

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. Hospitals are expected to respond to any follow-up/clarifying questions from staff to ensure completeness and accuracy of the report.

For technical assistance, contact [HCbHelp@hilltop.umbc.edu](mailto:HCbHelp@hilltop.umbc.edu).

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

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

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

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

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> Median household income                              | <input checked="" type="checkbox"/> Race: percent White                   |
| <input checked="" type="checkbox"/> Percentage below federal poverty level (FPL)         | <input checked="" type="checkbox"/> Race: percent Black                   |
| <input checked="" type="checkbox"/> Percent uninsured                                    | <input checked="" type="checkbox"/> Ethnicity: percent Hispanic or Latino |
| <input checked="" type="checkbox"/> Percent with public health insurance                 | <input checked="" type="checkbox"/> Life expectancy                       |
| <input checked="" type="checkbox"/> Percent with Medicaid                                | <input checked="" type="checkbox"/> Crude death rate                      |
| <input type="checkbox"/> Mean travel time to work  | <input checked="" type="checkbox"/> Other                                 |
| <input checked="" type="checkbox"/> Percent speaking language other than English at home |   |

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

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

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

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

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

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

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

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

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

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

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

*This question was not displayed to the respondent.*

Q34. How did your hospital identify its CBSA?

Based on ZIP codes in your Financial Assistance Policy. Please describe.

Based on ZIP codes in your global budget revenue agreement. Please describe.

Based on patterns of utilization. Please describe.

The hospital CBSA is made up of its primary and secondary service areas looking at three years of discharge data. The zip codes accounting for the top 65% of discharges make up the primary service area, the next 20% of discharges account for the secondary service area.

Other. Please describe.

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

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

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

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

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

Yes

No

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

*This question was not displayed to the respondent.*

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

10/1/2022

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.adventisthealthcare.com/app/files/public/06933932-0e5e-4a74-b2a9-31e3e00a18e9/2023-CHNA-PGCHD.pdf>

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

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

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

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



N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
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Q45. Section II - CHNAs and Stakeholder Involvement Part 3 - Internal Hospital Community Benefit Partners

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

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

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (facility level)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	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)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Physician(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Nurse(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Hospital Advisory Board	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	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 2024 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is mandatory for FY 2024.

	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: Luminus Health Doctors Community Hospital, Medstar Southern Maryland Hospital Center, UM Capital Region Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Departments -- Please list the Local Health Departments here: Prince George's County Health Department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Improvement Coalition -- Please list the LHICs here: PGHAC	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Maryland Department of Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	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: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Govt. Organizations -- Please list the organizations here: Prince George's County Latino Affairs, Department of Corrections, Office of Veterans Affairs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress



Community/Neighborhood Organizations --  
Please list the organizations here:  
Langley Park Civic 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
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Consumer/Public Advocacy Organizations --  
Please list the organizations here:

Other -- If any other people or organizations were involved, please list them here:

q49. Section II - CHNAs and Stakeholder Involvement Part 5 - Follow-up

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

- Yes
- No

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

04/10/2023

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

<https://www.adventisthealthcare.com/app/files/public/962c7210-bb7c-433c-b305-3c51a531e660/2023-CHNA-PGCHD-ImplementationStrategy.pdf>

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

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.

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

- Health Behaviors - Preventive Care
- Health Behaviors - Safe Food Handling
- Health Behaviors - Sleep
- Health Behaviors - Tobacco Use
- Social Determinants of Health - Neighborhood and Built Environment
- Social Determinants of Health - Social and Community Context
- Other Social Determinants of Health
- Other (specify)

Q60. Why were these needs unaddressed?

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

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

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

Q62. Other than Charity Care, Graduate Medical Education, and the Nurse Support Programs, please select the rate supported programs in which your hospital participates:

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

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

## Q64. Section III - CB Administration

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

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

Q66. Please describe the third party audit process used.

*This question was not displayed to the respondent.*

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

- Yes
- No

Q68. Please describe the community benefit narrative audit process.

*This question was not displayed to the respondent.*

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

- Yes
- No

Q70. Please explain:

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

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

- Yes
- No

Q72. Please explain:

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

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

- Yes
- No

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

As part of Adventist HealthCare, Fort Washington Medical Center (FWMC) is dedicated to Community Benefit which aligns with the systems core mission and values. The Strategic Plan for FWMC as well as all of Adventist HealthCare (AHC) is based on our pillars of success: Bigger, Better (People; Quality and Safety; Experience; Finance), and Beyond. Each of the pillars are centered on measurable objectives and targets and is led by an overarching council with several committees reporting up to it. Population Health and community benefit efforts are all included within the Beyond pillar.

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

The strategic plan is not a publicly available document.

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

Diabetes - Reduce the mean BMI for Maryland residents

Through the HSCRC Catalyst Grant, FWMC is partnering with TLC-MD, a collaborative of 6 hospitals, to increase access to diabetes education in the community. The program is seeking to build capacity and increase access to DPP and DSMES, evidence based diabetes prevention and self-management programs. The program is focused on identifying and referring patients underserved and minority patients, as well as those with Medicaid and Medicare.

Opioid Use Disorder - Improve overdose mortality

The Mosaic Grant is a federally funded program that FWMC implemented to identify patients that have substance abuse disorders by doing a SBIRT screening on all patients in the ED. If the patient is identified with a positive screening, then the Peer Recovery Coach contacts the patient while still in the department or via phone if they had been discharged. If the patient accepts assistance, they are referred to an inpatient and/or outpatient program for treatment.

Maternal and Child Health - Reduce severe maternal morbidity rate

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

None of the Above

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

#### Q78. Section IV - Physician Gaps & Subsidies

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

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

#### Q80. Section V - Financial Assistance Policy (FAP)

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

[AHC-FinancialAssistance-Policy.pdf](#)  
627.9KB  
application/pdf

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

<https://www.adventisthealthcare.com/patients-visitors/billing-financial/assistance/>

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.

Percentage of Federal Poverty Level

200 300 400 500 600 700 800 Not Applicable

200

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.

Lowest FPL

Highest FPL

200 300 400 500 600 700 800 Not Applicable

600

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.

Lowest FPL

Highest FPL

0 100 200 300 400 500 600 700 800 Not Applicable

201 601

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

Debt as Percentage of Income

0 10 20 30 40 50 60 70 80 90 100

25

## Q88. Section VI - Tax Exemptions

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

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

## Q90. Summary & Report Submission

Q91. **Attention Hospital Staff! IMPORTANT!**

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


We strongly urge you to contact us at [hcbhelp@hilltop.umbc.edu](mailto: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: [\(39.26, -76.7125\)](#)

Source: GeolP Estimation



The image shows a map of the Northeastern United States, including parts of Pennsylvania, New York, New Jersey, Delaware, Maryland, Virginia, and West Virginia. A yellow diamond marker is placed over Baltimore, Maryland. Other cities labeled on the map include Pittsburgh, Harrisburg, Allentown, New York, New Jersey, Wilmington, Frederick, Annapolis, and Washington. The map shows major roads and geographical features like the Chesapeake Bay and the Atlantic Ocean.

# 2022

## PRINCE GEORGE'S COUNTY



# COMMUNITY HEALTH

# ASSESSMENT

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



**HEALTH  
DEPARTMENT**  
Prince George's County

Approved and adopted by Adventist HealthCare October 2022

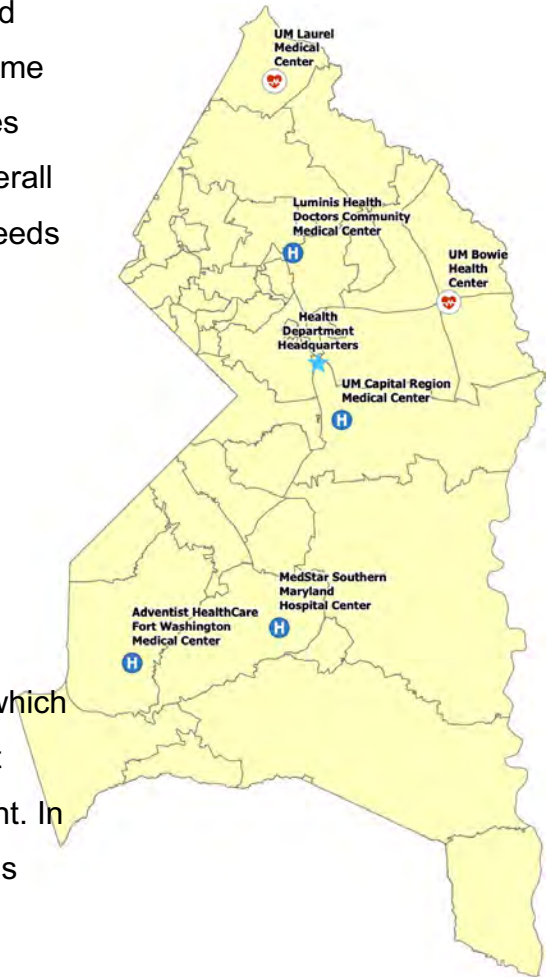
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# INTRODUCTION

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

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



## **CHA Core Team**

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

There are four hospitals located within the County: Luminis Health Doctors Community Hospital, Adventist HealthCare Fort Washington Medical Center, MedStar Southern Maryland Hospital Center, and UM Capital Region Medical Center with two freestanding emergency facilities in

Laurel and Bowie. All four hospital systems and the Health Department appointed staff to facilitate the 2022 CHA process.

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<sup>1</sup> <http://www.pgplanning.org/Resources/Publications/PHSP.htm>



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# PROCESS OVERVIEW

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

**“A community focused on health and wellness for all.”**

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

- Collaboration
- Equity
- Trust
- Safety
- Prevention

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

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

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

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<sup>2</sup> <https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp>



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

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

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

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

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



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# KEY FINDINGS

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## Drivers of Poor Health Outcomes:

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



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



## Leading Health Challenges

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

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



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

## Recommendations

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



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



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Population Profile

Health Indicators

Key Informant Interviews

Community Expert Survey

Resident Survey



# COMMUNITY HEALTH ASSESSMENT

2022 EXECUTIVE SUMMARY



PRINCE GEORGE'S COUNTY HEALTH DEPARTMENT

Prepared by the Office of Assessment and Planning, June 14, 2022

Health-OAP@co.pg.md.us

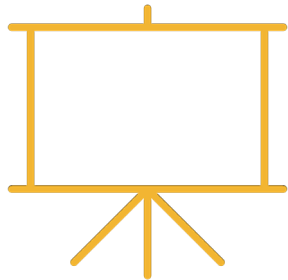


**HEALTH DEPARTMENT**  
Prince George's County

Community Health Assessment

# OVERVIEW

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



## CHA PROCESS

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

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

2019 Values:

- Collaboration
- Equity
- Trust
- Safety
- Prevention

## 2022 CHA Components

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

## 2022 CHA Core Team

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



## 2022 PRIORITIES

### **Determined by consensus to retain the four priority areas:**

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



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

## WE WILL NEED TO REVISIT SOME DATA SOURCES:

- **Census 2020:** We know our population grew much more than estimated.
  - 2019 American Community Survey Estimate: 909,327
  - 2020 Census: 967,201
- **Maryland Department of Health Cyberattack**
  - Still no Maryland Behavioral Risk Factor Surveillance System Data website
  - Moratorium on hospital discharge data
  - 2020 Vital Statistics data has not yet been released

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



PRIORITY #1

# SOCIAL DETERMINANTS OF HEALTH

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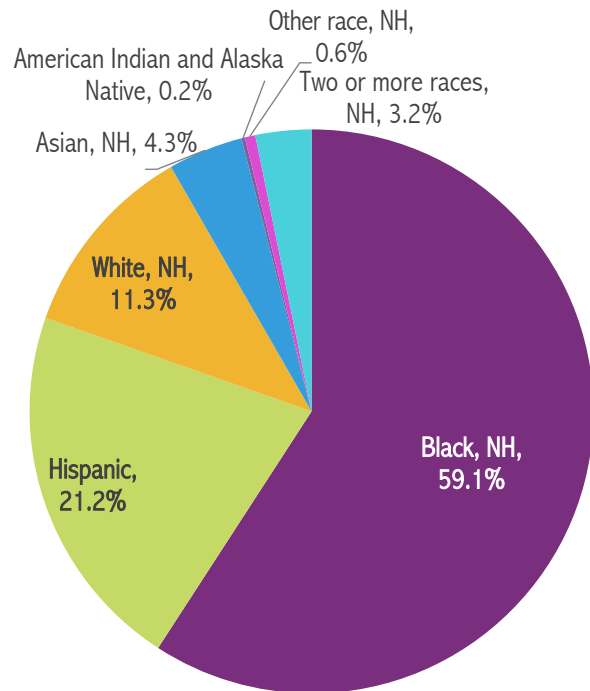




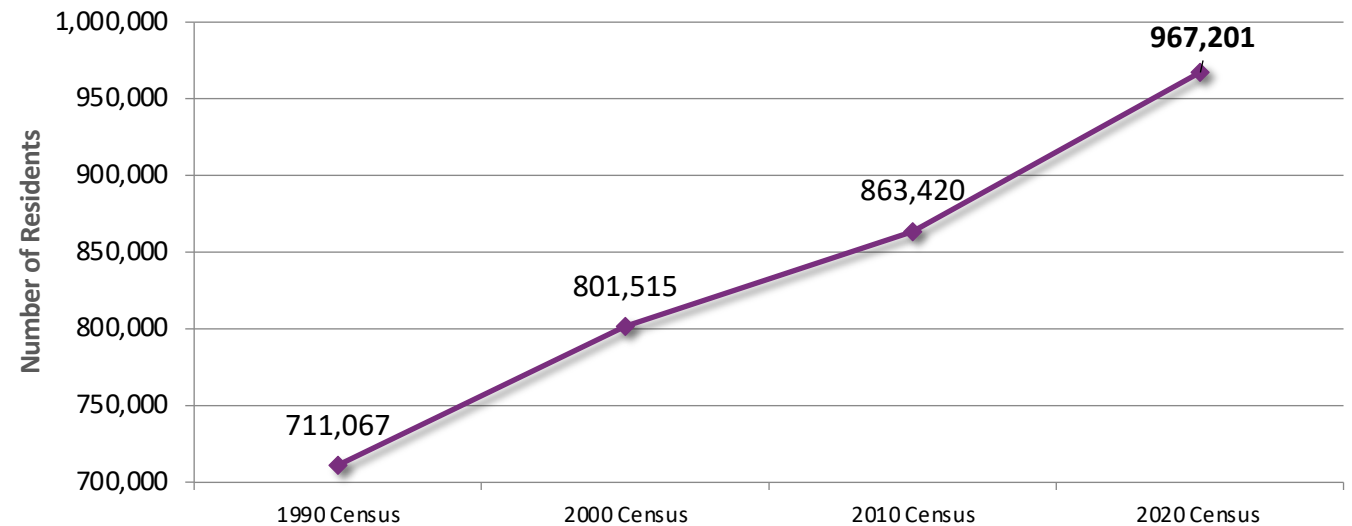
# Population Changes

## HIGHLIGHTS

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



PRINCE GEORGE'S COUNTY POPULATION, 1990-2020





## ACCESS TO CARE

### Indicators

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

### RESIDENTS WITH HEALTH INSURANCE, 2016-2020

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

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



## ACCESS TO CARE

### Resident Surveys

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

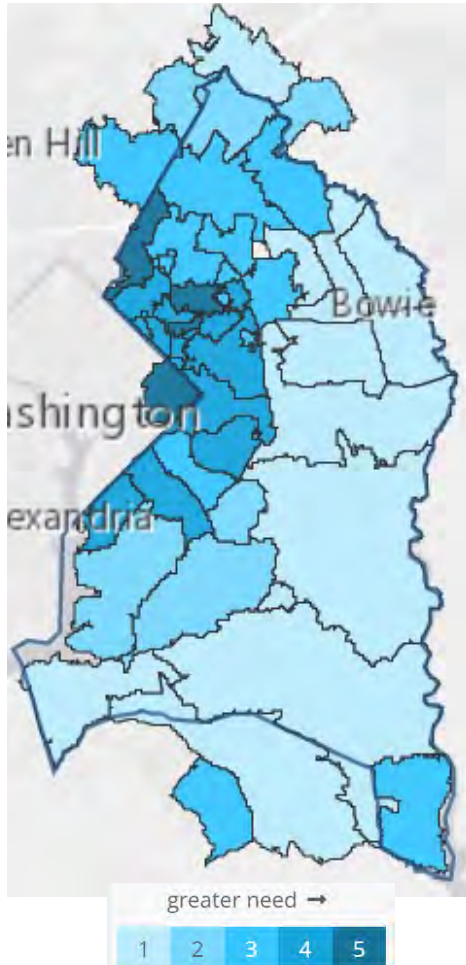
### Community Experts for Special Populations

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



# Socioeconomic Factors

2022 SOCIONEEDS INDEX  
PRINCE GEORGE'S COUNTY



Source: [www.PGCHHealthZone.org](http://www.PGCHHealthZone.org)

## Indicators

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

## Resident Surveys

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

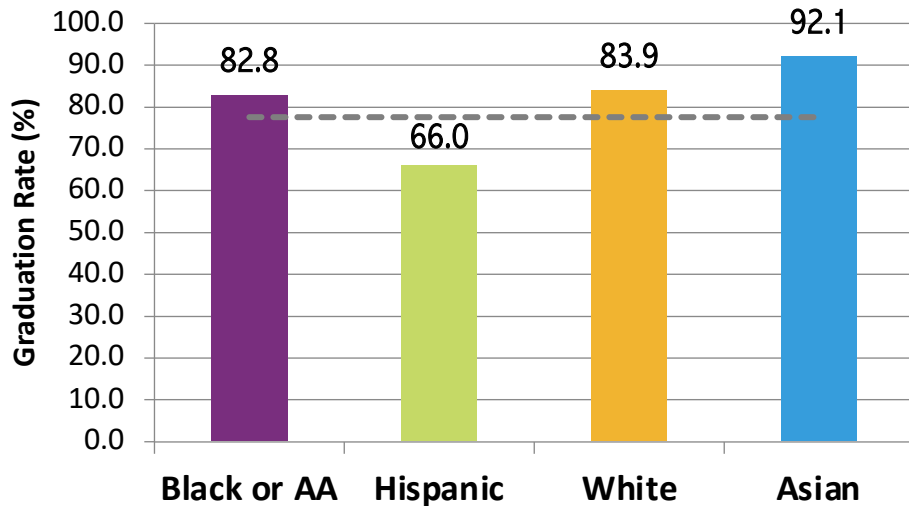
## Community Experts

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



## Education

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



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

Source: 2021 [Maryland Public Schools Report Card](#)

### Indicators

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

### Resident Surveys

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

### Community Experts

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



# Housing

## 2021 FAIR MARKET RENT

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

Source: [National Low Income Housing Coalition](#)

## Indicators

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

## Resident Surveys

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

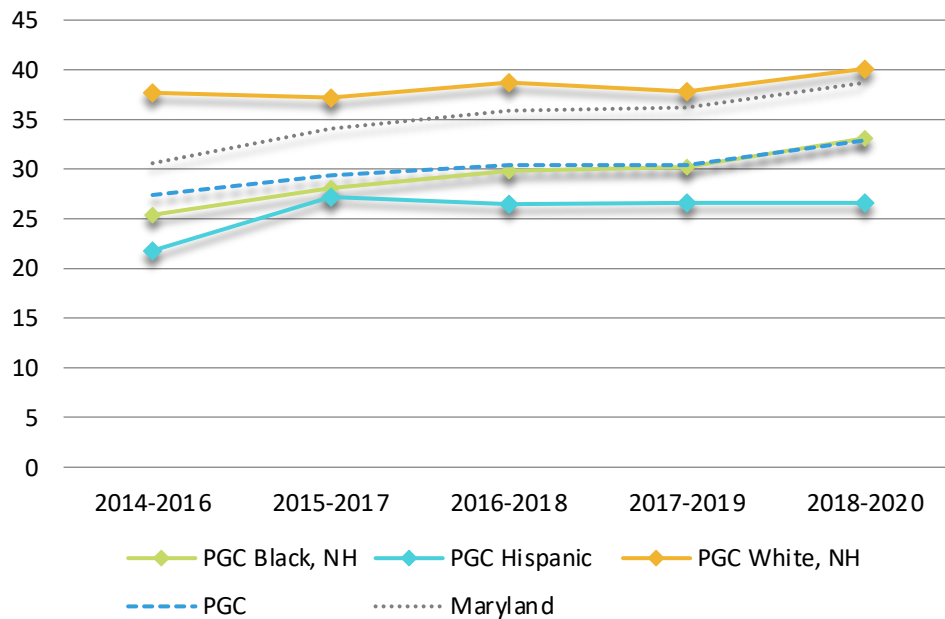
## Community Experts

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



# NEIGHBORHOOD & BUILT ENVIRONMENT

UNINTENTIONAL INJURY AGE-ADJUSTED MORTALITY RATE  
2014-2020



Source: CDC Wonder

## Indicators

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

## Resident Surveys

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

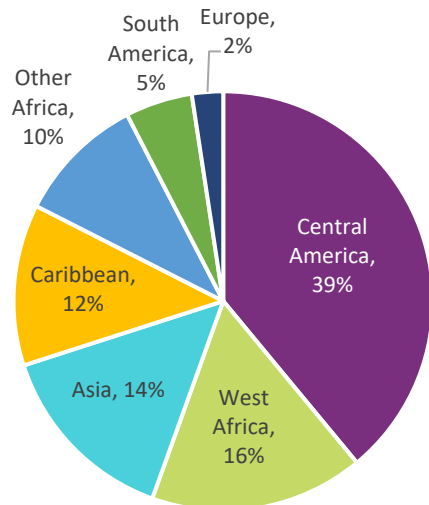
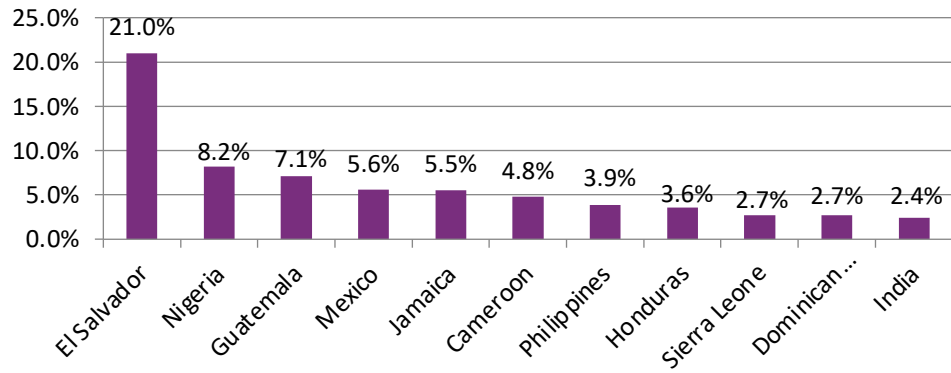
## Community Experts

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



# SOCIAL & COMMUNITY CONTEXT

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



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

## Indicators

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

## Resident Surveys

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

## Community Experts

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



## SDOH BIG PICTURE

### What's happened since the last CHA?

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

### What's in the works?

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

### Where do gaps/opportunities remain?

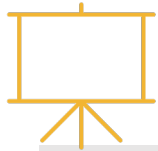
- New County Council members coming in 2022 who will need to be briefed
- Lack of adequate resources in the County (office/positions): Estimated County spending on health and human services departments is \$39 per person, about one-third to one-seventh the per-person spending of surrounding Maryland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

PRIORITY #2

# BEHAVIORAL HEALTH

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# MENTAL HEALTH

## HEALTH INDICATORS & DISPARITIES

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

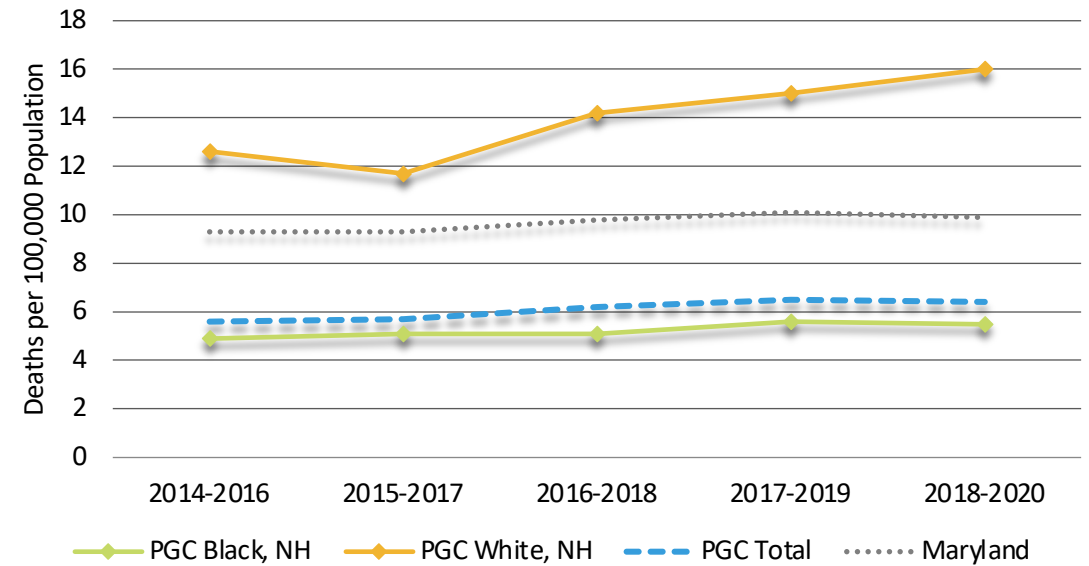
## TRENDS (COMPARED TO 2019 CHA)

- - Increase in MH providers to 550:1 in 2021 from 810:1 in 2018
- - Almost one in five high school students indicated they had seriously considered suicide and 16% made a plan in 2018, similar to 2016
- - Suicide mortality rate for Black, NH has remained between 5.0 - 5.5. per 100,000.
- - Suicide mortality rate for White, NH increased from 11.7 per 100,000 in 2015-2017 to 16.0 in 2018-2020

## RISK FACTORS

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

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



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

## COMMUNITY PERCEPTION

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



# SUBSTANCE ABUSE

## HEALTH INDICATORS & DISPARITIES

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

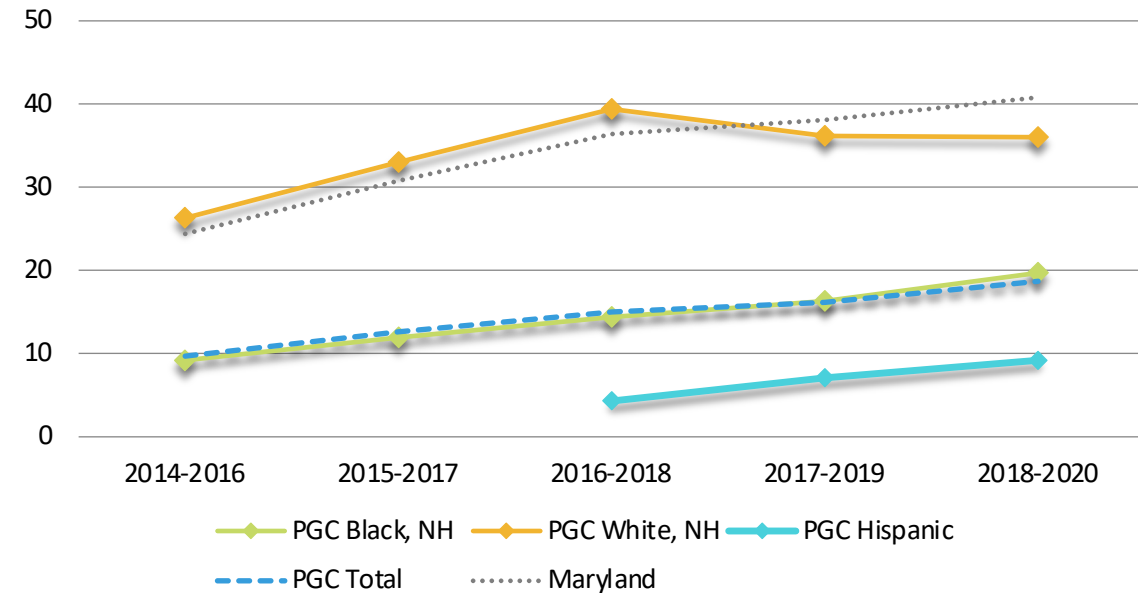
## TRENDS (COMPARED TO 2019 CHA)

- Drug-related mortality rate for white NH residents has decreased from a high of 39.4 per 100,000 (2016-2018) to 36.0 (2018-2020)
- High school students who used tobacco products in the past month decreased to 9.5% in 2018, from 13.3% in 2013
- Overall, adults who binge drink remained steady, at 12.9% in 2019
- Drug-related mortality rate for the County and specifically Black NH and Hispanic residents has been steadily increasing
- Adults who reported binge drinking increased for both Black, NH and white, NH residents

## RISK FACTORS

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

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



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

## COMMUNITY PERCEPTION

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



# BEHAVIORAL HEALTH BIG PICTURE

## What's happened since the last CHA?

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

## What's in the works?

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

## Where do gaps/opportunities remain?

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

PRIORITY #3

# OBESITY & METABOLIC SYNDROME

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# OBESITY

## HEALTH INDICATORS & DISPARITIES

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

## TRENDS (COMPARED TO 2019 CHA)

- - Decrease in adults who reported being obese from 42.0% in 2017 to 35.0% in 2019
- - Decrease in adults who reported being obese or overweight from 73.5% in 2017 to 71.2% in 2019
- - About half of adults reported engaging in regular physical activity in 2019, similar to 2017
- - No negative trends identified

## RISK FACTORS

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

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

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

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

## COMMUNITY PERCEPTION

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



# HEART DISEASE

## HEALTH INDICATORS & DISPARITIES

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

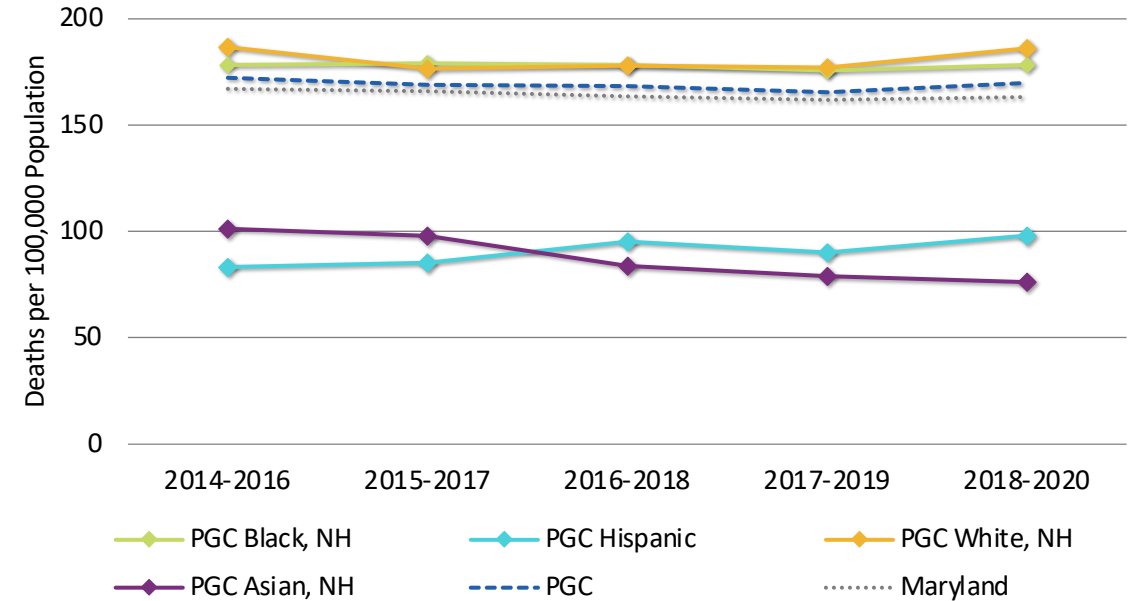
## RISK FACTORS

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

## TRENDS (COMPARED TO 2019 CHA)

- - Decrease in risk factor of adults who reported being obese from 42.0% in 2017 to 35.0% in 2019
- - No neutral trends identified
- - Increase in heart disease mortality across nearly all races/ethnicity
- - Increase in residents on Medicare being treated for Heart Failure (14.7% in 2018 compared to 13.4% in 2015)

HEART DISEASE AGE-ADJUSTED MORTALITY RATE, 2014-2020



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

## COMMUNITY PERCEPTION

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



# DIABETES

## HEALTH INDICATORS & DISPARITIES

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

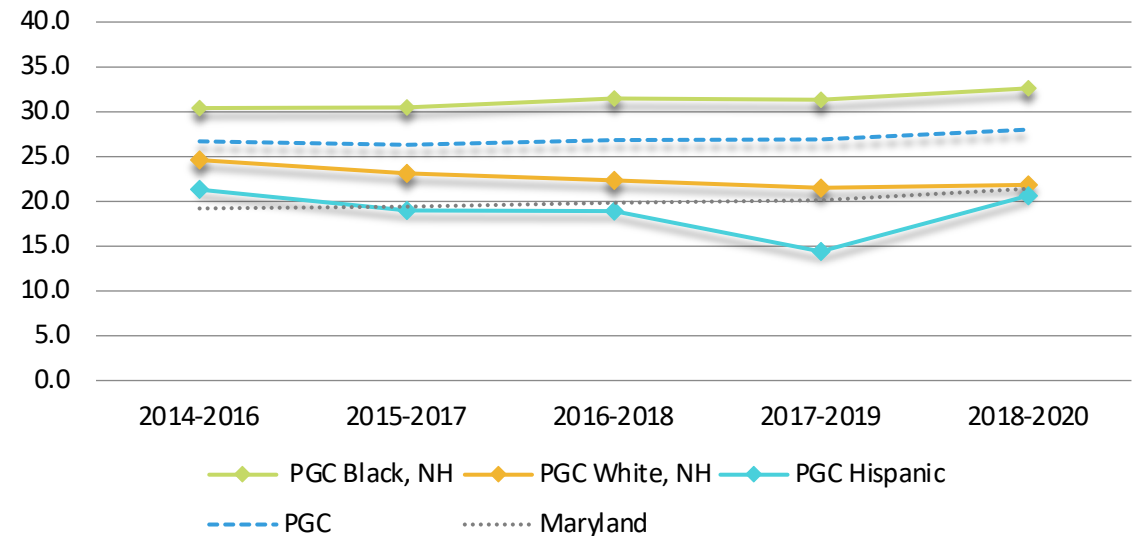
## TRENDS (COMPARED TO 2019 CHA)

- - No positive trends identified
- - No neutral trends identified
- - Increase in prevalence from 12.3% in 2017 to 13.8% in 2019
- - Increase in inpatient visit rate due to diabetes (18.2 per 10,000, 2017-2019); highest for Black residents at 18.5
- - Increase in diabetes mortality to 28.0 per 100,000 residents

## RISK FACTORS

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

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



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

## COMMUNITY PERCEPTION

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



# HYPERTENSION & STROKE

## HEALTH INDICATORS & DISPARITIES

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

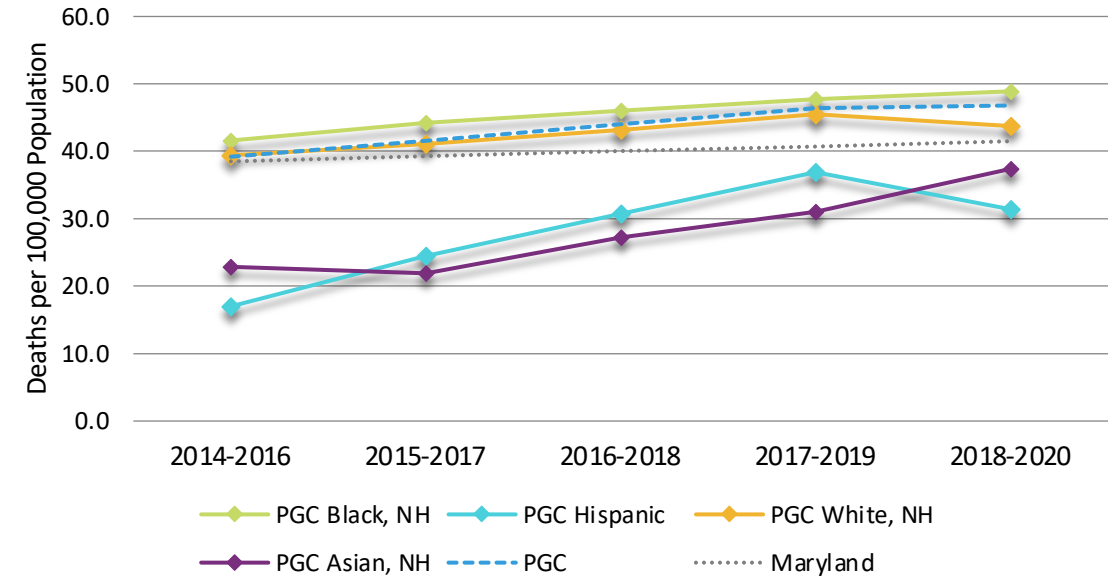
## TRENDS (COMPARED TO 2019 CHA)

- - No positive trends identified
- - No neutral trends identified
- - Overall increase in resident adults who have been told they have high blood pressure by a healthcare provider
- - Increase in inpatient visit rate due to hypertension
- - Increase in stroke mortality, from 39.2 in 2014-2016 to 46.8 in 2018-2020

## RISK FACTORS

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

STROKE AGE-ADJUSTED MORTALITY RATE, 2014-2020



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

## COMMUNITY PERCEPTION

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



# OBESITY & METABOLIC SYNDROME BIG PICTURE

## What's happened since the last CHA?

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

## What's in the works?

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

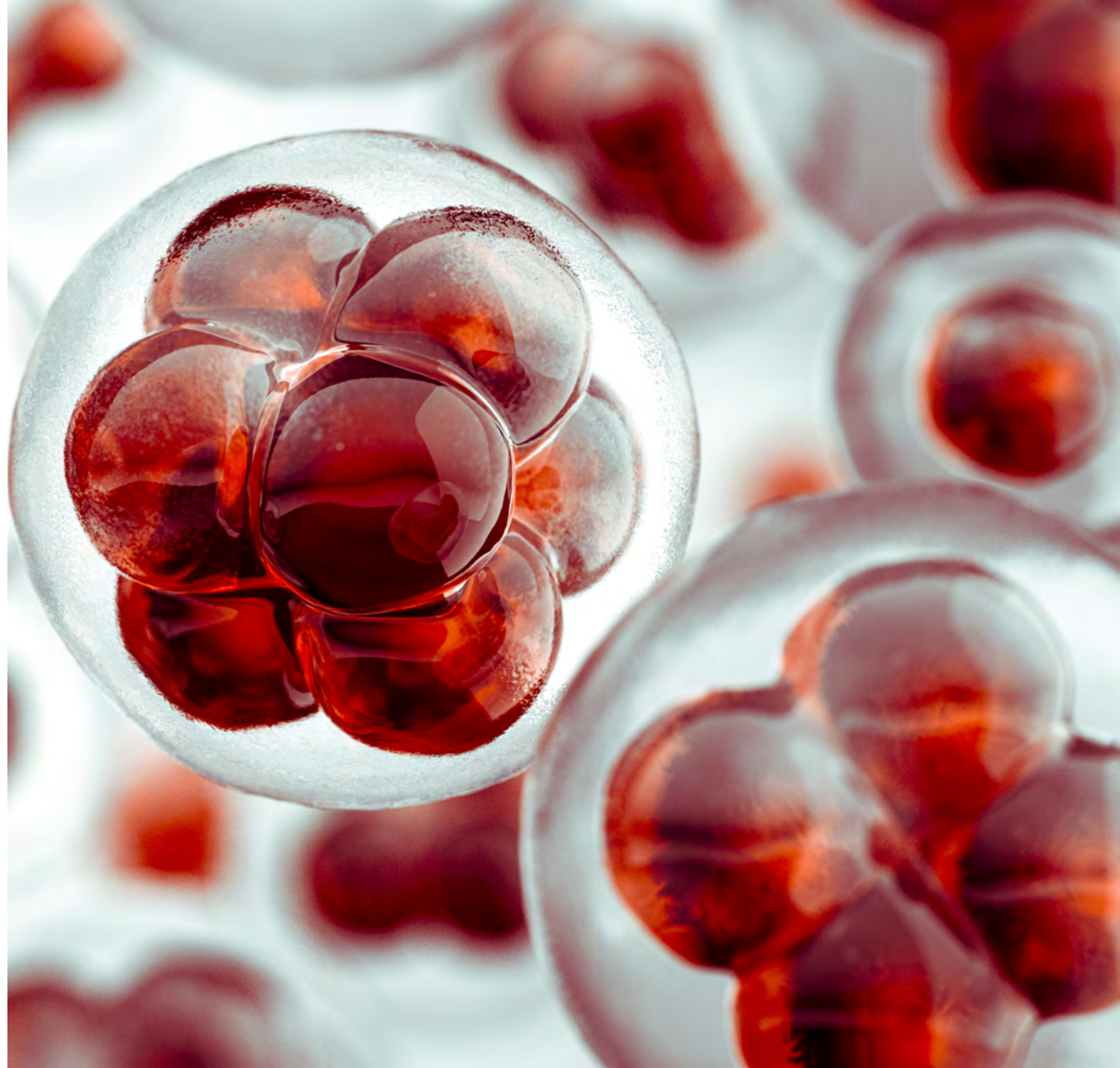
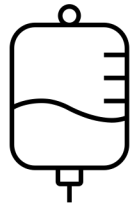
## Where do gaps/opportunities remain?

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

PRIORITY #4

# CANCER

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# CANCER

## HEALTH INDICATORS & DISPARITIES

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

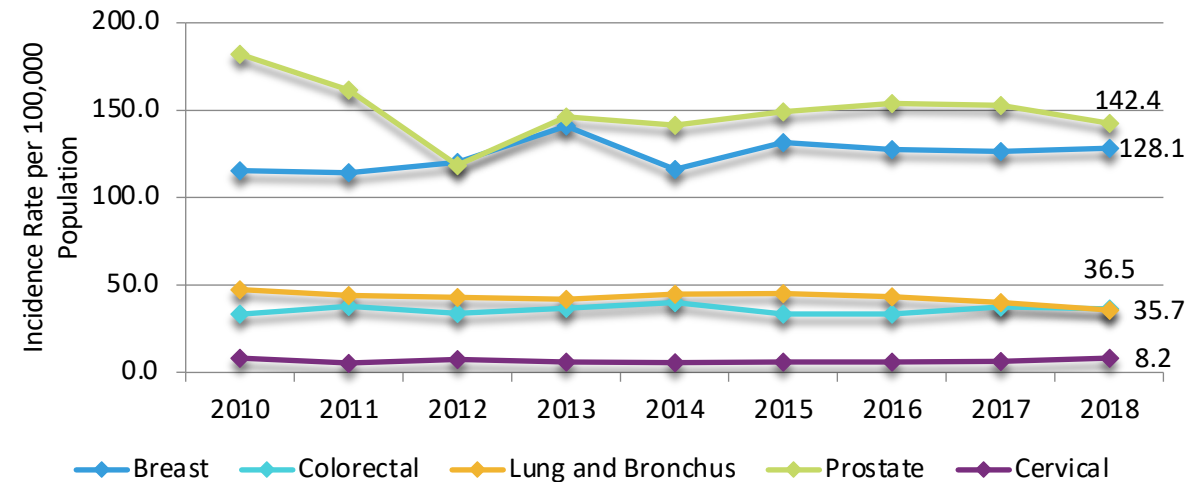
## RISK FACTORS

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

## TRENDS (COMPARED TO 2019 CHA)

- - Overall cancer mortality rate has declined over the last decade to a low of 141.7 per 100,000 (2018-2020), lower than Maryland (145.5)
  - Decrease in incidence rate for Colorectal and Lung and Bronchus Cancers
- - No neutral trends identified
- - Mortality rate for Hispanic residents increased to 82.8 per 100,000 (2018-2020)
  - Increase in incidence rate for breast and cervical cancer
  - Increase in incidence rate for breast, colorectal, and lung and bronchus cancer for Black residents

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



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

## COMMUNITY PERCEPTION

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



# BREAST CANCER

## HEALTH INDICATORS & DISPARITIES

- Black, NH women have highest incidence rate (131.6 per 100,000, 2014-2018) and mortality rate (27.4 per 100,000, 2018-2020)
- Incidence Rate (125.9, 2014-2018) is lower than the state (130.8), but mortality rate is higher (PG 24.4, MD 20.7, 2018-2020)
- White, NH women reported lower mammogram screenings in the past 2 years (68.7%, 2018) compared to Black, NH women (90.5%)

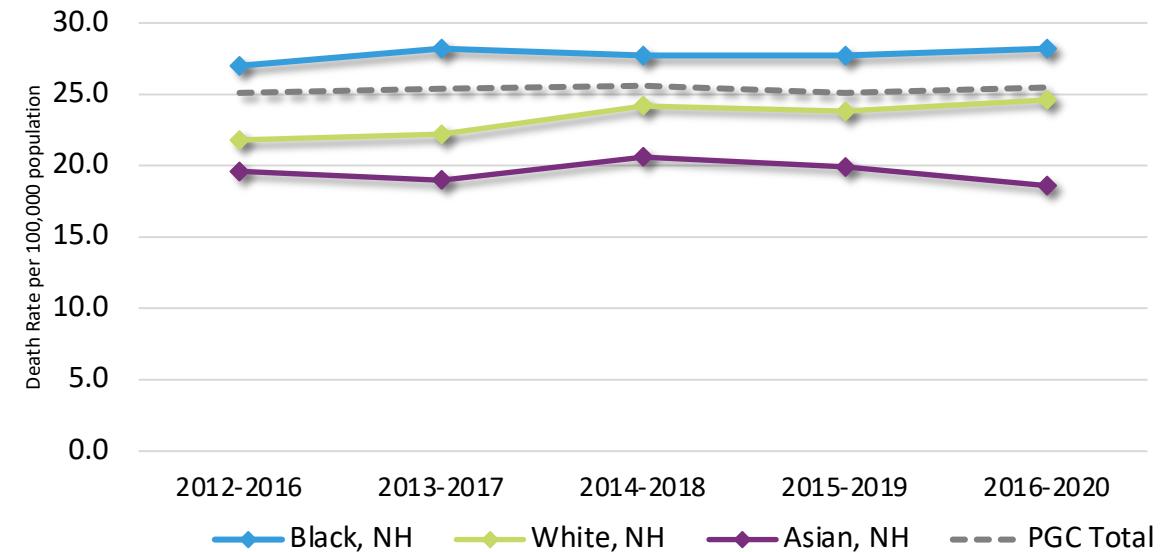
## TRENDS (COMPARED TO 2019 CHA)

- - Slight decrease in mortality rate for Black NH women, from 28.2 per 100,000 (2015-2017) to 27.4 (2018-2020)
- - Increase in women (50+ years) who received a mammogram from 82.3% in 2016 to 86.2% in 2018
- - Incidence rate has remained about the same from 2015-2018
- - Slight increase in mortality rate for white NH women, from 22.4 per 100,000 (2015-2017) to 24.2 (2018-2020)

## RISK FACTORS

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

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



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

## COMMUNITY PERCEPTION

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




# PROSTATE CANCER

## HEALTH INDICATORS & DISPARITIES

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

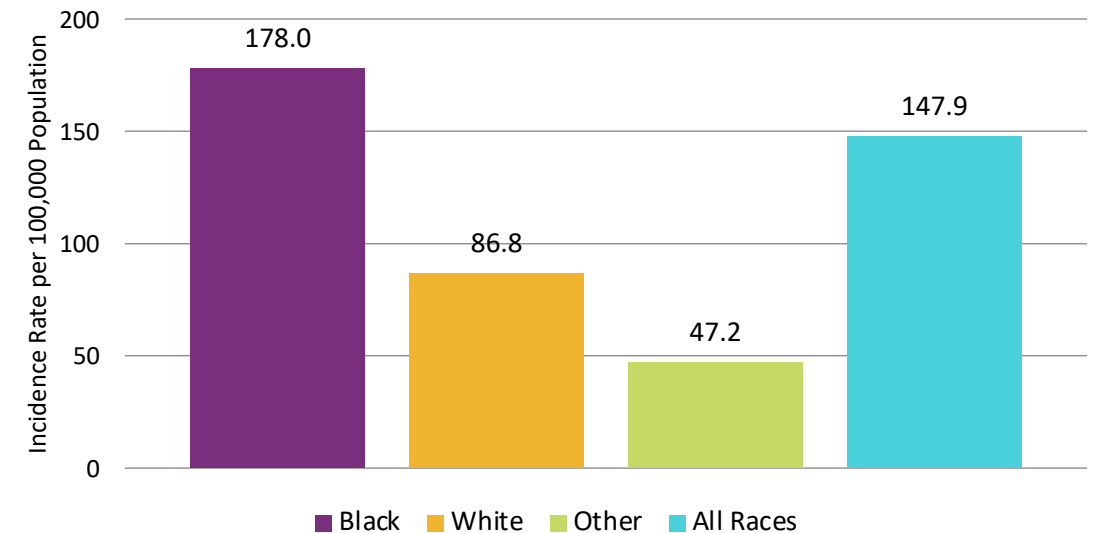
## TRENDS (COMPARED TO 2019 CHA)

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

## RISK FACTORS

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

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



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

## COMMUNITY PERCEPTION

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



## CANCER BIG PICTURE

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What's happened since the last  
CHA?

What's in the works?

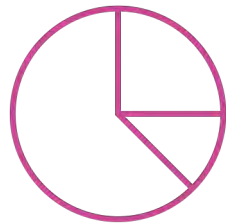
- New Regional Cancer Center at UMC CRH (opening in 2024)

Where do gaps/opportunities  
remain?

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

# ADDITIONAL AREAS OF INTEREST

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# HIV

## HEALTH INDICATORS & DISPARITIES

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

## RISK FACTORS

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

## TRENDS (COMPARED TO 2019 CHA)



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

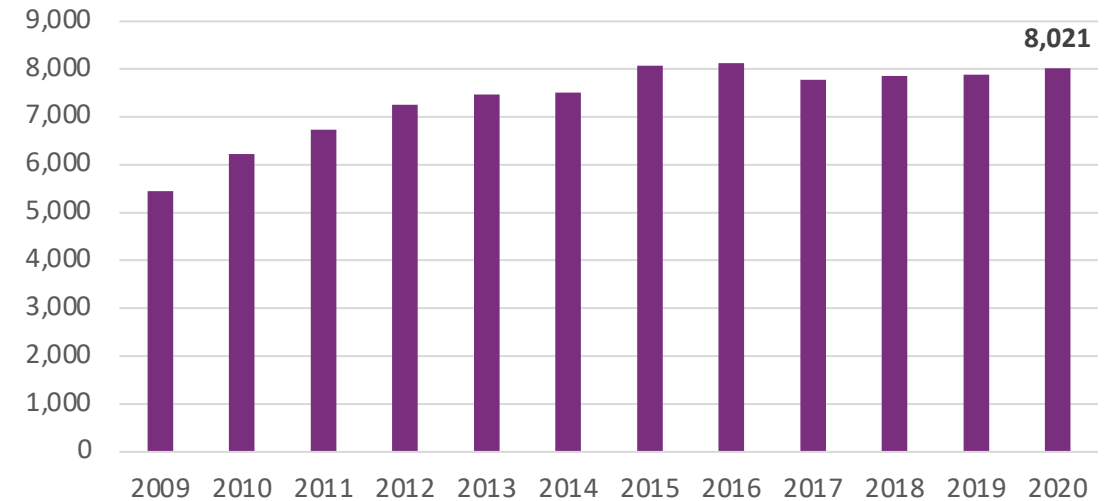


- The number of new cases for ages 40-59 stayed about the same for 2020 compared to 2017
- The percent of new cases linked to care within one month was 88.7% in 2020, about the same as 2017 (89.1%)



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

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



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

## COMMUNITY PERCEPTION

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



# MATERNAL & INFANT HEALTH

## HEALTH INDICATORS & DISPARITIES

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

## RISK FACTORS

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

## TRENDS (COMPARED TO 2019 CHA)



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

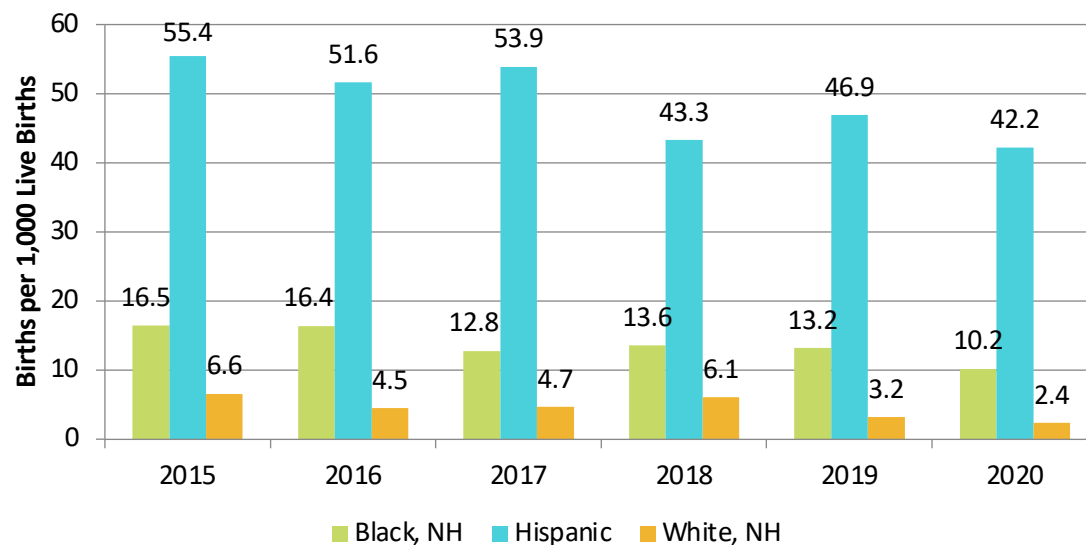


- The percent of infants with late or no prenatal care in 2020 was 9.8%, similar to 2017 at 10.2%.



- No negative trends identified

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



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

## COMMUNITY PERCEPTION

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

# THEMES & NEXT STEPS





## CHA EMERGENT THEMES

### WHAT ROSE TO THE TOP?



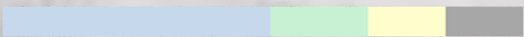
- **There's progress, but** it's not enough to meet the demand (noted across multiple areas, especially for behavioral health)
- **Housing:** lack of enough affordable quality housing
- **Meeting the needs of foreign-born residents:** this was also a theme in 2019, but in addition to supporting uninsured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



## NEXT STEPS

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



# **POPULATION** profile

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# POPULATION PROFILE

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Population Demographics

Foreign Born Residents

Poverty

Food Stamps (SNAP)

Income

Disability

Education

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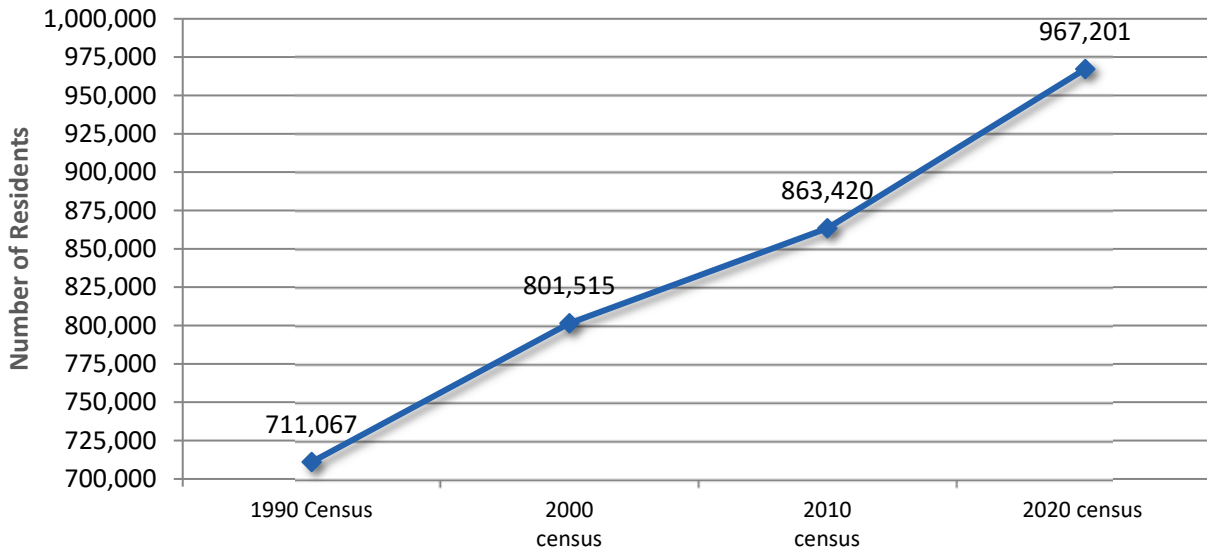
Fair Market Rent

Health Equity Index

## Overall Population

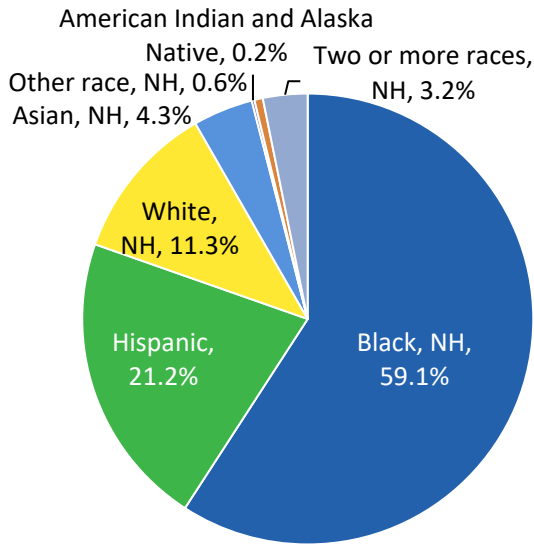
According to the 2020 U.S. Census, Prince George’s County has the **second-largest population in Maryland at 967,201** accounting for nearly 16% of the State’s residents. Prince George’s County’s population increased by over 100,000, or 12%, over the last decade, outpacing the State with an overall growth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

**Prince George’s County Population, 1990-2020**



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

**Prince George’s County by Race and Ethnicity, 2020**



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

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

## Population Demographics, 2020

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

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

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

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

## Population Demographics, 2019

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

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

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

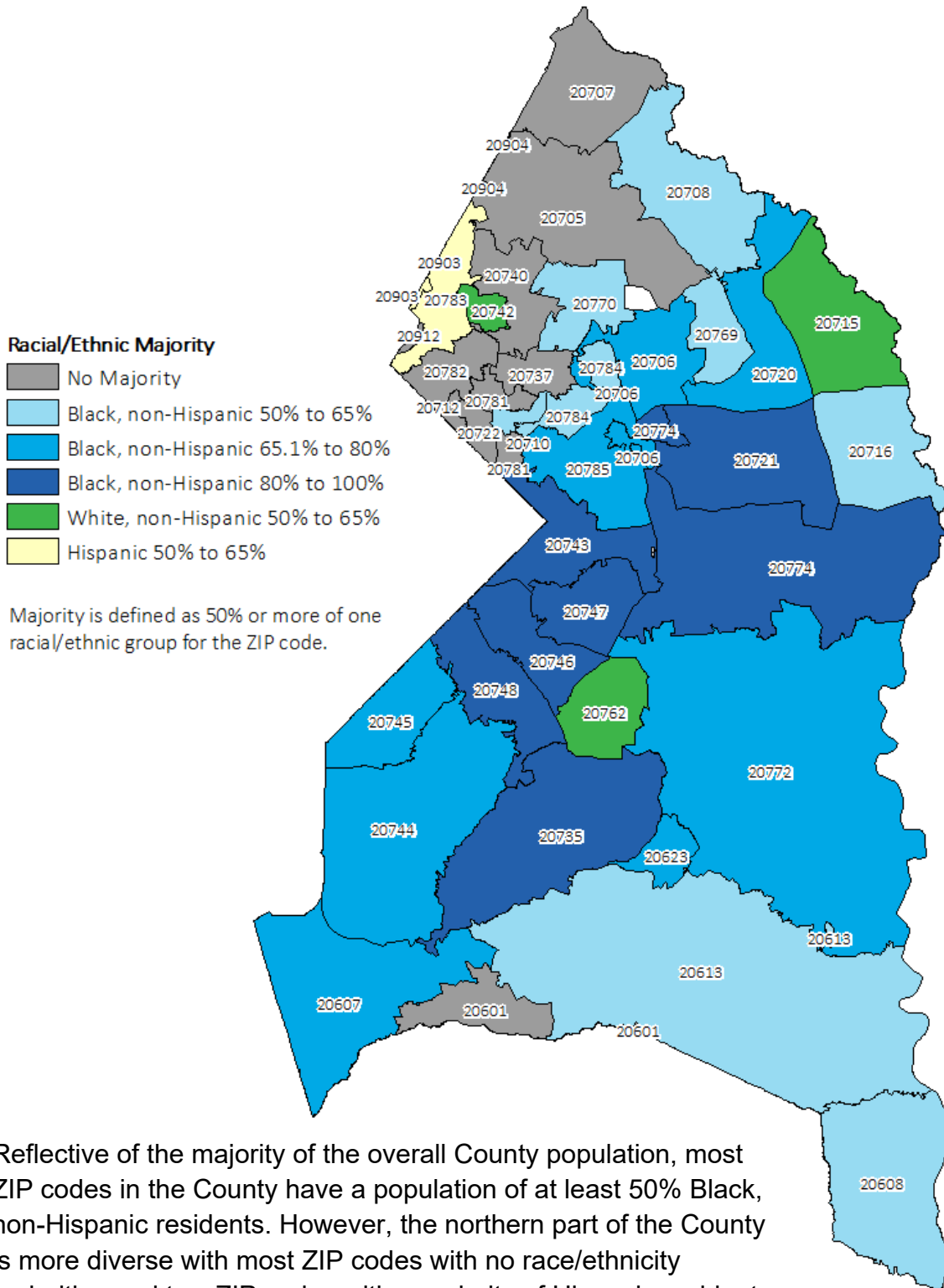
Race and Ethnicity	Median Age (yrs.)
Black	40.1
Hispanic, Any Race	28.8
White, NH	40.3
Asian	39.8

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

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

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

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



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

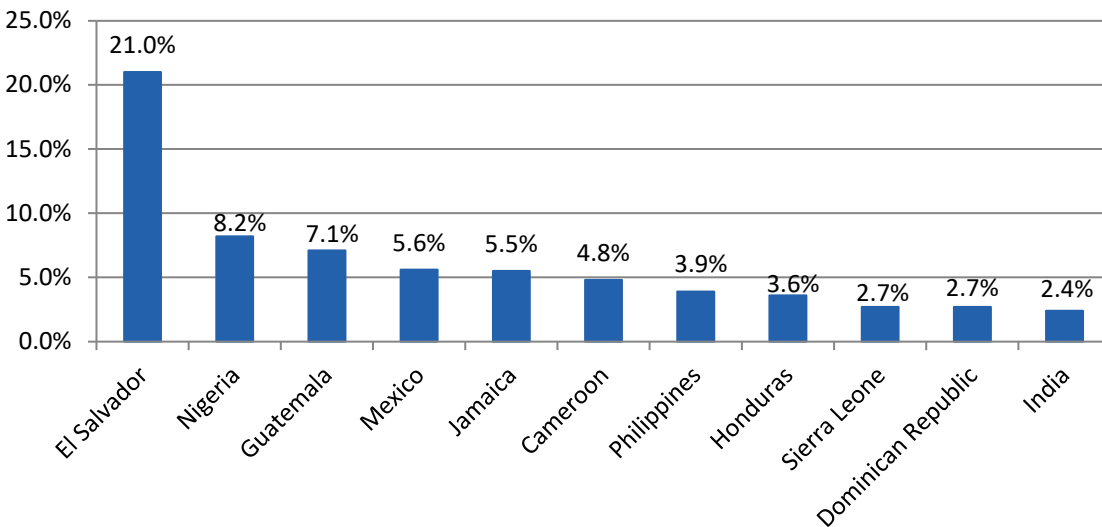
**Data Source:** 2016-2020 American Community Survey 5-Year Estimates, Table B03002

## Foreign-Born Residents

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

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

Country of Origin of Foreign-Born Residents,  
Prince George’s County, 2016-2020



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

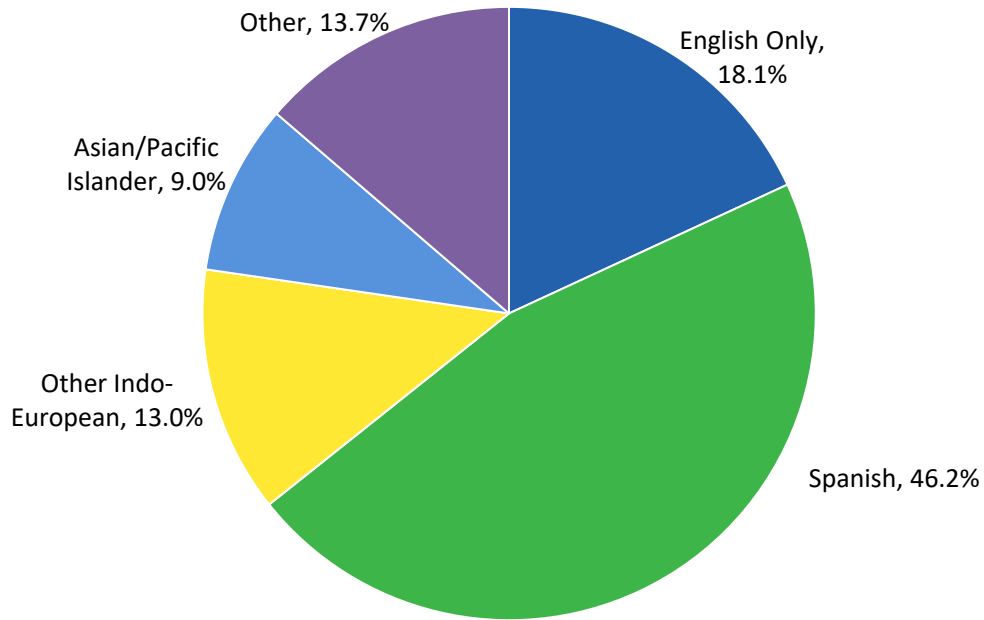
Approximately 18% of foreign-born residents speak only English as their primary language, and an additional 32% are estimated to speak English “very well.” About half of foreign-born residents are estimated to speak English less than “very well”, and of those, most speak Spanish as their primary language.<sup>3</sup>

<sup>1</sup> American Community Survey 5-year estimates, 2016-2020, Table S0501

<sup>2</sup> American Community Survey 1-year estimates, 2019, Table S0501

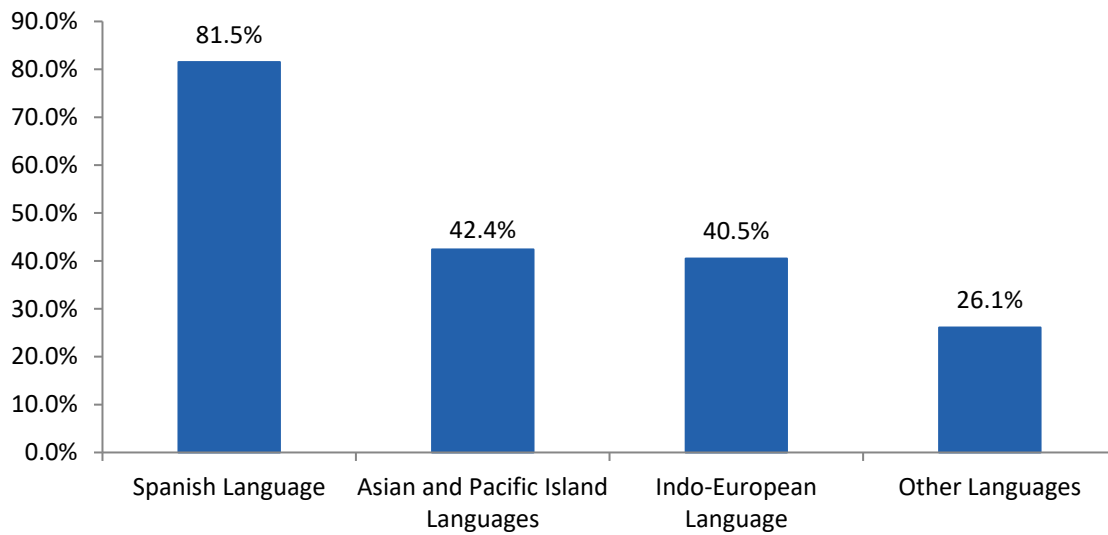
<sup>3</sup> American Community Survey, 1-year estimates, 2019, Table B06007

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



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

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

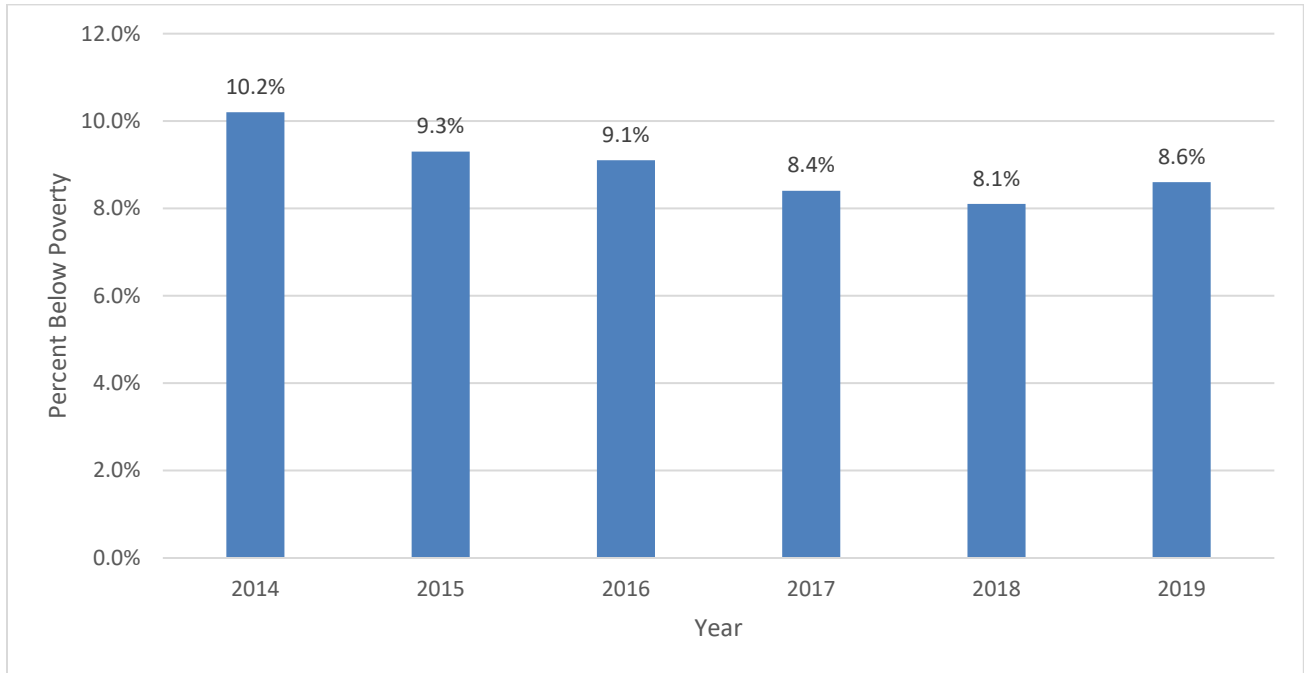


Data Source: 2019 American Community Survey 1-year estimates, Table C16005

## Poverty

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

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



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

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

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

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

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

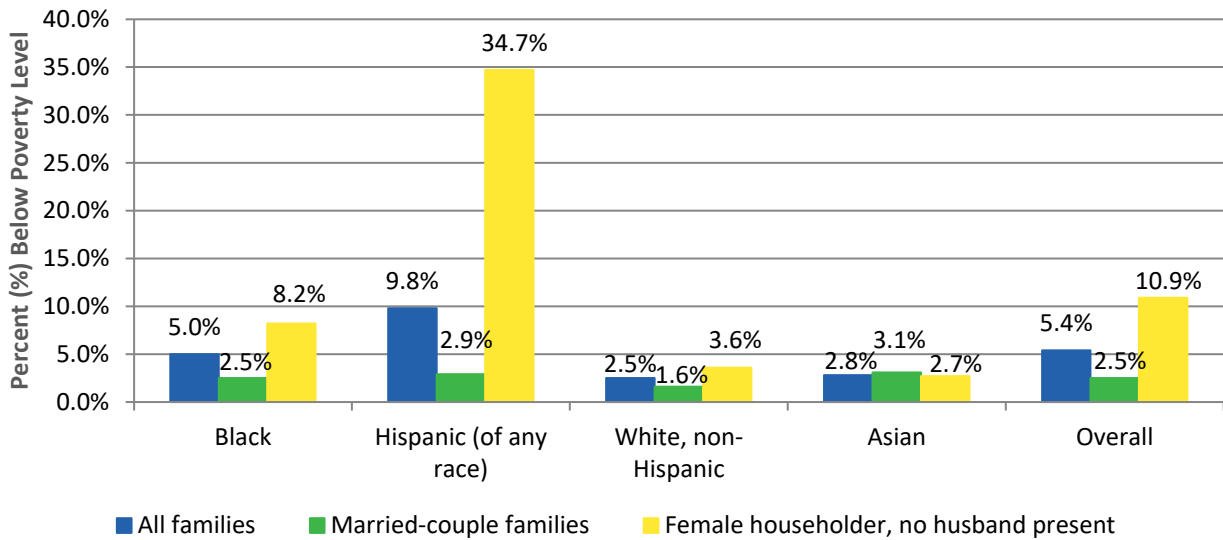
## Family Poverty Status in the Past 12 Months, 2019

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

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

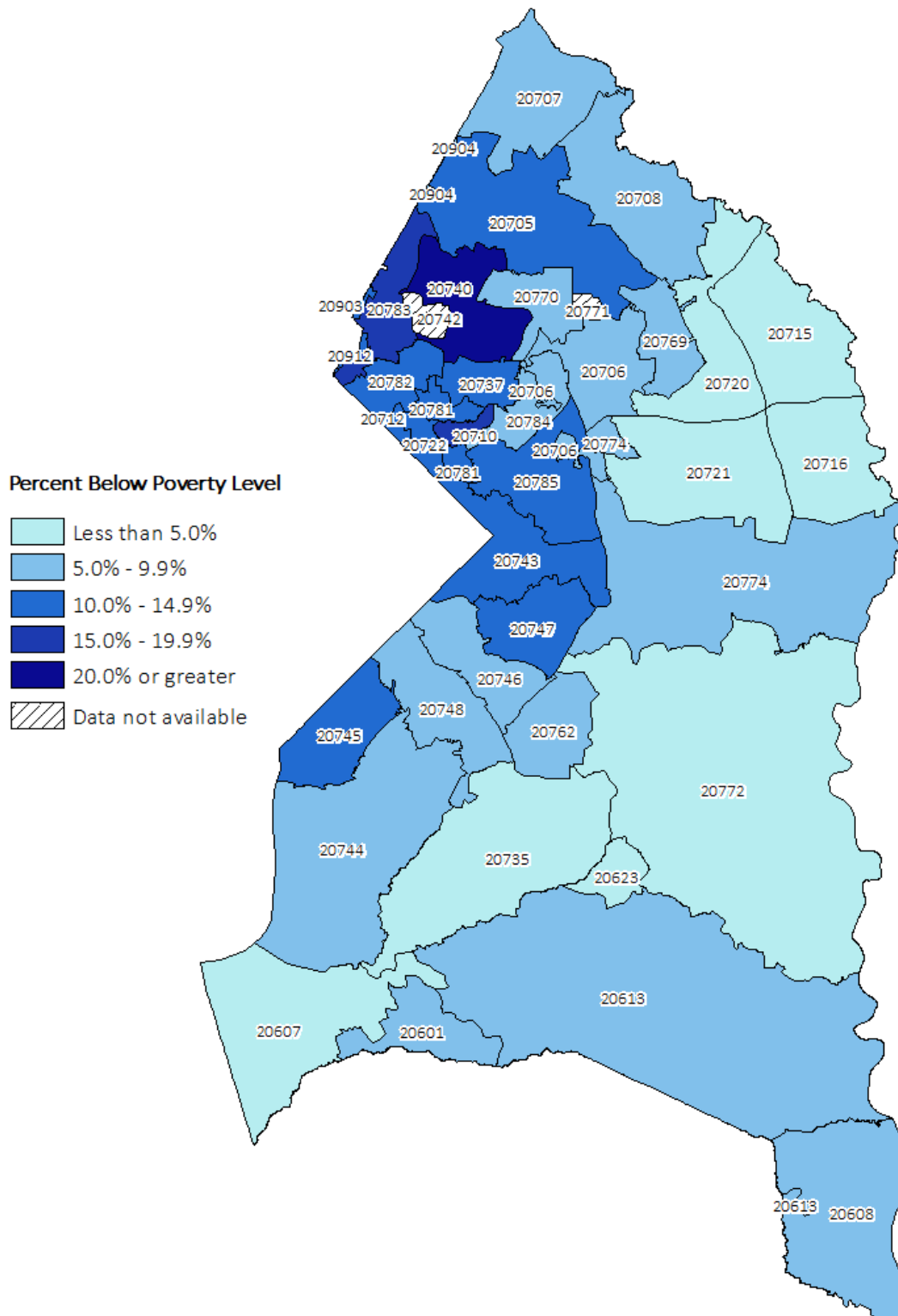
Poverty status among families in Prince George’s County decreased from an estimated 7% in 2014 to 5.4% in 2019, lower than both Maryland at 5.8% and the United States at 8.6%. However, over one in ten (10.9%) families with only a female head of household lives in poverty in the County, and this increases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

**Poverty by Family Status and Race & Ethnicity,  
Prince George's County, 2019**



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

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



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

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

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

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

## Food Stamp/Supplemental Nutrition Assistance Program (SNAP) Benefits

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

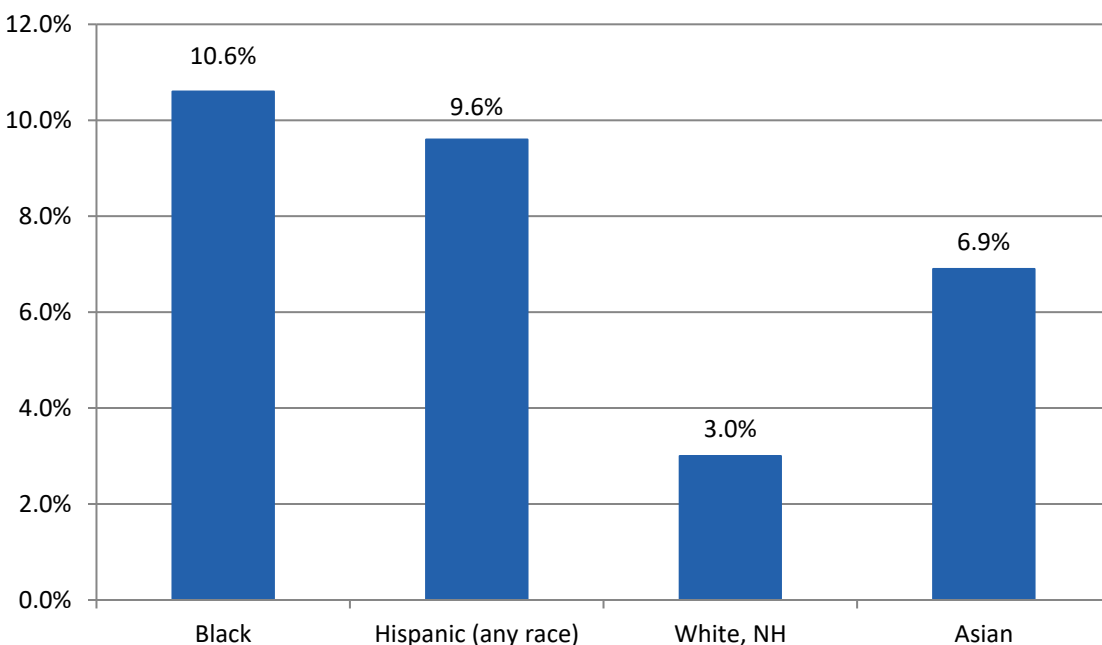
### Percentage of Households with Food Stamp/SNAP Benefits, 2019

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

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

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

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



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

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

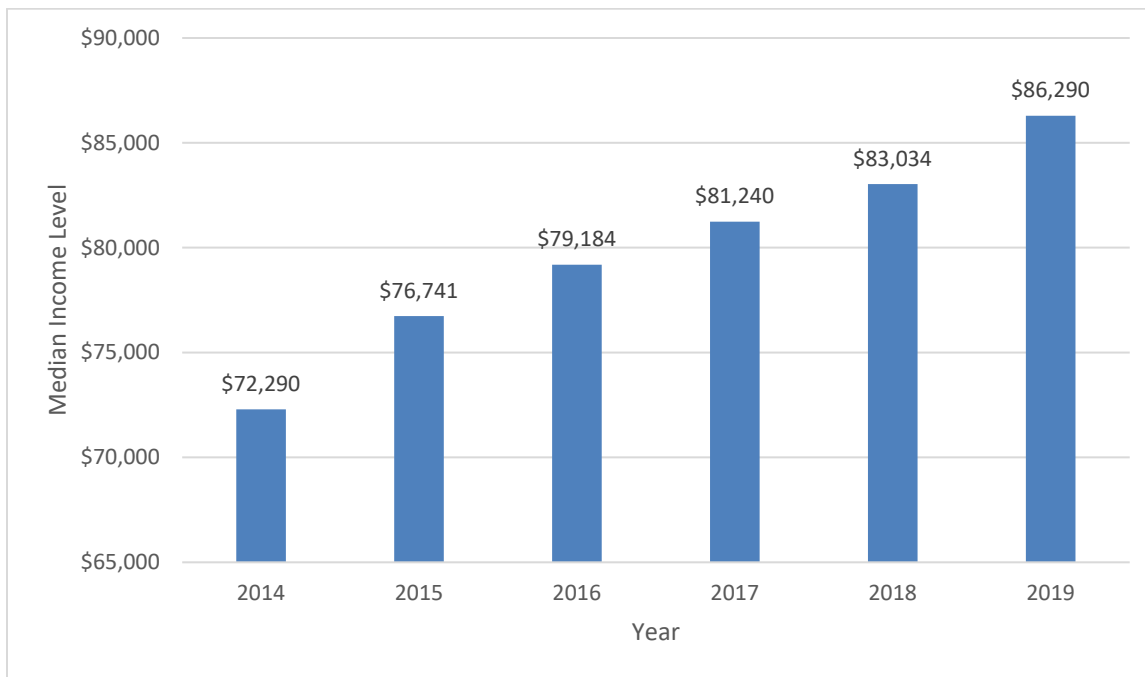
ZIP	Area	Percent of Households on SNAP
20601	Waldorf	6.7%
20607	Accokeek	4.9%
20608	Aquasco	3.4%
20613	Brandywine	5.5%
20623	Cheltenham	5.9%
20705	Beltsville	5.5%
20706	Lanham	8.5%
20707	Laurel	9.0%
20708	Laurel	12.8%
20710	Bladensburg	19.5%
20712	Mount Rainier	8.9%
20715	Bowie	3.4%
20716	Bowie	5.6%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

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

## Income

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

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



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

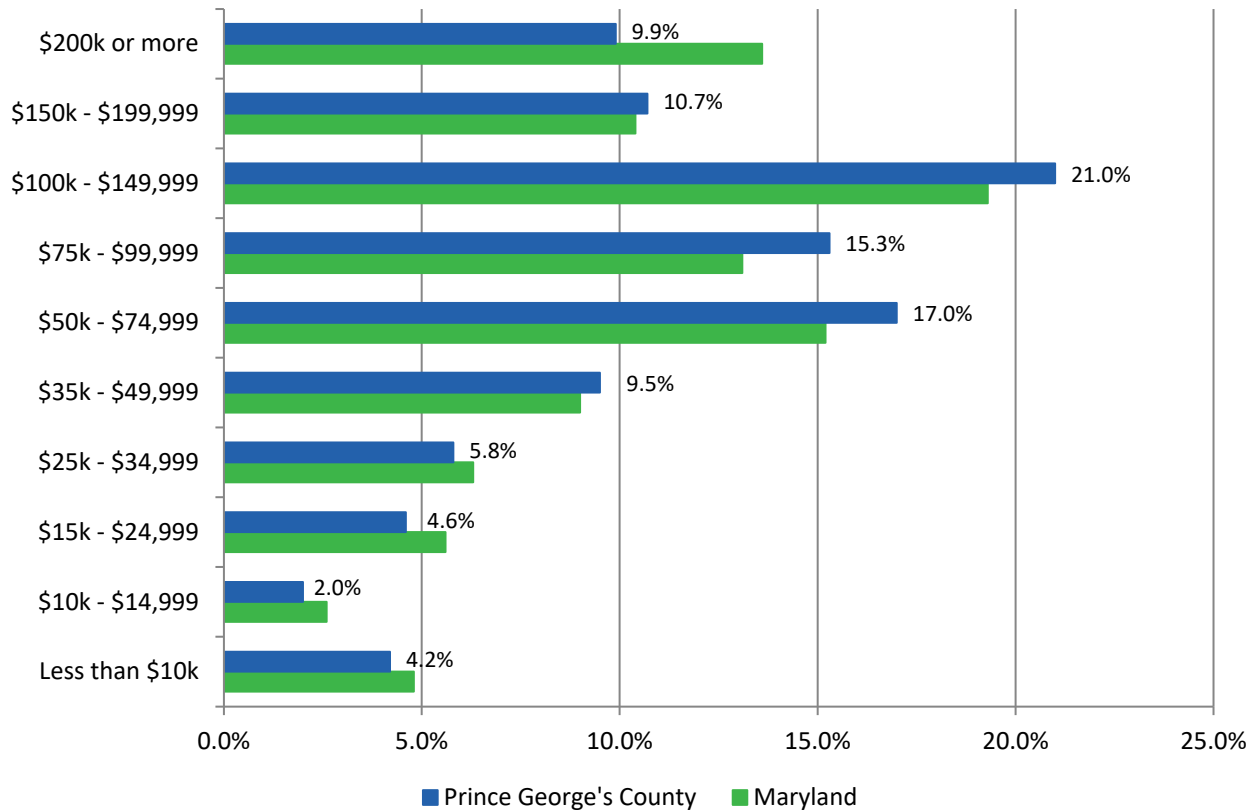
### Income in the Past 12 Months (In 2019 Inflation-Adjusted Dollars)

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

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

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

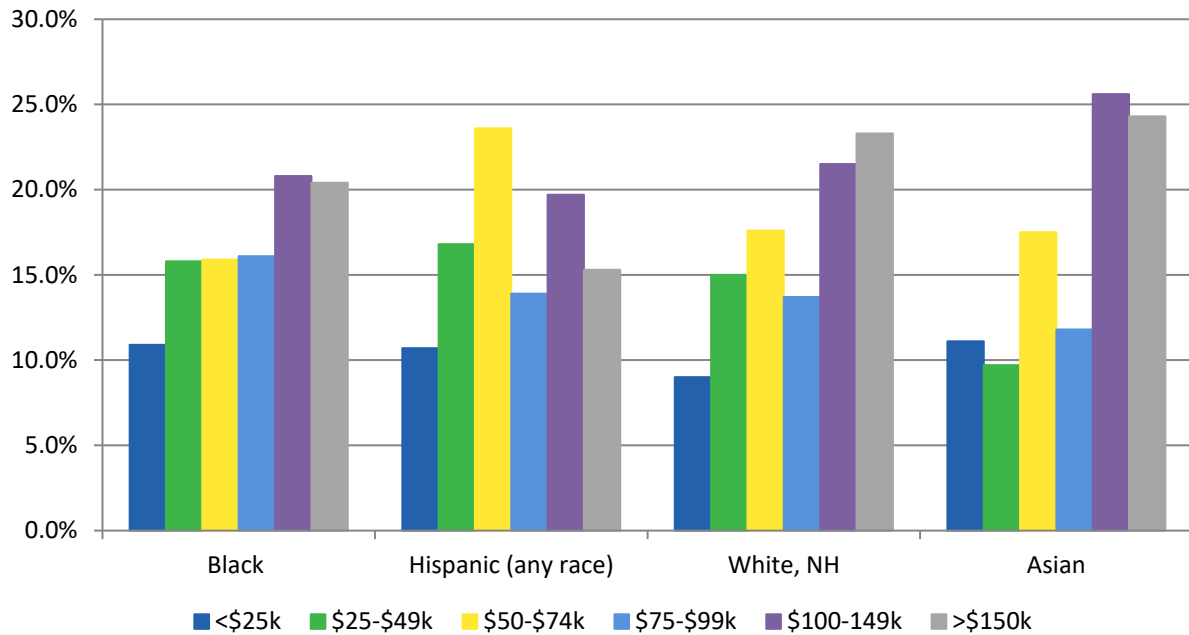
### Household Income (In 2019 Inflation-Adjusted Dollars)



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

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

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



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

## Disability

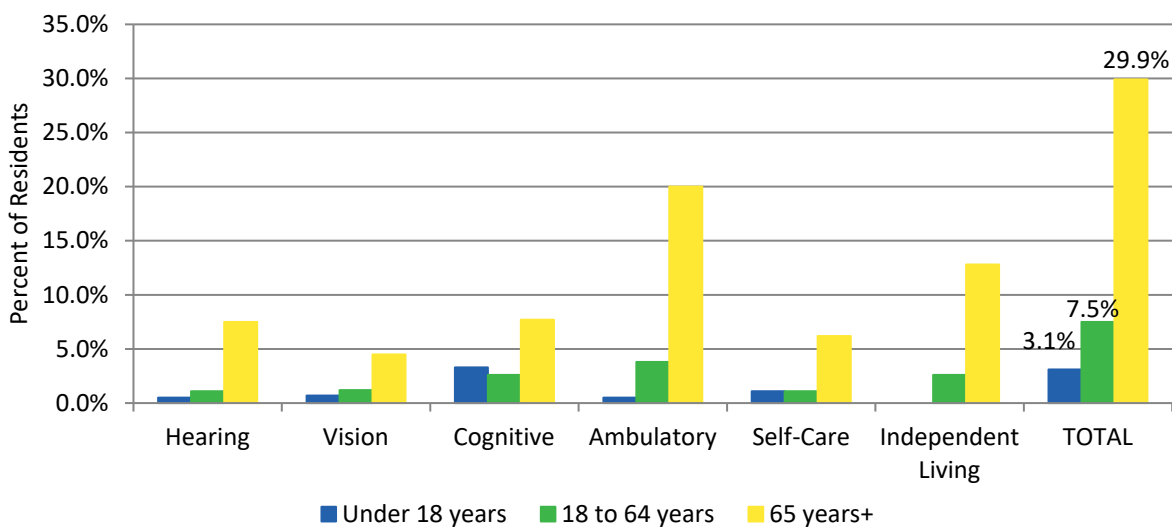
The definition of disability has changed over the past 40 years. In the 1960s and 1970s, a medical definition of disability was generally used, limited primarily to physical impairments. As time progressed, the definition expanded to include social and mental impairments as well as independence<sup>4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

### Percentage of Residents with a Disability, 2019

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

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

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



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

<sup>4</sup> <https://www.census.gov/topics/health/disability/about.html>

## Education

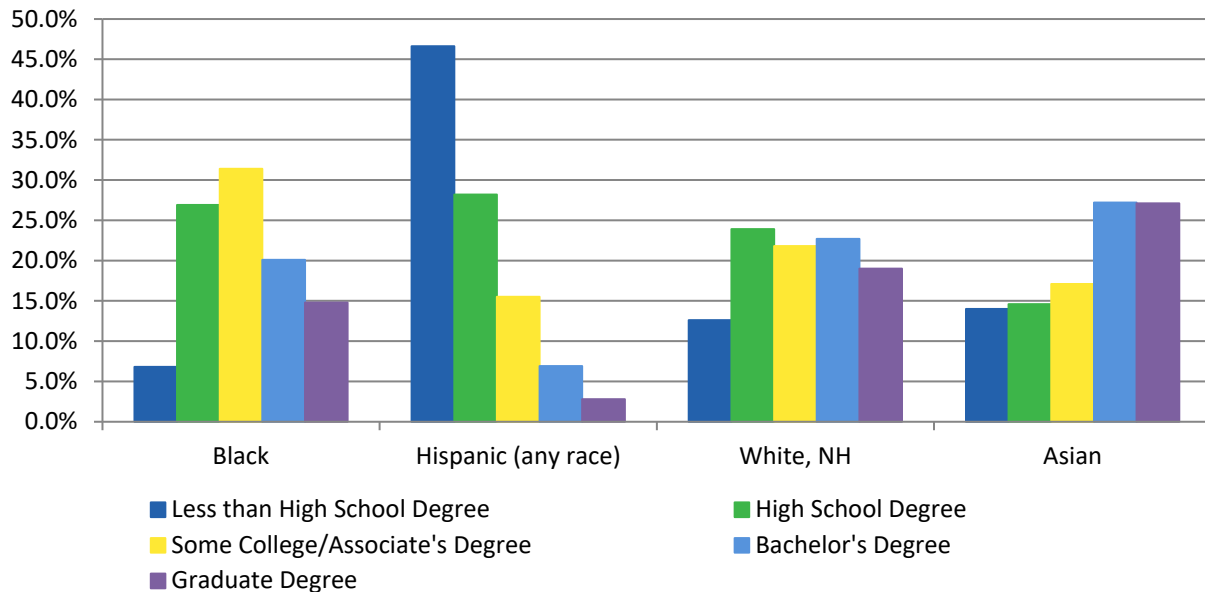
In 2019, about 87% of Prince George’s County residents 25 years and older have at least a high school education, lower than Maryland (90.4%) and the U.S. (88.6%). One-third of County residents have at least a bachelor’s degree or higher, similar to the country; however, this lags behind the state where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

### Percentage of Residents 25 Years and Older by Education, 2019

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

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

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

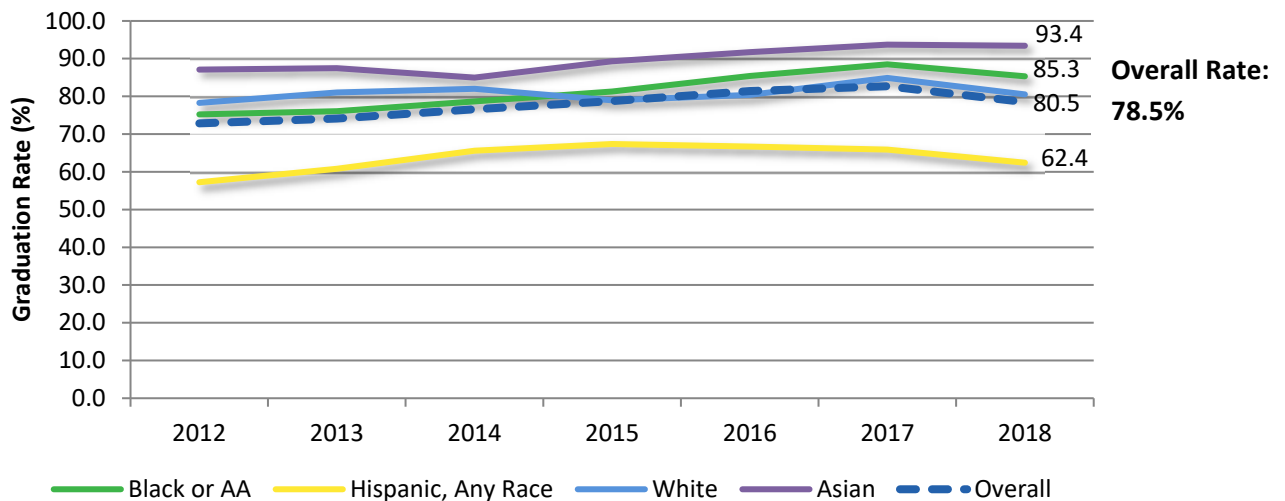


Data Source: 2019 American Community Survey 1-Year Estimates, Table B15002

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

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

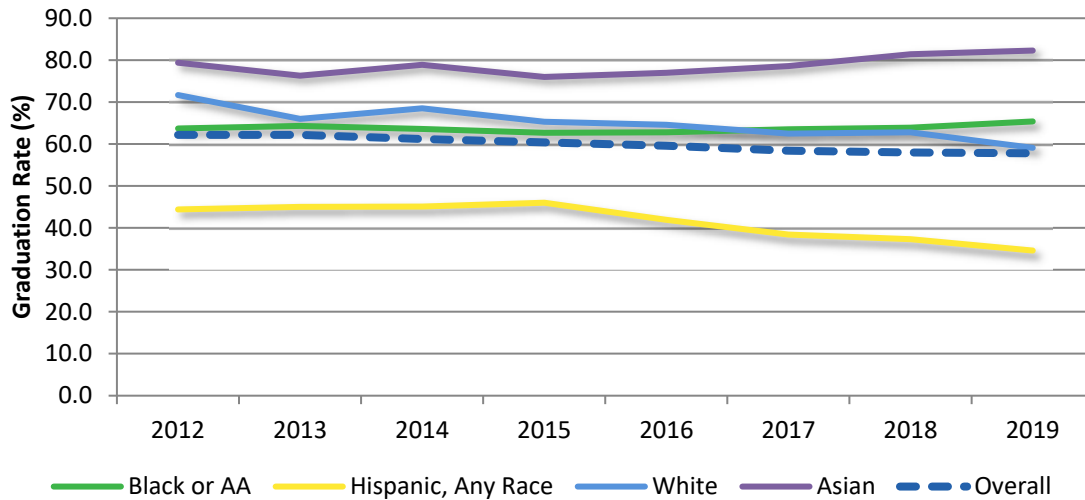
### Graduation Rate by Race/Ethnicity, Prince George’s County Public Schools



Data Source: 2012-2018 Maryland Report Card

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

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



Data Source: 2012-2019 Maryland Report Card

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

<b>ZIP</b>	<b>Area</b>	<b>Percent Without High School or Equivalent</b>
20601	Waldorf	6.8%
20607	Accokeek	6.5%
20608	Aquasco	9.2%
20613	Brandywine	7.1%
20623	Cheltenham	6.6%
20705	Beltsville	12.5%
20706	Lanham	15.0%
20707	Laurel	10.0%
20708	Laurel	9.3%
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20737	Riverdale	35.3%
20740	College Park	15.0%
20743	Capitol Heights	13.7%
20744	Fort Washington	10.1%
20745	Oxon Hill	17.5%
20746	Suitland	10.2%
20747	District Heights	9.2%
20748	Temple Hills	8.0%
20762	Andrews Air Force Base	1.2%
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20782	Hyattsville	23.1%
20783	Hyattsville	41.9%
20784	Hyattsville	21.8%
20785	Hyattsville	11.4%
20903	Silver Spring	34.9%
20904	Silver Spring	9.6%
20912	Takoma Park	15.9%

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

## Employment

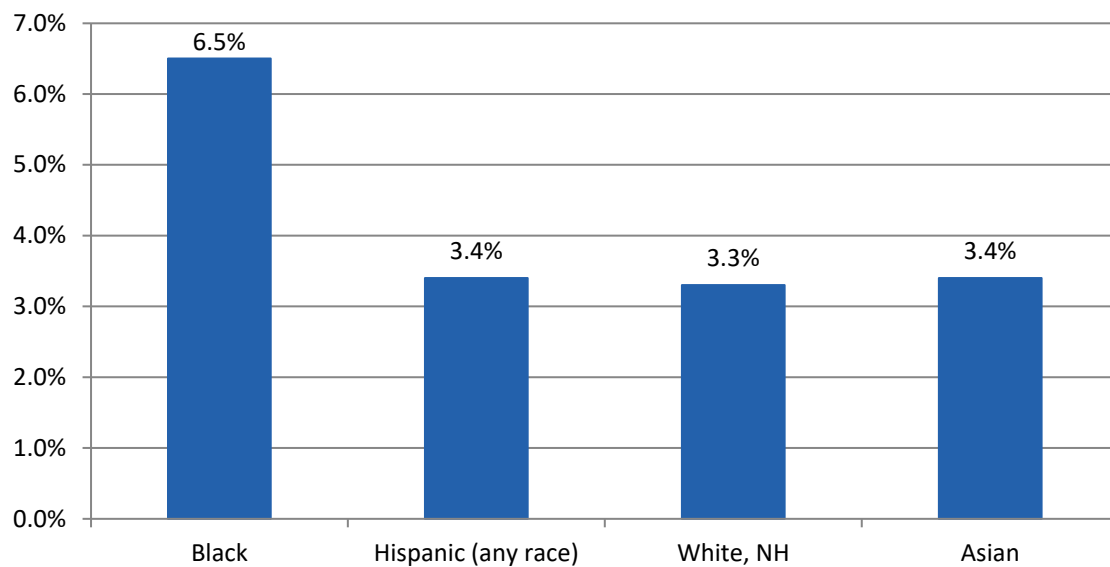
Unemployment in Prince George’s County has decreased considerably; in 2014, an estimated 9.1% of residents were unemployed compared to 5.5% in 2019. However, the unemployment rate for the County remains slightly higher than Maryland (4.5%) and the U.S. (4.5%). The County unemployment rate varies by education,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

### Unemployment Rate for Residents 16 Years and Older, 2019

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

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

### Unemployment Rate, Prince George’s County, 2019



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

## Housing

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

### Housing Characteristics, 2019

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

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

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

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

## Fair Market Rent

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

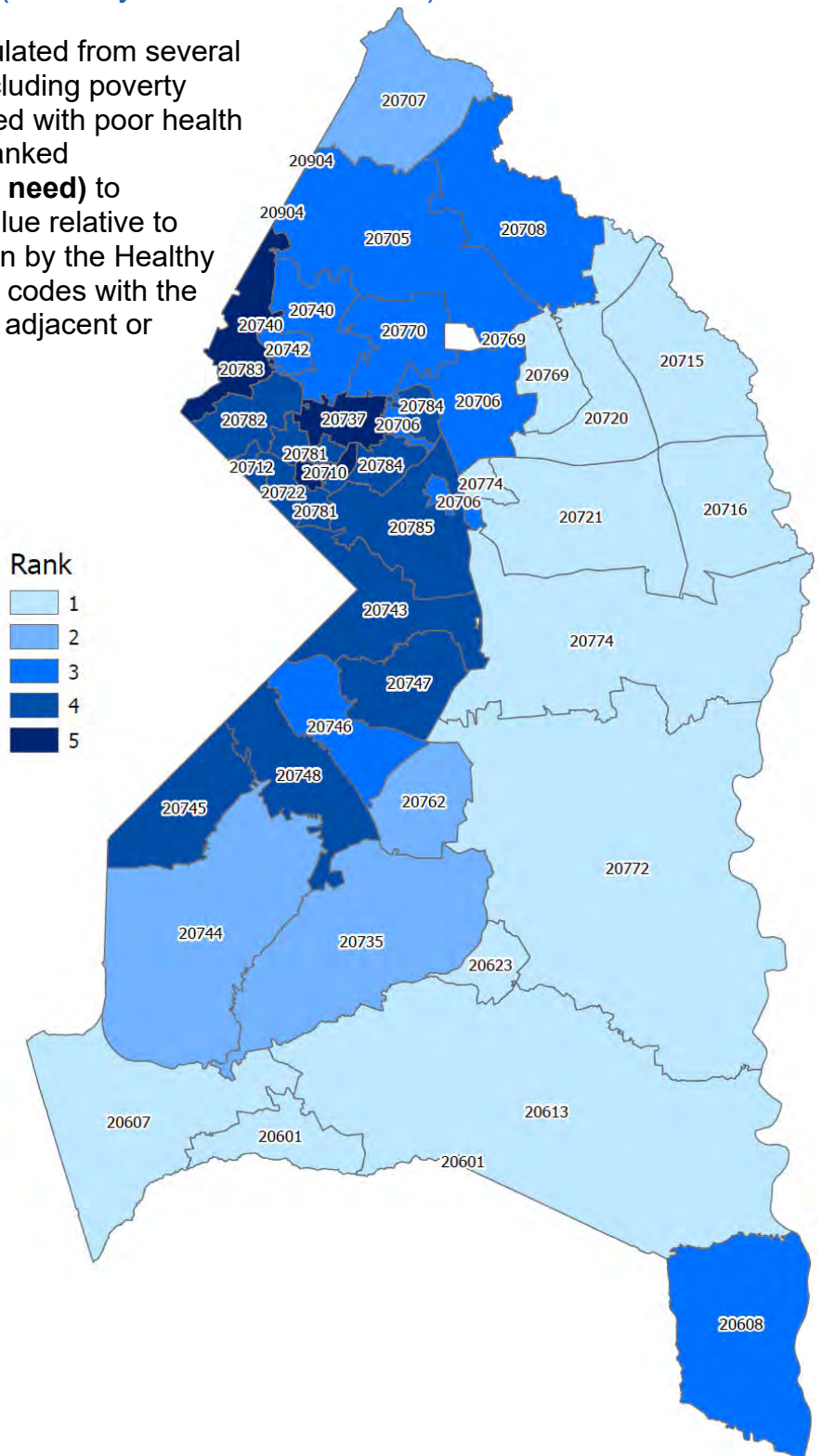
### Fair Market Rent, 2021

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

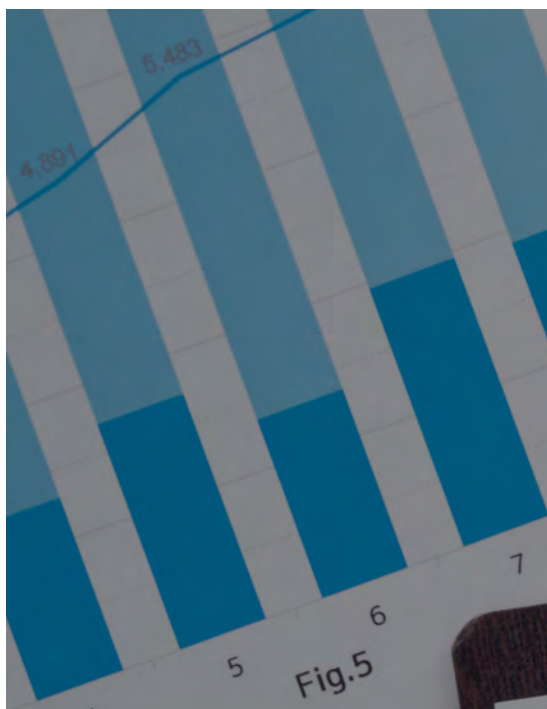
**Data Source:** National Low Income Housing Coalition, [www.nlihc.org](http://www.nlihc.org)

## 2021 Health Equity Index (formerly SocioNeeds Index)

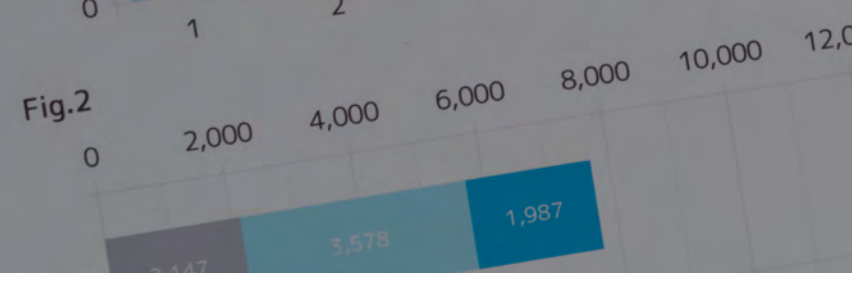
The Health Equity Index is calculated from several social and economic factors, including poverty and education, that are correlated with poor health outcomes. The ZIP codes are ranked based on the index, from **1 (low need)** to **5 (high need)** based on their value relative to similar locations within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



<sup>5</sup> [www.pgchealthzone.org](http://www.pgchealthzone.org)



# health INDICATORS



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# HEALTH INDICATORS REPORT

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## Introduction

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

## Methods

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

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

## Limitations

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

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

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

## Definitions

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

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

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

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

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

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

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

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

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

### Racial and Ethnic Groups:

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

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

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

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

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

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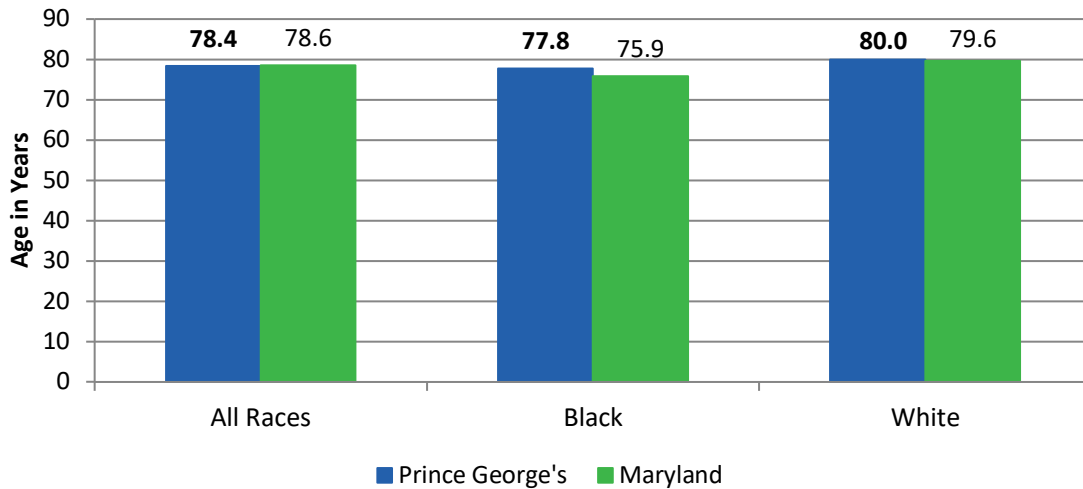
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# Health Status Indicators

## Life Expectancy

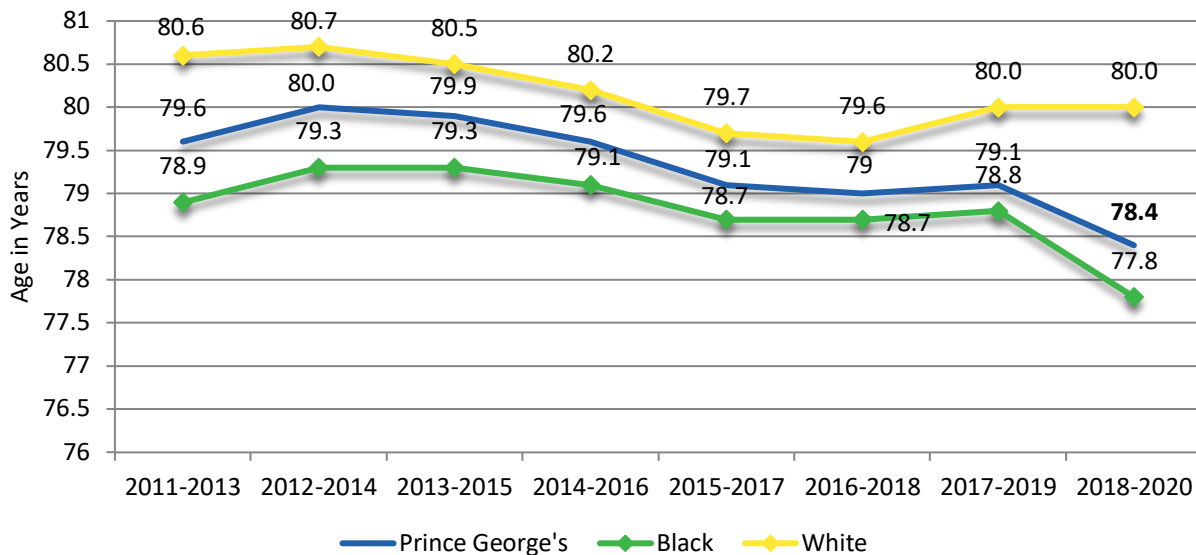
As of 2020, a Prince George’s County resident is expected to live 78.4 years, similar to the 78.6 years for any Maryland resident. Life expectancy in the County and State has declined. At its peak the life expectancy for a County resident was 80.0 from 2012 to 2014. This is also a national trend, with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

### Life Expectancy at Birth by Race, 2018-2020



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

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



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

## Mortality

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

### Leading Causes of Death, 2018-2020

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

\*CLRD=Chronic Lower Respiratory Disease, includes both chronic obstructive pulmonary disease and asthma

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

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

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

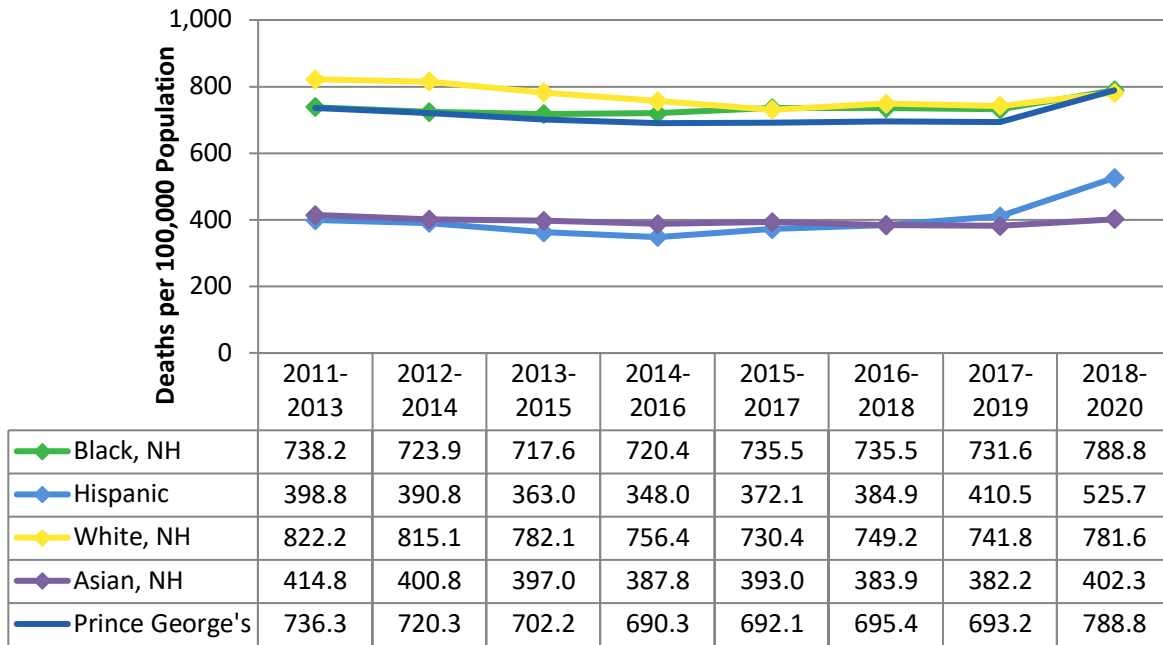
### Age-Adjusted Death Rate per 100,000 by Race, Ethnicity, and Sex, 2018-2020

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

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

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

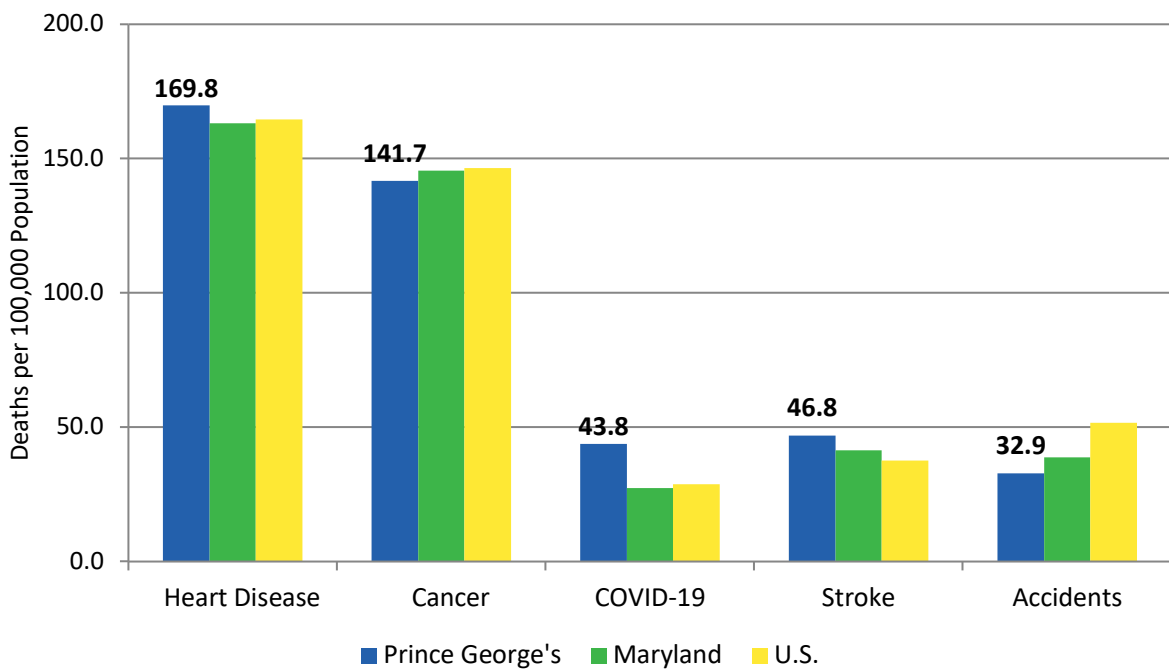
## Age-Adjusted Death Rate per 100,000 for All Causes of Death by Race\* and Ethnicity, Prince George's County, 2011-2020



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

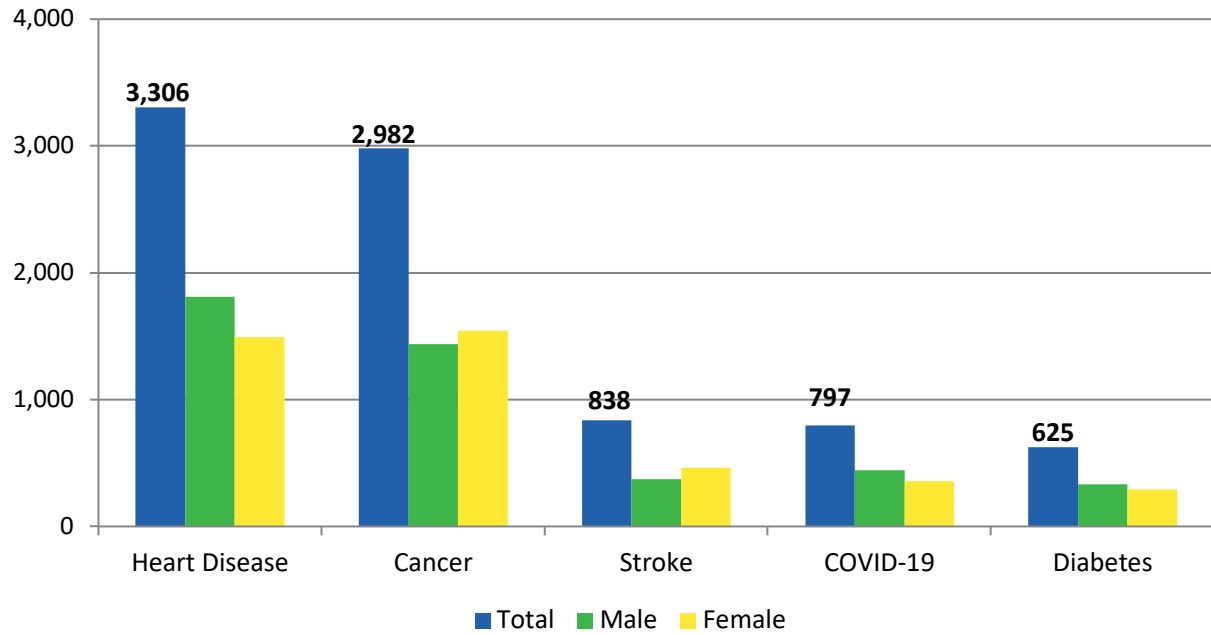
Out of the five leading causes of death in Prince George's, the County has a higher age-adjusted death rate compared to Maryland and the U.S. for heart disease, COVID-19, and stroke.

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



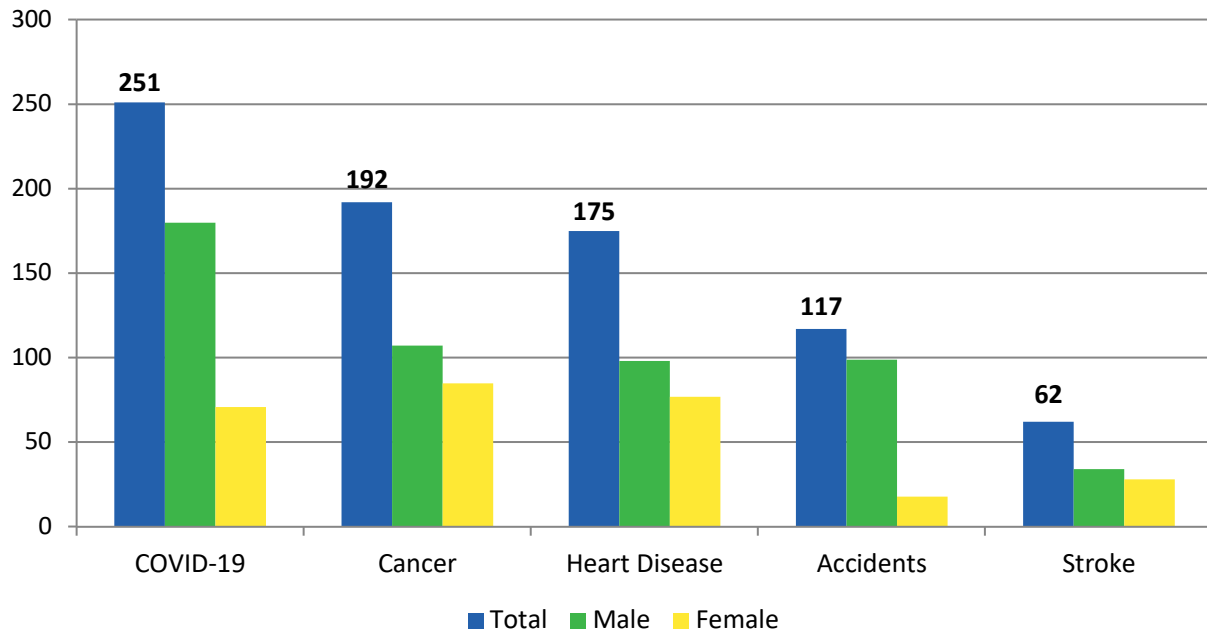
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

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



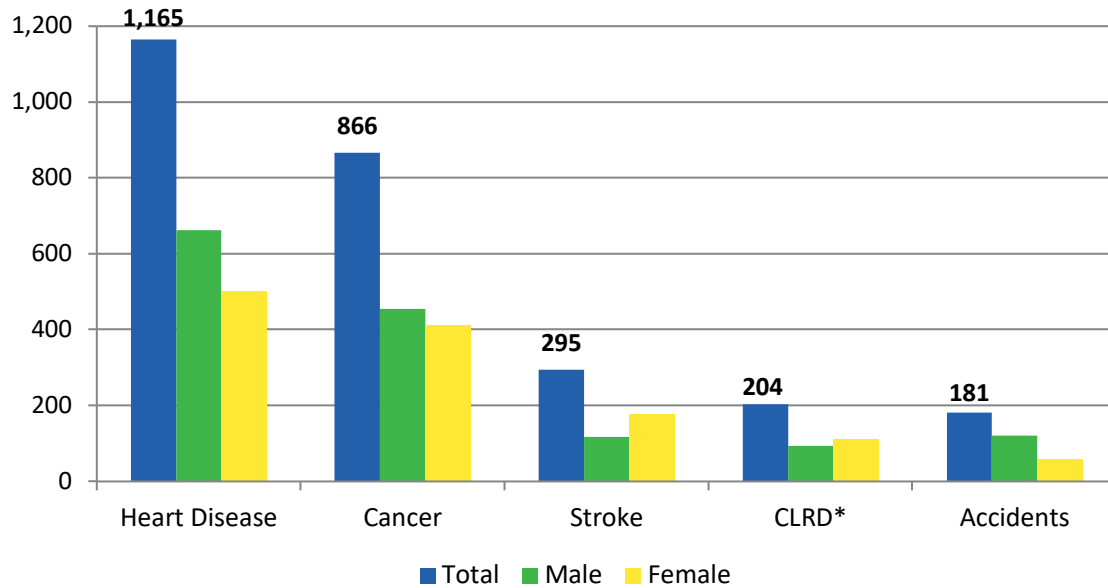
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

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



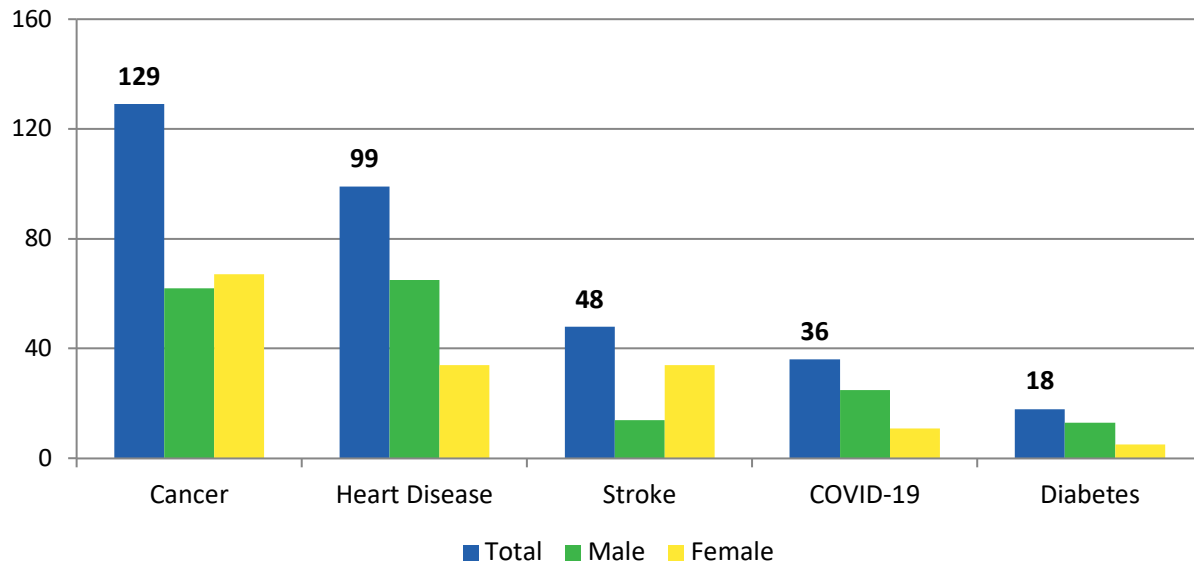
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

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



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

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



**Data Source:** Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database  
 While the leading cause of death by race and Hispanic ethnicity is consistently heart disease and cancer, there is variation for the remaining causes. For white, non-Hispanic (NH), Black NH, and Asian NH residents the third leading cause of death is stroke, but for Hispanic residents it is heart disease. Diabetes is a leading cause of death for both Black NH and Asian NH residents, while chronic lower respiratory diseases (CLRD) are included in the top five leading causes of death for white NH residents.

## Access to Health Care

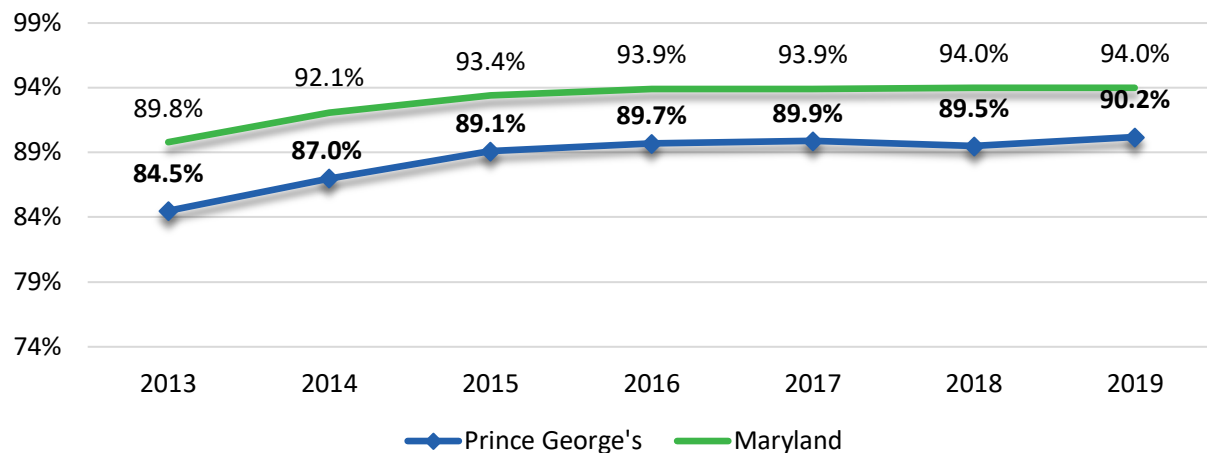
The percentage of residents with health insurance increased in Prince George’s County following the implementation of the major provisions of the Affordable Care Act (ACA) in 2014. However, an estimated 92,790 residents remained uninsured as of 2020. By age, residents ages 26 to 44 years were least likely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

### Residents with Health Insurance, 2020

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

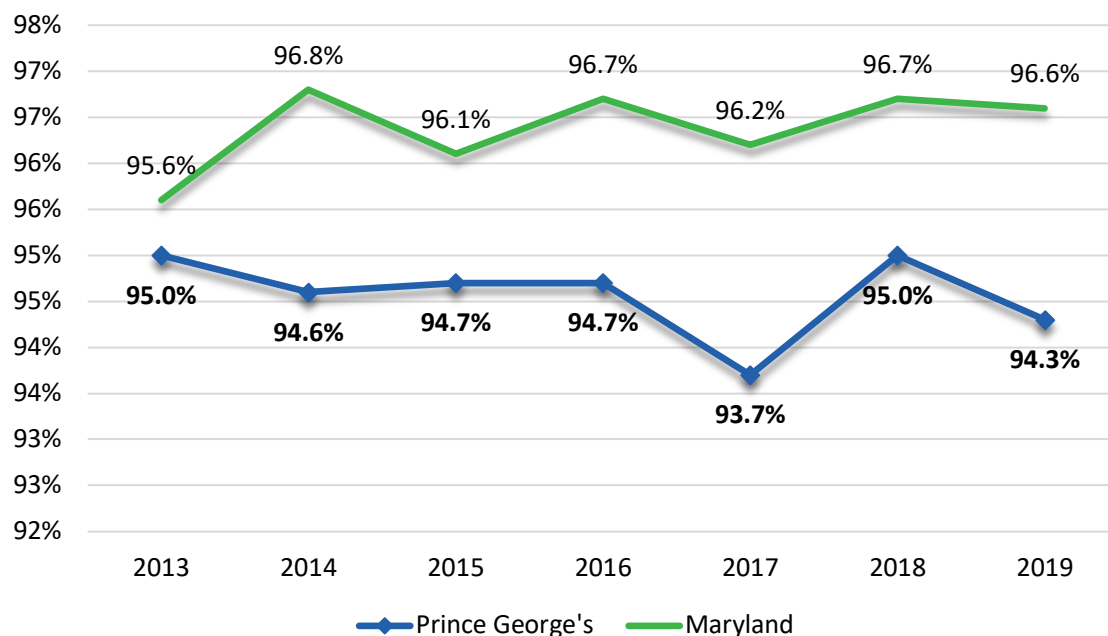
Data Source: 2016-2020 American Community Survey 5-Year Estimates, Table S2701

### Residents with Health Insurance, 2013-2019



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

## Children with Health Insurance, 2013-2019



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

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

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

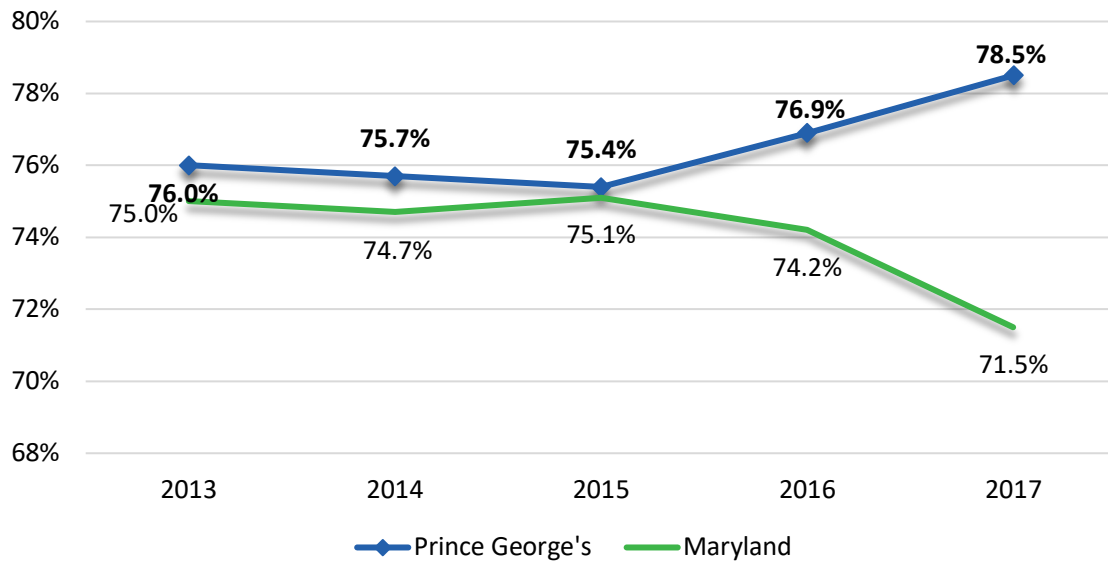
Demographic	Prince George's	Maryland
<b>Race/Ethnicity</b>		
Black, non-Hispanic	81.4%	79.0%
Hispanic	70.9%	62.6%
White, non-Hispanic	72.8%	67.4%
<b>Sex</b>		
Male	74.7%	67.6%
Female	82.9%	75.2%
<b>Age Group</b>		
18 to 44 Years	72.2%	63.3%
45 to 64 Years	83.6%	76.9%
Over 65 Years	89.2%	87.5%
<b>Total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

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

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

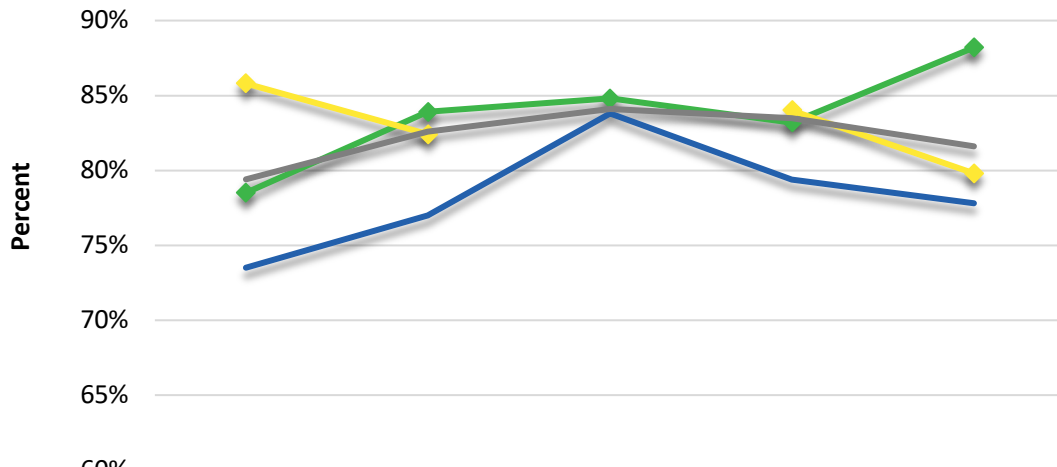
a routine checkup (81.4%) within the County. Due to the MDH cyberattack, more updated data was not available.

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



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

### Residents with a Usual Primary Care Provider, 2013-2017



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

\*\* White, NH data for 2015 not presented due to small number of events.

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

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

**Resident to Provider Ratios**

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

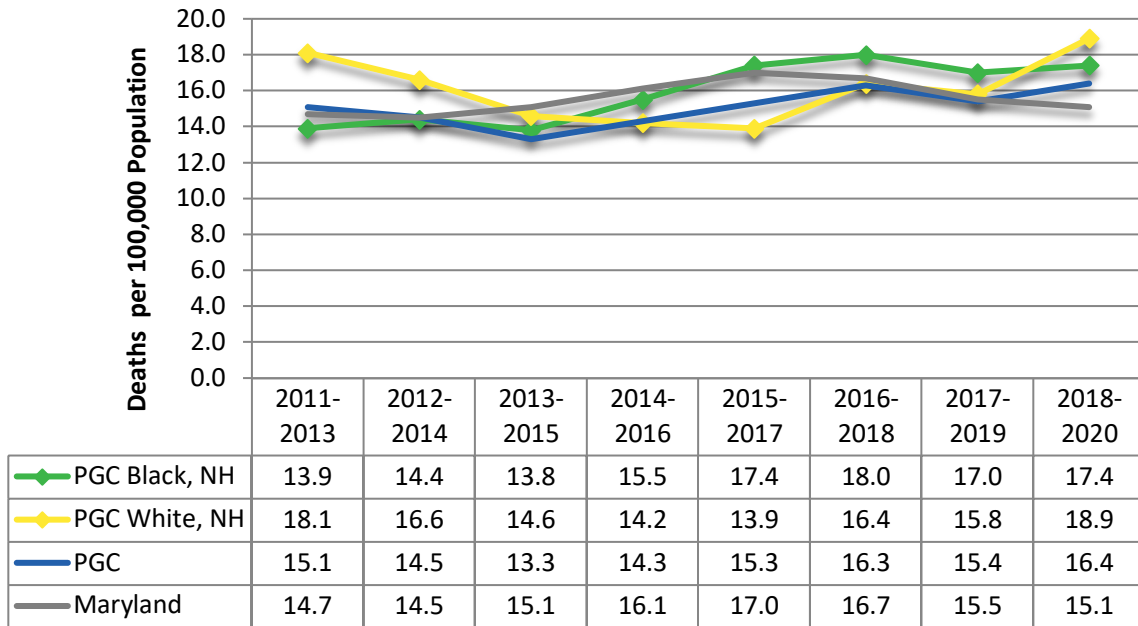
Data Source: 2022 County Health Rankings, [www.countyhealthrankings.org](http://www.countyhealthrankings.org)

# Diseases and Conditions

## Alzheimer's Disease

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

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



\* Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers

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

## Cancer

Overview	
<b>What is it?</b>	Cancer is a term used for diseases in which abnormal cells divide without control and can invade other tissues; there are more than 100 kinds of cancer.
<b>Who is affected?</b>	In 2018, 4,025 residents were diagnosed with cancer in the County, and the cancer incidence rate was 399.1 per 100,000 residents. In 2020, there were 1,406 deaths from cancer in the County, which accounted for 17% of all deaths and was the second leading cause of death. Prostate and breast cancer are the most common types of cancer in the County, and in 2018 accounted for 35% of all new cancer cases. Overall, Black residents have the highest age-adjusted rate for new cancer cases and the highest age-adjusted death rate due to cancer. Prostate cancer has the highest age-adjusted death rate for County residents, followed by lung and bronchus cancer.
<b>Prevention and Treatment</b>	<p>According to the CDC, there are several ways to help prevent cancer:</p> <ul style="list-style-type: none"> <li>• Healthy choices can reduce cancer risk, like avoiding tobacco, limiting alcohol use, protecting your skin from the sun, and avoiding indoor tanning, eating a diet rich in fruits and vegetables, keeping a healthy weight, and being physically active.</li> <li>• The human papillomavirus (HPV) vaccine helps prevent most cervical cancers and several other kinds of cancer. The hepatitis B vaccine can lower liver cancer risk.</li> <li>• Screening for cervical and colorectal cancers helps prevent these diseases by finding precancerous lesions so they can be treated before they become cancerous. Screening for cervical, colorectal, and breast cancers also helps find these diseases at an early stage, when treatment works best.</li> </ul> <p>Cancer treatment can involve surgery, chemotherapy, radiation therapy, targeted therapy, and immunotherapy.</p>
<b>What are the outcomes?</b>	Remission (no cancer signs or symptoms), long-term treatment and care, and death.
<b>Disparity</b>	Overall, men had a higher age-adjusted cancer incidence rate per 100,000 (424.1) than women (386.7), and Black residents had a higher incidence rate (401.3) compared to White residents in 2018 (384.7). From 2018 to 2020, cancer mortality rates for Black, non-Hispanic (NH) residents was highest (150.7) compared to other race/ethnicities. By cancer site, Black residents in the County had higher incidence and mortality rates for breast and prostate cancers.
<b>How do we compare?</b>	Prince George's County's 2018 age-adjusted cancer incidence rate was 399.1 per 100,000 residents, much lower than the state at 445.9; other Maryland counties range from 372.1 (Montgomery) to 572.9 (Dorchester). The age-adjusted death rate for the County from 2018 to 2020 was 141.7, slightly lower compared to Maryland at 145.5.

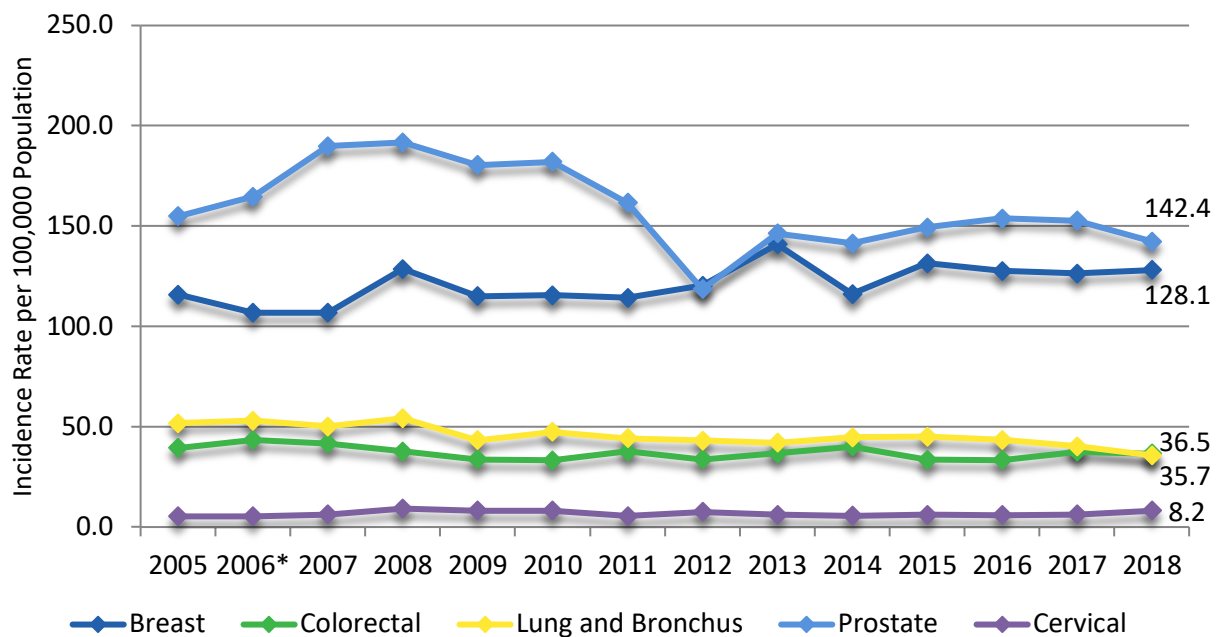
Overall, Prince George’s County age-adjusted cancer incidence rate is less than Maryland and the U.S. for most leading types of cancer. Prostate cancer incidence remained higher in Prince George’s County (147.9 cases per 100,000) compared to Maryland (126.3 cases per 100,000) and the U.S. (106.2) cases per 100,000).

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

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

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

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



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

Data Source: Maryland Department of Health, Annual Cancer Reports

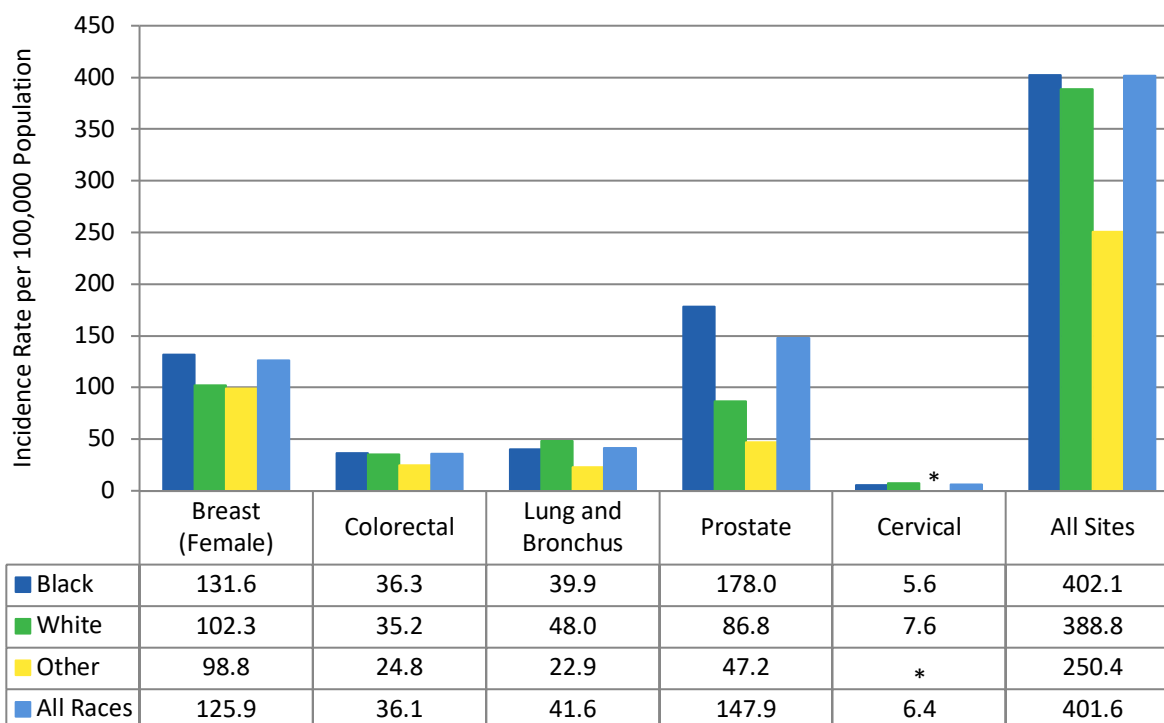
## Cancer Age-Adjusted Incidence Rates by Site, Prince George's County, 2005-2018

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

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

Data Source: Maryland Department of Health, Annual Cancer Reports

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



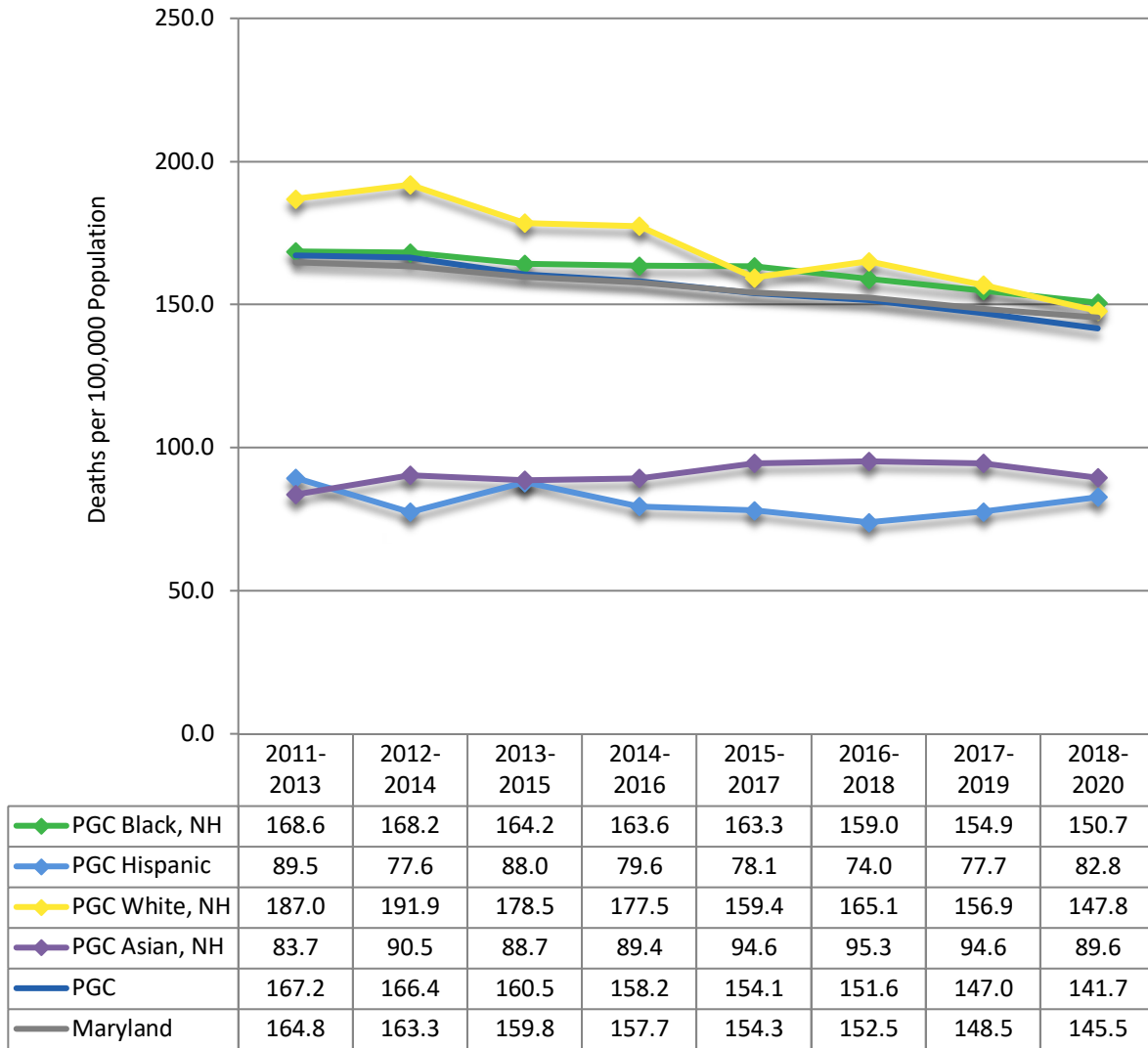
\*Age-adjusted incidence rate unavailable due to small number of cases

Data Source: Maryland Department of Health, Annual Cancer Report, 2021

Individuals of Hispanic origin were included within the White or Black estimates and are not listed separately

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

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



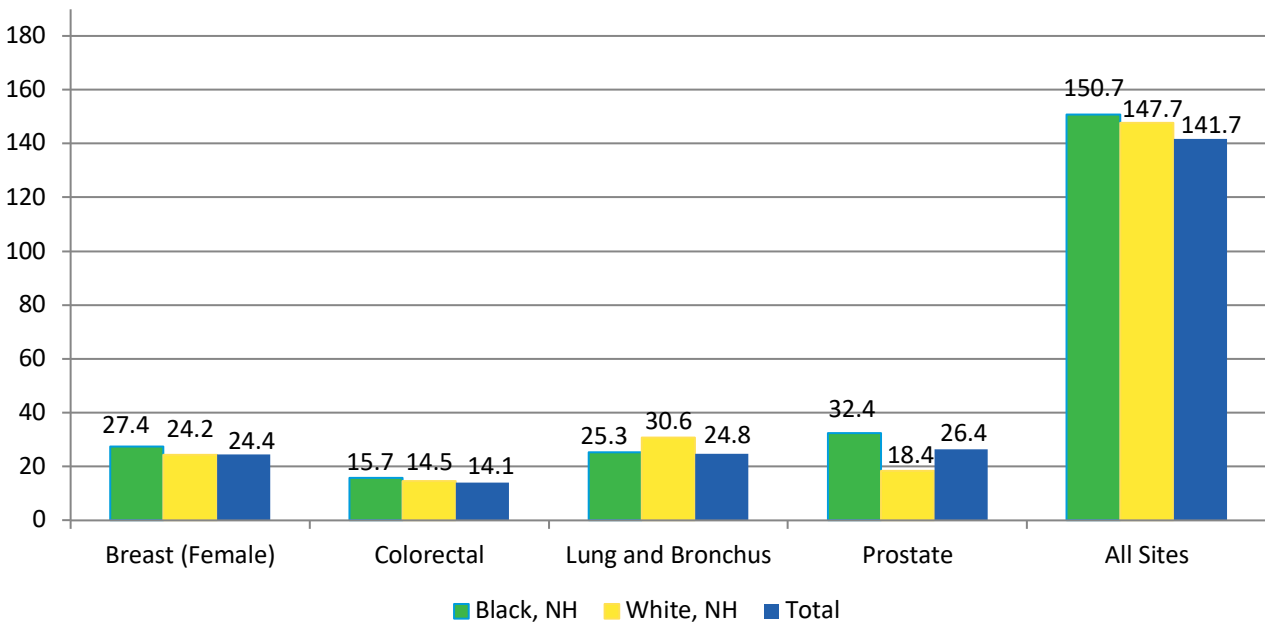
**Data Source:** Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

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

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

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

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



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

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

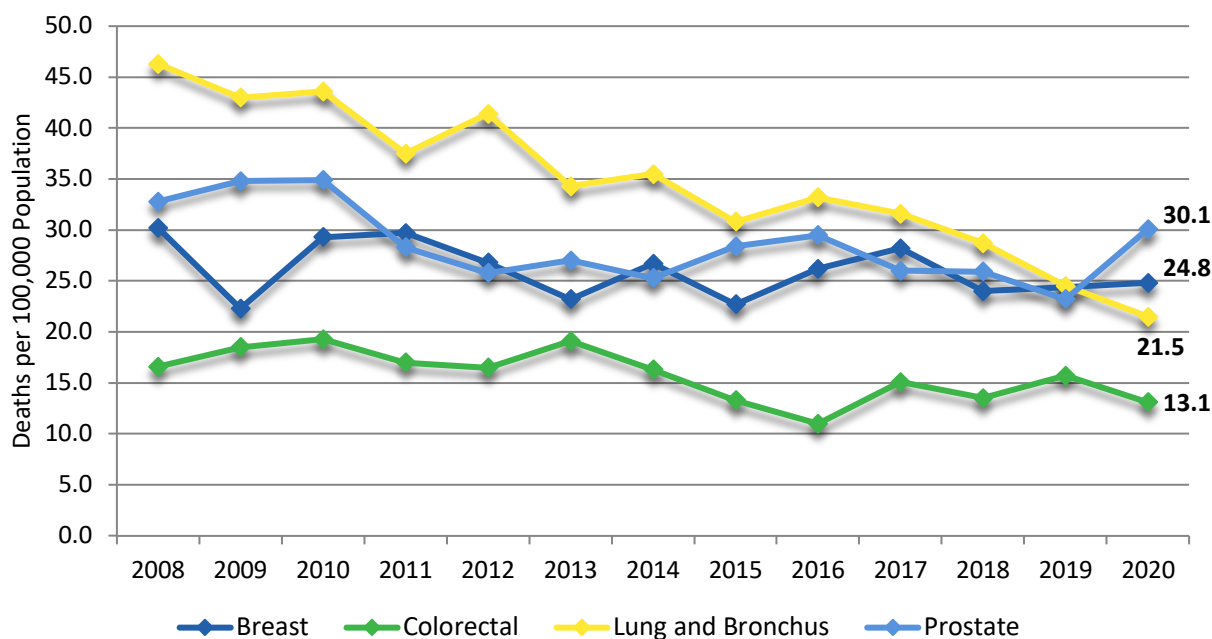
## Cancer Age-Adjusted Death Rates per 100,000 by Site\*, Prince George's County, 2008-2020

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

\* Cervical cancer statistics not included due to insufficient numbers.

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

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

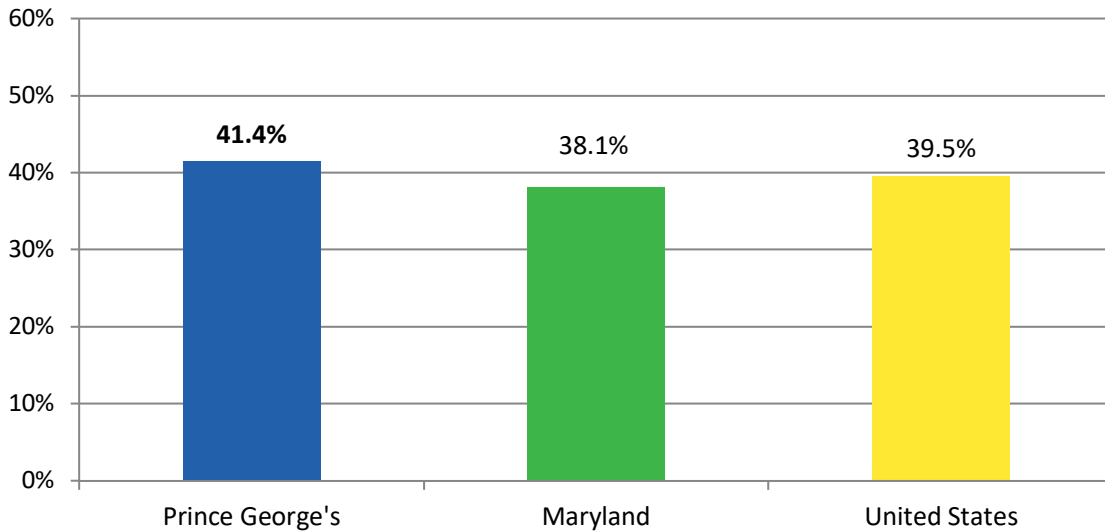


Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

## Cancer Screening

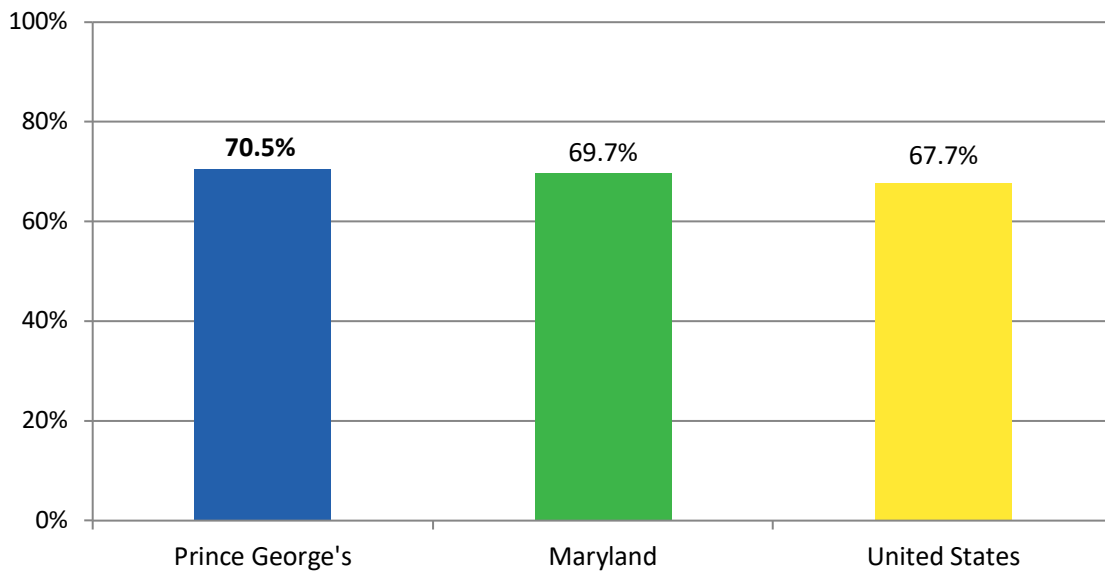
In 2016, Prince George's County had slightly higher cancer screening rates compared to the State and nation for prostate, colorectal, and breast cancers, and slightly lower screening rate for cervical cancer. Updated Maryland Behavioral Risk Factor Surveillance System data is not available due to the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

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



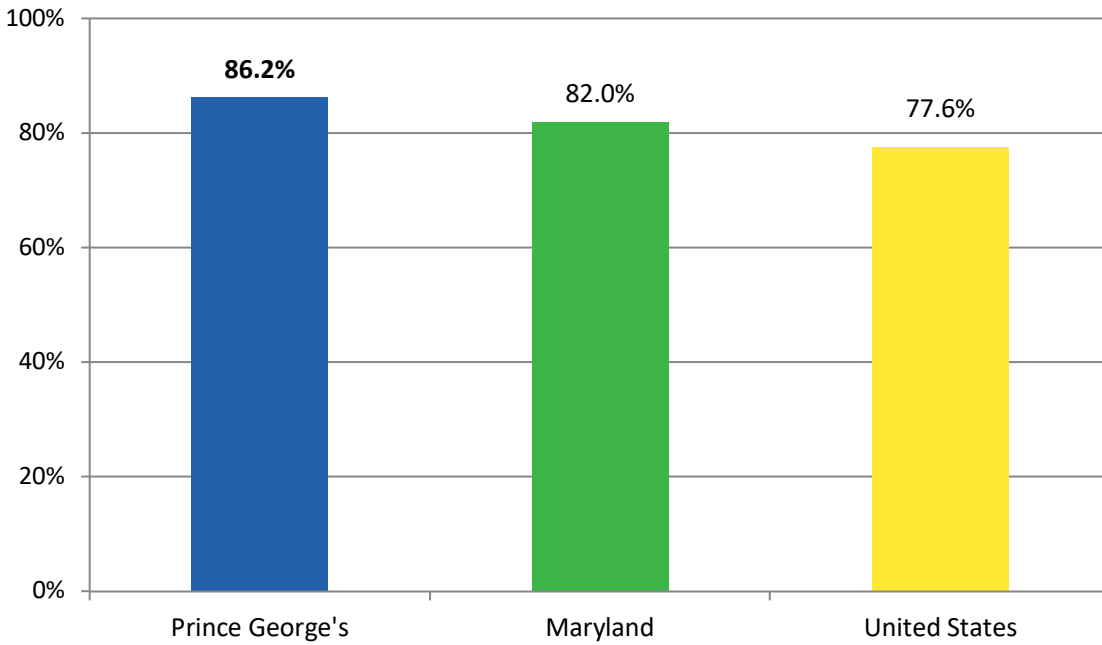
**Data Source:** 2016 Maryland Behavioral Risk Factor Surveillance System, <https://ibis.health.maryland.gov>, accessed 5/13/2019; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

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



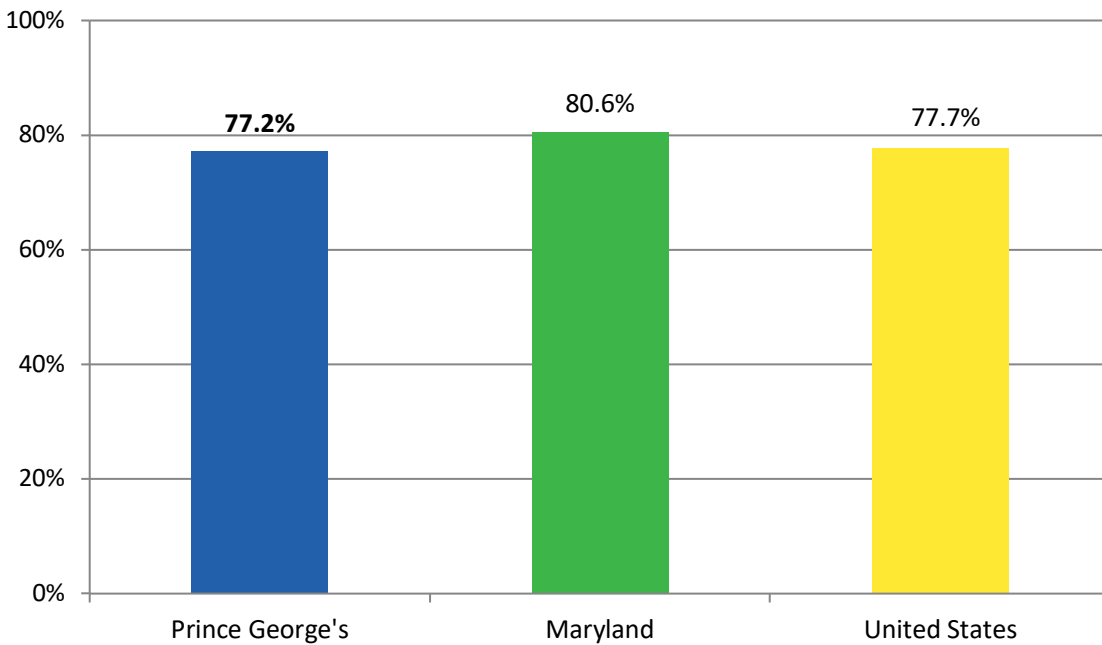
**Data Source:** 2016 Maryland Behavioral Risk Factor Surveillance System, <https://ibis.health.maryland.gov>, accessed 5/13/2019; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

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



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

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



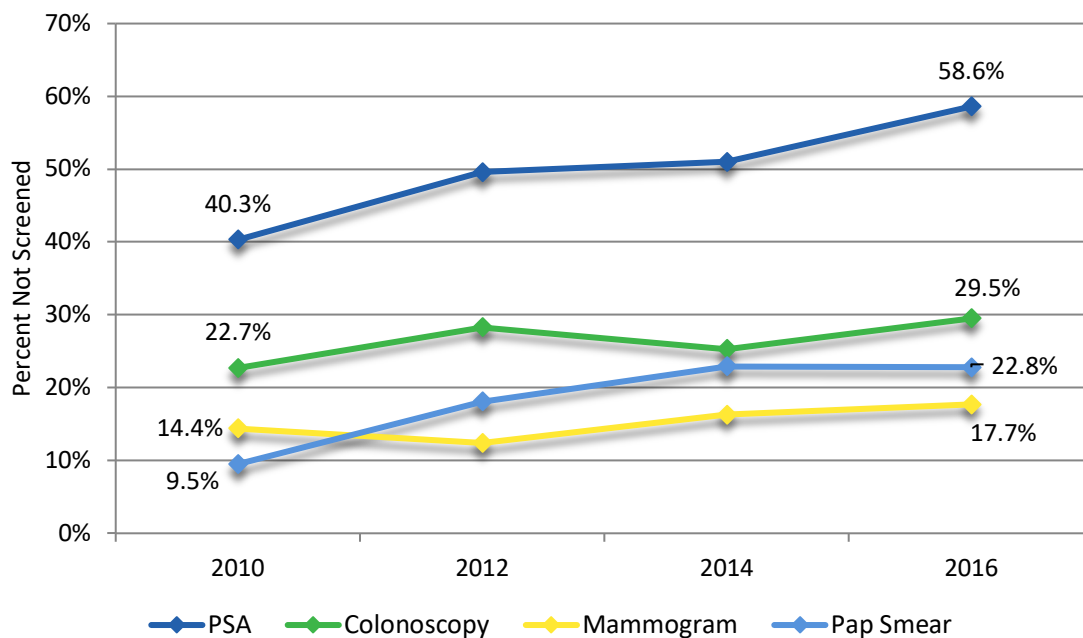
**Data Source:** 2016 Maryland Behavioral Risk Factor Surveillance System, <https://ibis.health.maryland.gov>, accessed 5/13/2019; CDC National Center for Chronic Disease Prevention Health Promotion, Division of Public Health, BRFSS

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

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

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

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



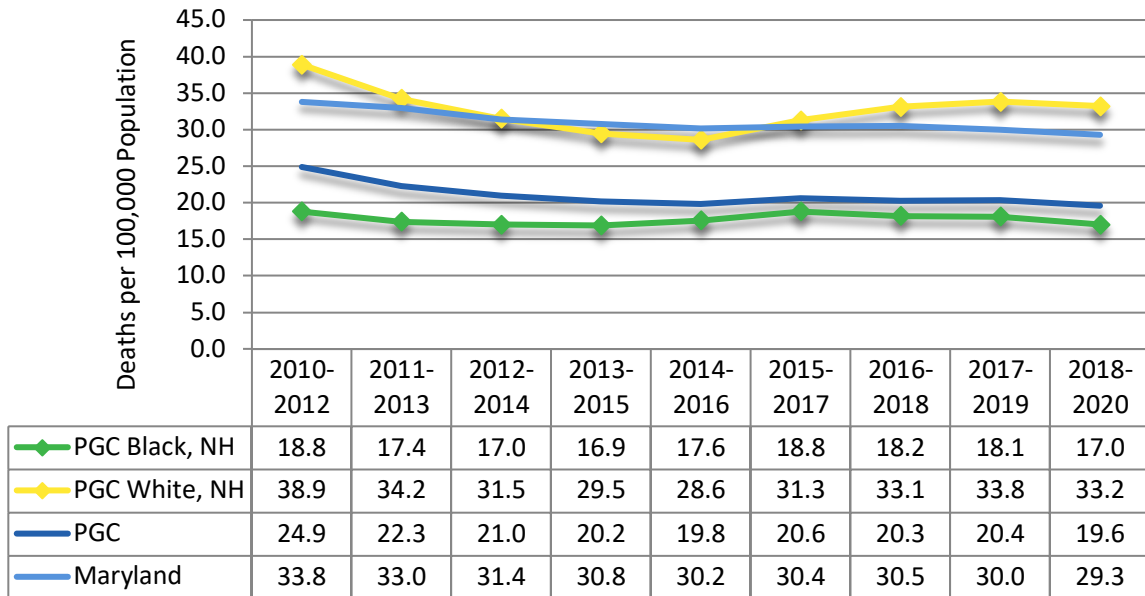
Data Source: 2010-2016 Maryland Behavioral Risk Factor Surveillance System, <https://ibis.health.maryland.gov>, accessed 5/13/2019

## Chronic Lower Respiratory Disease (CLRD)

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

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

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

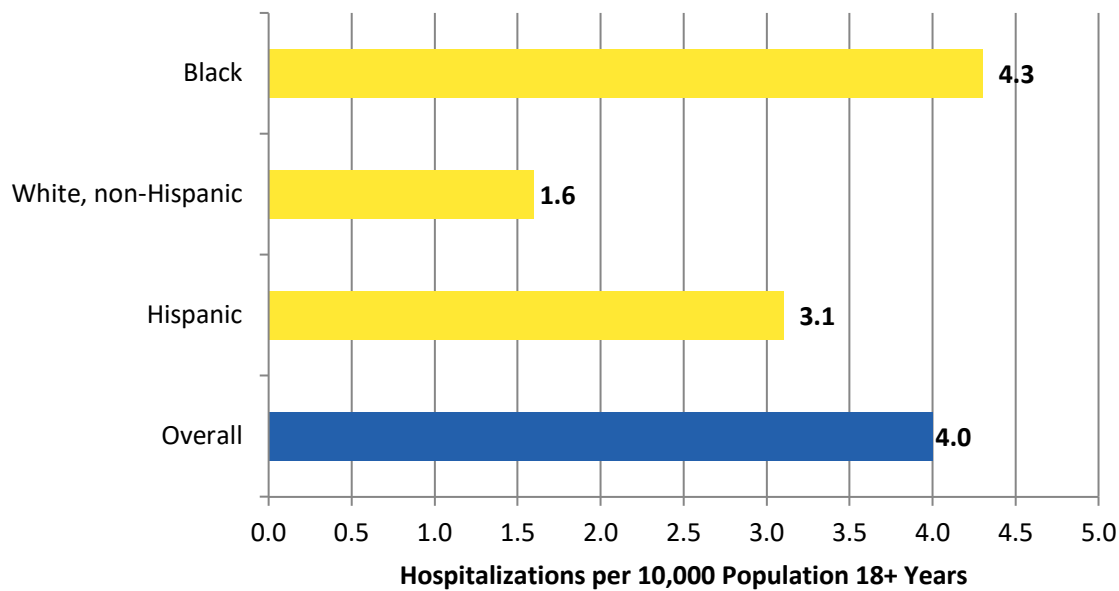


\* Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers

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

## Adult Asthma

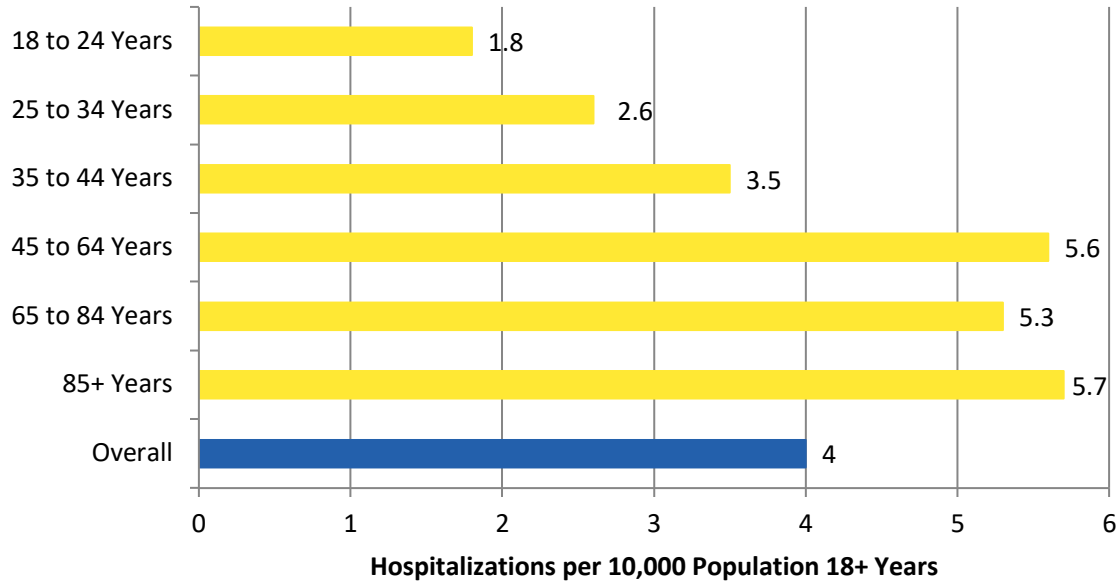
### Age-Adjusted Hospital Inpatient\* Visit Rate due to Adult Asthma by Race and Ethnicity, Prince George's County, 2017-2019



\* Includes visits only to Maryland hospitals

Data Source: [www.pghealthzone.org](http://www.pghealthzone.org); The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

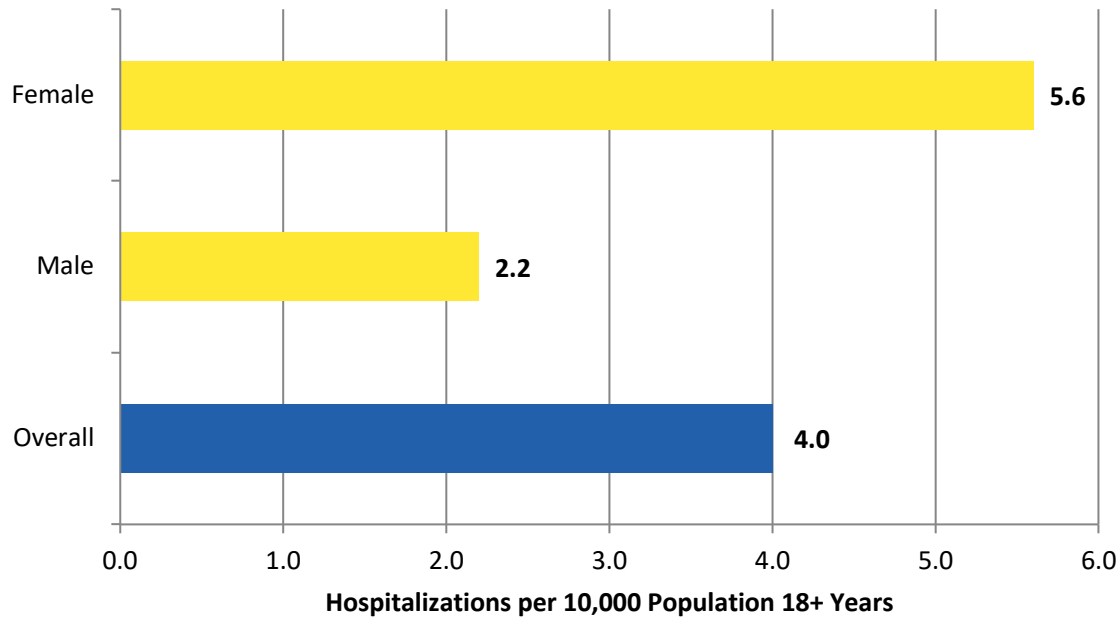
**Age-Adjusted Hospital Inpatient\* Visit Rate due to Adult Asthma by Age Group, Prince George’s County, 2017-2019**



\* Includes visits to only Maryland hospitals

Data Source: [www.pgchealthzone.org](http://www.pgchealthzone.org); The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

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

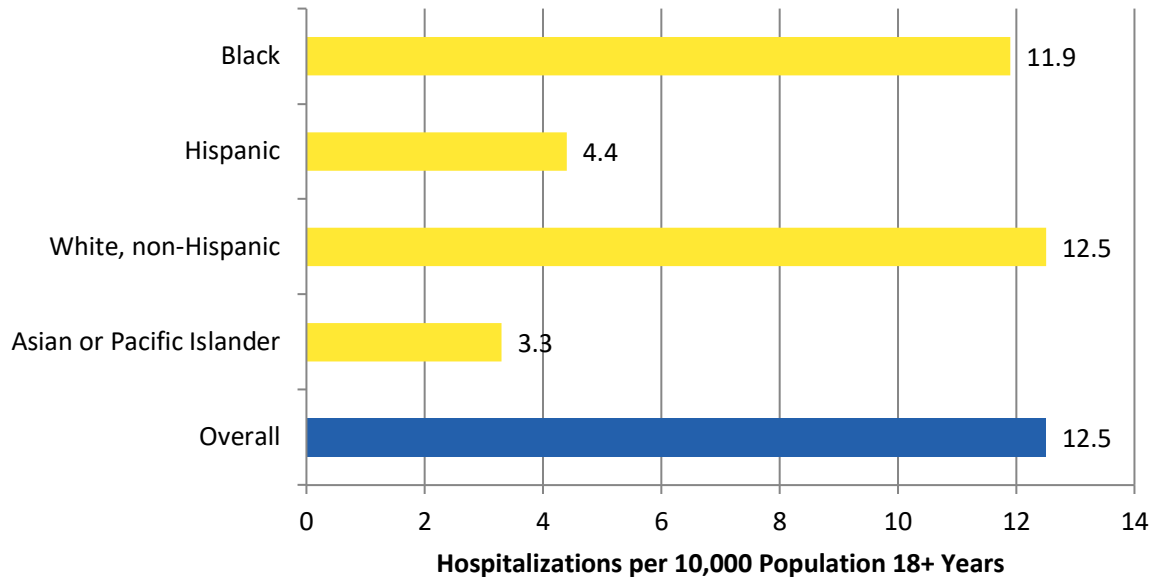


\* Includes visits to only Maryland hospitals

Data Source: [www.pgchealthzone.org](http://www.pgchealthzone.org); The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

## Chronic Obstructive Pulmonary Disease (COPD)

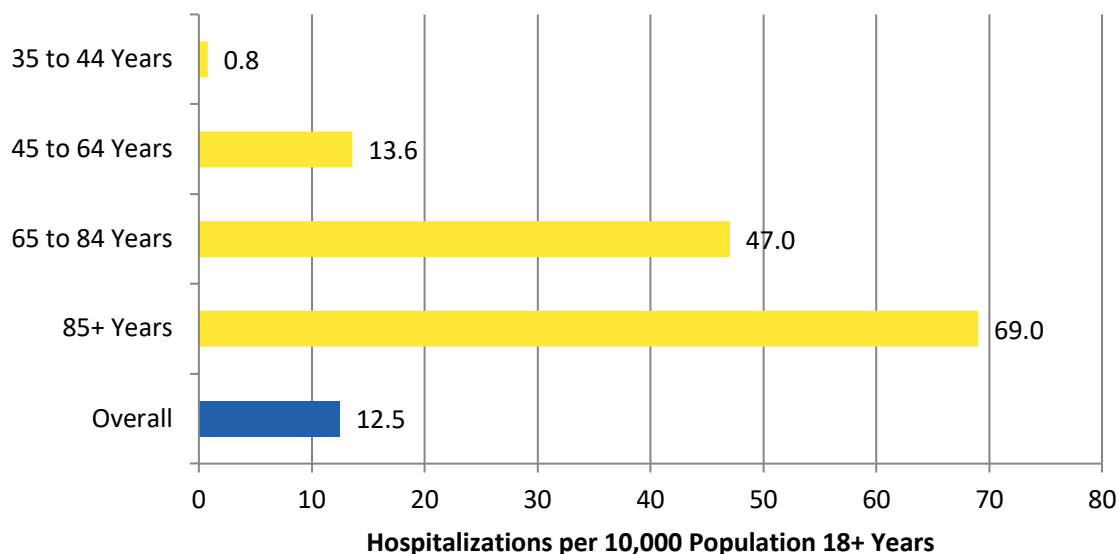
### Age-Adjusted Hospital Inpatient\* Visit Rate due to COPD by Race and Ethnicity, Prince George's County, 2017-2019



\* Includes visits to only Maryland hospitals

Data Source: [www.pghealthzone.org](http://www.pghealthzone.org); The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

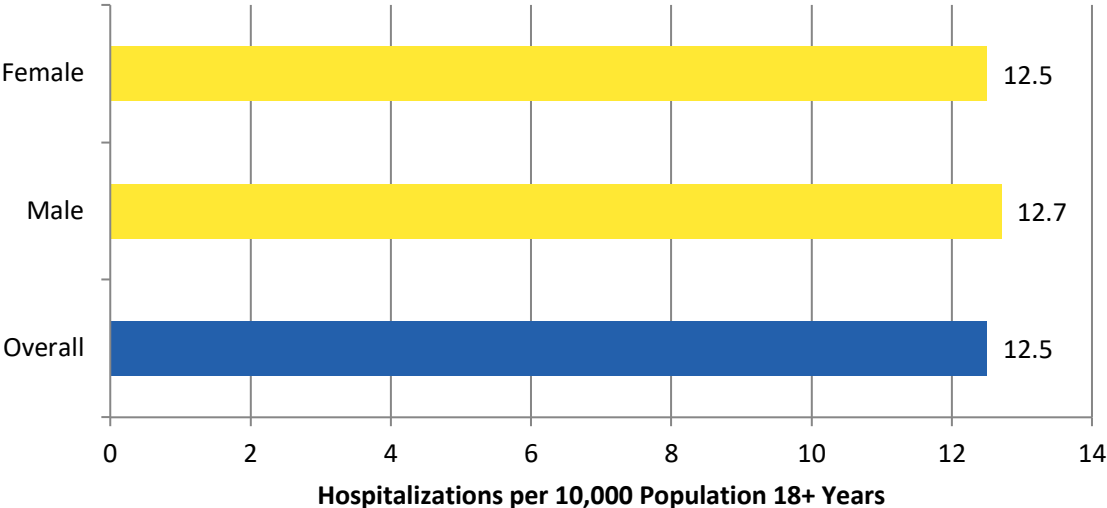
### Age-Adjusted Hospital Inpatient\* Visit Rate due to COPD by Age Group, Prince George's County, 2017-2019



\* Includes visits to only Maryland hospitals

Data Source: [www.pghealthzone.org](http://www.pghealthzone.org); The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

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



\* Includes visits to only Maryland hospitals

Data Source: [www.pgchealthzone.org](http://www.pgchealthzone.org); The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

## Diabetes

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

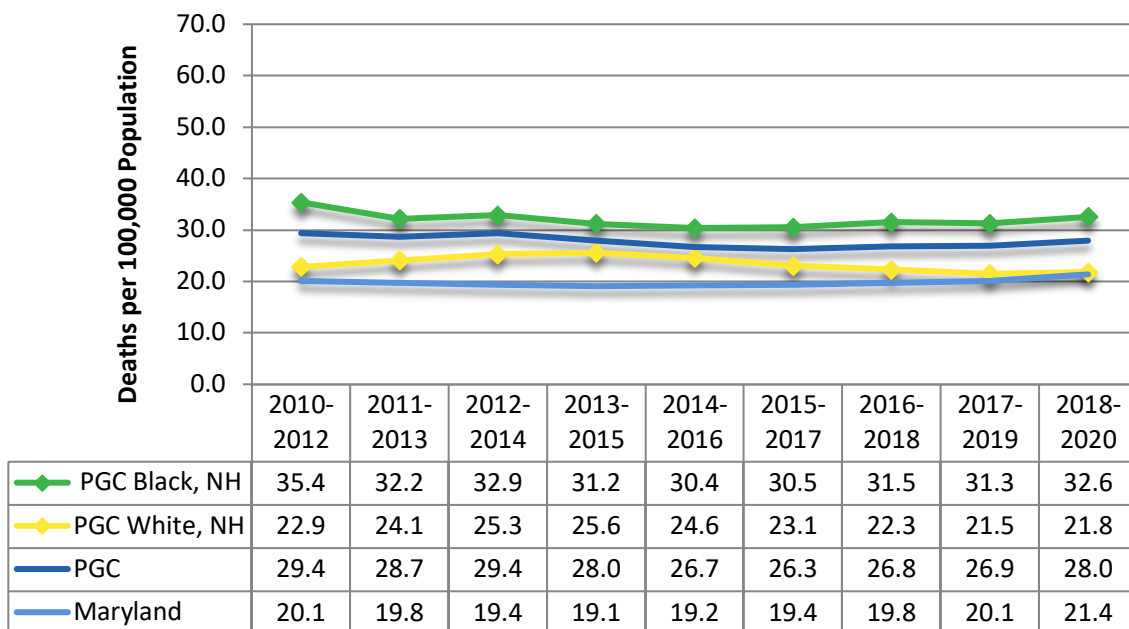
## Percentage of Adults Who Have Ever Been Told By a Health Professional That They Have Diabetes, 2017 (Excludes Diabetes During Pregnancy)

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

\* Individuals of Hispanic origin and ages 18-34 years were not included due to insufficient numbers

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

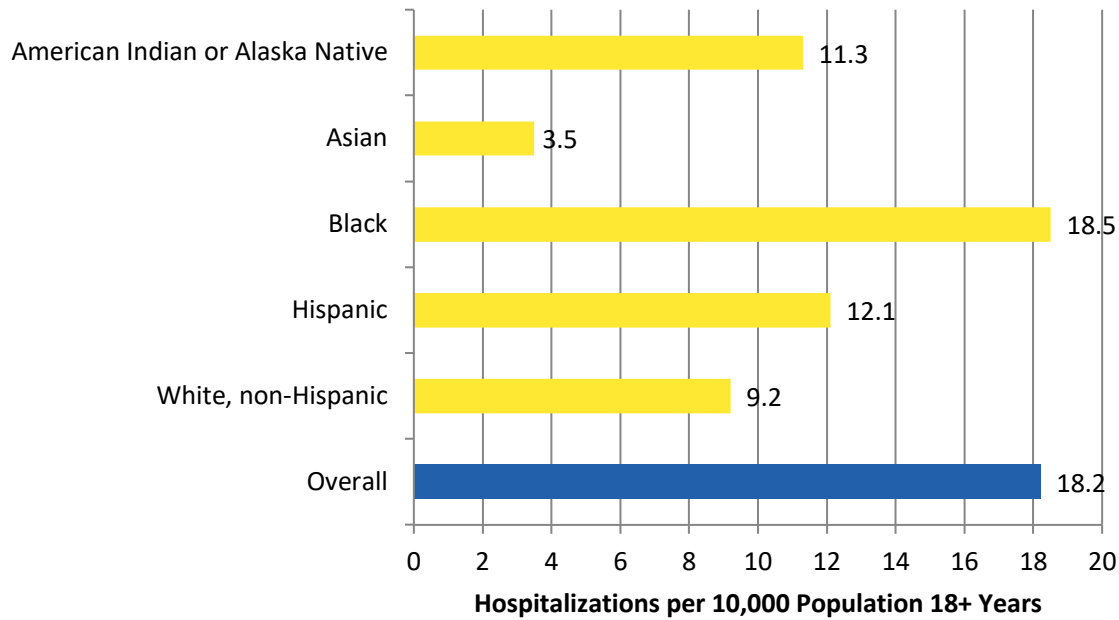
## Age-Adjusted Death Rate per 100,000 for Diabetes, 2010-2020



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

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

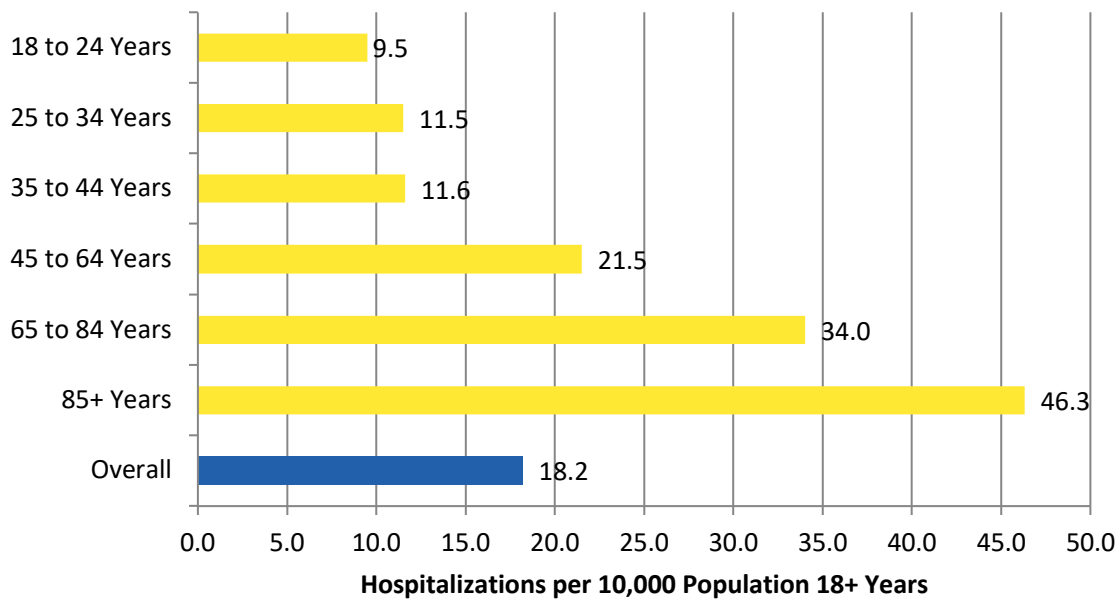
## Age-Adjusted Hospital Inpatient\* Visit Rate due to Diabetes by Race and Ethnicity, Prince George's County, 2017-2019



\* Includes visits to only Maryland hospitals

Data Source: [www.pghealthzone.org](http://www.pghealthzone.org); The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

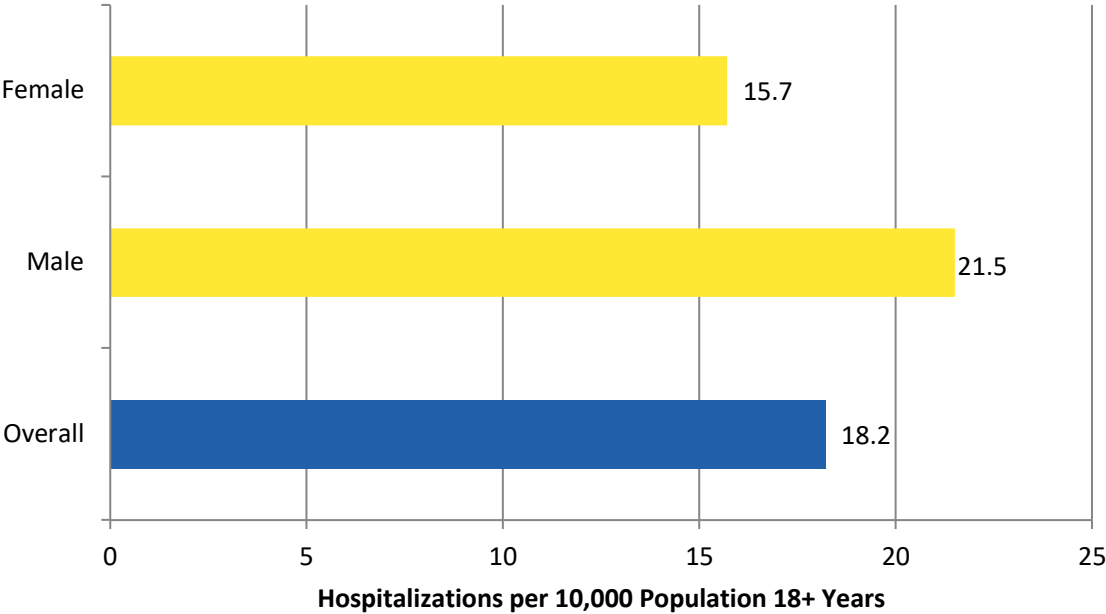
## Age-Adjusted Hospital Inpatient\* Visit Rate due to Diabetes by Age Group, Prince George's County, 2017-2019



\* Includes visits to only Maryland hospitals

Data Source: [www.pghealthzone.org](http://www.pghealthzone.org); The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

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

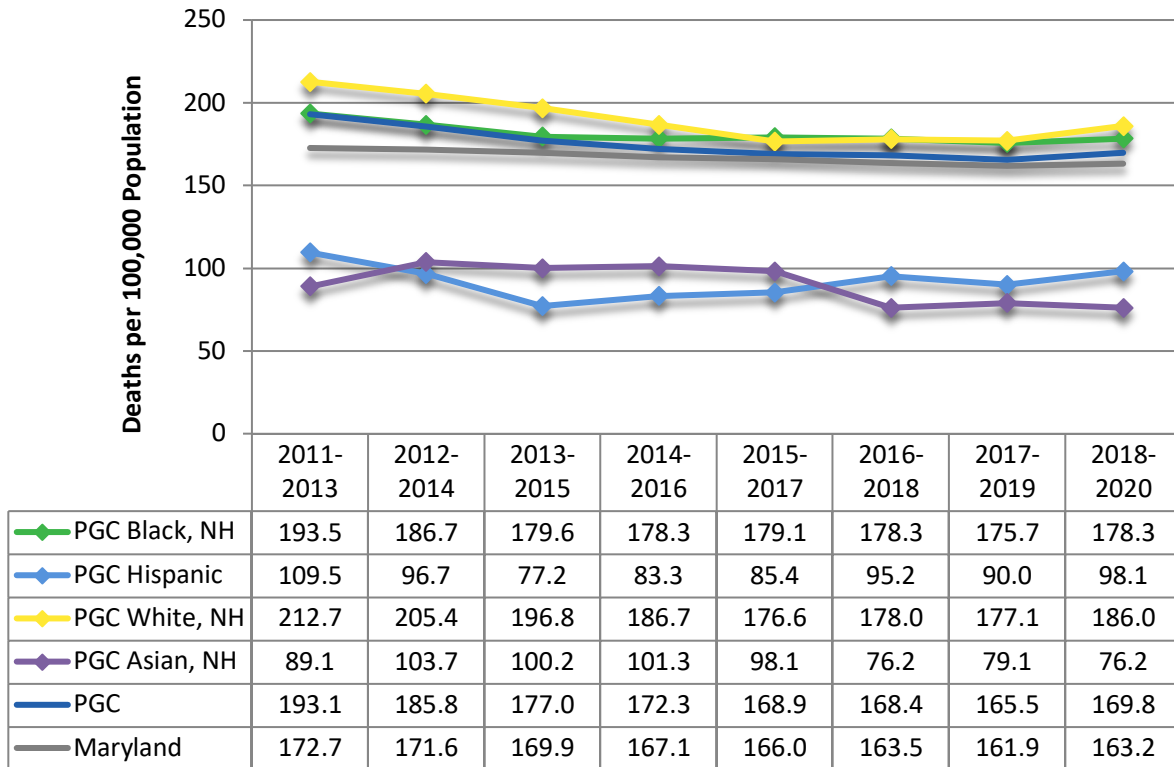


\* Includes visits to Maryland and Washington, D.C. hospitals  
**Data Source:** [www.pgchealthzone.org](http://www.pgchealthzone.org); The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

# Heart Disease

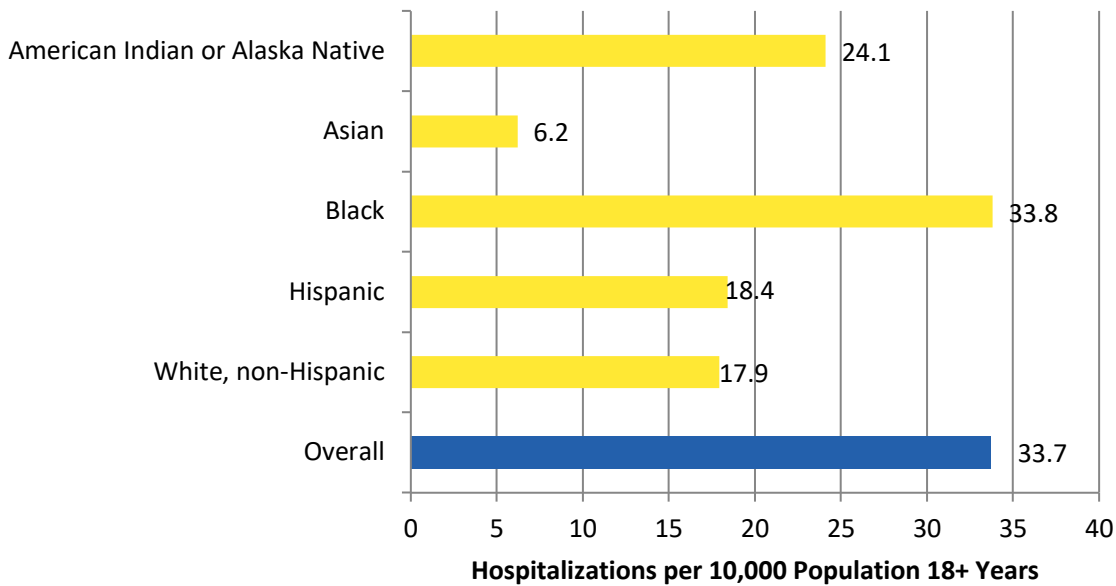
Overview	
<b>What is it?</b>	Heart disease is a disorder of the blood vessels of the heart that can lead to a heart attack, which happens when an artery becomes blocked. Heart disease is one of several cardiovascular diseases.
<b>Who is affected?</b>	Heart disease was the leading cause of death in the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

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



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

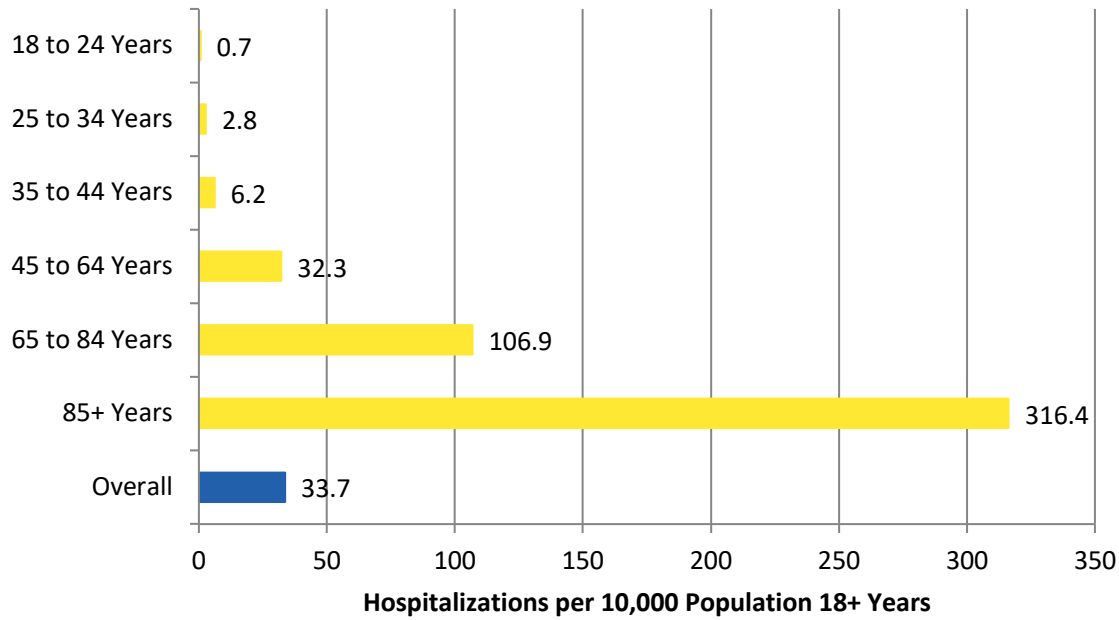
### Age-Adjusted Hospital Inpatient\* Visit Rate due to Heart Failure by Race and Ethnicity, Prince George’s County, 2017-2019



\* Includes visits to only Maryland hospitals

Data Source: [www.pghealthzone.org](http://www.pghealthzone.org), Maryland Health Services Cost Review Commission; Maryland Health Care Commission;

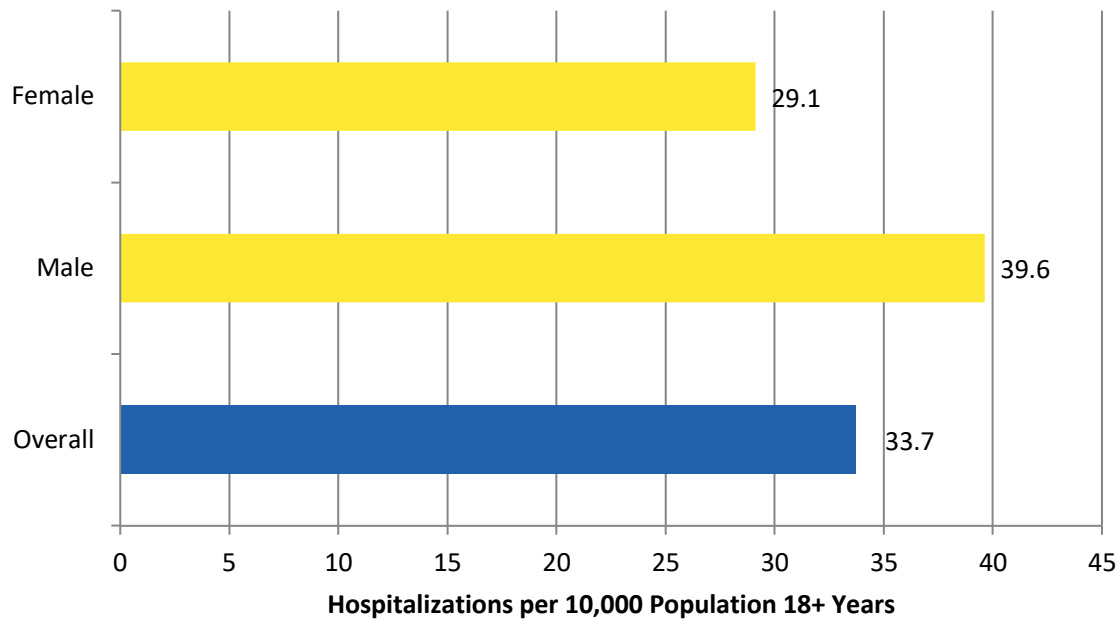
### Age-Adjusted Hospital Inpatient\* Visit Rate due to Heart Failure by Age, Prince George's County, 2017-2019



\* Includes visits to only Maryland hospitals

Data Source: [www.pghealthzone.org](http://www.pghealthzone.org), Maryland Health Services Cost Review Commission; Maryland Health Care Commission

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



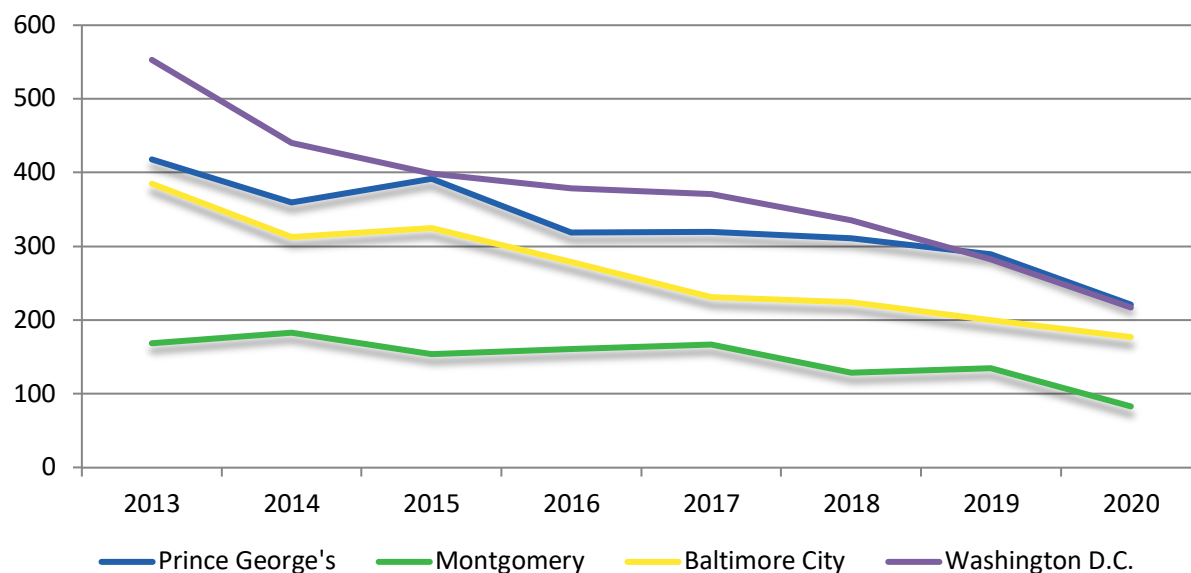
\* Includes visits to only Maryland hospitals

Data Source: [www.pghealthzone.org](http://www.pghealthzone.org), Maryland Health Services Cost Review Commission; Maryland Health Care Commission

# Human Immunodeficiency Virus (HIV)

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

## New HIV Cases by Jurisdiction, 2013-2020



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

## Demographics of New HIV Cases, 2020

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

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

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

## New HIV Cases by Exposure, 2020

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

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

## Demographics of Total Living HIV Cases, 2020

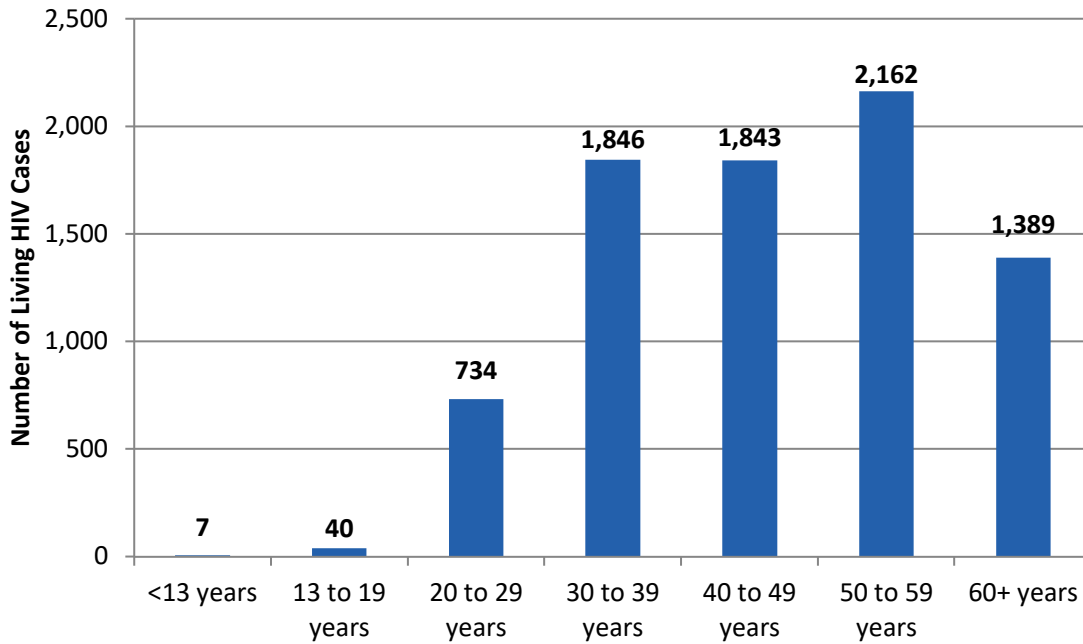
	Prince George's		Maryland	
	Number	Rate*	Number	Rate*
<b>Sex at Birth</b>				
Male	5,431	1,501.5	20,908	855.4
Female	2,583	645.4	10,768	405.6
<b>Race/Ethnicity</b>				
Black, non-Hispanic	6,630	1,375.0	23,554	1,537.6
Hispanic	646	484.5	2,233	457.2
White, non-Hispanic	315	323.0	3,879	148.2
Asian, non-Hispanic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

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

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

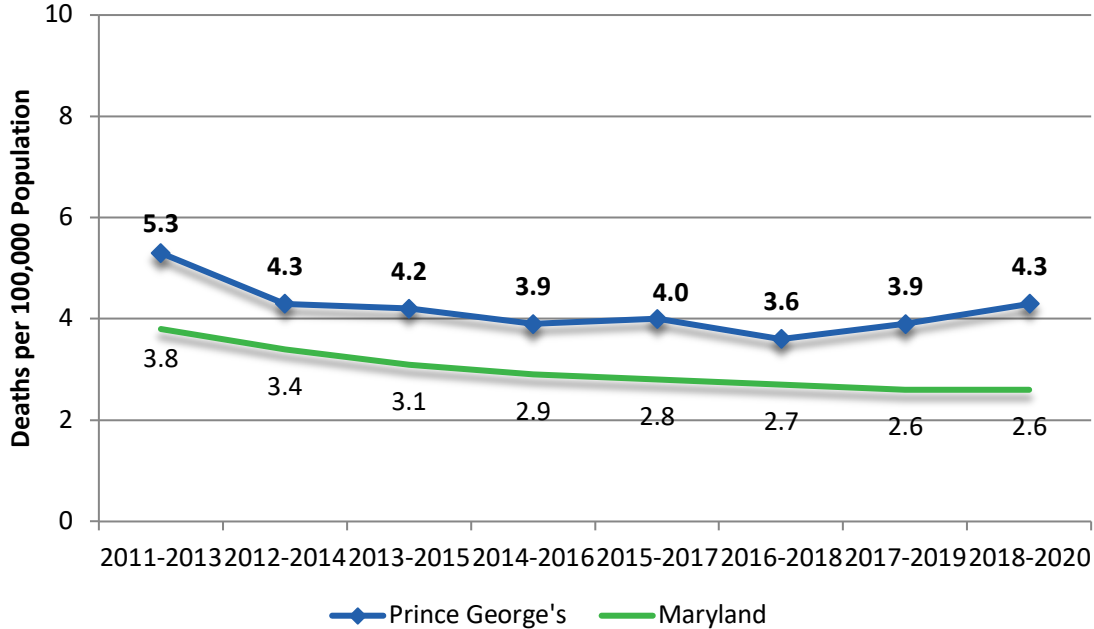
In Prince George's County, approximately one out of every 100 residents are living with HIV. The County's rate for living HIV cases (1,053.5 per 100,000 residents) is 68% higher compared to Maryland at 626.9.

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



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

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



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

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

# Hypertension and Stroke

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

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

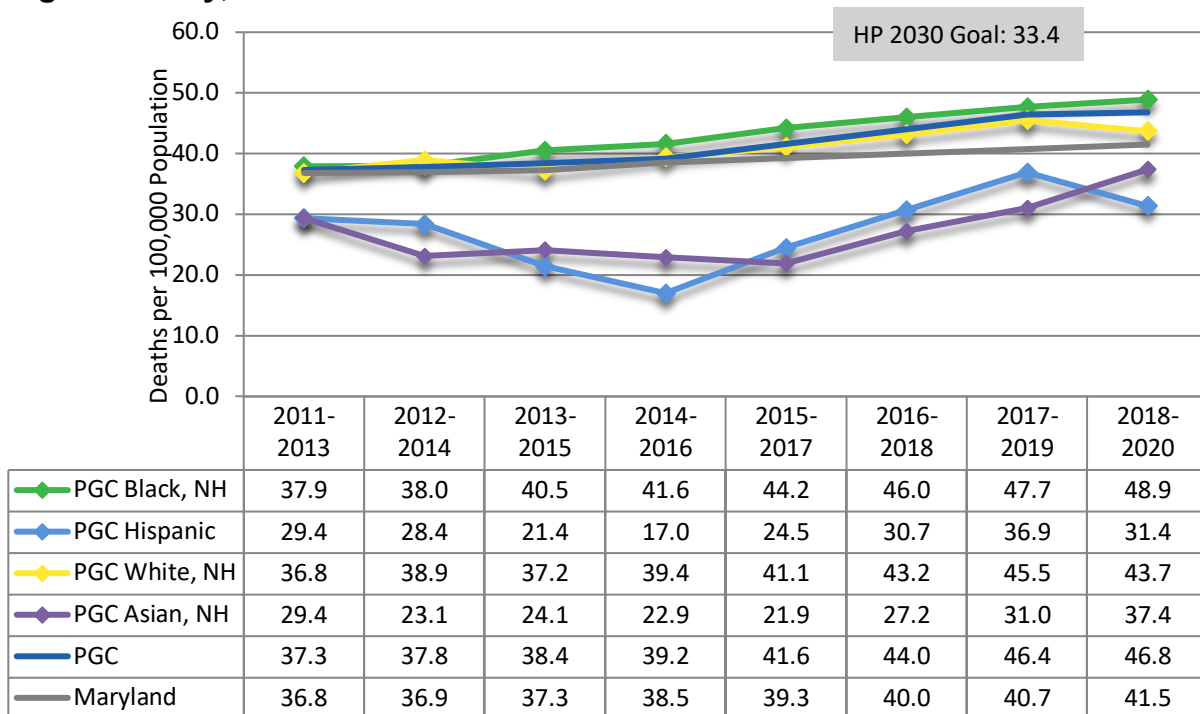
	Prince George's	Maryland
<b>Sex</b>		
Male	32.8%	33.0%
Female	31.1%	28.2%
<b>Race/Ethnicity</b>		
Black, non-Hispanic	34.2%	37.4%
Hispanic	34.6%	28.1%
White, non-Hispanic	28.3%	28.6%
<b>Age Group</b>		
18 to 34 Years	11.6%	10.9%
35 to 49 Years	19.2%	21.2%
50 to 64 Years	48.0%	45.4%
Over 65 Years	70.0%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

\*Excludes women told only during pregnancy and borderline hypertension

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

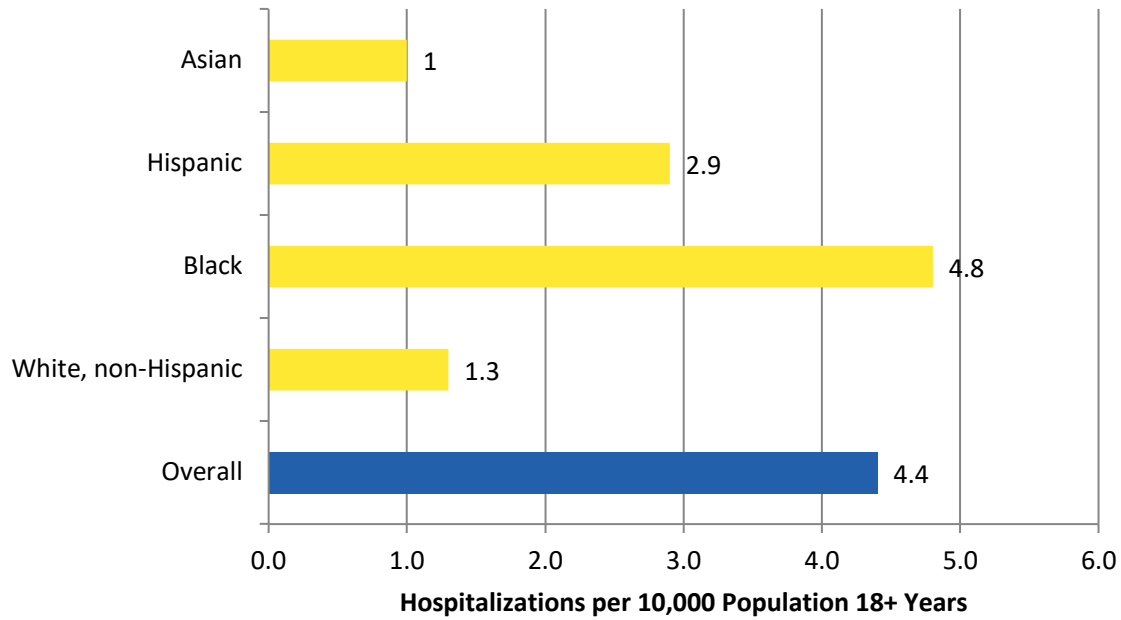
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System; <https://ibis.health.maryland.gov>, accessed 5/13/2019

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



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

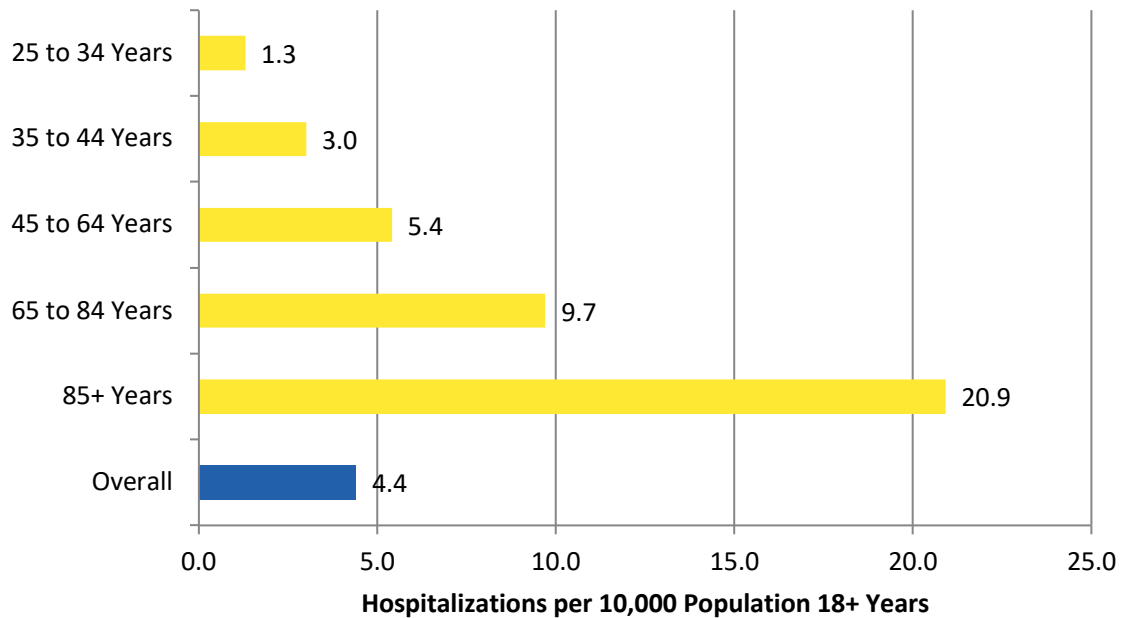
**Age-Adjusted Hospital Inpatient\* Visit Rate due to Hypertension by Race and Ethnicity, Prince George’s County, 2017-2019**



\* Includes visits to only Maryland hospitals

Data Source: [www.pghealthzone.org](http://www.pghealthzone.org); The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

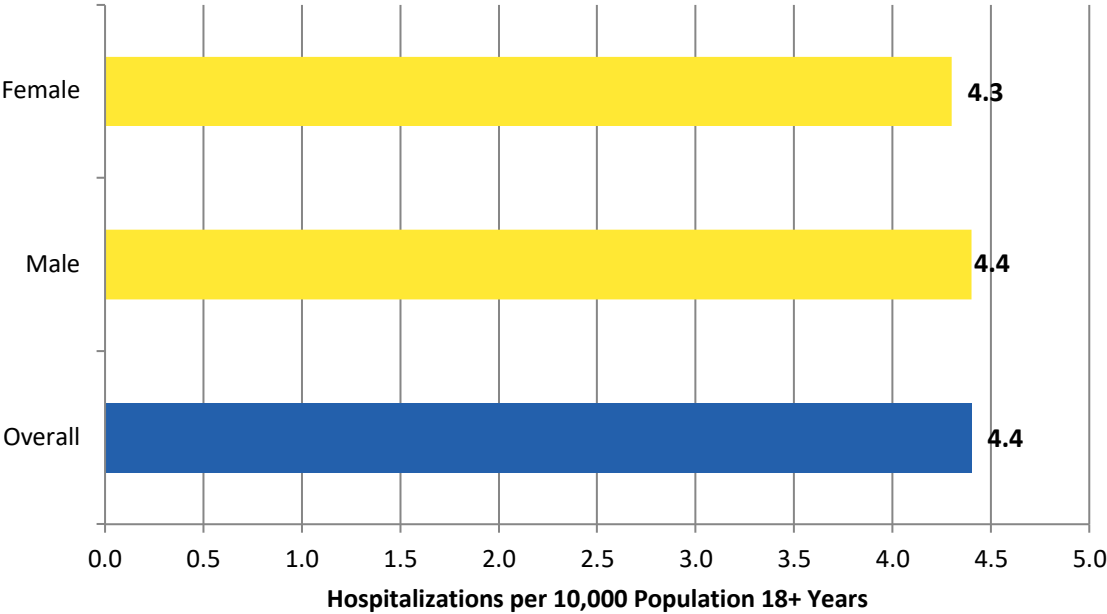
**Age-Adjusted Hospital Inpatient\* Visit Rate due to Hypertension by Age Group, Prince George’s County, 2017-2019**



\* Includes visits to only Maryland hospitals

Data Source: [www.pghealthzone.org](http://www.pghealthzone.org); The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

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



\* Includes visits to Maryland and Washington, D.C. hospitals  
**Data Source:** [www.pghealthzone.org](http://www.pghealthzone.org); The Maryland Health Services Cost Review Commission & Maryland Health Care Commission

## Infectious Disease

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

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

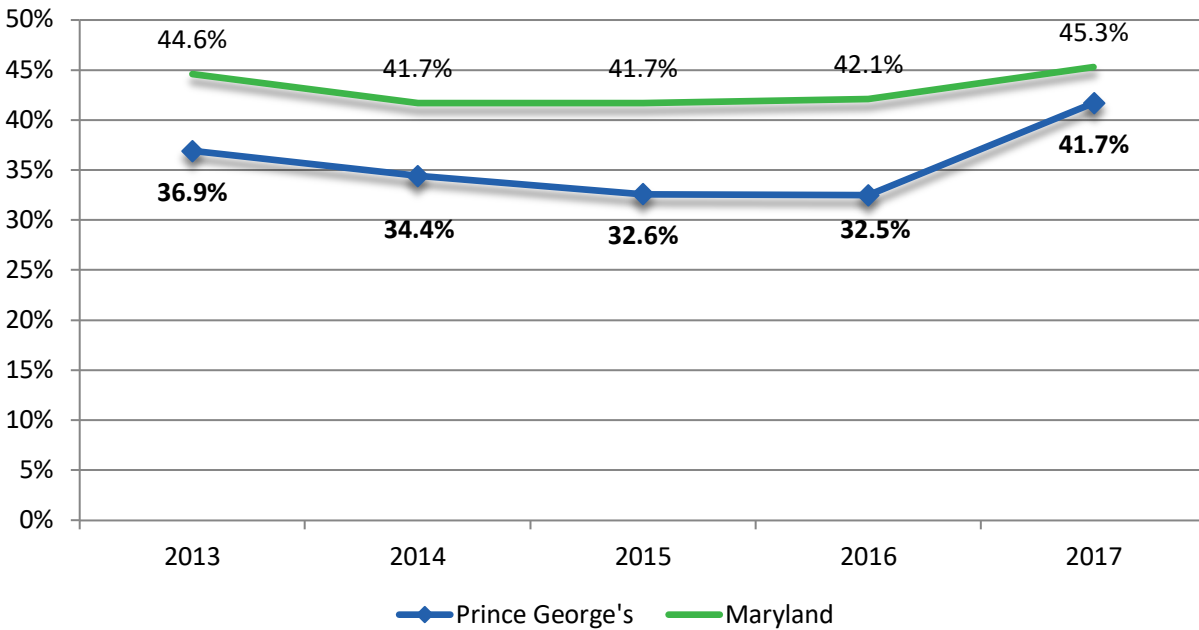
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, MDH

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

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

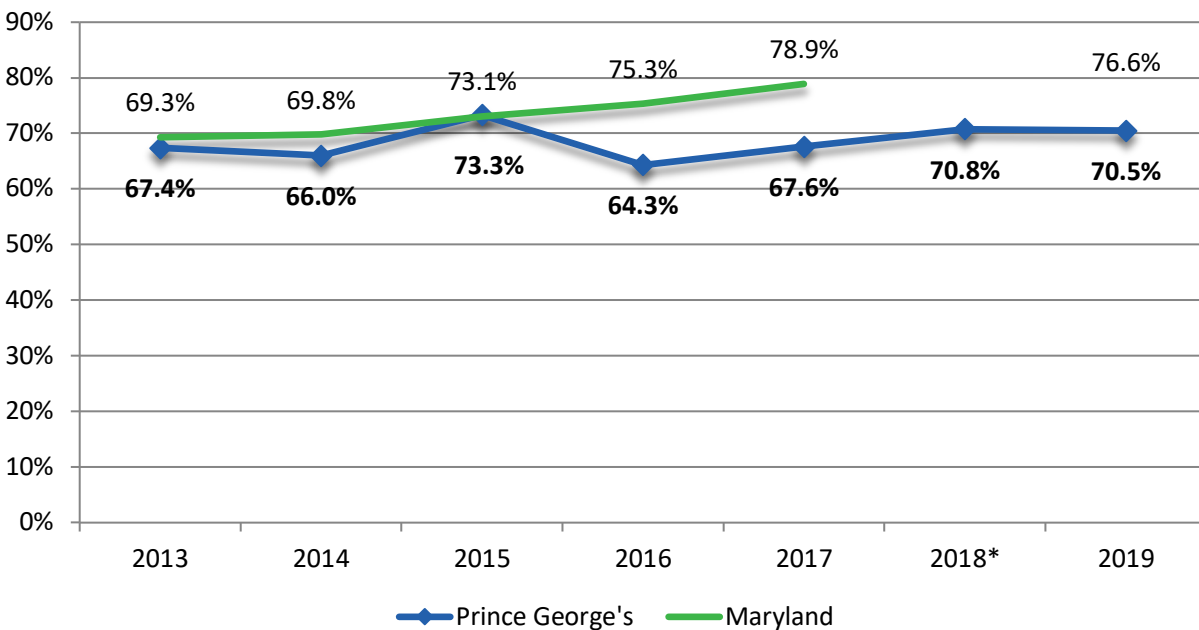
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, <https://ibis.health.maryland.gov>, accessed 5/13/2019

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



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

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



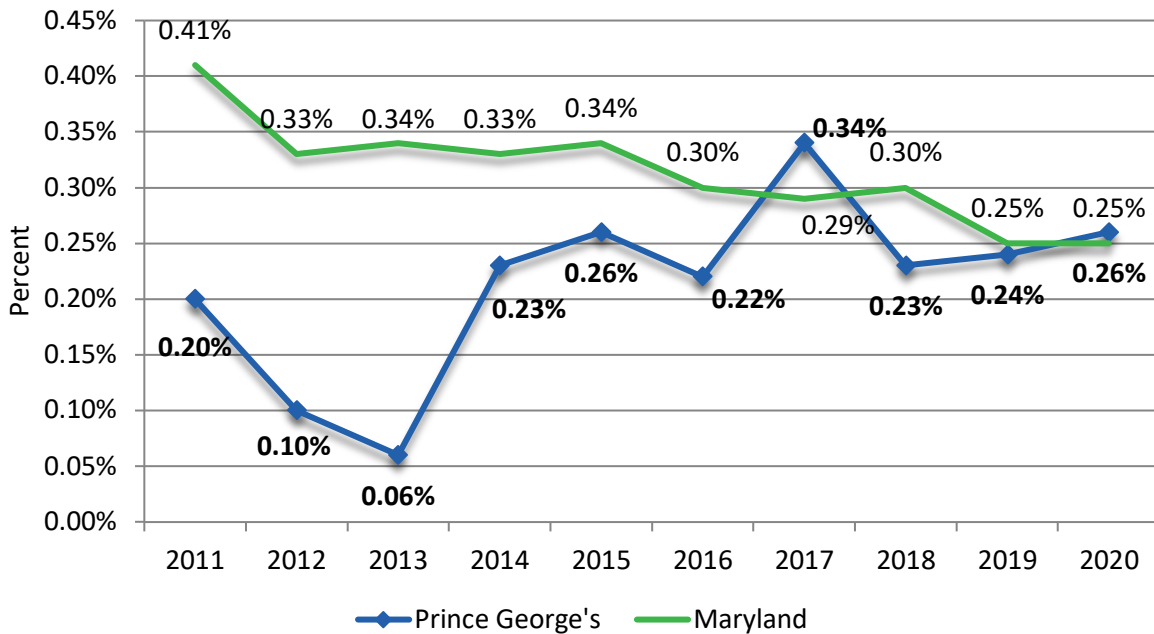
\* Maryland 2018 value unavailable

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

## Lead Poisoning

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

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



Data Source: Maryland Department of the Environment

## Maternal and Infant Health

### Live Birth Rate per 1,000 Population, 2020

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

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

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

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

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

### Number and Percentage of Births by Age Group, 2020

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

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

### Infant Mortality Rate\*, 2020

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

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

## Infant Deaths, 2016-2020

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

\*\*Rates based on <5 deaths are not presented since they are subject to instability.

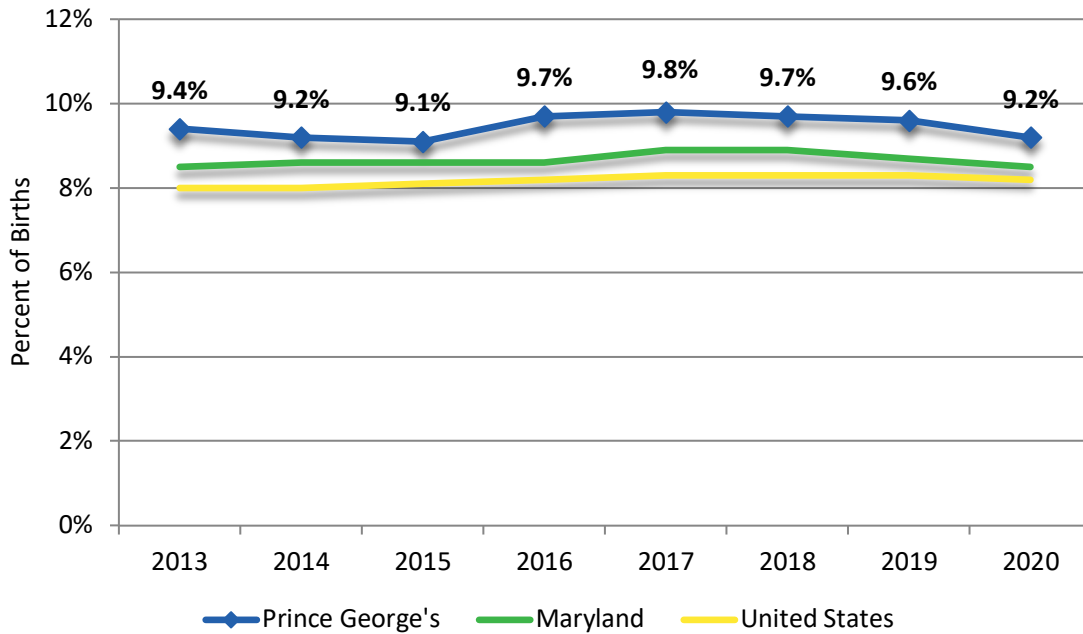
Data Source: Maryland Department of Health, Vital Statistics Administration, 2016-2020 Annual Infant Mortality Reports

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

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

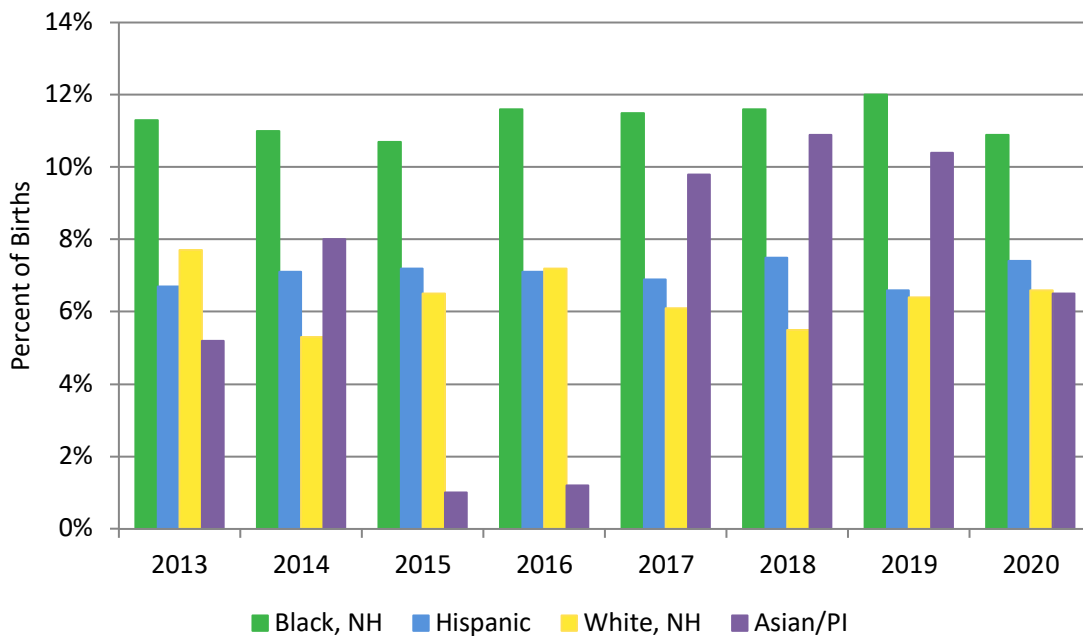
Data Source: Maryland Department of Health, Vital Statistics Administration, 2020 Annual Report; National Center for Health Statistics, Births Final Data for 2020

### Percentage of Low Birth Weight Infants, 2013-2020



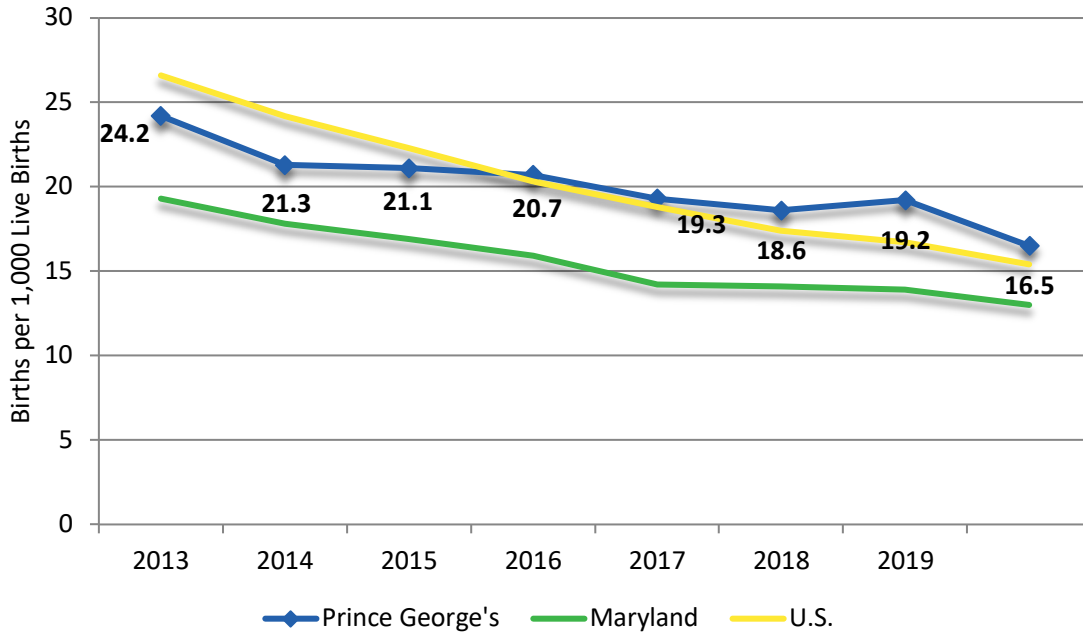
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2020 Annual Reports; National Center for Health Statistics, National Vital Statistics Report

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



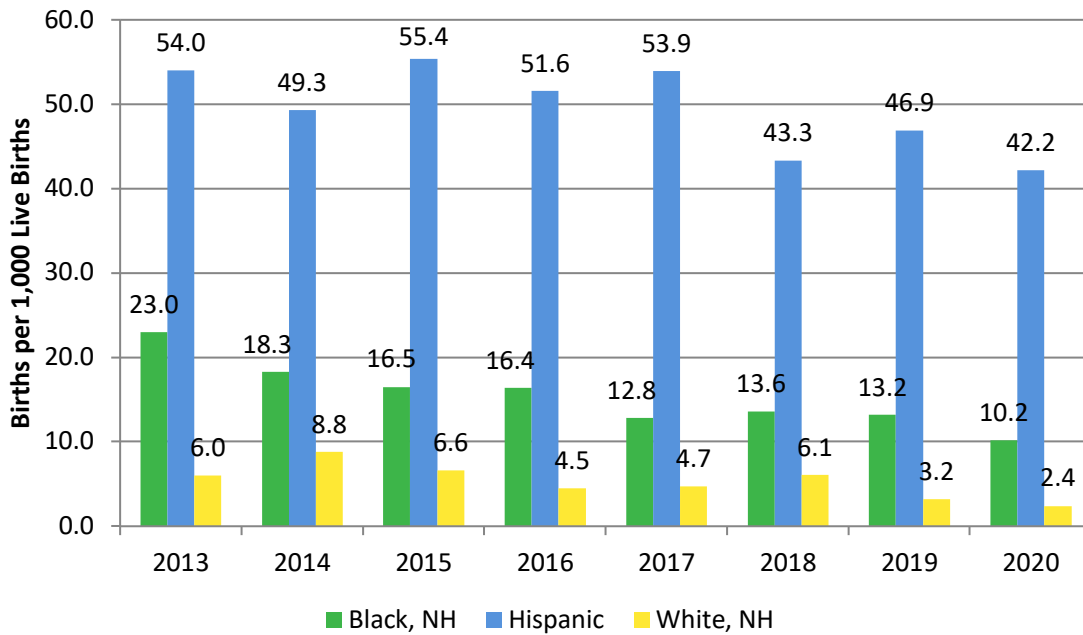
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2020 Annual Reports

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



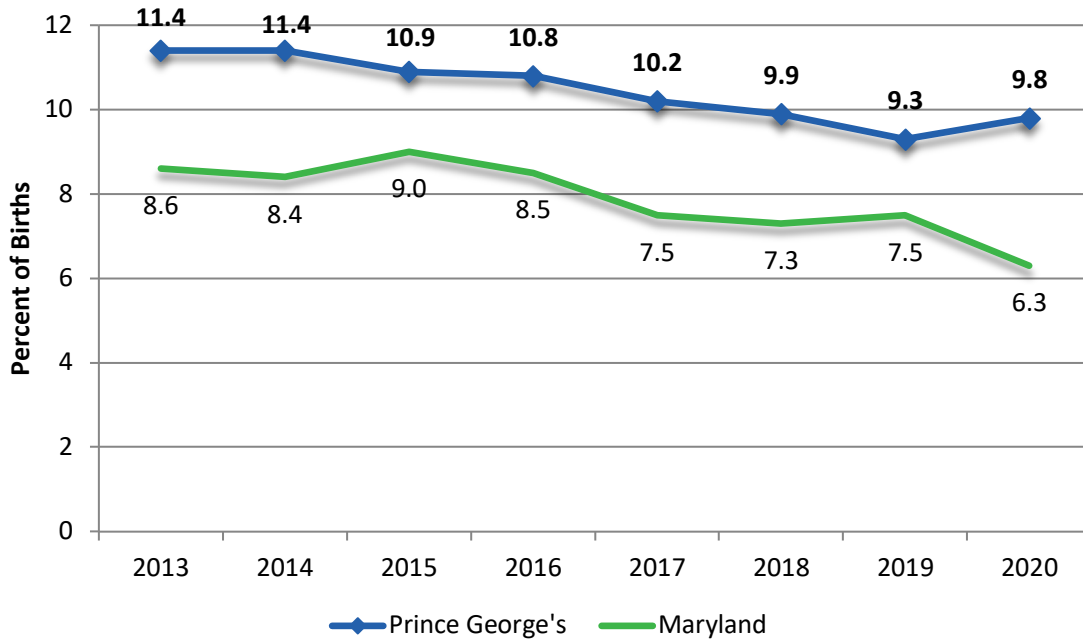
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2020 Annual Reports; National Center for Health Statistics, National Vital Statistics Report

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



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

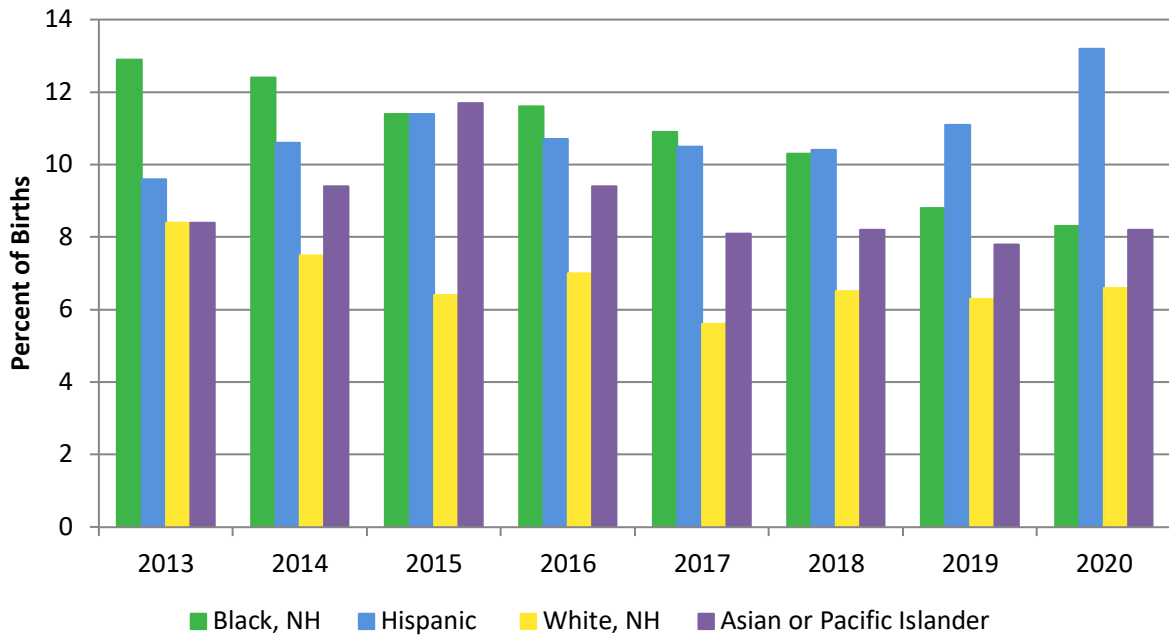
### Percentage of Births with Late or No Prenatal Care\*, 2013-2020



\*Late care refers to care beginning in the third trimester.

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

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



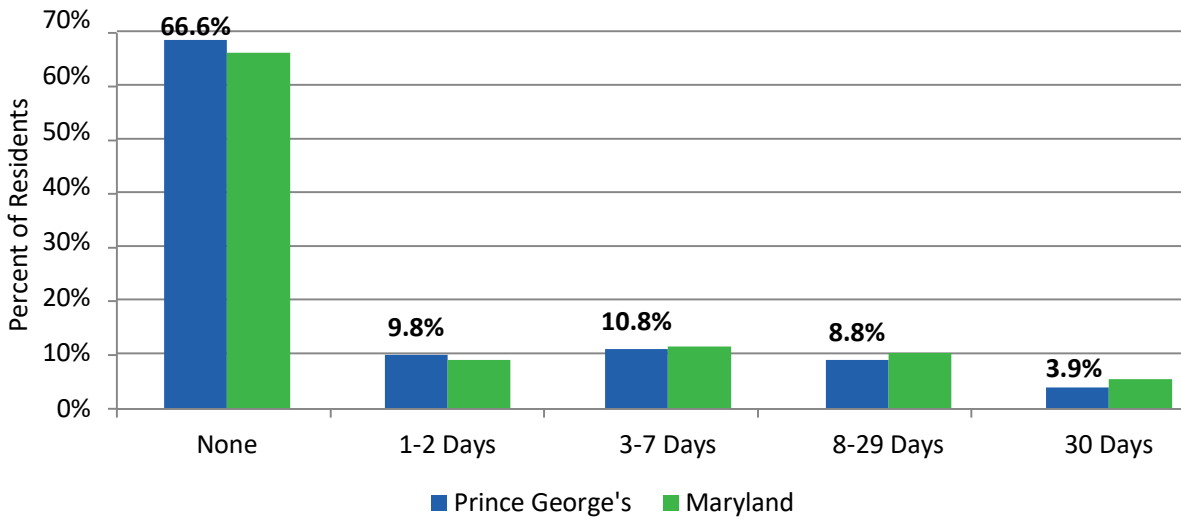
\*Late care refers to care beginning in the third trimester.

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

## Mental Health

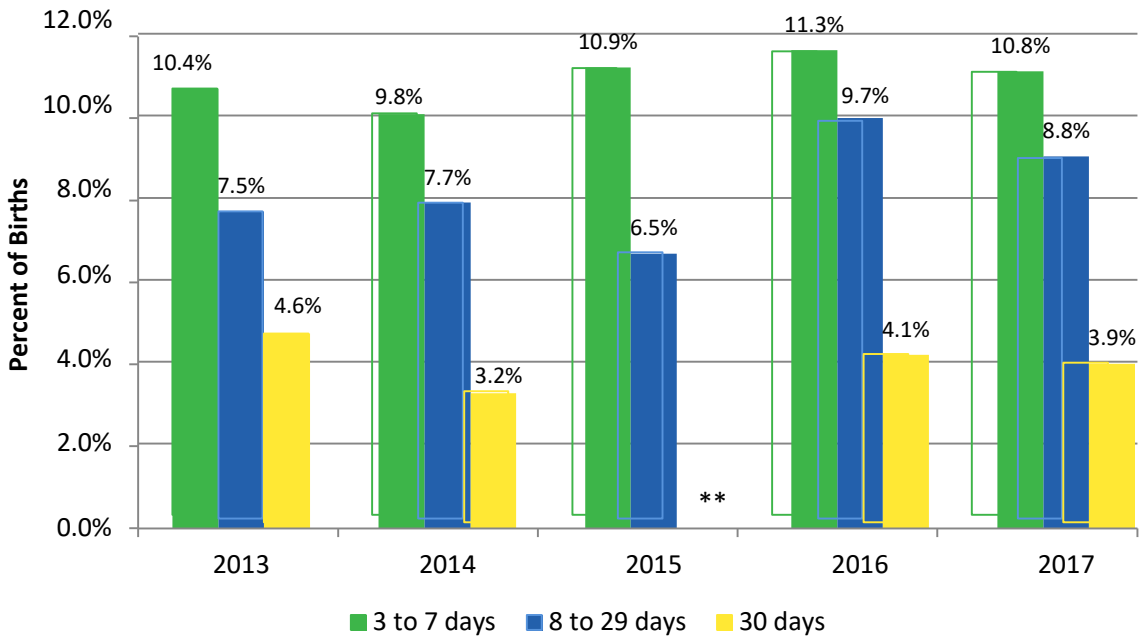
Overview	
<b>What is it?</b>	Mental health includes emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices.
<b>Who is affected?</b>	One in five adults in America experience a mental illness.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

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



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

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



\*\*Data not available; small number of observations.

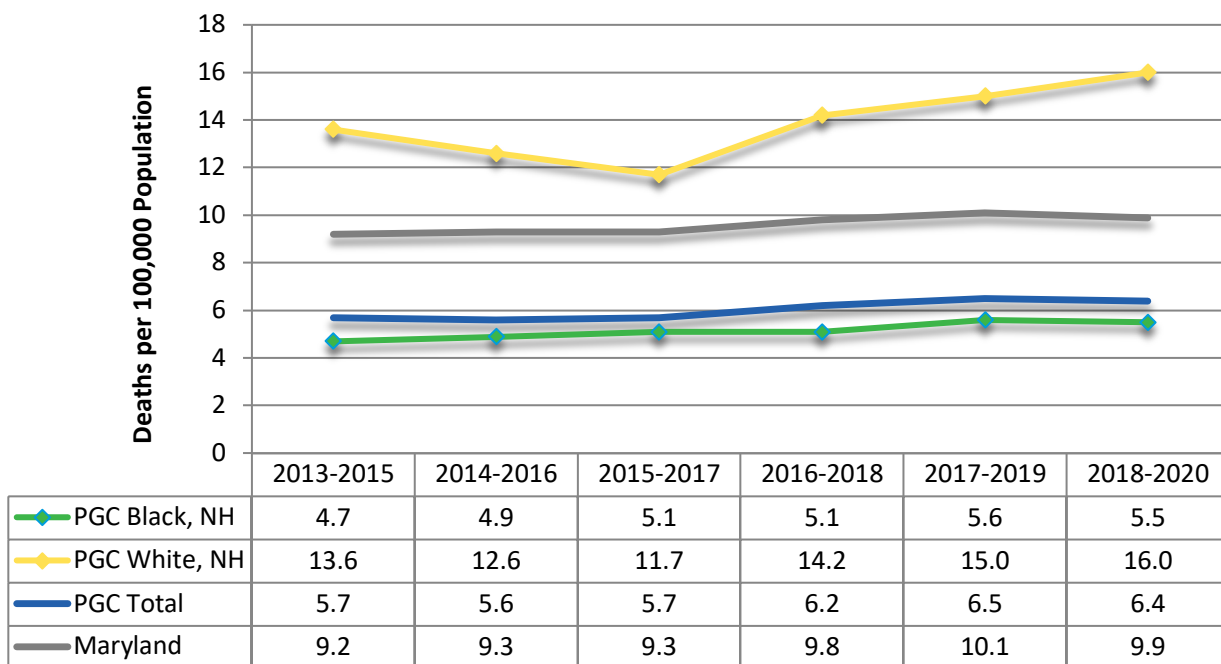
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, <https://ibis.health.maryland.gov>, accessed 5/31/2019

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

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

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

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

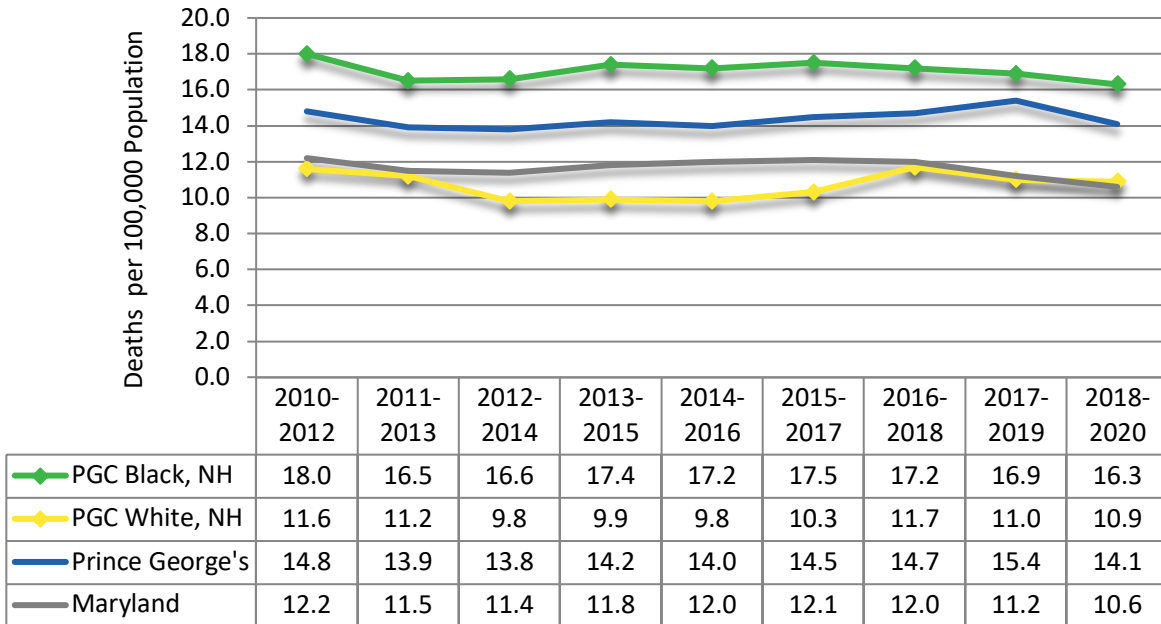


\* Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers

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

## Nephritis (Chronic Kidney Disease)

### Age-Adjusted Death Rate for Nephritis, 2010-2020



\* Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers

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

## Obesity

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

### How Obesity Is Classified

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

Data Source: Centers for Disease Control and Prevention

## Percentage of Adults Who Are Obese, 2017

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

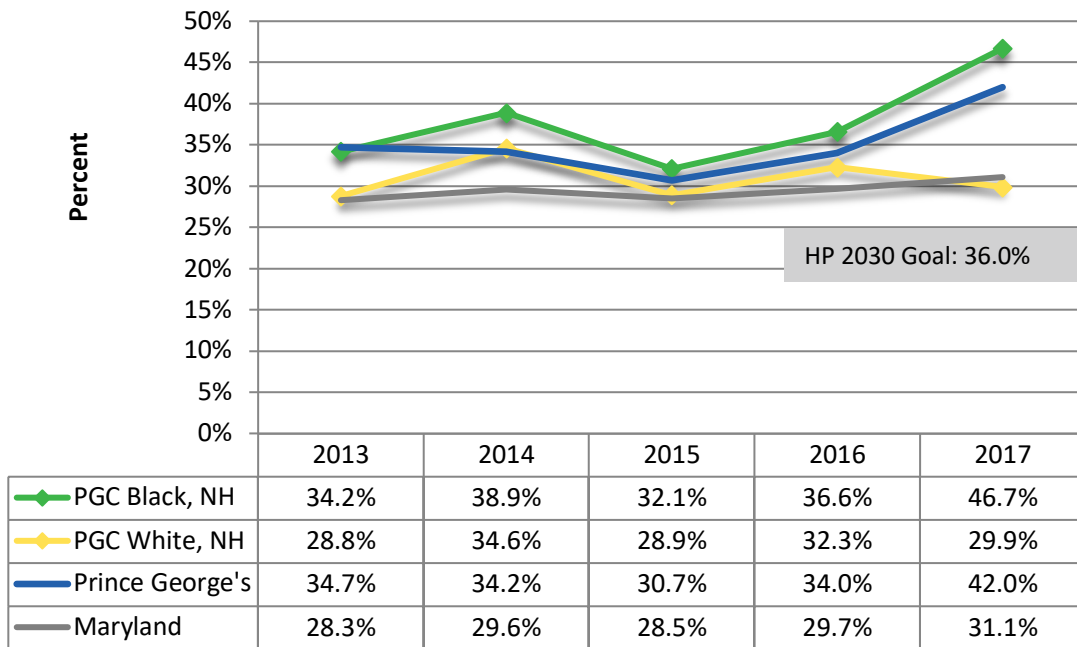
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, <https://ibis.health.maryland.gov>, accessed 5/13/2019

## Percentage of Adults Who Are Overweight, 2017

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

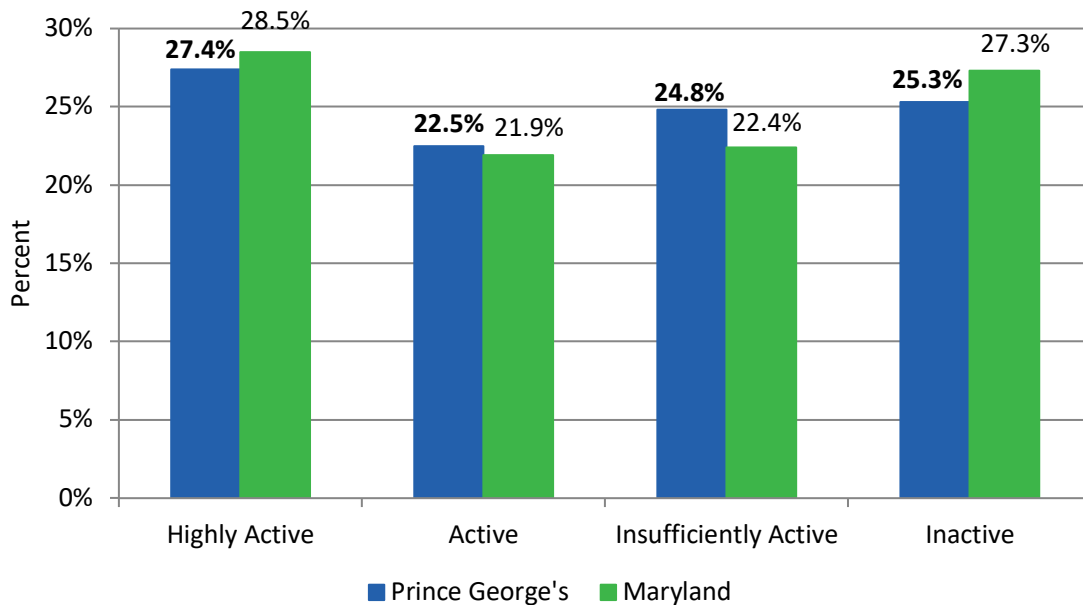
Data Source: 2017 Maryland Behavioral Risk Factor Surveillance System, <https://ibis.health.maryland.gov>, accessed 5/13/2019

### Percent of Adults Who Are Obese, 2013-2017



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

### Percentage of Adults by Physical Activity Level, 2017



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

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

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

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

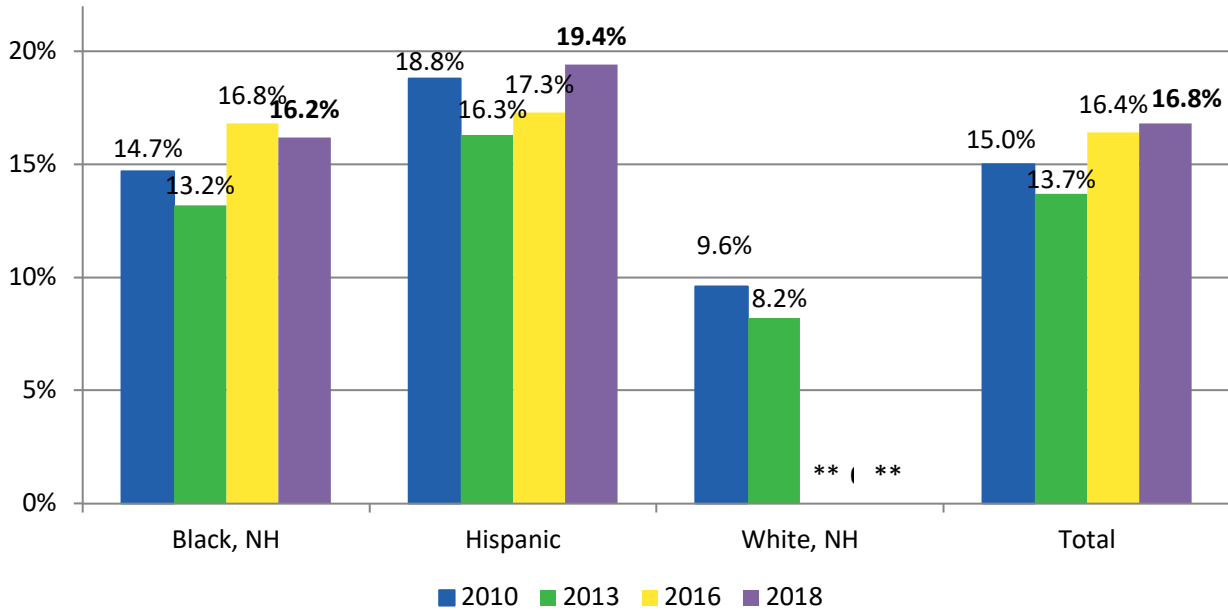
### Percentage of High School Students Who are Obese, 2018

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

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

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

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



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

Data Source: 2013, 2016, and 2018 Youth Risk

Behavior Survey Report for Prince George's County and Maryland, MDH

## Percentage of High School Students Who are Overweight, 2018

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

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

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

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

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

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

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

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

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

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

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

## Oral Health

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

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

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

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

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

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

Data Source: 2018 Maryland Youth Risk Behavior Survey

## Sexually Transmitted Infections

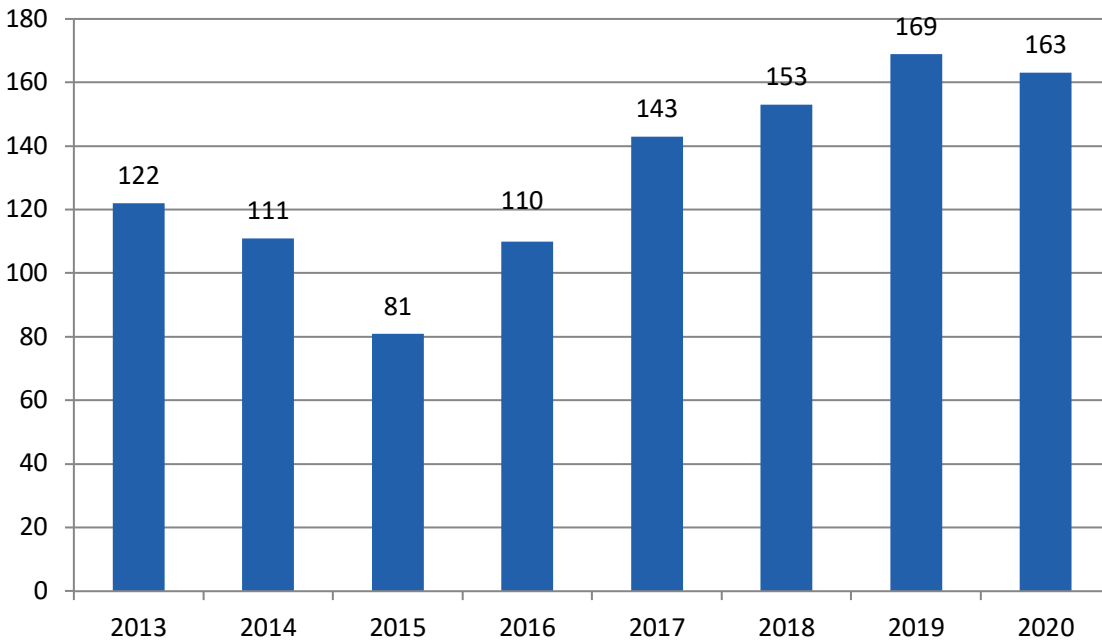
### Number of Sexually Transmitted Infections, Prince George's County

STI	2016	2017	2018	2019	2020	5-Year Mean
Chlamydia	6,752	7,365	8,013	8,262	6,974	6,080
Gonorrhea	1,832	2,001	2,020	2,195	2,406	2,091
Syphilis*	110	143	153	169	163	148

\*Includes both Primary and Secondary Syphilis

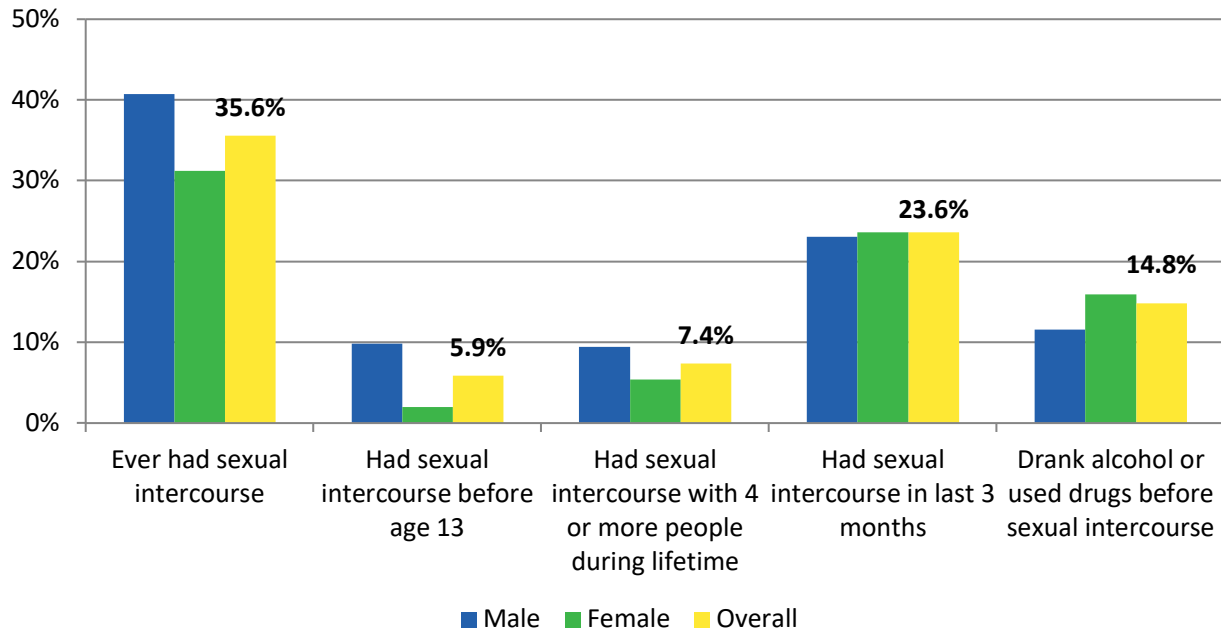
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, MDH

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



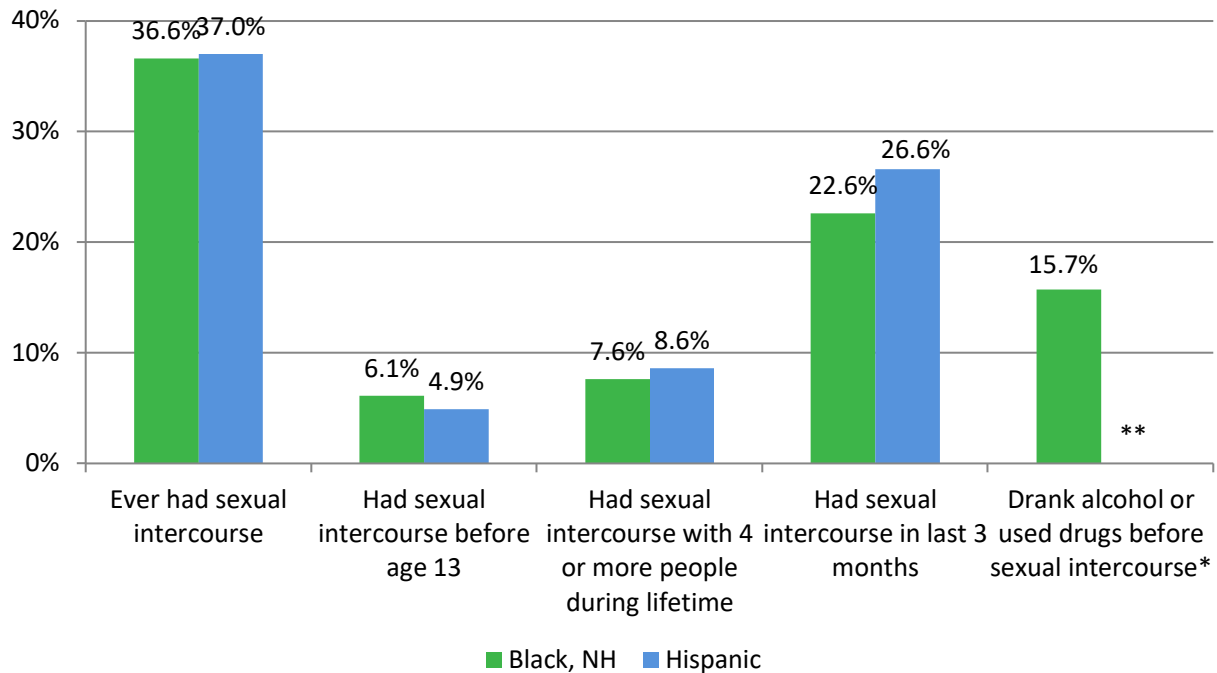
Data Source: Infectious Disease Bureau, Prevention and Health Promotion Administration, MDH

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



Data Source: 2018 Youth Risk Behavior Survey, MDH

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



\*White, NH not displayed due to insufficient data

Data Source: 2018 Youth Risk Behavior, MDH

## Substance Use Disorder

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

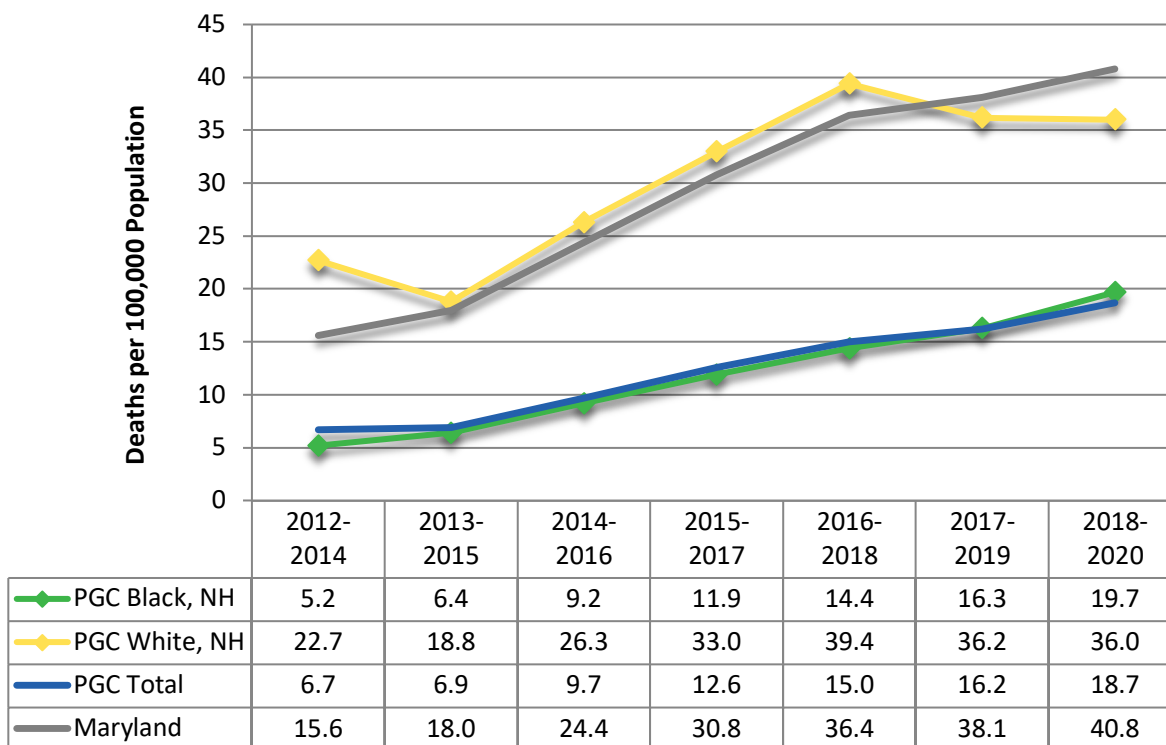
## Emergency Department Visits\* for Alcohol- and Substance-Related Conditions as the Primary Discharge Diagnosis, Prince George's County, 2017

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

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

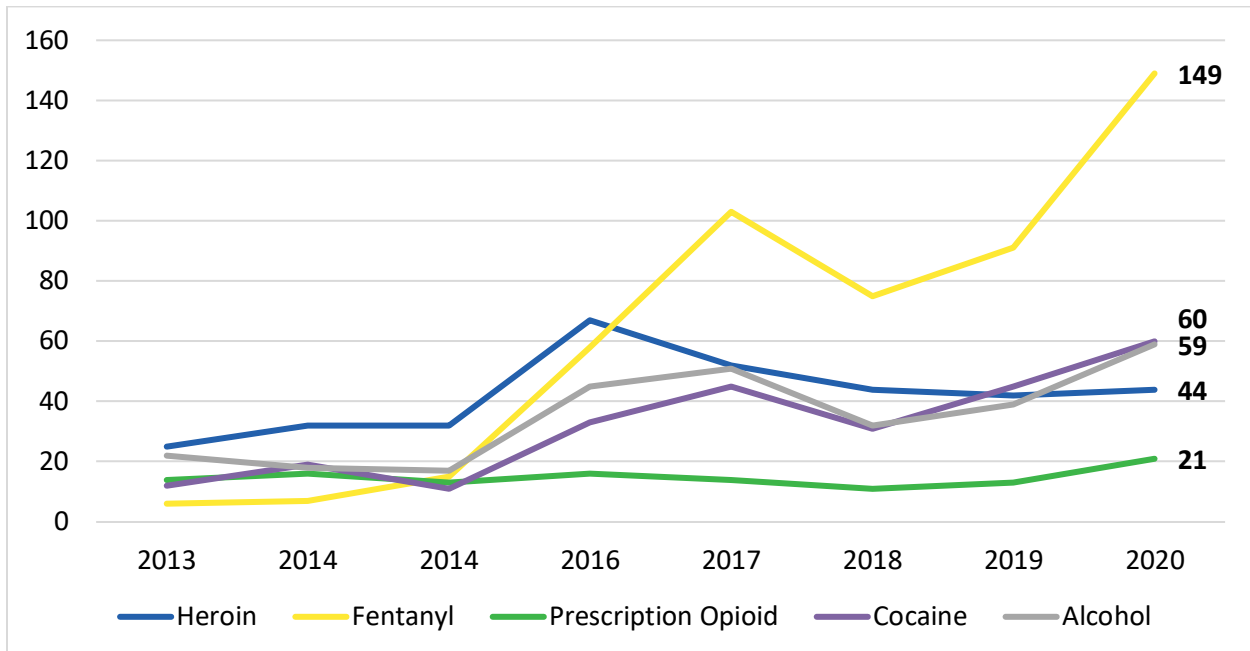
**Data Source:** Outpatient Discharge Data File 2017, Maryland Health Services Cost Review Commission; Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

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



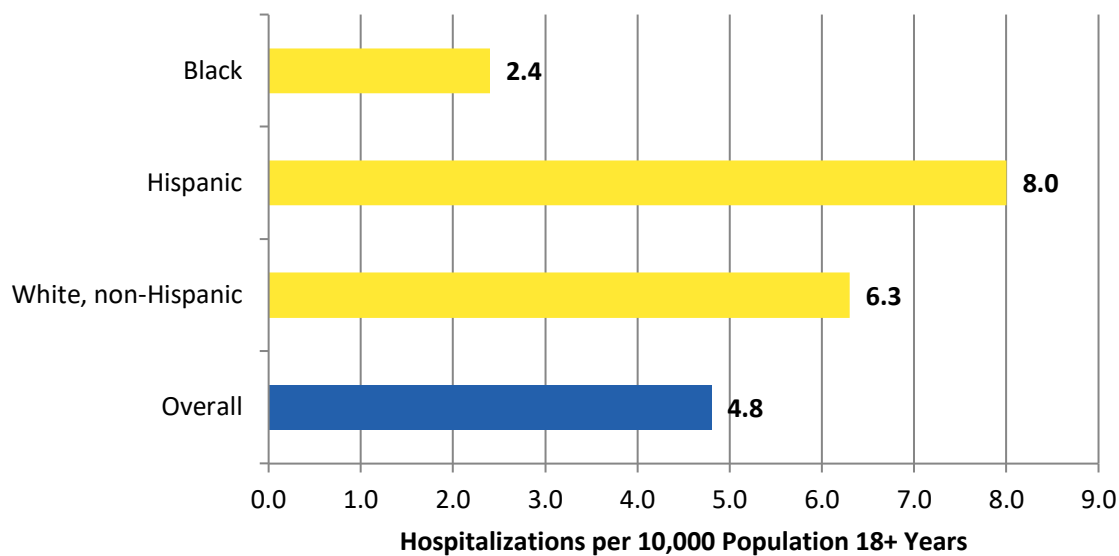
**Data Source:** Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database

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



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

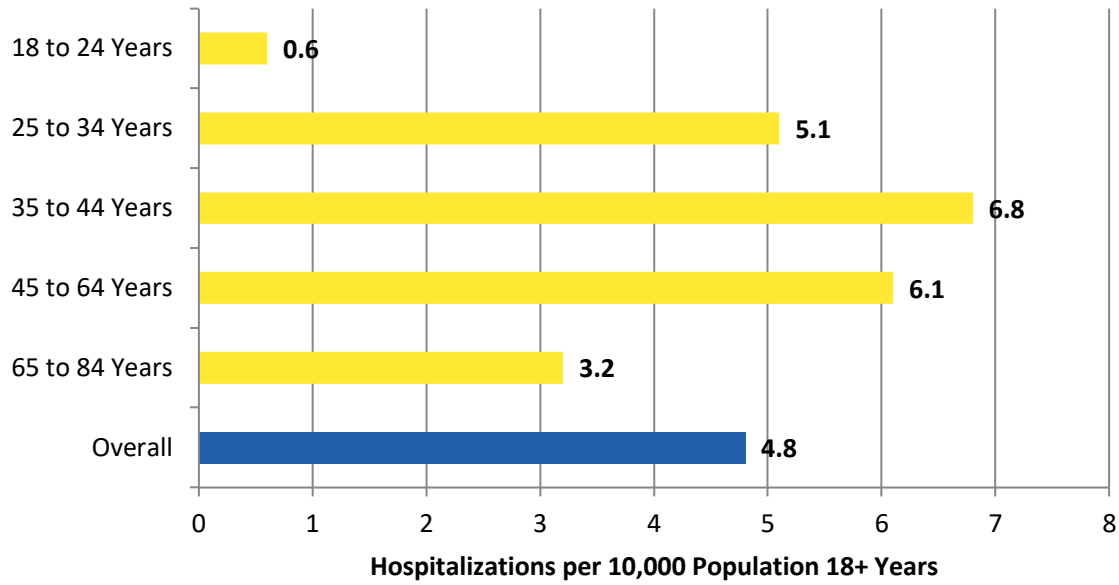
### Age-Adjusted Hospital Inpatient\* Visit Rate due to Alcohol Use by Race and Ethnicity, Prince George's County, 2017-2019



\* Includes visits to only Maryland hospitals

Data Source: [www.pghealthzone.org](http://www.pghealthzone.org); The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

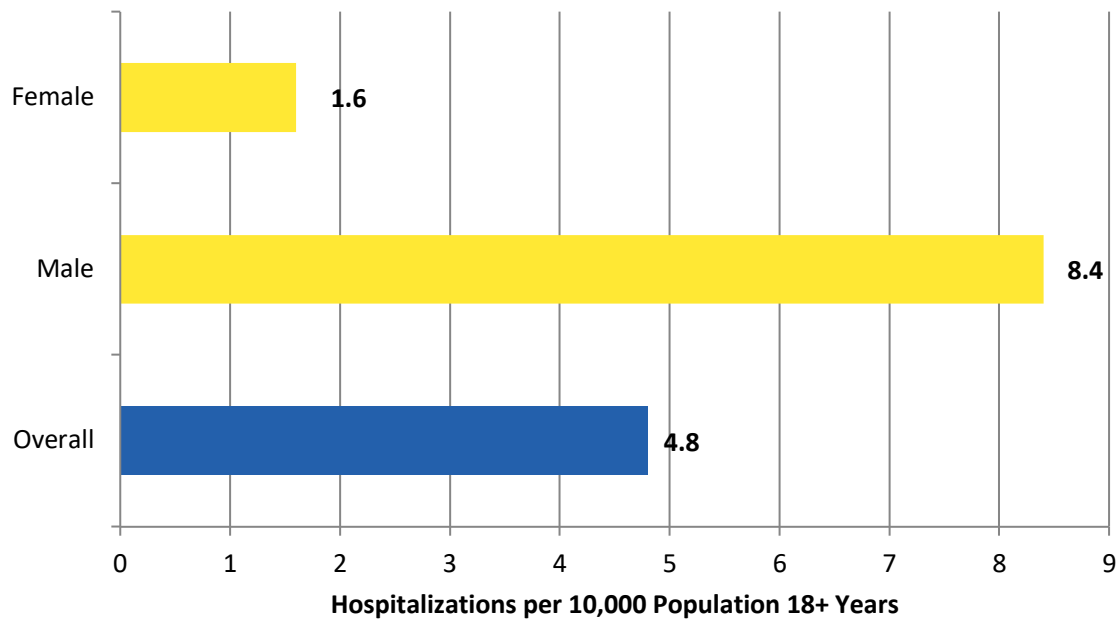
**Age-Adjusted Hospital Inpatient\* Visit Rate due to Alcohol Use by Age Group, Prince George's County, 2017-2019**



\* Includes visits to only Maryland hospitals

Data Source: [www.pghealthzone.org](http://www.pghealthzone.org); The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

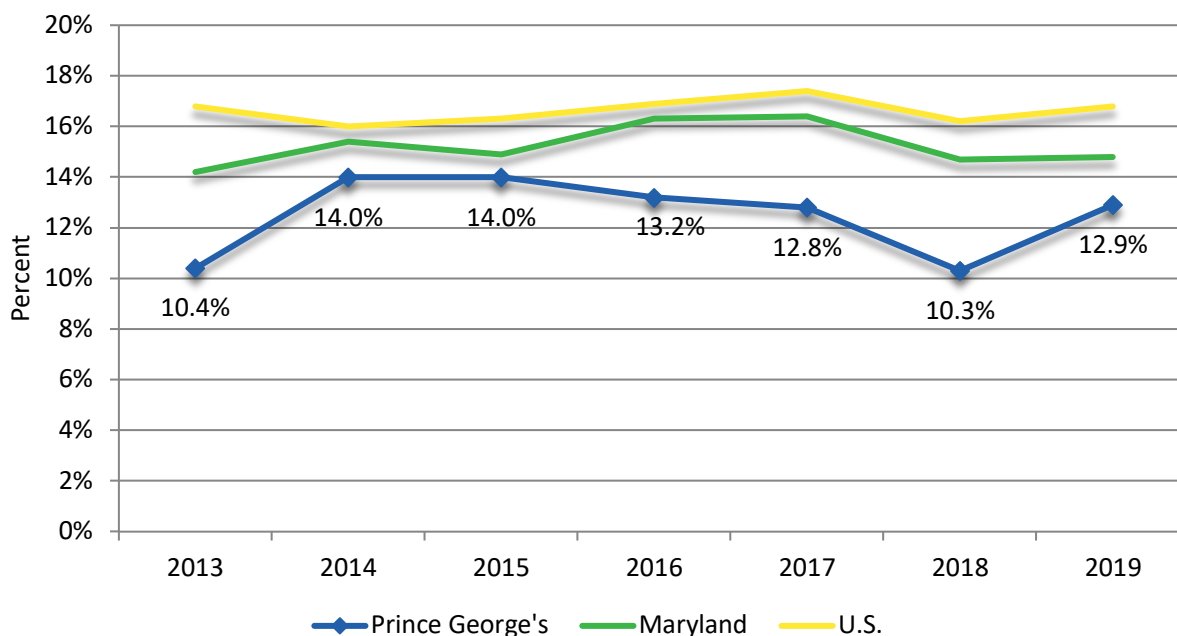
**Age-Adjusted Hospital Inpatient\* Visit Rate due to Alcohol Use by Sex, Prince George's County, 2017-2019**



\* Includes visits only to Maryland hospitals

Data Source: The Maryland Health Services Cost Review Commission; Maryland Health Care Commission

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



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

Data Source: 2013-2017 Maryland Behavioral Risk Factor Surveillance System, <https://ibis.health.maryland.gov>, accessed 5/13/2019, [www.pgchhealthzone.org](http://www.pgchhealthzone.org)

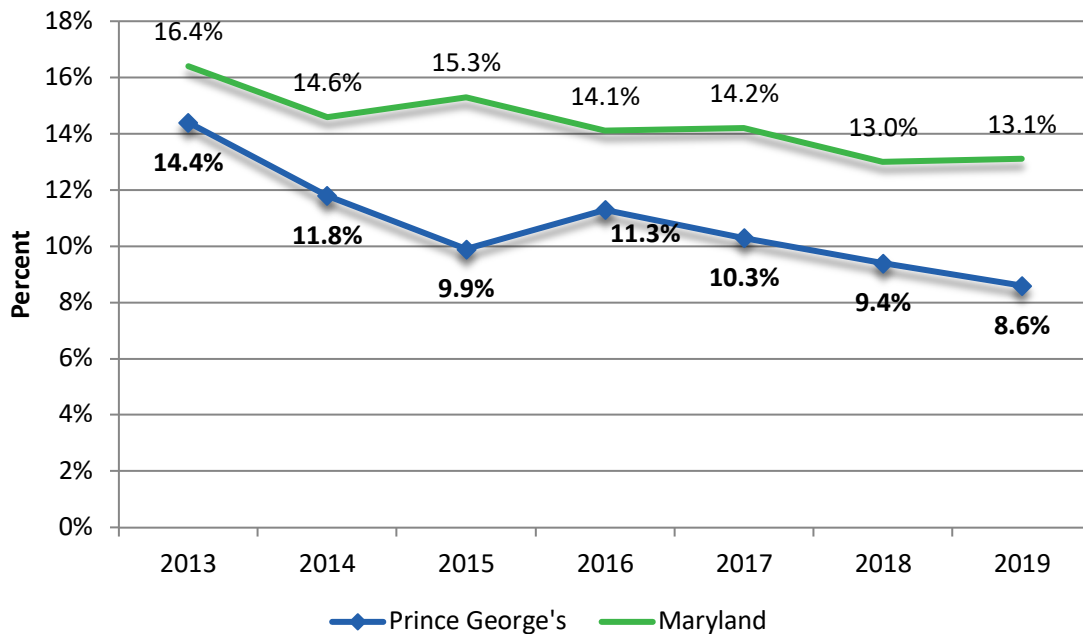
## Percentage of Adults Who Currently Smoke, 2017

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

\*\*Over 65 years not presented due to insufficient data

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

## Percentage of Current Adult Smokers, 2013 to 2019



**Data Source:** 2013-2017 Maryland Behavioral Risk Factor Surveillance System, <https://ibis.health.maryland.gov>, accessed 5/13/2019, [www.pgchealthzone.org](http://www.pgchealthzone.org)

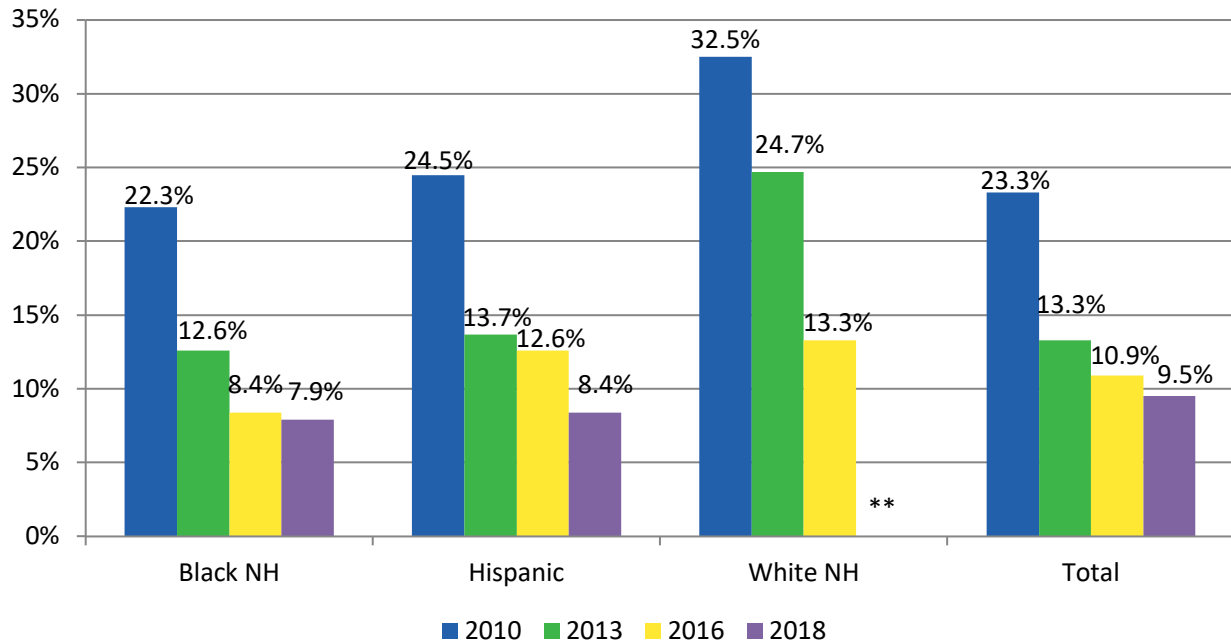
## Percentage of Students who Drank Alcohol During the Past Month, 2018

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

\*\* White, non-Hispanic not presented due to insufficient data

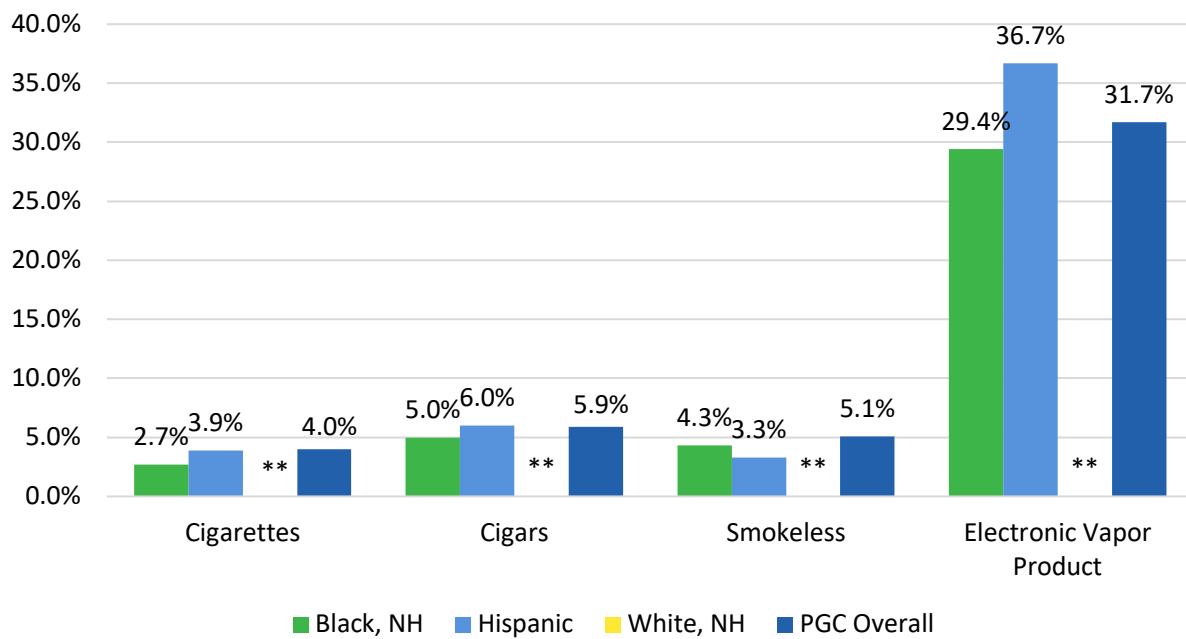
**Data Source:** 2018 Youth Risk Behavior Survey Report for Prince George's County and Maryland, MDH

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



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

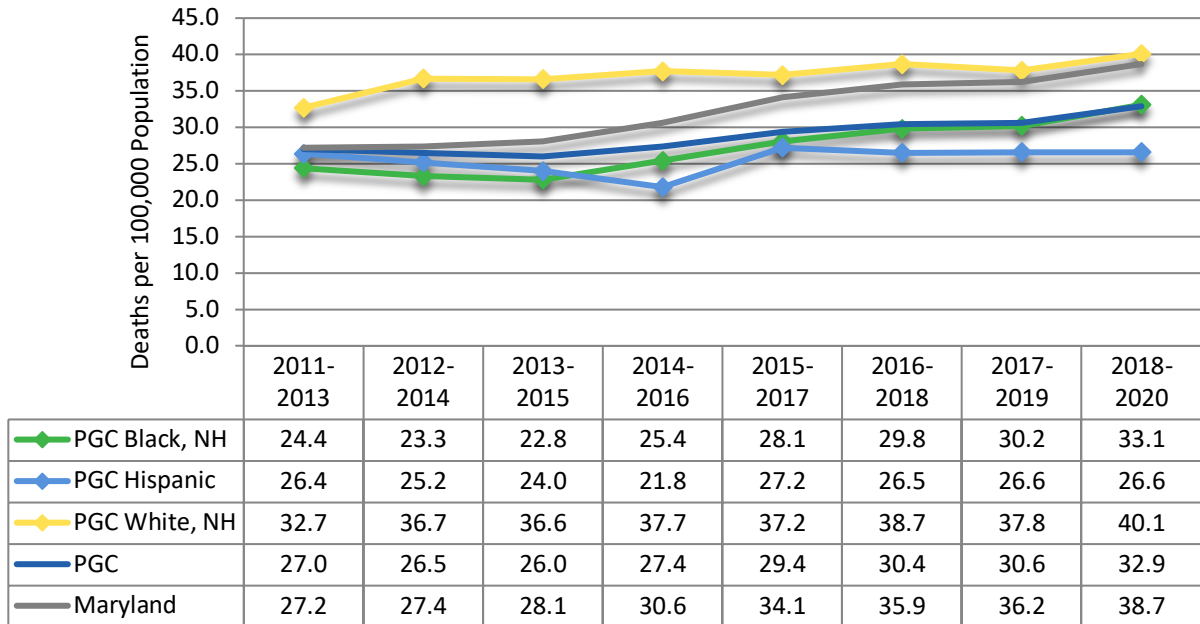
### Tobacco Products Used by High School Students During the Past Month by Race/Ethnicity, Prince George's County, 2018



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

## Unintentional Injuries (Accidents)

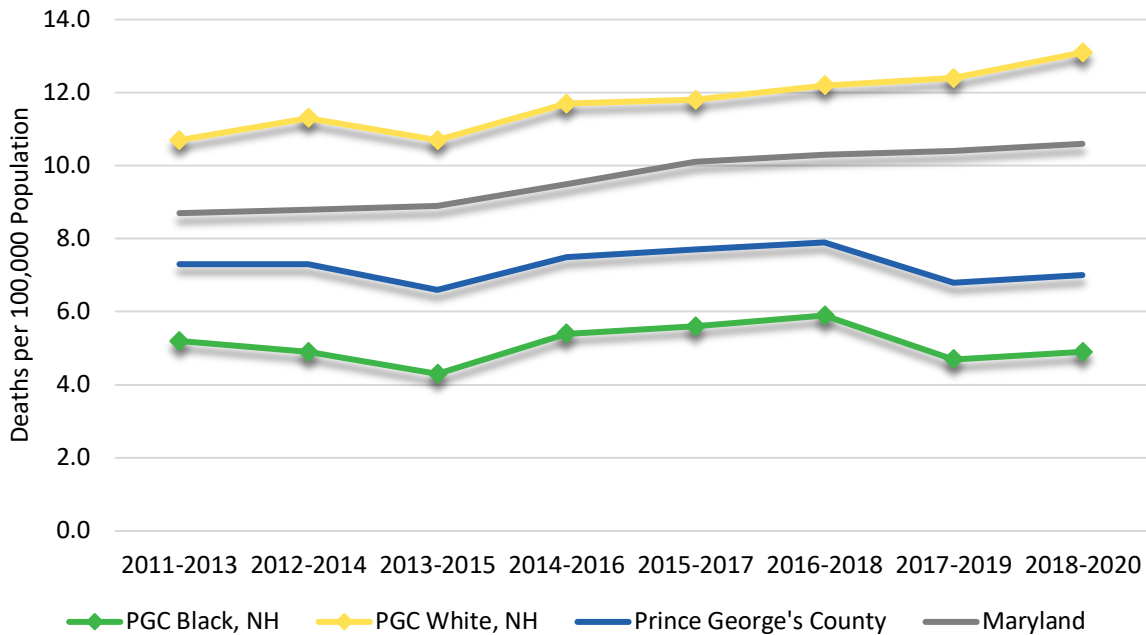
### Age-Adjusted Death Rate per 100,000 for Unintentional Injuries, 2011-2020



\* Asian/Pacific Islanders were not included due to insufficient numbers

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

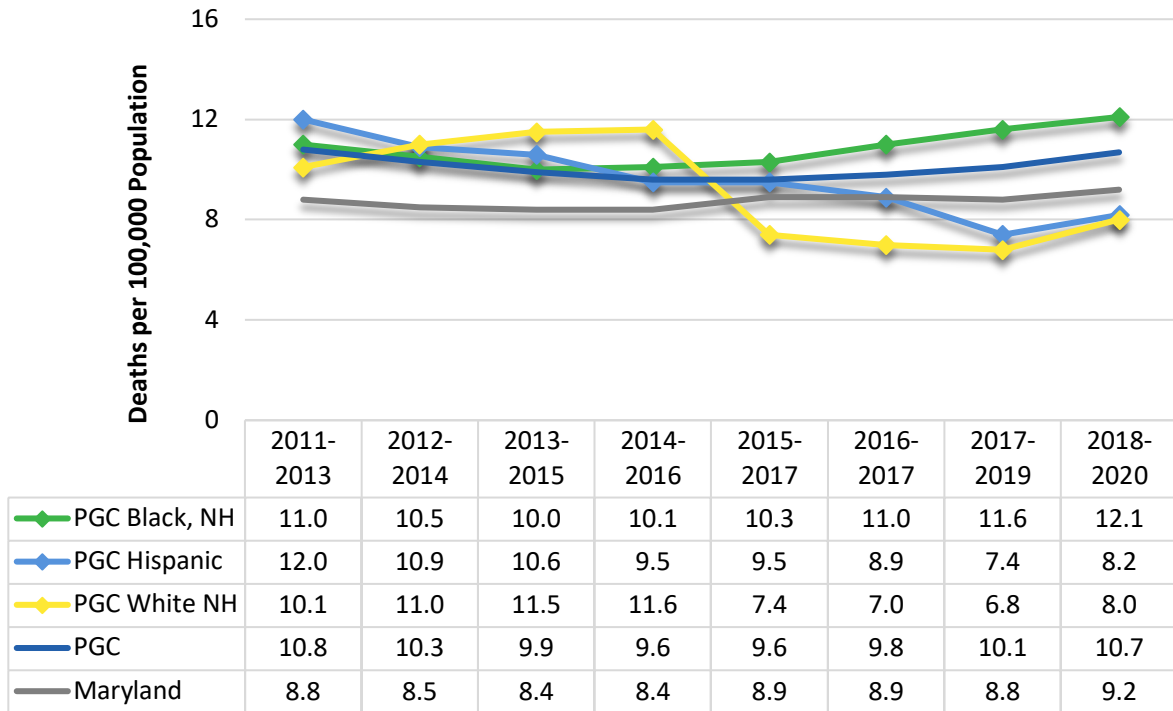
### Age-Adjusted Fall-Related Death Rate, 2011 to 2020



\* Residents of Hispanic Origin and Asian/Pacific Islanders were not included due to insufficient numbers

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

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

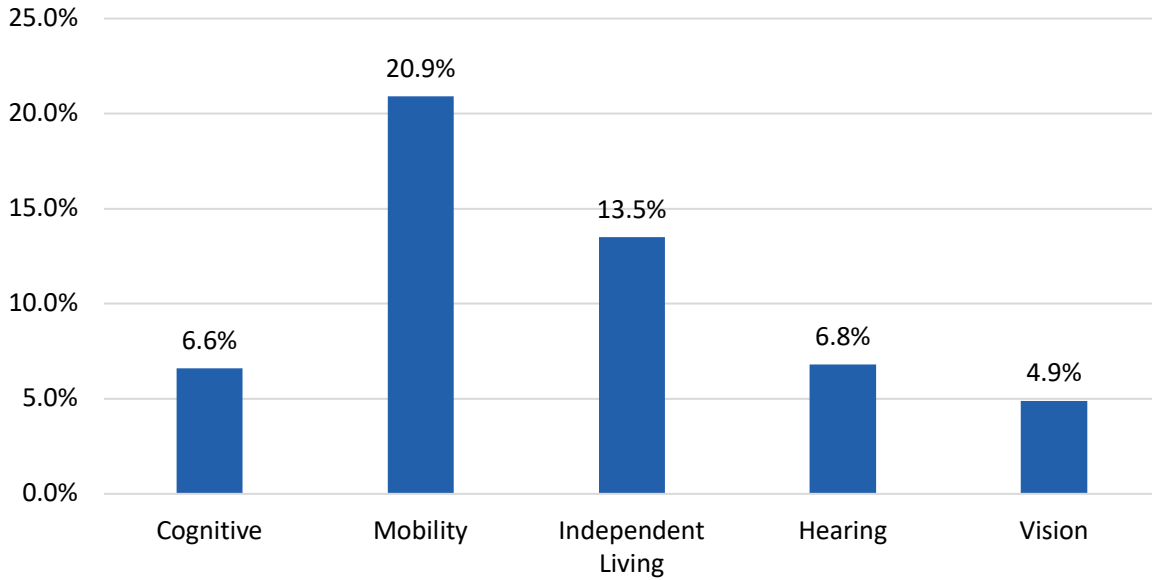


\* Asian/Pacific Island Residents were not included due to insufficient numbers

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

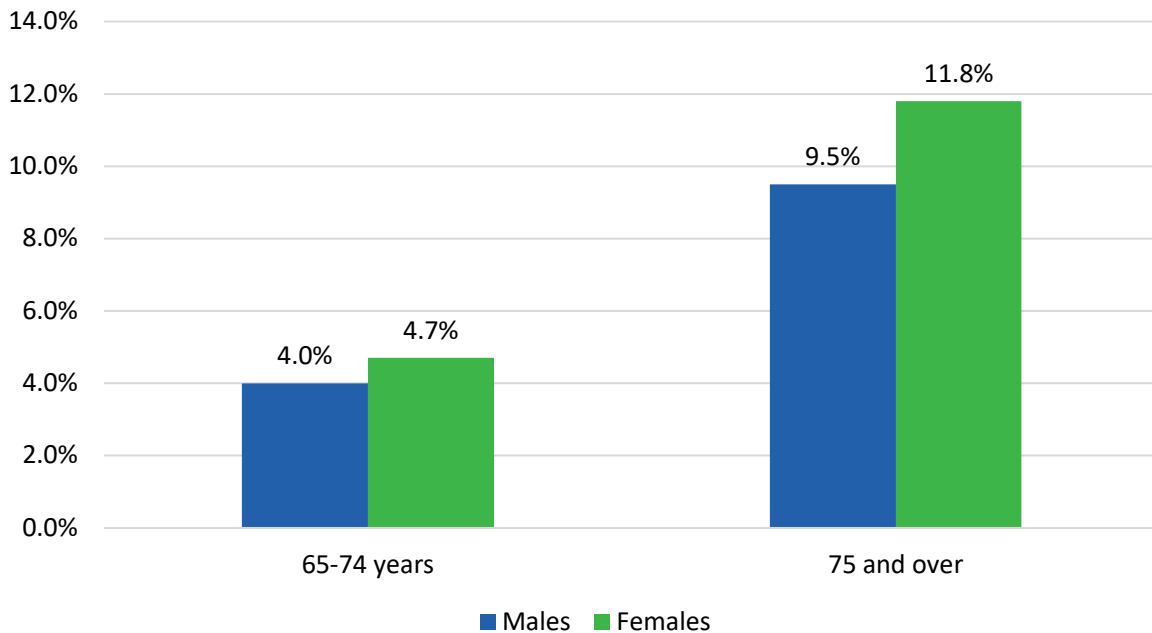
## Senior Health

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



Data Source: 2021 American Community Survey, Table S1810

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

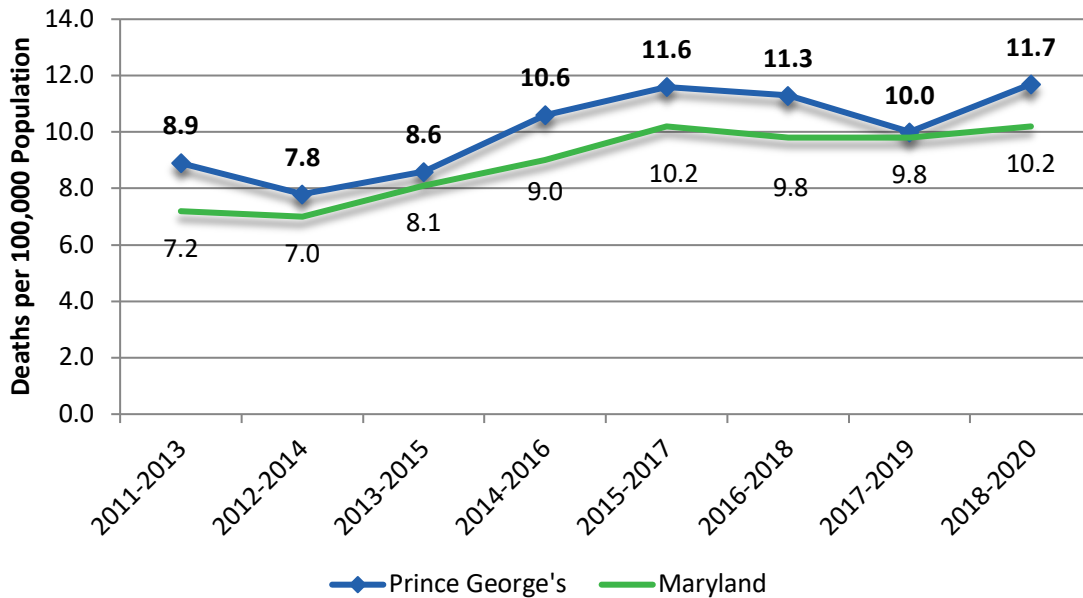


Data Source: 2021 American Community Survey, Table B18106

## Violence and Domestic Violence

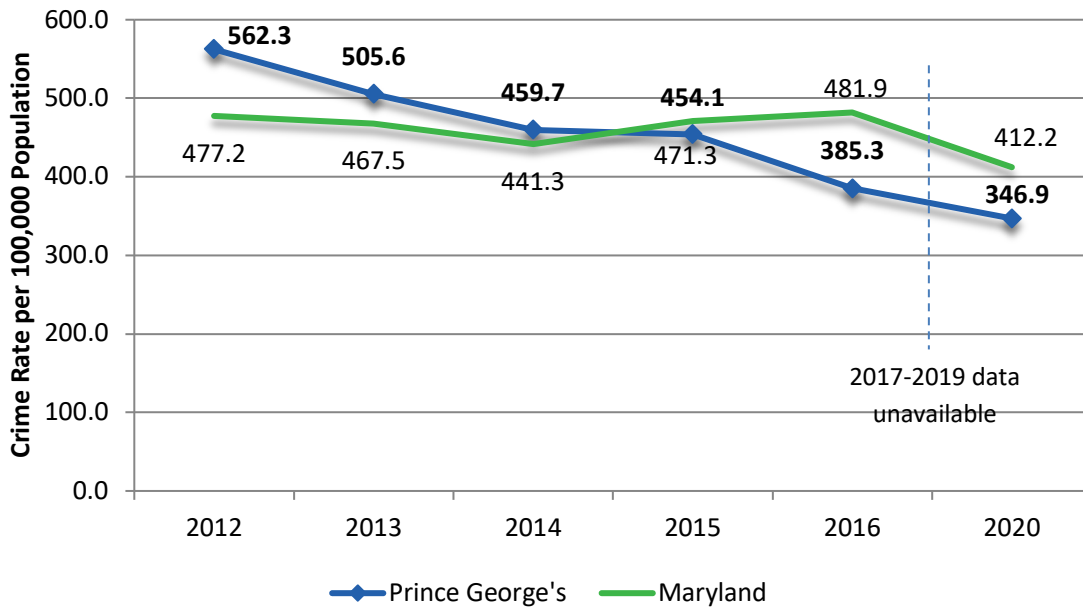
Overview	
<b>What is it?</b>	Violence affects all stages of life and includes child abuse, elder abuse, sexual violence, homicides, and domestic violence. Domestic violence is a pattern of abusive behavior including willful intimidation, physical assault, battery, and sexual assault used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can happen to anyone regardless of age, economic status, race, religion, sexual orientation, nationality, sex, or educational background (Source: National Coalition Against Domestic Violence).
<b>Who is affected?</b>	There were 3,161 violent crimes (includes homicide, rape, robbery, and aggravated assault) in 2020, and 138 residents in the County died by homicide. In 2020, there were 1,802 domestic-related crimes in the County and 12 domestic violence-related deaths. (Source: Maryland Network Against Domestic Violence).
<b>Prevention and Treatment</b>	Domestic violence prevention efforts depend on the population and include: <ul style="list-style-type: none"> <li>• Prevent domestic violence before it exists (primary prevention).</li> <li>• Decrease the start of a problem by targeting services to at-risk individuals and addressing risk factors (secondary prevention).</li> <li>• Minimize a problem that is clear evidence and causing harm (tertiary prevention) (Source: Maryland Network Against Domestic Violence).</li> </ul>
<b>What are the outcomes?</b>	Apart from deaths and injuries, domestic violence is associated with adverse physical, reproductive, psychological, social, and health behaviors. (Source: CDC.gov).
<b>Disparity</b>	No data is currently available about disparities for violence and domestic violence. However, anyone can experience domestic violence. Women generally experience the highest rates of partner violence compared to males. Teenaged, pregnant, and disabled women are especially at risk. (Source: MD Network Against Domestic Violence).
<b>How do we compare?</b>	The County's age-adjusted death rate due to homicide from 2018 to 2020 was 11.7, compared to the State overall at 10.2 and the U.S. at 6.6 per 100,000 population. The County's violent crime rate in 2020 was 346.9, below the State rate of 412.2 per 100,000. (Source: MD Governor's Office of Crime Control and Prevention).

### Age-Adjusted Death Rate for Homicide, 2011-2020



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

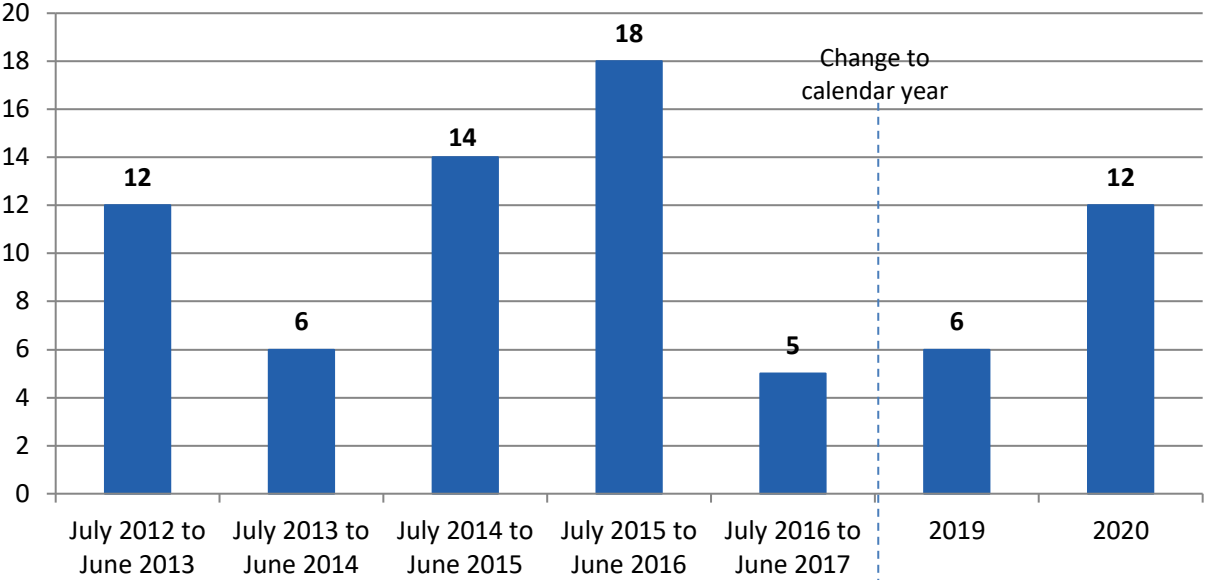
### Violent Crime\* Rate, Prince George's County Compared to Maryland, 2012-2020



\*Violent crimes include homicide, rape, robbery, and aggravated assault.

Data Source: Maryland Uniform Crime Report, 2020 Maryland Crime Dashboard

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



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

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# KEY INFORMANT INTERVIEWS

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## Introduction

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

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

## Key Findings

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



specialized behavioral health providers.

- Residents were concerned with both the natural environment (i.e., air quality, respiratory issues caused by pollen and transportation) and the built environment (i.e., poor walking environmental conditions, lack of adequate housing, lack of walkable communities, and need for more beautification efforts and clean neighborhoods).
- One challenge facing County leadership is that although there are several different initiatives addressing health that are active in the County, there is still a sense amongst residents that there is a lack of resources and services to address all of the concerns. **Residents do not want to see temporary fixes. They want to see and experience a permanent change in the County regarding health outcomes.** Although some are optimistic about future directions, residents must be made aware of what transformative changes are taking place in the County and what role they can also play in making hopeful changes into realities.
- Visible and sustainable partnerships and collaborations are needed in the County to address many of the identified health issues. Residents and leaders of County organizations, systems, and businesses need to have more opportunities to collaborate and plan to increase “buy-in” on various community and evidence-based health approaches in the County.
- Overall, more needs to be done to address issues surrounding an aging population, transportation, housing, undocumented individuals and families, chronic diseases and chronic disease management, and behavioral health issues.

## Methodology

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

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

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



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

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

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

## Question-by-Question Analysis

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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



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

(i) Lack of Adequate Mental Health Services

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

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

*"It is difficult to find social support."*

(ii) Lack of Awareness About Health Programs and Resources

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

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

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

(iii) Limited Primary Care Access/Specialists

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

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

(iv) Health Literacy

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

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

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



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

*“Transportation is definitely an issue, especially with our older residents.”*

- (vi) Housing Concerns: The identified key housing issues included: affordability, adaptability, differing quality and standards of housing across the County, and concerns surrounding the lack of stability for some school-aged children.
- (vii) Post-COVID-19 Effects: Some respondents shared that they felt that the County is presently dealing with chronic diseases and mental health concerns that are related to COVID-19 and that this would be an issue that will continue to be of concern for some time.

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

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

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

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

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

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

*“We just don’t have enough of it!”*

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

*“The cost (for housing) is simply too high!”*

*“There is not enough housing.”*



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

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

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

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

*“You need to have accessibility of services to stay healthy.”*

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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



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

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

**Natural Environment:**

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

**Built Environment:**

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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



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

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

*“We need a program for undocumented individuals in this County.”*

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

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

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

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

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

*“More funding for the Health Department and Department of Family Services and Social Services because they departments work so closely together and provide most of the services for our seniors.”*

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



*“Increase health literacy and community outreach and education-they are currently doing a lot with the ACA.”*

*“The County needs to invest in its population (resources, work development, etc.).”*

*“The school system is doing their best with contracting mental health clinicians but they can still do... better.”*

*“Improve technology literacy.”*

*“Increase funding for aging services and family support.”*

*“Expand the multi-service centers to other areas of the County.”*

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

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

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

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

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

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

*“We need more funding and someone to lead and monitor actions and implement bidirectional partnership amongst organizations in the County. We need to create more authentic partnerships.”*



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

**15. What are the 3 most important emerging threats to health and well-being in the County?**

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

- (i) Mental Health: Many respondents shared their opinions about the cyclical nature of these conditions and made a connection between the high levels of mental health concerns, such as stress and depression, and the behaviors that individuals may engage in to reduce the stress, such as consuming substances and the lack of physical activity, thus making them vulnerable to chronic diseases. They were also concerned with access to mental health care and treatment. An emerging concern was for senior residents in the County:  
*"We also are seeing a lot of seniors with more mental health issues than before, maybe it is because we are paying more attention to those behaviors at this time but it is very concerning."*
- (ii) Housing: Housing concerns have been mentioned extensively throughout this report. This should be interpreted not as being merely repetitive but as an issue that appears to transcend many of the issues that respondents have discussed.
- (iii) Life With Covid-19/The lasting effects of COVID-19. Many respondents shared that they felt that we still had not seen all of the lasting effects of COVID, physically, mentally, emotionally, or socially, and felt we needed to keep increased funding available to be able to accommodate for this possible reality, in addition to pre-COVID health challenges.  
*"All of the challenges that the community had prior to the pandemic, they still have them and those resources are still needed. There is also no need to put up a program that the community did not ask for."*  
  
*"The effects of kids in the school system and the pandemic, we still don't know the full effect it will have on them."*
- (iv) Employment Concerns: Several respondents mentioned that members of their respective community need to be re-trained or newly trained to better function in the "new" employment space (whether it be spaces to work remotely or skills to find new employment as their jobs may have been lost as a result of the pandemic).  
*"Many will need vocational training-workforce development-many people lost their jobs and many do not want to go back to such uncertain jobs."*
- (v) Language barriers/Cultural and linguistic diversity: Respondents shared that the "face" of the County is changing and that we need to be able to accommodate this for the benefit of the County as a whole.



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

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

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

The respondents' closing remarks centered on ensuring that as a County we address the top needs that they had shared about the various aspects of health. Many respondents shared that we can only address the current, emerging, and future challenges if organizations and governments collectively organize, strategize and implement programs and policies that will benefit our residents. Finally, all respondents shared that our County is resilient, and we have overcome several obstacles, especially over the last few years with the COVID-19 pandemic, and that we need to maintain our relationships and take our "lessons learned" and "press forward" to address and overcome new challenges. Overall, all the respondents were ready to see (and continue to work towards) significant change in the County.



## Appendix A: List of Key Informants

NAME	ORGANIZATION	POPULATION
Michelle LaRue	Representative from <a href="#">CASA</a>	Immigrant and Refugee
Alison Flores	Prince George's County Executive Latino Affairs Liaison	Hispanic
Patricia Chiancone	Prince George's County Public Schools <a href="#">International Student Admissions and Enrollment</a>	Immigrant and Refugee
Lisa Walker	Hyattsville Aging in Place	Seniors
Tisa Holley	Prince George's County Public Schools, <a href="#">McKinney Vento Program</a>	Homeless/Housing Insecurity
Patricia Fletcher	AERS Program	Seniors
James Dula	Office of Veterans Affairs, Department of Family Services	Veteran
Anthony Smith	Office of Veterans Affairs, Department of Family Services	Veteran
Stacey Little	University of Maryland Capital Region Health	Affiliated/Supporting Groups Business
Dushanka Kleinman	University of Maryland, College Park, School of Public Health	Affiliated/Supporting Groups Higher Education
Norberto Martinez	Langley Park Civic Association	Hispanic
Guy Merritt	Department of Corrections	Homelessness/Housing Insecurity
Anna Cazes	Fort Washington Medical Center	Filipino
Col. Jimmy Slade	Community Ministries	Homelessness/Housing Insecurity
Jean Drummond	HCDI, Inc	Affiliated/Supporting Groups Business
Andre Pittman	First Baptist Church of Glenarden Military Care Ministry:	Veteran



## Appendix B: Community Health Assessment

### Key Informant Interview Protocol

1. *What is your/your organization's (program's) role relative to the health and well-being of County residents?*
2. *How long have you/ your organization/ program played this role?*
3. *In your opinion has the health of County residents of (name the group that the person has been selected to represent) improved, stayed the same, or declined over the past few years? What makes you say that?*
4. *What are the County's three most important assets/strengths relative to the health and well-being of ((name the group that the person has been selected to represent) residents?*
5. *What are the County's three most important barriers relative to the health and well-being of (name the group that the person has been selected to represent) residents?*
6. *What do you think are the three most important social determinants of health in the County for (name the group that the person has been selected to represent)? (Social determinants of health are factors related to the social environment, physical environment, health services, and structural and societal characteristics.)*
7. *What do you think are the three most important physical health needs or concerns of (name the group that the person has been selected to represent) County residents?*
8. *What do you think are the three most important behavioral/mental health needs that (name the group that the person has been selected to represent) face in the County?*
9. *What do you think are the three most important health-related environmental concerns (name the group that the person has been selected to represent) face in the County?*
10. *Now if you had to prioritize and select the three most important health issues facing the (name the group that the person has been selected to represent) in the County from among those you just mentioned what would they be?*
11. *In what way does your organization/ program address each of the three issues you just mentioned?*
12. *How well is the County as a whole responding to these issues?*
13. *Based on your experience and expertise, what else needs to be done in the County and by which organizations/ programs to address the needs of (name the group that the person has been selected to represent) in Prince George's County?*
14. *What resources are needed but not available to address each of the three issues?*

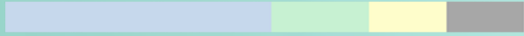


*15. What are the 3 most important emerging threats to health and well-being in the County for (name the group that the person has been selected to represent)?*

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

*17. Do you have any other comments to add relative to health and the County pertaining to (name the group that the person has been selected to represent)?*





# COMMUNITY EXPERT survey

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# COMMUNITY EXPERT SURVEY

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## Introduction

Prince George's County is diverse, and our growing population has a wide range of needs, disparities, and perceptions about health. The Community Expert Survey was developed as a strategy that complements the overall Community Health Assessment (CHA) goal of identifying the health needs and issues among the County's different populations, through providers, community-based organizations, local governments, and population representatives that can speak for the communities they serve.

## Methodology

The Core CHA team provided lists of community-based partners and representatives to be included in the survey such as the membership of the Prince George's County Health Action Coalition, as well as and community leaders, and representatives of specific populations. The survey was developed based on existing community surveys with some modifications specific to the County. Efforts were made to ensure the survey questions corresponded with the Community Resident Survey which was also part of CHA data collection efforts. An email request was sent to approximately 100 participants by the Prince George's County Health Department in April 2022, and hospital partners were also provided with the survey link to share with their community experts.

The survey questions included multiple choice, yes/no, and open-ended responses. Each multiple-choice question is presented as a simple descriptive statistic. Not all participants responded to every question; each question includes the number (N) of participants who did respond. Open-ended response questions were initially reviewed for content analysis, which was used to identify common categories and overarching themes that emerged as patterns in the data. Each response was then reviewed and analyzed according to the categories and themes, with summary responses presented to capture the participants' information.

## Participation

Surveys were submitted by 27 participants though not all participants responded to every question. Participants represented knowledge bases from across the County geography. Participants represented a variety of organizations (question 20): government organizations (50%), non-profits (22.2%), public health organizations (16.7%), healthcare providers (11.1%), faith-based organizations (11.1%), social service organizations (5.6%), mental/behavioral health organizations (5.6%), and education/youth services (5.6%); participants also worked with a variety of populations in the County (question 22).

## Key Findings

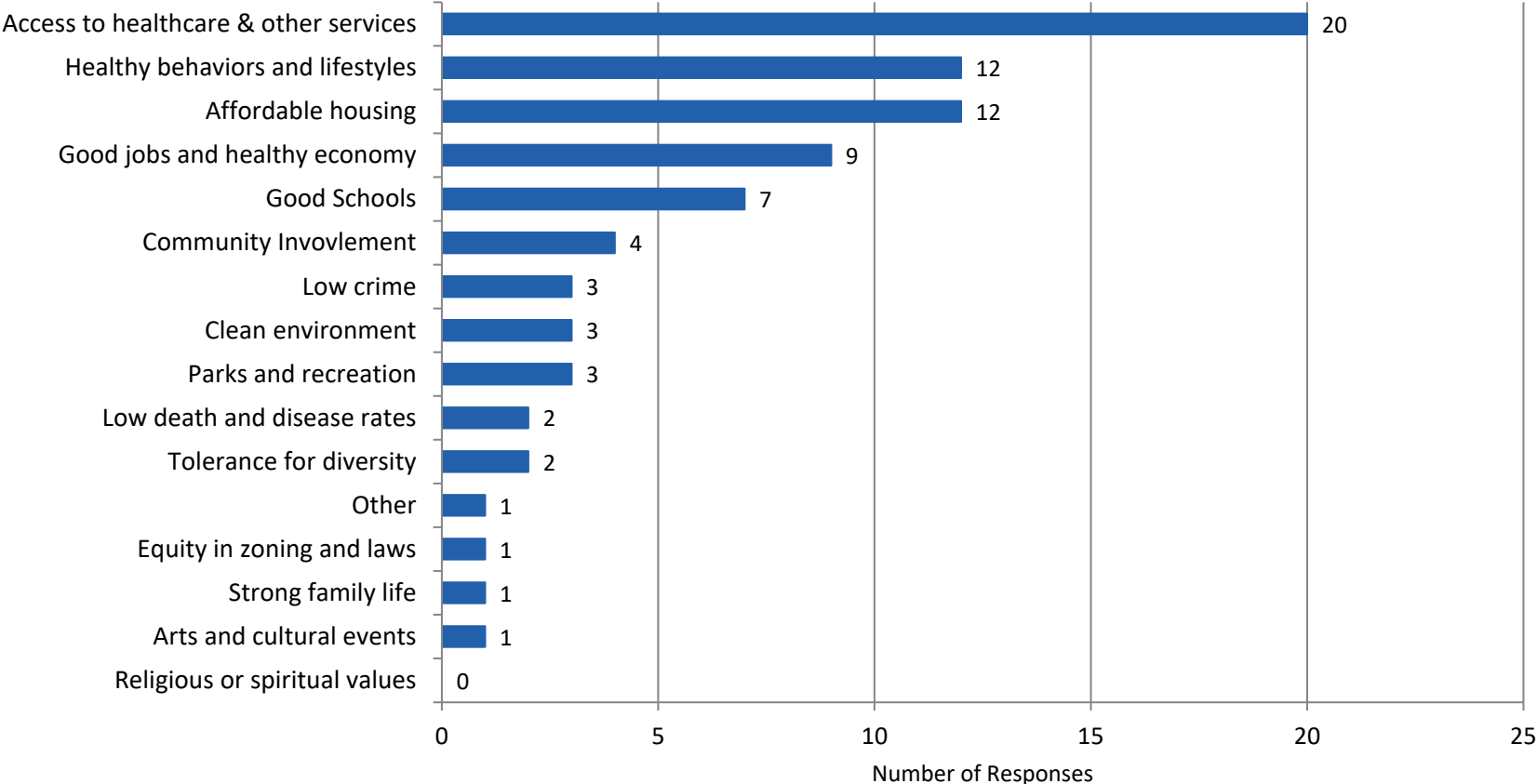
- **Healthy community:** Access to healthcare, healthy behaviors and lifestyles, affordable housing, and good jobs/healthy economy were the most important factors defining a “healthy community” identified by community experts. All survey participants (20 responses) believe that the overall health of the community they serve is unhealthy, and over half believe the communities they serve are either unsatisfied or very unsatisfied with the healthcare system.
- **Discrimination:** Two new questions were added to the 2022 survey about discrimination. Participants indicated that the people they serve experience the following at least several times per year: treated with less courtesy compared to others (60%), receive poorer service at restaurants and stores (35%), and being treated as if they are not smart (20%). Participants identified for those they serve the leading reasons for these experiences were race (55%), education or income level (45%), and ancestry or national origin (20%).
- **Leading health issues:** Similar to 2019, chronic disease and related issues including diabetes and poor diet, as well as mental health, aging problems, and dental health, led as the most pressing issues for the overall County. Other issues of concern were stroke/high blood pressure, alcohol and drug abuse, COVID, heart disease, physical inactivity, and cancer. By ranking, diabetes, mental health, and issues associated with aging were the most important health issues identified by participants.
- **Access to healthcare:** Participants were more likely to disagree or somewhat disagree that most residents could access providers in the County, including mental health providers (85%), medical specialists (80%), dentists (85%), and primary care providers (55%). Almost half of survey participants disagreed or somewhat disagreed that providers incorporate cultural competency and health literacy into their practice, and over 60% disagreed or somewhat disagreed that providers accept Medicaid or provide services for residents who do not qualify for insurance. Nearly three-fourths of survey participants disagreed or somewhat disagreed that transportation is available to the majority of residents for medical appointments, and 80% disagreed or somewhat disagreed residents can afford their medication.
- **Leading barriers:** The most significant barrier to accessing healthcare in the County identified by participants was the inability to pay out of pocket expenses, followed by lack of insurance coverage, the inability to navigate the healthcare system, basic needs not met, and availability of providers/appointments.

- **Resources to improve access:** Survey participants identified key areas of resources that are needed to improve health care access in the County (those with at least 4 responses):
  - *Better health navigation, education, and information* – increased community health worker capacity, increased communication, engagement, and outreach services, add health literacy to the education system, countywide marketing of where to gather information
  - *More providers and access to providers* – more providers across all disciplines, need medical personnel to be at community centers and senior centers, need providers who reflect the populations they serve
  - *Affordable healthcare* – financial support directly or through expanded reimbursement, County funded programs for specialty healthcare access and services for the low income and uninsured populations, more trauma informed healthcare and behavioral health providers that are affordable for the immigrant population and the poorest among us, co-pay assistance and lower prescription costs
  - *Primary language considerations* – increasing provider access to translation services by phone and during appointments, bilingual staff in offices
- **Underserved populations:** The populations that were selected as most underserved were immigrants, Latinos, seniors, and low-income minorities, similar to those identified in the 2019 Community Health Assessment.
- **Primary barriers to accessing healthcare for underserved populations:**
  - *Lack of financial and basic resources* – having to take time off work, low income and live in rural communities, no County subsidized program for medical specialty care access, lack affordable healthcare options and ability to earn a living wage to cover basic needs
  - *Cultural/language barriers* – lack of bilingual providers and staff, limited resources for non-English speakers, limited education and language, cultural competency
  - *Access to care* – lack of access to primary and specialty care, lack of access to providers who will see patients regardless of insurance status, not enough hospital beds, not enough providers that understand the needs of the residents they serve

- *Engagement and awareness of services and resources* – lack of awareness of resources and providers, lack of knowledge and experience with innovative technology, inability of agencies to understand how to saturate the community with quality messaging that resonates and triggers action, availability of appropriate services
- *Lack of trust* – fear of identification consequences among the undocumented and immigrant populations, little trust in the system
- **Recommendations to improve health:** An increased focus on health inequities and increased communication and awareness were the most frequent recommendations to encourage and support community involvement around health issues in the county. Open-ended responses from participants included increasing and improving access to providers and clinics in the County, health education and outreach, and increase health funding.
- **What is working well:** Similar to the 2019 survey, participants reported that collaboration and partnerships among healthcare providers, hospitals, health department, and community-based services and programs continues to work well. Participants identified that several County agencies are contributing towards better health outcomes, with the County Health Department and Federally Qualified Health Centers (FQHCs) being mentioned the most. Programs focused on specific communities and community outreach and education were also viewed positively. As far as healthcare systems, the construction of the new hospital (UM Capital Region Medical Center) was positively mentioned by several participants, as well as the implementation of community/population health initiatives in the hospital systems.

# Results

**Question 1:** What do you think are the **three** most important factors that define a “healthy community” (what most affects the quality of life in a community) for the community you serve in Prince George’s County? (N=27 responses)

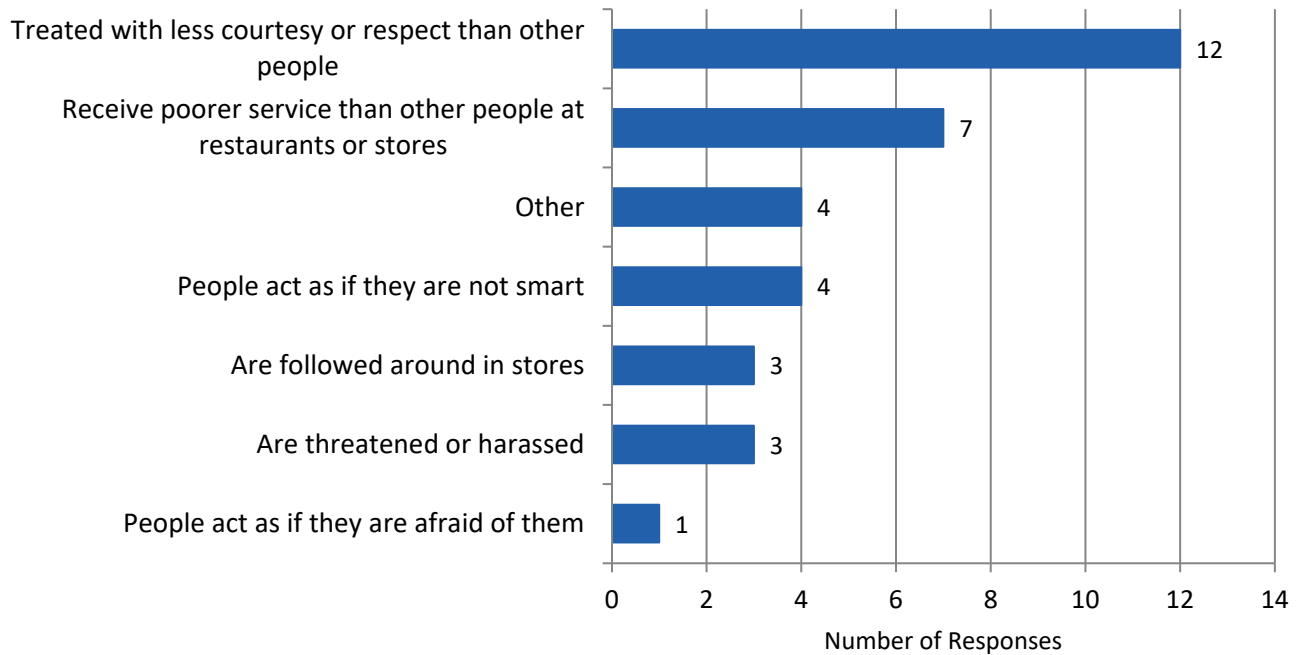


**“Other” Included:** improvements in collaboration between health care system and the community at large

**Question 2:** How satisfied do you think the Prince George’s County communities you serve are with the following? (N=27 responses)

	Very Unsatisfied	Somewhat Unsatisfied	Neutral	Somewhat Satisfied	Very Satisfied
The quality of life	2 (7.4%)	4 (14.8%)	4 (14.8%)	15 (55.6%)	2 (7.4%)
The health care system	6 (22.2%)	9 (33.3%)	3 (11.1%)	9 (33.3%)	0 (0.0%)
A good place to raise children	4 (14.8%)	6 (22.2%)	7 (25.9%)	9 (33.3%)	1 (3.7%)
Economic opportunity	2 (7.4%)	6 (22.2%)	10 (37.0%)	7 (25.9%)	2 (7.4%)
A safe place to live	4 (14.8%)	6 (22.2%)	8 (29.6%)	7 (25.9%)	2 (7.4%)
The quality of the environment	2 (7.4%)	7 (25.9%)	4 (14.8%)	14 (51.9%)	0 (0.0%)

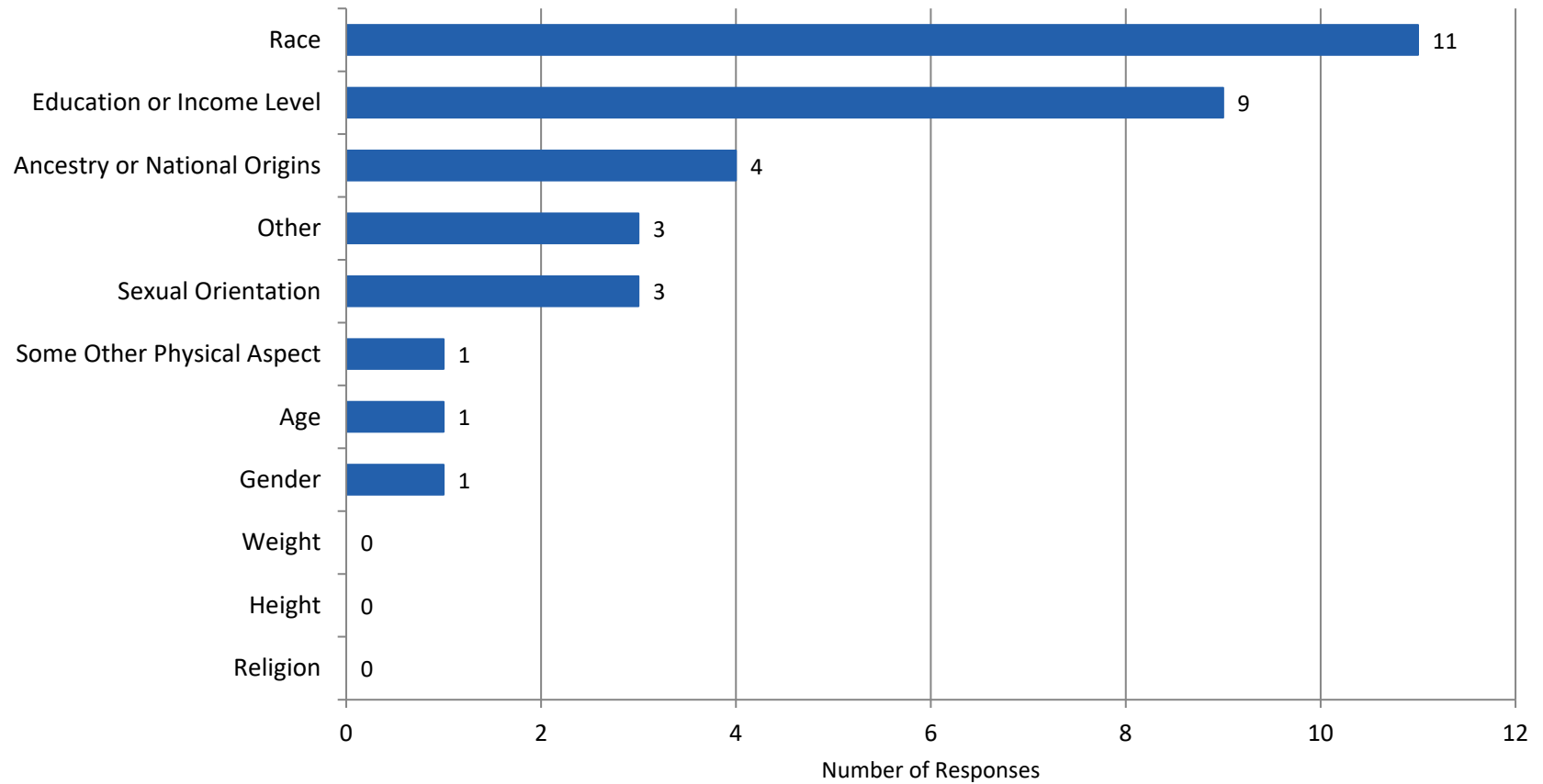
**Question 3:** Do the community members you serve experience any of the following at least a few times per year? (N=20 responses)



**“Other” Included:** Inequities in access to healthcare and education and housing, lack of access to specialty healthcare services



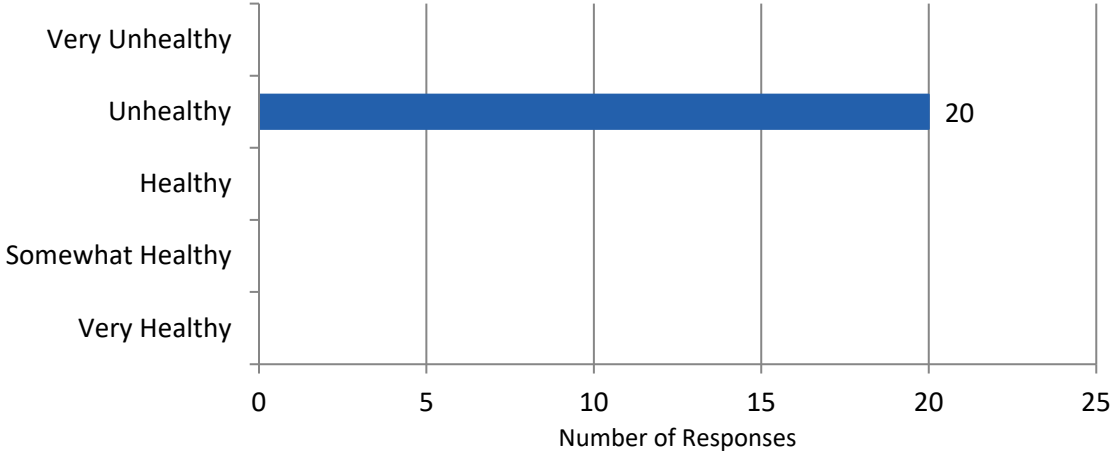
**Question 4:** If you selected any of the responses in the question above (question 3), what do you think is the main reason for these experiences? Please select all that apply. (N=20 responses)



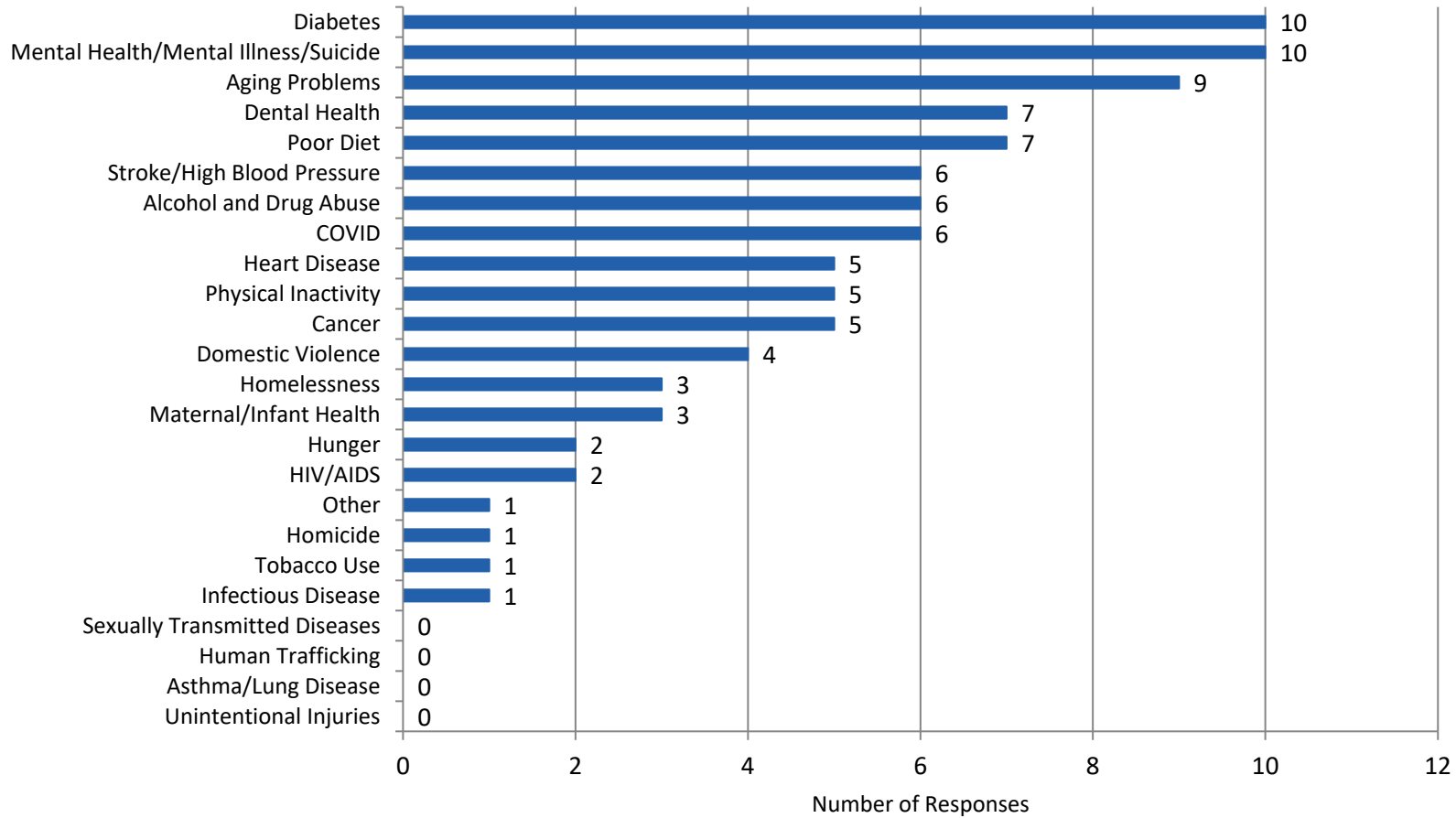
**“Other” Included:** ZIP code, county does not have programs to support access to specialty healthcare services for the low-income/uninsured populations



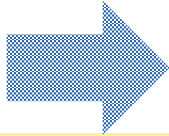
**Question 5:** How would you rate the overall health of the community you serve in Prince George's County? (N=20 responses)



**Question 6:** What are the leading health problems that impact the community you serve in Prince George’s County?  
Please select up to five from the list below. (N=20 responses)



**“Other” Included:** affordable housing, financial stresses, health literacy



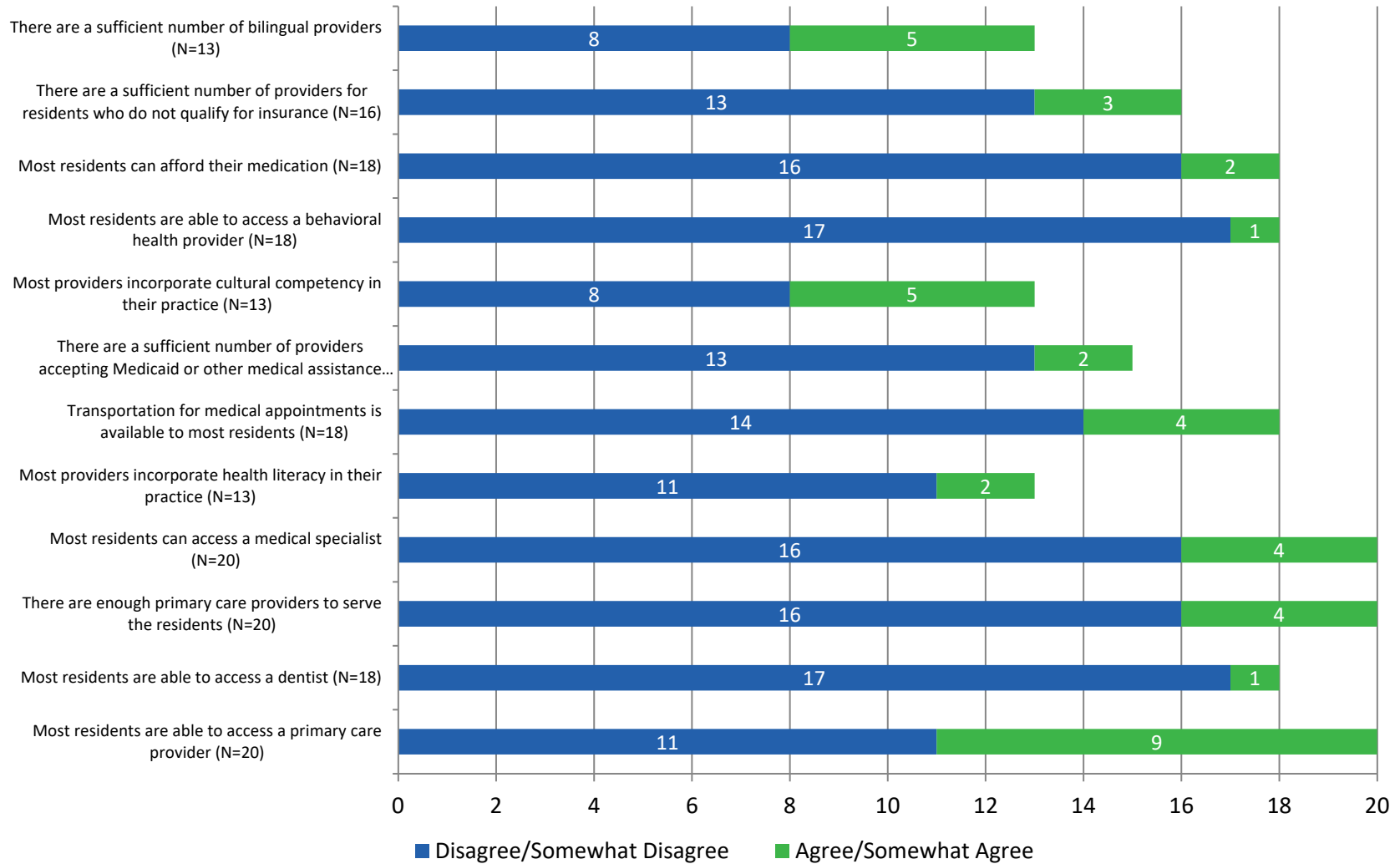
**Question 7:** Respondents were asked to share any additional information about health issues in the County in an open-ended response (N=5 responses). The responses are summarized in the table

Issues mentioned	Number of Responses	Summary of Responses
Specific Health Issues	3	Diabetes, dental health, stroke/high blood pressure are of highest concern. Many health issues are interrelated.
Lack of Insurance/Healthcare Challenges	1	Many residents lack insurance or are unable to afford co-pays. Challenges with navigating the healthcare system and residents don't know how to utilize services. More bilingual providers to address behavioral health issues.
Lack of Collaboration and Resources	1	Too many systems operating in silos and the lack of appropriate/adequate distribution of resources.
Lack of Affordable Healthcare	1	Community lacks affordable healthcare insurance programs for underinsured people.

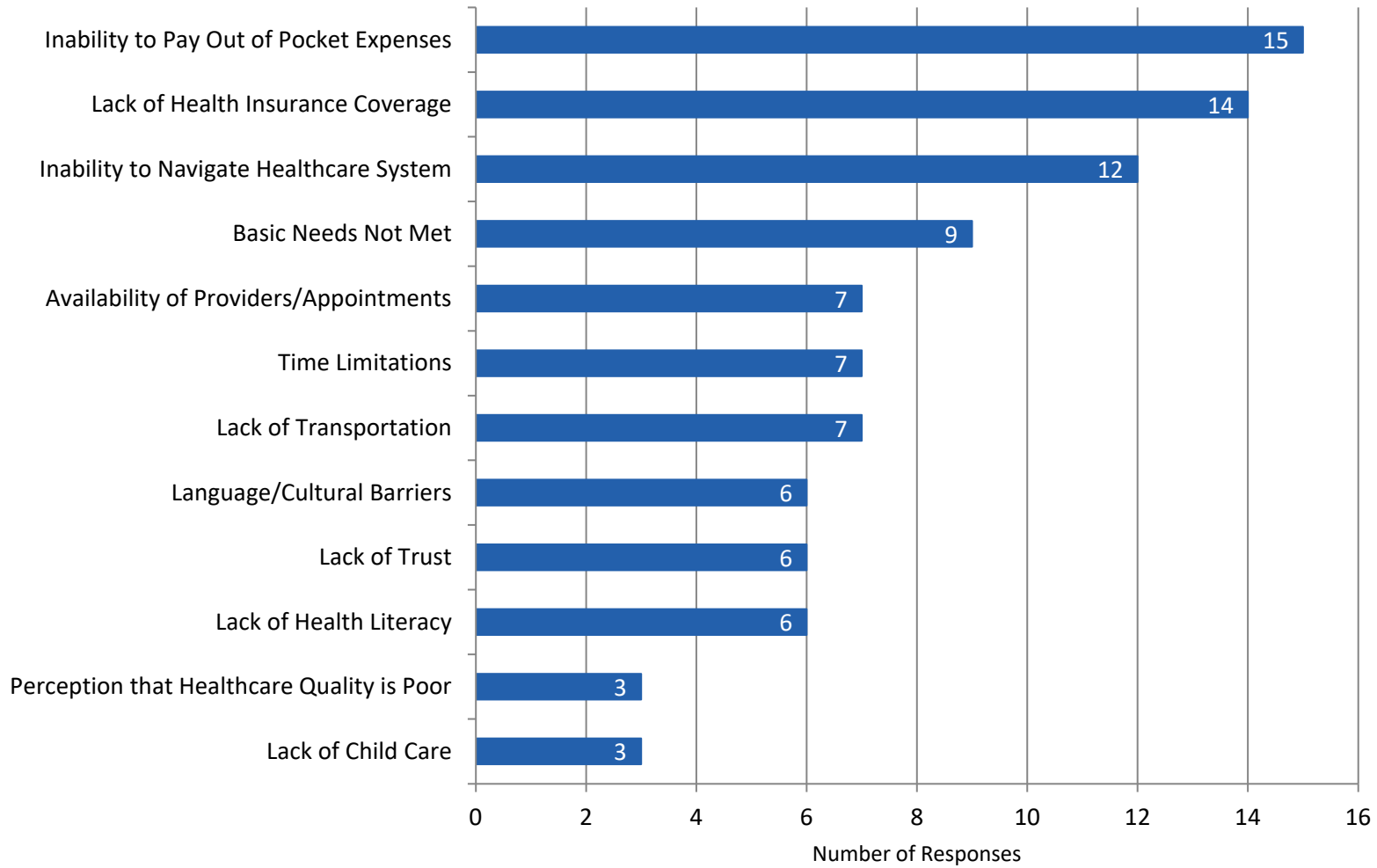
**Question 8:** Please rate the following statements about healthcare access in Prince George’s County for the community you serve based on the scale below. (N=20 responses)

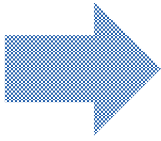
	<b>Disagree</b>	<b>Somewhat Disagree</b>	<b>Somewhat Agree</b>	<b>Agree</b>	<b>No Opinion/ Don’t Know</b>
Most residents are able to access a primary care provider.	6 (30.0%)	5 (25.0%)	9 (45.0%)	0 (0.0%)	0 (0.0%)
There are enough primary care providers to serve the residents.	9 (45.0%)	7 (35.0%)	4 (20.0%)	0 (0.0%)	0 (0.0%)
Most residents are able to access a medical specialist.	9 (45.0%)	7 (35.0%)	4 (20.0%)	0 (0.0%)	0 (0.0%)
Most residents can access a behavioral health provider (such as for mental health or substance use treatment).	12 (60.0%)	5 (25.0%)	1 (5.0%)	0 (0.0%)	2 (10.0%)
Most residents are able to access a dentist.	9 (45.0%)	8 (40.0%)	1 (5.0%)	1 (5.0%)	1 (5.0%)
Transportation for medical appointments is available to most residents.	10 (50.0%)	4 (20.0%)	4 (20.0%)	0 (0.0%)	2 (10.0%)
Most residents can afford their medication.	11 (55.0%)	5 (25.0%)	2 (10.0%)	0 (0.0%)	2 (10.0%)
There are a sufficient number of providers accepting Medicaid or other forms of medical assistance.	6 (30.0%)	7 (35.0%)	2 (10.0%)	0 (0.0%)	5 (25.0%)
There are a sufficient number of providers for residents who do not qualify for insurance.	9 (45.0%)	4 (20.0%)	3 (15.0%)	0 (0.0%)	4 (20.0%)
There are a sufficient number of bilingual providers.	6 (30.0%)	2 (10.0%)	4 (20.0%)	1 (5.0%)	7 (35.0%)
Most providers incorporate cultural competency in their practice.	5 (25.0%)	3 (15.0%)	4 (20.0%)	1 (5.0%)	7 (35.0%)
Most providers incorporate health literacy in their practice.	5 (25.0%)	6 (30.0%)	2 (10.0%)	0 (0.0%)	7 (35.0%)

**Question 8:** Please rate the following statements about healthcare access in Prince George’s County. (N=20 responses)



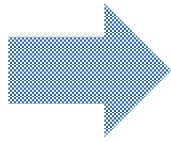
**Question 9:** From the list below, please select up to 5 leading barriers that keep the community you serve in Prince George's County from accessing healthcare. (N=20 responses)





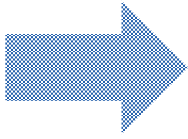
**Question 10:** Respondents were asked to name two key resources or services that are needed to improve access to healthcare for County residents in an open-ended response (N=19 responses). The responses are grouped and summarized in the table below. Some responses included statements about multiple issues.

Key Resources	Number of Responses	Summary of Responses
More Providers and Access to Providers	8	Need for: more providers across all disciplines, need medical personnel to be at community centers and senior centers, providers who reflect the populations they serve, centers specially equipped to manage underserved populations, high speed broadband for access to telehealth, better access to mental health services, particularly for children
Affordable Healthcare/Health Insurance	7	Need for: financial support directly or through expanded reimbursement, County funded programs for specialty healthcare access and services for the low income and uninsured populations, more trauma informed healthcare and behavioral health providers that are affordable for the immigrant population and the poorest among us, co-pay assistance and lower prescription costs, provide a more robust safety net system, have social services help people with medical insurance, health insurance for all
Health Navigation, Education, and Information	5	Need for: increased community health worker capacity; increased communication, engagement, and outreach services; add health literacy to the education system beginning in middle school; county wide marketing of where to gather information
Primary Language Considerations	4	Need for: increasing provider access to translation services by phone during appointments; bilingual staff in offices
Transportation	3	Need for: more transportation; improved access to transportation
Improved Healthcare Quality	3	Need for: providers that are culturally competent; better care coordination and case management for patients; improve service quality
Basic Needs (housing, food, employment)	2	Need for: increased healthy eating options around the County, childcare



**Question 11:** Respondents were asked what population they think is most underserved for health-related services in Prince George’s County in an open-ended response (N=20 responses). The responses are summarized in the table below.

Populations mentioned	Number of Responses	Summary of Responses
Immigrants	4	Immigrants, those with limited English proficiency
Minorities	4	Latinos, Blacks and Latinos, Black men
Low income	4	Lower income minorities, unemployed and underemployed residents, homeless individuals, and no access to a computer
Seniors	3	Seniors, African American seniors
Rural	1	Residents living in rural areas
Behavioral Health	1	Those with behavioral health
Transgender	1	Transgenders
Children	1	Children
Working class	1	Working class

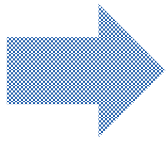


**Question 12:** Respondents were asked what the primary barriers are for the populations listed in question 11 in an open-ended response (N=20 responses). The responses are grouped and summarized in the table below. Many responses included statements about multiple issues.

Primary Barriers	Number of Responses	Summary of Responses
Access to Care	9	Lack of access to primary and specialty care, lack of access to providers who will see patients regardless of insurance status, not enough hospital beds, not enough providers that understand the needs of the residents they serve, no County subsidized program for medical specialty care access, lack of affordable healthcare options, availability of appropriate services
Cultural/Language Barriers	7	Lack of bilingual providers and staff, limited resources for non-English speakers, limited education and language, cultural competency
Engagement and Awareness of Services and Resources	6	Lack of awareness of resources and providers, lack of knowledge and experience with innovative technology, inability of agencies to understand how to saturate the community with quality messaging that resonates and triggers action, lack of information available to understand and navigate behavioral health resources
Lack of Financial and Basic Resources	6	Having to take time off work, low income and live in rural communities, unable to earn a living wage to cover basic needs, low access to healthy foods
Lack of Trust	4	Fear of identification consequences among the undocumented and immigrant populations, little trust in the system
Lack of Insurance	3	Those ineligible for insurance will have unmet health needs, primarily undocumented immigrant populations, ineligibility for Medicare/Medicaid
Transportation	2	Need for more transportation options
Health Literacy	1	Inadequate resources to provide community-based education and healthy literacy where residents live, work, and play
Mental Health	1	Stigma of behavioral health and continuous criminalization of mental illness

**Other responses:** racism in all its forms





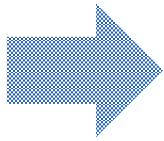
**Question 13:** Respondents were asked what is being done well in Prince George’s County within communities to improve health and well-being and by whom in an open-ended response (N=15 responses). The responses are grouped and summarized in the table below. Many responses included statements about multiple activities and contributing organizations.

Agencies/Organizations	Number of Responses	Specific Program/Service/Action
Prince George’s County Health Department	5	County Health Officer is determined to improve the quality of life and quality of healthcare for all residents, health education, COVID Cares Program, Health Assures program
Federally Qualified Health Centers	4	Variety of services under one roof - simplifying navigation for the most vulnerable
Prince George’s County Parks and Recreation	1	Parks and Planning maintain a good number of community centers, playgrounds, trails, and other facilities that residents use to stay active
Hospital System	1	Building of the medical center
Prince George’s County Council	1	Council members delivering food on a weekly or biweekly basis
Prince George’s Department of Social Services	1	Provides excellent services to eligible residents to access health coverage
University of Maryland School of Public Health Center for Health Equity	1	Provides much needed health information to customers (i.e. barbershop & salons program)

Other organizations mentioned (without specified programs or services): Capital Area Food Bank, Brighter Bites

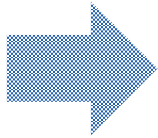
Some respondents listed programs and services occurring in the county without association to a specific agency or organization:

Other Areas of Action	Number of Responses	Specific Program/Service/Action
Collaboration and Partnerships	5	This community health assessment, COVID-19 response, passage of Blueprint for Excellence, educating the community about COVID-19 and getting people vaccinated, including and partnering with other organizations to improve the health of the community
Community-Based Services and Programs	5	Programs to connect qualifying residents to medical insurance, having bilingual centers and personnel to address community needs, COVID testing, hosting free healthcare events
Navigating Resources	2	Individuals doing their best to navigate the available resources they know about, sharing of resources
Healthy Lifestyles	2	Food insecurity initiatives are improving access to food for many residents, food distribution centers
Healthcare Access	2	Increasing number of providers, school-based clinics



**Question 14:** Respondents were asked what is being done well by the healthcare systems in Prince George’s County to improve health and well-being and by whom in an open-ended response (N=13 responses). The responses are grouped and summarized in the table below.

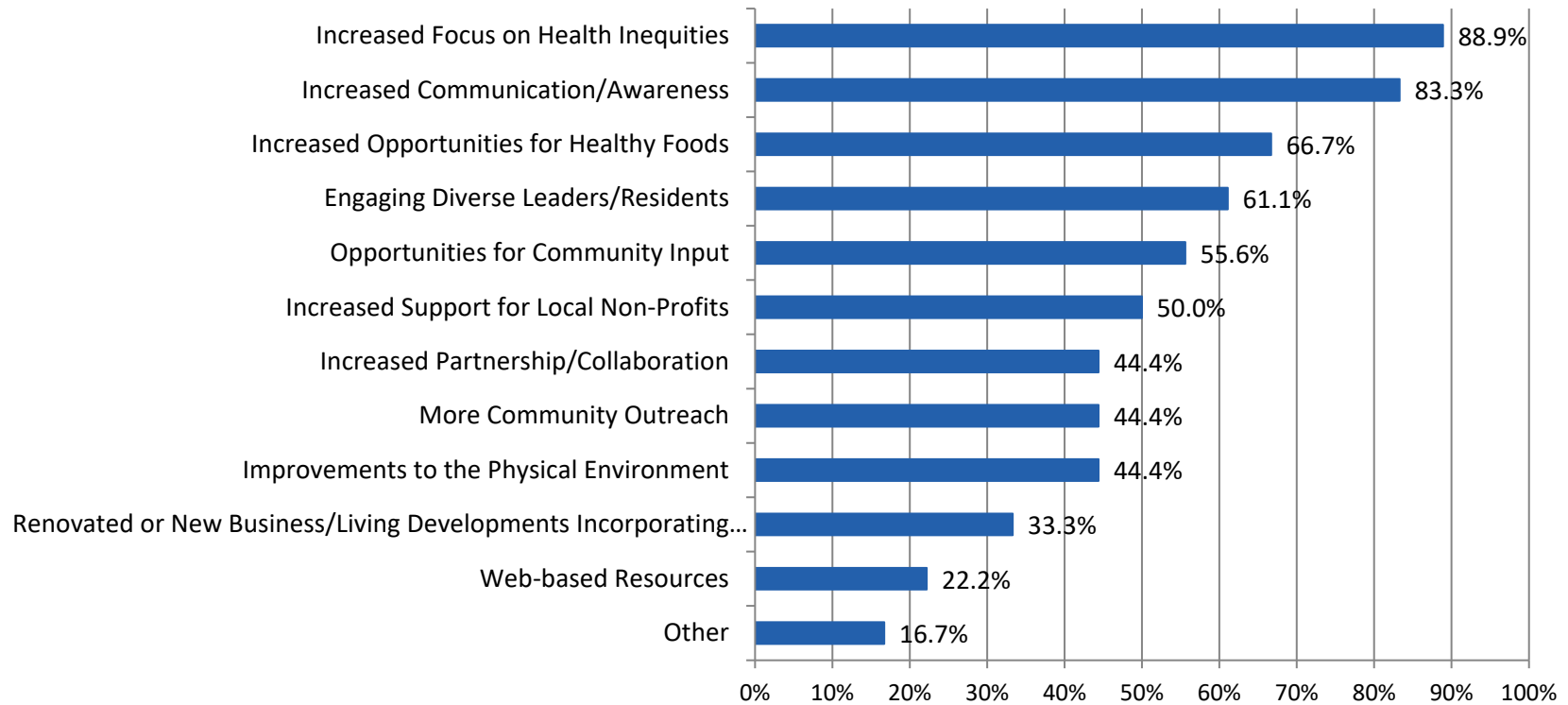
Areas of Action	Number of Responses	Specific Program/Service/Action
Improving Hospital Quality and Facilities	6	New systems in the County (Capital Region Health, MedStar, Luminus Health), improved quality of inpatient care with the new hospital, hospitals are investing more in the County, new hospital is addressing cancer and mental health, capacity expansions for the local healthcare systems, creating more facilities near public transportation
Education and Outreach	4	More advertisement in the community letting residents know of the services available to them, public notice of resources, getting information into the community, hospital community benefit programs are reaching a lot more residents based on lessons learned from COVID
Funding	2	Funding for Health Assures, Health Assures program is a start but should be amended, expanded, and retooled to address affordability, portability, and sustainability
Access to Providers and Clinics	1	Hospitals should be working closer with FQHCs to improve care, keep patients in their medical homes and out of the ER, and provide more access to specialists and diagnostics



**Question 15:** Respondents were asked what recommendations or suggestions they have to improve the health and quality of life in Prince George’s County in an open-ended response (N=15 responses). The responses are grouped and summarized in the table below. Some responses included multiple recommendations.

Recommendations	Number of Responses	Summary of Responses
Increase and Improve Access to Providers & Clinics	8	Identify and eradicate barriers to establishing healthcare practices in the County, increased number of providers and beds with a greater need to expand certain specialties such as behavioral health providers, reduce the number of residents who resort to using emergency medical services or emergency departments for non-emergency matters, work to decriminalize behavioral health and implement a 911 diversion program for residents with behavioral health concerns, improve access to primary care appointments and scale, expand school-based clinics; more services to the northern part of the County
Health Education, Outreach and Navigation	4	Help residents navigate healthcare in the County through a centralized user-friendly hub of terminology and community resources, cultural competency, integrate health literacy in schools, appeal personally to residents
Increase Public Health and Healthcare Funding	4	Develop a clear vision for the Health Department and provide necessary funding, increase salaries to be more competitive to avoid turn over in the health department and social services agencies, use community benefit money to sustain innovations emerging from the pandemic response, advocate for a more robust program that include funding for specialty care and medications
Affordable Healthcare	3	Continue funding and expanding services/programs for those who cannot obtain care through insurance, assisting residents with or without insurance at a reasonable rate, universal insurance program
Basic Needs	3	Improve social economic conditions so all residents have access to a living wage, affordable housing, healthy food, education, and transportation, address food insecurity, look at a holistic approach that includes a living wage so they can afford healthcare in addition to rent, childcare, and food
Collaboration	2	Link clinical and social care, bring the entire system together in collaboration instead of working in silos
Support Healthy Lifestyles	2	Improve access to healthy food for all residents, healthier eating and food options
Community Engagement	2	Engage community members to fight for and demand more resources to improve the health care system, engagement from schools, churches, municipalities, and civic associations

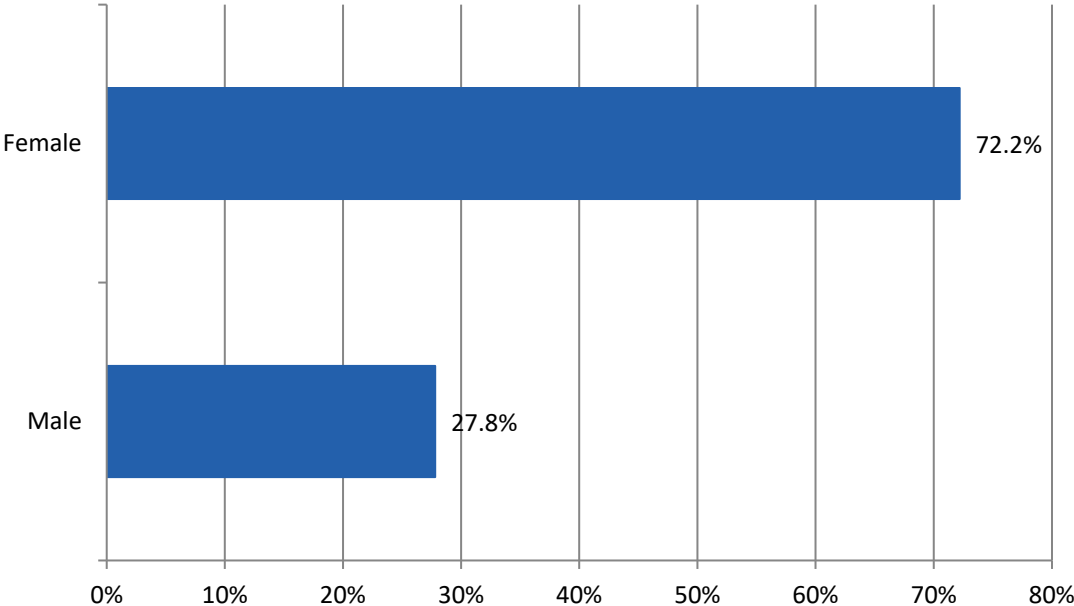
**Question 16:** What do you think could encourage and support more community involvement to improve health and well-being in Prince George’s County (select all that apply)? (N=18 responses)



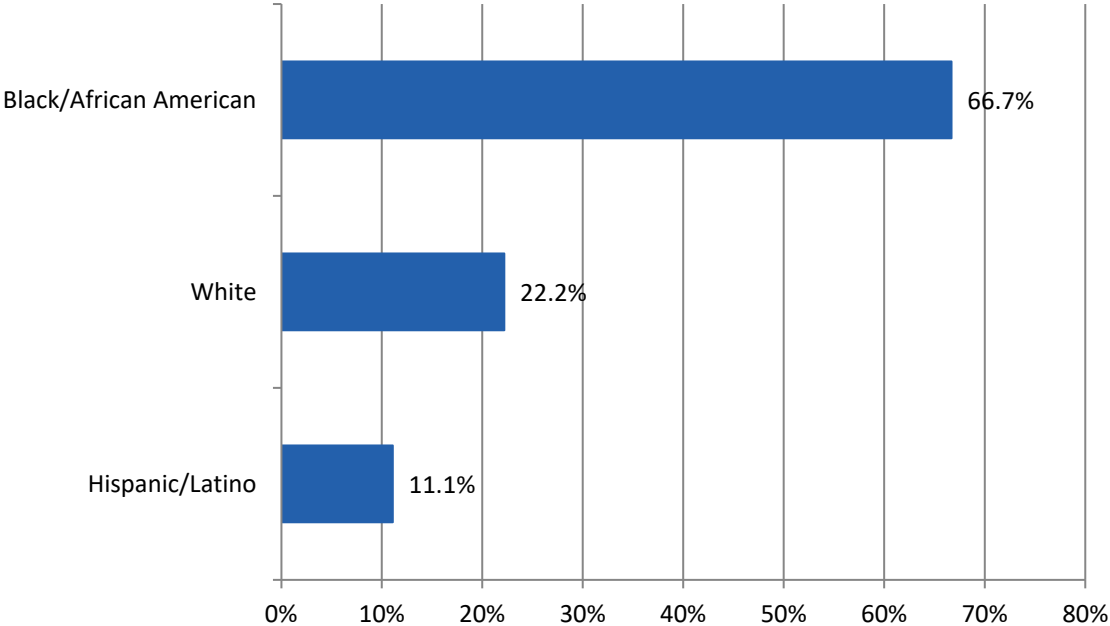
**“Other” Included:** all tactics would improve the health and well-being of residents, keep up with the Zoom Townhalls and working groups, pay the full amount it would take to fully fund Assures year-round as the Universal Primary Care program is retooled to address affordability, portability, and sustainability

# Participant Profile

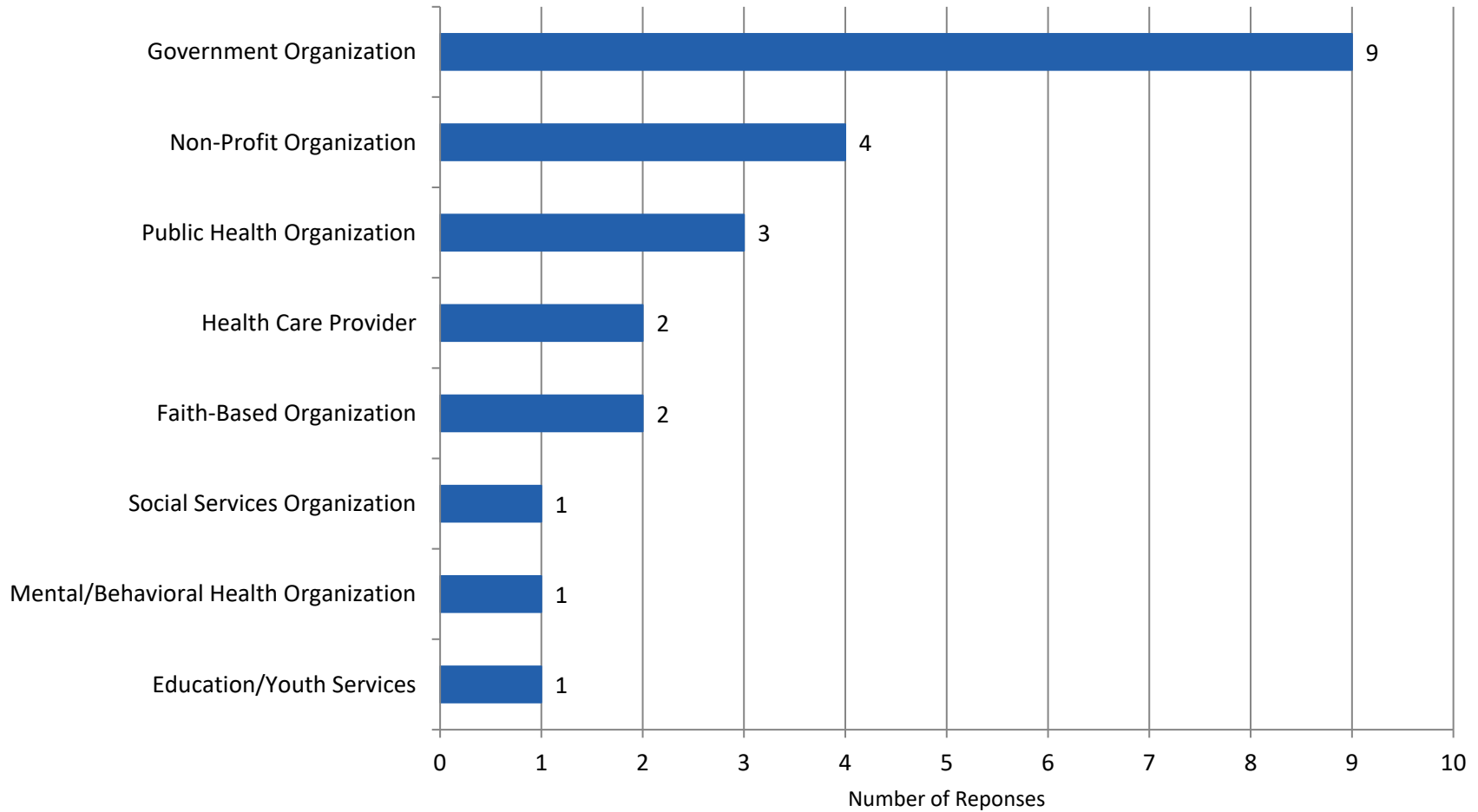
**Question 18:** What is your gender (N=18 responses)



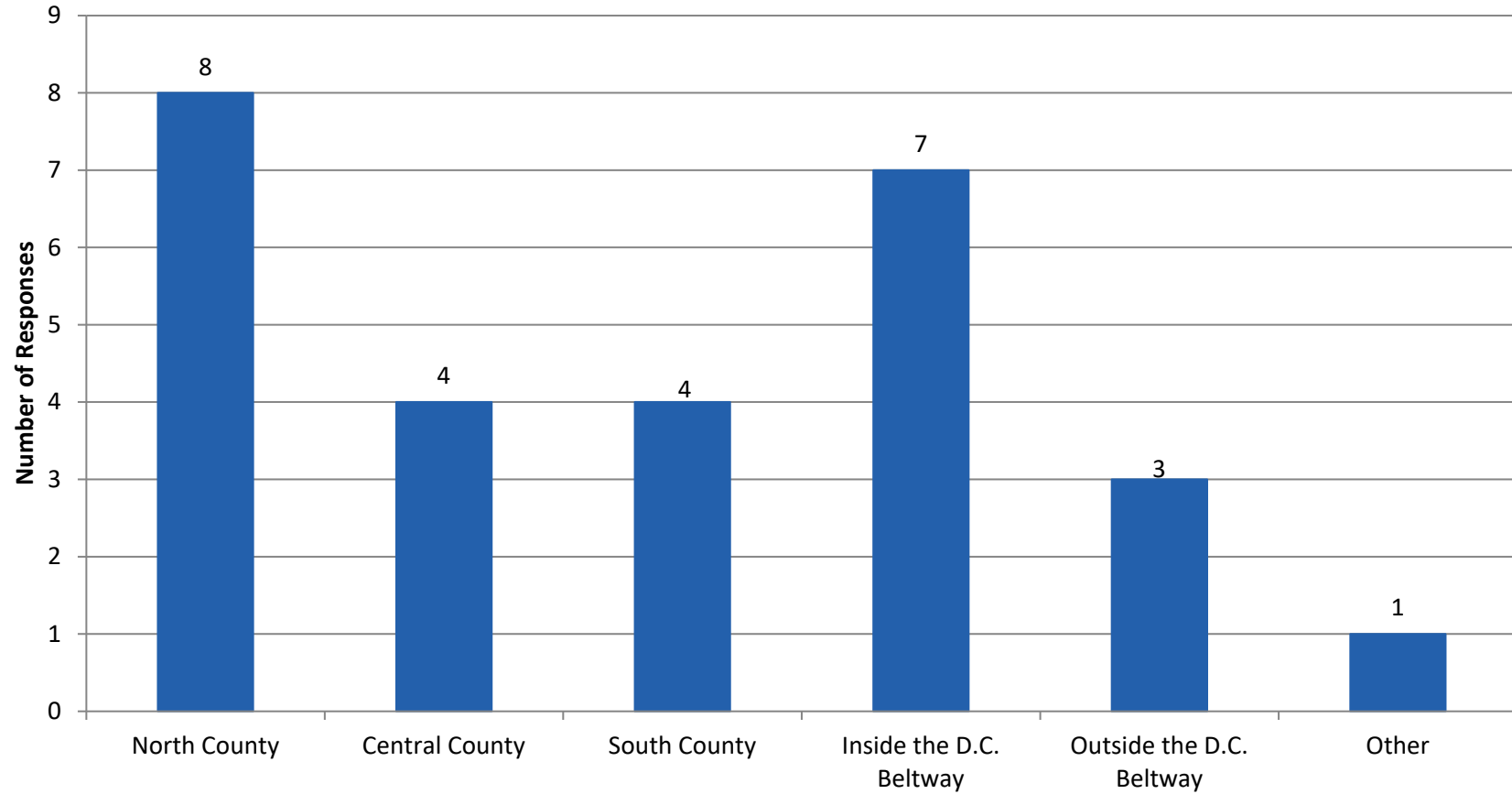
**Question 19:** What race/ethnicity best identifies you? (N=18 responses)



**Question 20:** Which of these categories would you say best represents your community affiliation? Participants were asked to select all that apply. (N=18 responses)

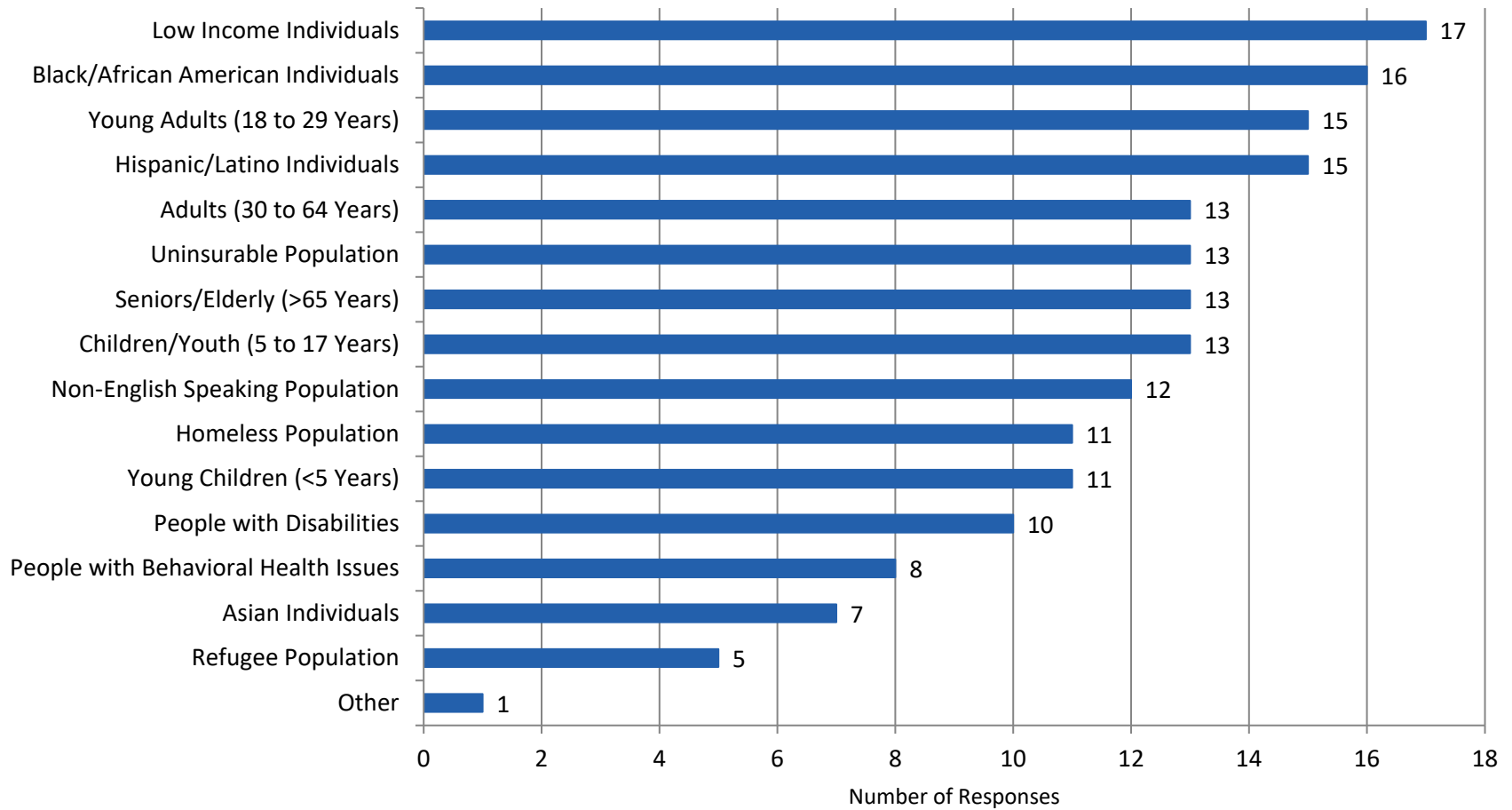


**Question 21:** In what geographic part of Prince George’s County are you most knowledgeable about the population?  
Participants were asked to select all that apply. (N=18 responses)

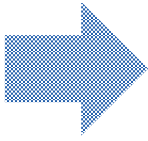


**“Other” included:** knowledge across the entire County

**Question 22:** Please indicate the populations you serve or represent in Prince George’s County through either personal, professional, or volunteer roles. Participants were asked to select all that apply. (N=18 responses)



**“Other” included:** all the above

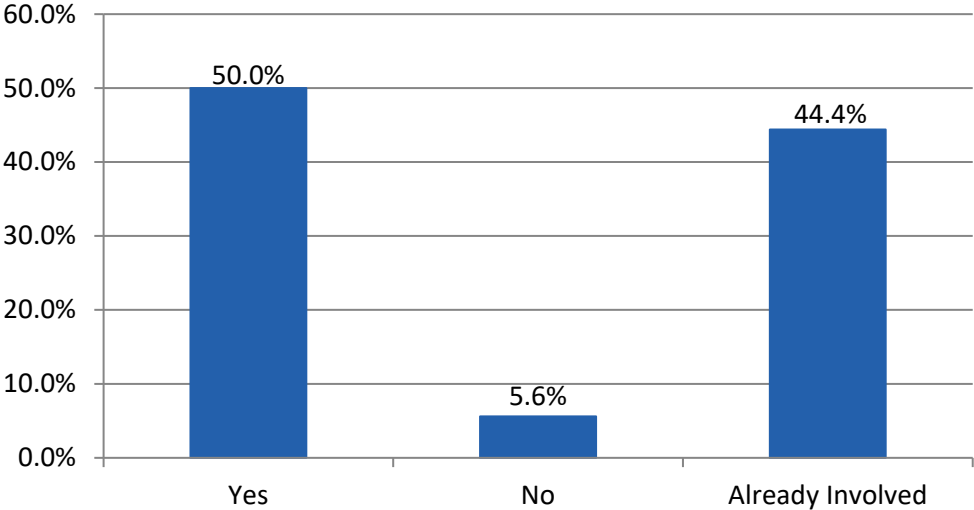


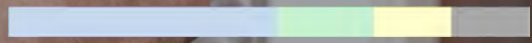
**Question 23:** Respondents were asked to share the most pressing needs of the populations they serve based on their experience (N=18 responses). The responses are grouped and summarized in the table below. The majority of these responses reiterated information that had already been provided in previous questions.

Additional Information	Number of Responses	Summary of Responses
Basic Needs	9	Improving the health and well-being and overall quality of life for County residents, ensuring all residents have access to a living wage, affordable housing, healthy food, education, and transportation, support to those experiencing homelessness
Healthcare Access	8	Increase number of providers and beds, behavioral health; over-reliance on emergency services, improved access to primary care, lack of access to medical specialty care
Healthy Environment	5	Lower crime, healthier food options, fewer liquor and tobacco stores, and higher paying jobs in the area, accessibility of healthy lifestyle practices (parks, trails, pools, etc.), managing the social needs that ultimately exacerbate overall physical and mental health status
County Services and Funding	4	Crisis response, services for the most vulnerable populations, additional funding for social programs, funding for specialty care and medications
Affordable Healthcare	4	Healthcare affordability, health insurance
Health Literacy and Health Education	2	Cultural competency, health literacy education
Cultural and Language Considerations	2	Education for Spanish population on services, support, and working on the gap for trust, people do not trust the system
Immigration Issues	2	Legal status, re-entry services
Better Education Outcomes	1	Lack of education
Care coordination and information	1	Resources and options



**Question 24:** Would you be interested in becoming more involved in local health initiatives?  
(N=18 responses)





**RESIDENT**  
survey

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# COMMUNITY RESIDENT SURVEY

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## Introduction

Prince George's County is home to over 967,000 residents and growing, with a wide range of health needs and disparities. The Community Resident Survey was a strategy developed to complement the overall Community Health Assessment (CHA) goal of identifying the health needs and issues for the County's diverse population by hearing directly from our residents.

## Methodology

The 2022 Community Resident Survey was modified from the 2019 Community Resident Survey, with any adaptations based on the Community Health Status and Assessment recommendations of the Mobilizing for Action Through Planning and Partnerships (MAPP) framework<sup>1</sup>. Efforts were made to ensure the survey questions corresponded with the Community Expert Survey, another key assessment of the MAPP framework. The survey questions included mostly multiple choice and rating scales with a few open-ended responses for demographics and an option for writing in a response if the participant answered with "other."

The survey was translated into Spanish (the most common language spoken in the County after English) and was made available online and through printed copies. Due to time limitations, the survey was distributed as a convenience sample. The Health Department made the survey available by website, social media, and through provided services at department locations; the survey link was also posted electronically by the County government. Survey distribution began in March 2022 and ended on May 11, 2022.

For analysis, each multiple choice and rating scale question is presented as a simple descriptive statistic. Because the surveys were collected as a convenience sample, the results were intended as an additional method of gaining community input in support of the overall process, while acknowledging the lack of an adequate sample size to statistically represent the County. Responses from the English survey were excluded if the participant indicated they were not a County resident or if residency information was completely missing to make that determination. All responses in the Spanish surveys were included in the final analysis, regardless of residency information; the results are presented separate from the English responses for most questions. Each question includes the number (N) of responses.

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<sup>1</sup> <https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp>



## Participation

Surveys were completed by 118 participants: 106 in English and 12 in Spanish. Nearly all areas of the County were represented by the participants except for some of the most southern part of the County (a map of representation is available with Question 19). Over four-fifths of survey participants were female, which is higher than the County. However, survey participation by race and ethnicity was similar to the County population. Spanish survey participants were younger and all between the ages of 25-44 years, while English survey participants were more evenly distributed by age. Over 70% of all survey participants had a college degree or higher; however, 80% of the Spanish survey participants did not have higher than a high school degree. Although English survey participants reported a wide range of annual household incomes, all Spanish participants reported an annual household income of less than \$49,999.

## Key Findings

- **Healthy Community:** Over half of all survey participants said that access to healthcare was one of the most important factors defining a “healthy community,” followed by low crime, good schools, and affordable housing. Spanish survey participants also considered good jobs/healthy economy as one of the most important factors, while English survey participants said community involvement and healthy behaviors also defined a healthy community. Compared to the 2019 survey, low crime and affordable housing were leading indicators of a healthy community, while in the 2019 survey good jobs and a healthy economy were of higher importance. Four-fifths of all survey participants reported that parks were the places they went most frequently in Prince George’s County, followed by libraries and rivers/lakes/woods.
- **Community Determinants of Health:** Almost half of survey respondents (48.1%) agreed that their community has easy access to fresh fruits and vegetables; however, this was much lower (37.5%) among the Spanish participants. Over half (60.4%) of English and 87.5% of Spanish survey participants disagreed or somewhat disagreed that there is enough affordable housing in their community, higher than the 2019 survey. Spanish survey respondents were more likely (87.5%) than English survey respondents (32.6%) to disagree or somewhat disagree that their community was safe with little crime.
- **Discrimination:** Over 30% of all survey participants reported that a few times a month or more they are treated with less courtesy or respect than other people. Notably, 100% of Spanish survey participants reported this happening a few times a month or more, compared to just 25% of English survey participants. Nearly 16% of English survey participants and 57% of Spanish survey participants reported receiving poorer service than other people at restaurants or stores a few times a month or more. When asked about the main reason for these experiences, nearly 60% of all participants reported their race as a reason followed by their gender (33%). Ancestry and age were also listed as main reasons for these experiences by over 20% of all participants.
- **Leading health issues:** COVID-19, mental illness, and diabetes, as well as substance use (alcohol, drug, and tobacco) led as the major health problems identified by survey



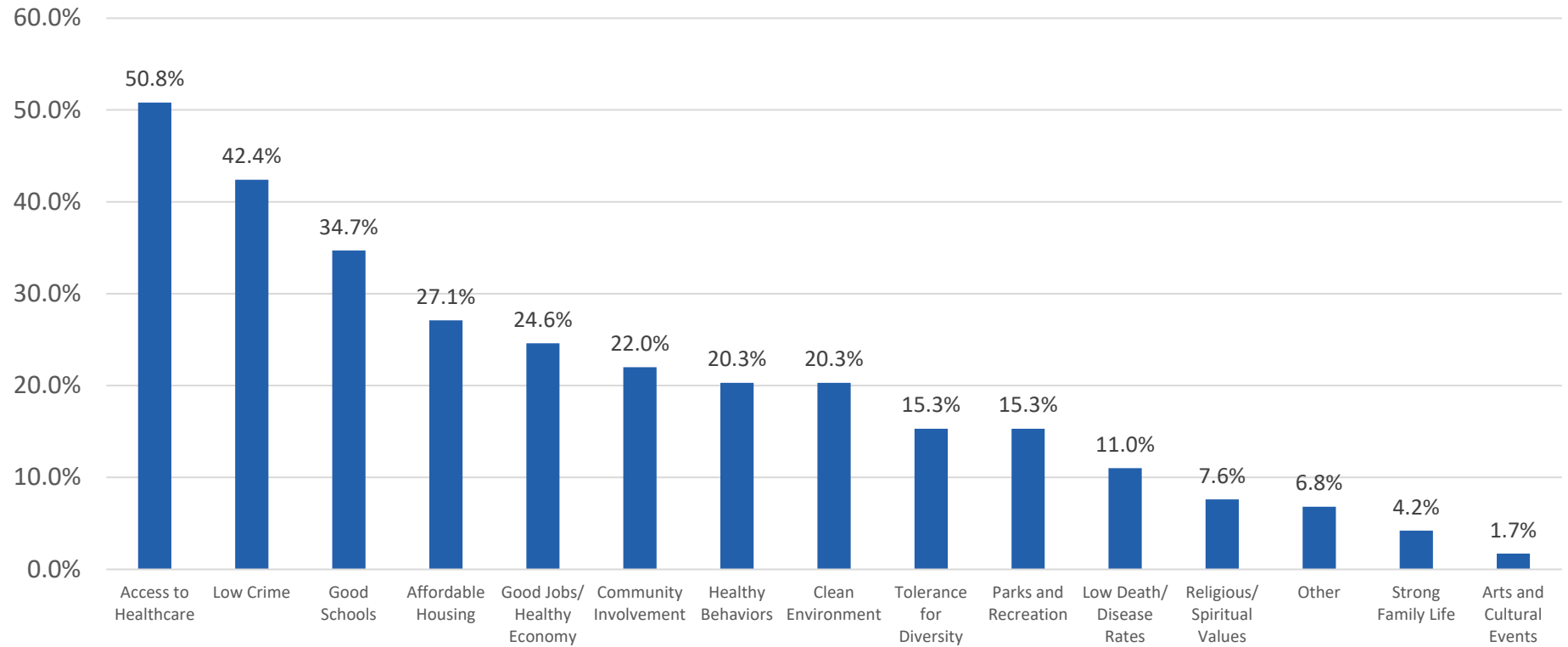
participants. For Spanish survey participants, homelessness and homicide were also identified as leading issues while for English survey participants aging problems and poor diet were identified.

- **Access to healthcare:** Over 65% of English survey participants and 80% of Spanish survey participants agreed or somewhat agreed that residents in their community could access a primary care provider, slightly higher compared to 2019 survey responses. However, less survey participants agreed or somewhat agreed that there are enough providers for the number of residents in their community, that most residents are able to access medical specialists in their community and that most residents can access a mental health provider in their community. Although 55% of English survey participants said most residents in their community could access a dentist, only 20% of Spanish survey participants felt the same. More participants disagreed or somewhat disagreed that most residents can afford their medication in their community.
- **Leading barriers:** Overall, lack of money for co-pays and prescriptions, time limitations, and lack of health insurance coverage were indicated as the leading barriers to accessing healthcare in the County. For English survey participants, 56% also reported that lack of childcare was a major or moderate problem, while over three quarters (80%) of Spanish survey participants reported lack of transportation as a barrier to accessing care.
- **Health Care:** Overall, 79.8% of survey participants reported having some type of insurance and most (92.1%) reported seeing a primary care doctor in the past year. However, among the Spanish survey participants, 60% did not have health insurance and 20% did not see a primary care doctor in the past year. Almost 20% of both English and Spanish survey participants reported being unable to access needed medical care in the past year, primarily due to the wait time being too long. Lack of transportation and childcare were also barriers for those unable to get care in the past year.
- **Health Communication:** Both English (94%) and Spanish (80%) survey participants said that doctors were the most trusted source of health and lifestyle information in their community. Following doctors, English participants reported health screenings (57.8%) as trusted sources of health information, followed by counseling. Spanish survey participants said that health fairs were trusted sources of health information (40%) followed by phone counseling. Regarding the dissemination of health information, both English participants (73.8%) and Spanish participants (80%) were most likely to prefer e-mail. Following this nearly half of overall participants preferred to receive health information in person or through a website. For Spanish survey participants, two-thirds indicated they preferred texting.
- **Recommendations to improve health:** Overall, all survey participants recommended increased communication and awareness followed by increased focus on health inequities to encourage and support more community involvement around health issues in Prince George's County. Among Spanish survey participants, an increased number of healthcare practitioners and more community-specific outreach were also important factors in community health.

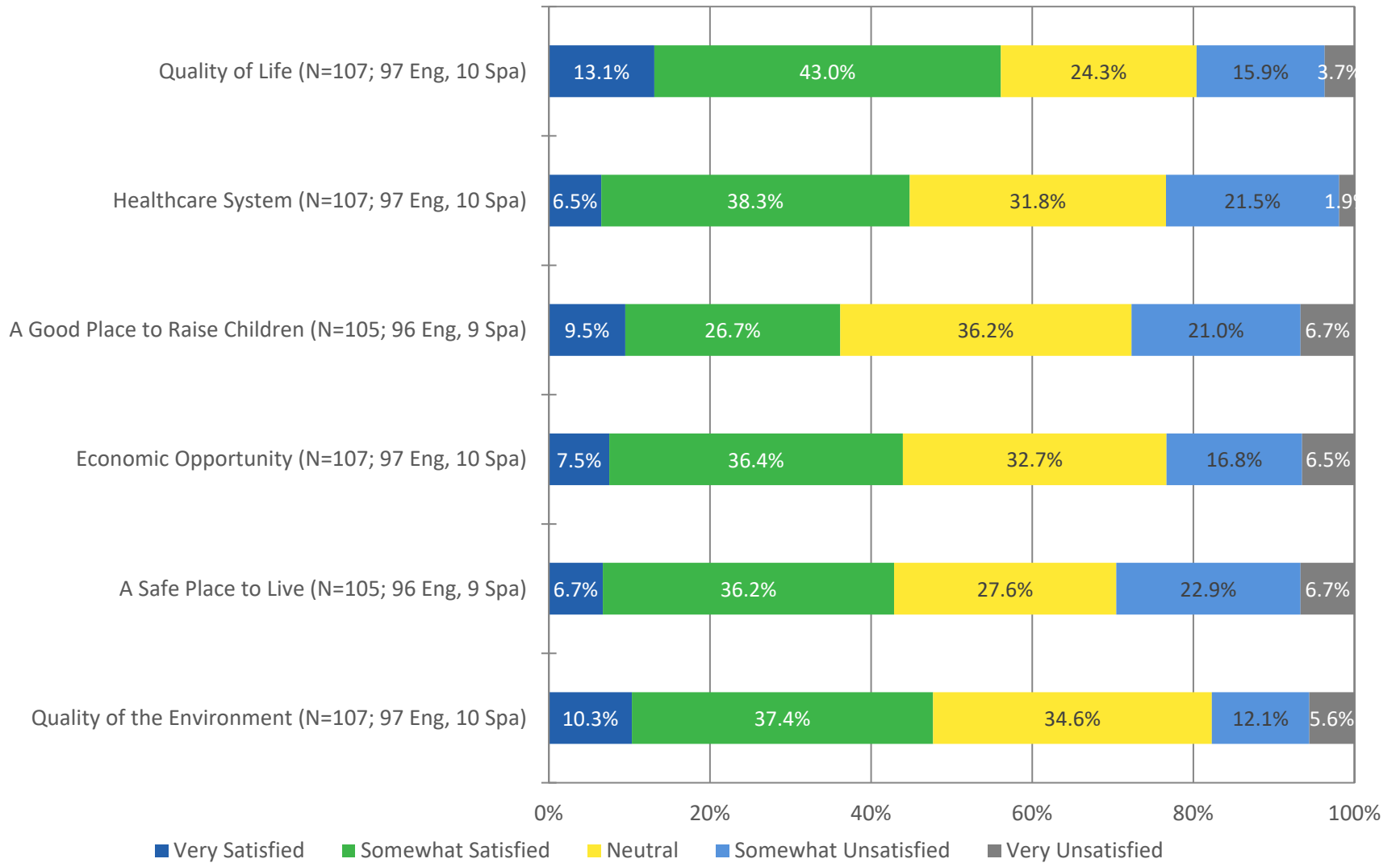


## Results

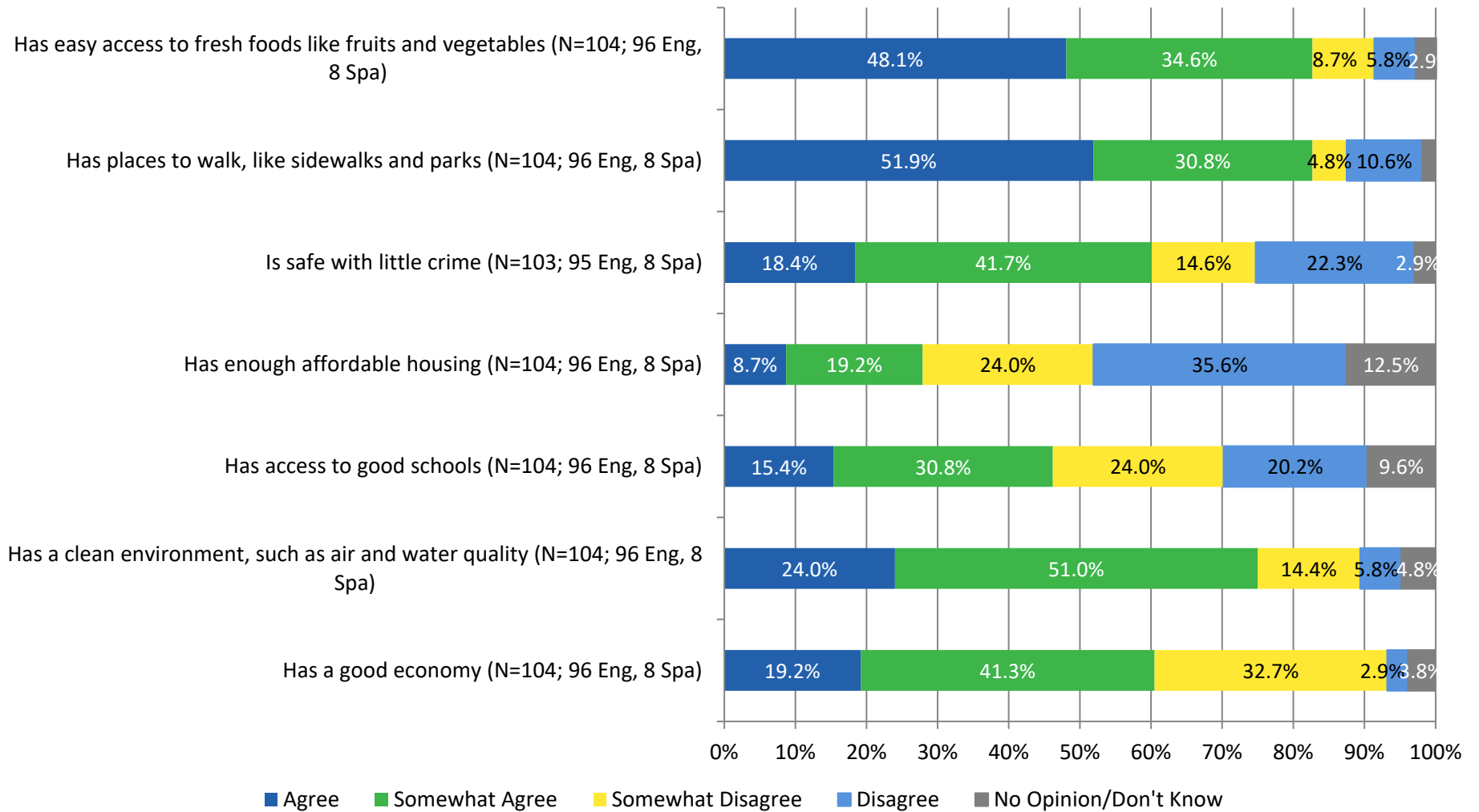
**Question 1:** What do you think are the three most important factors that define a “Healthy Community” (what most affects the quality of life in a community)? (N=118 responses; 106 English, 12 Spanish)



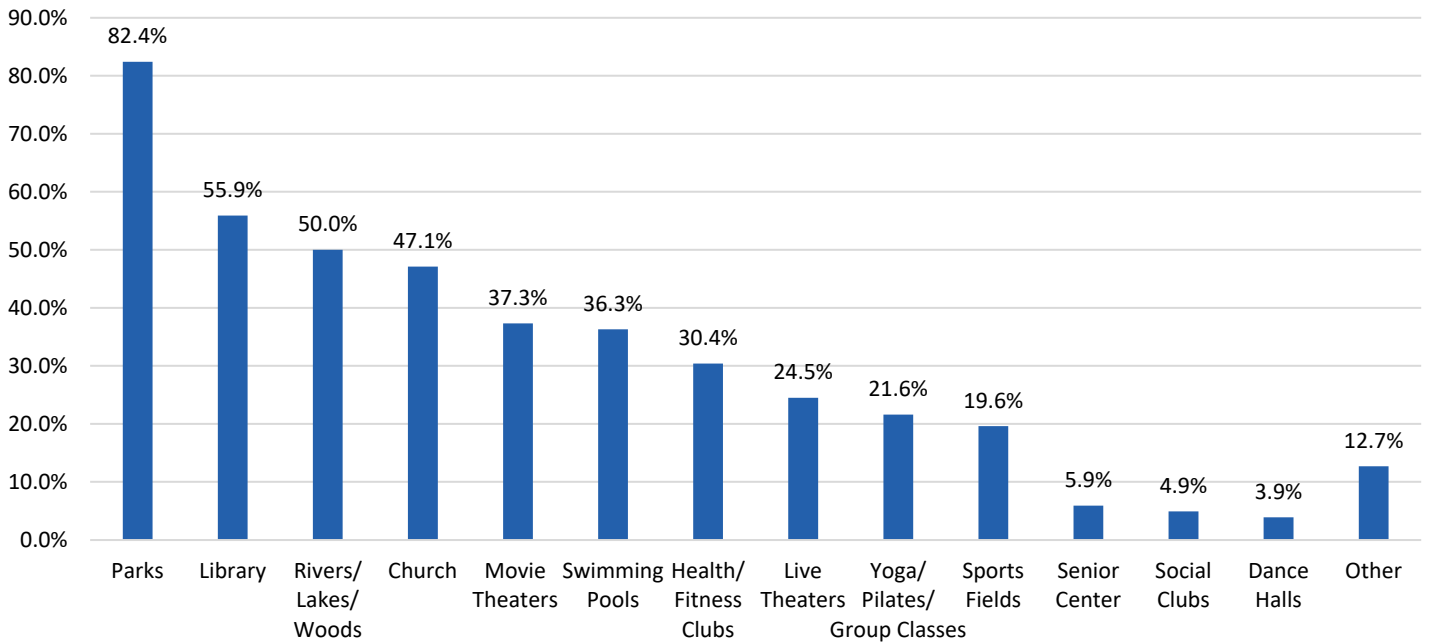
**Question 2: How satisfied are you with the following in Prince George's County?**



**Question 3:** Please rate each of the following statements for your community.



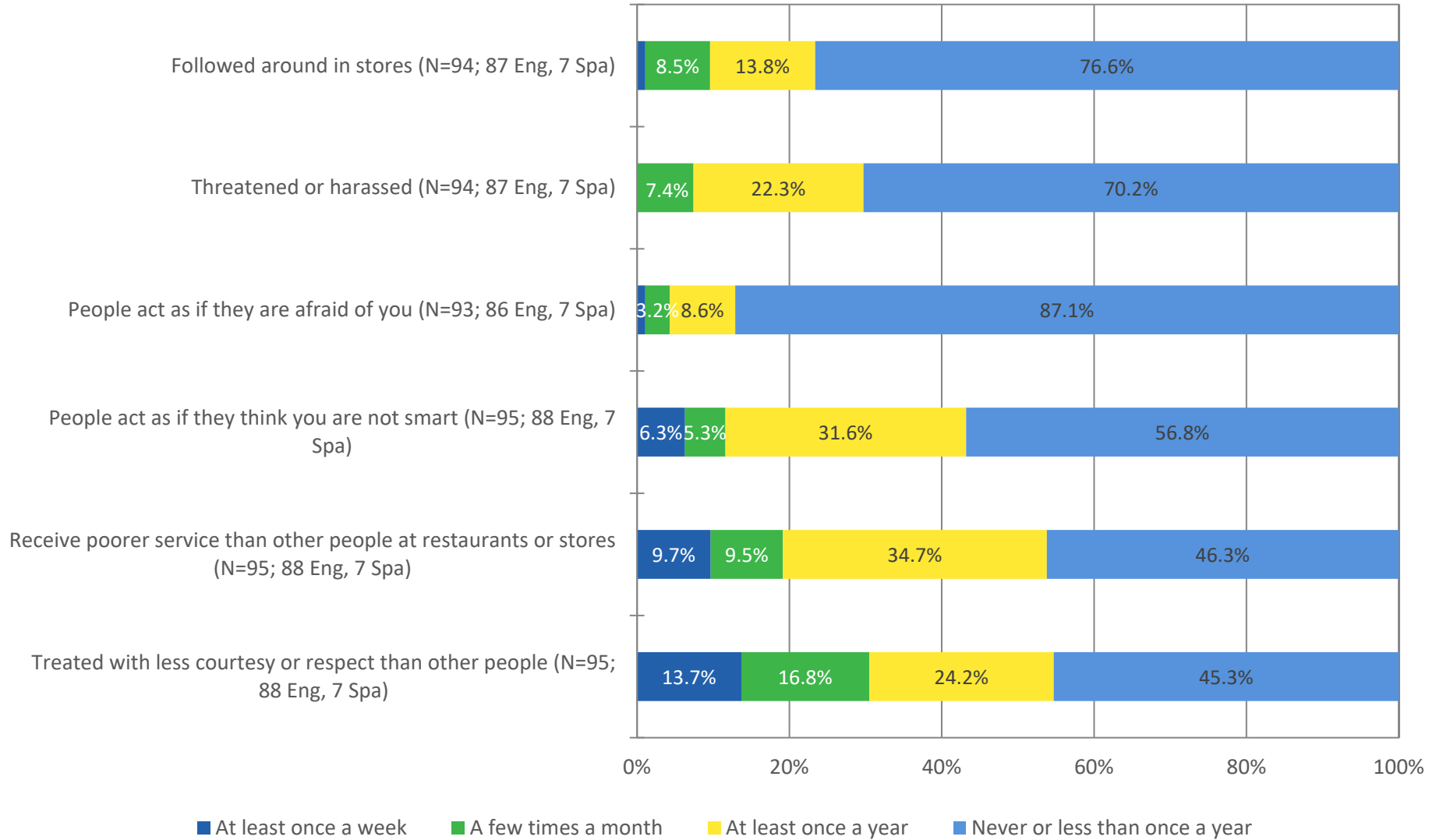
**Question 4:** The places where I go in my community most often in Prince George’s County are (select all that apply). If you changed your activities due to COVID, please include the places you are likely to return to in the future. (N=102 responses; 95 English, 7 Spanish)



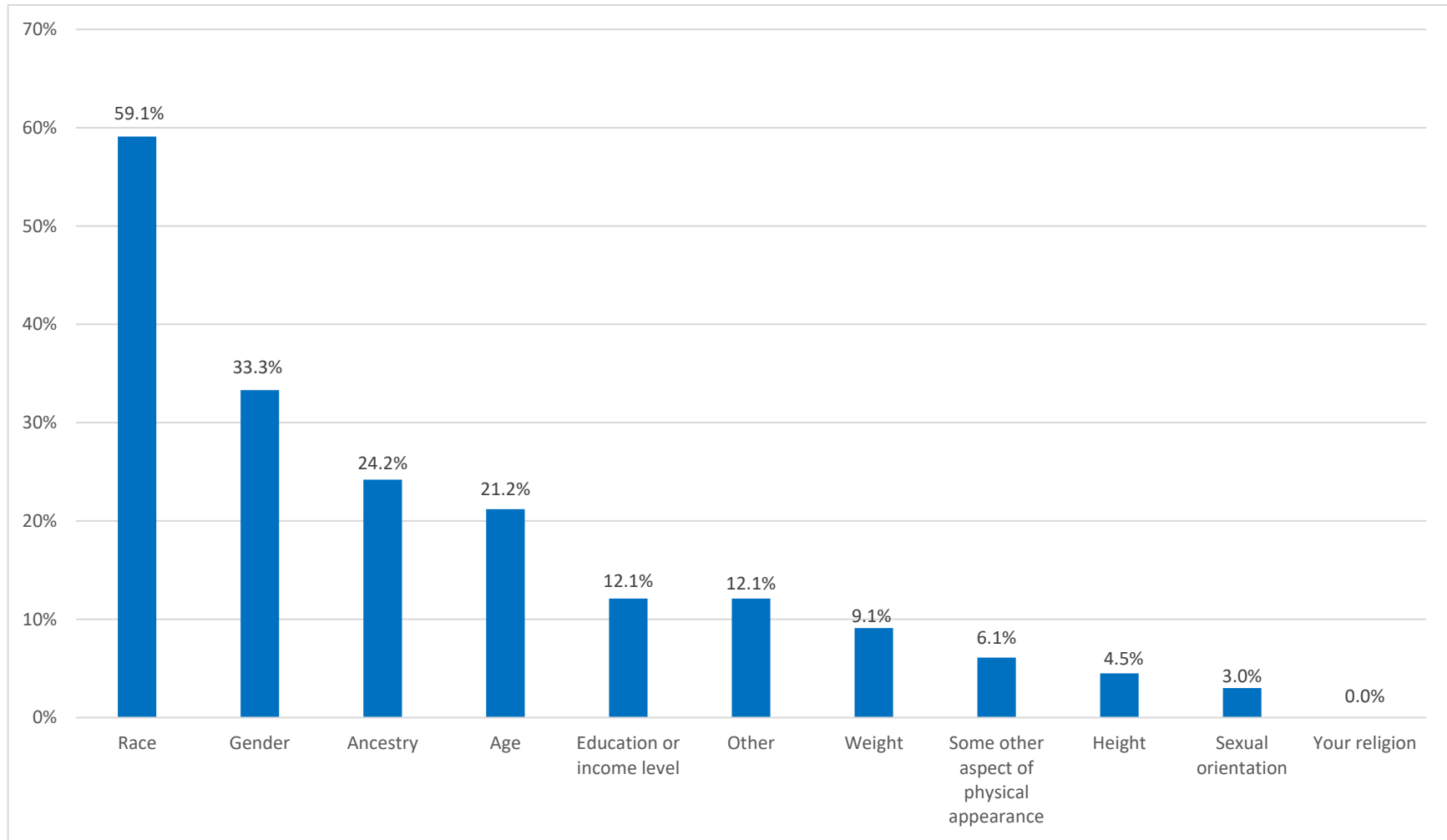
**“Other”** included: restaurants, grocery store, work, community center, ice skating, gymnasiums, markets, malls, tennis courts, recreational centers



**Question 5:** In your day-to-day life, how often have any of the following things happened to you?

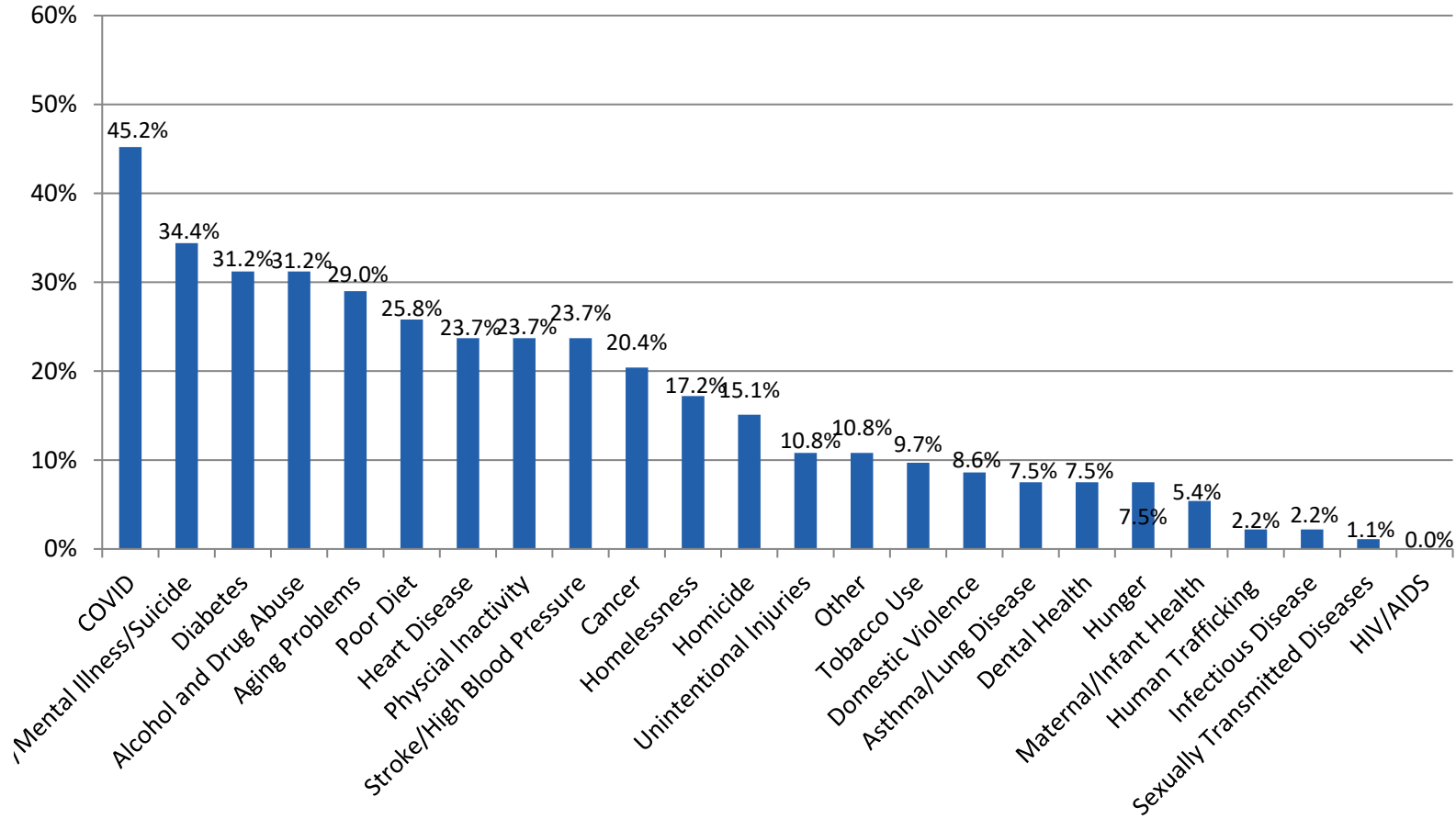


**Question 6:** If you answered at least once a year or more for any question above (in question 5), what do you think is the main reason for these experiences? Please select all that apply. (N=66 responses; 60 English, 6 Spanish)



**“Other”** included: obliviousness, people having a bad day, ignorance, and I don’t know

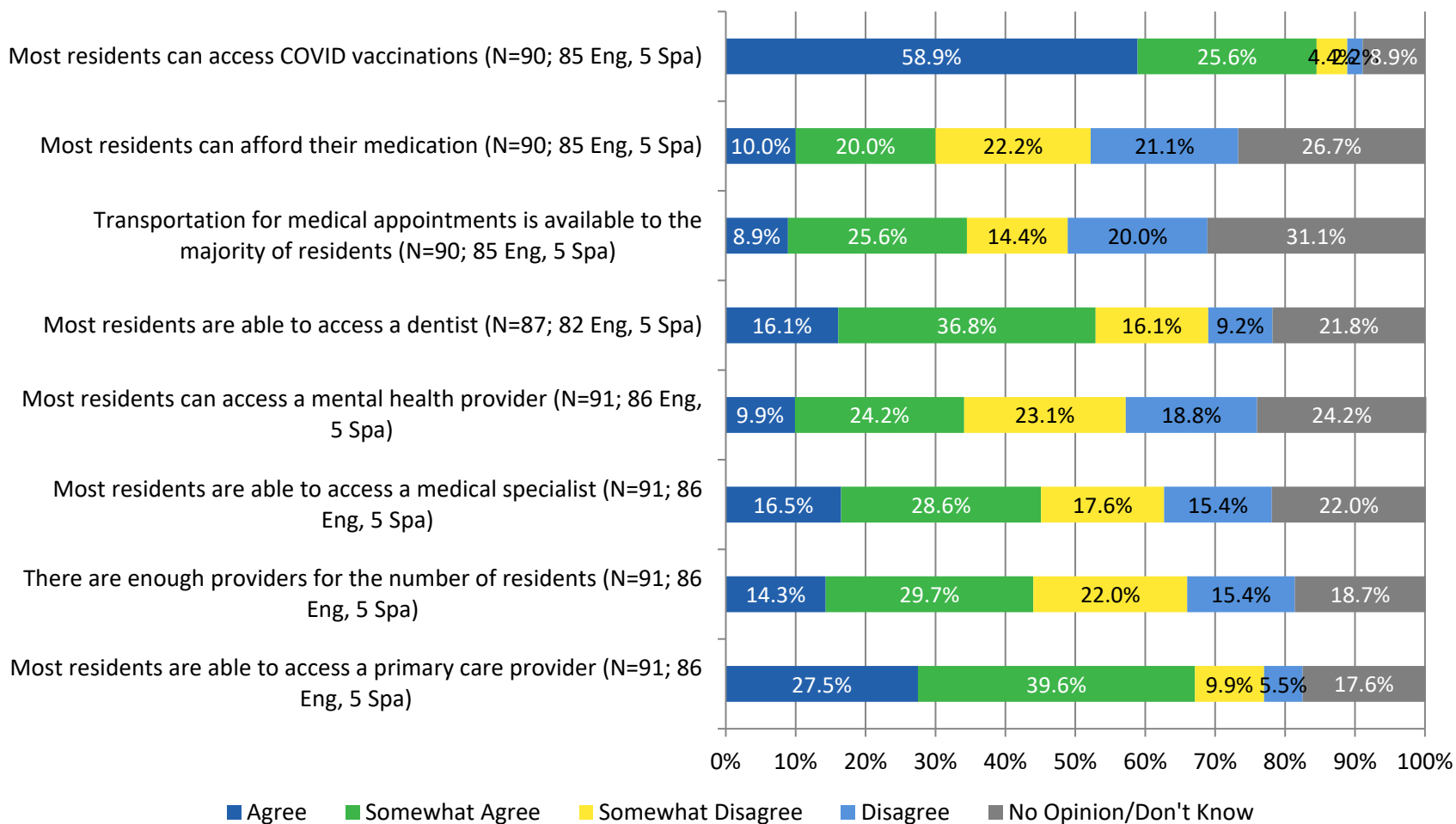
**Question 7:** What are the leading health problems that impact your neighborhood or community? Please select up to five from the list below. (N=93 responses; 87 English, 6 Spanish)



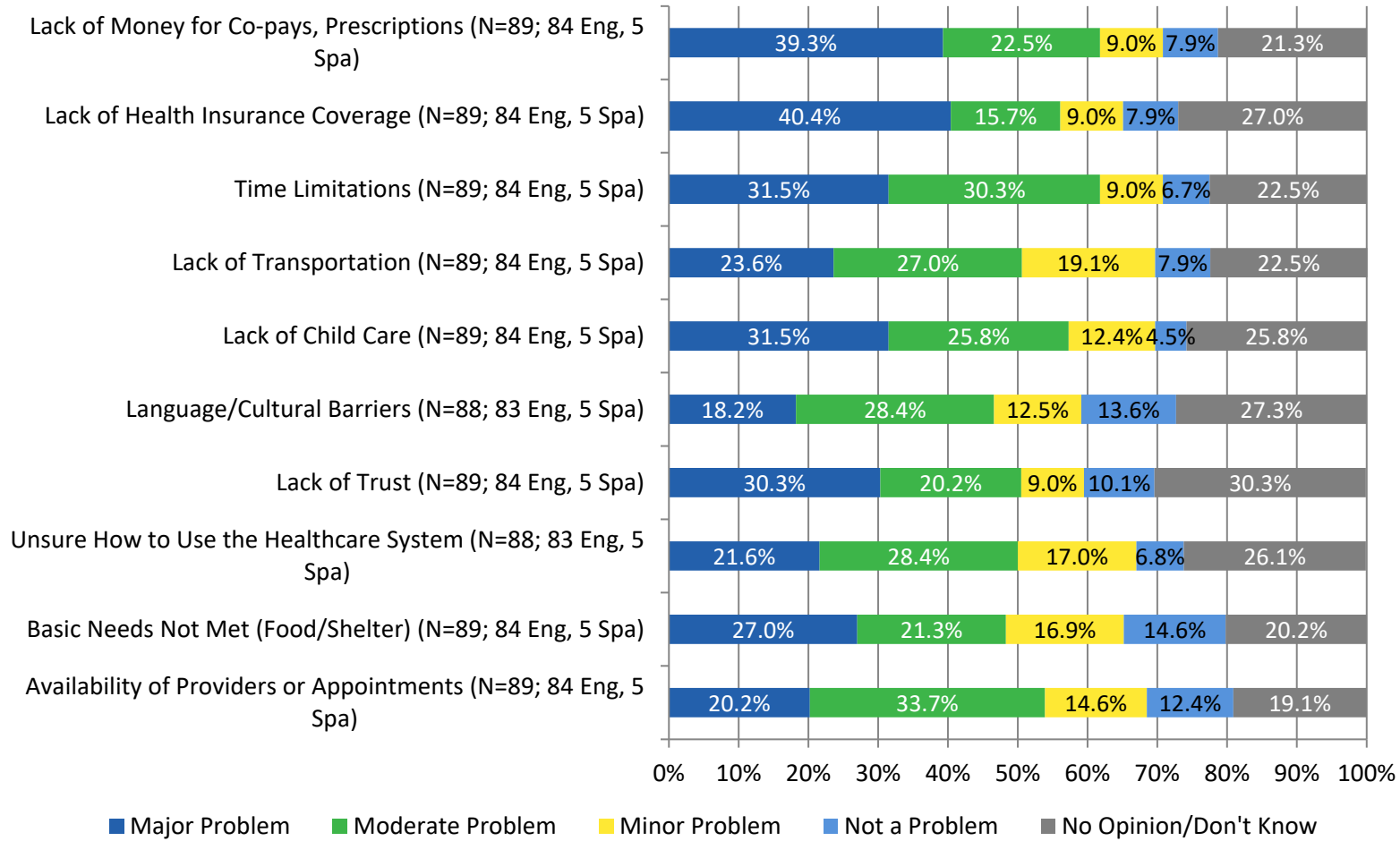
“Other” included: need more transportation, marijuana use, Isolation, lack of access to healthy and nutritious foods at local restaurants, crime, and chronic kidney disease



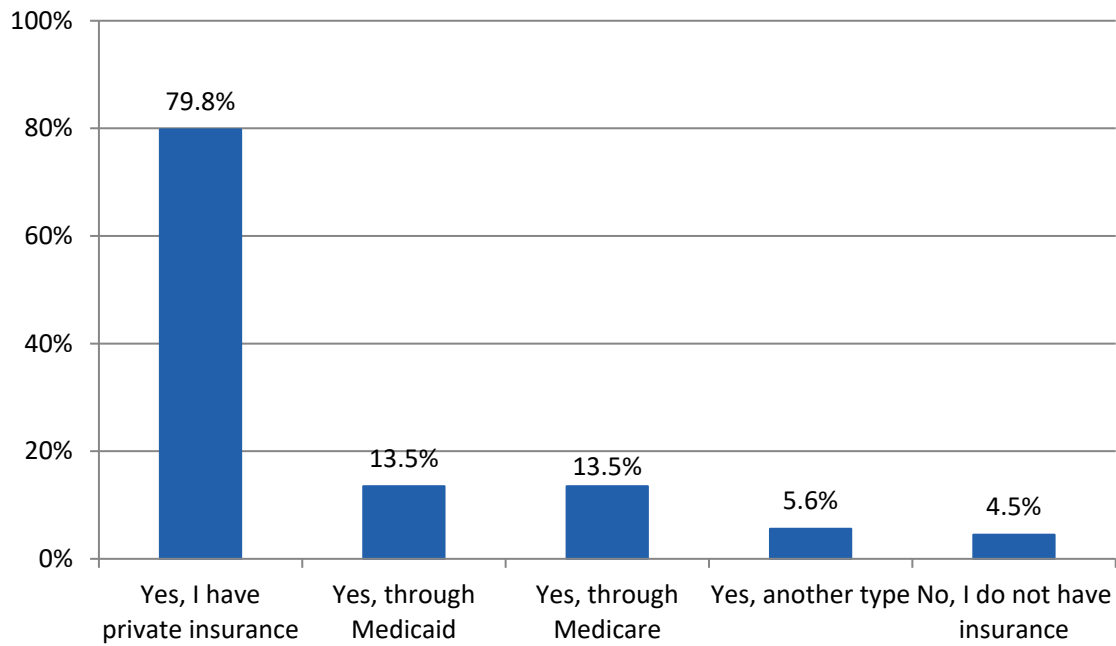
**Question 8:** Please rate each of the following statements about healthcare access in your community based on the scale below.



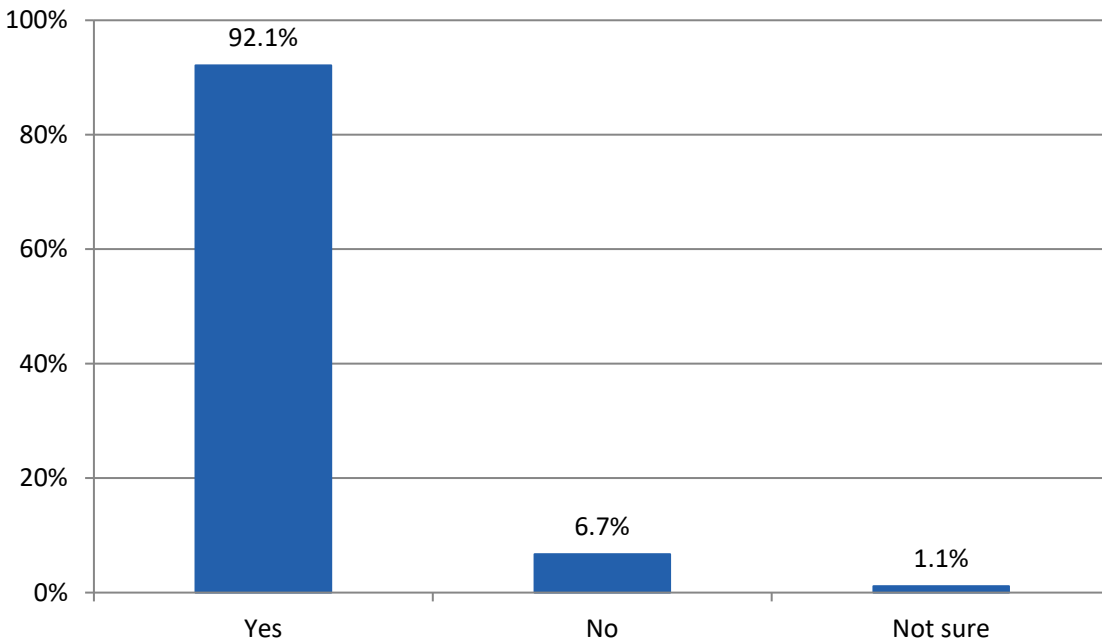
**Question 9:** Please indicate if you believe the barriers listed below are a major problem, moderate problem, minor problem, or not a problem that keep people in your community from accessing healthcare. (All responses)



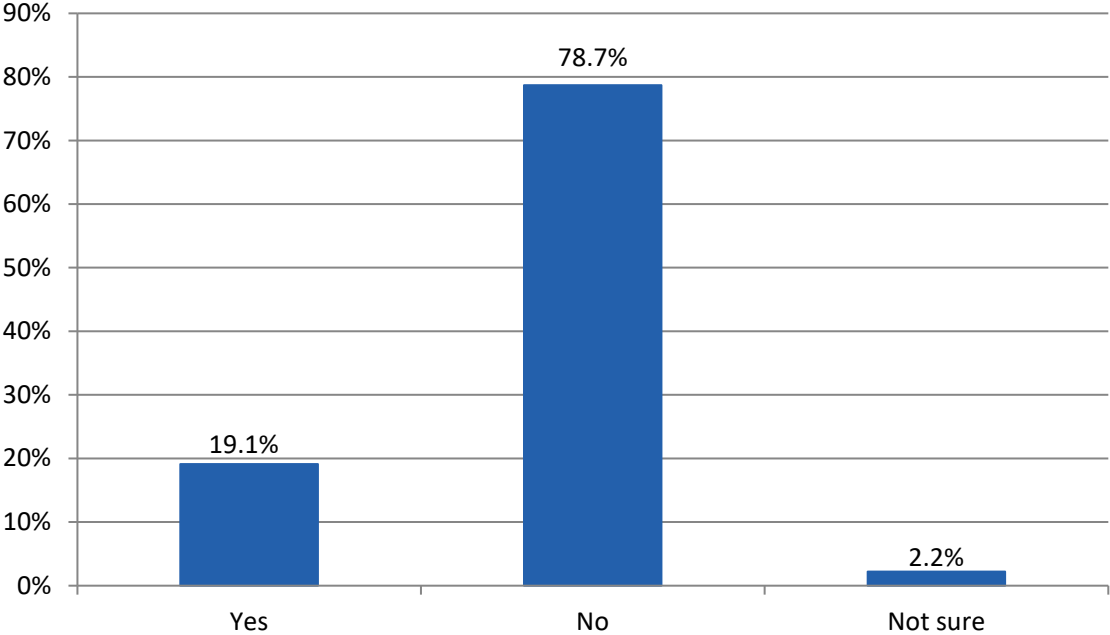
**Question 10:** Do you have health insurance? Please select all that apply. (N=89 responses; 84 English, 5 Spanish)



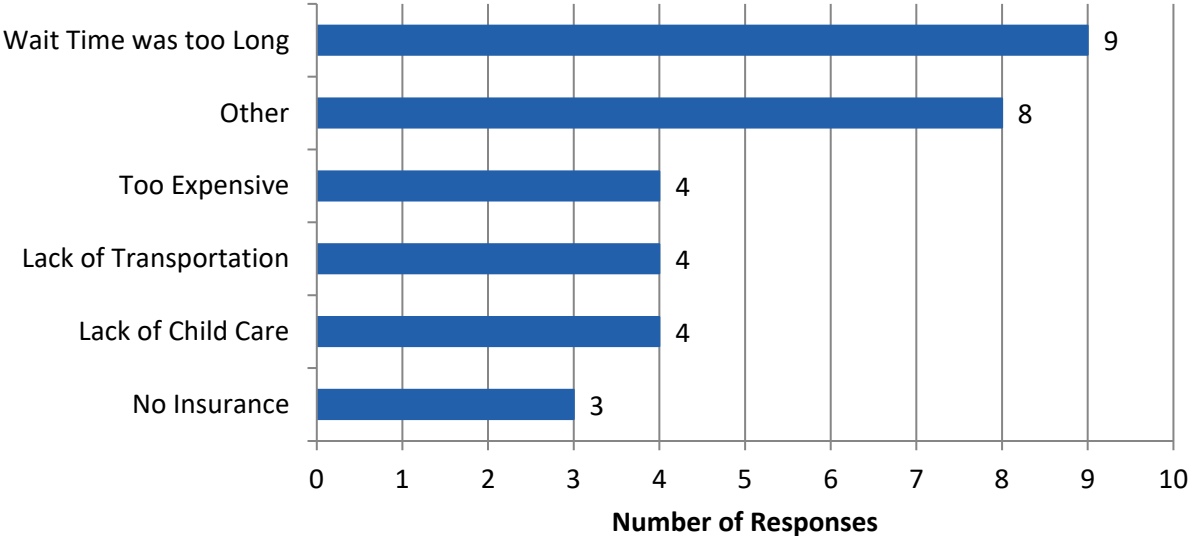
**Question 11:** Did you see a primary care doctor in the last year? A primary care doctor can be a family practice doctor, for example. (N=89 responses; 84 English, 5 Spanish)



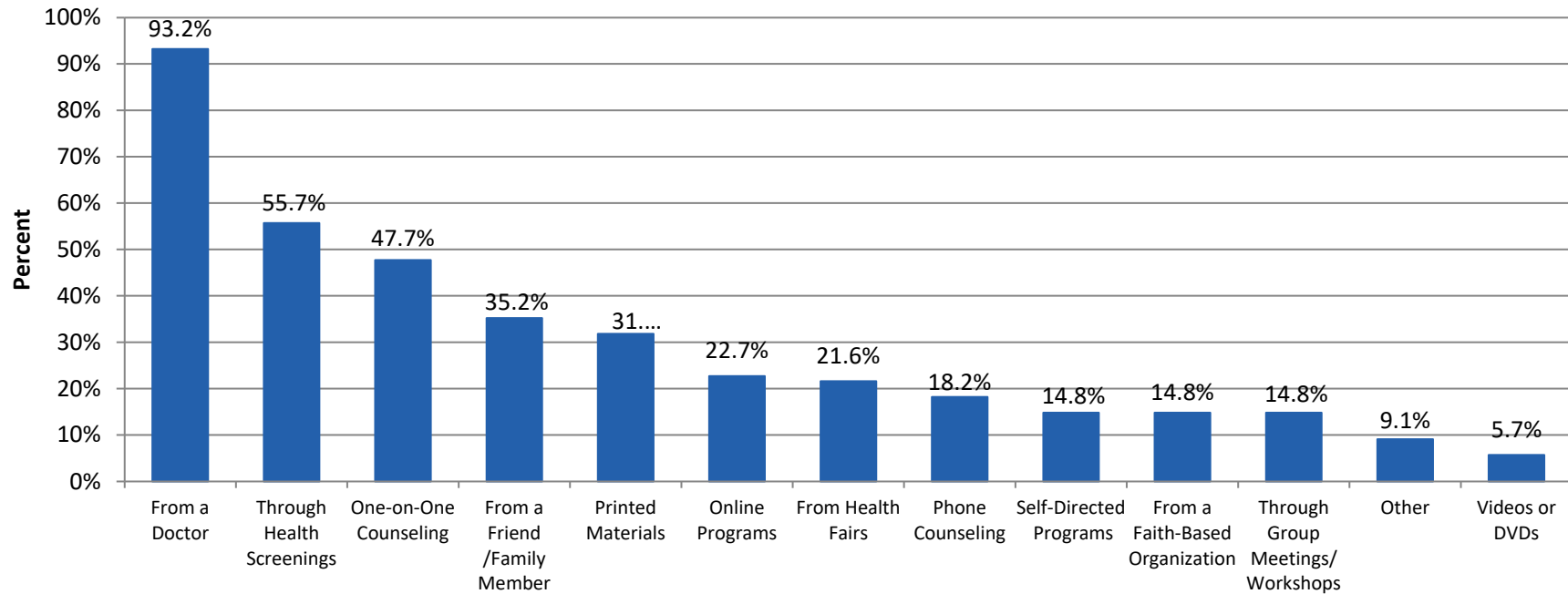
**Question 12:** Has there been a time in the past year when you needed medical care but were not able to get it? (N=89 responses; 84 English, 5 Spanish)



**Question 13:** If you answered that you were unable to receive medical care, what prevented you from getting the medical care you needed? Please select all that apply. (N=16 responses; 15 English, 1 Spanish)

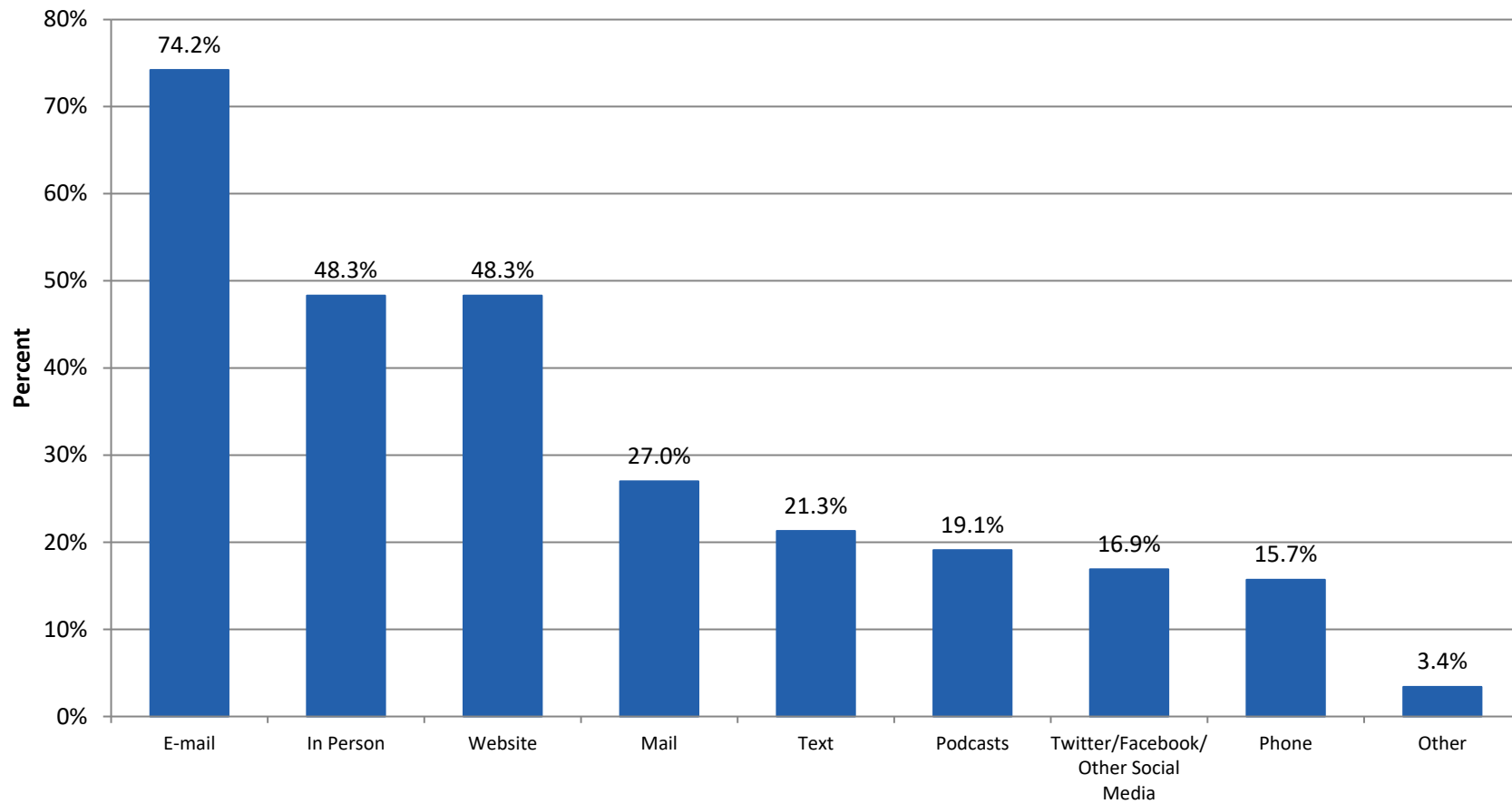


**Question 14:** What sources do you trust for health and lifestyle information? Please select all that apply. (N=88 responses; 83 English, 5 Spanish)



“**Other**” included: PubMed, a group of healthcare professionals, books, newspapers, scientific journal articles, WebMD, physical therapist, two responses noted issues with trust for communications from a doctor.

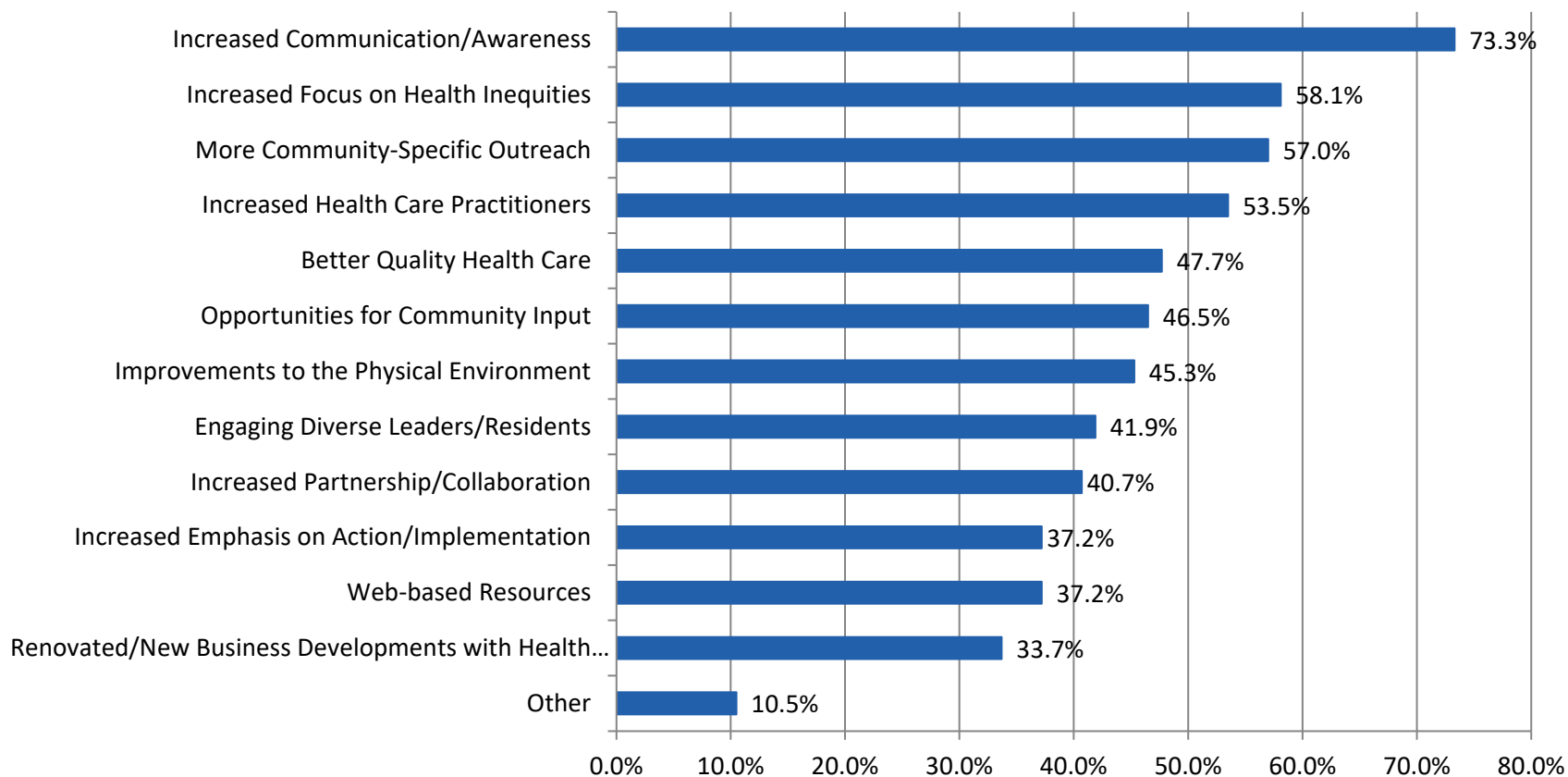
**Question 15:** How do you like to receive communication about health topics? Please select all that apply. (N=89 responses; 84 English, 5 Spanish)



“Other” included: reading, health experts on TV, and a website



**Question 16:** What do you believe could encourage and support your community’s health? Please select all that apply. (N=86 responses; 81 English, 5 Spanish)



“Other” included: transportation, more mental health services, use of patient feedback, community centers with free resources such as pools and senior and youth programs, free all day preschool for all as well as low cost and high quality childcare, innovative health food options and partnerships, helping residents to gain access to resources (affordable medical, dental, and mental health care services, translation and transportation services, clean and safe housing), food as medicine initiative, increased support and access to alternative and neuropathic health resources, incentivizing more restaurant and businesses and grocery stores with healthier food options to come to our communities, access to medical personnel, a system that’s not gamed (comment did not include what system this referenced).

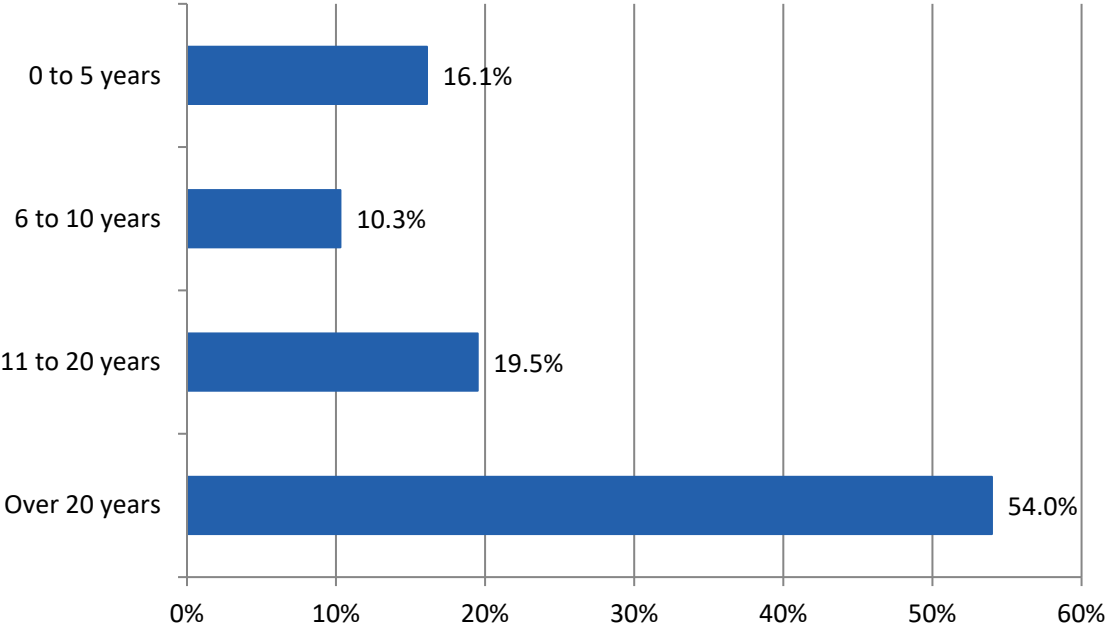


**Question 17:** If you could change one thing in your community, what would it be?

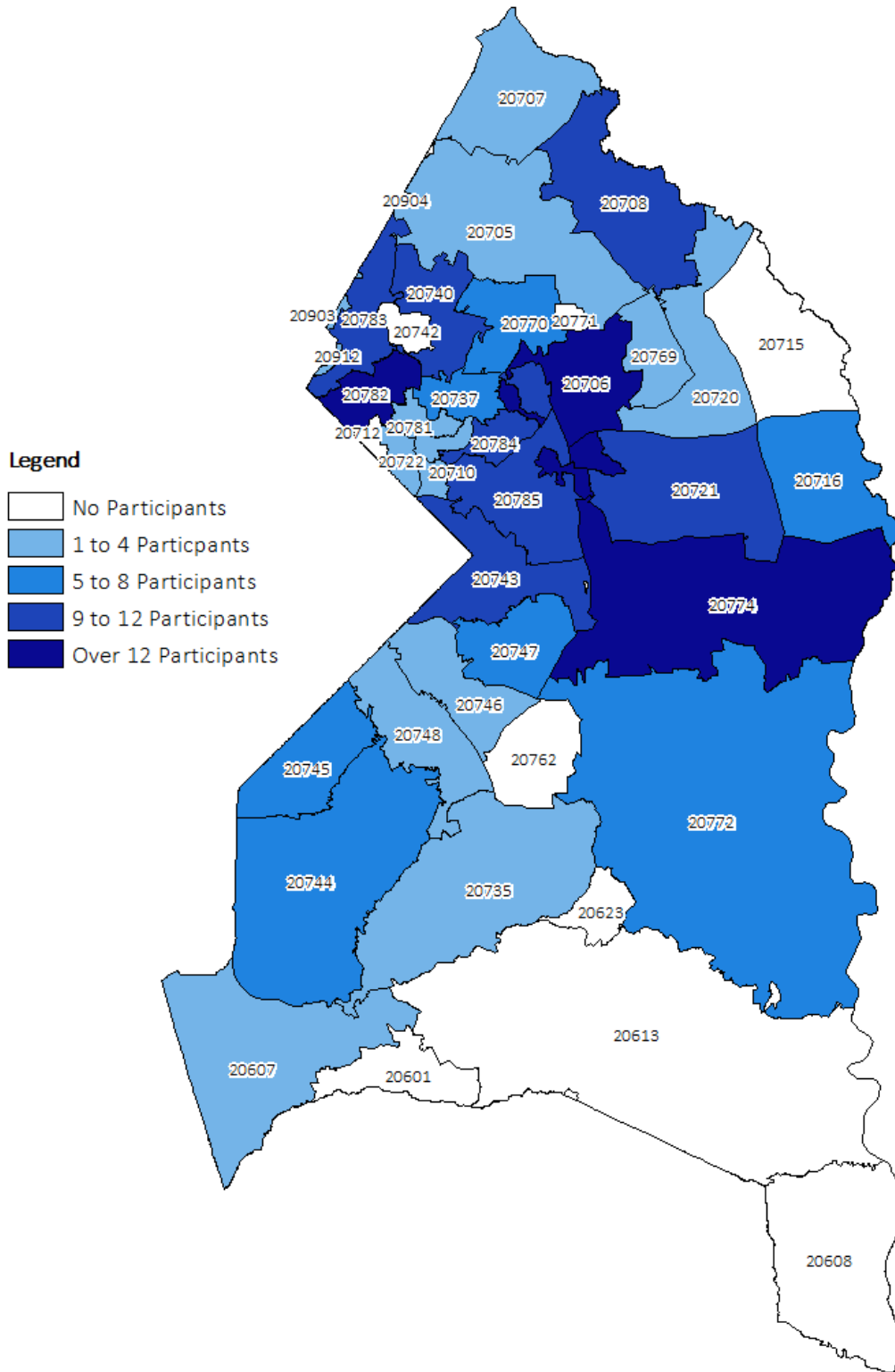
Issues mentioned	Number of Responses	Summary of Responses
Addressing the Social Determinants of Health	15	Improve affordability – lower costs of living and affordable housing, better schools and educational attainment outcomes, insurance coverage for all, reduce inequity to basic needs like food, housing, healthcare, allow accessory housing
Cleaner Neighborhoods and Environments	15	More parks, trails, and green spaces, more lighting in developments, reduce the number of roads and cars, reduce trash in communities
Community Engagement and Education	8	More community organizing, including increased community events and meetings to allow for more input, more health programs and screenings for those communities, more sporting activities for youth, 24-hour youth focused facility
Increased Safety	8	Decrease the crime rate and focus on citizen security, alleviate traffic congestion, slower, safer driving, more community friendly policing
Better Access to and Quality of Providers	8	More providers in the community, beyond urgent care, no limitations to services provided, more bilingual staff and professionals, more medical information provided to communities, more up to date hospitals and services, mobile dentists and medical vans, more affordable prescriptions
Better Access to Healthy Foods	6	Closer grocery stores with more/better options, fewer fast-food outlets in communities, healthier food options and eating places
Transportation and Infrastructure	5	More transportation options, safer transportation, better roads, more walkability and sidewalks, better public transit
Senior Population Considerations	2	More services for seniors (e.g., independent living and group housing, countywide programs)
Decreased Drug Use	1	Fewer drugs in the community



**Question 18:** How long have you lived in Prince George’s County? (N=87 responses; 82 English, 5 Spanish)



**Question 19:** What is the ZIP code where you live? (N=85 responses; 80 English, 5 Spanish)



## Participant Profile

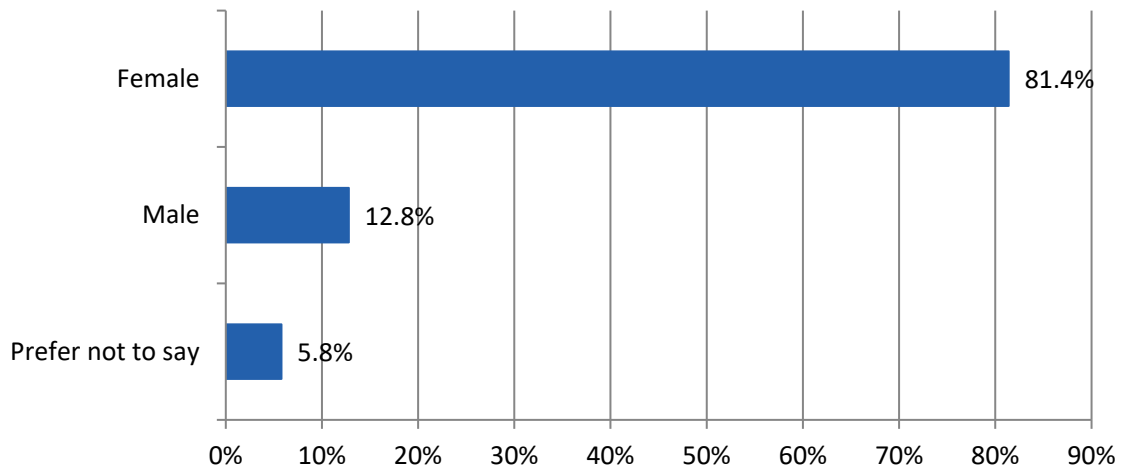
**Question 20:** What is the name of your neighborhood? (N=73 responses; 68 English, 5 Spanish)

Community	All Participants
Adelphi	1
Adnell Woods	1
Allure Apollo	1
Andrews Estate	1
Barclay Square	1
Beltsville	1
Bladensburg	1
Bowie	4
Brentwood	1
Calverton	1
Cameron Grove	1
Capitol Heights	4
Cherry Glen Condos	1
Cherry View Park	1
Chillum	2
College Park	3
Collington Station	2
Colony Square	1
Coral Hills	1
District Heights	3
Dower House	1
Ementor Ave	1
Fairwood	1
Franklin Park	1
Glassmanor	1
Greenbelt	3
Greenbriar	1
Hyattsville	1
Kentland	1
Kingsford	1
Kirby Woods	1
Lake Arbor	2
Landover	1
Lanham	1
Largo	1
Laurel	2
Marlboro West	1
New Carrollton	3
North Tantallon	1

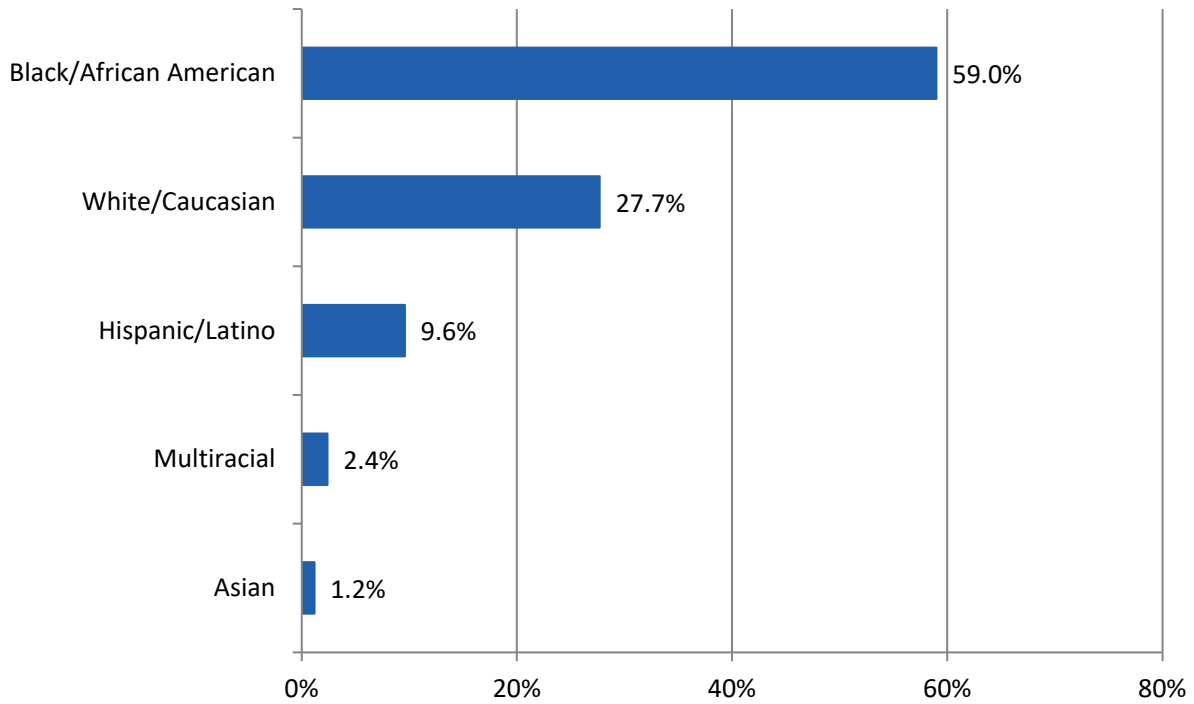


Community	All Participants
Overbrook	1
Oxon Knolls	1
Perrywood	1
Riverdale	1
University Park	8
Unknown	1
Upper Marlboro	1
Village of Morgan Metro	1
Woodland Hills	1

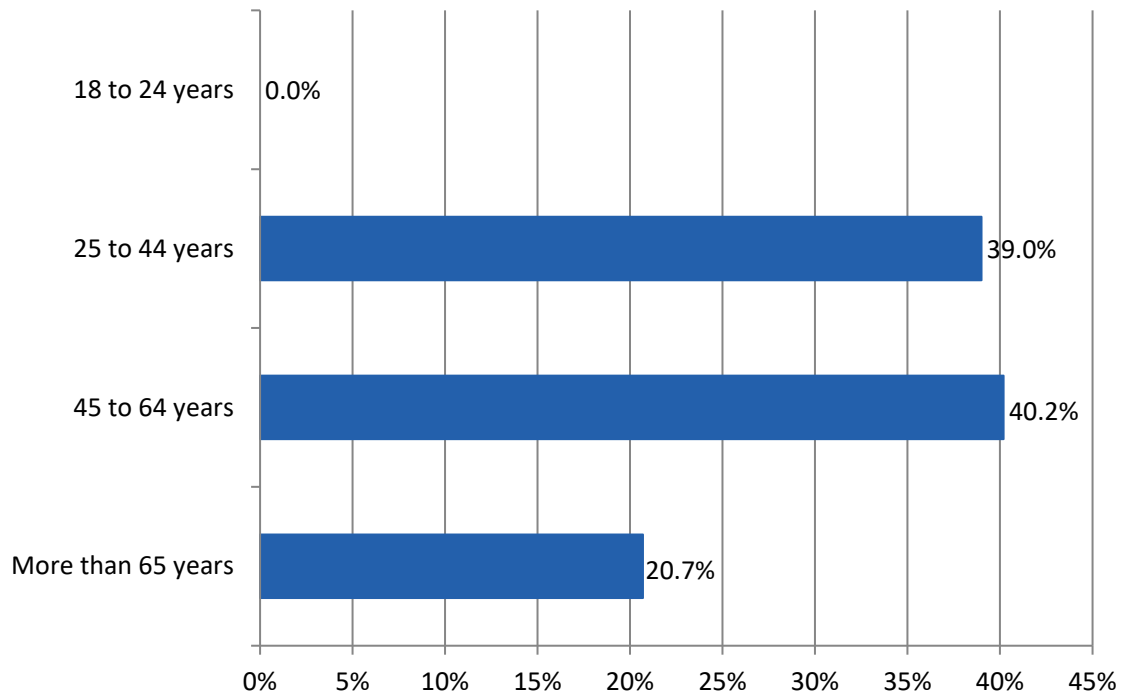
**Question 21:** What is your gender? (N= 86 responses; 81 English, 5 Spanish)



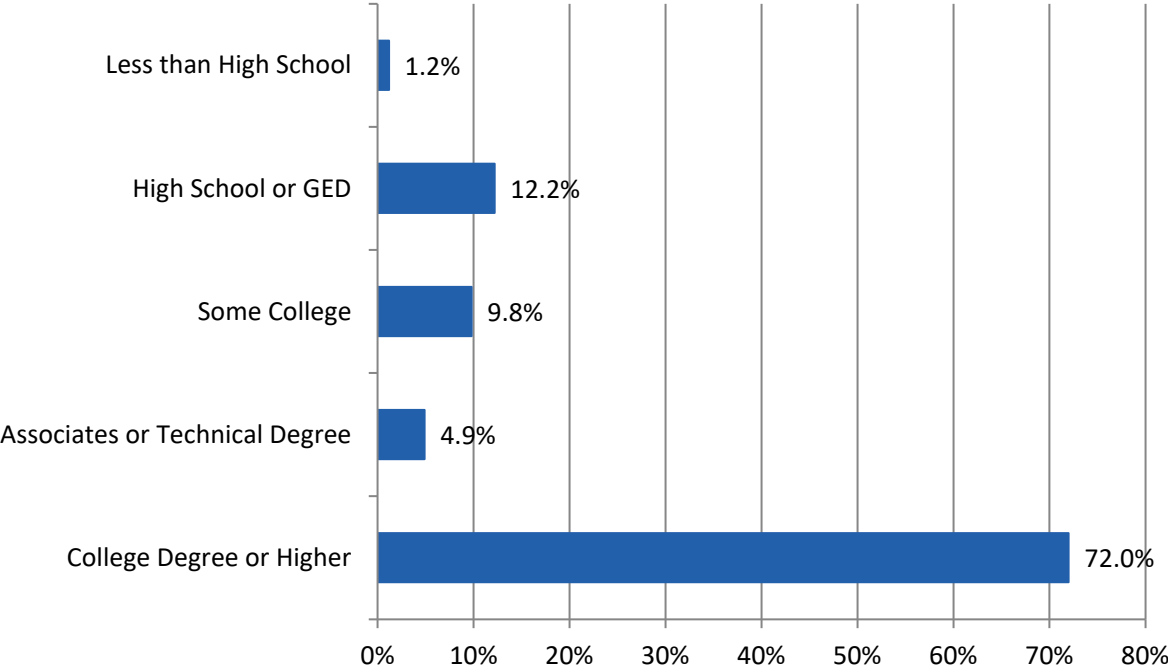
**Question 22:** What race/ethnicity best identifies you? (N=83 responses; 78 English, 5 Spanish)



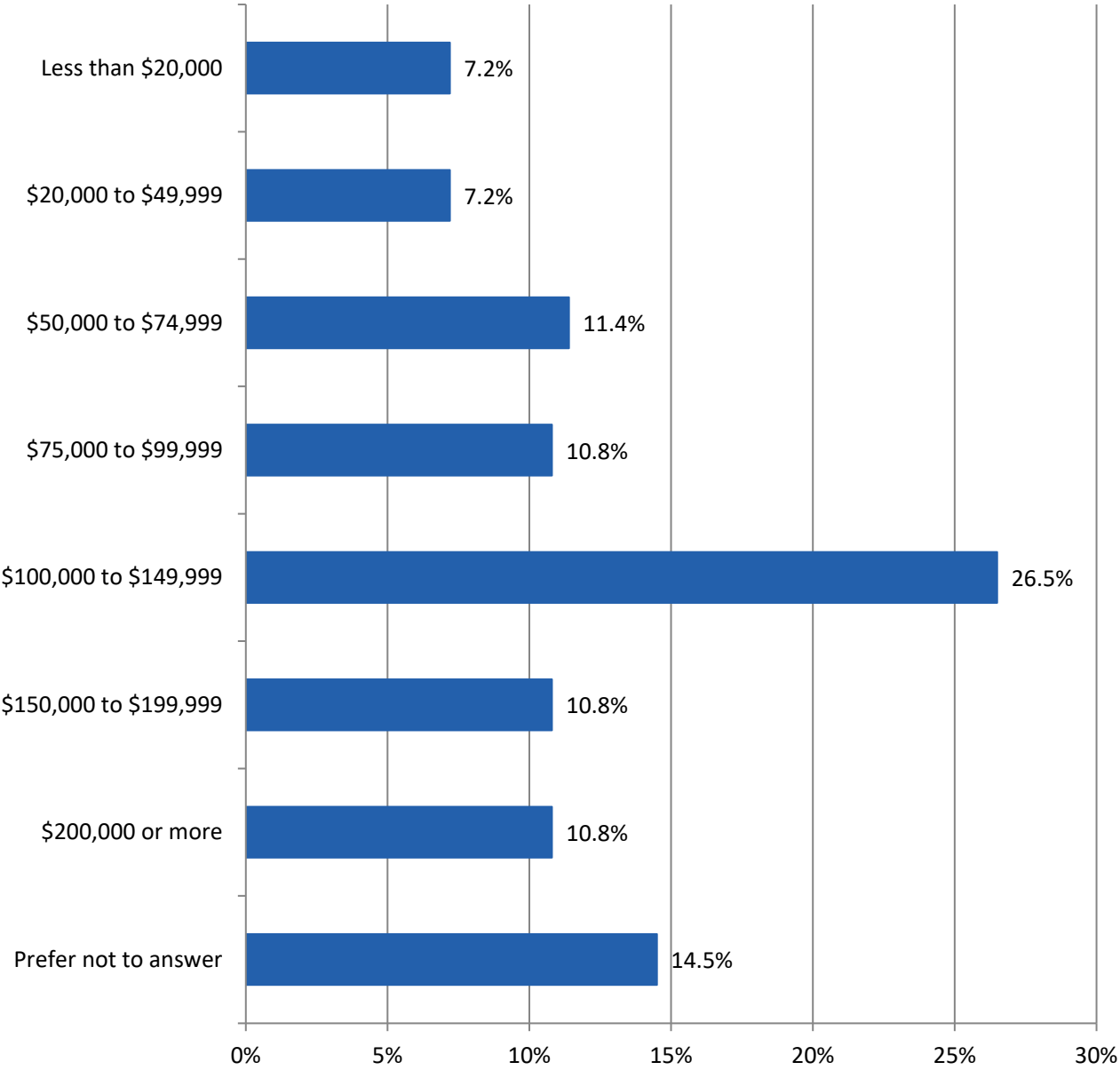
**Question 23:** How old are you? (N=82 responses; 77 English, 5 Spanish)



**Question 24:** What is the highest level of education you completed? (N=82 responses; 77 English, 5 Spanish)



**Question 25:** What is your annual household income? (N=83 responses; 78 English, 5 Spanish)



**Question 26:** In what country were you born? (N=81 responses; 76 English, 5 Spanish)

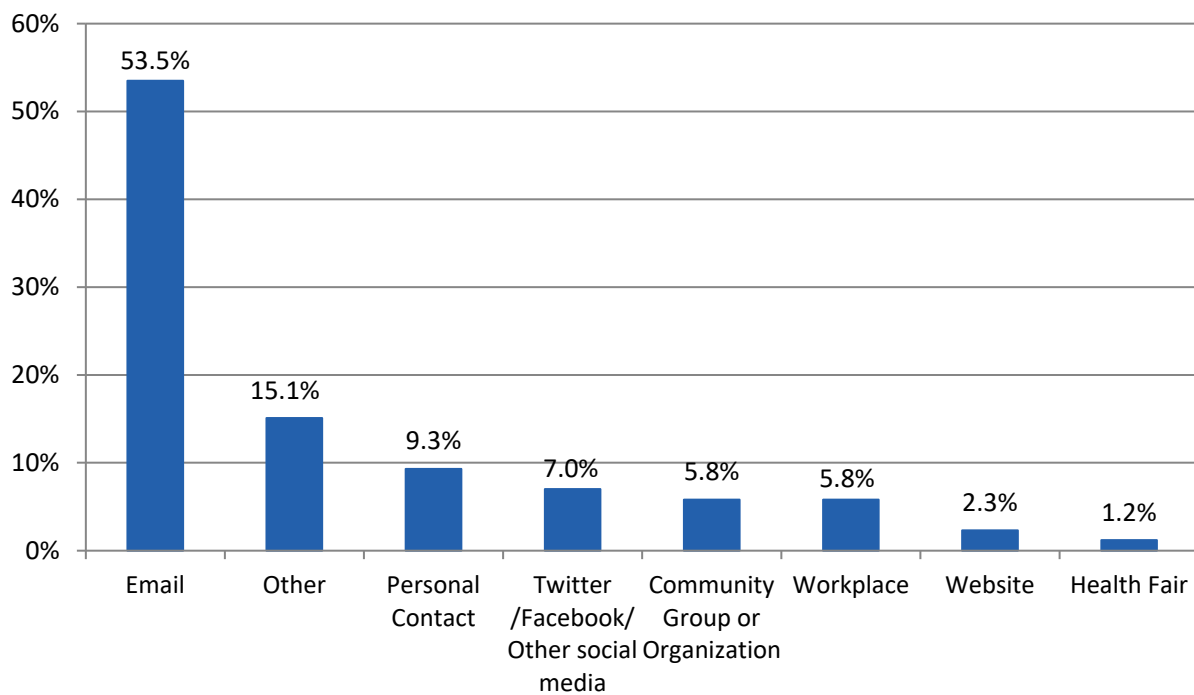
<b>Community</b>	<b>All Participants</b>
Dominican Republic	1
El Salvador	3
Germany	1
Ireland	1
Mexico	2
United States	73



**Question 27:** What language do you speak at home? (N=81 responses; 76 English, 5 Spanish)

Community	All Participants
English	74
English & Spanish	2
German	1
Spanish	4

**Question 28:** How did you receive this survey? (N=86 responses; 81 English, 5 Spanish)



For personal contact participants mentioned specific locations in the “Other” free-text field: library, DFS, child’s school, school email, text message



**Adventist HealthCare Fort Washington  
Medical Center Community Health  
Needs Assessment: *Implementation  
Strategy 2023-2025***

*Adopted on April 10, 2023.*



***Adventist HealthCare Fort Washington Medical Center completed a comprehensive Community Health Needs Assessment (CHNA) process in collaboration with the Prince George's County Health Department and county hospitals.***

***Complete CHNA reports are available online at:***

***<https://www.adventisthealthcare.com/about/community/health-needs-assessment/>***

# Introduction

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

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

There are four hospitals located within the County: Adventist HealthCare Fort Washington Medical Center, Luminis Health Doctors Community Hospital, MedStar Southern Maryland Hospital Center, and University of Maryland Capital Region



## CHNA CORE TEAM:

- Adventist HealthCare Fort Washington Medical Center
- Luminis Health Doctors Community Hospital
- MedStar Southern Maryland Hospital Center
- Prince George’s County Health Department
- University of Maryland Capital Region Health

Medical Center with two freestanding emergency facilities in Laurel and Bowie. All four hospital systems and the Health Department appointed staff to facilitate the 2022 CHNA process.

# Organizational Overview

## About Us

Adventist HealthCare, based in Gaithersburg, Md., is a faith-based, not-for-profit organization of dedicated professionals who work together each day to improve the health and well-being of people and communities through a ministry of physical, mental and spiritual healing.

Founded in 1907, Adventist HealthCare is the first, largest and only health system headquartered in Montgomery County, Maryland and operates:

- Three nationally accredited acute-care hospitals:
  - *Adventist HealthCare Fort Washington Medical Center*
  - *Adventist HealthCare Shady Grove Medical Center*
  - *Adventist HealthCare White Oak Medical Center*
- A nationally accredited rehabilitation hospital
  - *Adventist HealthCare Rehabilitation Hospital*
- Mental health services
- Home health agencies
- Physician networks
- Urgent Care Centers
- Imaging Centers

## Mission & Values

### Our Mission

We extend God's care through the ministry of physical, mental and spiritual healing.

### Our Values

Adventist HealthCare has identified five core values that we use as a guide in carrying out our day-to-day activities:

1. **Respect:** We recognize the infinite worth of each individual.
2. **Integrity:** We are conscientious and trustworthy in everything we do.
3. **Service:** We care for our patients, their families and each other with compassion.
4. **Excellence:** We do our best every day to exceed expectations.
5. **Stewardship:** We take ownership to efficiently and effectively extend God's care.

## Our Hospital

### Fort Washington Medical Center

In the late 1970s, residents in Fort Washington explored the idea of establishing a hospital in the area. Their dream was partially realized when the Fort Washington Ambulatory Care Center opened in 1983 as a 16-hour emergency treatment facility with outpatient surgery.

The Center was expanded in 1991 creating what is now Fort Washington Medical Center - an acute care hospital, admitting patients 24 hours a day.

In October 2019, Fort Washington Medical Center became part of the Adventist HealthCare system and was renamed Adventist HealthCare Fort Washington Medical Center.

Today, the hospital provides general inpatient services including adult medical and surgical care, ambulatory surgical services, laboratory, radiology and diagnostic services, as well as bariatric, cardiovascular, gastrointestinal, orthopedic, rehabilitation, and respiratory therapy. In addition, Fort Washington operates one of the busiest emergency rooms in the metropolitan area, seeing more than 40,000 patients each year, and has just over 400 employees.

Adventist HealthCare is excited to open the Adventist HealthCare Surgery Center at National Harbor in 2023. Specialty services including podiatry, ophthalmology, urology and more will be offered at this location. This expansion aligns with our strategy to provide quality compassionate care throughout the metropolitan area.

This health destination will serve as a link between nearby Adventist HealthCare Fort Washington Medical Center and its new primary care facility, located just minutes away from the hospital. Together, the facilities will provide the critical services that are essential to meeting the healthcare needs of the community.

## Communities Served

Fort Washington Medical Center serves patients in the Fort Washington, Oxon Hill, Accokeek, and Temple Hills areas, as well as parts of southeast Washington, DC.

As a community-based hospital, health professionals at Fort Washington engage monthly in activities and services including free health screenings, educational workshops, and health fairs. They also offer an Infectious Diseases Program that provides free HIV and Hepatitis C testing and education.

# Process Overview

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

**“A community focused on health and wellness for all.”**

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

✓ **Collaboration**      ✓ **Equity**      ✓ **Trust**      ✓ **Safety**      ✓ **Prevention**

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

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

- A community resident survey available in English, Spanish, and French distributed by the hospitals and Health Department.
- Secondary data analyses that included the County demographics and population description through socioeconomic indicators, and a comprehensive health indicator profile.
- Hospital Service Profiles to detail the residents served by the Core Team.
- A community expert survey and key informant interviews; and
- A prioritization process that included the Core Team and Prince George’s Healthcare Action Coalition leadership.

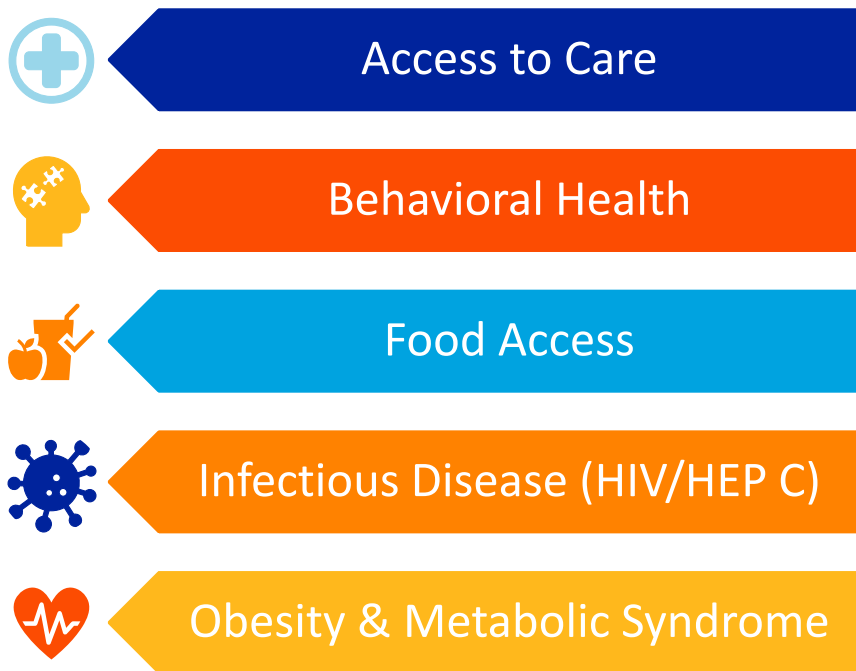
While the Core Team led the data gathering process, there was recognition that health is a shared responsibility. The community data collection strategies and the prioritization process were intentionally developed with this consideration and set the foundation for coordination moving forward.

Due to the pandemic, the Core Team determined to maintain the same priorities from 2019 since they are still relevant and much of the planned work from 2019 had to be suspended. The 2023-2025 priorities will continue to be:

- Social Determinants of Health
- Behavioral health
- Obesity and Metabolic Syndrome
- Cancer

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

After several planning sessions with hospital leadership, Adventist HealthCare Fort Washington Medical Center will focus specifically on the following five areas:



## Action Plan 2023-2025

The following table outlines the major activities Adventist HealthCare Fort Washington Medical Center is implementing to address the unmet needs identified through the collaborative Community Health Needs Assessment. The objectives listed for each priority area derived from Healthy People 2030. The Implementation Strategy should be considered a living plan that is updated and evaluated, at a minimum, each year or as emerging needs arise.

**FWMC Implementation Plan 2023-2025**

**Priority 1: Access To Care**

CHNA Impact						2022 CHNA Baseline	Target	Actual
Reduce the number of people who can't afford to see a doctor						MD: 7.5%	3.3%	MD: 7.5%
Increase the proportion of people with a usual primary care provider						PGC: 78.9%	84.0%	PGC: 78.9%
Program Name	Program Goal	Timeframe			Metrics/Population	Existing and Potential Partners	Status <i>(This information will be updated at the end of every year)</i>	
		Year 1	Year 2	Year 3				
Diabetes Primary Care Clinic	Increase access to Diabetes complication prevention services and self-management resources.	✓			<b>Metrics:</b> <ul style="list-style-type: none"> <li># of educational sessions provided in the community</li> <li>% of diabetic patients referred to the diabetes-related Cardiovascular Clinic</li> <li>% of diabetic patients seen at the diabetes-related Cardiovascular Clinic</li> <li># of diabetic patients seen at the diabetes-related Cardiovascular Clinic</li> <li>% of patients with poor control</li> </ul>	• Adventist Medical Group (AMG)	Year 1:	
					<b>Focus Population:</b> National Harbor & surrounding Ft. Washington service area		Year 2:	
							Year 3:	
Medication Assistance Program	To provide medication assistance for low-income patients with chronic illnesses to improve medication compliance and overall health.	✓			<b>Metrics:</b> <ul style="list-style-type: none"> <li># of participants</li> </ul>	• Allentown Discount Pharmacy	Year 1:	
					<b>Focus Population:</b> FWMC Service Area		Year 2:	
							Year 3:	

**FWMC Implementation Plan 2023-2025**  
**Priority 2: Food Access**

CHNA Impact						2022 CHNA Baseline	Target	Actual
Decrease percent of households that are food insecure						PGC: 7.3%	6.0%	PGC: 7.3%
Program Name	Program Goal	Timeframe			Metrics/Population	Existing and Potential Partners	Status <i>(This information will be updated at the end of every year)</i>	
		Year 1	Year 2	Year 3				
Feed the Fridge	Increase access to fresh meals in the Glassmanor Oxon Hill neighborhood while supporting locally owned restaurants.	✓			<b>Metrics:</b> • # of meals supplied through the grant	• Feed the Fridge	Year 1:	
					<b>Focus Population:</b> Oxon Hill neighborhood		Year 2:	
					Year 3:			

**FWMC Implementation Plan 2023-2025**

**Priority 3: Infectious Diseases**

**Overarching Goal:**

CHNA Impact	2022 CHNA Baseline	Target	Actual
Reduce the number of new HIV infections	N/A	3,000	N/A
Reduce the number of new HIV diagnoses	29 per 100,000	3835	N/A

Program Name	Program Goal	Timeframe			Metrics/Population	Existing and Potential Partners	Status <i>(This information will be updated at the end of every year)</i>
		Year 1	Year 2	Year 3			
HIV/HEP C Screening Program	Improve the care of individuals living with HIV and Hepatitis C Virus by providing a private, safe, and effective means of testing.	✓			<b>Metrics:</b> <ul style="list-style-type: none"> <li>• Every ED person offered HIV screening</li> <li>• Complete 2500 HIV screenings and 2500 Hep C screenings yearly</li> <li>• % of patients who tested positive that receive education</li> <li>• % of patents who tested positive that are linked to care</li> </ul> <b>Focus Population:</b> FWMC service area	<ul style="list-style-type: none"> <li>• Gilead</li> <li>• Prince George's County Health Department</li> <li>• Dr. Iman Choudhoury (?)</li> <li>• Heart to Hand</li> </ul>	<b>Year 1:</b>
							<b>Year 2:</b>
							<b>Year 3:</b>

**FWMC Implementation Plan 2023-2025**

**Priority 4: Behavioral Health**

CHNA Impact					2022 CHNA Baseline	Target	Actual
Decrease mental health related ER visits					PGC: 1,955.6	3,152	PGC: 1,955.6
Program Name	Program Goal	Timeframe			Metrics/Population	Existing and Potential Partners	Status <i>(This information will be updated at the end of every year)</i>
		Year 1	Year 2	Year 3			
Reverse the Cycle	Decrease the number of drug and alcohol abuse in the community by screening everyone patient that comes into the ED for drug and alcohol abuse and connect the patient to treatment.	✓			<b>Metrics:</b> <ul style="list-style-type: none"> <li>• % of patients coming through ED are screened (75%)</li> <li>• % who received interventions (60%)</li> <li>• % referred to TX (15%)</li> <li>• % linkage to treatment (50%)</li> </ul>	• MOSAIQ	Year 1:
					<b>Focus Population:</b> FWMC service area		Year 2:
					Year 3:		

**FWMC Implementation Plan 2023-2025**

**Priority 5: Obesity**

CHNA Impact					2022 CHNA Baseline	Target	Actual
Reduce the proportion of adults aged 20 and older who are obese					TBD	TBD	TBD
Reduce the proportion of children and adolescents who are obese or overweight					PGC: 35.5%	15.5%	PGC: 35.5%
Program Name	Program Goal	Timeframe			Metrics/Population	Existing and Potential Partners	Status <i>(This information will be updated at the end of every year)</i>
		Year 1	Year 2	Year 3			
Bariatric Service Line	Provide needed bariatric services in the community which otherwise would not be available. This includes evaluation, treatment, and management of obesity-related health conditions (diabetes, hypertension, and sleep apnea), as well as the provision of surgical and non-surgical weight loss options.	✓			<b>Metrics:</b> <ul style="list-style-type: none"> <li># of targeted bariatric screening events</li> <li># of referrals from community doctors</li> <li># of patients/encounters per condition</li> <li># of gastrectomy sleeve laparoscopic procedures</li> </ul>	<ul style="list-style-type: none"> <li>Adventist HealthCare Medical Group (AMG)</li> </ul>	Year 1:
					<b>Focus Population:</b> FWMC service area		Year 2:
							Year 3:
Community Outreach and Screening Events (farmers market and other community events)	Promote health through screenings, education, and building awareness and connections to local resources	✓			<b>Metrics:</b> <ul style="list-style-type: none"> <li># of events attended</li> <li># of blood pressure readings</li> <li># of education encounters</li> <li>% of elevated BP readings that were referred to care</li> </ul>	<ul style="list-style-type: none"> <li>Fort Washington Forward</li> </ul>	Year 1:
					<b>Focus Population:</b> FWMC Service Area		Year 2:
							Year 3:
Target BP		✓			<b>Metrics:</b> TBD	<ul style="list-style-type: none"> <li></li> </ul>	Year 1:
					<b>Focus Population:</b> FWMC Service Area		Year 2:
							Year 3:

# ADVENTIST HEALTH CARE, INC.

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### Financial Assistance (Formerly “Charity Care”)

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## FINANCIAL ASSISTANCE POLICY SUMMARY

### SCOPE:

This policy applies to the following Adventist HealthCare facilities: Shady Grove Medical Center, Germantown Emergency Center, White Oak Medical Center, Adventist Rehabilitation Hospital of Maryland, and Fort Washington Medical Center collectively referred to as AHC.

### PURPOSE:

In keeping with AHC’s mission to demonstrate God’s care by improving the health of people and communities Adventist HealthCare provides financial assistance to low to mid income patients in need of our services. AHC’s Financial Assistance Plan provides a systematic and equitable way to ensure that patients who are uninsured, underinsured, have experienced a catastrophic event, and/or and lack adequate resources to pay for services can access the medical care they need.

Adventist HealthCare provides emergency and other non-elective medically necessary care to individual patients without discrimination regardless of their ability to pay, ability to qualify for financial assistance, or the availability of third-party coverage. In the event that third-party coverage is not available, a determination of potential eligibility for Financial Assistance will be initiated prior to, or at the time of admission. This policy identifies those circumstances when AHC may provide care without charge or at a discount based on the financial need of the individual.

Printed public notification regarding the program will be made annually in Montgomery County, Maryland and Prince George’s County, Maryland newspapers and will be posted in the Emergency Departments, the Business Offices and Registration areas of the above named facilities.

This policy has been adopted by the governing body of AHC in accordance with the regulations and requirements of the State of Maryland and with the regulations under Section 501(r) of the Internal Revenue Code.

This financial assistance policy provides guidelines for:

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- prompt-pay discounts (%) that may be charged to self-pay patients who receive medically necessary services that are not considered emergent or non-elective.
- special consideration, where appropriate, for those individuals who might gain special consideration due to catastrophic care.

#### **BENEFITS:**

Enhance community service by providing quality medical services regardless of a patient’s (or their guarantors’) ability to pay. Decrease the unnecessary or inappropriate placement of accounts with collection agencies when a charity care designation is more appropriate.

#### **DEFINITIONS:**

- **Medically Necessary:** health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine
- **Emergency Medical Services:** treatment of individuals in crisis health situations that may be life threatening with or without treatment
- **Non-elective services:** a medical condition that without immediate attention:
  - o Places the health of the individual in serious jeopardy
  - o Causes serious impairment to bodily functions or serious dysfunction to a bodily organ.
  - o And may include, but are not limited to:
    - Emergency Department Outpatients
    - Emergency Department Admissions
    - IP/OP follow-up related to previous Emergency visit
- **Catastrophic Care:** a severe illness requiring prolonged hospitalization or recovery. Examples would include coma, cancer, leukemia, heart attack or stroke. These illnesses usually involve high costs for hospitals, doctors and medicines and may incapacitate the person from working, creating a financial hardship
- **Prompt Pay Discount:** The state of Maryland allows a 1% prompt-pay discount for those patients who pay for medical services at the time the service is rendered.

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- **FPL** (Federal Poverty Level): is the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services.
- **Uninsured Patient**: Person not enrolled in a healthcare service coverage insurance plan. May or may not be eligible for charitable care.
- **Self-pay Patient**: an Uninsured Patient who does not qualify for AHC Financial Assistance due to income falling above the covered FPL income guidelines

## POLICY

### 1. General Eligibility

- 1.1. All patients, regardless of race, creed, gender, age, sexual orientation, national origin or financial status, may apply for Financial Assistance.
- 1.2. It is part of Adventist HealthCare’s mission to provide necessary medical care to those who are unable to pay for that care. The Financial Assistance program provides for care to be either free or rendered at a reduced charge to:
  - 1.2.1. those most in need based upon the current Federal Poverty Level (FPL) assessment, (i.e., individuals who have income that is less than or equal to 200% of the federal poverty level (See current FPL).
  - 1.2.2. those in some need based upon the current FPL, (i.e., individuals who have income that is between 201% and 600% of the current FPL guidelines
  - 1.2.3. patients experiencing a financial hardship (medical debt incurred over the course of the previous 12 months that constitutes more than 25% of the family’s income), and/or
  - 1.2.4. absence of other available financial resources to pay for urgent or emergent medical care
- 1.3. This policy requires that a patient or their guarantor to cooperate with, and avail themselves of all available programs (including those offered by AHC, Medicaid, workers compensation, and other state and local programs) which

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might provide coverage for services, prior to final approval of Adventist HealthCare Financial Assistance.

- 1.4. **Eligibility for Emergency Medical Care:** Patients may be eligible for financial assistance for Emergency Medical Care under this Policy if:
  - 1.4.1. They are uninsured, have exhausted, or will exhaust all available insurance benefits; and
  - 1.4.2. Their annual family income does not exceed 200% of the current Federal Poverty Guidelines to qualify for full financial assistance or 600% of the current Federal Poverty Guidelines for partial financial assistance; and
  - 1.4.3. They apply for financial assistance within the Financial Assistance Application Period (i.e. within the period ending on the 240th day after the first post-discharge billing statement is provided to a patient).
- 1.5. **Eligibility for non-emergency Medically Necessary Care:** Patients may be eligible for financial assistance for non-emergency Medically Necessary Care under this Policy if:
  - 1.5.1. They are uninsured, have exhausted, or will exhaust all available insurance benefits; and
  - 1.5.2. Their annual family income does not exceed 200% of the current Federal Poverty Guidelines to qualify for full financial assistance or 600% of the current Federal Poverty Guidelines for partial financial assistance; and
  - 1.5.3. They apply for financial assistance within the Financial Assistance Application Period (i.e. within the period ending on the 240th day after the first post-discharge billing statement is provided to a patient) and
  - 1.5.4. The treatment plan was developed and provided by an AHC care team
- 1.6. **Considerations:**

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- 1.6.1. Insured Patients who incur high out of pocket expenses (deductibles, co-insurance, etc.) may be eligible for financial assistance applied to the patient payment liability portion of their medically necessary services
- 1.6.2. Pre-approved financial assistance for medical services scheduled past the 2nd midnight post an ER admission are reviewed by the appropriate staff based on medical necessity criteria established in this policy and may or may not be approved for financial assistance.
- 1.7. **Exclusions:** Patients are INELIGIBLE for financial assistance for Emergency Medical Care or other non-emergency Medically Necessary Care under this policy if:
  - 1.7.1. Purposely providing false or misleading information by the patient or responsible party; or
  - 1.7.2. Providing information gained through fraudulent methods in order to qualify for financial assistance (EXAMPLE: using misappropriated identification and/or financial information, etc.)
  - 1.7.3. The patient or responsible party refuses to cooperate with any of the terms of this Policy; or
  - 1.7.4. The patient or responsible party refuses to apply for government insurance programs after it is determined that the patient or responsible party is likely to be eligible for those programs; or
  - 1.7.5. The patient or responsible party refuses to adhere to their primary insurance requirements where applicable.
- 1.8. **Special Considerations (Presumptive Eligibility):** Adventist Healthcare makes available financial assistance to patients based upon their “assumed eligibility” if they meet one of the following criteria:
  - 1.8.1. Patients, unless otherwise eligible for Medicaid or CHIP, who receive benefits from a social security program as determined by the Department and the Commission, including but not limited to those listed below are eligible for

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free care, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below

- 1.8.1.1. Households with children in the free or reduced lunch program;
  - 1.8.1.2. Supplemental Nutritional Assistance Program (SNAP);
  - 1.8.1.3. Low-income-household energy assistance program;
  - 1.8.1.4. Women, Infants and Children (WIC)
- 1.8.2. Patients who are beneficiaries of the Montgomery County programs listed below are eligible for financial assistance after meeting the copay requirements mandated by the program, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below:
- 1.8.2.1. Montgomery Cares;
  - 1.8.2.2. Project Access;
  - 1.8.2.3. Care for Kids
- 1.8.3. Additionally, patients who fit one or more of the following criteria may be eligible for financial assistance for emergency or nonemergency Medically Necessary Care under this policy with or without a completed application, and regardless of financial ability. IF the patient is:
- 1.8.3.1. categorized as homeless or indigent
  - 1.8.3.2. unable to provide the necessary financial assistance eligibility information due to mental status or capacity
  - 1.8.3.3. unresponsive during care and is discharged due to expiration

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- 1.8.3.4. individual is eligible by the State to receive assistance under the Violent Crimes Victims Compensation Act or the Sexual Assault Victims Compensation Act;
- 1.8.3.5. a victim of a crime or abuse (other requirements will apply)
- 1.8.3.6. Elderly and a victim of abuse
- 1.8.3.7. an unaccompanied minor
- 1.8.3.8. is currently eligible for Medicaid, but was not at the date of service

For any individual presumed to be eligible for financial assistance in accordance with this policy, all actions described in the “Eligibility” Section and throughout this policy would apply as if the individual had submitted a completed Financial Assistance Application form and will be communicated to them within two business days of the request for assistance.

- 1.9. **Amount Generally Billed:** An individual who is eligible for assistance under this policy for emergency or other medically necessary care will never be charged more than the amounts generally billed (AGB) to an individual who is not eligible for assistance. The charges to which a discount will apply are set by the State of Maryland's rate regulation agency (HSCRC) and are the same for all payers (i.e. commercial insurers, Medicare, Medicaid or self-pay) with the exception of Adventist Rehabilitation Hospital of Maryland which charges for patients eligible for assistance under this policy will be set at the most recent Maryland Medicaid interim rate at the time of service as set by the Department of Health and Mental Hygiene.
- 2. **Policy Transparency:** Financial Assistance Policies are transparent and available to the individuals served at any point in the care continuum in the primary languages that are appropriate for the Adventist HealthCare service area.
  - 2.1. As a standard process, Adventist HealthCare will provide Plain Language Summaries of the Financial Assistance Policy
    - 2.1.1. During ED registration

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- 2.1.2. During financial counseling sessions
- 2.1.3. Upon request
- 2.2. Adventist HealthCare facilities will prominently and conspicuously post complete and current versions of the Plain Language Summary of the Financial Assistance policy
  - 2.2.1. At all registrations sites
  - 2.2.2. In specialty area waiting rooms
  - 2.2.3. In specialty area patient rooms
- 2.3. Adventist HealthCare facilities will prominently and conspicuously post complete and current versions of the following on their respective websites in English and in the primary languages that are appropriate for the Adventist HealthCare service area:
  - 2.3.1. Financial Assistance Policy (FAP)
  - 2.3.2. Financial Assistance Application Form (FAA Form)
  - 2.3.3. Plain Language Summary of the Financial Assistance Policy (PLS)

### 3. Policy Application and Determination Period

- 3.1. The Financial Assistance Policy applies to charges for medically necessary patient services that are rendered by one of the referenced Adventist HealthCare facilities. A patient (or guarantor) may apply for Financial Assistance at any time within **240 days after the date it is determined that the patient owes a balance.**
- 3.2. Probable eligibility will be communicated to the patient within 2 business days of the request for assistance
- 3.3. Each application for Financial Assistance will be reviewed, and a determination made based upon an assessment of the patient’s (or guarantor’s) ability to pay. This could include, without limitations the needs of the patient and/or guarantor, available income and/or other financial resources. Final Financial Assistance decisions and awards will be communicated to the patient

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within 10 business days of the submission of a completed application for Financial Assistance.

3.4. Pre-approved financial assistance for scheduled medical services is approved by the appropriate staff based on criteria established in this policy

3.5. **Policy Eligibility Period:** If a patient is approved for financial assistance under this Policy, their financial assistance under this policy **shall not exceed past 12 months from the date of the eligibility award letter**. Patients requiring financial assistance past this time must reapply and complete the application process in total.

4. **POLICY EXCLUSIONS:** Services not covered by the AHC Financial Assistance Policy include, but are not limited to:

4.1. Services deemed not medically necessary by AHC clinical team

4.2. Services not charged and billed by an Adventist HealthCare facility listed within this policy are not covered by this policy. Examples include, but are not limited to; charges from physicians, anesthesiologists, emergency department physicians, radiologists, cardiologists, pathologists, and consulting physicians requested by the admitting and attending physicians.

4.3. Cosmetic, other elective procedures, convenience and/or other Adventist HealthCare facility services which are not medically necessary, are excluded from consideration as a free or discounted service.

4.4. Patients or their guarantors who are eligible for County, State, Federal or other assistance programs will not be eligible for Financial Assistance for services covered under those programs.

4.5. Services Rendered by Physicians who provide services at one of the AHC locations are NOT covered under this policy.

4.5.1. Physician charges are billed **separately** from hospital charges. **Roles**

**and Responsibilities**

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#### 4.6. Adventist HealthCare responsibilities

- 4.6.1. AHC has a financial assistance policy to evaluate and determine an individual’s eligibility for financial assistance.
- 4.6.2. AHC has a means of communicating the availability of financial assistance to all individuals in a manner that promotes full participation by the individual.
- 4.6.3. AHC workforce members in Patient Financial Services and Registration areas understand the AHC financial assistance policy and are able to direct questions regarding the policy to the proper hospital representatives.
- 4.6.4. AHC requires all contracts with third party agents who collect bills on behalf of AHC to include provisions that these agents will follow AHC financial assistance policies.
- 4.6.5. The AHC Revenue Cycle Function provides organizational oversight for the provision of financial assistance and the policies/processes that govern the financial assistance process.
- 4.6.6. After receiving the individual’s request for financial assistance, AHC notifies the individual of the eligibility determination within two business days
- 4.6.7. AHC provides options for payment arrangements.
- 4.6.8. AHC upholds and honors individuals’ right to appeal decisions and seek reconsideration.
- 4.6.9. AHC maintains (and requires billing contractors to maintain) documentation that supports the offer, application for, and provision of financial assistance for a minimum period of seven years.
- 4.6.10. AHC will periodically review and incorporate federal poverty guidelines for updates published by the United States Department of Health and Human Services.

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#### 4.7. Individual Patient’s Responsibilities

- 4.7.1. To be considered for a discount under the financial assistance policy, the individual must cooperate with AHC to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for healthcare, such as Medicare, Medicaid, third-party liability, etc.
- 4.7.2. To be considered for a discount under the financial assistance policy, the individual must provide AHC with financial and other information needed to determine eligibility (this includes completing the required application forms and cooperating fully with the information gathering and assessment process).
- 4.7.3. An individual who qualifies for a partial discount must cooperate with the hospital to establish a reasonable payment plan.
- 4.7.4. An individual who qualifies for partial discounts must make good faith efforts to honor the payment plans for their discounted hospital bills. The individual is responsible to promptly notify AHC of any change in financial situation so that the impact of this change may be evaluated against financial assistance policies governing the provision of financial assistance.

#### 5. Identification Of Potentially Eligible Individuals

- 5.1. Identification through socialization and outreach
  - 5.1.1. Registration and pre-registration processes promote identification of individuals in need of financial assistance.
  - 5.1.2. Financial counselors will make best efforts to contact all self-pay inpatients during the course of their stay or within 4 days of discharge.
  - 5.1.3. The AHC hospital facility’s PLS will be distributed along with the FAA Form to every individual before discharge from the hospital facility.
  - 5.1.4. Information on how to obtain a copy of the PLS will be included with billing statements that are sent to the individuals

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5.1.5. An individual will be informed about the AHC hospital facility’s FAP in oral communications regarding the amount due for his or her care.

5.1.6. The individual will be provided with at least one written notice (notice of actions that may be taken) that informs the individual that the hospital may take action to report adverse information about the individual to consumer credit reporting agencies/credit bureaus if the individual does not submit a FAA Form or pay the amount due by a specified deadline. This deadline cannot be earlier than 120 days after the first billing statement is sent to the individual. The notice must be provided to the individual at least 30 days before the deadline specified in the notice.

5.2. **Requests for Financial Assistance:** Requests for financial assistance may be received from multiple sources (including the patient, a family member, a community organization, a church, a collection agency, caregiver, Administration, etc.).

5.2.1. Requests received from third parties will be directed to a financial counselor.

5.2.2. The financial counselor will work with the third party to provide resources available to assist the individual in the application process.

5.2.3. If available, an estimated charges letter will be provided to individuals who request it.

5.2.4. **AUTOMATED CHARITY PROCESS** for Accounts sent to outsourced agencies: Adventist HealthCare recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional financial assistance application process. If the required information is not provided by the patient, Adventist HealthCare may employ an automated, predictive scoring tool to qualify patients for financial assistance. The Payment Predictability Score (PPS) predicts the likelihood of a patient to qualify for Financial Assistance based on publicly available data sources. PPS provides an estimate of the patient’s likely socio-economic standing, as well as, the patient’s

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Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13, 2/01/16, 11/09/17, 08/26/19, 12/20	Page: 13 of 14

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household income size. Approval used with PPS applies only to accounts being reviewed by Patient Financial Services. All other dates of services for the same patient or guarantor will follow the standard Adventist HealthCare collection process.

6. **Executive Approval Board:** Financial assistance award considerations that fall outside the scope of this policy must be reviewed and approved by AHC CFO of facility rendering services, AHC Vice President of Revenue Management, and AHC VP of Patient Safety/Quality.
  
7. **POLICY REVIEW AND MAINTAINENCE:**
  - 7.1. This policy will be reviewed on a bi-annual basis
  - 7.2. The review team includes Adventist HealthCare entity CFOs and VP of Revenue Management for Adventist HealthCare.
  - 7.3. Updates, edits, and/or additions to this policy must be reviewed and agreed upon, by the review team and then by the governing committee designated by the Board prior to adoption by AHC.
  - 7.4. Updated policies will be communicated and posted as outlined in section 2- Policy Transparency of this document.

#### CONTACT INFORMATION AND ADDITIONAL RESOURCES

Adventist HealthCare Patient Financial Services Department  
820 W Diamond Ave, Suite 500  
Gaithersburg, MD 20878  
(301) 315-3660

# ADVENTIST HEALTH CARE, INC.

## Corporate Policy Manual

### Financial Assistance (Formerly “Charity Care”)

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Effective Date: 01/08

Cross Referenced: Previously: Financial Assistance Policy  
(see AHC 3.19.1 for Decision Rules / Application)

Reviewed: 02/09, 9/19/13, 10/10/17

Revised: 05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13,  
2/01/16, 11/09/17, 08/26/19, 12/20

Policy No: AHC 3.19

Origin: PFS / FC

Authority: EC

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The following information can be found at [Adventist HealthCare’s Public Notice of Financial Assistance & Charity Care](#):

<b>Document Title</b>
AHC Financial Assistance Plain Language Summary - English
AHC Financial Assistance Plain Language Summary - Spanish
AHC Federal Poverty Guidelines
AHC Financial Assistant Application - English
AHC Financial Assistant Application - Spanish
List of Providers not covered under AHC’s Financial Assistance Policy