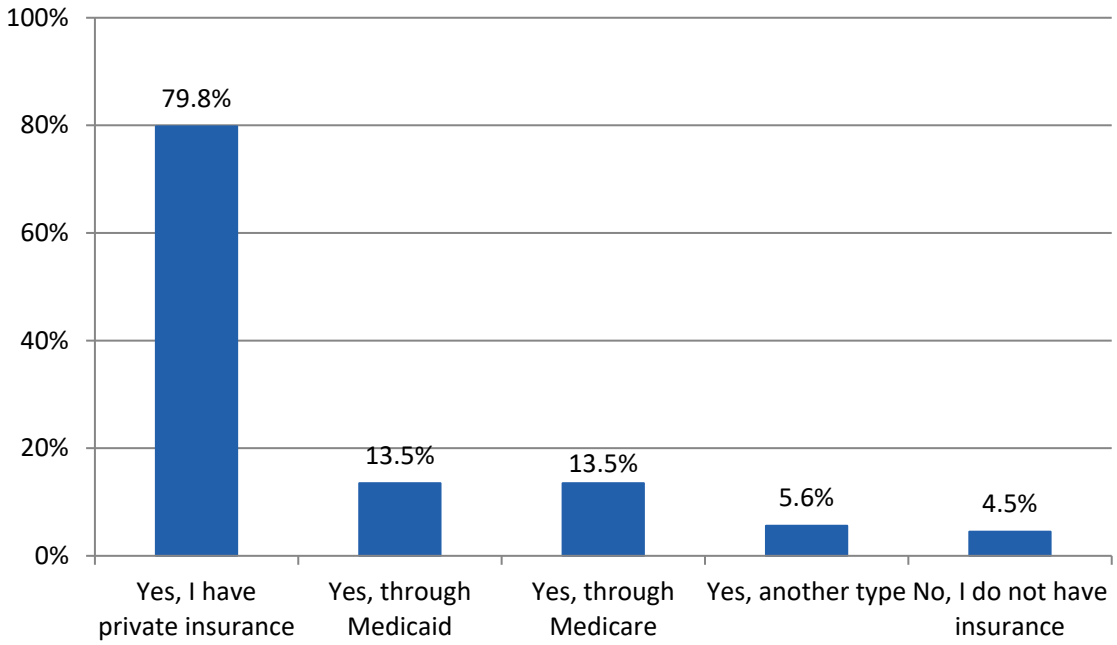
Question 8: Please rate each of the following statements about healthcare access in your community based on the scale below.



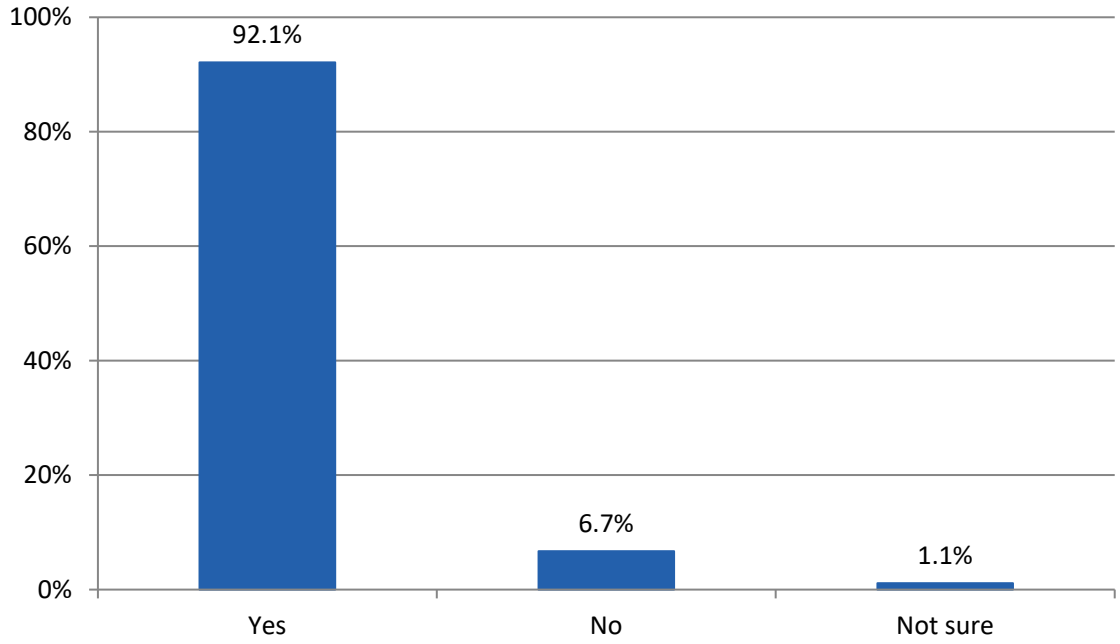
Question 9: Please indicate if you believe the barriers listed below are a major problem, moderate problem, minor problem, or not a problem that keep people in your community from accessing healthcare. (All responses)



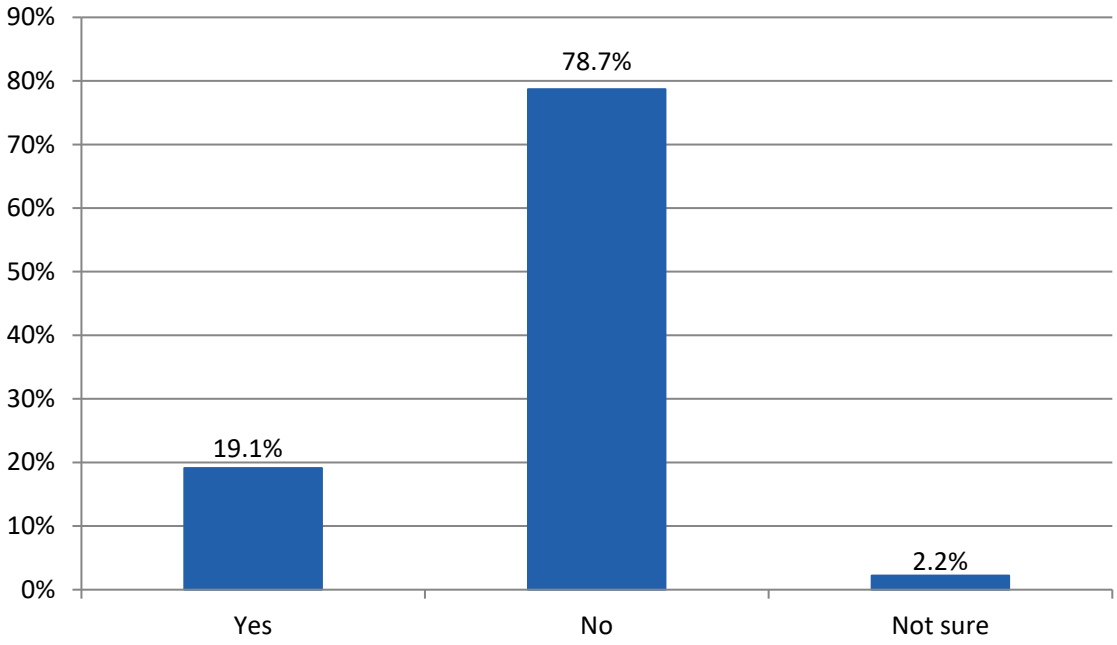
Question 10: Do you have health insurance? Please select all that apply. (N=89 responses; 84 English, 5 Spanish)



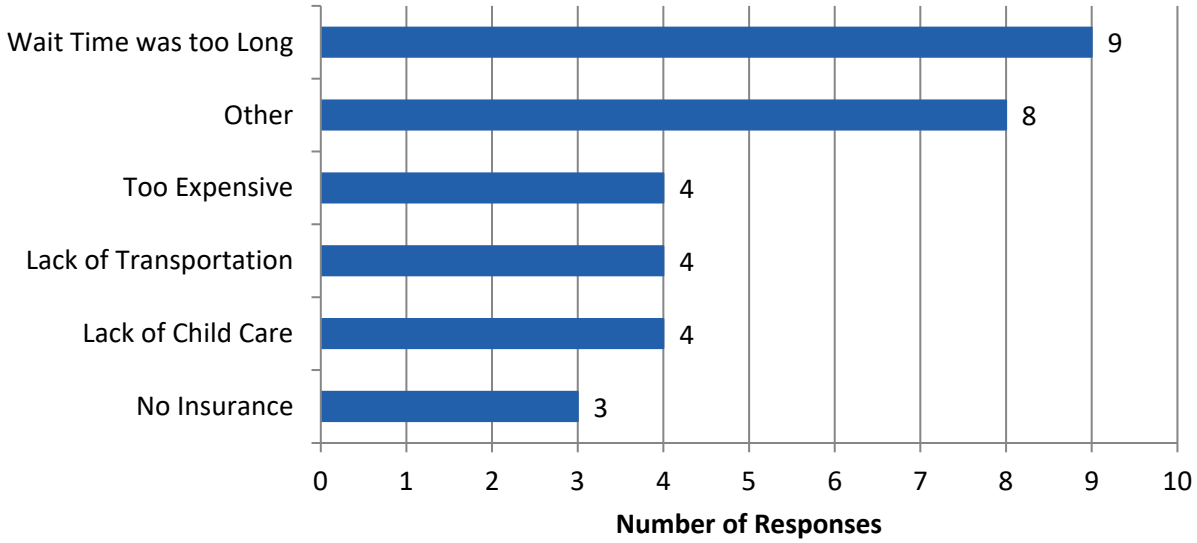
Question 11: Did you see a primary care doctor in the last year? A primary care doctor can be a family practice doctor, for example. (N=89 responses; 84 English, 5 Spanish)



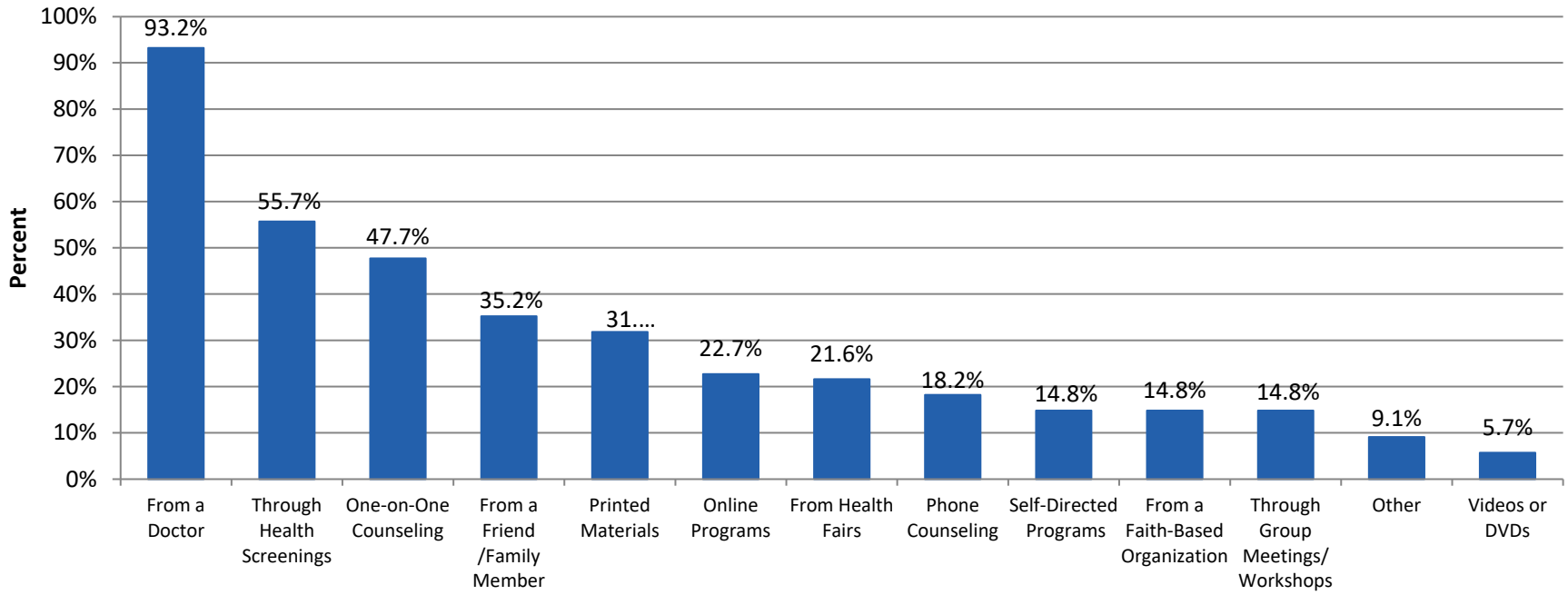
Question 12: Has there been a time in the past year when you needed medical care but were not able to get it? (N=89 responses; 84 English, 5 Spanish)



Question 13: If you answered that you were unable to receive medical care, what prevented you from getting the medical care you needed? Please select all that apply. (N=16 responses; 15 English, 1 Spanish)

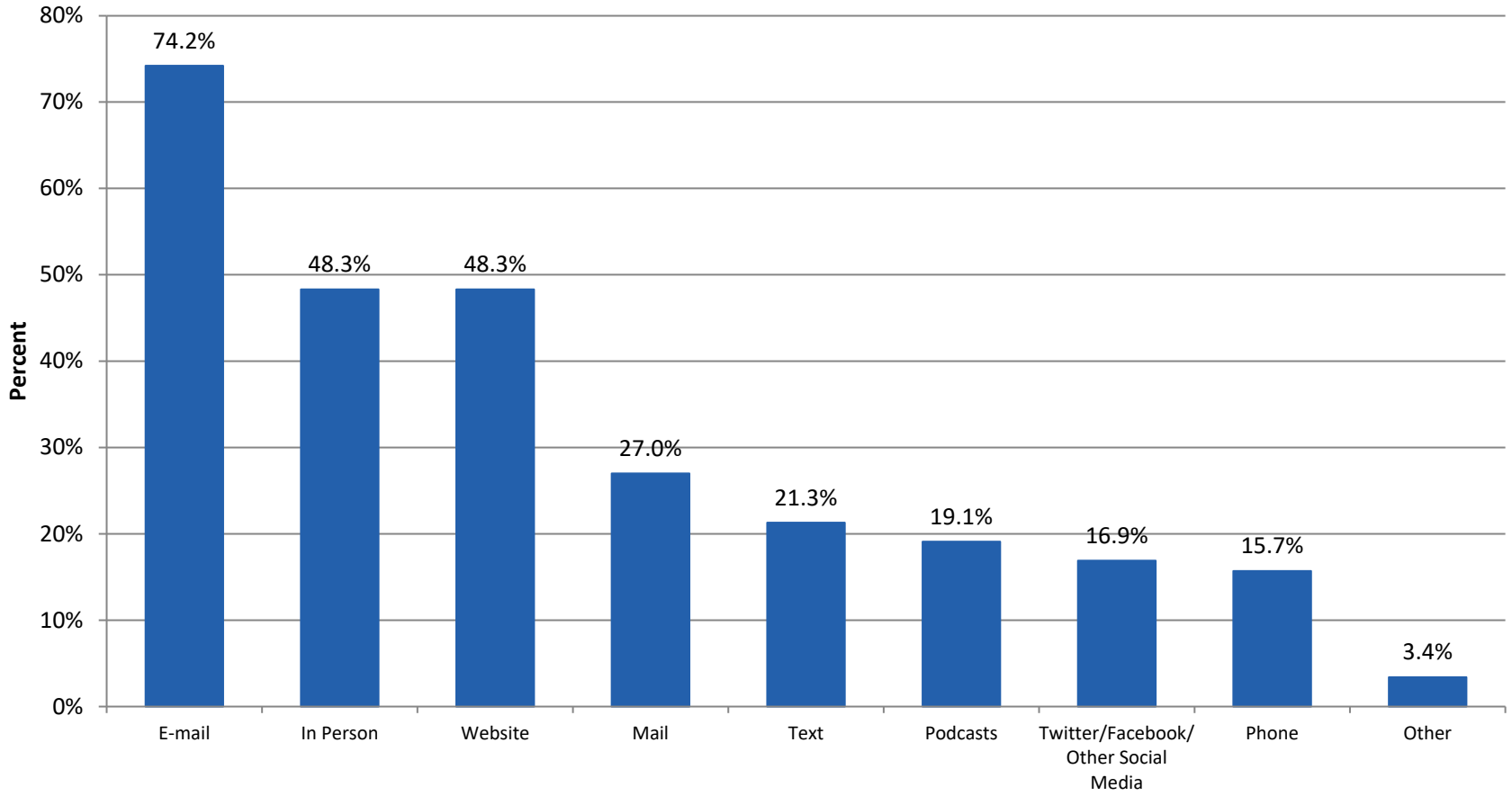


Question 14: What sources do you trust for health and lifestyle information? Please select all that apply. (N=88 responses; 83 English, 5 Spanish)



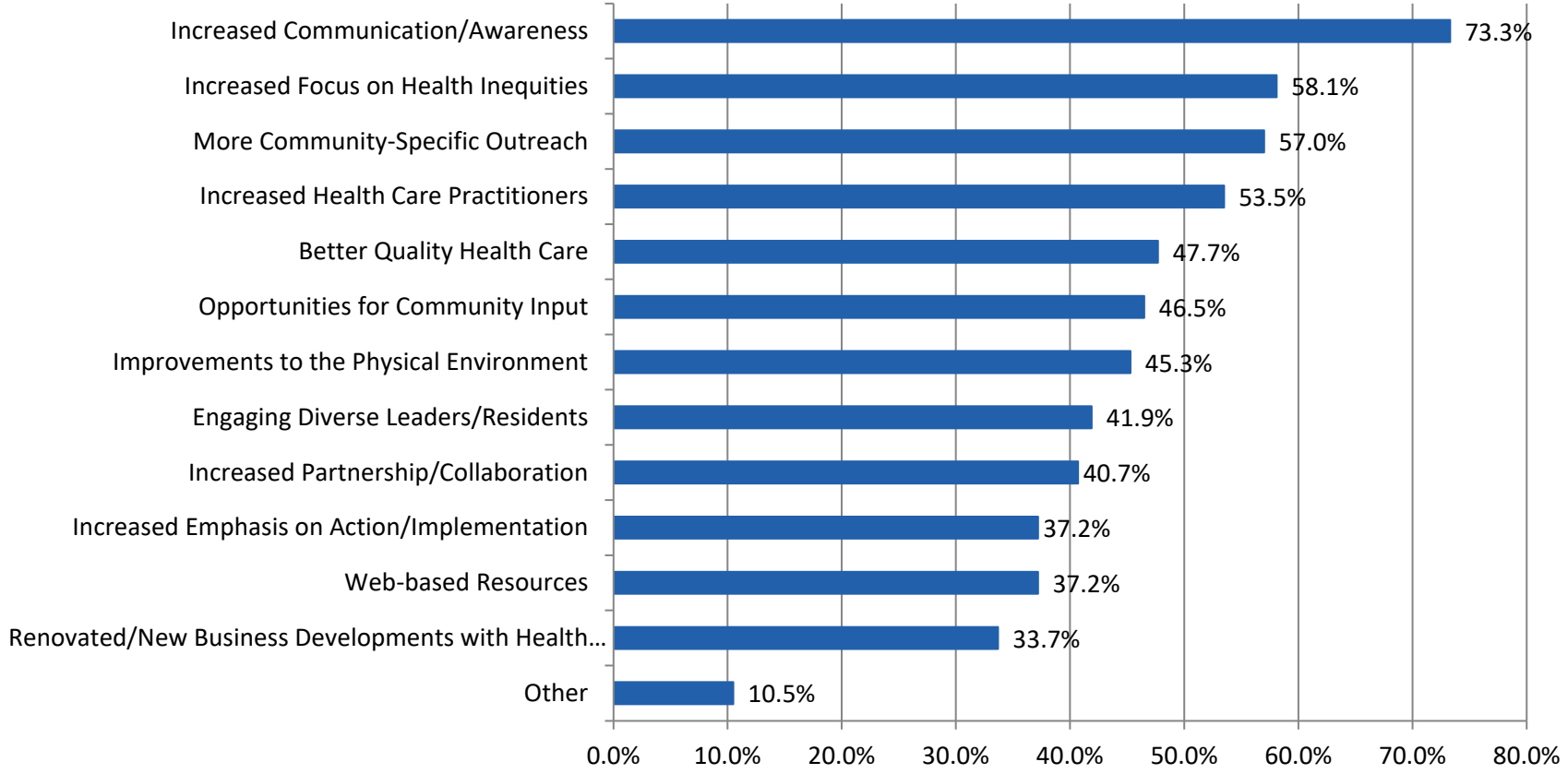
"Other" included**:** PubMed, a group of healthcare professionals, books, newspapers, scientific journal articles, WebMD, physical therapist, two responses noted issues with trust for communications from a doctor.

Question 15: How do you like to receive communication about health topics? Please select all that apply. (N=89 responses; 84 English, 5 Spanish)



"Other" included**:** reading, health experts on TV, and a website

Question 16: What do you believe could encourage and support your community's health? Please select all that apply. (N=86 responses; 81 English, 5 Spanish)

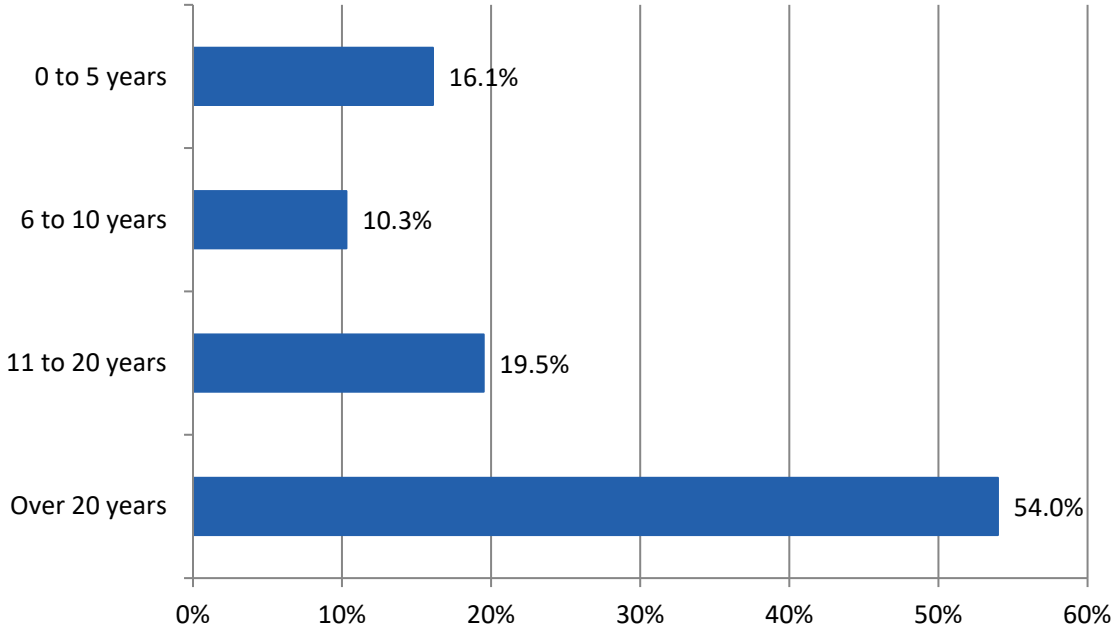


"Other" included**:** transportation, more mental health services, use of patient feedback, community centers with free resources such as pools and senior and youth programs, free all day preschool for all as well as low cost and high quality childcare, innovative health food options and partnerships, helping residents to gain access to resources (affordable medical, dental, and mental health care services, translation and transportation services, clean and safe housing), food as medicine initiative, increased support and access to alternative and neuropathic health resources, incentivizing more restaurant and businesses and grocery stores with healthier food options to come to our communities, access to medical personnel, a system that's not gamed (comment did not include what system this referenced).

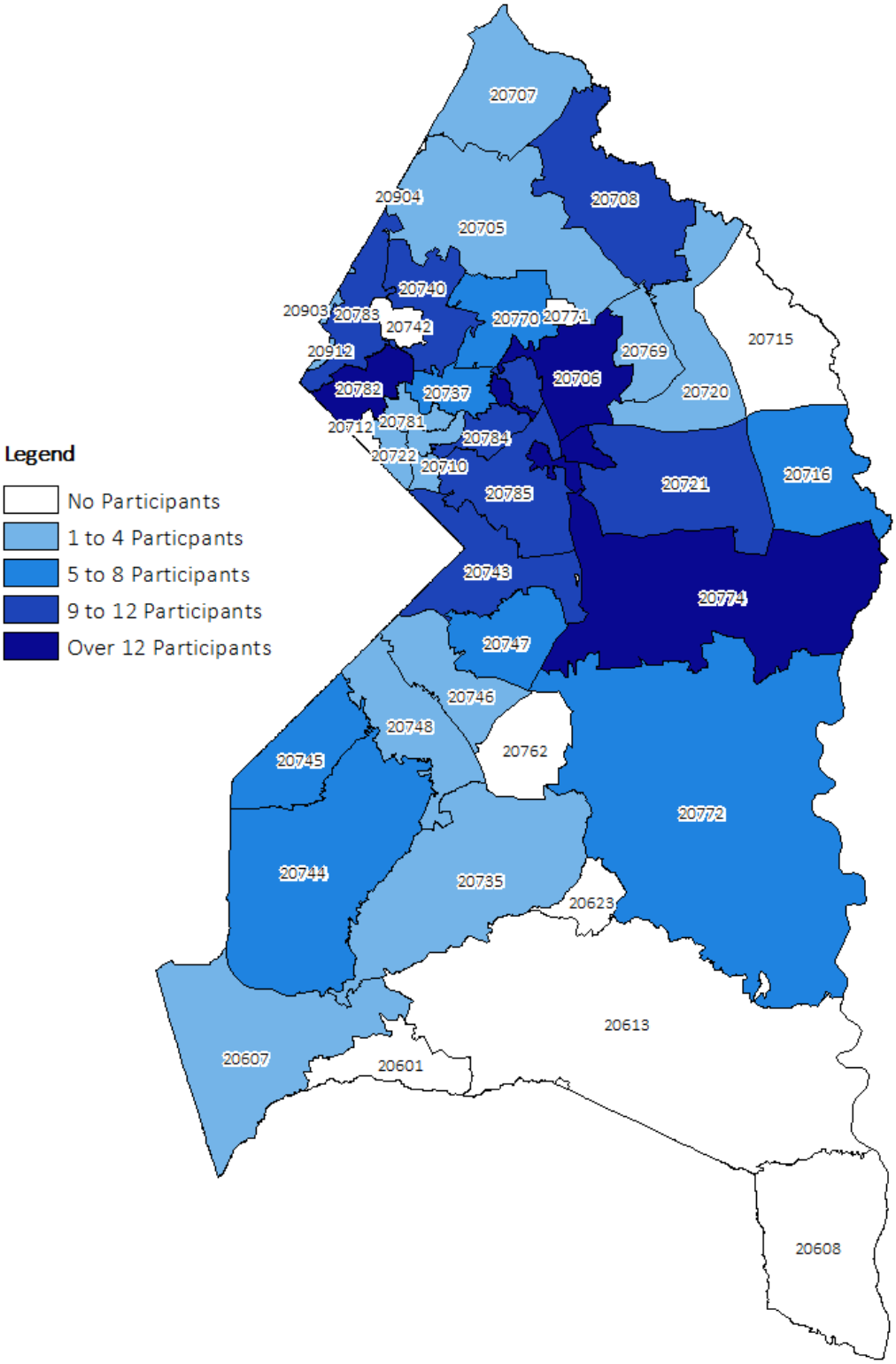
Question 17: If you could change one thing in your community, what would it be?

Issues mentioned	Number of Responses	Summary of Responses
Addressing the Social Determinants of Health	15	Improve affordability – lower costs of living and affordable housing, better schools and educational attainment outcomes, insurance coverage for all, reduce inequity to basic needs like food, housing, healthcare, allow accessory housing
Cleaner Neighborhoods and Environments	15	More parks, trails, and green spaces, more lighting in developments, reduce the number of roads and cars, reduce trash in communities
Community Engagement and Education	8	More community organizing, including increased community events and meetings to allow for more input, more health programs and screenings for those communities, more sporting activities for youth, 24-hour youth focused facility
Increased Safety	8	Decrease the crime rate and focus on citizen security, alleviate traffic congestion, slower, safer driving, more community friendly policing
Better Access to and Quality of Providers	8	More providers in the community, beyond urgent care, no limitations to services provided, more bilingual staff and professionals, more medical information provided to communities, more up to date hospitals and services, mobile dentists and medical vans, more affordable prescriptions
Better Access to Healthy Foods	6	Closer grocery stores with more/better options, fewer fast-food outlets in communities, healthier food options and eating places
Transportation and Infrastructure	5	More transportation options, safer transportation, better roads, more walkability and sidewalks, better public transit
Senior Population Considerations	2	More services for seniors (e.g., independent living and group housing, countywide programs)
Decreased Drug Use	1	Fewer drugs in the community

Question 18: How long have you lived in Prince George's County? (N=87 responses; 82 English, 5 Spanish)



Question 19: What is the ZIP code where you live? (N=85 responses; 80 English, 5 Spanish)



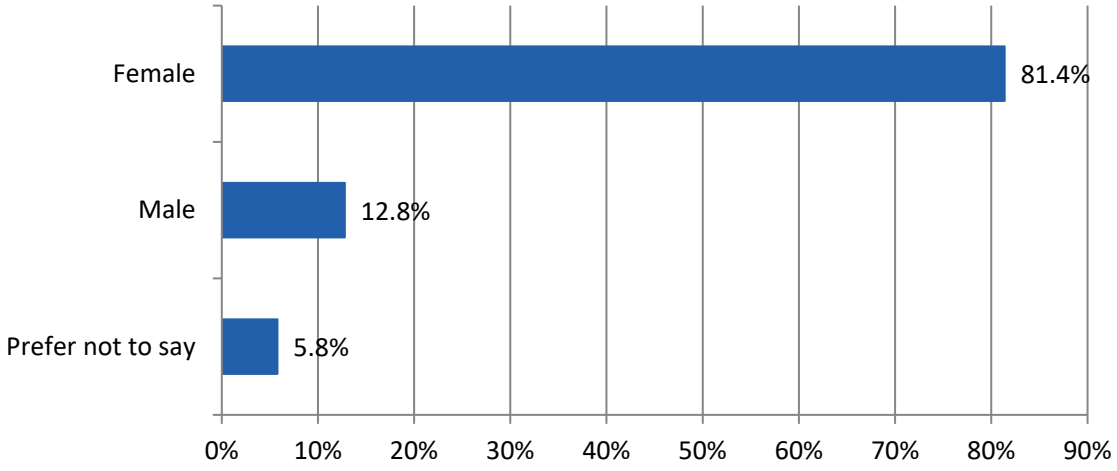
Participant Profile

Question 20: What is the name of your neighborhood? (N=73 responses; 68 English, 5 Spanish)

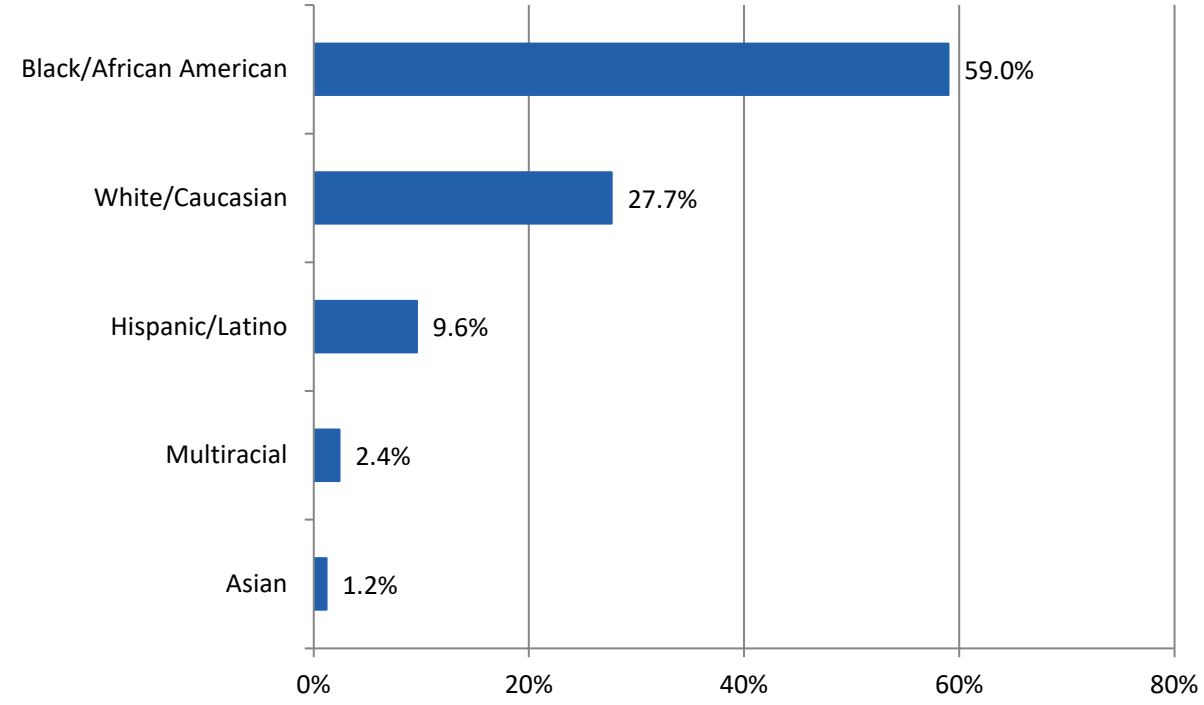
Community	All Participants
Adelphi	1
Adnell Woods	1
Allure Apollo	1
Andrews Estate	1
Barclay Square	1
Beltsville	1
Bladensburg	1
Bowie	4
Brentwood	1
Calverton	1
Cameron Grove	1
Capitol Heights	4
Cherry Glen Condos	1
Cherry View Park	1
Chillum	2
College Park	3
Collington Station	2
Colony Square	1
Coral Hills	1
District Heights	3
Dower House	1
Ementor Ave	1
Fairwood	1
Franklin Park	1
Glassmanor	1
Greenbelt	3
Greenbriar	1
Hyattsville	1
Kentland	1
Kingsford	1
Kirby Woods	1
Lake Arbor	2
Landover	1
Lanham	1
Largo	1
Laurel	2
Marlboro West	1
New Carrollton	3
North Tantallon	1

Community	All Participants
Overbrook	1
Oxon Knolls	1
Perrywood	1
Riverdale	1
University Park	8
Unknown	1
Upper Marlboro	1
Village of Morgan Metro	1
Woodland Hills	1

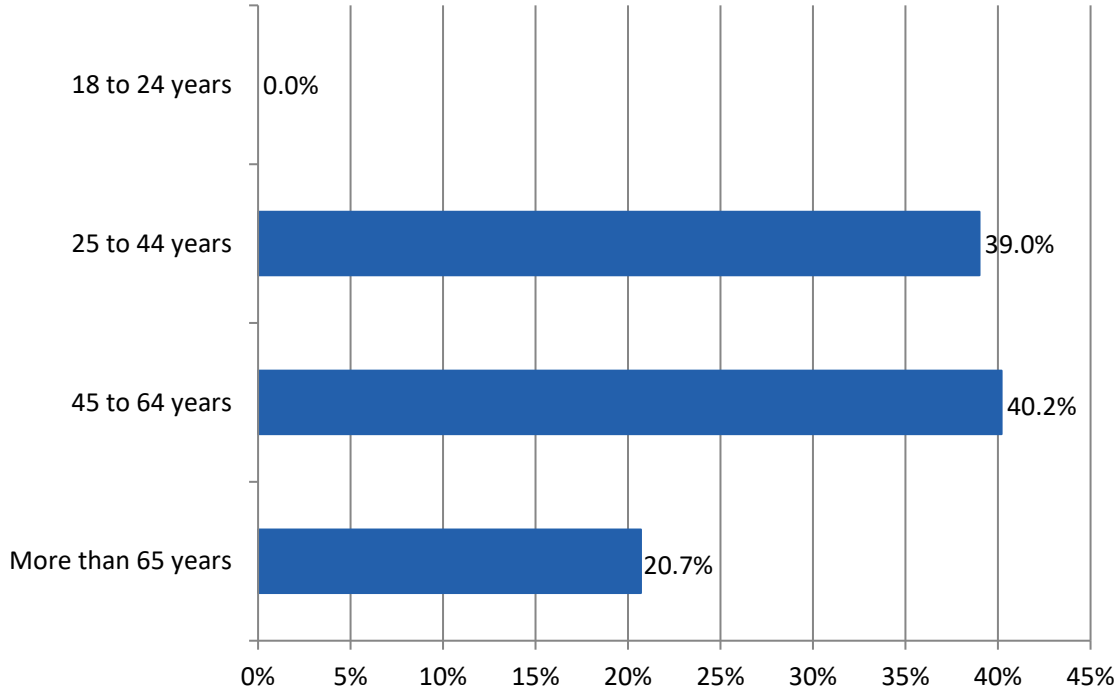
Question 21: What is your gender? (N= 86 responses; 81 English, 5 Spanish)



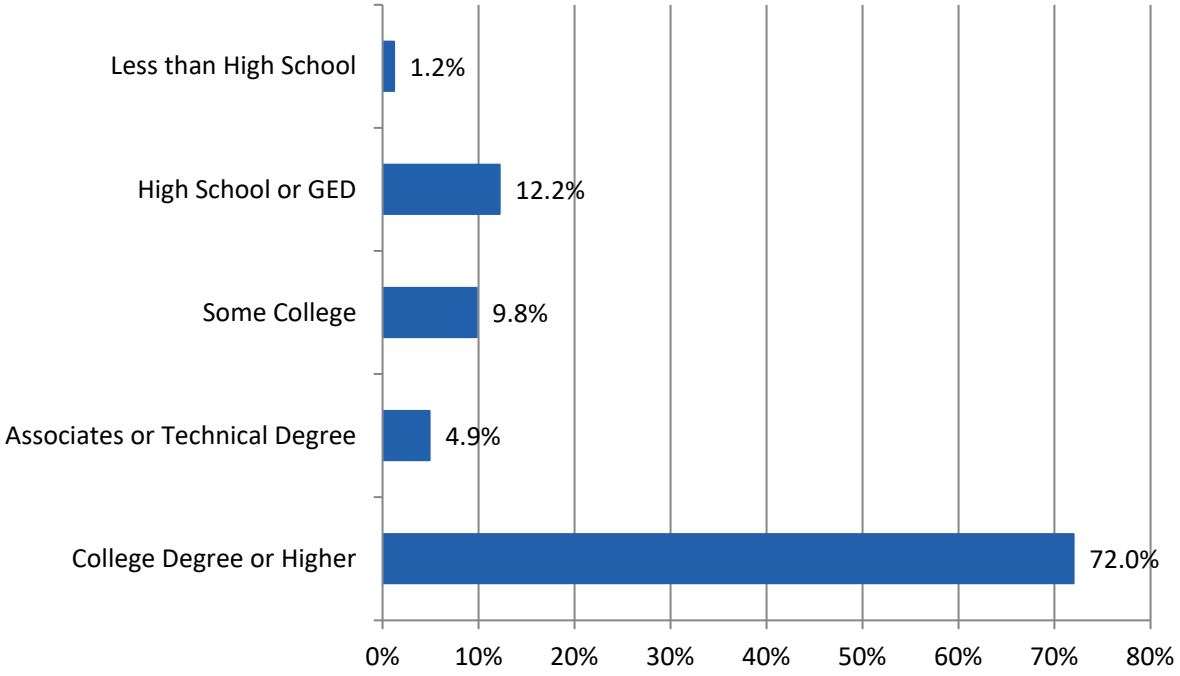
Question 22: What race/ethnicity best identifies you? (N=83 responses; 78 English, 5 Spanish)



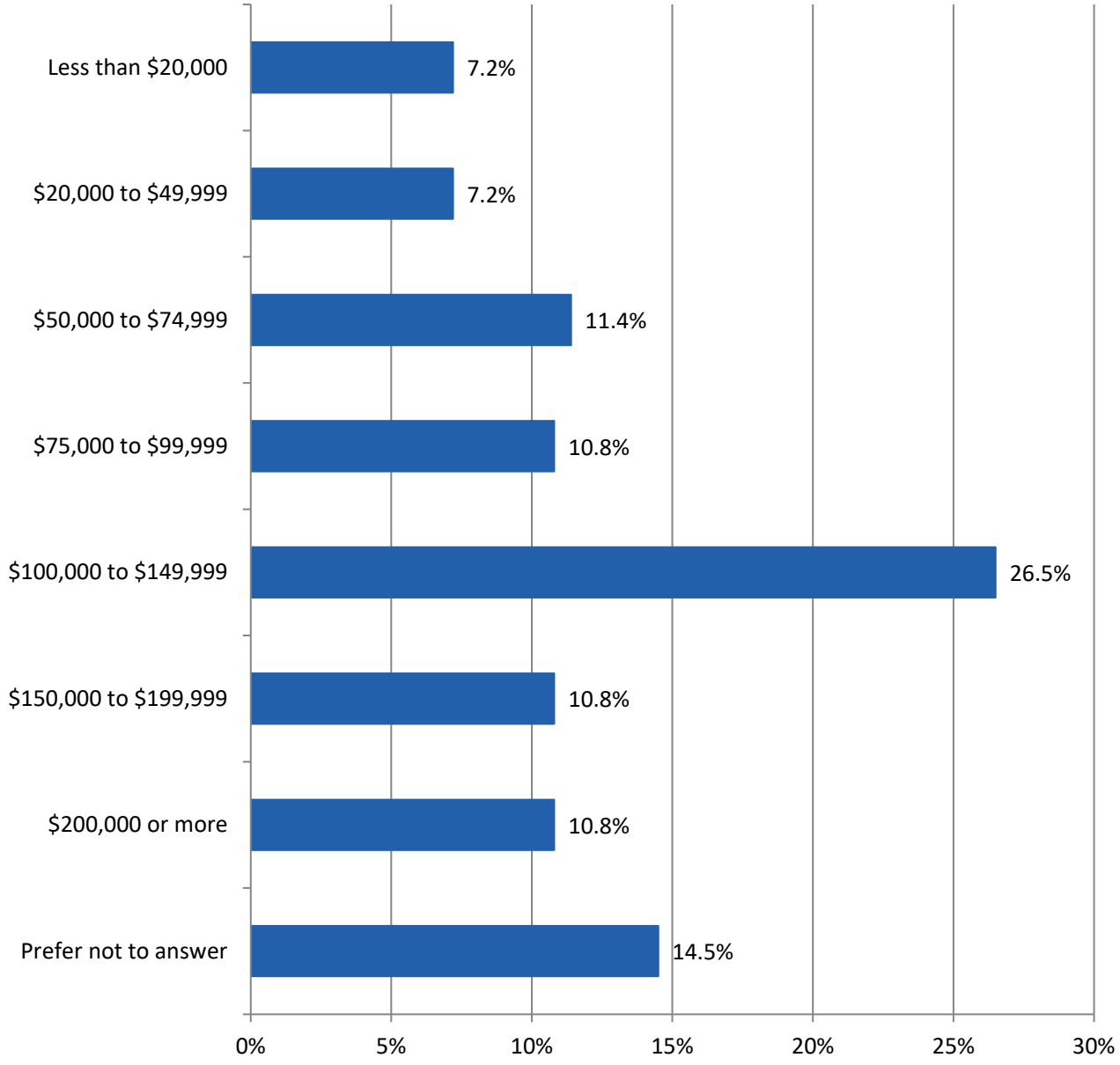
Question 23: How old are you? (N=82 responses; 77 English, 5 Spanish)



Question 24: What is the highest level of education you completed? (N=82 responses; 77 English, 5 Spanish)



Question 25: What is your annual household income? (N=83 responses; 78 English, 5 Spanish)



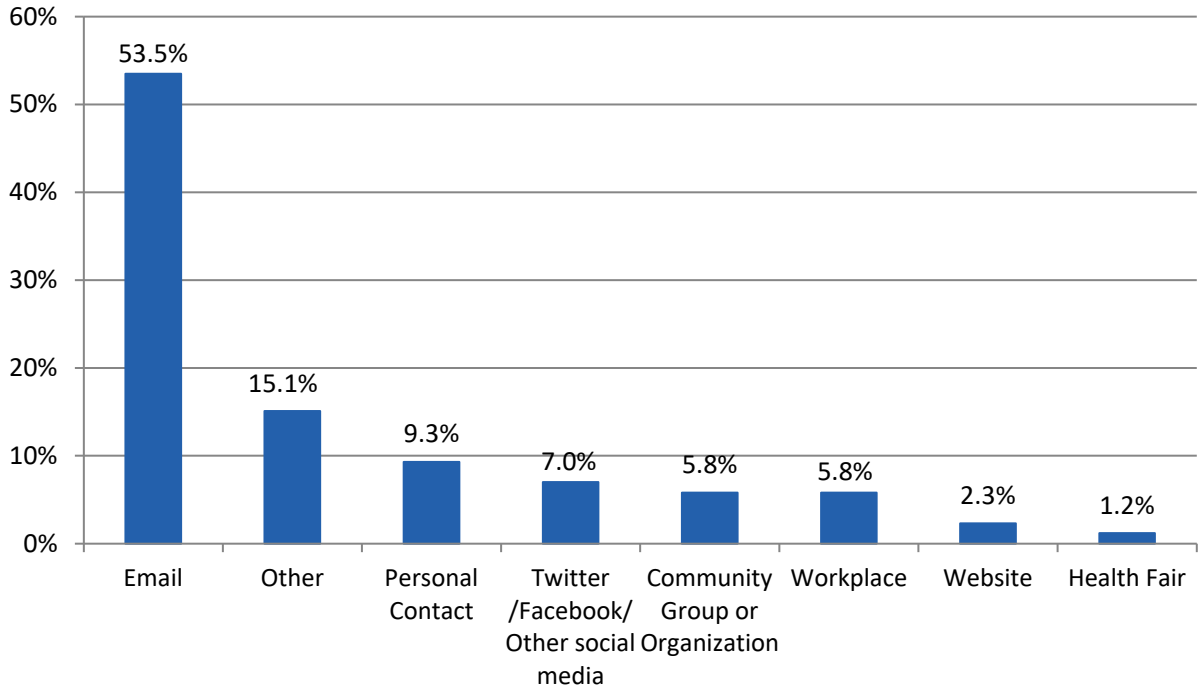
Question 26: In what country were you born? (N=81 responses; 76 English, 5 Spanish)

Community	All Participants
Dominican Republic	1
El Salvador	3
Germany	1
Ireland	1
Mexico	2
United States	73

Question 27: What language do you speak at home? (N=81 responses; 76 English, 5 Spanish)

Community	All Participants
English	74
English & Spanish	2
German	1
Spanish	4

Question 28: How did you receive this survey? (N=86 responses; 81 English, 5 Spanish)



F**or <u>personal contact</u> participants mentioned specific locations in the "Other" free-text field**: library, DFS, child's school, school email, text message

Fort Washington Medical Center

2020-2022 Community Health Needs Assessment Implementation Strategy

Adopted June 30, 2019

Implementation Strategy Development & Adoption

As a requirement of the Patient Protection and Affordable Care Act, not-for-profit hospitals such as Fort Washington Medical Center (FWMC), must participate in a Community Health Needs Assessment (CHNA) every three (3) years. The most recent health assessment was conducted by the Prince George's County Health Department in 2019. While the CHNA data is inclusive of Prince George's County, FWMC is focused specifically on the health needs of individuals living in the service areas of Fort Washington (20744), Oxon Hill (20745), Temple Hills (20748), and Accokeek (20607). FWMC serves 14.6 percent (133,101) of the residents in Prince George's County (912,756), and its largest population is African American, and then Hispanic and white.

Based on the results of the CHNA, the Executive team developed an implementation strategy, which identifies initiatives FWMC is undertaking to improve disparities for the communities it serves.

Use the following link to access the Prince George's County 2019 joint Community Health Needs Assessment. Participating hospitals include, Doctors Community Health System, MedStar Southern Maryland Hospital Center, University of Maryland Capital Regional Health, Prince George's County Health Department, and Prince George's Healthcare Actional Coalition Leadership. https://www.fortwashingtonmc.org/wp-content/uploads/2019/06/FINAL_-2019-Prince-Georges-CHNA.pdf

The following factors were considered in completing the prioritization process.

Incidence and Prevalence	• Is the problem affecting a large proportion of community members?
Presence and Magnitude of Disparities	• Are some populations disproportionately burdened?
Change over Time	• Has the need improved, worsened, or seen no change in recent years?
Community Input	• Based on input from the community, what are the most significant areas of need as identified by the community?
Existing Resources, Expertise, and Partnerships	• Does FWMC have resources, existing programing, expertise, or existing/potential partnerships that can be leveraged to effectively address the need?
Gaps and Resources in the Community	• Are there existing resources sufficiently addressing the need or are additional resources needed? Where specifically do the gaps lie?
Potential for Measurable and Achievable Outcomes	• Are there relevant outcome measures? Will it be possible to make an impact?

2019 CHNA Prince George's County Health Care Priorities

Completion of the 2019 CHNA revealed four (4) health care priorities for Prince George's County. Data below show areas that have worsened since the previous Assessment in 2016. The data below is the most updated data released by the health department.

Priority 1: Social Determinants of Health

Resident to Provider Ratios increased for primary care and mental health providers

- In 2013, 1 primary care provider for every 1,860 residents; in 2015, 1 primary care provider for every 1,910 residents
- In 2015, 1 mental health provider for every 860 residents; in 2017, 1 mental health provider for every 890 residents

High School Graduation Rate for Hispanic students decreased: from 67.4% (2015) to 65.9% (2017); Hispanic students have a much lower graduation rate compared to other races and ethnicities

Fair Market Rental Pricing increased substantially: for an efficiency unit, rental pricing increased from $1,167 (2015) to $1,504 (2018)

- The median income for a renter in the county is $53,774 (2018), which falls short of the median income needed for an efficiency unit by more than $6,000 ($60,160 estimated income needed)

Priority 2: Behavioral Health

Adults with Poor Mental Health Days have increased:

- 3-7 Poor Mental Health Days increased from 9.8% (2014) to 10.8% (2017)
- 8-29 Poor Mental Health Days increased from 7.7% (2014) to 8.8% (2017)
- 30 Poor Mental Health Days increased from 3.2% (2014) to 3.9% (2017)

High School Students Who Seriously Considered Suicide increased: from 14.7% (2014) to 17.7% (2016)

- Disparity: 21.7% of White Non-Hispanic (NH) students reported seriously considering suicide, followed by students of Other Races (20.4%).

High School Students Bullied on School Property increased: from 12.1 % (2014) to 14.5% (2016)

- Disparity: More White NH students reported being bullied (24.8%)

Total Behavioral Health ED Visits increased by 23%: from 6,842 (2014) to 8,420 (2017) for residents going to Maryland hospitals

Drug-Related Mortality Rate increased: from 6.4 deaths per 100,000 (2012-2014) to 12.2 (2015-2017)

- Disparity: White NH residents have the highest mortality rate at 32.1 per 100,00 (2015-2017)

High School Students Who Used Prescription Drugs without a Doctor's Prescription increased: from 13.9% (2014) to residents (2014) to 15.6% (2017)

Priority 3: Obesity and Metabolic Syndrome

Adult Obesity Prevalence has increased: from 34.2 (2014) to 42.8% (2017)

- Disparity: Black, NH residents have the highest prevalence at 46.7%

High School Student Obesity and Overweight Prevalence have increased: from 15.1% (2014) to 16.4% (2016) for obesity, and 17.4% (2014) to 19.1% (2016) for overweight; overall, one in three high school students are overweight or obese in the county

- Disparity: Hispanic students were more likely to be obese or overweight

Diabetes Prevalence has increased: from 11.5% (2014) to 12.3% (2017)

- Disparity: Hispanic residents had a higher prevalence at 16.7%

Stroke Mortality Rate has increased: from 37.8 deaths per 100,000 (2012-2014) to 41.6 (2015-2017)

- Disparity: Black NH residents have the highest mortality rate at 44.2 per 100,00

Hypertension Emergency Department Visit Rate has increased: from 261.7 visits per 100,000 residents (2014) to 351.2 visits (2017) (ED visits include all Maryland hospitals); the ED visit rate increased for those ages 40 to 64 years from 377.3 (2014) to 433.9 (2017), and for residents ages 65 and over from 670.2 (2014) to 885.8 (2017)

Priority 4: Cancer

Screening for Breast and Prostate Cancer has declined: from 83.7% of women 50+ with a mammogram in past 2 years (2014) to 82.3% (2016); from 49% of men 40+ with a PSA in the past two years to 41.4% (2016)

- Disparity: White, NH residents are less likely to be screened compared to Black, NH residents

Female Breast Cancer Incidence has increased: from 116.1 new cases per 100,000 women (2007-2011) to 121.7 (2010-2014)

- Disparity: Black women have a higher Incidence Rate (126.4) compared to White women (105.0)

Female Breast Cancer Mortality has increased**:** from 25.6 deaths per 100,000 women (2012-2014) to 25.8 (2015-2017)

- Disparity: Black women have a higher Mortality Rate (28.2) compared to White women (22.4)

Prostate Cancer Mortality has increased**:** from 26.0 deaths per 100,000 men (2012-2014) to 27.9 (2015-2017)

- Disparity: Black men have a Mortality Rate (36.3) twice that of White men (16.5)

Source: Prince George's County 2019 Community Health Assessment Resident and Community Expert Surveys

Significant Community Health Needs Identified

The CHNA identified heart disease, diabetes, stroke, and hypertension as underlying health indicators for the FWMC service areas. Secondary countywide health indicators that also affect the FWMC service areas are breast cancer, prostate cancer, HIV, STI's, senior health, and asthma. To develop the hospital-specific prioritizations, FWMC assessed whether they align with the overall priorities of the county, prior improvements and outcomes, existing programs and services, and opportunities for collaborations.

Additionally, FWMC examined its SocioNeeds Index, which ranks zip codes from 0 (low need) to 100 (high need) – as well as its service area profile. The service area profile, which identifies income, demographics, diagnosis, and education – found that Oxon Hill, one of its four service areas has: (1) more families below the poverty line; (2) more residents without a high school degree; (3) more unemployed; and (4) a substantially lower median household income compared to the county. Oxon Hill's SocioNeeds Index is 72.4, well above the country's average, which is 50.

Considering that FWMC serves 14.6 percent (133,101) of the residents in Prince George's County (912,756), and based on the CHNA results, Service Area Profile, and the ability to sufficiently address care and close disparity gaps, FWMC will focus on the following health needs priorities (in no particular order).

- Access to Care
- Community Engagement
- Infectious Diseases (HIV/HEP C)
- Mental Health
- Obesity (Diabetes, heart diseases, stroke)
- Telehealth

Implementation Strategy Overview: Health Education/Prevention/Awareness

Goal: To educate, increase awareness, and provide accessible resources to prevent and/or manage (preventable) illnesses such as chronic diseases.

Objectives:

- Increase engagement with organizations that can help fill the gaps in access to care, i.e. transportation and civic groups.
- Create programs/methodologies that will increase access to care.
- Increase community outreach activities by specifically targeting deficient/disparity areas.
- Convert community outreach residents into healthy patients.

Strategy 1: Mental Health Evaluation & Referral Program

a. Work with county experts to develop and implement a mental health referral program.
b. Partner with area organizations, physicians, physician groups, etc., to provide mental health service referrals based on evaluations initially conducted by FWMC.

Potential Partners: Adventist Behavioral Health and Wellness, Urban Behavioral Associates, and Prince George's County Health Department

Strategy 2: Telemedicine Program

a. Telemental health services are provided through a partnership with Adventist Healthcare. Behavioral health patients often present in crisis to the FWMC emergency department. These patients are assessed and placed in facilities as needed via this program service.
b. Other consult services are being considered.

Potential Partners: Adventist Behavioral Health and Wellness, Urban Behavioral Associates, and Prince George's County Health Department

Strategy 3: Community Survey

a. Survey residents within the FWMC service areas to glean what programs and community services are demonstrating impact; i.e. are they positively impacting quality of life.

Potential Partners: Area hospitals, agencies on aging, local health department, local health improvement coalitions, faith-based organizations, colleges & universities, as well as behavioral health organizations, social services groups, advocacy organizations, community and health care organizations, Prince George's County School system, and local government agencies such as human resources, natural resources, and environmental

Committed Resources:

1. Participate in community health events that specifically target deficient demographics.
2. Distribute impactful, evidenced-based educational materials via print and online.
3. Distribute health care equipment, i.e. glucometers, blood pressure cuffs, tele-health cameras, and monitors – things considered costly for some demographics.
4. Provide counseling services.
5. Leverage Public Relations/ media platforms.

Measures of Success:

1. Establish benchmarks.
2. Provide quarterly quantitative measurements.
3. Provide quarterly cost of implementation and management.
4. Review and implement, when necessary, alternative courses of action.
5. Provide reports of rationale for deficiencies and/or improvements.

Plan of Action & Monitoring Progress		
AREA OF NEED	**ACTION**	**EVALUATION**
Infectious Diseases (HIV & HCV Awareness & Reduction)	Patients have access to free testing/screening through FWMC Emergency Department; participate in targeted community health fairs that address priority needs; program outreach through online and print marketing	# of individuals screened through the ED # of individuals screened through community events # of positive HIV /HCV patients identified along with linkage to care
Access to Care	Patients have an additional way to seek immediate treatment through the FWMC/NOW primary care/urgent care facility; recruitment of highly qualified nurses and doctors; pursuit of HSCRC nursing grants; management of Gilead HIV grant; management of TLC Transition Grant; host quarterly CME educational series for affiliated physicians on access concerns, health disparities and wellness; and referral partnerships with area physicians who can provide specialty services	# of total re-admission rates # of patients screened # of patients diagnosed with chronic conditions # of positive HIV /HCV patients identified along with linkage to care # of CME opportunities offered # of providers who utilize CME opportunities offed by FWMC
Wellness Program	Patients have access to a free Diabetes Education Program managed by registered dieticians, and certified diabetes educator; community walking program, free yoga and Zumba classes for the community; host one (1) event per month specific to Diabetes and nutrition; weight loss and exercise challenge programs provided to staff and	# of classes held # of participants in the Diabetes Education Program, which is measured through physician referrals and class sign-in sheets. Lab values are obtained by a health care provider and are then shared with the CDE every 3-4 months or so, who evaluates if progress has been made. Blood Pressure control is tracked through the AHA database. The

Plan of Action & Monitoring Progress		
AREA OF NEED	**ACTION**	**EVALUATION**
	community The diabetes educator will continue to work collaboratively with health care providers within the community and community centers. Assist those within the community in practicing the 7 Self-Care-Core Behaviors and Goals to achieve and maintain normal hemoglobin A1c and cholesterol levels. Partner with the American Heart Association to assist individuals with maintaining good blood pressure control. Provide the community with appropriate resources through the collaboration of the CDE with pharmaceutical companies to provide glucometers and educational materials along with the local pharmacies to assist those in need of low cost diabetes medications.	CDE has access to the information and can follow-up with physicians and participants regarding progress and modifications that may need to occur. The tracking of glucometers and low cost medication cards will be done through documentation of the number of glucometers given on a monthly basis along with the number of medication assistance cards given.
Mental Health (Increased awareness of mental health)	Conduct staff training; development of referral program and evaluation/screening program; continue psych program and partner with psychiatry.	# of people screened through ED # of in-patients who also receive psych evaluations # of Psych consults # of referrals and transfers
Care Transition	Partner with Totally Linking Care collaborative, a population health and transitional care program anchored by 7 community hospitals including FMWC, community health workers,	# of patients enrolling in TLC program prior to discharge, thus reducing hospital readmissions; # of patients enrolled in program to address specific health and social needs; # of engaged pharmacist to ensure

Plan of Action & Monitoring Progress		
AREA OF NEED	**ACTION**	**EVALUATION**
	medical devices and community partners; and medication management and patient navigation	patient medication therapy management; and provide resources and follow-up once patients are discharged

Additional Areas of Need That Cannot be Addressed by Fort Washington Medical Center

Through community collaborations, FWMC's will continue focusing on community health initiatives that provide health equity, eliminate care disparities, and engage community health workers, in order to advance health care in the county and improve outcomes. There are priority areas FMWC is not sufficiently able to address.

1. **Social Determinants of Health** – FWMC currently does not provide programs and services that directly address all of the social determinants of health identified in the CHNA. For example, FWMC does not have programs that address, employment, housing, and access to food. The hospital does provide counseling for patients without insurance and access to Medicare and other programs. In addition, provides community outreach that promotes access to care through its free Wellness Program and building healthy communities.

2. **Cancer Care** – FWMC currently provides cancer care as part of the services offered including mammography, general surgery, and routine acute care. The hospital does not have a comprehensive cancer care program and it is currently cost prohibitive to develop one. The current cancer outreach includes providing preventative information to civic groups, and faith-based entities via presentations, demonstrations, and educational material.

A Nexus Health Company

FWMC

FORT WASHINGTON MEDICAL CENTER

Mission: Our mission is to ensure high quality, compassionate and responsive health care services dedicated to advancing the health of our community customers.

Vision: We aim to be recognized as a superior, innovative health care system exhibiting excellence in patient care and safety, illness prevention, and the wellness needs of our communities.

2018 At-A-Glance	
400	Employees
7,180	Inpatient Patient Days
2,064	Admissions
3.48	Average Length of Stay
53.2	Occupancy Percentage
66.2	Adjusted Occupancy Percentage
1,690	Inpatient & Outpatient Surgeries
1,417	Observation Visits
37,912	Emergency Room Visits
29,766	Ancillary Services

Safety and Quality Achievements

Healthgrades five-star commendation in orthopedics for treatment of hip fractures

Healthgrades five-star commendation in cardiac for treatment of heart failure

Healthgrades Patient Safety Excellence Award™

Healthgrades five-star commendation for gallbladder removal surgery

Health Quality Innovators Award for prevention of falls

Fort Washington Medical Center is a community-based, not-for-profit, acute care hospital in Prince George's County, Maryland serving patients in the Fort Washington, Oxon Hill, Temple Hills, and Accokeek areas, as well as parts of southeast Washington, DC. We provide general inpatient services including adult medical and surgical care, ambulatory surgical services, laboratory, radiology and diagnostic services, as well as gastrointestinal, orthopedic, plastic, rehabilitation, and respiratory therapy. Specialty services include gynecology, neurology, urology, and ophthalmology. Two prominent community-based programs include at no cost, an outpatient Diabetes Education Program and an Infectious Diseases Program (HIV and Hepatitis C testing/education).

2019
PRINCE GEORGE'S COUNTY

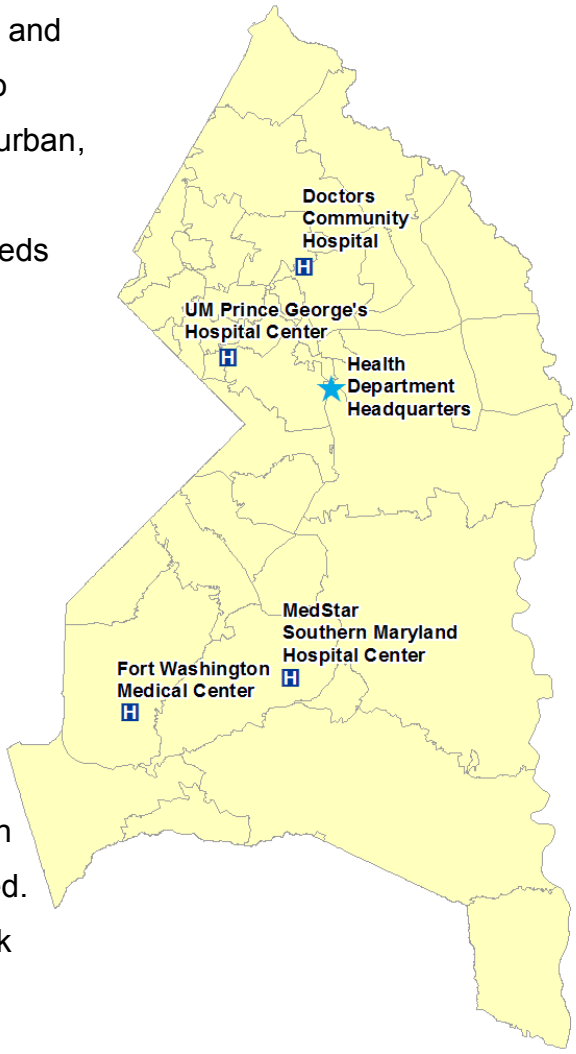
COMMUNITY HEALTH ASSESSMENT

Prepared by:
Prince George's County Health Department
Office of Assessment and Planning
Health-OAP@co.pg.md.us

HEALTH DEPARTMENT
Prince George's County

INTRODUCTION

Prince George's County is located in the state of Maryland and is part of the Washington, D.C. metropolitan area. Home to more than 900,000 diverse residents, the county includes urban, suburban, and rural regions. The county, while overall considered affluent, has many communities with higher needs and poor health outcomes.



In 2015, the Prince George's County government and Maryland-National Capital Parks and Planning Commission conducted a special study to develop a Primary Healthcare Strategic Plan[1] in preparation for enhancing the healthcare delivery network. A key recommendation from the plan was to "build collaboration among Prince George's County hospitals", which included conducting a joint community health assessment (CHA) with the Prince George's County Health Department. In 2016, the first inclusive CHA was completed. The hospitals and Health Department agreed to again work collaboratively to update the 2016 CHA in 2019.

CHA Core Team

Doctors Community Health System
Fort Washington Medical Center
MedStar Southern Maryland Hospital Center
Prince George's County Health Department
Prince George's Healthcare Action Coalition
University of Maryland Capital Region Health

There are four hospitals located within the county: Doctors Community Hospital; Fort Washington Medical Center, MedStar Southern Maryland Hospital Center; and UM Prince George's Hospital Center. All four hospitals and the Health Department appointed staff to facilitate the 2019 CHA process. The core team began meeting in September 2018 and included leadership from the Prince George's Healthcare Action Coalition during the data review and prioritization process.

[1] http://www.pgplanning.org/Resources/Publications/PHSP.htm

PROCESS OVERVIEW

The CHA Process was developed to 1) maximize community input, 2) learn from the community experts, 3) utilize existing data, and 4) ensure a comprehensive prioritization process. Elements of the Mobilizing for Action through Planning and Partnerships (MAPP)[2] process where used in the 2019 CHA to shift data collection towards community perceptions of health and consideration of the local health system. The Core Team developed a shared Vision at the start of the process of

"A community focused on health and wellness for all."

The group agreed upon five shared values to provide focus, purpose, and direction for the CHA process:

- Collaboration
- Equity
- Trust
- Safety
- Prevention

The Core Team were also asked to consider what they would like the local health system to look like in five to ten years. The emergent themes included:

- all residents to feel safe accessing health-related services (regardless of immigration status);
- residents will have a better perception of health care in the county;
- better utilization of local services;
- a system that allows residents to access services close to home;
- consideration of needs of all residents.

In summary, the Core Team envisioned **"a system that is perceived as available to serve all with quality services"**.

The Health Department staff led the CHA process in developing the data collection tools and analyzing the results with input from the hospital representatives. The process included:

- A community resident survey available in English, Spanish, and French distributed by the hospitals and health department;

[2] https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

- Secondary data analyses that included the county demographics and population description through socioeconomic indicators, and a comprehensive health indicator profile;
- Hospital Service Profiles to detail the residents served by the core team;
- A community expert survey and key informant interviews; and
- A prioritization process that included the Core Team and Prince George's Healthcare Action Coalition leadership.

While the Core Team led the data gathering process, there was recognition that **health is a shared responsibility**. The community data collection strategies and the prioritization process were intentionally developed with this consideration and set the foundation for coordination moving forward.

After initially reviewing the data collection results (the data reviewed is available in the Prioritization Process section), the Core Team determined that the priorities selected in the 2016 CHA should remain the 2019 priorities based on the community and expert input in the process that focused on these areas, the challenges remaining in the county from the population and health indicators, and acknowledgment that it is realistic for such substantial priorities to require more than three years to "move the needle". The 2019 priorities will continue to be:

- the social determinants of health,
- behavioral health,
- obesity and metabolic syndrome, and
- cancer.

The results of this process will guide the health department and hospitals in addressing the health needs of the county. Additionally, the Core Team committed to reconvene to coordinate assets and resources to addresses the priorities and determine opportunities for further collaboration.

KEY FINDINGS

Drivers of Poor Health Outcomes:

- **Social determinants of health drive many of our health disparities.**
    - Poverty, food insecurity, access to healthy food, affordable housing, employment, lack of educational attainment, inadequate financial resources, access to care, and a disparate built environment result in poorer health outcomes.
    - Growth in the county, while benefiting some, may harm others. For example, in just 3 years the income needed for an efficiency rental has grown by over $13,000. However, the median renter household income has grown by only $3,000, potentially making affordable housing less attainable for some residents.
    - Education was a consistent concern for residents and key informants; resident surveys ranked good schools as the third most important aspect of a healthy community. There is notable disparity in high school graduation rates, with only 66% of Hispanic students graduating compared to 85% and higher for other groups.
    - Resources available in communities with greater needs continue to be perceived as lower quality, such as healthcare and fresh food.
- **Access to health insurance through the Affordable Care Act has not helped everyone.**
    - Many residents still lack health insurance (some have not enrolled, some are not eligible).
    - Those with health insurance struggle to afford healthcare (such as co-pays, high premiums, and deductibles) and prescriptions, and difficulty accessing care due to transportation challenges.
- **Residents lack knowledge of or how to use available resources.**
    - The healthcare system is challenging to navigate, and providers and support services need more coordination.
    - There are services available, but they are perceived as underutilized because residents do not know how to locate or use them.

- Low literacy and low health literacy contribute to poor outcomes.

- **The county does not have enough healthcare providers to serve the residents.**
  - There is a lack of behavioral health providers, dentists, specialists, and primary care providers (also noted in the 2015 Primary Healthcare Strategic Plan for the county[3]). While there has been some growth in providers, it has struggled to keep pace with the population growth and has been unable address deficits.
- **There is a perception that the county lacks quality healthcare providers.**
  - Surrounding jurisdictions are perceived to have better quality providers; residents with resources are perceived as often traveling outside the county for healthcare needs.
  - There is a lack of culturally competent and bilingual providers.
- **Lack of ability to access healthcare providers**
  - There are limited transportation options available, and the supply does not meet the need. There is also a lack of transportation for urgent but non-emergency needs that cannot be scheduled in advance.
  - The distribution of providers is uneven in the county; some areas have a high geographic concentration of providers, while other areas have very few or no providers available nearby.
- **Disparities in health outcomes are complicated**
  - Even though Black, non-Hispanic residents are more likely to be screened for cancer, they still have higher cancer mortality rates. The infant mortality rate for Black, non-Hispanic residents is significantly higher compared to other race/ethnic groups. It is challenging to determine how elements such as stress, culture, structural racism, and implicit bias contribute to health disparities along with the social determinants of health, healthcare access, and healthcare utilization, for example.

[3] Primary Healthcare Strategic Plan, 2015, http://www.pgplanning.org/Resources/Publications/PHSP.htm

Leading Health Challenges

- **Chronic conditions such as heart disease, diabetes, and stroke continue to lead in poor outcomes for many county residents.**
    - Residents have not adopted behaviors that promote good health, such as healthy eating and active living.
    - An estimated three-fourths of adults and one-third of high school students in the county are obese or overweight.
    - The lack of physical activity and increased obesity is closely related to residents with **metabolic syndrome**[4], which increases the risk for heart disease, diabetes, and stroke.
- **Behavioral health needs often overlap with other systems and can be exacerbated by other unmet needs such as housing.**
    - The hospitals, public safety, and criminal justice system see many residents needing behavioral health services and treatment.
    - The county lacks adequate resources needed to address residents with significant behavioral health issues.
    - Homeless residents often have unmet behavioral health needs, but addressing those needs is not often possible without stable housing.
    - Stigma around behavioral health continues to be an ongoing challenge in the county.
- **While the trends for many health issues have improved in the county, we still have significant disparities. For example:**
    - **Cancer:** Black residents in the county had higher mortality rates for breast, and prostate cancers, despite having higher screening rates.
    - **HIV:** Prince George's County had the second highest rate of HIV diagnoses in the state in 2017 and had the highest number of actual cases in the state.
    - **Substance Use:** White, non-Hispanic residents have a drug-related mortality rate nearly three times higher compared to Black, non-Hispanic residents (2015-2017).

[4] Metabolic Syndrome is a group of risk factors that raises the risk of heart disease and other health problems such as diabetes and stroke. The risk factors include: a large waist; high triglycerides (fat in the blood); low HDL or "good" cholesterol; high blood pressure, and high blood glucose (sugar). Source: NIH, accessed on 6/1/16, http://www.nhlbi.nih.gov/health/health-topics/topics/ms

- **Teen Births:** The Hispanic Teen Birth Rate is four times higher than Black, non-Hispanic teens and eleven times higher than White, non-Hispanic teens (2017).

Recommendations

- **Increase care coordination resources**
  - Trained community health workers were recognized as improving health outcomes for residents by navigating services and ensuring residents have the support and knowledge they need.
  - Residents need education about the available resources, and how to utilize and navigate them.
- **Increase community-specific outreach and education**
  - Similar to the 2016 findings, more outreach and education is needed at a community-level to be culturally sensitive and reach residents.
- **More funding and resource for health and support services.**
  - Funding is needed to strengthen the health safety net for those unable to access health insurance or unable to afford what is available.
  - There must be a focus on ensuring basic needs are being met for residents experiencing vulnerabilities in order for them to manage their health.
- **Attract a culturally-diverse quality healthcare workforce.**
  - One in five residents in the county were born outside the U.S. A diverse workforce would potentially help to address the cultural and language barriers experienced by residents.
  - Incentives to attract and academic partnerships to develop a quality workforce are needed to address identified deficits as well as increase provider availability in the county.
- **Increased partnerships and collaborative efforts are needed.**
  - Current coordinated efforts in the county were recognized as improving outcomes through care coordination and by and addressing systemic issues in the county.

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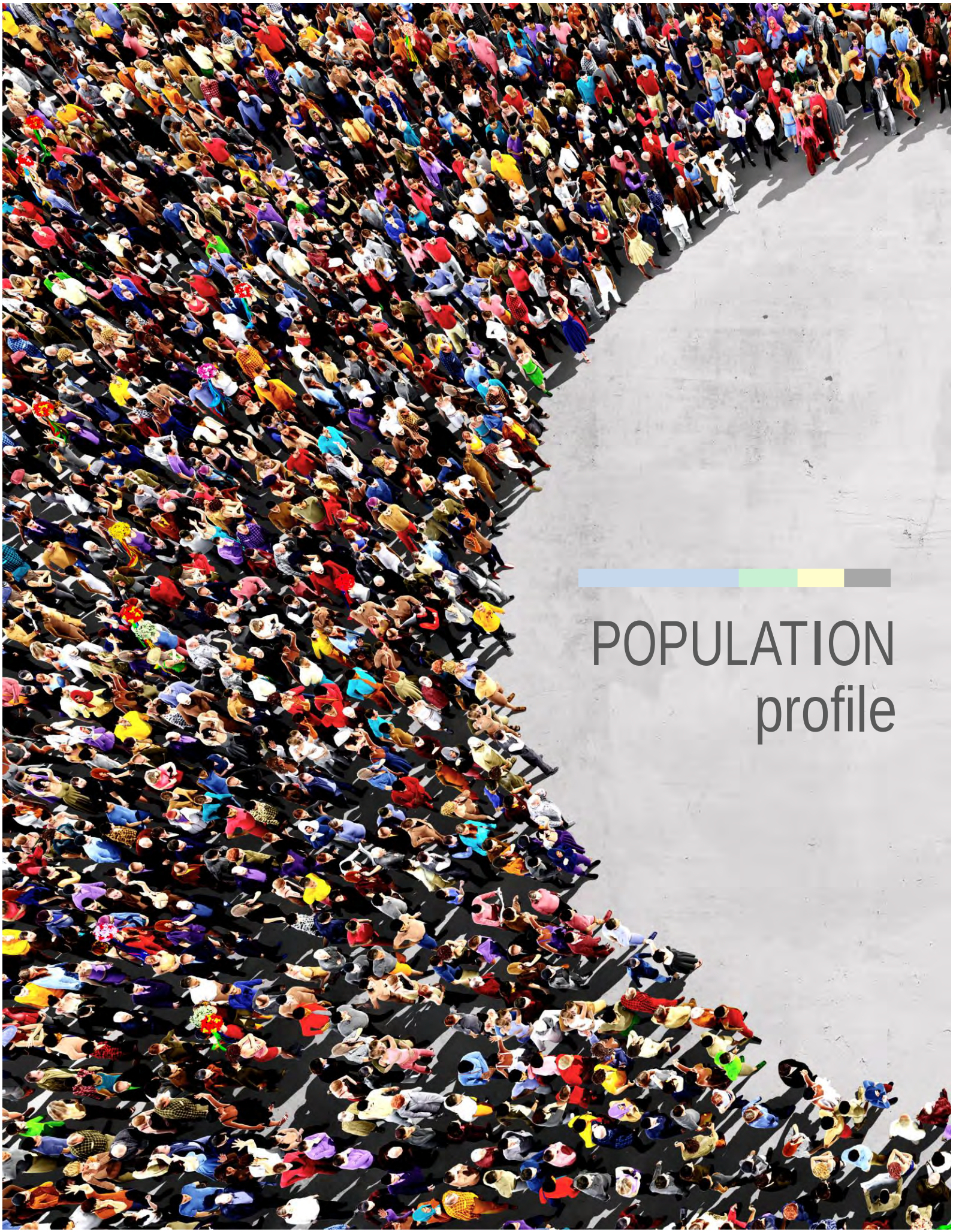

POPULATION profile

POPULATION PROFILE

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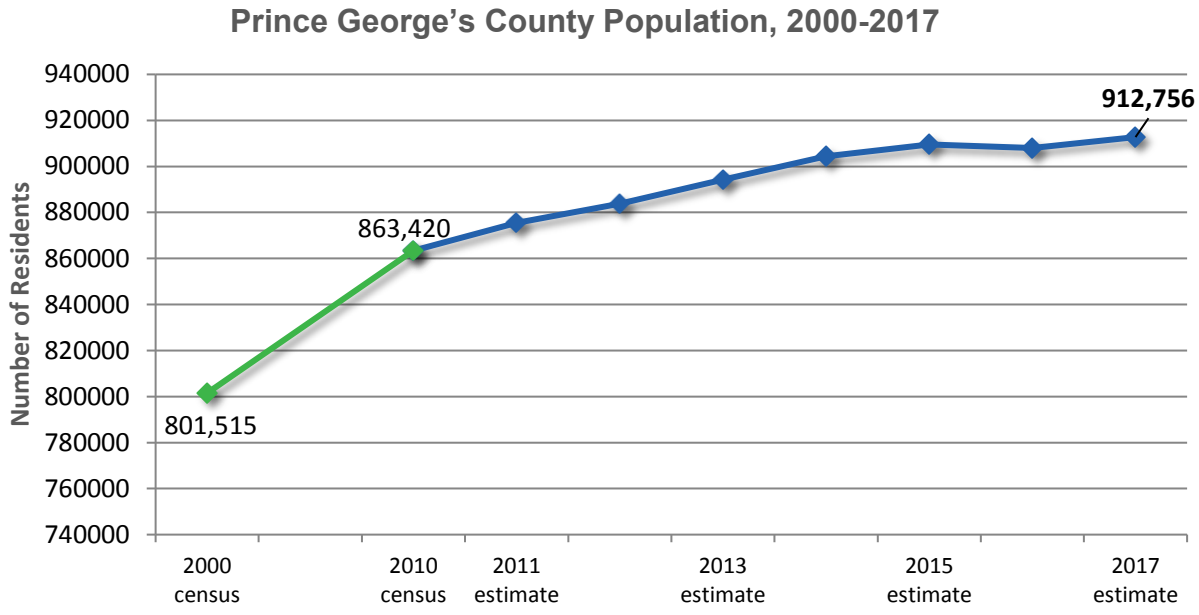
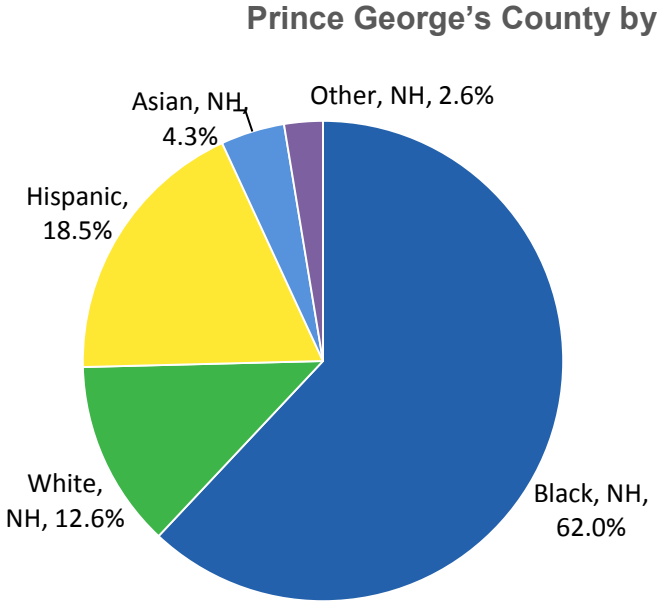
Overall Population

Prince George's County is the second largest jurisdiction in Maryland. The population of Prince George's County increased by over 110,000 residents since 2000. Between 2010 and 2017, the population increased by nearly 50,000 or 5.7%.



Data Source: U.S. Census, Annual Population Estimates;



The racial and ethnic composition of Prince George's County differs from Maryland and the United States. Black, non-Hispanics represent the majority of residents (62.0%), followed by Hispanics (18.5%). Since 2010, the Hispanic population has grown rapidly by 31.1%. The Asian, non-Hispanic population grew by 11.6% and the Black, non-Hispanic population grew by 3.2%. The White, non-Hispanic population declined by roughly 14,000 residents.

Data Source: 2017 American Community Survey 1-Year Estimates, Table DP05

Population Demographics, 2017

2017 Estimates	Prince George's	Maryland	United States
Population			
Total Population	**912,756**	**6,052,177**	**325,719,178**
Female	472,979 (52%)	3,116,355 (51%)	165,316,674
Male	439,777 (48%)	2,935,822 (49%)	160,402,504
Race and Hispanic Origin			
Black, NH	566,032 (62%)	1,776,692 (29%)	40,129,593 (12%)
Hispanic (any race)	169,032 (19%)	612,709 (10%)	58,846,134 (18%)
White, NH	115,126 (13%)	3,066,146 (51%)	197,285,202 (61%)
Asian, NH	38,838 (4%)	389,297 (6%)	17,999,846 (6%)
Other, NH	23,721 (2%)	207,333 (3%)	11,458,403 (3%)
Age			
Under 5 Years	59,081 (6%)	363,313 (6%)	19,795,159 (6%)
5-17 Years	144,244 (16%)	983,637 (16%)	53,853,524 (17%)
18-24 Years	90,094 (10%)	537,623 (9%)	30,820,412 (9%)
25-44 Years	256,964 (28%)	1,609,807 (27%)	86,083,640 (26%)
45-64 Years	245,420 (27%)	1,655,211 (27%)	84,350,731 (26%)
65 Years and Over	116,953 (13%)	902,586 (15%)	50,815,712 (16%)
Median Age (years)	37.2	38.7	38.1

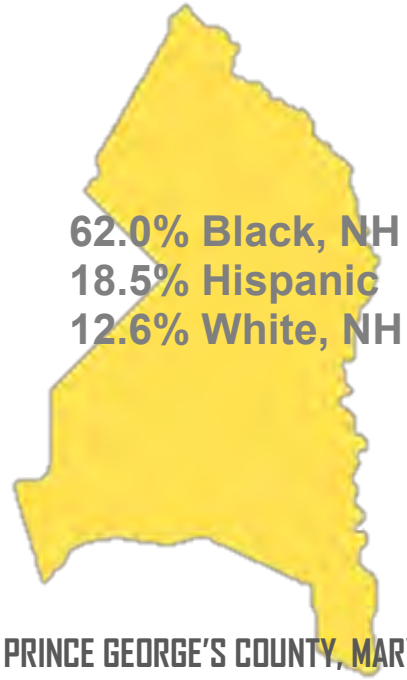
Data Source: 2017 American Community Survey 1-Year Estimates, Table DP05; U.S. Census Population Estimates

Prince George's County, Median Age by Race and Ethnicity, 2017

Race and Ethnicity	Median Age (yrs.)
Black	39.3
Hispanic, Any Race	28.7
White, NH	46.2
Asian	39.2

Data Source: 2017 American Community Survey 1-Year Estimates, Table B01002

Overall, the demographics of Prince George's County differ from the state of Maryland. While Maryland has a majority White, non-Hispanic (NH) population, Prince George's County has a majority Black, NH population. Prince George's County also has a higher proportion of Hispanic residents compared to the state.



PRINCE GEORGE'S COUNTY, MARYLAND

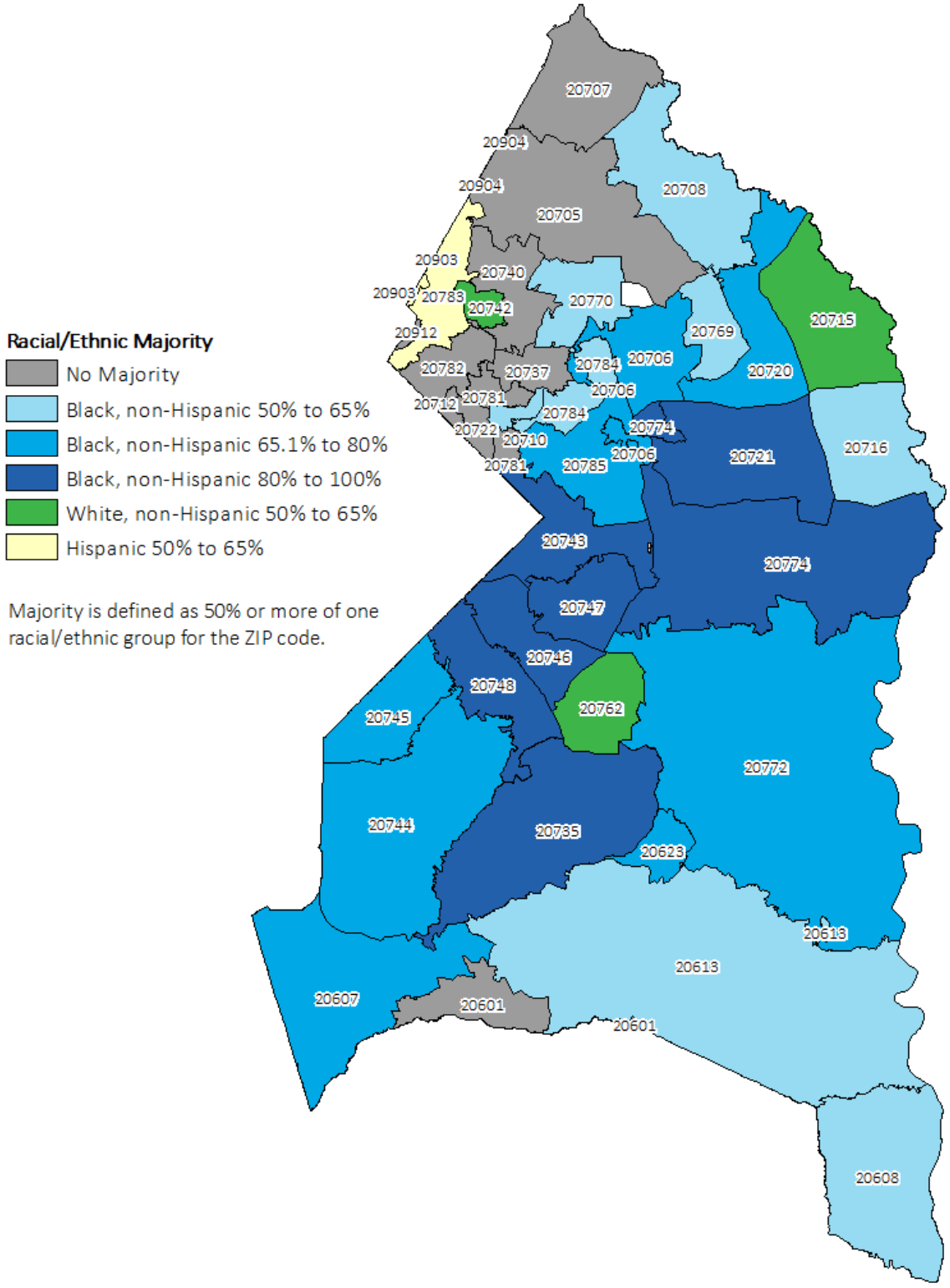
STATE OF MARYLAND

As of 2017, the median age in the county is 37.2 years, an increase of 1.1 years compared to 2014. However, the median age of the state and the United States remains higher than the county (38.7 and 38.1 years respectively). The population of county residents age 65 years and older is increasing: in 2014, 11% of the overall population was over the age of 65; in 2017, the 65 and older age group represents 13% of the population.

However, the median age varies substantially by race and ethnicity in the county. There is a 17.5 year difference between the median age of White, non-Hispanic residents (46.2 years) and Hispanic residents (28.7 years) in Prince George's County.

Reflective of the majority of the overall county population, the majority of ZIP codes in the county have a population of at least 50% Black, non-Hispanic residents. The northern part of the county continues to be more diverse with more ZIP codes with no race/ethnicity majorities.

ZIP Codes by Population Racial and Ethnic Majority, Prince George's County, 2013-2017

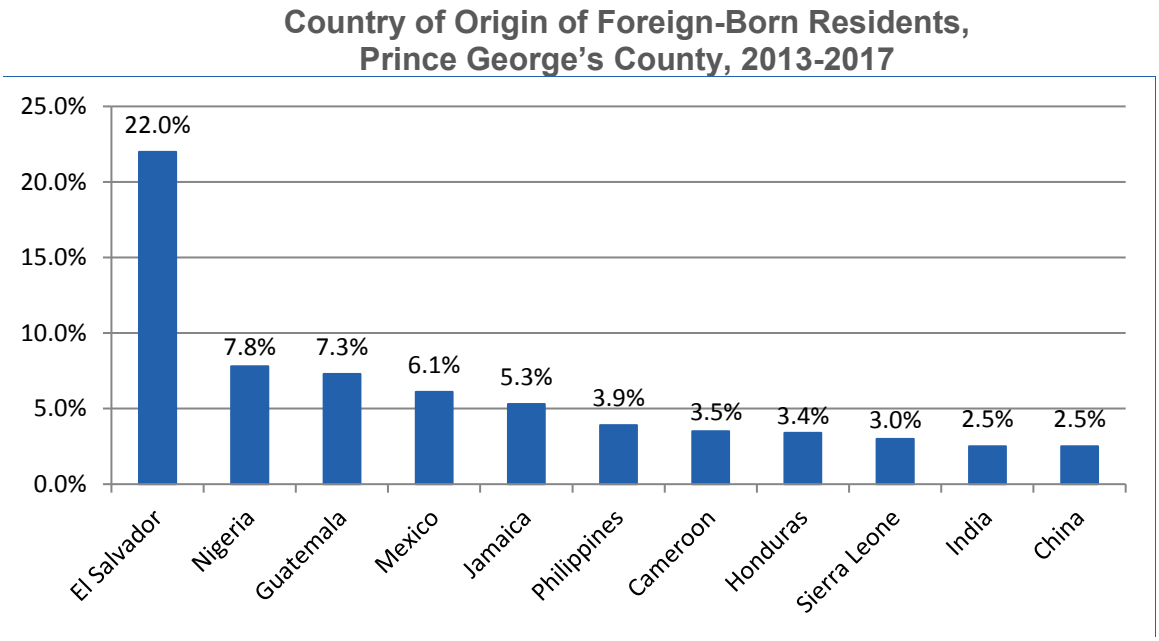


Data Source: 2013-2017 American Community Survey 5-Year Estimates, Table B03002

Foreign Born Residents

In Prince George's County, 1 out of every 5 residents (22.6%)[1] are born outside the United States. The countries that contribute the most to the foreign-born population include El Salvador, Nigeria, Guatemala, Mexico, and Jamaica: these five countries account for nearly half of the total foreign-born population. Residents born in the African countries of Cameroon and Sierra Leone increased compared to the previous 5-year period.

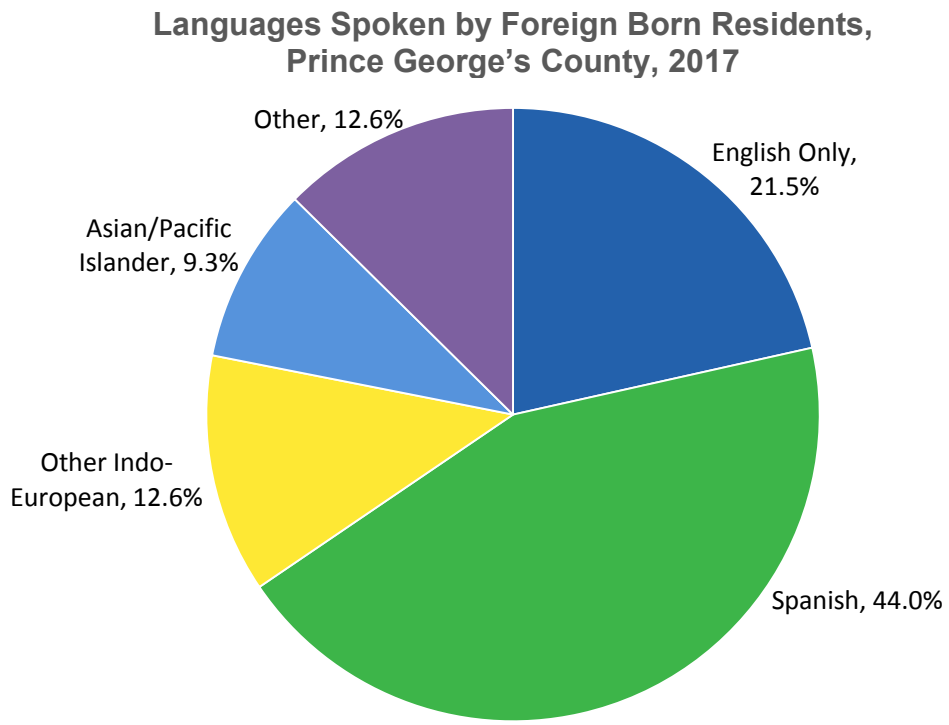
In 2017, there were over 200,000 foreign-born residents in the County. Of those residents, 45% are naturalized U.S. citizens with a median household income of $88,036, compared to $60,269 for the 55% who are not U.S. citizens.



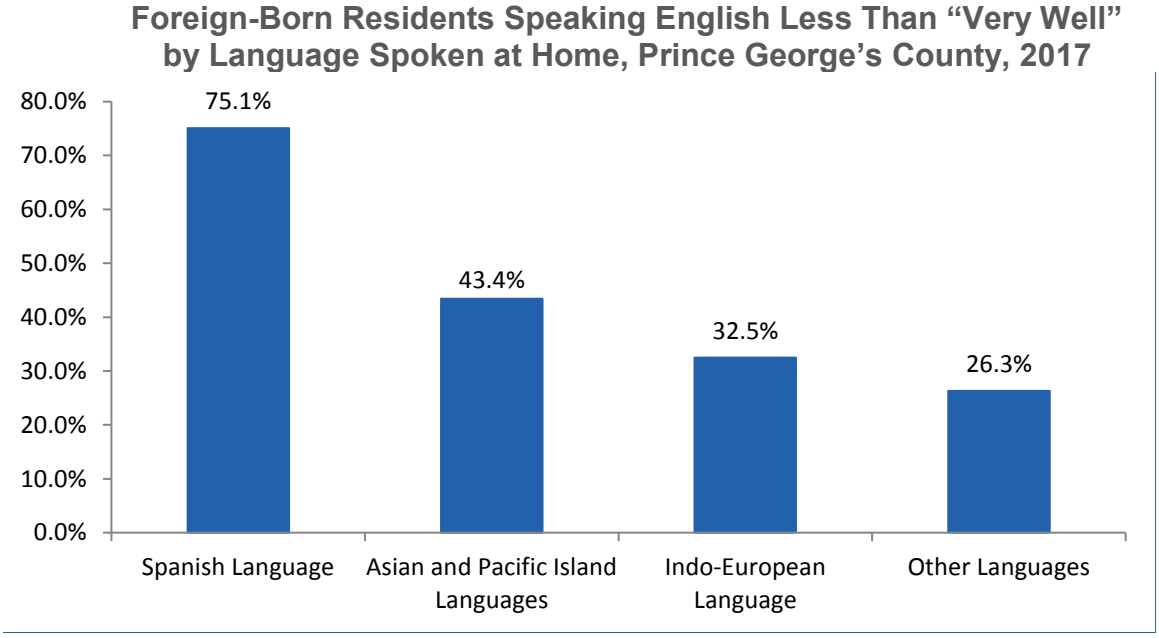
Data Source: 2013-2017 American Community Survey 5-Year Estimates, Table B05006

One in five (21.5%) of foreign-born residents speaks English as their primary language, down from 33.6% in 2014. Of the three-quarters of foreign-born residents speaking a language other than English, 44.5% report speaking English "very well." However, comfort with the English language is not the same for all foreign-born residents. Three out of four Spanish-speaking residents report speaking English less than "very well," substantially higher than residents speaking Asian, Indo-European and other languages.

[1] American Community Survey 1-year estimates, 2017, Table S0501



Data Source: 2017 American Community Survey 1-year estimates, Table C16005



Data Source: 2017 American Community Survey 1-year estimates, Table C16005

Poverty

The proportion of individuals living in poverty in Prince George's County decreased to 8.4% in 2017 from 10.2% in 2014. The proportion of individuals living in poverty is lower in the county compared to Maryland and the U.S, but disparities continue to exist across several sociodemographic factors. One in ten females live in poverty in the county, compared to only 6.9% of males. The proportion of individuals living in poverty decreases with age and higher levels of educational attainment. Eleven percent of children (under 18 years of age) in the county live in poverty as of 2017. Poverty across individuals of different races and ethnicities also varies. About 13% of Hispanic residents in the county live in poverty, compared to 8.4% of White, non-Hispanic and 7.0% of Black, non-Hispanic residents.

Individual Poverty Status in the Past 12 Months, Prince George's County, 2017

Indicators	Prince Georges County		Maryland	U.S.
	N	% Poverty	% Poverty	% Poverty
Total individuals in poverty	74,902	8.4%	9.3%	13.4%
Male	29,778	6.9%	8.4%	12.2%
Female	45,124	9.7%	10.1%	14.5%
Age				
Under 18 years	22,031	11.0%	12.0%	18.4%
18 to 64 years	45,004	7.8%	8.6%	12.6%
65 years and over	7,867	6.9%	7.9%	9.3%
Race & Ethnicity				
Black	39,460	7.0%	13.3%	23.0%
Hispanic (of any race)	21,501	12.8%	13.1%	19.4%
White, non-Hispanic	8,987	8.4%	6.3%	9.6%
Asian	2,556	6.9%	7.0%	11.1%
Educational Attainment (population 25 years+)				
Less than high school	11,860	14.9%	20.4%	24.7%
High school graduate (or equivalent)	13,667	8.3%	11.6%	13.7%
Some college, associate's degree	9,219	5.3%	7.0%	9.5%
Bachelor's degree and higher	6,919	3.5%	3.2%	4.3%

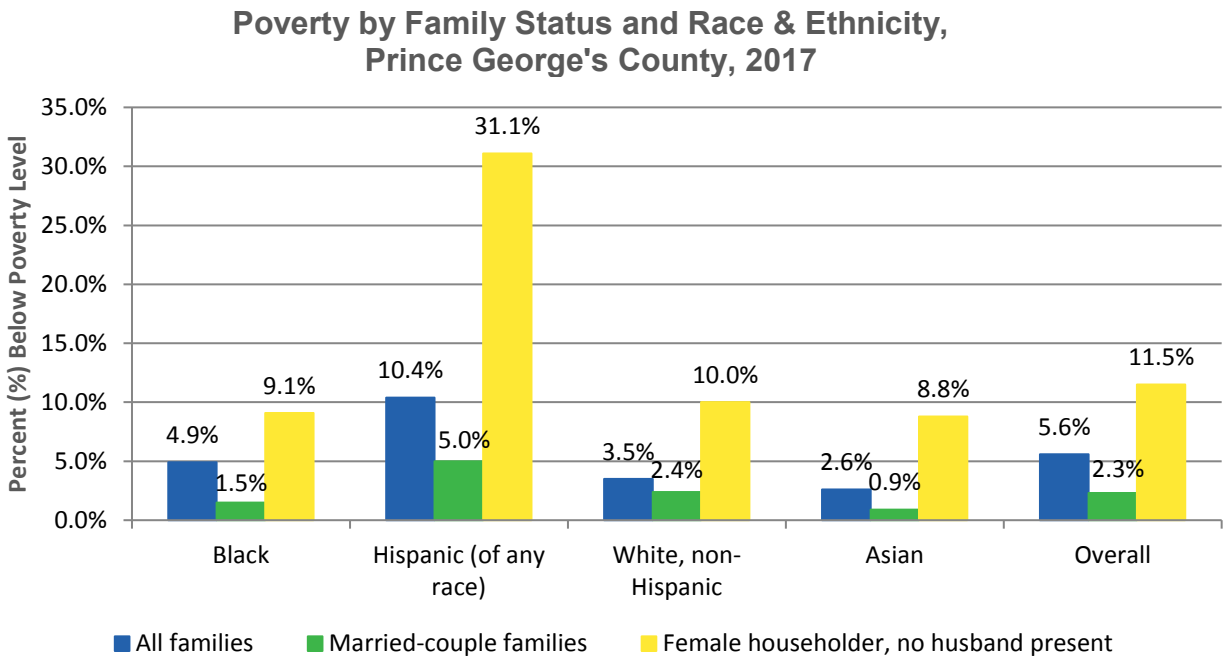
Data Source: American Community Survey 1-Year Estimates, 2017, Table S1701

Poverty status among families in Prince George's County decreased from 7% in 2014 to 5.6% in 2017, lower than both Maryland at 6.2% and the United States at 9.5%. Over one in ten (11.5%) families with only a female head of household lives in poverty in the county, a figure that increases to 17.7% if the household has children under age 18. Almost one-third of Hispanic families with only a female head of household live in poverty in 2017, which is two times higher compared to single female households of other race/ethnicities.

Family Poverty Status in the Past 12 Months, 2017

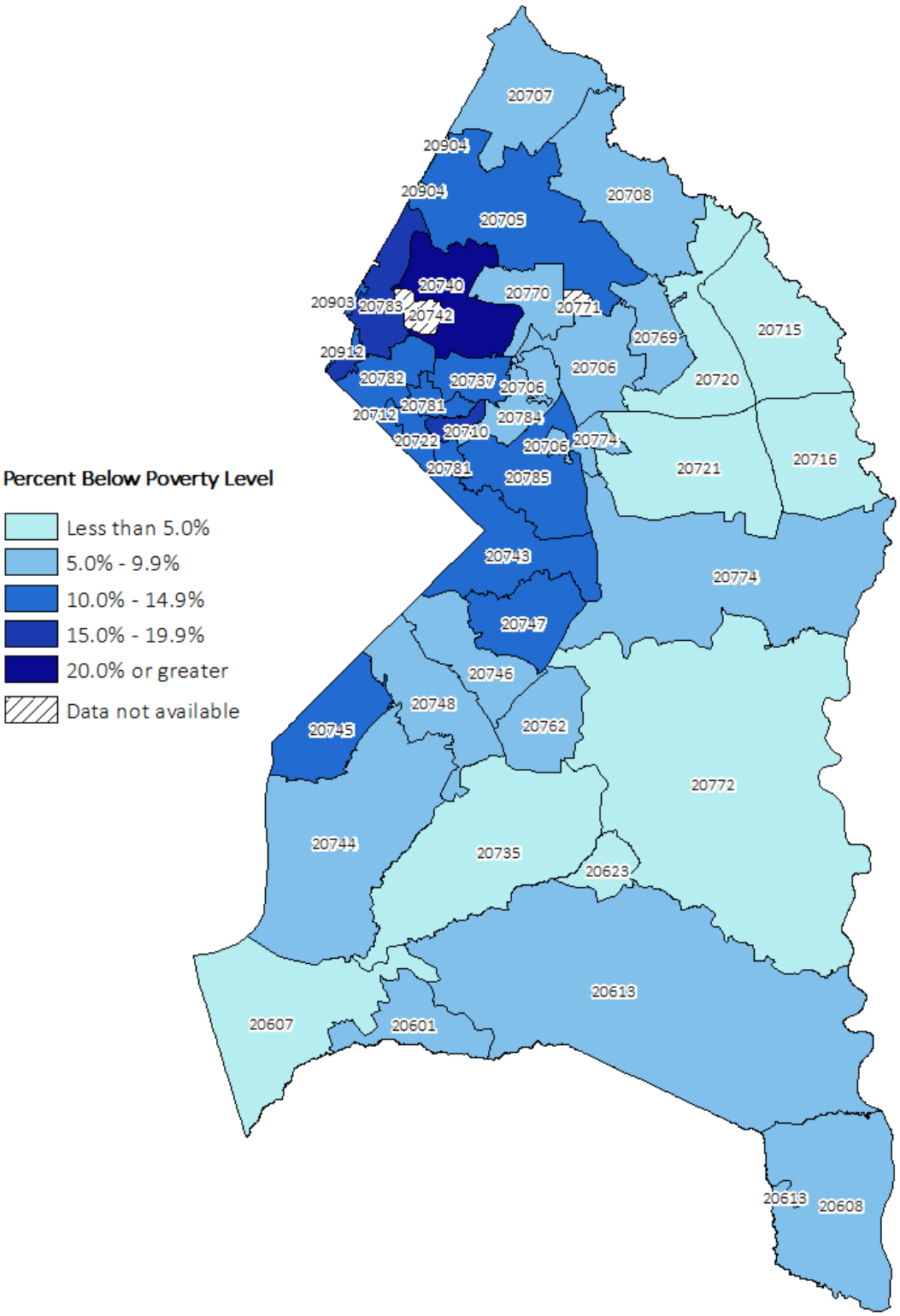
	Prince George's County % Poverty	Maryland % Poverty	United States % Poverty
All families	5.6%	6.2%	9.5%
With related children under 18 years	8.4%	9.2%	15.0%
Married couple families	2.3%	2.6%	4.8%
With related children under 18 years	3.3%	2.8%	6.6%
Families with female householder, no husband present	11.5%	17.4%	26.2%
With related children under 18 years	17.7%	24.5%	35.7%

Data Source: 2017 American Community Survey 1-Year Estimates, Table S1702



Data Source: 2017 American Community Survey 1-Year Estimates, Table S1702

Percent of Residents Living in Poverty by ZIP Code, Prince George's County, 2013-2017



Data Source: 2013-2017 American Community Survey 5-Year Estimates, Table S1701

Percent of Residents Living in Poverty by ZIP Code, Prince George's County, 2013 - 2017

ZIP	Area	Poverty Percentage
20601	Waldorf	6.0%
20607	Accokeek	3.1%
20608	Aquasco	5.8%
20613	Brandywine	5.2%
20623	Cheltenham	1.6%
20705	Beltsville	10.4%
20706	Lanham	9.4%
20707	Laurel	7.5%
20708	Laurel	7.2%
20710	Bladensburg	19.4%
20712	Mount Rainier	10.7%
20715	Bowie	3.6%
20716	Bowie	4.3%
20720	Bowie	3.2%
20721	Bowie	4.7%
20722	Brentwood	12.6%
20735	Clinton	4.9%
20737	Riverdale	14.8%
20740	College Park	23.5%
20743	Capitol Heights	13.5%
20744	Fort Washington	8.5%
20745	Oxon Hill	11.7%
20746	Suitland	9.5%
20747	District Heights	10.5%
20748	Temple Hills	8.7%
20762	Andrews Air Force Base	5.4%
20769	Glenn Dale	5.6%
20770	Greenbelt	9.3%
20772	Upper Marlboro	4.5%
20774	Upper Marlboro	6.1%
20781	Hyattsville	10.4%
20782	Hyattsville	11.7%
20783	Hyattsville	15.4%
20784	Hyattsville	7.6%
20785	Hyattsville	11.8%
20903	Silver Spring	13.7%
20904	Silver Spring	8.5%
20912	Takoma Park	11.6%

Data Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table DP03

Food Stamp/Supplemental Nutrition Assistance Program (SNAP) Benefits

Prince George's County had a lower proportion of households receiving food stamps/ SNAP benefits in 2017 (8.6%) compared to Maryland (10.3%) and the United States (11.7%). Almost 40% of county residents receiving food stamps/SNAP have a disability and 37.9% have at least one person in the household over 60 years of age.

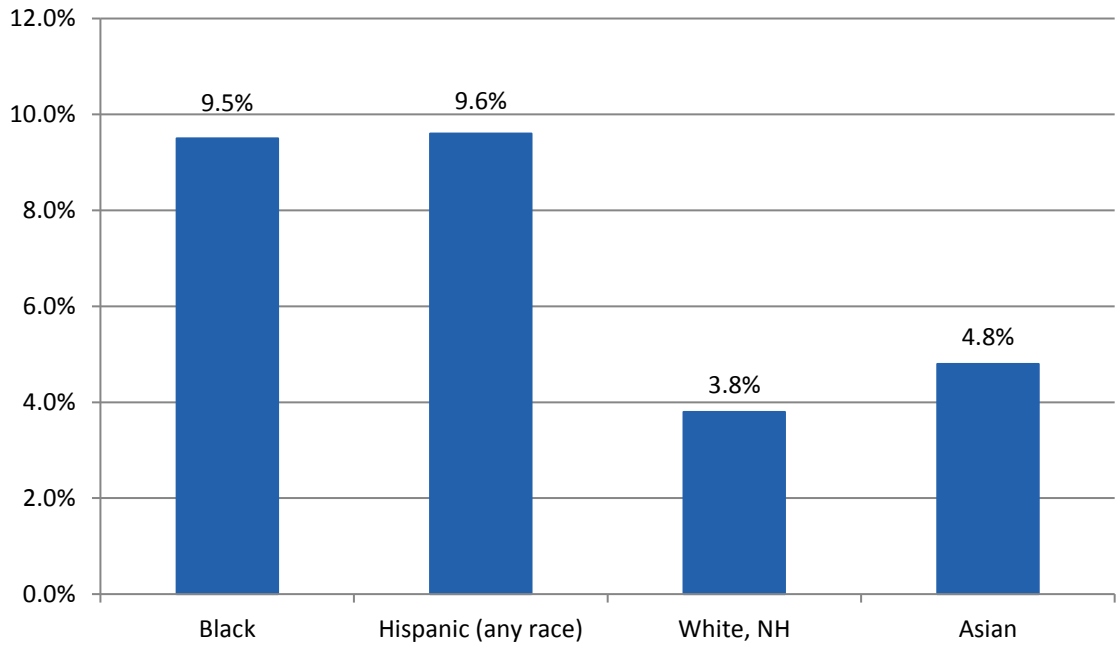
Percent of Household with Food Stamp/SNAP Benefits, 2017

	Prince George's County	Maryland	United States
Households Receiving Food Stamps/SNAP	8.6%	10.3%	11.7%

Data Source: 2017 American Community Survey 1-Year Estimates, Table S2201

Almost one in ten Hispanic (9.6%) and Black, non-Hispanic (9.5%) households received food stamps/SNAP in 2017, twice that of White, non-Hispanic (3.8%) and Asian (4.8%) households. Households receiving food stamps/SNAP across county ZIP codes ranged from 2.4% (Cheltenham) to 24.9% (Bladensburg).

Percent of Households Receiving Food Stamps/SNAP by Race and Ethnicity, Prince George's County, 2017



Data Source: 2017 American Community Survey 1-Year Estimates, Table B22005

Percentage of Households with Food Stamp/SNAP Benefits by ZIP Code, Prince George's County, 2013-2017

ZIP	Area	Percent of Households on SNAP
20601	Waldorf	6.1%
20607	Accokeek	7.8%
20608	Aquasco	6.6%
20613	Brandywine	4.9%
20623	Cheltenham	2.4%
20705	Beltsville	9.1%
20706	Lanham	10.2%
20707	Laurel	7.6%
20708	Laurel	9.3%
20710	Bladensburg	24.9%
20712	Mount Rainier	15.0%
20715	Bowie	2.6%
20716	Bowie	4.7%
20720	Bowie	3.4%
20721	Bowie	4.3%
20722	Brentwood	14.9%
20735	Clinton	6.9%
20737	Riverdale	18.6%
20740	College Park	7.5%
20743	Capitol Heights	21.2%
20744	Fort Washington	7.2%
20745	Oxon Hill	19.0%
20746	Suitland	14.6%
20747	District Heights	14.6%
20748	Temple Hills	13.8%
20762	Andrews Air Force Base	2.5%
20769	Glenn Dale	10.8%
20770	Greenbelt	9.8%
20772	Upper Marlboro	7.5%
20774	Upper Marlboro	7.0%
20781	Hyattsville	9.8%
20782	Hyattsville	10.1%
20783	Hyattsville	10.5%
20784	Hyattsville	12.8%
20785	Hyattsville	17.0%
20903	Silver Spring	15.4%
20904	Silver Spring	10.1%
20912	Takoma Park	11.3%

Data Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table DP03

Income

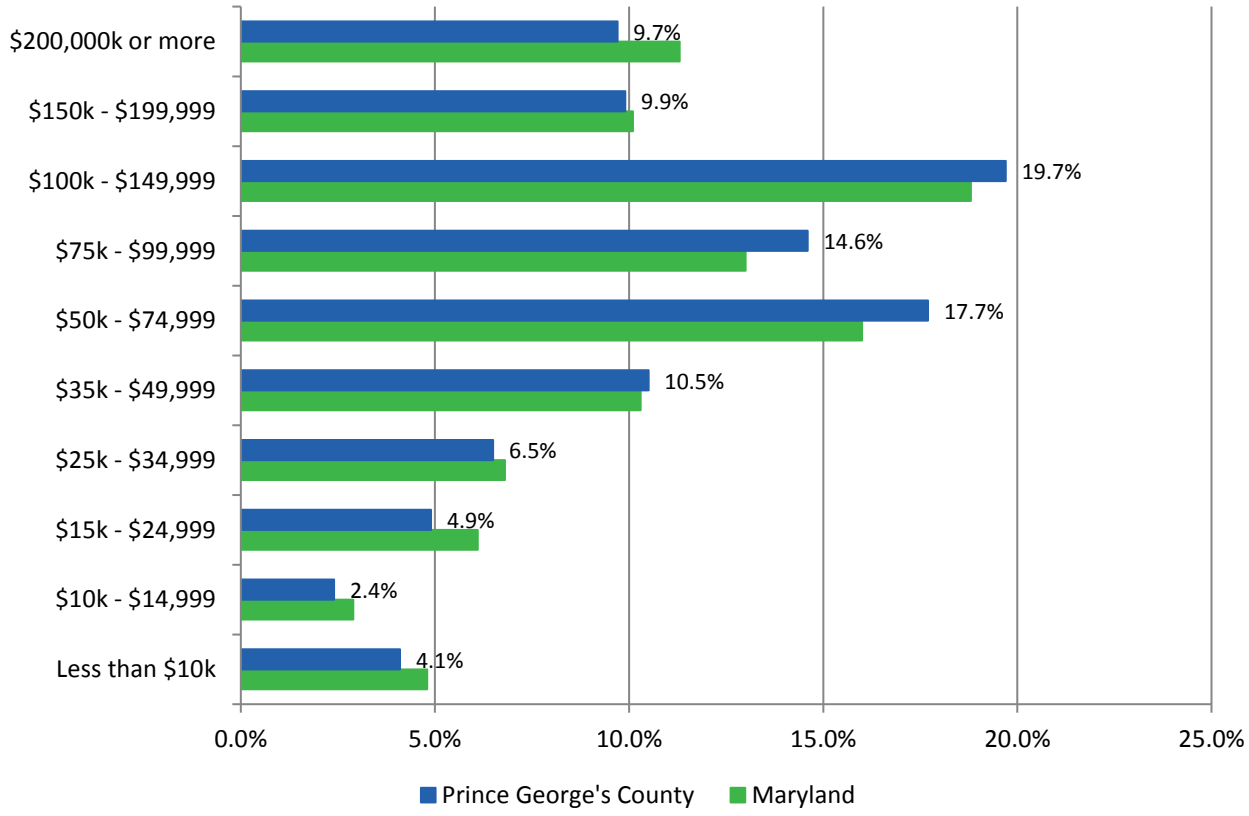
The median household income in the County is $81,240, exceeding both Maryland ($80,776) and the U.S. ($60,336). This is a noticeable increase from 2014 with a median household income of $72,290 for the county. In 2017, almost 40% of county households make more than $100,000 per year, similar to the state.

Income in the Past 12 Months (In 2017 Inflation-Adjusted Dollars)

	Prince George's County	Maryland	United States
Median household income	$81,240	$80,776	$60,336
Mean household income	$99,417	$106,035	$84,525
Median family income	$94,069	$98,393	$73,891
Mean family income	$112,461	$123,678	$99,114

Data Source: 2017 American Community Survey 1-Year Estimates, Table S1901

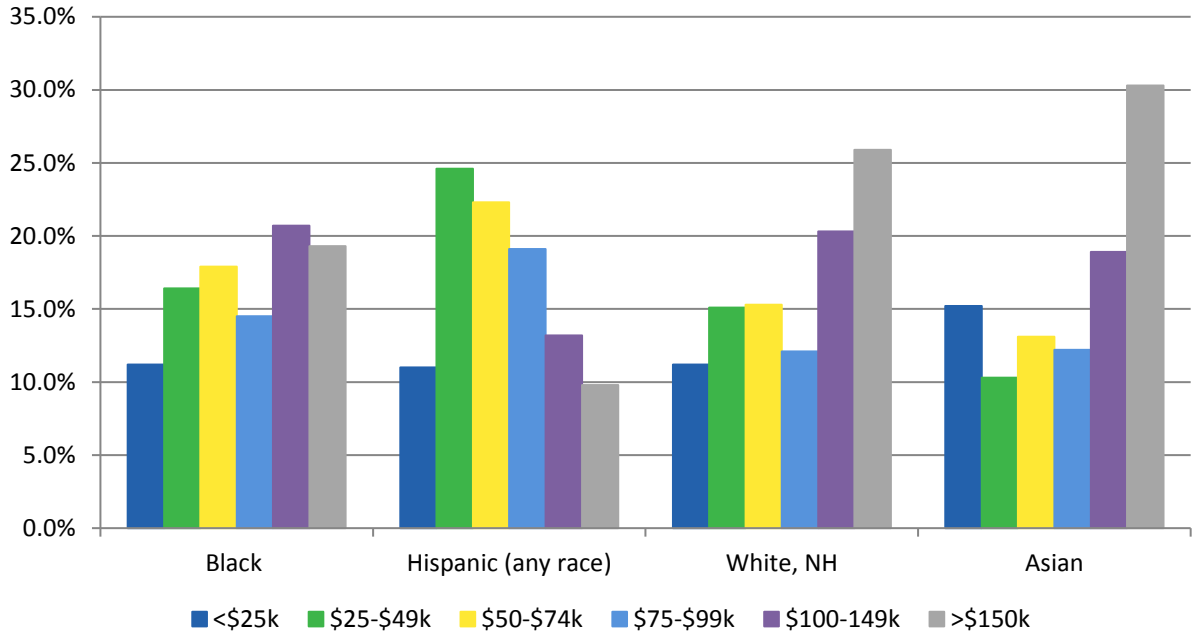
Household Income (In 2017 Inflation-Adjusted Dollars)



Data Source: 2017 American Community Survey 1-Year Estimates, Table S1901

By race, a higher percentage of Asian households earn below $25,000 (15.2%) but they also comprise the highest percentage earning $100,000 and more (49.2%). There continues to be an income disparity for Hispanic residents compared to other races and ethnicities: over one-third (35.6%) of Hispanic households earn less than $50,000 per year.

Household Income (In 2017 Inflation-Adjusted Dollars) by Race and Ethnicity, Prince George's County



Data Source: 2017 American Community Survey 1-Year Estimates, Table B19001

Disability

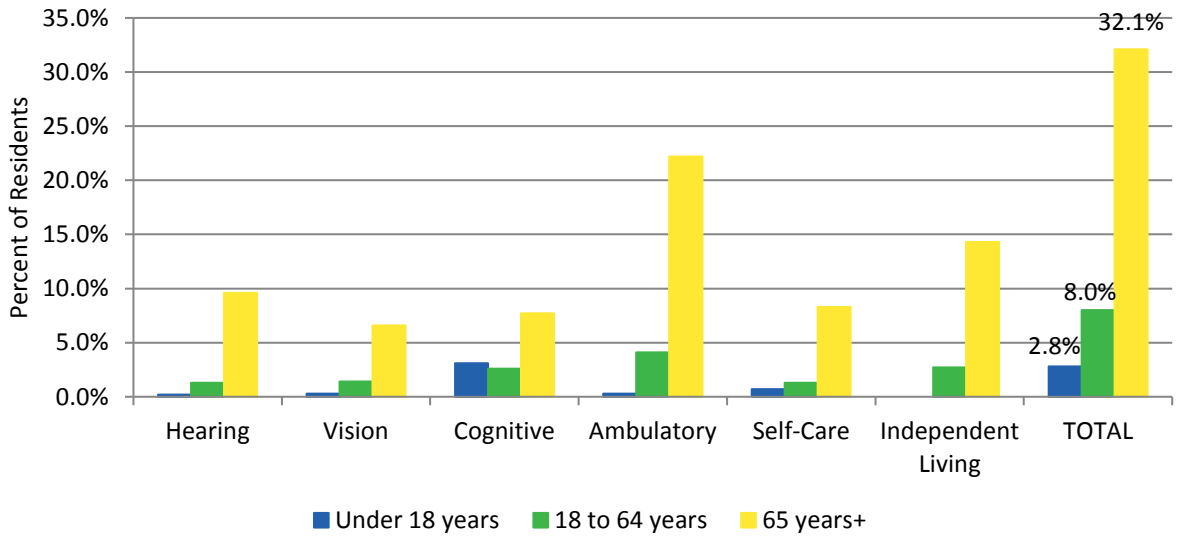
The accepted definitions of disability have changed over the past 40 years. In the 1960's and 1970's, a medical definition of disability was generally used, limited primarily to physical impairments. However, as time progressed, definitions expanded to include social and mental impairments as well as independence[2]. In 2017, one in ten Prince George's County residents lives with a disability, lower than the state at 11.1% and the U.S. at 12.7%. One-third of county residents over the age of 65 lives with a disability, the majority with ambulatory disabilities.

Percent of Residents with a Disability, 2017

Indicators	Prince George's County	Maryland	U.S.
Total individuals in poverty	9.9%	11.1%	12.7%
Male	8.7%	10.6%	12.6%
Female	10.9%	11.5%	12.8%
Age Group			
Under 18 years	2.7%	3.8%	4.2%
18 to 64 years	8.0%	9.0%	10.3%
65 years and over	32.1%	31.2%	34.6%
Race/Ethnicity			
Black	10.4%	12.0%	14.0%
Hispanic (of any race)	4.9%	6.3%	9.0%
White, non-Hispanic	14.4%	12.2%	14.0%
Asian	8.0%	6.6%	7.1%

Data Source: 2017 American Community Survey 1-Year Estimates, Table S1810

Percent of Residents by Disability and Age, Prince George's County, 2017



Data Source: 2017 American Community Survey 1-Year Estimates, Table S1810

[2] https://www.census.gov/topics/health/disability/about.html

Education

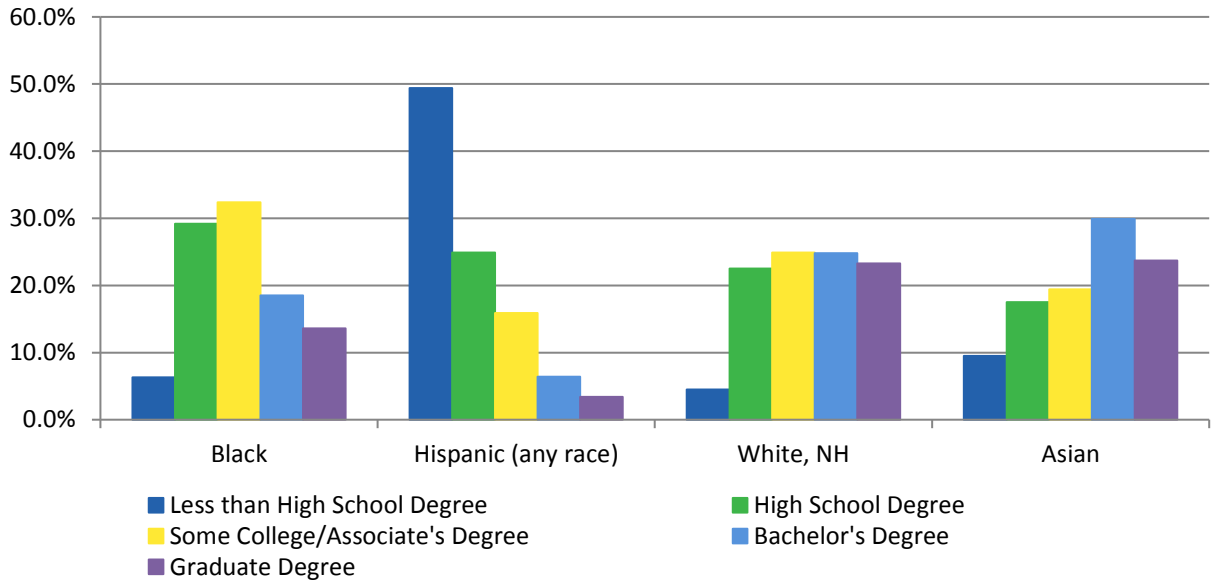
In 2017, about 87% of Prince George's County residents 25 years and older have at least a high school education, up from 85% in 2014 but lower than Maryland (90%) and the U.S. (88%). One-third of county residents have at least a bachelor's degree or higher, similar to the country; however, this lags behind the state where almost 40% have at least a bachelor's degree.

Percent of Residents 25 Years and Older by Education, 2017

	Prince George's County (n=619,337)	Maryland (n=4,167,604)	United States (n=221,250,083)
Less than 9th Grade	6.5%	4.0%	5.1%
9th to 12th Grade, No Diploma	6.4%	6.1%	6.9%
High School Graduate	26.9%	24.5%	27.1%
Some College, No Degree	21.8%	18.9%	20.4%
Associate's Degree	6.4%	6.8%	8.5%
Bachelor's Degree	18.1%	21.3%	19.7%
Graduate or Professional Degree	14.0%	18.3%	12.3%

Data Source: 2017 American Community Survey 1-Year Estimates, Table S1501

Percent of Residents 25 Years and Older by Education and Race/Ethnicity, Prince George's County, 2017

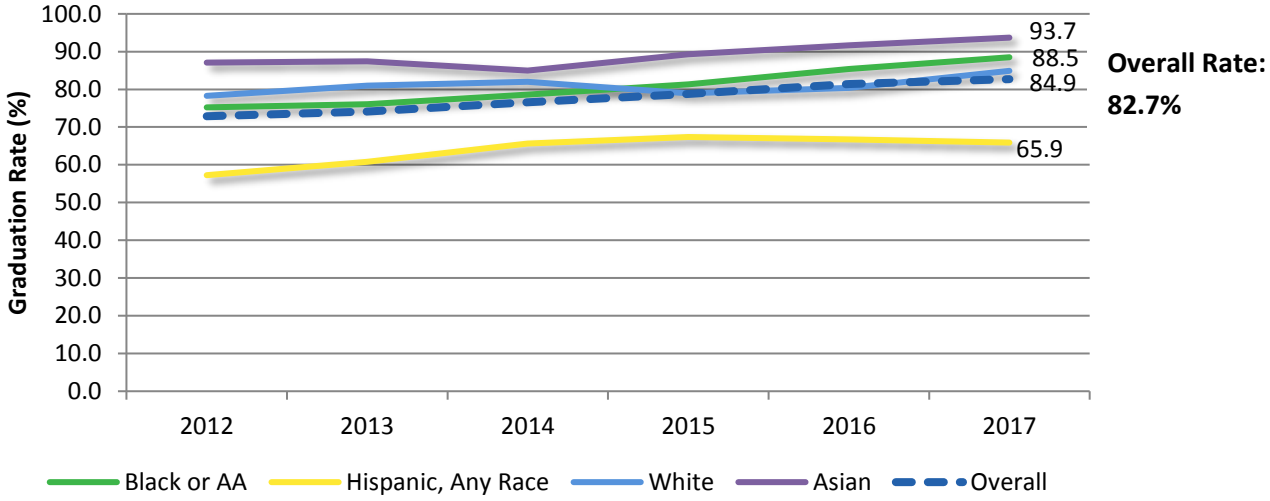


Data Source: 2017 American Community Survey 1-Year Estimates, Table B15002

Education level attainment varies across races and ethnicities in Prince George's County. Almost half of county Hispanic residents 25 years and older do not have a high school degree and less than 10% have at least a bachelor's degree. Conversely, over half of White, non-Hispanic and Asian, non-Hispanic residents 25 years and older have at least a bachelor's degree. Although most Black, non-Hispanics have at least a high school degree, less have at least a bachelor's degree compared to White, NH and Asian, NH residents.

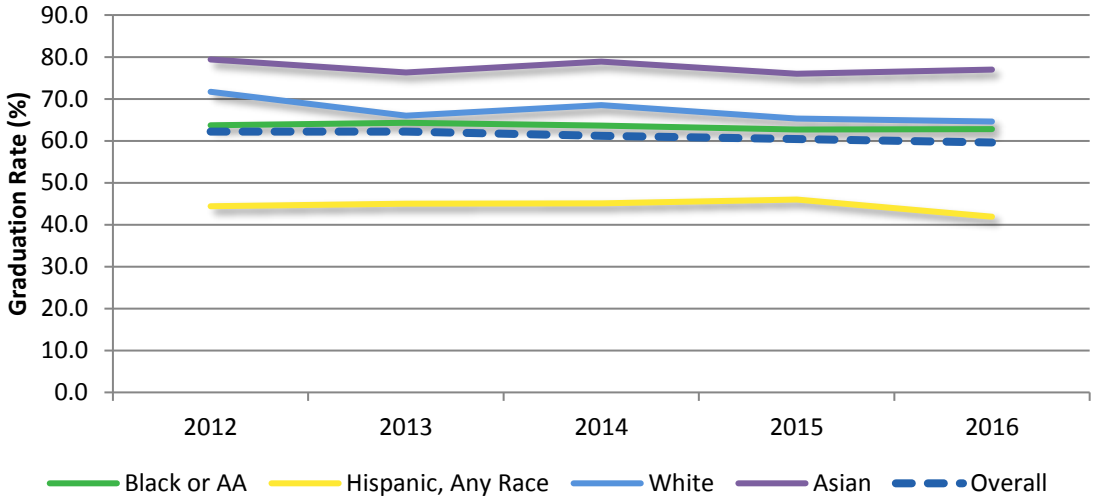
In 2017, the overall rate of graduation in Prince George's County Public Schools was 82.7%. While the overall graduation rate has increased since 2012, Hispanic students are much less likely than other race/ethnicities to complete high school in the County. Overall, the graduation rate in Prince George's County was lower compared to Maryland (87.7%) in 2017.

Graduation Rate by Race/Ethnicity, Prince George's County Public Schools



Data Source: 2012-2017 Maryland Report Card

Nationwide College Enrollment 16 Months Post High School by Race/Ethnicity, Prince George's County Public Schools



Data Source: 2012-2017 Maryland Report Card

Percentage of Residents Without High School or Equivalent Education by ZIP Code, Prince George's County, 2013-2017

ZIP	Area	Percent Without High School or Equivalent
20601	Waldorf	6.9%
20607	Accokeek	4.7%
20608	Aquasco	21.8%
20613	Brandywine	9.0%
20623	Cheltenham	7.1%
20705	Beltsville	16.6%
20706	Lanham	16.6%
20707	Laurel	12.3%
20708	Laurel	12.3%
20710	Bladensburg	23.3%
20712	Mount Rainier	26.4%
20715	Bowie	4.5%
20716	Bowie	5.3%
20720	Bowie	6.1%
20721	Bowie	3.1%
20722	Brentwood	33.8%
20735	Clinton	7.5%
20737	Riverdale	33.5%
20740	College Park	12.0%

20743	Capitol Heights	16.8%
20744	Fort Washington	8.5%
20745	Oxon Hill	16.6%
20746	Suitland	9.9%
20747	District Heights	10.6%
20748	Temple Hills	9.3%
20762	Andrews Air Force Base	3.0%
20769	Glenn Dale	8.0%
20770	Greenbelt	10.7%
20772	Upper Marlboro	6.2%
20774	Upper Marlboro	4.9%
20781	Hyattsville	27.6%
20782	Hyattsville	24.7%
20783	Hyattsville	45.2%
20784	Hyattsville	24.2%
20785	Hyattsville	13.8%
20903	Silver Spring	35.0%
20904	Silver Spring	9.4%
20912	Takoma Park	14.1%

Data Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table S1501

Employment

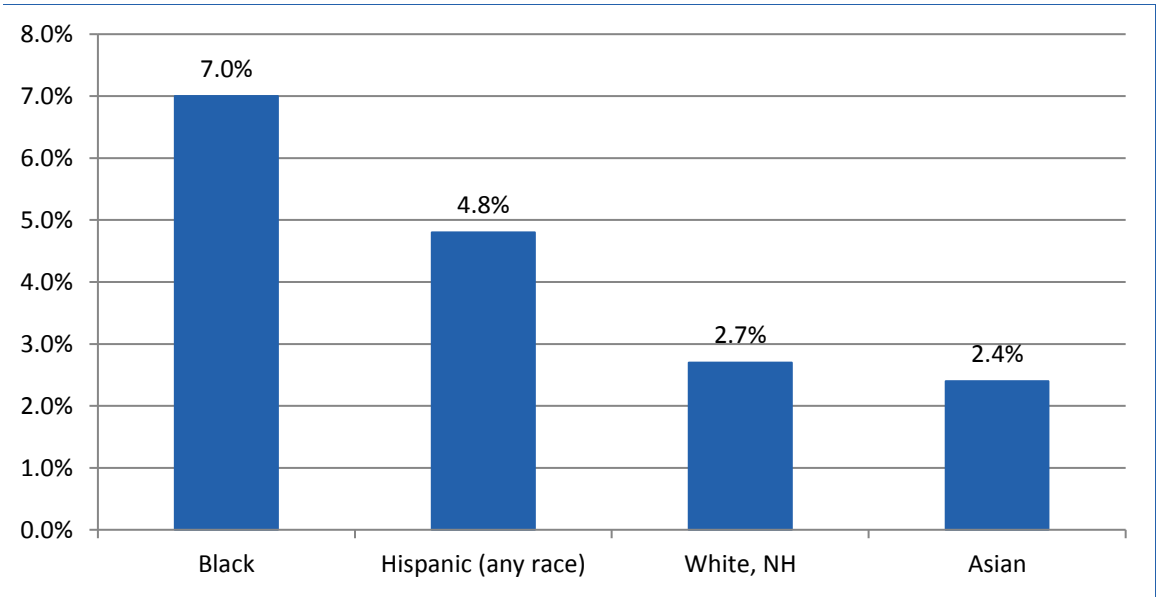
Since 2014, unemployment in Prince George's County has decreased considerably. In 2014, 9.1% of county residents were unemployed. In 2017, 5.9% of county residents were unemployed; however, the rate remains slightly higher than Maryland (5.2%) and the U.S. (5.3%). The county unemployment rate varies by education, disability status, and by race and ethnicity. One-quarter of unemployed individuals live in poverty, and over one in ten unemployed individuals have a disability. In 2017, unemployment was highest among Black residents, and lowest among Asian residents.

Unemployment Rate for Residents 16 Years and Older, 2017

	Prince George's County	Maryland	United States
Population 16 years and older	5.9%	5.2%	5.3%
Below Poverty Level	24.4%	20.9%	20.9%
With Any Disability	11.6%	11.5%	11.5%
Educational Attainment (Ages 25-64 Years)			
Less than High School	5.3%	8.6%	8.0%
High School Graduate	6.6%	6.5%	5.7%
Some College or Associate's Degree	5.8%	4.4%	4.3%
Bachelor's Degree or Higher	2.5%	2.4%	2.6%

Data Source: 2017 American Community Survey 1-Year Estimates, Table S2301

Unemployment Rate, Prince George's County, 2017

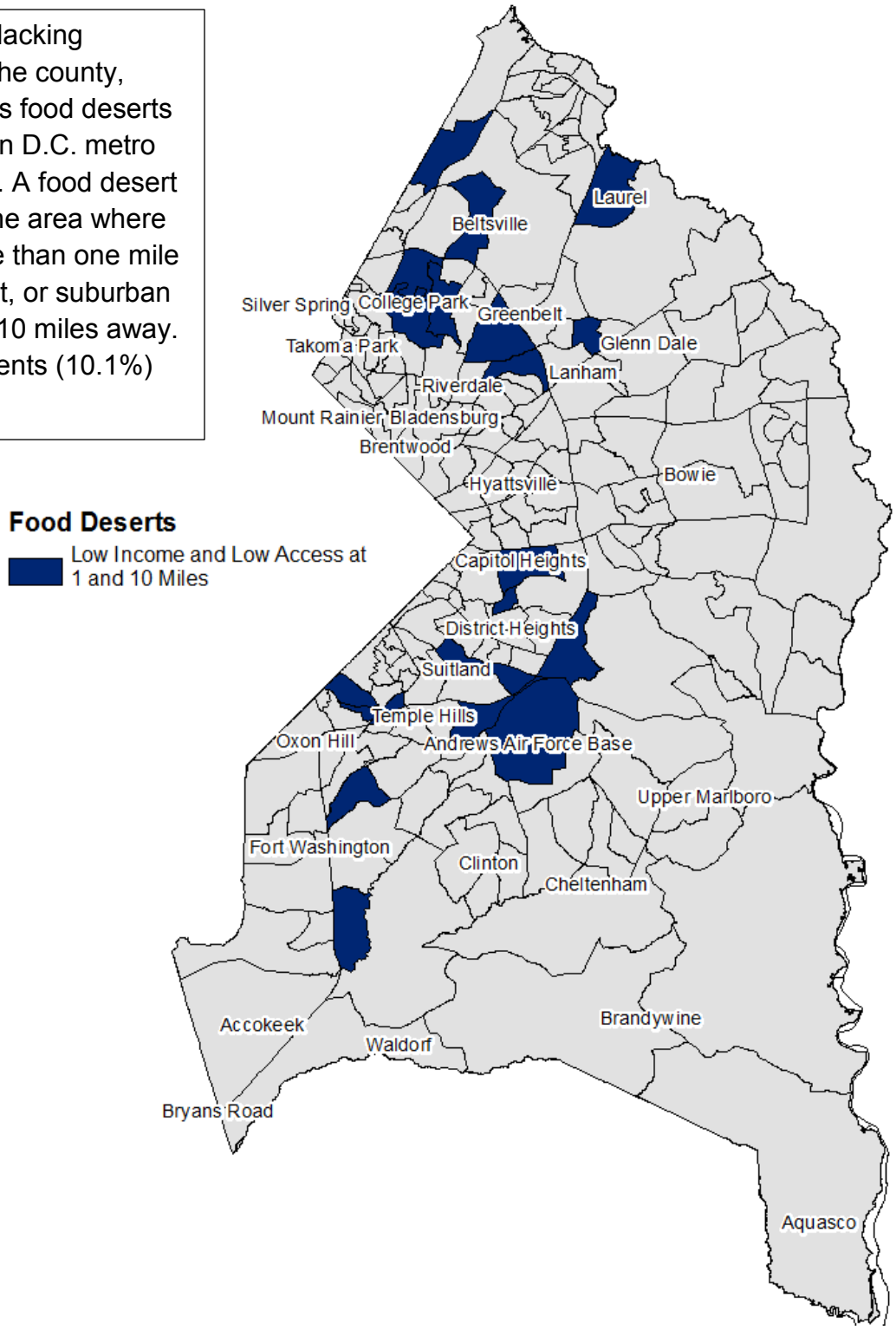


Data Source: 2017 American Community Survey 1-Year Estimates, Table S2301

Access to Food

A food desert is an area lacking supermarket access. In the county, most areas designated as food deserts are within the Washington D.C. metro area (inside the beltway). A food desert is defined as a low income area where urban residents are more than one mile away from a supermarket, or suburban residents are more than 10 miles away. As of 2015, 94,000 residents (10.1%) live in a food desert.

Food Deserts, Prince George's County, 2015

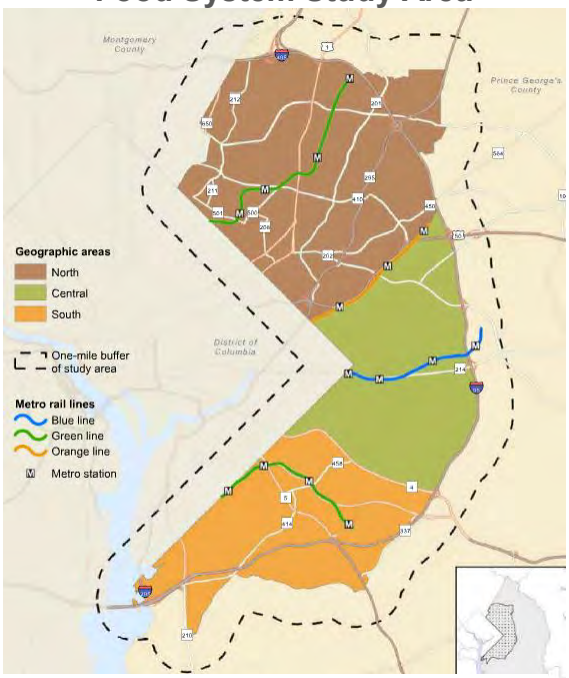


Data Source: United States Department of Agriculture, Economic Research Service, 2015 Food Access Research Atlas

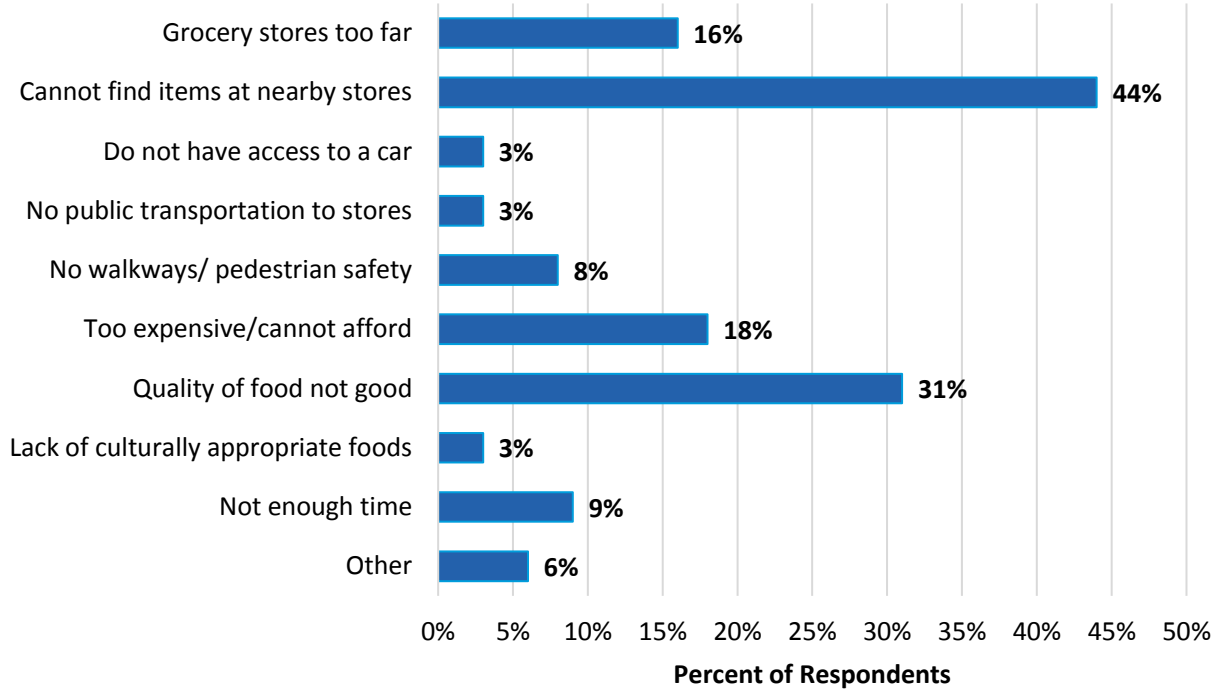
Prince George's County Food System Study, 2015

A 2015 food system study of the area of Prince George's County adjacent to Washington, DC, found that many residents had food access challenges related to the quality of local stores and what they carry than the physical access to food outlets. Many residents do not patronize nearby supermarkets but travel elsewhere, even to other jurisdictions, where more variety and better quality food are sold for less".[3] This finding was confirmed by a survey of the local food outlets that indicated small markets had limited healthy food alternative available. The study area was noted to have numerous supermarkets, but that the quality and availability of food even within the same retailer varied.

Food System Study Area



Food Access Challenges



[3] Healthy Food for all Prince George's County, Maryland National Park and Planning Commission, Prince George's County Planning Department, 2015

Housing

Housing vacancies decreased to 6.5% in 2017 from 7.1% in 2014; vacancies in the county are lower than both Maryland (9.9%) and the U.S. (12.6%). There are fewer owner-occupied residences in the county (61.9%) compared to the state (66.7%) and the U.S. (63.9%), and about half (48.9%) of those owner-occupied housing units are married couple family households.

Housing Characteristics, 2017

	Prince George's		Maryland		U.S.	
Indicators	**N**	**%**	**N**	**%**	**N**	**%**
Total Housing Units	**332,156**		**2,449,123**		**137,407,308**	
						Vacancy
Occupied Housing Units	310,730	93.5%	2,207,343	90.1%	120,062,818	87.4%
Vacant Housing Units	21,426	6.5%	241,780	9.9%	17,344,490	12.6%
For Rent	6,555		46,946		2,897,808	
Occupied Housing Units						
Owner-occupied	192,427	61.9%	1,472,500	66.7%	76,684,018	63.9%
Renter-occupied	118,303	38.1%	734,843	33.3%	43,378,800	36.1%
Owner-Occupied Units Household Type						
Married couple family	137,201	48.9%	863,626	58.7%	46,121,067	60.1%
Male householder, no wife present	8,652	4.5%	58,632	4.0%	3,179,980	4.1%
Female householder, no husband present	34,399	17.9%	159,388	10.8%	6,856,495	8.9%
Nonfamily household	55,226	28.7%	390,854	26.5%	20,526,476	26.8%
Renter-Occupied Units Household Type						
Married couple family	29,547	25.0%	188,671	25.7%	11,726,507	27.0%
Male householder, no wife present	11,849	10.0%	46,067	6.3%	2,706,681	6.2%
Female householder, no husband present	25,447	21.5%	153,446	20.9%	8,040,433	18.5%
Nonfamily household	51,460	43.5%	346,659	47.2%	20,905,179	48.2%
Average Household Size						
Owner-occupied	2.93		2.76		2.72	
Renter-occupied	2.80		2.51		2.51	
Severe Housing Problems*		20%		17%		18%

***Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.**

Data Source: 2017 American Community Survey 1-Year Estimates, Tables B25004, S2501, S2502, B25010; 2019 County Health Rankings

Fair Market Rent

About four in ten occupied housing units in Prince George's County are rentals. Renters in the county have a median income of $53,774, higher than the state at $49,902, but much lower than the median household income countywide of $81,240. Based on the Fair Market Rent values in Prince George's County, the income to afford rent starts as $60,160 for an efficiency, $6,386 more than the median renter income.

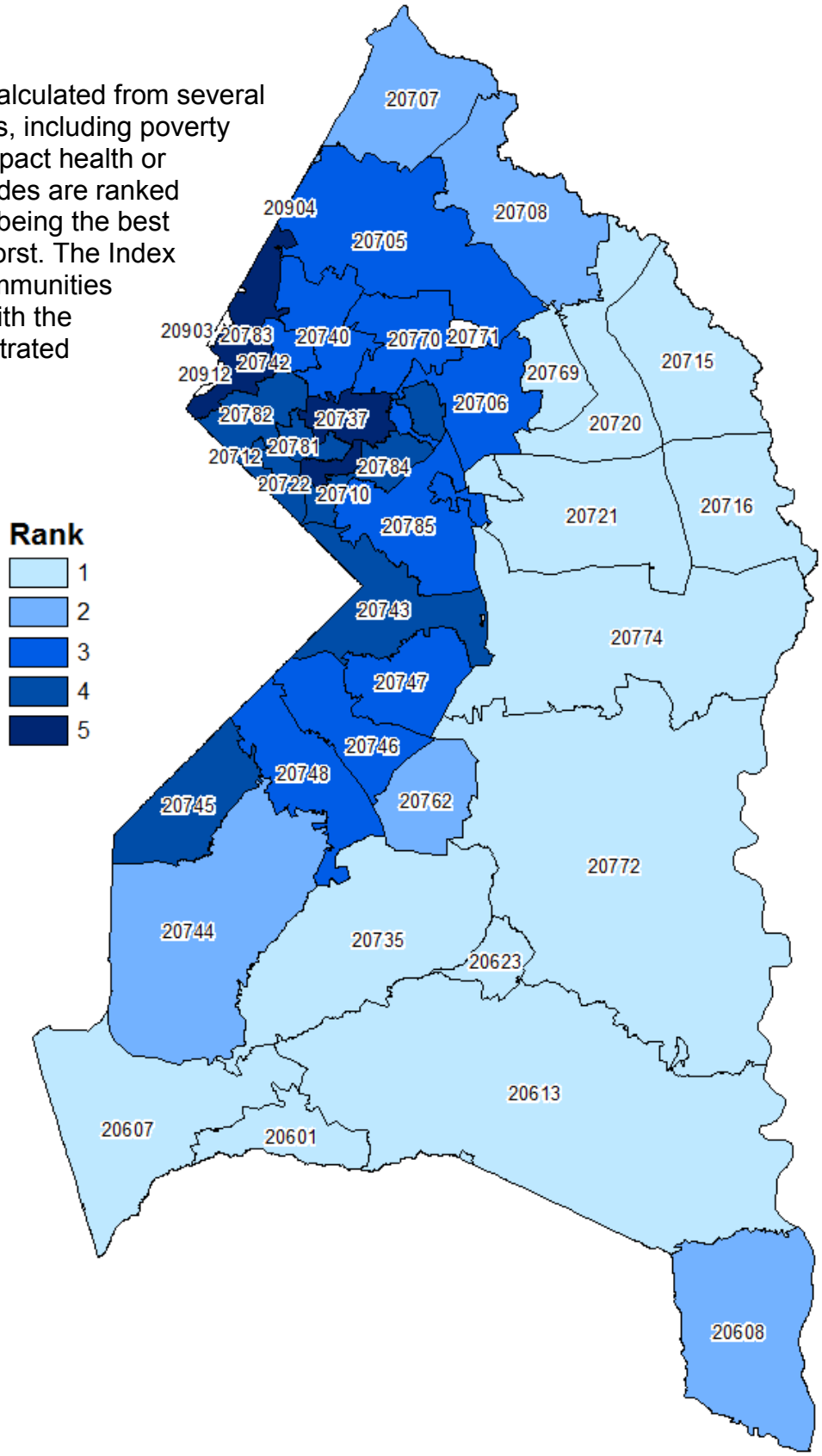
Fair Market Rent, 2018

	Prince George's County	Maryland
		Fair Market Rent by Unit
Efficiency	$1,504	$1,119
One bedroom	$1,561	$1,256
Two bedroom	$1,793	$1,510
Three bedroom	$2,353	$1,966
Four bedroom	$2,902	$2,362
	Income Needed to Afford Fair Market Rent by Unit	
Efficiency	$60,160	$44,776
One bedroom	$62,440	$50,238
Two bedroom	$71,720	$60,406
Three bedroom	$94,120	$78,631
Four bedroom	$116,080	$94,479
		Income of Renter
Estimated renter median income	$53,774	$49,902
Rent affordable for households earning the renter median income	$1,344	$1,248

Data Source: National Low Income Housing Coalition, www.nlihc.org

SocioNeeds Index

The SocioNeeds Index is calculated from several social and economic factors, including poverty and education, that may impact health or access to care. The ZIP codes are ranked based on the index, with 1 being the best ranking, and 5 being the worst. The Index is calculated by Health Communities Institute[4]. The ZIP codes with the highest ranking are concentrated within the D.C. metro area.



[4] www.pgchealthzone.org


health
INDICATORS

HEALTH INDICATORS REPORT

Introduction

The following report includes existing health data for Prince George's County, compiled using the most current local, state, and national sources. This report was developed to inform and support a joint Community Health Needs Assessment for the Health Department and area hospitals, and was used as part of the Prioritization Process to determine area of focus for the next three years.

Methods

Much of the information in this report is generated through diverse secondary data sources, including: Maryland Health Services Cost Review Commission; Maryland Vital Statistics Annual Reports, Maryland Department of Health's (MDH) Annual Cancer Reports, Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention's CDC WONDER Online Database, Centers for Medicare and Medicaid Services, National Vital Statistics Reports, Maryland State Health Improvement Plan (SHIP), and the Prince George's County Health Department data website: www.pgchealthzone.org. Some of the data presented, specifically some birth and death data as well as some emergency room and hospitalization data, were analyzed by the Health Department using data files provided by Maryland MDH. The specific data sources used are listed throughout the report.

When available, state (noted as MD SHIP) and national (noted as HP 2020) comparisons were provided as benchmarks. Most topics were analyzed by gender, race and ethnicity, age group, ZIP Code, and include trends over time to study the burden of health conditions, determinants of health and health disparities.

Limitations

While efforts were made to include accurate and current data, data gaps and limitations exist. One major limitation is that Prince George's County residents sometimes seek services in Washington, D.C.; because this is a different jurisdiction the data for these services may be unavailable (such as Emergency Room visits and hospitalizations). Another major limitation is that the diversity of the county is often not captured through traditional race and ethnicity. The county has a large immigrant population, but data specific to this population is often not available related to health issue. Data with small numbers can also be difficult to analyze and interpret and should be viewed carefully.

Also of note, the 2017 methodology for identifying ED visits and inpatient hospitalizations was based on the ICD-10 diagnosis coding system, instituted on October 1, 2015. Unfortunately, mapping between ICD-9 diagnosis codes (in use during the 2016 CHA analyses) and the ICD-10 is not one-to-one; therefore, comparability may be limited between the previous CHA and this publication.

Definitions

Crude Rate - The total number of cases or deaths divided by the total population at risk. Crude rate is generally presented as rate per population of 1,000, 10,000 or 100,000. It is not adjusted for the age, race, ethnicity, sex, or other characteristics of a population.

Age-Adjusted Rate - A rate that is modified to eliminate the effect of different age distributions in the population over time, or between different populations. It is presented as a rate per population of 1,000, 10,000 or 100,000.

Frequency - Often denoted by the symbol "n", frequency is the number of occurrences of an event.

Health Disparity - Differences in health outcomes or health determinants that are observed between different populations. The terms health disparities and health inequalities are often used interchangeably.

Health People 2020 (HP 2020) – Healthy People 2020 is the nation's goals and objectives to improve citizens' health. HP2020 goals are noted throughout the report as a benchmark.

Incidence Rate - A measure of the frequency with which an event, such as a new case of illness, occurs in a population over a period of time.

Infant Mortality Rate - Defined as the number of infant deaths per 1,000 live births per year. Infant is defined as being less than one year of age.

Maryland SHIP (MD SHIP) – Maryland's State Health Improvement Plan is focused on improving the health of the state; measures for the SHIP areas are included throughout the report as a benchmark.

Prevalence Rate - The proportion of persons in a population who have a particular disease or attribute at a specified point in time (point prevalence) or over a specified period of time (period prevalence).

Racial and Ethnic Groups:

Black or African American - A person having origins in any of the black racial groups of Africa.

Hispanic or Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

White - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Vietnam etc.

American Indian or Alaska Native - A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

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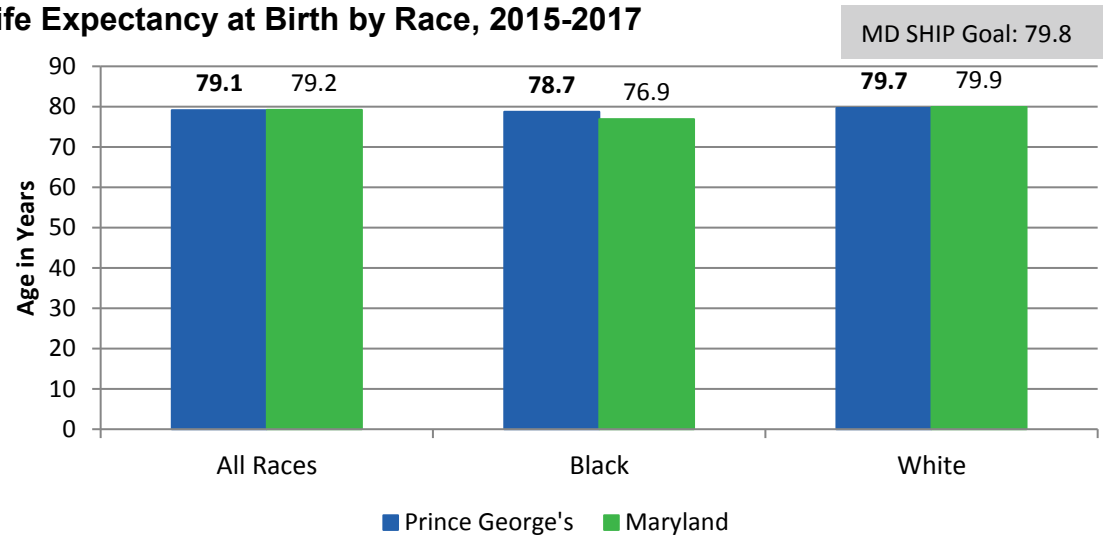
Health Status Indicators

Life Expectancy

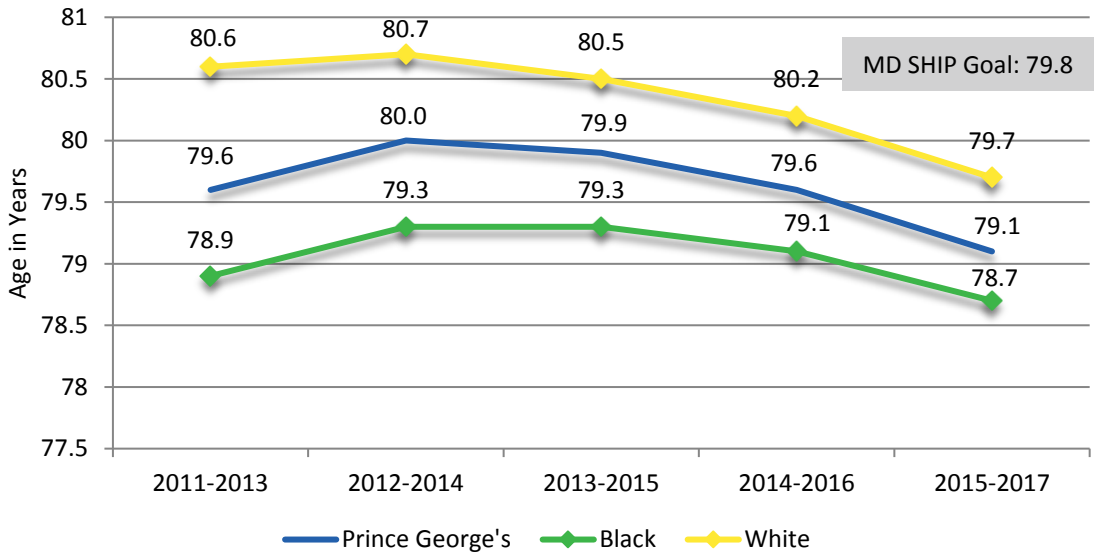
As of 2017, a Prince George's County resident is expected to live 79.1 years, similar to the 79.2 years for any Maryland resident. Although the Maryland SHIP goal of 79.8 years was met in 2014, life expectancy in the county and state has declined. This is also a national trend, with a life expectancy in 2017 of 78.6 years, down from 78.9 years in 2014.

Life Expectancy at Birth by Race, 2015-2017



Data Source: Mortality in the United States, 2017, Centers for Disease Control and Prevention, National Center for Health Statistics; Maryland Vital Statistics Annual Report 2017, Maryland Department of Health, Vital Statistics Administration

Life Expectancy at Birth by Race, Prince George's County, 2011-2017



Data Source: Maryland Vital Statistics Annual Report 2013-2017, Maryland Department of Health, Vital Statistics Administration

Mortality

From 2015-2017, 17,825 deaths occurred among Prince George's County residents. Almost half of all deaths in the county were due to heart disease or cancer. The age-adjusted death rate for the county was lower than both Maryland and the United States. However, for the leading causes of death the county's age-adjusted mortality rates are higher than Maryland and the U.S. for heart disease, stroke, diabetes, septicemia, nephritis, homicide, hypertension, and perinatal conditions.

Leading Causes of Death, 2015-2017

Cause of Death	Prince George's County Deaths		Age-Adjusted Death Rates per 100,000 Population			Healthy People 2020 Target	Maryland SHIP Goal
	Number	Percent	Prince George's	Maryland	U.S.		
All Causes	**17,825**	**100%**	**692.1**	**713.8**	**731.2**	---	---
Heart Disease	4,328	24.3%	168.9	166.0	166.3	---	166.3
Cancer	4,191	23.5%	154.1	154.3	155.5	161.4	147.4
Stroke	1,005	5.6%	41.6	39.3	41.0	34.8	---
Accidents	799	4.5%	29.4	34.1	46.7	36.4	---
Diabetes	681	3.8%	26.3	19.4	21.2	66.6	---
CLRD*	506	2.8%	20.6	30.4	41.0	---	---
Nephritis	369	2.1%	14.5	12.1	13.2	---	---
Influenza and Pneumonia	350	2.0%	14.5	15.6	14.3	---	---
Septicemia	339	1.9%	13.2	13.0	10.7	---	---
Alzheimer's	330	1.9%	15.3	17.0	30.3	---	---
Homicide	318	1.8%	11.6	10.2	6.0	10.2	9.0
Hypertension	295	1.7%	11.8	8.0	8.7	5.5	---
Perinatal Conditions	177	1.0%	6.9	5.0	4.0	3.3	---

*CLRD=Chronic Lower Respiratory Disease, includes both chronic obstructive pulmonary disease and asthma

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

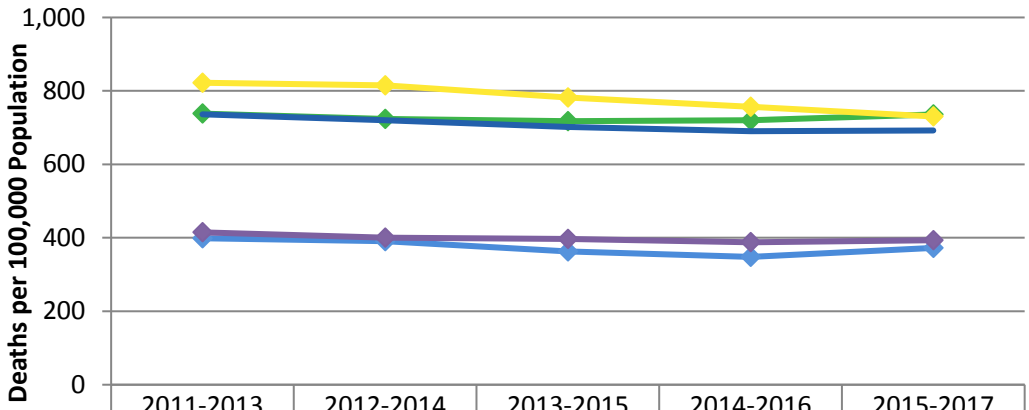
Overall, Black non-Hispanic (NH) male residents have the highest age-adjusted death rate in the county, but lower than in Maryland and the U.S.

Age-Adjusted Death Rate per 100,000 by Race, Ethnicity, and Sex, 2015-2017

Race and Ethnicity	Prince George's County	Maryland	U.S.
Black, non-Hispanic	735.5	820.7	880.0
Male	905.3	1038.9	1078.2
Female	614.1	664.7	731.0
Hispanic, any race	372.1	334.9	525.2
Male	433.1	380.2	630.8
Female	316.9	291.1	436.2
White, non-Hispanic	730.4	721.1	752.4
Male	862.7	850.1	881.9
Female	615.8	612.4	641.3
Asian, non-Hispanic	393.0	336.3	395.3
Male	495.8	393.3	468.5
Female	321.7	289.2	337.7
All Races and Ethnicities	692.1	713.8	731.2
Male	838.0	853.8	862.8
Female	581.0	600.4	620.4

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

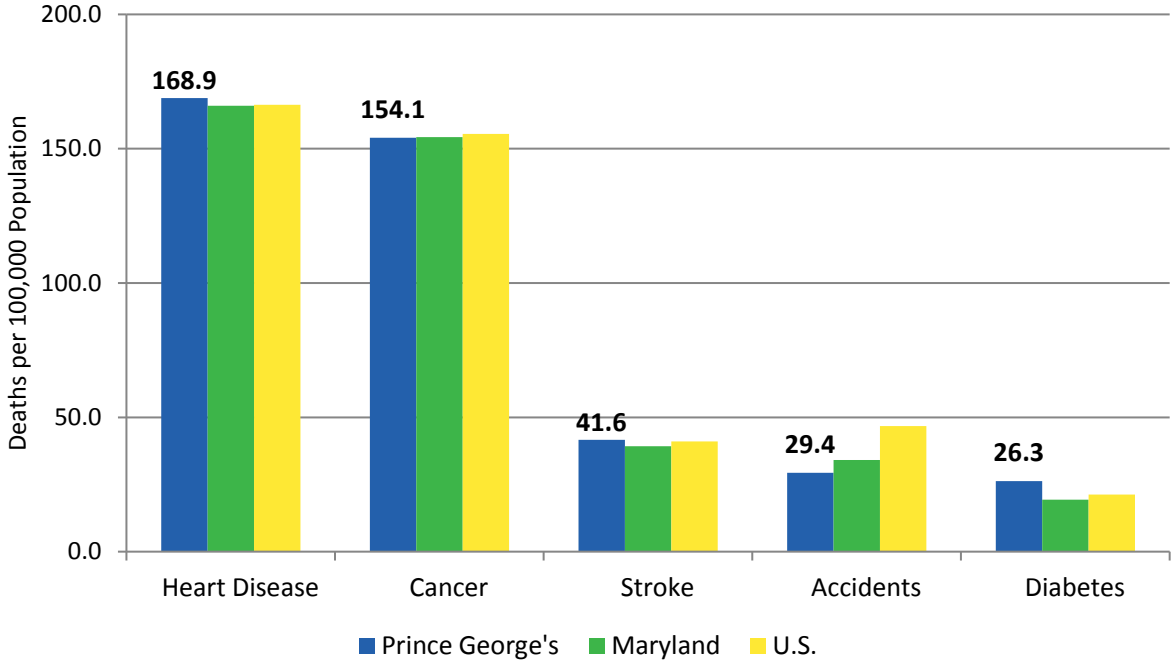
Age-Adjusted Death Rate per 100,000 for All Causes of Death by Race and Ethnicity, Prince George's County, 2011-2017



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017
Black, NH	738.2	723.9	717.6	720.4	735.5
Hispanic	398.8	390.8	363.0	348.0	372.1
White, NH	822.2	815.1	782.1	756.4	730.4
Asian, NH	414.8	400.8	397.0	387.8	393.0
Prince George's	736.3	720.3	702.2	690.3	692.1

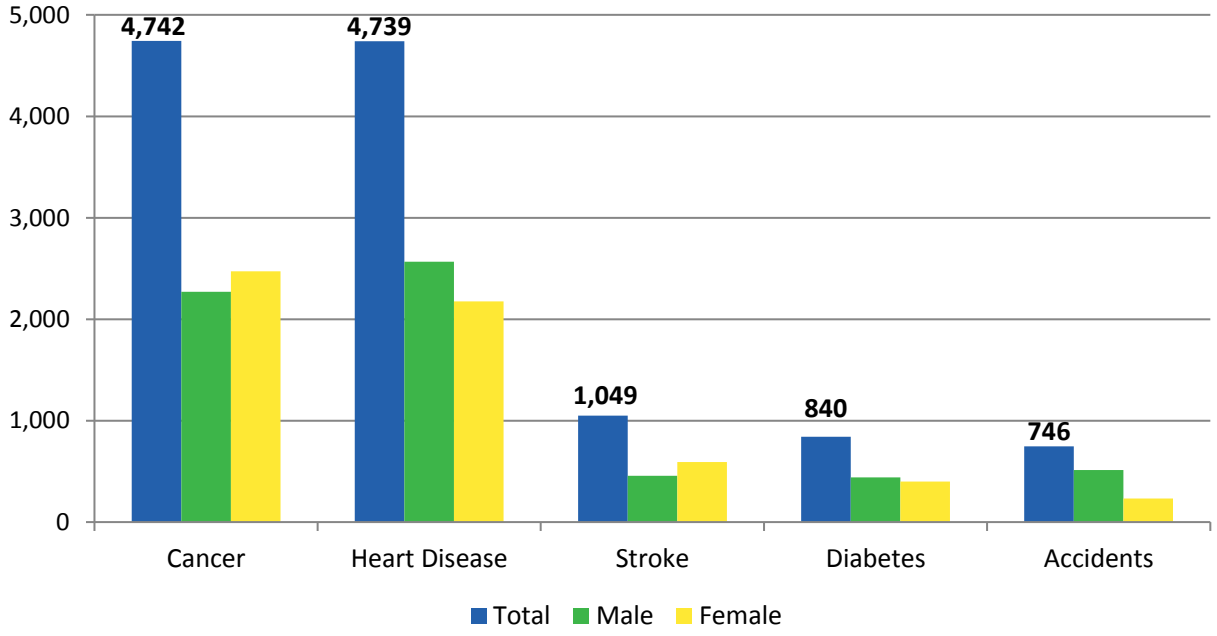
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Leading Causes of Death, Age-Adjusted Rates, 2015-2017



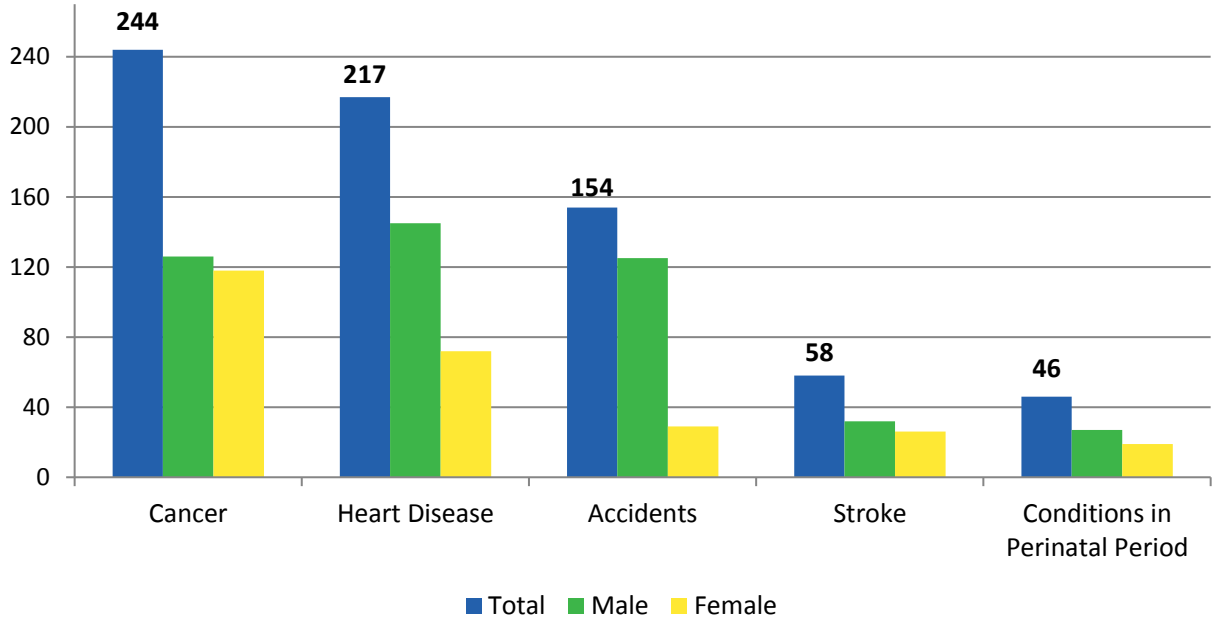
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Leading Causes of Death for Black Non-Hispanic Residents, Prince George's County, 2013-2017 (N=19,310)



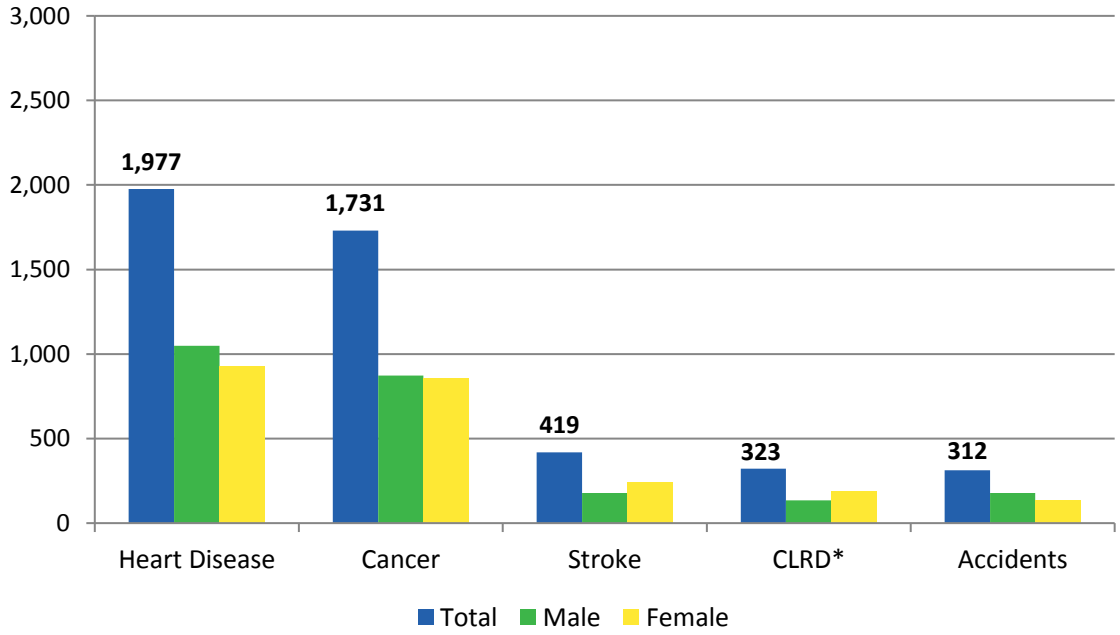
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Leading Causes of Death for Hispanic Residents (of Any Race), Prince George's County, 2013-2017 (N=1,210)



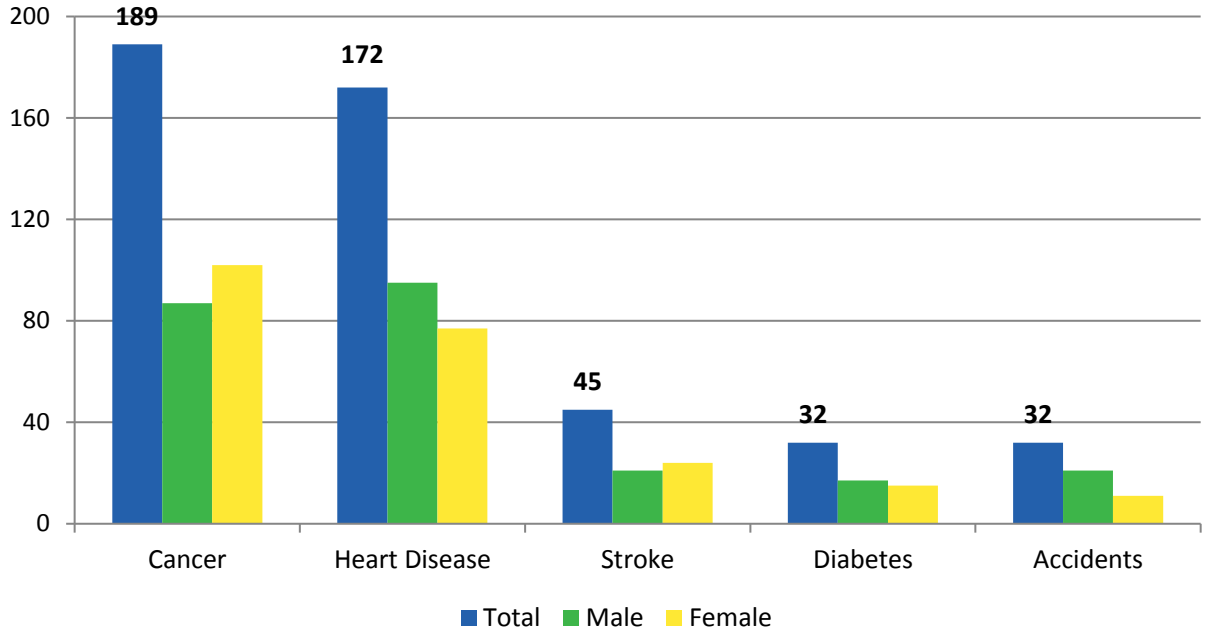
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Leading Causes of Death for White Non-Hispanic Residents, Prince George's County, 2013-2017 (N=7,710)



*CLRD=Chronic Lower Respiratory Disease, includes both chronic obstructive pulmonary disease and asthma
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Leading Causes of Death for Asian Non-Hispanic Residents, Prince George's County, 2013-2017 (N=731)



Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

While the leading cause of death by race and Hispanic ethnicity is consistently heart disease and cancer, there is variation for the remaining causes. For White non-Hispanic (NH), Black NH, and Asian NH residents the third leading cause of death is stroke, but for Hispanic residents it is accidents. Diabetes is a leading cause of death for both Black NH and Asian NH residents, while perinatal period conditions are included in the five leading causes of death for Hispanic residents and chronic lower respiratory diseases (CLRD) are included in the five leading causes of death for White NH residents.

Emergency Department (ED) Visits

County resident ED Visits to Maryland hospitals have decreased by 6.5% since 2014 (251,411 visits compared to 235,101 in 2017).

Emergency Department Visits*, Prince George's County, 2017

	Number of ED Visits	Age-Adjusted Rate per 1,000 Population
Race/Ethnicity		
Black, non-Hispanic	135,960	242.7
Hispanic	26,116	160.8
White, non-Hispanic	20,221	165.8
Asian, non-Hispanic	1,845	46.5
Sex		
Male	97,829	222.3
Female	137,269	287.6
Age		
Under 18 Years	32,680	160.7
18 to 39 Years	90,010	310.5
40 to 64 Years	77,590	256.4
65 Years and Over	34,821	297.7
Total	**235,101**	**255.8**

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Outpatient Discharge Data File 2017, Maryland Health Services Cost Review Commission

Emergency Department Visits* by Diagnosis, Prince George's County, 2017

	Principal Diagnosis	Frequency	Percent of Visits
1	Sprains and strains	14,091	6.0%
2	Chest pain	12,546	5.3%
3	Abdominal pain	11,144	4.7%
4	Upper respiratory infections	10,076	4.3%
5	Back pain	9,793	4.2%
6	Superficial injury or contusion	8,867	3.8%
7	Urinary tract infection	6,249	2.7%
8	Injuries due to external causes	6,010	2.6%
9	Headache, including migraine	5,990	2.6%
10	Other connective tissue disease	5,685	2.4%

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Outpatient Discharge Data File 2017, Maryland Health Services Cost Review Commission

Hospital Admissions

Hospital Inpatient Visits* (Admissions), Prince George's County, 2017

	Number of Hospitalizations	Age-Adjusted Rate per 1,000 Population
Race/Ethnicity		
Black, non-Hispanic	41,058	75.2
Hispanic	8,561	57.0
White, non-Hispanic	10,199	68.8
Asian, non-Hispanic	1,402	37.8
Sex		
Male	26,236	62.6
Female	38,762	79.9
Age		
Under 18 Years	9,794	48.2
18 to 39 Years	16,300	56.2
40 to 64 Years	18,224	60.2
65 Years and Over	20,680	176.8
Total	**64,998**	**70.9**

* Inpatient Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Inpatient Data File 2017, Maryland Health Services Cost Review Commission

Hospital Inpatient Visits* (Admissions) by Diagnosis, Prince George's County, 2017

	Principal Diagnosis	Frequency	Percent
1	Live Birth	9,049	13.9%
2	Septicemia (except in labor)	3,661	5.6%
3	Hypertension with complications	2,796	5.3%
4	Other complications of birth	2,154	3.3%
5	Mood disorders	1,546	2.4%
6	Acute cerebrovascular disease	1,529	2.4%
7	Osteoarthritis	1,471	2.3%
8	Diabetes with complications	1,379	2.1%
9	C-section	1,293	2.0%
10	Schizophrenia and other psychotic disorders	1,211	1.9%

* Inpatient Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Inpatient Discharge Data File 2017, Maryland Health Services Cost Review Commission

Access to Health Care

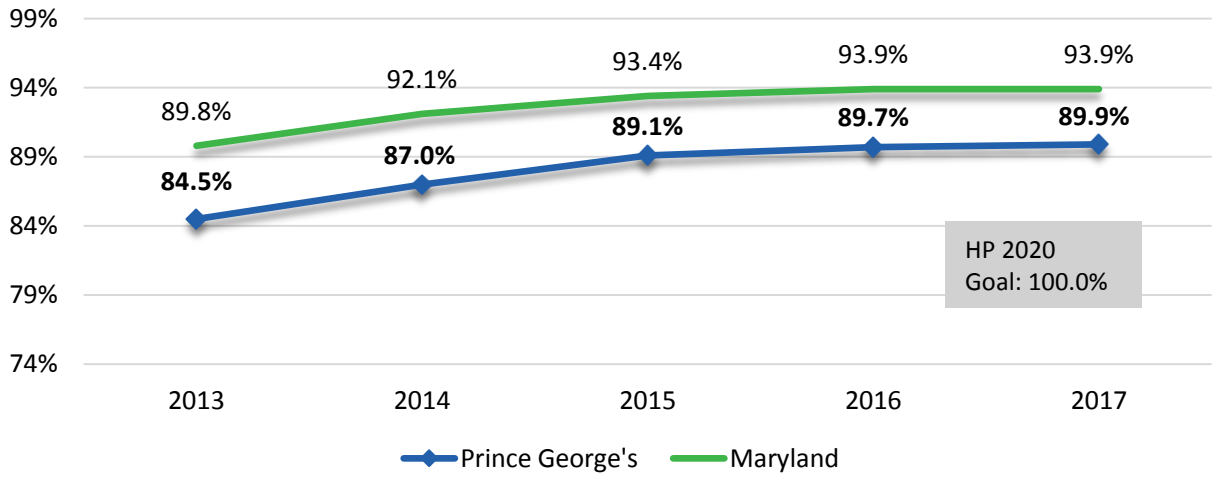
The percentage of residents with health insurance increased in Prince George's County following the implementation of the major provisions of the Affordable Care Act (ACA) in 2014. However, an estimated 91,565 residents remained uninsured as of 2017. By age, residents ages 26 to 34 years were least likely be be insured with one in four lacking health insurance.

Residents with Health Insurance, 2017

HP 2020 Goal: 100.0%	Prince George's	Maryland
Race/Ethnicity		
Black	92.4%	92.5%
Hispanic	66.8%	75.5%
White, non-Hispanic	94.6%	95.9%
Asian	89.3%	91.6%
Sex		
Male	85.7%	91.4%
Female	90.3%	93.8%
Age Group		
Under 19 Years	93.7%	96.2%
19 to 25 Years	83.6%	88.1%
26 to 34 Years	76.2%	85.6%
35 to 44 Years	80.1%	88.6%
45 to 54 Years	88.2%	92.0%
55 to 64 Years	91.9%	94.1%
65 Years and Older	98.6%	99.1%
Total	**89.9%**	**93.9%**

Data Source: 2017 American Community Survey 5-Year Estimates, Table S2701

Residents with Health Insurance, 2013-2017



Data Source: 2017 American Community Survey 1-Year Estimates, Table S2701

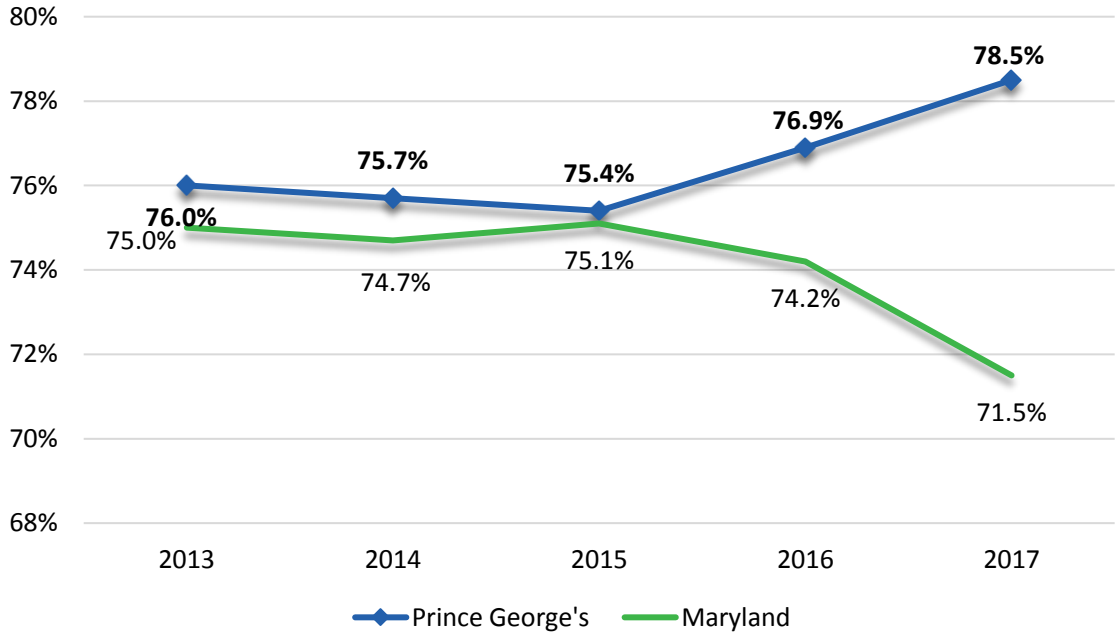
Adults who had a Routine Checkup Within the Last Year, 2017

Demographic	Prince George's	Maryland
Race/Ethnicity		
Black, non-Hispanic	81.4%	79.0%
Hispanic	70.9%	62.6%
White, non-Hispanic	72.8%	67.4%
Sex		
Male	74.7%	67.6%
Female	82.9%	75.2%
Age Group		
18 to 44 Years	72.2%	63.3%
45 to 64 Years	83.6%	76.9%
Over 65 Years	89.2%	87.5%
Total	**78.5%**	**71.5%**

Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

More county adults reported having a routine checkup within the last 2 years (90.1%) compared to Maryland (86.0%). By race, Black, NH residents were more likely to report having a routine checkup (95.2%) within the county.

Adults who had a Routine Checkup Within the Last Year, 2013-2017



Data Source: 2013-2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

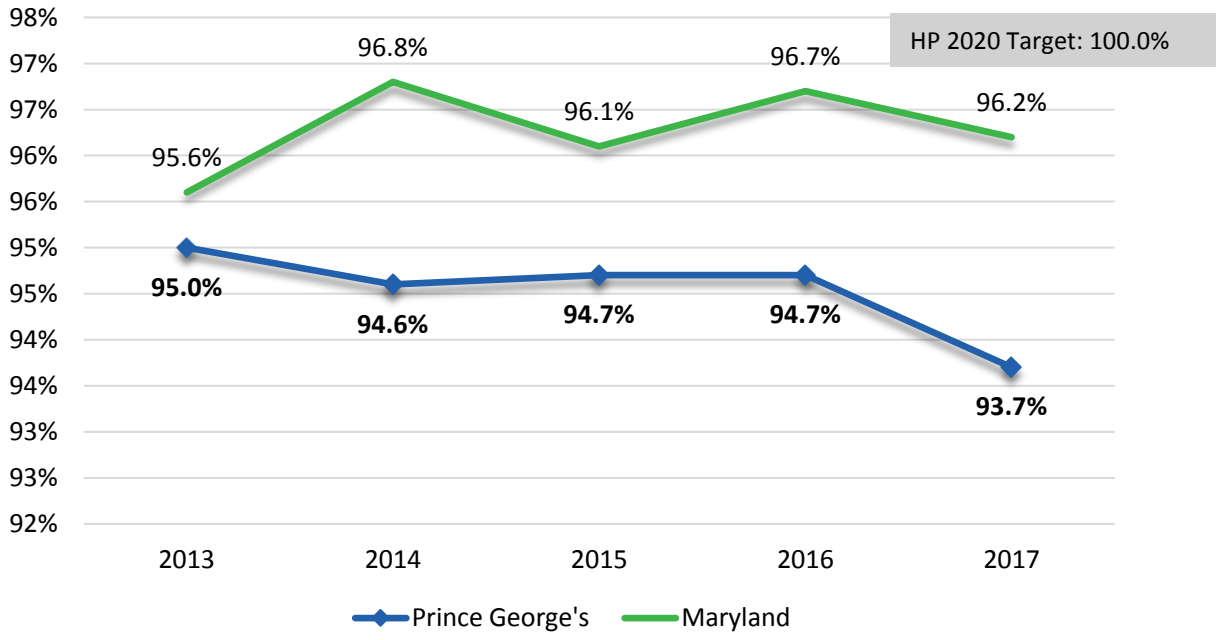
Children with Health Insurance, 2017

HP 2020 Target: 100.0%	Prince George's	Maryland
Race/Ethnicity		
Black	95.7%	96.4%
Hispanic	91.5%	88.5%
White, non-Hispanic	95.6%	97.5%
Asian	94.8%	95.6%
Sex		
Male	94.1%	96.4%
Female	93.3%	96.0%
Age Group		
Under 6 Years	95.5%	96.6%
6 to 18 Years	92.8%	96.0%
Total	**93.7%**	**96.2%**

Data Source: 2017 American Community Survey 1-Year Estimates, Table S2701

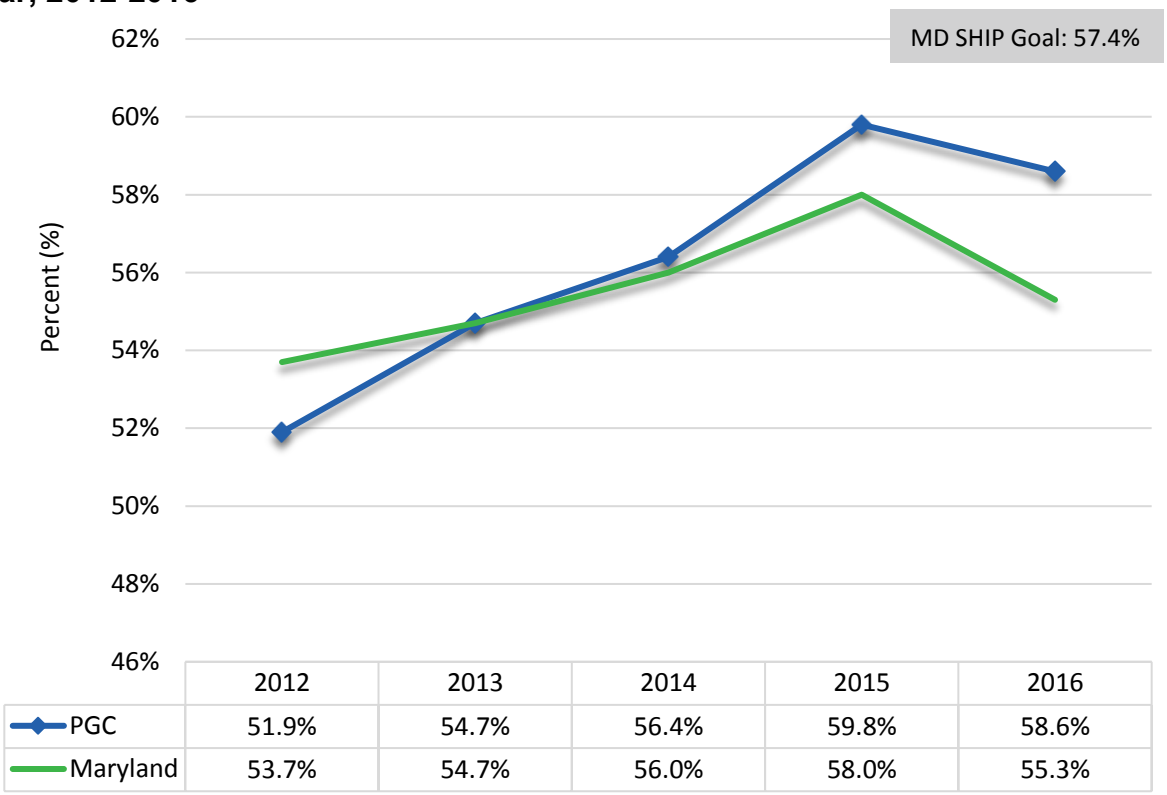
The estimated percentage of children with health insurance in the county decreased in 2017 to 93.7%. By race and ethnicity, Hispanic children within the county are less likely to have health insurance.

Children with Health Insurance, 2013-2017



Data Source: 2017 American Community Survey 1-Year Estimates, Table S2701

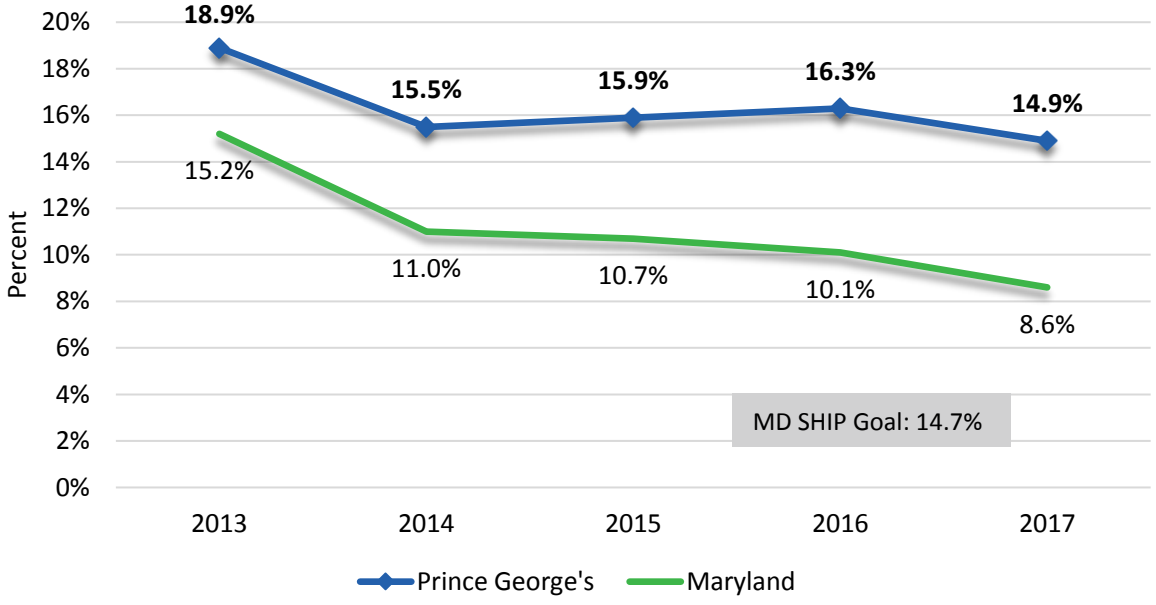
Adolescents Enrolled In Medicaid* Who Received a Wellness Checkup in the Last Year, 2012-2016



	2012	2013	2014	2015	2016
PGC	51.9%	54.7%	56.4%	59.8%	58.6%
Maryland	53.7%	54.7%	56.0%	58.0%	55.3%

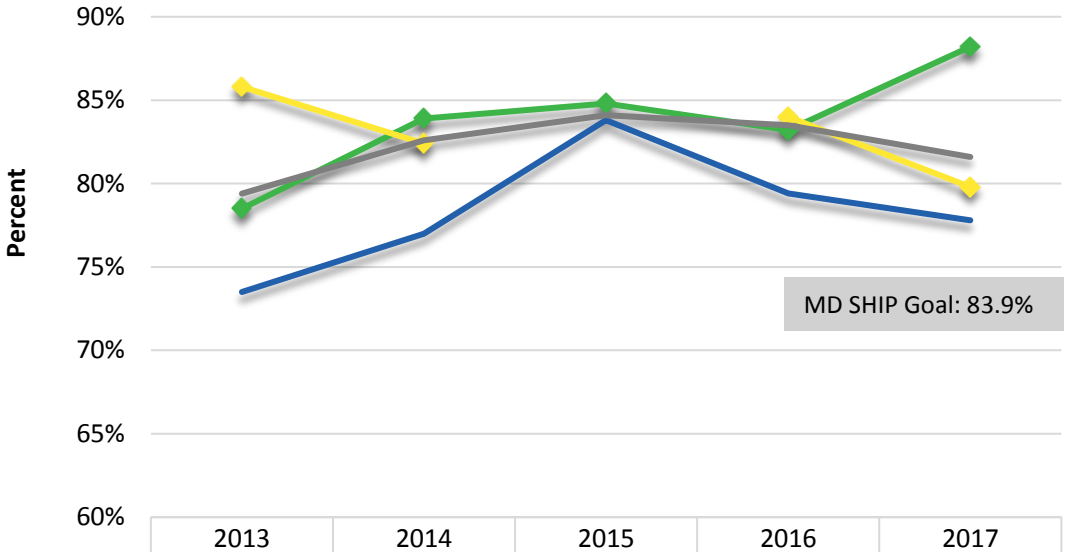
*Number of adolescents aged 13 to 20 years enrolled in Medicaid for at least 320 days
Data Source: Maryland Medicaid Service Utilization

Uninsured Emergency Department Visits, 2013-2017



Data Source: Maryland Health Services Cost Review Commission (HSCRC) Research Level Statewide Outpatient Data Files

Residents with a Usual Primary Care Provider, 2013-2017



	2013	2014	2015	2016	2017
PGC Black, NH	78.5%	83.9%	84.8%	83.2%	88.2%
PGC White, NH	85.8%	82.4%	**	84.0%	79.8%
PGC	73.5%	77.0%	83.8%	79.4%	77.8%
Maryland	79.4%	82.6%	84.1%	83.5%	81.6%

** White, NH data for 2015 not presented due to small number of events.
Data Source: 2013-2017 Maryland Behavior Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Prince George's County meets the national benchmark ofr 2,000 residents for every 1 primary care physician; however, the county has a much higher ratio compared to the state.

Resident to Provider Ratios

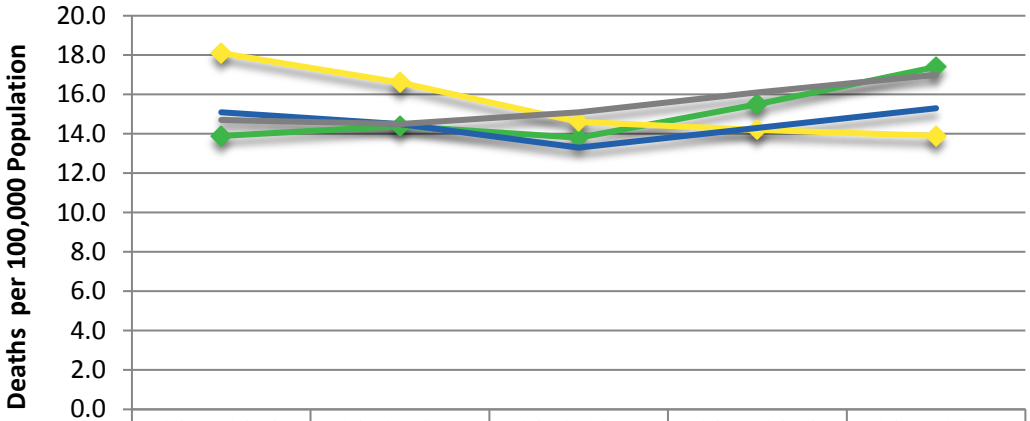
	Prince George's County Ratio	Maryland Ratio	Top U.S. Counties (90th percentile)
Primary Care Physicians (2015)	1,910:1	1,140:1	1,030:1
Dentists (2016)	1,650:1	1,320:1	1,280:1
Mental Health Providers (2017)	890:1	460:1	330:1

Data Source: 2018 County Health Rankings, www.countyhealthrankings.org

Diseases and Conditions

Alzheimer's Disease

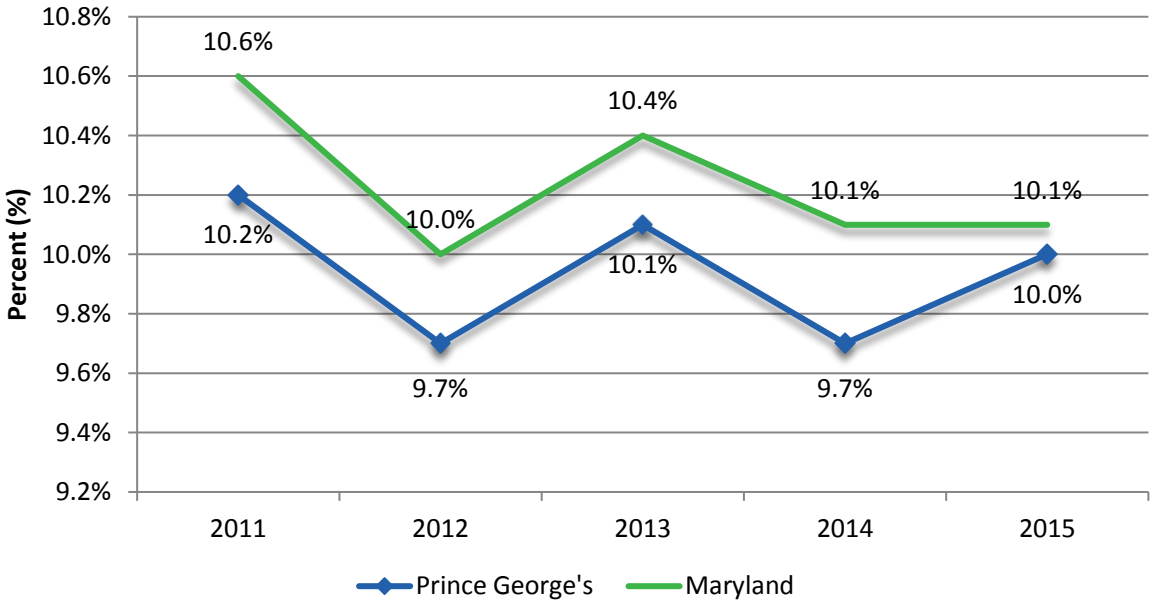
Age-Adjusted Death Rate per 100,000 for Alzheimer's Disease 2013-2017



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017
PGC Black, NH	13.9	14.4	13.8	15.5	17.4
PGC White, NH	18.1	16.6	14.6	14.2	13.9
PGC	15.1	14.5	13.3	14.3	15.3
Maryland	14.7	14.5	15.1	16.1	17.0

* Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Percentage of Medicare Beneficiaries Treated for Alzheimer's Disease or Dementia, 2011-2015



Data Source: Centers for Medicare and Medicaid Services

Cancer

Overview	
What is it?	Cancer is a term used for diseases in which abnormal cells divide without control and can invade other tissues; there are more than 100 kinds of cancer.
Who is affected?	In 2014, 3,602 residents were diagnosed with cancer in the county, and the cancer incidence rate was 397.0 per 100,000 residents. In 2014, there were 1,417 deaths from cancer in the county, which accounted for one out of every four deaths. Prostate and breast cancer are the most common types of cancer in the county, and in 2014 accounted for 34% of all new cancer cases. Overall, Black residents have the highest age-adjusted rate for new cancer cases and the highest age-adjusted death rate due to cancer. Lung and bronchus cancer has the highest age-adjusted death rate for county residents, followed by prostate cancer.
Prevention and Treatment	According to the CDC, there are several ways to help prevent cancer: • Healthy choices can reduce cancer risk, like avoiding tobacco, limiting alcohol use, protecting your skin from the sun and avoiding indoor tanning, eating a diet rich in fruits and vegetables, keeping a healthy weight, and being physically active. • The human papillomavirus (HPV) vaccine helps prevent most cervical cancers and several other kinds of cancer; the hepatitis B vaccine can lower liver cancer risk. • Screening for cervical and colorectal cancers helps prevent these diseases by finding precancerous lesions so they can be treated before they become cancerous. Screening for cervical, colorectal, and breast cancers also helps find these diseases at an early stage, when treatment works best. Cancer treatment can involve surgery, chemotherapy, radiation therapy, targeted therapy, and immunotherapy.
What are the outcomes?	Remission (no cancer signs or symptoms); long-term treatment and care; death.
Disparity	Overall, men had a higher age-adjusted cancer incidence rate per 100,000 (441.5) than women (369.2), and Black residents had a higher rate (397.2) compared to White resdients in 2014 (389.3). Cancer mortality rates for Black, non-Hispanic (NH) were the highest (163.3) compared to other race/ethnicities. In 2014, men had a higher cancer mortality rate at 199.4 compared to women (149.9). By cancer site, Black residents in the county had higher incidence and mortality rates for breast and prostate cancers.
How do we compare?	Prince George's County 2014 age-adjusted cancer incidence rate was 397.0 per 100,000 residents, much lower than the state at 440.2; other Maryland counties range from 368.8 (Montgomery) to 549.5 (Wicomico). The age-adjusted death rate for the county from 2015-2017 was 154.1, similar to Maryland at 154.3. The county is similar to the state for cancer screening for breast, cervical and prostate cancers.

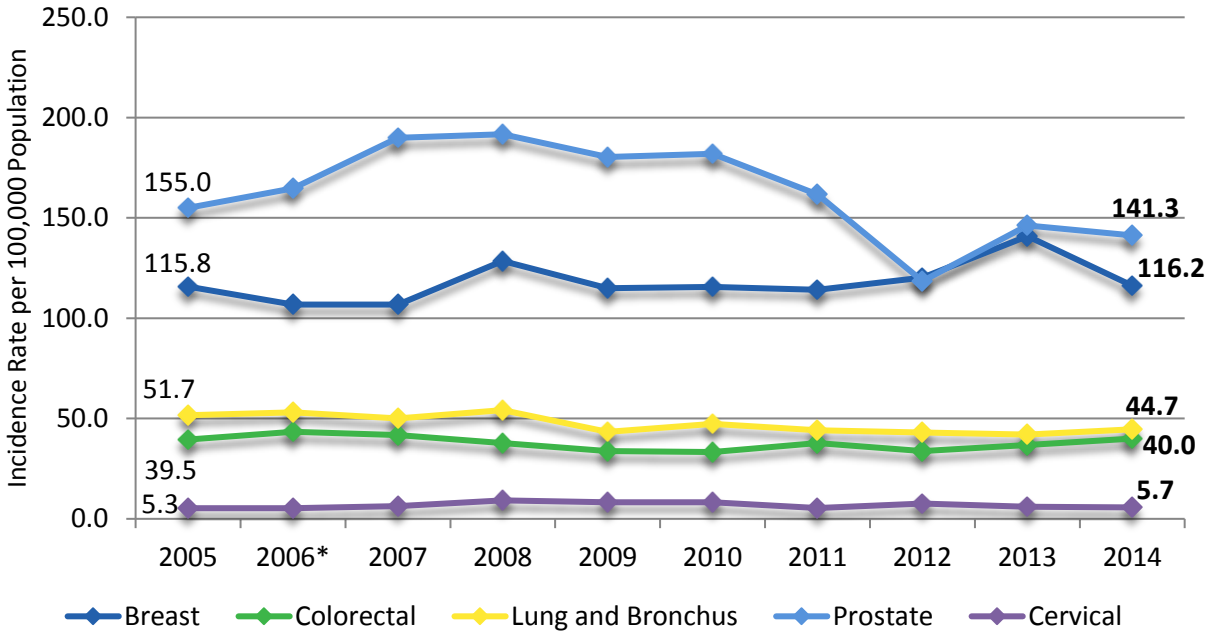
Overall, Prince George's County age-adjusted cancer incidence rate is less than Maryland and the U.S, and for most leading types of cancer. Prostate cancer incidence remained higher in Prince George's County (149.2 cases per 100,000) compared to Maryland (125.4 cases per 100,000) and the U.S. (116.1 cases per 100,000).

Cancer Age-Adjusted Incidence Rates per 100,000 Population by Site, 2010-2014

Site	Prince George's	Maryland	United States	HP 2020 Goal
All Sites	396.5	443.4	454.9	---
Breast (Female)	121.7	129.2	124.1	---
Colorectal	36.3	36.7	40.0	39.9
Male	42.8	41.8	46.0	---
Female	31.6	32.7	34.9	---
Lung and Bronchus	44.2	56.6	61.5	---
Male	52.7	64.6	73.0	---
Female	38.0	50.7	52.9	---
Prostate	149.2	125.4	116.1	---
Cervical	6.6	6.4	7.6	7.2

Data Source: Maryland Department of Health, Annual Cancer Report, 2017; CDC National Center for Health Statistics, CDC WONDER Online Database

Cancer Age-Adjusted Incidence Rates by Site, Prince George's County, 2005-2014



*2006 incidence rates are lower than actual due to case underreporting

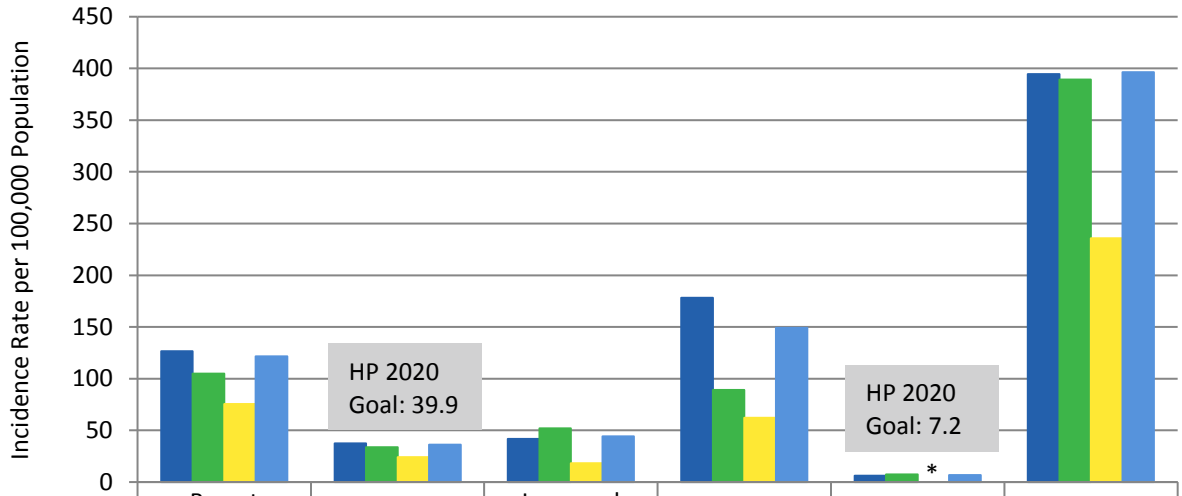
Data Source: Maryland Department of Health, Annual Cancer Reports

Cancer Age-Adjusted Incidence Rates by Site, Prince George's County, 2005-2014

Year	All Sites	Breast	Colorectal	Lung and Bronchus	Prostate	Cervical
2005	**386.3**	115.8	39.5	51.7	155.0	5.3
2006*	**364.4**	106.8	43.4	53.0	164.7	5.3
2007	**409.8**	106.8	41.7	50.1	189.9	6.3
2008	**429.1**	128.6	37.7	54.2	191.7	9.2
2009	**387.6**	115.0	33.7	43.3	180.4	8.2
2010	**403.5**	115.6	33.3	47.4	182.0	8.2
2011	**390.0**	114.2	37.7	44.2	161.7	5.4
2012	**376.7**	120.3	33.7	43.1	118.5	7.6
2013	**414.5**	140.9	36.8	42.0	146.3	6.1
2014	**397.0**	116.2	40.0	44.7	141.3	5.7

*2006 incidence rates are lower than actual due to case underreporting
Data Source: Maryland Department of Health, Annual Cancer Reports

Cancer Age-Adjusted Incidence Rates by Race, Prince George's County, 2010-2014

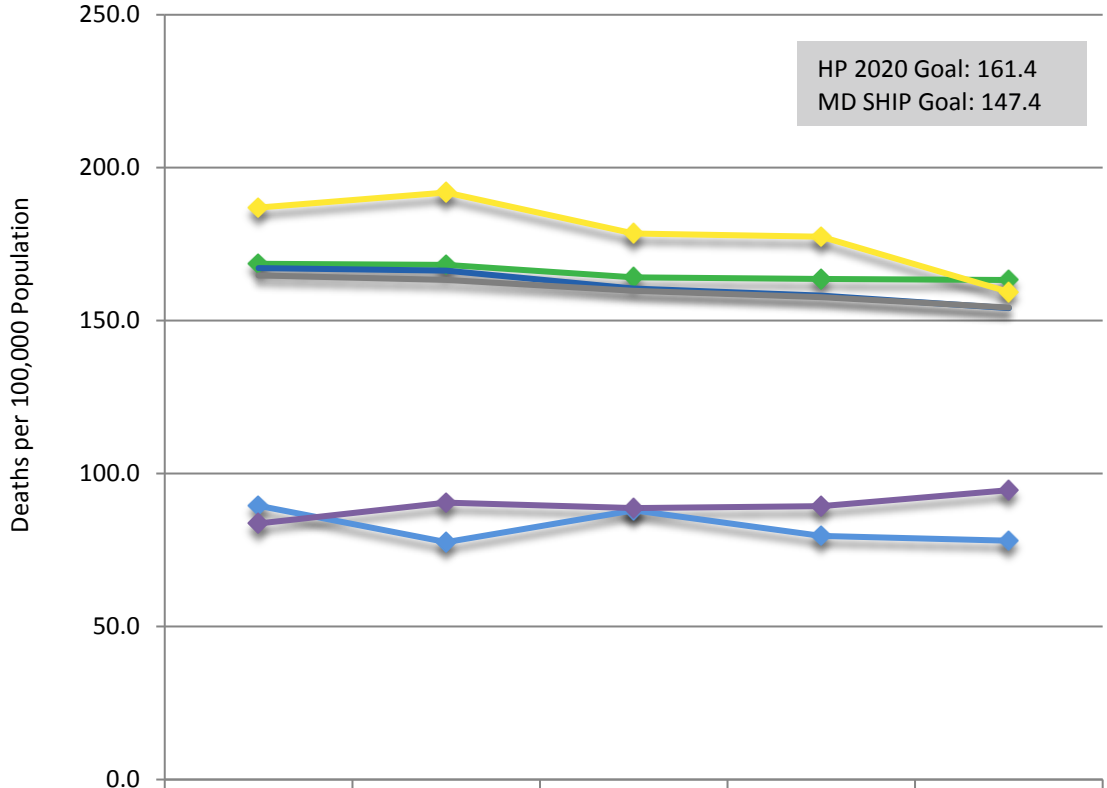


	Breast (Female)	Colorectal	Lung and Bronchus	Prostate	Cervical	All Sites
Black	126.4	37.4	41.6	178.3	6.2	394.6
White	105.0	33.7	51.9	89.2	7.4	389.2
Other	75.3	24.0	18.2	62.1	*	235.9
All Races	121.7	36.3	44.2	149.2	6.6	396.5

*Age-adjusted incidence rate unavailable due to small number of cases
Data Source: Maryland Department of Health, Annual Cancer Report, 2017
Individuals of Hispanic origin were included within the White or Black estimates and are not listed separately

Deaths due to cancer decreased in the county by nearly 8% from 2011-2013 to 2015-2017; meeting the Healthy People 2020 Goal of a cancer death rate of 161.4. Black, non-Hispanic (NH) residents have the highest age-adjusted death rate due to cancer at 163.3, followed by White, non-Hispanic (NH) residents at 159.4. Hispanic residents have the lowest death rate due to cancer in the county, at 78.1.

Age-Adjusted Death Rate per 100,000 for Cancer by Race and Ethnicity, Prince George's County, 2011-2017



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017
PGC Black, NH	168.6	168.2	164.2	163.6	163.3
PGC Hispanic	89.5	77.6	88.0	79.6	78.1
PGC White, NH	187.0	191.9	178.5	177.5	159.4
PGC Asian, NH	83.7	90.5	88.7	89.4	94.6
PGC	167.2	166.4	160.5	158.2	154.1
Maryland	164.8	163.3	159.8	157.7	154.3

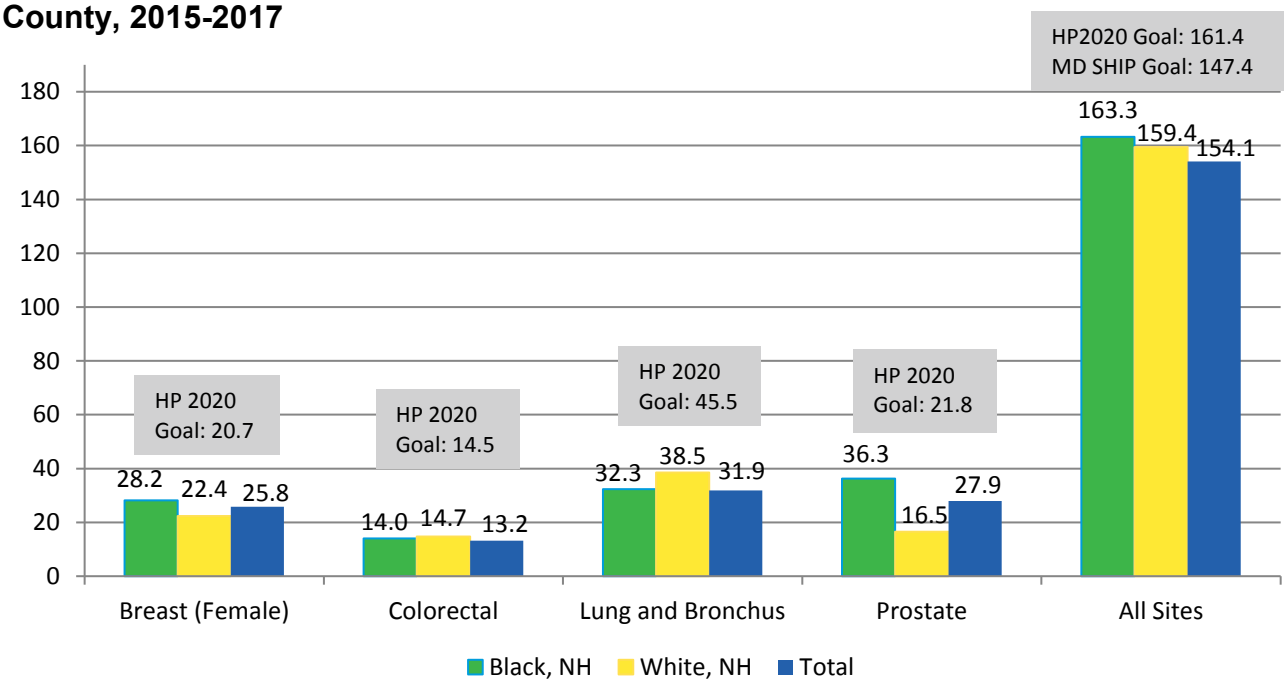
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Cancer Age-Adjusted Death Rates per 100,000 by Site and Sex, 2015-2017

Site	Prince George's	Maryland	United States	HP 2020 Goal	MD SHIP 2017 Goal
All Sites	**154.1**	154.3	155.5	161.4	147.4
Breast (Female)	**25.8**	21.5	20.1	20.7	
Colorectal	**13.2**	13.9	13.9	14.5	
Male	**16.5**	16.3	16.5	---	
Female	**10.9**	12.0	11.9	---	
Lung and Bronchus	**31.9**	37.0	38.5	45.5	
Male	**38.0**	44.1	46.8	---	
Female	**27.3**	31.8	32.0	---	
Prostate	**27.9**	20.3	18.9	21.8	
Cervical	**2.6**	1.9	2.2	2.2	

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database; MDH Maryland SHIP http://ship.md.networkofcare.org/ph/; Healthy People 2020 https://www.healthypeople.gov/

Cancer Age-Adjusted Death Rates by Race* and Hispanic Origin, Prince George's County, 2015-2017



* Asian/Pacific Islander and Hispanic resdients were not included due to insufficient numbers; Cervical cancer age-adjusted rates not shown by race due to insufficient numbers

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

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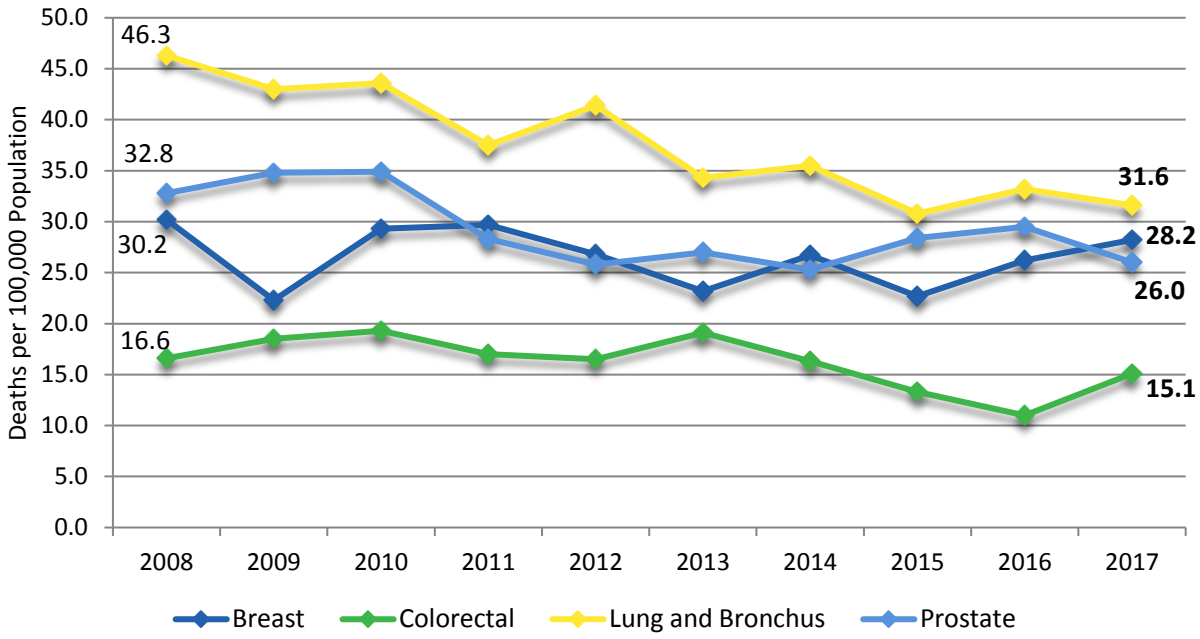
Cancer Age-Adjusted Death Rates per 100,000 by Site*, Prince George's County, 2008-2017

Year	All Sites	Breast (Female only)	Colorectal	Lung and Bronchus	Prostate
2008	184.9	30.2	16.6	46.3	32.8
2009	178.8	22.3	18.5	43.0	34.8
2010	182.4	29.3	19.3	43.6	34.9
2011	171.3	29.7	17.0	37.5	28.3
2012	168.4	26.8	16.5	41.4	25.8
2013	162.1	23.2	19.1	34.3	27.0
2014	168.4	26.7	16.3	35.5	25.3
2015	151.3	22.7	13.3	30.8	28.4
2016	155.4	26.2	11.0	33.2	29.5
2017	155.7	28.2	15.1	31.6	26.0

* Cervical cancer statistics not included due to insufficient numbers.
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Cancer Age-Adjusted Death Rates by Site, Prince George's County, 2008-2017

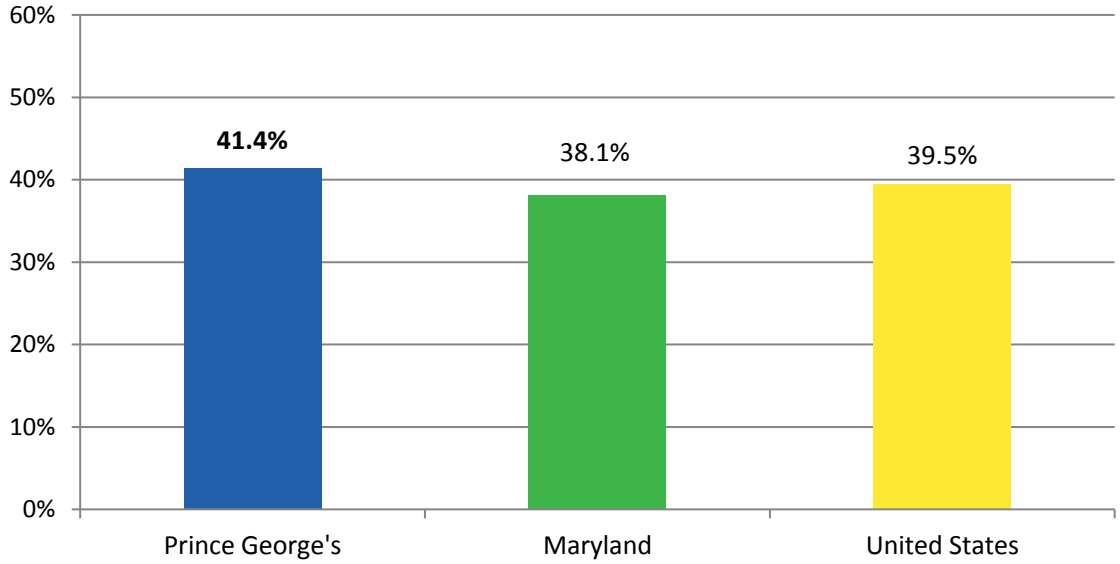


Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Cancer Screening

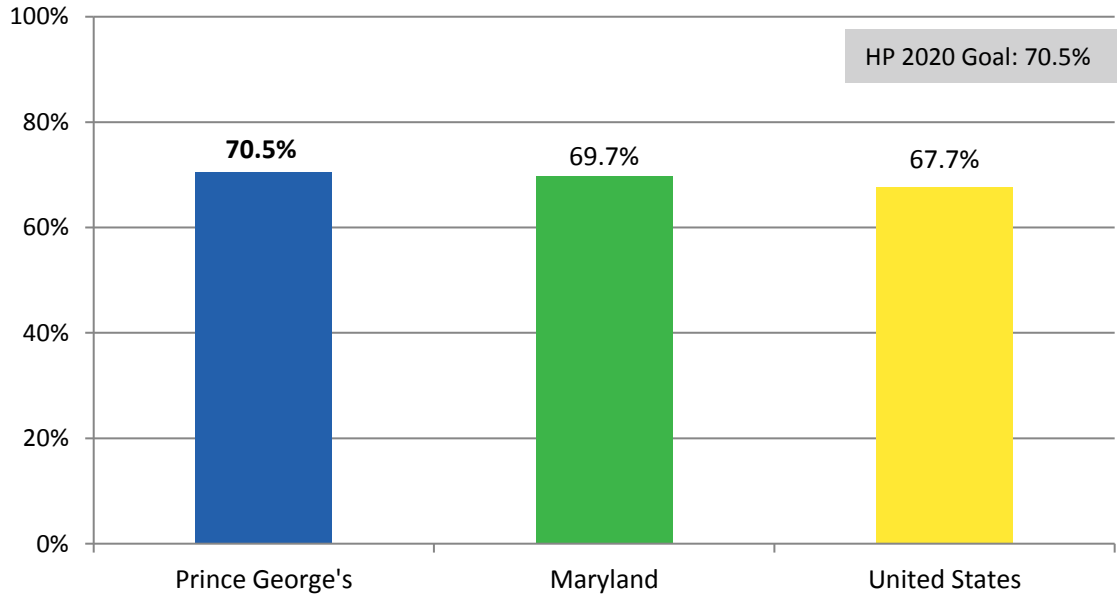
In 2016, Prince George's County had slightly higher cancer screening rates compared to the state and nation for prostate, colorectal, and breast cancers, and slightly lower screening rate for cervical cancer.

Men (40 years+) With a Prostate-Specific Antigen Test in the Past Two Years, 2016



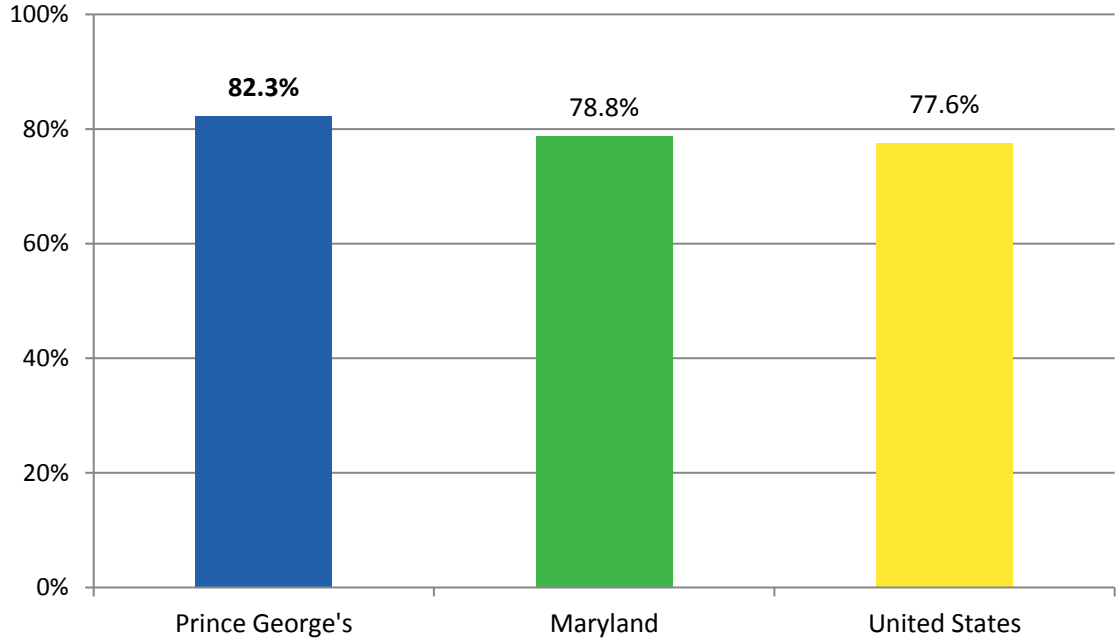
Data Source: 2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

Men and Women (50 – 75 years) Fully Meeting Colorectal Cancer Screening Recommendation, 2016



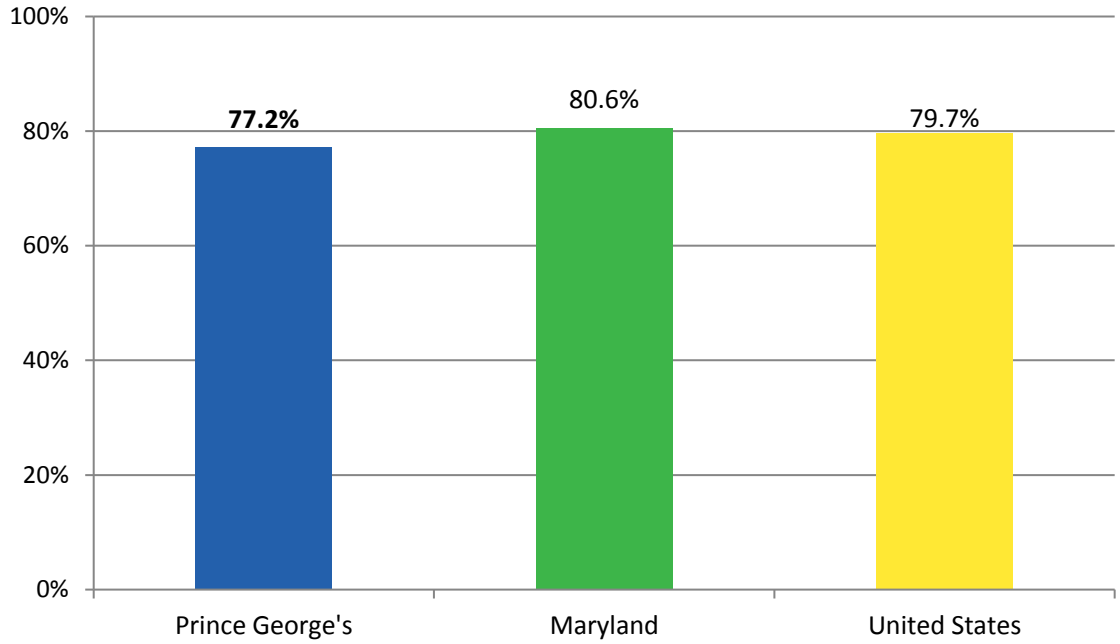
Data Source: 2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

Women (50+ years) who had a Mammography in the Past 2 Years, 2016



Data Source: 2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

Women (21-65 years) who had a Pap Smear in the Past Three Years, 2016



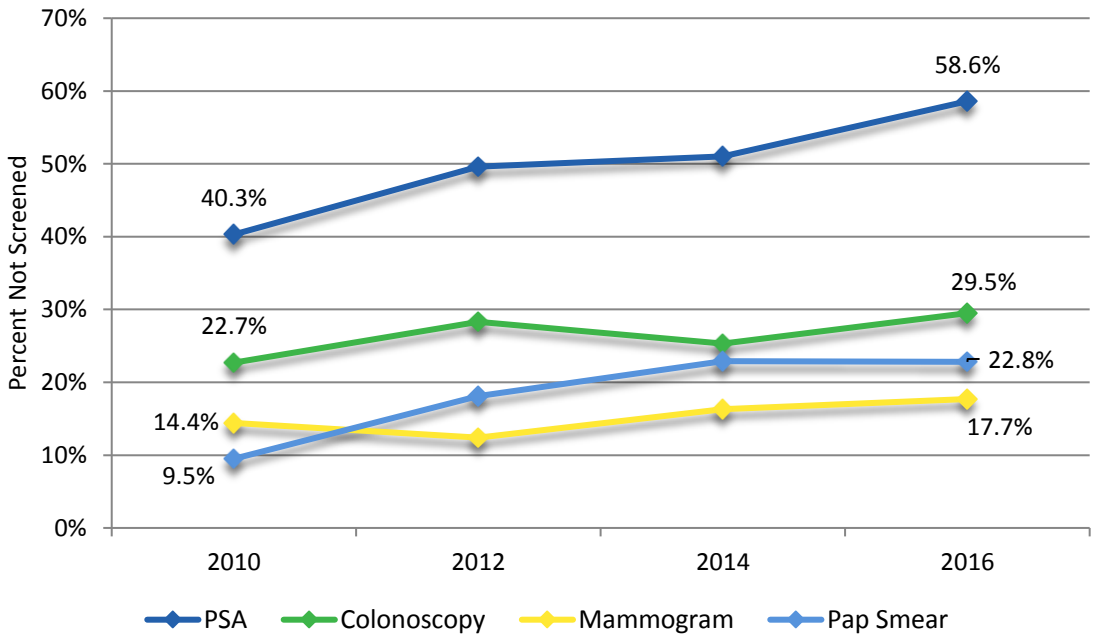
Data Source: 2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

Population Not Screened for Selected Cancer, Prince George's County, 2016

Cancer Screening	Target Group	Total Population	Percentage not Screened	Estimated Population not Screened
Prostate Specific Antigen (PSA) in past 2 years	Men 40 years and above	186,282	**58.6%**	**109,161**
Colorectal Cancer Screening	Men and women 50 - 75 years	251,357	**29.5%**	**74,150**
Mammography in past 2 years	Women 50 years and above	163,232	**17.7%**	**28,892**
Pap Smear in past 3 years	Women 21 - 65 years	291,708	**22.8%**	**66,509**

Data Source: 2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019; 2016 1-Year Estimates, U.S. Census Bureau, Table B01001 www.census.gov

Population Not Screened for Selected Cancers, Prince George's County, 2010-2016



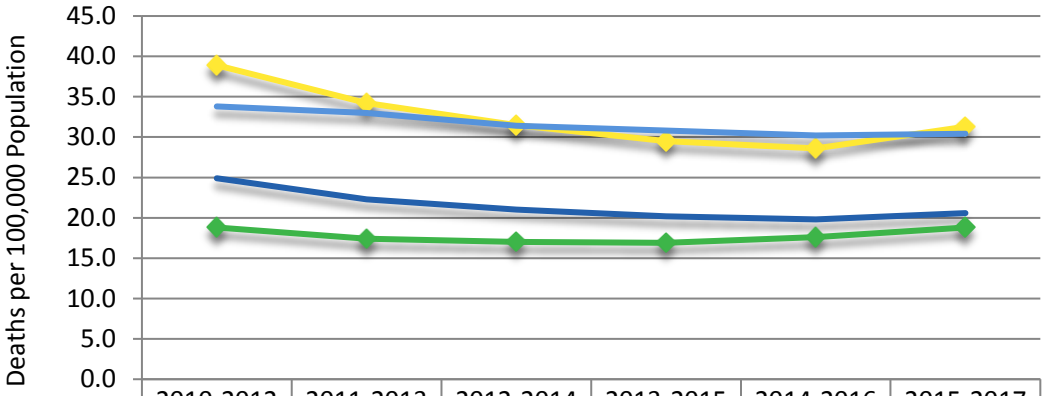
Data Source: 2010-2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Chronic Lower Respiratory Disease (CLRD)

CLRD are diseases that affect the lungs, which includes COPD (chronic obstructive pulmonary disease) and asthma. COPD consists of emphysema which means the air sacs in the lungs are damaged, and chronic bronchitis where the lining of the lungs are red and swollen and become clogged with mucus. Cigarette smoking is the main cause of COPD, and is strongly associated with lunch cancer. Asthma is a disease that also affects the lungs that is commonly is diagnosed in childhood. Asthma is described further below:

Asthma Overview	
What is it?	Asthma is a chronic disease involving the airways that allow air to come in and out of the lungs. Asthma causes airways to always be inflamed; they become even more swollen and the airway muscles can tighten when something triggers your symptoms: coughing, wheezing, and shortness of breath.
Who is affected?	13.3% (64,354) of adults are estimated to have asthma (MD 2017 BRFSS) and 13.9% (33,294) of children are estimated to have asthma (MD 2013 BRFSS).
Prevention and Treatment	Asthma cannot be prevented and there is no cure, but steps can be taken to control the disease and prevent symptoms: use medicines as your doctor prescribes and try to avoid triggers that make asthma worse. (NHLBI.NIH.gov; AAAAI.org)
What are the outcomes?	People with asthma are at risk of developing complications from respiratory infections like influenza and pneumonia. Asthma complications can be severe and include decreased ability to exercise, lack of sleep, permanent changes in lung function, persistent cough, trouble breathing, and death (NIH.gov).
Disparity	The age-adjusted emergency department (ED) visit rate for asthma was 2.5 times higher for Black, non-Hispanic residents compared to White, non-Hispanic and Hispanic residents in 2017. The rate of ED visits for asthma decreased with age. For adults (18 years of age and older), age-adjusted hospitalization rates for asthma were highest for females (compared to males) and Black residents (compared to other races). Among children, Asian/Pacific Islanders had the highest age-adjusted hospitalization rate (33.2 per 10,000), followed by American Indian and Alaskan Native residents (26.4). Higher ED visit and hospitalization rates in 2017 were mostly concentrated around the Washington, D.C. border.
How do we compare?	While 13.3% of adult county residents have asthma, other Maryland counties range from 5.9% to 22.3%; the state overall is 15.5% (2017 MD BRFSS) and the U.S. is at 14.2% (2017 BRFSS).

Age-Adjusted Death Rate per 100,000 for Chronic Lower Respiratory Disease (CLRD) by Race and Ethnicity, 2010-2017



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017
PGC Black, NH	18.8	17.4	17.0	16.9	17.6	18.8
PGC White, NH	38.9	34.2	31.5	29.5	28.6	31.3
PGC	24.9	22.3	21.0	20.2	19.8	20.6
Maryland	33.8	33.0	31.4	30.8	30.2	30.4

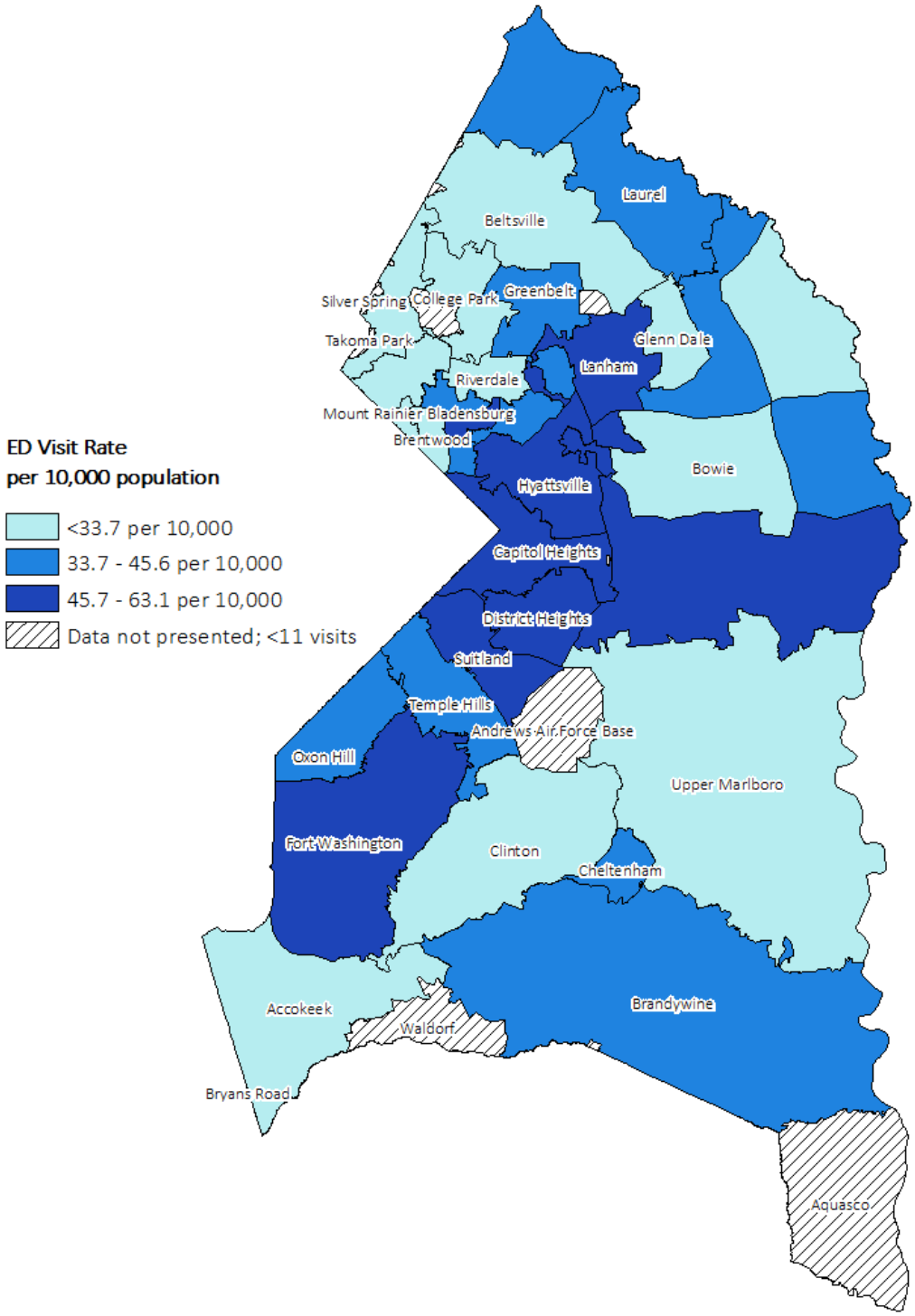
***** Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Emergency Department* Visits for Asthma, 2017

	Number of ED Visits	Age-Adjusted Rate per 10,000 Population
Race/Ethnicity		
Black, non-Hispanic	2,293	41.8
Hispanic	296	16.4
White, non-Hispanic	163	16.4
Asian, non-Hispanic	23	6.3
Sex		
Male	1,604	36.7
Female	2,017	42.4
Age		
Under 18 Years	942	46.3
18 to 39 Years	1,294	44.6
40 to 64 Years	1,105	36.5
65 Years and Over	280	23.9
Total	**3,621**	**48.9**

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.
Data Source: Outpatient Discharge Data File 2017, Maryland Health Services Cost Review Commission;

Emergency Department* Visit Rate per 10,000 Population, Asthma as Primary Discharge Diagnosis, Prince George's County, 2017

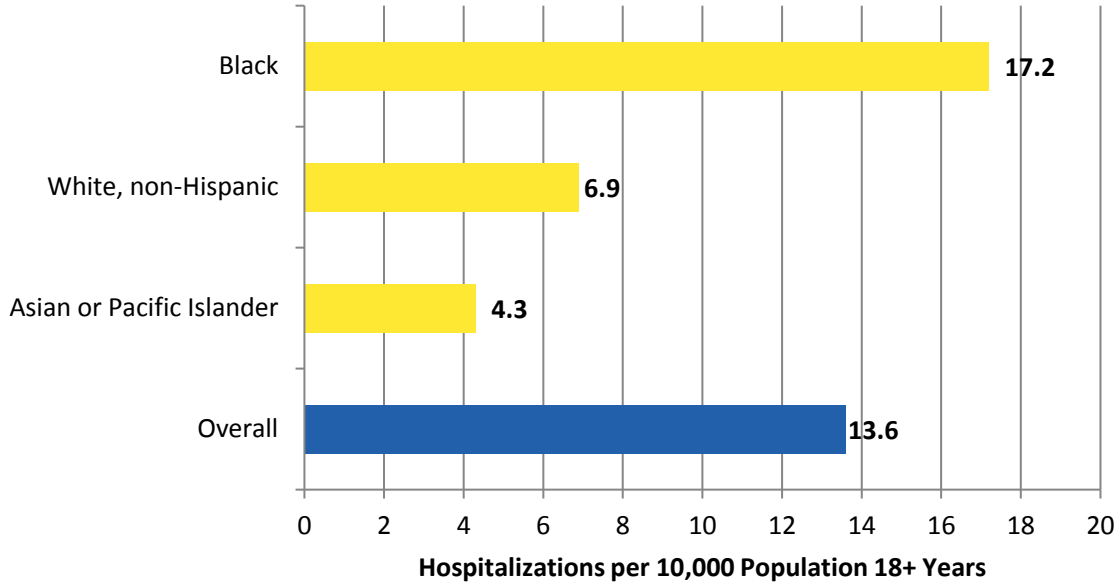


* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Outpatient Discharge Data File 2017, Maryland Health Services Cost Review Commission

Adult Asthma

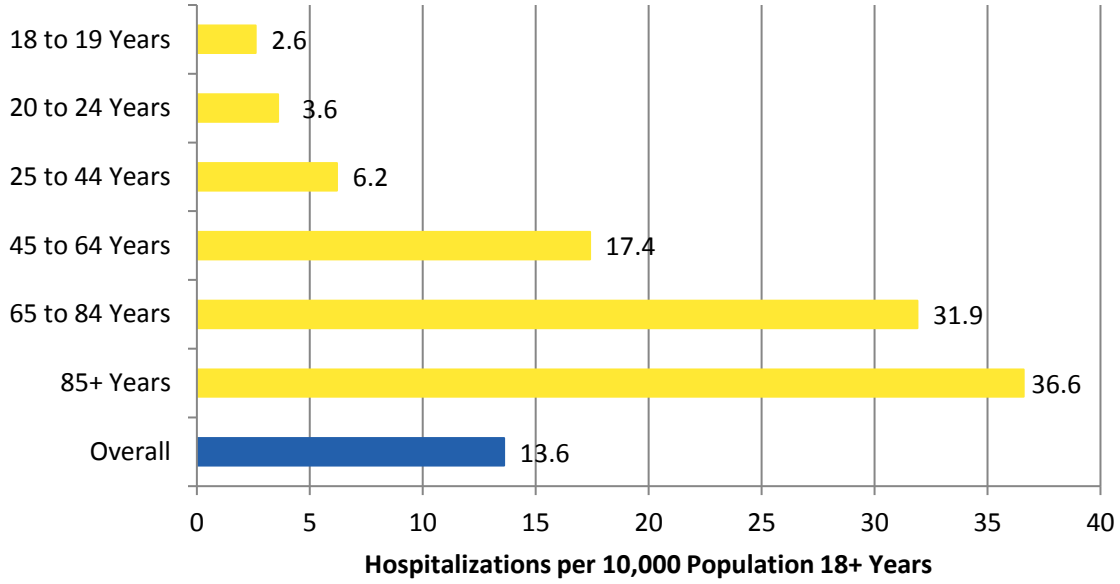
Age-Adjusted Hospital Inpatient* Visit Rate due to Adult Asthma by Race and Ethnicity, Prince George's County, 2013-2015



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

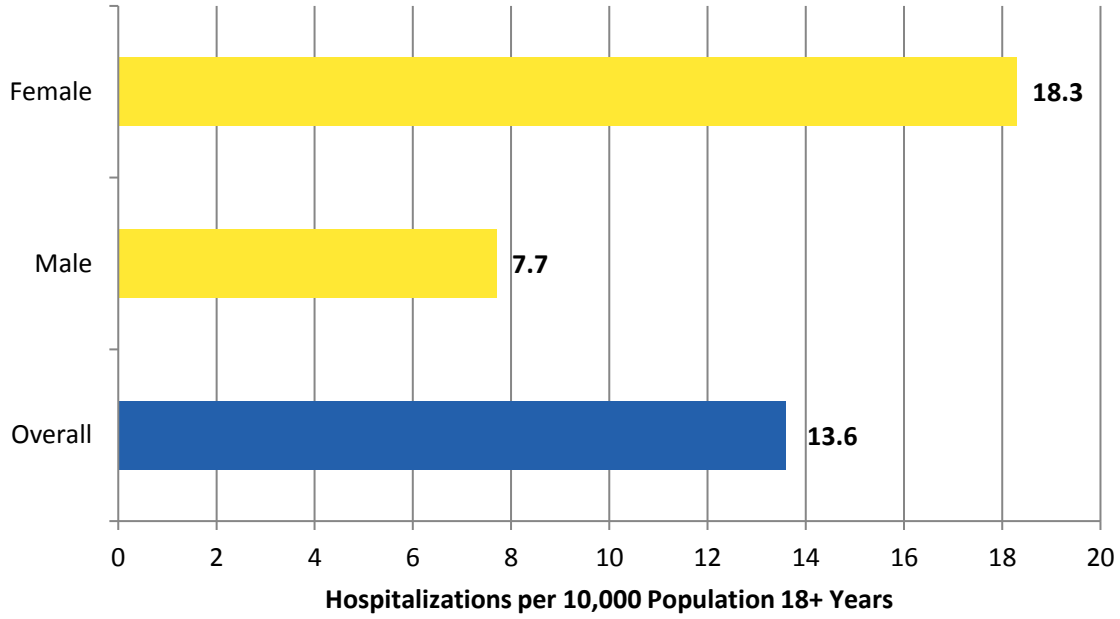
Age-Adjusted Hospital Inpatient* Visit Rate due to Adult Asthma by Age Group, Prince George's County, 2013-2015



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

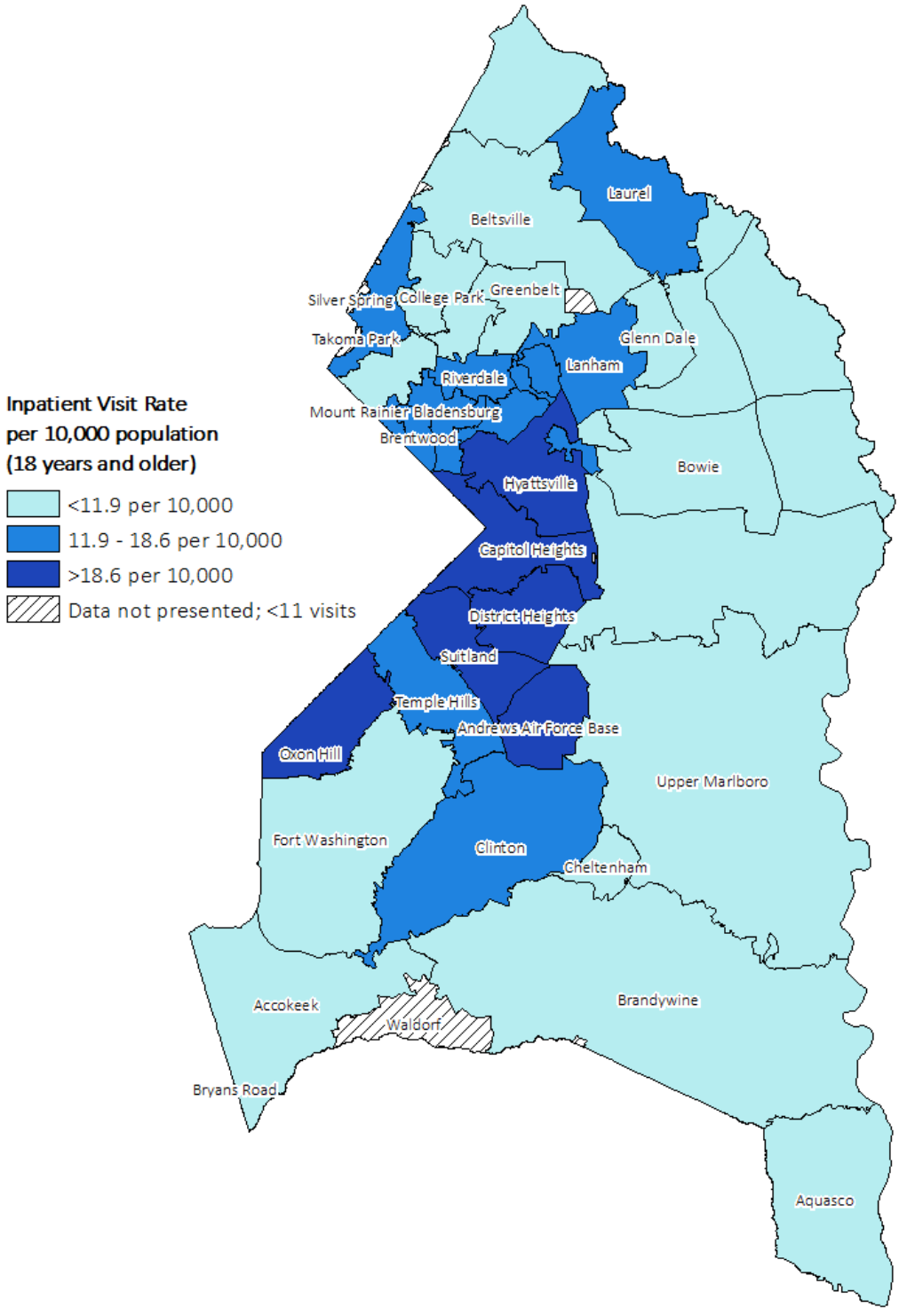
Age-Adjusted Hospital Inpatient* Visit Rate due to Adult Asthma by Sex, Prince George's County, 2013-2015



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Adult Asthma, Prince George's County, 2013-2015

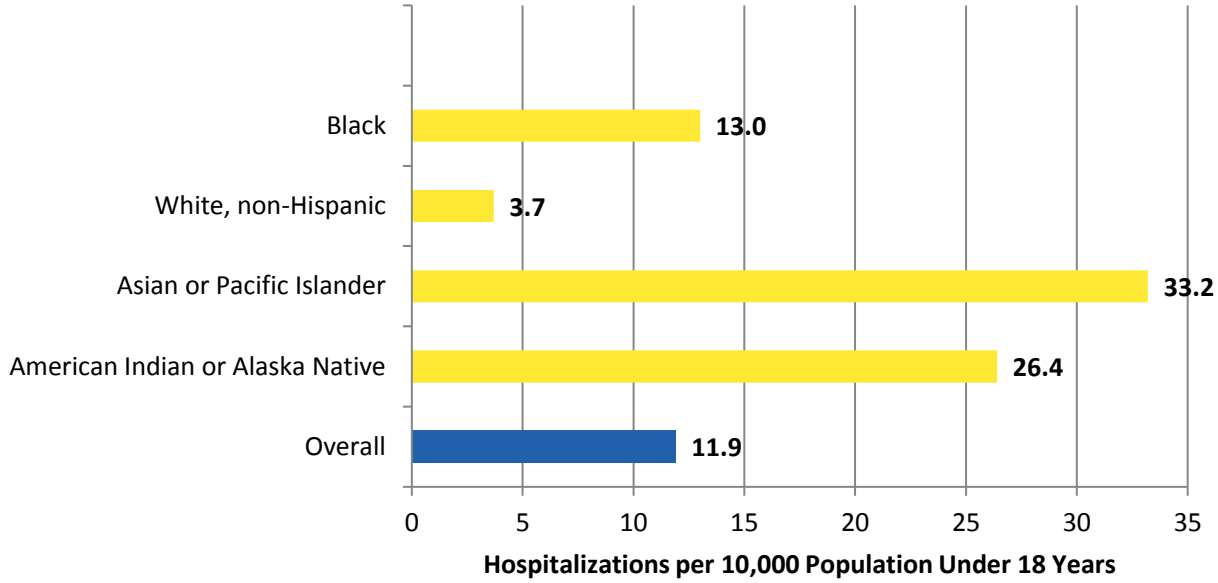


* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Pediatric Asthma

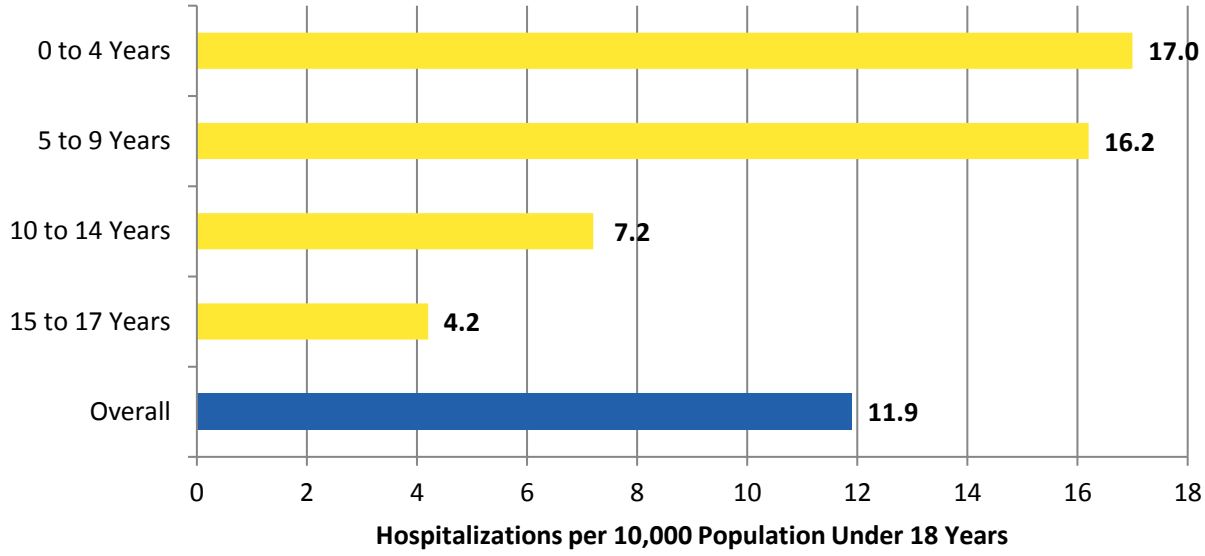
Age-Adjusted Hospital Inpatient* Visit Rate due to Pediatric Asthma (Under 18 Years) by Race and Ethnicity, Prince George's County, 2013-2015



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

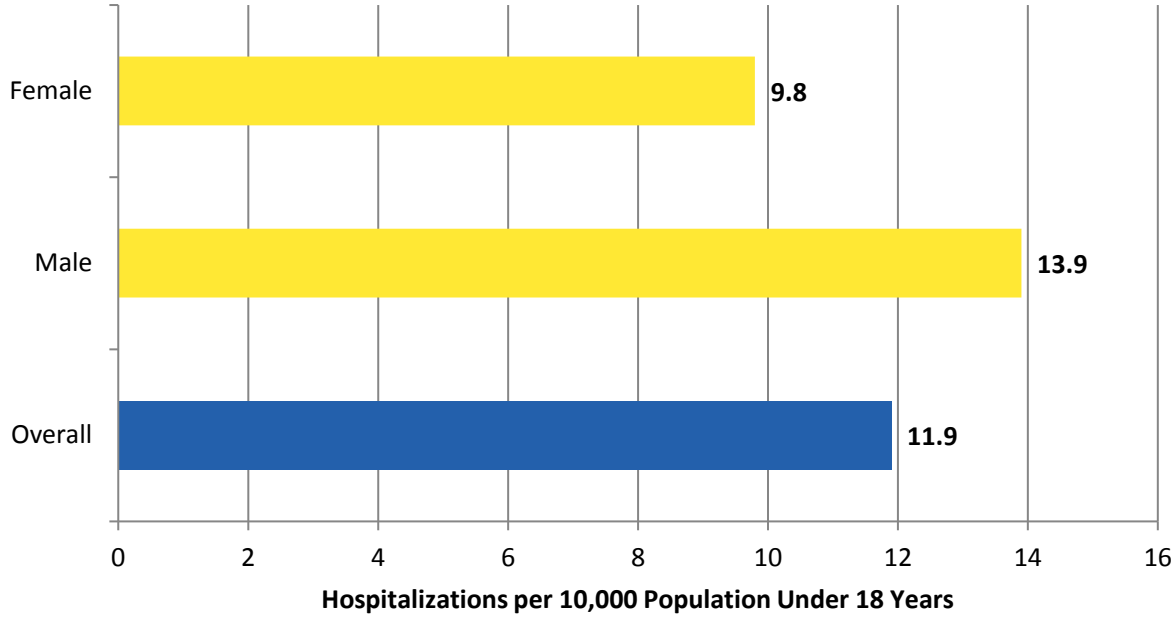
Age-Adjusted Hospital Inpatient* Visit Rate due to Pediatric Asthma (Under 18 Years) by Age, Prince George's County, 2013-2015



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

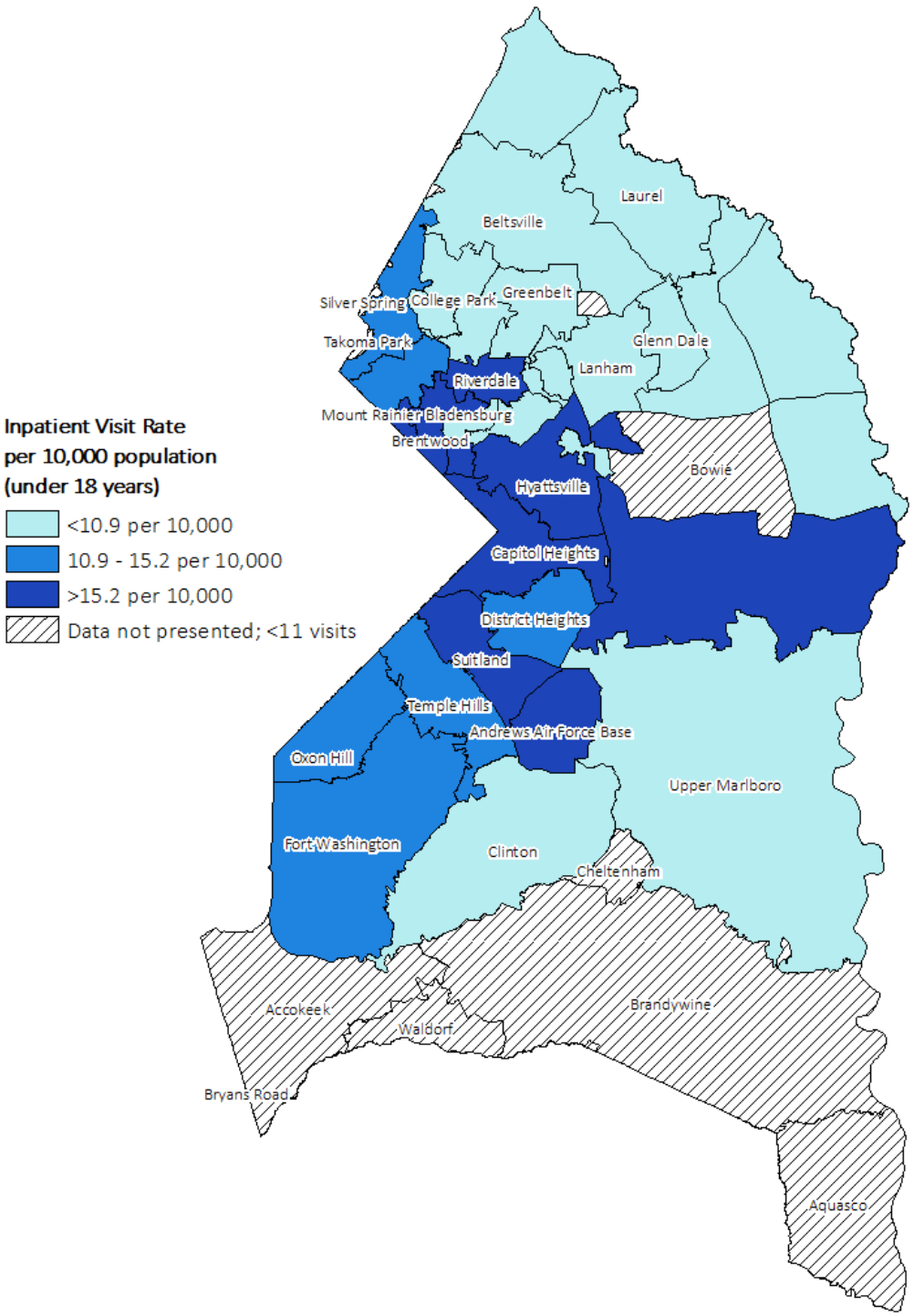
Age-Adjusted Hospital Inpatient* Visit Rate due to Pediatric Asthma (Under 18 Years) by Sex, Prince George's County, 2013-2015



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Pediatric Asthma (Under 18 Years), Prince George's County, 2013-2015

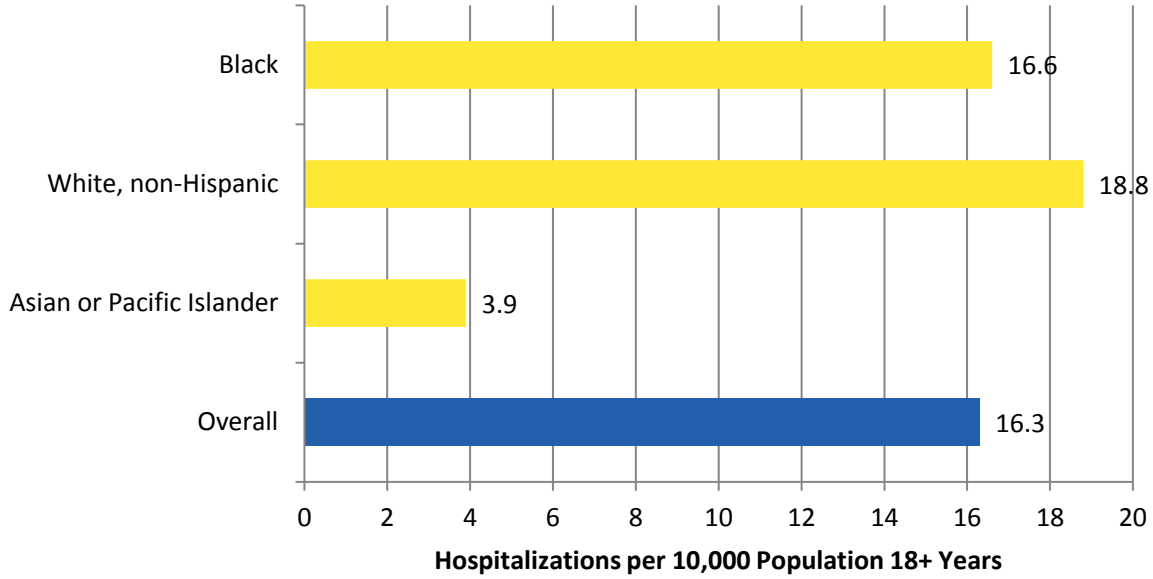


* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

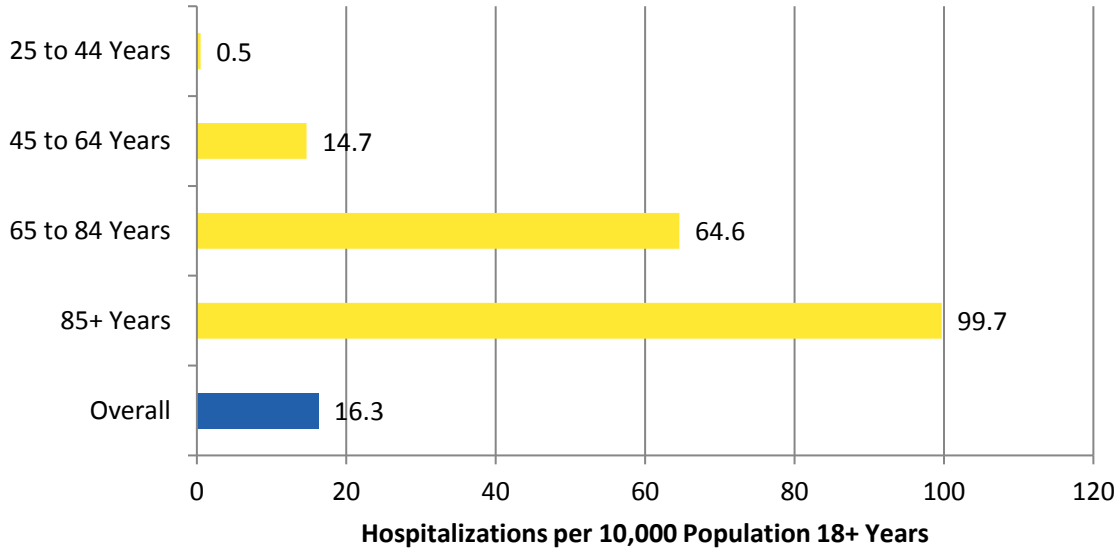
Chronic Obstructive Pulmonary Disease (COPD)

Age-Adjusted Hospital Inpatient* Visit Rate due to COPD by Race and Ethnicity, Prince George's County, 2013-2015



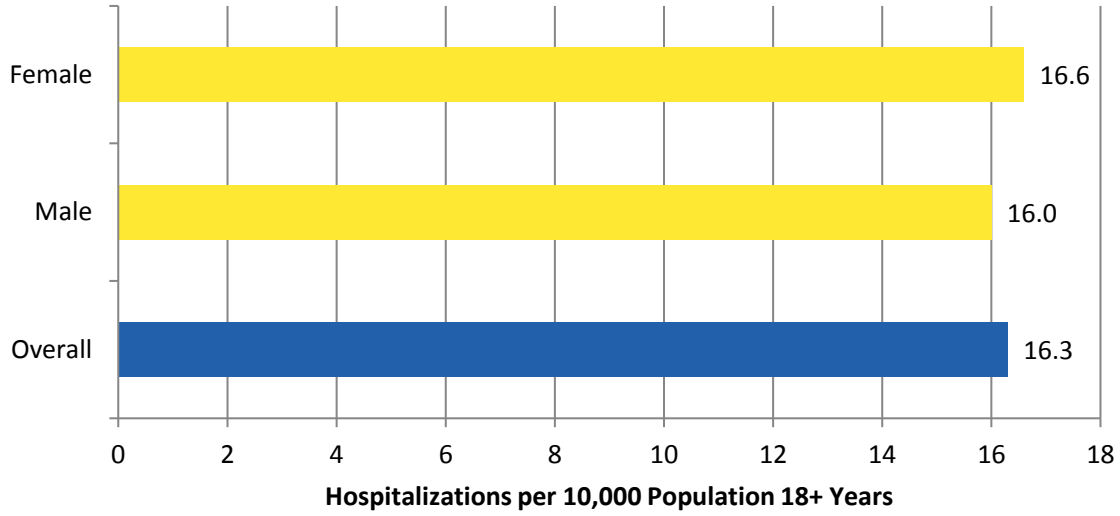
* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to COPD by Age Group, Prince George's County, 2013-2015



* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

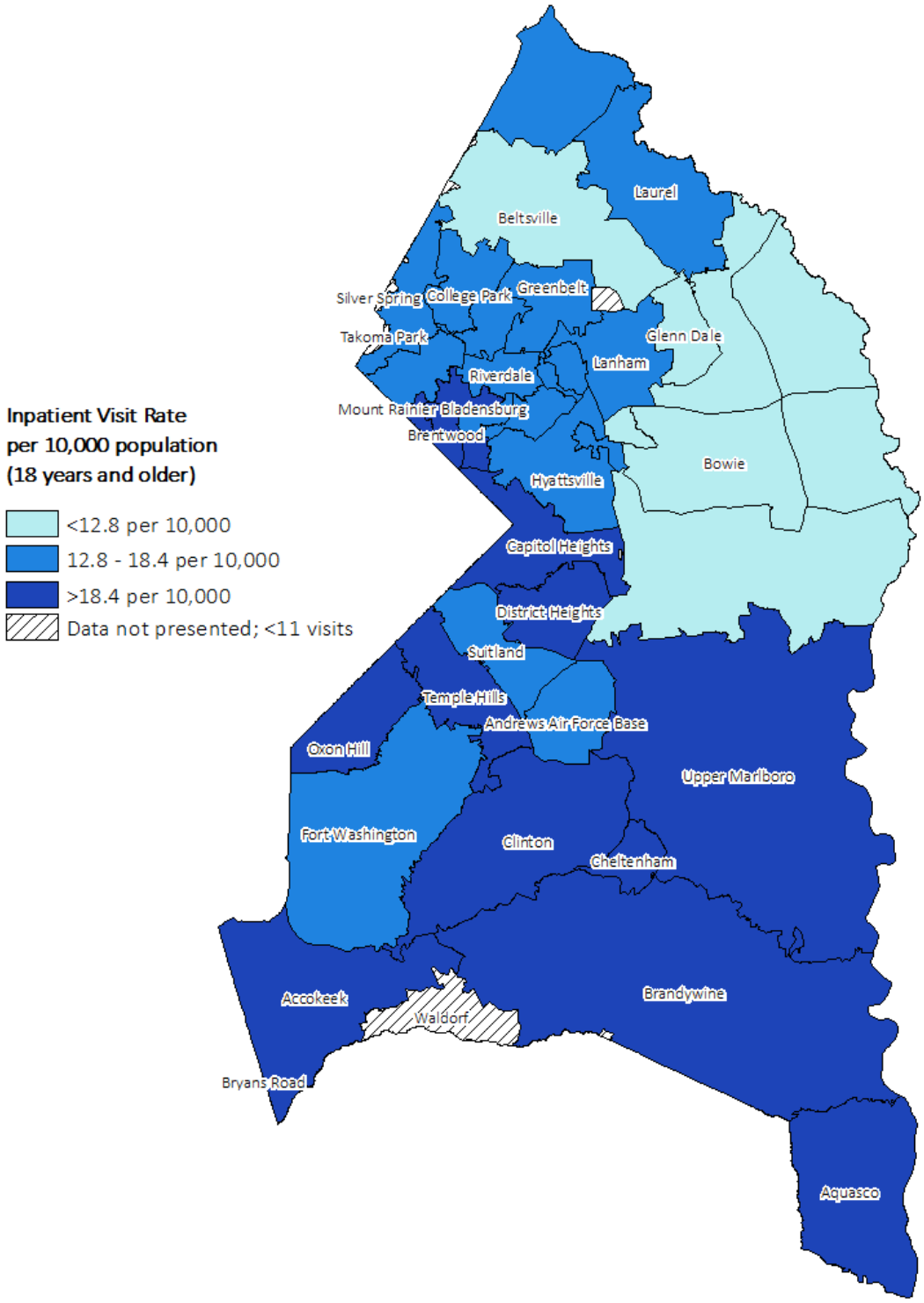
Age-Adjusted Hospital Inpatient* Visit Rate due to COPD by Sex, Prince George's County, 2013-2015



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to COPD, Prince George's County, 2013-2015



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Diabetes

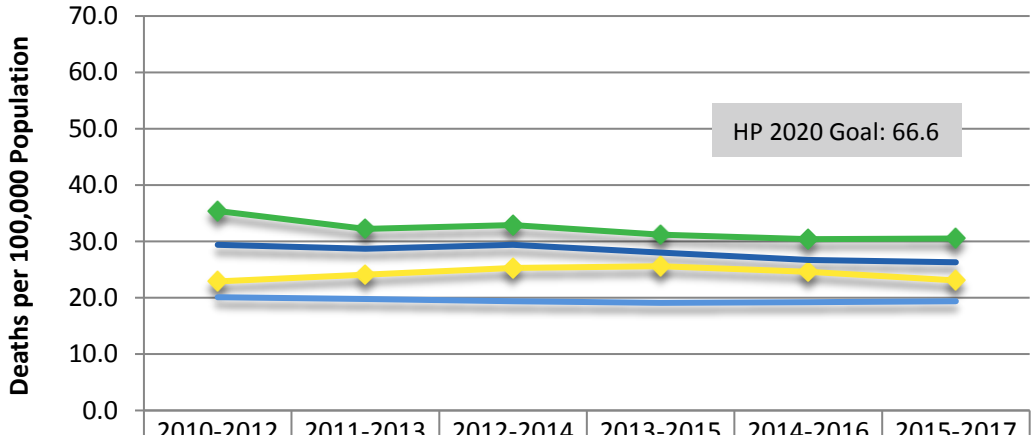
Overview	
What is it?	Diabetes is a condition in which the body either doesn't make enough of a hormone called insulin or can't use its own insulin, which is needed to process glucose (sugar) (Source: CDC).
Who is affected?	12.3% (87,260) of adults in the county are estimated to have diabetes. (2017 MD BRFSS). In 2017, diabetes was the fifth leading cause of death in the county, with 253 deaths (3.9% of all resident deaths).
Prevention and Treatment	Diabetes can be prevented or delayed by losing a small amount of weight (5 to 7 percent of total body weight) through 30 minutes of physical activity 5 days a week and healthier eating. (Source: CDC Diabetes Prevention Program) The goals of diabetes treatment are to control blood glucose levels and prevent diabetes complications by focusing on: nutrition, physical activity, and medication. (source: Joslin Diabetes Center)
What are the outcomes?	Complications from diabetes include: heart disease, kidney failure, lower-extremity amputation, and death
Disparity	In 2017, the age-adjusted emergency department visits for diabetes were twice as high among Black, non-Hispanic residents (211.4 per 100,000) compared to White, non-Hispanic residents (109.2). Black, non-Hispanic residents were also more likely to die from diabetes in 2017 (30.5 per 100,000) compared to White, non-Hispanic residents (23.1). Slightly more men (13.0%) were estimated to have diabetes compared to women (12.0%). Diabetes prevalence increases with age; nearly one in three residents ages 65 and over are estimated to have diabetes.
How do we compare?	Diabetes in other Maryland counties ranged from 7.3% to 14.4%; the state overall is 9.6% (2017 MD BRFSS), and the U.S. is at 10.5% (BRFSS). Between 2015-2017, Prince George's County had the third highest age-adjusted death rate due to diabetes (26.9 per 100,000), following Baltimore City (31.0) and Washington County (28.1).

Percentage of Adults Who Have Ever Been Told By a Health Professional That They Have Diabetes, 2017 (Excludes Diabetes During Pregnancy)

	Prince George's County	Maryland
Sex		
Female	12.0%	8.9%
Male	13.0%	10.4%
Race/Ethnicity		
Black, non-Hispanic	13.6%	13.5%
Hispanic	16.7%	12.7%
White, non-Hispanic	10.5%	7.6%
Age Group		
18 to 34 Years	*	1.6%
35 to 49 Years	10.6%	7.2%
50 to 64 Years	19.3%	15.1%
Over 65 Years	28.7%	21.6%
Total	**12.3%**	**9.6%**

***** Individuals of Hispanic origin and ages 18-34 years were not included due to insufficient numbers
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Age-Adjusted Death Rate per 100,000 for Diabetes, 2010-2017



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017
PGC Black, NH	35.4	32.2	32.9	31.2	30.4	30.5
PGC White, NH	22.9	24.1	25.3	25.6	24.6	23.1
PGC	29.4	28.7	29.4	28.0	26.7	26.3
Maryland	20.1	19.8	19.4	19.1	19.2	19.4

***** Individuals of Hispanic origin and Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database;

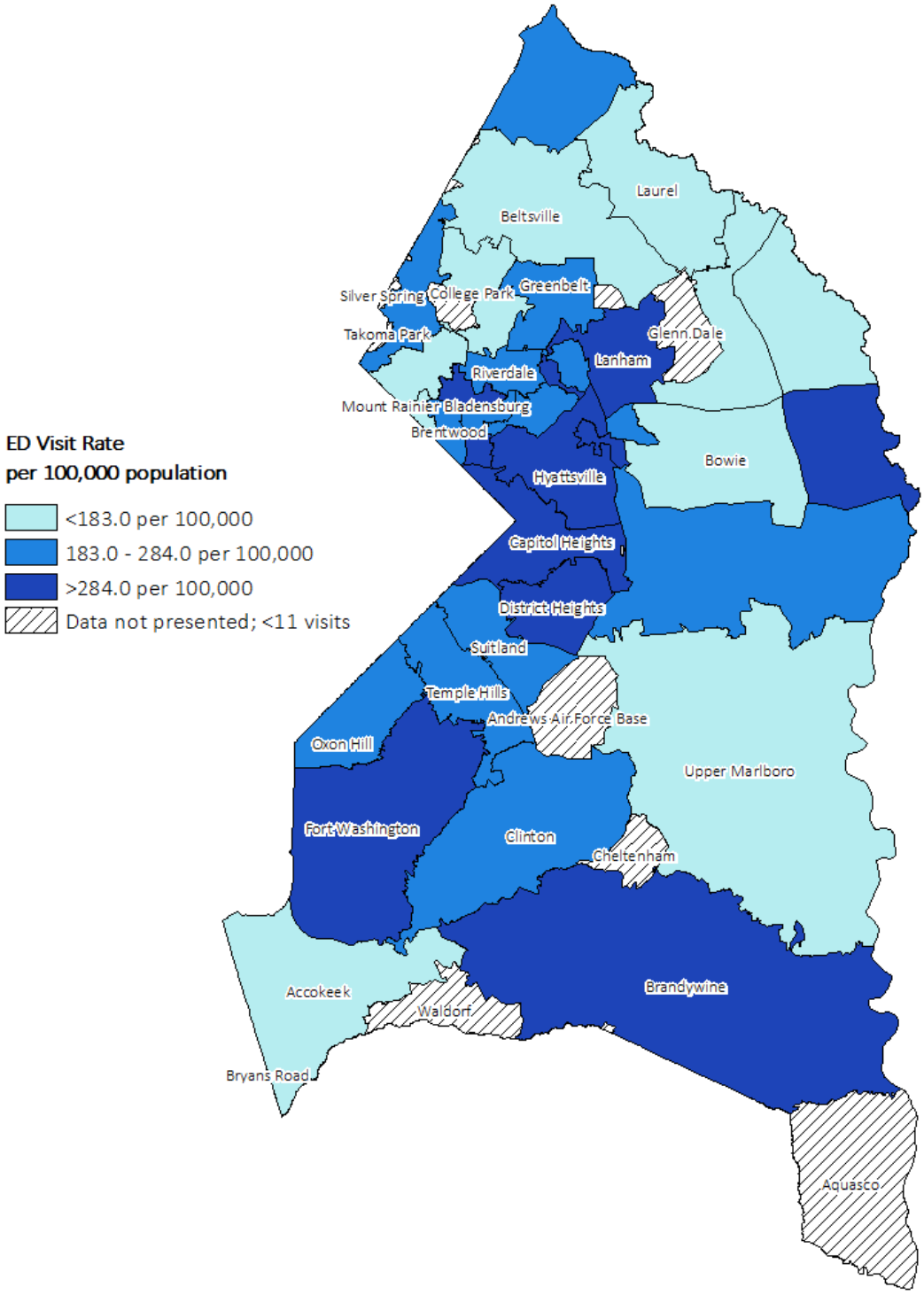
Emergency Department* Visits for Diabetes, 2017

	Number of ED Visits	MD SHIP Goal: 186.3	Age-Adjusted Visit Rate per 100,000 Population
Race/Ethnicity			
Black, non-Hispanic	1,284		211.4
Hispanic	171		128.0
White, non-Hispanic	151		109.2
Asian, non-Hispanic	14		33.2
Sex			
Male	1,062		233.2
Female	1,041		197.8
Age			
Under 18 Years	43		21.1
18 to 39 Years	413		142.5
40 to 64 Years	1,125		371.8
65 Years and Over	522		446.3
Total	**2,103**		**215.0**

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Outpatient Discharge Data File 2017, Maryland Health Services Cost Review Commission;

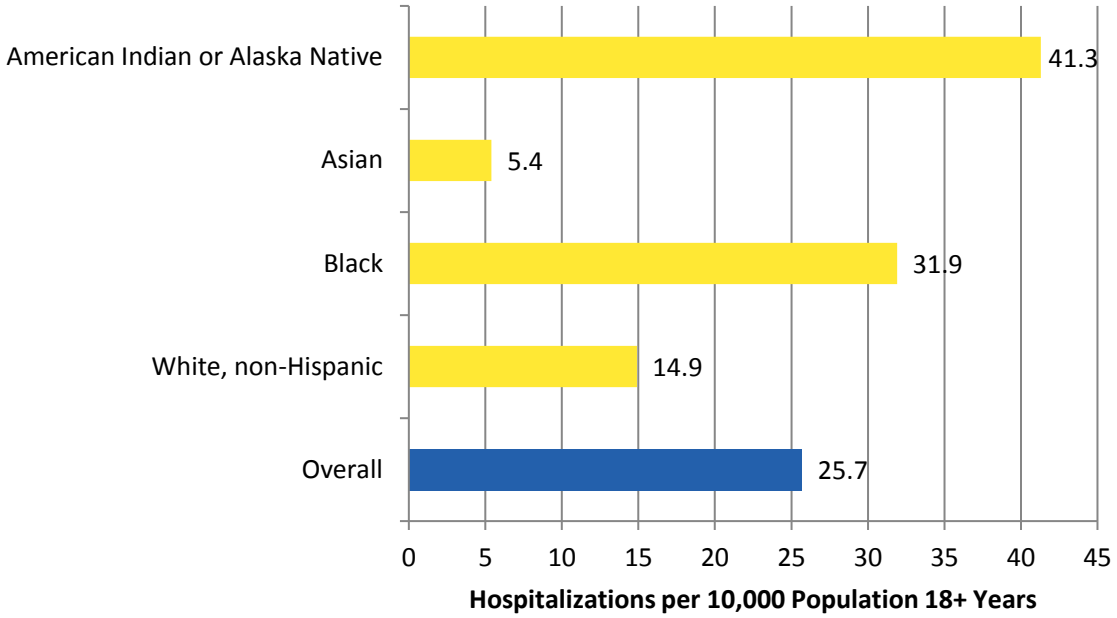
Emergency Department Visit Crude Rate per 100,000 Population, Diabetes as Primary Discharge Diagnosis, Prince George's County, 2017



* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

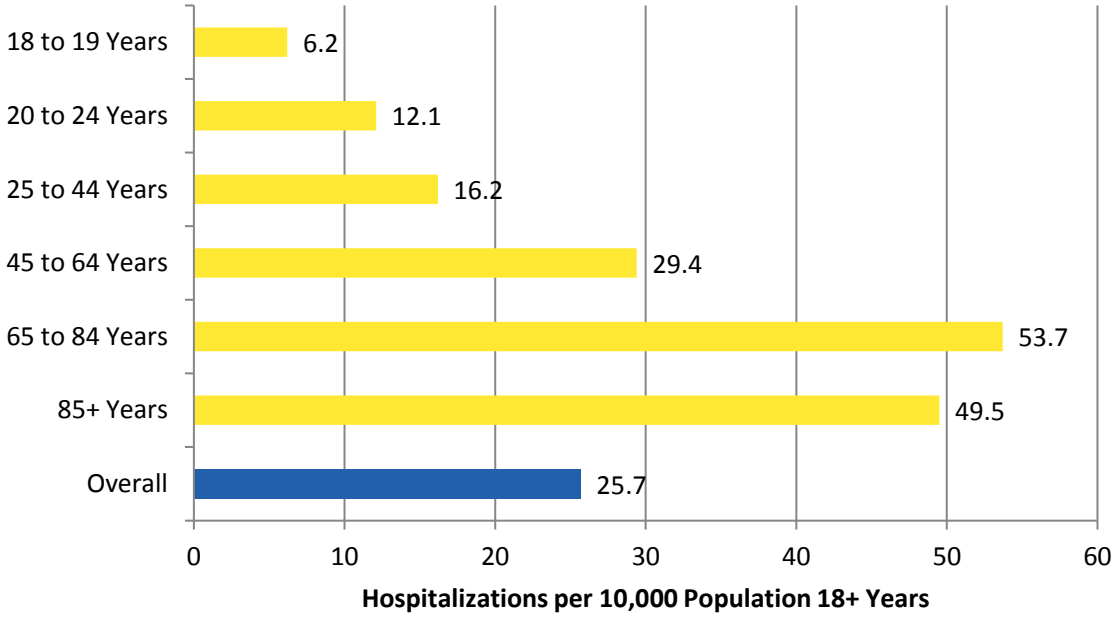
Data Source: Outpatient Discharge Data File 2017, Maryland Health Services Cost Review Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Diabetes by Race and Ethnicity, Prince George's County, 2013-2015



* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Diabetes by Age Group, Prince George's County, 2013-2015



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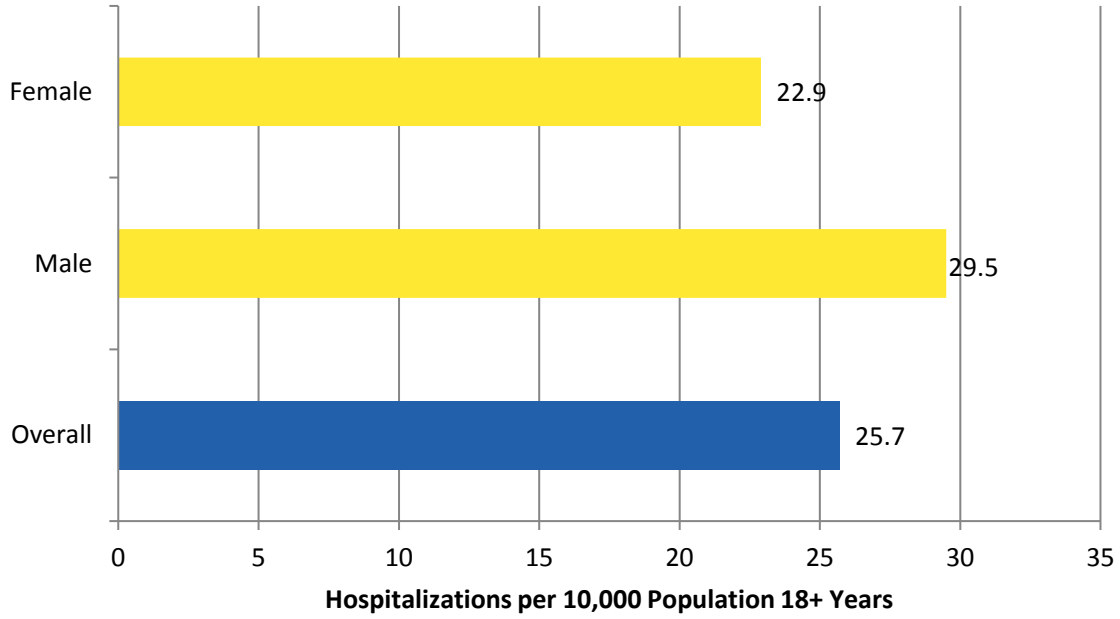
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

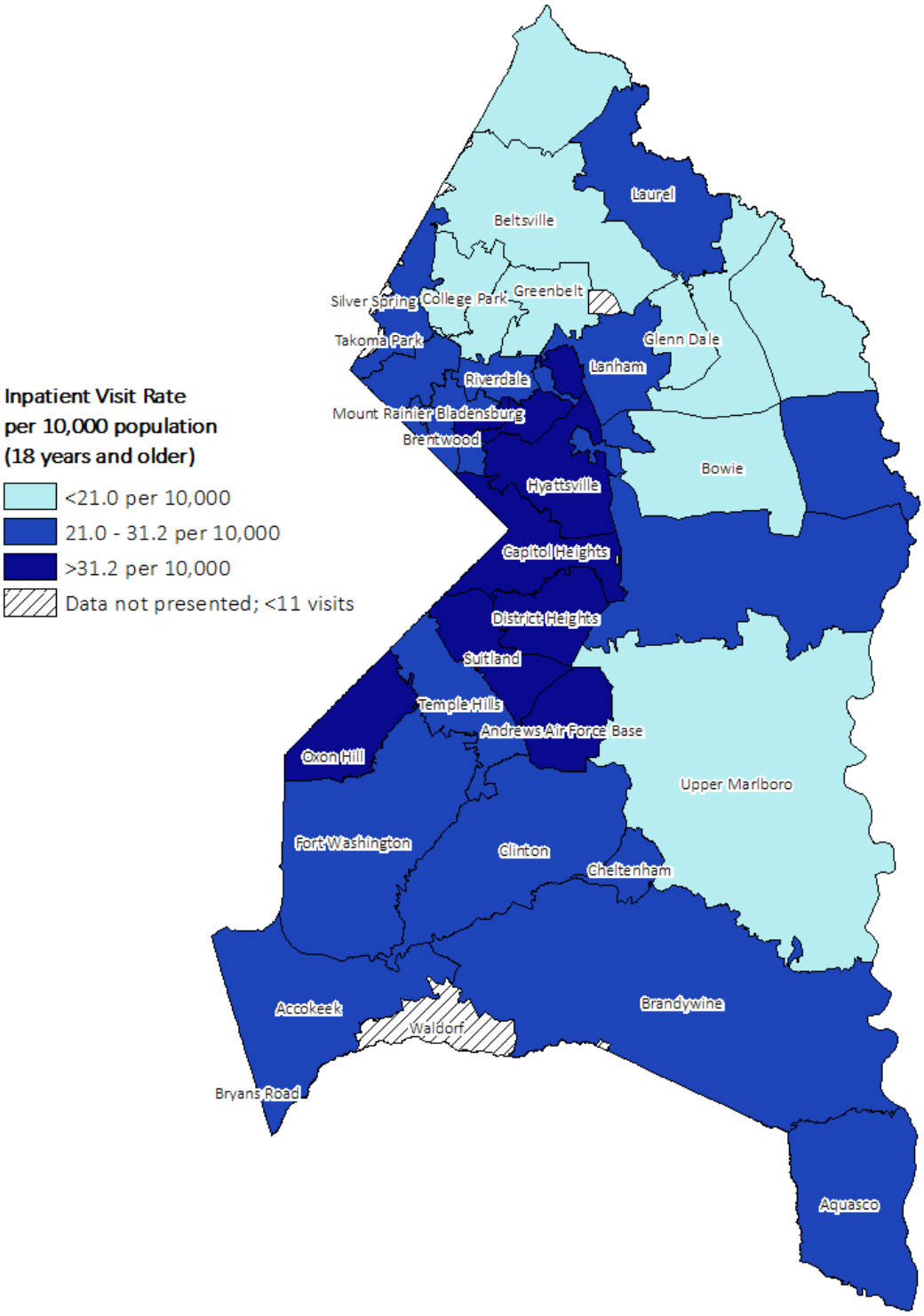
Age-Adjusted Hospital Inpatient* Visit Rate due to Diabetes by Sex, Prince George's County, 2013-2015



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Diabetes, Prince George's County, 2013-2015



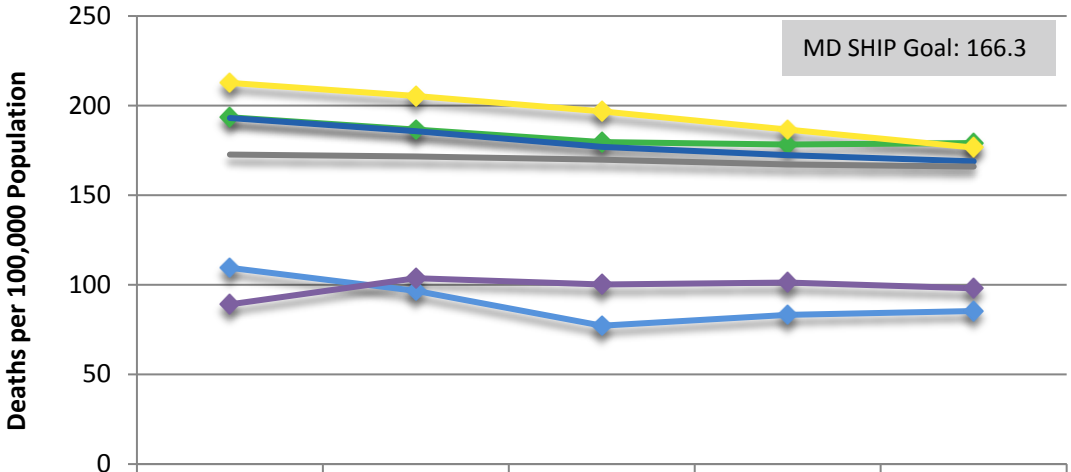
* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

Heart Disease

Overview	
What is it?	Heart Disease is a disorder of the blood vessels of the heart that can lead to a heart attack, which happens when an artery becomes blocked. Heart Disease is one of several cardiovascular diseases.
Who is affected?	Heart disease was the leading cause of death in the county in 2017, with 1,552 deaths (23.7% of all resident deaths). However, the age-adjusted death rate from heart disease has decreased from 193.1 deaths per 100,000 in 2011-2013 to 168.9 deaths per 100,000 in 2015-2017 (CDC Wonder).
Prevention and Treatment	Eating a healthy diet, maintaining a healthy weight, getting enough physical activity, not smoking, and limiting alcohol use can lower the risk of heart disease. (Source: CDC). The goals of heart disease treatment is to control high blood pressure and high cholesterol by focusing on: eating healthier, increasing physical activity, quitting smoking, medication, and surgical procedures. (Source: CDC).
What are the outcomes?	Complications of heart disease include: heart failure, heart attack, stroke, aneurysm, peripheral artery disease, and sudden cardiac arrest.
Disparity	Men had a higher rate of emergency department (ED) visits and inpatient hospitalizations for heart disease than women in 2017. Black, non-Hispanic (NH) residents had the highest age-adjusted death rate (179.1), followed closely by White, NH residents (176.6). Black, NH residents also had the highest 2017 age-adjusted ED visit rate. In 2017, almost half (48%) of heart disease ED visits were made by residents 65 years of age and older.
How do we compare?	The age-adjusted death rate for heart disease for other Maryland counties ranged from 105.4 (Montgomery) to 296.3 (Somerset) deaths per 100,000 population. The county rate of 168.9 is similar to Maryland overall at 166.0 deaths per 100,000 population, and the United States (166.3 per 100,000 population).

Age-Adjusted Death Rate per 100,000 for Heart Disease by Race and Ethnicity, 2010-2017



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017
PGC Black, NH	193.5	186.7	179.6	178.3	179.1
PGC Hispanic	109.5	96.7	77.2	83.3	85.4
PGC White, NH	212.7	205.4	196.8	186.7	176.6
PGC Asian, NH	89.1	103.7	100.2	101.3	98.1
PGC	193.1	185.8	177.0	172.3	168.9
Maryland	172.7	171.6	169.9	167.1	166.0

Data Source: CDC, National Center for Health Statistics, CDC WONDER Online Database

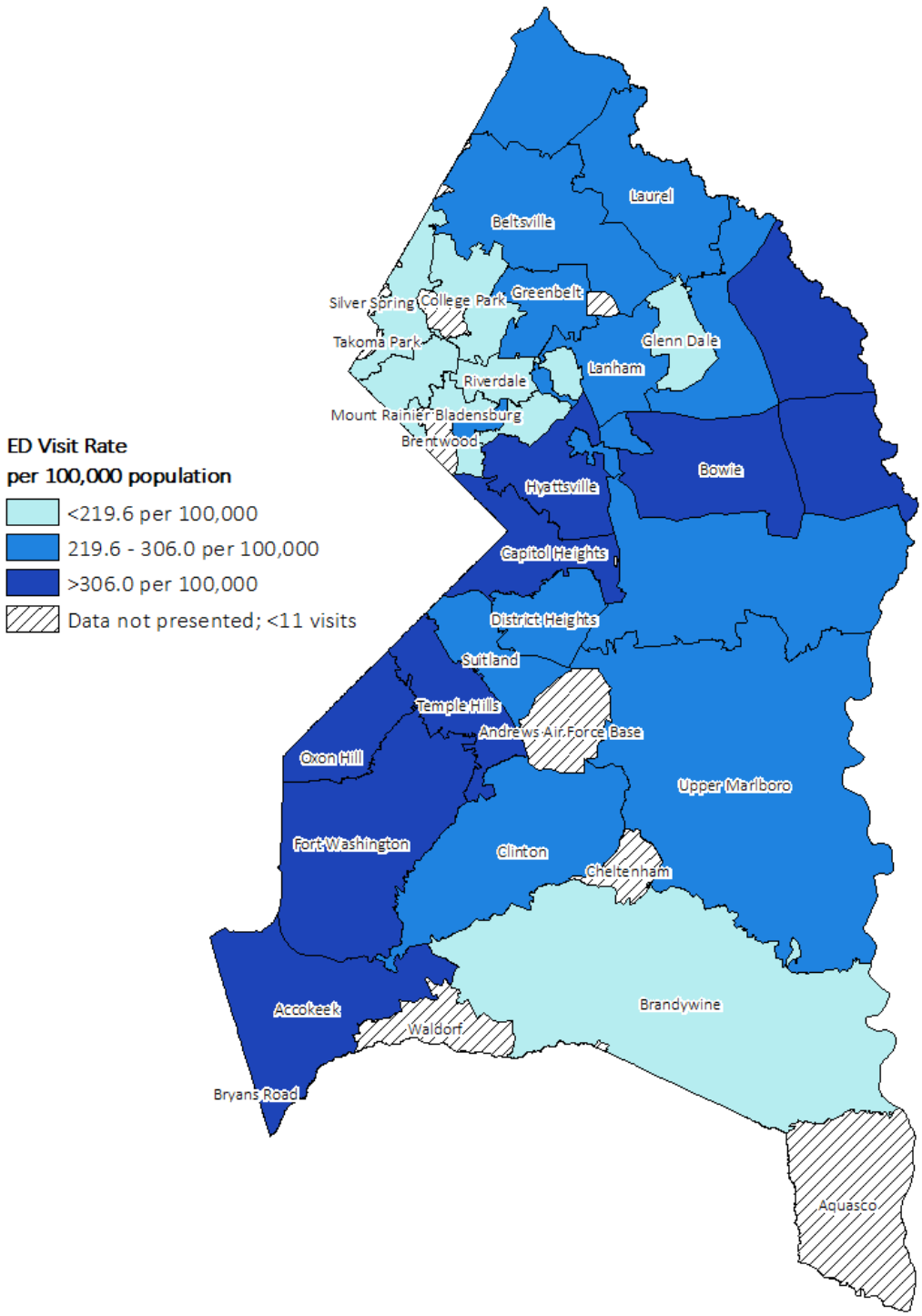
Emergency Department* Visits for Heart Disease, 2017

Demographic	Number of ED Visits	Age-Adjusted Rate per 100,000 Population
Race and Ethnicity		
Black, non-Hispanic	1,445	256.7
Hispanic	130	143.4
White, non-Hispanic	389	224.1
Asian, non-Hispanic	35	81.9
Gender		
Male	1,268	296.0
Female	1,188	231.5
Age		
Under 18 Years	36	17.7
18 to 39 Years	218	75.2
40 to 64 Years	1,008	333.1
65 Years and Over	1,194	1020.9
Total	**2,456**	**261.8**

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Outpatient Discharge Data File 2017, Maryland Health Services Cost Review Commission; Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Emergency Department Visit* Crude Rate per 100,000 Population, Heart Disease as Primary Discharge Diagnosis, Prince George's County, 2017



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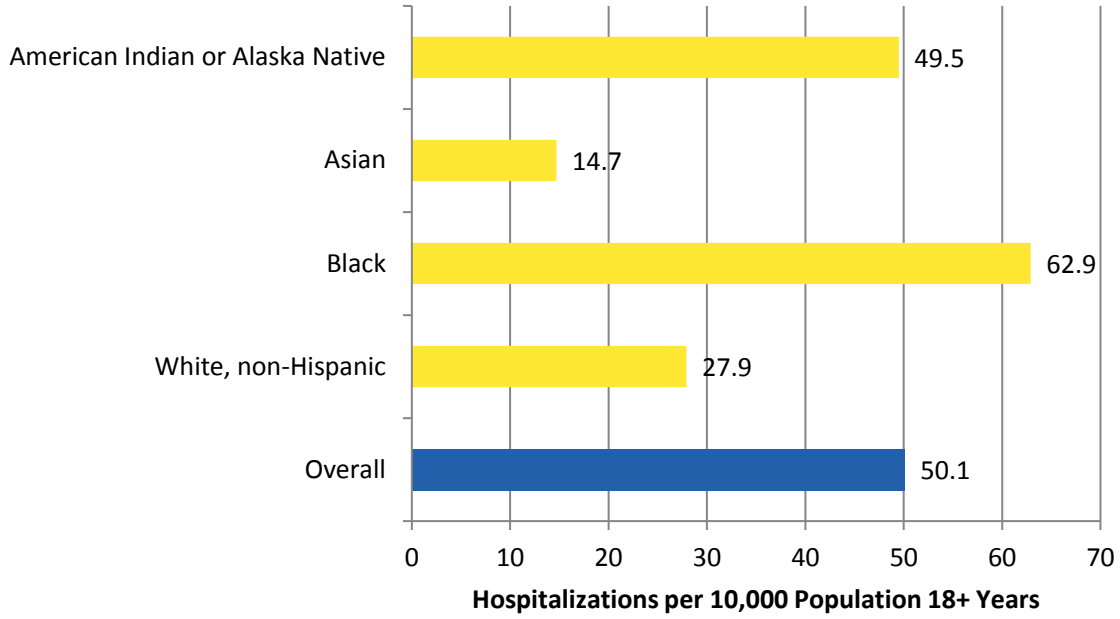
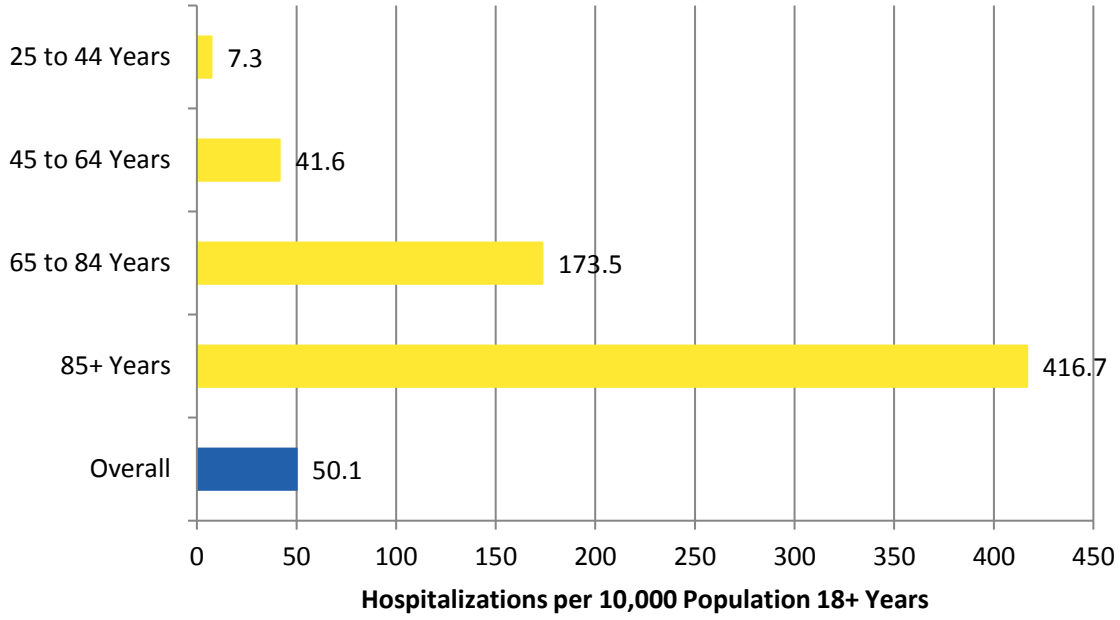
Data Source: Outpatient Discharge Data File 2017, Maryland Health Services Cost Review Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Heart Failure by Race and Ethnicity, Prince George's County, 2013-2015



* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: www.pgchealthzone.org, Maryland Health Services Cost Review Commission; Maryland Health Care Commission;

Age-Adjusted Hospital Inpatient* Visit Rate due to Heart Failure by Age, Prince George's County, 2013-2015



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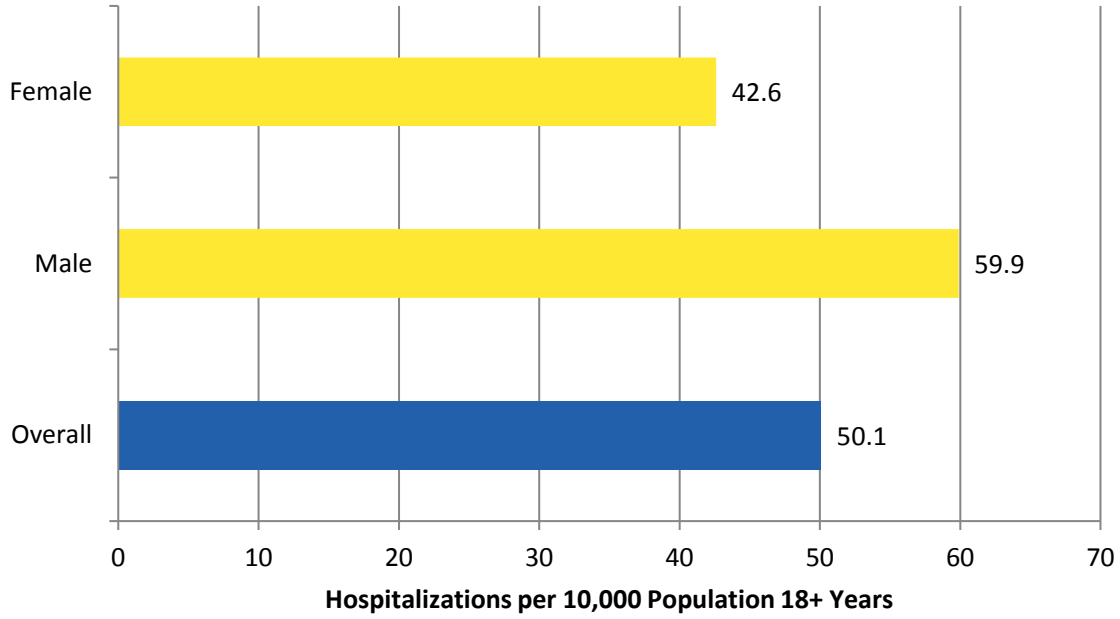
Data Source: www.pgchealthzone.org, Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Heart Failure by Sex, Prince George's County, 2013-2015



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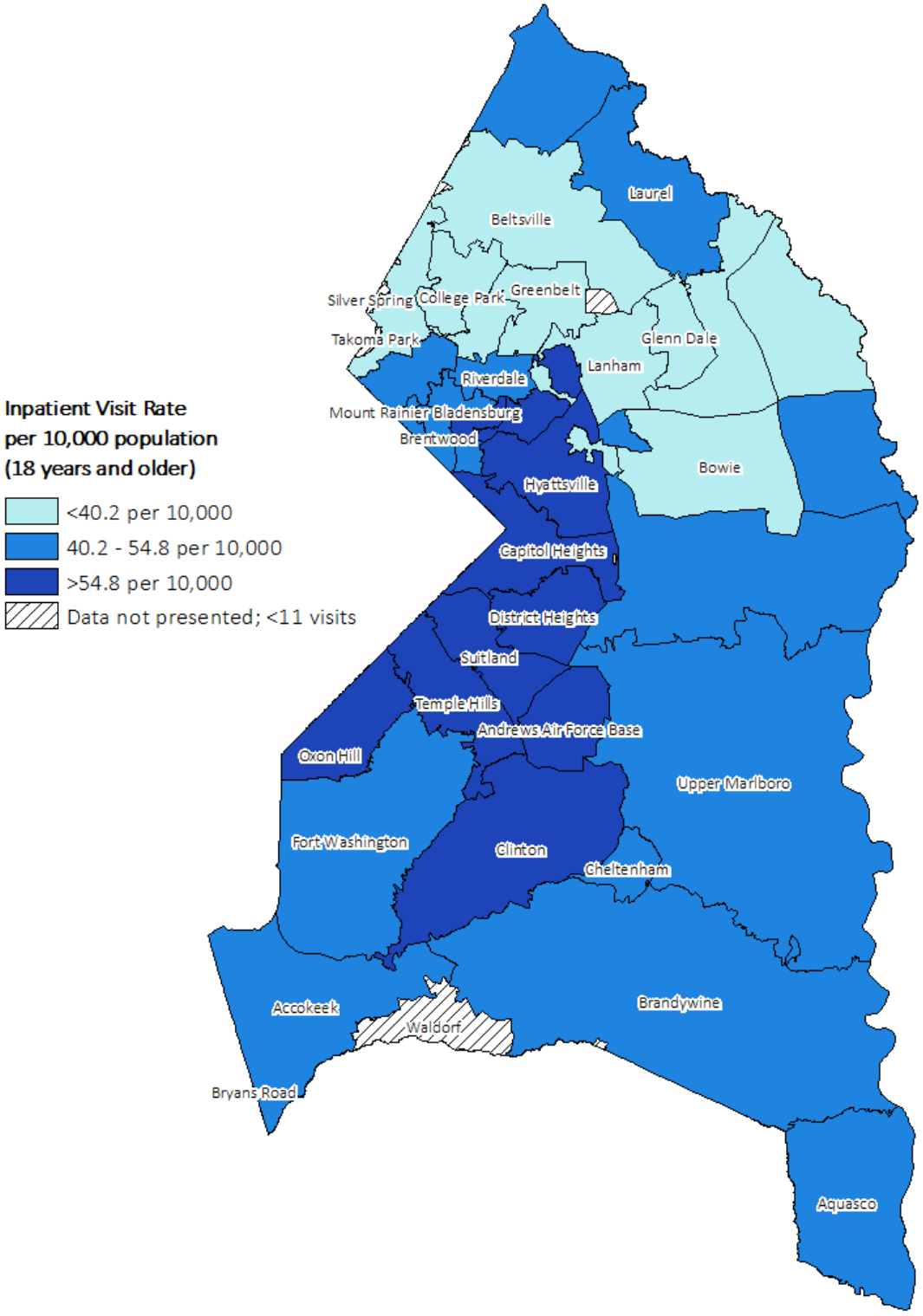
Age-Adjusted Hospital Inpatient* Visit Rate due to Heart Failure, Prince George's County, 2013-2015



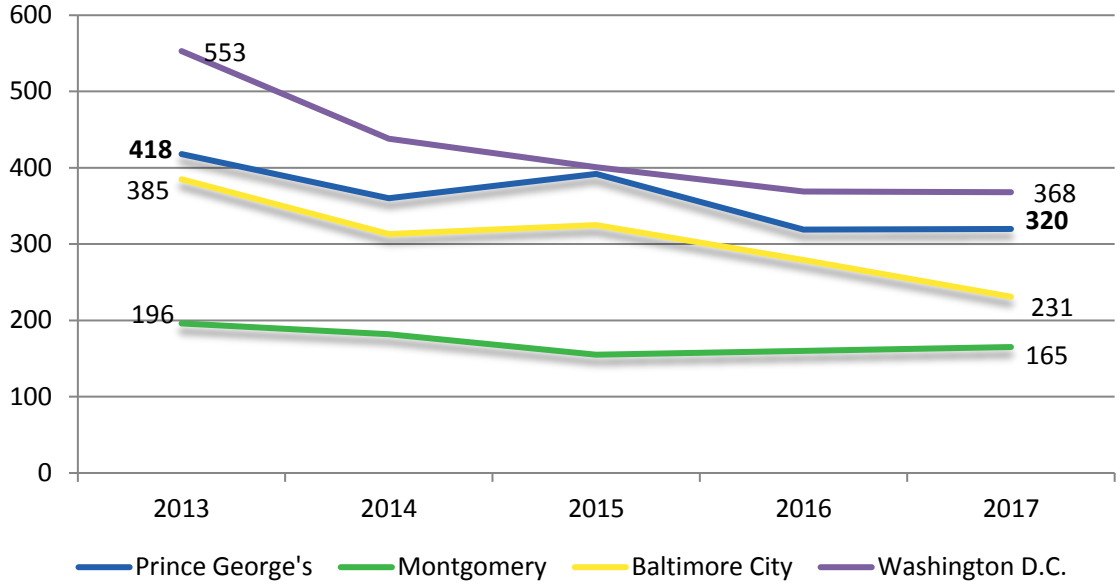
* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org, Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Human Immunodeficiency Virus (HIV)

Overview	
What is it?	HIV is a virus that attacks the body's immune system and can, over time, destroy the cells that protect us from infections and disease.
Who is affected?	In 2017, 320 residents were diagnosed with HIV, a rate of 42.7 per 100,000 population. The total number of living HIV cases (with or without AIDS) was 7,434, and almost 40% of living HIV cases in Prince George's County are over the age of 50 years. Between 2015-2017, 117 residents died from HIV with an age-adjusted death rate of 4.0 per 100,000 population.
Prevention & Treatment	HIV can be prevented by practicing abstinence, limiting the number of sexual partners, using condoms the right way during sex, and never sharing needles. Medications are also available to prevent HIV. (CDC) There is no cure for HIV but antiretroviral therapy (ART) is available which helps to control the virus so you can live a longer, healthier life and reduce the risk of transmitting HIV to others. (AIDS.gov)
What are the outcomes?	HIV weakens the immune system leading to opportunistic infections (OIs). OIs are the most common cause of death for people with HIV/AIDS and can include *Cryptococcus*, *cytomegalovirus* disease, *histoplasmosis*, *tuberculosis,* and *pneumonia*. (AIDS.gov)
Disparity	In 2017, eight out of every ten new HIV cases occurred among Black, non-Hispanic residents, and seven out of every ten new HIV cases occurred among men. Almost two-thirds (64%) of new HIV cases were among residents aged 20 to 39 years, and over half were among men who have sex with men.
How do we compare?	In 2017, Prince George's County had the second highest rate of HIV diagnoses (41.9 per 100,000 population) in the state after Baltimore City. In terms of the number of new cases, the county had the highest number of actual cases in the state, 320, followed by Baltimore City with 231. The rate of HIV diagnoses in other Maryland counties range from 0.0 (Somerset and Talbot counties) to 44.7 per 100,000 population (Baltimore City). The state overall had a rate of 20.4 per 100,000 population and the U.S. had a rate of 11.8 per 100,000.

New HIV Cases by Jurisdiction, 2013-2017



Data Source: 2017 County Annual HIV Epidemiological Profile for Prince George's County, MDH; 2018 HAHSTA Annual Epidemiology and Surveillance Report for Washington, D.C

Demographics of New HIV Cases, 2017

MD SHIP Goal: 26.7	Prince George's		Maryland	
	Number	Rate*	Number	Rate*
Sex at Birth				
Male	228	62.7	752	30.8
Female	92	23.0	288	10.9
Race/Ethnicity				
Black, non-Hispanic	258	53.3	736	49.0
Hispanic	40	32.1	106	23.2
White, non-Hispanic	13	12.4	148	5.5
Asian, non-Hispanic	1	2.8	14	4.1
Age				
13 to 19 Years	16	19.8	57	10.6
20 to 29 Years	111	83.5	364	45.1
30 to 39 Years	96	74.2	269	32.8
40 to 49 Years	53	43.5	151	19.5
50 to 59 Years	28	21.8	126	14.5
60+ Years	16	9.4	73	5.7
Country of Birth				
United States	238	42.1	832	20.0
Foreign-born	60	32.5	149	17.8
Total	**320**	**42.7**	**1,040**	**20.8**

*Rate per 100,000 Adult/Adolescents 13 years or older

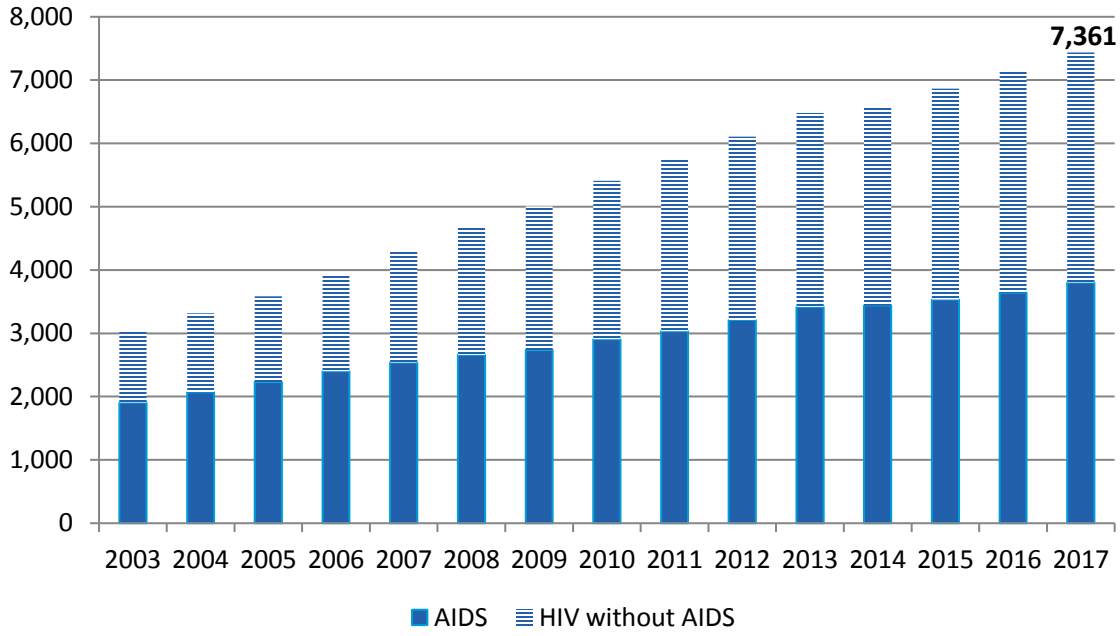
Data Source: 2017 County Annual HIV Epidemiological Profile for Prince George's County, MDH; Maryland State Health Improvement Process (SHIP)

New HIV Cases by Exposure, 2017

	Prince George's		Maryland	
	Number	Percent	Number	Percent
Exposure				
Men who have Sex with Men (MSM)	173	54.2%	560	53.8%
Injection Drug Users (IDU)	11	3.3%	72	6.9%
MSM & IDU	2	0.7%	16	1.5%
Heterosexual	133	41.5%	391	37.6%
Perinatal	1	0.3%	2	0.2%
Total	**320**	**42.7**	**1,040**	**20.8**

Data Source: 2017 County Annual HIV Epidemiological Profile for Prince George's County, MDH

Living HIV Cases, Prince George's County, 2003 to 2017



Data Source: 2017 County Annual HIV Epidemiological Profile for Prince George's County, MDH

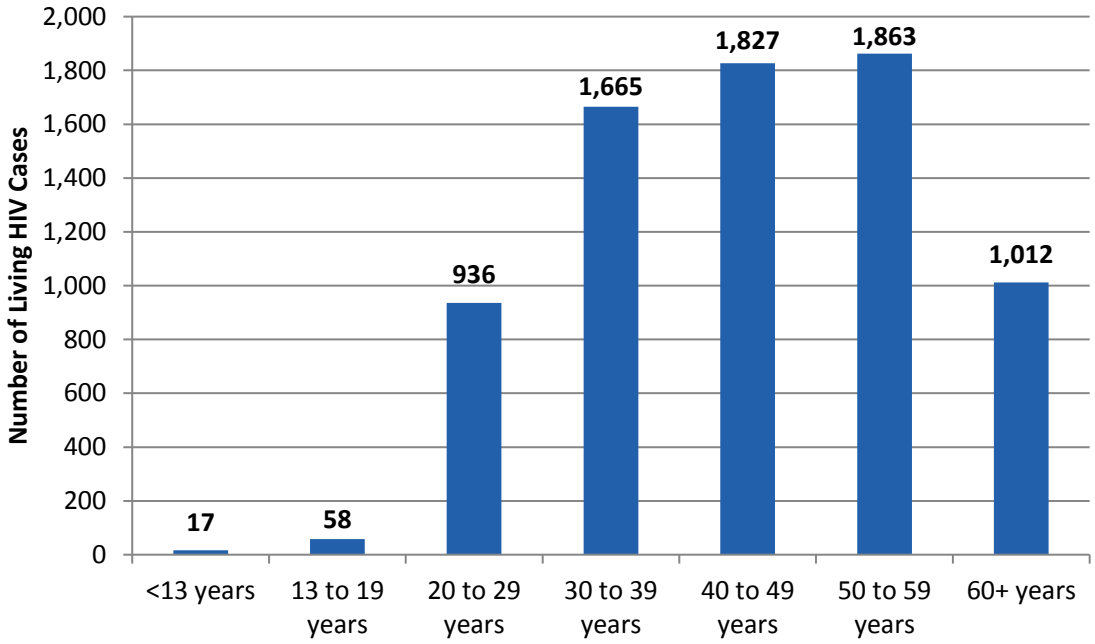
Demographics of Total Living HIV Cases, 2017

	Prince George's		Maryland	
	Number	Rate*	Number	Rate*
Sex at Birth				
Male	4,944	1,359.5	20,179	826.4
Female	2,417	604.6	10,387	392.8
Race/Ethnicity				
Black, non-Hispanic	6,121	1,265.4	22,683	1,509.8
Hispanic	581	466.9	1,980	433.2
White, non-Hispanic	295	281.6	3,926	146.5
Asian, non-Hispanic	31	87.7	196	57.7
Current Age				
13 to 19 Years	58	71.9	194	52.9
20 to 29 Years	936	704.1	3,060	835.2
30 to 39 Years	1,665	1,286.3	5,636	1,538.3
40 to 49 Years	1,827	1,500.9	6,838	1,866.3
50 to 59 Years	1,863	1,447.9	9,364	2,555.8
60+ Years	1,012	595.4	5,474	1,494.1
Country of Birth				
United States	6,264	1,109.0	26,757	644.1
Foreign-born	931	504.8	2,914	349.0
Total	**7,361**	**982.4**	**30,566**	**612.7**

*Rate per 100,000 Adult/Adolescents 13 years or older

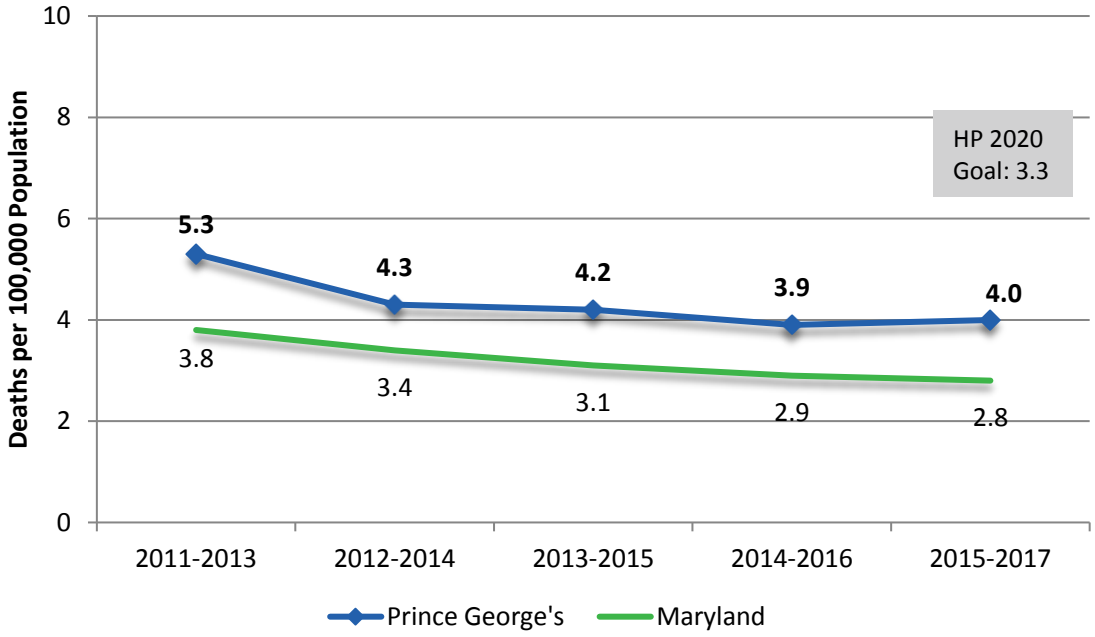
Data Source: 2017 County Annual HIV Epidemiological Profile for Prince George's County, MDH

Total Living HIV Cases by Current Age, Prince George's County, 2017



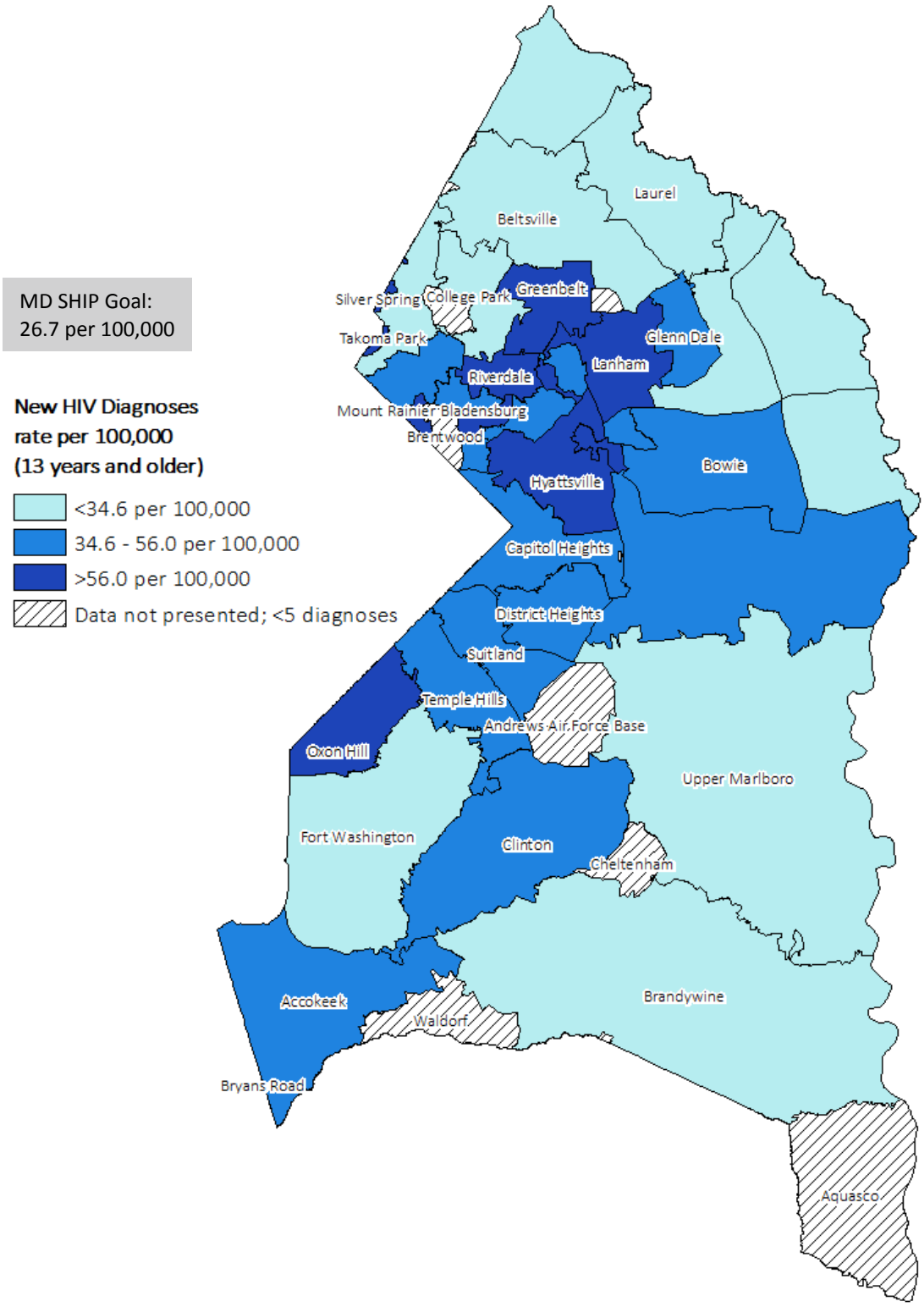
Data Source: 2017 County Annual HIV Epidemiological Profile for Prince George's County, MDH

HIV Age-Adjusted Mortality Rate, Prince George's County Compared to Maryland, 2011-2017



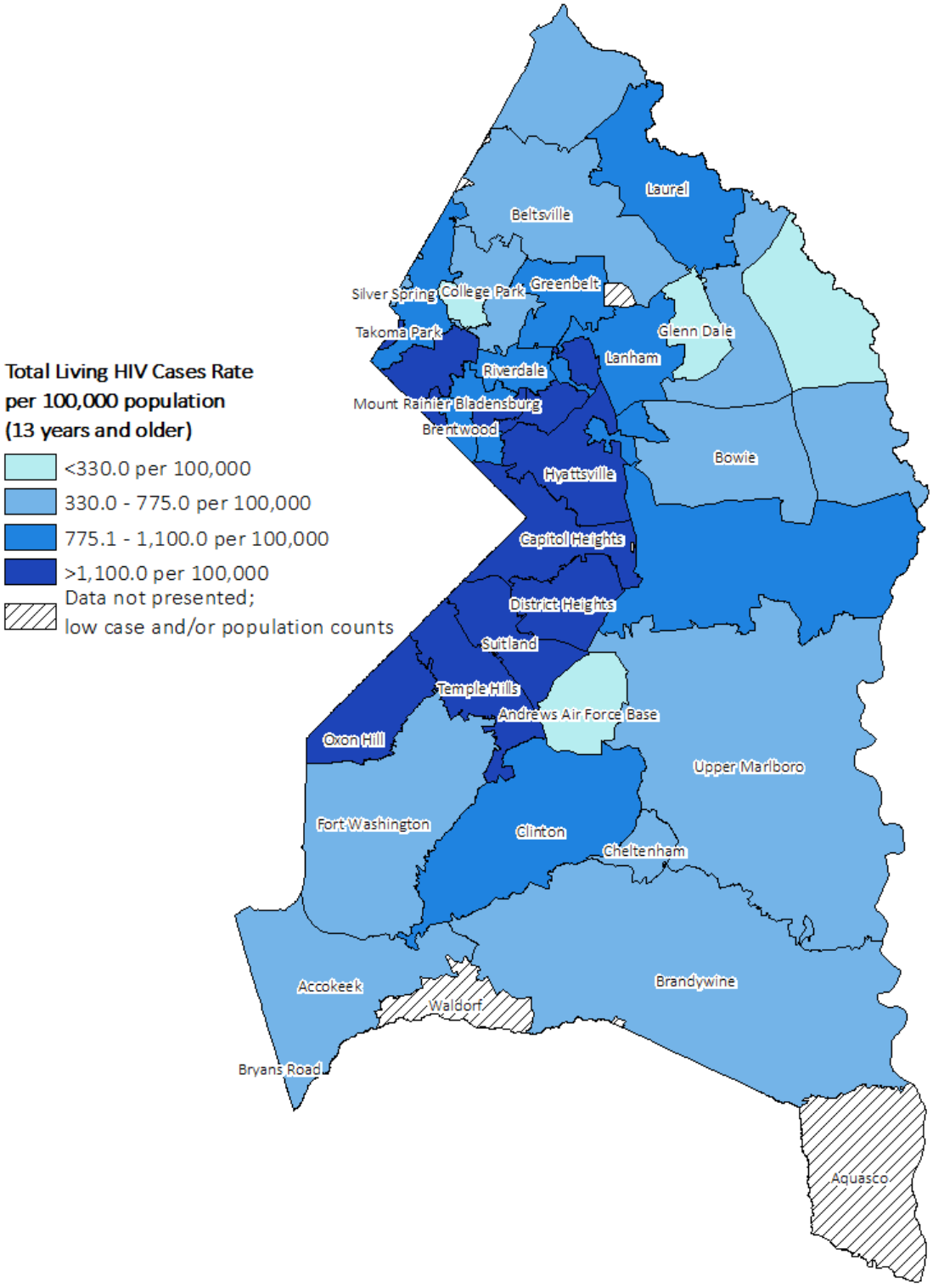
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

2017 New HIV Cases per 100,000 Population, Age 13 and Over



Data Source: 2017 County Annual HIV Epidemiological Profile for Prince George's County, MDH

2017 Total Living HIV Cases per 100,000 Population, Age 13 and Over



Data Source: 2017 County Annual HIV Epidemiological Profile for Prince George's County, MDH

Hypertension and Stroke

Overview	
What is it?	High blood pressure, or hypertension, is when the force of blood pumping through the arteries is too strong. Hypertension is a risk factor for stroke, which is when the flow of blood (and thus oxygen) to the brain is blocked.
Who is affected?	In the county, 31.9% (226,627) of adults are estimated to have hypertension (MD BRFSS 2017). In 2017, 412 county residents died from stroke, the third leading cause of death. Over two-thirds of county residents 65 years and older were hypertensive in 2017.
Prevention & Treatment	Hypertension and stroke can be prevented by eating a healthy diet, maintaining a healthy weight, exercising regularly, avoiding stress, and limiting alcohol and tobacco use (source: CDC) The goal of stroke treatment is to maintain healthy blood pressure through proper nutrition, exercise, and medication (source: American Heart Association).
What are the outcomes?	Complications from hypertension include damage to the heart and coronary arteries, stroke, kidney damage, vision loss, erectile dysfunction, angina, and death. (Source: American Heart Association).
Disparity	In 2017, the age-adjusted rate of emergency department visits for hypertension was considerably higher among Black, non-Hispanic residents (292.6 per 100,000) compared to White, non-Hispanic (112.6 per 100,000) residents, although the estimated prevalence of hypertension was not largely different between the two populations. Both Black, non-Hispanic (44.2 per 100,000) and White, non-Hispanic (41.1 per 100,000) residents had higher mortality rates due to stroke compared to other races and ethnicities.
How do we compare?	Hypertension in other Maryland counties ranged from 21.6% (Kent County) to 57.2% (Somerset County). The 31.9% of Prince George's County residents with hypertension is similar to the state at 30.6% (MD BRFSS 2017) and the U.S. at 32.3% (BRFSS). The county has a higher age-adjusted death rate due to stroke (41.6 per 100,000) compared to the state (39.3 per 100,000) and U.S (37.6 per 100,000).

Percentage of Adults Who Have Ever Been Told By A Health Professional They Have High Blood Pressure*, 2017

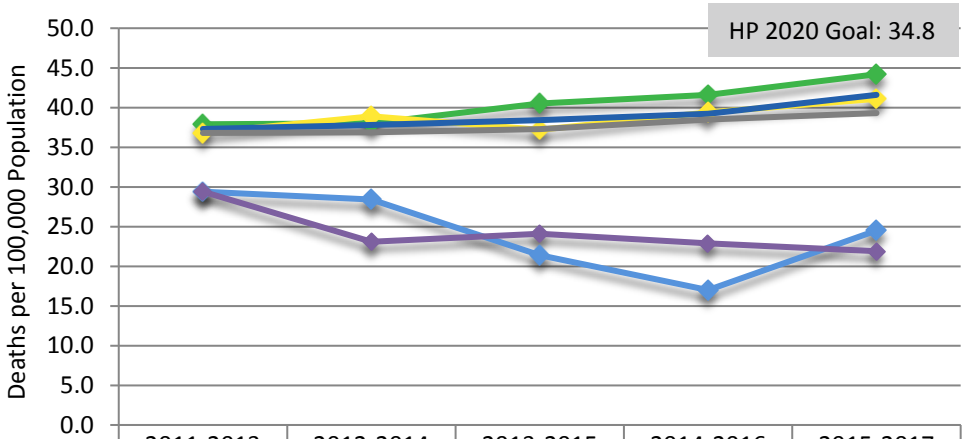
	Prince George's	Maryland
Sex		
Male	32.8%	33.0%
Female	31.1%	28.2%
Race/Ethnicity		
Black, non-Hispanic	34.2%	37.4%
Hispanic	34.6%	28.1%
White, non-Hispanic	28.3%	28.6%
Age Group		
18 to 34 Years	11.6%	10.9%
35 to 49 Years	19.2%	21.2%
50 to 64 Years	48.0%	45.4%
Over 65 Years	70.0%	63.6%
Total	**31.9%**	**30.6%**

*Excludes women told only during pregnancy and borderline hypertension

** Individuals of Hispanic origin and Asian/Pacific Islanders were not included due to insufficient numbers

Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System; https://ibis.health.maryland.gov, accessed 5/13/2019

Age-Adjusted Death Rate per 100,000 for Stroke by Race and Ethnicity, Prince George's County, 2011-2017



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017
PGC Black, NH	37.9	38.0	40.5	41.6	44.2
PGC Hispanic	29.4	28.4	21.4	17.0	24.5
PGC White, NH	36.8	38.9	37.2	39.4	41.1
PGC Asian, NH	29.4	23.1	24.1	22.9	21.9
PGC	37.3	37.8	38.4	39.2	41.6
Maryland	36.8	36.9	37.3	38.5	39.3

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

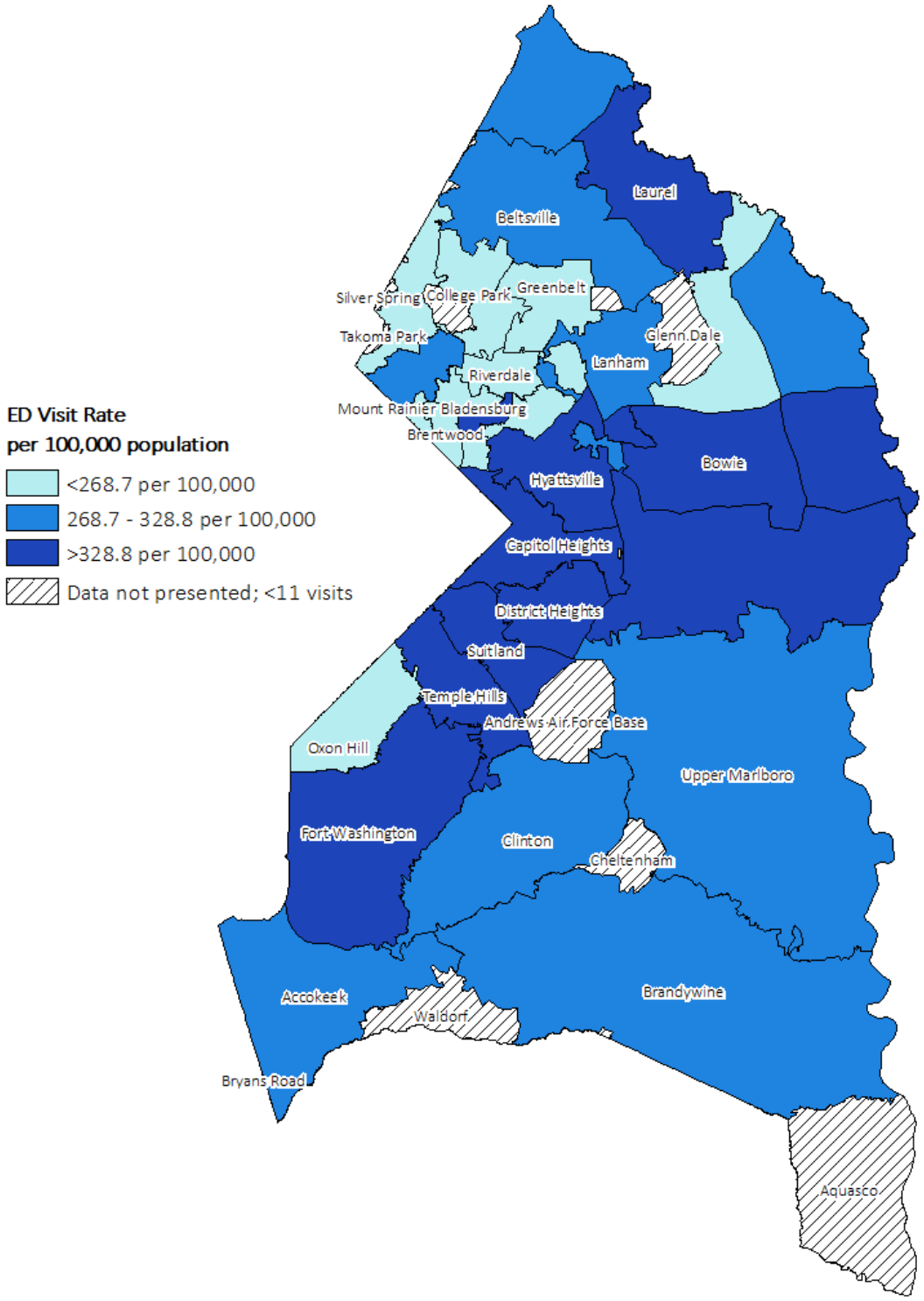
Emergency Department* Visits for Hypertension, 2017

Demographics	Prince George's County Number of ED Visits	MD SHIP Goal: 234.0	Age-Adjusted ED Visit Rate per 100,000 Population
Race and Ethnicity			
Black, non-Hispanic	1,726		292.6
Hispanic	182		189.7
White, non-Hispanic	187		112.6
Asian, non-Hispanic	48		115.8
Sex			
Male	1,200		274.0
Female	1,513		289.7
Age			
Under 18 Years	<11		--
18 to 39 Years	360		124.2
40 to 64 Years	1,313		433.9
65 Years and Over	1,036		885.8
Total	**2,713**		**351.2**

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Outpatient Discharge Data File 2017, Maryland Health Services Cost Review Commission

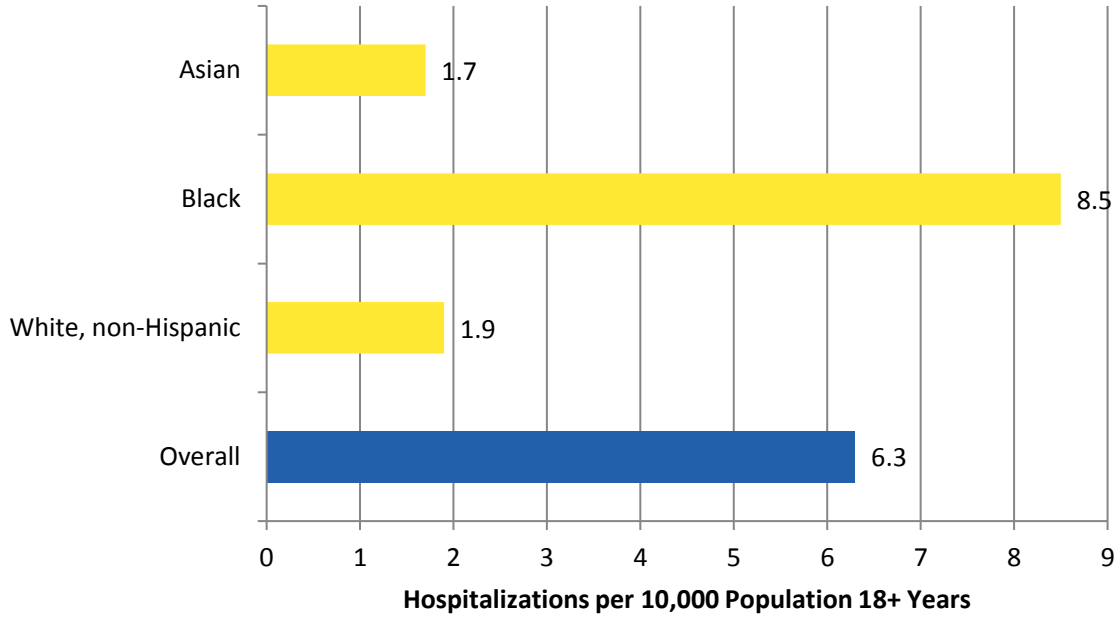
Emergency Department* Visit Crude Rate per 100,000 Population, Hypertension as Primary Diagnosis, Prince George's County, 2017



* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

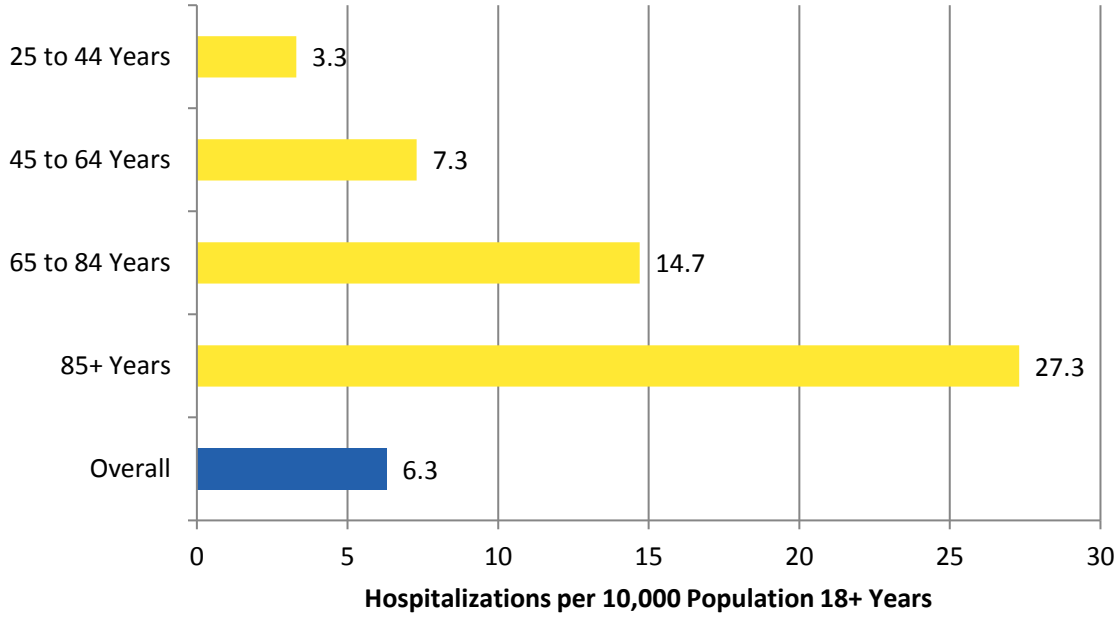
Data Source: Outpatient Discharge Data File 2017, Maryland Health Services Cost Review Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Hypertension by Race and Ethnicity, Prince George's County, 2013-2015



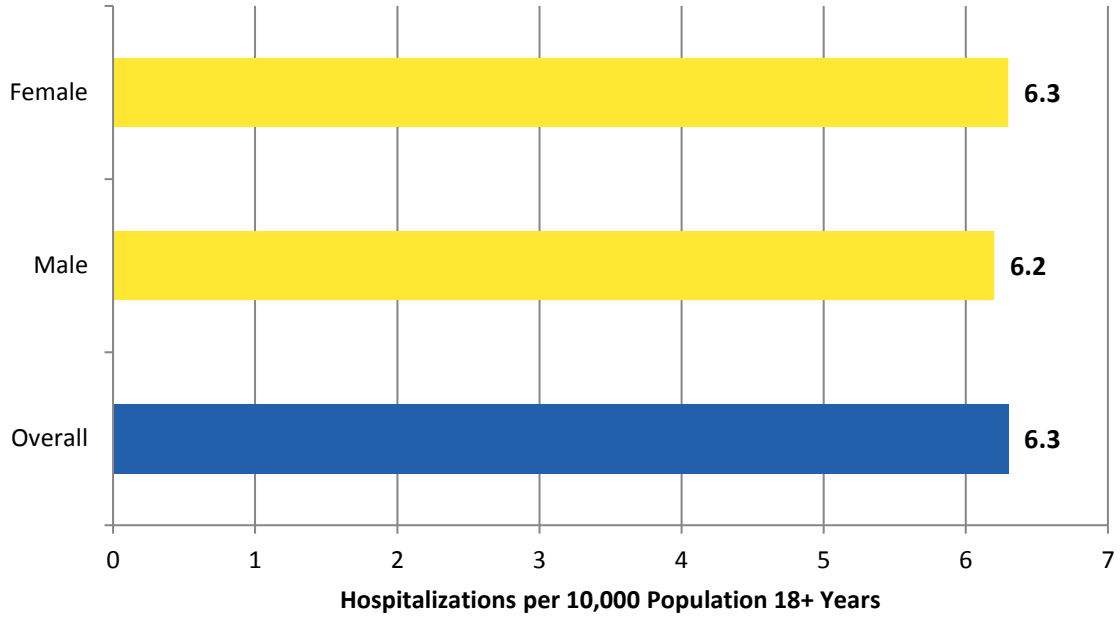
* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Hypertension by Age Group, Prince George's County, 2013-2015



* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

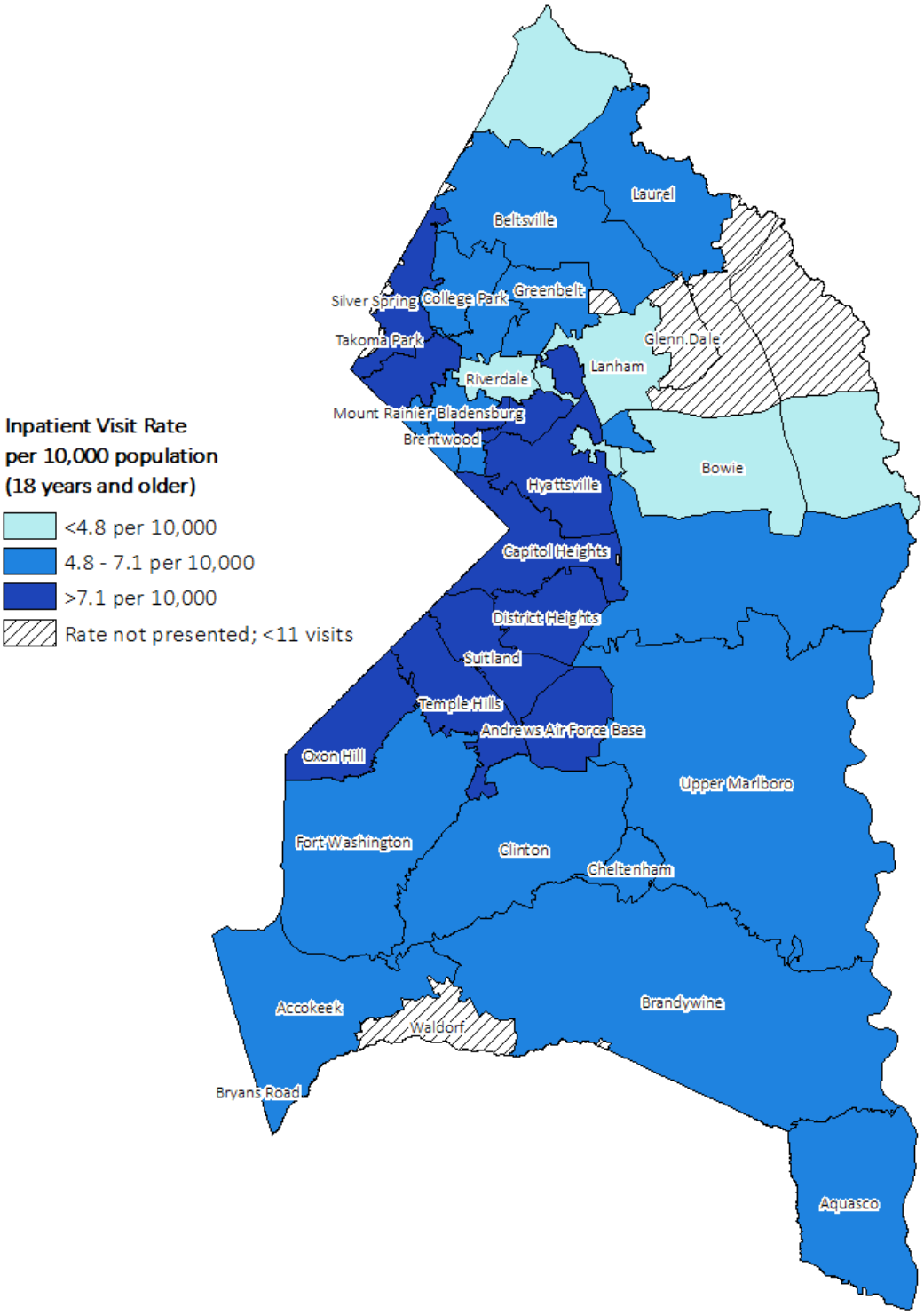
Age-Adjusted Hospital Inpatient* Visit Rate due to Hypertension by Sex, Prince George's County, 2013-2015



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Hypertension, Prince George's County, 2013-2015



* Includes visits to Maryland and Washington, D.C. hospitals

Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

Infectious Disease

Selected Reportable Disease, Prince George's County, 2015-2017

Morbidity	2015	2016	2017	5-Year Mean
Campylobacteriosis	43	42	58	44
H. influenza, invasive	17	40	11	12
Hepatitis A, acute	2	5	3	3
Legionellosis	30	23	41	28
Measles	0	0	1	0
Meningitis, viral	64	49	47	53
Meningitis, meningococcal	0	0	2	0
Pertussis	9	22	8	13
Salmonellosis	100	97	103	90
Shiga-toxin producing E.coli	7	4	10	6
Shigellosis	38	30	27	35
Strep Group B	91	68	80	74
Strep pneumonia, invasive	49	48	39	44
Tuberculosis	43	50	47	47
Outbreaks				
Outbreaks: Gastrointestinal	4	3	7	6
Outbreaks: Respiratory	7	0	8	3
Animal-Related Illness				
Animal Bites	1,010	1,057	1,119	970
Animal Rabies	20	15	10	17

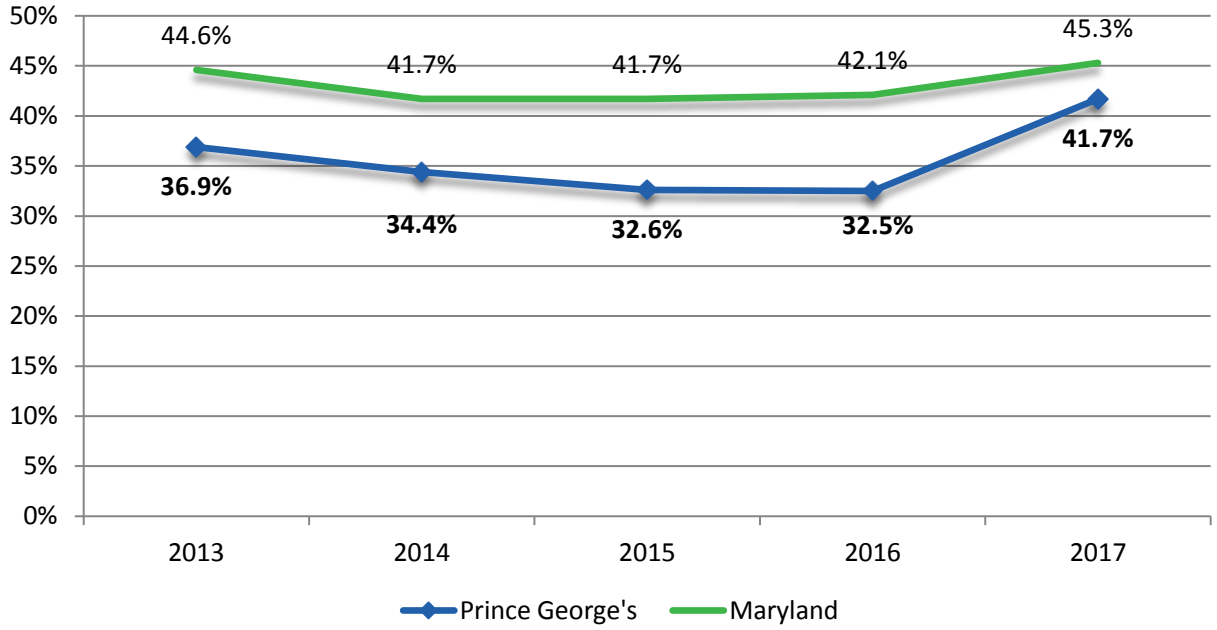
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, MDH

Percentage of Adults Who Had a Seasonal Influenza Shot or Influenza Vaccine Nasal Spray During the Past Year, 2017

	Prince George's	Maryland
Male	39.7%	42.3%
Female	44.3%	48.3%
Race/Ethnicity		
Black, non-Hispanic	38.2%	39.4%
Hispanic	41.5%	51.2%
White, non-Hispanic	49.8%	46.3%
Age Group		
18 to 34 Years	37.8%	34.1%
35 to 49 Years	38.9%	42.9%
50 to 64 Years	37.9%	48.3%
Over 65 Years	58.3%	66.8%
Total	**41.7%**	**45.3%**

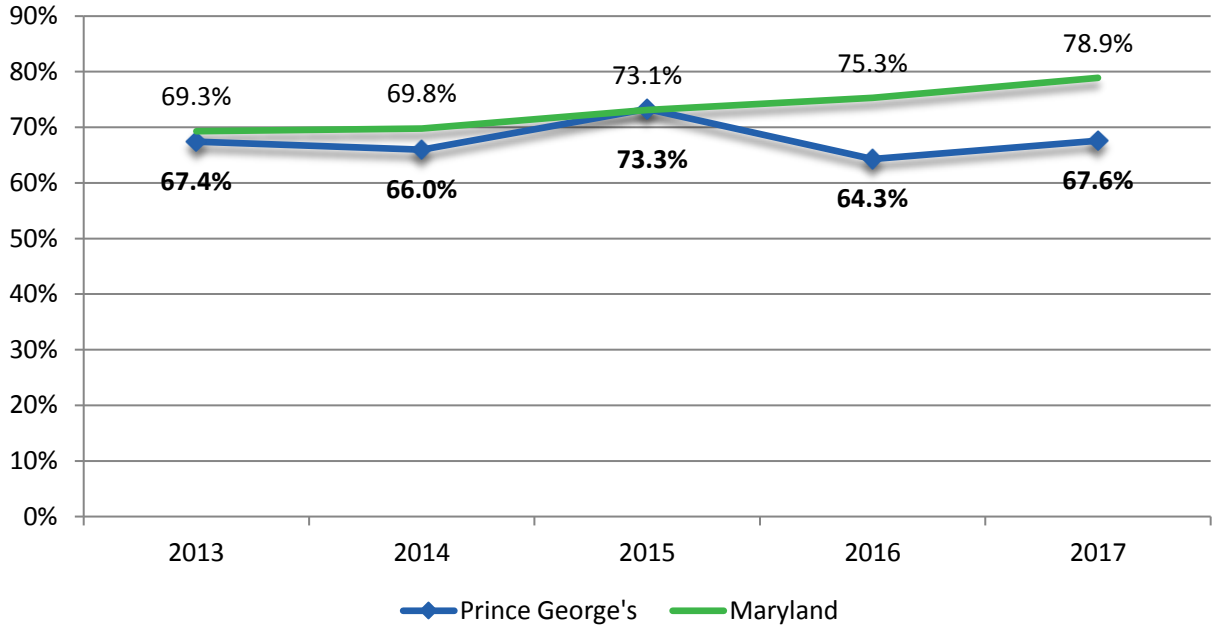
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Percentage of Adults Who Had a Seasonal Influenza Shot or Influenza Vaccine Nasal Spray During the Past Year, 2013-2017



Data Source: 2013-2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 3/8/2019

Percentage of Adults Age 65+ Who Ever Had a Pneumonia Vaccine, 2013-2017

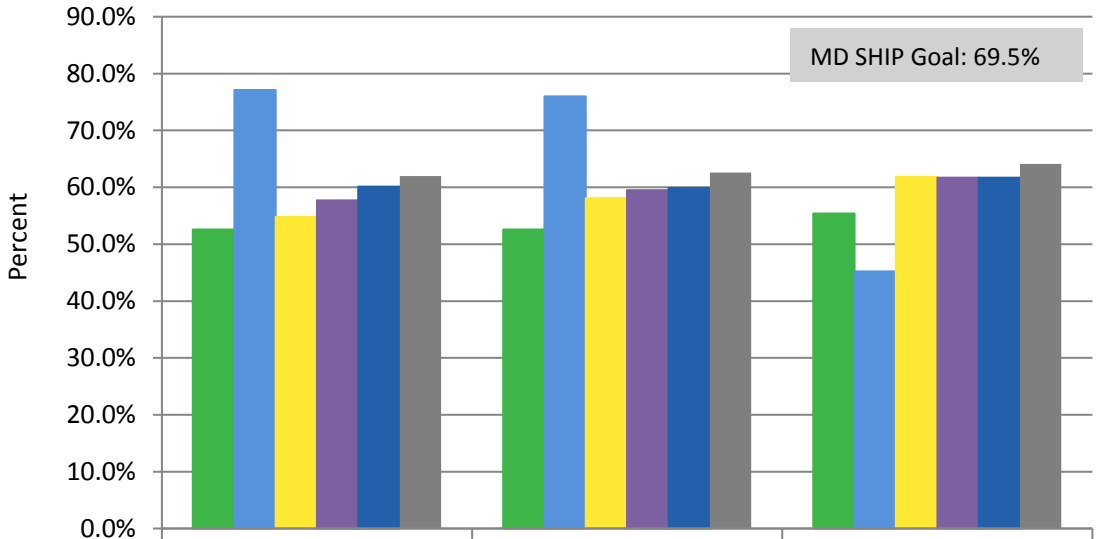


Data Source: 2013-2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Lead Poisoning

Children can be exposed to lead through lead-based paint and dust with lead in it. Although lead paint was banned in 1978 it can be found in homes built before then, and the deterioration of the paint results in the contaminated dust. Lead exposure often occurs without symptoms and can go unrecognized; however, lead can affect nearly every system in the body. There is no safe blood lead level in children, and action is recommended with levels above 5 micrograms per deciliter. Lead poisoning can result in damage to the brain, slowed development and growth, learning and behavior problems, and hearing and speech problems (CDC).

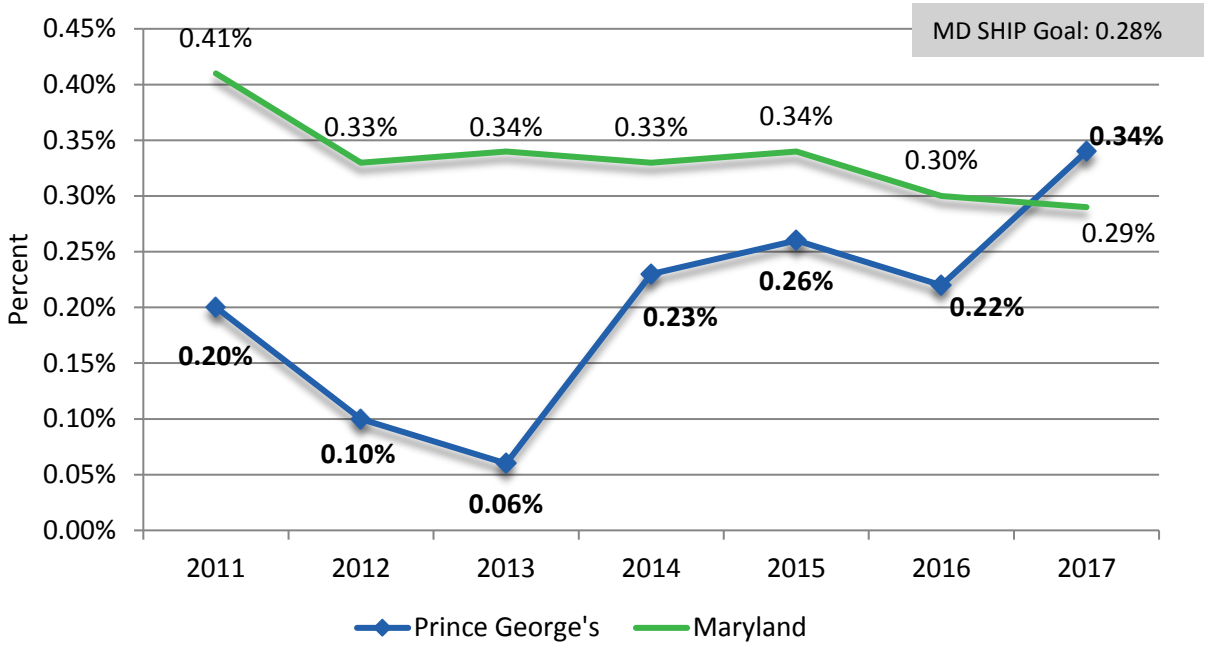
Percentage of Children Ages 12-35 Months Enrolled in Medicaid* Who Received a Blood Lead Test, 2014-2016



	2014	2015	2016
PGC Black	52.6%	52.6%	55.4%
PGC Hispanic	77.1%	76.0%	45.2%
PGC White	54.8%	58.1%	61.8%
PGC Asian	57.7%	59.5%	61.7%
Prince George's	60.1%	59.9%	61.7%
Maryland	62.0%	62.6%	64.1%

***** Includes children enrolled in Medicaid for at least 90 days
Data Source: Maryland Medicaid Service Utilization, Maryland SHIP

Percentage of Children Under Six Years of Age Tested for Blood Lead who have 10 or More Micrograms/Deciliter of Lead in Blood, 2011 to 2017



Data Source: Maryland Department of the Environment

Maternal and Infant Health

Live Birth Rate per 1,000 Population, 2017

	Prince George's	Maryland	United States
Live Births per 1,000 Population	13.6	11.8	12.4

Data Source: Maryland Department of Health, Vital Statistics Administration, 2017 Annual Report; National Center for Health Statistics, National Vital Statistics Report, 2017

Number of Births by Race and Ethnicity of Mother, Prince George's County, 2017

Race/Ethnicity	Number of Live Births	Percent of Births	Birth Rate per 1,000 population
Black, NH	6,805	54.8%	11.8
Hispanic (any race)	3,819	30.7%	22.6
White, NH	1,178	9.5%	9.9
Asian, NH	528	4.3%	12.4
American Indian/Alaska Native, NH	24	0.2%	7.5
All Races	**12,422**	**100.0%**	**13.6**

Data Source: Maryland Department of Health, Vital Statistics Administration, 2017 Annual Report

Number and Percentage of Births by Age Group, 2017

	Prince George's		Maryland	United States
Age Group	**Number**	**Percent**	**Percent**	**Percent**
<15 years	9	0.1%	0.1%	0.1%
15 to 17 years	164	1.3%	1.0%	1.3%
18 to 19 years	394	3.2%	2.7%	3.8%
20 to 24 years	2,259	18.2%	15.4%	19.8%
25 to 29 years	3,376	27.1%	26.9%	29.1%
30 to 34 years	3,470	27.9%	31.9%	28.3%
35 to 39 years	2,169	17.5%	17.9%	14.4%
40 to 44 years	531	4.3%	3.9%	3.0%
45+ years	50	0.4%	0.2%	0.2%

Data Source: Maryland Department of Health, Vital Statistics Administration, 2017 Annual Report; National Center for Health Statistics, National Vital Statistics Report, 2017

Infant Mortality Rate*, 2017

HP 2020 Goal: 6.3 MD SHIP Goal: 6.0	Prince George's	Maryland	HP 2020 Goal	MD SHIP Goal
Infant Mortality Rate per 1,000 Births	**8.2**	6.5	6.0	6.3

Data Source: Maryland Department of Health, Vital Statistics Administration, 2017 Annual Report

Infant Deaths, 2015-2017

	2015	2016	2017
Prince George's County Infant Deaths			
Black, non-Hispanic	94	67	82
Hispanic (any race)	9	22	19
White, non-Hispanic	4	2	1
Total Deaths	110	94	102
Infant Mortality Rate: All Races per 1,000 Live Births			
Prince George's	**8.9**	**7.6**	**8.2**
Maryland	6.7	6.5	6.5
Infant Mortality Rate: Black, non-Hispanic per 1,000 Live Births			
Prince George's	**13.4**	**9.7**	**12.0**
Maryland	11.3	10.5	11.2
Infant Mortality Rate: Hispanic (any race) per 1,000 Live Births			
Prince George's	**2.6**	**6.1**	**5.0**
Maryland	5.5	5.4	4.7
Infant Mortality Rate: White, non-Hispanic per 1,000 Live Births			
Prince George's	**	**	**
Maryland	4.0	4.3	4.0

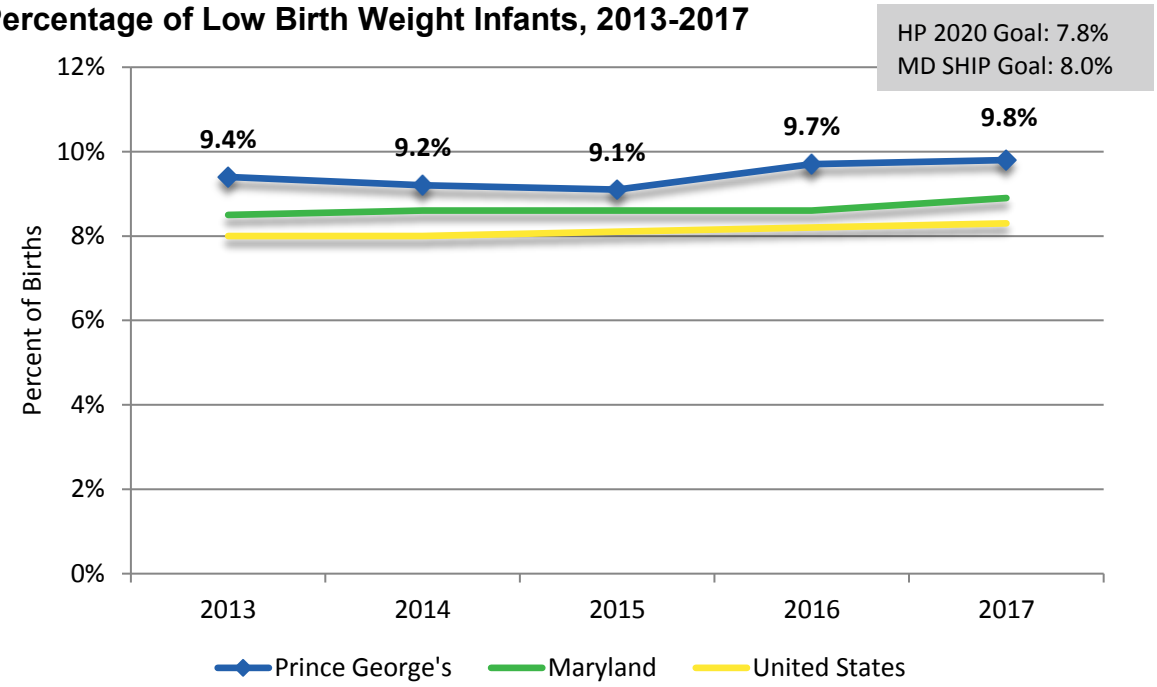
**Rates based on <5 deaths are not presented since they are subject to instability.
Data Source: Maryland Department of Health, Vital Statistics Administration, 2015-2017 Annual Infant Mortality Reports

Low Birth Weight (<2500g) by Race/Ethnicity and Age, 2017

HP 2020 Goal: 7.8% MD SHIP Goal: 8.0%	Prince George's	Maryland	United States
Race/Ethnicity			
Black, NH	12.1%	13.0%	13.9%
Hispanic (any race)	6.9%	7.2%	7.4%
White, NH	6.1%	6.6%	7.0%
Asian/PI	9.8%	8.6%	8.5%
Age Group			
Under 20 years	9.3%	10.6%	9.9%
20 to 24 years	9.3%	9.5%	8.6%
25 to 29 years	9.1%	8.7%	7.7%
30 to 34 years	8.8%	8.0%	7.7%
35 to 39 years	11.1%	9.2%	8.8%
40 + years	16.0%	12.6%	11.5%
Total	**9.8%**	**8.9%**	**8.3%**

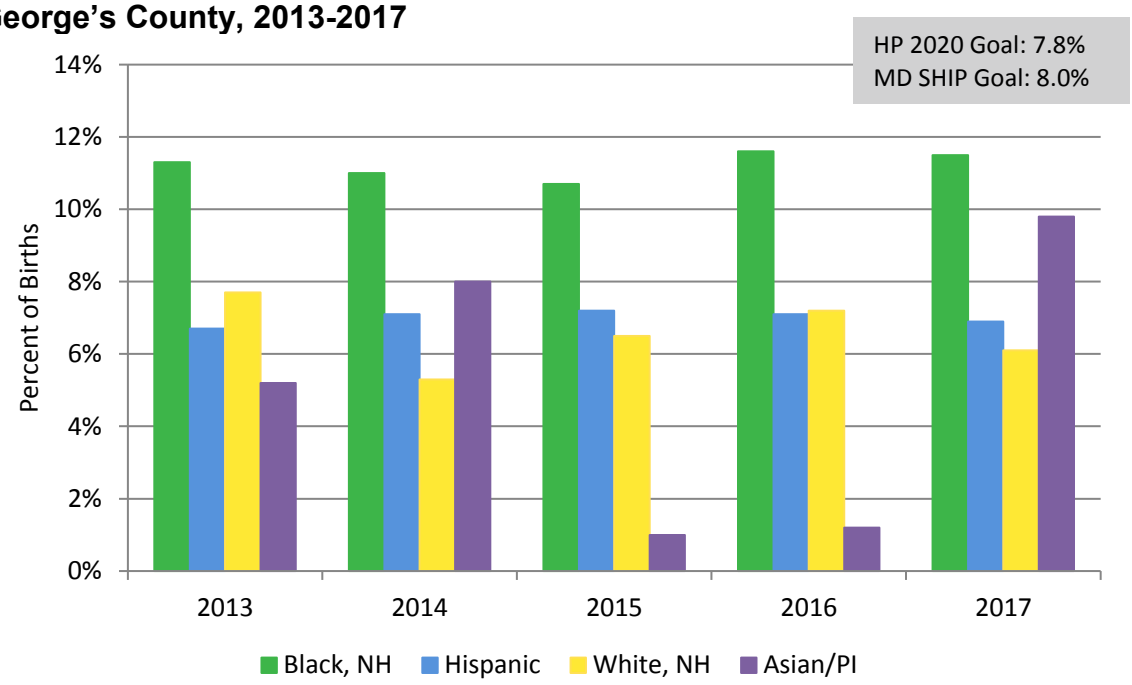
Data Source: Maryland Department of Health, Vital Statistics Administration, 2017 Annual Report; National Center for Health Statistics, Births Final Data for 2017

Percentage of Low Birth Weight Infants, 2013-2017



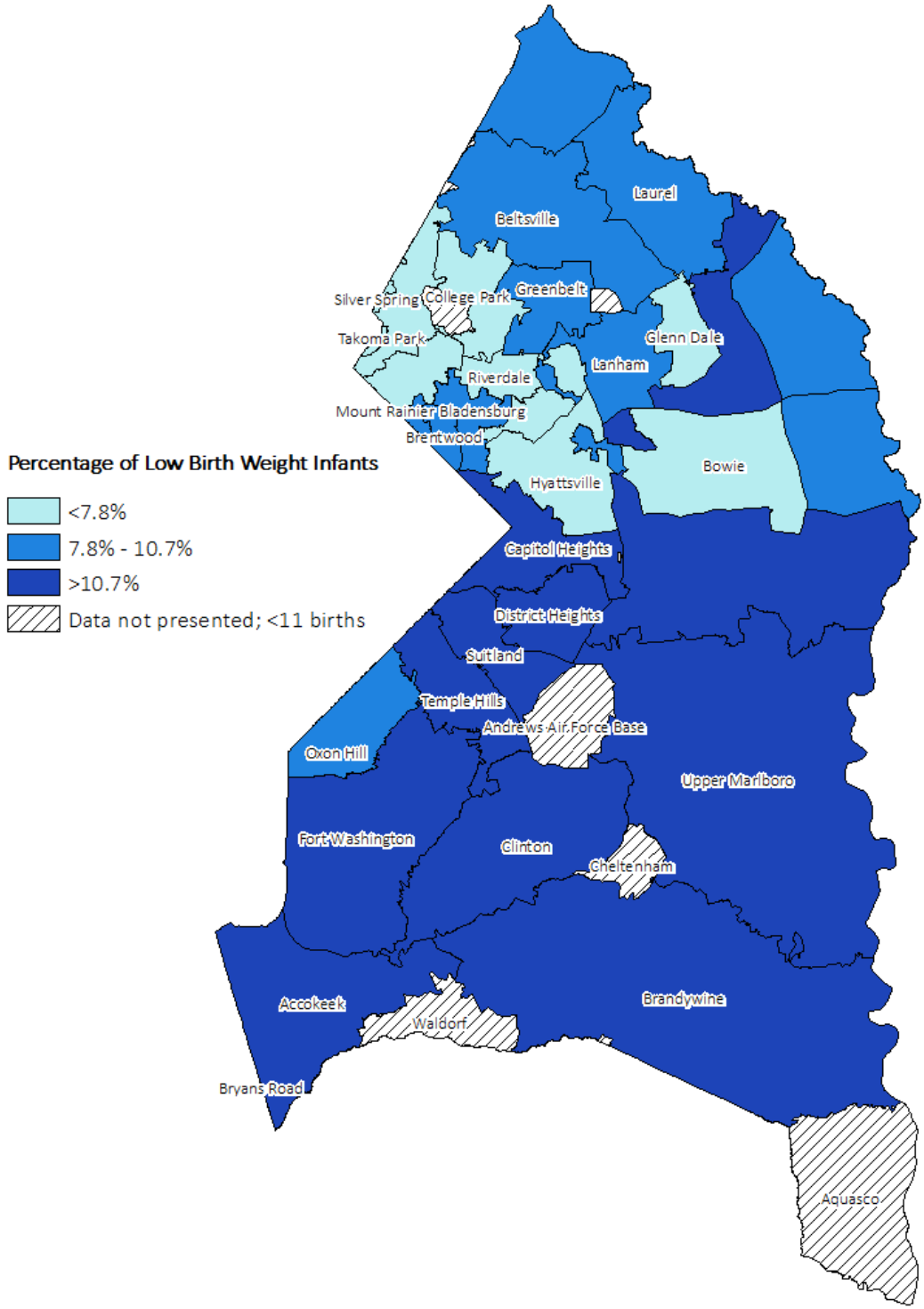
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2017 Annual Reports; National Center for Health Statistics, National Vital Statistics Report

Percentage of Low Birth Weight (<2500g) Infants by Race and Ethnicity, Prince George's County, 2013-2017



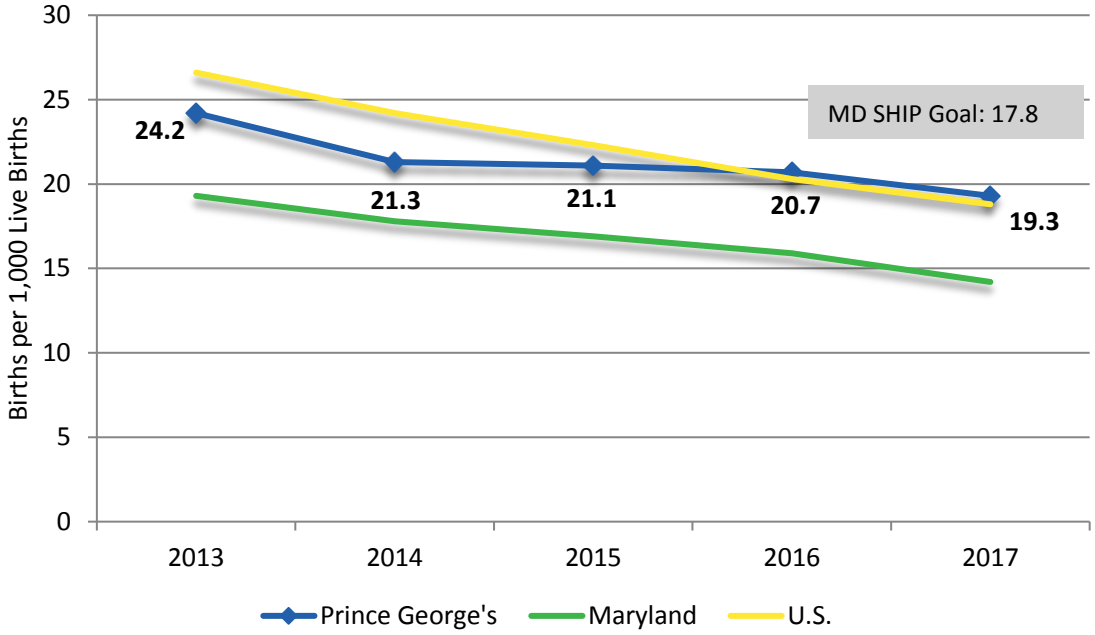
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2017 Annual Reports

Percentage of Low Birth Weight Infants by ZIP Code, Prince George's County, 2015-2017



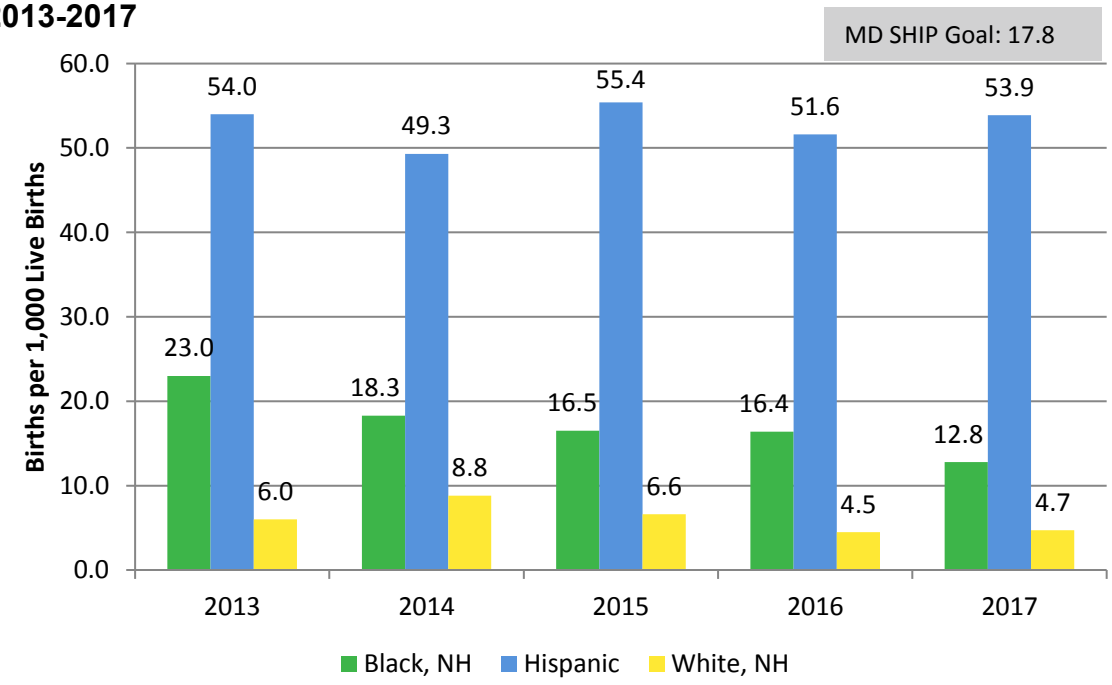
Data Source: Maryland Department of Health, Vital Statistics Administration, 2015-2017 Birth Data Files

Teen Birth Rate (Ages 15 to 19 Years), 2013-2017



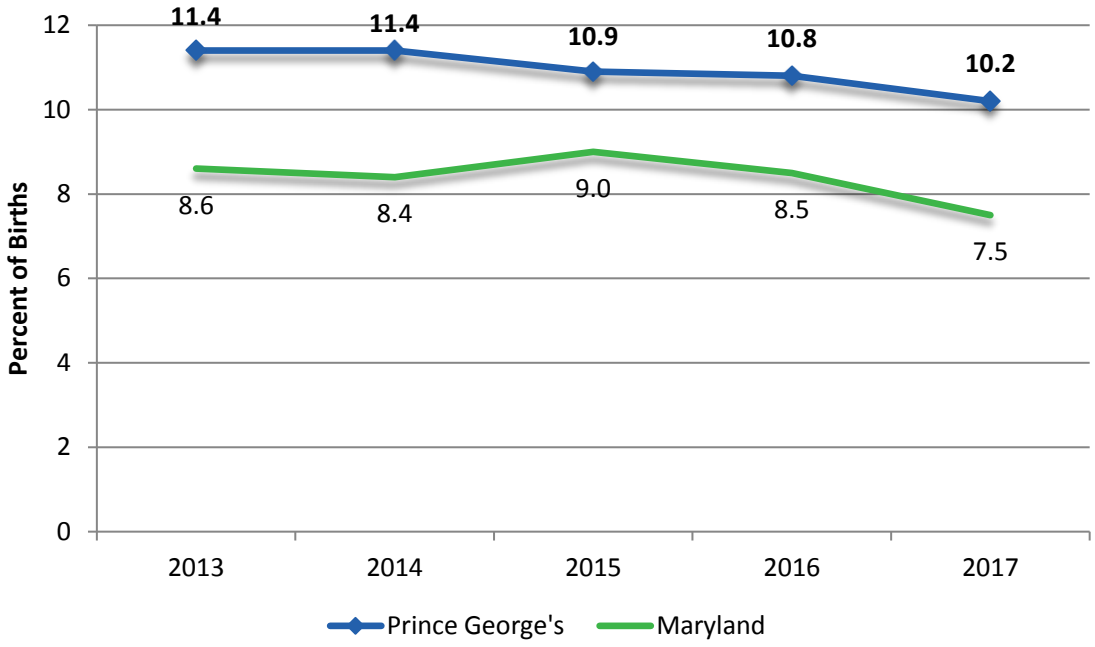
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2017 Annual Reports; National Center for Health Statistics, National Vital Statistics Report

Teen Birth Rate (Ages 15 to 19) by Race and Ethnicity, Prince George's County, 2013-2017



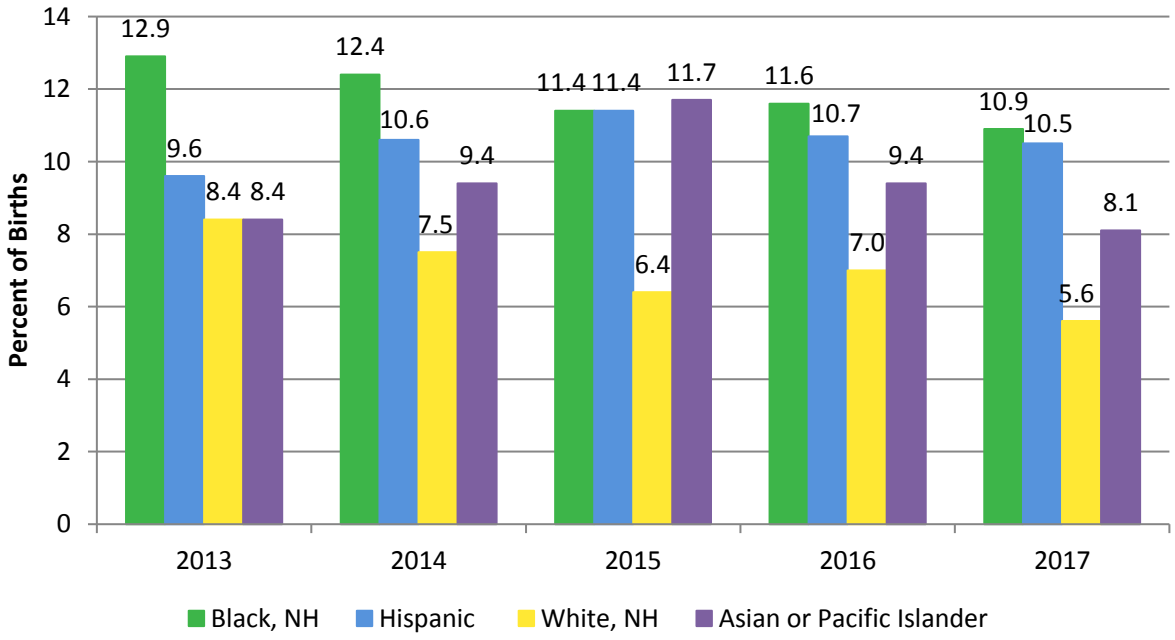
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2017 Annual Reports

Percentage of Births with Late or No Prenatal Care*, 2013-2017



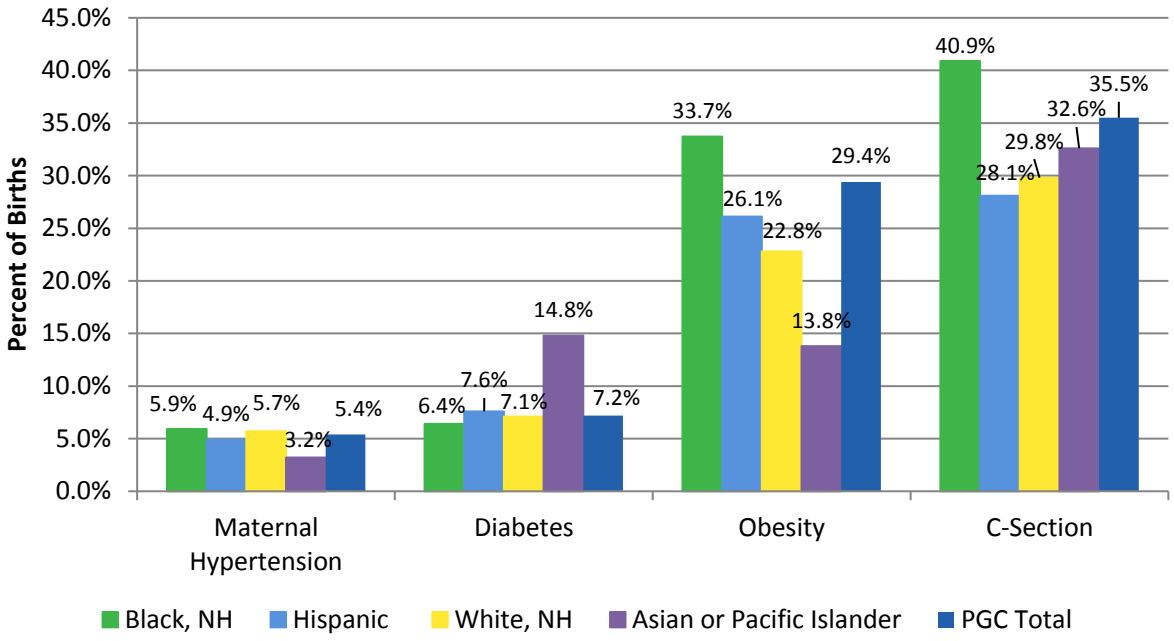
*Late care refers to care beginning in the third trimester.
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2017 Annual Reports

Percentage of Births with Late or No Prenatal Care by Race and Ethnicity, Prince George's County, 2013-2017



*Late care refers to care beginning in the third trimester.
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2017 Annual Reports

Percentage of Births with Maternal Risk Factors by Race and Ethnicity, Prince George's County, 2017



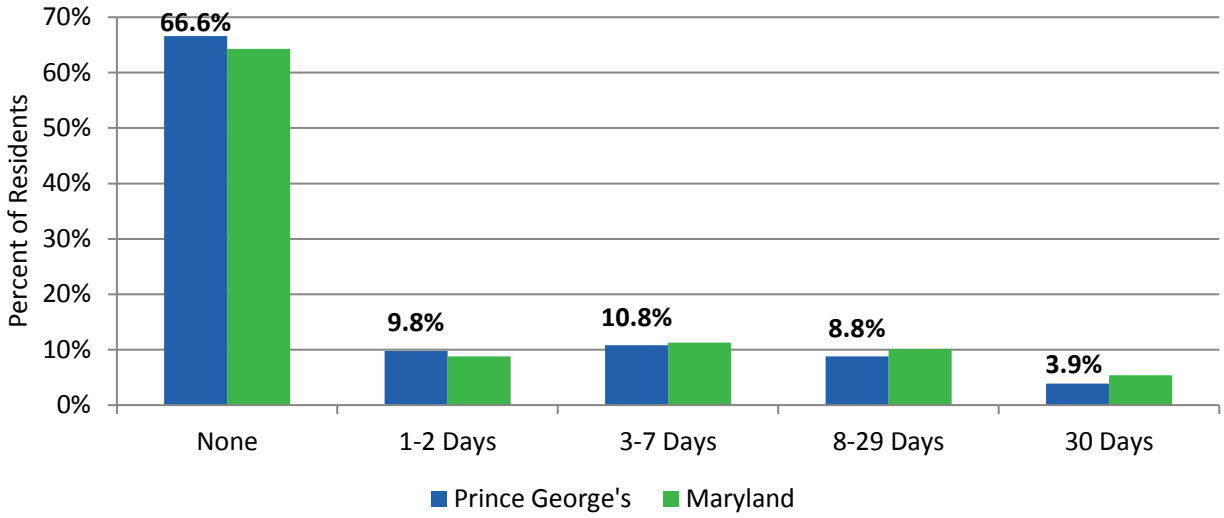
Pregnancy-Related Maternal Mortality, Prince George's County and Maryland, 2008-2017

	Prince George's Number of Deaths	Prince George's Rate per 100,000 Live Births	Maryland Number of Deaths	Maryland Rate per 100,000 Live Births
Race/Ethnicity				
Black, NH	27	37.4	108	44.9
Hispanic	*	*	17	19.1
White, NH	*	*	63	15.6
Asian/PI, NH	*	*	10	18.8
Total	**35**	**28.6**	**198**	**26.9**

Mental Health

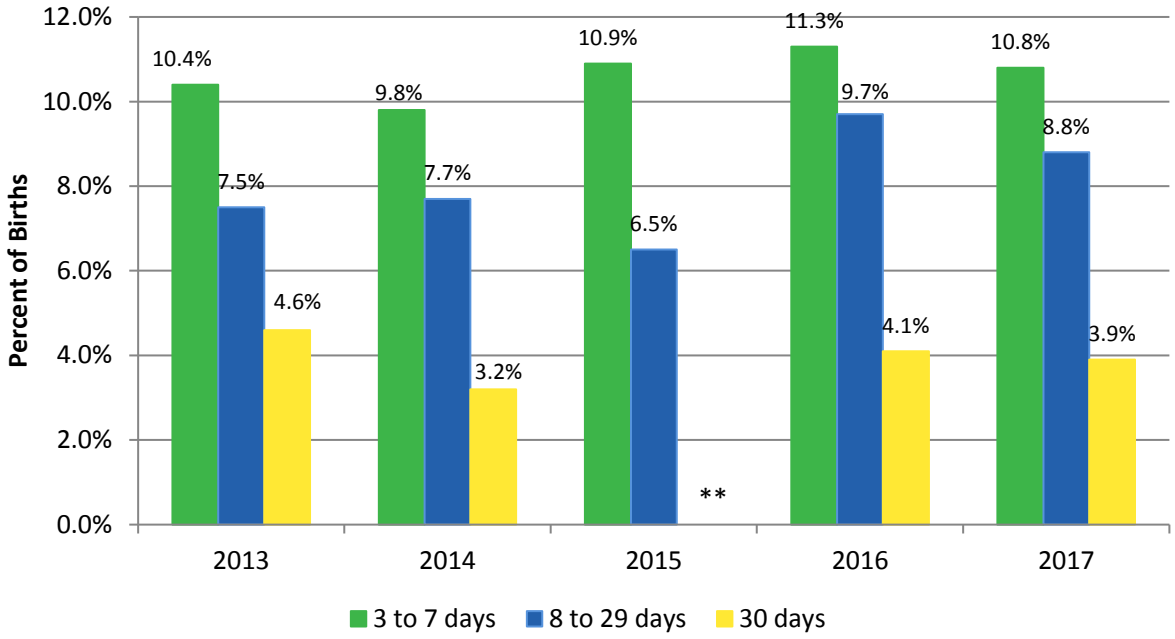
Overview	
What is it?	Mental health includes emotional, psychological, and social well-being. It affects how we think, feel and act. It also helps determine how we handle stress, relate to others, and make choices.
Who is affected?	One in five adults in America experience a mental illness. For Prince George's County, this translates to 141,938 county residents with mental health needs (2017 U.S. Census population estimates; NAMI). In addition, over 15,000 county youth (ages 13-18) are estimated to be living with a mental health condition, and nearly 10,000 children ages 5-13 are estimated to have ADHD (NAMI). 12.7% (90,098) of adult residents reported experiencing at least 8 days of poor mental health during the last 30 days (2017 MD BRFSS). Almost one-third of high school students felt sad or hopeless impeding normal activity in the past year; 18% of students seriously considered suicide and 15% made a plan in the past year (2016 YRBS). Overall in the county in 2017 there were 62 suicide deaths.
Prevention & Treatment	Poor mental health prevention includes helping individuals develop the knowledge, attitudes, and skills they need to make good choices or change harmful behaviors (SAMHSA.gov). Mental health treatment includes psychotherapy, medication, case management, partial hospitalization programs, support groups, and peer support.
What are the outcomes?	Mental health covers a number of different conditions that can vary in outcomes. Early engagement and support are crucial to improving outcomes.
Disparity	Although a decrease since 2012, White, non-Hispanic residents were twice as likely than Black, non-Hispanic residents to die from suicide in 2017. Among youth in 2016, female students (38.9%) were more likely than male students (24.0%) to report feeling sad or hopeless so that it impaired usual activities for more than two weeks in a row. Female students were also more likely than male students to seriously consider suicide (22.8% vs 12.3%) and to make a plan on how to attempt suicide (18.5% vs 10.8%).
How do we compare?	While 12.7% of county residents reported at least 8 poor mental health days, the state overall is 15.5% (2017 MD BRFSS). In 2017, the county has the lowest suicide age-adjusted death rate in the state (5.7 per 100,000; Maryland average was 9.3 per 100,000). In 2016, county high school students reported similar prevalenace across mental health risk factors (for feelings of sad or hopelessness, considering and planning suicide); however, Prince George's County students were statistically less likely to report bullying on school property (14.5% vs 18.2%) or electronic bullying (10.5% vs 14.1%) than the state.

Percentage of Residents with Poor Mental Health Days within a Month, 2017



Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Percentage of Residents with Poor Mental Health Days within a Month, 2013-2017



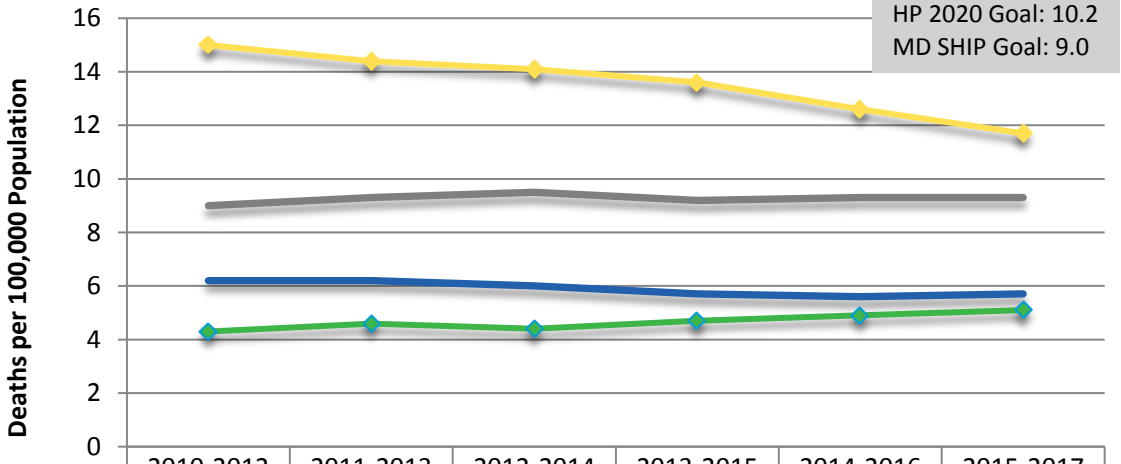
**Data not available; small number of observations.
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/31/2019

Percentage of High School Students Reporting Risk Factors for Suicide in the Past Year, Prince George's County, 2016

	Felt Sad or Hopeless 2+ Weeks or More	Seriously Considered Suicide	Made a Plan to Attempt Suicide
Male	24.0%	12.3%	10.8%
Female	38.9%	22.8%	18.5%
Race/Ethnicity			
Black, non-Hispanic	28.6%	16.1%	14.1%
Hispanic	37.6%	18.2%	14.5%
White, non-Hispanic	33.3%	21.7%	16.3%
Age Group			
15 or younger	28.7%	19.2%	14.8%
16 or 17	33.4%	16.5%	14.5%
18 or older	36.5%	15.1%	16.7%
Total	**31.5%**	**17.7%**	**14.8%**

Data Source: 2016 Maryland Youth Risk Behavior Survey for Prince George's County

Age-Adjusted Suicide Rate per 100,000, 2010-2017



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017
PGC Black, NH	4.3	4.6	4.4	4.7	4.9	5.1
PGC White, NH	15.0	14.4	14.1	13.6	12.6	11.7
PGC Total	6.2	6.2	6.0	5.7	5.6	5.7
Maryland	9.0	9.3	9.5	9.2	9.3	9.3

* Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers

Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Emergency Department Visits* for Behavioral Health Conditions, Prince George's County, 2017

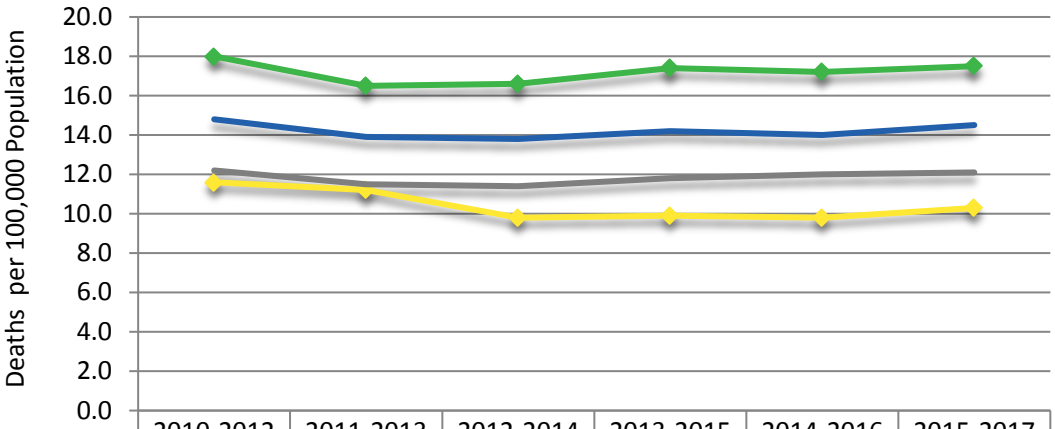
Behavioral Health Condition	Frequency	Percent
Alcohol-related disorders	1,887	22.4%
Mood disorders	1,671	19.9%
Anxiety disorders	1,340	15.9%
Substance-related disorders	1,140	13.5%
Schizophrenia and other psychotic disorders	905	10.8%
Suicide and intentional self-inflicted injury	551	6.5%
Delirium dementia and amnestic and other cognitive disorders	296	3.5%
Attention-deficit conduct and disruptive behavior disorders	198	2.4%
Adjustment disorders	164	2.0%
Miscellaneous mental health disorders	126	1.5%
Impulse control disorders	43	1.0%
Total	**8,420**	**100%**

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County numbers and percent.

Data Source: Outpatient Discharge Data File 2017, Maryland Health Services Cost Review Commission

Nephritis (Chronic Kidney Disease)

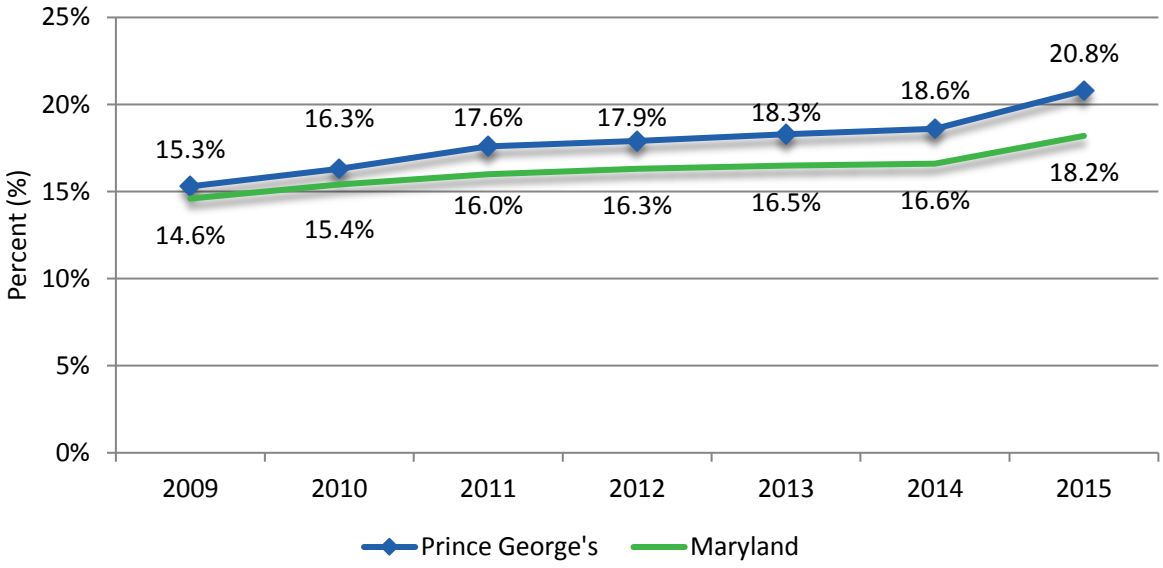
Age-Adjusted Death Rate for Nephritis, 2010-2017



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017
PGC Black, NH	18.0	16.5	16.6	17.4	17.2	17.5
PGC White, NH	11.6	11.2	9.8	9.9	9.8	10.3
Prince George's	14.8	13.9	13.8	14.2	14.0	14.5
Maryland	12.2	11.5	11.4	11.8	12.0	12.1

***** Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Percentage of Medicare Beneficiaries Who Were Treated for Chronic Kidney Disease, 2009-2015



Data Source: Centers for Medicare and Medicaid Services

Obesity

Overview	
What is it?	Weight that is higher than what is considered a healthy weight for a given height is described as overweight or obese. Body Mass Index (BMI) is used as a screening tool for overweight or obesity that takes into consideration height and weight. Children and adolescents are measured differently based on their age and sex.
Who is affected?	In 2017, almost three-quarters of adults in the county were either obese (42.0%) or overweight (31.5%) (2017 MD BRFSS). An estimated 355,425 county adults did not meet physical activity recommendations of participating in at least 150 minutes of aerobic physical activity per week in 2017. One quarter (25.0%) of county high school students reported being physically active for at least an hour on five or more days per week in 2016.
Prevention and Treatment	The key to achieving and maintaining a healthy weight is not short-term dietary changes; it's about a lifestyle that includes healthy eating and regular physical activity (CDC.gov). Follow a healthy eating plan, focus on portion size, be active, reduce screen time and a sedentary lifestyle, and keep track of your weight (NHLBI.NIH.gov).
What are the outcomes?	Obesity causes an increased risk for hypertension, type 2 diabetes, heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and breathing problems, some cancers, low quality of life, and mental illness. (CDC.gov)
Disparity	Black, NH adult residents (46.7%) were more likely to be obese than White, NH (29.9%) adult residents in the county; however, Hispanic (41.8%) and White, NH (35.8%) residents were more likely than Black, NH residents (29.8%) to be overweight in 2017. More adult females (44.5%) are estimated to be obese compared to males (40.0%), but fewer adult females (26.2%) were overweight compared to males (36.1%). Almost half of adults between the ages of 45 and 64 were overweight. Obesity in high schoolers was highest among Hispanic students (17.3%) in 2016.
How do we compare?	Obesity in Maryland was estimated at 31.1%, substantially lower than the 42.0% in Prince George's County (2017 MD BRFSS). 16.4% of high school students in the county were obese in 2016, higher than the state (12.6%).

How Obesity Is Classified

Body Mass Index (BMI)	Weight Status
Below 18.5	Underweight
18.5 – 24.9	Normal or Healthy Weight
25.0 – 29.9	Overweight
30.0 and Above	Obese

Data Source: Centers for Disease Control and Prevention

Percentage of Adults Who Are Obese, 2017

HP2020 Goal: 30.5%	Prince George's	Maryland
Sex		
Male	40.0%	30.1%
Female	44.5%	32.0%
Race/Ethnicity		
Black, non-Hispanic	46.7%	42.0%
Hispanic	34.5%	31.4%
White, non-Hispanic	29.9%	28.0%
Age		
18 to 44 Years	37.0%	27.7%
45 to 64 Years	49.3%	36.3%
Over 65 Years	39.8%	31.2%
Total	**42.0%**	**31.1%**

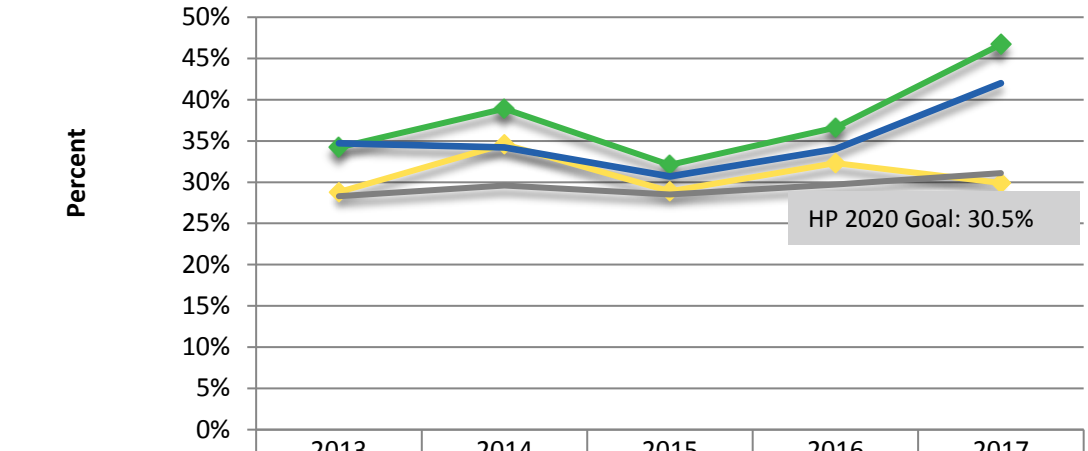
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Percentage of Adults Who Are Overweight, 2017

	Prince George's	Maryland
Sex		
Male	36.1%	40.5%
Female	26.2%	28.8%
Race/Ethnicity		
Black, non-Hispanic	29.7%	32.6%
Hispanic	41.8%	35.4%
White, non-Hispanic	35.8%	35.4%
Age		
18 to 44 Years	28.5%	32.8%
45 to 64 Years	33.7%	36.3%
Over 65 Years	38.6%	37.1%
Total	**31.5%**	**34.7%**

Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

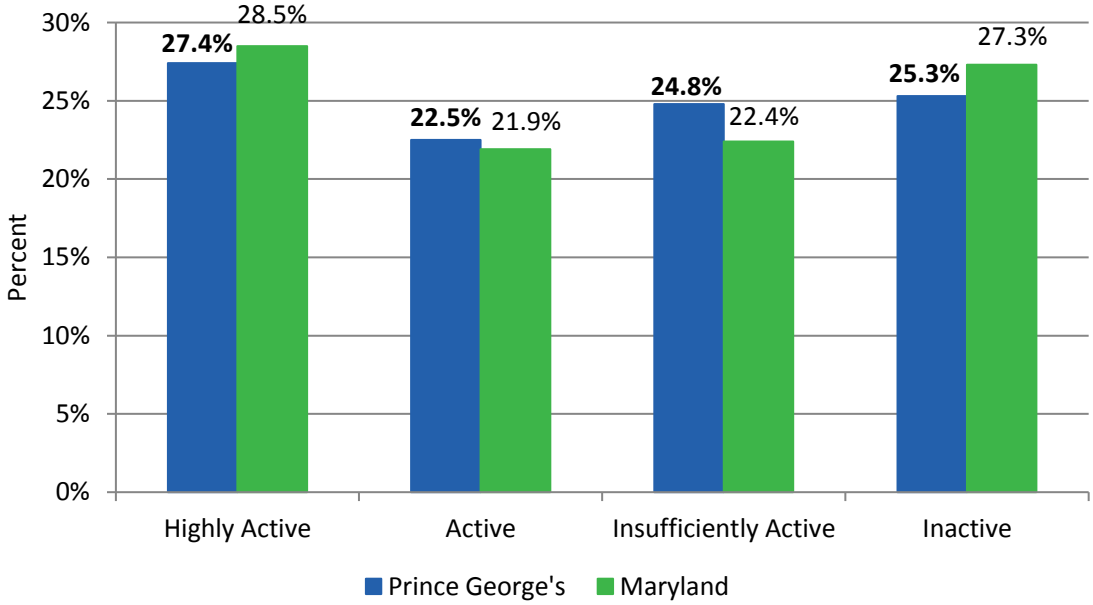
Percent of Adults Who Are Obese, 2013-2017



	2013	2014	2015	2016	2017
PGC Black, NH	34.2%	38.9%	32.1%	36.6%	46.7%
PGC White, NH	28.8%	34.6%	28.9%	32.3%	29.9%
Prince George's	34.7%	34.2%	30.7%	34.0%	42.0%
Maryland	28.3%	29.6%	28.5%	29.7%	31.1%

Data Source: 2013-2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Percentage of Adults by Physical Activity Level, 2017



Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Percentage of Adults Who Participated in at least 150 Minutes of Moderate Physical Activity or 75 Minutes of Vigorous Activity per Week, 2017

MD SHIP Goal: 50.4%	Prince George's	Maryland
Sex		
Male	51.8%	52.7%
Female	49.3%	48.3%
Race/Ethnicity		
Black, non-Hispanic	50.5%	48.0%
Hispanic	43.4%	43.4%
White, non-Hispanic	51.3%	52.4%
Age Group		
18 to 44 Years	52.3%	48.6%
45 to 64 Years	50.9%	52.7%
Over 65 Years	43.1%	52.6%
Total	**50.1%**	**50.4%**

Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

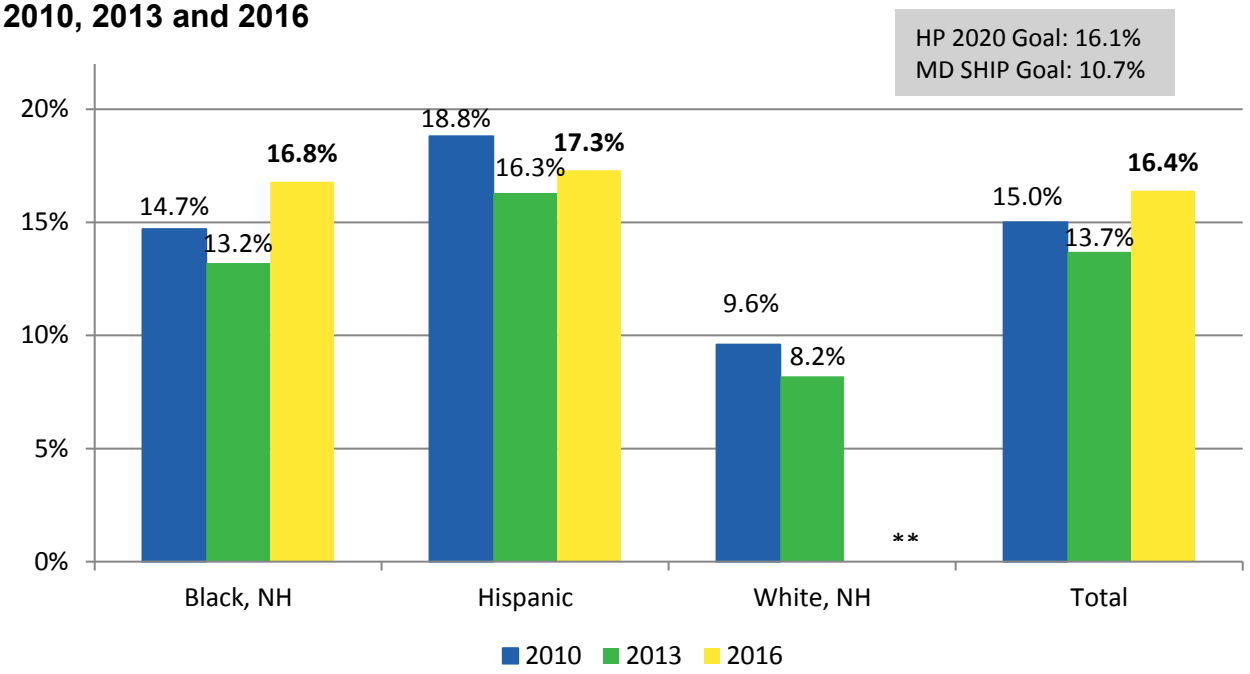
Percentage of High School Students Who are Obese, 2016

HP 2020 Goal: 10.7% MD SHIP Goal: 16.1%	Prince George's	Maryland
Sex		
Male	17.5%	14.7%
Female	15.3%	10.4%
Race/Ethnicity		
Black, non-Hispanic	16.8%	16.3%
Hispanic	17.3%	14.7%
White, non-Hispanic	**	9.9%
Age Group		
15 or Younger	15.4%	11.8%
16 or 17 Years	17.7%	13.2%
18 or Older	14.7%	13.8%
Total	**16.4%**	**12.6%**

** Individuals of White, non-Hispanic origin were not included due to insufficient numbers

Data Source: 2016 Youth Risk Behavior Survey Report for Prince George's County and Maryland, MDH

Percentage of High School Students who are Obese, Prince George's County, 2010, 2013 and 2016



** Individuals of White, non-Hispanic origin were not included due to insufficient numbers
Data Source: 2013 and 2016 Youth Risk Behavior Survey Report for Prince George's County and Maryland, MDH

Percentage of High School Students Who are Overweight, 2016

	Prince George's	Maryland
Sex		
Male	17.6%	14.4%
Female	21.0%	16.0%
Race/Ethnicity		
Black, non-Hispanic	17.7%	17.5%
Hispanic	24.7%	18.1%
White, non-Hispanic	**	12.9%
Age Group		
15 or Younger	21.2%	16.1%
16 or 17 Years	17.4%	14.4%
18 or Older	19.8%	15.4%
Total	**19.3%**	**15.2%**

** Individuals of White, non-Hispanic origin were not included due to insufficient numbers
Data Source: 2016 Youth Risk Behavior Survey Report for Prince George's County and Maryland, MDH

Percentage of High School Students Who Ate Vegetables Three or More Times per day During the Past Week, 2016

	Prince George's	Maryland
Sex		
Male	12.6%	12.7%
Female	8.0%	11.1%
Race/Ethnicity		
Black, non-Hispanic	8.8%	9.7%
Hispanic	12.0%	13.3%
White, non-Hispanic	**	11.7%
Age Group		
15 or Younger	10.8%	12.1%
16 or 17 Years	9.9%	11.5%
18 or Older	15.2%	16.4%
Total	**10.7%**	**12.0%**

** Individuals of White, non-Hispanic origin were not included due to insufficient numbers
Data Source: 2016 Youth Risk Behavior Survey Report for Prince George's County and Maryland, MDH

Percentage of High School Students who were Physically Active for a Total of at Least 60 Minutes per day on Five or More of the Past Week, 2016

	Prince George's	Maryland
Sex		
Male	29.6%	23.4%
Female	20.6%	12.6%
Race/Ethnicity		
Black, non-Hispanic	27.1%	16.1%
Hispanic	18.6%	13.5%
White, non-Hispanic	**	21.5%
Age Group		
15 or Younger	27.5%	19.4%
16 or 17 Years	23.2%	16.9%
18 or Older	21.0%	14.9%
Total	**25.0%**	**17.9%**

** Individuals of White, non-Hispanic origin were not included due to insufficient numbers
Data Source: 2016 Youth Risk Behavior Survey Report for Prince George's County and Maryland, MDH

Oral Health

Percentage of Adults Who Visited a Dentist in the Past Year, 2016

	Prince George's	Maryland
Sex		
Male	60.9%	65.4%
Female	68.4%	70.8%
Race/Ethnicity		
Black, non-Hispanic	69.0%	63.4%
Hispanic	50.9%	57.6%
White, non-Hispanic	69.1%	73.3%
Age Group		
18 to 34 Years	61.2%	64.0%
35 to 49 Years	65.4%	69.3%
50 to 64 Years	69.6%	71.4%
Over 65 Years	66.2%	70.3%
Total	**64.9%**	**68.1%**

Data Source: 2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

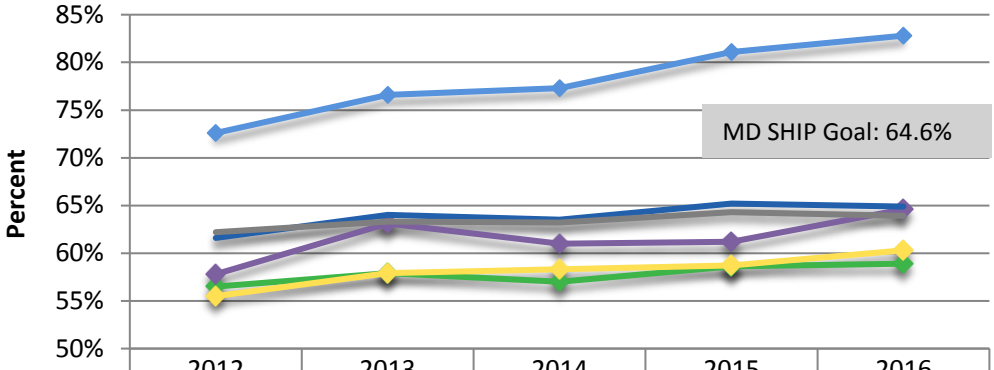
Percentage of High School Students Who Visited a Dentist in the Past Year, 2016

	Prince George's	Maryland
Sex		
Male	68.0%	75.6%
Female	70.8%	78.3%
Race/Ethnicity		
Black, non-Hispanic	69.5%	69.7%
Hispanic	71.1%	72.4%
White, non-Hispanic	**	84.2%
Age Group		
15 or younger	68.4%	77.8%
16 or 17	71.0%	77.1%
18 or older	58.2%	63.5%
Total	**69.0%**	**76.6%**

** Individuals of White, non-Hispanic origin were not included due to insufficient numbers

Data Source: 2016 Maryland Youth Risk Behavior Survey

Percentage of Children (0 to 20 years) Enrolled in Medicaid who had a Dental Visit within the Past 12 Months*, 2012 to 2016



	2012	2013	2014	2015	2016
PGC Black, NH	56.5%	57.9%	57.0%	58.6%	58.9%
Hispanic	72.6%	76.6%	77.3%	81.1%	82.8%
PGC White, NH	55.5%	57.9%	58.3%	58.7%	60.3%
PGC Asian	57.8%	63.1%	61.0%	61.2%	64.6%
Prince George's	61.6%	64.0%	63.5%	65.2%	64.9%
Maryland	62.2%	63.3%	63.2%	64.3%	63.9%

*Only children enrolled in Medicaid for at least 320 days were included in the measure
Data Source: Maryland Department of Health, Maryland State Health Improvement Process

Sexually Transmitted Infections

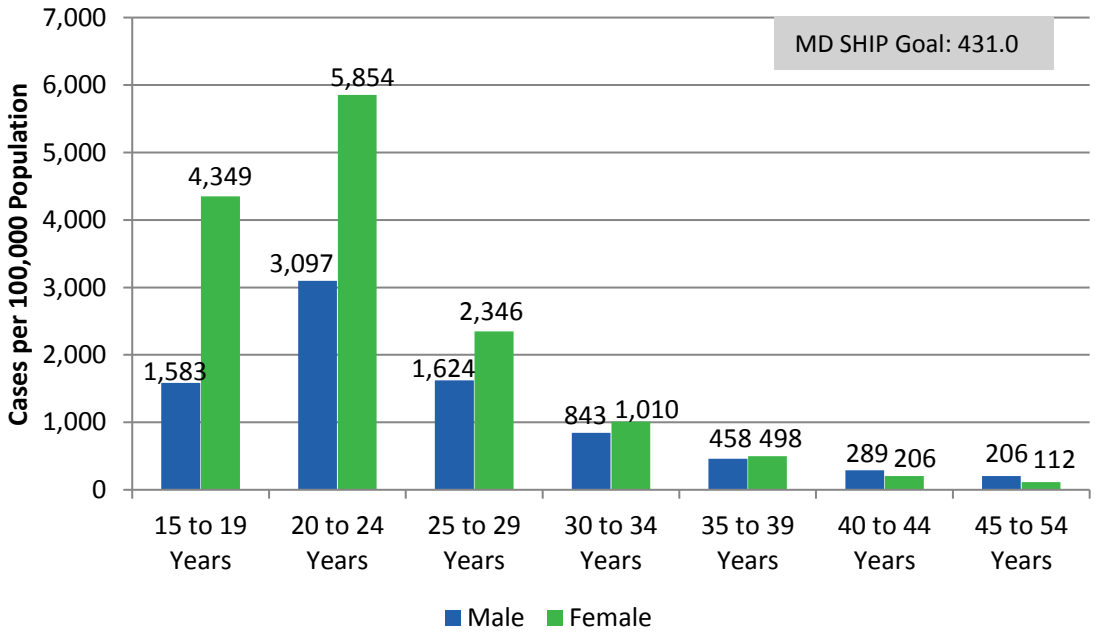
Number of Sexually Transmitted Infections, Prince George's County

STI	2015	2016	2017	5-Year Mean
Chlamydia	6,153	6,752	7,365	6,513
Gonorrhea	1,282	1,832	2,001	1,575
Syphilis*	81	110	143	113

*Includes both Primary and Secondary Syphilis

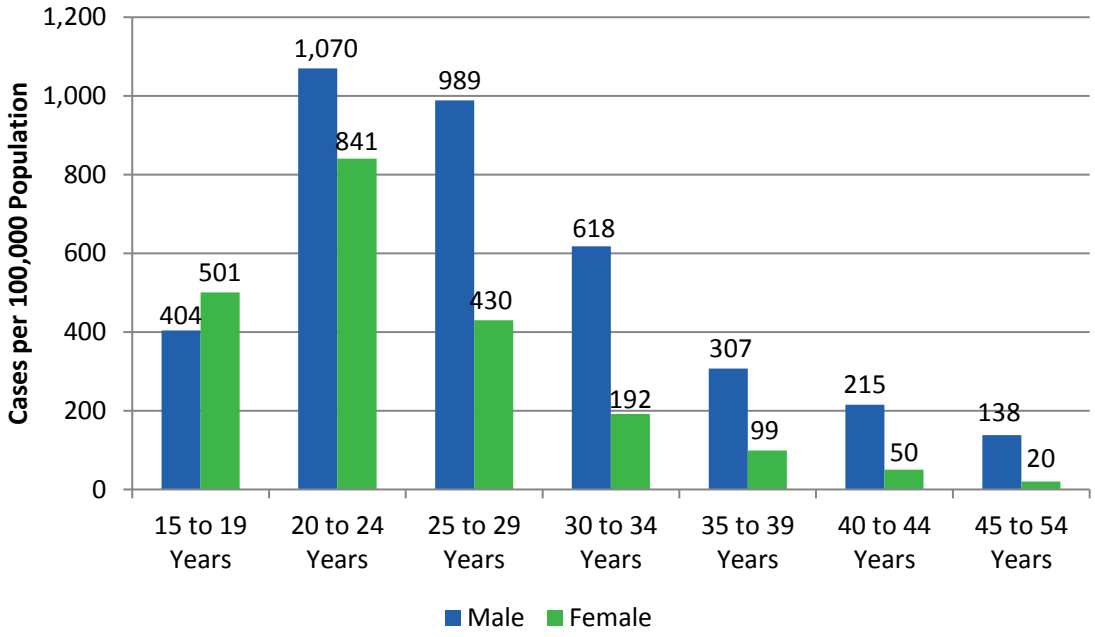
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, MDH

Chlamydia Rates by Age Group and Sex, Prince George's County, 2017



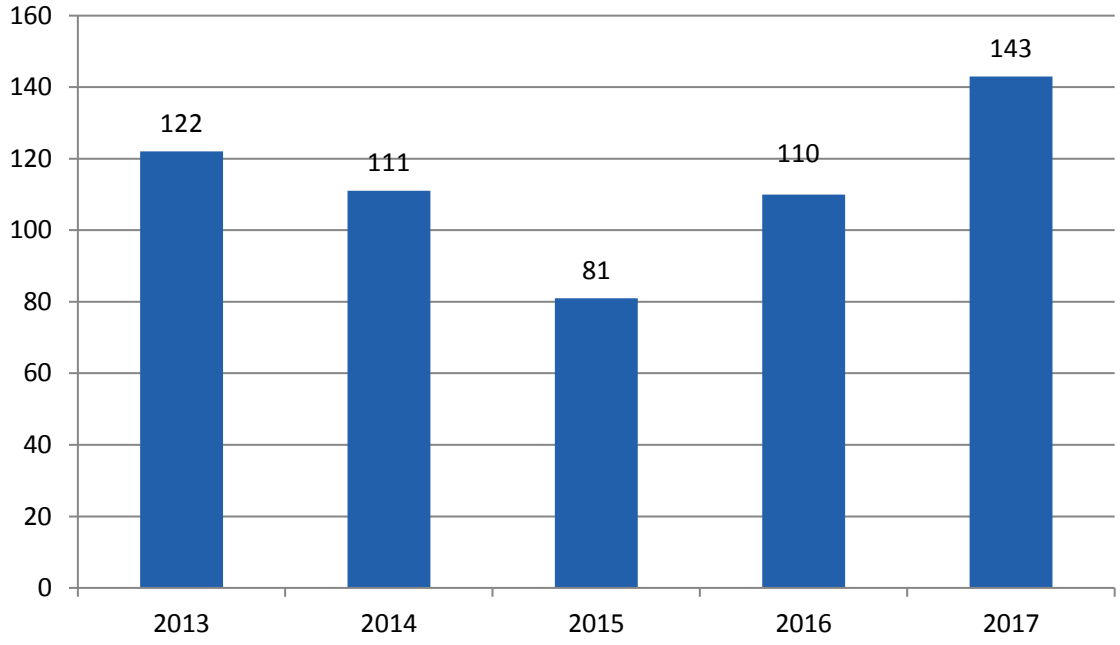
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, MDH

Gonorrhea Rates by Age Group and Sex, Prince George's County, 2017



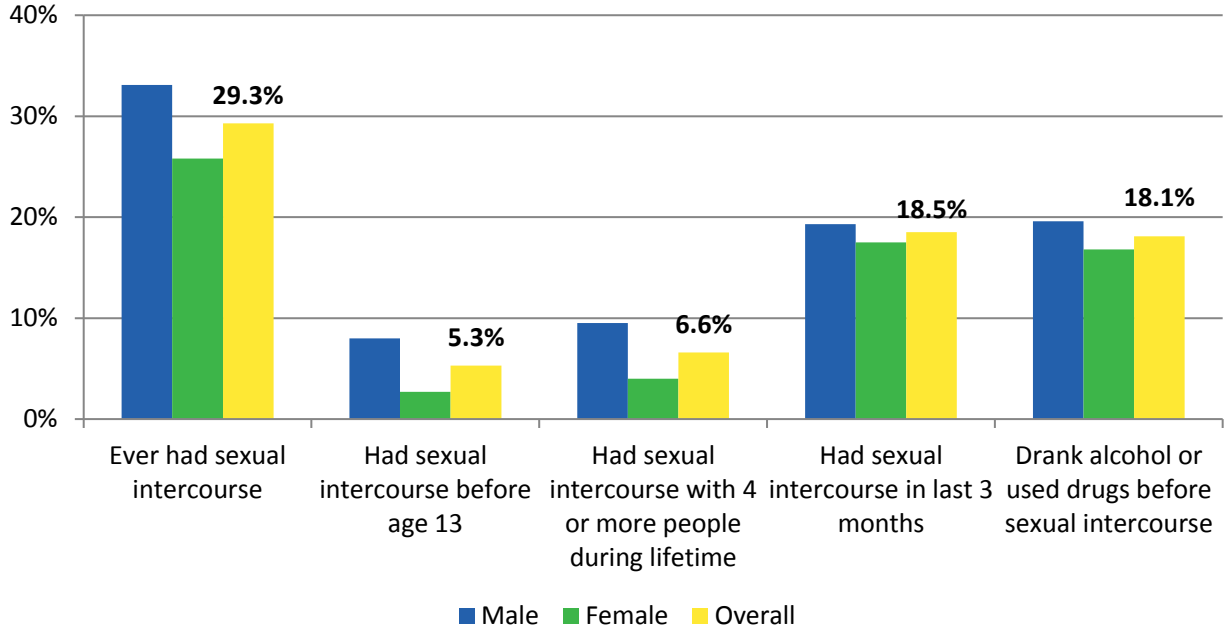
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, MDH

Number of Primary/Secondary Syphilis Cases, Prince George's County, 2013-2017



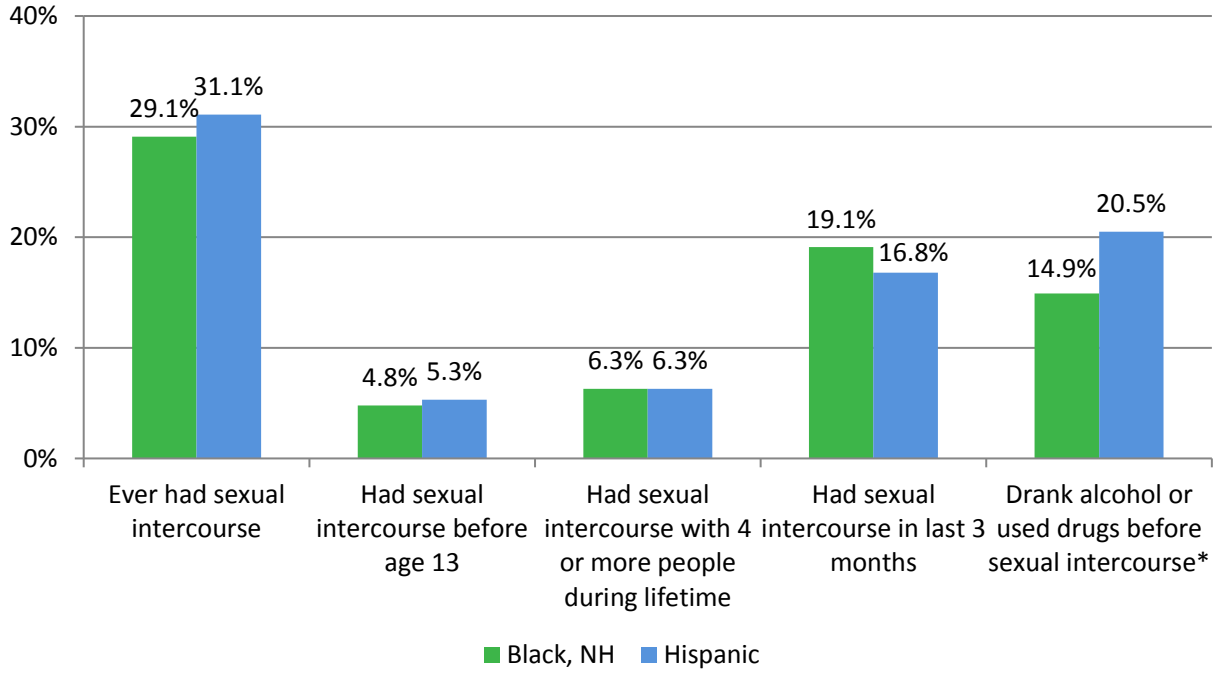
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, MDH

Sexual Behavior of High School Students by Sex, Prince George's County, 2016



Data Source: 2016 Youth Risk Behavior Survey, MDH

Sexual Behavior of High School Students by Race/Ethnicity, Prince George's County, 2016



*White, NH not displayed due to insufficient data
Data Source: 2016 Youth Risk Behavior, MDH

Substance Use Disorder

Overview	
What is it?	Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability and failure to meet major responsibilities at work, school, or home. (SAMHSA.gov)
Who is affected?	In 2017, 12.8% of county residents reported binge drinking (four or more drinks for a woman in one time period and five or more drinks in one time period for a man). In 2016, 10.9% of adolescents reported using tobacco. Over half (54%) of alcohol- and substance-related emergency department visits in 2017 were among residents 18 to 39 years of age. In 2017, there were 124 opioid-related deaths that occurred in Prince George's County, the majority (83%) of which were related to fentanyl.
Prevention & Treatment	Substance use prevention includes helping individuals develop the knowledge, attitudes, and skills they need to make good choices or change harmful behaviors (SAMHSA.gov). Substance use treatment includes counseling, inpatient and residential treatment, case management, medication, and peer support.
What are the outcomes?	Substance use disorders result in human suffering for the individual consuming alcohol or drugs as well as their family members and friends. Substance use disorders are associated with lost productivity, child abuse and neglect, crime, motor vehicle accidents and premature death (SAMHSA).
Disparity	White, non-Hispanic residents had a much higher drug-related death rate compared to other county residents in 2017. A higher percentage of males and White, non-Hispanic residents binge drank in 2017 compared to other residents. Males were 3.5 times more likely to have an alcohol- or substance-related emergency department visit than females in 2017.
How do we compare?	Ten percent of adult county residents were current smokers, compared to 14% statewide. Prince George's County had the 4th highest number of opioid-related deaths (by occurrence) in 2017, surpassed by Baltimore City, Baltimore County and Anne Arundel.

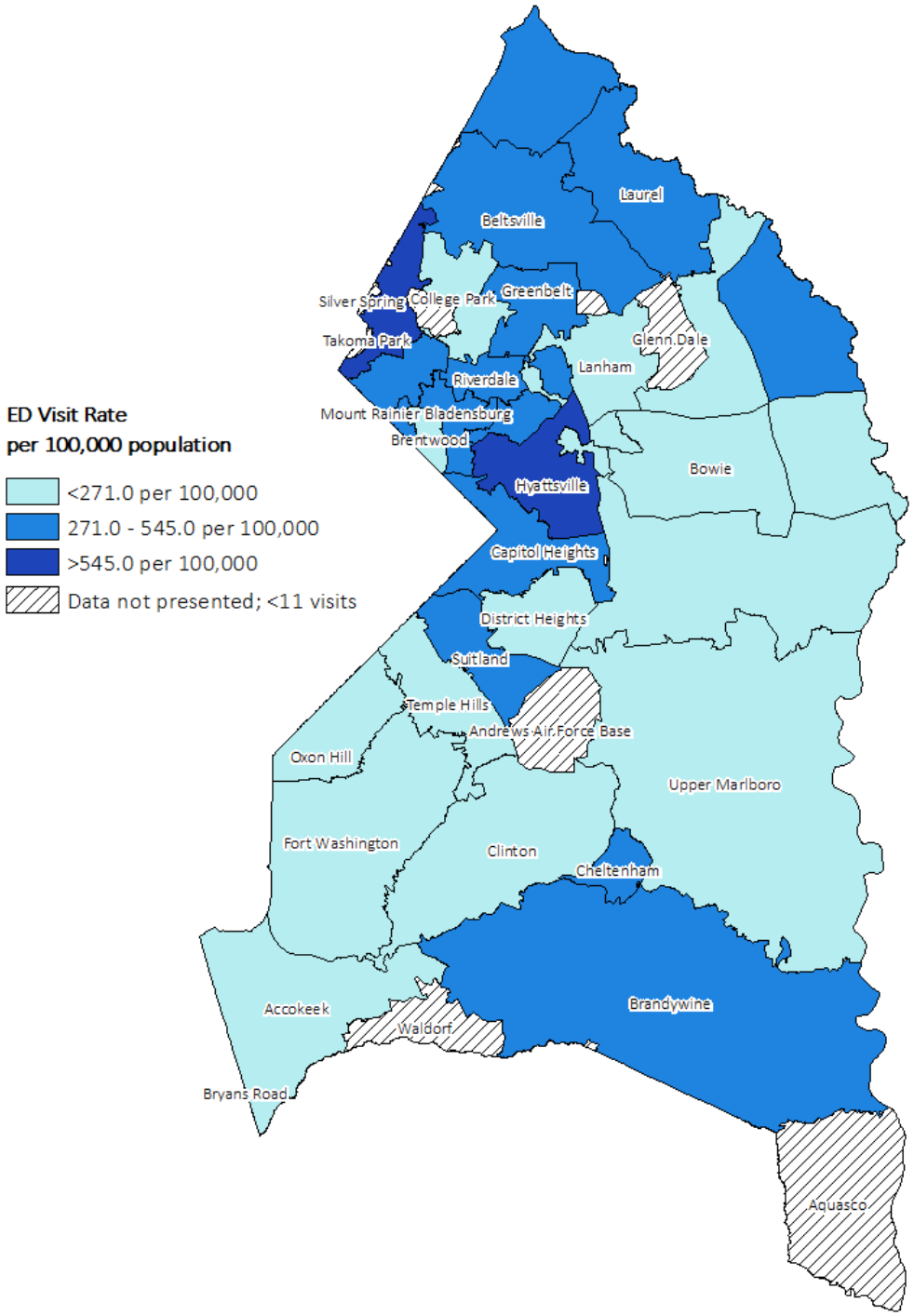
Emergency Department Visits* for Alcohol- and Substance-Related Conditions as the Primary Discharge Diagnosis, Prince George's County, 2017

	Number of ED Visits	Age-Adjusted ED Visit Rate per 100,000 Population
Sex		
Male	2,331	508.8
Female	696	144.5
Race/Ethnicity		
Black, non-Hispanic	1,551	265.1
Hispanic	587	353.4
White, non-Hispanic	440	371.0
Age		
Under 18 Years	54	26.6
18 to 39 Years	1,622	559.5
40 to 64 Years	1,218	402.5
65 Years and Over	133	113.7
Total	**3,027**	**320.7**

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County numbers and rate. As noted in the introduction, 2017 data is not comparable to the 2014 data used in the previous health needs assessment due to changes in ICD codes.

Data Source: Outpatient Discharge Data File 2017, Maryland Health Services Cost Review Commission; Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

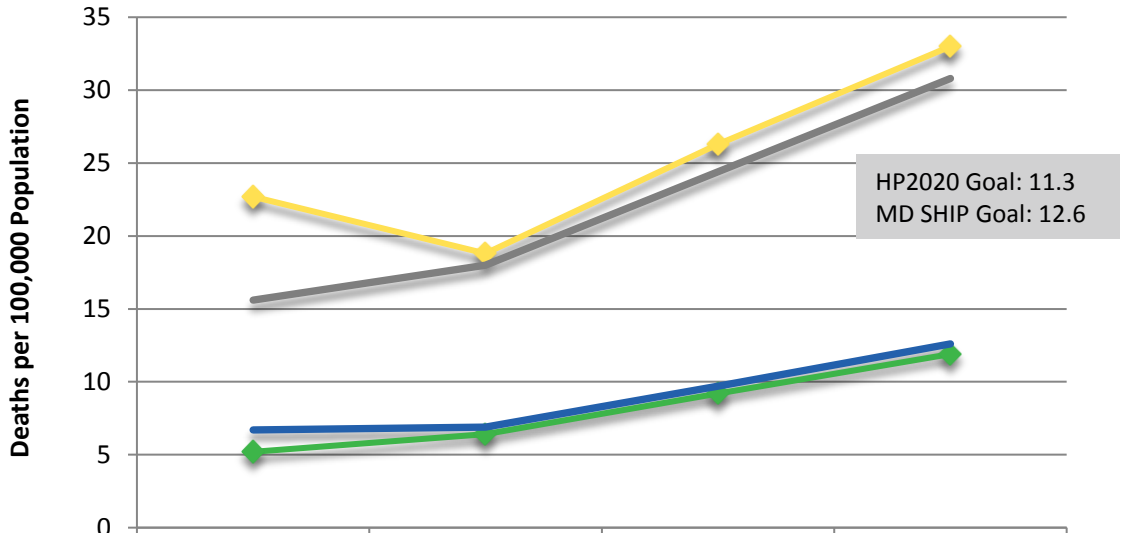
Emergency Department Visit* Crude Rate per 100,000 Population, Alcohol- and Substance-Related Conditions as Primary Discharge Diagnosis, Prince George's County, 2017



* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Outpatient Discharge Data File 2014, Maryland Health Services Cost Review Commission

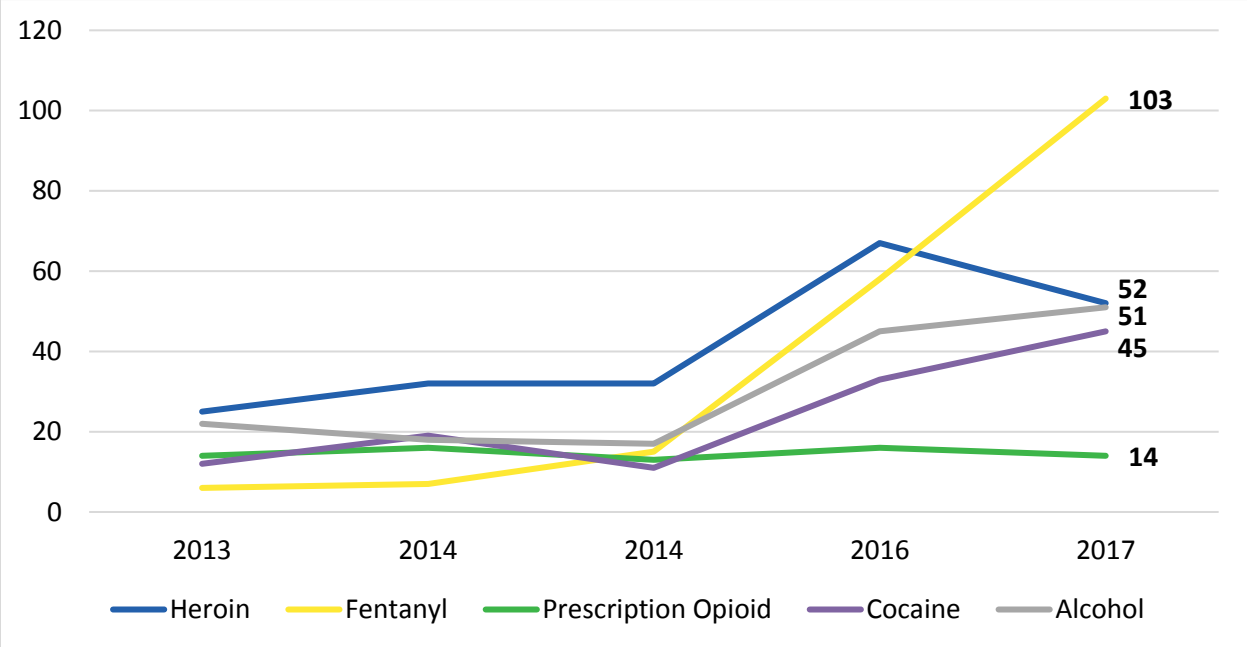
Drug-Related Age-Adjusted Death Rate per 100,000 Population, 2012 to 2017



	2012-2014	2013-2015	2014-2016	2015-2017
PGC Black, NH	5.2	6.4	9.2	11.9
PGC White, NH	22.7	18.8	26.3	33.0
PGC Total	6.7	6.9	9.7	12.6
Maryland	15.6	18.0	24.4	30.8

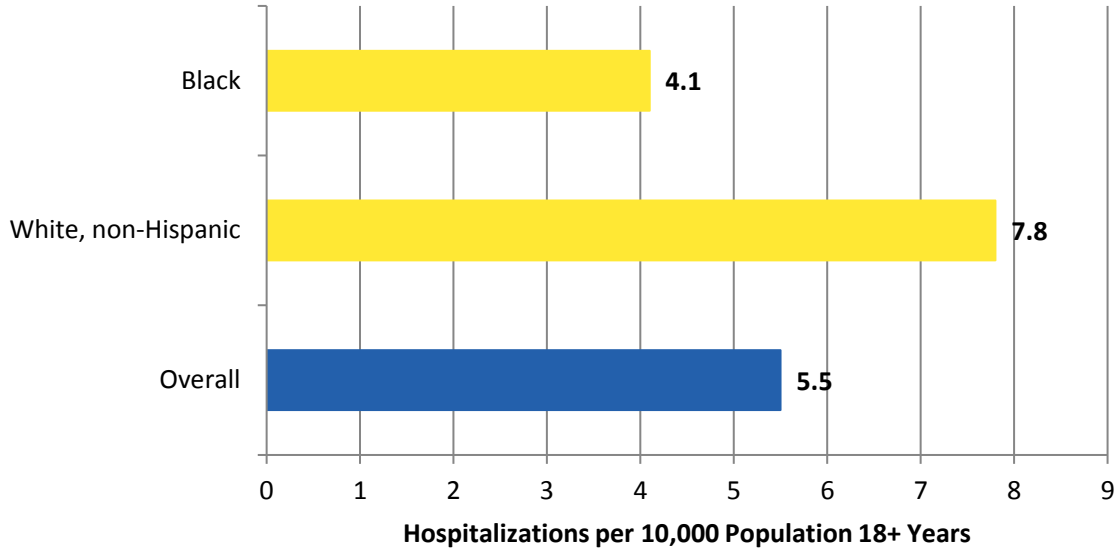
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Drug and Alcohol Intoxication Deaths by Place of Occurrence, Prince George's County, 2013-2017



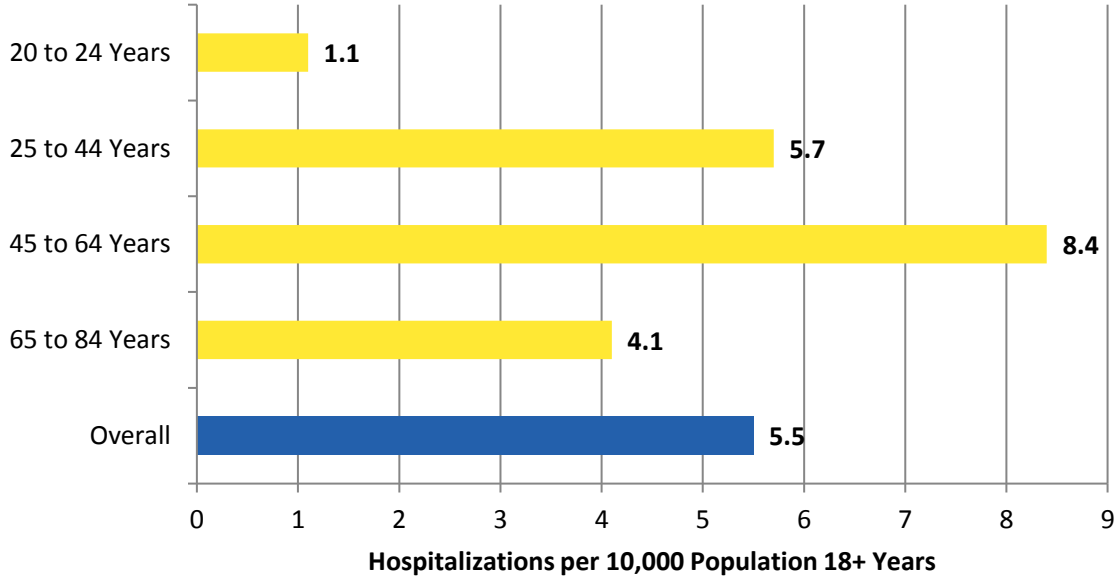
Data Source: 2017 Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland Annual Report

Age-Adjusted Hospital Inpatient* Visit Rate due to Alcohol Abuse by Race and Ethnicity, Prince George's County, 2013-2015



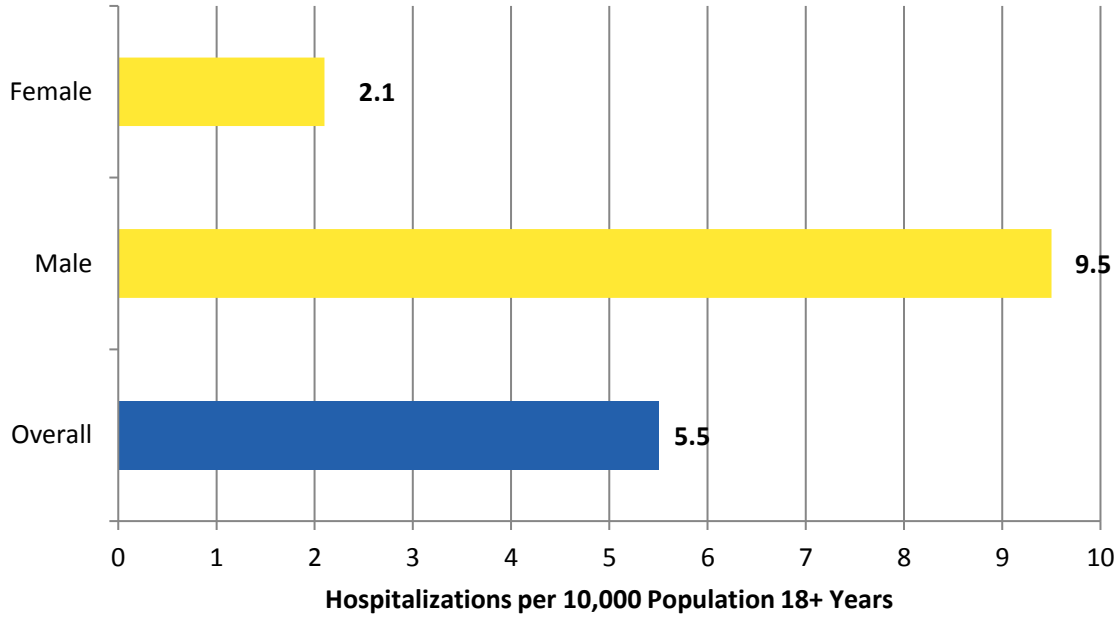
* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Alcohol Abuse by Age Group, Prince George's County, 2013-2015



* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Age-Adjusted Hospital Inpatient* Visit Rate due to Alcohol Abuse by Sex, Prince George's County, 2013-2015



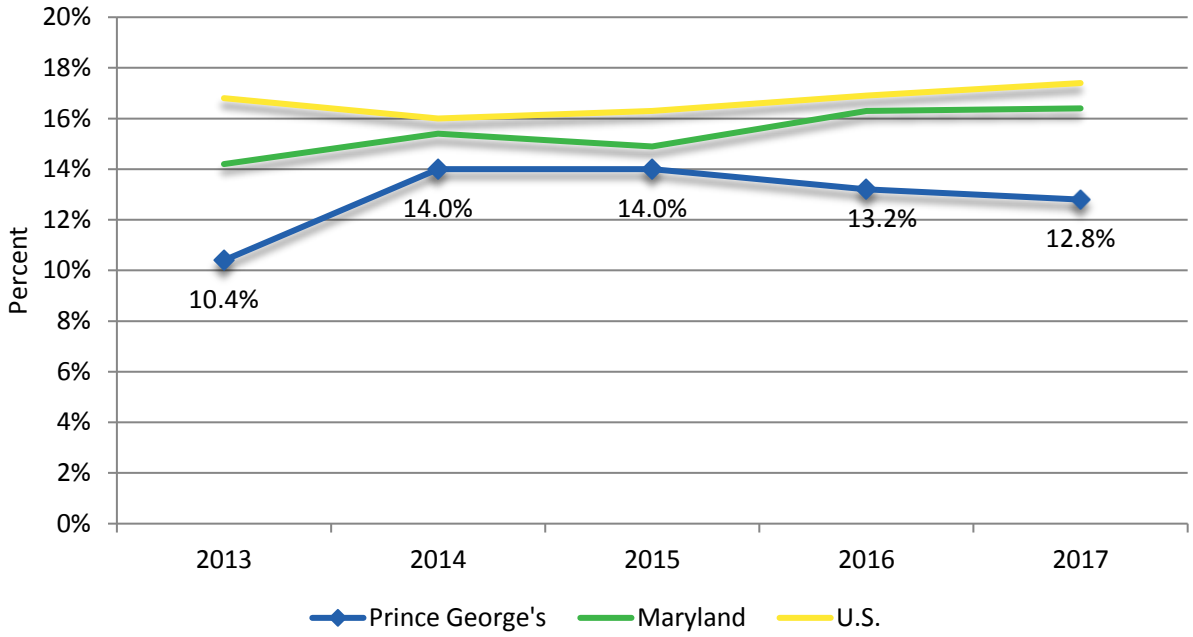
* Includes visits to Maryland and Washington, D.C. hospitals
Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Percentage of Adult Binge Drinkers* in the Past Month, 2017

	Prince George's	Maryland
Sex		
Male	16.2%	19.9%
Female	9.7%	13.0%
Race/Ethnicity		
Black, non-Hispanic	10.9%	13.2%
Hispanic	19.5%	14.0%
White, non-Hispanic	17.3%	21.3%
Age Group		
18 to 34 Years	19.7%	25.7%
35 to 49 Years	13.5%	16.4%
50 to 64 Years	9.3%	11.7%
Over 65 Years	**	4.3%
Total	**12.8%**	**16.4%**

*Binge drinking is defined as males having five or more drinks on one occasion, females having four or more drinks on one occasion
** Over 65 years not presented due to insufficient data.
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, MDH; https://ibis.health.maryland.gov , accessed on 5/13/2019

Percentage of Adult Binge Drinkers* in the Past Month, 2013 to 2017



*Binge drinking is defined as males having five or more drinks on one occasion, females having four or more drinks on one occasion

Data Source: 2013-2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

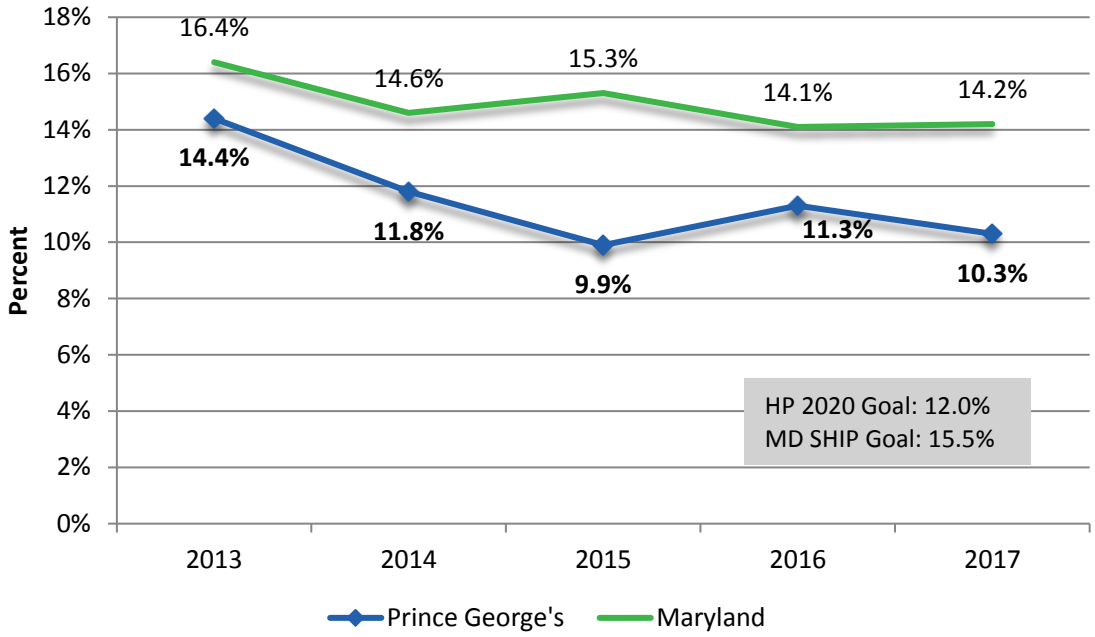
Percentage of Adults Who Currently Smoke, 2017

	Prince George's	Maryland
Sex		
Male	13.1%	16.4%
Female	7.0%	12.0%
Race/Ethnicity		
Black, non-Hispanic	9.0%	15.1%
Hispanic	20.7%	13.9%
White, non-Hispanic	13.8%	15.1%
Age Group		
18 to 34 Years	9.3%	15.4%
35 to 49 Years	10.4%	15.0%
50 to 64 Years	10.8%	15.4%
Over 65 Years	**	8.2%
Total	**10.3%**	**14.2%**

**Over 65 years not presented due to insufficient data

Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Percentage of Current Adult Smokers, 2013 to 2017



Data Source: 2013-2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

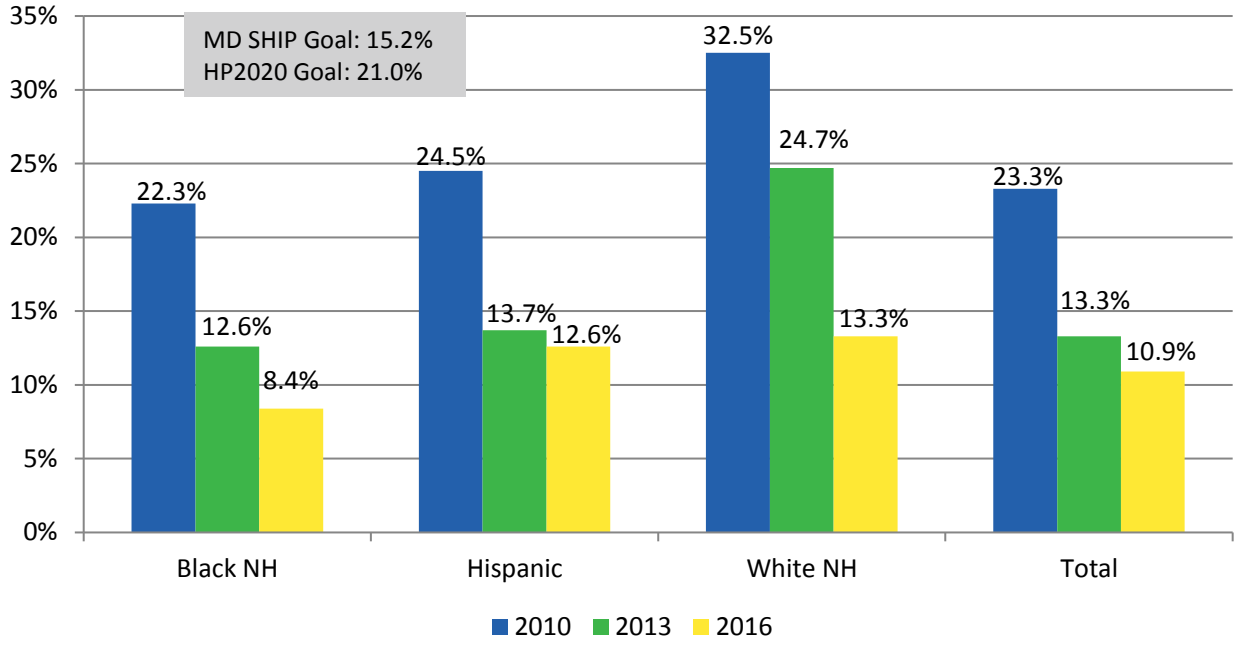
Percentage of Students who Drank Alcohol During the Past Month, 2016

	Prince George's	Maryland
Sex		
Male	11.7%	22.2%
Female	21.9%	28.6%
Race/Ethnicity		
Black, non-Hispanic	15.2%	17.8%
Hispanic	19.5%	23.5%
White, non-Hispanic	**	33.2%
Age Group		
15 or Younger	14.0%	18.7%
16 or 17 Years	19.6%	31.0%
18 or Older	19.2%	32.4%
Total	**17.0%**	**25.5%**

** White, non-Hispanic not presented due to insufficient data

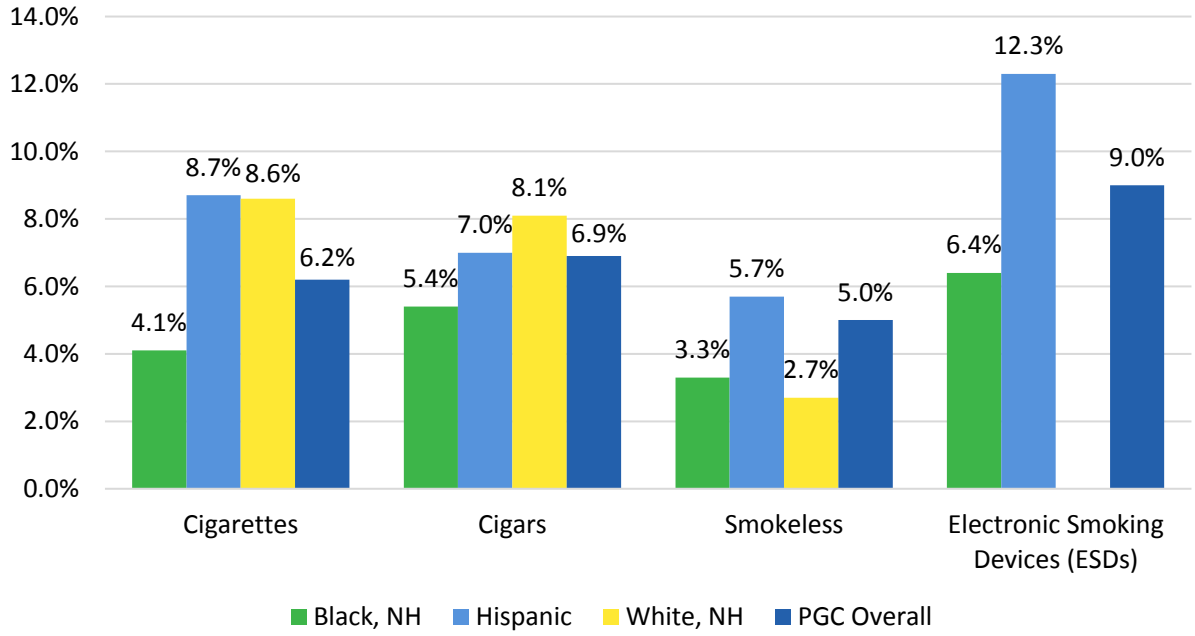
Data Source: 2016 Youth Risk Behavior Survey Report for Prince George's County and Maryland, MDH

High School Students Who Used Tobacco Products During the Past Month, Prince George's County, 2010, 2013 and 2016



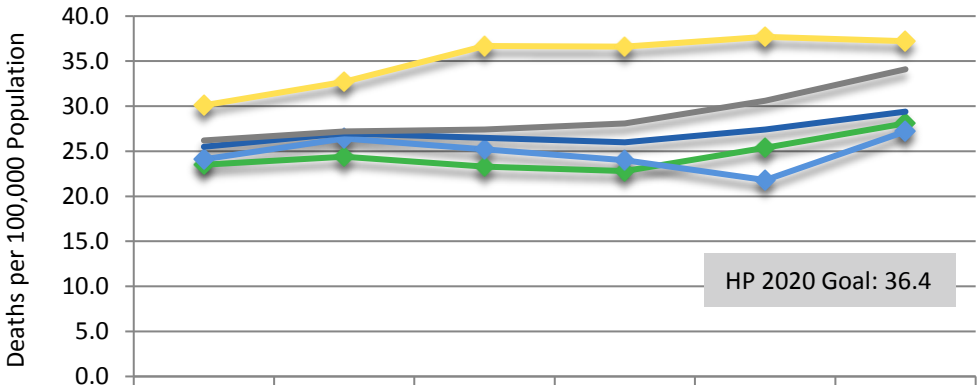
Data Source: 2010-2016 Youth Risk Behavior Survey Report for Prince George's County and Maryland, MDH

Tobacco Products Used by High School Students During the Past Month by Race/Ethnicity, Prince George's County, 2016



Unintentional Injuries (Accidents)

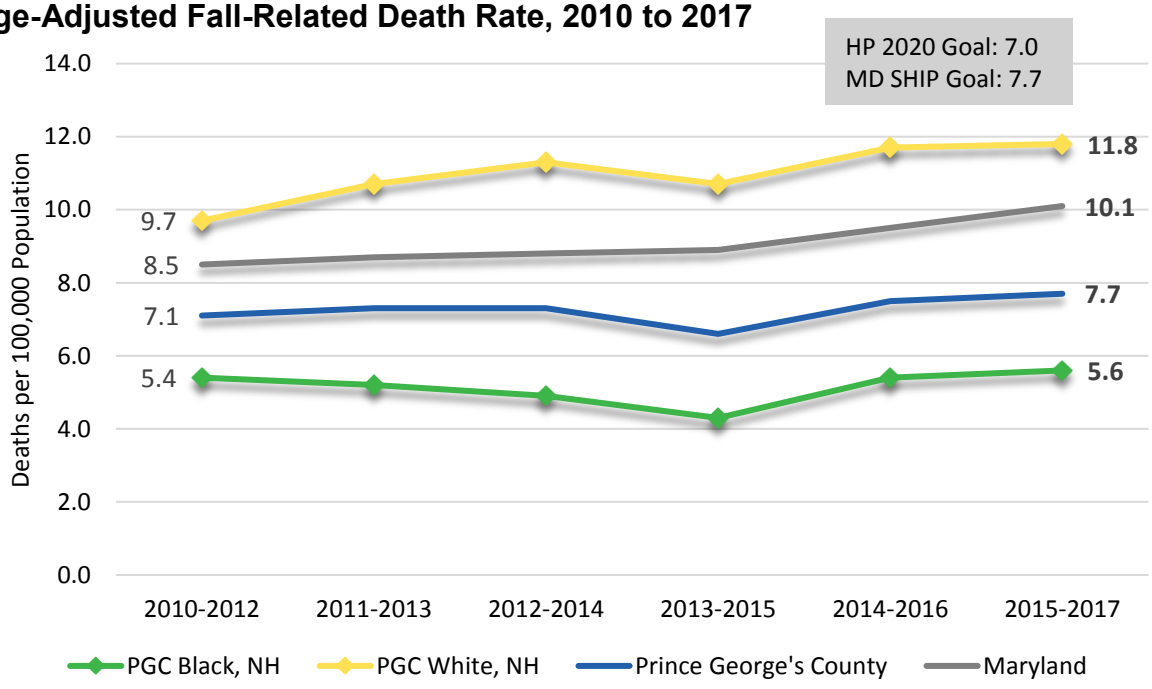
Age-Adjusted Death Rate per 100,000 for Unintentional Injuries, 2010-2017



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017
PGC Black, NH	23.5	24.4	23.3	22.8	25.4	28.1
PGC Hispanic	24.1	26.4	25.2	24.0	21.8	27.2
PGC White, NH	30.1	32.7	36.7	36.6	37.7	37.2
PGC	25.5	27.0	26.5	26.0	27.4	29.4
Maryland	26.2	27.2	27.4	28.1	30.6	34.1

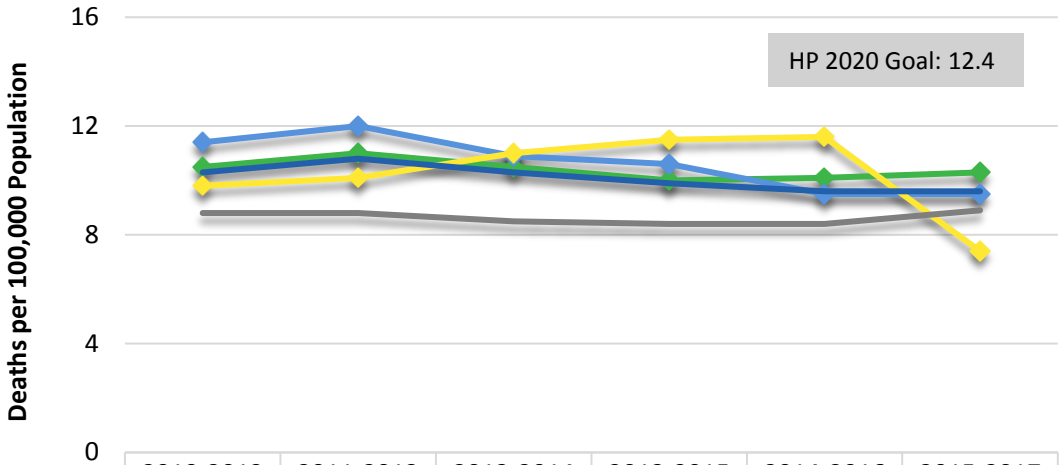
***** Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Age-Adjusted Fall-Related Death Rate, 2010 to 2017



***** Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database;

Age-Adjusted Death Rate due to Motor Vehicle Accidents, 2010-2017

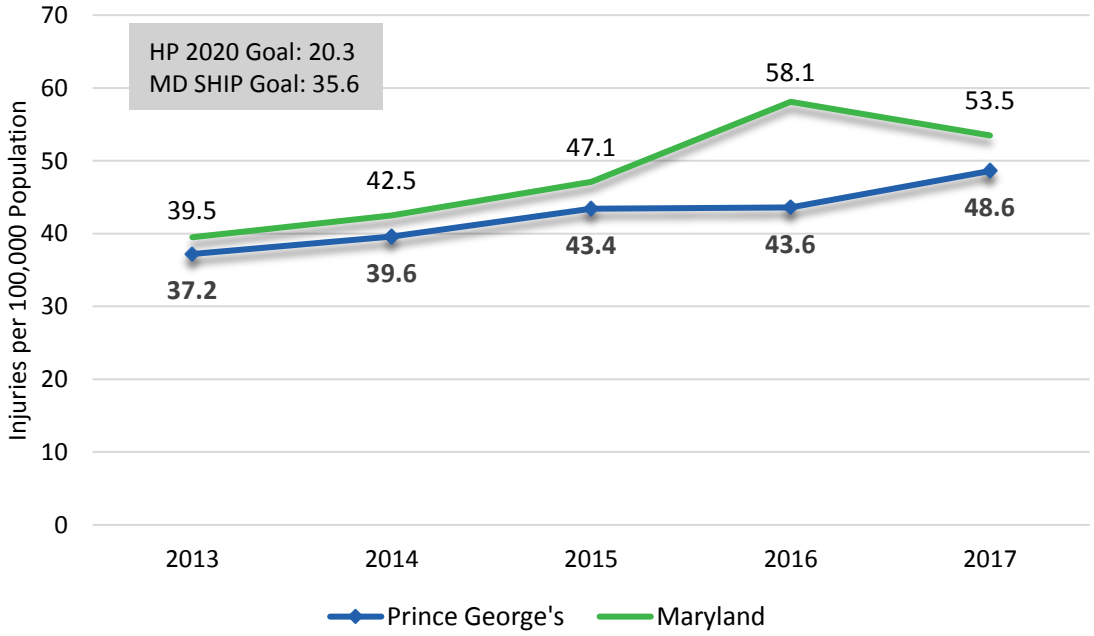


	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017
PGC Black, NH	10.5	11.0	10.5	10.0	10.1	10.3
PGC Hispanic	11.4	12.0	10.9	10.6	9.5	9.5
PGC White NH	9.8	10.1	11.0	11.5	11.6	7.4
PGC	10.3	10.8	10.3	9.9	9.6	9.6
Maryland	8.8	8.8	8.5	8.4	8.4	8.9

***** Asian/Pacific Island Residents were not included due to insufficient numbers

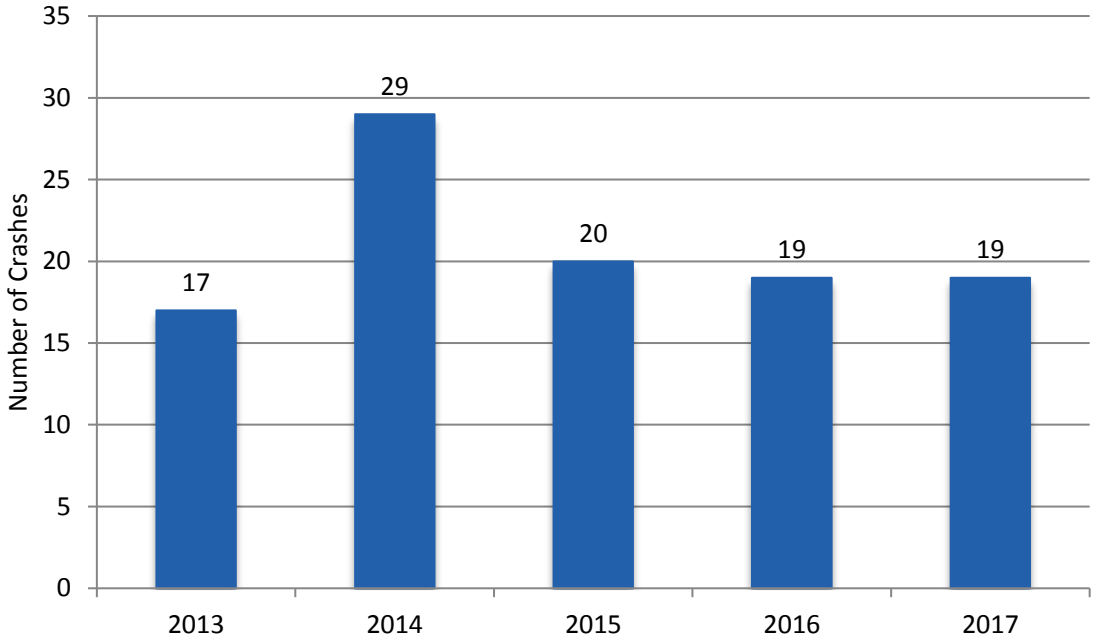
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database; Healthy People 2020 https://www.healthypeople.gov/

Pedestrian Injury Rate on Public Roads, 2013-2017



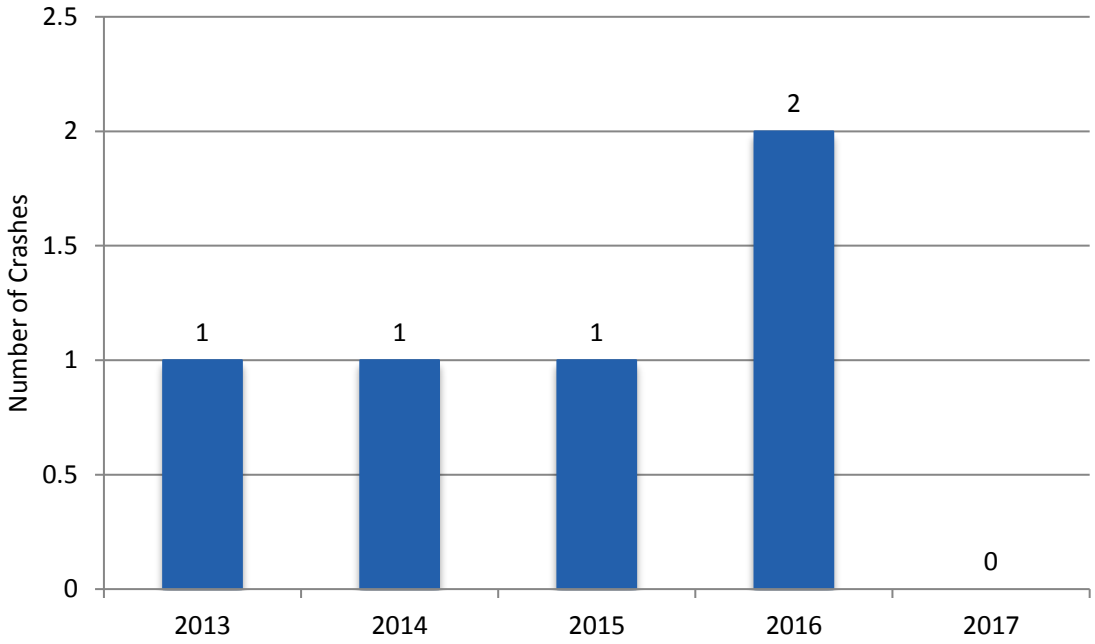
Data Source: Maryland State Highway Administration (SHA)

Fatal Motor Vehicle Crashes Involving Pedestrians on Foot, Prince George's County, 2013-2017

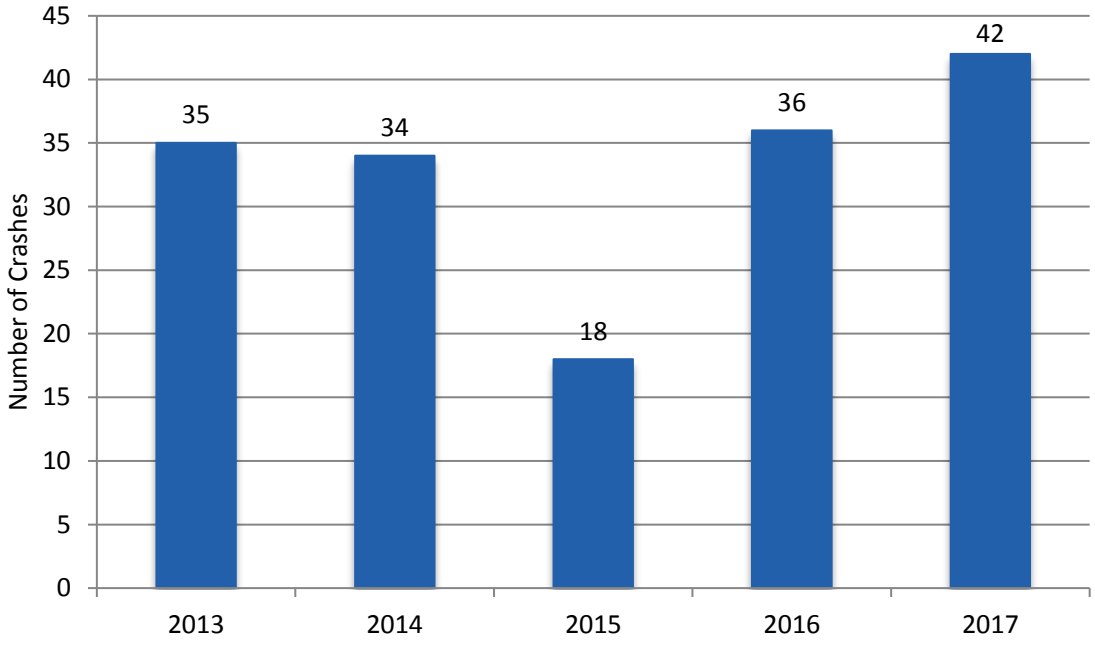


Data Source: Maryland Highway Safety Office, Maryland Department of Transportation

Fatal Motor Vehicle Crashes Involving Bicycles or Other Pedalcycles, Prince George's County, 2013-2017

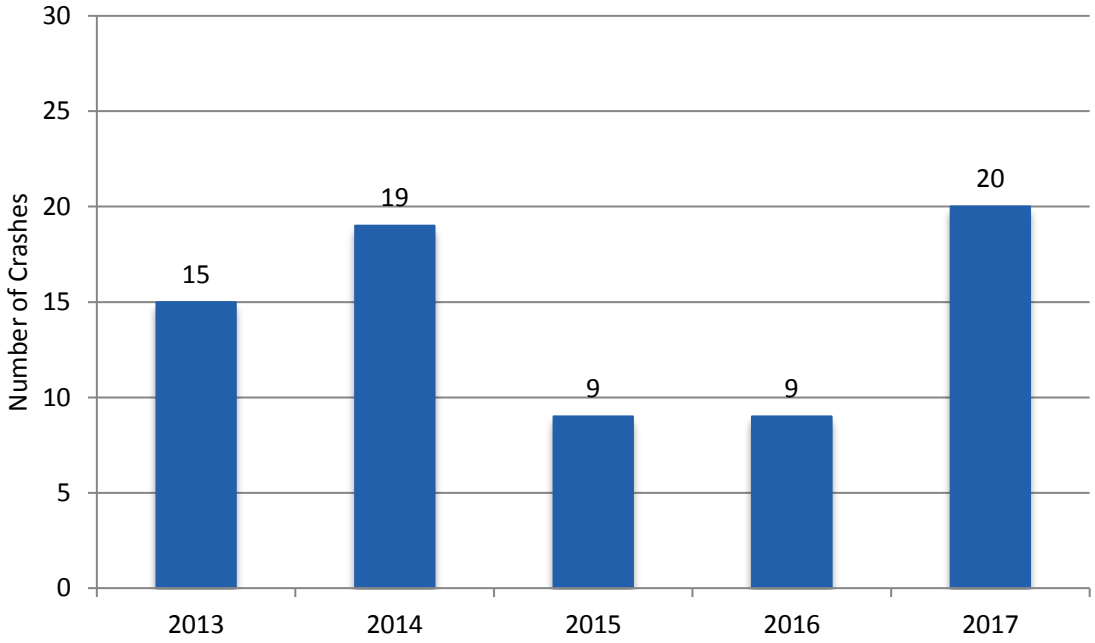


Fatal Motor Vehicle Crashes Involving Distracted Driving, Prince George's County, 2013-2017



Data Source: Maryland Highway Safety Office, Maryland Department of Transportation

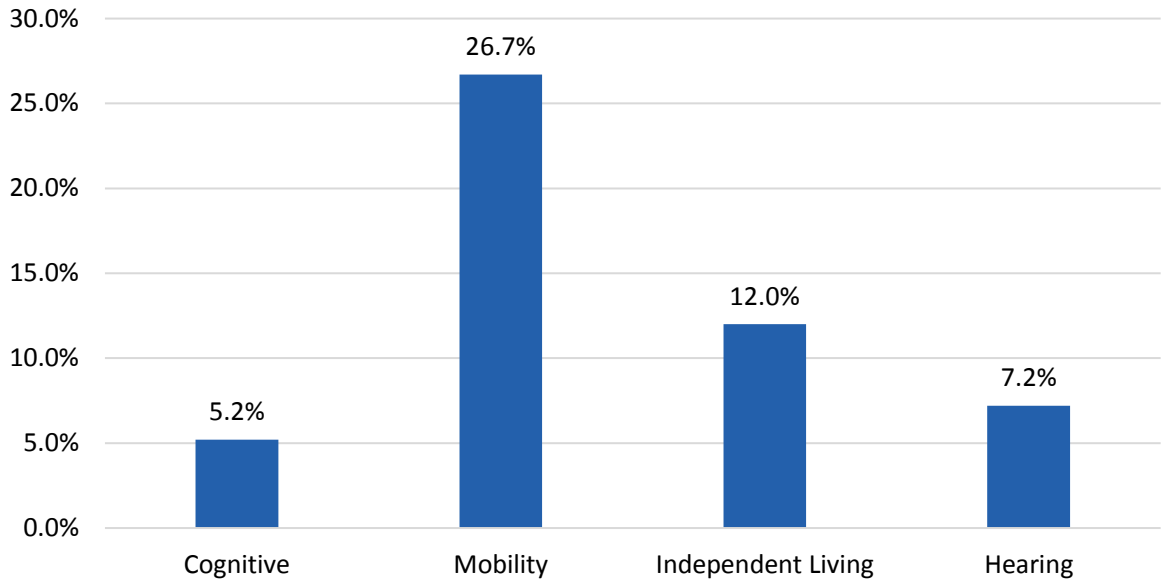
Fatal Motor Vehicle Crashes Involving Driver Speed, Prince George's County, 2013-2017



Data Source: Maryland Highway Safety Office, Maryland Department of Transportation

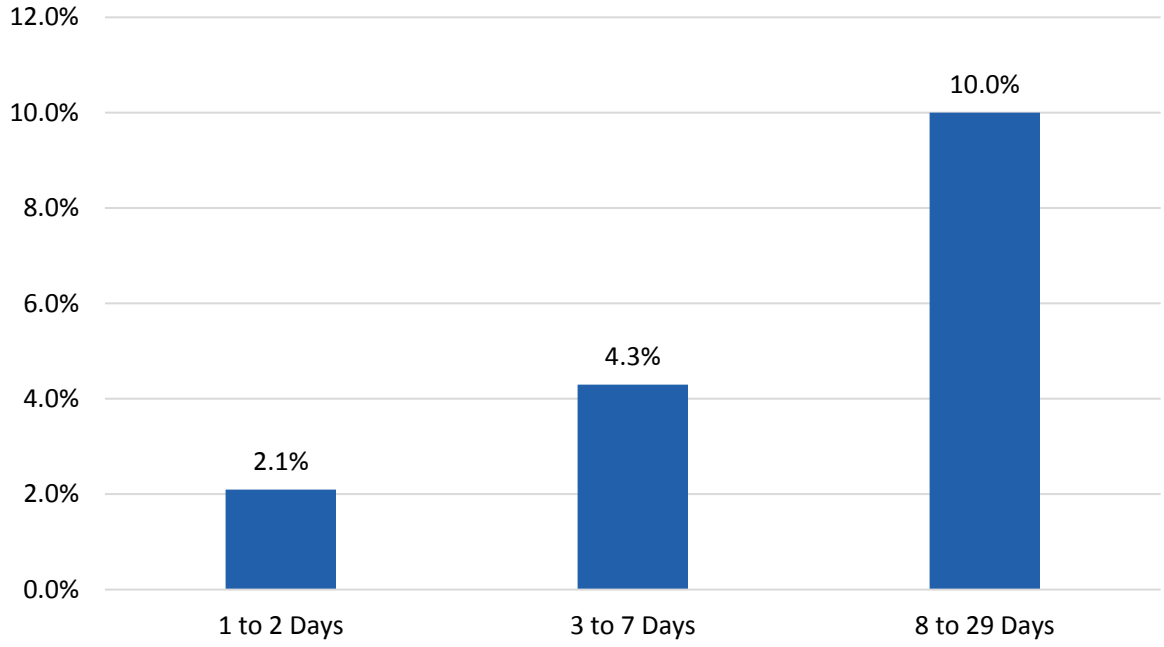
Senior Health

Percentage of Seniors (65+ Older) by Disability Type, Prince George's County, 2017



Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System; Accessed 6/6/2019

Percentage of Seniors (65+ Older) Reporting Physical or Mental Health Kept Them From Usual Activities in the Past Month, Prince George's County, 2017

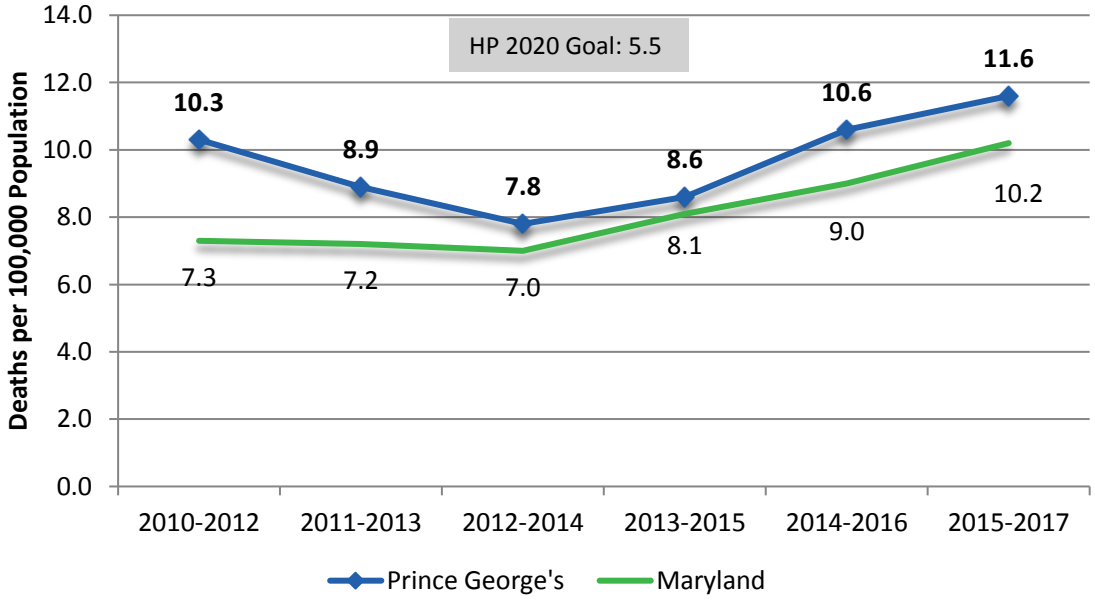


Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System; Accessed 6/6/2019

Violence and Domestic Violence

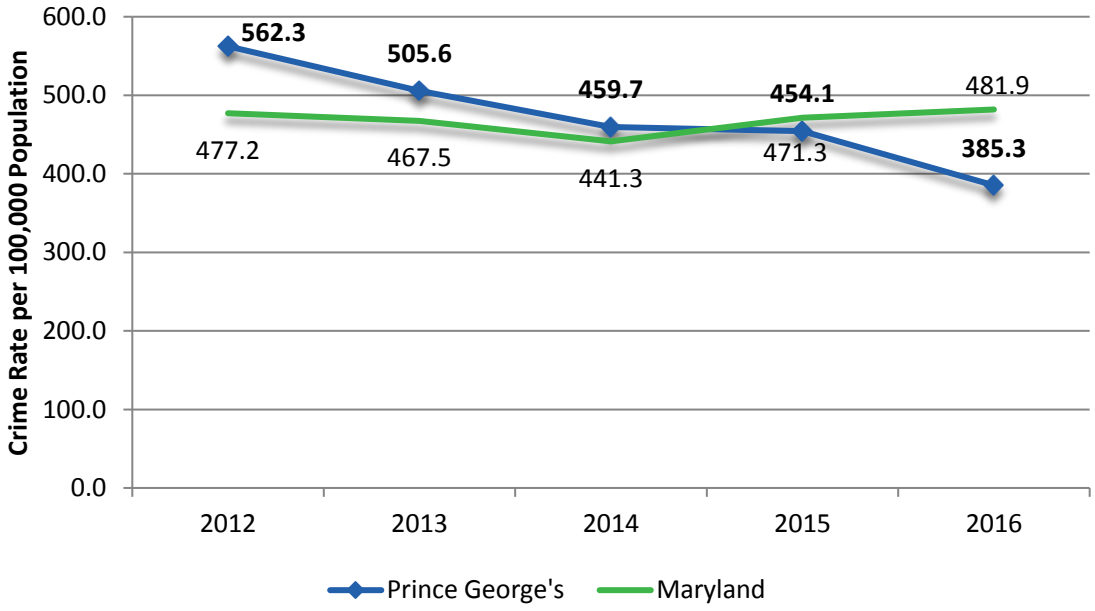
Overview	
What is it?	Violence affects all stages of life and includes child abuse, elder abuse, sexual violence, homicides, and domestic violence. Domestic violence is a pattern of abusive behavior including willful intimidation, physical assault, battery, and sexual assault used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can happen to anyone regardless of age, economic status, race, religion, sexual orientation, nationality, sex, or educational background (National Coalition Against Domestic Violence).
Who is affected?	There were 2,949 violent crimes (includes homicide, rape, robbery, and aggravated assault) in 2017, and 93 residents in the county died by homicide. (MD Vital Statistics). In 2017, there were 1,711 reports of domestic violence in the county, and from July 2016 to June 2017 there were 5 domestic violence-related deaths. (Maryland Network Against Domestic Violence).
Prevention and Treatment	Domestic violence prevention efforts depend on the population and include: • Prevent domestic violence before is exists (primary prevention) • Decrease the start of a problem by targeting services to at-risk individuals and addressing risk factors (secondary prevention) • Minimize a problem that is clear evidence and causing harm (tertiary prevention) (Maryland Network Against Domestic Violence).
What are the outcomes?	Apart from deaths and injuries, domestic violence is associated with adverse physical, reproductive, psychological, social, and health behaviors. (CDC.gov).
Disparity	No data is currently available about disparities for violence and domestic violence. However, anyone can experience domestic violence. Women generally experience the highest rates of partner violence compared to males. Teenaged, pregnant, and disabled women are especially at risk. (MD Network Against Domestic Violence).
How do we compare?	The county's age-adjusted death rate due to homicide in 2017 was 11.6, compared to the state overall at 10.2 and the U.S. at 6.0 per 100,000 population. The county's violent crime rate in 2017 was 385.3, below the state rate of 481.9 per 100,000. (MD Governor's Office of Crime Control and Prevention)

Age-Adjusted Death Rate for Homicide, 2010-2017



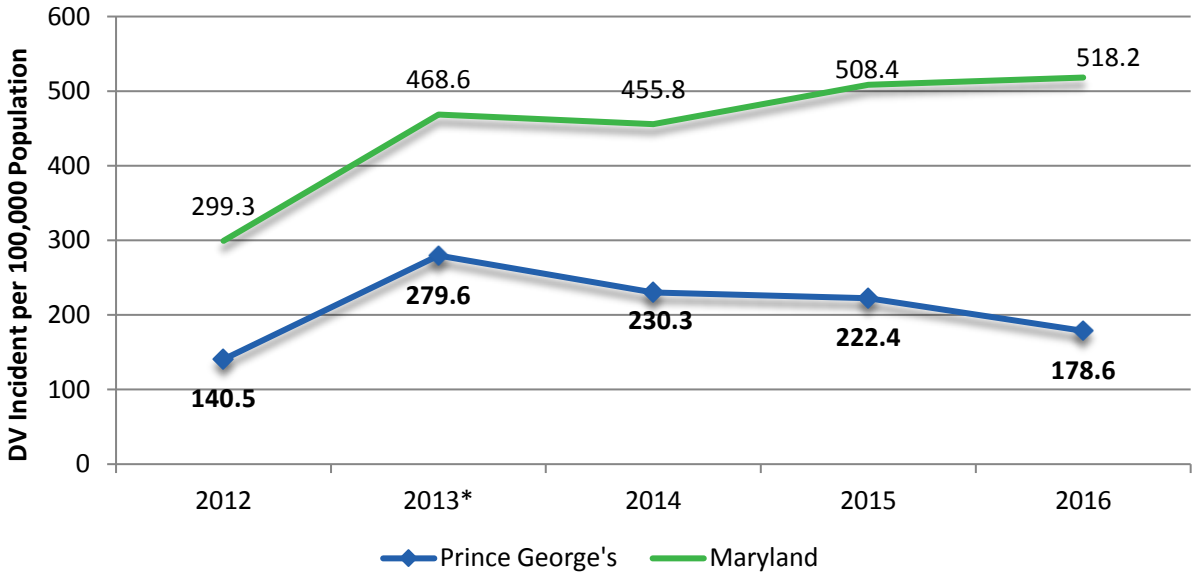
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Violent Crime* Rate, Prince George's County Compared to Maryland, 2012-2016



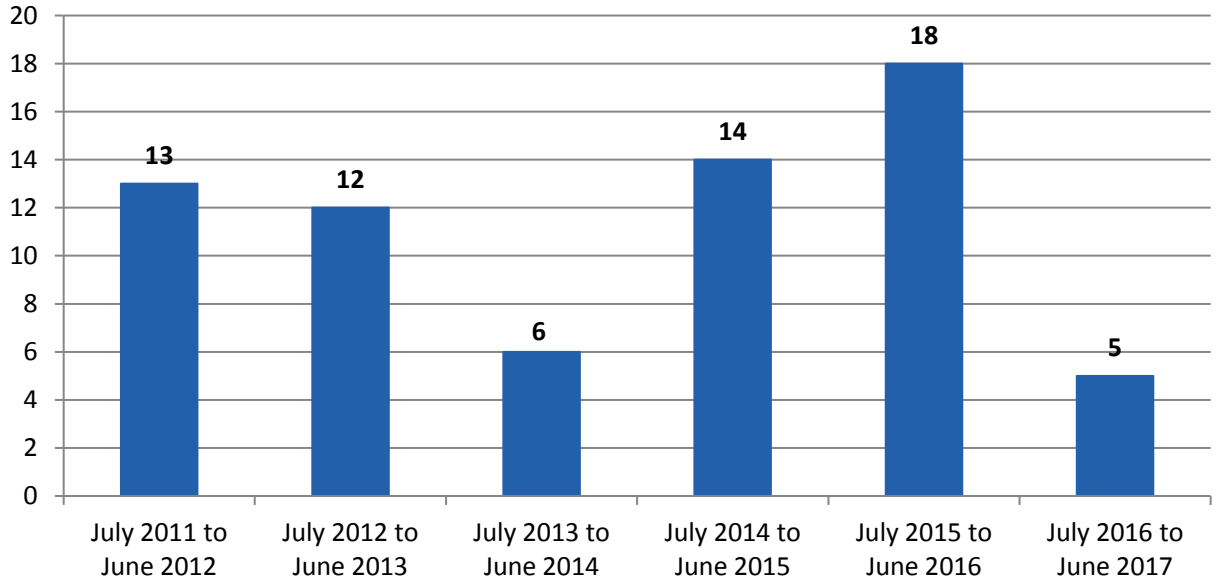
*Violent crimes include homicide, rape, robbery, and aggravated assault.
Data Source: Maryland Uniform Crime Report

Rate of Domestic Violence, Prince George's Compared to Maryland, 2012-2016



*In 2013, domestic violence data reporting was expanded to include additional relationships and reflect changes in Maryland law. This change explains the increase in the total number of Domestically Related Crimes reported.
Data Source: Maryland Uniform Crime Report

Domestic Violence-Related Deaths in Prince George's County, 2012-2017



Data Source: Maryland Network Against Domestic Violence

KEY INFORMANT interviews

KEY INFORMANT INTERVIEWS

Introduction

As part of the 2019 Community Health Assessment conducted in partnership with the county's hospitals, the Prince George's County Health Department (PGCHD) conducted key informant interviews with 14 County leaders drawn from diverse backgrounds with varying perspectives on health in the County. This report summarizes the approach to the interviews and the findings.

Key Findings

- The most important health issues facing the County are behavioral health, chronic disease, access to care, and issues surrounding healthy eating and active living (i.e. food insecurity, food deserts).
- The most important social determinants of health in the County are (1) Housing, (2) Lack of transportation, (3) education, (4) economic issues such as employment, (5) access to affordable health care and (6) access to healthy food.
- The most important barriers relative to the health and well-being of residents are (1) limited access to healthcare due to lack of insurance, (2) transportation issues, (3) the intersection between pockets of poverty, provider shortages, housing, perception of health care in the county, and limited access to healthy foods.
- The leading physical health concerns are the incidence and prevalence of chronic disease, including cardiovascular disease, hypertension, Type 2 diabetes, as well as contributing factors such as obesity and physical health management.
- Several issues surrounding behavioral health are of heightened concern for Prince George's County residents. Issues such as lack of adequate housing for homeless individuals who often have comorbid mental health issues and need stable housing while they are recovering from their behavioral health concerns; the stigma surrounding mental health issues and receiving treatment; a perception of inadequate facilities for children and adolescents who are facing mental health challenges and an overall sense of increased stress in the county which will continue to inevitably affect the residents.

- Environmental health concerns surrounded issues such increased asthma reports in children, concerns about the quality of our air and water as a result of the increase in flooding (water) and the high rates of transportation (thus emissions) in the county. Representatives also mentioned responsible land use issues such as zoning, landfills and housing construction.
- One of the challenges that county leadership is faced with is that although there are several different initiatives addressing health that are active in the county, there is still a sense amongst residents that not enough work is being done. Residents do not want to see temporary fixes, they want to see and experience permanent change in the county regarding health outcomes. Although some are optimistic about future directions, it is important that local residents are made aware of what transformative changes are taking place in the county and what role they can also play in making hopeful changes into realities.
- Visible and sustainable partnerships and collaborations are needed in the county to address many of the health concerns that were shared by the representatives. Residents and leaders of county organizations, systems and businesses need to have more opportunities to collaborate and plan so that they can execute and have more "buy-in" on various community and evidence-based health approaches in the county.
- More needs to be done to address issues surrounding rising immigration, gentrification, chronic diseases and behavioral health issues.

Methodology

Sample: Twenty-nine individuals were identified by the area hospitals and PGCHD as key informants. These individuals represented local government; hospital systems, patient advocates; faith-based organizations; the public school system; local politicians; academia; public safety; safety net providers; state government; physician providers; private industry; local philanthropy and special populations. The representatives reside and work in all areas of the County. Of the 28 potential respondents, 14 individuals completed the interviews. Despite multiple attempts to schedule interviews, it is recognized that there are various groups that were not represented due to lack of response and/or time limitations. However, efforts were made to include representation in the Community Expert Survey for under-represented populations to ensure inclusion in the Community Health Assessment process.

Appendix A presents the list of persons who completed the interviews.

Interview Protocol: The comprehensive interview guide developed for the 2016 Community Health Assessment was utilized for consistency (see **Appendix B**), which consisted of 17 open ended questions with related probes. The guide addressed the following focus areas: assets and barriers relative to health promotion in the County; opinions on the leading health threats currently facing the County; specific priorities in the areas of physical, behavioral and environmental health; and emerging threats to residents' health. All interviews were conducted by Dr. Sylvette LaTouche-Howard, a Clinical Professor at the University of Maryland School of Public Health.

Implementation: The interviewer conducted all of the interviews by telephone. Interviews ranged from 30 to 75 minutes in duration, and respondents were emailed the questions in advance of the interview. All interviews were conducted between April 8, 2019 and May 7, 2019.

Analysis: Preliminary analysis of the interview data occurred at the conclusion of each data collection activity. The interviewer identified and recorded first impressions and highlights. The second stage of analysis identified common categories and overarching themes that emerged as patterns in the data. In the presentation of the interview findings, key patterns are reported along with supportive quotes.

Question-by-Question Analysis

1. What is your organization/ program's role relative to the health and well-being of County residents?

See **Appendix A** for a list of participants.

2. How long has your organization/ program played this role?

The key informant sample was drawn to reflect various disciplines including local government; patient advocates; faith-based organizations; safety net providers; state government; academia; private industry; and special populations. Local government agencies represented included the Health Department; Department of Social Services; Department of the Environment, Department of Corrections, the Memorial Library System and Police Department. Other respondents included a representative from the County's Chamber of Commerce, a faith leader representing the health ministries in their respective organization, a higher education representative, a local community college representative, two hospital administrators and a safety net provider. The respondents represent over 450 years of active service in the County.

3. In your opinion has the health of County residents improved, stayed the same, or declined over the past few years? What makes you say that?

A little over 40% (N=6) of the respondents believed that over the past few years, residents' health have improved. An equal amount of respondents reported that they believed that the health of the county had either stayed the same or that they were uncertain of the county's status because although some indicators had improved others had declined. The Robert Wood Johnson County Health Rankings Report was referenced by many respondents stating that the county's health was improving as its overall ranking increased over the past few years (currently at #11, an increase from #16 in 2016 and #14 in 2017 and 2018). Respondents also highlighted other indicators, such as: the arrival of the new hospital, increasing amount of conversations surrounding health and well-being in the county, an increase in engagement of organizations in the county with a focus on becoming a healthier county and more awareness of the current health issues.

For those who felt that the health of the county had either stayed the same or were unsure, many expressed that health insurance (lack of and ability to maximize its use) was still a prevalent issue for county residents, mental illness-related issues appeared to be on the rise, and the number of individuals with chronic diseases (e.g., diabetes, hypertension, and cardiovascular disease) and related deaths are increasing in the county.

Chronic disease and mental health were also mentioned by respondents who believed resident health in the county had worsened, while also acknowledging that resolving these issues would be complex. Responses regarding maternal and child health were mixed. Some respondents felt that the county had improved, while others noted that there had been a decline in this area; however, the arrival of the new Deputy Chief Administrative Officer for Health and Human Services, with a background in pediatric care, to the county's executive team, led some to believe that issues in this area will improve. All respondents reflected an overall sense of vigilance about the health of the county:

> *"Our county is healthier according to their (RWJ rankings) criteria, we can claim that. We are not satisfied with that however because we use other criteria and those areas like STD's and Cancer rates we are not getting better, we have a lot of work still to do".*

4. What are the County's three most important assets/strengths relative to the health and well- being of residents?

Due to the varying roles the respondents have in the county, responses ranged across an array of different answers. The most common responses were (in descending order of frequency): the county's vast array of green space and the Prince George's County Parks and Recreation which provides opportunities for physical activity and well-being; the new County Executive and leadership in the county and their commitment to increasing the quality of life for its residents, as one resident stated:

> *"Ms. Alsobrooks talks about Prince George's County as being a treasure and I believe that it is true"*

And a strong sense of community:

> *"The pride of the Prince George's County resident is amazing- so many people want to see this county succeed and that is like none other."*

The UMD Capitol Regional Health Center was viewed as a valuable asset to the county, due to its potential to increase residents' access to health care and provision of a quality health care system that residents can trust. PGCHD also received some accolades for its ability to bring various organizations together in collaboration to address varying health issues for its residents. PGCHD is also seen as leading the effort to design interventions, solutions, and programs that are data-driven and evidence based. Respondents would like to see other County agencies adopt a similar approach as they work in the health arena.

The Prince George's Community College and the Prince George's County Memorial Library System were also mentioned as an asset to the county for providing quality, affordable training and resources to support the workforce and offering courses to residents to keep them marketable (PGCC) with up-to-date information and resources (Memorial Library System).

5. What are the County's three most important barriers relative to the health and well-being of residents?

In contrast to the variation observed in the responses about the County's assets relative to health, there was a consensus about the most important barriers (in descending order of frequency): limited access to healthcare due to lack of insurance, transportation issues, poverty, provider shortages, housing, perception of health care in the county, limited access to healthy foods as evidenced by food deserts in some communities and the pervading presence of fast food restaurants in lower wealth areas; and poor adoption of behaviors and activities that promote healthy eating and active living.

<u>Access to Quality Care:</u> Respondents shared that while the county has great resources, they were not always accessible to all residents. Additionally, there was a predominant perception that not enough money had been invested in the health of county residents in the past, which is why the county is currently dealing with so many chronic disease and other health-related issues. Although there is a lot of optimism surrounding the new

regional hospital center, respondents were aware that the hospital system could not solve all of the problems in the county, and, they felt it was important that somehow residents understood that, or that it was communicated to them. Some respondents shared that they felt that a concerted and combined effort of all of the organizations (public and private) in the county was imperative if the county were to overcome the access barrier:

> *"We need to work better together-there is not a concerted effort to address the social determinants of health so that we can fill in the gap because the health care budget cannot do it all".*

The overall perception of poorer quality of care in the county was an issue raised by approximately one-third of the respondents. Respondents shared that the healthcare system needed to *"regain the trust"* of its residents as many of them are getting their care outside of the county.

> "*We have approximately 63 percent of our population going outside of the county for (their) care and we have 8 out of 10 babies (who) are born outside of Prince George's County so the resident mothers are choosing 8 times out of 10 to have their babies delivered somewhere else and that is a very personal choice."*

Transportation:

> *"There are some really beautiful places where you can go but really you can't go to them because you don't have a car" The purple line may help with some of that but then again the purple line is going to displace a whole bunch of people".*

Transportation issues were mentioned by several respondents. Many shared that in order to get around the county and experience the best that the county has to offer, transportation is a must. Moreover, respondents said that the existing transportation system was not extensive enough to meet the need of the residents, thus causing residents with access to vehicles to use them a lot more than perhaps desired:

> *"We are still too vehicular dependent even though we have a lot of metro stations, you still even have to drive to a good grocery store."*

Poverty: Whether it was the issue of displaced populations due to gentrification (the perception that many individuals who can no longer afford to live in the District are currently moving into the county) or it was viewed as the income differences in the urban areas bordering Washington, D.C (commonly referred to as "inside the beltway" referring to the area within Capital Beltway or I-495) compared to the areas further away (outside the beltway), most of the interview respondents agreed that areas of concentrated poverty were not only evident in the county but it was a very strong barrier for the overall health of county residents:

> "*We need to have a regional conversation of health and wealth and ensure that our surrounding neighbors stop pushing problems to Prince George's County."*

Some respondents shared concerns that residents living in lower income areas of the county may be eligible for, but did not "take advantage" of, the services available to them, or were not even aware that such services existed. Other respondents believed that low rates of health seeking behavior may be attributed to the increasing cost of healthcare, leading to residents only seeking out needed services only when their health was severely worse.

> "*The county does not have a safety net system and desperately needs one*."

Respondents also shared that it was difficult to get all of your support services in one place, and it was not always easy for a resident to get the services that they need in a limited amount of time:

> *"A resident of the county cannot go to one place and get all the services they need. They have to go to multiple places… sometimes they even have to go out of the county."*

Perception of Care and Stigma: Stigma often serves as a barrier to health seeking behavior, engagement in care and adherence to treatment across a range of health conditions. The lives of people with disease and disability are worsened by stigma which can often contribute to negative implications for health and well-being. Some respondents shared that stigma and lack of awareness may cause some individuals not to seek the care that they needed. Although most respondents shared that reducing stigma was important, a concrete plan on how to do that did not emerge from the interviews.

Access to Healthy Food: According to respondents limited access to healthy and affordable food caused by food deserts, and the presence of numerous fast food establishments do not support healthy eating. Several respondents felt that the combination of a stressful and busy lifestyle and the availability of unhealthy foods in lower wealth areas were a "*recipe*" for the increased rates of obesity and other chronic diseases experienced by residents in the county.

6. What do you think are the three most important social determinants of health in the County? (Social determinants of health are factors related to the social environment, physical environment, health services, and structural and societal characteristics.)

Social determinants mentioned in order of frequency were: Housing, lack of transportation (details included in discussion of Question 5 above), education, economic issues (e.g., employment), access to affordable health care, and access to healthy food (details included in discussion of Question 5 above).

Housing: Over half of respondents shared that housing was one of the most important determinants of health in the county. Several issues about housing were raised:

- Stability: Many residents in the county facing mental health issues also have unstable housing, contributing to their inability to manage their health. Many are considered as "high utilizers" and often are in and out of either the emergency room or the jail system.
- Affordability and accessibility: One respondent noted that some of the best affordable places to live in the county are inaccessible to people who do not have their own personal transportation. Conversely, when housing is accessible and is located in a "good" area, it is usually unaffordable for many residents.

  "Housing is one of the essential things for people, the county still has an opportunity to make this situation better as they think of county growth so that people can grow and thrive in Prince George's County and not have to leave the county…Why is it when the malls are filled and the area gets pretty do all the poor people have to move out?"

- Suitable for all populations: Having housing in the county that is available and suitable for all age groups was also a concern. As the population of the county continues to age, there will be an increasing need for assisted living facilities.

  "As individuals age, many do not want to live in the large homes that once accommodated their large family, neither do they want to live in a nursing home. Also we need to help people to plan. People are out-living their money. And that's a real issue because they do not qualify for nursing home levels of care. But they can't afford assisted living so what are they supposed to do, someone needs to answer that".

  On the other hand, another respondent shared that it was

  "essential that the county consider the type of housing that would attract millennials because they are the working individuals needed to help the economy to thrive and based on the current housing trends most of them will not want the big houses that were created in county in the late 90's and early 2000's".

Education:

"We cannot fix the health of individuals if we don't fix the education system"

Nearly half of the respondents chose education as one of the top three social determinants of health in the county. Many were concerned about the overall quality of the K-12 public school system. Many respondents were encouraged that this was a priority for the new County Executive; however, understandably, many felt that it would take a while to see a shift happen. In the meantime, the status of the school system will still affect the health of the county. Respondents felt strongly that in order to have a thriving county, you need children that are also thriving, that are healthy and have good mental health. One respondent shared that many individuals are reluctant to send their children to the public school system in the county and may even make them reconsider staying in the county.

"You only get one chance with your kid's education."

Many also shared their feelings about the importance of the schools making a commitment to providing more recreational activities/physical education classes so that kids can learn about their bodies and their overall health.

Economy: Employment, more specifically livable wage employment was a concern for over half of the respondents.

"We need to push for GOOD livable wages; yes it hurts small businesses because they cannot always afford to pay $15-16 an hour and we have to figure that out, but then again how are people supposed to live?"

The increasing amount of residents working outside of the county because of higher wages/salary compensation was also a concern.

"Nearly 70% of the work population live outside the county. When you are not making the PTA meeting it is because you are on the road, or missing the civic council meeting or any type of civic duties you cannot do because you work outside the county. So we need to do better with work and place so that people can be the citizens we desire them to be."

Many respondents cited lack of access to opportunities and lack of resources for some county residents were by-products of the poor economic conditions in the county.

7. What do you think are the three most important physical health needs or concerns of County residents?

Chronic diseases, such as Type 2 diabetes, cardiovascular disease, cancer and hypertension were mentioned by two-thirds of the participants. All respondents were concerned about the overall physical health of county residents and believed that provider care (whether it was access to or availability of) was a major issue in the

county, strongly related to the amount of physical health conditions existing in the county. The lack of regular routine checkups, trust of medical professionals in the county, and the lack of adequate healthcare were cited as possible causes for some of the physical health issues experienced in the county. One respondent shared that, because some residents only seek care when they are severely ill and/or cannot manage their daily activities, they end up being more severely plagued by their chronic condition when it could have been better managed if they had sought earlier treatment.

Physical health management was also cited as an issue respondents felt needed to be addressed, ranging from having adequate transportation to get individuals to their medical care appointments, to helping a resident manage their multiple comorbid conditions. Obesity was also frequently mentioned, both as an effect of another physical health concern (e.g., lack of access to healthy food options and/or walkable areas) or as a risk factor for other chronic diseases. Family planning, dental services and mobility for seniors were also mentioned.

8. What do you think are the three most important behavioral/mental health needs facing the County?

All respondents expressed that the rising incidence of behavioral health problems among adults and children, the stigma around seeking help for mental conditions, and the limited access to behavioral health services due to a lack of providers, are three pressing problems in the County. Substance abuse, depression, anxiety, and suicide provoked by the stresses of long commutes, the high cost of living, limited social support, and for some immigrants and seniors, feelings of isolation from the greater community, are prevalent concerns. Some respondents mentioned the relationship between poor mental health and overall health, stating if residents are not feeling overwhelmed by mental health issues, they are more likely to engage in activities that are good for their overall health (e.g., physical activity, healthy eating, or going to medical appointments). Most respondents felt that the mental health issues in the county need to be addressed immediately, as these issues are the basis for the overall health of the residents in the county.

> "*The mental health issues have gotten really out of proportion; people are feeling inadequate, they are turning to all kinds of ways that they can alleviate the pain."*

Many respondents believed that seeking mental health treatment was traditionally stigmatized in the African American community and other communities of color and that not enough was being done to reduce the stigma. Others believed that residents were

not aware of the available resources or the mental health indicators they should be aware of, either for themselves and/or others.

There was an overwhelming sense of concern and a need for more resources for children, adolescents and homeless populations. The majority of the respondents mentioned that homelessness was related to behavioral health and that homeless individuals needed to have stable housing in order to assist with their behavioral health concerns. Some respondents also raised concerns about the high rates of individuals in the emergency room and the jails with behavioral health needs. Similarly, the lack of child and adolescent mental health services in the county, including a need for more dedicated beds and facilities for those age groups, were mentioned.

Many respondents shared that a better understanding of health insurance and its offerings would also be beneficial. Assistance finding qualified mental health providers in the county, could help demystify how the system actually works. The faith community was also mentioned as a place where mental health stigma could be addressed, and mental health care could be promoted. One respondent noted that few of the local faith organizations actively promote care seeking for mental disorders yet are one of the most trusted sources of health information, counseling and social support for many residents, particularly those who lack ready access to healthcare.

9. What do you think are the three most important health-related environmental concerns facing the County?

Nearly all of the respondents cited air quality, water, and responsible land use as their most important health-related environmental concerns.

Air Quality: The quality of the air in the county was a concern to some of the respondents, eluding to the possible relationship between physical health conditions (e.g., asthma) and air quality.

> *"There is a major opportunity to improve the health of the county related to air quality-it affects a lot of pulmonary conditions here, so whether it's the pollen or its summertime, everybody's driving and all those emissions are stinking up the air! I definitely think that the air quality is a concern."*

Water: Most respondents were not certain about factors contributing to their concern about the water; however, many felt that there should be an examination of the water quality and purity based on the increase in flooding that residents experienced over the past few years.

Responsible Land Use: The concerns around responsible land use spanned across several issues. Many respondents were concerned about the abundance of landfills in the county:

> *"...they (landfills) seem to be everywhere, trucks come from all over the state, and it seems to bring their trash into Prince George's County."*

Other respondents shared concerns about development projects in the county and their effects on the abundance of green space in the county. One respondent felt that all of the development in the county was encroaching on the community and that more attention needed to be put towards maintaining and creating more walkable green spaces and installing more bike trails so that residents could be less dependent on their vehicles.

> *"Parks are great, but if no one can get to them or they are too far away, it is not of much good to most people."*

> *"We need more complete streets when they are building the new construction projects. The type of streets that they promote all types of traffic be it physical like walking or biking or driving a car, in a safe manner."*

Personal responsibility was mentioned by some of the respondents, such as community cleanliness and demanding more information about environmental health issues.

> *"We talk about gorgeous Prince George's but people have to be accountable for their personal environments as well."*

Other areas of environmental health concerns mentioned included: road infrastructure, transportation concerns, quality housing, food insecurity, and lead in older homes.

10. Now if you had to prioritize and select the three most important health issues facing the County from among those you just mentioned what would they be?

Nearly all respondents mentioned behavioral health and chronic disease as the most important health issues facing the county. The third most important health issue was a tie between housing, access to care, education (quality amongst K-12 schools in the county) and issues related to healthy eating (i.e. food insecurity, food deserts). Several respondents expressed that the reputation of the county will be based on our ability to address the aforementioned issues and that our health ranking in the state will remain relatively the same unless we address these issues. All agreed that intentional discussions and action plans surrounding these issues were essential. Several

respondents mentioned the need to address persons who utilize hospital inpatient and emergency services because they either lack a medical home and/or do not practice effective self-management.

Respondents were equally adamant that the County must curtail the proliferation of fast food restaurants, actively work to end food deserts, and make farmers markets and full service supermarkets readily accessible to all residents. Respondents proposed that increased public and private collaboration to raise awareness of available services and resources through social marketing campaigns and enhancing the capacity of faith- and community-based organizations would further this goal.

Many respondents agreed that the County should put health at the center of all its planning, including economic development, education, housing, and transportation. Policies that support living wages, the expansion of the safety net, and the creation of more jobs within the County will reduce poverty and thereby reduce financial stress. Less stress will allow residents to focus more on prevention and have the financial resources to practice effective preventive behaviors.

11. In what way does your organization/ program address each of the three issues you just mentioned?

Efforts to address the myriad of health problems and concerns raised by the respondents fell into three main categories: direct services; community health education and outreach; and partnerships and collaborations.

Direct Service: All of the direct service providers reported working at capacity and still being unable to meet the demand. Many predict that the demand for services will continue to rise and, given the significant proportion of highly educated residents in the County, consumers will increasingly demand high quality services. All noted that in addition to the provider shortage the non-profit sector particularly in the area of supportive services is very underdeveloped often leaving providers with no referral options.

Education and Outreach: Many respondents felt that one of their most important roles was to provide community health education and outreach to local residents. Several respondents expressed they wished to do more; however, their organizations were already at capacity and needed to expand to be better equipped to provide needed resources to additional residents in Prince George's County.

Partnerships and Collaborations: Several respondents reported having partnerships and collaborations with various local, state and national organizations and were passionate about the importance of collaborating with others for the benefit of the local residents.

Additionally, respondents were adamant about not "meeting for the sake of meeting" and actually having productive and engaging conversation *and* action surrounding the vast array of issues that were significant in the county.

12. How well is the County as a whole responding to these issues?

> *"I am encouraged by the conversations that we have had here in the county. I am seeing it more and more, where people are at least willing to have the conversation and then doing something about it."*

All of the respondents emphasized that they were optimistic about the current direction of the County Executive and their push towards a better Prince George's and being "*all in*."

> *"The County Executive is generating a lot of hope, and I believe we will see the results."*

The majority of the respondents were mindful that change does not happen rapidly but in fact takes several years to see positive outcomes. Most respondents mentioned that there definitely was a "*buzz*" and that lots of conversations were being held in the county about creating strategies to reduce and eliminate many of the health issues that county residents were dealing with. Many respondents eluded to a sense of urgency, noting that many of the health issues they discussed were not new to the county, yet, there was still so much that needed to be done. Respondents felt that residents were getting frustrated and inpatient, and a few questioned if health was seen as a priority to the local county government based on how long issues have taken in the past to be financially addressed.

> *"The county is responding; it's a slow conversion. It's as if there are a tsunami of responses, when the county is confronted with the facts of a crisis, they start to move towards healthier behaviors. This is because health is not a priority in the county. It has been this way for a number of years, perhaps it is due to the lack of dollars that come into the health department, it has not had adequate systems to address specific needs and disease states for several years."*

Some respondents were not confident that the county had done its fair share in the past to reduce the prevalent health issues in the county. Regarding that level of confidence:

> *"I honestly do not think they are, When the county shuts down services for pregnant women, that is an indicator of how they feel although it was*

because they said that they could not afford it, it does not push the problem away, in fact it gets bigger. The County is very good at planning and doing really good reports… However, there needs to be more planning and sometimes there is but there needs to be more follow through".

A number of respondents shared that the county was developing rapidly, perhaps more rapidly than anticipated, whether it be through immigration, increases in births and/or individuals moving into the county from the surrounding jurisdictions. Based on all of the rapid changes in the county, the majority of the respondents shared that there is a strong need for an executable action plan for all residents that is easy to follow and monitor.

Respondents supported the hospital and investment in the facility, but the management of the hospital concerning to some of the respondents, wanting to ensure that the enthusiasm would remain the same even after the "ribbon cutting."

"We have a new hospital that's coming but hopefully we will get all of the services that we need, no matter how much money it costs because care costs money, In order to save money you have to spend money, spend money on the prevention you guys spend money to make sure people are insured and make sure that they use their insurance, make sure that there's access to services. If we don't spend money on the front end, we will definitely spend it on the other end and it will cost more."

13. What more needs to be done and by which organizations/ programs?

"There is a lot to do, but we all have to "step up."

Promoting service integration across public and private providers and developing systems of care for physical and behavioral health were noted as high priorities by most respondents. Furthermore, the desire to have as many agencies, organizations and institutions around the table for a guided discussion with this same question pertaining to the health of the residents was important.

"Everyone needs to come to one central table and we all sit at the table, have a community to county forum and all other professional/educational programs in the county. There is no forum that I know of for everyone to share with each other."

Many respondents suggested that the Health Department's should be responsible for getting that accomplished; some respondents specifically mentioned two Health Equity forums in 2018 that brought various stakeholders together as an example. This would

entail spearheading a more comprehensive, but streamlined, health planning process countywide that engages a wide array of stakeholders; increased care coordination efforts; and leveraging the expertise of local academic institutions to ensure that proposed interventions are state of the art and evidence-based and then sharing the findings to help the navigation process for next steps.

> "*This is an opportunity for the Health Department to produce the research and the data that supports whatever we're going to conclude will be our largest challenges and demonstrate that to folks and then go from there I don't think there's any better advocate than our County Executive to take up the charge on that, but then she can't be everywhere and would need others to help lead the charge."*

The majority of the respondents expressed a need for increased services for *all* residents, especially young families and senior citizens. An increase in transportation services, especially for senior residents, was referenced to enable community engagement.

> *"It's fine to have a ride to the doctor but there's a whole lot of other things that people want to do and should be able to do…You always have to pay someone to take you to church well maybe you want to go to Bible study on Wednesday nights or in the morning and you just can't get somebody to drive you. Yeah, your adult children will take you to the doctor but what about getting your hair done, or getting your nails done. Those to me are quality of life issues. And so once people can do that or be in walkable communities where those things are, that is a big deal."*

Most respondents pointed to the local government to provide these much needed services to the county. All of the respondents agreed that more funding needed to be distributed to organizations and agencies that worked for the betterment of the residents in Prince George's County. The majority of respondents strongly suggested that two entities that could benefit from more funding would be the Health Department and the Department of Social Services because of their dedication to the county and the fact that they desperately need more resources to address the increasing needs of the residents.

Two other important needs identified were attracting more service providers to the county, either through a county-supported loan forgiveness program or another incentive to attract early career primary care providers to the community; and education.

> *"In order to have individuals that are thriving, they need to be healthy, have good mental health, have good housing, have good physical health, so all of these areas need to collaborate/comingle for the benefits of the*

children. Schools need to make commitments to recreational activities/physical education classes so that kids can learn about their bodies, their overall health."

Most of the respondents shared that they knew that funding was difficult to attain; however, they believed that, because the county government should know that, they would need to be very creative with their public-private partnerships and other entities.

"I would like to see the county be more creative in accommodating and filling these existing gaps, for instance we have tremendous provider gaps. The poorest ratio of primary care providers per capita, we need to attract more providers"

The sentiment among most of the residents was although it takes a lot of work, it is possible, and, as one respondent stated: *"If they can do it for the purple line, why can't they do it for healthcare?"*

The role of nonprofits was less clear. Respondents expressed the sentiment that more nonprofits need to be involved in addressing the County's health needs but acknowledged that many lack the capacity to do so.

"We have to address the nonprofits, we have to create a pathway for them to survive, we have to build an economy that supports them."

Therefore, a pressing priority is capacity building for non-profits so that more may participate meaningfully in promoting and protecting the health of residents is necessary. Capacity building may include technical assistance in board development, grant writing, and program planning, monitoring and evaluation in addition to professional development to ensure that staff is linguistically and culturally competent. Respondents did not identify who should deliver the proposed capacity building or how it would be funded.

14. What resources are needed but not available to address each of the three issues?

The majority of the responses centered around housing, transportation, the economy (e.g. sources of funding and the workforce), and health and human services as essential resources needed to address the current key health issues. The majority of the respondents reiterated their concern about housing (detailed discussion in Questions 5, 6, and 10) and transportation (detailed discussion in Questions 5, 6, 7, 9,12 and 13). Respondents also shared that a more concerted effort needed to be made in strengthening the county's economic situation. There is a disparity in the funding allocated to health in the County compared to the funding made available to the health departments of neighboring counties and the District of Columbia. Many suggested that

the county needed to have more innovative collaborations with the surrounding counties based on the fact that individuals travel seamlessly between these geographical locations.

> *"There is not enough innovation in the county to address and challenge the status quo - that is dangerous."*

Other respondents felt that workforce development and placement was paramount. Many residents comprise the workforce in other surrounding counties because there are more opportunities and higher wages, and we are not doing our best to compete. Most respondents mentioned that an increase in health and human resources was needed for the viability of the county, citing having more practitioners, especially practitioners based in the county that they serve, more behavioral health beds, and more mobile units to reach the individuals who may need services but are unable to access them.

Another resources mentioned was a more viable education program for 0-5 year-olds and the K-12 program, adding in health components such as healthy eating and physical activity back into the curriculum. The new hospital system was also mentioned as a resource that the county desperately needs to have active and functioning residents.

15. What are the 3 most important <u>emerging</u> threats to health and well-being in the County?

There were several issues of concern for emerging threats to health and well- being in the county. The most common concerns were the health resources needed for the growing immigration population, gentrification, chronic disease, and mental health conditions.

<u>Immigrant Population Health Needs:</u> Many respondents shared that they were encouraged and pleased with the increased diversity of the county. However, many respondents were concerned that there did not seem to be a clear plan as to how to address the increased amount of immigrants who were entering into the county with varying health concerns and no health insurance.

<u>Gentrification</u>: Many respondents shared that there are several issues that surround gentrification and with individuals leaving the District of Columbia (primarily), there may be a feeling of identity loss for some individuals which could lead to various behavioral health concerns such as stress and depression, moreover, many of these individuals may not have all of the health coverage that they need to address some of their health concerns which will "pull from" the already limited resources in the county.

Chronic Diseases and Mental Health: Many respondents were concerned about the increasing rates of obesity, diabetes, cardiovascular disease and cancer and felt that it was hard to "wrap their minds around" how to confront this emerging threat in the county. Many shared their opinions about the cyclical nature of these conditions and made a connection between the high levels of mental health concerns, such as stress and depression, and the behaviors that individuals may engage in to reduce the stress, such as eating unhealthy foods, consuming substances and the lack of physical activity, thus making them vulnerable to chronic diseases. The rising rates of certain diseases in adolescents and children were also of concern.

> *"Stress is compromising our immune systems; it is also leading to depression and teen suicide, our children are stressed, stressed of going into poverty or being in poverty and feeling isolated, now they have rising rates of hypertension and diabetes, we must figure out a way to reduce community stress."*

Issues related to chronic disease and an aging population in the county was also raised as a concern.

> *"They (the older adults) will have more chronic diseases and complications-are we ready? Are we ready for the population to be 20, 30, 40% older adults?"*

Other potential emerging threats that were shared surrounded issues, including: efforts to dismantle the Affordable Care Act; the political environment; consumer confidence; increased use of technology and the role that it plays in the everyday lives of county residents (e.g., texting while driving, cyberbullying, gambling, gaming); substance use (e.g., unknown effects about legalizing marijuana and the opioid crisis); and climate change.

> *"We cannot ignore the major impact of climate change on the eastern seaboard is increased storms and more fierce storms and what the impact is, meaning more flooding. Hundreds of homes…are experiencing flooding every year people are quite frustrated by that."*

16. How is your organization/program addressing these emerging threats?

Aside from sharing information where appropriate to their respective targeted population, respondents uniformly agreed that, although they are able to identify several threats, their organizations are not able to address all of them because they are too occupied with responding to current needs. In addition, some respondents believe that

the identified threats require a uniform, comprehensive approach and not siloed actions undertaken by individual organizations. Some respondents shared that, whenever possible, they do their best to join organizations, coalitions or task forces and they direct individuals to the services that they know exist in the county. Others addressed emerging threats through lobbying activities, advocacy, strategic communication, tailoring existing funds to meet emerging needs, attracting businesses to the county, integrating health into other activities, helping individuals to see all aspects of health as being important to one's overall well-being, and creating networks.

17. Do you have any other comments to add relative to health and the County?

> *"The key to growing and successful community starts with each family, each individual in the community and no one's needs should be less or less prioritized than another person's needs"*

The respondents' closing remarks centered on the following key recommendations: the County needs to improve access to care by strengthening the safety net; attend to the behavioral health issues that are prevalent in the county; develop and implement a strategy to address the existing and rising chronic disease conditions; foster stronger collaborations across all related entities in the county and ensure stable levels of funding that are commensurate to the size and scope of identified and emerging health needs in the County. Overall, all of the respondents were optimistic about the future of the county and its direction and they were ready to see (and continue to work towards) significant change.

> *"We have never had more real potential or people aware of our potential."*

> *"We each have to take a role in redefining this county in the region and in our own backyards"*

Appendix A: List of Key Informants

NAME	ORGANIZATION	TYPE
Georgina Agyekum Manzano	First Baptist Church of Glenarden	Faith-based
David Harrington	PGC Chamber of Commerce	Business
Cathy Stasny, RD, L.D.	PGC Area Agency on Aging	Seniors
Maria Gomez	Mary's Center	FQHC, Hispanic Population
Ernest Carter, M.D.	PGC County Health Department	Local Government
Gloria Burnet Brown	PGC Health and Human Services	Local Government
Angela D. Anderson	PGC Community College	Higher Education
Joseph Wright, M.D.	UM Capital Region Health	Medical
Robin Jacobsen	Prince George's County Memorial Library System	Community
Dushanka Kleinman, D.D.S., MScD	University of Maryland, College Park	Higher Education
Mary McDonough	PGC Department of Corrections	Local Government
Joseph Gill	PGC Department of the Environment	Local Government
Tiffany Sullivan	University of Maryland Capital Region Health	Hospital System
Henry Stawinski III	Prince George’s County Police Department	Local Government

Appendix B: Community Health Needs Assessment

Key Informant Interview Protocol

1. What is your/your organization (program's) role relative to the health and well being of County residents?

2. How long have you/ your organization/ program played this role?

3. In your opinion has the health of County residents improved, stayed the same, or declined over the past few years? What makes you say that?

4. What are the County's three most important assets/strengths relative to the health and well being of residents?

5. What are the County's three most important barriers relative to the health and well being of residents?

6. What do you think are the three most important social determinants of health in the County? (Social determinants of health are factors related to the social environment, physical environment, health services, and structural and societal characteristics.)

7. What do you think are the three most important physical health needs or concerns of County residents?

8. What do you think are the three most important behavioral/mental health needs facing the County?

9. What do you think are the three most important health-related environmental concerns facing the County?

10. Now if you had to prioritize and select the three most important health issues facing the County from among those you just mentioned what would they be?

11. In what way does your organization/ program address each of the three issues you just mentioned?

12. How well is the County as a whole responding to these issues?

13. What more needs to be done and by which organizations/ programs?

14. What resources are needed but not available to address each of the three issues?

15. What are the 3 most important <u>emerging</u> threats to health and well being in the County?

16. How is you/ your organization/program addressing these emerging threats?

17. Do you have any other comments to add relative to health and the County?


COMMUNITY EXPERT
survey

COMMUNITY EXPERT SURVEY

Introduction

Prince George's County is diverse and our growing population has a wide range of needs, disparities, and perceptions about health. The Community Expert Survey was developed as a strategy that complements the overall Community Health Assessment (CHA) goal of identifying the health needs and issues among the county's different populations, through providers, community-based organizations, local governments, and population representatives that can speak for the communities they serve.

Methodology

The Core CHA team provided lists of community-based partners and providers to be included in the survey; this included the membership of the Prince George's County Health Action Coalition, as well as hospital board members, partners, and community leaders. The survey was developed based on existing community surveys, with some modifications specific to the county. Efforts were made to ensure the survey questions corresponded with the Community Resident Survey which was also part of CHA data collection efforts. An email request was sent to approximately 270 participants by the Prince George's County Health Department with an electronic link for the survey on April 12, 2019 with efforts made to resolve missing or incorrect emails. One reminder request was sent to those who had not yet participated during the collection period, and the survey closed on April 26, 2019.

The survey questions included multiple choice, ranking, and open-ended responses. Each multiple choice question is presented as a simple descriptive statistic. Questions 6 and 8 both required ranking; each ranked score was weighted in reverse order, with the participants first choice having the largest weight, and their last choice with a weight of one. For Question 6 there were three ranked slots, so a first choice was given a weight of 3; for Question 8 with five ranked slot the first choice was given a weight of 5. An example of how each response was weighted is provided below, with 83 participants total responding to the question:

Rank	Number of Responses	Weight	Response*Weight	Sum of Weighted Responses/Total N
1	4	3	12	$\frac{12+6+2}{83}$ =0.24
2	3	2	6	
3	2	1	2	

Not all participants responded to every question; each question includes the number (N) of participants that did respond. Open-ended response questions were initially reviewed for

content analysis, which was used to identify common categories and overarching themes that emerged as patterns in the data. Each response was then reviewed and analyzed according to the categories and themes, with summary responses presented to capture the participants' information.

Participation

Surveys were submitted by 83 participants, with a return rate of 31%. Participants represented knowledge bases from across the county geography. Participants represented a variety of organizations (Question 19): Government Organizations (28.6%), Healthcare Providers (28.6%), non-profits (27.1%), Public Health Organizations (15.7%), Community Members (12.9%), Social Service Organizations (10.0%) and Mental/Behavioral Health Organizations (10.0%); participants also worked with a variety of populations in the county (Question 21).

Key Findings

- ***Healthy community***: Access to healthcare, healthy behaviors and lifestyles, a healthy economy and good jobs, were the most important factors defining a "healthy community" identified by community experts. Almost two-thirds of survey participants believe that the overall health of Prince George's County is unhealthy, and half believe the communities they serve are either unsatisfied or very unsatisfied with the healthcare system.

- ***Leading health issues***: Similar to 2016, chronic disease and related issues including heart disease, diabetes, stroke/hypertension and poor diet led as the most pressing health issues for the overall county, although every health issue was designated either a major or moderate problem by at least half of community experts. By ranking, diabetes, mental health and homelessness were the most important health issues identified by participants.

- ***Access to healthcare***: Participants were more likely to disagree or somewhat disagree that most residents could access providers in the county, including: mental health providers (75.4%), medical specialists (62.4%), dentists (50.7%), and primary care providers (45.5%). Over half of survey participants disagreed or somewhat disagreed that providers incorporate cultural competency and health literacy into their practice, as well as accept Medicaid or provide services for residents who do not qualify for insurance. Two-thirds of survey participants disagreed or somewhat disagreed that transportation is available to the majority of residents for medical appointments, and 83% disagreed or somewhat disagreed residents can afford their medication.

- ***Leading barriers****:* The most significant barrier to accessing healthcare in the county identified by participants was the lack of health insurance, followed by the inability to navigate the healthcare system, the inability to pay, basic needs not met and the lack of health literacy in the community and in practice.

- ***Resources to improve access:*** Survey participants identified key areas of resources that are needed to improve health care access in the county (those with at least 10 responses):

    - *Better health navigation, education and information* – increased community health worker capacity in the access pathways and supporting training for those community health workers; incorporating cultural competency throughout the entire process; special considerations for the aging and homebound; health literacy education for consumers;

    - *More access to those providers with improved quality* – more providers that are culturally competent; more providers accepting all types of insurance and/or providing services to the uninsured; providers closer to public transportation;

    - *More behavioral health capacity* – more behavioral health providers throughout the county; more crisis beds for psychiatric emergencies; more services for children and adolescents;

    - *Transportation options* – an improved public bus system in the county; subsidized use of ridesharing applications for medical appointments; more low-cost and/or free options;

    - *Basic needs assistance* – more affordable housing options, better services for the homeless population, more job training and placement;

    - *Affordable health care* – help for those that can't pay for their medications and help with out-of-pocket costs (e.g., high deductibles, co-pays, etc.).

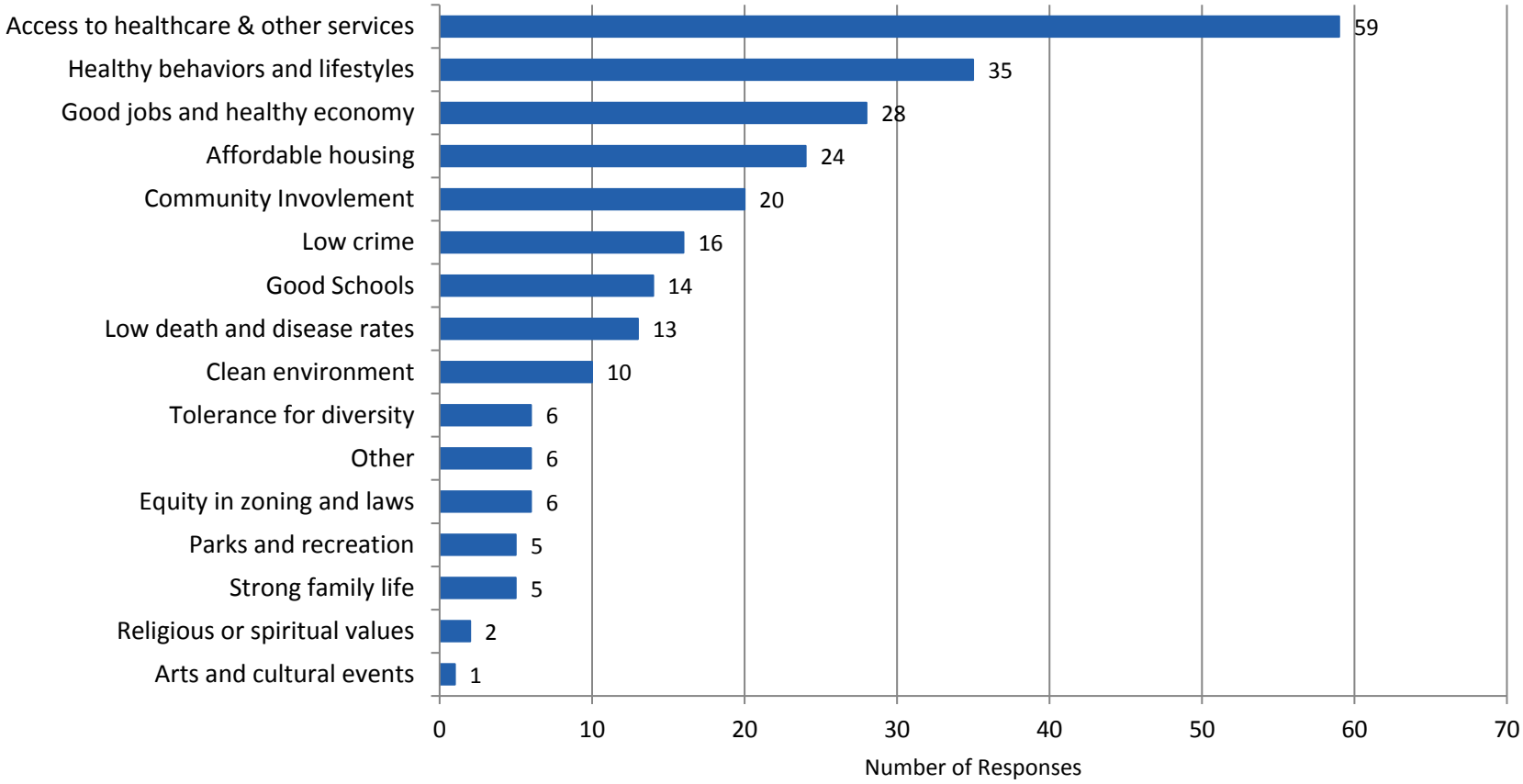
- ***Underserved populations***: The populations that were selected as most underserved included the homeless, those with low incomes, immigrants, the non-English speaking, and seniors.

- ***Primary barriers to accessing healthcare for underserved populations*:**
    - *Lack of financial and basic resources* – healthcare overall is unaffordable and is not a priority if there are competing needs not met already (e.g., housing, food, work, etc.); low incomes and unaffordable housing are key drivers;
    - *Access to care* – provider participation in Medicaid is low; provider hours are not convenient due to the lack of evening and weekend hours; geographically, services are not evenly spread throughout the county and many seek services outside of the county;
    - *Cultural/language barriers* – there is a lack of bilingual providers and staff, as well as a lack of resources for non-English speakers in the county;
    - *Engagement and awareness of services and resources* – lack of targeted outreach to known populations that typically do not use the healthcare system;
    - *Lack of health insurance* – residents who are ineligible for health insurance will continue to have unmet health needs, primarily immigrant populations; focus on residents that make too much for Medicaid but not enough for private insurance or high out-of-pocket costs.
- ***Recommendations to improve health:*** An increased focus on health inequities and increased communication and awareness were the most frequent recommendations to encourage and support community involvement around health issues in the county. Open-ended responses from participants included an increased focus on healthy lifestyles, health education and outreach, and increasing and improving access to providers and clinics in the county.

- ***What is working well:*** Similar to 2016, participants reported that collaboration and partnerships among healthcare providers, hospitals, health department, and community-based organizations continues to work well. Participants identified that several county agencies are moving towards Health in All Policies as a well to incorporate health considerations across sectors. Programs focused on specific communities and community outreach and education were also viewed positively. As far as healthcare systems, the construction of the new hospital (UM Capital Region Health) was positively mentioned by several participants, as well as the implementation of community/population health initiatives in the hospital systems.

Results

Question 1: What do you think are the **three** most important factors that define a "healthy community" (what most affects the quality of life in a community)? (N=83 responses)

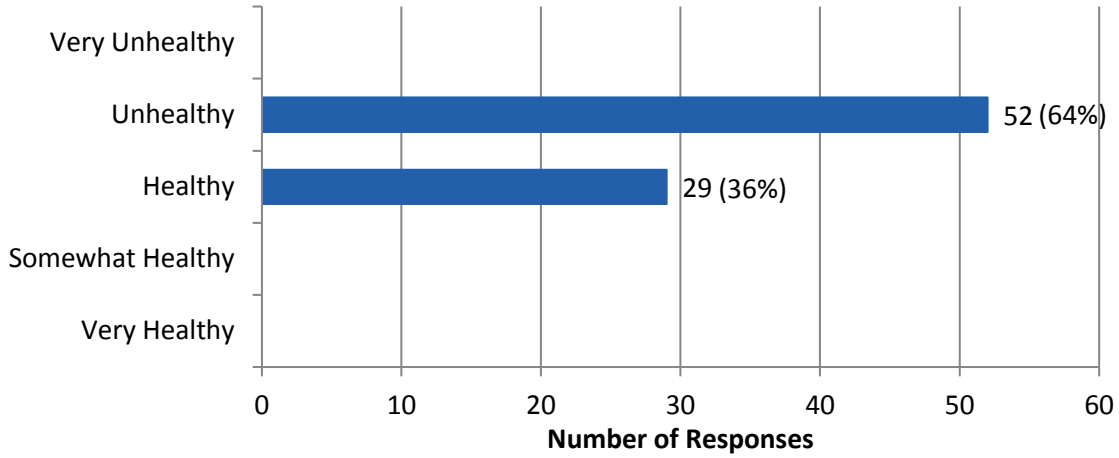


"Other" Included: affordable transportation; safety/feeling safe – beyond low crime levels; access to fresh and healthy foods; lack of poverty; libraries.

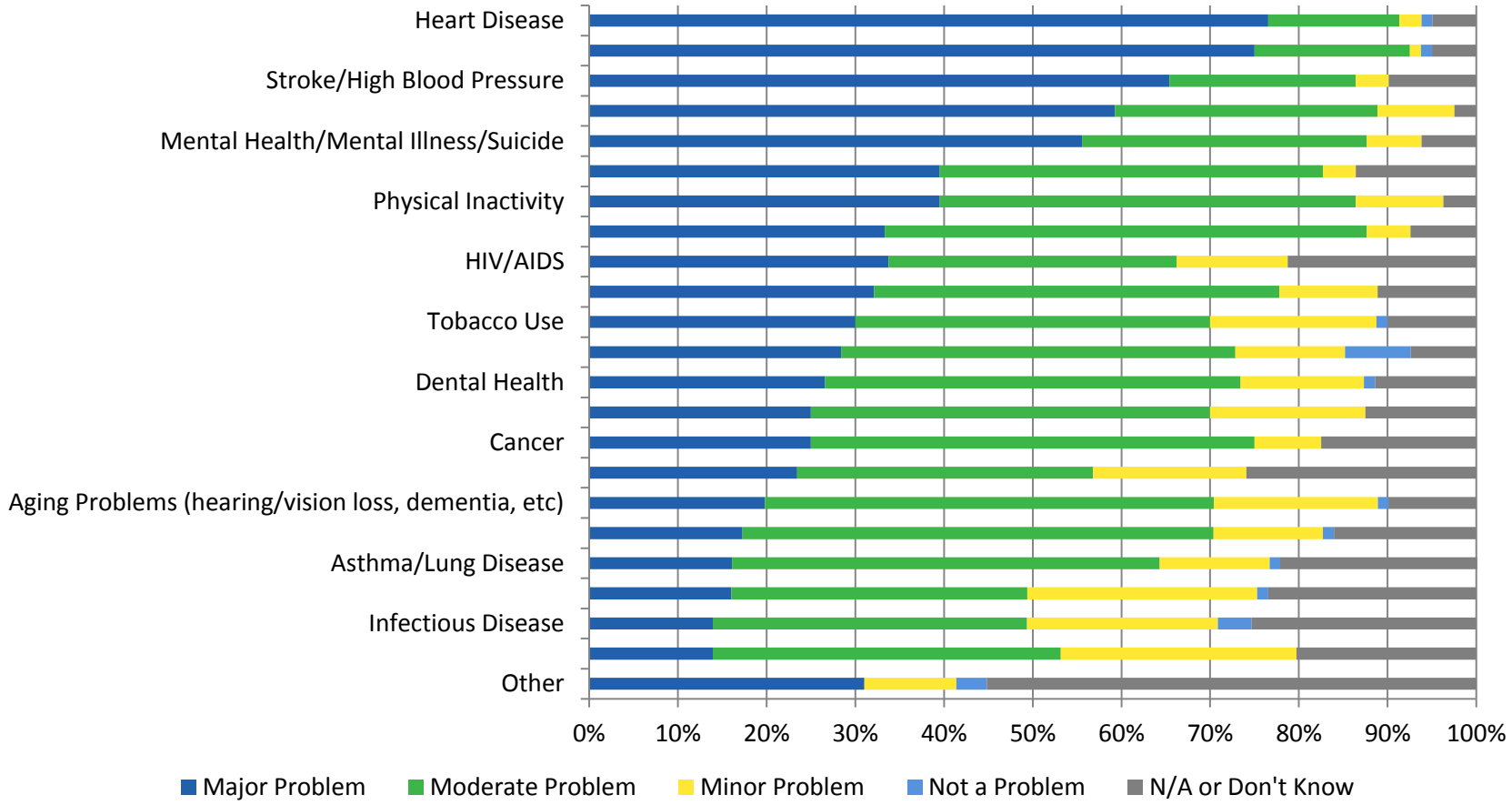
Question 2: How satisfied do you think the Prince George's County communities you serve are with the following? (Number of respondents listed by each statement).

	Very Unsatisfied	Somewhat Unsatisfied	Neutral	Somewhat Satisfied	Very Satisfied
The quality of life (N=83)	1 (1.2%)	20 (24.1%)	17 (20.5%)	45 (54.2%)	0 (0.0%)
The health care system (N=83)	13 (15.7%)	29 (34.9%)	11 (13.3%)	29 (34.9%)	1 (1.2%)
A good place to raise children (N=81)	4 (4.9%)	21 (25.9%)	23 (28.4%)	31 (38.2%)	2 (2.5%)
Economic opportunity (N=83)	6 (7.2%)	26 (31.3%)	15 (18.1%)	33 (39.8%)	3 (3.6%)
A safe place to live (N=83)	6 (7.2%)	19 (22.9%)	19 (22.9%)	34 (41.0%)	5 (6.0%)
The quality of the environment. (N=82)	5 (6.1%)	19 (23.2%)	19 (23.2%)	36 (43.9%)	3 (3.6%)

Question 3: How would you rate the overall health of Prince George's County? (N=81 responses)



Question 4: Please indicate if you believe the issues listed below are a major problem, moderate problem, minor problem, or not a problem that impact health in Prince George's County. (N=81 responses)

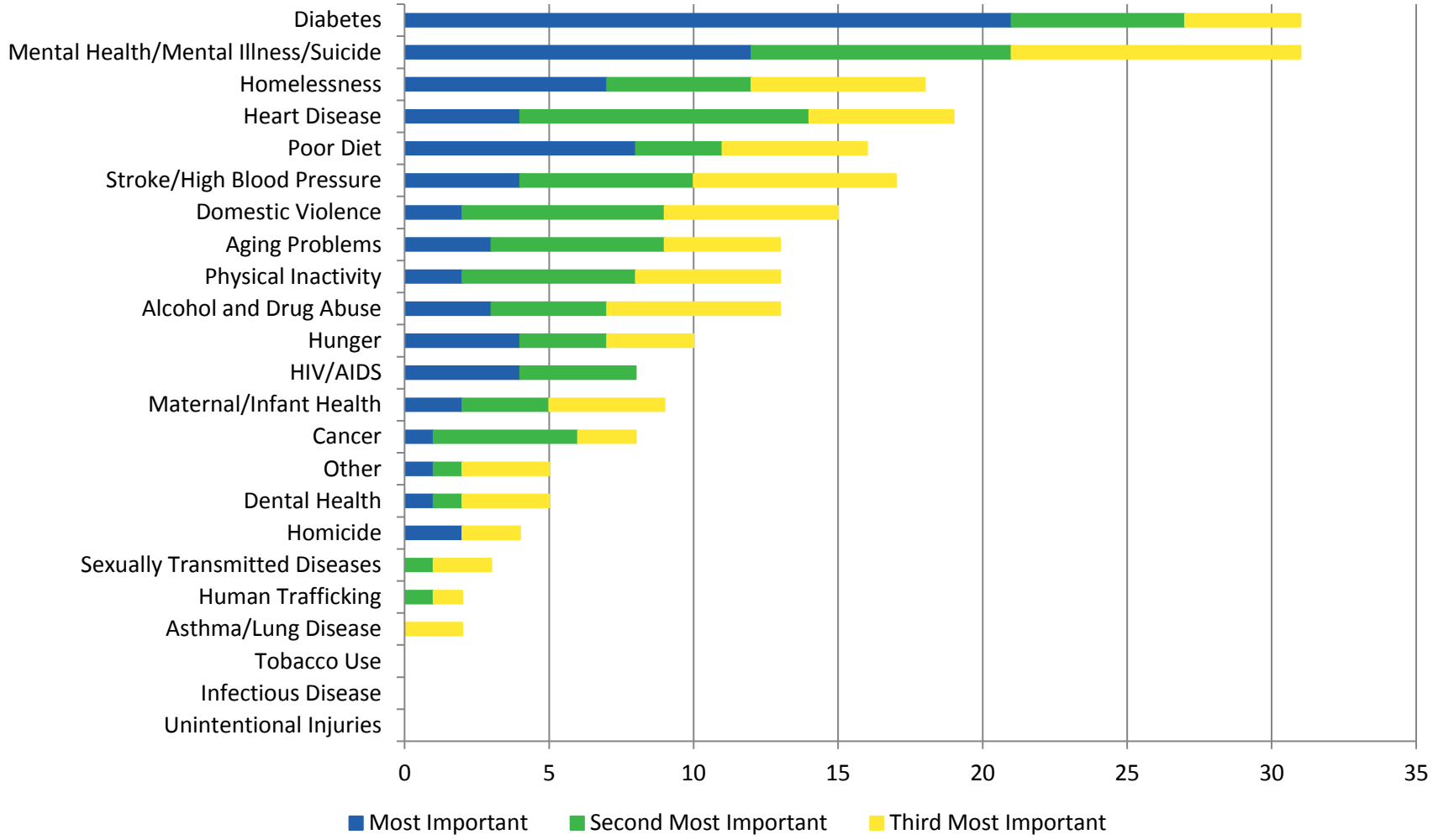


"**Other" Included:** unaffordable housing and lack of transitional housing for those with substance use and mental health issues; obesity; pedestrian and vehicle safety; social isolation; health equity; access/affordability/availability of healthy food; affordable child care.

Question 5: Respondents were asked to share any additional information about health issues in the county in an open-ended response (N=24 responses). The responses are summarized in the table below; many responses included statements about multiple issues.

Issues mentioned	Number of Responses	Summary of Responses
Behavioral Health (Mental Health and Substance Use)	6	Need for more mental health and substance use disorder treatment beds throughout the county; more emergency mental health services for youth; better mental health outcomes for those using public services; suggestion that the county use more core funds on behavioral health beyond State funding; observation that behavioral health is a catalyst for several of the other health issues facing residents.
Awareness, Access and Provision of Available Services and Resources	5	Need to improve the communication and knowledge base about services provided in the county; access to resources about preventative and chronic disease self-management programs are limited; lack of resources to support youth in overcoming daily challenges; little financial support for healthy lifestyle education programs; senior residents have significant barriers to accessing resources (due to social isolation, mobility, etc.).
Social Determinants of Health/Basic Needs	5	Socioeconomic status is a major determinant of health; low income associated with several health outcomes (poor diet, overcrowding, homelessness, substance use, domestic violence, mental health, etc.); affordable housing is limited in the county; K-12 education is not a priority and children are lacking education on life skills; the county cannot simply divide the population into the "haves" and "have nots" as there are many layers to health problems.
Health Disparities/ Vulnerable Populations	5	The number of homeless throughout out the county is on the rise and there is a need for more shelters/housing for this population; immigrant populations in the county may be facing changing health issues (specifically mentioned – African immigrants and the rise in chronic diseases in that population); poor birth outcomes are disproportionate among Black, NH; older populations in the county can be isolated and hard to connect to resources.
Healthy Food Access and Obesity	4	Access to healthy food is very limited in the county (specific mention of south county grocery store options); an accessible healthy diet could be a solid foundation for better health outcomes and subsequent healthcare cost savings; obesity is prevalent and on the rise in the county; extreme overweight is associated with several other health issues facing residents.
Health Insurance/ Affordable Care	2	Sense in the community that many are eligible for health insurance but do not apply for a number of reasons; no safety net for the uninsured in the county.
South County	2	There is little economic development outside of National Harbor; bilingual services are needed greatly in this area as well.

Question 6: From the list for Question 4, please select the three overall most important health issues in Prince George's County. (Shown in order of ranked score) (N=80 responses)

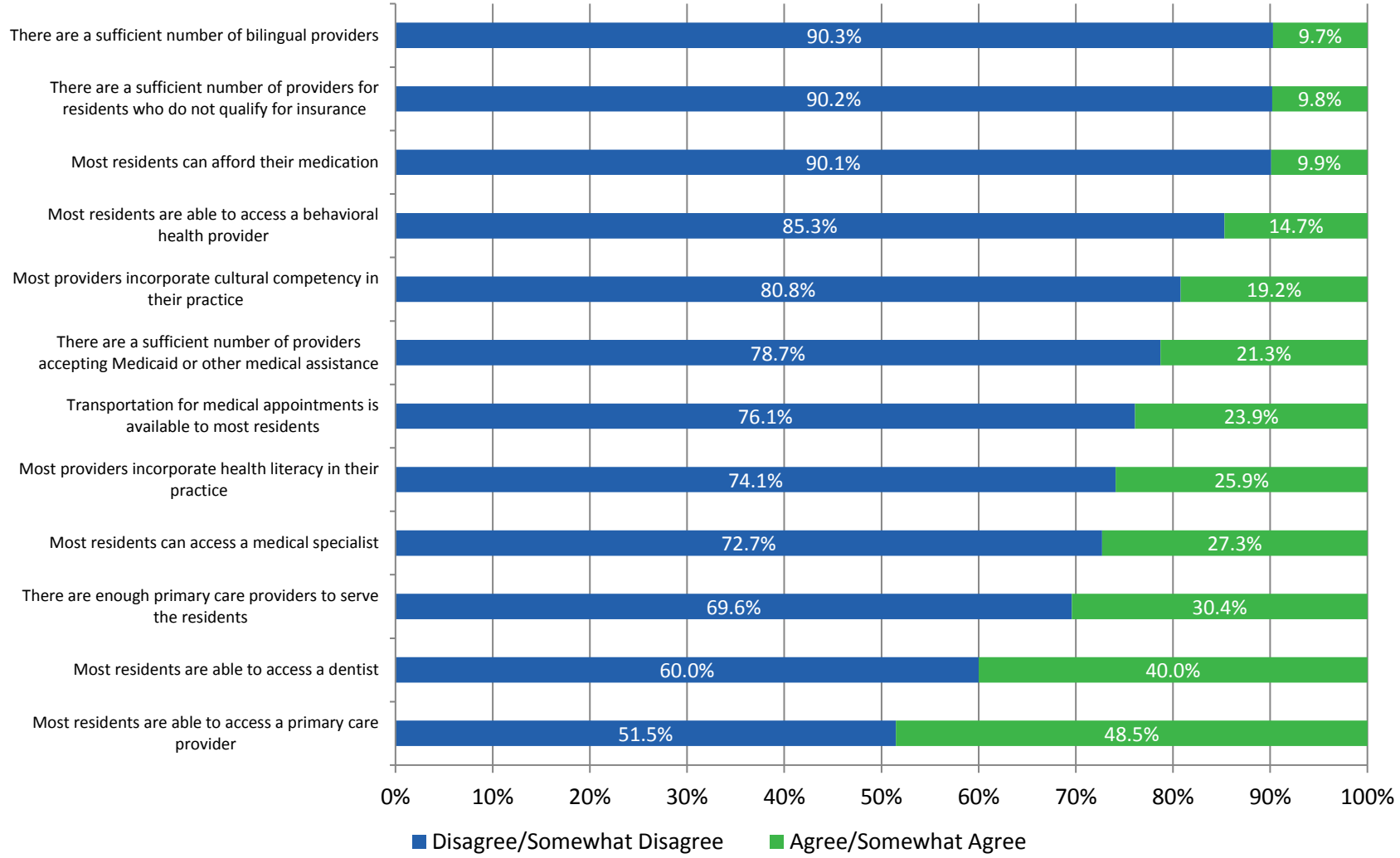


"Other" Included: equitable access to quality healthcare and services; access to good schools; a healthy economy; kidney disease; pedestrian injuries and fatalities; feeling of safety in communities; obesity.

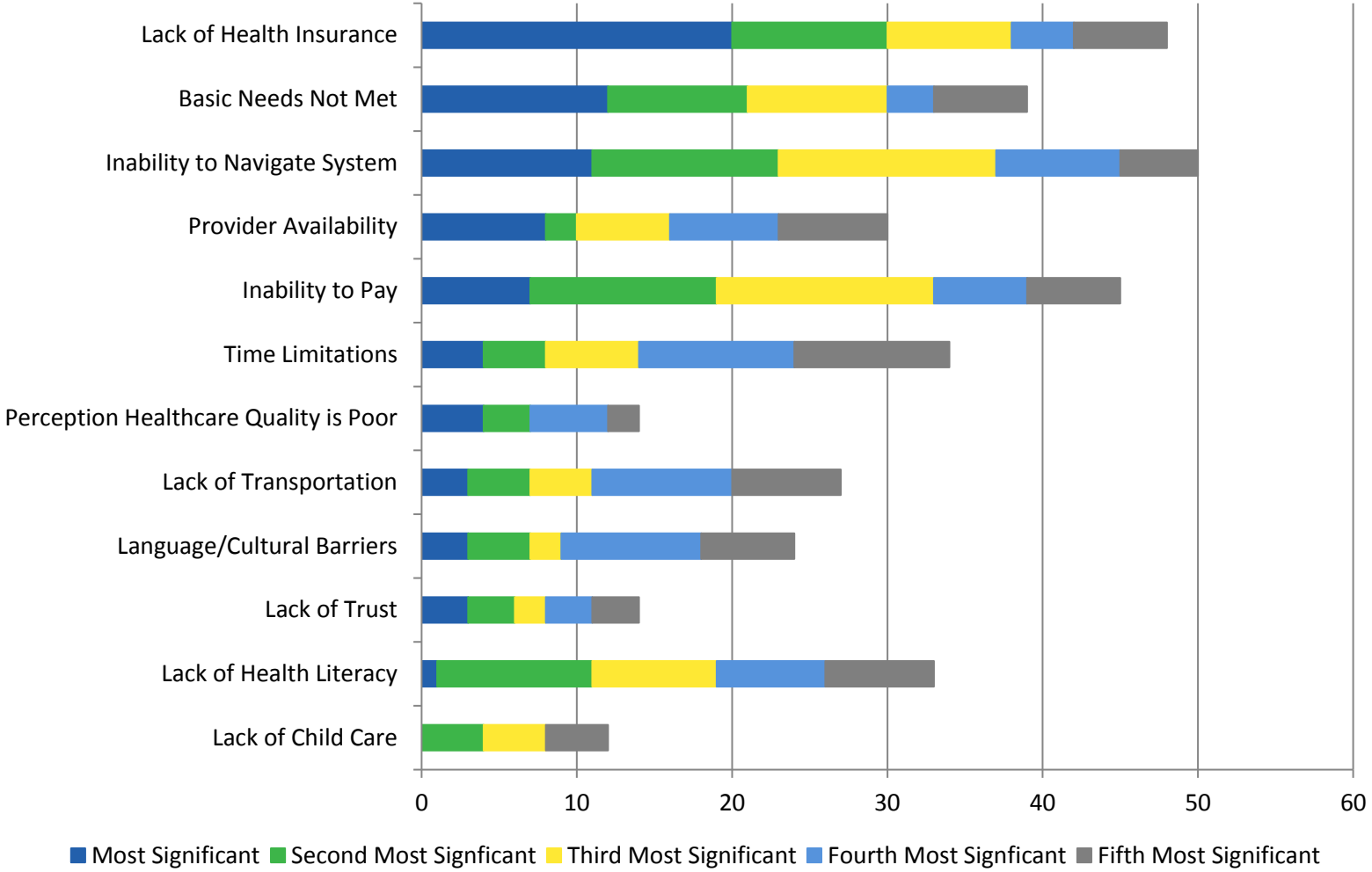
Question 7: Please rate the following statements about health care access in Prince George's County. (N=77 responses)

	Disagree	Somewhat Disagree	Somewhat Agree	Agree	No Opinion/ Don't Know
Most residents in are able to access a primary care provider.	15 (19.5%)	20 (26.0%)	29 (37.7%)	4 (5.2%)	9 (11.7%)
There are enough primary care providers to serve the residents.	26 (33.8%)	22 (28.6%)	19 (24.7%)	2 (2.6%)	8 (10.4%)
Most residents are able to access a medical specialist.	20 (26.0%)	28 (36.4%)	15 (19.5%)	3 (3.9%)	11 (14.3%)
Most residents can access a behavioral health provider (such as for mental health or substance use treatment).	37 (48.1%)	21 (27.3%)	7 (9.1%)	3 (3.9%)	9 (11.7%)
Most residents are able to access a dentist.	17 (22.1%)	22 (28.6%)	23 (29.9%)	3 (3.9%)	12 (15.6%)
Transportation for medical appointments is available to the majority of residents.	27 (35.1%)	24 (31.2%)	13 (16.9%)	3 (3.9%)	10 (13.0%)
Most residents can afford their medication.	34 (44.2%)	30 (39.0%)	6 (7.8%)	1 (1.3%)	6 (7.8%)
There are a sufficient number of providers accepting Medicaid or other forms of medical assistance.	21 (27.3%)	27 (35.1%)	12 (15.6%)	1 (1.3%)	16 (20.8%)
There are a sufficient number of providers for residents who do not qualify for insurance.	39 (50.7%)	16 (20.8%)	4 (5.2%)	2 (2.6%)	16 (20.8%)
There are a sufficient number of bilingual providers.	38 (49.4%)	18 (23.4%)	5 (6.5%)	1 (1.3%)	15 (19.5%)
Most providers incorporate cultural competency in their practice.	24 (31.2%)	18 (23.4%)	10 (13.0%)	0 (0.0%)	25 (32.5%)
Most providers incorporate health literacy in their practice.	24 (31.2%)	16 (20.8%)	12 (15.6%)	2 (2.6%)	23 (29.9%)

Question 7: Please rate the following statements about health care access in Prince George's County



Question 8: Please rank the top five most significant barriers that keep people in Prince George's County from accessing health care. (Shown in order of ranked score) (N=77 responses)

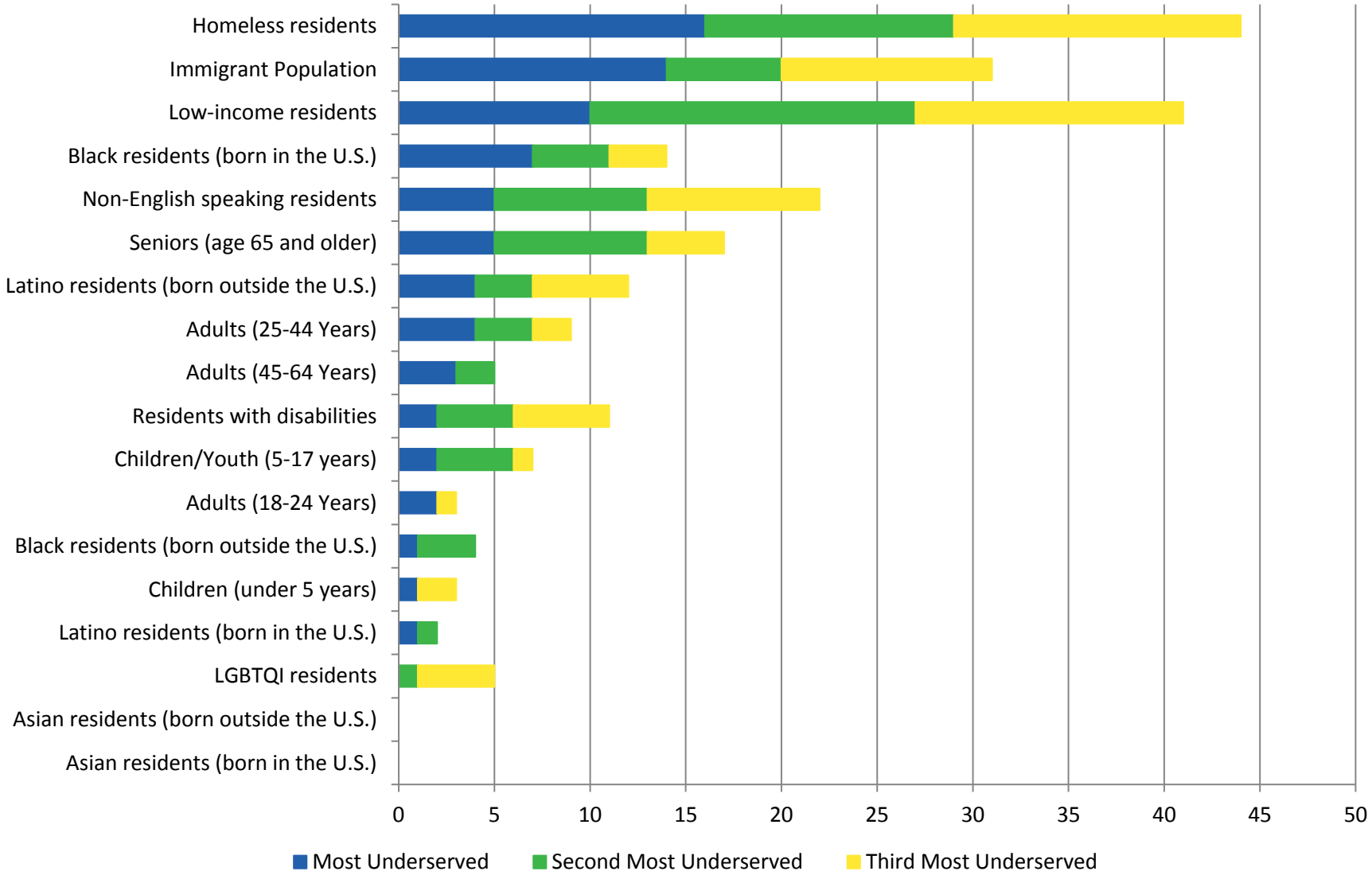


Question 9: Respondents were asked to name two key resources that are needed to improve access to health care for County residents in an open-ended response (N=76 responses). The responses are grouped and summarized in the table below; some responses included statements about multiple issues.

Key Resources	Number of Responses	Summary of Responses
Health navigation, education, and information	31	Need for: increased community health worker capacity in the access pathways; supporting training for community health workers; incorporating cultural competency throughout the entire process; health literacy education for consumers; special consideration for the aging and homebound; better education on improving poor diet and physical inactivity
More providers and Access to providers	16	Need for: more providers across all disciplines; providers closer to public transportation; providers who are culturally competent; providers accepting Medicaid/Medicare or serve the uninsured
More Behavioral Health Capacity	15	Need for: youth mental health partial hospitalization programs; embedding mental health providers in primary care; crisis beds for psychiatric emergencies; acute/subacute care services for children/adolescents
Transportation	15	Need for: an improved public bus system in the county; subsidized use of ridesharing applications (e.g., Uber and Lyft) for residents to use for medical appointments; low-cost and/or free transportation options
Basic Needs (Housing, Food, Employment)	11	Need for: affordable housing; services for the homeless; job training and placement
Affordable Healthcare	10	Need for: help for those that cannot afford their medications – many will go without due to competing priorities; help with out-of-pocket costs (e.g,. high deductibles, co-pays, etc.)
More Community Health Centers	8	Need for: wellness clinics in schools; possible “one-stop shop” family services center in the county; centers inside the beltway; centers closer to immigrant populations
Health Insurance	6	Need to: enroll eligible uninsured residents; provide safety nets for those that are ineligible
More Provider Hours	5	Need for: flexible hours including evenings and weekends
Improved Healthcare Quality	4	Need for: providers that are culturally competent; better care coordination and case management for patients; an improved reputation – many go to Montgomery County or D.C. for care
Primary Language Considerations	4	Need for: increasing provider access to translation services by phone during appointments, using translated text reminders and printed materials for clients; bilingual staff in offices; bilingual services online
Legislation	2	Need for: paid sick leave; gun control
Dental Care Coverage	2	Need for: making dental a standard healthcare provision with Medicaid; more provider participation

Other responses: free health screenings; mobile primary care services; improved walkability; having the right stakeholders at the table when decisions are made to improve health outcomes (e.g., the CBO)

Question 10: Please select the three populations most underserved for health-related services in Prince George's County (N=77 responses)



Question 11: Respondents were asked what the primary barriers are for the populations listed in Question 9 in an open-ended response (N=77 responses). The responses are grouped and summarized in the table below; many responses included statements about multiple issues.

Primary Barriers	Number of Responses	Summary of Responses
Lack of Financial and Basic Resources	42	Healthcare overall is unaffordable; healthcare is not a priority if there are competing needs not met (housing, food, work, etc.); low incomes and unaffordable housing are key drivers
Access to Care	27	Provider participation in Medicaid is low; low income residents are underserved due to the lack of evening and weekend PCP hours; lack of accountable providers; services not spread evenly throughout the county, especially inside the beltway; many specialists are located outside of the county; no dental benefit in Medicaid; lack of services for children; no coordinated system to provide services to homeless
Cultural/Language Barriers	27	Lack of bilingual providers and staff; limited resources for non-English speakers; non-English speaking residents may wait for months to get a routine physical through an FQHC
Engagement and Awareness of Services and Resources	16	Targeted outreach to known populations that typically do not use the healthcare system; increase number of services and staff
Lack of Insurance	15	Those ineligible for insurance will have unmet health needs, primarily undocumented immigrant populations; focus on residents that make too much for Medicaid but not enough for private insurance or high out-of-pocket costs
Navigation of Services/ Care Coordination	12	A large number of residents are relying only on urgent care doctors due to lack of knowledge on how to select a PCP; follow-up from encounters is an issue (adherence to discharge instructions, completing further testing, filling medication, etc.)
Transportation	14	Need for more transportation options and money to fund
Health Literacy	9	Improvements in health literacy would help improve emergency department diversion – residents using ED's for primary care
Lack of Trust	9	Fear and lack of trust with the healthcare system and its providers; lack of trust with government agencies; fear of identification consequences among the undocumented and immigrant populations
Social Environment	6	Discriminatory Federal laws; racism and implicit bias; stigma
Mental Health	2	Homeless are disproportionately affected; need for more mental health care in schools, especially for students with trauma

Question 12: Respondents were asked what is being done well in Prince George's County within communities to improve health and well-being and by whom in an open-ended response (n=74 responses). The responses are grouped and summarized in the table below; many responses included statements about multiple health and wellness activities and contributing organizations.

Agencies/Organizations	Number of Responses	Specific Program/Service/Action [Responses if >1]
Prince George's County Health Department	10	Health fairs [3]; community outreach, including HIV and STI prevention [3]; focus on social determinants of health and policies, systems, environment; naloxone
Prince George's County Parks and Recreation	7	Central Avenue Connector Trail providing a way for people to connect people in Capitol Heights to services in Largo, as well as safe walking and biking connections; Initiatives to help individuals become more active
Faith-Based Organizations	5	Providing direct services
Prince George's County Food Equity Council	2	Advocating for policies and zoning regulations to address health
Prince George's County Healthcare Alliance	2	Community health worker care coordination services [2]
Prince George's County Fire/EMS	2	Mobile Integrated Health [2]
University of Maryland Capital Region Hospital	2	Mama and Baby Bus program [2]
City of Hyattsville	2	Efforts to encourage exercise and fitness [2]
Prince George's County Community College	2	Training of community health workers; Fitness and education classes
Prince George's County Dept. of Family Services Aging and Disabilities Services Division	2	Partnership with Meals on Wheels to deliver meals to the homebound; Partnership with MNCPPC to offer physical fitness activities in senior centers
Prince George's County FQHCs	2	Variety of services under one roof - simplifying navigation for the most vulnerable
Prince George's County Healthcare Action Coalition	2	Organizing the community around enhancing health outcomes; Healthy Eating Active Living workgroup
New Hospital (under construction)	2	Will be centrally located and on a Metro line
La Clinica del Pueblo	1	Providing services and resources in Spanish
City of Seat Pleasant	1	SMART City Initiatives
Prince George's Department of Social Services	1	Administration of the SNAP program/coordination with local food pantries
Prince George's Child Resource Center	1	Healthy Families Prince George's program
HSCRC	1	Fostering population health and helping the hospitals to this end

Other organizations mentioned (without specified programs or services): Heart to Hand, Laurel Advocacy and Referral Services, Shabach Ministries, The American Job Center, Bridge Center at Adam's House, Prince George's County Health Connect, Food and Friends, WIC, Early Head Start

Some respondents listed programs and services occurring in the county without association to a specific agency or organization:

Other Areas of Action	Number of Responses	Specific Program/Service/Action
Collaboration and Partnerships	9	This community health assessment; stakeholders and government agencies coming together to share resources and develop innovative measure to collect data; several county agencies working towards Health in All Policies; recognition by all stakeholders of the need to expand healthcare to underserved populations and implement health-related programming
Community-Based Services and Programs	9	Community health workers engaging in the process to improve and facilitate care coordination services; publication of community education events; efforts by community members in 20743 to replace the Safeway that closed; youth mentorship programs
Provider Capacity	6	New providers in the area with evening and weekend hours; building more health centers; providers in communities that can bring in outside practitioners when needed (e.g., healthcare navigation, primary care for the uninsured); access to holistic health; hospital systems adding urgent care capacity
Healthy Lifestyles	5	Increased numbers of outdoor and green spaces; farmer's markets; county and state efforts to eliminate food deserts; increased bike share vendors near trails
Visibility	2	Several county agencies with noticeable presence in communities; seeing County Executive Alsobrooks and Dr. Carter in public events demonstrating healthy living
Mental Health	2	PRP programs for the Medicaid insured population; more young people are talking about and dealing with mental health compared to the past

Question 13: Respondents were asked what is being done well by the healthcare systems in Prince George's County to improve health and well-being and by whom in an open-ended response (N=74 responses). The responses are grouped and summarized in the table below; many responses included multiple recommendations.

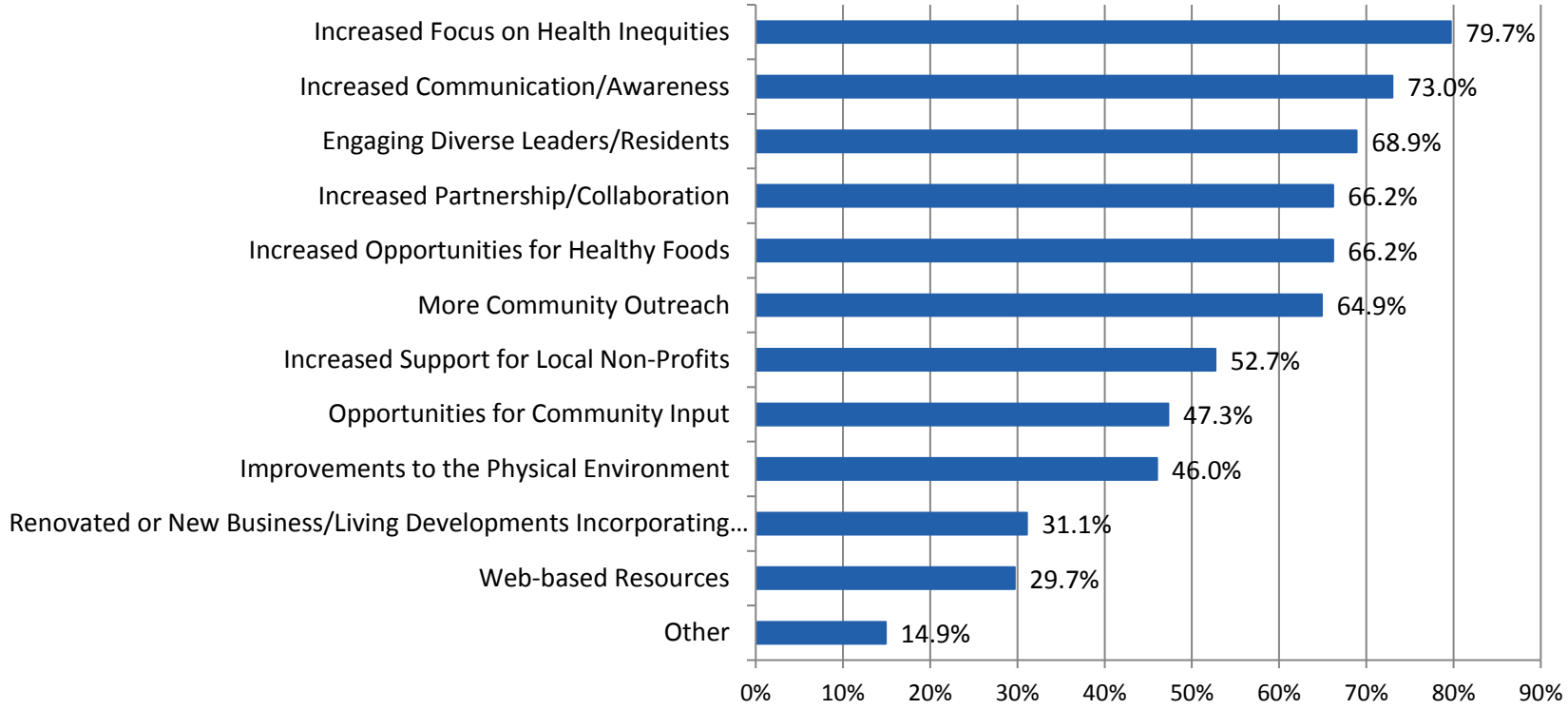
Areas of Action	Number of Responses	Specific Program/Service/Action [Responses if >1]
Improving Hospital Quality	15	Construction of the new hospital [10]; all hospitals incorporating population health in planning [3]; UMCR increasing ambulatory behavioral health services; hospitals providing primary/specialty care
Partnerships	12	All hospitals partnerships with community health programs [3]; University of Maryland Medical System partnerships [2]; PGCHD's partnership with DSS [2]; PGCHD's partnerships with hospitals for HIV screening; PGHAC; future launch of MDPCP; use of task forces
Coordination of Care	11	TLC-MD collaboration of county hospitals for care coordination in at-need populations [4]; creating access pathways for people to get services [2]; providing integrated services, inclusive of behavioral health; PGCHD's Care Coordination Team; use of community health workers throughout the process; use of CRISP to connect providers of the same patient
Prevention	9	Use of evidence-based prevention programs [3]; clinicians are providing more preventative information during visits on a regular basis [2]; Doctors Hospital's free cancer screenings; PGCHD's efforts to steer public thinking towards prevention and harm reduction; PGCHD's timely follow up to positive HIV and STI cases; free immunizations for children under age 19
Education and Outreach	8	PGCHD's outreach and education programs [3]; Doctors Hospital's use of mobile van to address chronic disease in communities [2]; MedStar health and wellness programs; UMCR programs to address nutrition and obesity; health fairs
Community Engagement	7	Providing community-based services and programs to vulnerable populations [4]; engaging stakeholders in planning and policymaking [2]; Kaiser Permanente community revitalization
Access to Providers and Clinics	4	Incentives to bring quality providers to the area; Greater Baden serving those most in need; CCI Health and Wellness Services has two locations with sliding scales and interpretation; expansions of larger health care providers have been close to transportation hubs
Data	3	Using the Community Health Assessment to inform the Community Health Improvement Plan
Access to Health Insurance	2	Improving access to insurance options for low income families
Economic Development	2	Economic development agencies are attracting healthier choices to the county
Mobility	2	Mobile health units; telemedicine
Funding	1	County council now appropriating general funds to address needs, such as domestic violence

Additional healthcare agencies mentioned (without associated programs/services): La Clinica Del Pueblo, Mary's Center

Question 14: Respondents were asked what recommendations or suggestions they have to improve health and quality of life in Prince George's County in an open-ended response (N=74 responses). The responses are grouped and summarized in the table below; many responses included multiple recommendations.

Recommendations	Number of Responses	Summary of Responses
Focus on Healthy Lifestyles	13	Increase opportunities for physical activity and decreasing food swamps/deserts; stop allowing fast food places to swamp the county; more sidewalks and trails; increase food resources in South County; avoid mixed messaging (e.g., supporting unhealthy food-related "National" days while promoting healthy eating); provide incentives to municipalities to promote healthy living
Health Education and Outreach	15	Use online platforms and social media to provide programs and web-based health care and resources; devote more staff for outreach; be visible and promote services outside of healthcare facilities; be culturally competent
Increase and Improve Access to Providers & Clinics	13	More behavioral health inpatient facilities and providers; incorporate health services where people are most (e.g., employers, community sites); simplify the referral process between physicians and social services; more providers in Maryland Healthy Smiles; quality of care should equal neighboring jurisdictions
Partnerships	9	Work with other counties to learn best practices, have joint task forces and coalitions; strengthen public and private collaboration; establish a regular meeting of County agencies to address health; engage the faith-based community with behavioral health services;
Increase Health Funding	9	More funding for programs and services; County support to provide health insurance for the uninsured/ineligible; Council funding for a master Health Equity plan; increase Medicaid reimbursement rate
Basic Needs	5	Make the process to place the homeless streamlined and transparent; more transitional and permanent housing for residents finding themselves homeless – abandoned homes could be refurbished as group residences, psychological rehab programs and independent living residences; address poverty
Strengthen Services	4	Health department should strengthen core reinstitute maternity services; better maintenance of local, state and national parks; refine the health impact assessment process; use GIS for health concerns in the county
Affordable Healthcare	4	Provide insurance to more residents; offer programs for the emotional growth of children that are affordable
Community Engagement	2	Engage community members and local leaders to be change agents
Transportation	5	Enhance the public bus system; expand MA transportation hours beyond 9am-5pm
Address Language Concerns	2	Provide better language access; establish a universal language line for both public and private providers

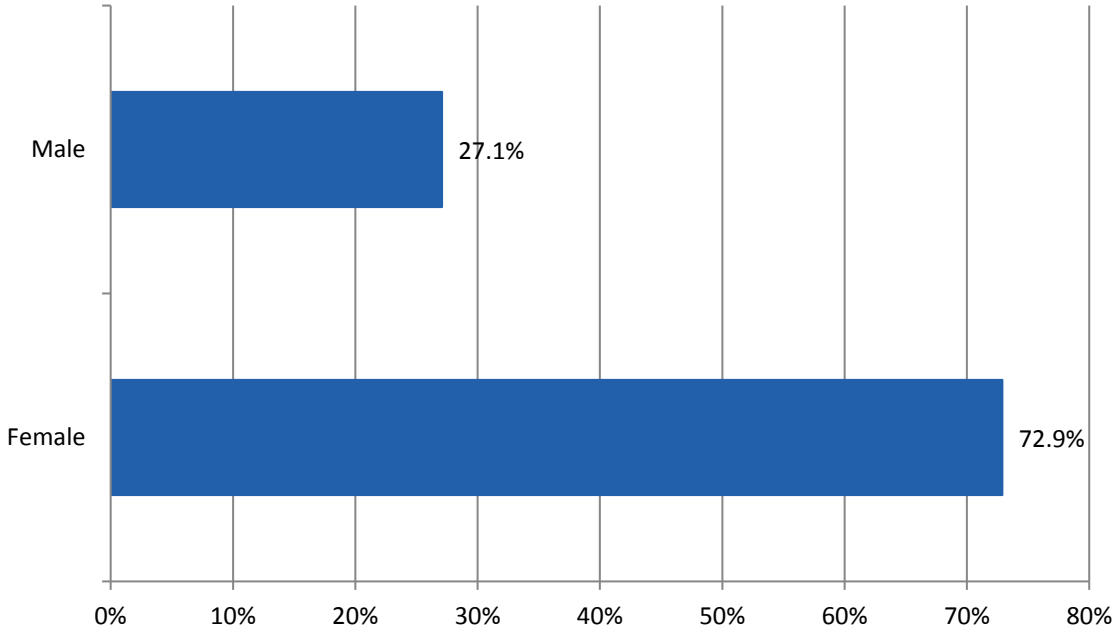
Question 15: What do you think could encourage and support more community involvement around health issues in Prince George's County (select all that apply)? (N=74 responses)



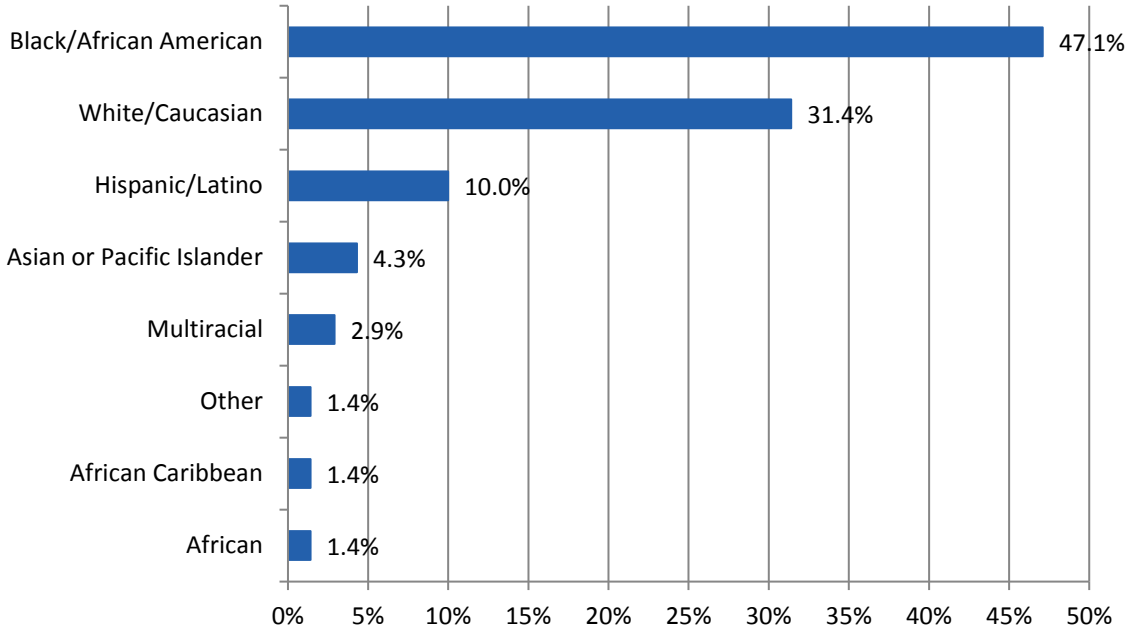
"Other" Included: increased public transportation; decreasing access to unhealthy foods, especially in food deserts; partnerships with local providers; engagement with existing churches and civic groups to get involved with health; targeted approaches to engage new immigrant, Black and Latino communities; focus on areas of county where expansion of services may have halted due to preconceived notions about the community; addressing that many residents must travel to find quality services; County Police and Fire may be resource limited at times due to high utilizers; encouraging residents to be engaged and support their communities;

Participant Profile

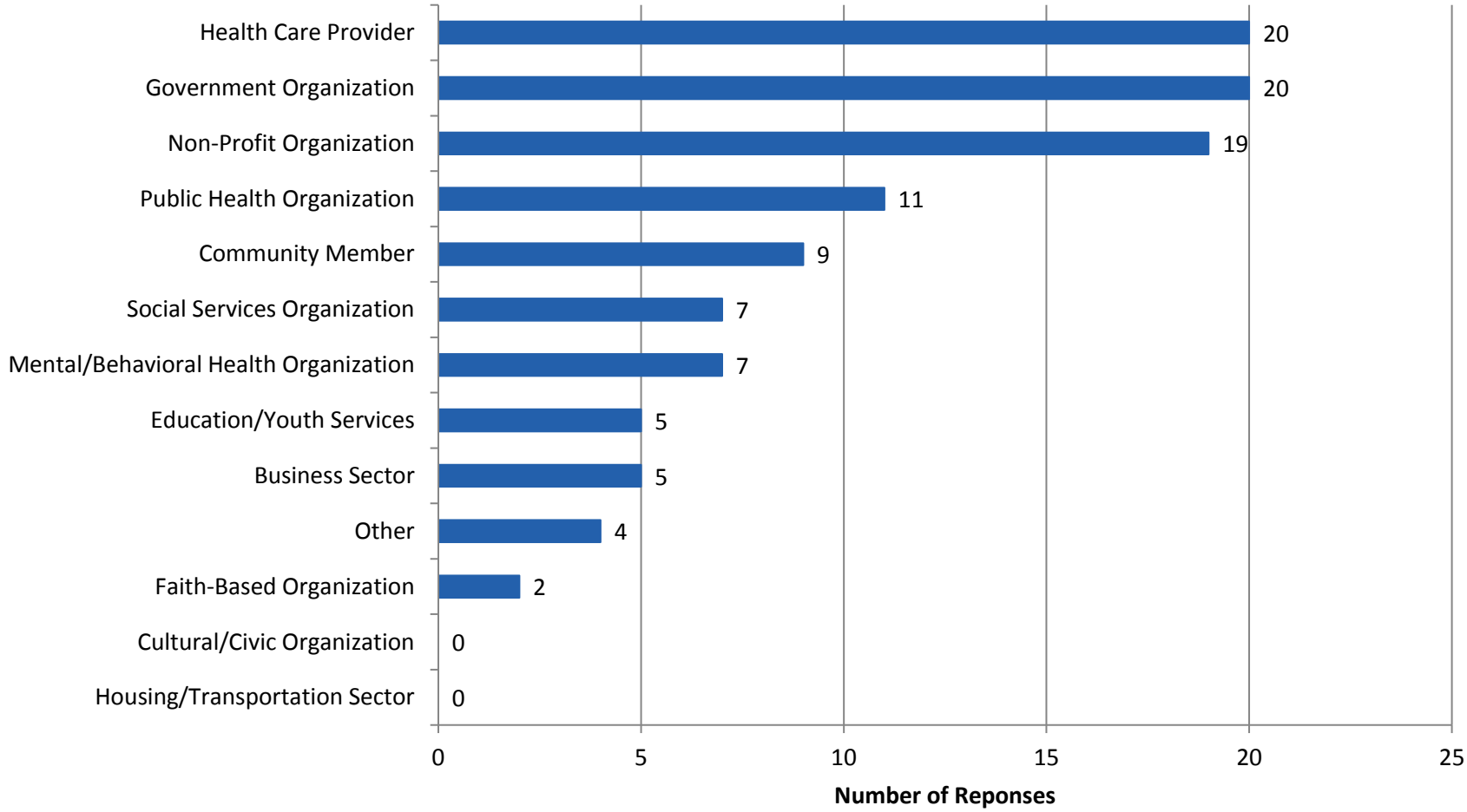
Question 17: What is your gender (N=70 responses)



Question 18: What race/ethnicity best identifies you? (N=70 responses)

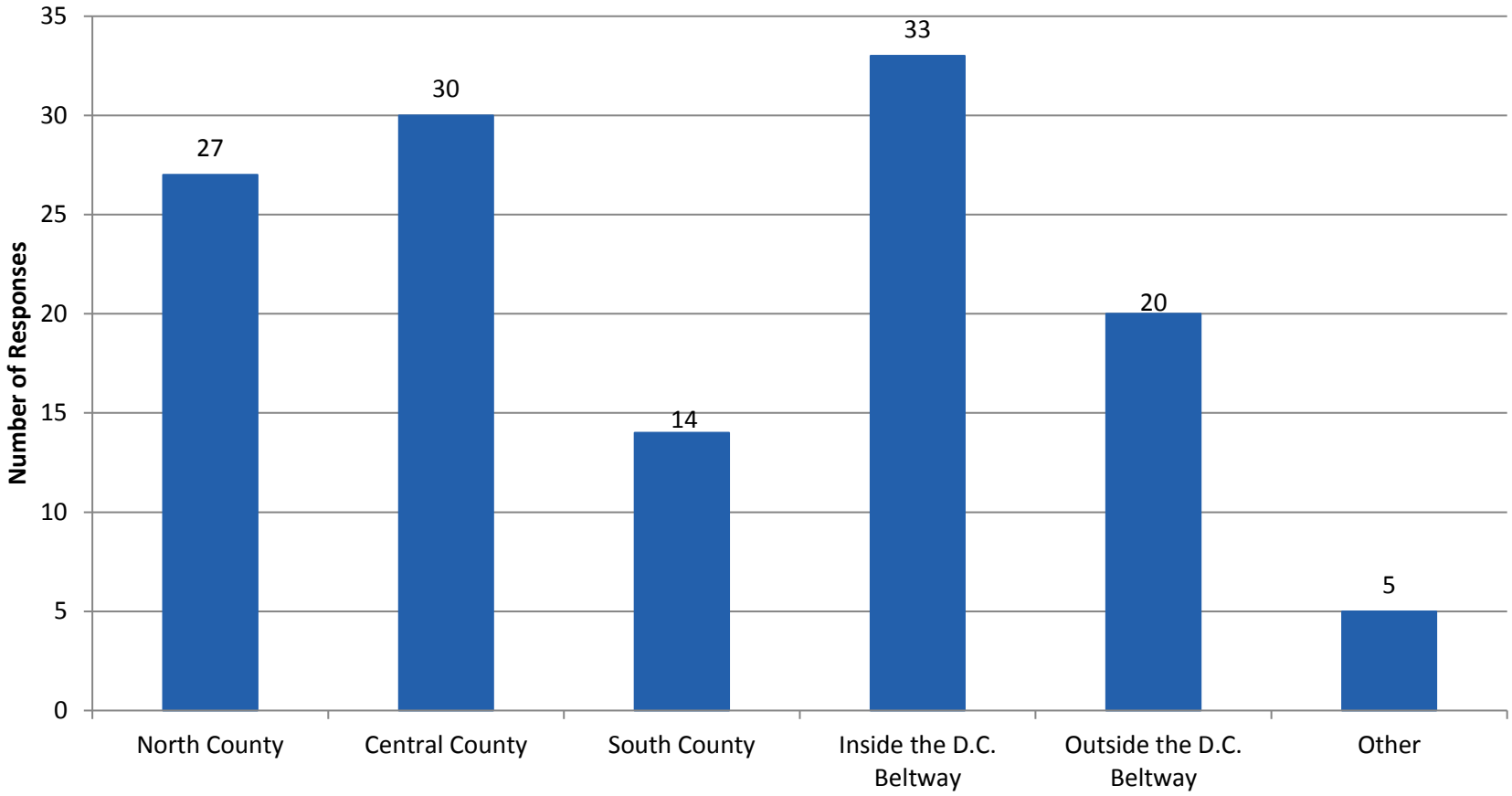


Question 19: Which of these categories would you say best represents your community affiliation? Participants were asked to select all that apply. (N=70 responses)



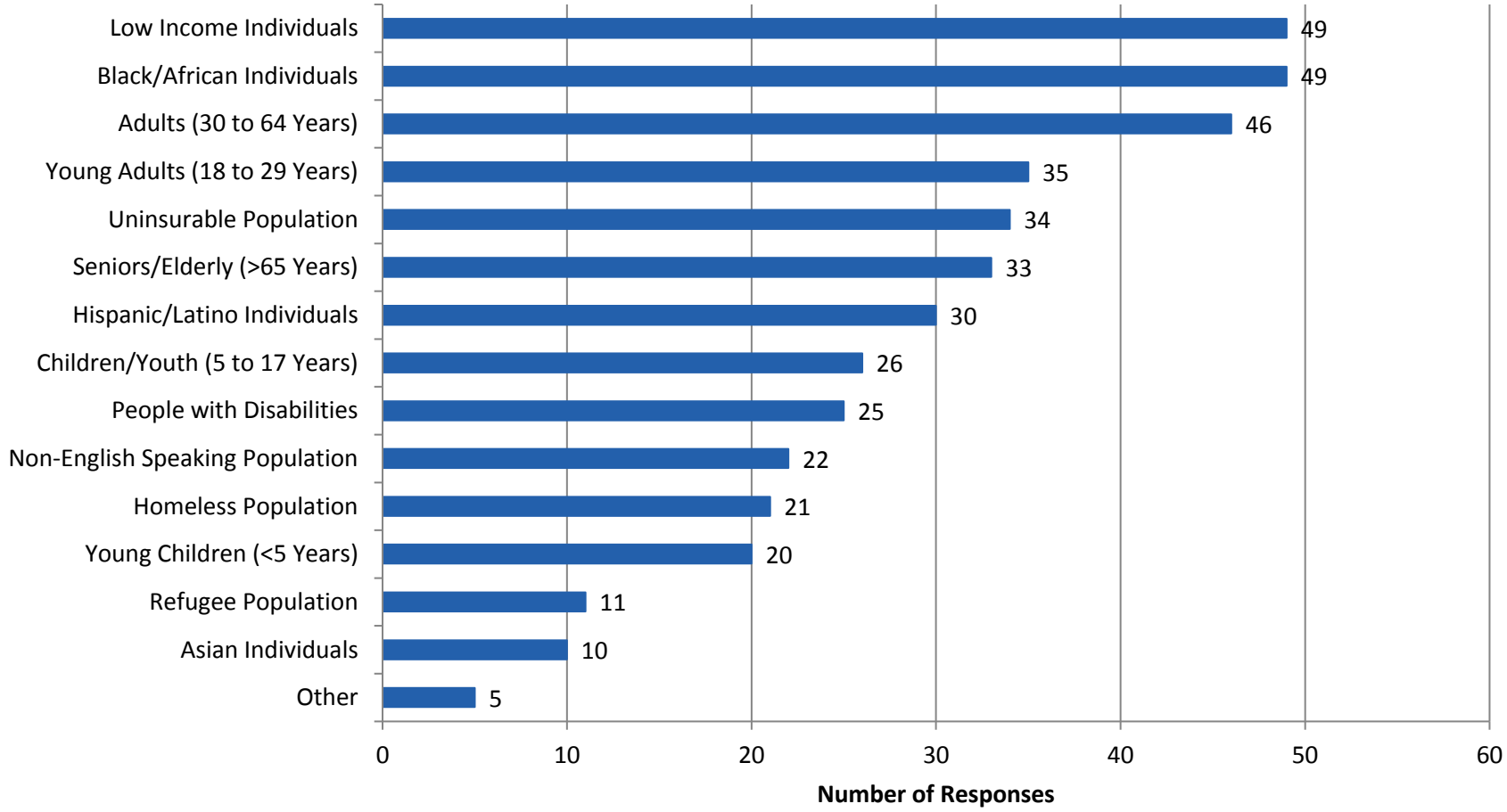
"Other" Included: workforce development; anti-hunger/anti-poverty; food pantry; advocate.

Question 20: In what geographic part of Prince George's County are you most knowledgeable about the population? Participants were asked to select all that apply. (N=70 responses)



"Other" included: knowledge across the entire county or responding that knowledge of one part of the county did not exceed other areas of the county.

Question 21: Please select the types of populations you can represent in Prince George's County through either personal, professional or volunteer roles. Participants were asked to select all that apply. (N=69 responses)

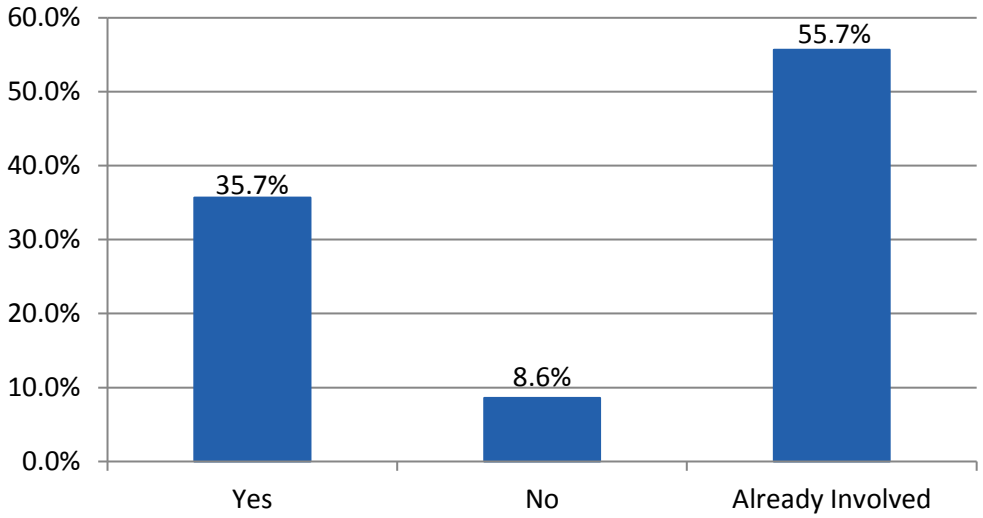


"Other" included: immigrant populations; veterans; those undergoing treatment of cancer and their families; residents utilizing public benefit programs.

Question 22: Respondents were asked to share the most pressing needs of the populations they serve (N=70 responses). The responses are grouped and summarized in the table below; the majority of these responses reiterated information that had already been provided in previous questions.

Additional Information	Number of Responses	Summary of Responses
Affordable Healthcare	23	Need for more affordable care overall - even with insurance, healthcare can be costly, especially difficult for low income and single parent families in the county; affordable childcare
Engagement in Healthy Lifestyles	17	Need access to healthy foods through better grocery stores and the opportunities to grow one's own food; limit food insecurities; nutrition support and education on the relationship between food and health; more physical activity and exercise
Better Healthcare Quality	14	Behavioral health quality improvements should be a priority; patients and providers should establish trust and connect without judgment; establishing a dental home for all residents 21+ years old; incentivize quality providers to move to the area
Safe, Affordable Housing	13	Need for transitional and permanent supportive housing
Health Literacy and Health Education	13	Need for more community outreach; classes on parenting skills and support for parents; education on avoiding poor health decisions; classes on diabetes and cardiovascular care
Cultural and Language Considerations	8	Need for more cultural competency in all areas; more bilingual services; translation in languages other than English and Spanish; focus on equity for all residents
Transportation	6	Need for a reduction on the dependency of cars as a sole method of transportation in the county
Better Education Outcomes	6	Need for more good schools in the county; more residents completing high school
Care coordination and information	6	Need for residents to be aware of and be able to access services; centralize navigation services in one area (Medicaid/MCO/Transportation Assistance/Unemployment etc)
County Development and Services	6	Need to encourage growth of good jobs in the county without long commutes; workforce development;
Health Insurance	4	Need for more eligible residents to access health insurance
Safe, Clean Environment	4	Need for more walkability in areas; lower crime; addressing the social determinants of health
Social Isolation	4	Need to increase access for seniors where isolation is a concern; help all residents with a lack of social or family support
Immigration Issues	3	Need to address issues facing our undocumented populations; allay fears involving ICE
County Funding	1	Need for funding to be flexible to reach underserved populations

Question 23: Would you be interested in becoming more involved in local health initiatives?



RESIDENT survey

COMMUNITY RESIDENT SURVEY

Introduction

Prince George's County is home to over 910,000 residents and growing, with a wide range of health needs and disparities. The Community Resident Survey was a strategy developed to complement the overall Community Health Assessment (CHA) goal of identifying the health needs and issues for the county's diverse population by hearing directly from our residents.

Methodology

The 2019 Community Resident Survey was modified from the 2016 Community Resident Survey, with any adaptations based from the Community Health Status and Assessment recommendations of the Mobilizing for Action Through Planning and Partnerships (MAPP) framework[1]. Efforts were made to ensure the survey questions corresponded with the Community Expert Survey, another key assessment of the MAPP framework. The survey questions included mostly multiple choice and rating scales with a few open-ended responses for demographics and an option for writing in a response if the participant answered with "other".

The survey was translated into Spanish (the most common language spoken in the county after English) and French and was made available online and through printed copies. Due to time limitations, the survey was distributed as a convenience sample. The Health Department made the survey available by website, social media, and through provided services at department locations; the survey link was also posted electronically by the County government. Survey distribution began on March 15, 2016 and ended on April 30, 2019.

For analysis, each multiple choice and rating scale question is presented as a simple descriptive statistic. Because the surveys were collected as a convenience sample, the results were intended as an additional method of gaining community input in support of the overall process, while acknowledging the lack of an adequate sample size to statistically represent the county. Responses from the English survey were excluded if the participant indicated they were not a county resident or if residency information was completely missing to make that determination. All responses in the Spanish and French surveys were included in the final analysis, regardless of residency information; the results are presented separate from the English responses for most questions. Each question includes the number (N) of responses.

[1] https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

Participation

Surveys were completed by 218 participants: 178 in English, 42 in Spanish and 2 in French. Additionally, the 2016 version of the survey was distributed at an event in November 2018 before the finalization (and translation) of the 2019 version was available; of the 74 responses, 34 were from Prince George's County residents and retained for further analysis. Due to the changes in some of the questions between the 2016 and 2019 resident surveys, responses from this small cohort are only incorporated where both the question and answer selections were the same in both surveys. Nearly all areas of the county were represented by the participants, with the exception of the most southern part of the county (a map of representation is available with Question 17). Almost two-thirds of survey participants were female, which is higher than the county. However, survey participation by race and ethnicity was similar to the county. Spanish survey participants skewed younger and were mostly between the ages of 25-44 years, while English survey participants were more evenly distributed by age. Over 45% of all survey participants had a college degree or higher; however, 38% of the Spanish/French survey participants did not have at least a high school degree. Although survey participants reported a wide range of annual household incomes, over half (51%) of Spanish/French participants reported an annual household income of less than $20,000.

Key Findings

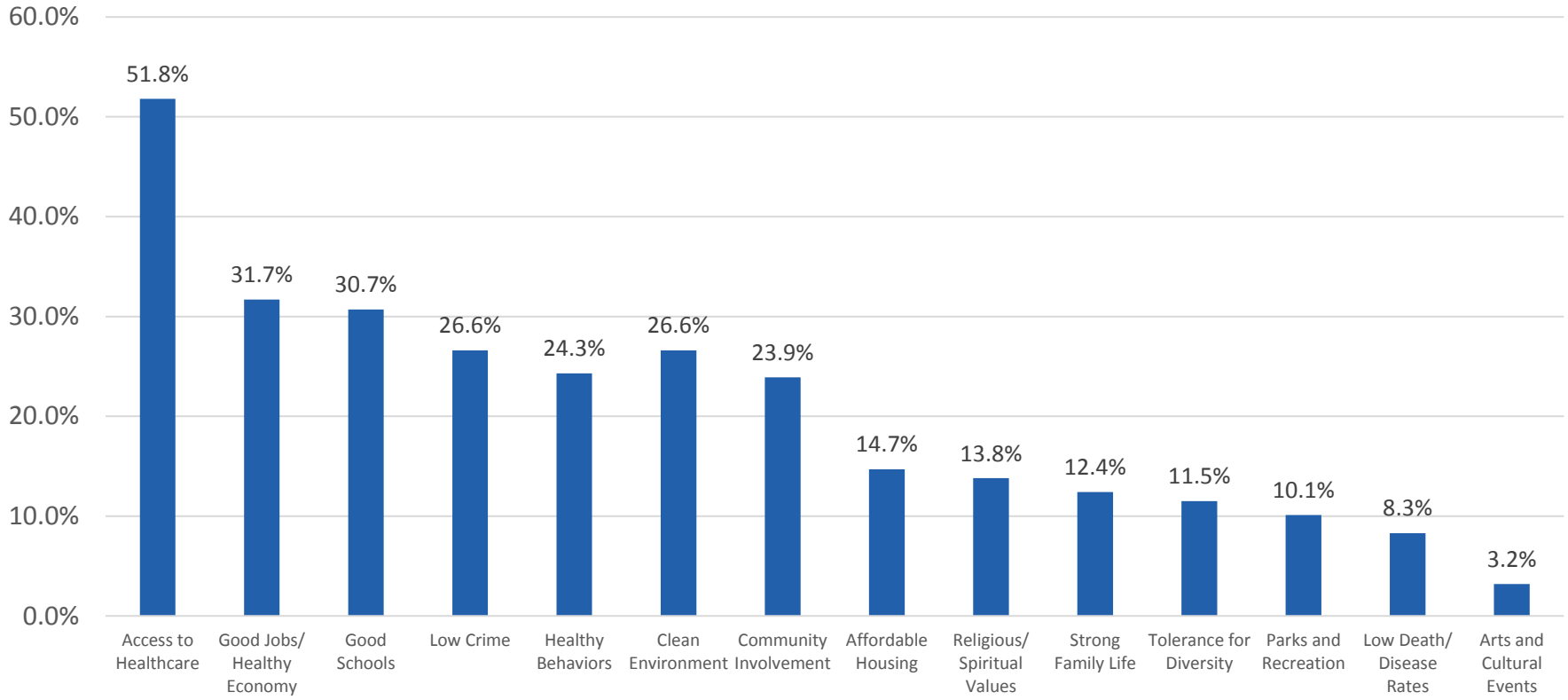
- ***Healthy Community***: Over half of all survey participants said that access to healthcare was one of the most important factors defining a "healthy community," followed by good jobs and healthy economy, and good schools. Spanish/French survey participants also considered a clean environment as one of the most important factors, while English survey participants said low crime and healthy behaviors also defined a healthy community. Two-thirds of all survey participants reported that parks were the places they went most frequently in Prince George's County, followed by churches and movie theaters.
- ***Community Determinants of Health:*** Over half of survey respondents (57%) agreed that their community has easy access to fresh fruits and vegetables; this was much higher (84%) among the Spanish/French participants. Almost half (49%) of English and 36% of Spanish/French survey participants disagreed or somewhat disagreed that there is enough affordable housing in their community. Spanish/French survey respondents were also more likely (40%) than English survey respondents (29%) to disagree or somewhat disagree that their community was safe with little crime.
- ***Leading health issues***: Chronic illness and related factors, including diabetes, poor diet and physical inactivity, as well as substance use (alcohol, drug and tobacco) led major health problems for all survey participants. For Spanish/French survey participants, dental health and cancer were also highly ranked. However, nearly every health issue had over half of the overall participants indicate it was at least a major or moderate problem in the county.
- ***Access to healthcare***: Almost 60% of English survey participants and over half of Spanish/French survey participants agreed or somewhat agreed that residents in their

community could access a primary care provider. However, less survey participants agreed or somewhat agreed that there are enough providers for the number of residents in their community, that most residents are able to access medical specialists in their community and that most residents can access a mental health provider in their community. Although 60% of English survey participants said most residents in their community could access a dentist, only 40% of Spanish/French survey participants felt the same. More participants in both surveys disagreed or somewhat disagreed that most residents can afford their medication in their community.

- ***Leading barriers**:* Overall, lack of knowledge to navigate the healthcare system, lack of money for co-pays and prescriptions and time limitations were indicated as the leading barriers to accessing healthcare in the county. For English survey participants, 44% also reported that the availability of providers or appointments was a major or moderate problem, while over three quarters (77%) of Spanish/French survey participants reported lack of insurance coverage as a barrier to accessing care.
- ***Health Care:*** Overall, 81% of survey participants reported having some type of insurance and most (73%) reported seeing a primary care doctor in the past year. However, among the Spanish/French survey participants, 41% did not have health insurance and 40% did not see a primary care doctor in the past year. Over 20% of English survey participants and 46% of Spanish survey participants reported being unable to access needed medical care in the past year, primarily due either the lack of health insurance coverage or cost considerations. The wait time to access a medical care appointment was also a barrier for those unable to get care in the past year.
- ***Health Communication:*** Both English (90%) and Spanish/French (78%) survey participants said that doctors were the most trusted source of health and lifestyle information in their community. Following doctors, English participants reported health screenings (50%) as trusted sources of health information, while Spanish/French survey participants (31%) said that health fairs were trusted sources of health information. One-on-one counseling was the third trusted sources of information in both surveys. Regarding the dissemination of health information, English participants (61%) were much more likely to prefer e-mail compared to Spanish/French participants (21%). In-person (43%) or over the phone (31%) were the most preferred methods of communication for Spanish/French survey participants.
- ***Recommendations to improve health:*** Overall, all survey participants recommended increased communication and awareness followed by community-level outreach to encourage and support more community involvement around health issues in Prince George's County. Among Spanish/French survey participants, an increased number of healthcare practitioners was also an important factor in community health.

Results

Question 1: What do you think are the three most important factors that define a “Healthy Community” (what most affects the quality of life in a community)? (N=176 English responses; N=42 Spanish/French responses)



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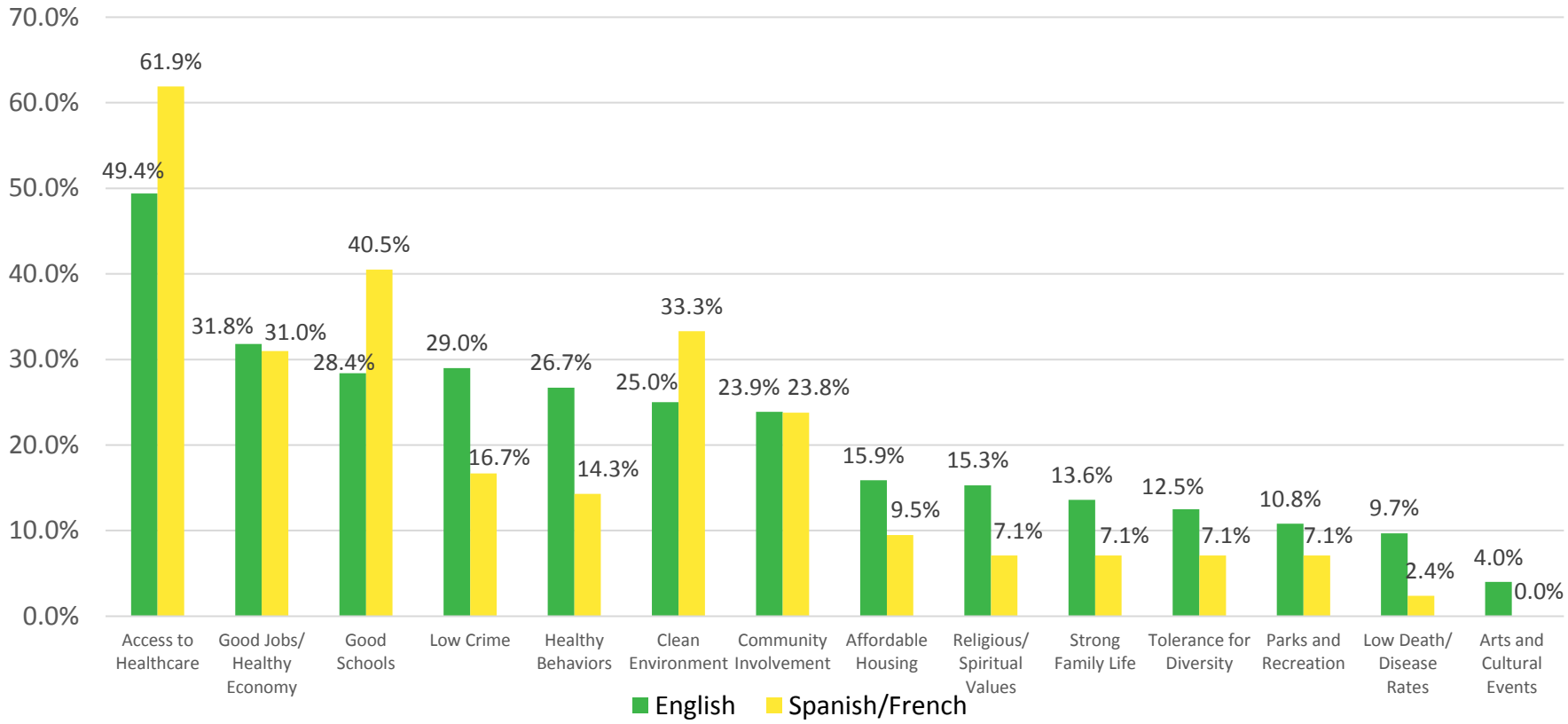
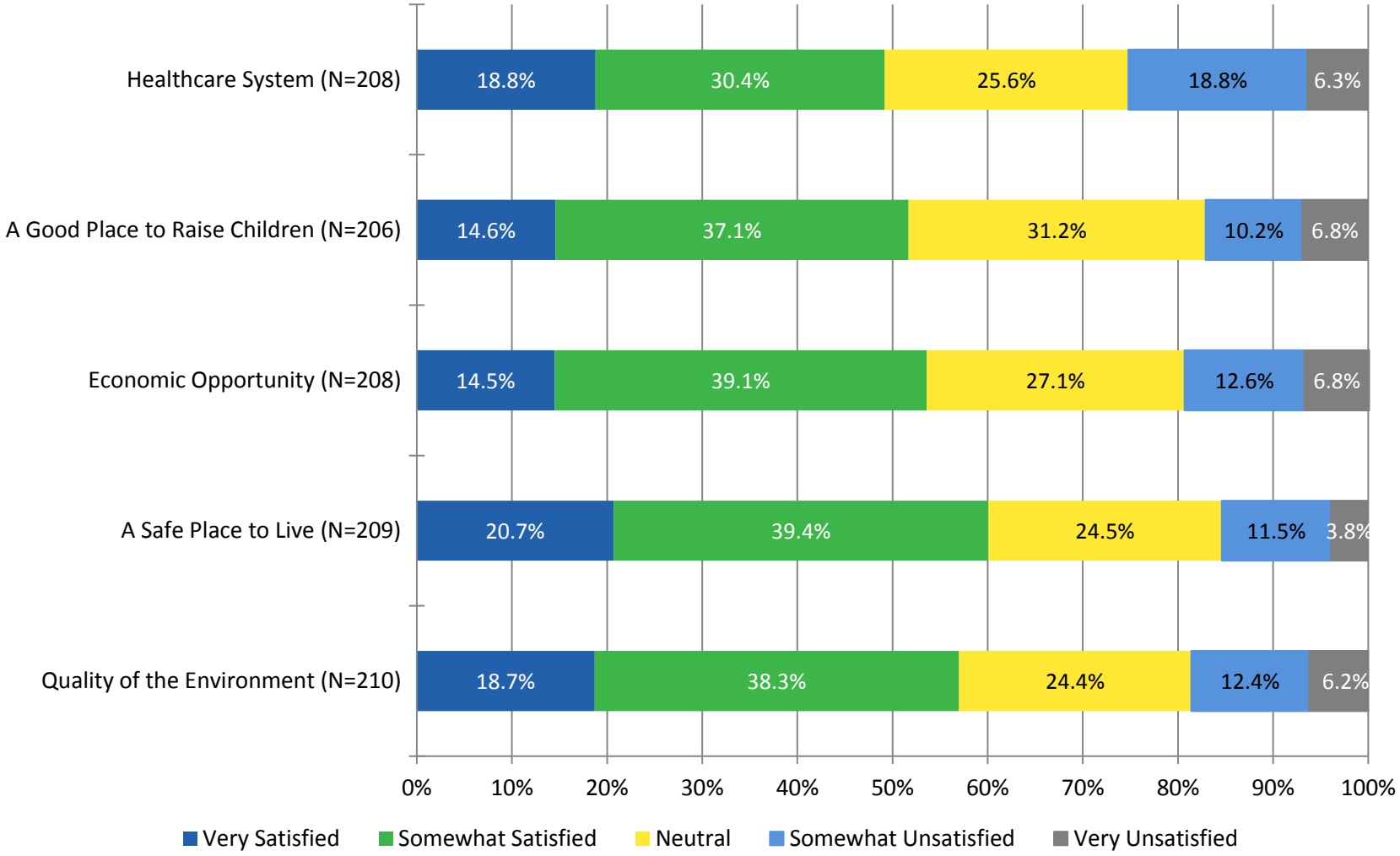
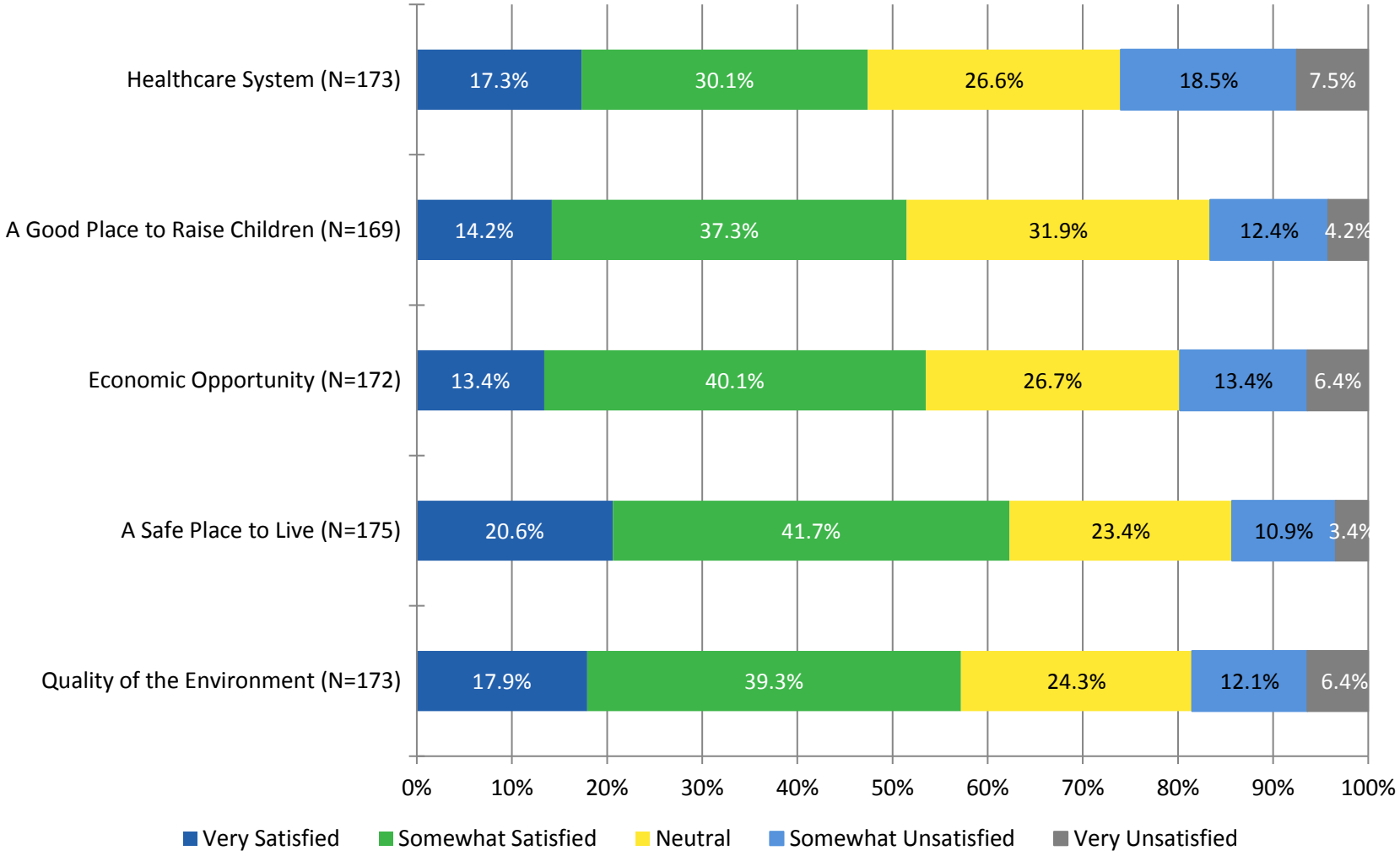


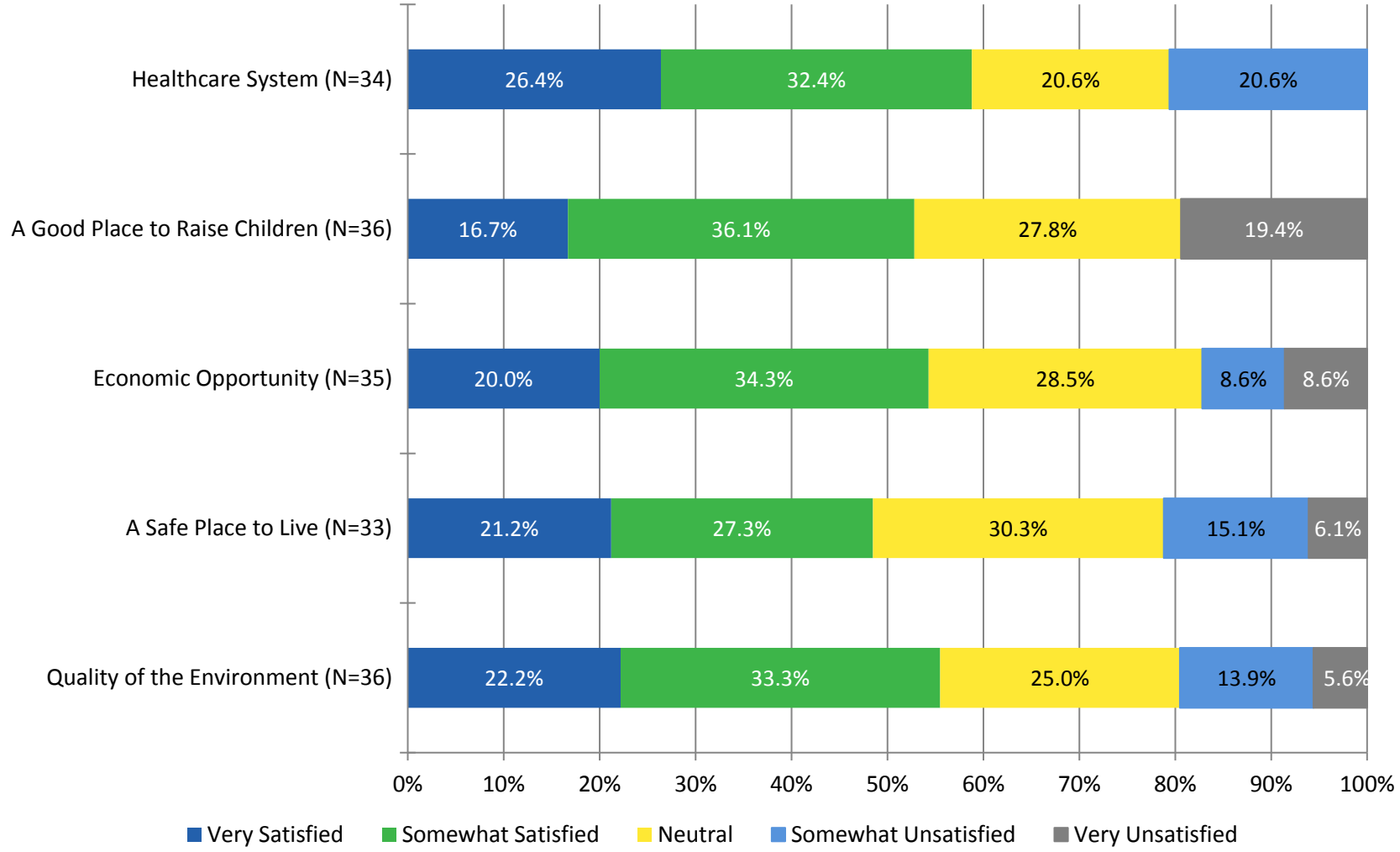
Question 2: How satisfied are you with the following in Prince George's County (All responses)?



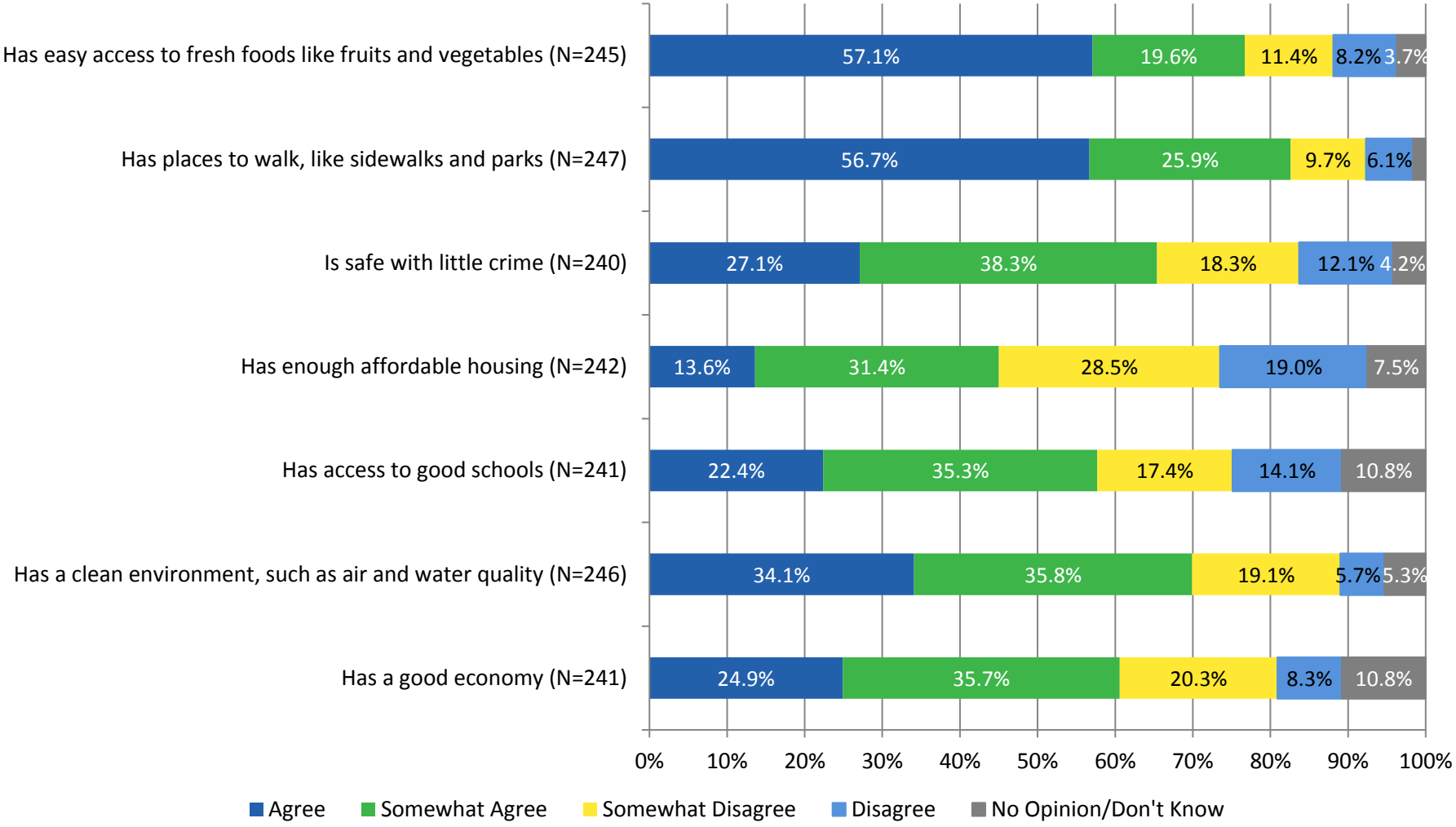
Question 2: How satisfied are you with the following in Prince George's County (English responses)?



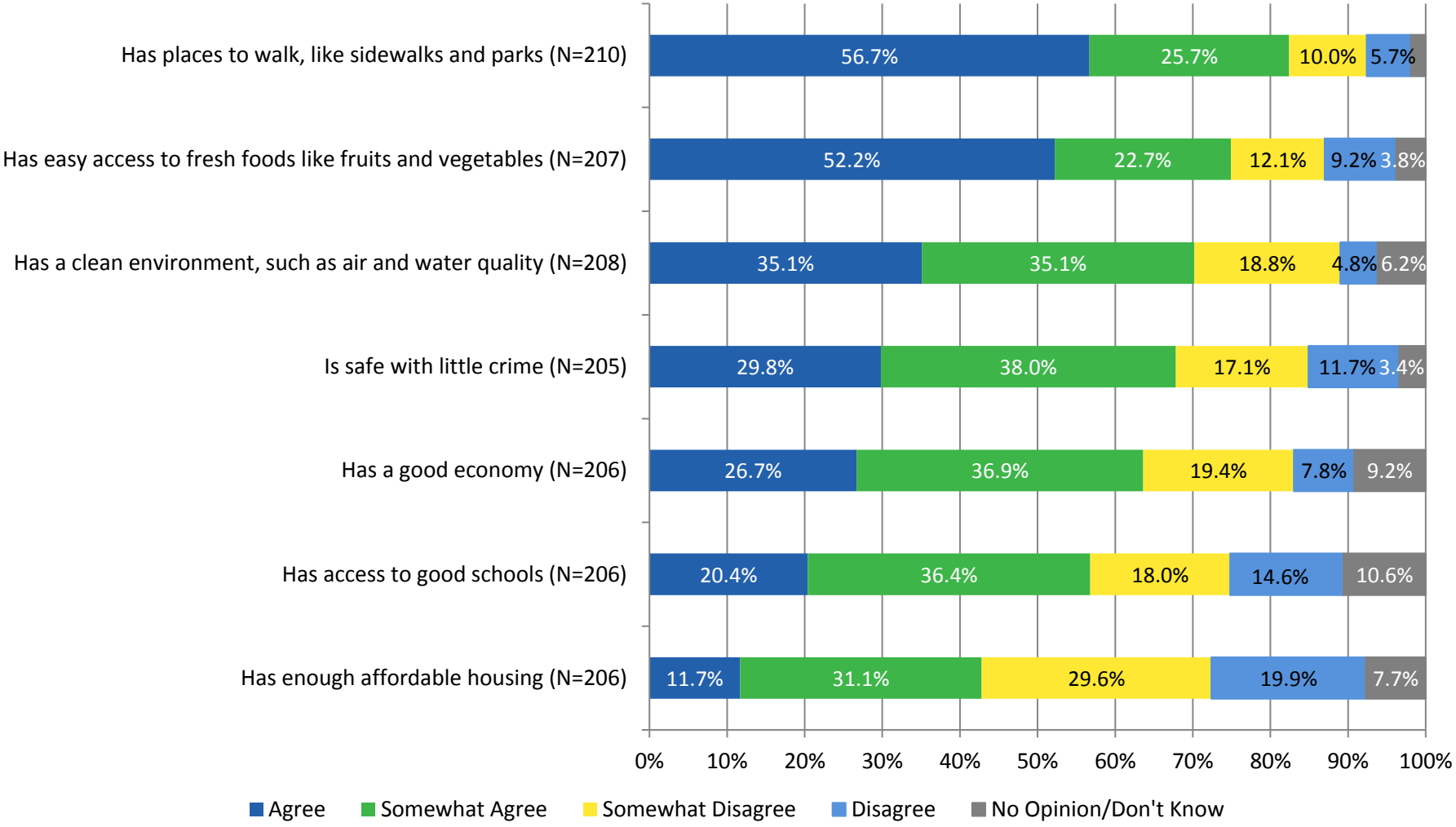
Question 2: How satisfied are you with the following in Prince George's County (Spanish/French responses)?



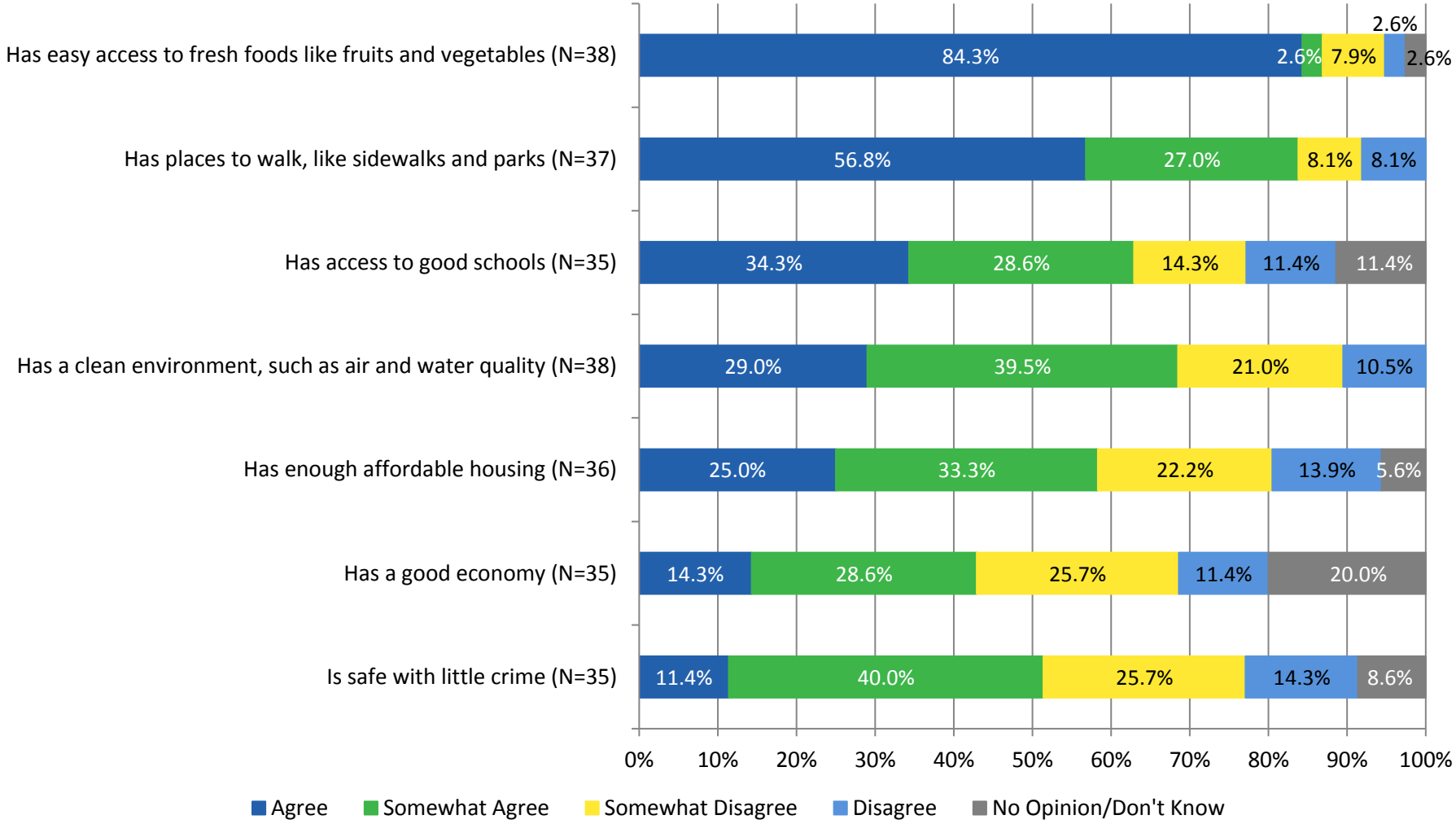
Question 3: Please rate each of the following statements for your community (All responses).



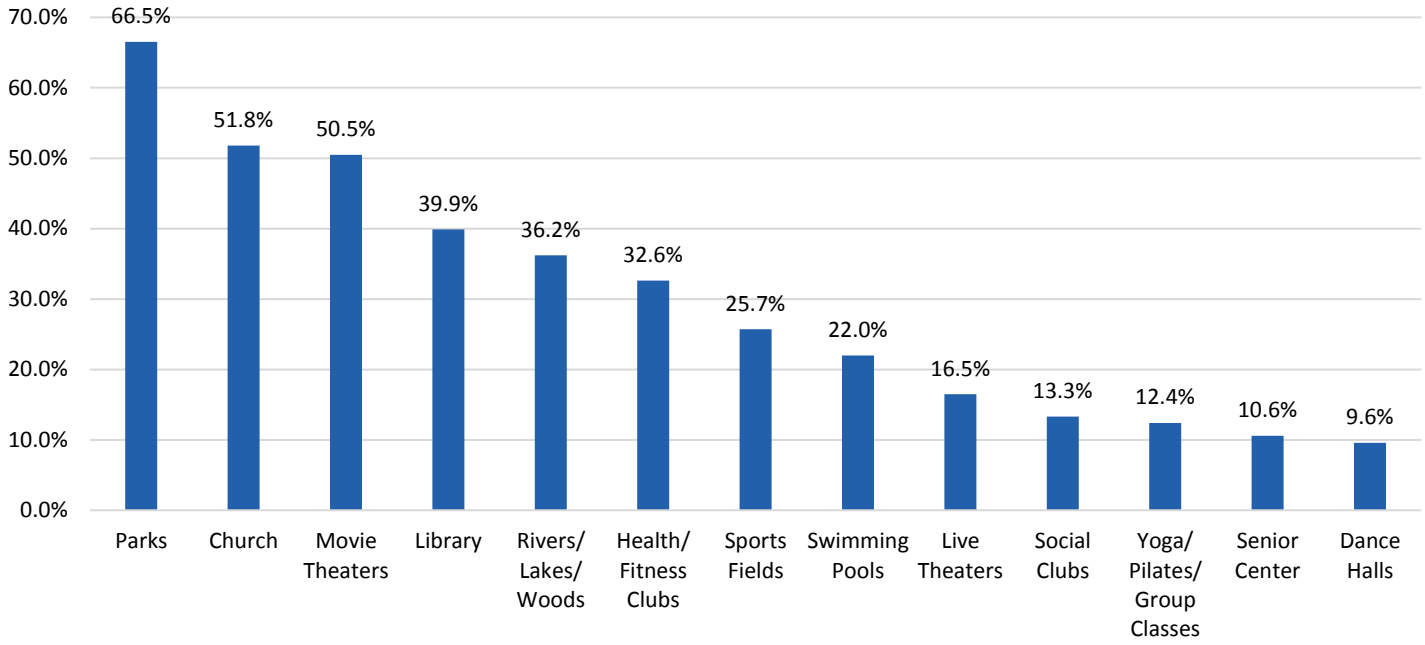
Question 3: Please rate each of the following statements for your community (English responses).



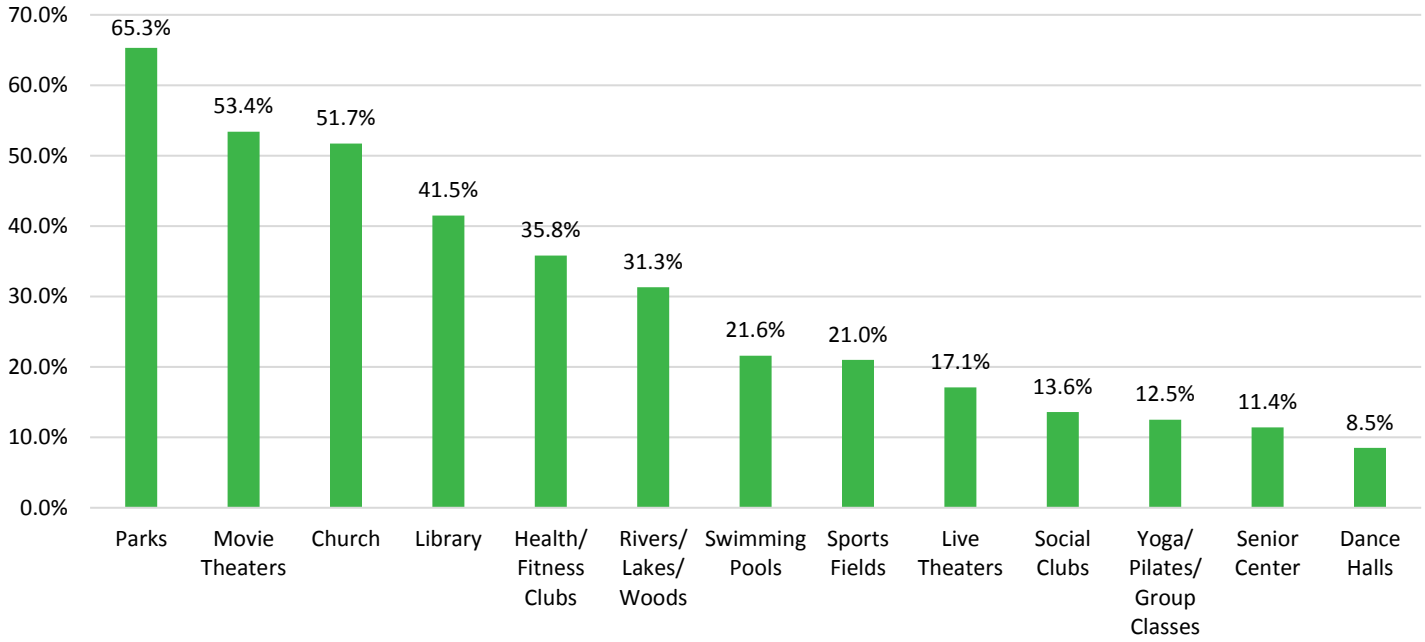
Question 3: Please rate each of the following statements for your community (Spanish/French responses).



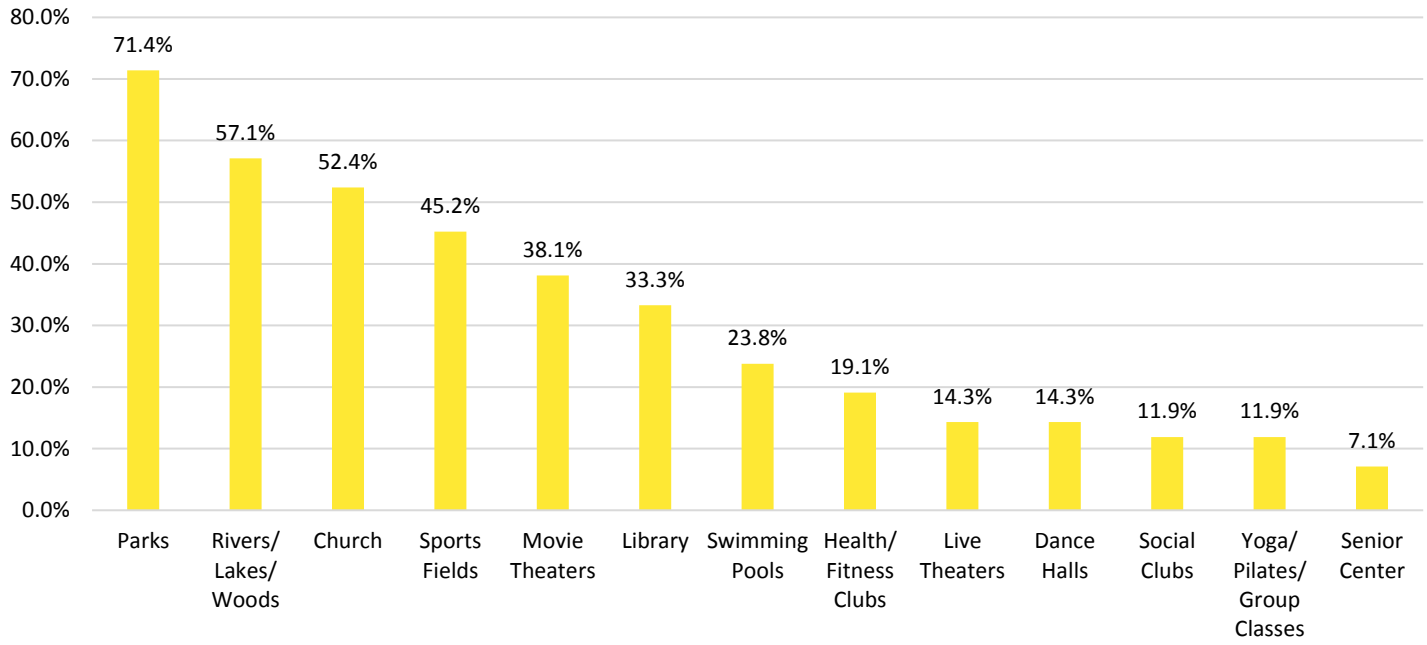
Question 4: The places where I go in my community the most often in Prince George's County are (select all that apply) (N=218 responses):



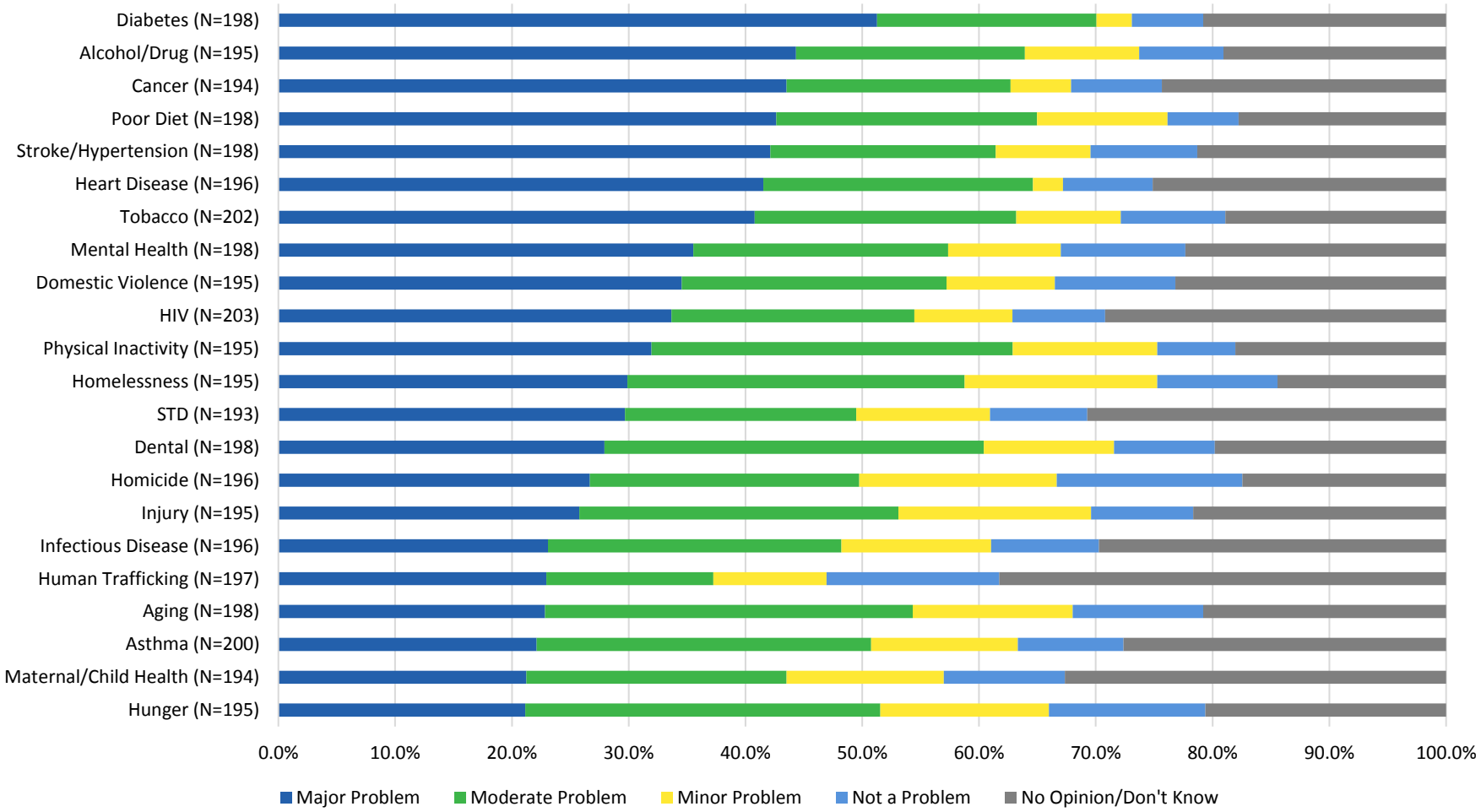
Question 4: The places where I go in my community the most often in Prince George's County are (select all that apply) (N=176 English responses):



Question 4: The places where I go in my community the most often in Prince George's County are (select all that apply) (N=42 Spanish/French responses):

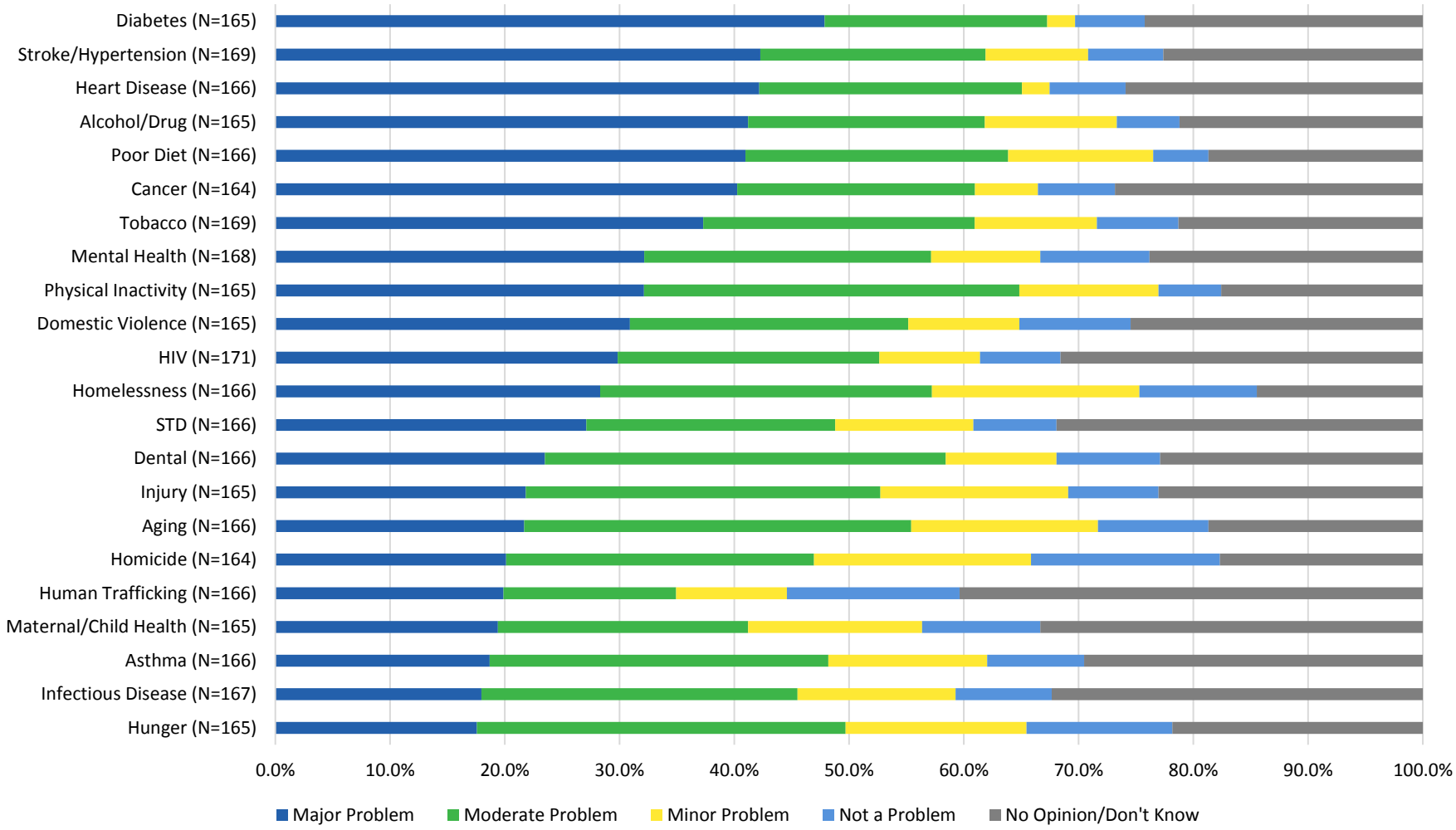


Question 5: Please rate the following health issues for your neighborhood or community (All Responses).

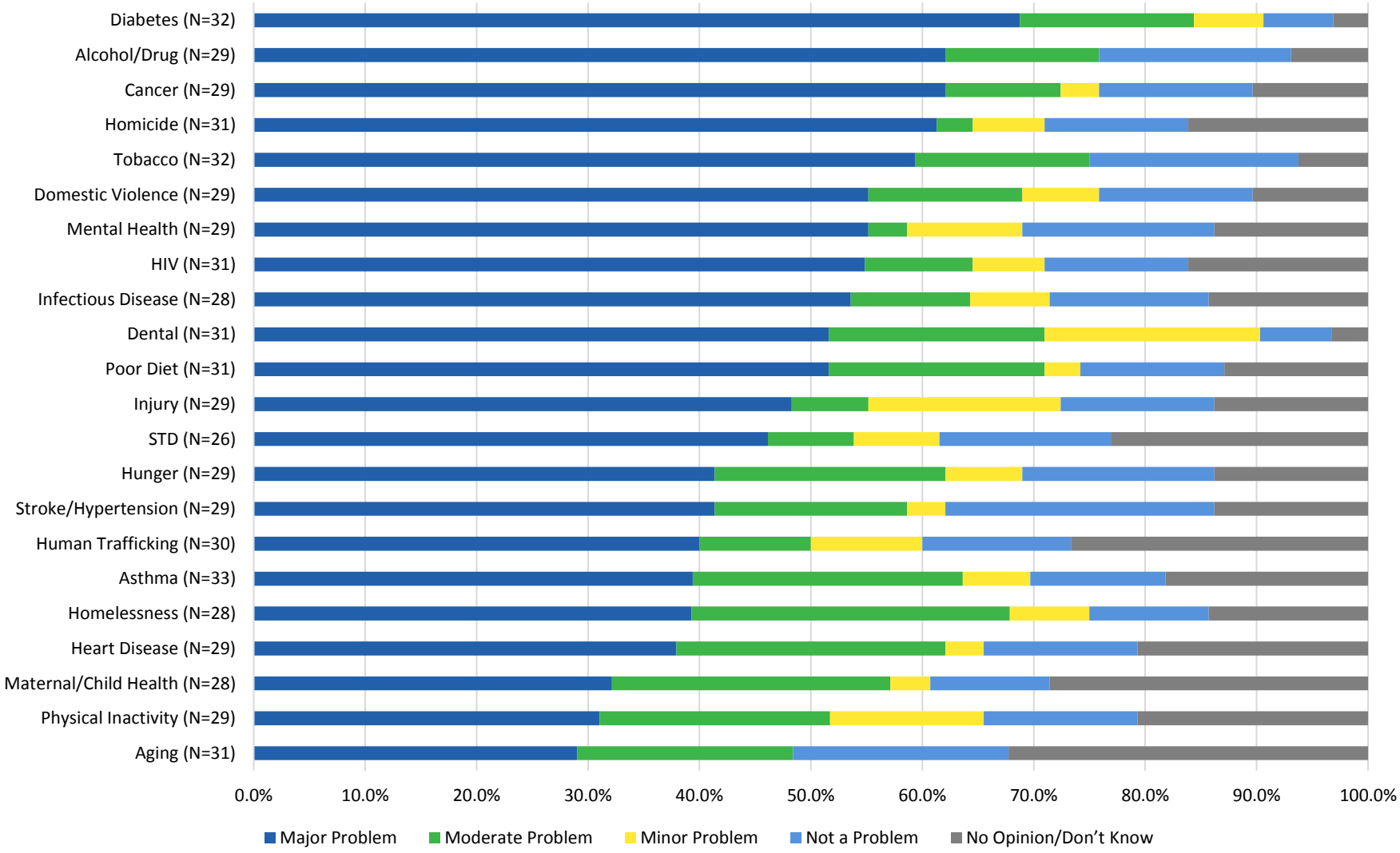


"Other" Included: renal failure; stress management

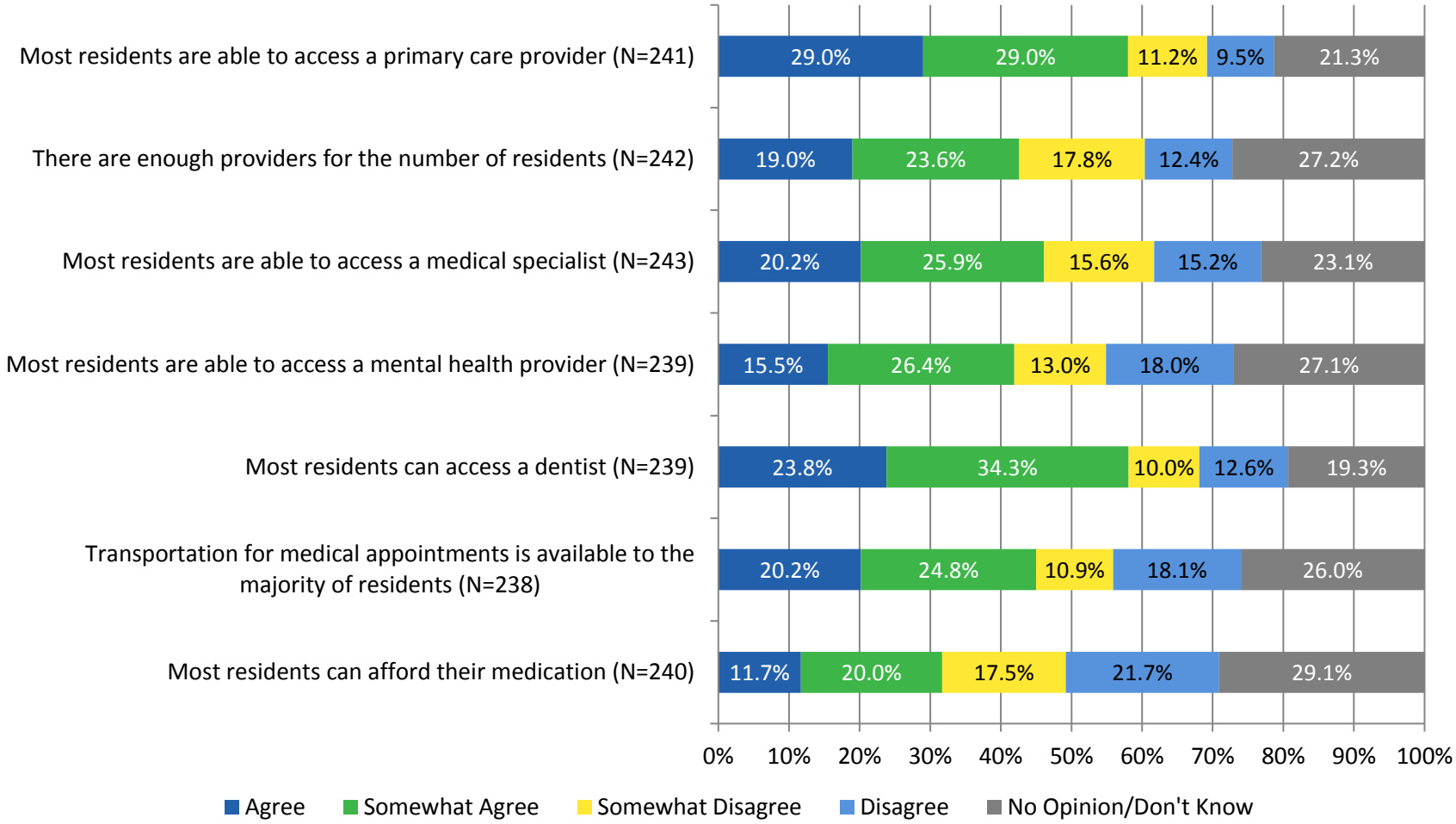
Question 5: Please rate the following health issues for your neighborhood or community (English Responses).



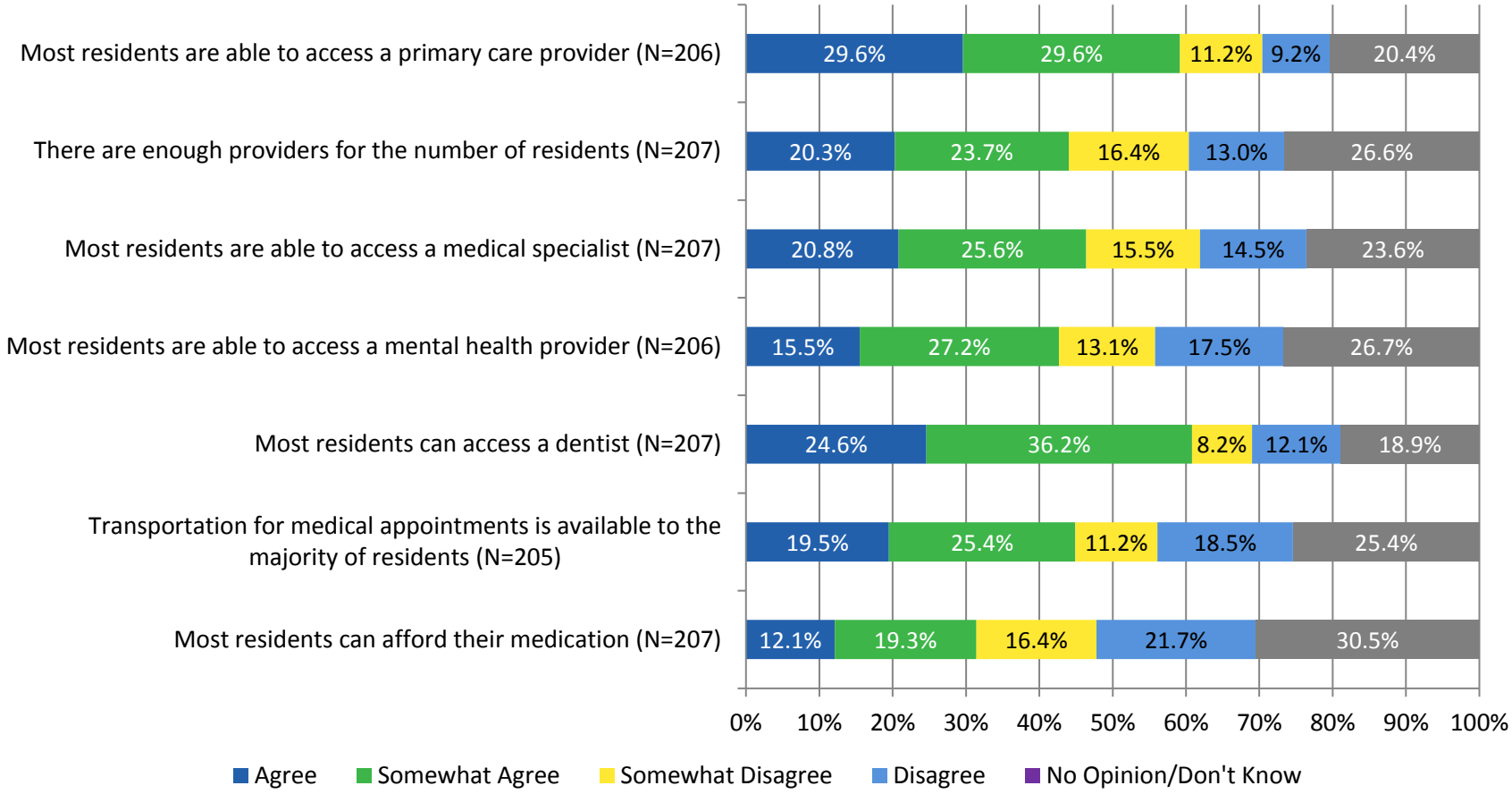
Question 5: Please rate the following health issues for your neighborhood or community (Spanish/French Responses).



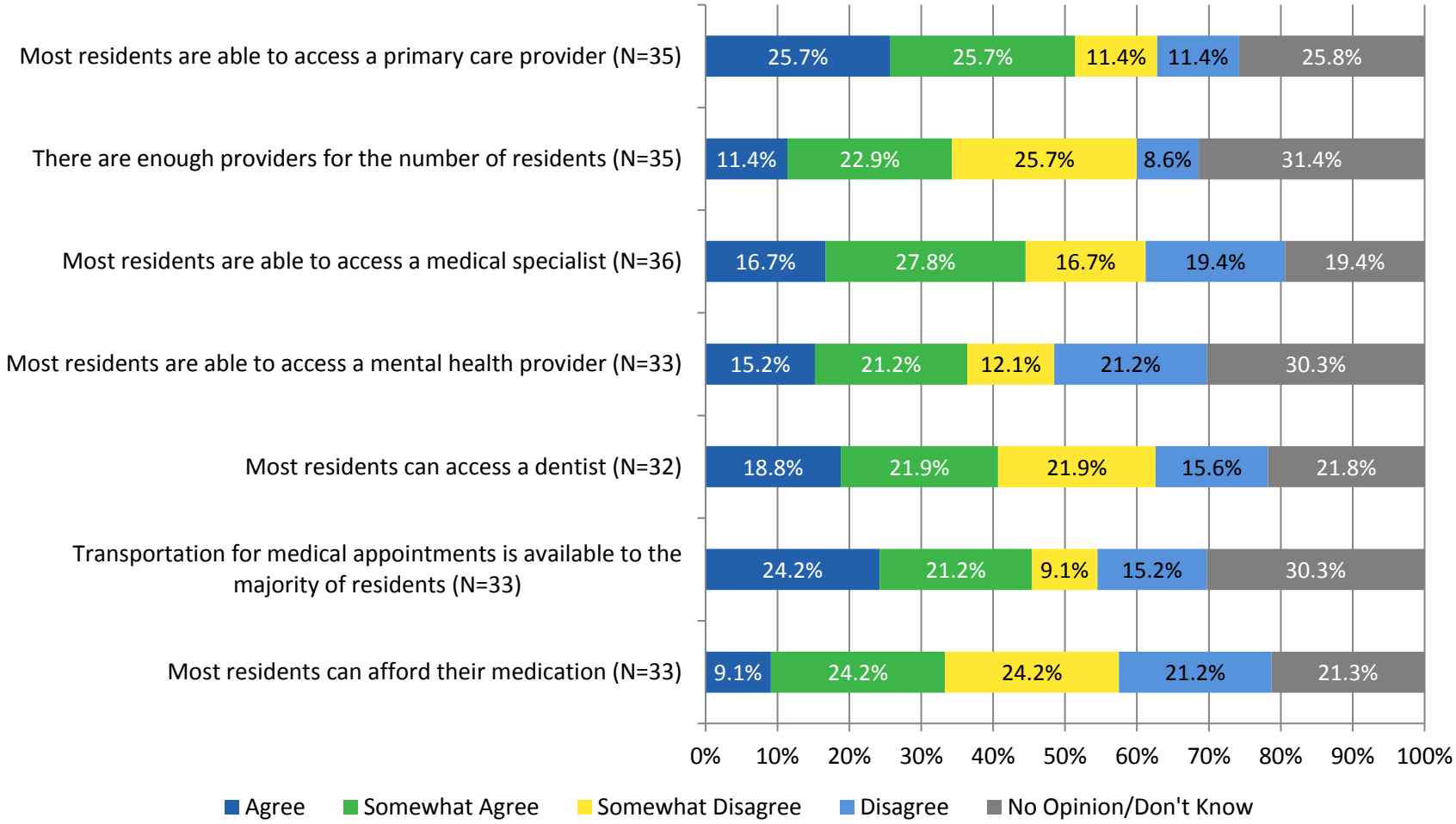
Question 6: Please rate each of the following statements about health care access in your community (All responses).



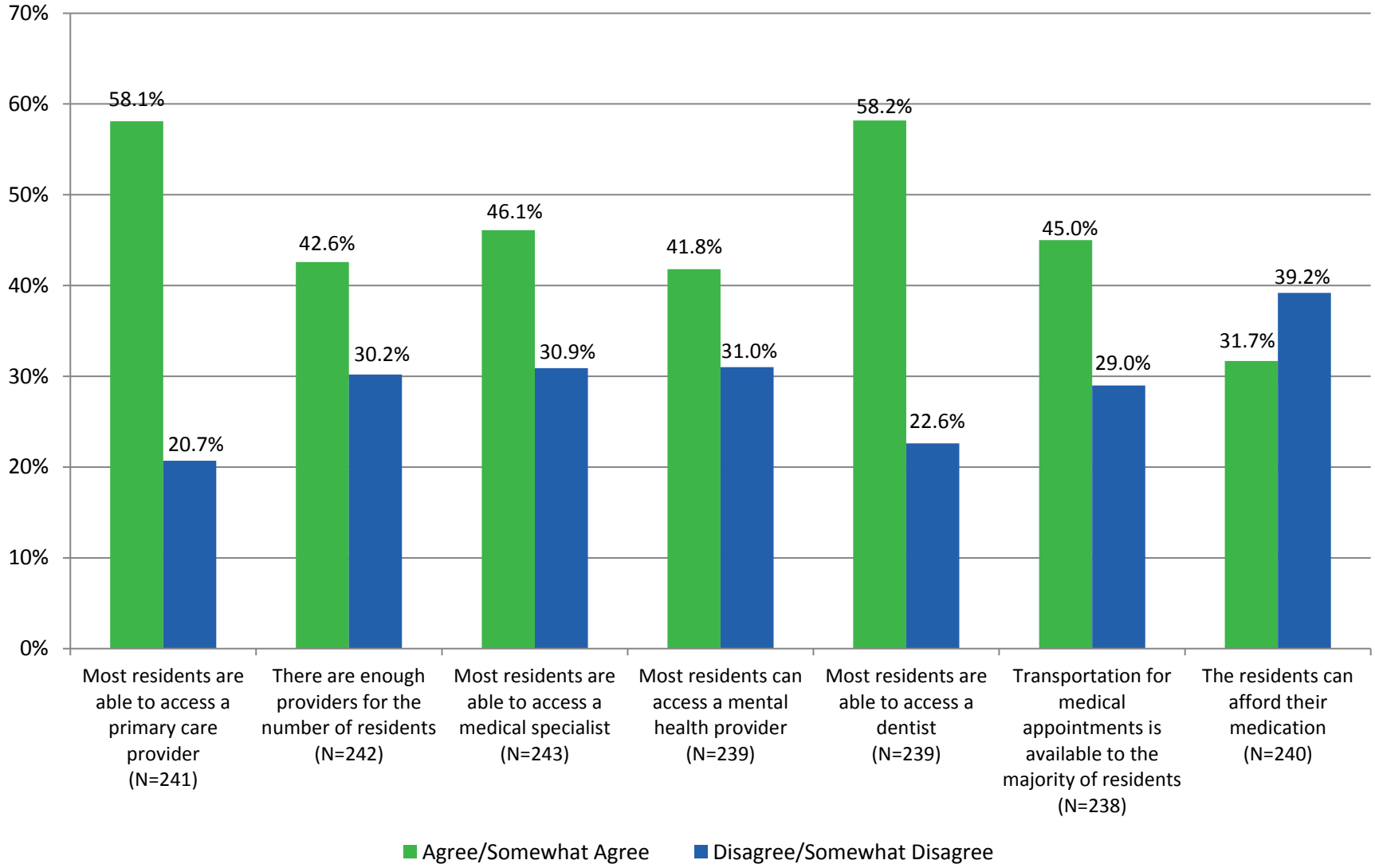
Question 6: Please rate each of the following statements about health care access in your community (English Responses).



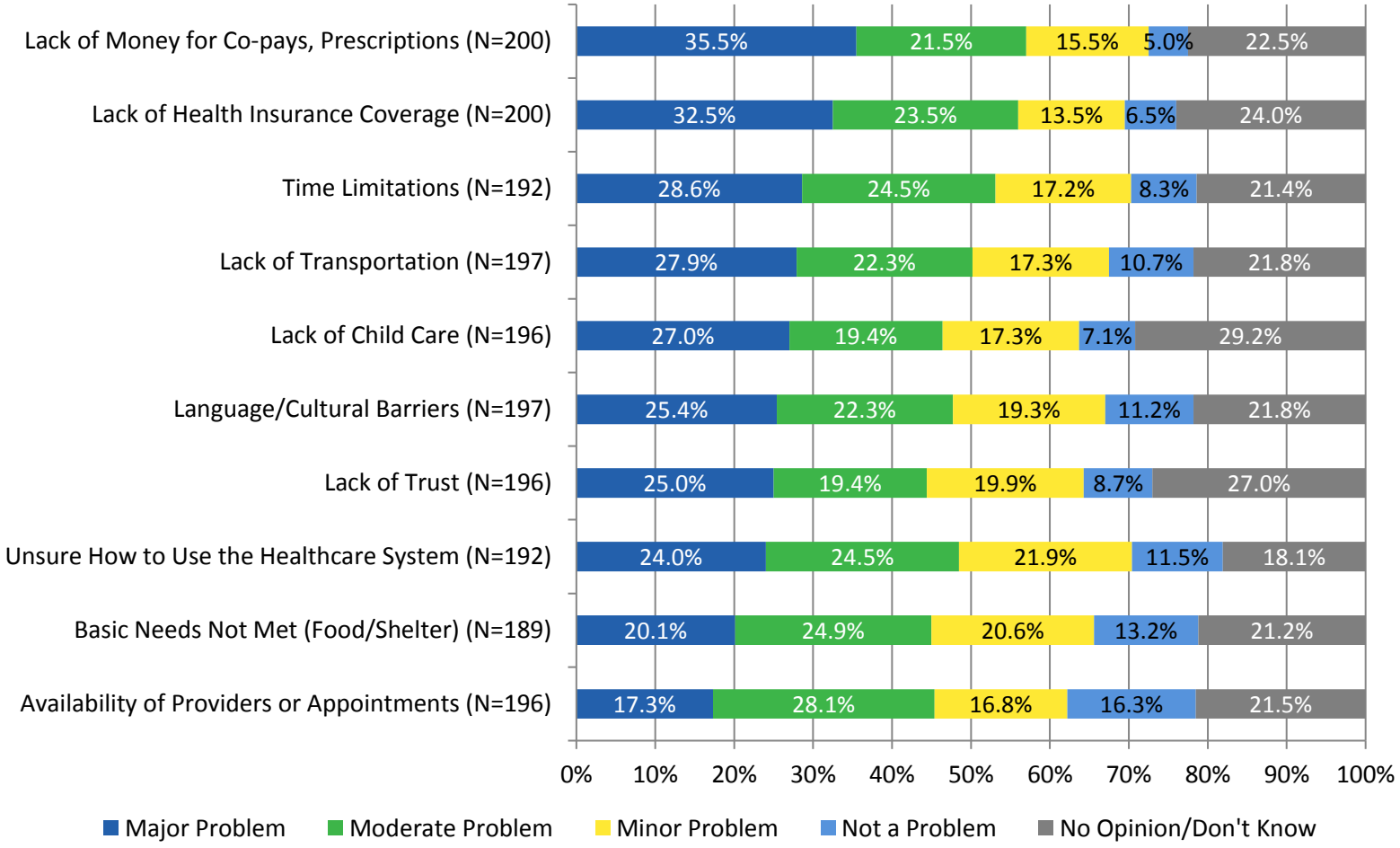
Question 6: Please rate each of the following statements about health care access in your community (Spanish/French Responses).



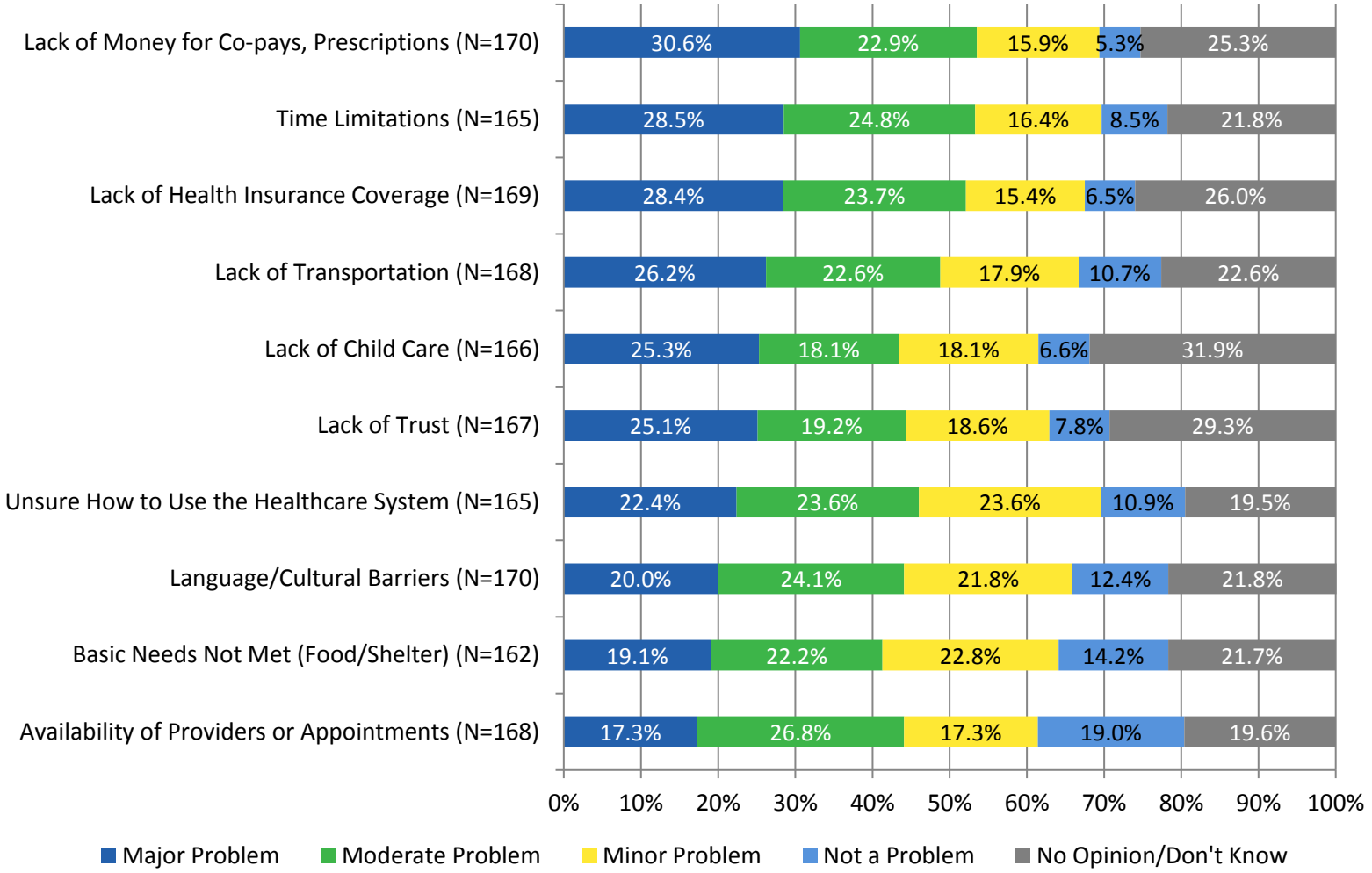
Question 6: Please rate the following statements about health care access in your community (All responses with opinion).



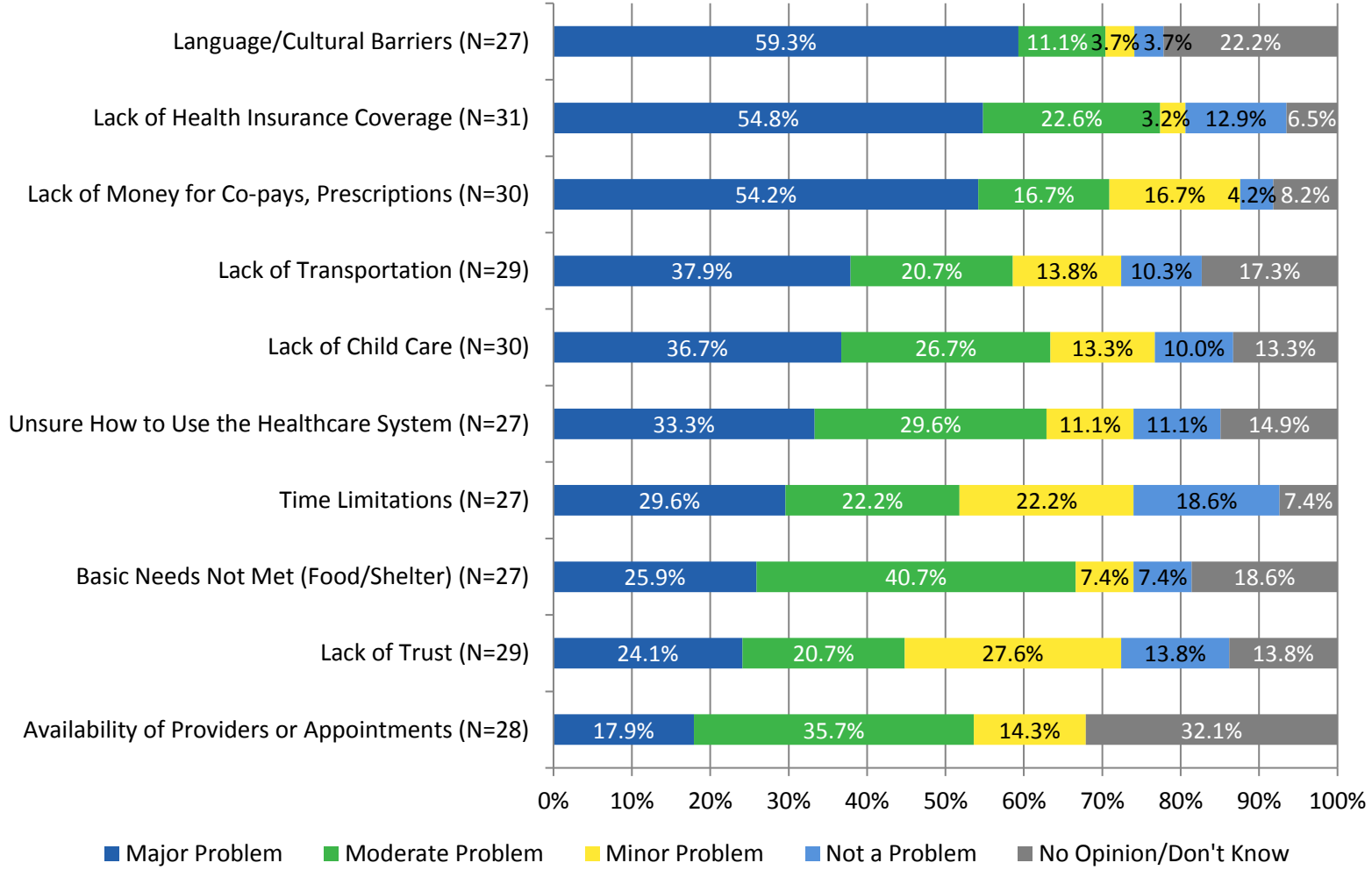
Question 7: Please indicate if you believe the barriers listed are a major, moderate, minor or not a problem that keep people in your community from accessing health care.



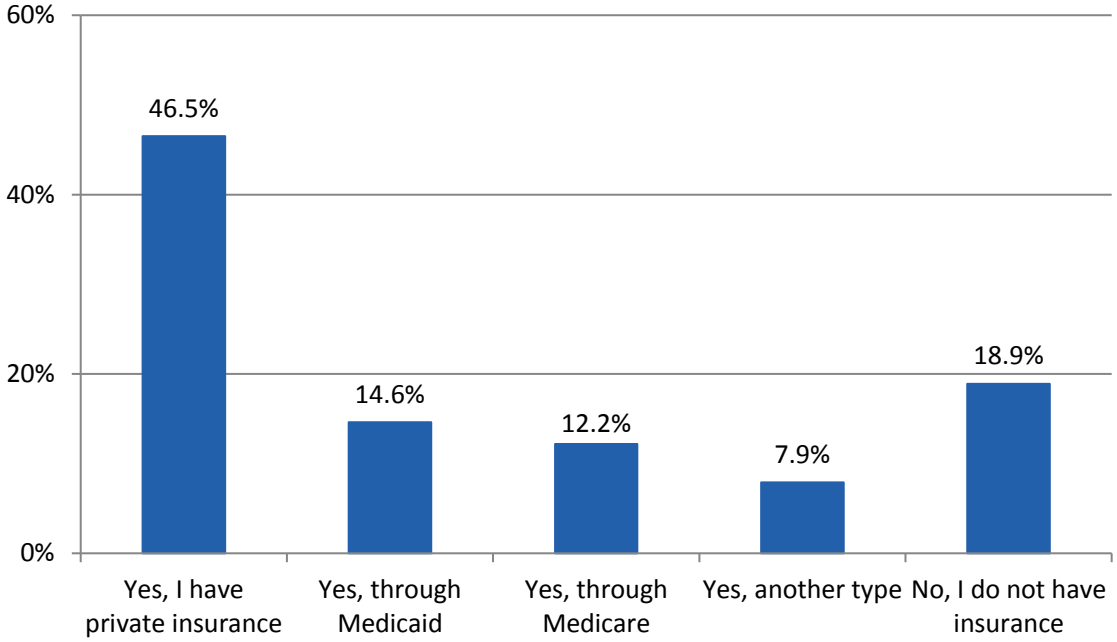
Question 7: Please indicate if you believe the barriers listed are a major, moderate, minor or not a problem that keep people in your community from accessing health care (English responses)



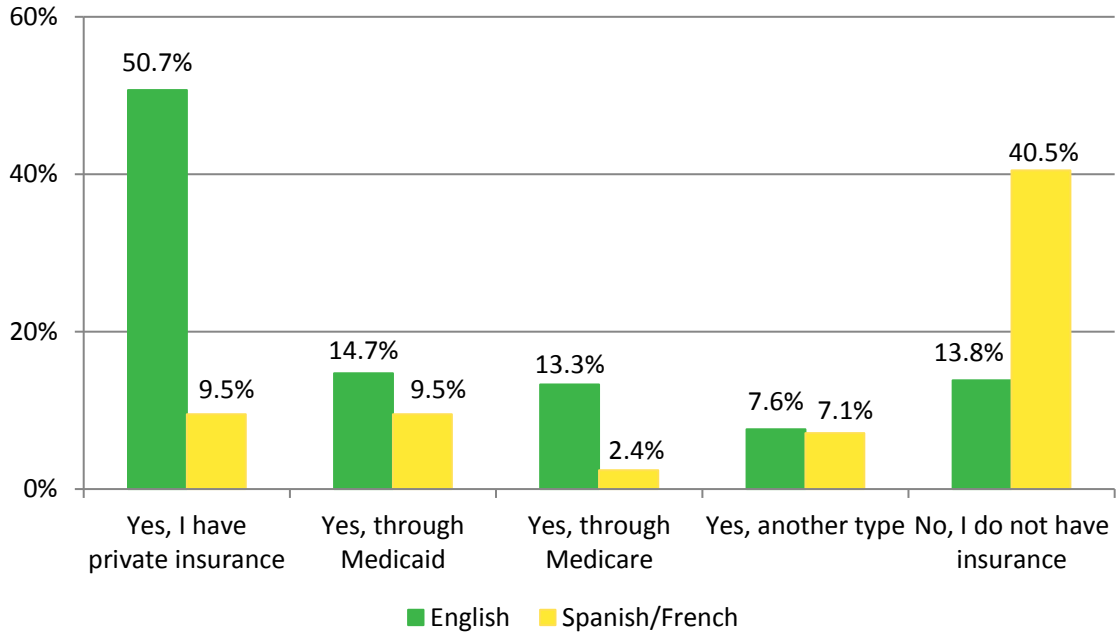
Question 7: Please indicate if you believe the barriers listed are a major, moderate, minor or not a problem that keep people in your community from accessing health care (Spanish/French responses).



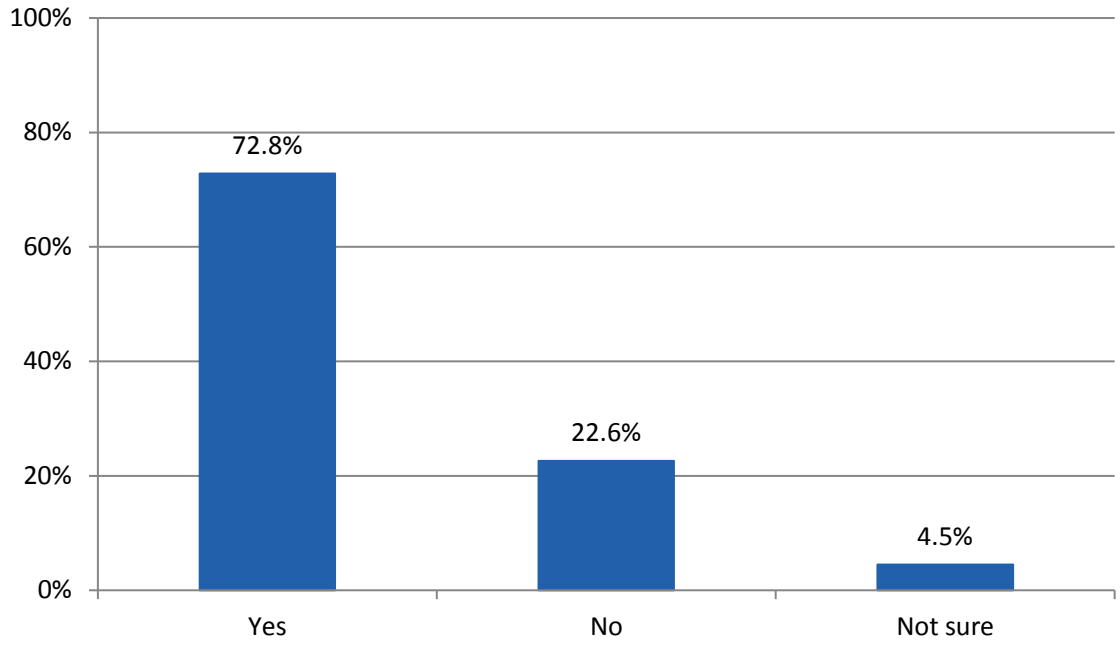
Question 8: Do you have health insurance (select all that apply)? (N=254 responses)



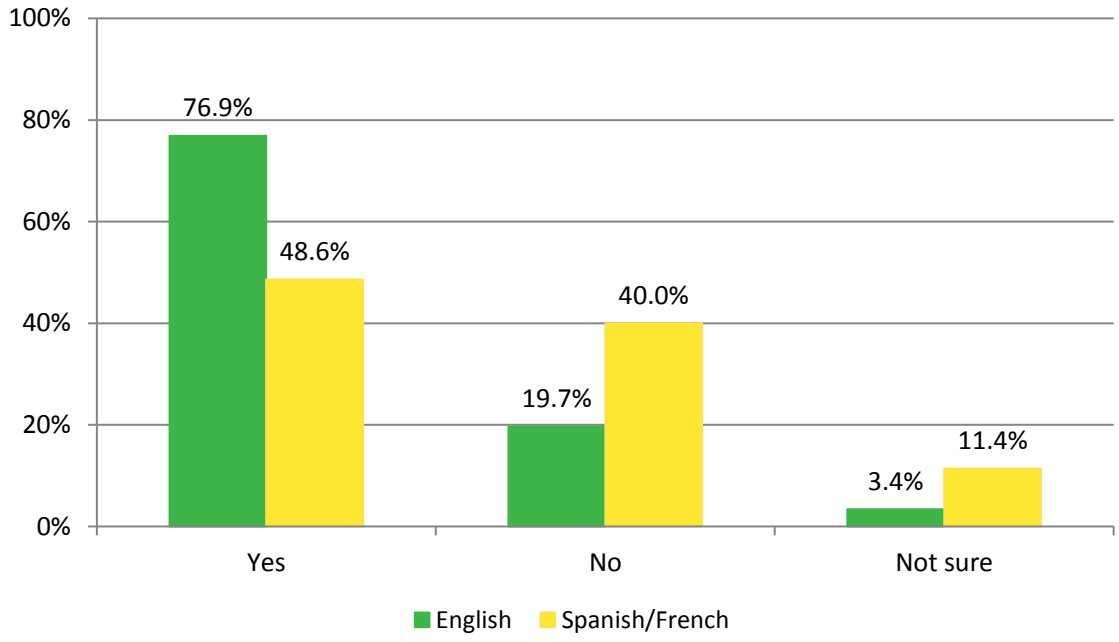
Question 8: Do you have health insurance (select all that apply)? (N=225 English responses; N=29 Spanish/French responses)



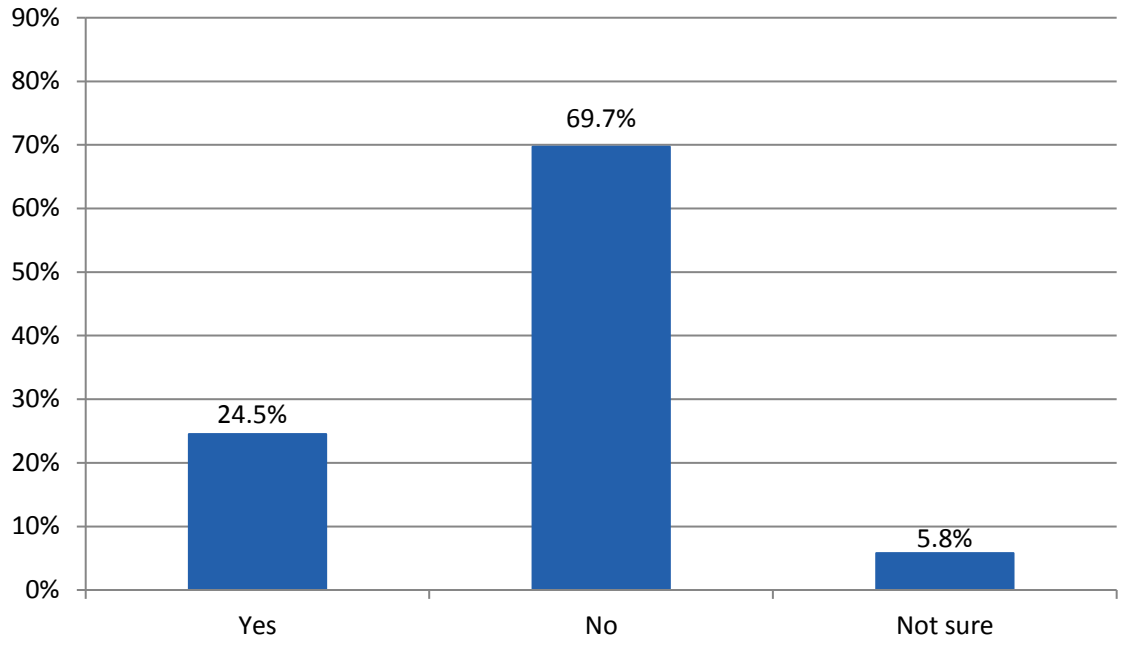
Question 9: Did you see a primary care doctor in the last year? (N=243 responses)



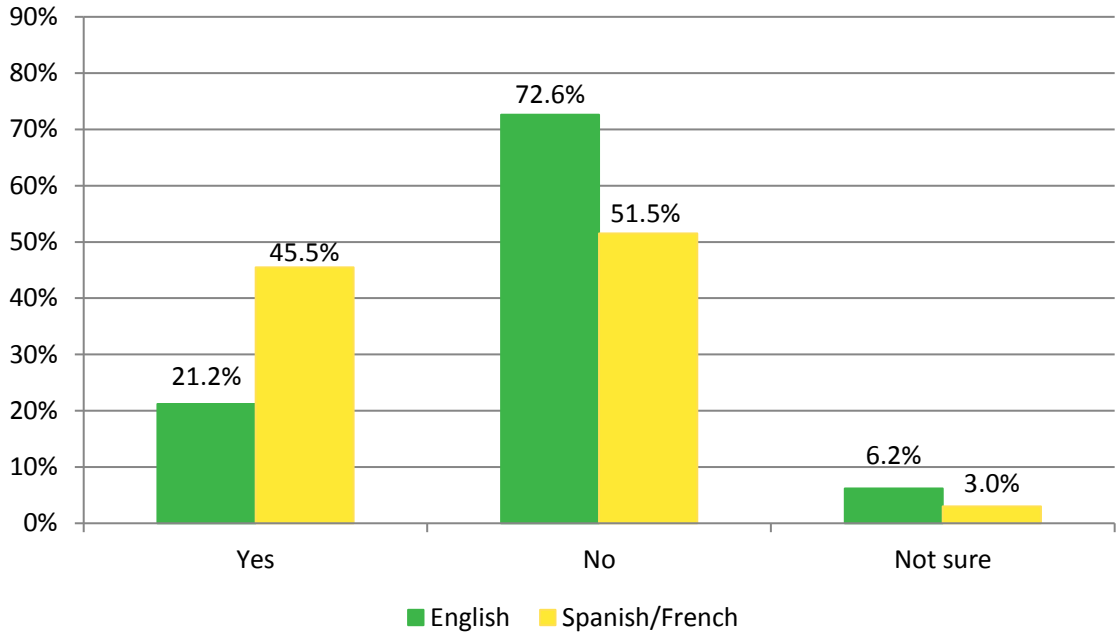
Question 9: Did you see a primary care doctor in the last year? (N=208 English responses; N=35 Spanish/French responses)



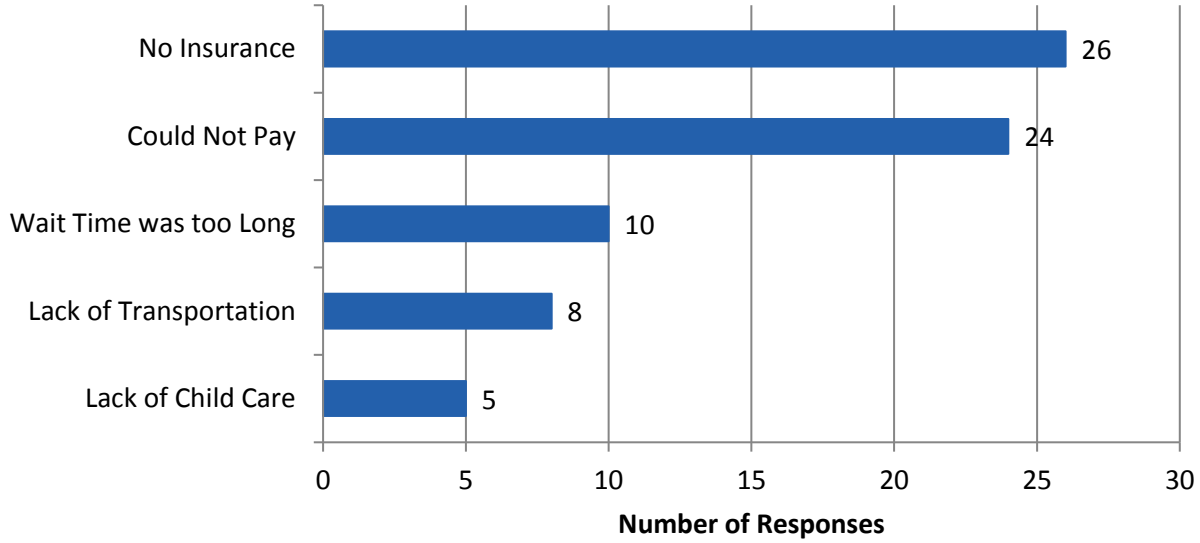
Question 10: Has there been a time in the past year when you needed medical care but were not able to get it? (N=241 responses)



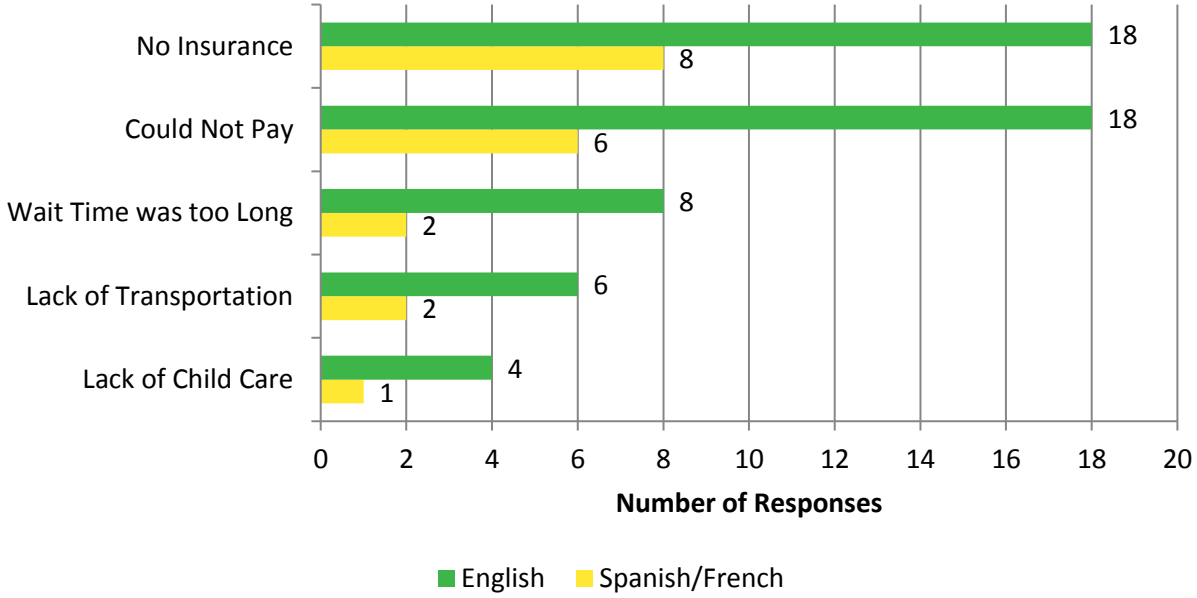
Question 10: Has there been a time in the past year when you needed medical care but were not able to get it? (N=208 English responses; N=33 Spanish/French responses)



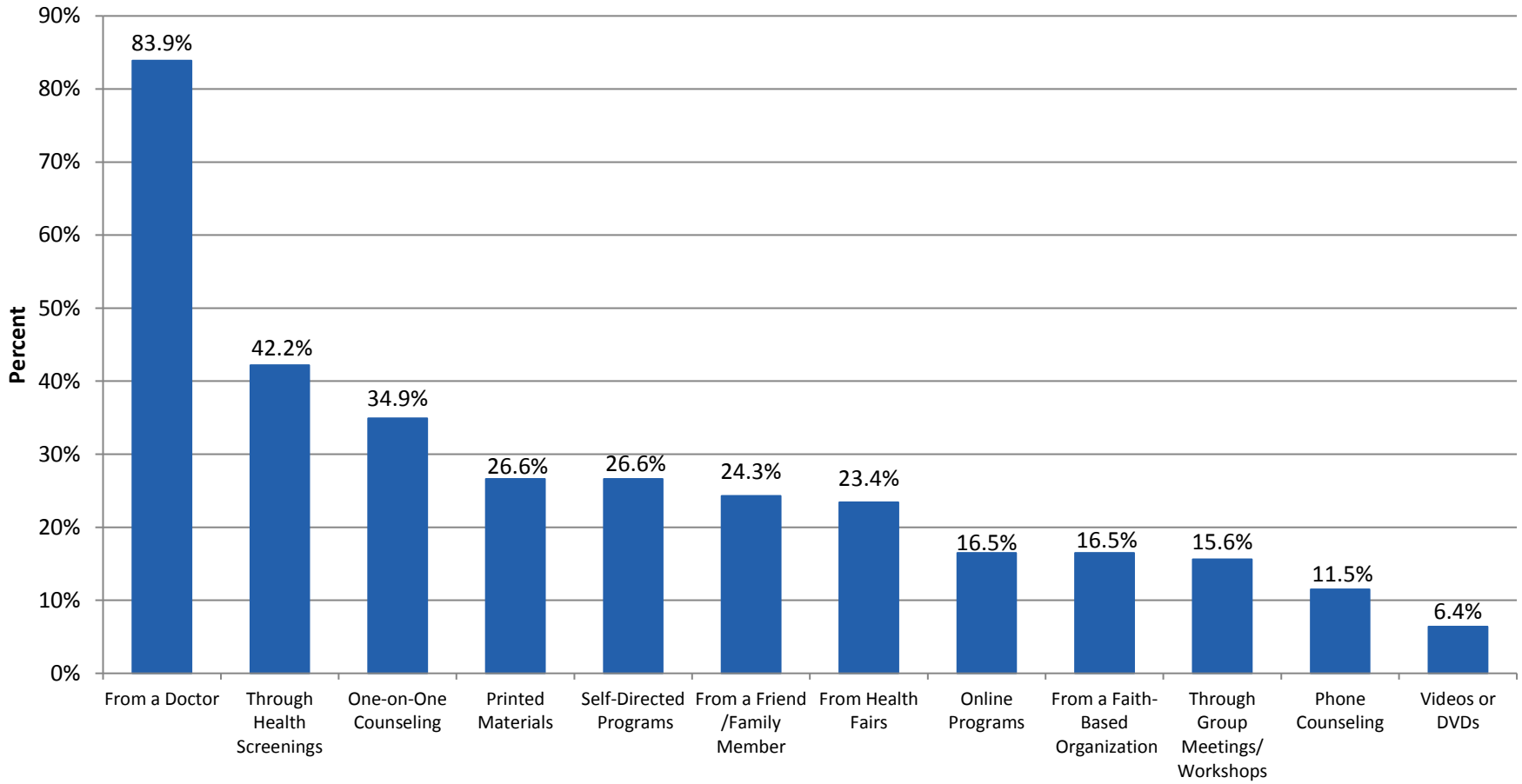
Question 11: If you answered that you were unable to get medical care, what prevented you from getting the medical care you needed (select all that apply)? (N=59 responses)



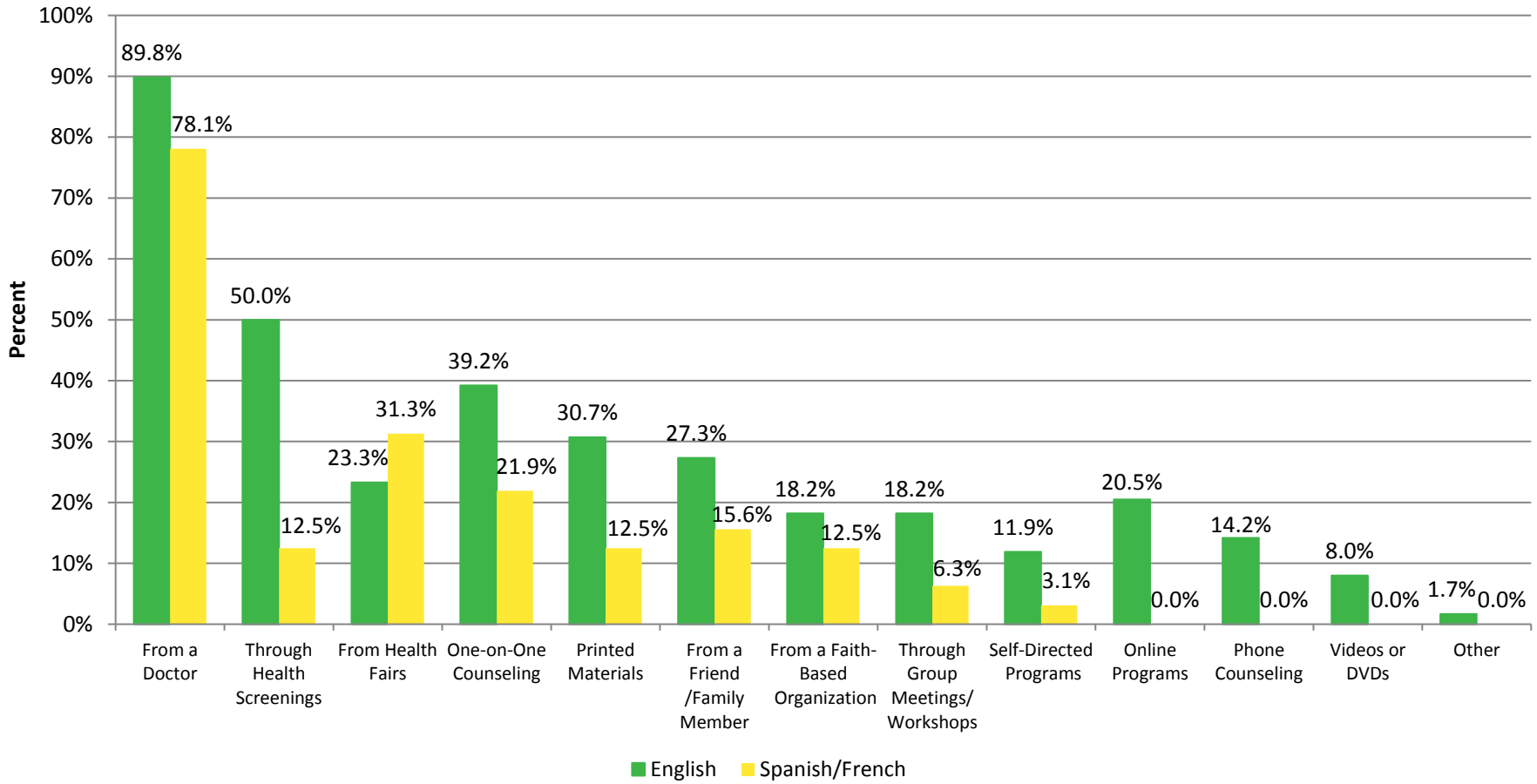
Question 11: If you answered that you were unable to get medical care, what prevented you from getting the medical care you needed (select all that apply)? (N=36 English responses; N=12 Spanish/French responses)



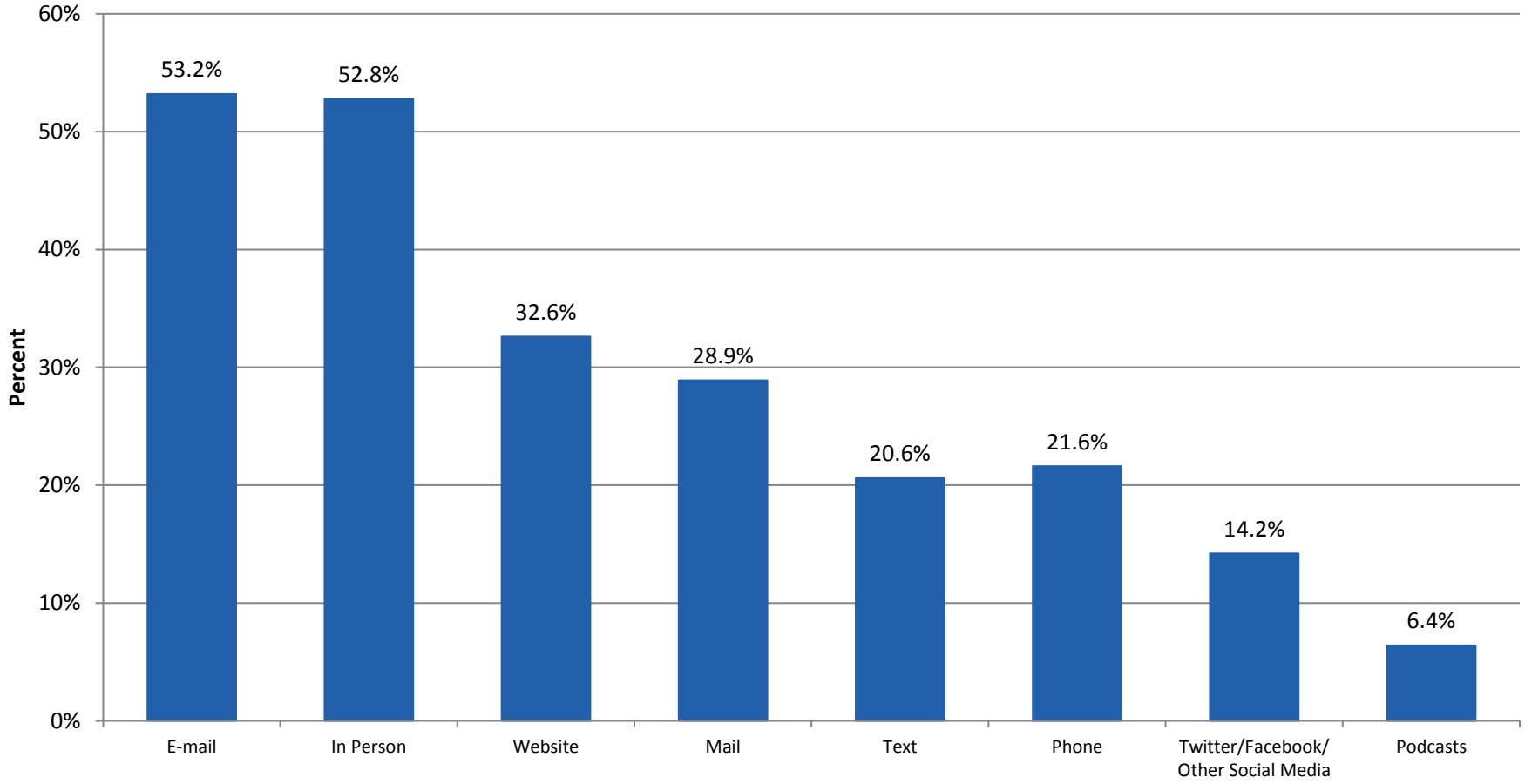
Question 12: What sources do you trust for health and lifestyle information (select all that apply)? (N=208 responses)



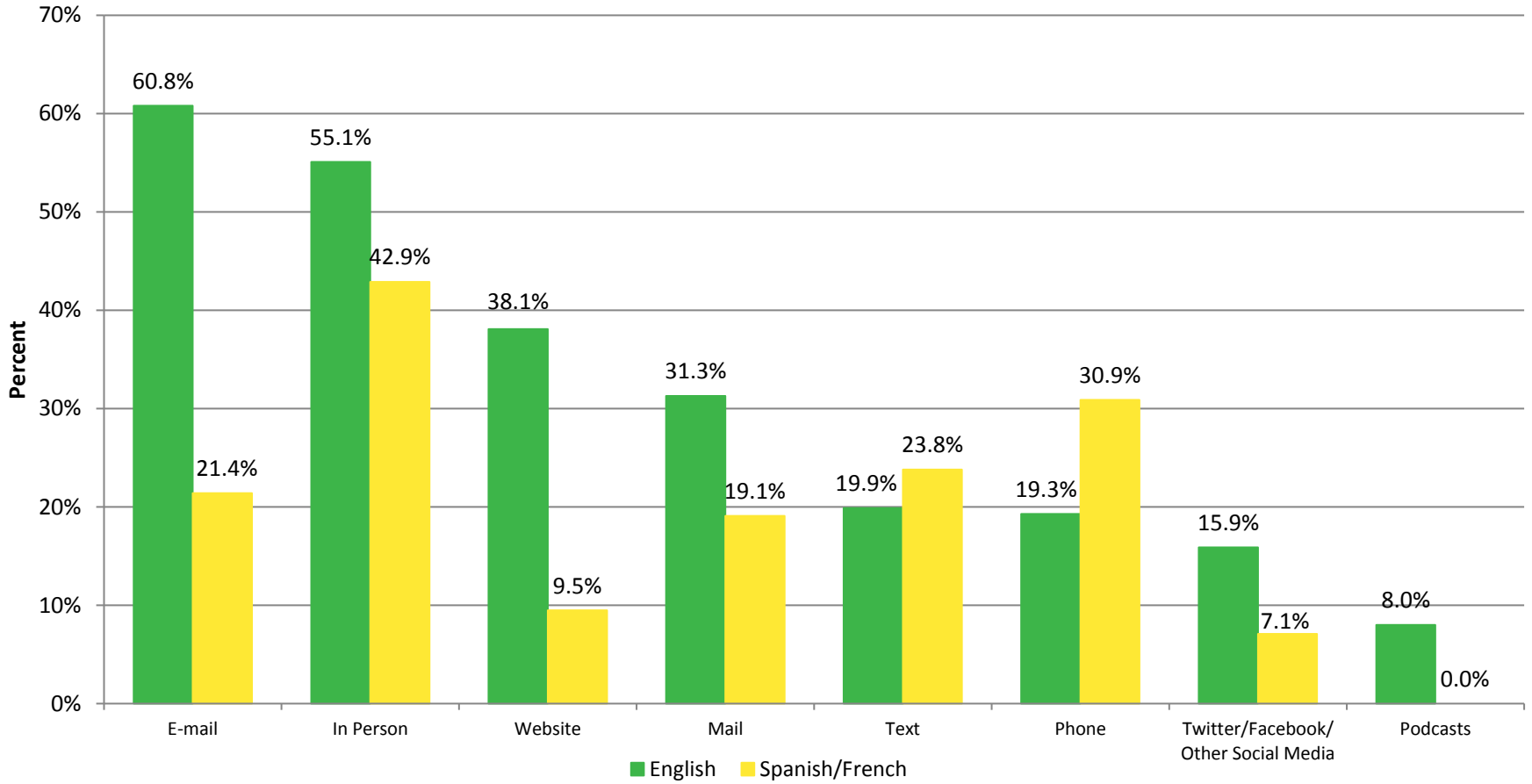
Question 12: What sources do you trust for health and lifestyle information (select all that apply)? (N=176 English responses; N=32 Spanish responses)



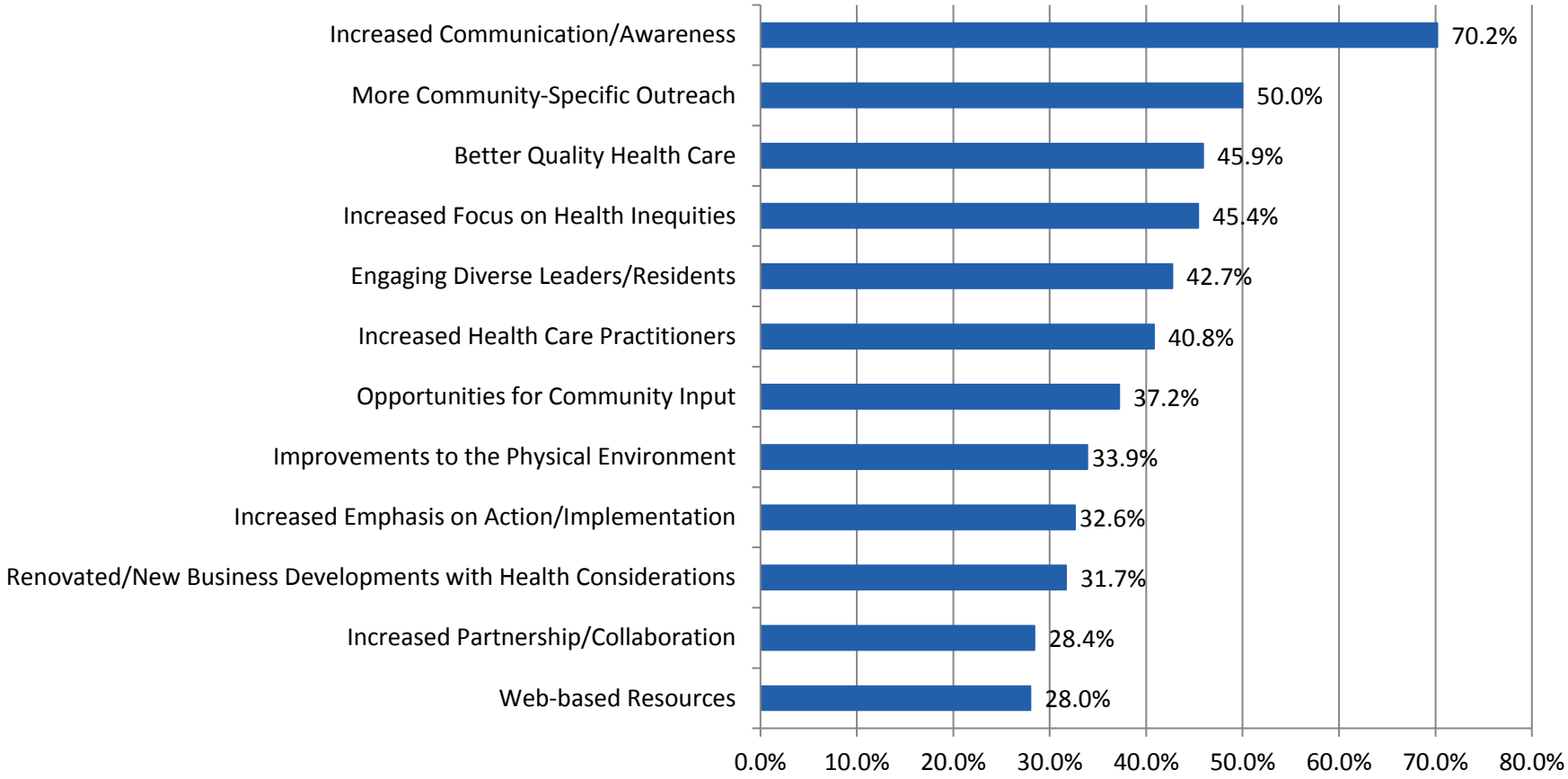
Question 13: How do you like to receive communication about health topics (select all that apply)? (N=218 responses)



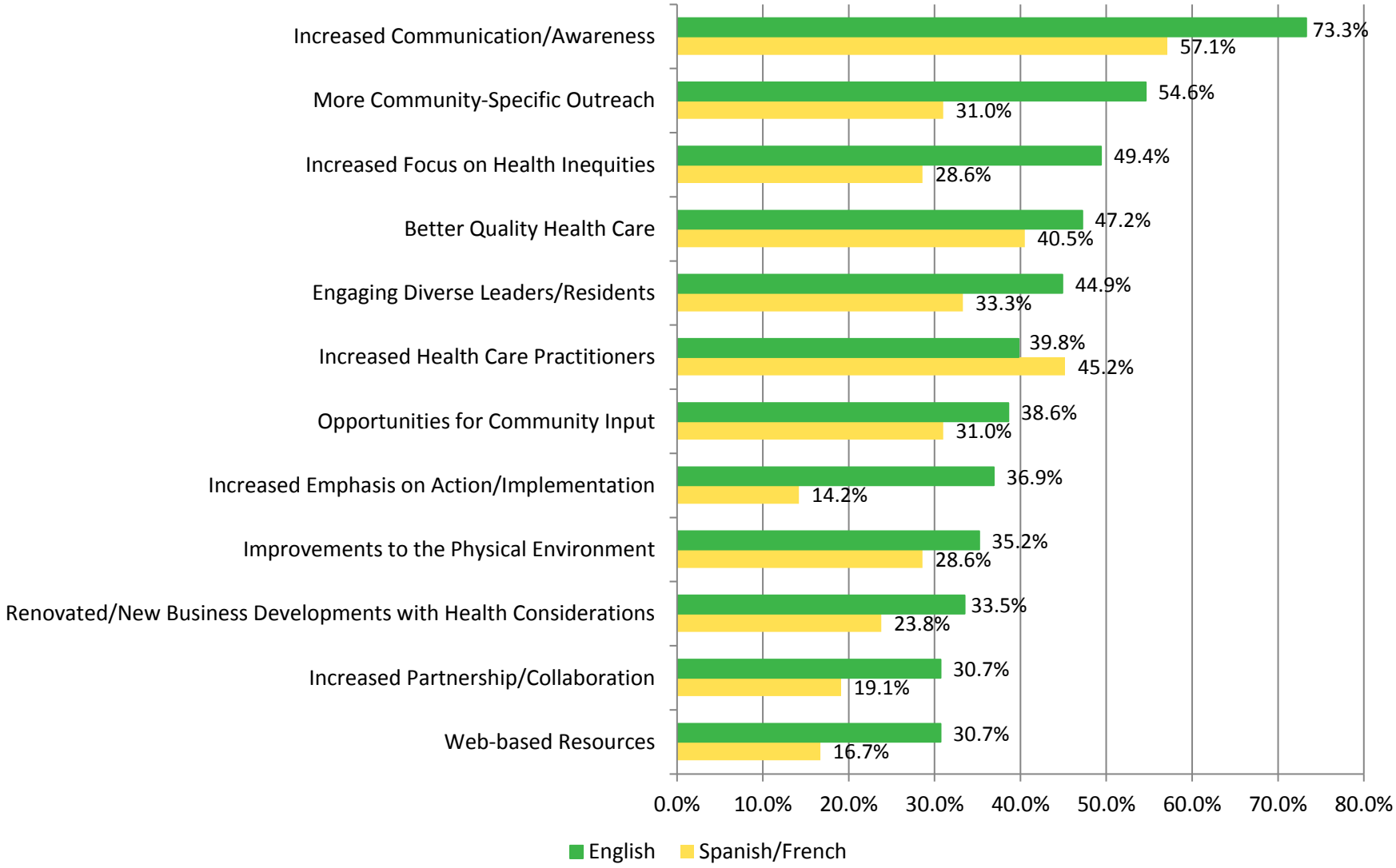
Question 13: How do you like to receive communication about health topics (select all that apply)? (N=176 English Responses N=42 Spanish/French Responses)



Question 14: What do you believe could encourage and support your community's health (select all that apply)? (N=218 responses)



Question 14: What do you believe could encourage and support your community's health (select all that apply)? (N=176 English responses; N=42 Spanish/French responses)

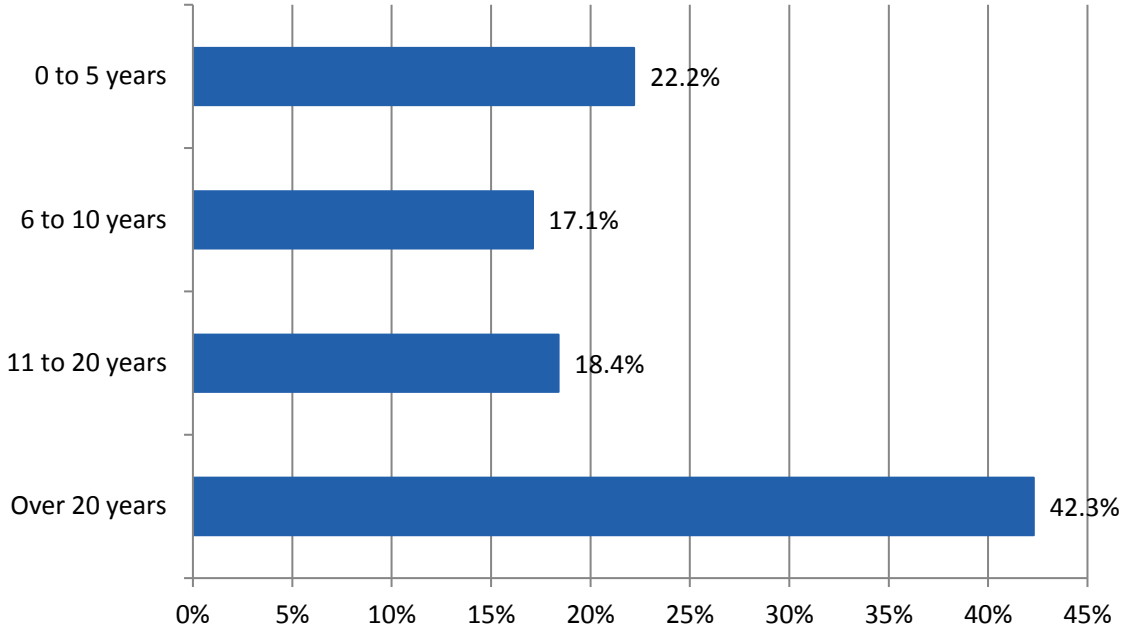


Question 15: If you could change one thing in your community, what would it be? (Open-ended responses).

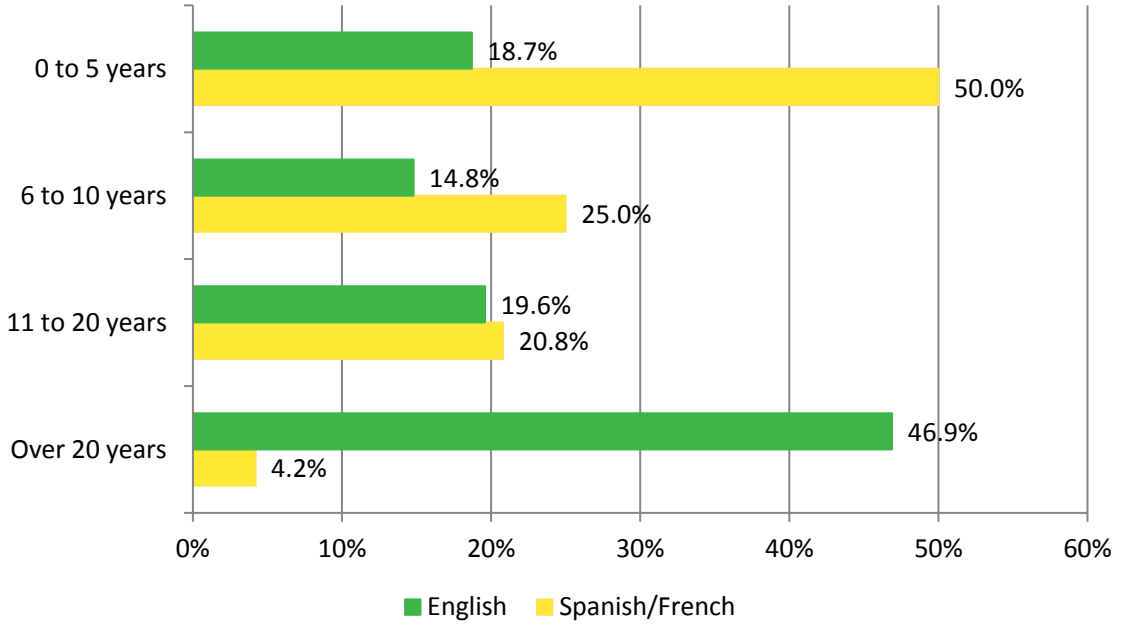
Issues mentioned	Number of English Responses	Number of Spanish/ French Responses	Summary of Responses
Addressing the Social Determinants of Health	18	2	Improve affordability – better, higher paying jobs, higher incomes, lower costs of living, affordable housing, affordable child care; better schools and educational attainment outcomes; universal full-day preschool and kindergarten; insurance coverage for all
Transportation and Infrastructure	12	0	More transportation options, decreased costs for transportation; safer transportation; better roads – no potholes and repave some area roads; more walkability and sidewalks (Laurel specifically mentioned)
Community Engagement and Education	12	2	More community organizing, including increased community events and meetings, more health programs and screenings for those communities; identify a County liaison to the smaller municipalities so that they know the communities more intimately, to advocate for funding and services in those areas; involve the Hispanic community and encourage their participation in organizations – they live ignored; more sporting activities for youth
Cleaner Neighborhoods and Environments	9	1	More parks; more trails; more bikeshares; more green spaces; more lighting in developments; mobile recreation centers; modernize the buildings
Increased Safety	5	4	Decrease the crime rate and focus on citizen security; alleviate traffic congestion; slower, safer driving, including no phone use in the car
Better Access to and Quality of Providers	5	4	More providers in the community, beyond urgent care; many residents seek care in D.C. or neighboring counties; no limitations to services provided; more bilingual staff and professionals; more medical information provided to communities
Better Access to Healthy Foods	4	0	Closer grocery stores with more/better options; fewer fast food outlets in communities
Lower Death and Disease Rates	4	0	Overall decrease in the disease and death rates in the community; at home STD testing; increased outreach about safe sex and the importance of STD testing
Senior Population Considerations	2	0	More services for seniors (e.g., independent living and group housing); more help with access as technology advances – some seniors do not know how to access resources online without help

Participant Profile

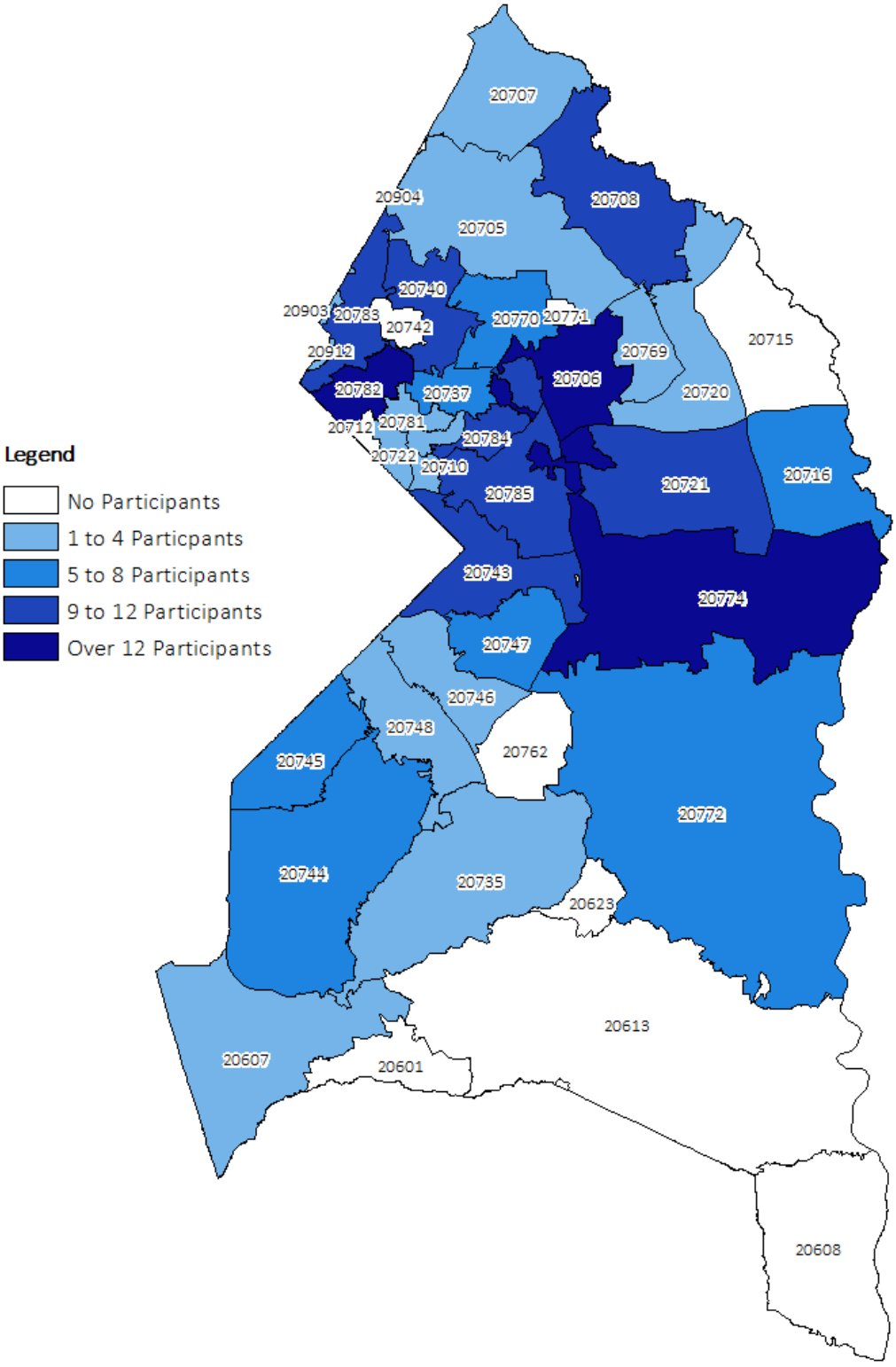
Question 16: How long have you lived in Prince George's County? (N=234 responses)



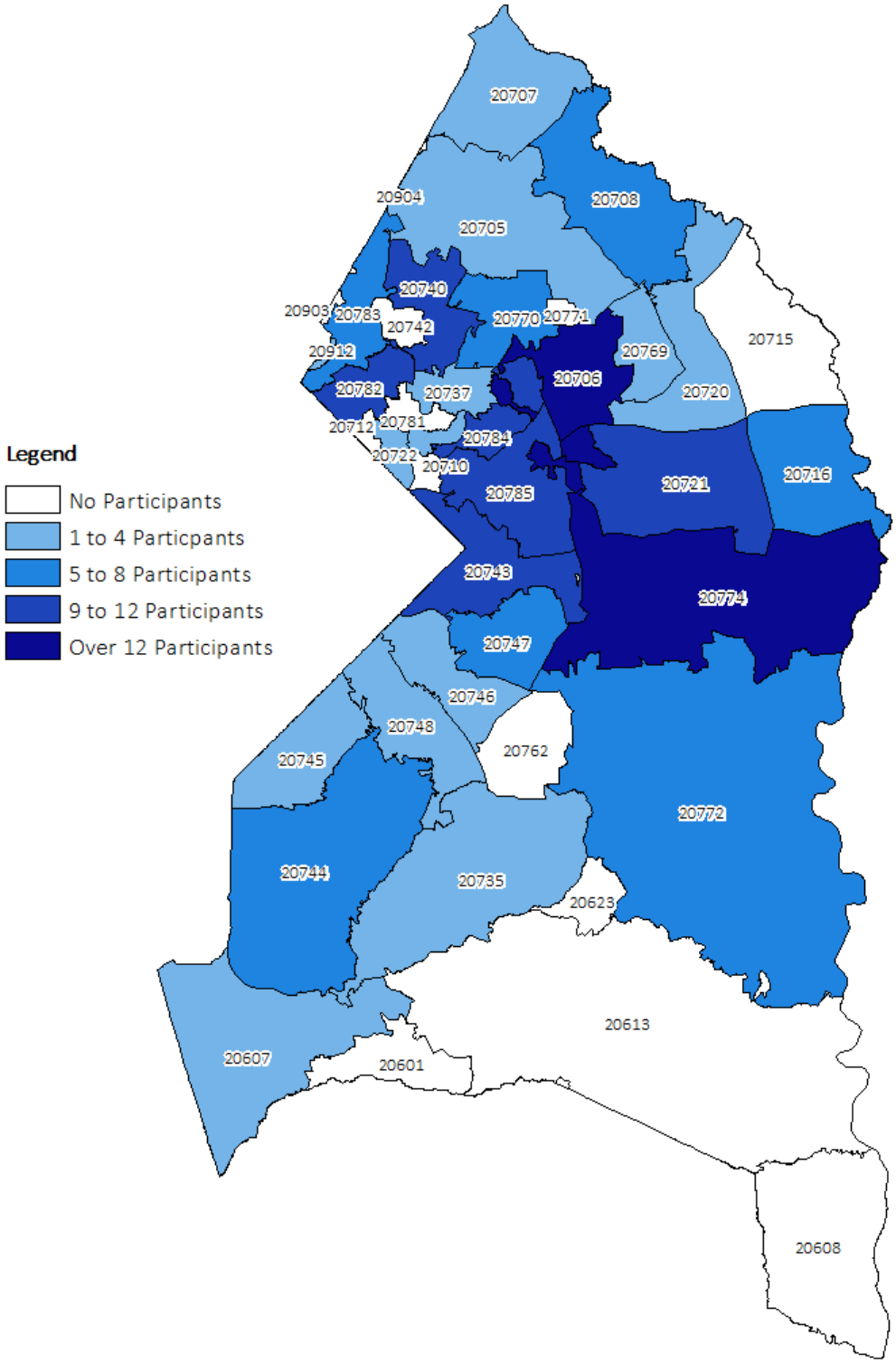
Question 16: How long have you lived in Prince George's County? (N=209 English responses; N=25 Spanish/French responses)



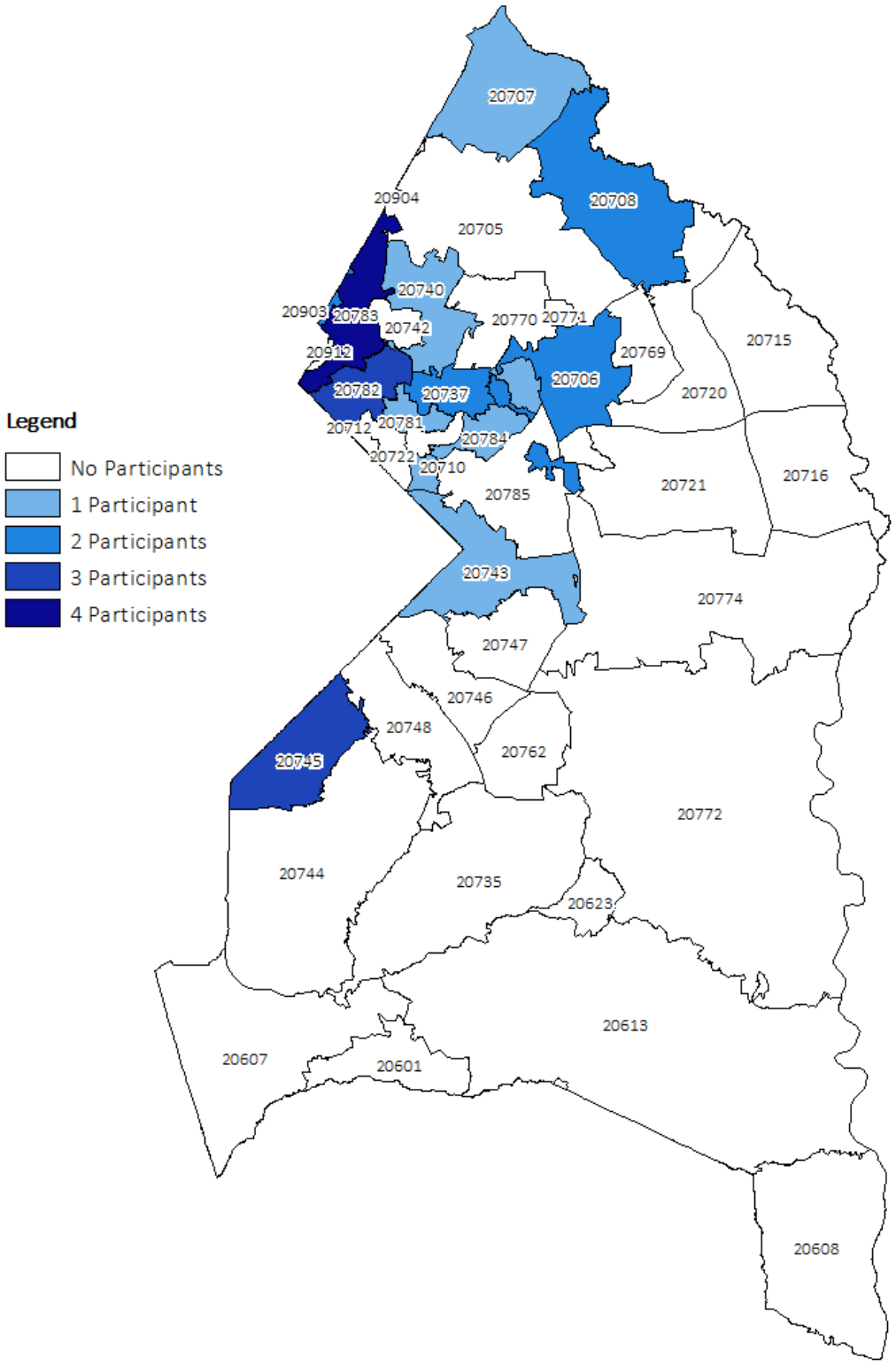
Question 17: What ZIP code do you live in? (N=225 responses)



Question 17: What ZIP code do you live in? (N=201 English responses)



Question 17: What ZIP code do you live in? (N= 24 Spanish/French responses)



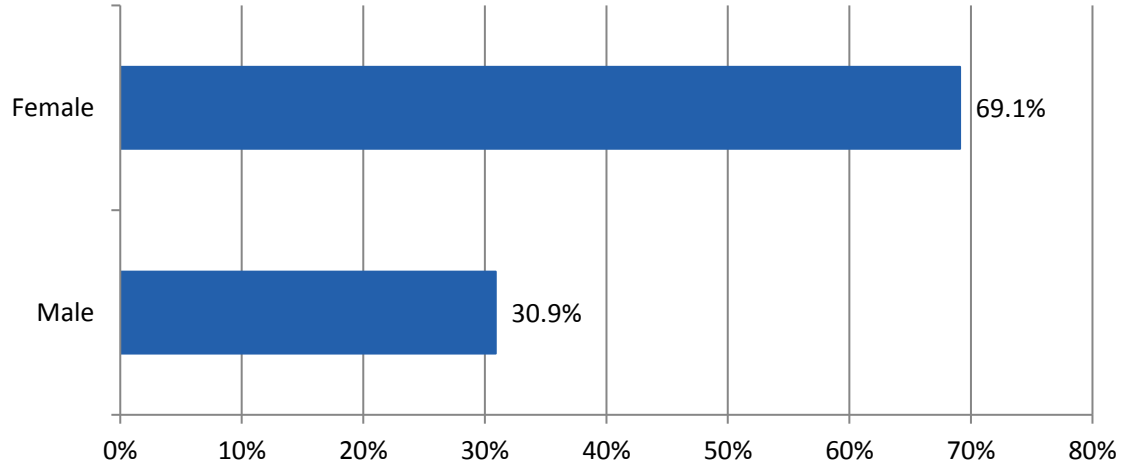
Question 18: What community do you live in? (N=152 English responses; 21 Spanish responses)

Community	English Participants	Spanish/French Participants
Amherst Rd	1	0
Ashford	1	0
Ashton Heights	1	0
Berwyn Heights	0	1
Bladensburg	1	0
Bowie	7	0
Boxwood Village	1	0
Breezewood Terrace	1	0
Brentwood	1	0
Brock Hall Manor	1	0
Brock Hills	1	0
Brooksquare Condo	1	0
Calvert Hills	1	0
Camp Springs	1	0
Capitol Heights	5	0
Carmody Hills	1	0
Cherry Lane Laurel	0	1
Cheverly	1	0
Chillum	0	2
Clinton	2	0
College Park	5	0
Collington Station	1	0
Colmar Manor	1	0
Contee Road Deerfield	0	1
Coral Hills	1	0
Covington Station	1	0
District Heights	1	0
Dresden Green	2	0
Enterprise Estates	1	0
Enterprise Knolls	1	0
Estate Neighborhood	1	0
Forestville	1	0
Fort Washington	1	0
Glenarden	2	0
Glendale Estates	1	0
Good Luck Road	1	0
Greenbelt	4	1
Greenbriar	1	0
Harbors Edge	0	1
Heritage Park	0	1
High Point	1	0
Hill Oak	1	0
Hillcrest Heights	1	0

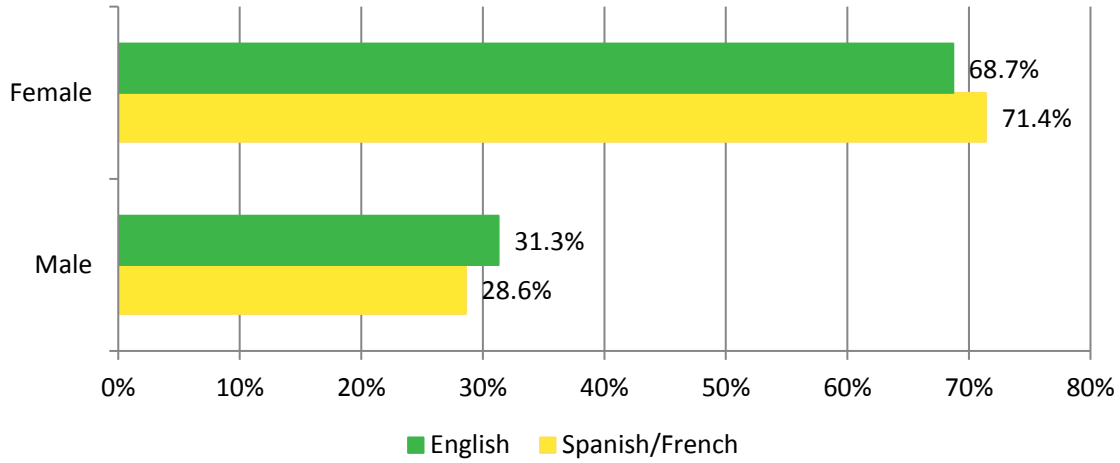
Community	English Participants	Spanish/French Participants
Hillendale	1	0
Hollywood	2	0
Holton Lane	1	0
Hyattsville	7	4
Hynesboro	1	0
Imperial Gardens	1	0
Jefferson St	1	0
Lake Arbor	1	0
Landover	6	0
Langley Park	1	1
Lanham	3	1
Largo	8	0
Laurel	4	1
Laurel Ridge	1	0
Lewisdale	1	0
Marlton	1	0
Mitchellville	1	0
Montpelier	2	0
Mt. Airy Estates	2	0
New Carrollton	3	1
Oak Creek	2	0
Oakcrest	1	0
Old Stage	1	0
Owens Rd	1	0
Oxon Hill	1	1
Palmer Park	1	0
Peppermill Village	1	0
Potomac Ridge	1	0
Riggs Avenue	1	0
Riverdale	1	1
Saint Barnabas Rd	0	1
Simmons Acres Accokeek	1	0
Silver Spring	0	2
Squire Wood	1	0
Strawberry Glenn	1	0
Swann Road	1	0
Tall Oaks	2	0
Tantallon	2	0
Templeton Knolls	1	0
Tiffin Court	1	0
Truman Park	1	0
University Hills	1	0
University Park	9	0
Unknown	2	0
Upper Marlboro	4	0
Village Green	1	0

Community	English Participants	Spanish/French Participants
Vilma	1	0
Walker Mill	1	0
West Hyattsville	1	0
West Lanham Hills	1	0
Woodlark	1	0
Woodlawn	1	0
Woodmore	1	0
Woodstream	1	0

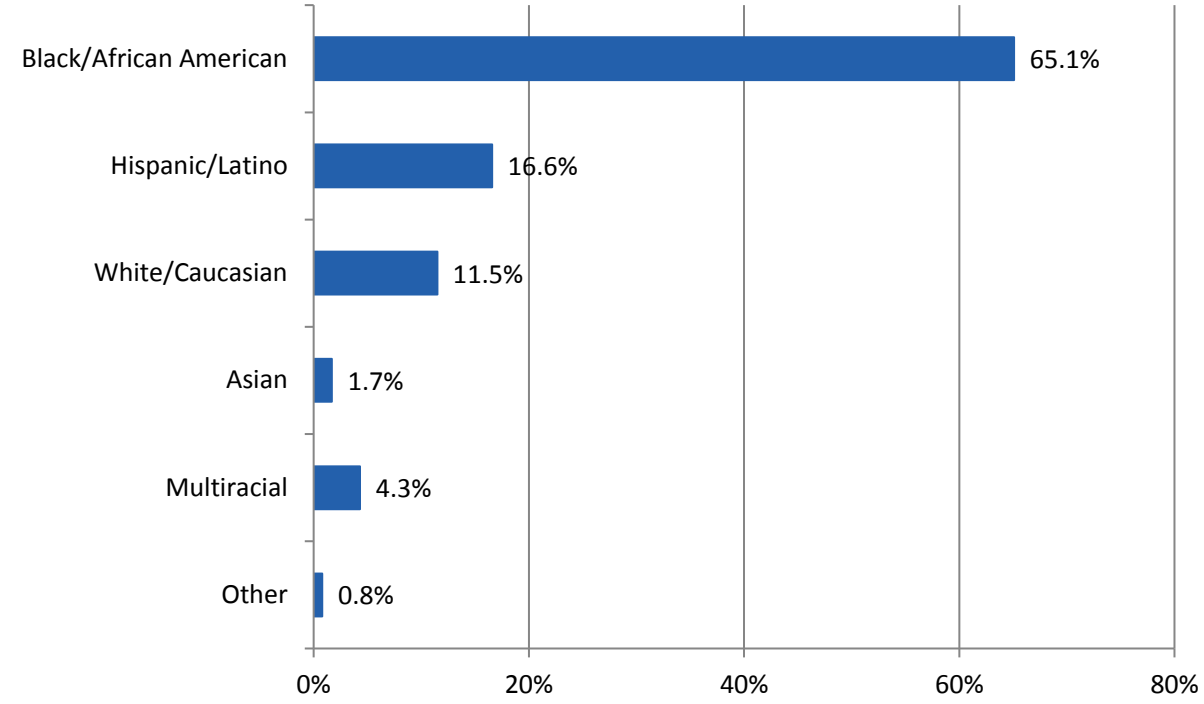
Question 19: What is your gender? (N= 236 responses)



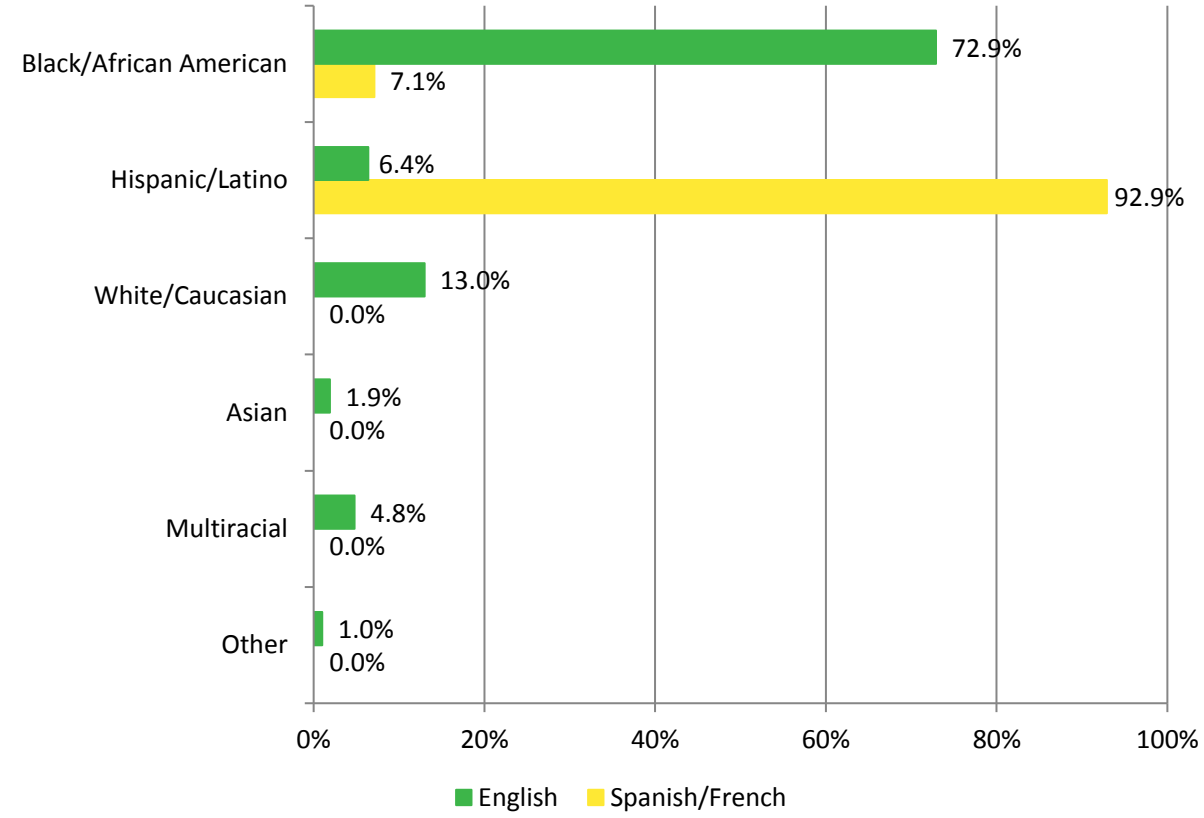
Question 19: What is your gender? (N= 208 English responses; N=28 Spanish/French responses)



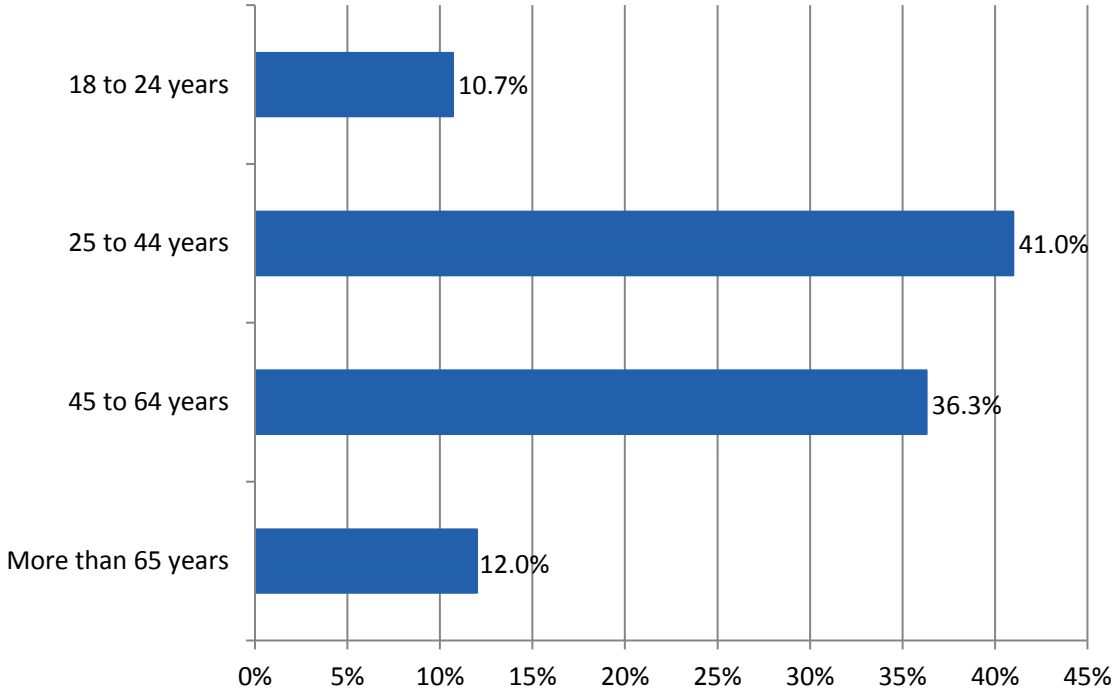
Question 20: What race/ethnicity best identifies you? (N=235 responses)



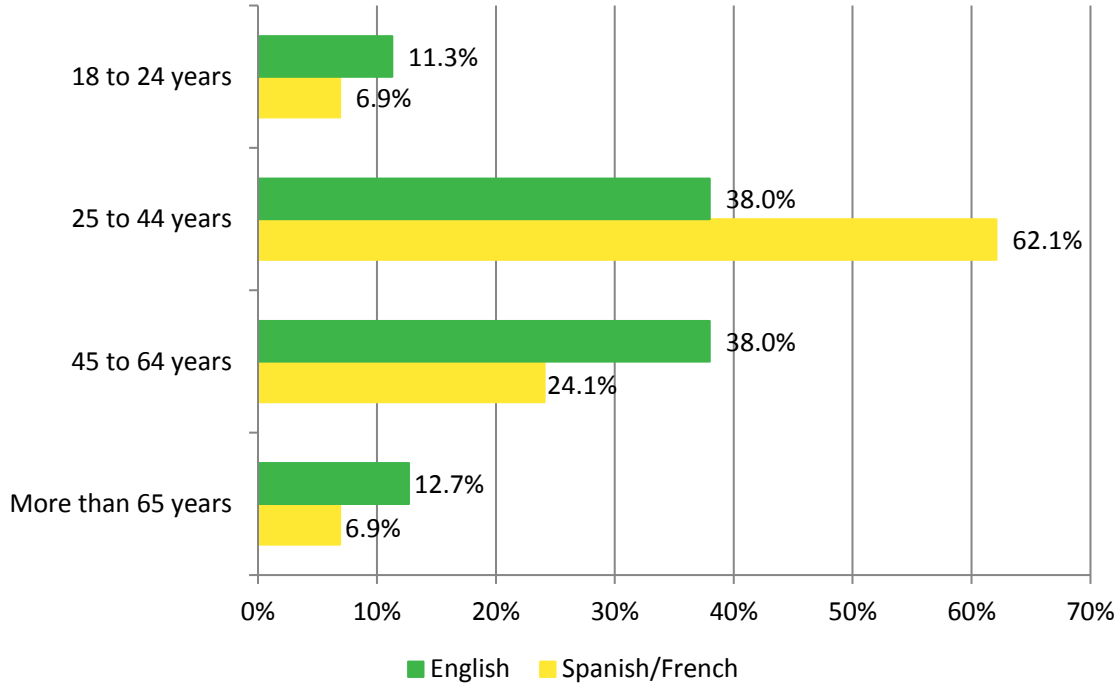
Question 20: What race/ethnicity best identifies you? (N=207 English responses; N=28 Spanish/French responses)



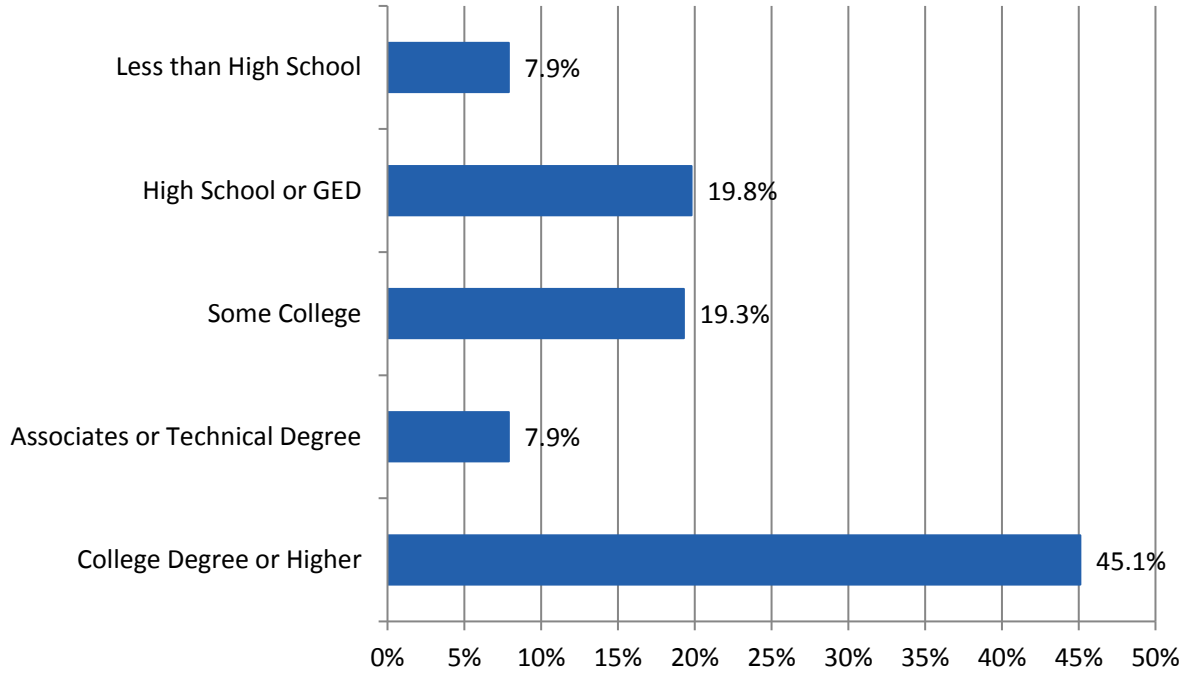
Question 21: How old are you? (N=234 responses)



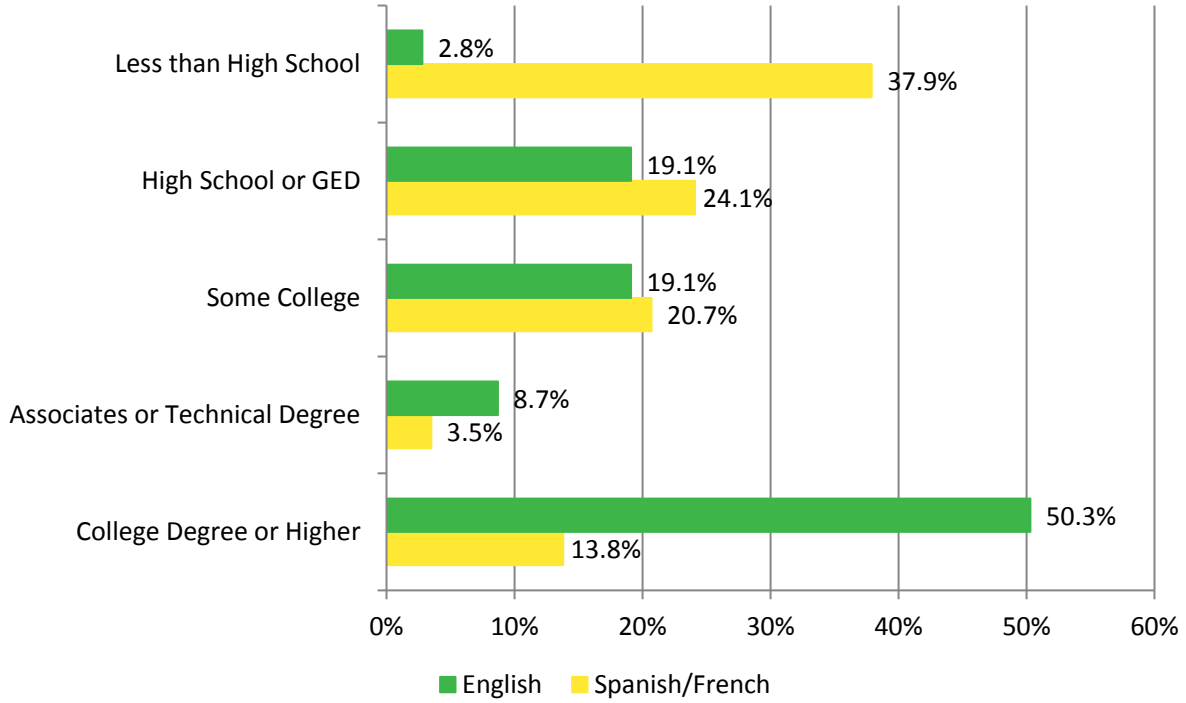
Question 21: How old are you? (N=205 English responses; N=29 Spanish/French responses)



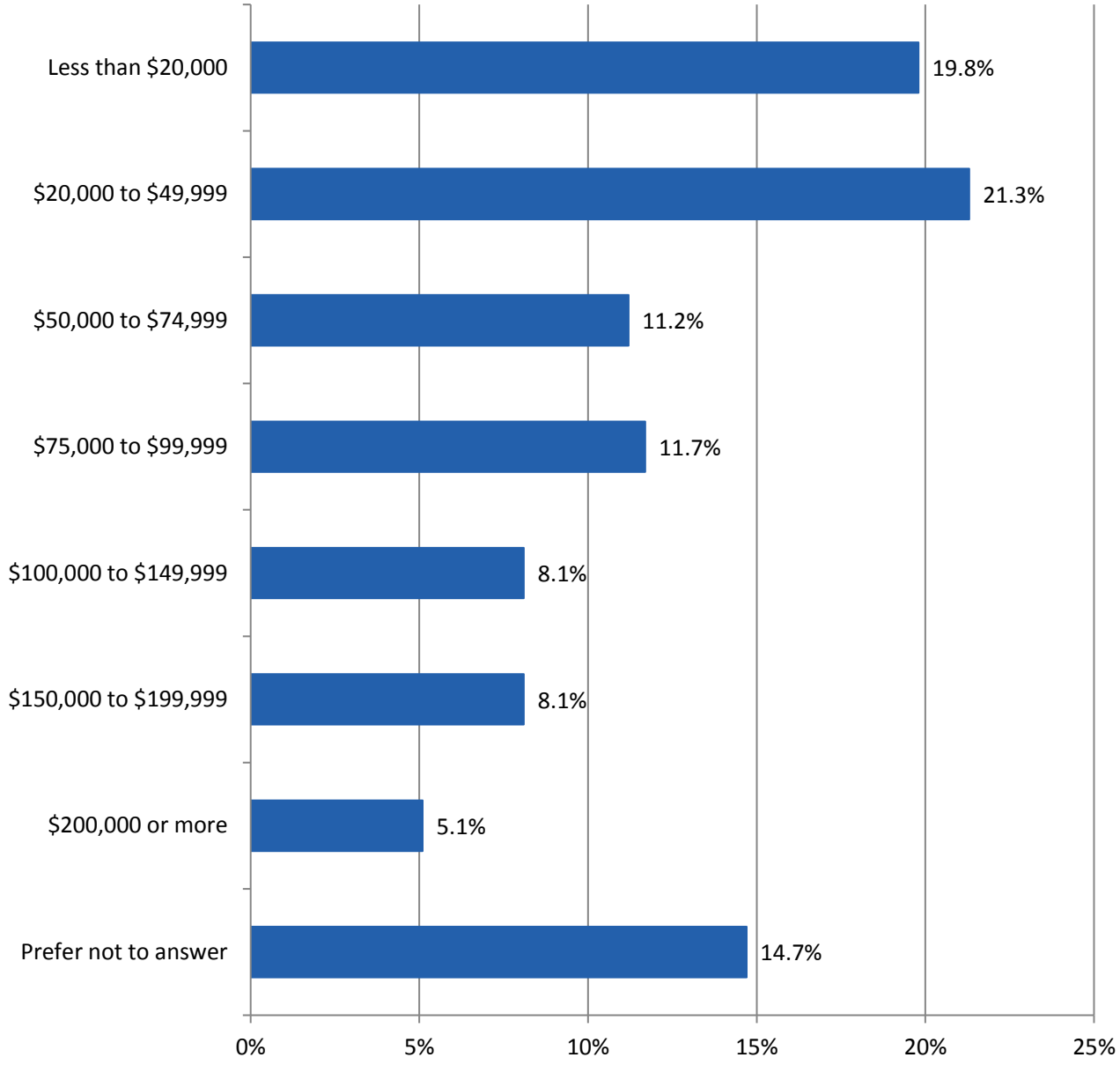
Question 22: What is the highest level of education you completed? (N=202 responses)



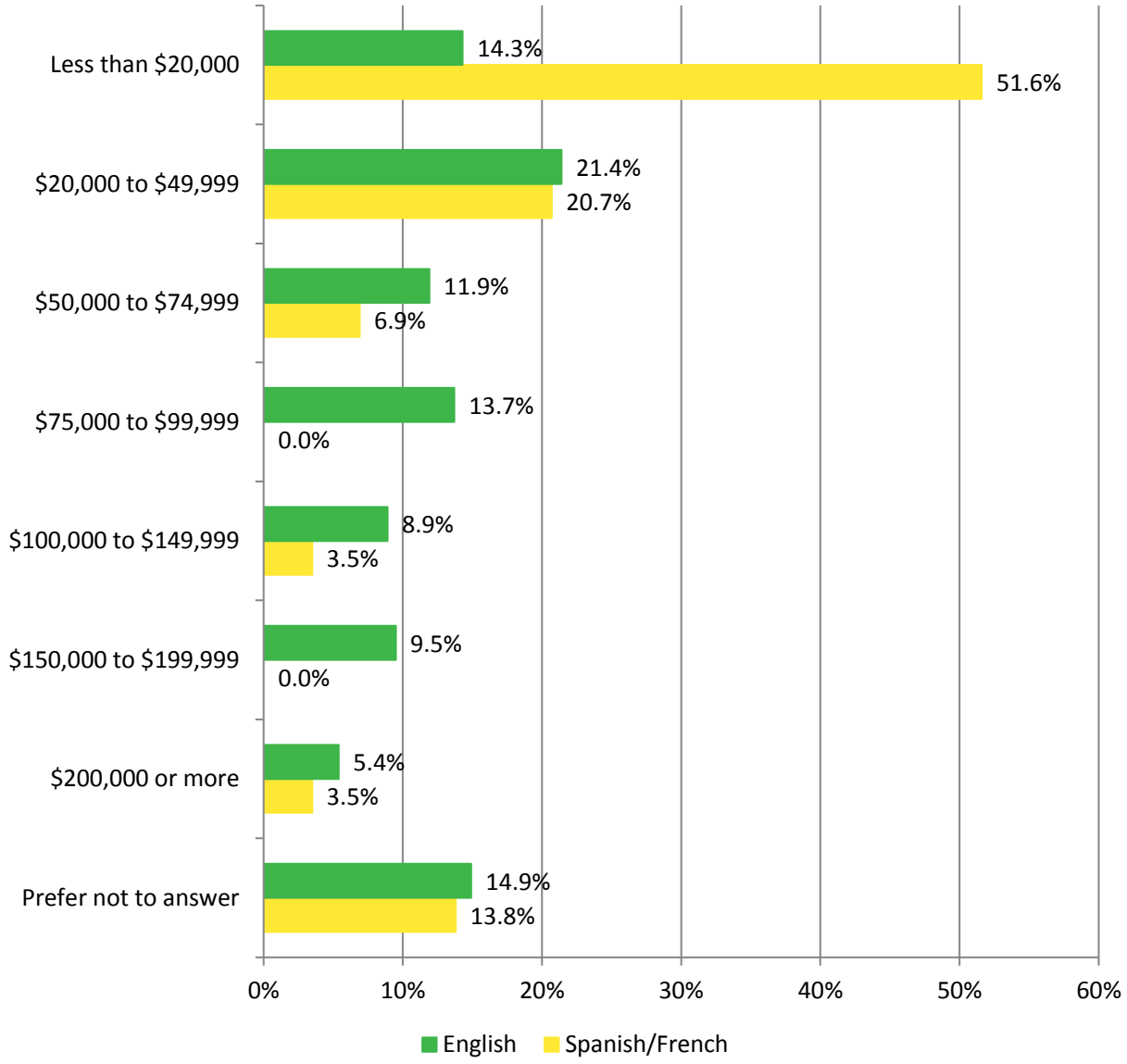
Question 22: What is the highest level of education you completed? (N=173 English responses; N=29 Spanish/French responses)



Question 23: What is your annual household income? (N=197 responses)



Question 23: What is your annual household income? (N=168 English responses; N=29 Spanish/French responses)



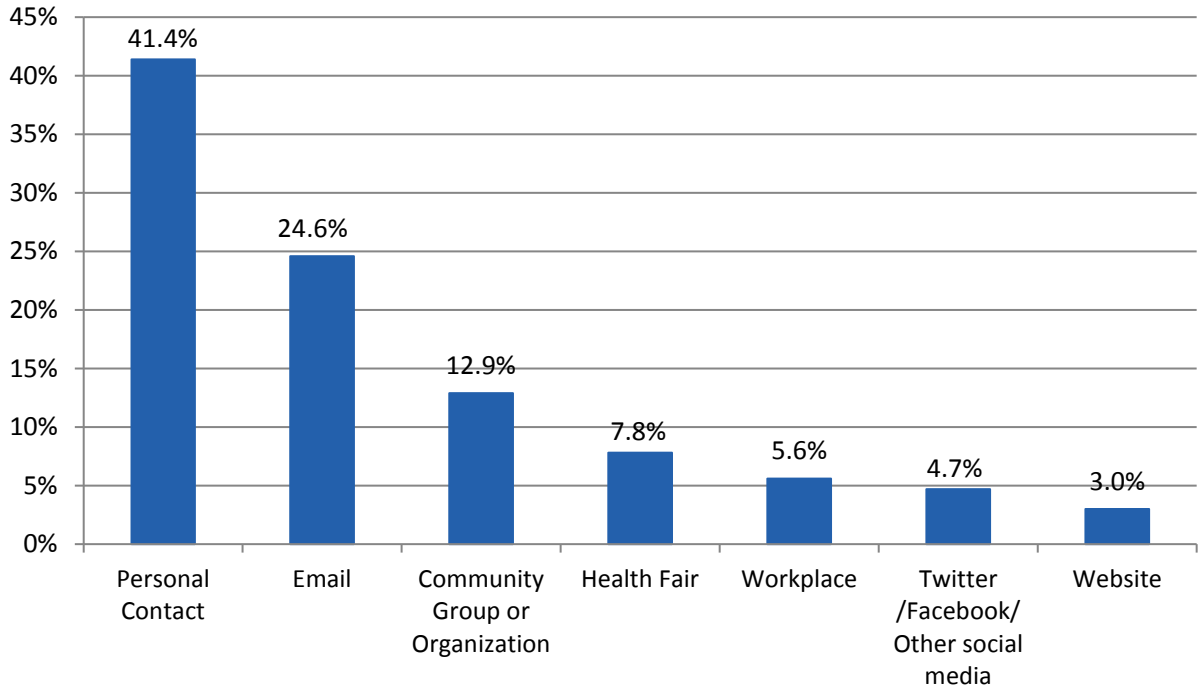
Question 24: What country were you born in? (N=195 English responses; N=24 Spanish/French responses)

Community	English Participants	Spanish/French Participants
Bermuda	1	0
Cameroon	3	1
Dominican Republic	1	1
El Salvador	1	10
Georgia	1	0
Guatemala	1	3
Honduras	0	3
India	1	0
Ireland	1	0
Ivory Coast	2	0
Jamaica	4	0
Kenya	1	0
Mexico	0	4
Nicaragua	0	1
Nigeria	5	0
Philippines	2	0
Sierra Leone	1	0
St. Lucia	1	0
Togo	0	1
United Kingdom	1	0
United States	168	0

Question 25: What language do you speak at home? (N=195 English responses; N=25 Spanish/French responses)

Community	English Participants	Spanish/French Participants
English	175	0
English & ASL	1	0
English & Filipino	1	0
English & French	0	1
English & Hausa	1	0
English & Pegm	1	0
English & Spanish	5	4
English & Spanish & Japanese	1	0
English & Yoruba	2	0
French	2	1
Igbo	1	0
Spanish	4	19
Swahili	1	0

Question 26: How did you receive this survey? (N=232 responses)



F**or <u>personal contact</u> participants mentioned specific locations in the "Other" free-text field**: health clinics; health center; healthcare facility; hospital; health department; Langley Park multi-service center.


PRIORITIZATION
process

PRIORITIZATION PROCESS

Introduction

The 2019 Community Health Assessment (CHA) for Prince George's County provides an updated from the first ever joint CHA in 2016 with a partnership between five local hospitals and the Health Department. The Core Team again included all area hospitals and the Health Department, who began the process of collecting primary and secondary data to describe the residents and needs in the county. This data was planned to be used during the prioritization process to determine the overall county health priorities. In 2016, broad community participation was used for the prioritization process. For 2019, the review of the initial findings indicated that the priority areas were likely to remain the same based on the data collection, but the Core Team wanted to ensure input from community representatives, resulting in an invitation for the leadership for the Prince George's Healthcare Action Coalition to participate in the prioritization process.

Participants

The area hospitals and Health Department provided representatives of the healthcare and public health system. Six workgroup Co-Chairs for the Coalition were also invited, who represented different populations and county agencies including the Department of Corrections, Department of Social Services (Maryland Health Connection), Food Equity Council, and the Department of Parks and Recreation. A list of participants in the prioritization process is included in **Attachment A**.

Process Summary

To make the best use of the prioritization meeting and ensure adequate discussion time for the issues, the Core Team organized the discussion around: 1) community perception of health, 2) changes in the local health system, 3) the four 2016 priority areas, 4) seven additional areas of interest, and 5) emergent themes from the data collection process, as noted below.

2016 Priorities	Additional Areas of Interest	Emergent Themes

• Social Determinants of Health
• Behavioral Health:
  • Mental Health
  • Substance Use
• Obesity and Metabolic Syndrome:
  • Diabetes
  • Heart Disease
  • Hypertension
• Cancer
	• HIV
	• STIs
	• Infant Health
	• Maternal Health
	• Senior Health
	• Asthma
	• Oral Health
		• Housing Stability
		• Low-Income and Employed
		• Needs of Immigrants
		• Need for Innovative Outreach

An agenda for the prioritization process meeting is included in **Attachment B**. The prioritization process began with an overview of the purpose of the CHNA, the steps taken to ensure community input in the process, and a data overview of the selected issues (**Attachment B**). The data overview included summaries of each topic, including indicators, trends, and resident, community expert, and key stakeholder input as well as active discussion by the participants by posing questions, providing insight for the population represented, providing anecdotal examples, discussing resources and services provided, and discussing data limitations, such as the lack of data for specific populations, the challenges with obtaining data for services provided in Washington D.C. to our residents, and lag time for some data secondary data sources, such as the cancer registry.

Prince George's County Health Department facilitated the prioritization process. The process was designed around consensus building and allowed participants to ask more specific questions through epidemiology staff present during the process. After reviewing the data, participants were instructed to consider the following:

- **Magnitude:** How many people are affected
- **Severity:** What are the outcomes and how long do they last
- **Trend:** Changes since 2016
- **Disparity:** Who is disproportionately affected
- **Community Perception:** Results from Resident Survey, Community Expert Survey, and Key Informant Interviews

Prioritization Discussion

During the initial discussion, participants noted the following:

- Approximately 50,000 residents are ineligible for insurance. Estimated that around 35,000 are eligible but uninsured.
- The provider ratios have not improved despite efforts.
- Better integration of mental health with somatic care is occurring, but there is still work to be done (several participants noted work being done around mental health).
- The role of the school system is critical in addressing the social determinants of health

    - Health department has not worked synergistically with schools; is a priority that needs to be done
    - A lot of risk factors deal with diet; PGCPS could really play into this as a primary source of nutrition, there should be more alignment here.
    - There is a huge link between nutrition and behavioral issues. What is the capacity of counselors to deal with issues?
    - County supports a robust community advocate program in 40 school, behavioral health in particular. May not be called "SDOH" but they are doing the work.
    - Two prevalent issue – resources and priorities; link between parents and school system is not strong- perception that if parents connect to resources through the schools system, there will be stigma implications for a long time.
- More information about cancer staging at diagnosis would be helpful to better understand the disparities
    - Cultural differences may contribute to later diagnoses; there are some groups working with specific populations for this
    - Are there differences in treatment based on race and staging?
- Behavioral health crosses many comorbidities, and we are far from where we should be to address this
    - The expense of behavioral health is an issue, especially in the jails; we need to do better getting those in need connected with resources

During the discussion, all the hospital systems represented agreed that the work they started in 2016 is not yet complete, and the data and community input are reflective of this. The stakeholders therefore agreed to maintain the four main priority areas during the next three years:

Social Determinants of Health

Behavioral Health

Obesity and Metabolic Syndrome

Cancer

Next Steps

The Health Department agreed to provide summary slides for the priority areas that can be shared with the Hospital Boards **(Attachment C).** Participants agreed to reconvene in August to share:

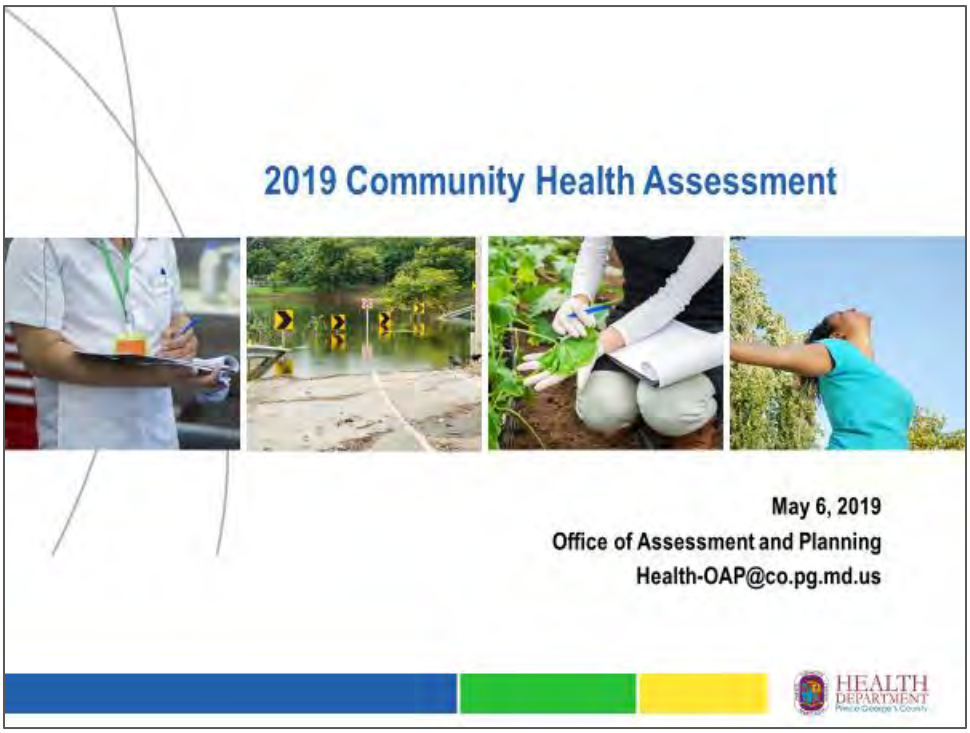
- Community assets available or needed to address the priority areas
- Each hospital system's implementation plan
- Potential areas for collaboration among hospitals
- Potential areas for collaboration with the Healthcare Action Coalition

The Health Department agreed to facilitate the arrangements for the next meeting.

Attachment A: Prioritization Participants and Attendance

Name	Organization	Title	Attended
Anthony Nolan	Department of Parks and Recreation, MNCPPC; PGHAC Health Eating Active Living Workgroup	Chief, Special Programs Division	Yes
Caitlin Murphy	Prince George's Health Department	Special Assistant to the Health Officer	Yes
Camille Bash	Doctors Community Hospital	CFO/Treasurer	Yes
Chantay Moye	Nexus Health-Fort Washington Medical Center	Corporate Director, Marketing, Communications & Public Relations	Yes
Dr. Chile Ahaghotu	MedStar Southern Maryland Hospital Center	Vice President, Medical Affairs	No
Chloe Waterman	Friends of the Earth; PGHAC Health Eating Active Living Workgroup	Senior Food Campaigner	Yes
Christina Gray	Prince George's Health Department	Epidemiologist	Yes
Donna Perkins	Prince George's Health Department	Epidemiologist	Yes
Ernest Carter	Prince George's Health Department; PGHAC Chair	Acting Health Officer	Yes
Guy Merritt	Prince George's Department of Corrections; PGHAC Behavioral Health Workgroup	Chief, Community Corrections Division	Yes
Howard Ainsley	Nexus Health-Fort Washington Medical Center	Senior Vice President & Chief Operating Officer	Yes
Dr. Joseph Wright	University of Maryland Capital Region Health	Chief Medical Officer	No
Katie Boston-Leary	University of Maryland Capital Region Health	Chief Nursing Officer	No
Kent Alford	University of Maryland Capital Region Health; PGHAC Behavioral Health Workgroup	Systems Behavioral Health Director	No
Michael Jacobs	University of Maryland Capital Region Heath	Vice President, Community Relations	Yes
Nikki Yeager	Doctors Community Hospital	Vice President Ambulatory Services & Network Strategy	Yes
Sabra Wilson	University of Maryland Capital Region Health	Director of Community Health	Yes
Shari Curtis	Department of Social Services; PGHAC Health Equity Workgroup	Program Manager, Maryland Health Connection	Yes
Sharon Zalewski	Regional Primary Care Coalition; PGHAC Health Equity Workgroup	Executive Director	No
Trudy Hall	UM Capital Region Health-Laurel Medical Center	Vice President of Medical Affairs	Yes
Valerie Barnes	MedStar Southern Maryland Hospital Center	Director of Case Management and Population Health	No

Attachment B: Prioritization Agenda and Presentation



Core CHA Team

- Doctors Community Health System
- Fort Washington Medical Center
- MedStar Southern Maryland Hospital Center
- UM Capital Regional Health
- Health Department
- Prince George's Healthcare Actional Coalition Leadership

Background

Previous Community Assessments:

- 2011 Local Health Improvement Plan
- UMD Transforming Health: Public Health Impact Study (2012) focus on healthcare services
- Primary Healthcare Strategic Plan (2015) also focused on healthcare services
- Behavioral Health Needs Assessment (2015)
- Community Health Needs Assessment (2016)

Current (2016) CHA Priorities

- Social Determinants of Health
- Behavioral Health
- Obesity & Metabolic Syndrome
- Cancer

2019 CHA Framework

- Mobilizing for Action through Planning and Partnership (MAPP)
- **Vision:** A community focused on health and wellness for all.
- **Values:**
  - Collaboration
  - Equity
  - Trust
  - Safety
  - Prevention

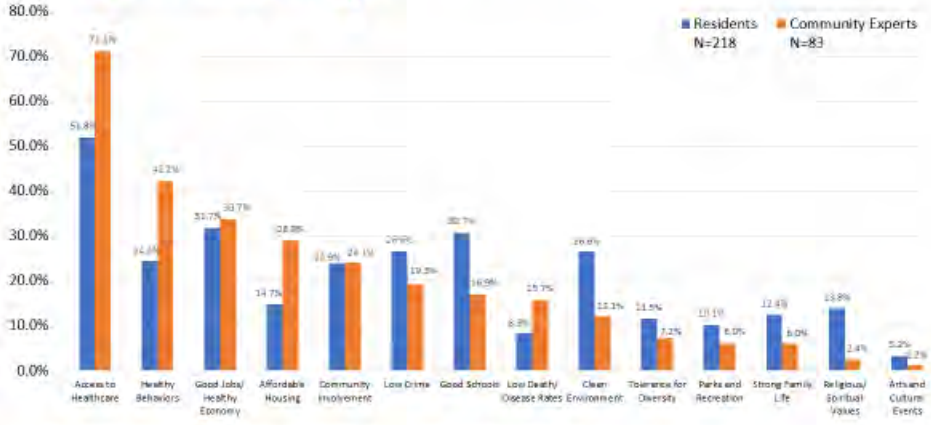
2019 Data Collection

- Demographics and Population Description
- Health Indicators
- Key Informant Interviews (N=14, ongoing)
- Community Expert Survey (N=82)
- Community Resident Survey (N=176 English, N=40 Spanish, N=2 French)

2019 CHA Findings

What makes a Community Healthy?

What Factors Define a Healthy Community?



Source: 2019 Community Health Assessment Resident and Community Expert Surveys

What Factors Define a Healthy Community?

Top 5 Responses by Survey Type

Residents	Community Experts
1. Access to Healthcare	1. Access to Healthcare
2. Good Jobs and Healthy Economy	2. Healthy Behaviors and Lifestyle
3. Good Schools	3. Good Jobs and Healthy Economy
4. Low Crime	4. Affordable Housing
5. Healthy Behaviors and Lifestyle	5. Community Involvement

Source: 2019 Community Health Assessment Resident and Community Expert Surveys

What Factors Define a Healthy Community?

Source: 2019 Community Health Assessment Resident and Community Expert Surveys

What Factors Define a Healthy Community?

Top 5 Resident Responses by Survey Language

English	Spanish and French
1. Access to Healthcare	1. Access to Healthcare
2. Good Jobs and Healthy Economy	2. Good Schools
3. Low Crime	3. Clean Environment
4. Good Schools	4. Good Jobs and Healthy Economy
5. Healthy Behaviors	5. Community Involvement

Source: 2019 Community Health Assessment Resident and Community Expert Surveys

2016 Priority #1 Social Determinants of Health

Social Determinants of Health

Socioeconomic Factors
Income
Employment
Housing Costs

Social & Community Context
Quality of Life
Voter Participation
Community Engagement
Incarceration

Education
School Environment
High School Graduation
College Enrollment

Access to Care
Health Insurance
Provider Availability
Medical Expenses
Health Literacy

Neighborhood & Built Environment
Access to healthy food
Opportunity for physical activity
Safety

HEALTH DEPARTMENT
Prince George's County

Prince George's County

A population on the rise

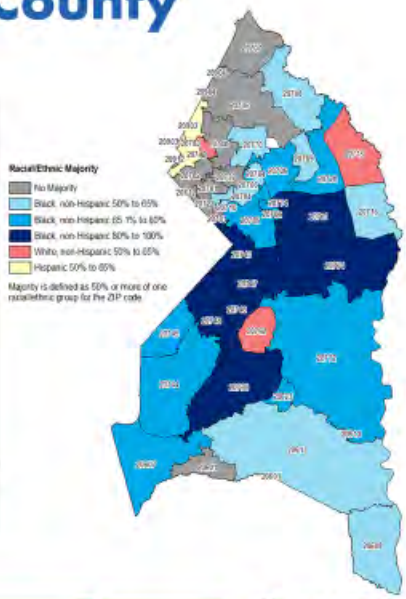
912,756 residents as of 2017, an increase of 50,000 residents since 2010

An aging population

Those 65 years and older represent 13% of the total population. Median age of residents is 37.2 years compared to 34.9 years in 2010.

A diverse population

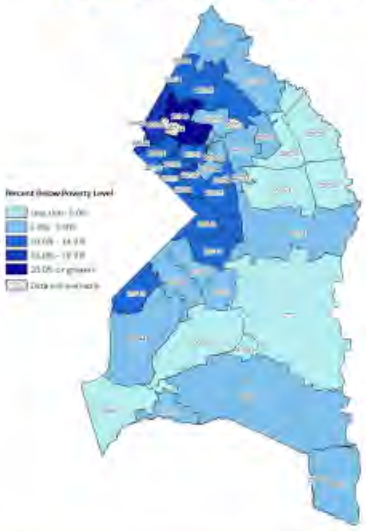
Over one-quarter of residents speak a language other than English at home. In 2017, one in five residents was born outside of the United States.



Source: 2017 American Community Survey, 1- and 5-Year Estimates

HEALTH DEPARTMENT
Prince George's County

Socioeconomic Factors



Indicators

- 12% of children live in poverty
- One-third of Hispanic, female single parent families live in poverty
- Unemployment has declined since 2014, but remains highest for Black residents
- Annual income needed for fair market efficiency $6K more than median renter income

Residents

- Only half reported satisfaction with the economic opportunities in their communities
- Communities lack enough affordable housing

Community Experts

- Socioeconomic factors frequently mentioned as key drivers and determinants of health
- Believe only 43% of the communities they serve are happy with the economic opportunities in their area

Source: 2017 American Community Survey, 1- and 5-Year Estimates; 2019 Community Health Assessment Resident and Community Expert Surveys

Access to Care

Indicators

- 91,000 residents remain uninsured; one-quarter of residents 26-34 years are uninsured
- One-quarter of Hispanic and 10% of Black, NH residents were unable to see a doctor in the past year due to cost
- Provider to Resident ratios:
  - 1 PCP to 1,910 residents
  - 1 Dentist to 1,650 residents
  - 1 Mental Health Provider: 890 residents

Residents

- One-quarter are unsatisfied with the healthcare system in the county
- 1 out of 5 believe residents of their community cannot access a primary care provider; even higher (one-third) for specialists or mental health providers
- Less than half say transportation is available for appointments
- Top barriers to care: No money for co-pays or medications, no health insurance, time limitations

Community Experts

- Top barriers to care: Lack of health insurance, navigation of the system, money for co-pays/medications, basic needs not met
- Over half responded that there is not enough health literacy, cultural competency or provision of language considerations in the system
- New hospital is viewed positively, but will not address overall access to care issues

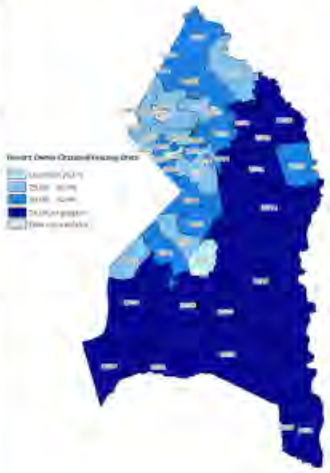
Source: 2017 American Community Survey, 1- and 5-Year Estimates; 2017 Maryland Behavioral Risk Factor Surveillance System; 2018 County Health Rankings; 2019 Community Health Assessment Resident and Community Expert Surveys; 2019 Key Informant Interviews

Social & Community Context

Indicators
- 62% of occupied housing units are owned in the county, slightly lower than the state (66%)
- 73.6% voter participation in 2016 and 55.8% in 2018 elections, similar statewide

Residents
- 65% are satisfied with the quality of life in their community
- Half identified their church as one of the places they go most in the county (#2 overall)
- 70% believe that an increase in community awareness and engagement would support health in their area
- Half prefer community outreach specific to their community

Community Experts
- 54% believe the communities they serve are satisfied with the quality of life in their area
- 73% believe an increase in community awareness and engagement would support health in their areas they serve
- 80% believe an increased focus on health inequities and 69% believe engaging diverse leaders and residents would benefit the health of the communities they serve



Source: 2017 American Community Survey, 1- and 5-Year Estimates; 2019 Community Health Assessment Resident and Community Expert Surveys

Neighborhood & Built Environment

Indicators
- About 94,000 residents (10.1%) live in food deserts
- 1 in 5 households have severe housing problems (e.g., overcrowding)
- Violent crime rate fell below the state in 2016

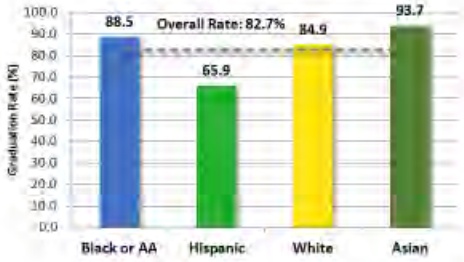
Residents
- 60% believe their community is a safe place to live
- 4 out of 5 report access to fresh foods (fruits/veg)
- Two-thirds reported parks as the place they go most often in their community (#1 overall)

Community Experts
- Believe 47% of the communities they serve are satisfied with safety in their area
- Healthy food access, physical activity and obesity leading concerns
- Key Informants noted inequity in resources in different communities as an issue

Source: 2015 USDA Food Atlas; 2018 County Health Rankings; 2019 Community Health Assessment Resident and Community Expert Surveys;

Education

2017 Graduation Rate by Race/Ethnicity
Prince George's County Public Schools



Source: 2017 American Community Survey, 5-Year Estimates; 2017-2018 Maryland Department of Education Report Card; 2016 Maryland Youth Risk Behavior Survey; 2019 Community Health Assessment Resident and Community Expert Surveys;

Indicators

- 87% of residents 25+ years and older have at least a high school education, lower than state
- Half of Hispanic residents have less than a high school education
- Only 60% of high school graduates enrolled in college, compared to 69% for the state; this drops to 42% for Hispanic graduates
- 14.5% of county high school students bullied on school property (past year); higher for White students (24.5%)

Residents

- One-third disagree that their communities have access to good schools
- Half agree that the county is a good place to raise children

Community Experts

- Believe 40% of the communities they serve are satisfied that the county is a good place to raise children
- Better access to affordable (or free) programs for child activities and emotional growth needed

HEALTH DEPARTMENT

2016 Priority #2

Behavioral Health

HEALTH DEPARTMENT

Mental Health

Health Indicators & Disparities

- White, NH twice as likely to die from suicide as Black, NH residents
- Overall poor mental health days better than the state
- Almost one-third of high school students felt sad or hopeless impeding normal activity(past year); highest for Hispanic students
- 18% of HS students seriously considered suicide and 15% made a plan in the past year

Risk Factors

- Gender (Female)
- Substance use disorder
- Family history
- No social and/or family support
- Trauma
- Abuse/neglect

Trends *(compared to 2016 CHNA)*

- Overall suicide mortality rate decreased from 6.0 (2012-2014) to 5.7 (2015-2017)
- Suicide mortality rate for White, NH decreased to 11.7 per 100,000(2015-2017) from 14.1 (2012-2014)
- Overall poor mental health days for residents
- Suicide mortality rate for Black, NH (4.4 per 100,000 in0 2012-2014; 5.1 per 100,000 in 2015-2017)
- Overall number of Maryland ED visits for Behavioral Health conditions

Maryland Emergency Department Visits for Behavioral Health Conditions, Prince George's County, 2017

Behavioral Health Condition	Frequency	Percent
Alcohol-related disorders	1,287	32.4%
Mood disorders	1,071	13.9%
Anxiety disorders	1,340	15.9%
Substance-related disorders	1,140	12.5%
Schizophrenia and other psychotic disorders	905	10.8%
Suicide and intentional self-inflicted injury	593	6.5%
Delirium dementia and amnestic and other cognitive disorders	296	3.5%
Attention-deficit conduct and disruptive behavior disorders	198	2.4%
Adjustment disorders	164	2.0%
Miscellaneous mental health disorders	126	1.3%
Impulse control disorders	43	1.0%
Total	8,421	100%

PGC High School	2014	2016
Sad/Hopeless	27.3%	31.5%
Consider Suicide	14.7%	17.7%
Plan for Suicide	12.2%	14.8%

Source: 2017 Maryland Behavioral Risk Factor Surveillance System; 2016 Maryland Youth Risk Behavior Survey; 2019 Community Health Assessment Resident and Community Expert Surveys; 2019 key informant interviews; 2017 HSCRC Outpatient Files; 2017 CDC Wonder Online Database

Community Perception

- #11 ranked health issue for residents; #2 for community experts survey
- Leading issue for key informant interviews, with connection to homelessness, incarceration, and chronic disease management noted; stress and depression were frequently identified as a concern

Substance Abuse

Health Indicators & Disparities

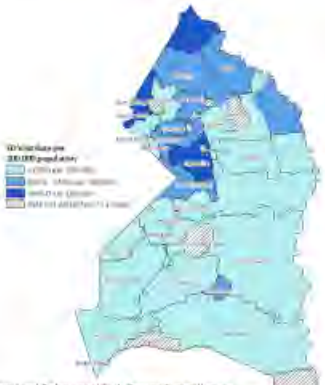
- Drug-related mortality rate highest for White, NH
- Binge drinking in adults highest for males and White, NH
- Binge drinking in high school highest for females; Hispanic students
- ED visits for alcohol and substance use 3.5x higher for males
- Electronic vapor use down in 2016 (35% in 2014 to 32%)

Risk Factors

- Mental health disorders
- Family history of addiction
- Age (younger use exposure more likely later SUDs)
- No social and/or family supports

Trends *(compared to 2016 CHNA)*

- Overall adult binge drinking
- Binge drinking for residents 18-34 years
- Overall adult smokers
- Alcohol abuse hospitalization rate for White, NH
- Drug overdose mortality rate doubled from 6.4 in 2012-2014 to 12.2 in 2015 to 2017
- Alcohol abuse hospitalization rate for Black, NH, males and residents 45-64 years



Source: 2017 Maryland Behavioral Risk Factor Surveillance System; 2016 Maryland Youth Risk Behavior Survey; 2017 HSCRC Inpatient and Outpatient Files; 2019 Community Health Assessment Resident and Community Expert Surveys;

Community Perception

#3 ranked health issue for residents; #10 for community experts

2016 Priority #3
Obesity and Metabolic Syndrome

Obesity

Health Indicators & Disparities

- Highest levels of obesity among Black, NH residents (46.7%); Hispanic resident obesity 35% in 2017
- Adult females more likely to be obese than adult males
- Obesity highest for Hispanic high school students; 29% of female Hispanic students are overweight
- Overall obesity prevalence higher than the state

Risk Factors

- Lack of physical activity
- Poor diet
- Age
- Race/ethnicity (Black and Hispanic)
- Gender (Women)
- Stress

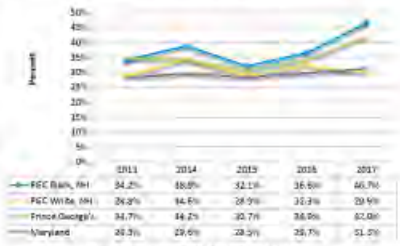
Trends *(compared to 2016 CHNA)*

- Obesity prevalence for residents over 65 years
- Residents with recommended physical activity

- No neutral trends identified

- Overall obesity prevalence among high school students and adults
- Obesity prevalence for Black, NH residents
- Obesity prevalence for residents 18-64 years
- High school students eating vegetables 3+ times/wk

Percent of Adults Who Are Obese, 2013-2017



Healthy People 2020 Goal: 30.5%

Source: 2017 Maryland Behavioral Risk Factor Surveillance System; 2016 Maryland Youth Risk Behavior Survey; 2019 Community Health Assessment Resident and Community Expert Surveys; 2019 Key Informant Interviews

Community Perception

- Residents ranked poor diet #2 and physical inactivity #5 for top health issues
- Community Experts ranked poor diet #5 and physical inactivity #9 for top health issues
- Concern for key informants along with long-term consequences

Heart Disease

Health Indicators & Disparities

- #1 Underlying Cause of Death
- Black, NH have highest Mortality Rate and Maryland ED Visits
- Males have more ED Visits
- Ages 65+ have more ED Visits

Risk Factors

- Age
- Gender (Male)
- Obesity
- Poor diet
- Lack of physical activity
- Smoking
- Alcohol Use

Trends *(compared to 2016 CHNA)*

- Overall Heart Disease Mortality Rate (168.9, MD SHIP Goal is 166.3)

- Maryland ED Visit Rate for White and Black Residents
- Overall Inpatient Visit Rate for Heart Failure (MD and DC hospitals)

- Maryland ED Visit Rate for Hispanic and Asian Residents
- Maryland ED Visit Rate for ages 40 years and older
- Inpatient Visit Rate for Heart Failure ages 65 and over (MD and DC hospitals)
- Increase in Obesity and Overweight

Source: 2017 Maryland HSCRC Outpatient File; 2019 Community Health Assessment Resident and Community Expert Surveys; 2017 CDC Wonder Online Database

Community Perception

- Residents ranked as #9 for top health issues
- Community Experts ranked as #4 top health issues
- Overall chronic disease was a major concern along with long-term consequences

HEALTH DEPARTMENT

Diabetes

Health Indicators & Disparities

- #5 leading cause of death in the county
- Black, NH Maryland ED visit rate is double White, NH
- Mortality rate also highest among Black, NH
- Diabetes prevalence (12.3%) is higher than the state (9.6%)
- One in five residents ages 50-64 have diabetes

Risk Factors

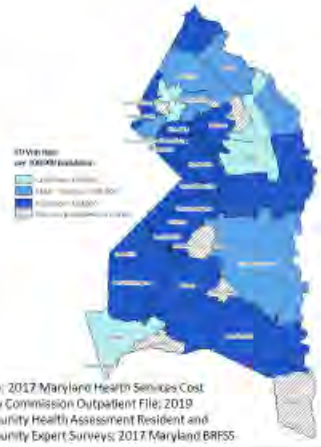
- Overweight or obesity
- Age
- Race/ethnicity
- Hypertension
- No physical activity
- History of heart disease/stroke

Trends *(compared to 2016 CHNA)*

- Diabetes prevalence among residents 65+ and older
- Diabetes prevalence among White, NH residents
- Overall mortality rate (26.3; meets HP 2020 Goal of 66.6)

- Diabetes prevalence among Black, NH residents

- Overall prevalence
- Diabetes prevalence among residents 50-64 years
- Diabetes prevalence among males
- Overall Maryland ED visit rate
- Maryland ED visits among residents 40+ years



Source: 2017 Maryland Health Services Cost Review Commission Outpatient File; 2019 Community Health Assessment Resident and Community Expert Surveys; 2017 Maryland BRFSS

Community Perception

- #1 ranked health issue for residents and community experts
- Overall chronic disease was a major concern along with long-term consequences

HEALTH DEPARTMENT

Hypertension and Stroke

Health Indicators & Disparities

- Hypertension prevalence and Maryland ED visits highest for Black, NH residents (Prevalence of 34.2%)
- Half of residents ages 50-64 have hypertension
- Over two-thirds of residents 65+ years and older have hypertension
- Stroke #3 leading cause of death

Risk Factors

- Age
- Race (Black)
- Gender
- Tobacco use
- Alcohol use
- Poor diet (sodium)
- No physical activity

Trends *(compared to 2016 CHNA)*

- Overall Maryland hypertension hospitalization rate
- Stroke mortality rate for Hispanic residents

- Maryland ED visits for hypertension for Black, NH and White, NH residents

- Overall Maryland ED visit rate for hypertension
- Maryland ED visits for hypertension for Hispanic residents
- Stroke mortality rate for Black, NH and White, NH
- Overall mortality rate (41.6) is above HP 2020 rate of 34.8

Source: 2017 Maryland HSCRC Outpatient File; 2017 Maryland BRFSS; 2019 Community Health Assessment Resident and Community Expert Surveys;

Community Perception

- #6 ranked health issue for residents and community experts
- Overall chronic disease was a major concern along with long-term consequences

HEALTH DEPARTMENT

2016 Priority #4

Cancer

HEALTH DEPARTMENT

Cancer

Health Indicators & Disparities

- #2 Underlying Cause of Death
- Males have highest age-adjusted incidence and mortality rate
- Black, NH have highest age-adjusted mortality rate (163.3)

Risk Factors

- Tobacco use
- Age
- Family history
- Poor diet
- UV radiation
- Alcohol use
- Obesity

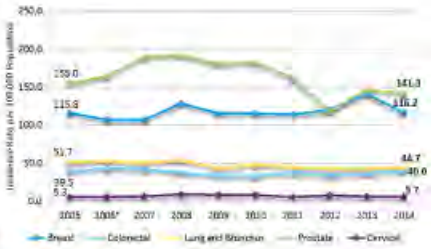
Trends *(compared to 2016 CHNA)*

- Overall cancer mortality rate (154.1); meets HP 2020 Goal of 161.4, but not MD SHIP Goal of 147.4
- Lung cancer incidence rate among men
- Overall cancer incidence rate for Black residents

- Overall cancer incidence rate
- Colorectal cancer incidence rate

- Overall cancer mortality rate for White, NH residents

Cancer Age-Adjusted Incidence Rates by Site, Prince George's County, 2005-2014



Source: 2017 Maryland Annual Cancer Report; 2017 CDC Wonder Online Database; 2019 Community Health Assessment Resident and Community Expert Surveys.

Community Perception

- Residents ranked as #7 for top health issues
- Community Experts ranked as #14 top health issues

Breast Cancer

Health Indicators & Disparities

- Black, NH women have highest mortality rate
- Incidence rate is lower than the state, but mortality rate is higher
- 82.3% of women with mammogram (past two years), higher than state (78.8%)

Risk Factors

- Alcohol use
- Older age
- Obesity
- Inherited risk of breast cancer

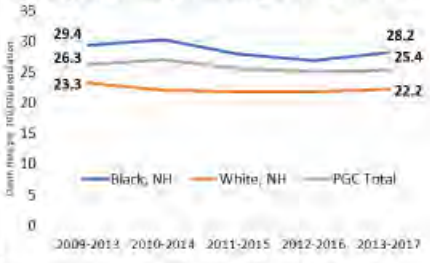
Trends *(compared to 2016 CHNA)*

- No positive trends identified

- Overall mortality rate among all county residents (25.4); does not meet HP 2020 Goal of 20.7
- Women over 50 with a mammogram (past 2 years)

- Overall county incidence rate
- Incidence rate among Black and White residents

Female Breast Cancer Rolling 5-Year Age-Adjusted Mortality Rates by Race/Ethnicity, Prince George's County, 2009-2017



Healthy People 2020 Goal: 20.7

Source: 2017 Maryland Annual Cancer Report; CDC Wonder Online Database; 2017 Maryland BRFSS; 2019 Community Health Assessment Resident and Community Expert Surveys

Community Perception

Cancer overall was a concern, but breast cancer was not specifically noted.

Prostate Cancer

Health Indicators & Disparities

- Incidence and mortality rates higher than state
- Incidence and mortality rates among Black, NH (35.3) are twice as high as White, NH (16.4)
- 43% of men (40 years+) had a prostate-specific antigen test in past 2 years (similar to MD at 39%); higher for Black, NH men (47%)

Risk Factors

- Older age (over 50 years)
- Race (Black)
- Family history of prostate cancer

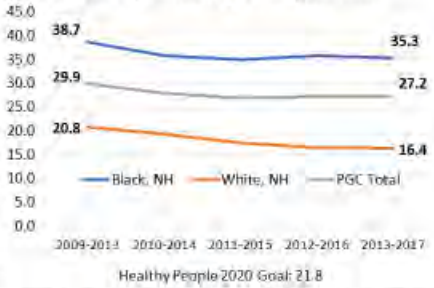
Trends *(compared to 2016 CHNA)*

- Overall county incidence and mortality rates
- Incidence rate among Black and White residents

- No neutral trends identified

- Men 40+ years with a Prostate-Specific Antigen test in the past two years

Prostate Cancer Rolling 5-Year Age-Adjusted Mortality Rates by Race/Ethnicity, Prince George's County, 2009-2017



Healthy People 2020 Goal: 21.8

Source: 2017 Maryland Annual Cancer Report; CDC Wonder Online Database; 2017 Maryland BRFSS; 2019 Community Health Assessment Resident and Community Expert Surveys

Community Perception

Cancer overall was a concern, but prostate cancer was not specifically noted.

HEALTH DEPARTMENT

Additional Areas of Interest

HEALTH DEPARTMENT

HIV

Health Indicators & Disparities

- Diagnoses are decreasing, but have the highest number and 2nd highest rate (41.9) of new diagnoses in the state (MD SHIP Goal is 26.7)
- 8 out of 10 new diagnoses among Black, NH residents
- Two-thirds of new diagnoses 20-39 years old
- Over half of new diagnoses were MSM
- 63% Viral Suppression

Risk Factors

- Age (Younger)
- MSM
- Intravenous drug use
- Race/ethnicity (Black)

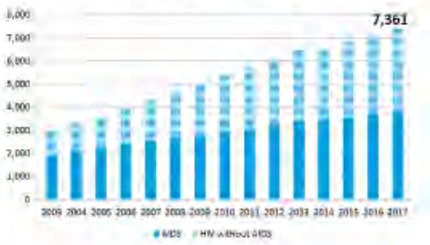
Trends *(compared to 2016 CHNA)*

- Overall HIV diagnosis rate (13 years and older)
- HIV diagnosis rate among Black, NH residents
- HIV diagnosis rate among residents under 30 or over 40 years

- HIV diagnosis rate among residents 30-39 years

- HIV diagnosis rate among Hispanic residents

Living HIV Cases, Prince George's County, 2003 to 2017



Source: 2017 Prince George's HIV Epidemiological Profile; 2019 Community Health Assessment Resident and Community Expert Surveys;

Community Perception

#16 ranked health issues for residents; #12 for community experts

STI's

Health Indicators & Disparities

- Chlamydia/gonorrhea incidence highest for 20-24 years
- 62% of high school students used a condom during last sexual intercourse encounter
- Syphilis cases increased by 30% between 2016 and 2017

Risk Factors

- Unprotected sex (condom)
- Multiple sexual partners
- Risky sexual behaviors
- IVDU

Trends *(compared to 2016 CHNA)*

- No positive trends identified

- No neutral trends identified

- Overall incidence rates for STIs
- Chlamydia and gonorrhea incidence rate for 20-29 years
- Percentage of high school students using a condom during last sexual intercourse encounter

Number of Sexually Transmitted Infections, Prince George's County, 2015-2017

STI	2015	2016	2017	5-Year Mean
Chlamydia	6,153	6,752	7,365	6,513
Gonorrhea	1,282	1,832	2,001	1,575
Syphilis	81	110	143	113

Rate of Sexually Transmitted Infections, Prince George's County, Maryland and the United States, 2017

STI	Prince George's	Maryland	United States
Chlamydia	**806.9**	552.1	524.6
Gonorrhea	**219.2**	181.4	170.6

MD SHIP Goal: Chlamydia Rate of 431.0

Source: 2016 Maryland Youth Risk Behavior Survey; Maryland Prevention and Health Promotion, Center for STI Prevention; 2019 Community Health Assessment Resident and Community Expert Surveys;

Community Perception

#18 ranked health issue for residents and community experts

Infant Health

Health Indicators & Disparities

- Infant mortality rate has decreased (8.2), but still higher that the state (6.5) and for Black, NH infants (12.0); HP 2020 Goal is 6.3 and MD SHIP Goal is 6.0
- Percent low birth weight, preterm and Cesarean deliveries for highest for Black, NH infants

Risk Factors

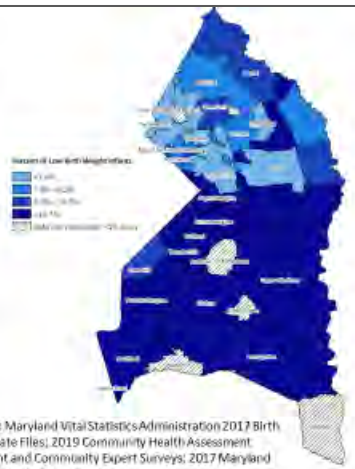
- Maternal health and behaviors
- Low birth weight
- Prematurity
- Low SES

Trends *(compared to 2016 CHNA)*

- Overall infant mortality rate (2013-2017 vs 2008-2012)
- Preterm births and low birth weight for White, NH infants

- Overall percent of preterm births

- Mortality rate for Black, NH infants
- Preterm births and low birth weight for Black, NH and Hispanic infants
- Overall percent low birth weight



Source: Maryland Vital Statistics Administration 2017 Birth Certificate Files; 2019 Community Health Assessment Resident and Community Expert Surveys; 2017 Maryland Vital Statistics Annual Report

Community Perception

Maternal and Child Health ranked #21 for top health issue for residents (second to last); #13 for community experts

Maternal Health

Health Indicators & Disparities

- Birth rate for Hispanic teens are 10 times higher compared to White NH teens
- Birth rate among older mothers (35-44 years) increasing
- 7.2% of mothers diabetic; 5.4% hypertensive in 2017
- 60% of mothers received adequate prenatal care in 2017; lower for Hispanic mothers at 53%
- 41% of births to Black NH mothers were by C Section, compared to <30% for Hispanic and White NH births

Risk Factors

- Low SES
- Race/ethnicity
- Education
- Social support

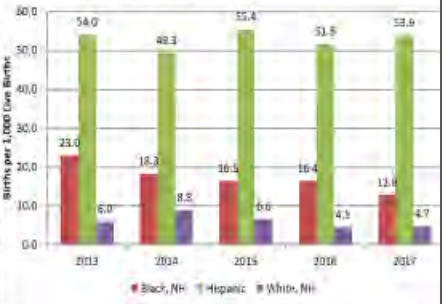
Trends *(compared to 2016 CHNA)*

- Birth rate for Black, NH and White, NH teens
- Births by Cesarean Section (35.5%)

- Birth rate for Hispanic teens

- Percent of mothers with diabetes and pregnancy-associated hypertension
- Percent of mothers receiving adequate prenatal care

Teen Birth Rate (Ages 15 to 19) by Race and Ethnicity, Prince George's County, 2013-2017



Source: Maryland Vital Statistics Administration 2017 Annual Report; 2017 Maryland Birth Certificate Files; 2019 Community Health Assessment Resident and Community Expert Surveys

Community Perception

Maternal and Child Health ranked #21 for top health issue for residents (second to last); #13 for community experts

Senior Health

Health Indicators & Disparities

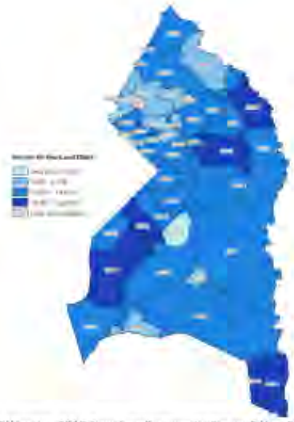
- Mortality rate for Alzheimer's/dementia highest for Black, NH
- Overall mortality rate for Alzheimer's/dementia, percent of Medicare beneficiaries treated lower than the state
- 36.1% of seniors (65+ years) have one or more disability (22% for the state)
- 1 in 10 seniors reported at least one week (previous month) where poor physical or mental health kept them from usual activities

Risk Factors

- Age
- Gender (Women)
- Genetics
- Social Support
- Vascular factors (hypertension, diabetes, smoking)

Trends *(compared to 2016 CHNA)*

- Alzheimer's mortality rate for White, NH residents
- Medicare beneficiaries treated for dementia
- Alzheimer's mortality rate for Black, NH residents



Source: CDC Wonder; 2017 American Community Survey 5-Year Estimates; Centers for Medicare and Medicaid Services; 2017 Maryland Behavioral Risk Factor Surveillance System; 2019 Community Health Assessment Resident and Community Expert Surveys;

Community Perception

Aging problems #15 ranked health issue for residents; #8 for community experts

HEALTH DEPARTMENT

Asthma

Health Indicators & Disparities

- ED visit rates for Black, NH residents (41.8) was more than twice that of Hispanic and White NH residents (16.4)
- Hospitalization rates highest for females
- Among children, hospitalization rates highest for Asian/Pacific Islanders

Risk Factors

- Age (younger)
- Environmental irritants

Trends *(compared to 2016 CHNA)*

- Overall Maryland ED visit rate (all races/ethnicities)
- Maryland ED visit rate for residents under 39 years
- Overall Maryland pediatric hospitalization rate
- Maryland pediatric hospitalization rate for <14 yrs.
- Maryland ED visit rate for residents 40-64 years
- Maryland adult hospitalization rate
- Maryland pediatric hospitalization rate for Asian/Pacific Islanders
- Maryland pediatric hospitalization rate for 15-17 yrs.

Source: 2017 Maryland Health Services Cost Review Commission Outpatient File; 2019 Community Health Assessment Resident and Community Expert Surveys;

Community Perception

#19 ranked health issue for residents and community experts

HEALTH DEPARTMENT

Oral Health

Health Indicators & Disparities

- Maryland ED visit rate for dental care highest for Black, NH residents
- Males and White, NH residents less likely to have seen a dentist in the past year
- 1 Dentist to 1,650 residents

Risk Factors

- Low SES
- Genetics

Trends *(compared to 2016 CHNA)*

- Overall Maryland ED visit rate for dental care
- Residents 18-49 years seeing a dentist (past year)
- Black, NH and Hispanic residents seeing a dentist (past year)
- Adult residents and high school students seeing a dentist (past year)
- Dentist to resident ratio
- Residents 50-64 years seeing a dentist (past year)
- White, NH residents seeing a dentist (past year)

PGC High School Students	2014	2016
Saw a dentist in the past year	68.9%	69.0%
Black, NH	70.0%	69.5%
Hispanic	68.5%	71.1%
White, NH	73.1%	**

**Data not presented – small number of observations

Source: 2016 Maryland Youth Risk Behavior Survey; 2018 County Health Rankings; 2017 Maryland Behavioral Risk Factor Surveillance System 2019 Community Health Assessment Resident and Community Expert Surveys;

Community Perception

#10 ranked health issue for residents; #16 for community experts

HEALTH DEPARTMENT

Emergent Themes

- Housing Stability
  - Homeless identified as the most underserved population by community experts
  - Process to place and care for homeless should be streamlined and transparent
  - Affordable Housing was noted as a significant challenge
- Asset-Limited, Income-Constrained, Employed
  - Low-income residents may be insured but are unable to pay for high deductibles, co-pays and medications

HEALTH DEPARTMENT

Emergent Themes

- Meeting the needs of our foreign-born residents
  - Hispanic residents increased 31% since 2010
  - One-third of Hispanic residents are uninsured
  - Fear may drive undocumented populations to not seek care
  - Cultural competency is critical
- Innovative outreach and awareness of services
  - Outreach should be community-specific
  - Special considerations for seniors and homebound

Local Health System

- Closure of Providence Hospital
- Change of UM Laurel Medical Center to emergency services
- Upcoming UM Capital Region Medical Center
- Primary care providers have increased, but so has our population
- Cost of care (co-pays), uninsured, transportation, health literacy, culturally competent providers, perception of quality of care were themes

Local Health System

How do you envision the local health system in the next 5 or 10 years:

- Want all residents to feel safe accessing health-related services (regardless of immigration status)
- Residents will have a better perception of health care in the county
- Better utilization of local services
- A system that is perceived as available to serve all with quality services
- A system that allows residents to access services close to home
- Consideration of needs of all residents

Prioritization Discussion

Prioritization Criteria

- Magnitude: How many people are affected
- Severity: What are the outcomes and how long do they last
- Trend: Changes since 2016
- Disparity: Who is disproportionately affected
- Community Perception: Results from Resident Survey, Community Expert Survey, and Key Informant Interviews

Resources and Next Steps

Attachment C: Priority Area Summary

Prioritization Results

- The Core CHA Team determined by consensus to retain the four priority areas from 2016:
  - Social Determinants of Health
  - Behavioral Health
  - Obesity & Metabolic Syndrome
  - Cancer

Overall, it was noted that these are challenging priorities to "move the needle" in only 3 years, many of the associated indicators have not improved, there are still notable disparities, and these areas continue to be a community priority.

Priority 1: Social Determinants of Health

● Trend is Worsening

	Indicator	2016 Assessment	2019 Assessment
Access to Care	Uninsured Residents	**All: 17.5% (2014)** Black, NH: 10.5% Hispanic: 52.9% White, NH: 8.2%	**All: 10.1% (2017)** Black, NH: 7.6% Hispanic: 33.2% White, NH: 5.4%
	Resident to Provider Ratios	Primary Care: 1,860:1 (2013) Dentists: 1,680:1 (2014) Mental Health: 860:1 (2015)	Primary Care: 1,910:1 (2015) ● Dentists: 1,650:1 (2016) Mental Health: 890:1 (2017) ●
Economic Status	Individual Poverty Status	**All: 10.2% (2014)** Black: 8.6% Hispanic: 17.1% White, NH: 9.3% Asian: 8.6%%	**All: 8.4% (2017)** Black: 7.0% Hispanic: 12.8% White, NH: 8.4% Asian: 6.9%
	Median Household Income	**All: $72,290 (2014)** Black: $72,652 Hispanic: $58,254 White, NH: $84,621 Asian: $79,491	**All: $81,240 (2017)** Black: $82,147 Hispanic: $65,258 White, NH: $93,762 Asian: $96,585
Community Indicators	High School Graduation Rate	**All: 78.8% (2015)** Black: 81.3% Hispanic: 67.4% White: 79.0% Asian: 89.3%	**All: 82.7% (2017)** Black: 88.5% Hispanic: 65.9% ● White: 84.9% Asian: 93.7%
	Income Needed for an Efficiency Unit Rental	**$46,680 (2015)**	**$60,160 (2018)** ●
	Median Renter Income	**$50,792 (2015)**	**$53,774 (2018)**
	Violent Crime Rate per 100,000 Population	**All: 624 per 100,000 (2012)**	**All: 423 per 100,000 (2016)**

Priority 1: Social Determinants of Health

What has Improved since the 2016 Community Health Assessment?

- Percentage of Uninsured Residents has decreased: from 17.5% (2014) to 10.1% (2017)
  - Disparity: Although decreased from 2014, percentage of uninsured Hispanic residents higher than other race/ethnicities
- Overall High School Graduation Rate has increased: from 78.8% (2015) to 82.7% (2017)
- Individuals Below Poverty Level has decreased: from 10.2% (2014) to 8.4% (2017)
- Violent Crime Rate has decreased: from 624 crimes per 100,000 (2012-2014) to 423 per 100,000 (2014-2016), lower than the state rate as of 2016

What has Worsened since the 2016 Community Health Assessment?

- Resident to Provider Ratios increased for primary care and mental health providers
  - In 2013, 1 primary care provider for every 1,860 residents; in 2015, 1 primary care provider for every 1,910 residents
  - In 2015, 1 mental health provider for every 860 residents; in 2017, 1 mental health provider for every 890 residents
- High School Graduation Rate for Hispanic students decreased: from 67.4% (2015) to 65.9% (2017); Hispanic students have a much lower graduation rate compared to other races and ethnicities
- Fair Market Rental Pricing increased substantially: for an efficiency unit, rental pricing increased from $1,167 (2015) to $1,504 (2018)
  - The median income for a renter in the county is $53,774 (2018), which falls short of the median income needed for an efficiency unit by more than $6,000 ($60,160 estimated income needed)

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Priority 2: Behavioral Health

● Trend is Worsening

	Indicator	2016 Assessment	2019 Assessment
Substance Use	Drug-Related Age-Adjusted Mortality Rate (per 100,000)	**All: 6.4 (2012-2014)** Black, NH: 5.1 White, NH: 22.1	**All: 12.2 (2015-2017)** ● Black, NH: 11.6 ● White, NH: 32.1 ●
Substance Use	High School Students Who Ever Took Prescription Drugs Without a Doctor's Prescription Note: question was altered in 2016 to be specific for "prescription pain medication"	**All: 13.9% (2014)** Black, NH: 12.4% Hispanic: 13.8% White, NH: 14.9% All Other Races, NH: 21.6%	**All: 15.6% (2016)** ● Black, NH: 13.9% ● Hispanic: 16.4% ● White, NH: NA All Other Races, NH: 16.0%
Mental Health and Suicide	Adults with Poor Mental Health Days	3-7 Days: 9.8% (2014) 8-29 Days: 7.7% 30 Days: 3.2%	3-7 Days: 10.8% (2017) ● 8-29 Days: 8.8% ● 30 Days: 3.9% ●
Mental Health and Suicide	High School Students who Seriously Considered Attempting Suicide (in last 12 months)	**All: 14.7% (2014)** Black, NH: 12.8% Hispanic: 17.1% White, NH: 16.4% All Other Races, NH: 19.6%	**All: 17.7% (2016)** ● Black, NH: 16.1% ● Hispanic: 18.2% ● White, NH: 21.7% ● All Other Races, NH: 20.4% ●
Mental Health and Suicide	High School Students who Made a Plan About How They Would Attempt Suicide (in last 12 months)	**All: 12.2% (2014)** Black, NH: 9.7% Hispanic: 16.8% White, NH: 13.7% All Other Races, NH: 20.1%	**All: 14.8% (2016)** ● Black, NH: 14.1% ● Hispanic: 14.5% White, NH: 16.3% ● All Other Races, NH: 17.5%
Mental Health and Suicide	Suicide Age-Adjusted Mortality Rate (per 100,000)	**All: 6.0 (2012-2014)** Black, NH: 4.4 White, NH: 14.1	**All: 5.7 (2015-2017)** Black, NH: 5.1 ● White, NH: 11.7

HEALTH DEPARTMENT

Priority 2: Behavioral Health

What has Improved since the 2016 Community Health Assessment?

- Suicide Mortality Rate has decreased: from 6.0 deaths per 100,000 (2012-2014) to 5.7 (2015-2017)

What has Worsened since the 2016 Community Health Assessment?

- Adults with Poor Mental Health Days have increased:
  - 3-7 Poor Mental Health Days increased from 9.8% (2014) to 10.8% (2017)
  - 8-29 Poor Mental Health Days increased from 7.7% (2014) to 8.8% (2017)
  - 30 Poor Mental Health Days increased from 3.2% (2014) to 3.9% (2017)
- High School Students Who Seriously Considered Suicide increased: from 14.7% (2014) to 17.7% (2016)
  - Disparity: 21.7% of White NH students reported seriously considering suicide, followed by students of Other Races (20.4%).
- High School Students Bullied on School Property increased: from 12.1% (2014) to 14.5% (2016)
  - Disparity: More White NH students reported being bullied (24.8%)
- Total Behavioral Health Emergency Department Visits increased by 23%: from 6,842 (2014) to 8,420 (2017) for residents going to Maryland hospitals
- Drug-Related Mortality Rate increased: from 6.4 deaths per 100,000 (2012-2014) to 12.2 (2015-2017)
  - Disparity: White NH residents have the highest mortality rate at 32.1 per 100,00 (2015-2017)
- High School Students Who Used Prescription Drugs Without a Doctor's Prescription increased: from 13.9% (2014) to residents (2014) to 15.6% (2017)

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Priority 3: Obesity & Metabolic Syndrome

● Trend is Worsening

Prevalence

Indicator	2016 Assessment	2019 Assessment
Adult Obesity (Body Mass Index (BMI) of >=30)	**All: 34.2% (2014)** Black, NH: 38.9% Hispanic: 20.9% White, NH: 34.6%	**All: 42.8% (2017)** ● Black, NH: 46.7% ● Hispanic: 34.5% ● White, NH: 29.9%
Adult Overweight (BMI of 25-29)	**All: 34.1% (2014)** Black, NH: 35.9% Hispanic: 34.6% White, NH: 32.0%	**All: 32.2% (2017)** Black, NH: 29.7% Hispanic: 41.8% ● White, NH: 35.8%
High School Student Obesity (>=95th percentile for BMI, 2000 CDC growth charts)	**All: 15.1% (2014)** Black, NH: 14.8% Hispanic: 15.3% White, NH: 13.8% All Other Races, NH: 13.2%	**All: 16.4% (2016)** ● Black, NH: 16.8% ● Hispanic: 17.3% ● White, NH: N/A All Other Races, NH: 8.7%
High School Student Overweight (>=85th percentile but <95th percentile for BMI, 2000 CDC growth charts)	**All: 17.4% (2014)** Black, NH: 15.2% Hispanic: 23.8% White, NH: 11.8% All Other Races, NH: 20.4%	**All: 19.3% (2016)** ● Black, NH 17.7% ● Hispanic: 24.7% ● White, NH: N/A All Other Races, NH: 23.1% ●
Adult Diabetes Prevalence (Have Been Told by a Health Professional They Have Diabetes)	**All: 11.5% (2014)** Black, NH: 13.4% Hispanic: N/A White, NH: 13.7%	**All: 12.3% (2017)** ● Black, NH: 13.6% ● Hispanic: 16.7% White, NH: 10.5%
Adult Hypertension Prevalence (Have Been Told by a Health Professional They Have Hypertension)	**All: 37.9% (2013)** Black, NH: 42.6% Hispanic: 29.9% White, NH: 29.9%	**All: 31.9% (2017)** Black, NH: 34.2% Hispanic: 34.6% ● White, NH: 28.3%

HEALTH DEPARTMENT

Priority 3: Obesity & Metabolic Syndrome

What has Improved since the 2016 Community Health Assessment?

- Hypertension Prevalence has decreased: from 37.9% of adults (2013) to 31.1% (2017)
- Heart Disease Mortality Rate has decreased: from 185.8 deaths per 100,000 (2012-2014) to 168.9 (2015-2017)
- Diabetes Mortality Rate has decreased: from 29.4 deaths per 100,000 (2012-2014) to 26.3 (2015-2017)

What has Worsened since the 2016 Community Health Assessment?

- Adult Obesity Prevalence has increased: from 34.2 (2014) to 42.8% (2017)
  - Disparity: Black, NH residents have the highest prevalence at 46.7%
- High School Student Obesity and Overweight Prevalence has increased: from 15.1% (2014) to 16.4% (2016) for obesity, and 17.4% (2014) to 19.1% (2016) for overweight; overall, one in three high school students are overweight or obese in the county.
  - Disparity: Hispanic students were more likely to be obese or overweight
- Diabetes Prevalence has increased: from 11.5% (2014) to 12.3% (2017)
  - Disparity: Hispanic residents had a higher prevalence at 16.7%
- Stroke Mortality Rate has increased: from 37.8 deaths per 100,000 (2012-2014) to 41.6 (2015-2017)
  - Disparity: Black NH residents have the highest mortality rate at 44.2 per 100,00
- Hypertension Emergency Department Visit Rate has increased: from 261.7 visits per 100,000 residents (2014) to 351.2 visits (2017) (ED visits include all Maryland hospitals); the ED visit rate increased for those ages 40 to 64 years from 377.3 (2014) to 433.9 (2017), and for residents ages 65 and over from 670.2 (2014) to 885.8 (2017)

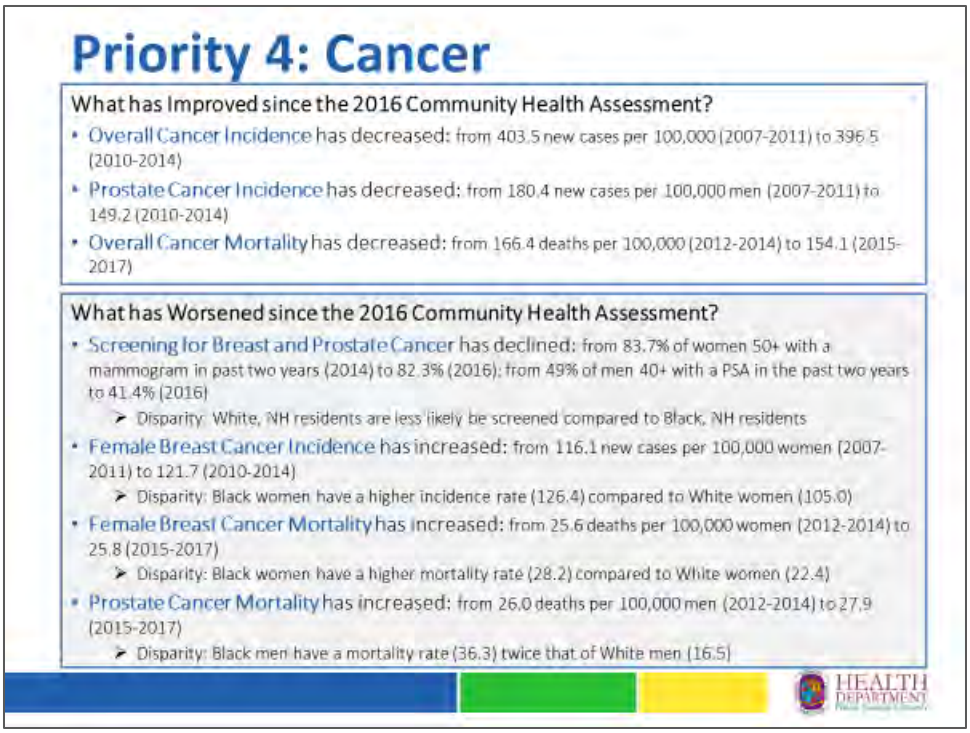
HEALTH DEPARTMENT

Priority 4: Cancer

● Trend is Worsening

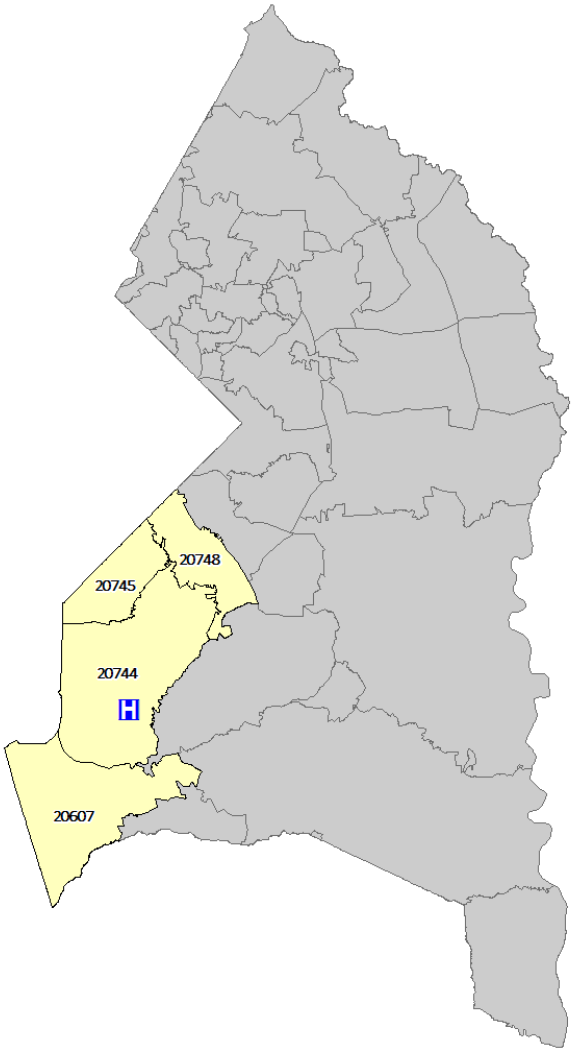
	Indicator	2016 Assessment	2019 Assessment
Screening	Cancer Screening: Women 50+ with Mammogram in Past Two Years	**All: 83.7% (2014)** Black, NH: 85.8% White, NH: 78.4%	**All: 82.3% (2016)** ● Black, NH: 89.6% White, NH: 68.6% ●
Screening	Men 40 years+ with a Prostate-Specific Antigen Test in the Past Two Years	**All: 49.0% (2014)** Black, NH: 51.4% White, NH: 56.8%	**All: 41.4% (2016)** ● Black, NH: 45.6% ● White, NH: 36.7% ●
Incidence	Cancer Age-Adjusted Incidence Rate (per 100,000)	**All: 403.5 (2007-2011)** Black: 415.0 White: 374.1	**All: 396.5 (2010-2014)** Black: 394.6 White: 389.2 ●
Incidence	Female Breast Cancer Age-Adjusted Incidence Rate (per 100,000)	**All: 116.1 (2007-2011)** Black: 122.7 White: 98.1	**All: 121.7 (2010-2014)** ● Black: 126.4 ● White: 105.0 ●
Incidence	Prostate Cancer Age-Adjusted Incidence Rate (per 100,000)	**All: 180.4 (2007-2011)** Black: 220.8 White: 112.4	**All: 149.2 (2010-2014)** Black: 178.3 White: 89.2
Mortality	Cancer Age-Adjusted Mortality Rate (per 100,000)	**All: 166.4 (2012-2014)** Black, NH: 168.2 White, NH: 191.9 Hispanic: 77.6	**All: 154.1 (2015-2017)** Black, NH: 163.3 White, NH: 159.4 Hispanic: 82.3 ●
Mortality	Female Breast Cancer Age-Adjusted Mortality Rate (per 100,000)	**All: 25.6 (2012-2014)** Black, NH: 27.9 White, NH: 21.8	**All: 25.8 (2015-2017)** ● Black, NH: 28.2 ● White, NH: 22.4 ●
Mortality	Prostate Cancer Age-Adjusted Mortality Rate (per 100,000)	**All: 26.0 (2012-2014)** Black, NH: 33.2 White, NH: 16.9	**All: 27.9 (2015-2017)** ● Black, NH: 36.3 ● White, NH: 16.5

HEALTH DEPARTMENT


Priority 4: Cancer
What has Improved since the 2016 Community Health Assessment?
• Overall Cancer Incidence has decreased: from 403.5 new cases per 100,000 (2007-2011) to 396.5 (2010-2014)
• Prostate Cancer Incidence has decreased: from 180.4 new cases per 100,000 men (2007-2011) to 149.2 (2010-2014)
• Overall Cancer Mortality has decreased: from 166.4 deaths per 100,000 (2012-2014) to 154.1 (2015-2017)
What has Worsened since the 2016 Community Health Assessment?
• Screening for Breast and Prostate Cancer has declined: from 83.7% of women 50+ with a mammogram in past two years (2014) to 82.3% (2016); from 49% of men 40+ with a PSA in the past two years to 41.4% (2016)
➢ Disparity: White, NH residents are less likely be screened compared to Black, NH residents
• Female Breast Cancer Incidence has increased: from 116.1 new cases per 100,000 women (2007-2011) to 121.7 (2010-2014)
➢ Disparity: Black women have a higher incidence rate (126.4) compared to White women (105.0)
• Female Breast Cancer Mortality has increased: from 25.6 deaths per 100,000 women (2012-2014) to 25.8 (2015-2017)
➢ Disparity: Black women have a higher mortality rate (28.2) compared to White women (22.4)
• Prostate Cancer Mortality has increased: from 26.0 deaths per 100,000 men (2012-2014) to 27.9 (2015-2017)
➢ Disparity: Black men have a mortality rate (36.3) twice that of White men (16.5)
HEALTH DEPARTMENT


HOSPITAL
profile

FORT WASHINGTON MEDICAL CENTER



Primary Service Area Profile

Fort Washington Medical Center (FWMC) is located in Prince George's County, Maryland, which is part of the Washington, D.C. metropolitan area. Fort Washington Medical Center is located in the south westerern part of the county. The majority of Fort Washington's inpatient visits (83%) are from four ZIP codes, as illustrated on the adjacent map and described in Table 1.

The service area ZIP codes include a mix of suburban and rural communities, with an estimated population of 133,101 (14.6% of the county's population). All but one ZIP code (20748) in the service area has experienced an increase in population since 2010. This area has a larger proportion of Black residents compared to the county, and has fewer residents of Hispanic ethnicity (Chart 2).

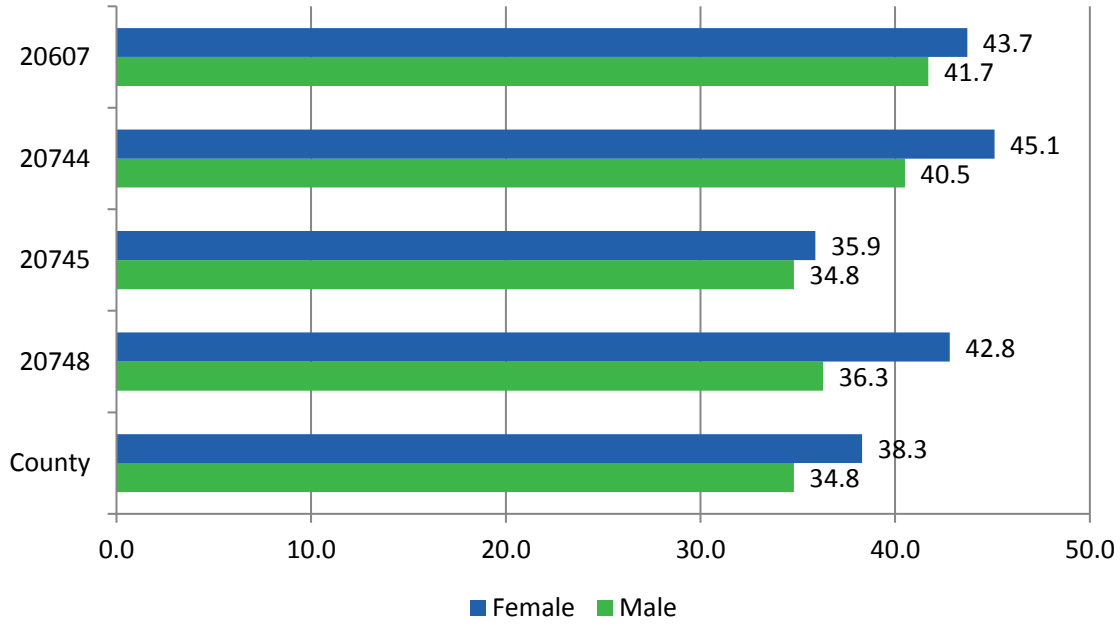
Table 1: Service Area ZIP Codes

ZIP Code	Name	Percent of Inpatient Visits
20744	Fort Washington	48.1%
20745	Oxon Hill	16.2%
20748	Temple Hills	10.4%
20607	Accokeek	8.3%

Data Source: Maryland HSCRC Inpatient File, 2017

The median age in ZIP codes 20607, 20744, and 20748 skews considerably older compared to the County for both males and females, which may play a role in community needs.

Chart 1: Median Age by Gender



Data Source: American Community Survey, 5-Year Estimates, Table S0101

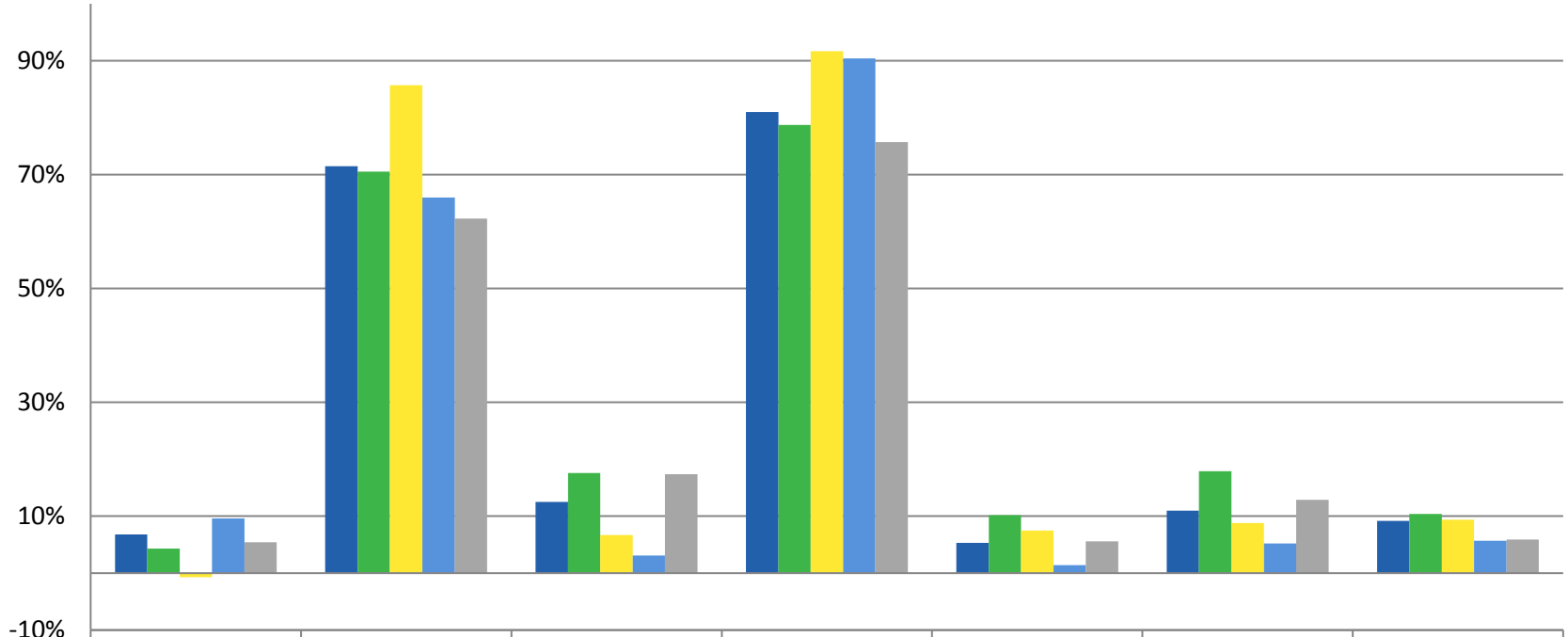
Three of the four ZIP codes in the service area have smaller proportions of populations under 18 years compared to the county, which is in alignment with higher median ages. Two of the four ZIP codes have slightly smaller proportions of populations over the age of 65 years compared to the county, while ZIP codes 20744 and 20748 include a noticeably higher proportion of those age 65 and older.

Table 2: Population Estimates

ZIP Code	Name	Population Estimate	Population <18 Years	Population Age 65+
20744	Fort Washington	54,163	9.868 (18.2%)	9,782 (18.1%)
20745	Oxon Hill	29,673	6,883 (23.2%)	3,069 (10.3%)
20748	Temple Hills	38,521	7,896 (20.5%)	6,045 (15.7%)
20607	Accokeek	10,744	2,208 (20.6%)	1,160 (10.8%)
County	**Prince George's**	**912,756**	**203,800 (22.3%)**	**106,530 (11.7%)**

Data Source: American Community Survey, 5-Year Estimates, Table S0101

Chart 2: Population Description and Socio-Economic Indicators

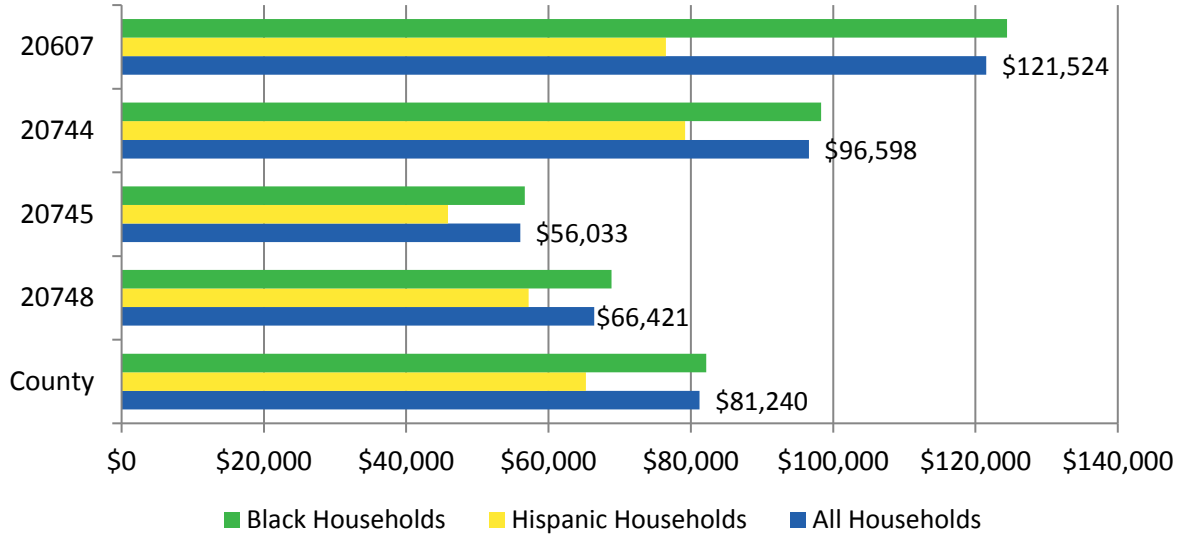


	% Population Growth (from 2010)	% Black, NH	% Hispanic	% Speak Only English at Home	% Families Below Poverty	% No High School Degree	% Unemployment
20744	6.8%	71.5%	12.5%	81.0%	5.3%	11.0%	9.2%
20745	4.3%	70.5%	17.6%	78.7%	10.2%	17.9%	10.4%
20748	-0.7%	85.7%	6.7%	91.7%	7.5%	8.8%	9.4%
20607	9.6%	66.0%	3.1%	90.4%	1.4%	5.2%	5.7%
County	5.4%	62.3%	17.4%	75.7%	5.6%	12.9%	5.9%

Data Source: 2013-2017 American Community Survey, 5-Year Estimates, Tables DP05, S1601, S1501, DP03

Oxon Hill (20745) has more families below the poverty line, more residents without a high school degree, more unemployed and a substantially lower median household income compared to the county (Charts 2 and 3). More residents in the Fort Washington Medical Center service area residents speak only English in the home compared to the County. In 2017, the median household income in the county was $81,240, however, the service area ranged from $56,033 to $121,524, a $65,000 difference among the ZIP codes.

Chart 3: Median Household Income



Data Source: 2013-2017 American Community Survey, 5-Year Estimates, Table B19013

The SocioNeeds Index (created by Healthy Community Institute), is a composite measure of socioeconomic factors for all the ZIP codes in the United States, and ranking them in an index from 0 (low need) to 100 (high need). For example, an index of 50 would be average compared to the entire country. Table 3 highlights the large disparity in need based on the SocioNeeds Index. The ZIP codes in the hospital's service area range from a very low area of need in Accokeek (20607) to a high area of need in Oxon Hill (20745).

Table 3: SocioNeeds Index

ZIP Code	Name	SocioNeeds Index (0 is best)	Rank (1 is best)
20744	Fort Washington	18.6	2
20745	Oxon Hill	72.4	4
20748	Temple Hills	40.9	3
20607	Accokeek	4.8	1

Data Source: www.pgchealthzone.org, Healthy Communities Institute

Hospital Inpatient Profile

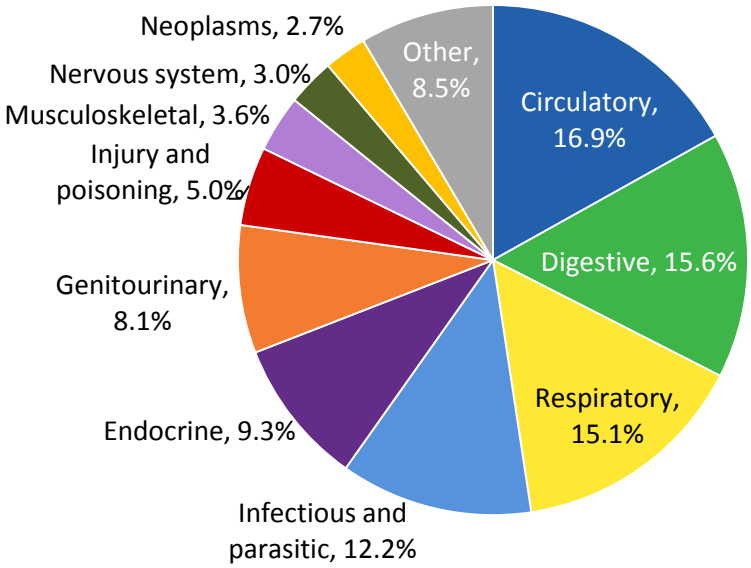
Inpatient data for Fort Washington Medical Center was analyzed to determine the leading causes for hospitalization for the patients it serves. In 2017, three out of five hospital inpatient hospitalizations were for one of four discharge diagnoses: circulatory, digestive, respiratory or infectious diseases.

Table 4: Top Ten Inpatient Diagnoses

Diagnostic Cause	Percent (%)
Circulatory	16.9%
Digestive	15.6%
Respiratory	15.1%
Infectious and parasitic	12.2%
Endocrine	9.3%
Genitourinary	8.1%
Injury and poisoning	5.0%
Musculoskeletal	3.6%
Nervous system	3.0%
Neoplasms	2.7%
Other	8.5%

Data Source: Maryland HSCRC Inpatient File, 2017

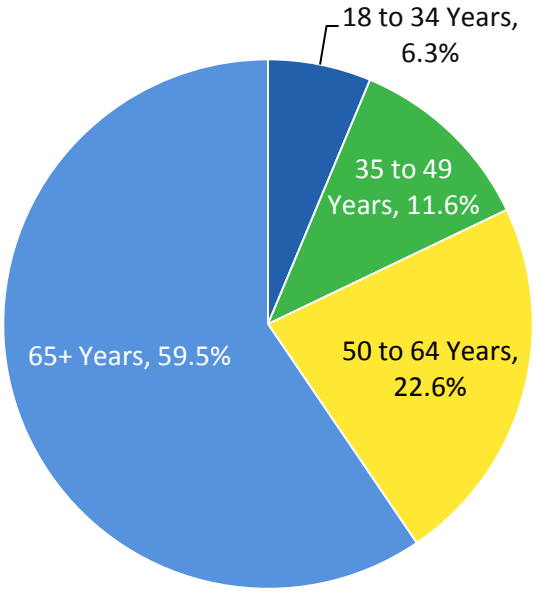
Chart 4: Inpatient Visits by Diagnosis



Data Source: Maryland HSCRC Inpatient File, 2017

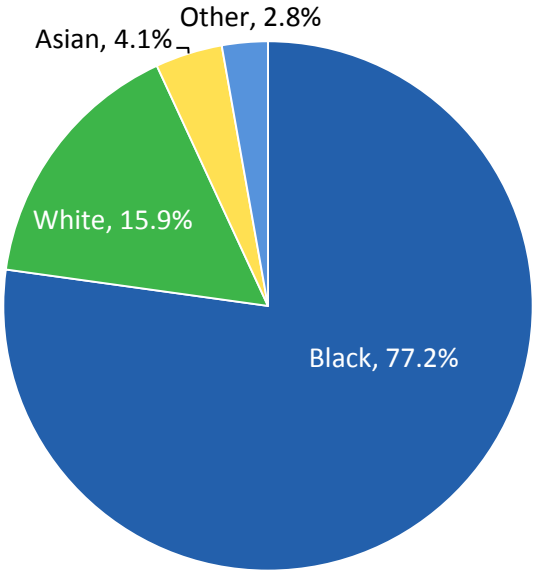
Seniors age 65 and older comprise well over half of all inpatient hospitalizations (Chart 5). Three-quarters of patients hospitalized at Fort Washington Medical Center are Black (Chart 6), similar to the composition of the overall population served by hospital.

Chart 5: Inpatient Diagnoses by Age Group



Data Source: Maryland HSCRC Inpatient File, 2017

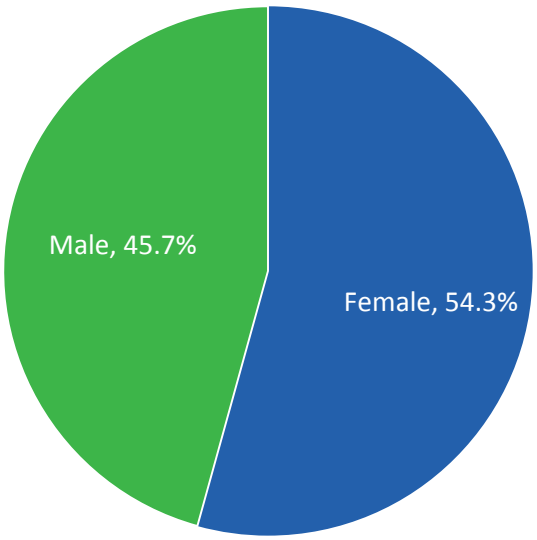
Chart 6: Inpatient Diagnoses by Race



Data Source: Maryland HSCRC Inpatient File, 2017

Over half of inpatient hospitalizations for Fort Washington Medical Center are among women.

Chart 7: Inpatient Diagnoses by Sex



Data Source: Maryland HSCRC Inpatient File, 2017

Hospital Emergency Department Profile

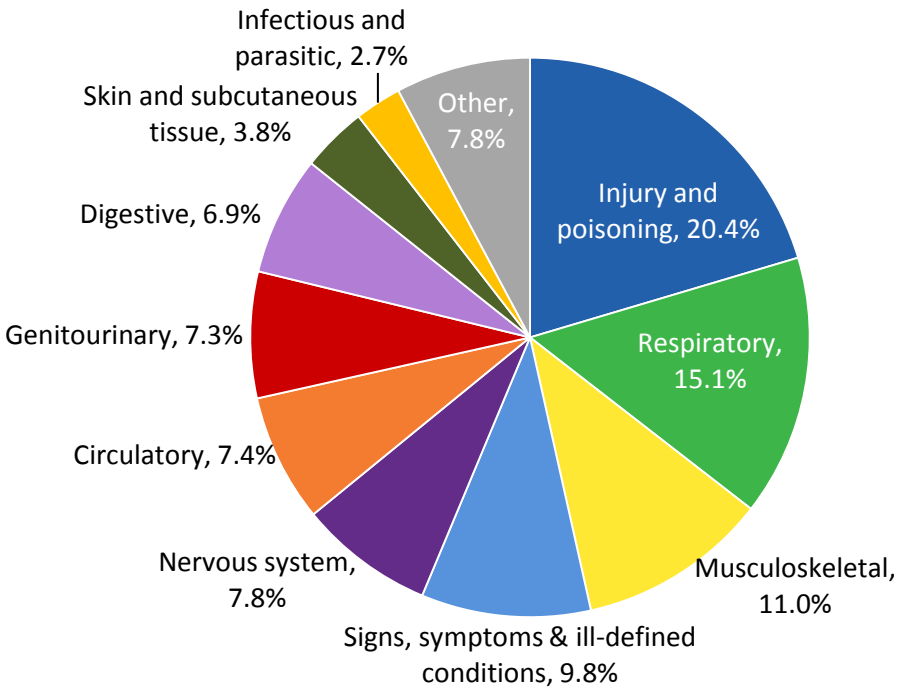
Emergency department data for Fort Washington Medical Center was analyzed to determine the leading causes for visits. One-fifth of emergency encounters were for injury, followed by respiratory and musculoskeletal symptoms. One in ten emergency encounters were for general symptoms.

Table 5: Top Ten Emergency Department Diagnoses

Diagnostic Cause	Percent (%)
Injury and poisoning	20.4%
Respiratory	15.1%
Musculoskeletal	11.0%
Signs, symptoms & ill-defined conditions	9.8%
Nervous system	7.8%
Circulatory	7.4%
Genitourinary	7.3%
Digestive	6.9%
Skin and subcutaneous tissue	3.8%
Infectious and parasitic	2.7%
Other	7.8%

Data Source: Maryland HSCRC Outpatient File, 2017

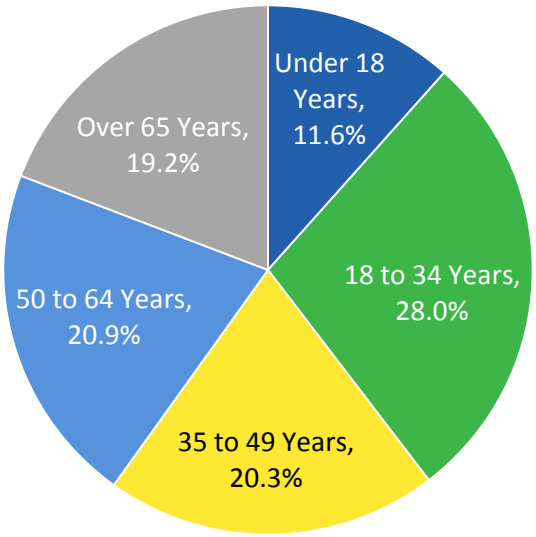
Chart 8: Top Ten Emergency Department Diagnoses



Data Source: Maryland HSCRC Outpatient File, 2017

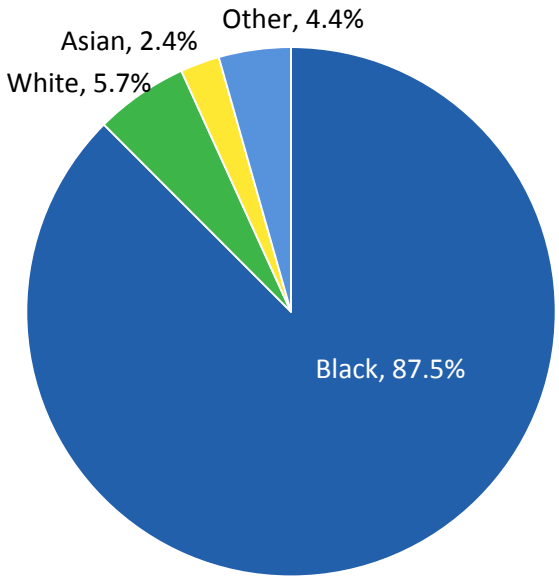
Almost half of emergency department encounters for Fort Washington Medical Center are among those 18 – 39 years of age. By race, the majority of emergency department encounters are among Black individuals, followed by White and Asian.

Chart 9: Emergency Department Visits by Age Group



Data Source: Maryland HSCRC Outpatient File, 2017

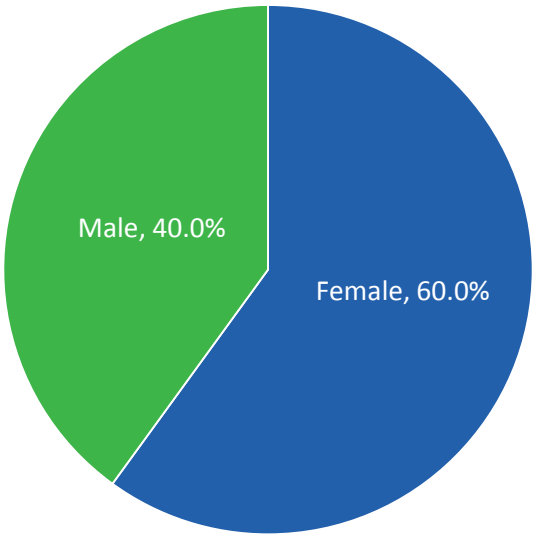
Chart 10: Emergency Department Visits by Race



Data Source: Maryland HSCRC Outpatient File, 2017

The majority of emergency department encounters are among women.

Chart 11: Emergency Department Visits by Sex



Data Source: Maryland HSCRC Outpatient File, 2017

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance

(Formerly "Charity Care")

Effective Date: 01/08	Policy No:	AHC 3.19
Cross Referenced: Previously: Financial Assistance Policy (see AHC 3.19.1 for Decision Rules / Application)	Origin:	PFS / FC
Reviewed: 02/09, 9/19/13, 10/10/17	Authority:	EC
Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13, 2/01/16, 11/09/17, 08/26/19, 12/20	Page:	1 of 14

FINANCIAL ASSISTANCE POLICY SUMMARY

SCOPE:

This policy applies to the following Adventist HealthCare facilities: Shady Grove Medical Center, Germantown Emergency Center, White Oak Medical Center, Adventist Rehabilitation Hospital of Maryland, and Fort Washington Medical Center collectively referred to as AHC.

PURPOSE:

In keeping with AHC's mission to demonstrate God's care by improving the health of people and communities Adventist HealthCare provides financial assistance to low to mid income patients in need of our services. AHC's Financial Assistance Plan provides a systematic and equitable way to ensure that patients who are uninsured, underinsured, have experienced a catastrophic event, and/or and lack adequate resources to pay for services can access the medical care they need.

Adventist HealthCare provides emergency and other non-elective medically necessary care to individual patients without discrimination regardless of their ability to pay, ability to qualify for financial assistance, or the availability of third-party coverage. In the event that third-party coverage is not available, a determination of potential eligibility for Financial Assistance will be initiated prior to, or at the time of admission. This policy identifies those circumstances when AHC may provide care without charge or at a discount based on the financial need of the individual.

Printed public notification regarding the program will be made annually in Montgomery County, Maryland and Prince George's County, Maryland newspapers and will be posted in the Emergency Departments, the Business Offices and Registration areas of the above named facilities.

This policy has been adopted by the governing body of AHC in accordance with the regulations and requirements of the State of Maryland and with the regulations under Section 501(r) of the Internal Revenue Code.

This financial assistance policy provides guidelines for:

- prompt-pay discounts (%) that may be charged to self-pay patients who receive medically necessary services that are not considered emergent or non-elective.
- special consideration, where appropriate, for those individuals who might gain special consideration due to catastrophic care.

BENEFITS:

Enhance community service by providing quality medical services regardless of a patient's (or their guarantors') ability to pay. Decrease the unnecessary or inappropriate placement of accounts with collection agencies when a charity care designation is more appropriate.

DEFINITIONS:

- **Medically Necessary:** health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine
- **Emergency Medical Services**: treatment of individuals in crisis health situations that may be life threatening with or without treatment
- **Non-elective services:** a medical condition that without immediate attention:
    - Places the health of the individual in serious jeopardy
    - Causes serious impairment to bodily functions or serious dysfunction to a bodily organ.
    - And may include, but are not limited to:
        - Emergency Department Outpatients
        - Emergency Department Admissions
        - IP/OP follow-up related to previous Emergency visit
- **Catastrophic Care**: a severe illness requiring prolonged hospitalization or recovery. Examples would include coma, cancer, leukemia, heart attack or stroke. These illnesses usually involve high costs for hospitals, doctors and medicines and may incapacitate the person from working, creating a financial hardship
- **Prompt Pay Discount**: The state of Maryland allows a 1% prompt-pay discount for those patients who pay for medical services at the time the service is rendered.

- **FPL** (Federal Poverty Level): is the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services.
- **Uninsured Patient**: Person not enrolled in a healthcare service coverage insurance plan. May or may not be eligible for charitable care.
- **Self-pay Patient**: an Uninsured Patient who does not qualify for AHC Financial Assistance due to income falling above the covered FPL income guidelines

POLICY

1. General Eligibility

1.1. All patients, regardless of race, creed, gender, age, sexual orientation, national origin or financial status, may apply for Financial Assistance.

1.2. It is part of Adventist HealthCare's mission to provide necessary medical care to those who are unable to pay for that care. The Financial Assistance program provides for care to be either free or rendered at a reduced charge to:

1.2.1. those most in need based upon the current Federal Poverty Level (FPL) assessment, (i.e., individuals who have income that is less than or equal to 200% of the federal poverty level (See current FPL).

1.2.2. those in some need based upon the current FPL, (i.e., individuals who have income that is between 201% and 600% of the current FPL guidelines

1.2.3. patients experiencing a financial hardship (medical debt incurred over the course of the previous 12 months that constitutes more than 25% of the family's income), and/or

1.2.4. absence of other available financial resources to pay for urgent or emergent medical care

1.3. This policy requires that a patient or their guarantor to cooperate with, and avail themselves of all available programs (including those offered by AHC, Medicaid, workers compensation, and other state and local programs) which

might provide coverage for services, prior to final approval of Adventist HealthCare Financial Assistance.

1.4. **Eligibility for Emergency Medical Care:** Patients may be eligible for financial assistance for Emergency Medical Care under this Policy if:

1.4.1. They are uninsured, have exhausted, or will exhaust all available insurance benefits; and

1.4.2. Their annual family income does not exceed 200% of the current Federal Poverty Guidelines to qualify for full financial assistance or 600% of the current Federal Poverty Guidelines for partial financial assistance; and

1.4.3. They apply for financial assistance within the Financial Assistance Application Period (i.e. within the period ending on the 240th day after the first post-discharge billing statement is provided to a patient).

1.5. **Eligibility for non-emergency Medically Necessary Care:** Patients may be eligible for financial assistance for non-emergency Medically Necessary Care under this Policy if:

1.5.1. They are uninsured, have exhausted, or will exhaust all available insurance benefits; and

1.5.2. Their annual family income does not exceed 200% of the current Federal Poverty Guidelines to qualify for full financial assistance or 600% of the current Federal Poverty Guidelines for partial financial assistance; and

1.5.3. They apply for financial assistance within the Financial Assistance Application Period (i.e. within the period ending on the 240th day after the first post-discharge billing statement is provided to a patient) and

1.5.4. The treatment plan was developed and provided by an AHC care team

1.6. **Considerations:**

1.6.1. Insured Patients who incur high out of pocket expenses (deductibles, co-insurance, etc.) may be eligible for financial assistance applied to the patient payment liability portion of their medically necessary services

1.6.2. Pre-approved financial assistance for medical services scheduled past the 2nd midnight post an ER admission are reviewed by the appropriate staff based on medical necessity criteria established in this policy and may or may not be approved for financial assistance.

1.7. **Exclusions:** Patients are INELIGIBLE for financial assistance for Emergency Medical Care or other non-emergency Medically Necessary Care under this policy if:

1.7.1. Purposely providing false or misleading information by the patient or responsible party; or

1.7.2. Providing information gained through fraudulent methods in order to qualify for financial assistance (EXAMPLE: using misappropriated identification and/or financial information, etc.)

1.7.3. The patient or responsible party refuses to cooperate with any of the terms of this Policy; or

1.7.4. The patient or responsible party refuses to apply for government insurance programs after it is determined that the patient or responsible party is likely to be eligible for those programs; or

1.7.5. The patient or responsible party refuses to adhere to their primary insurance requirements where applicable.

1.8. **Special Considerations (Presumptive Eligibility)**: Adventist Healthcare makes available financial assistance to patients based upon their "assumed eligibility" if they meet one of the following criteria:

1.8.1. Patients, unless otherwise eligible for Medicaid or CHIP, who receive benefits from a social security program as determined by the Department and the Commission, including but not limited to those listed below are eligible for

free care, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below

1.8.1.1. Households with children in the free or reduced lunch program;

1.8.1.2. Supplemental Nutritional Assistance Program (SNAP);

1.8.1.3. Low-income-household energy assistance program;

1.8.1.4. Women, Infants and Children (WIC)

1.8.2. Patients who are beneficiaries of the Montgomery County programs listed below are eligible for financial assistance after meeting the copay requirements mandated by the program, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below:

1.8.2.1. Montgomery Cares;

1.8.2.2. Project Access;

1.8.2.3. Care for Kids

1.8.3. Additionally, patients who fit one or more of the following criteria may be eligible for financial assistance for emergency or nonemergency Medically Necessary Care under this policy with or without a completed application, and regardless of financial ability. IF the patient is:

1.8.3.1. categorized as homeless or indigent

1.8.3.2. unable to provide the necessary financial assistance eligibility information due to mental status or capacity

1.8.3.3. unresponsive during care and is discharged due to expiration

1.8.3.4. individual is eligible by the State to receive assistance under the Violent Crimes Victims Compensation Act or the Sexual Assault Victims Compensation Act;

1.8.3.5. a victim of a crime or abuse (other requirements will apply)

1.8.3.6. Elderly and a victim of abuse

1.8.3.7. an unaccompanied minor

1.8.3.8. is currently eligible for Medicaid, but was not at the date of service

For any individual presumed to be eligible for financial assistance in accordance with this policy, all actions described in the "Eligibility" Section and throughout this policy would apply as if the individual had submitted a completed Financial Assistance Application form and will be communicated to them within two business days of the request for assistance.

1.9. **Amount Generally Billed:** An individual who is eligible for assistance under this policy for emergency or other medically necessary care will never be charged more than the amounts generally billed (AGB) to an individual who is not eligible for assistance. The charges to which a discount will apply are set by the State of Maryland's rate regulation agency (HSCRC) and are the same for all payers (i.e. commercial insurers, Medicare, Medicaid or self-pay) with the exception of Adventist Rehabilitation Hospital of Maryland which charges for patients eligible for assistance under this policy will be set at the most recent Maryland Medicaid interim rate at the time of service as set by the Department of Health and Mental Hygiene.

2. **Policy Transparency:** Financial Assistance Policies are transparent and available to the individuals served at any point in the care continuum in the primary languages that are appropriate for the Adventist HealthCare service area.

2.1. As a standard process, Adventist HealthCare will provide Plain Language Summaries of the Financial Assistance Policy

2.1.1. During ED registration

2.1.2. During financial counseling sessions

2.1.3. Upon request

2.2. Adventist HealthCare facilities will prominently and conspicuously post complete and current versions of the Plain Language Summary of the Financial Assistance policy

2.2.1. At all registrations sites

2.2.2. In specialty area waiting rooms

2.2.3. In specialty area patient rooms

2.3. Adventist HealthCare facilities will prominently and conspicuously post complete and current versions of the following on their respective websites in English and in the primary languages that are appropriate for the Adventist HealthCare service area:

2.3.1. Financial Assistance Policy (FAP)

2.3.2. Financial Assistance Application Form (FAA Form)

2.3.3. Plain Language Summary of the Financial Assistance Policy (PLS)

3. Policy Application and Determination Period

3.1. The Financial Assistance Policy applies to charges for medically necessary patient services that are rendered by one of the referenced Adventist HealthCare facilities. A patient (or guarantor) may apply for Financial Assistance at any time within **240 days after the date it is determined that the patient owes a balance.**

3.2. Probable eligibility will be communicated to the patient within 2 business days of the request for assistance

3.3. Each application for Financial Assistance will be reviewed, and a determination made based upon an assessment of the patient's (or guarantor's) ability to pay. This could include, without limitations the needs of the patient and/or guarantor, available income and/or other financial resources. Final Financial Assistance decisions and awards will be communicated to the patient

within 10 business days of the submission of a completed application for Financial Assistance.

3.4. Pre-approved financial assistance for scheduled medical services is approved by the appropriate staff based on criteria established in this policy

3.5. **Policy Eligibility Period:** If a patient is approved for financial assistance under this Policy, their financial assistance under this policy **shall not exceed past 12 months from the date of the eligibility award letter**. Patients requiring financial assistance past this time must reapply and complete the application process in total.

4. **POLICY EXCLUSIONS:** Services not covered by the AHC Financial Assistance Policy include, but are not limited to:

4.1. Services deemed not medically necessary by AHC clinical team

4.2. Services not charged and billed by an Adventist HealthCare facility listed within this policy are not covered by this policy. Examples include, but at are not limited to; charges from physicians, anesthesiologists, emergency department physicians, radiologists, cardiologists, pathologists, and consulting physicians requested by the admitting and attending physicians.

4.3. Cosmetic, other elective procedures, convenience and/or other Adventist HealthCare facility services which are not medically necessary, are excluded from consideration as a free or discounted service.

4.4. Patients or their guarantors who are eligible for County, State, Federal or other assistance programs will not be eligible for Financial Assistance for services covered under those programs.

4.5. Services Rendered by Physicians who provide services at one of the AHC locations are NOT covered under this policy.

4.5.1. Physician charges are billed **separately** from hospital charges. **Roles and Responsibilities**

4.6. **Adventist HealthCare responsibilities**

4.6.1. AHC has a financial assistance policy to evaluate and determine an individual's eligibility for financial assistance.

4.6.2. AHC has a means of communicating the availability of financial assistance to all individuals in a manner that promotes full participation by the individual.

4.6.3. AHC workforce members in Patient Financial Services and Registration areas understand the AHC financial assistance policy and are able to direct questions regarding the policy to the proper hospital representatives.

4.6.4. AHC requires all contracts with third party agents who collect bills on behalf of AHC to include provisions that these agents will follow AHC financial assistance policies.

4.6.5. The AHC Revenue Cycle Function provides organizational oversight for the provision of financial assistance and the policies/processes that govern the financial assistance process.

4.6.6. After receiving the individual's request for financial assistance, AHC notifies the individual of the eligibility determination within two business days

4.6.7. AHC provides options for payment arrangements.

4.6.8. AHC upholds and honors individuals' right to appeal decisions and seek reconsideration.

4.6.9. AHC maintains (and requires billing contractors to maintain) documentation that supports the offer, application for, and provision of financial assistance for a minimum period of seven years.

4.6.10. AHC will periodically review and incorporate federal poverty guidelines for updates published by the United States Department of Health and Human Services.

4.7. **Individual Patient's Responsibilities**

4.7.1. To be considered for a discount under the financial assistance policy, the individual must cooperate with AHC to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for healthcare, such as Medicare, Medicaid, third-party liability, etc.

4.7.2. To be considered for a discount under the financial assistance policy, the individual must provide AHC with financial and other information needed to determine eligibility (this includes completing the required application forms and cooperating fully with the information gathering and assessment process).

4.7.3. An individual who qualifies for a partial discount must cooperate with the hospital to establish a reasonable payment plan.

4.7.4. An individual who qualifies for partial discounts must make good faith efforts to honor the payment plans for their discounted hospital bills. The individual is responsible to promptly notify AHC of any change in financial situation so that the impact of this change may be evaluated against financial assistance policies governing the provision of financial assistance.

5. Identification Of Potentially Eligible Individuals

5.1. Identification through socialization and outreach

5.1.1. Registration and pre-registration processes promote identification of individuals in need of financial assistance.

5.1.2. Financial counselors will make best efforts to contact all self-pay inpatients during the course of their stay or within 4 days of discharge.

5.1.3. The AHC hospital facility's PLS will be distributed along with the FAA Form to every individual before discharge from the hospital facility.

5.1.4. Information on how to obtain a copy of the PLS will be included with billing statements that are sent to the individuals

5.1.5. An individual will be informed about the AHC hospital facility's FAP in oral communications regarding the amount due for his or her care.

5.1.6. The individual will be provided with at least one written notice (notice of actions that may be taken) that informs the individual that the hospital may take action to report adverse information about the individual to consumer credit reporting agencies/credit bureaus if the individual does not submit a FAA Form or pay the amount due by a specified deadline. This deadline cannot be earlier than 120 days after the first billing statement is sent to the individual. The notice must be provided to the individual at least 30 days before the deadline specified in the notice.

5.2. **Requests for Financial Assistance**: Requests for financial assistance may be received from multiple sources (including the patient, a family member, a community organization, a church, a collection agency, caregiver, Administration, etc.).

5.2.1. Requests received from third parties will be directed to a financial counselor.

5.2.2. The financial counselor will work with the third party to provide resources available to assist the individual in the application process.

5.2.3. If available, an estimated charges letter will be provided to individuals who request it.

5.2.4. **AUTOMATED CHARITY PROCESS** for Accounts sent to outsourced agencies: Adventist HealthCare recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional financial assistance application process. If the required information is not provided by the patient, Adventist HealthCare may employ an automated, predictive scoring tool to qualify patients for financial assistance. The Payment Predictability Score (PPS) predicts the likelihood of a patient to qualify for Financial Assistance based on publicly available data sources. PPS provides an estimate of the patient's likely socio-economic standing, as well as, the patient's

household income size. Approval used with PPS applies only to accounts being reviewed by Patient Financial Services. All other dates of services for the same patient or guarantor will follow the standard Adventist HealthCare collection process.

6. **Executive Approval Board:** Financial assistance award considerations that fall outside the scope of this policy must be reviewed and approved by AHC CFO of facility rendering services, AHC Vice President of Revenue Management, and AHC VP of Patient Safety/Quality.

7. **POLICY REVIEW AND MAINTAINENCE:**

   7.1. This policy will be reviewed on a bi-annual basis

   7.2. The review team includes Adventist HealthCare entity CFOs and VP of Revenue Management for Adventist HealthCare.

   7.3. Updates, edits, and/or additions to this policy must be reviewed and agreed upon, by the review team and then by the governing committee designated by the Board prior to adoption by AHC.

   7.4. Updated policies will be communicated and posted as outlined in section 2- Policy Transparency of this document.

CONTACT INFORMATION AND ADDITIONAL RESOURCES

Adventist HealthCare Patient Financial Services Department
820 W Diamond Ave, Suite 500
Gaithersburg, MD 20878
(301) 315-3660

Effective Date: 01/08	Policy No:	AHC 3.19
Cross Referenced: Previously: Financial Assistance Policy (see AHC 3.19.1 for Decision Rules / Application)	Origin:	PFS / FC
Reviewed: 02/09, 9/19/13, 10/10/17	Authority:	EC
Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13, 2/01/16, 11/09/17, 08/26/19, 12/20	Page:	14 of 14

The following information can be found at Adventist HealthCare's Public Notice of Financial Assistance & Charity Care:

Document Title
AHC Financial Assistance Plain Language Summary - English
AHC Financial Assistance Plain Language Summary - Spanish
AHC Federal Poverty Guidelines
AHC Financial Assistant Application - English
AHC Financial Assistant Application - Spanish
List of Providers not covered under AHC's Financial Assistance Policy