

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 Rehabilitation	<input checked="" type="radio"/>	<input type="radio"/>	
Your hospital's ID is: 3029	<input checked="" type="radio"/>	<input type="radio"/>	
Your hospital is part of the hospital system called Adventist HealthCare.	<input checked="" type="radio"/>	<input type="radio"/>	
The primary hospital community benefit (HCB) Narrative contact at your hospital is Gina Maxham.	<input checked="" type="radio"/>	<input type="radio"/>	
The primary HCB Narrative contact email address at your hospital is gmaxham@adventisthealthcare.com	<input checked="" type="radio"/>	<input type="radio"/>	
The primary HCB Financial report contact at your hospital is Jacqueline Pourahmadi, Sean Love	<input checked="" type="radio"/>	<input type="radio"/>	
The primary HCB Financial report contact email at your hospital is JPourahm@adventisthealthcare.com; slove@adventisthealthcare.com	<input checked="" type="radio"/>	<input type="radio"/>	

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, and hospitalization 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.

- | | | |
|--|---|--|
| <input type="checkbox"/> Allegany County | <input type="checkbox"/> Charles County | <input checked="" type="checkbox"/> Prince George's County |
| <input type="checkbox"/> Anne Arundel County | <input type="checkbox"/> Dorchester County | <input type="checkbox"/> Queen Anne's County |
| <input type="checkbox"/> Baltimore City | <input checked="" type="checkbox"/> Frederick County | <input type="checkbox"/> Somerset County |
| <input type="checkbox"/> Baltimore County | <input type="checkbox"/> Garrett County | <input type="checkbox"/> St. Mary's County |
| <input type="checkbox"/> Calvert County | <input type="checkbox"/> Harford County | <input type="checkbox"/> Talbot County |
| <input type="checkbox"/> Caroline County | <input type="checkbox"/> Howard County | <input type="checkbox"/> Washington County |
| <input type="checkbox"/> Carroll County | <input type="checkbox"/> Kent County | <input type="checkbox"/> Wicomico County |
| <input type="checkbox"/> Cecil County | <input checked="" type="checkbox"/> Montgomery County | <input type="checkbox"/> 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.

- | | | |
|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> 20842 | <input type="checkbox"/> 21719 | <input type="checkbox"/> 21775 |
| <input type="checkbox"/> 20871 | <input type="checkbox"/> 21727 | <input type="checkbox"/> 21776 |

- | | | |
|---|---|--------------------------------|
| <input checked="" type="checkbox"/> 21701 | <input type="checkbox"/> 21754 | <input type="checkbox"/> 21777 |
| <input checked="" type="checkbox"/> 21702 | <input type="checkbox"/> 21755 | <input type="checkbox"/> 21778 |
| <input checked="" type="checkbox"/> 21703 | <input type="checkbox"/> 21757 | <input type="checkbox"/> 21780 |
| <input type="checkbox"/> 21704 | <input type="checkbox"/> 21758 | <input type="checkbox"/> 21783 |
| <input type="checkbox"/> 21705 | <input type="checkbox"/> 21759 | <input type="checkbox"/> 21787 |
| <input type="checkbox"/> 21710 | <input type="checkbox"/> 21762 | <input type="checkbox"/> 21788 |
| <input type="checkbox"/> 21713 | <input type="checkbox"/> 21769 | <input type="checkbox"/> 21790 |
| <input type="checkbox"/> 21714 | <input type="checkbox"/> 21770 | <input type="checkbox"/> 21791 |
| <input type="checkbox"/> 21716 | <input checked="" type="checkbox"/> 21771 | <input type="checkbox"/> 21793 |
| <input type="checkbox"/> 21717 | <input type="checkbox"/> 21773 | <input type="checkbox"/> 21798 |
| <input type="checkbox"/> 21718 | <input type="checkbox"/> 21774 | |

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.

- | | | | | | |
|---|---|---|---|---|---|
| <input type="checkbox"/> 20058 | <input type="checkbox"/> 20824 | <input checked="" type="checkbox"/> 20850 | <input checked="" type="checkbox"/> 20872 | <input type="checkbox"/> 20891 | <input type="checkbox"/> 20907 |
| <input type="checkbox"/> 20207 | <input type="checkbox"/> 20825 | <input checked="" type="checkbox"/> 20851 | <input checked="" type="checkbox"/> 20874 | <input type="checkbox"/> 20892 | <input checked="" type="checkbox"/> 20910 |
| <input type="checkbox"/> 20707 | <input type="checkbox"/> 20827 | <input checked="" type="checkbox"/> 20852 | <input type="checkbox"/> 20875 | <input type="checkbox"/> 20894 | <input type="checkbox"/> 20911 |
| <input type="checkbox"/> 20777 | <input type="checkbox"/> 20830 | <input checked="" type="checkbox"/> 20853 | <input checked="" type="checkbox"/> 20876 | <input checked="" type="checkbox"/> 20895 | <input checked="" type="checkbox"/> 20912 |
| <input checked="" type="checkbox"/> 20783 | <input checked="" type="checkbox"/> 20832 | <input checked="" type="checkbox"/> 20854 | <input checked="" type="checkbox"/> 20877 | <input type="checkbox"/> 20896 | <input type="checkbox"/> 20913 |
| <input type="checkbox"/> 20787 | <input checked="" type="checkbox"/> 20833 | <input checked="" type="checkbox"/> 20855 | <input checked="" type="checkbox"/> 20878 | <input type="checkbox"/> 20898 | <input type="checkbox"/> 20914 |
| <input type="checkbox"/> 20810 | <input type="checkbox"/> 20837 | <input type="checkbox"/> 20857 | <input checked="" type="checkbox"/> 20879 | <input type="checkbox"/> 20899 | <input type="checkbox"/> 20915 |
| <input type="checkbox"/> 20811 | <input type="checkbox"/> 20838 | <input type="checkbox"/> 20859 | <input type="checkbox"/> 20880 | <input checked="" type="checkbox"/> 20901 | <input type="checkbox"/> 20916 |
| <input type="checkbox"/> 20812 | <input type="checkbox"/> 20839 | <input type="checkbox"/> 20860 | <input checked="" type="checkbox"/> 20882 | <input checked="" type="checkbox"/> 20902 | <input type="checkbox"/> 20918 |
| <input checked="" type="checkbox"/> 20814 | <input checked="" type="checkbox"/> 20841 | <input type="checkbox"/> 20861 | <input type="checkbox"/> 20883 | <input checked="" type="checkbox"/> 20903 | <input type="checkbox"/> 20993 |
| <input checked="" type="checkbox"/> 20815 | <input type="checkbox"/> 20842 | <input type="checkbox"/> 20862 | <input type="checkbox"/> 20884 | <input checked="" type="checkbox"/> 20904 | <input type="checkbox"/> 21770 |
| <input checked="" type="checkbox"/> 20816 | <input type="checkbox"/> 20847 | <input checked="" type="checkbox"/> 20866 | <input type="checkbox"/> 20885 | <input checked="" type="checkbox"/> 20905 | <input type="checkbox"/> 21771 |
| <input checked="" type="checkbox"/> 20817 | <input type="checkbox"/> 20848 | <input type="checkbox"/> 20868 | <input checked="" type="checkbox"/> 20886 | <input checked="" type="checkbox"/> 20906 | <input type="checkbox"/> 21797 |
| <input type="checkbox"/> 20818 | <input type="checkbox"/> 20849 | <input checked="" type="checkbox"/> 20871 | <input type="checkbox"/> 20889 | | |

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

- | | | | |
|--------------------------------|---|---|---|
| <input type="checkbox"/> 20233 | <input type="checkbox"/> 20710 | <input type="checkbox"/> 20742 | <input checked="" type="checkbox"/> 20772 |
| <input type="checkbox"/> 20389 | <input checked="" type="checkbox"/> 20712 | <input type="checkbox"/> 20743 | <input type="checkbox"/> 20773 |
| <input type="checkbox"/> 20395 | <input type="checkbox"/> 20715 | <input checked="" type="checkbox"/> 20744 | <input checked="" type="checkbox"/> 20774 |
| <input type="checkbox"/> 20588 | <input type="checkbox"/> 20716 | <input type="checkbox"/> 20745 | <input type="checkbox"/> 20775 |
| <input type="checkbox"/> 20599 | <input type="checkbox"/> 20717 | <input checked="" type="checkbox"/> 20746 | <input checked="" type="checkbox"/> 20781 |
| <input type="checkbox"/> 20601 | <input type="checkbox"/> 20718 | <input checked="" type="checkbox"/> 20747 | <input checked="" type="checkbox"/> 20782 |
| <input type="checkbox"/> 20607 | <input type="checkbox"/> 20720 | <input checked="" type="checkbox"/> 20748 | <input checked="" type="checkbox"/> 20783 |
| <input type="checkbox"/> 20608 | <input checked="" type="checkbox"/> 20721 | <input type="checkbox"/> 20749 | <input checked="" type="checkbox"/> 20784 |
| <input type="checkbox"/> 20613 | <input type="checkbox"/> 20722 | <input type="checkbox"/> 20750 | <input checked="" type="checkbox"/> 20785 |
| <input type="checkbox"/> 20616 | <input type="checkbox"/> 20724 | <input type="checkbox"/> 20752 | <input type="checkbox"/> 20790 |
| <input type="checkbox"/> 20623 | <input type="checkbox"/> 20725 | <input type="checkbox"/> 20753 | <input type="checkbox"/> 20791 |

- | | | | |
|---|---|---|--------------------------------|
| <input type="checkbox"/> 20703 | <input type="checkbox"/> 20726 | <input type="checkbox"/> 20757 | <input type="checkbox"/> 20792 |
| <input type="checkbox"/> 20704 | <input type="checkbox"/> 20731 | <input type="checkbox"/> 20762 | <input type="checkbox"/> 20799 |
| <input checked="" type="checkbox"/> 20705 | <input type="checkbox"/> 20735 | <input type="checkbox"/> 20768 | <input type="checkbox"/> 20866 |
| <input checked="" type="checkbox"/> 20706 | <input checked="" type="checkbox"/> 20737 | <input type="checkbox"/> 20769 | <input type="checkbox"/> 20903 |
| <input checked="" type="checkbox"/> 20707 | <input type="checkbox"/> 20738 | <input checked="" type="checkbox"/> 20770 | <input type="checkbox"/> 20904 |
| <input checked="" type="checkbox"/> 20708 | <input checked="" type="checkbox"/> 20740 | <input type="checkbox"/> 20771 | <input type="checkbox"/> 20912 |
| <input type="checkbox"/> 20709 | <input type="checkbox"/> 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.

Based on patterns of utilization. Please describe.

The hospitals total service area is approximately 85.0 percent of total discharges for years 2016-2018. The first 60.0 percent of discharges account for the primary service area and the remaining 25.0 percent account for the secondary service area.

Other. Please describe.

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

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)

12/30/2019

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/c2371c88-1fb4-4ea9-8b44-757fd9f99d7b/2020-chna-rehab.pdf>

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

[REHAB 2020-2022 CHNA.pdf](#)
7.2MB
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										Other - If you selected "Other (explain)," please type your explanation below:
	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)	
CB/ Community Health/Population Health Director (facility level)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	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 explanation below:
CB/ Community Health/ Population Health Director (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Chair of the Community Benefit Steering Committee
	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 explanation below:

Senior Executives (CEO, CFO, VP, etc.) (facility level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Member of the Community Benefit Steering Committee
	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 explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Member of the Community Benefit Steering Committee
	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 explanation below:
Board of Directors or Board Committee (facility level)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	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 explanation below:
Board of Directors or Board Committee (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Review and approved final reports
	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 explanation below:
Clinical Leadership (facility level)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	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 explanation below:
Clinical Leadership (system level)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	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 explanation below:
Population Health Staff (facility level)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	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 explanation below:
Population Health Staff (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Member of the Community Benefit Steering Committee
	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 explanation below:
Community Benefit staff (facility level)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	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 explanation below:
Community Benefit staff (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Member of the Community Benefit Steering Committee

	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 explanation below:
Physician(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nurse(s)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social Workers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hospital Advisory Board	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify) Community Benefit Steering Committee	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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										Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
	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)		
CB/ Community Health/Population Health Director (facility level)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
CB/ Community Health/ Population Health Director (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
Senior Executives (CEO, CFO, VP, etc.) (facility level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		

	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)
Social Workers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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)
Hospital Advisory Board	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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 (specify) Community Benefit Steering Committee	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	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)

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 health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals -- Please list the hospitals here: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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 health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Departments -- Please list the Local Health Departments here: Montgomery County Health Department	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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 health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Improvement Coalition -- Please list the LHICs here: Healthy Montgomery	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

	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 health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Maryland Department of Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other State Agencies -- Please list the agencies here:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local Govt. Organizations -- Please list the organizations here:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asian American Health Initiative, African American Health Initiative, Latino Health Initiative	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Faith-Based Organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School - K-12 -- Please list the schools here:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Greencastle Elementary School, Montgomery County Public Schools	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School - Colleges, Universities, Professional Schools -- Please list the schools here:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
University of Maryland	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Behavioral Health Organizations -- Please list the organizations here:
 EveryMind, Inc., Lourie Center

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 health issues Document and communicate results Plan Implementation Strategies Implement Improvement Plans Evaluate Progress

Social Service Organizations -- Please list the organizations here:
 Manna, Montgomery County Coalition for the Homeless, WorkSource Montgomery, Vietnamese American Services, Thriving Germantown, Adventist Community Services of Greater Washington

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 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 health issues Document and communicate results Plan Implementation Strategies Implement Improvement Plans Evaluate Progress

Community/Neighborhood Organizations -- Please list the organizations here:
 Healthcare Initiative Foundation, Lollipop Kids Foundation, Spirit Club Foundation

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 health issues Document and communicate results Plan Implementation Strategies Implement Improvement Plans Evaluate Progress

Consumer/Public Advocacy 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

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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 health issues Document and communicate results Plan Implementation Strategies Implement Improvement Plans Evaluate Progress

Other -- If any other people or organizations were involved, please list them here:
 Montgomery County Police, Montgomery County Fire and Rescue, and Montgomery County Crisis Intervention Team

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 health issues Document and communicate results Plan Implementation Strategies Implement Improvement Plans Evaluate Progress

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
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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.

7/13/2020

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

<https://www.adventisthealthcare.com/app/files/public/af087e4a-4571-420a-8caf-c0b4166ea484/2020-CHNA-AHC-ImplementationStrategy.pdf>

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

[2020-2022 AHC Implementation Strategy July 10 2020 - FINAL.pdf](#)
479.1KB
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 - Physical Activity
- Health Behaviors - Preventive Care
- Health Behaviors - Safe Food Handling
- Health Behaviors - Sleep
- Health Behaviors - Tobacco Use
- 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
- 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 Rehabilitation does not currently provide ongoing community outreach or programs specific to chronic diseases (cancer and diabetes) because they are being addressed by other organizations in the community including Shady Grove Medical Center and White Oak Medical Center, both of which are part of the Adventist HealthCare system.

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:

- 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.

- Yes, by the hospital's staff
- 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.

Adventist HealthCare Rehabilitation Hospital (Rehab) is dedicated to Community Benefit which aligns with the systems core mission and values. The Strategic Plan for Rehab 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.

The strategic plan is not a publicly available document.

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

NEXUS Montgomery Diabetes Catalyst Grant. Through this partnership all of the Montgomery County hospitals are working to increase access to evidence-based diabetes education programs in our region. The main program of focus are Diabetes Self Management training (DSMT) and Diabetes Prevention Program (DPP). We also provide funding through our Community Partnership Fund to community clinics which also ensure access to affordable care.

Opioid Use Disorder - Improve overdose mortality

Maternal and Child Health - Reduce severe maternal morbidity rate

We provide funding through our Community Partnership Fund to community clinics which also ensure access to affordable care.

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>

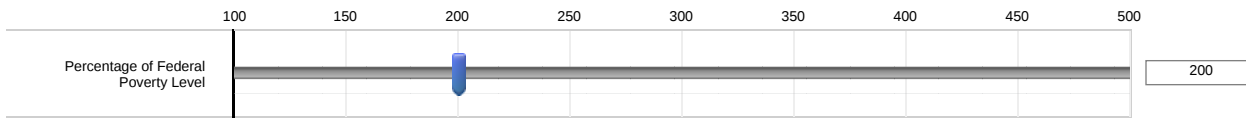
Q83. Has your FAP changed within the last year? If so, please describe the change.

No, the FAP has not changed.

Yes, the FAP has changed. Please describe:

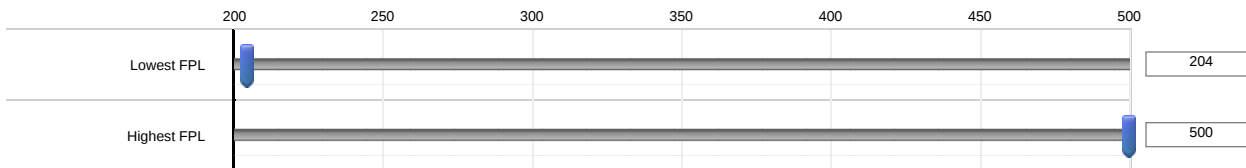
Q84. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



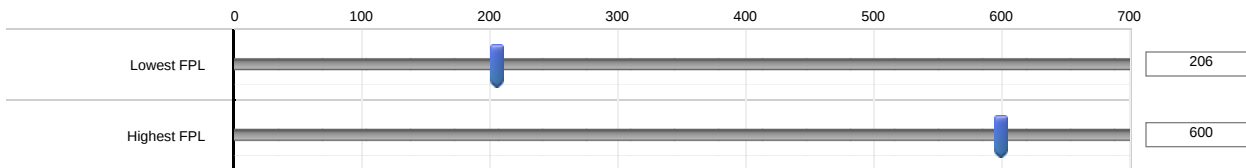
Q85. Maryland acute care and chronic care hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

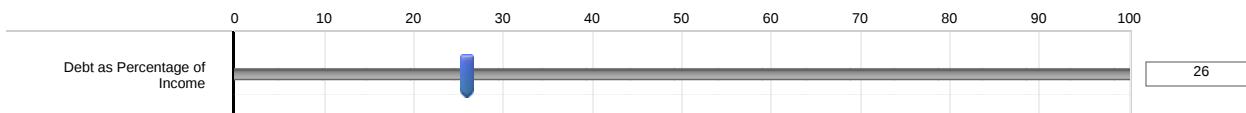


Q86. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3)(a) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial 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)

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

Q90. Summary & Report Submission

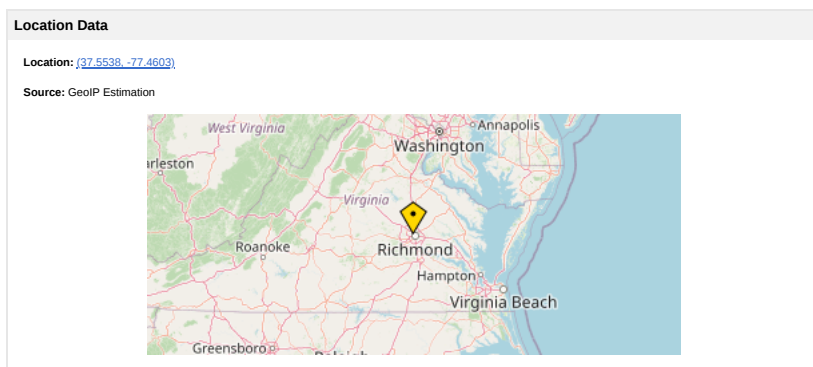
Q91.

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.

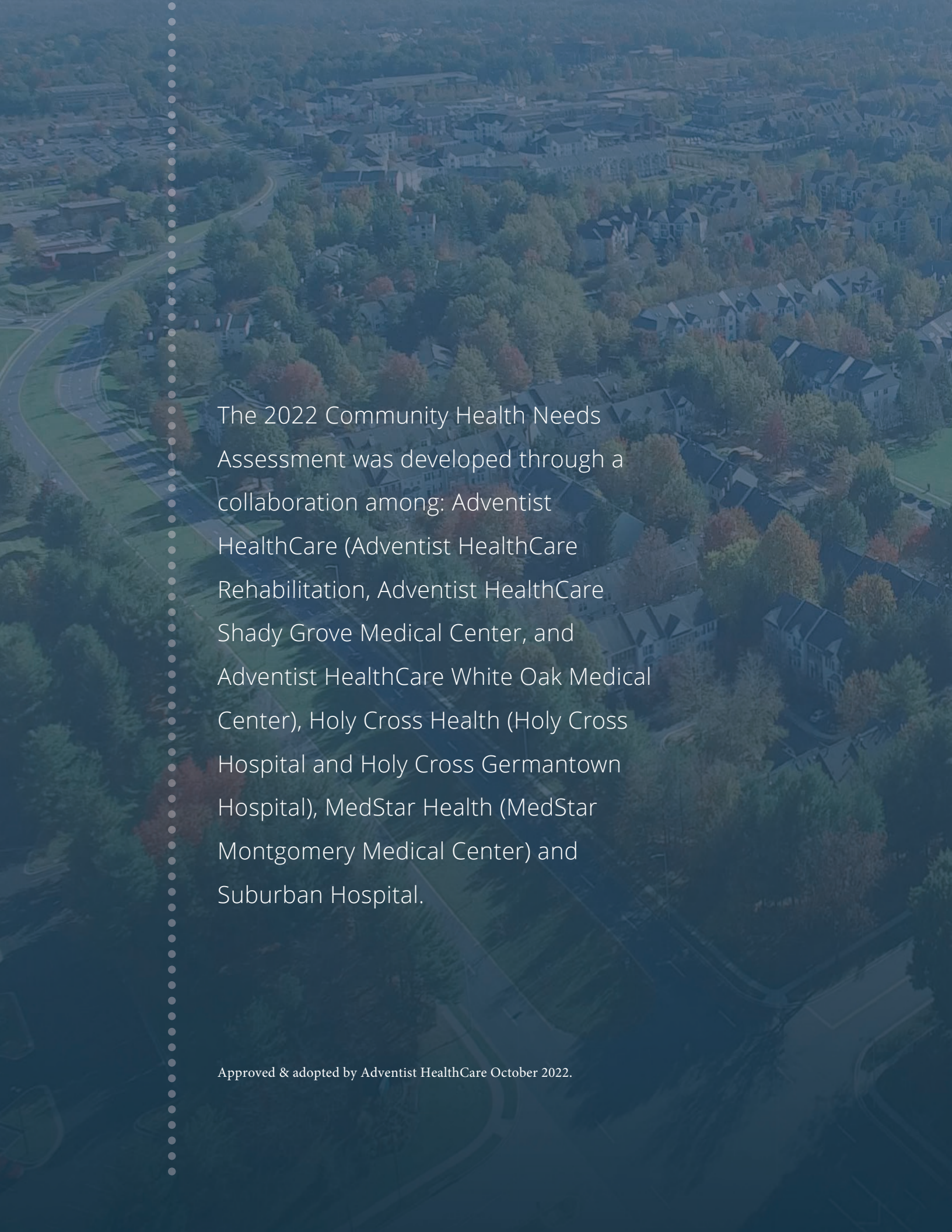




2022

MONTGOMERY COUNTY HOSPITAL COLLABORATIVE **COMMUNITY HEALTH NEEDS** ASSESSMENT





The 2022 Community Health Needs Assessment was developed through a collaboration among: Adventist HealthCare (Adventist HealthCare Rehabilitation, Adventist HealthCare Shady Grove Medical Center, and Adventist HealthCare White Oak Medical Center), Holy Cross Health (Holy Cross Hospital and Holy Cross Germantown Hospital), MedStar Health (MedStar Montgomery Medical Center) and Suburban Hospital.

Approved & adopted by Adventist HealthCare October 2022.

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GLOSSARY

A list of commonly used terms and acronyms is provided below as well as a list of acronyms used in this report to refer to various organizations, departments, offices, programs, data collection and surveillance systems.

Commonly Used Terms

Age-Adjustment	Age-adjustment is a statistical process applied to rates of disease, death, injury, or other health outcomes that allows for the comparison of rates among populations having different age distributions.
Incidence	The number of newly diagnosed cases of disease occurring in a specific population during a specific time.
Risk Factor	Something that can increase the chance of developing disease.
Morbidity	The incidence of disease within a population.
Mortality	The number of deaths during a specific time.

Acronyms

ACA	Affordable Care Act
CBSA	Community Benefit Service Area
CDC	Centers for Disease Control and Prevention
MC	Montgomery County, Maryland
PGC	Prince George's County, Maryland
MCHC	Montgomery County Hospital Collaborative
PSA	Primary Service Area
SNAP	Supplemental Nutrition Assistance Program
SDOH	Social Determinants of Health
USDA	United States Department of Agriculture

In addition to the commonly used terms and acronyms provided, a list of how race and ethnicity is used in this report is provided below. Race and ethnicity are not precisely defined constructs and multiple terms can be used to define both race and/or ethnicity. For this report, the term “race” indicates one of the five categories specified in the United States Office of Management and Budget 1997 Standards and “ethnicity” indicates Hispanic or non-Hispanic origin (VanEenwyk, 2010).

Race

American Indian or Alaska Native (AIAN)

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.

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, and Vietnam.

Black or African American

A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American.”

Native Hawaiian or Other Pacific Islander (NHOPI)

A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White

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

Ethnicity

Hispanic or Latino	A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race. The term “Spanish origin” can be used in addition to “Hispanic or Latino.”
Non-Hispanic or Latino	A person not of Hispanic or Latino origin

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EXECUTIVE SUMMARY

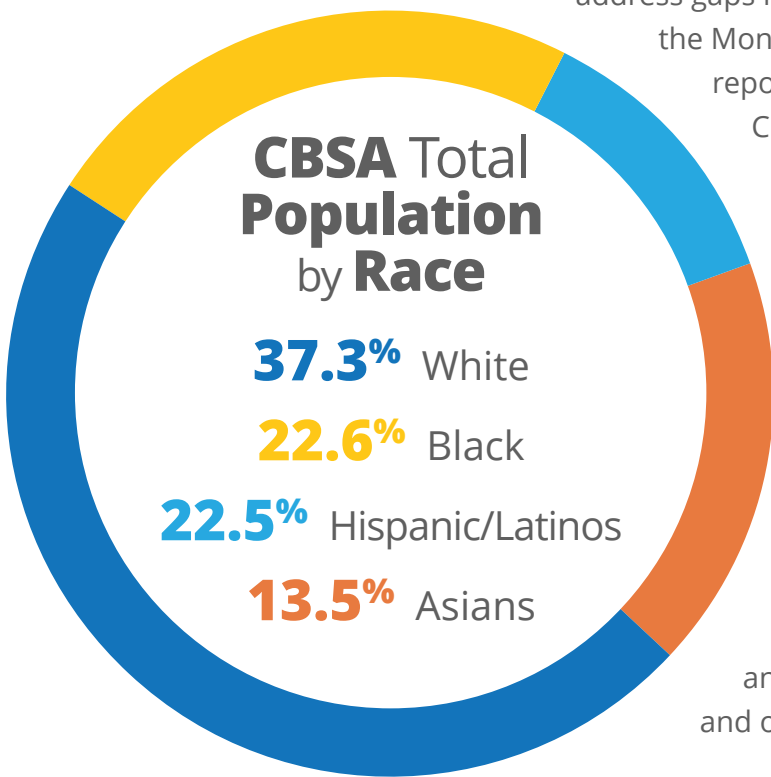
In 2010, Congress enacted the Patient Protection and Affordable Care Act (The ACA) to enhance the quality of health care for all Americans through a deliberate method of comprehensive health insurance reform. Specifically, the ACA requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) and adopt an implementation strategy every three years. The CHNA and implementation strategy aim to identify the most important health issues in a defined community benefit service area (CBSA), as well as develop a plan to implement programs and services to meet identified unmet community needs.

Healthy Montgomery is Montgomery County’s community health improvement process (CHIP) and dually serves as the local health improvement coalition (LHIC). Established in June 2009, Healthy Montgomery brings together County government agencies, County hospital systems, minority health programs/initiatives, advocacy groups, and other stakeholders to achieve optimal health and well-being for all Montgomery County residents.

Through the development of Healthy Montgomery, the Montgomery County hospitals (Adventist HealthCare, Holy Cross Health, MedStar Health, and Suburban Hospital) recognized the opportunity to meet as a subgroup and work together to leverage community benefit resources, identify overlapping implementation strategies, and decrease duplication of efforts. In 2015, the Montgomery County hospitals began working together to steward resources and address gaps in access to care by program mapping. In 2021,

the Montgomery County hospitals (referred in this report as the Montgomery County Hospital Collaborative [MCHC]) further advanced their dedication to collective impact by developing a joint Community Health Needs Assessment (CHNA) and Implementation Strategy.

Montgomery County ranks as one of the healthiest counties in Maryland, yet barriers to improving the well-being for many pockets of our community persist. While the hospitals serve residents from every corner of the County and throughout the region, the MCHC narrowed its CBSA to 38 zip codes covering portions of Montgomery and Prince George’s Counties where the needs and opportunities for improvement are greatest.



The 2022 MCHC CHNA relied on multiple tools and resources to understand and identify the unmet health needs of the people we serve, including:

- Federal, state, and local health surveillance data sets
- External advisory groups comprising of officers from state and local government agencies and leaders from community-based organizations, foundations, churches, colleges, coalitions, and associations.
- A 19-question Community Health Needs Assessment Survey completed in 2021
- Community Conversations and Key Informant Interviews
- Existing needs assessments from local health initiatives, government agencies, and non-profit community health organizations

The MCHC used this information, in tandem with local public health leaders, service providers, and community advocates, to prioritize root causes of health inequities outlined into the three domains below:

1. Access to Care

- Access to mental health providers
- Access to primary care providers
- Lack of insurance

2. Healthy Behaviors

- Food insecurity
- Adult obesity
- Physical inactivity

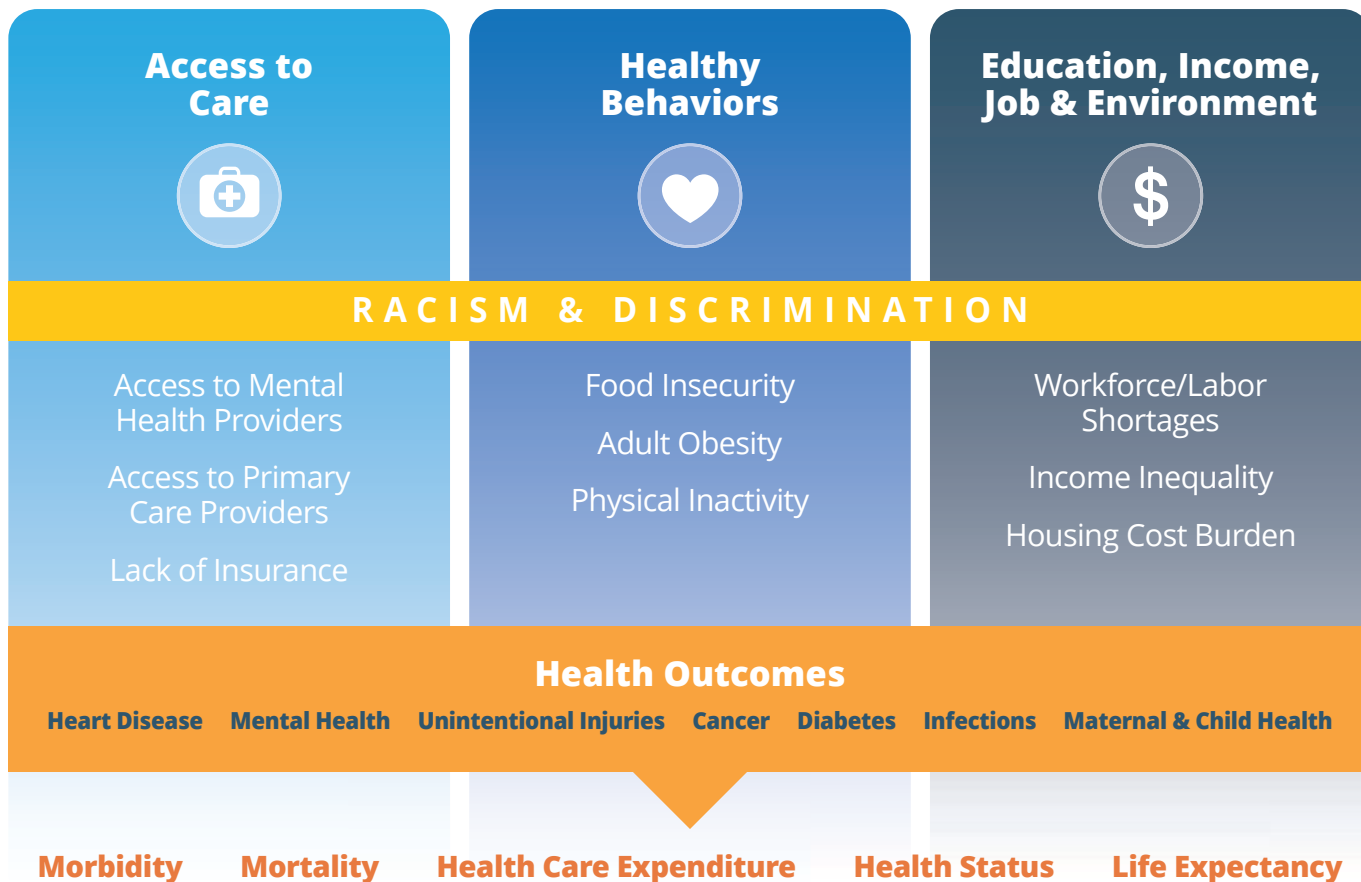
3. Education, Income, Job & Environment

- Workforce/labor shortages
- Income inequality
- Housing cost burden

By addressing these nine root causes of health inequities, a promising impact in reducing the burden of the top health outcomes - heart disease, diabetes, mental health, cancer, maternal and child health, infections, and unintentional injuries – can be achieved.

Next, the MCHC will develop an implementation plan that serves as a strategic roadmap to prioritize health needs. The collaborative nature of this CHNA will leverage resources, capacities, and mobilization of health improvement initiatives to cultivate a more equitable foundation for health.

The Montgomery County Hospital Collaborative Model for Improved Health Outcomes.



Graphic adapted from the Kaiser Family Foundation, 2020

For further information on how the MCHC hospitals plan to address each identified unmet health need, please reference the Multi-Year CHNA Implementation Plan.

Letter from Hospital Leadership

June 20, 2022

Dear Residents and Partners,

In Montgomery County, six hospitals are working collectively and collaboratively to reimagine health care that extends far beyond our hospital walls. In fact, caring for our community and investing in holistic approaches to improve health are a deliberate commitment.

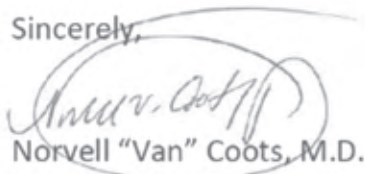
We are setting the standard for this community commitment by creating our first joint Community Health Needs Assessment (CHNA) and Implementation Strategy. This collaborative CHNA addresses 34 zip codes served by Adventist HealthCare, Holy Cross Health, MedStar Health and Suburban Hospital, Johns Hopkins Medicine. The identified and prioritized health needs will guide the resources, program development, and collaborations required to address gaps in care, advance health equity and improve quality of life.

While Montgomery County ranks as one of the healthiest counties in Maryland, barriers to improving the well-being for many members of our community persist. Steps to address the complex social factors that influence health must incorporate both population and public health strategies. Integrating the expertise, guidance, resources and influence of partnerships beyond the healthcare environment are integral to achieving equity for all.

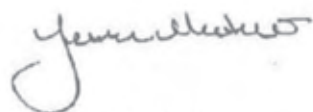
The data outlined in the 2022 Community Health Needs Assessment is extensive and far-reaching. We invite you to read with curiosity and excitement. The assessment process would not be possible without the critical and timely feedback of our community residents, stakeholders and thought leaders, who tirelessly shared their time to inform our prioritization, strategy model, and most importantly, how we will evaluate and track our progress. There is much more work ahead and we cannot do it without broad participation from our community!

We are stronger together.

Sincerely,



Norvell "Van" Coots, M.D.
President & CEO
Holy Cross Health



Jessica Melton
President and COO
Suburban Hospital (Johns Hopkins Medicine)



Terry Forde
President & CEO
Adventist HealthCare



Thomas J. Senker, FACHE
President, MedStar Montgomery Medical Center
Senior Vice President, MedStar Health



SECTION 1.

INTRODUCTION & METHODOLOGY

In 2010, Congress enacted the Patient Protection and Affordable Care Act (The ACA) to enhance the quality of health care for all Americans through a deliberate method of comprehensive health insurance reform. Specifically, the ACA requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) and adopt an implementation strategy every three years. The CHNA and implementation strategy aim to identify the most important health issues in a defined community benefit service area (CBSA), as well as develop a plan to implement programs and services to meet identified unmet community needs.

Healthy Montgomery is Montgomery County’s community health improvement process (CHIP) and dually serves as the local health improvement coalition (LHIC). Established in June 2009, Healthy Montgomery brings together County government agencies, County hospital systems, minority health programs/initiatives, advocacy groups, academic institutions, community-based service providers and other stakeholders to achieve optimal health and well-being for all Montgomery County residents. Most important, Healthy Montgomery is the central catalyst to meet Affordable Care Act (ACA) requirements and local health department PHAB¹ accreditation. Healthy Montgomery centralizes data to identify priority issues among community partners, develop and implement strategies for action, as well as establish accountability to ensure measurable health improvement outcomes (NACCHO, 2022).

Through the development of Healthy Montgomery, the Montgomery County hospitals (see Figure 1) recognized the opportunity to meet as a subgroup and work together to leverage community benefit resources, identify overlapping implementation strategies, and decrease duplication of efforts. In 2015, the hospitals began working together to steward resources and address gaps in access to care by program mapping.

In 2021, the Montgomery County hospitals (referred to in this report as the Montgomery County Hospital Collaborative [MCHC]) further advanced their dedication to collective impact by developing a joint Community Health Needs Assessment (CHNA) and Implementation Strategy. The 2022 collaborative CHNA will serve to guide resources and program development to meet the needs of shared community and address gaps in care, health equity, and improve the quality of life for all residents. See Appendix A for a list of comprehensive services for each hospital.

Figure 1: Health System Logos



¹The Public Health Accreditation Board (PHAB) is a nonprofit organization dedicated to advancing the continuous quality improvement of Tribal, state, local, and territorial public health departments (www.phaboard.org).

DATA SOURCES

The 2022 MCHC CHNA relied on multiple tools and resources to understand and identify the unmet health needs of the people we serve. Using the County Health Rankings model as the guide for factors that influence length and quality of life, over 100 indicators were identified and integrated to create a health profile of Montgomery and Prince George's County. In addition to gathering timely, reliable, and valid secondary health data and reports, the MCHC collected first-hand information from the community and experts in the field via our community health improvement process (Healthy Montgomery), external advisory board conversations, and key informant interviews.

HEALTHY MONTGOMERY

Serving as the Local Health Improvement Coalition (LHIC), Healthy Montgomery brings together Montgomery County government agencies, the four hospital systems, the minority health initiatives/health programs, advocacy groups, academic institutions, community-based service providers, the health insurance community, and other stakeholders to set a health priority agenda and an action plan for Montgomery County's prioritized needs. Healthy Montgomery's aims to:

- Improve access to health and social services
- Achieve health equity for all residents
- Enhance the physical and social environment to support optimal health and well-being

The MCHC contributes \$150,000 annually to support the infrastructure of Healthy Montgomery. In addition to providing financial support, representatives from each health system play an active role through representation on multiple Healthy Montgomery committees and planning groups, including the Healthy Montgomery Steering Committee, which is the governing body for the group (see Appendix B for a full list of steering committee members).

EXTERNAL ADVISORY GROUPS

The four health systems have convened a group of external participants representing the broad interest of the community we serve to share advice and feedback. Participants include: the public health officer, the director of the Montgomery County Department of Health and Human Services, various individuals from local and state governmental agencies, leaders from community-based organizations, foundations, churches, colleges, coalitions, and associations. These participants are experts in a range of areas, including public health, health care, minority populations and disparities in health care, social determinants of health (SDOH), and social services. Through feedback and advice, they provide ongoing input to ensure that we have identified and responded to the most pressing community health needs. Throughout the CHNA, advisory Group members were invited to participate, particularly in the prioritization process, thought leaders discussion, and data exploration process. A comprehensive list of members of the external advisory groups is available in Appendix C.

COMMUNITY SURVEYS, CONVERSATIONS, AND KEY INFORMANT INTERVIEWS

In 2021, the MCHC widely distributed a 19-question Community Health Needs Assessment Survey centered on health status, access to care, and perceived community health needs and strengths. The survey is available in both English and in Spanish. Survey dissemination includes community events, programs, via email, listservs, social media, community partners and organizations.

Community Conversations and Key Informant Interviews were conducted in partnership with Healthy Montgomery and the Montgomery County Department of Health and Human Services oversight, participation, and support. The findings from the key informant interviews are referenced in Appendix D.

NEEDS ASSESSMENTS AND REPORTS

As available, the MCHC used a range of needs assessments and reports to identify unmet needs, especially for underserved minorities, seniors, and women and children.

- African American Health Program Annual Report FY2020
- African American Health Program Geographic Hot Spot Report 2019
- Asian American Health Initiative Annual Report FY2021
- Blueprint for Asian American Health Initiative 2020-2030
- Blueprint for Latino Health in Montgomery County 2017-2026
- CDC National Diabetes Statistics Report 2020
- Community Action Partnership, Community Needs Assessment 2019-2022
- Latino Health Initiative Annual Report FY2019
- Montgomery County Collaboration Council, Community Needs Assessment, 2020
- Montgomery County Department of Health and Human Services, Health Equity in Montgomery County 2010-2018
- Montgomery County Department of Health and Human Services, Status of Health in Montgomery County FY2018
- Montgomery County Food Council Annual Report 2020
- Prince George's County Community Health Assessment 2019
- Prince George's County Food Security Task Force Report 2021
- Prince George's County Health Department, Health Report 2018
- State of Maryland Vital Statistics Annual Report 2019
- State of Maryland, Diabetes in Maryland Action Plan
- Surveillance Report on Population Health, Health in Montgomery County 2010-2019
- Thrive Montgomery 2050
- Trinity Health System – Full Assessment Report 2021
- Trust for America's Health, The State of Obesity Report 2021
- University of Wisconsin Population Health Institute's County Health Rankings Data
- USDA Economic Research Report, Household Food Security in the US 2020

OTHER AVAILABLE DATA

The MCHC also reviewed internal patient data (i.e. emergency room utilization, patient re-admissions), and where available accessed publicly available data on market analyses, health

indicators, and social determinants of health. These sets of data helped provide a detailed look at the community we serve by identifying potential disparities that might not surface when looking at only county or state data. In addition, members of the MCHC regularly participate in coalitions, commissions, committees, partnerships, and panels, affording a deep understanding of health opportunities and challenges resonating within the community.

INDICATORS AND MEASUREMENT LIMITATIONS

Health indicators are measures designed to summarize information about a given priority topic in population health or health system performance. These indicators can be used to describe the health of a population, health differences within a population, or to determine if a program's objectives are being met. Healthy People 2030 contains 355 core (measurable) objectives, with a smaller set of 23 Leading Health Indicators (LHIs), which communicate high-priority health issues and actions that can be taken to address them (Office of Disease Prevention and Health Promotion, 2022). The most common HP2030 LHIs are those related to birth and death, such as life expectancy, premature mortality, or adequacy of prenatal care.

At the time this report was produced, not all data was available at the zip-code level for Montgomery or Prince George's County. Therefore, county or state-level data was used to assess and analyze health needs. In addition, not all indicators were available for all races/ethnicities, so available race/ethnicity or data combining all races/ethnicities was used.

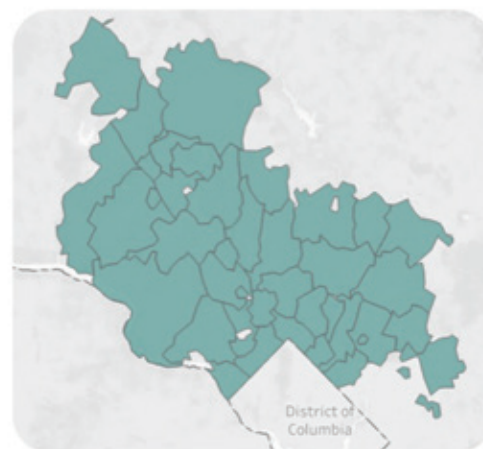
DEFINING COMMUNITIES SERVED

The MCHC serves portions of Montgomery, Prince George's, Frederick, Carol, and Howard Counties, and the District of Columbia, spanning 86 zip codes and almost 2.3 million people. However, the goal of this CHNA is to identify and prioritize key areas and communities of focus for meaningful engagement. In order to do this, the MCHC identified zip codes in each hospital's primary service area as our collective Community Benefit Service Area (CBSA) and highlighted communities of focus within the CBSA to provide a valuable snapshot of the hospital's existing communities served and new areas of interest.

DESCRIPTION OF SERVICE AREA

The MCHC CBSA comprises 38 zip codes (see Figure 2) that span approximately 388 square miles of Montgomery County and northern Prince George's County, with a total population of 1,250,503 (Center for Applied Research and Engagement Systems, 2022). The population density for this area, estimated at 3,218 persons per square mile, is greater than Montgomery County (2,116 persons per square mile), Prince George's County (1,883 persons per square mile), and the state (620 persons per square mile). For a full listing of the zip codes comprising the MCHC CBSA see Appendix E.

Figure 2: The MCHC Community Benefit Service Area



The MCHC CBSA serves portions of Montgomery and Prince George’s Counties, two majority-minority counties² rich in cultural diversity. The largest populations by race/ethnicity within the service area are Non-Hispanic Whites (37.3%), Non-Hispanic Blacks (22.6%), Hispanic or Latino (22.5%) and Non-Hispanic Asian (13.5%) (see Table 1).

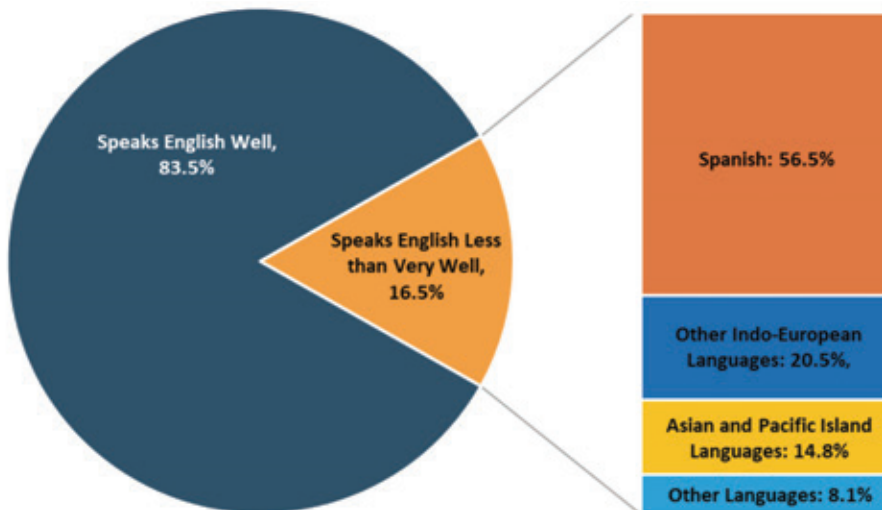
Table 1: Population by Combined Race Ethnicity

Report Area	NH White	NH Black	NH Asian	NH AIAN*	NH NHOPI*	NH Some Other Race	NH Multiple Races	Hispanic or Latino
MCHC CBSA	37.3%	22.6%	13.5%	0.1%	0.03%	0.7%	3.4%	22.5%
Frederick County, MD	72.4%	9.5%	4.4%	0.2%	0.1%	0.2%	3.3%	10.0%
Montgomery County, MD	43.1%	18.0%	14.9%	0.1%	0.04%	0.7%	3.7%	19.5%
Prince George's County, MD	12.3%	61.2%	4.2%	0.2%	0.03%	0.5%	2.7%	18.8%
Maryland	50.2%	29.4%	6.3%	0.2%	0.03%	0.4%	3.3%	10.3%
United States	60.1%	12.3%	5.6%	0.6%	0.2%	0.3%	2.8%	18.2%

Source: Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract 5

More than 33% of the MCHC CBSA population are of foreign birth compared to 32% in Montgomery County, 23% in Prince George’s County, and 15.2% in Maryland. The languages spoken in this region also reflect its diversity. However, approximately 16.5% of the CBSA population, aged 5 and older, speak English less than very well compared to 7% of the Maryland population (see Figure 3).

Figure 3: English Proficiency within the MCHC CBSA



Data Source: US Census Bureau, American Community Survey. 2016-20.

² A Majority-Minority County is a county where less than 50% of the population is non-Hispanic white.

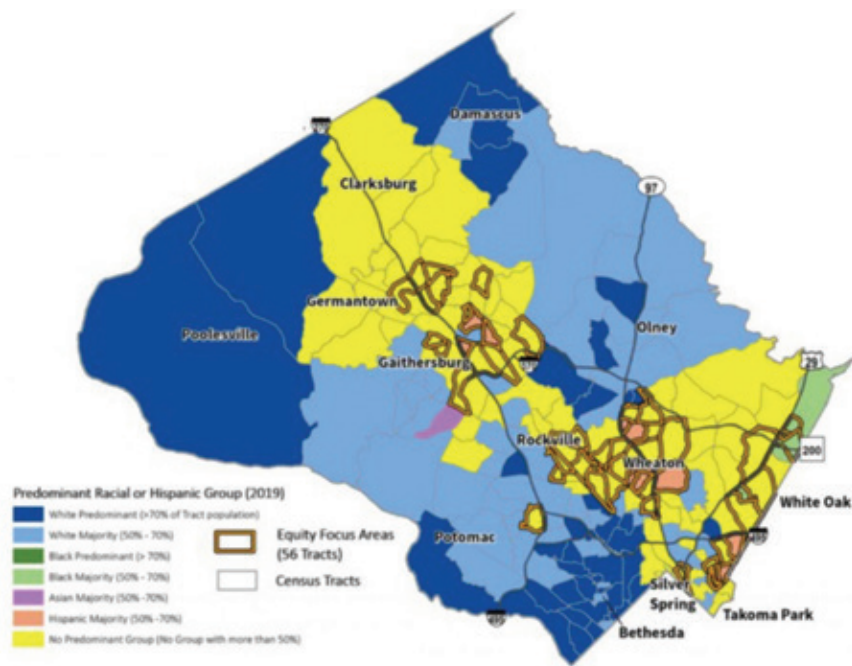
Limited English proficiency (LEP), or the inability to speak English well, creates barriers to health care access, provider communications, and health literacy/education. The highest percentage of limited English proficiency by language spoken in the home is Spanish (United States Census Bureau, 2022).

The CBSA is not only rich in diversity but also in resources. The area has over 170 private and county-run fitness and recreation facilities, roughly 75% of residents live within ½ a mile of a park, more than 240 grocery stores serve the area, and there are more than 100 social and professional organizations per person. The average household income of \$138,054 for persons in the MCHC CBSA is higher than the state average of \$111,417 and the Prince George's County average of \$102,593, but lower than that for Montgomery County overall (\$149,437). However, despite the plethora of resources and above-average incomes, disparities exist, particularly for populations experiencing vulnerabilities.

VULNERABLE POPULATIONS

Populations experiencing vulnerability (also referred to as vulnerable populations) are groups and communities at a higher risk for poor health outcomes as a result of the barriers they experience due to structural and societal factors they face, such as systemic racism, discrimination, stigma, and poverty (Baciu, Negussie, Geller, & et al., 2017). In 2021, the Equity Data Team of Montgomery County's Planning Department developed a mapping tool to identify vulnerable populations within Montgomery County. The team identified 56 Equity Focus Areas (EFAs) by looking at demographic data at the census tract level (see Appendix F for a full list of demographic data). They focused on identifying areas that had high concentrations of lower-income households, people of color, and individuals who may speak English less than very well (Zorich, Mukherjee, & Blyton, 2021) (see Figure 4). Approximately one-quarter of Montgomery County's population resides in the EFAs.

Figure 4: Equity Focus Areas and Predominant Race or Hispanic Origin



Source: Research and Strategic Projects, Montgomery Planning Department, 2021.

In addition to populations residing in the EFAs, other populations experiencing vulnerabilities include low-income, racial and ethnic minorities, uninsured, seniors, pregnant women and infants, the homeless and those with disabilities.

LOW-INCOME POPULATIONS

Low-income status and poverty are linked to poor health outcomes due to their correlation with adverse conditions such as substandard housing, homelessness, food insecurity, inadequate childcare, lack of access to health care, unsafe neighborhoods, and under-resourced schools which adversely impact our nation's children (U.S. Department of Health and Human Services, 2022). Approximately 20.4%, or 250,418 individuals, within the MCHC CBSA, live in households with incomes below 200% of the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access, including health services, healthy food, and other necessities that contribute to poor health status (Center for Applied Research and Engagement Systems, 2022).

RACIAL ETHNIC MINORITIES

Minorities, also referred to as Black, Indigenous and People of Color, often experience higher rates of illness and death across a wide range of health conditions, including diabetes, hypertension, obesity, asthma, and heart disease, when compared to their White counterparts (Centers for Disease Control and Prevention, 2021). Although minorities experience higher rates of illness and death, it is important to note the mantra coined by Dr. Joia Crear-Perry, that "racism, not race, causes health disparities" (Chadha et al., 2020). In the CBSA, more than 40% of the population is Non-Hispanic, Non-White and 22.5% are Hispanic.

UNINSURED POPULATIONS

The lack of health insurance is considered a key driver of health status. People without insurance coverage have barriers to accessing care and often postpone or forgo health care, causing many chronic conditions to go undiagnosed or poorly treated compared to those with insurance. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected (Kaiser Family Foundation, 2022). In the CBSA, 9.1% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is greater than the state average of 6.1%.

SENIOR POPULATIONS

The 2017-2020 State Plan on Aging for Maryland estimates that between 2015 and 2030, the population of adults aged 60 and greater will increase by 40%, from 1.2 to 1.7 million (Maryland Department of Aging, 2021). This growth reflects advances in health care and medicine, allowing individuals to live longer than ever before. A similar estimate was made by the Montgomery County Commission on Aging (2018), predicting that nearly 25% of all residents will be 60 years or greater by 2030. While this represents one of the crowning achievements of the last century, it also poses significant social and economic challenges due to the unique needs of the senior population.

According to Seniors First BC (2016), the risk for chronic illness and the need for long-term care increases directly with age, increasing seniors' vulnerability. Three main risk factors that contribute to vulnerability in older adults are:

- health status
- cognitive ability, and
- social network

Of the estimated 1,250,503 total population in the CBSA, an estimated 177,072, or 14.2%, are adults aged 65 and older. This percentage is comparable to Montgomery County and slightly higher than Prince George's County (Montgomery Planning M-NCPPC, 2018).

MATERNAL/INFANT POPULATIONS

The well-being of mothers, infants, and children can help predict future public health challenges for families, communities, and the health care system (Office of Disease Prevention and Health Promotion, 2021). Access to quality preconception (before pregnancy), prenatal (during pregnancy), and interconception (between pregnancies) care can reduce the risk of maternal/infant mortality and improve birth outcomes. Healthy birth outcomes or early detection and treatment of developmental delays and disabilities can prevent poor health outcomes, such as death and disabilities, and allow children to reach their full potential (Office of Disease Prevention and Health Promotion, 2021)

HOMELESS POPULATIONS

The definition of homelessness is broad and includes people living on the streets or other places not intended for human habitation; living in shelters; lacking a fixed, regular, and adequate nighttime residence; temporarily staying with friends and relatives; and even those at risk for homelessness (Health Quality Ontario, 2016). In Montgomery County, the point-in-time count for homelessness has steadily declined over the past five years, with a 35% decrease between 2017 and 2021. The issue of homelessness affects individuals of all ages. For instance, out of the 187,380 students enrolled in school during the 2019-2020 school year, 1,499, or .8%, were homeless compared to the statewide rate of 1.7%.

LGBTQ COMMUNITY

Disparities in health outcomes are experienced across several population groups, including racial and ethnic minorities, geographical location, and health insurance status. However, there is an increasing need for more information on other groups that are medically underserved and suffer poor health outcomes. One such group is the lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) community, also referred to as sexual minorities. Sexual minorities represent between 3 to 12% of the adult U.S. population (Mattingly, Smith, Williams, & Tai, 2020). They span all races, ethnicities, ages, socioeconomic statuses, and regions of the United States.

There is insufficient data on sexual minorities in national databases and registries. However, sexual minorities appear to have a higher prevalence of smoking, alcohol use, and obesity. In addition, surveys show that many sexual minorities underutilize and delay seeking health care.

This underutilization is often related to concerns about discrimination and stigma. The common perception of a barrier to health care access demonstrates the need for culturally competent health care providers and welcoming health care systems. Indeed, health care providers need to focus on providing a safe environment for LGBTQ+-friendly services.

POPULATIONS WITH DISABILITIES

According to Healthy People 2030, until recently, people with disabilities had been overlooked in public health surveys, data analyses, and health reports, making it challenging to raise awareness about their health status and existing disparities. Emerging data indicate that individuals with disabilities, as a group, experience health disparities in routine public health areas such as health behaviors, clinical preventive services, and chronic conditions (Office of Disease Prevention and Health Promotion, 2021).

Compared with individuals without disabilities, individuals with disabilities are:

- Less likely to receive recommended preventive health care services, such as routine teeth cleanings and cancer screenings
- At high risk for poor health outcomes such as obesity, hypertension, falls-related injuries, and mood disorders such as depression
- More likely to engage in unhealthy behaviors that put their health at risk, such as cigarette smoking and inadequate physical activity (Office of Disease Prevention and Health Promotion, 2021)

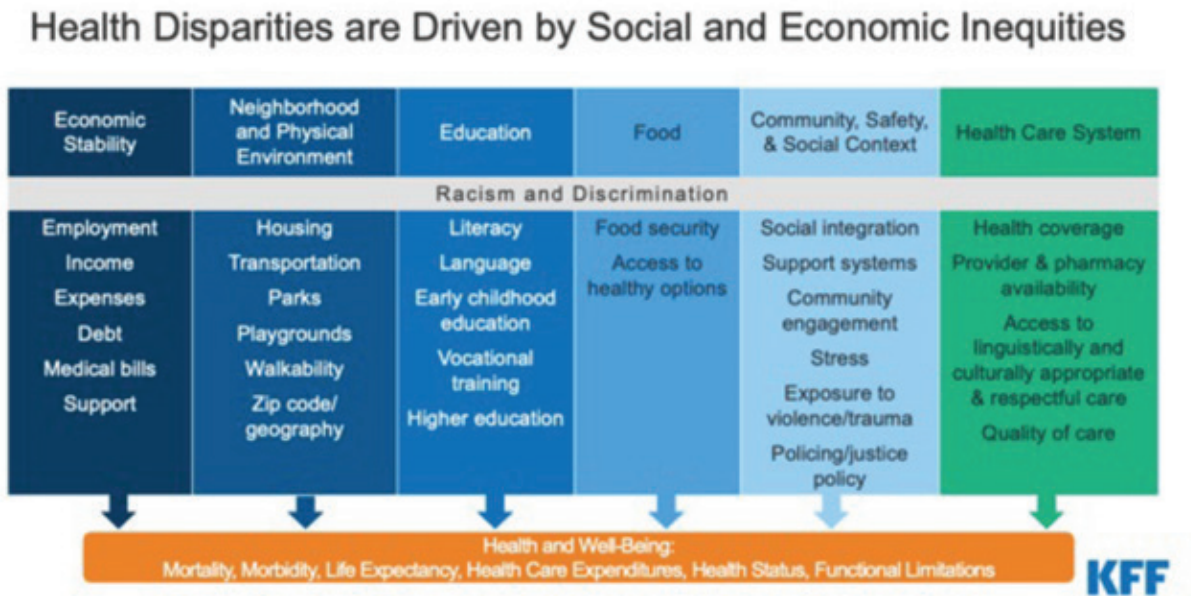
Within the CBSA, 8% (99,809) of the total civilian non-institutionalized population has one or more disabilities.

RACISM AS A PUBLIC HEALTH CRISIS

Racism is a key driver of disparities in mental and physical health outcomes. Systematic bias and structural racism cut across all social determinants of health (see Figure 5) and lead to inequities that have severe consequences (Stanley, Harris, Cormack, Waa, & Edwards, 2019). Racism and its effect on health is not a new concept. However, in the wake of protests and unrest following the killing of George Floyd³ and many other Black people at the hands of police and the stark contrast of COVID-19 morbidity and mortality data based on race and ethnicity, a spotlight was shone on the negative impact of systemic and institutional racism on people of color, especially Black Americans (Kaur & Mitchell, 2020). In response, racism was declared a public health crisis by many states and local governments, and bills, such as Maryland's Shirley Nathan-Pulliam Health Equity Act of 2021 (SB0052), were passed to identify and address health inequities rooted in racism.

³ The killing of George Floyd by a Minneapolis police officer on May 25, 2020, sparked days of unrest in Minneapolis and St. Paul and mass protests across the globe over the mistreatment of Black people by police. <https://www.mprnews.org/crime-law-and-justice/killing-of-george-floyd>

Figure 5: Health Disparities are Driven by Social and Economic Inequities



Source: Ndugga & Artiga, 2021.



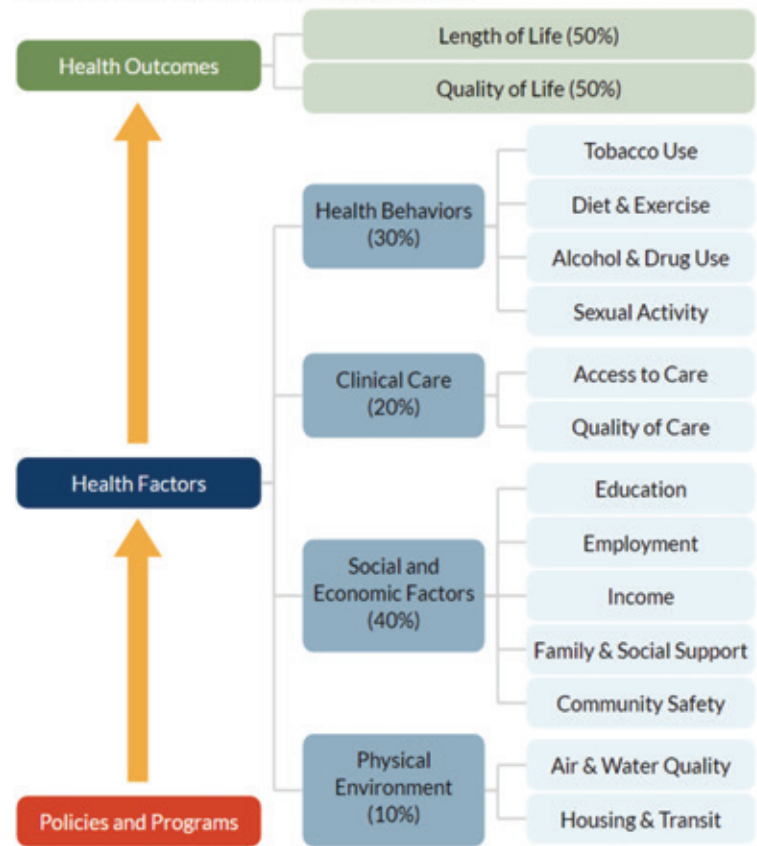
SECTION 2.

HEALTH OUTCOMES

Health outcomes measure how well and how long people live, and the foundation of these measures reflects both physical and mental well-being. Length of life measures the life expectancy of a population. High rates of premature death signal that individuals are not living as long and are not as healthy as other populations. On the other hand, quality of life tells us how satisfied people are with their health. Health outcomes represent a community's overall well-being and underscore the importance of physical, mental, social, and emotional health from birth to adulthood. Another way to look at the intersection of health outcomes and health factors is with the County Health Rankings model (see Figure 6), which aligns many factors that help stakeholders address what

drives health outcomes (University of Wisconsin Population Health Institute, 2022). When looking at the 2022 overall rankings for health outcomes for the 24 counties in Maryland, Montgomery County ranked #1 and Prince George’s County ranked #12. When looking at the overall rankings for health factors, Montgomery County ranked #2 and Prince George’s County ranked #17 (see Appendix G for a complete list of Maryland’s County Health Rankings). In this assessment, the health factors were grouped into three categories - (1) health behaviors, (2) clinical care, (3) and the socioeconomic and physical environment)- and were used to create a health profile of health needs for the MCHC CBSA.

Figure 6: The County Health Rankings Model



County Health Rankings model © 2014 UWPHI

Source: University of Wisconsin Population Health Institute, 2022.

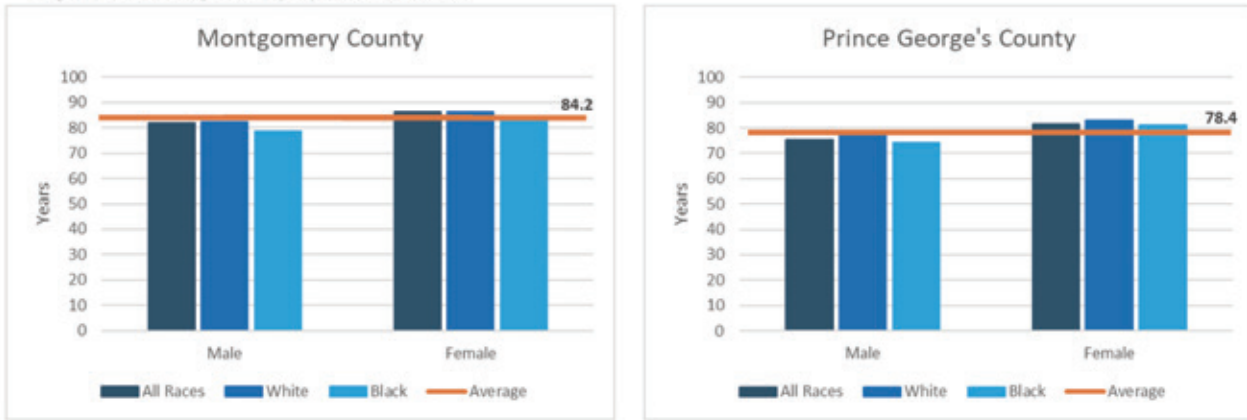
LENGTH OF LIFE

LIFE EXPECTANCY

The life expectancy at birth measures health status across all age groups and is a barometer for the overall health of a community (Tejada-Vera, Bastian, Arias, Escobedo, & Salant, 2020). In Maryland, life expectancy has remained relatively flat at 79.3 for all sexes and races since 2010. However, the life expectancy for an infant born in 2020 dropped to 77.3. In addition to the two-year decline in life expectancy, significant differences in life expectancy can be seen throughout the CBSA when comparing geographic areas (see Figure 7). A person’s health is highly influenced by where they live. For instance, areas with higher SDOH needs have lower life expectancies (Holmes, Tootoo, Chosy, Bowie, & Starr, 2018). The life expectancy within the MCHC CBSA ranges from 74.7 to 96.1.

Differences in life expectancy can also be seen when comparing race and sex for both Montgomery and Prince George’s County. For example, Montgomery County White males live 3.6 years longer than Black males residing in Montgomery County and 8.2 years longer than Black males residing in Prince George’s County.

Figure 7: Life Expectancy by Sex and Race



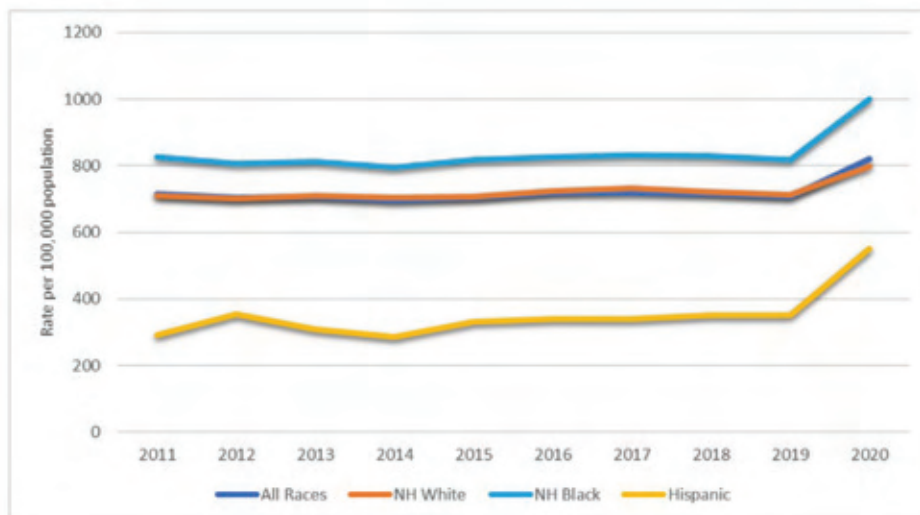
Source: Maryland Department of Vital Statistics, 2022.

MORTALITY

Mortality rate measures the frequency of death within a defined population for a specific time. It is important because it can show the impact of a particular disease or indicate the health status, social conditions, and economic development of a country (Kanchan, Kumar, & Unnikrishnan, 2016). For example, maternal and infant mortality rates in the United States not only tell us the total number of deaths for pregnant women and infants but also gives us a glimpse into the quality of life for these two populations (Kanchan, et al., 2016).

Age and death are strongly correlated; therefore, mortality rates are almost always adjusted for age or presented in age categories. In Maryland, the 2020 age-adjusted mortality rate was 820.5 per 100,000 population- an increase of 114.7 from the 2019 rate of 705.8. When stratifying death rates by race and ethnicity, disparities are evident (see Figure 8). For example, in 2020, for the state of Maryland, there was a 22.7% difference between the overall age-adjusted mortality rate for Non-Hispanic Blacks (1000.8) and the rate for Non-Hispanic Whites (796.8) and a 36.8% difference when the overall rate for Non-Hispanic Whites is compared to the overall rate for Hispanics (549.2) (Maryland Department of Health Vital Statistics Administration, 2022).

Figure 8: All Cause Age-Adjusted Death Rate by Race and Hispanic Origin, Maryland, 2011-2020



Source: Maryland Department of Vital Statistics, 2022.

MATERNAL MORTALITY

A maternal death is defined by the World Health Organization as, “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes” (Hoyert, 2021, pg. 1). It has been documented that the U.S. has the highest maternal mortality rate compared with other industrialized countries, with experts in maternal health blaming the high rate on poverty, untreated chronic conditions, and a lack of access to health care.

It is also discussed that disparities in maternal mortality are rooted in racism. Structural racism in health care and social service delivery means African American women often receive poorer quality care than White women. These stressors and the cumulative experience of racism and sexism, especially during sensitive developmental periods, trigger a chain of biological processes known as “weathering” that undermine African American women’s physical and mental health. It is theorized that African American women enter pregnancies with high levels of cumulative stress that may cause their bodies to age faster than the bodies of their counterparts (Geronimus, et al., 2010).

The long-term psychological toll of racism puts African American women at higher risk for a range of medical conditions that threaten the lives of both the mother and the child. Some of these life-threatening conditions include preeclampsia (pregnancy-related high blood pressure), eclampsia (a complication of preeclampsia characterized by seizures), embolisms (blood vessel obstructions), and mental health conditions. It is also assumed that the strain placed on hospitals and health care providers during the COVID-19 pandemic may have heightened the barriers African American women already faced in accessing health care.

Despite pervasive racial disparities in maternal and infant deaths, public attention has only recently focused on this issue as a public health crisis (Taylor et al., 2019). And the full extent of the crisis is not yet known due to incomplete data. Compared with data on infant mortality, data on maternal mortality are less reliable. While the disparities in maternal mortality across race are clear within individual states, a reliable national estimate has not been possible because data across states have been inconsistent and incomplete.

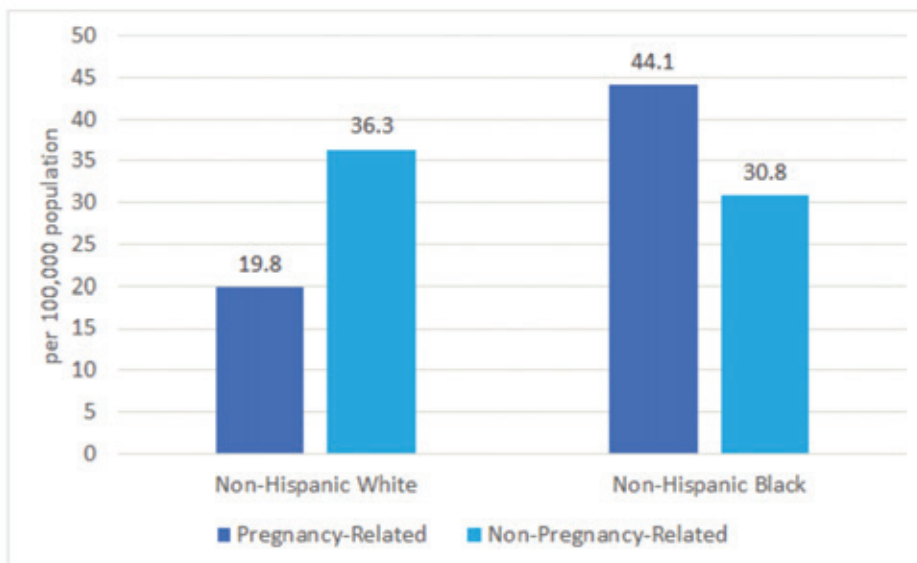
According to the report from the National Center for Health Statistics, during the first year of the coronavirus pandemic (2020), the total number of maternal death rate rose 14%, to 861 (754 in 2019), (Hoyert, 2022). The 2020 national maternal mortality rate was 23.8 deaths per 100,000 live births (an increase from 20.1 deaths per 100,000 in 2019). Maternal mortality significantly afflicts women of color. The mortality rate was highest for Non-Hispanic Black women: 55.3 deaths per 100,000 live births, compared to 19.1 deaths per 100,000 live births for Non-Hispanic White women, an almost 3 to 1 ratio. The mortality rate jumped 26% in 2020 for Black women. Hispanic women had a rate of 18.2 per 100,000 live births, which was below the overall U.S. rate, but a 44% spike from 2019. Maternal mortality rates also increased with maternal age. Rates in 2020 were

13.8 deaths per 100,000 live births for women under age 25, 22.8 for those aged 25–39, and 107.9 for those aged 40 and over. The rate for women aged 40 and over was 7.8 times higher than the rate for women under age 25.

The latest statewide data on maternal mortality based on 5-year population estimates is from 2014-2018, and the mortality rate was 18.4 per 100,000 live births (Maryland Department of Health, 2021). This rate is lower than the national average for the same timeframe (20.7 maternal deaths per 100,000 live births) but remains above the Healthy People 2030 target of 15.7 maternal deaths per 100,000 live births. In 2018, 18 pregnancy-related deaths and 20 non-pregnancy-related deaths occurred in Maryland. Ten or 56% of the 18 pregnancy-related deaths were in Non-Hispanic Black women. Among the 20 non-pregnancy-related deaths, 11 (55%) occurred among Non-Hispanic White women and 35% (7) among Non-Hispanic Black women. Of the 18 pregnancy-related deaths in Maryland, one was a resident of Montgomery County and two were Prince George’s County residents (Maryland Department of Health, 2021).

When observing racial disparities in Maryland, Black women have the highest pregnancy-related maternal mortality rate (44.1) compared to any other racial or ethnic group, with hemorrhage deaths being the leading cause of death, followed by homicide and non-cardiovascular medical conditions (seizure disorders, asthma, cancer, etc.) (see Figure 9). White women have higher rates of non-pregnancy-related death, the leading cause being unintentional overdose. Most deaths in Maryland (85 percent of non-pregnancy-related deaths and 83 percent of pregnancy-related deaths) are considered preventable or potentially preventable (Maryland Department of Health, 2021).

Figure 9: Pregnancy-Related and Non-Pregnancy-Related Mortality Rates by Race/Ethnicity, Maryland, 2018



Source: Vital Statistics Administration and Maryland Maternal Mortality Review Program.

INFANT MORTALITY

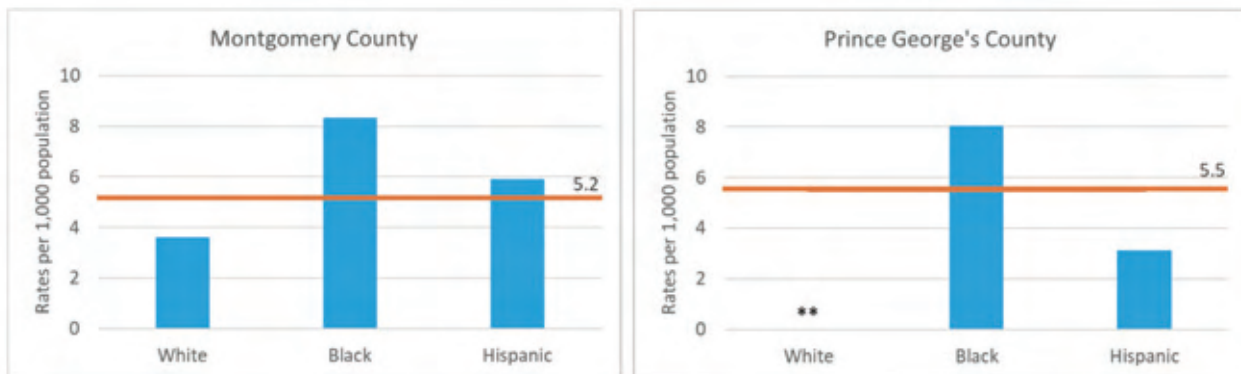
Infant mortality is defined as the death of an infant before one year of age and continues to be one of the most widely used indicators of the overall health status of a community. The main

causes of mortality in infants in the U.S. include birth defects, premature delivery (birth before 37 weeks of age), maternal complications of pregnancy, Sudden Infant Death Syndrome (SIDS), and injuries. Per the CDC, in 2019, the infant mortality rate in the United States was 5.6 deaths per 1,000 live births, which is higher than most other developed countries. Nationally, African Americans have the highest infant mortality rate of any racial or ethnic group in the United States.

Maryland’s infant mortality rate in 2020 was 5.7 per 1,000 live births, a 3% decrease compared with the 2019 rate. This is the lowest infant mortality rate recorded in Maryland’s history, but is still higher than the national average. The infant mortality rate increased by 6% between 2019 and 2020 among Non-Hispanic Black infants, and decreased by 10% among Hispanic infants during the same period. The average infant mortality rate has fallen by 6% in Maryland over the past decade, with a 7% decline in the average rate among Non-Hispanic Black infants and a 6% decline among Non-Hispanic White infants. Over the same time period, the Hispanic infant mortality rate has risen by 2% (Maryland Department of Health Vital Statistics Administration, 2022).

Montgomery County’s infant mortality rate rose from 4.2 infant deaths per 1,000 births in 2019 to 5.2 infant deaths in 2020, which is higher than the Healthy People 2030 target of 5.0 per 1,000 live births. Prince George’s County’s infant mortality rate has decreased from 6.2 infant deaths in 2019 to 5.5 infant deaths in 2020; although still higher than the Healthy People 2030 target, the rate has experienced a steep decline from 8.0 infant deaths. Racial disparities exist in both counties, with Non-Hispanic Black infant mortality rates being significantly higher than women of other races and ethnicities (Maryland Department of Health Vital Statistics Administration, 2022) (see Figure 10).

Figure 10: Infant Mortality by Race/Ethnicity (2020)



Source: Maryland Department of Health Vital Statistics Administration, 2022.

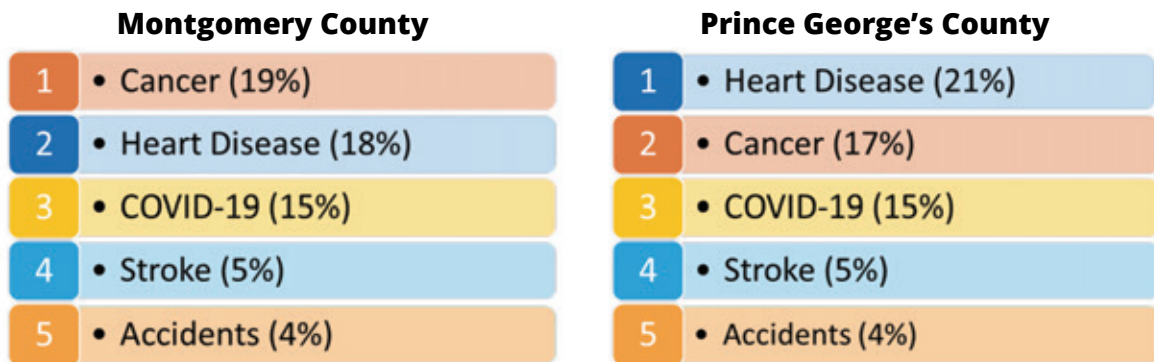
**Rates based on <5 deaths are not shown since rates based on small numbers are statistically unreliable

LEADING CAUSES OF DEATH

Nationally, COVID-19 was the third leading cause of death for most of 2020. However, in December of 2020 and the start of 2021, there was a surge of cases, briefly making COVID-19 the number one cause of death in the United States, surpassing cancer and heart disease. As of June 2021, COVID-19 was the 7th leading cause of death in the U.S (Ortaliza, Orgera, Amin, & Cox, 2021). In 2020, the most recent data available, COVID-19 was also the third leading cause of death among Marylanders.

In 2020, before the mass distribution of vaccines, COVID-19 ranked 3rd among the leading causes of death for Montgomery and Prince George’s Counties and across all races. COVID-19 was the leading cause of death for Hispanics, accounting for 31% of all deaths in Montgomery County and 39% in Prince George’s County (Maryland Department of Health Vital Statistics Administration, 2022) (see Figure 11).

Figure 11: Leading Causes of Death for 2020



Source: Maryland Department of Health Vital Statistics Administration, 2022.

LEADING CAUSES OF DEATH FOR CHILDREN AND YOUTH

According to Bendix (2022), car-related deaths are no longer the leading cause of death among children and youth. Nationally, for the first time, firearms were the leading cause of death among youth ages 1 to 19 in 2020, surpassing vehicle crashes, drug overdoses and cancer. More than 4,300 youth died of firearm-related injuries in 2020, an increase of 29% from 2019, with the majority associated with homicides rather than suicides and attributed to youth 14 and older.

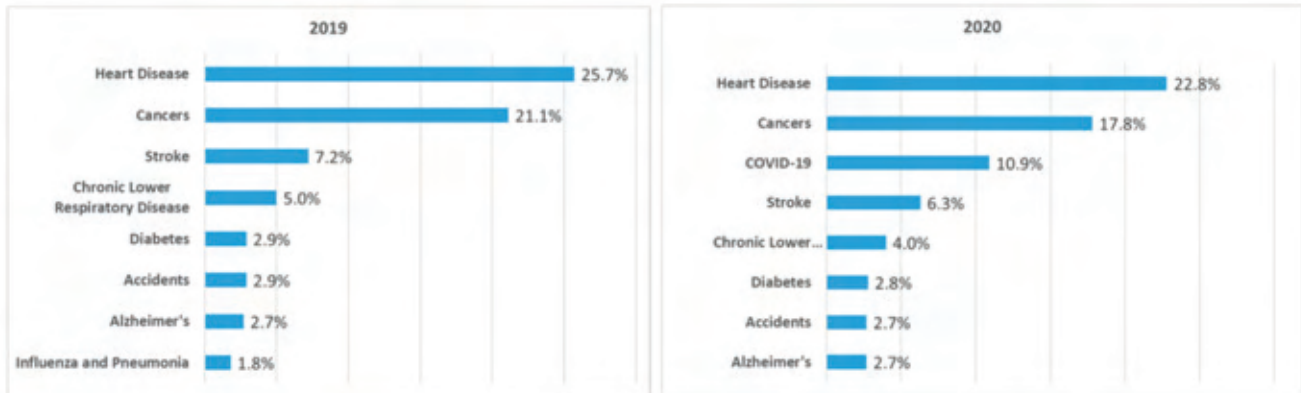
A study published by the Annals of Internal Medicine found gun ownership increased during the COVID-19 pandemic, resulting in 5 million youth under 18 becoming newly exposed to guns in the household (Miller et al., 2022). A similar study by the American Academy of Pediatrics examined the correlation between the rise of firearm acquisitions during the pandemic and high rates of youth fatal and non-fatal gun injuries (Cohen et al., 2021). It was suggested that youth confined to homes due to school closings, decreased adult supervision, and natural curiosity may have also attributed to this emerging trend. In Maryland, firearm deaths among youth rose from 59 deaths in 2019 to 73 deaths in 2020, a 24% increase (CDC, 2021).

LEADING CAUSE OF DEATH FOR 65+

A study conducted in 2007 by the World Health Organization, the World Bank, and the U.S. National Institute on Aging predicted that in a few decades, the loss of health and life worldwide would be greater from non-communicable or chronic diseases (e.g., cardiovascular disease, cancer, diabetes) than from infectious diseases, childhood diseases, and accidents combined (National Institute on Aging, 2007). This prediction was made based on a few factors: declining fertility rates and increasing life expectancy. Older persons are more likely to die from non-communicable diseases than communicable diseases, such as influenza and pneumonia; therefore as the average age of the population shifts, mortality rates from non-communicable diseases will also increase.

Almost two decades later, the prediction seemed to still be accurate, with heart disease, cancer, and stroke being the top three leading causes of death for more than the past ten years. However, in 2020 the COVID-19 pandemic altered the prediction made in the study. A communicable disease, COVID-19, was the third leading cause of death for persons 65+ (see Figure 12).

Figure 12: Leading Cause of Death (65+) in Maryland 2019 vs. 2020



Source: Maryland Department of Health Vital Statistics Administration, 2022.

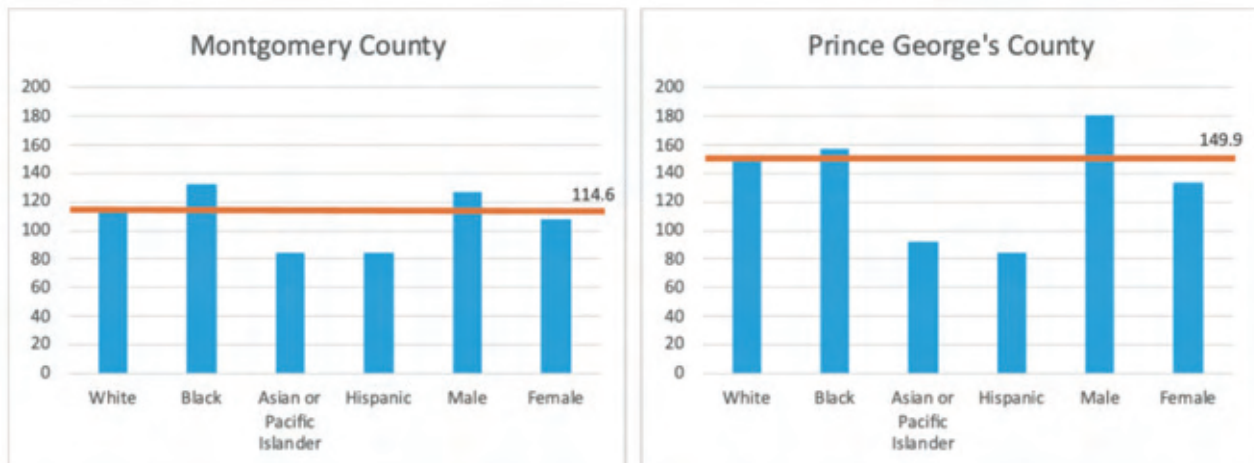
CHRONIC CONDITIONS

CANCER

Every year, more than 1.6 million people are diagnosed with cancer. Cancer is the second leading cause of death in the U.S., with approximately 600,000 associated deaths. In addition to human loss, cancer is also a burden on the nation's health care system. U.S. cancer care costs were projected to reach \$208.9 billion by 2020, and lost productivity due to early death from cancer were projected to add an additional \$147.6 billion (National Cancer Institute, 2022; Bradley, et al., 2008).

The age-adjusted death rates in Montgomery and Prince George's Counties are 114.6 and 149.9, respectively. Overall, African Americans/Blacks have the highest rates of cancer deaths with Hispanics having the lowest rates (see Figure 13).

Figure 13: Age-Adjusted Death Rate per 100,000 Due to Cancer by Sex, Race/Ethnicity (2019)



Source: National Cancer Institute, 2020.

The National Cancer Institute (2021) identifies 13 types of cancers as the most common cancers in the United States. This identification was based on incidence rates of 40,000 cases or more for 2021. Among these cancer types, breast cancer, with 284,200 expected cases in 2021, was labeled the most common, followed by prostate and lung cancer (National Cancer Institute, 2021). Other types of cancer in the most common list include colorectal, kidney, skin, pancreatic, and thyroid cancer. Cancer risk factors include, but are not limited to, age, alcohol use, tobacco use, a poor diet, certain hormones, and sun exposure. Although some risk factors, such as age, cannot be avoided, limiting exposure to avoidable risk factors may lower the risk of developing certain cancers.

Cancer screenings and early detection are a crucial part of cancer prevention. Unfortunately, research shows that the overall cancer screening rate is lower among Black, Hispanic, Asian, and American Indian or Alaskan Native populations than their White counterparts. In addition, data suggest that the COVID-19 pandemic contributed to decreases or delays in cancer screening, which may have exacerbated racial/ethnic disparities in cancer screening (Tong et al., 2022).

It is important to note that disparities are not limited to racial differences. The LGBTQ community, or sexual minorities, have a higher prevalence of cancer risk factors (smoking, alcohol use, etc.) that may lead to increased cancer rates in this population. However, due to data gaps, the specific rates for this population are unknown (Mattingly et al., n.d.). Populations with disabilities also experience disparities in cancer outcomes and accessing preventive and therapeutic care. Barriers to accessing care include transportation and perception of prejudice on the part of the provider. Immigrants are also at an increased risk due to risk factors experienced in their countries of origin and language and cultural barriers. Additionally, health issues and potentially carcinogenic exposures (including sun and pesticide exposure) in the migrant worker population in Maryland are an emerging public health concern.

The COVID-19 pandemic's impact on cancer screenings and care could potentially impact survivorship rates for years to come, especially in populations with increased risk factors, such as people of color (Patt et al., 2020; Fernandez, 2022). During the pandemic, cancer patients experienced delays and cancellations of appointments and challenges in paying for current or future care. From March 2020 to May 2020, approximately 10 million people missed cancer screenings, and the overall rate of surgical procedures decreased by 48% compared to 2019 (Fernandez, 2022).

BREAST CANCER

Breast cancer is a disease caused by the uncontrolled growth of cells, leading to tumor formation. The most serious condition is caused by the spread of cancerous cells to other parts of the body, leading to metastatic breast cancer. Within the United States, about 12% (1 in 8) of women develop breast cancer during their lifetime. Breast cancer is also the second most common cancer among women in the United States, only second to skin cancer (National Institute of Environmental Health, 2021).

The age-adjusted incidence rate for breast cancer in Maryland is 132.2, and both Montgomery County's (125.7) and Prince George's County's (127.7) rates are lower than the state (see Figure 14).

Figure 14: Age-Adjusted Incidence Rate per 100,000 Due to Breast Cancer by Race/Ethnicity (2014-2018)



Source: National Cancer Institute, 2020.

From 2015-2019, the age-adjusted death rate due to breast cancer was 21.0 in Maryland, compared to 19.0 in Montgomery County and 25.1 in Prince George's County (see Figure 15). Disparities can be seen, with the death rate for African American/Black women higher than all other races/ethnicities. In 2019, the breast cancer mortality rate was 2.7 times higher among Black female residents and 1.9 times higher among White female residents compared to Asian and Pacific Islander female residents. Data also show that although White women in Montgomery County have a higher incidence rate when compared to African American/Black women, Black women are more likely to die from the diagnosis.

Figure 15: Age-Adjusted Death Rate per 100,000 Due to Breast Cancer by Race/Ethnicity (2015-2019)



Source: National Cancer Institute, 2020.

MAMMOGRAPHY SCREENING

Regardless of ethnicity or geographic location, mammograms are important in breast cancer early detection. Mammograms are an X-ray of the breast that can be used to detect changes in the breast such as tumors and calcifications. The procedure may be done for screening or for diagnostic purposes. A positive screening mammogram leads to further testing to determine if cancer is present. Mammograms may also be used to evaluate known cases of breast cancer.

Although mammograms do not detect all cases of breast cancer, they have been shown to increase early detection, thus reducing mortality.

The United States Preventive Services Task Force (USPSTF) recommends that women 50-74 years old and at average risk for breast cancer get a mammogram every two years. In addition, insurance plans governed by the federal ACA must cover screening mammography as a preventive benefit every 1–2 years for women age 40 and over without requiring copayments, coinsurance, or deductibles. In addition, many states require that Medicaid and public employee health plans cover screening mammography.

Healthy People 2030 national health target is to increase the proportion of females 50-74 years old who had a mammogram in the previous two years from 72.8% (2018) to 77.1%. In 2018, the most recent data available, the mammogram screening rates for both Montgomery County (77.1%) and Prince George’s County (80.3%) were on a trajectory to exceed the Healthy People 2030 target (National Center for Chronic Disease Prevention and Health Promotion, 2021).

CERVICAL CANCER

Cervical cancer, when detected early, is one of the most successfully treated cancers and is found most commonly in women over the age of 30. The leading cause of cervical cancer is a long-lasting infection of certain types of human papillomavirus (HPV), a sexually transmitted infection. According to the National Cancer Institute (2022), data from 2017 to 2019 show that approximately 0.7% of women will be diagnosed with cervical cancer at some point during their lifetime. Data also show that in 2018, an estimated 295,381 women were living with cervical cancer in the United States (National Cancer Institute, 2022)

For the period 2014-2018, the age-adjusted incidence rate for the state of Maryland was 6.7 cases per 100,000, lower than the national average of 7.7. Montgomery County and Prince George’s County incidence rates were 5.7 and 6.5, respectively (see Figure 16). The mortality rate was highest for Prince George’s County at 2.6 per 100,000, compared to 1.3 for Montgomery County and 2.0 for the state of Maryland. The national average for the same period was 2.2 per 100,000.

Figure 16: Age-Adjusted Incidence Rate per 100,000 Due to Cervical Cancer by Race/Ethnicity (2014-2018)



Source: National Cancer Institute, 2019.

*Rates <5 events in the numerator are suppressed.

The American College of Obstetricians and Gynecologists recommends that all women aged 21-29 have a Pap test every three years, while women aged 30-65 should have a Pap test and an HPV test every five years or a Pap test alone every three years. The Healthy People 2030 national health target is to increase the proportion of women (aged 21-65) who receive a cervical cancer screening to 84.3% (both Montgomery and Prince George's Counties exceed the target at 86.3% and 87.2%, respectively).

COLORECTAL

According to the CDC, colorectal cancer is one of the most diagnosed cancers. It is the third most common cancer in men and women and is also the third leading cause of cancer-related deaths in the United States. Colorectal cancer is a type of cancer that originates in the colon or rectum. It usually starts as a growth, also known as polyp, inside the colon or rectum. Since this growth is an early indication, detecting and removing these polyps is a powerful prevention tool for colorectal cancer (National Cancer Institute, 2021). The CDC estimates that if all adults aged 50 or older had regular screening tests for colon cancer, as many as 60% of the deaths from colorectal cancer could be prevented. The risks and benefits of using different screening methods, such as stool-based tests, sigmoidoscopies, and colonoscopies, vary.

The USPSTF recommends that screening begin at age 50 and continue until age 75; however, testing may need to begin earlier or be more frequent if colorectal cancer runs in the family or if there is a previous diagnosis of inflammatory bowel disease. The Healthy People 2030 national health target is to increase the proportion of adults screened for colorectal cancer from 65.2% (2018) to 74.4%. In Montgomery and Prince George's Counties, the screening rate for adults 50+ years for colorectal cancer is at 68.6% and 68.9%, respectively (CDC, 2018).

While colon cancer is mostly found in Americans over age 50, there is an increase in younger adults being diagnosed. Most recently, actor Chadwick Boseman died of the disease at age 43 after a four-year battle with colon cancer. Based on data from 2016-2018, approximately 4.1% of men and women will become diagnosed with colorectal cancer at some point in their lifetime (American Cancer Society, 2022). In 2018, an estimated 1,365,135 Americans were living with colorectal cancer.

For the period 2014-2018, the age-adjusted incidence rate for colorectal cancer in the United States was 38.0 cases per 100,000. The incidence rate for the state of Maryland was 36.4, while Montgomery and Prince George's Counties had incidence rates of 30.2 and 36.2, respectively. Both incidence and death rates of colorectal cancer are slightly higher among African Americans compared to rates for Whites, Asians, and Hispanics (see Figure 17 and Figure 18).

Figure 17: Age-Adjusted Incidence Rate per 100,000 Due to Colorectal Cancer by Race/Ethnicity (2015-2018)



Source: National Cancer Institute, 2019.

Figure 18: Age-Adjusted Death Rate per 100,000 Due to Colorectal Cancer by Race/Ethnicity (2014-2018)



Source: National Cancer Institute, 2020.

LUNG

Lung cancer is caused by the uncontrolled growth of cells within the lungs leading to the creation of tumors in the lungs, mainly occurring in people over the age of 65. According to the CDC, lung cancer is the leading cause of death due to cancer in both men and women in the United States, making up almost 25% of all cancer deaths. Each year, more people die of lung cancer than colon, breast, and prostate cancers combined. Even though the duration and quantity of cigarette smoking are the leading cause of lung cancer, this cancer can also be caused by other substances such as asbestos and other forms of tobacco. Recently, lung cancer rates in the United States have been steadily decreasing due to the overall decrease in cigarette use and advancements in early lung cancer detection and treatments.

The American Cancer Society notes that nationally, the chance that a man will develop lung cancer in his lifetime is about 1 in 15; for a woman, the risk is about 1 in 17 (among both smokers and non-smokers). Black men are about 12% more likely to develop lung cancer than White men. The

rate is about 16% lower in Black women than in White women. Black and White women have lower rates than men, but the gap is closing. The lung cancer rate has been dropping over the past few decades for men and the last decade for women.

Nationally, since it was first recommended, screening rates have increased yearly. However, the national rate did not change from 2019 to 2020, likely due to COVID-19 limiting access to health care resources and the public’s reticence to enter medical facilities during the pandemic. In addition, those diagnosed with lung cancer experienced additional challenges, as frequent visits to hospitals during the COVID-19 epidemic and receiving anticancer treatments with immunosuppressive properties might considerably increase the risk of infection.

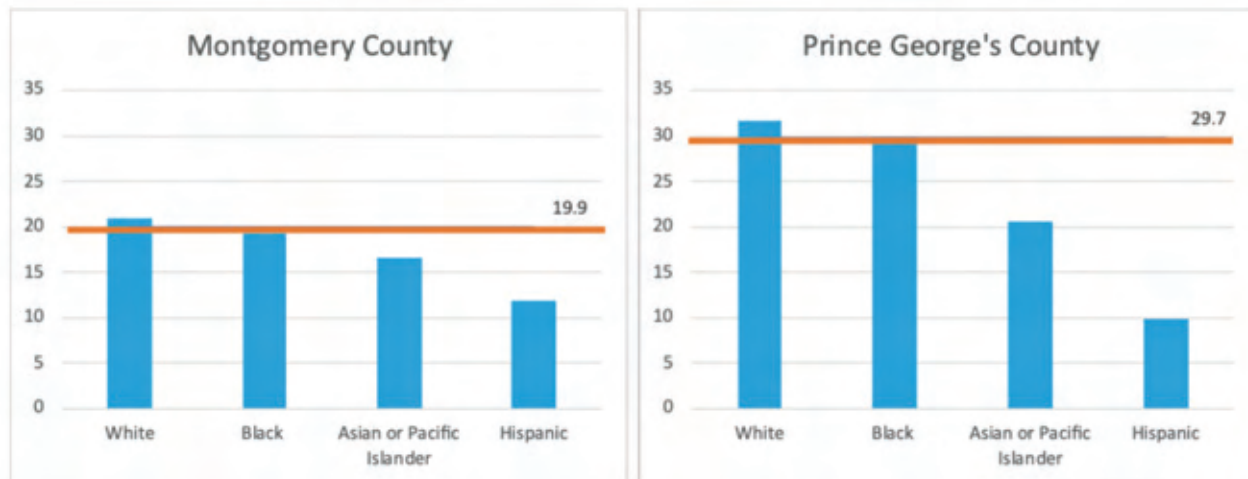
From 2014-2018, the age-adjusted lung cancer incidence rate in Montgomery County was 30.5, and 42.2 in Prince George’s County (see Figure 19). Both counties fared better than the state of Maryland and the national average with rates of 55.1 and 57.3, respectively. This data is also similar to the age-adjusted mortality rates for lung cancer. Rates in Montgomery County (19.9) and Prince George’s County (29.7) fare better than the state (35.3) and national (36.7) rates (see Figure 20).

Figure 19: Age-Adjusted Incidence Rate per 100,000 Due to Lung Cancer by Race/Ethnicity (2014-2018)



Source: National Cancer Institute, 2019.

Figure 20: Age-Adjusted Death Rate per 100,000 Due to Lung Cancer by Race/Ethnicity (2015-2019)



Source: National Cancer Institute, 2020.

PROSTATE

Even though the exact cause of prostate cancer is unknown, the condition starts with unregulated changes in the DNA of cells leading to uncontrolled cell division and growth. The accumulation of these abnormal cells leads to the creation of tumors (Mayo Clinic Staff, 2021). Prostate cancer is the most prevalent cancer type and the second leading cause of cancer deaths among men in the United States (American Cancer Society, 2022). According to the American Cancer Society, about 1 in 7 men will be diagnosed with prostate cancer, and about 1 in 36 will die.

The age-adjusted incidence rate for the state of Maryland (2014-2018) was 128.1 cases per 100,000 men, which was higher than the national average of 106.2. Montgomery County had an incidence rate of 113.4, and Prince George’s County had an incidence rate of 149.9. The incidence rate for Black or African American men is nearly 50% higher than for White men in Montgomery and Prince George’s Counties (see Figure 21).

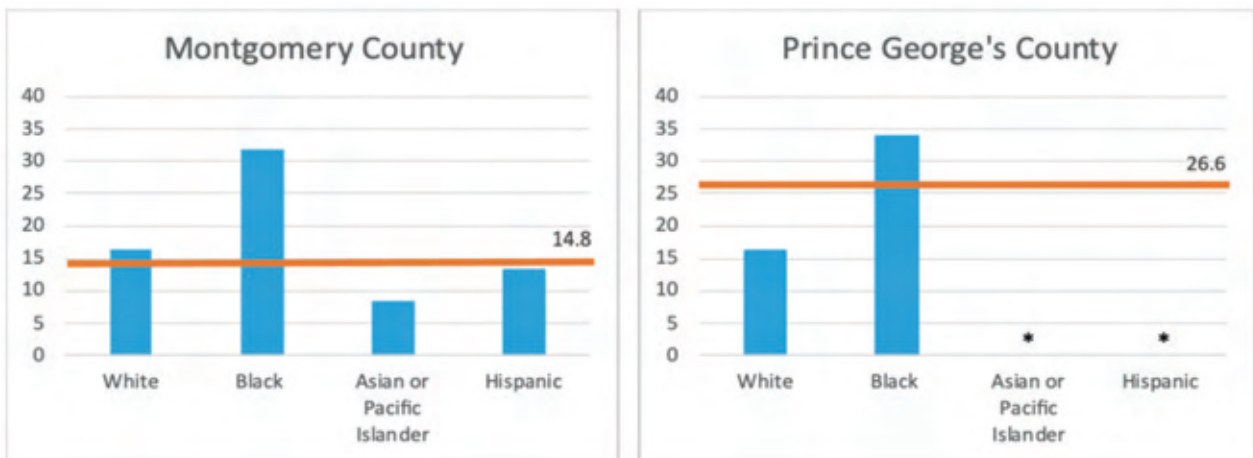
The age-adjusted prostate cancer mortality rate for the state of Maryland (2015-2019) is 20.3, Montgomery County has a rate of 14.8, and Prince George’s County has a rate of 26.6. The death rate of Black or African American men in both counties is more than 50% higher than their White counterparts (see Figure 22).

Figure 21: Age-Adjusted Incidence Rate per 100,000 Due to Prostate Cancer by Race/Ethnicity (2014-2018)



Source: National Cancer Institute, 2019.

Figure 22: Age-Adjusted Death Rate per 100,000 Due to Prostate Cancer by Race/Ethnicity (2015-2019)



Source: National Cancer Institute, 2020.

*Rates <5 events in the numerator are suppressed.

SKIN

Skin cancer is the most common type of cancer in the United States. The three most common types of skin cancer are squamous cell carcinoma, basal cell carcinoma, and melanoma. Although melanoma is the least common type, it is the cause of most deaths from skin cancer (American Cancer Society, 2022). The most preventable cause of skin cancer is overexposure to ultraviolet (UV) light, either from the sun or from artificial sources like tanning beds. According to the National Cancer Institute (2022), data from 2016-2018 show that approximately 2.3 % of men and women will be diagnosed with skin cancer during their lifetime. Anyone can get skin cancer but people with certain characteristics are at greater risk. A lighter natural skin color, skin that burns, freckles, reddens easily, or becomes painful in the sun, blue or green eyes, blond or red hair, certain types and a large number of moles, a family history of skin cancer, a personal history of skin cancer, and older age are risk factors for skin cancer.

In Maryland, the age-adjusted incidence rate for skin cancer from 2014-2018 was 24.1 cases per 100,000. The incidence rate in Montgomery County is 19.0 and 5.9 in Prince George's County. The age-adjusted death rate in 2015-2019 is 1.8 in the State, 1.4 in Montgomery County, and 0.8 in Prince George's County.

DIABETES

Diabetes is a metabolic condition that affects how the body regulates glucose levels in the blood, with three main types (Type 1, Type 2, and Gestational). Most diabetes cases in the U.S. are Type 2 Diabetes (T2D), making it the most common form of diabetes. According to the 2020 National Diabetes Statistics Report, more than 34.1 million adult Americans (about 13% of the U.S. population) have diabetes. While T2D most often develops in people over age 45, the prevalence is become more frequent in children, teens, and young adults (CDC, 2020). Additionally, 7.3 million adults aged 18 years or older are unaware they have diabetes (undiagnosed diabetes), representing 2.8% of all U.S. adults and 21.4% of all U.S. adults with diabetes. Diabetes can be a life-threatening disease that requires life-long management and is the 8th leading cause of death in the U.S. However, T2D can be prevented through healthy lifestyle choices, including proper diet and exercise (Centers for Disease Control and Prevention, 2020).

The rate of newly diagnosed diabetes (around 1.5 million newly diagnosed cases each year) has remained relatively flat from 2000 (6.2 cases per 1,000) to 2018 (6.7 per 1,000), and the rates decreased significantly between 2008 (8.4) to 2018 (6.7) (Centers for Disease Control and Prevention, 2020). Diabetes can have harmful effects on organ systems in the human body; it is a frequent cause of end-stage renal (kidney) disease, non-traumatic lower-extremity amputation, and a leading cause of blindness among working-age adults. In addition, persons with diabetes are at increased risk for ischemic heart disease, neuropathy, and stroke.

According to an article in *Diabetes Care* (2018), the economic costs of diabetes, after adjusting for inflation, increased 26% between 2012 and 2017. Caring for people diagnosed with diabetes accounts for 25% of health care dollars spent (\$16,750 per person per year), with every \$1 in \$7

going to direct medical expenses (see Figure 23), with more than half directly attributed to diabetes. The estimated cost of diabetes in 2017 was \$327 billion, with indirect costs, such as absenteeism, lost productivity, and premature death, estimated at \$110.6 billion (Petersen, 2018).

Figure 23: The Staggering Cost of Diabetes



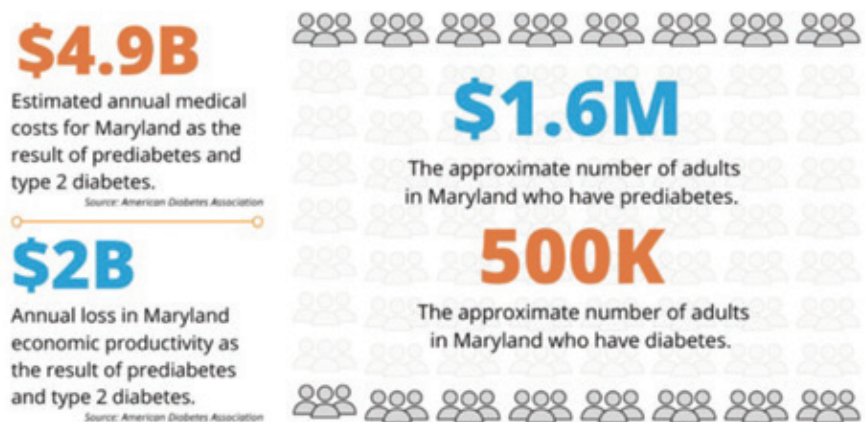
Source: American Diabetes Association, 2020.

Diabetes disproportionately affects minority populations and the elderly. Its incidence is likely to increase as minority populations grow and the U.S. population ages. Diabetes is the sixth leading cause of death in both Montgomery and Prince George’s County (Maryland Department of Health Vital Statistics Administration, 2022).

The COVID-19 pandemic has had a significant impact on diabetes patients. A systemic review and meta-analysis by Mahamat-Saleh et al. (2021) found that diabetes increased the absolute risk of death from COVID-19 by 14%. In addition, another study found that decreased routine diabetes care due to the pandemic increased diabetes mortality rates by 11% (Valabhji, et al., 2022).

In Maryland, 10.5% of adults have diabetes (nearly 500,000) and 34% have prediabetes (approximately 1.6 million), resulting in an estimated annual spending of \$4.9 billion (Maryland Department of Health, 2019) (see Figure 24).

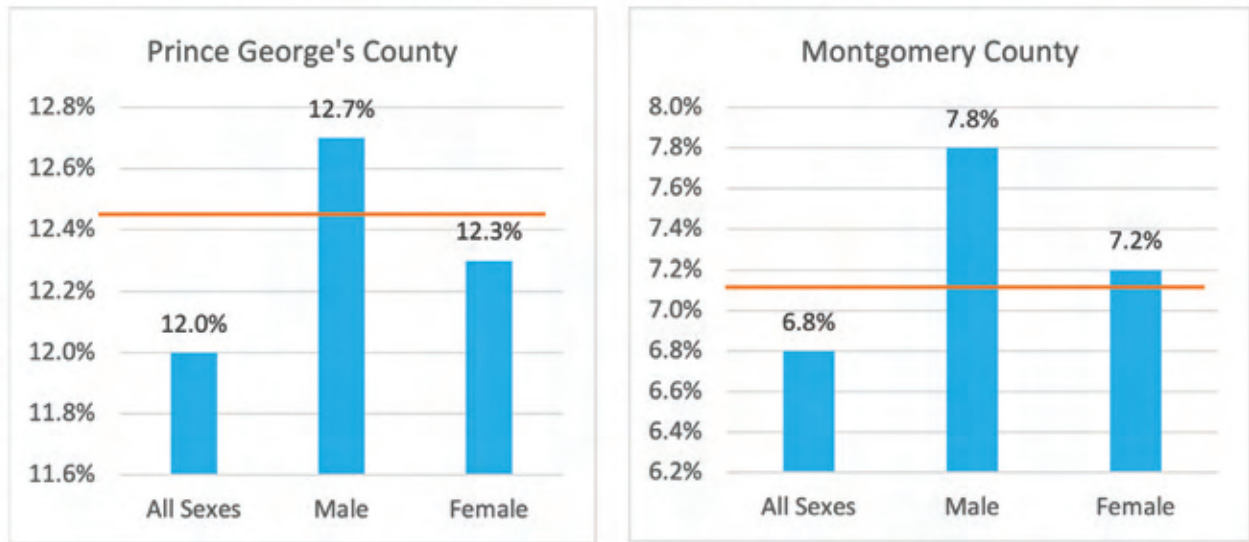
Figure 24: Diabetes Costs in Maryland



Source: Maryland Department of Health, 2019.

Within the MCHC CBSA, the crude rate of adults 18 and over ever diagnosed with diabetes was 9.0% (BRFSS, 2019). Seven percent of adults aged 20 years and older have been told that they have diabetes in Montgomery County, below both state and national levels. In Prince George’s County 12.3% of adult residents have diabetes, higher than state and national levels (BRFSS, 2019; CDC, 2019) (see Figure 25). In both Montgomery and Prince George’s Counties, adult males and residents over age 65 have a higher percentage of diabetes diagnoses, and African American/Black residents are more likely to die from diabetes than White residents. Mortality rates are also higher in residents aged 65 and older and in men compared to women in both counties.

Figure 25: Percent of Adults Age 20+ Who Have Been Diagnosed with Diabetes by Sex (2019)



Source: Sparkmap, 2019.

PREDIABETES

Prediabetes is a condition in which blood glucose levels are higher than normal but not high enough for a diagnosis of diabetes. Prediabetes puts individuals at increased risk of developing type 2 diabetes, heart disease, and stroke (Centers for Disease Control and Prevention, 2021). Healthy lifestyle choices can help prevent prediabetes and its progression to type 2 diabetes. More than eighty-eight million American adults 18 years or older have prediabetes, and of those with prediabetes, nearly 85% do not even know they have it. In Maryland, 1.6 million, or 34% of the population, have prediabetes (Maryland Department of Health, 2019).

CHILDHOOD DIABETES

Diabetes prevalence is also increasing among children and youth. Approximately 210,000 children and adolescents in the U.S. younger than 20 years have been diagnosed with diabetes (including 187,000 with type 1) (CDC, 2020). The increasing frequency of type 1 and type 2 diabetes in young people is a growing clinical and public health concern. For ages 10 to 19 years, the incidence of type 2 diabetes remained stable among Non-Hispanic Whites and increased for all others, especially Non-Hispanic Blacks. Prediabetes among youth is also a rising threat – affecting 1 in 5 U.S. youths ages 12-18, with this group also having higher cholesterol and blood pressure concerns (Andes et al., 2020). Prediabetes and diabetes among youth are primarily attributed to the increasing prevalence of obesity, sedentary lifestyles, and unhealthy nutrition.

DIABETES IN THE SENIOR POPULATION

Diabetes is also prevalent in the senior population. The number of older adults with diabetes is increasing in the United States and worldwide due to increased lifespan and the increased prevalence of diabetes in the geriatric population (Milanesi & Weinreb, 2020). According to the National Diabetes Statistics Report, the prevalence of diabetes in the U.S. senior population is

nearly 26.8% for those aged 65 or higher (CDC, 2020). Diabetes is a major cause of morbidity and mortality in this population, with the latter largely attributable to macrovascular complications. The American Geriatrics Society (AGS) guidelines for the management of diabetes in the elderly identify conditions that elderly patients with diabetes are at increased risk of having. Conditions include polypharmacy (the simultaneous use of multiple drugs to treat a single ailment or condition), depression, cognitive impairment, urinary incontinence, injurious falls, vision impairment, and pain.

CARDIOVASCULAR DISEASE

Cardiovascular disease is responsible for two of the five leading causes of death in Montgomery and Prince George's Counties. Heart disease is the leading cause of death in Prince George's County and the second leading cause in Montgomery County and stroke is the fourth leading cause of death in both counties. Together, heart disease, stroke, and other cardiovascular diseases are among the most widespread and costly health problems facing the nation today, accounting for approximately \$320 billion in health care expenditures and related expenses annually (Mozaffarian, et al., 2016). Fortunately, they are also among the most preventable. The leading controllable risk factors for heart disease and stroke are high blood pressure, high cholesterol, cigarette smoking, diabetes, unhealthy diet and physical inactivity, overweight, and obesity. Maryland's age-adjusted death rate for heart disease was 168.3 deaths per 100,000 in 2020. For that same year, the death rate in Montgomery County was 97.9 deaths per 100,000 population and 139.8 per 100,000 in Prince George's County (Maryland Department of Health Vital Statistics Administration, 2022)

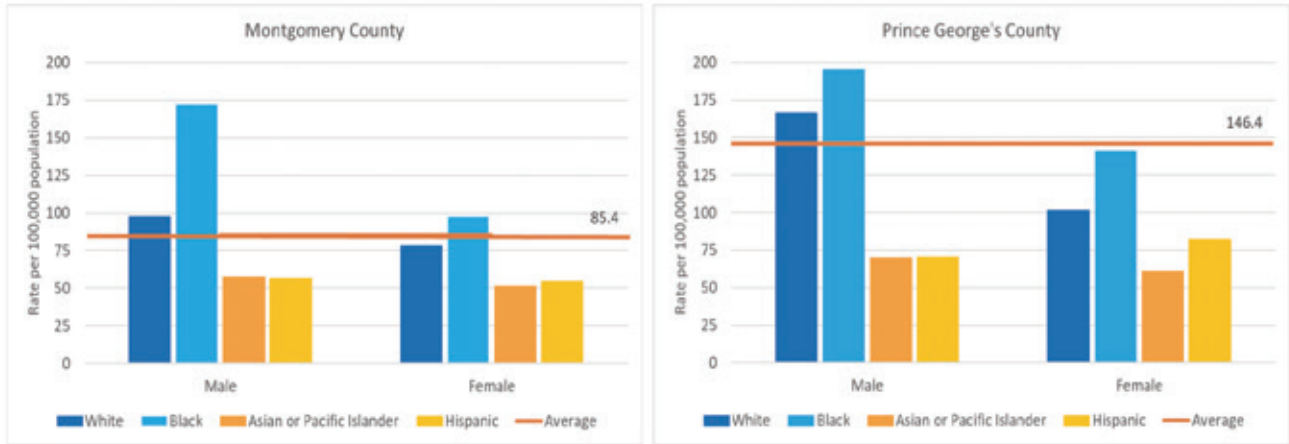
HIGH BLOOD PRESSURE AND CHOLESTEROL

High blood pressure, or hypertension (140/90 mm Hg or higher), is the number one modifiable risk factor for stroke. In addition to stroke, high blood pressure contributes to heart attacks, heart failure, kidney failure, and atherosclerosis. In the United States, nearly half of all adults (47% or 116 million) have high blood pressure; however, only about 25% of those adults have their hypertension under control (Center for Disease Control and Prevention, 2021). Hypertension is particularly prevalent in African Americans/Blacks, older adults, obese people, heavy drinkers, and women taking birth control pills (Center for Disease Control and Prevention, 2020). The hypertension prevalence rate among adults in Montgomery County is 29.8% and 37.2% in Prince George's County (Center for Disease Control and Prevention, 2020). The Healthy People 2030 national health target is to reduce the proportion of adults with high blood pressure to 27.7% (Office of Disease Prevention and Health Promotion, n.d.).

As high blood pressure is asymptomatic and frequently goes undetected, it is often called the "silent killer." In 2019, more than half a million deaths in the United States had hypertension as a primary or contributing cause (Center for Disease Control and Prevention, 2019). The hypertension death rate in Montgomery County is 85.4, and the rate in Prince George's County is 146.4. While hypertension can be controlled through lifestyle changes, including eating a heart-healthy diet, limiting alcohol, avoiding tobacco, controlling your weight, and staying physically

active, data reveals that the death rate from hypertension is higher in men compared to women. In Montgomery County, disparities can be seen in the death rates of African Americans/Blacks, and in Prince George’s County, disparities can be seen in African Americans/Blacks and Hispanics (see Figure 26).

Figure 26: Hypertension Death Rate by Sex, Race/Ethnicity (2017-2019)



Source: Office of Disease Prevention and Health Promotion, 2020.

According to the CDC, about one in six adults have high blood cholesterol. High blood cholesterol, which is asymptomatic, is one of the major risk factors for heart disease and can go undetected. Lowering cholesterol levels lessens the risk of developing heart disease and reduces the chance of having a heart attack. High cholesterol prevalence is 32.7% for Prince George’s County residents and 33.4% for Montgomery County residents aged 18 and older.

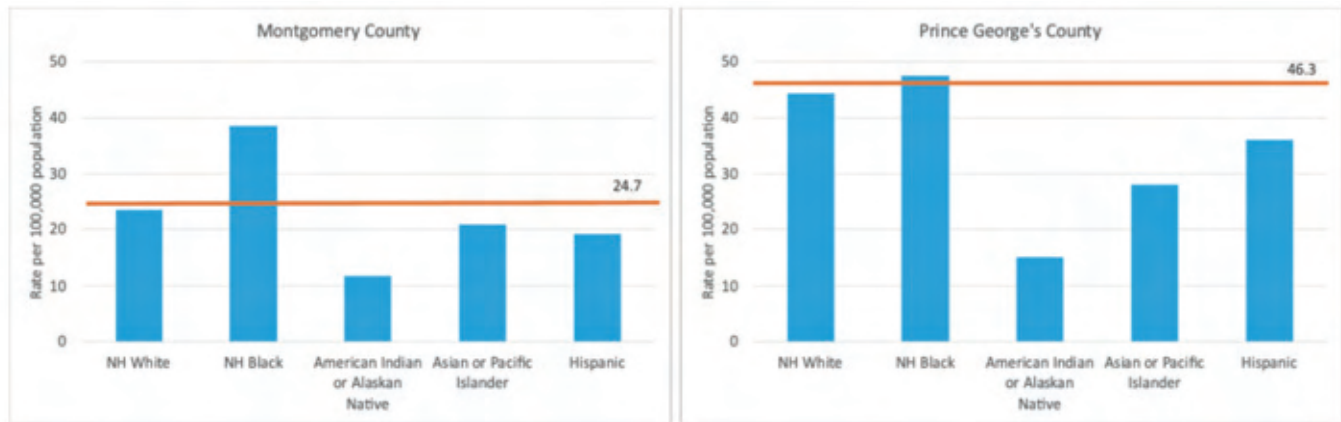
CEREBROVASCULAR DISEASE/STROKE

Cerebrovascular disease is the most common life-threatening neurological event in the U.S. It includes a variety of medical conditions that affect the system that supplies blood to the brain. The most common presentation of this disease is ischemic stroke, or mini-stroke, followed by hemorrhagic stroke.

Each year in the United States, over 795,000 people suffer a stroke, of which 610,000 are first-time events (CDC, 2017). Stroke leads to over 140,000 deaths each year, and prior to COVID-19, it was the third leading cause of death in Montgomery and Prince George’s Counties. A stroke occurs when the brain is deprived of oxygen, usually when blood vessels carrying oxygen to the brain become blocked or burst. High blood pressure is the number one controllable risk factor for stroke and can be prevented through regular care and lifestyle changes.

In Maryland, the age-adjusted death rate for cerebrovascular disease increased by 8.6% from 2010 to 2019. Montgomery County’s stroke death rate was 24.7 per 100,000 population and the death rate for Prince George’s County was 46.3 per 100,000 (see Figure 27) (Center for Disease Control and Prevention, 2020). The Healthy People 2030 national health goal is to reduce stroke to 33.4 deaths per 100,000 population (Office of Disease Prevention and Health Promotion, n.d.).

Figure 27: Stroke Death Rate, All Ages, 2017-2019

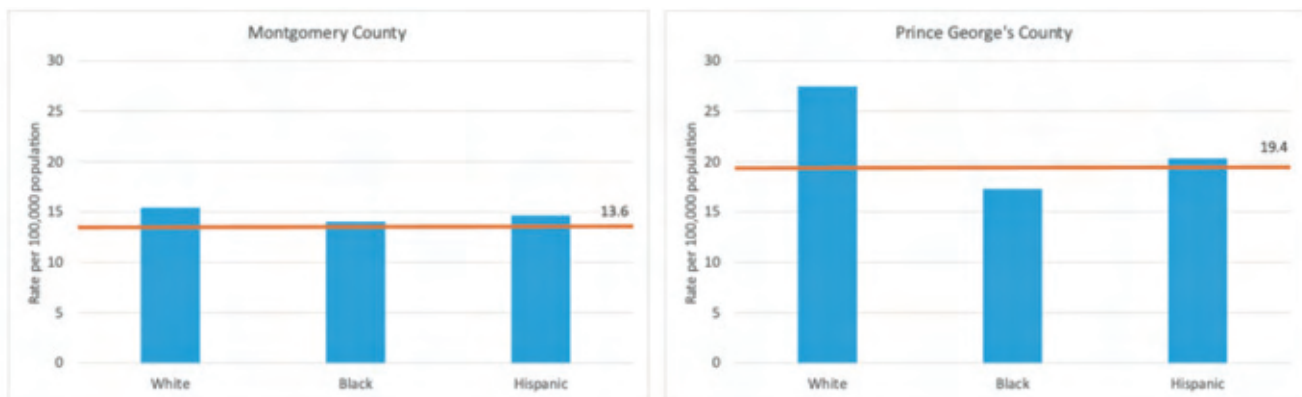


Source: Interactive Atlas of Heart Disease and Stroke.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE /CHRONIC LOWER RESPIRATORY DISEASE

Chronic lower respiratory disease (CLRD) causes airflow blockage and breathing-related issues, including chronic obstructive pulmonary disease (COPD), emphysema, bronchitis, and asthma. CLRD is a leading cause of death, with approximately 124,000 deaths yearly, and generally occurs among older adults. However, this estimate is considered low because CLRD is often cited as a contributory, not underlying, cause of death on the death certificate. In Montgomery County, 4.3% of adults have CLRD, while 4.8% of adults in Prince George's County have CLRD (National Center for Chronic Disease Prevention and Health Promotion, 2021). In 2020, Montgomery County and Prince George's County's overall age-adjusted death rates for CLRD were 13.6 and 19.4, respectively (see Figure 28) (Center for Disease Control and Prevention, National Center for Health Statistics, 2021).

Figure 28: Age-Adjusted Death Rate due to Chronic Lower Respiratory Disease by Race/Ethnicity (2020)



Source: CDC WONDER Online Database, 2021.

COPD

COPD has no known cure, with many conditions often undiagnosed (CDC, 2021). It is comprised of two main conditions, emphysema and chronic bronchitis, and patients may experience many conditions simultaneously (LiveStories, n.d). COPD slowly damages the lung air sacs causing wheezing, tightness of the chest, and shortness of breath, and can often lead to other more serious health issues if left untreated (United Health Foundation, 2020). Genetic and environmental factors,

such as exposure to tobacco smoke, air pollutants and respiratory infections, play a key role in developing COPD (CDC, 2021c). Rates of adults diagnosed with COPD have declined from 2019 to 2020. Nationally, rates have dropped from 6.5% in 2019 to 6.2% in 2020. Statewide, rates have also declined from 5.4% in 2019 to 4.8% in 2020.

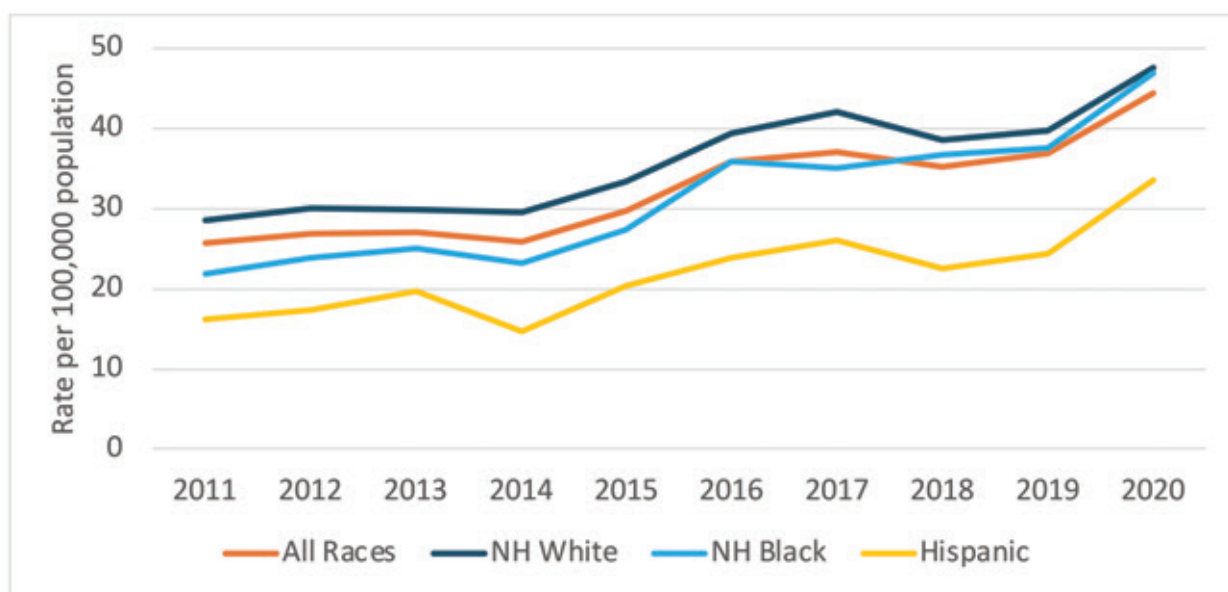
UNINTENTIONAL INJURIES (ACCIDENTS)

Injury, unlike disease, is damage to the body caused by an external force or physical trauma. It is a broad term that is first classified based on whether there is an intent to harm. Intentional injury is injury inflicted by positive, willful, and aggressive conduct. Examples include self-harm or interpersonal violence. Both intentional and unintentional injury may cause prolonged illness or death. In addition to intent, injury is also classified by several other factors, including severity, setting, activity, mechanism, and nature of the injury. There is no single comprehensive and mutually exclusive method for injury categorization. However, all classifications have merit, and often a combination is chosen (World Health Organization [WHO], 2009).

Public health practitioners have moved towards updating terminology in this area from “accident” to “injury event” to infer that these events can be studied, measured, and prevented and also to remove connotations of inevitability or lack of apparent cause. In some cases, however, the term accident is still used.

While accidents represented a small percentage (4.9%) of all Maryland deaths in 2020, the rate of increase over the last decade has been significant compared to other leading causes of death. For example, the statewide age-adjusted rate for accidents increased 73.4% from 2011 to 2020 (Figure 29). Similar rates of increase were seen among Non-Hispanic Whites (67%), with the highest percent change occurring for Non-Hispanic Blacks (113.7%) and Hispanics (106.8%) (Maryland Department of Health Vital Statistics Administration, 2022).

Figure 29 Age-Adjusted Death Rate for Accidents by Race and Ethnicity, Maryland

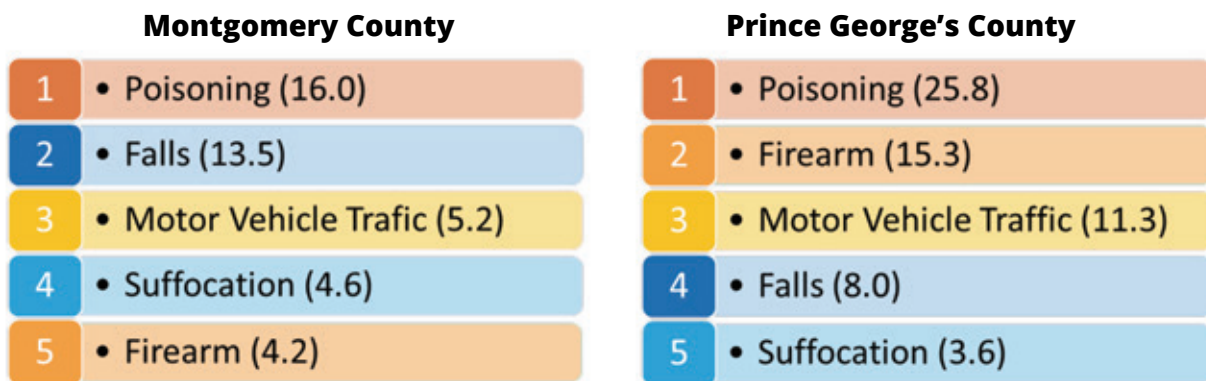


Source: Maryland Department of Health Vital Statistics Administration, 2022.

When considering the different injury types, unintentional injuries are a leading cause of death for Americans of all ages, regardless of gender, race, or economic status. Major unintentional injuries include motor vehicle collisions, drowning, fires and burns, poisonings, suffocation/aspiration, and falls caused by negligence or a mishap. According to the CDC, approximately 40 deaths per 100,000 occur each year due to unintentional injuries.

The crude death rates from unintentional injuries in Montgomery County were 48.0 per 100,000 in 2020 and 74.4 per 100,000 in Prince George’s County. In 2020, the leading cause of preventable, unintentional injury in Montgomery County and Prince George’s County was poisoning (see Figure 30) (Center for Disease Control and Prevention, National Center for Health Statistics, 2021).

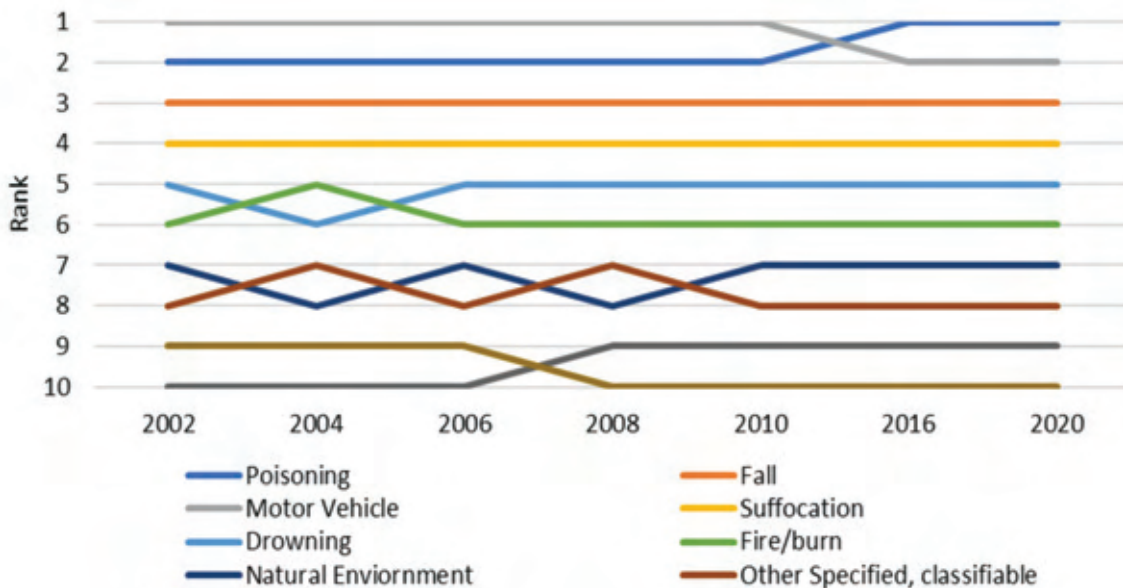
Figure 30: Crude Death Rates for Leading Causes of Death from Unintentional Injury (2020)



Source: CDC WONDER Online Database, 2021.

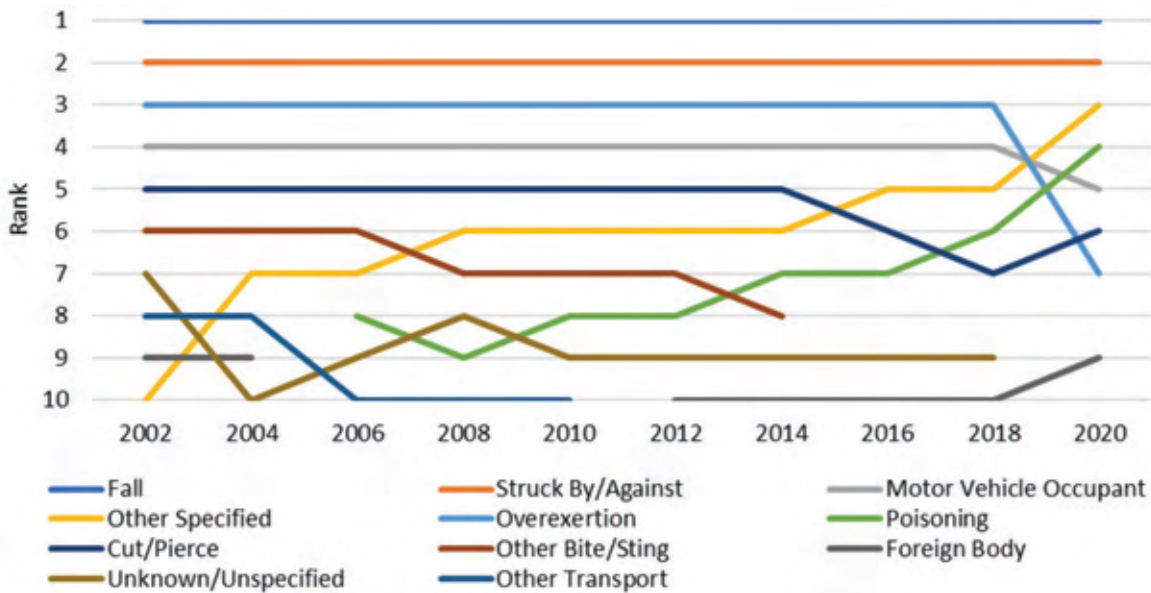
Figure 31 and Figure 32 illustrate the U.S. top 10 preventable deaths from unintentional injuries and the top 10 preventable nonfatal unintentional injuries over the last decade.

Figure 31 Top 10 Preventable Deaths from Injury in the United States (2002 – 2020)



Source: Web-based Injury Statistics Query and Reporting System (WISQARS), 2021

Figure 32: Top 10 Nonfatal Injuries in the United States (2002 - 2020)



Source: Web-based Injury Statistics Query and Reporting System (WISQARS).

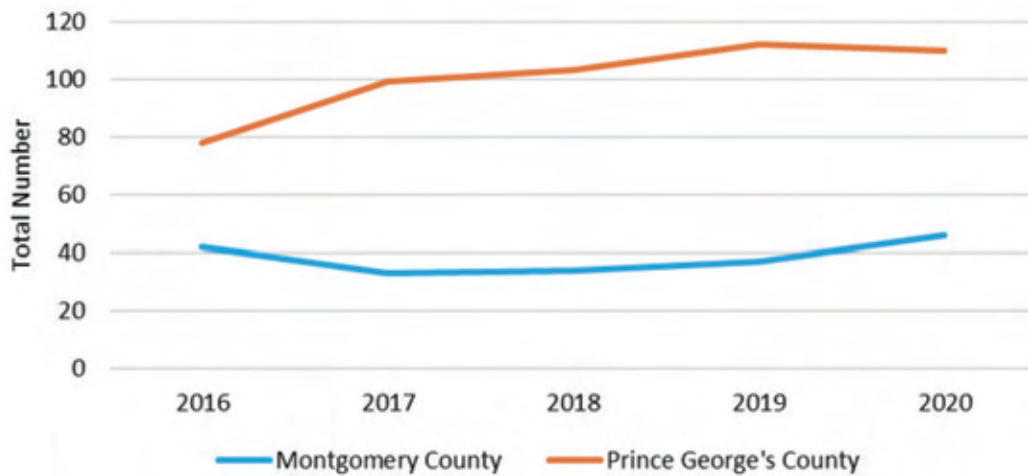
MOTOR VEHICLE ACCIDENTS

Motor vehicle collisions are the leading cause of death among people ages 5 through 34 in the United States. Many more people are injured or disabled in motor vehicle accidents each year. In addition to negative health effects, motor vehicle collisions have significant economic impacts; the costs of medical care and productivity losses resulting from motor vehicle accidents are estimated at around \$100 billion per year. In Montgomery County, the age-adjusted death rate for motor vehicle traffic collisions was 5.1 per 100,000 population and the rate for Prince George’s County is 11.1. In both counties, African American/Blacks and Hispanic rates are more than double their White counterparts (Centers for Disease Control and Prevention, 2020)

One’s physical environment greatly influences the risk of suffering harm from an unintended injury; this means that existing social and environmental factors will either protect or inhibit risk. For example, pedestrian and motor vehicle fatalities are many times higher in places with lower socioeconomic status and higher exposure to traffic. A fatal crash is a metric distinct from a motor vehicle fatality.

Fatal crashes are a count of the number of incidents where at least one fatality occurred because of a motor vehicle crash, whereas fatalities are a count of the total number of persons killed in a motor vehicle crash; some fatal crashes involve more than one fatality. The driver has the highest risk of death in crashes, accounting for 61% of fatalities from crashes in 2020 (Motor Vehicle Administration, 2021). Passengers and pedestrians also have an increased risk of death, accounting for 12.4% and 22.9% of fatalities in Maryland in 2020. Overall, between 2016 and 2020, fatalities in Prince George’s County have trended up, while in Montgomery County, during the same period, the number has remained steady (see Figure 33).

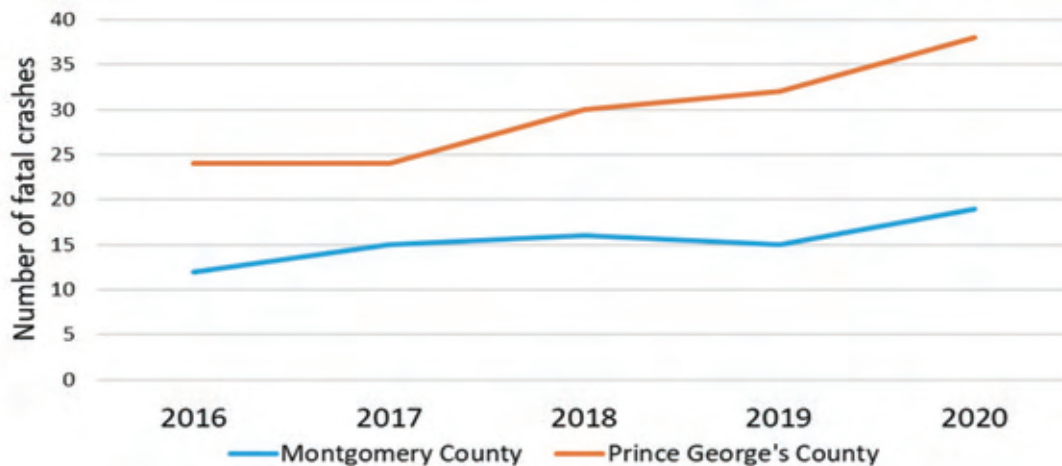
Figure 33: Number of Total Fatalities (2016-2020)



Source: Maryland Department of Transportation Motor Vehicle Administration, 2021.

After driver and passenger deaths, the highest fatality rate was among walking pedestrians. In 2018, there were 6,283 pedestrians killed in traffic crashes in the United States - a 50% increase over the past decade. In 2020 there were 131 walking pedestrian fatalities, representing 23% of fatal motor vehicle deaths in Maryland; 19 in Montgomery County and 38 in Prince George's County (Motor Vehicle Administration, 2021; Vision Zero Prince Georges, n.d.). This number represents the number of incidents where at least one pedestrian fatality occurred because of a motor vehicle crash. Injuries among pedestrians have increased between 2016 and 2020 across Montgomery and Prince George's Counties (see Figure 34).

Figure 34: Trend in Number of Total Fatalities Involving Pedestrians on Foot (2016-2020)



Source: Maryland Department of Transportation Motor Vehicle Administration, 2021.

FALLS

Falls, occurring most often in those aged 65 and over, are a leading cause of unintentional injury and death and as the population ages, the number of falls each year is expected to rise (see Figure 35). Falls commonly produce bruises, hip fractures, and head trauma. These injuries can increase

the risk of early death and make it difficult for older adults to live independently. Most fatal falls occur among adults aged 65 or over but are also the leading cause of work-related injury death, especially among construction workers. Most falls are preventable. Strong, active bodies, corrected vision, medication management, and safe physical environments are all key to fall prevention.

Figure 35: Number of Older Adult Falls (2020)



Source: Centers for Disease Control and Prevention Center for Injury Prevention and Control, 2021.

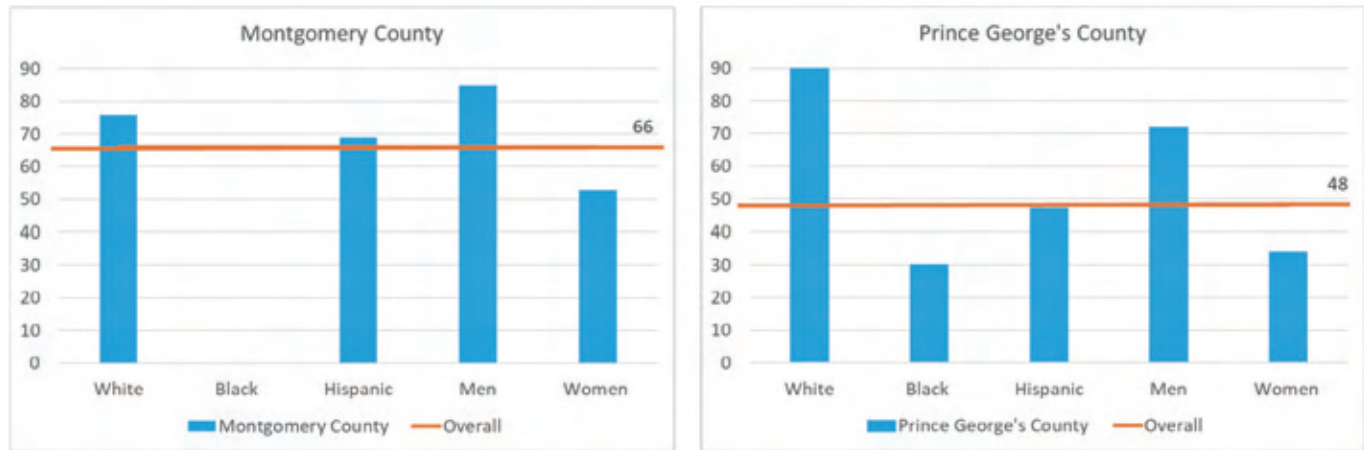
According to the CDC, in 2020, 66.1 per 100,000 Montgomery County older residents and 48 per 100,000 Prince George’s County older residents died from falls. The Healthy People 2030 national health goal is to reduce fall-related deaths among older adults to 63.4 per 100,000.

While it is estimated that as many as one in four adults experience a fall, many go unreported to their health care provider. According to the CDC, falling once also increases one’s risk of falling again. Falls are a threat to the health of older adults and can reduce their ability to remain independent. Serious injury, including fractured bones and head wounds, can result from a fall, sending many to the hospital. Head injuries are especially serious if the person is taking certain medicines like blood thinners. Even if no injury results from a fall, many people who fall become afraid of falling, causing them to cut down on their everyday activities. A decrease in regular activity leads to weaker bodies and an increase in falling.

The effects of falls extend beyond psychological and minor physical injuries. Falls are the most common cause of nonfatal injuries and hospital admissions for trauma. In the United States, more than one-third of adults 65 and older fall each year. Twenty to thirty percent of older adults who fall suffer from moderate to severe injuries. Falls are also very costly. The CDC estimates that each year in the U.S., about \$50 billion is spent on medical costs related to non-fatal fall injuries and \$754 million is spent related to fatal falls.

In Montgomery and Prince George’s Counties, the 2020 overall age-adjusted rate for falls was 66.1 and 48.0, respectively. Higher rates can be seen in both counties in men compared to women and Whites compared to African Americans/Blacks and Hispanics (see Figure 36).

Figure 36: Age-Adjusted Death per 100,000 Rates (age 65+) Due to Falls (2020)



Source: CDC WONDER Online Database, 2021.

BEHAVIORAL HEALTH

Social and emotional support refers to the subjective sensation of feeling loved and cared for by those around us. Research has shown that individuals with social and emotional support experience better health outcomes compared to individuals who lack such support. In addition, it has been shown that social and emotional support have beneficial effects on recovery time post cardiac surgery, coping with cancer pain, and overall longevity.

SUBSTANCE ABUSE

Substance abuse, which is the recurrent use of alcohol and/or other drugs, can cause major health and social issues, including problems in the workplace, school, and home (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2022). Alcohol is also the third-leading preventable cause of death in the United States and contributes to 18.5% of emergency department visits and 22.1% of overdose deaths related to prescription opioids, causing an estimated 95,000 people to die from alcohol-related causes each year (NIAAA, 2022). Some of the leading causes of death are related to chronic conditions that are alcohol-associated such as liver disease, heart disease and stroke, liver cirrhosis, upper aerodigestive tract cancers, liver cancer, cardiac dysrhythmia, alcohol use disorder, breast cancer, and hypertension creating a global and economic burden. According to the National Institutes of Health, in 2010, the misuse of alcohol cost the the U.S. an estimated \$249 billion (NIAAA, 2022).

BINGE OR HEAVY DRINKING

Excessive alcohol consumption, binge, or heavy drinking is a health behavior with adverse health outcomes and is associated with multiple risk factors such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes (CDC, 2022b). Binge or heavy drinking is defined as consuming five or more drinks on an occasion for men and four or more drinks on an occasion for women. More than 90% of adults

who drink excessively report binge drinking (CDC, 2022c). Nearly 17% of U.S. adults are considered binge drinkers (CDC, 2022c). In 2018, the most recent data available, the percent of adults who self-reported binge or heavy drinking over a 30-day period for Montgomery and Prince George's Counties was 13% and 14%, respectively (County Health Rankings & Roadmaps, 2021).

DRUG AND ALCOHOL RELATED INTOXICATION DEATHS

An intoxication death is defined as a death resulting from recent ingestion or exposure to alcohol or another type of drug, including heroin, fentanyl, cocaine, prescription opioids, benzodiazepines, phencyclidine (PCP), methamphetamines, and other prescribed and non-prescribed drugs.

In 2020, Montgomery County reported 139 deaths (13.3 per 100,000 population) and Prince George's County reported 203 deaths (22.3 per 100,000 population) (Maryland Department of Health, 2021b). Both counties saw an increase in deaths when compared to 2019.

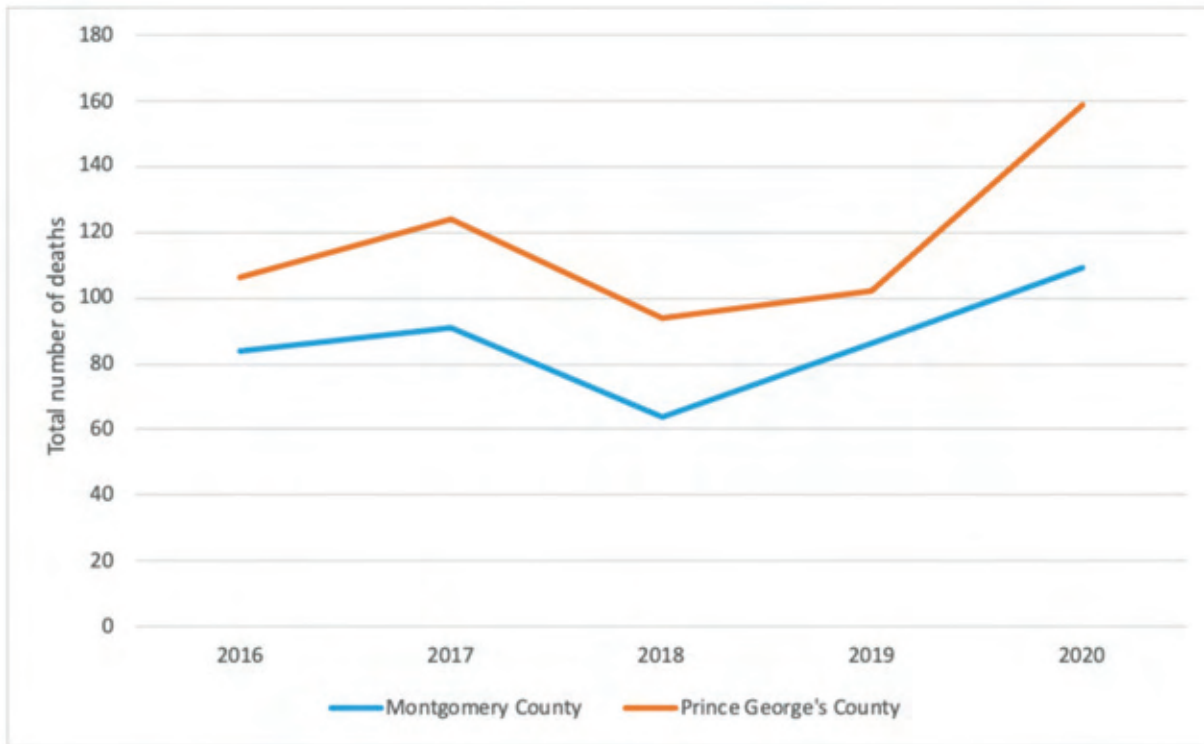
OPIOID AND PRESCRIPTION-RELATED DEATHS

Opioids include heroin and prescription medications used as pain relievers such as morphine, codeine, methadone, oxycodone, hydrocodone, fentanyl, hydromorphone, and buprenorphine (Office of Planning and Epidemiology, 2018). Overdose from prescription opioid pain relievers is a driving factor in the alarming increase in drug overdose morbidity and mortality.

Maryland, Montgomery County, and Prince George's County have seen a rise in heroin overdose over the past five years due to individuals switching to heroin after becoming addicted to prescription opioids because of its relatively low cost (Maryland Department of Health, 2016). Ninety percent of all intoxication deaths in Maryland in 2020 were opioid-related (Maryland Department of Health, 2021, p. 6). Between 2016-2020, opioid-related deaths increased 46% in Montgomery County and 127% in Prince George's County (Figure 37) in Maryland, the percent increase in deaths was 93%, with a large proportion of deaths attributed to the use of fentanyl (Maryland Department of Health, 2021b).

Fentanyl-related deaths began increasing in late 2013 due to overdoses involving nonpharmaceutical fentanyl (nonprescription fentanyl produced in clandestine laboratories and mixed with, or substituted for, heroin or other illicit substances). Nearly all fentanyl-related deaths in recent years have involved the use of nonpharmaceutical fentanyl. Fentanyl is many times more potent than heroin and greatly increases the risk of overdose death. In Maryland, fentanyl-related deaths have increased rapidly since 2013, with a 229% increase between 2015 and 2016. Deaths related to fentanyl increased sharply again in 2020, rising 22% to a 10-year high of 2,342 deaths (Maryland Department of Health, 2021, p. 7). Fentanyl-related deaths in Maryland have seen the highest increases between 2019 and 2020 among those 25-34 years (25%), those 55 and older (28%), among non-Hispanic Whites (19%) non-Hispanic Blacks (20%), and Hispanics, with rates that have nearly doubled, increasing 96% from 2019.

Figure 37: Opioid-Related Intoxication Deaths (2016 - 2020)



Source: Maryland Department of Health, 2021.

BEHAVIORAL AND MENTAL HEALTH

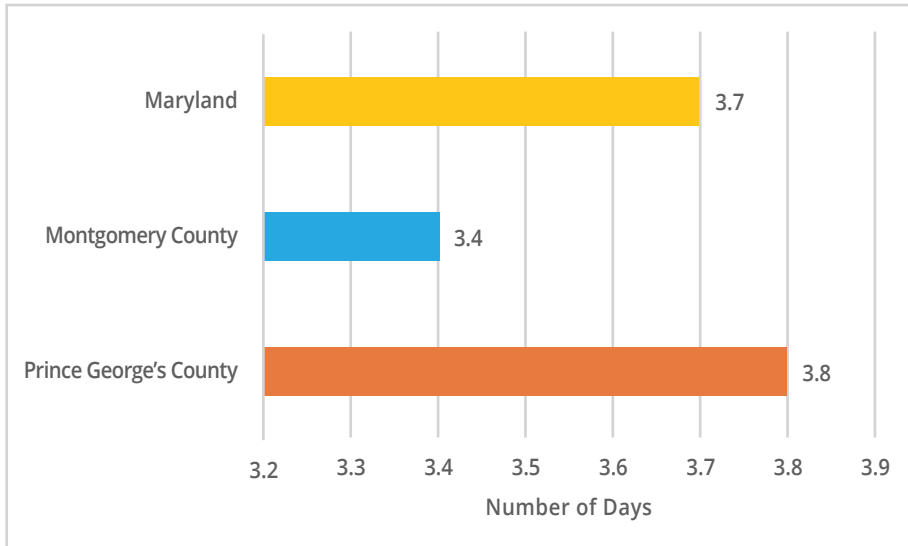
Behavioral and mental health have become prominent at the national level and described as an epidemic. One in five adults has experienced a mental illness and twelve million adults had serious thoughts of suicide in the U.S. (National Alliance for Mental Health [NAMI], 2020). Approximately one in six adolescents experience a major depressive episode (NAMI, 2020b).

In a recent study, mental health-related ER visits have exponentially increased due to the COVID-19 pandemic. This includes visits from mental health conditions, suicide attempts, drug overdoses, domestic abuse and child abuse and neglect (Holland et al., 2021). On a national level, pandemic anxiety, economic stress, social isolation, and addiction contributed to rises in cases of mental health visits to hospitals. As the impact of the COVID-19 pandemic spread across all communities, Montgomery and Prince George's counties residents faced similar risk factors affecting their mental health. In February 2021, 39.1% of adults in Maryland reported symptoms of anxiety or depression (NAMI, 2021).

Self-reported health assessments have been shown to be predictors of mortality and can be valuable for population health monitoring. Through County Health Rankings, one measure of quality of life is to examine the number of poor mental health days, which is the average number of mentally unhealthy days reported in the past 30 days (see Figure 38). While in Montgomery County residents reported an average of 3.4 mentally unhealthy days within the past 30 days and Prince George's County residents reported 3.8 days (CHR&R, 2021). Within the MCHC CBSA, 11.6% of adults report fourteen or more days during which their mental health was 'not good' compared

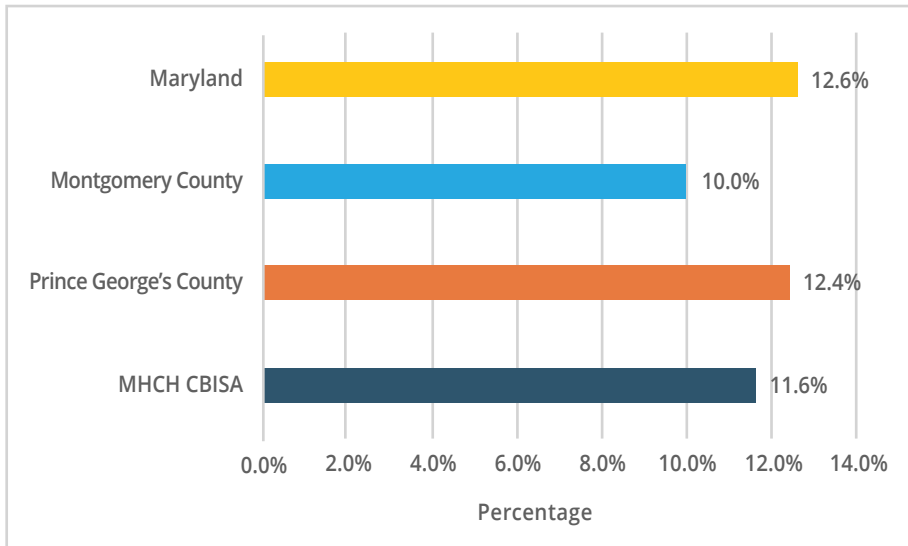
to 10.0% of those living in Montgomery County and 12.4% in Prince George’s County (BRFSS, 2019) (see Figure 38).

Figure 38 Number of Poor Mental Health Days in Adults 18+ (2018)



Source: County Health Rankings & Roadmaps, 2021.

Figure 39: Percentage of Adults with Poor Mental Health (2019)



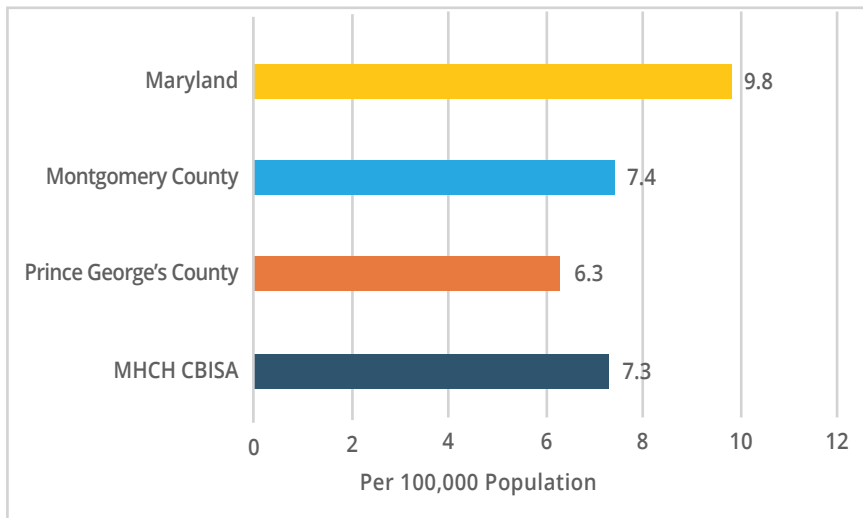
Source: Notes. Behavioral Risk Factor Surveillance System [BRFSS, Centers for Disease Control and Prevention, 2019.

Depression is a common mood disorder caused by a combination of genetic, biological, environmental, and physiological factors. Symptoms of depression include feeling hopeless, loss of interest and fatigue and can impact all aspects of a person’s life, including how they think, feel, and handle daily activities. In general, there is a higher prevalence among Hispanic, White, and Black adults and affects women compared to men. It is a risk factor for dying by suicide. In 2020, 15.7% of the Maryland population was diagnosed with depression (United Health Foundation, 2021).

SUICIDE

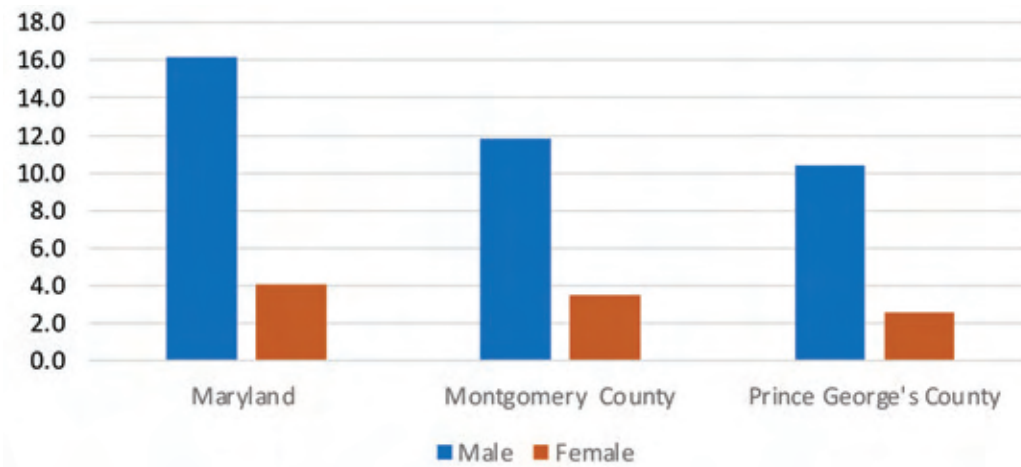
In recent years, the rate of suicide deaths has increased. For example, in Maryland, death from suicide increased 7.6% from 9.1 to 9.8 per 100,000 between 2015 and 2019. In the MCHC CBSA, there were 477 deaths from suicide with the age-adjusted death rate of 7.3 from 2016-2020. Comparing genders, a greater number of males than females died by suicide (see Figure 40).

Figure 40 Age-Adjusted Suicide Mortality (2016-2020)



Source: National Vital Statistics System, Centers for Disease Control and Prevention, 2021.

Figure 41 Suicide Mortality, Age-Adjusted Rate per 100,000 by Gender (2016-2020)

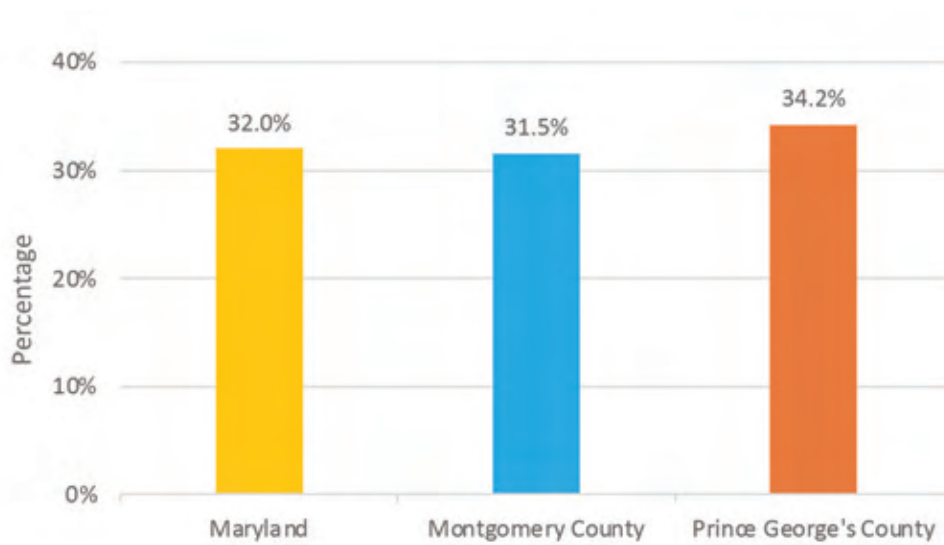


Source: National Vital Statistics System, Centers for Disease Control and Prevention, 2021.

Depression is not an adult-only problem. According to the CDC (2022f), 8 in 10 children receive treatment for depression, while the most commonly diagnosed mental disorders include anxiety, ADHD, behavior problems, and depression. Furthermore, cases of depression and anxiety have increased over the years. Suicide is the second leading cause of deaths among adolescents between the ages of 15 to 19 years old on the national level.

In recent years, both Prince George’s and Montgomery Counties have seen a rise in middle and high school students who have stated they felt sad or hopeless. The Youth Risk Behavior Survey reported 32% of Montgomery County students and 34% of students in Prince George’s County reported feeling sad or hopeless every day for two weeks or more during the past 12 months. Within the Montgomery County Public School system, crisis referrals rose from 1,804 in FY18 to 1,954 in FY19 (Yao, 2021). The number one reason for a crisis intervention referral was suicide threat. When looking at high school students who seriously considered attempting suicide, Black students in Prince George’s County and White students in Montgomery County have the highest percentage (Center for Chronic Disease Prevention and Control, 2021). Interestingly, female high school students in both counties had a higher percentage of considering suicide compared to males.

Figure 42 Percentage of Students Feeling Sad or Hopeless



Source: Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS) 2018 – 2019, Maryland Department of Health CCDCPC Surveys & Reports, 2021.

INFECTIOUS DISEASE

Infectious diseases are disorders that are caused by organisms such as bacteria, viruses, fungi, or parasites that are passed, directly or indirectly, from one person to another (Mayo Clinic, 2022; Department of Molecular Virology and Microbiology, n.d.). Other routes of transmission are zoonotic (exposure to an infected animal that harbors a pathogenic organism that is capable of infecting humans), consuming contaminated food or water, or being exposed to organisms in the environment. Many infectious diseases are reportable and considered to be a danger to public health. It is a requirement that local, state, and national agencies report these diseases when they are diagnosed by doctors or laboratories. Reporting allows for the collection of statistics, which helps researchers identify disease trends and track disease outbreaks. See Table 2 for a list of notifiable infectious conditions in Maryland.

Table 2 Cases of Selected Notifiable Conditions Reported in Maryland (2019)

Condition Name	Maryland	Montgomery County	Prince George's County
Amebiasis	0.4	0.6	0.9
Animal bites	174.1	91.8	132.3
Anthrax	0.1	0.4	0.1
Campylobacteriosis	14.7	16.3	6.3
Cryptosporidiosis	1.8	2	1.5
Cyclosporiasis	3.6	15.9	0.4
Dengue Fever	0.4	0.7	0.2
Giardiasis	2.9	0	4.1
Hepatitis A	1.5	1.3	1.6
Kawasaki Syndrome	0.1	0.7	0
Listeriosis	0.4	0.5	0.4
Lyme Disease	23.5	12.8	2.4
Malaria	3	5	6.5
Meningitis, Fungal	0.7	0.4	0.9
Mumps	0.3	0.8	0.3
Mycobacteriosis, Other than TB & Leprosy	13.8	23.7	12.3
Pertussis	1.7	2.9	1.2
Shiga toxin-producing E. coli (STEC)	4	6.6	3.4
Shigellosis	3.3	5.2	4.8
Strep Group B	9	6.1	8.6
Typhoid Fever – Acute	0.3	0.7	0.2
WNV Symptomatic Infections	0.1	0.2	0.3
Yersiniosis	1.6	2.7	1.2

Source: Maryland Department of Health NEDSS and PRISM databases, 2021.

TUBERCULOSIS

Tuberculosis (TB) is a bacterial disease that usually affects the lungs, although other parts of the body can also be affected. The TB bacteria are spread through the air when a person with untreated pulmonary TB coughs or sneezes. Prolonged exposure to a person with untreated TB is usually necessary for infection to occur. In 9 out of 10 exposed people, the immune system halts the spread of the infection and the infected person does not become sick or spread disease to others. However, the bacilli remain dormant and can be activated if the immune system becomes severely weakened by HIV, diabetes, chemotherapy cancer treatments, or other causes. A person

with TB disease is contagious until he/she has been on appropriate treatment for several days to weeks. The most effective way to stop the spread of tuberculosis is for TB patients to cover the mouth and nose when coughing, and to take all TB medicine exactly as prescribed by their physician. The Healthy People 2030 national health target is to reduce tuberculosis cases to 1.4 cases per 100,000 population. Montgomery and Prince George’s counties had higher rates of Tuberculosis than Maryland from 2016 -2019. Montgomery County had a decreasing trend while Prince George’s County had an increasing trend (see Table 3).

Table 3 Cases of Tuberculosis Reported in Maryland (2016 – 2019)

Location	2016	2017	2018	2019
Maryland	3.7	3.4	3.5	3.5
Montgomery County	7.2	6	6.1	5.9
Prince George’s County	5.5	5.1	6.7	6.4

Source: Maryland Department of Health Prevention and Health Promotion Administration, 2021.

SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted infections (STIs) are also called sexually transmitted diseases, or STDs. STIs are usually spread by having vaginal, oral, or anal sex. An STI is an infection passed from one person to another person through sexual contact. An infection is when a bacteria, virus, or parasite enters and grows in or on your body. According to the CDC, nearly 20 million people in the United States get an STI each year. These infections affect women and men of all backgrounds and economic levels and half of all new infections are among young people 15 to 24 years old. Women often have more serious health problems from STIs than men, including infertility. Though consistently lower than Maryland and Prince George’s County, the sexually transmitted infections (chlamydia, gonorrhea, and syphilis) in Montgomery County have increasing trends.

In 2020, 2.4 million cases of STDs were reported in the U.S. (CDC, 2022a). The syphilis epidemic continued to surge, driving another year of increases in congenital syphilis. Congenital syphilis (CS) is a disease that occurs when a mother with syphilis passes the infection on to her baby during pregnancy). Jurisdictions reported more than 2,100 cases of congenital syphilis, an increase of almost 15% since 2019 and a 235% increase since 2016. Gonorrhea and primary and secondary syphilis cases increased by 10% and 7% from 2019 to 2020, while reported cases of chlamydia declined 13%. However, chlamydial infections are usually asymptomatic and identified through screening. Therefore, this decline is likely due to decreases in STD screening and underdiagnosis during the pandemic, rather than a reduction in new infections. The 2020 STD data also show that some racial and ethnic minority groups, gay and bisexual men, and our nation’s youth continue to experience high rates of STDs.

Focused attention is needed to combat the surge in congenital syphilis, which has dramatically increased in the past five years. In 2020, nationally, there were 149 stillbirths and infant deaths,

reflecting a startling 210 percent increase since 2016. Data show that 47 states reported at least one case of congenital syphilis in 2020, compared to only 24 states in 2011. The most common missed congenital syphilis opportunity occurred when mothers did not receive timely prenatal care or syphilis testing (41%). Fueling this national trend are parallel increases in P&S syphilis (i.e., most infectious phases) among women aged 15-44 years by more than 156% from 2016 to 2020. In 2019, Montgomery County reported a case rate of 25.1 cases per 100,000 live births and Prince George’s County case rate of 42.4 cases per 100,000 live births (Prevention and Health Promotion Administration, 2019). The Healthy People 2030 national health target is to reduce congenital syphilis cases to 33.9 cases per 100,000 population.

In addition to syphilis, chlamydia is also a common STI that can infect both men and women. It can cause serious, permanent damage to a woman’s reproductive system, resulting in infertility. Chlamydia can also cause a potentially fatal ectopic pregnancy (pregnancy that occurs outside the uterus). Under-reporting of chlamydia is substantial because most people with chlamydia are not aware of their infections and do not seek testing. Nationally, during 2019–2020, rates of reported chlamydia decreased among both males and females, in all regions of the United States, and, except for rates among non-Hispanic persons of multiple races, among all racial/Hispanic ethnicity groups. In 2019, Montgomery County reported a case rate of 447 cases per 100,000, which is drastically lower than the Prince George’s County case rate of 906.4 cases per 100,000 (see Table 4).

Table 4 Cases of Chlamydia Reported in Maryland (2016-2019)

Location	2016	2017	2018	2019
Maryland	509.6	552.1	587.2	623.9
Montgomery County	328.3	380.5	419	447
Prince George’s County	740.4	806.9	881.2	906.4

Source: Maryland Department of Health Prevention and Health Promotion Administration, 2021.

The other common STI, gonorrhea, can also infect both men and women, and is the second most common notifiable STI in the U.S. in 2020. It can cause infections in the genitals, rectum, and throat. It is a very common infection, especially among young people ages 15-24 years. It is typically asymptomatic, but easy to treat. However, gonorrhea has developed resistance to antibiotics over the years, complicating treatment. Left untreated, gonorrhea can cause serious and permanent health problems in both women and men. In women, gonorrhea is a common cause of pelvic inflammatory disease. In the United States, the highest reported rates of infection are among sexually active teenagers, young adults, and African Americans. In 2019, Montgomery County reported a case rate of 79.3 cases per 100,000, which is drastically lower than the Prince George’s County case rate of 240.8 cases per 100,000 (see Table 5).

Table 5 Cases of Gonorrhea Reported in Maryland (2016 – 2019)

Location	2016	2017	2018	2019
Maryland	158.3	181.4	170.5	191.5
Montgomery County	53.9	68.6	62.7	79.3
Prince George’s County	200.9	219.2	222.1	240.8

Source: Maryland Department of Health Prevention and Health Promotion Administration, 2021.

According to the CDC, after reaching an all-time low in 2000, cases of primary and secondary (infectious) syphilis are on the rise in the United States, particularly among men having sex with men. New cases of primary and secondary syphilis in men having sex with men are often characterized by co-infection with HIV. In addition, syphilis can also be passed from mother to infant during pregnancy causing a disease called congenital syphilis. Pregnant women with untreated early syphilis experience perinatal death in up to 40% of cases.

Syphilis is divided into stages (primary, secondary, latent, and tertiary), with different signs and symptoms associated with each stage. A person with primary syphilis generally has a sore or sores at the original site of infection. These sores usually occur on or around the genitals, around the anus or in the rectum, or in or around the mouth. These sores are usually (but not always) firm, round, and painless. Symptoms of secondary syphilis include skin rash, swollen lymph nodes, and fever. The signs and symptoms of primary and secondary syphilis can be mild, and they might not be noticed. During the latent stage, there are no signs or symptoms. Tertiary syphilis is associated with severe medical problems. A doctor can usually diagnose tertiary syphilis with the help of multiple tests. It can affect the heart, brain, and other organs of the body. In 2019, Montgomery County reported 8.5 per 100,000 cases of primary and secondary syphilis, which is drastically lower than the Prince George’s County case rate of 18.5 per 100,000 (see Table 6).

Table 6 Cases of Syphilis Reported in Maryland (2016 – 2019)

Location	2016	2017	2018	2019
Maryland	8.5	9.5	12.2	14.3
Montgomery County	3.2	5	6.3	8.5
Prince George’s County	12.1	15.7	16.8	18.5

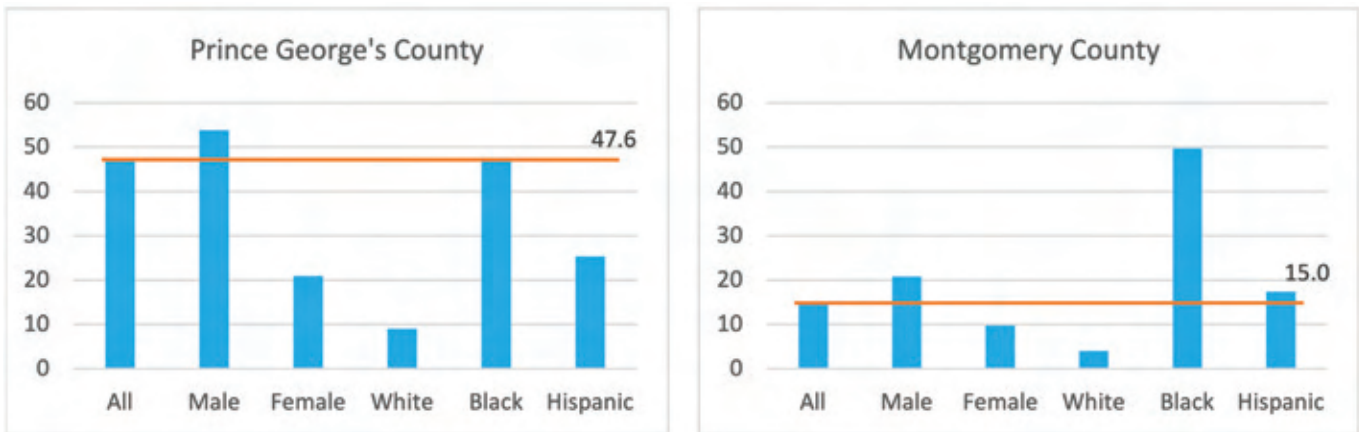
Notes. The data is from the “Cases of Selected Conditions Reported in Maryland” the Maryland’s Department of Health Prevention and Health Promotion Administration, 2021. <https://health.maryland.gov/phpa/Pages/disease-conditions-count-rates.aspx>. In the public domain.

HIV/AIDS

Human immunodeficiency virus (HIV) attacks one’s immune system by destroying CD4 cells that help in fighting off infections and diseases (CDC, 2020b). HIV infection can progressively worsen in stages until it becomes Acquired Immunodeficiency Syndrome (AIDS), the most severe phase of

HIV infection. HIV can be transmitted through sexual behaviors and needle/syringe use. HIV/AIDS affects people of all races, ethnicities, genders, and sexual orientations. However, the most at-risk population is men who have sex with men, particularly Black men who have sex with men and young people under 30. In Maryland, HIV diagnosis are down, as of 2019. When comparing the two counties, Prince George’s County has more than two times the number of new HIV cases than Montgomery County (see Figure 43) (CDC, 2021d). Prince George’s County is the highest in new HIV diagnosis in the state. Four people are diagnosed with HIV in Prince George’s County every week and two people in Maryland every day. While HIV can be controlled through treatment, to date, there is no cure (Prevention and Health Promotion Administration, 2021b).

Figure 43 HIV Diagnosis by Race & Ethnicity and Gender (2019)



Source: Centers for Disease Control and Prevention, National Center for HIV, Viral Hepatitis, STD, and TB Prevention, 2019.

INFLUENZA/PNEUMONIA

Influenza is a contagious disease caused by the influenza virus. The flu can cause severe illness and life-threatening complications particularly in older people, young children, pregnant women, and people with certain health conditions. It can lead to pneumonia and can be dangerous for people with heart or breathing conditions.

The CDC estimates that in the United States, 5% to 20% of the population on average gets the flu and more than 200,000 people are hospitalized each year. While flu seasons can vary in severity, during most seasons, people 65 years and older bear the greatest burden of severe flu disease and have the highest flu-related mortality. The seasonal influenza vaccine can prevent serious illness and death. The CDC recommends annual vaccinations to prevent the spread of influenza. According to the Maryland Vital Statistics Administration (2019a), in 2019, influenza and pneumonia were the 9th leading cause of death in the state at 11.4 deaths per 100,000. In 2019, Montgomery County’s death rate for influenza and pneumonia was 8.4 deaths per 100,000. Prince George’s County death rate was 10.3 deaths per 100,000.

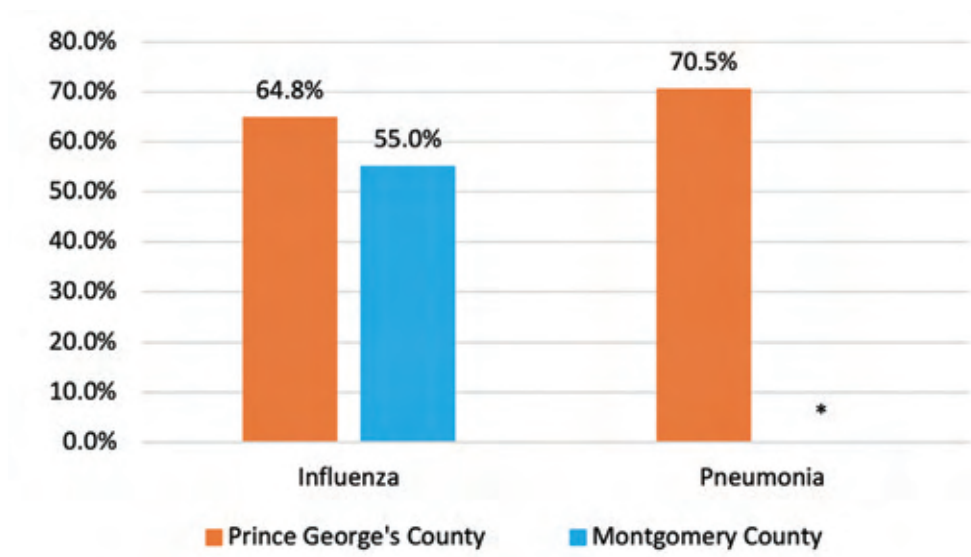
Pneumococcal pneumonia is a serious condition characterized by high fever, cough, shortness of breath, and meningitis. It is a contagious disease and can be spread by respiratory secretions from

coughing or sneezing. Pneumococcal pneumonia is the leading cause of vaccine-preventable death and illness in the United States--it kills about 1 out of every 20 people who develop the disease. The pneumococcal vaccine is very effective at preventing severe disease, hospitalization, and death. The CDC recommends the current vaccine for adults ages 65 years and older and for children ages 2 and older who are at high risk for disease.

PERCENT VACCINATED ADULTS 65+

As we age, the immune system does not respond to infections as well as it once had. Therefore, it is important for older adults to stay up to date on recommended vaccines and boosters. Influenza is an entirely preventable infection whose risk is mitigated by vaccination. In 2019, 55% of Montgomery County and 64.8% of Prince George's County residents 65+ received an influenza vaccination in the past year (see Figure 44).

Figure 44 Percent of Vaccinated Adults 65+ for Influenza and Pneumonia (2019)

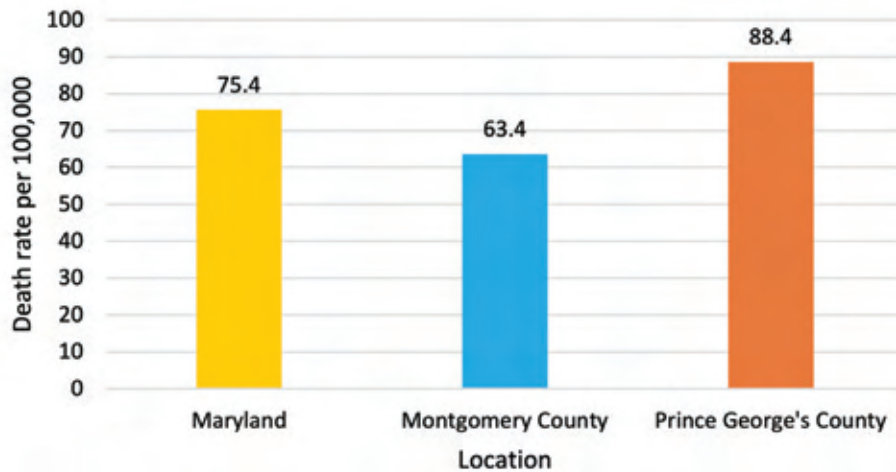


Source: Maryland Behavioral Health Risk Surveillance System, 2019.

*Insufficient or missing data.

In 2020, Prince George's County had the highest influenza and pneumonia death rate for individuals 65+ at 88.4 per 100,000 population when compared to Montgomery County (63.4) and the state of Maryland (75.4) (see Figure 45) (CDC, 2021).

Figure 45 Influenza/Pneumonia Death Rates per 100,000 for Individuals 65+ (2020)



Source: CDC WONDER Online Database, Centers for Disease Control and Prevention, 2021.

COVID-19

The first case of COVID-19 was reported on December 1, 2019, and the cause was a then-new coronavirus later named SARS-CoV-2. SARS-CoV-2 may have originated in an animal and changed (mutated) allowing it to cause illness in humans. In the past, several infectious disease outbreaks have been traced to viruses originating in birds, pigs, bats and other animals. Research continues, and more studies may reveal how and why the coronavirus evolved to cause pandemic disease. As of now, researchers know that the coronavirus is spread through droplets and virus particles released into the air when an infected person breathes, talks, laughs, sings, coughs or sneezes. Larger droplets may fall to the ground in a few seconds, but tiny infectious particles can linger in the air and accumulate in indoor places, especially where many people are gathered and there is poor ventilation. Therefore mask-wearing, hand hygiene and physical distancing are essential to preventing COVID-19.

In addition to hygiene-based prevention, immunizations are also a crucial part of the prevention process. The prioritization of immunization among seniors has risen since 2019 with the worldwide pandemic that ravaged the nation starting in early 2020. As of April 2022, 86.7% and 75.9% of Montgomery and Prince George's residents, respectively, have been fully vaccinated against the SARS-CoV-2 virus. Over 90% of adults 65+ in both Montgomery and Prince George's Counties have been fully vaccinated.

SEPSIS

Septicemia or sepsis is the body's response to infection. Sepsis is a serious and relatively common disorder and represents the leading cause of death worldwide surpassing cancer and coronary disease (Faculty of Medicine, 2020). Sepsis and septic shock can result from an infection such as pneumonia, influenza, or urinary tract infections (UTIs). According to the Sepsis Alliance (2022), one-third of people who develop sepsis die worldwide. Many who do survive are left with life-changing effects, such as post-traumatic stress disorder (PTSD), chronic pain and fatigue, organ dysfunction, and/or amputations. Although sepsis does not discriminate, those at higher risk include people with chronic conditions (such as diabetes and cancer), compromised immune systems, and pneumonia

(Johns Hopkins Medicine, n.d.). Older adults are particularly vulnerable because they often delay treatment and do not recognize the symptoms of infections. For example, urinary tract infections (UTIs) can be treated quickly and effectively with antibiotics. However, over 50% of sepsis cases among older adults are caused by a UTI because the infections go undiagnosed (Sepsis Alliance, 2021).

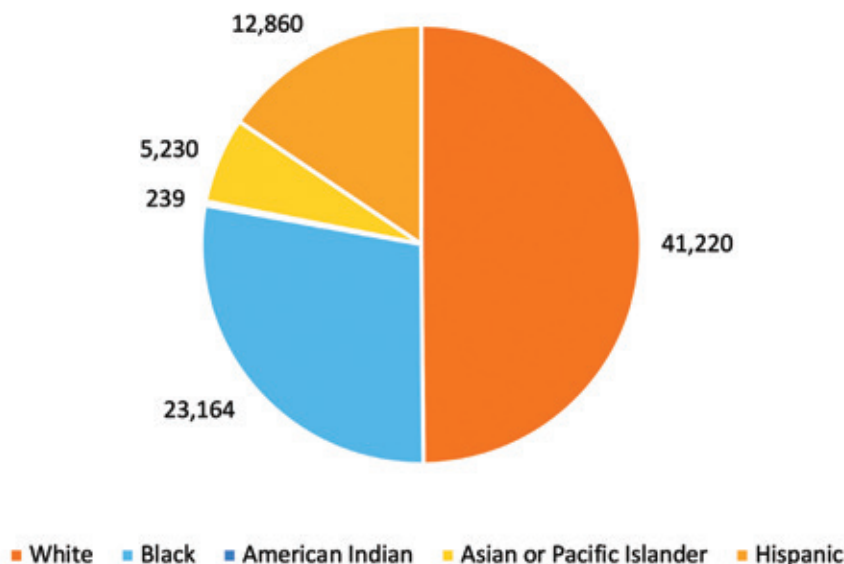
MATERNAL AND INFANT HEALTH

Improving the well-being of mothers, infants, and children is an important public health goal for the United States. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system. Pregnancy can provide an opportunity to identify existing health risks in women and to prevent future health problems for women and their children.

Maternal and infant health is an important indicator of the health and well-being of a nation. The CDC contends that the factors that affect the health of a population also typically impact the mortality rate of infants. This makes understanding infant mortality and the risk factors surrounding it especially valuable for public health research and practice. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy), prenatal (during pregnancy), and interconception (between pregnancies) care.

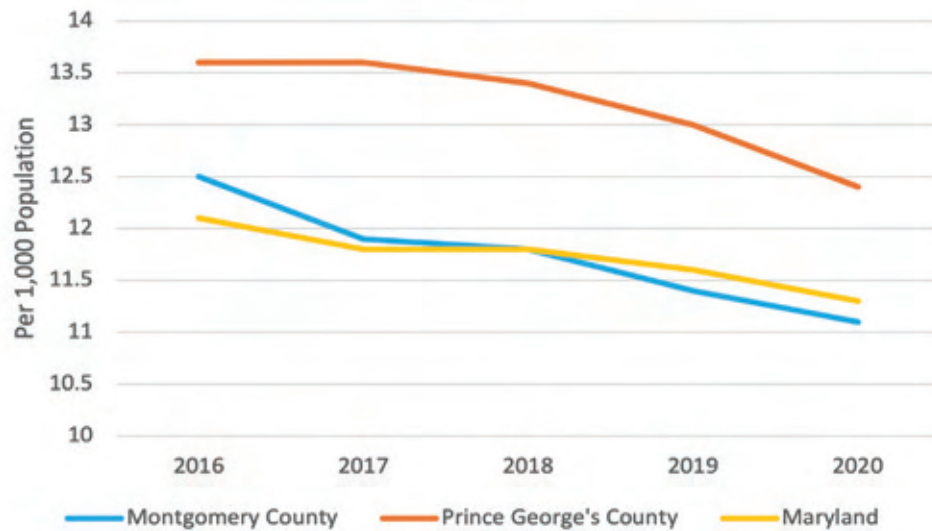
According to data from the Maryland Department of Health Vital Statistics, the birth rates at the state level have been on the decline since 2016 (see Figure 47). In 2020, Maryland had a rate of 11.3 births per 1,000 population. However, Prince George’s County birth rate of 12.4 continues to be higher than the state and Montgomery County (11.1).

Figure 46 Number of Births by Race/Ethnicity in Maryland (2019)



Maryland Department of Health Vital Statistics Administration, 2019.

Figure 47 Trends in Birth Rate by State and County (2016-2020)



Source: National Center for Health Statistics, 2022.

PRENATAL CARE

Prenatal care is a well-established determinant for the optimal health of the mother and infant and it is believed up to half of pregnancy-related infant deaths can be prevented through early prenatal care including nutrition and behavior education. Prenatal care is the most routine source of care, pregnancy education, and support for expectant parents in the United States. However, barriers to this care remain, especially for younger people, people of color, people with low incomes, linguistic minorities, and other marginalized groups.

Prenatal care is critical in ensuring healthy outcomes for all. Compared with infants born to mothers who received prenatal care, infants whose mothers did not receive prenatal care are three times more likely to have a low birth weight—defined by the World Health Organization as a weight of less than 5.5 pounds—and are five times more likely to die in infancy. Low weight and preterm birth in infants contribute to additional complications, including an increased risk of sudden infant death syndrome (SIDS), respiratory and gastrointestinal problems, and other long-term health complications. Women who do not receive prenatal care are also three to four times more likely to die from pregnancy-related complications than those who do receive care.

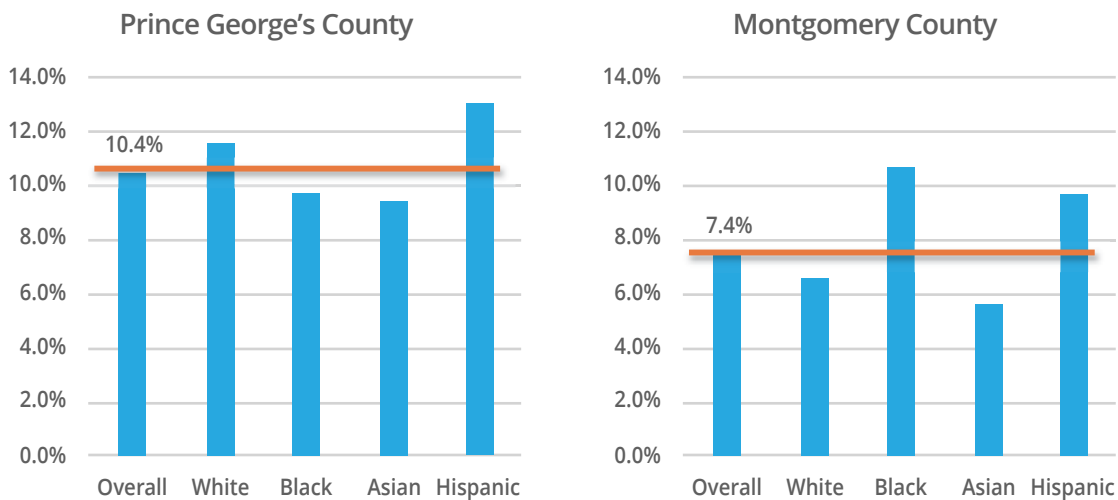
Early prenatal care (i.e., care in the first trimester of a pregnancy) allows women and their health care providers to identify and, when possible, treat or correct health problems and health-compromising behaviors. Increasing the number of women who receive prenatal care, and who do so early in their pregnancies, can improve birth outcomes and lower health care costs by reducing the likelihood of complications during pregnancy and childbirth. Healthy People 2030 has a target of 80.5% of pregnant women receiving early and adequate prenatal care; 70.2% of Montgomery County and 59.4% of Prince George's County women received care in the first trimester (Vital Statistics Administration, 2020).

Despite the importance of prenatal care for maternal and infant health, not all people receive adequate or timely care (prenatal care after the 7th month of pregnancy). In 2016, nearly 1 in 4

women in the U.S. started care late or received fewer than the medically recommended number of visits (Osterman & Martin, 2018). Health insurance plays a critical role in accessing prenatal care, and people living in states that refused the ACA's Medicaid expansion are more likely to remain uninsured and therefore struggle to access prenatal care. Nationally, the share of women receiving inadequate care is higher for women under age 20 (37%), women with less than a high school degree (37%), and women of color—including Hispanic women (29%), Black women (34%), American Indian or Alaska Native women (41%), and Native Hawaiian or other Pacific Islander women (50%). Across all races, the rate of women receiving late, or no prenatal care is higher in Prince George's County than Montgomery County and the State (see Figure 48).

Barriers to care have both structural and individual dimensions. Structural barriers include high service costs, poor transportation options to and from care settings, long wait times, a lack of childcare for other children, and unwelcoming provider attitudes. Individual dimensions include fear or distrust of medical providers and procedures, lack of health insurance, lack of social support, and mental health conditions—such as depression—that make seeking care difficult (Taylor et al., 2019).

Figure 48 Percent of women who receive late or no prenatal care

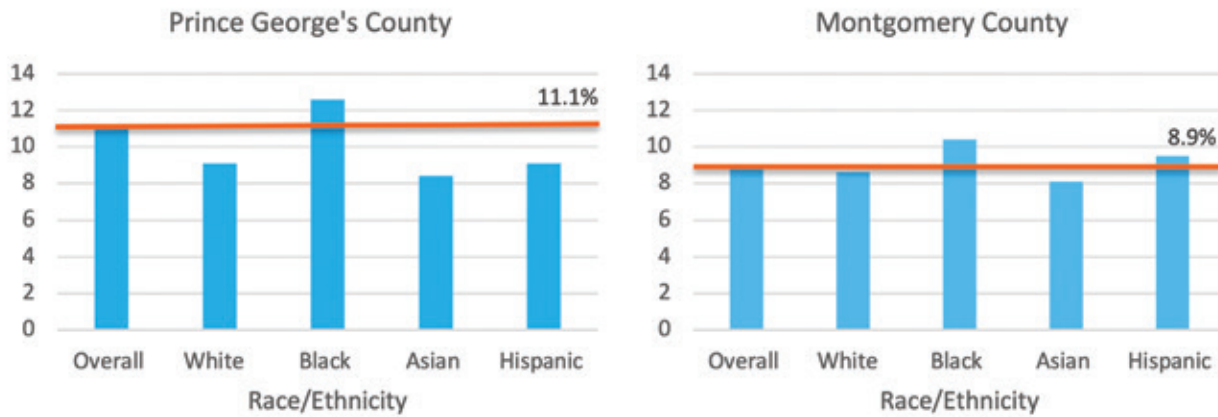


Source: Maryland Department of Health, Vital Statistics Administration, 2019.

PRETERM AND LOW BIRTH WEIGHT

Preterm birth, which refers to when an infant is born before 37 weeks of pregnancy, is a leading cause of infant mortality. These infants also have a higher risk of infections, developmental problems, and breathing problems. In 2020, the CDC estimated preterm births affected 1 of every 10 infants born in the United States. Healthy People 2030 has a target of reducing preterm births to 9.4%. In 2020, the percentage of preterm births is highest among Hispanics in Montgomery County (10.5%) and Non-Hispanic Blacks in Prince George's County (11.3%) (see Figure 49).

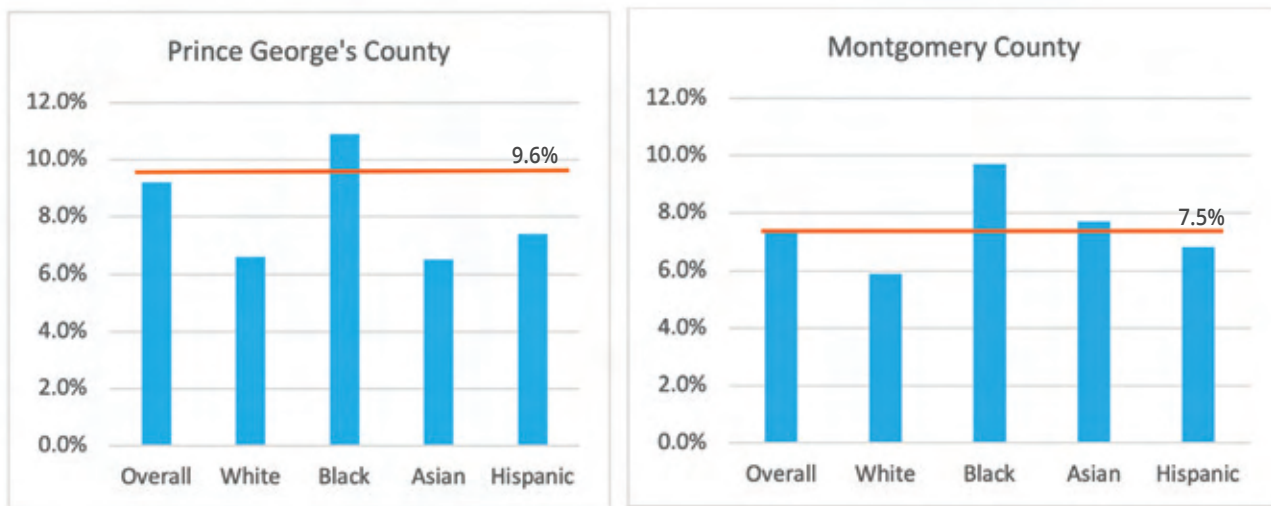
Figure 49 Percent preterm births by county and race



Source: Maryland Department of Health, Vital Statistics Administration, 2019.

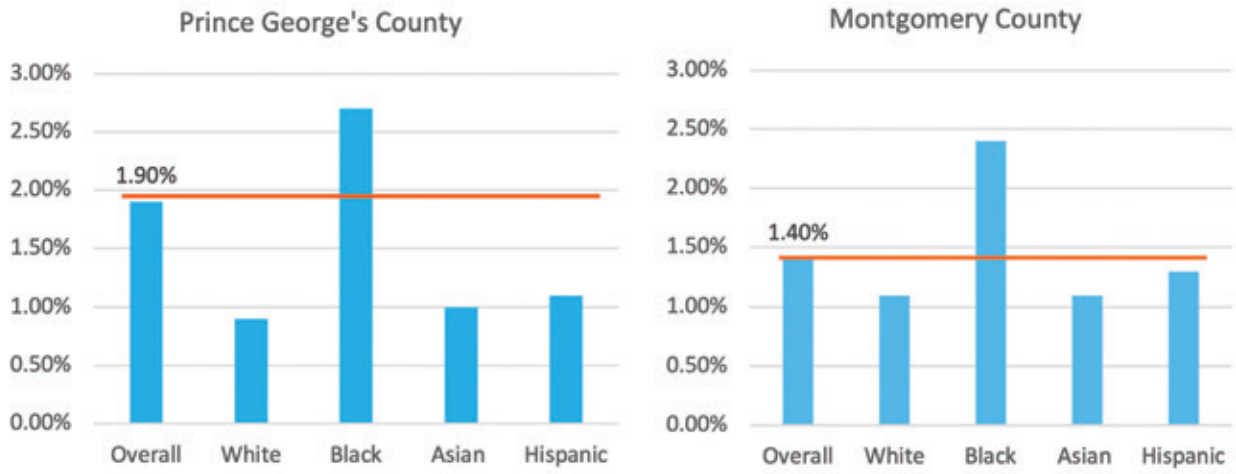
Low birthweight (less than 5 lbs. 8 oz.) or very low birthweight (less than 3 lbs. 5 oz.) is a common complication of infants who are born prematurely, and these babies are more likely than babies of normal weight to have health problems and require specialized medical care in the neonatal intensive care unit. In 2020, the CDC estimates 8.2% of all infants were born with low birthweight while 1.3% had very low birthweight. Low birth weight and very low birthweight is typically caused by premature birth and fetal growth restriction, both of which are influenced by a mother’s health and genetics. In addition to preterm delivery, maternal risk factors include chronic health conditions; infections; complications with the placenta; inadequate weight gain during pregnancy; or previously having a low birthweight baby. Lifestyle choices such as smoking, alcohol, street drugs and abusing prescriptions are also associated with low birthweight. Low birthweight babies are more likely to suffer short-term effects including respiratory distress syndrome or bleeding in the brain and are also more likely to develop diabetes, high blood pressure, metabolic syndrome or obesity later in life. Across both counties and the state of Maryland, Black babies have the highest percentage of low and very low birth weight when compared to any other race and ethnicity (see Figures 50 and 51).

Figure 50 Percent of Babies born with Low Birth Weight by Race/Ethnicity



Source: Maryland Department of Health Vital Statistics Administration, 2019.

Figure 51 Percent of babies born with Very Low Birth Weight by Race



Source: Maryland Department of Health Vital Statistics Administration, 2019.



SECTION 3.

SOCIOECONOMIC & PHYSICAL ENVIRONMENT

Social and economic factors, such as income, education, employment, community safety, and social supports can significantly affect how well and how long we live. These factors affect our ability to make healthy choices, afford medical care and housing, manage stress, and more. For example, employment provides income that shapes choices about housing, education, childcare, food, medical care, and more. In contrast, unemployment limits these choices and the ability to accumulate savings and assets that can help cushion in times of economic distress. Social and economic factors are not commonly considered when it comes to health; yet strategies to improve these factors can have an even greater impact on health over time than those traditionally associated with health improvement.

Across the nation, there are meaningful differences in social and economic opportunities for residents in communities that have been cut off from investments or have experienced discrimination. These gaps disproportionately affect people of color – especially children and youth (CHR&R, 2022). Per County Health Rankings & Roadmap, the physical environment is where individuals live, learn, work, and play. People interact with their physical environment through the air they breathe, water they drink, houses they live in, and the transportation they access to travel to work and school. Poor physical environment can affect our ability and that of our families and neighbors to live long and healthy lives. Clean air and safe water are necessary for good health. Air pollution is associated with increased asthma rates and lung diseases, and an increase in the risk of premature death from heart or lung disease. Water contaminated with chemicals, pesticides, or other contaminants can lead to illness, infection, and increased risks of cancer. Stable, affordable housing can provide a safe environment for families to live, learn, grow, and form social bonds. However, housing is often the single largest expense for a family and when too much of a paycheck goes to paying the rent or mortgage, this housing cost burden can force people to choose among paying for other essentials such as utilities, food, transportation, or medical care.

Our collective health and well-being depend on opportunity for everyone. Yet, across and within counties there are stark differences in the opportunities to live in safe, affordable homes, especially for people with low incomes and people of color. These differences emerge from discrimination and institutional racism in the form of long-standing, deep-rooted, and unfair systems, policies, and practices such as redlining, restrictive zoning rules, and predatory bank lending practices that reinforce residential segregation and barriers to opportunity. It is important to dig into the data to understand how factors related to the physical environment are playing out in Montgomery and Prince George's County.

EDUCATION

Education gives people the tools they need to lead fulfilling lives, thrive personally, and contribute to their communities. In addition, education makes it more likely a person can access quality health care, find employment that pays a living wage, and live in a safe, non-polluted environment — all factors that affect well-being. In fact, people who live in lower socioeconomic conditions are at greater risk for a host of health issues, including higher rates of disease, mental illness, and premature death. Access to quality education early in life, high school graduation, and a college education can all provide opportunities for people to shift their socioeconomic status, reducing the likelihood of these negative health outcomes in return. Because of this, understanding how education impacts the health of communities is vital for public health professionals fighting to end health inequity.

People who have access to quality education throughout their lives tend to stay healthier than people who don't. Not only does education give individuals a chance at upward mobility, which places them in better financial circumstances to access quality health care, it also keeps them better informed about how to take care of their health. For example, an individual with a college degree

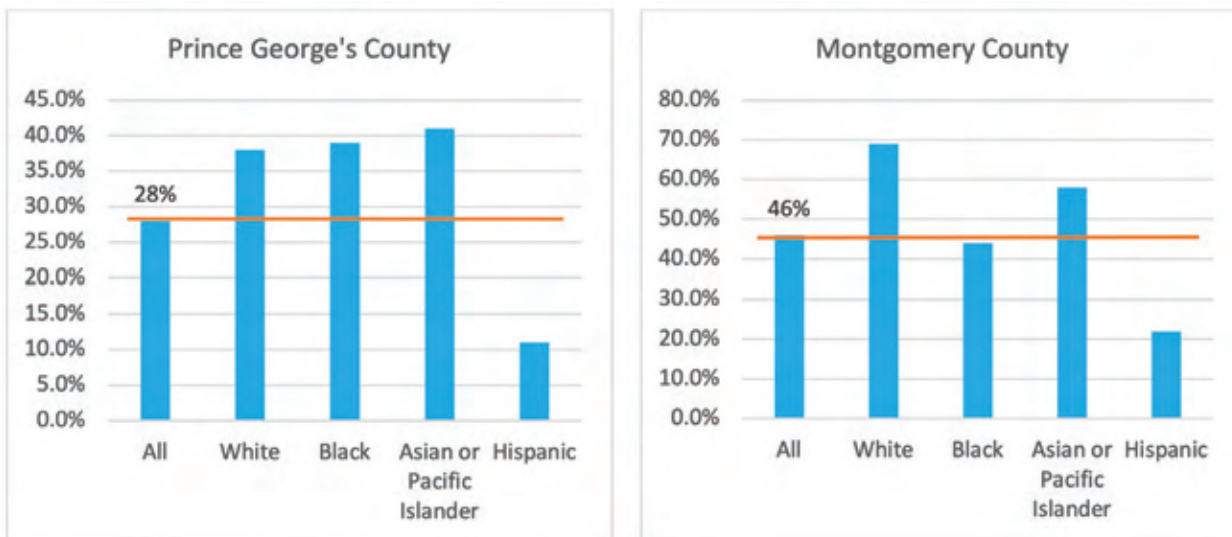
may have better skills to evaluate conflicting or complex information they read on the internet about how to care for their prediabetes. In addition, someone with less formal education may be less prepared to decide between reliable and unreliable information.

Less education is linked to lower income, which is linked to poorer health. Numerous studies show that people in lower socioeconomic situations experience more obesity, asthma, diabetes, heart disease and other health problems than people in better financial circumstances. Additionally, a recent study also shows higher education helps individuals secure higher paying work with fewer safety risks. Ultimately, more highly educated people have greater economic resources to afford things like better housing far away from environmental toxins and expert doctors trained in the most effective techniques.

KINDERGARTEN READINESS

Kindergarten readiness is strongly linked to later school success, which is predictive of adult health. Full readiness to learn is defined as consistently demonstrating skills, knowledge, and behaviors which are needed to successfully engage in the kindergarten curriculum. For the 2021-2022 school year in Maryland, Montgomery County had the highest rates of students entering kindergarten ready to learn with 46%. Prince George’s County had the lowest rate with 28% (see Figure 52). In Maryland students identifying as White and Asian had the highest rates of readiness. In Montgomery County, students identifying as White and two or more races had the highest rates of readiness. In Prince George’s County, students identifying as two or more races and Asian had the highest rates of readiness.

Figure 52 Percent of Kindergarten Students Demonstrating Readiness (2020-2021)



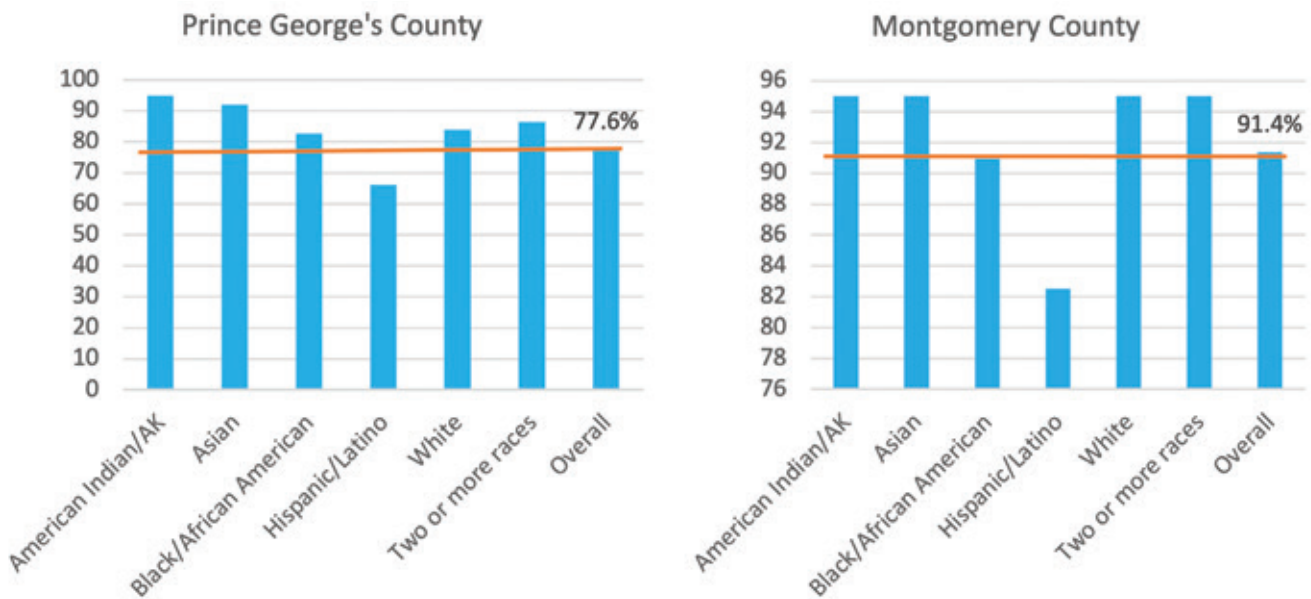
Source: Maryland State Department of Education, 2022.

HIGH SCHOOL GRADUATION

Individuals who do not finish high school are more likely than people who finish high school to lack the basic skills required to function in an increasingly complicated job market and society. Adults with limited education levels are more likely to be unemployed, on government assistance,

or involved in crime (Healthy Communities Institute, 2019). In 2021, Montgomery County's 4-year high school graduation rate was 91.4%, which is higher than the state of Maryland (87.2%) and Prince George's County (77.6%) (see Figure 43). The Healthy People 2030 national health target is to increase the proportion of high school students who graduate in 4 years to 90.7%. Asian students in Maryland and Montgomery County had the highest graduation rates. In Prince George's County, students who identify as American Indian/Alaska Native had the highest graduation rate, followed by Asian students. Hispanic/Latino students had the lowest graduation rate across both jurisdictions.

Figure 53 Percent of 4-Year High School Graduation Rate (2021)



Source: Maryland Department of Education, 2021.

Graduating high school is an important personal achievement and is essential for an individual's social and economic advancement. According to the Office of Disease Prevention and Health Promotion, high school graduation leads to lower rates of health problems as well as risk for incarceration.

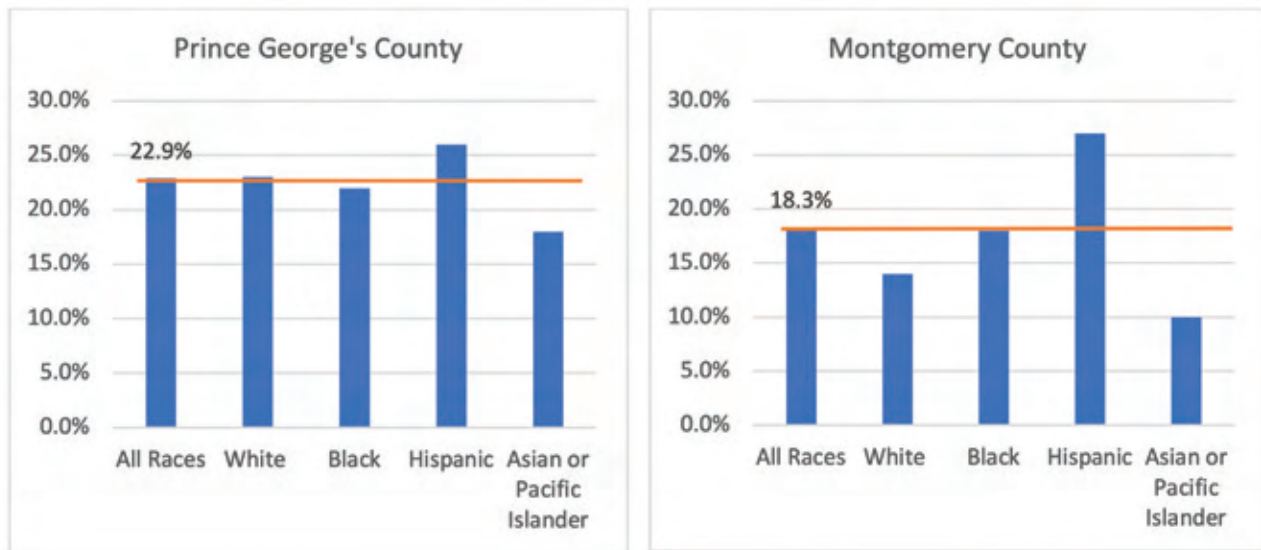
In 2015-2019 the population of people 25 years old and over with no high school diploma varied in both counties, with about 9% of the population in Montgomery County and more than 13% of the population in Prince George's County. Altogether, the MCHC CHNA area has a low percentage at 11.29% compared to 12% nationally, but higher than the state rate of 9.80% (United States Census Bureau, n.d).

The 2021 Maryland State Report Card reports the percent of youth dropouts in Montgomery County was 4.47%. Prince George’s County’s percentage of youth dropouts was 15.36% in 2021. When comparing the two counties, Prince George’s County has the highest rate of youth dropouts at 5.20%.

CHRONIC ABSENTEEISM

Chronic absence (missing 15 or more school days) can jeopardize students’ academic proficiency, social engagement, and opportunities for long-term success. Compared to the national rate of 15.9%, the MCHC CBSA area chronic absence rate was 19.0% for the 2017-2018 school year (U.S. Department of Education, n.d.). Prince George’s County chronic absenteeism rate was 22.9% compared to Montgomery County at 18.3% (see Figure 54).

Figure 54 Percent of Students Absent 15 or more School Days (2017-2018)

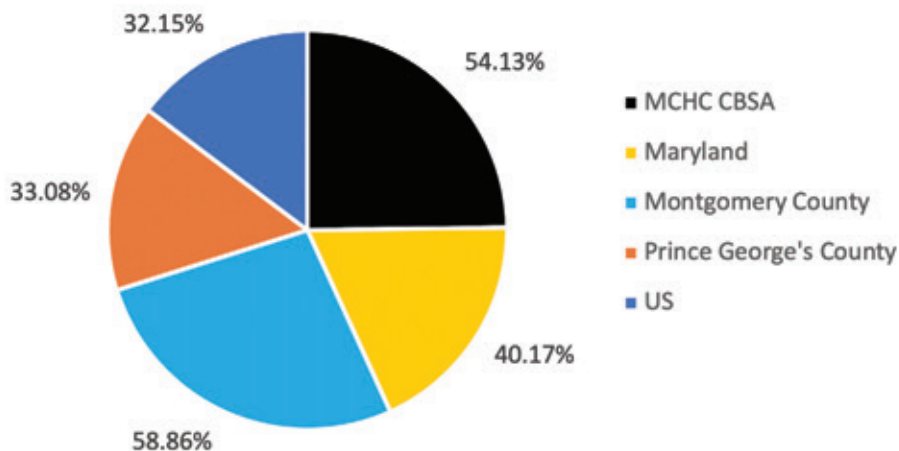


Source: U.S. Department of Education, n.d.

COLLEGE

Montgomery County and Prince George’s County enjoy relatively high education levels. More than half of Montgomery County residents hold a bachelor’s degree or higher, and a little more than 30% of Prince George’s County residents hold a bachelor’s degree or higher. Altogether, more than 54% of residents in the MCHC CBSA area had a bachelor’s degree or higher (see Figure 55).

Figure 55 Percent of Residents Age 25+ with Bachelor's Degree or Higher (2015-2019)

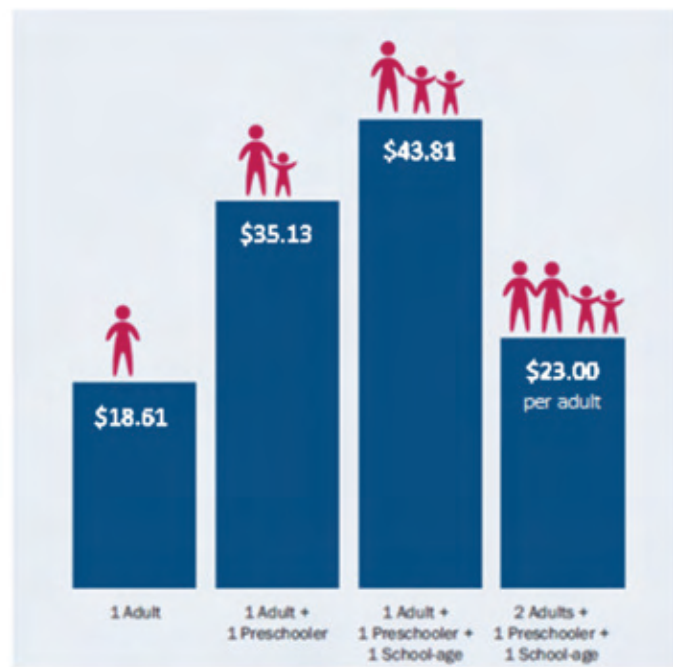


Source: US Census Bureau, American Community Survey, 2015-19.

INCOME

Montgomery County is an affluent community in aggregate. The median household income is \$111,812 compared to the statewide median household income of \$87,063. However, 45% of households earn less than \$100,000 in a community where the self-sufficiency standard for a family of four (income needed to meet basic needs without public subsidies or private/informal assistance) requires an annual income of \$99,756. A single parent with one infant would need to make \$77,215, and one adult living in Montgomery County would need to make \$39,303—or \$18.61 per hour, \$3.61 more than the Minimum Wage of \$15.65 per hour (see Figure 56). In Prince George’s County, the median household income is \$86,994, slightly lower than the state, and 40.4% of households earn less than \$75,000 in a community with a self-sufficiency standard of \$79,712 for a family of four. A single parent with one infant would need to make \$62,890, and one adult would need to make \$34,458—or \$16.32 per hour (University of Washington Center for Women’s Welfare, 2019).

Figure 56 Hourly Wage to be Self-Sufficient in Montgomery County by Family Type



Source: Self-Sufficiency Standard Montgomery County, Maryland

UNEMPLOYMENT

Another key indicator of the local economy is the unemployment rate. Unemployment occurs when local businesses cannot supply enough jobs for local employees or when the labor force cannot supply appropriate skills to employers (Healthy Communities Institute, 2019). During periods of unemployment, individuals are likely to experience severe economic strain and mental stress. Unemployment is also related to access to health care, as many individuals receive health insurance through their employer. A high unemployment rate strains financial support systems as unemployed persons qualify for unemployment benefits and food stamp programs. Due to the availability of jobs at many federal agencies and contractors, Montgomery and Prince George's Counties generally enjoy low unemployment compared to the U.S. Although, the unemployment rates of both counties have been steadily declining since 2011. The global pandemic and its effect on businesses caused a rise in the unemployment rates in both counties. Montgomery County's rate went from 2.9% in 2019 to 6.2% in 2020, and 5.5% in 2021. In Prince George's County, the rate rose from 3.7% in 2019 to 8.0% in 2020, and 7.5% in 2021 (State of Maryland, 2022). In February 2022 the unemployment rate was 4.2% within the MCHC CBSA, 3.9% in Montgomery County, 5.3% in Prince George's County, and 4.4% for the state (U.S. Bureau of Labor Statistics, 2022); showing improvement from what was reported in previous years. However, these figures do not account for people who have stopped looking for employment.

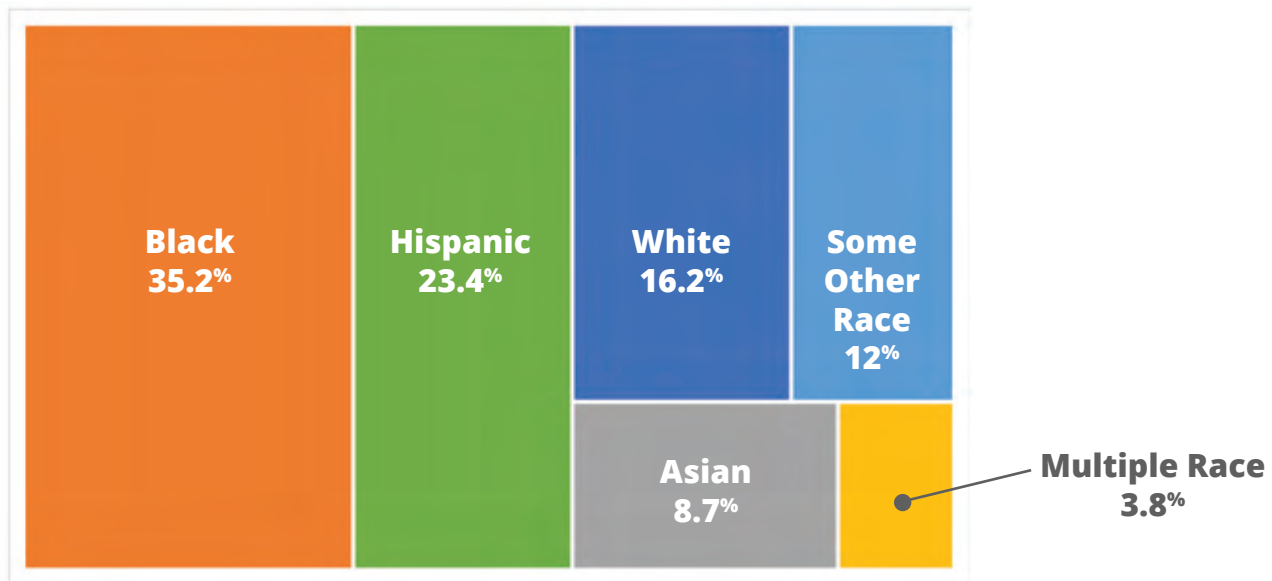
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

According to the Center on Budget and Policy, in 2019, one in nine people in the U.S. have used the Supplemental Nutrition Assistance Program (SNAP or food stamps), the nation's largest nutrition assistance program. SNAP recipients receive funds monthly, which are loaded on an electronic benefit transfer card that they can use to purchase food and beverages from participating retailers. SNAP benefits vary depending on the need of the participant, but the average Maryland SNAP benefit for each member of a household was \$128 per month in fiscal year 2019 (or \$1.29 per meal per person). In Maryland, 10% of the state's population receive SNAP benefits, with more than 62% of SNAP participants being families with children, almost 38% are families with members who are elderly or disabled, and more than 34% are in working families (Hall & Nchako, 2022).

SNAP has been proven effective in helping low-income households buy food, reducing food insecurity by 30%, reducing child poverty by 28%, and creating economic activity (every \$1 in SNAP, generates \$1.80 in economic growth), and reducing health care costs. However, the program is underutilized due to stigma, immigration fears, lack of information/misinformation about eligibility, lack of knowledge about how to apply, lengthy application process, frequent recertification requirements, and low benefit amount.

In the Joint CHNA service area, an estimated 29,164 (6.7%) households receive SNAP benefits, with Black or African Americans and Hispanic/Latino households making up the highest populations to receive SNAP benefits (see Figure 57).

Figure 57 Households Receiving SNAP Benefits by Race/Ethnicity by MCHC CBSA, Total



Notes: U.S. Census Bureau, American Community Survey Office, 2020.

Underutilization is not only limited to SNAP use. The Capital Area Food Bank Hunger Report 2021 also notes that food insecure individuals exhibited low engagement with public benefits and social services. Of the nearly 2,000 Greater Washington Area residents surveyed, only 23% of local households that the United States Department of Agriculture (USDA) would classify as food insecure receive SNAP, and 15% receive free and reduced-price school meals. These numbers shift from state to state in the region, with DC households reporting the highest rates of SNAP enrollment. Nearly 1 in 5 households surveyed are not receiving any government benefits, with the highest reasons being they do not believe themselves to be eligible, not being aware of food assistance programs; and not understanding the application process.

A closer look at local government benefits utilization patterns shows higher utilization rates in Black and White households compared to Asian and Hispanic households. One potential reason for this trend is the higher percentage of immigrants in Asian and Hispanic households, who may either not qualify for these programs or experience barriers of risk, low trust, or low awareness of government agencies. When considering the fast growth rates among Asian and Latino populations, these trends of low utilization strongly suggest prioritizing support and outreach to these groups. It is estimated that 28% of Montgomery County residents and 34% of Prince George’s County residents are food insecure and ineligible for state or federal nutrition assistance (Feeding America, 2017).

Nationally, about 4.8 million older adults (aged 60+) are enrolled in SNAP. Yet this figure represents less than half of the eligible population; approximately three out of five seniors who qualify to receive SNAP are missing out on benefits—an estimated 5 million people in all (McGovern, 2021). Older adults may not be aware that they are eligible, or may feel stigma about receiving food assistance, putting this group at increased risk of food insecurity, and having harmful impacts on their health and well-being.

The Benefits Data Trust 2017 study examined the association between both hospital and nursing home utilization. Researchers studied 54,000 Maryland seniors on Medicaid and Medicare (dual eligible). Individual-level medical claims data was cross-matched against the SNAP enrollment data and used to analyze the impact of receiving the benefit on health care utilization and costs. The study found that:

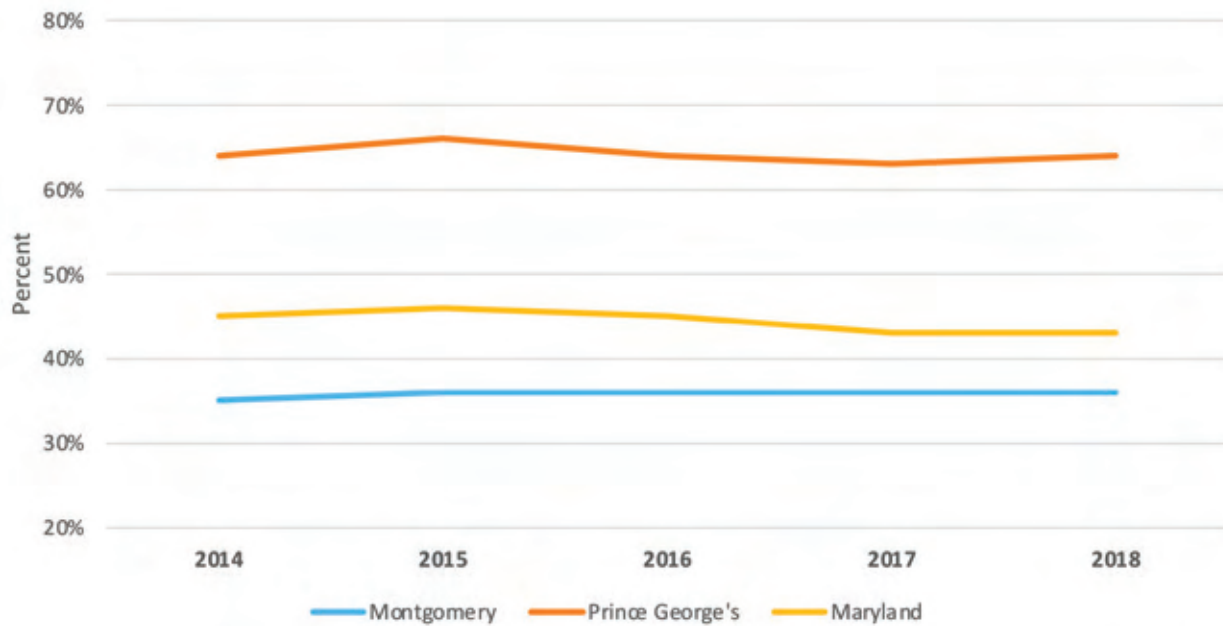
- Although they qualify, 49 percent of seniors on Medicaid are not enrolled in SNAP.
- The average annual income for an older dual eligible was just \$5,860.
- Access to SNAP reduces a senior’s likelihood of admission into a hospital by 14% and a nursing home by 23%.
- Every \$10 increase in monthly SNAP benefits further reduced the odds of additional days in the hospital and shortened nursing home length of stay.
- Increased access to SNAP delivers \$2,100 in annual health care savings per senior enrolled.

CHILDREN ELIGIBLE FOR FREE AND REDUCED MEAL PROGRAMS (FARMS)

Federal child nutrition programs—including the National School Lunch Program, the School Breakfast Program, and the summer meals programs—together form the nation’s second-largest nutrition-assistance effort. These programs ensure that millions of American schoolchildren are eating healthy meals on a regular basis. The child nutrition programs are federally funded and operate in public and private schools, daycare centers, after-school programs, and residential child-care centers. Even when schools closed due to the pandemic nationwide, the School Lunch Program alone served 3.2 billion meals in FY 2020, with an average of 22.4 million children participating in the program. For millions of children, child nutrition programs help address food insecurity, an important social determinant of health. With school closures limiting access to these programs, many families were at increased risk of lacking consistent access to nutritious food.

The number of children and youth eligible for free/reduced-price meals at public schools typically reflects the income and poverty levels of the surrounding neighborhoods, with nearly 47% of all Maryland students receiving free and reduced school meals. In Montgomery County during the 2021-2022 school year, 51,944 students received free lunch and 11,020 students received reduced-price lunch. Nearly 40% of the county’s student population is enrolled in the free/reduced-price meal program. In Prince George’s County, 71,151 students are enrolled in free lunch and 8,436 students are enrolled in reduced-price lunch. Nearly 67% of the county’s student population is enrolled in free/reduced-price lunch. The percentage of Montgomery County students receiving free and reduced meals has been historically lower than the state average, conversely, the percentage of Prince George’s County students has remained higher than the state average (see Figure 58).

Figure 58 Percent of Students Receiving Free & Reduced School Meals (2014-2018)



Source: Maryland Center on Economic Progress.

HOUSING AND TRANSIT

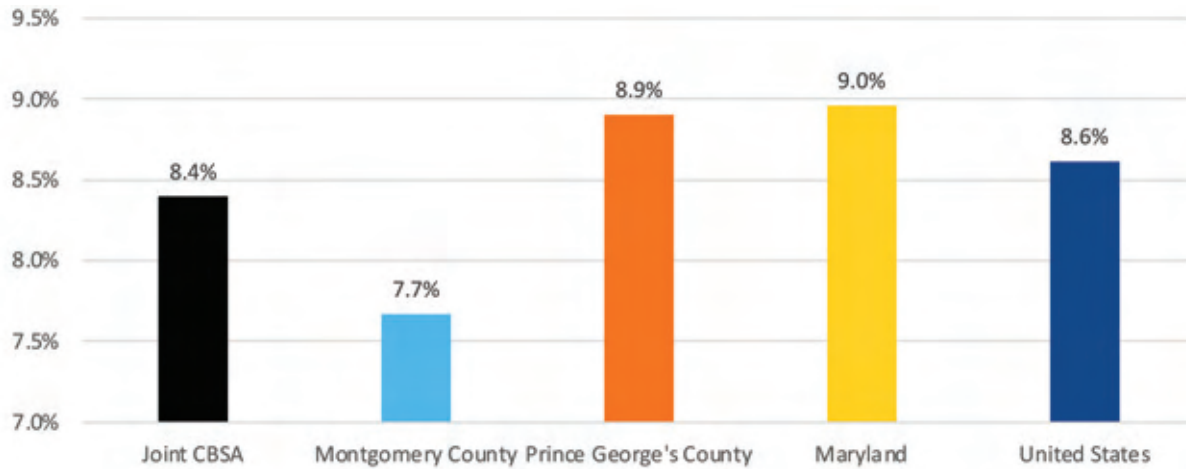
TRANSPORTATION

Transportation plays an integral part in accessing health care and other resources that promote healthy living, such as parks and recreation facilities; Therefore, barriers to transportation limits this access and can have a negative effect on health. Montgomery and Prince George's Counties have a vast network of public transportation options that range from metro rail, bus and train transport, including subsidized services for seniors and people with disabilities. However, ridership dictates the number and location of stops, leaving many residents in less populated areas with limited access to county services and resources. A lack of reliable and safe transportation remains a burden for many residents in Montgomery and Prince George's Counties, especially for seniors, people with disabilities, and people of limited income. Transportation burdens include the need to travel long distances, lack of vehicle, transportation costs, and inadequate infrastructure. A lack of transportation also causes barriers in accessing medical health appointments, obtaining routine care as well as filling prescriptions.

Since vehicle ownership is directly related to the ability to travel, it creates a disparity between vehicle owners and those who do not own their own vehicles. In general, people living in a household without a vehicle make fewer than half the number of needed trips compared to those with a vehicle. This limits their access to essential local services such as supermarkets, post offices, doctors' offices, and hospitals. Most households with above-average incomes own a vehicle while only half of low-income households own a vehicle. According to the 2015-2019 American

Community Survey, 9.0% of Maryland residents reported not having a motor vehicle. On a county level, 7.7% of residents in Montgomery County and 8.9% of residents in Prince George’s County do not have access to a motor vehicle and must rely on public transportation or walking in high traffic areas (see Figure 59).

Figure 59 Percent of Households with No Motor Vehicle (2015-2019)



Source: American Community Survey 2015-2019, US. Census.

However, transportation programming that does exist has income or geographic requirements or are available to older adults or those with a disability. Some examples of transportation resources in Montgomery and Prince George’s counties include county government resources such as Call-N-Ride, Same-Day Access, Ride on Programs as well as MetroAccess, a reduced fare program specific to the Washington Metropolitan Area. In addition, there are services offered by nonprofit organizations such as Villages, Village Rides, Connect-A-Ride, and Senior Rides. However, there remains a gap for reliable transportation services to youth, young adults, adults with children as well as working adults.

Those with access to public transit may take up to twice as long to reach the destination than it would with access to a private vehicle, with trips taking longer in areas with infrequent transit service. In some cases, the time it takes to get to and from the transit stop can exceed the overall expected trip time. The extra planning time, and time constraints can serve as an added barrier to those needing to utilize public transportation. In the MCHC CBSA, 15.3% of the population uses public transit to commute to work.

HOUSING

The home environment, which consists of living conditions and surrounding neighborhoods, has an impact on health status. Substandard neighborhoods and living conditions such as overcrowding, have been linked to poor health outcomes and can lead to an increased risk of cardiovascular disease, mental health issues, and unfavorable birth outcomes. Unfortunately, in many communities, there are persistent barriers to health and opportunity to thrive. Where one

lives can determine how long or how well one lives, and those in substandard neighborhoods lack access to healthy foods, quality schools, stable housing, good jobs with fair pay, and safe places to exercise and play.

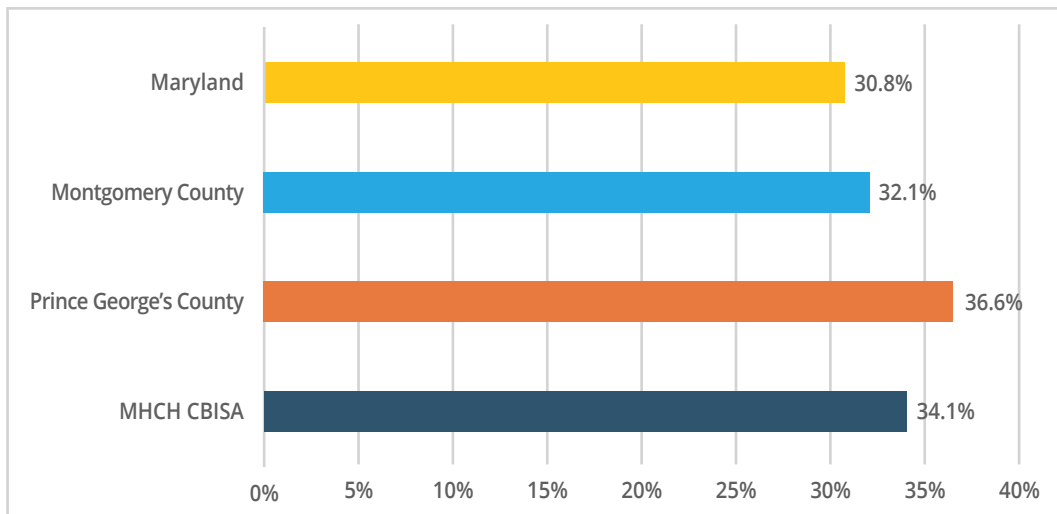
Quality housing is an important determinant to overall health and wellbeing. However, many individuals experience several housing issues such as a high-cost burden, one or more substandard living conditions as well as overcrowding which furthers the risk of other health challenges. The high cost of living affects residents' access to safe, healthy housing. Paying a high rent can create a financial hardship, especially for those with a limited income, leaving little money for other expenses such as food, transportation, medical services and savings. A housing cost burden is defined as the percentage of households (homeowners and renters) where housing costs are 30% or more of the total household income.

Collectively in the MCHC CBSA, which encompasses 435,433 total households, 146,834 or 33.7% of the population live in a cost burdened home (US Census Bureau, n.d.). Most recently, 31.4% of Maryland residents experience high housing costs, however, in Montgomery County, 32.1% of people live in homes that exceed 30% of income, while 36.7% of Prince George's County residents experience a housing cost burden (see Figure 60). The Healthy People 2030 national health target is to reduce the proportion of families that spend more than 30% of income on housing to 25.5%.

SEVERE HOUSING COST BURDEN

Spending a high percentage of household income on housing can create financial hardship, especially for lower-income homeowners. With a limited income, high monthly housing costs may not leave enough money for other expenses, such as food, transportation and medical care. Moreover, high housing costs reduce the proportion of income a household can allocate to savings each month. The income needed to afford fair market rent, which is defined as the 40th percentile of rent paid by recent residents within the last two years, is another contributing factor to cost burden. Maryland is calculated to have the 8th highest rent in the country with Montgomery and Prince George's Counties exceeding the Maryland average income to afford fair market rent (RentData, 2022). In 2022, yearly income for both Montgomery and Prince George's Counties for a studio apartment is \$18,468 for a studio costing on average \$1,539 and \$18,804 a year for a one-bedroom apartment with a monthly rent of about \$1,567. For a two-bedroom apartment with an average rent of \$1785, the projected yearly income needed is \$21,420. A yearly income of \$27,120 is needed to afford a 3-bedroom apartment with an average monthly rent of \$2,260.

Figure 60 Housing Cost Burden 30% (2015-2019)



Source: American Community Survey, US Census Bureau, 2022.

SEVERE HOUSING PROBLEMS/SUBSTANDARD HOUSING

Housing units where the quality of living or housing conditions are considered substandard is another challenge that can contribute to poor health outcomes. This can include households with at least 1 of the 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. Residents who do not have a complete kitchen (a sink with a faucet, a stove or range, or a refrigerator) in their home are more likely to depend on unhealthy convenience foods. A lack of plumbing facilities, such as hot and cold running water, a flush toilet, or a bathtub or shower, increases the risk of infectious disease. Research has found that young children who live in crowded housing conditions are at increased risk of food insecurity, which may impede their academic performance. In areas where housing costs are high, low-income residents may be forced into substandard living conditions with an increased exposure to mold and mildew growth, pest infestation, and lead or other environmental hazards.

According to the American Community Survey (2015-2019), Maryland has 31.5% of housing units that have one or more substandard conditions (US Census Bureau, n.d.). In the MCHC CBSA, 34.7% of housing units meet the criteria for substandard housing (32.5% in Montgomery County and 37.8% in Prince George's County).

Overcrowding, or units with more than one occupant per room, goes hand-in-hand with low-paying essential jobs. People forced by poverty into overcrowded homes are much more likely to be people of color, due to historic patterns of discriminatory housing, education and banking policies that segregated neighborhoods and made it more difficult for Non-White families to amass wealth.

Overcrowding has been associated with increased communicable disease transmission and increased accidents. In the age of COVID-19, people of color also are more likely to live in overcrowded households and suffer chronic conditions, such as diabetes or high blood pressure, that can worsen COVID-19 outcomes. The average household size is measured by dividing the

number of persons in households by the number of households. Collectively in Maryland, there are on average 2.67 members living in one household. However, there is a slightly higher average in Montgomery County with 2.76 people per household and 2.86 average household size in Prince George's County. In the MCHC CBSA, 7.5% of housing units are overcrowded. In Prince George's County, 22% of housing units are considered overcrowded, compared to 5.4% of housing units in Montgomery County (US Census Bureau, n.d.).

BROADBAND ACCESS

The 21st century has placed an ever-increasing reliance on internet access. The County Health Rankings & Roadmaps measures broadband access as the percentage of households with broadband internet connection. This indicator is important because access to reliable, high-speed broadband internet improves access to education, employment, and health care opportunities and is associated with increased economic development.

Researchers at the University of Chicago found that one of the factors most consistently associated with a high risk of death due to COVID-19 in the U.S. was the lack of internet access, whether broadband, dial-up, or cellular (Paykin, Halpern, Martinez-Cardoso, & Kolak, 2022). This was regardless of other demographic risk factors like socioeconomic status, education, age, disability, rent burden, health insurance coverage, or immigration status. The study authors estimated that for every additional 1 percent of residents in a county who have internet access, between 2.4 and six deaths per 100,000 people could be prevented, depending on the makeup of the region. The findings held more surprises. The trend held true not just in rural areas with sparse internet access, but also in urban areas, where most homes can be wired for broadband internet. That is, residents living in areas where internet access is available, but unable to be accessed, are also at increased risk of dying from COVID-19. The COVID-19 pandemic has revealed that the ability to get online might be a matter of life or death.

More than a quarter of Americans still don't have home broadband internet, and the proportion without access is twice as high for those without any college education and those who earn less than \$30,000 a year. These inequities were not created by chance. In the U.S., private internet service providers developed the infrastructure for broadband internet access where it was profitable. Consequently, many of the country's most marginalized communities have the fewest, most expensive, and lowest-quality choices when it comes to an internet service provider. Having broadband internet access means having access to education and financial stability, which on their own contribute to our well-being. Broadband internet performs as a gateway to information and services, and the Federal Communications Commission (FCC) is now framing broadband internet access as a "super" determinant of health. In December of 2020, the FCC reported that broadband access has remained extremely high in Montgomery County (99%) and Prince George's County (97.7%), including the MCHC CBSA (99.3%).



SECTION 4.

HEALTH BEHAVIORS

The County Health Rankings & Roadmaps states that health behaviors are actions individuals take that affect their health. They include actions that lead to improved health, such as eating well and being physically active, and actions that increase one's risk of disease, such as tobacco use, excessive alcohol intake, and risky sexual behavior.

Many of the leading causes of death and disease are attributed to unhealthy behaviors. For example, poor nutrition and low levels of physical activity are associated with higher risk of cardiovascular disease, type 2 diabetes, and obesity. Tobacco use is associated with heart disease, cancer, and poor pregnancy outcomes if the mother smokes during pregnancy. Excessive alcohol use is associated with injuries, certain types of cancers, and cirrhosis.

It is important to consider that not everyone has the means and opportunity to make healthy decisions. Policies and programs put in place have marginalized some population groups and communities, keeping them from the support and resources necessary to thrive. Addressing health behaviors requires strategies to encourage individuals to engage in healthy behaviors, as well as ensuring that they can access nutritious foods, safe spaces to be physically active, and support to make healthy choices.

TOBACCO USE

Tobacco use is the leading cause of preventable death and disease in the United States, killing more than 480,000 people each year. Nearly 40 million U.S. adults smoke cigarettes, and about 4.7 million middle and high school students use at least one type of tobacco product, e-cigarettes included. Almost 30% of all cancer deaths in the United States are linked to smoking.

Approximately 90% and 80% of lung cancer deaths among men and women, respectively, are due to smoking. Lung and bronchus cancers are the leading causes of cancer deaths in Maryland among both men and women. Maryland's Black or African American adults die from lung and bronchus cancer at the same rates as White adults even though they have lower smoking rates. This difference may be attributed to high menthol cigarette use and limited access to care in African American communities (Mattingly et al, n.d.).

The Healthy People 2030 national health target is to reduce current cigarette smoking in adults to 5.0%. In addition to the direct damage to health, tobacco use also causes a major financial burden on the nation. Smoking costs the U.S. billions each year, with the total annual economic cost of smoking being more than \$300 billion, including more than \$225 billion in direct medical care for adults, and more than \$156 billion in lost productivity due to premature death and exposure to secondhand smoke (U.S. Department of Health and Human Services, 2014).

Both Montgomery and Prince George's Counties have lower rates of tobacco use when compared to the state and national rates. About 9% of Montgomery County adults and more than 13% of Prince George's County adults report smoking at least 100 cigarettes in a lifetime and are current smokers.

Per the CDC, cigarette smoking is responsible for more than 480,000 deaths per year in the United States, including more than 41,000 deaths resulting from secondhand smoke exposure. This is about one in five deaths annually, or 1,300 deaths every day.

YOUTH SMOKING

The CDC estimates that 9 out of 10 adults who smoke cigarettes daily first try smoking by the age of 18, and 99% first try by age 26. Each day in the U.S., about 1,600 youth smoke their first cigarette and nearly 200 youth become regular, daily smokers. If smoking among U.S. youth continues at the current rate, 5.6 million of U.S. youth are expected to die prematurely from a smoking-related illness. This represents about 1 in every 13 Americans aged 17 years or younger

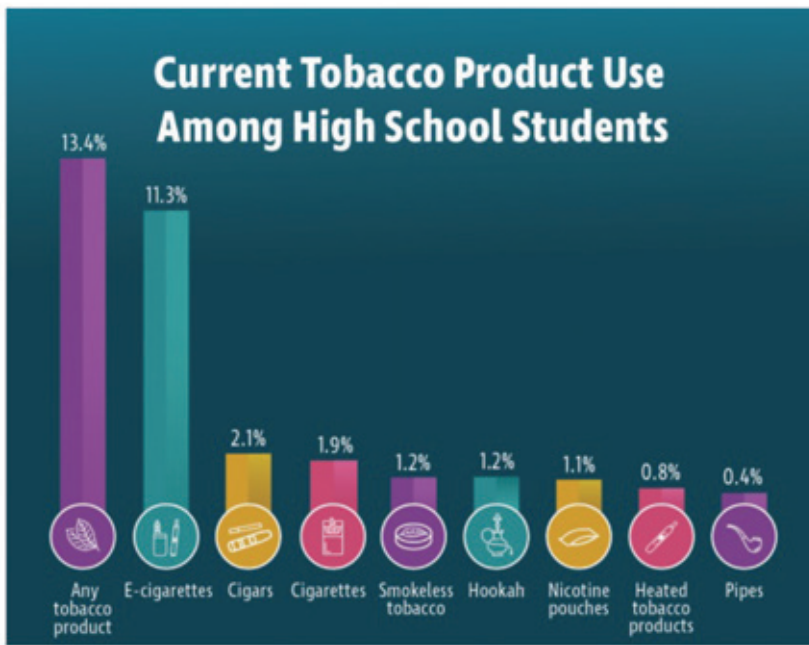
who are alive today. In 2019, the state of Maryland joined 17 other states and the District of Columbia to pass Tobacco 21, a law that increases the minimum legal sale age for any tobacco product to 21. The law is intended to cut down on the access that teenagers have to cigarettes and other tobacco and nicotine products, including e-cigarettes.

Use of cigarettes and cigars decreased significantly among youth from 2000 to 2018, but electronic smoking device (ESD) use increased dramatically, causing a reversal of the nearly 20 years of progress (Mattingly et al, n.d.). Many youths are unaware of the potentially serious side effects of electronic vapor products such as e-cigarettes, vapes, electronic nicotine delivery systems, and similar devices. These devices typically deliver nicotine, flavorings, and other additives to users through an inhaled aerosol. Electronic vapor products are usually flavored and are of particular concern due to their high nicotine content and nicotine's harmful effects on the developing adolescent brain. Additionally, the aerosol emissions can contain heavy metals such as nickel, lead and tin, and flavoring such as diacetyl, a chemical linked with lung disease.

Flavored tobacco products are more appealing to youth. In 2021, 80.2% of high school students and 74.6% of middle school students in the U.S. who used tobacco products in the past 30 days reported using a flavored tobacco product during that time. Also, in 2021, 85.8% of high school students and 79.2% of middle school students in the U.S. who used e-cigarettes in the past 30 days reported using a flavored e-cigarette during that time (CDC, 2022f).

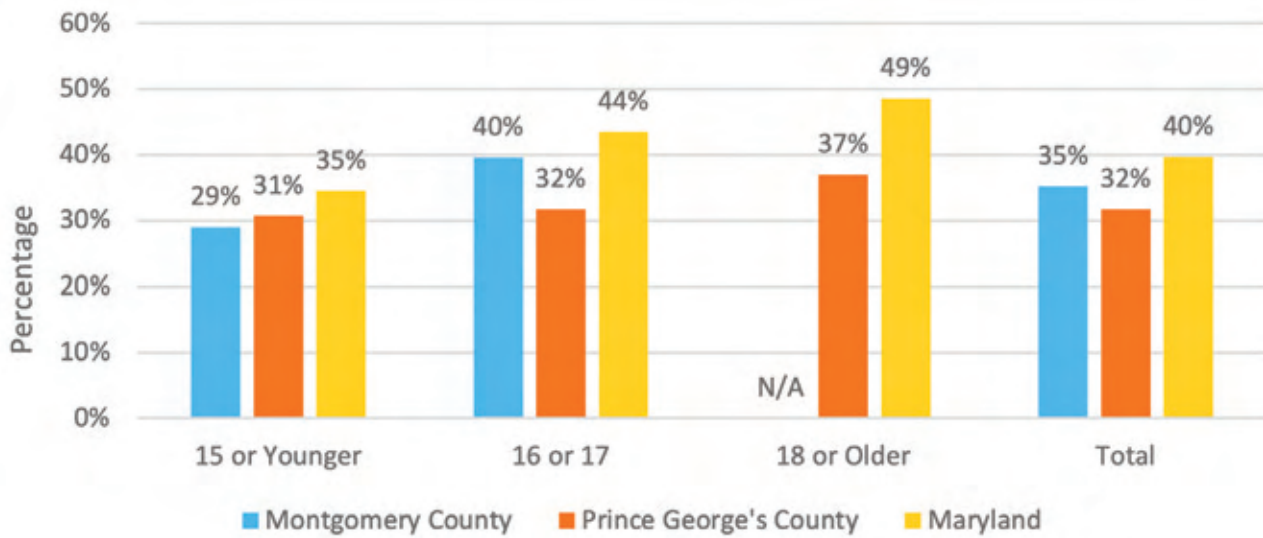
Figures 62 and 63 depict the popularity of e-cigarettes among high school students. The percentage of high school students' age 16 or 17 reporting ever used electronic vapor products, between 2018-2019, was higher in Montgomery County than Prince George's County. Males in Montgomery County and Prince George's County and females in Maryland have higher rates of high school students who have ever used electronic vapor products. Among high school students who ever used electronic vapor products, White students in Maryland and Montgomery County, and Hispanic students in Prince George's County have the highest rates compared to any other race or ethnicity.

Figure 61 Current Tobacco Product Use Among High School Students (2021)



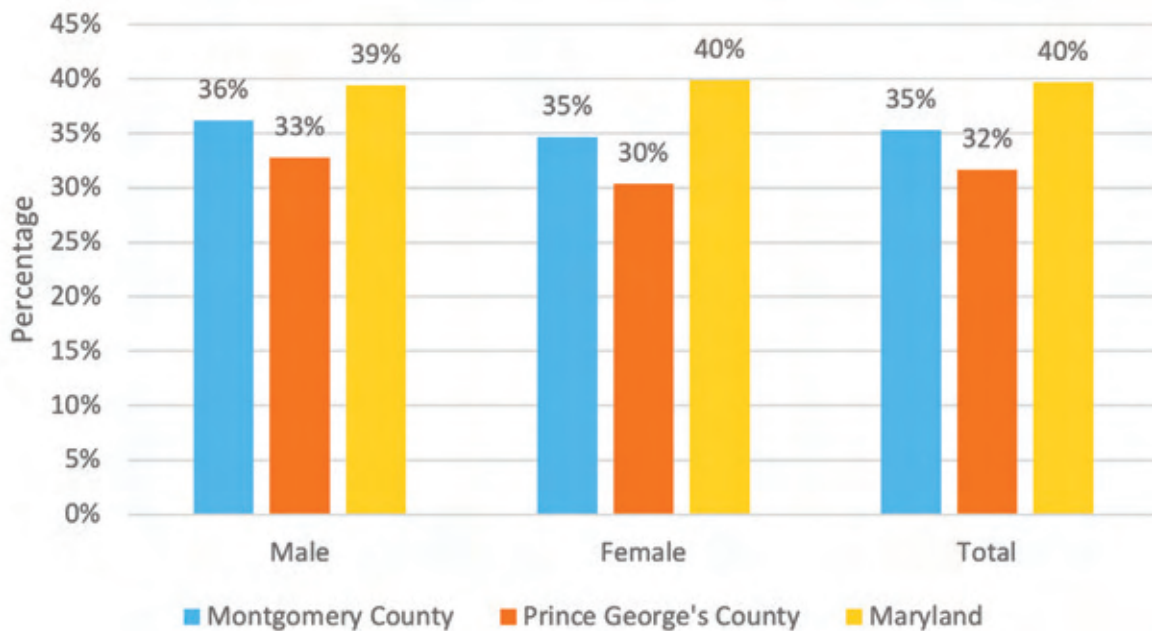
Source: Centers for Disease Control and Prevention, 2022.

Figure 62: Percent of High School Students Who Ever Used Electronic Vapor Product by Age (2018-2019)



Source: Youth Risk Behavior Survey/Youth Tobacco Survey, Center for Chronic Disease Prevention and Control, 2021.

Figure 63 Percent of High School Students Who Ever Used Electronic Vapor Product by Gender (2018-2019)



Source: Youth Risk Behavior Survey/Youth Tobacco Survey, Center for Chronic Disease Prevention and Control, 2021.

DIET AND EXERCISE

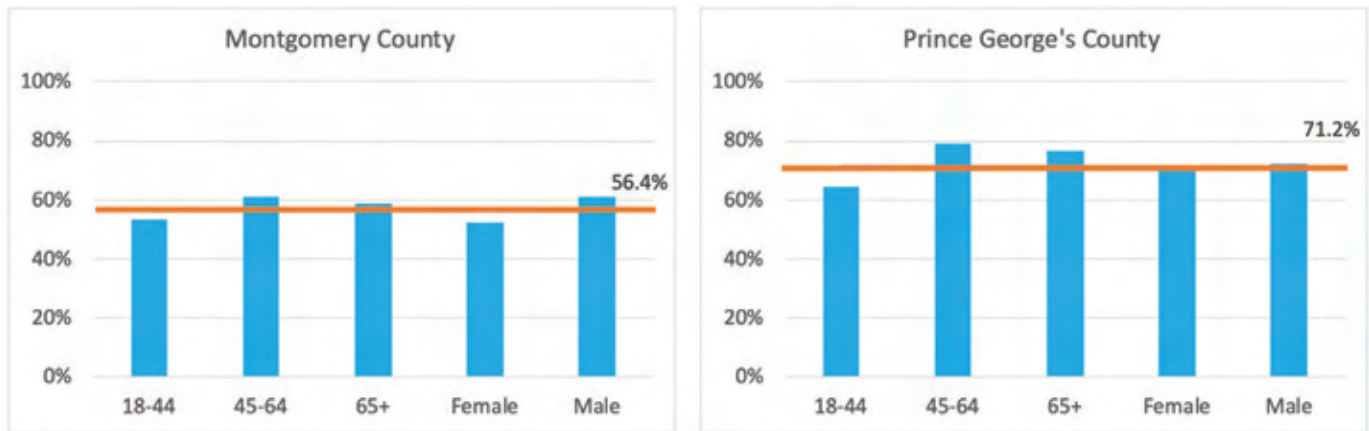
Obesity is an indicator of the overall health and lifestyle of a community. During the past twenty years, obesity rates have continually increased in the United States, doubling for adults and tripling for children. Obesity increases the risk of many diseases and health conditions, including heart disease, type 2 diabetes, cancer, hypertension, stroke, liver and gallbladder disease, respiratory problems, and osteoarthritis. An adult is classified as obese if their Body Mass Index

(BMI) is 30.0 and greater or overweight if the BMI is 25.0 to 29.9. The Healthy People 2030 national health target is to reduce the proportion of adults aged 20 and older who are obese to 36%. The 2019 Behavioral Risk Factor Surveillance System estimates that 30% of the US adult population is obese.

ADULT OBESITY

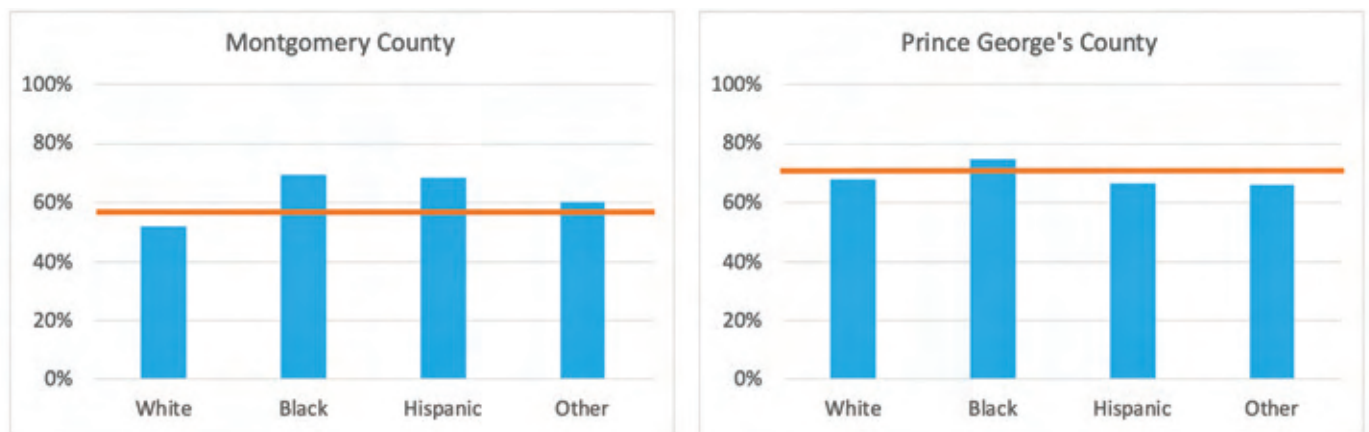
The rates of adults who are either obese or overweight in the state of Maryland are also concerning. In Maryland and the MCHC CBSA, 32.1% and 31.1% of adults age 18 and older are considered obese, respectively. In comparison, 56.4% of Montgomery County residents and 71.2% of Prince George’s County residents are overweight or obese. Obesity affects all populations, regardless of age, sex, race, ethnicity, and socioeconomic status, however, disparities do exist (see Figures 64 and 65).

Figure 64 Percent of Adults Who are Overweight or Obese by Age and Gender (2019)



Source: Behavioral Risk Factor Surveillance System, Maryland Department of Health, 2019.

Figure 65 Percent of Adults Who are Overweight or Obese by Race and Ethnicity (2019)



Source: Behavioral Risk Factor Surveillance System, Maryland Department of Health, 2019.

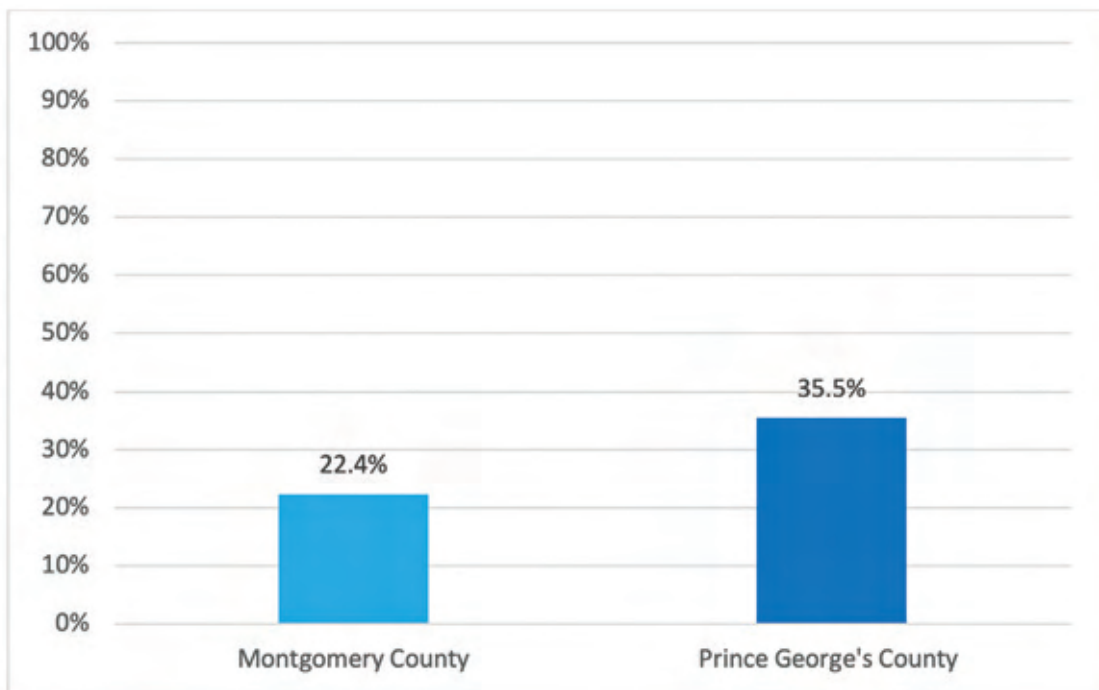
An important preventive tool to reduce obesity is the promotion of healthy eating and an active lifestyle. Eating a balanced diet and being physical active can help maintain a healthy weight and reduce risk factors associated with many chronic diseases, including cancer, diabetes and obesity. Unhealthy food intake and insufficient exercise have economic impacts for individuals and

communities. Current estimates for obesity-related health care costs in the U.S. range from \$147 billion to nearly \$210 billion annually, and productivity losses due to obesity-related job absenteeism cost an additional \$4 billion each year (Levi et al., 2013). Inadequate physical activity results in \$117 million annually in additional health care costs (CDC, 2020b).

ADOLESCENT/YOUTH OBESITY

Many children and adolescents in the United States are considered obese. In addition to being at a higher risk of diseases and health conditions in their youth (and more severe as adults), children with obesity are also more likely to be bullied and to have obesity as adults. Contributing factors to childhood obesity include dietary patterns, physical inactivity, genetics, medication use, and the physical and social environment. In Montgomery County, 22.4% of high school students are obese or overweight, and 35.5% of Prince George’s County high school students are obese or overweight (see Figure 66). The Healthy People 2030 target is to reduce the proportion of children and adolescents with obesity to 15.5%.

Figure 66 Percent of Overall High School Students Who are Obese or Overweight (2018-2019)



Notes. Youth Behavior Risk Survey 2018-2019, Centers for Disease Control and Prevention, 2021.

OBESITY AND COVID-19 PANDEMIC

Emerging data suggest that one of the indirect effects of the pandemic was weight gain. National self-reported survey data showed weight gain was common across youth and adults. A survey conducted by the Harris Poll in 2021 found that 42% of adults in the United States reported undesired weight gain since the start of the pandemic. The average reported weight gain was 29 pounds (American Psychological Association, 2021). Younger adults ages 18 to 42 (Gen Z and Millennials), parents, essential workers, and Latinos were disproportionately likely to report weight gain (of any amount), while adults aged 25 to 42 (Millennials), essential workers, parents, men, and

Blacks reported the largest number of pounds gained (American Psychological Association, 2021b). Social determinants of health (SDOH) have always been connected with obesity, and COVID-19’s interaction with SDOH has intensified certain effects on choices, behaviors, and health, including obesity. During the pandemic, the following factors influenced unhealthy weight gain:

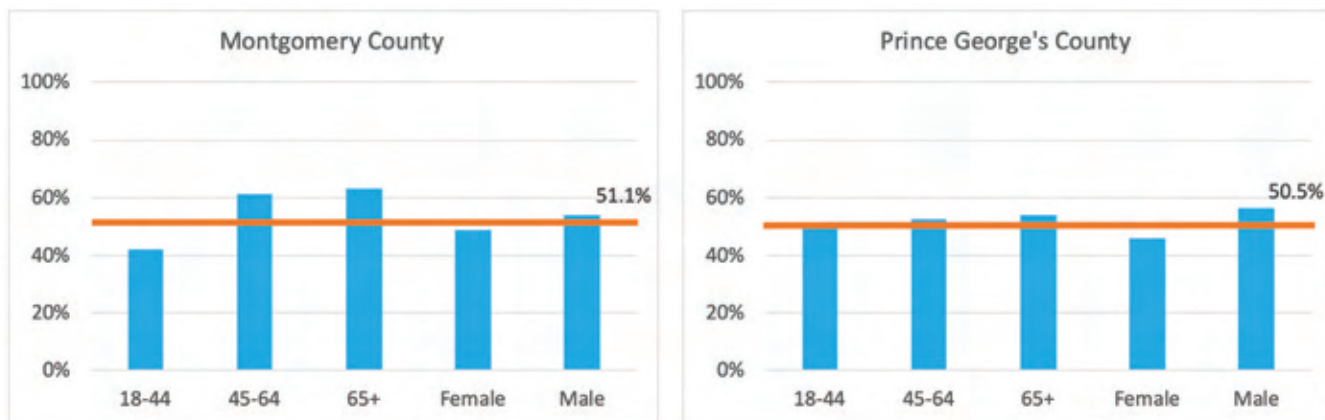
- Closing of farmer’s markets reduced access to fresh produce
- Job loss/reduced hours meant a reduction in income to purchase healthy food
- Childcare and school closing reduced access to nutritious lunches for children
- Reduction in physical activity due to gyms, community centers, and recreation facility closures
- Increased sedentary behavior and work from home mandates reduced activity levels
- Increased stress levels due to mental distress and social isolation and subsequent “comfort eating” habits

PHYSICAL ACTIVITY

Similar to eating a balanced diet, regular physical activity reduces the risk of multiple chronic diseases and helps maintain a healthy weight and reduce body fat. Active individuals reduce their risk of many serious health conditions including obesity, heart disease, diabetes, stroke, colon cancer, and high blood pressure. Physical activity also reduces symptoms of anxiety and depression, improves mood and feelings of well-being, and promotes healthy sleep patterns.

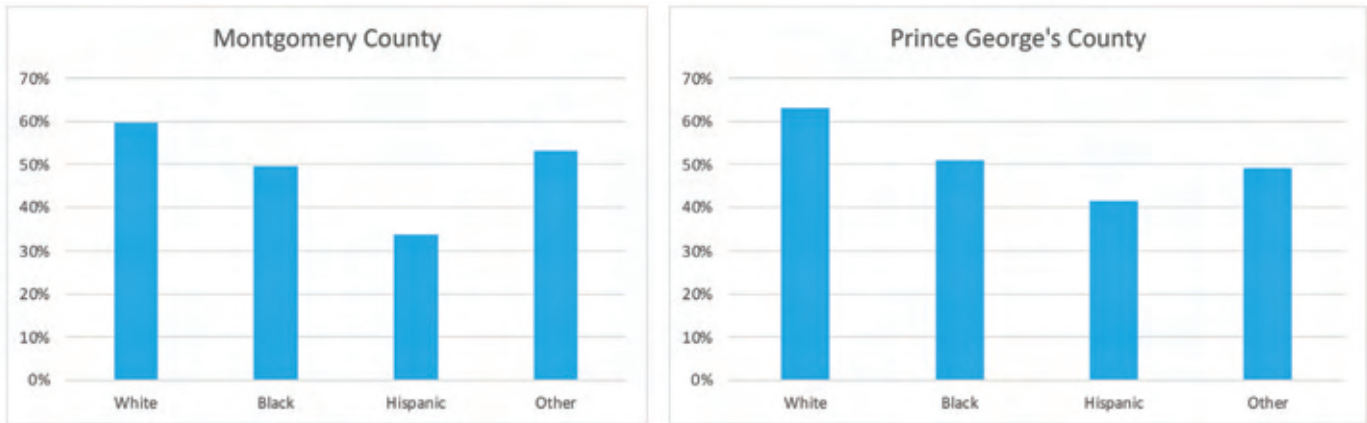
The American College of Sports Medicine (ACSM) recommends that active adults perform physical activity three to five times each week for 20 to 60 minutes at a time to improve cardiovascular fitness and body composition. Unfortunately, only 25% of adults or 1 in 5 adolescents in the United States engage in the recommended amount of physical activity (U.S. Department of Health and Human Services, 2018). However, the percentage of physically active adults in Montgomery County (51.1%) and Prince George’s County (50.5%) is higher than the national average (see Figures 67 and 68).

Figure 67 Percent of Adults Who Participated in at Least 150 Minutes or 75 Minutes of Moderate or Vigorous Physical Activity by Age and Gender (2019)



Source: Behavioral Risk Factor Surveillance System, Maryland Department of Health, 2019.

Figure 68 Percent of Adults Who Participated in at Least 150 Minutes of Physical Activity or 75 Minutes of Moderate or Vigorous Physical Activity by Race and Ethnicity (2019)



Source: Behavioral Risk Factor Surveillance System, Maryland Department of Health, 2019.

Proximity to exercise opportunities, such as parks and recreation facilities, has been linked to an increase in physical activity among residents. The role of the built environment is important for encouraging physical activity. Individuals who live closer to sidewalks, parks, and gyms are more likely to exercise. One hundred percent (100%) of Montgomery County residents, and 98.3% of Prince George’s County residents live reasonably close to a location for physical activity.

ADOLESCENT/YOUTH PHYSICAL ACTIVITY

Adolescents need at least 60 minutes of physical activity a day, including muscle-strengthening activities at least 3 days a week. Physical activity improves heart, muscle, bone, and mental health in adolescents. In Montgomery County, 45.9% of male high school students and 29.7% of female high school students were physically active at least five days of the past week. In Prince George’s County, 29.6% of high school males and 18.9% of females were physically active at least five days of the past week (Maryland Department of Health, 2019).

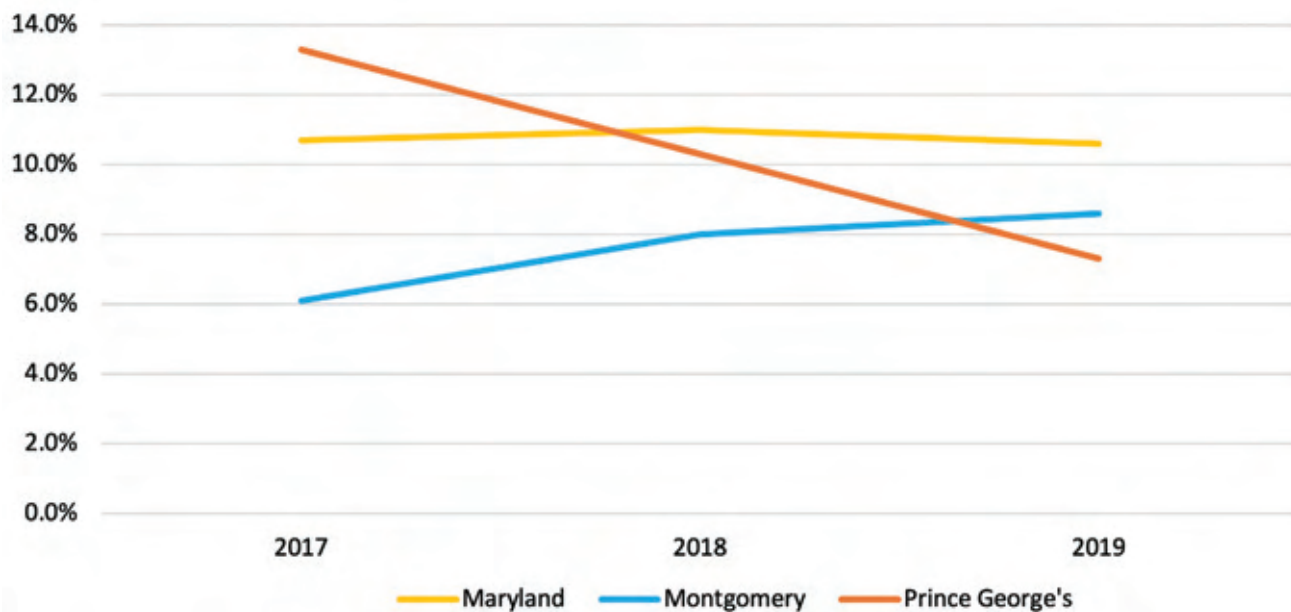
FOOD INSECURITY

Food insecurity is an economic and social indicator of the health of a community. The USDA defines food insecurity as a lack of consistent access to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Food insecurity can be temporary or long term. Poverty and unemployment are frequently predictors of food insecurity in the United States, and hunger is a potential consequence. Any discussion of food insecurity must come with the acknowledgment that this issue does not exist in a vacuum. It has many contributing factors and is most often an indicator of other individual and societal barriers. At the root of most food insecurity is financial instability, along with its numerous related challenges—namely, the forced trade-offs between nutritious food and other necessities. Other common and interconnected issues include unemployment, low availability of affordable housing, race/ethnicity, disability status, social isolation, and transportation hurdles that make it difficult to travel to work or a distant grocery store.

The USDA Economic Research Service (2022) now divides food insecurity into the following two categories:

- Low food security: “Reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake.” These food-insecure households obtained enough food to avoid substantially disrupting their eating patterns or reducing food intake by using a variety of coping strategies, such as eating less varied diets, participating in Federal food assistance programs, or getting food from community food pantries. Approximately 6.6% (8.6 million) of U.S. households had low food security in 2020.
- Very low food security: “Reports of multiple indications of disrupted eating patterns and reduced food intake.” In these food-insecure households, normal eating patterns of one or more household members were disrupted and food intake was reduced at times during the year because they had insufficient money or other resources for food and affected 3.9 % (5.1 million) of U.S. households at some time during 2020.

Figure 69 Food Insecurity Rate (2017-2019)



Source: Feeding America, 2021.

Pre-pandemic data demonstrates a reduction in the food insecurity rate in Prince George’s County, compared to an increase in Montgomery County. However, both counties have rates that are lower than those for the state of Maryland of 10.6% (see Figure 69). Due to the pandemic, Feeding America (2021b) projects 2020 data to show drastic adjustments in the food insecurity rate. The report projects Montgomery County rates to increase to 11.1% and Prince George’s County rates to increase to 10.3%. Nationally, food insecurity rates had been at their lowest in 20 years pre-pandemic (35.2 million). The current climate is likely to reverse those figures, with 2021 food insecurity rates estimated to hover around 42 million people.

Similar to other social determinants of health, food insecurity is also more prevalent in low-income communities. Communities of color, especially Black and Hispanic communities, experience hunger, poverty, and unemployment at much higher rates than White people. This is because of long-standing racial injustice that leads to barriers in education, employment, housing, and more. According to USDA data, 19.1% of Black households and 15.6% of Hispanic households experienced food insecurity in 2019. White Americans fell below the national average, with 7.9% experiencing food insecurity (Silva, 2020).

People living with a disability and people living with chronic conditions are more likely to experience hunger and lower incomes. Living with a disability or chronic condition may lead to higher medical costs, prevent people from working regularly, or simply make grocery shopping more difficult. Adults who have a disability and are not in the work force experience more than two times the rate of food insecurity as adults who do not have a disability. For those without a high school degree, the food insecurity rate is nearly 27%, in comparison to college graduates who have a food insecurity rate of 5%.

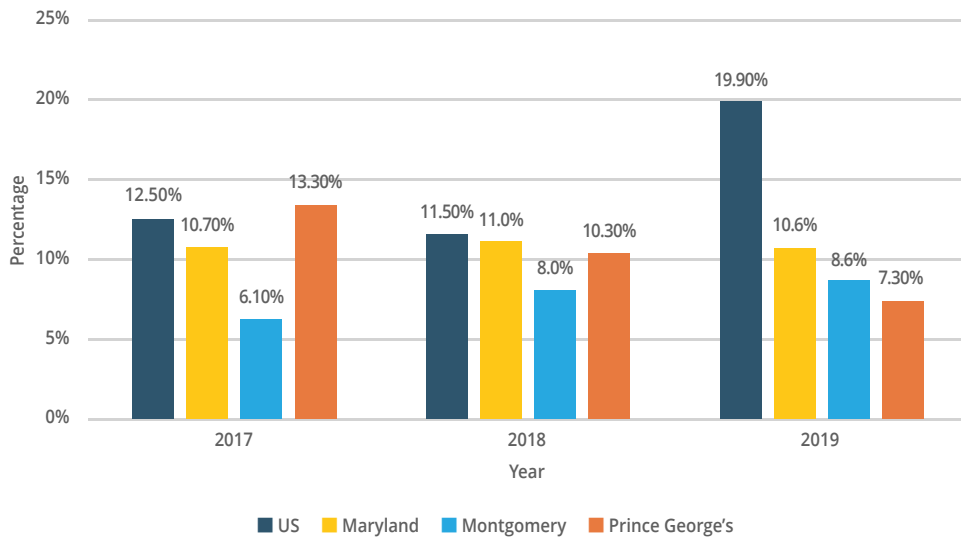
The Capital Area Food Bank (CAFB) Hunger Report 2021 notes that since the start of the pandemic, the data around persons in the U.S. who only become food insecure is staggering and reached unprecedented levels. The need for free food as a result of COVID-19, and visits to food pantries/banks rose among those who never needed these services before. Across several socioeconomic dimensions, those who are newly food insecure are markedly different from those who were experiencing food insecurity before the pandemic. Those newer to food insecurity are more likely to be older adults, children, immigrants (e.g., Hispanic, West Africans and newly-arrived Afghans), single mothers, and grand-families or multigenerational households. They tend to be employed, to live in larger households with more children, to fall into more severe levels of food insecurity, and to be facing eviction. They are less likely to have a fluent English speaker in the household, to know of more than one place to access free food, and to understand the process of applying for government benefits. The newly food insecure population is also far less likely to be receiving benefits from the public sector. The report suggests that even programs that were targeted to those most affected by the pandemic did not benefit the newly food insecure as much as it did those who were already food insecure, mainly due to those newer to food insecurity were more likely to say they did not believe they were eligible. The overrepresentation of Hispanics among the newly food insecure can be explained in part by the concentration of Latino laborers in industries that were hit particularly hard by the pandemic. Latinos exhibited higher rates of lost full-time employment and reduced hours at work due to the pandemic.

CHILDHOOD FOOD INSECURITY

Food insecurity has the potential to be harmful to individuals of any age, but it can be especially devastating to children. Food insecure children are at an increased risk of obesity and linked to childhood developmental problems, mental health issues, and poorer school performance. Health consequences among food insecure children include increased illness and higher associated health costs. In non-pandemic times, households with children were nearly 1.5 times more likely

to experience food insecurity than households without children. Figure 70 displays child food insecurity rates prior to the pandemic. In the summer of 2021 (during the pandemic), an analysis by the Brookings Institution found that 27.5% of households with children were food insecure — meaning 13.9 million children lived in a household characterized by child food insecurity. A separate analysis by researchers at Northwestern found insecurity has more than tripled among households with children to 29.5%.

Figure 70 Child Food Insecurity Rate (2017-2019)



Source: Feeding America Research, 2018.

The fall 2018 Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS) was approved to add two CDC-approved food insecurity questions to Maryland High and Middle School students.

- During the past 12 months, how often was your family worried that your food would run out before you got money to buy more?
- During the past 12 months, how often did the food your family bought not last and they did not have money to get more?

Food insecurity was most prevalent in Prince George’s County (40.7% for High School students, 34.4% for Middle School students) and least prevalent in Montgomery County (21.9% for High School students, 18.4% for Middle Schools students). Overwhelmingly, Black and Hispanic/Latino high school students in Montgomery and Prince George’s Counties attested to having a greater risk of food insecurity, as compared to their White peers.

ACCESS TO HEALTHY FOODS

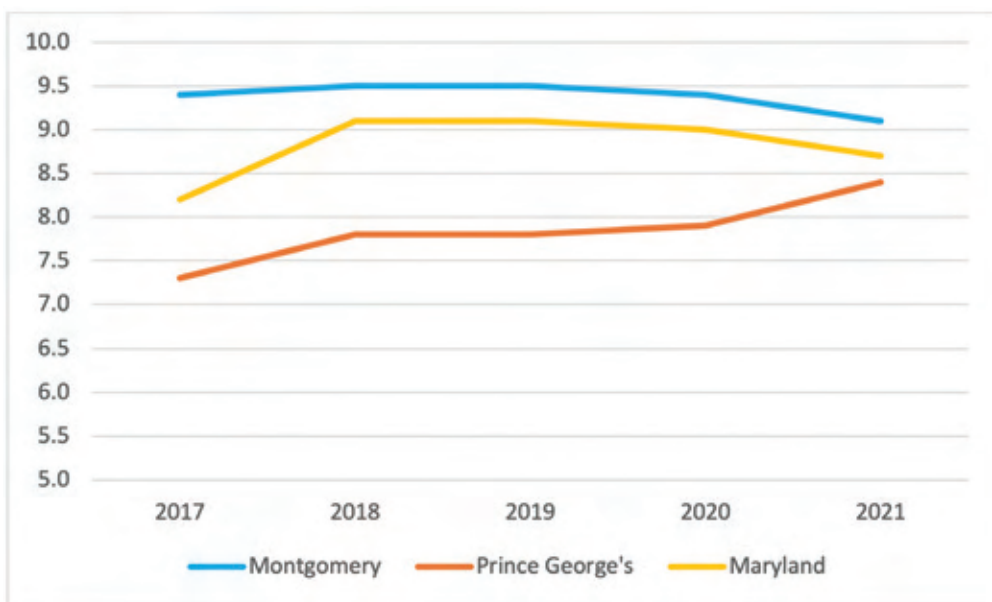
Food access refers to the ability to source good, quality food—food that’s filling and adequate for our individual needs. For many, this means having access to fresh and minimally processed foods that are good for the physical and environmental health of the community. Access to food is

determined by space and money and determines one’s food security and quality. The World Health Organization considers access to safe and adequate food a basic individual right—but still, as of 2020, over 37 million Americans were unable to acquire enough food to meet their needs or uncertain of where their next meal might come from. For about a third of these households, access to food was so limited that their eating patterns were disrupted, and food intake was reduced (Silva, 2020). The rest were able to obtain enough food to avoid completely disrupting their eating patterns but had to cope by eating less varied diets or utilizing food assistance programs.

FOOD ENVIRONMENT INDEX

The County Health Rankings measure of the food environment accounts for both proximity to healthy foods and income. This measure includes access to healthy foods by considering the distance an individual lives from a grocery store or supermarket, locations for healthy food purchases in most communities, and the inability to access healthy food because of cost barriers. The Food Environment Index ranges from a scale of 0 (worst) to 10 (best) and equally weighs two indicators of the food environment: limited access to healthy foods and food insecurity. In 2021, the average food environment index value (median) for Maryland counties was 8.7 and most counties fell between about 6.6 and 9.2. As can be seen in Figure 71, the food environment index for Montgomery County has been higher than Maryland since 2017, the opposite is true for Prince George's County.

Figure 71 Food Environment Index (2017-2021)



Source: County Health Rankings & Roadmaps, 2021.

FOOD DESERTS

According to a 2015 USDA report, about 19 million people, or roughly 6% of the population, lived in a food desert, without access to affordable, healthy food (Coleman-Jensen, Rabbitt, Gregory, & Singh, 2016,). The definition of food desert can change depending on where you live. In urban settings, you need to live more than a mile away from a supermarket to be considered inside a

food desert. For rural areas, it's greater than 10 miles. Rural areas are slightly more likely to be food deserts than urban areas and, according to Feeding America, and while they make up just 63% of counties in the country, they make up 87% of counties with the highest rates of food insecurity.

People who live in food deserts are often more likely to experience food insecurity because affordable, healthy food is harder to obtain where they live, as these neighborhoods may have limited access to full-service supermarkets or grocery stores. On the other hand, these communities have an overabundance of convenience stores and small independent stores that provide unhealthy food options. These stores often carry foods that are of a lower quality and have less variety. Furthermore, groceries sold in food deserts can cost significantly more than groceries sold in suburban markets, meaning people in low-income communities impacted by food insecurity often pay more money for their food. Access to healthy foods is also affected by lack of transportation resources to utilize better food options, or the distance is too consuming. Those with disabilities, residents in rural areas, and some minority groups often face lack of transportation issues to obtain healthy food.

Census tracts qualify as food deserts if they meet low-income and low-access thresholds:

- low-income (LI): poverty rate of 20% or greater, or median family income at or below 80% of the statewide or metropolitan area median family income
- low-access (LA): a low-income tract with at least 500 people or 33% of the tract's population living more than 1 mile (urban areas) or more than 10 miles (rural areas) from the nearest supermarket or grocery store.

From 2015-2019, the number of LILA census tracts in Montgomery County decreased from five to three while in Prince George's County they increased from 20 to 25 (see Table 7 and Table 8).

Table 7: Total Food Desert (LILA) Census Tracts Montgomery County (2015 & 2019)

	Year	
	2015	2019
24031700310		24031700310
24031700818		24031700818
24031700819		24031703301
24031703215		
24031703220		
Total LILA Census Tracts	5	3

Source: Economic Research Service, United States Federal Agriculture Service, 2015-2019.

Table 8: Total Food Desert (LILA) Census Tracts Prince George’s County (2015 & 2019)

	Year	
	2015	2019
24033800206		24033800412
24033800412		24033800601
24033801104		24033800704
24033801312		24033801406
24033801406		24033801409
24033801704		24033801704
24033801708		24033801708
24033801904		24033802001
24033801906		24033802201
24033802001		24033802404
24033802201		24033802405
24033802404		24033802700
24033802804		24033802803
24033803605		24033802804
24033806706		24033802805
24033807000		24033803100
24033807200		24033803524
24033807301		24033803606
24033807404		24033803608
24033807407		24033803610
		24033806706
		24033806711
		24033807301
		24033807404
		24033807407
Total LILA Census Tracts	20	25

Source: Economic Research Service, United States Federal Agriculture Service, 2015-2019.

FOOD APARTHEID

The term “food desert” is becoming viewed as an inaccurate and misleading term that pulls focus from the underlying root causes of the lack of access to healthy food in communities. The term implies the lack of healthy and affordable food is naturally occurring in “desert” barren landscapes. On the contrary, these communities are often the direct result of systematic racism and discrimination, as well as oppression in the form of zoning codes, lending practices, systemic disinvestment, and other discriminatory policies. Many groups are now using the term “food

apartheid” to correctly highlight how racist policies shaped these areas and led to limited access to healthy food. Apartheid is a system of institutional racial segregation and discrimination, and these areas are food apartheid because they too are created by racially discriminatory policies. Using the term “apartheid” focuses the examination on the intersectional root causes that created low-income and low food access areas, and importantly, points towards working for structural change to address these root causes.



SECTION 5.

HEALTH CARE/ CLINICAL CARE

According to County Health Rankings, access to affordable, quality, and timely health care can help prevent diseases and detect issues sooner, enabling individuals to live longer, and healthier lives. While part of a larger context, looking at clinical care helps us understand why some communities can be healthier than others.

Advances in clinical care over the last century, including breakthroughs in vaccines, surgical procedures like transplants and chemotherapy, and preventive screenings, have contributed significantly to increases in life expectancy. Care continues to evolve, with promising advances in fields like tele-health and care coordination leading to improved quality and availability of clinical care.

Despite the advances in clinical care, many individuals do not have access to a provider. Nearly 30 million Americans remain without health insurance, generally considered the first barrier to receiving quality health care. Others do not access health services because of high deductible costs, language barriers, distance to a provider, or lack of specialists in their geographic area or health network. Those without regular access to quality providers and care are often diagnosed at later, less treatable stages of a disease than those with insurance, and, overall, have worse health outcomes, lower quality of life, and higher mortality rates. Health care access and quality also vary widely both by place, race, ethnicity, and income.

HEALTH INSURANCE

Having access to health care is essential to both achieving and maintaining good health. Because detection and prevention are pivotal to improved health outcomes, access to health care allows individuals to live longer, healthier lives. Access to health care accounts for 20% of an individual's health outcomes according to the County Health Rankings model. The model stresses the importance of not just access to care, but to the quality of available health care. High quality health care is timely, safe, effective, and affordable—the right care for the right person at the right time.

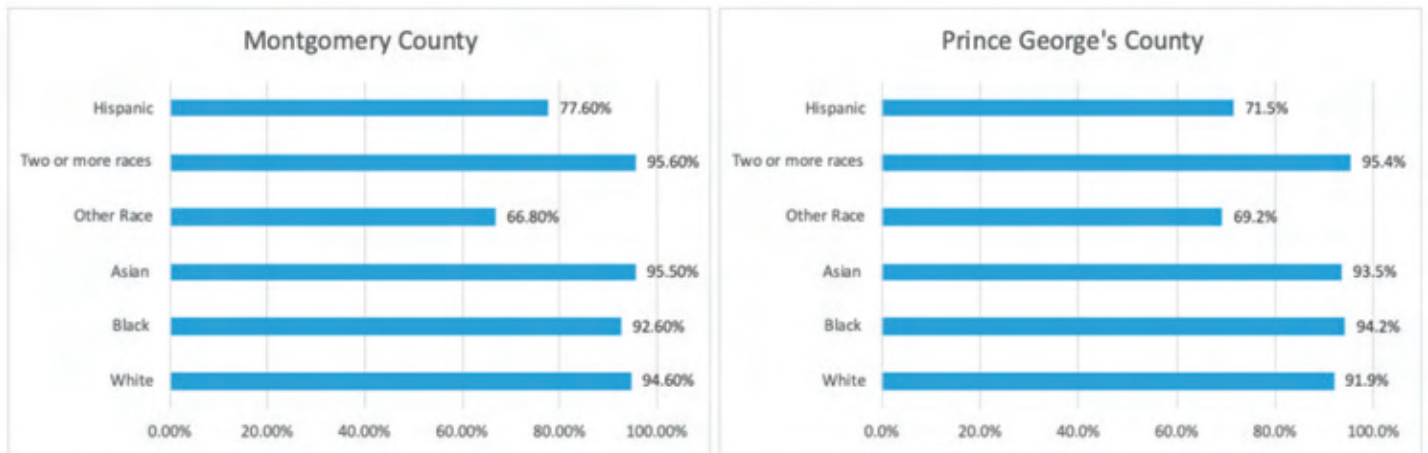
Health insurance is a resource that covers part or all expenses of an individual's need for health care. The amount paid on behalf of the individual is associated with his or her level of risk to the insurer, which can be public, e.g., Medicare, or private. According to Healthy People 2030, 1 in 10 Americans do not have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Delaying medical care can negatively impact health and increase the cost of care, including out of pocket expenses. People who cannot access the care they need may have more preventable complications, hospitalizations, emotional stress, and higher expenses.

The Patient Protection and Affordable Care Act (ACA or commonly known as Obamacare) was signed into law by President Obama on March 23, 2010. The ACA significantly changed the health care system in the U.S. by reducing the amount individuals and families paid in uncompensated care. The act requires every American to have health insurance and provides assistance to those who cannot afford a plan. In response, Maryland established the Maryland Health Benefit Exchange (MHBE), and recently marked 10 years of providing a marketplace for Marylanders to explore health insurance plans, compare rates, and determine program eligibility. The MHBE has benefited communities who historically lacked health insurance coverage. From 2011 to 2019, Black Marylanders have seen uninsured rates drop from 12.2% to 5.8%, Hispanic Marylanders have seen a drop from 31.4% to 21.4%, and Young Adult Marylanders have seen a decrease from 21% to 12%. During the 2021 open enrollment period, MHBE had a 4.5% increase in enrollees, the largest in the history of the program. Both Montgomery and Prince George's Counties saw enrollment gains from 2020 to 2021 (2.6% and 1.8% respectively).

In response to the COVID-19 pandemic, Maryland leadership launched a special enrollment to assist those in need of health insurance obtain the coverage needed. During this period, over 200,000 Marylanders were enrolled, with 63% enrolling in Medicaid. Demographically, nearly 70,000 young adults, 60,000 Blacks, and over 25,000 Latinos were able to obtain coverage they may not have received otherwise.

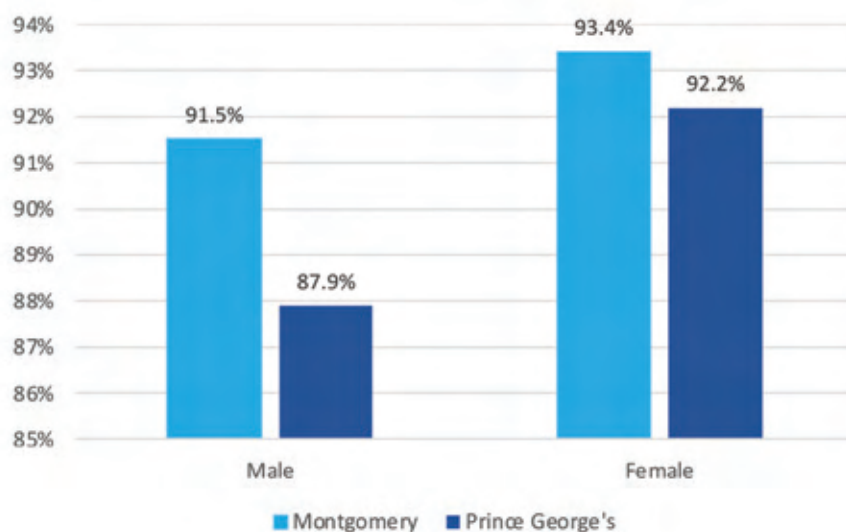
Persons who benefit from having health insurance coverage also benefit from better health outcomes. In 2019, Keisler-Starkey and Bunch (2020) found that 92% of Americans had public or private health insurance for all or part of the year, which is closely aligned with the MCHC CBSA insured rate of 90.9% (US Census Bureau, n.d.). Montgomery County's insured rate is 92.3% and Prince George's County's insured rate is 89.9%. See Figures 72 and 73 for a breakdown of insurance coverage based on race, ethnicity, and gender. The Healthy People 2030 target is to increase the proportion of people with health insurance under age 65 to 92.1%. Men, Blacks, and Hispanics have some of the lowest insured rates in both counties.

Figure 72 Percentage Health Insurance Coverage by Race/Ethnicity (2019)



Source: United States Census Bureau, n.d..

Figure 73 Percentage Health Insurance Coverage by Gender (2019)



Source: United States Census Bureau, n.d..

The United States spends more on health care than any other country in the Organization for Economic Co-operation and Development (OECD) yet provides fewer resources and ranks 29th for life expectancy at birth of the 38 member nations. The high cost of health care in the U.S. is a major barrier to accessing health care, along with inadequate or no insurance coverage and lack of culturally competent care. Lack of access to health care has long been associated with increased preventable hospitalizations and missed opportunities to prevent disease and manage chronic conditions, all of which can lead to worse and more expensive health outcomes. Meanwhile, the cost of U.S. health care is projected to continue trending upward for the next 30 years. Currently, the average American spends more than \$11,000 a year on health care (America's Health Rankings, n.d.).

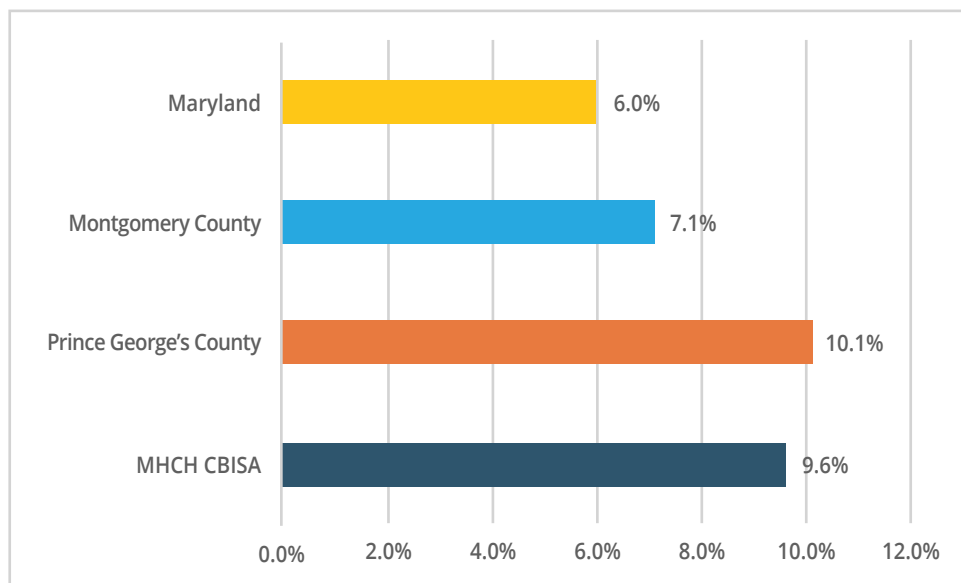
Adults who are uninsured are more likely to have problems paying medical bills compared with adults who have health insurance. Even among insured adults, those enrolled in high-deductible health plans are nearly twice as likely to delay or entirely forgo care due to cost compared with adults enrolled in traditional health plans. In Maryland, 8.7% of adults report a time in the past 12 months when they needed a doctor but could not go because of cost (America's Health Ranking, n.d.). This group tends to be Hispanic, female, aged 18-44, have less than high school education, and earns less than \$25,000.

UNINSURED

Lack of insurance is a primary barrier to health care access including regular primary care, specialty care, and other health services that contribute to poor health status. Access to affordable health insurance represents only one barrier to access care. Availability, affordability and language also play a role in preventing Montgomery and Prince George's Counties residents from accessing quality health care. Compared with insured adults, uninsured adults have more health disadvantages, including, worse health outcomes and higher rates of mortality and premature death, higher rates of cancer mortality and greater risk of a late-stage cancer diagnosis, inadequate access to quality care, including preventive services, and expensive medical bills due to undiagnosed or untreated chronic conditions, and more emergency room visits.

While the ACA has assisted many to obtain insurance coverage, as of 2019, there were still 6.1% of Marylanders who are not covered by private or public health insurance, primarily due to cost or ineligibility (America's Health Ranking, n.d.). Within the MCHC CBSA, 9.1% of the population is uninsured – 10% in Prince George's County and 7% in Montgomery County; the rate was 6% in Maryland in 2019 (see Figure 74).

Figure 74 Percentage of population without health insurance (2019)



Source: United States Census Bureau, n.d..

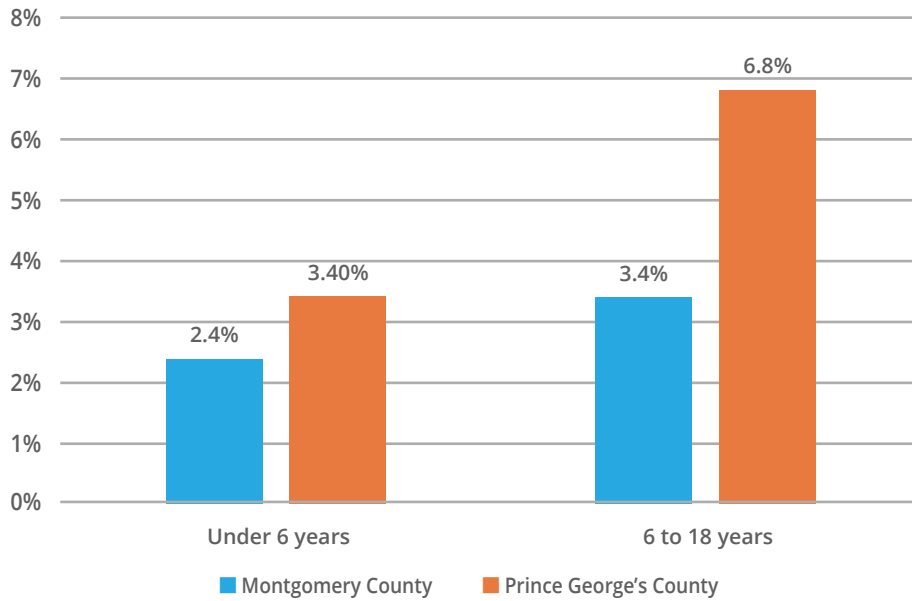
UNINSURED CHILDREN

Health insurance for children is particularly important. To stay healthy, children require regular checkups, dental and vision care, and medical attention for illness and injury. Children with health insurance are more likely to have better health throughout their childhood and adolescence. They are more likely to receive required immunizations, fall ill less frequently, obtain necessary treatment when they do get sick, and perform better at school. Having health insurance lowers barriers to accessing care, which is likely to prevent the development of more serious illnesses. This is not only of benefit to the child but also helps lower overall family health costs. In 2019, nearly 7% of children older than six years old residing in Prince George's County were not covered by insurance- the rate was half that for the same age range in Montgomery County. For children younger than six years old, less were uninsured and the coverage between counties was closer (see Figure 75).

In Maryland, there are two public insurance programs that cover children ages 0-19. Medicaid covers the entire age range for youth whose family earns up to a percentage of the federal poverty level. The Children's Health Insurance Plan, or CHIP, supports children whose families earn too much for Medicaid but otherwise remain uninsured.

Maryland Children's Health Insurance Program provides coverage for many important medical services. Services covered by CHIP include preventive care like doctor's visits and immunizations as well as emergency care and mental health services. CHIP also covers x-rays and laboratory tests, dental care, vision care, transportation to medical appointments, prescription medication, and substance use treatments. The services covered by CHIP often come with a small copayment, whereas those enrolled in Medicaid will have more services covered and will not have to pay for these treatments.

Figure 75 Percentage of Uninsured Children by Age (2019)



Source: United States Census Bureau, n.d..

MEDICAID

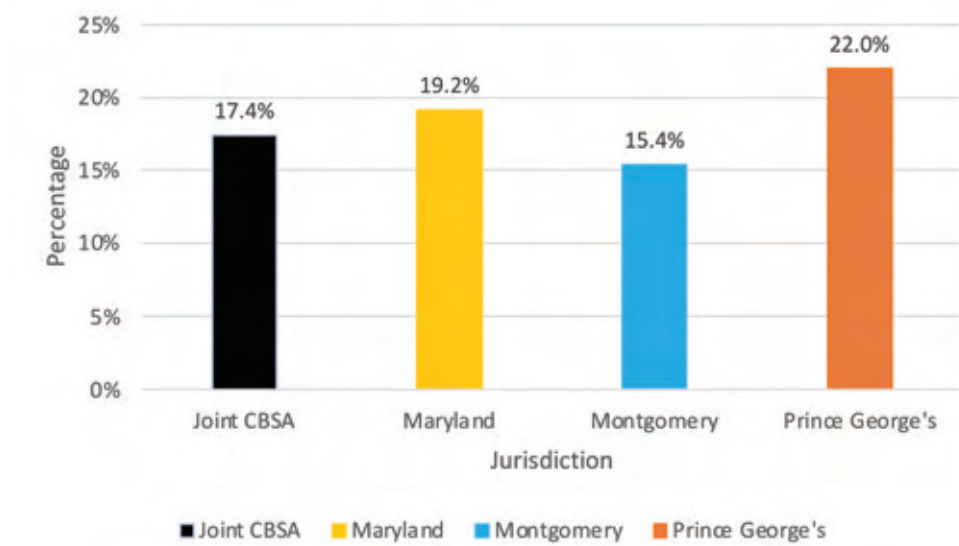
Medicaid is the nation's public health insurance program for people with low income. The Medicaid program covers 1 in 5 Americans, including many with complex and costly needs for care (US Census Bureau, n.d.). The program is the principal source of long-term care coverage for Americans. The vast majority of Medicaid enrollees lack access to other affordable health insurance. Medicaid covers a broad array of health services and limits enrollee out-of-pocket costs. Medicaid finances nearly a fifth of all personal health care spending in the U.S., providing significant financing for hospitals, community health centers, physicians, nursing homes, and jobs in the health care sector.

As with so many aspects of American life, the COVID-19 pandemic had a dramatic impact on the nation's health sector in 2020, driving a 9.7% growth in total national health care spending, bringing spending to \$4.1 trillion according to the 2020 National Health Expenditures (NHE) Report, prepared by the Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS). Medicaid spending grew faster in 2020, increasing 9.2% to \$671.2 billion compared to 3.0% growth in 2019, primarily driven by increased enrollment due to the pandemic. Maryland Medicaid spending from October 1, 2019, to September 30, 2020, was nearly \$12 million (Kaiser Family Foundation, n.d.-c).

Each state runs its own Medicaid program which means eligibility varies depending on residence. The intended beneficiaries of Maryland's Medicaid are vulnerable populations, including pregnant women, individuals with disabilities, and low-income individuals. Those enrolled pay little to no

cost for this health care benefit. In addition to reducing the barriers to health care previously mentioned, Medicaid opens the doors for these individuals to access services such as physician-recommended specialty care, substance use disorder treatment, mental health physician and facility treatment, transportation to health care visits, dental care for individuals under the age of 21, and prescription coverage. According to the American Community Survey (2015-2019), 1.01 million Marylanders are enrolled in Medicaid (US Census Bureau, n.d.). Figure 76 illustrates Medicaid coverage by jurisdiction.

Figure 76 Percentage of Insured Population Receiving Medicaid (2015-2019)



Source: United States Census Bureau, n.d..

ACCESS TO CLINICIANS

People with a usual source of care (typically a primary care provider) are more likely to receive routine checkups and screenings, and are more likely to know where to go for treatment in acute situations. Not having a usual source of care or a usual place to go to when sick or in need of health advice can cause a delay of necessary care, leading to increased risk of complications. The Healthy People 2030 national health target is to increase the proportion of people with a usual primary care provider to 84.0%. In Maryland, 83.2% of the population report they have one provider they think of as a personal doctor or health care provider (Office of Population Health Improvement, 2021). On a jurisdiction level, 78.0% of Montgomery County and 78.9% of Prince George’s County residents identified a primary care provider.

Health care providers are fundamental when it comes to clinical care. Having a regular health care provider allows the patient and provider to build a stable, long-term relationship that is associated with several benefits, including better care of chronic conditions. Increased physician density is found to be associated with a decreased mortality rate from cardiovascular, cancer and respiratory conditions. The United States is currently facing a shortage of physicians due to the

nation's growing health care needs. Primary care physicians provide direct patient care and counsel patients on the appropriate use of specialists and advanced treatment options. They are typically the patient's first point of contact with the health care system and provide critical preventive care, disease management and referrals to specialists. Having a sufficient supply of primary care physicians in a community has numerous benefits, including, lower rates of low birthweight births, lower all-cause mortality and longer life spans, reductions in health system costs, and reductions in health disparities.

The number of primary care physicians per 100,000 population changes due to evolving state populations, physician retirement, new physicians entering the system and physicians changing states and/or specialties. The Health Resources & Services Administration has estimated that, as of 2021, an additional 14,860 primary medical care providers are necessary to meet current U.S. health care needs. Projections for primary care shortages by 2034 range from 17,800 to 48,000 physicians, mainly due to population growth and aging (America's Health Rankings, n.d.).

In addition to general primary care, dental care is also an important component of a healthy community. Oral health provides a window into general health. Many underlying health conditions, such as eating disorders, diabetes, and immune disorders, have close connections to oral health. Dentists diagnose oral diseases, create treatment plans, promote oral health and disease prevention, perform surgical procedures, and manage oral trauma. Oral infections and periodontal (gum) disease are associated with diabetes, heart disease, respiratory disease, cancer, and Alzheimer's disease. Despite projections of steady growth in the number of working dentists, the Health Resources and Services Administration has identified many areas and populations that have an inadequate supply of dentists to meet current or future needs. Some of the most significant oral health disparities are in rural communities. Disparities in oral health care contribute to higher rates of dental caries and edentulism (having no natural teeth) in rural populations compared with urban populations. Contributing factors to these disparities include, an inadequate supply of dentists, higher uninsurance rates and fewer dentists accepting Medicaid patients, patient difficulty in traveling to a dentist, poverty, lack of a fluoridated community water supply, and a growing population of older adults.

In addition to primary care physicians and dentists, there is also a demand for mental health professionals. Mental health providers offer essential care to adults and children who have a mental or behavioral disorder by offering services such as assessment, diagnosis, treatment, medication and therapeutic interventions. The mental health workforce includes a broad array of professionals, including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, professionals treating alcohol and other drug abuse and advanced practice nurses specializing in mental health care.

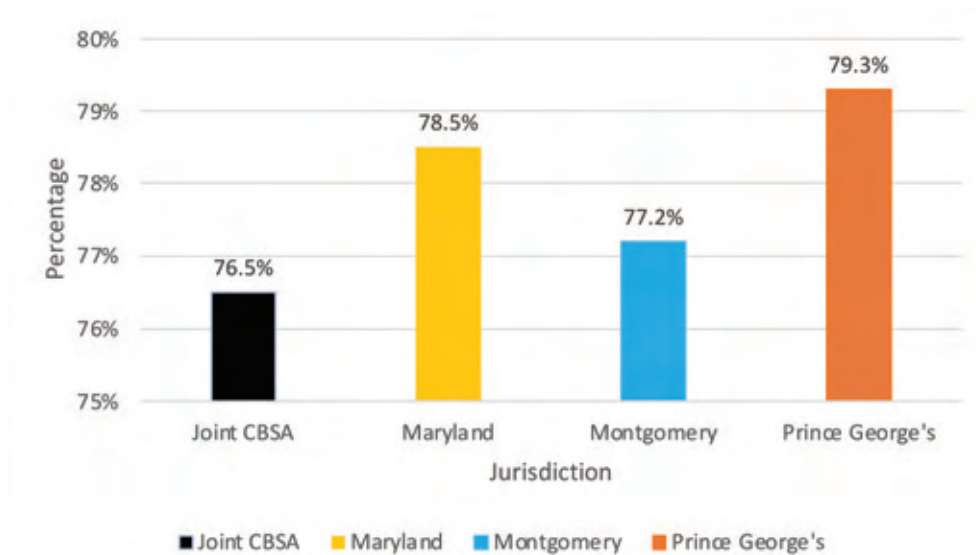
According to the National Institutes of Mental Health, in 2019, about one in five Americans experienced some form of mental illness (not including substance abuse disorders), but only 44.8% of adults with any mental illness and 65.5% with a serious mental illness reported receiving

treatment in the past year. An analysis by the Kaiser Family Foundation found that more than 119 million Americans live in mental health shortage areas, and only 26.9% of the need is being met. The National Council for Mental Wellbeing reported that 77% of counties in the United States are experiencing a severe shortage of mental health providers. The demand for mental health professionals is projected to increase during and after the COVID-19 pandemic. Populations identified with limited access to mental health care include, rural communities, which are less likely to have a mental health treatment facility than metropolitan counties, communities with a higher percentage of Black or Hispanic individuals, and low-income communities

RECENT PRIMARY CARE VISIT

Accessing preventive health care services, such as getting routine physical checkups, receiving recommended vaccinations on appropriate schedules, and checking blood pressure and cholesterol and maintaining them at health levels, can reduce morbidity and mortality from chronic diseases. The 2018 Behavioral Risk Factor Surveillance System measured adults 18 and older with one or more visits to a doctor for routine checkup within the past one year. While there is a shortage of providers in Prince George’s County compared to Montgomery County, the percentage of Prince George’s County adults reporting a recent routine PCP visit was notably higher compared to both Montgomery County and the state (see Figure 77).

Figure 77 Percentage of Adults with Recent Primary Care Visit (2019)



Source: Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System, 2019.

Access to emergency services is essential for emergency care-sensitive conditions such as acute myocardial infarction (heart attack), stroke, sepsis, and major trauma. People without health insurance are more likely to be in poor health than the insured. Lack of health insurance can result in increased visits to the emergency department and decreased routine care visits with a primary care provider. The rate of individuals accessing emergency department services in 2017 was

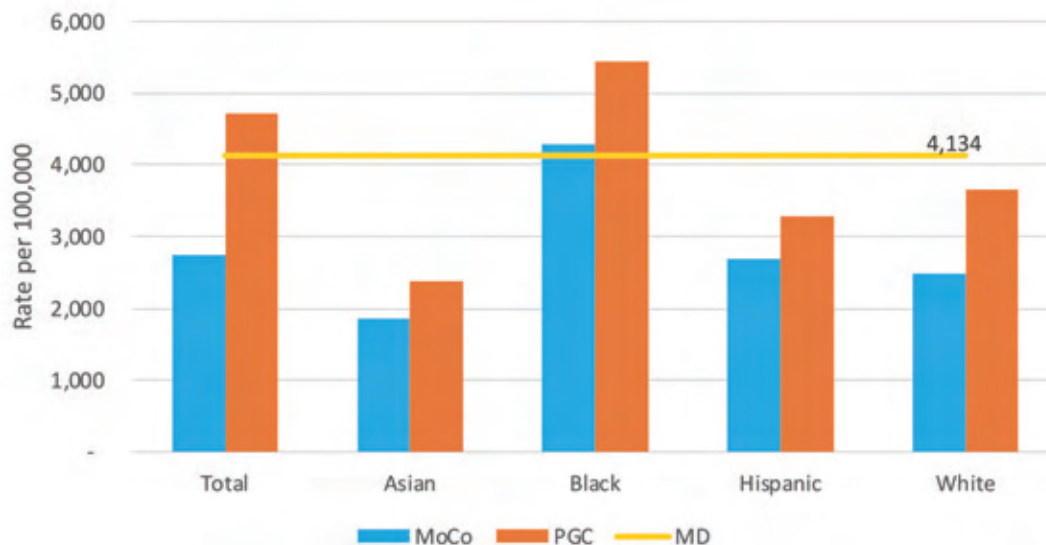
highest in Prince George's County (14.9%) compared to Montgomery County (13.4%). Both were higher than the state rate of 8.6% (Open Data Portal, 2020a). Diabetes can lead to blindness, heart and blood vessel disease, stroke, kidney failure, amputations, nerve damage, pregnancy complications and birth defects. When uncontrolled, complications arise and lead to an increase in emergency department visits. In Maryland, there were 12,907 emergency department visits for primary diagnosis of diabetes (Open Data Portal, 2020b). Similarly, high blood pressure drives emergency department visits. In Maryland, 30% of all deaths in 2017 were attributed to heart disease and stroke. Heart disease and stroke can be prevented by control of high blood pressure (Open Data Portal, 2020c). Due to the shortage of mental health providers, individuals often have nowhere to turn but the emergency department, placing a heavy burden on the health care system. In Maryland, there were 207,650 mental health disorder-related emergency department visits in 2014. Examples of disorders included in this figure are adjustment disorders, anxiety disorders, attention deficit disorders, disruptive behavior disorders, mood disorders, personality disorders, schizophrenia and other psychotic disorders, suicide and intentional self-inflicted injury and miscellaneous mental disorders (Open Data Portal, 2020d). Substance abuse problems also place a heavy burden on the health care system, particularly when persons in crisis utilize emergency departments instead of other sources of care when available. In Maryland, there were 96,991 emergency department visits for substance related disorders from 2012-2014 (Open Data Portal, 2020e). Asthma is a chronic health condition which causes very serious breathing problems. When properly controlled through close outpatient medical supervision, individuals and families can manage their asthma without costly emergency intervention. In 2017, there were nearly 50,000 emergency department visits related to asthma (Open Data Portal, 2020f). The utilization of dental services in emergency departments has steadily risen over the last decade. Dental emergency department visits are growing as a percentage of all emergency department visits throughout the United States. In 2014, there were 52,631 outpatient dental visits in emergency departments in Maryland (Open Data Portal, 2020g).

PREVENTABLE HOSPITAL STAYS

Some hospital admissions related to chronic conditions or acute illnesses can be prevented through adequate management and treatment in outpatient settings. The number of preventable hospital stays reflects the overuse of the hospital as a primary source of care and the accessibility and quality of primary care for outpatient services. Preventable hospitalizations place financial burdens on patients, insurance providers, and hospitals. In 2017, \$33.7 billion in hospital costs were attributed to preventable hospitalizations, of which the majority were for chronic conditions, such as heart failure, diabetes, and chronic obstructive pulmonary disease. Populations that experience higher rates of preventable hospitalizations include, Black adults compared with Asian/Pacific Islander adults, adults ages 65 and older, who have a rate of preventable hospitalization more than 12 times that of those ages 18-44, and adults from lower-income communities compared with those from higher-income communities.

Preventable hospital stays, as measured by County Health Rankings & Roadmap (n.d.), is the rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. The average number of preventable hospital stays in Maryland in 2018 was 4,134 per 100,000 Medicare population (see Figure 78). Populations with highest preventable hospital stays in Maryland tend to be Black, followed by American Indian/Alaska Native and White.

Figure 78 Preventable Hospital Stays by Race (2018)



Source: County Health Rankings & Roadmaps, 2018.

Since 2014, Maryland hospitals have been funded under a global budget system, or fixed annual revenue cap, that is adjusted for inflation, quality performance, reductions in potentially avoidable utilization, market shifts, and demographic growth. Under this system, hospitals are incentivized to transition services to the most appropriate setting. If the transition results in cost savings via improved health care delivery (e.g., reduced avoidable utilization, readmissions, hospital-acquired infections), the hospitals may retain the difference. By the end of 2018, the Medicare readmission rate in Maryland was 15.4%, which was below the national rate of 15.4%. The readmission rates in Maryland continue to improve. The most recent 12 months of data (through September 2019) reported Maryland’s Medicare readmission rate at 15.1% compared to the national rate of 15.5%. Racial and socioeconomic differences in readmission rates are well documented and have been a source of significant concern among health care providers and regulators for years. In 2018, the readmission rate for Black individuals was 2.6% points higher than for White individuals, and the rate for Medicaid enrollees was 3.4 points higher than for other patients (Maryland Health Services Cost Review Commission [HSCRC], 2020).

SECTION 6.

COMMUNITY INPUT



The Montgomery County Hospital Collaborative (MCHC) was deliberate in seeking input from the community for the 2022 Community Health Needs Assessment (CHNA). To achieve this goal, a questionnaire was designed to understand the health priorities, barriers to care, and health behavior prevalence in the MCHC defined Community Benefit Service Area (CBSA). Due to COVID-19 restrictions and to help widen our reach, the questionnaire was made available electronically in both English and Spanish. In an effort to reach community stakeholders, the medically underserved, low-income, and minority populations, a questionnaire was distributed via various channels, including community classes, hospital's community newsletters, vaccination and safety-net clinics, and through community partners. For a complete list of distribution channels, please see Appendix H.

A total of 580 individuals responded to the questionnaire, but only 488 responses met the inclusion criteria for the analysis: adults who reside in the 2022 CHNA CBSA. This section of the report will highlight findings from the 488 respondents. The findings from the community input survey will be compared against secondary level data and used in the prioritization process.

DEMOGRAPHICS

Overall, survey respondents self-identified as non-Hispanic white (63%), women (82%), over the age of 55 (65%), heterosexual or straight (89%), with a bachelor’s degree or higher (85%). Exactly 70% of respondents reported living in one of the four major cities in Montgomery County: Silver Spring (26%), Rockville (22%), Bethesda (15%), and Gaithersburg (7%).

Ethnic and racial minorities accounted for 38% of the responses (n=488). African Americans/Blacks (14%) were the second most common group to participate in the survey. Latinos/Hispanics accounted for 13% of respondents and Asians for 7%. The Latino/Hispanic respondents most often reported their race as white (53%), other (27%), or preferred not to answer (11%). Survey respondents belonged to various age groups, with majority (65%) of respondents being adults over the age of 65. Respondents were asked to share their highest level of education completed. 98% completed high school and 81% a combination of a bachelor’s and/or Post Graduate degree. Respondents' demographic information is illustrated by age, race and ethnicity in Figures 79 and 80.

Figure 79 Respondents’ Age Distribution

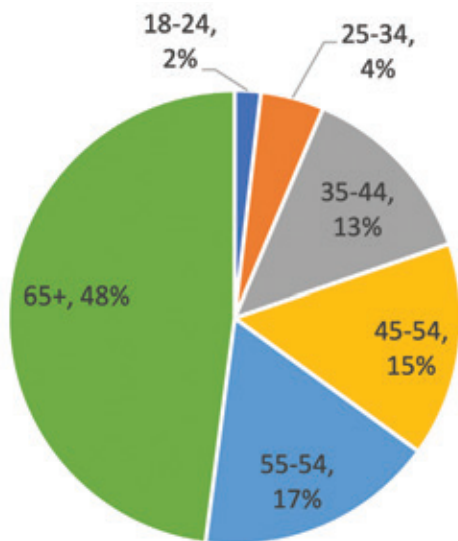
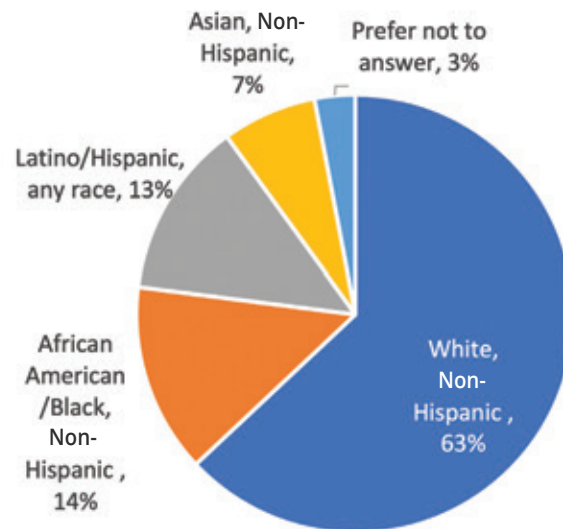


Figure 80 Respondents’ Race/Ethnicity Distribution

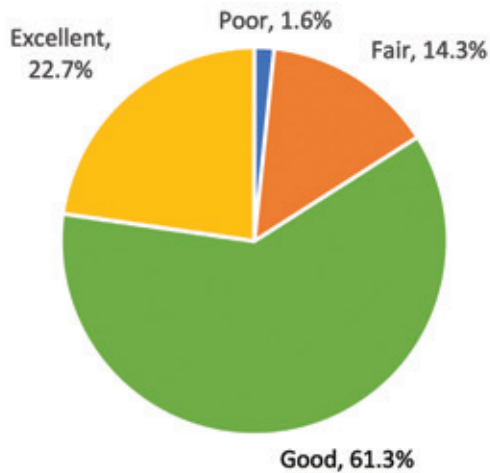


RESPONDENTS’ HEALTH

HEALTH STATUS

Respondents were asked to rate their general health on a scale from “Poor” to “Excellent.” Out of 488 responses, 22.7% rated their health as “excellent,” 61.1% rated their health as “good,” 14.3% rated their health as “fair,” and 1.6% rated their health as “poor” (see Figure 81).

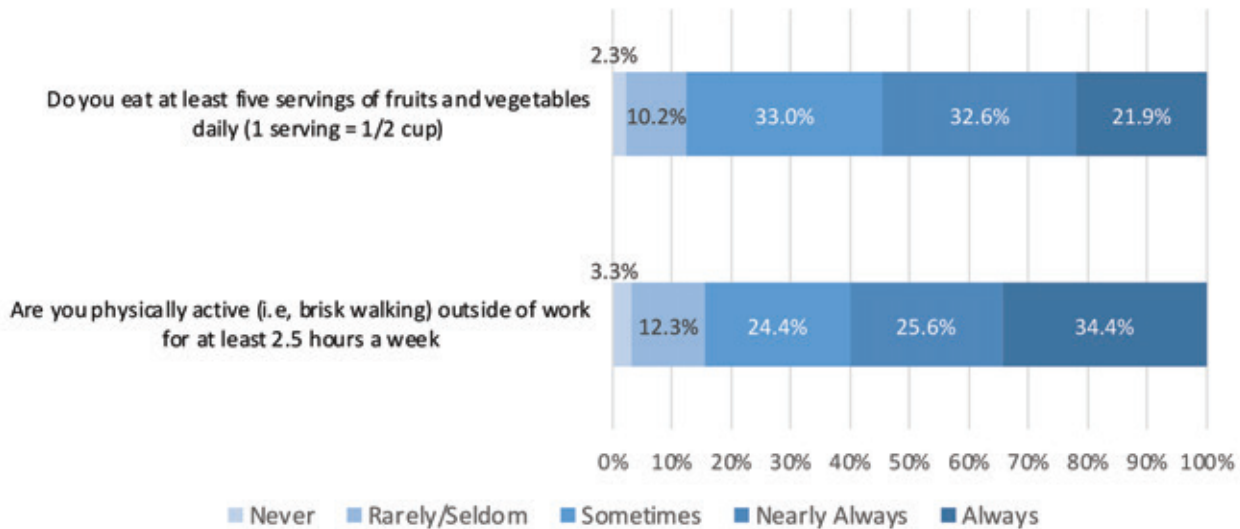
Figure 81 Self-Rated General Health



HEALTHY BEHAVIORS

When asked about the frequency of their healthy behaviors, 54.5% of respondents said they “always” or “nearly” always eat at least five servings of fruits and vegetables daily, 33% said they did so “sometimes,” and 12.5% said they did so “rarely” or “never.” A slightly higher percentage, 60%, of respondents said they were “always” or “nearly always” physically active outside of work for at least 2.5 hours a week; 24% reported doing so “sometimes,” and 15.6% said they did so “rarely” or “never.”

Figure 82 Frequency of Healthy Behaviors (n=488)



When asked about the frequency of their unhealthy behaviors, over 90% of respondents said they “never” or “rarely/seldom” overuse prescription drugs (92.1%), use illicit drug (96.5%), or use tobacco products (95.2%). Comparatively, more people reported that they text while driving, consume more than 5 alcoholic drinks a week, or feel stressed/anxious/depressed/ emotionally overwhelmed. Around 11.9% of respondents reported “sometimes” texting while driving, while 1.8% reported doing so “always” or “nearly always.”

Alcohol consumption of more than 5 drinks per week similarly had 12.1% report “sometimes,” though 9.2% (nearly 1 in 10) respondents reported drinking that amount “always” or “nearly always.” More than 1/3 (37.9%) of respondents reported feeling stressed, anxious, depressed, and/or emotionally overwhelmed. Around 1/5 (20.5%) reported feeling this way “always” or “nearly always.”

PERCEIVED BARRIERS TO HEALTH CARE

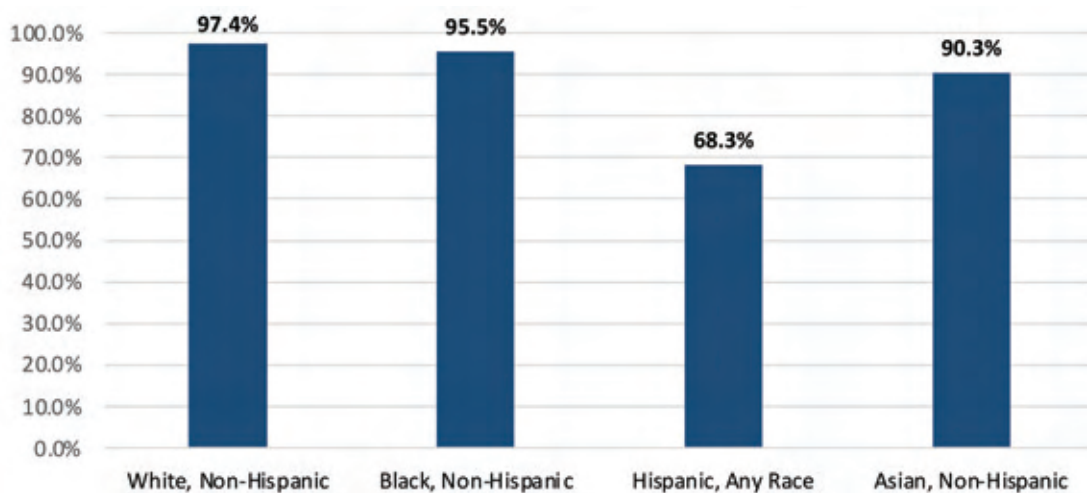
Respondents were asked to select barriers keeping them from seeking health care. More than half of total respondents (57.8%) said they had no barriers keeping them from seeking care. If barriers were present, “lack of available appointments” (20%) and “cost” (19.5%) were noted as the top two reasons. However, when the data for barriers to health care was stratified by race/ethnicity, the following observations were noted:

- All race/ethnicity categories except Hispanics predominantly chose “none” when asked their top (three) barriers to seeking health care
- Hispanic respondents cited “cost” (41.3%) as their top barrier. Additionally, the number of different barriers selected per person were also higher among Hispanic respondents.

INSURANCE STATUS

When it came to insurance status, 90% of respondents stated they had some sort of insurance and 10% either did not have insurance or did not know their insurance type. Insurance status was noticeably lower among Latino/Hispanic respondents of any race (see Figure 83). Only 68.3% of Hispanic respondents had some form of insurance. In comparison, 97.4% of White or Caucasian respondents, 95.5% of Black or African American respondents, and 90.3% of Asian respondents had some form of insurance.

Figure 83 Percent of Respondents with Any Form of Health Insurance (n=468)

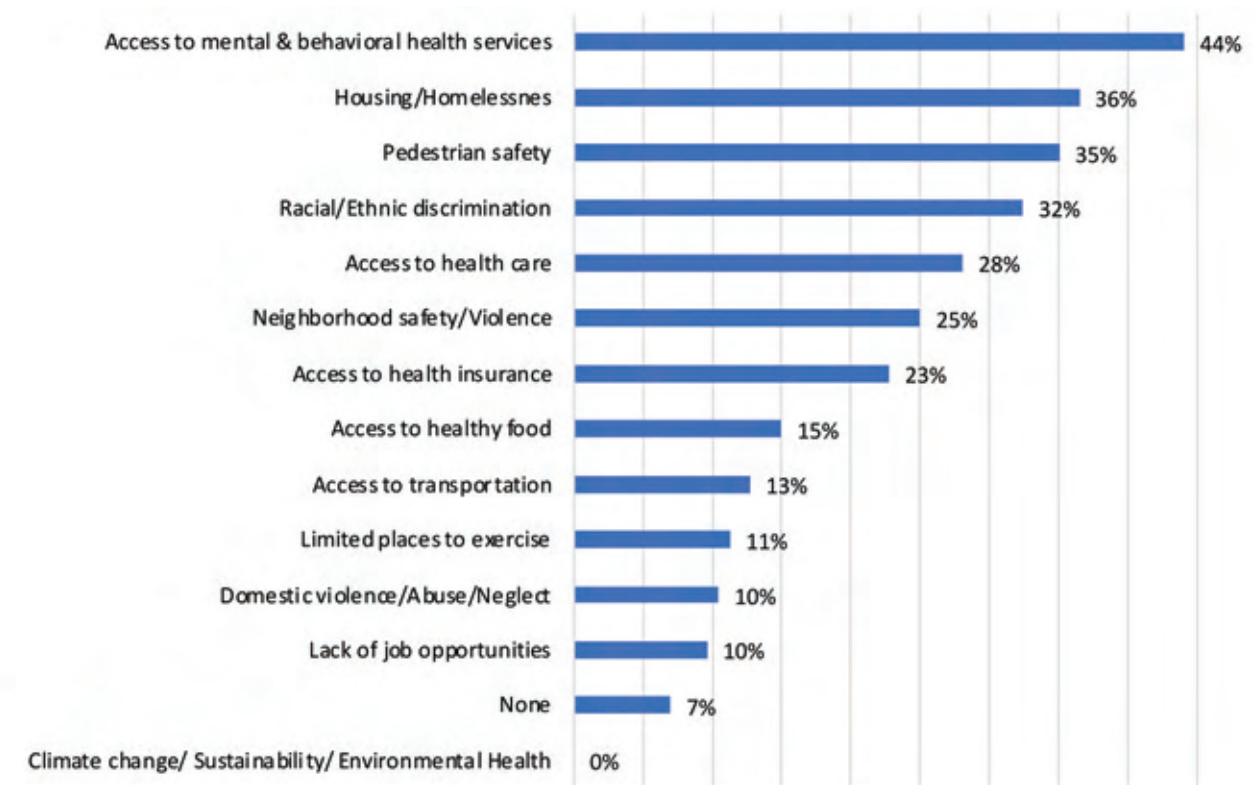


RESPONDENTS' HEALTH PRIORITIES & NEEDS

SOCIAL/ENVIRONMENTAL CONCERNS

When asked to rank the most important social and environmental problems affecting their community, 44.1% of respondents chose “access to mental & behavioral health services,” around 1 in 3 chose “housing/homelessness,” “pedestrian safety,” and “racial/ethnic discrimination.”

Figure 84 Most Important Social/Environmental Problems Affecting Community



Notes: The percentages on this graph will not add to 100% since respondents were able to select between three and five choices each.

When broken down by race/ethnicity, respondents' chosen priorities were different compared to the total sample size (n=488).

- Non-Hispanic White respondents most commonly chose “access to mental and behavioral health services” as one of their top three social/environmental community problem (48.7%).
- Non-Hispanic Black respondents most commonly chose “racial/ethnic discrimination” (50%), comparatively it was the 4th most chosen among Non-Hispanic White and the 6th most chosen among Asian respondents.
- Hispanic respondents most commonly chose “access to health insurance” (50.8%), comparatively it was the 7th most chosen among Non-Hispanic White respondents, the 8th most chosen among Non-Hispanic Black respondents, and the 5th most chosen among Asian respondents.

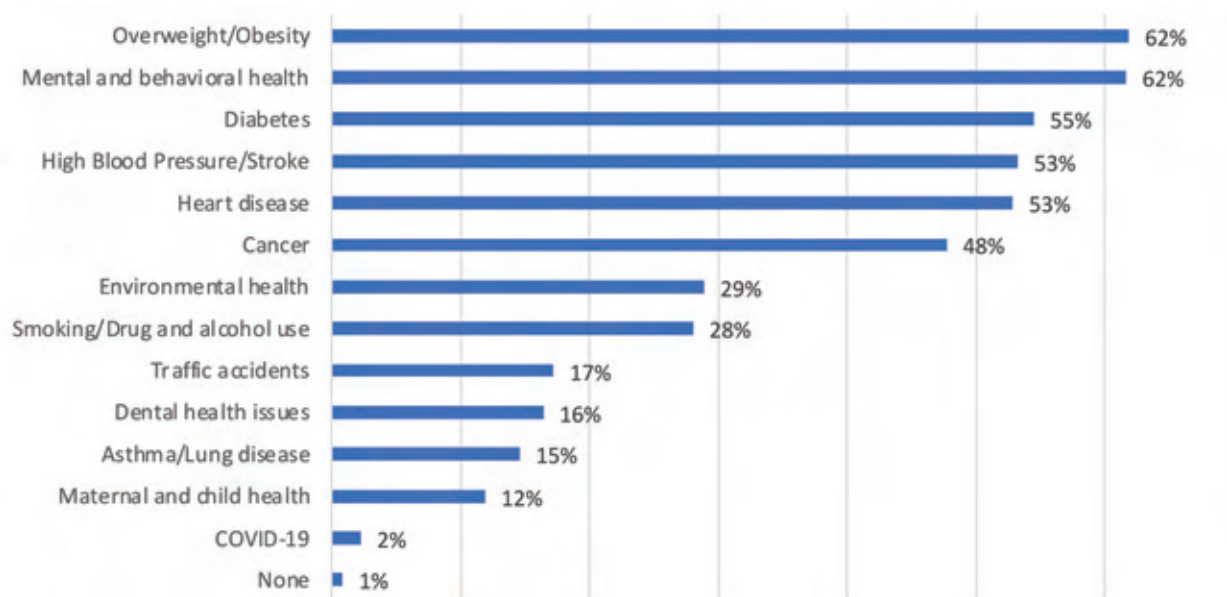
- Asian respondents most commonly chose “pedestrian safety” (38.7%), comparatively it was the 3rd most chosen among Non-Hispanic White respondents, the 4th most chosen among Non-Hispanic Black respondents, and the 6th most chosen among Hispanic respondents.

In summary, when comparing the top five social and environmental problems chosen most frequently by the four racial/ethnic groups, only “access to mental and behavioral health services” appeared in all four groups. Other problems that appeared in three out of four racial/ethnic groups (White, Black, and Asian) were “racial/ethnic discrimination” and “pedestrian safety.” Interestingly, the top three most chosen problems among Hispanic respondents all related to health care (access to health insurance, access to health care, and access to mental and behavioral health services).

HEALTH PRIORITIES

When respondents were asked to list the “top five most important health issues present in their communities,” nearly 62% selected “overweight/obesity” and “mental and behavioral health.” Slightly more than half chose “diabetes,” “high blood pressure/stroke,” and “heart disease.”

Figure 85 Most Important Health Issues in Community (n=488)



Responses to “most important health issues affecting their communities” also differed by race/ethnicity, though less drastically.

- The most frequently chosen health issue among Non-Hispanic White respondents was “mental and behavioral health” (66%), compared to being the 6th most chosen among Non-Hispanic Black respondents, the 3rd most chosen among Hispanic/Latino respondents, and the 4th most chosen among Asian respondents.
- Among Non-Hispanic Black respondents, the most chosen health issue was a tie between “diabetes” and “high blood pressure/stroke” (both 72.7%). In comparison, “diabetes” was the 6th most chosen among Non-Hispanic White respondents, the 2nd most chosen among

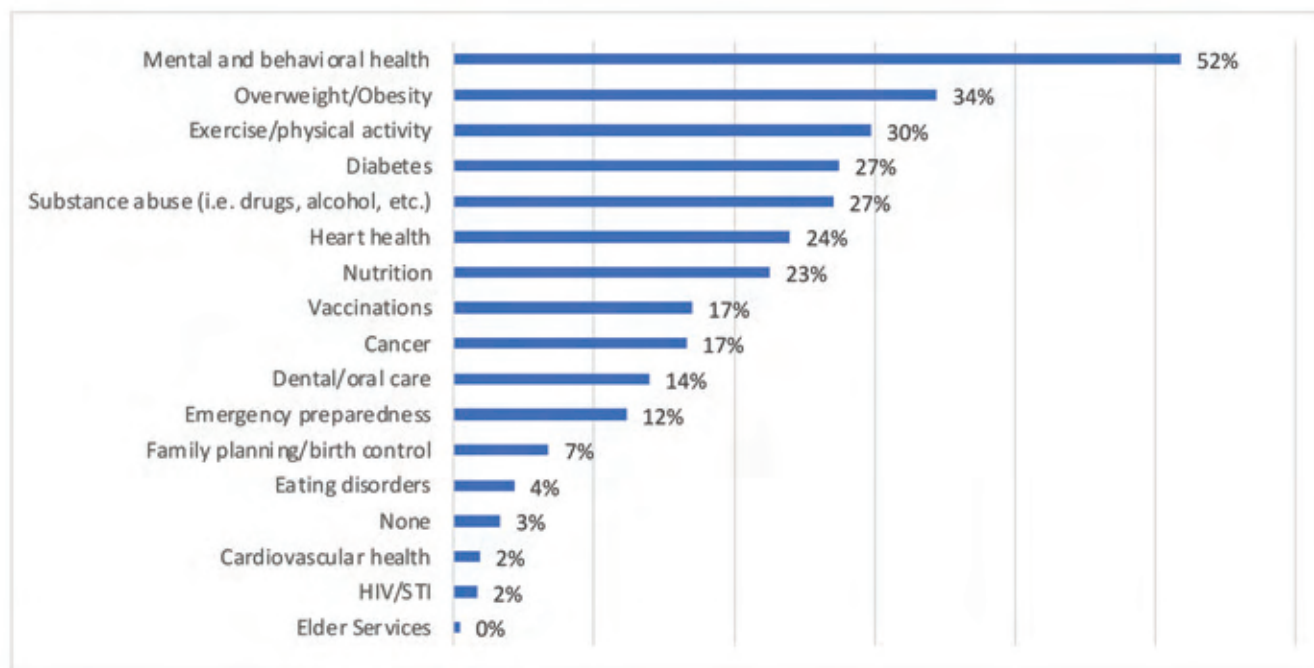
Hispanic respondents, and the 3rd most chosen among Asian respondents. “High blood pressure/stroke” was the 5th most chosen among Non-Hispanic White respondents, the 5th most chosen among Hispanic/Latino respondents, and the 2nd most chosen among Asian respondents.

- Among Hispanic/Latino respondents, the most chosen was “overweight/obesity” (76.2%), compared to being the 2nd most chosen among Non-Hispanic White respondents, the 3rd most chosen among Non-Hispanic Black respondents, and the 5th most chosen among Asian respondents.
- Among Asian respondents, the most chosen was “heart disease” (71%), compared to being the 4th most chosen among Non-Hispanic White, Non-Hispanic Black, and Hispanic/Latino respondents.

PERCEIVED COMMUNITY NEEDS

To understand what health prevention services community members felt were needed in their community, respondents were asked to select their top three “health prevention services needed in your community.” Figure 86 lists the top prevention services selected by respondents. “Mental and behavioral health” services (51.8%) were most commonly selected as a needed service, followed by “overweight/obesity” (34.4%), and “exercise/physical activity” (29.7%).

Figure 86 Most Selected Health Prevention Services Needed in Community (n=488)



PERCEIVED TREATMENT

The community survey also asked respondents about other people’s behavior towards them. On a scale of “never,” “less than once a year,” “few times a year,” “a few times a month,” “at least once a week,” and “almost every day,” respondents were asked to rate the frequency of the described

behavior. The graphs below show the percentage of respondents who answered “a few times a month” or more often (“at least once a week” or “almost every day”) to the suggested behavior.

Black respondents reported that they are “treated with less courtesy or respect” than others at least “a few times a month” at 3 times the amount Non-Hispanic White respondents did so (36.4% vs 12%). Around 23.8% of Hispanic respondents of any race and 22.6% of Asians respondents reported experiencing this behavior “a few times a month” to “almost every day.”

Around 1 in 5 (20%) of Black, Hispanic, and Asian respondents reported receiving “poorer service than other people at restaurants or stores” “at least a few times a month” to “almost every day,” compared to only 3.2% of Non-Hispanic White respondents.

More than 1/4 (25.8%) of Black respondents and 1/5 (22.2%) of Hispanic respondents reported that “people act as they think you are not smart” at least “a few times a month” or more often. Around 16% of Asian respondents reported this behavior toward them at this frequency, compared to 7.8% of Non-Hispanic White respondents.

When asked how often “people act as if they are afraid of you,” around 1/4 (24.2%) of Black respondents answered “a few times a month” or more often, around 10.5 times more than the proportion of Non-Hispanic White respondents answered the same (2.3%). Around 8% of Hispanic respondents and 3.2% of Asian respondents reported this behavior at least “a few times a month” or more.

Non-Hispanic Blacks (16.7%) were twice as likely to feel threatened or harassed compared to Hispanic/Latinos (9.5%), and almost three times as likely to Asians (6.5%). A small percentage of Non-Hispanic Whites reported feeling “threatened or harassed” a few times a year or more.

When asked how often respondents felt “followed around in stores,” approximately a quarter of Hispanic/Latinos (25.4%) and Non-Hispanic Blacks (22.7%) respondents expressed it happens to them “a few times a year or more.”

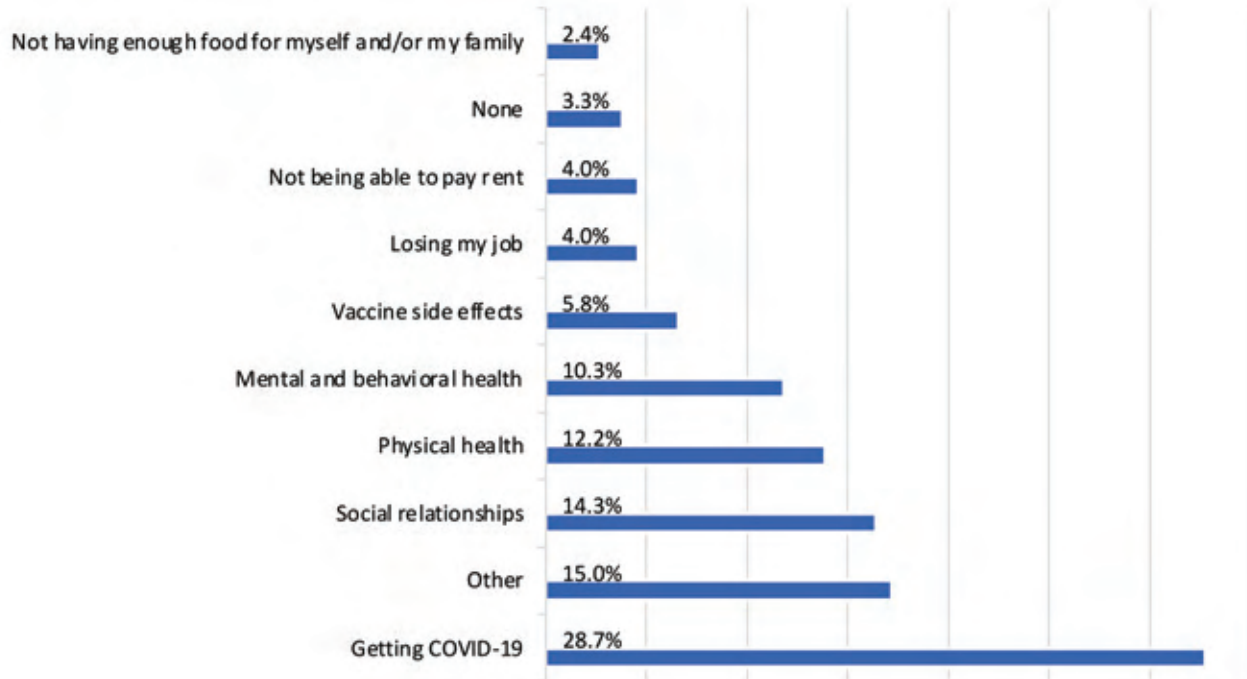
In general, those who reported feeling mistreated “a few times a year or more” were asked to list the main reason for these experiences. For Non-Hispanic Whites the difference in experience was attributed to their age and gender; Non-Hispanic Blacks & Asians (48.5%) attributed the difference to their race (68.2%); and Hispanic/Latinos attributed the difference to their Ancestry/National Origins (38.1%) and race (20.6%).

COVID-19

This survey was distributed a year after the COVID-19 pandemic started to help understand lasting and emerging concerns related to the pandemic. A year into the pandemic, respondents (n=488) listed “getting COVID-19” as a top concern, followed by “other” (15%), social relationships (14%), and physical health (12%) (respondents were able to select more than one concern). Those who selected “other” as their response cited “concern for their kids or a family member getting COVID-19” and vulnerability from exposure to unvaccinated individuals (at the time, vaccines were not widely available and there was a lot of vaccine hesitancy present in the community). When the list

of concerns was stratified by race and ethnicity, Latino/Hispanic respondents labeled “mental & behavioral health” and “not being able to pay rent” as a second and third concern, respectively. Non-Hispanic Blacks and Asians noted their “physical and mental health” as their second and third concerns. For Non-Hispanic Whites “social connections” and “physical health” were among the top three concerns. Across all four racial and ethnic group, “getting COVID-19” was the main concern.

Figure 87 Respondents’ COVID-19 Related Concerns (n =488)





SECTION 7.

RESPONSE TO FINDINGS & CONCLUSION

The MCHC CHNA used a systematic data collection and analysis process to identify key health needs and issues that persist in our community. In addition to using the highest quality data available from private and public sources, the MCHC CHNA was pro-active in engaging a broad and diverse level of stakeholders at key stages of the assessment via surveys and community conversations.

RESPONSE TO FINDINGS

A fundamental component of a community health needs assessment, as described by the Catholic Health Association, is the prioritization of the identified needs. To effectively achieve this goal, the MCHC engaged local public health leaders, service providers, and community advocates to

participate in the priority-setting process (see Appendix I for a list of community stakeholders invited to partake in this process). Three criteria were used to prioritize the needs identified from the primary and secondary data analysis: severity (high level of seriousness or urgency in the community), feasibility (could realistically improve in the next three years), and outcome (potential impact on the greatest number of people identified). Using the criteria, their professional expertise and experience, our stakeholders informed nine health factors, as top unmet needs:

1. Access to Care

- Access to mental health providers
- Access to primary care providers
- Lack of insurance

2. Healthy Behaviors

- Food insecurity
- Adult obesity
- Physical inactivity

3. Education, Income, Job & Environment

- Workforce/labor shortages
- Income inequality
- Housing cost burden

These nine health factors are recognized as root causes that impact a person's health, well-being, and quality of life. By addressing these root causes, meaningful changes can be made to decrease risk for the top health outcomes in our community: heart disease, diabetes, mental health, cancer, maternal and child health, infections, and unintentional injuries (see Figure 88).

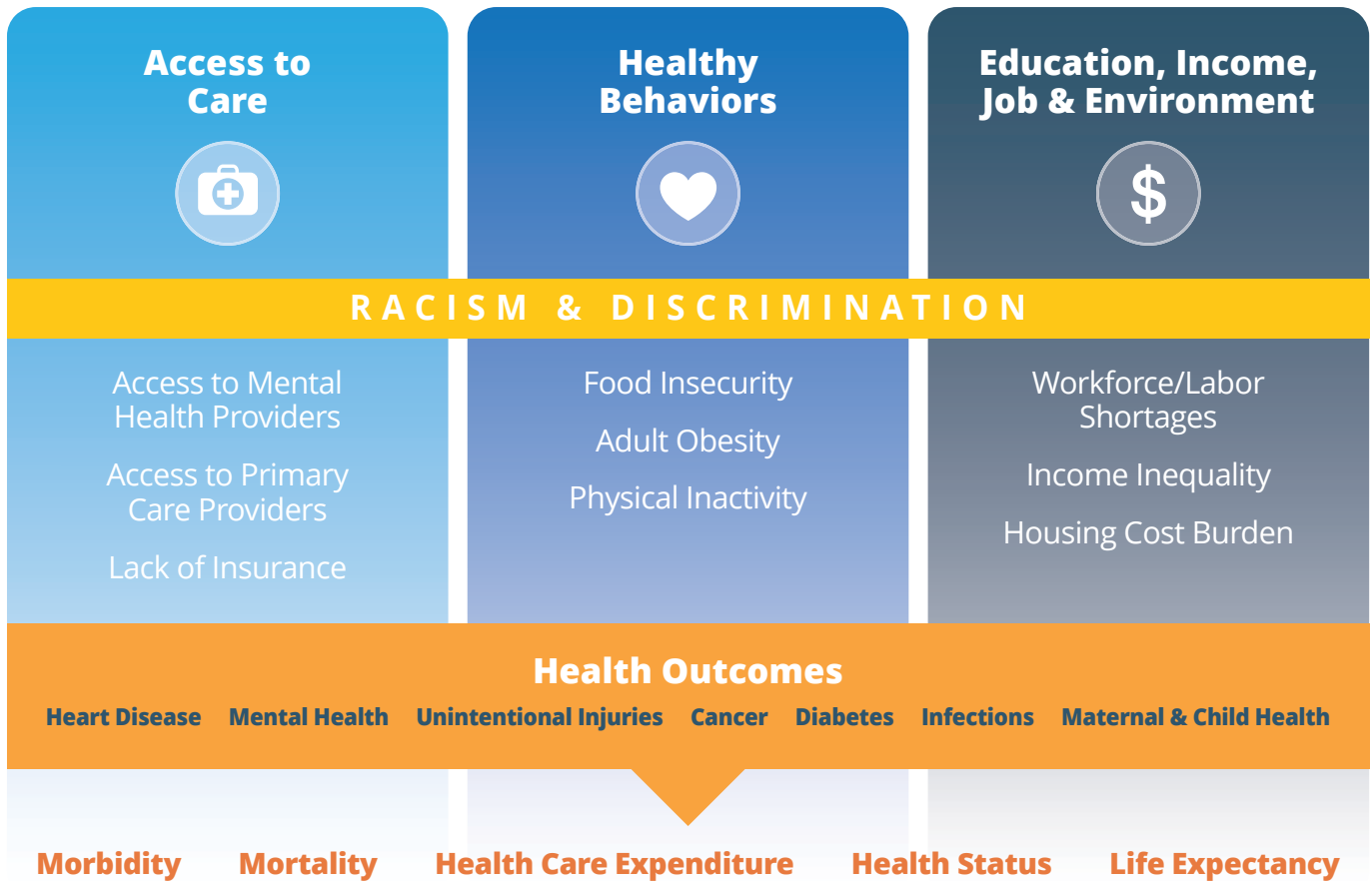
Through a multi-sectoral collaboration, the MCHC will seek to address these top health factors in a collaborative implementation strategy, while paying particular attention to the most vulnerable populations in our communities. Appendix K provides a list of existing resources within the community currently available to meet the identified community health needs.

CONCLUSION

The 2022 MCHC CHNA is an initial collaborative assessment that will serve as a starting point for ongoing evaluation of collaborative improvement efforts. Progress on identified health priorities based on measurements from the individual hospital's CHNA's from previous years can be found in Appendix J. The MCHC will work diligently over the next three years to ensure that the valuable information attained from the 2022 CHNA is an indispensable tool to measure and evaluate meaningful health impact in the communities we serve. The collaborative implementation plan which is elaborated in response to the findings of this report will provide strategies to reduce and prevent health inequities so all members of our community have the opportunity to achieve optimal health.

The 2022 MCHC CHNA report marks a monumental step towards building the ecosystem that is needed to maximize impact and advance health equity through collective action. In addition to guiding our implementation plan, we hope this report provides residents, partners, and community groups with valuable information for community-based planning.

Figure 88. The Montgomery County Hospital Collaborative Model for Improved Health Outcomes.



Graphic adapted from the Kaiser Family Foundation, 2020

For further information on how the hospitals of the MCHC plan to address each identified unmet need, please review our Multi-Year CHNA Implementation Plan.

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APPENDIX

APPENDIX A LISTING OF COMPREHENSIVE SERVICES BY HOSPITAL

Adventist HealthCare

Founded in 1907, Adventist HealthCare is a faith-based, not-for-profit organization of dedicated professionals who work together to improve the health of people and communities through the ministry of physical, mental and spiritual healing. This total well-being approach has been so successful in helping our community achieve the best health outcomes that Adventist HealthCare has grown to become a comprehensive health system and are seen as leaders, particularly in the areas of heart, orthopedics, maternity and mental health.

Adventist HealthCare is headquartered in Montgomery County, Maryland, and supports the Washington, D.C., metro area through:

- Three acute care hospitals
- Two rehabilitation hospitals
- Two community cancer centers
- Mental health services
- Home care services
- Imaging centers
- Urgent care centers
- Community outreach

Adventist HealthCare also promotes collaboration through the One Health Quality Alliance, our clinically integrated network of over 1,700 health care providers who work together to improve both the quality of care and patient outcomes throughout the region.

For a detailed list of our specialties and services, please visit AdventistHealthCare.com

Holy Cross Health

Holy Cross Health offers our community access to a wide range of quality health care. Our programs at Holy Cross Hospital in Silver Spring, Md. provides area adults and children an array of inpatient and outpatient services. Holy Cross Health also offers community health care, health education and support services, as well as home-based health and hospice care to meet a lifetime of health needs.

Specialties and services:

- Cancer Institute Home-Based Services
- Emergency Center Hospitalists and Intensivists
- Neurosciences Medical Imaging Services
- Senior Services Pain Management Center

- Surgical Services Palliative Care
- Women and Infant Services Pediatric Services
- Cardiac Services Physical Medicine And
- Rehabilitation Program
- Critical Care Sleep Center
- Dialysis Services

For a detailed list of our specialties and services, please visit <http://www.holycrosshealth.org/programs-services>

MedStar Health, MedStar Montgomery Medical Center

MedStar Health operates 10 hospitals across Baltimore, central Maryland, Washington, D.C., and southern Maryland. Our facilities offer a full range of health care services and are recognized both regionally and nationally for excellence in medical care.

MedStar Montgomery Medical Center is a not-for-profit, acute care community hospital serving Montgomery County, Maryland. For 100 years, MedStar Montgomery Medical Center has served as a medical care provider and community health resource offering high-quality, personalized care. MedStar Montgomery Medical Center provides a broad range of health care specialties, advanced technologies, and treatments not traditionally found at community hospitals—including cutting-edge care in obstetrics, orthopedics, breast health, and oncology. MedStar Health is the region’s largest non-profit and most trusted integrated health care delivery system, giving patients access to the latest in modern medicine and medical technology within a community hospital setting.

Clinical specialties:

- Bariatric Surgery
- Breast Health
- Gastroenterology
- Non-Surgical Weight Loss
- Orthopedics
- Pulmonology
- Behavioral Health & Psychiatry
- Cardiology
- Geriatrics
- Oncology
- Physical Therapy & Rehabilitation
- Women’s Health

For a detailed list of our programs, services, and providers, visit MedStarHealth.org

Suburban Hospital, Johns Hopkins Medicine

Suburban Hospital is a community-based, not-for-profit hospital serving Montgomery County and the surrounding area since 1943. The hospital provides all major services except obstetrics. The hospital is one of nine regional trauma centers in Maryland and is the state-designated Level II Trauma Center for Montgomery County, with a fully equipped and elevated helipad.

Primary services include:

- Radiation and surgical oncology a part of the Johns Hopkins Kimmel Cancer Center in the National Capital Region and recognized by the American College of Surgeons Commission on Cancer.
- Cardiac surgery including elective and emergency angioplasty and inpatient, diagnostic, and rehabilitation services through the Johns Hopkins Medicine Structural Heart Disease Program at Suburban Hospital.
- Treatment for multiple brain and nervous system conditions—including brain tumors, movement disorders and general neurosurgical care—provided by Johns Hopkins neurosurgical team.
- Home to inpatient and outpatient behavioral health programs, and an Addiction Treatment Center, offering day treatment programs to adolescents and adults.
- A 24-hour stroke team, as well as state-of-the-art diagnostic pathology and radiology departments.
- A full-service Emergency Department treating more than 40,000 patients annually and includes the Shaw Family Pediatric Emergency Center exclusively for children and adolescents.
- Inpatient Diabetes Management Service (IDMS), which is a special diabetes clinical consultation service designed to promote better glycemic (blood sugar levels) control and reduce hypoglycemia (low blood sugar) and glucose-related safety challenges in hospitalized patients. Suburban Hospital also offers the Diabetes Self-Management Training (DSMT) which a certified diabetes educator meets one on one with individuals living with diabetes to improve their health outcomes.
- An extensive community health and wellness program that invested more than \$33.6 million in community benefit contributions in FY 2021, including 5,612 community health improvement programs, biometric screenings, wellness classes and community building activities that served 52,049 individuals in Montgomery County.
- Suburban Hospital achieved Magnet designation in recognition of its nursing excellence from the American Nurses Credentialing Center, becoming the first and only hospital in Montgomery County with this distinct recognition.

For a detailed list of our specialties and services, please visit https://www.hopkinsmedicine.org/suburban_hospital/

APPENDIX B HEALTHY MONTGOMERY STEERING COMMITTEE MEMBERS

STEERING COMMITTEE

CO-CHAIRS

Manna Food Center	Jackie DeCarlo, Chief Executive Officer
Montgomery County DHHS	Christopher Rogers, Policy & Strategy Officer of Public Health Services

MEMBERS

Adventist HealthCare	Gina Maxham, Director, Community Benefit & Engagement
African American Health Program	Jacquelyn Williams, Co-Chair, African American Health Program Steering Committee
Asian American Health Initiative	Nguyen Nguyen, Chair, Asian American Health Initiative Steering Committee
Commission on Health	Crystal DeVance-Wilson, Commissioner
EveryMind	Kathy McCallum, President, Board of Directors
Holy Cross Health	Kimberley McBride, Vice President, Community Health
Latino Health Initiative	Dr. Olivia Carter-Pokras, Latino Health Initiative Steering Committee
MedStar Health, MedStar Montgomery Medical Center	Diana Saladini, Director, Population Health
Montgomery County Department of Planning	Amy Lindsey, Senior Planner
Montgomery County Department of Transportation	Samuel Oji, Chief, Enhanced Mobility and Senior Services Section
Montgomery County Collaboration	Jade-Ann Rennie, Program Manager, Public Health
Montgomery County Public Schools	Victoria Thompson, Coordinator, Student Health Care Services
Montgomery County Recreation	Stephanie McKay, Recreation Specialist
Montgomery Parks	Cristina Sasaki, Parks Planner Coordinator/Urban Designer
Primary Care Coalition of Montgomery County	Leslie Graham, President & Chief Executive Officer
Suburban Hospital	Monique Sanfuentes, Administrative Director, Community Affairs & Population Health
UnitedHealth care Community Plan MCO	Lynn Mejia, Bilingual Community Development Specialist

APPENDIX C HOSPITAL ADVISORY GROUPS AND EXTERNAL REVIEW COMMITTEES

MEMBERS

Addiction Treatment Center - Suburban Hospital	Beth Kane Davidson, Department Director ATC
Adventist HealthCare	Nicolas Cacciabeve, MD, Pathologist
Adventist HealthCare Behavioral Health & Wellness Services	Marissa C. Leslie, MD, Medical Director
Adventist HealthCare	Terry Forde, President & CEO
American University	Anastasia Snelling, Ph.D., Department Chair, Health Studies
AQUAS, Inc.	Carmen Larsen, President
Asian American Health Initiative	Sanjana Qusem, Program Manager
Bethesda NEWtrition & Wellness Solutions	Diana Rapalo, Nurse Practitioner
Bethesda NEWtrition & Wellness Solutions	Rose Oshinsky, Diabetes Nurse Educator
Bradley Hills Village	Betsy Carrier, Treasurer
Cancer Center - Suburban Hospital	Jamie Borns, Nurse Care Coordinator Oncology
Chesapeake Conference of Seventh-day Adventists	Rick Remmers, President
Chevy Chase Trust	Stacy Murchison, Chief Marketing Officer
City of Gaithersburg	Mary Armbruster, Senior Program Coordinator
City of Gaithersburg	Maureen Herndon, Division Manager
Columbia Union Conference of Seventh-day Adventist	David E. Weigley, President
Columbia Union Conference of Seventh-day Adventists	Emmanuel Asiedu, CFO/Treasurer
Community Physician	Michael Smith, M.D., Radiologist and brother of Alpha Phi Alpha Fraternity, Montgomery County Chapter
Cross Community	Ben Wikner, Executive Director and Pastor
Events DC	Henry Mosley, CFO
EveryMind	Karishma Sheth, Chief Program Officer
Everymind- Linkages to Learning	Reina Guerrero, Community School Coordinator
Community Advocate	Karin Bertozzi
Gaithersburg Chamber of Commerce	Marilyn Balcombe, President and CEO
Girls on the Run, Montgomery County	Elizabeth McGlynn, Executive Director
GT Health	Gerti Tashko, MD
Healthcare Initiative Foundation	Crystal Townsend, President & CEO
Healthy Montgomery/ DHHS Office	Felicia Hugee, Planning Specialist

Holy Cross Health Center-Aspen Hill	Jacqueline Williams-Hubbard, Director
Housing Opportunities Commission	Marsha Batista, Resident Counselor III
Impact Silver Spring	Michael Rubin, Interim Executive Director
Kamehameha Schools	Janet Devinney, Director-Orivate Equity & Venture Capital
Latino Health Initiative	Paola Fernan-Zagarra, Planning and Quality Assurance Manager
Laurel Medical Associates	Darryl Hill, MD
Leisure World of Maryland Corporation	Susan Montgomery, Director of Social Services
Lerch Early & Brewer	Paul Alpuche Jr., Attorney
MC Chapter of National PanHellenic Council	Bertha Ballew, President
MedStar Health, MedStar Montgomery Medical Center	Debbie Otani, Cancer Nurse Navigator
MedStar Health, MedStar Montgomery Medical Center	Lynda Suh, Director, Quality and Risk
MedStar Health, MedStar Montgomery Medical Center	Ngozi Wexler, MD, VP, Medical Affairs
MedStar Health, MedStar Montgomery Medical Center	Deana Cho, Social Worker, Center for Successful Aging
MedStar Health, MedStar Montgomery Medical Center	Lisa King, Patient Family Advisory Council Member
Millian United Methodist Church	Edith Williams, Community Representative
Mindoula	Danielle Dennis, Readmissions Reduction Case Manager
Montgomery College	Karla Silvestre, Director of Community Engagement
Montgomery County Department of Health and Human Services	James Bridgers, PhD, Acting Health Officer & Chief
Montgomery County Department of Health and Human Services	Christopher Rogers, PhD, Policy & Strategy Officer of Public Health Services
Montgomery County Government	Ken Hartman, Director of Strategic Partnerships at Montgomery County Government
Montgomery County Police 2nd District	Officer Dana Stroman, Community Services Officer
Montgomery County Public Schools	Ana Schmitz, Community School Coordinator
Montgomery County Recreation	Amanda DeFilippo, Manager III
Olney Home for Life	Audrey Partington, Chair, Outreach
Olney Theater	Debbie Ellinghaus, Community Representative
Pastoral Care - Suburban Hospital	Philip Ridley, Director
Primary Care Coalition	Mary Jane Joseph, Project Manager
Resident of Montgomery County	Belle O'Brien, Community Advocate
Seventh-day Adventists	Charles Tapp, President

Southern Asian Seventh-day Adventist Church	Franklin David, Senior Pastor
Suburban Hospital	Jeanmarie Gallagher, Manager Cardiac Rehabilitation
Suburban Hospital	Fayyaz Hashmi, MD, Clinical Associate – Cardiac Surgery
Suburban Hospital	Carolyn Wu, MD, Cardiology
Suburban Hospital	Mihail “Misha” Zilbermint, MD, MBA, Endocrinologist
Summit Leadership Solutions	James Boyle, President & CEO
The RJ Clarke Group LLC	Robert Clarke, Principal
United Way of the National Capital Area	Ian Gordan, Vice President, Community Impact
University of Maryland	Stephen B. Thomas, PhD, Professor, Department of Health Policy & Management and Director, Maryland Center for Health Equity
USACS East	Brett Gamma, MD, Medical Director
Washington Adventist University	Cheryl Kisunzu, Provost
YMCA of Metropolitan Washington	Carla Larrick, Vice President of Operations
National Institutes of Health	Meg Whelpley, Nurse Practitioner
Patient & Family Advisory Committee, Suburban Hospital	Elsie Durland, Community Advocate
Patient & Family Advisory Committee, Suburban Hospital	Jacqueline Beale, Community Advocate
JDRF (Juvenile Diabetes Research Foundation)	Barbara Kahl, Community Advocate



Community Health Improvement Process
2021-2022 Community Health Needs Assessment
Community Conversation with *Key Informants*

Introduction

The purpose of the key informant interview (KII) component of the Community Health Needs Assessment (CHNA) was to gather thoughts and perspectives from key Montgomery County stakeholders on the local environment, to identify the most pressing needs of the community, and to prioritize significant health needs of the Montgomery County community over the next several years. A total of 56 stakeholders participated in the 11 KIIs. The KIIs included stakeholders from the following County entities: organizations primarily serving Asian Americans, organizations primarily serving Latino/a or Hispanic Individuals, organizations primarily serving Black, African or African Americans, Faith Leaders, Adventist HealthCare, Suburban Hospital, Medstar Health, Holy Cross Hospital, and Montgomery County Boards, Committees and Commissions (Racial Equity and Social Justice Advisory Committee, Fire and Emergency Services Commission, and Board of Social Services).

The participants of the KIIs represented the diversity of the communities they served. Participants noted that certain services or needs are greater in some zip codes as compared to others. Notable health issues, concerns, barriers or needs of the communities served were identified by participants as inadequate housing, increasing homelessness among low-income individuals, lack of advance care planning among older adults, expensive medication, human trafficking, and domestic violence. Participants emphasized the need for an integrated approach to solving the health care needs in the community that provided resources and client/patient education.

Health Issues, Concerns, Barriers or Needs of the Community

Health behaviors were discussed by stakeholders as issues, concerns, barriers, or needs affecting the health of the community. Teen pregnancy was stated as a health concern in the community. Participants shared concerns over increases in the number of pregnant teens that are engaging in substance use (marijuana). Further, use of opioids, specifically fentanyl, and alcohol use disorders are increasing health concerns in Montgomery County. One participant stated from their experience that calls to 911 involving alcohol use disorders have increased during the pandemic.

Intimate partner sexual violence, including physical abuse, was a health issue described by participants. Participants cited additional barriers to intimate partner sexual violence are related to culture (such as beliefs about divorce or having both parents for the children, even in the face of violence) and economic need (individuals perceived inability to leave abusers due to financial dependence). Multiple families residing in one dwelling, often related to economic insecurity, presents a heightened risk factor related to intimate partner sexual violence, cited one participant.

Social, economic, and demographic factors were discussed by stakeholders as issues, concerns, barriers, or needs affecting the health of the community. Participants felt that economic stability,

specifically financial insecurity among low-income community members was a barrier that affected the health of individuals served. Transportation was referenced by many participants as a barrier to medical appointments, especially for low-income individuals seeking primary care, though in some areas participants mentioned, clients do live near clinics that serve this population.

Food security and access to healthy foods was an issue discussed by many participants across the interviews. Stakeholders shared those individuals in the communities they serve, specifically those with chronic conditions or low-income, experience barriers associated with affordable healthy food options based on dietary preferences. One stakeholder commented that individuals' feedback on their organization's current nutritional resources reveal that these services are inadequate. Feedback results showed that individuals who are referred to nutritional counseling or support find that these services do not meet their needs.

Some residents have no health insurance or limited health insurance benefits. Participants shared concerns for the availability of health insurance that impacts one's ability to pay co-payments for mental health and wellness visits.

Participants emphasized concerns around employment as a health barrier. Some community residents may be underemployed (limited hours or pay to support needs) or have lost their job due to the COVID-19 pandemic. Those most impacted by employment concerns are the working poor, which includes:

- Women
- Part-time workers
- Service workers
- Young workers
- Unrelated individuals (people who live together but are not blood relatives)

Participants also noted that as stakeholders, they too can find it difficult to navigate information on the availability of additional resources to support their clients and patients. "We're blessed. Montgomery County has an incredible amount of resources and information available, except, there is so much, you can get overwhelmed going on the MontgomeryCounty.gov website", as one participated stated. Participants agreed that assistance with the navigation of county resources and services would be helpful to them. One participant felt that low-income individuals fear completing government assistance applications due to undocumented status. Other low-income individuals, stakeholders stated have difficulties navigating government/accessing services.

Clinical care factors were discussed as issues, concerns, barriers, or needs for access to affordable, quality, and timely health care that can help prevent diseases and detect issues sooner. Access to specialty care health services was a need identified by stakeholders. One participant cited from their experience a growing increase of younger adults with renal failure noting, there is "no clinics" to send patients to for hemodialysis, especially if they are uninsured or undocumented. These patients may end up "hospital hopping" in order to receive care, which in the long run is not good for continuity of patient care or for hospital resources. The other specialty care needs within the community include barriers dental care associated with costs, and the need to travel to this care. Participants expressed that even if families get the money to pay for dental care and find a dentist, they are often spread out so far that individuals must take multiple buses to get there or rely on someone giving them a ride.

Participants discussed insufficient fiscal and human resources support to meet the mental health needs of the communities. For example, mental health facilities lacked support for those needing

behavioral health care, making it challenging to place those in need of substance use treatment/detox and assistance with a mental health condition. Also, participants cited that many existing facilities do not have enough space for patients to keep up with the demand of treatment needs.

Post-hospital discharge support services for individuals who are uninsured, underinsured, or homeless was a concern mentioned by participants. One participant shared concern around there not being enough facilities to meet the safe hospital discharge needs of the older adult population. Access to a primary care provider was also cited as a barrier to health care services for individuals who are uninsured or underinsured. The unaffordable cost of prescription medications was another barrier experienced by and concern for the uninsured and underinsured communities. One participant shared that some patients come to the emergency room because they have run out of their maintenance prescriptions for conditions like diabetes or hypertension.

Participants discussed **physical and built environment** issues, concerns, barriers, or needs that affect where individuals live, learn, work, and play. Stakeholders emphasized housing affecting health as a concern for Montgomery County communities. Housing concerns includes both homelessness and the availability of affordable housing. Housing insecurity (e.g., overcrowding, landlords who operate poorly maintained properties) participants noted has critical implications related to health care (e.g., medications that require refrigeration) and safety (e.g., domestic abuse, family stress, etc.).

Access to transportation was discussed by many participants as a barrier that impacts the ability to access health services, which can affect one's health if one cannot get routine care. Having limited transportation options, one participant noted, can also be a source of stress.

Internet access to find information about available support services was discussed as a barrier.

Environmental conditions and climate change concerns are issues discussed by stakeholders across the key informant interviews. Some examples provided are general concerns about air quality, radon levels in homes, mold in housing, health issues related to lead paint, unmaintained air conditioning units that could lead to Legionnaires' disease, and safe environments for animals.

Stakeholders across all interviews discussed several **quality of life** issues, concerns, barriers, or needs that represent the lack of health of people in the community. Participants shared an overall concern for patients who decided to delay their annual preventive health care screenings due to the COVID-19 pandemic. Preventable conditions like obesity, hypertension and diabetes were listed as health concerns. Several participants felt that these conditions are more prevalent among minority communities, specifically Blacks and Latinos. One participant cited that obesity can also be impacted by mental health and other co-morbidities, so a "one-size-fits-all approach to address obesity does not work." Another participant mentioned from their experience there is an increase incidence of younger adults presenting to the hospital emergency room with diabetic ketoacidosis and heart disease.

Breast cancer was stated as a health issue that adversely affects the quality of life for women in Montgomery County communities. One participant cited concerns for late-stage breast cancer diagnosis for individuals that have delayed preventive screenings due to the COVID-19 pandemic.

Stakeholders identified mental and behavioral health concerns affecting the community they serve. Participants discussed that community members are impacted by depression, mania, bipolar, schizophrenia, and other chronic mental health concerns. Participants shared concerns for the overall mental health for low-income community residents, especially as a result of the COVID-19

pandemic. Participants further expressed concern that youth and adolescents are dealing with mental and behavioral health issues including depression, anxiety, and suicide ideation. One participant shared that mental health conditions among pregnant teens is a growing issue in the community they serve. Participants stated that trauma and grief in low-income individuals is an issue affecting the health of the community they serve. One participant shared from their own experience that mental health-related calls to 911 have increased during the COVID-19 pandemic.

Participants identified Alzheimer's or other dementia as an increasing memory care issue for the older adult population of Montgomery County. Of note was a need for more in-home care for older adults with Alzheimer's or other dementias. One participant shared those older adults like to stay in their homes, so when a medical emergency arises, they may delay seeking care for fear they will not return home and will be placed in a nursing home or other assisted living facility. Participants voiced concern that familial support may not be readily available for aging adults as this community was described by one participant as being "a very transient area".

Resources to Support Healthy Living

Stakeholders across the KIIIs shared their thoughts on resources that currently exist and would like to see in the community that can help people live a healthy life. These resources support several health issues, concerns, needs, and barriers identified in the previous section, including behavioral health, mental health, substance use, food security, housing, and dental care.

Clinical Care Resources

- A "middle level" facility, for example a step-down from a skilled nursing facility, that can address mental and behavioral health needs of the community by providing daily counseling and a more holistic care approach.
- Montgomery County Restoration Center to support behavioral health and substance use.
- Suicide prevention groups within schools to provide resources to youth
- Montgomery County should continue existing programs that support mental health, especially for minority populations, like African American Health Program, the Latino Health Initiative, and the Asian American Health initiative. These programs were described as "good programs, and we would like to see those continue."
- Ancillary behavioral health services including Vesta and Cornerstone Montgomery
- Specialized resources/services and safe spaces for individuals to be able to come forward and report when they are experiencing traumas and being targeted by law enforcement.
- Avery Road and Maryland treatment services for mental health
- Medical respite homes for the homeless
- Mobile units bringing dental care to communities
- Offering family and nursing care, which sends nurses to patients' home to conduct safety checks and connect to community resources.
- Resources to make medication freely available to clients

Social, Economic, and Demographic Resources

- Maximize the use of local services within the Montgomery County cities are good as these agencies and programs often work together to provide more tailored and holistic support to the community. These types of initiatives could serve as models for county-level programs.

- Integration of social services into medical care services: eligibility and support services, especially to help food security, foster care programs, and leveraging county resources with existing HHS funded programs
- Interfaith Works Program
- Community wrap-around services that offer food and shelter resources
- Homeless shelters
- Homeless programs to connect individuals to temporary housing, for example hotels
- United US and Info Montgomery are websites used to look up existing resources to address social determinants of health.
- Expanded online health and human services repositories to look up and identify resources quickly.
- Case managers to connect individuals to social services
- Neighborhood networks to strengthen partnerships between health care and community-based organizations.
- Living wages

Quality of Life

- Public awareness of intimate partner sexual violence community resources available
- Specialized training/capacity building, such as trauma-informed interpretation (as opposed to mere translation)
- Building a trusting relationship between a client/patient (or potential clients/patients) and provider so that those who need services feel safe seeking help if/when needed.

Health Behaviors

- Culturally appropriate health education and resources tailored to the Black and Latino populations to address diabetes and obesity.
- Chronic diseases self-management education to understand the disease process and to promote healthier eating based on dietary preferences.
- Health education for pregnant teens about the dangers engaging in substance use (marijuana) poses to the baby.
- Maximize the use of technology platforms such as WhatsApp and YouTube to provide tailored health information to special populations.

Built Environment

- Enhance the built environment with more grocery stores in the County in order to support a healthy lifestyle
- Enhance the built environment with more parks and greenspaces in the County in order to support a healthy lifestyle

* *The 2021-2022 Community Health Needs Assessment Community Conversation with Key Informants was prepared by Healthy Montgomery staff.*

APPENDIX E MCHC CBSA ZIP CODES

ZIP CODE	CITY
20705	BELTSVILLE
20706	LANHAM
20707	LAUREL
20740	COLLEGE PARK
20742	COLLEGE PARK
20770	GREENBELT
20782	HYATTSVILLE
20783	HYATTSVILLE
20814	BETHESDA
20815	CHEVY CHASE
20816	BETHESDA
20817	BETHESDA
20832	OLNEY
20850	ROCKVILLE
20851	ROCKVILLE
20852	ROCKVILLE
20853	ROCKVILLE
20854	POTOMAC
20855	DERWOOD
20866	BURTONSVILLE
20871	CLARKSBURG
20874	GERMANTOWN
20876	GERMANTOWN
20877	GAITHERSBURG
20878	GAITHERSBURG
20879	GAITHERSBURG
20882	GAITHERSBURG
20886	MONTGOMERY VILLAGE
20895	KENSINGTON
20899	GAITHERSBURG
20901	SILVER SPRING
20902	SILVER SPRING
20903	SILVER SPRING
20904	SILVER SPRING
20905	SILVER SPRING
20906	SILVER SPRING
20910	SILVER SPRING
20912	TAKOMA PARK

APPENDIX F DEMOGRAPHICS OF EQUITY FOCUS AREAS (2018)

Montgomery County, Md	% of Equity Focus Areas	% of Area Outside of EFAs	% of County
POPULATION			
Total population	275,873	764,260	1,040,133
% of County's population	26.5%	73.5%	
Population living in households	274,447	756,839	1,031,286
Age Distribution			
Total population	275,873	764,260	1,040,133
0-4 years	7.7%	5.9%	6.4%
5-17 years	16.8%	17.1%	17.0%
18-34 years	26.1%	19.0%	21.0%
35-44 years	15.3%	13.2%	14.0%
45-64 years	23.7%	28.7%	27.0%
65 years and older	10.5%	16.1%	14.6%
Race and Hispanic Origin Combined ¹			
Total population	275,873	764,260	1,040,133
Not Hispanic	64.8%	86.5%	80.7%
White	22.0%	52.6%	44.5%
Black	25.7%	14.8%	17.7%
Asian or Pacific Islander	13.6%	15.0%	14.6%
Other race	3.5%	4.1%	3.9%
Hispanic or Latino ¹	35.2%	13.5%	19.3%
Language Spoken at Home			
Population 5 years and over	254,609	718,824	973,433
Speak language other than English	57.8%	34.6%	40.6%
Speak English less than "very well"	24.0%	10.5%	14.0%
Educational Attainment			
Persons 25 years and older	182,898	531,597	714,495
Less than high school diploma	17.5%	5.7%	8.7%
High school graduate, some college or associate	42.7%	28.6%	32.3%
Bachelor's degree	21.4%	29.1%	27.1%
Graduate or professional degree	18.5%	36.5%	31.9%
Residence 1 Year Ago			
Population 1 year and over	271,567	756,455	1,028,022
Same house	81.9%	86.8%	85.5%
Different house in U.S.	16.4%	11.5%	12.8%
Abroad	1.8%	1.6%	1.7%
LABOR FORCE			
Class of Worker ²			
Civilian employed population 16 years and over	150,339	405,924	556,263
Private wage and salary	77.7%	70.6%	72.5%
Government	16.7%	23.0%	21.3%
Self-employed in own not incorporated business	5.5%	6.2%	6.0%

Source: Research and Strategic Projects, Montgomery Planning Department, M-NCPPC (March 2021).

Equity Focus Areas & Area Outside of EFAs (2018)

Montgomery County, Md	% of Equity Focus Areas	% of Area Outside of EFAs	% of County
Occupation			
<i>Civilian employed population 16 years and over</i>	150,339	405,924	556,263
Management, business, science, and arts	38.0%	62.9%	56.2%
Service	24.8%	12.0%	15.5%
Sales and office	18.5%	16.7%	17.2%
Natural resources, construction, and maintenance	10.6%	4.0%	5.8%
Production, transportation, and material moving	8.0%	4.3%	5.3%
Work Trip			
<i>Workers 16 years and over</i>	147,143	401,371	548,514
Drove	75.0%	75.2%	75.1%
Alone	61.8%	66.6%	65.3%
Carpool	13.2%	8.6%	9.8%
Public transportation	18.6%	13.8%	15.1%
Walked and other means	3.5%	3.8%	3.7%
Worked at home	3.0%	7.3%	6.1%
Average travel time to work (minutes)	34.3	37.3	34.6
Work Location			
<i>Workers 16 years and over</i>	147,143	401,371	548,514
In County	62.3%	60.8%	61.2%
Outside County, in Maryland	12.3%	10.4%	10.9%
In another state	25.3%	28.9%	27.9%
HOUSEHOLD INCOME			
2018 Household Income Distribution			
<i>Households</i>	94,019	276,208	370,227
Under \$25,000	13.3%	7.9%	9.3%
\$25,000 to \$49,999	19.9%	9.9%	12.4%
\$50,000 to \$74,999	18.8%	11.5%	13.4%
\$75,000 to \$99,999	14.7%	11.1%	12.0%
\$100,000 to 149,999	18.0%	19.7%	19.3%
\$150,000 to 199,999	8.7%	13.7%	12.4%
\$200,000+	6.7%	26.3%	21.3%
2018 average household income	\$89,950	\$163,368	\$144,723
People whose income is below the poverty level	11.9%	5.1%	6.9%

Source: Research and Strategic Projects, Montgomery Planning Department, M-NCPPC (March 2021).

Equity Focus Areas & Area Outside of EFAs (2018)

Montgomery County, Md	% of Equity Focus Areas	% of Area Outside of EFAs	% of County
HOUSING			
<i>Housing units</i>	99,578	288,676	388,254
% of County's housing units	25.7%	74.4%	
Households	94,019	276,208	370,227
Average Household Size	2.92	2.74	2.79
Housing Units in Structure			
<i>Housing units</i>	99,578	288,676	388,254
1-unit, detached	29.1%	53.8%	47.4%
1-unit, attached	19.6%	17.9%	18.4%
2 to 4 units	2.7%	1.5%	1.8%
5 to 9 units	10.4%	3.3%	5.1%
10 to 19 units	20.0%	5.7%	9.4%
20 to 49 units	3.5%	2.6%	2.8%
50 or more units	14.4%	15.1%	14.9%
Mobile homes, RV	0.2%	0.1%	0.2%
Households by Type			
<i>Households</i>	94,019	276,208	370,227
Family households	66.7%	71.0%	69.9%
Families with children under 18	34.2%	32.4%	32.8%
Nonfamily households	33.3%	29.0%	30.1%
Householder living alone	26.4%	24.3%	24.8%
Households by Tenure			
<i>Households</i>	94,019	276,208	370,227
Owner-occupied	46.0%	72.0%	65.4%
Renter-occupied	54.0%	28.0%	34.6%
Owner-Occupied Housing Value (2018 dollars)			
<i>Owner-occupied households</i>	43,280	198,983	242,263
less than \$300,000	38.7%	15.5%	19.6%
\$300,000 to \$399,999	29.7%	15.2%	17.8%
\$400,000 to \$499,999	20.2%	15.7%	16.5%
\$500,000 to \$749,999	10.2%	27.6%	24.5%
\$750,000 to \$999,999	0.8%	14.0%	11.7%
\$1,000,000 or more	0.5%	12.0%	9.9%
Average housing value	\$344,664	\$628,725	\$561,998
Selected Monthly Owner Costs			
<i>Households with a mortgage</i>	31,862	147,310	179,172
Less than \$1,500	21.2%	11.1%	12.9%
\$1,500 to \$1,999	29.6%	15.4%	17.9%
\$2,000 to \$2,499	22.3%	18.3%	19.0%
\$2,500 to \$2,999	14.7%	16.4%	16.1%
\$3,000 to \$3,999	9.8%	20.3%	18.4%
\$4,000 or more	2.4%	18.5%	15.6%
Average monthly mortgage cost	\$2,136	\$2,983	\$2,844

Source: Research and Strategic Projects, Montgomery Planning Department, M-NCPPC (March 2021).

Equity Focus Areas & Area Outside of EFAs (2018)

Montgomery County, Md	% of Equity Focus Areas	% of Area Outside of EFAs	% of County
Gross Rent (including utilities)			
<i>Households paying rent</i>	49,824	74,623	124,447
Less than \$1,000	9.2%	8.8%	9.0%
\$1,000 to \$1,499	29.7%	18.6%	23.0%
\$1,500 to \$1,999	44.7%	32.2%	37.2%
\$2,000 to \$2,499	12.7%	22.5%	18.6%
\$2,500 or more	3.8%	17.9%	12.3%
Average monthly rent	\$1,591	\$2,787	\$1,769
Households Spending More Than 35% of Income on Housing Costs			
<i>Households</i>	94,019	276,208	370,227
Homeowners with a mortgage	25.9%	19.2%	20.4%
Renters	44.2%	38.5%	41.3%
Households with Available Vehicles			
<i>Households</i>	94,019	276,208	370,227
No vehicles available	11.3%	6.4%	7.6%
1 vehicle	39.4%	31.7%	33.6%
2 vehicles	34.2%	41.8%	39.8%
3 or more vehicles	15.2%	20.2%	18.9%

Note: The profile is derived from the aggregation of U.S. Census Block Groups from the 2018 American Community Survey, 5-year estimates.

¹ Those of Hispanic origin may be of any race. ² Unpaid family workers are not shown.

* Data reliability was judged on a scale of good, fair, caution, or poor. The majority of reported estimates are judged as "good" the highest level of reliability with the exception of mobile homes rates as "poor".

Source: 2018 American Community Survey, 5-year estimates, U.S. Census Bureau; compiled by Research & Strategic Projects, Montgomery County Planning Department, M-NCPPC (March 2021).

Source: Research and Strategic Projects, Montgomery Planning Department, M-NCPPC (March 2021).



The 2022 Rankings include deaths attributable to COVID-19 from 2020. See our FAQs for more information on COVID-specific data.

Compare Counties

2022 Rankings

	Maryland	Prince George's (PG), MD X	Montgomery (MO), MD X PEER COUNTY
Health Outcomes			
Length of Life			
Premature death	7,500	7,500	4,300
Quality of Life			
Poor or fair health**	14%	17%	13%
Poor physical health days**	3.2	3.5	2.9
Poor mental health days**	4.0	4.1	3.6
Low birthweight	9%	9%	7%
Health Factors			
Health Behaviors			
Adult smoking**	13%	13%	9%
Adult obesity**	32%	37%	25%
Food environment index**	8.7	9.1	9.0
Physical inactivity**	23%	27%	19%
Access to exercise opportunities	88%	97%	99%
Excessive drinking**	16%	15%	15%
Alcohol-impaired driving deaths	28%	31%	22%
Sexually transmitted infections**	624.9	908.6	447.2
Teen births	15	20	10
Clinical Care			
Uninsured	7%	10%	8%
Primary care physicians	1,120:1	1,890:1	720:1
Dentists	1,260:1	1,570:1	800:1
Mental health providers	330:1	550:1	280:1
Preventable hospital stays	3,568	3,855	2,185
Mammography screening	42%	38%	41%
Flu vaccinations	51%	40%	54%
Social & Economic Factors			
High school completion	91%	87%	91%
Some college	71%	63%	78%
Unemployment**	6.8%	8.2%	6.3%

Children in poverty	11%	13%	8%
Income inequality	4.5	3.8	4.5
Children in single-parent households	26%	33%	20%
Social associations	9.0	8.0	8.8
Violent crime**	459	423	173
Injury deaths	88	62	43
Physical Environment			
Air pollution - particulate matter	7.4	6.3	8.7
Drinking water violations		No	No
Severe housing problems	16%	19%	17%
Driving alone to work	72%	66%	63%
Long commute - driving alone	50%	61%	54%

** Compare across states with caution

^ This measure should not be compared across states

Note: Blank values reflect unreliable or missing data

APPENDIX H COMMUNITY INPUT SURVEY DISTRIBUTION CHANNELS

Artistry	Thought Leaders (Behavioral Health, Cancer, Heart, Diabetes, Infections, and Injuries)
The FitSolution	WellWorks
Community Ministries of Rockville	BCC Chamber – Health & Wellness Workgroup
AAHP	PFAC
PG County Health Department	Village Ambassadors
HCH Senior Source	Barrington Apartments – vaccine clinics
Montgomery County Stroke Association	Montgomery County Food Council
Capital Digestive Care	Bethesda Beat
Life Insurance for Diabetics	SH – Community Health Improvement Council
Maryland Metro Ostomy Association	EveryMind
GKV	Girls of the Run
Maryland Physicians Care	Neighborhood Patches
Very Vegalicious	Regional Service Newsletter
Kensington Lions Club	Latino Health Initiative
The Michael and Mauritia Patch Foundation	InterStaff Communication
Organo Gold	BCC Rotary Club
White Oak Physical Therapy	YMCA
Columbia Lighthouse for the Blind	Greater Bethesda Chamber of Commerce
Montgomery Hospice	Scotland Community
Safe Places	Safe Kids MoCo
Mont Co - Energy Program	Transamerica
Fitness for Less Gym	Center for Vein Restoration
Montgomery County Cancer Crusade	Schrier Physical Therapy
Foot and Ankle Specialists	Giant Food
Senior Life Insurance Company	Montgomery County Police Department
MC DHHS - Dental	Holistic Acupuncture and Physical Therapy
MC Fire & Rescue	Bemer Microcirculation
MC Library - Gaithersburg	Jewish Council for The Aging
Primary Care Coalition	Germantown and Women’s Imaging Center, Community Radiology Associates
Scion Dental - Smile Program	Capital Women’s Care
Family Services, Inc	Potomac Valley Associates
Gold’s Gym - Germantown	Waters Landing Elem School
Mobile Eye Care	Montgomery College, Germantown

Healing Our Village	Southern Management
African Women's Cancer Awareness Association	Margaret Schweinhaut
Prevention of Blindness Society	Bauer Park Apartments
Commission on Indian Affairs	Langley Park Community Center
Mt. Jezreel Baptist Church	MarComm Department - external and internal
Hunter Memorial AME Church	Germantown Baptist Church
First Baptist Church of Glenarden	Bethel World Outreach Church
Taking Effective Action, Inc	Washington Adventist University
First United Methodist Church	Matsunaga Elem School
Clifton Park Baptist Church	

APPENDIX I PRIORITIZATION PROCESS KEY STAKEHOLDERS/INFORMANTS LIST

Area	Organization
Minority Health Initiatives	African American Health Program
	Latino Health Initiative
	National Pan-Hellenic Council
Healthy Montgomery Steering Committee (LHIC)	Manna Food Center
	Montgomery County DHHS
	Commission on Health
	Latino Health Initiative
	Primary Care Coalition of Montgomery County
	Montgomery County Department of Planning
	Ronald D. Paul Cos., Inc.
	Montgomery County Recreation
	United Healthcare Community Plan MCO
	Asian American Health Initiative
	Montgomery County Department of Transportation
	Montgomery County Collaborative
	Montgomery Parks
Social Services	African American Health Program
	CASA de Maryland
	CHEER
	Gaithersburg HELP
	St. Ann's Center for CYF (PGC)
	United Way (PGC)
	Taking Effective Action, Inc (PGC)
	Prince George's County Health Department
	Langley Park Civic Association (PGC)
	Gilchrist Immigrant Resource Center
County Government	City of Gaithersburg
	City of New Carrollton (PGC)
	Gaithersburg/Germantown Chamber of Commerce
	Prince George's County County Council
	Bethesda Chevy Chase Regional Services Center
Behavioral & Mental Health	EveryMind
	Mindoula
	CentrePointe Counseling (PGC)

Faith-based Organizations	Faith Community leader
	Millian United Methodist Church
	Cross Community
	National Wesleyan Church (PGC)
	Zion Church Greenbelt (PGC)
	Metropolitan Seventh-Day Adventist Church (PGC)
	Kingdom Fellowship
Community Clinics	SHABACH! Ministries (PGC)
	Holy Cross Health Center- Aspen Hill
	Mary's Center
	Mary's Center
	Mary's Center
	Mary's Center
	La Clinica del Pueblo (PGC)
	Primary Care Coalition
Housing	CCI (PGC)
	Maple Ridge Apartments (PGC)
	MC DHHS/End and Prevent Homelessness
Youth	MCCH or County Housing Services
	Identity
	MCPS
Food	YMCA of Metropolitan Washington
	Manna
	Homestead Hustle and Healing
	La Sirenita Restaurant (PGC)
Older Adults	PGC Food Equity Council
	Leisure World of Maryland Corporation
	County Office of Aging
	Suburban's Parent and Family Advisory Council
	Prince George's County Advisory Committee on Aging
	Bradley Hills Village
	Potomac Community Village
	Friendship Heights Village
	PGC Parks & Recreation
OASIS	
Other	Olney Theater
	MC Department of Recreation
	ElevateHER
	University of Maryland, School of Public Health (Director, Maryland Center for Health Equity)
	Healthcare Initiative Foundation
	American Mega Laudromat (PGC)
	Coco Cabana (PGC)
	PGHAC (LHIC) - Healthy Eating Active Living Workgroup
	PGHAC (LHIC) - HEAL
	PGHAC (LHIC) - Health Equity Workgroup
PGHAC (LHIC) - Behavioral Health	

APPENDIX J EVALUATION OF PREVIOUS CHNAS

ACCESS TO HEALTH CARE SERVICES

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/CURRENT (CBSA) ^a	ACTUAL/CURRENT (MC)	ACTUAL/CURRENT (PGC)
Uninsured rate (%)	7.1%	0%†	9.6%	7.1%	10.1%

PROGRAMS AND SERVICES

Holy Cross Health: Operate four health centers for the un/underinsured in geographically accessible locations; Implement plan to link uninsured Maternity Partnership patients to primary care services at HC Health Centers to create a medical home for the whole family

Medstar Montgomery: Provide financial support to two safety-net clinics within the CBSA, including Holy Cross Health Center Aspen Hill and Proyecto Slaud Clinic Olney; Assist patients in need of Insurance through screenings, referrals and linkage to community resources through hospital-based programs and Community Health Advocate program.

Suburban Hospital: MobileMed/NIH Heart Clinic at Suburban Hospital, MobileMed/NIH Endocrine Clinic at Suburban Hospital

BEHAVIORAL HEALTHS

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/CURRENT (CBSA) ^a	ACTUAL/CURRENT (MC)	ACTUAL/CURRENT (PGC)
Decrease percentage of adults with poor mental health	16.8%	16.8%Δ	11.6%	10.0%	12.4%
ER visits for behavioral health conditions (per 100,000)	752.0	3152.6††	N/A	1376.4	1955.6
Decrease suicide rate (per 100,000)	6.8	9.0††	7.3	7.4	6.3

PROGRAMS AND SERVICES

Adventist HealthCare: Behavioral Health Support Groups & Workshops (Overcoming Winter Blues, Tools for Effective Communication, How to Stop Avoiding Issues and Become a Stronger Communicator, Grief & Loss, Becoming Resilient Person); Behavioral Health Education (partnership with MC Hospitals & EveryMind, Inc.); Behavioral Health Internships; Mental Health First Aid; Forensic Medical Unit at Shady Grove Medical Center.

Holy Cross Health: Behavioral health screenings with links to treatment at the HCH Health Centers; Provide behavioral health services and links to treatment through the Nexus Montgomery Crisis House, ACT Teams, and behavioral health Integration; Offer Stanford University's Chronic Pain Self-Management Program; Collaborate with community partners to address behavioral health in the community

MedStar Montgomery: Conduct Screenings through Brief Interventions and Referral to Treatment (SBIRT) Program in the Emergency Room, supported by Peer Recovery Coaches; Mindoula Behavioral Health Program; Engage as a member of Nexus Montgomery Regional partnership by centralizing crisis services ecosystem, expanding mobile crisis delivery, and offering same day access services; Behavioral Health Education (Partnership with MC Hospitals and EveryMind, Inc.).

Suburban Hospital: Concerned Persons Program, Addiction Treatment Center, Widowed Persons Social Group, Support to Parents Encouragement Program with their Critical Topics in Parenting Series, Village Ambassador Alliance, Monthly Health Webinars, Men's Health Symposium: Brain-Gut Health, Engaged as a member of Nexus Montgomery Regional partnership, Charles E. Smith Life Communities Symposium- COVID-19 Pandemic: Mental Health Effects on Older Adults and their Health Care Providers.

CHRONIC DISEASE: DIABETES

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA) ^a	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Decrease percentage of adults with Diabetes	13.5%	10.2% \downarrow	9.00%	7.2%	12.3%
Decrease ER Visits for Diabetes (per 100,000)	280.5	186.3 $\uparrow\uparrow$	N/A	444.4	229.2

PROGRAMS AND SERVICES

Adventist HealthCare: NEXUS Montgomery Regional Partnership Catalyst Diabetes Project; Community Health Screenings & Lectures; Integrative Medicine Programs; Food & Nutrition Classes

Holy Cross Health: Provide care management, education and nutrition counseling at HC Health Centers for high-risk patients; Expand diabetes programming (English and Spanish) with Nexus Montgomery Regional Partnership Catalyst Diabetes Project (NMRP) (DPP and DSMT metric); Offer Stanford University's Diabetes Self-Management Program in English and Spanish

MedStar Montgomery: Host and provide access to healthy lifestyle educational programs, wellness activities, community screenings and support groups; Diabetes Support Group, Pre-Diabetes Support Group.

Suburban Hospital: Pre-Diabetes: Laying the Foundation, Thrive 365 Education and Support Group Meetings in English and Spanish, Diabetes A-Z Management, JDRF Type 1 Support Group, Baltimore Metropolitan Diabetes Regional Partnership, Health Education Webinars, MobileMed/NIH Endocrine Clinic at Suburban Hospital.

CHRONIC DISEASE: CANCER

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA) ^a	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Decrease cancer mortality rate (per 100,000)	134.1	147.4 $\uparrow\uparrow$	118.7	114.6	149.9
Increase percent of colorectal cancer screening for adults 50+	72.9%	73% \downarrow	N/A	68.6%	68.9%
Decrease colorectal cancer mortality (per 100,000 men)	11.7	14.5 \uparrow	N/A	10.0	13.6
Increase percent of women who have a Pap in past 3 years	83.0%	93.0% \uparrow	N/A	86.3%	87.2%
Decrease prostate cancer incidence (per 100,000)	159.3	135.0 \downarrow	N/A	113.4	149.9
Decrease Prostate Cancer Mortality (per 100,000 men)	18.8	21.8 \uparrow	N/A	14.8	26.6
Decrease breast cancer mortality (per 100,000 women)	20.1	20.7 \uparrow	N/A	19.0	25.1

PROGRAMS AND SERVICES

Adventist HealthCare: Navigating Cancer (First Step Workshop, Young Women with Breast Cancer Monthly Support Group, Newly Diagnosed: Navigating the New Normal Support Group); Mind, Body, Spirit (Gentle Yoga with Meditation, Gentle Hatha Yoga, Mindfulness for Self-Care, Mindfulness Based Stress Reduction); Eating Well (Nutritional Management of Side Effects for Treatment, Ask a Dietitian, Cooking with Patty and Nick, Healthy Eating After Treatment, and Good Nutrition for Cancer Care).

Holy Cross Health: Provide access to mammogram services for uninsured and underinsured women; Provide outreach and education on cancer prevention in Montgomery and Prince George's County through an equitable lens; Provide outreach and education on tobacco-free living; Provide HC Health Center referrals for breast, colonoscopies, and obesity and tobacco cessation referrals and/or counseling to eligible health center patients

MedStar Montgomery: Gentle Flow Yoga for Cancer Patients.

Suburban Hospital: American Lung Association’s Better Breathers Club, American Lung Association’s Freedom from Smoking Program, Roundtable: African Americans & Colorectal Cancer, Roundtable: Young Adults & Colon Cancer, Talk & Walk for Breast Cancer Survivors, Yoga for Cancer Survivors, Prostate Cancer Support Group, Prostate Cancer Symposium, Annual Living with Breast Cancer Symposium.

CHRONIC DISEASE: CARDIOVASCULAR HEALTH

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA) ^a	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Decrease heart disease mortality (per 100,000)	136.4	166.3††	N/A	97.9	181.3
Decrease stroke (cerebrovascular) mortality (per 100,000)	30.1	34.8†	N/A	41.8	46.8
Decrease percentage of high blood pressure prevalence in adults	21.6%	26.9%†	N/A	29.8%	37.2%

PROGRAMS AND SERVICES

Adventist HealthCare: Community Health Screenings and Lectures; Faith Community Health Network

Holy Cross Health: Implement care management team at HC Health Centers for high risk patients; Provide community fitness classes for adults and older adults aged 55+; Offer Stanford University’s Chronic Disease Self-Management Program

MedStar Montgomery: Host and provide access to healthy lifestyle education programs, wellness activities, community screenings, and support groups; Annual Wine Women and Heart Health webinar; Senior Strength and Balance Fitness class; Gentle Flow Yoga for Seniors.

Suburban Hospital: Yoga from the Heart, Senior Shape Exercise Program including several classes that focus on Aerobics, Weight Training, Flexible Strength and Stability Ball, Dine, Learn & Move, Cocina, Meuvete & Aprende, Blood pressure screenings, Health Education Webinars, Women’s Health Symposium, MobileMed/NIH Heart Clinic at Suburban Hospital, Nutrition Counseling

CHRONIC DISEASE: OBESITY

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA) ^a	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Decrease the percent of adults who are overweight or obese	55.2%	64.3%††	N/A	56.4%	71.2%
Decrease percent of adolescents who are overweight or obese* (previously obese only)	13.7%	10.7%††	N/A	22.4%	35.5%
Decrease percent of adolescents with no physical activity	23.2%	18%Δ	N/A	20.20%	30.50%

PROGRAMS AND SERVICES

Adventist HealthCare: Community Health Screenings and Lectures; Faith Community Health Network

Holy Cross Health: BMI assessments and diagnosis of obesity for health center patients

MedStar Montgomery: Host and provide access to healthy lifestyle education programs, wellness activities, community screenings, and support groups; Senior Strength and Balance fitness class; Gentle flow Yoga for Sneiors.

INFECTIONS

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA) ^a	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Septicemia Age-Adjusted Death Rate	10.3	N/A	N/A	8.6	N/A
Influenza & Pneumonia Age-Adjusted Death Rate	12.5	N/A	N/A	8.4	10.3

PROGRAMS AND SERVICES

Suburban Hospital: COVID-19 community testing, COVID-19 community vaccination clinics, Health Education webinars, Knots for Shots: Flu Vaccination Initiative.

UNINTENTIONAL INJURY

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA) ^a	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Accidents/Unintentional Injury Deaths (per 100,000)	36.2	36.4†	N/A	33.4	32.9

PROGRAMS AND SERVICES

Suburban Hospital: Senior Shape Exercise Program including 18 classes that focus on Aeorbics, Weight Training, Flexible Strenght and Stability, Tai Chi, Intermediate Taiji, Pilates for Seniors with Core.

DISABILTY AND REHABILITATION SERVICES

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA) ^a	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Traumatic brain injury related ED visits (MD)	39,721	N/A	N/A	N/A	N/A

PROGRAMS AND SERVICES

Adventist HealthCare: Disability & Rehab Support Groups (Brain Injury Support Group - available in English & Spanish, Amputee Support Group, Stroke Support Group); Athletic Trainer Program/Student Athlete Concussion Program.

AGING AND OLDER ADULTS/SENIORS

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA) ^a	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Life expectancy	79.2	79.8††	N/A	84.2	78.4
Decrease death rate due to falls in older adults (per 100,000)	47.2	47.0†	N/A	66.1	44.0

PROGRAMS AND SERVICES

Holy Cross Health: Provide physical and social activity programs for seniors 55+; Provide evidence-based memory programs for seniors 55+

MedStar Montgomery: Host and offer age friendly senior wellness services, health education programs, and online/in-person senior exercise programs; Partner with local skilled nursing facilities to improve transitions of care and quality between hospitals and nursing home; Expansion of Center for Successful Aging.

Suburban Hospital: Metro Washington Oasis Lifelong Learning for Active Older Adults & Village Ambassador Alliance.

MATERNAL/INFANT/CHILD HEALTH

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/CURRENT (CBSA) ^a	ACTUAL/CURRENT (MC)	ACTUAL/CURRENT (PGC)
Decrease infant mortality rate (per 1,000 births)	5.5	6.3††	N/A	5.2	5.5
Increase percent of mothers receiving early prenatal care	63.1%	66.9%††	N/A	70.2%	59.4%
Reduce percentage preterm births	8.6%	9.4%†	N/A	8.9%	11.1%
Decrease percentage of low birth weight infants	8.2%	8%††	7.9%	7.5%	9.6%
Decrease percentage of very low birth weight infants	1.3%	1.4%†	N/A	1.4%	1.9%

PROGRAMS AND SERVICES

Adventist HealthCare: Parent and Family Education Support Groups (Breastfeeding Education Support & Togetherness - B.E.S.T., Discovering Motherhood, Navigating Fatherhood, Perinatal Loss Support Group); Warm Line (Lactation Support with International Board Certified Lactation Consultant); Maternity Partnership/Prenatal Care Program.

Holy Cross Health: Provide prenatal care to 60% of Montgomery County Maternity Partnership patients; Provide perinatal education, baby care programs, and support services to expecting and new families in Montgomery & Prince George's County; Provide Early Care and Education Program to decrease costs to government; Increase educational achievement (and therefore greater earning power); and increase opportunity in adulthood; Increase the number of programs focusing on healthy birth outcomes for women of color (morbidity and mortality)

MedStar Montgomery: Breastfeeding support group, Babysitting CPR Course.

Suburban Hospital: Safe Sitter Babysitting Program, Health Partner of Girls on the Run Montgomery County, Bethesda Chevy Chase YMCA and Parents Encouragement Program.

FOOD ACCESS/FOOD INSECURITY

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/CURRENT (CBSA) ^a	ACTUAL/CURRENT (MC)	ACTUAL/CURRENT (PGC)
Reduce percent of population that experienced food insecurity at some point in a year	7.9%	6.0%†	7.6%	8.6%	7.3%

PROGRAMS AND SERVICES

Adventist HealthCare: Hungry Harvest Rx

Holy Cross Health: Increase availability and access to healthy and/or culturally appropriate food

MedStar Montgomery: Provide social needs screenings for food insecurity through Community Health Advocate program and Aunt Bertha social needs screening tool; Pop-up food pantries in collaboration with Manna Food Center and local community organizations; Sponsor Manna Food Center Smart Sacks program.

HOUSING AND HOMELESSNESS

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/CURRENT (CBSA) ^a	ACTUAL/CURRENT (MC)	ACTUAL/CURRENT (PGC)
Reduce the proportion of families that spend more than 30% of income on housing	34.6%	34.6%†	33.7%	32.1%	36.7%

PROGRAMS AND SERVICES

Holy Cross Health: Pathways to Independent Employment Program.

EDUCATION

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/CURRENT (CBSA) ^a	ACTUAL/CURRENT (MC)	ACTUAL/CURRENT (PGC)
Increase percentage of students who graduate high school in 4 years	79.0%	95.0%††	88.7%	87.2%	91.4%

PROGRAMS AND SERVICES

Adventist HealthCare: Education & Workforce Development (Medical Careers Program, Stepping Stones, Clinical Shadowing, Internships & Fellowships).

Suburban Hospital: Medical Exporling Program for high school students interested in healthcare careers, Clinical Shadowing, Internships and Fellowship with Healthcare Professional Development.

OTHER

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/CURRENT (CBSA) ^a	ACTUAL/CURRENT (MC)	ACTUAL/CURRENT (PGC)
Number of grants and sponsorships awarded to community organizations addressing CHNA priority areas	27*	N/A	N/A	79	25

PROGRAMS AND SERVICES

Adventist HealthCare: Community Partnership Fund (CPF).

Notes:

^a Refers to the current collaborative CHNA

* Indicator measurement changed which prevents comparison

+ Provided Target value from Healthy People 2020

Δ Median or mean value for all counties in the state

†† MD SHIP Target

◇ Represents the top 50th percentile of all MD counties

^Number of cases (state level)

N/A = not available

Rates are age-adjusted per 100,000 population unless otherwise noted

APPENDIX K COMMUNITY ASSETS & RESOURCES

List of available community or social needs resources based on the priority areas identified by the findings of the 2022 MCHC CHNA. This is not a comprehensive list of available resources and will not be updated beyond the published date of the 2022 MCHC CHNA. For a larger and more up to date list of community resources, please refer to organizations which specialize in organizing and verifying social needs programs, such as 211 or the Findhelp Network.

Health Care/Clinical: Access to mental health services; access to primary care physicians; lack of insurance

Montgomery Cares by: Primary Care Coalition (PCC)

Montgomery Cares provides basic medical services for people who do not have, and cannot get, insurance. If you have Montgomery Cares, the program pays part of the cost of your health services, but you may also have to pay something.

Services provided:

- Medical checkups
- Sick visits to diagnose and treat illness
- Age-appropriate screenings and preventive health services
- Behavior health care
- Some medicines
- Vaccinations/Immunization

Eligibility: Must be a resident of Montgomery County. Must be unable to get health insurance. This program helps people who are older than 17 years old. This program helps people with income at or below 250% of federal poverty guidelines.

Address: 2424 Reddie Drive, Suite 125, Wheaton-Glenmont, MD 20902

Phone: 301-962-6173

Outpatient Mental Health Clinic (OMHC) by: Vesta, Inc.

Vesta, Inc. offers the Outpatient Mental Health Clinic (OMHC) to provide therapy and medication management to clients who are experiencing mental health symptoms. The team of therapists and psychiatric nurse practitioners assist the client in the development of a customized plan to meet the individual's goals and needs.

This program provides:

- Diagnostic evaluation
- Individual and group therapy
- Medication management
- Substance use assessment and
- Services for co-occurring disorders

Interested clients can complete the referral form and submit it with a copy of your ID and your insurance card. Vesta, Inc. accepts Maryland Medicaid and Medicare.

8737 Colesville Road, 700, Silver Spring, MD 20910

Phone: 240-296-5860 ext. 6

Child and Adolescent Mental Health Program by: Montgomery County Department of Health and Human Services - Silver Spring

The Department of Health and Human Services (DHHS) Silver Spring Center offers the Child and Adolescent Mental Health Program. This program provides family-focused, outpatient mental health services to children, adolescents, and their families to help address severe emotional, behavioral, substance abuse, and victimization issues. We are also able to provide all services in Spanish for Spanish speaking clients. Services include:

- Mental health screening & assessment
- Diagnostic evaluation
- Family, individual and group psychotherapy
- Clinical case management
- Drug and alcohol assessment and education
- Behavioral and medication management
- Follow up services
- Outreach treatment and support services in the selected school sites

The Department of Health and Human Services accepts Medical Assistance (Medicaid) and we offer a sliding scale to individuals with no health insurance.

Eligibility: This program helps people who are 5 to 18 years old.

Address: 8818 Georgia Avenue, Silver Spring, MD 20910

Phone: 240-777-0311; 240-777-1450

Mental Health by: Children's National Health System

The Children's National Health System's Mental Health program provides comprehensive services for a variety of issues and conditions. Mental health specialists draw upon the latest research and expertise when designing a care plan for your child.

This program provides:

- Emergency consultation
- Medical psychology
- Tele-psychiatry
- Evaluation
- Counseling
- Inpatient psychiatry
- Outpatient clinics

Children's National Health System accepts Medicaid and offers Financial Assistance for those who are eligible. Services may vary based on location. Please call your nearest location to determine which services are offered. Please call 800-787-0021 anytime between 9:00 a.m. and 4:00 p.m. Monday through Friday to speak with a representative about financial assistance options and insurance.

Eligibility: This program helps children and adolescents struggling with mental health issues.

Address: 6833 4th Street Northwest, Washington, DC 20012

Phone: 202-729-3300

Adult Behavioral Health Program by: Montgomery County Department of Health and Human Services

The Adult Mental Health Program provides outpatient mental health services to low-income residents of Montgomery County who are experiencing serious mental illness and who are unable to access the public mental health system due to lack of public benefits or their immigration status or income. We seek to improve the mental health of clients and to assist them in increasing their adaptive functioning in the community.

Services include:

- Individual and group psychotherapy
- Office-based case management
- Psychiatric medication monitoring

We also serve in special situations, such as those discharged from a psychiatric hospital or incarceration, those involved with other health and human service agencies, or those who have experienced treatment failures in the public mental health system. Most staff members are bilingual in either Spanish and English or Vietnamese and English. Translation services are available via the Language Line.

Adult Behavioral Health accepts Maryland Medical Assistance and Medicare. We also offer a sliding fee scale to uninsured patients; however, clients are not turned away due to inability to pay.

Call Access to Behavioral Health Services to apply to the program. The Adult Mental Health Program does not accept walk-ins or direct referrals.

Eligibility: This program helps people who are older than 17 years old. Must be a Montgomery County resident. Must have a serious mental illness. Must not have private insurance. Must be low-income. Must not be able to find services elsewhere in the public mental health system.

Address, 11002 Veirs Mill Road, Suite 705, Silver Spring, MD 20902

Phone: 240-777-1770

Maryland Children's Health Program (MCHP) by: Maryland Department of Health (MDH)

Maryland Department of Health (MDH) operates the Maryland Children's Health Program (MCHP) to give full health benefits to children up to age 19.

This program provides:

- Doctor Visits (well and sick care)
- Hospital Care
- Work and Tests
- Dental Care
- Vision Care
- Immunizations (shots)
- Prescription Medicines
- Transportation to Medical Appointments
- Mental Health Services
- Substance Abuse Treatment

If you or your child is found eligible for MCHP, you can select an Managed Care Organization right away. MCHP Premium requires a small monthly premium per family based on income. Enrollment is year round. You can enroll in Medicaid/MCHP at any time if you qualify.

Eligibility: This program helps people who are younger than 19 years old. Must not be insured. This program helps people with income at or below 211% of federal poverty guidelines.

Address: 8630 Fenton Street, 10th floor, Silver Spring, MD 20910

Phone: 855-642-8572; 240-777-3066

Maryland Medicaid by: Maryland Department of Health (MDH)

Medicaid pays the medical bills of eligible individuals. It is administered by the State and pays medical bills with Federal and State funds.

This program provides:

- Health insurance

You can apply for Medicaid at any time and eligible applicants can enroll year-round. Individuals who receive Supplemental Security Income (SSI) are automatically eligible and do not need to apply.

Eligibility: Must meet income eligibility requirements.

Address: 401 Hungerford Drive, 5th Floor, Rockville, MD 20850

Phone: 855-642-8572; 240-777-4513

Employed Individuals with Disabilities (EID) by: Maryland Department of Health (MDH)

The Employed Individuals with Disabilities Program provides Medical Assistance (also called Medicaid) to working Marylanders with disabilities.

This program provides:

- Covers most medical services for individuals who have no other health insurance
- Saves individuals with Medicare \$1,000 - \$12,000 a year
- Pays for some services that the other insurance does not cover

The monthly premium amount depends on income. People who sign up for EID almost always save much more than they pay for premiums. Apply on your own or with help from other agencies. To apply on your own, complete the EID Application , gather the supporting documents you have available, enclose the supporting documents, and mail in. To get free assistance in filling out the application, contact Center For Independent Living closest to you.

Eligibility: Applicant must be at least 18 years old but not yet 65 years old. Applicant must be U.S. citizen or qualified alien. Applicant must have a disability that meets Social Security's medical criteria. Applicant must be working for pay. Applicants must have assets under the \$10,000 limit if you are unmarried. The limit is \$15,000 if you are married.

Address: 12301 Old Columbia Pike, Suite 101, Silver Spring, MD 20904

Phone: 410-767-7090; 301-277-2839

Holy Cross Health Centers by: Holy Cross Health

Holy Cross Health Centers are primary care medical centers providing affordably priced health care services to children and adults who face financial barriers to accessing care.

Services provided:

- Physical exams
- Lab work
- Vaccinations
- Disease management
- Social service referrals
- Behavioral health services
- Post-hospital and emergency room discharge follow-up care
- Health education
- On site pharmacy

Holy Cross Health Centers provide services to uninsured children and adults for an adjusted fee based on financial need, and to community members enrolled in Maryland Medicaid/Maryland Children's Health Program.

Eligibility: Anyone can access this program.

13975 Connecticut Avenue, Ste 250, Silver Spring, MD 20906

Phone: 301-557-1870

Mobile Medical Care - Primary Care by: Mobile Medical Care Inc

Mobile Medical Care provides all of its patients with a full array of primary care services. These services fill critical gaps in care delivery in underserved areas.

Services include:

- Physical exams
- Screenings
- Labs
- Vaccinations
- Medications
- Integrated behavioral health (including counseling)
- Arrangements for diagnostic testing
- Referrals to specialty care, if necessary

MobileMed accepts Montgomery Care, Medicare, and most Medicaid.

Address: 3820 Aspen Hill Road, Aspen Hill, MD 20906

Phone: 301-493-2400

Affordable Health Care by: Mary's Center

Federally Qualified Health Center (FQHC) that delivers affordable, accessible, quality, and value-based primary health care to everyone in our community regardless of their ability to pay. Our work helps to deliver care to the nation's most vulnerable individuals and families, including people experiencing homelessness, agricultural workers, residents of public housing, and the nation's veterans.

Services provided include:

- High quality, culturally competent, comprehensive primary care
- Connections to pharmacy, mental health, substance use disorder, and oral health services
- Diagnostic assessments & treatment planning
- Individual and family therapy
- Medication evaluation and management by Board-Certified Psychiatrists
- Community support/case management
- Supportive services such as health education, translation, and transportation
- Primary pediatric care
- Prevention and treatment of illness and injury
- Vaccinations

FQHCs accept Medicaid, Medicare, and provide a sliding-scale fee structure for those who do not have insurance or are underinsured.

Due to COVID-19 many of our offices are not taking in-person appointments but will be offering virtual visits. Please call us and we will schedule the appropriate appointment for your needs.

Eligibility: Anyone can access this program.

Address: 344 University Boulevard West, Silver Spring, MD 20901

Phone: 844-796-2797

General Medical Services by: Catholic Charities Archdiocese of Washington

We provide low-cost, patient-centered primary care services and specialty services on-site, including minor surgery, Gynecology, Cardiology, Pulmonology, Dermatology, Orthopedics, Acupuncture and referrals to other specialty services including Physical Therapy.

Services provided:

- Primary care
- Minor surgery services
- Cardiology
- Pulmonology
- Dermatology
- Orthopedics
- Reproductive health services
- Acupuncture
- Referrals to specialty services

We welcome people of all ages who are low-income and uninsured, or covered by DC Alliance, Medstar and Amerihealth.

Medical Clinics in D.C. and Silver Spring remain open but are restricted to patients who have been pre-screened. Patients with flu-like symptoms should leave their phone number, and a doctor will contact them. Telemedicine appointments are offered for sick patients.

Address: 12247 Georgia Avenue, Silver Spring, MD 20902

Phone: 301-857-9144

Health Care by: Community Clinic, Inc. (CCI) - Silver Spring

Community Clinic, as your Primary Care Home, will identify and address your physical & behavioral health needs. We utilize a team-based patient-centered approach to care for adults and children.

Services include:

- Routine visits (adult and pediatric)
- Common laboratory tests
- Acute and chronic care
- Routine immunizations
- Vaccinations
- Diabetes education
- Nutrition counseling
- Referral to specialists

Community Clinic accepts Medicaid and Medicare. If you do not have health insurance, call (240) 839-5810 and a team member will help you explore your coverage options. You may also be eligible for our sliding fee scale discount.

Address: 8630 Fenton Street, 12th floor, Silver Spring, MD 20910

Phone: 301-585-1250

Affordable Health care by: Neighborhood Health At The Casey Clinic

Federally Qualified Health Center (FQHC) that delivers affordable, accessible, quality, and value-based primary health care to everyone in our community regardless of their ability to pay. Our work helps to deliver care to the nation's most vulnerable individuals and families, including people experiencing homelessness, agricultural workers, residents of public housing, and the nation's veterans.

Services provided include:

- High quality, culturally competent, comprehensive primary care
- Supportive services such as health education, translation, and transportation
- Connections to pharmacy, mental health, substance use disorder, and oral health services

FQHCs accept Medicaid, Medicare, and provide a sliding-scale fee structure for those who do not have insurance or are underinsured.

Eligibility: Anyone can access this program.

Address: 1200 North Howard Street, Alexandria, VA 22304

Phone: 615-227-3000

Primary Care by: MedStar Montgomery Medical Center

MedStar Montgomery Medical Center offers primary care services to those in need in the community. Primary Care Physicians focus on the interactions of all your body systems and know how to help you with just about every complaint you may have: from asthma to arthritis, headaches to high blood pressure, and dizziness to diabetes.

Primary care services may include:

- Preventive medicine
- Sick care and injuries
- Chronic medical condition management
- Urgent medical care
- Annual and sports physicals
- School forms
- Immunizations, including flu shots
- Preoperative consults
- Health promotion and education
- Nurse phone line available 8 hours/day to speak live with an RN regarding medical concerns, advice, and appointments

MedStar Montgomery Medical Center offers financial assistance to those in need based on income and household size. This program also accepts Medicaid and Medicare.

Address: 18109 Prince Philip Drive, Olney, MD 20832

Phone: 301-774-8881

Mansfield Kaseman Health Clinic by: Community Reach of Montgomery County

Mansfield Kaseman Health Clinic delivers health care and education to medically uninsured and Maryland Medicaid insured adult residents of Montgomery County.

This program provides:

- Health education
- Lab services
- Pharmacy
- Primary care
- Specialty care

Mansfield Kaseman Health Clinic accepts adults who are low-income, uninsured, and those insured with Maryland Medicaid. Primary care and specialists in endocrinology, gastroenterology, gynecology, internal medicine, podiatry, and pulmonology are available to our patients. Lab work available onsite.

Eligibility: This program helps people who are older than 17 years old.

8 West Middle Lane, Rockville, MD 20850

Phone: 301-917-6800

Women's Health by: MedStar Health

Women's Health Centers provide comprehensive medical care that focuses on the health and well-being of women of all ages. MedStar Health has a commitment to investing in state-of-the-art-facilities that provide women with every possible treatment option available in health care today - no matter if you are delivering a baby or undergoing minimally invasive gynecologic surgery.

Specific services include:

- Childbirth and parenting education classes
- Fibroid treatments
- Genetic counseling
- Gynecology treatments and surgery
- Incontinence and pelvic surgery
- Lactation services
- Labor and delivery
- Mammography
- Maternity services, including fertility services and obstetrics
- Menopause
- Osteoporosis treatments
- Pediatric and adolescent gynecology
- Preconception counseling
- Pregnancy Planning
- Recommended health screenings for women of all ages
- Urogynecology treatments

MedStar Health is committed to ensuring that uninsured patients and underinsured patients meeting medical hardship criteria within the communities served who lack financial resources have access to emergency and medically necessary hospital services. Facilities can assist with enrollment in publicly-funded entitlement programs, referrals to State or Federal Insurance Exchange Navigator resources, and consideration of funding that may be available from other charitable organizations. Please call 800-280-9006 for support with financial assistance.

Address: 18101 Prince Philip Drive, Suite 5100, Olney, MD 20832

Phone: 301-570-7424

Primary Adult Health care by: Proyecto Salud Clinic

Proyecto Salud Clinic provides high quality, culturally competent, and affordable primary health care services to adults living in Montgomery County.

Primary care services may include:

- Preventive activities such as flu vaccination
- Nutritional education
- Pap smears
- Referrals for mammograms and colonoscopies

Proyecto Salud Clinic provides a sliding scale fee for uninsured individuals.

Eligibility: Must live in Montgomery county.

11002 Veirs Mill Road, Suite 700, Silver Spring, MD 20902

Phone: 301-962-6173

Adult Primary Care by: Mercy Health Clinic Inc

Mercy Health Clinic (MHC) provides quality care, free to reduced cost for individuals who are uninsured or have Medicaid. All patients are seen by a board-certified physician or nurse practitioner.

Services offered:

- Primary preventive care
- Diagnosis and treatment of general acute and chronic medical problems
- Management of chronic medical conditions, such as hypertension and diabetes
- Referrals for professional consultation, including to on-site dental clinic and behavioral health specialists
- Access to off-site specialty care, including surgical procedures when possible
- Patient navigation to assist with mammography and other areas

When scheduling your appointment via phone or email, include name, date of birth and phone number. Email service is currently for primary and specialty care patients. If your card has lapsed, you must call for any inquiries.

Due to COVID-19, MHC is not currently processing eligibility applications, but they are still accepting new patients. The clinic will be serving most patients via telemedicine.

Eligibility: This program helps people who are older than 17 years old. This program helps people with income at or below 250% of federal poverty guidelines. Must be a resident of Montgomery County. Must be uninsured or have Medicaid.

Address: 7 Metropolitan Court, Suite 1, Gaithersburg, MD 20878

Phone: 240-773-0300

Care for Kids by: Montgomery County Department of Health and Human Services - Juvenile Assessment Center

Care for Kids is a health care program that provides access to health care services for uninsured children in Montgomery County. Pediatric care includes:

- Well child visits
- Sick visits

- Prescription medicines
- Optometry
- Dental

The program is funded through Montgomery County and administered by the Primary Care Coalition. Most services offered by Care for Kids are low cost or discounted, although some do have a small fee or co-pay.

Families may have a co-payment of up to \$20 per visit with a health care provider. There is a \$5 co-pay for all prescription medications. Other fees and co-pays may be charged for lab work, radiology and some specialty care visits. Patients are informed of any fee before they go to their appointment.

The required documents are needed for this program:

- Proof of residence in Montgomery County
- Proof of family income
- Proof of child's identity: birth certificate, passport, school ID or report card

Eligibility: Child must be uninsured and not eligible for MCHP or MCHP Premium. Child must be a Montgomery County resident. This program helps people who are younger than 19 years old. This program helps people with income at or below 250% of federal poverty guidelines.

Address: 8513 Piney Branch Road, Silver Spring, MD 20901

Phone: 240-773-8260

Medical Visits by: FiveMedicine

With FiveMedicine, you can have access to health care anywhere and see an online health care provider in minutes.

Services provided:

- Virtual doctor visits

FiveMedicine treats over 55 routine medical conditions including common cold, allergies, constipation, cough, diarrhea, ear problems, pink eye, respiratory problems, sore throat, UTI, fever, flu, headache, nausea, vomiting, and more.

Services can be provided on a sliding fee scale.

Address: 724 Maiden Choice Lane, Suite 304, Catonsville, MD 21228

Phone: 207-719-2530

Health Care Services by: CCACC Pan Asian Volunteer Health Clinic

Pan Asian provides a variety of health care services, ranging from basic care to management of chronic conditions. Our services are provided by practicing doctors and nurses, and we're always seeking to expand our services in order to better serve our patients.

We offer the following services:

- Basic health care (family doctor services)
- LabCorp-provided inspections, lab testing, and radiology examinations

- Free or low-cost prescription drugs
- Free or low-cost routine blood tests
- Chronic disease management including asthma and diabetes
- Pain Management
- Diabetic Retinopathy
- Fecal Immunochemical Test (FIT)
- Hepatitis B screening, treatment, and treatment referral
- Mammogram screenings
- Mental health services
- Woman's Wellness
- Patient followup care
- Specialist referrals
- Public education and community outreach

Documents Required: ID; Utility Bills

Eligibility: Must be a resident of Montgomery County AND Must not have any insurance (including any commercial insurances, Medicaid, or Medicare). This program helps people with income at or below 250% of federal poverty guidelines.

Address: 9318 Gaither Road, Suite 205, Gaithersburg, MD 20877

Phone: 240-393-5950

Primary Care by: Patient First

Patient First provides a full range of preventive, primary, and urgent care services. When specialty care is required, patients are referred to outside physicians in the appropriate specialty.

Patient First accepts Medicare and offers a discounted self-pay program for uninsured patients.

No appointments are necessary.

Eligibility: This program helps people who are older than 7 years old.

Address: 8206 Georgia Avenue, Silver Spring, MD 20910

Phone: 301-960-4682

OB/GYN Clinics by: Holy Cross Health

The Obstetric/Gynecologic (OB/GYN) Clinic at Holy Cross Hospital and the OB Clinic at Holy Cross Germantown Hospital offer maternity care and services to patients in need, regardless of their ability to pay.

These clinics provide:

- Maternity care
- Routine obstetrical care
- Specialized care for high-risk pregnancies
- Prenatal care

- Post-delivery care
- Gynecological services and counseling

Address: 1500 Forest Glen Road, Silver Spring, MD 20910

Phone: 301-754-8200

Primary Medical Care by: La Clinica del Pueblo

At La Clinica del Pueblo, we are dedicated to providing high quality health care, putting you and your health first. Your primary care doctor is a key member of your health care team and helps coordinate patient care all in one place.

Services:

- Prenatal care
- Pediatrics
- Adolescent medicine
- Adult medicine
- Geriatrics
- Medical evaluations
- Reproductive health
- Health education
- Immunization
- Lab testing
- Diagnose and treat
- Referrals to outside specialist
- Onsite language and document interpretation

We also provide Care Management and Care Coordination for our patients, and offer Insurance Enrollment and Support.

La Clinica del Pueblo accepts Medicare.

If you are not eligible for coverage on other programs, we offer affordable health care to uninsured patients on a sliding fee scale based on a patient's income and family size. No patient is ever denied services because of his or her ability to pay.

Address: 2970 Belcrest Center Drive, #301, Hyattsville, MD 20782

Phone: 240-714-5247

Primary Care by: Maryland Physicians Care (MPC)

Maryland Physicians Care is a Medicaid company providing high-quality health care to individuals and families. The program's doctors serve as key members of your health care team and help coordinate patient care all in one place.

Services Include:

- Primary Care

- Urgent Care
- Pregnancy & New Mother Benefits
- Specialists Care
- Pharmacy Coverage
- Primary Mental Health Services
- Vision
- Dental Care

Eligibility: Must have Medicaid.

Address: 1201 Winterson Road, 4th floor, Linthicum Heights, MD 21090

Phone: 800-953-8854

THRIVE Program - Ryan White Services by: University of Maryland Center for Infectious Diseases

The THRIVE Program specializes in preventing, treating and managing a range of illnesses, including Hepatitis C and Human Immunodeficiency Virus (HIV).

This program provides:

- Outpatient ambulatory health services (primary care and HIV specialty care)
- Medical case management (clinic and community based)
- Mental health care
- Substance abuse outpatient (treatment for opioid use disorder, including Suboxone® prescriptions)
- Medical nutritional therapy (nutritionist consults, Ensure®)
- Food bank/home delivered meals
- Other professional services (legal services)
- Transportation (tokens for public transportation)
- Health insurance premium cost sharing (assistance with copays)
- Emergency financial assistance (medications)

Eligibility: Must be HIV positive. This program helps people with income at or below 500% of federal poverty guidelines. Must have lack of insurance coverage for needed services Must live in Baltimore or the 6 surrounding counties (for Part A Services) and/or in the state of Maryland (for Part B Services)

Address: 827 Linden Avenue, Armory Building, Suite B, Baltimore, MD 21201

Phone: 410-225-8369

Socioeconomic & Physical Environment: housing cost burden; income inequality; workforce/labor shortages

Housing Choice Voucher Program (HCV) by: Housing Opportunities Commission Of Montgomery County (HOC)

The Housing Choice Voucher Program a rent subsidy for very low-income households (single or family), the elderly, and the disabled to afford safe and quality affordable housing in Montgomery County. Participants who receive vouchers search for their own housing, and the housing subsidy is paid to the landlord directly by the HOC.

The subsidy amount is based on a payment standard set by HOC and the client's household information so that the client pays no more than 40% of their income on housing.

Eligibility: Family's gross annual income may not exceed 50% of the local median family income. This program helps people who are older than 17 years old. Must be a US Citizen or have eligible immigration status.

Address: 10400 Detrick Avenue, Kensington, MD 20895

Phone: 240-627-9400

Section 8 Housing Choice Vouchers by: Housing Opportunities Commission of Montgomery County

Montgomery County Housing Authority administers Housing Choice Vouchers to very low-income families, the elderly, and the disabled. HCVP is a U.S. Department of Housing and Urban Development (HUD) program created to give vulnerable families access to decent, safe, sanitary, and affordable housing in the private market.

People may apply online. Kiosks are available at HOC offices and public libraries in Montgomery County. To speak with a Customer Service Representative, please call 311 during business hours.

Eligibility: Must meet annual income guidelines.

Address: 10400 Detrick Avenue, Kensington, MD 20895

Phone: 240-773-9000

U.S. Department of Housing and Urban Development - VA Supportive Housing (HUD-VASH)

The HUD-VASH is a collaborative program between HUD and the VA that combines HUD housing vouchers with VA supportive services to help Veterans who are homeless and their families find and sustain permanent housing.

This program provides:

- HUD Housing vouchers
- Case management

Through public housing authorities, HUD provides rental assistance vouchers for privately owned housing to Veterans who are eligible for VA health care services and are experiencing homelessness. VA case managers may connect these Veterans with support services such as health care, mental health treatment and substance use counseling to help them in their recovery process and with their ability to maintain housing in the community.

To apply for HUD-VASH, please contact your local VA Medical Center (VAMC) and ask for a Homeless Coordinator. Veterans can contact the HUD-VASH program directly, or obtain a referral

from a case manager in another VA program, from a community program, or other referral sources. You can also call the National Call Center for Homeless Veterans at 1-877-4AID-VET (877-424-3838).

Eligibility: Must not be a sex offender. Must be enrolled or eligible for VA Health System benefits. This program serves homeless veterans and their families. Must have need or vulnerability requiring case management services in order to obtain and sustain independent community housing.

Address: 50 Irving Street Northwest, Washington, DC 20422

Phone: 877-424-3838; 202-745-8000

Section 8 Housing Choice Vouchers by: Rockville Housing Authority

Rockville Housing Authority administers Housing Choice Vouchers for very low-income families, the elderly, and the disabled. HCVP is a U.S. Department of Housing and Urban Development (HUD) program that gives vulnerable families access to decent, safe, sanitary, and affordable housing in the private market.

To be considered for the Housing Choice Voucher Program, a household must be on RHE's Housing Choice Voucher Program Wait List. RHE does not accept new applications when the Wait List is closed. Please periodically check both this Web site and Rockville Reports, the City of Rockville's monthly newspaper to determine when the wait list will be open again for new applications

A program participant's share of the rent is determined by formula (approximately 30% of household income).

Eligibility: Must meet income limits.

Address: 1300 Piccard Drive, Suite 203, Rockville, MD 20850

Phone: 301-424-6265

Emergency Rental Assistance Program by: Maryland Department of Housing and Community Development

The Maryland Department of Housing and Community Development will administer federal emergency rental funding either direct to local jurisdictions through the Maryland Eviction Partnership Program to support local rental assistance efforts or to property management on behalf of tenants residing in affordable rental properties that received federal or state financing through the Assisted Housing Relief Program.

Call the Maryland Emergency Rental Assistance Call Center at 877-546-5595 apply online.

Address: 2 North Charles Street, Suite 450, Baltimore, MD 21201

Phone: 877-546-5595; 410-209-5800

Montgomery County Workforce Program by: Latin American Youth Center (LAYC)

Our Montgomery County Workforce Program provides aid and support to out-of-school, unemployed, and disconnected youth. We offer a wide variety of services and classes to prepare our clients to enter the workforce.

Our program offers:

- Job readiness training
- GED Classes
- Career exploration services
- Certifications
- Internships
- Job placement and support

Participants of our Montgomery County workforce programs receive job placement and follow-up support. This may include updating a resume, cover letter, receiving targeted coaching on navigating a workplace situation and self-advocacy.

Eligibility: This program helps people who are 16 to 24 years old.

Address: 8700 Georgia Avenue, Suite 500, Silver Spring, MD 20910

Phone: 301-495-0441 ext. 226

YouthBuild USA by: YouthBuild International

YouthBuild is a non-residential, community-based alternative education program that provides classroom instruction and occupational skills training in construction and other in-demand occupations.

In the course of their full-time enrollment, they:

- Achieve their high school equivalency credentials or high school diplomas in a caring individualized context
- Obtain job skills and earn a stipend, wage, or living allowance for building affordable, increasingly green housing for homeless and low income people in their communities
- Gain industry-recognized certifications in preparation for productive careers (in addition to construction, some train for jobs in health care, technology, or customer service)
- Solve personal problems with counseling support, addressing urgent needs for housing or child care, record expungement, or other problems
- Give back and lead through participation in community service and advocating for their communities on the local and national levels.
- Transition into post-program placements, in college, registered apprenticeships, other postsecondary opportunities, and employment, with support of a transition coordinator and mentors

Low-income young people who have left high school without a diploma enroll full-time in YouthBuild Programs for about 10 months. They spend at least 50% of their time, usually alternate weeks, in caring academic classrooms, and at least 40% in hands-on job training building affordable housing or other community assets. A strong emphasis is placed on creating a safe and caring community of adults and peers committed to each other's success.

Eligibility: This program helps people who are 16 to 24 years old. The program serves youth who have dropped out of high school and who have been in the justice system, are aging out of foster care or are otherwise at-risk of failing to reach key educational and career milestones.

Address: 3014 14th Street NW, Washington, DC 20009

Phone: 202-319-0141

Job Skills and Training by: Job Corps

Job Corps provides hands-on career technical training in high-growth industries and can also help individuals get a GED or high school diploma if they don't already have one.

This program provides:

- Skill training and career development
- Job placement
- Optional residential for students

Eligibility: This program helps people who are 16 to 34 years old. Must be in need of job skills. Must be income eligible. Must be a U.S. citizen, is a legal U.S. resident, or is a resident of a U.S. territory and/or is authorized to work in the United States. Must make suitable arrangements for the care of any dependent children for the proposed period of enrollment. The student may not be eligible if they have certain criminal convictions or require court supervision. Must not exhibit behavioral problems that could keep them or others from experiencing Job Corps' full benefits. Must not use drugs illegally.

Address: 200 Constitution Avenue NW, Ste. N4463, Washington, DC 20210

Phone: 800-733-5627; 202-693-3000

Employment Programs by: Catholic Charities Archdiocese of Washington

We provide support and guidance for young adults and adults with developmental disabilities who have little to no work history entering the workforce. Through adaptive programming, a dedicated staff, open partnerships with businesses, families and community members, we find new opportunities for our consumers to grow, share and develop as independent adults.

Our services include:

- Intake: All participants must be referred by either the DC Office of Rehabilitation Services Administration (RSA), the Maryland Division of Rehabilitation Services (DORS) or the Maryland Developmental Disabilities Administration (DDA).
- Assessment of strengths and interests
- Skills development
- Job placement
- Continued support throughout employment
- More education

We do accept walk-ins. We have offices throughout Washington, DC, and Maryland. Please call your nearest office to get started today!

Address: 1010 Grandin Avenue, Rockville, MD 20851

Phone: 301-251-2860 ext.208

Refugee Employment Services by: Lutheran Social Services of the National Capital Area (LSS/NCA)

Upon arrival, every refugee adult is matched with a LSS/NCA Job Developer to help them secure work as quickly as possible. Job Developers meet our new neighbors to assess their skills and interests in order to match them with an appropriate first job in our country.

Services include:

- Job placement
- Orientation workshops
- Vocational trainings
- Help looking for jobs

After a placement is made, the Job Developers will remain in contact with the client for a minimum of 90 days to ensure the match is successful.

Newcomers may also participate in employment orientation workshops and vocational training, so that they may succeed in the American workforce. Pre-employment workshops address topics specific to the United States, including how to locate jobs, the application process, interview techniques, and American workplace culture. Job Developers assist clients to create resumes and cover letters.

With the strength and support of community members, LSS/NCA has helped thousands of refugees build careers in a variety of professions from health care workers to commercial drivers. Clients are eligible to return for employment services for up to five years.

Address: 4406 Georgia Ave NW, Washington, DC 20011

Phone: 202-723-3000

Adult Services - Employment & Meaningful Day by: The Arc Montgomery County

Employment Services provides adults with disabilities the opportunity to gain independence and contribute to their community by obtaining and maintaining gainful employment. Our employment process includes discovering a person's skills and interests, career counseling, resume building, developing a customized employment plan, job coaching and follow-along services to ensure job stability.

Eligibility: This program serves adults with intellectual and developmental disabilities. Individuals must apply with the Maryland Developmental Disabilities Administration to receive a Medicaid waiver.

Address: 7362 Calhoun Place, Derwood, MD 20855

Phone: 301-984-5777

PDGRS - Vocational Program by: Partnership Development Group (PDG)

Our Evidenced-Based Supported Employment (EBSE) program delivers individualized vocational services to those with mental illnesses. The moment a participant expresses a desire to work, the job search begins. The individual will work with an employment specialist to develop a personalized vocational plan. The whole treatment team will work together using an integrated approach to identify and address specific barriers to employment. This cohesive method facilitates the individual's long term success in the workforce.

Our specialized vocational staff provides workforce reentry training with:

- Job development and application assistance
- Interview and interpersonal skills
- On-site coaching and job retention
- Evidence-based supported employment services

The EBSE program also promotes long term stability by providing ongoing, uninterrupted job coaching and community support services after the individual has gained employment. Once employed, PDG delivers job coaching services for at least 90 days – during the critical adjustment period – thereby increasing the probability of job retention.

Address: 7529 Standish Place, Suite 103, Rockville, MD 20855

Phone: 410-863-7213

Vocational Services by: Sheppard Pratt Health System

Sheppard Pratt helps individuals with varying disabilities be work-ready through supported employment.

Services include:

- Individual placement and support
- Skill assessment
- Job training
- Job placement
- Ongoing job training as needed for job retention and personal growth

Sheppard Pratt works closely with the client and the employer to resolve any concerns that may arise. Please call your nearest office for more information.

Eligibility: This program serves adults with disabilities.

Address: 620 East Diamond Avenue, Gaithersburg, MD 20877

Phone: 301-840-3292

Career Gateway by: Jewish Council for the Aging (JCA)

The Jewish Council for the Aging (JCA) provides the Career Gateway Program for Seniors living in the capital region and parts of Virginia.

This program provides:

- Interview coaching
- Skills assessment
- Online job search training

The program fee is listed as \$75 but scholarships are available for anyone who needs one and no one is turned away.

Eligibility: This program helps people who are older than 49 years old.

Address: 12320 Parklawn Drive, Rockville, MD 20852

Phone: 301-255-4215

English and Adult Education - Computer Literacy by: CASA de Maryland

CASA's computer literacy class is a free class for residents of the Long Branch community. Students learn how to perform basic tasks such as explore the internet, send emails and create MS Word documents. They also learn how to effectively utilize their smartphones to access resources and perform everyday life tasks.

This program provides:

- Computer classes
- Skills & training

Three 9 week sessions are offered per year: Fall (9/6/16 to 11/3/16), Winter (1/17/17 to 3/16/17), and Spring (4/4/17 to 6/1/17) at our Pine Ridge Community Center. Students can register for classes that meet Tuesday and Thursday evening OR for classes meet on Saturday from 9:00 am to 1:00 pm.

Address: 2729 University Boulevard West, Silver Spring, MD 20902

Phone: 301-445-3139; 240-491-5772

Health Behaviors: food insecurity; adult obesity; physical inactivity

Food Bank by: MANNA Food Center

MANNA Food Center provides Food Pantries where anyone in need can obtain food to meet nourishment needs. Manna is temporarily waiving income requirements to provide food to any Montgomery County resident impacted by the COVID-19 crisis.

This program provides:

- Box of pantry staples (e.g. beans, pasta, canned vegetables, canned fruits)
- Box of fresh fruits and vegetables
- Bag of frozen meat

Manna needs to receive your call by 3:00 pm the day before you would like to receive food so your order will be prepared. Manna Food Center has waived all income requirements due to extraordinary circumstances resulting from the COVID-19 crisis. Manna Food Center does not ask about your immigration status and we do not report any of your personal information to the government.

Eligibility: Any resident of Montgomery County can access this program.

Address: 12901 Georgia Avenue, Silver Spring, MD 20906

Phone: 301-424-1130

Refugee Resettlement by: International Rescue Committee (IRC) - Silver Spring

The International Rescue Committee provides opportunities for refugees, asylees, victims of human trafficking, survivors of torture, and other immigrants to thrive in America. The IRC ensures that refugees receive a variety of support to address basic needs.

This program provides:

- A furnished home
- Help with rent
- Health care
- Nutritious, affordable food
- English language classes
- Help building job, computer, and financial literacy skills

- Education for their children
- Social services and community support
- Legal services towards residency and citizenship

Refugees are greeted and welcomed at the airport by IRC case workers and volunteers to ensure their transition is as comfortable as possible.

Eligibility: This program serves refugees.

Address: 8719 Colesville Road, 3rd Floor, Silver Spring, MD 20910

Phone: 301-562-8633

Groceries 2 Go! by: Up 2 Us Foundation

The Groceries 2 Go! program regularly provides free boxes of produce for curbside pickup to individuals and families in need at locations throughout the community. This service supplies critical nutrition to hungry people.

This program provides:

- Food to meet basic nutritional needs

To find out where and when the next Groceries 2 Go! distribution will take place, please visit the Facebook page. Please note, food is distributed at these events until supplies run out -on a first-come, first-served basis.

Eligibility: Anyone can access this program.

Address: 11160 Veirs Mill Road, Unit 164, Silver Spring, MD 20902

Phone: 202-440-3781

Hughes Mid County Consolidation Hub by: Hughes United Methodist Church

Hughes United Methodist Church has partnered with the Montgomery County Department of Health and Human Services to create the Hughes Mid County Consolidation Hub. The Hub is committed to provide food and essential item access to those impacted by the pandemic.

This program provides:

- Drive-in food distributions
- Walk-in food distributions
- Diaper distributions

Food distributions occur every Tuesday at 10:30AM. Diaper distributions are monthly and by appointment only. Appointments can be requested online or by calling HUMC.

Address: 10700 Georgia Avenue, Silver Spring, MD 20902

Phone: 301-949-8383

Food Pantry by: Luther Rice Memorial Baptist Church

Luther Rice Memorial Baptist Church addresses the needs of low-income individuals and households that lack a reliable access to affordable, nutritious food and may experience hunger on a regular basis.

This program provides:

- Nutritious foods

Address: 801 University Boulevard West, Silver Spring, MD 20901

Phone: 301-593-1130

Social Services by: Ayuda

The Social Services program offers holistic services in a culturally sensitive environment to low-income immigrant victims of crime, domestic violence/sexual assault/stalking, and human trafficking. The program serves both women and men from all over the world.

Domestic Violence and Sexual Assault services include the following:

- Help clients secure emergency and transitional shelter, food, clothing, medical and mental health care for themselves and their children
- Provide individual and group therapy for immigrant residents who have experienced domestic violence and/or sexual assault (DC and VA only)
- Provide case management

Ayuda provides comprehensive case management for trafficked persons. Social service staff assists clients with emergency and transitional housing needs, obtaining food and clothing, and providing referrals for medical and mental health needs. Ayuda's team also assists clients to enhance their education and life skills by helping clients enroll in English language courses, computer courses, GED courses and job training programs.

The Children and Youth services provide case management to neglected and vulnerable immigrant children in Fairfax, Virginia. Ayuda offers comprehensive case management, including:

- Connecting with educational resources, after school programs and activities
- Obtaining basic needs such as food, shelter, and clothing
- Social services to neglected and vulnerable immigrant children

Please call the appropriate office depending on your state of residence to receive services:

- Washington, D.C.: 202-387-4848
- Virginia: 703-444-7009
- Maryland: 240-594-0600

Eligibility: Human Trafficking Survivor Foreign born. Low income. Victim/survivor of domestic violence, sexual assault and/or stalking.

Address: 8757 Georgia Avenue, Suite 800, Silver Spring, MD 20910

Phone: 240-594-0600

Food Pantry by: Allen Chapel African Methodist Episcopal Church

Allen Chapel African Methodists Episcopal Church's food pantry serves everyone from low income families, single parents, senior citizens, unemployed individuals, disabled veterans, working poor, and anyone else that comes to the pantry. No one is turned away.

This program provides:

- Food to meet basic nutritional needs

This program is provided every second and fourth Saturday of the month from 8:00 a.m. to 10:00 a.m.

Proof of residency is required (must live in Maryland). Bring a government issued ID to confirm residency.

Eligibility: Anyone can access this program. Must prove that you live in Maryland with photo ID.

Address: 2518 Fairland Road, Silver Spring, MD 20904

Phone: 301-404-2688; 301-879-9232

Food Outreach by: Celestial Manna Inc

Celestial Manna provides quality food items to households experiencing food insecurity. This program supplies critical nutrition to hungry individuals and families.

This program provides:

- Food to meet basic nutritional needs

Please fill out the online form if you are in need of food. Please describe your situation and number of children, adults, and seniors in your family.

Eligibility: Anyone can access this program.

Address: 7800 Suthard Drive, Rockville, MD 20879

Phone: 301-915-7538

Basic Needs Assistance by: Bethesda Help

Bethesda Help offers immediate short-term assistance to residents of southern Montgomery County, Maryland, who are in financial crisis. This program offers help in several areas and is designed to keep families in crisis from slipping into homelessness or food insecurity.

This program provides:

- Help pay rent (for those facing eviction)
- Help pay utilities (for those about to have their utilities disconnected)
- Prescription assistance (for those with a verified physician's prescription)
- Emergency food deliveries to households in crisis (grocery bags containing a three-day supply of food for each member of the household)
- Referrals to additional resources

Please call to request services. If you are requesting food services, you must call on an odd day of the month (1,3,5, etc.) if your home address ends in an odd number. If your home address ends in an even number, you must call on an even day of the month (2,4,6, etc.).

Eligibility: This program serves individuals within a 25 mile radius bounded by the District of Columbia on the south; Falls Road, Montrose Road, and Randolph Road on the north; Veirs Mill Road, Georgia Avenue, and 16th Street on the east; and the Potomac River on the west.

Address: PO Box 34094, Bethesda, MD 20827

Phone: 301-365-2022

Homeless Veterans Program by: Vietnam Veterans of America

The Homeless Veterans Program provides medical exams, haircuts, clean clothes, food and a safe night's sleep through several short and long-term initiatives, multiple times throughout the year, to homeless veterans.

This program provides:

- Temporary shelter
- Emergency food
- Clothing
- Disease screening
- Personal hygiene

Eligibility: This program helps people who are older than 17 years old. This program serves Veterans.

Address: 8719 Colesville Rd, Suite 100, Silver Spring, MD 20910

Phone: 301-585-4000

Food Pantry by: EduCare Support Services

EduCare Support Services provides a food pantry for low-income individuals and families in the community who need support meeting their basic needs.

This program provides:

- Healthy food

Once per calendar month, participants may receive a three-day supply of food, measured by family size. Participants may select which food items they want with a choice pantry service model.

To receive services, please call EduCare's main office during regular business hours. They need to receive your call by 3:00 pm the day before you would like to receive food so that your order can be ready.

Eligibility: Must be a Montgomery County resident. Income must fall below what is necessary to be self-sufficient.

Address: 7001 New Hampshire Avenue, Takoma Park, MD 20912

Phone: 240-450-2092

WIC Centers by: Community Clinic, Inc. (CCI) Health & Wellness Services

Women, Infant and Children Supplemental Food Program is a nutrition program that provides health education, healthy foods, breastfeeding support, and other services free of charge to pregnant and postpartum women, infants and children who qualify in Montgomery and Prince Georges Counties. Our staff can assist clients in applying for WIC and accessing its services.

Services provided:

- Nutritional counseling and education
- Supplemental foods
- Breastfeeding promotion and support
- Referrals for health care

CCI Health & Wellness Services' WIC clinics in Maryland are currently closed due to the COVID-19 (Coronavirus) outbreak. We are able to assist you via phone. Please call your local WIC office at 301-762-9426 if you need any assistance.

If you are on Medicaid, TANF, or SNAP, you meet the income eligibility guidelines for WIC.

Eligibility: This program helps people with income at or below 185% of federal poverty guidelines. WIC serves pregnant, breastfeeding, and postpartum women, infants, and children (under 5 years old). Fathers, parents, step-parents, guardians, and foster parents of infants and children under the age of 5 can apply for their children. Must be a resident of Montgomery or Prince Georges county.

Address: 2730 University Boulevard West, Suite LL10, Wheaton-Glenmont, MD 20902

Phone: 301-762-9426; 301-933-6680

Supplemental Nutrition Assistance Program (SNAP) Outreach by: Montgomery County Food Council

Montgomery County Food Council provides an outreach team to help individuals prescreen for SNAP eligibility and assist with the SNAP application process.

This program provides:

- Assistance applying for SNAP
- Help navigating the system

Eligibility: This program serves U.S. citizens, lawful permanent residents (5 years), lawful permanent resident for any period of time with a disability, refugees or asylum seeker with refugee or asylee status. OR a U.S. citizen under 18, regardless of parent's citizenship status, and students considered "half-time" by educational institutions.

Address: 4825 Cordell Avenue, Suite 204, Bethesda, MD 20814

Phone: 301-818-3614; 240-630-0774

SHARE Food Network by: Catholic Charities Archdiocese of Washington

SHARE Food Network is a sustainable, social enterprise of Catholic Charities that provides nutritious groceries at a reduced cost. Everyone is welcome to purchase without application, qualification, identification, or documentation. Everyone receives the same, fresh, high-quality food.

Monthly value packages cost just \$22 and include \$40-\$50 worth of basic and healthy groceries, typically made up of 4-5 pounds of frozen protein products, 1-3 grocery items, and 8-9 pounds of fresh produce.

Each customer is asked to document at least two hours of service to their community each month before buying.

To receive services, please call the main program line or find the SHARE site closest to you on the program website.

Eligibility: Anyone can access this program.

Address: 3222 Hubbard Road, Hyattsville, MD 20785

Phone: 301-864-3115

Diabetes Prevention Program by: Holy Cross Health

The Diabetes Prevention Program can help individuals reduce the risk of developing Type 2 diabetes and help them adopt and maintain a healthy lifestyle to reduce your chances of developing diabetes.

This program lasts for one year. To learn more about the program, please call.

Eligibility: Must have Medicare or Maryland Medicaid. This program helps people who are older than 17 years old. Must be overweight. Must NOT be diagnosed with type 1 or type 2 diabetes. Must not be pregnant.

Address: 3720 Farragut Avenue, 2nd Fl, Kensington, MD 20895

Phone: 301-557-1231; 301-949-4242

CONTACT INFORMATION

We are grateful to the scholars, hospital staff, advocacy leaders, partners, and stakeholders who have expressed appreciation for easy access to previous CHNAs to reference comprehensive data on local community health status, needs, and issues. We hope the collaborative nature of the 2022 MCHC CHNA is valued as an *enhanced* asset. We invite all members of the community to submit questions and feedback regarding this collective assessment.

To request a print copy of this report, or to submit your comment, please contact:

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An electronic version of this Community Health Needs Assessment is publicly available at:

Adventist HealthCare website:

<https://www.adventisthealthcare.com/about/community/health-needs-assessment/>

Holy Cross Health website:

<https://www.holycrosshealth.org/about-us/community-involvement/community-benefit-planning/community-health-needs-assessment>

Suburban Hospital, Johns Hopkins Medicine website:

https://www.hopkinsmedicine.org/about/community_health/suburban-hospital/community_commitment/needs_assessment.html

MedStar Health, MedStar Montgomery Medical Center website:

<https://www.medstarhealth.org/locations/medstar-montgomery-medical-center/community-health>



Community Health Needs Assessment: **Implementation Strategy**

2020-2022

Adopted July 2020 for:

Adventist HealthCare Shady Grove Medical Center

Adventist HealthCare White Oak Medical Center

Adventist HealthCare Rehabilitation Rockville

Adventist HealthCare Rehabilitation Takoma Park



Adventist HealthCare completed a comprehensive Community Health Needs Assessment (CHNA) process for each of our hospitals. The CHNA reports were adopted by our Board of Trustees in October of 2019.

Complete CHNA reports are available online at:

<https://www.adventisthealthcare.com/about/community/health-needs-assessment/>

Organizational Overview

About Us

Adventist HealthCare, based in Gaithersburg, Md., is a faith-based, not-for-profit organization of dedicated professionals who work together each day to improve the health and well-being of people and communities through a ministry of physical, mental and spiritual healing.

Founded in 1907, Adventist HealthCare is the first, largest and only health system headquartered in Montgomery County, Maryland and operates:

- Three nationally accredited acute-care hospitals
- A nationally accredited rehabilitation hospital
- Mental health services
- Home health agencies
- Physician networks
- Urgent Care Centers
- Imaging Centers

Mission & Values

Our Mission

We extend God's care through the ministry of physical, mental and spiritual healing.

Our Values

Adventist HealthCare has identified five core values that we use as a guide in carrying out our day-to-day activities:

1. **Respect:** We recognize the infinite worth of each individual.
2. **Integrity:** We are conscientious and trustworthy in everything we do.
3. **Service:** We care for our patients, their families and each other with compassion.
4. **Excellence:** We do our best every day to exceed expectations.
5. **Stewardship:** We take ownership to efficiently and effectively extend God's care.

Our Hospitals

Shady Grove Medical Center

Shady Grove Medical Center is a licensed 443-bed acute care facility located in Rockville, Maryland. Opened in 1979, the hospital has since expanded to include a four-story patient tower with private rooms; a high-tech surgery department for inpatients and outpatients; a freestanding Emergency Center in Germantown; the comprehensive Aquilino Cancer Center; and inpatient and outpatient mental health services.

White Oak Medical Center

Adventist HealthCare White Oak Medical Center is a 180-bed acute-care facility located in Silver Spring, MD. The hospital first opened in 1907 in Takoma Park, MD, and was home to Montgomery County's first cardiac center, with hundreds of open-heart surgeries and thousands of heart catheterizations performed each year. Today, a new state-of-the-art hospital stands in Silver Spring, MD, which continues to provide high-quality cardiac, emergency, stroke, maternity, cancer, surgical and orthopedic care.

Rehabilitation: Rockville & Takoma Park

Adventist HealthCare Rehabilitation, which opened in January 2001, is the first and only acute rehabilitation hospital in Montgomery County, Maryland. Adventist HealthCare Rehabilitation offers comprehensive rehabilitation programs for brain injuries, spinal cord injuries, stroke, amputation, orthopedic injuries and surgeries, sports-related injuries, work-related injuries and neurological disorders. Adventist HealthCare Rehabilitation has two hospital locations: a free-standing 55-bed hospital in Rockville, Maryland, and a 42-bed hospital located in Takoma Park, Maryland. Adventist HealthCare Rehabilitation also provides outpatient rehabilitation services at our hospital location in Rockville and our community-based centers in Silver Spring, Maryland and Gaithersburg, Maryland. Adventist HealthCare Rehabilitation is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) for all four of its specialty programs including stroke, spinal cord injury, brain injury and amputee. Adventist HealthCare Rehabilitation was one of the first acute rehabilitation facilities in the nation to earn specialty accreditation for its amputee program.

Prioritization of Identified Needs

Process and Criteria Used

The prioritization of needs for this Community Health Needs Assessment (CHNA) cycle was completed on a system level. The initial prioritization was led by Adventist HealthCare's Community Benefit Steering Committee (CBSC). The purpose of the CBSC is to guide the community benefit work of Adventist HealthCare to fulfill our mission and improve the health and wellbeing of the community we serve. The CBSC is comprised of leaders from each of our hospital entities as well as from population health, mission integration and spiritual care, marketing, philanthropy, and finance.

To complete the prioritization process, the CBSC members were asked to evaluate each of the identified areas of need utilizing the following factors:

- **Incidence and Prevalence:** How big of a problem is the need in the community?
- **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?
- **County Alignment:** Is the health area aligned with Montgomery and Prince George's County priority areas?
- **Community Support:** Based on the community input collected, is this a significant area of 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?
- **Alignment with Adventist HealthCare Strategy:** Does this area align with an Adventist HealthCare strategy or area of focus?



- **Existing Adventist HealthCare Resources and Expertise:** Does Adventist HealthCare have expertise in this area? Are there existing resources that could be utilized to address this area of need?
- **Existing and Potential Partnerships:** Does Adventist HealthCare have relevant existing partnerships that can be leveraged or potential partnerships that can be developed?
- **Potential for Measurable and Achievable Outcomes:** Will it be possible to make an impact in this area? Are there relevant metrics that can be monitored and measured?

Based on these factors, CBSC members were asked to recommend which of the following would be an appropriate role for Adventist HealthCare to take in addressing the area of need:

- **Leader Role:** Adventist HealthCare is well positioned to take a leadership role in addressing this area.
- **Collaborator Role:** Adventist HealthCare will partner with other leading organizations to actively address this area.
- **Supporter Role:** While Adventist HealthCare recognizes the importance of this area of need on the wellbeing of our community, it is currently outside the scope of our strengths and resources to address directly. Adventist HealthCare will support the work of other organizations doing work in this area.

Prioritized Needs

For the 2020 - 2022 CHNA cycle, Adventist HealthCare has prioritized addressing unmet needs of uninsured and underserved populations in the following areas:

ACCESS TO CARE	SOCIAL DETERMINANTS OF HEALTH
Behavioral Health Chronic Disease Maternal and Child Health Disability and Rehabilitation Services	Food Access Housing and Homelessness Education Transportation

Since the completion of our CHNA, COVID-19 has emerged as a significant health need in the community. While COVID-19 continues to be prevalent, Adventist HealthCare will work to meet the clinical needs of our community as well as address the intersectionality of COVID-19 with our prioritized areas of need.

Needs that will not be Addressed

Adventist HealthCare will not directly address **cancer**, **asthma**, and **infectious diseases** (i.e. HIV/AIDS and influenza) as priority areas for this CHNA cycle. Due to the wide range of health issues identified and limited resources, Adventist HealthCare elected to focus on the areas of need identified as higher priority during the CHNA prioritization process.

Implementation Strategy Initiatives

Community Health Needs Assessment Findings by Priority Area

A more comprehensive review of findings can be seen in our CHNA reports: <https://www.adventisthealthcare.com/about/community/health-needs-assessment/>

CHNA PRIORITY AREA	CHNA KEY FINDINGS	ANTICIPATED IMPACT
<p>Chronic Disease <i>Goal:</i> Reduce the disease burden of chronic conditions such as diabetes mellitus and heart disease.</p>	<ul style="list-style-type: none"> 7% of adults in Montgomery County and 12% of adults in Prince George's County have diabetes. ER rates for diabetes increased in both Montgomery and Prince George's County with PGC having almost 2X the rate of MC. African Americans have the highest diabetes mortality and hospitalization rates in both Montgomery and Prince George's County. In Montgomery County, individuals 65+ have the highest rate of diabetes ER visits. 	<ul style="list-style-type: none"> Increased access to evidence-based education for diabetes prevention and self-management, as well as chronic disease self-management Decreased incidence of uncontrolled diabetes
<p>Behavioral Health <i>Goal:</i> Increase awareness of mental health needs and resources and access to appropriate mental health services and support resources.</p>	<ul style="list-style-type: none"> Mental health related ER visits have increased in both Montgomery and Prince George's County. African Americans, females, and individuals age 18-34 have the highest mental health ER visit rates in Montgomery County. Whites are more likely to die from suicide in Montgomery and Prince George's County compared to African Americans. A growing need for behavioral health services for youth was an emerging need identified through survey data and key informant interviews. 	<ul style="list-style-type: none"> Increased capacity and infrastructure to meet the mental health needs of the community Increased awareness of services and how to access them Decreased stigma in discussing mental health and seeking care
<p>Disability & Rehabilitation Services <i>Goal:</i> Improve the health, wellness and quality of life for individuals recovering from injury or living with a disability.</p>	<ul style="list-style-type: none"> In Maryland, the highest TBI related emergency room visits occurred in individuals age 15 – 24. At AHC Rehab, NH-White males were the majority of patients treated for TBI. In Prince George's County, the stroke mortality rate was highest among Black males and has increased over time from 2013 to 2017. 	<ul style="list-style-type: none"> Increased concussion awareness and identification, as well as improved management among high school athletes Increased access to supportive resources and services for families and individuals recovering from an injury or living with a disability or injury

<p>Maternal & Child Health <i>Goal:</i> Improve the health and well-being of women, infants, children, and families.</p>	<ul style="list-style-type: none"> • The infant mortality rate in Prince George’s County is almost 2X that of Montgomery County. • Hispanic women have the highest rate of teen pregnancies and are the least likely to receive early prenatal care in both Montgomery and Prince George’s County. • In both Montgomery and Prince George’s County, infant mortality disproportionately affects African American mothers. 	<ul style="list-style-type: none"> • Increased access to affordable pre-natal care for low-income and uninsured/ underinsured women • Increased access to pre- and post-natal education and support for women, children and families
<p>Social Determinants of Health <i>Goal:</i> Address social factors known to have a significant impact on physical and mental wellness.</p>	<ul style="list-style-type: none"> • 6.1% of Montgomery County residents and 13.3% of Prince George’s County residents are food insecure. • The child food insecurity rate is 13.5% in Prince George’s County compared to 12.3% in Montgomery County • From 2015 to 2018, the number of homeless people in Montgomery County decreased from 1,100 to 840 and in Prince George’s County decreased from 627 to 478. 	<ul style="list-style-type: none"> • Increased access to free and affordable healthy food options for food insecure individuals and households • Increased access to safe, stable and affordable housing • Increased opportunities for mentorship and internship opportunities for students • Increased access to affordable physical and mental health care for low-income and uninsured/ underinsured individuals

Implementation Strategy Initiatives

Priority Area: Chronic Disease

Goal: Reduce the disease burden of chronic conditions such as diabetes mellitus and heart disease

INITIATIVE	DESCRIPTION	SYSTEM ROLE	ADDITIONAL PRIORITY AREA(S) ADDRESSED	EVALUATION METRICS	POTENTIAL PARTNERS
Chronic Disease Self-Management Program (CDSMP)	The CDSMP is designed to help people gain self-confidence in their ability to manage their health and maintain active and fulfilling lives. Small group, highly interactive workshops are six weeks long, meeting once a week for 2.5 hours.	Leader	Behavioral Health	<ul style="list-style-type: none"> • # of individuals enrolled in CDSMP classes • # of CDSMP completers • # of completed workshops • Changes in self-reported health behaviors, knowledge and self-efficacy 	<ul style="list-style-type: none"> • Manna Food Center • Adventist HealthCare Faith Community Health Network • Montgomery County Office of Aging
Nexus Montgomery Regional Partnership: Catalyst Diabetes Project	<p>The Catalyst Diabetes Project will expand delivery capacity for the Diabetes Prevention Program (DPP) and Diabetes Self-Management Training (DSMT) and increase demand and participant retention for these programs.</p> <p>Centralized supports will be developed for participant recruitment, case management, and administrative and data services.</p>	Leader / Collaborator	Food Access, Transportation	<ul style="list-style-type: none"> • DPP and DSMT capacity • Percent of prediabetic residents referred to DPP • % of prediabetic residents that began and completed DPP • % of DPP participants that achieved 5% or 9% weight loss • % reduction in the diabetic rate compared to expected rate • % of diabetic Medicare recipients referred to DSMT • % of diabetic Medicare recipients that completed DSMT • Reduction in avoidable diabetes related hospital admissions 	<ul style="list-style-type: none"> • Holy Cross Health, Suburban Hospital, and Medstar Montgomery • Primary Care Coalition • Potomac Physicians Associates • Privia Health • Maryland Collaborative Care • Kaiser Permanente • YMCA • Bethesda Nutrition • Health Care Dynamics Inc. • Giant Food • Montgomery County DHHS • Solera Health • MNCPPC • AARP • American Diabetes Association

Diabetes Management Program	The Diabetes Management Program is a 12-week program that includes weekly group and self-paced education sessions. Participants receive regular one-on-one health coaching as well as web-based daily glucose monitoring.	Leader / Collaborator	N/A	<ul style="list-style-type: none"> • # of participants enrolled • # of participants that completed the program • Changes in participants' weight, BMI and A1C 	<ul style="list-style-type: none"> • Adventist HealthCare Life Work Strategies • One Health Quality Alliance Clinically Integrated Network
Food & Nutrition Classes	Free classes discussing the importance of eating healthy and nutritious food, especially pre- and post-cancer treatment. Classes include nutrition education, seasonal cooking demonstrations, and tips for becoming a savvy health shopper.	Leader	Food Access	<ul style="list-style-type: none"> • # of participants • # of classes held 	<ul style="list-style-type: none"> • Aquilino Cancer Center
Integrative Medicine Programs	Free mindfulness and low impact exercise classes.	Leader	Behavioral Health	<ul style="list-style-type: none"> • # of participants • # of classes held 	<ul style="list-style-type: none"> • Aquilino Cancer Center
Community Health Screenings & Lectures	Community health screenings and lectures are held regularly at several partner locations. Lectures are on varying health topics such as heart disease, diabetes, and mental health.	Leader	Behavioral Health	<ul style="list-style-type: none"> • # of screenings completed • # of participants (lectures) • Participant satisfaction (lectures) 	<ul style="list-style-type: none"> • Community Centers • Senior Centers • Senior Living Facilities
Faith Community Health Network	The Faith Community Health Network serves faith communities by providing guidance, technical assistance, and materials, empowering them to become places of health and healing; and training RNs to become Faith Community Nurses.	Leader	N/A	<ul style="list-style-type: none"> • # of congregations in the network • % participation in network meetings • # of nurses trained 	<ul style="list-style-type: none"> • AHC Faith Community Health Network

Priority Area: Behavioral Health

Goal: Increase awareness of mental health needs and resources, and access to appropriate mental health services and support resources

INITIATIVE	DESCRIPTION	SYSTEM ROLE	ADDITIONAL PRIORITY AREA(S) ADDRESSED	EVALUATION METRICS	POTENTIAL PARTNERS
Behavioral Health Support Groups and Workshops	The Outpatient Wellness Clinic (OWC) offers free support groups and workshops. Examples of the classes and support groups offered include: Overcoming the Winter Blues, Tools for Effective Communication: How to Stop Avoiding Issues and Become a Stronger Communicator, Grief & Loss Support Group, and Becoming Resilient Person.	Leader	N/A	<ul style="list-style-type: none">• # of workshops and support groups held• # of participants• % of participants who had an increase in knowledge & self-efficacy	N/A
Behavioral Health Education	In partnership with EveryMind and the other Montgomery County hospitals, a mental health topic is selected annually based on need. Throughout the year, interactive health education events are developed to address the selected topic. The content and format of each event is tailored to meet the needs of various target populations (e.g. older adults, youth, working adults, health professional, etc.).	Collaborator	N/A	<ul style="list-style-type: none">• # of activities held• # of participants• Satisfaction rate• Self-efficacy	<ul style="list-style-type: none">• EveryMind• Holy Cross Health• Suburban• Medstar Montgomery• Montgomery County HHS• Montgomery County Public Schools

Behavioral Health Internships	As part of their psychiatry residency program, fellows from Georgetown University Hospital specializing in child and adolescent psychiatry complete a rotation at Adventist HealthCare Shady Grove Medical Center - Behavioral Health. Fellows are with us for 9 months and can work closely with our doctors in multiple settings. Fellows work full days with the attending physicians four days a week. Additionally, AHC offers internship opportunities to Nursing and Social Work Students on Behavioral Health units	Collaborator	N/A	<ul style="list-style-type: none"> • # of students 	<ul style="list-style-type: none"> • Medstar Georgetown University Hospital • Local colleges and universities
Annual Youth Behavioral Health Symposium	The Youth Behavioral Health Symposium occurs annually in the Fall. Health professionals and community members hear from experts in the field and can earn continuing education credits.	Leader/ Collaborator	N/A	<ul style="list-style-type: none"> • # of symposium attendees • Participant satisfaction and knowledge change 	<ul style="list-style-type: none"> • Medstar Georgetown University Hospital

Mental Health First Aid	Mental Health First Aid is a course that teaches participants how to identify, understand and respond to signs of mental illnesses and substance use disorders. Participants are taught skills needed to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.	Leader	N/A	<ul style="list-style-type: none"> • # of trainings held • # of individuals trained • Participant satisfaction 	<ul style="list-style-type: none"> • Adventist HealthCare Faith Community Health Network • Hearts and Homes for Youth
Nexus Montgomery Regional Partnership: Catalyst Crisis Now Initiative	<p>The Crisis Now Initiative will work to replicate components of the Crisis Now Model in Montgomery County. This model includes the following two priority areas and activities:</p> <ul style="list-style-type: none"> • Develop a Community Crisis System Collaborative (CCSC) • Create of a “no wrong door” 24/7 Stabilization Center <p>Increase mobile crisis outreach team (MCOT) capacity and enhance MCOT fidelity to the Crisis Now model</p>	Leader / Collaborator	N/A	<ul style="list-style-type: none"> • Crisis Now model fidelity • ER utilization with primary BH diagnosis • ER boarding times • ER repeat utilization • Inpatient Utilization • Patient reported outcomes / patient experience • First responder satisfaction • Utilization of restoration center • Escalation to higher level of care • Appropriate follow up after crisis episode • Diversion of high utilizers • Timely receipt of MCOT services • Utilization of peer navigators 	<ul style="list-style-type: none"> • Holy Cross Health, Suburban Hospital, and Medstar Montgomery • Primary Care Coalition • Montgomery County DHHS • Montgomery County Police Department • Montgomery County Fire and Rescue • EveryMind

<p>Forensic Medical Unit (FMU) at Shady Grove Medical Center</p>	<p>The FMU is the only unit of its kind in Montgomery County, MD. The unit provides confidential care to victims of child abuse/neglect, sexual assault, human trafficking, domestic violence, non-fatal strangulation, and elder/vulnerable adult abuse and neglect. The unit's staff of specially trained forensic nurse practitioners and forensic nurse examiners work 24 hours a day, 365 days a year to provide medical services, forensic examinations, and safety planning for victims of violence. These services include specialized medical screening and treatment, evidence collection, STI and HIV counseling, screening and prevention, emergency contraception, admission planning, phone and bedside consultations, follow-up examinations, and safety disposition planning.</p>	<p>Leader</p>	<p>N/A</p>	<ul style="list-style-type: none"> • # of encounters • # of individuals placed on HIV prophylaxis • # of times able to recover usable DNA samples for investigation and prosecution • Staff time per patient 	<ul style="list-style-type: none"> • Emergency Medical Services • Family Justice Center
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Priority Area: Disability and Rehabilitation Services

Goal: Improve the health, wellness and quality of life for individuals recovering from injury or living with a disability

INITIATIVE	DESCRIPTION	SYSTEM ROLE	ADDITIONAL PRIORITY AREA(S) ADDRESSED	EVALUATION METRICS	POTENTIAL PARTNERS
Disability/Rehab Support Groups	Adventist HealthCare Rehabilitation Hospital hosts various community support groups and classes which include: <ul style="list-style-type: none"> • Brain Injury Support Group (available in both English & Spanish) • Amputee Support Group • Stroke Support Group 	Leader / Collaborator	Behavioral Health	<ul style="list-style-type: none"> • # of support groups held • # of participants 	<ul style="list-style-type: none"> • Brain Injury Association of Maryland • Montgomery County Stroke Association
Athletic Trainer Program/Student Athlete Concussion Program	Athletic trainers are placed in 13 Montgomery County high schools to raise awareness, provide education, prevent and manage injuries and concussion, and manage return to play.	Collaborator	N/A	<ul style="list-style-type: none"> • # of students who received ImPact baseline concussion testing • # of concussions diagnosed and treated • # of injuries managed 	<ul style="list-style-type: none"> • Montgomery County Public Schools
Adaptive Health and Fitness Class	Free adaptive fitness class will be offered in 6-week sessions. Classes will be taught by certified personal trainers and focus on fun, effective and safe adaptive aerobic exercises for children and adults with limited to no mobility.	Collaborator & Supporter	N/A	<ul style="list-style-type: none"> • Number of 6-week sessions • # of participants • Participant engagement and satisfaction 	<ul style="list-style-type: none"> • Disability Partnerships • Cruse Control Fitness

Priority Area: Maternal and Child Health

Goal: Improve the health and well-being of women, infants, children, and families

INITIATIVE	DESCRIPTION	SYSTEM ROLE	ADDITIONAL PRIORITY AREA(S) ADDRESSED	EVALUATION METRICS	POTENTIAL PARTNERS
Parent and Family Education Support Groups	Adventist HealthCare offers a series of free support groups to provide leader and peer support and education. Support groups include: <ul style="list-style-type: none"> • Breastfeeding Education Support & Togetherness (B.E.S.T.) • Discovering Motherhood • Navigating Fatherhood • Programa de Maternidad y Familia (in Spanish) • Perinatal Loss Support Group 	Leader	Behavioral Health	<ul style="list-style-type: none"> • # of support groups held • # of participants • # of people who completed program • Participant satisfaction • % of babies breastfeeding at 3, 6, and 12 months 	<ul style="list-style-type: none"> • One Health Quality Alliance Clinically Integrated Network • Manna Food Center • Mary’s Center
Warm Line	The Warm Line provides free telephone assistance for breastfeeding questions and concerns, as well as evidence-based information for breastfeeding mothers and families. The Warm Line is staffed by an IBCLC (International Board-Certified Lactation Consultant) and is available 7 days a week/365 day a year.	Leader	Behavioral Health	<ul style="list-style-type: none"> • # of individuals served • # of encounters 	N/A

Maternity Partnership/Prenatal Care Program	Adventist HealthCare participates in the Montgomery County Maternity Partnership / Prenatal Care Program. Through this program pregnant women who are low-income and uninsured are able to receive all of their pre- and post-natal care at a low fixed cost.	Collaborator	N/A	<ul style="list-style-type: none"> • # of women served • # of teenage deliveries • Pregnancy loss and infant mortality rates • Trimester that pre-natal care was initiated • % of babies born with a low birth weight 	<ul style="list-style-type: none"> • Montgomery County HHS • Mary's Center
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Priority Area: Social Determinants of Health (SDOH)

Goal: Address social factors known to have a significant impact on physical and mental wellness

INITIATIVE	DESCRIPTION	SYSTEM ROLE	ADDITIONAL PRIORITY AREA (IF APPLICABLE)	EVALUATION METRICS	POTENTIAL PARTNERS
Hungry Harvest Rx	The Hungry Harvest Rx program provides produce prescriptions to patients who are at or below 250% of the federal poverty level and need food assistance. Program participants receive free fresh produce deliveries from Hungry Harvest every 2 weeks for 2 months.	Leader	Food Access	<ul style="list-style-type: none"> • Pounds of food delivered • # of people enrolled in program 	<ul style="list-style-type: none"> • Hungry Harvest
Education & Workforce Development	Adventist HealthCare offers various career development opportunities that provide secondary, post-secondary, and technical students unique health and medical learning opportunities. Programs include: <ul style="list-style-type: none"> • Medical Careers Program • Stepping Stones • Clinical Shadowing • Internships/Fellowships 	Leader & Collaborator	Education	<ul style="list-style-type: none"> • # of student participants • # of encounters • Staff mentoring time 	<ul style="list-style-type: none"> • Montgomery County Public Schools • Montgomery County Fire & Rescue • Local colleges and universities

Priority Area: All

Goal: To partner with and provide support to organizations addressing community health needs identified and prioritized through our CHNA process

INITIATIVE	DESCRIPTION	SYSTEM ROLE	EVALUATION METRICS	POTENTIAL PARTNERS
Adventist HealthCare Community Partnership Fund	<p>The Adventist HealthCare Community Partnership Fund (CPF) provides funding for organizations whose activities support our mission to improve the health and wellbeing of our community, especially for those who have poor access to care and poor health outcomes.</p> <p>To qualify for grant or sponsorship funding, proposed activities must address a CHNA priority area and target populations that are socially and economically underserved.</p>	Leader/ Collaborator/ Supporter	<ul style="list-style-type: none"> • Dollars donated that count as community benefit • Distribution of dollars donated by priority area 	<ul style="list-style-type: none"> • Mary’s Center • Mobile Medical Care • Mercy Clinic • Kaseman Clinic • Community Clinic Inc. • CASA de Maryland • CHEER • Manna Food Center • Crossroads Community Food Network • Thriving Germantown • MCAEL • Montgomery Hospice • Identity • CentrePoint Counseling • Additional eligible not for profit organizations addressing health needs in Adventist HealthCare’s service area

Throughout the 2020 – 2022 Implementation Strategy cycle, Adventist HealthCare will continue to monitor the evolving needs of our community, emerging resources made available through other organizations, and changing circumstances (such as COVID-19). While committed to providing the necessary people and financial resources to successfully implement the initiatives outlined above, Adventist HealthCare reserves the right to amend this implementation strategy as circumstances warrant in order to best serve our community and allocate limited resources most effectively.

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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:

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- 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:
 - o Places the health of the individual in serious jeopardy
 - o Causes serious impairment to bodily functions or serious dysfunction to a bodily organ.
 - o 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.

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- **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

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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:**

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- 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

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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

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- 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

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- 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

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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 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

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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.

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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

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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

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: 13 of 14

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

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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



Community Health Needs Assessment

Adventist HealthCare Rehabilitation 2020 – 2022

*Approved by Adventist HealthCare
Board of Trustees in October 2019*



Adventist HealthCare
Rehabilitation

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Section I: Introduction



Letter from the President & CEO



Thank you for the opportunity to present the Adventist HealthCare 2020-2022 Community Health Needs Assessment (CHNA) report and findings. The assessment, which is done every three years, helps our organization identify the needs of our patients and local community members, and address those needs through collaborative partnerships and healthcare service offerings.

Adventist HealthCare is an integrated healthcare delivery network including four nationally accredited acute-care and specialty hospitals, behavioral health services, home health agencies, urgent care centers, primary care offices and imaging centers. Our role is to not only deliver high-quality care, but to contribute to societal well-being and equitable care throughout the Washington, D.C., metropolitan area.

For example, we will continue to focus on areas such as chronic disease prevention and management, behavioral health and maternal and child health. We will also look at the social determinants of health, such as homelessness and food insecurity.

Societal well-being is an important part of our Mission to extend God's care to the community we serve. Our community includes individuals and families who have access to resources like housing, transportation, education, employment and health care, which are important factors leading to good health and well-being. However, there are those in our community who face social and economic challenges—racial and social injustice, economic inequality, and lack of access to resources and services—that affect their quality of life and health outcomes. Paying attention to factors that affect health is imperative to improve care experience, improve quality, reduce costs and advance health equity for all.

Our Mission and values of respect and integrity call us to recognize the infinite worth of each individual and to be conscientious and trustworthy in everything we do. We demonstrate our commitment to equity and inclusion by acting with integrity, holding ourselves to the highest standards, and ensuring that everyone is treated respectfully and receives equitable healthcare.

I invite you to read more about the work we have done and our continued focus on delivering high-quality and compassionate care to the communities we serve.

A handwritten signature in black ink that reads "Terry Forde". The signature is written in a cursive, flowing style.

Terry Forde
President & CEO

Adventist HealthCare Rehabilitation Overview

Adventist HealthCare Rehabilitation

Adventist HealthCare Rehabilitation, which opened in January 2001, is the first and only acute rehabilitation hospital in Montgomery County, Maryland. Adventist HealthCare Rehabilitation offers comprehensive rehabilitation programs for brain injuries, spinal cord injuries, stroke, amputation, orthopedic injuries and surgeries, sports-related injuries, work-related injuries and neurological disorders.

Adventist HealthCare Rehabilitation has two hospital locations: a free-standing 55-bed hospital in Rockville, Maryland, and a 42-bed hospital located in Takoma Park, Maryland. Adventist HealthCare Rehabilitation also provides outpatient rehabilitation services at our hospital location in Rockville and our community-based centers in Silver Spring, Maryland and Gaithersburg, Maryland.

Adventist HealthCare Rehabilitation is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) for all four of its specialty programs including stroke, spinal cord injury, brain injury and amputee. Adventist HealthCare Rehabilitation was one of the first acute rehabilitation facilities in the nation to earn specialty accreditation for its amputee program.

Inpatient & Outpatient Rehabilitation Services

Specialized inpatient treatment programs are available for persons with functional limitations who are 18 years of age or older, and under special circumstances, emancipated minors.

Our acute inpatient rehabilitation programs are run by a team of rehabilitation experts who guide patients along a practical and personalized treatment program focused on increasing self-reliance and gaining independence. The team is led by a physiatrist, a medical doctor who specializes in physical medicine and rehabilitation. Specialized rehabilitation nursing is available twenty-four hours a day, seven days a week with services including the spinal cord injury program, amputee program, stroke program, brain injury program, general rehabilitation program (orthopedic, cardiac, and multi-trauma diagnoses), and prosthetics and orthotics.

Adventist HealthCare Rehabilitation's outpatient facilities are responsible for treating a variety of diagnoses and conditions for patients with physical challenges. These departments act not only as a continuation of our inpatient setting but also have a focus on new patients. In our outpatient setting, we concentrate on patients who come to us for rehabilitation services related, but not limited to, surgical recovery, immobility and strength deficiencies.

Similar to our inpatient facilities, our outpatient facilities treat patients who are 18 years of age or older. The outpatient rehabilitation services offered at our facilities include the Neuro Rehab and Balance Center, driver evaluation and rehabilitation program, lymphedema therapy, joint replacement program, seating and mobility clinic, sports medicine and Lee Silverman Voice Treatment (LSVT) speech language and swallowing therapy.

Accreditation

Adventist HealthCare Rehabilitation is accredited by the Joint Commission and CARF. The Joint Commission evaluates the quality and safety of care for more than 15,000 health care organizations. In order to earn and maintain accreditation, an extensive on-site review by a team of health care professionals from the Joint Commission is conducted once every three years. The purpose of this review is to evaluate performance in areas that affect patient care. We are proud to announce that Adventist HealthCare Rehabilitation was successfully reviewed by the Joint Commission and received accreditation for an additional three years.

Programs and services that have been accredited by CARF have demonstrated that they largely meet internationally recognized standards. Having earned a CARF accreditation, patients can be confident that Adventist HealthCare Rehabilitation has made a commitment to continuously enhance the quality of our programs and services.

Executive Summary

With increasing racial and ethnic diversity of residents in the greater Washington D.C. metropolitan area (including Montgomery and Prince George's counties), addressing the needs of a diverse community is an integral part of fulfilling Adventist HealthCare's mission. The Adventist HealthCare Population Health strategy aims to improve the patient experience of care, reduce the total cost of care, and advance health equity by coordinating health care and services for communities we serve. Disadvantaged populations--such as those experiencing poverty or homelessness, people of color, women, and others who have persistently experienced social disadvantage or discrimination--systematically experience worse health outcomes or greater health risks than more advantaged social groups (Braveman, 2006). Infant mortality is more than two times higher for Black women than for white women. Breast and prostate cancer mortality are higher for women and men of color, respectively. These disparities in health outcomes, which are widely proven to be avoidable and unjust, are very well documented.

Like many hospitals and healthcare systems across the nation, Adventist HealthCare works to bring the best quality of care and access to care to the populations we serve. However, our organization recognizes the importance of addressing the environment (housing and transportation, for example), health behaviors (nutrition, exercise, tobacco use) and socioeconomic factors (education, employment, income, support and safety systems) that affect health. The University of Wisconsin Population Health Institute Model

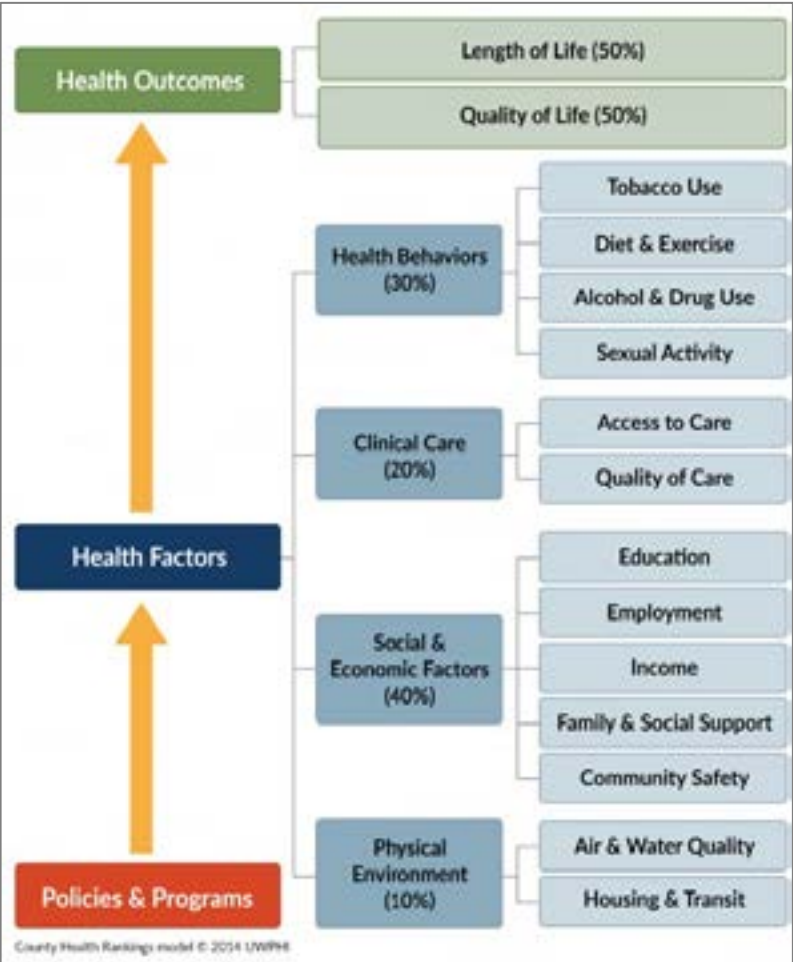


Figure 1. County Health Rankings Model
(Source: University of Wisconsin Population Health Institute)

(Figure 1) indicates that these factors contribute significantly to health outcomes (80%) such as one's quality of life and life expectancy. While hospitals have significant control over clinical care (20%), using a collaborative approach to address a broader set of community needs is required to ensure that everyone has a fair and just opportunity to achieve the best health possible (the definition of health equity). Through a comprehensive needs assessment, Adventist HealthCare has collected information about population demographics, existing community assets, and gaps in resources to share with patients and community members, community partners, and staff and leaders. Together with our partners, we share responsibility for improving the health of the community and exploring new ways to deliver patient-centered and equitable care.

The 2020-2022 Adventist HealthCare Community Health Needs Assessment (CHNA) reports include information about community-identified needs in areas where Adventist HealthCare offers health care and related services to our community. Each hospital has a report that summarizes information about the health status and health needs of residents in their particular service area (primarily in Montgomery and Prince George's Counties) using reliable and public data sources as well as input from community members, leaders, and organizations. Key representatives of the community are included in the input: diverse county residents; partners in public health, public safety, housing, and education; and communities with limited access to care, programs, and resources such as people with disabilities or those experiencing poverty, hunger, or homelessness. The comprehensive information in this report helps our organization learn about community-based organizations and local assets, resource gaps, racial inequities, and health and healthcare needs that our community deems important. Our goal is to use this information to focus our healthcare strategy on population-based care, programs, and services that promote healthy communities over the next three years.

There has been a myriad of evidence showing that disparities exist in quality of care, access to care, clinical conditions, and health outcomes. Factors such as race and ethnicity, sex and gender identity, housing conditions, access to healthy food, and others can influence health and access to healthcare. Many respondents to our primary survey noted a lack of trust in and bias among healthcare providers, and they expressed the desire for culturally sensitive health care. The section titled "**Our Community**" describes the changing demographics of diverse populations residing in specific zip codes in our community service area. Besides race, ethnicity, and age, the section includes information about the educational attainment, household income, poverty level, insurance coverage, and access to care of residents, particularly highlighting those who face barriers to equitable healthcare.

The **Methodology** section describes the data collection and analysis approaches used to assess health, social, and other community needs. The section also describes how we gathered input from community members and leaders through community conversations, key informant interviews, and an online survey. In addition, we include a description of the process for prioritizing and selecting areas of focus for strategic community health improvement planning and implementation.

In the **Findings** section, the report describes two system-wide priority areas of focus identified from the assessment: (1) increasing access to care and (2) addressing social determinants of health. For each hospital-specific report, the themes that came up most often were related to chronic disease prevention and management, maternal and child health, behavioral health, and social determinants of health such as homelessness and food insecurity. The section includes the findings from the various data collection methods and presents detailed information by chronic or infectious disease, overall health and wellness (e.g., maternal and child health, behavioral health), and topics related to societal well-being (e.g., education, food access, housing, and transportation).

Finally, the section on **Evaluation** shares the programs and outcomes of the 2017-2019 CHNA implementation strategy, including changes over time (improving, worsening, or staying the same) and disparities among different populations. This final summary of the last three-year cycle provides background on the activities to address concussion education and care for high school athletes.

Section II: Our Community



The Community We Serve

Introduction – Our Community

Adventist HealthCare Rehabilitation Hospital primarily services residents of Montgomery and Prince George’s Counties in Maryland.

Approximately 85.0 percent of discharges come from our Total Service Area, which is considered Adventist HealthCare Rehabilitation Hospital’s Community Benefit Service Area (CBSA). Within that area, 60.0 percent of discharges account for the Primary Service Area and include the following zip codes/cities:

20906 – Silver Spring, 20878 – Gaithersburg, 20850 – Rockville, 20854 – Potomac, 20874 – Germantown, 20904 – Silver Spring, 20902 – Silver Spring, 20877 – Gaithersburg, 20852 – Rockville, 20817 – Bethesda, 20901 – Silver Spring, 20853 – Rockville, 20783 – Hyattsville, 20886 – Montgomery Village, 20910 – Silver Spring, 20912 – Takoma Park, 20782 – Hyattsville, 20855 – Derwood, 20832 – Olney, 20814 – Bethesda, 20879 – Gaithersburg, 20876 – Germantown, 20706 - Lanham.

The remaining 25.0 percent of discharges account for our Secondary Service Area (SSA) which includes the following zip codes/cities:

20903 – Silver Spring, 20705 – Beltsville, 20815 – Chevy Chase, 20871 – Clarksburg, 20872 – Damascus, 20895 – Kensington, 20851 – Rockville, 20740 – College Park, 20785 – Hyattsville, 20774 – Upper Marlboro, 20905 – Silver Spring, 21703 – Fredrick, 20882 – Gaithersburg, 20770 – Greenbelt, 20784 – Hyattsville, 20743 – Capitol Heights, 20837 – Poolesville, 21702 – Frederick, 21701 – Frederick, 20011 – Washington, 20707 – Laurel, 20841 – Boyds, 20781 – Hyattsville, 20747 – District Heights, 20721 – Bowie, 20748 – Temple Hills, 20737 – Riverdale, 20866 – Burtonsville, 21771 – Mount Airy, 20012 – Washington, 20019 – Washington, 20744 – Fort Washington, 20712 – Mount Rainier, 20816 – Bethesda, 20833 – Brookeville, 20772 – Upper Marlboro, 20723 – Laurel, 20708 – Laurel, 20020 – Washington, 20746 – Suitland.

The map below depicts our primary and secondary service areas for Adventist HealthCare Rehabilitation Hospital based on total discharges for years 2016 – 2018 (Figure 1).

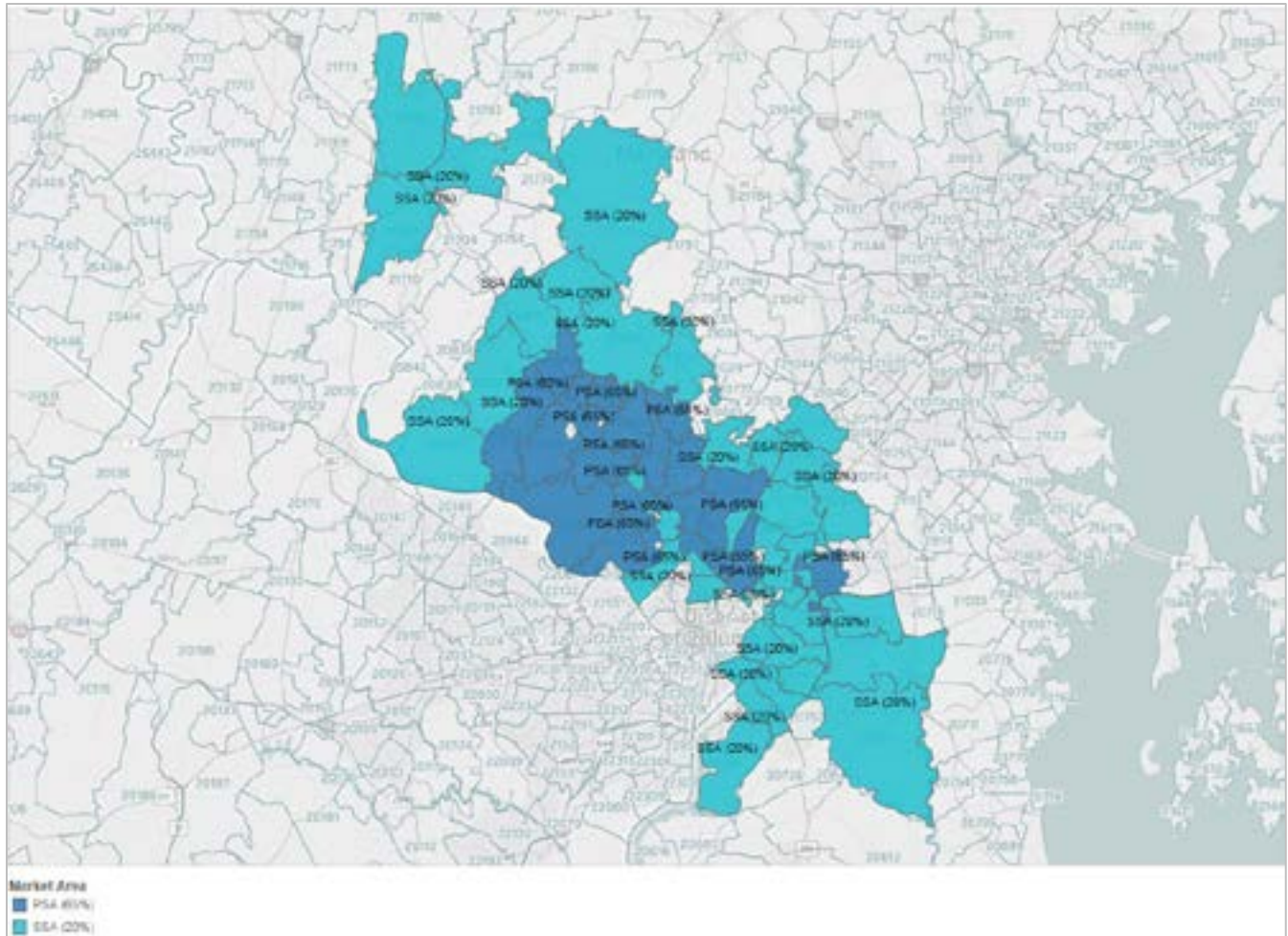


Figure 1. Map of Adventist HealthCare Rehabilitation Hospital’s Primary and Secondary Service Areas

Adventist HealthCare Rehabilitation Hospital’s CBSA, includes roughly 2,111,122 individuals (Figure 2). Of those individuals the majority are Black and White, each accounting for 38.9 percent of the population. Approximately a 17.7 percent of CBSA residents identify as Hispanic or Latino.

Adventist HealthCare Rehabilitation Community Benefit Service Area Demographics 2013 - 2017

Demographics	CBSA	
<i>Total Population*</i>	2,111,122	
	Number (N)	Percent (%)
<i>Total Population by Gender*</i>		
Male	1,015,033	48.1%
Female	1,096,089	51.9%
<i>Total Population by Race*</i>		
Asian	197,076	9.3%
Black	822,650	38.9%
Native American or Alaskan Native	6,829	0.32%
Native Hawaiian/Pacific Islander	906	0.04%
White	821,406	38.9%
Some Other Race	191,336	9.1%
Multiple Races	70,919	3.4%
<i>Total Population by Ethnicity*</i>		
Hispanic/Latino	373,235	17.7%
Male	193,749	51.9%
Female	179,486	48.1%
Not Hispanic or Latino	1,737,887	82.3%
<i>Hispanic Population by Race*</i>		
Asian	1,343	0.49%
Black	14,635	1.5%
Native American/Alaskan Native	3,044	44.5%
Native Hawaiian/Pacific Islander	38	15.5%
White	154,810	17.5%
Some Other Race	182,725	68.6%
Multiple Races	16,640	22.5%
<i>Non-Hispanic Population by Race*</i>		
Asian	195,733	11.3%
Black	808,015	46.5%
Native American or Alaskan Native	3,785	0.22%
Native Hawaiian/Pacific Islander	868	0.05%
White	666,596	38.4%
Some Other Race	8,611	0.5%
Multiple Races	54,279	3.1%
<i>Total Population by Age*</i>		
0 – 4	141,970	6.7%
5 – 17	349,983	16.6%
18 – 24	184,343	8.7%
25 – 34	305,093	14.5%
35 – 44	288,970	13.7%
45 – 54	300,470	14.2%
55 – 64	266,674	12.6%
65+	273,619	13.0%

<i>Educational Attainment**</i>		
Bachelor's Degree	646,853	45.08%
No schooling completed	164,727	11.48%
Notes:		
*Trinity Health Data Hub – Vital Statistics Report – Rehab CBSA		
**Buxton Data Software		

Figure 2. Adventist HealthCare Rehabilitation Hospital Community Benefit Service Area Demographics
 (Source: Trinity Health Data Hub & Buxton Analytics Software, 2019)

Health Inequity

People of color, low-income individuals, and other disadvantaged populations disproportionately experience poor health outcomes.¹ The Centers for Disease Control and Prevention (CDC) reports that communities with predominantly minority groups continue to have lower socioeconomic status; these groups face greater barriers to health-care access, greater risks for disease, and greater burden of disease as compared to other populations.² For example, the infant mortality rate among African Americans is more than double that of Whites^{3,4} and African American women regardless of their education and income level are three to four times more likely to die from preventable pregnancy-related complications than non-Hispanic White women.⁵ Furthermore, there is evidence that racial/ethnic minority groups are less likely to receive needed medical procedures, more likely to receive less useful medical procedures, and experience an overall reduced quality of health care services.⁶

Due to the persistent health disparities that exist in the U.S., health care experts have called for efforts to address the root causes of health disparities, by addressing both the biological and social determinants of health as well as healthcare spending. Research shows that health disparities lead to unnecessary healthcare spending and that addressing the root causes of health disparities will help to reduce the cost of health care in this country. A national study found that eliminating health disparities for racial/ethnic minority groups would reduce medical care expenditures by about \$230 million and indirect costs associated with illness and premature death by more than \$1 trillion.⁷ For health systems, reducing health disparities is not just the right thing to do; it can yield positive financial gains associated with improving quality of care and reducing health care costs for people who use health care services.

¹ Edgoose, J., Davis, S., Atwell, K., Balajee, S. S., Bazemore, A., Bierman, A. S., and et.al. (2018). A guidebook to health equity curricular toolkit. Retrieved from https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/health-equity-toolkit/hops19-he-guidebook.pdf

² CDC. (2019). Surveillance of health status in minority communities--Racial and ethnic approaches to community health across the U.S. (REACH U.S.). Risk Factor Surveillance Survey, United States, 2009. Retrieved from <https://www.cdc.gov/nccdphp/dnpao/division-information/data-stats/index.htm>

³ Centers for Disease Control and Prevention. (2019). Infant mortality. Retrieved from <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm>

⁴ Penman-Aguilar, A., Bouye, K., Liburd, L., Office of Minority Health and Health Equity, and Office of the Director, CDC. (2016). Background and rationale. Retrieved from https://www.cdc.gov/mmwr/volumes/65/su/su6501a2.htm?s_cid=su6501a2_w

⁵ Centers for Disease Control and Prevention. (2019). Pregnancy mortality surveillance system. Retrieved from <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm>

⁶ Institute of Medicine. (2003). Unequal treatment: Confronting racial and ethnic disparities in health care. National Academies Press.

⁷ LaVeist, T. A., Gaskin, D., & Richard, P. (2011). Estimating the economic burden of racial health inequalities in the United States. *International Journal of Health Services*, 41, 231-238.

According to Robert Wood Johnson Foundation, health equity means that everyone has a fair and just opportunity to be as healthy as possible. Specifically: "This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." This requires valuing everyone equally and working intentionally to combat the effects of bias and discrimination to eliminate health disparities. To the 2020-2022 CHNA survey question asking respondents the main reason why they thought they may have been treated unfairly when getting medical care, many noted bias among healthcare providers, and they expressed the desire for culturally sensitive health care.

Health inequities are differences in health outcomes that are systematic, avoidable, and unjust. In order to address health inequities, hospitals, physicians and other providers, and community partners must work collaboratively to identify and monitor community needs and barriers to accessing health care. The Institute for Healthcare Improvement (2016) suggests that organizations combine efforts to improve health equity with a plan to address multiple factors that affect health outcomes. In particular, they should find effective ways to care for the health of their communities in partnership with community organizations, and especially to eliminate barriers to accessing healthcare.

Demographics & Trends⁸

In Maryland, the population demographics are rapidly changing, particularly among residents living in Montgomery and Prince George's Counties (Figure 3). Adventist HealthCare serves two of the most diverse communities in the United States, constantly undergoing economic, social and demographic shifts that result from an ever-changing, ever-growing population (Figure 4).

Montgomery County is the most populous jurisdiction in Maryland and has retained its status as the second largest jurisdiction in the Washington, D.C. metropolitan area.⁹ From 1990 to 2017, Montgomery County's population grew 38 percent, increasing from 765,476 to 1,058,810 people.² The greatest population growth occurred inside the Capital Beltway (Interstate 495), which also includes Prince George's County. According to the Maryland-National Capital Park and Planning Commission (MNCPPC), the growth in Montgomery County was driven largely by births to residents and increasing international migration. At 32.6 percent, Montgomery County has a foreign-born population twice that of the state of Maryland. Prince George's County is the second-largest jurisdiction in Maryland with nearly one million residents.¹⁰ The county has seen significant population growth increasing by nearly 50,000 residents or 5.7 percent from 2010 to 2017.¹¹

Both Montgomery & Prince George's Counties are majority-minority counties meaning they are made up of less than 50 percent non-Hispanic Whites (Figure 3). The majority of residents (62.0 percent) in Prince George's County are Black, followed by Hispanic or Latino (19.1 percent). The majority of residents (43.4 percent) in Montgomery County are non-Hispanic White, followed by Black and Hispanic (19.9 percent each), and Asian (15.6 percent). The racial and ethnic diversity in the county has continued to increase with the increase in the overall population (Figures 5 and 6).

Regarding life expectancy, Montgomery County at 84.3 years is higher than that of Maryland (79.2 years) and Prince George's County (79.6 years) (Figure 7). In both counties, the life expectancy is slightly higher for Whites compared to Blacks.

⁸ U.S. Census Bureau. (2018). QuickFacts. Retrieved from <https://www.census.gov/quickfacts/fact/table/MD,montgomerycountymaryland/PST045218>

⁹The Maryland-National Capital Park and Planning Commission. (2019). Montgomery County Trends: A look at people, housing, and jobs since 1990. Retrieved from https://montgomeryplanning.org/wp-content/uploads/2019/01/MP_TrendsReport_final.pdf

¹⁰ U.S. Census Bureau. (2015). Maryland at a glance: Population. Retrieved from <http://msa.maryland.gov/msa/mdmanual/01glance/html/pop.html#county>

¹¹ Prince George's County, Maryland Health Department, Office of Assessment and Planning (2019). 2019 Prince George's County Community Health Assessment. Retrieved from https://www.fortwashingtonmc.org/wp-content/uploads/2019/06/FINAL_-2019-Prince-Georges-CHNA.pdf

2018 Population Estimates by County			
	Maryland	Montgomery County	Prince George's County
Total Population	6,042,718	1,052,567	909,308
Population by Race and Ethnicity, %			
Asian	6.7%	15.6%	4.5%
Black/AA	30.9%	19.9%	64.4%
Hispanic/Latino	10.4%	19.9%	19.1%
Native HI/PI	0.1%	0.1%	0.2%
White	58.8%	60.2%	27.0%
White alone, Not Hispanic or Latino	50.5%	43.4%	12.5%
Population by Age, %			
Under 5 Years	6.0%	6.3%	6.5%
Under 18 Years	22.2%	23.2%	22.2%
65 Years and Older	15.4%	15.5%	13.3%
Median Household Income	\$78,916	\$103,178	\$78,607
Population Characteristic			
Veterans, 2013 - 2017	380,555	43,481	57,387
Foreign-born persons, % 2013 – 2017	14.9%	32.6%	21.9%
Persons in Poverty, %	9.0%	6.9%	8.3%
Population by Educational Attainment, %			
Population 25+ with High School Diploma, %	89.8%	91.1%	86.1%
Population 25+ with bachelor's degree or Above, %	39.0%	58.3%	31.9%

Figure 3. 2018 Population Estimates by Race and Ethnicity in Maryland, Montgomery, and Prince George's Counties
(Sources: [U.S Census Bureau QuickFacts](#), 2018 & [American Community Survey](#), 2017)

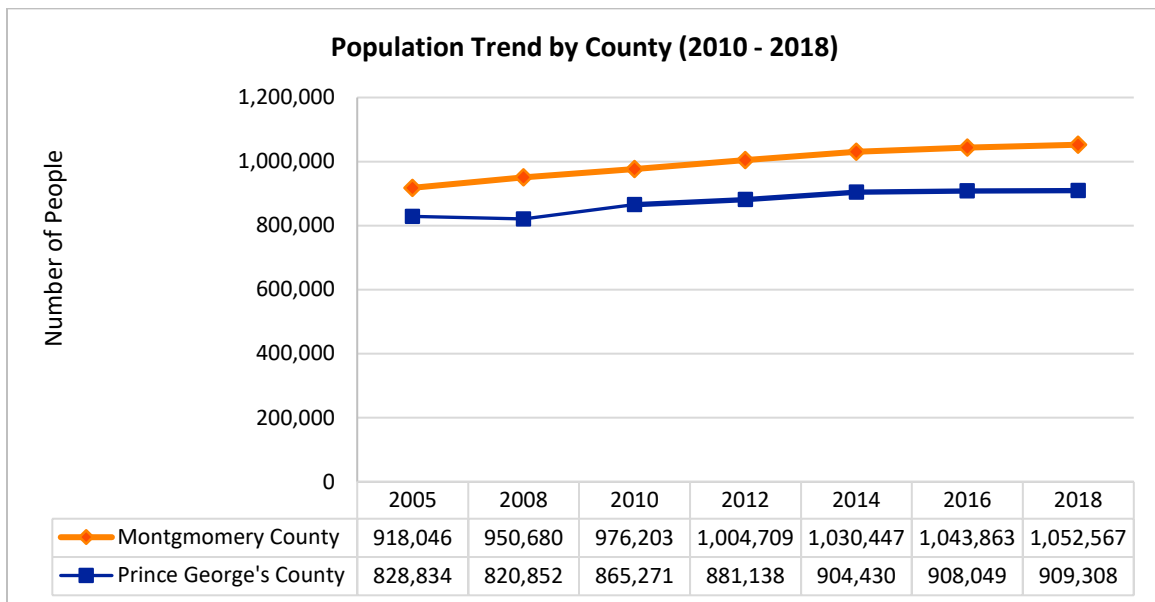


Figure 4. Population Trend by County 2010 – 2018

(Source: [American Community Survey – Population Total 1 – year Estimates, Tables B01003 and DP05](#), 2018)

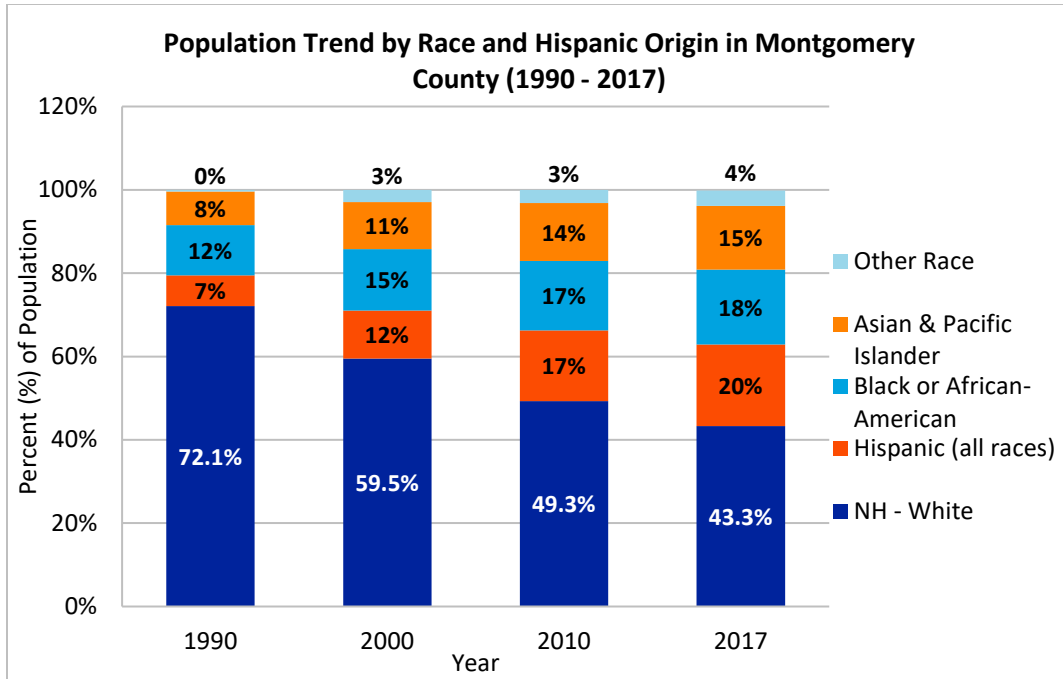


Figure 5. Population Trend by Race and Ethnicity in Montgomery County, 1990 – 2017
 (Source: [U.S. Census Bureau American Community Survey 1-year estimates, Table B03002](#) & [MNCPPC Report](#), 2019)

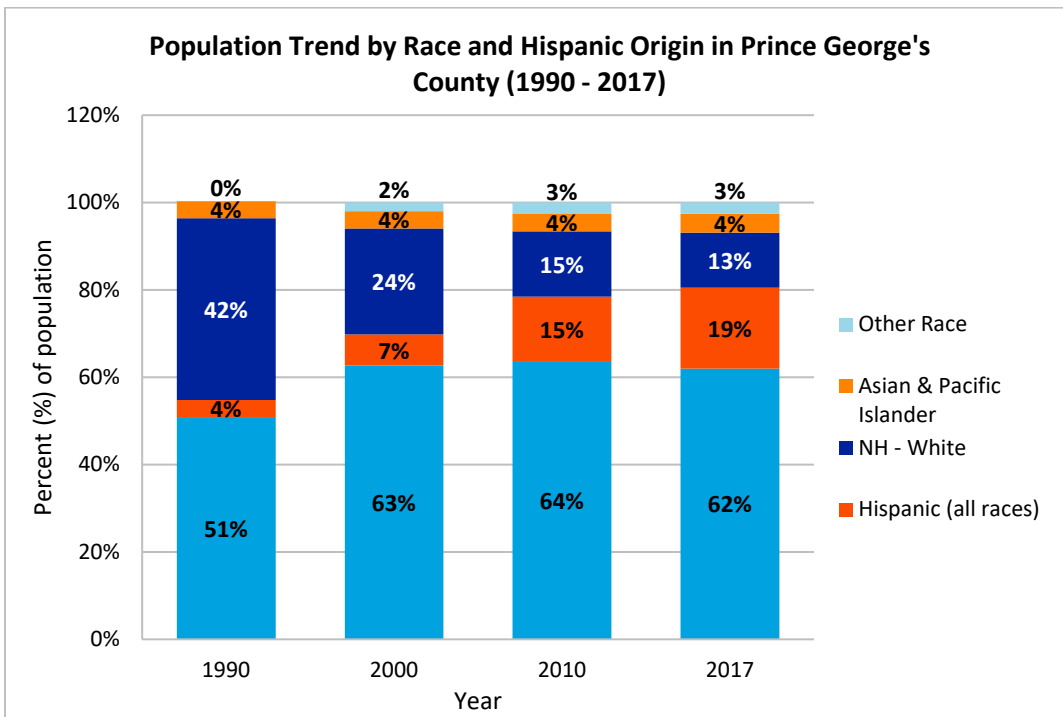


Figure 6. Population Trend by Race and Ethnicity in Prince George's County, 1990 – 2017
 (Source: [U.S. Census Summary Table DP-1, 2010](#); [American Community Survey 1-year estimates, Table B03002, 2010 - 2017](#) & [MD State Data Center Historical Census](#), 1990)

Life Expectancy by County			
	Maryland	Montgomery County	Prince George's County
Life Expectancy			
Overall	79.2	84.3	79.6
Race			
White	79.7	83.6	79.4
Black	76.9	82.0	78.4

Figure 7. Life Expectancy in Montgomery County and Prince George's County, Maryland
(Source: County Health Rankings & Roadmaps, 2015-2017)

Aging Population: Change Over Time, 1990 – 2016¹²

According to the Maryland-National Capital Park and Planning Commission (MNCPPC), there has been a noticeable population age shift in Montgomery County from 1990 to 2016, largely in part to the aging baby boomer generation born between 1946 and 1964 (Figure 8). From 1990-2016 the median age of residents in the county rose from 33.9 years to 39 years. Meanwhile, the percentage of young adults, 20 to 34 years, decreased by 7.7 percent and adults age 35 to 44 years decreased by 3.9 percent. Children under age 18 decreased marginally and are projected to remain steady.

According to data from the U.S. Census American Community Survey, there has also been a significant population age shift in Prince George's County from 1990 to 2016 (Figure 9). Similar to Montgomery County, the largest age group in 1990 was 20-34 years, compared to 45-64 years in 2016. The 35-44 age group has decreased 4.0 percent and children under age 18 decreased marginally and are projected to remain steady.

The fastest growing population, 65+, is projected to grow 7.0 percent in Montgomery and 9.0 percent in Prince Georges, reaching 21.0 percent of the population in both counties by the year 2040.

The aging of the population will have a significant impact on the health and wellbeing of the community. There will be a larger demand for services such as healthcare and a smaller workforce to meet the demand.

¹² Maryland-National Capital Park and Planning Commission (MNCPPC). (2019). Montgomery County Trends: A look at people, housing, and jobs since 1990. Retrieved from https://montgomeryplanning.org/wp-content/uploads/2019/01/MP_TrendsReport_final.pdf

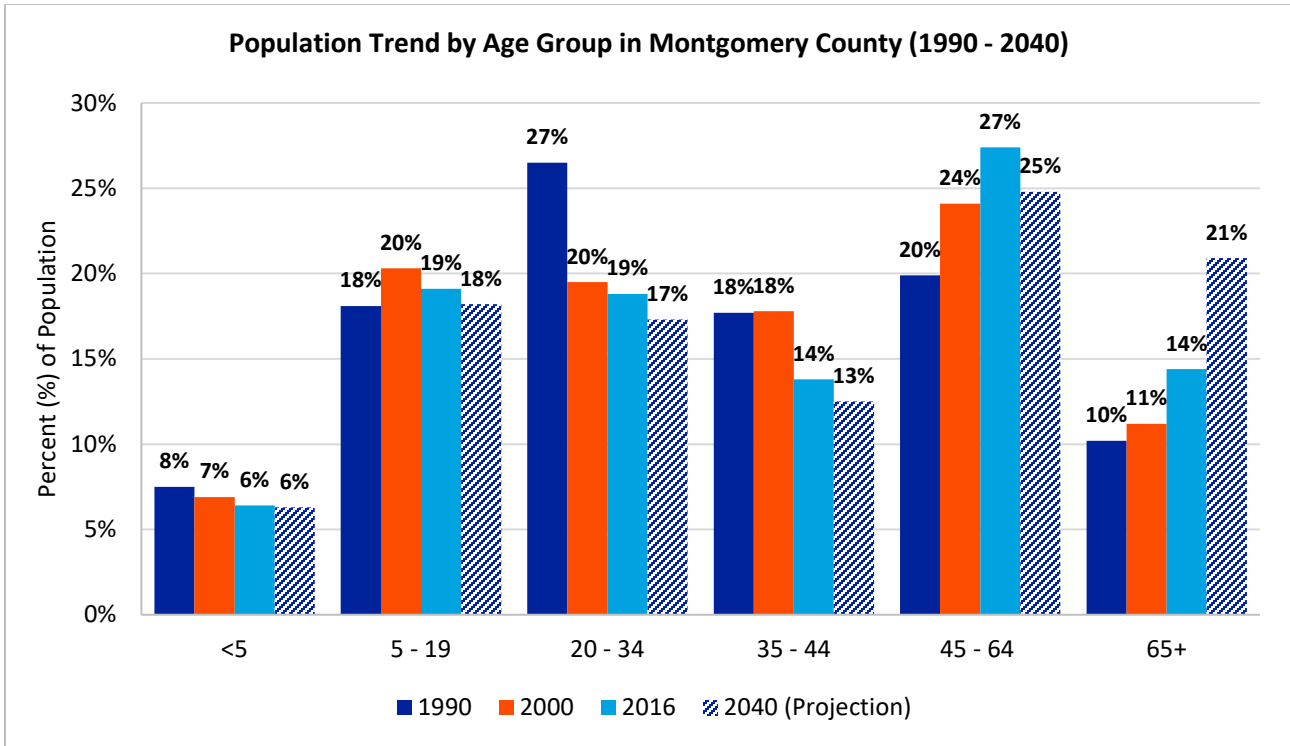


Figure 8. Percent of Population by Age Group in Montgomery County
 (Source: [U.S. Census American Community Survey 1-Year Estimates Table S0101](#), 2019)

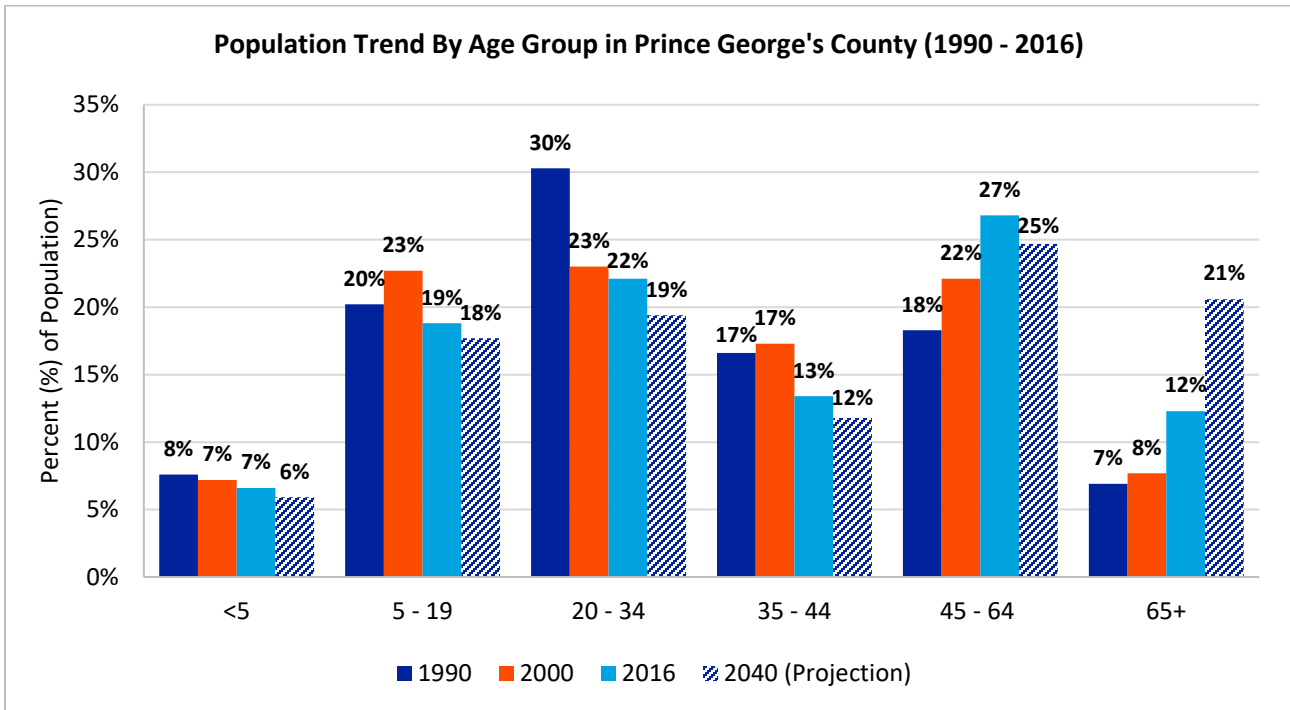


Figure 9. Percent of Population by Age Group in Prince George's County
 (Source: [U.S. Census American Community Survey 1-Year Estimates Table S0101](#), 2019)

Foreign-born Population¹³

According to the U.S. Census Bureau, Maryland is one of the top ten destinations for foreign-born individuals with a significant amount residing in Montgomery County.¹⁴ A foreign-born individual is anyone who was not a U.S. citizen or a U.S. national at birth. From 1980 to 2016, the population of foreign-born individuals living in Montgomery County increased from 12.0 percent to 33.0 percent. The majority of foreign-born residents who live in Montgomery County come from both Asia and Latin America, with the top five countries consisting of El Salvador, China, India, Korea, and Ethiopia (Figure 10). Of those individuals who are foreign-born and living in Montgomery County, 15.4 percent primarily speak English, 30.8 percent speak Spanish, 22.4 percent speak an Asian or Pacific Islander language and 21.4 percent speak an Indo-European language (Figure 11).

In Prince George's County, one out of every five residents or 22.6 percent are born outside the United States.^{15,16} In 2017 alone, there were over 200,000 foreign-born residents in the county. The top five countries that contribute the most to the foreign-born population include: El Salvador, Nigeria, Guatemala, Mexico, and Jamaica (Figure 12). Of the foreign-born residents living in Prince George's County, one in five or 21.5 percent speak English as their primary language and 44 percent speak Spanish (Figure 13).

In Adventist HealthCare Rehabilitation's CBSA, 12.4 percent of individuals aged 5+ are limited English proficient (Figure 14). The rate of limited English proficiency in Adventist Rehabilitation's CBSA is lower than that of Montgomery County, slightly higher than Prince George's County, and almost 2X that of Maryland.

Due to the diversity in language spoken and English proficiency levels in the community, it is crucial to provide interpreter and translation services to overcome language barriers for those accessing the healthcare, social service and education systems, among others.

¹³ Maryland-National Capital Park and Planning Commission (MNCPPC). (2019). Montgomery County Trends: A look at people, housing, and jobs since 1990. Retrieved from https://montgomeryplanning.org/wp-content/uploads/2019/01/MP_TrendsReport_final.pdf

¹⁸ U.S. Census Bureau. (2017). QuickFacts. Retrieved from <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

¹⁵ Prince George's County Health Department – Office of Assessment and Planning. (2019). Community Health Assessment. Retrieved from https://www.fortwashingtonmc.org/wp-content/uploads/2019/06/FINAL_-2019-Prince-Georges-CHNA.pdf

¹⁶ U.S. Census Bureau, 2017 American Community Survey 1-year estimates, Table S0501

Top 10 Countries of Birth among Foreign-born Residents in Montgomery County, Maryland		
Country of Origin	Population (N)	Percent (%) Foreign-Born
El Salvador	47,792	13.9%
China	28,243	8.2%
India	24,306	7.1%
Korea	15,185	4.4%
Ethiopia	15,139	4.4%
Vietnam	12,384	3.6%
Honduras	11,234	3.3%
Peru	10,229	3.0%
Iran	7,947	2.3%
Guatemala	7,564	2.2%

Figure 10. Top 10 Countries of Birth among Foreign-born Residents in Montgomery County, Maryland 2016
 (Source: [Maryland National Capital Park and Planning Commission – Montgomery County Trends Report](#), 2019)

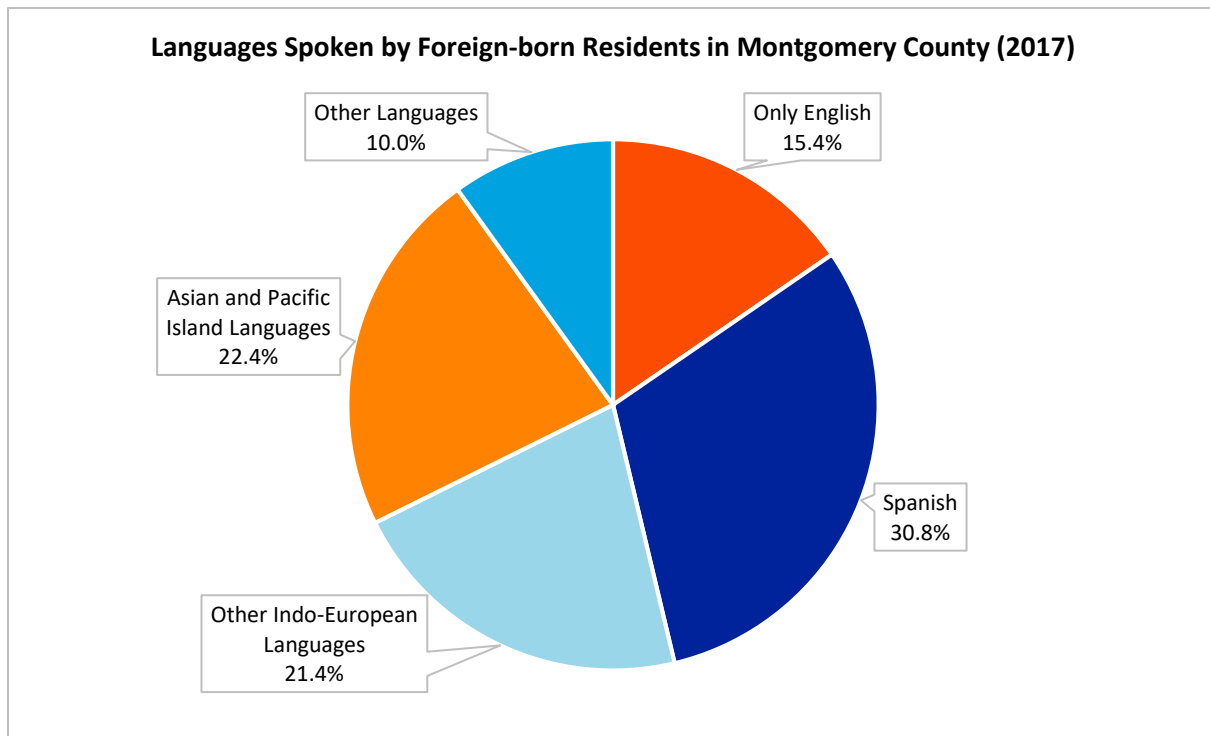


Figure 11. Languages Spoken by Foreign-born Residents in Montgomery County, 2017
 (Source: [U.S Census Bureau American Community Survey 1-year estimates, Table B06007 & C16005](#), 2017)

Top 10 Countries of Birth among Foreign-born Residents in Prince George's County, Maryland	
Country of Origin	Percent (%) Foreign-Born
El Salvador	22.0%
Nigeria	7.8%
Guatemala	7.3%
Mexico	6.1%
Jamaica	5.3%
Philippines	3.9%
Cameroon	3.5%
Honduras	3.4%
Sierra Leone	3.0%
India	2.5%

Figure 12. Top 10 Countries of Birth among Foreign-born Residents in Prince George's County, Maryland 2017
 (Source: [Prince George's County, MHD, Office of Assessment and Planning – Community Health Assessment, 2019](#) & [American Community Survey 5-Year Estimates, Table B05006, 2013 – 2017](#))

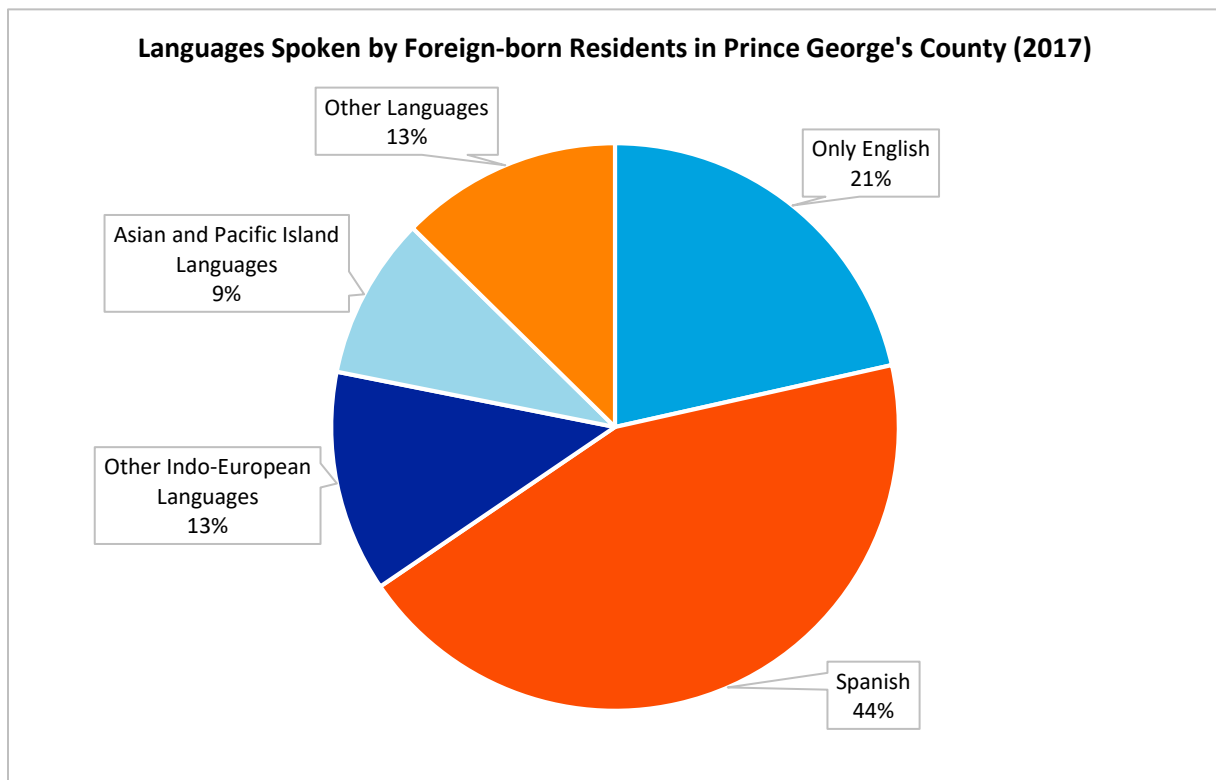


Figure 13. Languages Spoken by Foreign-born Residents in Prince George's County, 2017
 (Source: [U.S Census Bureau American Community Survey 1-year estimates, Table B06007 & C16005, 2017](#))

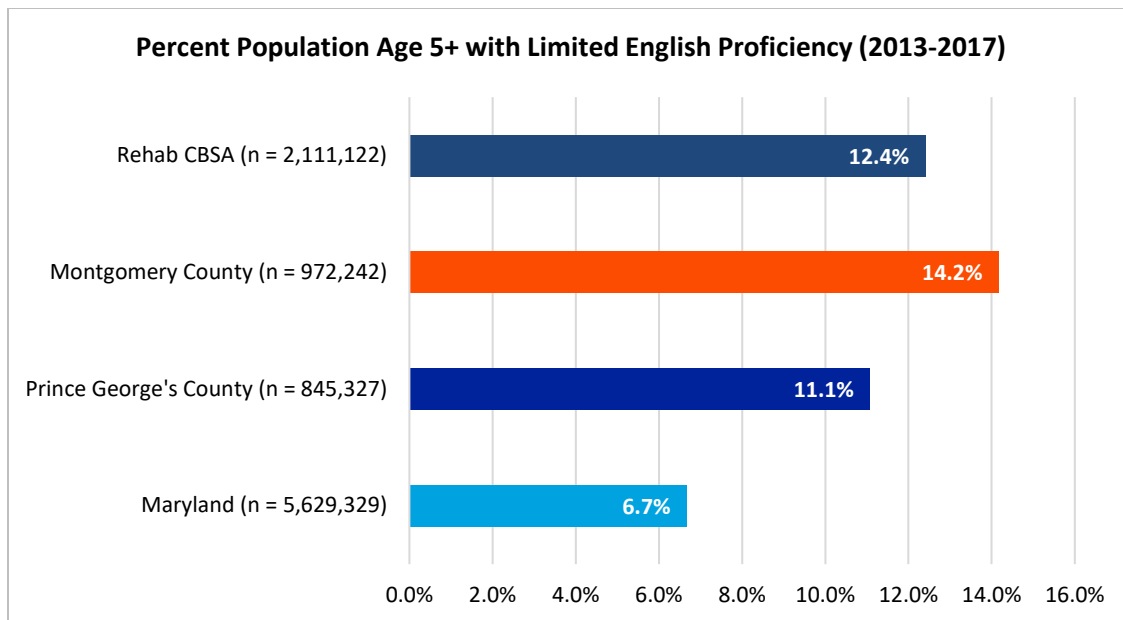


Figure 14. Percent of the Population Age 5+ with Limited English Proficiency, 2013 – 2017
 (Source: [U.S. Census Bureau American Community Survey 5-Year Estimates](#), 2013 – 2017)

As racial and ethnic minority populations become increasingly predominant, concerns regarding health disparities grow – persistent and well-documented data indicate that racial and ethnic minorities still fall behind nonminority populations in many health outcome measures. These groups are less likely to receive preventive care to stay healthy and are more likely to suffer from serious illnesses, such as cancer and heart disease.

Additionally, racial and ethnic minorities often have challenges accessing quality healthcare, either because they lack health insurance or the communities in which they live are underserved by health professionals. As the proportion of racial and ethnic minority residents continue to grow, it will become even more important for the healthcare system to understand the unique characteristics of these populations to meet the health needs of the overall community. As a result, this report examines health status and outcomes among different racial and ethnic populations in Montgomery and Prince George’s Counties, with the goal of eliminating disparities, achieving health equity, and improving the health of all groups.

Area Deprivation Index

The Area Deprivation Index (ADI) uses data from the American Community Survey 5-Year Estimates (ACS) to represent a geographic area-based measure of the socioeconomic deprivation experienced by a census block group/neighborhood. The index includes factors of income, education, employment, and housing quality. The ADI is typically used to inform health delivery and policy, primarily for the most disadvantaged neighborhood groups. The index has a measurement scale of 1 (blue = least disadvantaged block group) to 10 (red = most disadvantaged block group).

When looking at the state of Maryland overall (Figure 15), there are variations of both least and most disadvantaged neighborhoods/census block groups. The WOMC CBSA (Figure 16), is similar to Maryland with some of the most disadvantaged neighborhoods/block groups adjacent to neighborhoods that are least disadvantaged. Examples of neighborhoods that rank anywhere between 7 to 10 on the ADI include: Paint Branch, White Oak, Fairview Estates, Northwest Park, Adelphi, Langley Park, and Briggs Chaney to name a few.

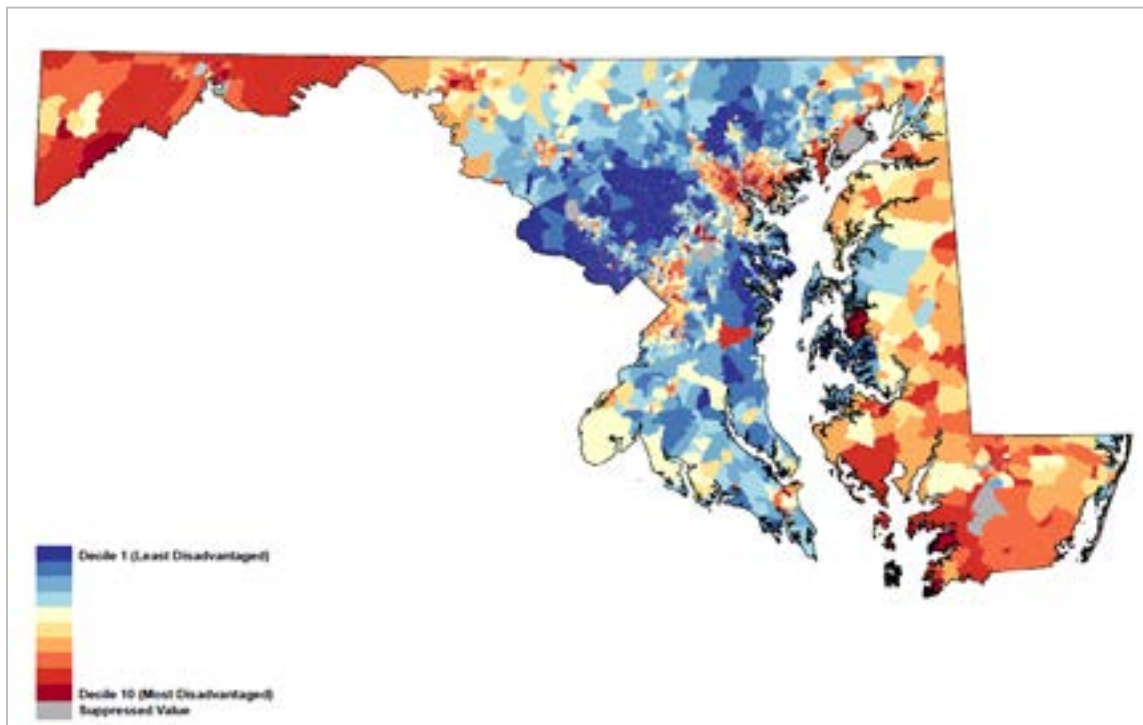


Figure 15. Maryland Area Deprivation Index (ADI) State Rankings, 2015

(Source: [University of Wisconsin School of Medicine and Public Health – Department of Medicine](#), 2015)

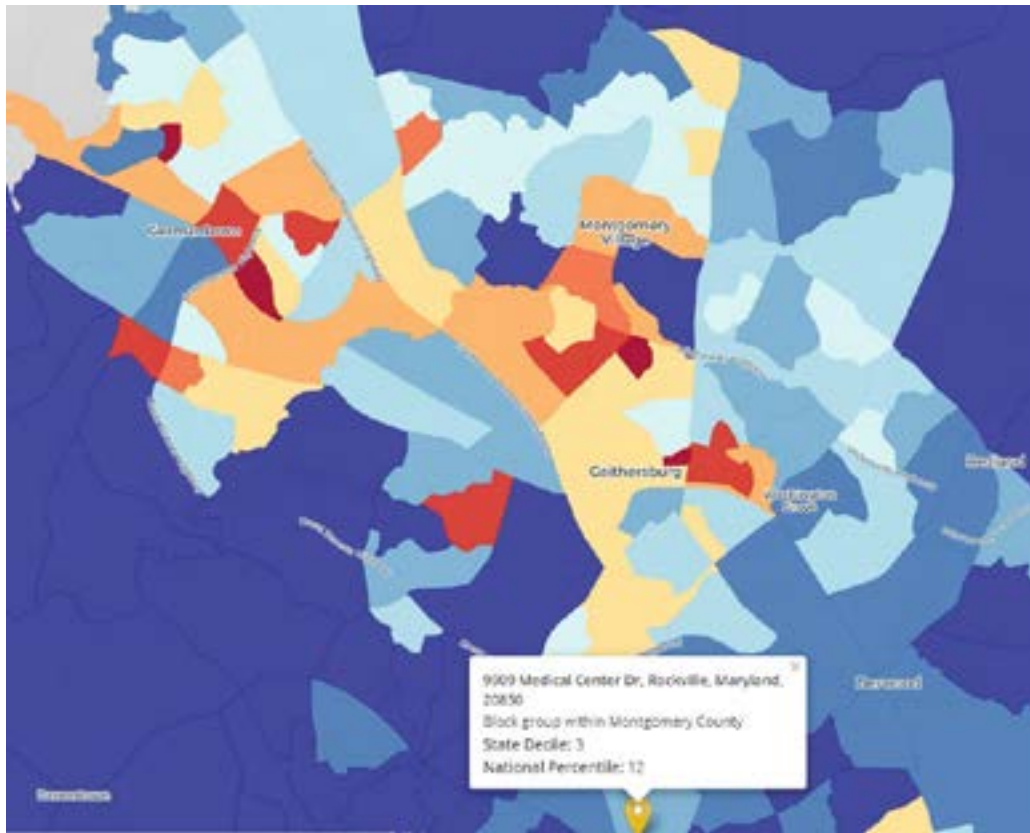


Figure 16. Area Deprivation Index – Map of Neighborhoods/Block Groups Near AHC Rehab
 (Source: [University of Wisconsin School of Medicine and Public Health – Department of Medicine](#), 2015)

County Health Rankings and Roadmaps (2019)¹⁷

The County Health Rankings Model (Figure 17) illustrates the wide range of factors that influence how long and well we live. Socioeconomic factors such as income, education, and employment can influence the way we make decisions about our health and access healthcare related services. Although some people have access to essential elements for healthy living, many people do not have the same opportunities and are significantly limited in access.

The County Health Rankings and Roadmaps (CHR&R) provide a snapshot of how health is influenced by more than just clinical care and the physical environment - health behaviors as well as social and economic factors have a much greater impact on health. The goal is to achieve the highest level of health for all and close the gap between those with the best and worst health outcomes. The CHR&R measures vital health factors which include high school graduation rates, obesity, smoking, unemployment, access to healthy foods, quality of air and water, income inequality, and teen births. The CHR&R also measures health outcomes which include both length and quality of life.

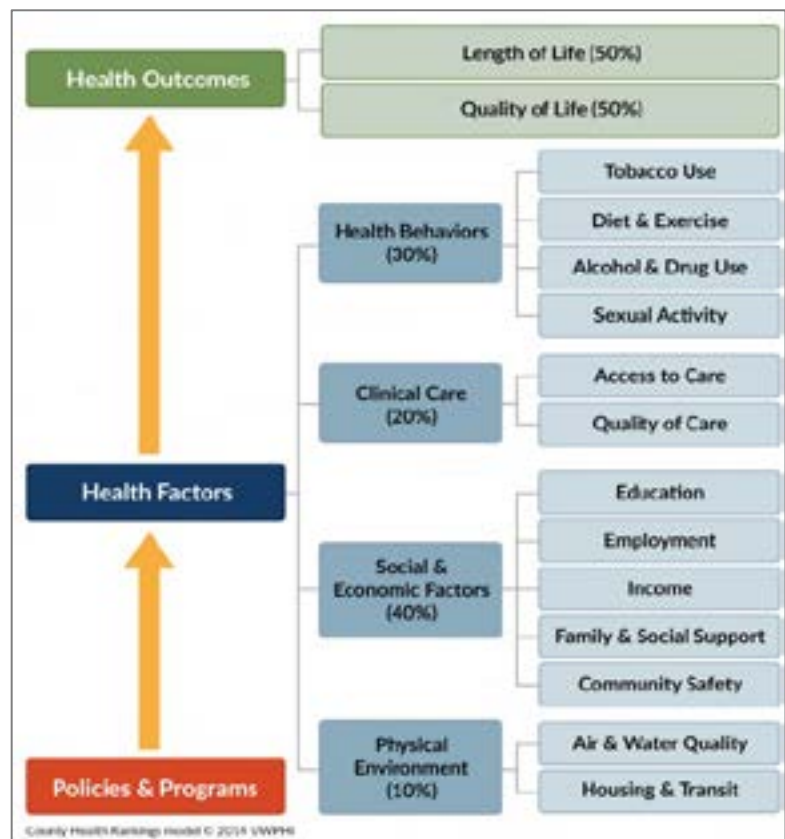


Figure 17. County Health Rankings Model

(Source: [County Health Rankings and Roadmaps – Building a Culture of Health County by County](#), 2019)

The Ranking scale listed below (Figure 18), provides a snapshot of how Montgomery and Prince George’s Counties compare to one another and the other 22 counties in Maryland. Based on the 2019 report, Montgomery County ranked number one for health outcomes overall and number two for health factors overall. In comparison, Prince George’s County was ranked 11th for health outcomes overall and 16th for health factors overall.

¹⁷ County Health Rankings & Roadmaps. (2019). About County Health Rankings and Roadmaps. Retrieved from <https://www.countyhealthrankings.org/about-us>

Maryland 2019 County Health Rankings			
Health Outcomes Overall		Health Factors Overall	
Rank	County	Rank	County
1	Montgomery	1	Howard
2	Howard	2	Montgomery
3	Fredrick	3	Carroll
4	Carroll	4	Fredrick
5	St. Mary's	5	Calvert
6	Calvert	6	Queen Anne's
7	Queen Anne's	7	Harford
8	Anne Arundel	8	Anne Arundel
9	Talbot	9	Talbot
10	Harford	10	Baltimore
11	Prince George's	11	St. Mary's
12	Charles	12	Charles
13	Baltimore	13	Garret
14	Kent	14	Kent
15	Garret	15	Washington
16	Worcester	16	Prince George's
17	Washington	17	Worcester
18	Cecil	18	Alleghany
19	Wicomico	19	Cecil
20	Alleghany	20	Wicomico
21	Caroline	21	Dorchester
22	Dorchester	22	Caroline
23	Somerset	23	Baltimore City
24	Baltimore City	24	Somerset

Figure 18. County Health Rankings in Maryland
 (Source: [County Health Rankings – Health Outcomes and Factors Overall](#), 2019)

Income and Poverty

The median household incomes in Montgomery and Prince George’s Counties are \$103,178 and \$78,607, respectively.¹⁸ Comparatively, the 2017 median household income in Maryland is \$78,916, which is higher than the U.S. median of \$57,652. When broken down by race and ethnicity, significant income disparities exist. In Montgomery County, the median income of White and Asian households is over \$30,000 higher than that of Black and Hispanic households (Figure 19). In Prince George’s County, Asian and White households have the largest Median household income, followed by Black households and Hispanic households who have the largest income inequality.

Household income has a direct influence on a family’s ability to pay for necessities, including health insurance and healthcare services.

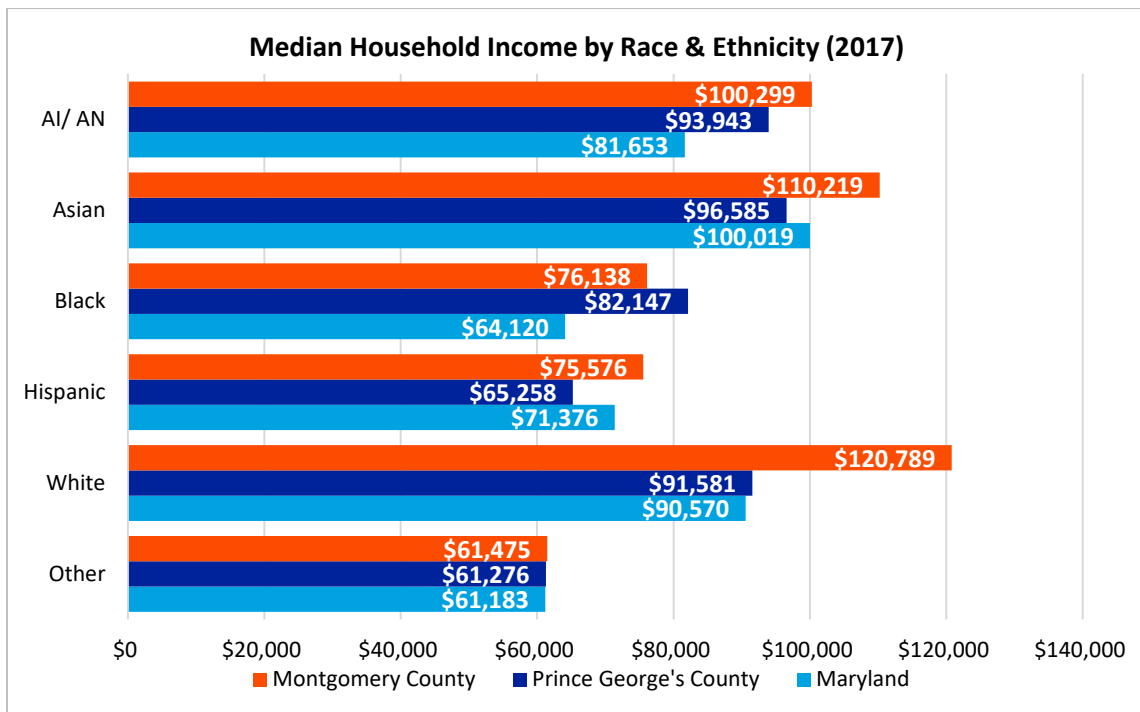


Figure 19. Median Household Income by Race and Ethnicity in Montgomery County, Prince George’s County, and Maryland, 2017

(Source: [United States Census Fact Finder](https://factfinder.census.gov), 2017)

Among the zip codes located in Rehab’s CBSA, the majority are below the county averages for median household income (indicated in red in Figure 20).

¹⁸ U.S. Census Bureau. (2017). Median household income in the past 12 months: 2017 American community survey 1-year estimates. Retrieved from <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>
http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_B19013&prodType=table

Adventist HealthCare Rehabilitation CBSA Median Household Income 2017		
Location	Zip Codes	Median Household Income
District of Columbia	20011	\$65,327
	20012	\$87,824
	20019	\$35,487
	20020	\$34,508
	<i>Overall</i>	\$77,649
Frederick County	21701	\$77,967
	21702	\$73,834
	21703	\$77,999
	21771	\$120,661
	<i>Overall</i>	\$88,502
Howard County	20723	\$109,230
	<i>Overall</i>	\$115,576
Montgomery County	20814	\$120,632
	20815	\$150,313
	20816	\$192,066
	20817	\$185,135
	20832	\$128,475
	20833	\$153,919
	20837	\$143,828
	20841	\$166,646
	20850	\$104,515
	20851	\$85,047
	20852	\$94,378
	20853	\$110,364
	20854	\$203,952
	20855	\$127,948
	20866	\$103,802
	20871	\$125,649
	20872	\$115,351
	20874	\$86,718
	20876	\$95,338
	20877	\$66,988
	20878	\$120,149
	20879	\$92,694
	20882	\$152,771
	20886	\$78,253
	20895	\$136,433
20901	\$103,830	
20902	\$87,244	
20903	\$63,106	

	20904	\$81,277
	20905	\$117,296
	20906	\$70,929
	20910	\$81,429
	20912	\$73,901
	<i>Overall</i>	\$103,178
Prince George's County	20705	\$82,351
	20706	\$74,700
	20707	\$78,183
	20708	\$68,673
	20712	\$51,592
	20721	\$123,923
	20737	\$61,286
	20740	\$63,369
	20743	\$60,942
	20744	\$96,598
	20746	\$64,762
	20747	\$60,583
	20748	\$66,421
	20770	\$69,601
	20772	\$104,743
	20774	\$95,560
	20781	\$74,241
	20782	\$65,622
	20783	\$63,366
	20784	\$64,969
20785	\$67,056	
<i>Overall</i>	\$78,607	
Maryland	<i>Overall</i>	\$78,916

Note: Green indicates the location's income is equal to or above the county value. Red indicates the location's income is below the county value (i.e. a potentially vulnerable population.)

Figure 20. Median Household Income by Zip Code, 2017
 (Source: [Median Household Income in the Past 12 Months 2017 ACS 5-Year Estimates](#))

The 2017 Federal Poverty Level for a family of four is \$24,600.¹⁹ Montgomery County experienced a decrease in residents living below the federal poverty level from 7.5 percent in 2015 to 7.0 percent in 2017. In 2017, across all counties in Maryland, less residents were living below the poverty level (9.7 percent) than in 2015 (10.0 percent). Despite the slight decrease in poverty rates, a large income inequality gap persists. In Maryland, White individuals have the lowest percentage of residents living in poverty when compared to non-White individuals. In Prince George’s County White residents have a higher percentage of individuals living in poverty compared to Black and Asian residents who experience the lowest rates of poverty (Figure 21). In Montgomery County Black and Hispanic residents experience poverty at a rate nearly three times that of White residents (Figure 21).

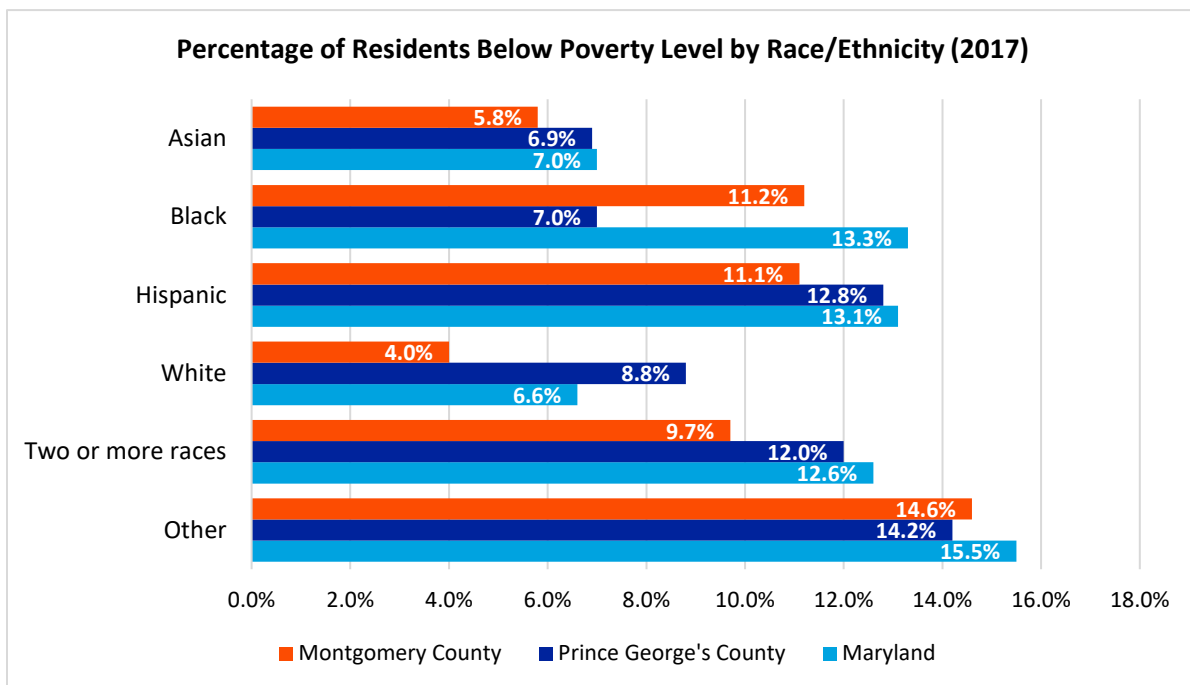


Figure 21. Percentage of Residents in Poverty by Race/Ethnicity in Montgomery and Prince George’s Counties and Maryland, 2017

(Source: [U.S. Census Bureau – 2017 American Community Survey 1-Year Estimates, Table S1701](https://www.census.gov/data/tables/2017/acs/tables.html), 2017)

¹⁹ Office of the Assistant Secretary for Planning and Evaluation. (2017). 2017 Poverty Guidelines. Retrieved from <https://aspe.hhs.gov/2017-poverty-guidelines>

Access to Care & Health Insurance Coverage

AHRQ’s 2015 National Healthcare Disparities Report defines access to healthcare as the efficient and timely use of personal health services to obtain the best health outcomes. The report states that people of color—as well as people with low incomes—are more likely to be uninsured or have coverage through public programs. Overall, people of color tend to have more limited access to healthcare services—and the care they do receive is often of poor quality—which results in a multitude of healthcare complications.²⁰

According to the Kaiser Family Foundation, approximately 7.0 percent of all Maryland residents under the age of 65 are uninsured. In 2017, 38 percent of Hispanics in Maryland were uninsured, which is higher than any other racial/ethnic group. Black individuals are most likely to be covered by Medicaid and White individuals are most likely to have health insurance coverage through an employer-based plan than any other racial or ethnic group (Figure 22). In AHC Rehab’s CBSA, 20.5 percent of the population is receiving Medicaid which is higher than Montgomery and Prince George’s counties as well as Maryland.²¹

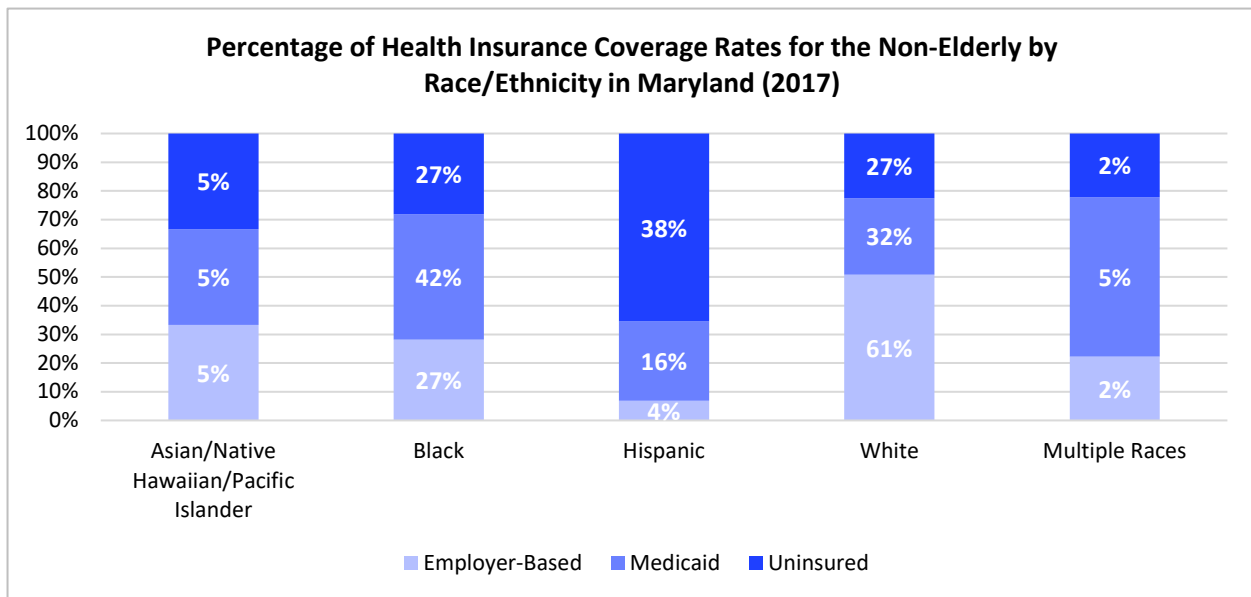


Figure 22. Health Insurance Coverage Rates of 0- to 64-Year Old’s by Race and Ethnicity in Maryland, 2017. (Source: [Kaiser Family Foundation](#), 2017)

*Note: Estimates are based on U.S. Census Bureau American Community Survey 2008 - 2017

²⁰ Agency for Healthcare Research and Quality. (2016). 2015 National healthcare quality and disparities report and 5th anniversary update on the national quality strategy. *AHRQ Pub, 16-0015*. Retrieved from <http://www.ahrq.gov/research/findings/nhqrdr/nhqrdr15/index.html>

²¹ Trinity Health Data Hub. (2019). Vital Signs Report – Rehab CBSA. Retrieved from <https://trinityhealthdatahub.org/vital-signs-report/>

Despite Montgomery County’s relative wealth regarding income, education and support for public services, between 80,000 and 90,000 residents are uninsured.²² More than 100,000 residents in Prince George’s County are uninsured.²³

In Montgomery and Prince George’s Counties as well as in Maryland overall, Hispanics are significantly more likely to not have health insurance coverage compared to White and Black individuals (Figure 23).

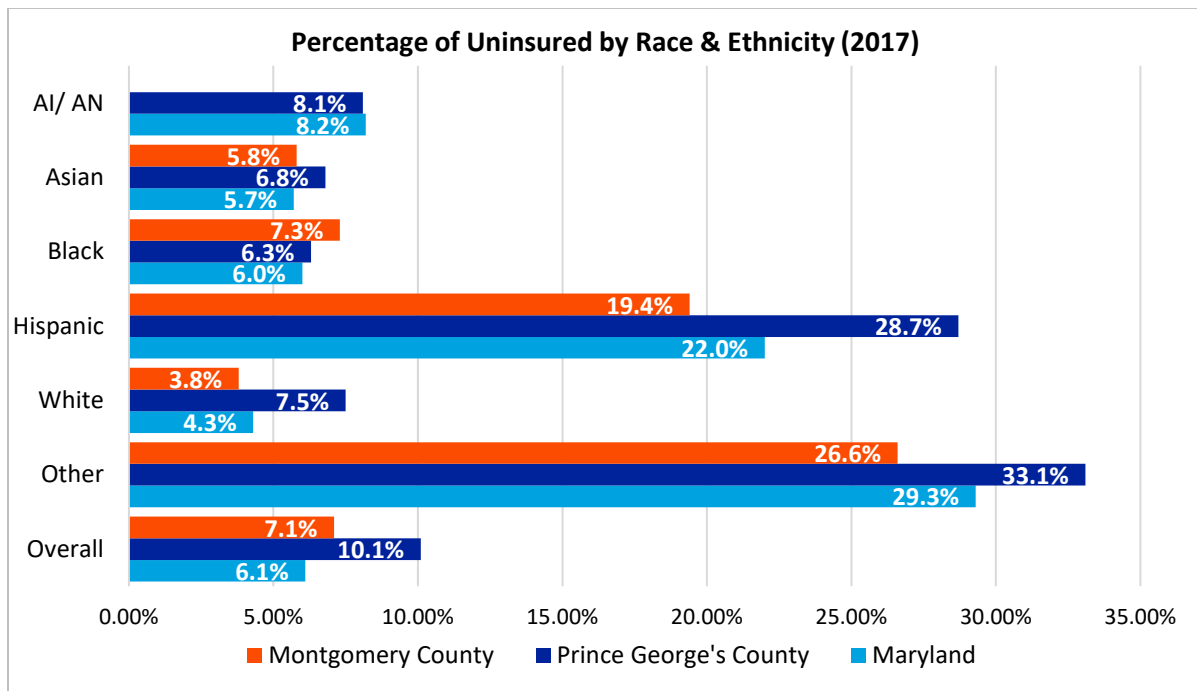


Figure 23. Percentage of Health Insurance Coverage by Race/Ethnicity in Montgomery and Prince George’s Counties, 2017

(Source: [U.S. Census Bureau-American Community Survey](https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF), 2017 1-year estimates)

In Montgomery and Prince George’s Counties, men are more likely to be uninsured than women (Figure 24). In Prince George’s County the gap is more pronounced with women being 30 percent more likely to be insured than men.

²² U.S. Census Bureau. (2017). Selected characteristics of health insurance coverage in Montgomery County: 2017 American community survey 1-year estimates. Retrieved from <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

²³ U.S. Census Bureau. (2017). Selected characteristics of health insurance coverage in Prince George’s county: 2017 American community survey 1-year estimates. Retrieved from <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

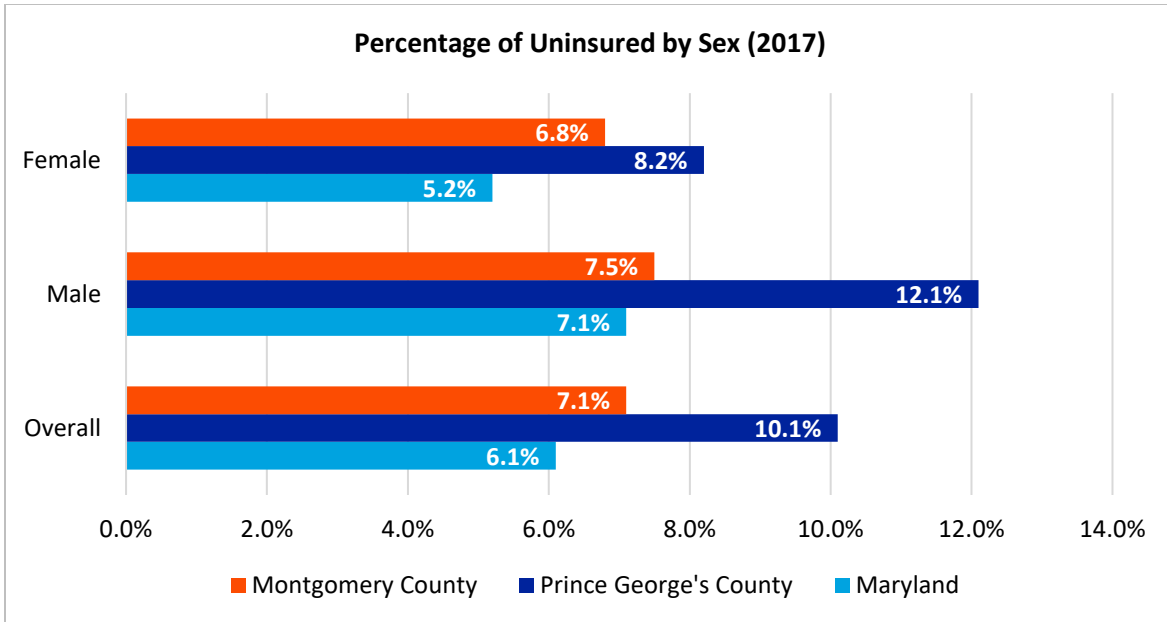


Figure 24. Percentage of Health Insurance Coverage by Sex in Montgomery, Prince George’s Counties, and Maryland, 2017

(Source: [U.S. Census Bureau-American Community Survey](https://www.census.gov/data/tables/2017/acs/5yrr/health.html), 2017 1-year estimates)

Within AHC Rehab’s CBSA, 10 percent of residents are uninsured.²⁴ The majority of zip codes located within Rehab’s CBSA are below the county averages for percent uninsured (indicated in red in Figure 25).

²⁴ Trinity Health System (2019). County vitals sign report - Montgomery County and Prince George’s County, Maryland. Retrieved from <https://cares.page.link/HoXh>

U.S. Census Bureau. (2017). Selected characteristics of health insurance coverage in Montgomery County: 2017 American community survey 1-year estimates. Retrieved from https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

Adventist HealthCare Rehabilitation CBSA Percent Uninsured 2017

Location	Zip Codes	Percent Uninsured
District of Columbia	20011	8.70%
	20012	5.40%
	20019	4.40%
	20020	4.50%
	<i>Overall</i>	4.70%
Frederick County	21701	5.60%
	21702	7.20%
	21703	7.80%
	21771	3.60%
	<i>Overall</i>	5.30%
Howard County	20723	8.60%
	<i>Overall</i>	4.80%
Montgomery County	20814	2.20%
	20815	3.70%
	20816	1.10%
	20817	2.10%
	20832	2.10%
	20833	4.30%
	20837	3.10%
	20841	3.20%
	20850	5.70%
	20851	21.70%
	20852	5.60%
	20853	9.60%
	20854	2.50%
	20855	5.60%
	20866	9.90%
	20871	4.80%
	20872	3.20%
	20874	7.60%
	20876	8.90%
	20877	18.70%
	20878	5.30%
	20879	9.40%
	20882	3.10%
20886	11.70%	
20895	4.40%	
20901	11.90%	
20902	16.20%	
20903	25.20%	

	20904	10.60%
	20905	7.10%
	20906	14.00%
	20910	6.00%
	20912	14.70%
	<i>Overall</i>	8.40%
Prince George's County	20705	11.80%
	20706	14.10%
	20707	9.70%
	20708	11.50%
	20712	18.80%
	20721	4.00%
	20737	26.60%
	20740	9.20%
	20743	10.70%
	20744	9.30%
	20746	10.00%
	20747	8.40%
	20748	8.70%
	20770	12.70%
	20772	5.50%
	20774	6.40%
	20781	19.10%
	20782	19.00%
	20783	35.00%
20784	17.50%	
20785	11.40%	
<i>Overall</i>	11.90%	
Maryland	<i>Overall</i>	7.30%

Note: **Green** indicates the location's uninsured percentage is below the county value. **Red** indicates the location's uninsured percentage is above the county value

Figure 25. Percent Uninsured by zip code, 2017

(Source: [Selected Characteristics of Health Insurance Coverage 2017 ACS 5-Year Estimates](#))

Section III: Methodology



Data Collection

Overview

In completing the Community Health Needs Assessment (CHNA) process, Adventist HealthCare strived to construct a complete picture of the needs and resources in the community. To do this, three strategies were utilized during the data collection and analysis process:

- **Collecting Input from the Community as well as from Reliable Secondary Sources**
Secondary data sources provide a big picture perspective of the needs in a community. They can provide information on the magnitude of a need, whether the need has increased or decreased over time, and how it compares to other population groups or geographic locations. Secondary data helps to answer the question of *what* the need is. This information can be made richer with the addition of input directly from community members and key stakeholders. From this input additional details, insights, and personal perspectives that may otherwise have been missed can be accounted for.
- **Focusing on Social Determinants of Health as well as Physical and Mental Health Needs**
Social determinants of health can begin to answer the question of *why*. By considering social determinants such as income, insurance status, and transportation, among others, additional insight can be obtained regarding underlying causes of health problems as well as barriers to addressing them.
- **Utilizing a Health Equity Lens**
Significant disparities continue to persist in health and health care. As permitted by availability, data in this report is presented stratified by demographics such as race, ethnicity, sex, and age. By stratifying the data disparities that may have otherwise been masked in aggregate are brought to the forefront. By stratifying, the question of *who* is most in need can be better answered.

Through a clearer understanding of what the needs are, who is most affected, and what barriers they may face, a more strategic and targeted plan of action can be developed to address the needs in the community.

Secondary Data Collection

Several sources of secondary data were utilized in completing this CHNA. Sources included but are not limited to: Healthy Montgomery, PGC Health Zone, the Maryland State Health Improvement Process, U.S. Census Bureau's American Community Survey, Maryland Behavioral Risk Factor Surveillance System, National Cancer Institute, Centers for Disease Control and Prevention, and Community Commons.

All secondary data is presented in a standard format. When possible:

- **Data is stratified by race, ethnicity, sex, and age** to highlight any disparities that may be present;
- **A time series is provided** to better understand how each indicator has changed over time, whether it is improving, worsening, or has plateaued; and
- **Relevant targets and benchmarks are included** to provide perspective on how each indicator on the local level compares to other geographic areas and/or established targets (e.g. Healthy People 2020 goals).

Community Input

A key priority of this CHNA was to gather input from a diverse and representative sample of the community. Several strategies were employed to achieve this including partnering with the Local Health Improvement Coalition (Healthy Montgomery), conducting a community survey, and completing key informant interviews and community conversations.

Partnership with Healthy Montgomery

Adventist HealthCare, in addition to the other Montgomery County hospitals, collaborates with Healthy Montgomery which serves as the Local health Improvement Coalition. Healthy Montgomery works to bring together the county government, hospital systems, minority health programs, advocacy groups, academic institutions, and other community-based stakeholders to achieve optimal health and well-being for all county residents. The group works to set a health priority agenda as well as an action plan to address the prioritized needs. In doing so, the group has established a core measure set for the top priority areas as well as a community health dashboard for the county. The dashboard encompasses indicators that span physical and mental health, health behaviors, and social determinants.

Adventist HealthCare contributes \$50,000 annually to support the infrastructure of Healthy Montgomery. In addition to providing financial support, representatives from Adventist HealthCare (AHC) play an active role through representation on multiple committees and planning groups including the Healthy Montgomery Steering Committee which sets the direction for the group.

In completing this CHNA, Adventist HealthCare utilized the Healthy Montgomery priority areas not only as a starting point for identifying the needs in the community but also as a factor for consideration when completing the prioritization process.

Community Survey

The Community Health Needs Assessment Survey consisted of thirteen questions centered on health status, access to care, and perceived community health needs and strengths. Available in English and Spanish, the survey was disseminated through several avenues including at community events and programs, via email and listservs, social media, and through community partners and organizations. To encourage participation, three prizes were offered as incentive. All survey participants were provided with the option to enter the voluntary raffle upon completing the survey for a chance to win a \$300 Amazon gift card or one of two \$50 Visa gift cards. Identifying information collected in connection with the raffle entry was stored separately from, and not associated with survey responses to maintain confidentiality.

Key Informant Interviews & Community Conversations

In complement to the data collected through the community survey, key informant interviews were conducted with community leaders and organizations that represent the interests of diverse and often hard to reach populations.

Stakeholders across Montgomery and Prince George's Counties were interviewed and included representatives from multiple sectors and populations such as:

- County Government
- Social Service & Advocacy Organizations
- Healthcare Foundations
- Health Care Practitioners & Clinics
- Fire and Rescue, Law Enforcement, and Crisis Intervention
- School & University Systems
- Behavioral Health
- Housing & Homelessness
- Food Security & Distribution
- Employment & Workforce Development
- Multiple Faith Communities & Denominations
- LGBTQ Communities
- People with Disabilities
- Minority and Immigrant Populations

To ensure consistency, a script was developed outlining the purpose of the interview, how the data would be used, and three primary questions to ask. Each interviewee was asked to identify what they believed to be the top issues impacting the health of the community; what strengths and resources are available in the community; and what services or resources they would like to see to address the health needs of their community.

In addition to the key informant interviews, Adventist HealthCare partnered with Manna Food Center to conduct community conversations at various community centers and schools. Similar to the community survey and key informant interviews, the community conversations centered around identifying community needs, existing resources, and desired services to address existing gaps.

Public Comment

Adventist HealthCare welcomes feedback from the public on past and current Community Health Needs Assessments. A dedicated email address (ourcommunity@adventisthealthcare.com) is listed on the Adventist HealthCare website along with each hospital's report.

Data Gaps & Limitations

Data gaps and limitations were present in both the secondary data collection as well as the community input collected.

When compiling and analyzing available secondary data, the following limitations persist:

- Data is often unavailable at the ZIP code or neighborhood level
- Race is often not differentiated in persons of Hispanic origin
- Varying data collection and analysis methodologies are utilized across databases
- While trend data is now more readily available, it is often unavailable or difficult to access historical data points stratified by race and ethnicity

A significant challenge when collecting input from community members is ensuring that a representative sample is being reached and that the voices of hard to reach populations are being heard. Surveys in particular tend to have overrepresentation of Whites, females, and individuals with higher income and education levels. While this cycle's survey results were more representative than in the previous Community Health Needs Assessment, the demographics were still skewed. To address this limitation, targeted key informant interviews and community conversations were conducted.

Prioritization of Needs

Process and Criteria Used

The prioritization of needs for this Community Health Needs Assessment cycle was completed on a system level. The initial prioritization was led by Adventist HealthCare's Community Benefit Steering Committee (CBSC). The purpose of the CBSC is to guide the community benefit work of Adventist HealthCare to fulfill our mission and improve the health and wellbeing of the community we serve. The CBSC is comprised of leaders from each of our hospital entities as well as from population health, mission integration and spiritual care, marketing, philanthropy, and finance.

To complete the prioritization process, the CBSC members were asked to evaluate each of the identified areas of need utilizing the following factors:

- **Incidence and Prevalence:** How big of a problem is the need in the community?
- **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?
- **County Alignment:** Is the health area aligned with Montgomery and Prince George's County priority areas?
- **Community Support:** Based on the community input collected, is this a significant area of 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?



- **Alignment with Adventist HealthCare Strategy:** Does this area align with an Adventist HealthCare strategy or area of focus?
- **Existing Adventist HealthCare Resources and Expertise:** Does Adventist HealthCare have expertise in this area? Are there existing resources that could be utilized to address this area of need?
- **Existing and Potential Partnerships:** Does Adventist HealthCare have relevant existing partnerships that can be leveraged or potential partnerships that can be developed?
- **Potential for Measurable and Achievable Outcomes:** Will it be possible to make an impact in this area? Are there relevant metrics that can be monitored and measured?

Based on these factors, CBSC members were asked to recommend which of the following would be an appropriate role for Adventist HealthCare to take in addressing the area of need:

- **Leader Role:** Adventist HealthCare is well positioned to take a leadership role in addressing this area.
- **Collaborator Role:** Adventist HealthCare will partner with other leading organizations to actively address this area.
- **Supporter Role:** While Adventist HealthCare recognizes the importance of this area of need on the wellbeing of our community, it is currently outside the scope of our strengths and resources to address directly. Adventist HealthCare will support the work of other organizations doing work in this area.

Prioritized Needs

For the 2020 - 2022 Community Health Needs Assessment Cycle, Adventist HealthCare has prioritized addressing unmet needs of uninsured and underserved populations in the following areas:

ACCESS TO CARE	SOCIAL DETERMINANTS OF HEALTH
Behavioral Health Chronic Disease Maternal and Child Health Disability and Rehabilitation Services	Food Access Housing and Homelessness Education Transportation

Specific initiatives addressing each of these areas -- including Adventist HealthCare's role, partner organizations and evaluation plans -- will be detailed in each hospital's Implementation Strategy to be released in May of 2020.

Section IV: Findings



Section IV: Findings

Part A: Community Input



Community Survey

Overview

In the spring of 2019 Adventist HealthCare conducted a thirteen question survey centered on health status, access to care, and perceived community health needs and strengths. A total of 1,957 community residents completed the survey. Additional information on the methodology for the survey data collection can be found in Section III of this report.

Demographics of Survey Respondents

Of the 1,957 respondents, 1,909 (97.5 percent) live in the Adventist HealthCare Rehabilitation Hospital community benefit service area. While the demographics of this cycle's survey respondents are more reflective of the community, there continues to be an overrepresentation of Whites, females and individuals with higher income and education levels.

- The majority of survey respondents identified as White (65.2 percent) followed by Black or African American (17.0 percent) (Figure 1).
- 11.1 percent of respondents identified as Hispanic or Latino (Figure 2).
- More than three times as many females responded to the survey as did males (Figure 3).
- Age groups of respondents were well distributed. Those aged 56-65 accounted for the largest group while those aged 18-25 accounted for the smallest group (Figure 4).

SURVEY RESPONDENTS BY RACE

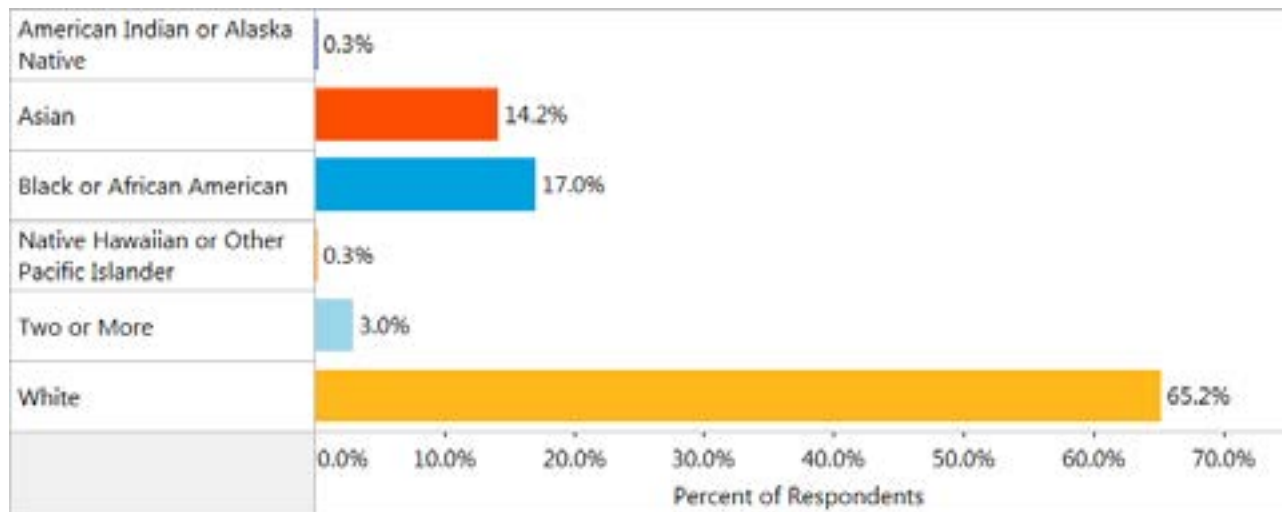


Figure 1. Survey Respondents by Race, 2019

SURVEY RESPONDENTS BY ETHNICITY

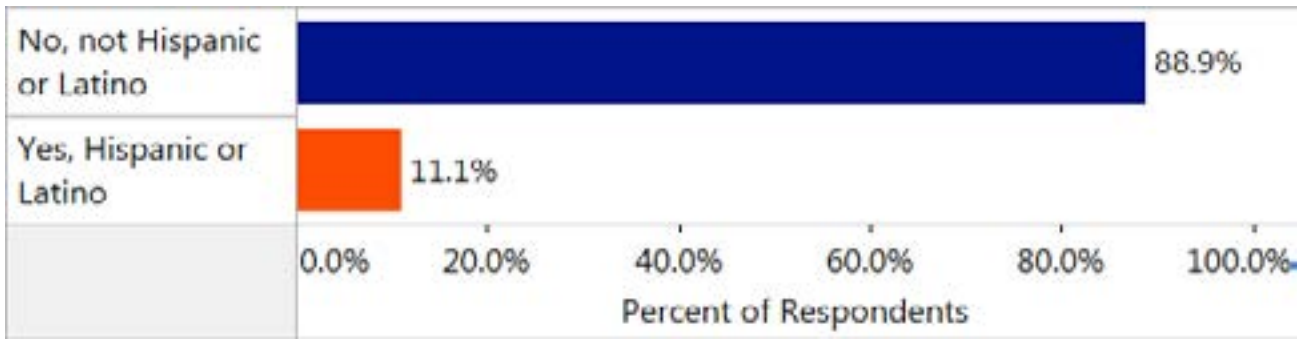


Figure 2. Survey Respondents by Ethnicity, 2019

SURVEY RESPONDENTS BY GENDER

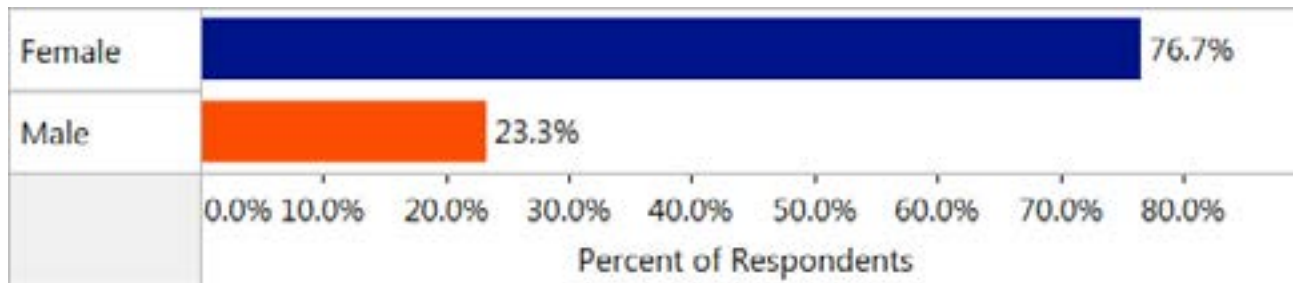


Figure 3. Survey Respondents by Gender, 2019

SURVEY RESPONDENTS BY AGE

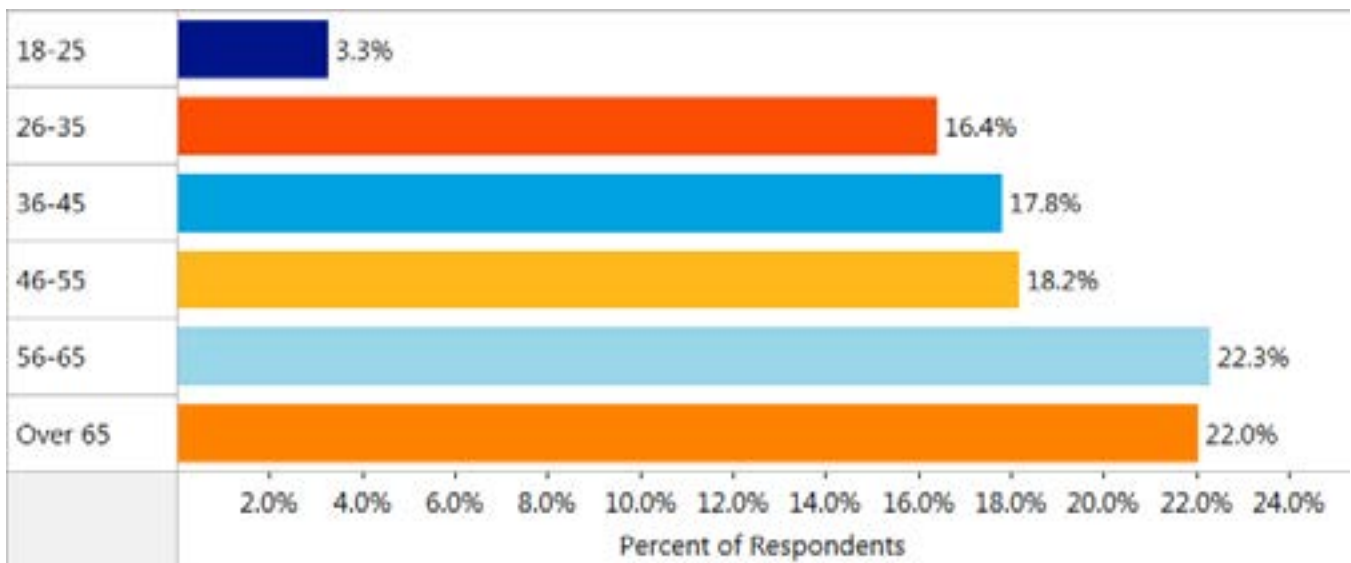


Figure 4. Survey Respondents by Age, 2019

In terms of socioeconomic status, as measured by annual income and highest level of education, the participant pool was skewed more towards the upper range. However, compared to previous CHNA cycles, there is better representation of lower income households.

- Over half of the respondents have an annual income exceeding \$75,000 (Figure 5).
- Over 70.0 percent of respondents have a college degree, with 40.2 percent having also earned a post graduate degree (Figure 6).

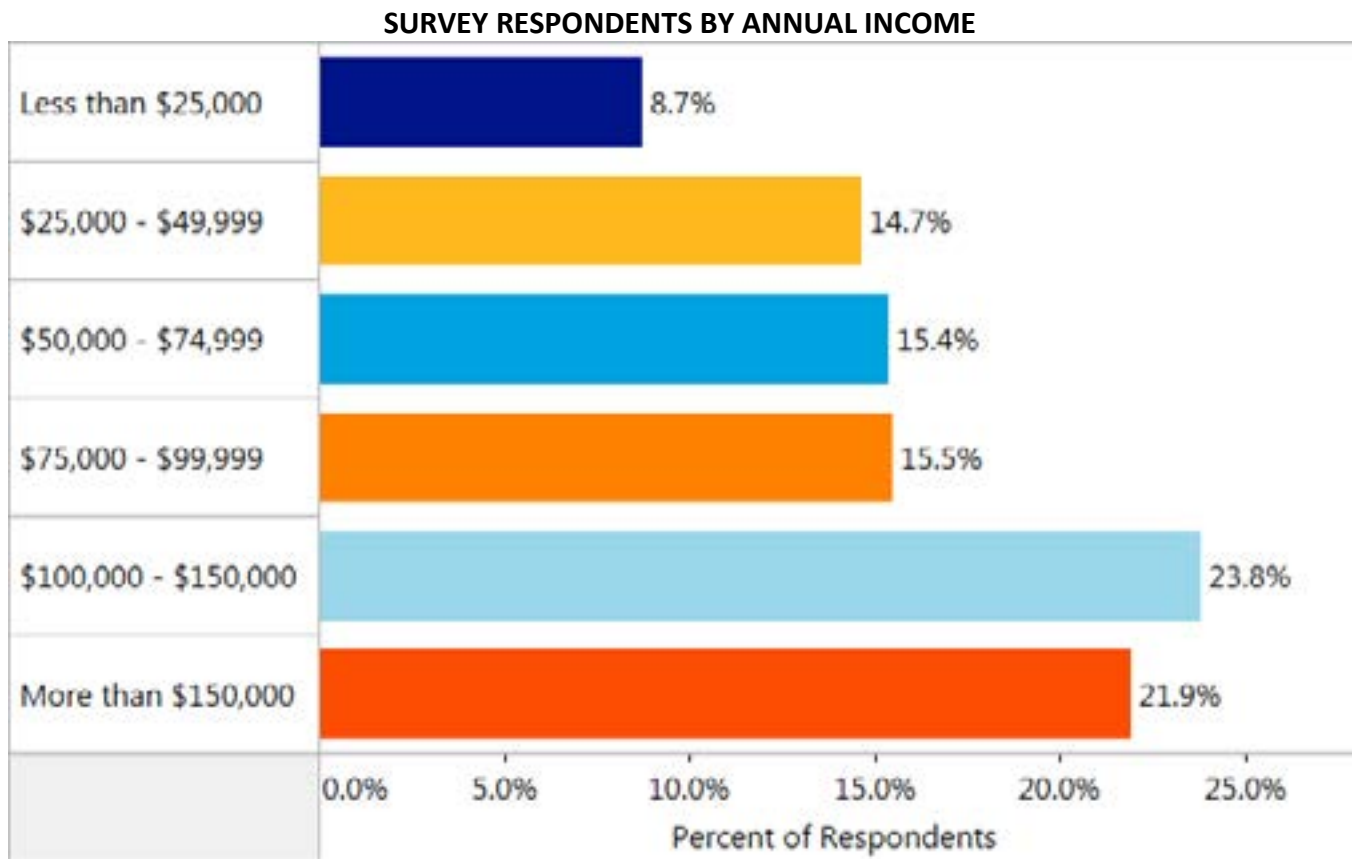


Figure 5. Survey Respondents by Annual Income, 2019

SURVEY RESPONDENTS BY HIGHEST LEVEL OF EDUCATION

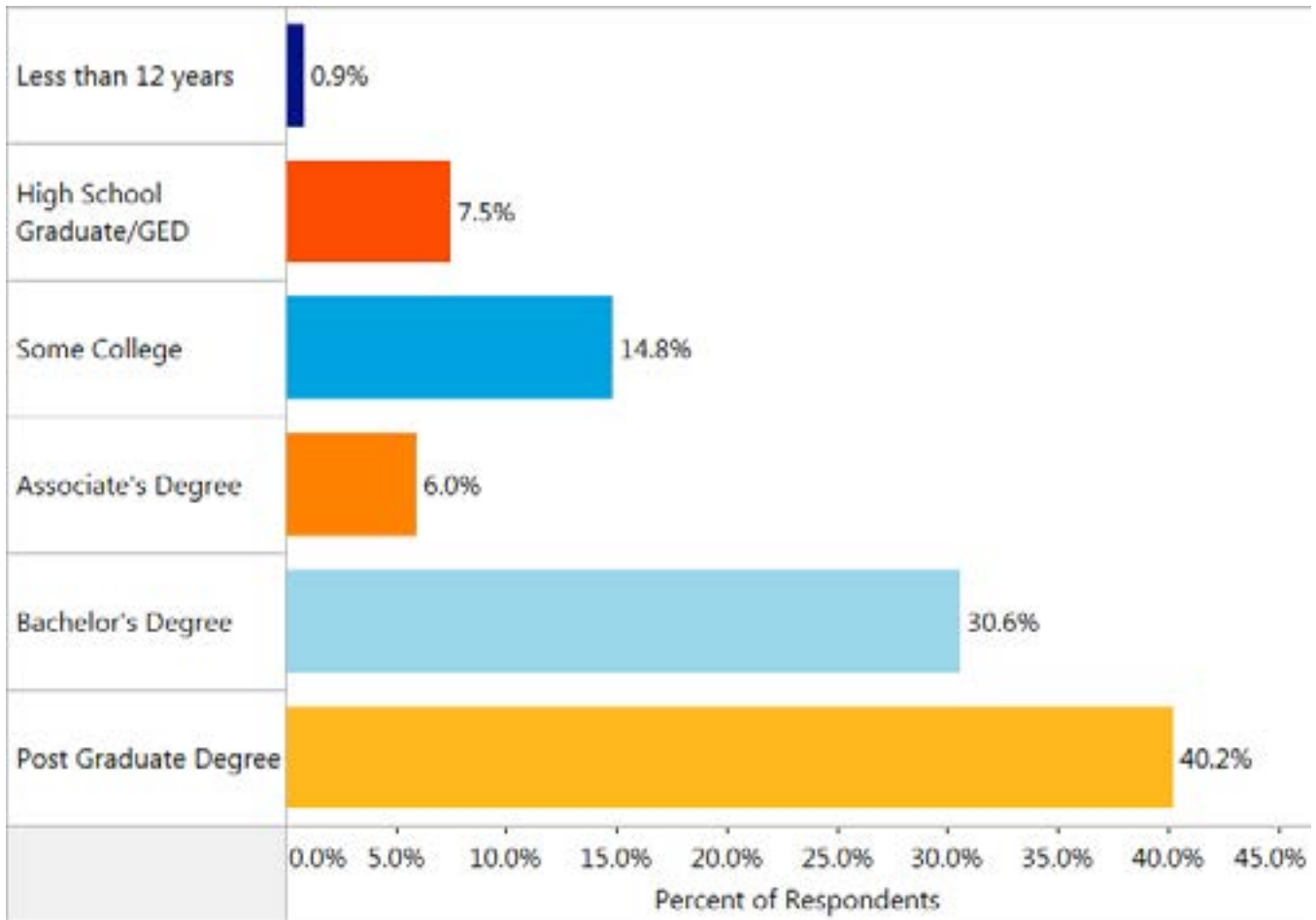


Figure 6. Survey Respondents by Highest Level of Education, 2019

Survey Findings

Participants were asked to rate their overall mental and physical health on a scale of poor to excellent.

- Over 60.0 percent of respondents rated their mental health as either very good or excellent (Figure 7).
- Most participants rated themselves to be in good (38.6 percent) or very good (31.9 percent) physical health (Figure 8).

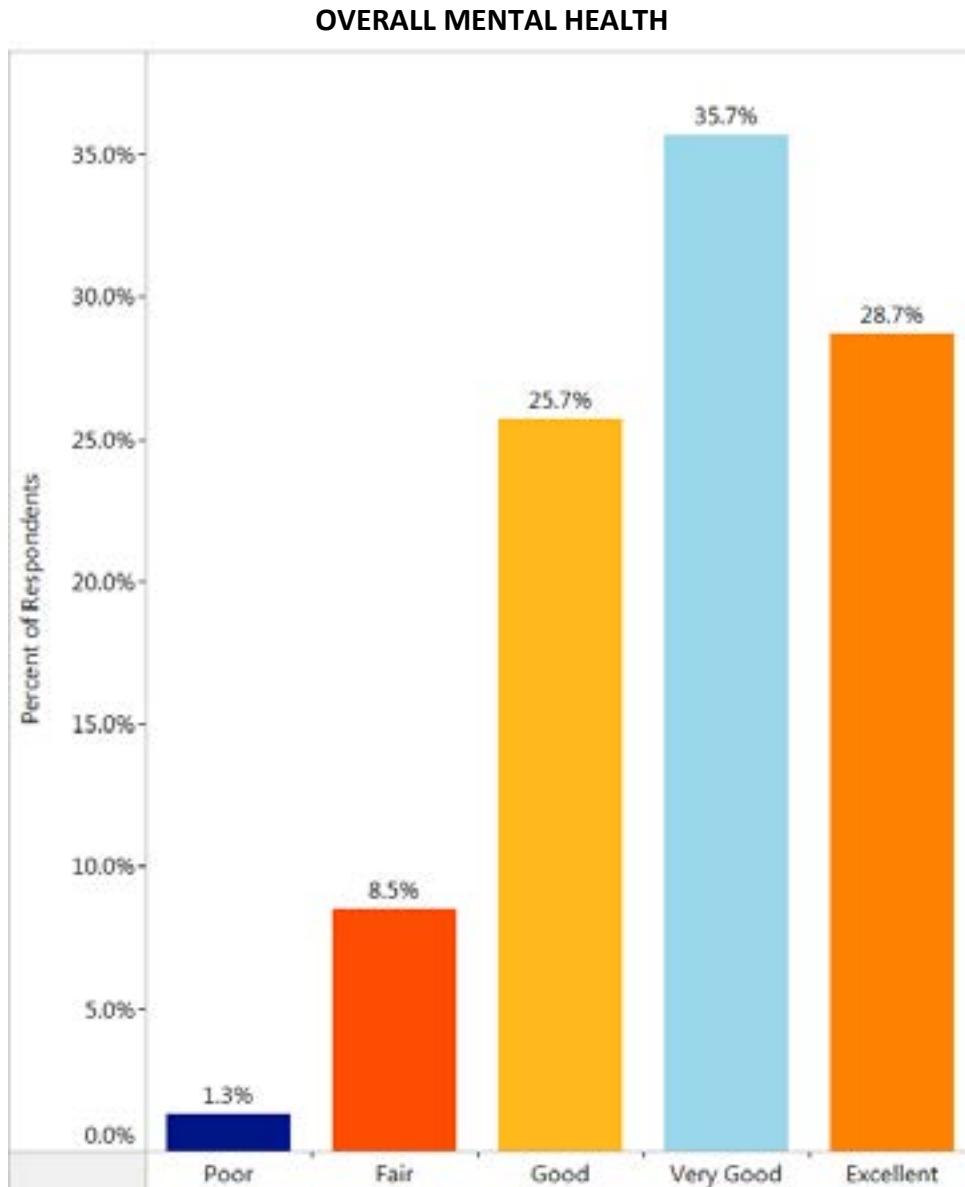


Figure 7. Survey Respondents Self-Reported Overall Mental Health, 2019

OVERALL PHYSICAL HEALTH

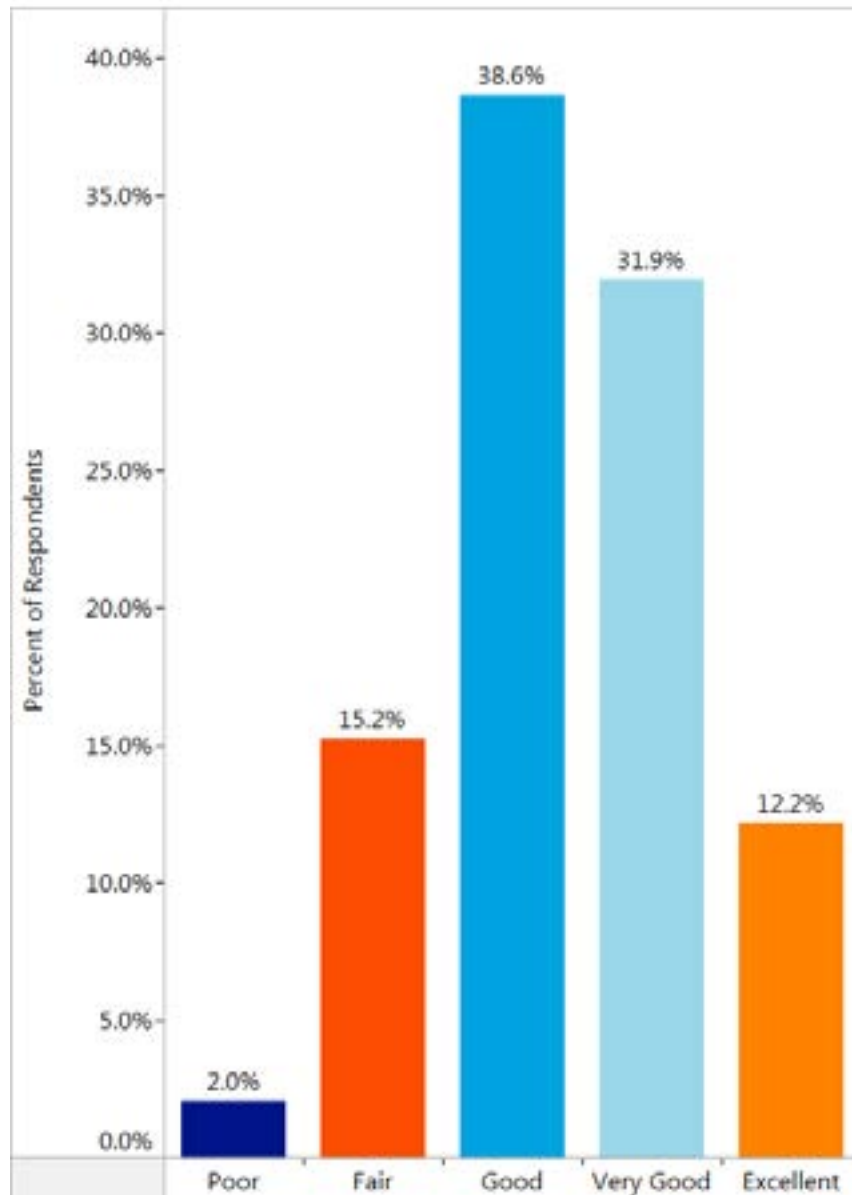


Figure 8. Survey Respondents Self-Reported Overall Physical Health, 2019

Survey participants were asked if they can visit a doctor (other than at a hospital or emergency room) when needed.

- 63.4 percent of respondents reported that they are always able to see their doctor when needed (Figure 9).
- Respondents unable to see a doctor when needed reported an inability to get an appointment quickly, busy work schedules, and inconvenient doctor's office hours as the top three barriers (Table 1).

ABILITY TO VISIT DOCTOR WHEN NEEDED

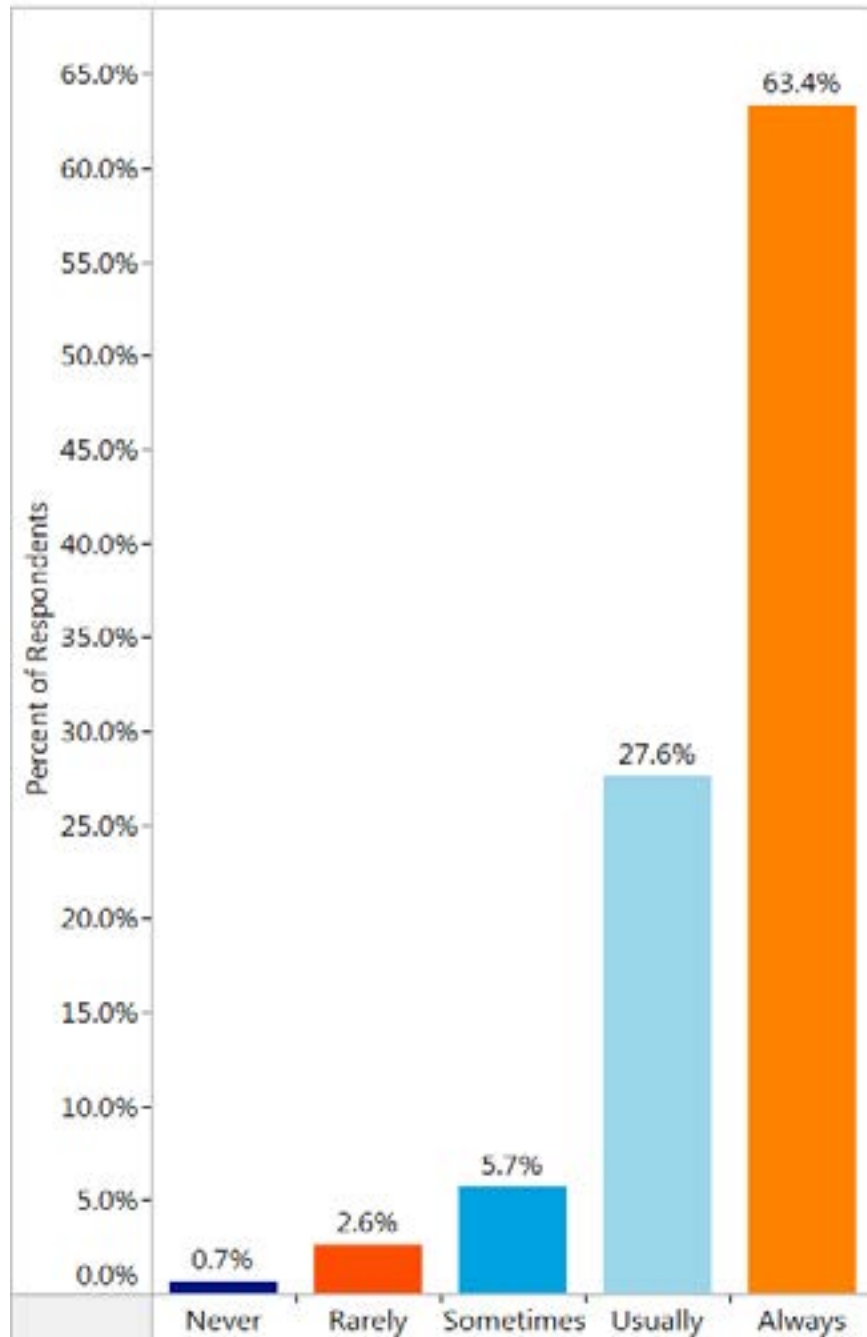


Figure 9. Survey Respondents Self-Reported Ability to visit a Doctor When Needed, 2019

Rank	Reasons for Not Being Able to Visit a Doctor	Number of Respondents
1	I cannot get an appointment quickly	274
2	I have a busy work schedule or am unable to take time off work	202
3	My doctor's office hours are not convenient	92
4	I am concerned that it would be too expensive	82
5	I do not have a regular doctor	75
6	I do not have health insurance	32
7	I am unable to get childcare	30
8	I cannot find a doctor that is accepting new patients	28
9	My doctor is too far away	26
10	I do not have access to transportation	22
11	I cannot find a doctor who accepts my insurance	20
12	<i>Other:</i> I need care outside of business hours or weekends	15
13	<i>Other:</i> I need a specialist	9
14	I cannot find a doctor that speaks my language	8
15	<i>Other:</i> Emergency situations	2
16	<i>Other:</i> Mental health services/providers are not available or hard to find	2
17	<i>Other:</i> My doctor is rude	2
18	<i>Other:</i> Unsure of what doctor to see	1
19	<i>Other:</i> Fatigue	1
20	<i>Other:</i> I sometimes need someone to come with me	1

Table 1. Reasons for Not Being Able to Visit a Doctor, 2019

Participants were asked about their health maintenance and prevention practices. Participants were asked to indicate when they last had a physical checkup, dental exam, mammogram, pap smear, colonoscopy, and flu shot.

The results show that most respondents completed doctor visits and screenings within the recommended time frames. For example, within the prior year 82.2 percent of respondents had a physical exam, 78.9 percent had a dental exam, and 76.2 percent received a flu shot (Table 2).

How long has it been since you last?	Less than 6 months	6 months to 1 year	1 – 2 years	3 – 5 years	More than 5 years	Never	N/A
Visited a doctor for routine check-up or physical (n= 1,896)	51.7%	30.5%	12.0%	3.0%	2.1%	0.4%	0.4%
Had a dental exam (n= 1,894)	58.9%	20.0%	10.9%	4.6%	4.4%	0.6%	0.7%
Had a mammogram (Women Only) (n= 1,679)	23.5%	22.2%	13.2%	3.7%	2.1%	17.1%	18.2%
Had a pap test/pap smear (Women Only) (n= 1,683)	19.4%	25.7%	22.7%	7.8%	4.4%	1.9%	18.0%
Had a sigmoidoscopy or colonoscopy to test for colorectal cancer (n= 1,878)	7.0%	6.7%	13.8%	17.3%	9.9%	37.0%	8.4%
Had a flu shot (n= 1,884)	64.4%	11.8%	6.3%	2.6%	3.6%	10.3%	1.1%
Had cholesterol checked (n= 1,878)	48.1%	29.7%	12.0%	3.3%	1.5%	4.1%	1.3%
Had blood sugar or A1C checked (n= 1,872)	49.2%	27.0%	10.3%	2.7%	1.6%	5.9%	3.3%
Had blood pressure checked (n= 1,891)	79.7%	14.0%	3.8%	1.2%	0.5%	0.6%	0.5%
Had a prostate exam (Men Only) (n= 1,427)	8.2%	6.0%	4.5%	2.5%	1.8%	12.1%	65.0%

Table 2. Survey Respondents Health Prevention and Maintenance History, 2019

Participants were asked about behaviors that may impact their health.

- Most participants indicated that they do not use tobacco products, however 15.6 percent are exposed to second hand smoke (Table 3)
- Over 25 percent of participants are consuming less than 2 servings of fruit per day over 20 percent are consuming less than two servings of vegetables (Table 3)
- Less than half of respondents are exercising for 30 minutes per day (Table 3)

In the last 30 days, did you?	Yes	No	Don't Know/Not Sure
Chew tobacco or smoke cigarettes, cigar, or pipes (n= 1,901)	4.6%	95.0%	0.6%
Use e-cigarettes or vape pens (n= 1,894)	2.0%	98.0%	0.5%
Breathe second hand smoke (n= 1,890)	15.6%	76.6%	7.8%
Take drugs not prescribed to you (n= 1,888)	1.3%	98.0%	0.9%
Have more than 2 (women) or 3 (men) drinks on a single occasion (n= 1,897)	18.7%	80.0%	1.3%
Eat at least 2 servings of vegetables a day (n= 1,886)	74.3%	20.2%	5.5%
Eat at least 2 servings of fruit a day (n= 1,776)	68.5%	26.5%	5.0%
Exercise for 30 minutes or more a day (n= 1,901)	48.8%	47.7%	3.5%

Table 3. Survey Respondents Health Behavior, 2019

Participants were asked whether in the past five years, they have been treated unfairly when receiving medical care. 38.9 percent of respondents indicated that they had been treated unfairly when receiving care (Figure 10).

- Most respondents indicated that they were unsure why they received unfair treatment. For those respondents that indicated a reason, the top responses included age, race or skin color, and gender or gender identity (Table 4)
- Common write-in responses included weight, insurance type or status, and the provider being rushed (Table 5)

IN THE LAST 5 YEARS, HAVE YOU BEEN TREATED UNFAIRLY WHEN GETTING MEDICAL CARE?

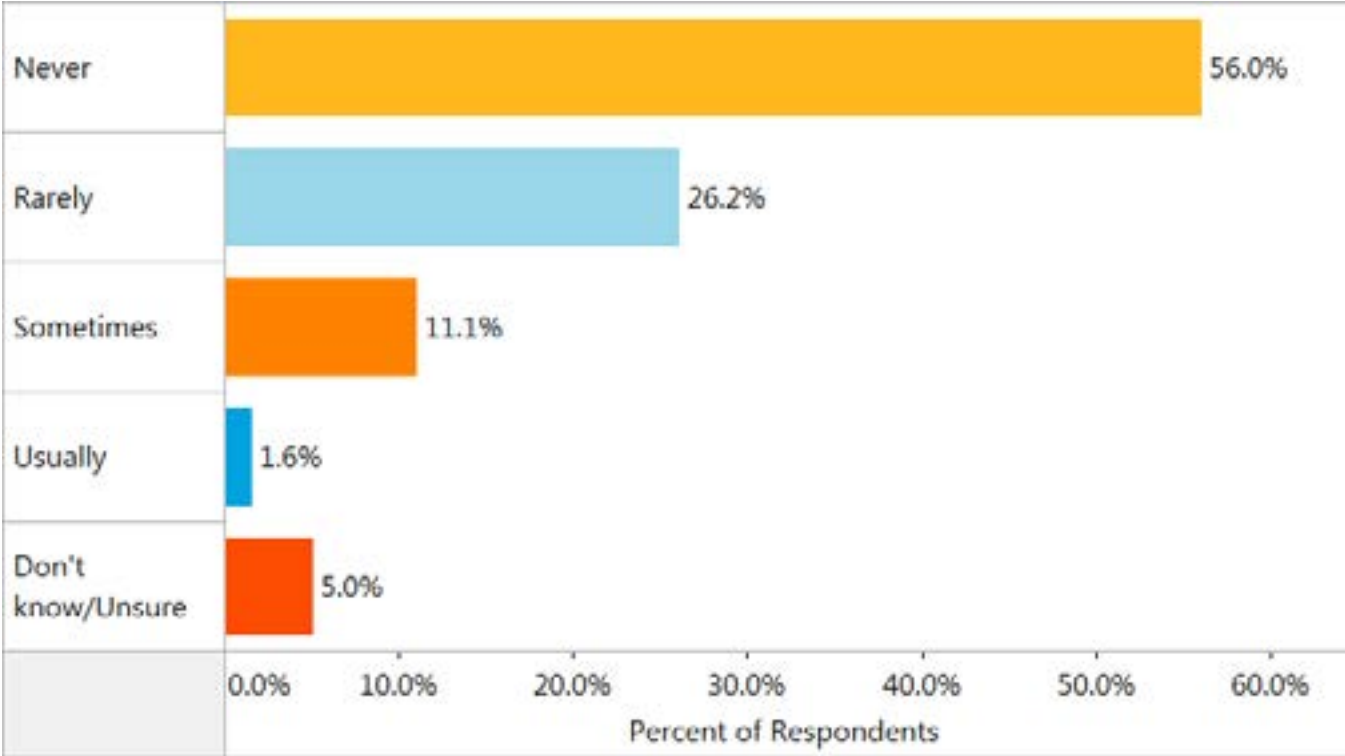


Figure 10. Survey Respondents Self-Reported Being Treated Unfairly When Getting Medical Care, 2019

Rank	Self-reported Reasons for Being Treated Unfairly When Getting Medical Care	Number of Respondents
1	Don't know/Unsure	357
2	Other	182
3	Your age	70
4	Your race or skin color	58
5	Your gender or gender identity	61
6	You speak with an accent	25
7	English is not your native language	28
8	Your ancestry or national origin	26
9	Your sexual orientation	5

Table 4. Survey Respondents Reason for Being Treated Unfairly When Getting Medical Care, 2019

"Other" Reasons for Being Treated Unfairly When Getting Medical Care	Number of Responses
Weight	46
Insurance type or status (uninsured/underinsured)	28
Provider was rushed	26
Provider was rude/had an attitude	12
Mental health condition	5
Lifestyle choices	5
Disability	4
Previous medical history	4
Patient's preference for provider gender	2
Tattoos	2
Socioeconomic status	2

Table 5. Survey Respondents "Other" Reason for Being Treated Unfairly When Getting Medical Care, 2019

Emerging Themes

Overview & Key Findings

In addition to the community survey, Adventist HealthCare conducted 35 key informant interviews with over 75 stakeholders and 4 community conversations with approximately 25 participants. Details on the methodology for each of these data collection strategies can be found in Section III of this report.

Survey participants, key informants and community conversation participants were all asked about the:

- top health needs and concerns affecting their community,
- strengths and resources in their community that contribute to wellbeing, and
- current gaps in resources or programming they would like to see filled to optimize the health of their community.

In response to the questions above, survey responses focused on the physical environment and wanting more community resources to provide free workout classes, low cost gyms, educational workshops on healthy eating habits, parenting workshops, and health screenings or wellness checks at main hubs of the community (Figure 11).



Figure 11. Community Survey Word Cloud for Community Needs and Gaps, 2019

Main points addressed during key informant interviews and community conversations centered on entering and exiting the healthcare system including the follow up after care, unintended utilization of healthcare services, behavioral health issues, unemployment and job security, physical health needs, and the growing senior population (Figure 12).

An additional recurring theme across all input received was the desire to see an increase in engagement of community members to counter experiences of isolation and stress (Figures 11 and 12).



Figure 12. Key Informant and Community Conversation Word Cloud for Community Needs, Strengths and Gaps, 2019

Findings

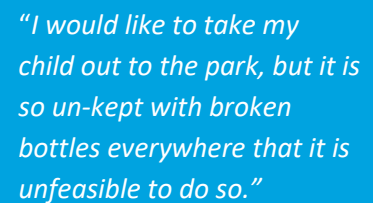
Physical Environment

Concerns with the physical environment were oriented to the safety of parks, sidewalks, litter or pollution, and the large number of fast food chains in the community.

Community members were concerned with the **condition and associated safety of their physical environment**. Some attributed the decline in their existing green spaces due to rapid development and construction in their neighborhoods. They also highlighted that parks should be upgraded and be accessible to all ages and physical abilities. Some had apprehensions about the safety of their parks which limited their desire to utilize them.

Many voiced issues around **poorly maintained sidewalks and roads** and that they desired “safer pedestrian walkways, raised crosswalks, and bike lanes.” There were also concerns surrounding **pedestrians being hit by cars** due to “not watching before crossing streets assuming cars will stop for them” and that others would like to see

reductions in car use and to make “more car free zone for pedestrians.” Some voiced that increasing car-sharing programs or bike rental services would assist in transportation for those that can’t easily afford it and reduce dependency on personal cars or public transportation. Concerns surrounding safety weren’t siloed to community parks but also to public and private transportation. One individual stated, “I have been in [metro] cars where I have felt that my personal safety or others’ could be at risk.”



“I would like to take my child out to the park, but it is so un-kept with broken bottles everywhere that it is unfeasible to do so.”

There were many complaints focused around **litter and pollution** within the community that were also tied to larger concerns about **climate change**. Some of these areas of pollution were due to large factories in their communities that they felt impacted the air quality and water contamination with one individual stating concerns of the “use of pesticides in agricultural areas that run off into our water supplies” while others stated that it was likely due to car exhaust.

The other major area mentioned about the physical environment was the large **number of fast food options** and few areas of healthy quick food options. Others specified wanting more **access to healthy food options** and would highlight wanting farmer’s markets and healthier food stores to move into their local neighborhoods.

Community Resource Hubs

Many community members discussed their desire to see community resource hubs that provide multiple services in one location. Desired services included health education classes, parenting resources, behavioral health screenings and treatment, physical health screenings, and treatments to address acute crisis.

Many community members voiced the desire for a distinct physical or online platform with multiple resources for various populations. This desire for this type of a resource was due to **difficulties navigating existing resources** in the community. One member specified wanting, “A service to help you find resources other than your insurance company.”

Some community members indicated that they desired **exercise and health education classes** that are free or low cost including “nutrition counselors and cooking classes to counteract [the] epidemic of obesity. Also teach people how to shop with in-store counselors and educators.” Others mentioned that health education courses should be focused on how to manage chronic illnesses like diabetes and should include “how to shop for healthy and culturally appropriate foods here.” Another area of interest for healthy eating behaviors was how to learn to garden and grow your own vegetables.

“If you are working you cannot engage in free activities that improve your health, they are offered during working hours.”

Other activities suggested to be provided by these resource centers were physical activity classes for all ages and physical abilities. There were concerns about the cost of these types of activities that might not be affordable to those with lower incomes.

Health literacy classes were also suggested including how to, “explain Medicare, vaccines, medical bills etc.” Some suggested having community health workers to provide these types of classes or information. They also desired for some level of **social services** to assist at these resource centers to provide information around paying for food and utilities. Some desired **behavioral health resources and coping mechanisms** like support groups, yoga, acupuncture, and meditation. One individual indicated the need for, “classes that focus on self-esteem for adults.”

Lastly, there was a desire for resources focused on new or single parents and youth. These resources included better **access to childcare for young children**, **parenting classes** to “educate parents on effective parenting”, “mom friendly fitness or rec centers for parents with young children that are more affordable”, and “access to **breastfeeding/postpartum supports** for mothers and families.” Other desires for the community involved more opportunities for **free or cost-effective activities for children**, including general recreational and educational afterschool programs.

Barriers to Healthcare Access

One of the most frequently mentioned topics was navigating the healthcare system. There were many concerns and barriers mentioned about entering the healthcare system, knowledge about insurance and government benefit programs, and how to navigate exiting the healthcare system and accessing needed follow-up care. Barriers entering the healthcare system were centered around language needs, insurance status, cost of care, transportation, and lack of quality healthcare providers.

Community members voiced a desire for information on **how to interact with healthcare providers** to be more knowledgeable about resources that would be available to them based on their **eligibility for government benefits** around disability, Medicare, and Medicaid. They also desired guidance on how to have discussions around **medication management**.

Some community members also discussed exiting the healthcare system and follow-up care as being areas of concern. After being released from the hospital there is often a **lack of resources and social support** for the patient to receive the care they need. This lack of family structure or “*who walks the journey with you*” was mentioned by many community members who expressed a need for **more guidance from healthcare professionals** and greater collaboration with family members to coordinate care to adequately meet the physical and social needs of the patient.

“When it comes to behavioral health calls, particularly for those with alcohol or substance abuse struggles, we are seeing the same people over and over. Unfortunately, we often don’t have anywhere else to take them other than the ER.” – EMS Personnel

Language was often cited as a barrier to accessing healthcare, more specifically **lack of translation and interpreter services** to provide information and care in multiple languages.

Cost of care was often brought up in conversations, often influenced by insurance status, high costs of co-pays, or self-pay

“Even though resources are out there, the problem remains that people or communities lack information due to factors like language barriers.”

costs. Many community members felt that the health insurance they have is too expensive or

“Unfortunately, many top ranked doctors and pediatricians do not take Medicaid.”

that the insurance they can afford has limited benefits. Others felt that they received subpar care from medical providers based on their insurance status, particularly if they had Medicaid. Many felt that lower costs of healthcare or insurance

would encourage individuals to seek healthcare more frequently. Others also expressed a need for “*more community services for those who don’t have medical coverage*” to help increase the uptake of

services. Some of these conversations were focused on increasing preventative care and avoiding the reliance on the emergency services.

Transportation challenges were another area of concern for some that could not afford public or private transportation. For those that frequently used public transportation, they discussed how it wasn't always reliable for arriving on time for appointments and that it was not always able to accommodate individuals with physical disabilities. For those with physical mobility constraints, there is also the extra challenge of getting out of their homes to get to the bus stop, medical taxi or other form of public transport.

A lack of **locally accessible quality providers and services** was also discussed. It was noted that many local providers had a long waitlist for services or that ideal providers weren't located locally. To meet the need of more locally available health services, many community members shared thoughts to mitigate this which included having free health screening clinics, mobile healthcare vans, and health fairs for free medical and dental screening. Additional suggestions included home or community visits from doctors or telemedicine options if in-person healthcare visits weren't feasible or if patients were experiencing homelessness.

Unintended Utilization of Services

Many Emergency Medical Service (EMS) providers discussed a heavy reliance on 911 and EMS for non-medical emergencies.

EMS providers indicated that many individuals would call 911 because they wanted to talk to someone due to **feelings of isolation**. At times individuals experiencing homelessness would call 911 services indicating suicidal ideation so that they could be transported to the hospital for a warm meal and housing. These services were also used by the elderly to be transported out of their homes due to **mobility limitations** preventing them from being able to leave the house without assistance. For the elderly, most of these calls occurred during off hours when their care nurse or aid was no longer in the home or the individual was back at their home after day care with no one there to help them with basic needs (i.e. showering, getting dressed, cooking, cleaning, etc.).

Behavioral Health

Behavioral health needs were mentioned frequently in the community survey responses and were mentioned during every key informant interview and community conversation. Discussions surrounding behavioral health focused on a lack of accessible mental health services, burnout and stress, substance use and abuse, and stigma around seeking out needed services.

Community members indicated a significant need for behavioral health services in their community. There were concerns voiced about the **number of quality service providers** and an inadequate number

of beds in hospital settings to address mental health and substance abuse needs. Among the limited providers in the area, there are often long **waitlists** to receive care or services. Some specified that there was a “*lack of access to affordable mental health services*” and one individual also highlighted the need for, “*more affordable therapists of color.*” For those with insurance coverage, co-pays and out of pocket costs were cited as a barrier, as were the number or duration of services that would be covered. For those without insurance, self-pay costs were cited as a significant barrier. These concerns were also often compounded with the **stigma** that still surrounds accessing behavioral health services.

An emerging area of need that was mentioned was for **behavioral health services for children and youth**. Stress, anxiety, and bullying were just some of the areas mentioned that are affecting children and coming on at younger ages.

Burnout and stress were noted for emergency service providers including police, paramedics, counselors, and crisis center workers. Even though these individuals provide services for others, they often have little support for themselves around the demands and stresses of their jobs. Some community members thought it would be beneficial to have therapists on staff for first responders to get support.

Substance use and abuse issues were discussed within the community with mention of alcohol, marijuana, opioids, and improper prescription medication usage as being prevalent. Marijuana was stated by some to be a gateway to higher level drugs, especially among those under 20 years of age. Alcoholism was also noted as being prevalent among community members. There were views that drug users were also overly reliant on Narcan where one individual linked it to being a “DD” or designated driver when it came to drug use.

Physical Health

Discussions surrounding physical health were focused around chronic disease, obesity, weight loss and sexual health.

Desires for **guidance and assistance for weight loss** were discussed by many participants. Two individuals discussed the value of fitness trackers to help with their weight loss with one individual highlighting how this would help them independently work on their weight loss goals, “*I wish I could get a Fitbit at no cost, for at least some period of time, so that I could track some of my personal fitness markers*” while the other indicated that they wished a Fitbit could be used by his healthcare provider to track his physical achievements virtually.

For those that wanted to engage in more physical activity they discussed how having **childcare for parents** who go to the gym at community centers would be extremely helpful. Also, that if the community hosted exercise challenges such as local 5K or running events, it would encourage

community members to engage more in physical activity. These types of activities were believed to help combat obesity, especially for children.

Others also discussed how their community needed additional sexual health services. Most prominent were discussions surrounding needing **STI screening services** and additional **women's health resources**.

Growing Senior Populations

With the senior population rapidly growing, many community members mentioned the need for more services for this population, particularly around home care and transportation.

For older adults it was indicated that there was a **need for care throughout the day** including after normal business hours (evenings and weekends) for those that attend day care centers as well as those with in-home care. Seniors may be financially strained or on a fixed income and therefore unable to afford additional assistance, or their insurance (or lack of insurance) does not cover sufficient in-home assistance.

"More services [are needed] to assist seniors and disabled persons with handling day to day life."

Others indicated that the lived reality for these individuals includes **feelings of isolation** because of physical limitations not allowing them to leave their house freely. Many seniors don't have a family member (or adult child) that lives in the area because they often relocate as adults which may lead this population to feel that they have **no support system**. Some voiced that having the support from an animal as company may help with these feelings, but that many condos and apartments in the area don't always allow for it. Some voiced the need for more group activities and programming, there *"really needs to be something for the in between - 50's and 60's."*

Community Engagement

A lack of community involvement and sense of community was often mentioned.

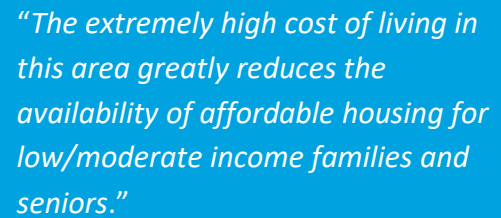
Many community members indicated that it was difficult to interact frequently and naturally with their neighbors. Many desired the notion of their community *"to become neighbors again"* which could be encouraged through community activities or events such as block parties, neighborhood walking clubs, outdoor games during the summer, and other ways to socialize and meet other community members. Others discussed that even when there are community events in their neighborhood, they often can't attend due to time and day of events, transportation issues, and inability to receive information.

"People are so stressed and busy, there's more tendency to go home after work & just stay there."

Housing

Many community members commented on the high cost of living, lack of affordable housing, and prevalence of homelessness.

Community members discussed the need for more **affordable housing options** including both rentals and homeownership. Efforts to increase affordable housing were thought to be able to reduce homelessness in their communities. Also, an increased availability of affordable housing near metro and town centers would allow for those employed to reduce their commute time to work.



“The extremely high cost of living in this area greatly reduces the availability of affordable housing for low/moderate income families and seniors.”

Employment and the Job Market

Specific needs surrounding job security and the job market were centered around challenges for those over age 55 to acquire a job, a lack of job availability for those with high level degrees, and barriers to obtaining unemployment benefits.

Community members 55 and over felt that many employers would turn them away from a potential position due to their age. Veterans, undocumented individuals, and individuals that were previously incarcerated were also noted as having unique difficulties to **entering the workforce**.

Additional discussions centered on **needing a more diverse pool of local jobs** including those that do not require a degree or trained skillset, as well as those that would allow individuals to utilize their higher-level degrees. This is a unique region with high proportions of residents earning a post-graduate degree, however, there are not enough jobs available locally for these individuals. This often leads to feelings of stress, defeat and low self-confidence surrounding entering the job market. Those that have worked in job centers have noted that these individuals tend to not come to job centers for assistance and often have a difficult time presenting themselves to employers as they may seem desperate or overqualified for available positions due to their multiple or advanced degrees. The **negative effects of unemployment on mental health** were also discussed for lower-income individuals, particularly those who have families and children.

There were also concerns raised surrounding the ease of **acquiring unemployment**. There were suggestions made for a mandatory program for individuals who are unemployed to acquire information on job opportunities at the same location that unemployment is offered.

Prejudice, Discrimination and Racism

There is a distrust of the health care and school systems for certain populations such as undocumented individuals, people of color and LGBTQ individuals.

Due to historic injustices and inequities that persist to this day, as well as the current political climate, certain populations are fearful, guarded, distrustful, and feel threatened and unsafe. These feelings stem from beliefs of *“intolerance of people of different faiths, ethnicities and sexuality”* which is why community members wanted more *“culturally sensitive health care.”* These feelings led one individual to state that, *“the hospital is a place to go to die, rather than live.”* Others highlighted they were concerned that they will get experimented on, that undocumented individuals will be reported to immigration services, healthcare workers do not want to help you get better, and providers have slow response times to provide care to minority populations.

Within the school environment community members recommended there to be LGBTQ liaisons at different locations where anxiety may arise when students may need to disclose their sexual orientation. It was also stated that additional education and **resources are needed throughout the community to avoid biases** at healthcare centers, counseling centers, and career centers.

Strengths and Resources in the Community

There is a vast number of organizations working to improve the health and wellbeing of the community. Organizations are constantly collaborating and adapting to share resources and meet the needs of the community. Community members value many resources available to them including community centers, parks and recreation areas, faith communities, and walking and hiking trails.

Community members often cited community centers, parks and recreation areas, and walking or hiking trails as valued resources in the community. It was discussed that the recreation department runs a lot of programs, *“but they cost money and don't fit with a working schedule with a long commute.”* Many also valued the healthy grocery stores, fitness centers and gyms, and hospitals or community clinics, but wanted more or larger ones in their community. *“Some hospitals offer classes but not at a time when the participants that need it most can participate.”* The other valued services were senior centers, public transportation, houses of worship, food banks, libraries, school services, and safe/well maintained parks.

Section IV: Findings


Part B: Secondary Data

Chapter 1: General Rehabilitation



General Rehabilitation

KEY FINDINGS

Disparities & Indicators	Trend Over Time
<ul style="list-style-type: none"> The majority of general rehabilitation patients at Adventist HealthCare Rehabilitation Hospital are White males Women are two times more likely to develop Multiple Sclerosis compared to men More women than men have primary knee and hip replacements across the United States 	 <ul style="list-style-type: none"> MD had an increasing trend of Parkinson's Disease mortality from 2014-2017
Community Perception ¹	
<div data-bbox="500 1290 1117 1421"> <p>"Metro Access is very hard to get into, have to go to DC in order to take the test to see if you qualify, there is also a long waitlist."</p> </div> <div data-bbox="500 1487 1117 1618"> <p>There was awareness in the community that there should be, "<i>more services to assist seniors and disabled persons with handling day to day life.</i>"</p> </div>	

¹ Adventist HealthCare. (2019). Community Health Needs Assessment Primary Data Survey.

General Rehabilitation

Overview

Physical medicine and rehabilitation is a field of medicine involved in the prevention, diagnosis, treatment, and management of disabling musculoskeletal, neuromuscular or neurological diseases, disorders and injuries. Physical therapy addresses issues such as joint pains, mobility issues, vascular conditions, and age-related disabilities. Physical rehabilitation services are used by people of all ages, ranging from children to seniors. The following sections cover specific types of orthopedic and neurological rehabilitation.

Orthopedic Rehabilitation

Joint Replacement

- Joint replacements, also known as joint arthroplasty, are common surgeries in the United States of America. The most common types of joint replacement surgeries are primary and revision hip and knee.
- There were 1,525,435 joint replacement procedures performed between 2012 and 2018, with primary total hip and knee accounting for 88.2 percent (Figure 1).

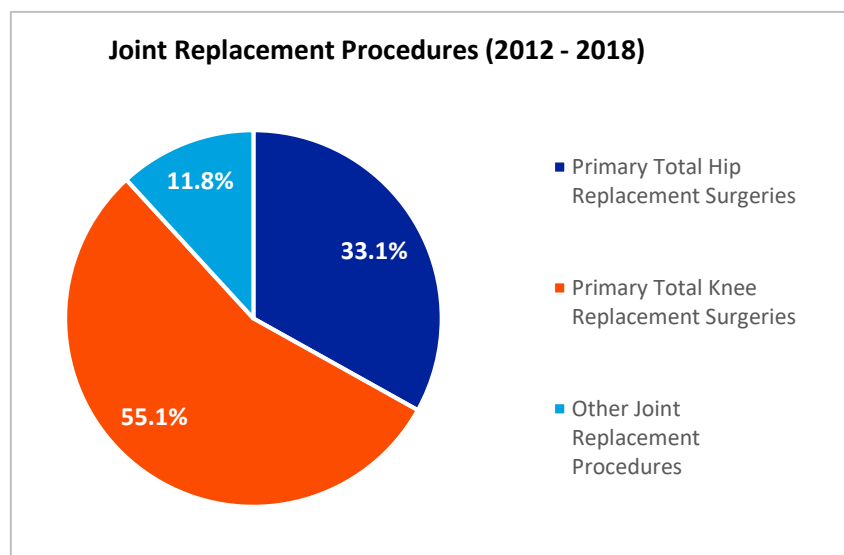


Figure 1. Joint Replacement Procedures, 2012 - 2018
(Source: [American Joint Replacement Registry Annual Report](#), 2019)

- Overall, the prevalence of joint replacement is higher among women than men. More than 50.0 percent of patients <59 years of age undergoing elective primary total hip arthroplasty were male. After the age of 60, females predominate and this trend increases with each additional decade of life (Figure 2).
- For patients undergoing total knee, women account for the majority across all age groups (Figure 3).

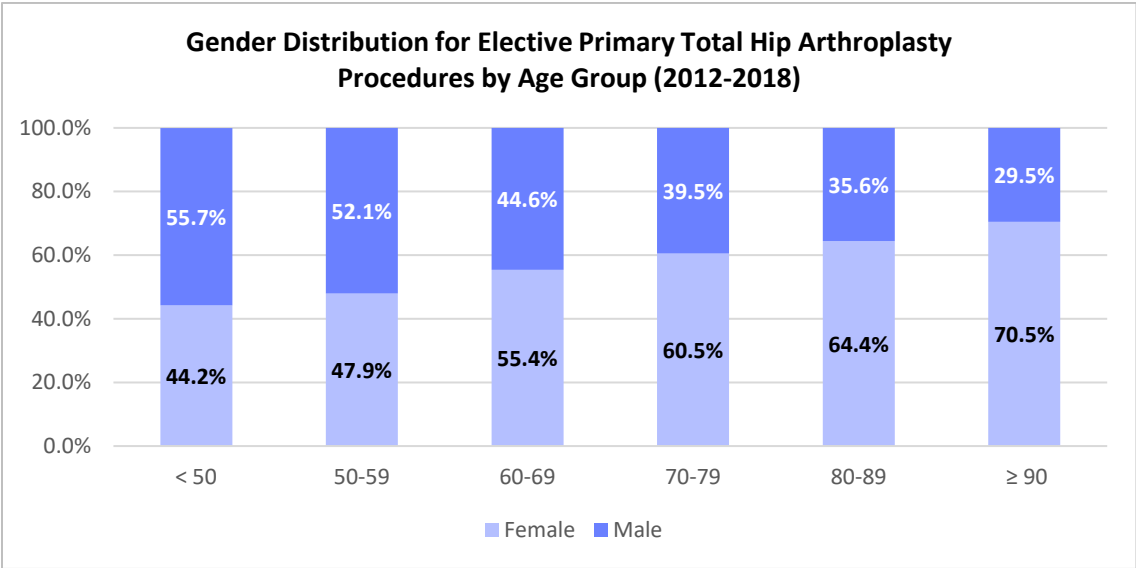


Figure 2. Gender Distribution for Elective Primary Total Hip Arthroplasty Procedures by Age Group, 2012-2018
(Source: American Joint Replacement Registry Annual Report, 2019)

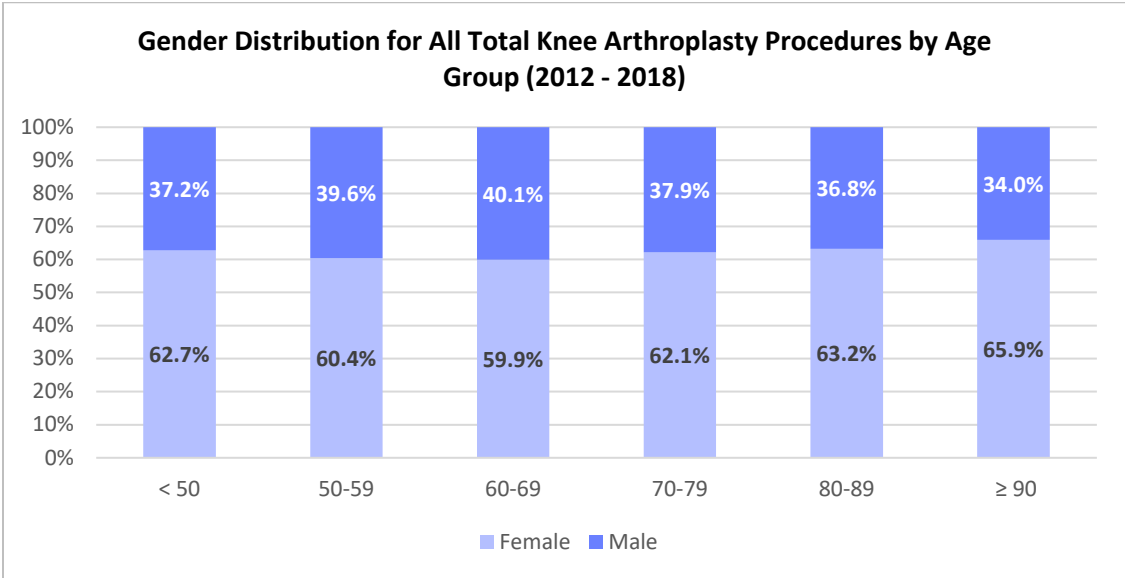


Figure 3. Gender Distribution for All Total Knee Arthroplasty Procedures by Age Group, 2012-2018
(Source: American Joint Replacement Registry Annual Report, 2019)

Hospital Data

- In 2018, Adventist HealthCare Rehabilitation Hospital served 381 orthopedic patients. The patients were majority female (Figure 4) and had an average age of 69 years.
- When stratified by race and ethnicity, there were 3X more White patients than African-American, which is the second largest group of patients (Figure 5).

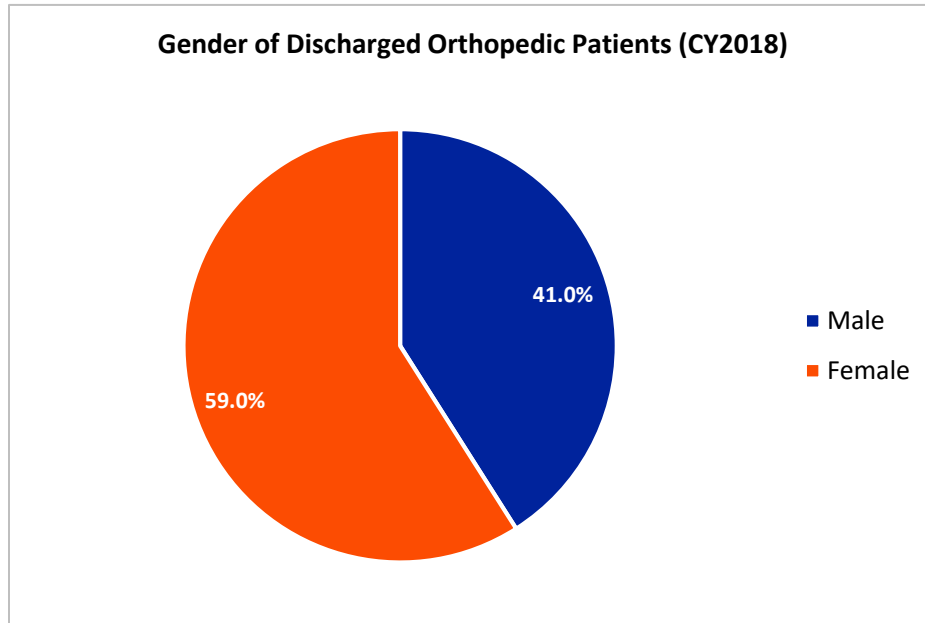


Figure 4. Gender of Discharged Orthopedic Patients, CY2018
(Source: Adventist HealthCare Rehabilitation Hospital, 2019)

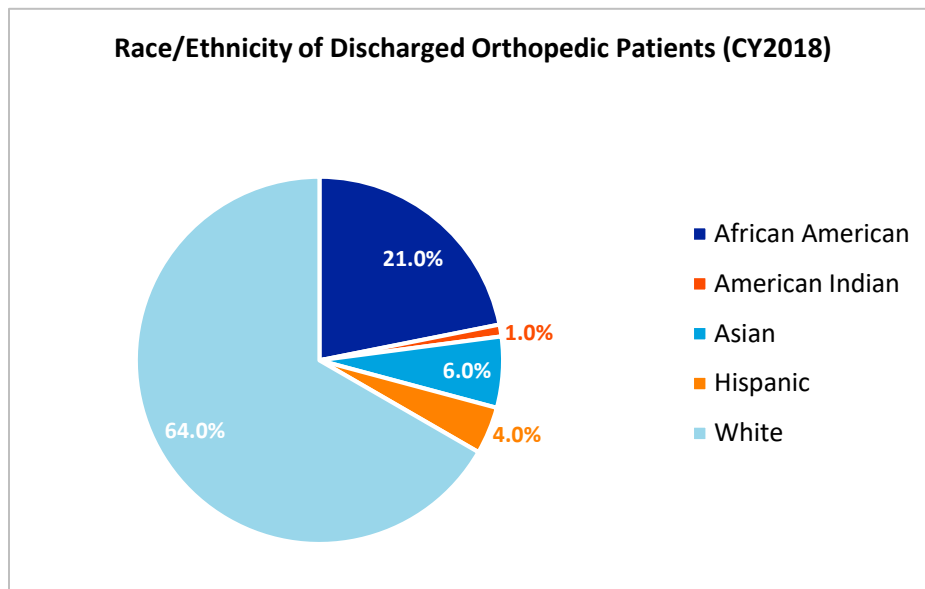


Figure 5. Race/Ethnicity of Discharged Orthopedic Patients, CY2018
(Source: Adventist HealthCare Rehabilitation Hospital, 2019)

Neurological Rehabilitation

Aphasia

Aphasia is an acquired communication disorder that impairs an individual's ability to speak and understand others, with a majority experiencing difficulty reading and writing. According to the National Aphasia Association, nearly two million Americans have aphasia, with an average of 180,000 people developing it annually. Aphasia results from damage to the left hemisphere of the brain and is most commonly caused by stroke. About 25 – 40.0 percent of stroke survivors develop aphasia.² In terms of gender, there are no significant differences in incidence rates. However, the severity and type of aphasia acquired may be different between the two genders. While aphasia affects people of all ages, races, nationalities, and gender, it is more common among older adults. Research shows that 15.0 percent of people under the age of 65 experience aphasia compared to 43.0 percent of people over the age of 85.³

Parkinson's Disease

There are approximately one million people living with Parkinson's disease (PD) in the United States. Around 60,000 Americans are diagnosed with PD every year, not including the cases that go undetected. The likelihood of developing PD increases with age, with about 4.0 percent of patients being diagnosed before age 50. Men are more at risk than women of developing PD.⁴

Research has also shown significant racial disparities among individuals with Parkinson's disease. When stratified by race and ethnicity, African-Americans suffering from PD are less likely to receive early treatment, therapeutic surgery, depression treatment, etc.⁵ Compared to White patients, African-Americans are less likely to receive care from a neurologist, which may lead to other disparities in treatment. It has also been found that African-Americans have lower health literacy regarding PD diagnosis and treatment.

Maryland had an increasing trend of Parkinson's Disease mortality for 2014 – 2017 (Figure 6).

² National Aphasia Association (2015). Aphasia FAQs. Retrieved from <http://www.aphasia.org/aphasia-faqs/>

³ American Speech-Language-Hearing Association (2016). Aphasia: Incidence and prevalence. Retrieved from http://www.asha.org/PRPSpecificTopic.aspx?folderid=8589934663§ion=Incidence_and_Prevalence

⁴ Parkinson's Foundation (2019). Understanding Parkinson's: Statistics. Retrieved from <https://www.parkinson.org/Understanding-Parkinsons/Statistics>

⁵ Dahodwala, N. (2013). What is known about racial disparities in Parkinson's disease diagnosis and treatment? *Neurodegenerative Disease Management*, 3(6). Retrieved from <http://www.futuremedicine.com/doi/pdf/10.2217/nmt.13.62>

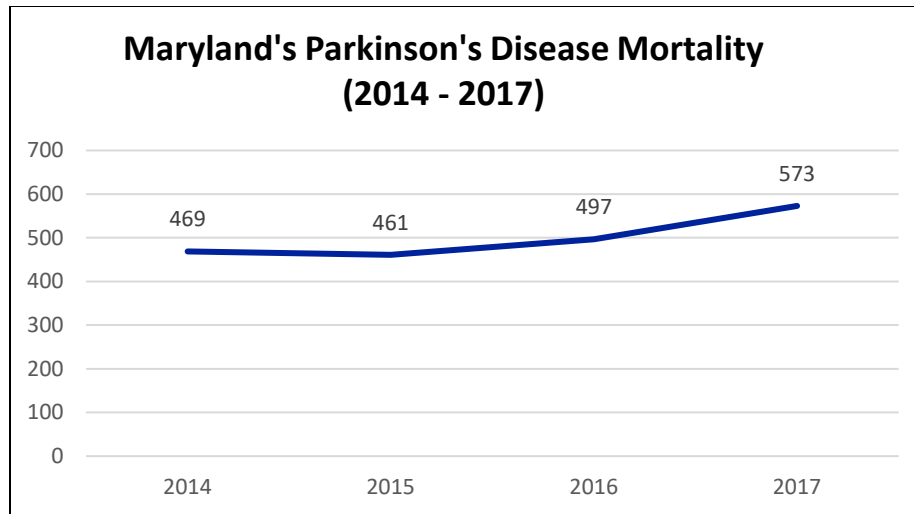


Figure 6. Maryland's Parkinson's Disease Mortality Rate, 2014 – 2017
(Source: [Centers for Disease Control and Prevention](#), 2019)

Multiple Sclerosis

Multiple sclerosis (MS) is an unpredictable disease affecting the central nervous system and disrupting the flow of information in the brain as well as between the brain and body. Symptoms of MS include, but are not limited to blurred vision, loss of balance, poor coordination, and paralysis. An estimated 400,000 people in the United States are living with MS and more than 200 people are diagnosed every week. Most diagnoses of MS have been between the ages of 20 and 50, with women being two times more likely to be diagnosed.^{6,7}

Dysphagia

Dysphagia is a difficulty swallowing or in some cases, the inability to swallow and may be associated with pain.⁸ While dysphagia is more common among older adults, about one in 25 adults in the United States has trouble swallowing. There is also a high prevalence of dysphagia among children with physical disabilities and developmental disorders.^{9,10} Studies have also shown that dysphagia has a high prevalence among people who have suffered from stroke, traumatic brain injury, dementia, Parkinson's, Huntington's, multiple sclerosis, and other neurological diseases.¹¹ Based on the type and

⁶ National Multiple Sclerosis Society (n.d.). What is MS? Retrieved from <http://www.nationalmssociety.org/What-is-MS>

⁷ Hersh, C.M. (2014). Multiple sclerosis. Cleveland Clinic Center for Continuing Education. Retrieved from: http://www.clevelandcliniced.com/medicalpubs/diseasemanagement/neurology/multiple_sclerosis/

⁸ May Clinic (n.d.). Dysphagia. Retrieved from <http://www.mayoclinic.org/diseases-conditions/dysphagia/basics/definition/con20033444>

⁹ American Speech-Language-Hearing Association (n.d.). Adult dysphagia. Retrieved from http://www.asha.org/PRPSpecificTopic.aspx?folderid=8589942550§ion=Incidence_and_Prevalence

¹⁰ American Speech-Language-Hearing Association (n.d.). Pediatric dysphagia. Retrieved from <http://www.asha.org/Practice-Portal/Clinical-Topics/Pediatric-Dysphagia/>

¹¹ Goyal, R., Shaker, R. (2006). Neurological disorders affecting oral, pharyngeal swallowing. Retrieved from <http://www.nature.com/gimo/contents/pt1/full/gimo34.html>

severity of dysphagia, various treatments can provide relief. One such treatment is exercising certain swallowing muscles to trigger the swallowing reflex.

Hospital Data

- In 2018, Adventist HealthCare Rehabilitation Hospital served 144 patients with neurological rehabilitation. The average age for the patients was 61 years and they were majority female (Figure 7).
- The majority of the neurological rehabilitation patients were White (Figure 8).

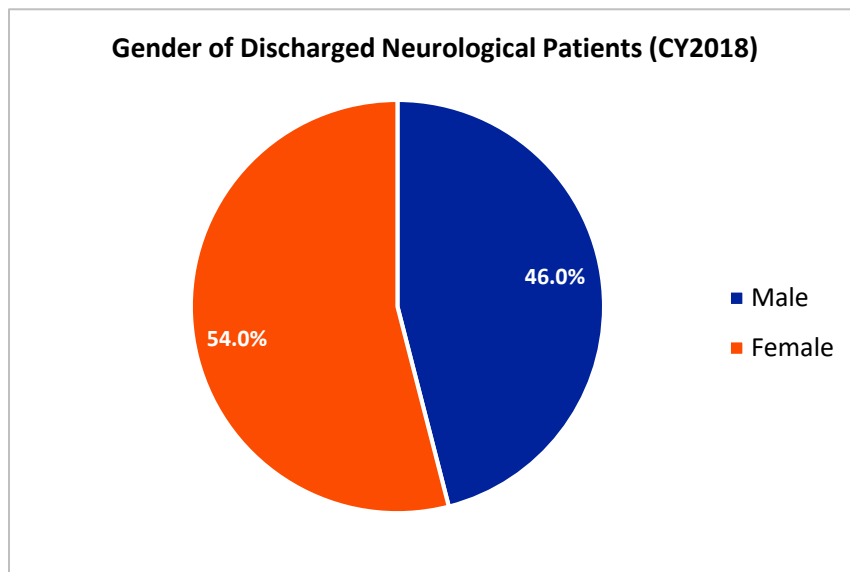


Figure 7. Gender of Discharged Neurological Patients, CY2018
(Source: Adventist HealthCare Rehabilitation Hospital, 2019)

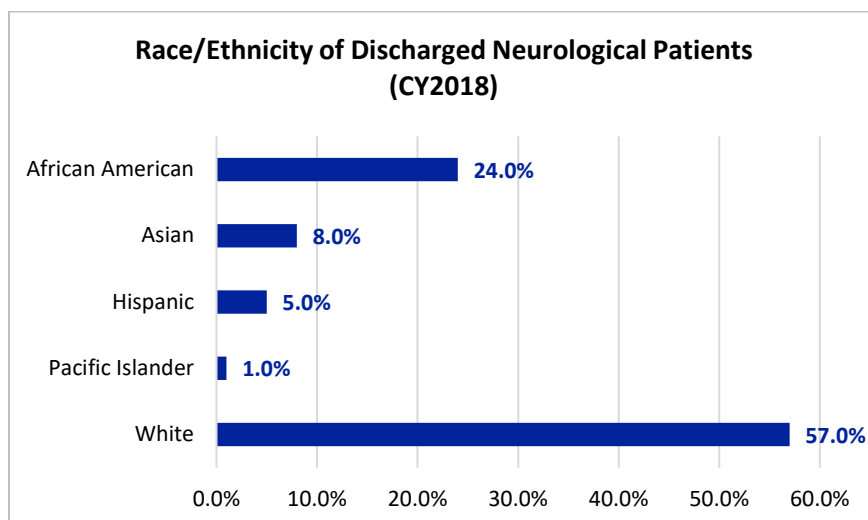


Figure 8. Race/Ethnicity of Discharged Neurological Patients, CY2018
(Source: Adventist HealthCare Rehabilitation Hospital, 2019)

General/Medical Rehabilitation

- In its general/medical rehabilitation program, Adventist HealthCare Rehabilitation Hospital served 357 patients with an average age of 73 years. The majority of the patients were male (Figure 9) and White (Figure 10).

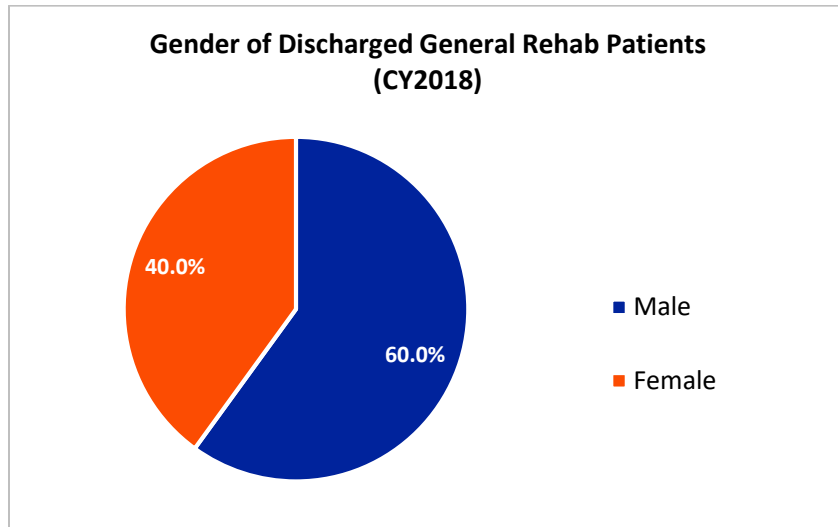


Figure 9. Gender of Discharged General Rehab Patients, CY2018
(Source: Adventist HealthCare Rehabilitation Hospital, 2019)

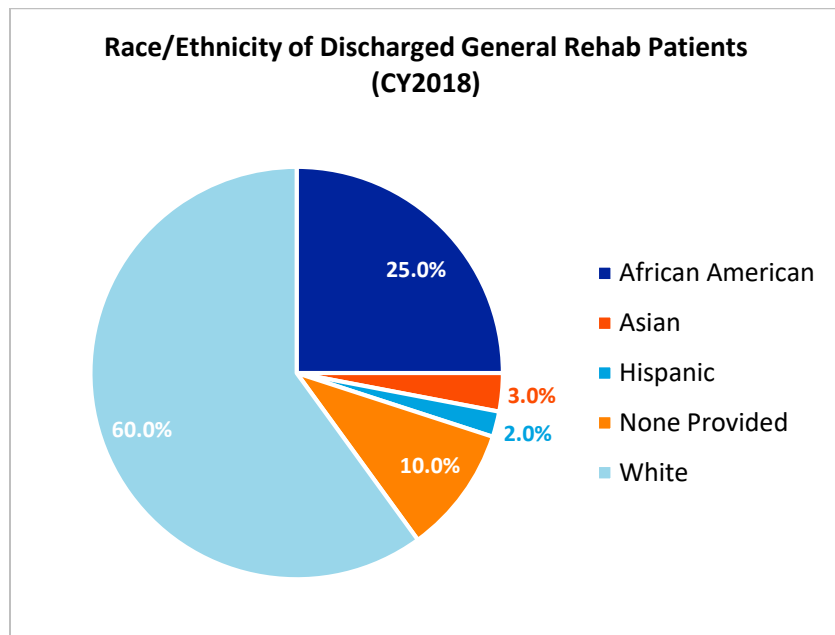


Figure 10. Race/Ethnicity of Discharged General Rehab Patients, CY2018
(Source: Adventist HealthCare Rehabilitation Hospital, 2019)

Community Resources

Adventist HealthCare Rehabilitation Hospital provides several therapies, treatment, and support services for those who require general physical rehabilitation services. Adventist HealthCare Rehabilitation Hospital and other local services in the Montgomery County and Prince George's County areas include:

1. ADVENTIST HEALTHCARE - REHABILITATION SERVICES

For free support groups and available community resources call or visit:

Phone: 1-800-542-5096

Website: [Adventist HealthCare Classes & Events](https://www.adventisthealthcare.com/Classes-Events)

2. MIRACLE 4 MELANIE

Is to honor our injured service men and women, wounded during OEF, OIF, and OND, by providing them with supplemental resources to aid in their day-to-day recovery and improve their daily morale.

Website: <http://miracle4melanie.org/>

3. AMPUTEE COALITION

Website: <https://www.amputee-coalition.org/>

4. DISABILITY PARTNERSHIPS

Website: <http://www.disabilitypartnerships.org/>

5. AMERICAN SPEECH – LANGUAGE – HEARING ASSOCIATION

Aphasia Resources

Website: <https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589934663§ion=Resources>

Adult Dysphagia Resources

Website:

<https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589942550§ion=Resources>

6. AMERICAN PARKINSON DISEASE ASSOCIATION

Maryland Chapter

Address: 110 S Paca Street, 3rd Floor, Baltimore, MD 21201

Phone: 410-328-3333

Website:

<https://www.apdaparkinson.org/community/maryland/>

7. RIGHT AT HOME – PARKINSON'S DISEASE CARE

Address: 11821 Parklawn Drive, Suite 302, Rockville, MD 20852

Phone: 301-255-0066

Website:

<https://www.rightathome.net/rockville-maryland/special-care-situations/parkinsons-disease>

8. COMFORT HOME CARE - PARKINSON'S DISEASE IN-HOME CARE

Address: 121 Congressional Lane, Suite 201 Rockville, MD 20852

Phone: 301-245-1941

Website:

<https://www.choosecomforthome.com/in-home-care/parkinsons-disease/>

9. NATIONAL MULTIPLE SCLEROSIS SOCIETY

Greater DC – Maryland

Address: 1800 M Street Northwest,
Suite B50 North, Washington, DC 20036

Phone: 202-296-5363

Website:

<https://www.nationalmssociety.org/Chapters/MDM>

10. FOOD & FRIENDS

Address: The William P. Bresler Building,
219 Riggs Road NE, Washington, DC
20011

Phone: 202-269-2277

Email: info@foodandfriends.org

Website: <https://foodandfriends.org/>

11. MONTGOMERY COUNTY STROKE ASSOCIATION

Phone: 301-681-6272

Email: info@mcstroke.org

Website: <https://www.mcstroke.org/>

12. STROKE COMEBACK CENTER

Phone: 301-605-7620

Email: info@strokecomebackcenter.org

Website:

<https://strokecomebackcenter.org/>

Section IV: Findings



Part B: Secondary Data

Chapter 2: Traumatic Brain Injury (TBI)



Traumatic Brain Injury

KEY FINDINGS

Disparities & Indicators	Trend Over Time
<ul style="list-style-type: none">In MD, most common cause of TBI related deaths is by firearm (279 deaths) followed by unintentional falls (278 deaths)In MD, the highest rate of TBI related ED visits were among ages 15-24 followed by ages 5-14NH-Whites were more likely (67%) to experience TBI at time of injury in 2017 in the Nation	<ul style="list-style-type: none"> MD TBI related deaths and hospitalizations decreased MD had an increasing trend of TBI related ED visits

Traumatic Brain Injury

Impact

According to the Centers for Disease Control and Prevention (CDC), a traumatic brain injury (TBI) is “a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head, or penetrating head injury.” It is one of the leading causes of death and disability in the United States. Traumatic brain injuries are categorized into mild, moderate, or severe. Brains are unique so everyone experiences brain injuries differently. Injuries can range from a brief change in mental status or consciousness to an extended period of unconsciousness or memory loss after the injury. Symptoms may include, but are not limited to: difficulty with memory, attention, learning, or coordination; headaches; fatigue; and sleep disturbances. Most TBIs are concussions, which fall into the mild category. Common sources of traumatic brain injury are falls, vehicle related collisions, violence (i.e. gunshot wounds, domestic violence, child abuse), sports injuries, and combat related injuries.^{1,2}

Prevalence

- The Traumatic Brain Injury Model Systems National Database, which tracks a sample of TBI patients in the United States, has found that males accounted for 73.6 percent of TBI cases as of June 2019 and the average age at the time of injury was 42.12 years (Figure 1).
- When stratified by race and ethnicity, the majority of TBI cases were among the White population (Figure 2).
- Half of the brain injuries in the database were caused by vehicular crashes, followed by falls, violent acts and other (Figure 3).³

¹ Centers for Disease Control and Prevention. (2019) <https://www.cdc.gov/traumaticbraininjury/index.html>

² Maryland Traumatic Brain Injury Advisory Board 2018 Annual Report. Retrieved from [https://bha.health.maryland.gov/Documents/2018%20TBI%20Advisory%20Board%20Annual%20Report%20\(1\).pdf](https://bha.health.maryland.gov/Documents/2018%20TBI%20Advisory%20Board%20Annual%20Report%20(1).pdf)

³ National Data and Statistical Center: Traumatic Brain Injury Model Systems (2019). *National Database: 2019 Profile of People within the Traumatic Brain Injury Model Systems*. Retrieved from <https://www.tbindsc.org/StaticFiles/Presentations/2019%20TBIMS%20National%20Database%20Update.pdf>

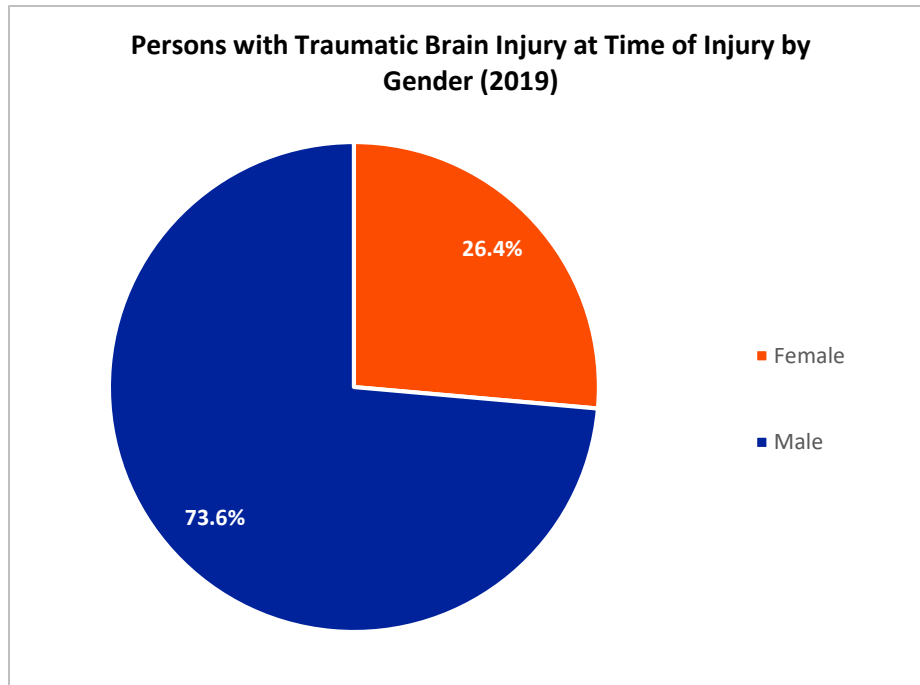


Figure 1. Persons with Traumatic Brain Injury at Time of Injury by Gender, 2019
 (Source: [National Database: 2019 Profile of People within the Traumatic Brain Injury Model Systems](#))

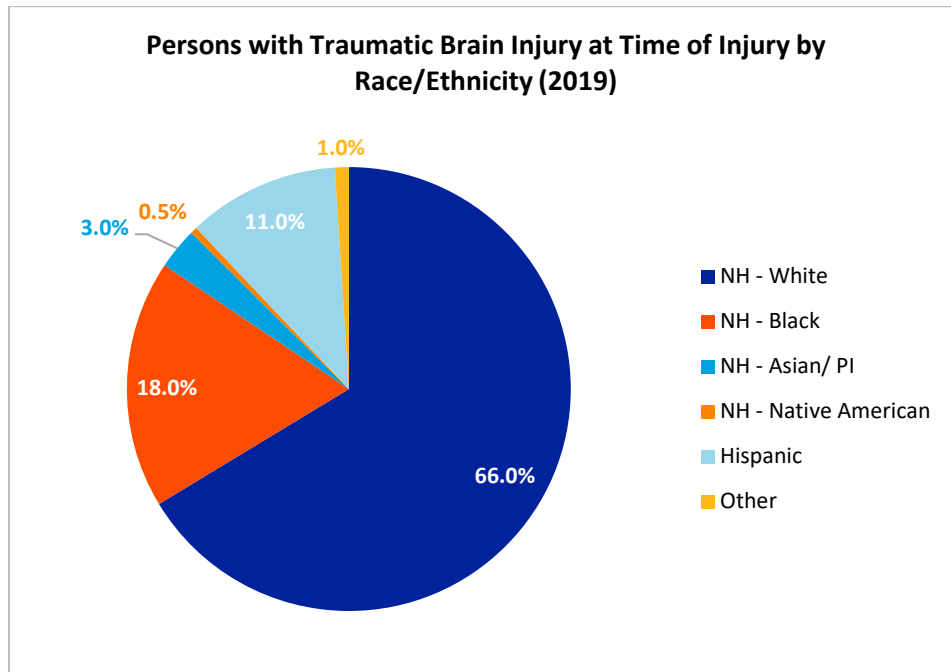


Figure 2. Persons with Traumatic Brain Injury at Time of Injury by Race/Ethnicity, 2019
 (Source: [National Database: 2019 Profile of People within the Traumatic Brain Injury Model Systems](#))

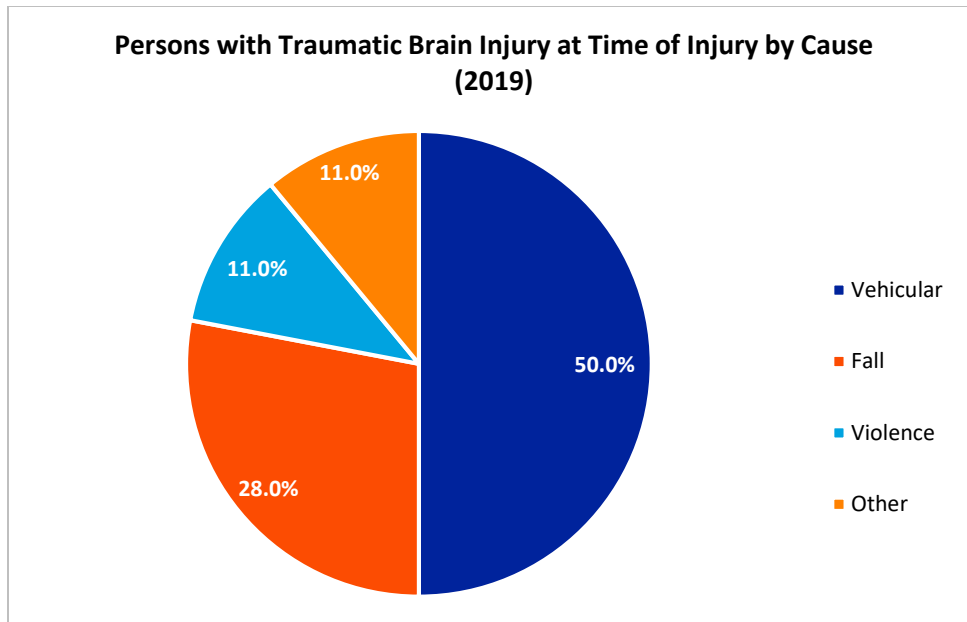


Figure 3. Persons with Traumatic Brain Injury at Time of Injury by Cause, 2019
 (Source: [National Database: 2019 Profile of People within the Traumatic Brain Injury Model Systems](#))

National Data

- Across the US, there has been an increase in emergency room visits and hospitalizations and a stabilization of deaths from 2011 – 2014 (Figure 4).

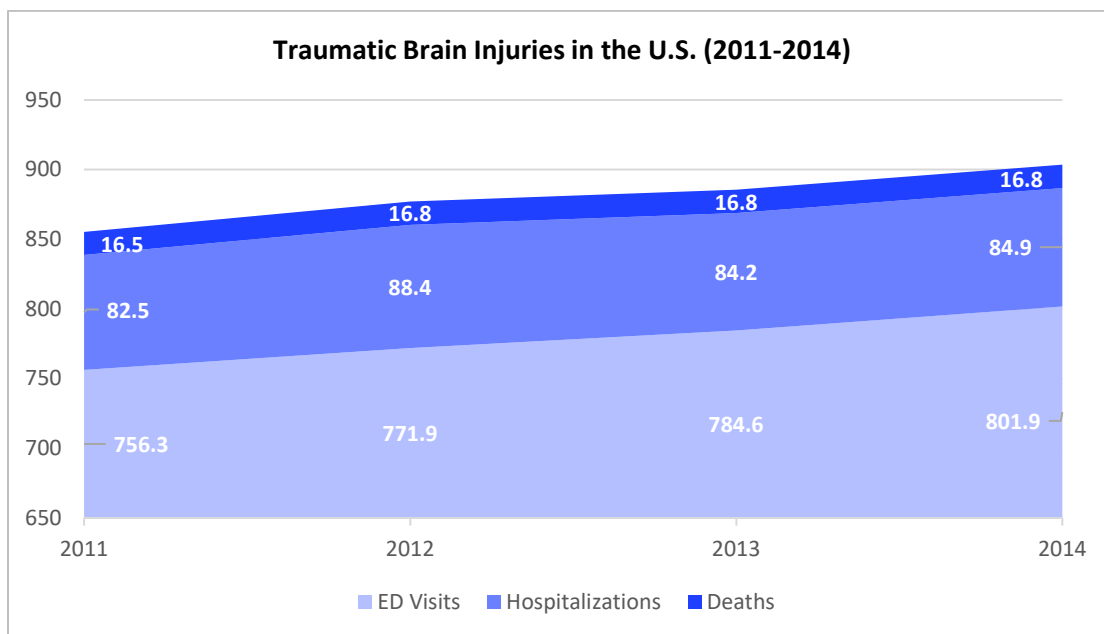


Figure 4. Traumatic Brain Injuries in the U.S., 2011-2014
 (Source: [Centers for Disease Control and Prevention, 2019](#))

State Data

- Between 2012 and 2015, there has been an overall decrease in TBI related deaths and hospitalizations and an increase in emergency department visits among Marylanders (Figure 5).
- In 2015, Seniors 65+ had the highest rates of TBI related deaths and hospitalizations.
- Residents aged 5 – 24 had the highest rate of TBI related ED visits.
- Unintentional falls are the leading cause of injury for TBI related deaths, ED visits, and hospitalizations.⁴

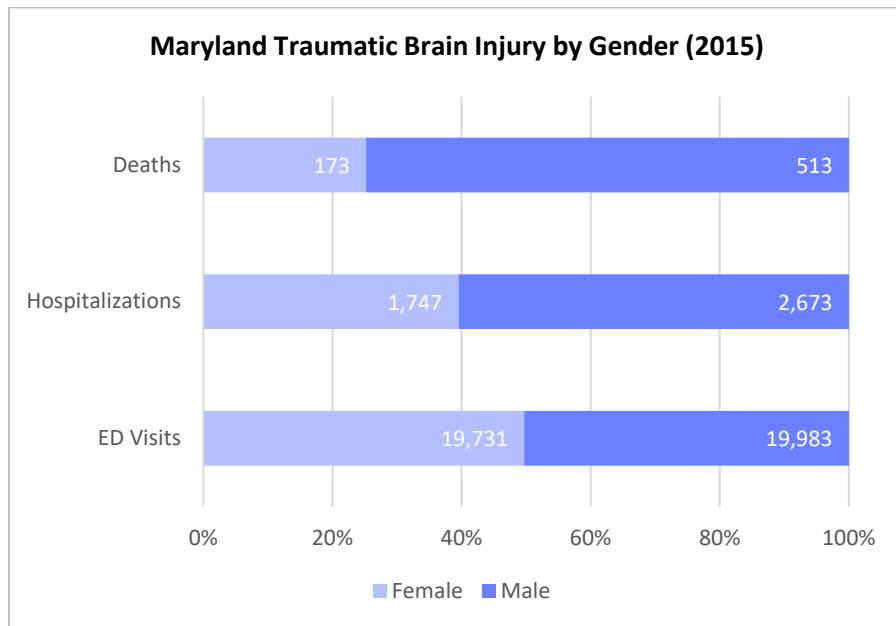


Figure 5. Maryland Traumatic Brain Injury by Gender, 2015
(Source: [Maryland Traumatic Brain Injury 2017 Annual Report](#))

⁴ Maryland Traumatic Brain Injury Advisory Board 2017 Annual Report. Retrieved from [https://bha.health.maryland.gov/Documents/2017%20-%20TBI%20Advisory%20Board%20Annual%20Report%20\(1\).pdf](https://bha.health.maryland.gov/Documents/2017%20-%20TBI%20Advisory%20Board%20Annual%20Report%20(1).pdf)

Hospital Data

- In 2018, AHC Rehabilitation served 98 TBI and 126 non-TBI patients. For both categories, males (Figure 6) and the White population (Figure 7) were the majority.
- For TBI, the average age was 70 and 65 for non-TBI (Figure 8).

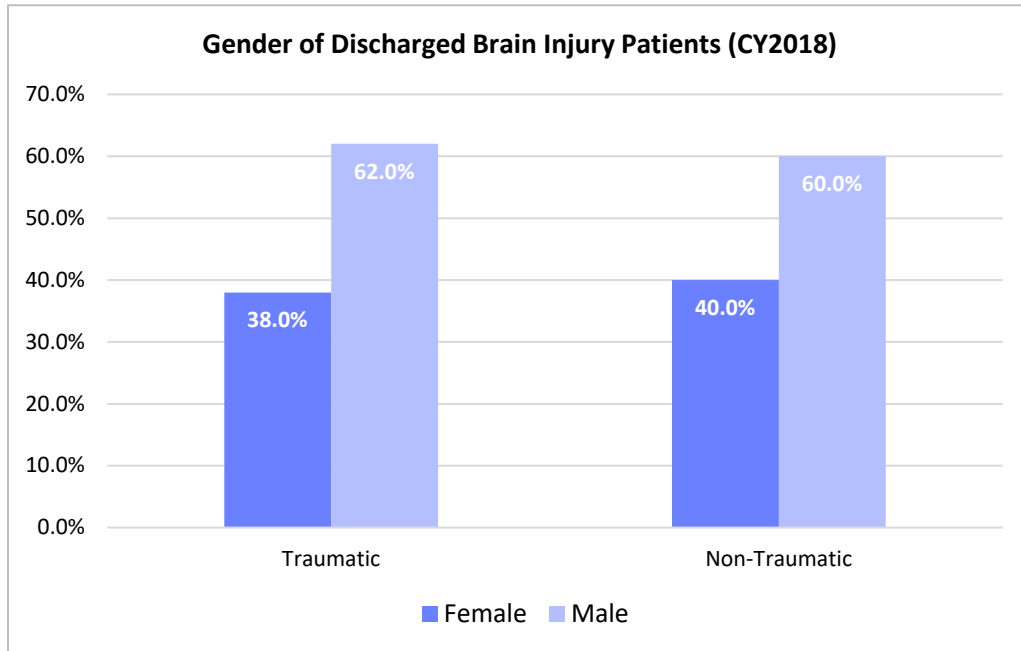


Figure 6. Gender of Discharged Brain Injury Patients, CY2018
(Source: Adventist HealthCare Rehabilitation Hospital, 2019)

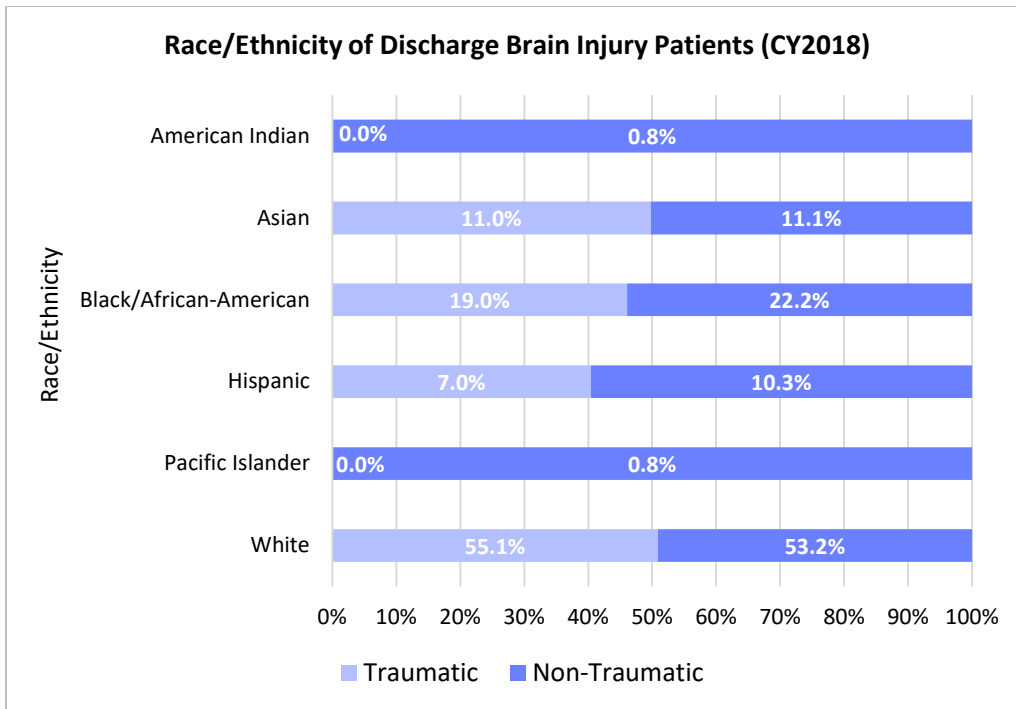


Figure 7. Race/Ethnicity of Discharged Brain Injury Patients, CY2018
 (Source: Adventist HealthCare Rehabilitation Hospital, 2019)

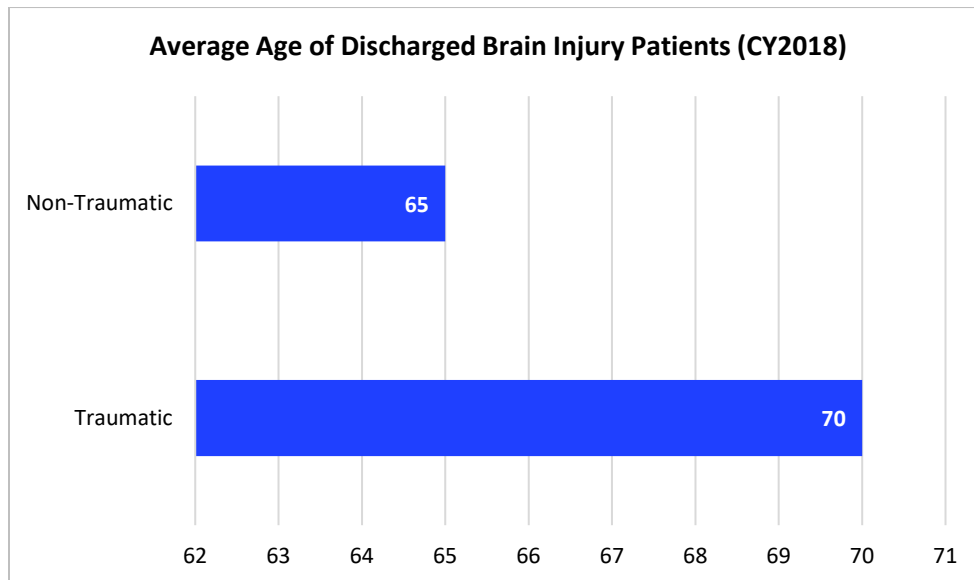


Figure 8. Average Age of Discharged Brain Injury Patients, CY2018
 (Source: Adventist HealthCare Rehabilitation Hospital, 2019)

Spotlight on Concussion

A concussion is a mild traumatic brain injury that affects your brain function. Concussion symptoms include, but are not limited to, headaches, nausea or vomiting, dizziness, balance problems, blurred vision, trouble thinking, and abnormal sleep patterns.⁵ Adventist HealthCare Rehabilitation Hospital offers a comprehensive concussion program where patients are evaluated and treated from a multidisciplinary perspective. Examples of physical therapy offered to patients with concussion are:

- Balance retraining
- Hand-eye coordination testing and training
- Sport-specific training
- Vestibular rehabilitation to relieve dizziness

Adventist HealthCare Rehabilitation Hospital works with Montgomery County Public Schools to offer baseline testing for high school student-athletes. The baseline testing measures the students' thinking skills, problem-solving skills, memorization skills, and ability to concentrate on tasks. If the student suffers from head trauma, the student is tested again to determine the impact of the head injury. These baseline tests are offered at various locations throughout the county.⁶

⁵ Mayo Clinic. (2019). Concussion. Diseases and Conditions. Retrieved from <https://www.mayoclinic.org/diseases-conditions/concussion/symptoms-causes/syc-20355594>

⁶ Adventist HealthCare (2019). Sports Injury Rehabilitation. Retrieved from <https://www.adventisthealthcare.com/services/rehabilitation/sports-injury/>

Community Resources

Adventist HealthCare Rehabilitation Hospital provides treatment and support for those who suffer from a traumatic brain injury. Adventist HealthCare Rehabilitation Hospital and other local services in the Montgomery and Prince George's County area include:

1. ADVENTIST HEALTHCARE - REHABILITATION SERVICES

For free support groups and available community resources call or visit:

Phone: 1-800-542-5096

Website: [Adventist HealthCare Classes & Events](#)

2. MIRACLE 4 MELANIE

Is to honor our injured service men and women, wounded during OEF, OIF, and OND, by providing them with supplemental resources to aid in their day-to-day recovery and improve their daily morale.

Website: <http://miracle4melanie.org/>

3. BRAIN INJURY ASSOCIATION OF MARYLAND

Phone: 1-800-221-6443

Washington DC Area Resources

Website:

<https://www.biamd.org/montgomerypg-dc-area.html>

4. HEAD INJURY REHABILITATION & REFERRAL SERVICES

Address: 11 Taft Court, Suite 100, Rockville, MD 20850

Phone: 301-309-2228

Email: tbi@headinjuryrehab.org

Website:

<http://www.headinjuryrehab.org/>

5. BRAIN INJURY ASSOCIATION OF WASHINGTON, D.C.

Address: 1232 Seventeenth Street, NW, Washington, DC 20036

Phone: 202-659-0122

Email: info@biadc.org

Website: <http://www.biadc.org/>

Support Group

Address: National Rehabilitation Hospital, 102 Irving St, NW Washington, DC.

Email: ellenwramsay@verizon.net

6. THE JOHN "JACK" GODFREY TRAUMATIC BRAIN INJURY SUPPORT GROUP

Address: 2900 Mercy Lane, Cheverly, MD 20785 (On the Campus of UM Prince George's Hospital Center)

Phone: 301-618-2160

Website:

<https://www.umms.org/capital/health-services/trauma/john-jack-godfrey-traumatic-brain-injury-support-group>

7. INNOVATIVE SPEECH THERAPY

Address: One Research Court, Suite 450, Rockville, MD 20850

Phone: 301-602-2899

Email: joan@innovativespeech.com

Website:

<https://innovativespeech.com/>

8. RIGHT AT HOME – TRAUMATIC BRAIN INJURY

Address: 11821 Parklawn Drive, Suite 302, Rockville, MD 20852

Phone: 301-255-0066

Website:

<https://www.rightathome.net/rockville-maryland/special-care-situations/traumatic-brain-injury>

9. MONTGOMERY COUNTY PUBLIC SCHOOLS – CONCUSSIONS, BASELINE TESTING, AND SUDDEN CARDIAC ARREST

Phone: 240-740-3000

Spanish Hotline: 240-740-2845

Email: ASKMCPS@mcpsmd.org

Website:

<https://www.montgomeryschoolsmd.org/departments/athletics/health/concussions.aspx>

10. PRINCE GEORGE’S COUNTY PUBLIC SCHOOLS – CONCUSSION – BASELINE TESTING – SUDDEN CARDIAC ARREST

Phone: 301-952-6000

Website:

<https://www1.pgcps.org/page.aspx?Pageid=234147&id=245500>

Section IV: Findings

Part B: Secondary Data

Chapter 3: Spinal Cord Injury



Spinal Cord Injury

KEY FINDINGS

Disparities & Indicators

- As age at injury increases, life expectancy decreases across all spinal injuries
- **The most common cause of SCI** is **vehicular** (38.3%) followed by **falls** (31.6%) since 2015
- About 78% of **new SCI cases** are **males**
- Since 2015, **NH-Whites** have been more likely (60.6%) to experience spinal cord injuries

Community Perception

“Parks should be upgraded and be accessible for all ages and physical abilities”

Spinal Cord Injury

Impact

A spinal cord injury (SCI) is damage to any part of the spinal cord or nerves at the end of the spinal canal.¹ SCIs often cause permanent changes in strength, sensation, and other body functions below the site of injury. Injuries to the spinal cord usually do not sever it. The injury is more likely to cause fractures and compression of the vertebrae, which results in destruction of axons. A few, many, or almost all axons can be damaged. Some SCIs are treatable and will lead to complete recovery, while others lead to complete or incomplete paralysis.²

Prevalence

- According to the National Spinal Cord Injury Statistical Center, since 2015 there have been approximately 17,700 new SCI cases annually.
- Vehicular crashes remain the leading cause of SCIs followed by falls and violence (Figure 1). Younger individuals are the dominate group for vehicular crashes; people over 65 for falls.³
- The majority of SCI patients are white (Figure 2).
- The average age at the time of SCI injury is 43 years; males account for about 78.0 percent of new SCI cases.⁴

¹ Mayo Clinic (2019). Spinal cord injury. Retrieved from <https://www.mayoclinic.org/diseases-conditions/spinal-cord-injury/symptoms-causes/syc-20377890>

² National Institute of Neurological Disorders and Stroke (2019). Spinal Cord Injury Information Page. Retrieved from <https://www.ninds.nih.gov/Disorders/All-Disorders/Spinal-Cord-Injury-Information-Page>

³ American Association of Neurological Surgeons (2019). Spinal Cord Injury. Retrieved from <http://www.aans.org/patient%20information/conditions%20and%20treatments/spinal%20cord%20injury.aspx>

⁴ National Spinal Cord Injury Statistical Center (2018). Spinal Cord Injury Facts and Figures at a Glance. Retrieved from <https://www.nscisc.uab.edu/Public/Facts%20and%20Figures%20-%202018.pdf>

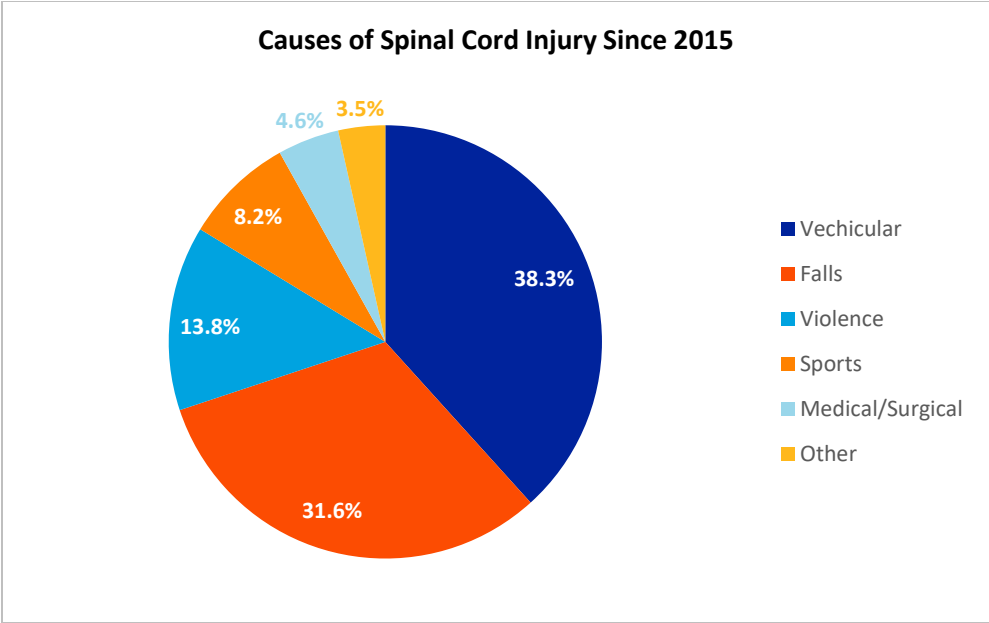


Figure 1. Causes of Spinal Cord Injury Since 2015
 (Source: [National Spinal Cord Injury Statistical Center](#), 2018)

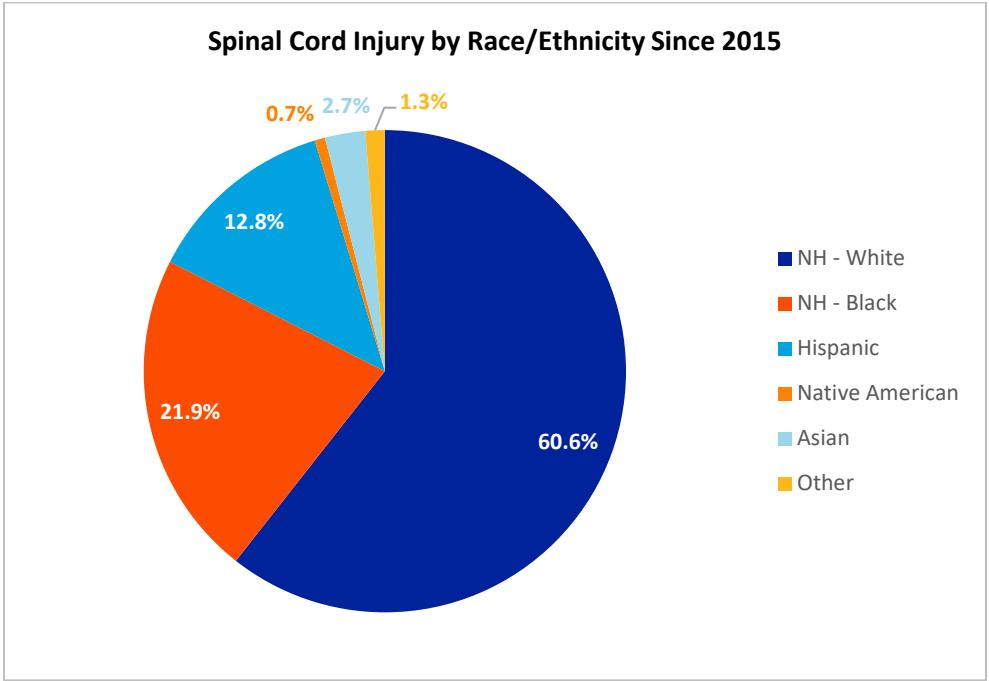


Figure 2. Spinal Cord Injury by Race/Ethnicity Since 2015
 (Source: [National Spinal Cord Injury Statistical Center](#), 2018)

There are three types of spinal cord injury: complete, incomplete, and penetrating.

- A complete SCI results in the patient not having any function on either side of the body below the level of injury; almost half of all SCI cases fall under this category.
- An incomplete SCI is when there is some function in the body below the location of injury.
- A penetrating SCI refers to open injuries to the spine that require the patient to be immobilized for a certain period of time until the fractured areas of the spine heal (for example, gunshots wounds to the back).⁵

Paralysis from a SCI may be classified as tetraplegia or paraplegia.

- Tetraplegia, also known as quadriplegia, means all four limbs and torso are affected.
- Paraplegia means the lower parts of the body and legs are affected.⁶
- Incomplete tetraplegia is the most common type of SCI since 2015 (Figure 3).

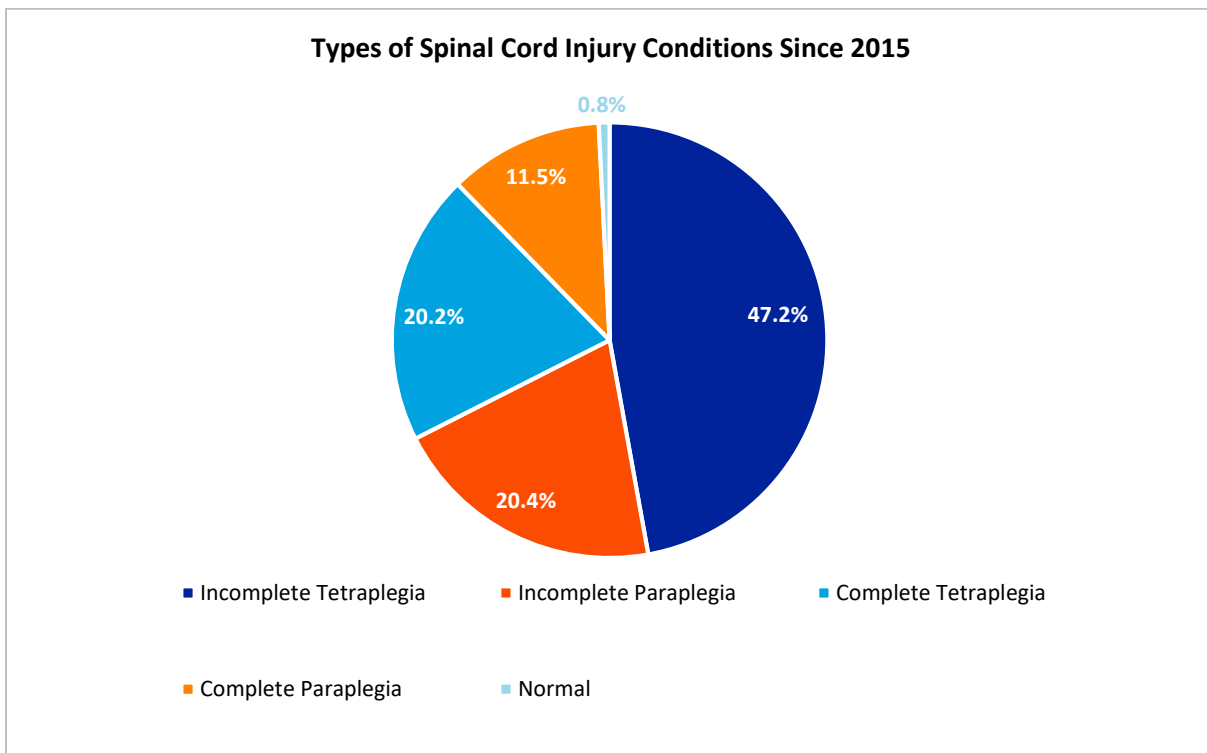


Figure 3. Types of Spinal Cord Injury Conditions Since 2015
(Source: [National Spinal Cord Injury Statistical Center](#), 2018)

⁵ American Association of Neurological Surgeons (2019). Spinal Cord Injury. Retrieved from <http://www.aans.org/patient%20information/conditions%20and%20treatments/spinal%20cord%20injury.aspx>

⁶ Mayo Clinic (2019). Spinal cord injury. Retrieved from <https://www.mayoclinic.org/diseases-conditions/spinal-cord-injury/symptoms-causes/syc-20377890>

There is a difference between life expectancy of the general population and those living with SCI. The life expectancy estimations for SCI populations are based on patients who survived the first 24 hours and at least one-year post-injury.

- Life expectancy for people living with SCI has not improved since the 1980s.
- Figures 4 and 5 below contrast life expectancy for the general population against the varying life expectancies for different SCI conditions based on age at injury.
- The risk of mortality is significantly higher during the first year after injury than the following years.⁷

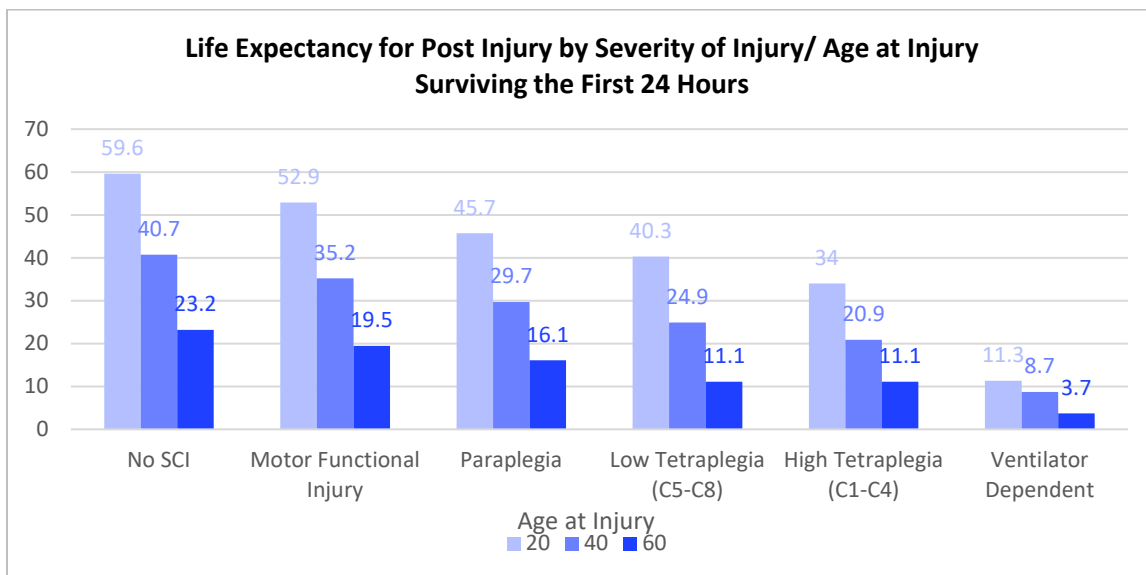


Figure 4. Life Expectancy for Post Injury by Severity of Injury/ Age at Injury Surviving the First 24 Hours (Source: [National Spinal Cord Injury Statistical Center](https://www.nscisc.uab.edu/Public/Facts%20and%20Figures%20-%202018.pdf), 2018)

⁷ National Spinal Cord Injury Statistical Center (2018). Spinal Cord Injury Facts and Figures at a Glance. Retrieved from <https://www.nscisc.uab.edu/Public/Facts%20and%20Figures%20-%202018.pdf>

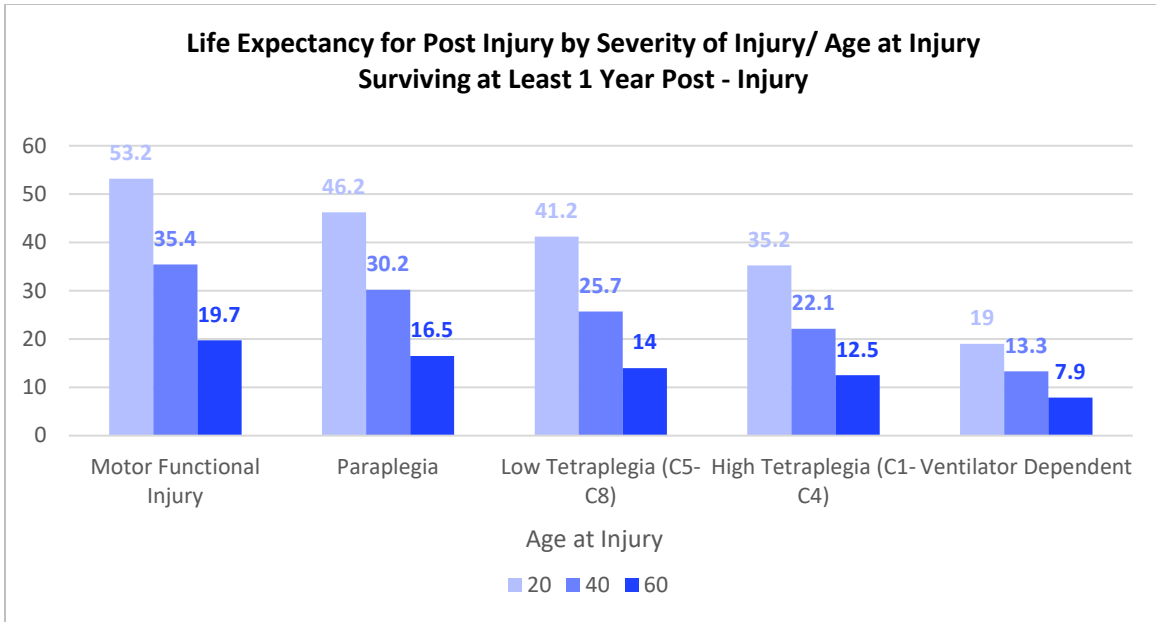


Figure 5. Life Expectancy for Post Injury by Severity of Injury/ Age at Injury Surviving at Least 1 Year Post-injury

(Source: [National Spinal Cord Injury Statistical Center](#), 2018)

Hospital Data

- In 2018, Adventist HealthCare Rehabilitation Hospital served a total of 214 spinal cord injury patients: 35 traumatic and 179 non-traumatic with an average age of 70 and 68 years, respectively.
- The majority of the patients were male (Figure 6).
- Whites made up the majority of both the traumatic and non-traumatic SCI patients (Figure 7).

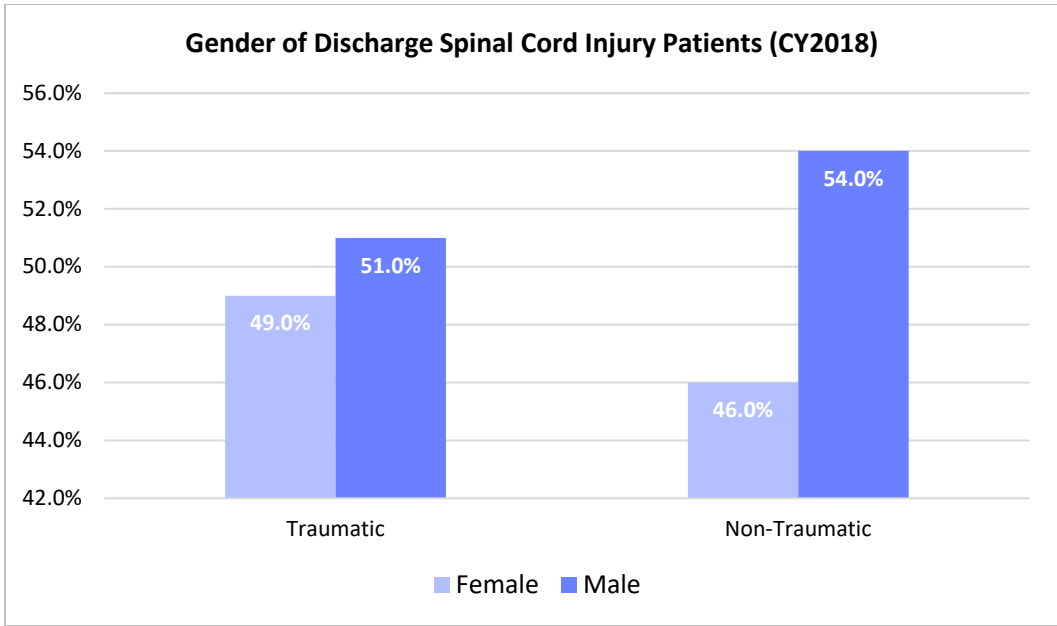


Figure 6. Gender of Discharged Brain Injury Patients, CY2018
(Source: Adventist HealthCare Rehabilitation Hospital, 2019)

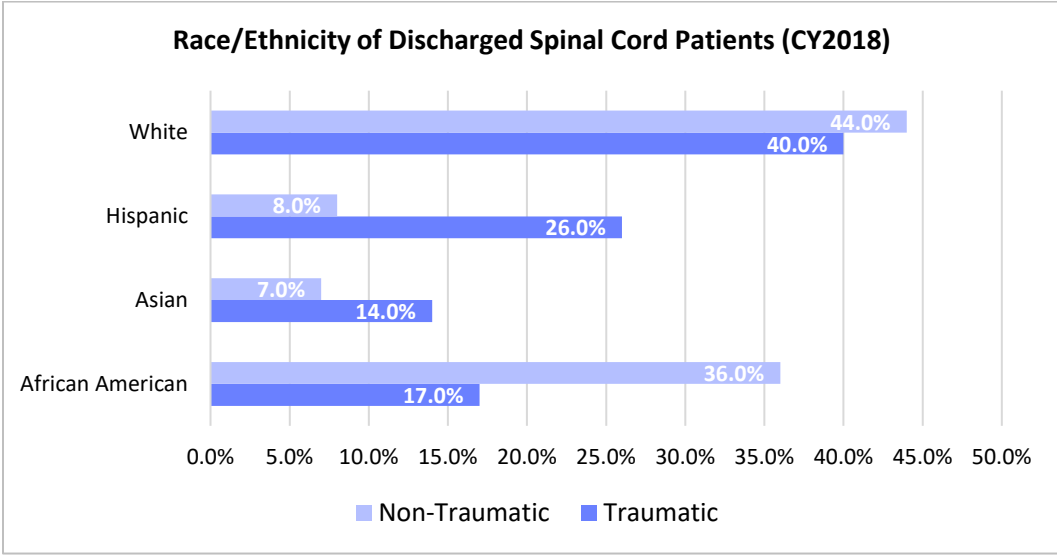


Figure 7. Gender of Discharged Brain Injury Patients, CY2018
(Source: Adventist HealthCare Rehabilitation Hospital, 2019)

Community Resources

Adventist HealthCare Rehabilitation Hospital provides several therapies, treatment, and support services for those who suffer from spinal cord injuries. Adventist HealthCare Rehabilitation Hospital and other local services in the Montgomery County and Prince George's County areas include:

1. ADVENTIST HEALTHCARE - REHABILITATION SERVICES

For free support groups and available community resources call or visit:

Phone: 1-800-542-5096

Website: [Adventist HealthCare Classes & Events](http://www.adventisthealthcare.com/classes-and-events)

2. AMPUTEE COALITION

Website: <https://www.amputee-coalition.org/>

3. DISABILITY PARTNERSHIPS

Website: <http://www.disabilitypartnerships.org/>

4. MIRACLE 4 MELANIE

Is to honor our injured service men and women, wounded during OEF, OIF, and OND, by providing them with supplemental resources to aid in their day-to-day recovery and improve their daily morale.

Website: <http://miracle4melanie.org/>

5. INDEPENDENCE NOW

Montgomery County Office

Address: 12301 Old Columbia Pike, Suite 101, Silver Spring, MD 20904

Phone: 301-277-2839

Prince George's County Office

Address: 1300 Caraway Court, Suite 200, Largo, MD 20774

Email: info@innow.org

Website: <http://www.innow.org>

6. DETERMINED2HEAL

Phone: 703-795-5711

Email: determined2heal@aol.com

Website: <http://www.determined2heal.org/>

7. SPINAL CORD INJURY NETWORK

Address: 14 Wolf Drive, Silver Spring, MD 20904

Website: <http://www.spinalcordinjury.net/>

8. THE SPINAL CORD INJURY MODEL SYSTEM INFORMATION NETWORK

Website: <https://www.uab.edu/medicine/sci/>

9. FACINGDISABILITY.COM

Phone: 312-284-2525

Email: info@facingdisability.com

Website: <https://facingdisability.com/>

10. SUNRISE COMMUNITY – MARYLAND

Address: 4801 Forbes Blvd., Lanham, MD 20706

Phone: 301-459-0566

Email: maryland@sunrisegroup.org

Website: <https://sunrisegroup.org/locations/MD>

Section IV: Findings

Part B: Secondary Data

Chapter 4: Cancer

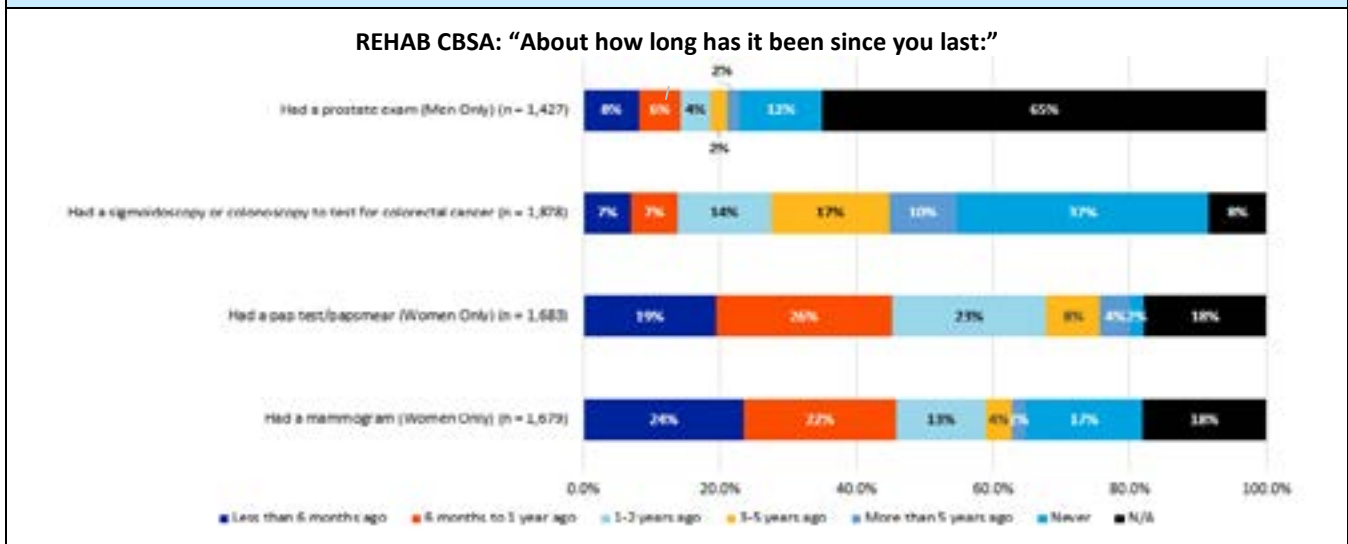
- 4.1: Breast Cancer
- 4.2: Lung Cancer
- 4.3: Colorectal Cancer
- 4.4: Prostate Cancer
- 4.5: Cervical Cancer
- 4.6: Skin Cancer
- 4.7: Oral Cancer
- 4.8: Thyroid Cancer

Cancer

KEY FINDINGS

Disparities & Indicators	Trend Over Time
<ul style="list-style-type: none"> In both counties, breast cancer screening rates are lowest among the Asian population (19% less screenings than Hispanics in MC and 7% less screenings than the Black population in PGC) Breast cancer mortality is 2X higher among the Black/AA population compared to Hispanics in PGC and almost 3X higher compared to Asian/PI in MC; Black/AA in both counties do not meet the HP 2020 target (20.7%); PGC overall does not meet the target Prostate incidence and mortality rates are significantly higher among Black/AA in MC and PGC, neither meets the HP 2020 mortality target (21.8); the PGC overall rate does not meet the HP 2020 target for prostate mortality In PGC, males do not meet the HP 2020 target (39.9) for colorectal cancer incidence; for colorectal cancer mortality, PGC Whites, Black/AA, males, and PGC overall do not meet the HP 2020 target (14.5) 	<ul style="list-style-type: none"> MC continues to have the lowest age-adjusted mortality rate due to cancer and meets the HP 2020 target (161.4) From 2008 – 2015, the age-adjusted mortality rate due to cancer decreased in MC and PGC The % of Medicare beneficiaries treated for cancer increased in PGC from 2014 (8.2%) to 2015 (8.4%) From 2012 – 2016, breast cancer screening rates for women 50+ decreased by 17% in MC and 25% in PGC

Community Perception¹



¹ Adventist HealthCare (2019). Community Health Needs Assessment Primary Data Survey.

Cancer

Impact

Cancer is among the leading causes of death worldwide. In 2018, it was estimated that 1.7 million new cases of cancer would be diagnosed in the United States and over 600,000 people would die from the disease². Cancer outcomes vary by different populations such as race/ethnicity, age, sex, socioeconomic status, health insurance status (uninsured/underinsured), and geographic area of residence. Preventable cancer deaths occur in individuals who do not receive effective cancer prevention, screening and treatment which is often time-sensitive³. The most significant cost of cancer is cancer treatment which has an estimated direct medical cost of \$80.2 billion dollars in the United States⁴. In Montgomery and Prince George's County Maryland, cancer mortality differs based on demographic groups (race/ethnicity, age, sex, etc.). In both counties, the groups most disproportionately affected by cancer include Black/African-American, White, males, and individuals over 85 years old⁵. By addressing the multifaceted barriers to healthcare, we can lessen the deaths due to cancer.

Cancer at the State Level

- From 2011 to 2015, the largest decreases in incidence were seen in prostate, brain & other nervous system (ONS), and leukemia, while the largest increases in incidence were seen in melanoma of the skin, bladder, uterus, and liver & bile duct cancers (Figure 1).

² National Cancer Institute (2018). Cancer Statistics. Retrieved from <https://www.cancer.gov/about-cancer/understanding/statistics>

³ Yabroff, K. R., Gansler, T., Wender, R. C., Cullen, K. J. and Brawley, O. W. (2019), Minimizing the burden of cancer in the United States: Goals for a high-performing health care system. *CA A Cancer J Clin*, 69: 166-183. doi:10.3322/caac.21556

⁴ American Cancer Society (2018). Economic Impact of Cancer. Retrieved from <https://www.cancer.org/cancer/cancer-basics/economic-impact-of-cancer.html>

⁵ LiveStories Statistics (2019). Montgomery County and Prince George's County cancer death statistics. Retrieved from <https://www.livestories.com/statistics/maryland/montgomery-county-cancer-deaths-mortality>

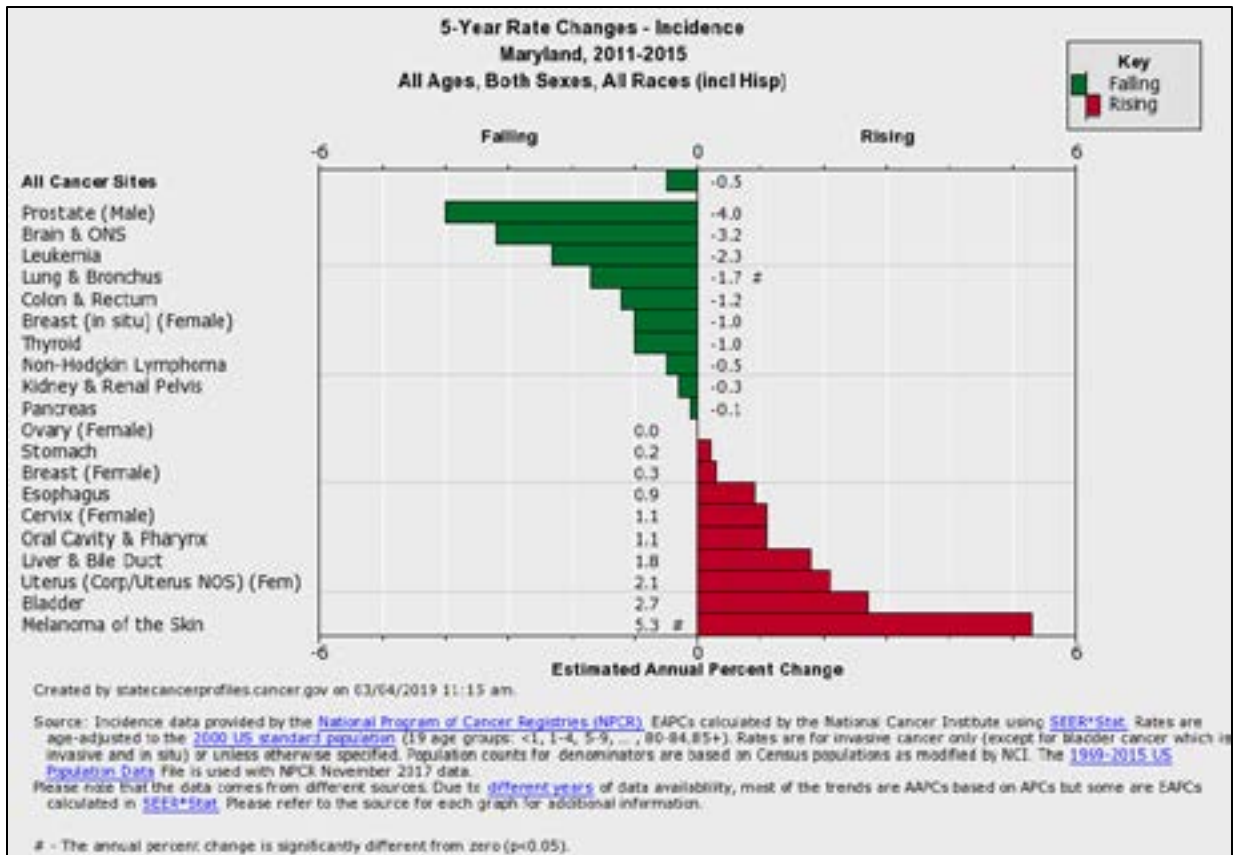


Figure 1. 5-year Rate Changes – Incidence Maryland, 2011 – 2015 All Ages, Both Sexes, All Races
(Source: [State Cancer Profiles](#), 2015)

- From 2011 to 2015, the state mortality rates for melanoma of the skin, colorectal, and lung cancers showed the greatest decreases (Figure 2).
- Mortality rates increased for thyroid, liver & bile duct, and uterine cancers in Maryland from 2011 to 2015 (Figure 2).

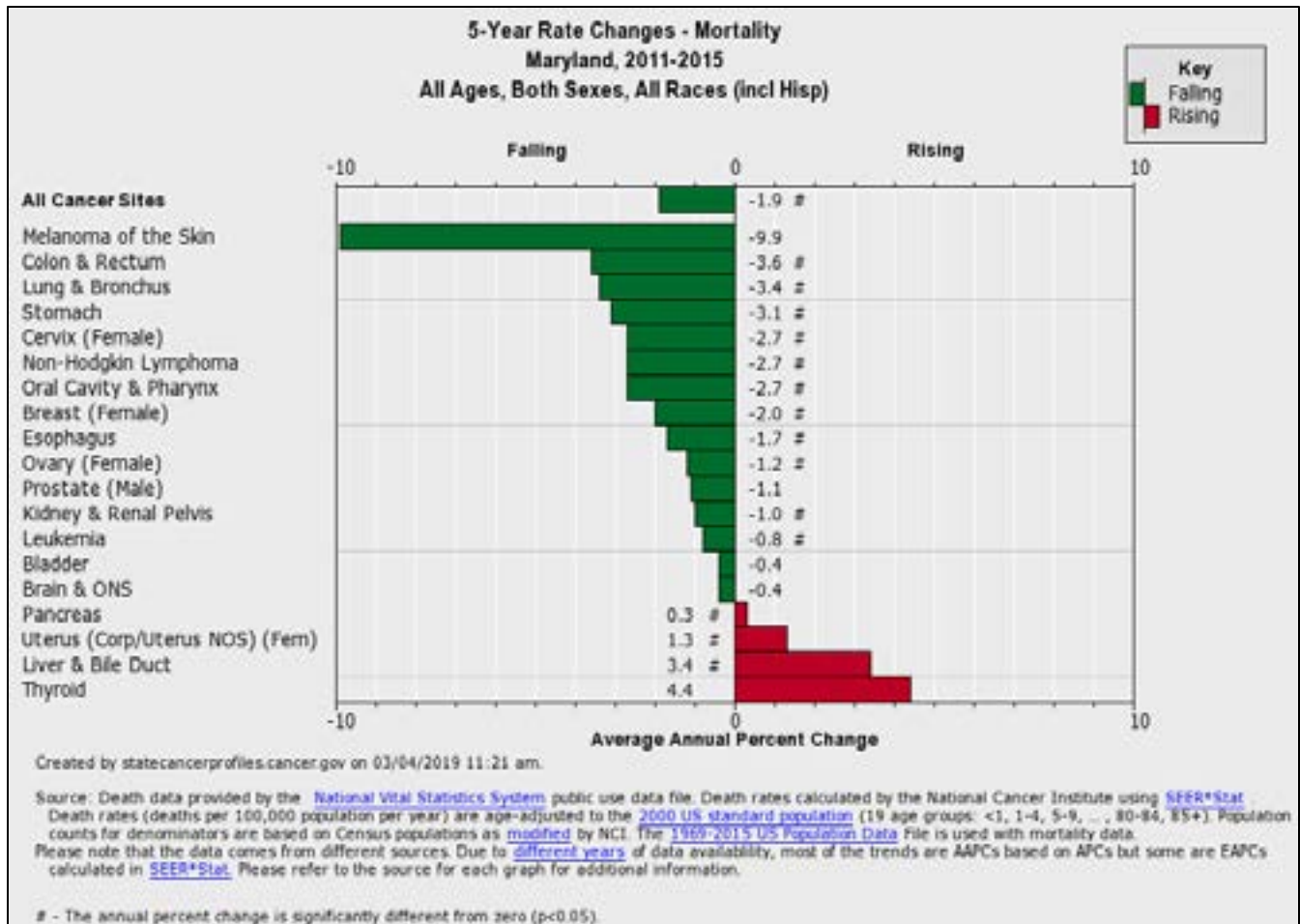


Figure 2. 5-Year Changes – Mortality Maryland, 2011 – 2015 All Ages, Both Sexes, All Races
 (Source: [State Cancer Profiles](#), 2015)

- From 2012 to 2016, Maryland’s invasive cancer specific incidence rates (per 100,000) were lower than the national rate for the following cancers: lung and bronchus, colon and rectum, Non-Hodgkin lymphoma, kidney and renal pelvis (Table 1).
- The rates were similar for urinary and bladder, corpus and uterus, NOS, and thyroid cancers (Table 1).
- When compared to the nation, Maryland had higher rates of cancer for female breast, prostate, and melanomas of the skin (Table 1).

Age-Adjusted Invasive Cancer Incidence Rates for the 10 Primary Sites with the Highest Rates within State- and Sex-Specific Categories

State vs. National Rates: 2012-2016, Male and Female, Maryland *†			
Rates per 100,000 ‡			
	Site	State	U.S.
1	Female Breast	131.5	125.2
2	Prostate	122.1	104.1
3	Lung and Bronchus	56.4	59.2
4	Colon and Rectum	36.4	38.7
5	Corpus and Uterus, NOS	27.5	26.6
6	Melanomas of the Skin	23	21.8
7	Urinary Bladder	20.9	20.1
8	Non-Hodgkin Lymphoma	17.4	19.2
9	Thyroid	15	14.5
10	Kidney and Renal Pelvis	14.9	16.6

Notes:
† Excludes basal and squamous cell carcinomas of the skin excluding occurrences on genital organs, and in situ cancers excluding urinary bladder
‡ Age-adjusted rates to the 2000 U.S. standard population (19 age groups – Census P25-1130). Rates are suppressed and not ranked if the stratified population is below 50,000 or with case counts under 16.

Table 1. Age-Adjusted Invasive Cancer Incidence Rates for the 10 Primary Rates for the 10 Primary Sites with the Highest Rates within State and Sex Specific Categories
(Source: [United States Cancer Statistics \(USCS\)](#), 2016)

- From 2012 to 2016, Maryland’s cancer specific mortality rates (per 100,000) for males and females were lower than the National rates for lung and bronchus, and Non-Hodgkin Lymphoma (Table 2).
- Rates were comparable between the state and U.S. for colon and rectum, ovary, and liver and intrahepatic bile duct (Table 2).
- Maryland had higher mortality rates than the U.S. for female breast, prostate, pancreas, and corpus and uterus, NOS (Table 2).

Age-Adjusted Cancer Mortality rates for the 10 Primary Sites with the Highest Rates within State- and Sex-Specific Categories

State vs. National Rates: 2012–2016, Male and Female , Maryland * * Rates per 100,000 †			
	Site	State	U.S.
1	Lung and Bronchus	40.3	41.9
2	Female Breast	22.1	20.6
3	Prostate	20.2	19.2
4	Colon and Rectum	14.1	14.2
5	Pancreas	11.5	11.0
6	Ovary	6.9	7.0
7	Liver and Intrahepatic Bile Duct	6.5	6.5
8	Leukemias	6.3	6.5
9	Corpus and Uterus, NOS	5.7	4.7
10	Non-Hodgkin Lymphoma	5.2	5.6

Notes:
 *Data are chosen from statewide and metropolitan area cancer registries that satisfy data quality requirements for all invasive cancer sites combined. Rates include approximately 99.0% of the U.S. population.
 † Excludes basal and squamous cell carcinomas of the skin excluding occurrences on genital organs, and in situ cancers excluding urinary bladder

Table 2. Age-Adjusted Cancer Mortality rates for the 10 Primary Sites with the Highest Rates within State and Sex Specific Categories

(Source: [United States Cancer Statistics \(USCS\)](#), 2016)

Cancer at the County Level

- Since 2008, Montgomery County has met the HP 2020 targets for age-adjusted mortality rates due to cancer (Figure 3).
- The age-adjusted mortality rate has decreased overall for Prince George’s County. However, they did not meet the HP 2020 target (Figure 3).
- Overall, Maryland has not met the HP 2020 target (Figure 3).

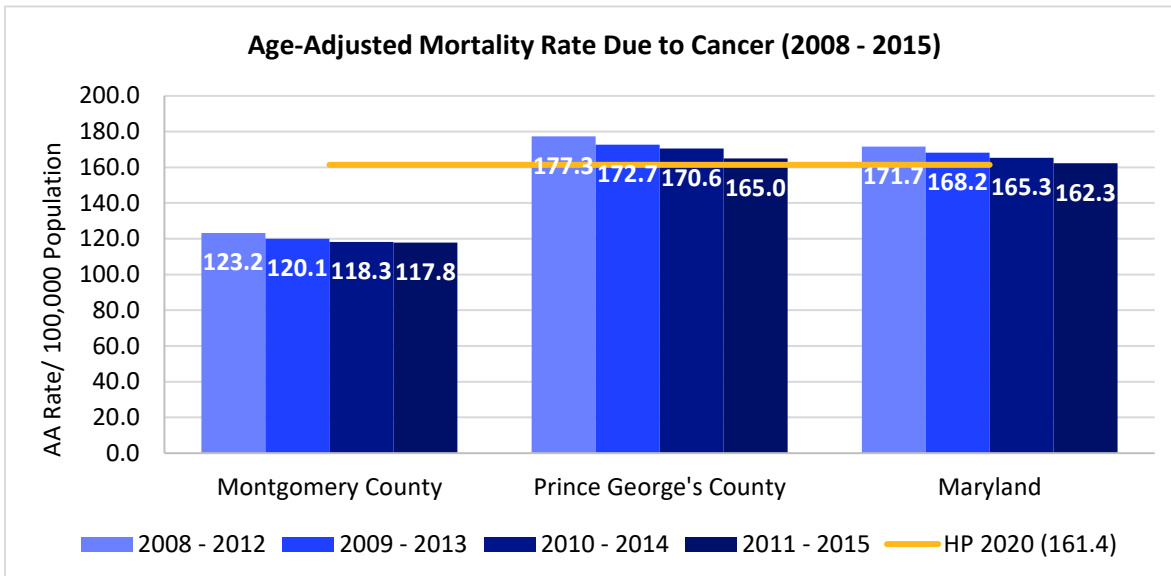


Figure 3. Age-Adjusted Mortality Rate due to Cancer in Montgomery County, Prince George’s County, and Maryland, 2008 – 2015
 (Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

- For both Montgomery and Prince George’s County, males had a higher age-adjusted mortality rate as compared to women. Overall, Prince George’s County has higher age-adjusted mortality rates (Figure 4).

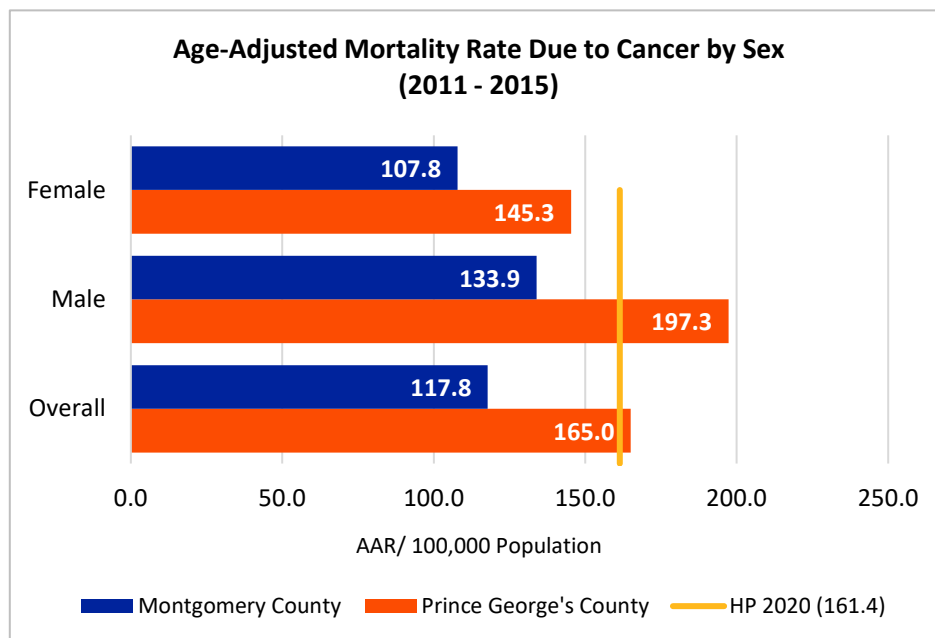


Figure 4. Age-Adjusted Mortality Rate due to Cancer by Sex in Montgomery County and Prince George’s County, 2011 – 2015
 (Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

- Mortality rates due to Cancer in Montgomery County were highest among Blacks, followed by Whites, Asian/Pacific Islander, and then Hispanic (Figure 5).
- In Prince George’s County, the highest mortality rates due to Cancer are attributed to Whites, followed by Blacks, Hispanic, and then Asian/Pacific Islander (Figure 6).

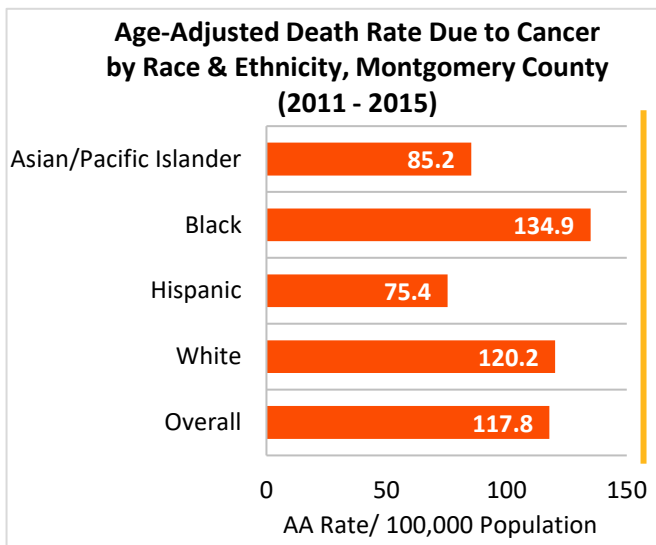


Figure 5. Age-Adjusted Mortality Rate due to Cancer by Race/Ethnicity in Montgomery County, 2011 – 2015
(Source: [Healthy Montgomery](#), 2018)

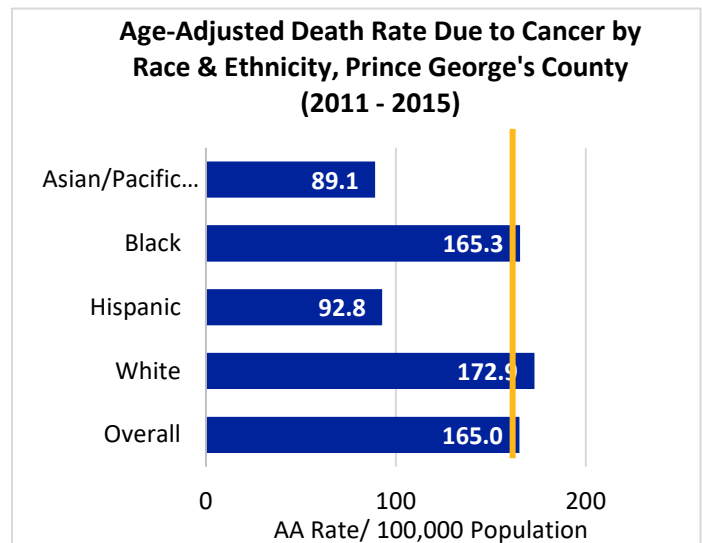


Figure 6. Age-Adjusted Mortality Rate due to Cancer by Race/Ethnicity in Prince George’s County, 2011 – 2015
(Source: [PGC Health Zone](#), 2018)

- Overall, the number of Medicare beneficiaries that were treated in Maryland decreased from 2013 to 2014, with a slight increase in 2015 (Figure 7).
- Prince George’s County had an increased trend of Medicare beneficiaries from 2014 to 2015 (Figure 7).
- When compared to Prince George’s County, Montgomery County demonstrated a decrease from 2013 to 2014. However, Montgomery County remained constant from 2014 to 2015 (Figure 7).

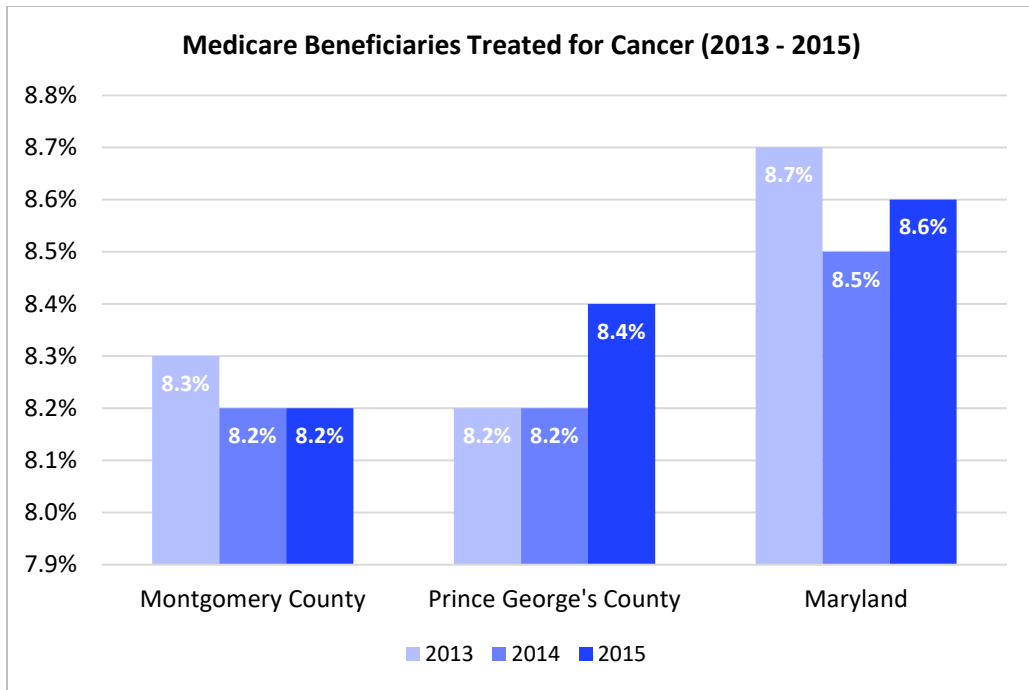


Figure 7. Percent of Medicare Beneficiaries that were Treated for Cancer in Montgomery County, Prince George’s County, and Maryland, 2013 – 2015
 (Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

4.1 Breast Cancer

Incidence

- From 2009 to 2015, Montgomery and Prince George’s County had an increased breast cancer incidence rate which was similar to Maryland overall (Figure 8).
- When compared to Montgomery County and Maryland, Prince George’s County has the lowest rates of breast cancer incidence (Figure 8).

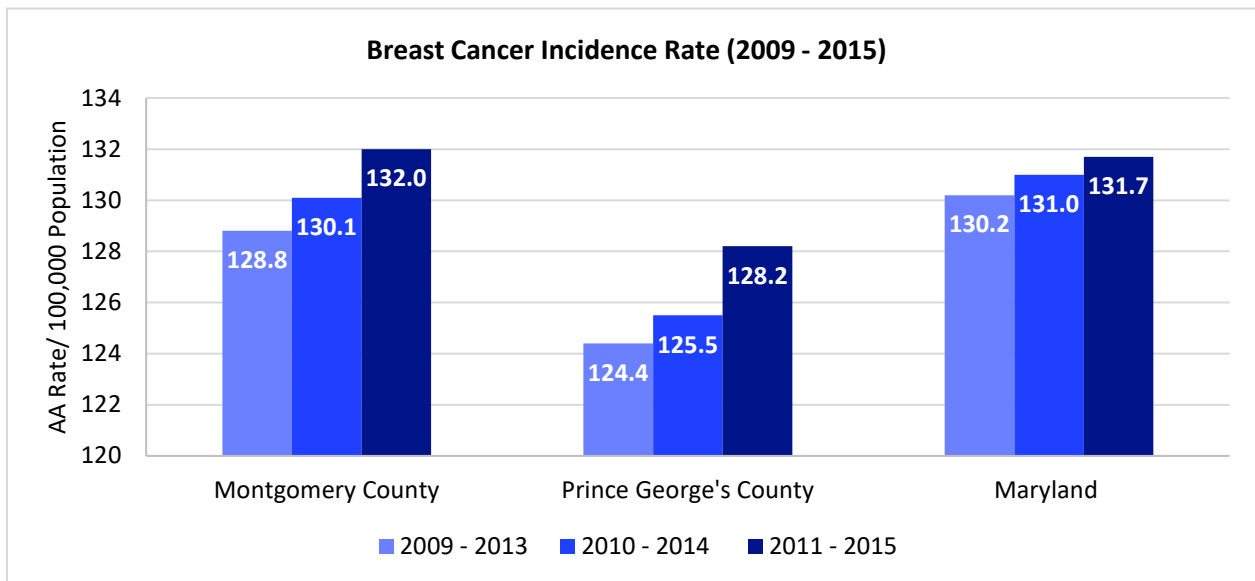


Figure 8. Age-Adjusted Incidence Rate for Breast Cancer in Montgomery County, Prince George’s County, and Maryland, 2009 – 2015

(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

- When comparing incidence rate by race/ethnicity and county, Montgomery County has a slightly higher overall breast cancer incidence rate than Prince George’s County (Figure 9).
- In Montgomery County, the population subgroup with the highest incidence rate for breast cancer is American Indian/Alaska Native (Figure 9).
- In Prince George’s County, the group with the highest incidence rate is Black individuals followed by White individuals (Figure 9).

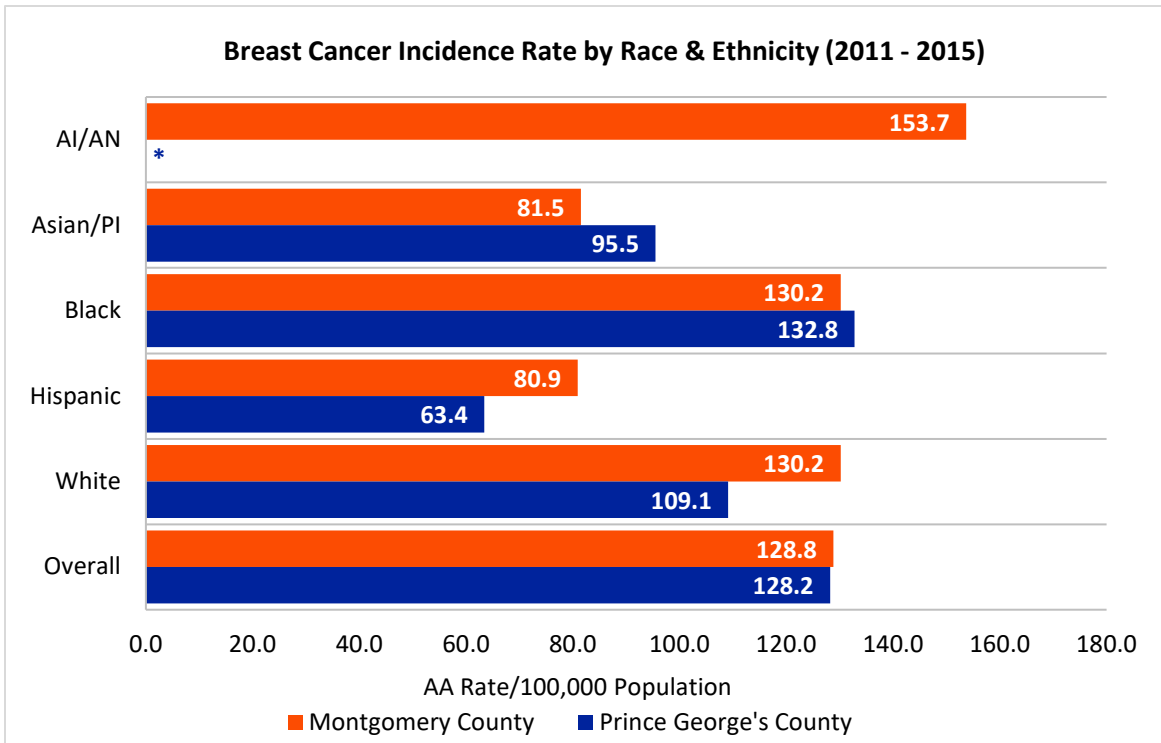


Figure 9. Age-Adjusted Incidence Rate for Breast Cancer by Race & Ethnicity in Montgomery & Prince George's County, 2011 – 2015

*Data not available/not applicable

(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

Screening

- Since 2012, the total percentage of women aged 50 and over who had their recommended mammogram in the past two years decreased by 20 percent in both counties (Figure 10).
- Both Montgomery County and Prince George's County had less breast cancer screenings than Maryland overall (Figure 10).

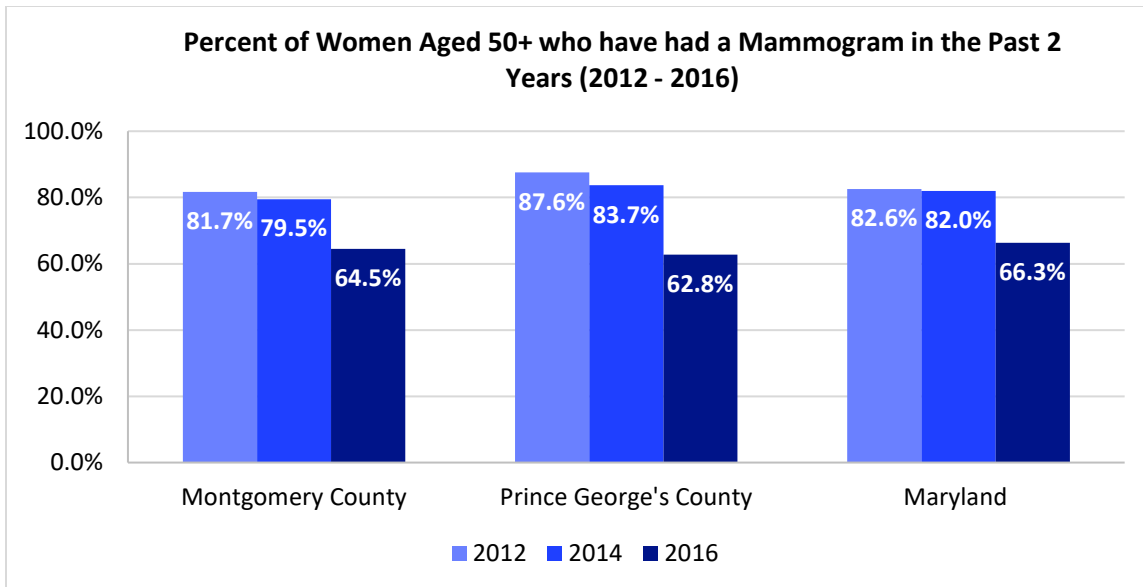


Figure 10. Percentage of Women aged 50 and over who have had a Mammogram in the Past Two Years in Montgomery and Prince George’s Counties, 2012 – 2016
(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

- In Montgomery County, there was a greater percentage of 65+ year old women who received a mammogram as compared to ages 50–64. In Prince George’s County, the percentages of individuals in both 65+ and 50–64-year old groups, were consistent with the overall rates, all being roughly 83–84.0 percent (Figures 11 and Figure 12).

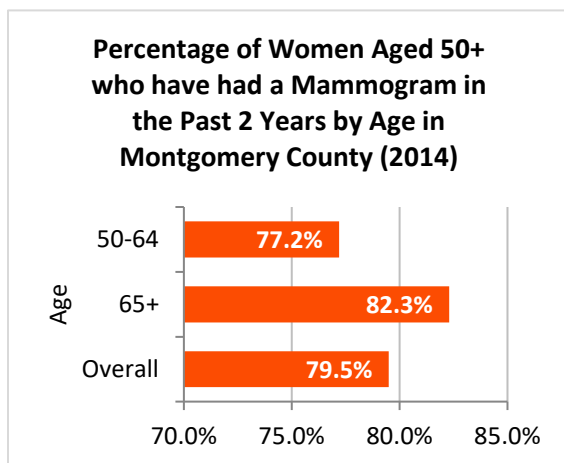


Figure 11. Percentage of Women aged 50 + who have had a Mammogram in the Past Two Years by Age in Montgomery County, 2014
(Source: [Healthy Montgomery](#), 2014)

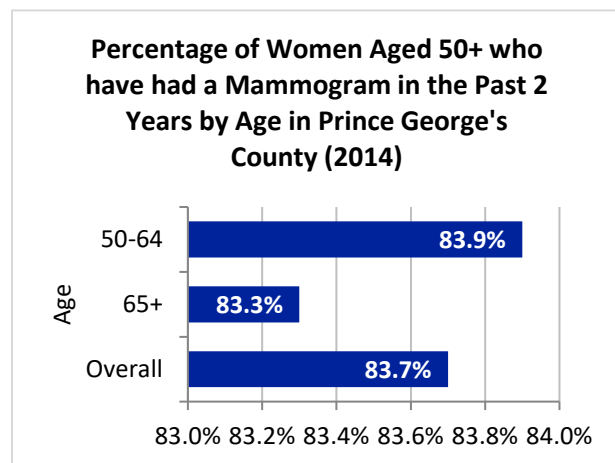


Figure 12. Percentage of Women aged 50+ who have had a Mammogram in the Past Two Years by Age in Prince George’s County, 2014
(Source: [PGC Health Zone](#), 2014)

- When evaluating mammography by race/ethnicity, in 2014, Montgomery County demonstrated the highest percentage group as Hispanic, followed by White and Black individuals (at about the same percentage), then Asian and then Other. For Prince George’s County, the highest percentage of mammography was demonstrated in Blacks, followed by Hispanics, then Whites, Asians, and then Other (Figures 13 and Figure 14).

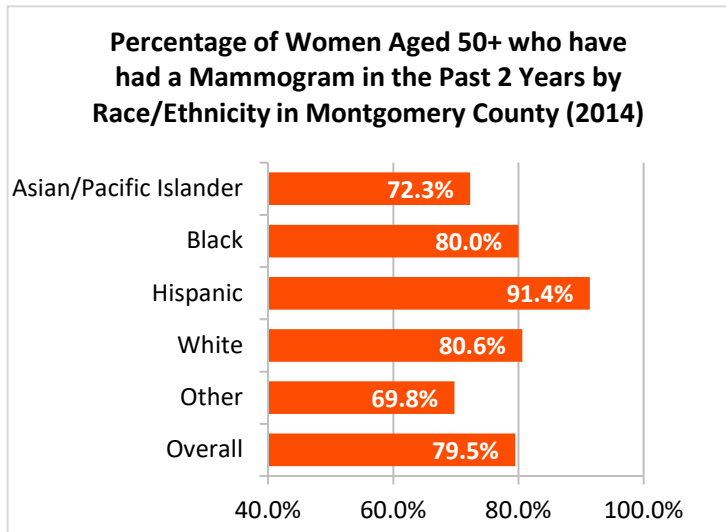


Figure 13. Percentage of Women aged 50 + who have had a Mammogram in the Past Two Years by Race/Ethnicity in Montgomery County, 2014
(Source: [Healthy Montgomery](#), 2014)

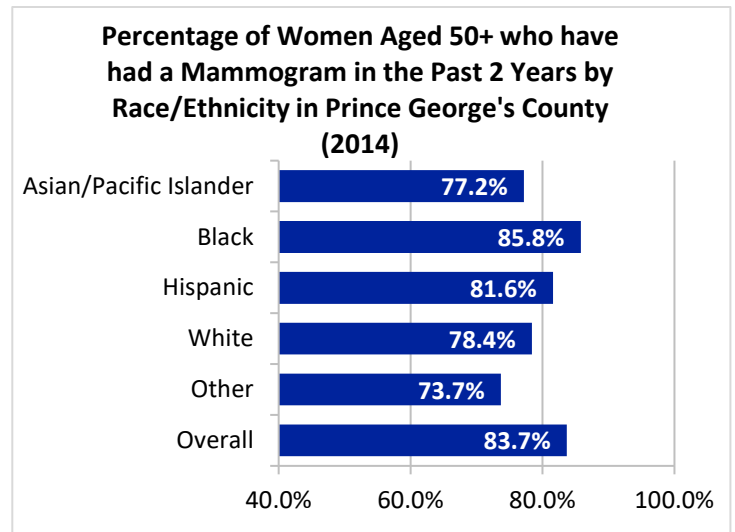


Figure 14. Percentage of Women aged 50+ who have had a Mammogram in the Past Two Years by Race/Ethnicity in Prince George’s County, 2014
(Source: [PGC Health Zone](#), 2014)

Mortality

- From 2009 to 2015, Montgomery County met the HP 2020 Target. However, Prince George’s County and Maryland did not (Figure 15).
- In Prince George’s County, there was a slight decrease in mortality from 2011 to 2015 as compared to previous years (Figure 15).
- In Maryland, the mortality rate due to breast cancer has decreased by 0.4 from 2010 to 2015 (Figure 15).

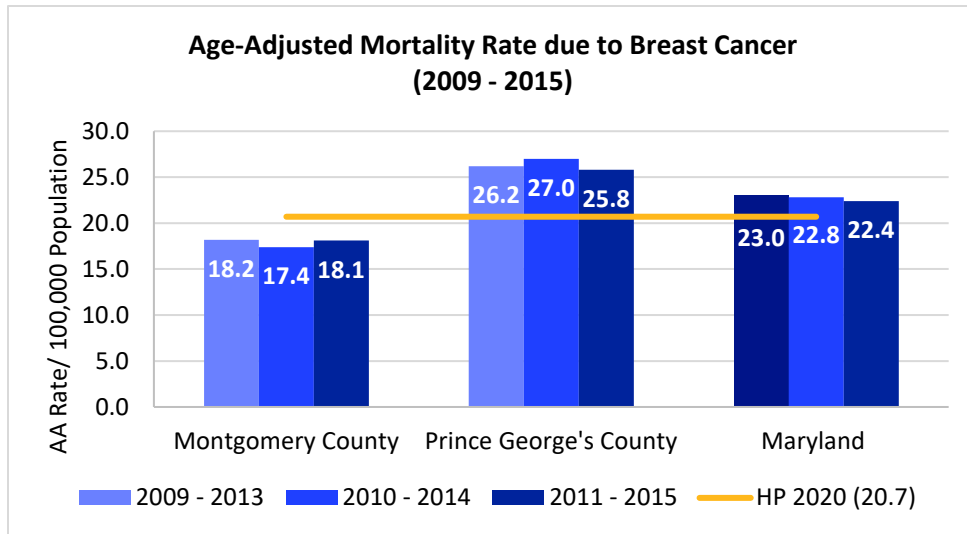


Figure 15. Age-Adjusted Mortality Rate to Breast Cancer in Montgomery County, Prince George's County, and Maryland, 2009 – 2015
(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

- When comparing race and ethnicity data, Montgomery County overall met the HP 2020 mortality rate due to breast cancer target (Figure 16).
- In Montgomery County, all the population subgroups except for Black met the HP 2020 Target (Figure 16).
- For Blacks in Montgomery and Prince George's County, the mortality rate is significantly higher than that of any other racial/ethnic group (Figure 16).
- In Prince George's County, none of the subpopulations met the HP 2020 target (Figure 16).

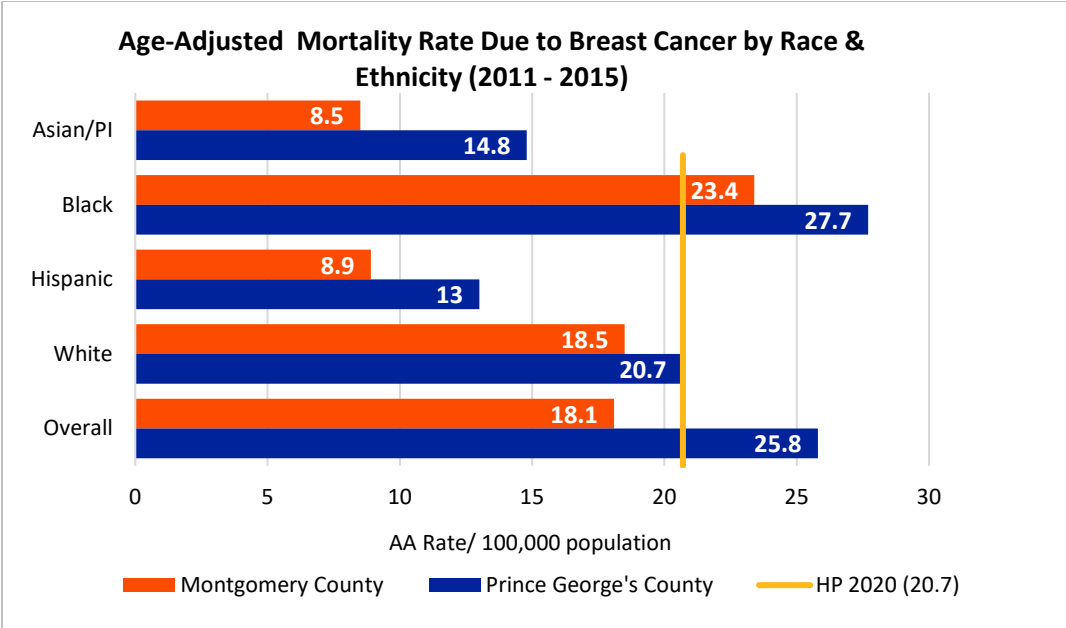


Figure 16. Age-Adjusted Mortality Rate by Race & Ethnicity in Montgomery & Prince George’s County, 2011 – 2015
 (Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

4.2 Lung Cancer

Incidence

- From 2008 to 2015, the lung cancer incidence rates decreased in both counties and Maryland. Montgomery County has the lowest incidence rate followed by Prince George's County and Maryland (Figure 18).

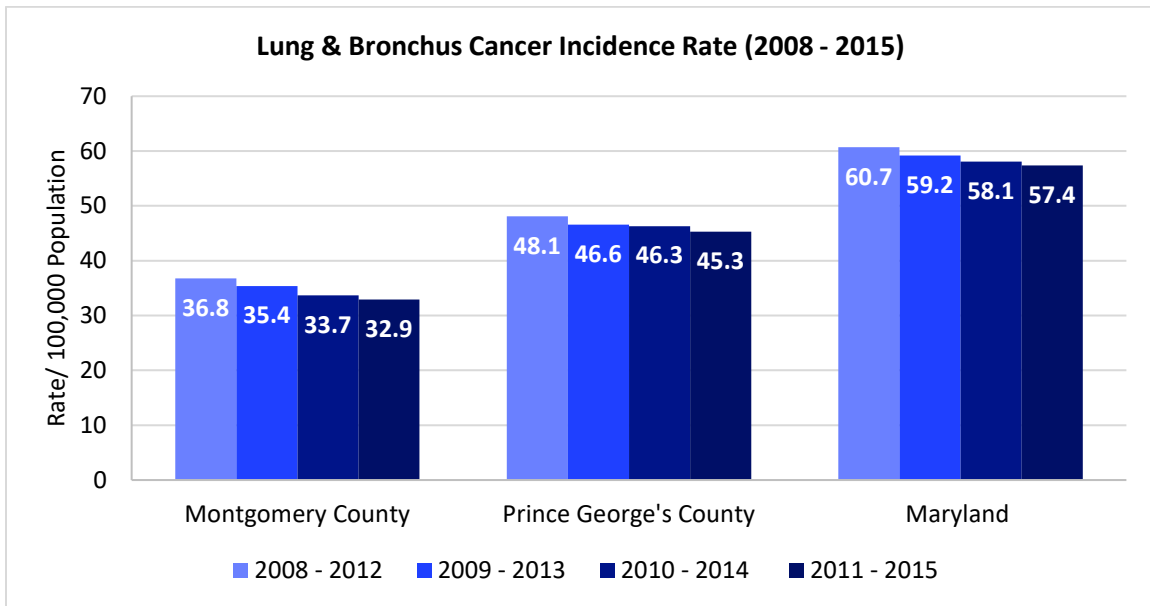


Figure 18. Age-Adjusted Incidence Rate for Lung and Bronchus Cancers in Montgomery County, Prince George's County, and Maryland, 2008 – 2015
(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2015)

- When evaluating lung and bronchus cancer incidence rates by sex, Montgomery and Prince George's County men had higher rates than women (Figure 19).
- Prince George's County had a larger gap for lung and bronchus cancer incidence rates when compared to Montgomery County (Figure 19).

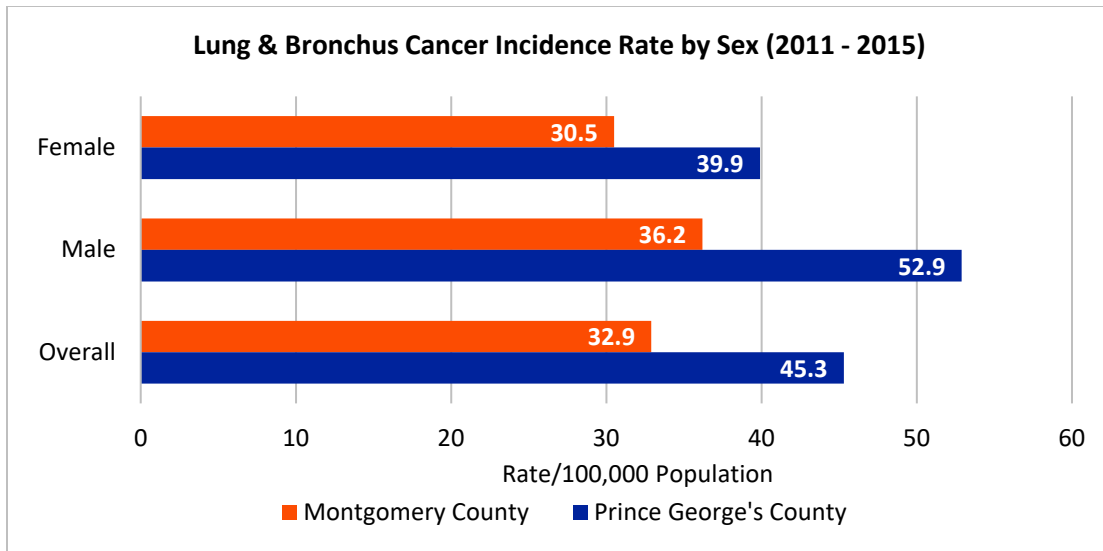


Figure 19. Age-Adjusted Incidence Rate for Lung and Bronchus Cancers by Sex in Montgomery and Prince George’s County, 2011 – 2015
(Source: [Healthy Montgomery](#) & [Prince George’s County](#), 2018)

- In Montgomery and Prince George’s County, White followed by Black individuals had the highest incidence rate for lung and bronchus cancer from 2011 to 2015 (Figure 20).
- White individuals had a higher incidence rate than the overall average for Prince George’s County (Figure 20).

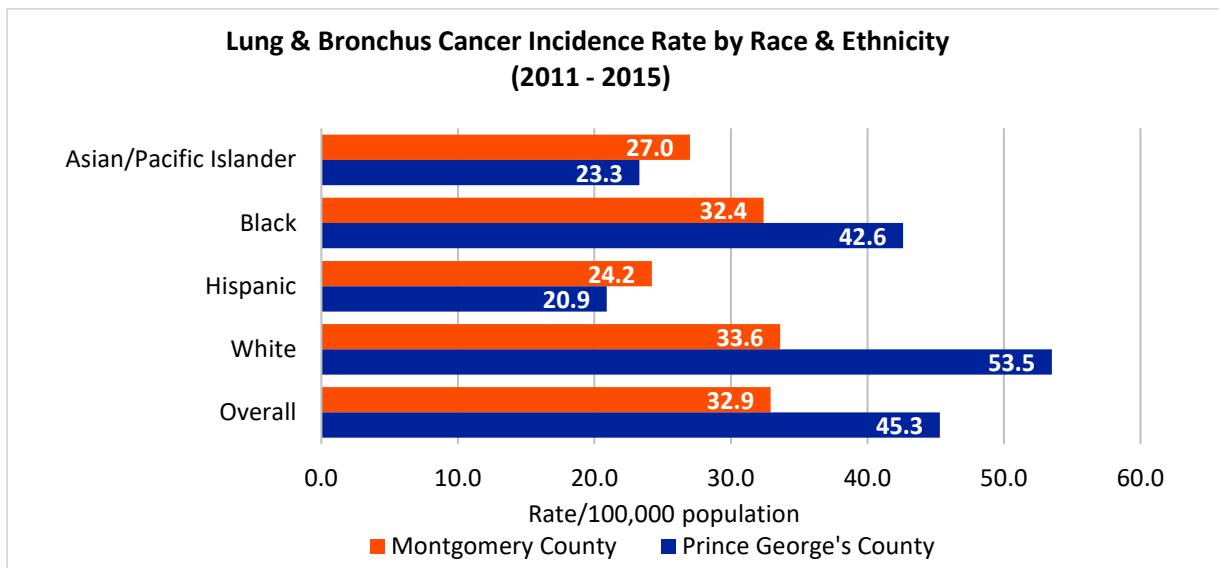


Figure 20. Age-Adjusted Incidence Rate for Lung and Bronchus Cancers by Race & Ethnicity, 2011 – 2015
(Source: [Healthy Montgomery](#) & [Prince George’s County](#), 2018)

Mortality

- From 2009 to 2015, the age-adjusted mortality rate due to lung cancer steadily decreased in both Montgomery and Prince George’s County and Maryland (Figure 21).
- When compared to Prince George’s County and Maryland, Montgomery County had significantly lower mortality rates due to lung cancer (Figure 21).

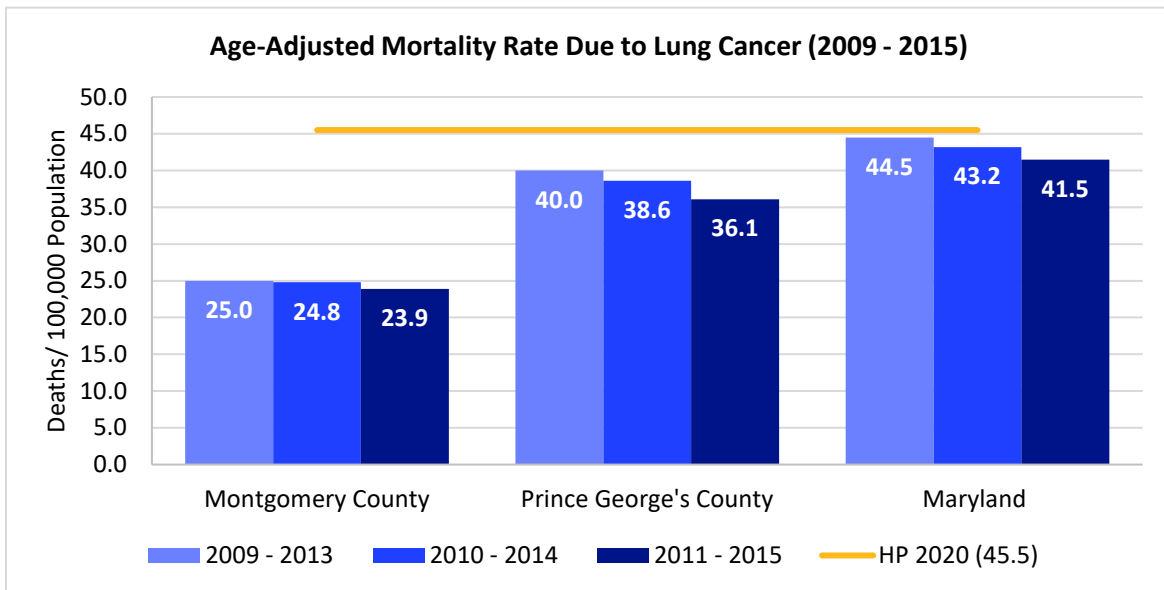


Figure 21. Age-Adjusted Mortality rate for Lung Cancers in Montgomery County, Prince George’s County, and Maryland, 2009 – 2015
(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

- From 2011 to 2015, both Montgomery and Prince George’s County met the HP 2020 goal for age-adjusted mortality rate due to lung cancer which is comparable to that of Maryland (Figure 22).
- Males in both counties and the state had a higher mortality rate when compared to women; however, Prince George’s County males had the highest mortality rate overall (Figure 22).

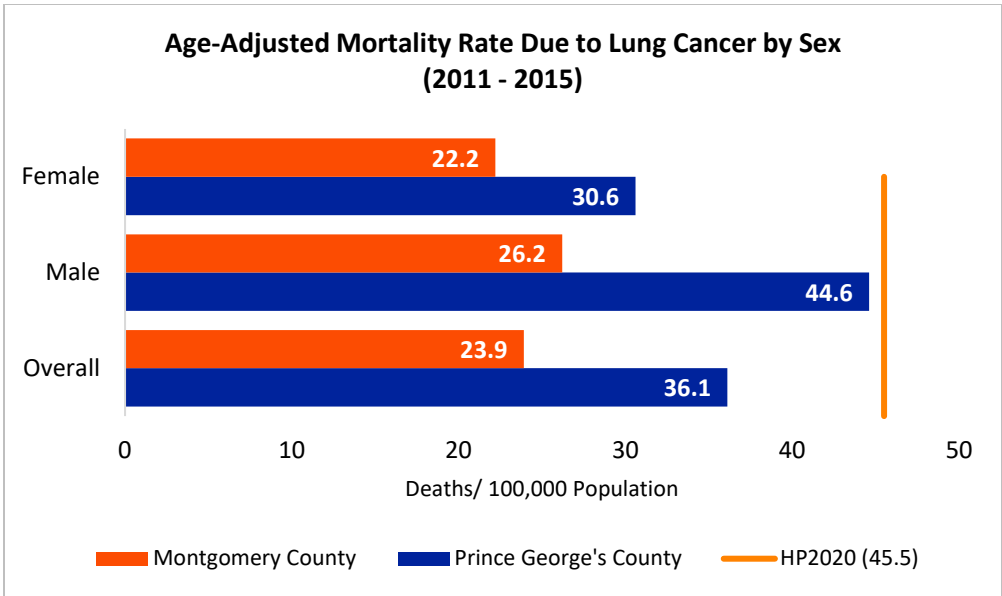


Figure 22. Age-Adjusted Mortality rate for Lung Cancers by Sex in Montgomery County, 2011 – 2015
(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

- Mortality rates due to lung cancer in both counties, when broken down by race/ethnicity, indicated that all categories surpassed the HP 2020 target (Figure 23).
- White individuals in both counties had the highest mortality rates followed by Black, Asian/Pacific Islander and then Hispanics (Figure 23).
- When comparing both counties by race and ethnicity, Prince George’s County’s White population had nearly 2X the mortality rate for lung cancer (Figure 23).

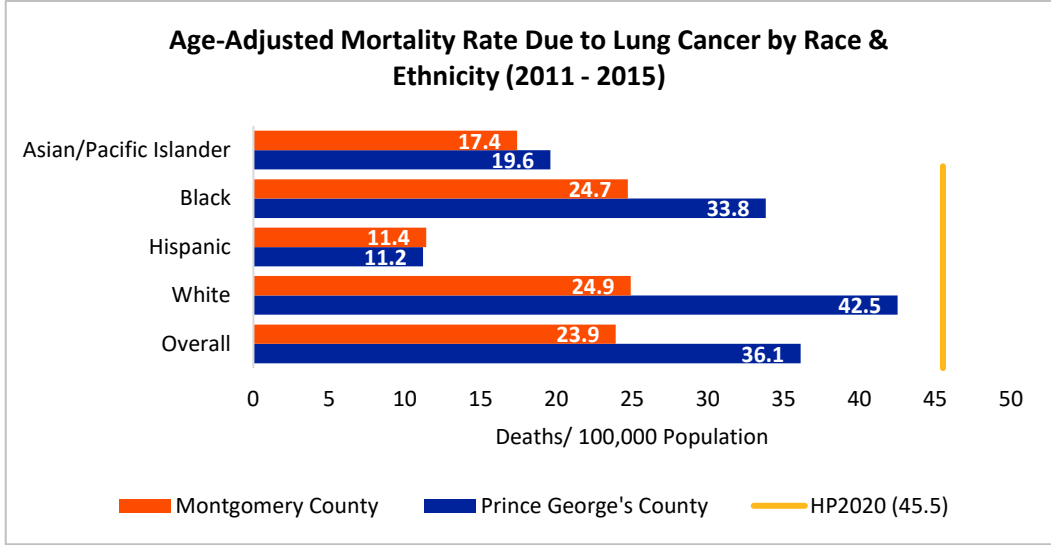


Figure 23. Age-Adjusted Mortality Rate for Lung Cancers per by Race/Ethnicity in Montgomery and Prince George’s County, 2011 – 2015
(Source: [Healthy Montgomery](#), 2018)

4.3 Colorectal Cancer

Incidence

- Overall, colorectal cancer incidence rates in Maryland have declined since 2008 which is similar to Montgomery and Prince George's County (Figure 24).
- Both counties and Maryland met the HP 2020 target (Figure 24).
- When comparing both counties, Montgomery County had the lowest incidence rates for colorectal cancer from 2008 to 2015 (Figure 24).

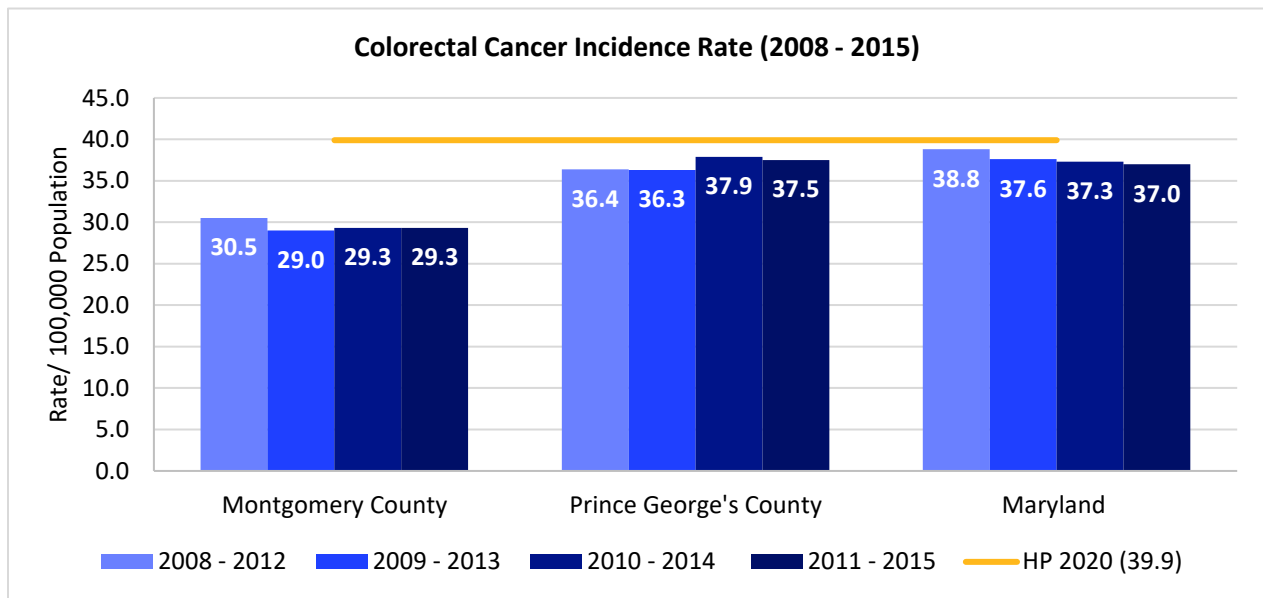


Figure 24. Age-Adjusted Incidence Rate for Colorectal Cancer in Montgomery County, Prince George's County, and Maryland, 2008 – 2015

(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

- When looking at incidence rates broken down by sex, males in both counties demonstrated higher incidence for colorectal cancer than females (Figure 25).
- Montgomery County rates met the HP 2020 target. However, in Prince George's County, the HP 2020 target was met only for female and overall rates; the rate for males did not meet the target (Figure 25).

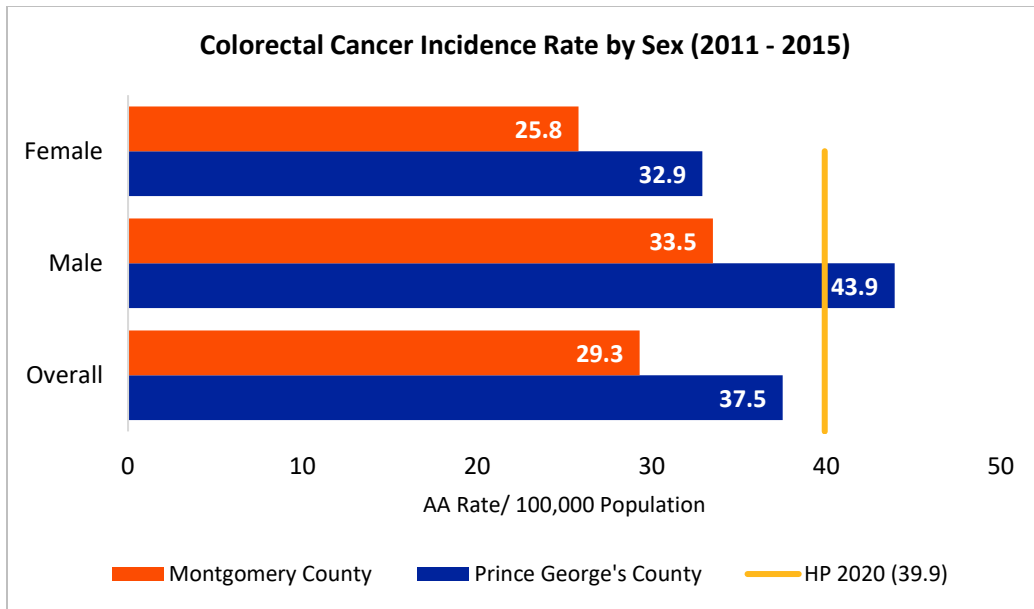


Figure 25. Colorectal Cancer Incidence Rate by Sex in Montgomery County, 2011 – 2015
 (Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

- When stratified by race/ethnicity, both counties met the HP 2020 target for colorectal cancer incidence rate (Figure 26).
- In both Montgomery and Prince George’s County, Black individuals had the highest incidence rates, followed by White, and Asian/Pacific Islander (Figure 26).

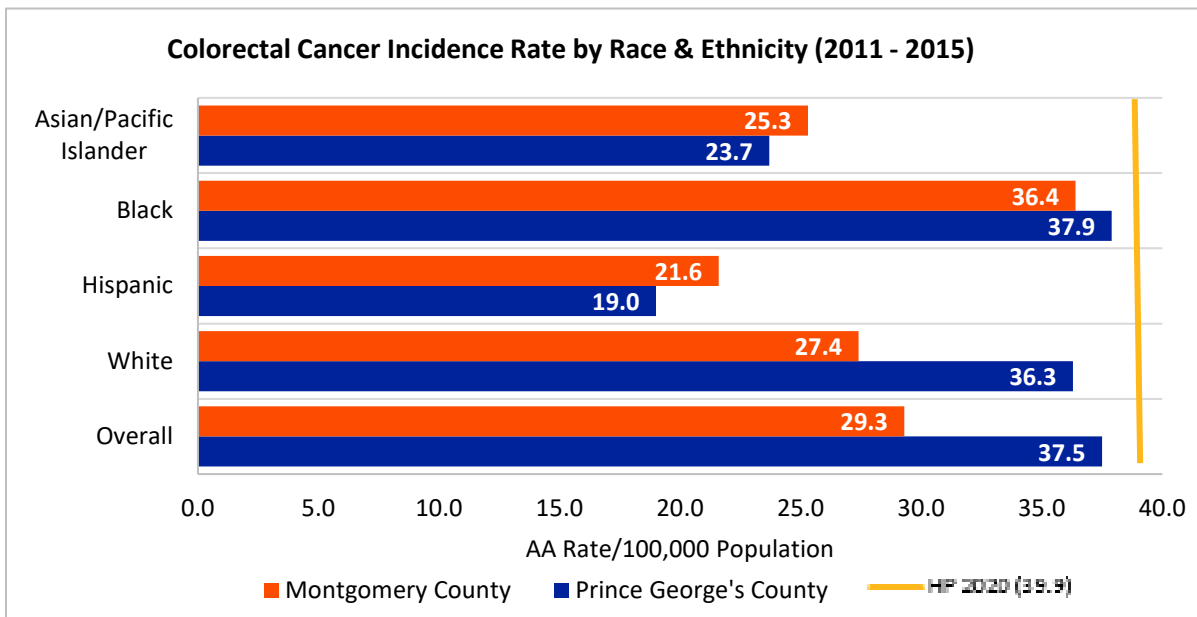


Figure 26. Colorectal Cancer Incidence Rate by Race/Ethnicity in Montgomery and Prince George’s County, 2011 – 2015
 (Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

Screening

- In Montgomery County, the percentage of adults aged 50 and over who ever had a sigmoidoscopy or colonoscopy exam increased by nearly 1.0 percent (Figure 27).
- In Prince George's county, the percentage of adults who were screened decreased by 2.3 percent from 2014 to 2016 (Figure 27).

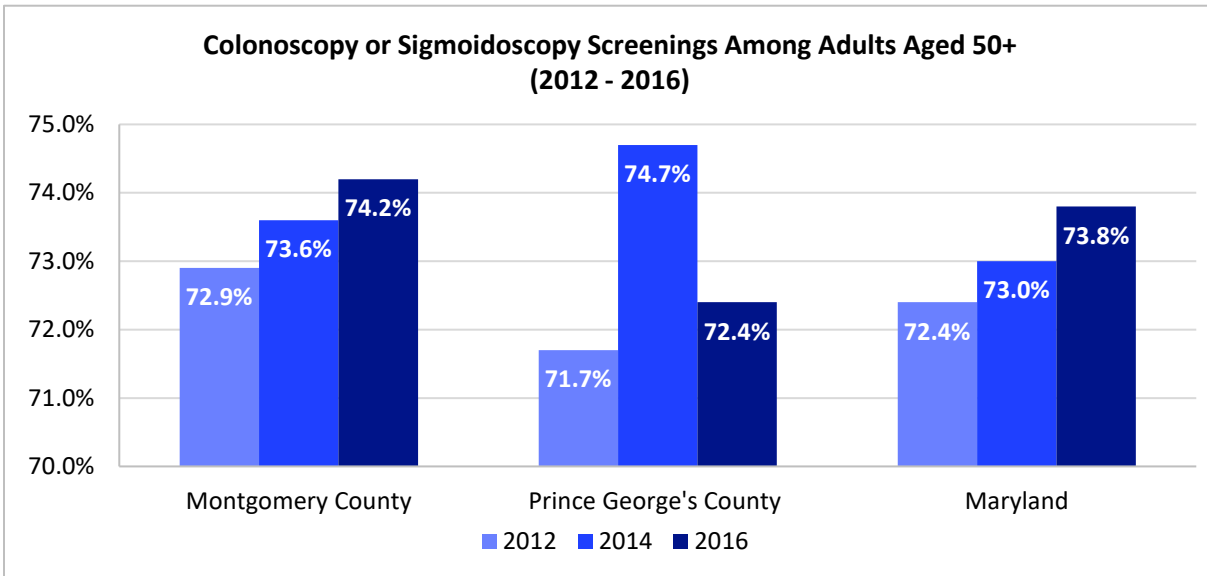


Figure 27. Percentage of Adults aged 50+ who have ever had a Sigmoidoscopy or Colonoscopy Screening in Montgomery and Prince George's Counties, 2012 – 2016
(Source: [Healthy Montgomery](#), 2018)

- In both Montgomery and Prince George's County, adults aged 65+ contributed a larger percentage of colonoscopy or sigmoidoscopy screenings than their 50 to 64-year-old counterparts (Figure 28).
- In both counties, the 65+ groups had higher percentages of screening than the county overall (Figure 28).

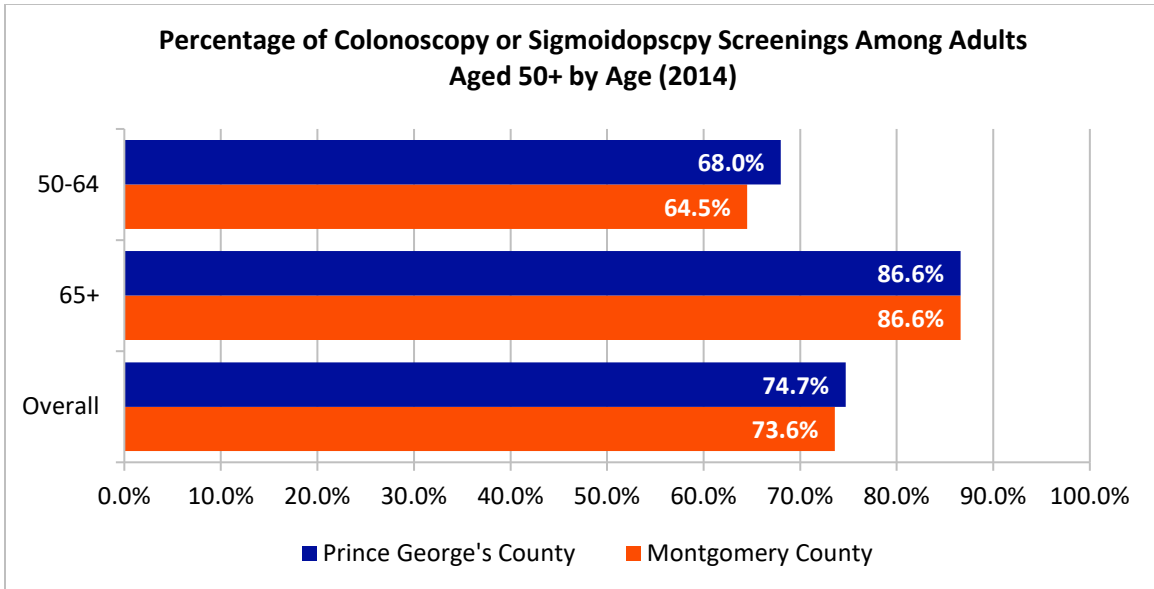


Figure 28. Percentage of Adults aged 50+ who ever had a Sigmoidoscopy or Colonoscopy Screening in Montgomery and Prince George’s Counties by Age, 2014
(Source: [Healthy Montgomery](#), 2018)

- In Montgomery and Prince George’s County, there was a higher percentage of females than males to receive the screening (Figure 29).
- For both counties, females had a higher percentage of screening than the overall percentage (Figure 29).

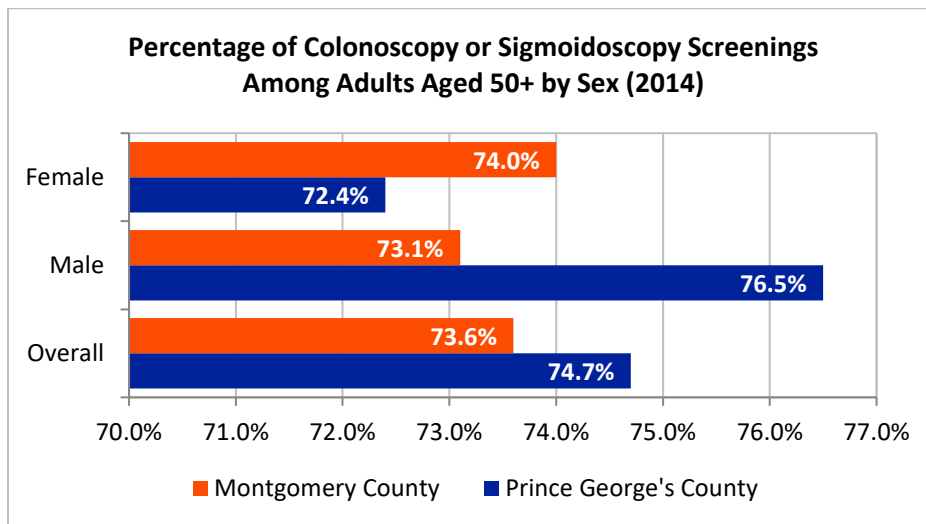


Figure 29. Percentage of Adults aged 50+ who ever had a Sigmoidoscopy or Colonoscopy Screening in Montgomery and Prince George’s Counties by Sex, 2014
(Source: [Healthy Montgomery](#), 2018)

- When examining the screening percentages within each county based on race and ethnicity, Montgomery County showed higher percentages of screenings in White individuals as compared to other race and ethnicities, followed by Other, Hispanic, Black, and then Asian (Figure 30).
- In Prince George’s County, the Other category had the highest percentage, followed by Hispanic and Black at roughly the same percentage, then White and Asian (Figure 31).

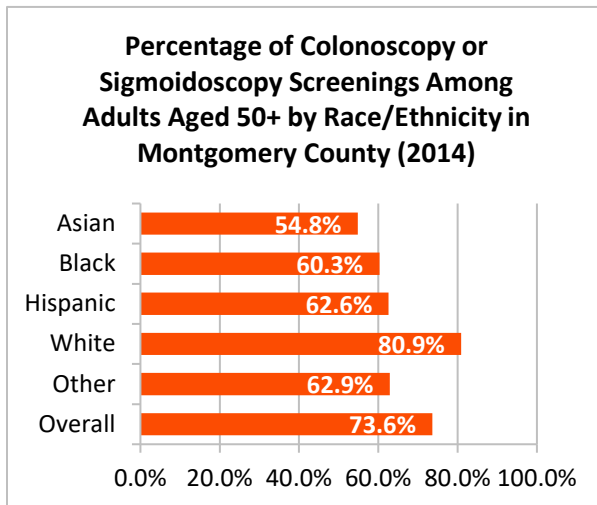


Figure 30. Percentage of Adults aged 50+ that ever had a Sigmoidoscopy or Colonoscopy Exam by Race/Ethnicity in Montgomery County, 2014 (Source: [Healthy Montgomery](#), 2018)

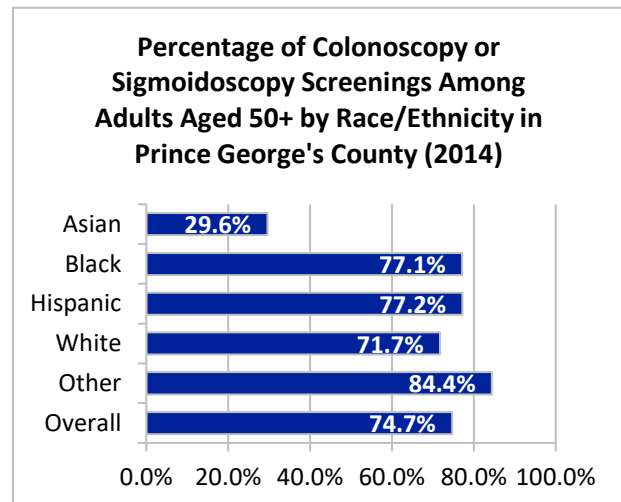


Figure 31. Percentage of Adults aged 50+ that ever had a Sigmoidoscopy or Colonoscopy Exam by Race/Ethnicity in Prince George’s County, 2014 (Source: [PGC Health Zone](#), 2018)

- In 2014, there was approximately a 5.0 percent decrease in adults aged 50 and over that ever had a blood stool test within the past two years in Montgomery County. In Maryland, the percentage remained the same (Figure 32).

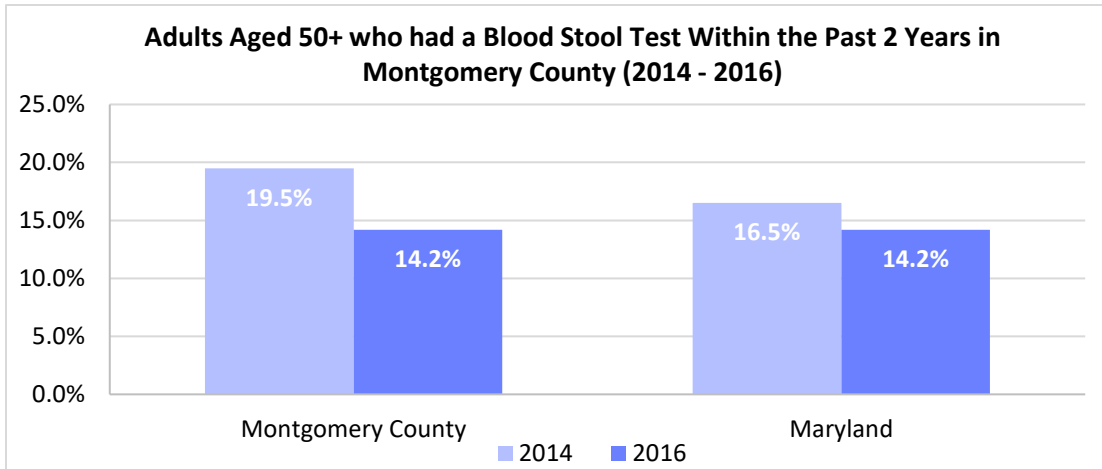


Figure 32. Percentage of Adults aged 50+ that have ever had a Blood Stool Test within the Past 2 Years in Montgomery County, 2014 - 2016
(Source: [Healthy Montgomery](#), 2018)

- In Montgomery County, adults aged 65+ who had a blood stool test in the past two years comprised a larger percentage than their 50 to 64-year-old counterparts (Figure 33).
- The percentages of males versus females who had a blood stool test, within that 50 and over age group, does not differ much from one another with nearly a 1.0 percent difference (Figure 34).

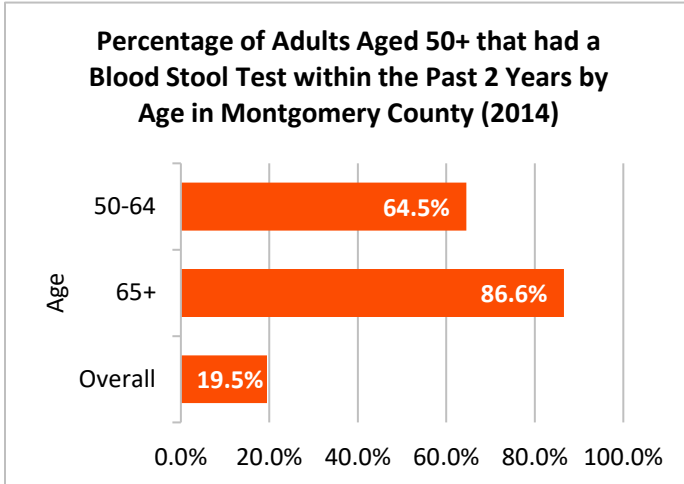


Figure 33. Percentage of Adults aged 50+ that have ever had a Blood Stool Test within the Past 2 Years by Age in Montgomery County, 2014
(Source: [Healthy Montgomery](#), 2014)

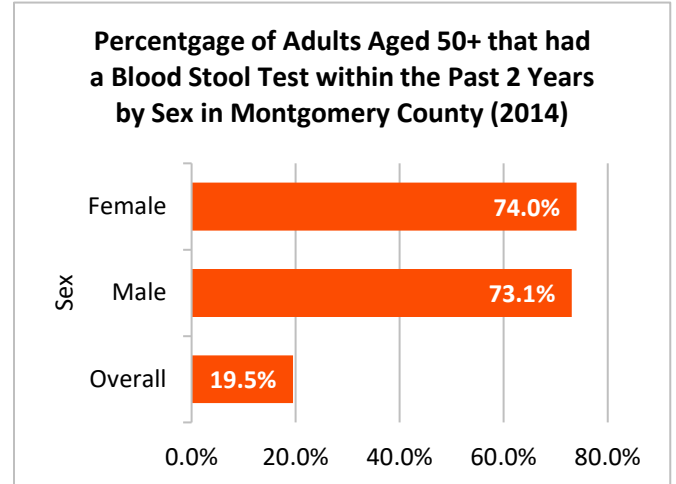


Figure 34. Percentage of Adults aged 50+ that have ever had a Blood Stool Test within the Past 2 Years by Sex in Montgomery County, 2014
(Source: [Healthy Montgomery](#), 2014)

Mortality

- Mortality rates due to colorectal cancer decreased in Maryland overall, with Maryland meeting the HP 2020 target for 2010 to 2014 and 2011 to 2015 (Figure 35).
- Montgomery County had the lowest mortality rate and meets the HP 2020 target. However, Prince George's County did not meet the target and had the highest rates overall (Figure 35).

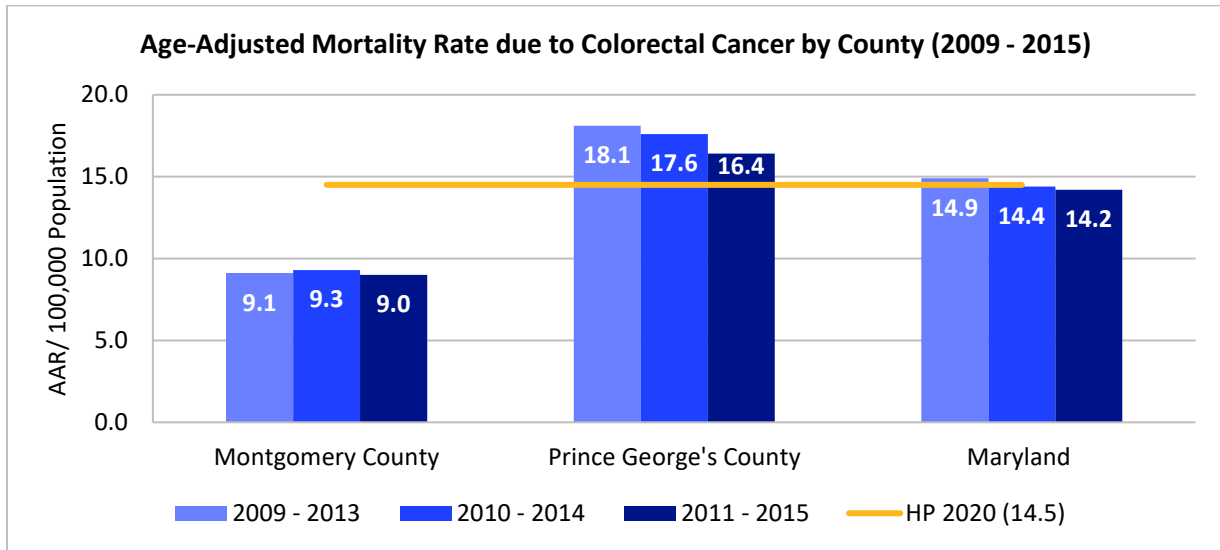


Figure 35. Age-Adjusted Mortality rate due to Colorectal Cancer in Montgomery County, Prince George's County, and Maryland, 2009 – 2015
(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

- When examining mortality rates due to colorectal cancer by race and ethnicity, Black individuals in both counties had the highest mortality rates when compared to other racial groups (Figure 36).
- Montgomery County met the HP 2020 target for all subcategories of race and ethnicity. The lowest mortality rates were seen in Hispanics (Figure 36).
- For the data available in Prince George's County, no category met the HP 2020 target (Figure 36).

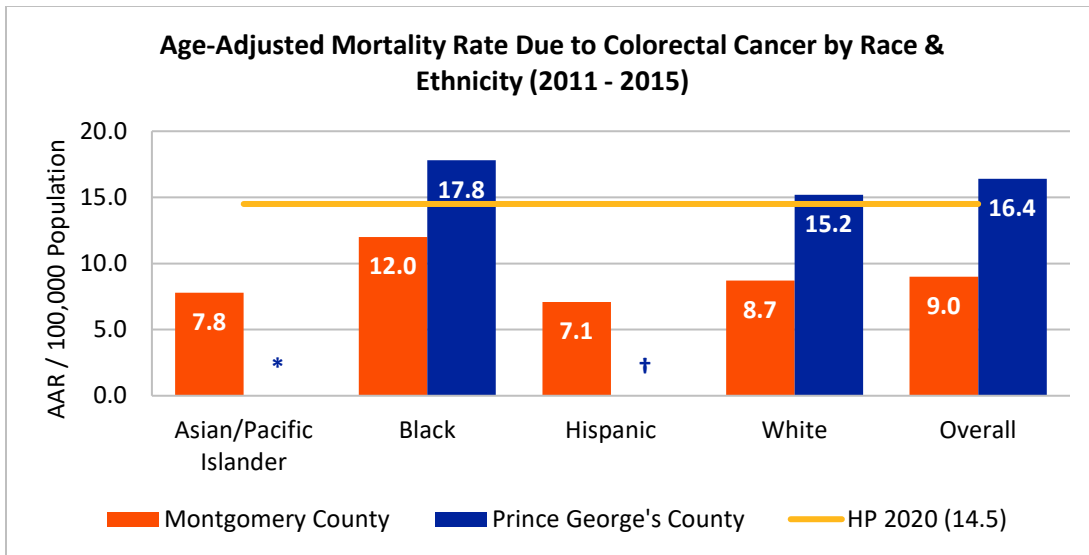


Figure 36. Age-Adjusted Mortality rate due to Colorectal Cancer by Race & Ethnicity in Montgomery and Prince George's County, 2011 – 2015

*†Data not available/not applicable

(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

- In Montgomery County, both males and females met the HP 2020 target; however, males in Prince George's County had nearly 2X the age-adjusted mortality rate when compared to Montgomery County (Figure 37).
- Males overall had the highest age-adjusted mortality rate in both counties (Figure 37).

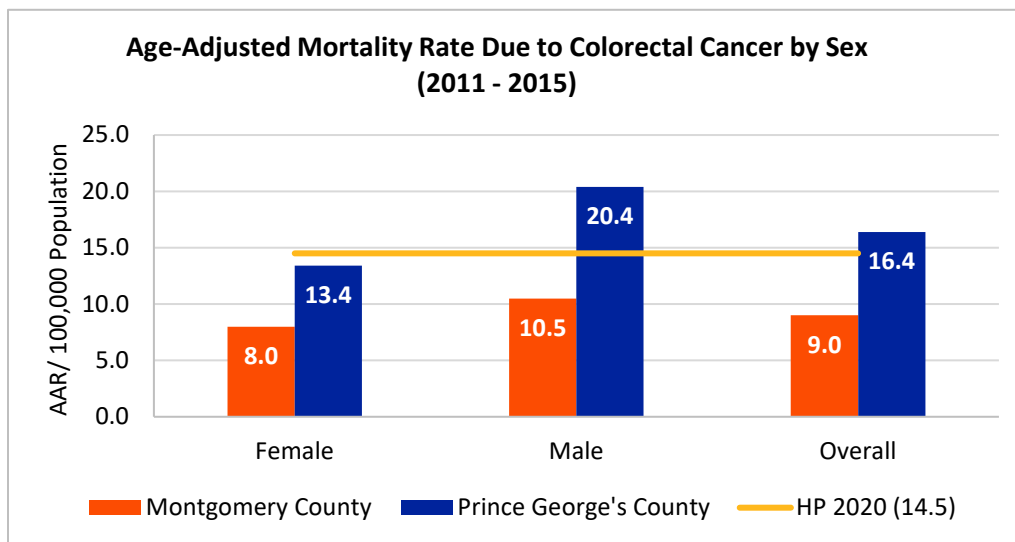


Figure 37. Age-Adjusted Mortality Rate due to Colorectal Cancer by Sex in Montgomery and Prince George's County, 2011 – 2015

(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

4.4 Prostate Cancer

Incidence

- The incidence of prostate cancer in the state of Maryland steadily decreased after 2009. The same trend is true for Montgomery County and Prince George's County specifically (Figure 38).
- Compared to Prince George's County and the state overall, Montgomery County had the lowest incidence rates for prostate cancer (Figure 38).

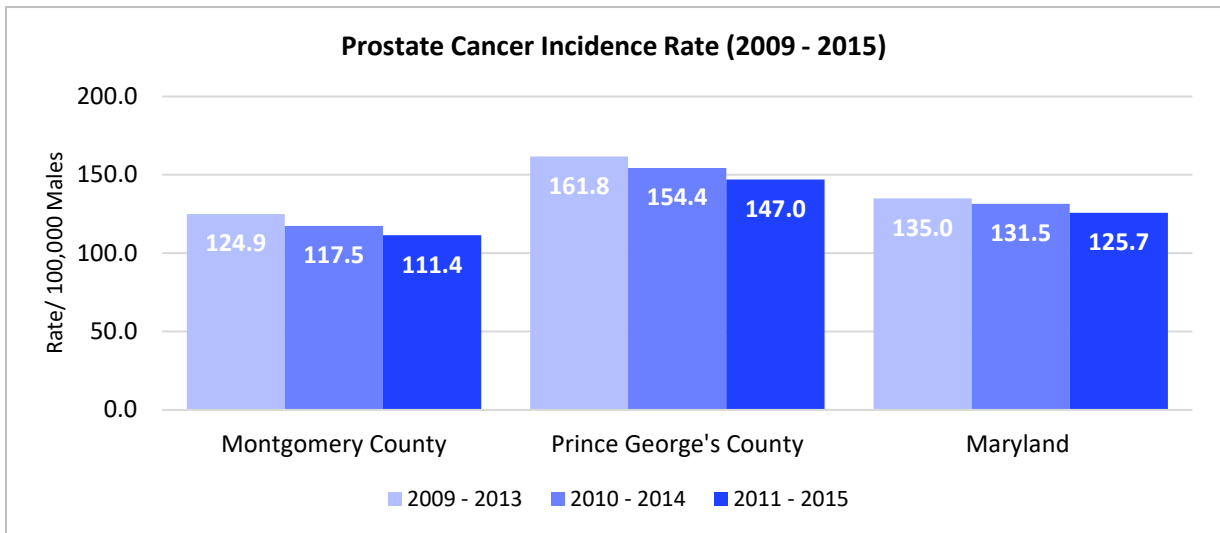


Figure 38. Age-Adjusted Incidence Rate for Prostate Cancer in Montgomery County, Prince George's County, and Maryland, 2009 – 2015

(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

- For both Montgomery and Prince George's County, Black individuals had the highest incidence rates for prostate cancer, and in both cases those rates are much higher than the overall rate for the county. Among other subgroups, White individuals followed by Hispanics had the next highest incidence rate (Figure 39).
- In Montgomery County, specifically, the incidence rate for Black individuals was nearly 2X the overall county rate (Figure 39).

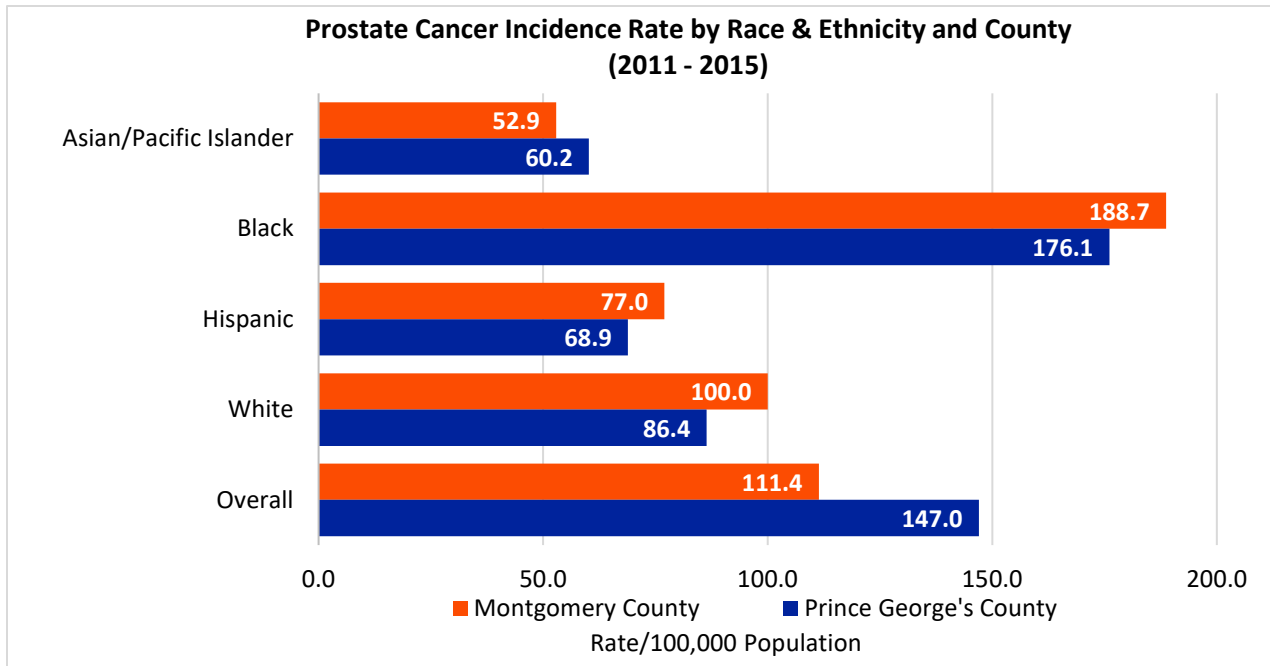


Figure 39. Age-Adjusted Incidence Rate for Prostate Cancer by Race/Ethnicity in Montgomery County, 2011 – 2015

(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

Mortality

- The mortality rate due to prostate cancer had a decreasing trend in both Maryland overall and in Prince George’s County. However, Montgomery County had a minor 0.4 increase from 2010 to 2015 (Figure 40).
- Since 2009, Maryland and Montgomery County consistently met the HP 2020 target. Prince George’s County; however, did not met the HP 2020 target (Figure 40).

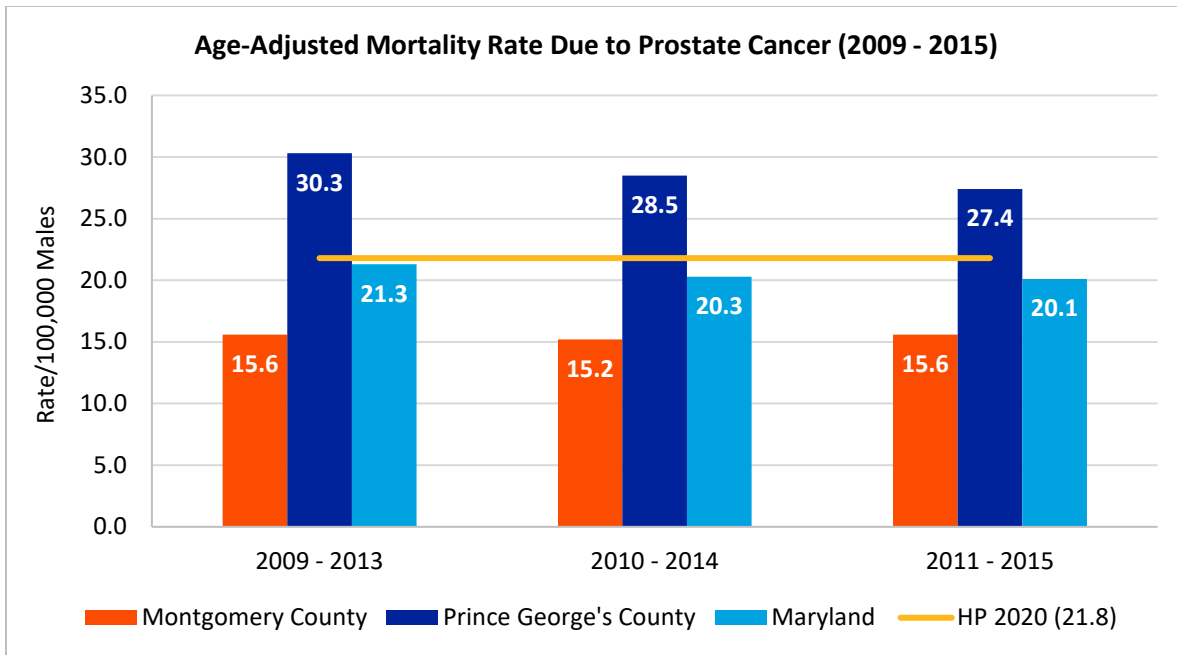


Figure 40. Age-Adjusted Mortality rate Due to Prostate Cancer in Montgomery County, Prince George's County, and Maryland, 2011 – 2015
(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

- In both Montgomery and Prince George's County, Black individuals had the highest mortality rates due to prostate cancer. Montgomery County had nearly 2X the mortality rate than the overall rate and Prince George's County had 1.3X the overall mortality rate (Figure 41).

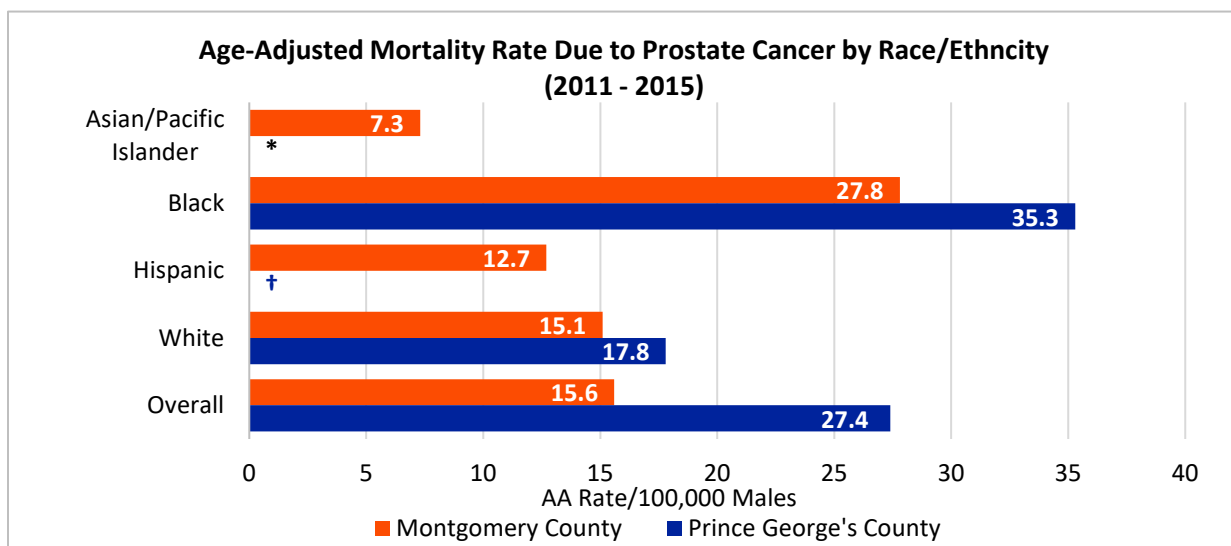


Figure 41. Age-Adjusted Mortality rate Due to Prostate Cancer by Race/Ethnicity in Montgomery and Prince George's County, 2011 – 2015
*†Data not available/not applicable
(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

4.5 Cervical Cancer

Incidence

- In Maryland, the incidence rate for cervical cancer among females decreased over time (Figure 42).
- Montgomery County maintained significantly lower incidence rates when compared to Prince George’s County and the state overall. However, the rates for both Prince George’s County and the state remained stable for the past five years (Figure 42).
- Prince George’s County had a decreasing trend for cervical cancer incidence rate from 2008 to 2015 (Figure 42).
- Both counties and the state met the HP 2020 target for the most recent data year (Figure 42).

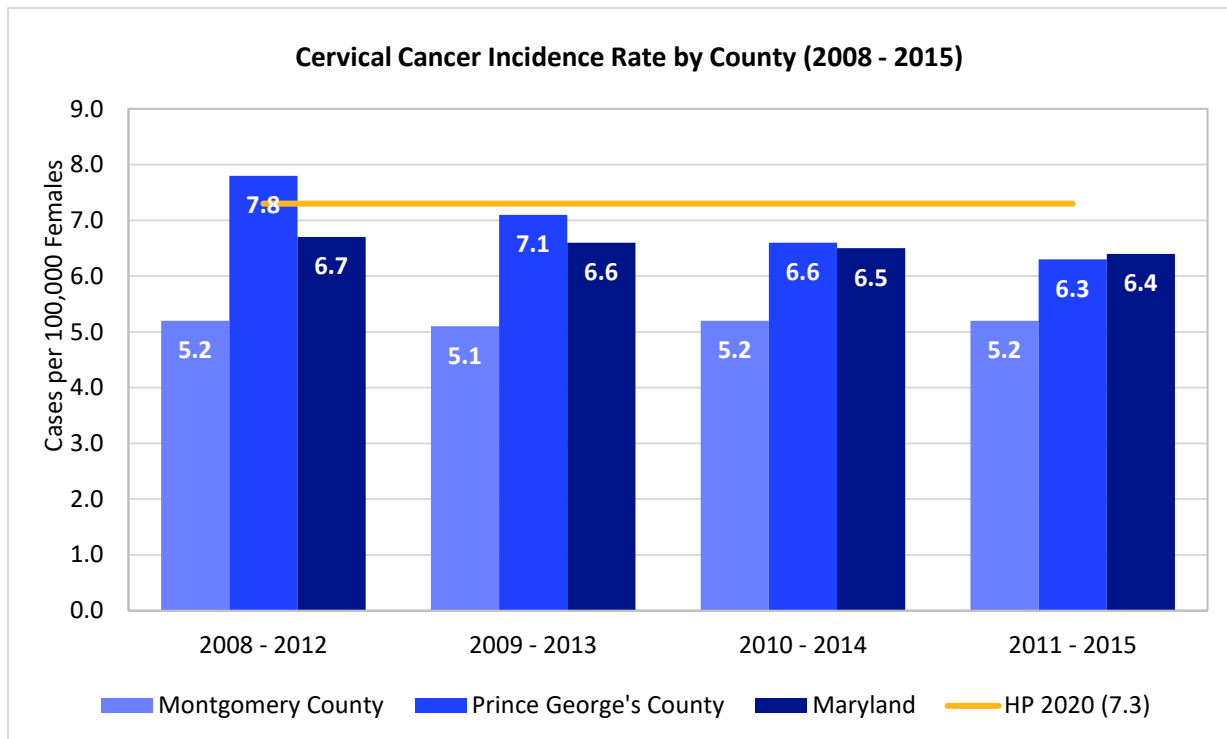


Figure 42. Age-Adjusted Incidence Rate for Cervical Cancer in Montgomery County, Prince George’s County, and Maryland, 2008 – 2015

(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

- Among population subgroups in both Montgomery and Prince George’s County, Hispanic women had the highest incidence rate of cervical cancer and surpass the HP 2020 target and the overall rate for the counties (Figure 43).
- In Prince George’s County, specifically, Hispanic women had nearly 2X the cervical cancer incidence rate when compared to the overall rate for the county (Figure 43).
- In Montgomery County, the HP 2020 target was met overall; Black and White women had lower rates than Hispanics. In Prince George’s County, the HP 2020 target was not met by any subgroup besides Black women. White women had the second highest incidence rate in the county (Figure 43).

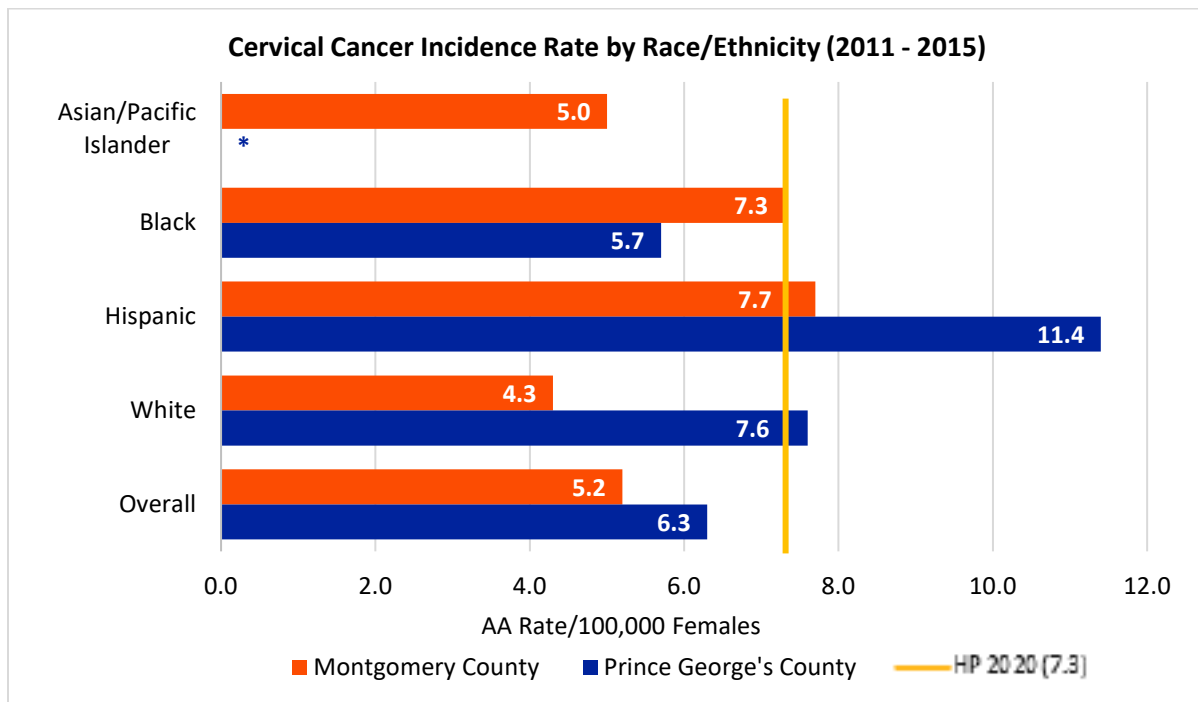


Figure 43. Age-Adjusted Incidence Rate for Cervical Cancer by Race/Ethnicity in Montgomery and Prince George’s County , 2011 – 2015

*Data not available/not applicable

(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

Screening

- When looking at pap smear screening rates for women aged 18 and over, both counties and Maryland had a significant percent increase since 2014 (Figure 44).
- Both counties and the state met the HP 2020 target in 2016 (Figure 44).

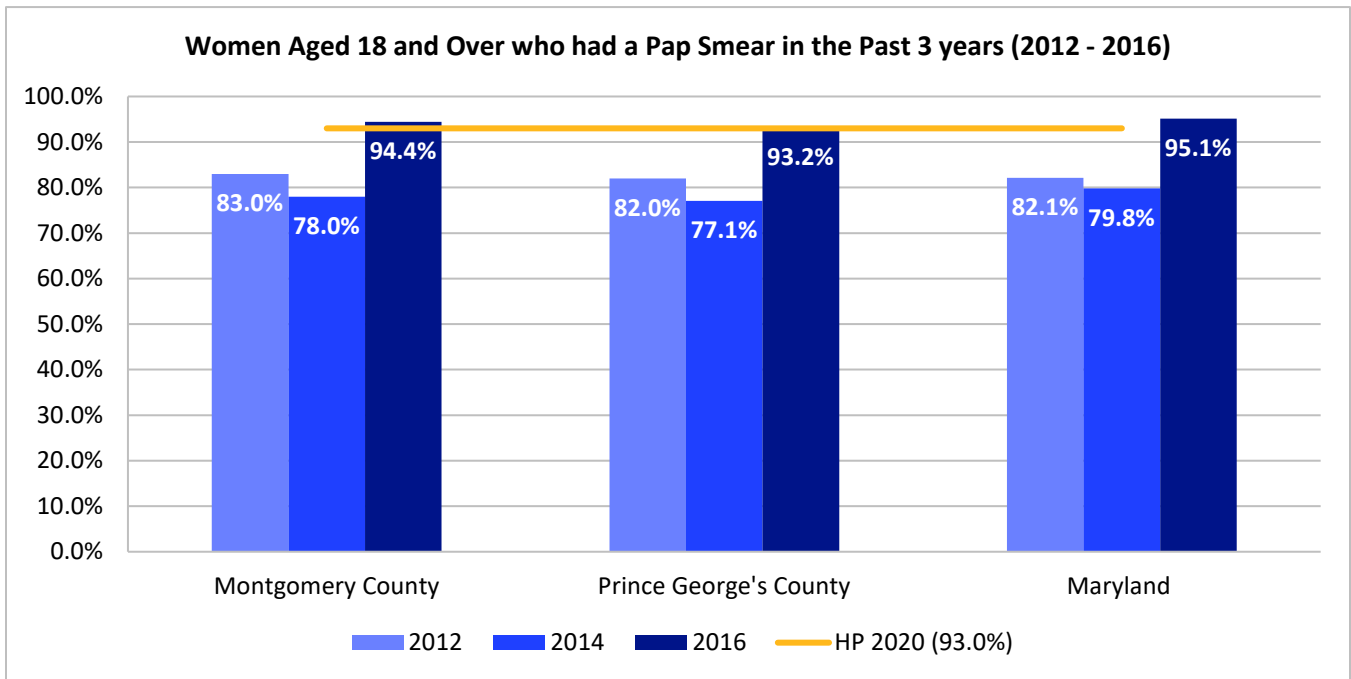


Figure 44. Percentage of Females aged 18 and over that had a Pap Smear in the past 3 Years in Montgomery County, Prince George’s County, and Maryland, 2012 – 2016
(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2018)

- For both Montgomery and Prince George’s County, the age groups with the highest percentage of pap testing were individuals between the ages of 46 to 64, followed by 18 to 44, and then 65 and older (Figure 45 and 46).



Figure 45. Percentage of Females aged 18 and over that had a Pap Smear in the past 3 years by Age in Montgomery County, 2014
(Source: [Healthy Montgomery](#), 2014)

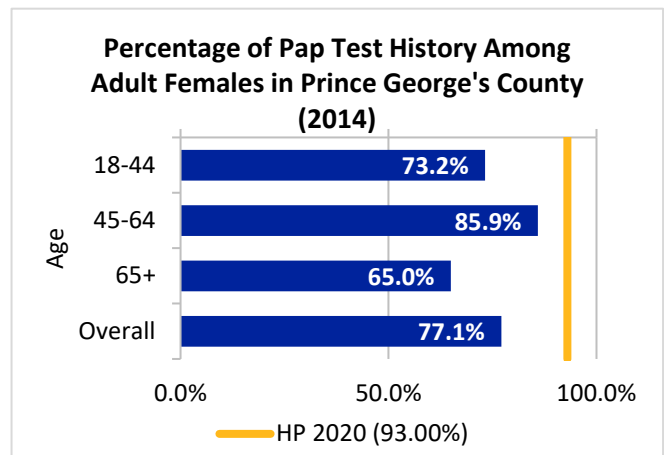


Figure 46. Percentage of Females aged 18 and over that had a Pap Smear in the past 3 years by Age in Prince George’s County, 2014
(Source: [PGC Health Zone](#), 2014)

- When reviewing females aged 18 and over that had a pap smear in the past 3 years, by race and ethnicity, both Montgomery and Prince George’s County had no groups meet the HP 2020 target (Figure 46 and 47).
- In Montgomery County, the group with the highest percentage of females tested were White women followed by Hispanic, Black, Asian, and Other.
- In Prince George’s County, the highest percentage was among Black females followed by Hispanic, Other, and Asian women (Figure 47).

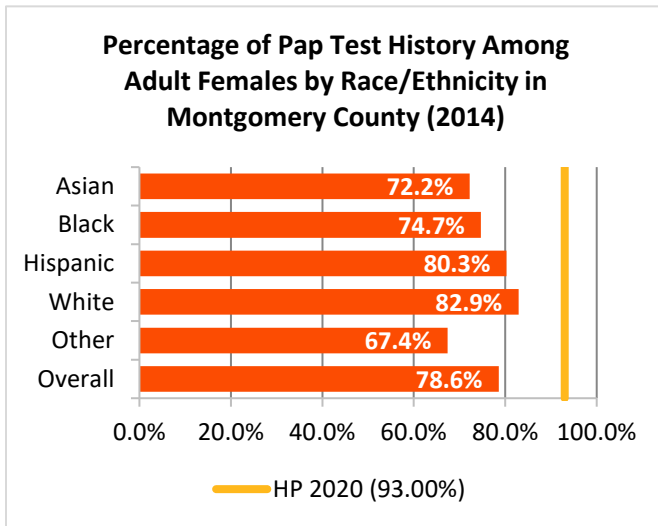


Figure 47. Percentage of Females aged 18 and over that had a Pap Smear in the past 3 years by Race/Ethnicity in Montgomery County, 2014
(Source: [Healthy Montgomery](#), 2014)

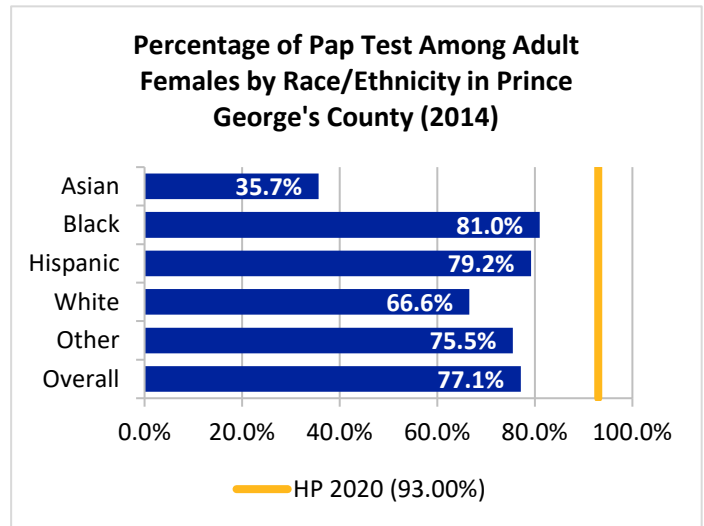


Figure 48. Percentage of Females aged 18 and over that had a Pap Smear in the past 3 years by Race/Ethnicity in Prince George’s County, 2014
(Source: [PGC Health Zone](#), 2014)

4.6 Skin Cancer

Incidence

- Compared to previous years, the rates for melanoma of the skin (all stages) increased slightly in Montgomery County and Maryland (Figure 49).
- In Prince George’s County, the rates fell from 6.6 to 6.1 per 100,000 from 2012 to 2016 (Figure 49).
- Overall, Prince George’s county had a significantly lower incidence rate than Montgomery County and the state (Figure 49).

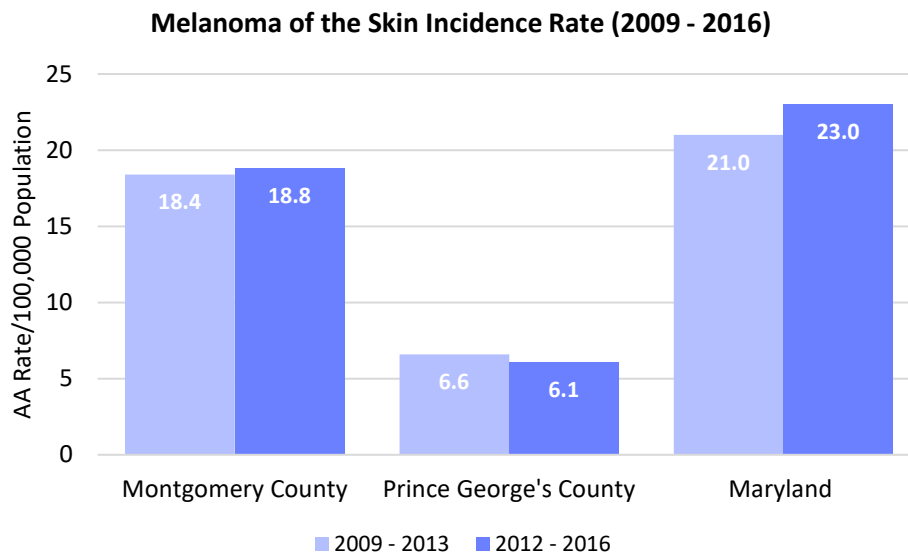


Figure 49. Melanoma of the Skin Incidence Rate in Montgomery County, Prince George’s County, and Maryland, 2009 – 2016
(Source: [State Cancer Profiles](#), 2019)

- In both Montgomery and Prince George’s County, skin cancer incidence rates were higher among men when compared to women (Figure 50).

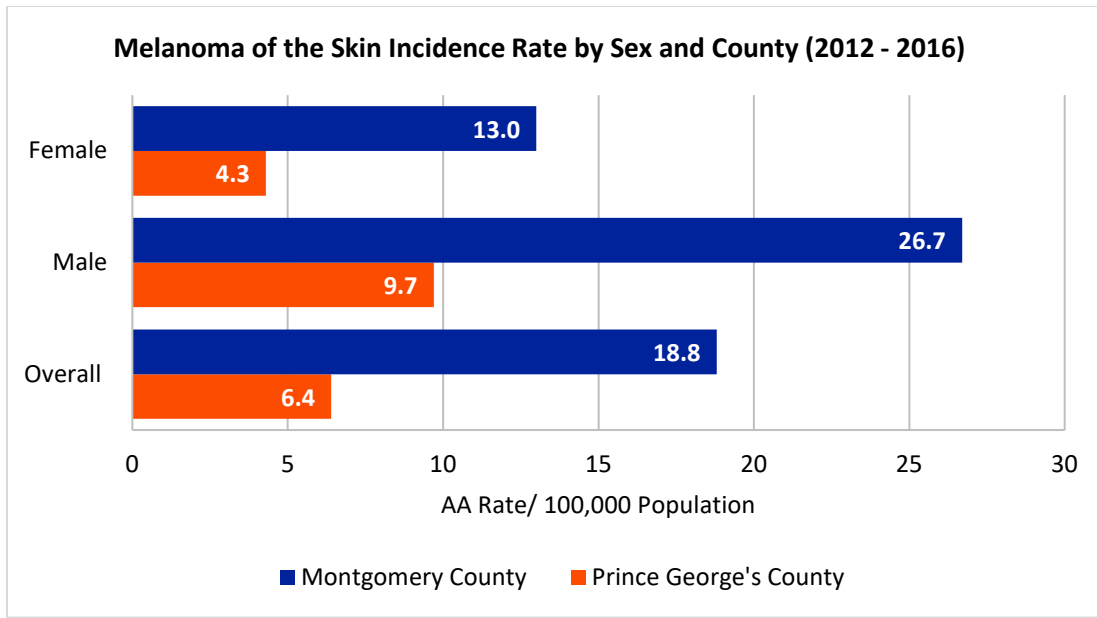


Figure 50. Melanoma of the Skin Incidence Rate by Sex in Montgomery County, Prince George's County, and Maryland, 2012 – 2016
(Source: [State Cancer Profiles](#), 2019)

- In both counties and Maryland, melanoma of the skin incidence rate was highest among individuals aged 65+ and 50+ (Figure 51).
- In Montgomery County, individuals aged 65+ had a 17X higher incident rate than those aged <50; in Prince George's County, the rate is 29X greater than individuals <50 (Figure 51).

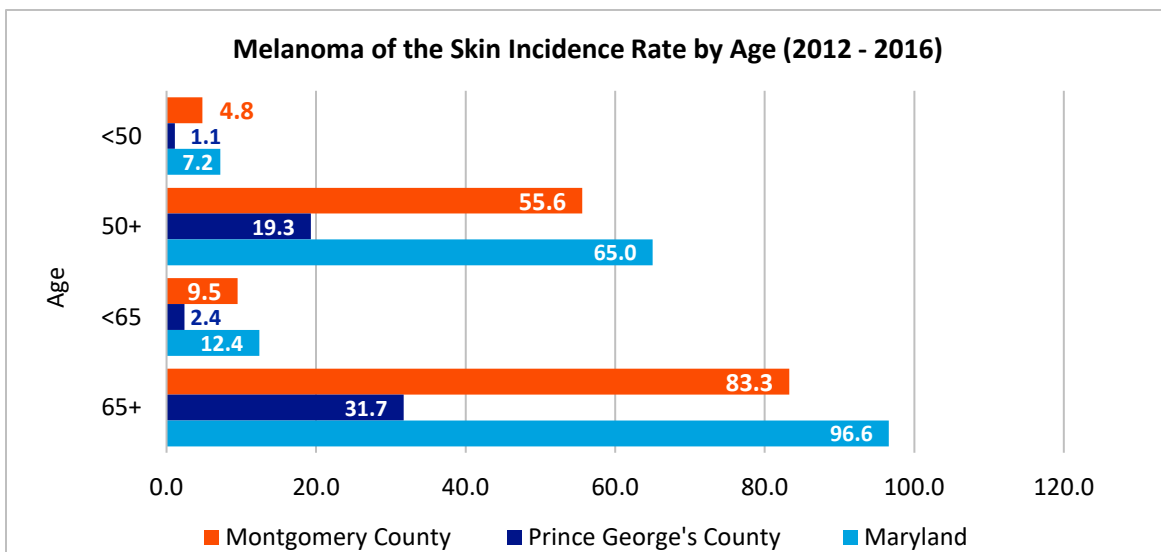


Figure 51. Melanoma of the Skin Incidence Rate by Age in Montgomery County, Prince George's County, and Maryland, 2012 – 2016
(Source: [State Cancer Profiles](#), 2019)

- When looking at melanoma of the skin by race/ethnicity in Montgomery County, White individuals (26.1 per 100,000) had an incidence rate nearly 6X greater than that of Hispanics (4.5 per 100,000) (Figure 52).
- In Prince George’s County, White individuals (19.4 per 100,000) had an incidence rate 3X greater than that of the overall rate for the county (6.1 per 100,000) (Figure 52).

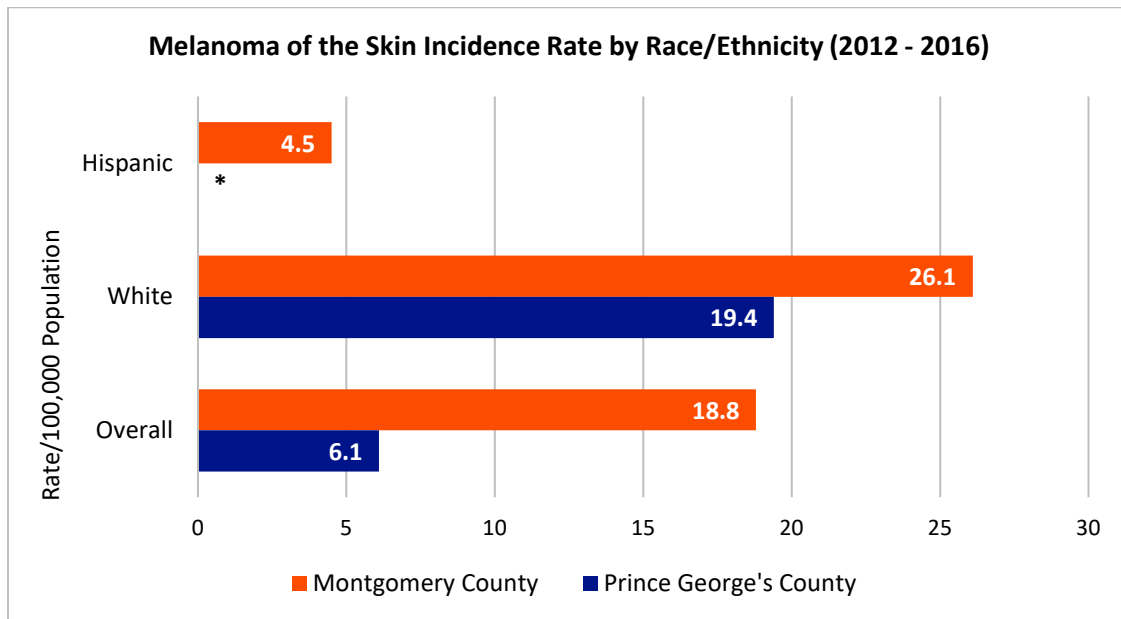


Figure 52. Melanoma of the Skin Incidence Rate by Race/Ethnicity in Montgomery County, Prince George’s County, and Maryland, 2012 – 2016

*Data not available/not applicable
 (Source: [State Cancer Profiles](#), 2019)

Mortality

- In Maryland and both counties, the mortality rates associated with melanoma of the skin have remained stable and meet the HP 2020 target of 2.4 per 100,000 (Figure 53).
- When looking at the mortality rate for melanoma of the skin by age, individuals aged 65+ had the highest mortality rate followed by individuals 50+ for both counties and the state (Figure 54).

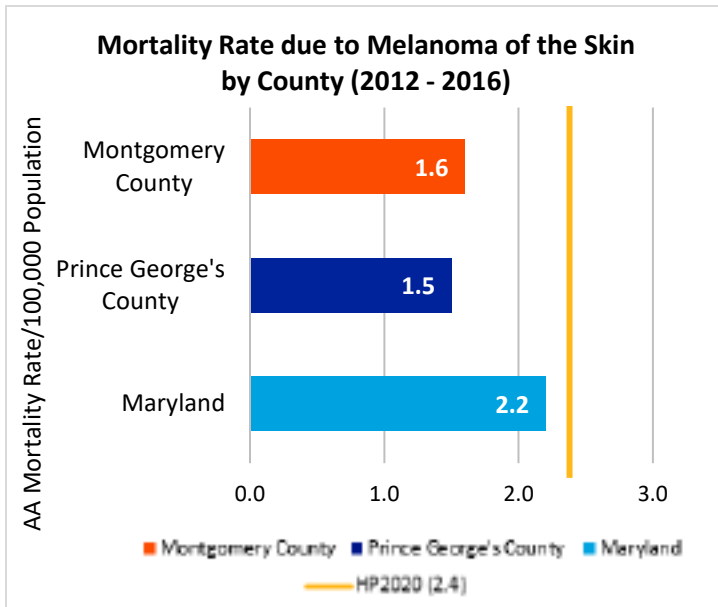


Figure 53. Melanoma of the Skin Mortality Rate in Montgomery County, Prince George’s County, and Maryland, 2012 – 2016.
(Source: [State Cancer Profiles](#), 2019)

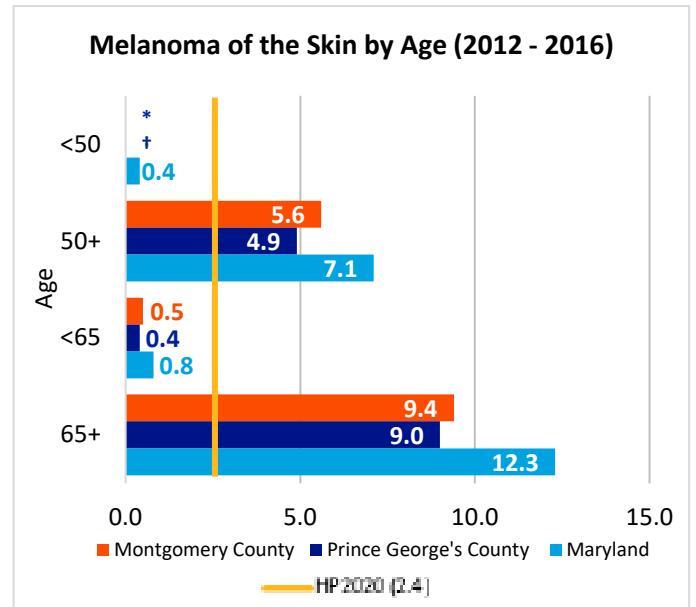


Figure 54. Melanoma of the Skin Mortality Rate by Age in Montgomery County, Prince George’s County, and Maryland, 2012 – 2016.
*†Data not available/not applicable
(Source: [State Cancer Profiles](#), 2019)

- In both Montgomery and Prince George’s County, females had lower mortality rates than males for melanoma of the skin (Figure 55 and 56).
- In Montgomery County, the mortality rate for males was approximately 2X greater than of their female counterparts; it was 3.5X the rate of females in Prince George’s County.
- The HP 2020 target was met for women in both counties and males in Montgomery County. The target was not met for males in Prince George’s County (Figures 55 and 56).

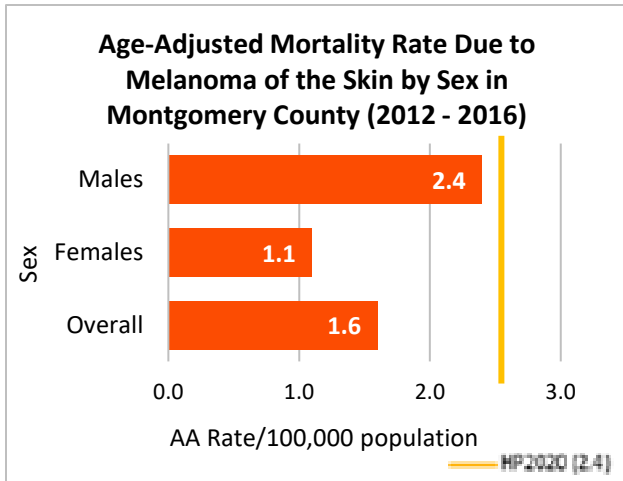


Figure 55. Age-Adjusted Mortality Rate due to Melanoma of the Skin by Sex in Montgomery County, 2012 – 2016
(Source: [State Cancer Profiles](#), 2019)

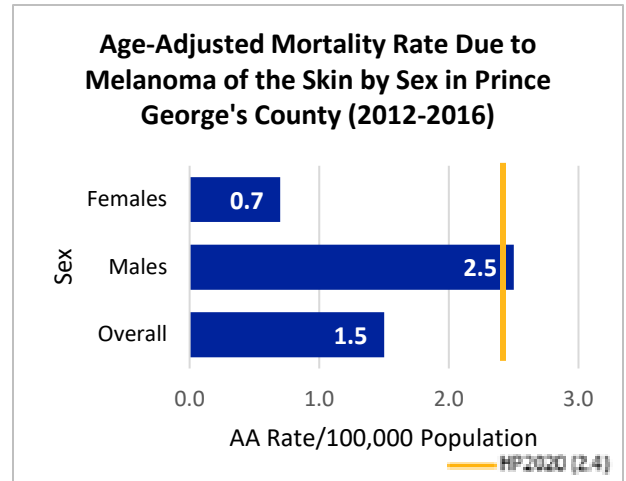


Figure 56. Age-Adjusted Mortality Rate due to Melanoma of the Skin by Sex in Prince George's County, 2012 – 2016
(Source: [State Cancer Profiles](#), 2019)

4.7 Oral Cancer

Incidence

- When comparing both counties and the state overall, Maryland followed by Montgomery County has a higher oral cancer incidence rate than Prince George's County (Figure 57).

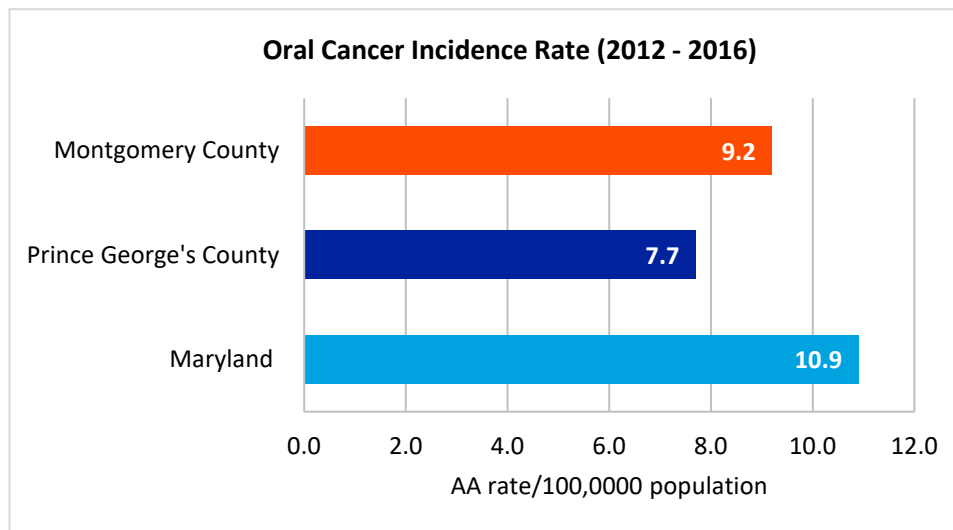


Figure 57. Oral Cancer Incidence Rate by County, 2012 – 2016
(Source: [State Cancer Profiles](#), 2019)

- In both counties, males were more likely to have oral cancer than females. In Montgomery County, both males and females had higher incidence rates when compared to Prince George's County (Figure 58).
- When looking at oral cancer in terms of race/ethnicity, White individuals had the highest incidence rate of oral cancer, followed by Asian, Black and Hispanic for both counties (Figure 59).

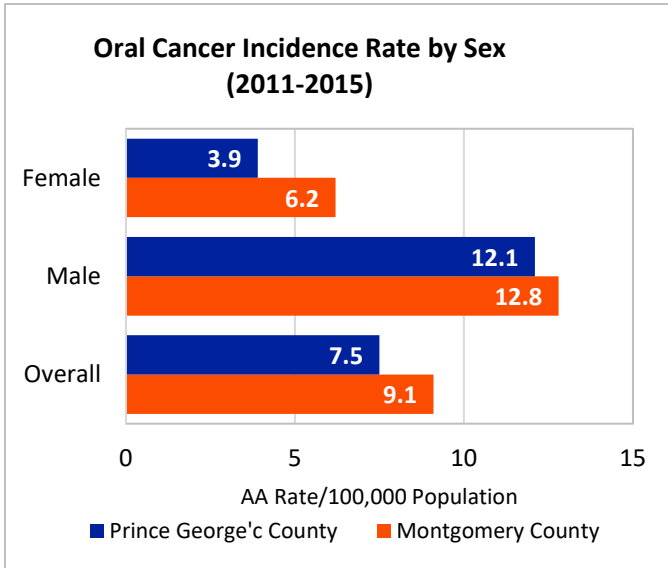


Figure 58. Oral Cancer Incidence Rate by Sex, 2012 – 2016
(Source: [State Cancer Profiles](#), 2019)

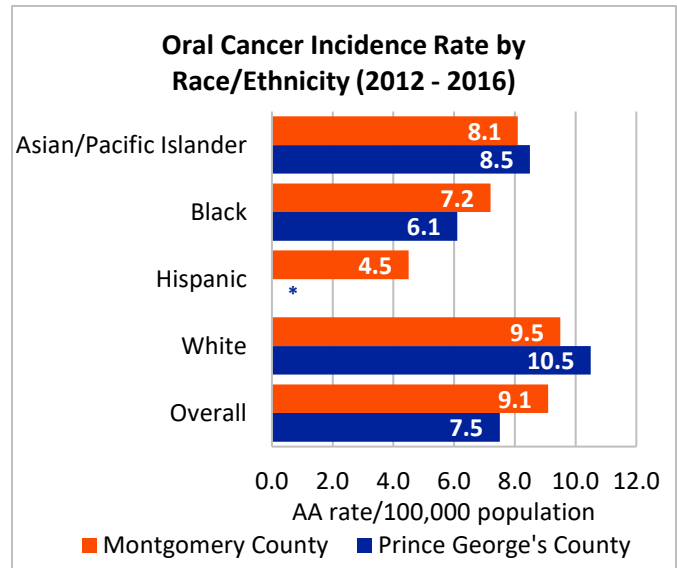


Figure 59. Oral Cancer Incidence Rate by Race/Ethnicity, 2012 – 2016
*Data not available/not applicable
(Source: [State Cancer Profiles](#), 2019)

Mortality

- In both counties and Maryland overall, the mortality rates of oral cancer remained relatively stable over the past several years (Figure 60).
- Montgomery County continuously met the HP 2020 target; Prince George's County and Maryland did not (Figure 60).

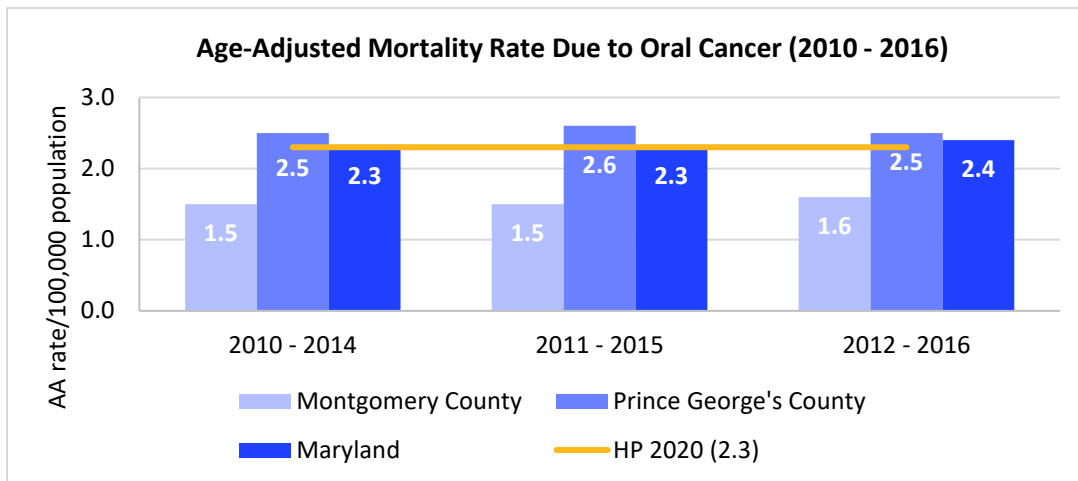


Figure 60. Age-Adjusted Mortality Rate due to Oral Cancer in Montgomery County, Prince George’s County, and Maryland, 2010 – 2016
(Source: [State Cancer Profiles](#), 2019)

- In both counties, males had a higher mortality rate due to oral cancer than females. Males in Prince George’s County, specifically, had a rate 3X higher than that of their female counterparts (Figure 61).
- The rate for both genders in Montgomery County met the HP 2020 target. In Prince George’s County, the mortality rate among men met the HP 2020 target, but the rate for women did not (Figure 61).

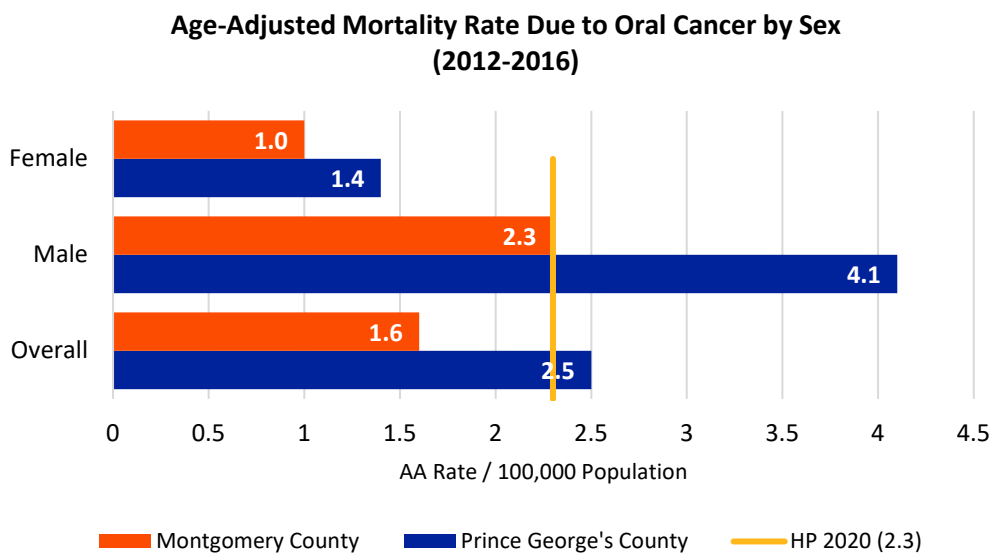


Figure 61. Age-Adjusted Mortality Rate by Sex in Montgomery County, Prince George’s County, and Maryland, 2012 – 2016
(Source: [State Cancer Profiles](#), 2019)

4.8 Thyroid Cancer

Incidence

- The incidence rate for thyroid cancer in Montgomery County was 1.3X higher than that of the state overall, while the rate in Prince George's County was lower than both (Figure 62).

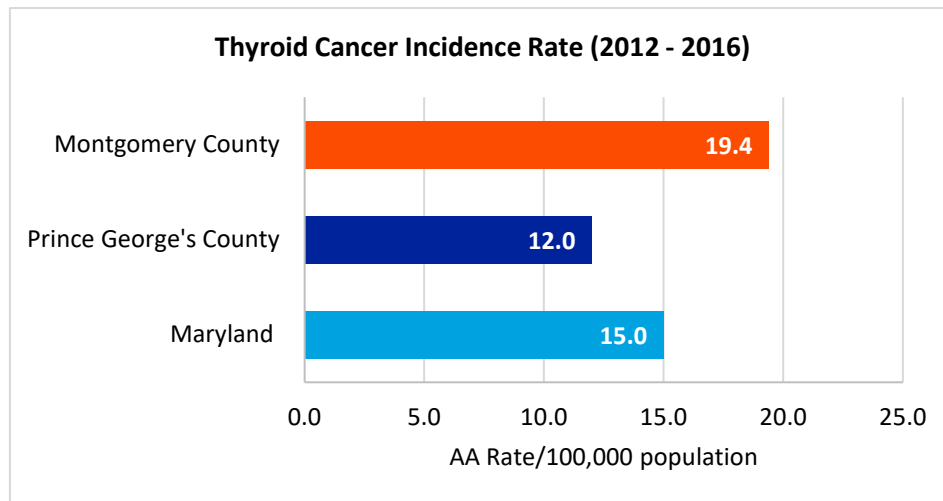


Figure 62. Thyroid Cancer Incidence Rate in Montgomery County, Prince George's County, and Maryland, 2012 – 2016
(Source: [State Cancer Profiles](#), 2019)

- When looking at incidence rate of thyroid cancer by sex, in both counties, females had a rate 3X higher than that of males (Figure 63).
- In both Montgomery and Prince George's County, Asian/Pacific Islanders followed by White individuals had the highest thyroid cancer incidence rates. (Figure 64).

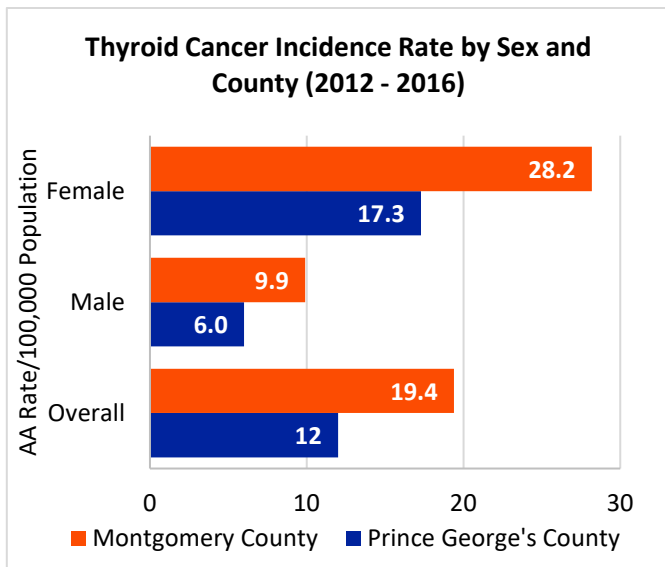


Figure 63. Thyroid Cancer Incidence Rate by Sex in Montgomery County, Prince George’s County, and Maryland, 2012 – 2016
(Source: [State Cancer Profiles](#), 2019)

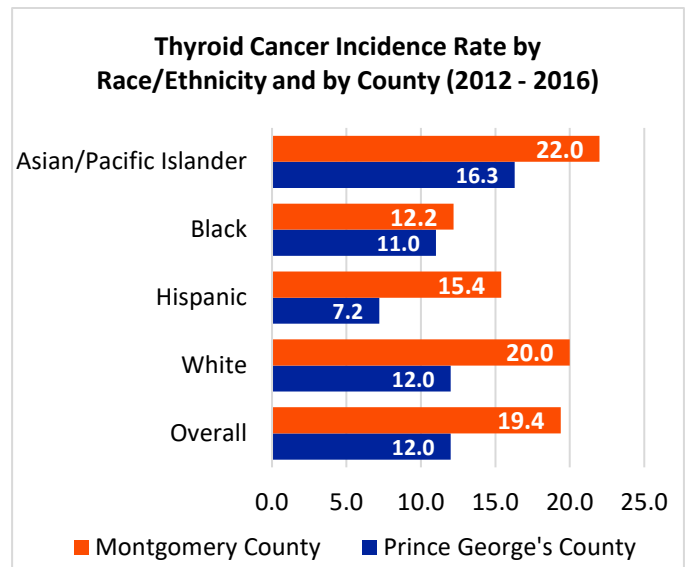


Figure 64. Thyroid Cancer Incidence Rate by Race/Ethnicity in Montgomery County, Prince George’s County, and Maryland, 2012 – 2016
(Source: [State Cancer Profiles](#), 2019)

Mortality

- From 2012 to 2016, the mortality rate for thyroid cancer in Maryland overall was consistent with the rate in both Montgomery and Prince George’s County (Figure 65).

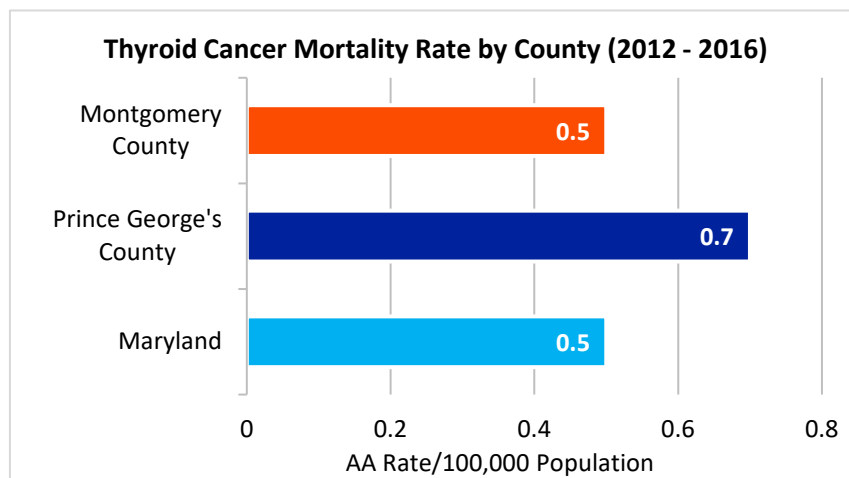


Figure 65. Thyroid Cancer Mortality Rate in Montgomery County, Prince George’s County, and Maryland, 2012 – 2016
(Source: [State Cancer Profiles](#), 2019)

Community Resources

Cancer resources and services in Adventist HealthCare's Rehabilitation Hospital Medical Center's Community Benefit Service Area are provided in various settings ranging from local physician practices, hospitals, and clinics, to county services. Diagnosis and treatment are provided by all hospitals in Montgomery County, the safety net clinics, and many physicians specializing in oncology care. Some of the services are targeted to specific types of cancer as well as to individuals who are most at-risk and needing prevention, screening, and/or treatment. The following is a listing of various services and providers:

1. ADVENTIST HEALTHCARE (AHC)

**Adventist HealthCare White Oak
Medical Center Oncology Program**

Address: 12100 Plum Orchard Dr, Silver
Spring, MD 20904

Phone: 301-891-7600

Website:

<https://www.adventisthealthcare.com/services/cancer/>

AHC Community Classes & Events –

various cancer related classes are offered to patients, family members, and the community such as Eat Well for Health: Nutrition & Cooking Class for Cancer Patients. To learn more about the classes offered and to register please visit the website below.

Phone: 1-800-542-5096

Website:

<https://www.adventisthealthcare.com/calendar/>

Shady Grove Adventist Aquilino Cancer Center

Address: 9905 Medical Center Drive,
Rockville, MD 20850

Phone: 240-826-6297

Website:

<https://www.adventisthealthcare.com/>

[ocations/profile/shady-grove-adventist-aquilino-cancer-center/](https://www.adventisthealthcare.com/locations/profile/shady-grove-adventist-aquilino-cancer-center/)

2. HOPE CONNECTIONS FOR CANCER SUPPORT

Address: 8401 Corporate Dr, Suite
100, Landover, MD 20785

Phone: 240-714-4744

Website:

<https://hopeconnectionsforcancer.org/>

3. WOMEN'S CANCER CONTROL PROGRAM

Phone: 240-777-1750

Website:

<https://www.montgomerycountymd.gov/>

4. COLORECTAL CANCER SCREENING

Address: 1401 Rockville Pike, Rockville,
MD 20852

Phone: 240-777-1222

Website:

<https://www.montgomerycountymd.gov/HHS-program/Program.aspx?id=PHS/PHSCancerscreen-p262.html>

5. STOP SMOKING

Address: 1401 Rockville Pike, Rockville, MD 20852

Phone: 240-777-1222

Website:

<https://www.montgomerycountymd.gov/HHS-Program/Program.aspx?id=PHS/PHSTobaccoStopPrevent-p296.html>

6. MARYLAND BREAST AND CERVICAL CANCER PROGRAM

Phone: 1-800-477-9774

Website:

https://phpa.health.maryland.gov/cancer/Pages/bccp_home.aspx

7. DOCTORS COMMUNITY HOSPITAL

Address: 8118 Good Luck Road, Lanham, MD 20706

Phone: 1-800-477-9774

Website: <https://www.dchweb.org/>

Support Services

Website:

<https://www.dchweb.org/specialties-services/center-comprehensive-breast-care/support-services>

Free Colonoscopy

Phone: 301-552-7705

Website:

<https://www.dchweb.org/about-us/free-colorectal-screenings>

Free Breast and Cervical Screenings

Phone: 301-552-7724

Website:

<https://www.dchweb.org/about-us/community-events/free-breast-and-cervical-screenings>

Look Good Feel Better

Website:

<http://lookgoodfeelbetter.org/>

8. CAMP KESEM

Phone: 253-736-3821

Email: support@campkesem.org

Website: <https://www.campkesem.org/>

9. CANCER + CAREERS

Phone: 646-929-8032

Email: cancerandcareers@cew.org

Website:

<https://www.cancerandcareers.org/en>

10. AMERICAN CANCER SOCIETY – MARYLAND

Website:

<https://www.cancer.org/about-us/local/maryland.html>

11. AFRICAN AMERICAN HEALTH PROGRAM – CANCER

Address: 14015 New Hampshire Avenue, Silver Spring, MD 20904

Phone: 240-777-1833

Email: info@aahpmontgomerycounty.org

Website:

<http://aahpmontgomerycounty.org/cancer>

12. AMERICAN CHILDHOOD CANCER ORGANIZATION

Address: 6868 Distribution Drive, Beltsville, MD 20705

Phone: 301-962-3520

Website: <https://www.acco.org/>

13. PROSTATE CANCER FOUNDATION

Phone: 310-570-4700

Email: info@pcf.org

Website: <https://www.pcf.org/>

14. MONTGOMERY HOSPICE

Address: 1355 Piccard Drive, Suite 100
Rockville, MD 20850

Phone: 301-921-4400

Website:

<https://www.montgomeryhospice.org/>

15. THYCA THYROID CANCER SURVIVORS' ASSOCIATION

Address: 2604 Thistledown Terrace,
Olney, MD 20832

Phone: 301-943-5419

Email: gbloom@thyca.org

Website:

https://montgomerycountymd.galaxydigital.com/agency/detail/?agency_id=76813

16. FOOD & FRIENDS

Address: 219 Riggs Road NE, Washington,
D.C. 20011

Phone: 202-269-2277

Email: info@foodandfriends.org

Website: <https://foodandfriends.org/>

17. HOLY CROSS HEALTH – CANCER SUPPORT GROUPS & PROGRAMS

Website:

<http://www.holycrosshealth.org/cancer-support-groups-programs>

Lymphedema Support Group

Phone: 301-754-7340 (Contact Person is Mike Collins)

Website:

http://www.holycrosshealth.org/body.cfm?id=1923&action=detail&ref=21756&limit_topic=Support%20Groups&limit_locationnext=

Support Group for Latinas with Cancer

Phone: 202-223-9100 (Contact Person is Claudia Campos at Nueva Vida)

Website:

<http://www.holycrosshealth.org/cancer-support-groups-programs>

THYCA: Thyroid Cancer Support Group

Phone: 301-943-5419

Website:

http://www.holycrosshealth.org/body.cfm?id=1923&action=detail&ref=20280&limit_topic=Support%20Groups&limit_locationnext=

Section IV: Findings

Part B: Secondary Data



Chapter 5: Cardiovascular Health

5.1: Heart Disease

5.2: Stroke

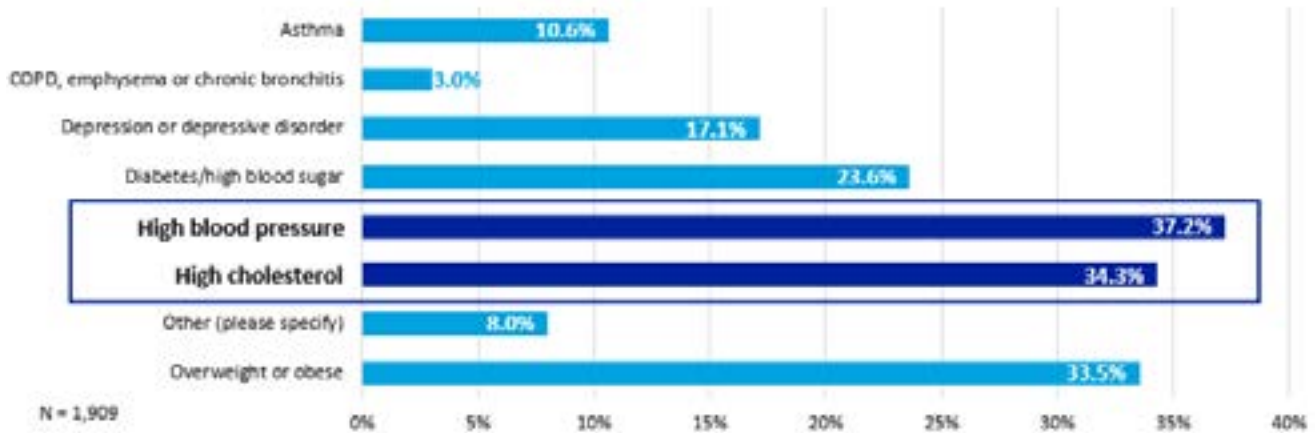
Cardiovascular Health

KEY FINDINGS

Disparities & Indicators	Trend Over Time
<ul style="list-style-type: none"> PGC overall, males, females, Black/AA and Whites do not meet the HP 2020 target (34.8) for stroke mortality; the overall rate increased over time MC and PGC do not meet the HP 2020 target (26.9%) for the high blood pressure prevalence In MC, heart disease mortality rate increased with age; people 65+ have the highest heart disease mortality and ER rate In MC and PGC, NH – Black/AA have the highest heart disease mortality rate followed by NH – White, Asian/PI, Hispanics, and males In PGC, the mortality rate due to stroke is highest among Black/AA and males; in MC, it is highest among females, 65+, and Black/AA 	<ul style="list-style-type: none">  Heart disease mortality rate had a decreasing trend in MC from 2014 – 2017  In PGC, the mortality rate due to stroke increased In MC and PGC, high blood pressure increased In both counties, the ER rate due to high blood pressure increased significantly

Community Perception¹

REHAB CBSA: “Has a doctor, nurse, or other health professional ever said you have, or are at risk for the following?”



¹ Adventist HealthCare (2019). Community Health Needs Assessment Primary Data Survey.

5.1 Heart Disease

Impact

While Maryland deaths due to heart disease have decreased by nearly 20 percent from a decade ago, heart disease is still the leading cause of death in the state.² Approximately 25 percent of all deaths in Maryland can be attributed to heart disease, which includes blood vessel diseases, heart rhythm problems, congenital heart defects, chest pains, heart muscle issues, heart valve problems, and stroke.³ In both Montgomery and Prince George’s County, heart disease mortality disproportionately affects non-Hispanic Black/African-Americans, Whites, individuals ages 65+, and males.

Mortality

- In Maryland, the overall death rate due to heart disease has decreased over time. However, over the past two years, the rates have increased for “all races” and Black individuals (Figure 1).
- Despite the constant decrease in mortality rates, Maryland has not met the Healthy People 2020 target of 103.4 (Figure 1).

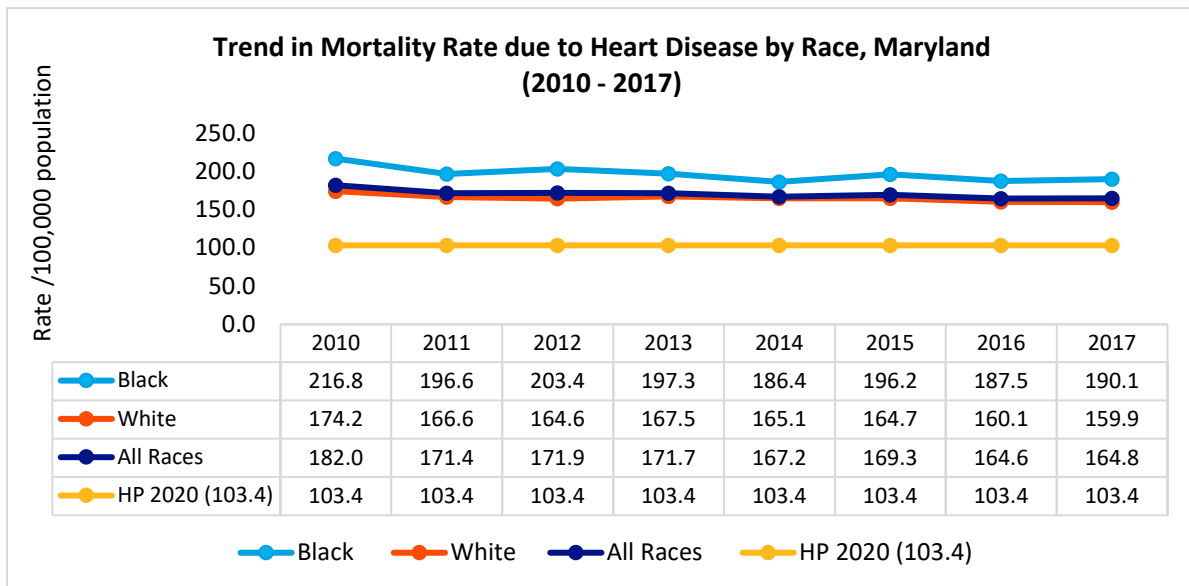


Figure 1. Trends in Mortality Rate due to Heart Disease, 2017
 (Source: [Annual Maryland Vital Statistics Report](#), 2017)

² Hogan, L., Mitchell, V., & Rutherford, B. (2014). Maryland Vital Statistics Annual Report, 2014. *Maryland Vital Statistics*. Retrieved from http://dhmh.maryland.gov/vsa/Documents/14annual_revised.pdf

³ Mayo Clinic. (2014). Diseases and conditions: Heart disease. Retrieved from <http://www.mayoclinic.org/diseases-conditions/heart-disease/basics/definition/con-20034056>

- Similar to the state, Montgomery County has seen a decline in deaths due to heart disease over the past several years (Figure 2). However, the rate in Prince George’s County increased (from 174 to 178 per 100,000) between 2014 to 2017 (Figure 3).
- Montgomery County has consistently had lower mortality rates due to heart disease in Maryland. However, in Prince George’s County, the mortality rate is higher than that of Maryland (Figure 2 and 3).
- Montgomery and Prince George’s Counties as well as Maryland have not met the HP 2020 target for mortality rate due to heart disease (Figure 2 and 3).

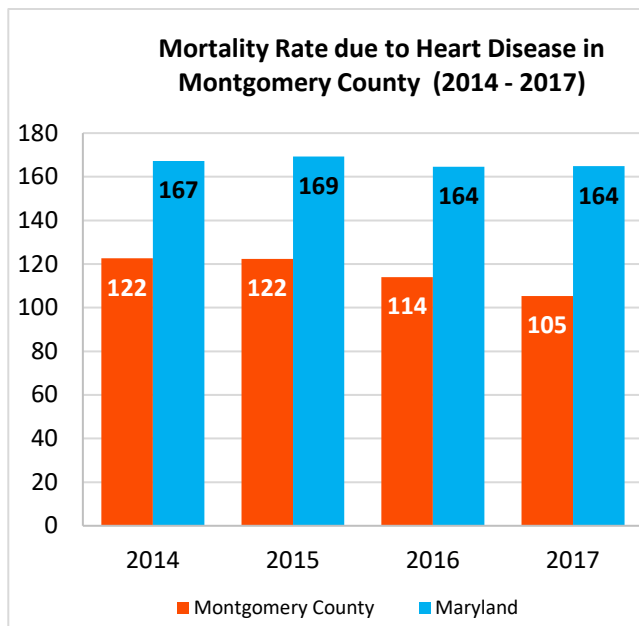


Figure 2. Age-Adjusted Mortality Rate due to Heart Disease per 100,000 population in Montgomery County and Maryland (2014 – 2017)
(Source: [Healthy Montgomery](#), 2018)

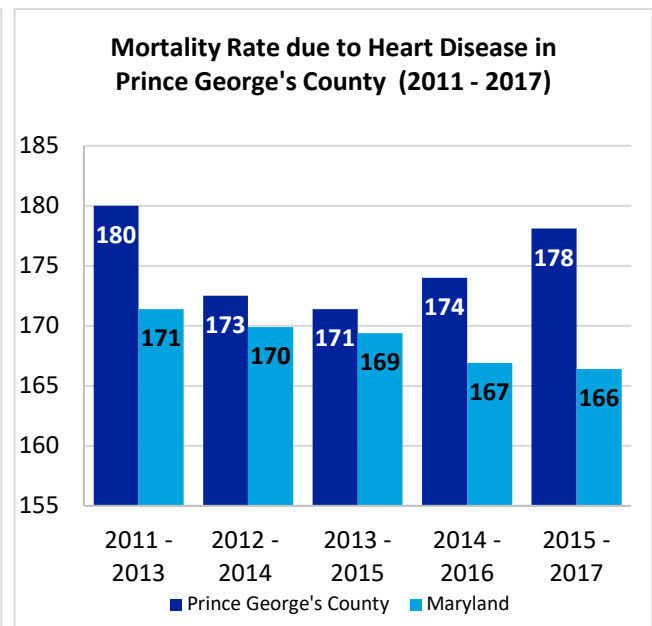


Figure 3. Age-Adjusted Mortality Rate due to Heart Disease per 100,000 population in Prince George’s County and Maryland (2011 – 2017)
(Source: [PGC Health Zone](#), 2018)

- When looking at mortality rates due to heart disease by age in Montgomery County, individuals aged 65+ have the highest rate with 726.1 per 100,000 population (Figure 4).

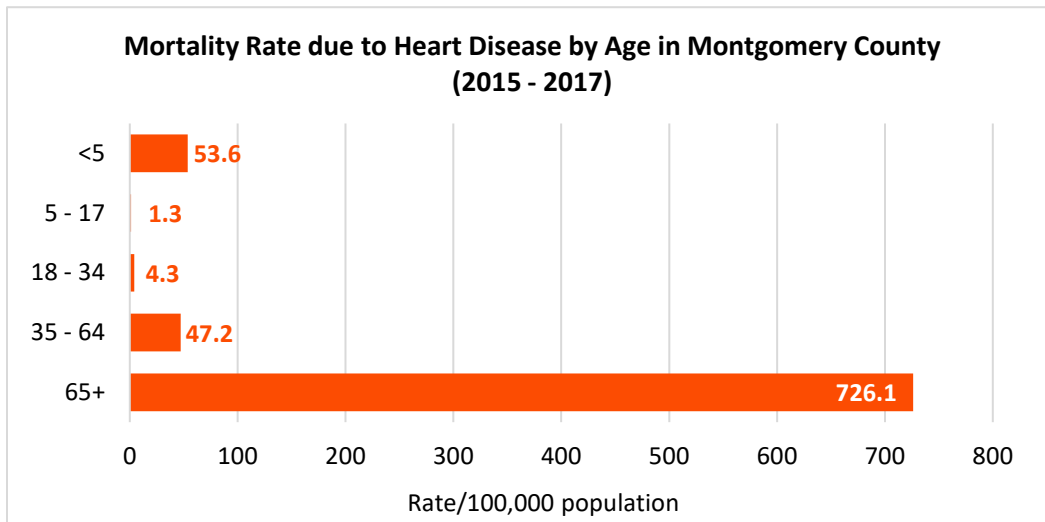


Figure 4. Mortality Rates due to Heart Disease by Age in Montgomery County, 2015 – 2017

(Source: [Healthy Montgomery Core Measures Report](#), 2019)

- Stratifying the mortality rate data by race/ethnicity and sex in Montgomery and Prince George’s County reveal that some groups are more affected by heart disease than others. Although, measurement periods for data shown below are different per county, Black followed by White individuals, still have the highest mortality rates in both counties (Figure 5).
- The mortality rate due to heart disease is 1.3X higher for males when compared to females in Montgomery County during 2015 to 2017 and 1.7X higher for males in Prince George’s County in 2017 (Figure 5 and 6).

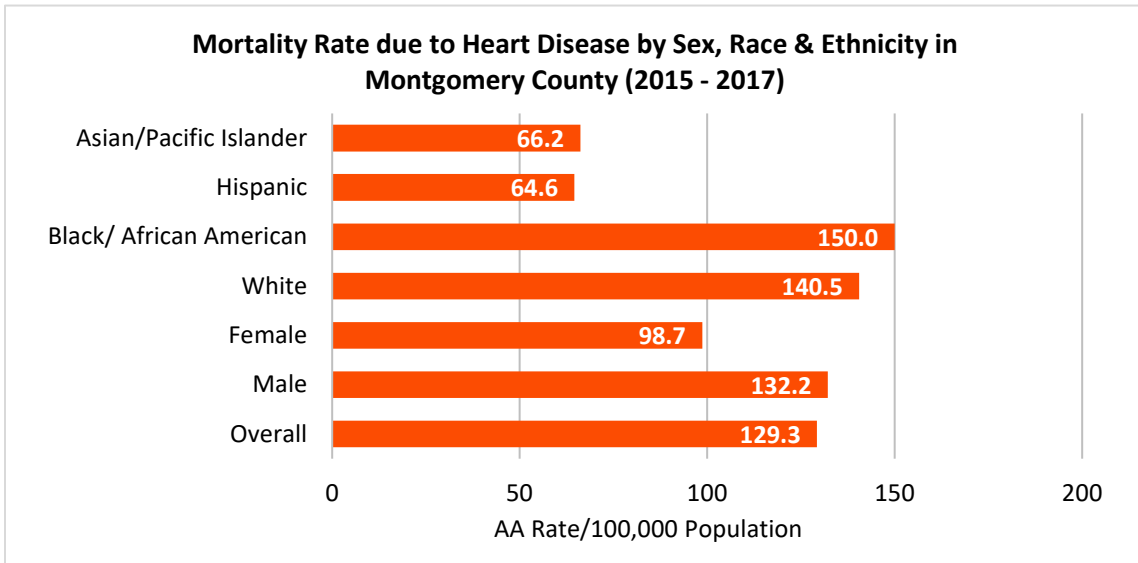


Figure 5. Mortality Rate due to Heart Disease by Sex and Race/Ethnicity in Montgomery County, 2015 – 2017
 (Source: [Healthy Montgomery Core Measures Report](#), 2019)

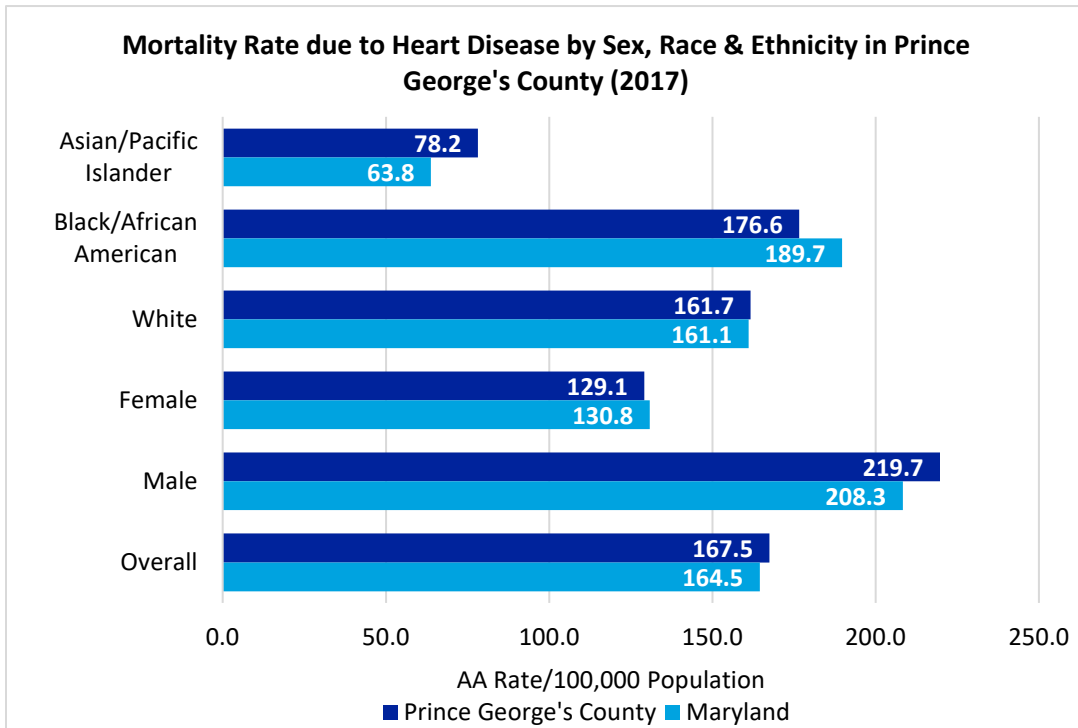


Figure 6. Mortality Rate due to Heart Disease by Sex and Race/Ethnicity in Prince George's County, 2017
 (Source: [LiveStories Statistics](#), 2019)

Hospitalization Rates

- Hospitalization rates due to heart failure for populations 18 and over shows that seniors over the age of 85 years are the most hospitalized population in both Montgomery and Prince George’s County (Figures 7 and 8).
- Although the figures below show data from two different measurement periods, Prince George’s County has an overall higher hospitalization rate due to heart failure than Montgomery County (Figure 7 and 8).

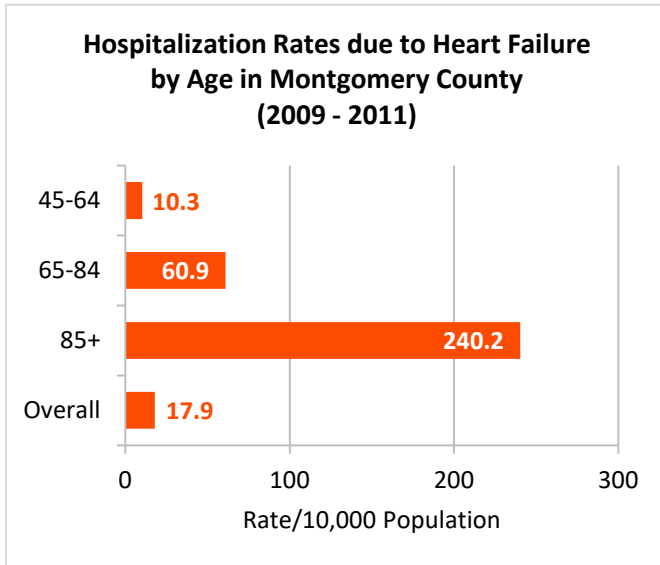


Figure 7. Hospitalization Rates due to Heart Failure by Age in Montgomery County

(Source: [Healthy Montgomery](#), 2009 - 2011)

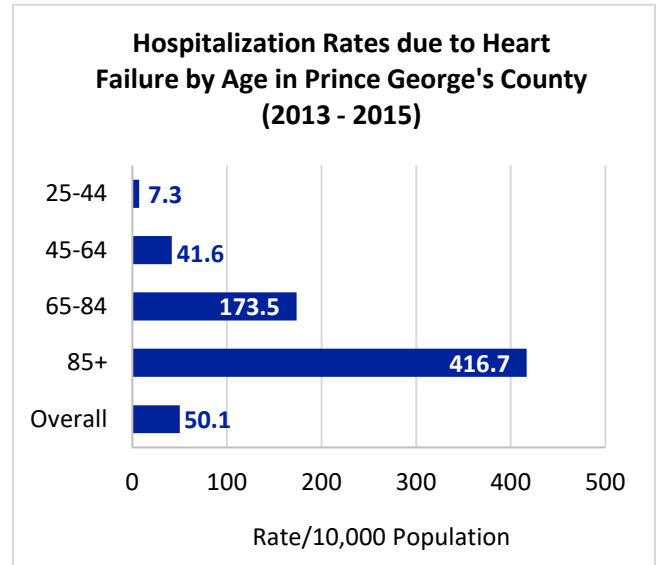


Figure 8. Hospitalization Rates due to Heart Failure by Age in Prince George’s County

(Source: [PGC Health Zone](#), 2013 - 2015)

- In Montgomery County, American Indian/Alaskan Natives are the most hospitalized population with a rate 3.4X higher than the overall rate (Figure 9). Black/African-American individuals are the second most hospitalized population in Montgomery County at 40.2 per 10,000 (Figure 9).
- In Prince George’s County, Black/African-American residents followed by American Indian/Alaskan Natives have the highest hospitalization rate (Figure 10).
- In both Montgomery and Prince George’s Counties, Asian/Pacific Islanders have the lowest hospitalization rate due to heart failure (Figure 9 and 10).

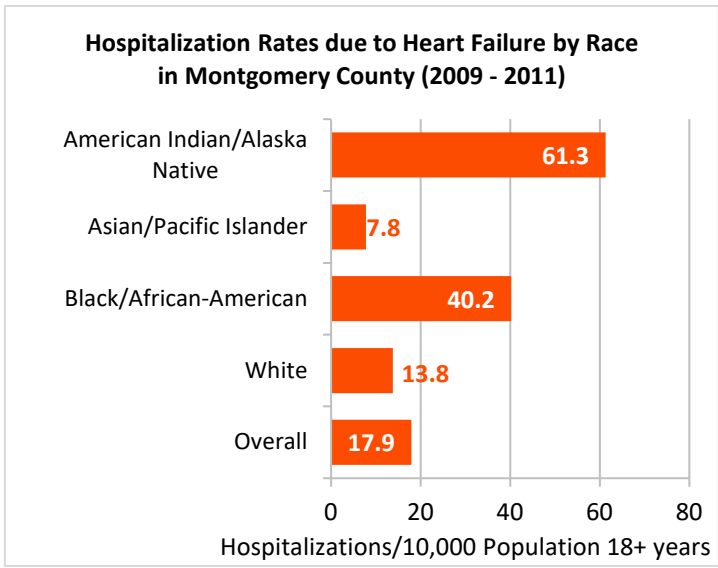


Figure 9. Hospitalization Rates due to Heart Failure by Race in Montgomery County
 (Source: [Healthy Montgomery](#), 2009 - 2011)

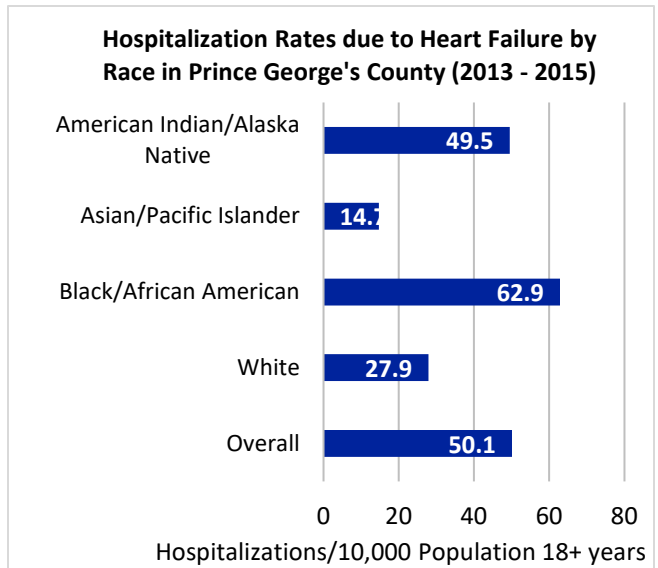


Figure 10. Hospitalization Rates due to Heart Failure by Race in Prince George's County
 (Source: [PGC Health Zone](#), 2013 - 2015)

5.2 Stroke

Impact

Stroke is the fifth leading cause of death in the United States of America and is the leading cause of disability.⁴ In Maryland, stroke is the third leading cause of death.⁵ Black/African-Americans die from stroke at a higher rate than White individuals and other races at both the national and state levels.⁶ Stroke can be prevented by addressing risk factors such as high blood pressure and high cholesterol. In both Montgomery and Prince George's County, the mortality rate due to stroke is highest among males, Black/African-American followed by White individuals.

Mortality

- In Maryland, the overall deaths due to stroke increased over the last several years (Figure 11).
- The death rate due to stroke is significantly higher among Black/African-Americans followed by White individuals when compared to other racial and ethnic groups (Figure 11).

⁴ American Stroke Association. (2016). *Heart Disease, Stroke and Research Statistics At-a-Glance, 2016*. Retrieved from http://www.heart.org/idc/groups/ahamah-public/@wcm/@sop/@smd/documents/downloadable/ucm_480086.pdf

⁵ Healthy Communities Institute. (2016). Leading causes of death, 2010-2012. *Healthy Montgomery*. Retrieved from <https://data.montgomerycountymd.gov/en/Health-and-Human-Services/Leading-causes-of-death-Total-Population-2010-2012/43d7-et7a>

⁶ American Stroke Association. (2016). *Heart Disease, Stroke and Research Statistics At-a-Glance, 2016*. Retrieved from http://www.heart.org/idc/groups/ahamah-public/@wcm/@sop/@smd/documents/downloadable/ucm_480086.pdf

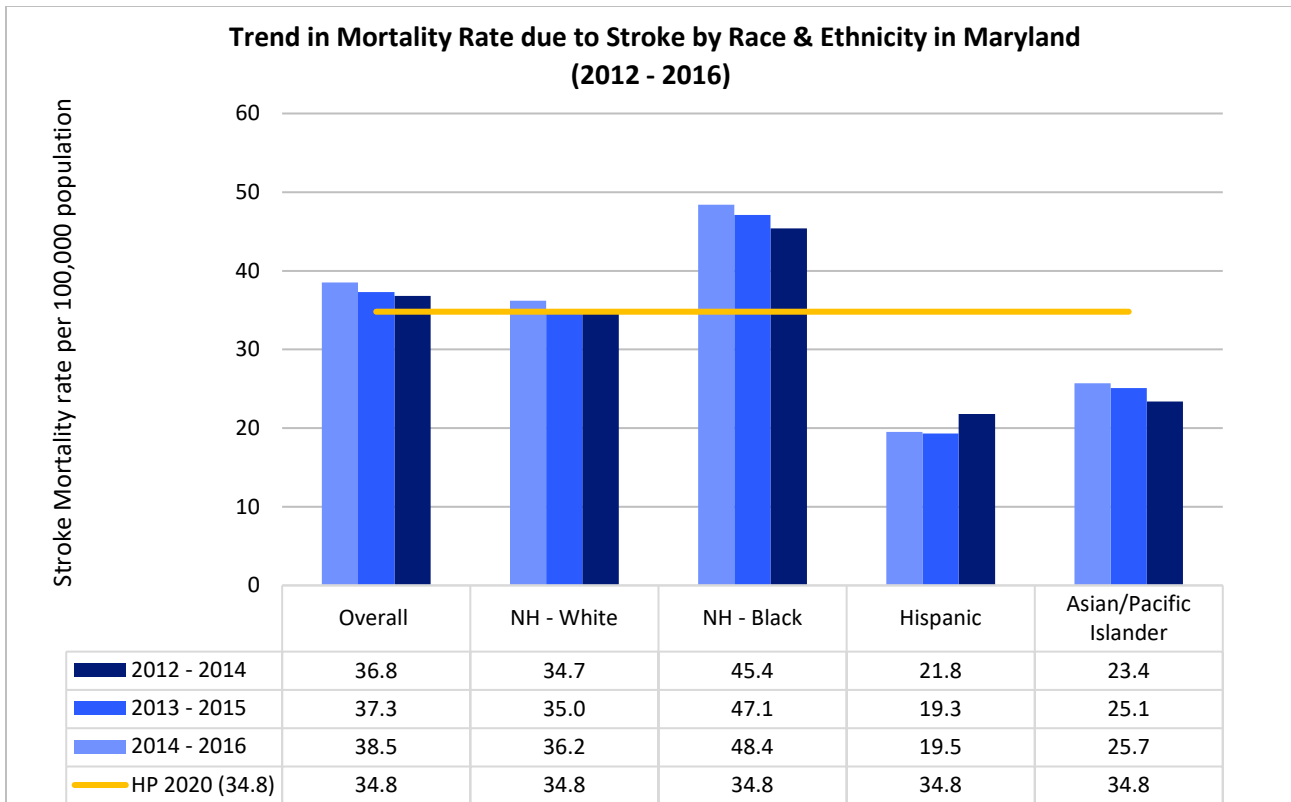


Figure 11. Trends in Death Rate due to Stroke by Race and Ethnicity in Maryland, 2012 - 2016
(Source: [Centers for Disease Control and Prevention](#), 2019)

- The stroke-related mortality rate in Montgomery County has been well below the Healthy People 2020 target of 34.8 deaths per 100,000 for several years in a row (Figure 12).
- Prince George’s County does not meet the national target and has been on an increasing trend for the past several years (Figure 12).

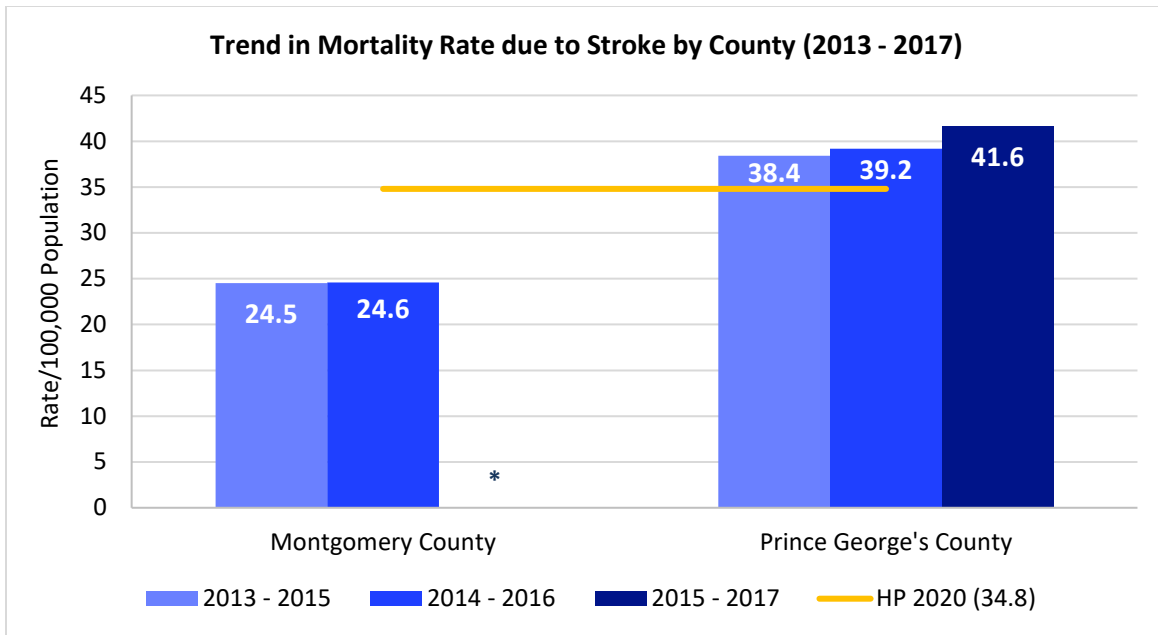


Figure 12. Trend in Mortality due to Stroke in Montgomery County and Prince George's County
 *Data is not available/not applicable
 (Source: [Healthy Montgomery](#) and [PGC Health Zone](#), 2019)

- When looking at death rate due to stroke by gender, from 2013 to 2015 in Montgomery County, females had the highest rate when compared to males. However, in Prince George's County during measurement period 2015 to 2017, males had the highest rate compared to females and the overall rate (43.3 per 100,000) (Figure 13 and 14).

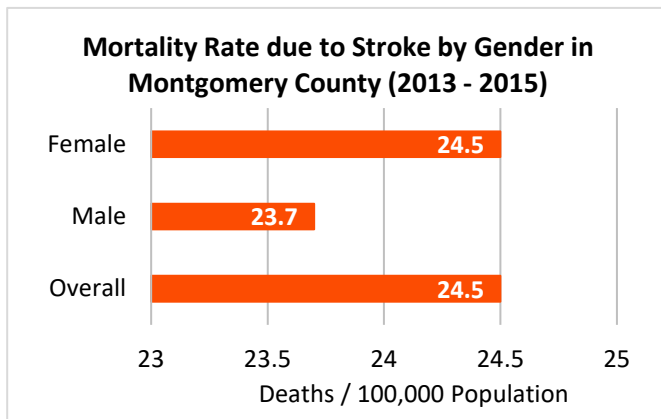


Figure 13. Mortality Rate due to Stroke by Gender in Montgomery County, 2013 – 2015
 (Source: [Healthy Montgomery](#), 2018)

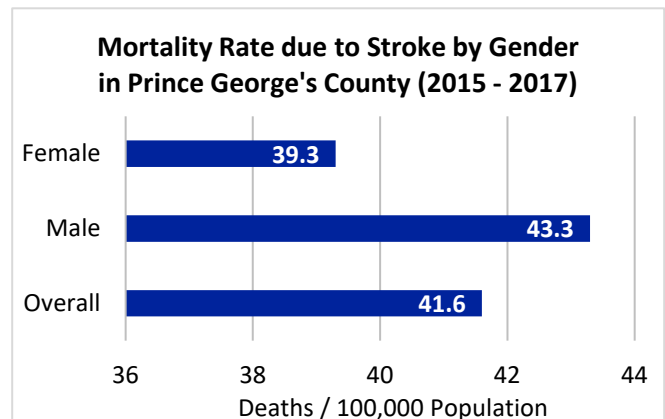


Figure 14. Mortality Rate due to Stroke by Gender in Prince George's County, 2015 – 2017
 (Source: [PGC Health Zone](#), 2018)

- In both Montgomery and Prince George’s County, stratifying the data by race and ethnicity shows that Black/African-Americans have the highest death rate due to stroke than any other race/ethnicity and the overall rate for each of their respective counties despite the different measurement periods (Figure 15 and 16).

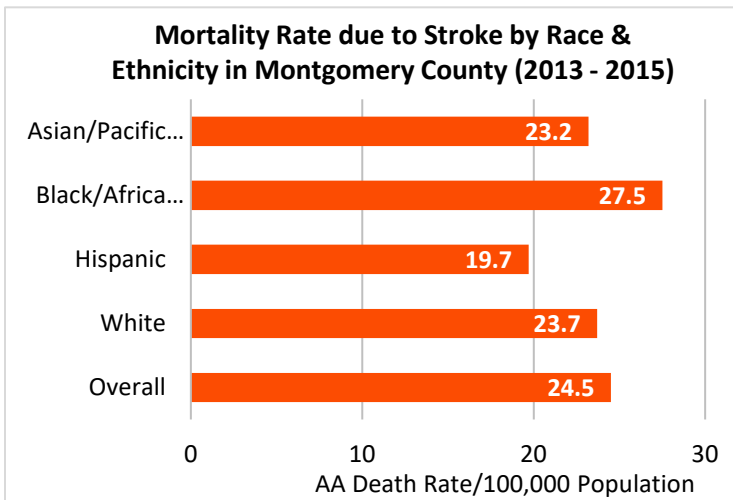


Figure 15. Mortality Rate due to Stroke by Race and Ethnicity in Montgomery County, 2013 – 2015
(Source: [Healthy Montgomery](#), 2018)

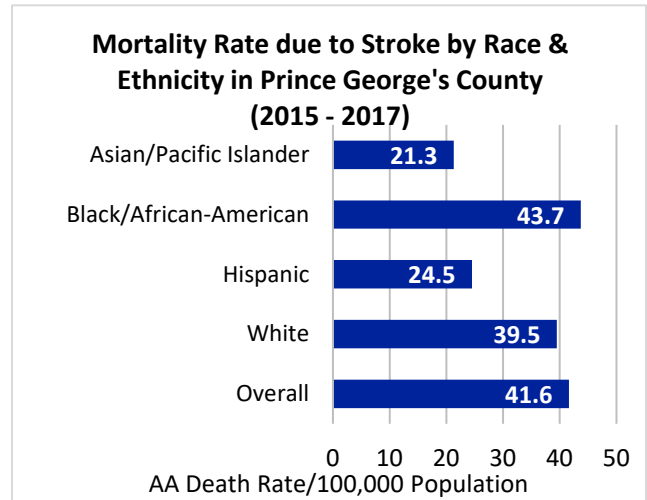


Figure 16. Mortality Rate due to Stroke by Race and Ethnicity in Prince George’s County, 2015 – 2017
(Source: [PGC Health Zone](#), 2018)

- When looking at the data stratified by age in Montgomery County, the mortality rate is highest for individuals ages 65+ (Figure 17).

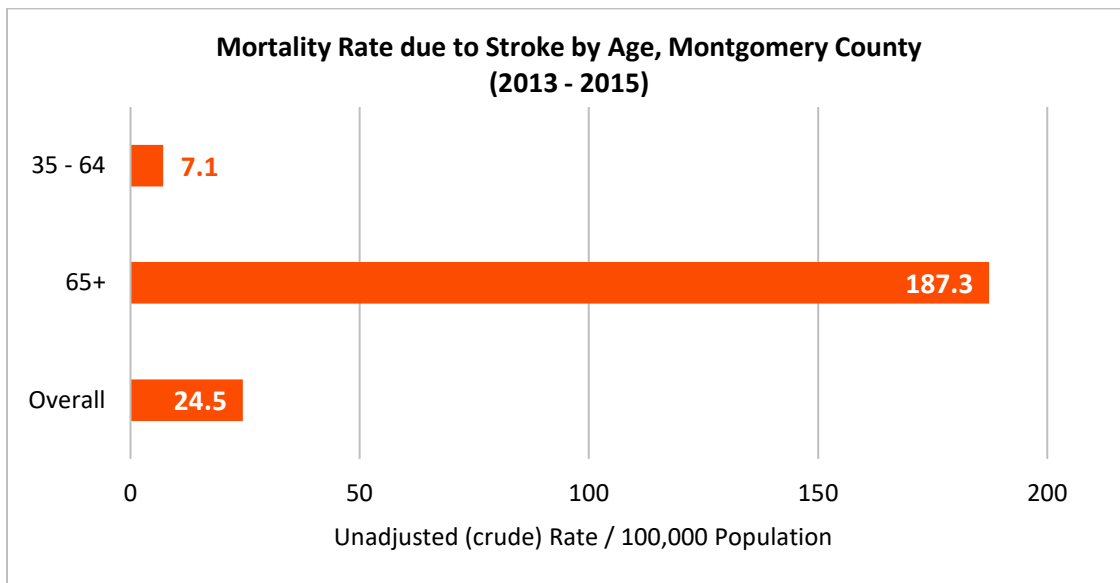


Figure 17. Mortality Rate due to Stroke by Age in Montgomery County, 2013 – 2015
(Source: [Healthy Montgomery](#), 2019)

High Blood Pressure

- The percentage of high blood pressure prevalence has worsened over time for both Montgomery and Prince George’s Counties (Figure 18).
- From 2015 to 2016, Montgomery County high blood pressure prevalence increased by 45.7 percent, in Prince George’s County the prevalence increased by 36.8 percent (Figure 18).
- The HP 2020 target has not been met for either county (Figure 18).

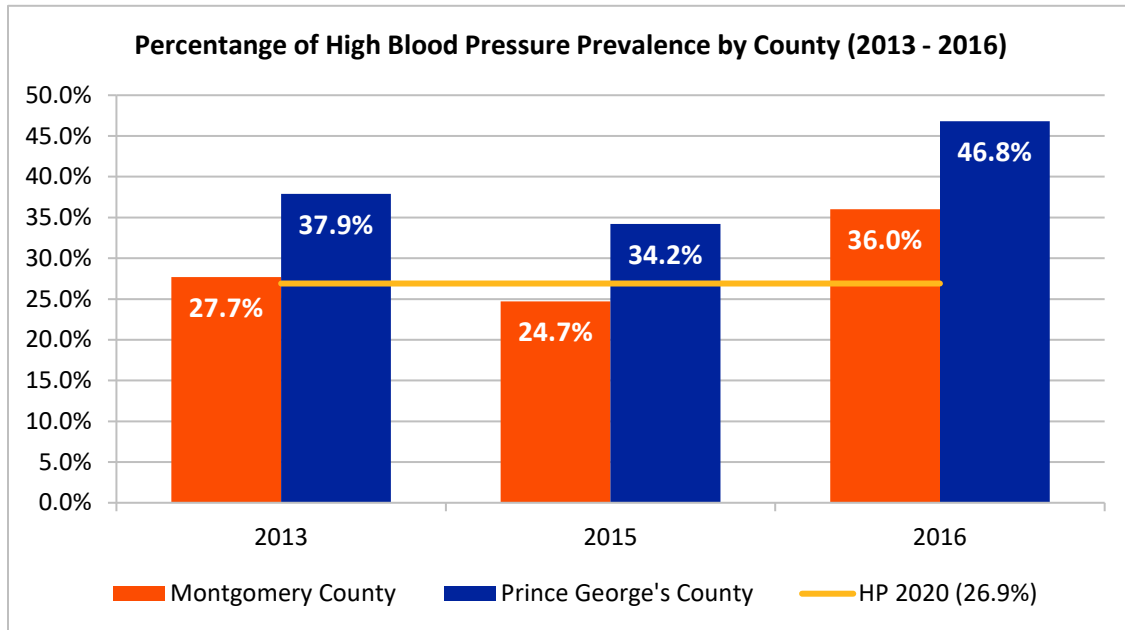


Figure 18. Percentage of High Blood Pressure Prevalence by County, 2013 – 2016
(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2019)

- When stratified by race and ethnicity, Black/African-American and White individuals are disproportionately burdened with high blood pressure in Montgomery County, whereas Black/African-American and those who identify as Other races are more burdened in Prince George’s County (Figure 19).

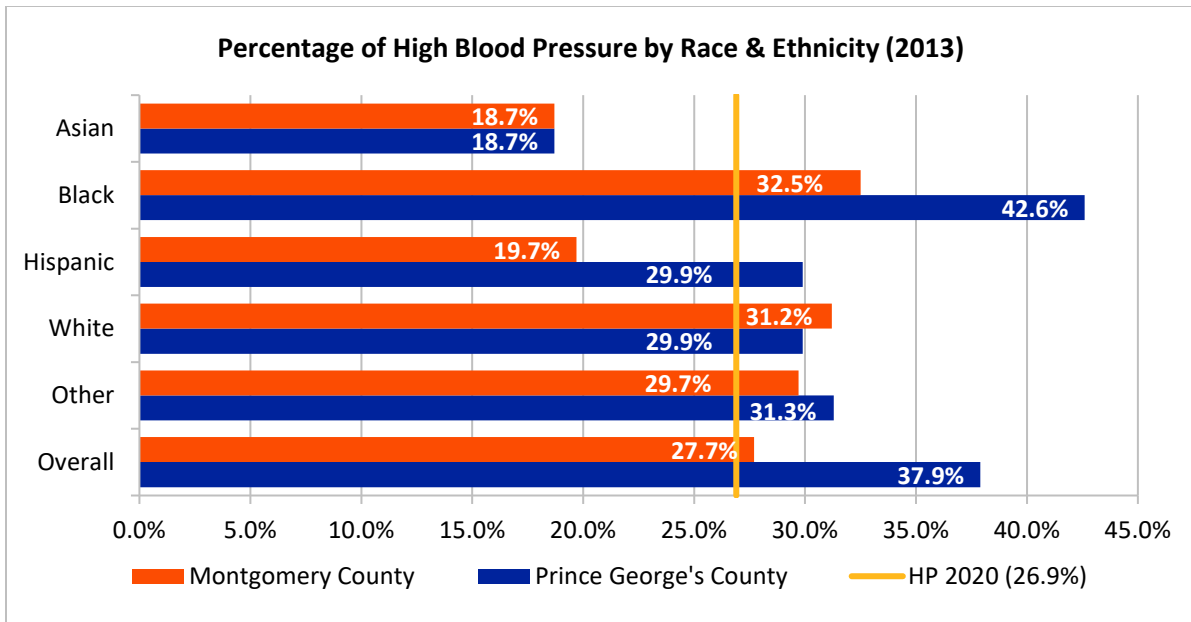


Figure 19. Prevalence of High Blood Pressure by Race and Ethnicity in Montgomery County and Prince George's County
(Source: [Healthy Montgomery](#) and [PGC Health Zone](#), 2013)

- When looking at percentage of high blood pressure prevalence by gender, males are more disproportionately affected than females in Montgomery and Prince George's (Figure 20).
- When broken down into age groups, seniors 65 and over have the highest prevalence of hypertension in both counties, followed by the 45 to 64 age group (Figure 21).

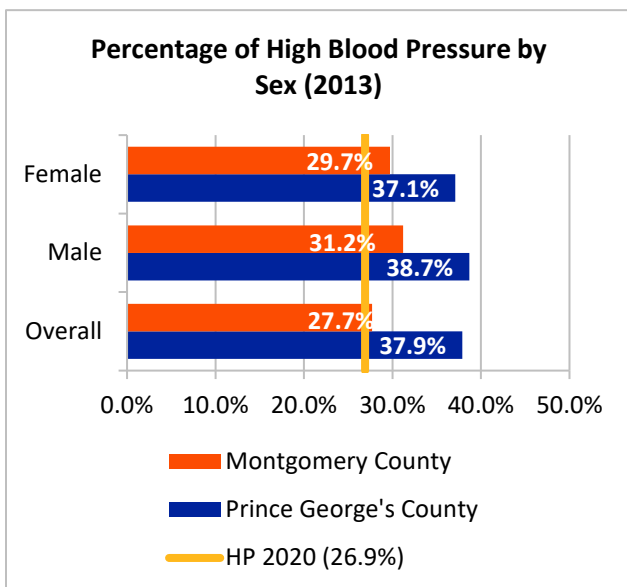


Figure 20. Prevalence of High Blood Pressure by Sex in Montgomery County and Prince George's County
(Source: [Healthy Montgomery](#) and [PGC Health Zone](#), 2013)

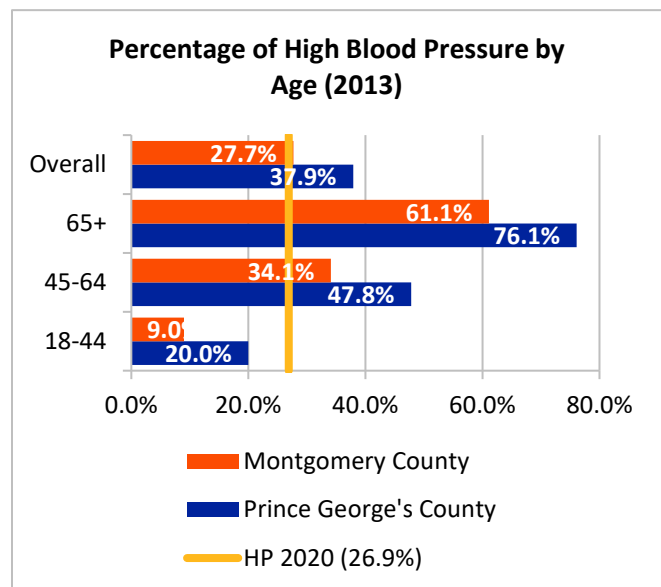


Figure 21. Prevalence of High Blood Pressure by Age in Montgomery County and Prince George's County.
(Source: [Healthy Montgomery](#) and [PGC Health Zone](#), 2013)

- In terms of emergency room visit rates, both Montgomery and Prince George’s County have an increasing trend in utilization over the past several years (Figure 22).
- When compared to one another, Prince George’s County has a significantly higher utilization rate than Montgomery County with a difference of 95.7 (Figure 22).

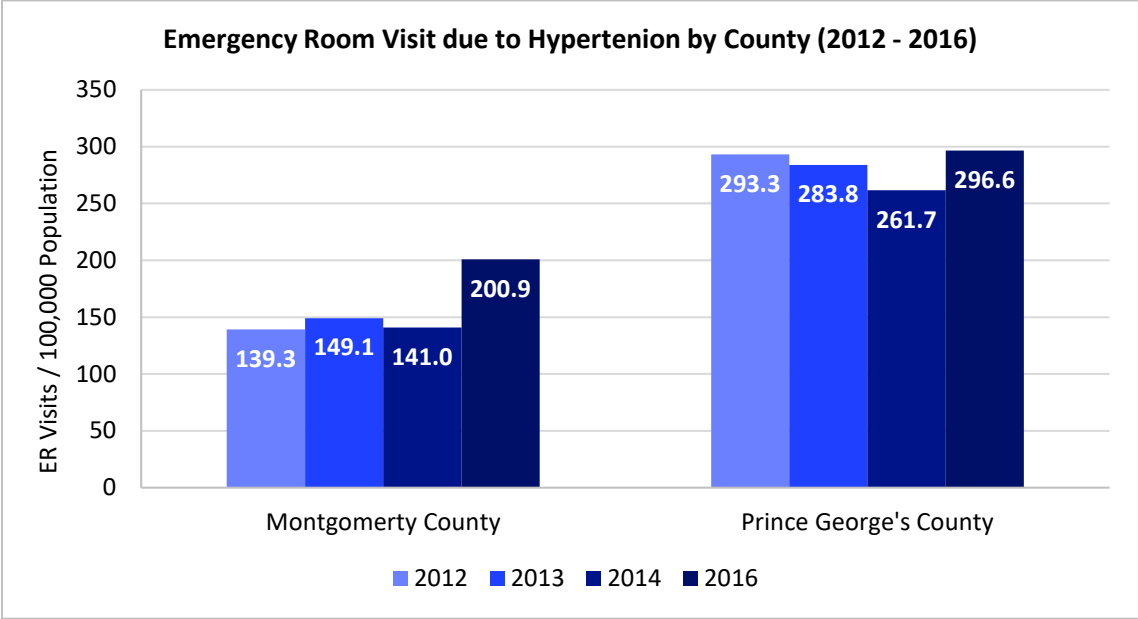


Figure 22. Trend in Emergency Room Visit Rate due to Hypertension in Montgomery County and Prince George’s County
 (Source: [Healthy Montgomery](#) and [PGC Health Zone](#), 2014)

High Cholesterol

- High cholesterol prevalence in Prince George’s County has decreased from 2013 to 2017 by nearly 10 percent. However, the county still does not meet the HP 2020 target of 13.5 percent (Figure 23).
- Similarly, Montgomery County has also seen a decrease in high cholesterol prevalence by 5.3 percent between 2013 to 2015, there is no data available through 2017. Despite the decrease, Montgomery County does not meet the HP 2020 target (Figure 23).

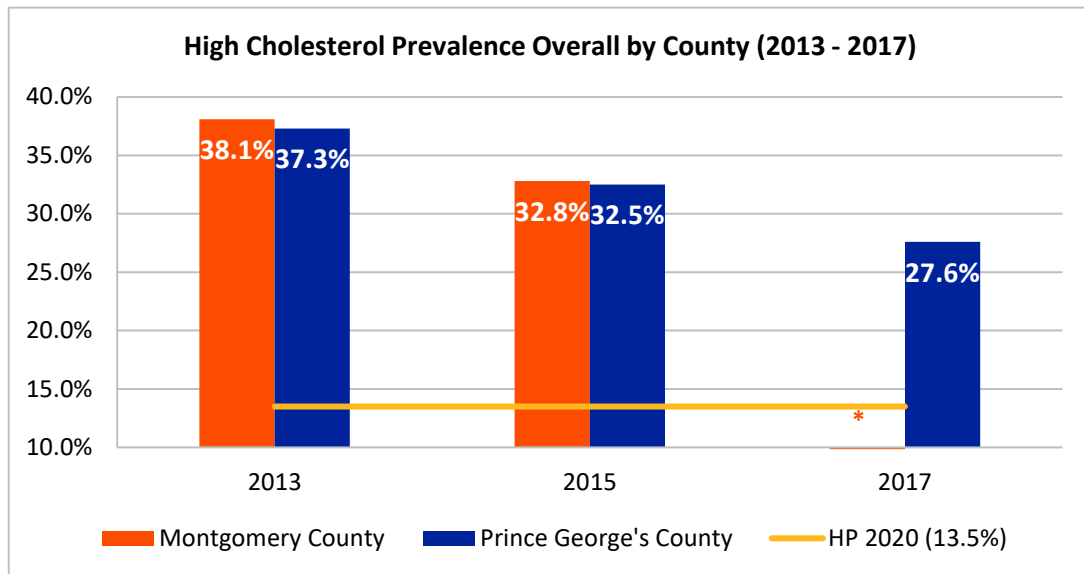


Figure 23. Prevalence of High Cholesterol in Montgomery and Prince George’s Counties
 *Data not available/not applicable
 (Source: [Healthy Montgomery](#) and [PGC Health Zone](#), 2018)

- Stratifying the data by race and ethnicity, shows that the prevalence of high cholesterol is highest among those who identify as Other and White in Montgomery County, whereas it is highest among White individuals followed by Others in Prince George’s County (Figure 24 and 25).

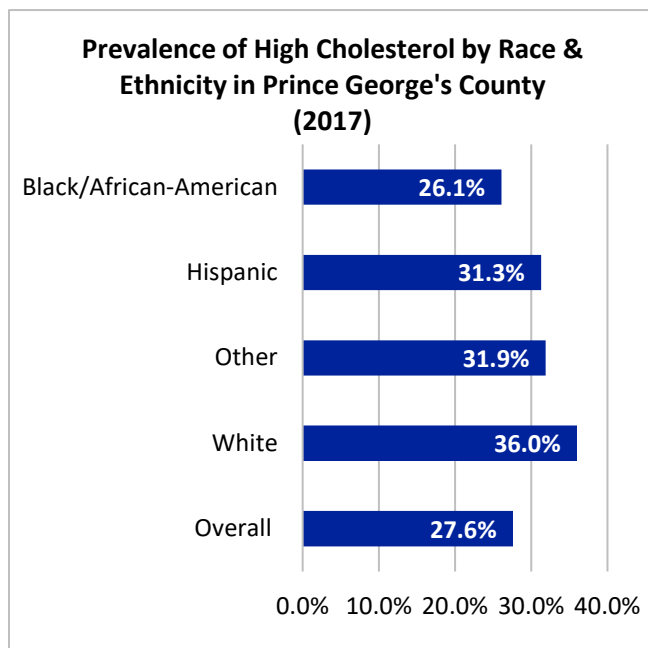


Figure 24. Prevalence of High Cholesterol in Prince George’s County by Race and Ethnicity
 (Source: [PGC Health Zone](#), 2018)

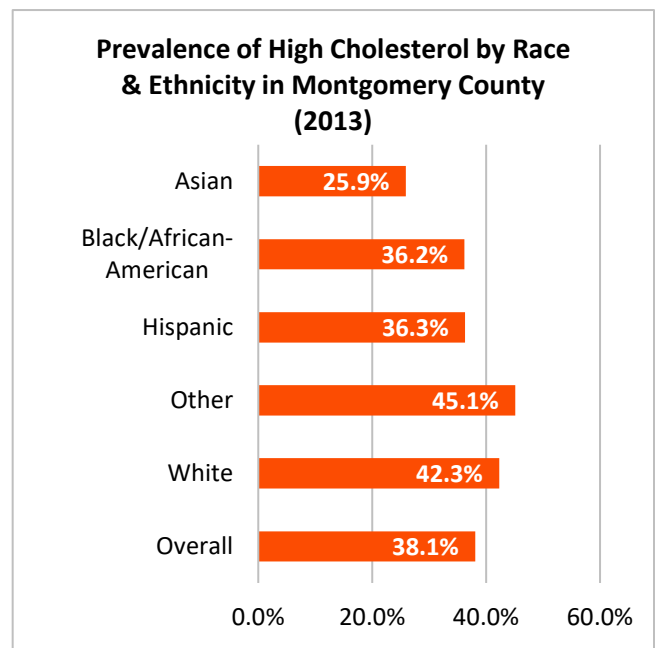


Figure 25. Prevalence of High Cholesterol in Montgomery County by Race and Ethnicity
 (Source: [Healthy Montgomery](#), 2016)

- In Prince George’s County during the 2017 measurement period, females were more affected by high cholesterol than males. However, in Montgomery County during the most recent measurement period in 2013, males were more affected (Figure 26 and 27).

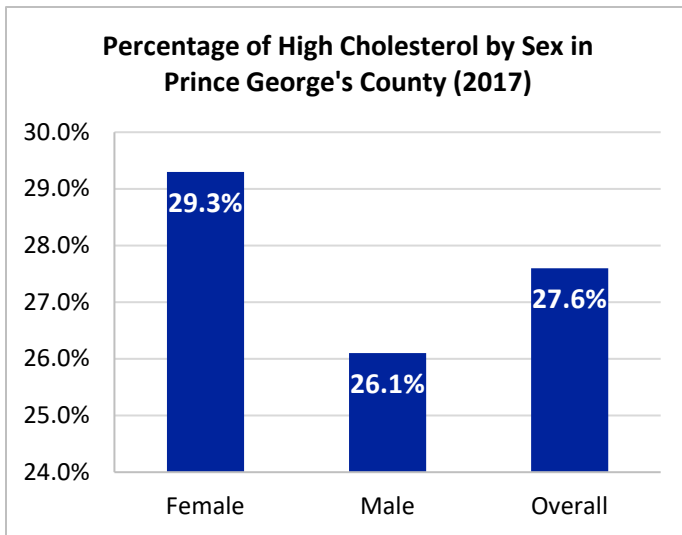


Figure 26. Prevalence of High Cholesterol by Gender in Prince George’s County, 2017
(Source: [PGC Health Zone](#), 2019)

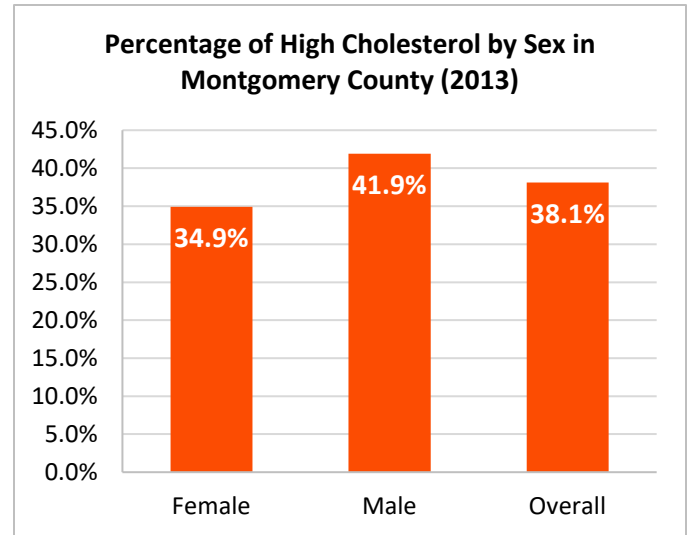


Figure 27. Prevalence of High Cholesterol by Gender in Montgomery County, 2013
(Source: [Healthy Montgomery](#), 2016)

- In terms of age, seniors over the age of 65, followed by residents between the ages of 45 and 64, have the highest prevalence of high cholesterol in both counties despite the different measurement periods (Figure 28 and 29).

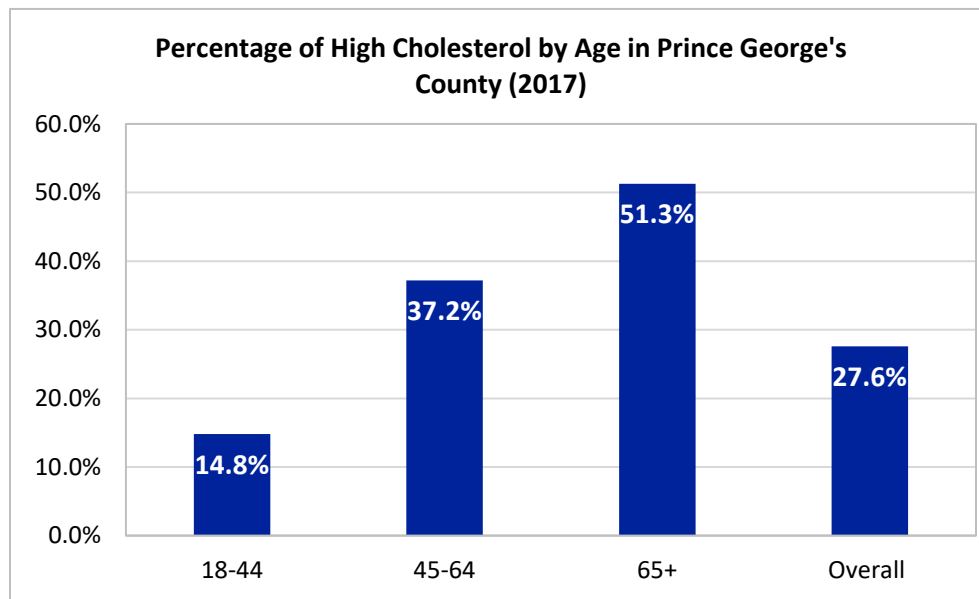


Figure 28. Prevalence of High Cholesterol by Age in Prince George’s County, 2017
(Source: [PGC Health Zone](#), 2019)

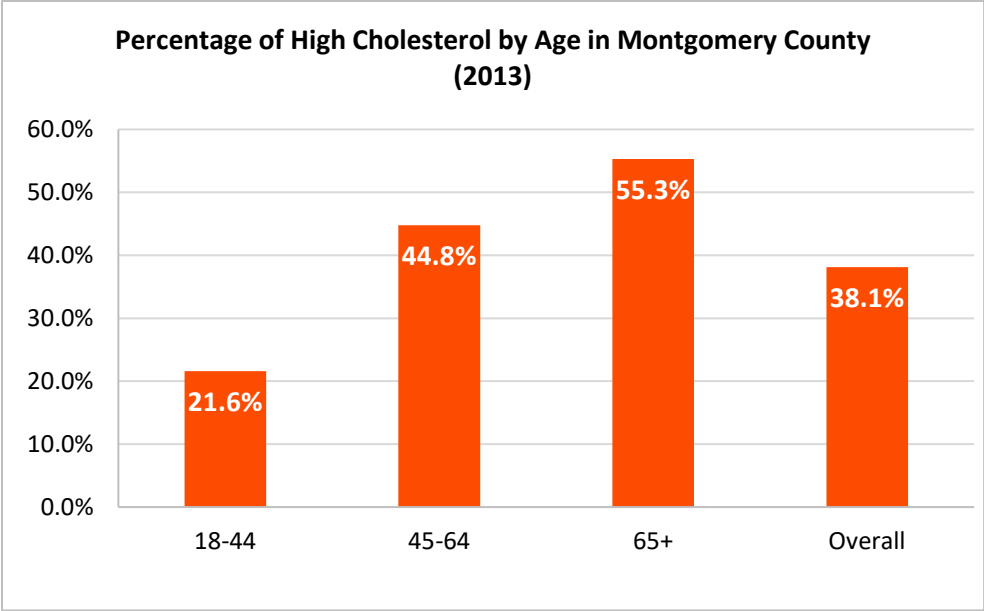


Figure 29. Prevalence of High Cholesterol by Age in Montgomery County, 2013
(Source: [Healthy Montgomery](#), 2016)

Community Resources

Acute care cardiology services are provided by all hospital providers in Prince George's and Montgomery Counties. In addition, there are numerous physician providers as well as clinics that provide diagnosis and treatment for heart disease and stroke. The following are additional resources and services for heart disease and stroke in the community:

1. ADVENTIST HEALTHCARE (AHC)

Heart & Vascular Care

Phone: 301-569-6961

Website:

<https://www.adventisthealthcare.com/services/heart-vascular/>

Free Monthly Blood Pressure Testing

Phone: 1-800-542-5096

Website:

<https://www.adventisthealthcare.com/calendar/details/dates/?topicId=68>

Stroke Rehabilitation

Website:

<https://www.adventisthealthcare.com/services/rehabilitation/neurological/stroke/>

Free Stroke Support Group

Phone: 301-569-6961

Website:

<https://www.adventisthealthcare.com/calendar/details/?eventId=e426205c-efd9-de11-9638-005056947103>

Stroke Treatment

Website:

<https://www.adventisthealthcare.com/services/brain-spine/stroke/>

2. PRINCE GEORGE'S COUNTY HEALTH & HUMAN SERVICES

Reduce Chronic Diseases by Reducing Obesity

Phone: 301-883-7879

Website:

<https://www.princegeorgescountymd.gov/2476/Reduce-Chronic-Diseases-by-Reducing-Obes>

3. MONTGOMERY COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES

Senior Nutrition Program

Address: 401 Hungerford Drive, Rockville, MD 20850

Phone: 240-777-3000

Website:

<https://www.montgomerycountymd.gov/hs-program/program.aspx?id=ads/adsseniornutr-p190.html>

4. DOCTORS COMMUNITY HOSPITAL

Stroke Support Group

Address: 9610 Good Luck Road, Lanham, MD 20706

Phone: 301-552-8144

Website:

<https://www.dchweb.org/wellness/support-groups/stroke-support-group>

5. WOMEN HEART

Phone: 202-728-7199

Email: mail@womenheart.org

Website: <https://www.womenheart.org/>

6. MENDED HEARTS

Phone: 1-888-432-7899

Resource Center: 229-518-2680

Email: info@mendedhearts.org

Website: <https://mendedhearts.org/>

7. AMERICAN HEART ASSOCIATION

Bethesda Chapter

Address: 8600 Old Georgetown Rd.

Bethesda, MD 20814

Phone: 301-530-3740

Website:

<https://www.stroke.org/en/stroke-groups/montgomery-county-stroke-association--bethesda-chapter>

Silver Spring Chapter

Address: 1000 Forest Glen Road, Silver Spring, MD 20901

Phone: 301-622-2282

Website: <https://www.stroke.org/en/stroke-groups/montgomery-county-stroke-association-silver-spring-chapter>

8. MONTGOMERY COUNTY STROKE ASSOCIATION

Phone: 301-681-6272

Email: info@mcstroke.org

Website: <https://www.mcstroke.org/>

9. AFRICAN AMERICAN HEALTH PROGRAM

Diabetes/Heart Health

Address: 14015 New Hampshire Avenue, Silver Spring, MD 20904

Phone: 240-777-1833

Email: info@aahpmontgomerycounty.org

Website:

<http://aahpmontgomerycounty.org/diabetes>

Section IV: Findings



Part B: Secondary Data

Chapter 6: Diabetes



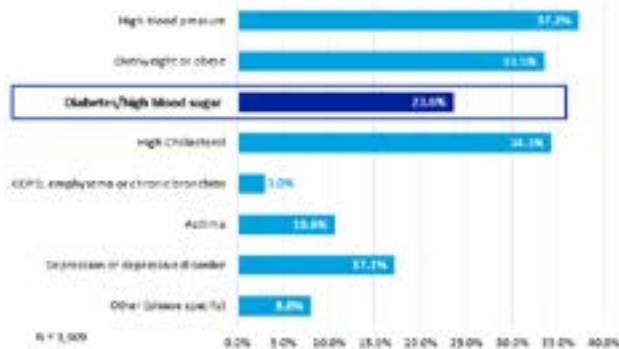
Diabetes

KEY FINDINGS

Disparities & Indicators	Trend Over Time
<ul style="list-style-type: none"> In MC and PGC, the overall age-adjusted ER rates for diabetes increased NH-Black/AA and males in MC and PGC have the highest mortality and hospitalization rates The Medicare population treated for diabetes increased for MC and PGC In MC, the diabetes ER visit rates increased with age; individuals 65+ have the highest rate with 1,099 per 100,000 population In PGC, AI/AN have the highest rate for uncontrolled diabetes compared to any other population subgroup 	 <ul style="list-style-type: none"> MC and PGC age-adjusted death rate due to diabetes had a decreasing trend from 2012 - 2017
	 <ul style="list-style-type: none"> MC and PGC age-adjusted ER rates due to diabetes had an increasing trend from 2012 - 2017 % of Medicare population treated for diabetes had an increasing trend in MC and PGC from 2013 - 2017

Community Perception

REHAB CBSA: “Has a doctor, nurse or other health professional ever said you have or are at risk for the following (select all that apply)?”¹



“Health education courses should be focused on how to manage chronic illnesses like **diabetes**.”²

¹ Adventist HealthCare. (2019). Community Health Needs Assessment Primary Data Survey.

² Adventist HealthCare. (2019). Key Informant Interview Quote - Primary Data.

Diabetes

Impact

Diabetes Mellitus is a metabolic condition that affects how the body regulates glucose levels in the blood. In type 1 diabetes, the body does not produce enough insulin, which results in excess blood glucose accumulation in the blood. This excess glucose can lead to serious health complications including heart disease, blindness, kidney failure, and lower-extremity amputations³. This type of diabetes can develop at any age and there is no known way to prevent it. In adults, type 1 diabetes accounts for about 5 percent of all diagnosed cases of diabetes. Most diabetes cases in the U.S. are type 2 diabetes. Type 2 diabetes occurs when the body cannot produce insulin properly and can develop at any age. Unlike type 1 diabetes, type 2 diabetes can be prevented through healthy lifestyle choices, including proper diet and exercise. About 30 percent of people will develop this disease in their lifetime. Gestational diabetes is a specific type of diabetes that develops during pregnancy. Typically, this type of diabetes disappears after the birth of the baby, however, it predisposes the mother to an increased risk of developing type 2 diabetes later in life⁴.

Diabetes can be a life-threatening disease that requires life-long management. It is the seventh leading cause of death in the U.S.⁵. More than thirty million people in the United States have diabetes, and 1 in 4 of them go undiagnosed; this puts them at a much higher risk for developing other health-related complications⁶. More than eighty-four million people have prediabetes, and ninety percent of them are unaware that they are at risk of developing diabetes. Diabetes is also a very costly disease; the total estimated cost of diagnosed diabetes in 2017 was \$327 billion, including \$237 billion in direct medical costs and \$90 billion in reduced productivity⁷.

Diabetes prevalence has also increased among children. While type 1 diabetes remains the primary type of diabetes in children, type 2 diabetes has become more common in children 10 years of age or

³ Centers for Disease Control and Prevention (CDC). (2015). Basics about diabetes. Retrieved from <http://www.cdc.gov/diabetes/basics/diabetes.html>

⁴ CDC. (2015). 2014 National diabetes statistics report. Retrieved from <http://www.cdc.gov/diabetes/data/statistics/2014statisticsreport.html>

⁵ CDC. (2015). Basics about diabetes. Retrieved from <http://www.cdc.gov/diabetes/basics/diabetes.html>

⁶ CDC. (2019). Diabetes Quick Facts. Retrieved from <https://www.cdc.gov/diabetes/basics/quick-facts.html>

⁷ American Diabetes Association (2018). Economic Costs of Diabetes in the U.S. in 2017. Retrieved from <https://care.diabetesjournals.org/content/41/5/917.full>

older⁸. This can be attributed to the increasing prevalence of obesity and being overweight in young populations⁹.

In Maryland the overall prevalence of diabetes is 11 percent¹⁰ and remains the sixth leading cause of death for the state¹¹. In Montgomery and Prince George's Counties, the percentage of individuals living with diabetes varies based on sociodemographic factors. In both counties, individuals living with diabetes was highest among males, individuals 65+, Asians (Montgomery County) and Hispanics (Prince George's County). However, hospitalization and mortality rates due to diabetes is highest among Black/African-American individuals for both Montgomery and Prince George's County. Although diabetes mellitus is a serious and costly chronic disease, early detection, improved delivery of care, and better self-management are important strategies that can help prevent the burden of diabetes¹².

Prevalence

- The overall prevalence of diabetes in Montgomery County has been stable at 7 percent since 2014 (Figure 1).
- In Prince George's County, the percent of adults with diabetes has slightly fluctuated over the past five years. In 2017, the percentage increased by 1.3 percent (Figure 1).

⁸ Centers for Disease Control and Prevention: National diabetes statistics report: estimates of diabetes and its burden in the United States, 2014. Atlanta, GA: U.S. Department of Health and Human Services; 2014. Retrieved from <https://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf>

⁹ Fagot-Campagna A, Pettitt DJ, Engelgau MM, et al. Type 2 diabetes among North American children and adolescents: an epidemiologic review and a public health perspective. *The Journal of pediatrics*. May 2000;136(5):664-672.

¹⁰ County Health Rankings (2019). Maryland Diabetes Prevalence. Retrieved from <https://www.countyhealthrankings.org/app/maryland/2019/measure/outcomes/60/data>

¹¹ CDC. (2019). Stats of the State of Maryland. Retrieved from <https://www.cdc.gov/nchs/pressroom/states/maryland/maryland.htm>

¹² Healthy in Montgomery County 2008 – 2016. A surveillance report on population health. Retrieved from <https://www.montgomerycountymd.gov/healthymontgomery/Resources/Files/HM-Resources/Publications/PopHealthReportFINAL.pdf>

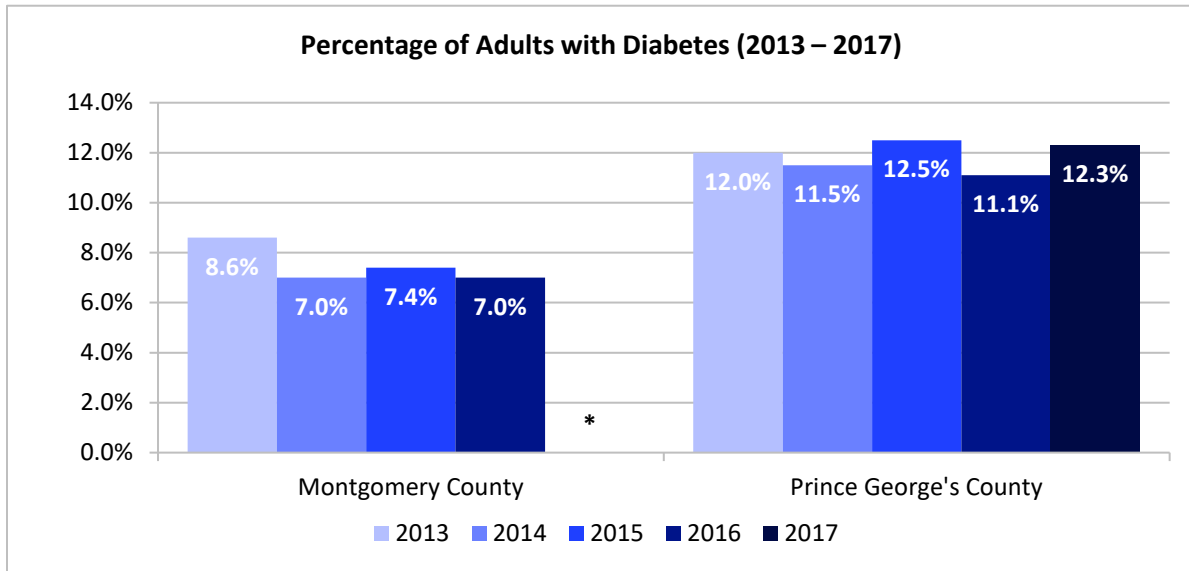


Figure 1. Percentage of Adults with Diabetes, 2013 – 2017.

*Data unavailable/not applicable

Note: Excludes diabetes cases during pregnancy.

Crude rates not comparable across county populations

(Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2019)

- In 2014, in Montgomery County, Asian individuals experienced the highest prevalence of diabetes at 9.3 percent compared to Black/African-Americans at 7.6 percent and White individuals at 7.2 percent (Figure 2).
- In 2017, in Prince George’s County, the greatest disparity was between Hispanics (16.7 percent) and White individuals (10.5 percent) (Figure 3).

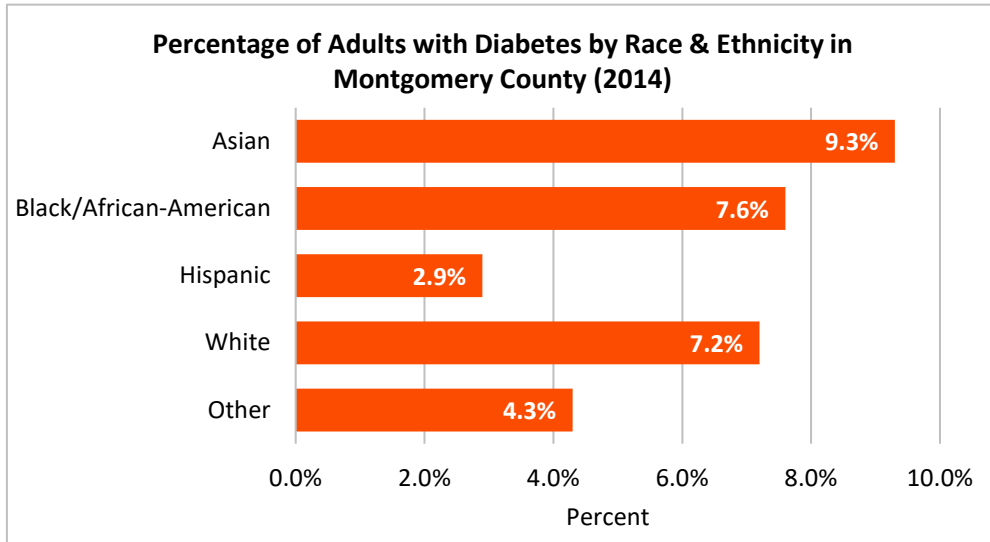


Figure 2. Percentage of Adults with Diabetes by Race/Ethnicity in Montgomery County, 2014
*Note: Excludes diabetes cases during pregnancy.
 Crude rates not comparable across county populations*
 (Source: [Maryland BRFSS Data](#), 2014)

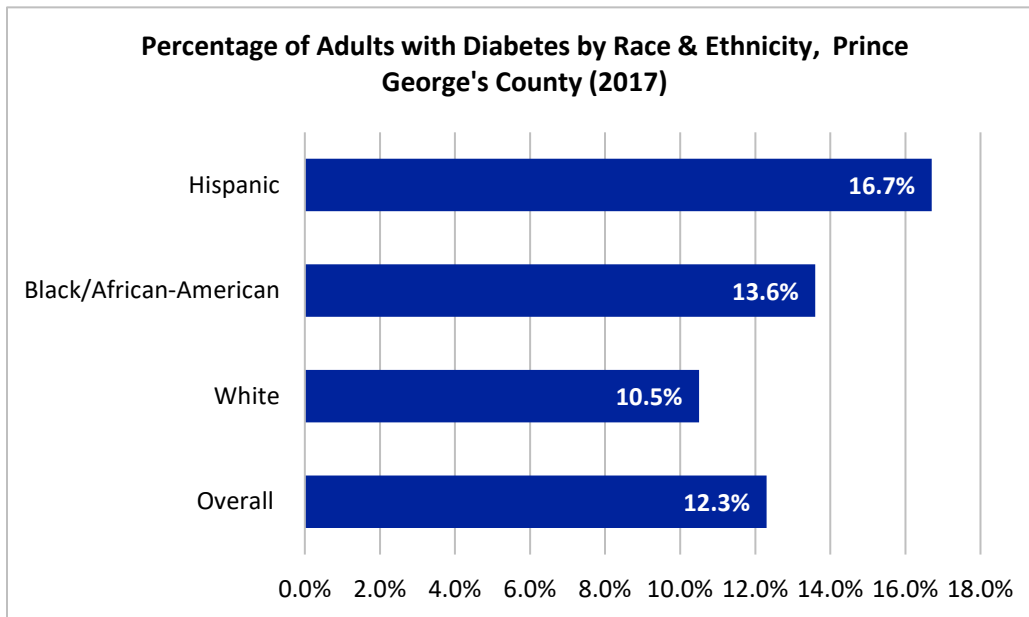


Figure 3. Percentage of Adults with Diabetes by Race/Ethnicity in Prince George's County, 2017
 (Source: [PGC Health Zone](#), 2019)

- In both Montgomery and Prince George’s County, males were more likely to be diagnosed with diabetes when compared to females during the year 2015 in Montgomery County and 2017 in Prince George’s County (Figure 4 and 5).

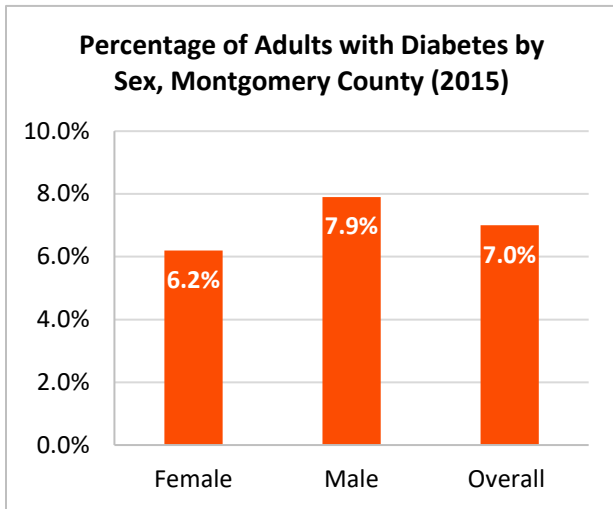


Figure 4. Percentage of Adults with Diabetes by Sex in Montgomery County, 2015
(Source: [CARES Engagement Network](#), 2019)

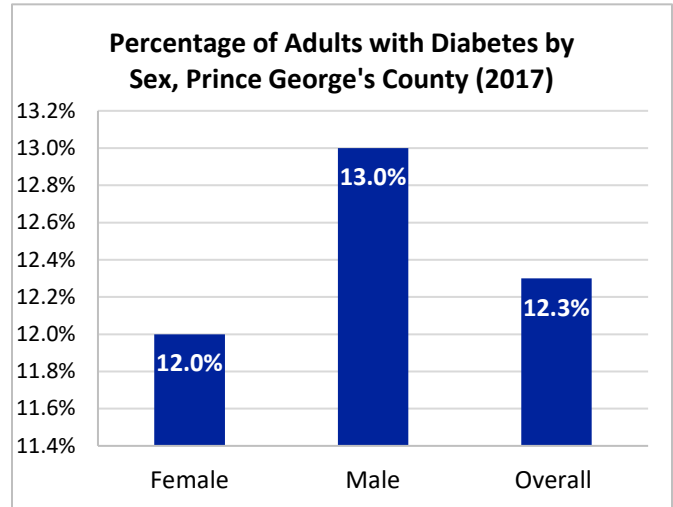


Figure 5. Percentage of Adults with Diabetes by Sex in Prince George’s County, 2017
(Source: [PGC Health Zone](#), 2019)

- In terms of age, individuals age 65+ were the most likely to have diabetes in both Montgomery County (for year 2014) and Prince George’s County (for year 2017) (Figure 6 and 7).

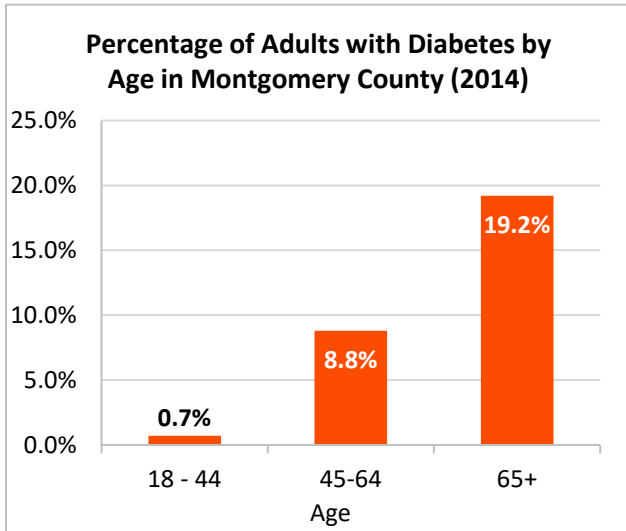


Figure 6. Percentage of Adults with Diabetes by Age in Montgomery County, 2014
Note: Excludes diabetes cases during pregnancy. Crude rates not comparable across county populations
 (Source: [Maryland BRFSS Data](#), 2014)

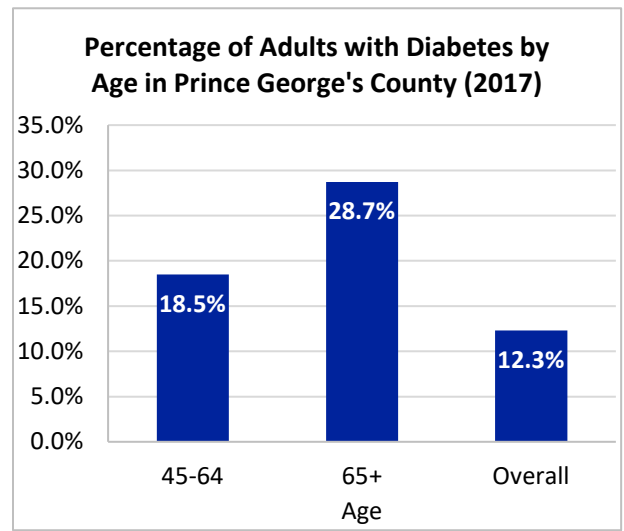


Figure 7. Percentage of Adults with Diabetes by Age in Prince George's County, 2017
Note: Excludes diabetes cases during pregnancy.
 (Source: [PGC Health Zone](#), 2019)

- The percentage of the Medicare population having received treatment for diabetes also illustrates the burden of disease on this potentially financially-strained group; especially in Prince George's County where the percentage is much higher when compared to Montgomery County and Maryland (Figure 8).
- There has been a slight gradual increase in the proportion of the Medicare population being treated for diabetes from 2014 to 2017 for both Montgomery and Prince George's Counties (Figure 8).

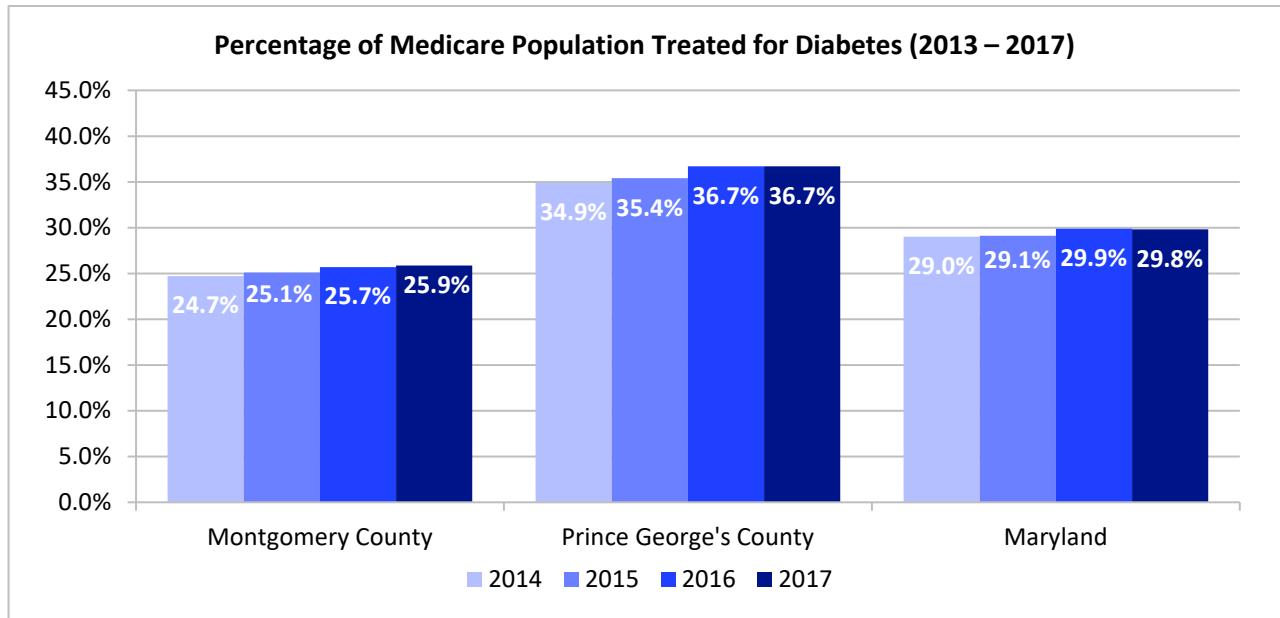


Figure 8. Percentage of Medicare Population Treated for Diabetes, 2013 – 2017
 (Source: [Centers for Medicare and Medicaid Services](#), 2019)

Emergency Room Rates

- Over time, when looking at the age-adjusted ER rates due to diabetes by county, Prince George's County continues to have the highest rate when compared to Montgomery County (Figure 9).
- In 2017, Maryland had the highest age-adjusted death rate due to diabetes with 243.7 per 100,000 population which is nearly 2X higher than that of Montgomery County for the same year (Figure 9).

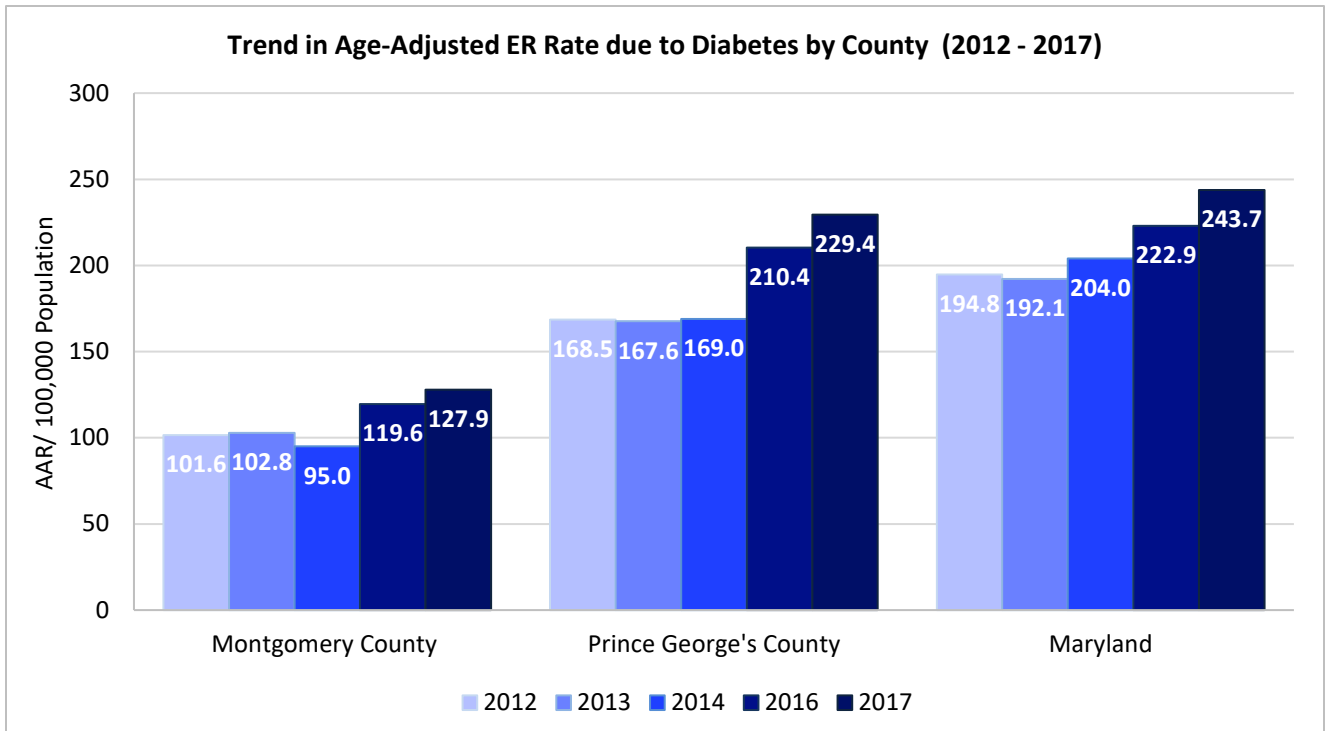


Figure 9. Trend in Age-Adjusted ER Rates due to Diabetes in Montgomery County, Prince George's County, and Maryland, 2012 – 2017
(Source: [Maryland SHIP](#), 2019)

- When looking at diabetes ER visits stratified by race and ethnicity in Montgomery County, Black/African-American individuals have a rate that is 6X greater and Hispanics have a rate 4X greater than Asians (Figure 10).
- In terms of ER visits by sex, both females and males have relatively similar rates with females being just 2.2 higher than males (Figure 10).

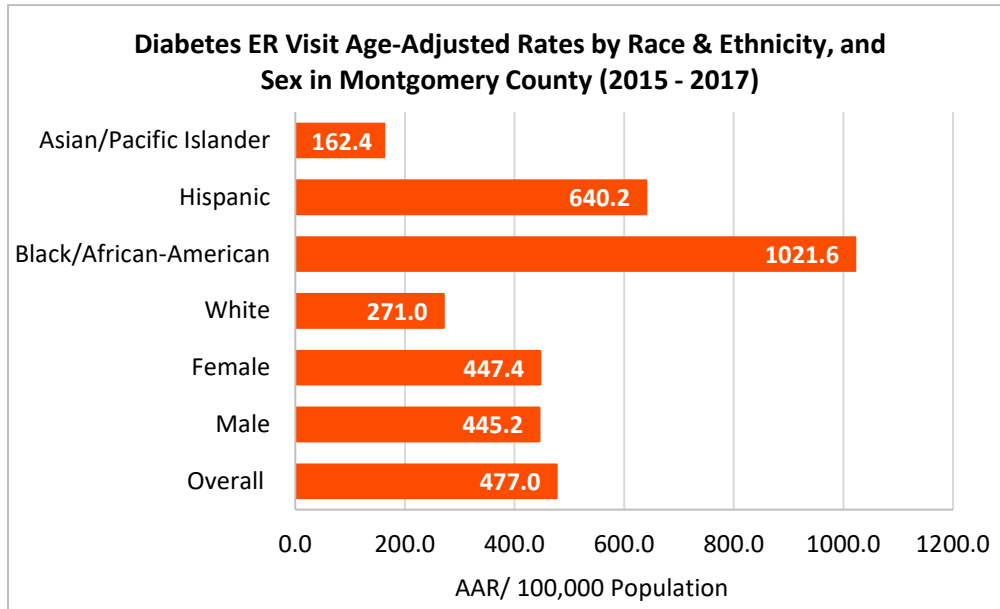


Figure 10. Diabetes ER Visit Age-Adjusted Rates by Race & Ethnicity and Sex in Montgomery County, 2015 – 2017
 (Source: [Healthy Montgomery Core Measures Report](#), 2019)

- Diabetes ER visit rates increased with age in Montgomery County (Figure 11).
- Individuals 65 and older have a rate 4.8X higher than persons aged 18 to 34, and 1.7X greater than persons 35 to 64 (Figure 11).

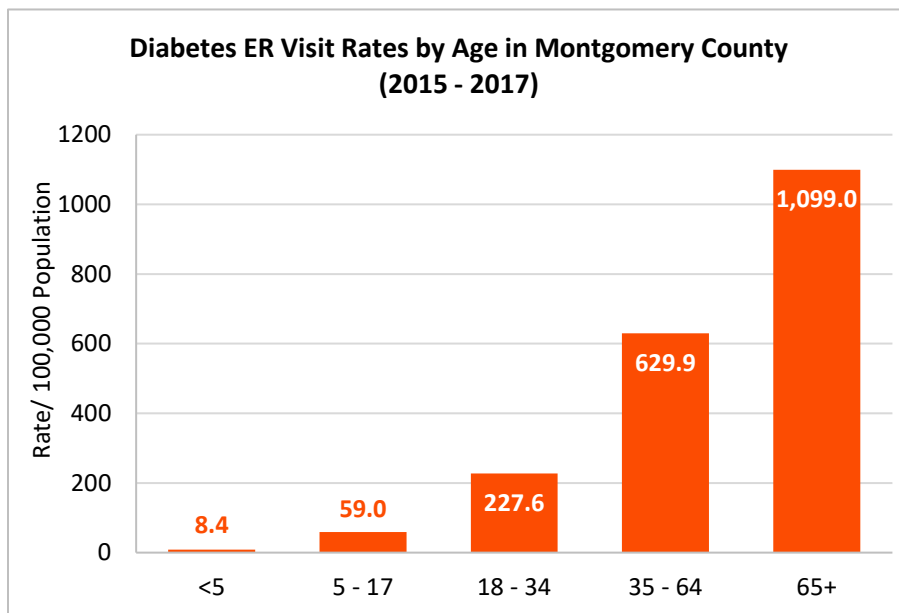


Figure 11. Diabetes ER Visit Age-Adjusted Rates by Age in Montgomery County, 2015 – 2017
 (Source: [Healthy Montgomery Core Measures Report](#), 2019)

Hospitalization Rates

- From 2015 to 2017, in Montgomery County, the age-adjusted hospitalization rates for diabetes overall is highest among individuals who are 65+, males, Black/African-American, and Hispanic individuals (Table 1).
- In Montgomery County the Individuals who are most affected by hospitalization rates due to diabetes based on level of complication varies by age, sex, and race/ethnicity (Table 1):
 - People 18 to 34 years old, Black/African-American, and Hispanic have the highest hospitalization rate for *short term complication* due to diabetes
 - Individuals who are 35 to 64 years old, male, Black/African-American, and Hispanic have the highest *long- term complications* due to diabetes
 - Seniors who are 65+, Black/African-American, and Hispanic individuals have the highest rate for *uncontrolled diabetes*

Montgomery County Age-Adjusted Hospitalization Rates per 100,000 Population (2015 - 2017)				
Characteristic	Diabetes	Short-term Complications of Diabetes	Long-Term Complications of Diabetes	Uncontrolled Diabetes
Age				
5 - 17	2.4	0.9	0.2	0.6
18 - 34	104.5	50.6	20.6	21
35 - 64	253.5	43.6	103.3	65.2
65+	873.3	43.9	367.6	205.9
Sex				
Male	258.2	35.0	111.2	58.3
Female	210.6	33.6	73.6	53.9
Race				
Asian/ Pacific Islander	124.7	7.8	42.9	30.3
Hispanic	279.1	37.9	99.4	76.7
Black/African-American	465.2	73.1	185.2	119.8
White	181.4	27.3	76.0	37.6

Table 1. Age-Adjusted Hospitalization Rates per 100,000 population in Montgomery County, 2015 – 2017
(Source: [Healthy Montgomery](#), 2019)

- From 2013 to 2015, in Prince George’s County, the age-adjusted hospitalization rates for diabetes overall is highest among individuals who are 65 to 84 and 85+, males, and Black/African-American (Table 2).
- In Prince George’s County, the Individuals who are most affected by hospitalization rates due to diabetes based on level of complication varies by age, sex, and race (Table 2):
 - People 65 to 84 years old and Black/African-American have the highest hospitalization rate for *short term complication* due to diabetes
 - Individuals who are 65 to 84, 85+, male, and Black/African-American, have the highest *long- term complications* due to diabetes
 - Seniors who are 65 to 84 and American Indian/Alaskan Native have the highest rate for *uncontrolled diabetes*

**Prince George's County Age-Adjusted Hospitalization Rates per 10,000 Population 18+ Years of Age
(2013 - 2015)**

Characteristic	Diabetes	Short-term Complications due to Diabetes	Long-Term Complications due to Diabetes	Uncontrolled Diabetes
Age				
18 - 19	6.2	5.9	*	*
20 - 24	12.1	9.7	1.9	*
25 - 44	16.2	8.8	6.4	0.8
45 - 64	29.4	9.7	17.1	2.1
65 - 84	53.7	10.4	38.5	4.1
85+	49.5	6.8	39.4	*
Overall	25.7	9.3	14.4	1.6
Sex				
Male	29.5	9.9	17.3	1.8
Female	22.9	8.8	12.3	1.5
Overall	25.7	9.3	14.4	1.6
Race				
American Indian/Alaskan Native	41.3	15.0	25.4	35.0
Asian/Pacific Islander	5.4	**	4.2	**
Black/African-American	31.9	11.4	17.8	2.1
White	14.9	6.0	8.2	0.6
Overall	25.7	9.3	14.4	1.6

Table 2. Age-Adjusted Hospitalization Rates per 10,000 population in Prince George's County, 2013 – 2015

*Data unavailable/not applicable

(Source: [PGC Health Zone](#), 2019)

**NOTE: AI/AN had no significant difference with the overall value for diabetes and short-term complications due to diabetes according to PGC Health Zone.

Mortality

- Diabetes mortality has an overall decreasing trend which is like that of Maryland (Figure 12).
- The mortality rate in Montgomery County has consistently been lower than that of Maryland and Prince George's County (Figure 12).
- The Prince George's county mortality rate has remained nearly constant over the last three years. When compared to Montgomery County and Maryland, the rates are significantly higher (Figure 12).

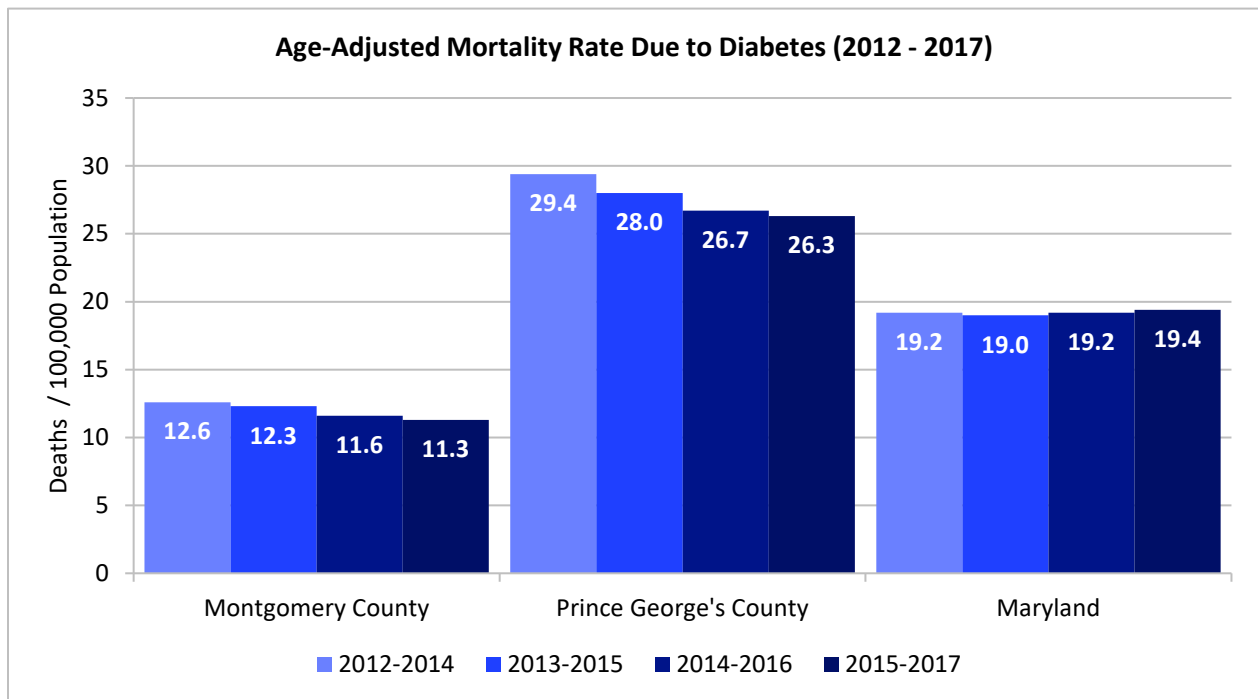


Figure 12. Age-Adjusted Death Rate Due to Diabetes per 100,000 Population in Montgomery County, Prince George's County, and Maryland, 2012 - 2017

(Source: [Maryland Department of Health and Mental Hygiene \(DHMH\)](#), 2019)

- When stratified by race and ethnicity, the mortality rate due to diabetes disproportionately affects Black/African-American individuals in both Montgomery and Prince George's County (Figure 13).
- Black/African-American's in Montgomery County have a mortality rate which is 2.2X higher than the overall average for the county. Additionally, the mortality rate is more than 3X higher when compared to the Asian/Pacific Islander individuals who have the lowest rate overall (7.8 per 100,000) (Figure 13).
- In Prince George's County, Black/African-American individuals have a rate that is 1.5X higher than Hispanic and 1.4X higher than White individuals (Figure 13).

- When comparing the two counties overall, Prince George’s age-adjusted mortality rate due to diabetes is 2.2X higher than Montgomery County (Figure 13).
- When comparing the same racial/ethnic group across county lines, White individuals in Prince George’s County have the largest gap (1.8X higher) than White individuals in Montgomery County (Figure 13).

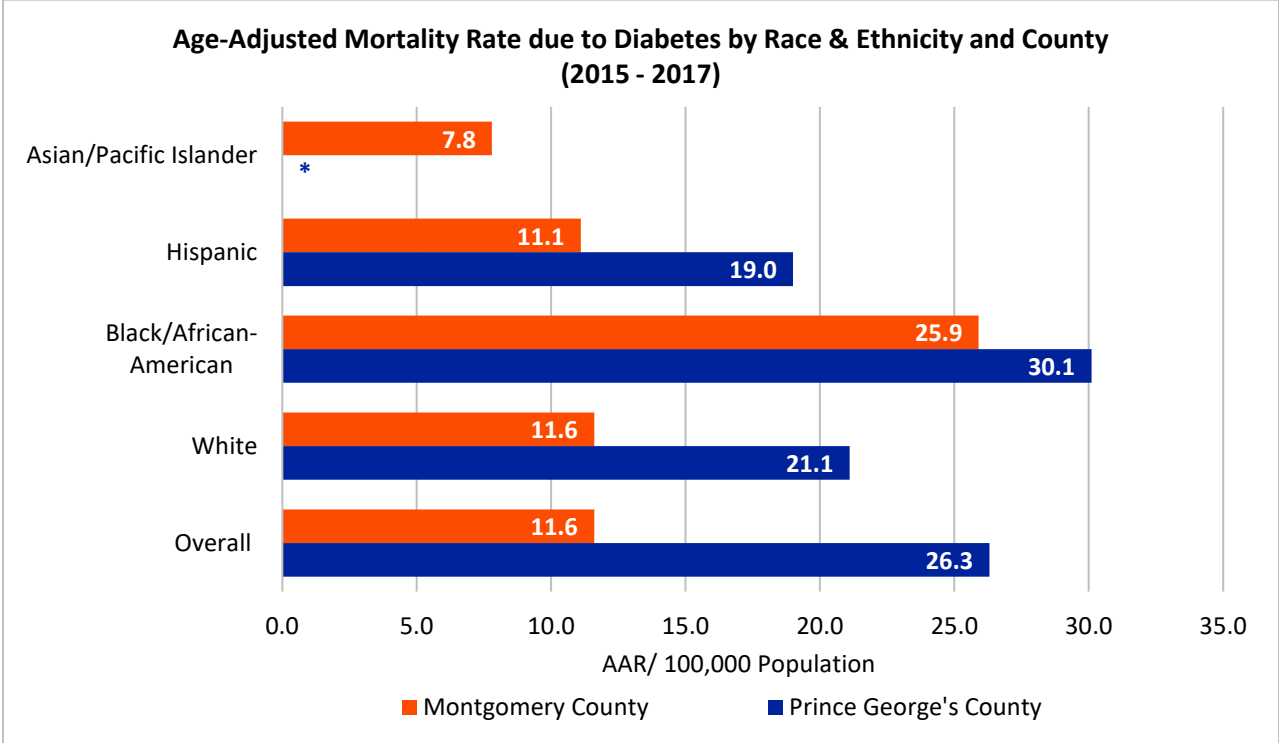


Figure 13. Age-Adjusted Mortality Rate due to Diabetes by Race & Ethnicity in Montgomery County and Prince George’s County (2015 – 2017)

*Data unavailable/not applicable

(Source: [Healthy Montgomery Core Measures Report](#) & [PGC Health Zone](#), 2019)

- The age-adjusted mortality rate due to diabetes by gender is highest among males for both counties (Figure 14).
- Prince George’s County has the highest mortality rate for both genders and overall when compared to Montgomery County (Figure 14).

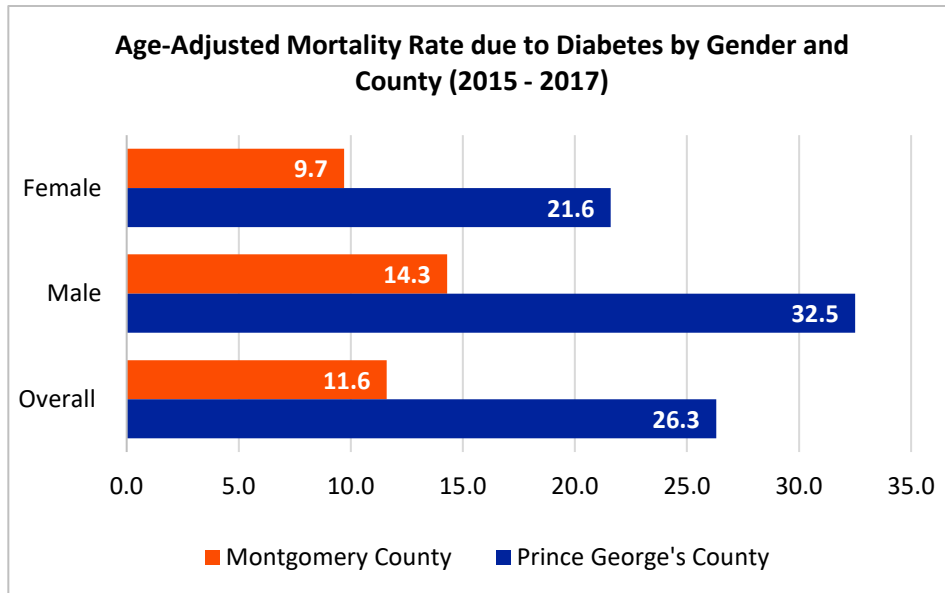


Figure 14. Age Adjusted Mortality due to Diabetes by Gender and County, 2015 – 2017
 (Source: [Healthy Montgomery Core Measures Report](#) & [PGC Health Zone](#), 2019)

- In Montgomery County, when looking at the age-adjusted mortality rate due to diabetes by age, the highest rate is among individuals 65+ (Figure 15).
- Individuals aged 65+ have a rate which is 343X larger than the reference group, individuals aged 18 – 34 (Figure 15).

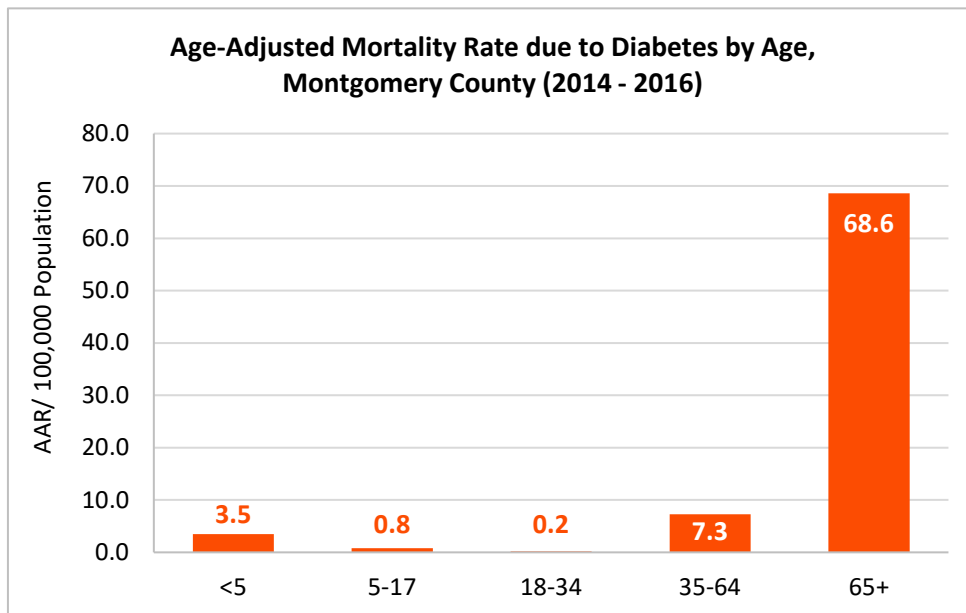


Figure 15. Age-Adjusted Mortality Rate due to Diabetes by Age in Montgomery County (2015 – 2017)
 (Source: [Healthy Montgomery Core Measures Report](#), 2019)

Amputees

- In the United States, there are currently 1.9 million people living with limb loss and an average of 507 amputations every day.¹³
- The majority of amputations in the United States are caused by complications of vascular diseases such as diabetes and peripheral arterial disease. Other causes are trauma and cancer (Figure 16).

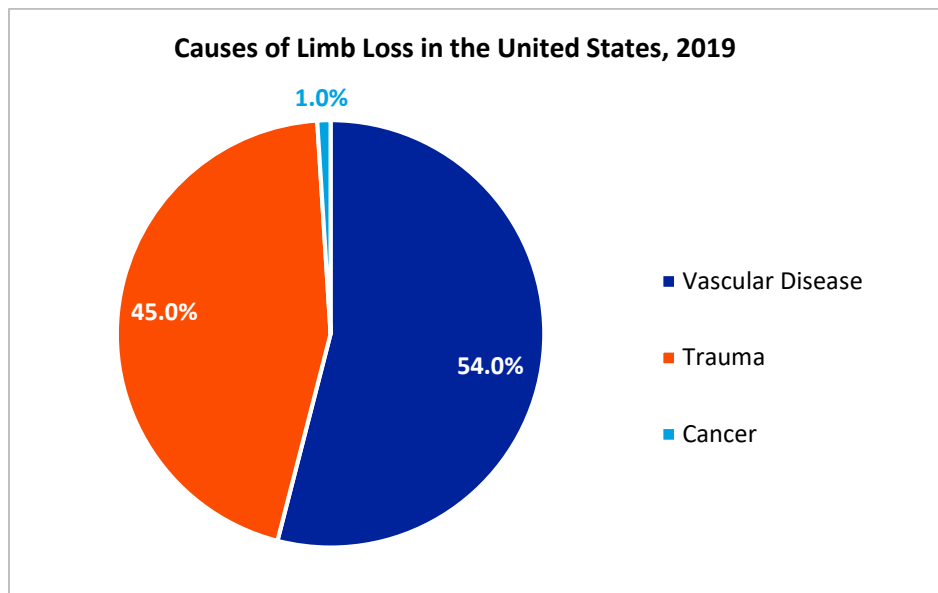


Figure 16. Causes of Limb Loss in the United States, 2019
(Source: [Amputee Coalition](#))

Maryland Data

- Hospitals across Maryland reported a total of 3,157 amputations in 2014.
- There has been a 5.66 percent increase in the number of amputations since 2009, when amputations were at a low (Figure 17).
- According to the Amputee Coalition, limb loss will continue to rise due to the prevalence of vascular diseases.

¹³ Amputee Coalition (2019). *Factsheet: Maryland*. Retrieved from <https://www.amputee-coalition.org/resources/maryland-2/>

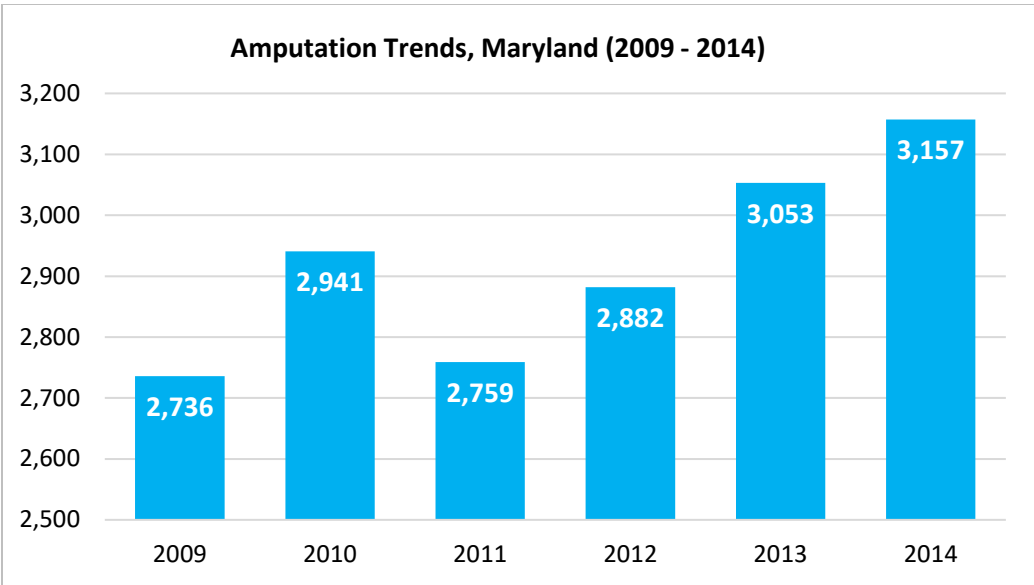


Figure 17. Amputation Trends, Maryland 2009-2014
(Source: [Amputee Coalition](#))

- Amputations are categorized into two groups: upper extremity and lower extremity. There was a total of 150 upper extremity and 2,979 lower extremity amputations performed in 2014 (Figure 18).

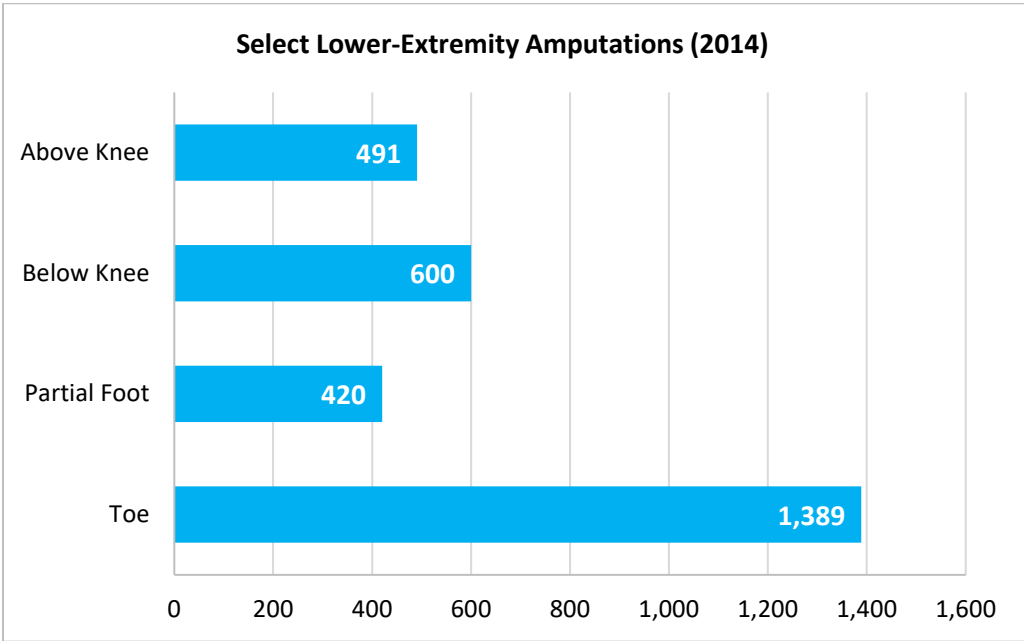


Figure 18. Select Lower-Extremity Amputations, 2014
(Source: [Amputee Coalition](#))

- Deconstructing the statewide data by race and ethnicity shows that the majority of amputee patients are White (Figure 19). However, the Black population is most disproportionately affected by amputations.

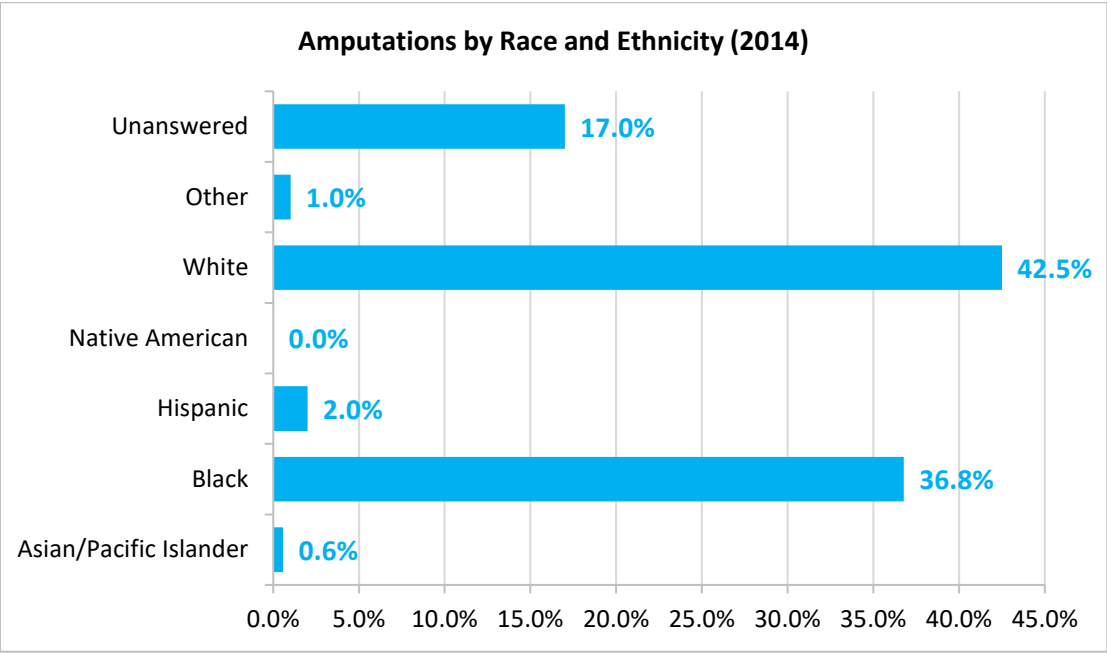


Figure 19. Amputations by Race and Ethnicity, 2014
(Source: [Amputee Coalition](#))

- When stratified by age and sex, the group with the highest rate of amputations is the 45-64 year old and males (Figure 20 and 21).

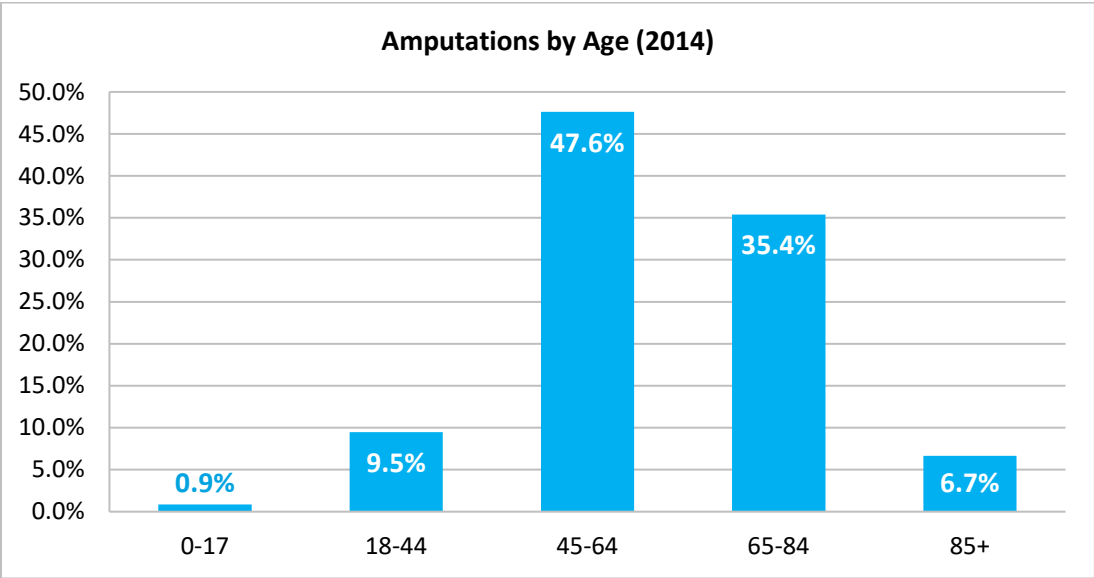


Figure 20. Amputations by Age, 2014
(Source: [Amputee Coalition](#))

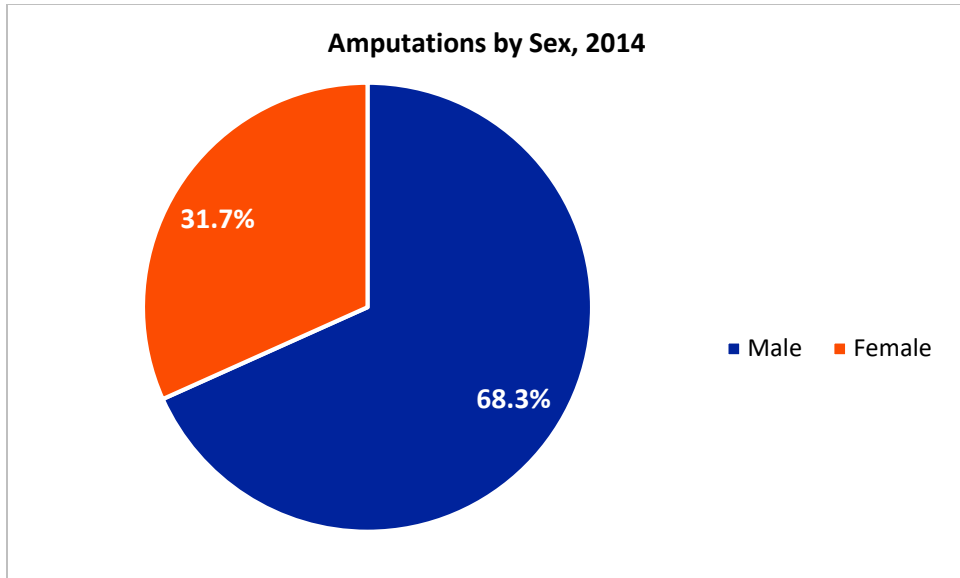


Figure 21. Amputations by Sex, 2014
(Source: [Amputee Coalition](#))

- Most amputees in Maryland were enrolled in Medicare, followed by private insurance (Figure 22).

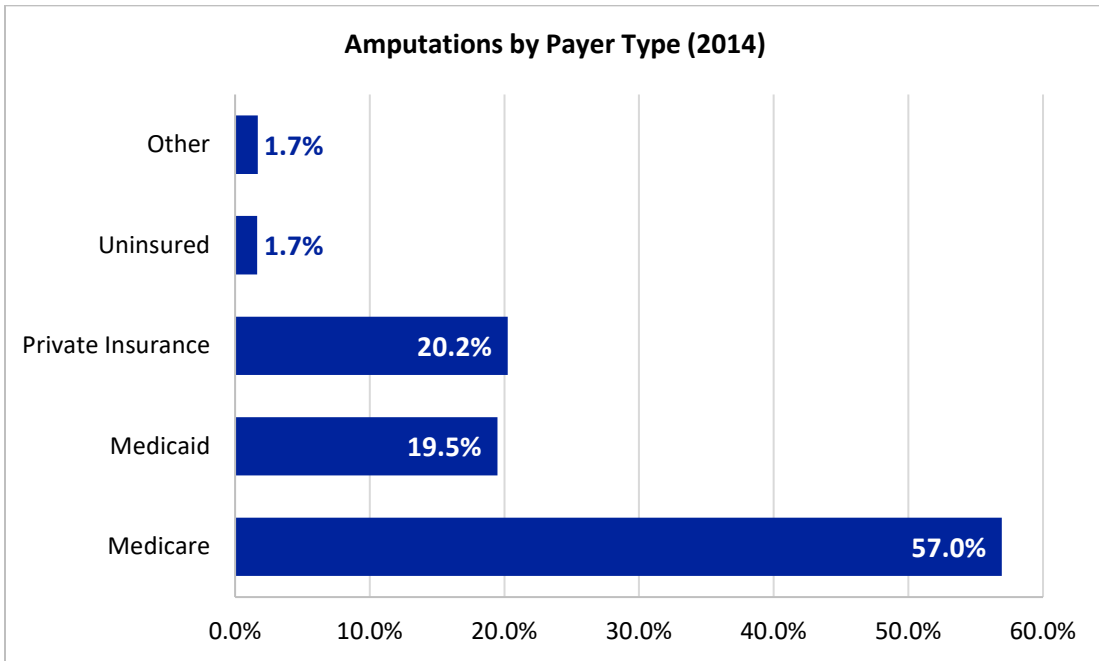


Figure 22. Amputations by Payer Type, 2014
(Source: [Amputee Coalition](#))

Hospital Data

- In 2018, Adventist HealthCare Rehabilitation Hospital served 49 amputee patients.¹⁴ The patients' average age was 62 years and they were mostly male patients (Figure 23).
- A racial breakdown of the patients served shows that most of the patients were White, followed by Blacks (Figure 23).

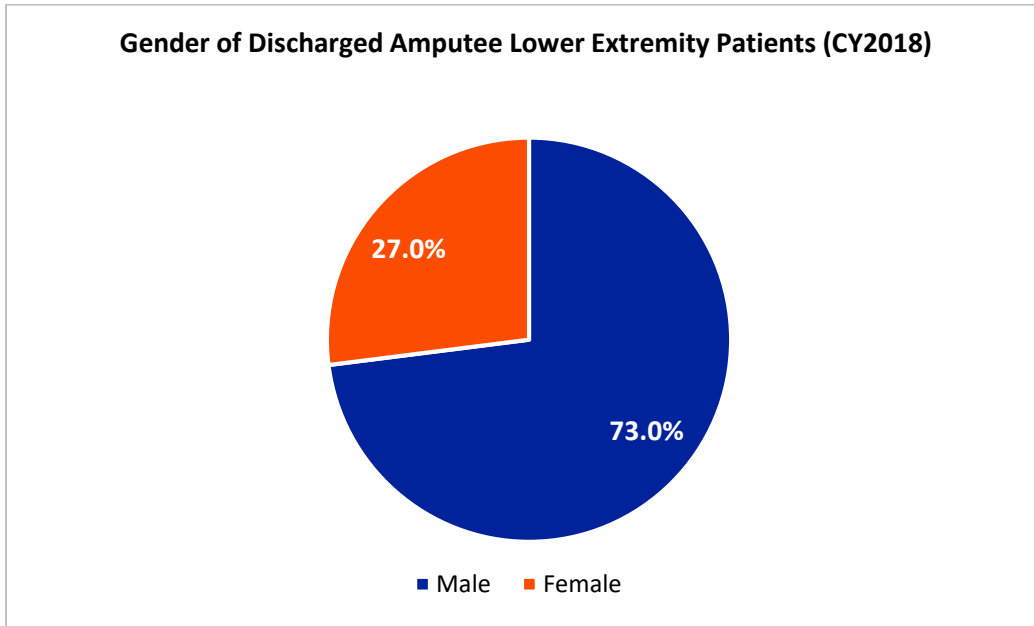


Figure 23. Gender of Discharged Amputee Lower Extremity Patients (CY2018)
(Source: Adventist HealthCare Rehabilitation Hospital, 2019)

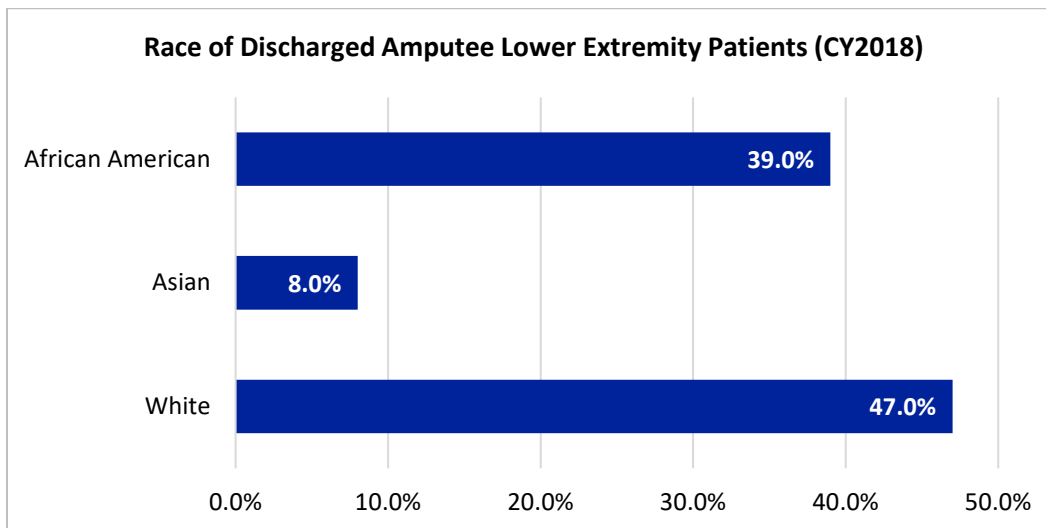


Figure 24. Race of Discharged Amputee Lower Extremity Patients (CY2018)
(Source: Adventist HealthCare Rehabilitation Hospital, 2019)

¹⁴ Adventist HealthCare Rehabilitation Hospital

Community Resources

There are a variety of diabetes-related services and programs available for residents in Adventist HealthCare Rehabilitation Hospital Community Benefit Service Area. These include hospital-based, community-based, and health department programs and services:

1. ADVENTIST HEALTHCARE (AHC)

Diabetes Education & Support

Phone: 1-800-542-5096 (Registration line)

Website:

<https://www.adventisthealthcare.com/services/diabetes-care-endocrinology/education-support/>

Diabetes Self-Management Education and Support (DSMES)

Phone: 301-891-6105 (White Oak, MD) or 301-315-3129 (Rockville, MD)

Website:

<https://www.adventisthealthcare.com/calendar/details/?eventId=788f34bf-cc14-e311-a8cd-2c768a4e1b84>

Diabetes Cooking Class

Website:

<https://www.adventisthealthcare.com/calendar/details/?eventId=c85b6b82-c58e-e911-a81c-000d3a611ea2>

Prediabetes Class

Website:

<https://www.adventisthealthcare.com/calendar/details/?eventId=335eb721-a98e-e911-a81c-000d3a611ea2>

Living Well with Diabetes

Website:

<https://www.adventisthealthcare.com/calendar/details/?eventId=c45986f4-4298-e911-a81e-000d3a611ea2>

Gestational Diabetes

Website:

<https://www.adventisthealthcare.com/calendar/details/?eventId=d4d5afda-c050-e511-8d72-2c768a4e1b84>

2. PRINCE GEORGE'S COUNTY - DIABETES

Address: 9314 Piscataway Rd

Clinton, MD 20735

Phone: 301-856-9643

Website:

<https://www.princegeorgescountymd.gov/2090/Diabetes>

3. MONTGOMERY COUNTY – DEPARTMENT OF HEALTH AND HUMAN SERVICES

Online Diabetes Education

Phone: 240-777-1833

Website:

https://www2.montgomerycountymd.gov/mcgportalapps/Press_Detail.aspx?Item_ID=22884

Senior Nutrition Program

Address: 401 Hungerford Drive, Rockville, MD 20850

Phone: 240-777-3000

Website:

<https://www.montgomerycountymd.gov/hs-program/program.aspx?id=ads/adsseniornutr-p190.html>

**4. UNIVERSITY OF MARYLAND CAPITAL
REGION HEALTH – DIABETES CARE**

Phone: 301-618-6555

Website:

<https://www.umms.org/capital/health-services/diabetes>

5. AMERICAN DIABETES ASSOCIATION

Summer Camps

Phone: 1-800-342-2383

Website:

<https://www.diabetes.org/community/camp/finding-a-camp>

**6. AFRICAN AMERICAN HEALTH PROGRAM –
DIABETES/ HEART HEALTH**

Address: 14015 New Hampshire Avenue
Silver Spring, MD 20904

Phone: 240-777-1833

Email: info@aahpmontgomerycounty.org

Website:

www.aahpmontgomerycounty.org

7. UNIVERSITY OF MARYLAND EXTENSION

Prince George's County

Address: 6707 Groveton Drive
Clinton, MD 20735

Phone: 301-868-9366

Email: nfitzhu@umd.edu

Website:

<https://extension.umd.edu/prince-georges-county>

Montgomery County

Address: 18410 Muncaster Road
Derwood, MD 20855

Phone: 301-590-9638

Email: yingling@umd.edu

Website:

<https://extension.umd.edu/montgomery-county>

8. RIGHT AT HOME

Prince George's County

Address: 1450 Mercantile Lane Suite 127
Upper Marlboro, MD 20774

Phone: 301-738-2225

Website:

<https://www.rightathome.net/upper-marlboro>

Montgomery County

Address: 11821 Parklawn Drive Suite 302
Rockville, MD 20852

Phone: 301-255-0066

Website:

<https://www.rightathome.net/rockville-maryland>

9. ASIAN AMERICAN HEALTH INITIATIVE

Address: 1401 Rockville Pike, 3rd Floor
Rockville, MD 20852

Phone: 240-777-4517

Email: info@aahiinfo.org

Website: <http://aahiinfo.org/>

10. HOLY CROSS HEALTH – DIABETES PREVENTION AND EDUCATION
Outpatient Diabetes Self-Management Education

Phone: 301-754-8200

Website:

<http://www.holycrosshealth.org/body.cfm?id=862&fr=true>

Diabetes Prevention Program

Phone: 301-557-1231

Website:

<http://www.holycrosshealth.org/body.cfm?id=860&fr=true>

Gestational Diabetes Program

Phone: 301-754-7449

Website:

<http://www.holycrosshealth.org/body.cfm?id=861&fr=true>

11. Adventist Healthcare - Rehabilitation Services

For free support groups and available community resources call or visit:

Phone: 1-800-542-5096

Website: [Adventist HealthCare Classes & Events](#)

12. Amputee Coalition

Website: <https://www.amputee-coalition.org/>

13. Disability Partnerships

Website:

<http://www.disabilitypartnerships.org/>

Section IV: Findings



Part B: Secondary Data

Chapter 7: Obesity



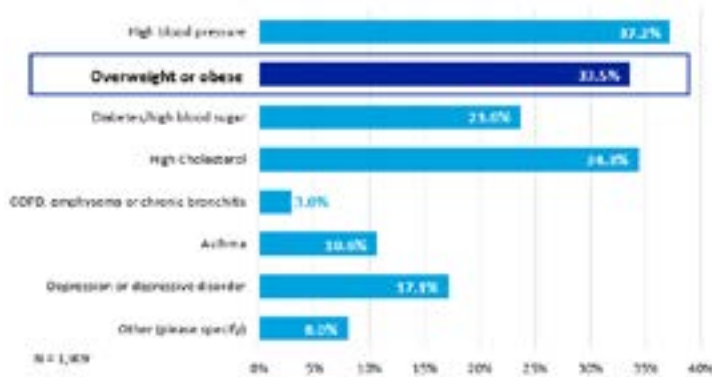
Obesity

KEY FINDINGS

Disparities & Indicators	Trend Over Time
<ul style="list-style-type: none"> MC met the HP 2020 target (30.5) for adult obesity but PGC did not from 2012-2016 In PGC, females have a higher % of obese adults and in MC, males have a higher % of obese adults MC met the HP 2020 target (16.1) for obese among adolescents, however, PGC did not in 2016 	<ul style="list-style-type: none">  In PGC the obesity trend was stable from 2012 - 2016  MC had an increasing trend from 2012 - 2016 for adult obesity MC and PGC had an increasing trend from 2013 - 2016 for adolescent obesity

Community Perception

REHAB CBSA: "Has a doctor, nurse or other health professional ever said you have or are at risk for the following (select all that apply)?"¹



"Provide nutrition counselors and cooking classes to counteract epidemic of obesity. Also teach people how to shop with in store counselors and educators."²

"Community should host exercise challenges."³

"Classes are offered during work hours, if you are working you cannot engage in free activities that improve your health."⁴

^{1,3} Adventist HealthCare. (2019). Community Health Needs Assessment – Community Survey.

^{2,4} Adventist HealthCare. (2019). Community Health Needs Assessment - Key Informant Interview.

Obesity

Impact

Adult obesity is defined as having a body mass index (BMI) greater than or equal to 30. Being overweight is defined as having a BMI of greater than or equal to 25. Obesity continues to be a highly prevalent condition in the United States with approximately 35 percent of adults and 17 percent of children 2 through 18 years of age qualifying as obese. Obesity is of particular concern because it is associated with many adverse health outcomes including heart disease, stroke, type 2 diabetes, and cancer. There also appear to be disparities in the burden of obesity across different demographic groups.^{3,4}

Prevalence

- In Maryland, the rate for adult obesity has steadily increased over time. From 2015 to 2017, the rate increased from 28.9 to 31.3. Currently, Maryland has not met the Healthy People 2020 target of 30.5 (Figure 1).

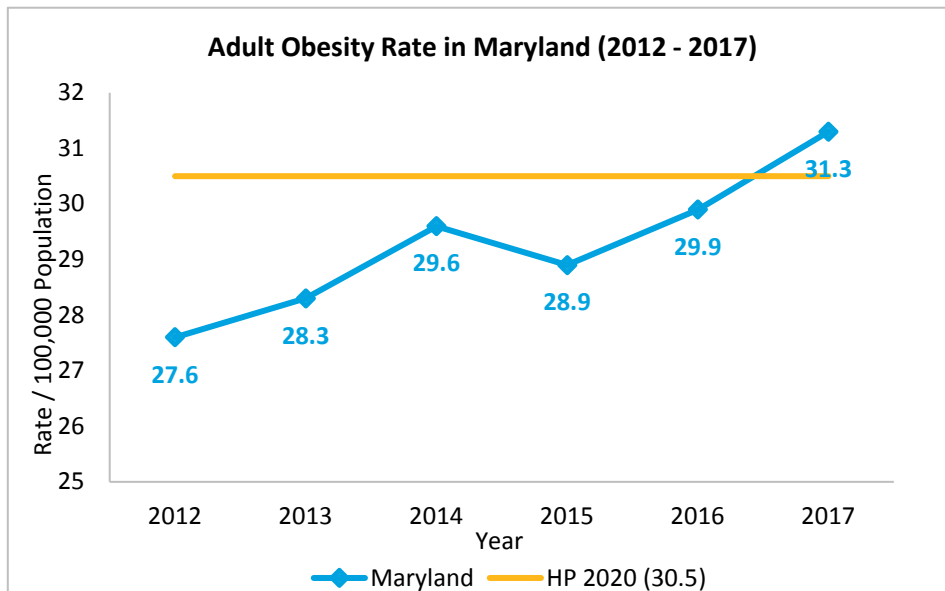


Figure 1. Adult Obesity Rate in Maryland, 2012 – 2017

(Source: [Trust for America's Health](#), 2018)

³ Centers for Disease Control and Prevention (CDC) – Division of Nutrition, Physical Activity, and Obesity, & National Center for Chronic Disease Prevention and Health Promotion. (2016). Childhood obesity facts. Retrieved from <http://www.cdc.gov/obesity/data/childhood.html>

⁴ CDC - Division of Nutrition, Physical Activity, and Obesity, & National Center for Chronic Disease Prevention and Health Promotion. Adult obesity facts. Retrieved, from: <http://www.cdc.gov/obesity/data/adult.html>

- In Maryland, the obesity rate was highest among Black/African-American individuals, women, and individuals aged 45 to 64 (Figure 2 and Figure 3).

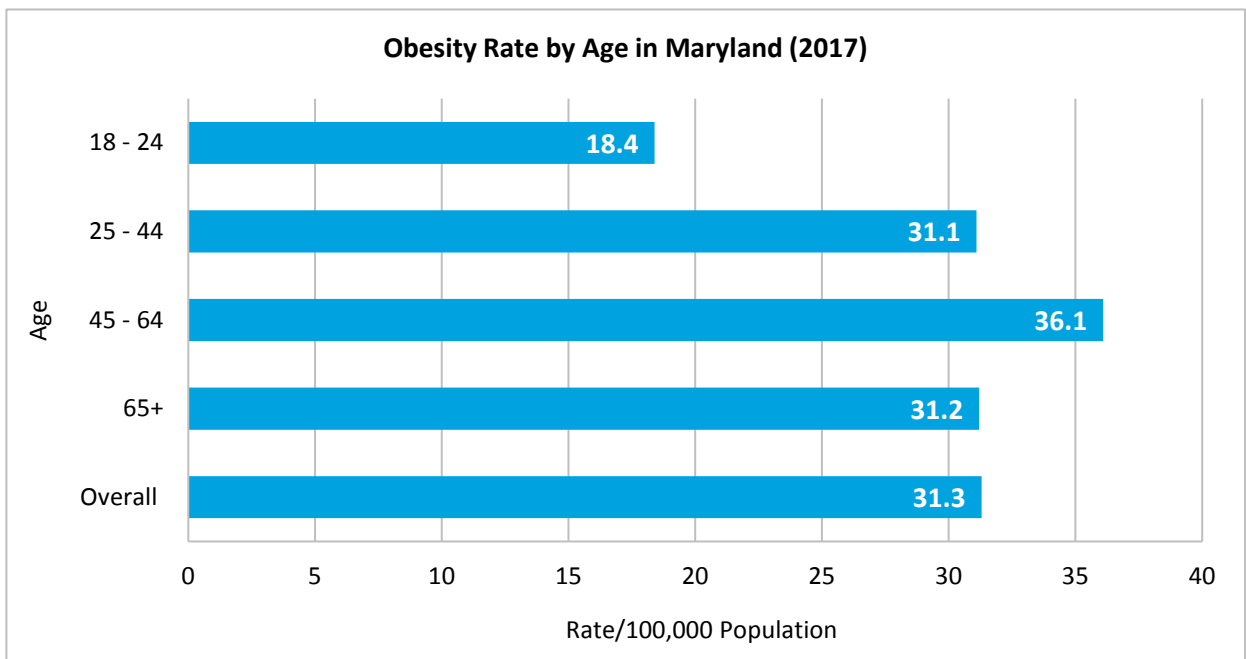


Figure 2. Obesity Rate by Age in Maryland, 2017
(Source: [The State of Obesity](#), 2018)

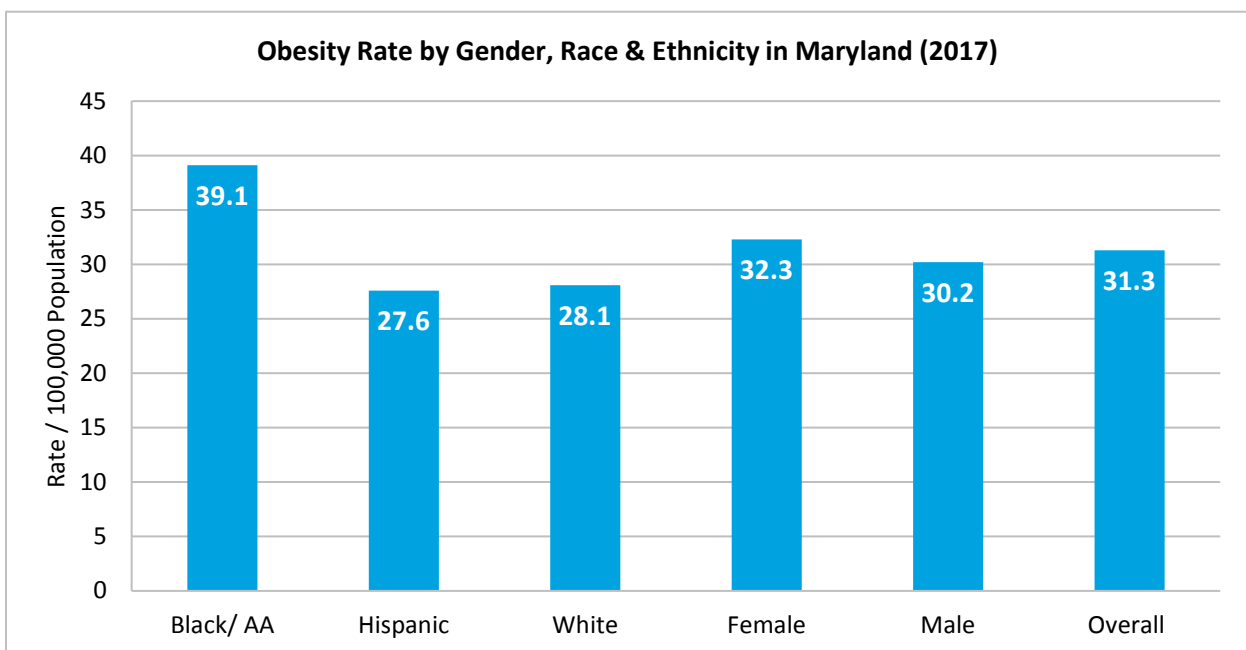


Figure 3. Obesity Rate by Gender, Race & Ethnicity in Maryland, 2017
(Source: [The State of Obesity](#), 2018)

- Prince George’s County did not meet the target set forth by Healthy People 2020 for the percentage of its residents who are obese (Figures 4).
- Montgomery County and Maryland met the Healthy People 2020 target for the percentage of its residents who are obese (Figure 4).

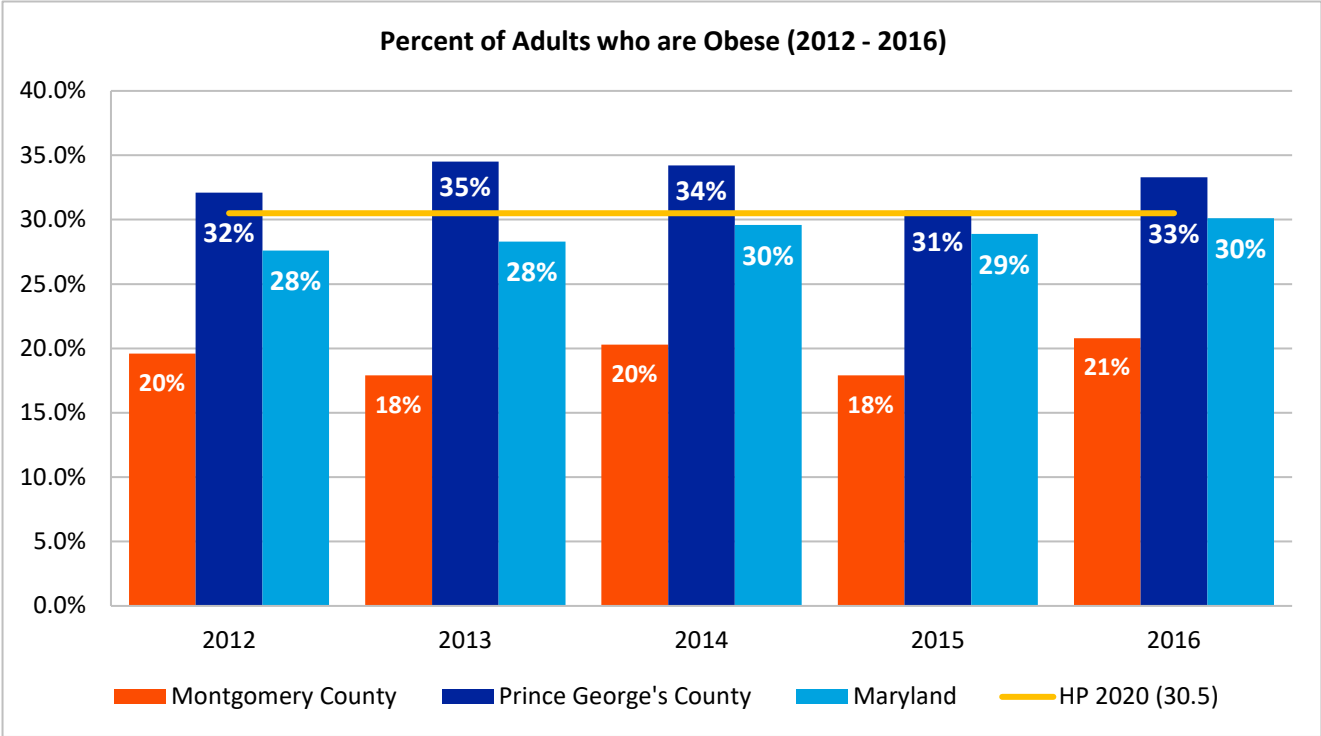


Figure 4. Percentage of Adults Who Are Obese, 2012 – 2016
 (Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2017)

- In 2016, Prince George's County had the highest percentage of adults who are overweight or obese with 72.2 percent when compared to Montgomery County and Maryland (Figure 5).
- Montgomery County had the lowest percentage of overweight or obese adults with 58.7 percent when compared to Maryland and Prince George's County (Figure 5).

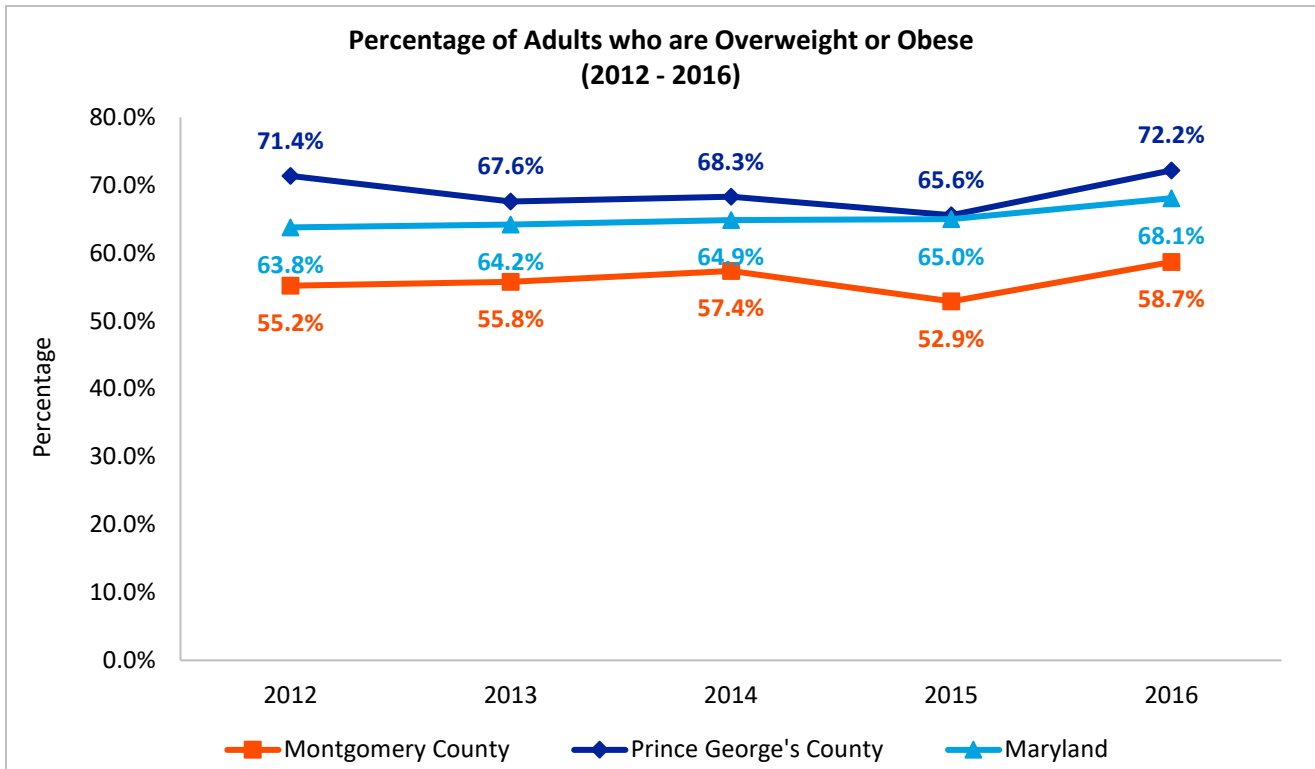


Figure 5. Percentage of Adults Who Are Overweight or Obese, 2012 – 2016
 (Source: [Healthy Montgomery](#) & [PGC Health Zone](#), 2017)

- In Montgomery County, only 36.7 percent of Asians are overweight or obese compared to 76.6 percent of Hispanics and 67.9 percent of Blacks (Figure 6).
- In Prince George’s County, 74.8 percent of Black residents and 76 percent of those classified as “Other” are overweight or obese compared to 66 percent of Whites, 55 percent of Hispanics and 21.2 percent of Asians (Figure 6).

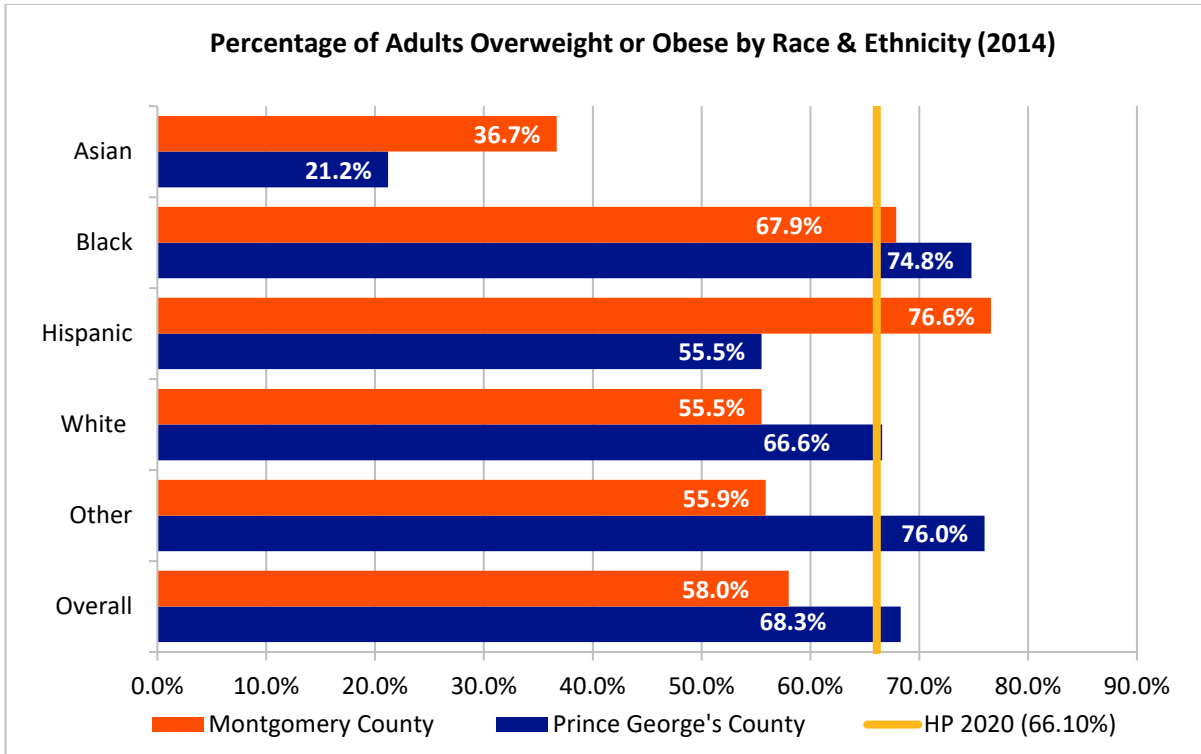


Figure 6. Percentage of Adults Who Are Overweight or Obese by Race & Ethnicity in Montgomery County and Prince George's County, 2014
(Source: [Maryland BRFSS](#), 2014)

- Females are more likely to be obese in Prince George's County at 39.2 percent compared to 30.8 percent of males (Figure 7).

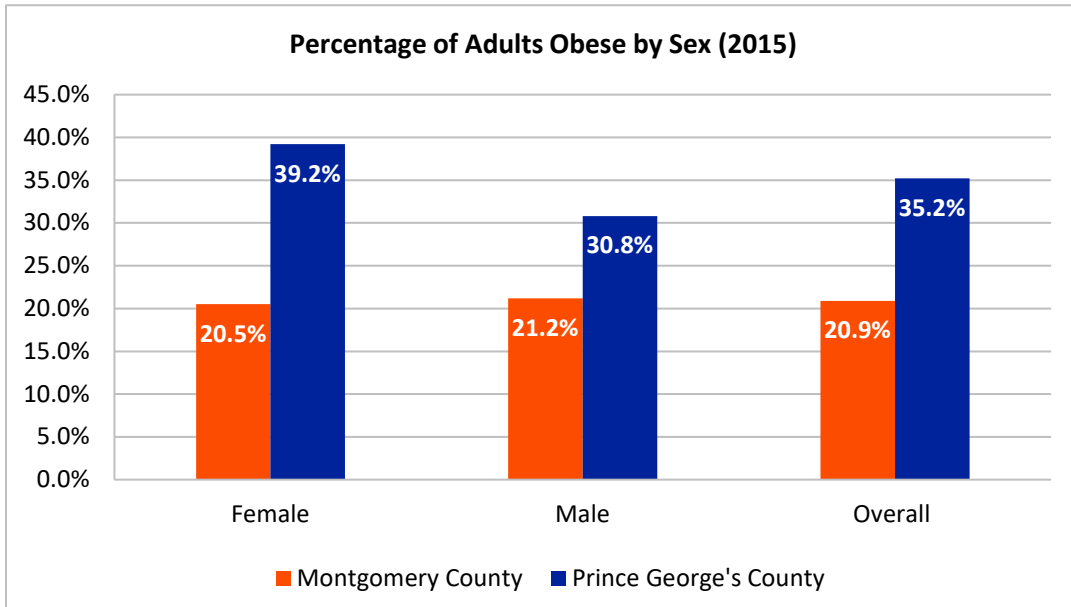


Figure 7. Percentage of Adults Who Are Obese by Sex in Montgomery and Prince George's County, 2015
(Source: [CARES - Montgomery County](#) & [CARES - Prince George's County](#), 2016)

- By age, the proportion of overweight or obese individuals increases with each age bracket except in Montgomery County, where there is a slightly lower rate of obesity in the 65+ population compared to the 45 to 64-year-old population (Figure 8).

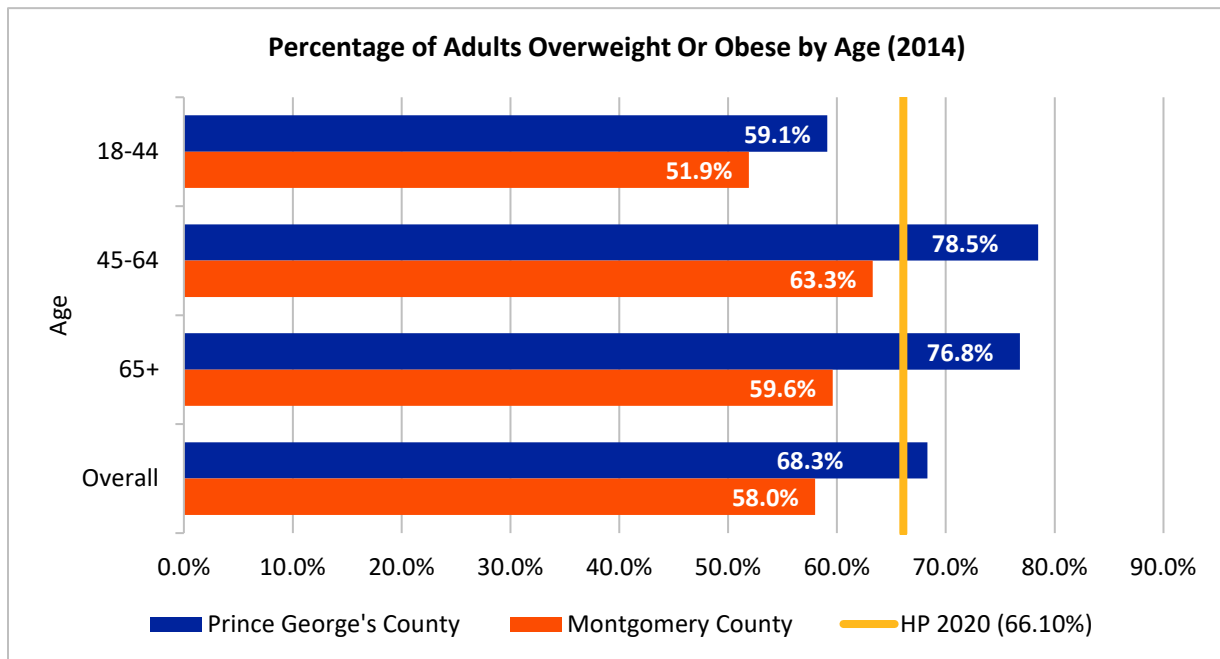


Figure 8. Percentage of Adults Who Are Overweight or Obese by Age, 2014
(Source: [Maryland BRFSS](#), 2014)

Childhood Obesity

As of 2019, the CDC reports that 18.5 percent of children and adolescents 2 to 19 years of age in the U.S. are obese. Similar to adults, Hispanic and Black children are disproportionately burdened with 25.8 percent and 22.0 percent obese, respectively, compared to 14.1 percent of white children.⁵

⁵ CDC – Division of Nutrition, Physical Activity, and Obesity. (2019). Childhood obesity facts. Retrieved October 3, 2019, from <https://www.cdc.gov/obesity/data/childhood.html>

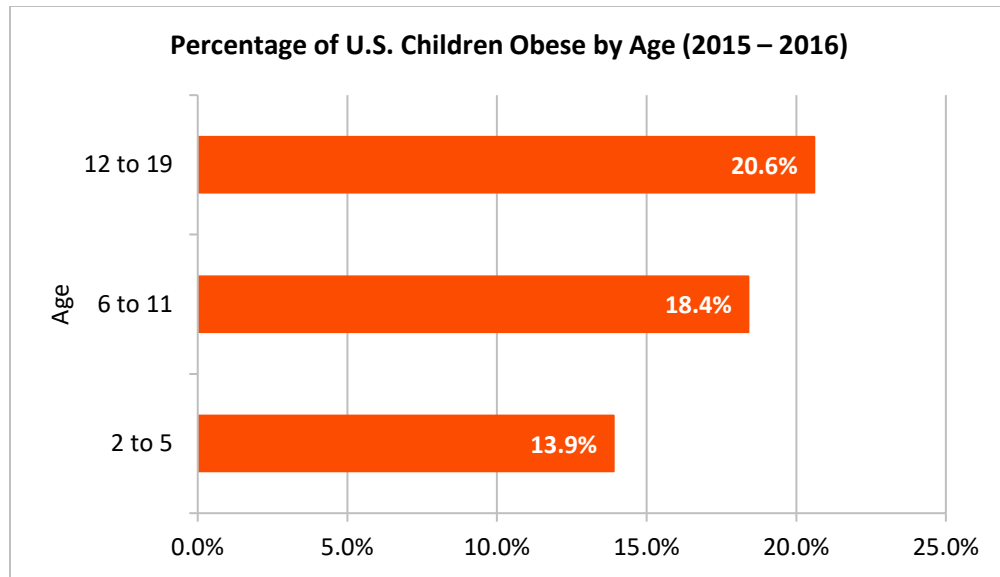


Figure 9. Percentage of U.S. Children Obese by Age, 2015 – 2016
(Source: [NCHS Data Brief](#), 2017)

Adolescents

- Prince George's County has a higher percentage and increasing trend of adolescent obesity when compared to Montgomery County and Maryland with 16.4 percent in 2016 (Figure 10).
- Both Maryland and Montgomery County met the Healthy People 2020 target. However, Prince George's County did not (Figure 10).

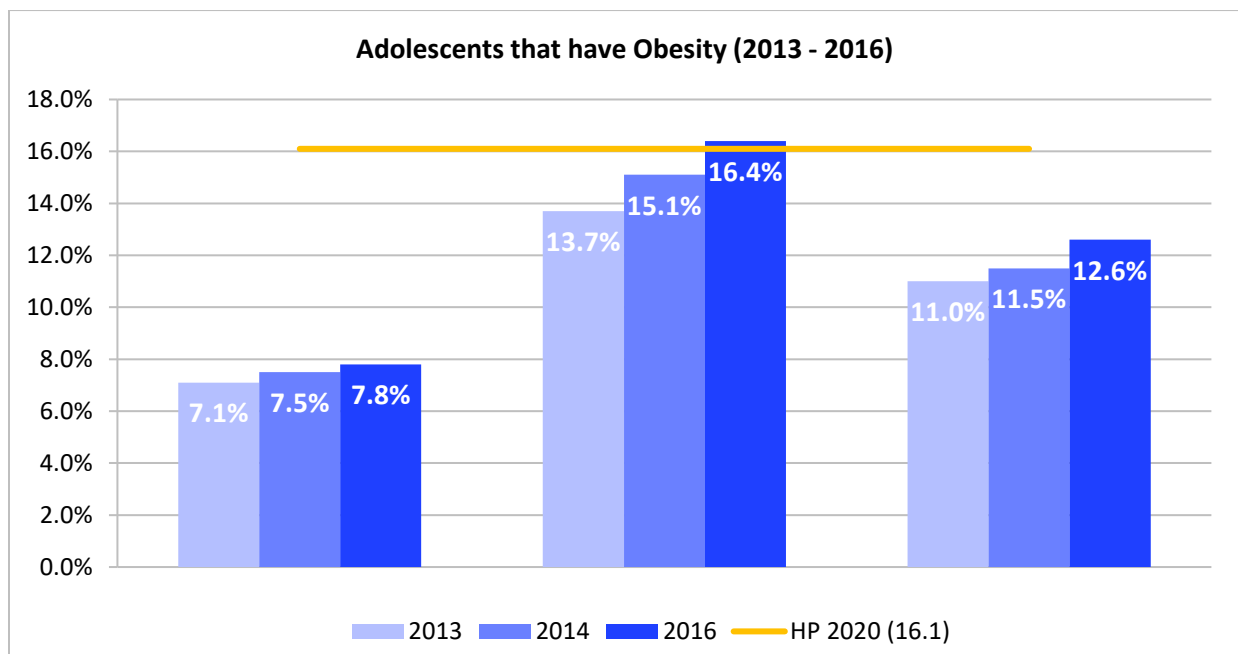


Figure 10. Adolescents That Have Obesity, 2013 – 2016
(Source: [PGC Health Zone](#) & [Healthy Montgomery](#), 2017)

- Over time, every race has steadily increased in percentage of adolescents that have obesity (Figure 11).
- In 2016, Black/African-Americans and Hispanics had the highest percentage of adolescents with obesity with 16.3 and 14.8. Black/African-Americans do not meet the Healthy People 2020 target (Figure 11).

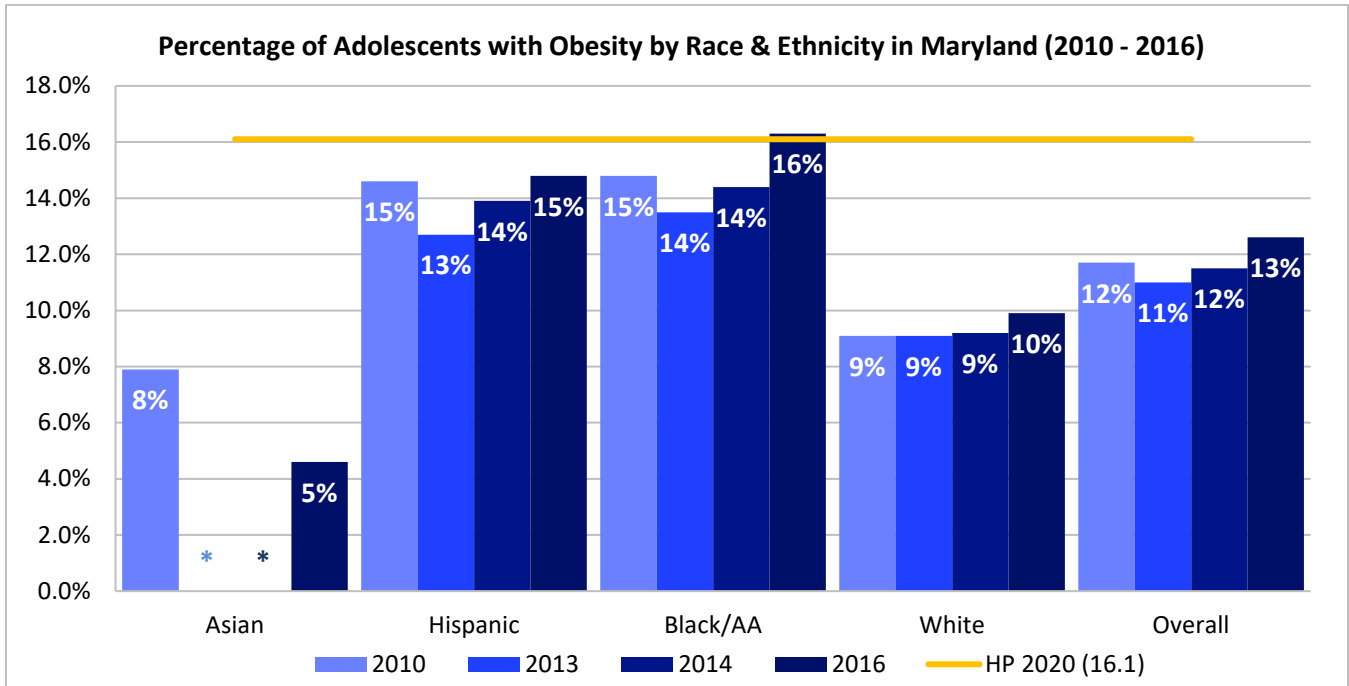


Figure 11. Percentage of Adolescents That Have Obesity by Race/Ethnicity in Maryland, 2010 – 2016
 *Data unavailable/not applicable
 (Source: MD SHIP, 2016)

Healthy Weight Behaviors

According to County Health Rankings, Montgomery County was ranked first in the state of Maryland in 2019 for various health behaviors including: adult obesity; food environment index; physical activity; access to exercise opportunities; adult smoking; and excessive drinking. Prince George’s County ranked 11th in the state for the same measure.⁶

Diet

- More adults in Montgomery County consumed at least 1 or more fruit per day compared to Maryland and Prince George’s County, where 36 percent had no daily fruit consumption (Figure 12).

⁶ University of Wisconsin: Population Health Institute. (2019). County Health Rankings. Retrieved from <https://www.countyhealthrankings.org/app/maryland/2019/rankings/montgomery/county/outcomes/overall/snapshot>

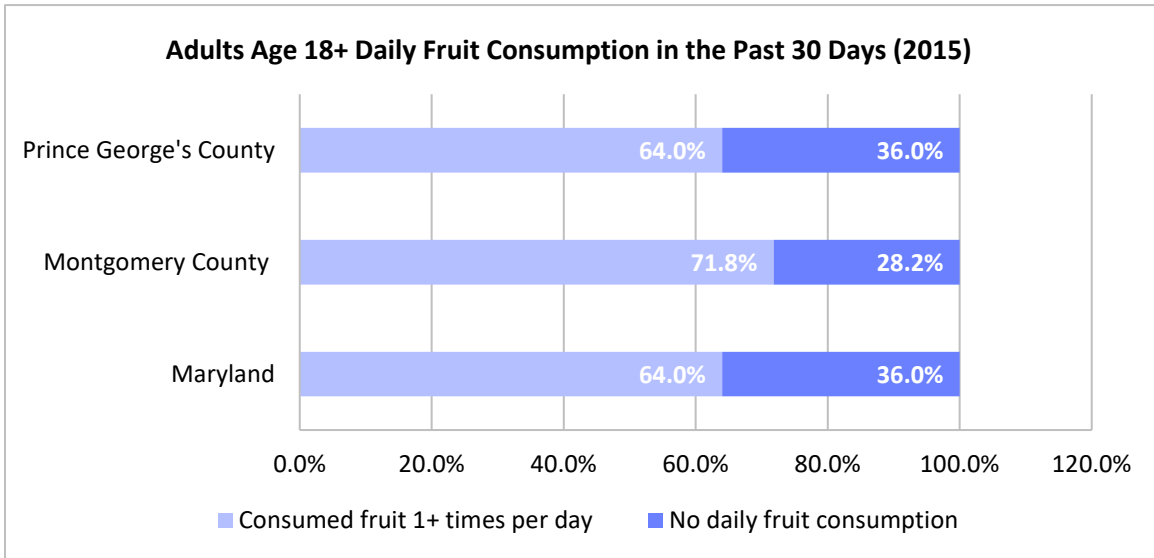


Figure 12. Percentage of Adults Age 18+ Daily Fruit Consumption in Montgomery County, Prince George's County, and Maryland, 2015
(Source: [Maryland BRFSS](#), 2017)

- In Maryland and Prince George's County, over 20 percent of the adult population have no daily vegetable consumption compared to Montgomery County's 13.9 percent (Figure 13).

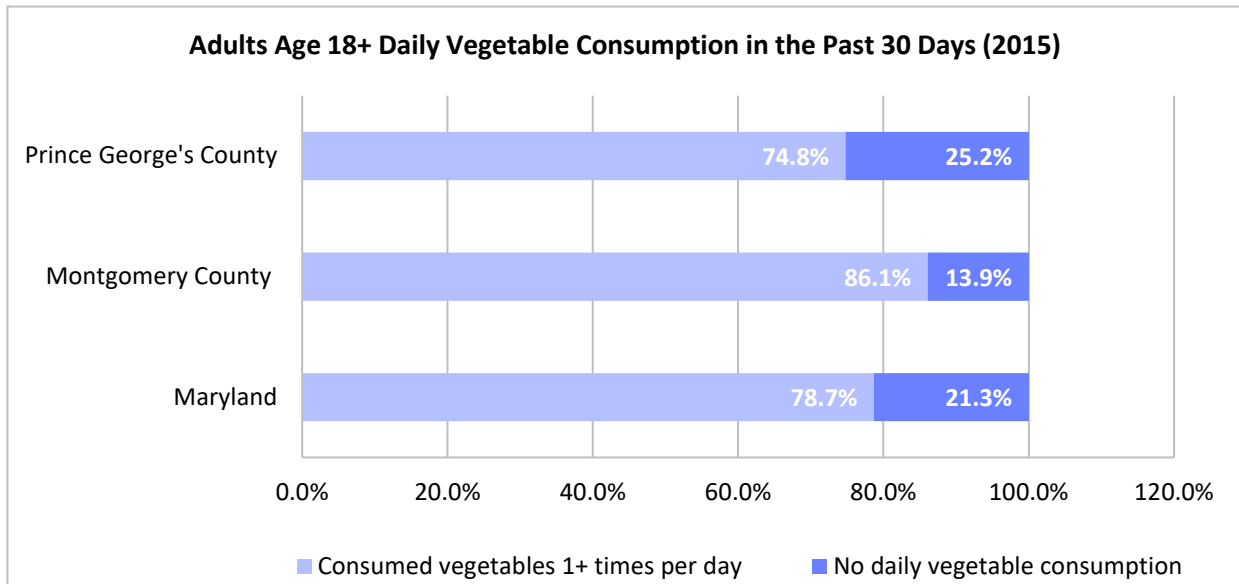


Figure 13. Percentage of Adults Age 18+ Daily Vegetable Consumption in Montgomery County, Prince George's County, and Maryland, 2015
(Source: [Maryland BRFSS](#), 2017)

Physical Activity

- In 2015, adults in Montgomery County participated in leisure time physical activity in the past 30 days more often than those in Prince George’s County or Maryland. However, both Prince George’s County and Maryland have a high percentage of adults who participate in leisure time physical activity (Figure 14).

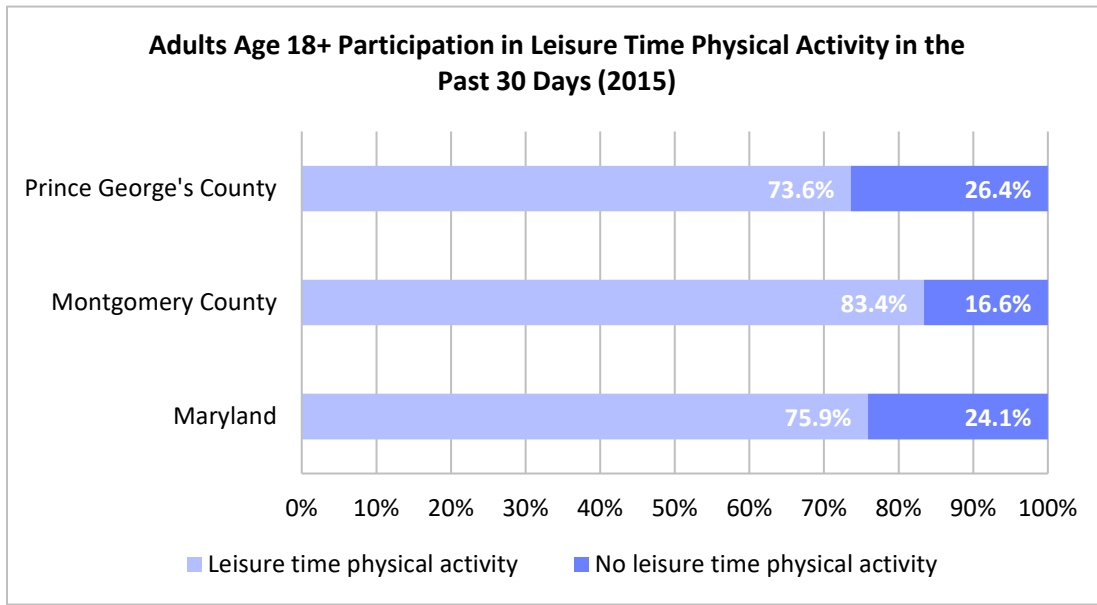


Figure 14. Percentage of Adults 18+ Participation in Leisure Time Physical Activity in Montgomery County, Prince George’s County, and Maryland, 2015
(Source: [Maryland BRFS, 2017](#))

Community Resources

Services and resources for obesity are often incorporated within other programs addressing diabetes, heart disease, and cancer. In Adventist HealthCare White Oak Medical Center's Community Benefit Service Area, there are local efforts in schools, clinics, and recreational centers to reduce and prevent obesity. Services include, but are not limited to the following:

- 1. PRINCE GEORGE'S COUNTY DEPARTMENTS OF PARKS AND RECREATION – HEALTH & WELLNESS**
Address: 6600 Kenilworth Ave,
Riverdale, MD 20737
Phone: 301-699-2255
Website:
<http://www.pgparcs.com/856/Health-Wellness>
- 2. MONTGOMERY COUNTY PARKS – ACTIVITIES**
Address: 9500 Brunett Avenue, Silver Spring, MD 20901
Phone: 301-495-2581
Email:
ProgramAccess@MontgomeryParks.org
Website:
<https://www.montgomeryparks.org/activities/>
- 3. PRINCE GEORGE'S COUNTY HEALTH SERVICES**
Address: 9314 Piscataway Road,
Clinton, MD 20735
Phone: 301-856-9643
Email: WellnessInfo@co.pg.md.us
Website:
<https://www.princegeorgescountymd.gov/2102/Classes>
- 4. MONTGOMERY COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES Senior Nutrition Program**
Address: 401 Hungerford Drive,
Rockville, MD 20850
Phone: 240-777-3810
Email:
hhsml@montgomerycountymd.gov
Website:
http://montgomery.md.networkofcare.org/mh/services/agency.aspx?pid=MontgomeryDepartmentofHealthandHumanServicesSeniorNutritionProgramSNP_680_2_0

YMAC of Upper Montgomery County
Address: 19236 Montgomery Village Avenue, Montgomery Village, MD 20886
Phone: 301-740-7599
Email: bpulgar@ymcawashdc.org
Website:
http://montgomery.md.networkofcare.org/mh/services/agency.aspx?pid=YMACofUpperMontgomeryCounty_680_2_0
- 5. ALLIANCE FOR A HEALTHIER GENERATION – RESOURCES**
Phone: 1-888-KID-HLTH
Website:
<https://www.healthiergeneration.org/resources>

6. IMPACT SILVER SPRING – SPORTS

Provides high quality recreational sports and enrichment for low-income and immigrant youth.

Address: 8807 Colesville Road, Lower Level, Silver Spring, MD 20910

Phone: 301-298-5117

Email: info@impactsilverspring.org

Website:

<https://impactsilverspring.org/sports>

7. REAL FOOD FOR KIDS – MONTGOMERY

Address: 12320 Parklawn Drive, Rockville, MD 20852

Phone: 301-202-4812

Email: info@healthyschoolfoodmd.org

Website:

<http://www.realfoodforkidsmontgomery.org/index.html>

8. CROSSROADS COMMUNITY FOOD NETWORK

Crossroads works to bolster the local food system through programs that support and unite those who grow, make, and eat fresh, healthy food.

Address: 6930 Carroll Avenue, Suite 426, Takoma Park, MD 20912

Website:

<https://www.crossroadscommunityfoodnetwork.org/>

9. CITY OF GAITHERSBURG – BENJAMIN GAITHER CENTER

Offers a variety of classes, trips, special events, and activities, for those 55 years of age and older.

Address: 80A Bureau Drive, Gaithersburg, MD 20878

Phone: 301-258-6380

Email:

benjamingaithercenter@gaitHERSBURGMD.GOV

Website:

<https://www.gaitHERSBURGMD.GOV/about-us/city-facilities/benjamin-gaither-center>

10. FOOD & FRIENDS

Address: 219 Riggs Road NE, Washington, DC 20011

Phone: 202-269-2277

Email: info@foodandfriends.org

Website: <https://foodandfriends.org/>

Section IV: Findings

Part B: Secondary Data

Chapter 8: Social Determinants of Health (SDOH)

- 8.1: Educational Attainment
- 8.2: Food Access
- 8.3: Housing
- 8.4: Transportation

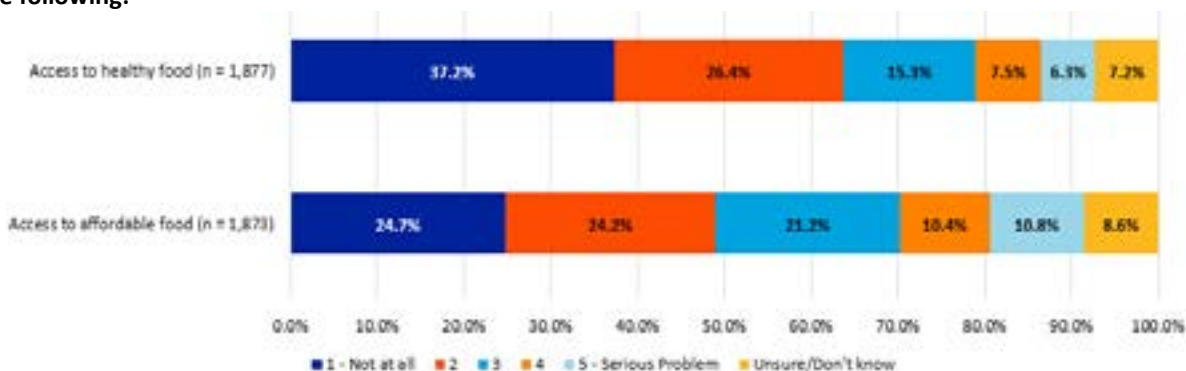
Social Determinants of Health

KEY FINDINGS – PART I

Disparities & Indicators	Trend Over Time
<p>Education</p> <ul style="list-style-type: none"> In PGC and MC, Hispanic high school students have the lowest graduation rates among all racial/ethnic groups; Asian students have the highest rates In both counties, NH – Black/AA and Hispanic students have the lowest proficiency in math and English language arts as compared to Asian students who have the highest rates overall Bachelor’s degree or higher is lowest among Hispanics and AI/AN as compared to Asian and White individuals who have the highest rates among all racial/ethnic groups <p>Food Access</p> <ul style="list-style-type: none"> There are 6.7% more fast food restaurants and 2.2% less grocery stores in PGC as compared to MC In PGC, the food insecurity rate is more than 2X greater than MC; neither county meets the HP 2020 target of 6.0% In MC, NH – Black/AA and Hispanic households are becoming more food secure as NH – White households are becoming less food secure 	<ul style="list-style-type: none"> Food insecurity rates had a 1.5% decrease in PGC from 2013 to 2017 PGC had a 6.1% increase in high school graduation rates from 2014 – 2017 From FY2013 – FY2018, households receiving SNAP decreased by 11.1% in MC and 20.4% in PGC MC has a stable trend from 2014 – 2017 for high school graduation with an average of 89.3% From 2014 – 2017, students entering kindergarten ready to learn remained stable for both MC (avg. 48.3%) and PGC (avg. 35.0%) From 2017 - 2018, the PGC high school graduation rate decreased by 4.2%




Community Perception

REHAB CBSA: Thinking about your local community/neighborhood, on a scale of 1-5, how much of a problem are each of the following:



Social Determinants of Health


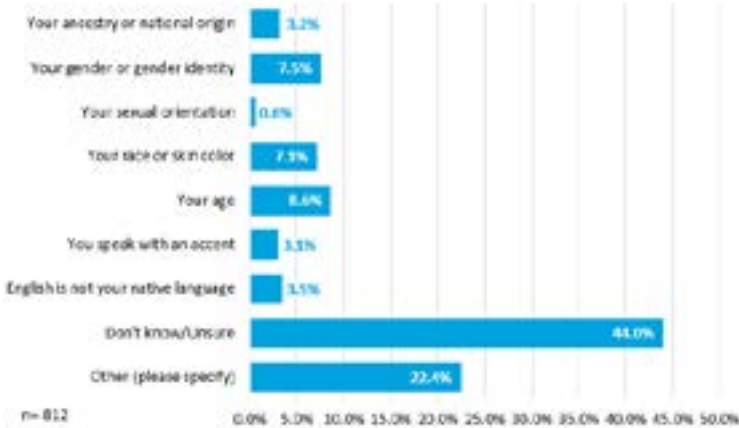
KEY FINDINGS – PART II

Disparities & Indicators	Trend Over Time
<p>Housing</p> <ul style="list-style-type: none"> MC has a higher homeless population than PGC In MC, the largest number of people who are homeless are individuals; in PGC, it's persons in families MC's largest subpopulation of homeless individuals are domestic violence victims with chronic health problems; PGC's largest subpopulations are individuals with chronic health problems and those with physical disabilities 17% of MC and 20% of PGC households have severe housing problems 	<ul style="list-style-type: none">  Adults who have had a routine check-up increased in PGC  Individuals experiencing homelessness in MC and PGC saw a decreasing trend  Increasing trend for adults who are unable to afford to see a doctor in PGC
<h3>Community Perception</h3>	
<p>Navigating the Healthcare System “When it comes to behavioral health calls, particularly for those with alcohol or substance abuse struggles, they are seeing the same people over and over. Unfortunately, we often don’t have anywhere else to take them other than the ER.”¹</p>	<p>Lack of quality providers in their area “It’s too easy to cross counties and go elsewhere because of the perception that there’s better care elsewhere.”⁴</p>
<p>Language Barriers “Even though resources are out there, the problem remains that people lack information due to factors like language barriers.”²</p>	<p>Housing “There should be more affordable housing options which should include both rentals and homeownership.”⁵ “The extremely high cost of living in this area greatly reduces the availability of affordable housing for low/moderate income families and seniors.”⁶</p>
<p>Cost of Care “Unfortunately, many top ranked doctors and pediatricians do not take Medicaid.”³</p>	

^{1,2,4} Adventist HealthCare Community Health Needs Assessment. (2019). Primary Data Collection – Key Informant Interview.
^{3,5,6} Adventist HealthCare Community Health Needs Assessment. (2019). Primary Data Collection – Community Survey.

Social Determinants of Health

KEY FINDINGS – PART III

Disparities & Indicators	Trend Over Time																				
<p>Transportation</p> <ul style="list-style-type: none"> • Pedestrian injury rate on public roads is increasing and higher than HP 2020 target (20) • Death rate due to motor vehicle traffic collisions in MC is highest for Hispanics <p>Discrimination</p> <ul style="list-style-type: none"> • For survey respondents that indicated “Other” as a reason for being treated unfairly/discriminated against, 51.9% of people in the WOMC CBSA stated that either weight or insurance type/status was the main reason for being treated unfairly/discriminated against when receiving medical care 	 <ul style="list-style-type: none"> • From 2013 – 2017 the pedestrian injury rate increased in PGC and MC 																				
Community Perception																					
<p>REHAB CBSA: “Which of these do you think is the main reason why you have been treated unfairly while getting medical care?”³</p>  <table border="1"> <thead> <tr> <th>Reason</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Your ancestry or national origin</td> <td>3.2%</td> </tr> <tr> <td>Your gender or gender identity</td> <td>7.5%</td> </tr> <tr> <td>Your sexual orientation</td> <td>0.8%</td> </tr> <tr> <td>Your race or skin color</td> <td>7.3%</td> </tr> <tr> <td>Your age</td> <td>8.6%</td> </tr> <tr> <td>You speak with an accent</td> <td>3.3%</td> </tr> <tr> <td>English is not your native language</td> <td>3.5%</td> </tr> <tr> <td>Don't know/uncare</td> <td>44.0%</td> </tr> <tr> <td>Other (please specify)</td> <td>22.4%</td> </tr> </tbody> </table> <p>n = 812</p>	Reason	Percentage	Your ancestry or national origin	3.2%	Your gender or gender identity	7.5%	Your sexual orientation	0.8%	Your race or skin color	7.3%	Your age	8.6%	You speak with an accent	3.3%	English is not your native language	3.5%	Don't know/uncare	44.0%	Other (please specify)	22.4%	<p>Transportation</p> <div data-bbox="922 1192 1438 1306"> <p>“Safer pedestrian walkways, raised crosswalks, bike lanes.”¹</p> </div> <div data-bbox="922 1336 1334 1450"> <p>“More care free zone for pedestrians.”³</p> </div> <div data-bbox="922 1480 1448 1720"> <p>Transportation was mentioned 57x as a gap/weakness. Affordability was mentioned as a barrier, as were additional mobility challenges for the elderly and those with physical disabilities.</p> </div>
Reason	Percentage																				
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Other (please specify)	22.4%																				

³ Adventist HealthCare. (2019). Community Health Needs Assessment – Community Survey.

8.1 Educational Attainment

In 2018, 88.4 percent of Montgomery County students graduated high school within 4 years. The 4-year graduation rate for the county is higher than that of the state (87.1 percent) (Figure 1).

- Over time, the 4-year high school graduation rate of Prince George's County students has been lower than both the state average and Montgomery County's average (Figure 1).
- From 2017 – 2018, the graduation rate in PGC decreased by 4.2 percent (Figure 1)

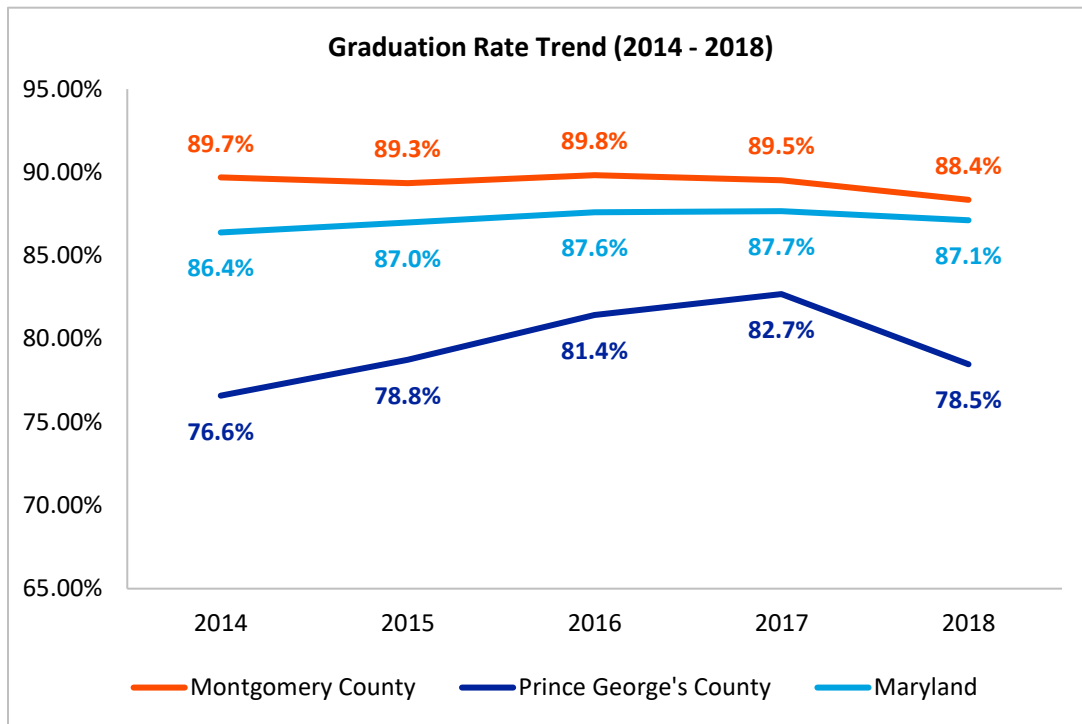


Figure 1. Graduation Rate Trend, 2014 - 2018
(Source: [Maryland Report Card](#), 2018)

- Asian and White students in Montgomery County have the highest graduation rates, at 97.3 and 96.0 percent respectively, while Hispanic students have the lowest rates at 78.5 percent (Figure 2).
- In Prince George's County, students who identify as Asian and two or more races have the highest graduation rates, while Hispanic students have the lowest graduation rates (Figure 2).
- Similar patterns can be found when looking at the graduation rates across the state of Maryland (Figure 2).

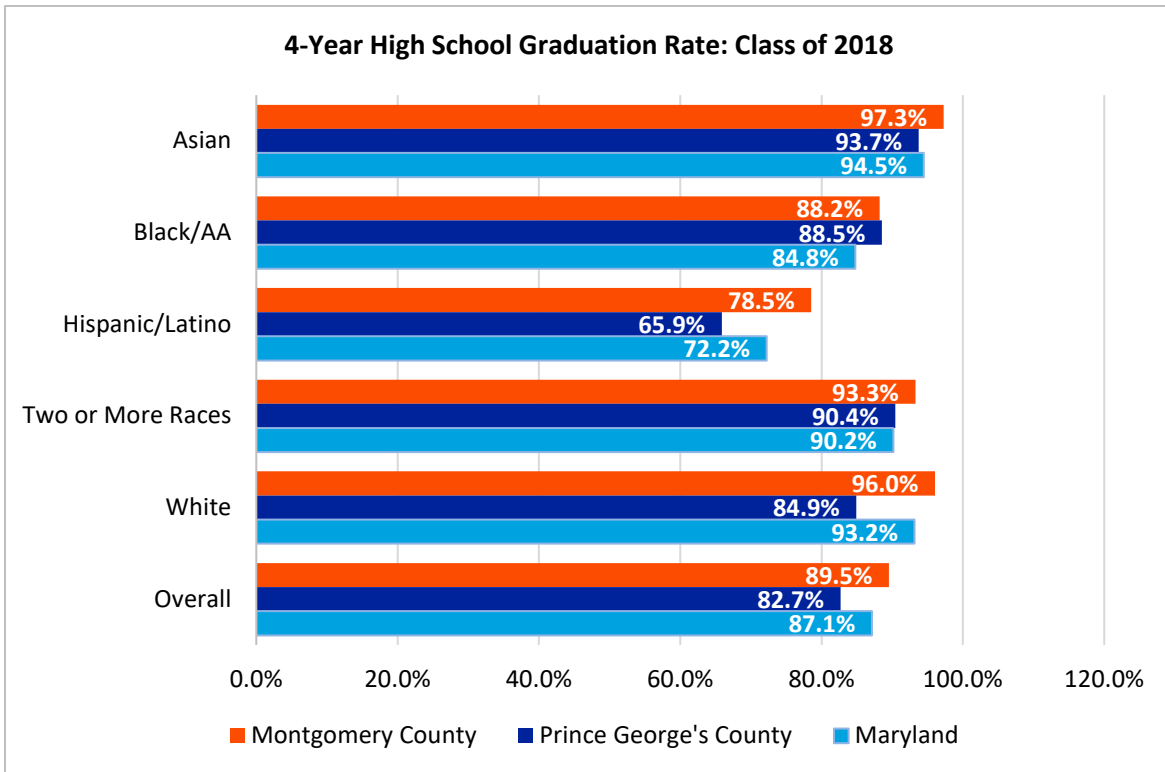


Figure 2. 4-Year High School Graduation Rate, 2018
 (Source: [Maryland Report Card](#), 2018)

- The overall percentage of adults in Montgomery County with a bachelor’s degree or higher is 58.3 percent (Figure 3).
- However, when stratified by race and ethnicity, the percentage goes as high as 71.3 among White students and as low as 25.1 among Hispanic students (Figure 3).
- In Prince George’s County, the overall percentage of adults with a bachelor’s degree is much lower at only 31.9 percent (Figure 3).
- When stratified by race and ethnicity, there are large disparities in Prince George’s County, with 56.4 percent of Asian students obtaining a bachelor’s degree compared to 10.3 percent of Hispanic students (Figure 3).
- A similar pattern can be found when looking at the state of Maryland (Figure 3).

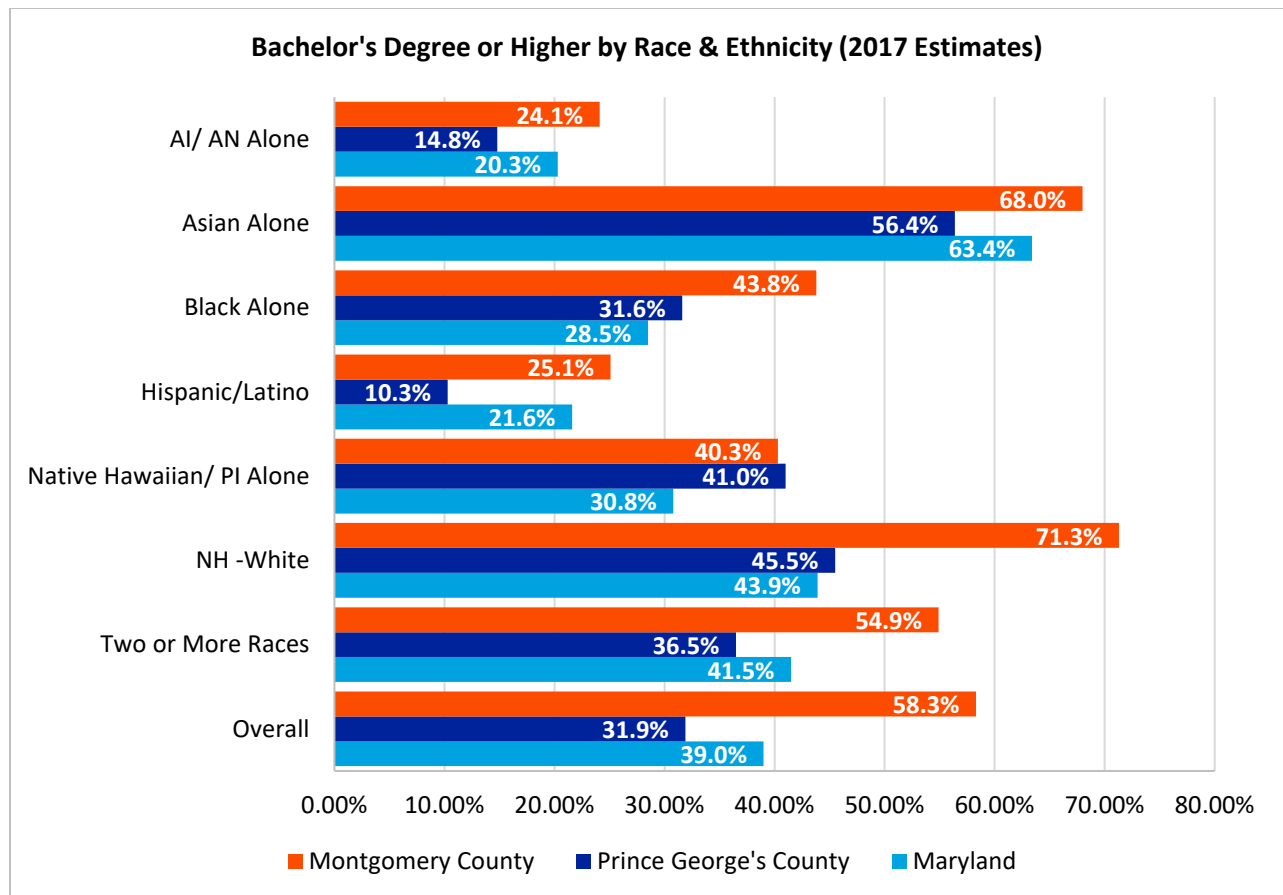


Figure 3. Bachelor's Degree or Higher by Race & Ethnicity, 2017
 (Source: [U.S. Census Bureau-American Community Survey 5-Year Estimates](#), 2017)

Reading & Math Proficiency

- 71.6 percent of Asian and 66.7 percent of White high school students are proficient in English language arts compared to 33.3 percent of Hispanic students and 35.6 percent of Black students in Montgomery County (Figure 4).
- In Prince George's County, there are disparities in English language arts proficiency among high school students of different races and ethnicities, with Asian students testing highest at 69.9 percent and Hispanic students testing the lowest at 33.8 percent (Figure 4).

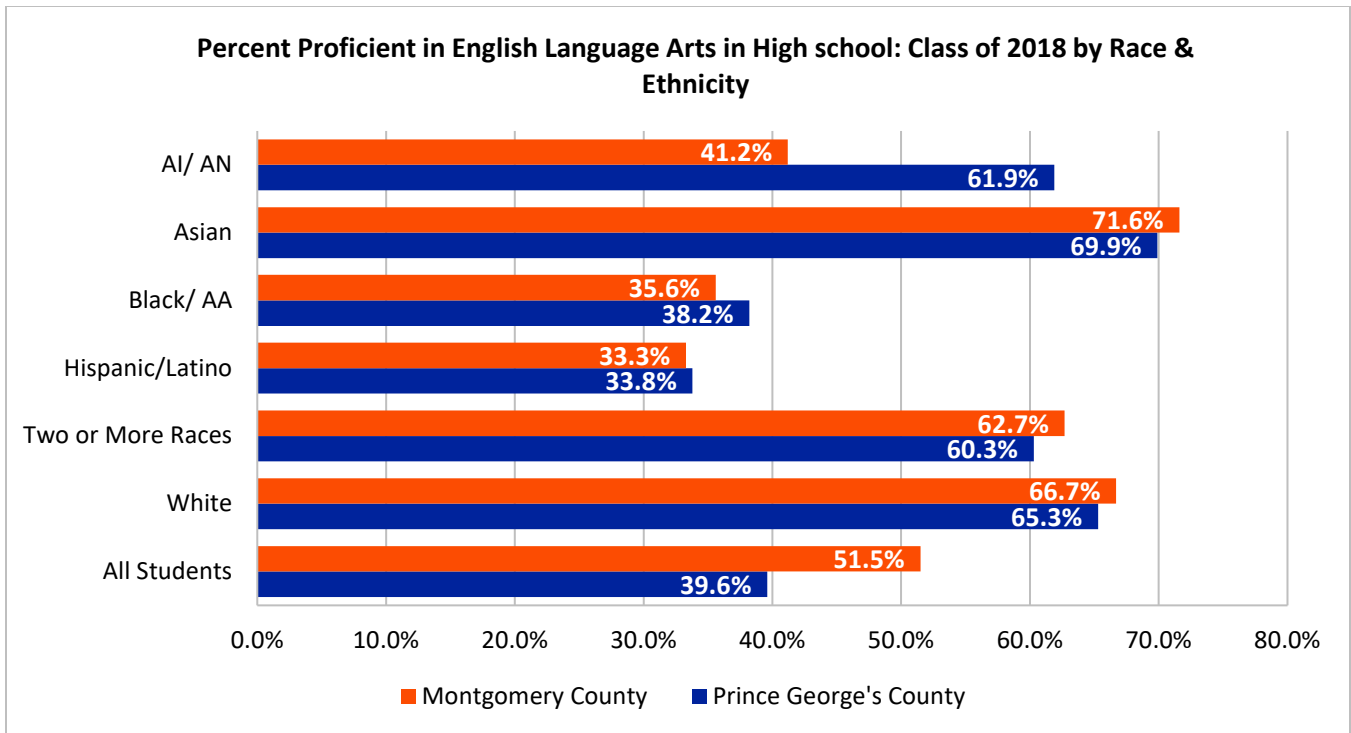


Figure 4. High School Students Proficiency in English Language Arts by Race & Ethnicity, 2018
 (Source: [Maryland Report Card](#), 2018)

- In Montgomery County, 82.0 percent of Asian and 76.4 percent of White high school students are proficient in math compared to only 38.9 percent of Black and 29.2 percent of Hispanic high school students (Figure 5).
- In Prince George’s County, 53.0 percent of Asian and 49.4 percent of White high school students are proficient in math compared to 13.1 percent of Hispanic and 20.6 percent of Black high school students (Figure 5).

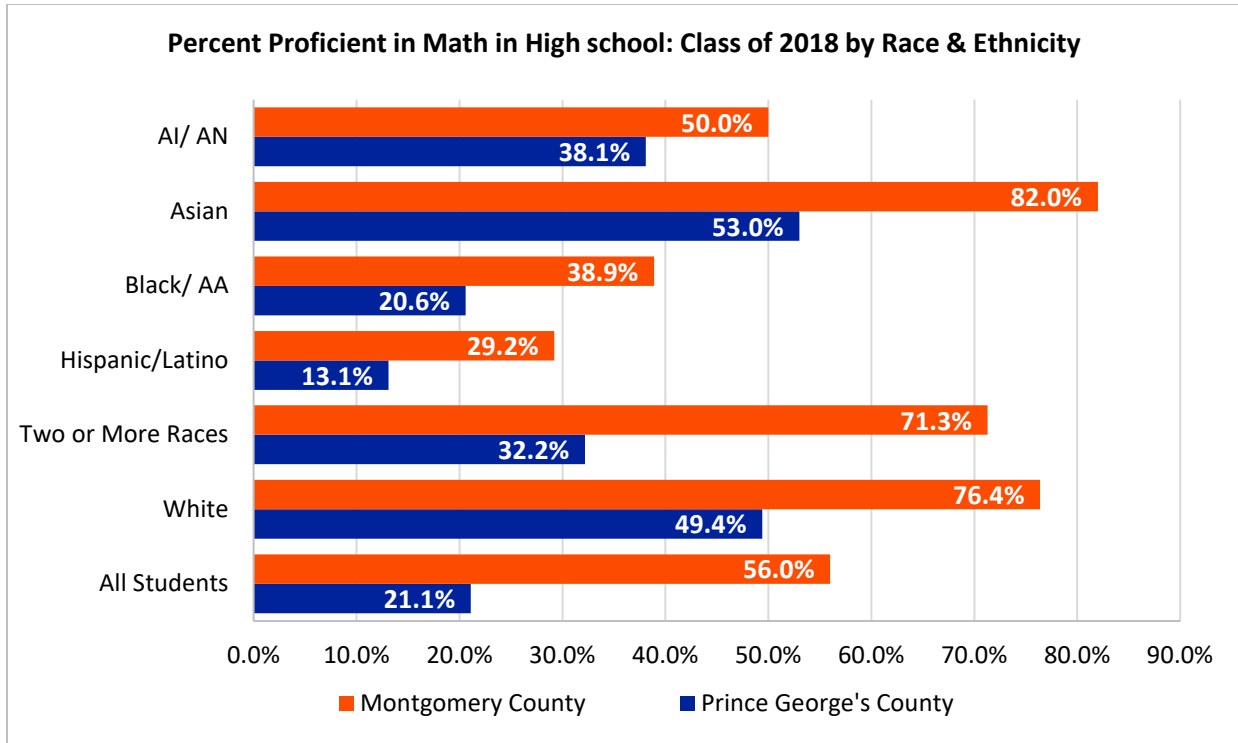


Figure 5. High School Students Proficiency in Math by Race & Ethnicity, 2018
 (Source: [Maryland Report Card](#), 2018)

Readiness for Kindergarten

- The percentage of children who enter kindergarten ready to learn in Montgomery County has remained constant and is higher than the state overall (Figure 6).
- The percentage of children who enter kindergarten ready to learn in Prince George’s County increased in 2015 to 38.0 percent but then decreased back down to 34.0 percent. The percentage is lower than the state overall (Figure 6).

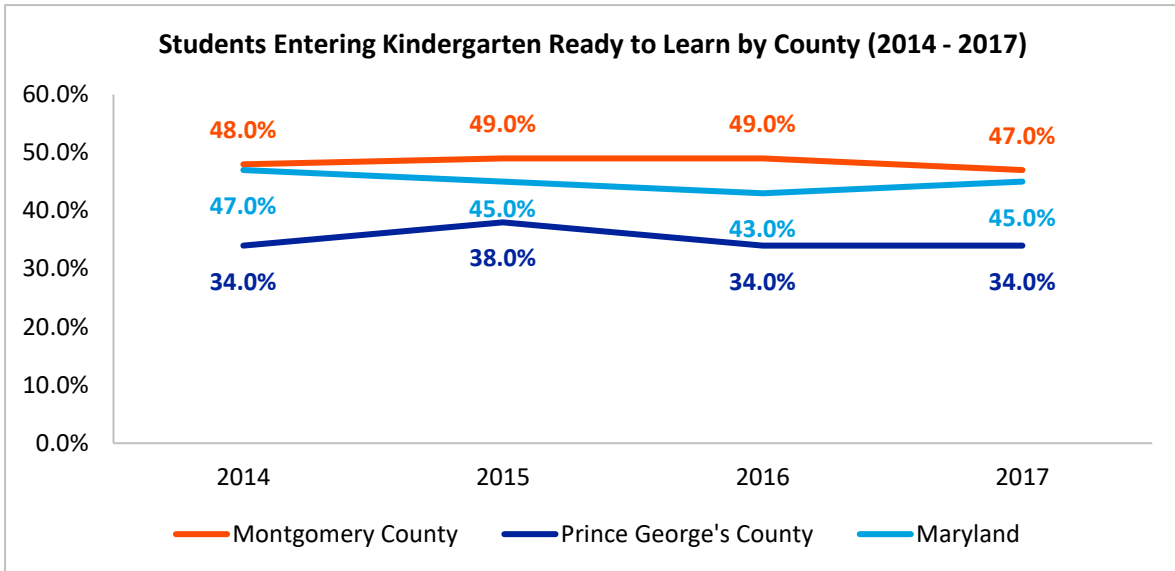


Figure 6. Percentage of Students Entering Kindergarten Ready to Learn, 2014-2017
(Source: [SHIP](#), 2017)

- Hispanic children were among those least likely to be prepared for kindergarten (24.0 percent). White (67.0 percent) and Asian (63.0 percent) children were among those most prepared to enter Kindergarten in Montgomery County (Figure 7).
- Hispanic children were the least likely to be prepared for kindergarten at 14.0 percent, while Asian and White children were among those most prepared to enter Kindergarten in Prince George’s County at 50.0 percent and 53.0 percent, respectively (Figure 7).

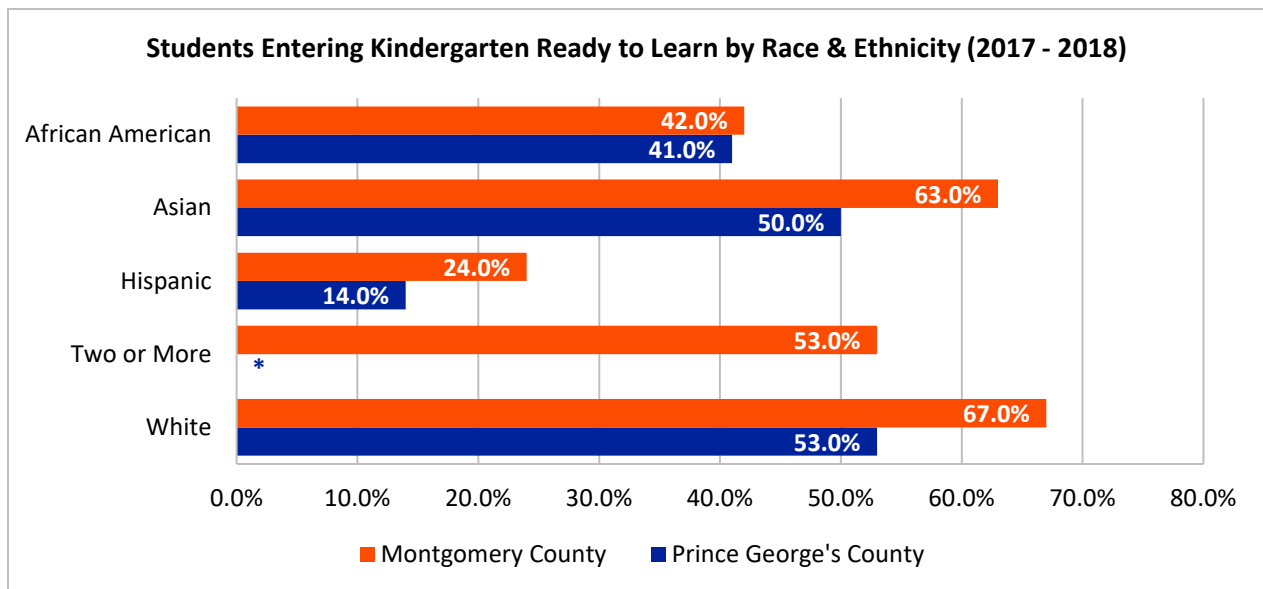


Figure 7. Percentage of Students Entering Kindergarten Ready to Learn by Race & Ethnicity, 2017 - 2018

*Data not available/not applicable

(Source: [Kindergarten Readiness Assessment Report](#), 2018)

Community Resources

Locally, community groups work to reduce the influence of educational disparities by offering supplemental education programs for all ages. Services include, but are not limited to, the following:

1. MONTGOMERY COALITION FOR ADULT ENGLISH LITERACY

The Montgomery Coalition for Adult English Literacy strengthens the countywide adult English literacy network to support a thriving community and effective workforce.

Address: 9210 Corporate Blvd #480, Rockville, MD 20850

Phone: 301-881-1338

Email: communications@mcael.org

Website: <https://www.mcael.org/>

2. LEADERSHIP MONTGOMERY

To educate, inspire, convene and connect leaders to advance Montgomery County

Address: 6010 Executive Boulevard Suite 200, Rockville, MD 20852

Phone: 301-881-3333

Website:

<https://leadershipmontgomerymd.org/>

3. IDENTITY- ACADEMIC SUPPORT

Address (Main Office): 414 East Diamond Ave. Gaithersburg, MD 20877

Phone: 301-963-5900

Email: info@identity-youth.org

Website: <https://identity-youth.org/what-we-do/academic-support/>

4. GENERATION HOPE

Help D.C. area teen parents become college graduates and help their children enter kindergarten at higher levels of school readiness.

Address: 415 Michigan Avenue NE, Suite 430, Washington, D.C. 20017

Phone: 202-734-5838

Email:

info@supportgenerationhope.org

Website:

<http://supportgenerationhope.org/>

5. FAMILY SERVICES

Address: 610 East Diamond Ave, Suite 100, Gaithersburg, MD 20877

Phone: 301-840-2000

Email: info@fs-inc.org

Website:

<https://www.sheppardpratt.org/family-services-inc/>

8.2 Food Access

Healthy Eating Behaviors

- More adults in Montgomery County consumed at least 1 or more fruit per day compared to Maryland and Prince George’s County, where 36 percent had no daily fruit consumption (Figure 1).

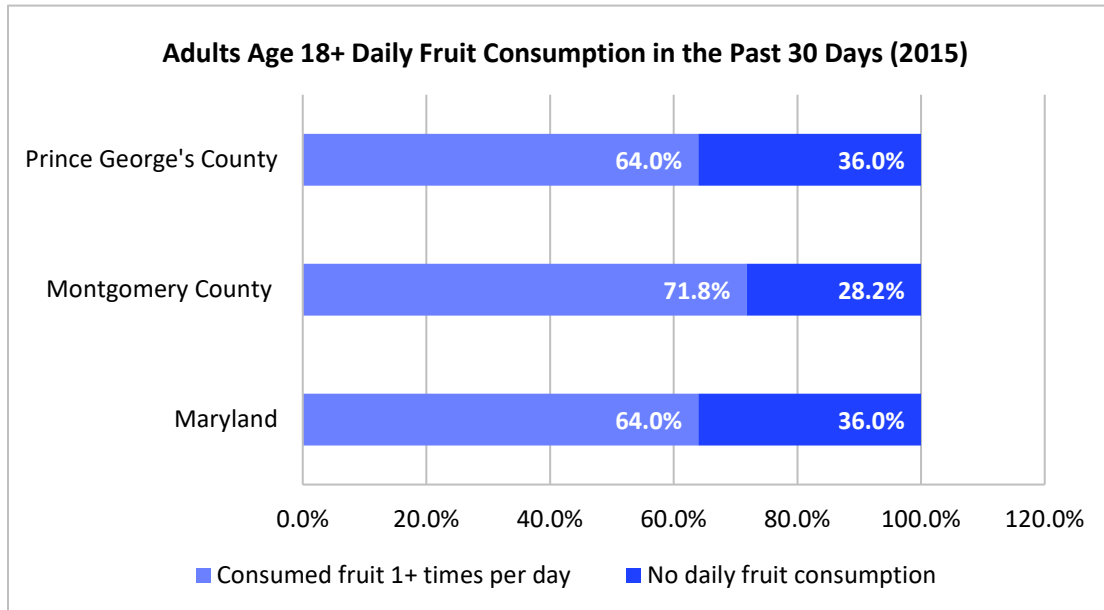


Figure 1. Percentage of Adults Age 18+ Daily Fruit Consumption in Montgomery County, Prince George’s County, and Maryland, 2015
(Source: [Maryland BRFS](#), 2017)

- In Maryland and Prince George’s County, over 20 percent of the adult population have no daily vegetable consumption compared to Montgomery County’s 13.9 percent (Figure 2).

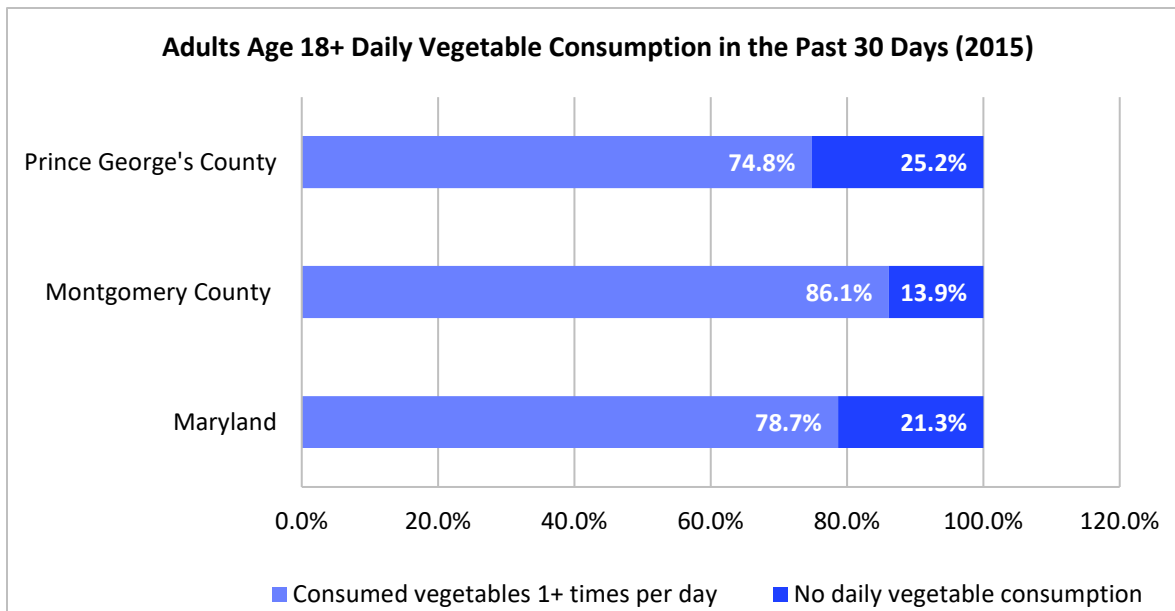


Figure 2. Percentage of Adults Age 18+ Daily Vegetable Consumption in Montgomery County, Prince George's County, and Maryland, 2015
(Source: [Maryland BRFSS](#), 2017)

Food Environment

Food insecurity is defined by the USDA as a lack of access to enough food for a healthy life and limited or uncertain availability of adequately nutritious foods.⁴

- Over the past four years, the food insecurity rate for both counties and Maryland have fluctuated. Most recently in 2017, 6.1 percent of the Montgomery County population experienced food insecurity, compared to 10.7 percent of Maryland and 13.3 percent of Prince George's County's (Figure 3).
- Neither county or Maryland met the Healthy People 2020 target of 6.0 percent (Figure 3).

⁴ Feeding America (2016). Food insecurity in the United States. *Feeding America*. Retrieved from <http://map.feedingamerica.org/county/2014/overall>

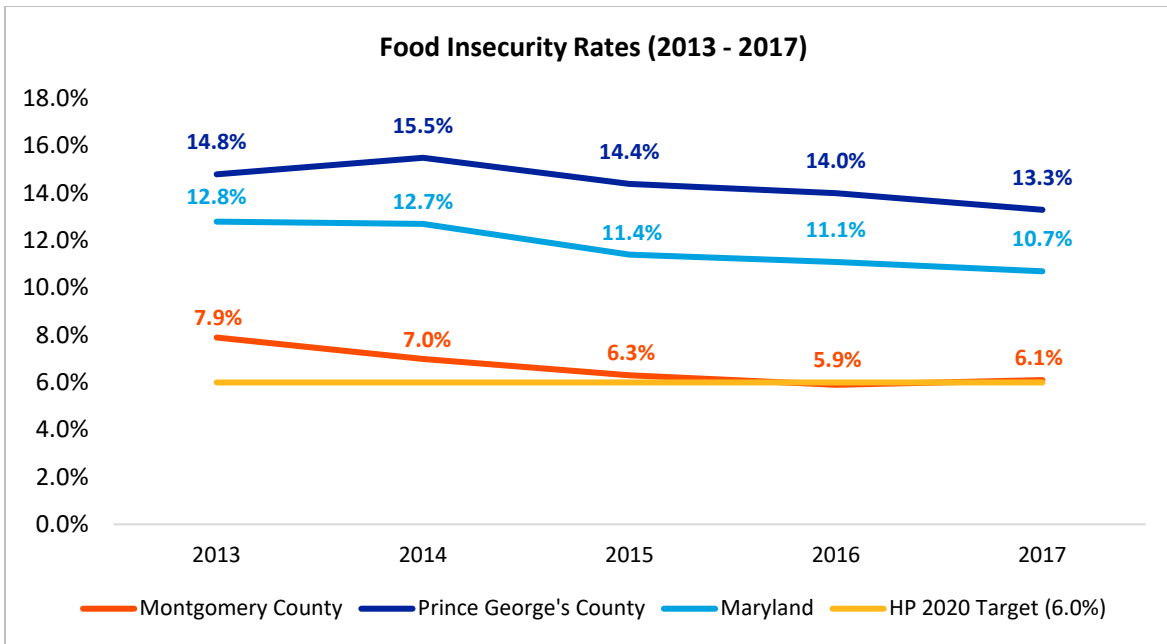


Figure 3. Food Insecurity Rates, 2013 - 2017
 (Source: [PGC Health Zone](#) & [Feeding America](#), 2017)

- Over time, in Montgomery County, non-Hispanic Black and Hispanic households are becoming more food secure while White households are becoming less food secure (Figure 4).

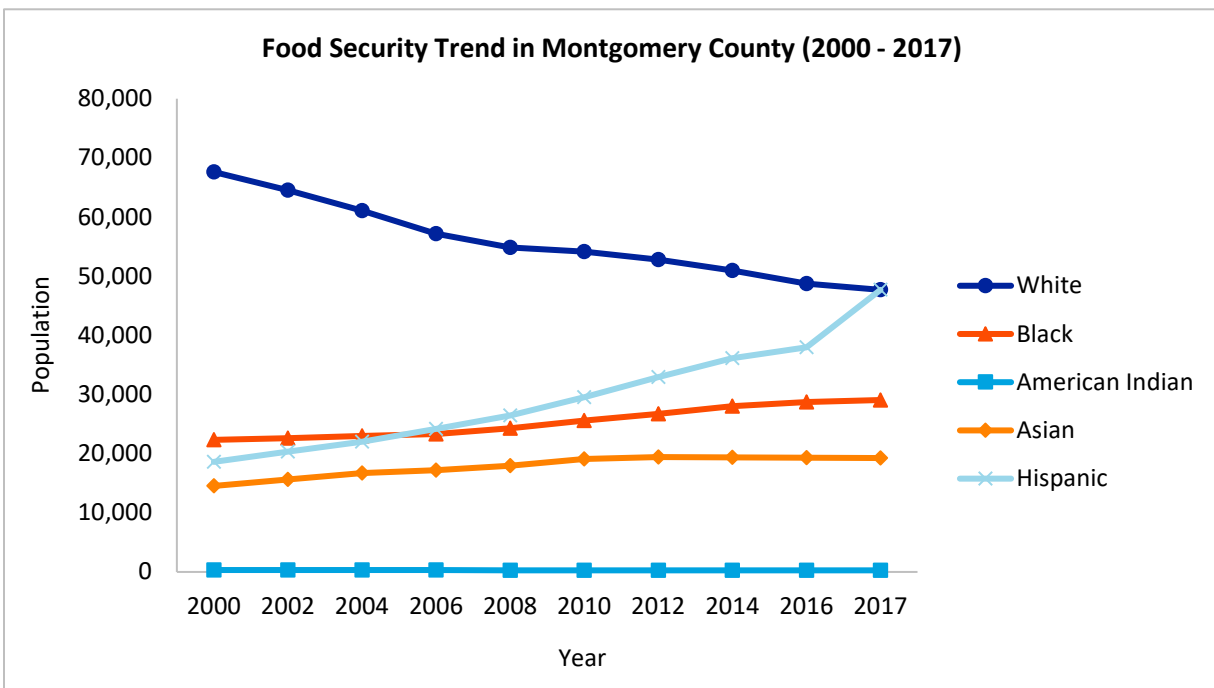


Figure 4. Food Security Trend in Montgomery County, 2000 – 2017
 (Source: [Montgomery County FoodStat](#), 2019)

- The child food insecurity rate is 1.2 percent higher in Prince George’s County than in Montgomery County, however, both counties are lower than the overall average for the state (15.2 percent) (Figure 5).

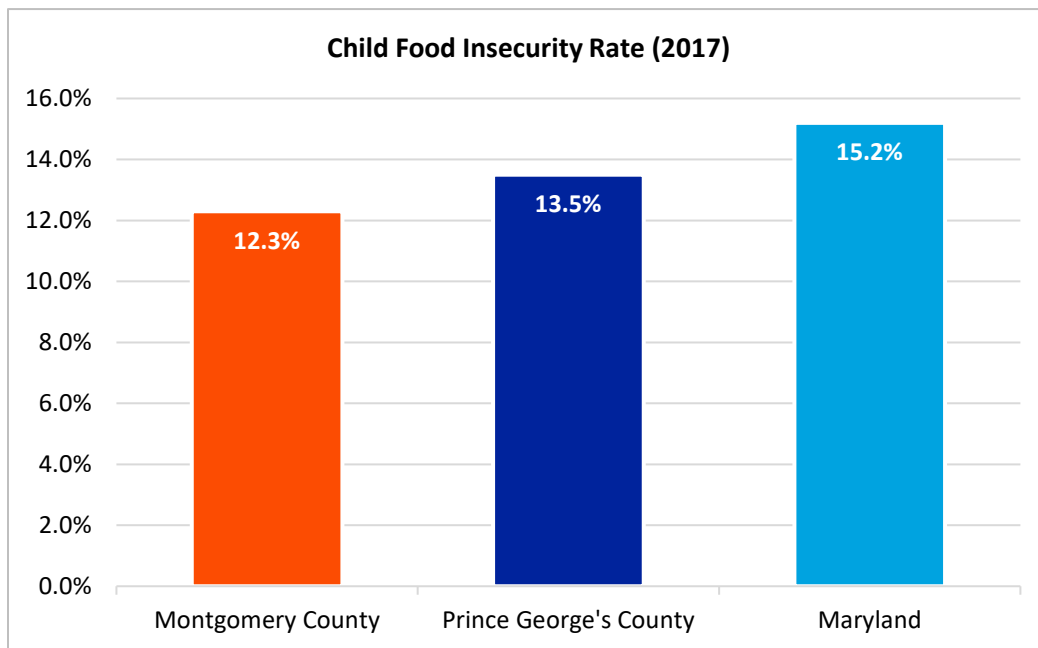


Figure 5. Child Food Insecurity Rate, 2017
(Source: [Feeding America](#), 2019)

- When looking at food insecure populations who are ineligible for assistance (total population and population under age 18 that experience food insecurity at some point during the year but are ineligible for State or Federal nutrition assistance⁵), children in both Montgomery and Prince George’s Counties and Maryland have the highest percentage; Montgomery county children have the highest percentage overall (Figure 6).

⁵ Trinity Health. (2019). Trinity Data Hub Vital Signs Report – Montgomery and Prince George’s County, Maryland. Retrieved from <https://cares.page.link/HoXh>

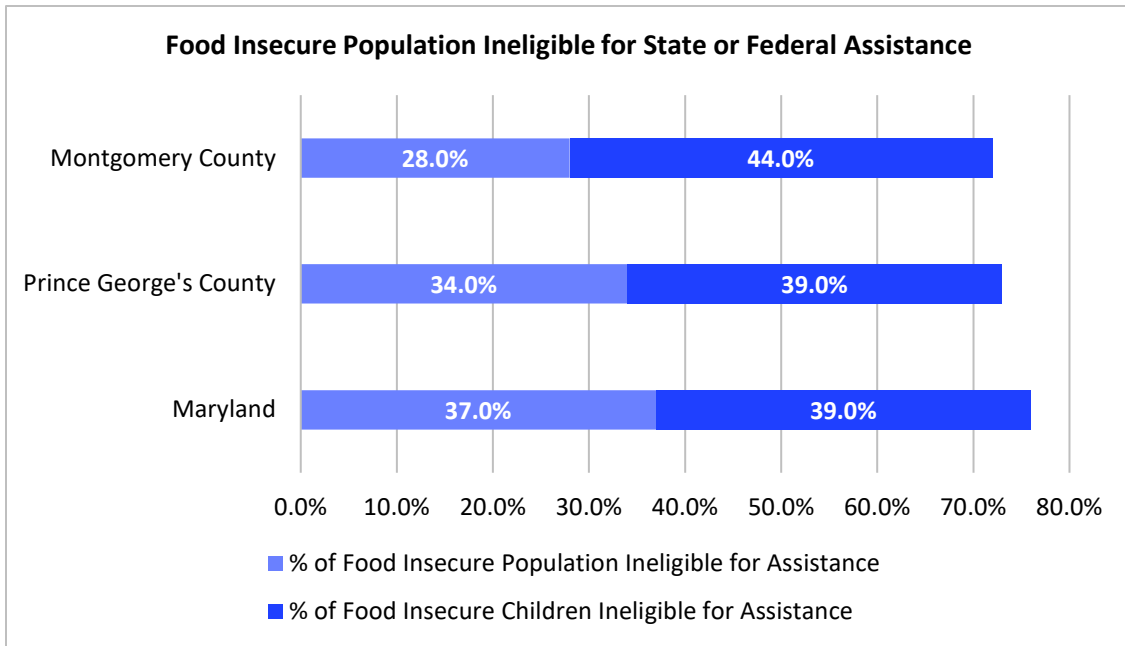


Figure 6. Food Insecure Population Ineligible for State or Federal Assistance
(Source: [Trinity Data Hub](#), 2019)

- In Montgomery County, there are 20.7 grocery stores per 100,000 population, a rate very similar to that of Maryland (21 per 100,000 population) (Figure 7).
- In Prince George's County, there are only 18.5 grocery stores per 100,000 population (Figure 7).

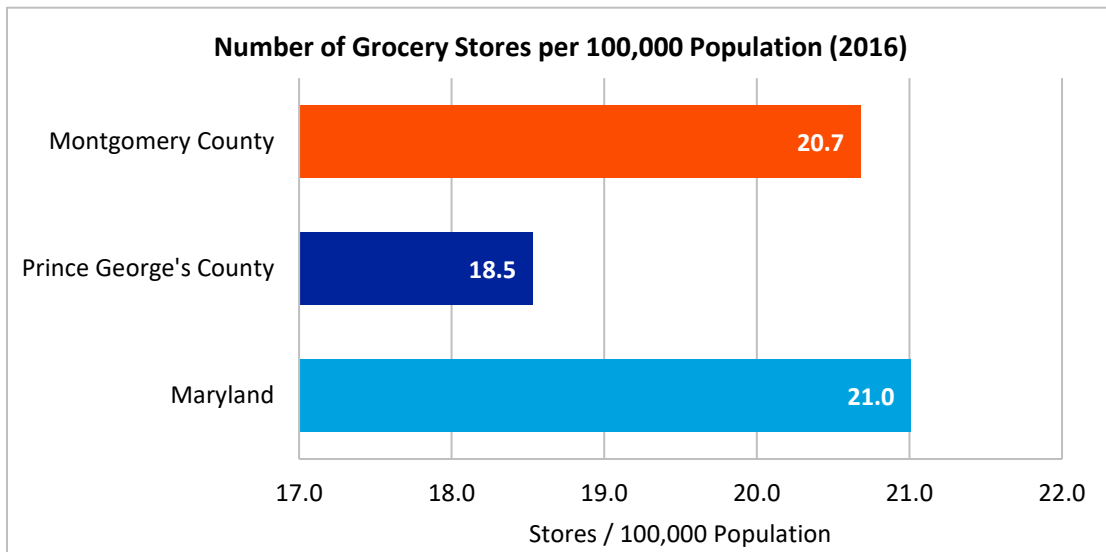


Figure 7. Number Grocery Stores per 100,000 Population, 2016
(Source: [CARES Network](#), 2019)

- In Prince George’s County, residents have access to fast food restaurants at a rate of 90.2 per 100,000 population, a rate higher than Montgomery County (83.5 establishments per 100,000 population), and slightly higher than Maryland (88.3 per 100,000 population) (Figure 8).

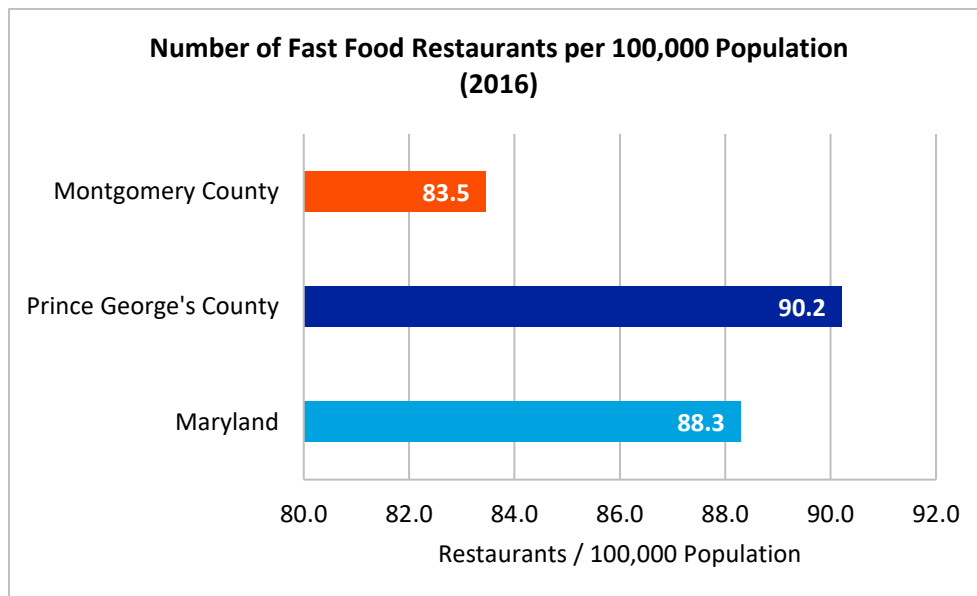


Figure 8. Number of Fast Food Restaurants per 100,000 Population, 2016
 (Source: [CARES Engagement Network](#), 2016)

- The number of operating farmers markets in Maryland are 111. Of those markets, there are 17 in Montgomery County and 11 in Prince George’s County (Figure 9).

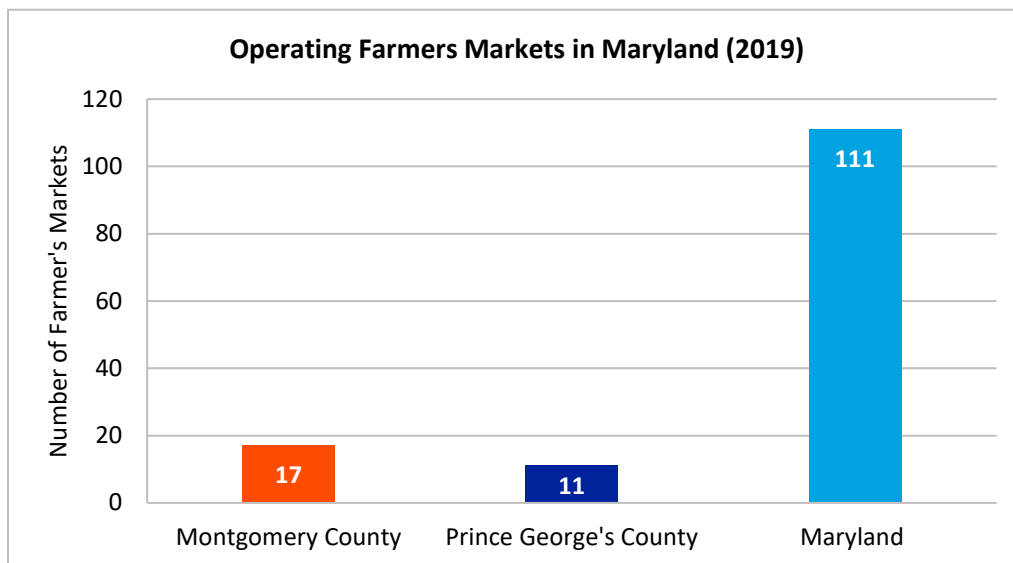


Figure 9. Number of Operating Farmer’s Markets in Montgomery County, Prince George’s County, and Maryland, 2019
 (Source: [Farmer’s Market Directory](#), 2019)

- From FY2013 – FY2018, the number of households participating in SNAP has decreased by 11.1 percent in Montgomery County, 20.4 percent in Prince George’s County, and 15.4 percent in Maryland (Figure 10).

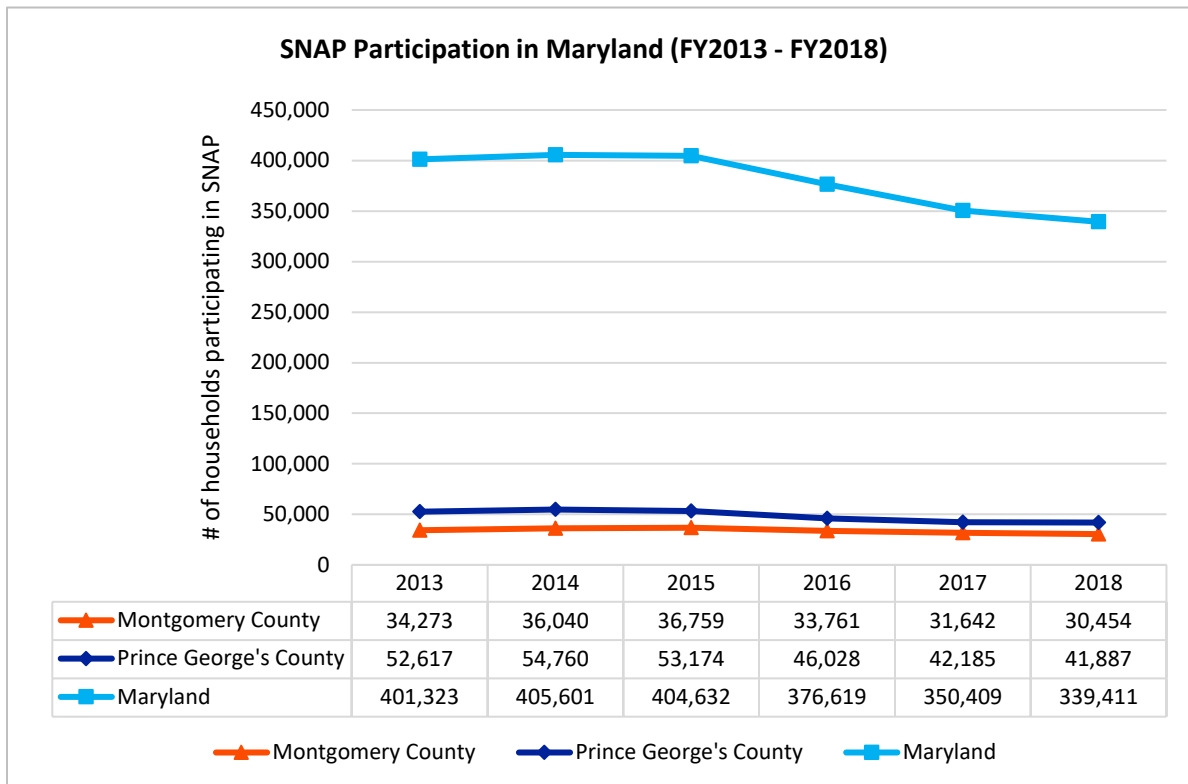


Figure 10. SNAP Participation in Maryland, FY2013 – FY2018
 (Source: [The Annie E. Casey Foundation – Kids Count Data Center](#), 2019)

- From 2013 – 2017, Black/African-American individuals across both counties and Maryland have the highest percentage of SNAP recipients (Figure 11).
- In Prince George’s County, Black/African-American individuals have the highest percentage of SNAP recipients with 67.6 percent or 63.8 percent more than the reference group (Asian population) (Figure 11).

- For Montgomery County, Black/African-American followed by White and Hispanic individuals have the next highest SNAP beneficiaries (Figure 11).

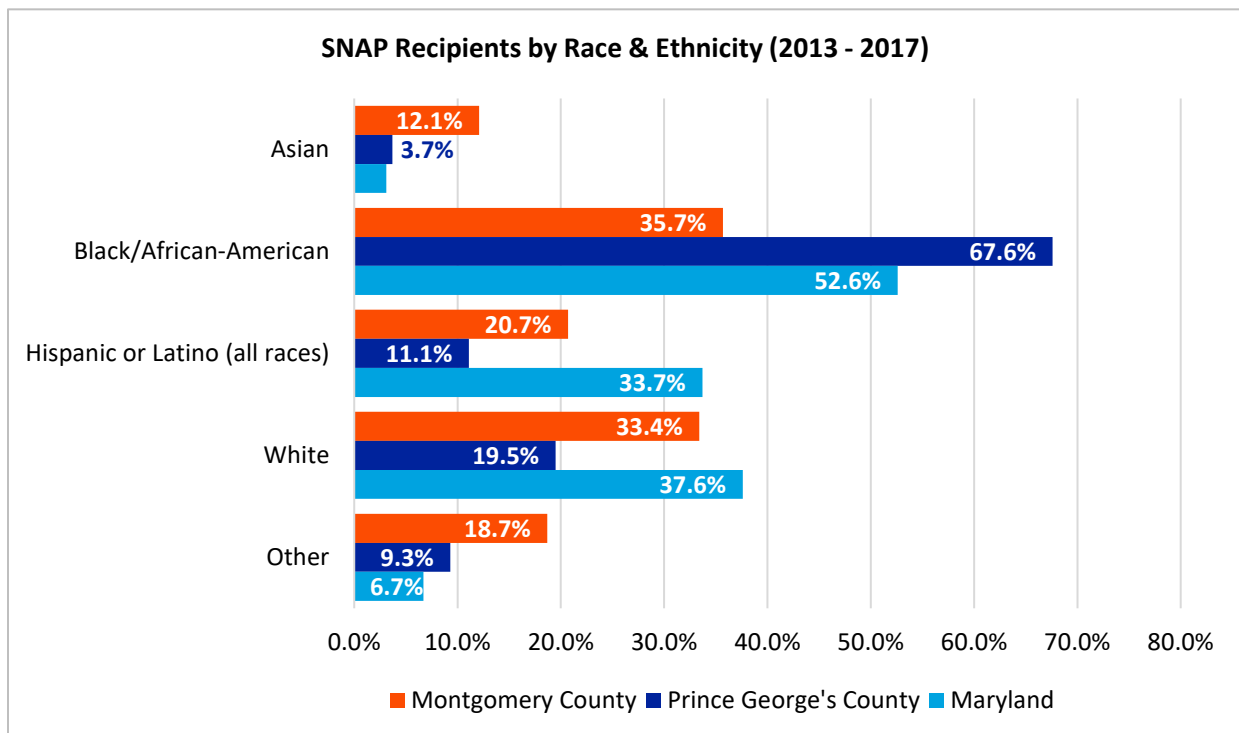


Figure 11. SNAP Recipients by Race & Ethnicity, 2013 – 2017

(Source: [U.S. Census Bureau, American Community Survey 5-Year Estimates – Table S2201](#), 2013 – 2017)

- In Prince George’s County, there are more SNAP authorized food stores in 2019 when compared to Montgomery County (Figure 12).

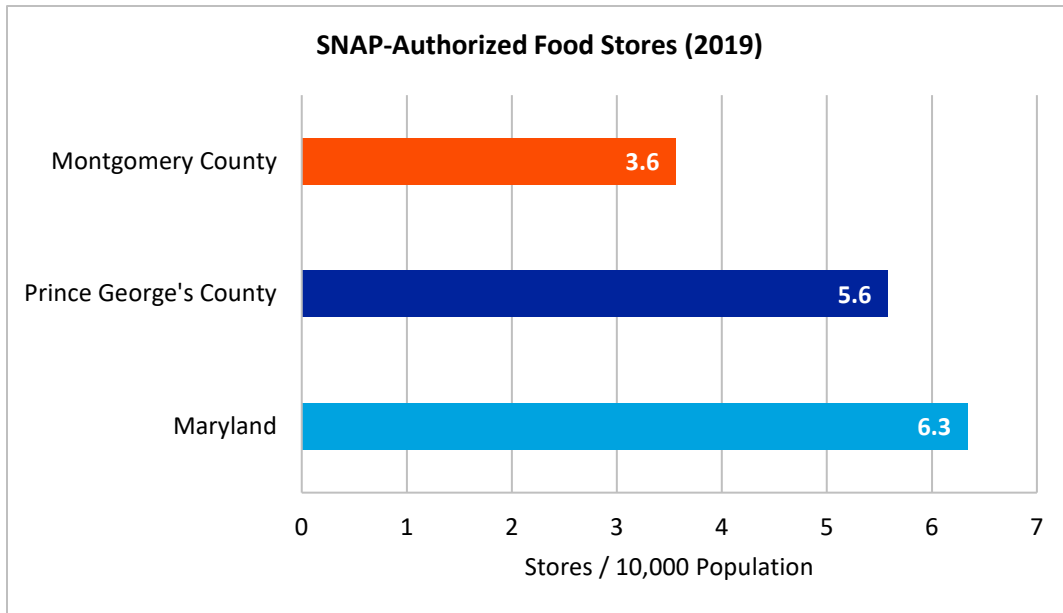


Figure 12. SNAP Authorized Food Stores, 2019
 (Source: [CARES Engagement Network](#), 2019)

- For students attending public school, the percentage of students who receive free and reduced school meals is highest and therefore worse among Prince George’s County students as compared to Montgomery County and Maryland (Figure 13).
- Between both counties and the state, Montgomery County has the lowest percentage of students with free or reduced school meals since 2014 (Figure 13).

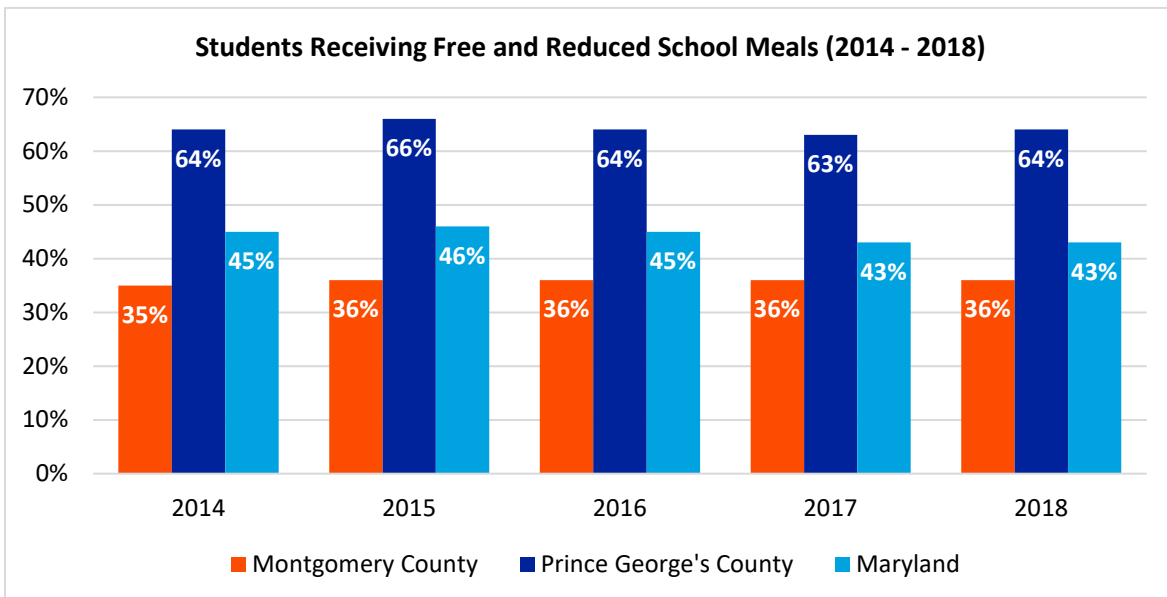


Figure 13. Students Receiving Free and Reduced School Meals, 2014 – 2018
 (Source: [The Annie E. Casey Foundation – Kids Count Data Center](#), 2019)

Community Resources

Local efforts aimed at improving access to healthy food include food banks, supplements to school lunch programs, and transportation solutions to help people access food resources. These organizations offer innovative approaches to providing food for people in need in Adventist HealthCare Rehabilitation Hospital Community Benefit Service Area. Services include, but are not limited to, the following:

1. ONE ACRE FARM

Mission: One Acre Farm provides fresh, certified naturally grown vegetables to DC locals.

Address (Farm Location): 18608 Wasche Rd, Dickerson, MD 20842

Phone: 301-503-3724

Website:

<https://www.oneacrefarm.com/>

2. MANNA FOOD CENTER

Ending hunger in Montgomery County through food distribution, education and advocacy.

Address: 12301 Old Columbia Pike, Silver Spring, MD 20904

Phone: 301-424-1130

Email: info@mannafood.org

Website: <https://www.mannafood.org/>

3. CROSSROADS COMMUNITY FOOD NETWORK

Crossroads works to bolster the local food system through programs that support and unite those who grow, make, and eat fresh, healthy food.

Address: 6930 Carroll Avenue, Suite 426, Takoma Park, MD 20912

Website:

<https://www.crossroadscommunityfoodnetwork.org/>

4. COMMUNITY SUPPORT SYSTEMS

Address: 14070 Brandywine Road, PO Box 206, Brandywine, MD 20613

Phone: 301-372-1491

Website:

www.communitysupportsystems.org

5. MONTGOMERY COUNTY FOOD COUNCIL

Cultivating a robust, sustainable, equitable local food system in Montgomery County, Maryland!

Address: 4825 Cordell Avenue, Suite 204, Bethesda MD 20814

Phone: 301-664-4010

Email: info@mocofoodcouncil.org

Website: <https://mocofoodcouncil.org/>

6. PRINCE GEORGE'S COUNTY FOOD EQUITY COUNCIL

The Prince George's County Food Equity Council is a local food policy council that works to help residents grow, sell, and choose healthy food.

Address: 1401 Mercantile Lane, Upper Marlboro, MD 20774

Phone: 240-253-1036

Website: www.pgcfec.org

7. ADVENTIST COMMUNITY SERVICES OF GREATER WASHINGTON – ASSISTANCE

Address: 501 Sligo Avenue, Silver

Spring, Maryland 20910

Phone: 301-585-6557

Website:

<https://www.acsgw.org/assistance.html>

8. PRINCE GEORGE’S COUNTY PUBLIC SCHOOLS – FOOD AND NUTRITION SERVICES

Leading the country in the nutritional quality, content, and integrity of school meals.

Address: 6311 Randolph Road, Suitland, MD 20746

Phone: 301-952 – 6580

Website:

<https://www.pgcps.org/foodandnutrition/>

9. FOOD & FRIENDS

Address: 219 Riggs Road NE, Washington, DC 20011

Phone: 202-269-2277

Email: info@foodandfriends.org

Website: <https://foodandfriends.org/>

10. SHEPHERD’S TABLE

Address: 8106 Georgia Ave, Silver Spring, MD 20910

Phone: 301-585-6463

Website: <https://shepherdstable.org/>

11. CAPITAL AREA FOOD BANK

The mission of the Capital Area Food Bank is to create access to good, healthy food in every community.

Address: 4900 Puerto Rico Ave NE, Washington, DC 20017

Phone: 202-644-9800

Website:

<https://www.capitalareafoodbank.org/>

8.3 Housing

Access to safe, affordable, and quality housing is one of the most basic and influential social determinants of health. Housing quality refers to “the physical condition of a person’s home as well as the quality of the social and physical environment in which the home is located.”⁶ Housing quality is affected by factors such as air quality, home safety, and the presence of mold, asbestos, or lead. Various studies have shown that poor-quality housing is associated with poorer health outcomes.⁷

- When looking at race and ethnicity on a national level, White individuals have a higher rate of experiencing moderate housing problems when compared to the other subpopulations (Figure 1).

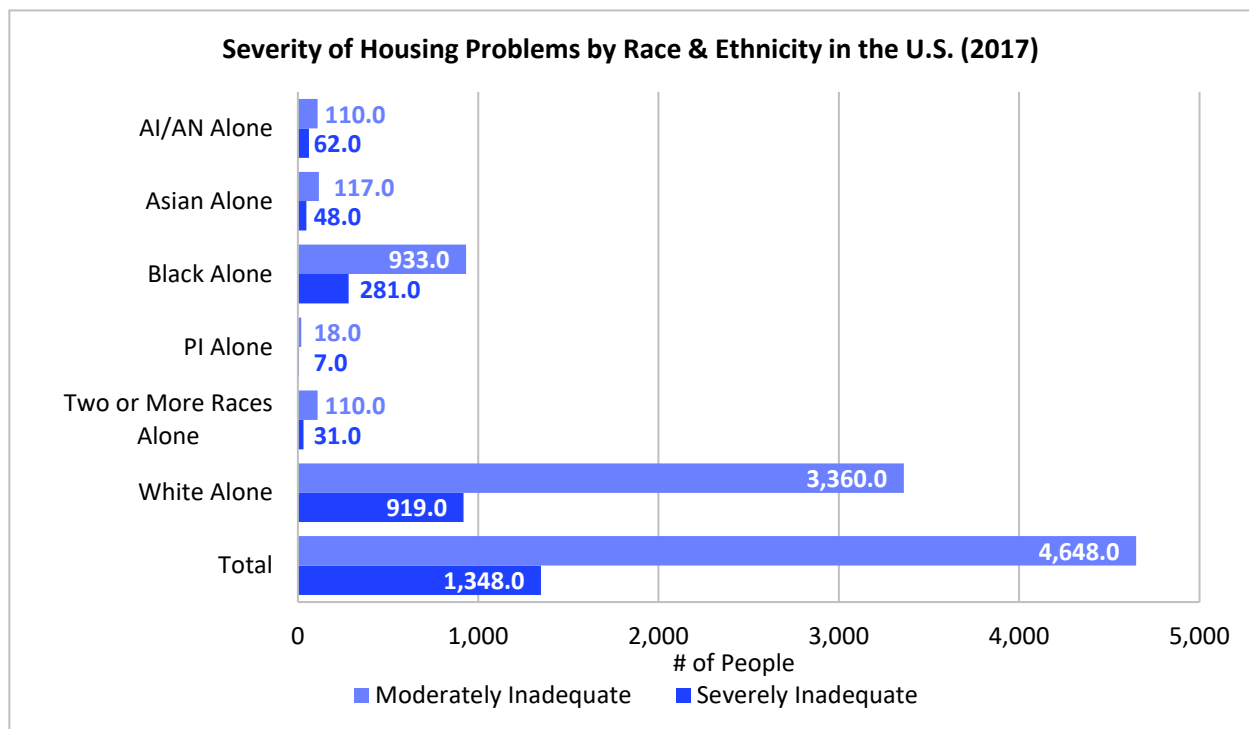


Figure 1. Severity of Housing Problems by Race/Ethnicity in the US, 2017
Note: Physical problems include plumbing, heating, electrical, and upkeep
(Source: [U.S. Census Bureau, American Housing Survey](https://www.census.gov/hhes/ahs/), 2017 ACS 5-Year Estimates)

⁶ Office of Disease Prevention and Health Promotion. (2019). Quality of Housing – Healthy People 2020. Retrieved from: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/quality-of-housing>

- In both Montgomery and Prince George’s County, renters spending 30 percent or more on household income was 51.2 and 49.0 percent, respectively (Tables 1 & 2).

MONTGOMERY COUNTY HOUSING STATISTICS	
Renters spending 30 percent or more of household income on rent (2017)	51.20%
Vacant Housing Units (2017)	4.50%
Housing units in multi-unit structures (2016)	34.20%
Housing units (2018)	390,664
Owner-Occupied Housing Unit Rate (2013 - 2017)	65.60%
Median value of owner-occupied housing units (2013 - 2017)	\$467,500
Households (2013-2017)	369,242
Persons per household (2013 - 2017)	2.79

Table 1. Montgomery County Housing Statistics, 2017
(Source: [County Stat](#), [Census Quick Fact](#), & [Montgomery County Trends](#), 2019)

PRINCE GEORGE’S COUNTY HOUSING STATISTICS	
Renters spending 30 percent or more of household income on rent (2017)	49.00%
Vacant Housing Units (2017)	7.20%
Housing units in multi-unit structures	33.00%
Housing units (2018)	333,862
Owner-Occupied Housing Unit Rate (2013 - 2017)	61.80%
Median value of owner-occupied housing units (2013 - 2017)	\$272,900
Households (2013 - 2017)	306,694
Persons per household (2013 - 2017)	2.89

Table 2. Prince George’s County Housing Statistics, 2017
(Source: [PGC Housing Opportunity](#), & [Census Quick Facts](#), 2019)

- Lead exposure has various negative health effects, from causing high blood pressure and anemia to irreversibly damaging the nervous system.
- Lead exposure can have serious effects on children’s health and behavior, even at low levels: slowed growth, lowered intelligence, learning disabilities, and behavior or attention problems.
- From 2015- 2017, elevated blood lead levels in children have been relatively stable in Montgomery County and Maryland, however it fluctuated in Prince George’s County (Figure 2).

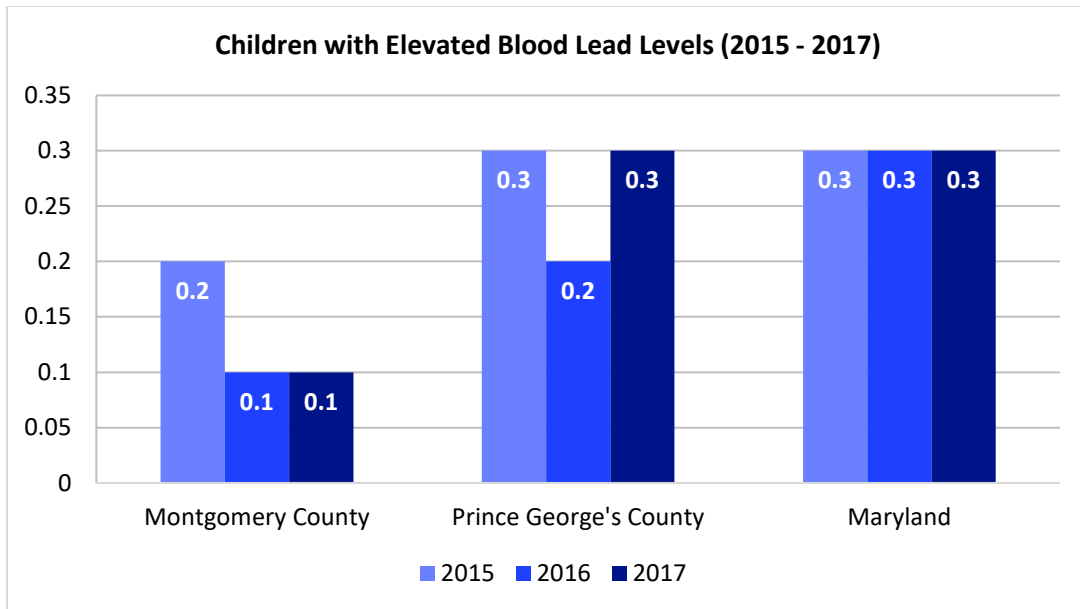


Figure 2. Children with Elevated Blood Levels (2015 - 2017)
 (Source: [Maryland Open Data Portal](#), 2019)

Spotlight on Homelessness

Perhaps the most extreme case of living situation having a negative impact on health is homelessness. Homelessness amplifies the threat of various health conditions and introduces new risks, such as exposure to extreme temperatures. People who experience homelessness have multidimensional health problems and often report unmet health needs, even if they have a usual source of care.

- From 2015 to 2016, there was a decrease in the homeless population in both Montgomery and Prince George's County by 11.0 percent and 13.0 percent, respectively (Figure 3).

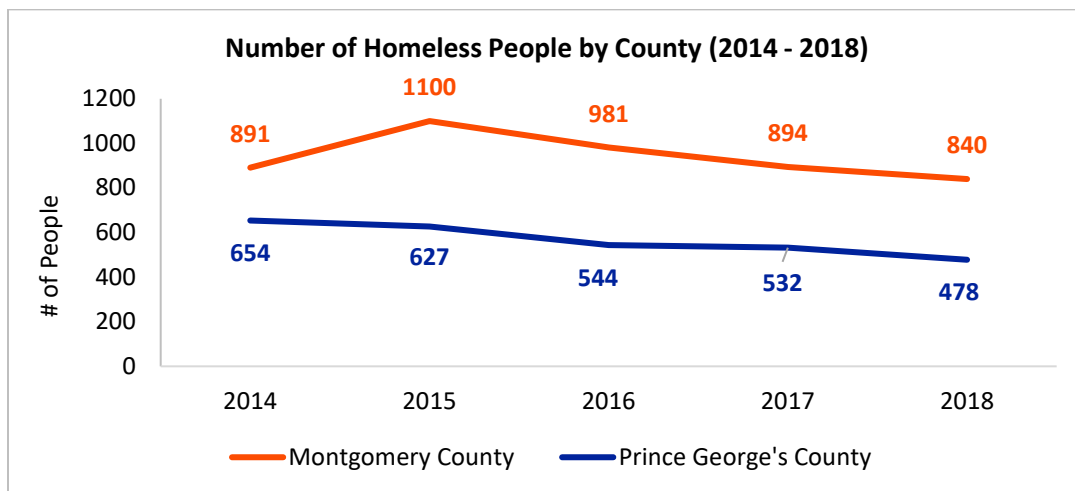


Figure 3. Number of Homeless People in Montgomery County and Prince George's County from 2014 to 2018
 (Source: [Homelessness in Metropolitan Washington](#), 2018)

- In Montgomery County, the homeless population included 180 children and 92 adults (Figure 4). Prince George’s County’s homeless population comprised of 105 family units, which included 118 adults, and 190 children (Figure 5).

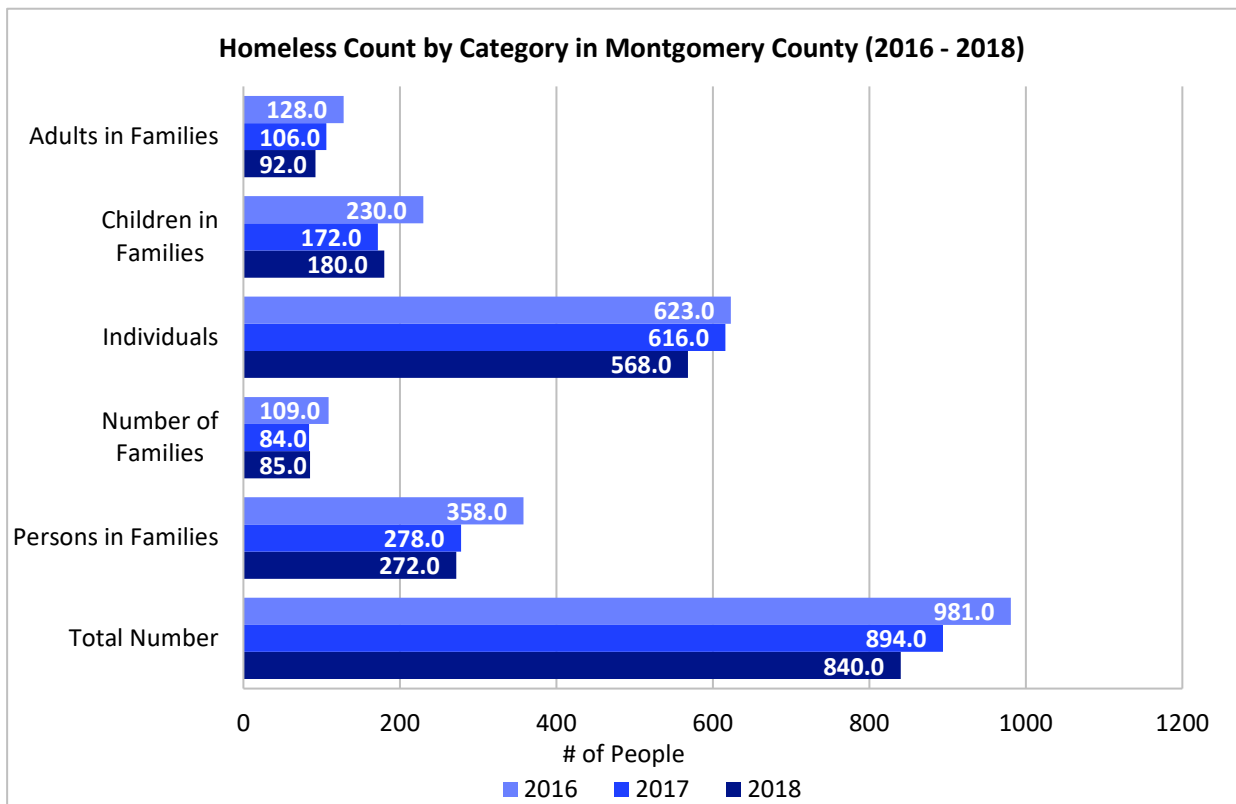


Figure 4. Homeless Populations in Montgomery County, 2016 - 2018
 (Source: [Homelessness in Metropolitan Washington](#), 2018)

- Prince George’s County’s homeless population in 2018 included 176 children and 97 adults (Figure 5).

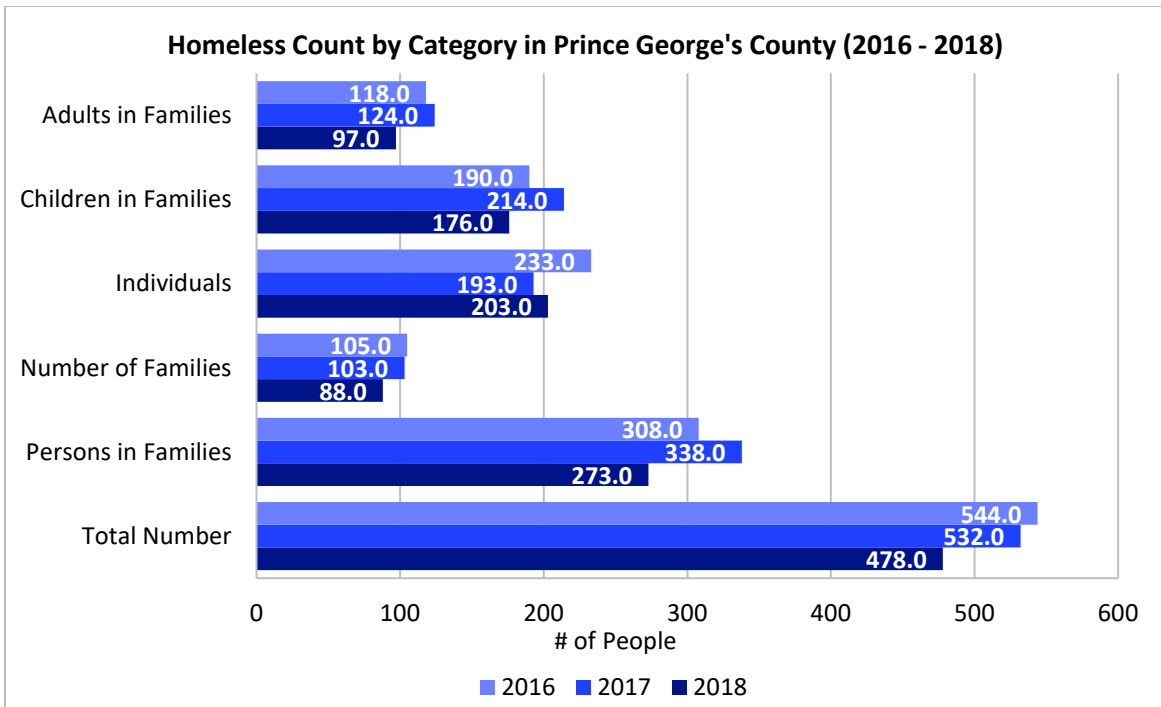


Figure 5. Homeless Populations in Prince George's County, 2016 - 2018
 (Source: [Homelessness in Metropolitan Washington](#), 2018)

- In Montgomery County, 124 individuals were chronically homeless, 18 were U.S. veterans, 147 were victims of domestic violence, 97 were suffering from co-occurring disorders (mental and substance abuse), 110 were physically disabled, and 63 were individuals with limited English proficiency. Similar issues were found among the Prince George's County homeless population (Figure 6).

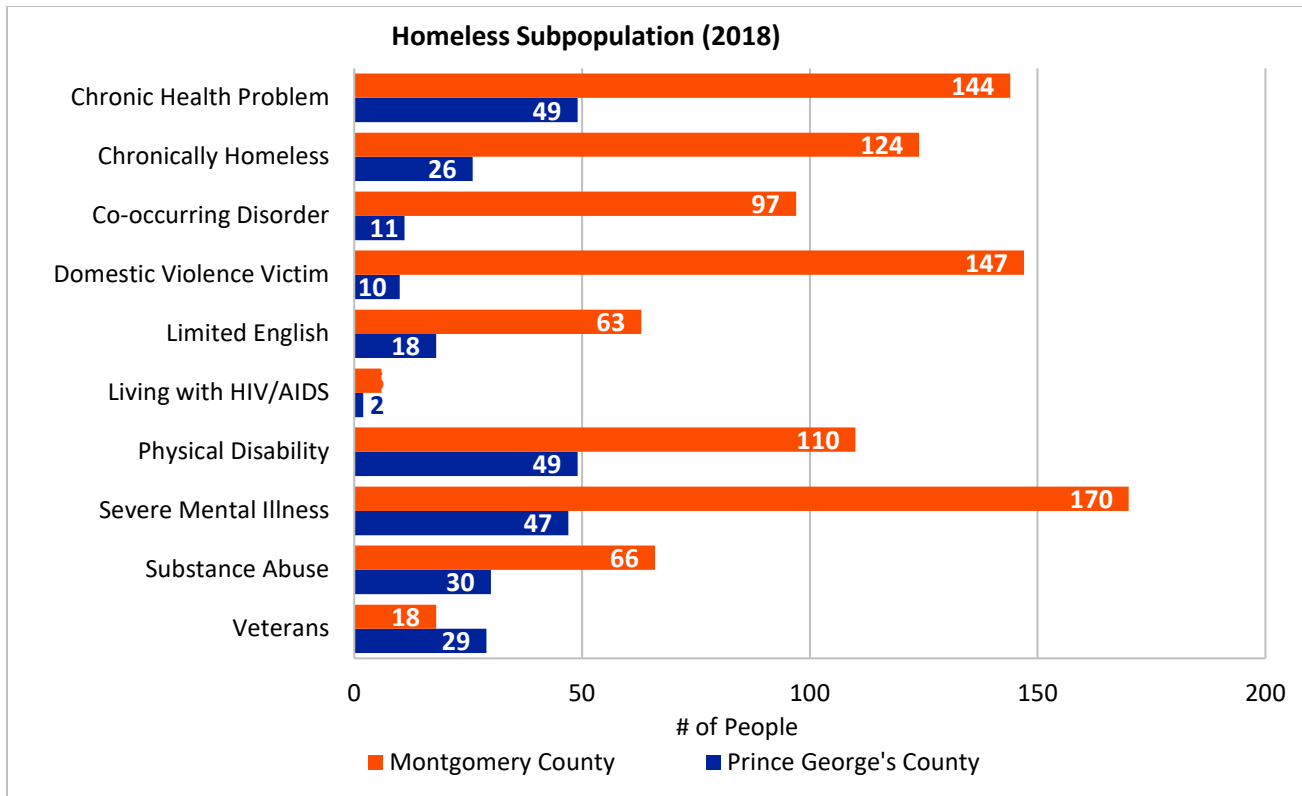


Figure 6. Homeless Subpopulations in Montgomery County and Prince George's County in 2018
 (Source: [Homelessness in Metropolitan Washington](#), 2018)

Community Resources

Several efforts in the Adventist HealthCare Rehabilitation Hospital Community Benefit Service Area aim to improve quality housing and the living situation for individuals experiencing homelessness. Each of the local programs listed below attempts to overcome challenges to people's housing and living situations. Services include, but are not limited to, the following:

1. HEARTS & HOMES FOR YOUTH

Address: 3919 National Drive Suite 400,
Burtonsville, MD 20866
Phone: 301-589-8444
Email: hhyinfo@heartsandhomes.org
Website: <https://heartsandhomes.org/>

**2. REBUILDING TOGETHER
MONTGOMERY COUNTY –
HOMEOWNER SERVICES**

Address: 18225-A Flower Hill Way,
Gaithersburg, Maryland 20879
Phone: 301-947-9400
Email: info@rebuildingtogethermc.org
Website:
<https://rebuildingtogethermc.org/homeowner-services/>

3. INTERFAITH WORKS

Helps people lift themselves out of poverty.
Address: 114 West Montgomery Ave.,
Rockville, MD 20850
Phone: 301-762-8682
Website: <http://www.iworksmc.org/>

**4. THE MONTGOMERY COUNTY
COALITION FOR THE HOMELESS**

End homelessness in Montgomery County by building a community.
Address: 600 B East Gude Drive,
Rockville, MD 20850
Phone: 301-217-0314
Email: mcch@mcch.net
Website: <https://mcch.net/>

5. EVERYMIND

Address: 1000 Twinbrook Pkwy,
Rockville, MD 20851
Phone: 301-424-0656
Email: info@every-mind.org
Website: www.every-mind.org

6. HOUSING INITIATIVE PARTNERSHIP

Creates housing and economic security for low- and moderate-income households and provides services that improve the quality of life in the communities we serve.
Address (Main Office): 6525 Belcrest Road, Suite 555, Hyattsville, MD 20782
Phone: 301-699-3835
Email: info@hiphomes.org
Website: <http://hiphomes.org/wp/>

**7. MONTGOMERY HOUSING
PARTNERSHIP**

We house people, empower families, and strengthen neighborhoods.

Address: 12200 Tech Road, Suite 250,
Silver Spring, MD 20904-1983
Phone: 301-622-2400
Email: info@mhpartners.org
Website: <https://www.mhpartners.org/>

**8. HABITAT FOR HUMANITY METRO
MARYLAND**

Address: 8380 Colesville Road, Suite
700, Silver Spring, MD 20910
Phone: 301-990-0014
Website: <https://www.habitatmm.org/>

**9. PRINCE GEORGE'S COUNTY LEAD AND
HEALTHY HOMES PROGRAM**

Address: 9021 Basil Court, Suite 318
Largo, MD 20774
Phone: 301-883-7662

Website:
<https://www.princegeorgescountymd.gov/2108/Testing-Services>

**10. CHILDHOOD LEAD POISONING
PREVENTION – MONTGOMERY
COUNTY**

Address: Silver Spring Health Center
8630 Fenton Street, Silver Spring, MD
20910

Phone: 240-777-3160

Website:
<https://www.montgomerycountymd.gov/HHS-Program/Program.aspx?id=PHS/PHSChildLeadPos-p264.html>

8.4 Transportation

- The majority of both Prince George's County (66.5 percent) and Montgomery County (65.3 percent) residents drive to work alone or utilize public transportation (Montgomery County: 15.5 percent, Prince George's County: 16.0 percent) (Figure 1).

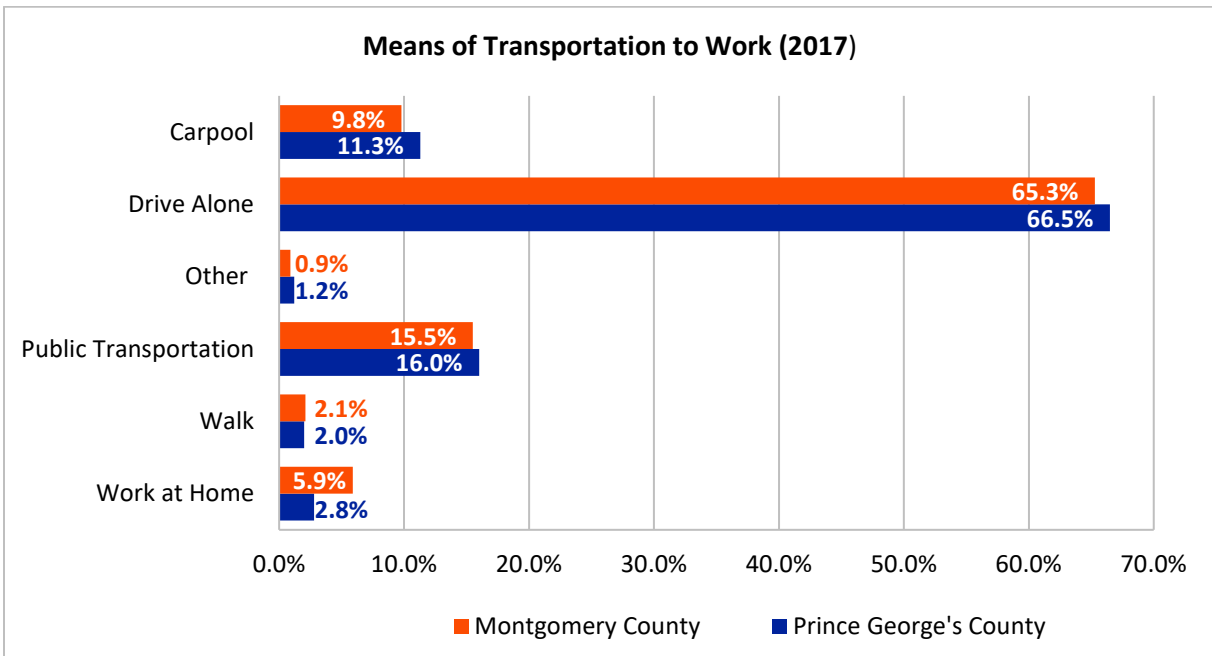


Figure 1. Means of Transportation to Work, 2017
(Source: [U.S. Census Bureau](https://www.census.gov), 2017 ACS 5-Year Estimates)

- The mean travel time to work for Montgomery County is 34.7 minutes; whereas the mean travel time for Prince George's County is 36.9 minutes (Figure 2).

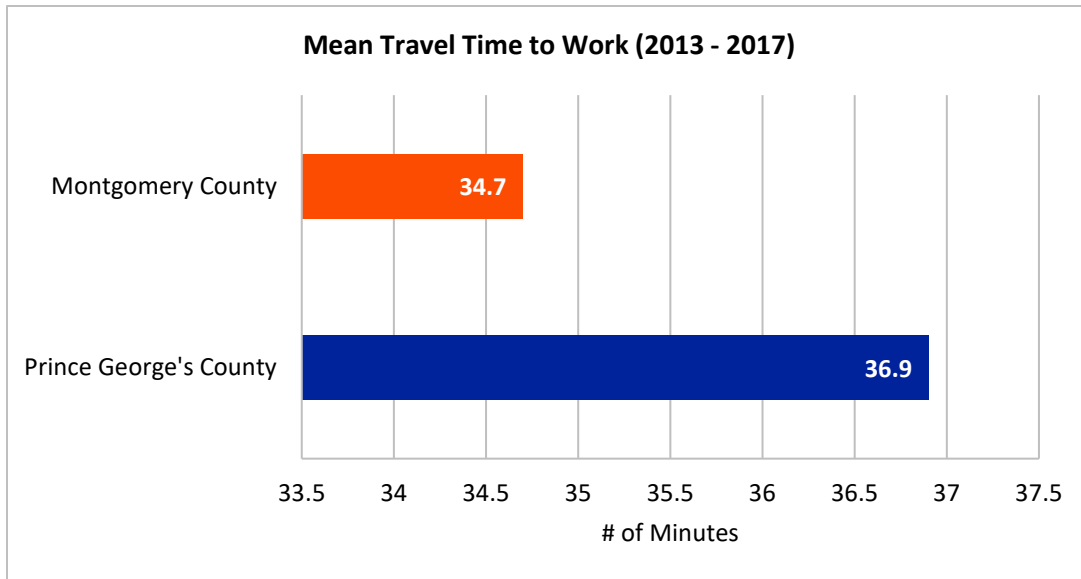


Figure 2. Means Travel Time to Work, 2013-2017
 (Source: [U.S. Census Bureau](#) & [PGC Health Zone](#), 2017)

- The mean travel time to work for females in Montgomery County is 33.2 minutes and in Prince George’s County it is 37.7 minutes. For males, the mean travel time to work is 36.1 minutes in both Montgomery and Prince George’s County (Figure 3).

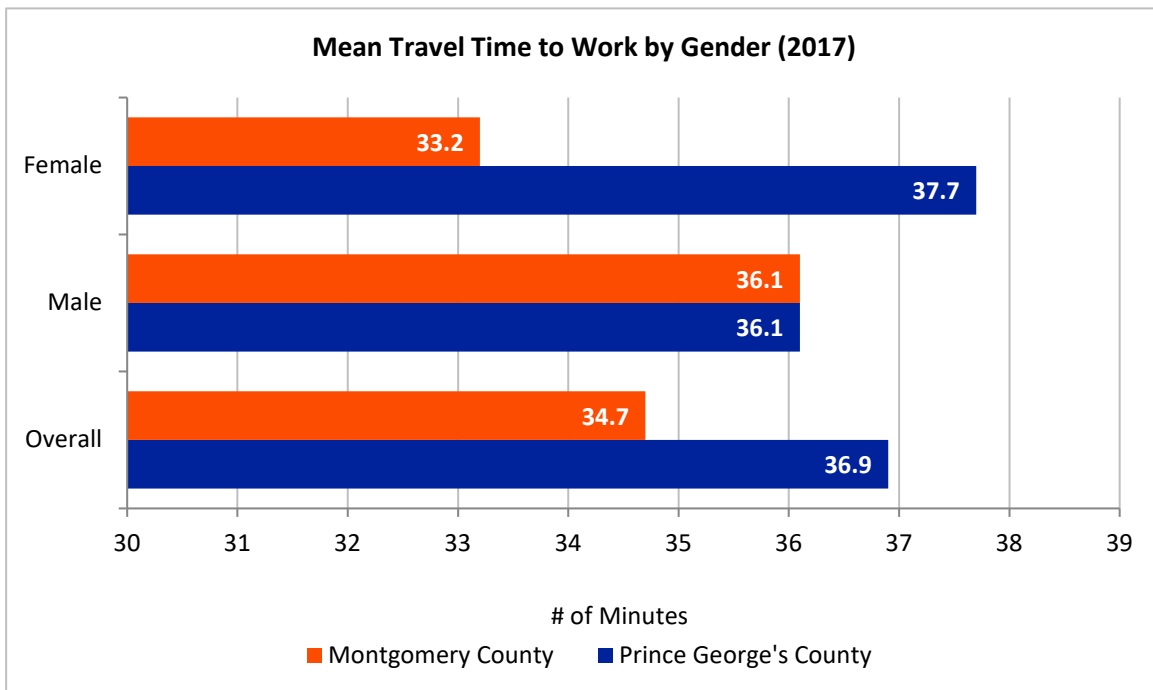


Figure 3. Mean Travel Time to Work by Gender for Prince George’s County and Montgomery County, 2017
 (Sources: [Healthy Montgomery](#) & [PGC Health Zone](#), 2017)

Pedestrian Safety

- The rate of pedestrian injuries on public roads in Montgomery County in 2017 was 46 per 100,000 population. In Prince George's County, the rate was 49 per 100,000 population. The rate for the state of Maryland is higher than both counties with 54 per 100,000 population (Figure 4).

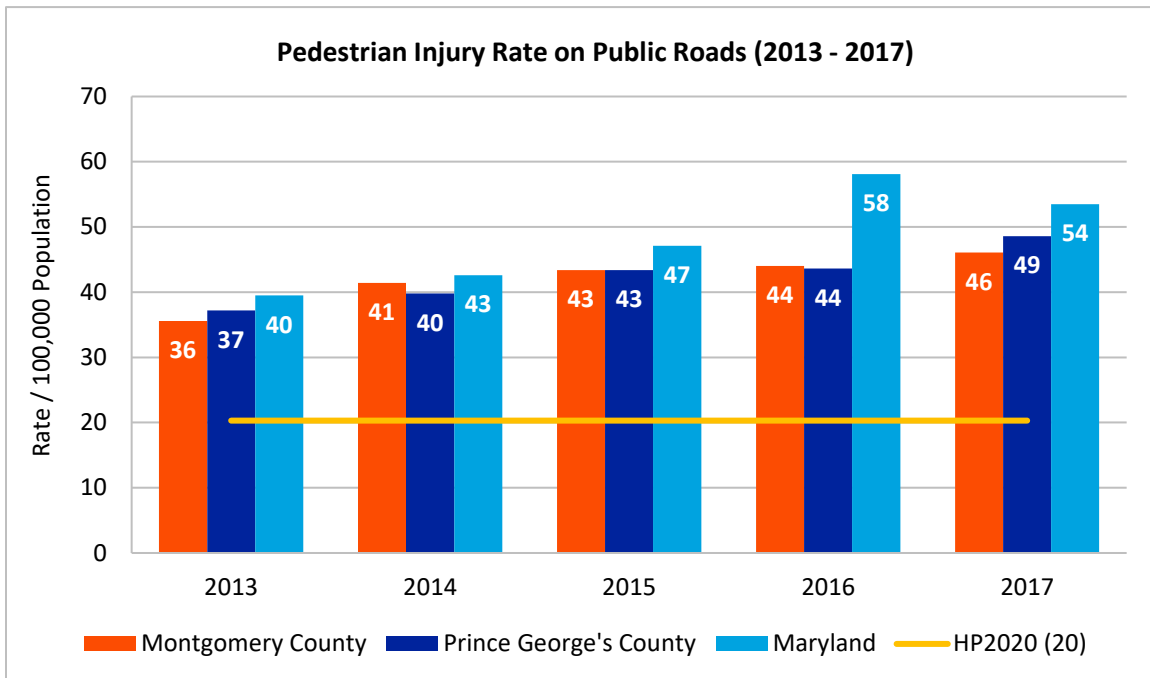


Figure 4. Rate of Pedestrian Injuries per 100,000 Population in Montgomery County, Prince George's County, & Maryland, 2013 - 2017
(Source: [MD SHIP](#), 2017)

- From 2011 to 2015, in Montgomery County, Black and Hispanic individuals experienced the highest number of traffic fatalities among both vehicle occupants and non-occupants (Figure 5).

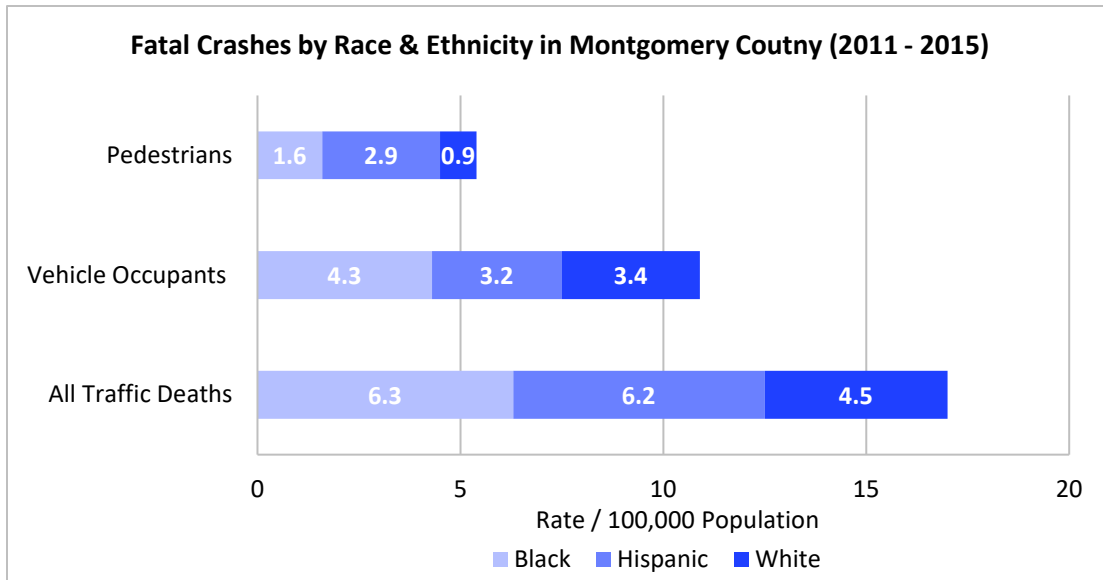


Figure 5. Montgomery County Fatalities by Race & Ethnicity, 2011 - 2015
 (Source: [Vision Zero](#), 2015)

- From 2012 to 2014, in Montgomery County, White non-Hispanic individuals experienced the highest number of traffic fatalities among both vehicle occupants and non-occupants (Table 1).
- From 2012 to 2014, in Prince George’s County, Black/African-American non-Hispanic individuals experienced the highest number of traffic fatalities among both vehicle occupants and non-occupants. (Table 2).

MONTGOMERY COUNTY TRAFFIC FATALITIES (2012 - 2014)				
PERSON TYPE BY RACE/HISPANIC ORIGIN		2012	2013	2014
Occupants (All Vehicle Types)	Hispanic	2	5	4
	White, Non-Hispanic	11	12	13
	Black, Non-Hispanic	7	6	4
	Asian, Non-Hispanic/Unknown	0	0	0
	All Other Non-Hispanic or Race	3	3	4
	Unknown Race and Unknown			
	Hispanic	7	1	3
<i>Total</i>	<i>30</i>	<i>27</i>	<i>28</i>	
Non-Occupants (Pedestrians, Pedal cyclists and Other/Unknown Non-Occupants)	Hispanic	0	1	1
	White, Non-Hispanic	4	6	4
	Black, Non-Hispanic	2	4	1
	Asian, Non-Hispanic/Unknown	0	1	1
	All Other Non-Hispanic or Race	0	0	0
	Unknown Race and Unknown			
	Hispanic	1	1	4
<i>Total</i>	<i>7</i>	<i>13</i>	<i>11</i>	
Total	Hispanic	2	6	5
	White Non-Hispanic	15	18	17
	Black, Non-Hispanic	9	10	5
	Asian, Non-Hispanic/Unknown	0	1	1
	All Other Non-Hispanic or Race	3	3	4
	Unknown Race and Unknown			
	Hispanic	8	2	7
<i>Total</i>	<i>37</i>	<i>40</i>	<i>39</i>	

Table 1. Montgomery County Fatalities by Person Type, Race and Ethnicity, 2012 - 2014
 (Source: [National Highway Traffic Safety Administration-Traffic Safety Facts](#), 2015)

PRINCE GEORGE'S COUNTY TRAFFIC FATALITIES (2012 - 2014)				
PERSON TYPE BY RACE/HISPANIC ORIGIN		2012	2013	2014
Occupants (All Vehicle Types)	Hispanic	5	7	3
	White Non-Hispanic	7	8	8
	Black, Non-Hispanic	36	35	47
	All Other Non-Hispanic or Race	0	3	1
	Unknown Race and Unknown Hispanic	15	17	9
	<i>Total</i>	63	70	68
Non-Occupants (Pedestrians, Pedal cyclists and Other/Unknown Non-Occupants)	Hispanic	1	0	4
	White Non-Hispanic	4	1	6
	Black/AA, Non-Hispanic	14	10	12
	All Other Non-Hispanic or Race	0	0	0
	Unknown Race and Unknown Hispanic	5	6	8
	<i>Total</i>	24	17	30
Total	Hispanic	6	7	7
	White Non-Hispanic	11	9	14
	Black/AA, Non-Hispanic	50	45	59
	All Other Non-Hispanic or Race	0	3	1
	Unknown Race and Unknown Hispanic	20	23	17
	<i>Total</i>	87	87	98

Table 2. Prince George's County Fatalities by Person Type, Race and Ethnicity, 2012 - 2014
(Source: [National Highway Traffic Safety Administration-Traffic Safety Facts](#), 2015)

- In Prince George's County, the age-adjusted death rate due to motor vehicle traffic collisions is slightly higher than the state of Maryland (Table 3).

Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions, 2015 - 2017	
Prince George's County	9.4
Maryland	8.8

Table 3. Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions in Prince George's County, 2015 – 2017
Death rate per 100,000 population
(Source: [PGC Health Zone](#), 2017)

- In Montgomery County the age-adjusted death rate due to motor vehicle traffic collisions is significantly lower than Maryland and Prince George’s County, despite the different measurement period (Table 3 and 4).

Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions, 2012 - 2016	
Montgomery County	4.7
Maryland	8.6

Table 4. Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions in Montgomery County, 2012 – 2016

(Source: [CARES Engagement Network](#), 2017)

- In Prince George’s County, when looking at the age-adjusted death rate by race/ethnicity, Whites have a higher date rate due to motor vehicle traffic collisions than the other races/ethnicities (Figure 8).
- When looking at the age-adjusted death rate by gender, males have a higher death rate due to motor vehicle traffic collisions (Figure 8).

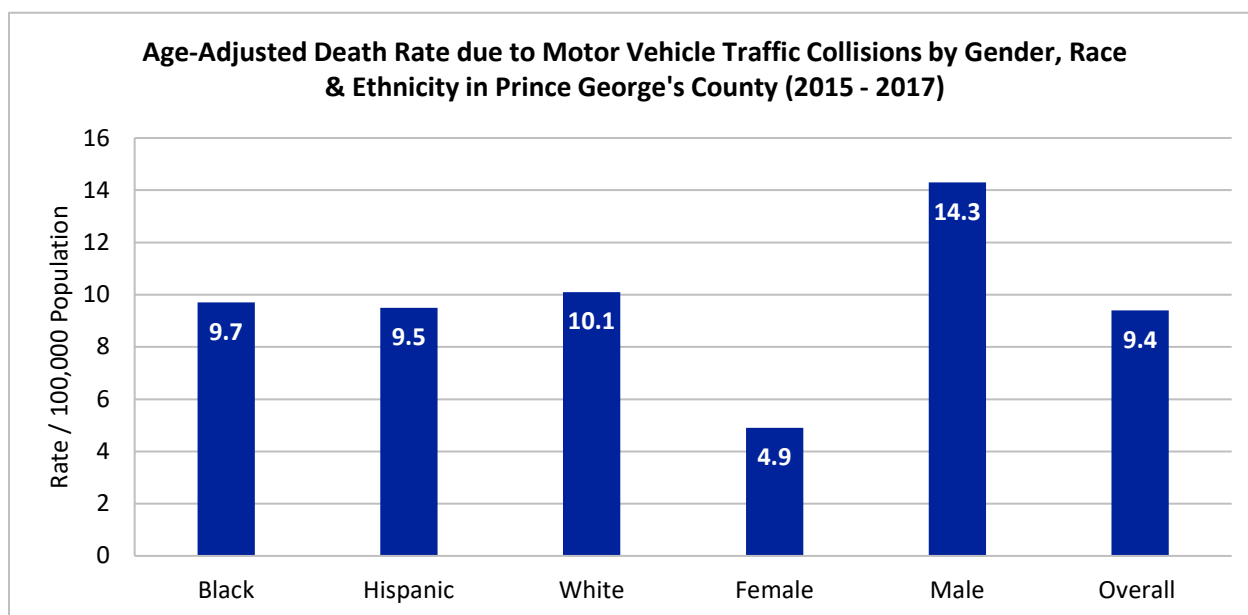


Figure 8. Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions by Race & Ethnicity and Gender in Prince George’s County, 2015 - 2017

(Source: [PGC Health Zone](#), 2017)

- In Montgomery County, when looking at the age-adjusted death rate by race/ethnicity, Hispanics have a higher death rate due to motor vehicle traffic collisions than the other races/ethnicities (Figure 9).

- When looking at the age-adjusted death rate by gender, males have a higher death rate due to motor vehicle traffic collisions (Figure 9).

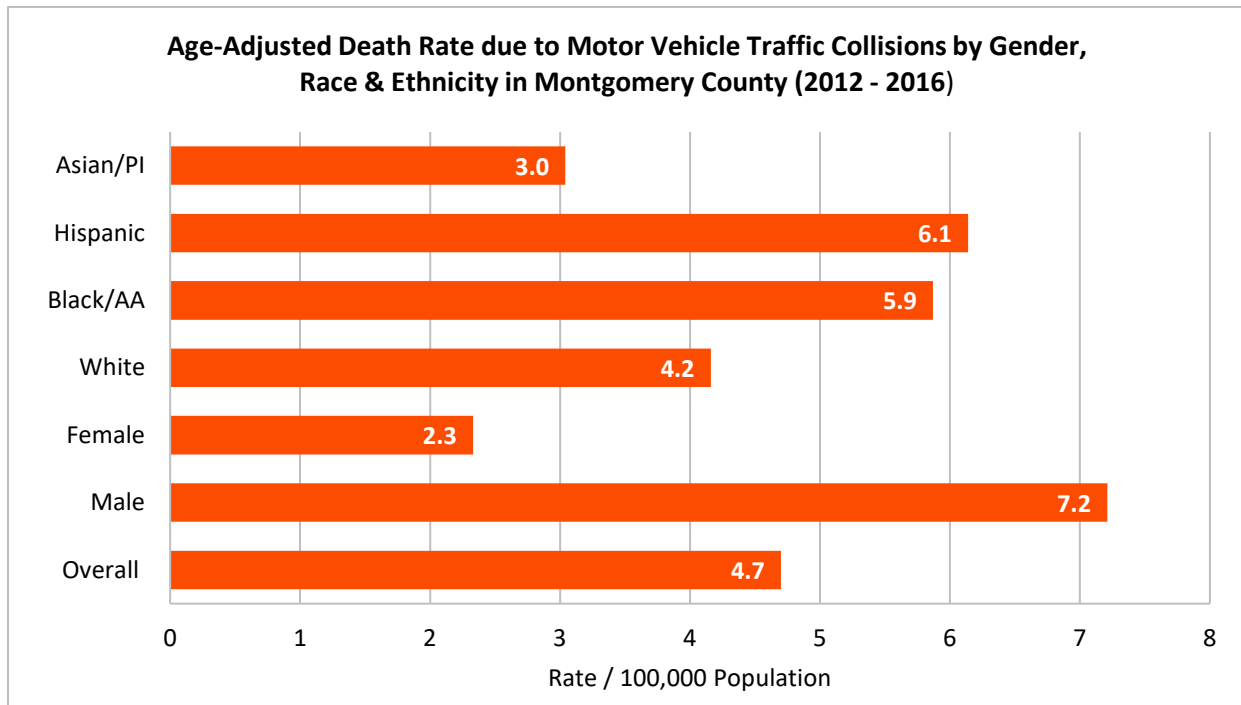


Figure 9. Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions in Montgomery County, 2012 – 2016
(Source: [CARES Engagement Network](#), 2017)

Community Resources

There are several public transportation options in Montgomery County and Prince George's County, these resources include, but are not limited to, the following:

1. MARYLAND TRANSPORTATION RESOURCE INFORMATION POINT

TRIP is your one-stop source for Maryland transit information.

Website: <https://www.mdtrip.org/>

2. MONTGOMERY COUNTY DEPARTMENT OF TRANSPORTATION

Website:

<https://www.montgomerycountymd.gov/dot/index.html>

Ride on Flex

Website:

<https://www.montgomerycountymd.gov/dot-transit/flex/index.html>

Senior Transportation

Website:

<https://www.montgomerycountymd.gov/senior/transportation.html>

Medical Assistance Transportation Program

Phone: 240-777-5890

Email:

medicaidtransportation@montgomerycountymd.gov

Website:

<https://www.montgomerycountymd.gov/HHS-Program/ADS/Transportation/MedAssist.html>

3. PRINCE GEORGE'S COUNTY – TRANSPORTATION

Website:

<https://www.princegeorgescountymd.gov/1099/Transportation>

Medical Assistance Transportation Program

Phone: 301-856-9555

Website:

<https://www.princegeorgescountymd.gov/2104/Medical-Assistance-Transportation-Program>

4. JEWISH COUNCIL FOR THE AGING

JCA helps seniors find transportation solutions through our Connect-A-Ride resource center

Address: 12320 Parklawn Drive
Rockville, MD 20852-1726

Phone: 301.255.4200

Email: Senior.HelpLine@AccessJCA.org

Website: <https://accessjca.org/>

5. DISABLED AMERICAN VETERANS

Provides free transportation (with ID) to VA medical facilities for injured and ill veterans.

Website:

<https://www.dav.org/veterans/i-need-a-ride/>

6. ANGEL WHEELS

Dedicated to providing non-emergency, long-distance ground transportation to financially disadvantaged, ambulatory patients who are traveling for treatment.

Website: <https://angelwheels.org/>

7. THE AMERICAN CANCER SOCIETY - TRANSPORTATION

Transportation shouldn't be a roadblock to cancer treatment.

Phone: 1-800-227-2345

Website:

<https://www.cancer.org/treatment/support-programs-and-services/patient-transportation.html>

8. CITY OF BOWIE, MARYLAND - TRANSPORTATION

Curb-to-curb transportation for Bowie senior citizens and adult individuals with disabilities.

Phone: 301-809-2324

Website:

<https://www.cityofbowie.org/563/Transportation-for-Seniors>

Section IV: Evaluation



Introduction

Based on the findings from the 2017 – 2019 Community Health Needs Assessment, Adventist HealthCare Rehabilitation Hospital developed an Implementation Strategy to address the prioritized areas of concussion care, screening and education. An overview of each of the major programs undertaken over the past three years, as well as their outcomes, is provided below.

Athletic Trainer Program

<p>Need</p> <p><i>As originally identified in the 2017 - 2019 CHNA</i></p>	<p>The Center for Disease Control and Prevention estimates that there are more than 3.8 million sports-related concussions per year in the United States. Data from the 2004 to 2009 college sports season showed sports-related concussions comprised 9.2 percent of all injuries sustained in women’s soccer, 7.4 percent in football, 6.3 percent in field hockey, 5.5 percent in men’s soccer and 4.1 percent in women’s volleyball¹. A high school sports-related injury surveillance study for the 2014 - 2015 school year found that head/face concussions comprised 20.9 percent of overall injuries sustained during both competitions and practice².</p> <p>In 2014, 4,279 Marylanders were hospitalized because of a traumatic brain injury (TBI) and 39,177 emergency department visits in Maryland were attributed to TBI-related injuries³.</p> <p>From 2006 to 2010, Montgomery County had the highest percentage of TBI-related emergency department visits in the state as well as the fourth highest percentage of TBI-related hospital discharges⁴. From 2010 to 2011, Adventist HealthCare Rehabilitation had a higher percentage (12.8 percent) of brain injury discharges than the region (11.4 percent) and the nation (10.7 percent)⁵.</p>
<p>Program Overview</p> <p><i>Programs and initiatives conducted in response to the need identified</i></p>	<p>Adventist HealthCare Rehabilitation implemented an athletic trainer program at 13 Montgomery County high schools. This included training and placing an athletic trainer in each of the schools to assist with timely on-site injury prevention and management.</p> <ul style="list-style-type: none"> • Trainers attended all ‘home’ athletic events as well as ‘away’ varsity football games • Trainers performed functions within the six domains of athletic trainers as established by the National Athletic Trainers Association: prevention; clinical evaluation and diagnosis; immediate care; treatment, rehabilitation, and reconditioning; organization and administration; and professional responsibilities

¹ Datalys Center: Sports Injury Research and Prevention, 2004-2009

² National High School Sports-Related Injury Surveillance Study: 2014 – 2015 School Year Convenience Sample Summary Report. http://www.ucdenver.edu/academics/colleges/PublicHealth/research/ResearchProjects/piper/projects/RIO/Documents/Convenience%20Report_2014_15.pdf

³ Maryland Traumatic Brain Injury Advisory Board (2016). Annual Report. Retrieved from http://www.biamd.org/uploads/8/5/7/7/85779996/2016_maryland_traumatic_brain_injury_advisory_board_report.pdf

⁴ Department of Health and Mental Hygiene, 2006-2010.

⁵ Patient Outcomes Report. Adventist Rehabilitation Hospital of Maryland. 2011. <http://www.adventistrehab.com/app/files/public/213/pdf-ARHM-Patient-Outcomes.pdf>

	<ul style="list-style-type: none"> • Trainers assisted in implementing school and system wide responsibilities related to the health and safety of student athletes • Trainers provided American Heart Association CPR/AED recertification for athletic staff at the 13 Montgomery County high schools <p>Schools included Churchill, Clarksburg, Einstein, Kennedy, Richard Montgomery, Northwest, Paint Branch, Poolesville, Rockville, Springbrook, Watkins Mill, Wheaton, and Wootton</p>
<p>Outcomes <i>Process and Outcome measures 2017 - 2019</i></p>	<p>Athletic Trainer Program Outcomes (2017 – 2019)</p> <ul style="list-style-type: none"> • 13 certified athletic trainers were present for all athletic seasons over the past three years in 13 Montgomery County High Schools. • A total of 1,738 injuries were evaluated, documented, and treated • 175 school personnel were either newly certified or recertified in basic life support and CPR

Concussion Program

<p>Need</p> <p><i>As originally identified in the 2017 - 2019 CHNA</i></p>	<p>The Center for Disease Control and Prevention estimates that there are more than 3.8 million sports-related concussions per year in the United States. Data from the 2004 to 2009 college sports season showed sports-related concussions comprised 9.2 percent of all injuries sustained in women’s soccer, 7.4 percent in football, 6.3 percent in field hockey, 5.5 percent in men’s soccer and 4.1 percent in women’s volleyball⁶. A high school sports-related injury surveillance study for the 2014 - 2015 school year found that head/face concussions comprised 20.9 percent of overall injuries sustained during both competitions and practice⁷.</p> <p>In 2014, 4,279 Marylanders were hospitalized because of a traumatic brain injury (TBI) and 39,177 emergency department visits in Maryland were attributed to TBI-related injuries⁸.</p> <p>From 2006 to 2010, Montgomery County had the highest percentage of TBI-related emergency department visits in the state as well as the fourth highest percentage of TBI-related hospital discharges⁹. From 2010 to 2011, Adventist HealthCare Rehabilitation had a higher percentage (12.8 percent) of brain injury discharges than the region (11.4 percent) and the nation (10.7 percent)¹⁰.</p>
<p>Program Overview</p> <p><i>Programs and initiatives conducted in response to the need identified</i></p>	<p>Adventist HealthCare Rehabilitation implemented a concussion screening and follow-up program for student athletes at 13 Montgomery County high schools.</p> <p>Baseline testing is a pre-season exam conducted by trained professionals to assess an athlete's cognitive functions including learning and memory skills, ability to concentrate and problem-solving skills. In the event that the athlete suffers a concussion, the results from these tests can be used in comparison with similar post-injury tests.</p> <p>Adventist HealthCare Rehabilitation used ImpACT™ (Immediate Post-Concussion Assessment Cognitive Test), a web-based, computerized tool used to measure memory, processing speed, reaction time, attention span and problem-solving skills.</p>

⁶ Datalys Center: Sports Injury Research and Prevention, 2004-2009

⁷ National High School Sports-Related Injury Surveillance Study: 2014 – 2015 School Year Convenience Sample Summary Report. http://www.ucdenver.edu/academics/colleges/PublicHealth/research/ResearchProjects/piper/projects/RIO/Documents/Convenience%20Report_2014_15.pdf

⁸ Maryland Traumatic Brain Injury Advisory Board (2016). Annual Report. Retrieved from http://www.biamd.org/uploads/8/5/7/7/85779996/2016_maryland_traumatic_brain_injury_advisory_board_report.pdf

⁹ Department of Health and Mental Hygiene, 2006-2010.

¹⁰ Patient Outcomes Report. Adventist Rehabilitation Hospital of Maryland. 2011. <http://www.adventistrehab.com/app/files/public/213/pdf-ARHM-Patient-Outcomes.pdf>

	<p>This test takes between 30 to 45 minutes and is considered one of the standard baseline tests for student athletes.</p> <p>The following strategies were implemented as a part of this initiative:</p> <ul style="list-style-type: none"> • Implemented ImPact™ baseline testing for student athletes in 13 Montgomery County high schools (with each student baseline tested every 2 years and retested following a concussion) <ul style="list-style-type: none"> ○ Schools included Churchill, Clarksburg, Einstein, Kennedy, Richard Montgomery, Northwest, Paint Branch, Poolesville, Rockville, Springbrook, Watkins Mill, Wheaton, and Wootton • Maintained and made available baseline test results to students, parents, and students’ health care providers at no cost • Provided retests following a concussion at no cost (analysis and treatment were an additional cost) • Provided follow-up testing and analysis for students as needed at a reasonable rate • Served as a resource on concussion education for students, parents, and coaches
<p>Outcomes <i>Process and Outcome measures 2017 - 2019</i></p>	<p>Baseline Concussion Testing (2017 – 2019)</p> <ul style="list-style-type: none"> • Baseline concussion testing was coordinated with school personnel for 13 Montgomery County High Schools over the last three school years • ImPact™ baseline testing was completed at 13 Montgomery County high schools with a total of 11,265 baseline tests conducted • A total of 288 concussions were diagnosed/or suspected and treated <p>Concussion Education Presentations for Student Athletes (2017)</p> <p>In addition to the baseline concussion testing, Adventist HealthCare Rehabilitation Hospital implemented a Concussion Education presentation for student athletes during the 2017 school year, due to unforeseeable challenges, the presentation was not continued from 2018 - 2019. The goal of the Concussion Education presentation was to increase knowledge and awareness of concussion symptoms, acute treatments, importance of recovery, and effects on every day activities beyond sports. The presentation covered topics such as traumatic brain injury, causes and symptoms, anatomy, and mechanism of injury, to name a few.</p> <ul style="list-style-type: none"> • One Concussion Education presentation occurred at John F. Kennedy High School with a total of 36 participants • From the presentation pre and post-test females had a 20 percent and males had a 26 percent increase in knowledge

Brain Injury Support Groups

<p>Need</p> <p><i>As originally identified in the 2017 - 2019 CHNA</i></p>	<p>In Maryland, the overall incidence of traumatic brain injury related emergency department visits increased between 2012 and 2015¹¹. Seniors ages 65 and older had the highest rates of traumatic brain injury related deaths and TBI related hospitalizations. The highest rate of TBI injury related emergency department visits was for Marylanders ages 5 to 24.</p> <p>Unintentional falls are the leading cause of injury for TBI related deaths, emergency department visits, and hospitalizations. Montgomery County had higher emergency department visits and deaths due to TBI when compared to Prince Georges County. According to Adventist HealthCare Rehabilitation 2015 hospital data, the average age of those suffering from TBI was 70 years, with males and white individuals accounting for the majority of patients.</p>
<p>Program Overview</p> <p><i>Programs and initiatives conducted in response to the need identified</i></p>	<p>The primary objective of this initiative was to provide support and education to individuals living with both traumatic and non-traumatic brain injuries, as well as their family members and caregivers.</p> <p>Brain Injury Support Group</p> <p>This support group, which met once a month, is for those with both traumatic and non-traumatic brain injuries. The group provided support and education, as well as guidance around available community resources. Participants were encouraged to bring family members and friends.</p> <p>Grupo de Apoyo para Personas con una Lesión Cerebral</p> <p>This support group met every third Tuesday of the month for two hours in the evenings. The growing Hispanic population in Montgomery County prompted the creation of the support group. The group was conducted in Spanish and was targeted to Spanish speaking individuals. All sessions were moderated by a therapist and cultural diversity liaison and focused on common themes which included: traumatic brain injury or stroke, community resources, back to work, mental health, memory loss, and recreational activities. Guest speakers from local community-based organizations occasionally attended and presented on resources their organizations were able to offer.</p>

¹¹ Maryland Traumatic Brain Injury Advisory Board. (2017). Annual Report. Retrieved from https://www.biamd.org/uploads/8/5/7/7/85779996/2017_-_tbi_advisory_board_annual_report.pdf

Outcomes <i>Process and Outcome measures 2017 - 2019</i>	Brain Injury Support Group <ul style="list-style-type: none">Over the last three years there were 48 sessions with a total of 531* encounters Grupo de Apoyo para Personas con una Lesión Cerebral <ul style="list-style-type: none">Over the last three years there were 32 sessions with a total of 345 encounters <p><i>*Encounters only include CY2018 and CY2019</i></p>
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