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: Doctor's Community Medical Center.	◉	○	
Your hospital's ID is: 210051	◉	○	
Your hospital is part of the hospital system called Luminis Health.	◉	○	
The primary hospital community benefit (HCB) Narrative contact at your hospital is Kelly Koorey (primary) and Lori Wishard.	○	◉	Temi Oshiyoye
The primary HCB Narrative contact email address at your hospital is kkoorey@luminishealth.org (primary); lwishard@luminishealth.org	○	◉	toshiyoye@luminishealth.org
The primary HCB Financial report contact at your hospital is Kevin Smith (primary), Renee Kilroy (interim position), Kelly Koorey and Lori Wishard.	○	○	Doug Wormer
The primary HCB Financial report contact email at your hospital is kevin.smith@luminishealth.org (primary), rkilroy@luminishealth.org; kkoorey@luminishealth.org; lwishard@luminishealth.org	○	○	dwomer@luminishealth.org

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.

DCMC uses the Community Health Needs Assessment to identify underserved areas.

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

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

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

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

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

  The CBSA is also determined by the hospital's patient population, CRISP data, and data from the county CHNA.

- [ ] Other. Please describe.

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

https://www.luminishealth.org/en/about-us/mission-vision-values?language_content_entity=en

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)

12/15/2021

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.luminishealth.org/sites/default/files/2022-11/2022-Prince-Georges-County-CHA-Luminis.pdf

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

2022-Prince-Georges-County-CHA-Luminis - Copy.pdf
7MB
application/pdf

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

9/22/2022

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

https://www.luminishealth.org/sites/default/files/2022-10/Luminis-Health-CHNA-Implementation-Plan-FY22-24.pdf

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

Luminis-Health-CHNA-Implementation-Plan-FY22-24.pdf
571.5KB
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.

Prioritizing Health Needs: There was an impactful response to the qualitative data collection process. In combination with the quantitative data analysis, it was determined that numerous health and social needs impact the health of Prince George's County residents. Therefore, the Prince George's County Department of Health held a prioritization discussion with the hospital systems in the county. During the discussion, all the hospital systems represented agreed that the work they started in 2016 is not yet complete, and the data and community input are reflective of this. The stakeholders therefore agreed to maintain the four main priority areas during the next three years; social determinants of health, behavioral health, obesity and metabolic syndrome, and cancer. Furthermore, DCMC leadership determined that the needs should support a strategic framework, maximize resources, and have an impact. Therefore, we prioritized obesity/metabolic syndrome, cancer, and behavioral health as our health priorities with an emphasis on developing innovative outreach strategies and developing community partnerships (as recommended by the PGCHD CHNA).

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 - 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

- [ ] Health Behaviors - Preventive Care
- [x] Health Behaviors - Safe Food Handling
- [x] Health Behaviors - Sleep
- [ ] Health Behaviors - Tobacco Use
- [x] 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?

Priorities were made based on the most pressing needs of the community. Setting these priorities ensure resources align with the mission of the health system

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

Luminis Health developed a plan to become a national model for justice, equity, diversity, and inclusion (JEDI). The HEART Force's goal is to help Luminis Health address structural racism and systemic inequity in health care. We do this by evaluating our processes, policies and practices. Our objective is to eliminate inequities from health care operations. The implementation of the plan began in 2020 with the formation of a system wide Health Equity and Anti-racism Task (HEART) force. This is a multidisciplinary group including members of board of trustee, senior leaders, medical staff, community partners and stakeholders. Recommendations from the HEART force were; lead as an anti-racist organization, and confront racism and eradicate inequities in health care, enhance cultural informed communications and community collaboration, measure and ingrate accountability. Luminis will continue to track these measures and ensure efforts to reduce disparity.

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.

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

Q66. Please describe the third party audit process used.

This question was not displayed to the respondent.

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

- (●) Yes
- ( ) No

Q68. Please describe the community benefit narrative audit process.

The narrative and financial information is collected from the department leaders and cross check by the financial team. The core team working on the community benefit report, complies this information and presents to senior leadership for accuracy and contribution. Edits and changes are made per senior leadership recommendations. Final reports are reviewed by the CEO of the health system. The report is submitted and final adoption is provided by the board of DCMC

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

- (●) Yes
- ( ) No

Q70. Please explain:

This question was not displayed to the respondent.

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

- (●) Yes
- ( ) No

Q72. Please explain:

This question was not displayed to the respondent.

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.

The foundation for Luminis Health is its mission, vision, values, and strategic framework. These are the fundamental principles by which we serve, defining both who we are and who we aspire to be. Our mission is our purpose, our vision represents our future, and our values serve as our guideposts. Our values are brought to life daily in the behaviors and attitudes we exhibit and the choices and decisions we make. They serve as a beacon to guide Luminis Health in allocating resources, in drafting policies and procedures and responding to daily and long-term situations. This is reviewed annually by senior leadership, clinical leadership, and administrative leadership to identify growth and health improvement opportunities through planning retreats, meetings, and data analysis. Strategic imperatives were chosen based on their ability to significantly impact the care of patients and the community: shift to focus on the health ecosystem, address health through social determinants, and adopt technology proactively. Luminis Health leaders identify Community Benefits through strategic initiatives and report the data and information to the Department of Community Health Improvement for collection and analysis. Community Health tracks the data and reports monthly to leadership through the True North Metrics process and the Annual Operating Plan.

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

https://www.luminishealth.org/sites/default/files/2022-04/Luminis%20Health%20Vision%202030.pdf

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.

- [x] Diabetes - Reduce the mean BMI for Maryland residents
- [x] Opioid Use Disorder - Improve overdose mortality
- [ ] Maternal and Child Health - Reduce severe maternal morbidity rate

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

- [ ] None of the Above

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

Q78. Section IV - Physician Gaps & Subsidies

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

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

Q80. Section V - Financial Assistance Policy (FAP)

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

FAP-FY21.pdf
191.6KB
application/pdf

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

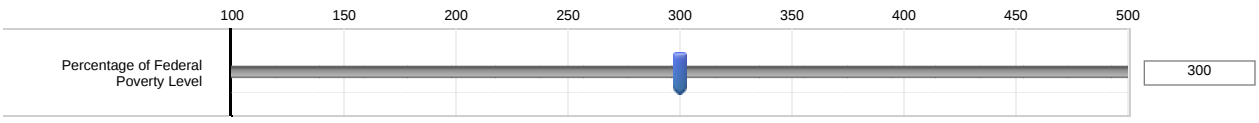
https://www.luminishealth.org/sites/default/files/2022-08/FAP-FY21.pdf

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

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

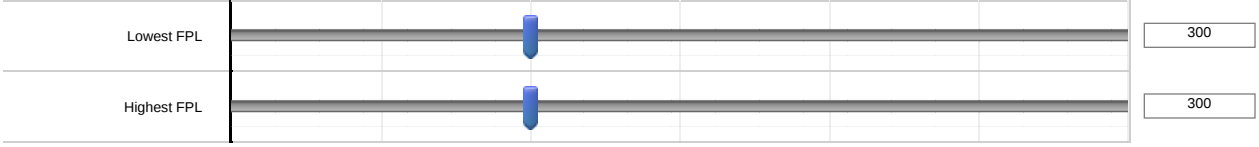
Q84. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



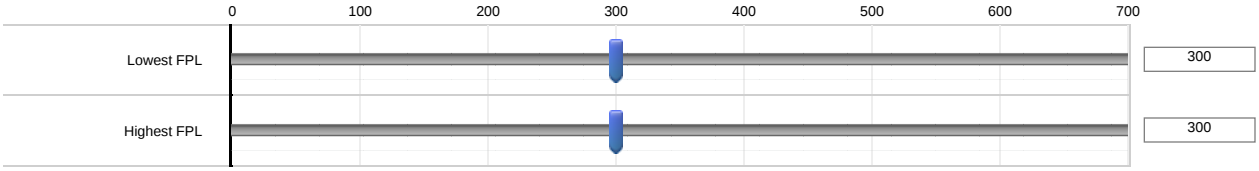
Q85. Maryland acute care and chronic care hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

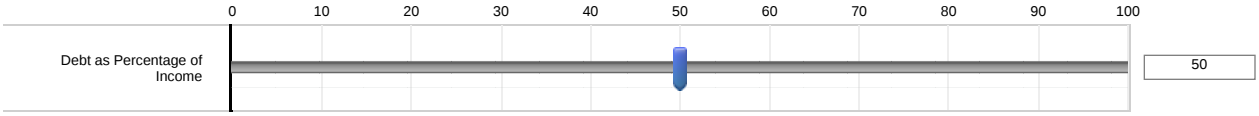


Q86. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3)(a) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial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

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



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



Q88. Section VI - Tax Exemptions

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

- [x] Federal corporate income tax
- [x] State corporate income tax
- [ ] 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.

Location Data

Location: (38.867, -76.8173)

Source: GeoIP Estimation

2022
PRINCE GEORGE'S COUNTY

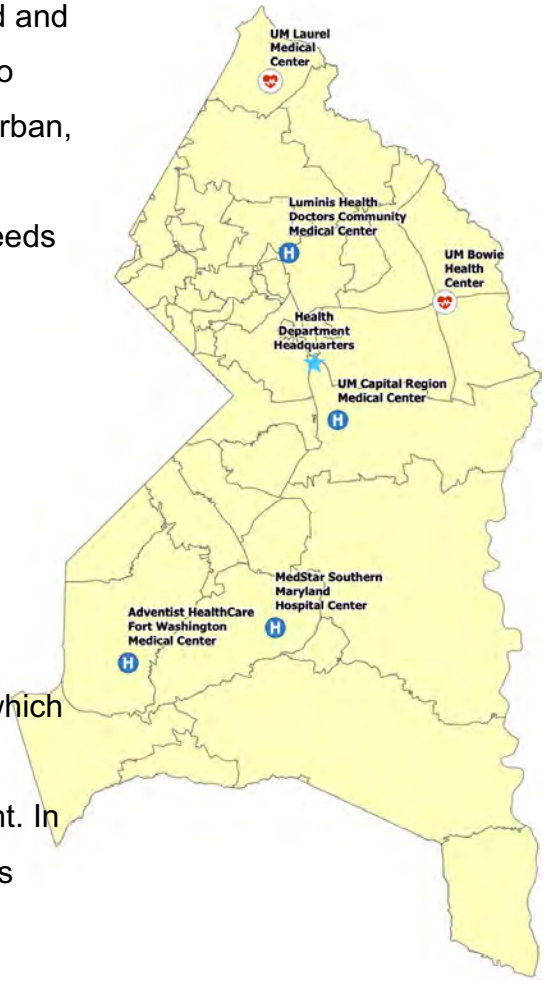
COMMUNITY HEALTH ASSESSMENT

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

HEALTH DEPARTMENT
Prince George's County

INTRODUCTION

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



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

CHA Core Team

Luminis Health Doctors Community Hospital

Adventist Healthcare Fort Washington Medical Center

MedStar Southern Maryland Hospital Center

Prince George's County Health Department

UM Capital Region Health

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

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

PROCESS OVERVIEW

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

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

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

- Collaboration
- Equity
- Trust
- Safety
- Prevention

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

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

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

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

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

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

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

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

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

KEY FINDINGS

Drivers of Poor Health Outcomes:

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

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

Leading Health Challenges

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

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

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

Recommendations

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

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

TABLE OF CONTENTS

COMMUNITY HEALTH ASSESSMENT

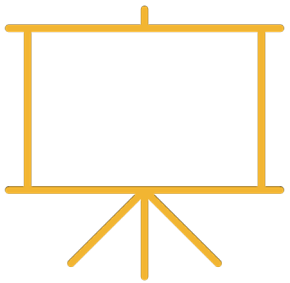
2022 EXECUTIVE SUMMARY

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

HEALTH DEPARTMENT
Prince George's County

Community Health Assessment

OVERVIEW



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

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

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

2019 Values:

- Collaboration
- Equity
- Trust
- Safety
- Prevention

2022 CHA Components

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

2022 CHA Core Team

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

2022 PRIORITIES

Determined by consensus to retain the four priority areas:

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

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

DATA LIMITATIONS

WE WILL NEED TO REVISIT SOME DATA SOURCES:

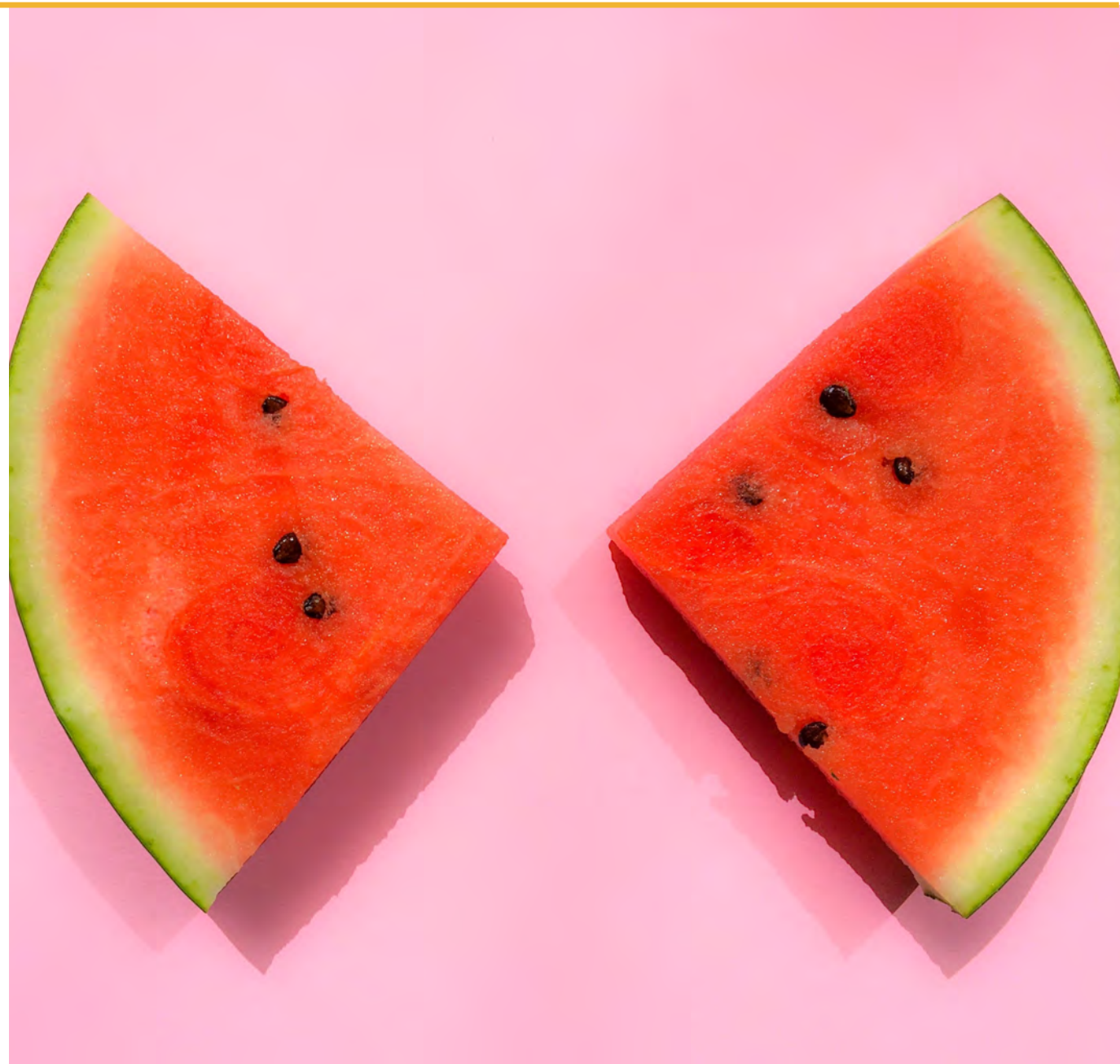
- **Census 2020:** we know our population grew much more than estimated
  - 2019 American Community Survey Estimate: 909,327
  - 2020 Census: 967,201

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

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

PRIORITY #1

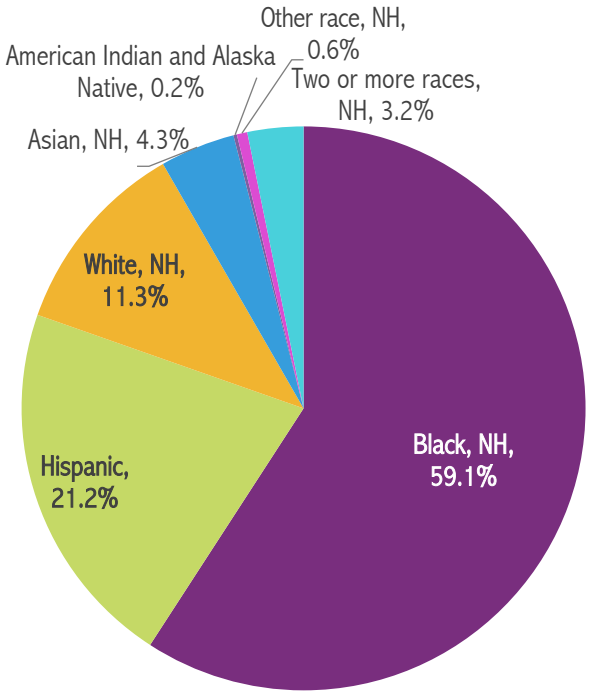
SOCIAL DETERMINANTS OF HEALTH

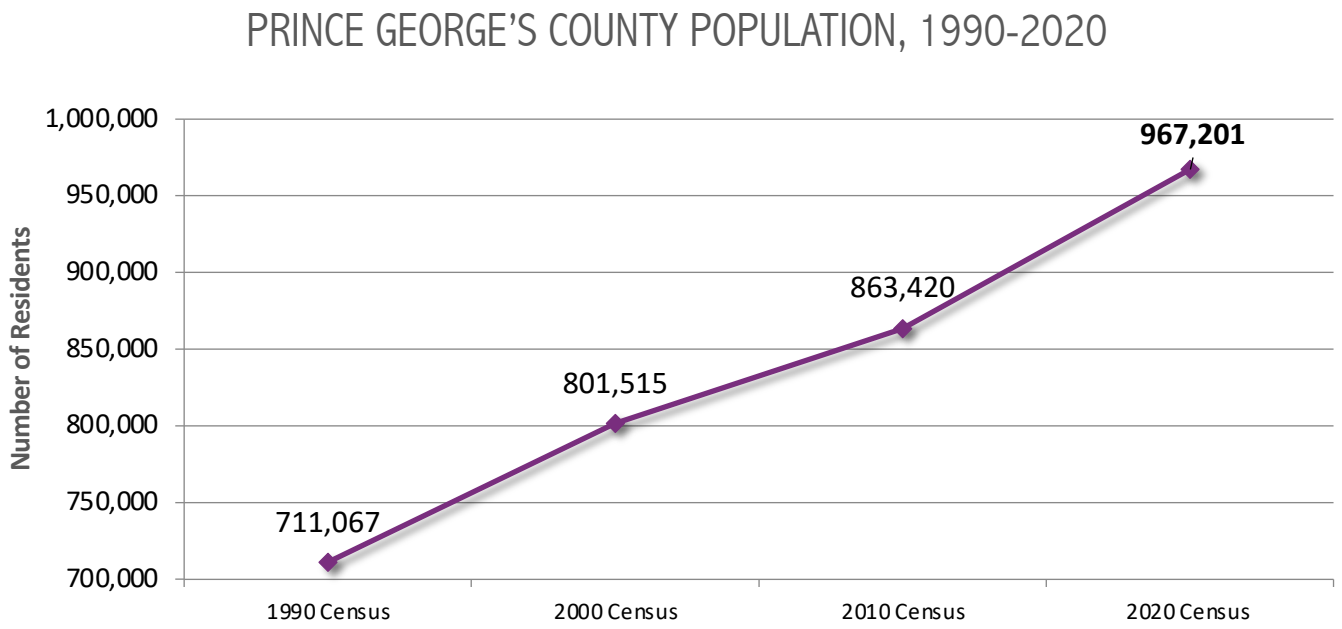


Population Changes

HIGHLIGHTS

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





ACCESS TO CARE

Indicators

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

RESIDENTS WITH HEALTH INSURANCE, 2016-2020

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

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

ACCESS TO CARE

Resident Surveys

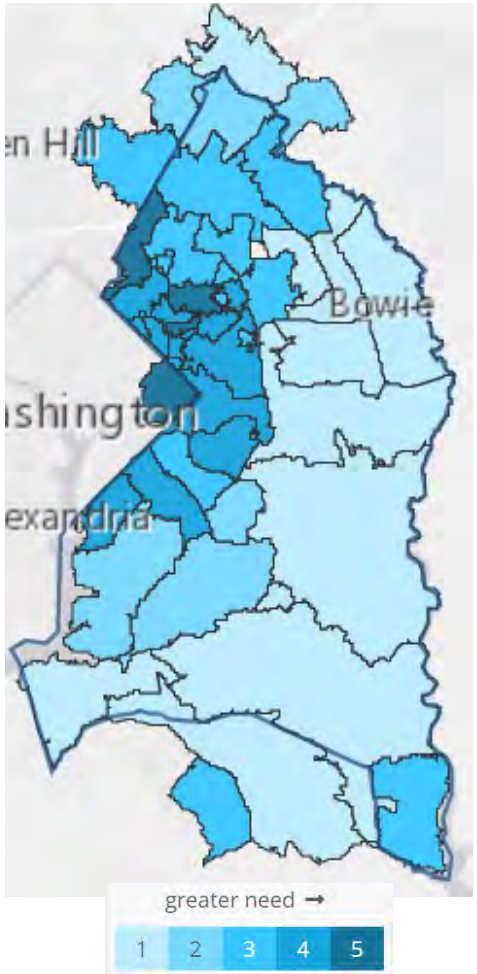
- Access to healthcare and related services was identified as the leading factor that defines a “healthy community”
- Nearly one-quarter are unsatisfied with the healthcare system in the county (same as 2019 results)
- Compared to 2019 results, fewer residents believed those in their community could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

Community Experts for Special Populations

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

Socioeconomic Factors

2022 SOCIONEEDS INDEX
PRINCE GEORGE'S COUNTY



Source: www.PGCHealthZone.org

Indicators

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

Resident Surveys

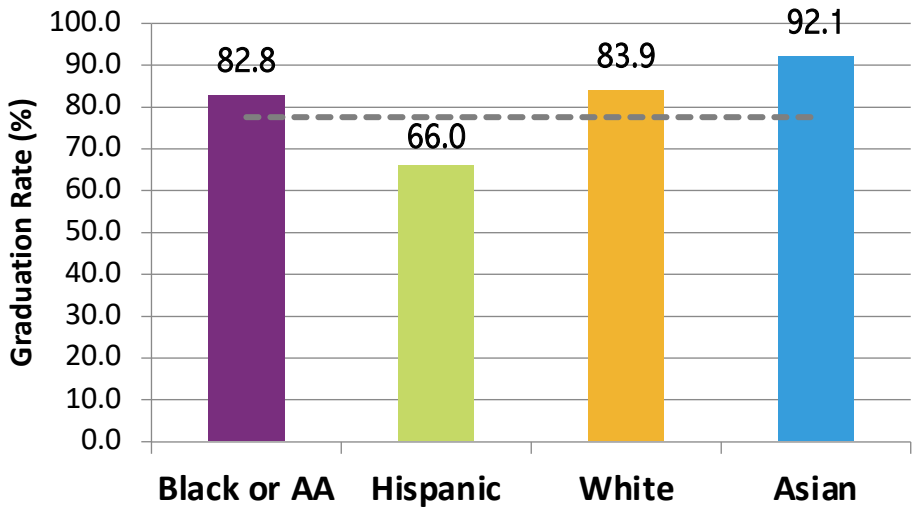
- 44% reported satisfaction with the economic opportunities in the overall county; 60% reported satisfaction the economy in their community
- Good jobs and a health economy were identified as the fifth most important factors for a health community
- One-third responded that transportation to medical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

Community Experts

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

Education

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



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

Source: 2021 Maryland Public Schools Report Card

Indicators

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

Resident Surveys

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

Community Experts

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

Housing

2021 FAIR MARKET RENT

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

Source: National Low Income Housing Coalition

Indicators

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

Resident Surveys

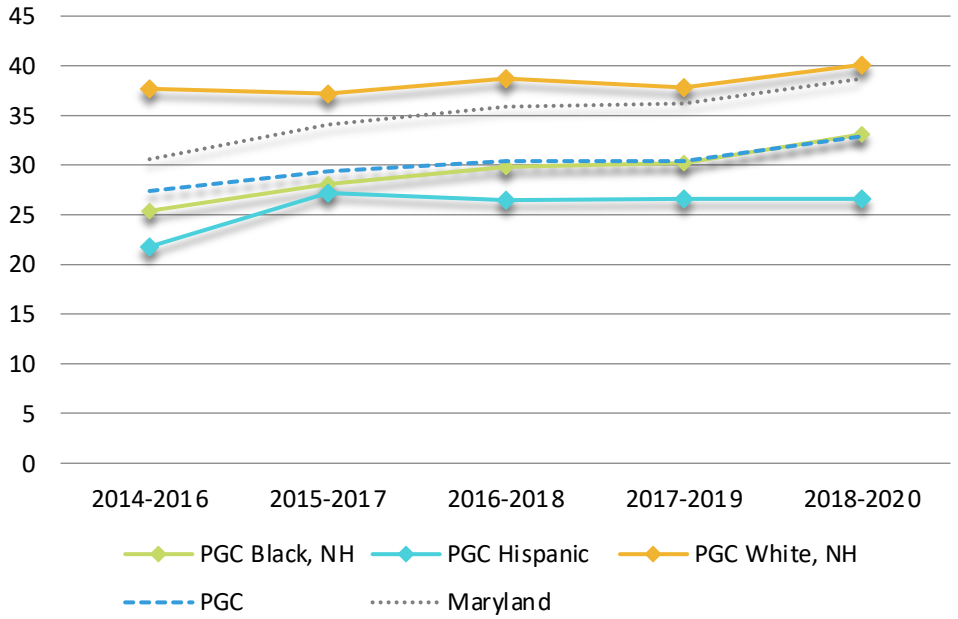
- "Affordable housing" was identified as the fourth most important factor for a health community
- Only 28% responded that their community has enough affordable housing

Community Experts

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

NEIGHBORHOOD & BUILT ENVIRONMENT

UNINTENTIONAL INJURY AGE-ADJUSTED MORTALITY RATE, 2014-2020



Source: CDC Wonder

Indicators

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

Resident Surveys

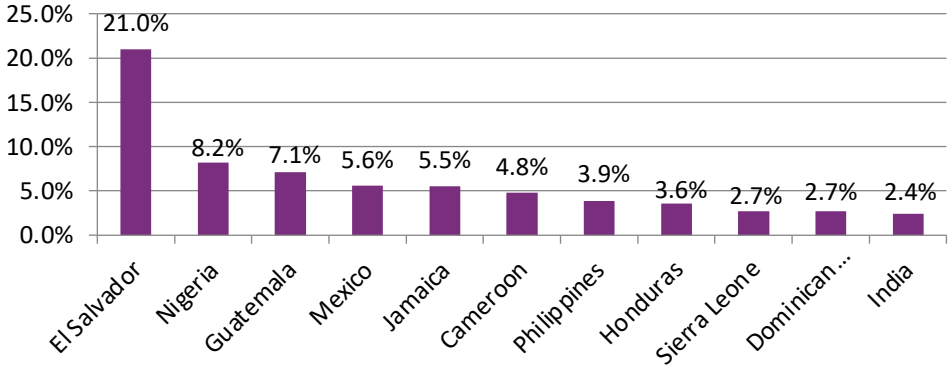
- 60% believe their community is a safe place to live, the same as in 2019
- Four out of five reported easy access to fresh food in their community, the same as in 2019
- Three-fourths reported parks as the places they go to most often in their community, followed by the library
- Aging within a community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

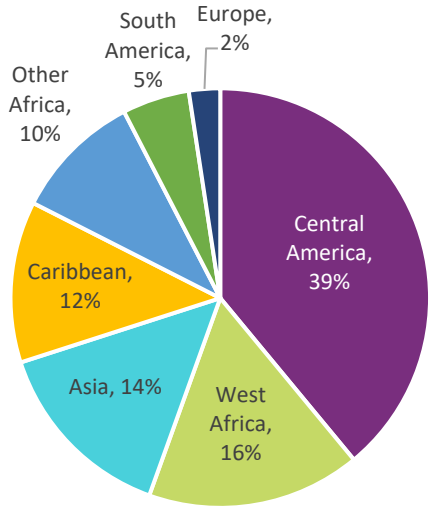
Community Experts

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

SOCIAL & COMMUNITY CONTEXT

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





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

Indicators

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

Resident Surveys

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

Community Experts

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

SDOH BIG PICTURE

What's happened since the last CHA?

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

What's in the works?

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

Where do gaps/opportunities remain?

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

PRIORITY #2

BEHAVIORAL HEALTH

MENTAL HEALTH

HEALTH INDICATORS & DISPARITIES

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

RISK FACTORS

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

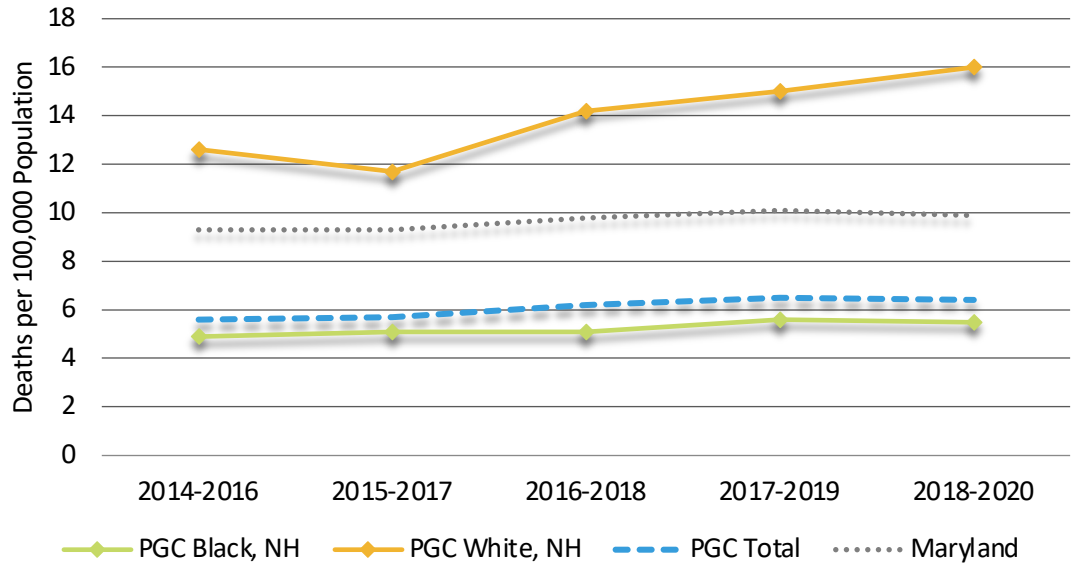
TRENDS (COMPARED TO 2019 CHA)

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

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

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

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



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

COMMUNITY PERCEPTION

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

SUBSTANCE ABUSE

HEALTH INDICATORS & DISPARITIES

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

RISK FACTORS

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

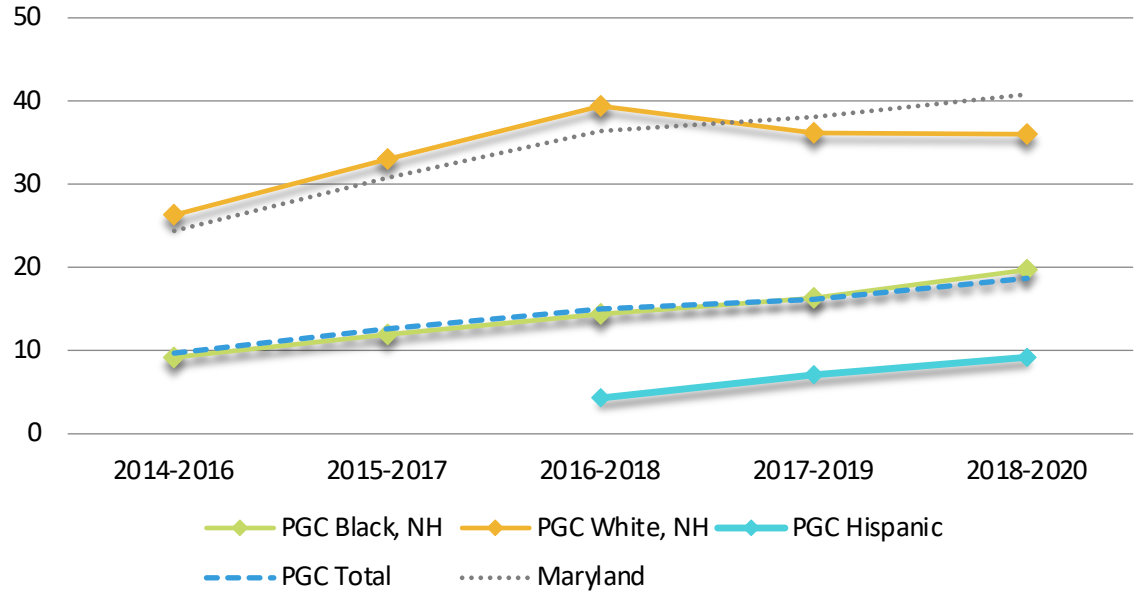
TRENDS (COMPARED TO 2019 CHA)

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

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

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

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



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

COMMUNITY PERCEPTION

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

BEHAVIORAL HEALTH BIG PICTURE

What's happened since the last CHA?

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

What's in the works?

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

Where do gaps/opportunities remain?

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

PRIORITY #3

OBESITY & METABOLIC SYNDROME

OBESITY

HEALTH INDICATORS & DISPARITIES

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

RISK FACTORS

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

TRENDS (COMPARED TO 2019 CHA)

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

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

- No negative trends identified

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

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

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

COMMUNITY PERCEPTION

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

HEART DISEASE

HEALTH INDICATORS & DISPARITIES

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

RISK FACTORS

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

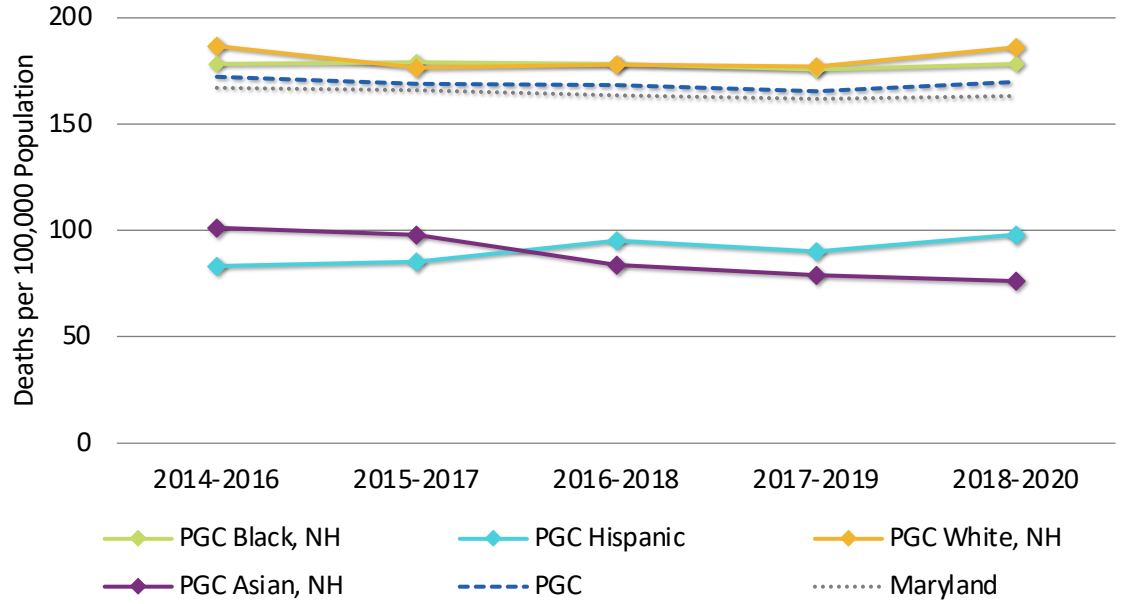
TRENDS (COMPARED TO 2019 CHA)

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

- No neutral trends identified

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

HEART DISEASE AGE-ADJUSTED MORTALITY RATE, 2014-2020



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

COMMUNITY PERCEPTION

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

DIABETES

HEALTH INDICATORS & DISPARITIES

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

RISK FACTORS

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

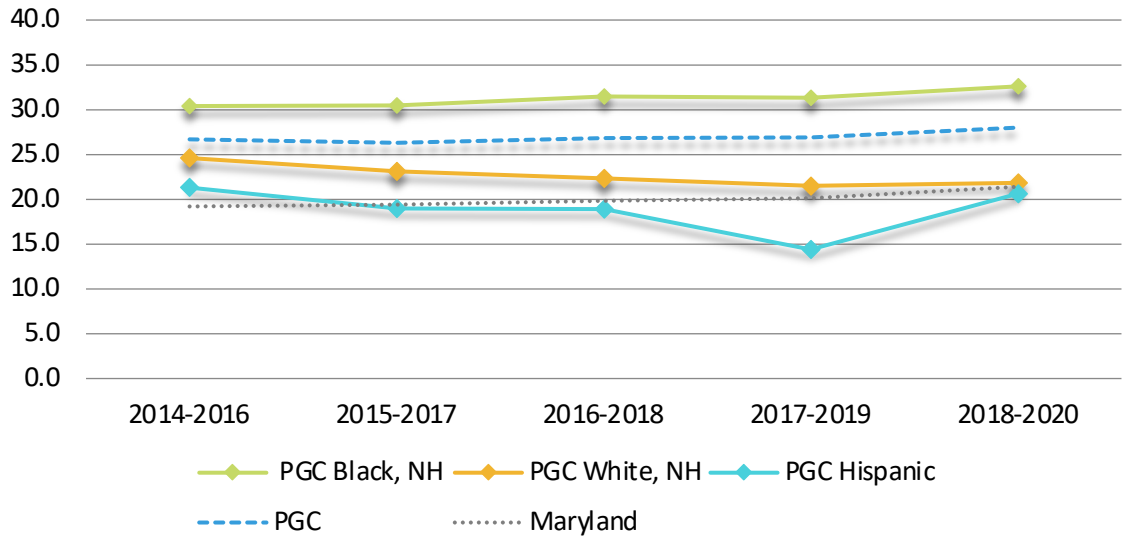
TRENDS (COMPARED TO 2019 CHA)

- No positive trends identified

- No neutral trends identified

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

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



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

COMMUNITY PERCEPTION

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

HYPERTENSION & STROKE

HEALTH INDICATORS & DISPARITIES

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

RISK FACTORS

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

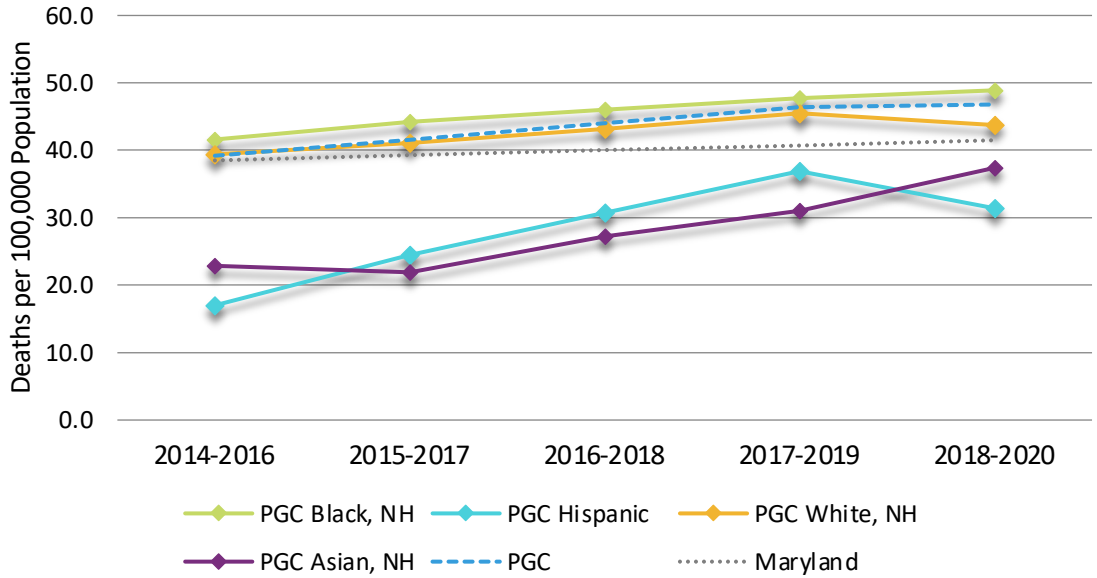
TRENDS (COMPARED TO 2019 CHA)

- No positive trends identified

- No neutral trends identified

- Overall increase in resident adults who have been told they have high blood pressure by a healthcare provider
- Increase in Inpatient visit rate due to Hypertension
- Increase in Stroke Mortality, from 39.2 in 2014-2016 to 46.8 in 2018-2020.

STROKE AGE-ADJUSTED MORTALITY RATE, 2014-2020



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

COMMUNITY PERCEPTION

- Stroke tied as #7 for top health issue by Residents
- Stroke tied as #6 by Community Experts as top health issue
- Overall chronic disease management was noted as a key issue in the county

OBESITY & METABOLIC SYNDROME BIG PICTURE

What's happened since the last CHA?

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

What's in the works?

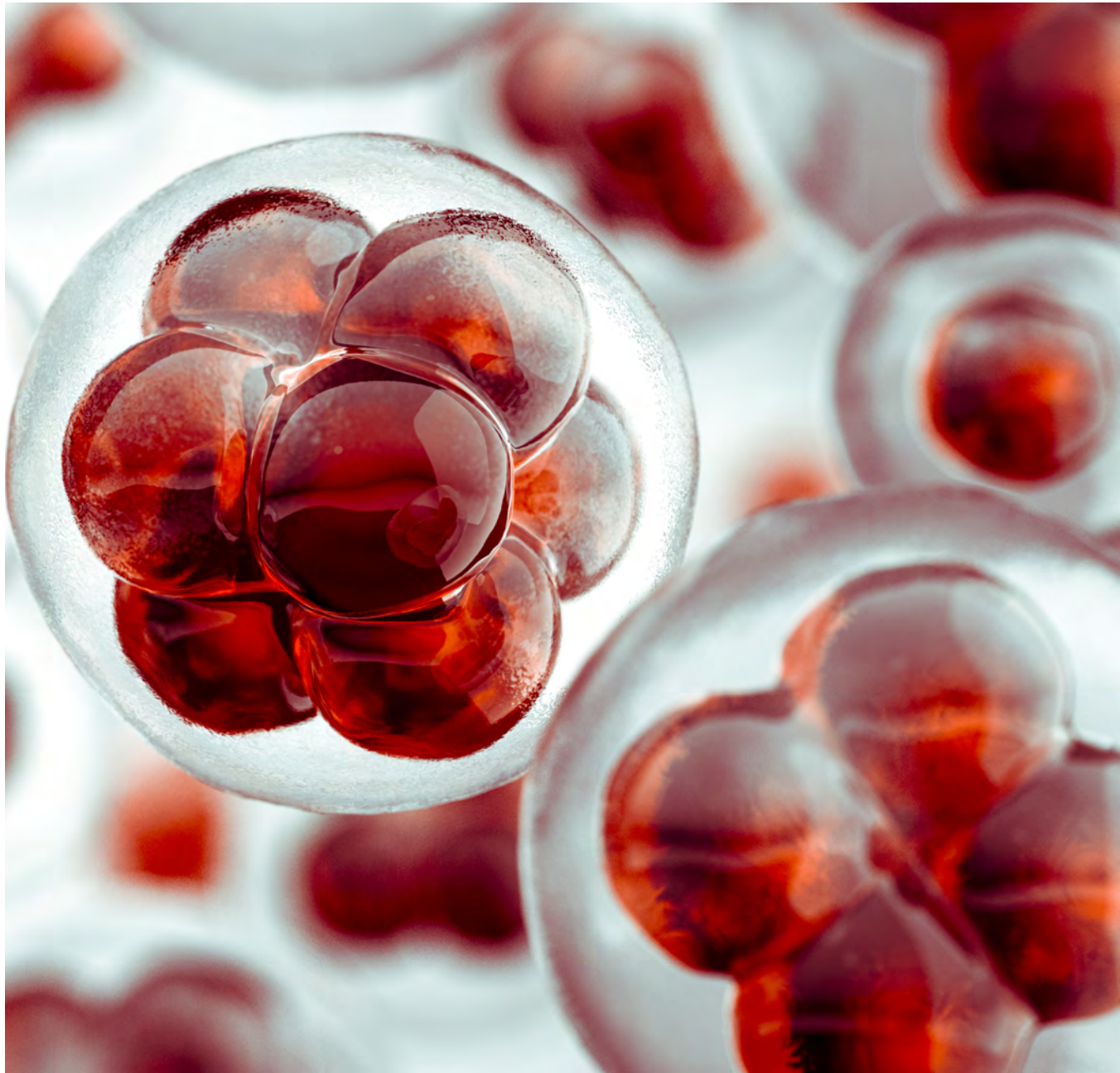
- Updating the Healthy Food Priority Areas methodology and data
- HD CHISS grant – CHWs to help obtain services for conditions that would lead to more severe covid including chronic diseases
- HD Remote Patient Monitoring pilot (PreventionLink)
- HD CHISS grant – expansion of 30 CHWs in community and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

Where do gaps/opportunities remain?

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

PRIORITY #4

CANCER



CANCER

HEALTH INDICATORS & DISPARITIES

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

RISK FACTORS

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

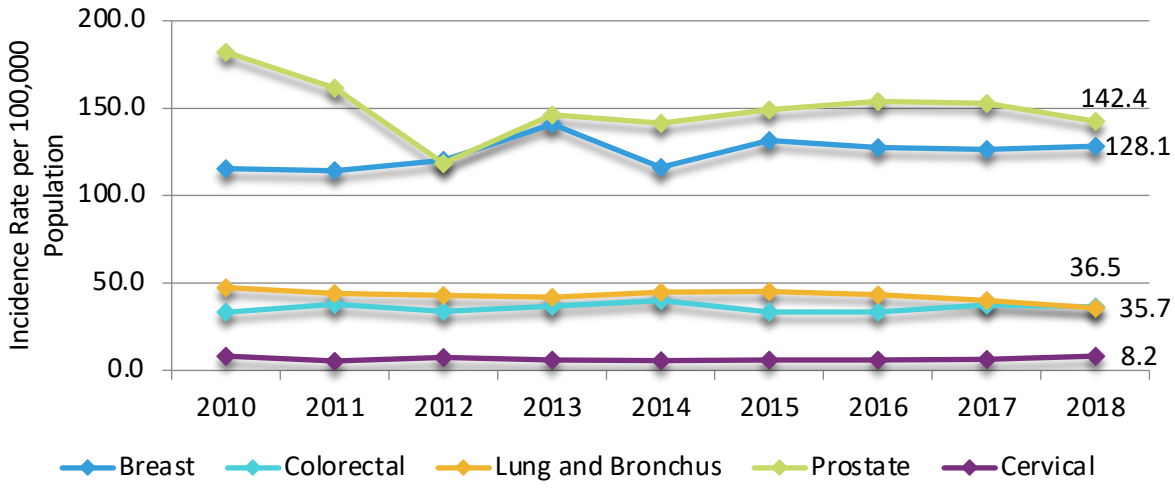
TRENDS (COMPARED TO 2019 CHA)

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

- No neutral trends identified

- Mortality rate for Hispanic residents increased to 82.8 per 100,000 (2018-2020)
- Increase in incidence rate for Breast and Cervical Cancer
- Increase in incidence rate for Breast, Colorectal, and Lung and Bronchus cancer for Black residents

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



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

COMMUNITY PERCEPTION

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

BREAST CANCER

HEALTH INDICATORS & DISPARITIES

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

RISK FACTORS

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

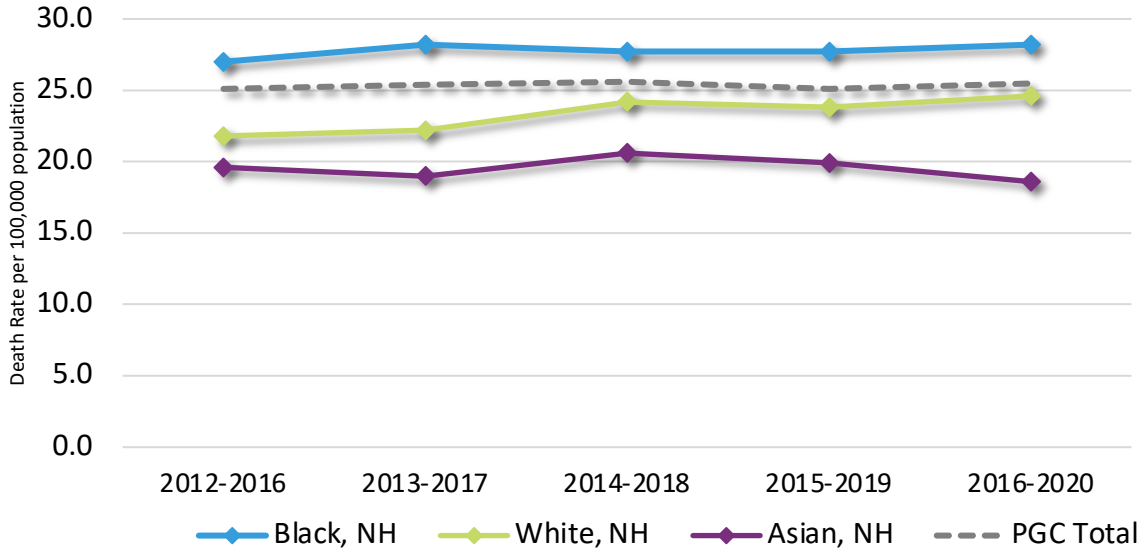
TRENDS (COMPARED TO 2019 CHA)

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

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

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

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



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

COMMUNITY PERCEPTION

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

PROSTATE CANCER

HEALTH INDICATORS & DISPARITIES

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

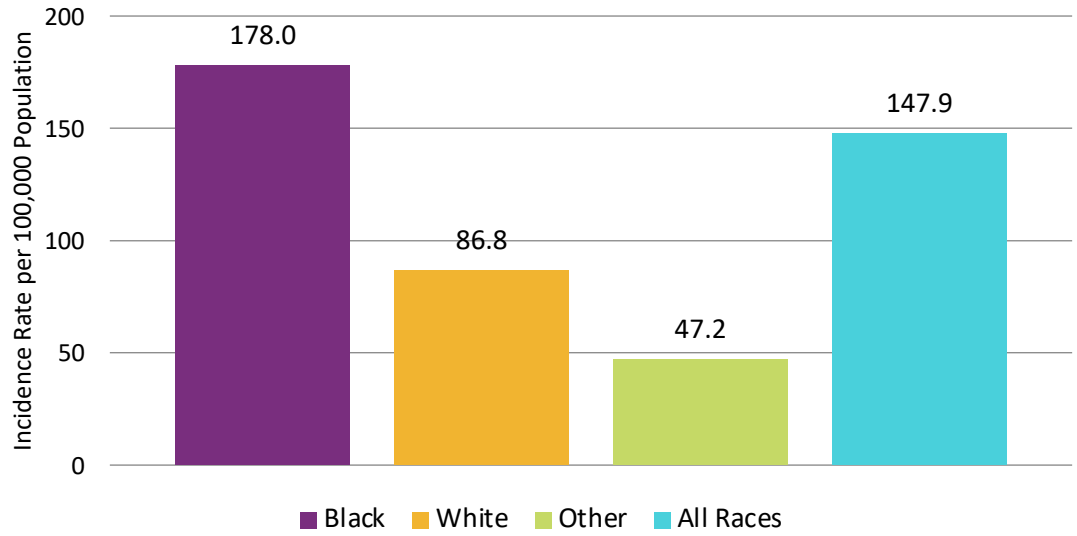
RISK FACTORS

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

TRENDS (COMPARED TO 2019 CHA)

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

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



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

COMMUNITY PERCEPTION

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

CANCER BIG PICTURE

What's happened since the last CHA?

What's in the works?

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

Where do gaps/opportunities remain?

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

ADDITIONAL AREAS OF INTEREST

HIV

HEALTH INDICATORS & DISPARITIES

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

RISK FACTORS

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

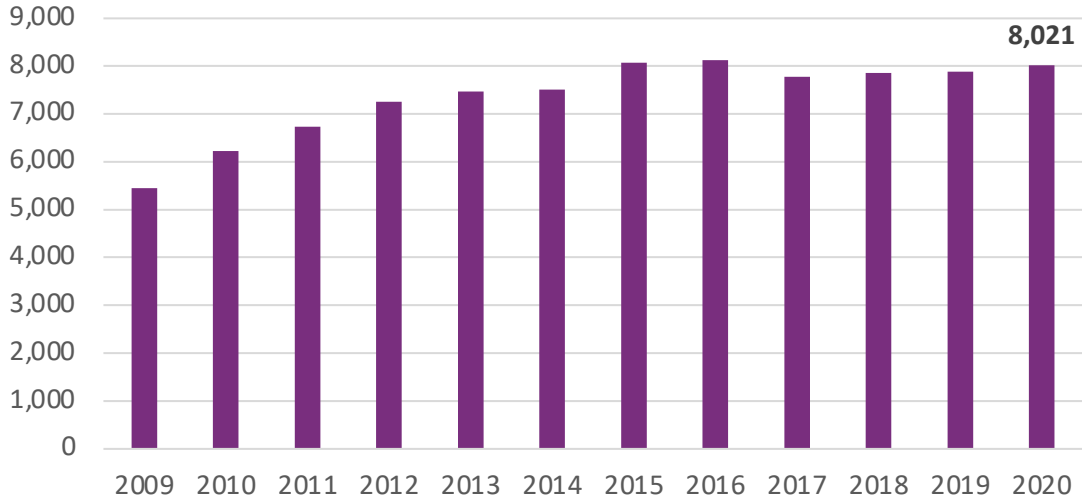
TRENDS (COMPARED TO 2019 CHA)

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

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

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

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



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

COMMUNITY PERCEPTION

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

MATERNAL & INFANT HEALTH

HEALTH INDICATORS & DISPARITIES

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

RISK FACTORS

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

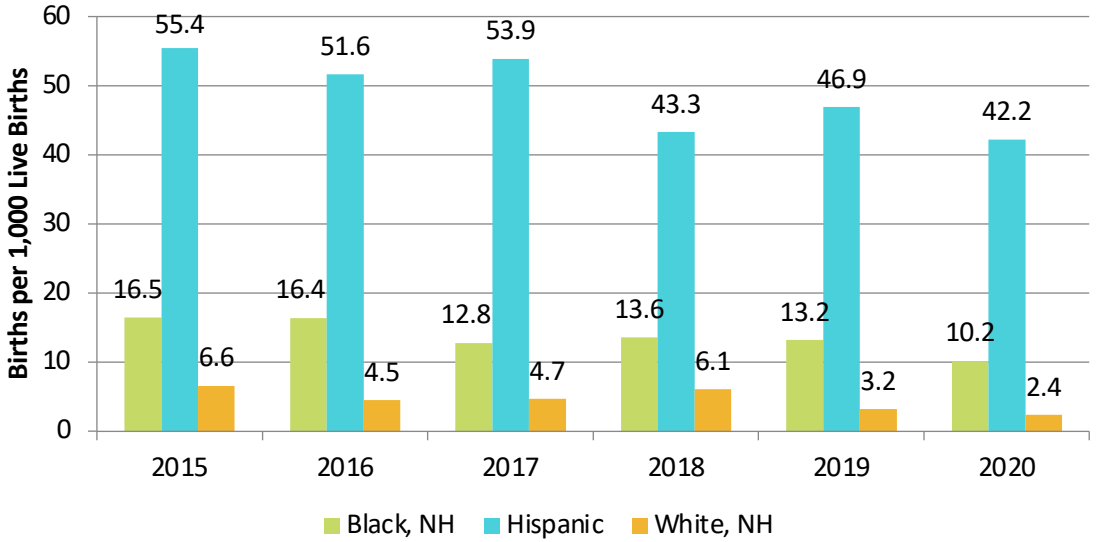
TRENDS (COMPARED TO 2019 CHA)

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

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

- No negative trends identified

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



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

COMMUNITY PERCEPTION

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

THEMES & NEXT STEPS

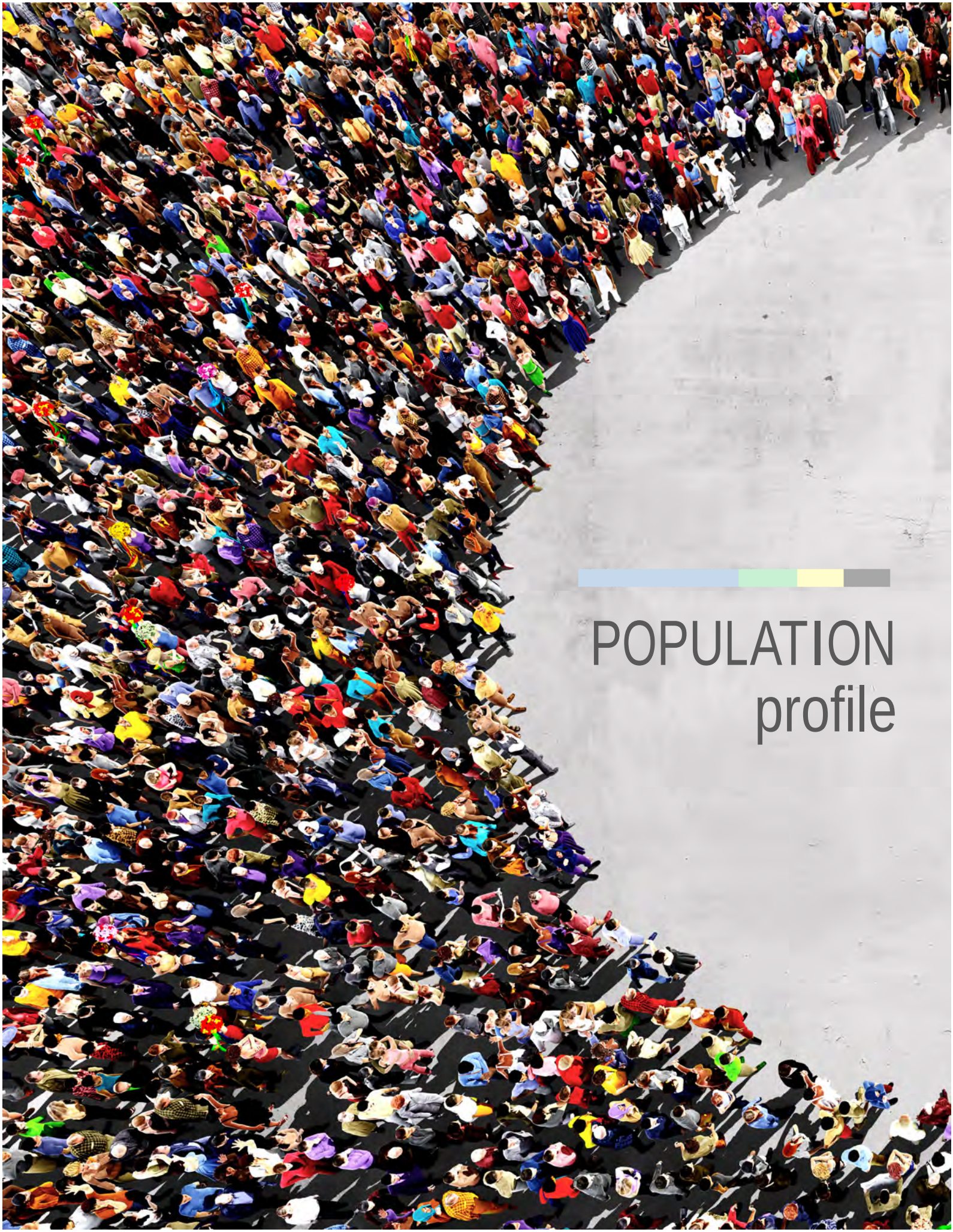
CHA EMERGENT THEMES

WHAT ROSE TO THE TOP?

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

NEXT STEPS

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



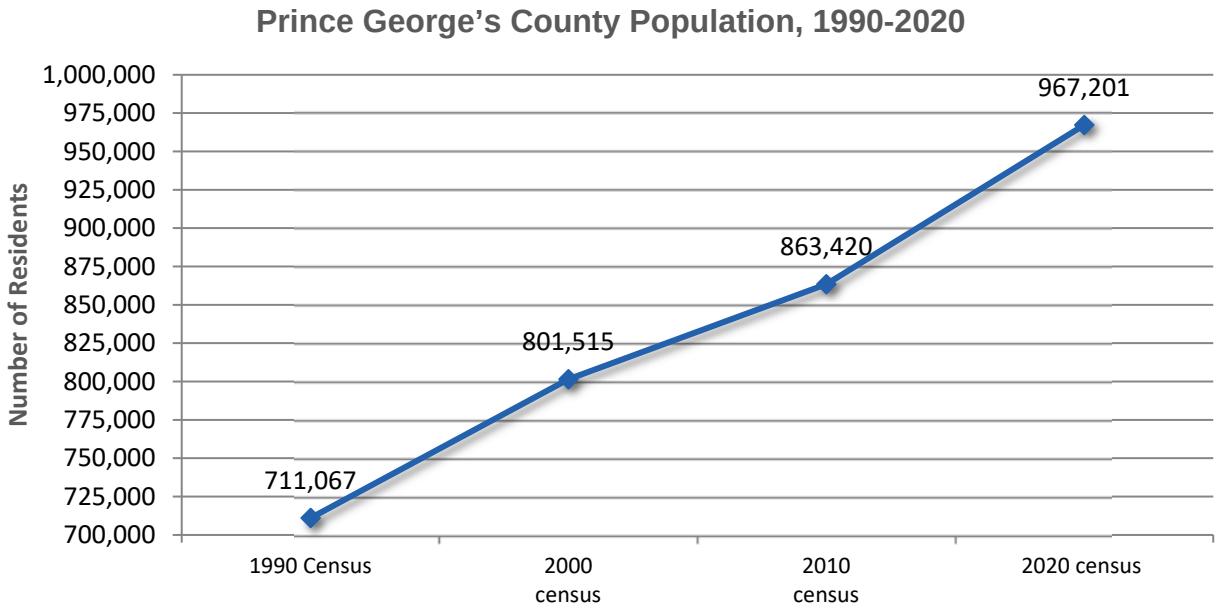
POPULATION profile

POPULATION PROFILE

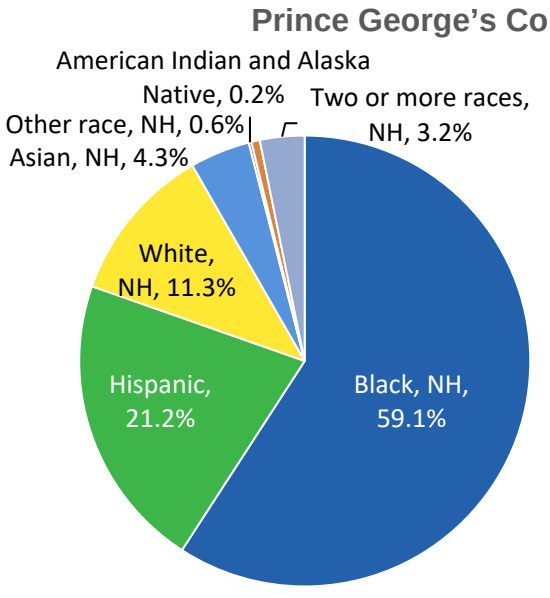
TABLE OF CONTENTS

Overall Population

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



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



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

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

Population Demographics, 2020

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

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

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

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

Population Demographics, 2019

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

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

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

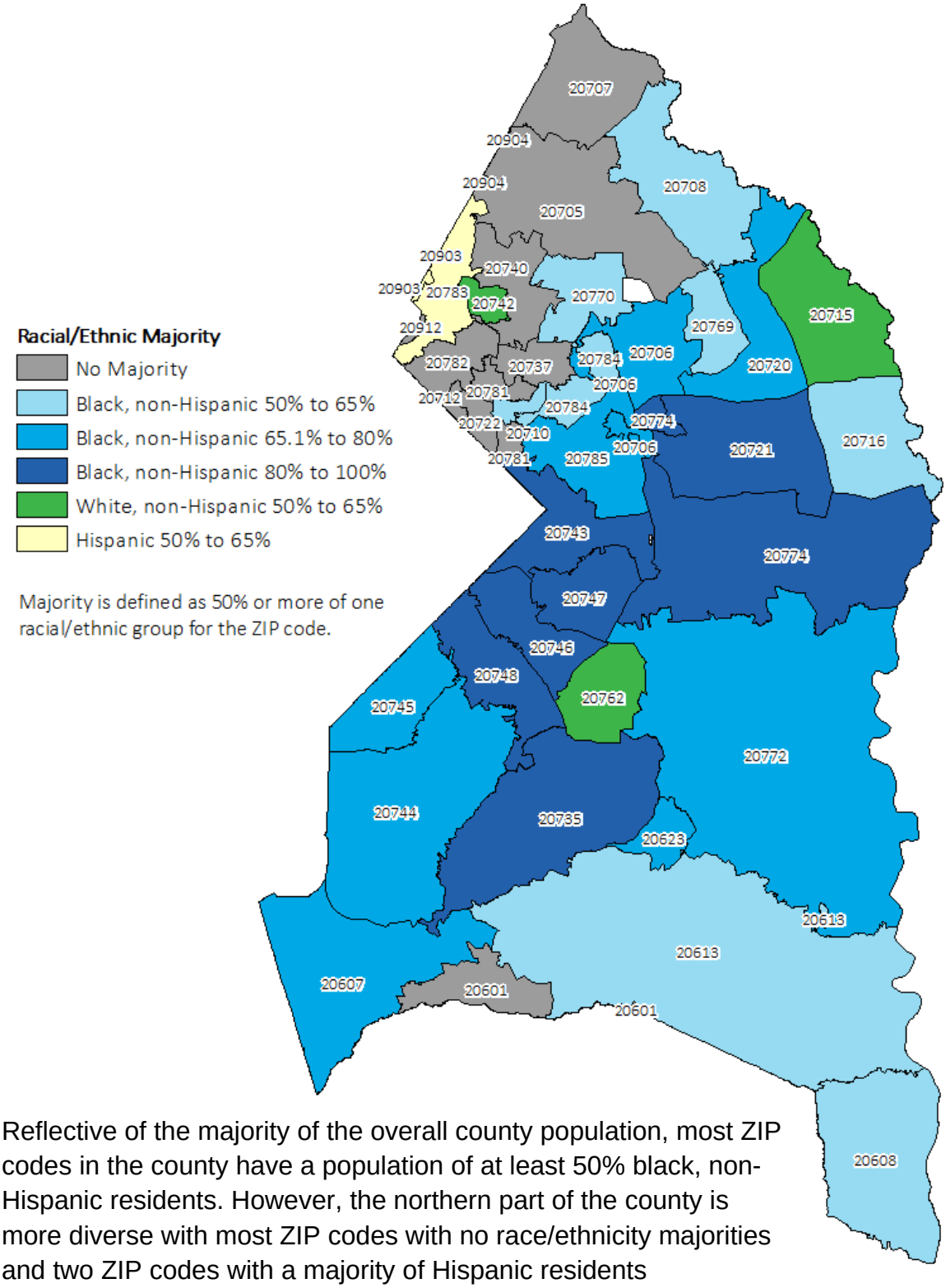
Race and Ethnicity	Median Age (yrs.)
Black	40.1
Hispanic, Any Race	28.8
White, NH	40.3
Asian	39.8

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

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

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

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



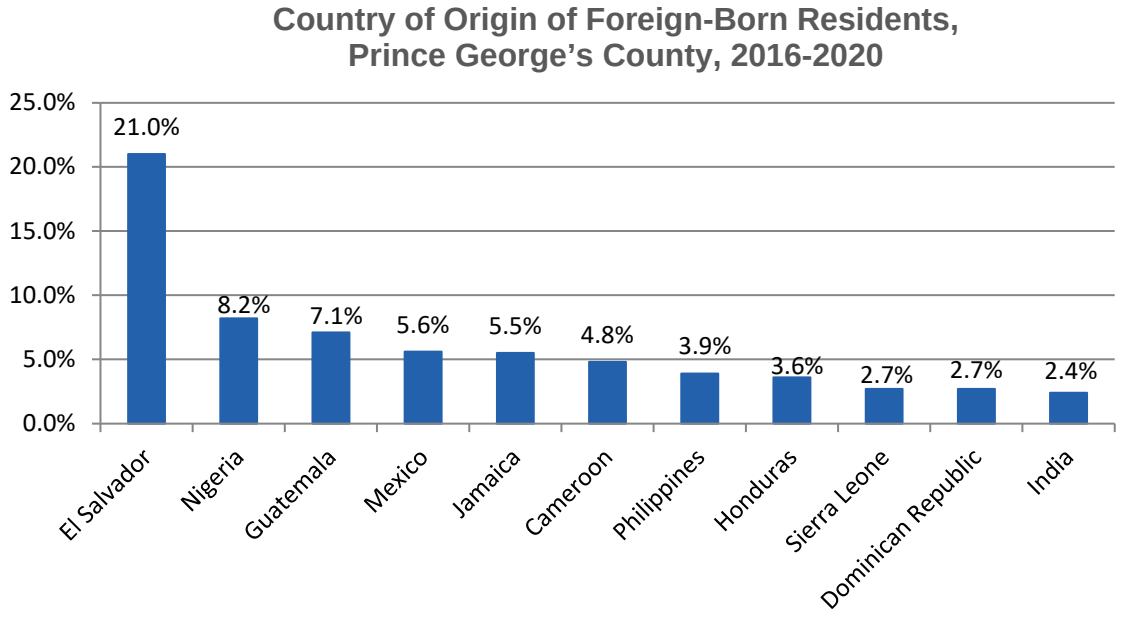
Reflective of the majority of the overall county population, most ZIP codes in the county have a population of at least 50% black, non-Hispanic residents. However, the northern part of the county is more diverse with most ZIP codes with no race/ethnicity majorities and two ZIP codes with a majority of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

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

Foreign-Born Residents

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

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

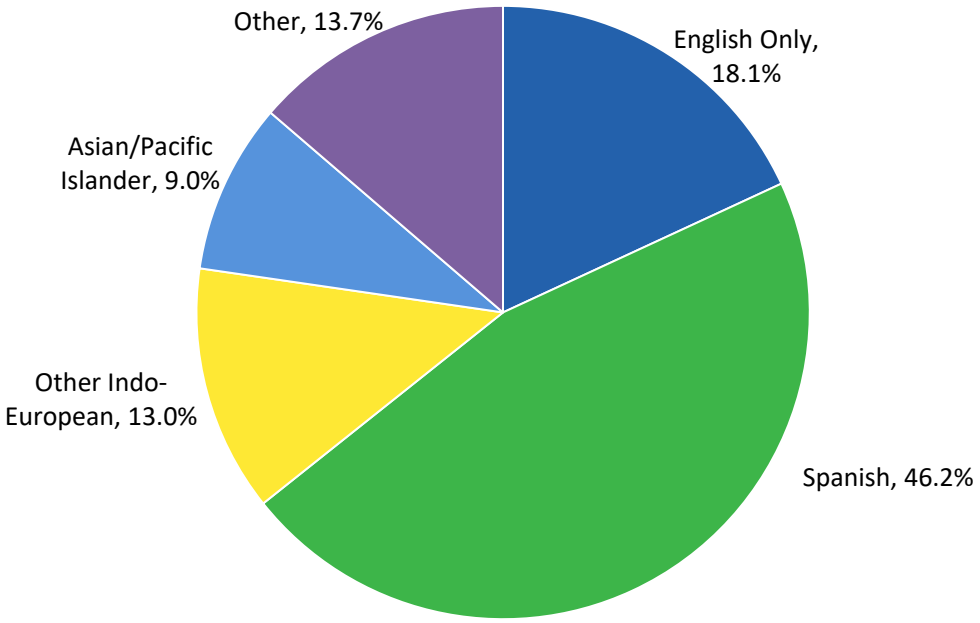


Data Source: 2016-2020 American Community Survey 5-Year Estimates, Table B05006

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

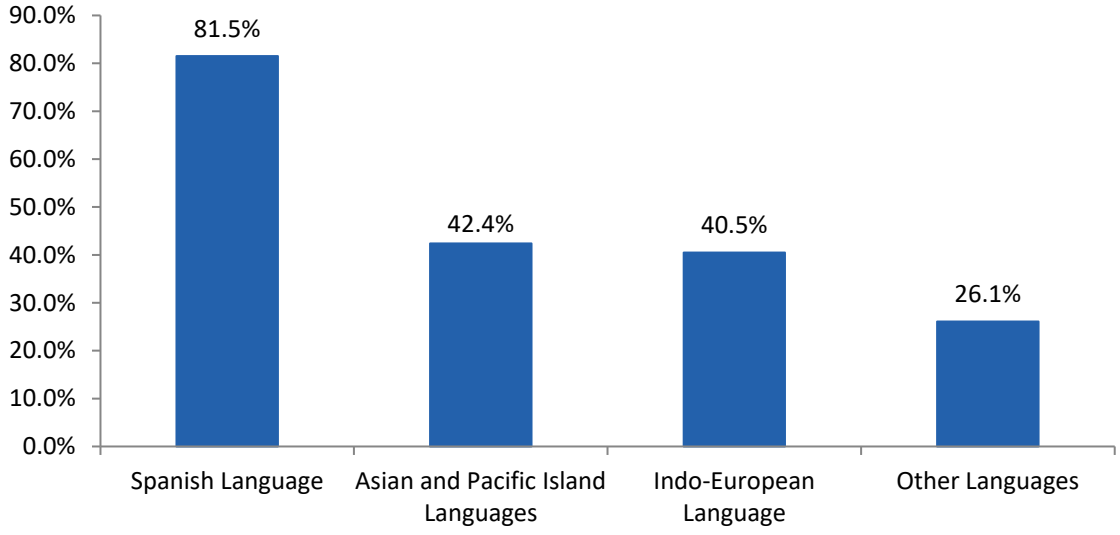
[1] American Community Survey 5-year estimates, 2016-2020, Table S0501
[2] American Community Survey 1-year estimates, 2019, Table S0501
[3] American Community Survey, 1-year estimates, 2019, Table B06007

Languages Spoken by Foreign-Born Residents, Prince George's County, 2019



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

Foreign-Born Residents Speaking English Less Than "Very Well" by Language Spoken at Home, Prince George's County, 2019

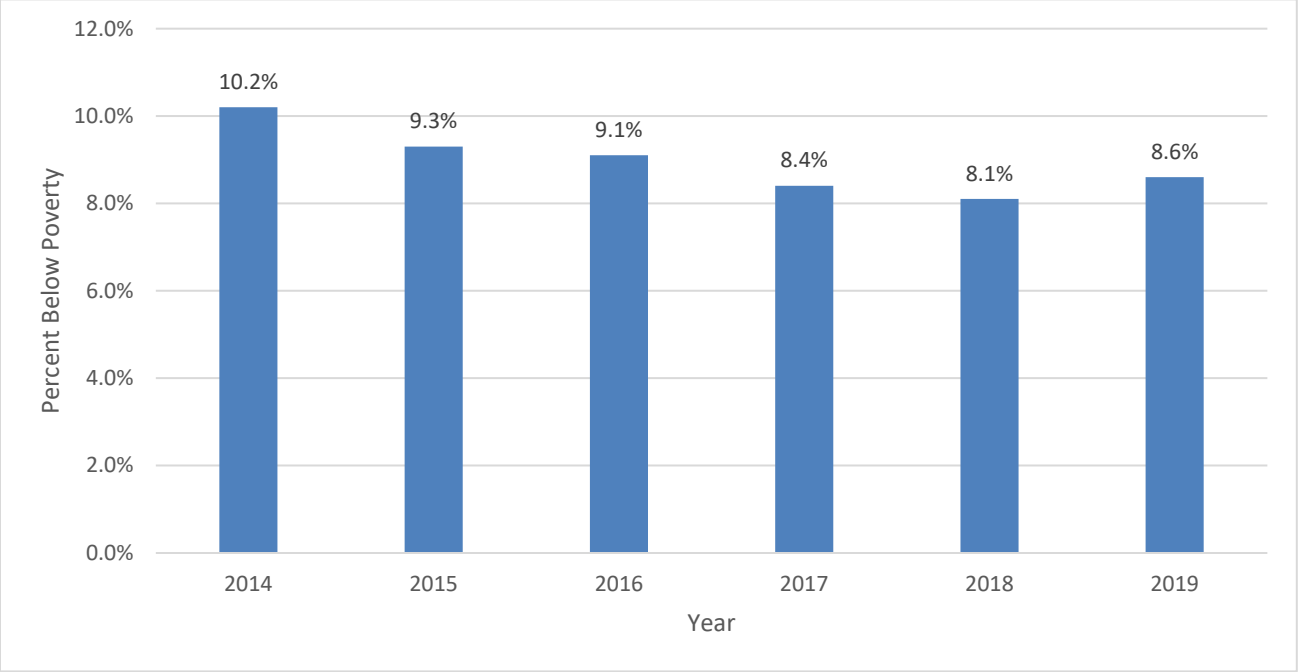


Data Source: 2019 American Community Survey 1-year estimates, Table C16005

Poverty

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

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



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

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

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

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

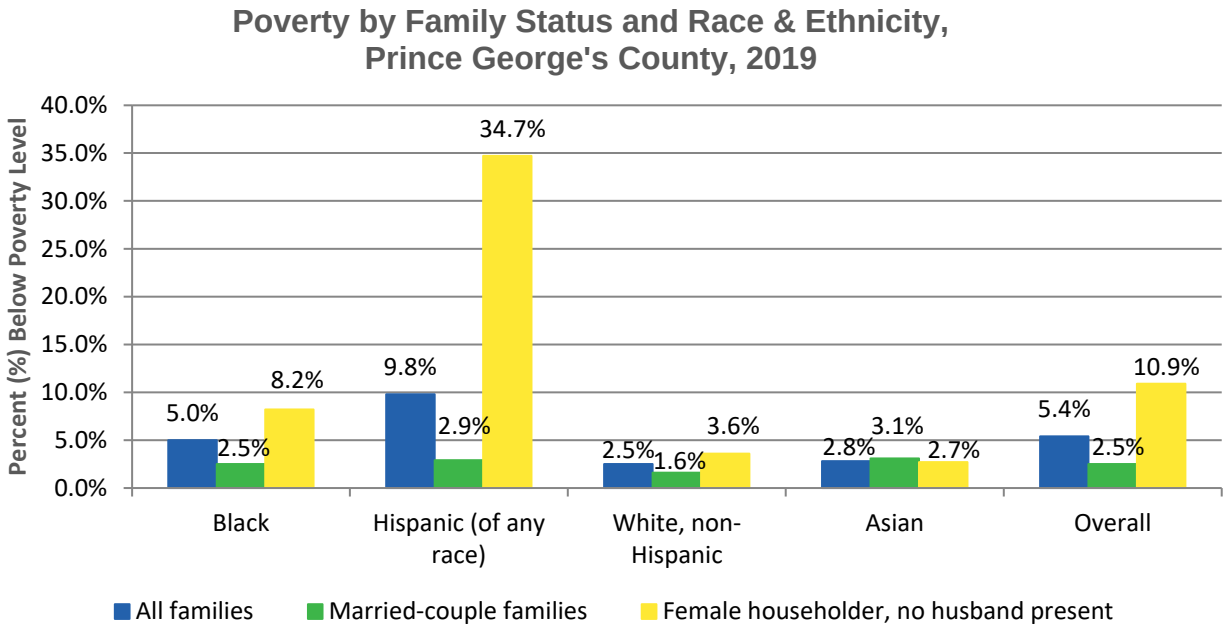
Data Source: American Community Survey 1-Year Estimates, 2019, Table S1701

Family Poverty Status in the Past 12 Months, 2019

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

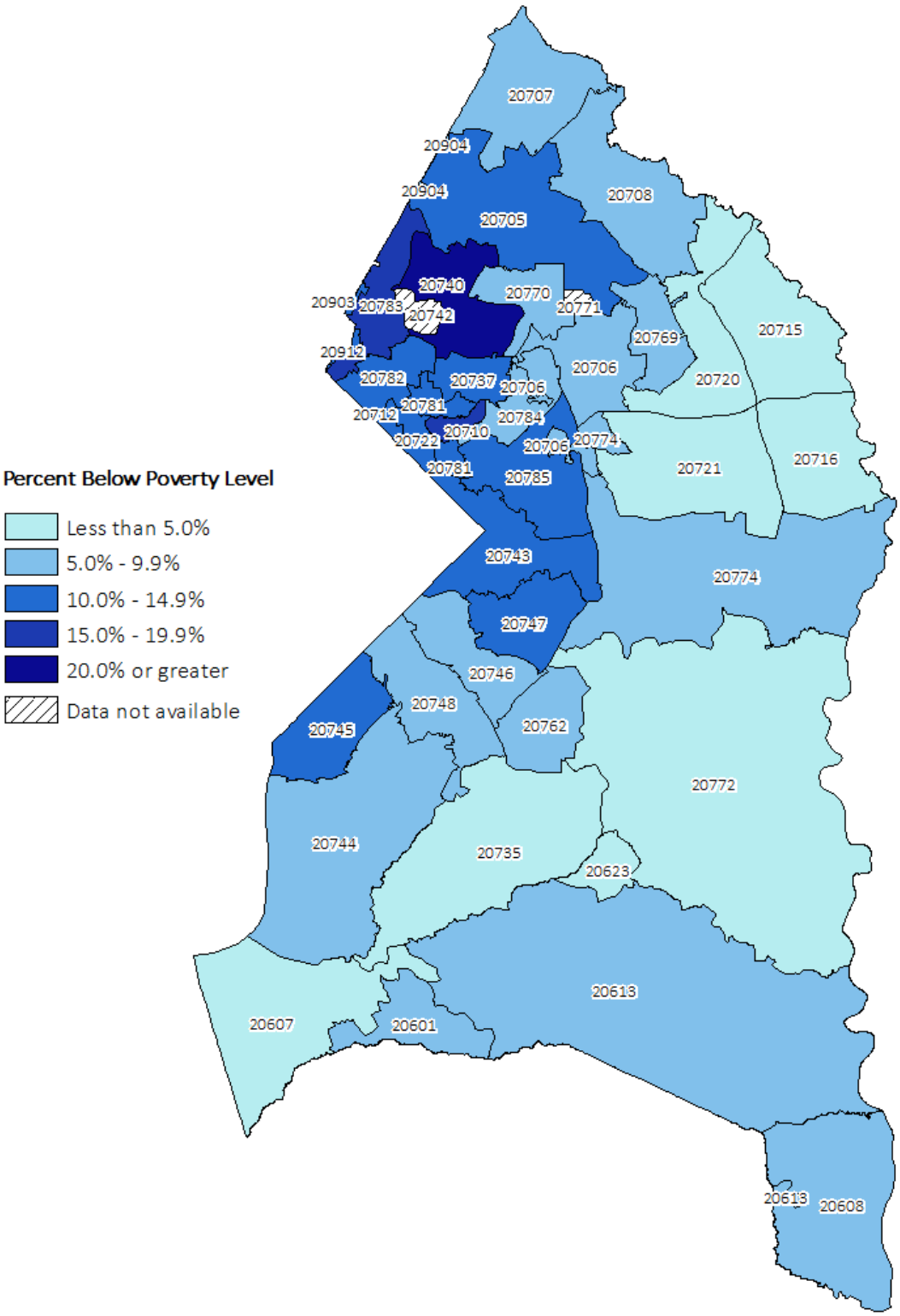
Data Source: 2019 American Community Survey 1-Year Estimates, Table S1702

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



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

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



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

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

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

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

Food Stamp/Supplemental Nutrition Assistance Program (SNAP) Benefits

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

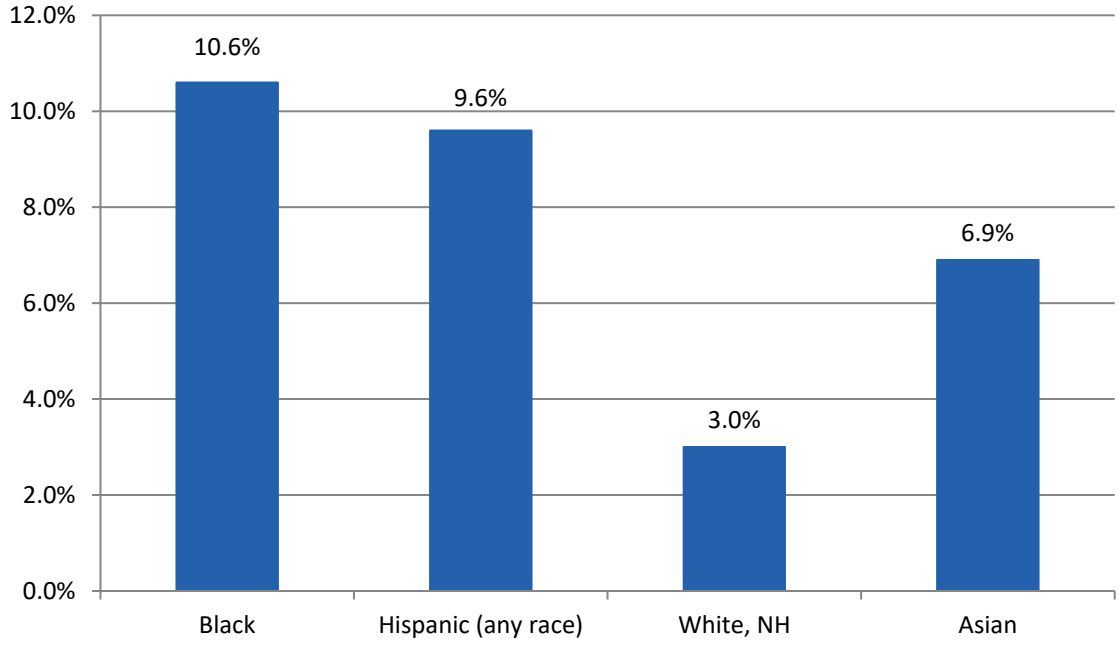
Percentage of Households with Food Stamp/SNAP Benefits, 2019

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

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

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

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



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

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

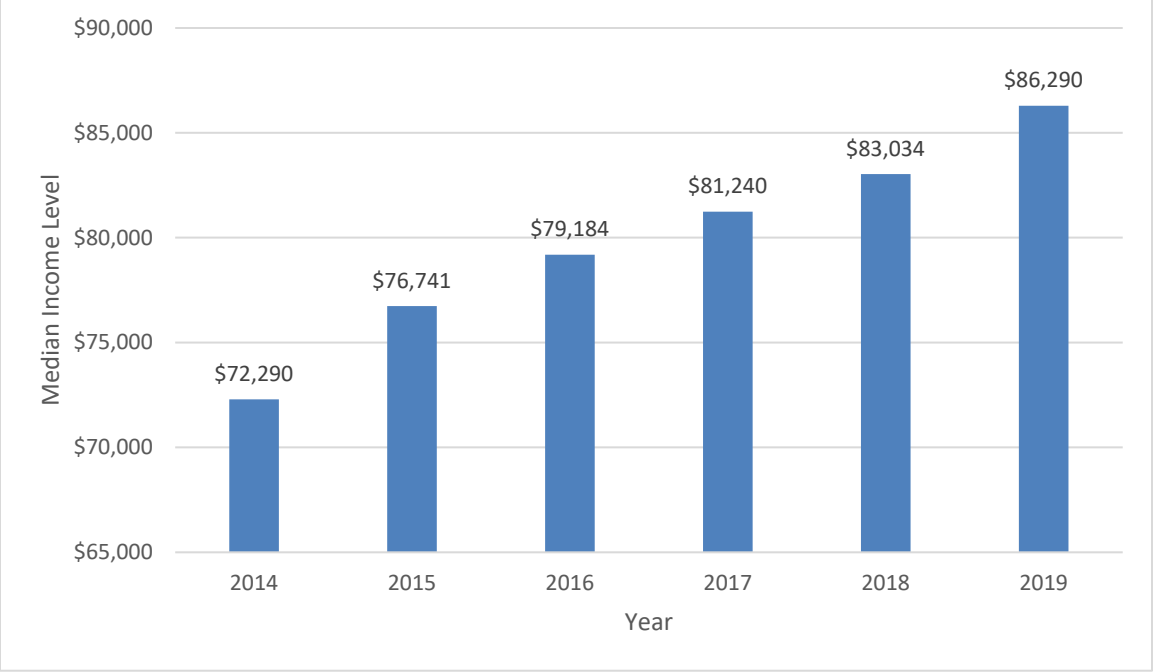
ZIP	Area	Percent of Households on SNAP
20601	Waldorf	6.7%
20607	Accokeek	4.9%
20608	Aquasco	3.4%
20613	Brandywine	5.5%
20623	Cheltenham	5.9%
20705	Beltsville	5.5%
20706	Lanham	8.5%
20707	Laurel	9.0%
20708	Laurel	12.8%
20710	Bladensburg	19.5%
20712	Mount Rainier	8.9%
20715	Bowie	3.4%
20716	Bowie	5.6%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

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

Income

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

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



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

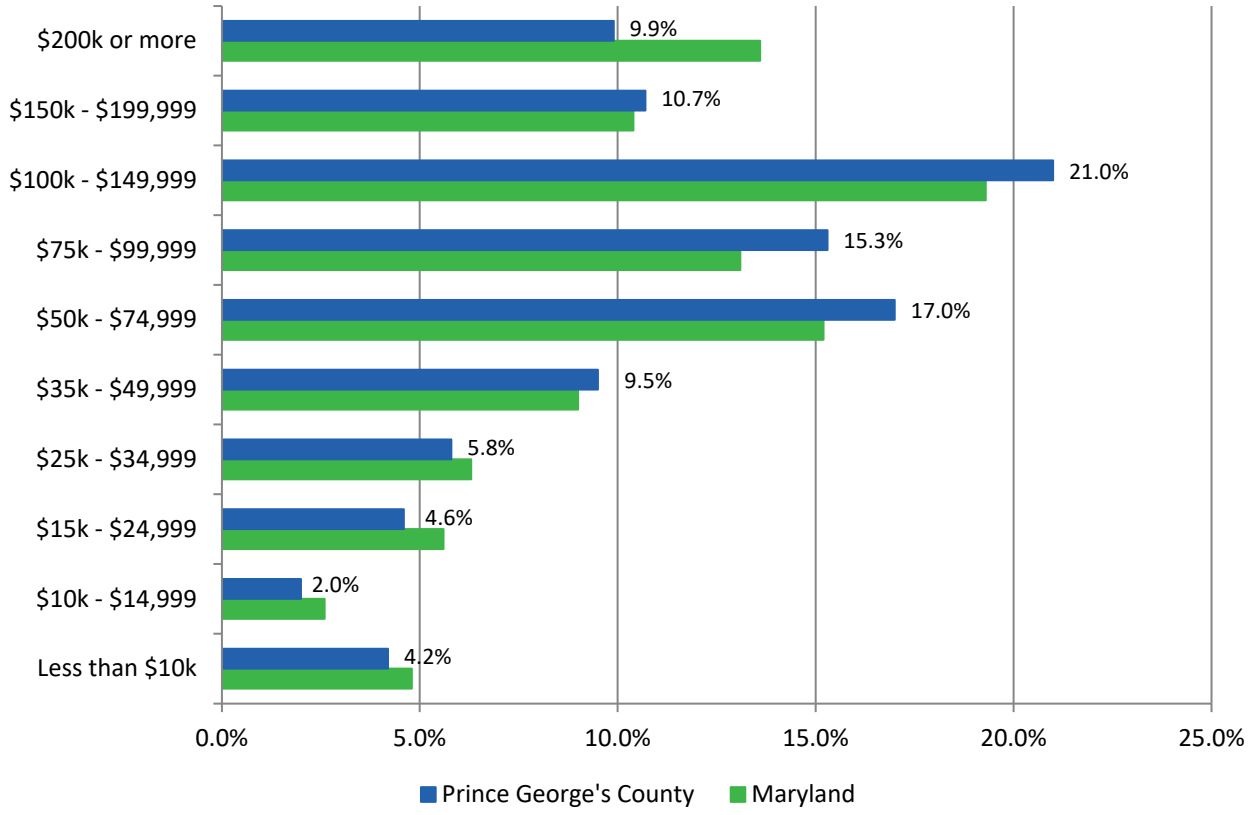
Income in the Past 12 Months (In 2019 Inflation-Adjusted Dollars)

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

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

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

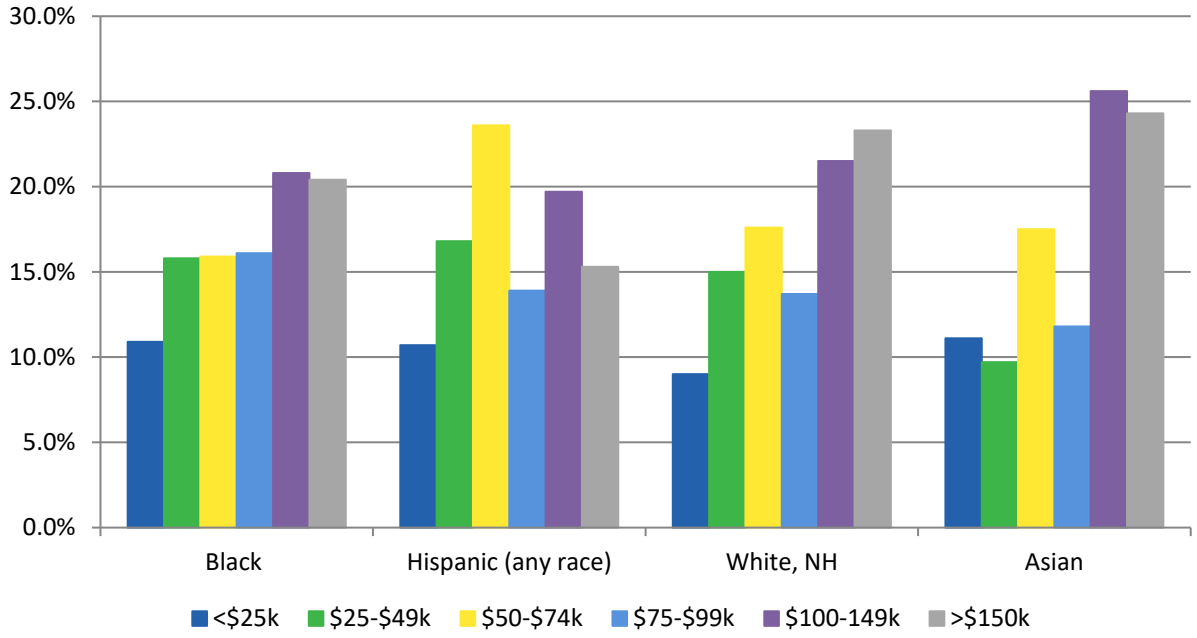
Household Income (In 2019 Inflation-Adjusted Dollars)



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

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

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



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

Disability

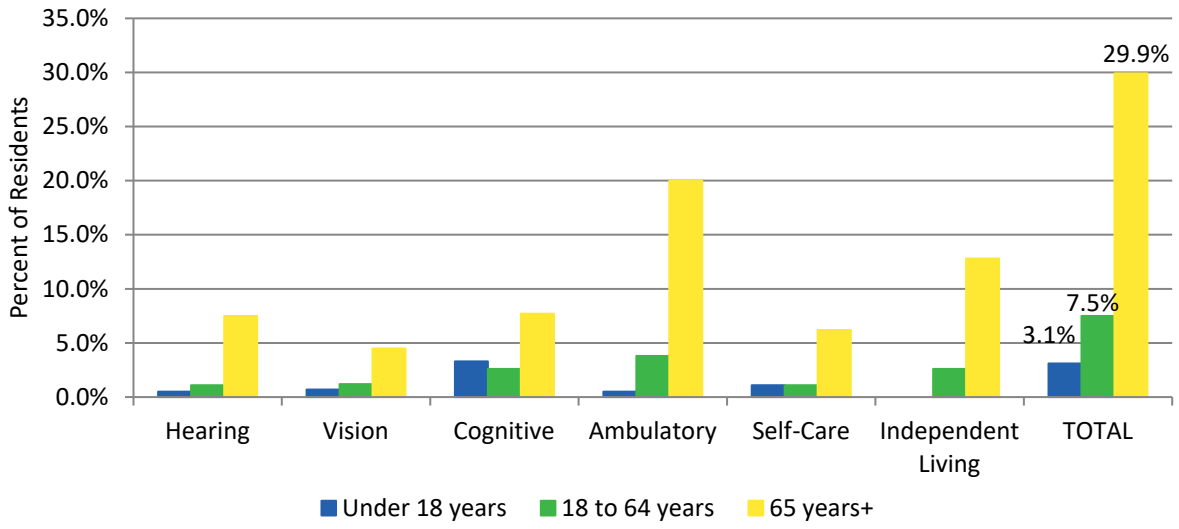
The definition of disability has changed over the past 40 years. In the 1960s and 1970s, a medical definition of disability was generally used, limited primarily to physical impairments. As time progressed, the definition expanded to include social and mental impairments as well as independence[4]. In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

Percentage of Residents with a Disability, 2019

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

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

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



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

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

Education

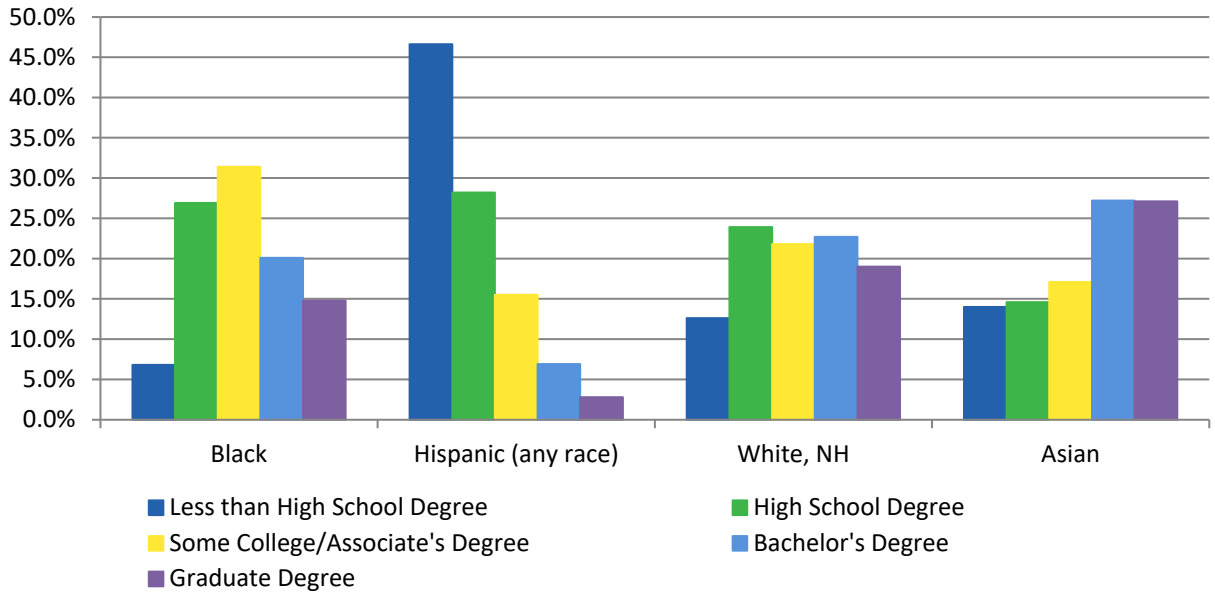
In 2019, about 87% of Prince George's County residents 25 years and older have at least a high school education, lower than Maryland (90.4%) and the U.S. (88.6%). One-third of county residents have at least a bachelor's degree or higher, similar to the country; however, this lags behind the state where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

Percentage of Residents 25 Years and Older by Education, 2019

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

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

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

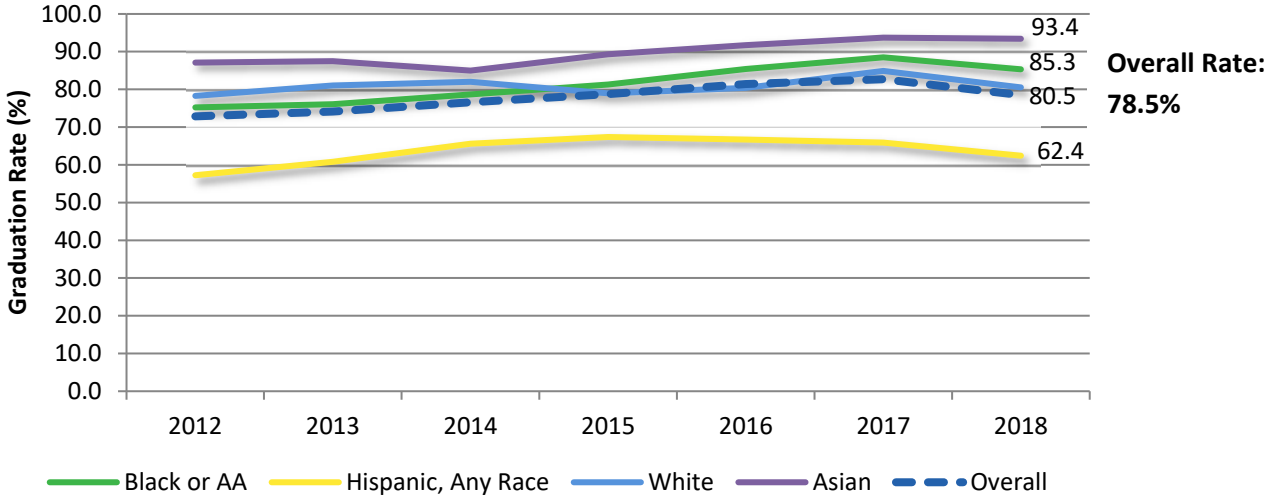


Data Source: 2019 American Community Survey 1-Year Estimates, Table B15002

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

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

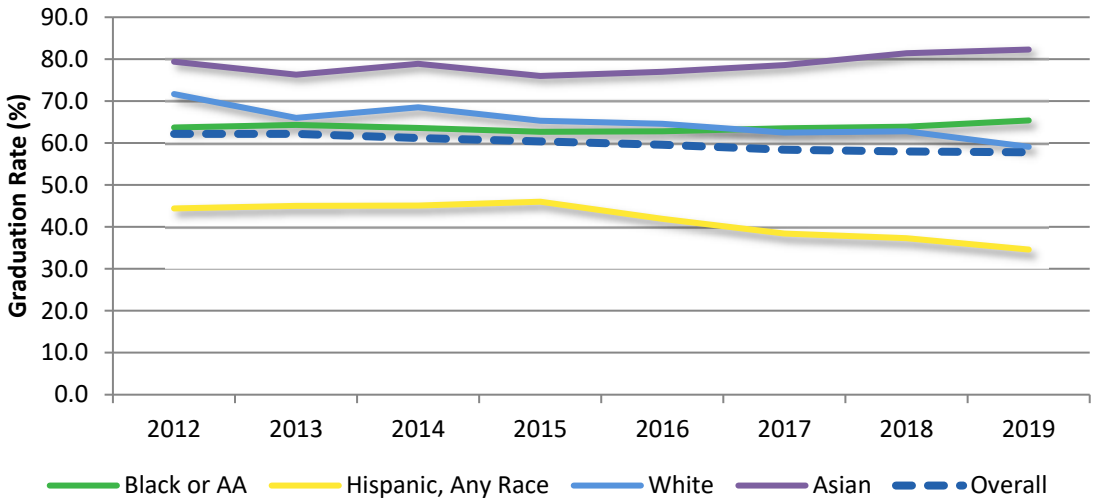
Graduation Rate by Race/Ethnicity, Prince George's County Public Schools



Data Source: 2012-2018 Maryland Report Card

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

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



Data Source: 2012-2019 Maryland Report Card

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

ZIP	Area	Percent Without High School or Equivalent
20601	Waldorf	6.8%
20607	Accokeek	6.5%
20608	Aquasco	9.2%
20613	Brandywine	7.1%
20623	Cheltenham	6.6%
20705	Beltsville	12.5%
20706	Lanham	15.0%
20707	Laurel	10.0%
20708	Laurel	9.3%
20710	Bladensburg	18.6%
20712	Mount Rainier	19.9%
20715	Bowie	4.4%
20716	Bowie	4.7%
20720	Bowie	5.0%
20721	Bowie	4.5%
20722	Brentwood	26.7%
20735	Clinton	6.2%
20737	Riverdale	35.3%
20740	College Park	15.0%
20743	Capitol Heights	13.7%
20744	Fort Washington	10.1%
20745	Oxon Hill	17.5%
20746	Suitland	10.2%
20747	District Heights	9.2%
20748	Temple Hills	8.0%
20762	Andrews Air Force Base	1.2%
20769	Glenn Dale	7.0%
20770	Greenbelt	9.6%
20772	Upper Marlboro	5.7%
20774	Upper Marlboro	4.3%
20781	Hyattsville	19.6%
20782	Hyattsville	23.1%
20783	Hyattsville	41.9%
20784	Hyattsville	21.8%
20785	Hyattsville	11.4%
20903	Silver Spring	34.9%
20904	Silver Spring	9.6%
20912	Takoma Park	15.9%

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

Employment

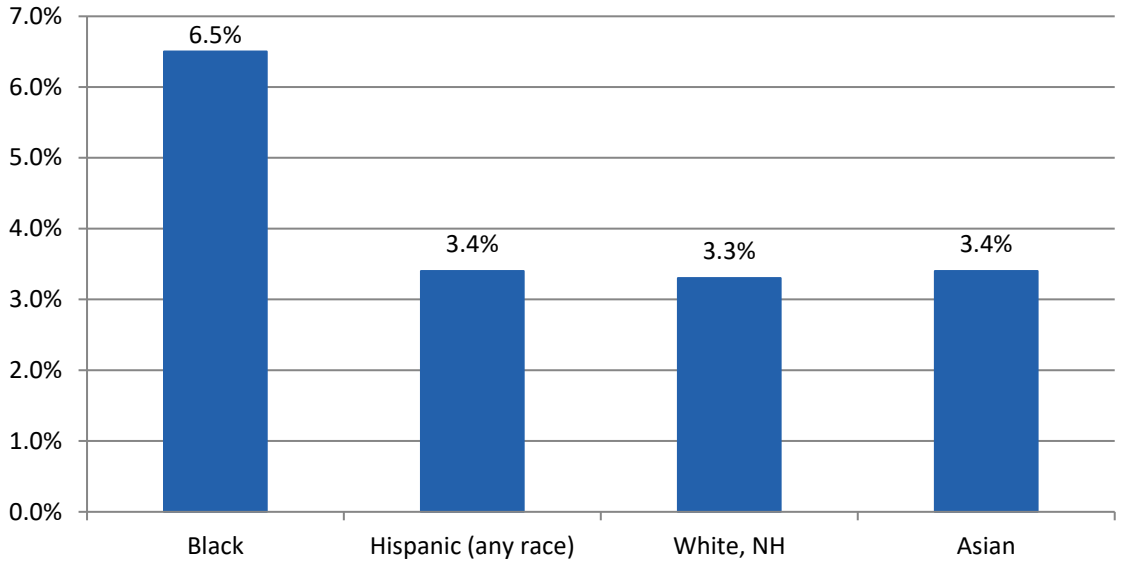
Unemployment in Prince George's County has decreased considerably; in 2014, an estimated 9.1% of residents were unemployed compared to 5.5% in 2019. However, the unemployment rate for the county remains slightly higher than Maryland (4.5%) and the U.S. (4.5%). The county unemployment rate varies by education,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

Unemployment Rate for Residents 16 Years and Older, 2019

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

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

Unemployment Rate, Prince George's County, 2019



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

Housing

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

Housing Characteristics, 2019

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

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

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

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

Fair Market Rent

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

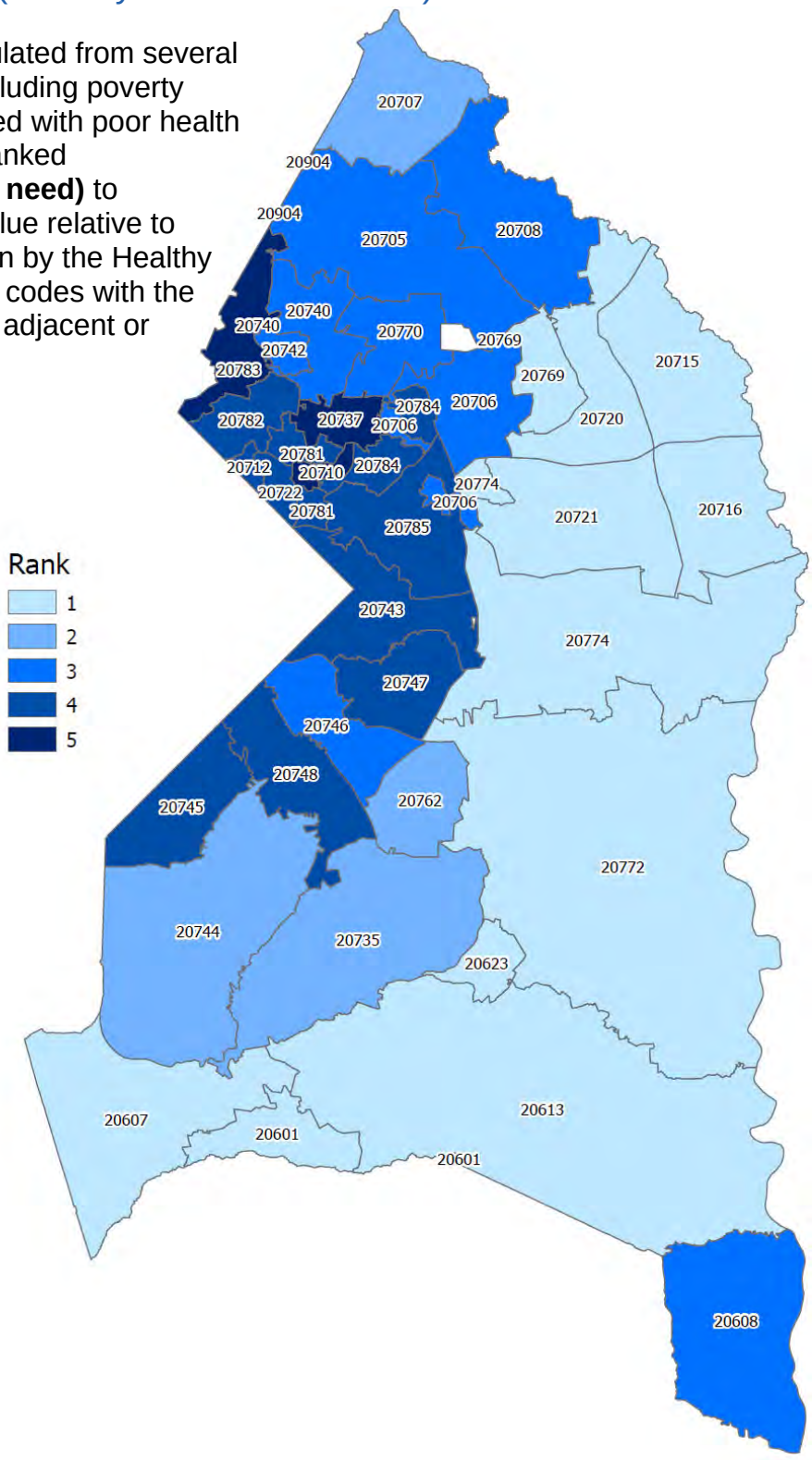
Fair Market Rent, 2021

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

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

2021 Health Equity Index (formerly SocioNeeds Index)

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



[5] www.pgchealthzone.org


health
INDICATORS

HEALTH INDICATORS REPORT

Introduction

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

Methods

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

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

Limitations

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

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

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

Definitions

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

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

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

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

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

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

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

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

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

Racial and Ethnic Groups:

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

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

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

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

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

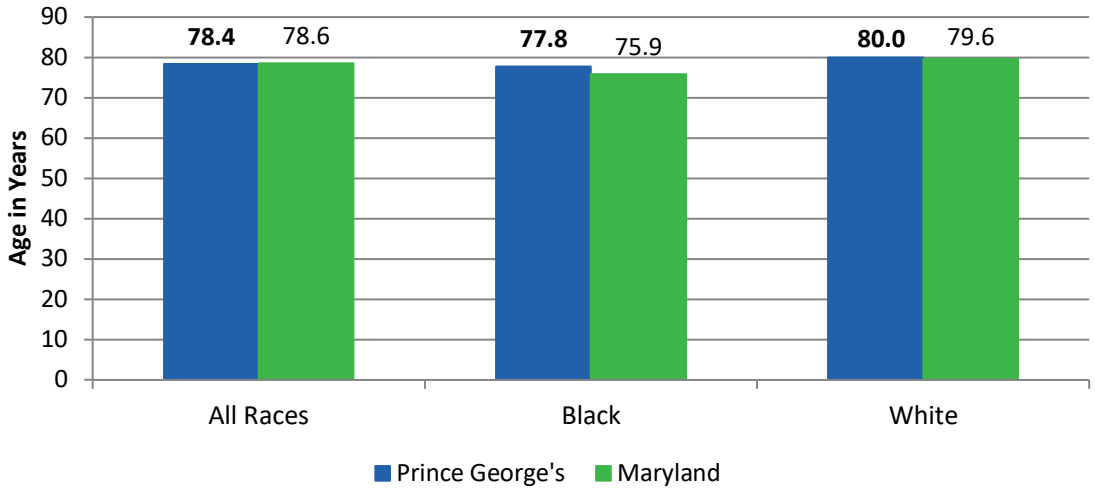
Table of Contents

Health Status Indicators

Life Expectancy

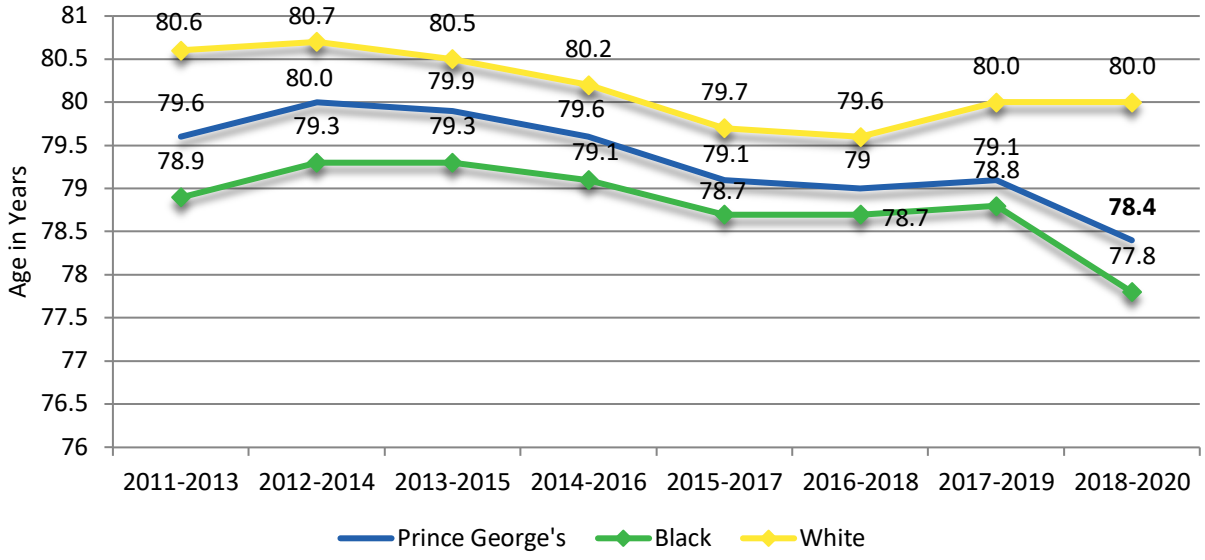
As of 2020, a Prince George's County resident is expected to live 78.4 years, similar to the 78.6 years for any Maryland resident. Life expectancy in the county and state has declined; at its peak the life expectancy for a county resident was 80.0 in 2012-2014. This is also a national trend, with a life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

Life Expectancy at Birth by Race, 2018-2020



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

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



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

Mortality

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

Leading Causes of Death, 2018-2020

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

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

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

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

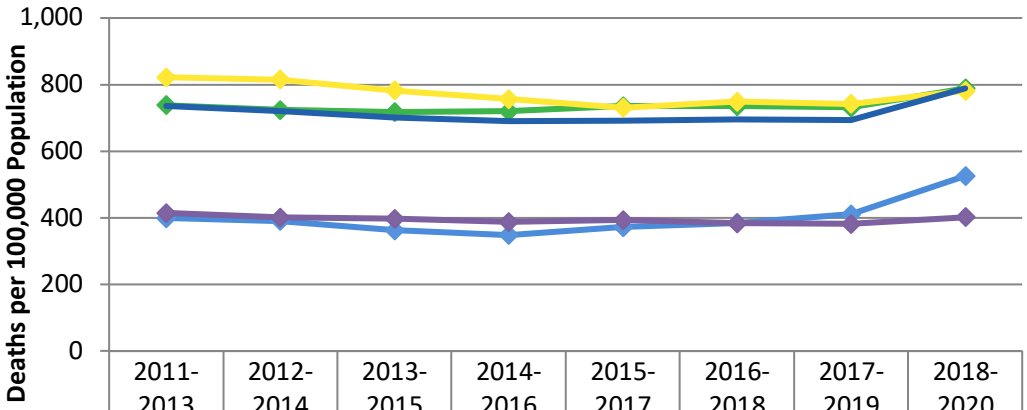
Age-Adjusted Death Rate per 100,000 by Race, Ethnicity, and Sex, 2018-2020

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

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

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

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

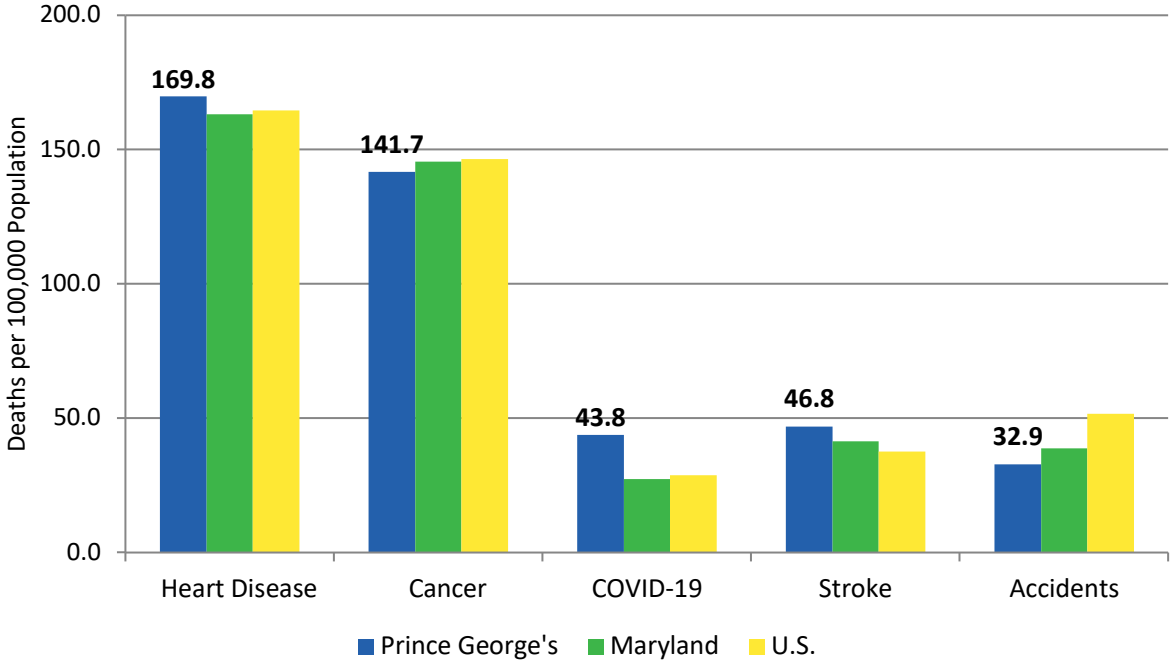


	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Black, NH	738.2	723.9	717.6	720.4	735.5	735.5	731.6	788.8
Hispanic	398.8	390.8	363.0	348.0	372.1	384.9	410.5	525.7
White, NH	822.2	815.1	782.1	756.4	730.4	749.2	741.8	781.6
Asian, NH	414.8	400.8	397.0	387.8	393.0	383.9	382.2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

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

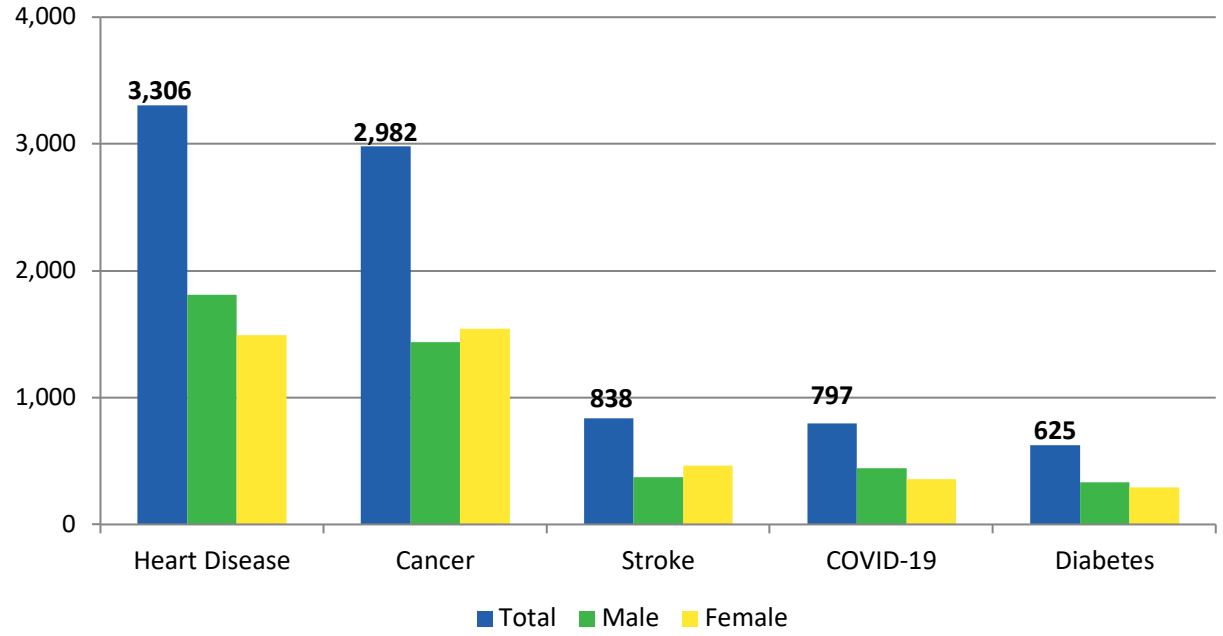
Out of the five leading causes of death in Prince George's, the county has a higher age-adjusted death rate compared to Maryland and the U.S. for heart disease, COVID-19, and stroke.

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



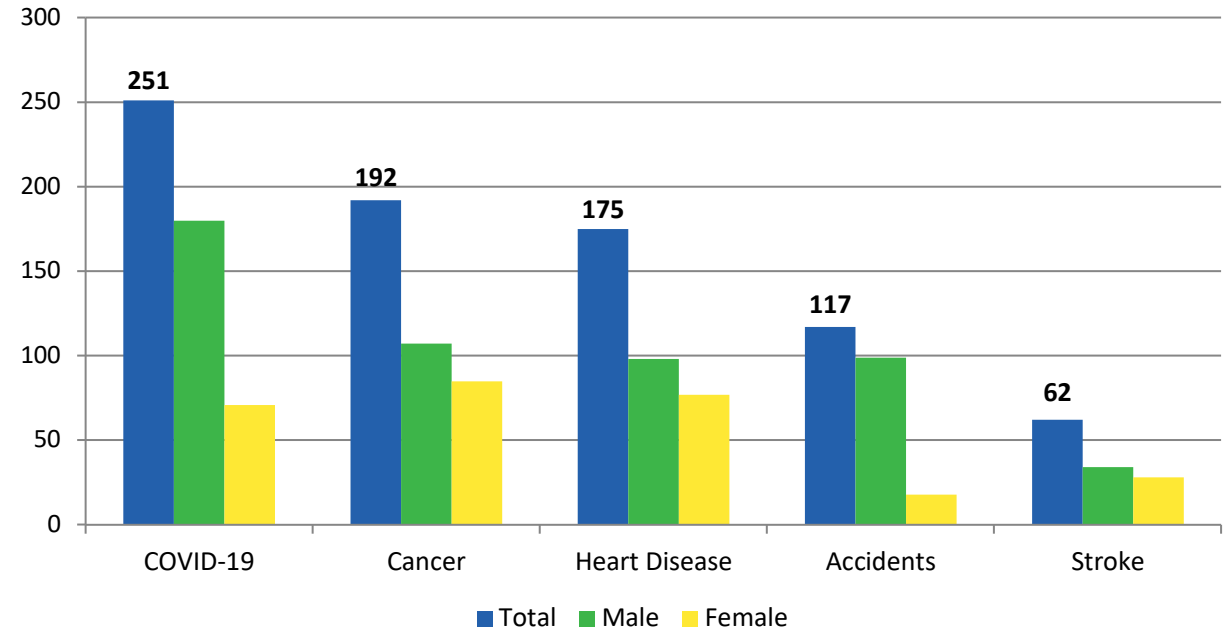
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

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



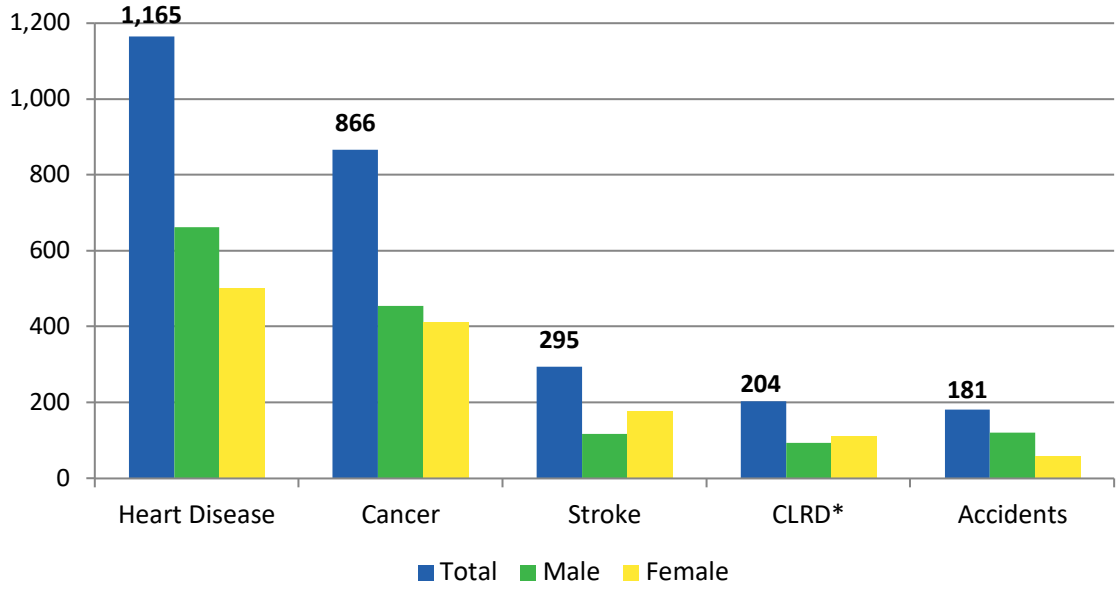
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

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



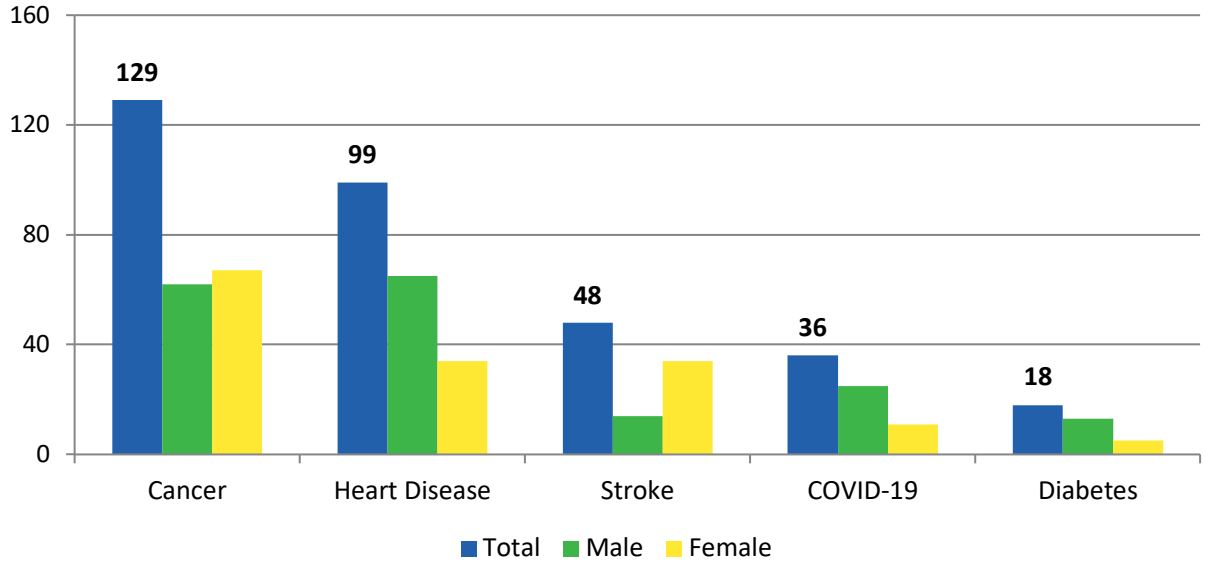
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

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



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

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



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

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

Access to Health Care

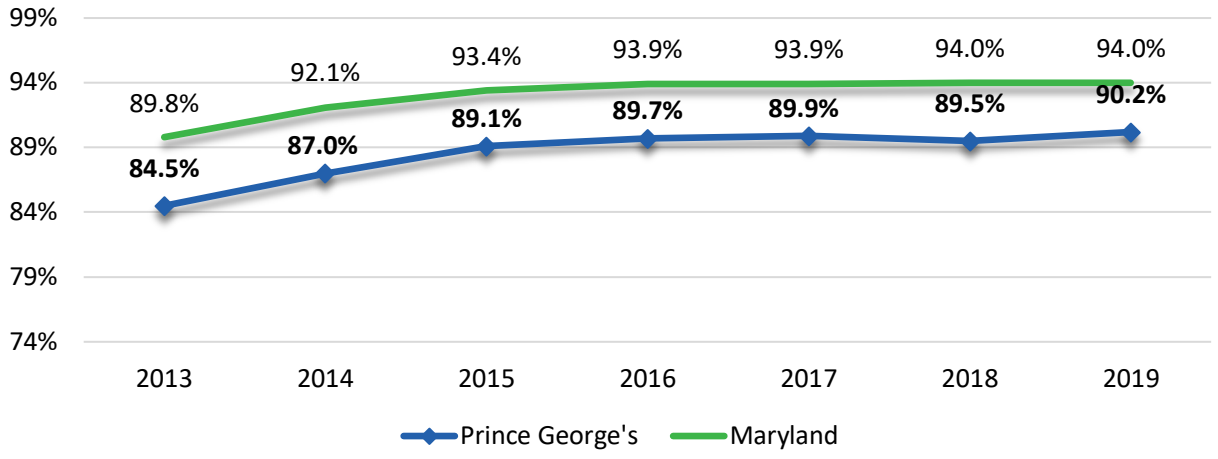
The percentage of residents with health insurance increased in Prince George's County following the implementation of the major provisions of the Affordable Care Act (ACA) in 2014. However, an estimated 92,790 residents remained uninsured as of 2020. By age, residents ages 26 to 44 years were least likely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

Residents with Health Insurance, 2020

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

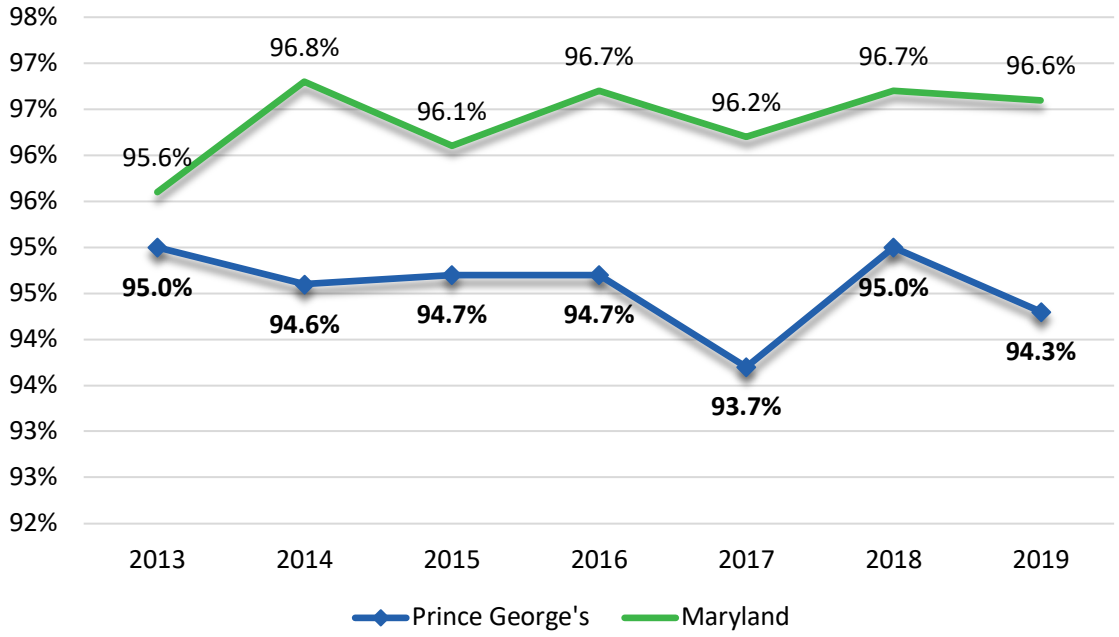
Data Source: 2016-2020 American Community Survey 5-Year Estimates, Table S2701

Residents with Health Insurance, 2013-2019



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

Children with Health Insurance, 2013-2019



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

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

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

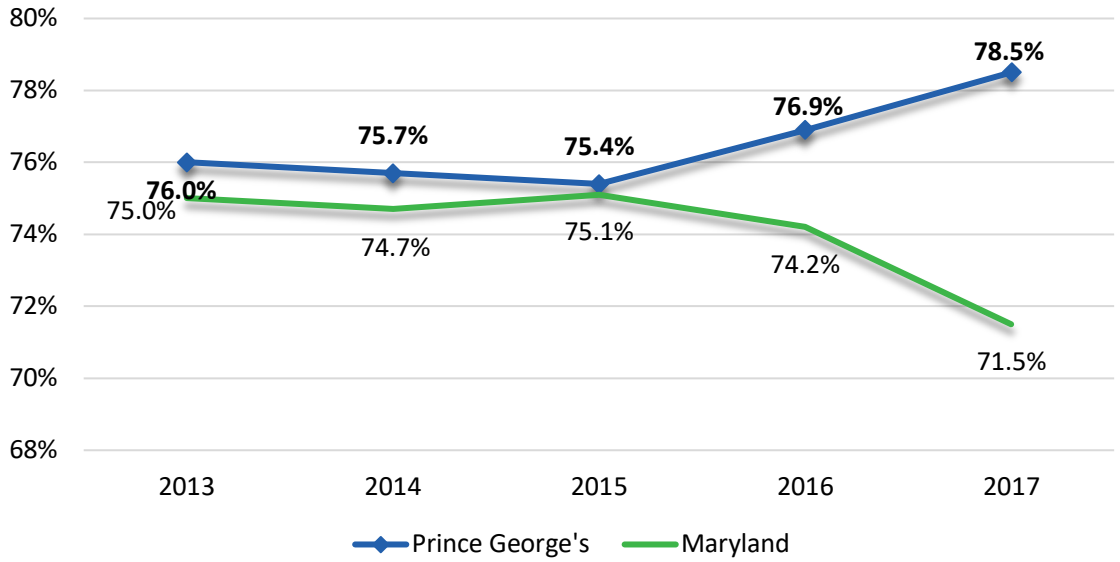
Demographic	Prince George's	Maryland
Race/Ethnicity		
Black, non-Hispanic	81.4%	79.0%
Hispanic	70.9%	62.6%
White, non-Hispanic	72.8%	67.4%
Sex		
Male	74.7%	67.6%
Female	82.9%	75.2%
Age Group		
18 to 44 Years	72.2%	63.3%
45 to 64 Years	83.6%	76.9%
Over 65 Years	89.2%	87.5%
Total	**78.5%**	**71.5%**

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

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

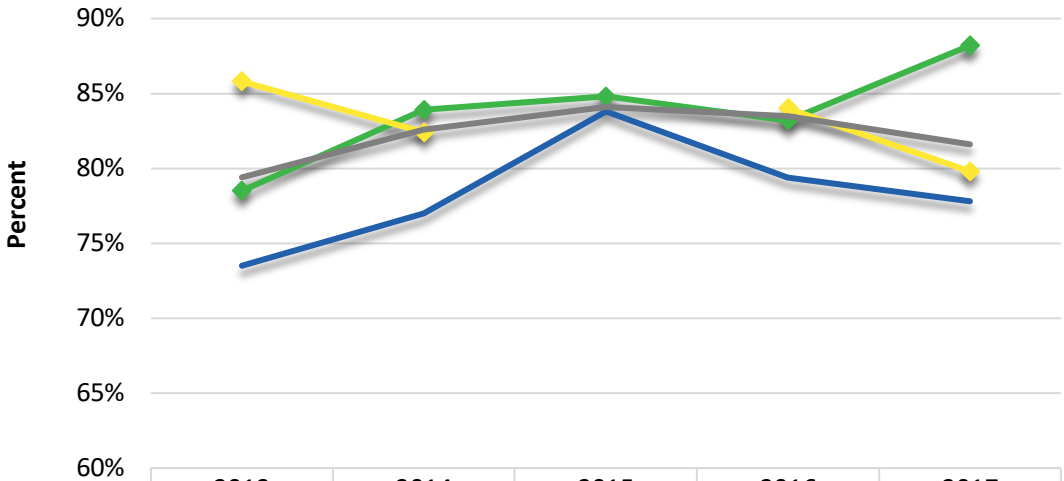
a routine checkup (81.4%) within the county. Due to the Maryland Health Department cyberattack more updated data was not available.

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



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

Residents with a Usual Primary Care Provider, 2013-2017



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

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

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

Resident to Provider Ratios

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

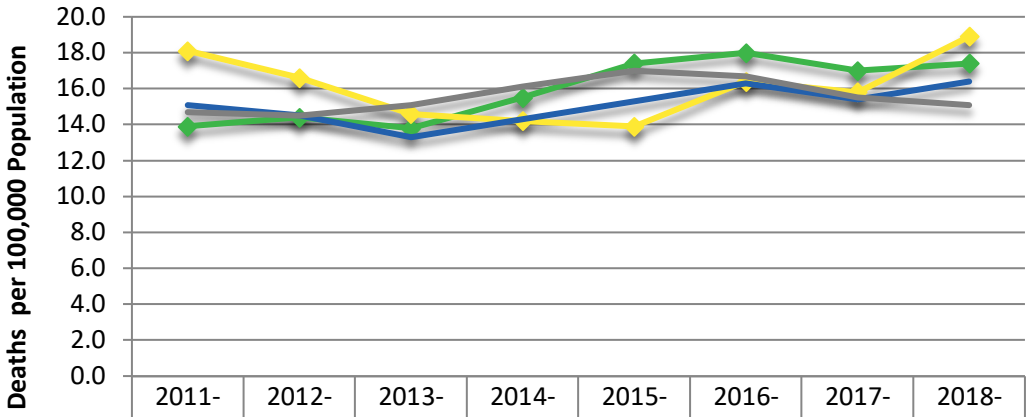
Data Source: 2022 County Health Rankings, www.countyhealthrankings.org

Diseases and Conditions

Alzheimer's Disease

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

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



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

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

Cancer

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

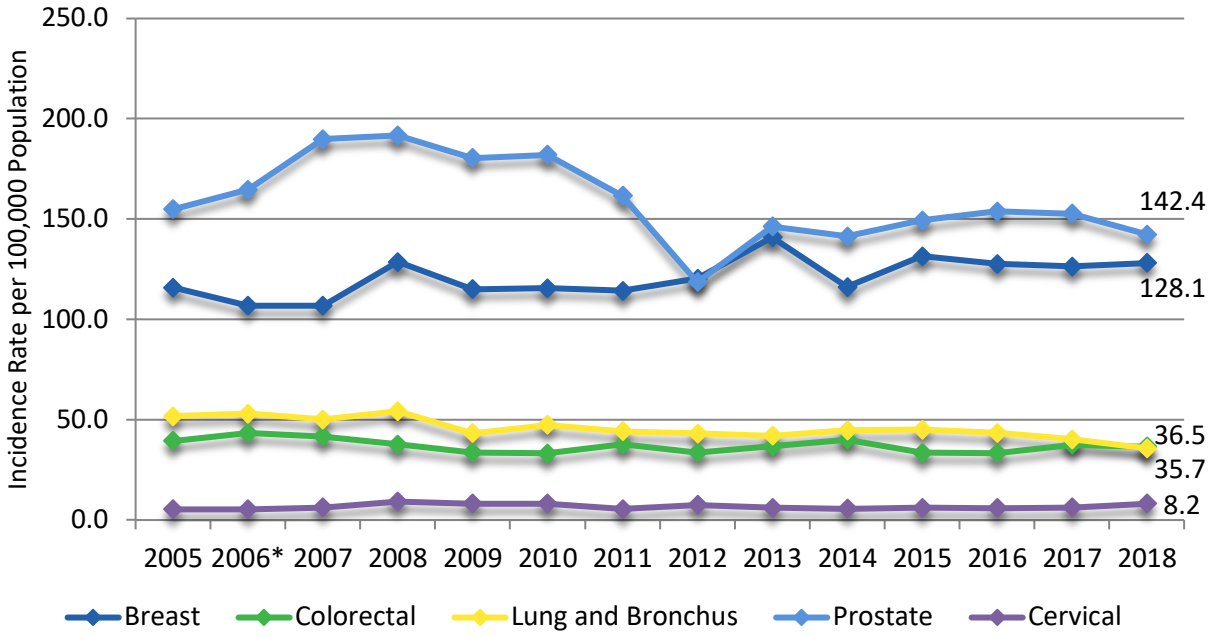
Overall, Prince George's County age-adjusted cancer incidence rate is less than Maryland and the U.S. for most leading types of cancer. Prostate cancer incidence remained higher in Prince George's County (147.9.4 cases per 100,000) compared to Maryland (126.3 cases per 100,000) and the U.S. (106.2) cases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

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

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

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

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



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

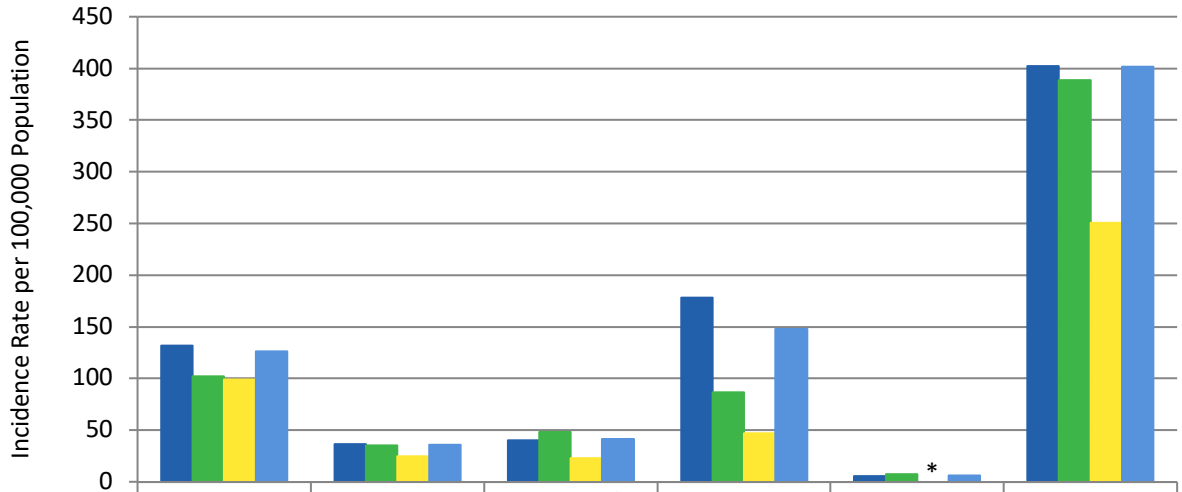
Data Source: Maryland Department of Health, Annual Cancer Reports

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

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

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

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

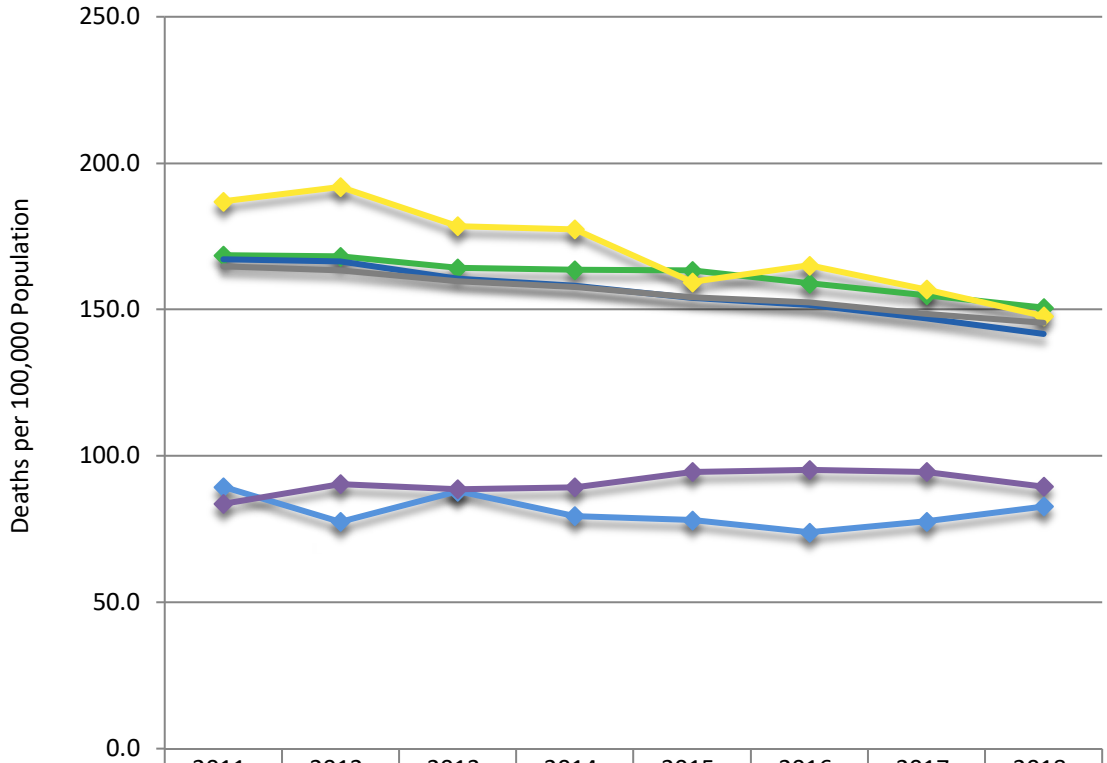


	Breast (Female)	Colorectal	Lung and Bronchus	Prostate	Cervical	All Sites
Black	131.6	36.3	39.9	178.0	5.6	402.1
White	102.3	35.2	48.0	86.8	7.6	388.8
Other	98.8	24.8	22.9	47.2	*	250.4
All Races	125.9	36.1	41.6	147.9	6.4	401.6

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

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

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



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

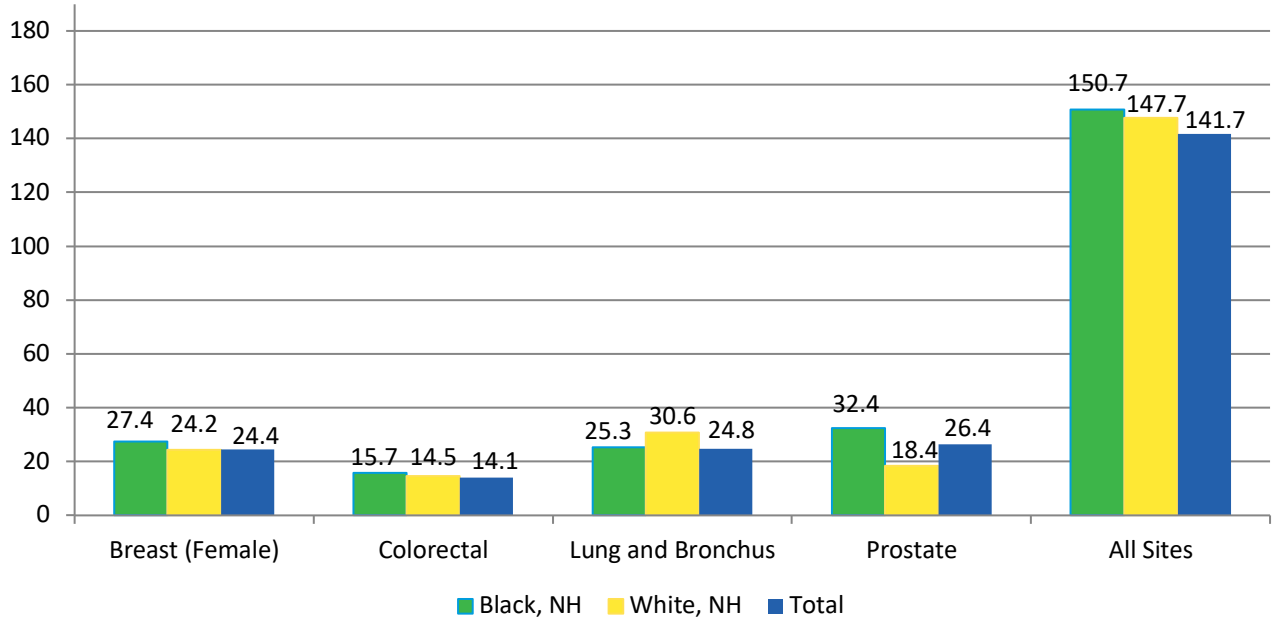
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

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

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

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

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



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

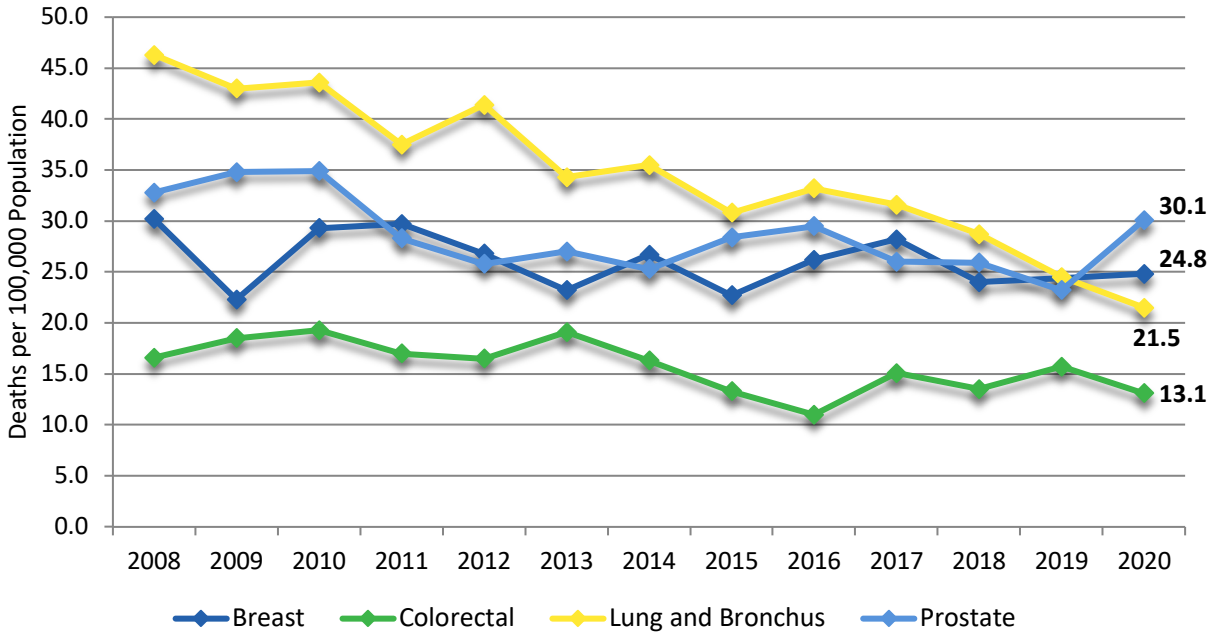
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

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

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

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

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

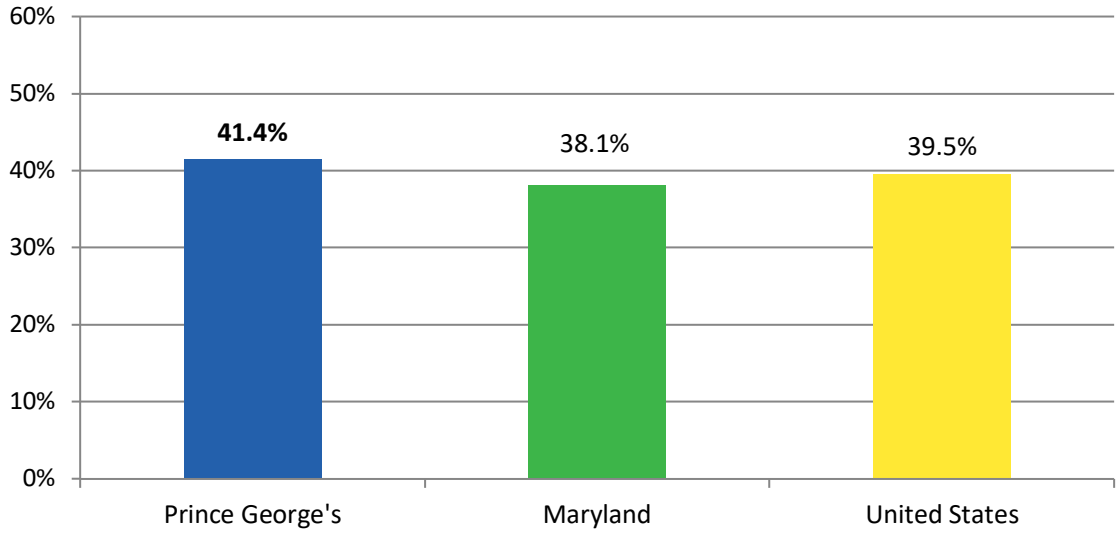


Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

Cancer Screening

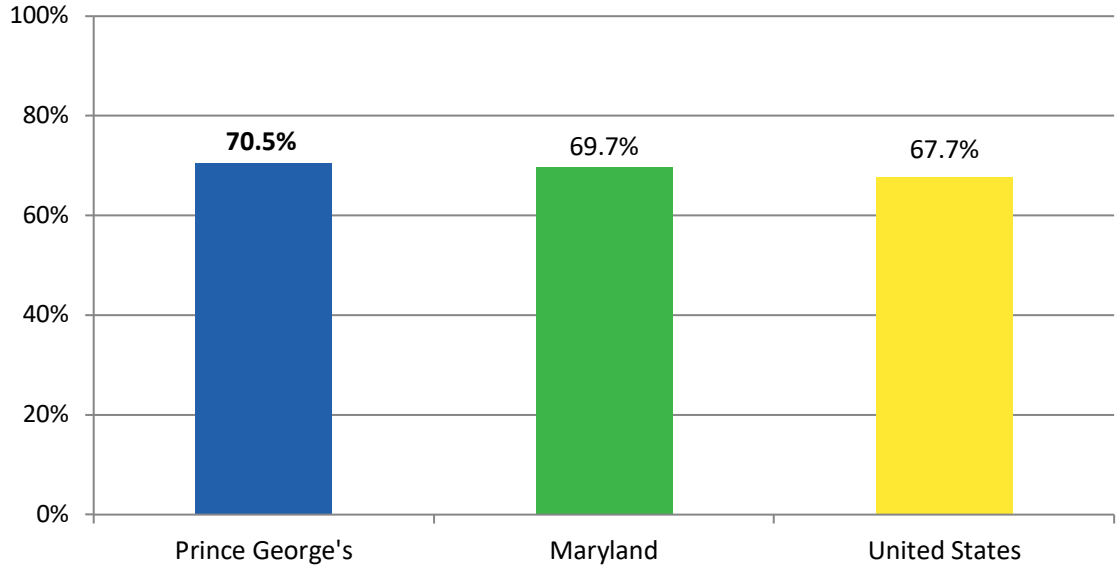
In 2016, Prince George's County had slightly higher cancer screening rates compared to the state and nation for prostate, colorectal, and breast cancers, and slightly lower screening rate for cervical cancer. Updated Maryland Behavioral Risk Factor Surveillance System data is not available due to the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

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



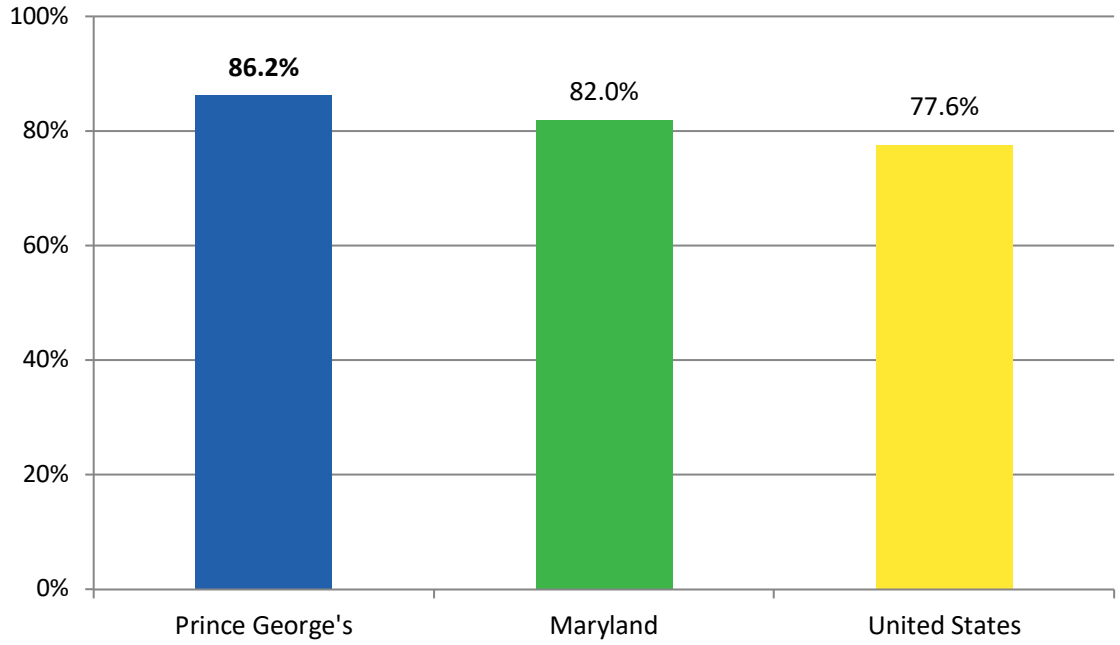
Data Source: 2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

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



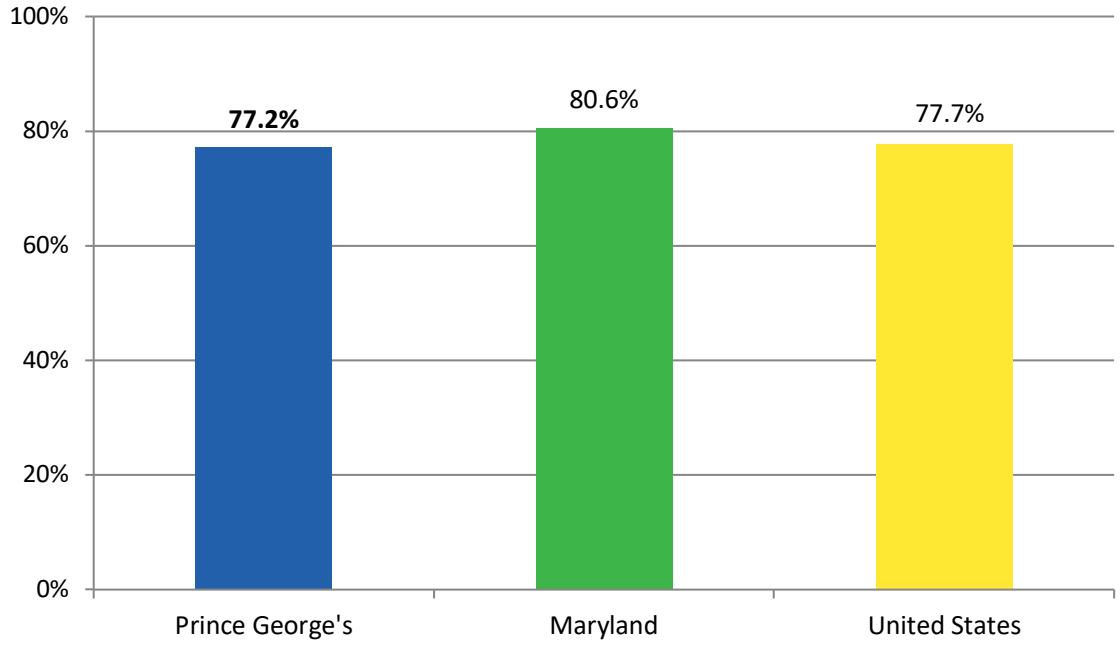
Data Source: 2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

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



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

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



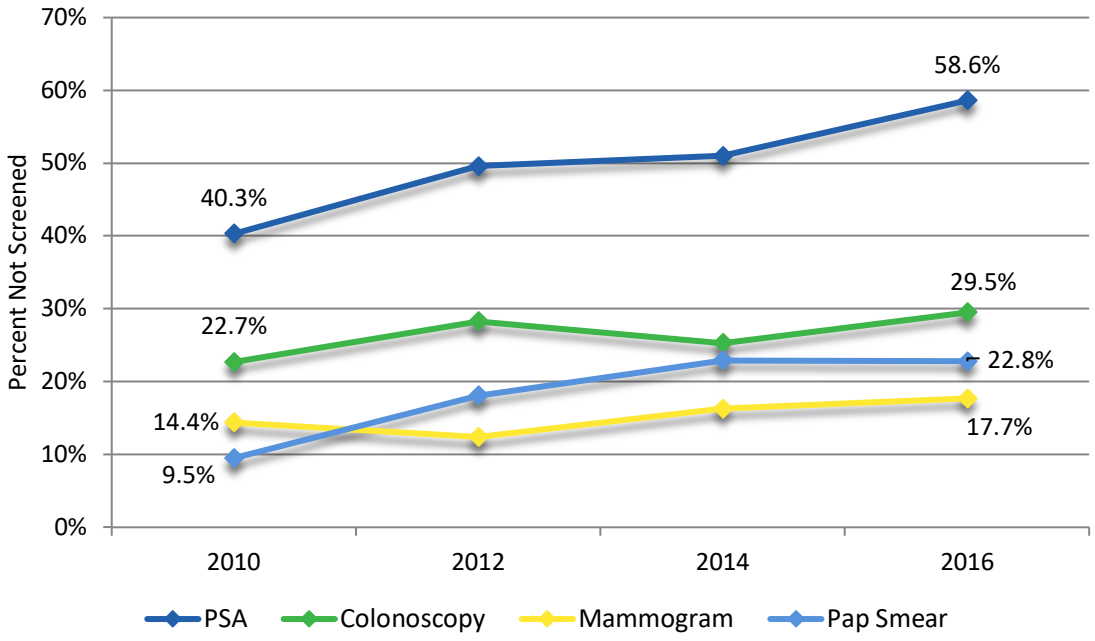
Data Source: 2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

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

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

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

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



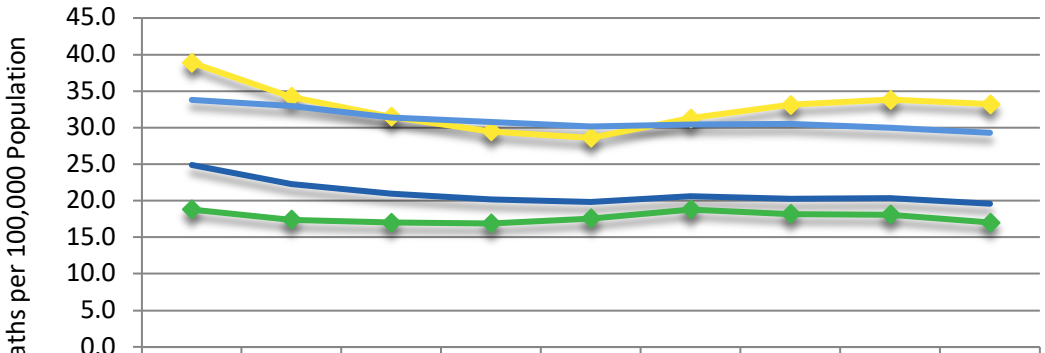
Data Source: 2010-2016 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Chronic Lower Respiratory Disease (CLRD)

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

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

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

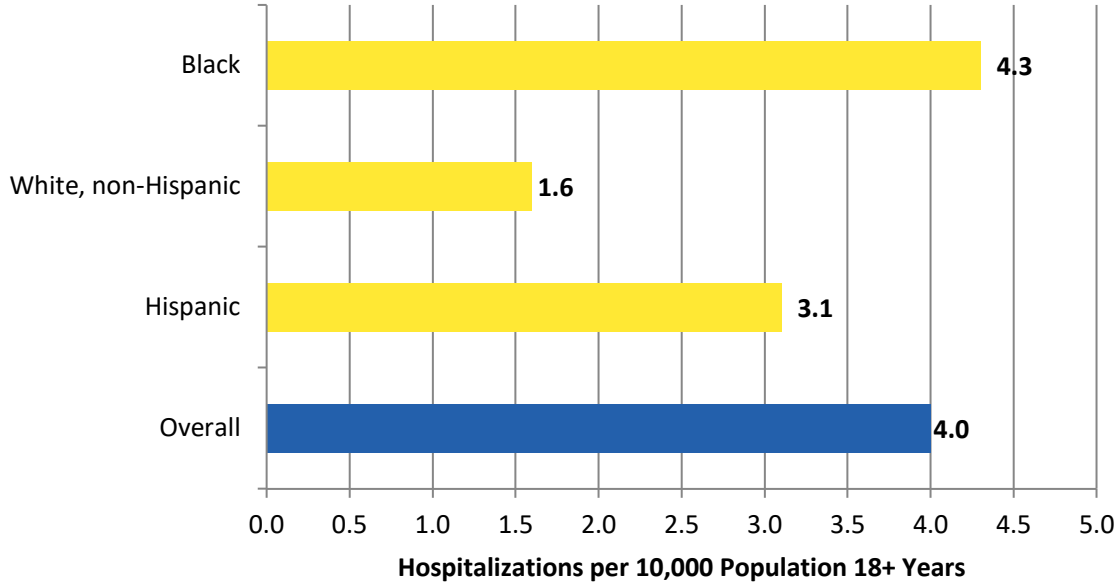


	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
PGC Black, NH	18.8	17.4	17.0	16.9	17.6	18.8	18.2	18.1	17.0
PGC White, NH	38.9	34.2	31.5	29.5	28.6	31.3	33.1	33.8	33.2
PGC	24.9	22.3	21.0	20.2	19.8	20.6	20.3	20.4	19.6
Maryland	33.8	33.0	31.4	30.8	30.2	30.4	30.5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

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

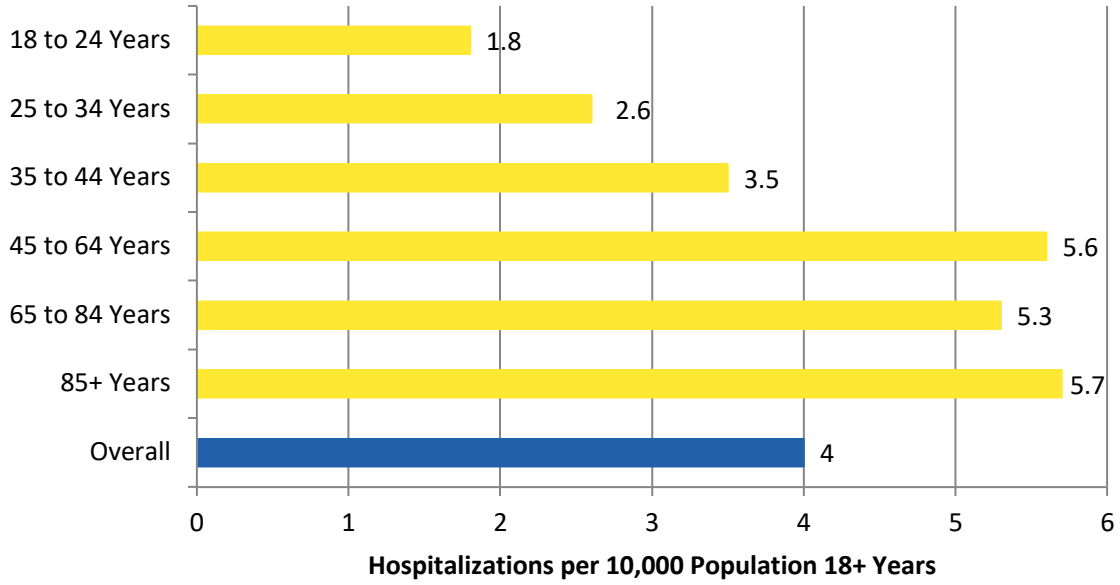
Adult Asthma

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



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

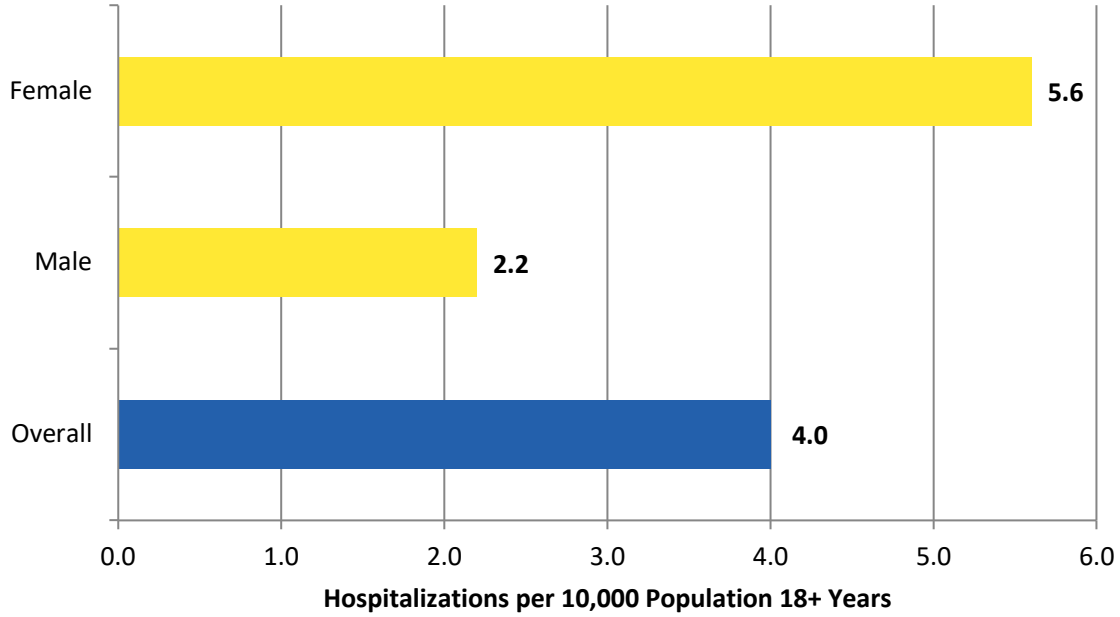
Age-Adjusted Hospital Inpatient* Visit Rate due to Adult Asthma by Age Group, Prince George's County, 2017-2019



* Includes visits to only Maryland hospitals

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

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

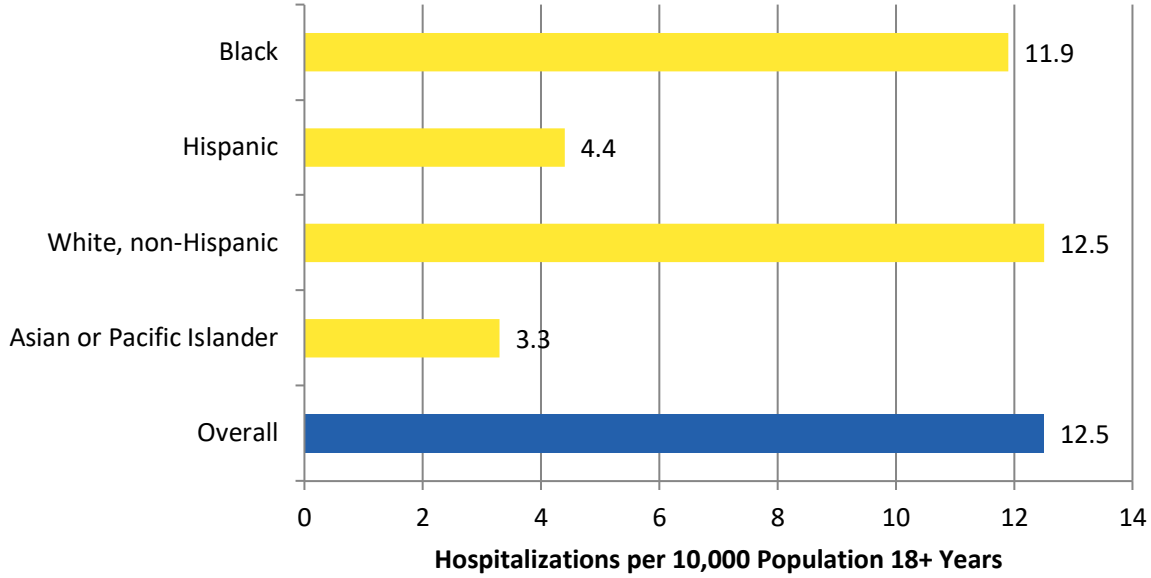


* Includes visits to only Maryland hospitals

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

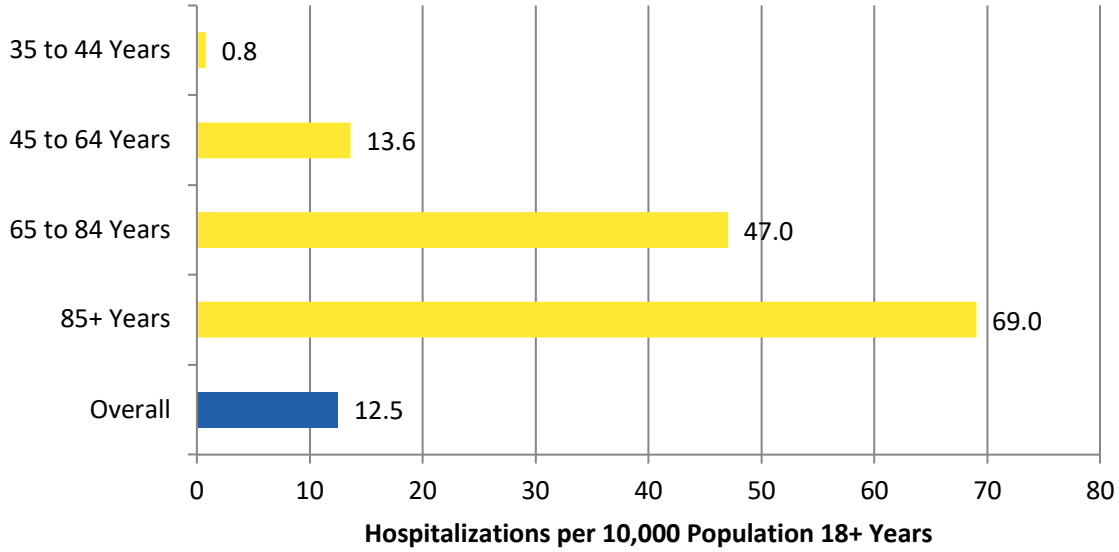
Chronic Obstructive Pulmonary Disease (COPD)

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



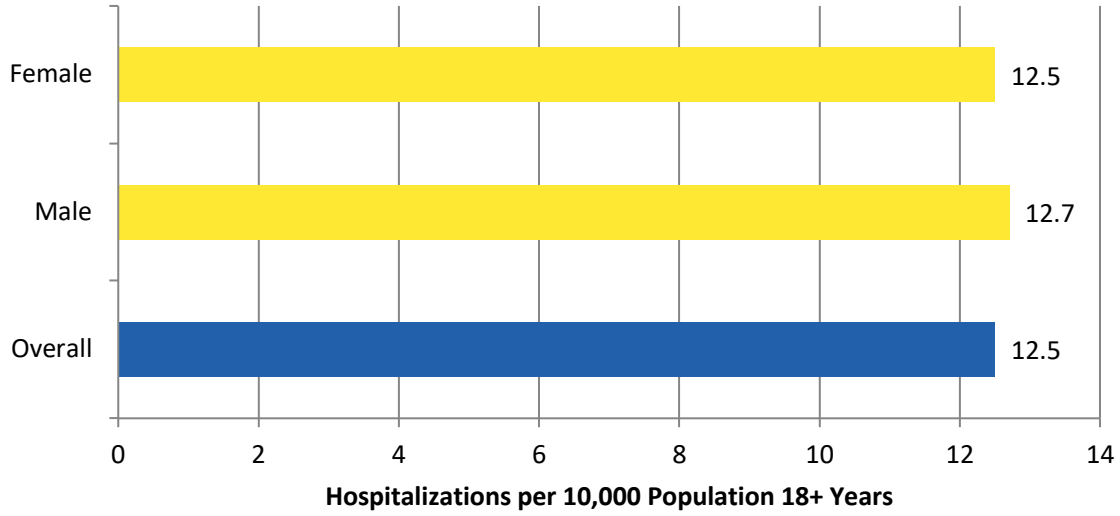
* Includes visits to only Maryland hospitals
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

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



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

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



* Includes visits to only Maryland hospitals

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

Diabetes

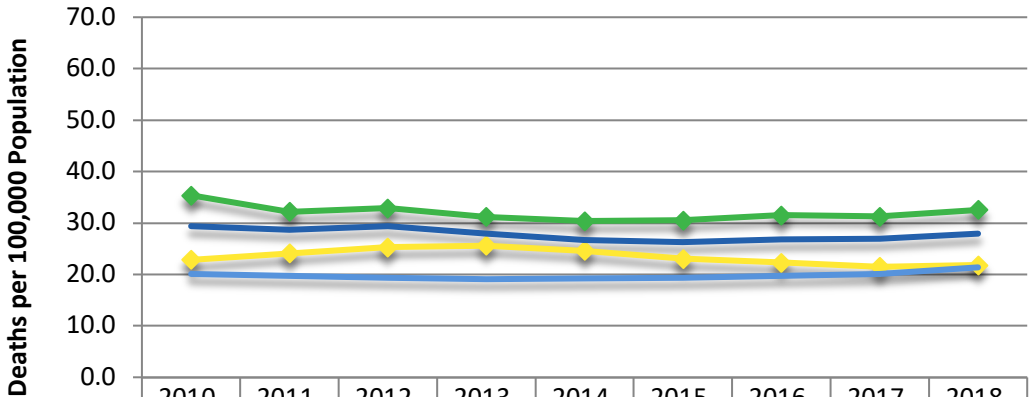
Overview	
What is it?	Diabetes is a condition in which the body either doesn't make enough of a hormone called insulin or can't use its own insulin, which is needed to process glucose (sugar) (Source: CDC).
Who is affected?	13.8% (97,685) of adults in the county are estimated to have diabetes. (2019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

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

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

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

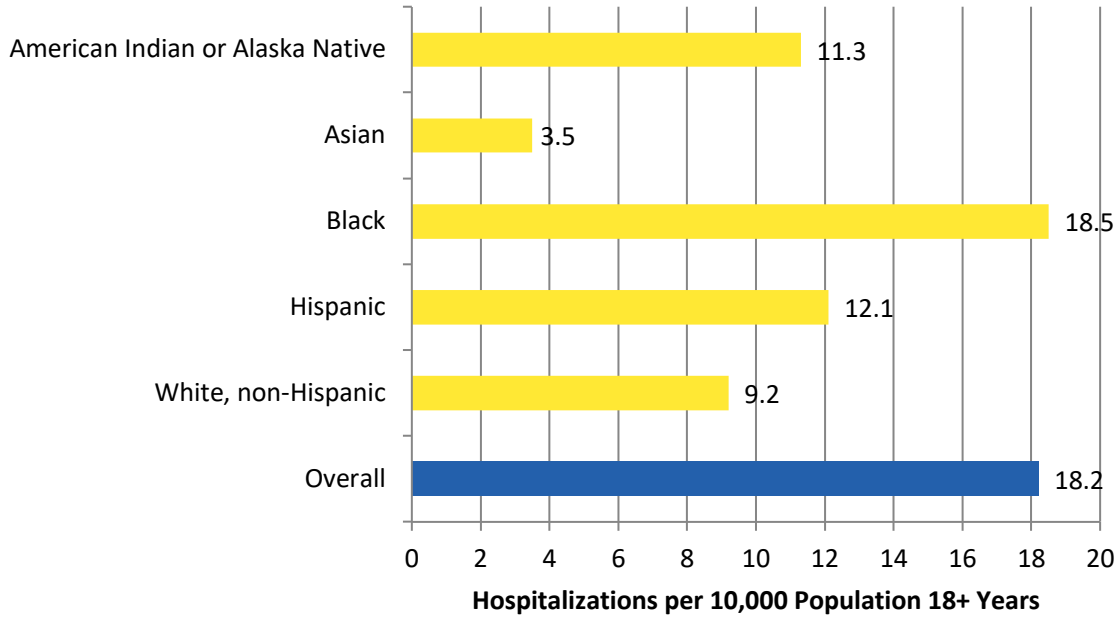
Age-Adjusted Death Rate per 100,000 for Diabetes, 2010-2020



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

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

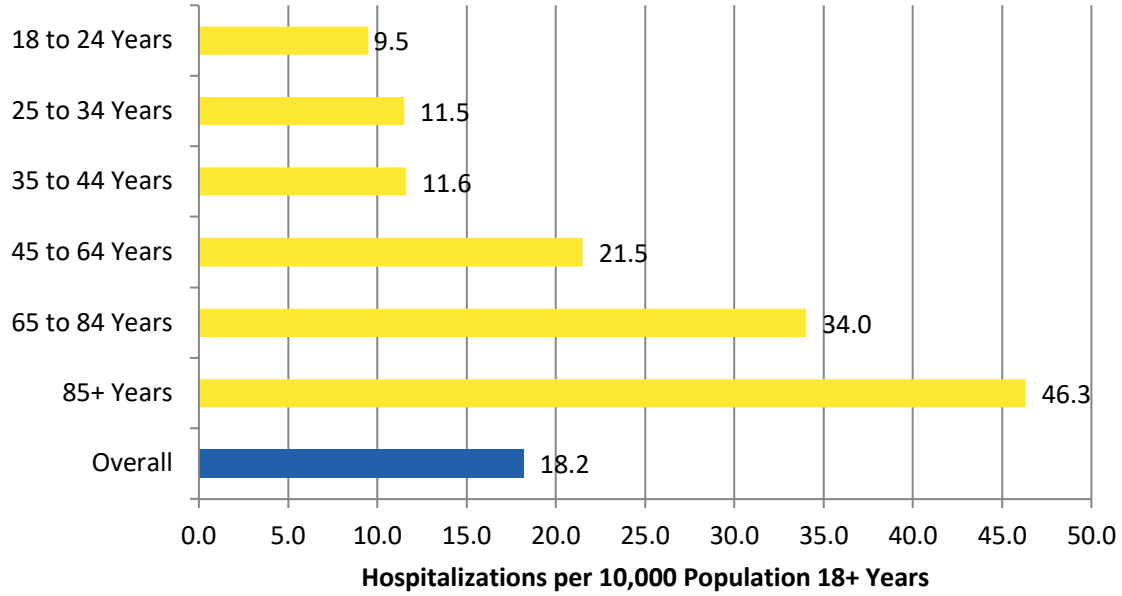
Age-Adjusted Hospital Inpatient* Visit Rate due to Diabetes by Race and Ethnicity, Prince George's County, 2017-2019



* Includes visits to only Maryland hospitals

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

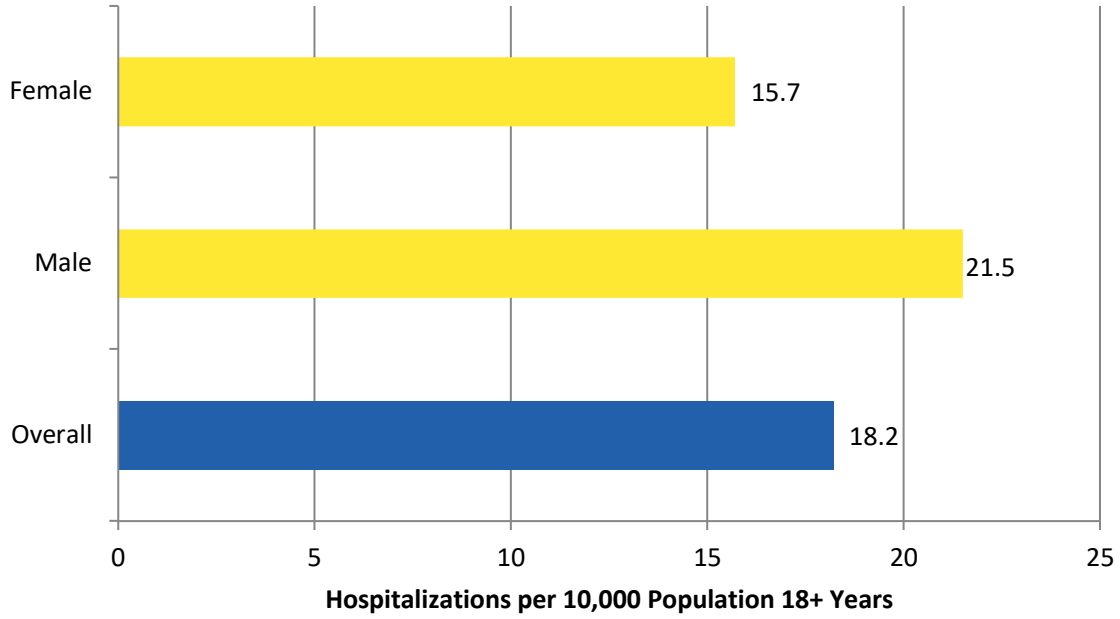
Age-Adjusted Hospital Inpatient* Visit Rate due to Diabetes by Age Group, Prince George's County, 2017-2019



* Includes visits to only Maryland hospitals

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

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



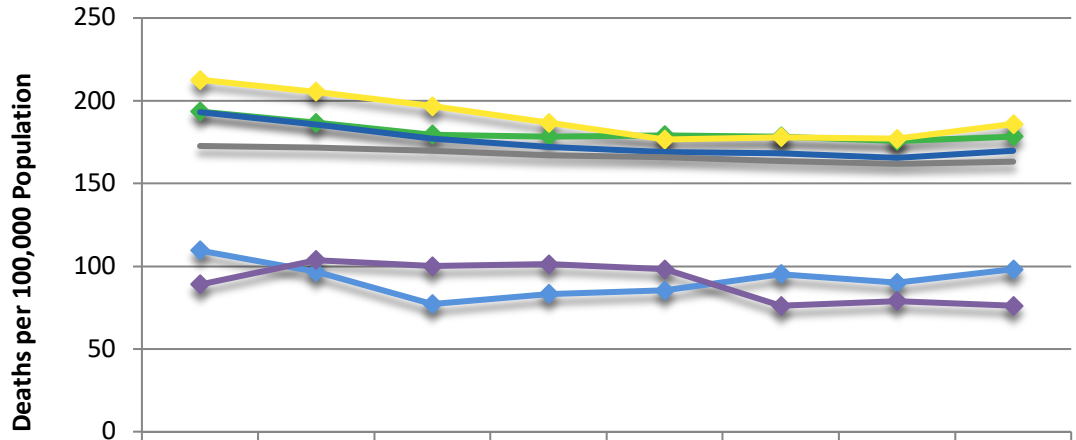
* Includes visits to Maryland and Washington, D.C. hospitals

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

Heart Disease

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

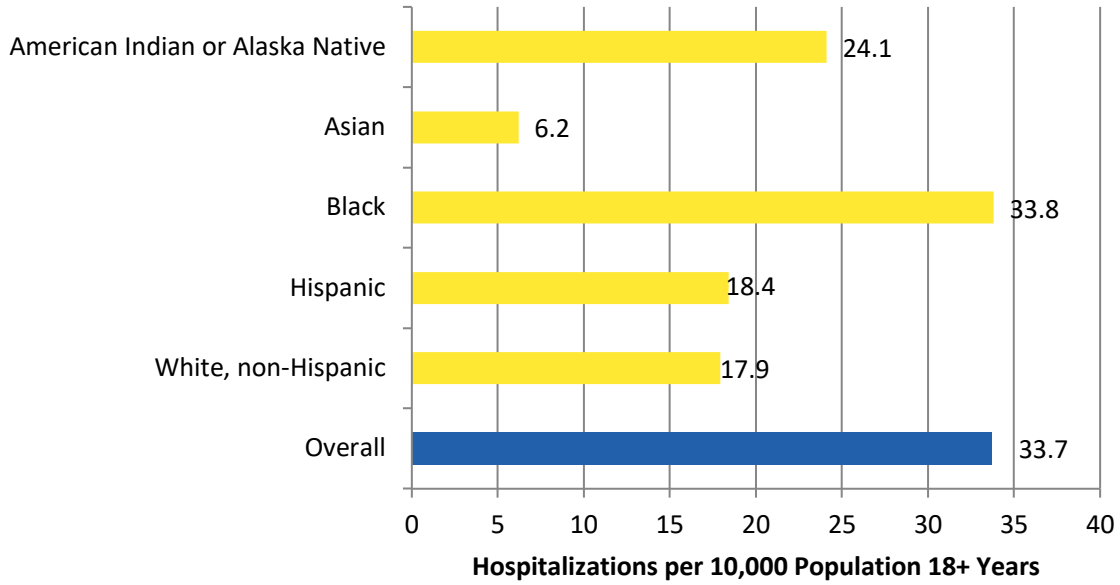
Age-Adjusted Death Rate per 100,000 for Heart Disease by Race and Ethnicity, 2010-2020



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

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

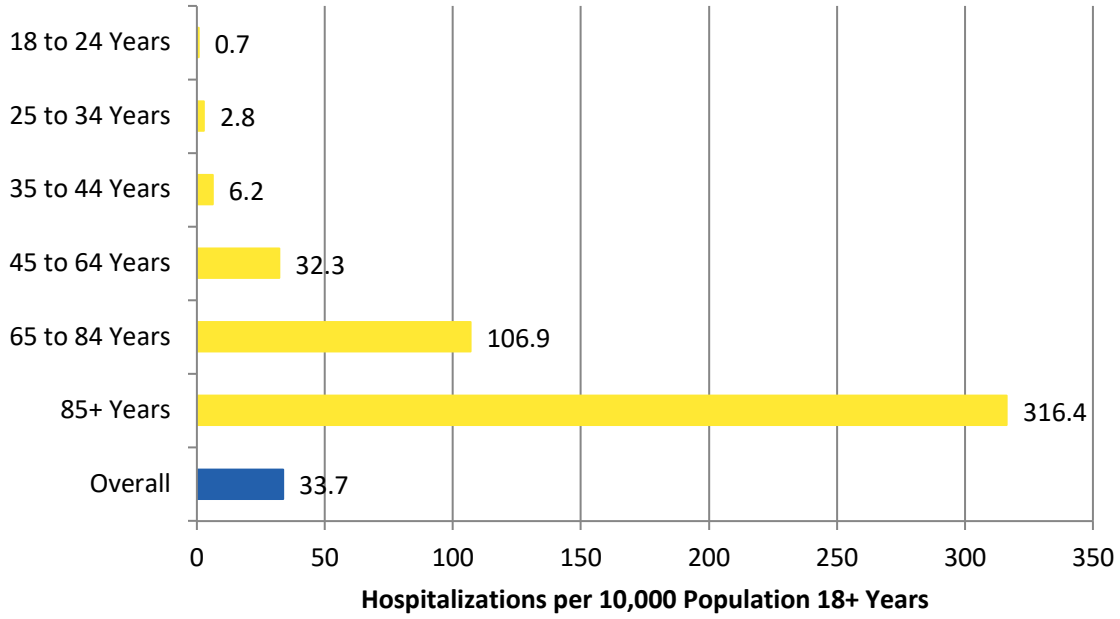
Age-Adjusted Hospital Inpatient* Visit Rate due to Heart Failure by Race and Ethnicity, Prince George's County, 2017-2019



* Includes visits to only Maryland hospitals

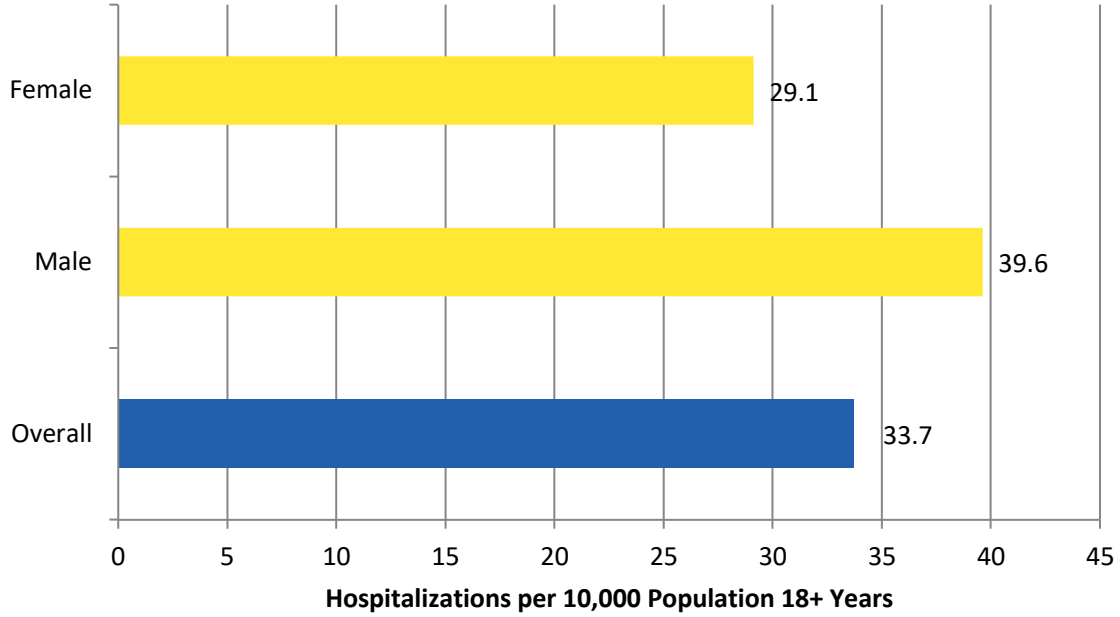
Data Source: www.pgchealthzone.org, Maryland Health Services Cost Review Commission; Maryland Health Care Commission;

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



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

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

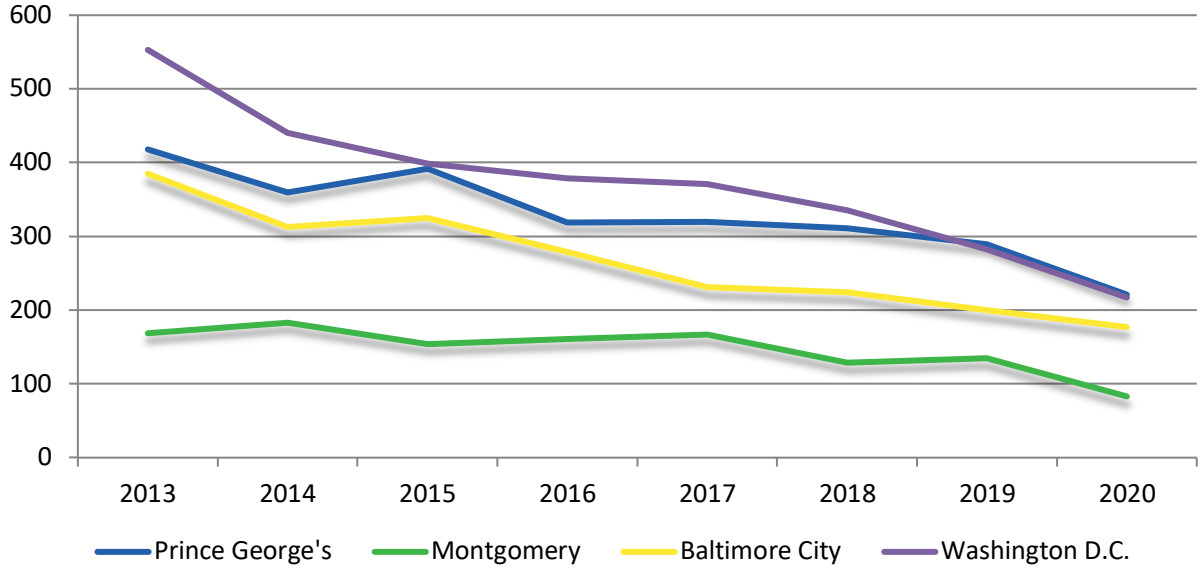


* Includes visits to only Maryland hospitals
Data Source: www.pgchealthzone.org, Maryland Health Services Cost Review Commission; Maryland Health Care Commission

Human Immunodeficiency Virus (HIV)

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

New HIV Cases by Jurisdiction, 2013-2020



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

Demographics of New HIV Cases, 2020

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

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

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

New HIV Cases by Exposure, 2020

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

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

Demographics of Total Living HIV Cases, 2020

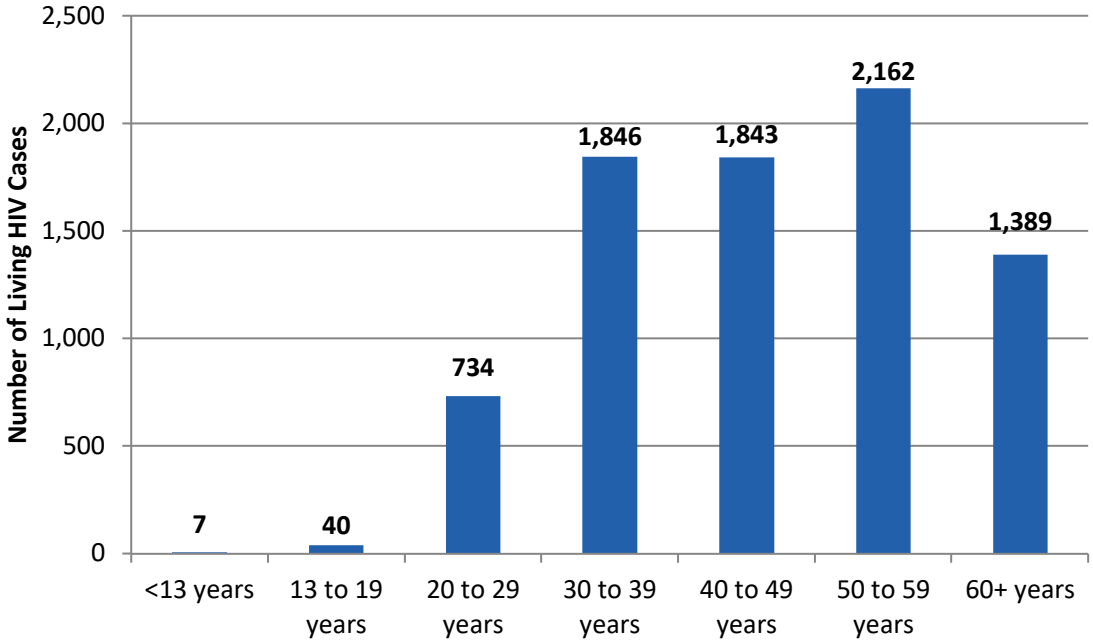
	Prince George's		Maryland	
	Number	Rate*	Number	Rate*
Sex at Birth				
Male	5,431	1,501.5	20,908	855.4
Female	2,583	645.4	10,768	405.6
Race/Ethnicity				
Black, non-Hispanic	6,630	1,375.0	23,554	1,537.6
Hispanic	646	484.5	2,233	457.2
White, non-Hispanic	315	323.0	3,879	148.2
Asian, non-Hispanic	42	125.5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

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

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

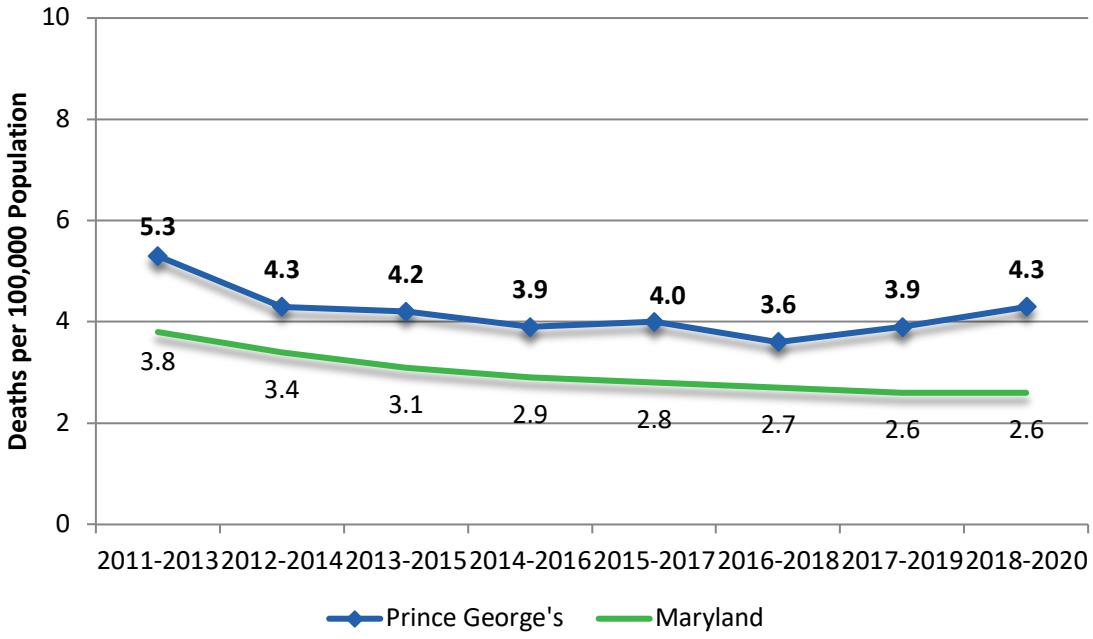
In Prince George's County approximately one out of every 100 residents are living with HIV. The county's rate for living HIV cases (1,053.5 per 100,000 residents) is 68% higher compared to Maryland at 626.9.

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



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

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



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

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

Hypertension and Stroke

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

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

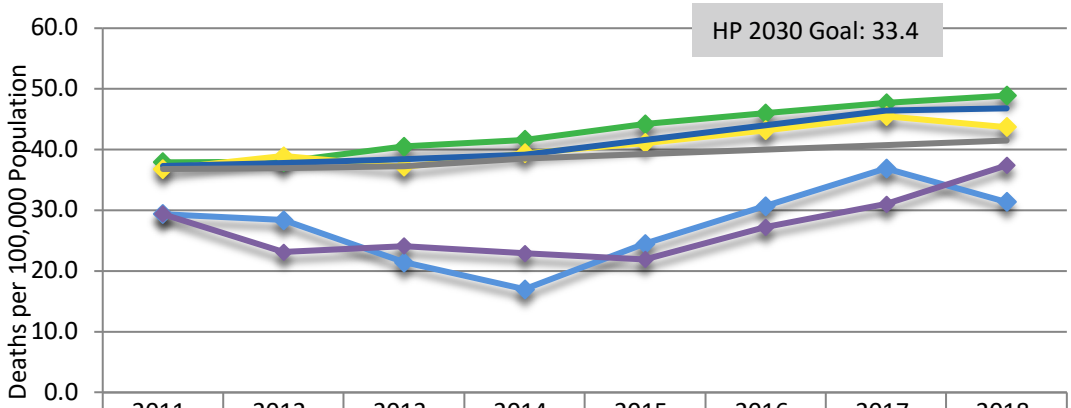
	Prince George's	Maryland
Sex		
Male	32.8%	33.0%
Female	31.1%	28.2%
Race/Ethnicity		
Black, non-Hispanic	34.2%	37.4%
Hispanic	34.6%	28.1%
White, non-Hispanic	28.3%	28.6%
Age Group		
18 to 34 Years	11.6%	10.9%
35 to 49 Years	19.2%	21.2%
50 to 64 Years	48.0%	45.4%
Over 65 Years	70.0%	63.6%
Total	**31.9%**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

*Excludes women told only during pregnancy and borderline hypertension

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

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

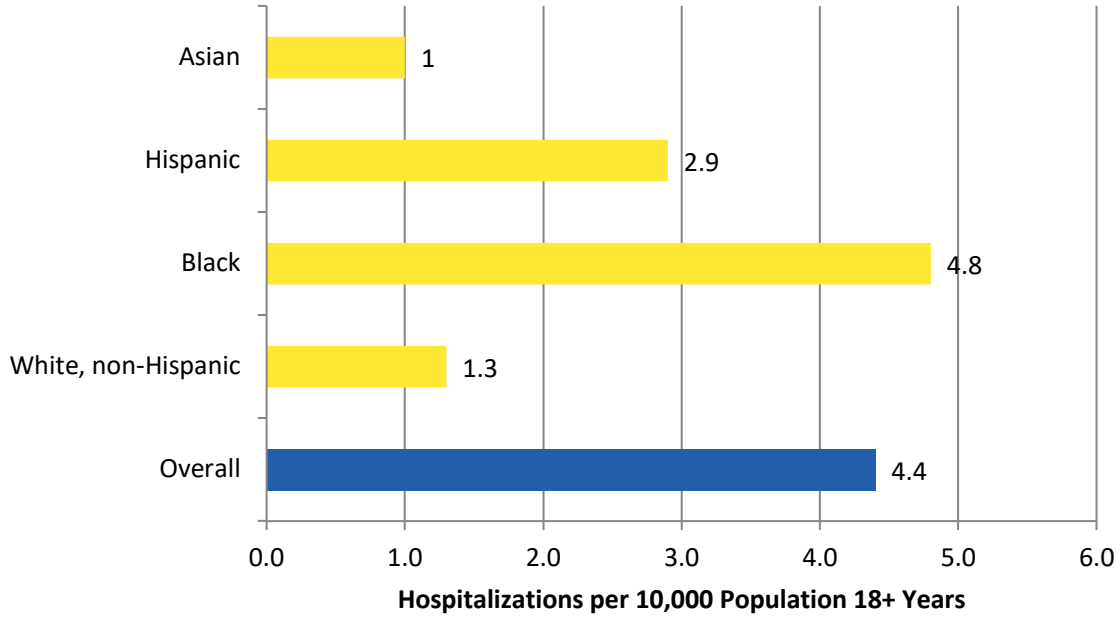
Age-Adjusted Death Rate per 100,000 for Stroke by Race and Ethnicity, Prince George's County, 2011-2020



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

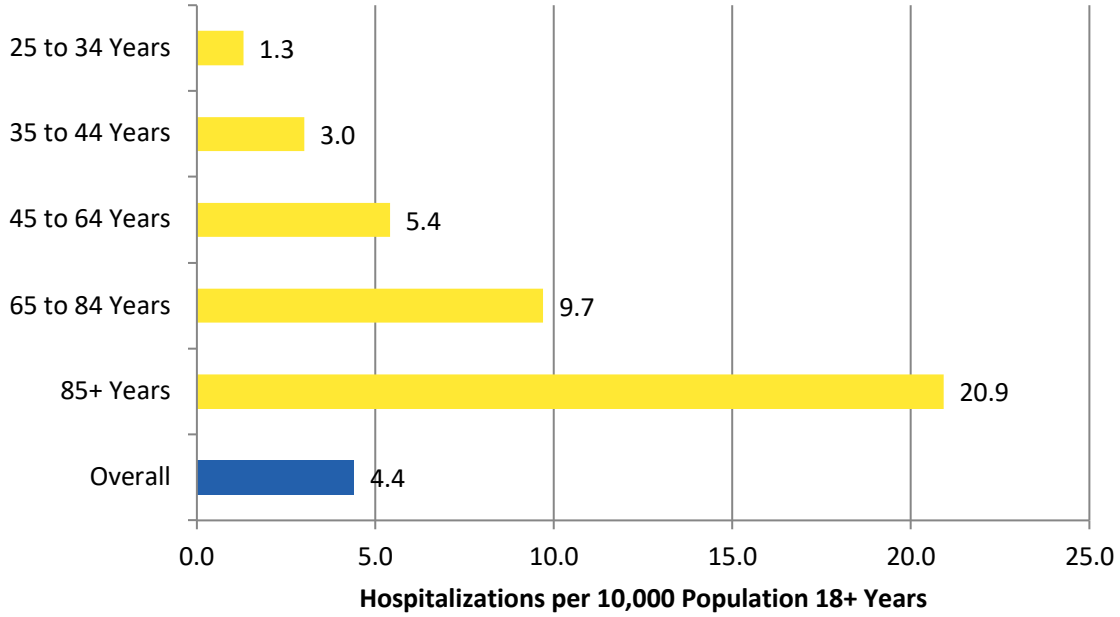
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

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



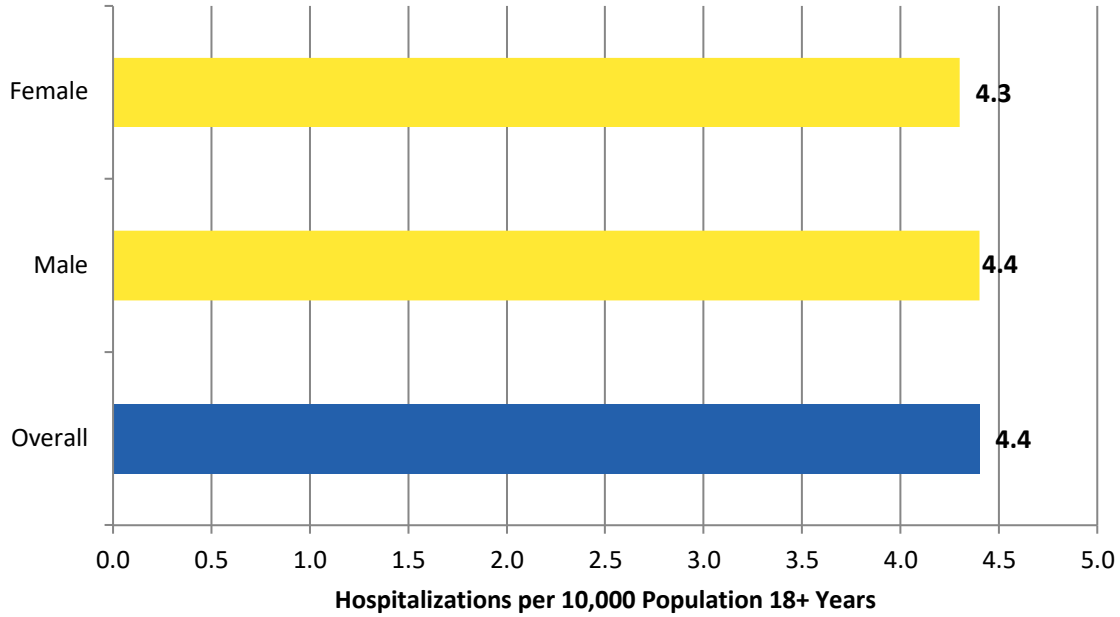
* Includes visits to only Maryland hospitals
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

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



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

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



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

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

Infectious Disease

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

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

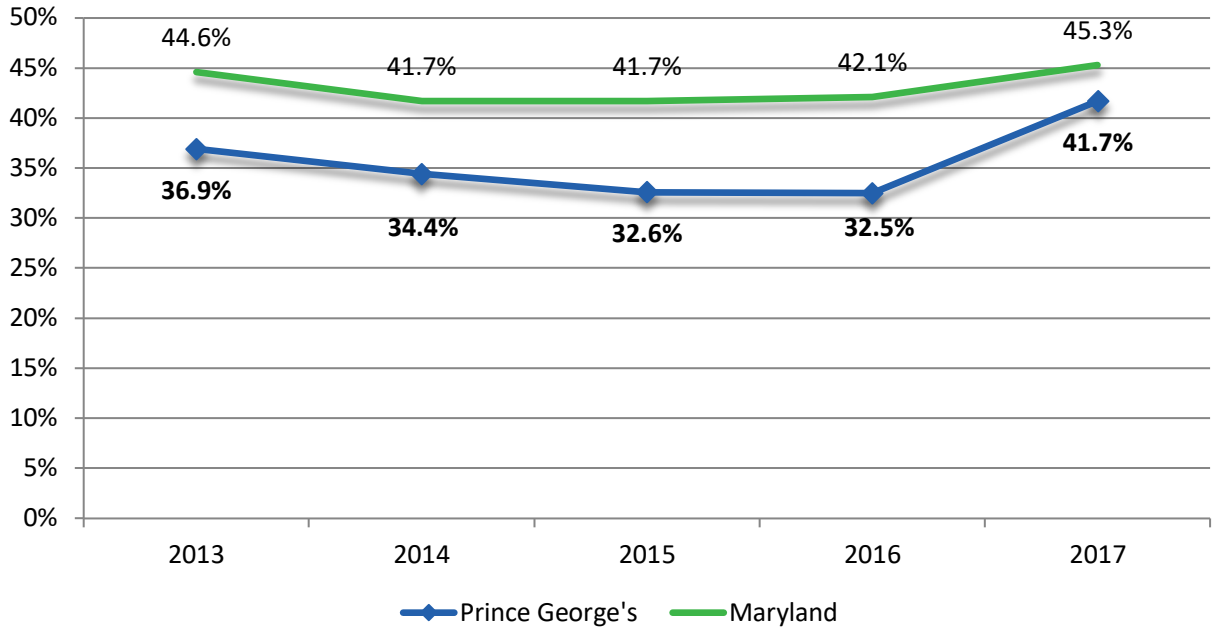
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, MDH

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

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

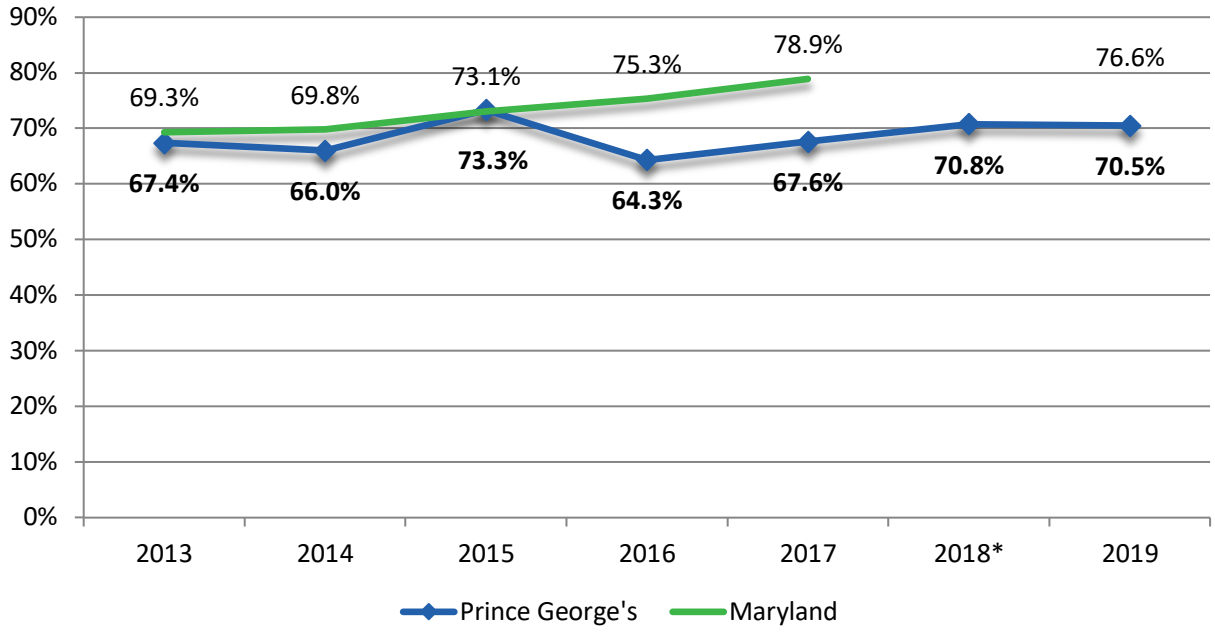
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

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



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

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

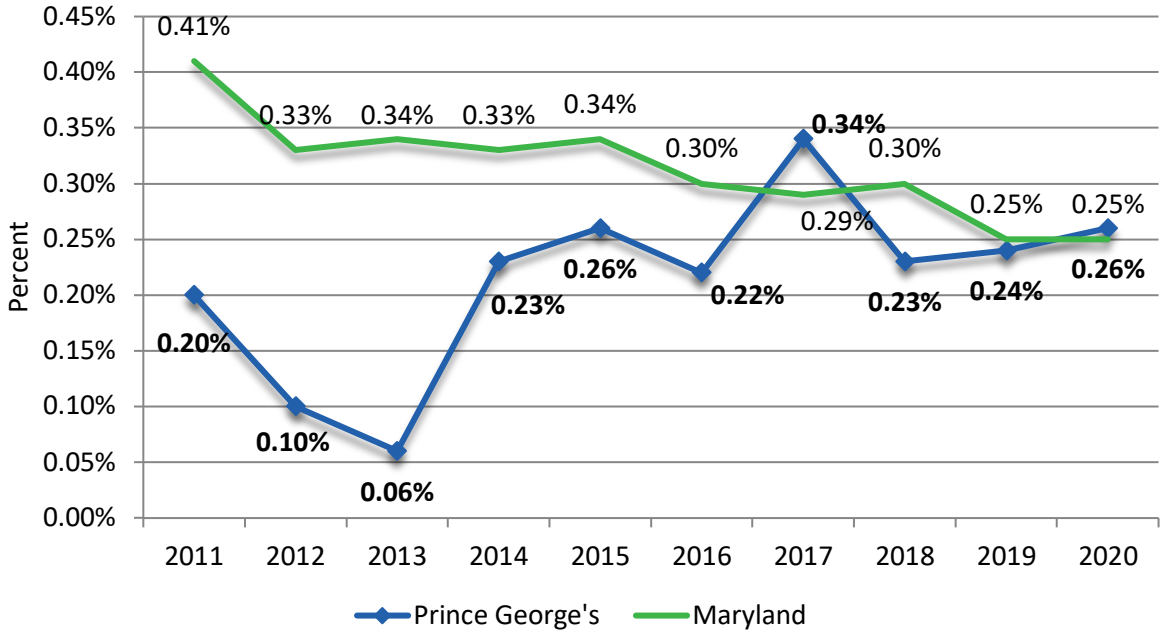


***** Maryland 2018 value unavailable
Data Source: 2013-2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Lead Poisoning

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

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



Data Source: Maryland Department of the Environment

Maternal and Infant Health

Live Birth Rate per 1,000 Population, 2020

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

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

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

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

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

Number and Percentage of Births by Age Group, 2020

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

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

Infant Mortality Rate*, 2020

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

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

Infant Deaths, 2016-2020

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

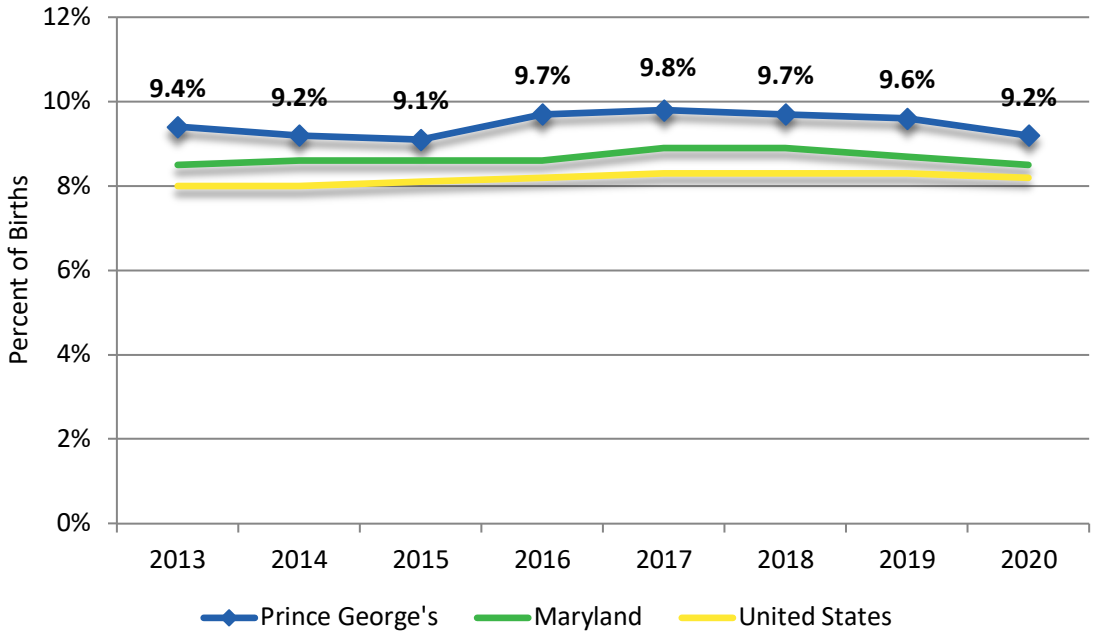
**Rates based on <5 deaths are not presented since they are subject to instability.
Data Source: Maryland Department of Health, Vital Statistics Administration, 2016-2020 Annual Infant Mortality Reports

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

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

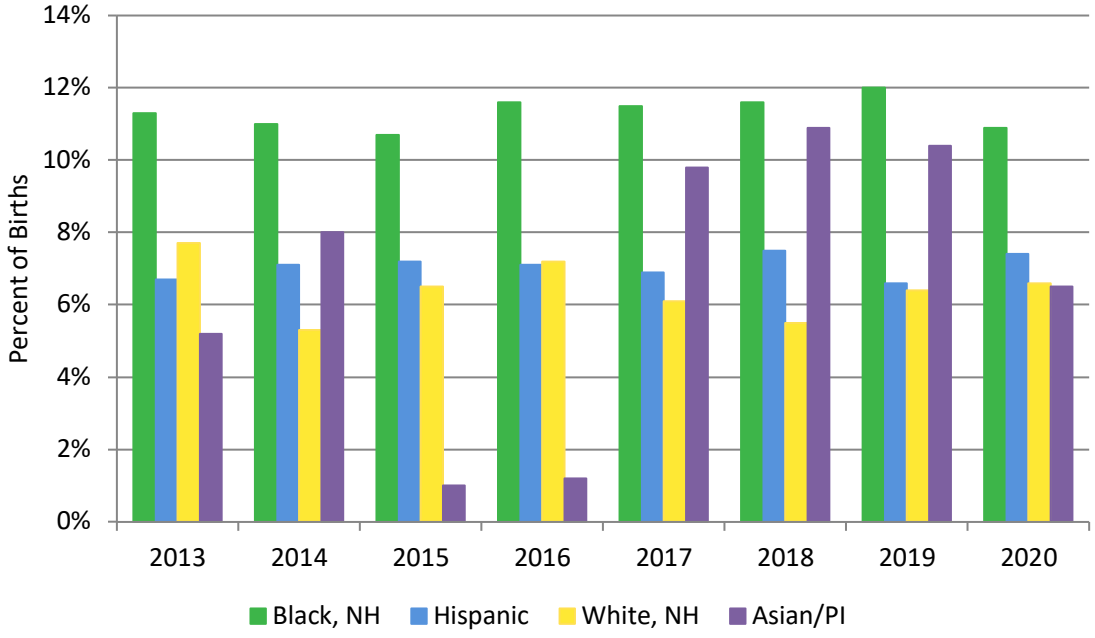
Data Source: Maryland Department of Health, Vital Statistics Administration, 2020 Annual Report; National Center for Health Statistics, Births Final Data for 2020

Percentage of Low Birth Weight Infants, 2013-2020



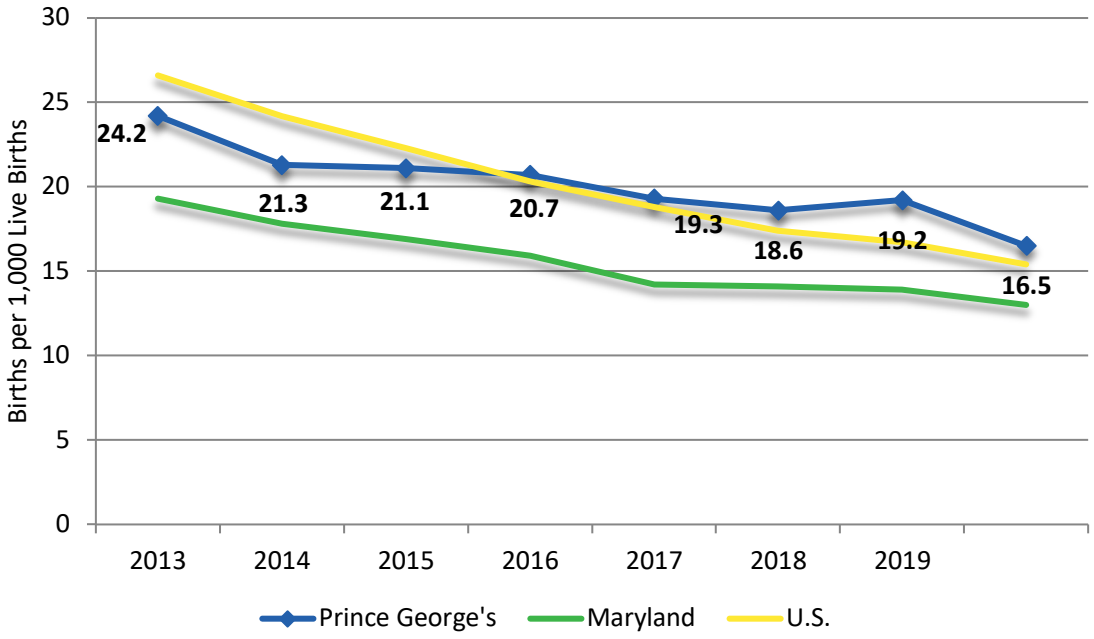
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2020 Annual Reports; National Center for Health Statistics, National Vital Statistics Report

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



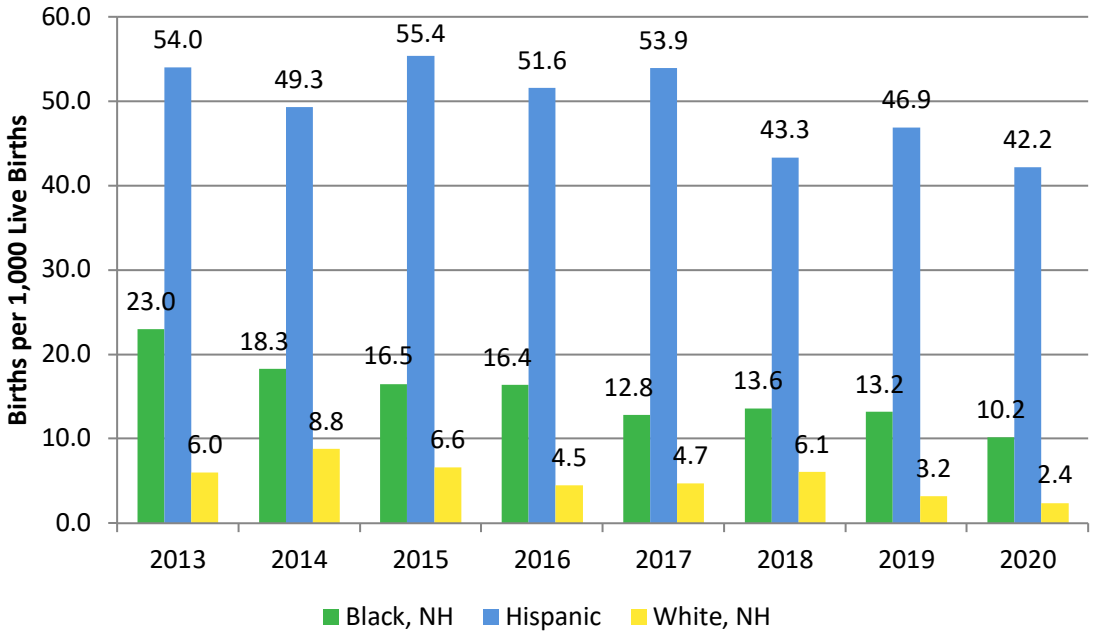
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2020 Annual Reports

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



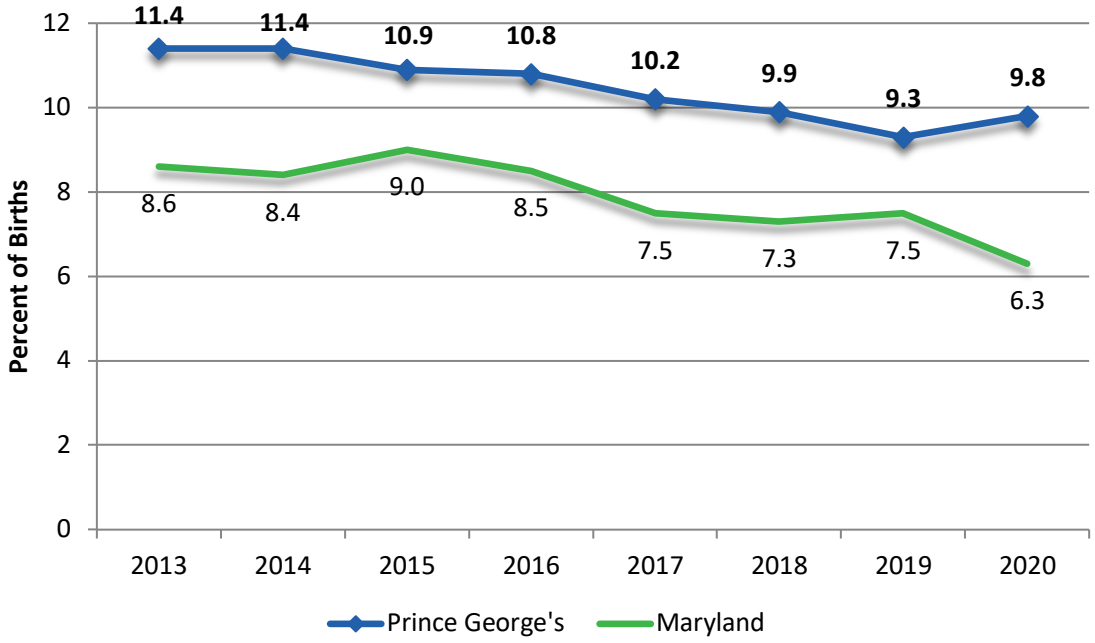
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2020 Annual Reports; National Center for Health Statistics, National Vital Statistics Report

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



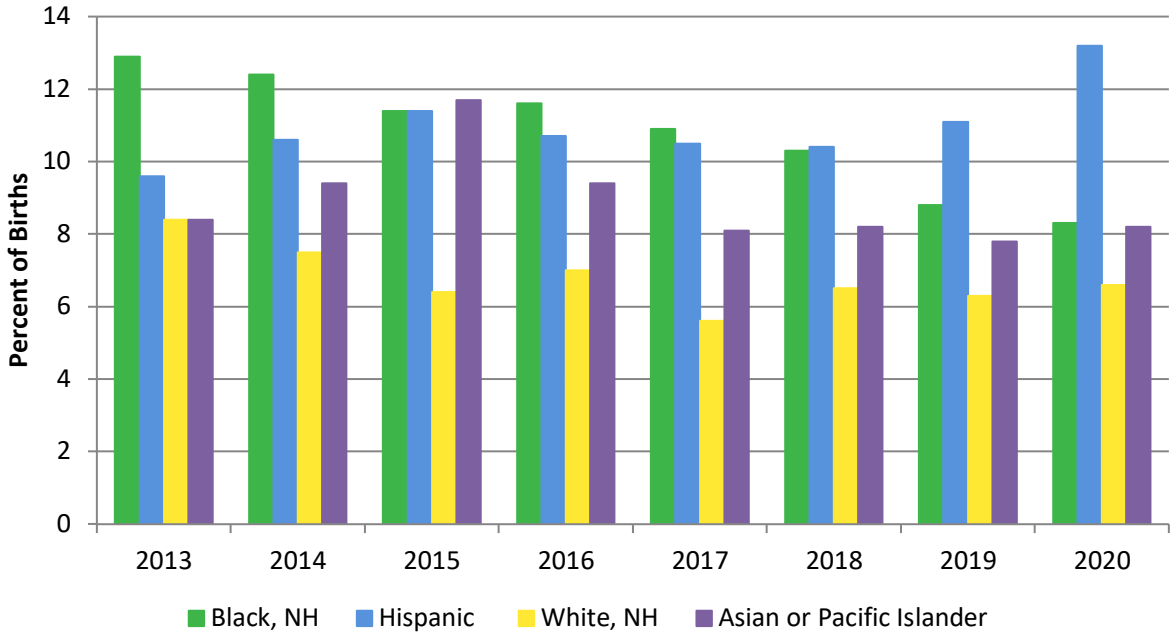
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2020 Annual Reports

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



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

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

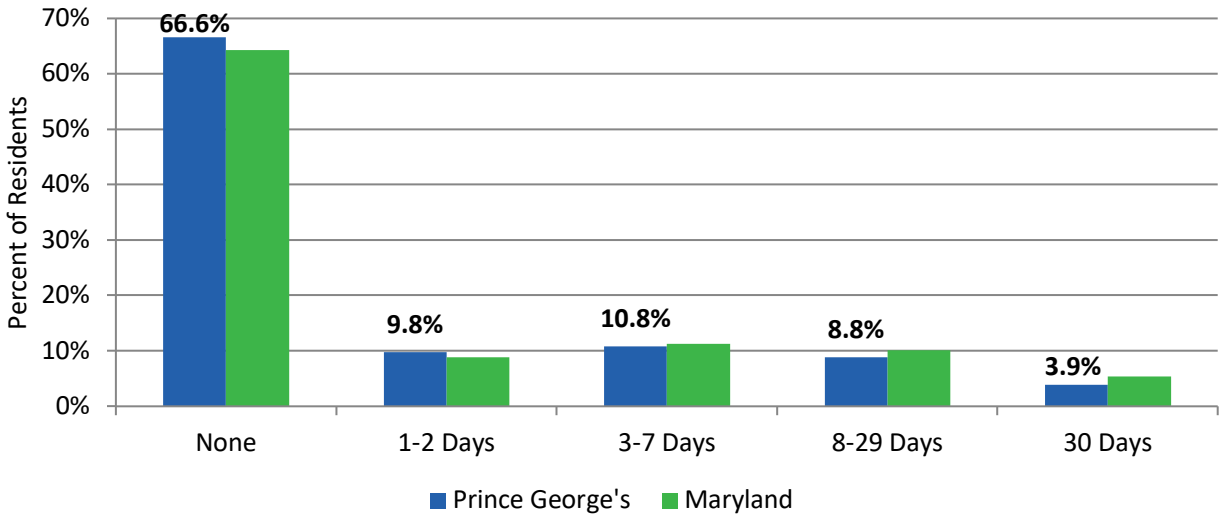


*Late care refers to care beginning in the third trimester.
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2020 Annual Reports

Mental Health

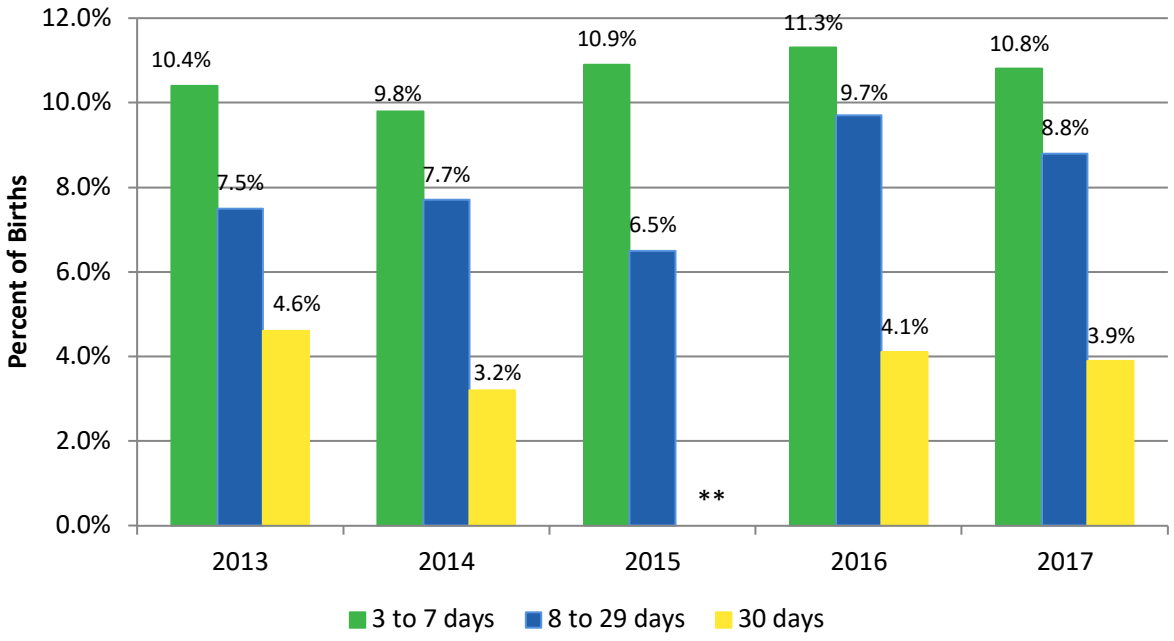
Overview	
What is it?	Mental health includes emotional, psychological, and social well-being. It affects how we think, feel and act. It also helps determine how we handle stress, relate to others, and make choices.
Who is affected?	One in five adults in America experience a mental illness. For Prince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

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



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

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



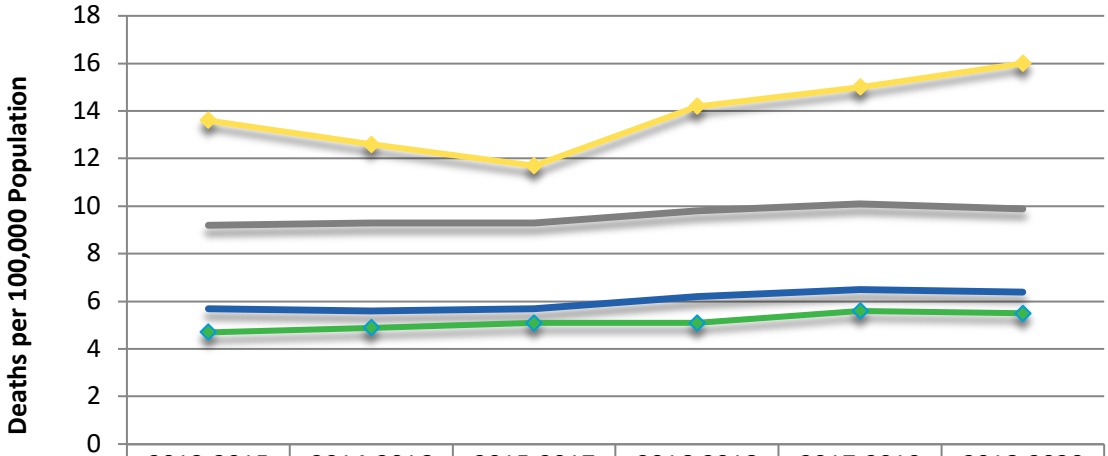
**Data not available; small number of observations.
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/31/2019

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

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

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

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

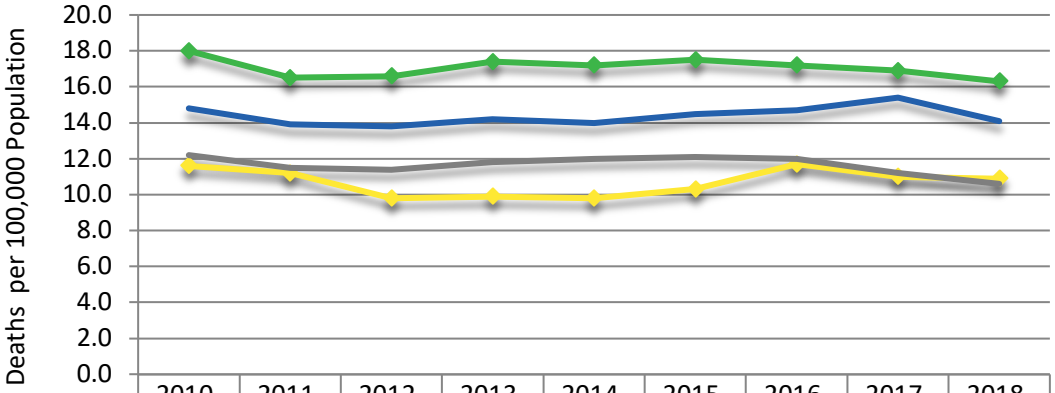


	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
PGC Black, NH	4.7	4.9	5.1	5.1	5.6	5.5
PGC White, NH	13.6	12.6	11.7	14.2	15.0	16.0
PGC Total	5.7	5.6	5.7	6.2	6.5	6.4
Maryland	9.2	9.3	9.3	9.8	10.1	9.9

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

Nephritis (Chronic Kidney Disease)

Age-Adjusted Death Rate for Nephritis, 2010-2020



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

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

Obesity

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

How Obesity Is Classified

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

Data Source: Centers for Disease Control and Prevention

Percentage of Adults Who Are Obese, 2017

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

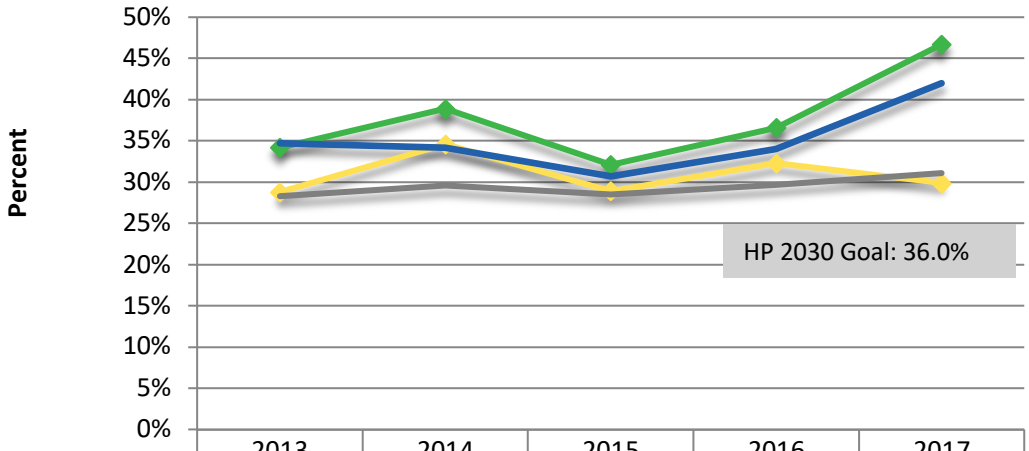
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019

Percentage of Adults Who Are Overweight, 2017

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

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

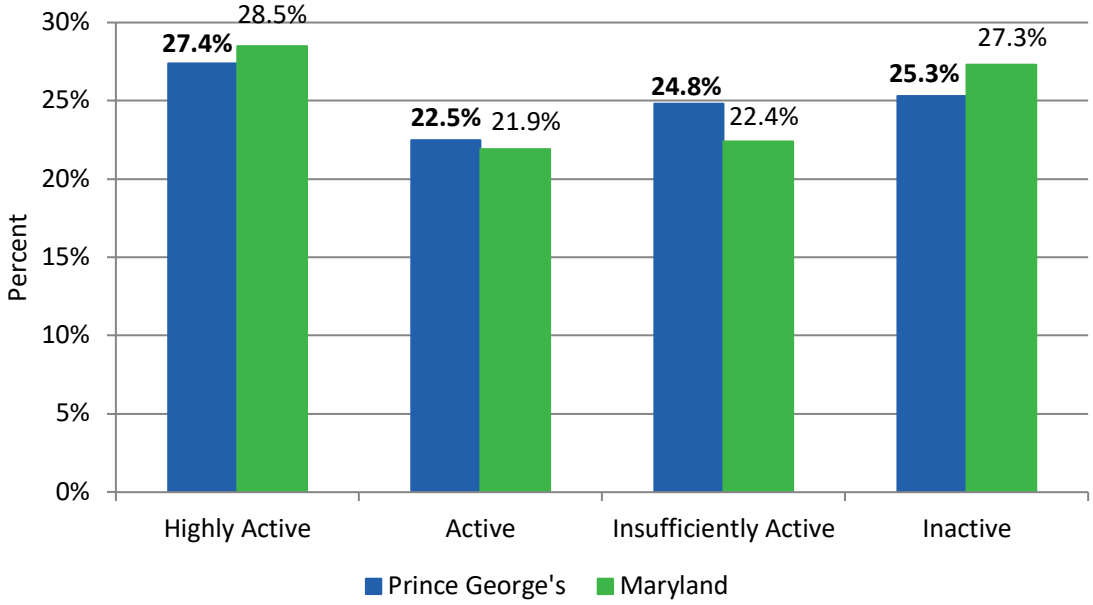
Percent of Adults Who Are Obese, 2013-2017



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

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

Percentage of Adults by Physical Activity Level, 2017



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

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

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

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

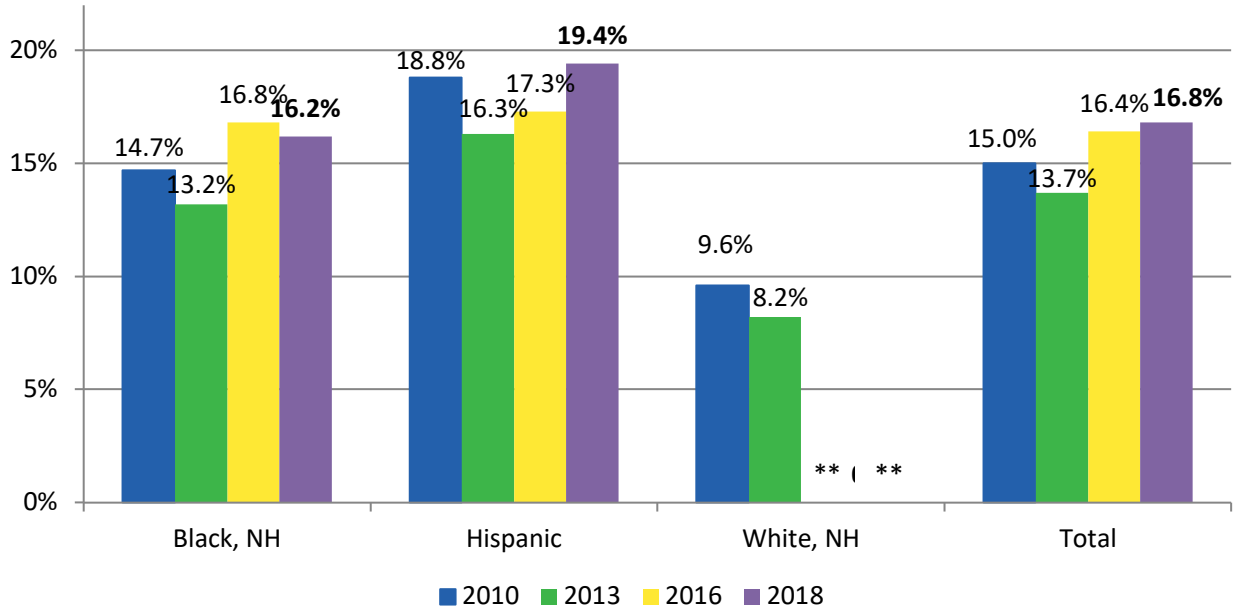
Percentage of High School Students Who are Obese, 2018

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

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

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

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



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

Percentage of High School Students Who are Overweight, 2018

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

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

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

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

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

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

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

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

Oral Health

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

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

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

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

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

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

Data Source: 2018 Maryland Youth Risk Behavior Survey

Sexually Transmitted Infections

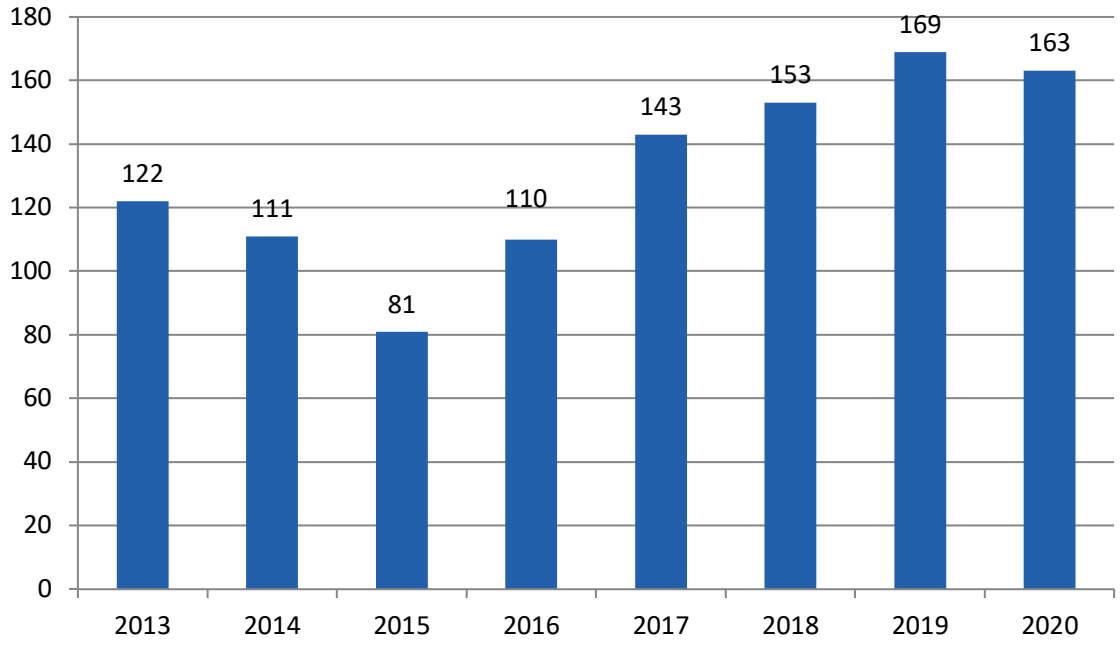
Number of Sexually Transmitted Infections, Prince George's County

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

*Includes both Primary and Secondary Syphilis

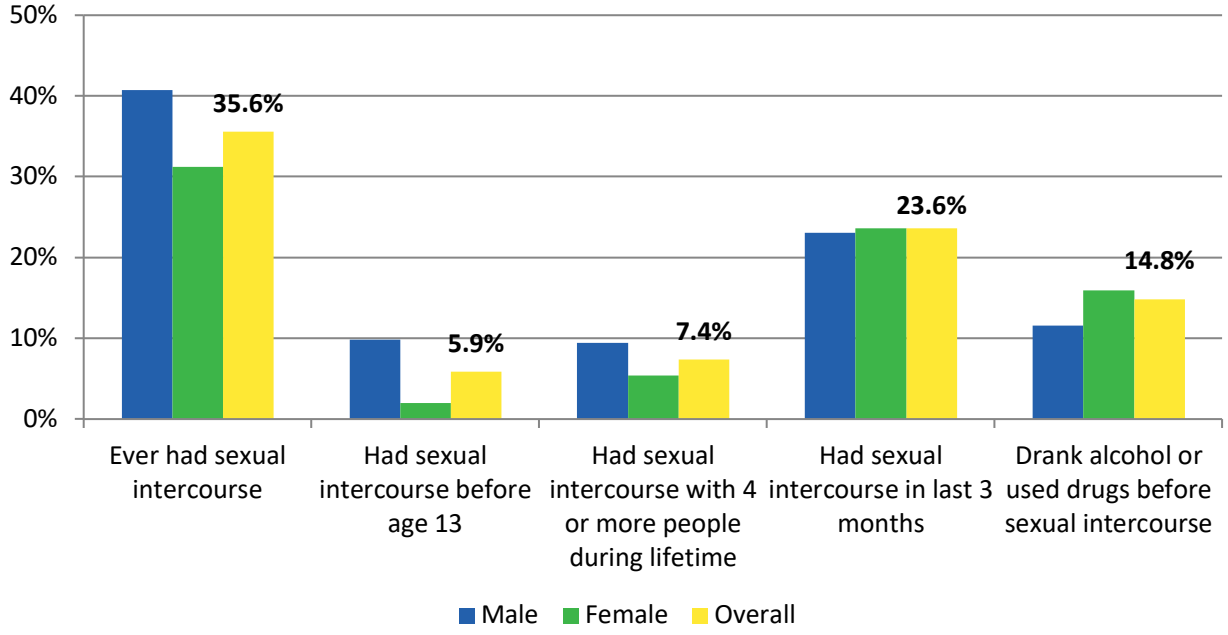
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, MDH

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



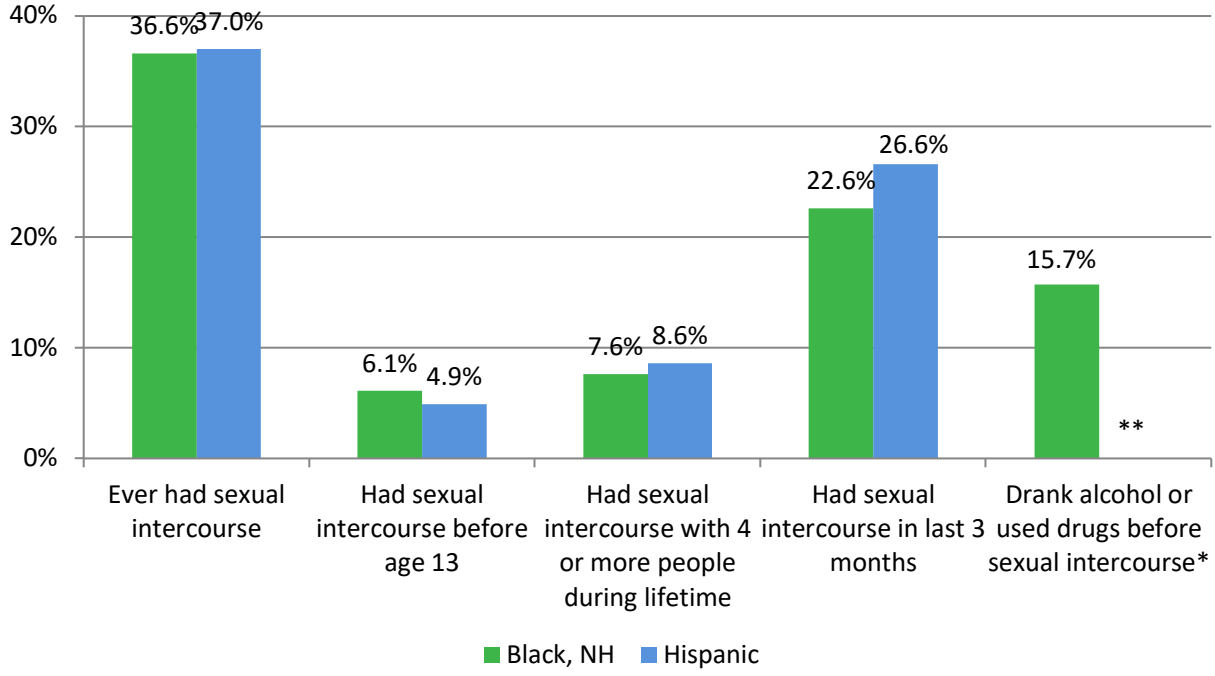
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, MDH

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



Data Source: 2018 Youth Risk Behavior Survey, MDH

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



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

Substance Use Disorder

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

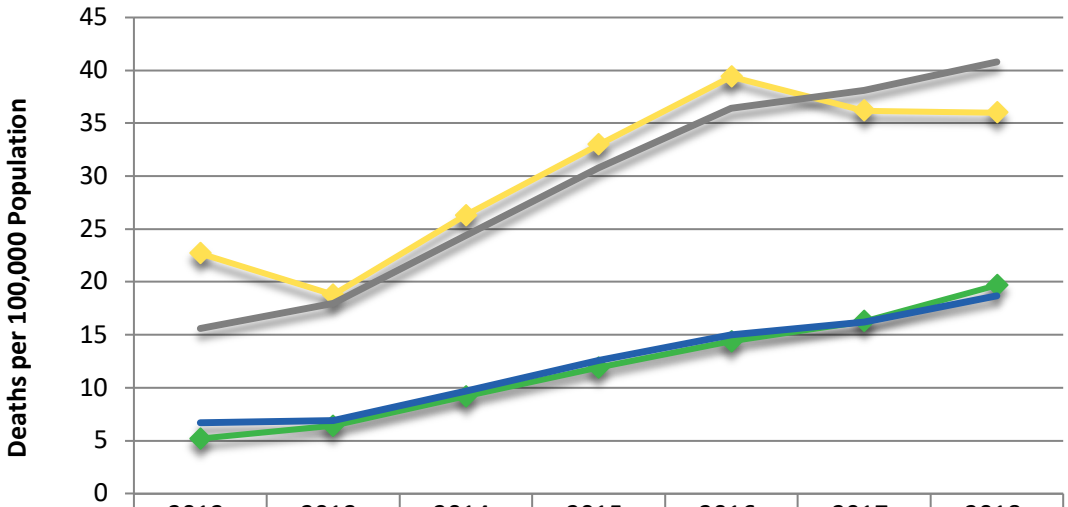
Emergency Department Visits* for Alcohol- and Substance-Related Conditions as the Primary Discharge Diagnosis, Prince George's County, 2017

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

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

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

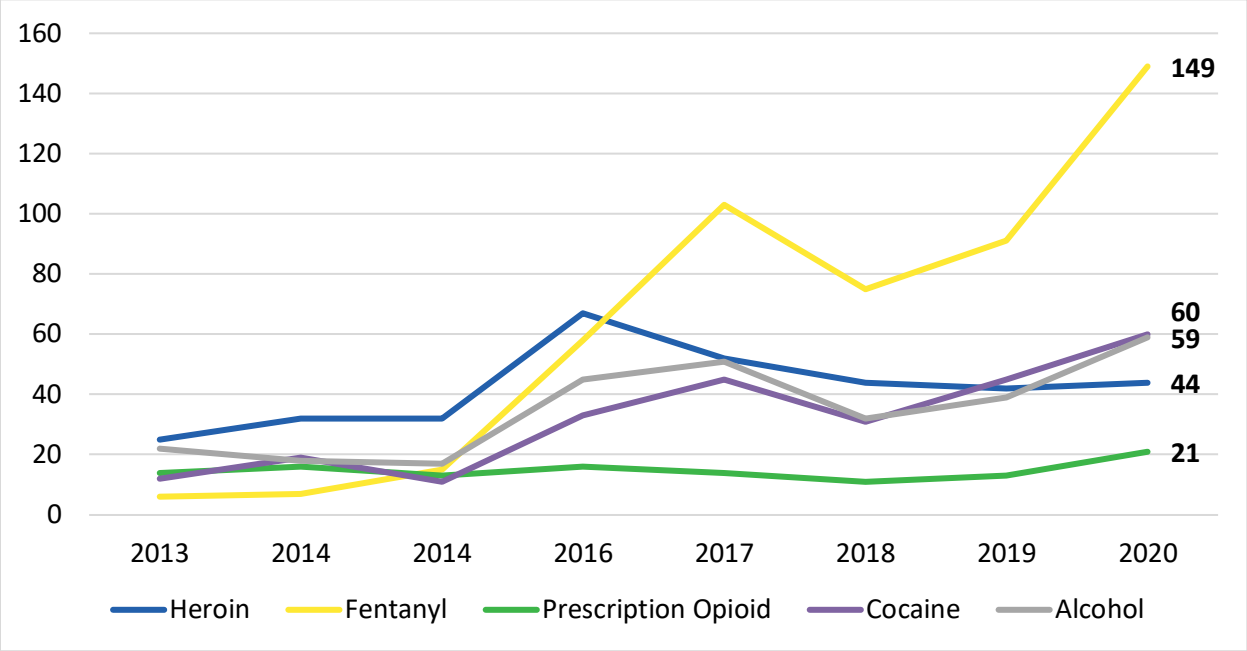
Drug-Related Age-Adjusted Death Rate per 100,000 Population, 2012 to 2020



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

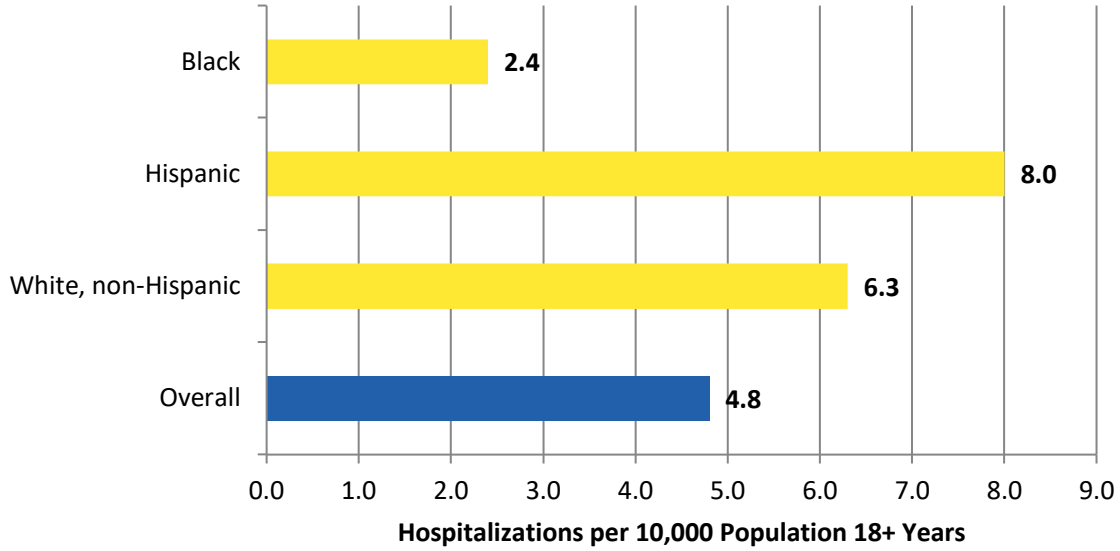
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

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



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

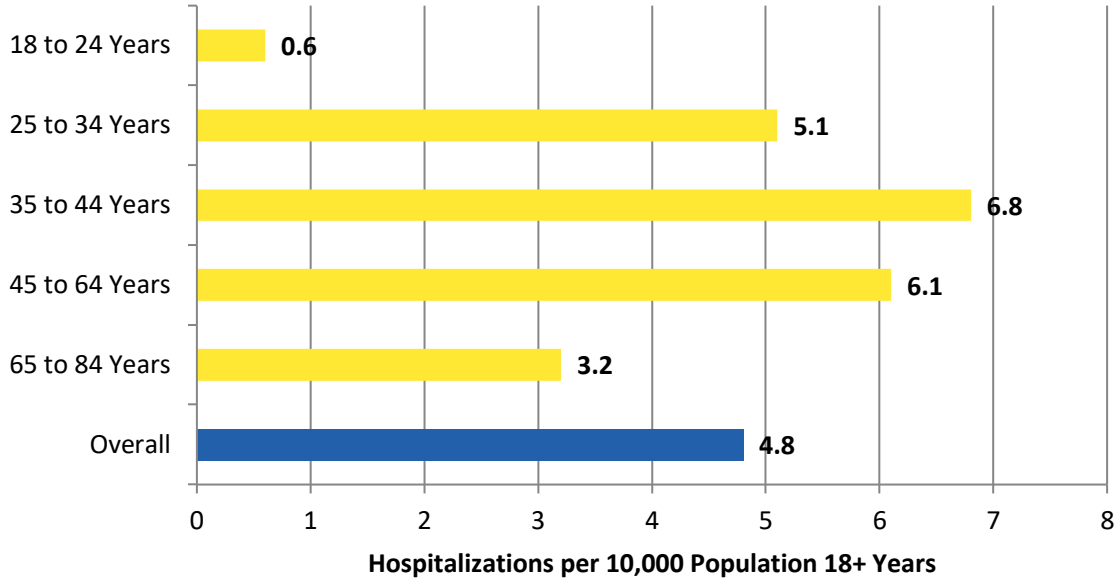
Age-Adjusted Hospital Inpatient* Visit Rate due to Alcohol Use by Race and Ethnicity, Prince George's County, 2017-2019



* Includes visits to only Maryland hospitals

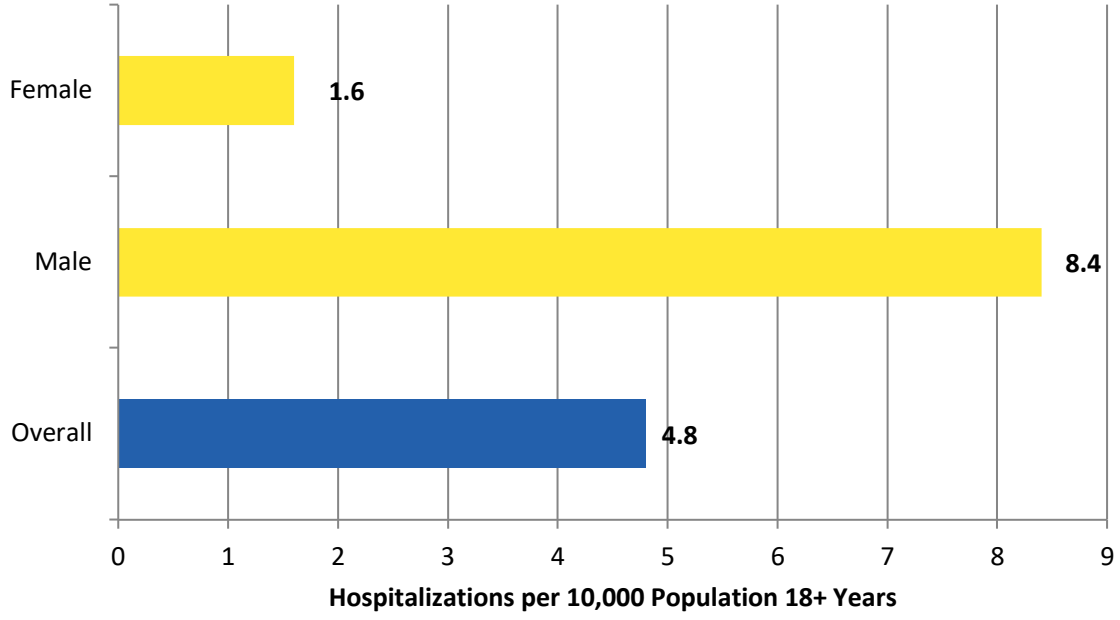
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

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



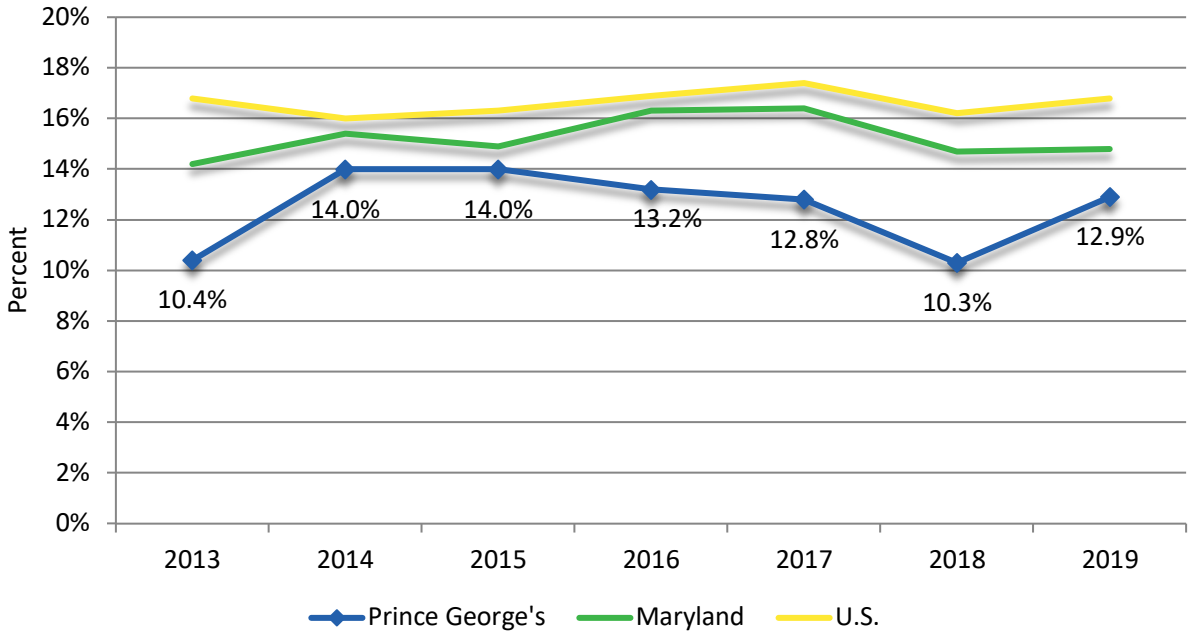
* Includes visits to only Maryland hospitals
Data Source: www.pgchealthzone.org; The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

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



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

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



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

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

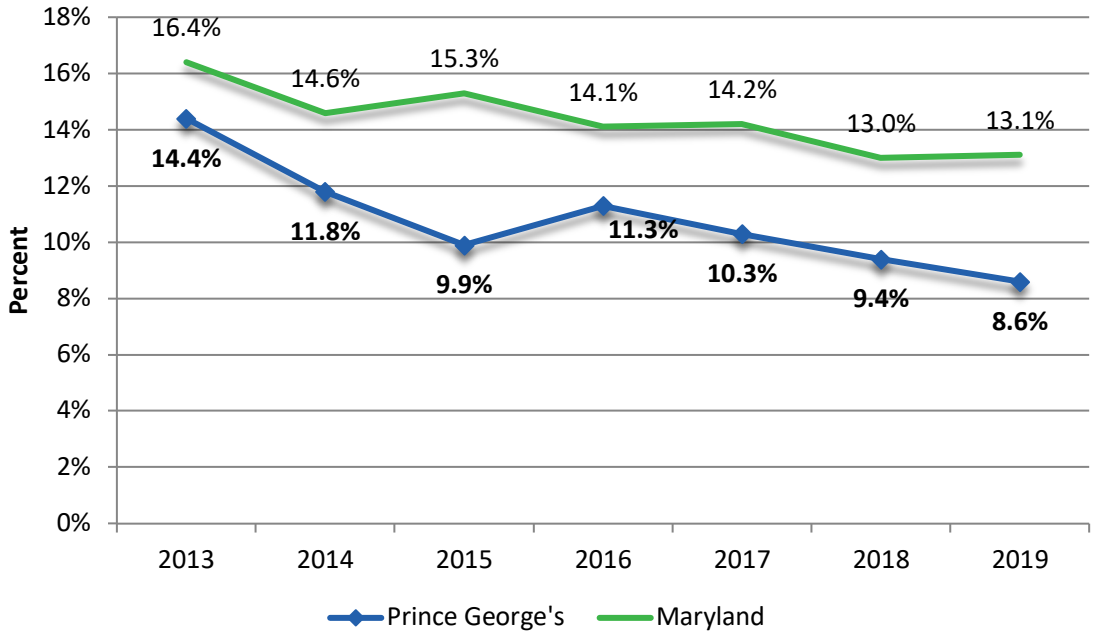
Percentage of Adults Who Currently Smoke, 2017

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

**Over 65 years not presented due to insufficient data

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

Percentage of Current Adult Smokers, 2013 to 2019



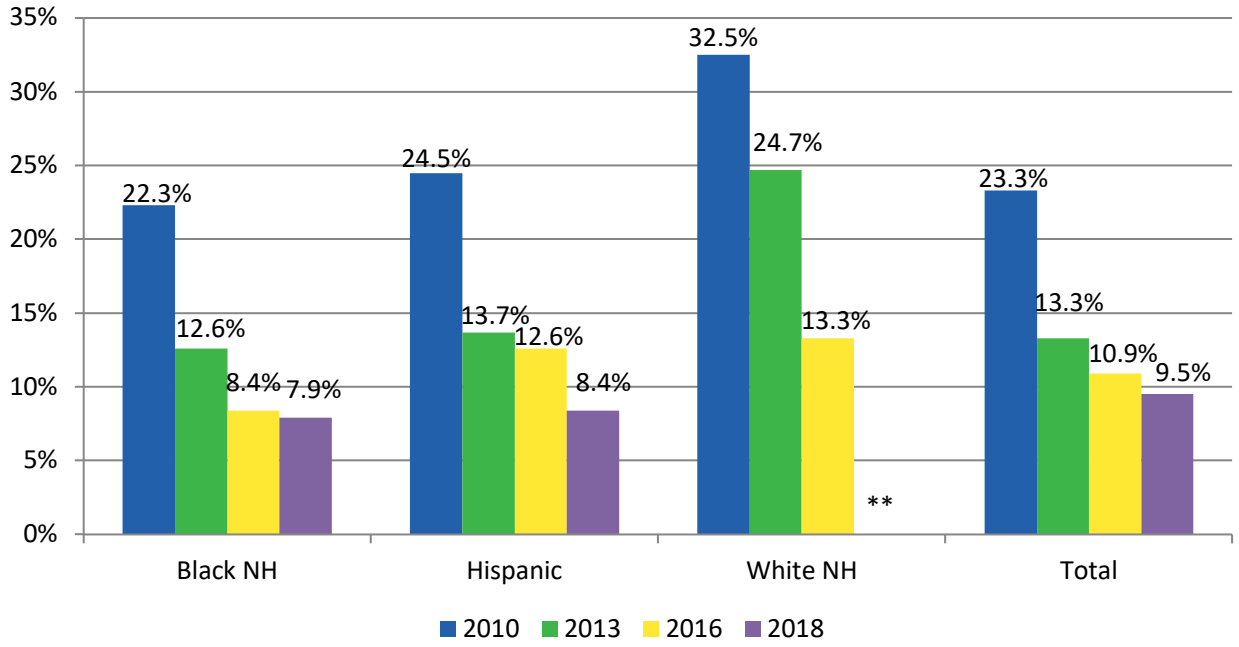
Data Source: 2013-2017 Maryland Behavioral Risk Factor Surveillance System, https://ibis.health.maryland.gov, accessed 5/13/2019, www.pgchealthzone.org

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

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

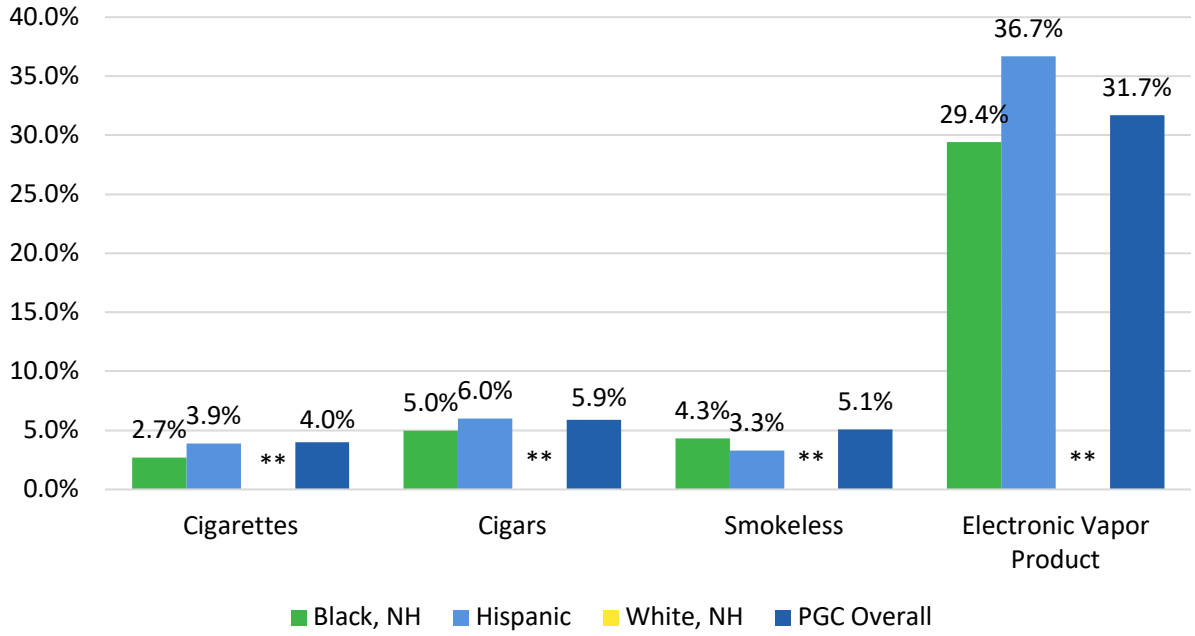
** White, non-Hispanic not presented due to insufficient data
Data Source: 2018 Youth Risk Behavior Survey Report for Prince George's County and Maryland, MDH

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



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

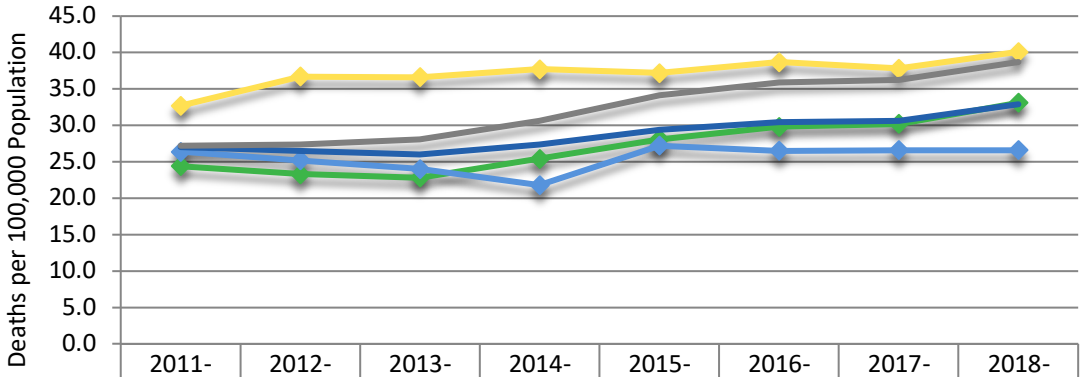
Tobacco Products Used by High School Students During the Past Month by Race/Ethnicity, Prince George's County, 2018



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

Unintentional Injuries (Accidents)

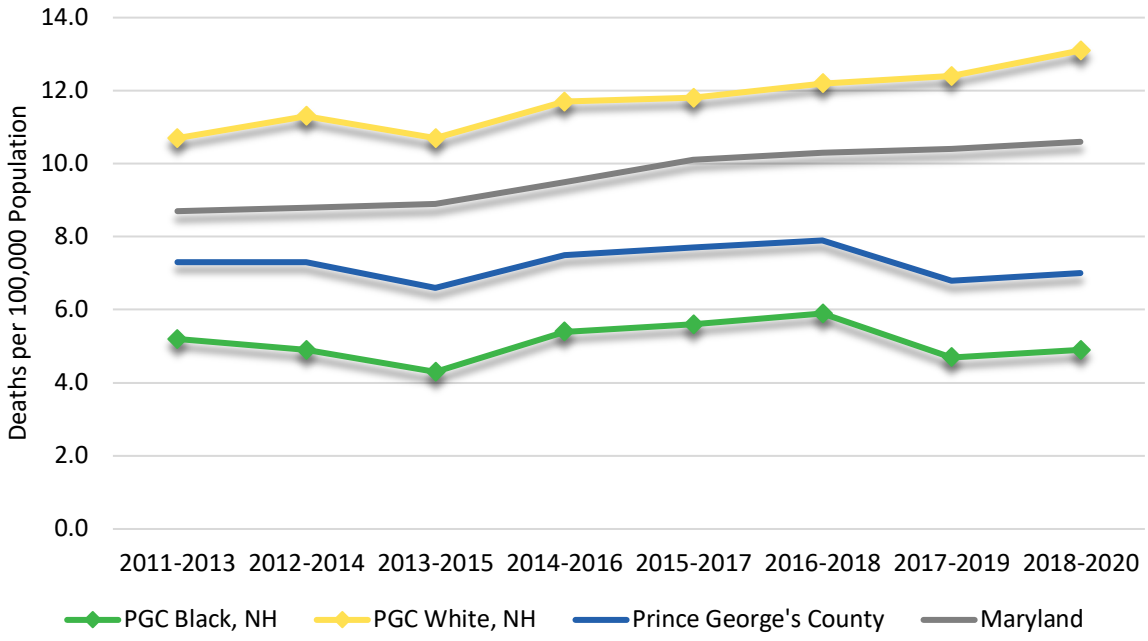
Age-Adjusted Death Rate per 100,000 for Unintentional Injuries, 2011-2020



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

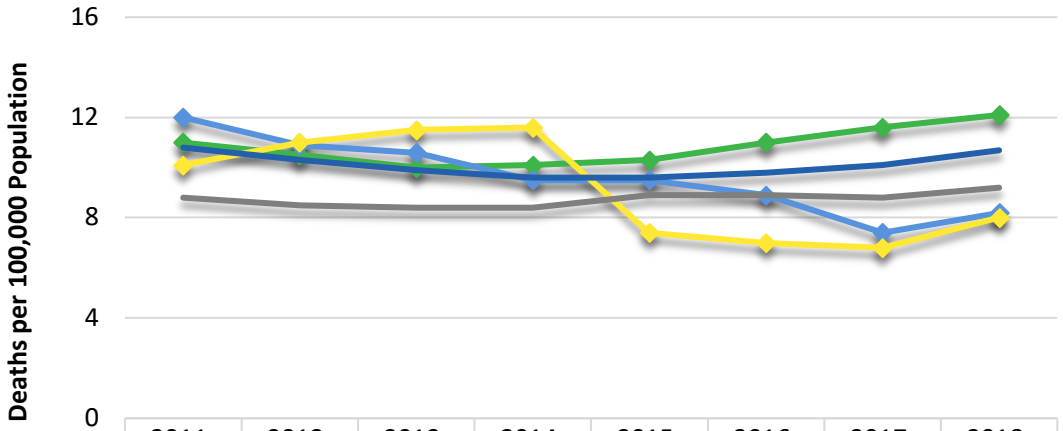
***** Asian/Pacific Islanders were not included due to insufficient numbers
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

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



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

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



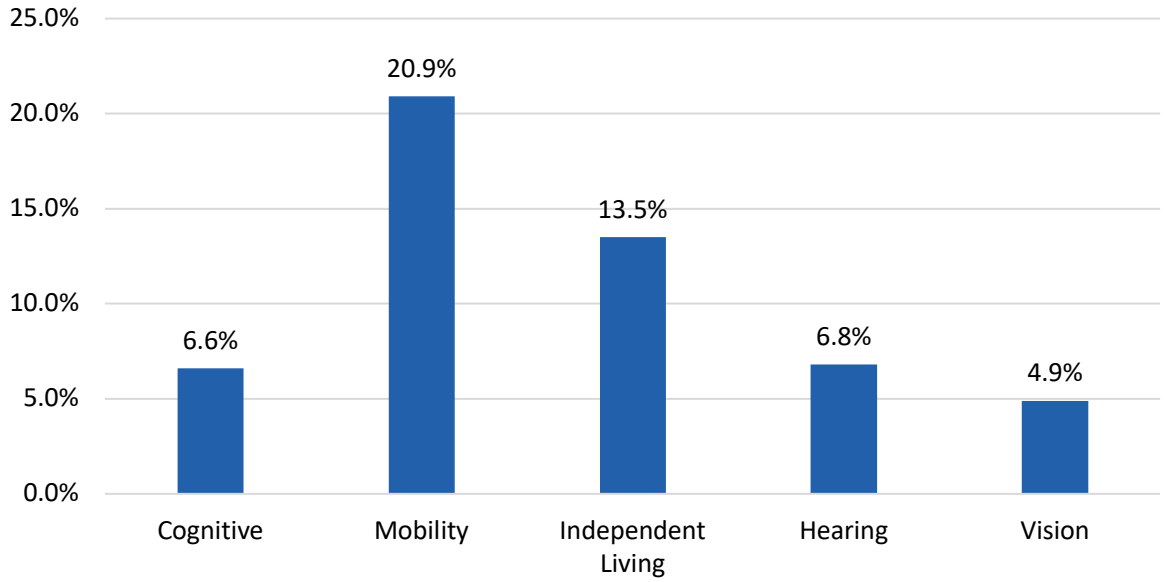
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2017	2017-2019	2018-2020
PGC Black, NH	11.0	10.5	10.0	10.1	10.3	11.0	11.6	12.1
PGC Hispanic	12.0	10.9	10.6	9.5	9.5	8.9	7.4	8.2
PGC White NH	10.1	11.0	11.5	11.6	7.4	7.0	6.8	8.0
PGC	10.8	10.3	9.9	9.6	9.6	9.8	10.1	10.7
Maryland	8.8	8.5	8.4	8.4	8.9	8.9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

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

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

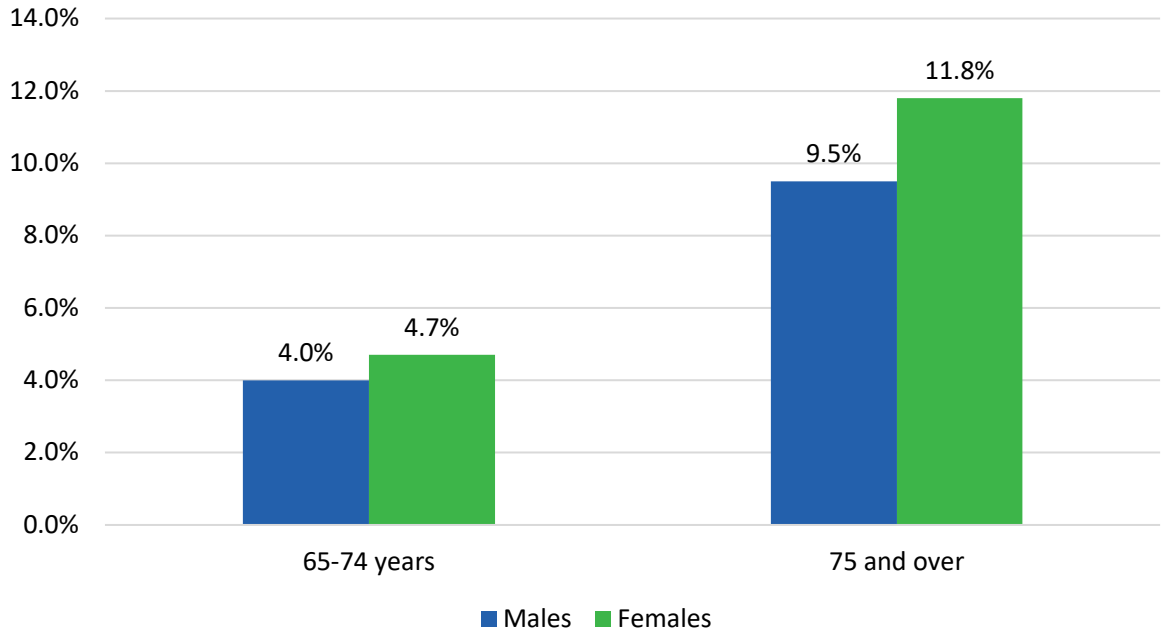
Senior Health

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



Data Source: 2021 American Community Survey, Table S1810

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

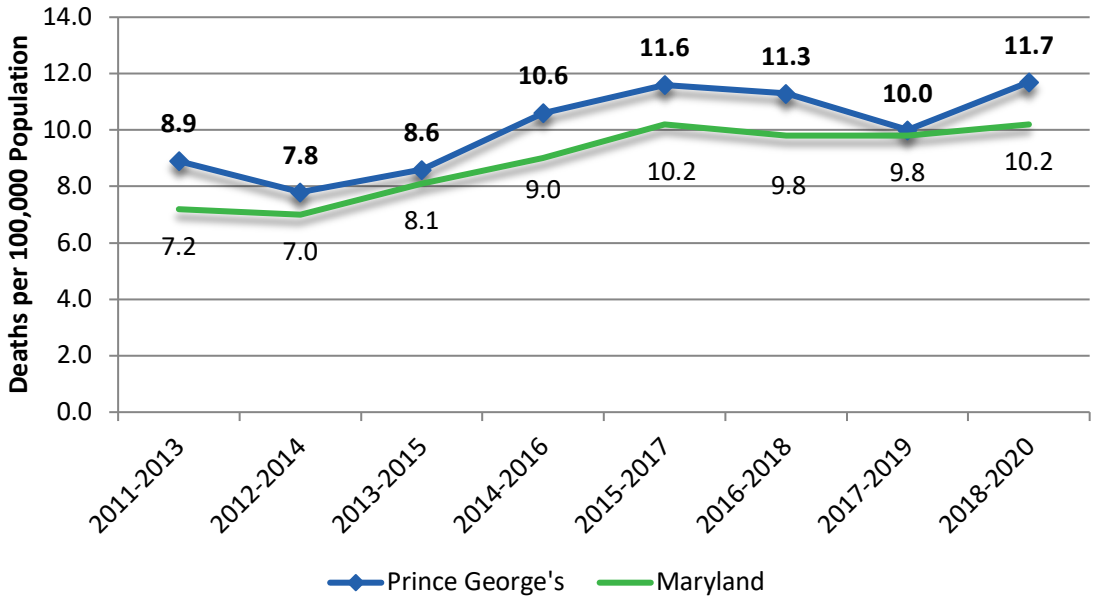


Data Source: 2021 American Community Survey, Table B18106

Violence and Domestic Violence

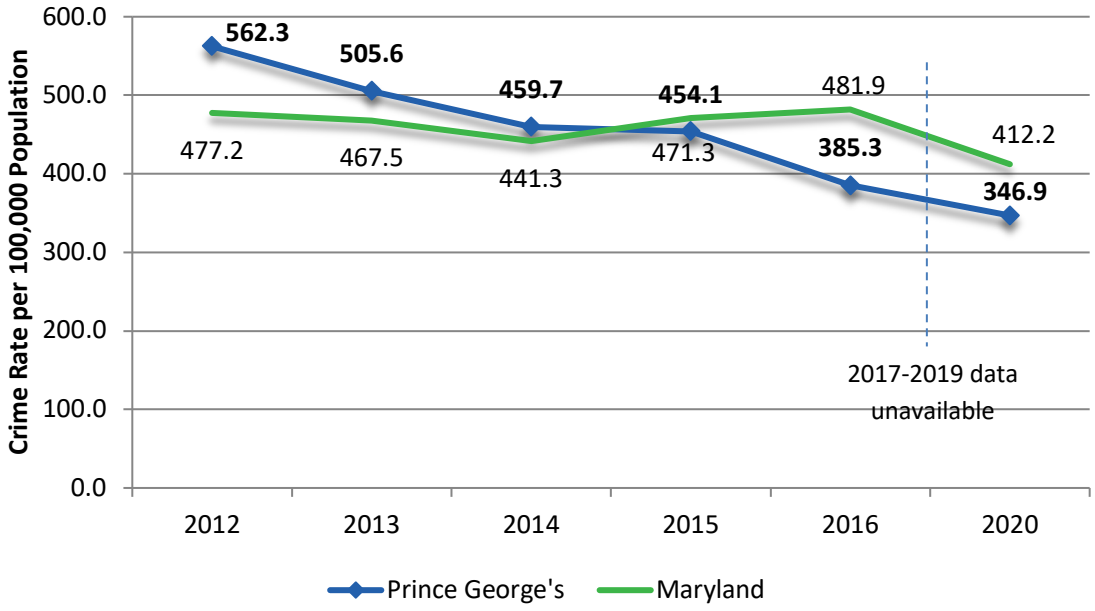
Overview	
What is it?	Violence affects all stages of life and includes child abuse, elder abuse, sexual violence, homicides, and domestic violence. Domestic violence is a pattern of abusive behavior including willful intimidation, physical assault, battery, and sexual assault used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can happen to anyone regardless of age, economic status, race, religion, sexual orientation, nationality, sex, or educational background (National Coalition Against Domestic Violence).
Who is affected?	There were 3,16 violent crimes (includes homicide, rape, robbery, and aggravated assault) in 2020, and 138 residents in the county died by homicide. In 2020, there were 1,802 domestically-related crimes in the county and 12 domestic violence-related deaths. (Maryland Network Against Domestic Violence).
Prevention and Treatment	Domestic violence prevention efforts depend on the population and include: • Prevent domestic violence before is exists (primary prevention) • Decrease the start of a problem by targeting services to at-risk individuals and addressing risk factors (secondary prevention) • Minimize a problem that is clear evidence and causing harm (tertiary prevention) (Maryland Network Against Domestic Violence).
What are the outcomes?	Apart from deaths and injuries, domestic violence is associated with adverse physical, reproductive, psychological, social, and health behaviors. (CDC.gov).
Disparity	No data is currently available about disparities for violence and domestic violence. However, anyone can experience domestic violence. Women generally experience the highest rates of partner violence compared to males. Teenaged, pregnant, and disabled women are especially at risk. (MD Network Against Domestic Violence).
How do we compare?	The county's age-adjusted death rate due to homicide in 2018-2020 was 11.7, compared to the state overall at 10.2 and the U.S. at 6.6 per 100,000 population. The county's violent crime rate in 2020 was 346.9, below the state rate of 412.2 per 100,000. (MD Governor's Office of Crime Control and Prevention).

Age-Adjusted Death Rate for Homicide, 2011-2020



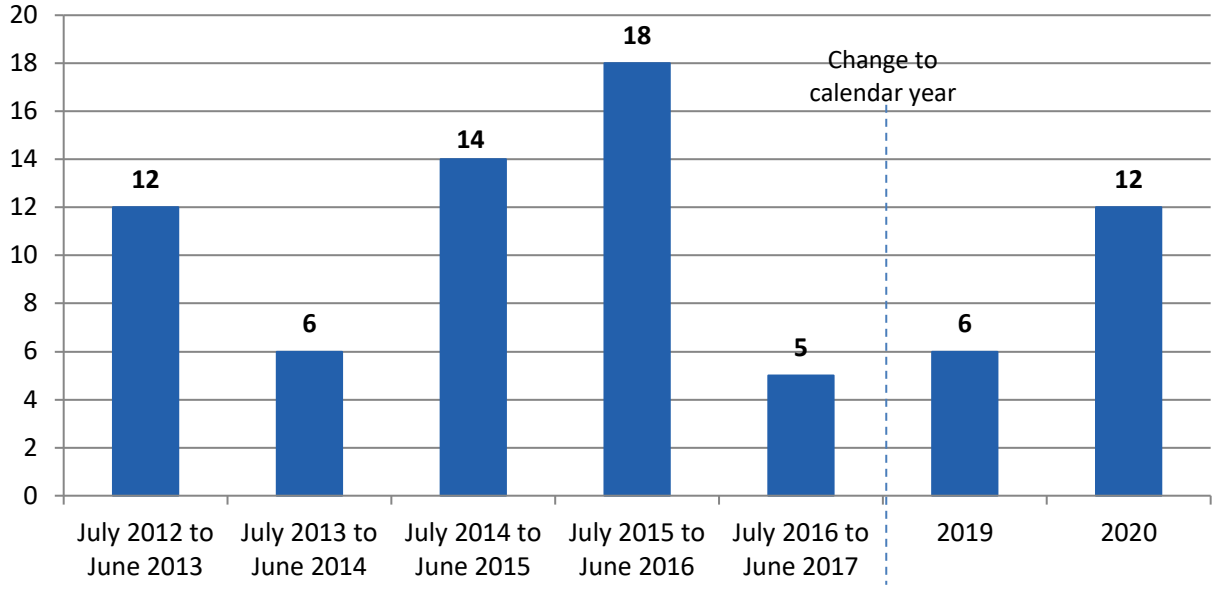
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

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



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

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



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

KEY INFORMANT INTERVIEWS

Introduction

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

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

Key Findings

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

specialized behavioral health providers.

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

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

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

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

Methodology

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

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

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

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

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

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

Question-by-Question Analysis

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) The Physical Location of the County

In several interviews, the actual physical location of the county relative to Washington DC, and Annapolis was repeatedly reported as a strength for the county. It represented strength, access to and influence.

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

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

well-being of the county's residents as they were about the strengths. The most important barriers relative to the health and well-being of residents are (i) Lack of Adequate Mental Health Services, (ii) Lack of Awareness about health programs and resources, (iii) Limited primary care access/specialists, (iv) Health Literacy, (v) lack of transportation, (vi) housing concerns, and (vii) the post-COVID-19 effects. Some quotes are provided below to highlight some of the sentiments associated with the above-mentioned concerns.

(i) Lack of Adequate Mental Health Services

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

"There is a lack of readily accessible intermediate care"

"It is difficult to find social support."

(ii) Lack of Awareness About Health Programs and Resources

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

"There needs to be a map where programs are physically happening, a map of communities where (individuals) can actively participate."

"There are language barriers, we need more cultural sensitivity and civic participation"

(iii) Limited Primary Care Access/Specialists

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

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

(iv) Health Literacy

"There are issues surrounding the digital divide, especially pertaining to seniors and veterans"

"A lot of information is being put online, however there are still access challenges that ranges across SES and other demographics"

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

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

"Transportation is more than just getting from one place to another but also being able to

connect to other parts of your community, such as clinics, etc., our infrastructure does not support community engagement"

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

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

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

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

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

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

(i) Economic Stability- The cost of living in the county and economic stability was identified as the most important social determinant of health in the county and seemed to be related to many other social determinants of health that were mentioned such as healthcare access and quality care.

"Making sure people have the ability to provide for themselves either through work or benefits (income)."

(ii) Transportation: Transportation was seen as another key social determinant of health in the county as it appeared to be essential to several of the components that were needed to be healthy and for an individual's well-being in the county. Many key informants reported that this was an urgent issue that has transpired for several years and needed to be addressed. One respondent summarized the transportation issue by stating:

"We just don't have enough of it!"

(iii) Housing: Economic stability seemed to be related to housing concerns (i.e., affordability and access). It was noted by many informants that some of the best affordable, quality places to live in the county are inaccessible to "too many" people

"The cost (for housing) is simply too high!"

"There is not enough housing"

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

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

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

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

"*You need to have accessibility of services to stay health"*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Built Environment:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"More funding for the Health Department and Department of Family Services and social services because they departments work so closely together and provide most of the services for our seniors."

"A lot more community outreach and education- especially with immigrant and refugee communities who are taking on so many new things you know, trying to find a job and trying to find housing and you know school enrollments and I think it's just so challenging. Their lists are so long and cumbersome BUT knowing and understanding that there are services that even if they cannot get to them now….they are available and that they can tap into them someday is helpful "

"Increase health literacy and community outreach and education-they are currently doing a lot with the ACA"

"The county needs to invest in its population (resources, work development, etc.)"

"The school system is doing their best with contracting mental health clinicians but they can still do… better. "

"*Improve technology literacy."*

"Increase funding for aging services and family support."

"Expand the multi-service centers to other areas of the County."

All the respondents agreed that more funding needs to be distributed to organizations and agencies that worked for the betterment of the residents of Prince George's County. The majority of respondents strongly suggested that two entities that could benefit from more funding would be the Health Department and the Department of Social Services because of their dedication to the County and the fact that they desperately need more resources to address the increasing needs of the residents. Capacity building was also mentioned as a need for local organizations, especially after surviving the complexities of COVID, but respondents did not identify who should deliver the proposed capacity building or how it would be funded.

14. What resources are needed but not available to address each of the three issues?

The majority of the responses centered around housing, transportation, the economy (e.g., sources of funding and the workforce), and health and human services as essential resources needed to address the current key health issues. The majority of the respondents reiterated their concerns about housing (detailed discussion in Questions 5, 6, and 10) and transportation (detailed discussion in Questions 5, 6, 7, 9,10, and 11).

Many respondents shared the need to see more collaboration and bidirectional partnerships with local organizations and the county government-

"The County should engage in more routine and regular dialogue with agencies at the executive level."

and that there should be better tracking of health actions and implementation:

"We need more funding and someone to lead and monitor actions and implement bidirectional partnership amongst organizations in the county. We need to create more authentic partnerships"

An appeal was made by all the respondents to increase the availability of all services such as primary care for undocumented residents, veterans, and seniors, train and hire more bilingual and trilingual staff and increase telehealth services and capacities, especially in areas and for individuals who have accessibility challenges.

15. What are the 3 most important <u>emerging</u> threats to health and well-being in the County?

There were several issues of concern for emerging threats to health and well-being in the county. The most common concerns were mental health conditions, housing, life with COVID and its after-effects, employment concerns, and lack of cultural and linguistic ongoing health delivery.

(i) Mental Health: Many respondents shared their opinions about the cyclical nature of these conditions and made a connection between the high levels of mental health concerns, such as stress and depression, and the behaviors that individuals may engage in to reduce the stress, such as consuming substances and the lack of physical activity, thus making them vulnerable to chronic diseases. They were also concerned with access to mental health care and treatment. An emerging concern was for senior residents in the county:

"We also are seeing a lot of seniors with more mental health issues than before, maybe it is because we are paying more attention to those behaviors at this time but it is very concerning"

(ii) Housing: Housing concerns have been mentioned extensively throughout this report. This should be interpreted not as being merely repetitive but as an issue that appears to transcend many of the issues that respondents have discussed.

(iii) Life With Covid-19/The lasting effects of COVID-19-Many respondents shared that they felt that we still had not seen all of the lasting effects of COVID-physically, mentally, emotionally, or socially and felt we needed to keep increased funding available to be able to accommodate for this possible reality, in addition to pre-COVID health challenges.

“All of the challenges that the community had prior to the pandemic, they still have them and those resources are still needed. There is also no need to put up a program that the community did not ask for”

“The effects of kids in the school system and the pandemic, we still don't know the full effect it will have on them.”

(iv) Employment Concerns: Several respondents mentioned that members of their respective community need to be re-trained or newly trained to better function in the “new” employment space (whether it be spaces to work remotely or skills to find new employment as their jobs may have been lost as a result of the pandemic.

“Many will need vocational training-workforce development-many people lost their jobs and many do not want to go back to such uncertain jobs”

(v) Language barriers/Cultural and linguistic diversity-Respondents shared that the “face” of the county is changing and that we need to be able to accommodate this for the benefit of the County as a whole.

16. How is your organization/program addressing these emerging threats?

Aside from sharing information where appropriate to their respective targeted population, respondents uniformly agreed that, although they can identify several threats, their organizations are not able to address all of them because they are too occupied with responding to current needs. In addition, some respondents believe that the identified threats require a uniform, comprehensive approach and not siloed actions undertaken by individual organizations, especially in areas such as emergency preparedness, advocacy, and outreach. Some respondents shared that, whenever possible, they do their best to join organizations, coalitions, or task forces. Others addressed emerging threats through lobbying activities, advocacy, strategic communication, providing information on available resources and services, tailoring existing funds to meet emerging needs, integrating health into other activities, helping individuals to see all aspects of health as being important to one's overall well-being, and creating networks.

17. Do you have any other comments to add relative to health and the County?

The respondents' closing remarks centered on ensuring that as a county we address the top needs that they had shared about the various aspects of health. Many respondents shared that we can only address the current, emerging, and future challenges if organizations and governments collectively organize, strategize and implement programs and policies that will benefit our residents. Finally, all respondents shared that our county is resilient and we have overcome several obstacles, especially over the last few years with the Covid-19 pandemic, we need to maintain our relationships and take our "lessons learned" and "press forward" to address and overcome new challenges. Overall, all the respondents were ready to see (and continue to work towards)significant change in the county.

Appendix A: List of Key Informants

NAME	ORGANIZATION	POPULATION
Michelle LaRue	Representative from CASA	Immigrant and Refugee
Alison Flores	Prince George's County Executive Latino Affairs Liaison	Hispanic
Patricia Chiancone	Prince George's County Public Schools International Student Admissions and Enrollment	Immigrant and Refugee
Lisa Walker	Hyattsville Aging in Place	Seniors
Tisa Holley	Prince George's County Public Schools, McKinney Vento Program	Homeless/Housing Insecurity
Patricia Fletcher	AERS Program	Seniors
James Dula	Office of Veterans Affairs, Department of Family Services	Veteran
Anthony Smith	Office of Veterans Affairs, Department of Family Services	Veteran
Stacey Little	University of Maryland Capital Region Health	Affiliated/Supporting Groups Business
Dushanka Kleinman	University of Maryland, College Park, School of Public Health	Affiliated/Supporting Groups Higher Education
Norberto Martinez	Langley Park Civic Association	Hispanic
Guy Merritt	Department of Corrections	Homelessness/Housing Insecurity
Anna Cazes	Fort Washington Medical Center	Filipino
Col. Jimmy Slade	Community Ministries	Homelessness/Housing Insecurity
Jean Drummond	HCDI, Inc	Affiliated/Supporting Groups Business
Andre Pittman	First Baptist Church of Glenarden Military Care Ministry:	Veteran

Appendix B: Community Health Assessment

Key Informant Interview Protocol

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

2. How long have you/ your organization/ program played this role?

3. In your opinion has the health of County residents of (name the group that the person has been selected to represent) improved, stayed the same, or declined over the past few years? What makes you say that?

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

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

6. What do you think are the three most important social determinants of health in the County for (((name the group that the person has been selected to represent)? (Social determinants of health are factors related to the social environment, physical environment, health services, and structural and societal characteristics.)

7. What do you think are the three most important physical health needs or concerns of (name the group that the person has been selected to represent) County residents?

8. What do you think are the three most important behavioral/mental health needs that (name the group that the person has been selected to represent) face in the County?

9. What do you think are the three most important health-related environmental concerns (name the group that the person has been selected to represent) face in the County?

10. Now if you had to prioritize and select the three most important health issues facing the (name the group that the person has been selected to represent) in the County from among those you just mentioned what would they be?

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

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

13. Based on your experience and expertise, what else needs to be done in the county and by which organizations/ programs to address the needs of (name the group that the person has been selected to represent) in Prince George's County?

14. What resources are needed but not available to address each of the three issues?

15. What are the 3 most important emerging threats to health and well-being in the County for (name the group that the person has been selected to represent)?

16. How is your organization/program addressing these emerging threats?

17. Do you have any other comments to add relative to health and the County pertaining to (name the group that the person has been selected to represent)?


COMMUNITY EXPERT
survey

COMMUNITY EXPERT SURVEY

Introduction

Prince George's County is diverse, and our growing population has a wide range of needs, disparities, and perceptions about health. The Community Expert Survey was developed as a strategy that complements the overall Community Health Assessment (CHA) goal of identifying the health needs and issues among the county's different populations, through providers, community-based organizations, local governments, and population representatives that can speak for the communities they serve.

Methodology

The Core CHA team provided lists of community-based partners and representatives to be included in the survey; this included the membership of the Prince George's County Health Action Coalition, as well as and community leaders, and representatives of specific populations. The survey was developed based on existing community surveys with some modifications specific to the county. Efforts were made to ensure the survey questions corresponded with the Community Resident Survey which was also part of CHA data collection efforts. An email request was sent to approximately 100 participants by the Prince George's County Health Department in April 2022, and hospital partners were also provided with the survey link to share with their community experts.

The survey questions included multiple choice, yes/no, and open-ended responses. Each multiple-choice question is presented as a simple descriptive statistic. Not all participants responded to every question; each question includes the number (N) of participants who did respond. Open-ended response questions were initially reviewed for content analysis, which was used to identify common categories and overarching themes that emerged as patterns in the data. Each response was then reviewed and analyzed according to the categories and themes, with summary responses presented to capture the participants' information.

Participation

Surveys were submitted by 27 participants though not all participants responded to every question. Participants represented knowledge bases from across the county geography. Participants represented a variety of organizations (Question 20): Government Organizations (50%), Non-profits (22.2%), Public Health Organizations (16.7%), Healthcare Providers (11.1%), Faith-Based Organizations (11.1%), Social Service Organizations (5.6%), Mental/Behavioral Health Organizations (5.6%), and Education/Youth Services (5.6%); participants also worked with a variety of populations in the county (Question 22).

Key Findings

- ***Healthy community***: Access to healthcare, healthy behaviors and lifestyles, affordable housing, and good jobs/healthy economy were the most important factors defining a "healthy community" identified by community experts. All survey participants (20 responses) believe that the overall health of the community they serve is unhealthy, and over half believe the communities they serve are either unsatisfied or very unsatisfied with the healthcare system.

- ***Discrimination:*** Two new questions were added to the 2022 survey about discrimination. Participants indicated that the people they serve experience the following at least several times per year: treated with less courtesy compared to others (60%), receive poorer service at restaurants and stores (35%), and being treated as if they are not smart (20%). Participants identified for those they serve the leading reasons for these experiences were race (55%), education or income level (45%), and ancestry or national origin (20%).

- ***Leading health issues***: Similar to 2019, chronic disease and related issues including diabetes and poor diet, as well as mental health, aging problems, dental health, and poor diet led as the most pressing issues for the overall county. Other issues of concern were stroke/high blood pressure, alcohol and drug abuse, COVID, heart disease, physical inactivity, and cancer. By ranking, diabetes, mental health, and issues associated with aging were the most important health issues identified by participants.

- ***Access to healthcare***: Participants were more likely to disagree or somewhat disagree that most residents could access providers in the county, including mental health providers (85%), medical specialists (80%), dentists (85%), and primary care providers (55%). Almost half of survey participants disagreed or somewhat disagreed that providers incorporate cultural competency and health literacy into their practice, and over 60% disagreed or somewhat disagreed that providers accept Medicaid or provide services for residents who do not qualify for insurance. Nearly three-fourths of survey participants disagreed or somewhat disagreed that transportation is available to the majority of residents for medical appointments, and 80% disagreed or somewhat disagreed residents can afford their medication.

- ***Leading barriers****:* The most significant barrier to accessing healthcare in the county identified by participants was the inability to pay out of pocket expenses, followed by lack of insurance coverage, the inability to navigate the healthcare system, basic needs not met, and availability of providers/appointments.

- ***Resources to improve access:*** Survey participants identified key areas of resources that are needed to improve health care access in the county (those with at least 4 responses):

    - *Better health navigation, education, and information* – increased community health worker capacity; increased communication, engagement, and outreach services; add health literacy to the education system; county wide marketing of where to gather information

    - *More providers and access to providers* – more providers across all disciplines; need medical personnel to be at community centers and senior centers; need providers who reflect the populations they serve

    - *Affordable health care* – financial support directly or through expanded reimbursement; county funded programs for specialty healthcare access and services for the low income and uninsured populations; more trauma informed healthcare and behavioral health providers that are affordable for the immigrant population and the poorest among us; co-pay assistance and lower prescription costs

    - *Primary language considerations* – increasing provider access to translation services by phone and during appointments; bilingual staff in offices

- ***Underserved populations***: The populations that were selected as most underserved were immigrants, Latinos, seniors, and low-income minorities, similar to those identified in the 2019 Community Health Assessment.

- ***Primary barriers to accessing healthcare for underserved populations*:**

    - *Lack of financial and basic resources* – having to take time off work; low income and live in rural communities; no county subsidized program for medical specialty care access; lack affordable healthcare options and ability to earn a living wage to cover basic needs

    - *Cultural/language barriers* – lack of bilingual providers and staff; limited resources for non-English speakers; limited education and language; cultural competency

    - *Access to care* – lack of access to primary and specialty care; lack of access to providers who will see patients regardless of insurance status; not enough hospital beds; not enough providers that understand the needs of the residents they serve

- *Engagement and awareness of services and resources* – lack of awareness of resources and providers; lack of knowledge and experience with innovative technology; inability of agencies to understand how to saturate the community with quality messaging that resonates and triggers action; availability of appropriate services

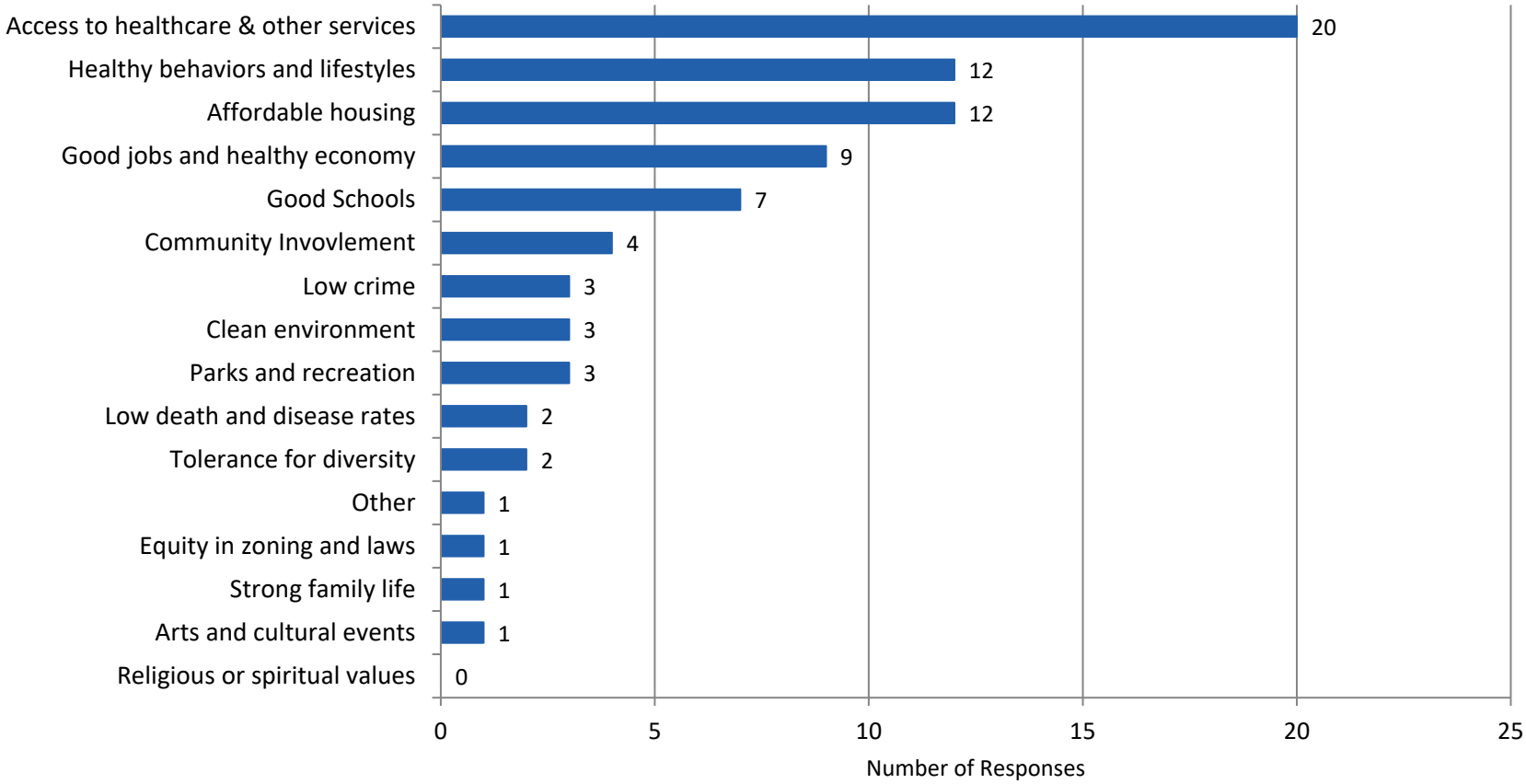
- *Lack of trust* – fear of identification consequences among the undocumented and immigrant populations; little trust in the system

- ***Recommendations to improve health:*** An increased focus on health inequities and increased communication and awareness were the most frequent recommendations to encourage and support community involvement around health issues in the county. Open-ended responses from participants included increasing and improving access to providers and clinics in the county, health education and outreach, and increase health funding.

- ***What is working well:*** Similar to the 2019 survey, participants reported that collaboration and partnerships among healthcare providers, hospitals, health department, and community-based services and programs continues to work well. Participants identified that several county agencies are contributing towards better health outcomes, with the County Health Department and FQHCs being mentioned the most. Programs focused on specific communities and community outreach and education were also viewed positively. As far as healthcare systems, the construction of the new hospital (UM Capital Region Health) was positively mentioned by several participants, as well as the implementation of community/population health initiatives in the hospital systems.

Results

Question 1: What do you think are the **three** most important factors that define a "healthy community" (what most affects the quality of life in a community) for the community you serve in Prince George's County? (N=27 responses)

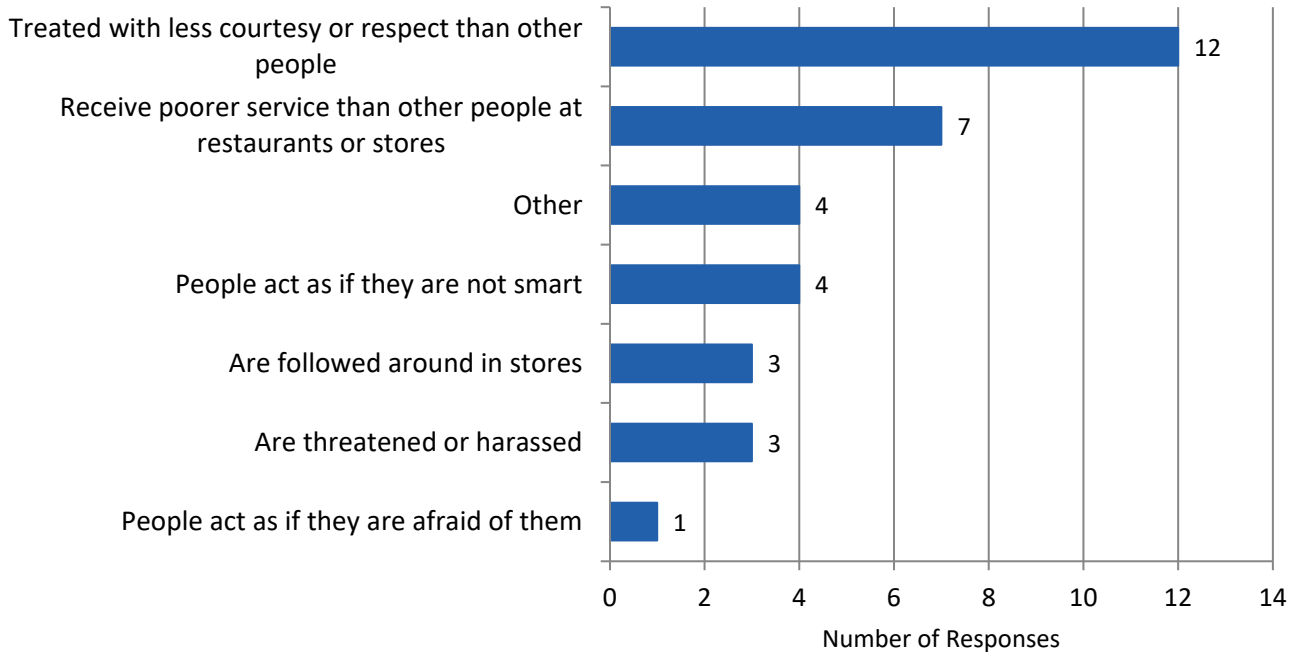


"Other" Included: improvements in collaboration between health care system and the community at large

Question 2: How satisfied do you think the Prince George's County communities you serve are with the following? (N=27 responses)

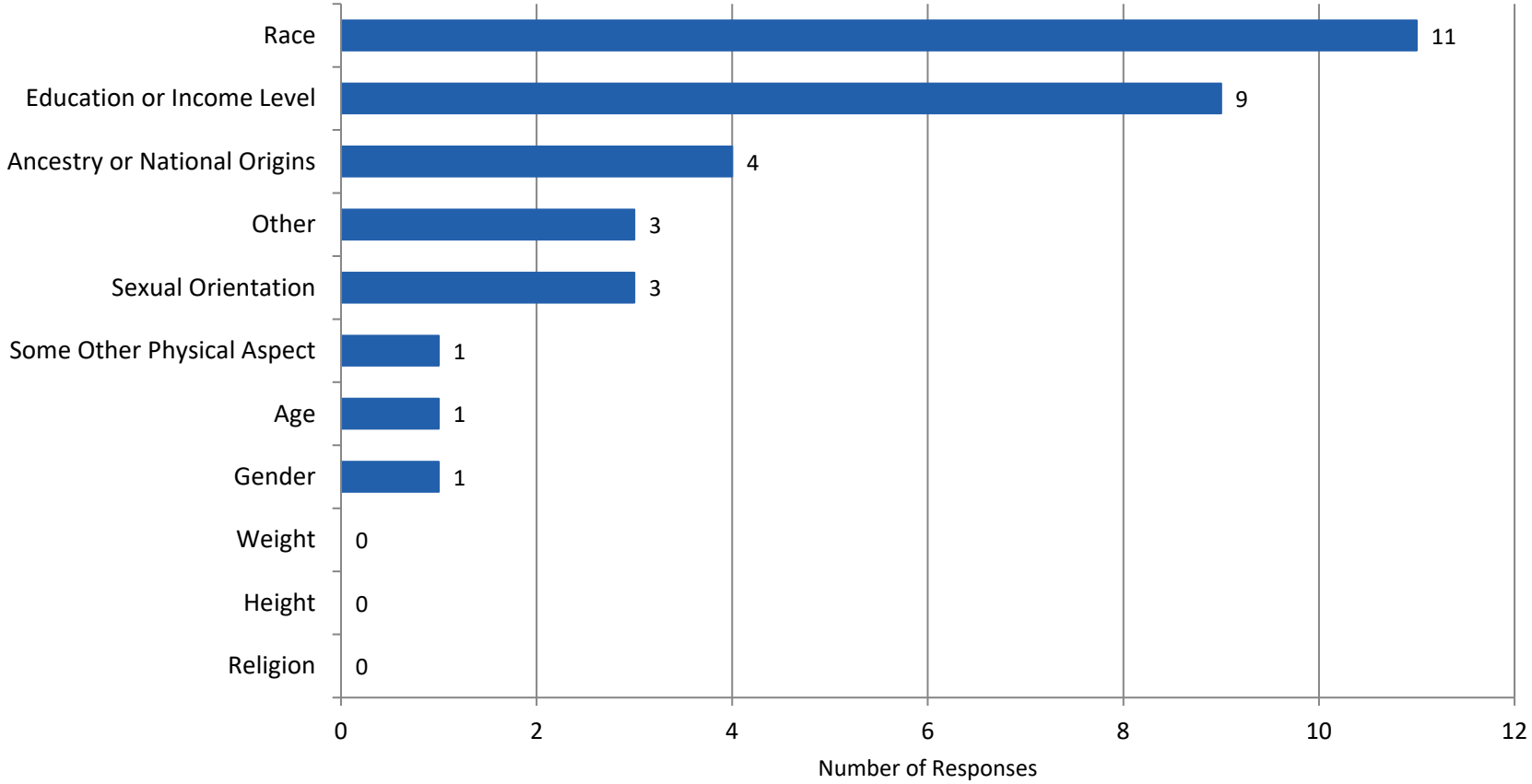
	Very Unsatisfied	Somewhat Unsatisfied	Neutral	Somewhat Satisfied	Very Satisfied
The quality of life	2 (7.4%)	4 (14.8%)	4 (14.8%)	15 (55.6%)	2 (7.4%)
The health care system	6 (22.2%)	9 (33.3%)	3 (11.1%)	9 (33.3%)	0 (0.0%)
A good place to raise children	4 (14.8%)	6 (22.2%)	7 (25.9%)	9 (33.3%)	1 (3.7%)
Economic opportunity	2 (7.4%)	6 (22.2%)	10 (37.0%)	7 (25.9%)	2 (7.4%)
A safe place to live	4 (14.8%)	6 (22.2%)	8 (29.6%)	7 (25.9%)	2 (7.4%)
The quality of the environment	2 (7.4%)	7 (25.9%)	4 (14.8%)	14 (51.9%)	0 (0.0%)

Question 3: Do the community members you serve experience any of the following at least a few times per year? (N=20 responses)



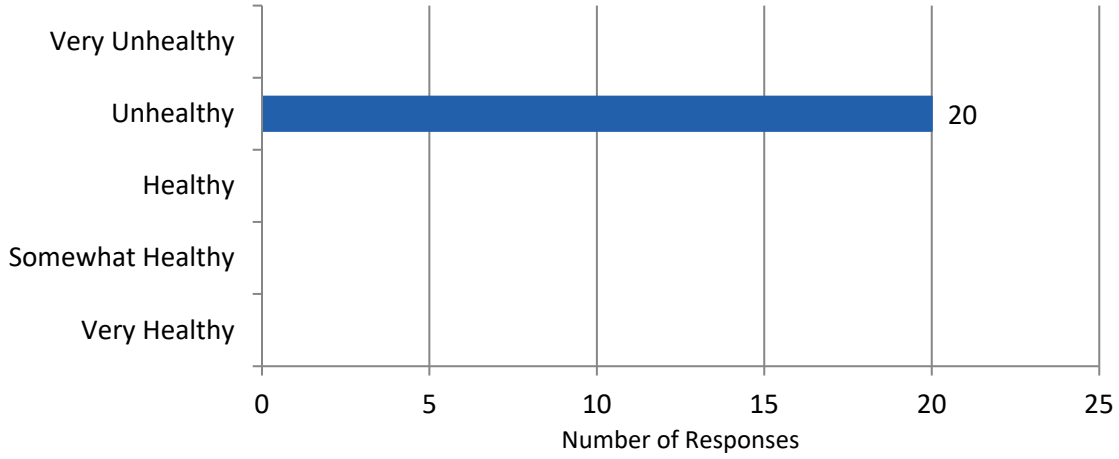
"Other" Included: Inequities in access to healthcare and education and housing, lack of access to specialty healthcare services

Question 4: If you selected any of the responses in the question above (question 3), what do you think is the main reason for these experiences? Please select all that apply. (N=20 responses)

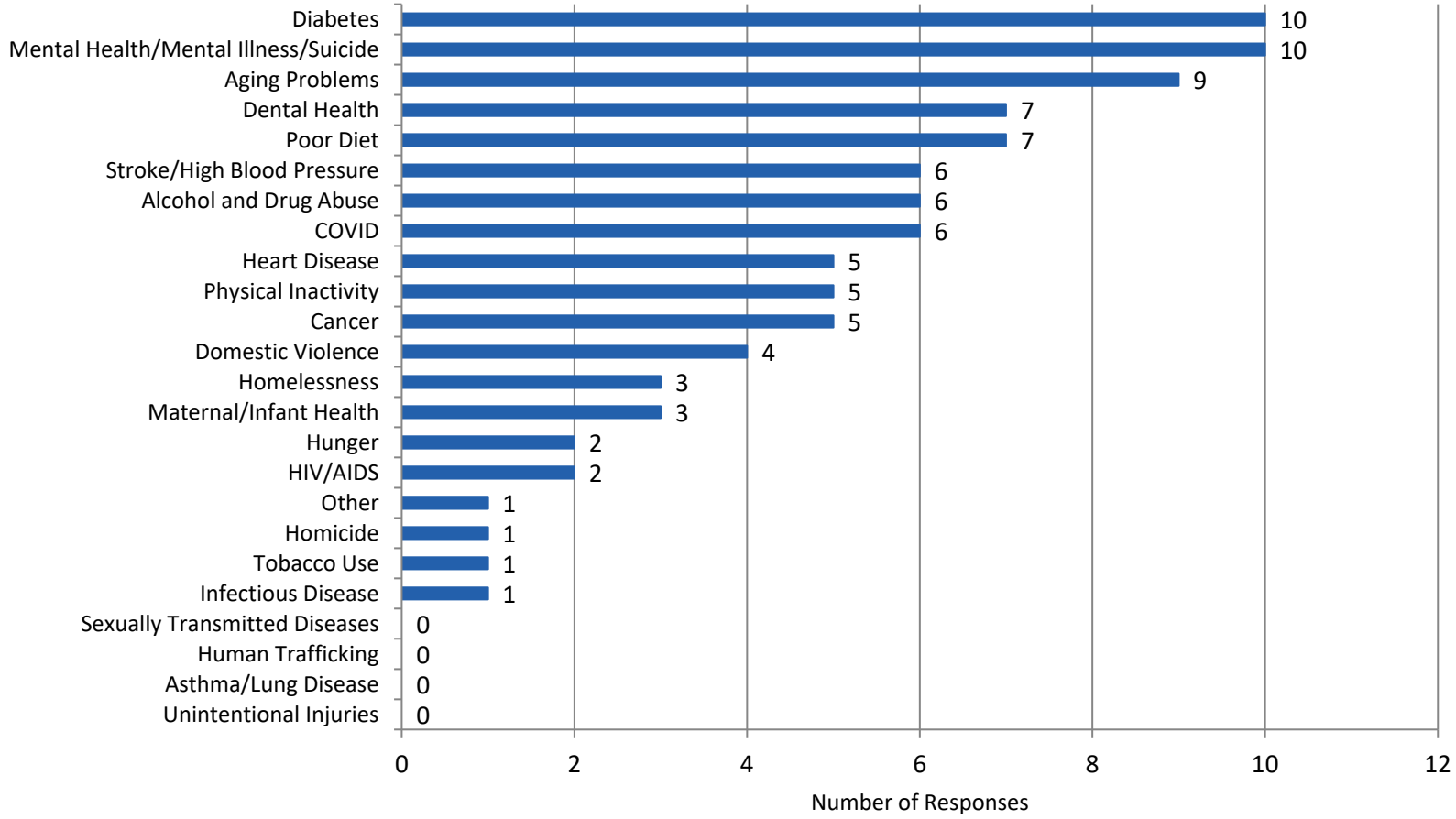


"Other" Included: ZIP code, county does not have programs to support access to specialty healthcare services for the low-income/uninsured populations

Question 5: How would you rate the overall health of the community you serve in Prince George's County? (N=20 responses)



Question 6: What are the leading health problems that impact the community you serve in Prince George's County? Please select up to five from the list below. (N=20 responses)



"Other" Included: affordable housing, financial stresses, health literacy

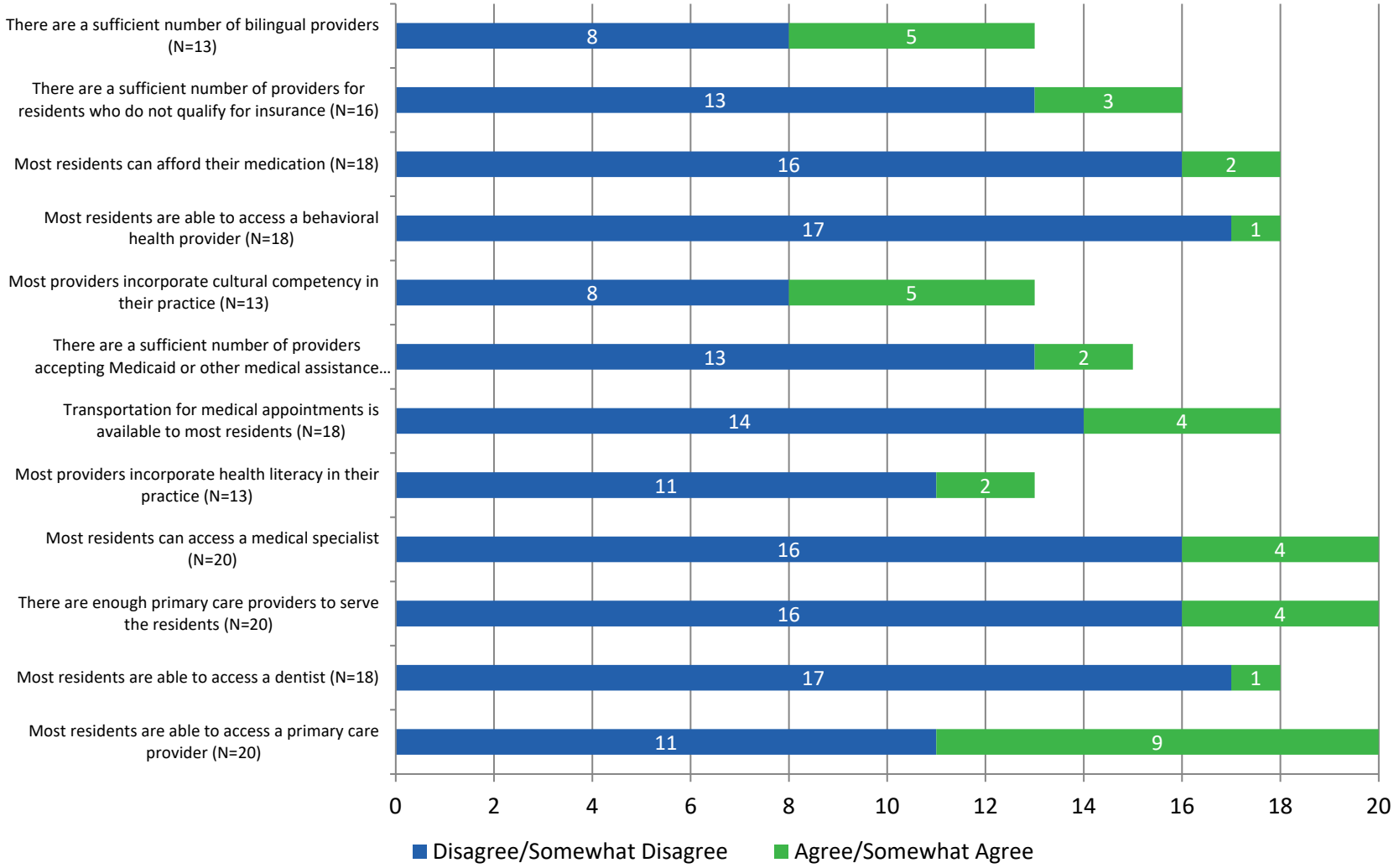
Question 7: Respondents were asked to share any additional information about health issues in the county in an open-ended response (N=5 responses). The responses are summarized in the table below.

Issues mentioned	Number of Responses	Summary of Responses
Specific Health Issues	3	Diabetes, dental health, stroke/high blood pressure are of highest concern. Many health issues are interrelated.
Lack of Insurance/Healthcare Challenges	1	Many residents lack insurance or are unable to afford co-pays. Challenges with navigating the healthcare system and residents don't know how to utilize services. More bilingual providers to address behavioral health issues.
Lack of Collaboration and Resources	1	Too many systems operating in silos and the lack of appropriate/adequate distribution of resources.
Lack of Affordable Healthcare	1	Community lacks affordable healthcare insurance programs for underinsured people.

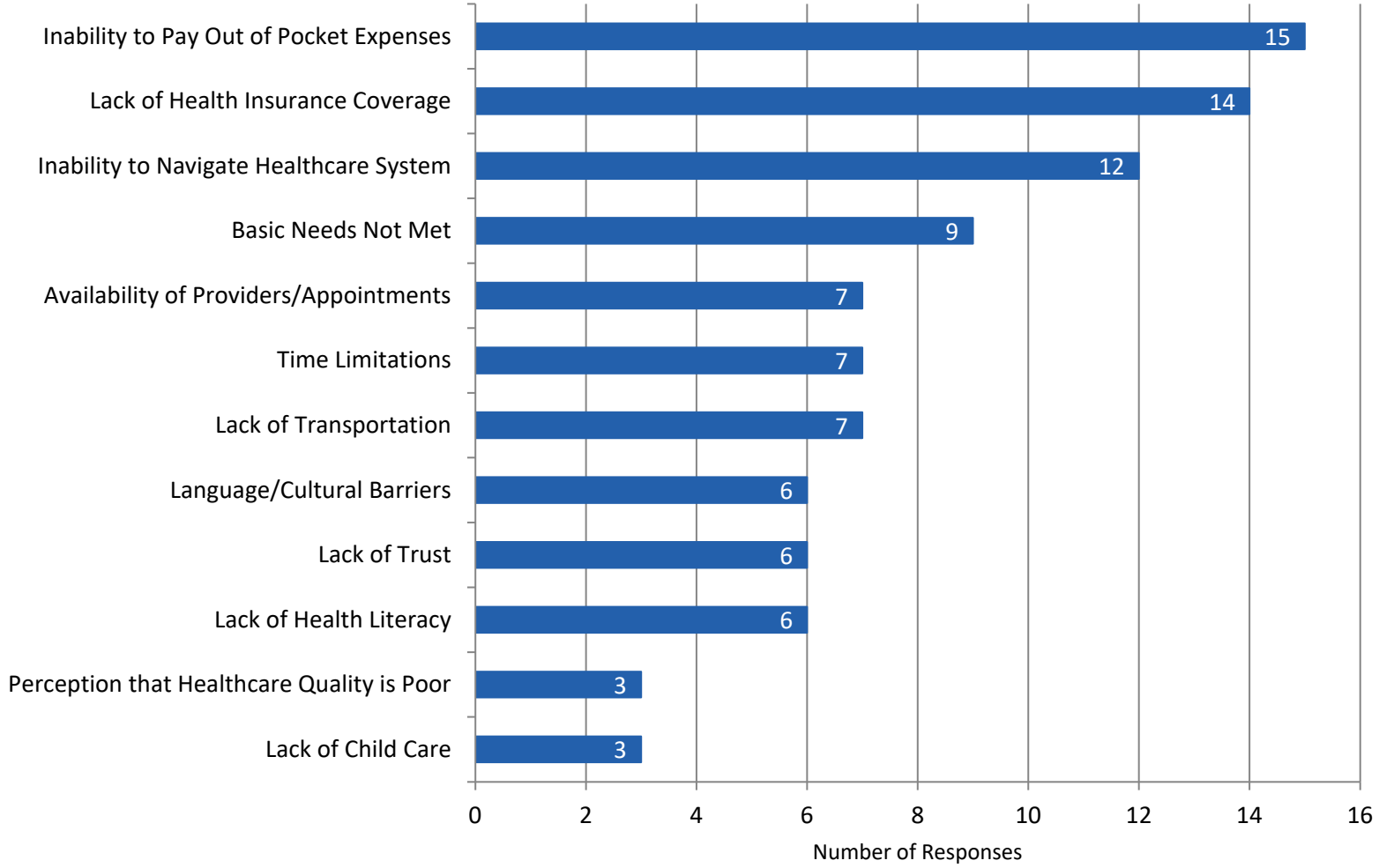
Question 8: Please rate the following statements about health care access in Prince George's County for the community you serve based on the scale below. (N=20 responses)

	Disagree	Somewhat Disagree	Somewhat Agree	Agree	No Opinion/ Don't Know
Most residents are able to access a primary care provider.	6 (30.0%)	5 (25.0%)	9 (45.0%)	0 (0.0%)	0 (0.0%)
There are enough primary care providers to serve the residents.	9 (45.0%)	7 (35.0%)	4 (20.0%)	0 (0.0%)	0 (0.0%)
Most residents are able to access a medical specialist.	9 (45.0%)	7 (35.0%)	4 (20.0%)	0 (0.0%)	0 (0.0%)
Most residents can access a behavioral health provider (such as for mental health or substance use treatment).	12 (60.0%)	5 (25.0%)	1 (5.0%)	0 (0.0%)	2 (10.0%)
Most residents are able to access a dentist.	9 (45.0%)	8 (40.0%)	1 (5.0%)	1 (5.0%)	1 (5.0%)
Transportation for medical appointments is available to most residents.	10 (50.0%)	4 (20.0%)	4 (20.0%)	0 (0.0%)	2 (10.0%)
Most residents can afford their medication.	11 (55.0%)	5 (25.0%)	2 (10.0%)	0 (0.0%)	2 (10.0%)
There are a sufficient number of providers accepting Medicaid or other forms of medical assistance.	6 (30.0%)	7 (35.0%)	2 (10.0%)	0 (0.0%)	5 (25.0%)
There are a sufficient number of providers for residents who do not qualify for insurance.	9 (45.0%)	4 (20.0%)	3 (15.0%)	0 (0.0%)	4 (20.0%)
There are a sufficient number of bilingual providers.	6 (30.0%)	2 (10.0%)	4 (20.0%)	1 (5.0%)	7 (35.0%)
Most providers incorporate cultural competency in their practice.	5 (25.0%)	3 (15.0%)	4 (20.0%)	1 (5.0%)	7 (35.0%)
Most providers incorporate health literacy in their practice.	5 (25.0%)	6 (30.0%)	2 (10.0%)	0 (0.0%)	7 (35.0%)

Question 8: Please rate the following statements about health care access in Prince George's County. (N=20 responses)



Question 9: From the list below, please select up to 5 leading barriers that keep the community you serve in Prince George's County from accessing health care. (N=20 responses)



Question 10: Respondents were asked to name two key resources or services that are needed to improve access to health care for County residents in an open-ended response (N=19 responses). The responses are grouped and summarized in the table below; some responses included statements about multiple issues.

Key Resources	Number of Responses	Summary of Responses
More Providers and Access to Providers	8	Need for: more providers across all disciplines; need medical personnel to be at community centers and senior centers; providers who reflect the populations they serve; centers specially equipped to manage underserved populations; high speed broadband for access to telehealth; need for: better access to mental health services, particularly for children
Affordable Healthcare/Health Insurance	7	Need for: financial support directly or through expanded reimbursement; county funded programs for specialty healthcare access and services for the low income and uninsured populations; more trauma informed healthcare and behavioral health providers that are affordable for the immigrant population and the poorest among us; co-pay assistance and lower prescription costs; provide a more robust safety net system; have social services help people with medical insurance; health insurance for all
Health Navigation, Education, and Information	5	Need for: increased community health worker capacity; increased communication, engagement, and outreach services; add health literacy to the education system beginning in middle school; county wide marketing of where to gather information
Primary Language Considerations	4	Need for: increasing provider access to translation services by phone during appointments; bilingual staff in offices
Transportation	3	Need for: more transportation; improved access to transportation
Improved Healthcare Quality	3	Need for: providers that are culturally competent; better care coordination and case management for patients; improve service quality
Basic Needs (housing, food, employment)	2	Need for: increased healthy eating options around the county; childcare

Question 11: Respondents were asked what population they think is most underserved for health-related services in Prince George's County in an open-ended response (N=20 responses). The responses are summarized in the table below.

Populations mentioned	Number of Responses	Summary of Responses
Immigrants	4	Immigrants; those with limited English proficiency
Minorities	4	Latinos; Blacks and Latinos; Black men
Low income	4	Lower income minorities; Unemployed and underemployed residents; homeless individuals and no access to a computer
Seniors	3	Seniors; African American seniors
Rural	1	Residents living in rural areas
Behavioral Health	1	Those with behavioral health
Transgender	1	Transgenders
Children	1	Children
Working class	1	Working class

Question 12: Respondents were asked what the primary barriers are for the populations listed in Question 11 in an open-ended response (N=20 responses). The responses are grouped and summarized in the table below; many responses included statements about multiple issues.

Primary Barriers	Number of Responses	Summary of Responses
Access to Care	9	Lack of access to primary and specialty care; lack of access to providers who will see patients regardless of insurance status; not enough hospital beds; not enough providers that understand the needs of the residents they serve; no county subsidized program for medical specialty care access; lack of affordable healthcare options; availability of appropriate services
Cultural/Language Barriers	7	Lack of bilingual providers and staff; limited resources for non-English speakers; limited education and language; cultural competency
Engagement and Awareness of Services and Resources	6	Lack of awareness of resources and providers; lack of knowledge and experience with innovative technology; inability of agencies to understand how to saturate the community with quality messaging that resonates and triggers action; lack of information available to understand and navigate behavioral health resources
Lack of Financial and Basic Resources	6	Having to take time off work; low income and live in rural communities; unable to earn a living wage to cover basic needs; low access to healthy foods
Lack of Trust	4	Fear of identification consequences among the undocumented and immigrant populations; little trust in the system
Lack of Insurance	3	Those ineligible for insurance will have unmet health needs, primarily undocumented immigrant populations; ineligibility for Medicare/Medicaid
Transportation	2	Need for more transportation options
Health Literacy	1	Inadequate resources to provide community-based education and healthy literacy where residents live, work, and play
Mental Health	1	Stigma of behavioral health and continuous criminalization of mental illness

Other responses: racism in all its forms

Question 13: Respondents were asked what is being done well in Prince George's County within communities to improve health and well-being and by whom in an open-ended response (N=15 responses). The responses are grouped and summarized in the table below; many responses included statements about multiple activities and contributing organizations.

Agencies/Organizations	Number of Responses	Specific Program/Service/Action
Prince George's County Health Department	5	County health officer is determined to improve the quality of life and quality of healthcare for all residents; health education; COVID Cares Program; Health Assures program
Federally Qualified Health Centers	4	Variety of services under one roof - simplifying navigation for the most vulnerable
Prince George's County Parks and Recreation	1	Parks and Planning maintain a good number of community centers, playgrounds, trails, and other facilities that residents use to stay active
Hospital System	1	Building of the medical center
PG County Council	1	Council members delivering food on a weekly or biweekly basis
Prince George's Department of Social Services	1	Provides excellent services to eligible residents to access health coverage
University of Maryland School of Public Health Center for Health Equity	1	Provides much needed health information to customers (i.e. Barbershop & Salons program)

Other organizations mentioned (without specified programs or services): Capital Area Food Bank, Brighter Bites

Some respondents listed programs and services occurring in the county without association to a specific agency or organization:

Other Areas of Action	Number of Responses	Specific Program/Service/Action
Collaboration and Partnerships	5	This community health assessment; COVID-19 response; passage of Blueprint for Excellence; educating the community about COVID-19 and getting people vaccinated; including and partnering with other organizations to improve the health of the community
Community-Based Services and Programs	5	Programs to connect qualifying residents to medical insurance; having bilingual centers and personnel to address community needs; COVID testing; hosting free healthcare events
Navigating Resources	2	Individuals doing their best to navigate the available resources they know about; sharing of resources
Healthy Lifestyles	2	Food insecurity initiatives are improving access to food for many residents; food distribution centers
Healthcare Access	2	Increasing number of providers; school-based clinics

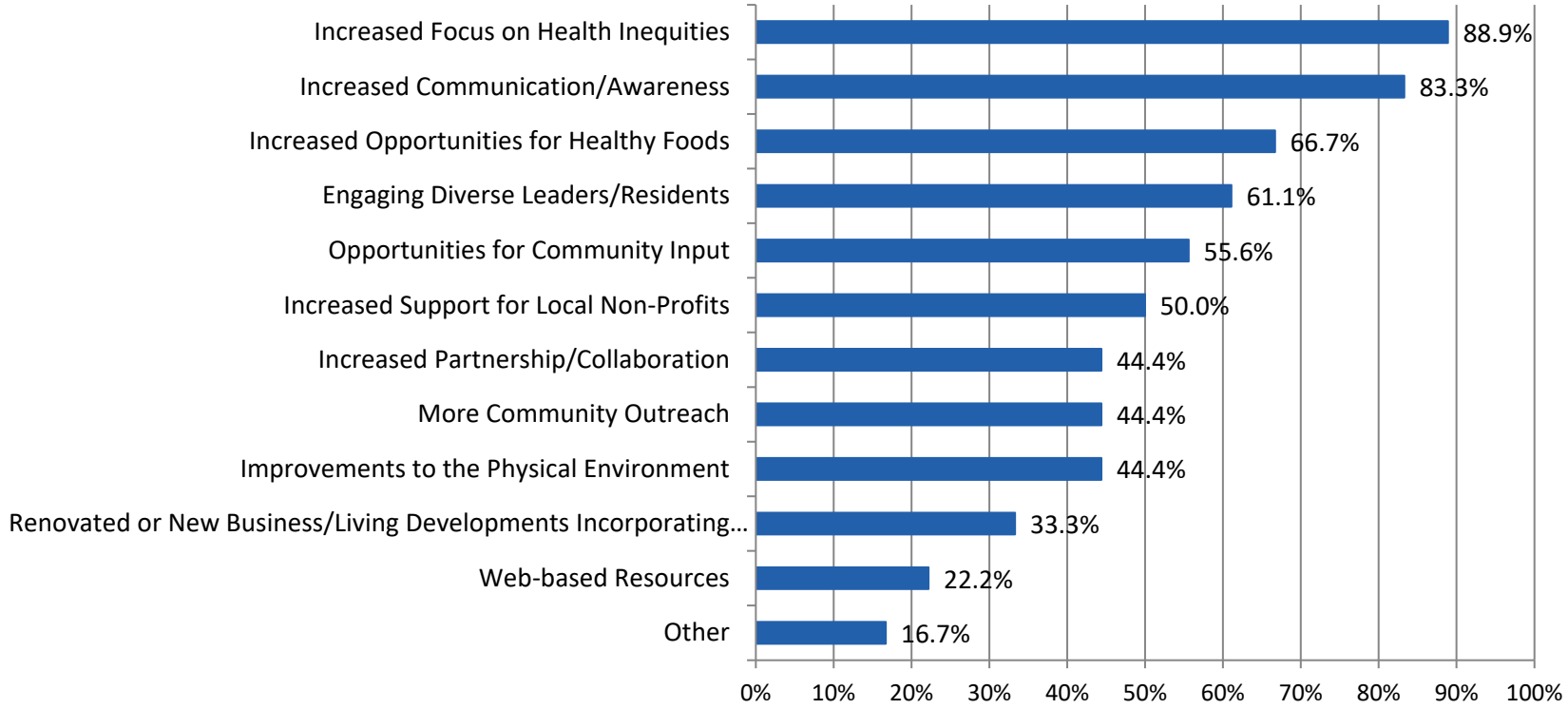
Question 14: Respondents were asked what is being done well by the healthcare systems in Prince George's County to improve health and well-being and by whom in an open-ended response (N=13 responses). The responses are grouped and summarized in the table below.

Areas of Action	Number of Responses	Specific Program/Service/Action
Improving Hospital Quality and Facilities	6	New systems in the county (Capital Region Health, MedStar, Luminus Health); improved quality of inpatient care with the new hospital; hospitals are investing more in the county; new hospital is addressing cancer and mental health; capacity expansions for the local healthcare systems; creating more facilities near public transportation
Education and Outreach	4	More advertisement in the community letting residents know of the services available to them; public notice of resources; getting information into the community; hospital community benefit programs are reaching a lot more residents based on lessons learned from COVID
Funding	2	Funding for Health Assures; Health Assures program is a start but should be amended, expanded, and retooled to address affordability, portability, and sustainability
Access to Providers and Clinics	1	Hospitals should be working closer with FQHCs to improve care, keep patients in their medical homes and out of the ER, and provide more access to specialists and diagnostics

Question 15: Respondents were asked what recommendations or suggestions they have to improve the health and quality of life in Prince George's County in an open-ended response (N=15 responses). The responses are grouped and summarized in the table below; some responses included multiple recommendations.

Recommendations	Number of Responses	Summary of Responses
Increase and Improve Access to Providers & Clinics	8	Identify and eradicate barriers to establishing healthcare practices in the county; increased number of providers and beds with a greater need to expand certain specialties such as behavioral health providers; reduce the number of residents who resort to using emergency medical services or emergency departments for non-emergency matters; work to decriminalize behavioral health and implement a 911 diversion program for residents with behavioral health concerns; improve access to primary care appointments and scale; expand school-based clinics; more services to the northern part of the county
Health Education, Outreach and Navigation	4	Help residents navigate healthcare in the county through a centralized user-friendly hub of terminology and community resources; cultural competency; integrate health literacy in schools; appeal personally to residents
Increase Public Health and Healthcare Funding	4	Develop a clear vision for the PG Health Department and provide necessary funding; increase salaries to be more competitive to avoid turn over in the health department and social services agencies; use community benefit money to sustain innovations emerging from the pandemic response; advocate for a more robust program that include funding for specialty care and medications
Affordable Healthcare	3	Continue funding and expanding services/programs for those who cannot obtain care through insurance; assisting residents with or without insurance at a reasonable rate; universal insurance program
Basic Needs	3	Improve social economic conditions so all residents have access to a living wage, affordable housing, healthy food, education, and transportation; address food insecurity; look at a holistic approach that includes a living wage so they can afford healthcare in addition to rent, childcare, and food
Collaboration	2	Link clinical and social care; bring the entire system together in collaboration instead of working in silos
Support Healthy Lifestyles	2	Improve access to healthy food for all residents; healthier eating and food options
Community Engagement	2	Engage community members to fight for and demand more resources to improve the health care system; engagement from schools, churches, municipalities, and civic associations

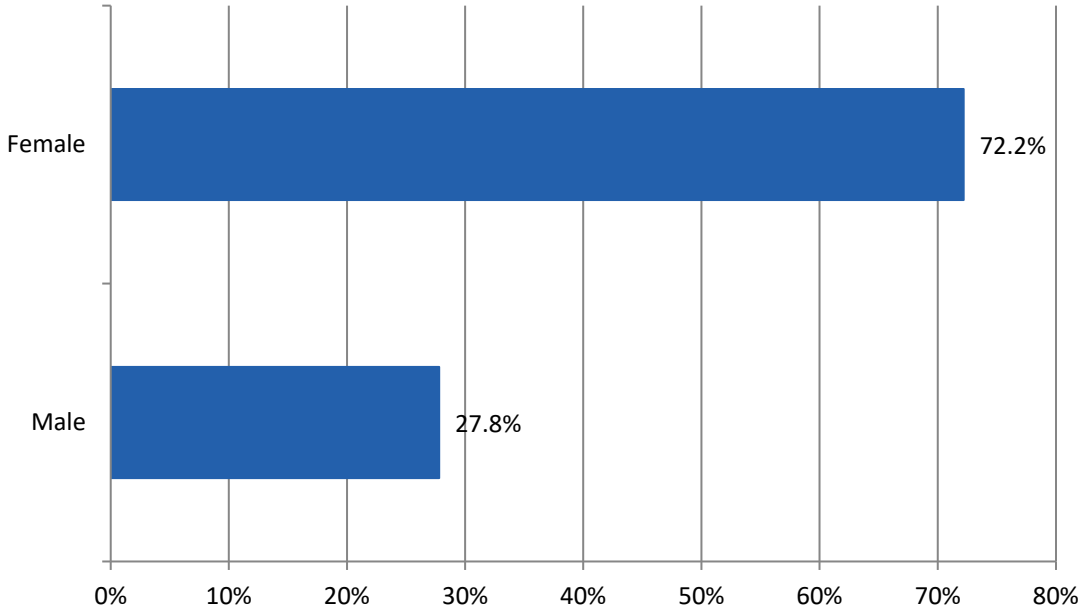
Question 16: What do you think could encourage and support more community involvement to improve health and well-being in Prince George's County (select all that apply)? (N=18 responses)



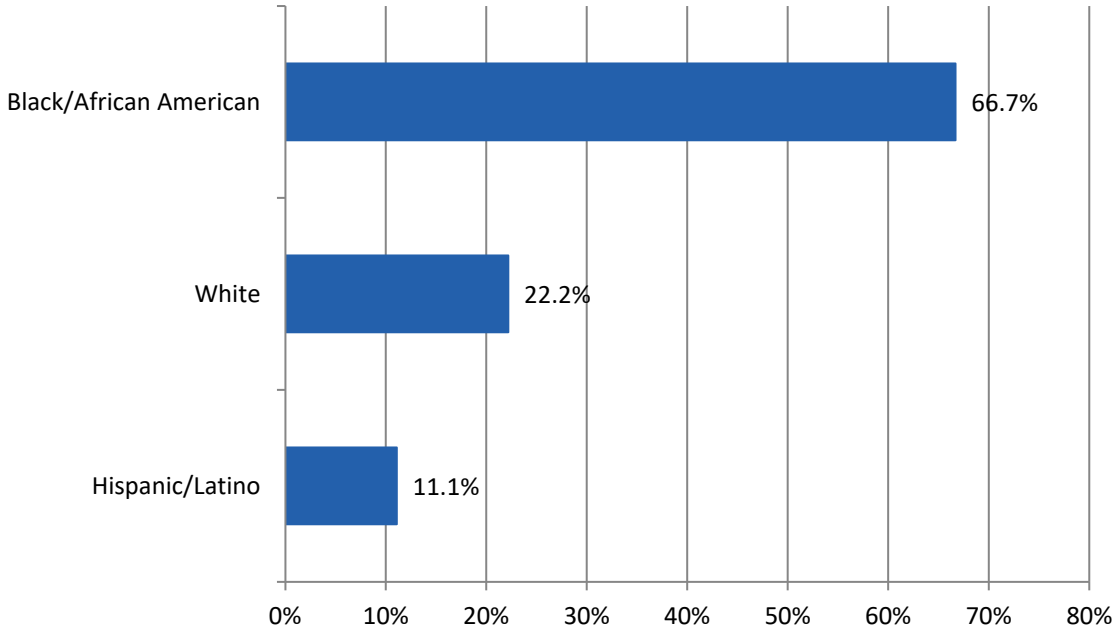
"Other" Included: all tactics would improve the health and well-being of residents; keep up with the Zoom Townhalls and working groups; pay the full amount it would take to fully fund Assures year-round as the Universal Primary Care program is retooled to address affordability, portability, and sustainability

Participant Profile

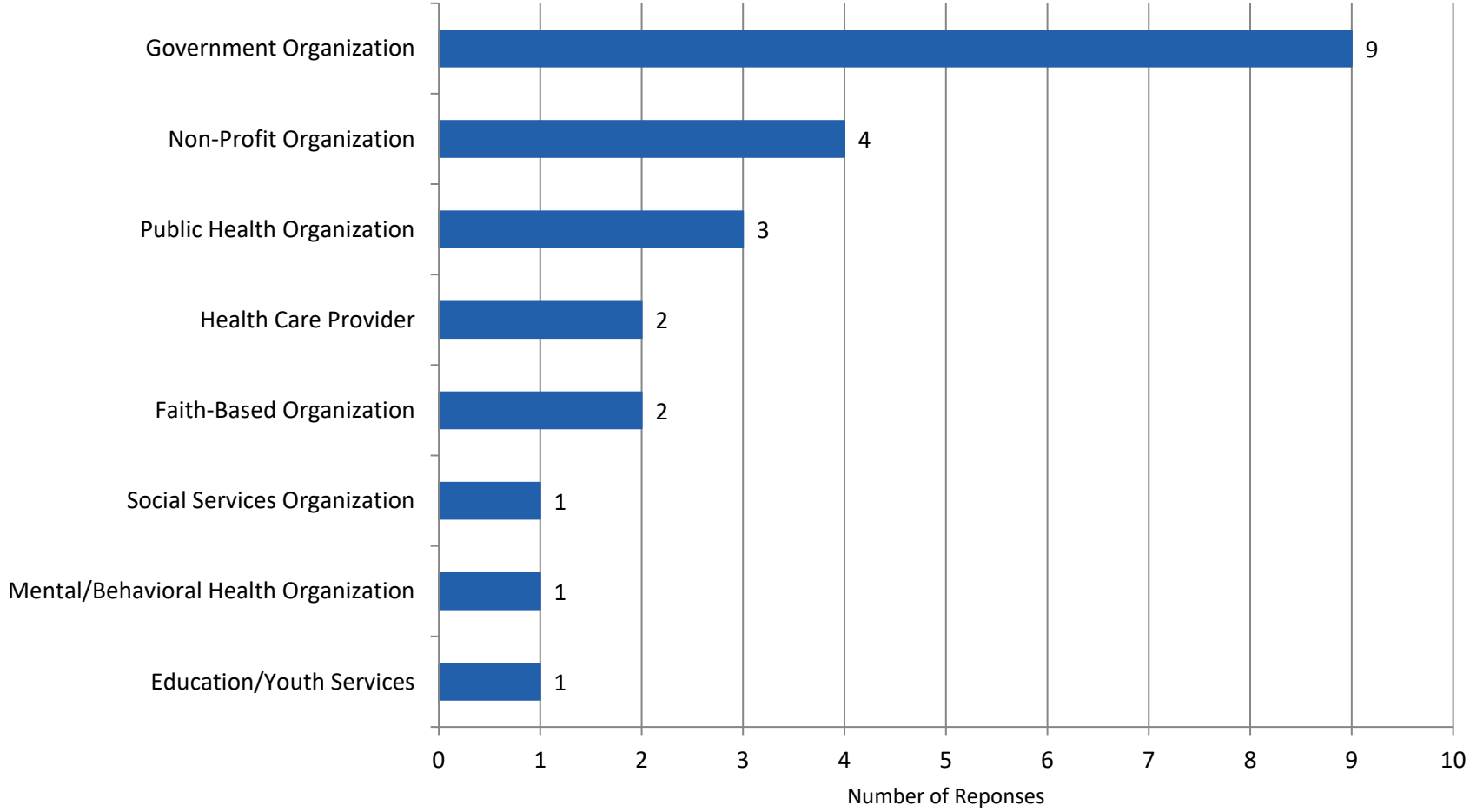
Question 18: What is your gender (N=18 responses)



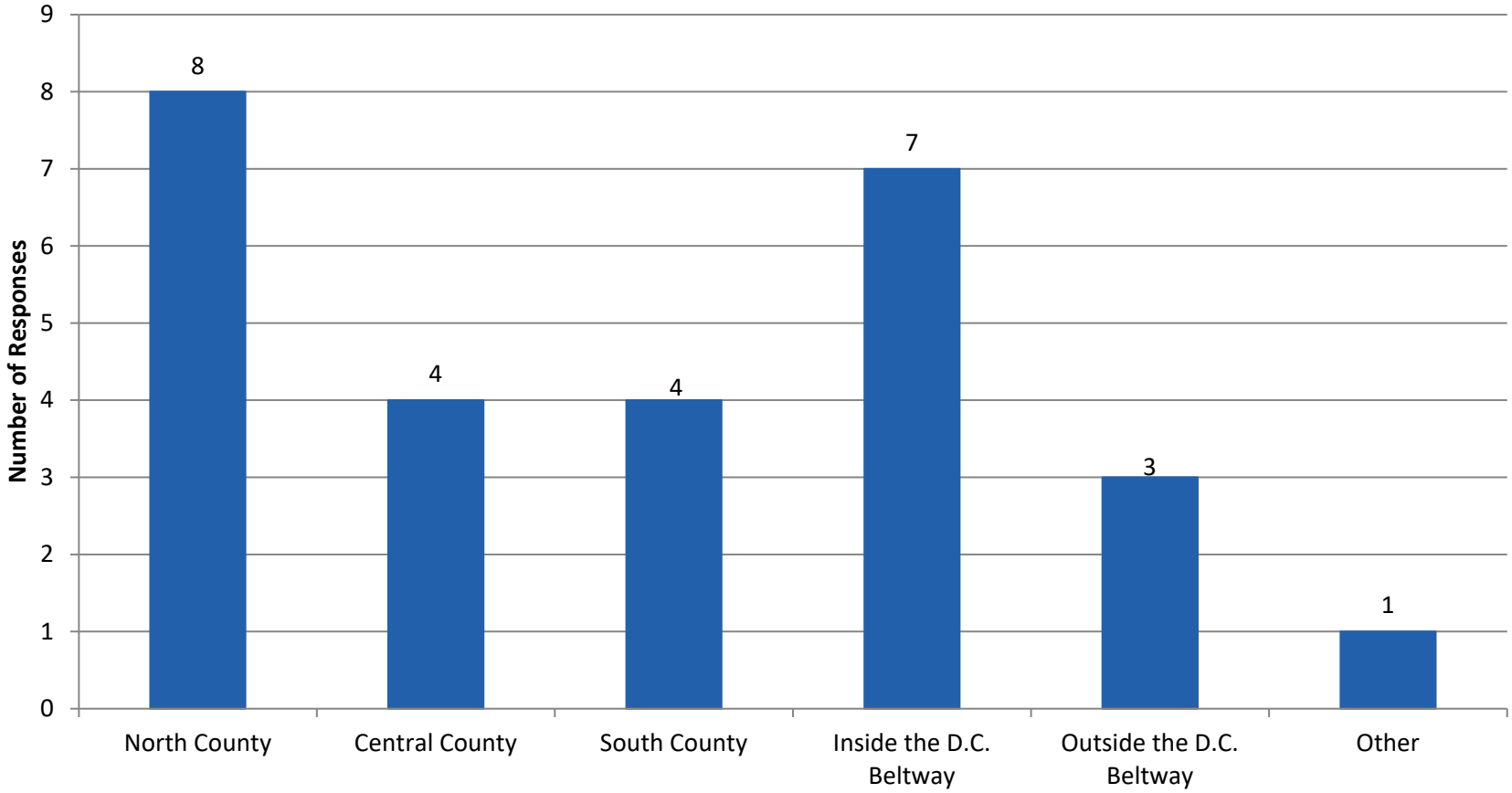
Question 19: What race/ethnicity best identifies you? (N=18 responses)



Question 20: Which of these categories would you say best represents your community affiliation? Participants were asked to select all that apply. (N=18 responses)

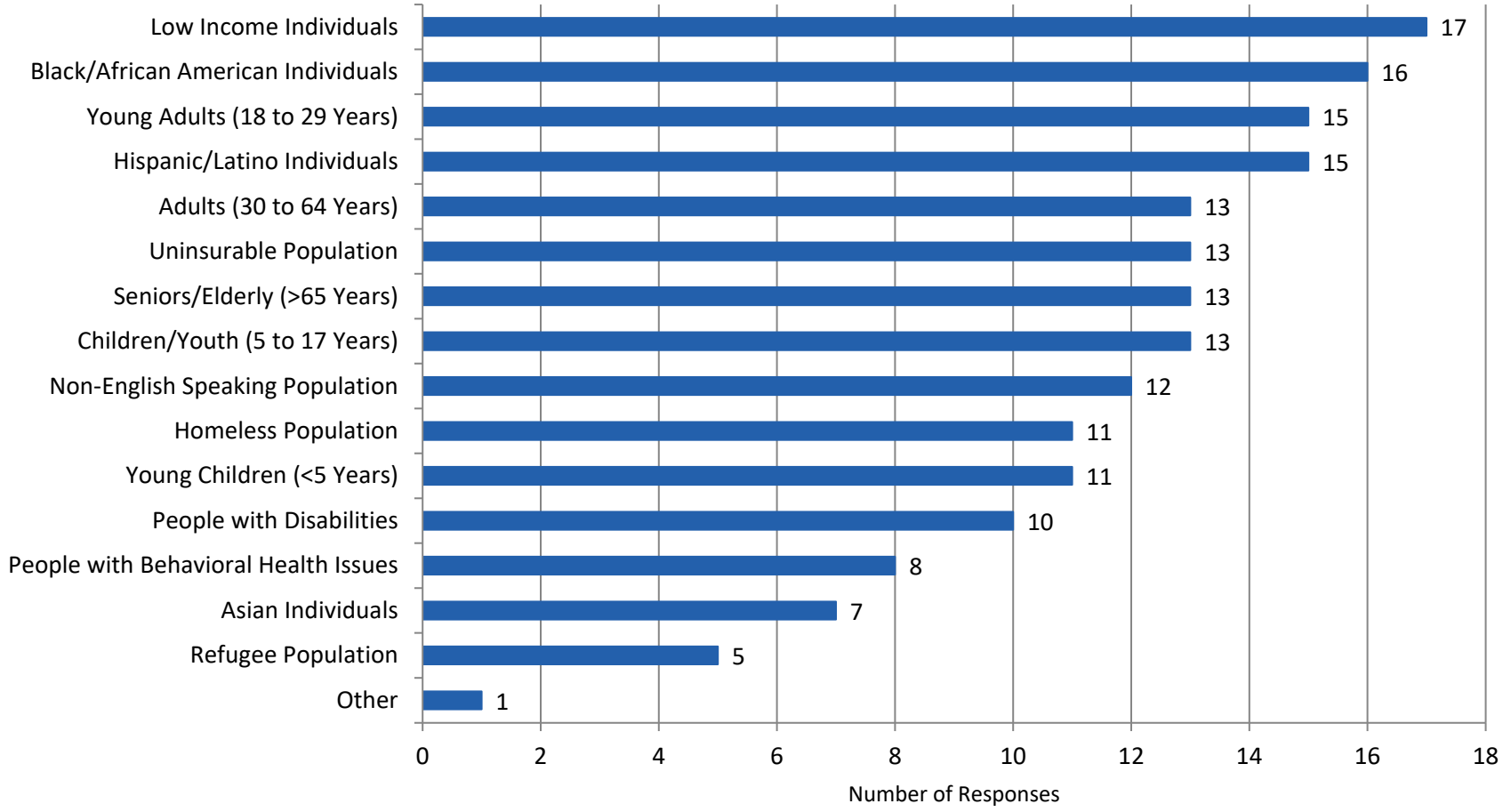


Question 21: In what geographic part of Prince George's County are you most knowledgeable about the population? Participants were asked to select all that apply. (N=18 responses)



"Other" included: knowledge across the entire county

Question 22: Please indicate the populations you serve or represent in Prince George's County through either personal, professional, or volunteer roles. Participants were asked to select all that apply. (N=18 responses)

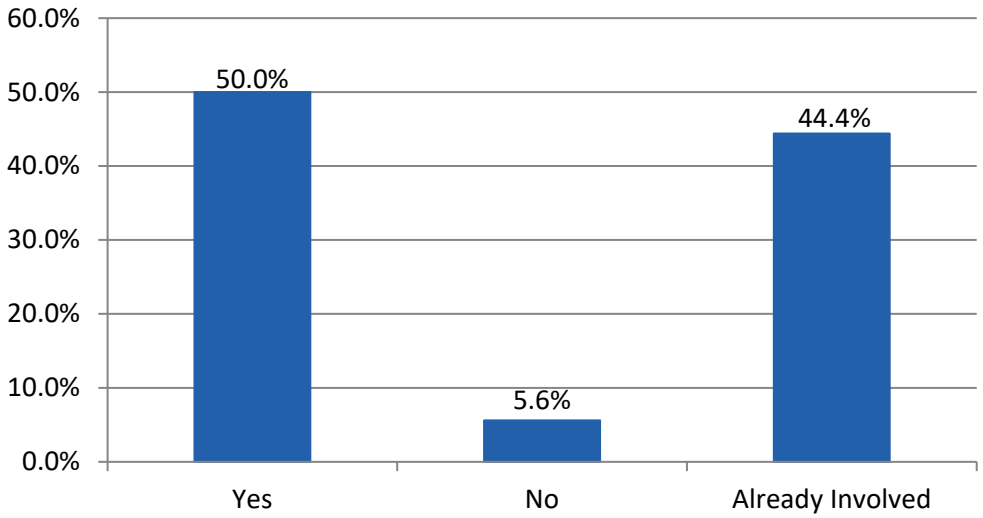


"Other" included: all the above

Question 23: Respondents were asked to share the most pressing needs of the populations they serve based on their experience (N=18 responses). The responses are grouped and summarized in the table below; the majority of these responses reiterated information that had already been provided in previous questions.

Additional Information	Number of Responses	Summary of Responses
Basic Needs	9	Improving the health and well-being and overall quality of life for county residents; ensuring all residents have access to a living wage, affordable housing, healthy food, education, and transportation; support to those experiencing homelessness
Healthcare Access	8	Increase number of providers and beds; behavioral health; over-reliance on emergency services; improved access to primary care; lack of access to medical specialty care
Healthy Environment	5	Lower crime; healthier food options, fewer liquor and tobacco stores, and higher paying jobs in the area; accessibility of healthy lifestyle practices (parks, trails, pools, etc.); managing the social needs that ultimately exacerbate overall physical and mental health status
County Services and Funding	4	Crisis response; services for the most vulnerable populations; additional funding for social programs; funding for specialty care and medications
Affordable Healthcare	4	Healthcare affordability, health insurance
Health Literacy and Health Education	2	Cultural competency; health literacy education
Cultural and Language Considerations	2	Education for Spanish population on services, support, and working on the gap for trust; people do not trust the system
Immigration Issues	2	Legal status; re-entry services
Better Education Outcomes	1	Lack of education
Care coordination and information	1	Resources and options

Question 24: Would you be interested in becoming more involved in local health initiatives? (N=18 responses)



RESIDENT survey

COMMUNITY RESIDENT SURVEY

Introduction

Prince George's County is home to over 967,000 residents and growing, with a wide range of health needs and disparities. The Community Resident Survey was a strategy developed to complement the overall Community Health Assessment (CHA) goal of identifying the health needs and issues for the county's diverse population by hearing directly from our residents.

Methodology

The 2022 Community Resident Survey was modified from the 2019 Community Resident Survey, with any adaptations based on the Community Health Status and Assessment recommendations of the Mobilizing for Action Through Planning and Partnerships (MAPP) framework[1]. Efforts were made to ensure the survey questions corresponded with the Community Expert Survey, another key assessment of the MAPP framework. The survey questions included mostly multiple choice and rating scales with a few open-ended responses for demographics and an option for writing in a response if the participant answered with "other".

The survey was translated into Spanish (the most common language spoken in the county after English) and was made available online and through printed copies. Due to time limitations, the survey was distributed as a convenience sample. The Health Department made the survey available by website, social media, and through provided services at department locations; the survey link was also posted electronically by the County government. Survey distribution began in March 2022 and ended on May 11, 2022.

For analysis, each multiple choice and rating scale question is presented as a simple descriptive statistic. Because the surveys were collected as a convenience sample, the results were intended as an additional method of gaining community input in support of the overall process, while acknowledging the lack of an adequate sample size to statistically represent the county. Responses from the English survey were excluded if the participant indicated they were not a county resident or if residency information was completely missing to make that determination. All responses in the Spanish surveys were included in the final analysis, regardless of residency information; the results are presented separate from the English responses for most questions. Each question includes the number (N) of responses.

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

Participation

Surveys were completed by 118 participants: 106 in English and 12 in Spanish. Nearly all areas of the county were represented by the participants except for some of the most southern part of the county (a map of representation is available with Question 19). Over four-fifths of survey participants were female, which is higher than the county. However, survey participation by race and ethnicity was similar to the county population. Spanish survey participants were younger and all between the ages of 25-44 years, while English survey participants were more evenly distributed by age. Over 70% of all survey participants had a college degree or higher; however, 80% of the Spanish survey participants did not have higher than a high school degree. Although English survey participants reported a wide range of annual household incomes, all Spanish participants reported an annual household income of less than $49,999.

Key Findings

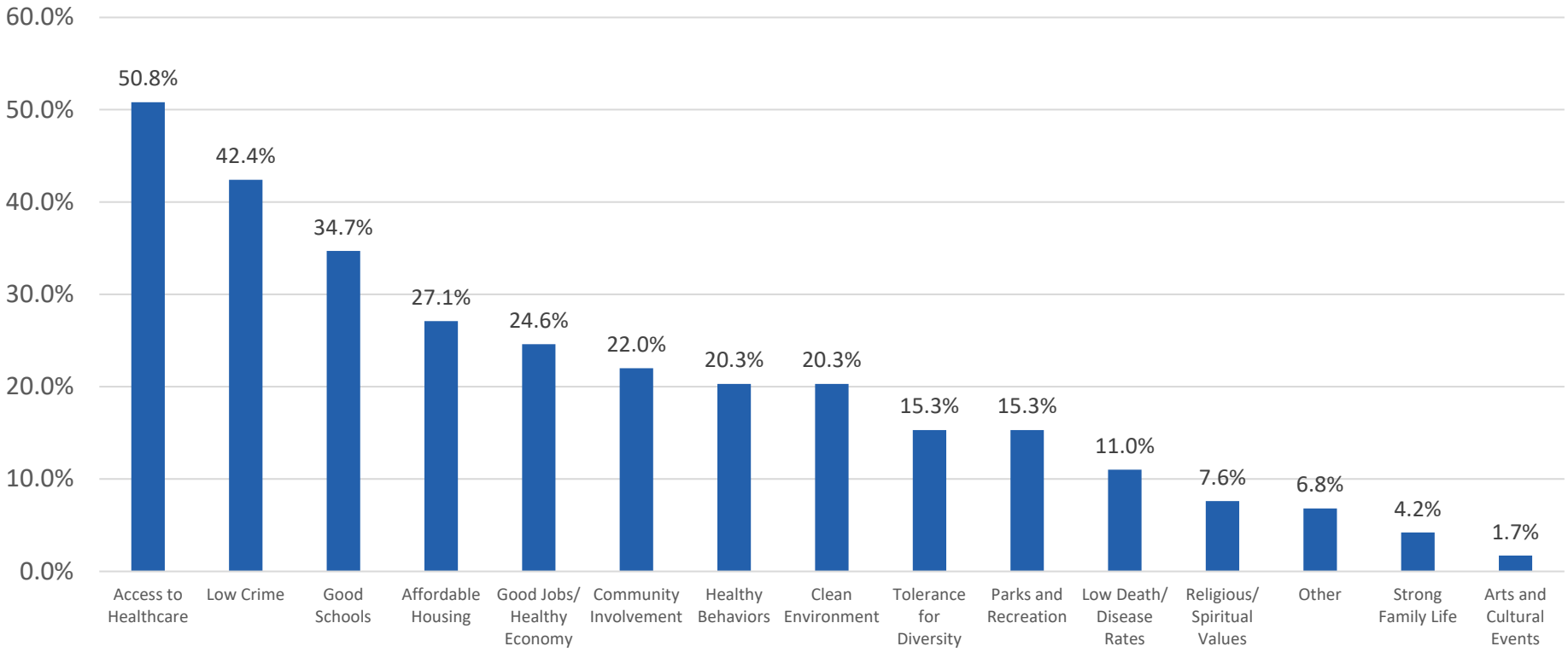
- ***Healthy Community***: Over half of all survey participants said that access to healthcare was one of the most important factors defining a "healthy community," followed by low crime, good schools, and affordable housing. Spanish survey participants also considered good jobs/healthy economy as one of the most important factors, while English survey participants said community involvement and healthy behaviors also defined a healthy community. Compared to the 2019 survey, low crime and affordable housing were leading indicators of a healthy community, while in the 2019 survey good jobs and a healthy economy were of higher importance. Four-fifths of all survey participants reported that parks were the places they went most frequently in Prince George's County, followed by libraries and rivers/lakes/woods.
- ***Community Determinants of Health:*** Almost half of survey respondents (48.1%) agreed that their community has easy access to fresh fruits and vegetables; however, this was much lower (37.5%) among the Spanish participants. Over half (60.4%) of English and 87.5% of Spanish survey participants disagreed or somewhat disagreed that there is enough affordable housing in their community, higher than the 2019 survey. Spanish survey respondents were more likely (87.5%) than English survey respondents (32.6%) to disagree or somewhat disagree that their community was safe with little crime.
- ***Discrimination:*** Over 30% of all survey participants reported that a few times a month or more they are treated with less courtesy or respect than other people. Notably, 100% of Spanish survey participants reported this happening a few times a month or more, compared to just 25% of English survey participants. Nearly 16% of English survey participants and 57% of Spanish survey participants reported receiving poorer service than other people at restaurants or stores a few times a month or more. When asked about the main reason for these experiences, nearly 60% of all participants reported their race as a reason followed by their gender (33%). Ancestry and age were also listed as main reasons for these experiences by over 20% of all participants.
- ***Leading health issues***: COVID-19, mental illness, and diabetes, as well as substance use (alcohol, drug, and tobacco) led as the major health problems identified by survey

participants. For Spanish survey participants, homelessness and homicide were also identified as leading issues while for English survey participants aging problems and poor diet were identified.

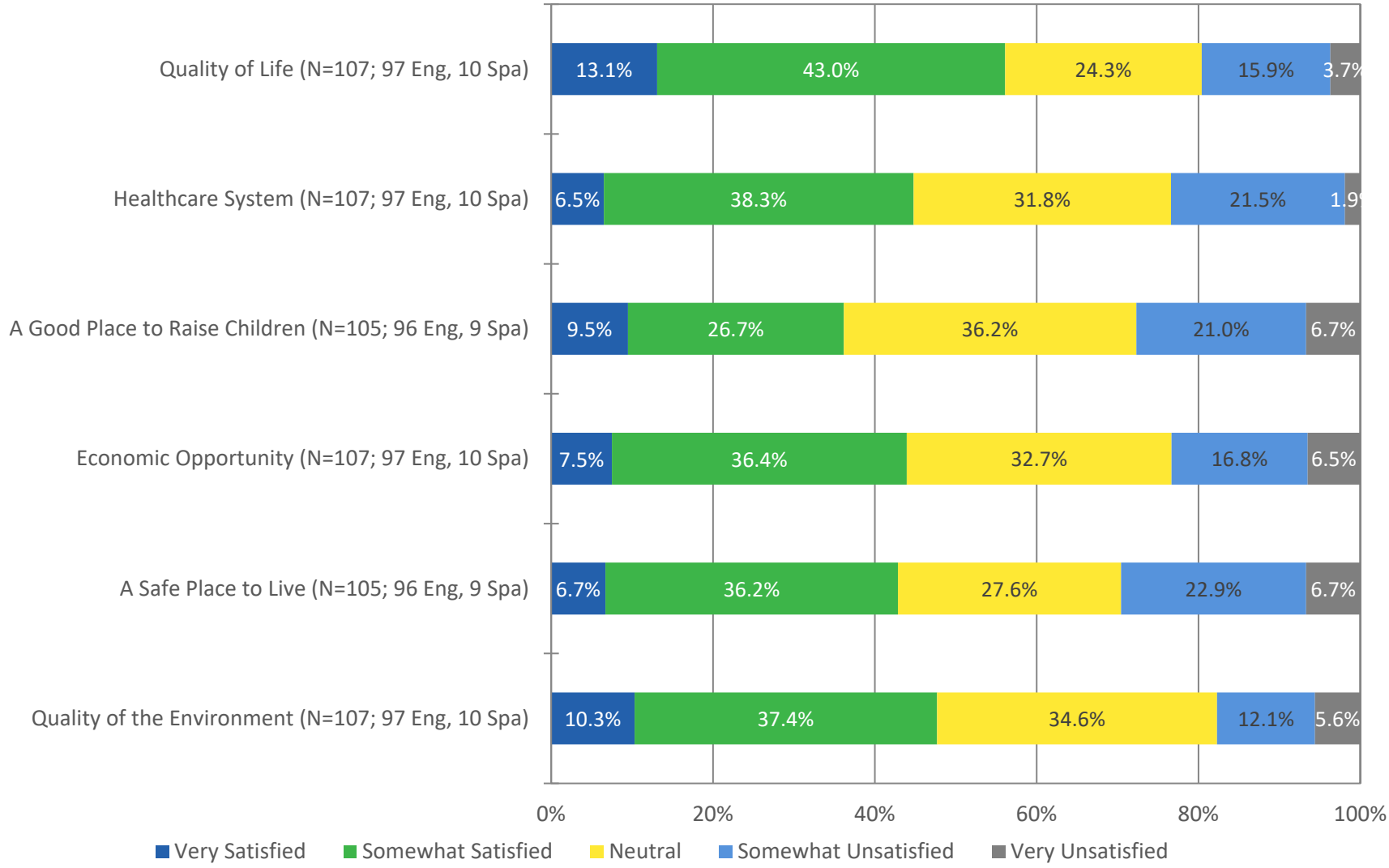
- ***Access to healthcare***: Over 65% of English survey participants and 80% of Spanish survey participants agreed or somewhat agreed that residents in their community could access a primary care provider, slightly higher compared to 2019 survey responses. However, less survey participants agreed or somewhat agreed that there are enough providers for the number of residents in their community, that most residents are able to access medical specialists in their community and that most residents can access a mental health provider in their community. Although 55% of English survey participants said most residents in their community could access a dentist, only 20% of Spanish survey participants felt the same. More participants disagreed or somewhat disagreed that most residents can afford their medication in their community.
- ***Leading barriers****:* Overall, lack of money for co-pays and prescriptions, time limitations, and lack of health insurance coverage were indicated as the leading barriers to accessing healthcare in the county. For English survey participants, 56% also reported that lack of childcare was a major or moderate problem, while over three quarters (80%) of Spanish survey participants reported lack of transportation as a barrier to accessing care.
- ***Health Care:*** Overall, 79.8% of survey participants reported having some type of insurance and most (92.1%) reported seeing a primary care doctor in the past year. However, among the Spanish survey participants, 60% did not have health insurance and 20% did not see a primary care doctor in the past year. Almost 20% of both English and Spanish survey participants reported being unable to access needed medical care in the past year, primarily due to the wait time being too long. Lack of transportation and childcare were also barriers for those unable to get care in the past year.
- ***Health Communication:*** Both English (94%) and Spanish (80%) survey participants said that doctors were the most trusted source of health and lifestyle information in their community. Following doctors, English participants reported health screenings (57.8%) as trusted sources of health information, followed by counseling. Spanish survey participants said that health fairs were trusted sources of health information (40%) followed by phone counseling. Regarding the dissemination of health information, both English participants (73.8%) and Spanish participants (80%) were most likely to prefer e-mail. Following this nearly half of overall participants preferred to receive health information in person or through a website. For Spanish survey participants, two-thirds indicated they preferred texting.
- ***Recommendations to improve health:*** Overall, all survey participants recommended increased communication and awareness followed by increased focus on health inequities to encourage and support more community involvement around health issues in Prince George's County. Among Spanish survey participants, an increased number of healthcare practitioners and more community-specific outreach were also important factors in community health.

Results

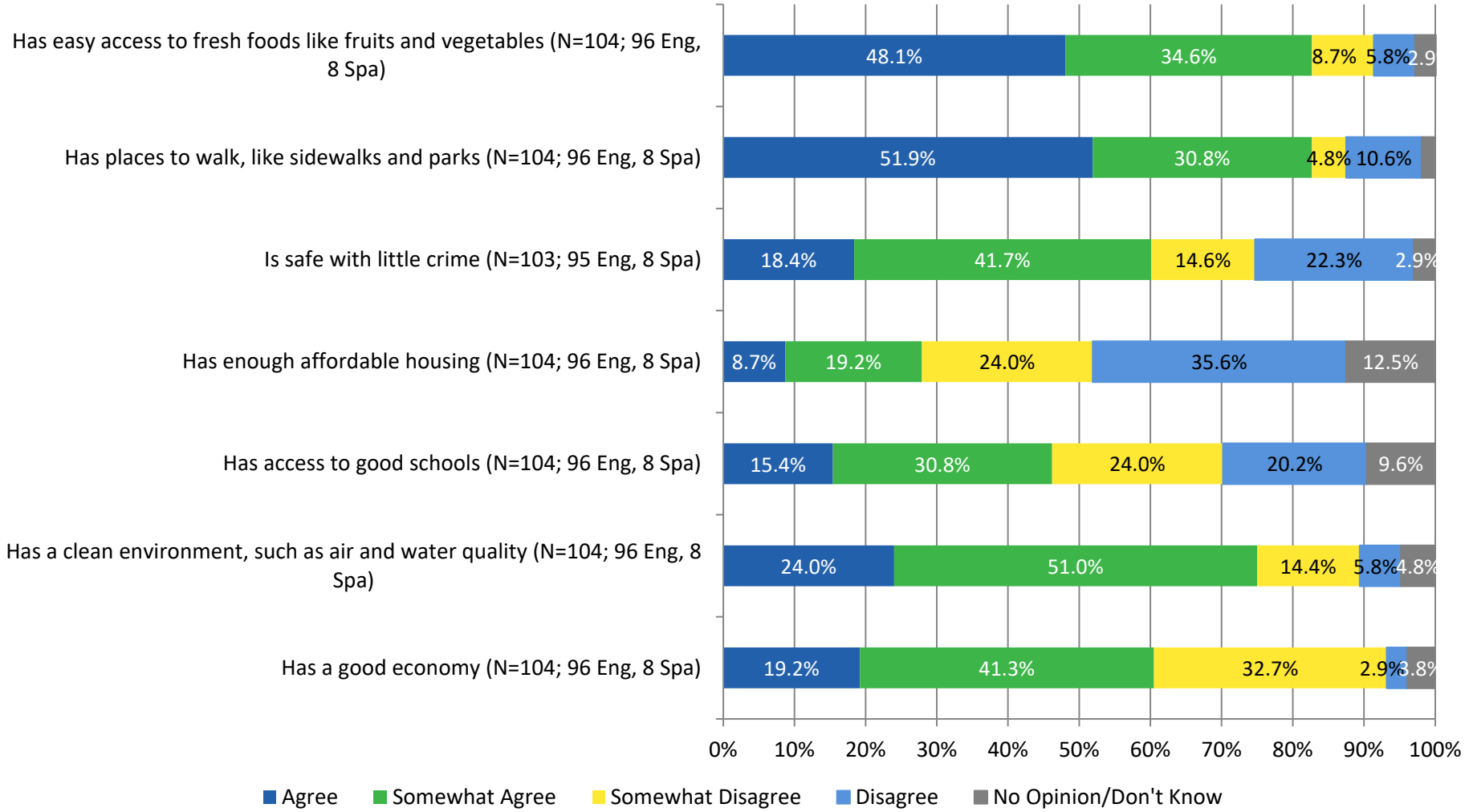
Question 1: What do you think are the three most important factors that define a “Healthy Community” (what most affects the quality of life in a community)? (N=118 responses; 106 English, 12 Spanish)



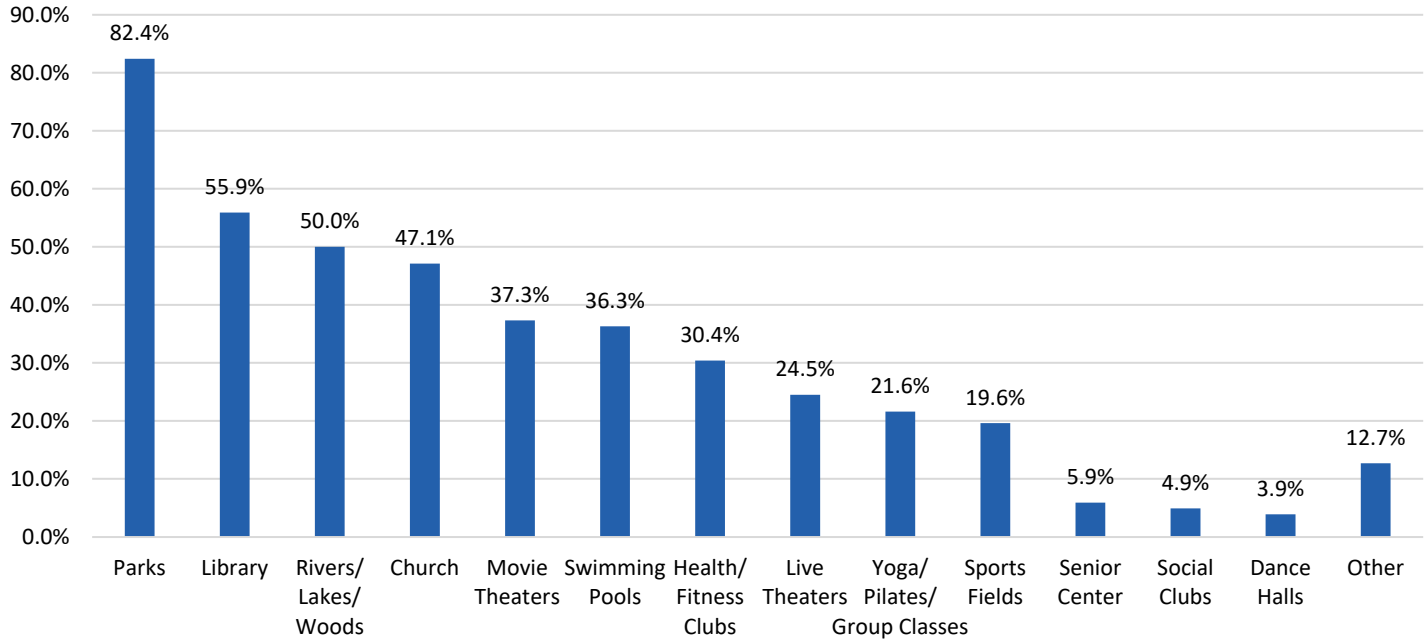
Question 2: How satisfied are you with the following in Prince George's County?



Question 3: Please rate each of the following statements for your community.

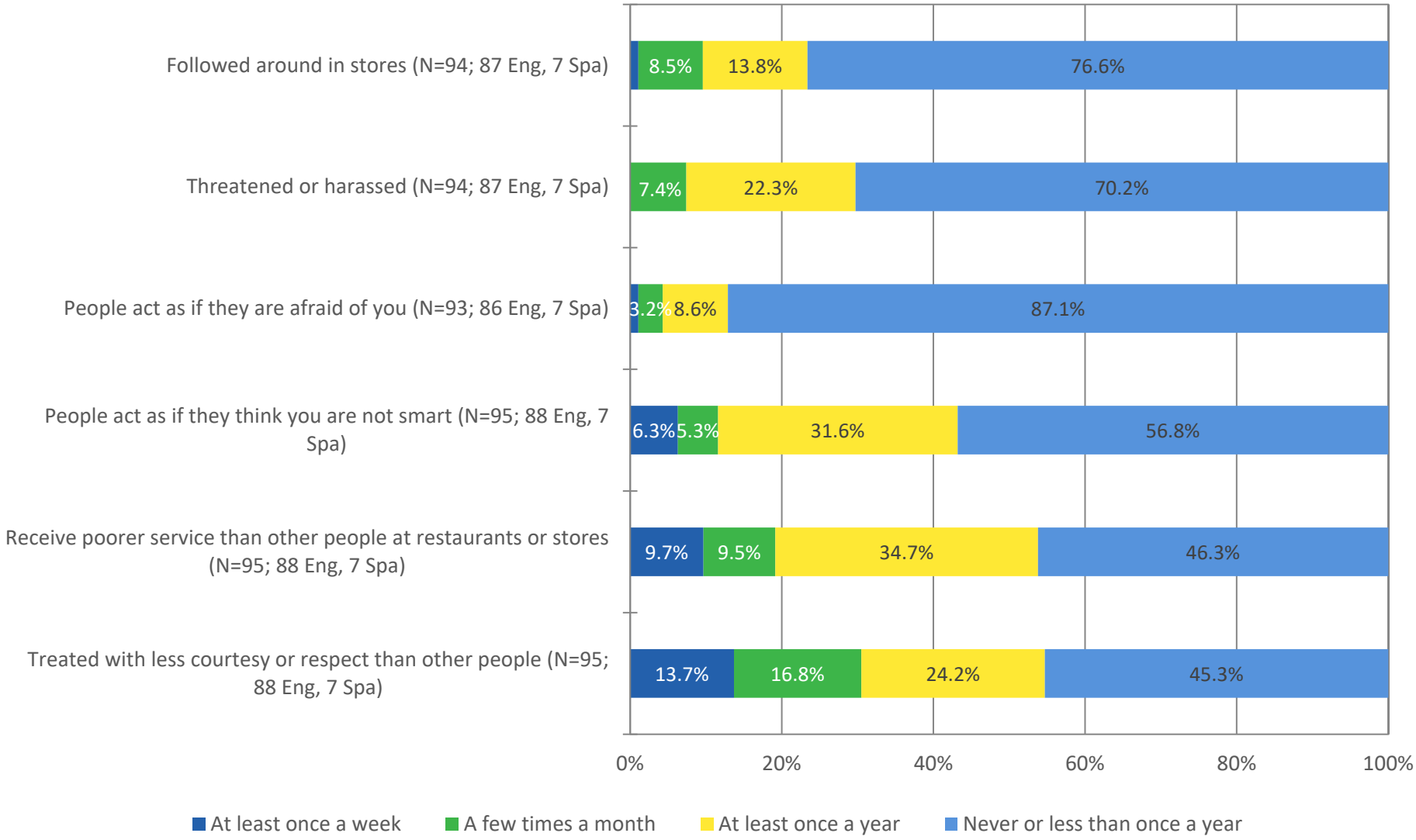


Question 4: The places where I go in my community most often in Prince George's County are (select all that apply). If you changed your activities due to COVID please include the places you are likely to return to in the future. (N=102 responses; 95 English, 7 Spanish)

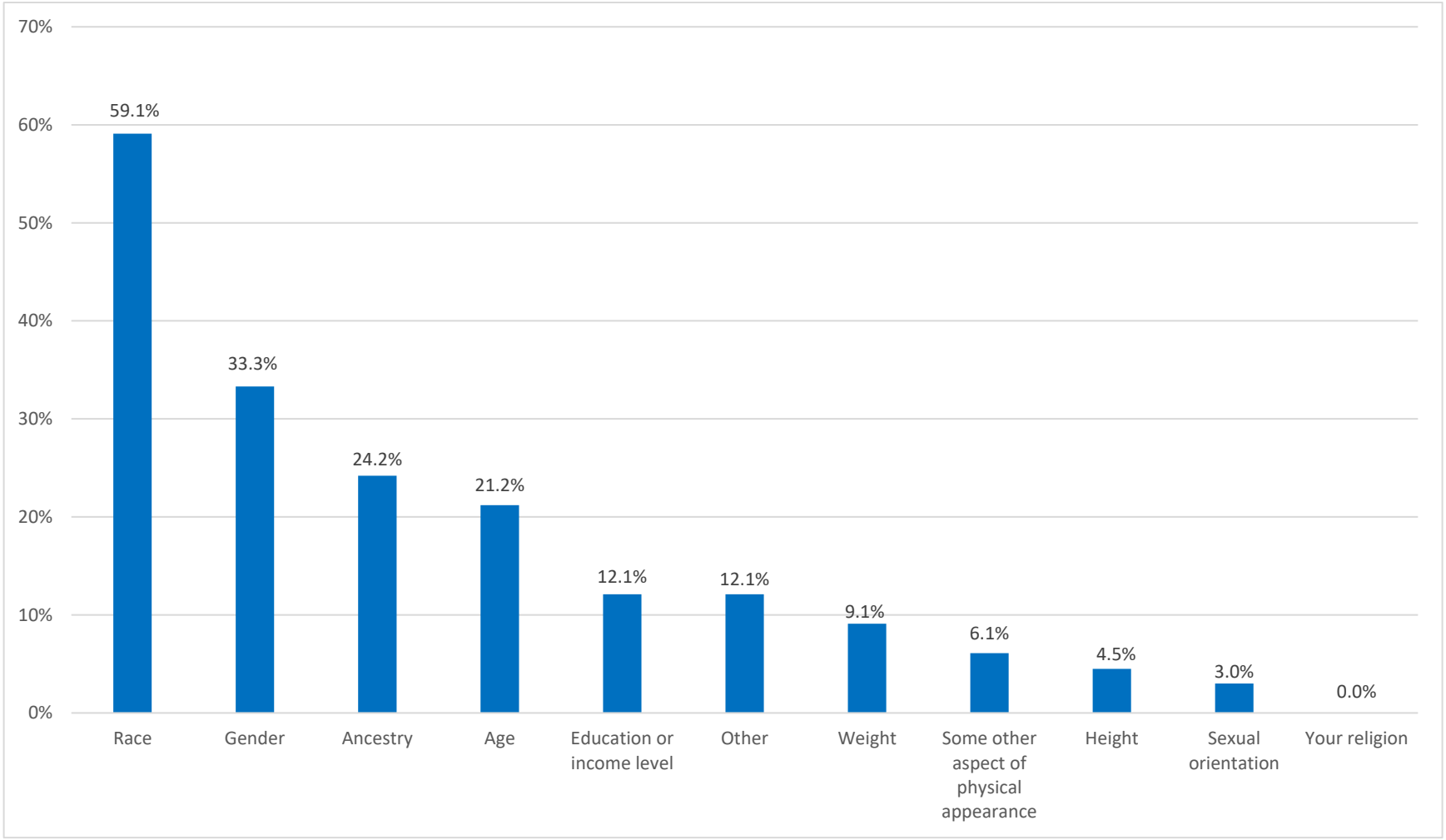


"Other" included**:** Restaurants, Grocery Store, Work, Community Center, Ice skating, Gymnasiums, Markets, Malls, Tennis Courts, Recreational Centers

Question 5: In your day-to-day life how often have any of the following things happened to you?

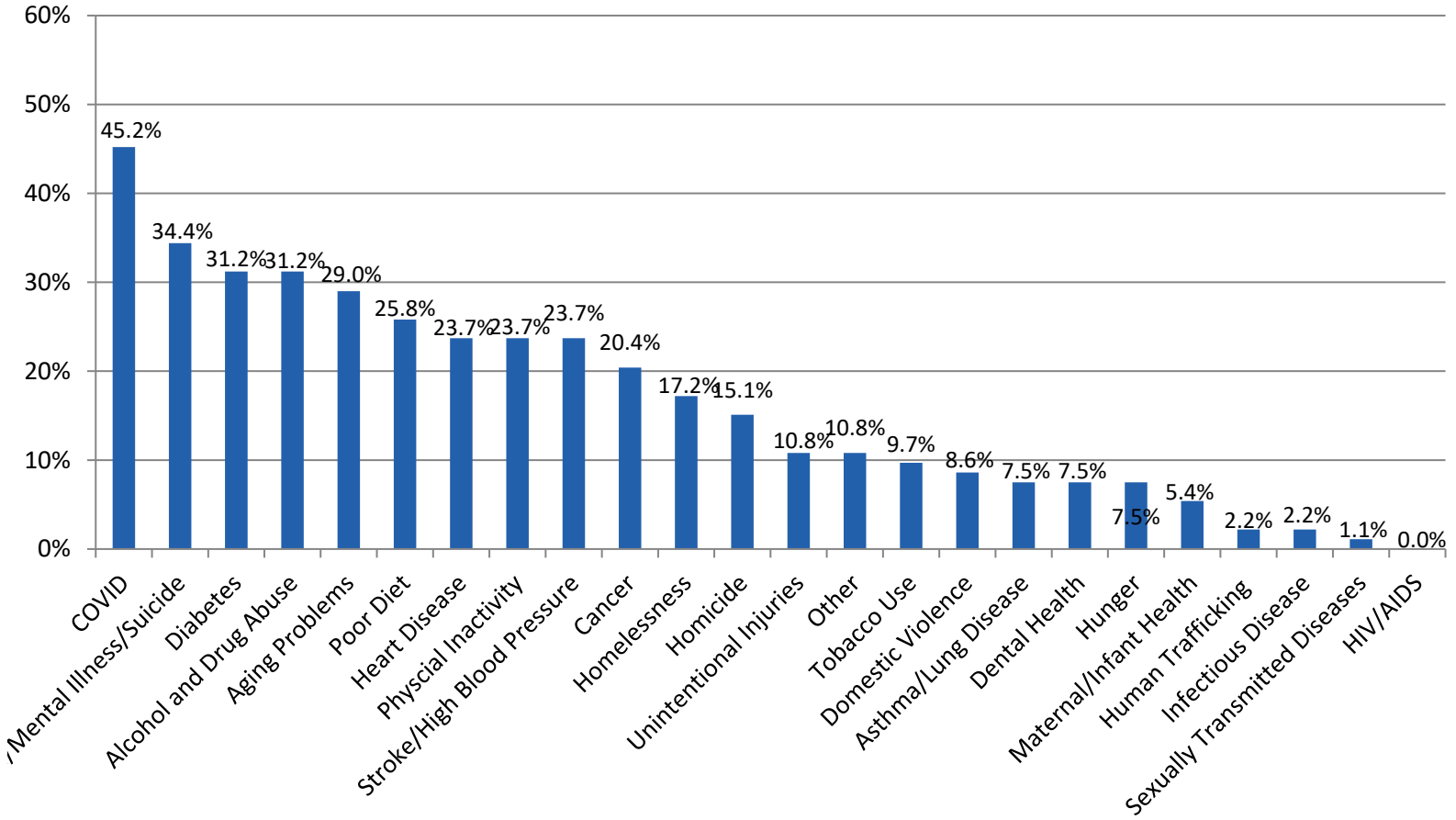


Question 6: If you answered at least once a year or more for any question above (in question 5), what do you think is the main reason for these experiences? Please select all that apply. (N=66 responses; 60 English, 6 Spanish)



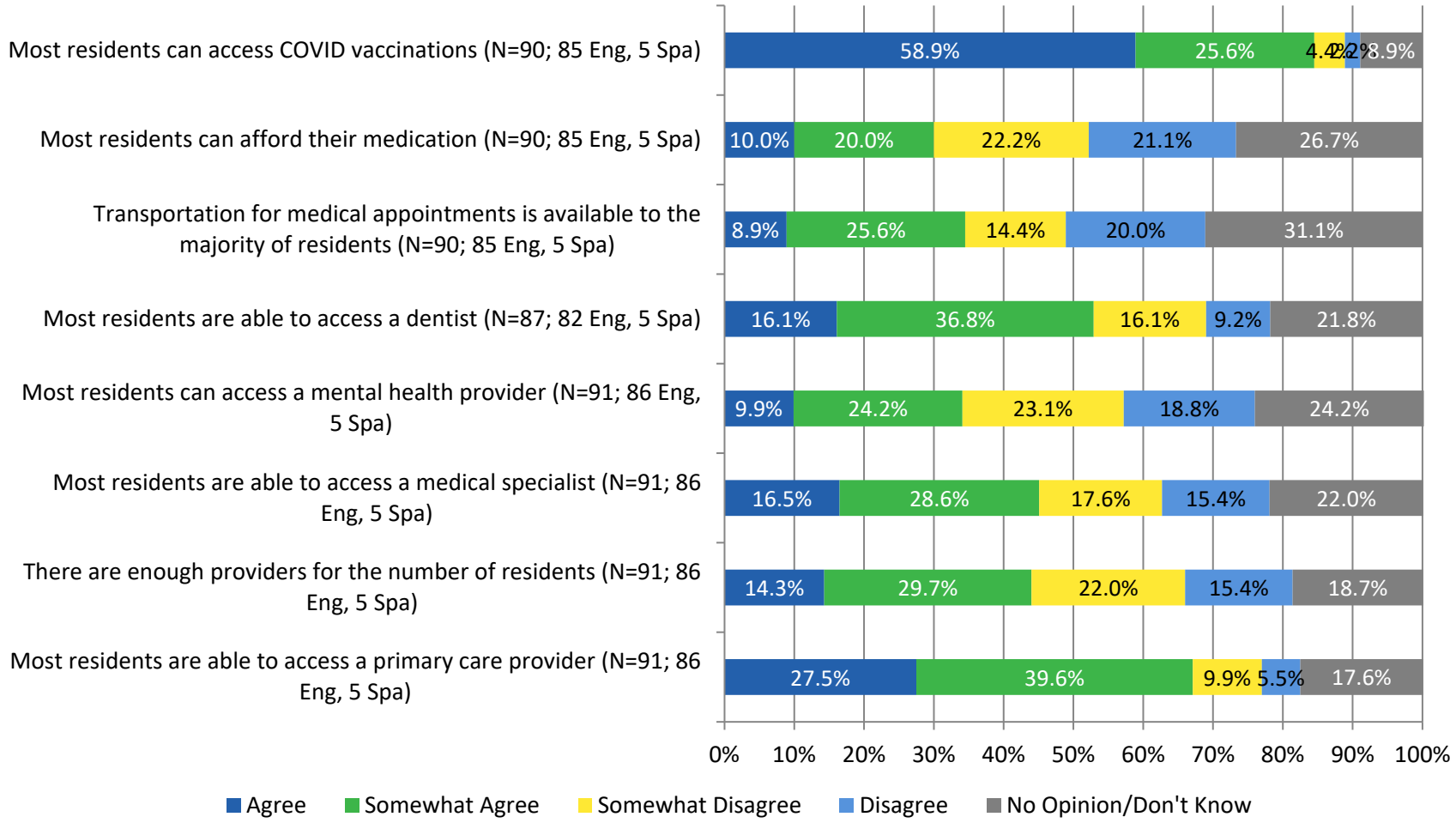
"Other" included**:** Obliviousness, people having a bad day, ignorance, and I don't know

Question 7: What are the leading health problems that impact your neighborhood or community? Please select up to five from the list below. (N=93 responses; 87 English, 6 Spanish)

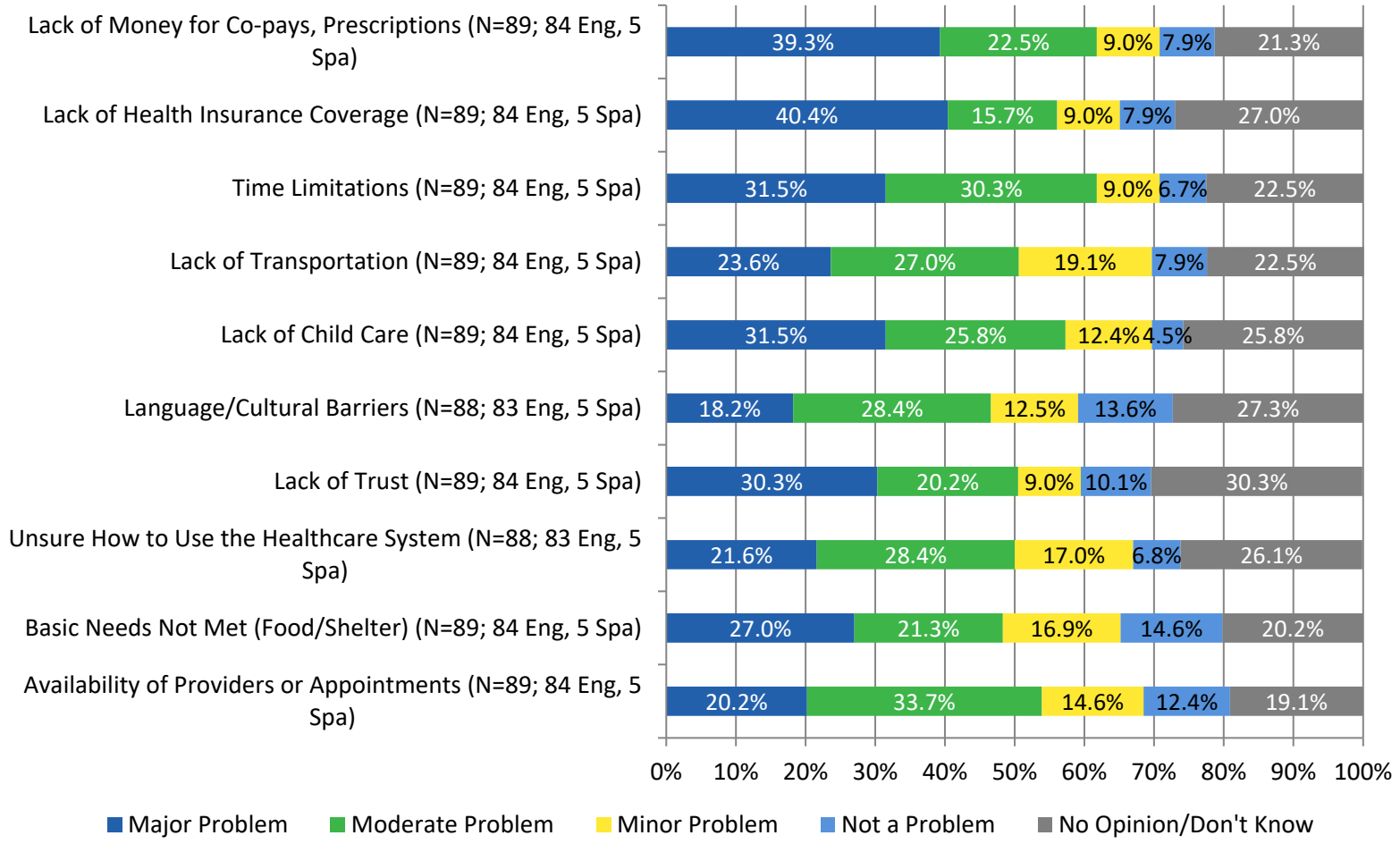


"Other" included**:** Need more transportation, marijuana use, Isolation, lack of access to healthy and nutritious foods at local restaurants, crime, and chronic kidney disease

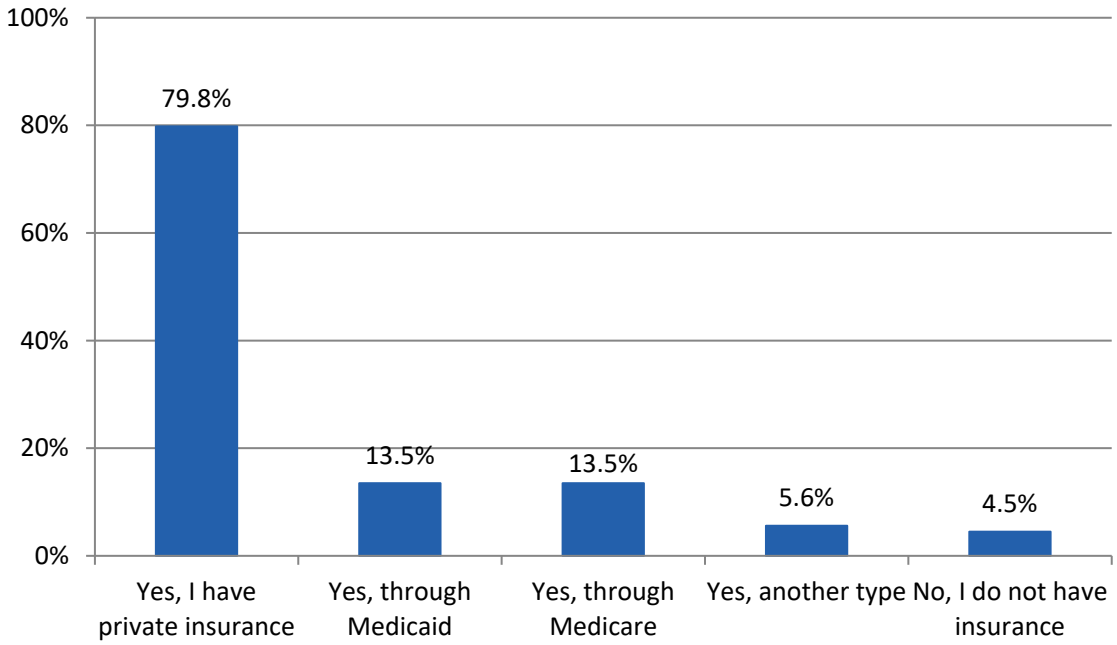
Question 8: Please rate each of the following statements about health care access in your community based on the scale below.



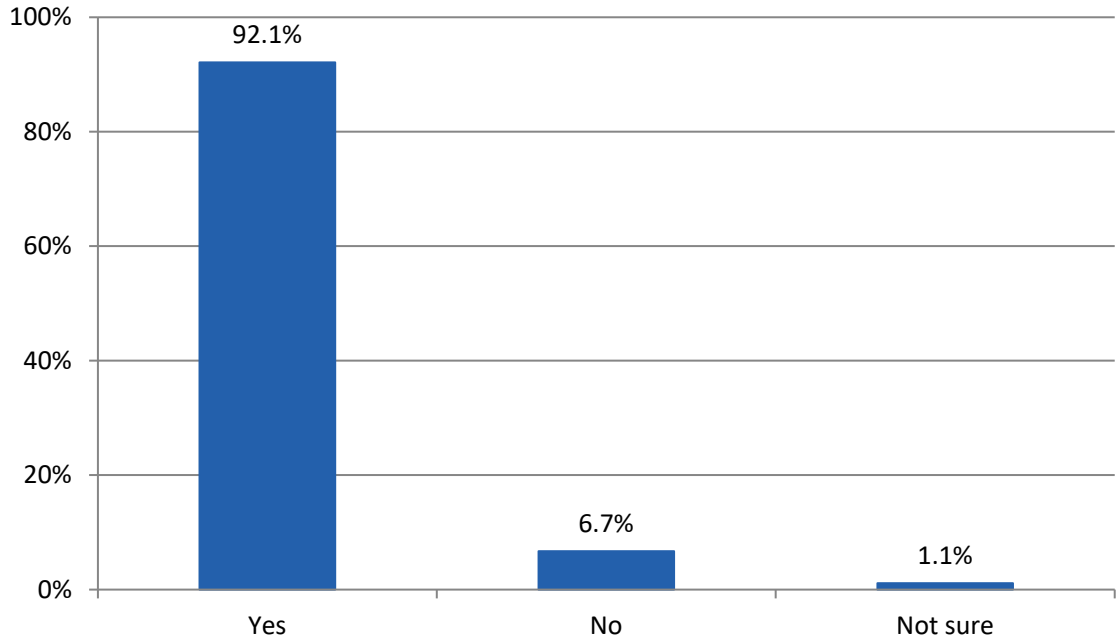
Question 9: Please indicate if you believe the barriers listed below are a major problem, moderate problem, minor problem, or not a problem that keep people in your community from accessing health care. (All responses)



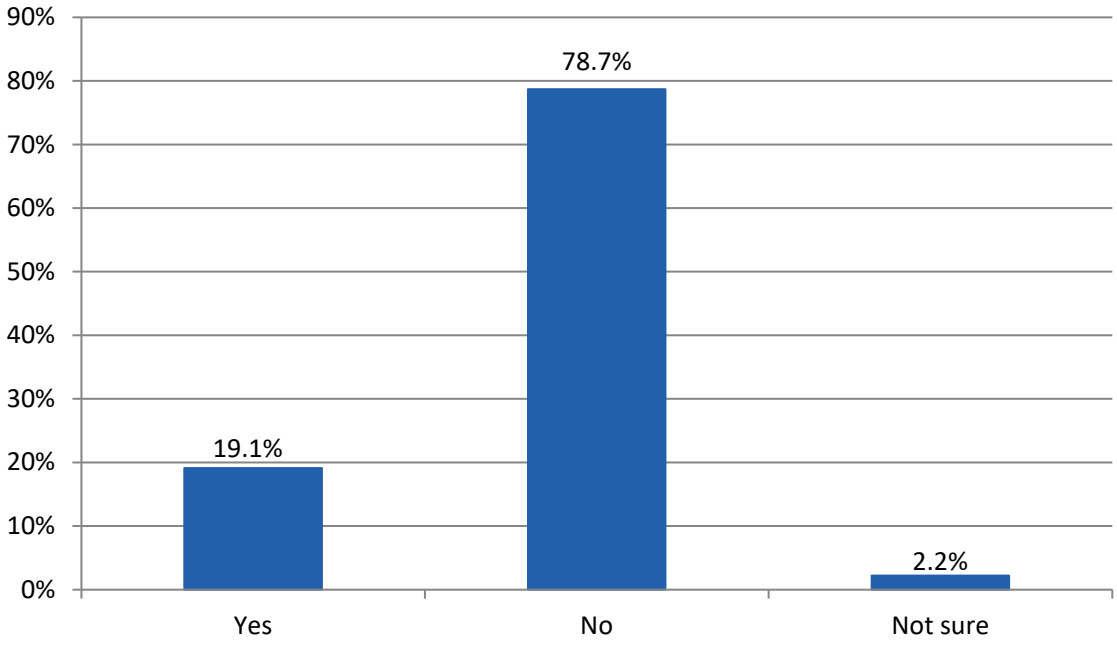
Question 10: Do you have health insurance? Please select all that apply. (N=89 responses; 84 English, 5 Spanish)



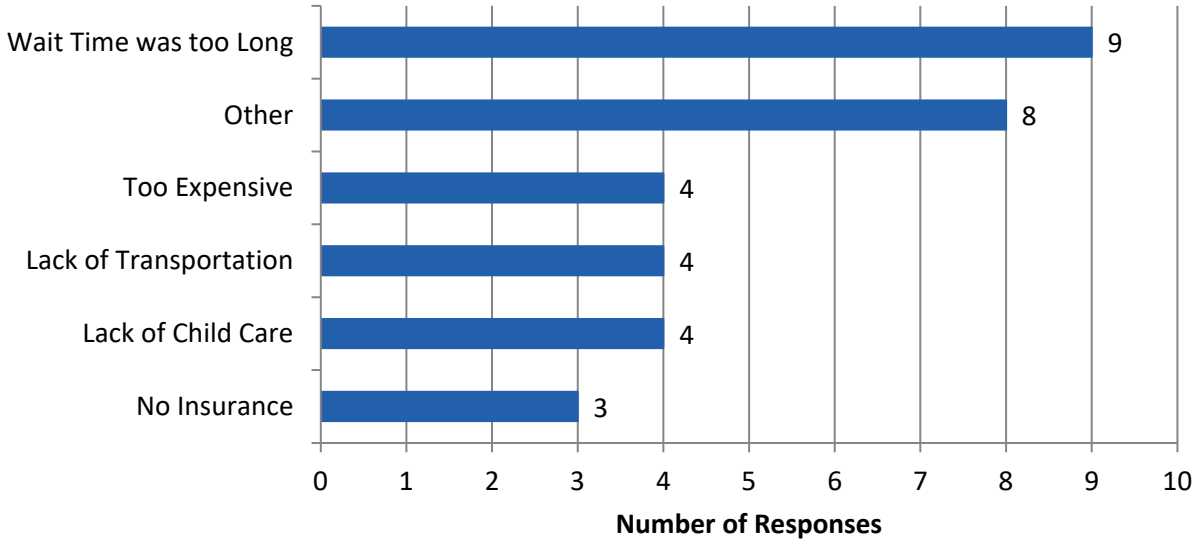
Question 11: Did you see a primary care doctor in the last year? A primary care doctor can be a family practice doctor, for example. (N=89 responses; 84 English, 5 Spanish)



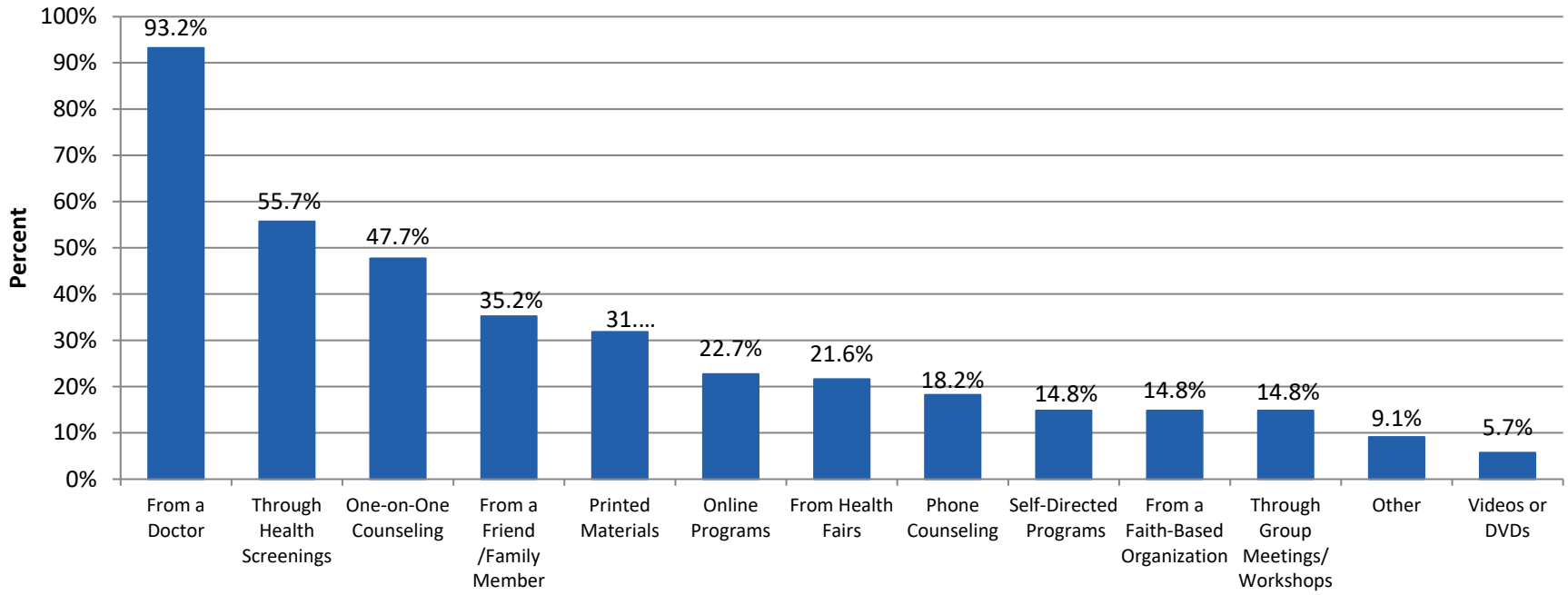
Question 12: Has there been a time in the past year when you needed medical care but were not able to get it? (N=89 responses; 84 English, 5 Spanish)



Question 13: If you answered that you were unable to receive medical care, what prevented you from getting the medical care you needed? Please select all that apply. (N=16 responses; 15 English, 1 Spanish)

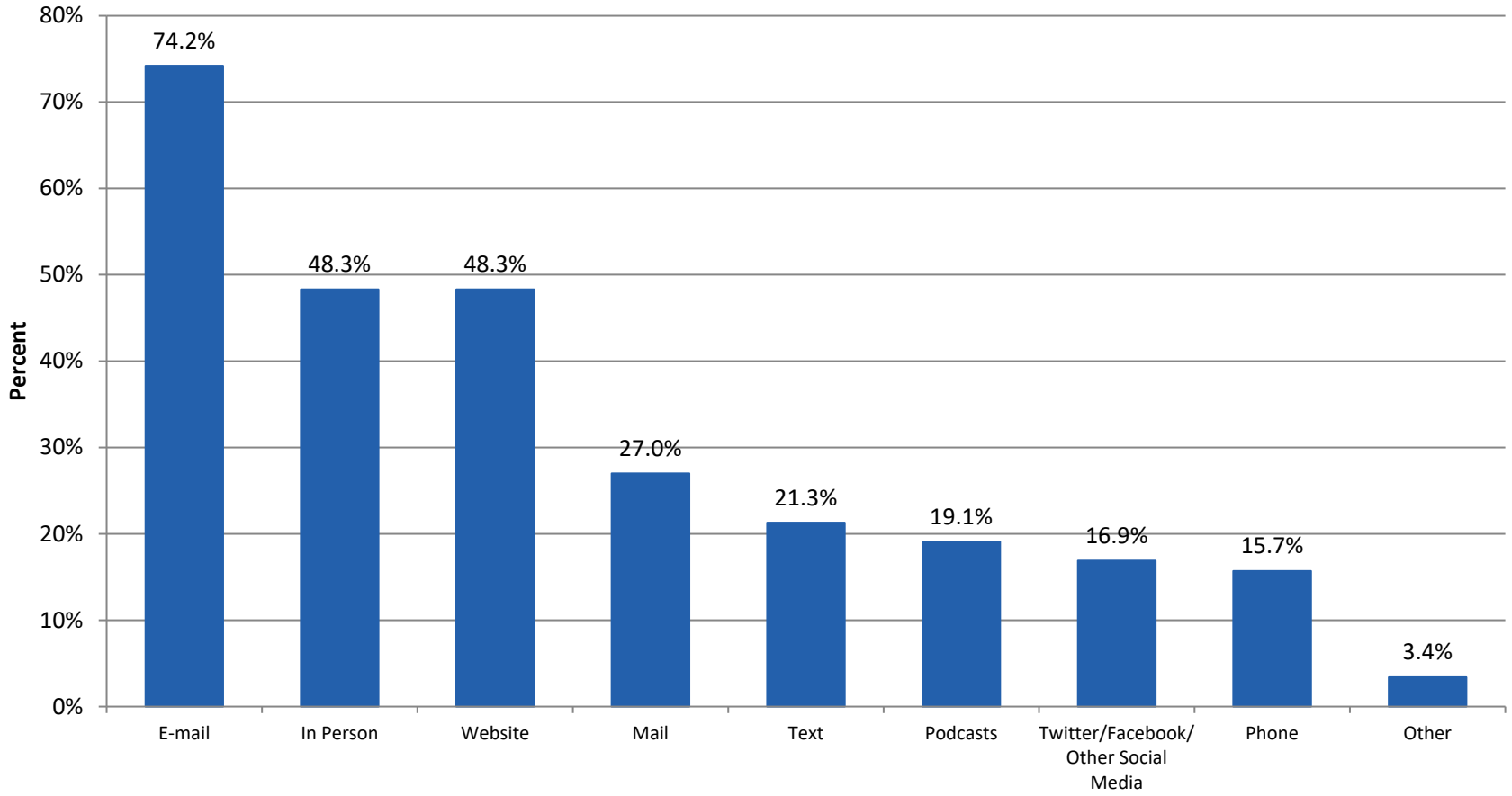


Question 14: What sources do you trust for health and lifestyle information? Please select all that apply. (N=88 responses; 83 English, 5 Spanish)



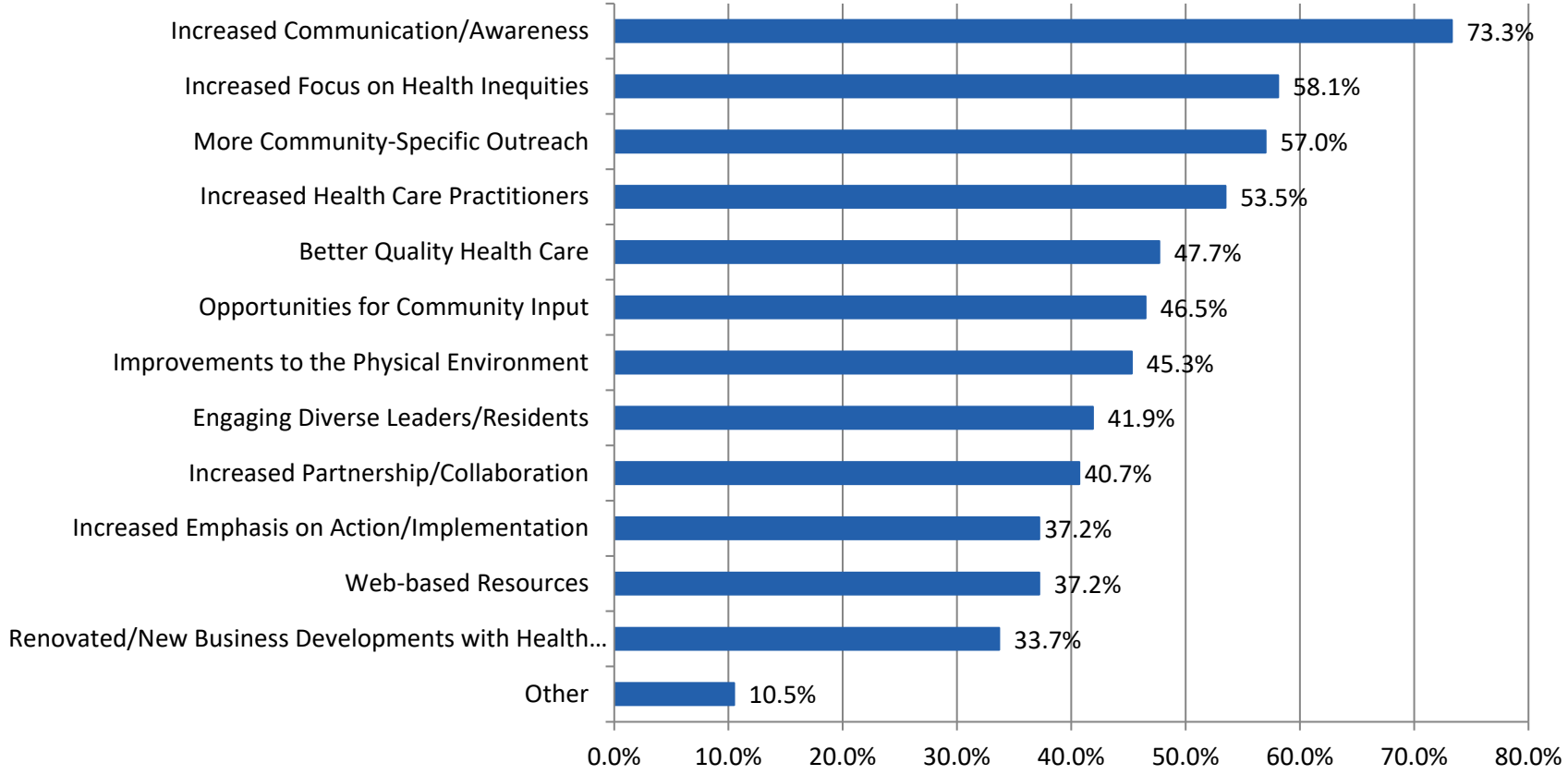
"Other" included**:** PubMed, a group of healthcare professionals, books, newspapers, scientific journal articles, WebMD, physical therapist, two responses noted issues with trust for communications from a doctor.

Question 15: How do you like to receive communication about health topics? Please select all that apply. (N=89 responses; 84 English, 5 Spanish)



"Other" included**:** Reading, health experts on TV, and a website

Question 16: What do you believe could encourage and support your community's health? Please select all that apply. (N=86 responses; 81 English, 5 Spanish)

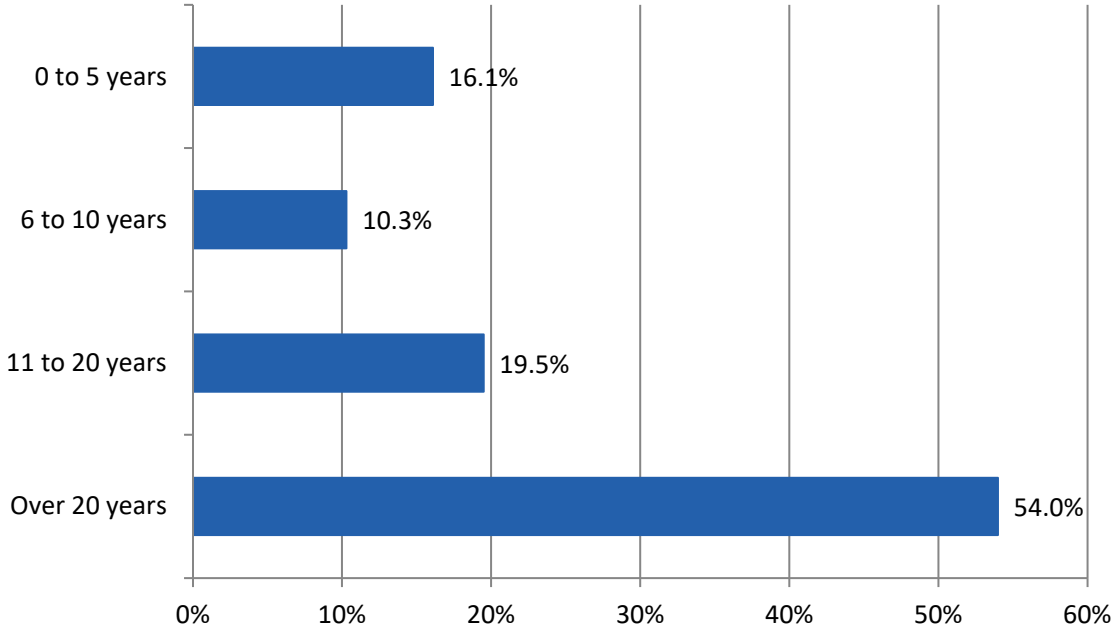


"Other" included**:** transportation, more mental health services, use of patient feedback, community centers with free resources such as pools and senior and youth programs, free all day preschool for all as well as low cost and high quality childcare, innovative health food options and partnerships, helping residents to gain access to resources (affordable medical, dental, and mental health care services, translation and transportation services, clean and safe housing), food as medicine initiative, increased support and access to alternative and neuropathic health resources, incentivizing more restaurant and businesses and grocery stores with healthier food options to come to our communities, access to medical personnel, a system that's not gamed (comment did not include what system this referenced).

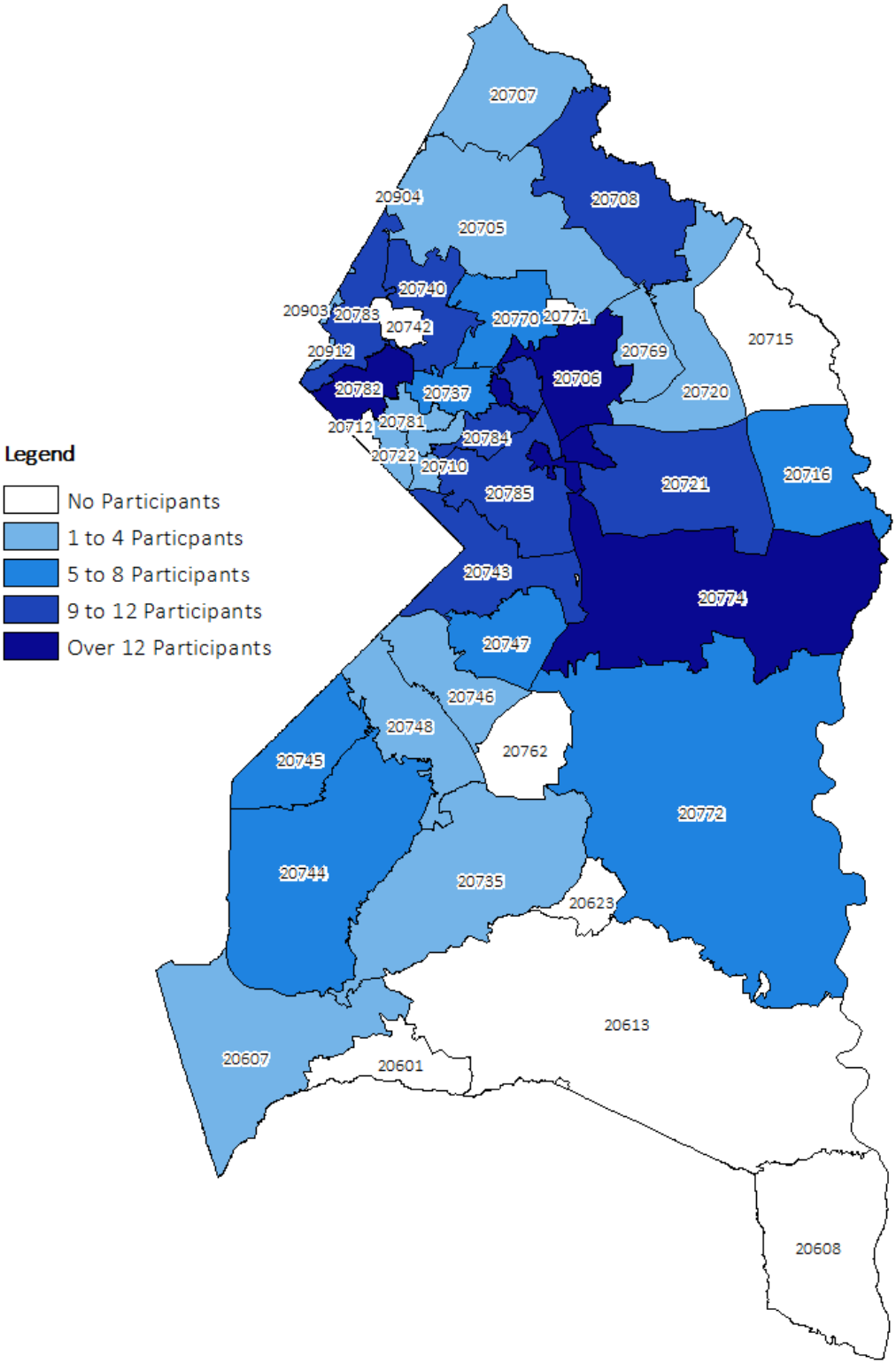
Question 17: If you could change one thing in your community, what would it be?

Issues mentioned	Number of Responses	Summary of Responses
Addressing the Social Determinants of Health	15	Improve affordability – lower costs of living and affordable housing; better schools and educational attainment outcomes; insurance coverage for all; reduce inequity to basic needs like food, housing, healthcare; allow accessory housing
Cleaner Neighborhoods and Environments	15	More parks; more trails; more green spaces; more lighting in developments; reduce the number of roads and cars; reduce trash in communities
Community Engagement and Education	8	More community organizing, including increased community events and meetings to allow for more input, more health programs and screenings for those communities; more sporting activities for youth; 24-hour youth focused facility
Increased Safety	8	Decrease the crime rate and focus on citizen security; alleviate traffic congestion; slower, safer driving; more community friendly policing
Better Access to and Quality of Providers	8	More providers in the community, beyond urgent care; no limitations to services provided; more bilingual staff and professionals; more medical information provided to communities; more up to date hospitals and services; mobile dentists and medical vans; more affordable prescriptions
Better Access to Healthy Foods	6	Closer grocery stores with more/better options; fewer fast-food outlets in communities; healthier food options and eating places
Transportation and Infrastructure	5	More transportation options; safer transportation; better roads; more walkability and sidewalks; better public transit
Senior Population Considerations	2	More services for seniors (e.g., independent living and group housing, countywide programs)
Decreased Drug Use	1	Fewer drugs in the community

Question 18: How long have you lived in Prince George's County? (N=87 responses; 82 English, 5 Spanish)



Question 19: What is the ZIP code where you live? (N=85 responses; 80 English, 5 Spanish)



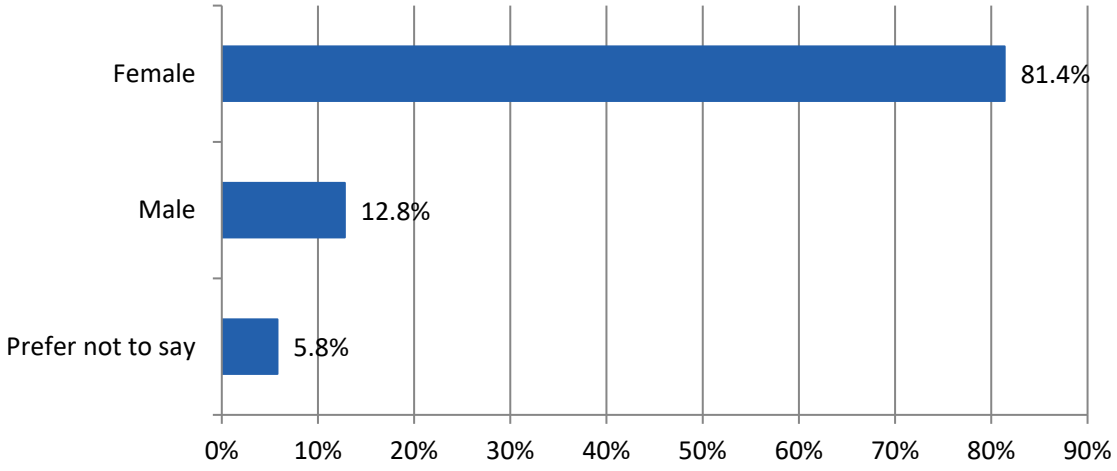
Participant Profile

Question 20: What is the name of your neighborhood? (N=73 responses; 68 English, 5 Spanish)

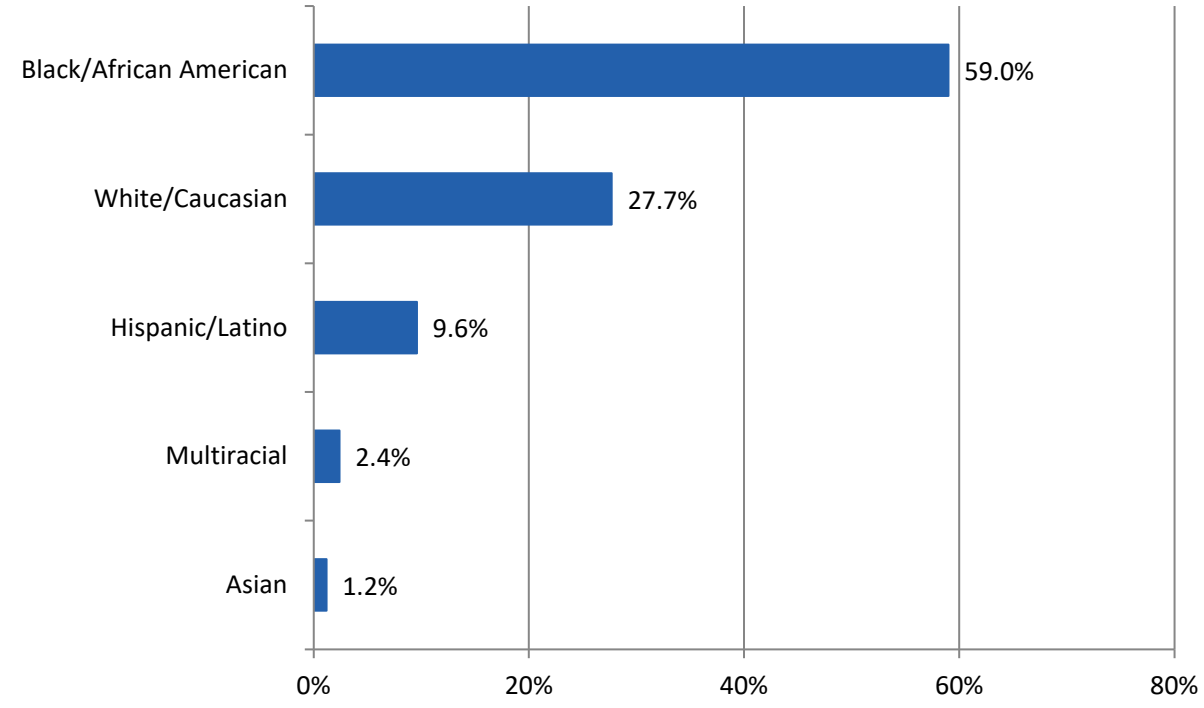
Community	All Participants
Adelphi	1
Adnell Woods	1
Allure Apollo	1
Andrews Estate	1
Barclay Square	1
Beltsville	1
Bladensburg	1
Bowie	4
Brentwood	1
Calverton	1
Cameron Grove	1
Capitol Heights	4
Cherry Glen Condos	1
Cherry View Park	1
Chillum	2
College Park	3
Collington Station	2
Colony Square	1
Coral Hills	1
District Heights	3
Dower House	1
Ementor Ave	1
Fairwood	1
Franklin Park	1
Glassmanor	1
Greenbelt	3
Greenbriar	1
Hyattsville	1
Kentland	1
Kingsford	1
Kirby Woods	1
Lake Arbor	2
Landover	1
Lanham	1
Largo	1
Laurel	2
Marlboro West	1
New Carrollton	3
North Tantallon	1

Community	All Participants
Overbrook	1
Oxon Knolls	1
Perrywood	1
Riverdale	1
University Park	8
Unknown	1
Upper Marlboro	1
Village of Morgan Metro	1
Woodland Hills	1

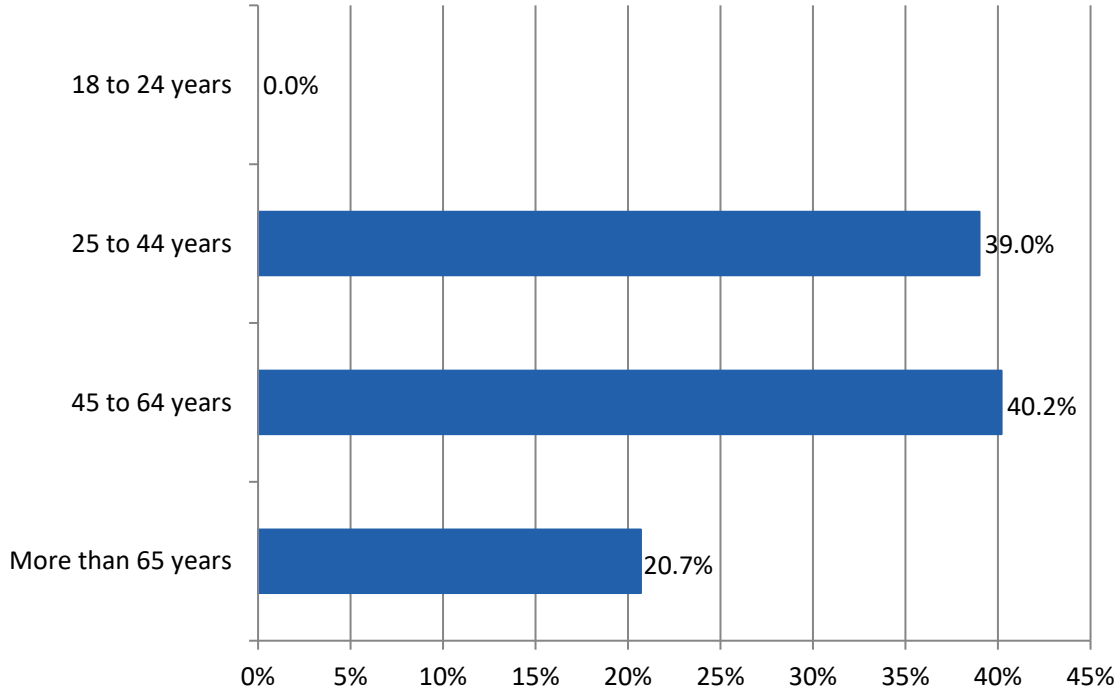
Question 21: What is your gender? (N= 86 responses; 81 English, 5 Spanish)



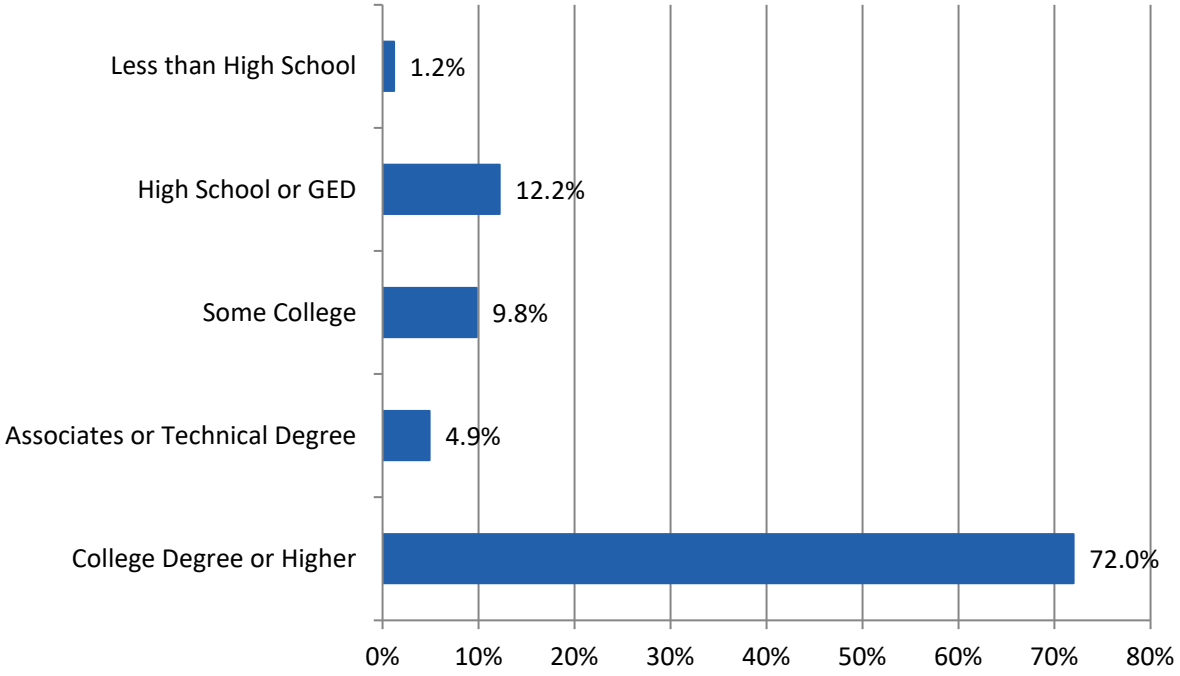
Question 22: What race/ethnicity best identifies you? (N=83 responses; 78 English, 5 Spanish)



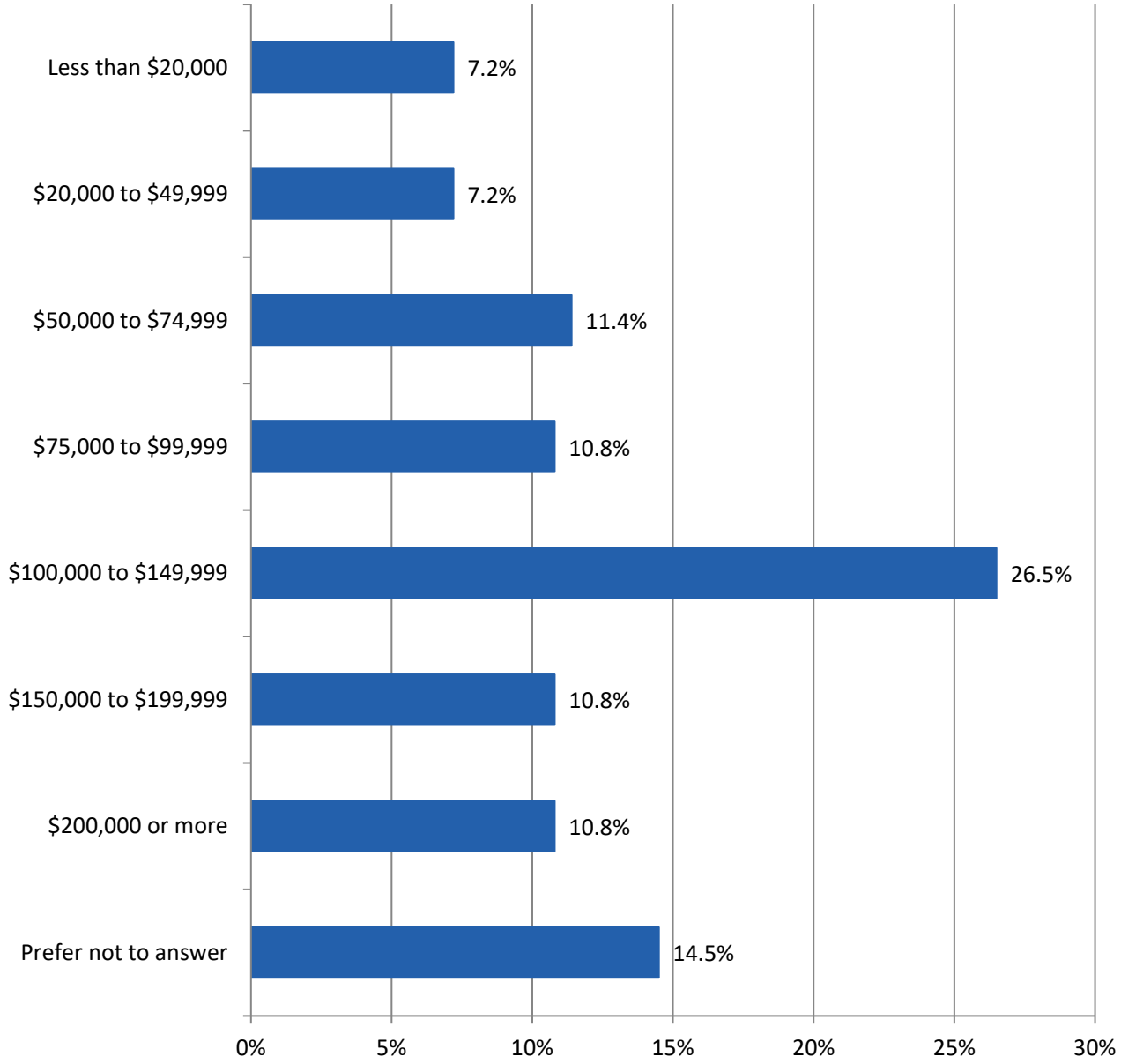
Question 23: How old are you? (N=82 responses; 77 English, 5 Spanish)



Question 24: What is the highest level of education you completed? (N=82 responses; 77 English, 5 Spanish)



Question 25: What is your annual household income? (N=83 responses; 78 English, 5 Spanish)



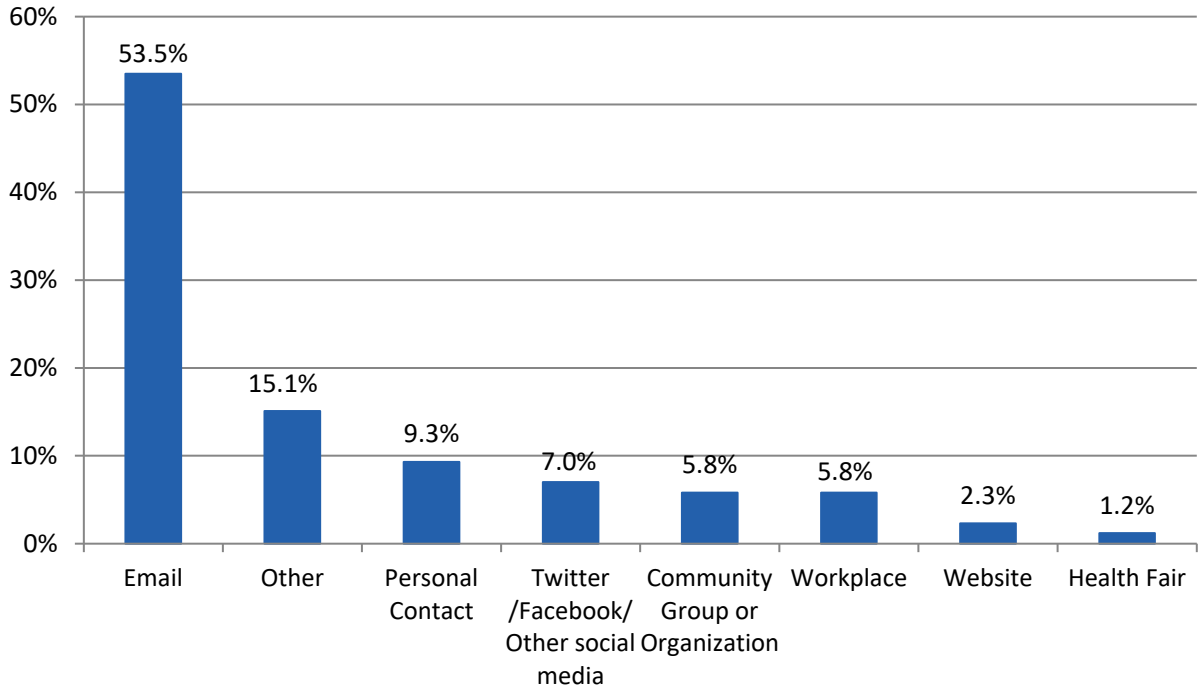
Question 26: In what country were you born? (N=81 responses; 76 English, 5 Spanish)

Community	All Participants
Dominican Republic	1
El Salvador	3
Germany	1
Ireland	1
Mexico	2
United States	73

Question 27: What language do you speak at home? (N=81 responses; 76 English, 5 Spanish)

Community	All Participants
English	74
English & Spanish	2
German	1
Spanish	4

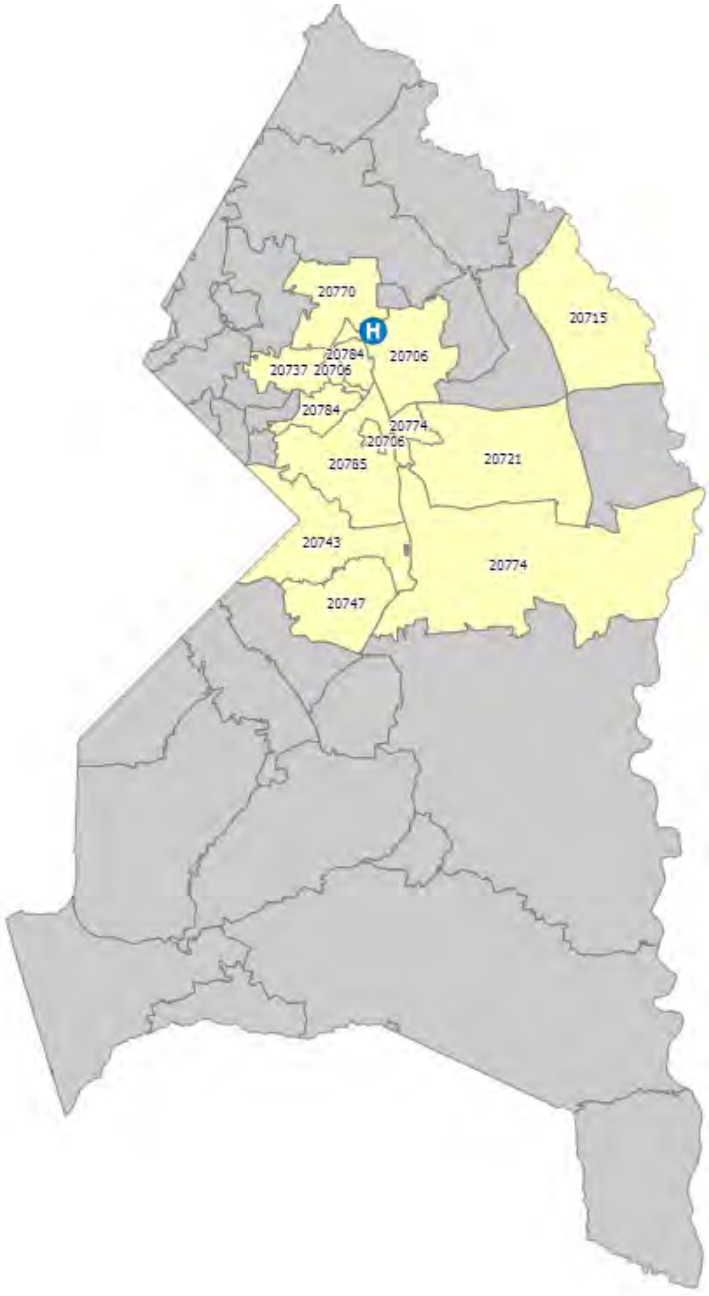
Question 28: How did you receive this survey? (N=86 responses; 81 English, 5 Spanish)



F**or <u>personal contact</u> participants mentioned specific locations in the "Other" free-text field**: library, DFS, child's school, school email, text message.


HOSPITAL
profile

LUMINIS HEALTH DOCTORS COMMUNITY MEDICAL CENTER



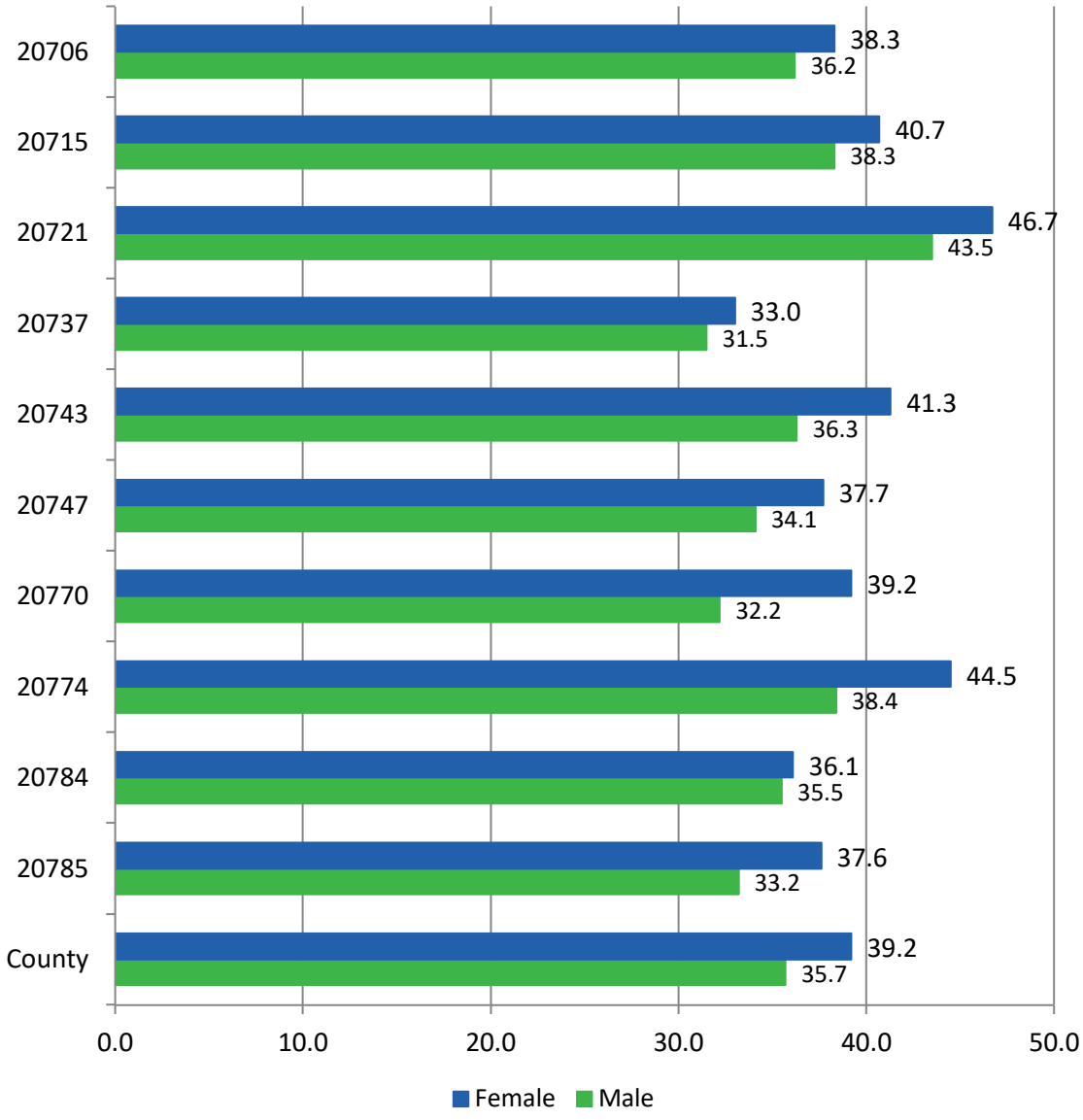
Service Area Profile

Luminis Health Doctors Community Medical Center is located in Prince George's County, Maryland, which is part of the Washington, D.C. metropolitan area. Most of Doctors inpatient visits are from ZIP codes in the central part of the County, as illustrated in the adjacent map.

The service area ZIP Codes include a mix of urban and suburban, with an estimated population of 349,478 (approximately 38% of the County's population). All but one ZIP code (20747) in the service area experienced an increase in population since 2010. This area is varied in race and Hispanic ethnicity (Chart 2), and in socio-economic indicators including poverty, education, and employment as displayed in Chart 3.

Chart 1 shows the median age by gender in each ZIP code of the service area. As of 2020, the median age for females in Prince George's County is 39.2 years; in the hospital's service area there is a wide range for the median age for females from 33.0 to 46.7 years. The median age for males in Prince George's County is 35.7 years; for ZIP codes in the hospital's service area, the median age for males ranges from 31.5 to 43.5 years.

Chart 1: Median Age by Gender



Data Source: 2016-2020 American Community Survey, 5-year Estimates, Table S0101

As displayed in Table 1, six of the ten ZIP codes in the primary service area of the hospital have a higher proportion of younger (under 18 years of age) residents compared to the county average (22.3%). Five of the ten ZIP codes in the hospital's service area have higher proportions of residents 65 years and older compared to the county.

Table 1: Population Estimates

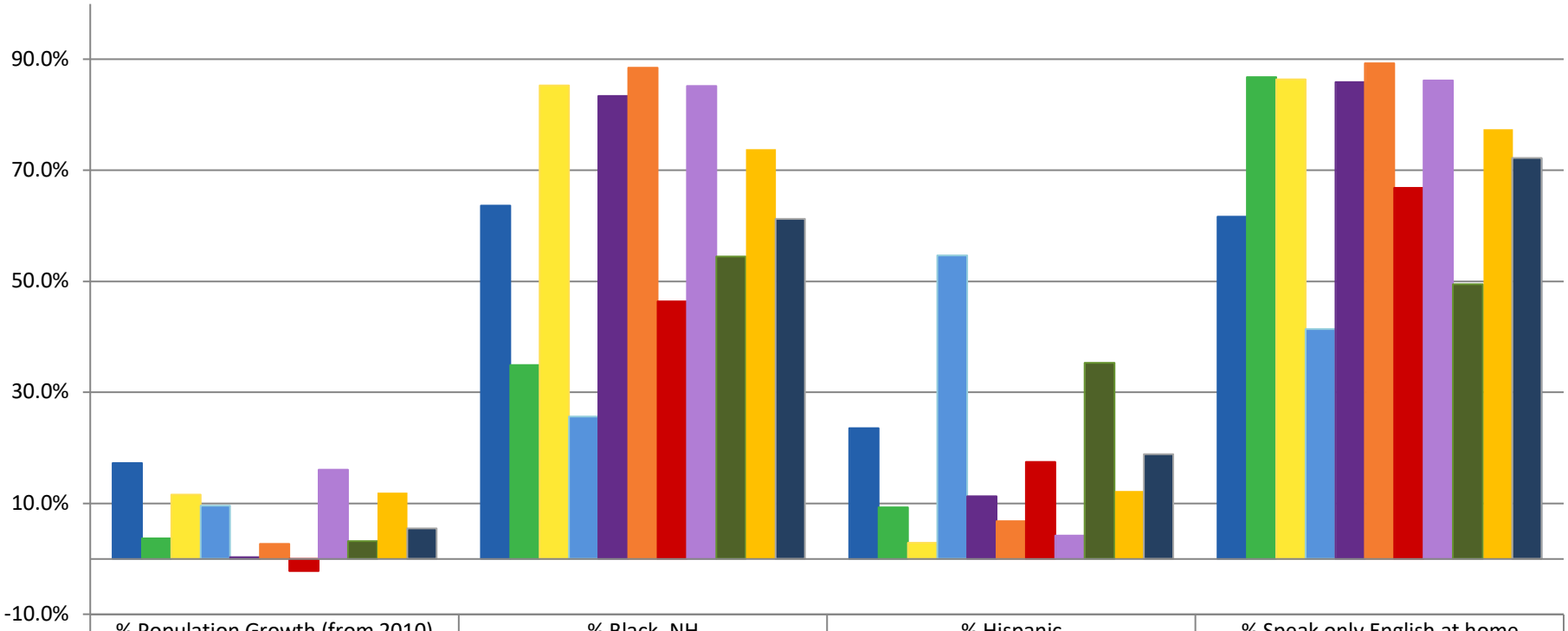
ZIP Code	Name	Population Estimate	Population <18 Years	Population Age 65+
20706	Lanham	45,329	11,105 (24.5%)	6,073 (13.4%)
20715	Bowie	27,360	5,698 (20.8%)	4,263 (15.6%)
20721	Bowie	30,121	5,909 (19.6%)	5,294 (17.6%)
20737	Riverdale	22,666	6,618 (29.2%)	1,769 (7.8%)
20743	Capitol Heights	38,747	8,432 (21.8%)	5,985 (15.4%)
20747	District Heights	41,128	9,248 (22.5%)	4,637 (11.3%)
20770	Greenbelt	24,602	5,810 (23.6%)	2,619 (10.6%)
20774	Upper Marlboro	49,907	10,439 (20.9%)	7,598 (15.2%)
20784	Hyattsville	30,381	7,512 (24.7%)	3,323 (10.9%)
20785	Hyattsville	39,237	10,464 (26.7%)	5,080 (12.9%)
County	**Prince George's**	**910,551**	**202,908 (22.3%)**	**121,208 (13.3%)**

Data Source: 2016-2020 American Community Survey, 5-Year Estimates, Table S0101

Similar to the county, most of the ZIP codes in the hospital's service area have a majority Black population (Chart 2). However, three of these ZIP codes have a Hispanic population over 20%, including Riverdale (20737) where over half of the residents are Hispanic. Roughly three-fourths of county residents speak only English at home, but two ZIP codes in the service area have a higher proportion of residents who speak a language other than English (20737 and 20784).

Unemployment is highest in the service areas for Hyattsville (20784) and Capitol Heights (20743). In Hyattsville, 21.8% of residents do not have a high school degree and 6.3% of families live below the poverty level (Chart 3). Almost two out of five residents of Riverdale (20737) do not have a high school degree and 7.7% of families live below the poverty level, the fourth highest in the service area (Chart 3).

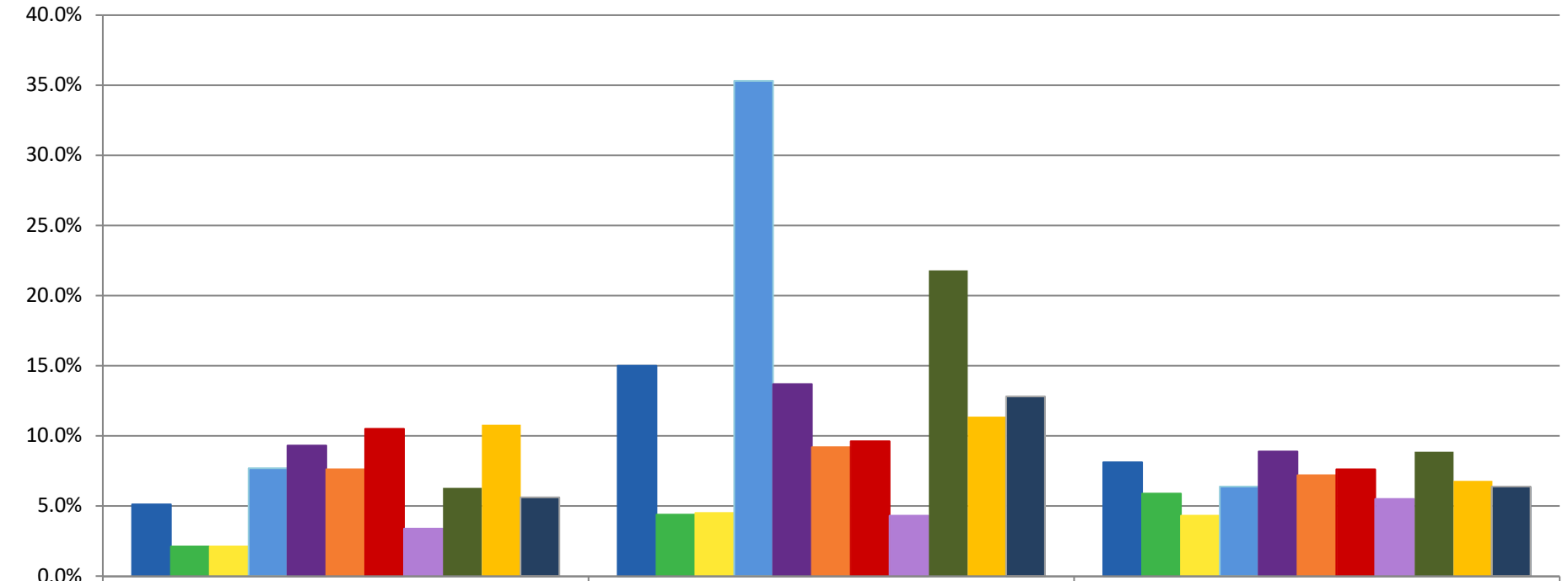
Chart 2: Population Description



	% Population Growth (from 2010)	% Black, NH	% Hispanic	% Speak only English at home
20706	17.2%	63.6%	23.5%	61.6%
20715	3.7%	34.9%	9.3%	86.8%
20721	11.5%	85.3%	2.9%	86.4%
20737	9.6%	25.6%	54.6%	41.4%
20743	0.3%	83.4%	11.2%	85.9%
20747	2.7%	88.5%	6.8%	89.3%
20770	-2.2%	46.4%	17.4%	66.8%
20774	16.0%	85.2%	4.2%	86.2%
20784	3.2%	54.4%	35.3%	49.5%
20785	11.9%	73.8%	12.2%	77.4%
County	5.5%	61.2%	18.8%	72.2%

Data Source: 2016-2020 American Community Survey, 5-Year Estimates, Tables DP05, S1601

Chart 3: Socioeconomic Indicators

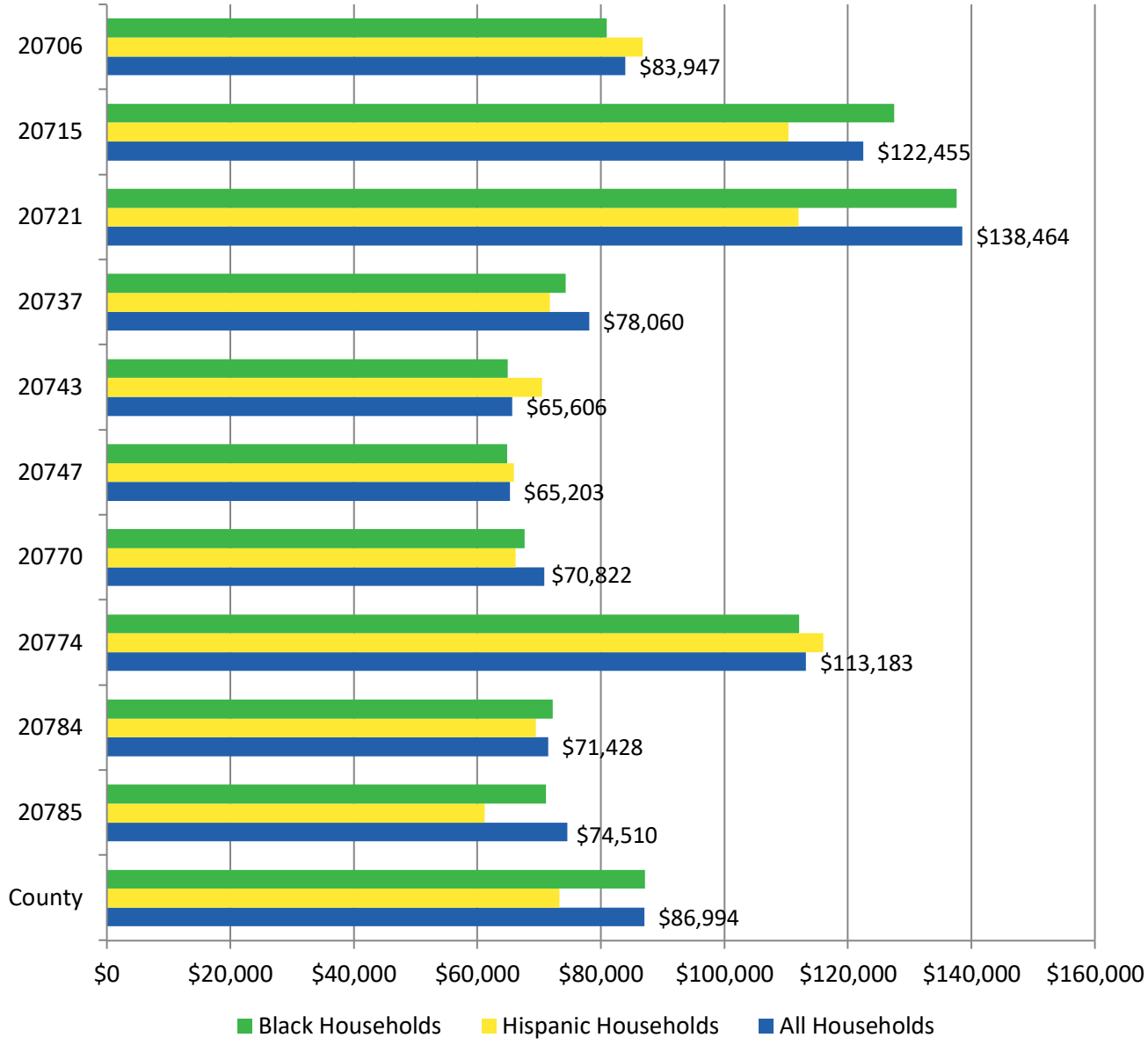


	% Families Below Poverty	% No High School degree	% Unemployment
20706	5.1%	15.0%	8.1%
20715	2.1%	4.4%	5.9%
20721	2.1%	4.5%	4.3%
20737	7.7%	35.3%	6.4%
20743	9.3%	13.7%	8.9%
20747	7.6%	9.2%	7.2%
20770	10.5%	9.6%	7.6%
20774	3.4%	4.3%	5.5%
20784	6.3%	21.8%	8.9%
20785	10.8%	11.4%	6.8%
County	5.6%	12.8%	6.4%

Data Source: 2016-2020 American Community Survey, 5-Year Estimates, Tables S1501, DP03

The median household income throughout Prince George's County is $86,994, but the service area ZIP codes have a broad range: the median household income ranges from $65,203 (District Heights) to $138,464 (Bowie). Household incomes are also noticeably different by race and ethnicity within some ZIP codes in the service area.

Chart 4: Median Household Income



Data Source: 2016-2020 American Community Survey, 5-Year Estimates, Table B19013

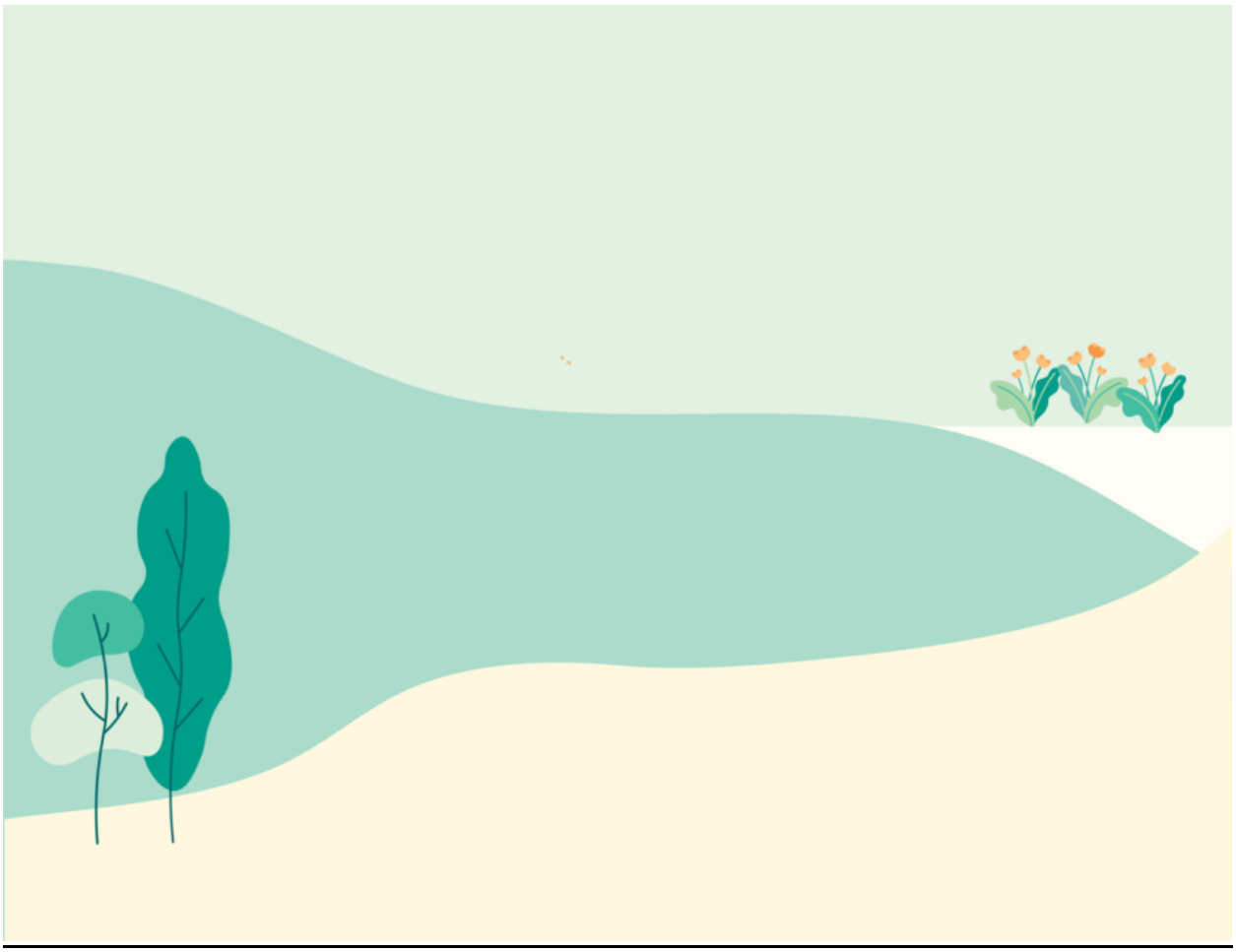
The Health Equity Index (formerly SocioNeeds Index)[1] created by Healthy Community Institute, is a composite measure of socioeconomic factors correlated with poor health outcomes for all the ZIP codes in the United States, ranking them in an index from 1 (low need) to 100 (high need). For example, an index of 50 would be average compared to the entire country. Table 2 highlights the large disparity in need based on the Health Equity Index. The ZIP codes in the hospital's service area range from a very low area of need in Bowie (20721) to a higher area of need in Riverdale (20737). Five of the ten ZIP codes in the service area have a SocioNeeds Index over 50, worse than the country average.

Table 2: Health Equity Index

ZIP Code	Name	Health Equity Index (0 is low need, 100 is high need)	Rank (1 is low need, 5 is high need)
20706	Lanham	46.4	3
20715	Bowie	6.6	1
20721	Bowie	3.6	1
20737	Riverdale	83.2	5
20743	Capitol Heights	64.8	4
20747	District Heights	52.3	4
20770	Greenbelt	40.9	3
20774	Upper Marlboro	10.8	1
20784	Hyattsville	71.3	4
20785	Hyattsville	57.3	4

Data Source: www.pgchealthzone.org, Healthy Communities Institute

[1] http://www.pgchealthzone.org/index.php?module=indicators&controller=index&action=socioneeds



Community Health Needs Assessment

Implementation Plan

FY2022 – FY2024

Luminis Health

Executive Summary

Luminis Health is pleased to provide the FY2022 through FY2024 Community Health Needs Assessment (CHNA) and Implementation Plan. This plan is inclusive of all three hospitals in the health system: Luminis Health Anne Arundel Medical Center (LHAAMC), Luminis Health Doctor's Community Medical Center (LHDCMC), and Luminis Health McNew Family Medical Center. This report is designed to describe the process of collecting information and ascertaining the community needs, prioritizing those needs and a description of our action plan to address those needs to improve health. For the purpose of this report, the community is defined within Anne Arundel and Prince George's Counties since the majority of patient discharges reside in this area. The Board of Directors approved this plan on September 22, 2022 in accordance with IRS regulations.

About Luminis Health

In 2019, Anne Arundel Medical Center added Doctors Community Medical Center and was renamed to Luminis Health (LH), remaining a not-for-profit health system that serves communities across central Maryland, from Washington D.C. to Delaware. Luminis Health includes three hospitals with 611 licensed beds and over 80 ambulatory locations. As a major employer in central Maryland, we have more than 1770 on the medical staff, 6,500 employees and 1,400 volunteers. Our mission is to enhance the health of the people and communities we serve.

Key Findings

The CHNA data was compiled from secondary data sources and qualitative information obtained from key informant interviews and several focus groups of diverse community members. It outlines multiple health needs in our community, county leaders have narrowed the top needs to chronic disease

(heart disease and cancer), obesity, diabetes/metabolic syndrome disease, behavioral health, and social determinants of health (SDOH). The results and correlating action plans are included in Table 1.

Table 1

Priority	Action Plans
Chronic Disease	Reduce incidence and mortality from Cancer by improving risk factors and screening rates. Reduce mortality from heart disease by providing education related to heart disease and risk factors. Improve access to cardiologists to reduce utilization.
Obesity/ Diabetes Prevention	Increase education for lifestyle risk factors to reduce obesity. Increase access to screenings and prevention programs to reduce incidence of diabetes.
Behavioral Health	Increase community awareness of programs. Increase access to behavioral health treatment for children, teens, and adults.
Social Determinants of Health (SDOH)	Create advisory councils to assist the health system to identify how to improve SDOH. Pilot and determine strategy to address food insecurity and how healthy food access can limit burden of disease (cancer, heart disease, diabetes).

CHNA Methodology and Process

Luminis Health participated in two separate CHNA processes, one for Anne Arundel County and one for Prince George's County. In both CHNA reports, the summative (quantitative) data was gathered from a variety of local, state and national sources. Qualitative data was obtained from key informant interviews, targeted population-based focus groups, and resident-household surveys. While both CHNA reports and data collection processes

were separate, each hospital participated with a diverse group of community partners to gather input including county health departments, hospital systems, public health leaders, faith based leaders, law enforcement, elected officials and business owners. While the CHNA reports are separate by county, Luminis Health has developed a comprehensive Implementation Plan that addresses the needs defined in Table 1.

Documenting and Communicating Results

The 2022–2024 Community Health Needs Assessment process fully embraced community involvement and collaboration with a broad group of community leaders, the general public, and health experts. This report will be posted on our website at (INSERT LINK).

Highlights of this report will also be documented in the Community Benefits Annual Report for FY2022-2024. Reports and data will also be shared with our community partners and community leaders as we work together to make a positive difference in our community by empowering and building healthy communities.

Priorities and Implementation Planning

Luminis Health aligned its identified community health priorities with the state health priorities (SIHIS, Maryland Behavioral Health Plan), and national quality benchmarks (HEIDS). Program objectives and outcome measures will be measured annually for each priority area through the related programming. Adjustments will be made to annual plans as other issues emerge or through our annual program evaluation.

Future Community Health Needs Assessments will be conducted every three years and strategic priorities will be re-evaluated then. Program evaluations

will occur annually, and adjustments to programs will be as needed. All community benefits reporting will occur annually to meet state and federal reporting requirements.

Unmet Community Needs

Each CHNA report contained additional topic areas that will not be addressed within this plan. Due to resource limitations, LH will focus the majority of its efforts on the identified strategic priorities. We will periodically review the complete set of needs identified in the CHNA for future collaboration and work.

The LH identified core priorities target the intersection of the identified community needs and the organization's key strengths and mission. The following table summarizes the programs either currently in use or to be developed to address the identified health priorities.

FY2022-FY2024 Community Health Improvement Implementation Plan

PRIORITY AREA: Chronic Disease- Cancer Heart Disease

Objectives Supporting SIHIS, MD Behavioral Health Plan, HEDIS:

1. Reduce morbidity and mortality related to cancer.
2. Reduce morbidity and mortality related to heart disease.

Objective	**Target Population**	**Strategy**
Increase access to breast, cervical and colorectal cancer screenings.	Patients who meet screening eligibility	Identify opportunities in the care continuum to educate and schedule patients for screenings. Outreach to patients who lack access to screenings and face barriers (language, transportation, insurance).
Increase access to tobacco cessation and prevention programs.	Patients who smoke/ at risk for smoking	Continue on-going efforts to recruit patients through referral process. Identify high risk patients (behavioral health, face barriers) and enroll into programs.
Promote heart failure awareness among community and patients	Community	Increase self-assessment abilities through interactive learning experiences
Encourage participants to assume responsibility for their own health choices through development of a personal wellness plan for maximizing heart health throughout life	Community	Provide educational opportunities for patients to better understand how to implement a heart healthy diet, maintain weight, omit tobacco use, limit alcohol and drug use, get regular exercise.

Increase access to ambulatory cardiology providers to reduce readmissions, ED visits, for CHF and Afib	Heart patients	Increase providers to improve patient wait times and follow up visit adherence Improve process to schedule follow up appointments with providers.

PRIORITY AREA: Obesity/ Diabetes Prevention

Objectives Supporting SIHIS, MD Behavioral Health Plan, HEDIS:

1. Expand Diabetes Prevention Programs across service area to reduce mean BMI, maintain HbA1c, and blood pressure monitoring in adults.
2. Expand diabetes prevention programs to non-English speaking populations.
3. Increase number of patients with access to healthy food.
4. Increase number of patients who are physically active.

Objective	**Target Population**	**Strategy**
Increase education and access to programs to improve health, reduce BMI, and reduce incidence of diabetes.	Patients and community who meet CDC diabetes prevention definitions	Expand DPP programs in English and Spanish Expand mobile van testing and screenings (HbA1c, total glucose, total cholesterol, blood pressure) Expand programs in Primary Care offices to improve HbA1c and blood pressure screenings Continue to support Prince George's County HSCRC Diabetes Catalyst Grant initiatives Expand the number of community partners to increase efforts

PRIORITY AREA: Behavioral Health

Objectives Supporting SIHIS, MD Behavioral Health Plan, HEDIS:

1. Reduce the suicide rate and reduce the emergency department visits related to mental health

2. Increase the proportion of persons with co-occurring substance use disorders and mental health disorders who receive treatment for both disorders

3. Increase the proportion of patients (Children, teens and adults) adults with behavioral health illnesses who receive treatment

Objective	**Target Population**	**Strategy**
Expand co-occurring capacity of Treatment and Prevention Programs	Staff	Provide awareness and education about programs ED continue to facilitate Naloxone distribution Partner with Sheppard Pratt to expand Collaborative Care Services in ambulatory practices
Explore new partnerships for community outreach and health promotion for mental health and substance use.	Community organizations	Provide awareness and education about programs
Improve access to Behavioral Health Care for children, teens, and adults	Patients	Expand consult service capacity for mental health and substance use within LHAAMC and LHDCMC Expand services at LHDCMC - open an inpatient psychiatric unit, Psychiatric Day Hospital, OMHC, Urgent care and residential addiction-crisis unit for adults Expand ED Evaluations at LHDCMC and offer Emergency Petition (EP) capacity Develop Child & Adolescent Outpatient Services on a regional basis to serve both Anne Arundel and Prince George's Counties

		Continue to monitor and evaluate programs and access for patients

PRIORITY AREA: Social Determinants of Health

Objectives Supporting SIHIS, MD Behavioral Health Plan, HEDIS:

1. Increase number of patients who have access to healthy food.
2. Reduce number of patients with risk factors for disease since they have access to healthy food.

Objective	**Target Population**	**Strategy**
Establish advisory councils for each hospital to develop strategies to address SDOH in a clinical setting and in the community.	Community leaders	Pilot SDOH faith based council at LHDCMC. Develop lessons learned and implement strategies at both hospitals. *Plan to be updated FY23-FY24

Luminis Health

ADM1.1.91 - Patient Financial Services – Hospital Financial Assistance, Billing & Collection

Dates Previously Reviewed/Revised: N/A **Newly Reviewed By:** F&A 9/2012, BOT 9/2012, HPRC 1/2015, BOT 6/2019, BOT6/2020, BOT 1/2021 **Approval Date:**1/2021 **Effective Date:** 1/2021	**Owner:** Director, Patient Financial Services
Approver Title: Chief Financial Officer On file _____ Approval Signature	

Scope:
This Luminis Health policy applies to hospital services provided at Anne Arundel Medical Center (AAMC), Doctors Community Medical Center (DCMC), J. Kent McNew Medical Center (MMC) and Pathways (collectively hospitals) only. Other providers, including all physicians who deliver emergency and medically necessary care at AAMC, DCMC, MMC and Pathways are not covered by this policy.

Policy Statement:
To promote access to all for medically necessary services regardless of an individual's ability to pay, to provide a method of documenting uncompensated care and to ensure fair treatment of all applicants and applications.

Purpose:

- To assure the hospital communicates patient responsibility amounts in a fair and consistent manner.
- To provide opportunity to resolve questions regarding charges or insurance benefits paid.
- To assure the hospital meets the requirements of Maryland standards for hospital billing and collection practices.
- To provide opportunity to resolve questions regarding charges or insurance benefits paid.
- To define the hospital's decision-making process for referral for collection or legal action.
- To assure the hospital meets the requirements of Maryland standards for hospital billing and collection practices.

Definitions: None

Policy/Procedure:
Financial Assistance:

- A patient's payment for reduced-cost care shall not exceed the amount generally billed (AGB) as determined by the Health Services Cost Review Commission's (HSCRC) approved rates.
- Patients may apply for Financial Assistance by the methods listed below.
  - By calling AAMC at 443-481-6500 or DCMC at 301-552-8093
  - Patients may apply in person at the Financial Advocacy Office which is located in the Ambulatory Care Pavilion on the first floor of AAMC's main campus between 8:30 a.m. and 4:00 p.m., Monday through Friday or at 7404 Executive Place, 3rd floor, Room 300A, Lanham, Maryland 20706

- The Financial Advocacy Office will mail a free copy of Luminis Health's financial assistance policy and financial assistance application to any patient who requests those documents
- Patients may apply on the internet at:
  https://luminis.health/aamc-fa-application for AAMC or MMC
  https://luminis.health/dcmc-fa-application for DCMC
- Applications are available in English and en Español

- The following two-step process shall be followed when a patient or a patient's representative requests or applies for financial assistance, Medical Assistance, or both:
  - Step One: Determination of Probable Eligibility. Within two business days following the initial request for financial assistance, application for Medical Assistance, or both, Luminis Health shall: (1) make a determination of probable eligibility, and (2) communicate the determination to the patient and/or the patient's representative. In order to make the determination of probable eligibility, the patient or his/her representative will be required to provide information about family size, insurance, assets and income, and the determination of probable eligibility will be based solely on the information provided by the patient or patient's representative. No application form, verification or documentation of eligibility will be requested or required for the determination of probable eligibility.
  - Step Two: Final Determination of Eligibility. Following a determination of probable eligibility, Luminis Health will make a final determination of eligibility for Financial Assistance, which (except as otherwise provided in this Policy) will be based on a completed Uniform Financial Assistance Application and supporting documentation of eligibility.

- Once a request for financial assistance has been approved, dates of service twelve months before the approval and twelve months after the approval shall be included in the adjustment. Service dates outside this twenty-four-month window may be included if approved by a Supervisor, Manager, or Director of the Patient Financial Services Department.

- PROVIDERS NOT COVERED BY FINANCIAL ASSISTANCE POLICY
  Unless otherwise specified, the Luminis Health Financial Assistance Policy does not apply to physicians or certain other medical providers who care for you while you are in the hospital. This includes emergency room doctors, anesthesiologists, radiologists, hospitalists, pathologists, and other providers. These doctors will bill you separately from the hospital bill. This policy does not create an obligation for the hospital to pay for the services of these physicians or other medical providers. The public may obtain a copy of this list by printing from the link below or contacting the Luminis Health Financial Counseling office.

  Providers excluded from the Luminis Health Financial Assistance policy (PDF)

- PROVIDERS COVERED BY FINANCIAL ASSISTANCE POLICY
  This policy applies to services provided by Luminis Health (facility charges) only. Medical professionals who care for you in the hospitals will bill you separately for their services (professional charges). Each of these medical professionals has their own policy and their bills are not covered by this Financial Assistance Policy.

Eligibility Criteria:

- Luminis Health provides 100% financial assistance to individuals with household income at or below 300% of the US Poverty guideline but deemed ineligible for any County, State or Federal Medicaid or other funding program.

- Luminis Health provides 100% financial assistance to individuals enrolled in a means-tested State or Local program. Patients who provide proof of enrollment in one of these programs do not have to complete an application or submit supporting documentation of income to be approved for financial assistance.

- A patient that has qualified for Medical Assistance (Medicaid) is deemed to automatically qualify for financial assistance under this policy. The amount due from a patient on these accounts may be written off to financial assistance with verification of Medicaid eligibility. Standard documentation requirements are waived.

- A patient of Luminis Clinical Enterprises who has been approved for financial assistance by that organization automatically qualifies for financial assistance under this policy at the same percentage of charges discount. The patient does not have to complete a separate application to be eligible under this policy. Some service exclusions may apply.

- Luminis Health provides a sliding fee scale for individuals with household income at or below 350% of the US poverty guideline but deemed ineligible for any County, State or Federal Medicaid or other funding program. The sliding scale provides 50% financial assistance to individuals up to 350%.

- Luminis Health provides financial assistance not only to the uninsured but to patients with a demonstrated inability to pay their deductibles, copayments and balance after insurance.

- Luminis Health recognizes that a portion of the uninsured or under insured population may not engage in the traditional financial assistance application process. If the required information is not provided by the patient, Luminis Health may employ an automated, predictive scoring tool to qualify patients for financial assistance. The patient's score predicts the likelihood of a patient to qualify for Financial Assistance based on publicly available data sources. Approval through the automated scoring method applies only to accounts where obtaining an application is not feasible as determined by the Patient Financial Services Department.

- For all income levels, Luminis Health will consider special circumstances such as the amount of the bill compared to income and cumulative impact of all medical bills from the hospitals. The guidelines in Maryland regulation regarding financial hardship will be followed to determine if a special circumstance is valid.

- AAMC developed an initiative with the Anne Arundel (AA) County Department of Health to help provide free prenatal diagnostic testing for uninsured unregistered immigrants. These individuals are not eligible for any Medicaid program.

- AAMC participates with an AA County specific program (REACH) administered through the AA County Department of Health to provide free care to low income uninsured or under-insured individuals (below 200% of the US Poverty Guideline). These individuals come to AAMC on an elective basis and are prescreened by the local Department of Social Services.

- Diagnostic and Treatment services are provided free of charge to referrals from the AAMC Outreach Free Clinic initiative located in downtown Annapolis.

- Payment plans are interest-free. Payment plans greater than four months will be handled by an external vendor. Payment plans are available to patients regardless of their household income.

Exclusions from Eligibility:

- Services not charged and billed by a Luminis Health Facility listed within this policy are not covered by this policy.

- Cosmetic, other elective procedures, convenience and/or Luminis Health facility services which are not medically necessary, are excluded from this policy.

- The Hospitals exclude assets such as:
    - Equity in the patient's primary residence
    - The first $15,000 of monetary assets
    - The value of transportation necessary to generate an income
    - Certain retirement benefits such as a 401k where the IRS has granted preferential tax treatment as a retirement account including but not limited to deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans where the patient would pay taxes and/or penalties by cashing in the benefit

- Patients who chose to become voluntary self-pay patients do not qualify for Financial Assistance for the amount owed on any account where they have elected to be self-pay.

Appealing an Unfavorable Decision

- Patients who feel they have been denied financial assistance inappropriately under this policy may contact the Health Education and Advocacy Unit of the Maryland Attorney General's Office.
- Email heau@oag.state.md.us
- Telephone 410-576-6300; En español 410-230-1712
- Address 200 St. Paul Place 16th Floor, Baltimore, MD 21202-2021
- Fax 410-576-6571
- Website https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx

Billing:

Patient Statement of Charges:

- A Summary Bill of charges, formally referred to as the Uniform Summary Bill is mailed to every inpatient within 15 days of discharge from the hospital. This contains information on the insurance company billed as well as how to contact the Patient Financial Services office for questions or assistance.

- Uninsured patients receive this Summary as well.

- Each bill for outpatient services includes detail charge information on the first request for payment.

- At any time, the patient may request a copy of their detailed itemized bill.

- The HSCRC required Patient Billing Information sheet data is printed on the Uniform Summary Bill and the back of all patient billing statements.

- A representative list of services and charges is available to the public on the hospital's website and in written form. The website will be updated quarterly with the most recent average charge per case for each of the services.

- Requests and inquires for current charges for specific procedures/services will be directed to the ACP Financial Coordinator or if applicable the specific department Financial Coordinator. The Coordinator will communicate with the patient and the patient's provider of care to provide the best possible estimate of charges. Using the CPT code, service description and/or other supply/hospitalization time charge estimates are based on, a) review of the charge master for the CPT code/service description, and/or b) review of cost of similar surgical procedures/treatments/hospital stays. The patient will be informed cost quotes are estimates and could vary based on the actual procedure(s) performed, supplies used, hospital stay/OR time & changes in HSCRC rates. If the Coordinator requires guidance or additional information to provide the estimate, he/she will contact the Reimbursement Department. Every effort will be made to respond to the request for charges within 2 business days depending on information needed to fulfill the patient's request.

Patient Balance Billing:

- From the point in which it is known that the patient has a balance for which they are responsible the hospital begins billing the patient to request payment.
- Each patient receives a minimum of 4 requests for payment over a 120-day period.
- Each patient bill includes contact information for financial assistance and states where to call to request a payment plan.
- Each bill informs the patient they may receive bills from physicians or other professionals.
- Short- and Long-term interest free payment plans are available. The hospital considers the balance of the bill and the patient's financial circumstances in determining the appropriate agreement.
- Should the patient contact Patient Financial Services Customer Service unit regarding inability to pay – financial assistance is offered, and the financial assistance screening process begins.
- Patients who have made payments to Luminis Health in excess of $25 and later become eligible for financial assistance on those dates of service will be entitled to a refund of the amount paid.
- Patient complaints about the billing or collection agency process should be directed to the Patient Financial Services general telephone number.

Collection Agency process:

- If there is no indication from the patient or a representative that they cannot pay and no attempt at payment or reasonable payment arrangements is made, the account is referred to a collection agency.
- The collection agency referral would typically occur between 120 – 150 days from the first request to the patient to pay assuming the patient made no attempt to work out payment arrangements or indicated financial need.
- The final statement to the patient communicates the account will be referred to an external agency if the balance is not satisfied.

Collections:

- The Director of Patient Financial Services oversees the hospital's business relationship with the Collection Agency. The Patient Financial Services Department is responsible for determining that reasonable efforts have been made to determine whether an individual is eligible for financial assistance before initiating extraordinary collection actions (ECAs).
- Luminis Health permits the following ECAs:
    - Reporting adverse information about an individual to credit agencies
    - Commencing a civil action against an individual**
- Luminis Health does not allow the following ECAs:
    - Selling an individual's debt to a third party
    - Deferring, or denying, or requiring a payment before providing medically necessary care because of non-payment of one or more bills for previously provided care
    - Placing a lien on an individual's property
    - Foreclosing on an individual's real property
    - Attaching or seizing an individual's bank account or other personal property
    - Causing an individual's arrest

- Causing an individual to be subject to a writ of body attachment
- Garnishing an individual's wages

** Commencing civil action against an individual is not the normal course of collection, however, Luminis Health reserves the right to pursue collections through civil action in extraordinary circumstances, at the discretion of senior management, to include, but not limited to:
  - When a patient's receivable is >= $5,000 and the patient's ability to pay has been verified
  - When an insurance company confirms payment has been made directly to the patient or patient representative

- If a financial assistance application is received within 240 days of the first post-discharge billing statement, and the account is with a collection agency, the agency will be notified to suspend all ECAs until the application and all appeal rights have been processed.

- Luminis Health does utilize a credit reporting bureau.

- Luminis Health does not charge interest to patients.

- The Luminis Health Business Office staff reviews each case before being referred for legal action.

- The collection agency is educated on how to make referrals to Luminis Health's financial counseling departments for individuals indicating they have an inability to pay.

- The collection agency will establish payment arrangements in compliance with Luminis Health's interest free commitment.

Hospital Financial Assistance Communications:

- The Financial Assistance Signage is conspicuously displayed in English & Spanish in each hospital's Emergency Department, Cashiering & Financial Counseling office. Patients desiring to discuss financial assistance in another language may call the contact numbers in this policy and interpretive services will be provided.

- The Financial Assistance Policy as well as a printable Uniform Financial Assistance Application is posted on the hospitals' websites.

- Financial Assistance information is included in each patient guide located in the inpatient rooms.

- Registration staff and Financial Coordinators are trained on how to refer patients for financial assistance.

- The Uniform Financial Assistance Application is available at all registration points in each hospital, including the Emergency Department.

- A brochure "Patient Information Sheet" is available at every patient access point in each hospital and is posted on the Luminis Health website. This brochure includes information regarding financial assistance/contact points and is available in English/Spanish.

- Individual notice regarding the Financial Assistance Policy shall be provided at the time of admission or preadmission to each person who seeks services in the hospital. It is mandatory that all inpatients receive the "Patient Information Sheet" brochure as part of the admission packet.

- Information is available through the patient access/registration staff to provide to the uninsured or any individual concerned about paying their hospital bill directing them to the hospital's Financial Counseling office for assistance.

- Hospital Patient Financial Service staff receive extensive training on the revenue cycle and are incentivized to obtain AAHAM Technical (CRCS) certification to demonstrate their expertise in billing and revenue cycle requirements.

References: Patient Protection and Affordable Care Act statutory section 501 (r)
IRS Notice 2015-46
Department of Treasury, Internal Revenue Service, Additional Requirements for Charitable Hospitals; Volume 77, No. 123, Part II, 26 CFR, Part 1
Maryland Health General Article § 19-214.2

Cross References: None