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?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Frederick Health Hospital.	◉	○	
Your hospital's ID is: 210005	◉	○	
Your hospital is part of the hospital system called None - Independent Hospital.	◉	○	
The primary hospital community benefit (HCB) Narrative contact at your hospital is Heather Kirby.	◉	○	
The primary HCB Narrative contact email address at your hospital is hkirby@frederick.health	◉	○	
The primary HCB Financial report contact at your hospital is Hannah Jacobs.	○	◉	jdevlin@frederick.health
The primary HCB Financial report contact email at your hospital is hjacobs@frederick.health	○	◉	jdevlin@frederick.health

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.

2023 United Way ALICE report. 2022 Community Foundation of Frederick - Human Needs Assessment

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
- [x] Frederick County
- [ ] Garrett County
- [ ] Harford County
- [ ] Howard County
- [ ] Kent County
- [ ] Montgomery County
- [ ] 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.

- [ ] 20842
- [ ] 20871
- [x] 21701
- [x] 21702
- [ ] 21719
- [x] 21727
- [x] 21754
- [x] 21755
- [x] 21775
- [ ] 21776
- [x] 21777
- [x] 21778

- [x] 21703
- [x] 21704
- [x] 21705
- [x] 21710
- [ ] 21713
- [x] 21714
- [x] 21716
- [x] 21717
- [x] 21718
- [x] 21757
- [x] 21758
- [ ] 21759
- [x] 21762
- [x] 21769
- [x] 21770
- [x] 21771
- [x] 21773
- [x] 21774
- [x] 21780
- [ ] 21783
- [ ] 21787
- [x] 21788
- [x] 21790
- [ ] 21791
- [x] 21793
- [x] 21798

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.

This question was not displayed to the respondent.

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.

- [x] Based on ZIP codes in your global budget revenue agreement. Please describe.

Appendix E of the Global Budget Revenue Agreement signed on 2/21/14 defines the hospital's primary and secondary service areas. The hospital routinely monitors our market share by analyzing changes in patient volumes that are derived from its primary and secondary service areas. There have been no significant changes in patient volumes from outside the PSA or SSA during the fiscal year.

- [ ] Based on patterns of utilization. Please describe.

- [ ] Other. Please describe.

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

https://www.frederickhealth.org/about/mission-vision-values/

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)

05/1/2022

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.frederickhealth.org/documents/page%20links/community%20health/2022-Frederick-County-CHNA-final_20220429070140712 2.pdf

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

2022-Frederick-County-CHNA-final_20220429070140712 2.pdf
7.1MB
application/pdf

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

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

	CHNA Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☐	☑	☑	☐	☐	
CB/ Community Health/ Population Health Director (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☐	☑	☑	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (facility level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	approval of CHNA at 3/22/22 meeting and subsequent approv implementation strategy at 10/14/22 meeting
Board of Directors or Board Committee (system level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Clinical Leadership (facility level)	☐	☐	☐	☑	☑	☐	☑	☑	☐	☐	

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

	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)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	The Quality Committee of the hospital board is briefed on the imple,ementation and evaluation of community initiatives during its monthly meetings
	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)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	

	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 (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:
Community Benefit staff (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:
Community Benefit staff (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:
Physician(s)	☐	☐	☐	☐	☐	☐	☐	☑	☑	☐	
	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:
Nurse(s)	☐	☐	☑	☐	☐	☐	☐	☑	☑	☐	
	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:
Social Workers	☐	☐	☑	☐	☐	☐	☐	☑	☑	☐	
	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:
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	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:
Other (specify) Community Benefit Committee	☐	☐	☑	☑	☑	☑	☐	☑	☑	☐	
	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:

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: Not applicable	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Departments -- Please list the Local Health Departments here: Frederick County Health Department	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Improvement Coalition -- Please list the LHICs here: Coalition for a Healthier Frederick County	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Maryland Department of Health	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other State Agencies -- Please list the agencies here: University of Maryland/Office of Minority Health Advancing Health Literacy Grant	☑	☐	☐	☑	☐	☐	☑	☐	☐	☑	☐	☑	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Govt. Organizations -- Please list the organizations here: Not applicable	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	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: Frederick County Public Schools	☑	☑	☐	☐	☐	☐	☑	☐	☐	☑	☐	☐	☑	☐
	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: Hood College	☑	☑	☐	☐	☐	☐	☑	☐	☐	☑	☐	☐	☑	☐
	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: Mental Health Association	☑	☑	☐	☐	☐	☐	☑	☐	☐	☑	☐	☐	☑	☐
	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: Not applicable	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	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: Not applicable	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	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: Asian American Center of Frederick, Spanish Speaking Community of Frederick, The Community Foundation of Frederick, Nigerian in Frederick	☑	☑	☐	☐	☐	☐	☑	☐	☐	☐	☐	☑	☑	☐
	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: Not Applicable	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	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: Not Applicable	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	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.

October 14, 2022

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

https://www.frederickhealth.org/documents/CHNA-Implementation-Strategy-Final-Draft-10.17.22.pdf

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

CHNA-Implementation-Strategy-Final-Draft-10.17.22.pdf
355.9KB
application/pdf

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

This question was not displayed to the respondent.

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

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

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

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

- ○ Yes
- ◉ No

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

- ☑ Health Conditions - Addiction
- ☐ Health Conditions - Arthritis
- ☐ Health Conditions - Blood Disorders
- ☑ Health Conditions - Cancer
- ☐ Health Conditions - Chronic Kidney Disease
- ☐ Health Conditions - Chronic Pain
- ☐ Health Conditions - Dementias
- ☐ Health Conditions - Diabetes
- ☐ Health Conditions - Foodborne Illness
- ☐ Health Conditions - Health Care-Associated Infections
- ☑ Health Conditions - Heart Disease and Stroke
- ☐ Health Conditions - Infectious Disease
- ☐ Health Conditions - Mental Health and Mental Disorders
- ☐ Health Conditions - Oral Conditions
- ☐ Health Conditions - Osteoporosis
- ☑ Health Conditions - Overweight and Obesity
- ☑ Health Conditions - Pregnancy and Childbirth
- ☐ Health Conditions - Respiratory Disease
- ☐ Health Conditions - Sensory or Communication Disorders
- ☐ Health Conditions - Sexually Transmitted Infections
- ☐ Health Behaviors - Child and Adolescent Development
- ☑ Health Behaviors - Drug and Alcohol Use
- ☐ Health Behaviors - Emergency Preparedness
- ☐ Health Behaviors - Family Planning
- ☐ Health Behaviors - Health Communication
- ☐ Health Behaviors - Injury Prevention
- ☐ Health Behaviors - 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

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

Q60. Why were these needs unaddressed?

11 community needs were identified through combining survey data, focus group input and secondary data. Subject matter experts provided additional information on all 11 topics. This information was then combined with scores from a Readiness Assessment and Prioritization Matrix and presented during a public input session (which included over 140 individuals and 69 different community organizations). The community input session culminated in the selection of 3 priority community needs to be addressed. Frederick Health addressed the 3 priority areas in our CB plan, however, did not address the others.

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

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
- [x] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program
- [x] The COVID-19 Long-Term Care Partnership Grant
- [x] The COVID-19 Community Vaccination Program
- [ ] The Population Health Workforce Support for Disadvantaged Areas Program
- [ ] Other (Describe)

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

Q64. Section III - CB Administration

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

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

Q66. Please describe the third party audit process used.

The data introduced on the financial spreadsheet is used in the development of the IRS-990 form which is completed and filed annually. The audit is completed by Ernst and Young, a third party accounting firm in collaboration with Frederick Health Hospital staff.

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 is reviewed by the Vice President of Integrated Care Delivery & Chief Population Health Officer as well as the Community Benefits Coordinator.

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

- ◯ Yes
- ◉ No

Q70. Please explain:

The data introduced on the financial spreadsheet is used in the development of the IRS-990 form which is completed and filed annually. The audit is completed by ____ , a third party accounting firm in collaboration with Frederick Health Hospital staff.

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

- ◯ Yes
- ◉ No

Q72. Please explain:

The entire narrative reports are not presented to the hospital board but is made available to members upon request. Initiatives and data included in the narrative are presented at regular intervals to the Quality Committee of the Board. The Quality Committee reports quarterly to the full Board. Included in this report are presentations and committee minutes.

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 Frederick Health strategic plan includes goals pertaining to population health, which are derived from community health, population health, SIHIS, and local health improvement priorities. The strategic planning process plays a significant role in planning the annual budget and allocation of resources (including capital resources). The entire Frederick Health leadership team actively engages in the strategic planning process annually through recurring Strategic Council meetings, as well as annual strategic planning sessions. The final strategic plan is presented to the board during the Spring retreat.

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

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

- [x] Diabetes - Reduce the mean BMI for Maryland residents

Diabetes was identified as a priority in the most recent CHNA; Frederick Health received funding through the Regional Partnership Grants for the implementation of community-based initiatives targeting, awareness, health literacy, healthy lifestyle programs (including Diabetes Prevention Program and Diabetes Self-Management), screening, access to primary care, etc.

- [ ] Opioid Use Disorder - Improve overdose mortality

- [x] Maternal and Child Health - Reduce severe maternal morbidity rate

Successfully implemented the Family Connects Universal Home Visiting Program serving 556 families

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

Navigation to timely follow-up care post hospital visit (ER/Inpatient)

- [ ] 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.

Financial Assistance Policy, FN 100.pdf
133.4KB
application/pdf

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

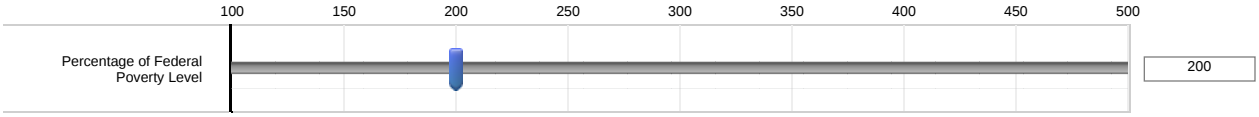
https://fmh.policystat.com/policy/13356789/latest

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

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

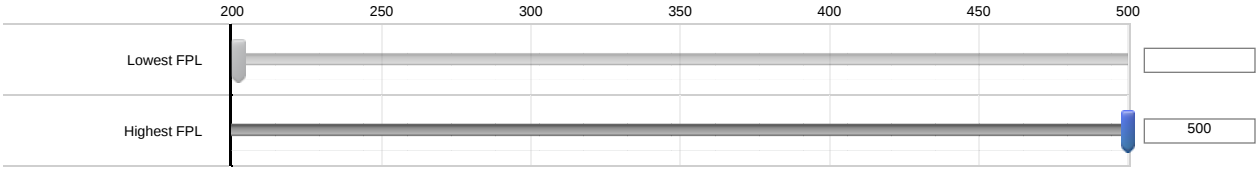
Q84. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



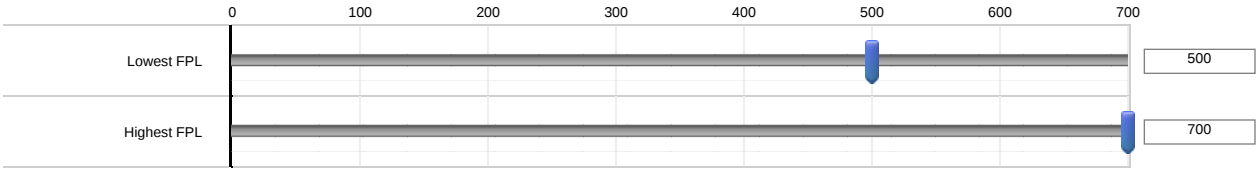
Q85. Maryland acute care and chronic care hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

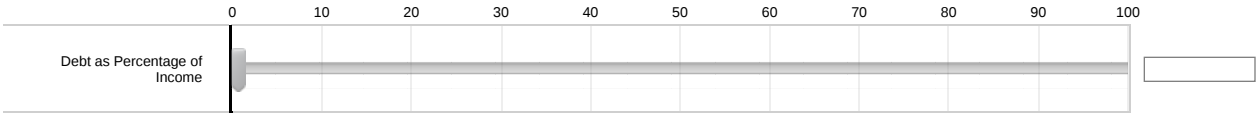


Q86. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3)(a) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial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

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



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



Q88. Section VI - Tax Exemptions

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

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

Q90. Summary & Report Submission

Q91.

Attention Hospital Staff! IMPORTANT!

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

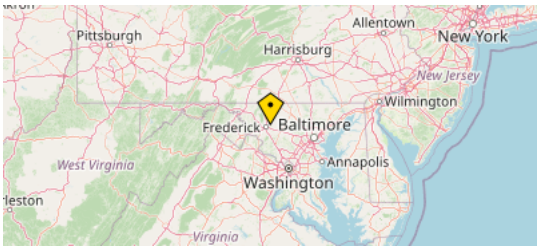
We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can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

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

Location Data

Location: (39.4442, -77.3393)

Source: GeoIP Estimation





FREDERICK COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT 2022

FREDERICK COUNTY HEALTHCARE COALITION

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Executive Summary

The 2022 Community Health Needs Assessment (CHNA) was conducted by the Frederick County Health Care Coalition (Coalition) to identify health issues in Frederick County and to provide critical information to those in a position to take positive steps that will impact the health of all area residents.

The Coalition is a nonprofit organization formed in 2006 in response to a need to coordinate efforts to address barriers to health care access. The Coalition's mission is to improve wellness and resiliency to equitably impact the lifelong health of all Frederick County residents through collective impact efforts that engage local organizations and citizenry. A core responsibility of the Coalition is the completion of a periodic assessment that informs and engages the community in health improvement initiatives. The assessment process is repeated every three years to reflect changing local conditions.

A CHNA examines disease and death statistics for the community and compares local outcomes to the state and other benchmarks. The CHNA also identifies available resources to address health issues and resident perceptions about health and social concerns. Finally, a CHNA identifies major health problems and health disparities and, with input from the public, narrows those health issues into a manageable set of priorities.

The 2022 CHNA analyzed Frederick County health data and the Coalition Board used a prioritization matrix and readiness assessment tool to determine five topics of interest. Subject Matter Experts presented these five topics to the community in a Public Health Input Session on January 19, 2022 and participants provided their ideas on possible interventions at various socio-ecological levels. The Coalition Board took input from these various tools and voted on the three health improvement priorities, two* of which were continued from the prior CHNA cycle.

- **Adverse Childhood Experiences***
- **Diabetes* (a subgroup of the previous Chronic Disease work group)**
- **Mental Health**

The Coalition has facilitated the formation of three community participant work groups charged with developing action steps to address each priority. Work plans will include measurable goals, strategies, and responsible parties, and will be compiled into a Local Health Improvement Plan that will be available to the public by Fall 2022. Over the next three years, the Coalition will evaluate the progress of the work groups and will report back to the community on a periodic basis.

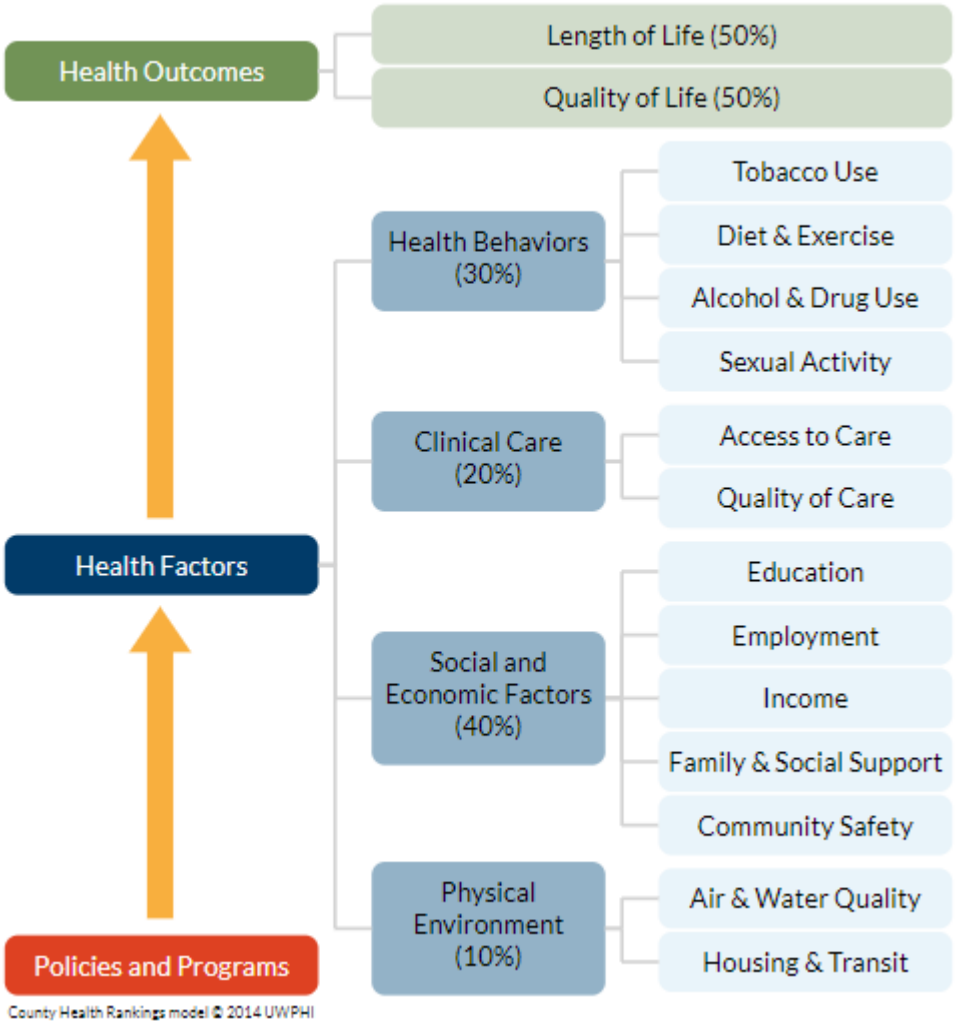
Introduction

Health is complex. The health of our community is like a building—it depends on a strong and stable foundation. A healthy physical environment includes things like safe and affordable housing, safe drinking water, and clean air. Social and economic factors like quality education, access to healthcare, community safety, and employment opportunities create a healthy community structure for everyone.

Good health for individuals is more than not being sick or getting routine medical care. The choices we make to be healthy depend on the options we have in our environment and within our means. The clinical care we receive, our lifestyles and our personal behaviors contribute to good individual health best when there is a foundation of strong community health. Individual health is rooted in the health of our community.

The picture to the right shows a framework of how influencing factors and health outcomes fit together. This framework is from County Health Rankings and is based on a concept of community health that includes both Health Outcomes (length and quality of life) and Health Factors.

The health issues included in this report (see Appendix 2) have been organized by this model. This framework is useful in identifying key drivers and where to focus interventions. The model is also helpful for future program design.



The foundations of our community and individual health are factors like education, safety of the neighborhood, air quality, housing conditions, poverty, and employment. These factors are called **social determinants of health**. These factors often overlap in individuals' lives. For example, communities may have affordable housing options that increase the risk for asthma and lead levels, which may impact success in school. Likewise, unemployment means people can lose health insurance and their usual transportation, which then makes accessing care more difficult and can result in worsening chronic health conditions. For some, losing health insurance is the starting domino leading to worsening chronic conditions, loss of employment and transportation. All these factors together form a complex web in our community and influence our health.

Source: Dahlgren and Whitehead (1991).

The 2022 CHNA was conducted by the Frederick County Health Care Coalition (Coalition), a non-profit organization dedicated to improving the health of Frederick County residents. Coalition board members represent a broad range of health and social service organizations, as well as community volunteers, committed to implementing health improvement solutions.

The CHNA was sponsored by the Frederick County Health Department (FCHD) and Frederick Health (FH). Participation in the CHNA process by FCHD and FH fulfills regulatory and accreditation requirements for conducting a periodic community health assessment with public input and participation.

The 2022 CHNA included collation of data from primary (qualitative) and secondary (quantitative) sources. Data analysis identified significant health problems experienced by various geographic sub-areas and resident populations within Frederick County. The CHNA answers the following questions:

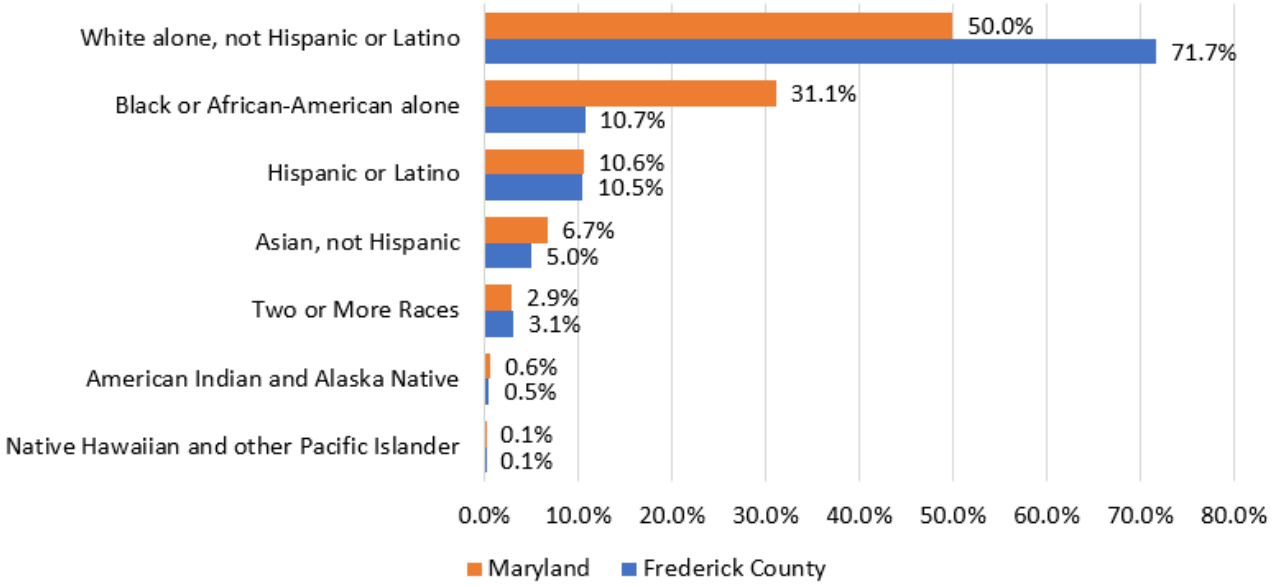
- What are the major causes of illness and death in the community?
- What health issues and behaviors are most concerning to local citizens and community organizations serving Frederick County?
- What barriers and resources exist for residents to achieve better health?

The following report presents the findings of the CHNA and the 2022-2024 health improvement priorities in Frederick County.

Frederick County Community Profile

The service area for this report is Frederick County, MD[1]. The county jurisdiction was selected because it constitutes the service area for the health and human service providers who are charged with implementing actions to address priority needs.

Frederick County is located in northern Maryland. In 2020, the County's population was 271,717. Compared to Maryland, Frederick County has a larger population of residents who are White, non-Hispanic than other demographic groups. The County's racial and ethnic composition has continued to change. Minority populations are increasing, creating a need for increased availability of translation and interpretation services and culturally appropriate service providers to meet the health needs of the changing population.



Other Facts about Frederick County Residents:

92.5% **are high school graduate or higher** **(25+ years)**

41.4% **have bachelor's degree+**

14.8% are 65 years or older

7.4% **have a disability** **(<65 years)**

14.6% speak a language other than English at home

10.2% are foreign-born

5.5% don't have health insurance (under 65 years)

5.7% are in poverty

Source: U.S. Census Bureau, QuickFacts: Frederick County, Maryland, population estimates April 1, 2020.
Bolded facts indicate that Frederick County is higher than Maryland; Non-bolded shows Frederick County is lower than Maryland.

[1] Frederick County constitutes the service area for Frederick Health Hospital, a sole community hospital and subsidiary of Frederick Health. The service area represents 86% of all patients discharged for acute care services. The CHNA service area definition meets the regulatory requirement for hospitals participating in a collaborative CHNA.

Key Factors for Our Community

Projected Growth

The Frederick County population has continued to grow and is projected to continue. The Frederick County Division of Planning and Permitting projects that the county will have more than 300,000 residents by 2030.

Year	Employment	Population	Households
2025	123,200	284,300	106,300
2030	128,600	304,500	115,400
2035	135,300	320,200	122,400
2040	141,100	334,600	128,100
2045	145,500	346,600	132,100

Source: Frederick County Population and Employment Projections.
https://www.frederickcountymd.gov/8017/Population-Employment-Projections

Seniors

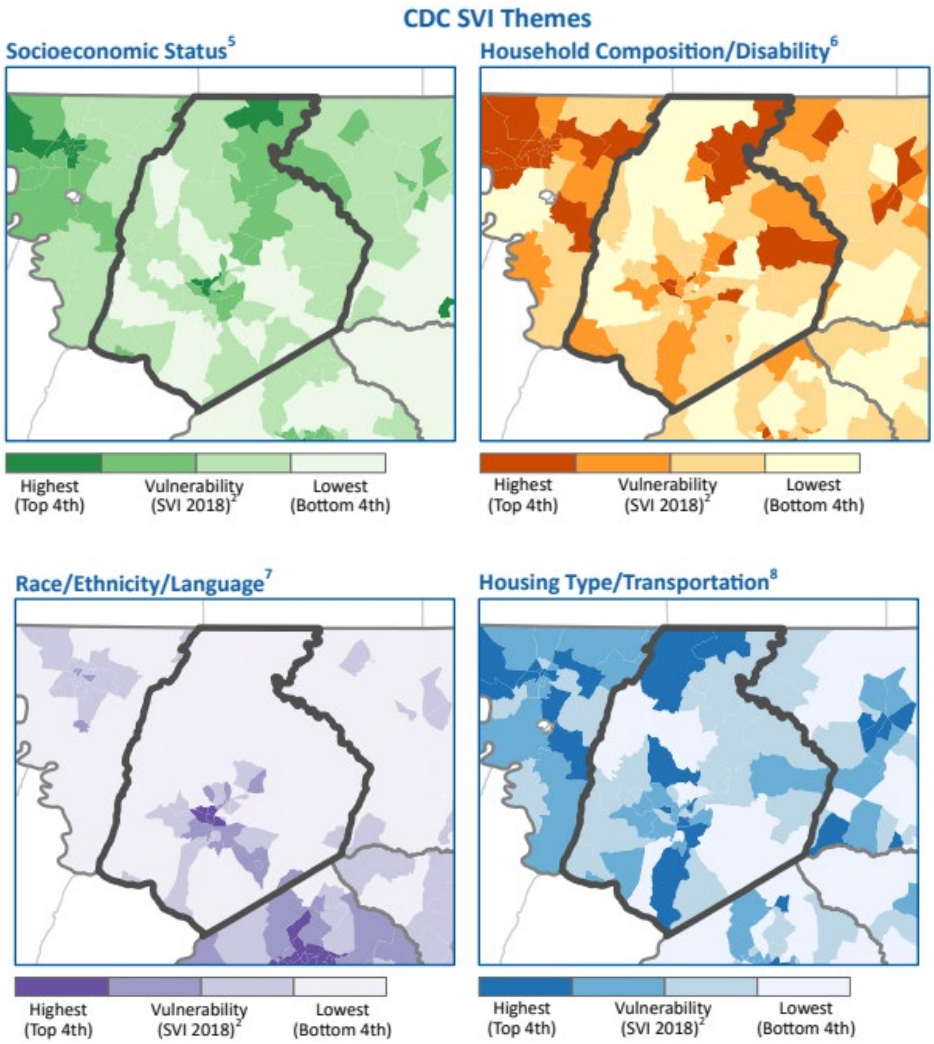
One area of the Frederick County population that is expected to see significant growth is the older adults age 60 years and older. This part of our community is expected to grow at a rate three times that of the overall county population. The baby boomer generation is aging, and over the next two decades, the population of adults 85 years and older in Frederick County is expected to almost quadruple. The need for in-home services as well as long-term care series continues to increase as the population ages.

Many older adults are on fixed incomes and are part of the population called ALICE - Asset Limited, Income Constrained, Employed. ALICE households have incomes above the Federal Poverty Level (FPL), but struggle to afford basic household necessities. The number of senior households (65 years and older) increased from 19,882 in 2016 to 22,623 in 2018, a more than 13 percent increase. The number of senior households with income below the ALICE Threshold grew at an even faster rate, increasing from 7,356 in 2010 to 10,757 in 2018, a 46 percent increase.

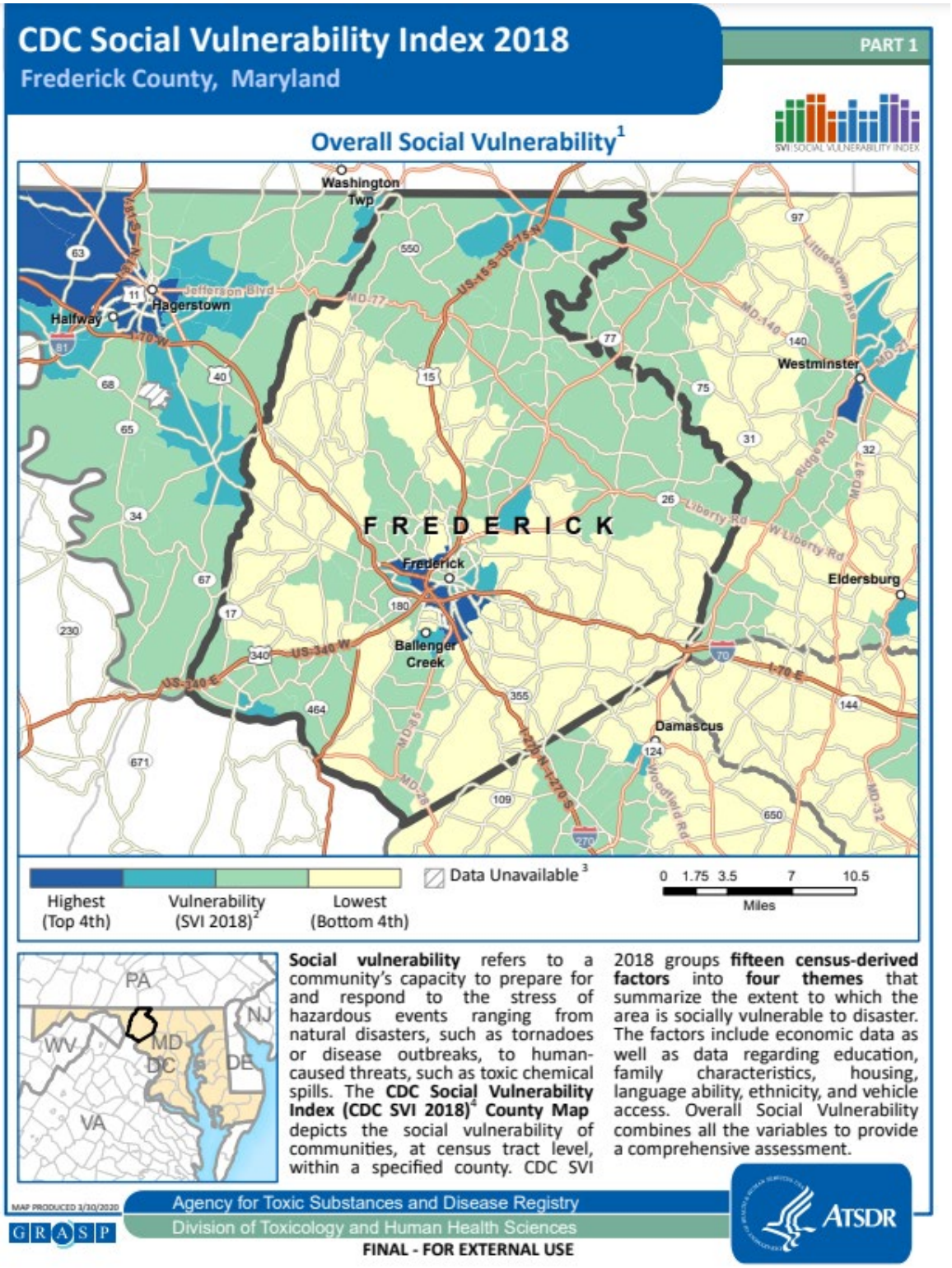
Social Vulnerability

Our health is impacted by the foundations of our community's health like housing, transportation, access to healthy food, literacy and educational levels and personal decisions like eating well and getting exercise. When the foundations of community health are weakened by poverty, lack of access to transportation, and crowded housing, then a community is less able to prevent human suffering and financial loss in a disaster. These factors are known as **social vulnerability**. Because of these factors, some communities in Frederick County are healthier than others.

The CDC/ATSDR SVI uses **U.S. Census data** to determine the social vulnerability of every census tract. Census tracts are subdivisions of counties for which the Census collects statistical data. The CDC/ATSDR SVI ranks each tract on **15 social factors**, including poverty, lack of vehicle access, and crowded housing, and groups them into four related themes. Maps of the four themes are shown in the figure below. Each tract receives a separate ranking for each of the four themes, as well as an overall ranking.



Source: CDC Social Vulnerability Index for Frederick County



Source: CDC Social Vulnerability Index for Frederick County

Food insecurity

Food insecurity, a longstanding problem for families with children, is also increasing among young adults and seniors. In 2018, households headed by adults under the age of 25 were more likely to be below the ALICE Threshold compared to other age groups in Maryland, and they often struggled to put food on the table. A survey of nearly 5,000 University of Maryland undergraduate and graduate students found that 20% were food insecure in the preceding 12 months. Students who were more likely to be food insecure included students from lower-income households, first-generation college students, students of color, immigrants and those who were financially independent.

There is also growing food insecurity at the other end of the age spectrum, with a projected 8 million food-insecure seniors nationwide by 2050. In Maryland in 2018, 11% of adults age 60 and older had experienced food insecurity in the prior 12 months. Compared to other seniors, food-insecure seniors are more than twice as likely to have depression, 91% more likely to have asthma, 66% more likely to have had a heart attack, and 57% more likely to have congestive heart failure. Public benefits help but do not eliminate the need for emergency assistance measures, such as food pantries.

The COVID-19 Pandemic exacerbated food insecurity for many in Frederick County. The Seniors Services Division operates the county's Meals on Wheels Program, which provides two meals a day to homebound adults age 60 or older, or adults of any age with a chronic health condition or disability who meet program eligibility guidelines, and live in Frederick County. The program went from approximately 400 clients in 2019 to over 900 clients during the pandemic.

Many non-profit agencies stepped up to provide food assistance during the pandemic. Frederick County Health Department COVID-19 vaccination efforts coordinated with food distribution to boost awareness and access of both services in 2021. Frederick County Government also created a central resource and app for food distribution at FeedingFrederick.com in 2021.

Emergency Medical Calls

The Frederick County Division of Fire and Rescue Services (DFRS) provides critical life safety services to the citizens and visitors of Frederick County. Uniformed, civilian, and volunteer personnel responded to 34,084 emergency medical calls in 2019. This dipped slightly in 2020 due to the COVID-19 pandemic with 30,525 calls. There were 18,360 calls in January through June 2021, putting 2021 ahead of prior years.

The types of emergency calls give an insight into the emergency health issues of the county. The top 10 call types in order are:

1. Trouble breathing
2. Injured Person
3. Chest Pain
4. Vehicle Accidents
5. Sick Person
6. Decreased Level of Consciousness
7. Cardiac Arrest
8. Unconscious Person
9. Cardiac Patients- non chest pain
10. Patient Assist – non-emergency

Impact of COVID-19

The COVID-19 pandemic has had a significant impact on our community. Some of this may be seen in the primary data gathered for this assessment, but much of the secondary data is from report periods prior to the pandemic.

- Current projections show that COVID-19 will be the third leading cause of death for Frederick County in 2020 and 2021.
- Many people postponed preventive healthcare visits as well as urgent visits, both out of caution and for lack of availability, and that may have far-reaching consequences on the chronic health issues for members of our community.
- Many in our community have experienced financial challenges during this pandemic due to job loss or uncertainty. Financial resources such as rental assistance and food banks have been made available, but the many of these resources are short-term solutions.
- The ongoing stress and uncertainty of the pandemic has highlighted the importance of mental health care.

Methodology

The Health Care Coalition formed an ad hoc CHNA Planning Committee comprised of Coalition board members and community partners. This group had oversight responsibility for the CHNA process and reviewed the components as they were accomplished. Additionally, a CHNA Data Sub-Committee was formed to conduct the detailed data analysis, which as then reported to the CHNA Planning Committee. See Appendix 8 for a member listing.

The 2022 CHNA includes data from primary (quantitative and qualitative) and secondary (quantitative) sources. Primary data was gathered through a community survey, and primary qualitative data was gathered through focus groups. Secondary quantitative data was gathered from a variety of data sources listed on the next page.

The CHNA process began with the distribution of a community survey available to any adult (over 18 years of age) Frederick County resident. Market Street Research assisted in the design and analysis of the survey. Topics included perceptions of community health, barriers to accessing healthcare, personal health and healthy behaviors, and social determinants of health. An online and paper version of the survey was distributed in July and August 2021 in English and Spanish. Community partners were asked to distribute, communicate and if requested, facilitate completion of the survey. A total of 4,094 surveys were received.

The next step in the CHNA process focused on input from vulnerable and known health disparity populations. Four focus groups were held, one for each of the following groups:

- **Hispanic/Latino Women:** known health disparity outcomes for Cancer, Diabetes, and other conditions; known delays in care leading to significant health conditions and high cost/care utilization; Hispanics represent 11% of total population
- **African American Women (Pregnant/Childbearing)**: known health disparity outcomes for infant mortality, maternal mortality and low birth weight babies; current efforts to address root causes in place; Maryland policy focus for Statewide Health Improvement Strategy tied to Medicare waiver with CMS; African Americans represent 10% of total population
- **Vulnerable Neighborhood:** census tracts in County have high social vulnerability index score; locations identified as target populations for COVID Vaccine and Diabetes grants; need deeper dive on assets in neighborhood, engagement strategies and intervention effectiveness
- **Low-income/ALICE Seniors:** current initiative with *Advocates for the Aging of Frederick County* to address needs for seniors in non-senior housing environment; seniors represent 15% of total population; county resources and potential funding sources for interventions

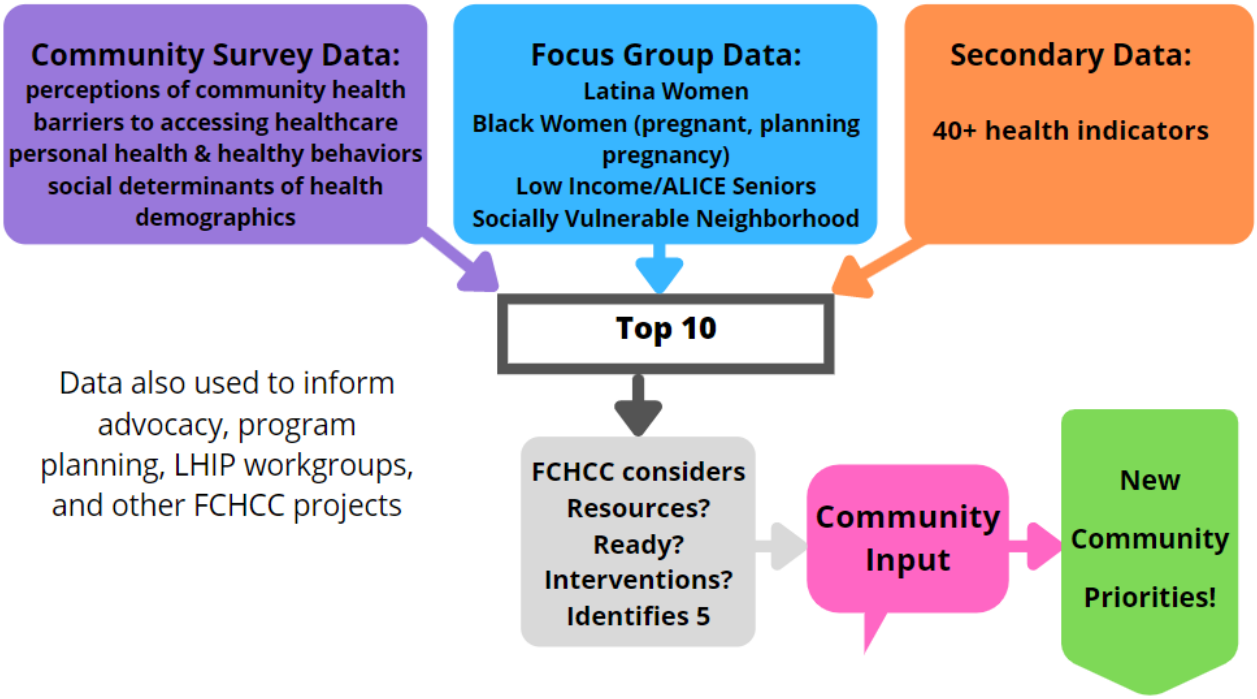
Market Street Research, a qualitative research firm, led a moderated discussion with each group in October 2021. A total of 31 community members participated in the focus groups. Participants were recruited by partner organizations that provide services or support to the target populations. The goal of the focus group was to understand the target population's health priorities and underlying reasons, identify perceived/actual barriers to care, assess population knowledge of preventive screenings and self-care, understand relationship of health literacy to personal health management, and identify unique cultural beliefs or behaviors that affect health outcomes and health equity.

Secondary data was gathered on health indicators prior to October 2021. The analysis of community health status described in this report is derived from the following sources:

- CDC Social Vulnerability Index for Frederick County https://svi.cdc.gov/Documents/CountyMaps/2018/Maryland/Maryland2018_Frederick.pdf
- County Health Rankings. https://www.countyhealthrankings.org/
- Drug and Alcohol Intoxication Deaths in Maryland https://health.maryland.gov/vsa/Pages/overdose.aspx
- Frederick Health Hospital primary diagnosis codes
- Healthy People 2030 https://health.gov/healthypeople
- Maryland Behavioral Risk Factor Surveillance System (BRFSS) https://ibis.health.maryland.gov/
- Maryland Cancer Reports https://health.maryland.gov/phpa/cancer/Pages/surv_data-reports.aspx
- Maryland Center for Zoonotic and Vectorborne Diseases Laboratory Confirmed Rabies in Maryland Reports. https://health.maryland.gov/phpa/OIDEOR/CZVBD/pages/Data-and-Statistics.aspx
- Maryland Child Welfare Trends Reports https://www.dhr.maryland.gov/documents/?dir=Data%20and%20Reports%2FSSA%2FMonthly%20Child%20Welfare%20Data
- Maryland Department of the Environment Annual Report on Childhood Blood Lead Surveillance in Maryland https://mde.maryland.gov/programs/Land/Pages/LandPublications.aspx
- Maryland Department of Health Reports of Selected Notifiable Conditions Reported in Maryland https://health.maryland.gov/phpa/Pages/disease-conditions-count-rates.aspx
- Maryland Department of Health Vital Statistics Annual Reports https://health.maryland.gov/vsa/pages/reports.aspx
- Maryland Department of Labor, Licensing & Regulations http://www.dllr.state.md.us/lmi/laus/
- Maryland Maternal Mortality Review https://health.maryland.gov/phpa/mch/Pages/mmr.aspx
- Maryland HIV Annual Epidemiological Profile https://health.maryland.gov/phpa/OIDEOR/CHSE/Pages/statistics.aspx
- Maryland STI Data and Statistics. https://health.maryland.gov/phpa/OIDPCS/CSTIP/Pages/STI-Data-Statistics.aspx
- Maryland Youth Risk Behavior Survey (YRBS) https://phpa.health.maryland.gov/ccdpc/Reports/Pages/yrbs.aspx
- Tejada-Vera B, Bastian B, Arias E, Escobedo LA., Salant B, Life Expectancy Estimates by U.S. Census Tract, 2010-2015. National Center for Health Statistics. 2020. https://www.cdc.gov/nchs/data-visualization/life-expectancy/
- U.S. Census Bureau: State and County Quick Facts https://www.census.gov/quickfacts/frederickcountymaryland

An Overview - Fitting it all Together

Community survey, focus group insights, and secondary data were compiled for the prioritization component of the CHNA process. A modified prioritization matrix method was used for prioritization of the data across several criteria in order to narrow down the information into the top health concerns. A change was made to this process from the last cycle. The list of prioritized top health concerns was then provided to the Health Care Coalition, which reviewed the data and narrowed the topics down to five through use of a readiness assessment. Community input was gathered on those five topics in January 2022. The Coalition took input from these various tools and voted on the three health improvement priorities. The information collected from the community survey and the four focus groups will inform local advocacy efforts and can be used for local advocacy and program planning.



Lessons Learned

Several changes were made in this cycle. In the 2019 Community Health Needs Assessment, the public was directly involved in the priority setting during a Priority Setting Summit and reviewed data on the top 10 health topics and then selected three via vote. Post vote discussion resulted in the combination of multiple topics into priority groups, which became difficult in subsequent months as workgroups needed to focus on specific goals and objectives, which left out some health topics. The Frederick County Health Care Coalition gained new members and became more robust and active in the last three years, and the Coalition decided to make an effort to involve more data-driven tools to inform the priority selection process.

Community Perceptions and Themes

Community Survey

Topics included in the 2021 Community Survey were similar to the 2018 survey to allow for comparison, and a set of questions on Social Determinants of Health was added. Topics included:

- **Perceptions of the health of the community**, including what makes for a healthy community and what are perceived to be the most important health issues in the community.
- **Barriers to accessing healthcare**, including services that are difficult to access and other challenges impeding access to healthcare.
- **Opportunities to increase access to healthcare**.
- **Engagement with healthcare**, including recent use of healthcare services.
- **Personal health** and engagement in healthy behaviors.
- **Experiences with social determinants of health**, including housing, financial security, access to food, transportation, social isolation, and physical safety.

See Appendix 1 for the detailed results and Appendix 7 for the survey.

The results of the 2021 Frederick County CHNA highlight a community with many strengths, and many challenges in terms of residents' access to and use of healthcare services.

Community Health Priorities

- Good hospitals, doctors, and clinics
- A clean environment
- Low crime and safe neighborhoods
- Good schools
- Safe places to play, socialize, and be active

Community Strengths

- Most community members feel relatively healthy
- Most have adequate housing and can pay for necessities
- Most have health insurance coverage
- The majority have seen doctors in the past year
- The majority are able to get healthcare when they need it

Top Challenges

- Realities of trying to live a healthy lifestyle
- Poverty and the impact of poverty on health
- Stress and mental health challenges
- Differential healthcare experiences: gender, race, and identity

CHALLENGE: Poverty exists in Frederick County and while less so than elsewhere in Maryland, upwards of 1 in 10 community members experience:

- Food insecurity
- Lack of transportation
- Challenges paying for basics and utilities
- Lack of health insurance

CHALLENGE: Stress is a significant challenge for many residents:

- 17% of community members struggle with mental health at least half the time in a typical month
- Stress is a major challenge for many—and right now, COVID-19 is the top stressor
- Social isolation affects about 11% of community residents

CHALLENGE: Many community members struggle with healthy living—they don't always exercise, eat healthy meals, or get recommended health screenings as often as they should:

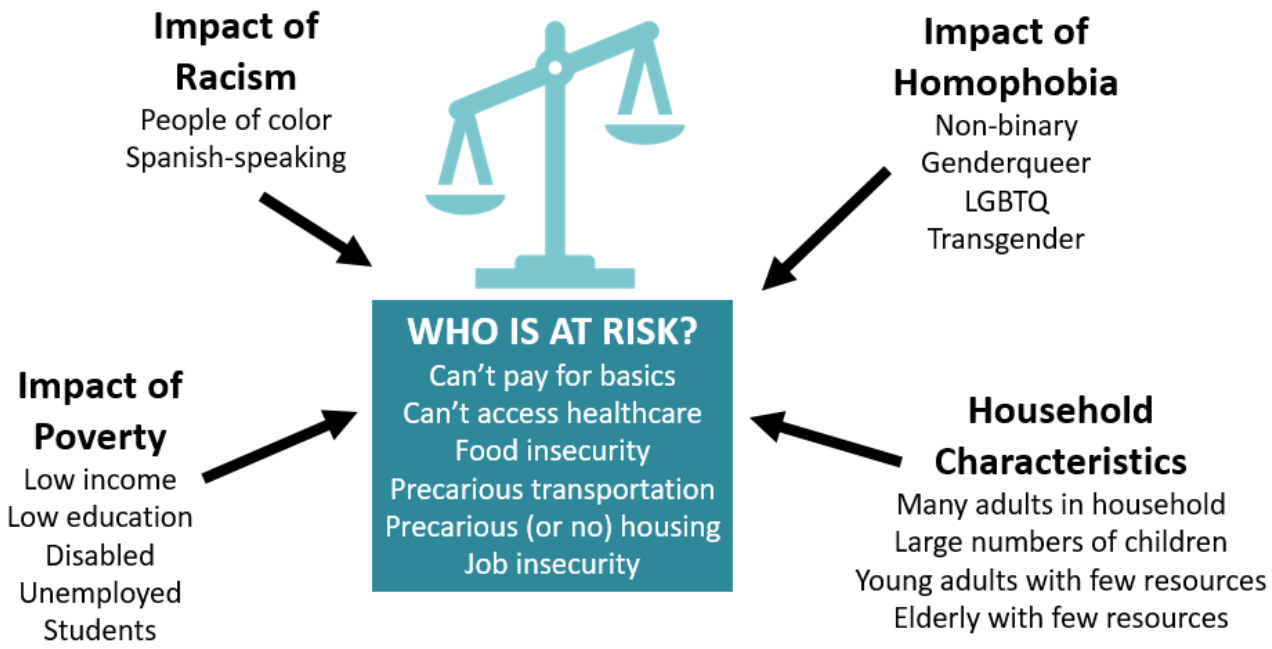
Who Is At Risk?

One way we looked at the data was to try to identify who is at risk in our community.

What we found was that factors that contribute to social risk are consistent regardless of the risk factor. Racism, poverty, homophobia, and certain household characteristics consistently showed up as significant contributors to being at risk in our community.

What does it mean to be at risk? People who can't pay for basics or access healthcare, are not sure if they have enough food or a steady job, transportation, or housing are all at risk of having poor health outcomes and other challenges in their lives that impact their health.

This is helpful to keep in mind when we think about interventions. While all these groups are at risk, it may be for different reasons, and we may need to reach them in different ways.



Health, Mental Health, and Stress

When we looked at who is at risk for physical health, mental health, and stress, community members who see themselves as unhealthy or who struggle with stress and mental health issues share some common characteristics, although factors associated with physical health and mental health are not always the same.

The survey results indicated that people with low incomes, people of color, people who speak languages other than English, individuals who have less education, people who are disabled, unemployed, and members of the LGBTQ community struggle most with physical health.

The groups that struggle most with stress and mental health, in contrast, were younger, more often women, parents/guardians/caregivers, households with many children, and lower income. The social impacts for both areas were similar, and unsurprisingly COVID pandemic continues to be the most important source of stress in people's lives.

Struggles most with physical health

Demographics

- Low income
- People of color
- Language other than English
- Low education
- Disabled, unemployed
- LGBTQ

Social Impacts

- Poverty-related
- Race/ethnicity-related
- Homophobia-related
- No health insurance

Struggles most with stress and mental health

Demographics

- Young adults
- More often women
- Parents, guardians, caregivers
- Large households, many children
- Low income

Social Impacts

- Significant life stress
- Social isolation
- Poverty-related
- Race/ethnicity-related
- Homophobia-related

Conducting this survey during the summer of 2021 gave us a snapshot of the impact of COVID-19 in our community. Results indicated that the pandemic continued to be the most important source of stress in people's lives. Social isolation has been a concern throughout the COVID-19 pandemic.

Key Points to highlight:

- Although only 1% of community members surveyed in 2021 are currently without steady housing, 5% are worried about losing their housing in the future.
- Community members who are precariously housed not only face poorer quality housing in general, but they face a greater array of problems not always experienced by those who have steady housing and aren't worried about the future.
- 25% of community residents find it hard to pay for basics.
- In the past year, 10% of community members were food insecure; that is, worried that their food would run out.
- 4% report that lack of reliable transportation has kept them from medical appointments, meetings, work, or from getting things they need.

Who does lack of transportation impact the most?

- People of color, especially Hispanics and Black/African-Americans
- Younger adults (under age 40)
- Precariously housed or currently houseless
- Has trouble paying for basics, has faced utility shutoffs
- No health insurance
- Large households
- High school or less education
- Disabled, unemployed, retired
- Low income (under $50,000)

- Most community members feel relatively healthy. Compared with 2018, this year, a significantly larger proportion of community members rated their own health as "excellent" or "very good." The proportion rating their health as "fair" or "poor" stayed about the same.
- The top things community members would do to improve their health are: (1) lose weight; (2) get more exercise; (3) find better treatments, medicines, or procedures that would end ongoing health issues; and (4) eat healthier food or improve their diet.
- Almost three-fourths (71%) of the community members surveyed feel have at least one day per month when their mental health is not good.
- Community members' greatest source of stress at the moment is the COVID-19 pandemic and related factors, such as change in work conditions and political/social issues.
- About half of the community members surveyed reported that they get the recommended amount of exercise daily, about 30 minutes, and 24% get very little or no exercise in an average day.
- Only about 1 in 5 of the community members surveyed report eating the recommended 5 or more servings of fruits and vegetables per day.
- Experiences with poor communication are a major reason why some community members don't trust doctors or dislike their doctors or medical staff.
- 29% of community members have at some point felt that their gender, race, language, or something similar affected how they were treated by doctors or medical staff.

The addition of questions focused on social determinants of health allowed for more insight into factors that contribute to health of our community.

Social factors can play a large role in one's ability to access and experiences with medical care, and experiences with those social factors vary considerably among community members.

Segmentation analysis of social determinants of health revealed three distinct groups.

Unsteady and Struggling

Tend to be younger, more impoverished, and struggling to make ends meet.

13% of respondents are in this group.

Stable and Working

Tend to be employed full time, but still experience a moderate level of daily stress.

35% of respondents are in this group

Social and Thriving

Tend to be older and happy. They experience few barriers in getting the care they need.

52% of respondents are in this group.

Each group has unique barriers and concerns that should be addressed to make care as effective as possible.

Unsteady and Struggling

- **Not getting healthcare** when needed is the largest medical concern in their community.
- Have the greatest difficulty getting access to medical services in their community.
- Affordability often prevents them from getting healthcare, recommended screening tests, and exercising.
- Desire extended appointment hours and help sharing the cost of a medical appointment.

Stable and Working

- **Lack of exercise** is the largest medical concern in their community.
- Most can access quality healthcare without a problem.
- Being too busy is one of the main reasons they do not get recommended screening tests or enough exercise.
- Are most likely to desire more appointment times and extended hours.

Social and Thriving

- **Lack of exercise** is the largest medical concern in their community.
- Most can access quality healthcare without a problem.
- Not wanting it or being too busy are the main reasons they do not get recommended screening tests.
- Would like more appointment times and extended hours, but many do not have any problems getting healthcare.

Focus Groups

Our four focus groups allowed us to have a deeper conversation with some parts of our community that experience health disparities.

- ✓ **Hispanic/Latino Women**
- ✓ **African American Women (Pregnant/Childbearing)**
- ✓ **Vulnerable Neighborhood**
- ✓ **Low-income/ALICE Seniors**

Discussions with each group focused on learning about their health priorities and underlying reasons, understanding the relationship of health literacy to personal health management from their perspective, and identifying unique cultural beliefs or behaviors that affect health outcomes and health equity. See Appendix 1 for detailed responses. Focus group support partners are provided in Appendix 8.

The vulnerable neighborhood selected was in the city of Frederick, census tract 7505.03.

Census Tract Profile: 7505.03
Description: north side of West Patrick Street to Shookstown Road
Population: 7,446
Race/Ethnicity: 30% Black, 7% Asian, 31% Hispanic
Per Capita Income: $24,771
Live in Poverty: 1 in 5 children, 1 in 4 seniors
Housing: 62% renters
Birthplace: 36% outside US

Key Takeaways:

- Even with the available resources, many members of community struggle to meet their basic needs.
- Lack of a centralized place to learn about and access available services prevents many residents from utilizing these services.
- Many residents feel information is not user friendly or communicated effectively to them.
- Many residents have felt discriminated against while accessing or receiving services and feel that their doctor does not listen to them.

Hispanic or Latinx Women

Hispanic or Latinx women face a variety of issues including prejudice, a language barrier, and interpreters that may not communicate everything. This leads many to avoid professionals and organizations that offer assistance.

"Maybe you need to go to the hospital or see a doctor and if you cannot communicate well, you're kind of given the cold shoulder. So, those are fears that sometimes keep you from going to the doctor."

African American Mothers

Many African American mothers feel a lack of representation among healthcare providers and are wary about opening their home to certain services.

"There is not one single midwife of any color in Frederick County. A lot more women would be more confident with more options."

Census Tract 7505.03

Those in this section of Frederick County often reported struggling to find providers who accepted their insurance and would often go without care.

"Frederick has a lot of doctors. The amount of doctors is plentiful. My son and I, right now, are on Maryland Medicaid and I'm having a really hard time finding doctors who accept whatever we have. That's a real challenge that makes it very limited."

ALICE Seniors

Low-income seniors are often faced with aging in place, which can make it difficult to perform daily tasks and get transportation.

"Some of them are not able to keep their apartments clean as they need to because they aren't able to do it physically. The woman next door is on oxygen 24/7. She can't get her garbage down to the garbage room, or get herself down to the laundry room, without taking this oxygen tank down and back."

The four focus groups identified the following health service needs and obstacles:

2016	2018	2021
✓Transportation ✓Health insurance cost ✓Awareness of services at Health Department	✓Affordable housing ✓Provider communications: relatability, language ✓Transportation ✓Awareness of community services and resources ✓Getting a provider appointment when needed	• Mental Health • Dental • Access to Healthy Food • Affordable housing • Transportation • Communication/awareness

Red text identifies new issue compared to prior cycle.

The key issues identified in the last couple cycles of focus groups are provided for comparison. The text in red showed that it was something new that had not been identified in the previous cycle.

The black text in the 2021 box above shows that transportation, affordable housing, and awareness of services keeps coming up. These same issues have recurred in the previous three cycles, which may mean that we have not yet made changes in our community to impact these issues.

One final takeaway from the focus group to stress is that the participants expressed the need to have their own voice heard more, and specifically in designing services.

Prioritization of Health Issues

Secondary data on Frederick County was collected for 45 health indicators to gain perspective on the health issues with the greatest adverse impact on Frederick County residents. A modified prioritization matrix was used to evaluate and rank the data. The criteria and scoring allowed for the qualitative survey data to be factored into the weighting of the quantitative secondary data.

		Scoring		
Criteria	**Definition**	**Low**	**Medium**	**High**
1. Size	Percent of population with health problem	1: 0-10% of population	2: 10-20% of population	3: >20% of population
2. Severity	Seriousness of health problem based on morbidity rates, mortality rates, economic loss, and the degree to which there is an urgency for intervention	1: Less severe, causes discomfort or acute illness, intervention not urgent	2: Moderately severe, causes disability or chronic illness, intervention strongly recommended	3: Very severe, causes death or significant disability, intervention urgent; in top 10 leading cause of death
3. Trend	Has the problem improved, worsened, or not changed in recent years?	-1: Trend is improving	0: Trend is staying the same	+1: Trend is getting worse
4. Impact on others	Does this issue impact the health outcomes and/or is a driver for other conditions?	1: Little impact on health outcomes or other conditions	2: Some impact on health outcomes or other conditions	3: Great impact on health outcomes or other conditions
5. Variance vs benchmarks	How do local rates compare to HP2030?	-1: Local rates are better than the benchmark	Local rates are the same as the benchmark or no benchmark available	+1: Local rates are worse than the benchmark
6. Community Perception	Has this issue been identified by more than 20% of survey respondents (question 4)	+1 for issues identified by 5-9% of community	+2 for issues identified by 10-19% of community	+3 for issues identified by 20+% community
7. Disparity	Are some populations disproportionately burdened?			+3 if disparity is known
8. SIHIS Goal *NEW*	Health conditions identified in the Statewide Integrated Health Improvement Strategy (SIHIS)			+3 if included in SIHIS goal or focus area

Health indicators were be scored in each category, totaled, and ranked by score.

See Appendix 5 for the detailed health indictor scoring for all health topics using the Prioritization Matrix.

As in the previous cycle, the plan was to take the top ten ranked topics from the prioritization matrix. Due to ties in ranking scores, eleven health topics were identified.

Health Indicators	Score	Rank
No Physical Activity (Adults & Adolescents)	17	1
Obesity (adults & adolescents)	17	2
Hypertension	14	3
Binge Drinking	13	4
Early Prenatal Care (did not get)	12	5
Tobacco Use (Current adult Smoker & Current Cigarette use adolescents)	12	6
Adverse Childhood Experiences (ACEs in adolescents) (1+)	11	7
Breast Cancer (incidence)	11	8
Diabetes	11	9
Mental Health (8-30 days not good/month)	11	10
Overdose deaths	11	11

Fact sheets were created for each of the top eleven health topics and are provided on the following pages.

No Physical Activity in Frederick County

QUICK FACTS:

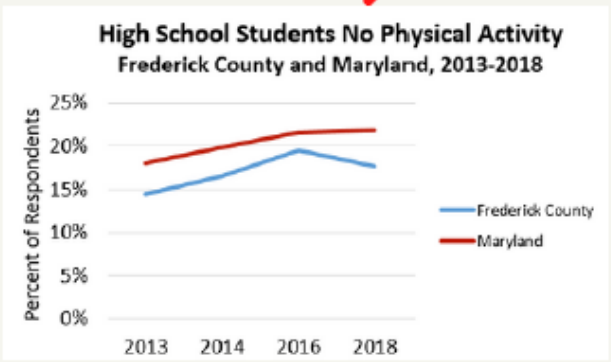
- Lack of physical activity has clearly been shown to be a risk factor for cardiovascular disease and other conditions

HOW MANY PEOPLE DOES THIS AFFECT?

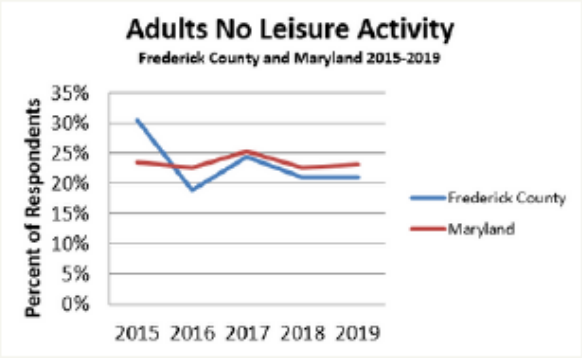
46,960 people reported no physical activity (21.0% of adults in 2019 & 17.6% of high school students in 2018.)

TRENDS

Worse for teens



Steady for adults



COMMUNITY PERCEPTION

Concern: lack of exercise

SIHIS GOAL

Risk factor for Diabetes

SEVERITY

Can contribute to chronic illness

DISPARITY

Higher for Black and Hispanic female adolescents

IMPACT

Increases risk of heart disease, some cancers

Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey
Frederick County, MD 2022 Community Health Needs Assessment

Obesity in Frederick County

QUICK FACTS:

- Diet and body weight are related to health status.
- Individuals who are not at a healthy weight are more likely to:
  - Develop chronic disease risk factors, such as high blood pressure or chronic diseases, such as type 2 diabetes, heart disease, osteoarthritis, and some cancers.

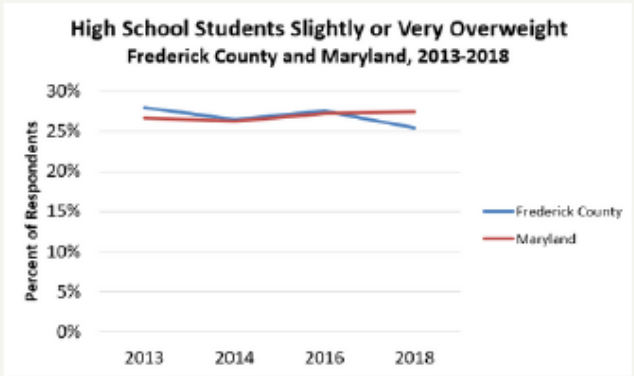
HOW MANY PEOPLE DOES THIS AFFECT?

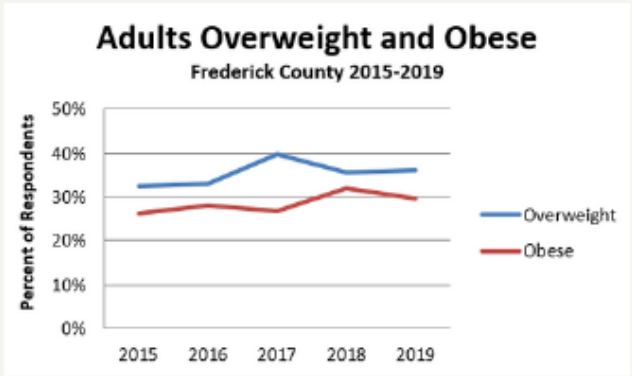
66,085 people were obese (29.5% of adults in 2019 & 25.4% of high school students in 2018.)

TREND

Decreasing for teens.

Slightly worsening for adults





COMMUNITY PERCEPTION

Concern: lack of exercise, poor eating habits

SIHIS GOAL

Risk factor for Diabetes

SEVERITY

Intervention strongly recommended

DISPARITY

Higher for White and Hispanic female adolescents

IMPACT

Increases risk of heart disease, some cancers

Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey
Frederick County, MD 2022 Community Health Needs Assessment

Hypertension in Frederick County

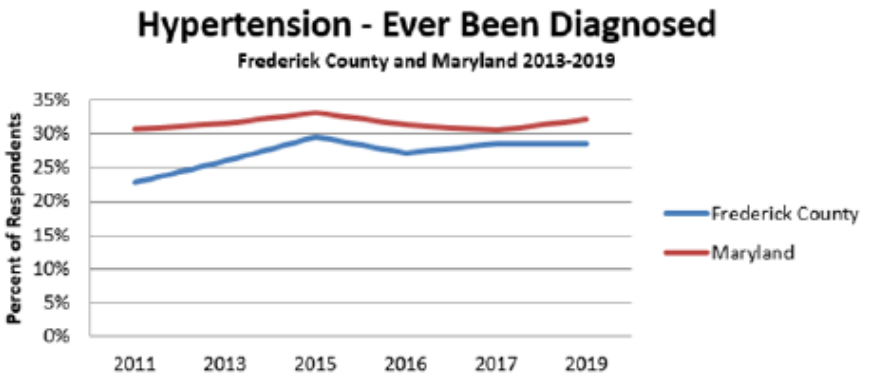
QUICK FACTS:

- High blood pressure is a common and dangerous condition. Having high blood pressure means the pressure of the blood in your blood vessels is higher than it should be.
- Hypertension increases the risk of heart disease, stroke, dementia, and kidney problems

HOW MANY PEOPLE DOES THIS AFFECT?

59,551 adults have hypertension or 28.5% in 2019.

TREND: WORSENING



COMMUNITY PERCEPTION

Not ranked

SIHIS GOAL

Timely Follow-Up after Acute Exacerbations of Chronic Conditions

SEVERITY

Intervention urgent; leading cause of death

DISPARITY

No Frederick County data available.

IMPACT

Increases risk of stroke, dementia, kidney problems, heart disease

Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS)
Frederick County, MD 2022 Community Health Needs Assessment

Binge Drinking in Frederick County

QUICK FACTS:

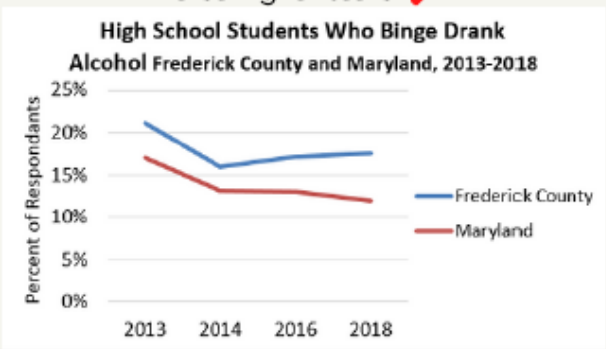
- Binge drinking is when men consume 5 or more drinks or women consume 4 or more drinks in about 2 hours.
- Binge drinking can lead to unintentional injuries such as car crashes or falls, as well as increased risk for many health problems.

HOW MANY PEOPLE DOES THIS AFFECT?

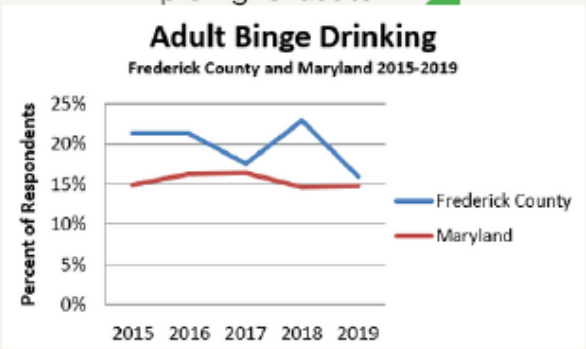
36,303 people binge drink (15.9% of adults in 2019 & 17.6% of high school students in 2018.)

TREND

Worsening for teens



Improving for adults



COMMUNITY PERCEPTION

Concern: alcohol misuse or abuse

SIHIS GOAL

No alignment

SEVERITY

Can contribute to chronic illness

DISPARITY

Higher for white female adolescents

IMPACT

Risk of liver disease, heart damage, some cancer

Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey
Frederick County, MD 2022 Community Health Needs Assessment

Early Prenatal Care in Frederick County

QUICK FACTS:

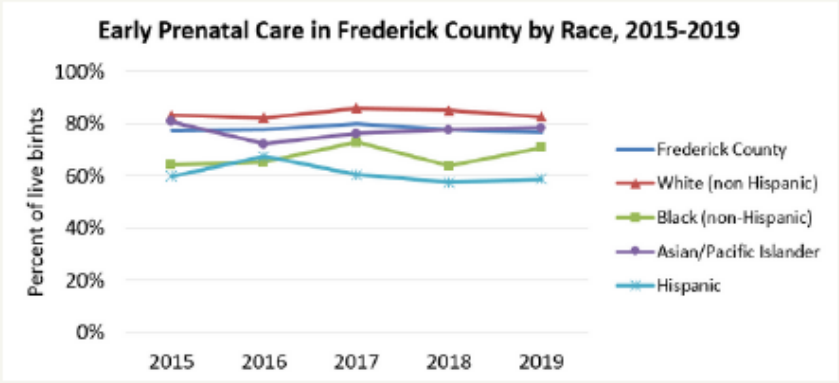
- Early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential.

HOW MANY PEOPLE DOES THIS AFFECT?

681 people who gave birth in 2019 (23.2%) did not have early prenatal care (within the first trimester).

TREND

Overall steady



COMMUNITY PERCEPTION

Not ranked

SIHIS GOAL

Maternal and Child Health Total Population Goal

SEVERITY

Lost opportunity for early intervention

DISPARITY

Worse in Hispanic and Black communities

IMPACT

Early screening reduces pregnancy complications

Source: Maryland 2019 Vital Statistics Report
Frederick County, MD 2022 Community Health Needs Assessment

Tobacco Use in Frederick County

QUICK FACTS:

- Smoking leads to disease and disability and harms nearly every organ of the body.
- Secondhand smoke can be dangerous for people around smokers.
- On average, smokers die 10 years earlier than nonsmokers.

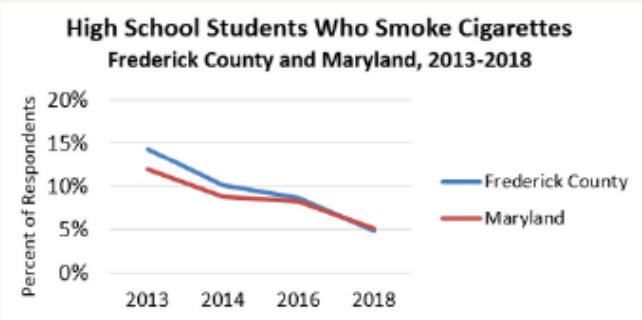
HOW MANY PEOPLE DOES THIS AFFECT?

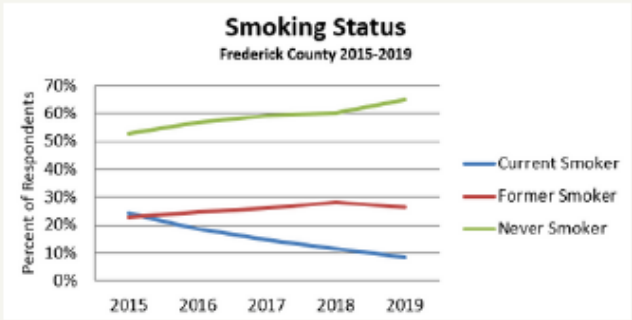
18,810 people currently smoke cigarettes (8.6% of adults in 2019 & 4.8% of high school students in 2018.)

TREND

Improving for teens

Improving for adults





COMMUNITY PERCEPTION

Concern: tobacco use

SIHIS GOAL

No alignment

SEVERITY

Can contribute to chronic illness

DISPARITY

Higher for Hispanic adolescents

IMPACT

Increases risk of cerebrovascular disease and some cancers

Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey
Frederick County, MD 2022 Community Health Needs Assessment

ACEs in Frederick County

QUICK FACTS:

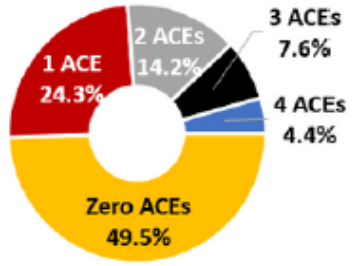
- Adverse Childhood Experiences (ACEs) are childhood exposures to physical, emotional, or sexual abuse, neglect, and other stressors.
- These include experiencing or witnessing violence, abuse or neglect, household substance misuse or mental health problems, or instability at home.
- ACEs are linked to chronic health problems, early death, mental health problems, and substance use in adulthood
- The more ACEs students are exposed to, the more likely they are engaged in certain risk behaviors.

HOW MANY PEOPLE DOES THIS AFFECT?

8,838 high school students (50.5%) reported having at least one ACE in 2018.

TREND

Not enough data yet for trend.



COMMUNITY PERCEPTION

Concern: child abuse or neglect

SIHIS GOAL

No alignment

SEVERITY

Can cause chronic, generational issues

DISPARITY

Household drug use and mental illness higher for females and Hispanic children. Household incarceration higher for Black and Hispanic children.

IMPACT

Chronic disease, early death, mental health problems, and substance use in adulthood

Source: Maryland Youth Risk Behavior Survey
Frederick County, MD 2022 Community Health Needs Assessment

Breast Cancer in Frederick County

QUICK FACTS:

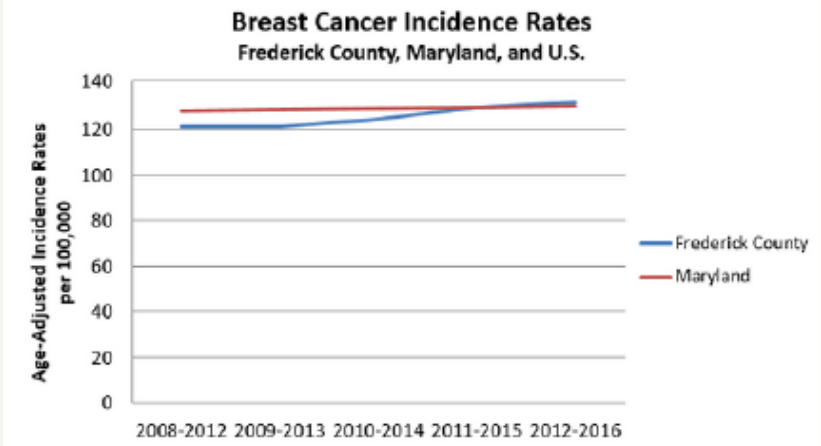
- Complex and interrelated factors contribute to the risk of developing cancers.
- Breast cancer risk can be reduced by early screening.
- Cancer continues to be the second leading cause of death in Frederick County.

HOW MANY PEOPLE DOES THIS AFFECT?

329 Frederick County women were diagnosed with breast cancer in 2019

TREND

Worsening, especially for blacks



COMMUNITY PERCEPTION

Not ranked

SIHIS GOAL

No alignment

SEVERITY

Intervention urgent; leading cause of death

DISPARITY

Higher for Black community

IMPACT

Higher risk of other cancers

Source: Maryland Cancer Data Report
Frederick County, MD 2022 Community Health Needs Assessment

Diabetes in Frederick County

QUICK FACTS:

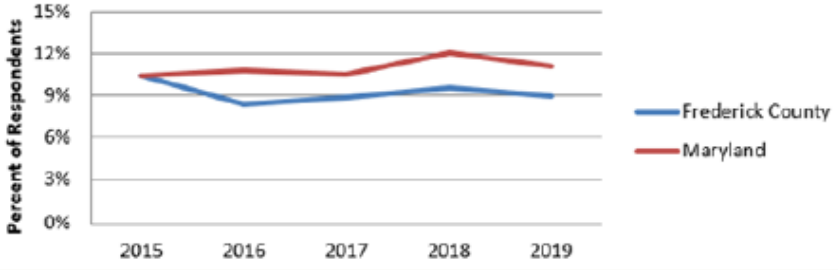
- Diabetes is a chronic (long-lasting) health condition that affects how your body turns food into energy.
- Diabetes can cause problems in the eyes, kidneys, feet, and nerves.
- Diabetes is a leading cause of death in Frederick County.

HOW MANY PEOPLE DOES THIS AFFECT?

18,806 adults have diabetes or 9.0% in 2019.

TREND

Incidence is steady, but mortality is increasing



COMMUNITY PERCEPTION

Not ranked

SIHIS GOAL

Diabetes Total Population Goal

SEVERITY

Leading cause of death, chronic condition, can cause disability

DISPARITY

No Frederick County data available.

IMPACT

Causes problems in eyes, kidneys, feet, nerves

Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS)
Frederick County, MD 2022 Community Health Needs Assessment

Mental Health in Frederick County

QUICK FACTS:

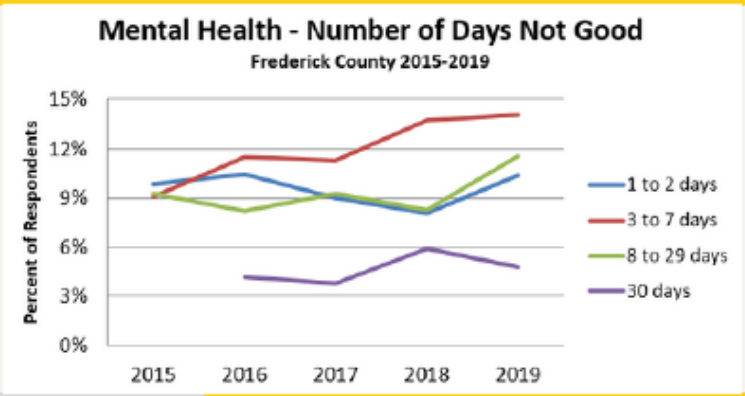
- Mental health is an important part of overall health and well-being and includes our emotional, psychological, and social well-being. It helps determine how we handle stress, relate to others, and make healthy choices and is important at every stage of life, from childhood and adolescence through adulthood.

HOW MANY PEOPLE DOES THIS AFFECT?

34,268 adults (16.4%) reported that they had more than 8 days of not good mental health a month in 2019.

TREND

Increasing for 8-29 days



COMMUNITY PERCEPTION

Concern: Mental health services difficult to get

SIHIS GOAL

No alignment

SEVERITY

Can contribute to chronic illness

DISPARITY

No Frederick County data available.

IMPACT

Linked to higher unemployment, poverty, disability

Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS)
Frederick County, MD 2022 Community Health Needs Assessment

Overdose Deaths in Frederick County

QUICK FACTS:

- Drug and alcohol related deaths include any death that was the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, fentanyl, alcohol, cocaine, prescription opioids, etc.

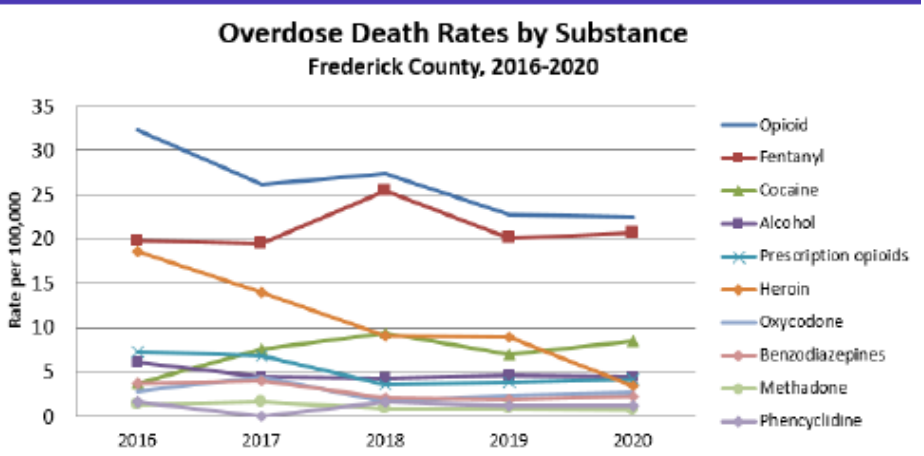
HOW MANY PEOPLE DOES THIS AFFECT?

78 adults died from an unintentional overdose in 2020.

TREND

Decreasing for opioid, heroin

Increasing or fentanyl, cocaine



COMMUNITY PERCEPTION

Concern: drug misuse or abuse

SIHIS GOAL

Opioids Use Total Population Goal

SEVERITY

Intervention urgent; leading cause of death

DISPARITY

No Frederick County data available.

IMPACT

Outcome is death.

Source: Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland Annual Report
Frederick County, MD 2022 Community Health Needs Assessment

Readiness Assessment: From 11 to 5

Subject Matter Experts from the Frederick community were recruited for each of these top eleven health topics. These experts prepared brief presentations that provided the background story for their topic, highlights from the fact sheets, possible actions, and community resources.

The Frederick County Health Care Coalition Board members reviewed the SME presentations, Prioritization Matrix, and fact sheets and scored each topic based on the following questions in the Readiness Assessment Worksheet.

Readiness Assessment Worksheet

1. What stage is our community at in addressing this problem?
   1=information gathering 2= awareness/education 3=advocacy and/or intervention

2. Do we have tangible resources/assets in our community available to address this problem?
   1=No/I don't think so 2=Some/Maybe 3=Yes/A Lot

   Comments/explain:

3. Are there existing efforts working to address this problem that are open to collaboration?
   1=No/I don't think so 2=Some/Maybe 3=Yes/A Lot

   Comments/explain:

4. What role could the Coalition play in addressing this problem?
   1=increasing awareness & data gathering 2=incubating community efforts 3=Establishing LHIP Workgroup or maintaining existing LHIP Workgroup

5. Can we see measurable results/change within 3 years?
   1=No/I don't think so 2=Some/Maybe 3=Yes/A Lot

6. Could working on this problem support other identified problems?
   1=No/I don't think so 2=Some/Maybe 3=Yes/A Lot

As a result of the Readiness Assessment, the following five topics were identified by the Coalition:

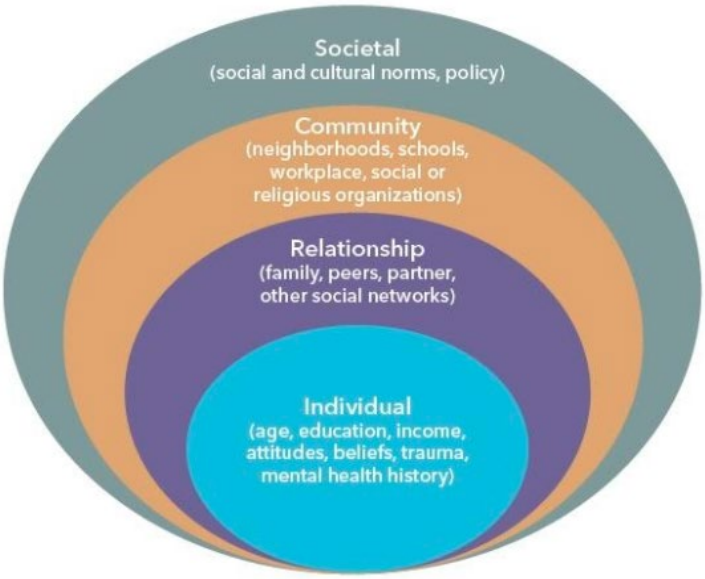
Diabetes
Adverse Childhood Experiences in Adolescents
Early Prenatal Care
Obesity in Adolescents and Adults
Mental Health

See Appendix 6 for Readiness Assessment detailed results.

Public Input Process

A Public Input Process event was held on January 19, 2022. This virtual event was open to the community, and over 140 individuals representing 69 different community organizations (see Appendix 8 for detailed list). Subject Matter Experts were invited again to give a brief presentation on their topic, this time for community members. Attendees chose a topic of interest from one of the five topics and joined small breakout groups for discussion.

Trained facilitators lead each group discussion through a series of questions focused around the Social-Ecological Model. This model considers the complex interplay between individual, relationship, community, and societal factors. This approach is more likely to sustain prevention efforts over time and achieve population-level impact.



Building community health includes access to healthcare services. But it also needs to include the building blocks for healthy individuals, families and friends, community, and society. Each question addresses one of these building blocks.

QUESTION 1: What actions could we take that would help **INDIVIDUALS** make the biggest improvement to [Health Topic]? Which action should be addressed first?

QUESTION 2: What action could we take that would help **FAMILIES/NEIGHBORS** make the biggest improvement to [Health Topic]? Which action should be addressed first?

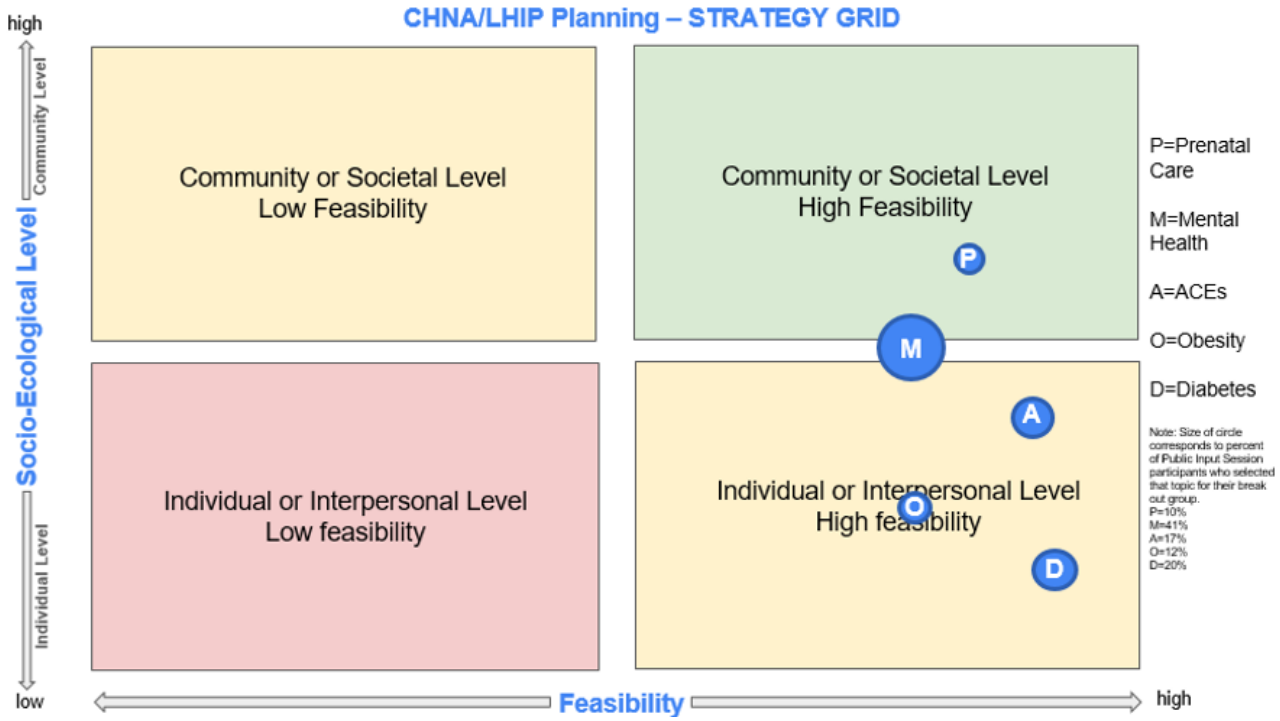
QUESTION 3: What action could we take that would help **COMMUNITIES** make the biggest improvement to [Health Topic]? Which action should be addressed first?

QUESTION 4: What action could we take that would help the **COUNTY/STATE/COUNTRY** make the biggest improvement to [Health Topic]? This could be a policy change or a social norm change.

QUESTION 5: Review your small group's responses to the four questions above with the group. Then, prompt the group to select the **one response of the four that should be addressed first** and record it below. If your group is unable to narrow down the actions to just one, please just document the feedback below.

Results from the Readiness Assessment and the Public Input Process were synthesized in a strategy grid designed to integrate the two datasets for each of the five health topics.

- X Axis: the results of the Readiness Assessment conducted by the Health Care Coalition were used to find where each of the five health topics landed on the X axis of feasibility.
- Y Axis: the answers each group gave to question 5, the one response they felt should be addressed first, was identified and evaluated to determine if the response was on the individual/interpersonal side of the socio-ecological scale, or on the community/society side. These results were tallied and the percent of responses in the community/societal side was calculated for each of the five topics. This number was plotted on the Y axis for each of the health topics.
- Circle size: the number of Public Input Process attendees who chose each topic in a breakout group was noted in the size of the circle representing each topic.



On February 2, 2022, the Frederick County Health Care Coalition reviewed the Strategy Grid and voted to determine the three topics that would become priorities for the next three years:

- ACEs
- Diabetes
- Mental Health

Community Resources

The following table inventories community resources that may be employed to address the top five health issues and the 2022 CHNA health improvement priorities.

Priority Area	Community Resources
Adverse Childhood Experiences (ACEs)	• ACEs work group • Interagency Early Childhood Committee • Multiple system collaborations • Service Providers
Diabetes	• Frederick Health Diabetes Partnership • Frederick Health – The Care Clinic (CDSMP/DSMP, nutrition services) • Diabetes Subcommittee of the Chronic Health LHIP Workgroup • University of Maryland Extension of Frederick County (Dining with Diabetes) • YMCA of Frederick County • Frederick County Health Department Diabetes Prevention Program (DPP) • Frederick County Senior Services Division • Asian American Center of Frederick (CHWs, DPP coach) • BeHealthyMaryland.org (MDH)
Mental Health	• Network of mental health providers, outpatient to residential across age groups • Partnerships between schools, courts, hospitals, healthcare providers and mental health systems • Center for Mind-Body Therapies • Mental Health Association of Frederick County • National Alliance on Mental Illness • Austin Addiction & Mental Health • Lead4Life, Psychiatric Rehabilitation Program • Advanced Behavioral Health • 24/7 call center • Suicide awareness, alertness, and intervention trainers providing evidence-based trainings • Mental Health Association walk-in program and mobile crisis teams • AFSP Suicide Awareness Walk • Survivor of Suicide Loss group • Frederick Hospital acute care services (emergency, behavioral health unit, partial hospitalization program) • Training for law enforcement • Existing crisis services collaborations • Community Crisis Services (CCSI), Hotline 2-1-1 Call Center • Safe Journey House
Prenatal Care	• Special Delivery Nurse Home Visiting • Healthy Families Frederick • Frederick County Infants & Toddlers Program • Frederick County Family Partnership • Community Health Workers • WIC Program • The Judy Center • Safe Kids Coalition • Head Start Advisory Board • Fetal Infant Mortality Review Committee • Substance Exposed Newborns Program • Care Net Pregnancy Center of Frederick
Obesity	• Girls on the Run • Livewell Frederick: 5-2-1-0 Program • Frederick County Public Schools nutrition and physical activity policies

Progress from 2019 CHNA Cycle

An important aspect of any planning cycle is evaluating the impact of actions completed during the prior planning cycle. This review can offer insight for future cycles, as well as practical takeaways on how to improve the planning process. A summary of key achievements of the 2016 cycle work groups are below[2]:

Adverse Childhood Experiences (ACEs)

The Frederick County ACEs & Infant Workgroup developed a logic model to guide its planning. This logic model identified seven outcomes – six of which were the primary organizing principles for the Workgroup's activities over the last 3 years:

- Adopt a shared language and understanding
- Change in practice and behavior
- Increase in financial support for child and family services
- Increase in evidence-based trauma-informed practices
- Increase in screening for ACEs
- Increase in trauma competent practitioners of somatic and behavioral health
- Increase skills and services that help children and families develop resiliency
- Increase workforce skills and opportunities for families *(not addressed)*

Adopt Shared Language & Understanding

The Workgroup hosted multiple trainings for health and social service providers and community groups on research-informed and tested communication strategies to engage the public in children's wellbeing, as well as training hundreds of community leaders utilizing the Brain Architecture Game.

- As a result, stakeholders have updated and revised their public communications.
- Workgroup is developing a shared communication campaign identity for public education on the science underlying resiliency and the impact of toxic stress – Strong Families.

Change in Practice and Behavior

The Workgroup identified two important steps to changing the experience of families and the capacity of health and social providers to meet families' needs -- combatting implicit bias and integrating behavioral and pediatric primary care.

- The Workgroup hosted trainings that helped to support strong agency commitments to the FCHD Maternal Child Health Collaborative which was focused on a project to improve outcomes for African American pregnant and parenting people and led to expanded diversity, equity and inclusion trainings at many social service providers.
- One private pediatric practice now has an integration model in place.

[2] See http://health.frederickcountymd.gov/LHIP for work group progress reports for the 2016 CHNA.

Increase in Funding for Child and Family Services

We Design – two community-wide events to improve outcomes for children – featuring the Harvard Center on the Developing Child in collaboration between the Workgroup and the Interagency Early Childhood Committee shifted understanding among local decision makers of the opportunity to prevent toxic stress and build resiliency in children.

- Frederick County Public Schools expanded its behavioral health resources for students across a variety of roles by about 20 positions.
- Frederick County Citizen Services funded the ACEs Liaison position – staff to the Workgroup for 20 months and provided three years of flexible direct funding for ACEs-related initiatives.
- YMCA Head Start added one FTE mental health and disability specialist to supplement services.
- The Workgroup collaborated with local stakeholders to develop two requests for new projects under the County's American Rescue Plan Act funds– both focused on reducing the impact of toxic stress – universal newborn home visiting and a childcare market initiative. Frederick Health will receive $8 million over four years to implement the universal newborn home visiting.

Increase in Evidence-based Trauma-informed Practices

Through its survey of mental health providers and research on effective models, the Workgroup was effective at helping its partners increase trauma-informed practices in a variety of settings.

- Frederick County first responders sent over 1000 Handle With Care notices to public school personnel and the Child Advocacy Center of Frederick County on behalf of children present at traumatic incidents between January 2019 and September 30, 2021. Notices sent to public school personnel were utilized to observe students of stress responses and respond with needed resources.
- Trauma-informed yoga trainings and practice expanded in early childhood programs including the YMCA Head Start's 13 classrooms as well as through classroom teachers at 5 Title 1 elementary schools – pre-pandemic and during the pandemic.
- Family Partnership added an onsite trauma therapist for families.
- The Mental Health Association implemented EMDR – eye movement desensitization and reprocessing – with three clinicians trained.
- A collaborative training is being planned to increase local capacity in evidence-based models among mental health professionals.
- Trauma Responsive Frederick – a new coalition raising awareness on the importance of trauma-informed practices – is developing additional strategies specifically focused on adults.
- Zero to Three, Frederick County Department of Social Services and Safe Baby Court Team provided trainings for Child Parent Psychotherapy for local practitioners.

Increase in Screening for ACEs & Trauma Symptoms

The Workgroup developed a logic model specifically for screening for ACEs – as a way of building support for the unique role of pediatric primary care providers in supporting children and their families.

- The Workgroup researched and identified a recommended screening tool – PEARLs -- developed by the Center of Youth Wellness and the National Pediatric Practice Community on ACEs.
- The Workgroup hosted training on implementing screening for health and social service providers. Screening has been expanded in a number of settings.
- The Workgroup continues to share resources for pediatric providers to develop screening protocols.

Increase in Trauma-Competent Practitioners of Somatic and Behavioral Health

The Workgroup collaborated on surveys for mental health providers and health care providers in pediatrics, family practice and ob-gyn. Responses to these surveys have helped guide the Workgroup's activities. The Workgroup's trainings – which have included audiences from health care, education social service providers -- have been in the following areas:

- Brain development, impact of toxic stress, science underlying resiliency
- Implementing a screening protocol for ACEs
- Diversity and inclusion strategies to improve health outcomes among African American and Latina women; and
- Model for integration of behavioral and pediatric primary care
- Analysis of Frederick County Youth Risk Behavior Survey & ACEs questions

The accomplishments of the Workgroup stem from the tremendous collaboration among the 20+ local organizations, in particular the Child Advocacy Center of Frederick, Frederick County Office for Children and Families, Frederick County Public Schools, Frederick County Health Department, Frederick Health, Family Partnership, Frederick County Public Libraries, United Way of Frederick County, Frederick County Health Care Coalition, Frederick County Department of Social Services, Asian American Center of Frederick, YMCA Head Start, Boys and Girls Club of Frederick County, Housing Authority of the City of Frederick, Community Foundation of Frederick County, Zero to Three, Mental Health Association of Frederick County, Heartly House, Blessings in a Backpack, and Children of Incarcerated Parents Program -- that have regularly contributed talent and time to advance our understanding of the impact of toxic stress on children and families and how we can support children and their families to prevent trauma and increase resiliency.

Behavioral Health

The Suicide Prevention Subcommittee of the Behavioral Health Workgroup was formed with the aim of creating a suicide safer community in Frederick County. The objectives of the Subcommittee were to increase the availability of evidence-based suicide training, to train community leaders, and to increase awareness of suicide prevention starting with the faith community. In December 2019, the Subcommittee held its first in-person, SafeTALK training session focused on developing suicide alert helpers. This training was 3.5 hours in length with 27 participants. There were 15 community members placed on a waiting list once the class was filled, indicating strong community interest in becoming a suicide alert helper. Additional SafeTALK trainings were scheduled but were not implemented due to the lack of available meeting space due to the onset of the COVID19 pandemic and the subsequent safety protocols. Trainings using another suicide prevention program, ASIST, had also been planned but were cancelled for the same reasons. During the 2020-2021 school year, FCPS did provide the 3.5-hour SafeTALK training for its staff. Although this was not a specific goal for this subcommittee, it should be noted as a step forward for the community towards suicide prevention awareness and readiness. The Subcommittee's plans to train community Leaders and to host a suicide symposium for faith-based leaders were not realized due to insufficient funding and COVID19 limitations.

The Substance Use Disorder Subcommittee and the Mental Health Subcommittee were each still recruiting members and trying to determine their purpose and direction when the COVID19 pandemic hit in March 2020. At that point, these two Subcommittees disbanded due to insufficient recruitment of members and a lack of clear objectives needed to move forward.

Chronic Health

Colorectal Cancer

The overall goal of the Colorectal Cancer subcommittee was to increase the screening for minority communities and see an eventual decline of disease as early screening reduces incidence and mortality rates.

The subcommittee's objectives were to increase the number of people screened and treated for colorectal cancer, sustain the involvement of 3 medical providers at community events, and ensure that 100% of individuals screened received at least one outreach attempt.

Drs. Naderge Pierre, Dawei Yang, and Carmen Hernandez helped implement these objectives by providing education and sharing their perspectives on colorectal cancer at roundtable discussions, community outreach events, and employee presentations. Slide presentations, printed materials, and videotaped discussions were developed for use in outreach events, and Call-to-Action response cards were distributed in person and made available online. Our second Roundtable event reached an audience of community stakeholders in February 2020 and included an update from the FCHD. Multiple presentations were also made to church and community groups that served targeted populations. Education and screening was

made available to diverse communities through annual Frederick County Health Fairs and smaller fairs held by community groups. CRC Steering Committee members participated in a Maryland CRC symposium and a learning collaborative through the American Cancer Society to share evidence-based strategies for continued improvement to colorectal cancer screening in our community.

Information about screening for CRC included discussions about FIT Kits as an alternative for some individuals. At outreach events where participants received education, FIT Kits were made available at no cost. Through a partnership with Polymedco, medical providers were educated about the use of FIT Kits. Distribution through a primary care setting is being evaluated and has initially been met with a favorable response.

The CARE Clinic at Frederick Health has developed a workflow to continue screening patients for CRC and responding to requests from the community for screening and information. Providers at the CARE Clinic refer patients to partners agencies for medical follow up that can include free colonoscopies for uninsured and underinsured individuals. The CARE Clinic continues to distribute FIT Kits requested online or by telephone, and workflow includes follow up or outreach to encourage ongoing screenings at recommended intervals for the prevention of colorectal cancer.

Diabetes

In January 2021, the Diabetes Subcommittee of the Chronic Health Workgroup, or Diabetes Partnership, was created during the 2019-2022 LHIP cycle to address diabetes and prediabetes in Frederick County. The short-term goal is to increase participation and retention in local evidence-based lifestyle change programs for people with prediabetes or diabetes, especially for racial/ethnic minorities and those disproportionately impacted by prediabetes, diabetes, or obesity. The longer-term goal would be a decline in the rate of new diagnoses of type 2 diabetes and/or complications in the Frederick County population with prediabetes or diabetes.

The Diabetes Partnership is a collaborative group and includes representation from Frederick Health, Frederick County Health Department, and broad community representation that is continually expanding. Community partners include the Asian American Center of Frederick, YMCA of Frederick County, University of Maryland Extension, Frederick County Senior Services Division, City of Frederick Health & Human Services (including the Community Health Center), Fire & Rescue Mobile Community Healthcare Program, Chamber of Commerce, Hood College, Nigerian in Frederick, Fusion Lions Club, local healthcare providers, health coaches, and a local pharmacy.

The Partnership strategy includes assessment of the prediabetes/diabetes landscape, assessment of the current diabetes prevention and management programs available, and identification of barriers to enrollment and retention. The initial assessments are followed by efforts to increase the number of lifestyle change program providers and the development of recruitment and implementation strategies to scale up local offerings of Diabetes Prevention Program (DPP) and diabetes self-management training (DSMT) services.

Frederick Health's participation in the Western Regional Diabetes Catalyst Partnership has provided critical funding and leadership needed to scale up the diabetes initiative in the county. A planning Summit convened in June 2021 and brought together community members and partners to learn more about the goals of the initiative and to strategize how to increase and promote the expanded offerings and to raise awareness and referrals in the community. Health Management Associates (HMA) performed the local diabetes landscape assessments. HMA reported on local prediabetes/diabetes hotspots, disparities, and high risk populations. Geographic hotspots include the following zip codes: 21701, 21702, 21703, 21758, and 21716. Data showed disparities among the African American and Hispanic populations, North County residents, and senior citizens. HMA conducted interviews with many community partners to identify the current providers of diabetes prevention and management programs, and related resources. They identified recognized National DPP programs offered by the Frederick County Health Department, YMCA of Frederick County, and the Asian American Center of Frederick. In addition, Frederick Health offers DSMP/DSMT and University of Maryland offers Dining with Diabetes. Findings revealed that the existing number of evidence-based lifestyle change programs and coaches is inadequate to address the needs in the county. Brainstorming activities by participants identified possible barriers and solutions for connecting with the prediabetes/diabetes community in Frederick. Brainstormed barriers included lack of awareness among providers in the county about DPP and DSMT programs leading to fewer referrals, lack of access to transportation to get to in-person DPP and DSMT classes, difficulties engaging racial and ethnic minority communities, especially monolingual Spanish-speaking communities given the lack of Spanish-speaking DPP and DSMT providers, and the cost of DPP and DSMT programs even with insurance. With these barriers, the community partners emphasized the need to build workforce capacity of community health workers, especially those from racial and ethnic minority communities, to help engage these communities and facilitate successful linkage of people with prediabetes and diabetes to DPP and DSMT programs. To address lack of awareness and referrals, community partners recommended expanding the sources of DPP referrals to include social service organizations, grocery stores, schools, and other community institutions to boost program awareness. For DSMT, community partners recommended incorporating pharmacists and endocrinologists as referral points, helping to spread awareness among providers and patients about the program. Finally, community partners recommended increased virtual DPP and DSMT program given current billing flexibilities because of the Public Health Emergency, helping to address transportation barriers.

In August 2022, Frederick Health became a recognized National DPP provider. Recruitment and training of DPP coaches began in October 2021 and is ongoing, including for Spanish language classes. There are 10 new, certified DPP coaches. The first three DPP cohorts (or classes) kicked off in January 2022. An integrated referral system is in development utilizing the internal Frederick Health Expanse system, the Shared Village system used by CHWs and CBOs, and specialized CRISP alerts for primary care providers to flag high risk patients. A link to the prediabetes risk test (www.frederickhealth.org/stopdiabetes) is now available, with its QR code, to provide a potential entry point for recruitment into the Diabetes Partnership's DPP programs for community members, community providers, community-based organizations, community health workers (CHWs), and self-referrals. DPP programs will remain free for participants during 2022. A billing system is under development with third party payers to address long-term program sustainability.

Community Health Workers, a key human resource for identifying and recruiting community members for lifestyle change programs and providing other social supports, are employed by Frederick Health and the Asian American Center of Frederick. In September 2021, and Educational Forum was held to provide 24 CHWs with an overview of the Diabetes Partnership goals and the important role they play in the workflow for community outreach, recruitment, and referrals. Training on Motivational Interviewing was provided by HMA to enhance CHWs' communications skills. The CHWs especially enjoyed this training on motivational interviewing because it gave them skills to address and support patient's hesitancy with DPP and DSMT—a common barrier they encounter. They also appreciated the training on the mechanisms and process for referring individuals to DPP and DSMT programs. In small breakout groups, CHWs were able to connect with one another and discuss some of the challenges they experience trying to engage individuals in DPP and DSMT programming. CHWs found this helpful because they were able to share resources, problem-solve together, and identify opportunities for future collaboration and networking.

The Diabetes Partnership team participates in local community events for outreach and promotion of the DPP program. In October 2021, team members at the Community Health Fair provided free A1c screenings; 94 prediabetes risk tests were completed with 32 people scoring in the "at risk" range who were provided with DPP program referrals and other resources. In April 2022, a community "5K on the Runway" is planned and will be held at the local airport.

Youth Obesity

Objective 1. Increase community knowledge of healthy eating/living habits by hosting four 5-2-1-0 outreach/education events targeting middle school age children and their parents by June 30, 2020.

- The committee strengthened partnerships with agencies serving teens and provided in-person and virtual health education presentations to increase knowledge of healthy/eating living habits. Teen mentors in the Asian American RSVP program, youth in the YMCA-Summer Serve Program, Frederick County Public Libraries' Teen Board and youth in Frederick County Workforce Services Summer Youth Employment Program participated. Approximately 100 teens participated in these presentations. Post presentation evaluations showed that some teens intended to reduce their consumption of sugary sweetened beverages. Encouraging teens to use their creativity and voice to reach their peers with this important health message, the Frederick YMCA teens created videos with the focus on healthier beverage choices. These videos are posted on the YMCA and Livewell Frederick websites. The committee partnered with Livewell Frederick to create easy to use toolkits to implement 5-2-1-0 concepts in the home and school. These free toolkits for families, teachers, and coaches are found in the Resource Section on the Livewell Frederick website.

Objective 2. School Wellness Goals – Maintain and support the % of FCPS middle schools that have wellness goals related to healthy eating/living habits at or above 75% by June 30, 2021.

- Frederick Health and the 5-2-1-0 program provided funding 12/21 -6/22 to FCPS School Health Council to support nutrition and physical fitness wellness goals.
- Six schools applied for and received funding to implement wellness goals supporting physical fitness and nutrition education.
- FCPS school and nutrition services conducted a comprehensive evaluation of the FCPS wellness goals.

Objective 3. Increase community healthy eating/living habits by hosting a 5-2-1-0 challenge by June 30, 2022.

- The committee works with Livewell Frederick and provided the following community challenges: Two Walk Across America Challenges, Healthy Habits Reset Challenge, Summer You Choose Challenge , and the ReThink Your Carbs Challenge participants shared tips and quotes on healthy eating/living for posting on the Livewell Frederick social media sites.

Other Community Assessments

Other recent community assessments were reviewed for consideration in the CHNA. Findings and issues emphasized in these assessments are similar to concerns expressed by the public in the CHNA process. These assessments may be useful for the health priority work groups as they identify target populations and design implementation strategies. In addition, the CHNA and these assessments strongly suggest community collaboration on social determinants of health and allocation of resources to fund initiatives to address improvement opportunities.

ALICE in Frederick County: A Financial Hardship Study, 2020 Frederick County, Maryland Report

The ALICE Report for Frederick County presents the latest ALICE data available – a point-in-time snapshot of economic conditions across the county in 2018. By showing how many Frederick County households were struggling then, the ALICE Research provides the backstory for why the COVID-19 crisis is having such a devastating economic impact. The availability of the ALICE data is especially important now as a resource for stakeholders to identify the most vulnerable in their communities and direct programming and resources to assist them throughout the pandemic and the recovery that follows. As Frederick County moves forward, this data can be used to estimate the impact of the crisis over time, providing an important baseline for changes to come.

The report presents the cost of basic needs in the Household Survival Budget for Frederick County as well as the number of households earning below this amount – the ALICE Threshold – and focuses on how households have fared from 2010 (when the Great Recession ended) to 2018. With these indicators, the Report shows that although the cost of living is higher in Frederick County than other places in the state, wages are also slightly higher. As a result, in 2018, 31 percent of households were ALICE and another 6 percent were living in poverty, totaling 37 percent with income below the ALICE Threshold, slightly less than the state average of 39 percent. The report also breaks down ALICE demographics by age, race/ethnicity, household type, town, zip codes, revealing several interesting trends in Frederick County. This research provides a unique set of data for community stakeholders to use to drive effective policy and strategic planning.

ALICE households often live-in areas with limited community resources, making it even more difficulty to makes ends meet. The lack of some resources has immediate and direct costs. For example, without public transportation or nearby publicly funded preschools, ALICE families pay more for transportation and childcare. Other costs, such as the consequences of limited access to health care providers, open space, or libraries, accumulate over time.

https://www.unitedwayfrederick.org/challenge-alice

COVID-19 Impact Survey, 2021 Frederick County, Maryland, Results Report

From March 15 to April 12, 2021, people living in Maryland were invited to take a survey about how their household has been impacted by the COVID-19 pandemic since March 1, 2020. This Report includes data for the respondents from Frederick County. United Way of Maryland managed the implementation of the survey throughout the state. United Way of Frederick County led the local survey distribution effort, in partnership with United For ALICE, a center of innovation, research, and action around financial hardship. Local participants were recruited through media outreach. As such, this survey relied on convenience sampling and those surveyed are not a representative sample of the county population. However, the survey results do provide some important insights into the issues facing households in Frederick County during this time of COVID19 pandemic.

Respondents were asked to identify their household's biggest concern during the COVID-19 pandemic, their top three responses were: (1) Household members getting COVID-19 was listed as the biggest concern for 51% of respondents, (2) Mental health issues such as depression and/or anxiety for 13% of respondents, and (3) Childcare/education for 12% of respondents.

https://www.unitedwayfrederick.org/COVIDSurvey

Frederick County Office for Children and Families: 2018-2019 Data Collaborative State of the Populations Report

The Fredrick County Office for Children and Families (OCF) is a department within the Citizens Services Division of the Frederick County Government which seeks to create a more efficient and effective system of care for the children and families of through:

- Developing service, family, community, and financial partnerships;
- Designating goal-directed services that are client centered and family focused;
- Targeting resources to families with the greatest needs; and,
- Implementing a monitoring system to determine client and cost outcomes.

The OCF is home to the Frederick County Local Management Board (LMB) that serves as an advisory board in the management and oversight of the implementation of the Frederick County OCF and the creation of the results-based interagency service delivery system for children, youth, and families. The shared mission of the OCF and LMB is to enhance the quality of the life of children, youth and families in Frederick County, Maryland. This encompasses planning, implementing, monitoring, and evaluating a comprehensive, integrated human service delivery system for youth and families and building on their capacity to be self-sufficient, safe, and healthy.

As part of its efforts, the Frederick County OCF and LMB complete a Community Needs Assessment (CNA) every three years, with the most recent report finalized in 2016. The purpose of the CNA is to gather local

data regarding the current needs of children, youth, and families in the Frederick County, community strengths and areas for improvement, and available and needed programs, services, and resources.

In 2018, the County identified the need for an additional assessment – a comprehensive data collaborative report focused on estimating the size of the population in need within four Strategic Goal Areas based on the Governor's Office for Children Strategic Goals:

- Improve Outcomes for Disconnected Youth – Population is comprised of youth, aged 16 to 24, who are not working and are not going to school;
- Reduce the Impact of Parental Incarceration on Children, Families, and Communities – Population is comprised of families with a parent under some form of correctional supervision (parole, probation, jail, or prison);
- Reduce Homeless Youth – Population is comprised of homeless youth who are not in the physical custody of a parent or guardian and who are between the ages of 14 and 25; and,
- Reduce Childhood Hunger – Population is comprised of food insecure children.

The results of the data collaborative study, which used both quantitative and qualitative data analysis, indicate that Frederick County has a significant number of children and youth in each of the four categories who are not receiving the necessary services to address these needs.

https://www.frederickcountymd.gov/DocumentCenter/View/321765/Frederick-County-OCF---Data-Collaborative-Report?bidId=

Hood College Food Security Network Updated

The Frederick Food Security Network is a community garden program based out of the Hood College Center for Coastal and Watershed Studies. This program is establishing a network of community gardens in Frederick in order to improve food security for low-income residents of low-access areas, decrease local water pollution by diverting roof top runoff for use as irrigation, and to promote better eating habits in Frederick County. FFSN partners with many local community organizations to provide on-site education and assistance for developing and maintaining graders, as well as support for produce distribution to low-income Frederick residents. Local partners include Boys & Girls Club of Frederick County, Frederick News-Post, The Islamic Society of Frederick County, and the Religious Coalition for Emergency Human Needs. Hood College and Frederick Hospital joined forces in 2017 to turn an unused lost on Hood's campus into an urban garden. In 2018, they joined the FFSN that has since supported the Resources Garden with student workers, produce distribution assistance, and construction of additional beds and most recently, a greenhouse.

Although many distribution sites were unavailable during the pandemic, two partners, the Housing Authority of Frederick, and Frederick County Action Agency, were able to maintain the distribution rate throughout 2020. The impact of the COVID-19 pandemic has resulted in food insecurity associated with obesity, hypertension, heart disease, depression, cancer, and other chronic health problems. FFSN food recipients have reported that benefits of the program include a decrease in financial strain from food shopping as well as an increase in consumption of vegetables. The majority of recipients served report having one or more children in the household.
https://www.hood.edu/sites/default/files/Coastal%20Studies/FFSN/2020%20Annual%20Report%20(FFSN).pdf

The Liveable Frederick Master Plan: 2019 Frederick County

Livable Frederick, through the creation of the Livable Frederick Master Plan (LFMP), adopted on 09/03/2019, embodies a policy and general growth strategy to guide Frederick County's path forward in the face of future change. This comprehensive plan charts the idea, concepts, principles, goals, and procedures for setting a course of future action and for establishing a normative basis of action by providing benchmarks for determining outcomes that are "good" (desirable) or "bad" (undesirable). The plan also includes a Comprehensive Plan Map, as well as future community, corridor, large area, and functional plans.

In addition, the LFMP describes approaches to communicating and structuring comprehensive planning in Frederick County that are unlike past planning efforts. Specifically, the LFMP sets goals for increasing access to exercise, promoting green space, increasing access to good nutrition, reducing injury in deaths from accidents and violence, ending abuse of all kinds, increasing behavioral health capacities, increasing supports for children and families, and improving health services for our growing senior population.

The vision of the Livable Frederick Master Plan reflects a holistic attitude toward public health that integrates the influence of the physical environment upon individual behavior, as well as the availability of services.

https://www.livablefrederick.org/master-plan

Other Public Health Initiatives

Service Coordination for Low-Income Seniors Living in Single-Unit Housing

Advocates for the Aging of Frederick County, Frederick Health, and the Housing Authority of the City of Frederick are partners in this grant-funded, 2-year project designed to introduce service coordination to a cadre of individuals usually excluded from such programs: low-income seniors living on their own in homes and apartments. The more typical service coordination program exists in multi-unit housing developed specifically for seniors. This project will enroll up to 100 seniors living on their own, provide service coordination, and collect data on needs, resources, gaps and disparities in services across the Social Determinants of Health. The project seeks to assess how providing service coordination to these individuals may:

- reduce health disparities
- increase access to services
- improve medical compliance and health outcomes
- reduce the use of emergency services for non-acute needs, resulting in costs savings
- help low-income seniors remain in their homes for as long as possible.

The project is designed to enroll and track up to 100 seniors over 2 years drawn from a population of low-income seniors, age 60 and over, who live in single unit homes with voucher-based housing subsidies. Basic demographics of the population of 99 participants at the end of year 1 (July 1, 2020 through October 31, 2021):

- 80% are between 60 and 82 years of age
- 18% are between 83 and 99 years of age
- Average age is 75
- 58% of participants identify as female
- 39 participants identify as Black/African American, 37 as White, 2 as Asian
- A majority of participants are single, widowed or divorced
- All are low-income, qualifying for rental housing assistance and food security benefits.

Tracking of 96 program participants receiving 2,952 unduplicated services falling into 25 service categories over year 1 shows seniors having strong need for support in the following areas:

- information and help with benefits/insurance management
- health care and services
- transportation
- home management/meeting requirements for annual voucher inspections
- monitoring for safety, health care compliance, general needs
- isolation prevention
- outreach to service providers
- need for assistive devices to avoid falls and maintain mobility

The program launched during the COVID-19 pandemic, thus placing emphasis on needs related to isolation, missed medical appointments, difficulty in utilizing public transportation, and in receiving adequate food resources. As vaccines became available, participants were encouraged and assisted in receiving vaccinations. At the end of the first quarter of 2021, with 60 individuals enrolled, 90% of participants had been fully vaccinated against COVID, with 5% refusing and 5% delayed due to medical reasons.

Service Coordination utilizes a collaborative approach, working with and referring to a broad array of local agencies and service providers to meet the needs of participants. At the end of year 1, the project staff had worked with 30 agencies and organizations throughout Frederick County to meet the needs of enrollees.

Lifting All Voices – Health Literacy Project

Lifting All Voices is a two-year project funded by the federal Office of Minority Health which addresses both individual and organizational health literacy needs. The project aims to improve Frederick residents' access to and understanding of culturally and linguistically appropriate COVID-19 vaccination and testing information, and to build the capacity of Frederick's healthcare providers to deliver COVID-19 vaccination and testing services aligned with health literacy best practices, thereby preparing them to serve residents more effectively post-pandemic.

Led by the Asian American Center of Frederick and the University of Maryland Horowitz Center for Health Literacy, the project includes partners from the City of Frederick, Frederick Health Hospital, the Frederick County Health Department, and the Frederick County Health Care Coalition, representing wide variety of stakeholders and perspectives. The uniquely well-integrated nature of the project partners facilitates communication and connection around project goals and activities.

The project leverages the cultural and linguistic expertise of local community health workers in conjunction with the University of Maryland (UMD)'s clear communications experts to provide Frederick residents with accurate, accessible, and actionable COVID-19-related health information in their preferred languages and formats. UMD will also lead training sessions to help local organizations identify and respond to health literacy issues in their own organizations and across the project partnership.

Running from July 2021 through June 2023, Lifting All Voices aims to establish a strong health literacy infrastructure in Frederick to facilitate communication and access to health services to enhance health equity for all Frederick residents."

Conclusions

The picture of Frederick County's health shown in this report is consistent with previous reports, as well as with other health assessments. Overall health in Frederick County is often, but not always, better than in Maryland. Improvements are seen in some health indicators, but chronic diseases like heart disease and cancer remain the leading causes of death. COVID-19 is expected to be the third leading cause of death for 2020 and 2021 and has had a significant financial and psychological impact on the community. Some populations within Frederick County continue to see poorer health outcomes. Social and environmental issues, specifically affordable housing and transportation, remain top concerns of Frederick County residents. Issues like racial disparity have become more apparent as having a direct impact on the health of our community, and more resources and attention are being dedicated to achieving health equity.

Working within The County Health Rankings framework of community health demonstrates the connections between health factors and health outcomes. Achieving positive change in the health status of Frederick County is only possible through the collaboration of all community sectors and alignment of effort and resources to focus on common concerns that can be addressed at the community and society levels.

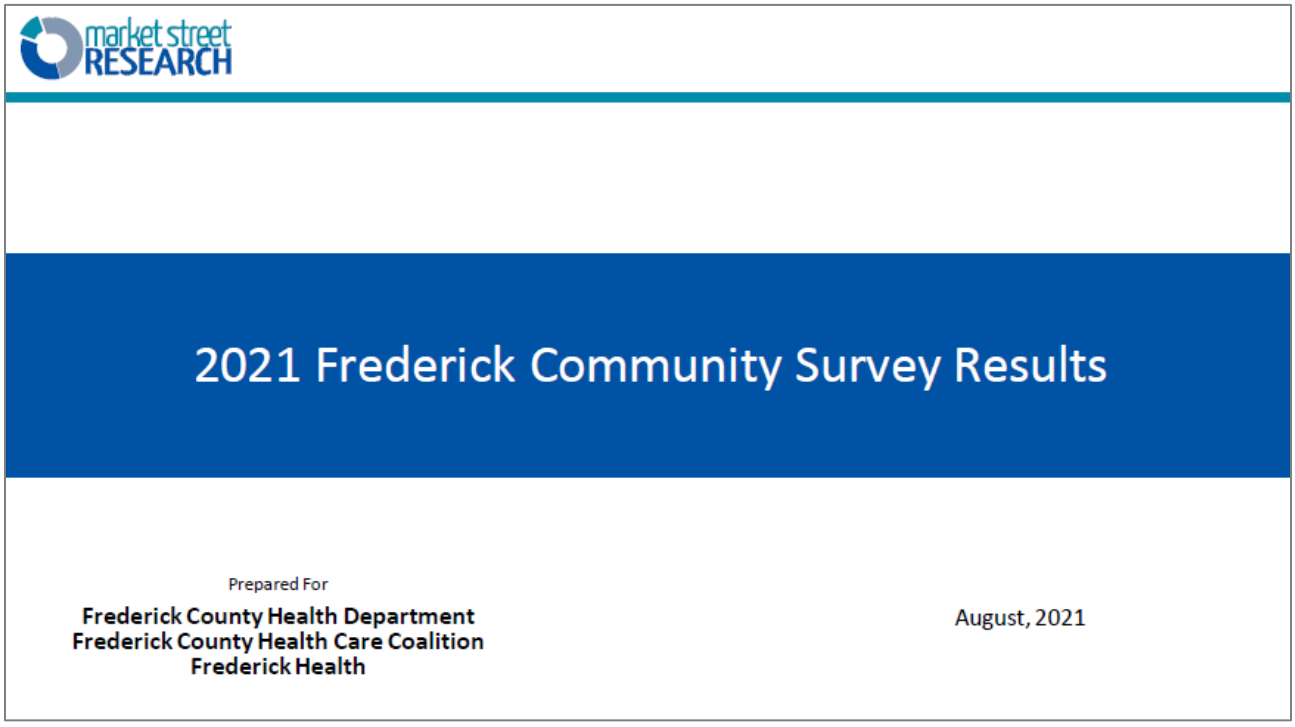
Local Health Improvement Plan work groups for each of the three priorities will establish their short- and long-term goals and objectives. These plans will be presented to the community when completed in Fall 2022. Progress reports will be posted for public review at http://health.frederickcountymd.gov/LHIP. The Frederick County Health Care Coalition will continue looking for ways for the community to become and remain involved.

CHNA data relevant to the work groups and other newly available health data will updated in 2020 and posted online at https://md-frederickcountyhealth.civicplus.com/455/Community-Health-Assessment.

Appendix 1. Primary Data

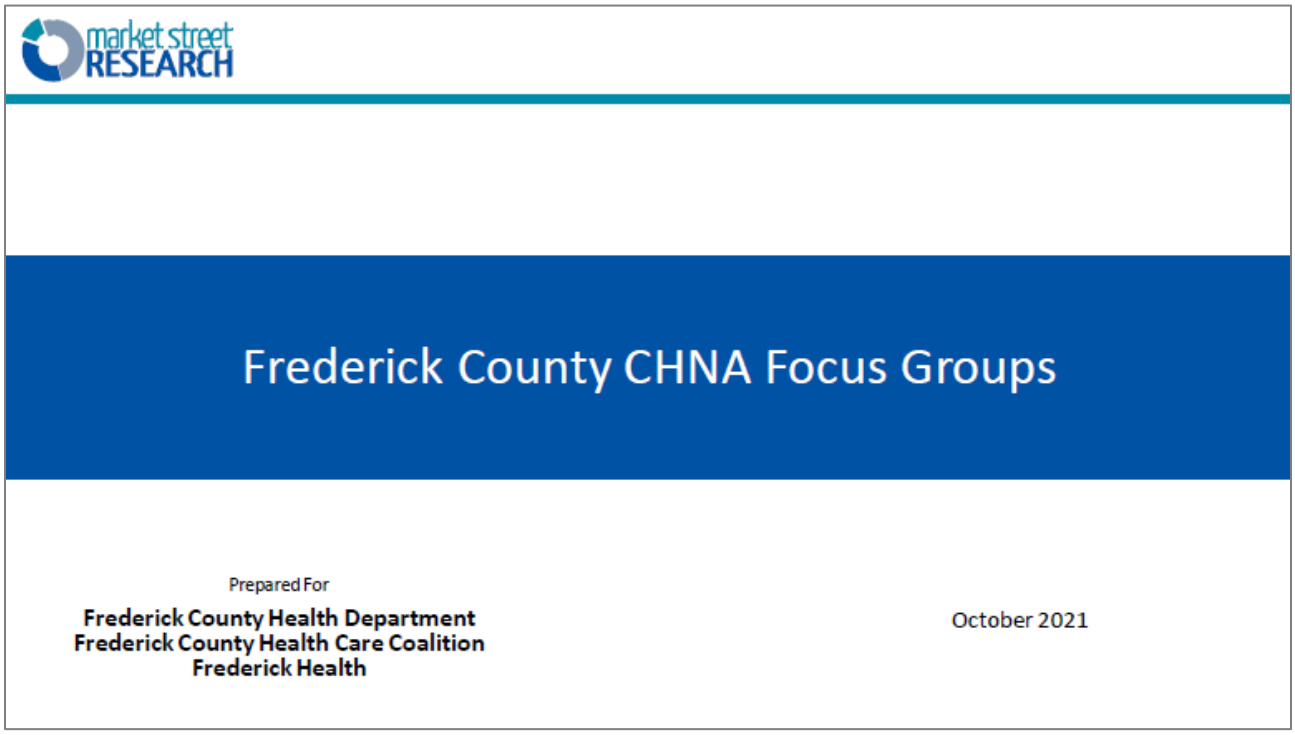
Community Survey Data

The details results of the 2021 Community Health Survey are available by clicking on the picture below, or this link: https://health.frederickcountymd.gov/DocumentCenter/View/7427/2021-Community-Survey-results-10121



Community Focus Groups

The details results of the 2021 focus groups are available by clicking on the picture below, or this link: https://health.frederickcountymd.gov/DocumentCenter/View/7428/2021-Focus-Groups-Final-Report-11321



Appendix 2. Secondary Data

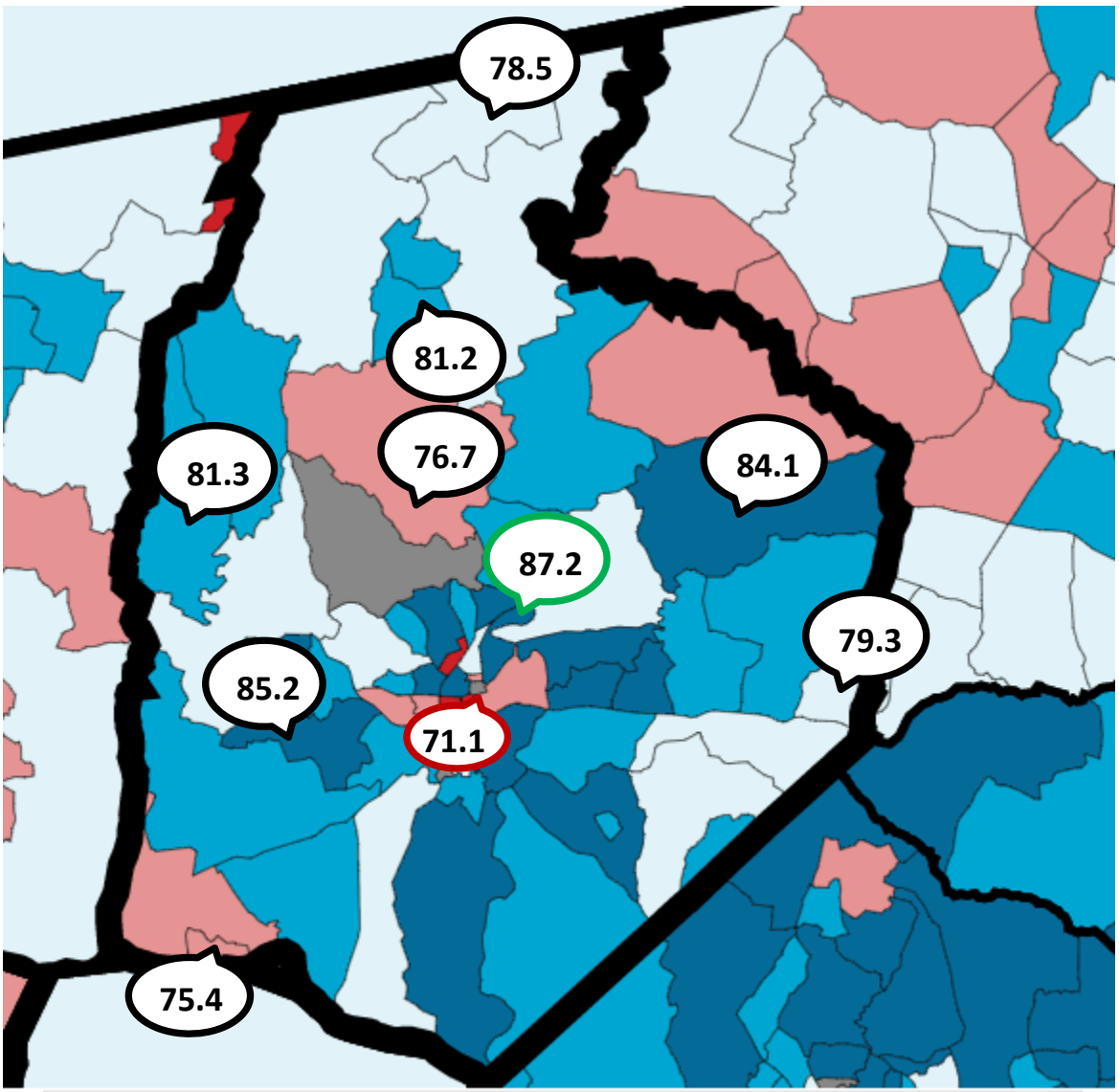
Demographics

Population estimates, April 1, 2020	Frederick County	Maryland	United States
Total Population	271,717	6,177,224	331,449,281
Gender			
Females	50.7%	51.6%	50.8%
Males	49.3%	48.4%	49.2%
Race			
White alone, not Hispanic or Latino	71.7%	50.0%	60.1%
Black or Africa-American alone	10.7%	31.1%	13.4%
American Indian and Alaska Native, NH	0.5%	0.6%	1.3%
Asian, NH	5.0%	6.7%	5.9%
Native Hawaiian and other Pacific Islander	0.1%	0.1%	0.2%
Two or More Races	3.1%	2.9%	2.8%
Hispanic or Latino	10.5%	10.6%	18.5%
Ages			
Under 5 Years Old	5.9%	6.0%	6.0%
Under 18 Years Old	23.1%	22.1%	22.3%
65 Years and Over	14.8%	15.9%	16.5%
Other Indicators			
High school graduate or higher (25+ years) (2015-2019)	92.5%	90.2%	88.0%
Bachelor's degree or higher (25+ years) (2015-2019	41.4%	40.2%	32.1%
Foreign born persons (2015-2019)	11.0%	15.2%	13.6%
Language other than English spoken at home, age 5+ years (2015-2019)	14.6%	19.0%	21.6%
Persons without health insurance (under age 65)	5.5%	6.9%	9.5%
Persons with a disability, under age 65 years (2015-2019)	7.4%	7.5%	8.6%
Persons in Poverty (2015-2019)	5.7%	9.0%	10.5%

Data Source: U.S. in 2020 Bureau: State and County Quick Facts

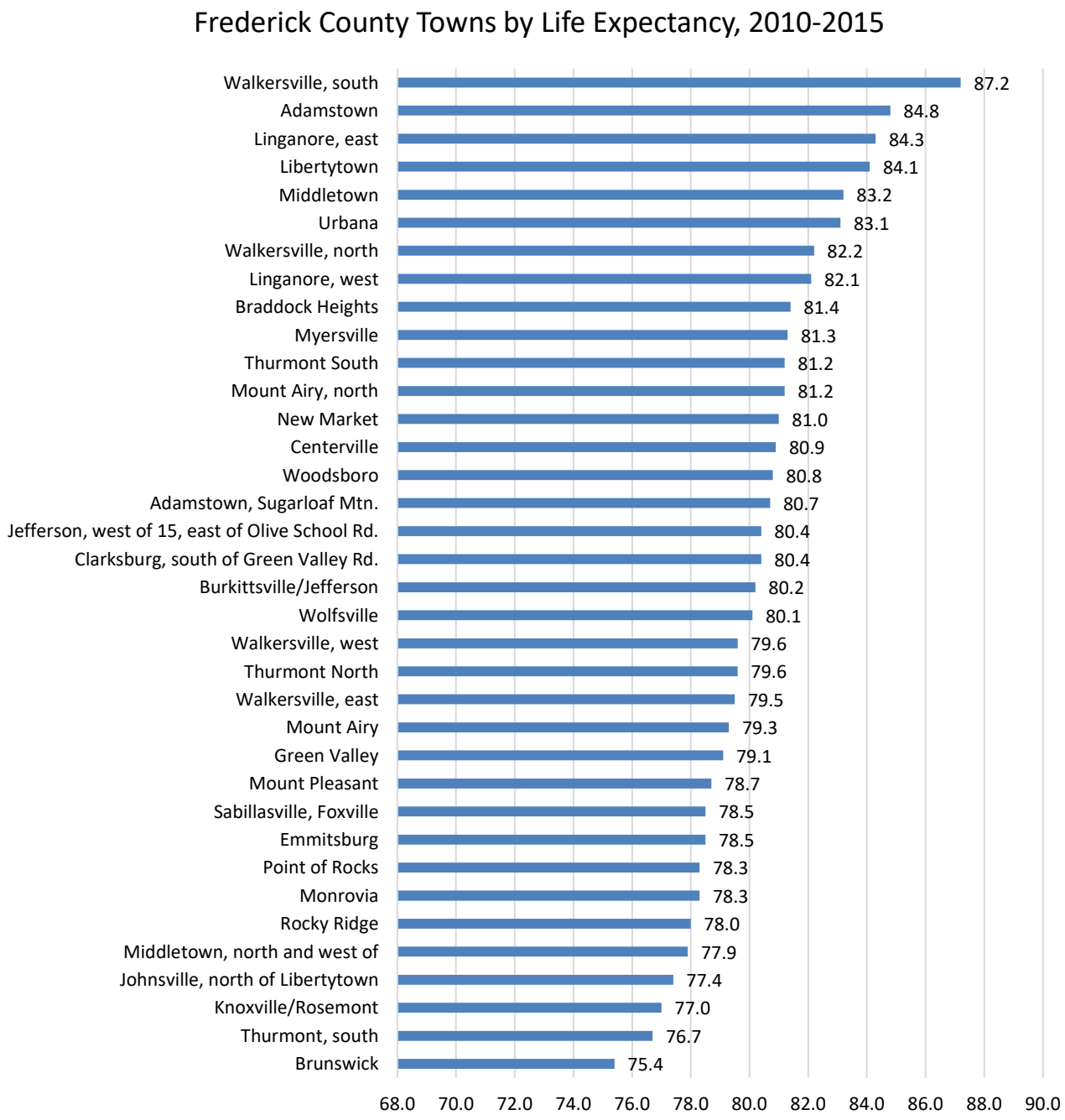
Life Expectancy, Map of Frederick County

The highest life expectancy in Frederick County is 87.2 years in Walkersville. The lowest life expectancy in Frederick County is 71.1 years in the city of Frederick in the area of South Benz and West South streets. Maryland state average life expectancy is 79.6 years.



Tejada-Vera B, Bastian B, Arias E, Escobedo LA., Salant B, Life Expectancy Estimates by U.S. Census Tract, 2010-2015. National Center for Health Statistics. 2020.

Life Expectancy, Map of Frederick County



Tejada-Vera B, Bastian B, Arias E, Escobedo LA., Salant B, Life Expectancy Estimates by U.S. Census Tract, 2010-2015. National Center for Health Statistics. 2020.

Life Expectancy, Frederick County Census Tracts

Tract	Area	LE		Tract	Area	LE
7523.02	Adamstown	84.8		7512.02	Frederick, Whittier	80.4
7522.01	Adamstown, Sugarloaf Mtn.	80.7		7521.02	Green Valley	79.1
7526.03	Braddock Heights	81.4		7525.02	Jefferson, west of 15, east of Olive School Rd.	80.4
7754.00	Brunswick	75.4		7516.00	Johnsville, north of Libertytown	77.4
7525.01	Burkittsville/Jefferson	80.2		7753.02	Knoxville/Rosemont	77.0
7522.02	Centerville	80.9		7517.02	Libertytown	84.1
7521.01	Clarksburg, south of Green Valley Rd.	80.4		7519.01	Linganore, east	84.3
7668.00	Emmitsburg	78.5		7756.00	Linganore, west	82.1
7501.00	Frederick, 3rd to 7th street	75.7		7526.01	Middletown	83.2
7507.01	Frederick, Amber Meadows/Govenors Choice	80.3		7707.00	Middletown, north and west of	77.9
7510.02	Frederick, Ballenger Creek Elementary School area	78.7		7519.03	Monrovia	78.3
7523.01	Frederick, Ballenger Creek south	80.3		7520.01	Mount Airy	79.3
7512.01	Frederick, Clover Hill/Yellow Springs	84.9		7518.02	Mount Airy, north	81.2
7722.00	Frederick, east, Sagner, fairgrounds	75.6		7517.01	Mount Pleasant	78.7
7505.05	Frederick, Frederick Heights/Overlook/Prospect View, Linden Hills	76.9		7528.02	Myersville	81.3
7512.03	Frederick, Gambrill Park, west of Kemp lane, east of Gambrill Park Rd	78.8		7518.01	New Market	81.0
7505.06	Frederick, Hillcrest Orchards/Monarch Ridge	77.1		7523.03	Point of Rocks	78.3
7510.03	Frederick, New Design/Crestwood	82.6		7675.00	Rocky Ridge	78.0
7505.03	Frederick, north of 40, west of Key Parkway	79.9		7529.00	Sabillasville, Foxville, Blue Ridge Summit	78.5
7519.04	Frederick, Pine Cliff Park	80.6		7530.02	Thurmont North	79.6
7506.00	Frederick, Rosedale/Baker Park/FMH	86.3		7530.01	Thurmont South	81.2
7508.01	Frederick, Selwyn Farms/Rose Hill	79.3		7513.02	Thurmont, southern Cunningham Falls State Park	76.7
7503.00	Frederick, South Benz, West South streets	71.1		7522.04	Urbana	83.1
7651.00	Frederick, south of Patrick, west of 355	74.9		7735.00	Walkersville, east	79.5
7519.02	Frederick, Spring Ridge	84.5		7508.02	Walkersville, north, Wormans Mill, Mill Island	82.2
7510.04	Frederick, Stoney Creek Farms	80.4		7508.03	Walkersville, south, Dearbought, Monocacy Park, Monocacy Crossing	87.2
7505.04	Frederick, Taskers Chance	82.2		7402.00	Walkersville, west	79.6
7507.02	Frederick, Villa Estates/Antietam Village	74.2		7528.01	Wolfsville	80.1
7526.02	Frederick, west of Mount Phillip, south of Braddock Heights	85.2		7676.00	Woodsboro	80.8

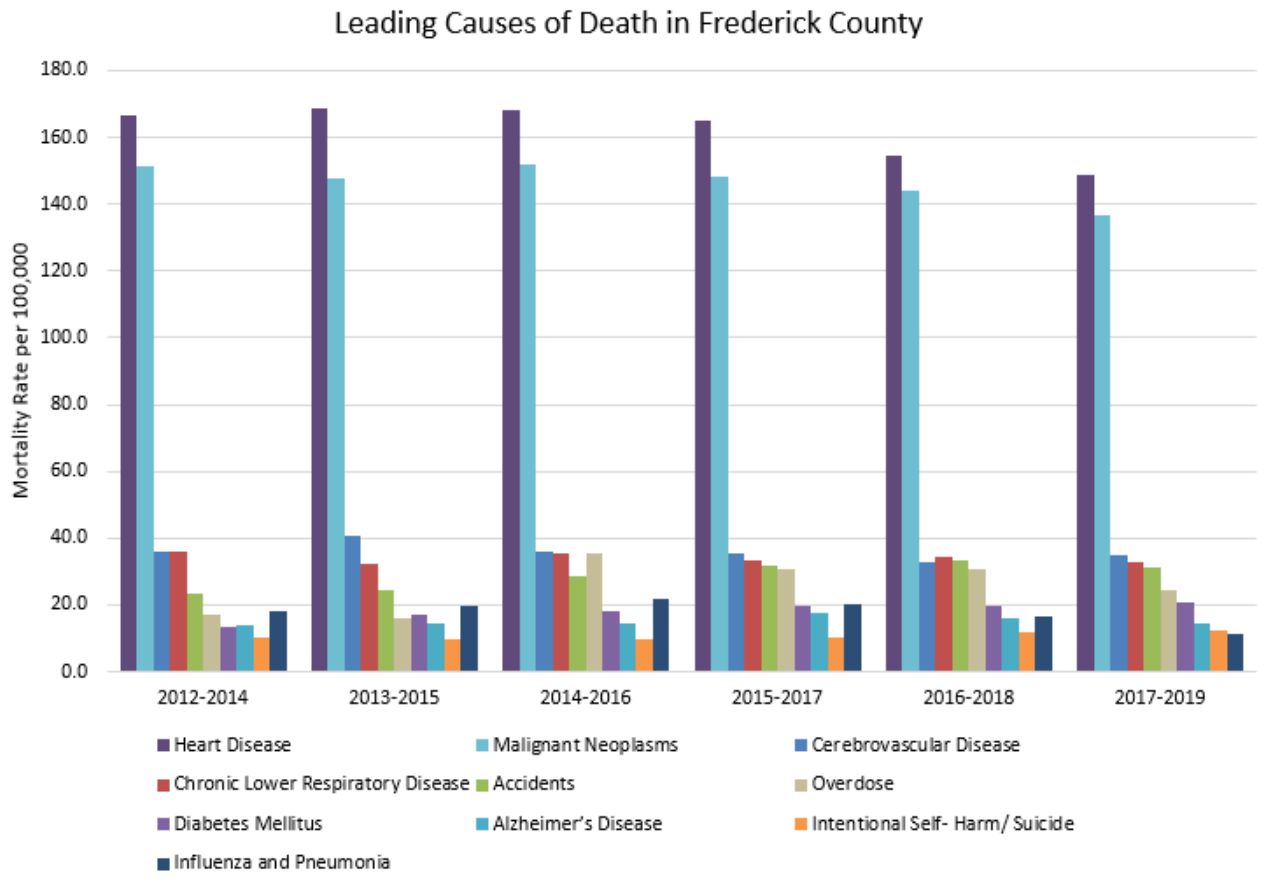
Tejada-Vera B, Bastian B, Arias E, Escobedo LA., Salant B, Life Expectancy Estimates by U.S. Census Tract, 2010-2015. National Center for Health Statistics. 2020.

Health Outcome: Length of Life

Leading Causes of Death

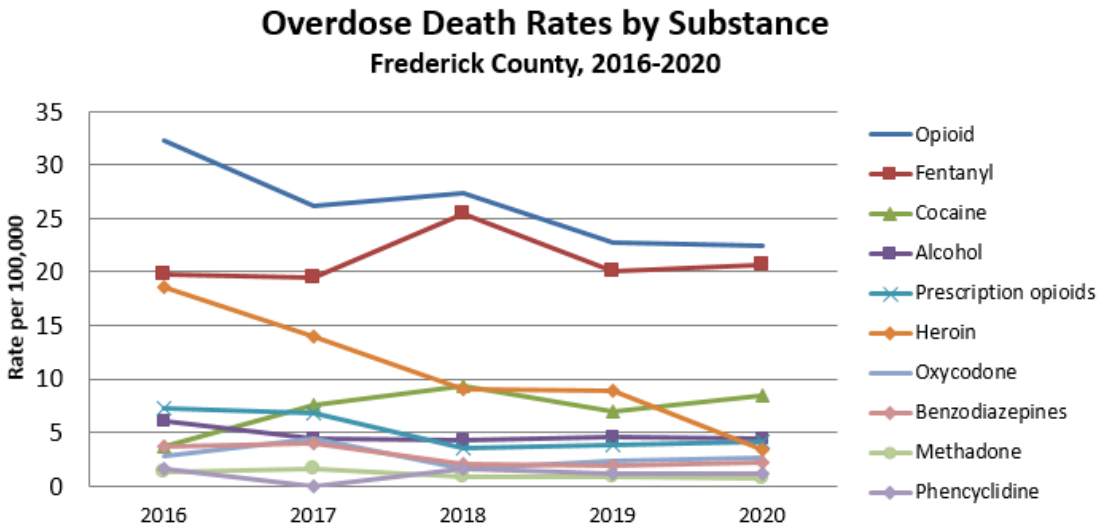
Leading Causes of Death in Frederick County, MD						Maryland
Mortality Rates per 100,000	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2017-2019
All Causes of Death (2017-2019)	664.7	691.2	695.6	683.7	662.0	713.0
Heart Disease	168.7	168.1	165.1	154.5	148.6	161.9
Malignant Neoplasms	147.8	152.0	148.2	143.8	136.6	148.6
Cerebrovascular Disease	40.8	36.0	35.6	32.8	35.2	40.7
Chronic Lower Respiratory Disease	32.2	35.5	33.2	34.2	33.0	30.0
Accidents	24.7	28.4	31.9	33.2	31.2	36.4
Diabetes Mellitus	17.2	18.3	19.5	19.6	20.6	20.1
Alzheimer's Disease	14.4	14.4	17.4	16.1	14.3	15.5
Intentional Self- Harm/ Suicide	10.0	9.6	10.3	12.0	12.4	10.1
Influenza and Pneumonia	19.7	21.8	20.3	16.5	11.5	13.0
	2015	2016	2017	2018	2019	2019
Overdose	16.3	35.5	30.9	30.5	24.7	39.4

Source: Maryland Vital Statistics, Drug and Alcohol Intoxication Deaths in Maryland



Drug and Alcohol Overdose Deaths

Drug and Alcohol Overdose Deaths in Frederick County, MD						Maryland
	2016	2017	2018	2019	2020	2020
Total Overdose Deaths	88	78	78	64	64	2799
Opioid	80	66	70	59	61	2518
Fentanyl	49	49	65	52	56	2342
Cocaine	9	19	24	18	23	921
Alcohol	15	11	11	12	12	566
Prescription opioids	18	17	9	10	11	453
Heroin	46	35	23	23	9	548
Oxycodone	7	11	4	6	7	108
Benzodiazepines	9	10	5	5	6	114
Methadone	3	4	2	2	2	279
Phencyclidine	4	0	4	3	3	75
Rates by Substance per 100,000:						
Total Overdose Death Rate	35.5	30.9	30.5	24.7	23.6	45.3
Opioid	32.3	26.2	27.4	22.7	22.4	40.8
Fentanyl	19.8	19.4	25.4	20.0	20.6	37.9
Cocaine	3.6	7.5	9.4	6.9	8.5	14.9
Alcohol	6.1	4.4	4.3	4.6	4.4	9.2
Prescription opioids	7.3	6.7	3.5	3.9	4.0	7.3
Heroin	18.6	13.9	9.0	8.9	3.3	8.9
Oxycodone	2.8	4.4	1.6	2.3	2.6	1.7
Benzodiazepines	3.6	4.0	2.0	1.9	2.2	1.8
Methadone	1.2	1.6	0.8	0.8	0.7	4.5
Phencyclidine	1.6	0.0	1.6	1.2	1.1	1.2

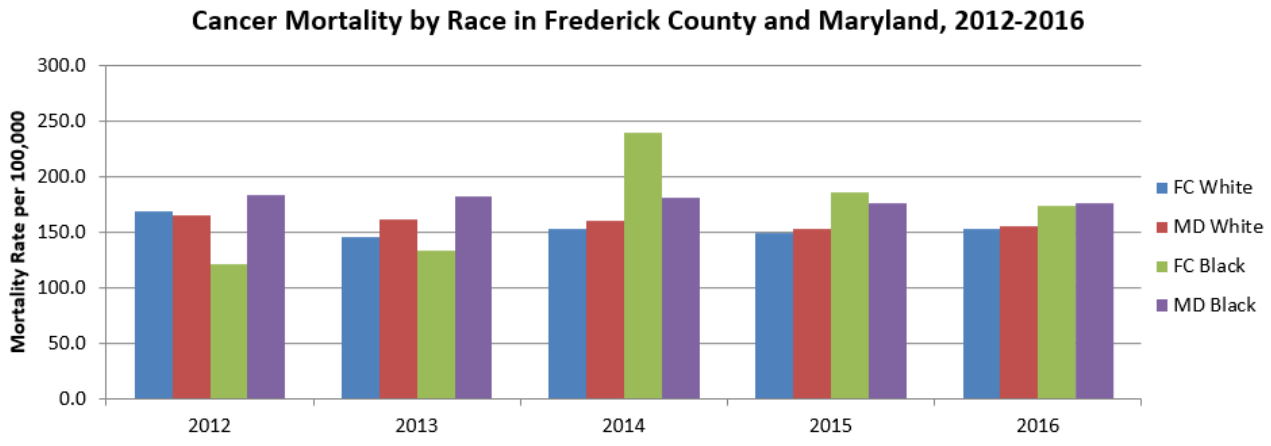


Source: Drug and Alcohol Intoxication Deaths in Maryland.

Cancer Deaths

Cancer Deaths in Frederick County, MD						Maryland
By Cancer Type	**2008-2012**	**2009-2013**	**2010-2014**	**2011-2015**	**2012-2016**	**2012-2016**
Lung and Bronchus Cancer Mortality	42.2	40.4	37.9	35.7	35.1	40.1
Male	51.0	47.4	45.0	40.9	40.9	48.3
Female	35.5	35.2	32.6	31.9	31	34.2
White	41.9	40.1	38.1	36.2	35.6	41.6
Black	57.4	55.8	49.3	41.1	41.3	40.5
Colorectal Cancer Mortality	16.8	16.0	15.5	14.8	13.9	14.1
Male	22.5	21.1	20.7	20	18.1	16.9
Female	12.6	12.1	11.4	11.1	10.9	11.9
Breast Cancer Mortality (Female only)	22.5	20.7	21.3	21.9	21.6	22.2
Prostate Cancer Mortality	21.9	21.7	21.3	20.7	19.1	20.1
Melanoma Cancer Mortality	3.2	2.9	2.4	2.1	2.3	2.2
Oral Cancer Mortality	*	*	*	1.6	1.8	2.4

Cancer Deaths in Frederick County, MD						Maryland
Cancer Mortality Rates (per 100,000)	**2012**	**2013**	**2014**	**2015**	**2016**	**2016**
All Cancers	162.8	141.8	156.0	149.5	152.5	156.5
Male	200.9	167.3	186.0	170.9	190.2	183.2
Female	138.2	124.5	133.2	137.0	125.5	138.4
White	169.1	145.9	152.2	149.4	152.6	154.7
Black	121.0	133.2	238.7	186.0	173.1	176.2



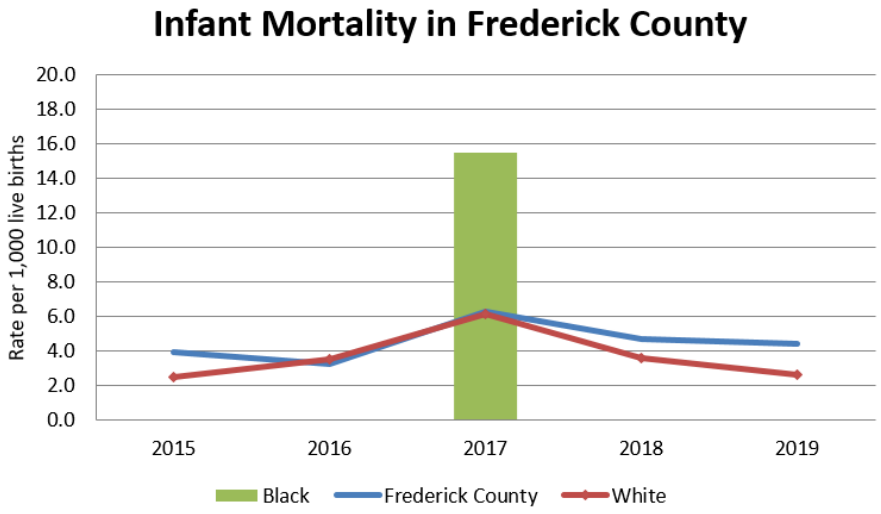
Source: Maryland Cancer Report. Rates are per 100,000 and are age-adjusted to 2000 US standard population.
*Rates based on case counts of 1-19 are suppressed per DHMH/MCR Data Use Policy and Procedures.

Infant Mortality

Infant Mortality in Frederick County, MD						Maryland
Rate per 1,000	2015	2016	2017	2018	2019	2019
Infant Mortality Rate	3.9	3.2	6.3	4.7	4.4	5.9
White	2.5	3.5	6.1	3.6	2.6	4.1
Black	*	*	15.5	*	*	9.3

Source: Maryland Vital Statistics Reports.

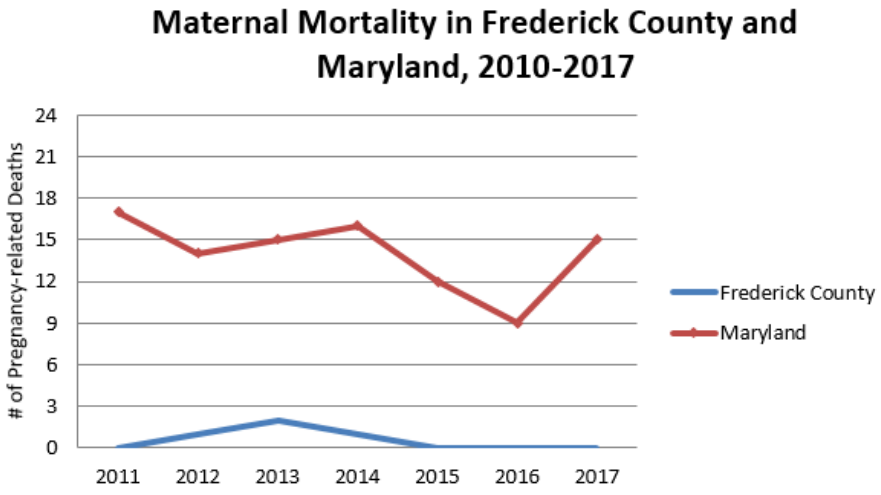
*Rates based on fewer than five events in the numerator are not presented since such rates are likely to be unstable.



Maternal Mortality

Pregnancy-related Deaths in Frederick County, MD						Maryland
	2013	2014	2015	2016	2017	2017
Pregnancy-related deaths	2	1	0	0	0	15

Source: Maryland Maternal Mortality Review



Health Outcomes: Quality of Life

Cancer Incidence

Cancer Incidence in Frederick County, MD						Maryland
Cancer Incidence Rates (per 100,000)	**2012**	**2013**	**2014**	**2015**	**2016**	**2016**
All Cancers	434.0	440.6	431.8	488.5	451.3	443.6
Male	456.3	463.5	467.2	515.5	479.9	481.6
Female	427.3	430.6	409.9	475.9	431.1	419.1
White	439.1	445.2	429.8	489.9	449.6	330.1
Black	383.0	454.8	485.3	550.0	512.2	453.0
By Cancer Type	**2008-2012**	**2009-2013**	**2010-2014**	**2011-2015**	**2012-2016**	**2012-2016**
Lung and Bronchus Cancer Incidence	54.0	50.7	48.1	48.2	46.9	55.6
Male	67.9	55.5	55.0	55.5	54.3	62.8
Female	52.0	47.6	43.2	43.1	41.7	50.4
White	55.1	52.0	49.0	49.2	47.6	58.4
Black	58.0	46.4	46.8	44.0	48.4	53.8
Colorectal Cancer Incidence	47.1	43.8	39.5	36.4	35.6	36.1
Male	57.9	53.4	49.0	44.8	43.6	40.4
Female	38.6	36.2	31.7	29.5	28.8	32.6
White	47.0	43.6	38.6	35.6	34.5	34.9
Black	49.6	47.9	48.3	39.6	40.8	39.7
Breast Cancer Incidence (Female only)	121.1	121.3	124.2	129.4	131.7	130.1
White	121.9	122.5	122.7	127.3	129.6	131.1
Black	102.3	110.6	136.5	156.9	158.8	130.6
Prostate Cancer Incidence	122.0	111.5	103.0	102.4	98.2	120.3
White	113.8	103.1	95.5	95.0	91.4	102.3
Black	226.6	231.2	217.4	221.3	214.5	180.4
Cervical Cancer Incidence	5.6	5.4	5.0	5.1	4.5	6.3
Oral Cancer Incidence	9.8	10.0	9.5	10.5	10.8	10.8
Male	15.1	15.2	14.0	15.9	15.8	16.4
Female	5.3	5.6	5.6	5.9	6.5	6.0
Melanoma Cancer Incidence	21.9	22.0	23.1	25.4	26.3	23.0
Male	29.2	27.9	29.6	31.3	30.9	30.7
Female	16.1	17.1	18.1	20.7	22.7	17.4

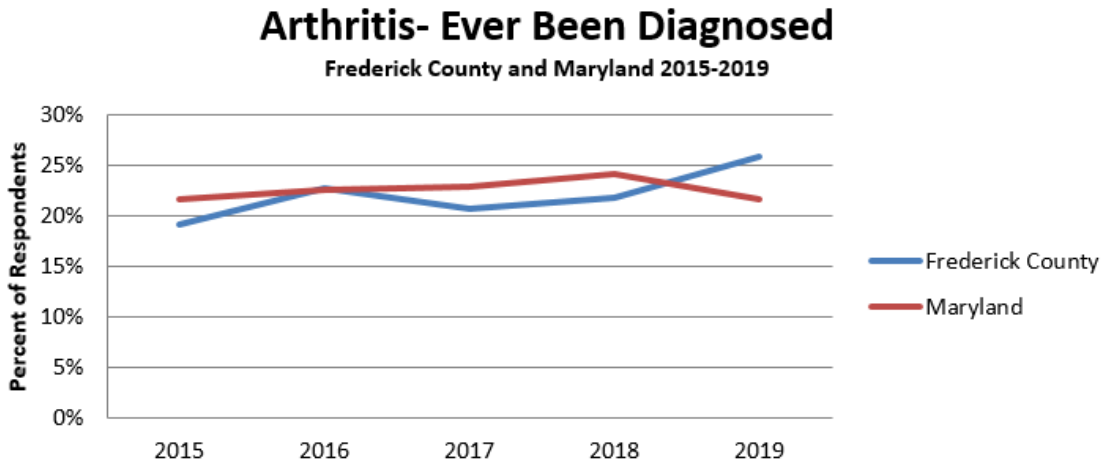
Source: Maryland Cancer Report. Rates are per 100,000 and are age-adjusted to 2000 US standard population.
*Rates based on case counts of 1-19 are suppressed per MDH/MCR Data Use Policy and Procedures

Chronic Conditions

Arthritis

Arthritis in Frederick County, MD						Maryland
	2015	2016	2017	2018	2019	2019
Arthritis (ever diagnosed)	19.2%	22.7%	20.7%	21.8%	25.9%	21.7

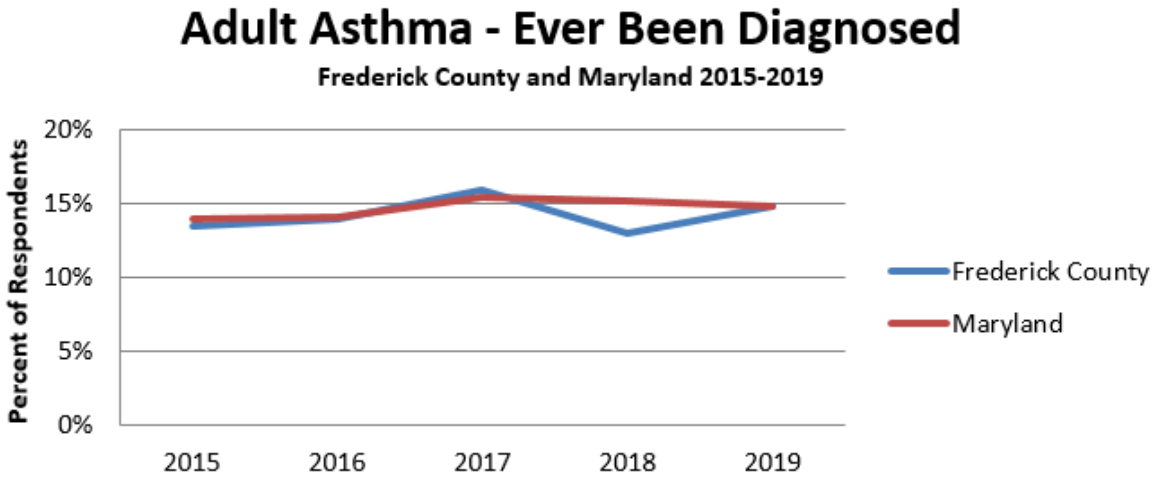
Source: Behavioral Risk Factor Surveillance Survey. Question: EVER BEEN TOLD BY A DOCTOR OR OTHER HEALTH PROFESSIONAL THAT YOU HAD ARTHRITIS?



Asthma

Adult Asthma in Frederick County, MD						Maryland
	2015	2016	2017	2018	2019	2019
Adult Asthma (ever diagnosed)	13.5%	14.0%	15.9%	13.0%	14.9%	14.9%

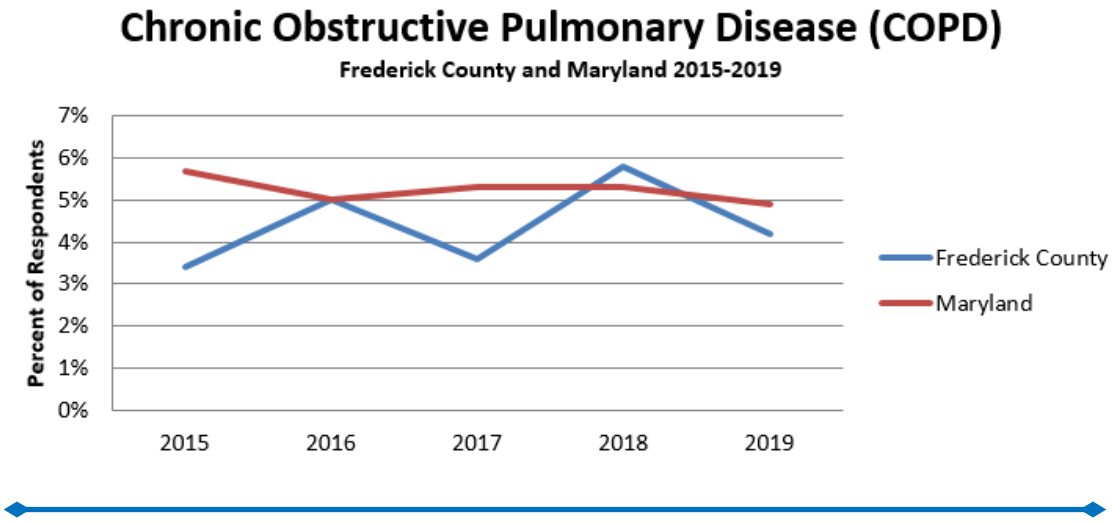
Source: Behavioral Risk Factor Surveillance Survey. Question: EVER BEEN TOLD BY A DOCTOR OR OTHER HEALTH PROFESSIONAL THAT YOU HAD ASTHMA?



COPD

Chronic Obstructive Pulmonary Disease in Frederick County, MD						Maryland
	2015	2016	2017	2018	2019	2019
COPD	3.4%	5.0%	3.6%	5.8%	4.2%	4.9%

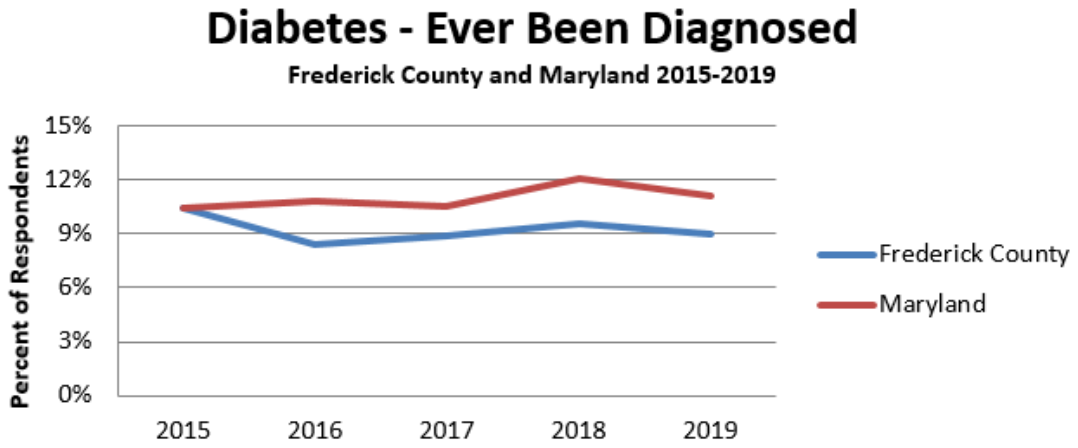
Source: Behavioral Risk Factor Surveillance Survey. Question: EVER BEEN TOLD YOU HAVE CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD), EMPHYSEMA, OR CHRONIC BRONCHITIS?



Diabetes

Diabetes in Frederick County, MD						Maryland
	2015	2016	2017	2018	2019	2019
Diabetes	10.4%	8.4%	8.9%	9.6%	9.0%	11.1%

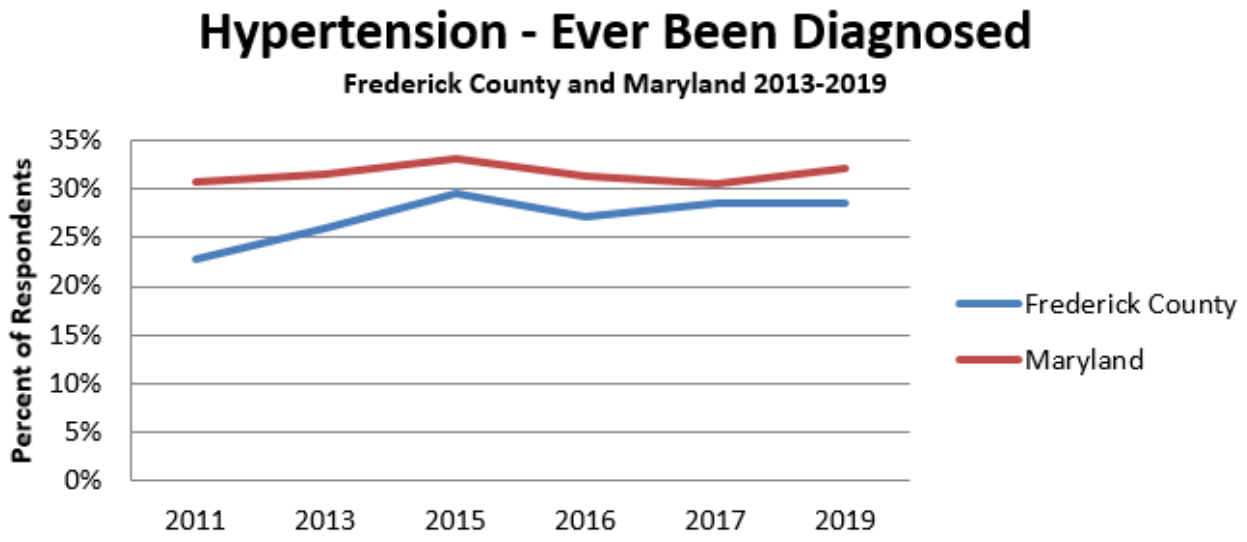
Source: Behavioral Risk Factor Surveillance Survey. Question: EVER TOLD BY A DOCTOR THAT YOU HAVE DIABETES? EXCLUDE: DIABETES AT PREGNANCY



Hypertension

Hypertension in Frederick County, MD						Maryland
	2013	2015	2016	2017	2019	2019
Hypertension	26.0%	29.6%	27.2%	28.6%	28.5%	32.2%

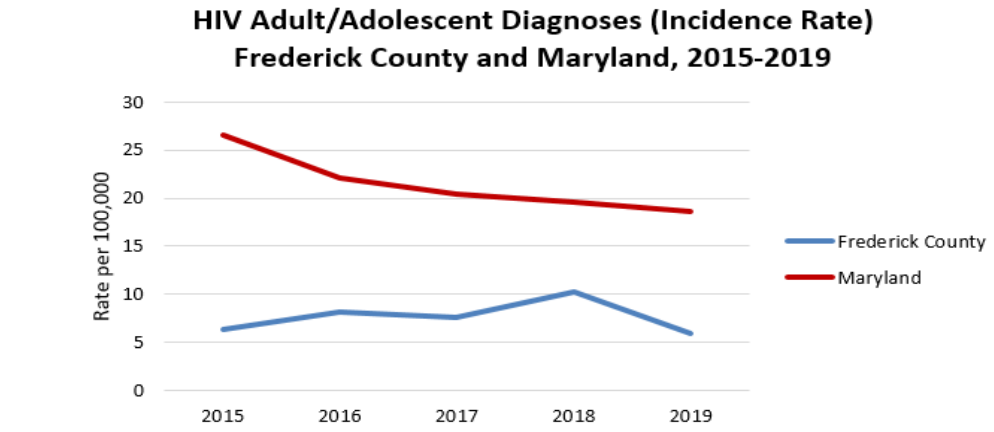
Source: Behavioral Risk Factor Surveillance Survey. Question: EVER TOLD BY A DOCTOR THAT YOU HAVE HIGH BLOOD PRESSURE? EXCLUDE: WOMEN TOLD DURING PREGNANCY AND BORDERLINE HYPERTENSION.



HIV

HIV Incidence Rate in Frederick County, MD						Maryland
Rate per 100,000	**2015**	**2016**	**2017**	**2018**	**2019**	**2019**
HIV Incidence Rate	6.4	8.2	8.5	10.3	6.0	18.6

Source: Maryland HIV Annual Epidemiological Profile. Incidence rate indicates new diagnoses of HIV in adults and adolescents.

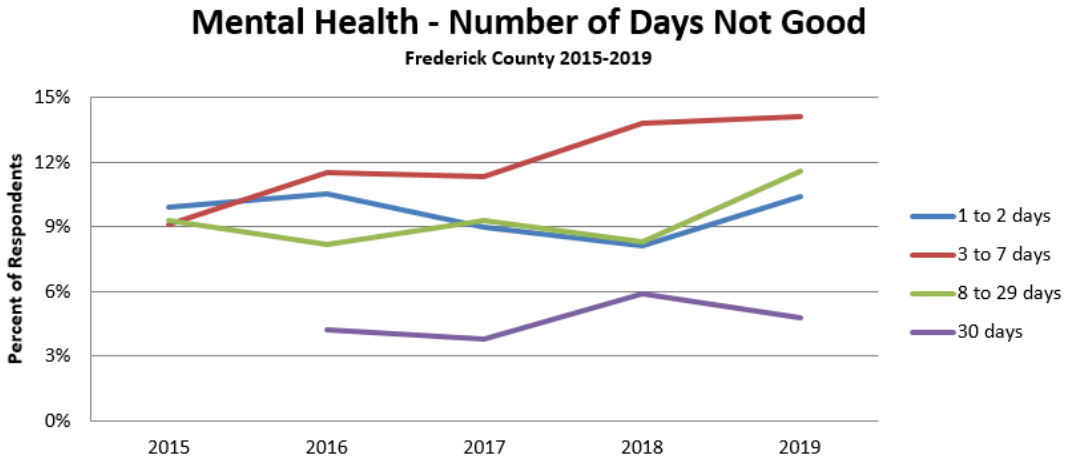


Mental Health

Mental Health in Frederick County, MD						Maryland
Days Mental Health Not Good	**2015**	**2016**	**2017**	**2018**	**2019**	**2019**
None	64.9%	65.7%	66.6%	63.9%	59.0%	60.5%
1 to 2 days	9.9%	10.5%	9.0%	8.1%	10.4%	9.7%
3 to 7 days	9.1%	11.5%	11.3%	13.8%	14.1%	13.1%
8 to 29 days	9.3%	8.2%	9.3%	8.3%	11.6%	11.5%
30 days	**	4.2%	3.8%	5.9%	4.8%	5.1%

Source: Behavioral Risk Factor Surveillance Survey. Question: NUMBER OF DAYS MENTAL HEALTH NOT GOOD.

***The estimate has been suppressed because the observed number of events is very small and not appropriate for publication.*



Maternal and Child Health

Adverse Childhood Experiences (ACEs) Adults

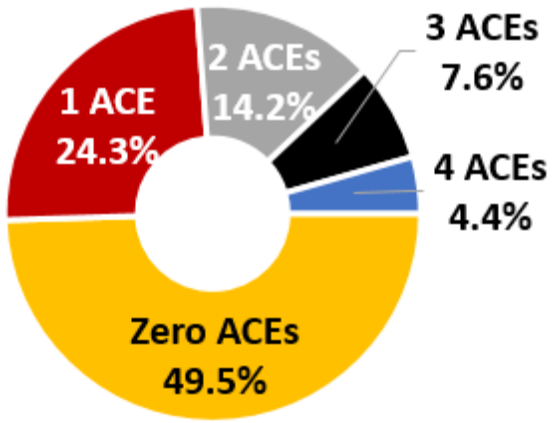
Adverse Childhood Experiences (Adults) in Frederick County, MD			Maryland
	2015	2018	2018
0 ACEs	39.3%	44.8%	36.9%
1 ACE	16.0%	17.7%	24.5%
2 ACEs	*	13.0%	15.0%
3 ACEs	*	9.1%	10.0%
4 or more ACEs	*	6.2%	14.0%

Source: Behavioral Risk Factor Surveillance Survey. * Suppressed due to denominator < 50 or relative standard error >= 30.0%.

Adverse Childhood Experiences (ACEs) Adolescents

Adverse Childhood Experiences (Adolescents) in Frederick County, MD	
High school Students	2018
0 ACEs	49.5%
1 ACE	24.3%
2 ACEs	14.2%
3 ACEs	7.6%
4 or more ACEs	4.4%
Total of 1+ ACEs	**50.5%**

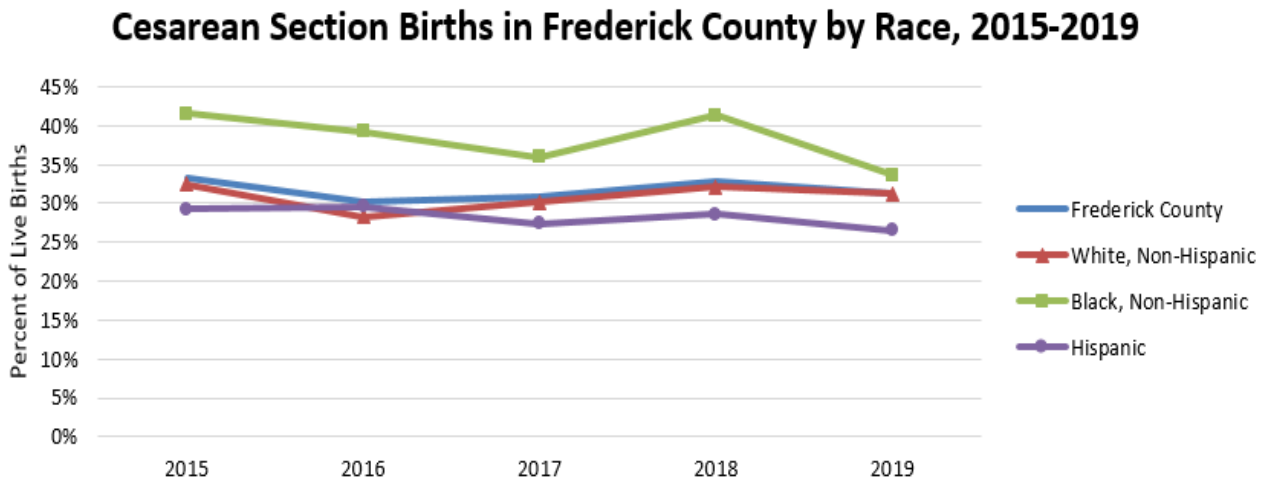
Source: Youth Risk Behavior Survey. Questions 113-116.



Cesarean Section

Cesarean Section Rates in Frederick County, MD						Maryland
	2015	2016	2017	2018	2019	2019
Frederick County	33.3%	30.2%	30.8%	32.8%	31.2%	32.9%
White	32.5%	28.3%	30.2%	32.1%	31.2%	31.1%
Black	41.5%	39.2%	36.0%	41.3%	33.7%	37.8%
Hispanic	29.3%	29.6%	27.4%	28.6%	26.5%	28.7%

Source: Maryland Vital Statistics Reports.

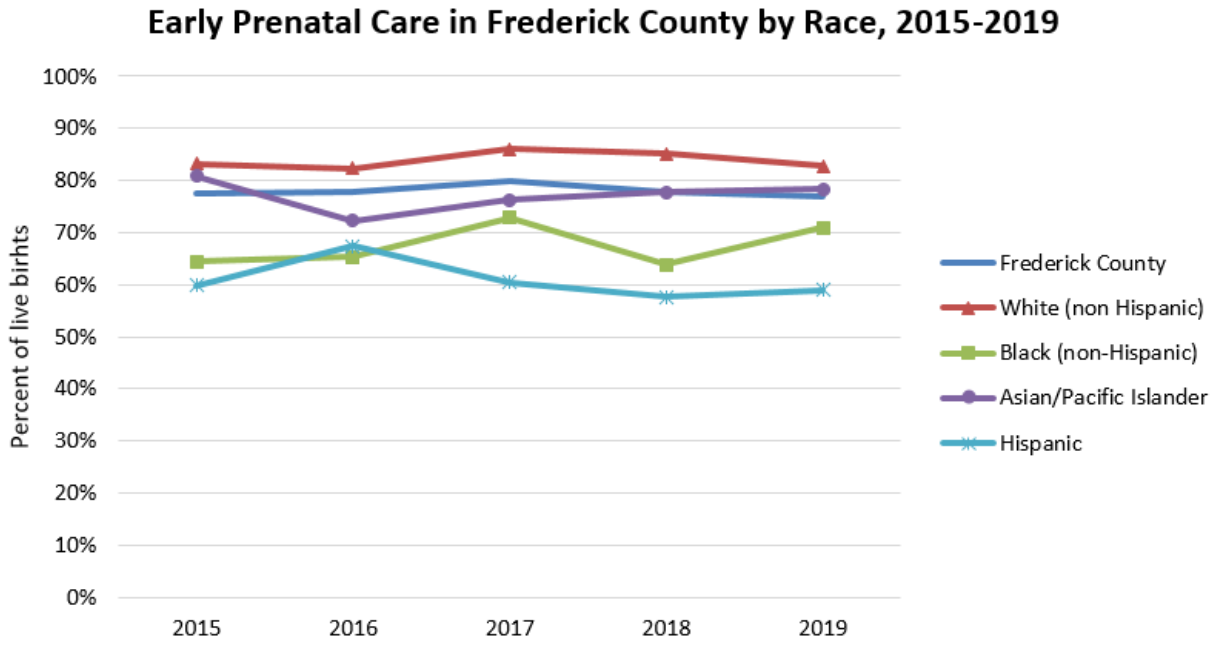


Early Prenatal Care

Early entry into prenatal care is defined as prenatal care beginning in the 1st trimester of pregnancy.

Early Prenatal Care in Frederick County, MD						Maryland
	2015	2016	2017	2018	2019	2019
Frederick County	77.5%	77.9%	80.0%	77.7%	76.8%	69.9%
White	83.2%	82.3%	86.0%	85.1%	82.7%	71.9%
Black	64.4%	65.3%	72.9%	63.8%	71.0%	66.0%
Asian/Pacific Islander	80.8%	72.2%	76.2%	77.8%	78.4%	73.8%
Hispanic	59.9%	67.4%	60.5%	57.6%	58.9%	52.0%

Source: Maryland Vital Statistics Reports.

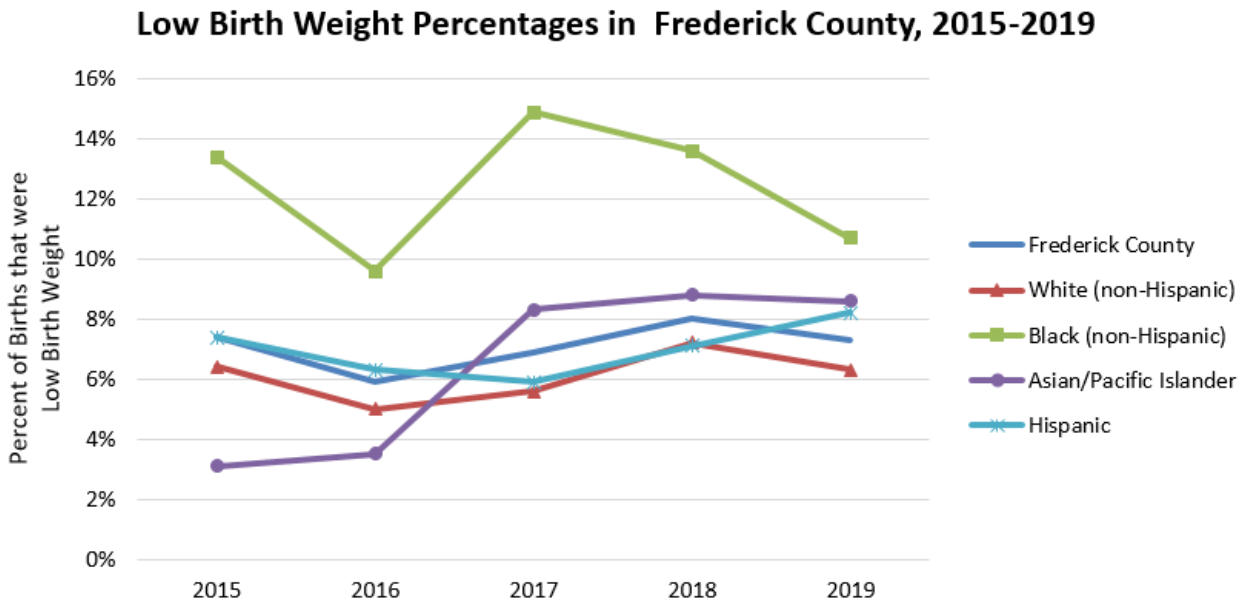


Low Birth Weight

Low birth weight is defined as a weight of less than 2500 grams at birth.

Low Birth Weight in Frederick County, MD						Maryland
	2015	2016	2017	2018	2019	2019
Frederick County	7.4%	5.9%	6.9%	8.0%	7.3%	8.7%
White	6.4%	5.0%	5.6%	7.2%	6.3%	6.6%
Black	13.4%	9.6%	14.9%	13.6%	10.7%	12.6%
Asian/Pacific Islander	3.1%	3.5%	8.3%	8.8%	8.6%	8.8%
Hispanic	7.4%	6.3%	5.9%	7.1%	8.2%	6.9%

Source: Maryland Vital Statistics Reports.

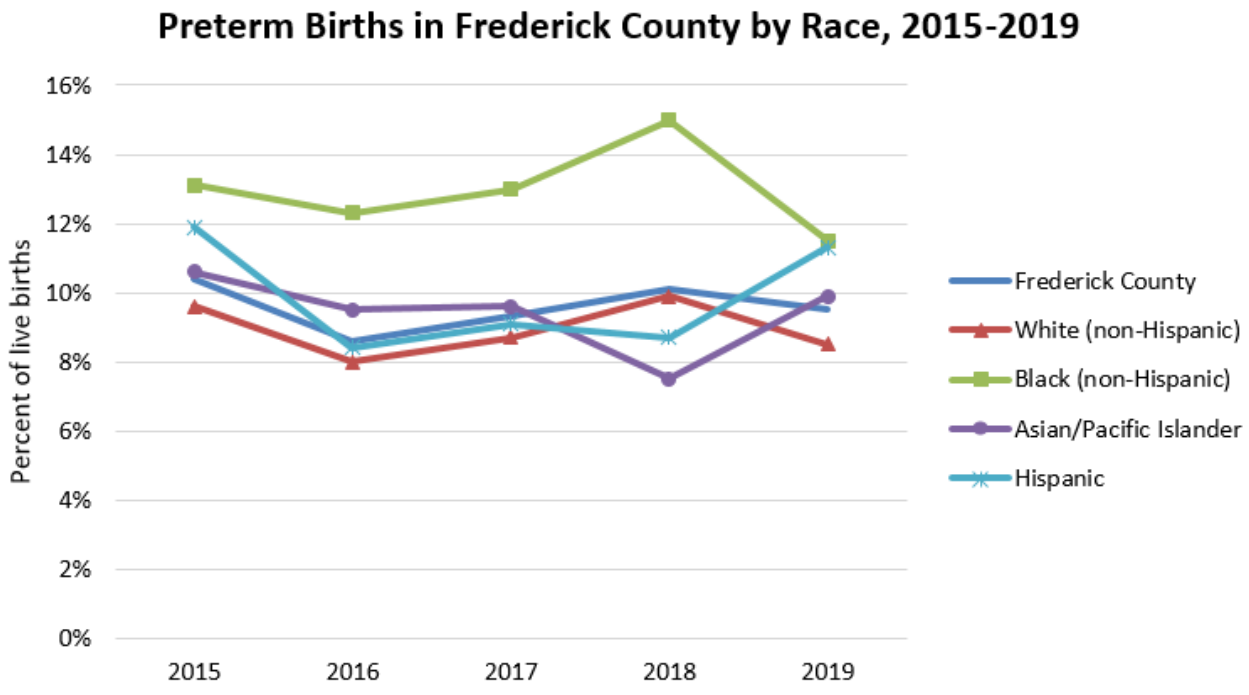


Preterm Birth

Preterm birth is less than 37 completed weeks of gestation.

Preterm Birth in Frederick County, MD						Maryland
	2015	2016	2017	2018	2019	2019
Frederick County	10.4%	8.6%	9.3%	10.1%	9.5%	10.3%
White	9.6%	8.0%	8.7%	9.9%	8.5%	8.9%
Black	13.1%	12.3%	13.0%	15.0%	11.5%	13.0%
Asian/Pacific Islander	10.6%	9.5%	9.6%	7.5%	9.9%	8.2%
Hispanic	11.9%	8.4%	9.1%	8.7%	11.3%	9.7%

Source: Maryland Vital Statistics Reports.

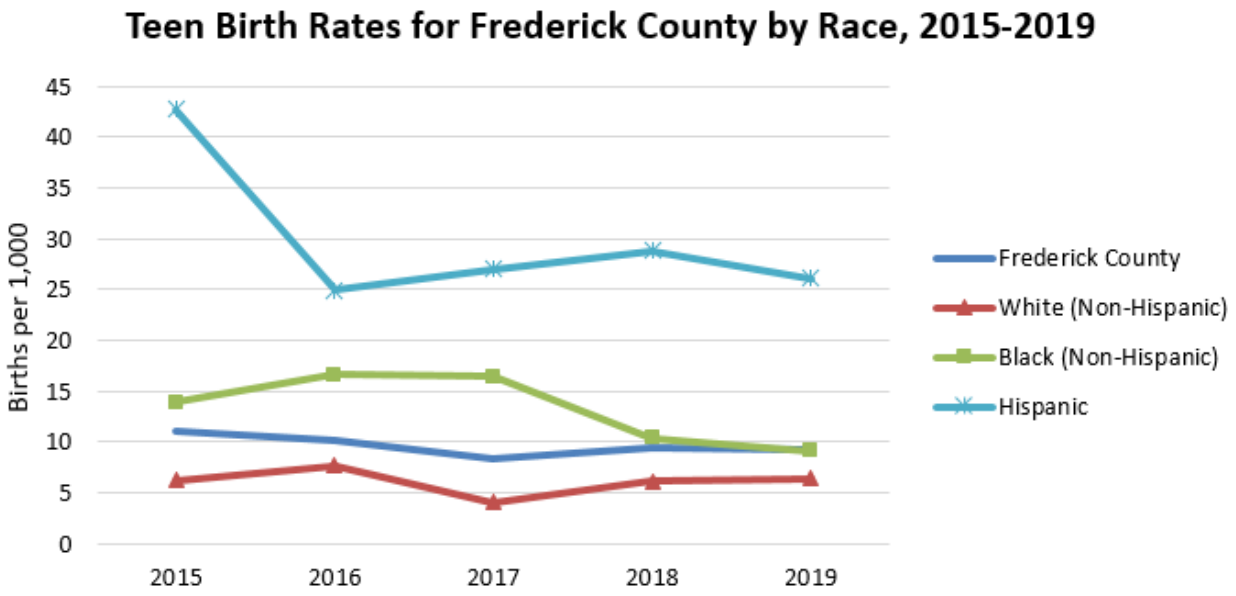


Teen Birth Rate

Teen Birth Rate in Frederick County, MD						Maryland
Rate per 1,000	**2015**	**2016**	**2017**	**2018**	**2019**	**2019**
Frederick County	11.0	10.2	8.3	9.4	9.2	13.9
White (Non-Hispanic)	6.2	7.7	4.1	6.1	6.4	7.3
Black (Non-Hispanic)	13.9	16.6	16.4	10.4	9.1	17.0
Hispanic	42.7	24.9	27.0	28.8	26.1	36.7

Source: Maryland Vital Statistics Reports.

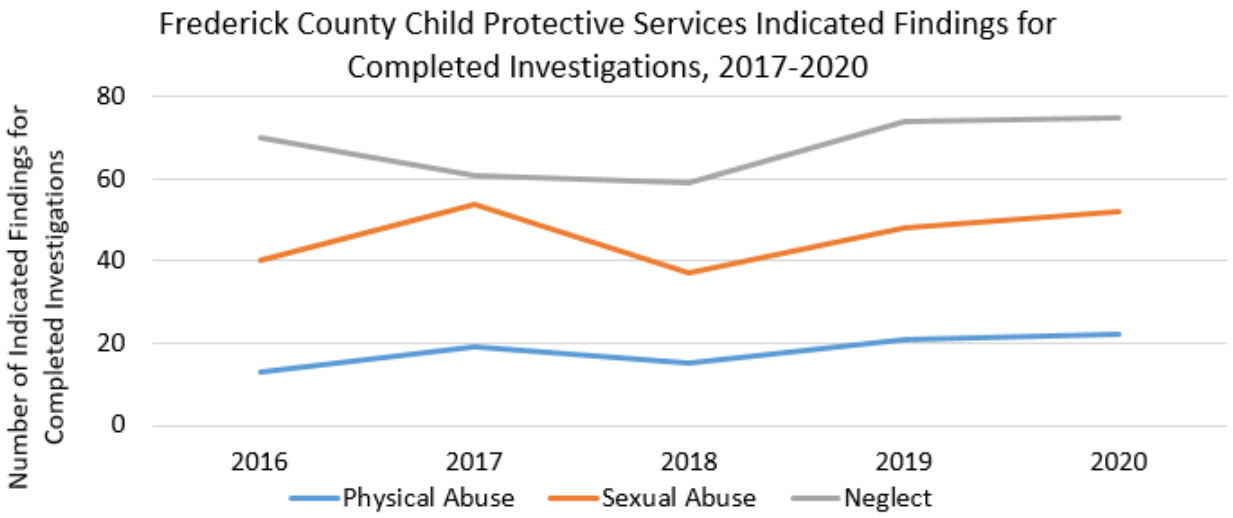
Note: Teen birth is defined as maternal age 15-19 years old. Frederick County has no data for births to mothers younger than 15 years for these report years.



Child Abuse and Neglect

Child Abuse and Neglect in Frederick County, MD					
Number of Indicated Findings for Completed Investigations	**2016**	**2017**	**2018**	**2019**	**2020**
Physical Abuse	13	19	15	21	22
Sexual Abuse	40	54	37	48	52
Neglect	70	61	59	74	75

Source: Maryland Child Welfare Trends Reports



Health Factors: Socio-Economic

Education

Population estimates, April 1, 2020	Frederick County	Maryland	United States
High school graduate or higher (25+ years) (2015-2019)	92.5%	90.2%	88.0%
Bachelor's degree or higher (25+ years) (2015-2019	41.4%	40.2%	32.1%

Data Source: U.S. Census Bureau: State and County Quick Facts; American Community Survey 5-year Estimates.

Income

Population estimates, April 1, 2020	Frederick County	Maryland	United States
Median Household Income (2015-2019)	$97,730	$84,805	$62,843
Owner-occupied housing unit rate (2015-2019)	75.2%	66.9%	64.0%
Persons per household (2015-2019)	2.67	2.67	2.62
Persons in Poverty	5.7%	9.0%	10.5%
Unemployment Rate, July 2021*	4.7%	5.8%	5.4%

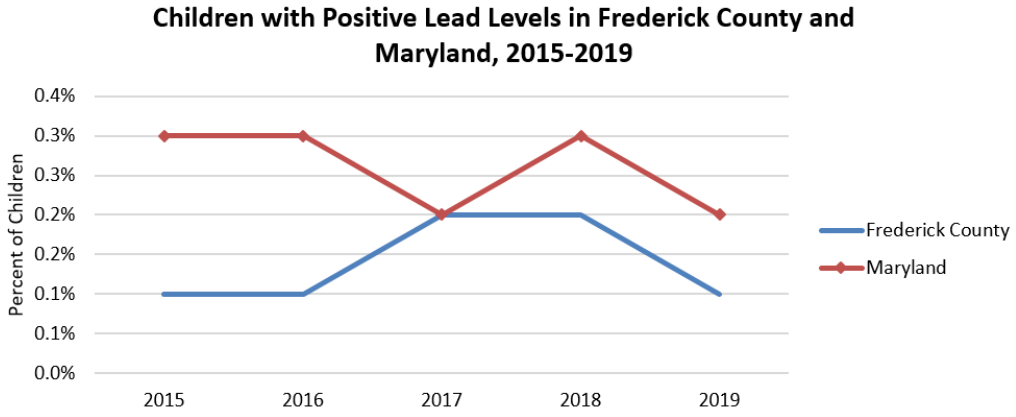
Data Source: U.S. Census Bureau: State and County Quick Facts; United States Department of Labor; Bureau of Labor Statistics
(*not seasonally adjusted preliminary unemployment rates)

Health Factors: Physical Environment

Lead Levels

Lead Levels in Frederick County, MD						Maryland
	2015	2016	2017	2018	2019	2019
Children* with positive lead levels	0.1%	0.1%	0.2%	0.2%	0.1%	0.3%

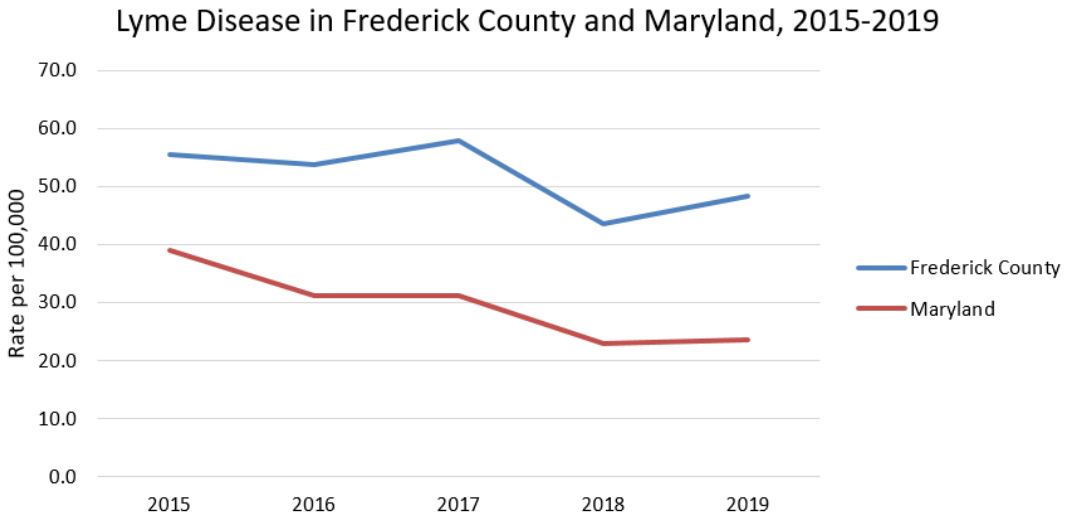
Source: Maryland Department of the Environment Annual Report on Childhood Blood Lead Surveillance in Maryland.
*Number of children (0-72 months old) with blood lead levels > 10 µg/dL



Lyme Disease

Lyme Disease in Frederick County, MD						Maryland
Rate per 100,000	2015	2016	2017	2018	2019	2019
Lyme Disease	55.4	53.7	57.9	43.4	48.3	23.5

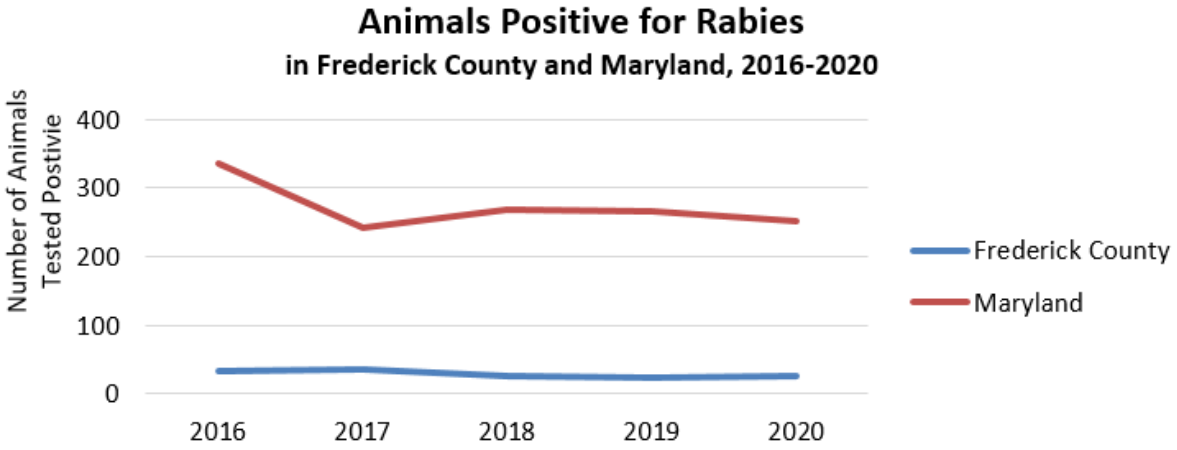
Source: Maryland Department of Health Reports of Selected Notifiable Conditions Reported in Maryland



Rabies

Rabies in Frederick County, MD						Maryland
	2016	2017	2018	2019	2020	2020
Animals testing positive for Rabies	34	35	27	25	26	251

Source: Maryland Center for Zoonotic and Vectorborne Diseases Laboratory Confirmed Rabies in Maryland Reports.

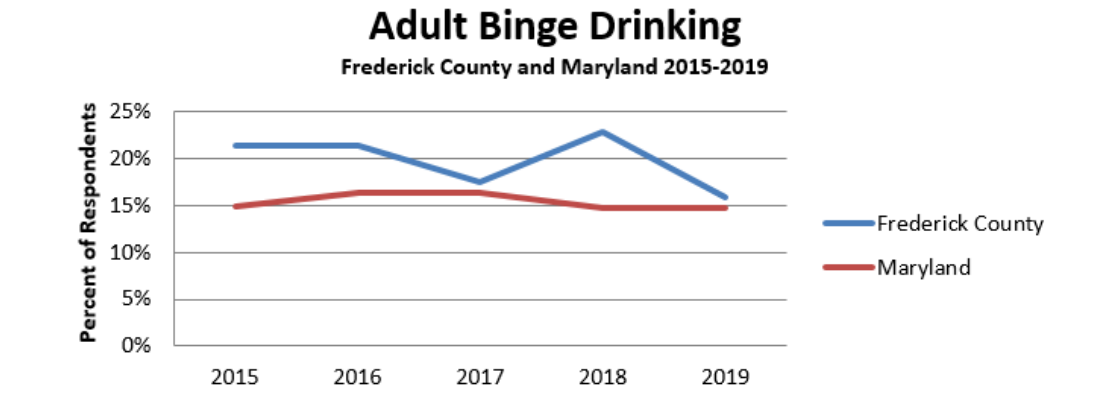


Health Factors: Health Behaviors

Alcohol

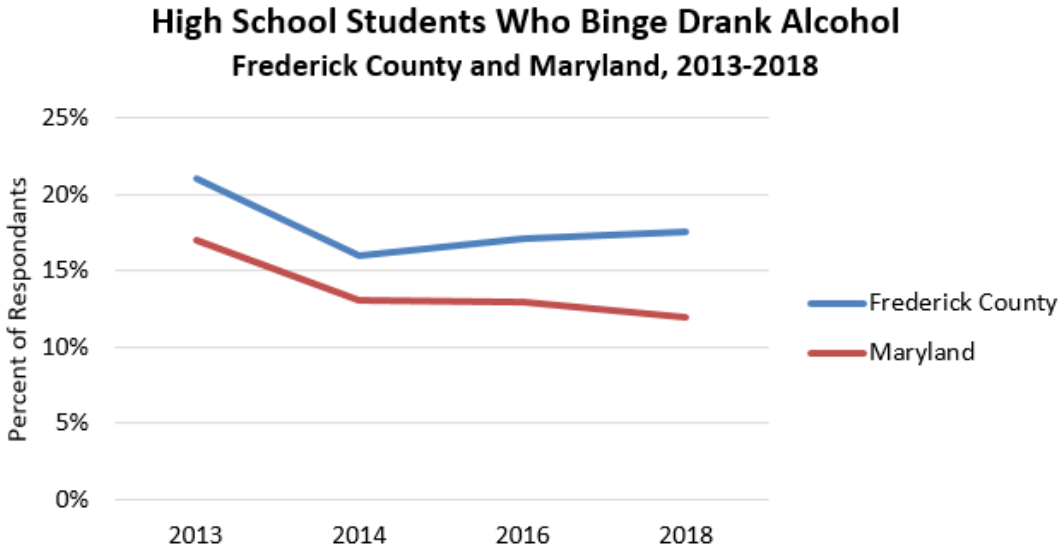
Alcohol Use (Adults) in Frederick County, MD						Maryland
	2015	2016	2017	2018	2019	2019
Binge Drinking (Adults)	21.3%	21.3%	17.5%	22.9%	15.9%	14.8%

Source: Behavioral Risk Factor Surveillance Survey. Question: BINGE DRINKERS (MALES HAVING FIVE OR MORE AND FEMALES HAVING FOUR OR MORE DRINKS ON ONE OCCASION IN THE PAST MONTH.



Alcohol Use (Adolescents) in Frederick County, MD					Maryland
	2013	2014	2016	2018	2018
Binge Drinking 1+ days per month (High School Students)	21.1%	16.0%	17.1%	17.6%	12.0%

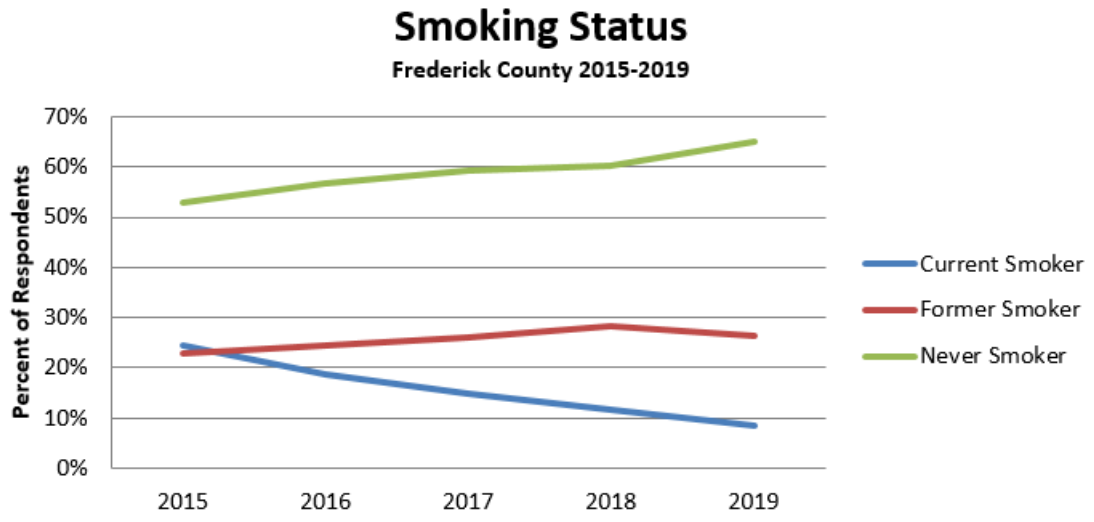
Source: Youth Risk Behavior Survey. Question: During the past 30 days, on how many days did you have 4 or more drinks of alcohol in a row, that is, within a couple of hours (if you are female) or 5 or more drinks of alcohol in a row, that is, within a couple of hours (if you are male)? Results show 1+ days in last 30 days.



Tobacco Use

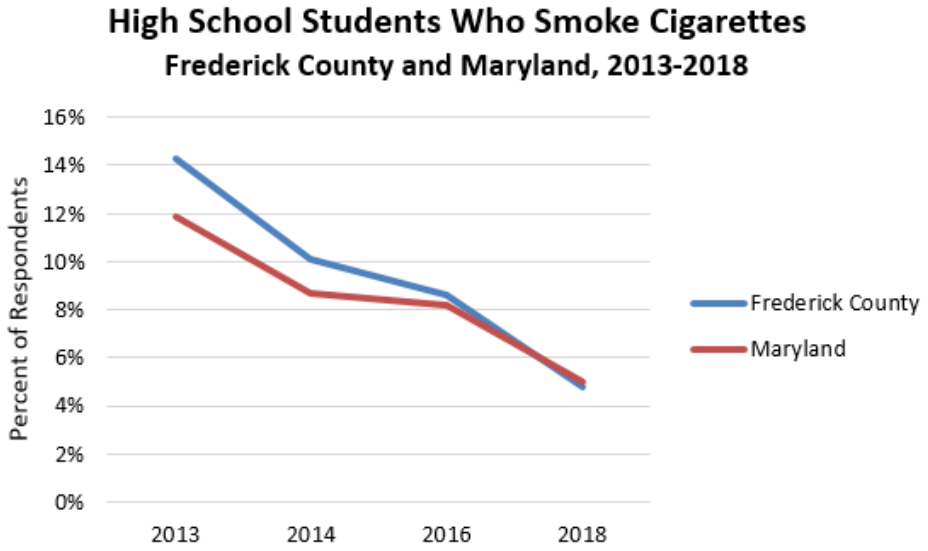
Current Smoker (Adults) in Frederick County, MD						Maryland
	2015	2016	2017	2018	2019	2019
Current Smoker	24.3%	18.7%	14.7%	11.6%	8.6%	13.1%
Former Smoker	22.8%	24.5%	26.1%	28.2%	26.4%	20.8%
Never Smoker	52.8%	56.8%	59.2%	60.2%	64.9%	66.0%

Source: Behavioral Risk Factor Surveillance Survey. Question: SMOKING STATUS.



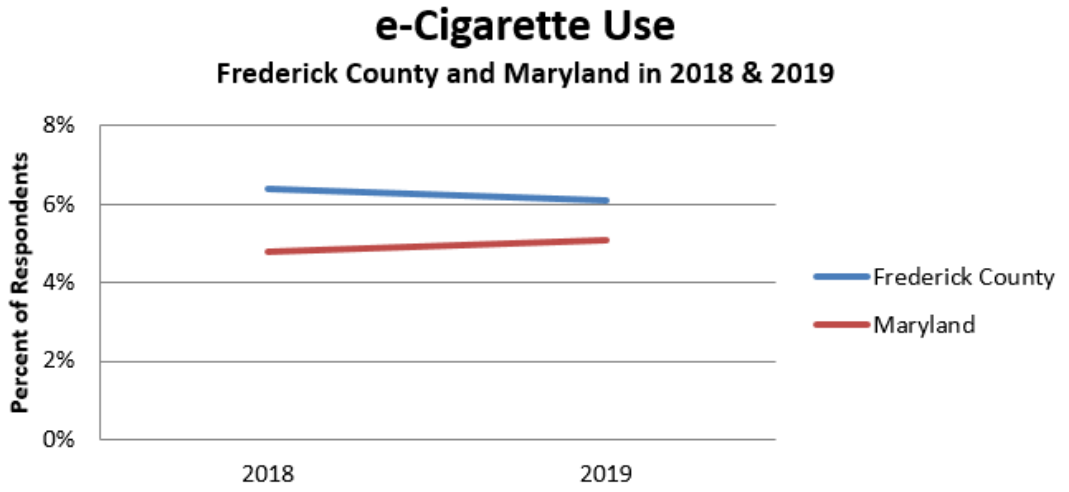
Tobacco Use (Adolescents) in Frederick County, MD					Maryland
	2013	2014	2016	2018	2018
Currently Smoke Cigarettes (High School Students)	14.3%	10.1%	8.6%	4.8%	5.0%

Source: Youth Risk Behavior Survey. Question: During the past 30 days, on how many days did you smoke cigarettes? (results show 1+ days)



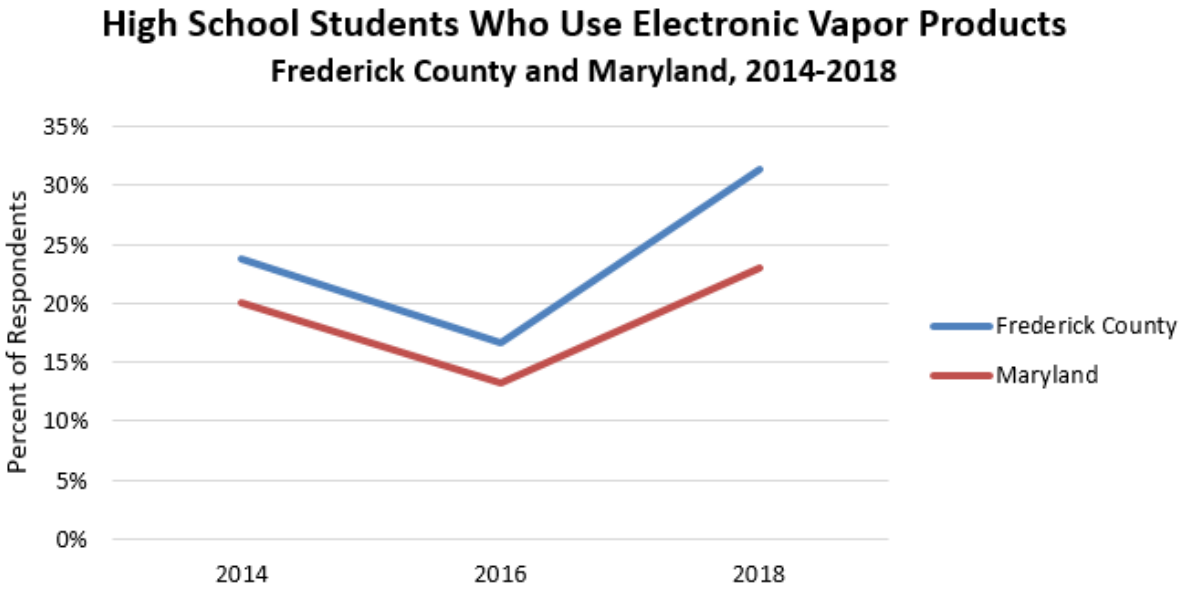
Use of e-Cigarettes (Adults) in Frederick County, MD			Maryland
	2018	2019	2019
Current e-cigarette user (Adults)	6.4%	6.1%	5.1%

Source: Behavioral Risk Factor Surveillance Survey. Question: Do you now use e-cigarettes or other electronic "vaping" products every day, some days, or not at all?



Use of e-Cigarettes (Adolescents) in Frederick County, MD				Maryland
	2014	2016	2018	2018
Current e-cigarette user (High School Students)	23.8%	16.6%	31.4%	23.0%

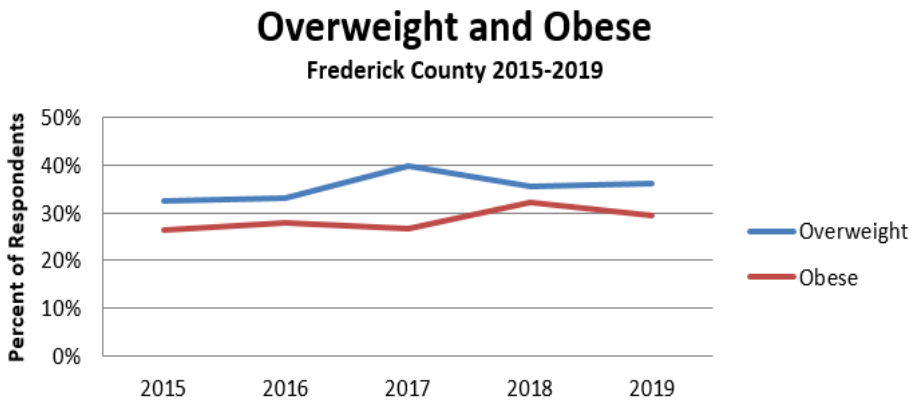
Source: Youth Risk Behavior Survey. Question: During the past 30 days, on how many days did you use an electronic vapor product? (results show 1+ days)



Weight & Exercise

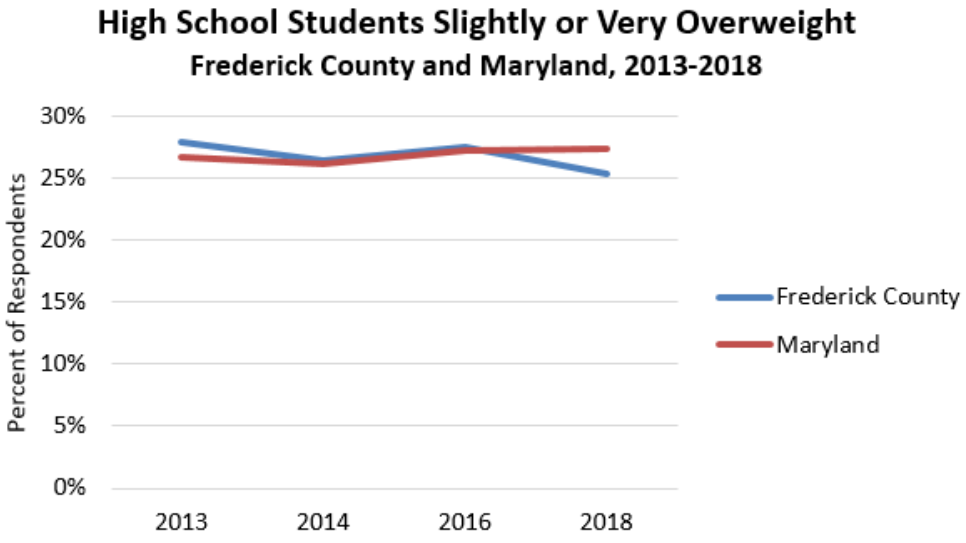
Obesity (Adults) in Frederick County, MD						Maryland
	2015	2016	2017	2018	2019	2019
Overweight	32.6%	33.0%	39.8%	35.6%	36.2%	34.6%
Obese	26.3%	28.0%	26.8%	32.1%	29.5%	32.7%

Source: Behavioral Risk Factor Surveillance Survey. Question: WEIGHT CLASSIFICATION.



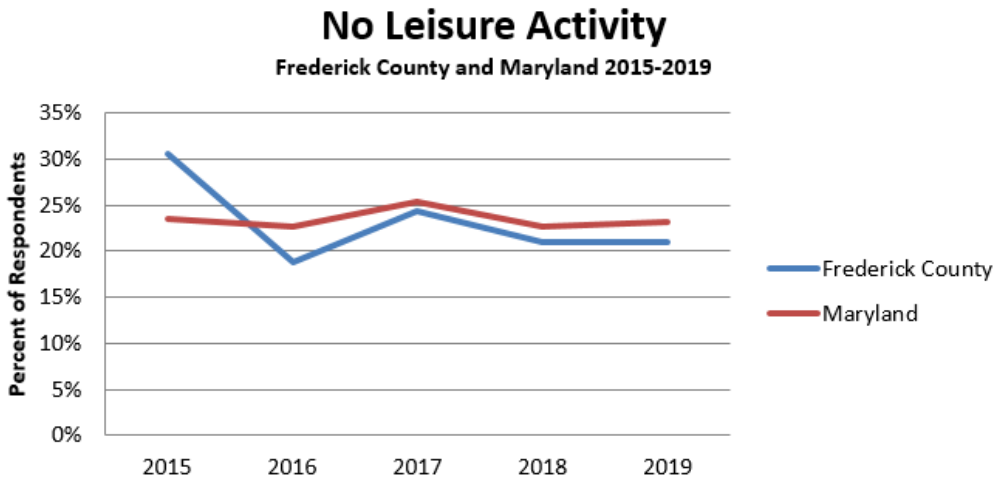
Weight (Adolescents) in Frederick County, MD					Maryland
	2013	2014	2016	2018	2018
Slightly or Very Overweight (High School Students)	27.9%	26.5%	27.5%	25.4%	27.4%

Source: Youth Risk Behavior Survey. Question: Percentage of students who described themselves as slightly or very overweight



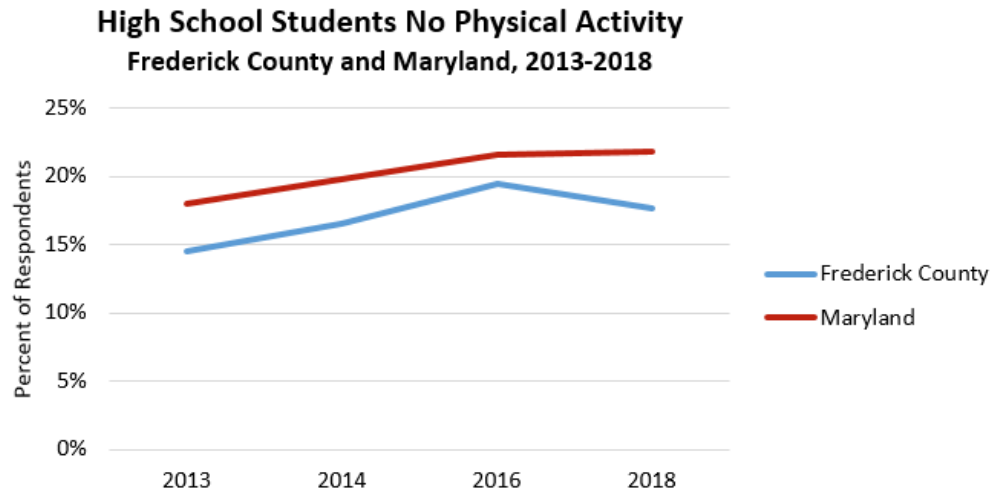
No Physical Activity (Adults) in Frederick County, MD						Maryland
	2015	2016	2017	2018	2019	2019
No Physical Activity (Adults)	30.5%	18.8%	24.4%	21.0%	21.0%	23.1%

Source: Behavioral Risk Factor Surveillance Survey. Question: NO LEISURE TIME ACTIVITY.



Physical Activity (Adolescents) in Frederick County, MD					Maryland
	2013	2014	2016	2018	2018
No Physical Activity (High School Students)	14.5%	16.5%	19.5%	17.6%	21.8%

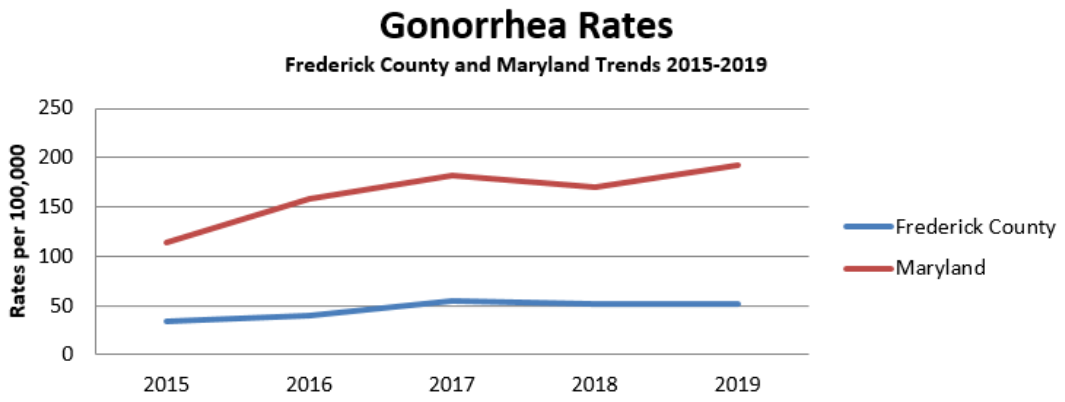
Source: Youth Risk Behavior Survey. Question: During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day?

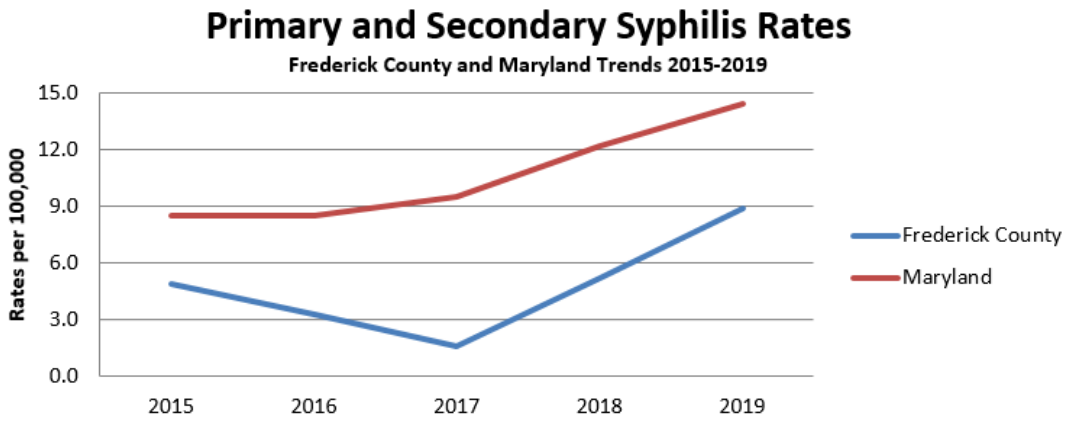


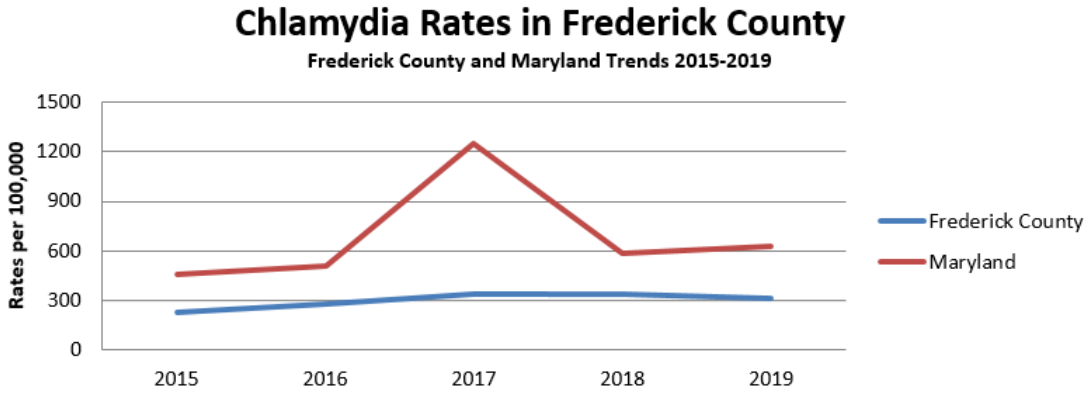
Sexual Health

Rates of Sexually Transmitted Infections in Frederick County, MD						Maryland
Rates per 100,000	**2015**	**2016**	**2017**	**2018**	**2019**	**2019**
Gonorrhea	34.6	40.2	54.8	52.0	51.2	191.8
Syphilis (Primary and Secondary)	4.9	3.3	1.6	5.2	8.9	14.4
Chlamydia	232.7	280.1	342.0	334.9	315.9	624.9

Source: Maryland STI Data and Statistics.



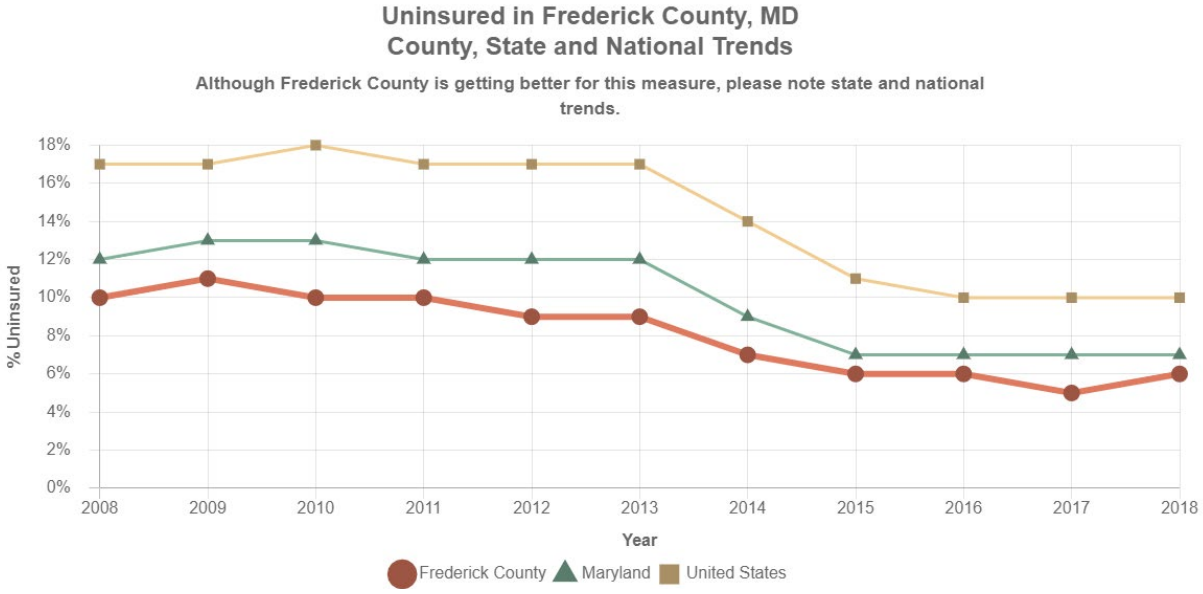


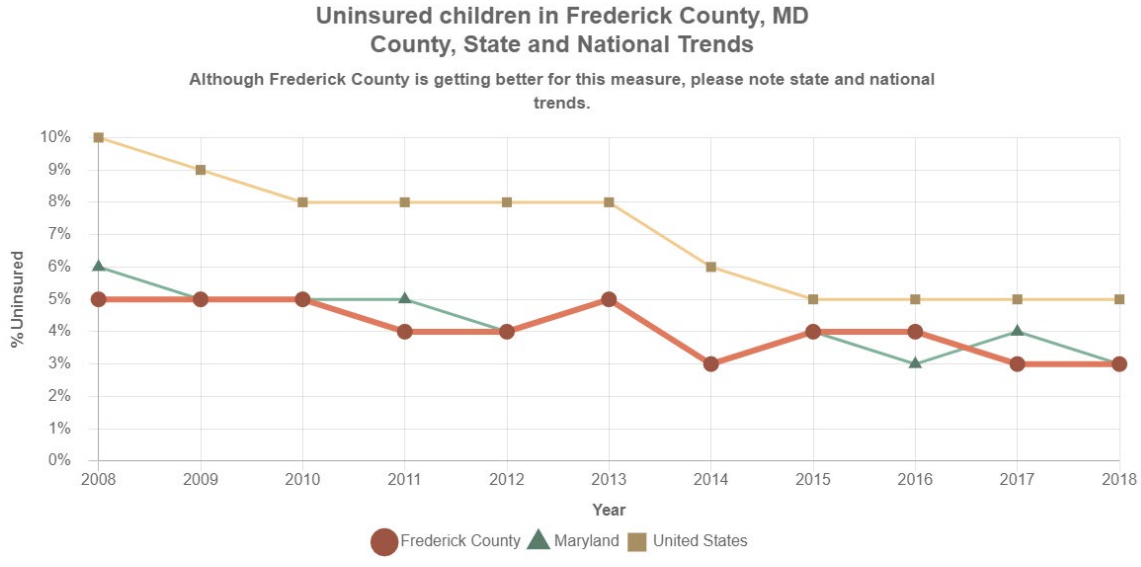


Health Factors: Clinical Care

Uninsured

Rates of Uninsured in Frederick County, MD						Maryland
Rates per 100 (%)	2014	2015	2016	2017	2018	2018
Uninsured	7.0	6.0	6.0	5.0	6.0	7.0
Uninsured Children under age 19	3.0	4.0	4.0	3.0	3.0	3.0

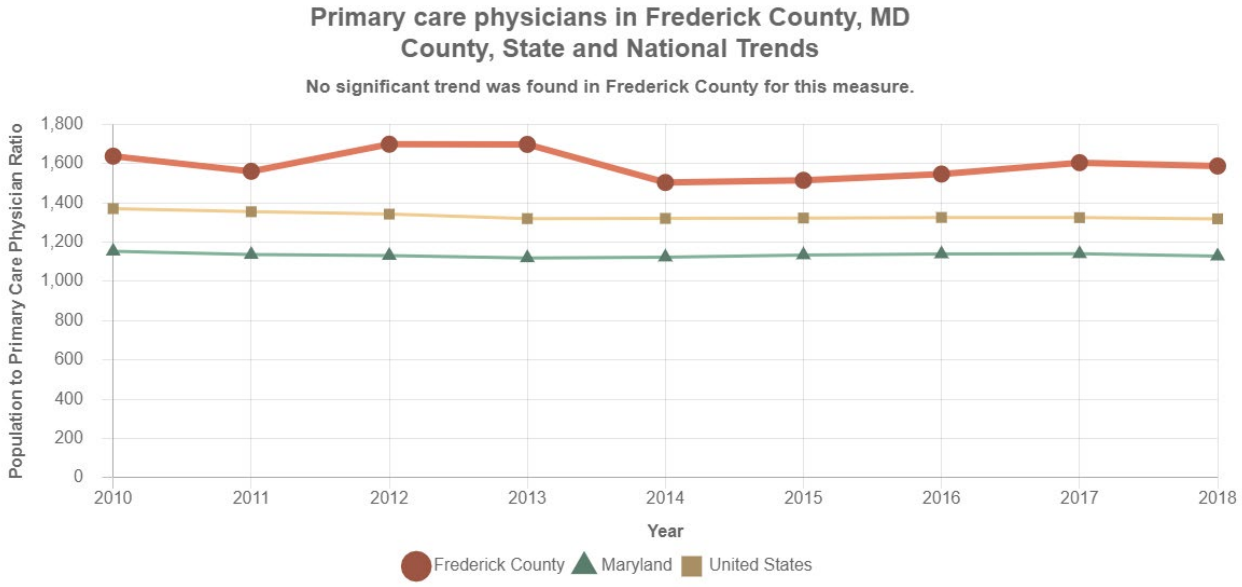




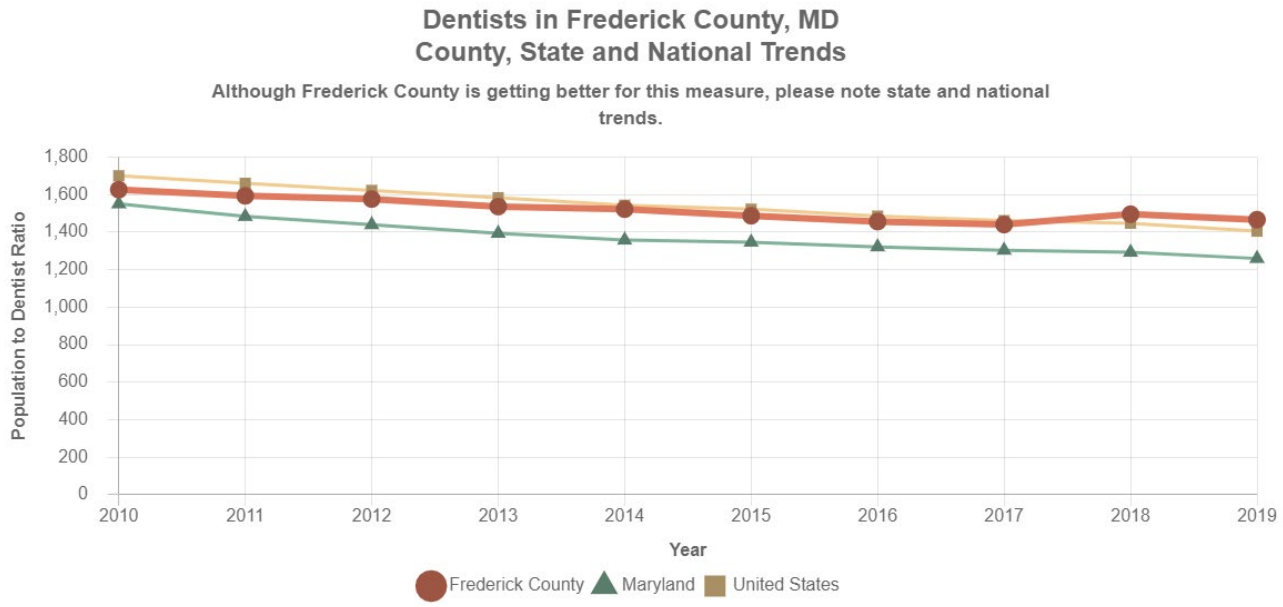
Source: County Health Rankings

Healthcare Providers

Primary Care Providers in Frederick County, MD						Maryland
Ratio of individuals served per provider #:1	2014	2015	2016	2017	2018	2018
Primary Care Providers	1504	1515	1547	1605	1588	1129



Dentists in Frederick County, MD						Maryland
Ratio of individuals served per provider #:1	2015	2016	2017	2018	2019	2019
Dentists	1487	1456	1440	1495	1466	1259

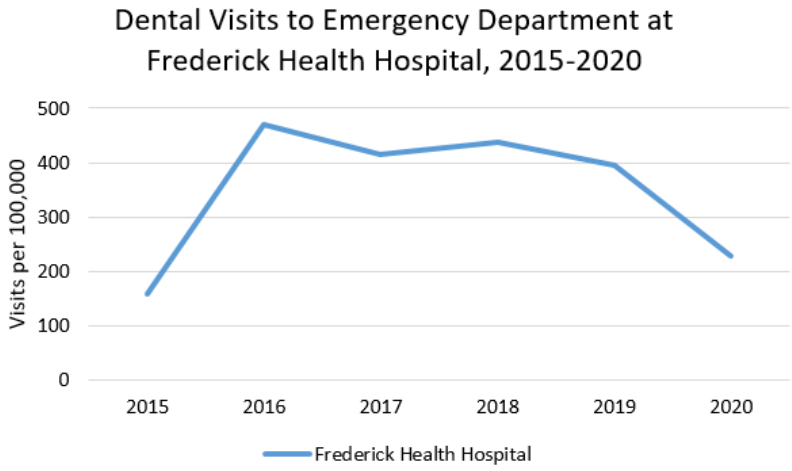


Source: County Health Ranking

Dental Visits to Emergency Department

Dental Visits to Emergency Department in Frederick County, MD							
Visits per 100,000 population	2015	2016	2017	2018	2019	2020	2021 (Jan-Jun)
Dental ED Visits	158.6	470.0	415.9	436.5	394.6	229.4	56.5

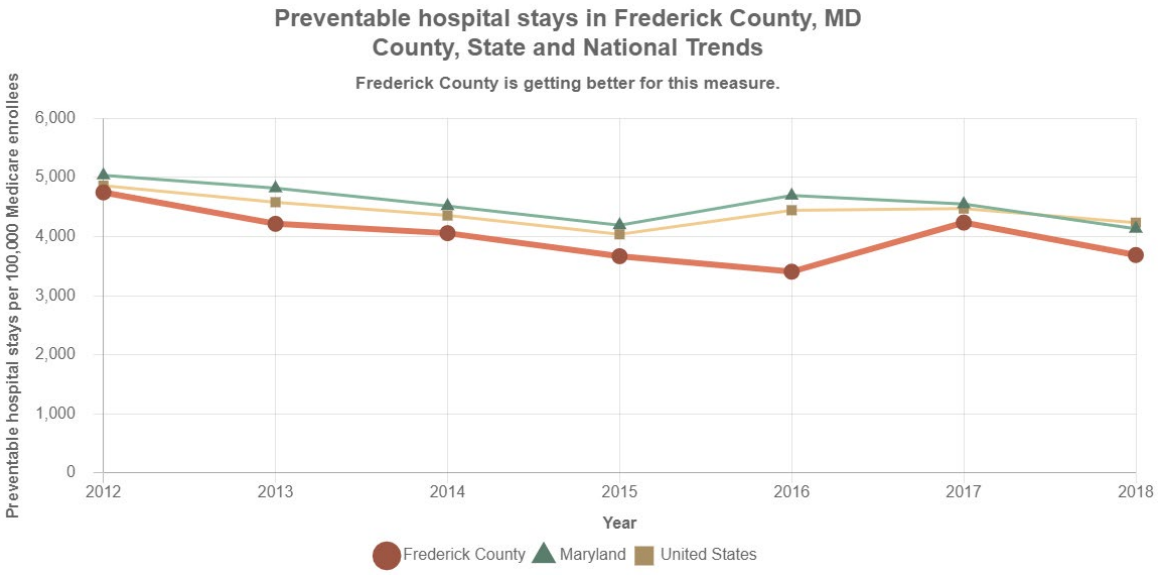
Source: Frederick Health Hospital primary diagnosis codes for all Emergency Department Visits Jan. 1, 2015 through June 30, 2021.



Preventable Hospital Stays

Preventable Hospital Stays in Frederick County, MD						Maryland
Stays per 100,000 Medicate Enrollees	2014	2015	2016	2017	2018	2018
Preventable Hospital Stays	4059	3669	3407	4238	3689	4134

Source: County Health Ranking



Appendix 3. Healthy People 2030 Goals Included in this Assessment

	Measure	HP2020 Goal	Frederick County Value	Frederick County Year	Did FC Meet Goal?
C-01	Reduce the overall cancer death rate to 122.7 deaths per 100,000 population.	122.7	152.5	2016	No
C-02	Reduce the lung and bronchus cancer death rate to 25.1 deaths per 100,000 population.	25.1	35.1	2012-2016	No
C-04	Reduce the female breast cancer death rate to 15.3 deaths per 100,000 population.	15.3	21.6	2012-2016	No
C-06	Reduce the colorectal cancer death rate to 8.9 deaths per 100,000 population.	8.9	13.9	2012-2016	No
C-08	Reduce the prostate cancer death rate to 16.9 deaths per 100,000 population.	16.9	19.1	2012-2016	No
D-09	Reduce diabetes death rate to 13.7 deaths per 100,000 population.	13.7	20.6	2017-2019	No
HDS-02	Reduce coronary heart disease deaths to 71.1 deaths per 100,000 population	71.1	148.6	2017-2019	No
HDS-04	Reduce the proportion of persons in the population with hypertension to 27.7%.	27.7%	28.5%	2019	No
MHMD-01	Reduce the suicide rate to 12.8 suicides per 100,000 population	12.8	12.4	2017-2019	Yes
MICH-01	Reduce rate of infant deaths to 5.7 deaths per 1,000 live births	5.7	4.4	2019	Yes
MICH-07	Reduce total preterm births to 9.4% of live births	9.4%	9.5%	2019	No
MICH-08	Increase the proportion of pregnant women who receive early and adequate prenatal care to 80.5%	80.5%	76.8%	2019	No
SU-10	Reduce the proportion of persons aged 21 years and over engaging in binge drinking of alcoholic beverages during the past 30 days to 25.4%	25.4%	15.9%	2019	Yes
TU-02	Reduce cigarette smoking by adults to 5.0%	5.0%	8.6%	2019	No

https://health.gov/healthypeople/objectives-and-data/browse-objectives

Appendix 4. Disparities

At this time, county level data is not available to examine the role of income, education, and other social determinants of health for health disparities. Some data is available for certain topics by gender, race and/or ethnicity. The following list shows health disparities in Frederick County. Other disparities may exist, but this list consists of topics where data was available at the county level for both genders and/or at least two races.

≠ Data shows health disparity

Health Indicator	Data Source	Disparities Identified		
		Gender	Race/ Ethnicity	Details
Adverse Childhood Experiences (ACEs in adolescents) (1+)	2018 YRBS	≠	≠	Vary by question
Binge Drinking	2019 BRFSS & 2018 MD YRBS	≠	≠	White female adolescents
Breast Cancer (incidence)	2019 MD CRF Report	N/A	≠	Black
Colorectal Cancer (incidence)	2019 MD CRF Report	≠	≠	Men and Black
C-section Births	2019 MD Vital Stats	N/A	≠	Black
Early Prenatal Care (did not get)	2019 MD Vital Stats	N/A	≠	Hispanic, Black
Electronic Vapor Product Use (Adults & adolescents)	2019 BRFSS & 2018 MD YRBS	≠	≠	White female and multiple race male adolescents
Infant mortality	2019 MD Vital Stats	Data not Available	≠	Black
Low birth weight	2019 MD Vital Stats	N/A	≠	Blacks, Hispanic, White
Lung Bronchus Cancer (incidence)	2019 MD CRF Report	≠	-	Men
Melanoma Cancer (incidence)	2019 MD CRF Report	≠	Insuff. data	Men
No Physical Activity (Adults & Adolescents)	2019 BRFSS & 2018 MD YRBS	≠	≠	Black and Hispanic female adolescents
Obesity (adults & adolescents)	2019 BRFSS & 2018 MD YRBS	≠	≠	White and Hispanic female adolescents
Oral Cancer (incidence)	2019 MD CRF Report	≠	Insuff. data	Men
Preterm birth	2019 MD Vital Stats	N/A	≠	Black, Asian, Hispanic
Prostate Cancer (incidence)	2019 MD CRF Report	N/A	≠	Black
Teen birth rate	2019 MD Vital Stats	N/A	≠	Black and Hispanic
Tobacco Use (Current adult Smoker & Current Cigarette use adolescents)	2019 BRFSS & 2018 MD YRBS	≠	≠	Male Hispanic adolescents

For detailed data, go to the Secondary Data.

Appendix 5. Frederick County Health Indicators: Prioritization Matrix

Health Indicators	Source	Size	Rate	Number affected*	% of FC population	Severity	Severity notes	Trend	Trend notes	Impact on other indicators	Impact notes	Variance vs benchmark	Benchmark	Community Perception	Notes	Disparity	Notes	SIHIS Goal	Score	Rank
No Physical Activity (Adults & Adolescents)	2019 BRFSS & 2018 MD YRBS	2	21.0% of adults and 17.6% high school students	46,960	17.3%	2	Can contribute to chronic illness	1	Trend worsening for Teens	3	Increases risk of heart disease, some cancers	0	No comparable benchmark	3	Concern: lack of exercise	3	Higher for black and hispanic female adolescents	3	17	1
Obesity (adults & adolescents)	2019 BRFSS & 2018 MD YRBS	3	29.5% of adults & 25.4% high school student	66,085	24.3%	2	Intervention strongly recommended	0	trend is slightly worsening for adults, decreasing for teens	3	Increases risk of heart disease, some cancers	0	No comparable benchmark	3	Concern: lack of exercise, poor eating habits	3	Higher for white and hispanic female adolescents	3	17	2
Hypertension	2019 BRFSS	3	28.5% of adults	59,551	21.9%	3	Intervention urgent; leading cause of death	1	trend is slightly worsening	3	Increases risk of stroke, dementia, kidney problems, heart disease	1	HP2020 27.7%				No disparity data available	3	14	3
Binge Drinking	2019 BRFSS & 2018 MD YRBS	2	15.9% of adults and 17.6% high school students	36,303	13.4%	2	Can cause chronic illness	0	Trend worsening	3	Risk of liver disease, heart damage, some cancer	0	No comparable benchmark	3	Concern: alcohol misuse or abuse	3	Higher for white female adolescents		13	4
Early Prenatal Care (did not get)	2019 MD Vital Stats	1	23.2% of births	681	0.3%	1	Lost opportunity for early intervention	0	Steady	3	reduces pregnancy complications	1	HP 2030 80.5% (FC 76.8%)			3	Worse: Hispanic, Black	3	12	5
Tobacco Use (Current adult Smoker & Current Cigarette use adolescents)	2019 BRFSS & 2018 MD YRBS	1	8.6% of adults & 4.8% high school student	18,810	6.9%	2	Can cause chronic illness	-1	trend improving	3	Increases risk of cerebralvascular disease and some cancers	1	HP 2030 5.0% (FC 8.6%)	3	Concern: tobacco use	3	Higher for hispanic adolescents		12	6
Adverse Childhood Experiences (ACEs in adolescents) (1+)	2018 YRBS	1	50.3% of high school students	8,838	3.3%	2	Early life impact can cause chronic, generational issues, intervention	0	Unknown	3	Increases risk for chronic disease, early death	0	No comparable benchmark	2	Concern: child abuse and neglect	3	Vary by question		11	7
Breast Cancer (incidence)	2019 MD CRF Report	1	121.1	329	0.12%	3	Intervention urgent; leading cause of death	1	trend worsening, especially for blacks	2	Higher risk of other cancers	1	death: HP 2030 15.3/100,000 (FC 21.6)			3	Worse: Black		11	8
Diabetes	2019 BRFSS	1	9.0% of adults	18,806	6.9%	3	Leading cause of death, chronic condition, can cause disability	1	Incidence steady, mortality increasing	2	Causes problems in eyes, kidneys, feet, nerves	1	Deaths: HP 2030 13.7 deaths per 100,000; FC at 20.6				No disparity data available	3	11	9
Mental Health (8-30 days not good/month)	2019 BRFSS	2	16.4% of adults	34,268	12.6%	2	Can contribute to chronic illness	1	increasing for 8-29 days	3	Linked to higher unemployment, poverty, disability, early death	0	No comparable benchmark	3	Concern: Services difficult to get		No disparity data available		11	10

Health Indicators	Source	Size	Rate	Number affected*	% of FC population	Severity	Severity notes	Trend	Trend notes	Impact on other indicators	Impact notes	Variance vs benchmark	Benchmark	Community Perception	Notes	Disparity	Notes	SIHIS Goal	Score	Rank
Overdose deaths	2020 Unintentional Drug- and Alcohol-Related Intoxication Deaths in	1	23.6	78	0.02%	3	Intervention urgent; leading cause of death	0	Decreasing for opioid, heroin, increasing for fentanyl, cocaine	1		0	No comparable benchmark	3	Concern: drug misuse or abuse		No disparity data available	3	11	11
Preterm birth	2019 MD Vital Stats	1	9.5% of births	279	0.1%	2	Can cause poor health outcomes	0	overall trending steady, improving for Black, worsening for Hispanic	3	risk of respiratory distress, developmental delays	1	HP 2030 9.4% (FC 9.5%)			3	Higher for Blacks, Asians, Hispanic		10	12
Asthma	2019 BRFSS	2	14.9% of adults	31,134	11.5%	2	Chronic condition that increases in severity, can cause disability	0	Trend steady	2	linked to anxiety and depression, other lung issues, physical activity	0	No comparable benchmark				No disparity data available	3	9	13
Child Abuse and Neglect	Maryland Child Welfare Trends Reports	1		149	0.1%	2	Intervention strongly recommended	1	Trend worsening	3	Childhood trauma can increase risk for diabetes, heart disease	0	No comparable benchmark	2	Concern: child abuse and neglect		No disparity data available		9	14
Heart disease (deaths)	2019 MD Vital Stats	1	148.6	404	0.15%	3	Leading cause of death	-1	Trend improving	2	Increased risk of stroke	1	HP 2030 71.1/100,000 (FC 148.6)				No disparity data available	3	9	15
Low birth weight	2019 MD Vital Stats	1	7.3% of births	214	0.1%	2	Can cause poor health outcomes	0	overall trending steady for Asian, improving for Black, worsening for Hispanic and White	3	increased risk of obesity, hypertension, diabetes, heart disease	0	No comparable benchmark			3	Higher for Blacks, Hispanic, White		9	16
Melanoma Cancer (incidence)	2019 MD CRF Report	1	23.6	64	0.02%	3	Intervention urgent	1	trend worsening	1		0	No comparable benchmark			3	Higher for men		9	17
Adverse Childhood Experiences (ACEs) (3+)	2018 BRFSS	2	15.3% of adults	31,969	11.8%	2	Early life impact can cause chronic, generational issues, intervention strongly rec.	1	Trend worsening	3	Increases risk for chronic disease, early death	0	No comparable benchmark				No disparity data available		8	18
Alcohol Use (binge adults)	2019 BRFSS	2	15.9% of adults	33,223	12.2%	2	Can cause chronic illness	-1	trend improving	3	Risk of liver disease, heart damage, some cancer	-1	HP 2030 25.4% (FC 15.9)	3	Concern: alcohol misuse or abuse		No disparity data available		8	19
Colorectal Cancer (incidence)	2019 MD CRF Report	1	35.6	97	0.04%	2	Intervention strongly recommended	-1	trend improving	2	Higher risk of other cancers	1	death: HP 2030 8.9/100,000 (FC 13.9)			3	Higher for men and Blacks		8	20
COPD	2019 BRFSS	1	4.2% of adults	8,776	3.2%	2	Chronic condition that increases in severity, can cause disability	0	Overall steady, slight increase	2	heart attacks, strokes, and lung cancer	0	No comparable benchmark				No disparity data available	3	8	21

Health Indicators	Source	Size	Rate	Number affected*	% of FC population	Severity	Severity notes	Trend	Trend notes	Impact on other indicators	Impact notes	Variance vs benchmark	Benchmark	Community Perception	Notes	Disparity	Notes	SIHIS Goal	Score	Rank
Lung Bronchus Cancer (incidence)	2019 MD CRF Report	1	46.9	127	0.05%	3	Intervention urgent	-1	trend improving	1		1	death: HP 2030 25.1/100,000 (FC 35.1)			3	Higher for men		8	22
Teen birth rate	2019 MD Vital Stats	1	9.2 per 1000 live births	79	0.03%	1		0	Trend steady	3	low birth weight, infant mortality	0	No comparable benchmark			3	Higher for Black and Hispanic		8	23
Child lead levels	2019, Childhood Blood Lead Surveillance in Maryland Annual Report	1	0.1% of children 0-72 mo.	5	0.002%	3	Intervention urgent	0	Trend steady	3	increased risk of neurological and learning issues	0	No comparable benchmark				No disparity data available		7	24
C-section Births	2019 MD Vital Stats	1	31.2% of births	916	0.3%	1	generally short term impact	0	Trend steady, slight decline for Blacks	2	major surgery, increases risk in future pregnancies	0	No comparable benchmark			3	Higher for Blacks		7	25
Electronic Vapor Product Use (Adults & adolescents)	2019 BRFSS & 2018 MD YRBS	1	6.1% of adults & 31.4% high school student	18,241	6.7%	1	long term effects still unknown	1	Trend worsening for Teens	1	long term effects still unknown, possible health risks	0	No comparable benchmark			3	Higher for white female and multiple race male adolescents		7	26
Oral Cancer (incidence)	2019 MD CRF Report	1	10.8	29	0.01%	2	Intervention strongly recommended	0	trend steady	1		0	No comparable benchmark			3	Higher for men		7	27
Syphilis	2019 MDH Report	1	8.9	24	0.01%	2	Intervention strongly recommended	1	trend is slightly worsening	3	dementia, blindness	0	No comparable benchmark				No disparity data available		7	28
Arthritis	2019 BRFSS	2	25.9% of adults	54,118	19.9%	2	Chronic condition that increases in severity, can cause disability	1	Worsening trend	1	linked to anxiety and depression, mobility, quality of life	0	No comparable benchmark				No disparity data available		6	29
Chlamydia	2019 MDH Report	1	313.9	858	0.32%	2	Intervention strongly recommended	0	Trend steady	3	infertility, pregnacy complications	0	No comparable benchmark				No disparity data available		6	30
Gonorrhea	2019 MDH Report	1	51.2	139	0.05%	2	Intervention strongly recommended	0	Trend steady	3	infertility, pregnacy complications	0	No comparable benchmark				No disparity data available		6	31
Infant mortality	2019 MD Vital Stats	1	4.4	12	0.44%	3	Intervention urgent	-1	Trend improving	1		-1	HP 2030 5.7/1,000 (FC 4.4)			3	Worse: Black		6	32
Influenza and Pneumonia (deaths)	2019 MD Vital Stats	1	11.5	31	0.01%	3	Leading cause of death	1	trend improving	1		0	No comparable benchmark				No disparity data available		6	33
Prostate Cancer (incidence)	2019 MD CRF Report	1	98.2	267	0.10%	1	Intervention not urgent	-1	trend improving	1		1	death: HP 2030 16.9/100,000 (FC 19.1)			3	Higher for Blacks		6	34
Accident (deaths)	2019 MD Vital Stats	1	31.2	85	0.03%	3	Leading cause of death	0	trend steady	1		0	No comparable benchmark				No disparity data available		5	35

Health Indicators	Source	Size	Rate	Number affected*	% of FC population	Severity	Severity notes	Trend	Trend notes	Impact on other indicators	Impact notes	Variance vs benchmark	Benchmark	Community Perception	Notes	Disparity	Notes	SIHIS Goal	Score	Rank
Cerebrovascular Disease (deaths)	2019 MD Vital Stats	1	35.2	96	0.04%	3	Leading cause of death	0	trend steady	1		0	No comparable benchmark				No disparity data available		5	36
Chronic Lower Respiratory Disease (deaths)	2019 MD Vital Stats	1	33.0	90	0.03%	3	Leading cause of death	0	trend steady	1		0	No comparable benchmark				No disparity data available		5	37
HIV	2019, MD Annual HIV Epidemiological Profile	1	6.0	13	0.01%	3	Untreated can lead to death	-1	recent improvement	2	risk of co-ocurring STIs	0	No comparable benchmark				No disparity data available		5	38
Intentional Self- Harm/ Suicide	2019 MD Vital Stats	1	12.4	34	0.01%	3	Leading cause of death	1	trend worsening	1		-1	HP 2030 12.8/100,000, FC 12.4				No disparity data available		5	39
Maternal Mortality	2019 MD Maternal Mortality Report	1	0 reported since 2014	0	0.00%	3		0	trend steady	1		0	No comparable benchmark				No local disparity data available		5	40
Rabies (animals testing positive)	2020 MD CZVBD	1		26 animals positive	N/A	3	Untreated can lead to death	0	trend steady	1		0	No comparable benchmark				No disparity data available		5	41
Alzheimer's Disease (deaths)	2019 MD Vital Stats	1	14.3	39	0.01%	3	Leading cause of death	-1	Trend improving	1		0	No comparable benchmark				No disparity data available		4	42
Dental Care (ED visits)	2020 FHH Data	1	229.4	623	0.23%	1		-1	trend improving, may be lower due to COVID	3	increase risk of heart attack, stroke	0	No comparable benchmark				No disparity data available		4	43
Lyme Disease	2019 MD Reportable Diseases	1	48.3	131	0.05%	2	Can cause chronic illness	-1	Overall improving	2	Untreated can cause arthritis and nervous system issues.	0	No comparable benchmark				No disparity data available		4	44
Cervical Cancer (incidence)	2019 MD CRF Report	1	4.5	12	0.005%	1	Intervention not urgent	0	trend steady	1		0	No comparable benchmark				No disparity data available		3	45

Appendix 6. Readiness Assessment Survey Results

Rank	Health Priority	1. What Stage?	2. Resources Available?	3. Existing Efforts?	4. Role of Coalition	5. Change in 3 yrs?	6. Impact other problems?	Total Score	Total Point Possible	Percent Score
1	Diabetes	29	31	29	24	30	31	174	198	88%
2	ACEs in Adolescents (1+)	29	29	31	24	28	31	172	198	87%
3	Early Prenatal Care (did not get)	29	27	27	25	27	27	162	198	82%
4	Mental Health (8-30 days not good/month)	25	23	27	25	25	28	153	198	77%
5	Obesity (adults & adolescents)	30	26	27	22	28	33	166	216	77%
6	Lack of Physical Activity	29	28	26	20	27	33	163	216	75%
7	Hypertension	22	25	27	26	30	29	159	216	74%
8	Breast Cancer (incidence)	27	28	27	14	26	22	144	198	73%
9	Overdose Deaths	28	26	26	15	25	23	143	198	72%
10	Tobacco Use (current adult smoker & current cigarette use adolescents)	25	25	24	16	24	27	141	198	71%
11	Binge Drinking	19	23	21	20	25	27	135	216	63%

Appendix 7. Community Health Survey

2021 Frederick Community Health Survey

The purpose of this survey is to get the opinions of Frederick County residents about the community health issues in Frederick County, Maryland. The Frederick County Health Care Coalition, Frederick County Health Department and Frederick Health will use this information to identify health priorities and to address these priorities through community action. All questions are optional and your answers are anonymous and confidential. This survey should take no more than 10 minutes of your time to complete.

1. To ensure we're reaching people in the right area, what is your zip code?

1 --21701	13 --21754	25 --21777
2 --21702	14 --21755	26 --21778
3 --21703	15 --21757	27 --21780
4 --21704	16 --21758	28 --21788
5 --21705	17 --21759	29 --21790
6 --21709	18 --21762	30 --21792
7 --21710	19 --21769	31 --21793
8 --21714	20 --21770	32 --21798
9 --21716	21 --21771	33 --Other--TERMINATE--
10 --21717	22 --21773	goto 52
11 --21718	23 --21774	
12 --21727	24 --21775	

2. To help us understand the needs of people your age, please select from the list below the category which includes your age.

1 --Under 20
2 --21 to 30
3 --31 to 40
4 --41 to 50
5 --51 to 60
6 --61 to 64

7 --65 to 70
8 --71 to 74
9 --75 and over
10 --Prefer not to answer

3. What do you think makes a healthy community? Check up to 5 answers.
1 --Absence of discrimination (racism, sexism)
2 --Affordable childcare options
3 --Affordable housing
4 --Arts and cultural events
5 --Churches and religious organizations
6 --Clean environment (clean water, air, etc.)
7 --Good hospitals, doctors, clinics
8 --Good jobs
9 --Good public transportation
10 --Good schools
11 --Good support network and places to get help when needed
12 --Healthy foods in all neighborhoods (stores with fresh fruits and vegetables)
13 --High-speed broadband (internet) access
14 --Low crime/safe neighborhoods
15 --Places to meet with people (community centers, social clubs, sports groups)
16 --Racially integrated neighborhoods
17 --Safe places to play and be active 18 --SPECIFY OTHER

4. Which of the following unhealthy behaviors among your family, friends or neighbors concern you the most? Check all that apply.
1 --Alcohol misuse or abuse
2 --Child abuse and neglect
3 --Distracted driving (texting or talking on phone while driving)
4 --Drug misuse or abuse
5 --Lack of exercise
6 --Marijuana use
7 --Not getting enough sleep
8 --Not getting healthcare when needed or recommended
9 --Poor eating habits (eating "junk" food, not eating vegetables, etc.)
10 --Self harm (cutting, self-injury)
11 --Tobacco use (cigarettes, cigars, e-cigarettes, chewing tobacco, dip, etc.)
12 --Unprotected or unsafe sex
13--Violence in the home

14 --SPECIFY OTHER

5. Which of the following negative experiences among you, your family, friends or neighbors concern you the most? Check all that apply.

1 --Adverse childhood experiences (intensely stressful events which impact lifelong health)
2 --Community violence
3 --Discrimination
4 --Impact of climate change
5 --Isolation
6 --Parental incarceration
7 --Police violence
8 --Political conflicts
9 --Poverty
10 --Racism
11 --Sexual assault
12 --Violence in the home

6. Which healthcare services are difficult to get in your community? Check all answers that apply.

1 --Abortion care
2 --Alcohol or drug abuse treatment
3 --Alternative therapies (acupuncture, etc.)
4 --Dental care
5 --Emergency medical care
6 --Family doctor
7 --Family planning (including birth control)
8 --Hearing aids
9 --Help navigating the healthcare system
10 --Mental health services
11 --Physical therapy and rehabilitation
12 --Pregnancy care
13 --Prescriptions (medicine)
14 --Primary care
15 --Services for the elderly
16 --Specialty medical care (cardiologist, neurologist, endocrinologist, etc.)
17 --Victim services
18 --Vision care (eye exam and glasses)
19 19 --SPECIFY OTHER

The next questions are about health and healthcare. Throughout the survey, we use the term "doctor" to refer generally to medical professionals including physicians, physicians' assistants, nurses, nurse practitioners and other medical professionals who might be involved in health care.

7. When was the last time you saw a doctor for any type of visit (in-person, video call or phone call)?
1 --Within the past year
2 --Between 1 and 3 years ago
3 --More than 3 years ago
4 --Don't know

[BARRIERS]
8. What do you feel are the problems for you getting healthcare for yourself or your family members? Check all that apply.
1 --I am able to get quality healthcare without problems-- goto 12
2 --I don't have health insurance
3 --I cannot afford or I'm afraid I cannot afford the cost
4 --Doctor or clinic doesn't take my insurance
5 --Wait time to get appointment is too long
6 --Lack of transportation (can't get ride to the doctor)
7 --Doctor not taking new patients
8 --Doctor or nurse does not speak my language
9 --Could not get an appointment at a time that worked for me
10 --I don't have a doctor or not sure where to go
11 --I don't like my doctor
12 --I'm anxious or afraid to go to the doctor
13 --I don't trust staff (doctors, nurses, reception staff, etc.)
14 --I don't have childcare during doctor's visits
15 --I cannot get time off of work for an appointment
16 --SPECIFY OTHER

[ASK IF Q8 [BARRIERS] = 13, 14 OR 15]

9. Please tell us why you don't like your doctor, or why you are anxious, afraid, or don't trust doctors or other medical staff?
1 --ENTER RESPONSE

10. Have you ever felt that your gender, race, language or immigration status, sexual identity, weight, class, or something similar affected how you were treated by doctors or other medical staff?
1 --Yes
2 --No
3 --Not sure

11. Please tell us about the most memorable time when you felt you were treated differently by doctors or other medical staff.
1 --ENTER RESPONSE

12. Which of the following, if any, would be most helpful to you in getting healthcare for yourself or your family members? Select up to three.
1 --Extended hours (early morning or evening) and weekend appointments
2 --More appointment times available / the ability to schedule an appointment sooner
3 --More convenient locations for appointments
4 --Online appointments, using a video call
5 --A translator to help with communication with medical staff
6 --Help paying the cost of care, such as sliding-scale rates or payment plans
7 --More doctors who take my insurance
8 --Transportation to or from appointments
9 --In-person healthcare visit in my home
10 --SPECIFY OTHER

13. How would you rate your own health? 1 --Excellent
2 --Very good
3 --Good
4 --Fair
5 --Poor

14. If you could instantly change one thing to improve your own health, what would that be?
1 --ENTER RESPONSE

15. What are some of the major stressors in your life? Check all that apply.
1 --None
2 --Not having stable affordable housing
3 --Providing care for elderly or disabled family members
4 --Responsibility providing care for your children or dependents
5 --Cost of providing care for children
6 --Not having a stable job or income
7 --Ongoing health problems
8 --Unsafe housing
9 --Unsafe neighborhood
10 --Not having reliable transportation
11 --Unable to afford / have access to healthy food
12 --Poor sleep
13 --Long commute / traffic
14 --Concern about COVID
15 --Relationship conflict in home
16 --Crowded living conditions in my home
17 --Noise in my neighborhood
18 --Isolation and loneliness
19 --Political or social issues
20 --Discrimination
21 --Racism

22 --Change in work (where you work, what you do for work, number or hours or times of day, etc.)
23 --SPECIFY OTHER

16. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?
1 --0
2 --1-2
3 --3-7
4 --8-15
5 --16-29
6 --30

17. Approximately how much exercise do you get on an average day? 1 --None
2 --Very little (less than 10 min/day) 3 --Some (about 15 min/day)
4 --A moderate amount (about 30 min/day)-- goto 19
5 --A lot (more than 40 min/day)-- goto 19
6 --Don't know-- goto 19

18. It is recommended that everyone spends at least 30 minutes per day 5 days a week exercising. What are some of the reasons you don't get 30 minutes of exercise or more on an average day? Please check all that apply.
1 --Costs too much
2 --Don't have safe places to exercise (park, sidewalks, etc.)
3 --Don't have someone to exercise with
4 --I don't enjoy it
5 --I have physical problems that keep me from exercising
6 --I'm not sure how to get started
7 --I never think about it
8 --Too busy / no time
9 --I have trouble sticking with an exercise plan
10 --I didn't know about the recommendation to get at least 30 minutes of exercise per day
11 --SPECIFY OTHER

19. About how many servings of fruits and vegetables do you typically eat per day? (For example, one serving is 1/2 cup cooked green vegetables, 1 cup leafy greens, or 1 banana.)
1 --0 servings
2 --1-2 servings
3 --3-4 servings
4 --5 or more servings-- goto 21
5 --Don't know

20. It is recommended that everyone eats at least 5 servings of fruits and vegetables per day. What are some of the reasons you eat fewer than 5 servings of fruits and vegetables per day? Check all that apply.
1 --Cost too much
2 --I don't like the taste
3 --I never think about it
4 --Where I shop doesn't have a good selection
5 --I don't eat that much
6 --Stores that carry fresh fruits and vegetables are too far away
7 --I didn't know about the recommendation to eat 5 or more serving per day
8 --SPECIFY OTHER

The next couple of questions are about health screenings that have to do with gender.

21. What is your gender?
1 --Female
2 --Male
3 --Non-binary or genderqueer
4 --Prefer not to answer
5 --SPECIFY OTHER

22. Are you transgender?
1 --Yes
2 --No
3 --Unsure

[ASK IF Q21 [GENDER] = 1, Q22 [TRANSGENDER] <> 1, AND Q2 [AGE] = 1,2,3,4,5 OR 6]

23. When did you last get a Pap smear? 1 --Within the last year
2 --Between 1 and 2 years ago
3 --Between 2 and 3 years ago
4 --More than 3 years ago
5 --Don't know

[ASK IF Q21 [GENDER] = 1, Q22 [TRANSGENDER] <> 1, AND Q2 [AGE] = 5,6,7 OR 8]

[MAMMOGRAM]
24. When did you last get a mammogram?
1 --Within the last year
2 --Between 1 and 2 years ago
3 --Between 2 and 3 years ago
4 --More than 3 years ago
5 --Don't know

[ASK IF Q2 [AGE] = 5,6,7 OR 8]

[COLON]

25. When did you last have a colon cancer screening?
1 --Within the last year
2 --Between 1 and 2 years ago
3 --Between 2 and 3 years ago
4 --More than 3 years ago
5 --Don't know

[ASK IF Q23 [PAP] = 4, Q24 [MAMMOGRAM]

Recommended health guidelines include the following regular screenings for cancer:

- For women up to age 65, a Pap smear every 3 years to screen for cervical cancer
- For women age 50 to 74, a mammogram every 2 years to screen for breast cancer
- For anyone age 50 to 75, a fecal occult blood testing, sigmoidoscopy or colonoscopy every 5 years to screen for colorectal cancer

26. According to your age and your answer(s) to the question(s) above, you have not followed one or more of these guidelines. What are some of the reasons you have not received this care?
1 --I can't get an appointment with my doctor
2 --I'm nervous, scared or don't want to
3 --I'm not sure if it's really needed
4 --I'm too busy to schedule it
5 --It's too expensive
6 --My doctor hasn't told me I need it
7 --Transportation is a problem
8 --I don't have childcare
9 --I can't get time off of work
10 --Not medically necessary for me (e.g., doctor told me I don't need it)
11 --SPECIFY OTHER

The following questions help us understand some of the conditions that can make it more difficult to live a healthy life.

27. What is your living situation today?
1 --I have a steady place to live
2 --I have a place to live today, but I am worried about losing it in the future
3 --I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

28. Think about the place you live. Do you have problems with any of the following? (Check all that apply.)
1 --Lack of air conditioning
2 --Lack of heat
3--Lead paint or pipes
4--Mold
5 --Oven or stove not working
6 --Pests such as bugs, ants, or mice
7 --Smoke detectors missing or not working
8 --Water leaks
9 --None of the above

29. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
1 --Very hard
2 --Somewhat hard
3 --Not hard at all

30. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
1 --Yes
2 --No
3 --Already shut off

Some people have made the following statement about their food situation. Please answer whether the statement was OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.

31. Within the past 12 months, you worried that your food would run out before you got money to buy more.
1 --Often true
2 --Sometimes true
3 --Never true

32. What kind of transportation do you regularly use? Check all that apply.
1 --I have a reliable car
2 --I have an unreliable car (doesn't always run)
3 --Public transportation
4 --Walking
5 --Rides from friends or family
6 --Bicycle
7 --SPECIFY OTHER

33. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?
1 --Yes
2 --No

34. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings.)
1 --Less than once a week
2 --1 or 2 times a week
3 --3 to 5 times a week
4 --More than 5 times a week
5 --Prefer not to answer

35. How often do you feel lonely or isolated from those around you?
1 --Always
2 --Often
3 --Sometimes
4 --Rarely
5 --Never

36. How often does anyone, including family and friends, threaten you with harm?
1 --Always
2 --Often
3 --Sometimes
4 --Rarely
5 --Never

37. Stress is a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?
1 --Not at all
2 --A little bit
3 --Somewhat
4 --Quite a bit
5 --Very much

Not all members of the community have the same experiences. Answering the following questions will help us better understand how health may be different by our zip code, gender, race or education so that we can help our community be healthier.

38. What is the primary source of your health care insurance coverage?
1 --I do not have health insurance
2 --Insurance from an employer or union
3 --Insurance that you pay for yourself (including "Obamacare" plans)

4 --Indian or Tribal Health Services
5 --TRICARE, military, or VA Benefits
6 --Medicaid or Health Choice
7 --Medicare (alone or with a Medicare supplement)
8 --SPECIFY OTHER

39. Is your health plan a "high-deductible health plan"? That is, does your health plan have a deductible of at least $1,200 per year for one person, which you must pay for healthcare before your insurance begins to pay a share?
1 --Yes
2 --No
3 --Don't know

40. Have you or anyone else in your household served in the military previously or are currently serving?
1 --Yes, myself
2 --Yes, member of household
3 --No
4 --Don't know

41. How many people live in your household (including yourself)?
1 --1
2 --2
3 --3
4 --4
5 --5+

42. Are you the parent or guardian of any children under age 18 or the caregiver of any other person in your personal life? Check all that apply.
1 --Yes
2 --No-- goto 44

43. How many children under age 18 live in your home?
1 --0
2 --1
3 --2
4 --3
5 --4
6 --5 or more

44. What is your sexual orientation? Choose all that apply.
1 --Asexual
2 --Bisexual
3 --Lesbian or Gay
4 --Pansexual
5 --Queer

6 --Straight or heterosexual
7 --Don't know / questioning
8 --Prefer not to answer
9 --SPECIFY OTHER

45. What is the highest level of school you have completed or highest degree you have received?
1 --I never attended school
2--Some school / did not graduate high school
3 --High school diploma / GED
4 --Vocational / technical training after high school
5 --Some college
6 --College degree
7 --Graduate or professional degree

46. What is your current employment status
1 --Disabled / unable to work
2 --Employed Full-Time
3 --Employed Part-Time
4 --Retired
5 --Self-Employed
6 --Stay-at-home parent
7 --Student
8 --Unemployed

47. What is your annual household income?
1 --Less than $25,000/year
2 --$25,001 - $50,000/year
3 --$50,001 - $60,000/year
4 --$60,001 - $75,000/year
5 --$75,001 or more/year

48. What is your race / ethnicity?
1 --White / Caucasian
2 --American Indian / Alaska Native
3 --Native Hawaiian and other Pacific Islander
4 --Hispanic
5 --Black / African-American
6 --Asian
7 --I identify with more than one race
8 --I identify with a race not listed

49. Do you or members of your household speak a language other than English at home?
1 --Yes
2 --No

50. What language other than English is spoken in your home? Check all that apply.
1 --ASL
2 --Burmese
3 --Chinese
4 --French
5 --Spanish
6 --A language not listed

[END]

Thank you for completing this survey!

Appendix 8. Planning Process Participants

The 2022 Frederick County Community Health Needs Assessment (CHNA) is the result of a collaborative community-wide effort involving a variety of organizations. The Frederick County Health Care Coalition thanks the following for their participation.

CHNA Planning Committee – responsible for guiding CHNA process, planning and oversight.
Denise Barton, Strategy & Business Development Coordinator, Frederick Health
Barbara Brookmyer, MD, MPH, Frederick County Health Officer
Douglas Brown, PA-C, EdD(c), Mason-Dixon Mobile Medicine
Lisa Brown, Project Manager, OMH Advancing Health Literacy Grant and CHW Supervisor, Asian American Center of Frederick
Jennifer Cooper, Assistant Professor of Nursing, Hood College
Bunmi Fakilede, Nigerian in Frederick (NIF)
Anamaria Matamoros Faustin, Hood Student Intern, Frederick Health
Diana Fulchiron, Behavioral Health Work Group Lead, Frederick County Health Care Coalition (FCHCC); Director of Community Impact, The Community Foundation of Frederick County
Malcolm Furgol, Executive Director, FCHCC; Community Benefit Specialist, Frederick Health
Stephanie Gonthier, President, Market Street Research (data consultant)
Rya Griffis, MPH, Project Coordinator, University of Maryland School of Public Health, Horowitz Center for Health Literacy
Maria Herrera, Spanish Speaking Community of Maryland (Frederick location)
Janet Harding, Director of Cultural Awareness & Inclusion, Frederick Health
Danielle Haskin, MSPH, Founder & Senior Advisor, It Looks Like Me
Inga James, MSW, PhD, Vice President, FCHCC; President & Executive Director, Heartly House
Elizabeth "Liz" Kinley, Project Manager, Community Health, Frederick Health
Heather Kirby, LSWA, MBA, AC-SW, Chronic Health Work Group Lead, FCHCC & Vice President, Integrated Care Delivery and Public Health Officer, Frederick Health
Pilar Olivo, President and ACEs/Infant Health Work Group Lead, FCHCC; ACEs Liaison, Frederick County Office or Children and Families
Leah Stansberry Richey, Project Coordinator, OMH Advancing Health Literacy Grant, University of Maryland School of Public Health, Horowitz Center for Health Literacy
Colleen Swank, LHIC Grant Coordinator, Frederick County Health Department (Recorder)
Sr. Roberta Treppa, DePaul Dental Program Manager, Seton Center
Rissah Watkins, MPH, CPH, Director of Planning, Assessment, and Communication, Frederick County Health Department

CHNA Data Subcommittee – responsible for data analysis.		
Name	**Organization**	**Expertise**
Diana Fulchiron	Community Foundation	Planning & Evaluation
Malcolm Furgol	Frederick County Health Care Coalition	Planning & Evaluation
Stephanie Gonthier	Market Street Research	Statistics, Planning & Evaluation
Hillary Gross	Frederick County Health Department	Statistics, Public Health
Janet Harding	Frederick Health	Cultural Diversity/Health Equity
Inga James	Heartly House, Frederick County Health Care Coalition	Statistics, Clinical Outcomes
Fanta Jawara	Frederick Health Intern	
Liz Kinley, RN	Frederick Health	Clinical Outcomes
Pilar Olivo	Frederick County Office for Children and Families, ACEs/Infant Health Work Group Lead, Frederick County Health Care Coalition	Planning & Evaluation
Tyler Silverman	Frederick Health	Statistics
Colleen Swank	Frederick County Health Department	Administrative Support
Rissah Watkins, MPH	Frederick County Health Department	Statistics, Public Health
Dr. Kathy Weishaar	Frederick Health	Clinical Outcomes

Focus groups were recruited and supported by:

- Spanish Speaking Community of Maryland
- Centro Hispano
- Frederick County Maternal and Child Health Collaborative
- Frederick County Judy Center
- Frederick County Public Schools
- Frederick County Senior Services Division
- Frederick County Senior Services Advisory Board

Special thanks to Hood College faculty and public health undergraduate students for assistance on secondary data collection in the summer of 2021.

- Dr. Jennifer Cooper
- Olga Dunlap
- Abby Mayes

Public Input Session Attending Organizations – responsible for reviewing data, providing feedback	
Advocates for the Aging	Golden Mile Alliance
Aetna Better Health of Maryland	Good Works Frederick
Analytic-Communications LLC	Health Care is A Human Right Maryland - Frederick Chapter
Asian American Center of Frederick	Heartly House
Ausherman Family Foundation	Helen J. Serini Foundation
Children of Incarcerated Parents Partnership	HomeCentris Personal Care
City of Frederick Housing and Human Services/FCAA	Hood College Department of Nursing
Community Engagement & Consultation Group	Hood College Public Health Program
Community Foundation of Frederick County	Housing Authority City of Frederick
Community Living, Inc	Leidos Biomedical Research Inc.
CoreLife	Listen Love Pray Foundation
CURA Strategies	Love for Lochlin Foundation
Dany Institute/Central East Mental Health Technology Transfer Center	Maryland Department of Health
Dept. of Housing and Human Needs - SBHC	Maryland Hunger Solutions
Encompass Integrative Wellness, LLC	Mental Health Association of Frederick County
Family Partnership	Mission of Mercy
Frederick Community College	National Academies/Quinn Chapel AME Church
Frederick County Chamber of Commerce	NCI, NIH
Frederick County Citizens Services Division	Nigerian in Frederick
Frederick County Council, District 4	Office of Senator Van Hollen
Frederick County Department of Social Services	On Our Own
Frederick County Developmental Center	OneFrederick Collaborative
Frederick County Government	Rachel Mandel MD Consulting
Frederick County Government, Office of the County Executive	Senior Services Advisory Board (Volunteer)- Retired RN
Frederick County Health Care Coalition	Seton Center Inc
Frederick County Health Department	Sheppard Pratt Frederick
Frederick County Office for Children & Families	SHIP of Frederick County
Frederick County Public Schools	Spanish Speaking Community of MD
Frederick County Public Schools Food and Nutrition Service and School Health Council	The Frederick Center
Frederick County Senior Services Division	Transit Services of Frederick County, MD
Frederick Health	United Way
Frederick Health / Supportive & Geriatric Care	University of Maryland Extension
Frederick News-Post	University of Maryland SPH Horowitz Center for Health Literacy
George Washington University	YMCA of Frederick County
	ZERO TO THREE

Frederick County Health Care Coalition

Board of Directors
Pilar Olivo, President & ACEs Work Group Lead, Frederick County Office of Children & Families
Inga James, Vice-President, Heartly House
Michael Planz, Treasurer, Community Living
Heather Kirby, Secretary & Frederick Health Representative, Chronic Health Work Group Co-Lead
Christina Brockett, Encompass Integrative Wellness
Barbara Brookmyer, Frederick County Health Department, ex-officio member
Elizabeth Chung, Asian American Center of Frederick
Miriam Dobson, Frederick County Health Department
Diana Fulchiron, Behavioral Health Work Group Lead, The Community Foundation of Frederick
Sherita Henry, Hood College
Ken Oldham, United Way of Frederick County
Roman Steichen, TransIT
Diane Tomasky, Frederick Health, Chronic Health Work Group Co-Lead
Jenifer Waters, Frederick County Public Schools
Rick Weldon, Chamber of Commerce

Staff

- Malcolm Furgol, Executive Director
- Colleen Swank, LHIC Grant Coordinator

Health Care Coalition | Frederick County Health Department, MD (frederickcountymd.gov)

This report was in part made possible thanks to the support of the Lifting All Voices advancing health literacy project of the City of Frederick. Lifting All Voices is funded by a grant from the U.S. Office of Minority Health.



In partnership with:

Frederick Health

Public Health
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Frederick County Health Department



Frederick Health
Community Health Needs Assessment
Implementation Strategy
FY 2023-2025

Introduction

Frederick Health is a sole community provider, and therefore plays a critical role in delivering health care services and community benefit to Frederick County residents. This implementation strategy describes how Frederick Health will address significant community health needs identified in the 2022 Community Health Needs Assessment (CHNA) conducted by the Frederick County Health Care Coalition. This commitment is part of Frederick Health meeting the requirements of serving as a nonprofit hospital, and articulates how the system is providing community benefit in alignment with reporting requirements for the Maryland Health Service Cost Review Commission (HSCRC).

This document delineates Frederick Health's intended actions to address the identified priority health needs from the CHNA, and also those needs that will not be addressed. Frederick Health will review progress against the action plan on a periodic basis, and amend this implementation strategy if necessary. Certain community health needs may become more pronounced during the next three years and merit revisions to the described strategic initiatives. Alternatively, other organizations may decide to increase resources devoted to addressing one or more of the significant community health needs, and as a result Frederick Health may amend its strategies and focus on other identified needs.

Significant Health Needs Identified in the CHNA

The 2022 CHNA identified a number of significant health needs in the community through a Prioritization Matrix which assessed Frederick County health data, responses to the CHNA survey, alignment with Healthy People 2030 and the Statewide Integrated Health Improvement Strategy (SIHIS) and existing health disparity data. The top eleven identified health needs by this matrix were as follows:

- Lack of Physical Activity
- Obesity (Adults and Adolescents)
- Hypertension
- Binge Drinking
- Lack of Early Prenatal Care
- Tobacco Use (Current Adult Smoker & Current Cigarette Use by Adolescents)
- Adverse Childhood Experiences (ACEs in adolescents) (1+)
- Breast Cancer (Incidence)
- Type 2 Diabetes
- Mental Health (8-30 days not good/month)
- Overdose Deaths

These eleven priorities were then presented to the Frederick County Health Care Coalition Board which completed a Readiness Assessment based on subject matter expert presentations, rankings from the Prioritization Matrix and facts sheets on each priority. As a result of the Readiness Assessment, the following five priorities were identified and presented at a Public

Input Session on January 19, 2022:

- Type 2 Diabetes
- Adverse Childhood Experiences
- Lack of Early Prenatal Care
- Obesity (Adults and Adolescents)
- Mental Health

Following the event, results from the Readiness Assessment and the Public Input Summit were synthesized in a strategy grid designed to visually illustrate the feasibility of successfully impacting the priorities over the next three years, the socio-ecological level of impact of each priority and the amount of community interest in each priority. The three local health improvement process (LHIP) priorities are as follows:

- Adverse Childhood Experiences
- Type 2 Diabetes
- Mental Health

Significant Health Needs Frederick Health Will Address

LHIP Priority #1 : Reducing the incidence and providing treatment & intervention for Adverse Childhood Experiences (ACEs)

LHIP Goals: Goal 1: **Awareness** – All sectors of Frederick County (including but not limited to healthcare, government, judicial and law enforcement, education, childcare, housing, employment, business, civic and faith-based groups, and parent networks) will recognize the impact of trauma on health from preconception onward and provide or support services for raising healthy children in safe, stable, nurturing environments.

Goal 2: **Prevention** – All Frederick County residents have access to evidence-based or research-informed programs, resources, information, and skills to raise healthy children in safe, stable, and nurturing environments.

Goal 3: **Treatment & Intervention** – An equitable community-wide system of trauma-informed care provides accessible evidence-based treatments from trained, knowledgeable, and culturally literate specialists in adequate supply.

Objective: Using survey baseline measurement and evidence-based resources, continue to support and increase awareness of childhood trauma and its lifelong effect on the individual in the health community and to diminish the prevalence of childhood trauma by providing early intervention measures.

Background: Adverse Childhood Experiences (ACEs) are traumatic incidents in a child's life that cause toxic stress--especially abuse, neglect, and exposure to violence. Without healthy support from adults, toxic stress can overwhelm a child's ability to cope when exposure to adversity happens, increasing the risk of negative physical and mental health outcomes. In Frederick County, 52, 578 adults or 27.2% of respondents to a 2015 survey[1] reported three or more ACEs; multiple ACEs increases risk for negative behavioral and mental outcomes, chronic disease, and premature death.

The physical and mental health of a newborn child and their mother lays the groundwork for all future experiences. Early identification of health conditions among infants and mothers can prevent death or disability and enable children to reach their full potential.

Activity	Target Date	Anticipated Impact or Result
Promote trainings and workshops, providing CMEs and CEUs as able, in partnership with the ACEs workgroup hosts, to employees and medical staff who provide care to the maternal/child health population and families. Assist with the development of applications, supporting materials, and evaluations to meet the needed	Annually through June 2025	80% of targeted employees and medical staff complete training as evidenced successful completion of a post-test.

[1] 2015 Maryland Behavioral Risk Factor Surveillance System (BRFSS)

Activity	Target Date	Anticipated Impact or Result
deadlines and requirements.		
Planning and Implementation of Family Connects universal home visiting program through Frederick Health Home Health Services and in collaboration with Women and Children's Services.	Implementation January 2023	• Sixty percent participation in FY23 and FY24. • Sixty-five percent participation in FY25.
Frederick Health will collaborate with ACEs Workgroup in outreach to pediatric providers to evaluate knowledge of ACEs, resiliency, and effective prevention activities.	June 2023	Number of surveys returned will provide a baseline measurement of awareness of ACEs, resiliency, and prevention activities.
Based on survey results, participate in the development of a plan for providing customized training and technical support to behavioral health treatment providers, para-professionals, and CHWs to increase expertise in evidence based, trauma informed behavioral health practices, especially EMDR, CPP, TF-CBT and PCIT.	June 2023	Plan developed.

Evidence Based Sources:

https://health.maryland.gov/phpa/ccdpc/Reports/Pages/brfss.aspx
http://phpa.dhmh.maryland.gov/ccdpc/Reports/Pages/brfss.aspx
https://www.cdc.gov/violenceprevention/aces/about.html
https://www.healthypeople.gov/
https://pophealth.health.maryland.gov/Pages/SHIP.aspx
https://www.ccfhnc.org/programs/family-connects-durham

Resources Required: Staff participation in the LHIP group; funding for CME programming, educational program development and operational expenses related to Family Connects, Behavioral Health trainings.

Alignment with State and National Priorities

Healthy People 2030	State Health Improvement Process (SHIP) and Statewide Integrated Health Improvement Strategy (SIHIS)
MICH-02 Reduce the rate of infant deaths within the first year of life IVP-15 Reduce child abuse and neglect deaths IVP-16 Reduce nonfatal child abuse and neglect IVP-D03 Reduce the number of young adults who report 3 or more adverse childhood experiences	Infant Death Rate - This indicator shows the infant mortality rate per 1,000 live births. (SHIP) Child maltreatment rate - This indicator shows the rate of children who are maltreated per 1,000 population under the age of 18. (SHIP) Severe Maternal Morbidity rate – this indicator shows the SMM rate per 10,000 delivery hospitalizations (SIHIS)

Partnerships Required: Frederick County Health Department, Frederick County Public Schools, Child Advocacy Center, Mental Health Association and Frederick County Health Care Coalition.

LHIP Priority #2 : Awareness of what Pre-Diabetes and Diabetes Is

LHIP Goal: Increase awareness and understanding among Frederick County residents about what pre-diabetes and diabetes is, what their individual risk is and how risks can be modified. Implement an intentional, targeted approach for identified populations experiencing a health disparity to increase the detection of undiagnosed T2D/prediabetes.

Objective: Increase the number of individuals from priority populations that know what pre-diabetes is.

Background: Diabetes is a chronic disease that continues to increase in prevalence. This increase is largely linked to obesity rates, poor dietary habits, and ethnic origins. 13% of adults in the United States have Diabetes (34 million). 21% of them do not know. In Frederick County 9.0% of adults have Diabetes (18,806).

35% of adults in the United States have pre-diabetes. 85% of them do not know. It is a disease that is often undiagnosed until complications arise requiring hospitalization.
In Maryland, diabetes is now the sixth leading cause of death.

Activity	Target Date	Anticipated Impact or Result
Conduct at least 2 listening sessions to understand how best to reach identified priority populations (locations, methods, etc.).	October 2022	These sessions will help guide how and what education is provided to what population.

Appropriate individuals from the workgroup will attend Health Literacy training. Including a marketing and communications representative is key to this training to ensure relevancy and impact for our priority populations.	November 2022	Create/adapt education and resource materials that are culturally competent and appropriate from a health literacy perspective. Including non-print materials.
Launch a County pre-diabetes/diabetes awareness media campaign to reach identified priority populations	November 2022	Initial launch will take place during Diabetes awareness month to kick off 3-year initiative. Will start with methods identified during listening sessions.
Educate community providers about local disparity data, cultural barriers/bias and local referral process and preventive program and treatment options.	June 2023	Conduct four continuing medical education (CME) programs for community providers
Engage providers, clinics, and other health institutions/programs to disseminate pre-diabetes/diabetes awareness materials	June 2023	Visit all practices in person
Engage community-based organizations to disseminate pre-diabetes/diabetes awareness materials to priority populations	June 2023	Visit all major community-based organizations in person
Integrate pre-diabetes and diabetes education at all community events.	November 2022	Increase the number of Frederick County residents educated about pre-diabetes and diabetes.
Conduct a minimum of four events per year on what pre-diabetes and diabetes is, what are the risk factors, and how can risk factors be modified. Focus on communities that represent identified priority populations.	June 2023	Increased community knowledge of the risk of hypertension as evidenced by increase of pre/post assessment by 100% of attendees.

Evidence Based Sources:

https://nationaldppcsc.cdc.gov/s/
http://health.frederickcountymd.gov/CHNA2022
Diabetes Action Plan (maryland.gov)

Resources Required: Funding for staff participation in events; funding for education material production and maintenance; staff to provide education for providers, community based organizations, and county residents; venues for listening sessions and educational events.

Alignment with State and National Priorities

Healthy People 2030	Statewide Integrated Health Improvement Strategy (SIHIS)
D- 02 Reduce the proportion of adults who don't know they have prediabetes D- D01 Increase the proportion of eligible people completing CDC-recognized type 2 diabetes prevention programs	Domain 3 – Total Population Health Diabetes Reduce the mean Body Mass Index (BMI) for adult Maryland residents

Partnerships Required: Mission of Mercy, City of Frederick Department of Housing & Human Services, Frederick County Health Department, Love for Lochlin Foundation, Centro Hispano, YMCA and Frederick County Public Schools.

LHIP Priority #2 : Pre-Diabetes Risk Screening

LHIP Goal: Increase screening for pre-diabetes risk, especially in identified priority populations, to reduce the incidence of diabetes.

Objective: Increase the number of individuals screened for pre-diabetes; engage providers and community-based organizations at awareness events; and increase the number of individuals navigated to lifestyle change programs, such as the National Diabetes Prevention Program (DPP), if they are identified at risk. Ensure individuals have the tools (wrap-around services) to be successful in making lifestyle modifications.

Background: Pre-diabetes is reversible. Individuals can prevent or delay pre-diabetes from progressing to diabetes with very simple, proven lifestyle changes and supports. But the first step is individuals being aware that they are at risk.

The National Diabetes Prevention Program was created in 2010. Evidenced based program focuses on modifiable lifestyle behaviors of healthy eating and physical activity. The research shows that individuals who actively/successfully participate in such a lifestyle change program can reduce their risk of developing type 2 diabetes by 58%. For individuals 60 years of age and older that increases to 71%.

Activity	Target Date	Anticipated Impact or Result
Host or participate in community events to conduct screening and resource navigation.	June 2023	• Participate in at least 1 screening event per month • Target at least 600

Activity	Target Date	Anticipated Impact or Result
		individuals screened
Increase the number of individuals diagnosed with pre-diabetes that are connected to lifestyle change programs.	December 2022 December 2022 December 2023	• 331 • 662 • 1324
Increase the number of individuals knowledgeable about healthy food preparation by conducting health cooking/meal prep classes for families.	June 2023	12 cooking classes
Increase the number of individuals educated about affordable food options.	June 2023	Conduct at least 1 grocery store tour per quarter
Increase opportunities available to engage in physical activity in safe locations.	June 2023	Conduct at least 1 5k to include a fun run and walking options

Evidence Based Sources:

https://nationaldppcsc.cdc.gov/s/
http://health.frederickcountymd.gov/CHNA2022
Diabetes Action Plan (maryland.gov)

Resources Required: Funding for staff to participate in community events, staff to facilitate DPP workshops, staff to process referrals and help connect individuals with financial resources, staff to facilitate grocery store tours, materials and equipment for workshops.

Alignment with State and National Priorities:

Healthy People 2030	Statewide Integrated Health Improvement Strategy (SIHIS)
D-02 Reduce the proportion of adults who don't know they have prediabetes D-D01 Increase the proportion of eligible people completing CDC-recognized type 2 diabetes prevention programs	Domain 3 – Total Population Health Diabetes Reduce the mean Body Mass Index (BMI) for adult Maryland residents

Partnerships Required: *LiveWell Frederick*, Frederick County Public Schools and School Health Council, Farm to School Network, Food Security Network, Local Food Banks, Local Pediatricians, YMCA, United Way, The Boys and Girls Club, and Frederick County Government Departments including Health, Public Library, Parks and Recreation, and University of Maryland Extension Service, Mission of Mercy and the Love for Lochlin Foundation.

LHIP Priority #2 : Improve Diabetes Management

LHIP Goal: Improve the successful management of individuals diagnosed with diabetes, especially those within identified priority populations.

Objective: Decrease the volume of avoidable acute care utilization for individuals diagnosed with diabetes.

Background: It is estimated that $4.9 billion is spent annually in Maryland to treat those with pre-diabetes and Diabetes. The American Diabetes Association's approach to improving the care for diabetic patients includes four recommendations:

- "A patient-centered communication style that incorporates patient preferences, assesses literacy, and numeracy, and addresses cultural barriers to care should be used"
- "Treatment decisions should be timely and based on evidenced-based guidelines that are tailored to individual patient preferences, prognoses, and comorbidities."
- "Care should be aligned with components of the Chronic Care Model to ensure productive interactions between a prepared proactive practice team and an informed activated patient."
- "When feasible, care systems should support team-based care, community involvement, patient registries, and decisions support tools to meet patient needs."

Activity	Target Date	Anticipated Impact or Result
Educate community providers on current best practices for diabetes management, local disparity data cultural barriers/bias, and local process for education and treatment options.	June 2023	Conduct four continuing medical education (CME) programs for community providers.
Reduce the number of care gaps associated with diabetes in targeted populations	June 2023	Positive trend for both FHMG practices and community practices noted each reporting period.
Increase the percentage of individuals connected to primary care providers, regardless of insurance status (especially those from identified priority populations).	June 2023	• Implement a process for unassigned patients discharging from FHH to be connected to primary care. • Implement a process for unassigned patients identified at community events to be connected to primary care.
Increase the number of individuals engaged in Diabetes Self-Management Training program.	2022 2024 2025	• 250 • 980 • 1500
Reduce avoidable acute care utilization for diabetic patients.	December 2025	5% reduction in PQI93 Outcome ratio

Evidence Based Sources:

https://nationaldppcsc.cdc.gov/s/
http://health.frederickcountymd.gov/CHNA2022
Diabetes Action Plan (maryland.gov)

Resources Required: Funding for staff to perform Diabetic Self-Management Training (DSMT) services, process prior authorizations, and process claims. Funding for staff to assist patients with financial assistance navigation. Physical space for classes and resources to cover the cost of educational modules.

Alignment with State and National Priorities:

Healthy People 2030	Statewide Integrated Health Improvement Strategy (SIHIS)
D- 03 Reduce the proportion of adults with diabetes who have an A1c value above 9 percent D- 06 Increase the proportion of people with diabetes who get formal diabetes education D- 08 Reduce the rate of foot and leg amputations in adults with diabetes MPS- D02 Reduce emergency department visits for insulin overdoses OA- 05 Reduce the rate of Frederick Health admissions for diabetes among older adults V- 04 Reduce vision loss from diabetic retinopathy	Domain 1 – Frederick Health Quality Reduce avoidable admissions and readmissions Domain 2 -Care Transformation Across the System Increase the amount of Medicare TCOC or number of Medicare beneficiaries under Care Transformation Initiatives (CTIs), Care Redesign Program, or successor payment model Improve care coordination for patients with chronic conditions Domain 3 – Total Population Health Diabetes Reduce the mean Body Mass Index (BMI) for adult Maryland residents

Partnerships Required:

Mission of Mercy, City of Frederick Department of Housing & Human Services, Frederick County Health Department, Community Providers and Community Pharmacists.

LHIP Priority #3 : Targeting Mental Health Needs – Suicide Prevention

LHIP Goal: Reduce the number of people that die by suicide in Frederick County.

Objective: Establish a suicide prevention coalition composed of key community stakeholders that are invested in continuing suicide prevention work beyond the LHIP cycle.

Background: Suicide is everyone's business. The COVID-19 pandemic has increased the frequency and severity of mental health concerns that contribute to suicide risk. Rural areas of Frederick County experience a disproportionate rate of death by suicide with a firearm. Specific populations in Frederick County are at greater risk of suicide: veterans, first responders, members of the LGBTQ community, youth, and senior citizens.

Activity	Target Date	Anticipated Impact or Result
Establish a suicide prevention coalition composed of key community stakeholders invested in continuing suicide prevention work beyond the LHIP cycle. • Frederick Health will participate on the Suicide Prevention Coalition • FH will participate in completing an agenda and scheduling a date/time for the first meeting of the coalition	June 2023 April 2023 May 2023	• FH representative attends at least 80% of the meetings • FH representative will participate in completion of agenda and attend the first meeting of the coalition

Evidence Based Sources:

https://www.samhsa.gov/
https://www.cdc.gov/mentalhealth/index.htm
https://www.healthypeople.gov/

Resources Required: Operational expenses related to Suicide Prevention Coalition meetings and activities.

Alignment with State and National Priorities

Healthy People 2030	Statewide Integrated Health Improvement Strategy (SIHIS)
OHM- 1 Overall well-being MHMD-01 Reduce the suicide rate	Domain 3 – Reduce the suicide rate

Partnerships Required: Frederick County Health Department, Mental Health Association, and Frederick County Health Care Coalition.

LHIP Priority #3 : Targeting Mental Health Needs – Community Engagement

LHIP Goal: Reduce stigma about mental health issues and services.

Objective: More Frederick County Residents are aware that mental health is health and support the use of mental health services for themselves and others.

Background: 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 healthy choices.

Mental health is important at every stage of life, from childhood and adolescence through adulthood[2]. 17% of community members struggle with mental health at least half the time in a typical month according to results from the 2021 Frederick County CHNA. Mental health issues may manifest as behavioral issues such as including substance use and suicidal ideation. In Frederick County 36 people died of drugs/alcohol and 29 from suicide in 2020[3], both of which are below the Healthy People 2030 goal[4] but are preventable, unnecessary deaths.

Activity	Target Date	Anticipated Impact or Result
Collaborate with LHIP in a sustainable campaign that reduces mental health stigma by educating organizations and the public about the importance and normalcy of mental health needs and services.	June 2025	FH will have at least one representative at 90% of the meetings of the community engagement subgroup of the mental health LHIP workgroup.
Provide education from the anti-stigma campaign to staff, both as employees and healthcare workers, and to patients to reduce mental health stigma.	May 2023	Identify a person to be the 'champion' or point person for bringing the anti-stigma campaign to FH staff and patients. That person will log at least 4 contacts per year with committee.
Information / ideas to reduce stigma will be shared in a variety of formats and more than once a year.	June 2024 – June 2025	FH Champion will log delivery of at least 2 educational sessions for staff and at least 2 shares of information in any reasonable medium with staff and at least 2 with patients.

Evidence Based Sources:

https://www.samhsa.gov/
https://www.cdc.gov/mentalhealth/index.htm

[2] CDC- Centers for Disease Control
[3] Frederick County LBHA https://health.frederickcountymd.gov/DocumentCenter/View/6953/DATA-AND-PLANNING-with-Analysis-5-26-21
[4] Healthy People 2030 – suicide rate goal = 12.8 per 100,000 and overdose rate goal = 20.7 per 100,000

https://www.healthypeople.gov/

Resources Required: Funding for staff participation in anti-stigma campaign discussions and implementation, operational expenses related to outpatient addictions treatment in the emergency department and post-partum support group.

Alignment with State and National Priorities:

Healthy People 2030	Statewide Integrated Health Improvement Strategy (SIHIS)
MHMD-03 Increase the proportion of children with mental health problems who get treatment MHMD-04 Increase the proportion of adults with serious mental illness who get treatment MHMD-05 Increase the proportion of adults with depression who get treatment MHMD-06 Increase the proportion of adolescents with depression who get treatment MHMD-07 Increase the proportion of people with substance use and mental health disorders who get treatment for both MHMD-D01 Increase the number of children and adolescents with serious emotional disturbance who get treatment MHMD-R01 Increase the proportion of homeless adults with mental health problems who get mental health services AH-D02 Increase the proportion of children and adolescents with symptoms of trauma who get treatment EMC-D04 Increase the proportion of children and adolescents who get appropriate treatment for anxiety or depression SU-01 Increase the proportion of people with a substance use disorder who got treatment in the past year	Domain 3 – Reduce the suicide rate

Partnerships Required: Frederick County Health Department, Mental Health Association, and Frederick County Health Care Coalition.

LHIP Priority #3 : Workforce Development/Capacity Building for Mental Health Service Providers

LHIP Goal: Frederick County residents will be able to access the full continuum of culturally competent, trauma-informed, high quality mental health treatment services in a timely manner, through an increased capacity of mental health professionals and other trained support persons (i.e., Recovery Coaches, Community Health Outreach Workers) who can offer services.

Objective: Increase the number of providers in the mental health field. Reduce the lengthy local provider wait lists and wait times for initial mental health prescriber appointments in order for mental health treatment slots to be available regardless of insurance status at the time an individual seeks services as well as individuals having reliable access to services in their native language, either directly or by a certified interpreter.

Background: There is a lack of licensed clinicians and prescribers employed in mental health service agencies. There is insufficient access to mental health treatment services for all populations, regardless of insurance status; however, this lack of access is more pronounced in those who are uninsured, underinsured, and/or speak languages other than English (especially Spanish and ASL).

Activity	Target Date	Anticipated Impact or Result
Develop a process with current local providers to create time slots for on demand treatment. Assess capacity/ability of local mental health providers to provide services to a culturally diverse population.	June 2024	Frederick Health will implement having a Behavioral Health NP available to see patients in crisis at the Comprehensive Care Clinic to assist with medication management and bridging those services to local mental health providers in the community when available.
Provide opportunities for Community Health Worker and Peer Recovery Support Specialist expansion for mental health providers to help alleviate barriers to care and social determinants of health.	June 2025	Frederick Health will deploy FH employed Community Health Workers that specialize in behavioral health to assist with referrals from Community mental health providers
Explore use of CHWs or other trained healthcare workers being certified as interpreters to serve agencies across the county.	December 2023	Frederick Health will cover the testing cost for interpreter medical certification for FH CHW's that are bilingual.

Activity	Target Date	Anticipated Impact or Result
Determine which agencies are enrolled in HRSA programs currently and explore paid internships with local providers (what would duties look like, funding)	June 2025	Frederick Health will develop and offer paid internships for current employees to advance their career in mental health field.

Evidence Based Sources:

https://www.samhsa.gov/
https://www.cdc.gov/mentalhealth/index.htm
https://www.healthypeople.gov/

Resources Required: Funding for new positions, funding staff participation and funding for costs associated with interpreting testing and internships.

Alignment with State and National Priorities:

Healthy People 2030	Statewide Integrated Health Improvement Strategy (SIHIS)
MHMD-01 Reduce the suicide rate MHMD-02 Reduce suicide attempts by adolescents MHMD-03 Increase the proportion of children with mental health problems who get treatment MHMD-04 Increase the proportion of adults with serious mental illness who get treatment MHMD-05 Increase the proportion of adults with depression who get treatment MHMD-06 Increase the proportion of adolescents with depression who get treatment MHMD-07 Increase the proportion of people with substance use and mental health disorders who get treatment for both MHMD-D01 Increase the number of children and adolescents with serious emotional disturbance who get treatment	Domain 3 – Reduce the suicide rate

MHMD-R01 Increase the proportion of homeless adults with mental health problems who get mental health services

AH-D02 Increase the proportion of children and adolescents with symptoms of trauma who get treatment

EMC-D04 Increase the proportion of children and adolescents who get appropriate treatment for anxiety or depression

SU-01 Increase the proportion of people with a substance use disorder who got treatment in the past year

Partnerships Required:

Frederick County Health Department, Mental Health Association, Frederick County Health Care Coalition, and Asian American Center of Frederick County.

Needs Frederick Health Will Not Address

The mission of Frederick Health is to positively impact the well-being of every individual in Frederick County. This implementation strategy does not include specific plans to address lack of physical activity, obesity, hypertension, binge drinking, lack of early prenatal care, tobacco use, breast cancer and overdose deaths which were identified as significant community health needs in the 2022 CHNA. These health issues were not selected as health priorities in the Local Health Improvement Plan, which is the community-wide action plan associated with the CHNA.

However, Frederick Health does provide diagnosis and treatment of patients who are pregnant and/or are diagnosed with obesity, hypertension, binge drinking, tobacco use, and breast cancer. In addition, Frederick Health currently conducts a smoker secession program and promotes increased physical activity for community members as part of the LiveWell Frederick initiative. As an active member of the Frederick County Health Care Coalition, Frederick Health will continue to work with community partners to address the health needs of our residents whenever that is possible.

Implementation Strategy Adoption

This implementation strategy was adopted by the Quality Committee of the Frederick Health Board of Trustees on October 14, 2022.

Daryl Boffman, Secretary FH Board of Trustees
Chair, Board Quality Committee

Date

Status **Active** PolicyStat ID **13356789**

Origination	01/2011
Last Approved	03/2023
Effective	03/2023
Last Revised	09/2022
Next Review	09/2024
Owner	Shawn McCardell: AVP Revenue Cycle
Area	Finance

Financial Assistance Policy, FN 100

This policy is intended as a guideline to assist in the delivery of patient care or management of hospital services. It is not intended to replace professional judgment in patient care or administrative matters.

PURPOSE:

Frederick Health is committed to providing quality health care for all patients regardless of their ability to pay and without discrimination on the grounds of race, color, national origin or creed. The purpose of this document is to present a formal set of policies and procedures designed to assist Patient Financial Services personnel in the day-to-day application of this commitment. The procedures describe how applications for Financial Assistance should be made, the criteria for eligibility, and the steps for processing applications. This policy is intended to comply with Section 501(r) of the Internal Revenue Code and applicable Maryland law and has been adopted by the Frederick Health Board of Directors.

POLICY:

This policy applies to all patients seeking emergency or other medically necessary care at Frederick Health Hospital. This policy also applies to patients seeking professional medical services from Frederick Health Medical Group. For this policy document only, Frederick Health Hospital and Frederick Health Medical Group are collectively referred to herein as "FHH/FHMG."

The Financial Assistance procedures are designed to assist individuals who qualify for less than full coverage under available Federal, State and Local Medical Assistance Programs, but whose outstanding "self-pay" balances exceed their own ability to pay. The underlying principle is that a person, over a reasonable period of time, can be expected to pay only a maximum percentage of their disposable income towards charges incurred while in the hospital. Any "self-pay" amount in excess of this percentage would place an undue financial hardship on the patient or their family and may be adjusted off as Financial Assistance. The Board of Directors of the Hospital shall review and approve the financial assistance and debt collection policies of the hospital at least every 2 years. All changes to the financial assistance or debt collection policies require approval by the Board of Directors.

PROCEDURE:

A. **OVERVIEW**

1. Financial Assistance can be offered before, during, or after services are rendered. After submission of an application, FHH/FHMG will send an acknowledgment letter to the patient within two (2) business days and an eligibility determination will be made within fourteen (14) days of a completed application.
    a. For purposes of this policy, "Financial Assistance" refers to healthcare services provided without charge or at a reduced charge to qualifying patients.
    b. FHH/FHMG maintains a list of all providers who may care for patients while at FHH/FHMG available at https://www.frederickhealth.org/find-a-provider/. Only providers employed by FHH/FHMG are covered under this policy and are indicated on the provider list. Non-FHH/ FHMG providers bill separately for their services and not all participate in the FHH/FHMG Financial Assistance Program. If a provider is not covered under this policy, patients should contact the provider's office to determine if Financial Assistance is available.
    c. Should a patient need assistance applying for Financial Assistance, help is available at our physical location 400 West Seventh St. Frederick, MD 21701. Patients can also call 240-566-4214 with any inquiries regarding the Financial Assistance application process.
2. Notice of the Availability of Financial Assistance:
    a. FHH/FHMG will make available brochures informing the public of its Financial Assistance Policy. Such brochures will be available throughout the community and within FHH/FHMG locations.
    b. Notices of the availability of Financial Assistance will be posted at appropriate admission areas, the Patient Financial Services department, and other key patient access areas.
    c. Notice of the Financial Assistance Policy will be provided to the patient, the patient's family, or the patient's authorized representative before discharging the patient and in each communication to the patient regarding collection of the bill.
    d. A statement on the availability of Financial Assistance will be included on patient billing statements.
    e. A Plain Language Summary of the FHH/FHMG Financial Assistance Policy will be provided to patients receiving inpatient services with their Summary Bill and will be made available to all patients upon request.
    f. The FHH/FHMG Financial Assistance Policy, a Plain Language Summary of the policy, and the Financial Assistance Application are available to patients upon request at FHH/FHMG, through mail (postal service), and on the FHH/FHMG website at https://www.frederickhealth.org/about/billing-financial-assistance/

g. The FHH/FHMG Financial Assistance Policy, Plain Language Summary, and Financial Assistance Application are available in Spanish.

i. On an annual basis, FHH/FHMG shall assess the needs of our limited English proficiency community and determine whether additional translations are needed.

3. Availability of Financial Assistance: FHH/FHMG retains the right, in its sole discretion, to determine a patient's ability to pay, in accordance with Maryland and Federal law.

a. Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.

b. All patients presenting for emergency services will be treated regardless of their ability to pay.

i. For emergent services, applications for Financial Assistance will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

4. Limitation of Charges: Individuals eligible for reduced-cost care under this policy will not be charged more than the hospital's standard charges, as set by Maryland's Health Services Cost Review Commission (HSCRC).

a. The Frederick Health Hospital rate structure is governed by the HSCRC rate setting authority. As an "all- payer system", all patient care in the regulated hospital setting is charged according to the resources consumed in treating them regardless of the patient's ability to pay.

b. Regulated hospital charges are developed based on a relative predetermined value set by the HSCRC at the approved unit rate developed by the HSCRC.

B. **PROGRAM ELIGIBILITY**

1. FHH/FHMG strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. FHH/FHMG reserves the right to grant Financial Assistance without formal application being made by patients. These patients may include the homeless or returned mailed with no forwarding address.

2. Patients who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care may be eligible for the FHH/FHMG Financial Assistance Program.

3. Healthcare services that are eligible for Financial Assistance are emergency medical care and other medically necessary services delivered by Frederick Health Hospital and Frederick Health Medical Group.

a. For these purposes, emergency medical care means care provided by Frederick Health Hospital for emergency medical conditions, which means a medical condition manifesting itself by acute symptoms of sufficient

severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, emergency medical conditions means that: (i) there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) transfer may pose a threat to the health or safety of the woman or the unborn child.

b. For these purposes, medically necessary services means services that are reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient that (i) endanger life; (ii) cause suffering or pain; (iii) result in illness or infirmity; (iv) threaten to cause or aggravate a handicap; or (v) cause physical deformity or malfunction.

4. Exclusions from Financial Assistance: Specific exclusions to coverage under the Financial Assistance program include the following:
    a. Patients whose insurance program or policy denies coverage for the services received (e.g., HMO, PPO, Workers Compensation, or Medicaid);
        i. Exceptions to this exclusion may be made, in FHH/FHMG's sole discretion, considering medical and programmatic implications.
    b. Unpaid balances resulting from cosmetic or other non-medically necessary services;
    c. Patient convenience items.
5. Ineligibility: Patients may become ineligible for Financial Assistance, for a specific date of service, for the following reasons:
    a. After being notified by FHH/FHMG, refusal to apply for or provide requested documentation or information required to complete a Financial Assistance Application within the 240 days after the patient receives the first post-discharge billing statement (approximately 8 months). (If an individual submits an incomplete Financial Assistance Application within 240 days after the patient receives the first post-discharge billing statement, FHH/FHMG shall give the individual a reasonable period of time to complete the application.)
    b. Unless seeking emergency medical services, having insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to FHH/ FHMG due to insurance plan restrictions/limits.
    c. Failure to pay co-payments as required by the Financial Assistance Program.
    d. Failure to keep current on existing payment arrangements with FHH/ FHMG, as further detailed in the Self Pay Collections Policy.

e. Failure to make appropriate arrangements on past payment obligations owed to FHH/FHMG (including those patients who were referred to an outside collection agency for a previous debt).

f. Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program, unless FHH/FHMG can readily determine that the patient would fail to meet the eligibility requirements.

6. Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a collection agency if the balance remains unpaid in the agreed upon time periods.
7. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance eligibility criteria (See Section D.2 below).
    a. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Senior Leadership for approval.
    b. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.
8. Coverage amounts will be calculated using a sliding fee scale based on federal poverty guidelines.

C. PATIENT FINANCIAL ASSISTANCE GUIDELINES

1. Services eligible under this Policy will be made available to the patient on a sliding fee scale as described in this section and in ***Appendix A***.
2. A patient's eligibility for Financial Assistance shall be calculated at the time of service or updated, as appropriate, to account for any change in financial circumstances of the patient that occurs within 240 days after the initial medical bill is provided.
3. Additionally, payment plans based on a patient's ability to pay are available on an individual basis to those patients with a family income between 200% and 500% of the federal poverty level who request assistance, irrespective of a patient's insurance status. Additional details regarding payment plans can be found in the Self Pay Collections Policy.
4. US Federal Poverty guidelines are updated annually by the Department of Health and Human Services and are available at https://www.healthcare.gov/glossary/federal-poverty-level-fpl/.

D. PRESUMPTIVE FINANCIAL ASSISTANCE

1. Patients may be eligible for Financial Assistance on a presumptive basis. There are instances when a patient may appear eligible for Financial Assistance, but there is no Financial Assistance application and/or supporting documentation on file. Often there is adequate information provided by the patient or other sources that is

sufficient for determining Financial Assistance eligibility.

a. In the event there is no evidence to support a patient's eligibility for Financial Assistance, FHH/
FHMG reserves the right to use outside agencies, or propensity to pay modeling in determining Financial Assistance eligibility.

b. Patients who are determined to satisfy presumptive eligibility will receive free care on that date of service. Presumptive Financial Assistance eligibility shall only cover the patient's specific date of service.

2. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

a. Active Medical Assistance pharmacy coverage;

b. Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums);

c. Homelessness;

d. Maryland Public Health System Emergency Petition patients;

e. Being a beneficiary/recipient of the following means-tested social service programs: Women, Infants and Children Programs ("WIC"); Food Stamp/ Supplemental Nutritional Assistance Program; households with children in the free or reduced lunch program; low-income-household energy assistance program; Primary Adult Care Program ("PAC"), until such time as inpatient benefits are added to the PAC benefit package; or other means-tested social services programs deemed eligible for hospital free care policies by the Maryland Department of Health and the HSCRC, consistent with HSCRC regulations;

f. Eligibility for other state or local assistance programs;

g. Deceased with no known estate; and

h. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program.

3. Patients deemed to be presumptively eligible for Financial Assistance based on participation in a social service program identified above must submit proof of enrollment within 30 days of such eligibility determination. A patient, or a patient's representative, may request an additional 30 days to submit required proof.

4. Exclusions from consideration for presumptive eligibility include:

a. Purely elective procedures (e.g., cosmetic procedures).

E. **MEDICAL HARDSHIP PROGRAM**

1. In addition to, but separate from, Patient Financial Assistance described elsewhere in this policy, eligible patients may qualify for the Medical Hardship Program.

a. Patients may qualify for this program if they have incurred collective family medical debt at FHH/ FHMG, exceeding 25% of the combined household

income, during a 12-month period, regardless of income.

i. Medical debt is defined as out-of-pocket expenses for medically necessary care received at FHH/FHMG, including co-payments, co-insurance, and deductibles.

2. FHH/FHMG applies the medical debt criteria set forth above to a patient's balance after any insurance payments have been received.
3. If determined eligible, patients and their immediate family qualify for a 20% reduction in the cost of medically necessary care, for a 12-month period effective on the date the medically necessary care was initially received.
4. In situations where a patient is separately eligible for both the Medical Hardship Program and the standard Financial Assistance Program, FHH/FHMG will apply the reduction in charges that is most favorable to the patient.
5. Patients are required to notify FHH/FHMG of their potential eligibility for the Medical Hardship Program.

F. **ASSISTANCE BASED ON INDIVIDUAL CIRCUMSTANCES**: FHH/FHMG reserves the right to consider individual patient and family financial circumstances to grant reduced-cost care in excess of State and this policy's established criteria.

1. The eligibility, duration, and discount shall be patient-situation specific.
2. Patient balance after insurance accounts may be eligible for consideration.
3. Cases falling into this category require management review and approval.

G. **ASSET CONSIDERATION**

1. Household monetary assets are generally not considered as part of Financial Assistance eligibility etermination unless they are deemed substantial enough to cover all or part of the patient's responsibility without causing undue hardship. When household monetary assets are reviewed, individual patient financial circumstances, such as the ability to replenish the asset and future income potential, are taken into consideration.
2. The following monetary assets that are convertible to cash are exempt from consideration:
   The first $10,000 of monetary assets for individuals, and the first $25,000 of monetary assets for families.
   Up to $150,000 in primary residence equity.
   Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account. Generally, this consists of plans that are tax exempt and/or have penalties for early withdrawal.

   One motor vehicle used for the transportation needs of the patient or any family member of the patient.
   Any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act.
   Prepaid higher education funds in a Maryland 529 Program account.
3. Monetary assets excluded from consideration shall be adjusted annually for inflation

in accordance with the Consumer Price Index effective as of January 1, 2021.

H. **APPEALS**

1. Patients whose Financial Assistance applications are denied have the option to appeal the decision. Appeals should be made in writing and mailed to: Frederick Health 400 West Seventh Street Frederick, MD 21701 Attn: Financial Counseling Team.
2. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
3. Appeals are documented and reviewed by the next level of management for additional reconsideration.
4. If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
5. Appeals can be escalated up to the Chief Financial Officer who will render the final decision.
6. Patients who have formally submitted an appeal will receive a letter of the final determination.
7. Patients have thirty (30) days after denial to submit their appeal.
8. The Health Education and Advocacy Unit ("HEAU") is available to assist patients and their authorized representatives in filing and mediating reconsideration requests/ appeals. The HEAU can be contacted using the following information:
   Office of the Attorney General Consumer Protection Division Health Education and Advocacy Unit 200 Saint Paul Place
   Baltimore, Maryland 21202-2021
   Phone number: 410-528-1840 or 1-877-261-8807 Email address: heau@oag.state.md.us
   Fax number: 410-576-6571
   Website: https://www.marylandattorneygeneral.gov/pages/cpd/heau/default.aspx
9. Patients may file a complaint against a hospital for an alleged violation of its Financial Assistance policy by sending the complaint to the Maryland Health Services Cost Review Commission at hscrc.patient-complaints@maryland.gov. Complaints may also be filed jointly with the HEAU using

I. **PATIENT REFUND**

1. If, within a two (2) year period after the date of service, a patient is found to be eligible for free or reduced-cost care under FHH/FHMG's Financial Assistance Program, for that date of service, the patient shall be refunded payments in excess of their financial obligation where such refund is greater than $5. For purposes of clarification and avoidance of doubt, the patient's eligibility for Financial Assistance for purposes of this sub-section shall be calculated consistent with Section C(2).
   a. The two (2) year period may be reduced to 240 days (approximately 8 months) after receipt of the first post-discharge billing statement where FHH/FHMG's documentation demonstrates a lack of cooperation by the

patient, or guarantor, in providing documentation or information necessary for determining patient's eligibility.

2. If a patient is found to be eligible for Financial Assistance after FHH/FHMG has initiated extraordinary collection actions (ECA), such as reporting to a credit agency, liens, or lawsuits, FHH/ FHMG will not take any further ECA and will take all reasonable steps available to reverse any ECA already taken as also set forth in the Self Pay Collections Policy. For purposes of clarification and avoidance of doubt, the patient's eligibility for Financial Assistance for purposes of this sub-section shall be calculated consistent with Section C(2).

J. **OPERATIONS**

1. FHH/FHMG will designate a trained person or persons who will be responsible for taking Financial Assistance Applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, or other designated trained staff.
2. Every effort will be made to determine eligibility prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
    a. Staff will complete an eligibility check with the applicable state Medicaid program to determine whether patients have current coverage or may be eligible for coverage.
        i. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations).
    b. FHH/FHMG will provide patients with the Maryland State Uniform Financial Assistance Application and a checklist of what paperwork is required for a final determination of eligibility.
        i. In addition to a completed Maryland State Uniform Financial Assistance Application, patients may be required to submit:
            a. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income);
            b. Proof of disability income (if applicable);
            c. A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income or documentation of how they are paying for living expenses;
            d. Proof of social security income (if applicable);
            e. A Medical Assistance Notice of Determination (if applicable);

f. Reasonable proof of other declared expenses; and

g. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.

3. If a patient has not submitted a completed Financial Assistance application or any required supporting documentation within 30 days after a formal request, a letter will be sent reminding the patient that Financial Assistance is available and informing the patient of the collection actions that will be taken if no documentation is received.
    a. A deadline for submission, prior to initiation of collection actions, will be included in the letter. Such deadline will be no earlier than 30 days after the date the reminder letter is provided.
    b. No extraordinary collection actions, such as reporting to a credit agency, liens, or lawsuits, will be taken prior to 180 days after the first post-discharge billing statement (approximately 6 months).
    c. If documentation is received after collection actions have been initiated, but within 240 days after the patient's receipt of the first post discharge billing statement, FHH/FHMG shall cease all collection actions and determine whether the patient is eligible for financial assistance.
4. A Plain Language Summary of this policy shall be included with the letter and FHH/FHMG staff must make a reasonable effort to orally notify the individual of FHH/FHMG's Financial Assistance program.
5. Once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for determination of eligibility based on FHH/FHMG guidelines.
    a. If the patient's application for Financial Assistance is determined to be complete and appropriate, appropriate personnel will recommend the patient's level of eligibility.
    b. For complete applications, the patient will receive a letter notifying them of approval/denial within 14 days of submitting the completed applications. FHH/FHMG shall suspend any billing or collections actions while eligibility is being determined.
    c. If an application is determined to be incomplete, the patient will be contacted regarding any additional required documentation or information
        i. If a patient is determined to be ineligible prior to receiving services, all efforts to collect co- pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.
        ii. If a patient is determined to be ineligible after receiving services, a payment arrangement will be offered on any balance due by

the patient.

6. Except as noted below, once a patient is approved for Financial Assistance, such Financial Assistance shall be effective as of the date treatment is received and the following twelve (12) calendar months.
    a. Presumptive Financial Assistance cases will apply to the date of service only.
    b. If additional healthcare services are provided beyond the approval period, patients must reapply to continue to receive Financial Assistance.
7. The following may result in the reconsideration of Financial Assistance approval:
    a. Post approval discovery of an ability to pay; and
    b. Changes to the patient's income, assets, expenses or family status which are expected to be communicated to FHH/FHMG.
8. FHH/FHMG will track patients' qualification for Financial Assistance or Medical Hardship. However, it is ultimately the responsibility of the patient to inform FHH/FHMG of their eligibility status (and any updates to such eligibility) at the time of registration, upon receiving a statement, or at any other time.
9. FHH/FHMG will not use a patient's citizenship or immigration status as an eligibility requirement for Financial Assistance or withhold Financial Assistance or deny a patient's application for Financial Assistance on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or on the basis of disability.

A. **CREDIT & COLLECTIONS POLICY**

1. FHH/FHMG maintains a separate Credit & Collections Policy that outlines what actions FHH/FHMG may take in the event a patient fails to meet their financial responsibility.
2. A copy of the Credit & Collections policy may be obtained by requesting a copy from FHH/FHMG staff or by visiting FHH/FHMG's website.
3. FHH/FHMG maintains a list of all non-FHH/FHMG providers who may care for patients while at FHH/ FHMG. Non-FHH/FHMG providers bill separately for their services and not all participate in FHH/ FHMG's Financial Assistance Program.
    a. A copy of this list may be obtained by requesting a copy from FHH/FHMG staff or by visiting FHH/ FHMG's website at https://www.frederickhealth.org/find-a-provider/.

Attachments

2023 Appendix A FA FPL Matrix Guidelines.pdf

Approval Signatures

Step Description	Approver	Date
Senior Leader Approval	Hannah Jacobs: Senior Vice President CFO	03/2023
Owner Approval	Shawn McCardell: AVP Revenue Cycle	03/2023

Standards

No standards are associated with this document